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Document Lodged:	Annexures
File Number:	ACT 5 of 2021
File Title:	RMSANZ APPLICATION FOR REVIEW OF AUTHORISATION AA1000542 DETERMINATION MADE ON 21 SEPTEMBER 2021
Registry:	VICTORIA – AUSTRALIAN COMPETITION TRIBUNAL

REGISTRAR

Dated: 16/05/2022 3:04 PM

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ANNEXURE A

UTS UNIVERSITY OF TECHNOLOGY SYDNEY

Claiming and Compliance under the Medicare Benefits Schedule: A Critical Examination of Medical Practitioner Experiences, Perceptions, Attitudes and Knowledge

by Margaret Annette Faux

Thesis submitted in fulfilment of the requirements for the degree of

Doctor of Philosophy

under the supervision of Professor Jon Wardle and Professor Jon Adams

University of Technology Sydney
Faculty of Health

July 2021

ANNEXURE A

Certificate of original authorship

I, Margaret Annette Faux declare that this thesis, is submitted in fulfilment of the requirements for the award of Doctor of Philosophy, in the Faculty of Health at the University of Technology Sydney.

This thesis is wholly my own work unless otherwise reference or acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

This document has not been submitted for qualifications at any other academic institution.

This research is supported by the Australian Government Research Training Program.

Margaret Faux

July 2021

Abstract

Medicare is Australia's taxpayer-funded universal health coverage system and the fourth-largest expenditure item in the federal budget. Leakage from Medicare caused by non-compliant medical billing is currently estimated at 5–15% of the scheme's total cost ($1.2–$3.6 billion annually). Despite the absence of evidence, this phenomenon is typically attributed to deliberate abuse by medical practitioners.

This unconscious bias may have its origins in a significant knowledge gap which this research investigates by examining the experiences, perceptions, attitudes, and knowledge of medical practitioners in relation to Medicare billing. The study is the first to examine the phenomenon of non-compliance from a legal, administrative and system perspective. Through a combination of quantitative and qualitative methods and a detailed doctrinal analysis of the regulatory layers of Medicare, a detailed understanding of compliance issues is presented as well as recommendations for reform.

The application of the Medicare Benefits Schedule was comprehensively examined, starting with its constitutional foundations and the Federal Government's overarching responsibility to account for public money. It was apparent that successive governments have continually tinkered with Medicare, often making misguided attempts at policy reform that have made the health payments system a morass of labyrinthine law that has become largely inaccessible and incomprehensible. This has led to rule of law problems, most notably in the areas of natural justice and the principle of legality. The research revealed a dearth of education on Medicare billing, and medical practitioners demonstrated low levels of legal literacy. Further, while legally liable for Medicare billing, medical practitioners were uninterested, preferring to delegate billing to third parties, many of whom may be significant contributors to non-compliance.

The research found that a principal cause of non-compliant Medicare billing in Australia is system issues, rather than deliberate abuse by medical practitioners. Medical practitioners have no choice but to try and comply with a complex system they cannot avoid, do not

understand, and feel powerless to change. Without reform, the government can expect no improvement in leakage, increased litigation and out-of-pocket costs for patients, and continued decreases in private health insurance uptake. Regulatory, educational, and digital reform are required urgently.

Findings from this research can assist policymakers to ensure the efficient delivery of health care services under the Australian Medicare scheme, as well as offering important learnings for other countries as they build the legal infrastructure for the health payment arrangements that will underpin their Universal Health Coverage systems.

Acknowledgments

Eight years of work have drawn to a close and there are many people to thank. Firstly, my supervisors, the two Jons – Professors Jon Wardle and Jon Adams – whose sage advice, humour, support, and guidance throughout this long journey was immeasurable. Medical billing probably wasn't where they imagined their academic careers would take them!

Gratitude also to my academic colleagues in the UTS Faculty of Health for their support throughout my Doctoral research studies and to the wonderful Priya and Jules in the HDR office, both endlessly patient administrators, who were my (and everyone's) 'go to' people to keep on track with administrative requirements throughout this journey.

I would also like to acknowledge and thank Angelica Thompson-Butel and Simran Dahiya, who appreciated the importance of this topic and helped complete the two scientific sections, both as researchers and co-authors. Digital health expert, health informatician and clinical coder, Heather Grain, deserves special mention because without her insights I would not have obtained the clarity I needed about Australian hospital coding, all of the codes, clinical terminologies, and classifications in use around the world, and which code set should be used when and why. Heather also confirmed the accuracy of the ICD, ACHI, and SNOMED codes in Table 17. Thanks also to Lisa McPherson, who bounced reform ideas around with me for years and helped formulate the central health payment post office concept. I also wish to thank consumer law expert and legal colleague Delia Rickard, who let me steal her valuable time to discuss some of the consumer law aspects of this work, Stream Design for their brilliant work on the framework figures, and Harry Bruce, who delivered above the brief with his amazing cartoons, one of which encapsulates this thesis in a single image. My work colleagues live and breathe medical billing, and not only kept me updated on the unending barrage of MBS item number changes they were constantly grappling with, but also listened to ideas, helped with design, and quickly resolved IT issues.

To the many doctors and other professionals who gave of their valuable time to participate in the two scientific phases of this research, I cannot thank you enough. It was a great privilege

to have permission to record and report your actual lived experiences, which ensured this thesis would be robustly populated with evidence and facts. I have endeavoured to honour your stories and insights, and as one participant put it, 'do good' with this work. Our many 'off the record' conversations could fill another thesis.

To the silent army of colleagues who work in this niche space and know the realities on the ground, sincere thanks to those of you who reached out to me during this journey to share details of your actual experiences (such as the hospital versus home chemotherapy example), or ask whether I would be addressing this problem or that problem in my thesis. While the methodology and design of the project ultimately determined the scope and inclusions, I hope I have nonetheless given voice to at least some of your daily struggles navigating the Medicare maze. I know the stories presented here are just the tip of the iceberg.

I also acknowledge and thank professional thesis editor, Campbell Aitken who tightened and polished the text and was invaluable in drawing my attention to areas requiring clarification before submission. His work was performed in accordance with the Institute of Professional Editors' *Guidelines for editing research theses*.

Love and thanks to my adult children Claudette and Josef, who have proudly observed their mother work towards a PhD in her second half century, Joe even helping with searches and formatting here and there. Four-legged Chelsea deserves a mention because she never once left my side during the timespan of this project and had become an arthritic senior citizen by its end. And finally, my deepest love, thanks, and gratitude to my husband Steven, who read and re-read this work over and over, listened patiently, debated respectfully, shared thoughtful insights and helpful suggestions, while never letting the chocolate supplies dwindle. It's fair to say he is looking forward to a break from discussing Medicare 24/7 and is frankly deserving of a doctorate of his own as a #MedicarePhDsurviver!

Publications and Presentations

Publications forming part of this thesis

1. *No payments, copayments and faux payments: are medical practitioners adequately equipped to manage Medicare claiming and compliance?* Margaret Faux, Jonathan Wardle and Jon Adams. Internal Medicine Journal 2015 https://doi.org/10.1111/imj.12665
2. *Educational needs of medical practitioners about medical billing: a scoping review of the literature.* Faux, M., Adams, J. & Wardle, J. Educational needs of medical practitioners about medical billing: a scoping review of the literature. *Hum Resour Health* 19, 84 (2021). https://doi.org/10.1186/s12960-021-00631-x
3. *Who teaches medical billing? A national cross-sectional survey of Australian medical educational stakeholders.* Margaret Faux, Jonathan Wardle, Angelica G Thompson-Butel, Jon Adams. BMJ Open 2018 https://bmjopen.bmj.com/content/8/7/e020712.abstract
4. *Medicare billing, law and practice: complex, incomprehensible and beginning to unravel*. Margaret Faux, Jonathan Wardle and Jon Adams, Journal of Law and Medicine 2019 https://opus.lib.uts.edu.au/handle/10453/136958
5. *Frenetic law making during the COVID-19 pandemic: the impact on doctors, patients and the Medicare system.* Margaret Faux. AUSPUBLAW (24 April 2020) https://auspublaw.org/2020/04/frenetic-law-making-during-the-covid-19-pandemic-the-impact-on-doctors-patients-and-the-medicare-system
6. *Wading through molasses: a qualitative examination of the experiences, perceptions, attitudes and knowledge of Australian medical practitioners regarding medical billing.* Margaret Faux, Jon Adams, Simran Dahiya, Jon Wardle. Published in *PLoS One* in January 2022. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0262211

Presentations arising from this work

1. Australasian Institute of Digital Health, Digital Health Institute Summit, 6 November 2020. Presentation titled: *Integrated and automated billing and coding: How close are we to this health financing system utopia?*
2. The Law Society of New South Wales, Government Solicitors Week 2020, 7 September 2020. Panel member in a session titled: *Law-Making During COVID-19: The Impact on the Medicare System.*
3. Australian Hospitals and Healthcare Association. 10 Year Health Agreement Blueprint Roundtable held on 4 October 2017. Presentation titled: *The Constitutional Framework of the Australian Health System. Reform: What's possible and realistic?*
4. 15th World Congress of Public Health, 2017, Melbourne. Two separate presentations.
    1) *Educate or incarcerate? An Australian case study of a global problem,* and
    2) *Medicare and the Chamber of Secrets. Analyzing the legal and administrative complexities of Australian medical billing under Medicare*

Industry contributions associated with this thesis

1. *Medicare365: Punting on Compliance.* Written by Margaret Faux. Published in the Medical Republic on 2 November 2021 and available at this link: https://medicalrepublic.com.au/medicare365-punting-on-compliance/57177
2. *When it comes to billing, doctors eat their young.* Written by Margaret Faux. Published in the Medical Republic on 20 October 2021 and available at this link: https://medicalrepublic.com.au/when-it-comes-to-billing-doctors-eat-their-young/56178
3. *Medical billing is full of reasonable doubts.* Written by Margaret Faux. Published in the Medical Republic on 5 October 2021 and available at this link: https://medicalrepublic.com.au/medical-billing-is-full-of-reasonable-doubts/
4. *Medicare: how it started, how it's going.* Written by Margaret Faux. Published in the Medical Republic on 21 September 2021 and available at this link: https://medicalrepublic.com.au/medicare-how-it-started-how-its-going/54258

5. *Why I did a PhD on Medicare claiming and compliance.* Written by Margaret Faux. Published in the Medical Republic on 7 September 2021 and available at this link: https://medicalrepublic.com.au/why-i-did-a-phd-on-medicare-claiming-and-compliance/52891
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11. *Opinion: telehealth is not quite the colt from old Regret but it sure as hell has got away.* Written by Margaret Faux and Heather Grain. Published in Pulse+IT Magazine on 18 May 2020 and available at this link: https://www.pulseitmagazine.com.au/australian-

ehealth/5509-opinion-telehealth-is-not-quite-the-colt-from-old-regret-but-it-sure-as-hell-has-got-away

12. *Hunt for the Man from SNOMED River* Written by Kate McDonald. Published in Pulse+IT Magazine on 22 May 2020 referencing the above opinion article and available at this link: https://www.pulseitmagazine.com.au/blog/5518-hunt-for-the-man-from-snomed-river
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41. *Let us break it down for you: How changes to Medicare could mean your pap smear costs more.* Written by Sarah-Jane Collins who sought opinion from and quoted Margaret Faux. Published in MamaMia on 21 January 2016 and available at this link: https://www.mamamia.com.au/pap-smears-medicare

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59. *Claiming on Consumables* Written by Margaret Faux. Published in The Private Practice Magazine on 9 December 2012 and available at this link: https://synapsemedical.com.au/news/2012/12/09/claiming-on-consumables-the-private-practice-magazine/
60. *Noteworthy* Written by Margaret Faux. Published in The Private Practice Magazine on 24 September 2012 and available at this link: https://synapsemedical.com.au/news/2012/09/24/note-worthy-the-private-practice-magazine/
61. *The cheque's in the mail: managing arrears and bad debt in private practice* Written by Margaret Faux. Published in The Private Practice Magazine on 24 September 2012 and available at this link: https://synapsemedical.com.au/news/2012/08/31/the-cheques-in-the-mail-managing-arrears-and-bad-debt-in-private-practice/
62. *Claiming Control* Written by Margaret Faux. Published in The Private Practice Magazine on 22 June 2012 and available at this link: https://synapsemedical.com.au/news/2012/06/22/claiming-control-the-private-practice-magazine/
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65. *Too Much Information* Written by Margaret Faux. Published in The Private Practice Magazine on 6 September 2011 and available at this link: https://synapsemedical.com.au/news/2011/09/06/too-much-information/
66. *Mind the gap, Medical Billing* Written by Margaret Faux. Published in The Private Practice Magazine on 6 September 2011 and available at this link: https://synapsemedical.com.au/news/2011/09/06/mind-the-gap-medical-billing-the-private-practice-magazine/
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Statement from co-authors for jointly authored works forming part of this thesis

1. The co-authors of the paper ***No payments, copayments and faux payments: are medical practitioners adequately equipped to manage Medicare claiming and compliance?*** located in chapter 1, confirm that Margaret Faux made the following contribution:
    - Conception and design of the research
    - Analysis and interpretation of the findings
    - Writing of the manuscript and critical appraisal of the content

2. The co-authors of the paper ***Educational needs of medical practitioners about medical billing: a scoping review of the literature***, located in chapter 2, confirm that Margaret Faux made the following contribution:
    - Conception and design of the research
    - Conducted the searches and collected the data
    - Analysis and interpretation of the findings
    - Writing of the manuscript and critical appraisal of the content

3. The co-authors of the paper ***Medicare billing, law and practice: complex, incomprehensible and beginning to unravel*****,** located in chapter 4, confirm that Margaret Faux made the following contribution:
    - Conception and design of the research
    - Analysis and interpretation of the findings
    - Writing of the manuscript and critical appraisal of the content

4. The co-authors of the paper ***Who teaches medical billing? A national cross-sectional survey of Australian medical educational stakeholders*****,** located in chapter 5, confirm that Margaret Faux made the following contribution:
    - Conception and design of the research
    - Participated in collecting the data
    - Analysis and interpretation of the findings

- Writing of the manuscript and critical appraisal of the content

5. The co-authors of the paper ***Wading through molasses: a qualitative examination of the experiences, perceptions, attitudes and knowledge of Australian medical practitioners regarding medical billing,*** located in chapter 6, confirm that Margaret Faux made the following contribution:
    - Conception and design of the research
    - Collected the data
    - Analysis and interpretation of the findings
    - Writing of the manuscript and critical appraisal of the content

In addition to the statements above, Margaret Faux was the first author who led the development of all of the above works, and the corresponding author on all publications.

Signed: 

Candidate

Date: 6 July 2021

As supervisor for the candidature upon which this thesis is based, I can confirm that the authorship attribution statements above are correct.

Signed: 

Principal Supervisor

Date: 6 July 2021

Abbreviations and Acronyms

ABF	Activity-Based Funding
ACSQHC	Australian Commission on Safety and Quality in Health Care
ACCC	Australian Competition and Consumer Commission
ACHI	Australian Classification of Health Interventions
ACL	Australian Consumer Law (*Competition and Consumer Act (Cwth) 2010)*
ADHA	Australian Digital Health Agency
AHPRA	Australian Health Practitioner Regulation Agency
ALJ	Administrative Law Judge
ALRC	Australian Law Reform Commission
AMA	Australian Medical Association
ANAO	Australian National Audit Office
ART	Assisted Reproductive Technology
ATO	Australian Taxation Office
BMA	British Medical Association
BRD	Beyond a Reasonable Doubt (the criminal law burden of proof)
CCAM	Classification Commune des Actes Médicaux (French medical billing codes)
CCC	Civil Conscription Caveat
CMS	Centre for Medicare and Medicaid Services
CPD	Continuing professional development
CPT	Current Procedural Terminology (U.S billing codes used for outpatients)
CTP	Compulsory Third Party (Insurance)
DIMSR	Diagnostic Imaging Multiple Service Rules
DOH	Department of Health
DPP	Department of Public Prosecutions
DVA	Department of Veterans Affairs
ECG	Electrocardiogram
ECLIPSE	Electronic Claim Lodgement and Information Processing Service Environment
ED	Emergency Department

ENT	Ear, Nose and Throat
FFS	Fee-For-Service
FTE	Full Time Equivalent (referring to salaried employees)
GDLP	Graduate Diploma of Legal Practice
GP	General Practitioner/s
HCPCS	The Healthcare Common Procedure Coding System (more U.S billing codes)
HFLP	Health Financing Law and Practice
HIA	*Health Insurance Act (Cwth) 1973*
HIC	Health Insurance Commission
HIMAA	Health Information Management Association of Australia
HIPPO	Health Industry Payment Post Office
HITH	Hospital in the Home
HHBG	Honeysuckle Health Buying Group
HST	Hospital Substitute Treatment
ICD	International Classification of Disease Codes
IFC	Informed Financial Consent
IHPA	Independent Hospitals Pricing Authority
JCPAA	Joint Committee of Public Accounts and Audit
MBAC	Medicare Benefits Advisory Committee
MBS	Medicare Benefits Schedule
MBSRT	MBS Review Taskforce
MDO	Medical Defence Organisation/s
MP	Medical Practitioner/s
MPPA	Medical Purchaser Provider Agreement
MRCA	*Military Rehabilitation and Compensation Act (Cwth) 2004*
MSAC	Medicare Services Advisory Committee
MSCI	Medical Services Committees of Inquiry
NCA	National Commission of Audit
NHRA	National Health Reform Agreement
NSW	New South Wales

OECD	The Organisation for Economic Co-operation and Development
OHIP	Ontario Health Insurance Plan (Canadian medical billing codes)
OOP	Out-of-Pocket (medical expense/s)
OPD	Outpatient Department/s
PBA	*Pharmaceutical Benefits Act 1944*
PBS	Pharmaceutical Benefits Scheme
PGPA	*Public Governance, Performance and Accountability Act (Cwth) 2013*
PHI	Private Health Insur/er/ers/ance
PSR	Professional Services Review Agency
PUR	Person Under Review
RACGP	Royal Australian College of General Practitioners
RACP	Royal Australasian College of Physicians
RMBA	Registered Medical Billing Agent/s
RN	Registered Nurse
ROPP	Right of Private Practice
RVG	Relative Value Guide
SIRA	State Insurance Regulatory Authority (NSW)
SMO	Salaried Medical Officer/s
SNOMED-CT	Systematized Nomenclature of Medicine Clinical Terms
SSCSDL	Senate Standing Committee for the Scrutiny of Delegated Legislation
UHC	Universal Health Coverage
UN	United Nations
VBC	Value-Based Care
VEA	*Veterans Entitlements Act (Cwth) 1986*
VMO	Visiting Medical Officer
VR	Vocationally Registered (referring to GPs with specialist qualifications)
WC	Workers Compensation
WHO	World Health Organization

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Dedication

"Walking on Eyre"

This PhD is dedicated to geologist, pioneer, educator, and writer Terry Krieg,
who was only satisfied once he had looked under every rock, and inspired in me the same spirit of exploration.

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Preface

On 16 January 2012, the *Medical Journal of Australia* published an opinion piece by the former Director of the Medicare watchdog, the Professional Services Review Agency, titled '***What is wrong with Medicare?***' (Webber 2012) The article alleged doctors rorting Medicare was costing taxpayers $2–3 billion per annum. It attracted intense media coverage and was the catalyst for what became this, my PhD.

For many years, I had perceived there was a growing problem with Medicare that no one was talking about, which was the antithesis of rorting and more complex and nuanced than the media could understand. I had been administering Australian medical billing since Medicare began, had worked in the system as a registered nurse, and by 2012 had had one too many conversations seeking clarity on some important aspect of Medicare billing that no one could answer, including Medicare.

Medicare is a system of laws. If as a lawyer, I was finding it difficult to navigate and understand, how on earth were doctors meant to manage? Yet everyone seemed to believe the problem of Medicare leakage lay squarely at the feet of dishonest doctors. It was beginning to feel like a rusted-on Medicare version of *The Emperor's New Clothes*, with collective denial about the facts in front of us. So, I embarked on a journey to find out whether doctors were really all out there deliberately rorting Medicare, or whether something else was going on.

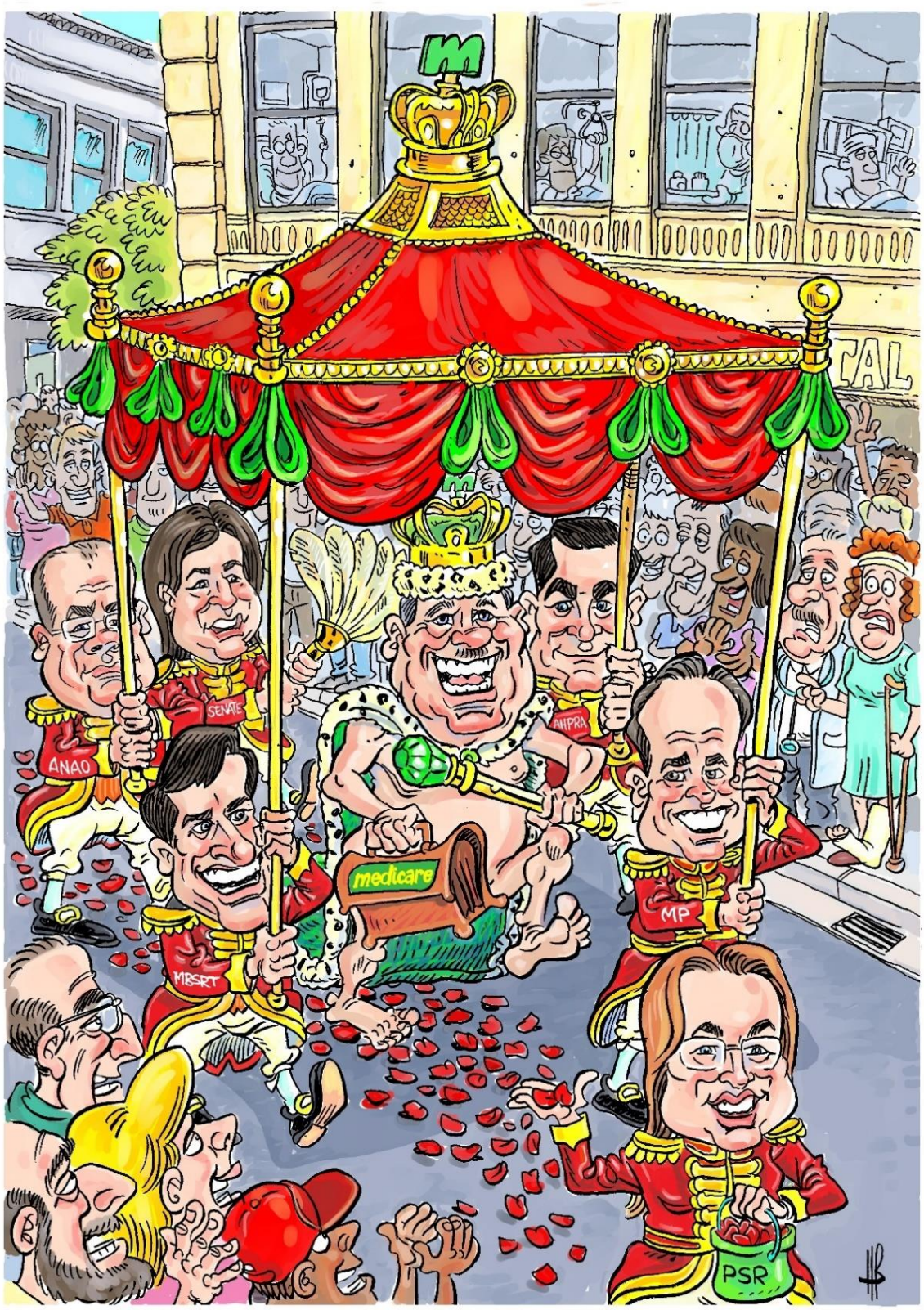
I administer health financing transactions, in many countries, for a living. I therefore occupy a unique position of not having to imagine what might go wrong if the regulatory structure of a health payment system becomes byzantine. Consequently, *all* examples in this thesis are real, having been drawn from actual cases, but anonymised to protect the innocent. Therefore, where I have suggested something *may* happen, it *has* happened during my lived experiences of processing Australian medical bills for over 30 years.

I hope policymakers will therefore read the detail in this work, because it may assist them to completely rethink Medicare compliance and understand that Australian doctors actually want to comply.

Medicare is loved by Australians, and I believe it is a masterpiece worth preserving.

CHAPTER 1: Introduction

Figure 1 - What is wrong with Medicare?



1.1 Introduction to the problem and thesis overview

The creation of a simple medical bill

The typical process through which a medical bill is generated in much of the world goes something like this: A patient makes an appointment to see a medical practitioner (MP). On arrival at the MP's office, the patient checks in at a reception desk and is asked to sit and wait until the MP is ready. The patient is subsequently called in to the MP's consulting room, where a clinical encounter between the MP and patient takes place. At the completion of the encounter, the patient returns to the reception desk and settles the bill with the reception staff before leaving. In Australia, the financial aspects of this typical medical appointment have become a mostly automated, tap-and-go affair, which most consumers would view as simple. If hospital treatment is required, medical bills can mount up and become harder to understand, but for the moment, let us pause and consider this common scenario.

It is easy to see why patients may perceive this transaction as simple. In Australia, at the reception desk, patients may be required to hand their Medicare card and possibly a credit card to the receptionist (though neither may be required if the patient's details are already held on file), and may need to enter a pin number or sign a slip of paper before leaving. In many ways the transaction would feel no different to tapping a credit card while making an over-the-counter purchase at a shop. But what is fundamentally and crucially different is that a tap-and-go shopping transaction usually involves the patient (or consumer in that context) spending their own money, whereas when they tap their Medicare card, they are spending someone else's money and the payer is not present. In the world of banking and finance, this type of transaction is described as a high risk 'card not present' transaction which attracts higher fees and charges to mitigate the increased risk of fraud (Australian Payments Network 2017). In health financing systems such as Australia's Medicare, *every* transaction is high risk because the payer, which may be a government or private insurer, is never present at the point of service when the money for which they are responsible is being spent, and patients

would not know if they had just tapped or signed approval for a service that had not been provided.

Who processes medical bills?

In addition to the inherent risks in medical billing transactions, the other obvious but often overlooked feature of this common billing scenario is that MP do not administer medical bills. It is not the MP who bills, but almost always the receptionist or another administrative person. In Australia, as this thesis will demonstrate, the MP will usually allocate a billing code or codes to the receptionist, but will have nothing further to do with the transaction other than being the recipient of the resulting payment. It is the receptionist who presses the buttons, fills in the forms and who is responsible for ensuring payment is received. Indeed, managing daily medical billing is a task within the remit of every medical receptionist (Australian Association of Practice Managers 2021) not just in Australia, but globally. Their work includes following-up part-paid or rejected claims, which may include sending emails, letters and making phone calls to discuss problematic claims with payers. Through this process, medical receptionists increase their knowledge and expertise around the operation of the schemes they administer.

Despite the fact that Australian MP appear to have very little practical experience or knowledge of what happens beneath the surface of a medical bill, they are regularly accused of rorting Medicare (Doran 2015; Evans 2018; Smith 2007; Sunrise TV 2018). This suggests a pervasive belief that MP in fact have deep knowledge of how Medicare works, because implicit in the concept of rorting is wilful conduct, or some level of reckless indifference to applicable rules. However, given it is receptionists who appear to have higher levels of expertise and practical experience actually processing medical bills than MP, a question arises concerning what level of knowledge MP actually have and where they obtained it if they have never administered medical bills.

How can something seemingly so simple, be so complex?

It is sometimes thought that medical billing and the operation of Medicare is relatively easy to understand, and MP can therefore learn relevant requirements on the job. The perception is that 'driving' Medicare is like driving a car, where all that is required is that the person behind the wheel of the car knows how to drive and the road rules. It is not necessary to know how a car engine works. However, road rules tend to be clear – stop at a red light, give way to the right, indicate when turning a corner. Imagine how the flow of traffic would be affected if the rules said – stop at a red light not being a light that appears orange, give way to the right except when approaching from the left, and indicate when turning a corner but only if you are over 75 or a concession card holder and attend up to a maximum of 10 corners during any single driving episode. These analogous examples are unfortunately *not* exaggerations of the types of nonsensical and confusing descriptions found throughout the Medicare scheme, which MP are required to interpret. The correspondence in **Appendix 1** provides a clear example of this type of incoherence, which can lead to serious penalties including criminal sanctions being imposed against MP if they bill incorrectly.

Australia spends approximately 10% of its Gross Domestic Product on health (Australian Institute of Health and Welfare 2020), a sector which unquestionably affects the lives of every citizen. Parallels with other similar sectors affecting the lives of all Australians such as banking and finance therefore sit well and can assist us to understand how outwardly simple transactions can be inwardly complex. Australia's recent Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (Hayne 2019b), shone a light into the darkest corners of the banking and finance sector, and demonstrated how common transactions can be profoundly complex and disturbingly secret beneath the surface. One example was banks charging fees for no service, which was invisible to consumers (Hayne 2019b). Similarly, this research will show that incomprehensible legal requirements effectively enable and even sometimes encourage MP to make claims against the Medicare scheme when they have provided no service.

Another sector where relevant parallels can be found is the Australian business sector. For if it can be shown that MP understand how to bill correctly, and are deliberately choosing not to, that would suggest the current punitive approaches to compliance are not working, or are too weak and need to be strengthened. On the other hand, if MP are genuinely billing with best intentions to comply but are ignorant of the rules or the rules have become incomprehensible or unable to be found, perhaps over time, we have unknowingly descended into deeper, more difficult to solve rule of law problems, like Australia's business laws. Recent commentary (Butler 2021) has highlighted the incomprehensibility of the *Corporations Act 2001 (Cwth)* (Australian Government 2001) and the rule of law problems flowing from that issue, which are now the subject of a law reform process expected to take ten years. A Federal Court Judge has commented on this problem as follows:

"I think the overarching problems, or the high-level problems, that have been identified thus far is that it's overly complex, that you can't find all the law in one place, because there's layer upon layer of primary legislation, regulation, orders and the like,"

"So it's very difficult to navigate your way through the actual obligations that are owed by people. And this creates a rule of law problem, because people actually cannot find the law that applies to them." (Butler 2021)

This research will show that the law of Medicare billing is also shrouded in layer upon layer of legislation, regulations, rules, determinations, and other legal instruments, which are creating rule of law problems similar to those affecting Australian businesses.

What is the size of the medical billing non-compliance problem?

The incidence of non-compliant medical billing has been estimated at 5-15% per annum ($1.2 - $3.6 billion) (Webber 2012). Being a taxpayer funded scheme, management of Medicare billing compliance very clearly and constitutionally sits within the remit of the federal government. It is therefore somewhat curious that the government recently handed reform of the entire medical billing system to MP (Department of Health 2017). This decision

appeared to have been based on a government assertion that the project involved clinical rather than system reform. However, Medicare is a system of laws in which each of the approximately 6000 available Medicare services is a regulation. It was therefore impossible for the project *not* to involve law reform, which MP did not have the skills or qualifications for. That said, there was of course some justification for MP being involved in reform of Australia's medical billing system, because the law deems MP responsible for every Medicare bill they submit for payment (Australian Government 1973a). The law therefore assumes MP know how to bill correctly, which in turn presupposes relevant education is provided to enable this knowledge acquisition. Whether any such education is available or has ever been provided is a key area of exploration in this thesis.

It is also necessary to position this study within the current climate of Australian consumers paying some of the highest out of pocket medical costs in the world (Organization for Economic Cooperation and Develpoment 2017), while an increasing number of MP are fighting court battles against the government describing the Medicare policing system as unfair and like 'robodebt' (Doran 2020). Media reports around these cases have begun to appear somewhat supportive of the aggrieved MP rather than the government (Hartley 2021), suggesting a tectonic shift may be taking place. The media appear to be listening to the 'other side' of this decades long debate about whether non-compliance is primarily caused by the system itself, or by deliberate misconduct of MP. At the same time, the Australian National Audit Office conservatively estimates that over $300 million in annual Medicare billing in public hospitals is non-compliant (Australian Auditor-General 2019). Reconciling these polar opposite positions and opinions is at the heart of this work.

Thesis structure

This PhD is the first Australian research to dive deep into the morass of regulatory layers beneath the surface of Medicare and focus attention on the legal and administrative operation of the Medicare billing system.

Being a PhD by compilation, multiple published works form part of the narrative journey, and where such articles are inserted, they are introduced and contextualised, as well as some having a post-script when there have been recent relevant developments. While the thesis generally follows the standard format of introduction, literature review, methods and then scientific chapters, the novel nature of the topic, which traverses the domains of health law, administrative law, health economics and health policy, necessitated a tailored approach which is detailed in chapter three. The research includes a quantitative survey of medical education stakeholders, qualitative interviews with MP, and a detailed doctrinal and policy analysis of the regulatory layers in Medicare's underbelly, which led to the rule of law problems just mentioned. The discussion chapter journeys deep into a labyrinthine, regulatory maze and highlights common areas identified by research participants, where application of the law in practice may be challenging, or even sometimes impossible, and where correct application of the rule of law may be absent for MP, with flow on effects to Australian citizens who pay for the Medicare system through their taxes.

In the context of this thesis, it is important to understand what Medicare is *not*, so as to avoid confusion about expertise in the area of medical billing compliance. Medicare is not a medical system of human anatomy and pathology requiring diagnosis and treatment. It is also not a system of health economics, and whilst the input of both MP and health economists is critical when reforming health, the system itself is neither medicine nor economics, it is law. MP are required to comply with provisions of the enabling legislation that moves the money through the health system, not the economic or clinical policy objectives informing that legislation. Fiscal accountability and compliance therefore require extensive knowledge and understanding below the superficial layers of the scheme, inside the regulations and

machinery provisions that make Medicare tick. In the same way the medical profession explores human anatomy and physiology at the molecular level to better understand and treat disease, a similarly deep examination of Medicare's underlying legal structure is the key to understanding why medical billing compliance has become such an intractable problem, and little improvement or progress has been made over the last 40 years.

What this thesis does not cover

Some areas of the health system are *not* the focus of this work. The Pharmaceutical Benefits Scheme (PBS), though an integral part of health service delivery, is not the focus of this project, nor is the broader question of how we pay for health and who should pay for health. However, in view of a finding there is a high likelihood that Medicare's fee-for-service (FFS) payment model will endure, the introduction chapter has been contextualised within the perennial global search for a perfect health system, in which FFS payments remain common.

Changes to increasingly sophisticated corporate structures around health service delivery have not been extensively studied in this thesis. However, it is not possible to examine medical billing compliance without touching upon the role of corporate stakeholders. Consequently, where corporate entities are mentioned, the focus is not on the corporate structure itself, but rather, the compliance impacts.

Another area of billing irregularity not comprehensively covered is potential incentive payments, sometimes referred to as 'kickbacks' which may exist in the medical billing market. However, one very clear example of a such a scheme is described in one of the legal case reviews in chapter two and solutions to prevent a repeat of that particular problem are presented in the recommendations chapter.

The question of whether Australians have benefitted from blended public/private payment arrangements and the rise of the private health insurance (PHI) market is also not asked or

answered in this study. A national conversation about whether there is an ongoing role for PHI is required to address current disquiet in this area.

Use of common terms

The terms 'Medicare billing' and 'medical billing' will be used synonymously, because in Australia *all* medical billing, including workers compensation and other third party payment schemes, connect with Australia's core Medicare Benefits Schedule (MBS) billing codes, either directly or indirectly. Further, Australian medical receptionists and medical billing administrators are required to process all types of medical bills every day. Receptionists in busy medical practices will typically process a variety of different billing types daily including Medicare bills, bills to the Department of Veteran's Affairs, as well as bills for patients covered under workers compensation and other compulsory third party schemes (Commonwealth Government 2013). In addition, medical receptionists processing bills for specialists practicing hospital based medicine, such as surgeons, anaesthetists, and many others, will typically administer the majority of bills through the private health insurers (PHI), who in turn, draw a portion of each payment from the Medicare funding pool (Australian Prudential Regulation Authority 2021). Medical billing compliance obligations of MP therefore span a wide spectrum of payers, including the PHI, which are inextricably linked to Medicare billing itemisation via legislation (Australian Government 2007). This research therefore seeks to unpack and examine compliance across the whole spectrum of Australia's medical billing eco-system, as it affects all MP, in all practice settings.

While 'Medicare billing' and 'medical billing' will continue to be used interchangeably, the word 'Medicare' requires separate identification as a brand name, just like 'Coca-Cola' or 'Facebook'. Medicare is the brand name of Australia's taxpayer-funded universal health coverage (UHC) system, administered by the Federal Government. The Medicare brand delivers healthcare services to eligible Australians in accordance with a vast, complex statutory scheme. The terms 'bill' and 'claim' will also be used synonymously because a bill generates a claim as a single continuum.

In view of the fact this thesis examines Medicare compliance through a legal lens, it is important to be clear that when the term 'fraud' is used, it is used in the strict legal sense. In the area of non-compliant medical billing, the term 'fraud' is often used for rhetorical effect to describe *every* type of incorrect bill including unintentional errors such as entering the wrong date of service or misunderstanding referral requirements (Australian Associated Press 2016). However, there is only one legal meaning of fraud. It is a serious criminal offence, which carries with it the criminal burden of proof, beyond a reasonable doubt (BRD). In order to meet the law's highest evidentiary burden, BRD, the prosecution must prove two elements – the *actus reus*, or criminal act, and the *mens rea*, or criminal mind.

It is the second element of the offence that typically confounds fraud investigations around medical bills, because it is difficult to prove the criminal mind of an MP who bills incorrectly, particularly given the evidence (which will be presented in this research) clearly demonstrates MP have never been taught how Medicare works or how to bill correctly at any point in their careers, and the so called 'rules' of medical billing are highly interpretive and deeply opaque.

Conclusion

Solving a problem as complex as health system leakage caused by non-compliant medical billing cannot begin until a detailed understanding of the root causes of the problem are identified. This necessitates obtaining deep insights into the lived experiences of MP when they process medical bills, as well as building an awareness of their perceptions, attitudes, and knowledge of how the Medicare system works, and then examining the system itself to contextualise that information.

The government can never hope to solve this problem until it listens and genuinely hears the challenges that MP have (for at least a decade) been saying they face when administering medical bills (Senate Committee 2011). This will require moving beyond binary, superficial, blame-based arguments, and taking responsibility for the many policy failures and administrative shortcomings described in this work.

Doing nothing about this problem is no longer an option. Australia cannot afford *not* to solve the problem of non-compliant medical billing, a phenomenon that has been described globally as 'the last great unreduced healthcare cost.' (World Health Organization 2010).

1.2 Medicare and the Australian Constitution

To understand Australian medical billing, it is necessary to begin with an examination of the constitutional foundations upon which the entire Medicare system was built.

Medicare was constructed on two constitutional pillars, Section 51(xxiiiA) and Section 96, both of which are discretionary powers in the Australian Constitution. The government is not obligated to use either provision as the basis for Australia's health system. Indeed, prior to 1975, neither provision supported Australia's voluntary, private health insurance arrangements. However, while constructing Australia's first Universal Health Coverage (UHC) system, Medibank (later Medicare) the federal government chose s 51(xxiiiA) and s 96 as the two pillars on which to build the scheme (Scotton and MacDonald 1993). This structure endures today.

Section 51(xxiiiA) grants the Commonwealth Government power to make laws for medical, dental and other social services in the following terms:

"The provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription), benefits to students and family allowances;" (Commonwealth Government 2012)

Section 51(xxiiiA) is the foundation upon which FFS reimbursements for private services rendered by MP under the Medicare scheme rest, enabled by the *Health Insurance Act 1973 (Cwth)*. The practical effect of the bracketed text in s 51(xxiiiA) which is known as the 'civil conscription caveat' (CCC) is that it prevents the Commonwealth Government from socialising medicine, such as by forcing MP into employed public service, and more broadly, prevents the Commonwealth Government from controlling MP fees (Faux, Wardle, and Adams 2019).

The MP fee control barrier is clearly articulated in the opening section of the Commonwealth Government's Medicare Benefits Schedule (MBS) book, which states:

'Medical practitioners are free to set their fees for their professional service.' (MBS Online 2020b)

In 2014, during a parliamentary debate concerning an ultimately unsuccessful Medicare co-payment initiative, then Australian Prime Minister, the Honourable Tony Abbott MP, reiterated the same position regarding the right of MP to set their fees as they wish when he said:

"As the member who asked the question would well know, in the end what people are charged is a matter for the doctors. That is a matter for the doctors." (Commonwealth Hansard 2014)

During the 1960's and early 1970's when Medibank was being developed, earlier interpretations of the CCC by the High Court would limit the options available to then future Prime Minister, the Honourable Gough Whitlam MP, when constructing a system of equitable and accessible health coverage for all Australians, including by subsidising private MP services. Faced with this constitutionally complex problem, Whitlam turned his focus to hospital-based care initially, and found a solution through s 96, which enables the Commonwealth Government to make specific-purpose grants to the States to administer public hospitals. These arrangements continue to be enabled by agreements between the federal and state and territory governments, the latest iteration of which is the *National Health Reform Agreement 2020-2025* (Commonwealth Government 2020). In the following passage from the 1961 Curtin Memorial Lecture, Whitlam, articulated his reasons for using s 96 as follows.

"The least defensible decisions of the High Court have been in the two pharmaceutical benefits cases. In the second case in 1949 such a fantastic interpretation was given to the ban in the Constitution on civil conscription in the provision of medical and dental services that a national health service on the New Zealand or British models is ruled out. A referendum 'to authorise

any form of civil conscription' would be the least meritorious and profitable to be imagined...While the constitutional positions precludes the socialisation of doctors, it permits the socialisation of hospitals. The Commonwealth could itself provide hospitals and clinics but would usually be duplicating existing facilities by doing so. It is clear that the proper approach in the Australian context is for the Commonwealth to make additional grants to the States on condition that they regionalise their hospital services and establish salaried and sessional medical and ancillary staffs in hospitals. Such measures would attack costs where they are greatest both for the individual and for the community. The greatest hardship to a breadwinner is brought about when he or a dependent is admitted to hospital. It is in hospitals that medical care is most expensive for the community." (Whitlam. G 1961)

The two pharmaceutical benefits cases referred to by Whitlam took place in 1945 and 1949, before and after a successful referendum.

In 1944, the *Pharmaceutical Benefits Act 1944 (Cwth)* (PBA) enabled the Federal Government to use appropriated reserves to impose certain prescribing conditions on both MP and chemists, the latter of whom were required to provide certain medications to Australians for free. Opposition to these arrangements was voiced by the British Medical Association (BMA) representing Australian MP (the AMA was incorporated in 1962), whose profit-sharing arrangements with chemists would be eroded should the scheme succeed. In a case brought by the Victorian Government against the Commonwealth, the High Court ruled that the Commonwealth did not have constitutional power to make laws for the provision of pharmaceutical benefits, which rendered the PBA unconstitutional ("Attorney-General (Vic); Ex rel Dale v Commonwealth ("Pharmaceutical Benefits case") [1945] HCA 30").

The Commonwealth based its defence on Section 81 of the Constitution, which provides for the appropriation of money, arguing the money appropriated from taxpayers could be used for purposes including pharmaceutical benefits, or in the alternative, that the incidental power conferred by Section 51(xxxix) validated the Statute ("Attorney-General (Vic); Ex rel Dale v

Commonwealth ("Pharmaceutical Benefits case") [1945] HCA 30"). Neither argument was successful, the court finding the PBA invalid, and it was subsequently repealed.

These events occurred during a time of immense social upheaval, when the Australian nation was rebuilding after WWII, a factor which undoubtedly contributed to the BMA's success being short-lived. On 28 Sept 1946 the nation held one of its most successful referendums in history (Australian Electoral Commission 2020), when post-war Australians made it clear they wanted secure social welfare arrangements and their pharmaceutical benefits back.

The case put to the people arguing in favour of what became Section 51(xxiiiA) of the Constitution was cited in a later High Court case which stated:

"… doctors and dentists cannot be forced to become professional officers of the Commonwealth under a scheme of medical and dental services." ("Wong v Commonwealth of Australia [2009] HCA 3": 45)

"The idea that doctors and dentists might be conscripted was the only real objection of the Opposition parties in Parliament. The Government has set that doubt at rest by agreeing to the insertion of a clause in the power itself that there shall be no conscription." ("Wong v Commonwealth of Australia [2009] HCA 3": 46)

Following the referendum, the PBA was redrafted and re-enacted, but tensions between the BMA and the Commonwealth persisted. Section 7A of the revised PBA directed that prescriptions be written on government-issued prescription pads, and a breach of this requirement resulted in a monetary penalty. Opposing this clause on the basis it practically compelled doctors to use government prescription pads in breach of the new s 51(xxiiiA), the BMA, this time acting in its own right, brought another action before the High Court succeeding on this point of law, but not overall ("British Medical Association v Commonwealth [1949] HCA 44").

The High Court held that s 7A did offend the new CCC and was therefore invalid, but the PBA as a whole was within the new powers conferred on the Commonwealth under s 51(xxiiiA). Section 7A of the PBA was subsequently repealed, but the remainder of the statute was declared valid and remains in force today.

In deliberations concerning what types of restrictions may offend the CCC, practical compulsion was discussed at length, with Webb J stating:

"To require a person to do something which he may lawfully decline to do but only at the sacrifice of the whole or a substantial part of the means of his livelihood would, I think, be to subject him to practical compulsion amounting to conscription in the case of services required by Parliament to be rendered to the people. If Parliament cannot lawfully do this directly by legal means it cannot lawfully do it indirectly by creating a situation, as distinct from merely taking advantage of one, in which the individual is left no real choice but compliance." ("British Medical Association v Commonwealth [1949] HCA 44")

Dixon J, in dissent, expressed a view that services such as writing prescriptions were not part of a professional service, but were instead ancillary to it, and could therefore not constitute civil conscription.

The last 70 years have seen a gradual shift in High Court interpretation of constitutional provisions towards expanded federal power, and the Dixon opinion regarding matters ancillary to a professional service, may now be considered current law reflected in the majority view of the High Court in the case of *Wong* ("Wong v Commonwealth of Australia [2009] HCA 3"). *Wong* was concerned with the operation of the Professional Services Review Agency (PSR), an important component of this research.

Wong confirmed that both legal and practical compulsion may offend the CCC, but held that the operation of the PSR did not in-and-of-itself compel any MP to treat any patient. Instead, the PSR imposed certain conditions on participation in the Medicare scheme which were

effectively ancillary to the provision of the professional service itself. *Wong* therefore provided clarity around the fact that ancillary matters *would not* offend the CCC, but the case did not provide certainty about *what would* offend it, other than that it must be something not ancillary.

In obiter remarks, Kirby J articulated areas of focus for the Court when determining whether a law may offend the CCC in the future as follows:

> *"1. Whether by its details and burdens, the regulation intrudes impermissibly into the private consensual arrangements between [doctors and patients].*
> *2. Practical compulsion is sufficient.*
> *3. Pretending to be a law to uphold the lawfulness and integrity of financial expenditures but which, instead, was properly to be characterised as one intruding into the individual relationship between [doctors and patients].*
> *4. Intrusive and coercive requirements and restrictions disproportionate to any legitimate federal interest, financial or otherwise.*
> *5. Blanket rules affecting the individual relationship between [doctors and patients], whether for reasons of cost minimisation or for the achievement of particular administrative outcomes in terms of medical or dental practice.*
> *6. Most obviously, any such disturbance would happen in the unlikely event of an attempt by the Parliament to revive the nationalisation of the healthcare professions or to force their members into full-time or part-time work for the federal government or its agencies."*
> ("Wong v Commonwealth of Australia [2009] HCA 3": 149)

Kirby J also characterised the CCC as a rare constitutional guarantee because it protects both MP and patients equally, by cocooning their relationship inside general principles of contract law. He stated:

"However, the prohibition on "any form of civil conscription" is designed to protect patients from having the supply of "medical and dental services", otherwise than by private contract,

forced upon them without their consent." ("Wong v Commonwealth of Australia [2009] HCA 3": 127)

"A rare constitutional guarantee: Because of its character as a guarantee or protection, both for the healthcare professionals identified and for the patients affected by the provision of their services, the exclusion of any form of "civil conscription" must be seen as one of the rare instances of an individual guarantee and protection spelt out in the Australian Constitution." ("Wong v Commonwealth of Australia [2009] HCA 3": 128)

Despite the obvious challenges presented by the CCC in the area of MP fee control, the Whitlam government successfully introduced UHC for all Australians on 1 July 1975. FFS payments were not the preferred model (Scotton and MacDonald 1993), but were the only viable solution in the circumstances, able to be cleverly designed to circumvent the CCC to serve the needs of patients. The original design of the scheme is described in more detail in various sections of this thesis, but it should be noted that the mere fact that Medicare's unchanged, basic legal structure, has continued to successfully deliver excellent healthcare to all Australians for 45 years is in no small part due to the system having been built on these two strong constitutional pillars.

However, the CCC undeniably exerts a powerful central force that stifles reform efforts in the Australian health sector today. One obvious example is the current out-of-pocket (OOP) medical fee crisis (Doggett 2018), which is rooted in the CCC. Australian MP effectively enjoy constitutionally sanctioned, uncapped access to public money, with no limits on the fees they charge for their services. In no other country do MP control the key health system lever determining rates and rebates right across the health sector to the same extent as Australian MP. When MP slowly ratchet up their fees, the government and private payers have few options other than to increase the rebates they offer to dampen and offset the effect of rising OOP medical expenses. Overseeing uncapped, uncontrolled expenditure is obviously challenging, and not an optimal position for any government or private payer to find itself in. But until such time as s 51(xxiiiA) of the Australian Constitution is again deliberated upon by

the High Court, MP will remain free to charge as they wish, and discussion around the limits of the constitutional provision will remain confined to legal scholarship. However, the answer to the question of what *will* offend the CCC cannot be nothing, because such a suggestion would mock the operation and purpose of this important constitutional placitum.

Australians have very little appetite for constitutional change. The nation has held 44 referendums since Federation in 1901, and only eight have passed (Australian Electoral Commission 2020). This fact alone suggests the CCC will endure. However, while immutable, the CCC does not prevent health system reform, it just restricts the reform approach the government is able to take. Notably, recent Medicare reforms precipitated by the Covid-19 pandemic suggest the government has an active interest in testing the limits of the CCC once again.

1.3 Frenetic law making during the COVID pandemic: the impact on doctors, patients and the Medicare system

The COVID-19 pandemic tested the agility and adaptability of Medicare and the system performed well, enabling implementation of whole-of-population telehealth in a matter of weeks. However, COVID-19 also brought the constitutional issues around the practical effect of the CCC to the fore once again, exposing potentially disastrous impacts on Australian consumers when the government missteps.

The material following in section 1.3 was published on the Australian Public Law Blog (AUSPUBLAW) which is "a collaborative blogging project bringing you expert commentary and analysis on recent cases and legislative change as well as updates on the latest research and scholarship in Australian public law. AUSPUBLAW posts contributions from leading public law experts – including academics and practitioners – across Australia." The article was peer reviewed prior to being published on 24 April 2020 as **Frenetic law making during the COVID pandemic: the impact on doctors, patients and the Medicare system**. It is also available at this link https://auspublaw.org/2020/04/frenetic-law-making-during-the-covid-19-pandemic-the-impact-on-doctors-patients-and-the-medicare-system/

Introduction

On 11 March 2020, Prime Minister Scott Morrison announced[1] a comprehensive $2.4 billion health package to protect Australians from COVID-19, including $100 million to fund new Medicare services. By 20 April 2020, there were twenty COVID-19 related delegated instruments, which were part of this initiative. All have been earmarked on the Senate Standing Committee for the Scrutiny of Delegated Legislation[2] (SSCSDL) website for consideration at a future meeting, meaning these Determinations are already in force, having bypassed the law making norm of being scrutinised by the SSCSDL. With federal Parliament adjourned from 23 March 2020 for almost five months, it is unclear when usual Senate scrutiny of these instruments will be undertaken, if at all. In a media release[3] dated 1 April

2020, the Chair of the SSCSDL announced that the committee had resolved to meet and report regularly over the coming months, though there is no current indication of meeting dates or schedules.

Each of the Medicare Determinations has been enabled by s 3C(1) of the *Health Insurance Act 1973* (Cth)[4] (HIA). In an unprecedented move, the government has made bulk billing[5] mandatory for the new COVID services (with some exceptions) whereas under both the Australian Constitution and the HIA, it is voluntary. This clear inconsistency is throwing the Medicare billing and payment system into chaos. This is not to criticise the undoubted good intentions of a government forced almost overnight to adapt a system built before the Internet to nationalised telehealth[6]. This post also does not seek to criticise doctors nor engage in moral arguments about whether they should be permitted to charge usual fees or should bulk bill everyone at a time when Australians are losing their jobs. Instead this post will explore and consider the short and potential long-term consequences of mandated bulk billing, including the likelihood of future legal challenges against the government, and the reality of causing increased out of pocket medical costs for Australians. Bulk billing is the lynchpin of Medicare and upending the way it operates at a time of crisis may not prove prudent.

Bulk billing and the Constitution

Mandatory bulk billing is constitutionally impermissible pursuant to the civil conscription caveat in s 51(xxiiiA)[7]. This provision[8] of the Constitution relevantly grants the Commonwealth Parliament power to legislate with respect to 'medical and dental services (but not so as to authorize any form of civil conscription)'. Numerous High Court decisions[7] have settled certain points of law in relation to this clause, including that the relationship between a privately practising doctor and a patient is governed by general principles of contract law, and that both legal and practical compulsion, such as for patients to be entitled to see only a particular doctor or for doctors to practice only as public servants, may offend the caveat (see e.g. *British Medical Association v Commonwealth* (1949)[9]; *General Practitioners Society in Australia v*

Commonwealth (1980)[10]; *Alexandra Private Geriatric Hospital Pty Ltd v Commonwealth* (1987)[11]; *Health Insurance Commission v Peverill* (1994)[12]; *Wong v Commonwealth* (2009))[13].

Since the enactment of the Australian Medicare system, Australian doctors have always been free to set their fees as they wish and not bulk bill if they don't want to. In 1973, to circumvent the Constitutional placitum, the Whitlam Government constructed key machinery provisions of what became Medicare, judiciously, on two simple pillars:

1. The only person entitled to a Medicare benefit is a patient (not a doctor), and
2. A patient may elect to assign their Medicare benefit to a doctor through a voluntary process known as bulk billing, which is described in s 20A[14] of the HIA.

By simultaneously making every Australian eligible for Medicare, and making bulk billing optional, the risk of offending s 51(xxiiiA) was all but eliminated, and everyone would bulk bill anyway because, well, who would say no? It really was quite brilliant, though of course success depended on the Medicare rebate being adequate and acceptable remuneration for doctors, and initially it was. Doctors are not permitted to charge any out of pocket amount when they bulk bill and must accept the government rebate as full payment for their service. Over time, as rebates have failed to keep pace with medical practice running costs, bulk billing rates have declined.

The expansion of telehealth services in response to COVID-19, and the introduction of mandatory bulk billing

The COVID pandemic has shaken even Medicare's pillars to their core and placed more than a virus under a microscope. Bulk billing is now the subject of experimentation in a petri dish of its own.

Prior to the Governor-General's declaration of a Biosecurity Emergency on 18 March 2020[15] changes to Medicare had begun. The Medicare scheme has included restricted telehealth

services for remote Australians and those living in residential aged care facilities for many years, but COVID necessitated a rapid expansion and rethink of telehealth, that balanced the demands of doctors with the need to ensure a viable Medicare system remained standing post pandemic. The government adopted a staged approach[16] to test these uncharted waters.

- **Stage 1** commenced on 13 March 2020, which was the day bulk billing was made mandatory (for the new COVID services) for the first time in history. The two Determinations[17] comprising Stage 1 introduced limited telehealth services for patients who met certain vulnerability criteria and for health professionals who were at risk of COVID, and required that these services be bulk billed.
- Three days later, on 16 March 2020, amendments were made to various unworkable provisions via a new **Stage 2** Determination[18], though bulk billing remained mandatory.
- After the Governor-General's Declaration on 18 March 2020, and simultaneously with the adjournment of Federal Parliament on 23 March 2020, **Stage 3** made further changes[19] to add vulnerable practitioners to the class of health professionals who were eligible to use the new COVID Medicare services. So, for example, a pregnant dermatologist met the Stage 3 criteria and was permitted to consult patients she would normally have seen face-to-face in her rooms, remotely from home. However, a non-pregnant, otherwise healthy dermatologist under the age of 70 was not permitted to use the new Stage 3 COVID Medicare services and had to continue to consult her patients face-to-face, unless the patients were at risk of COVID.
- Then on 30 March 2020, the Federal Health Minister announced the **Stage 4** whole of population telehealth[20] initiative. This stage[21] essentially dropped all prior vulnerability criteria for access to the new Medicare telehealth services and hinted at an end to mandatory bulk billing to come in Stage 5.

However, when **Stage 5** was announced on 6 April 2020[22], doctors were still required to bulk bill for vulnerable patients, and an expansive definition of 'vulnerable' ensured many doctors remained forced to bulk bill for most of their patients if their patient populations comprised

mostly patients fitting this criteria. A vulnerable patient was defined as a patient at risk of COVID-19 in the following terms (see sch 1 of the Stage 5 Determination[23]):

> *patient at risk of COVID-19 virus* means a person who:
>
> (a) is required to self-isolate or self-quarantine in accordance with guidance issued by the Australian Health Protection Principal Committee in relation to COVID-19; or
>
> (b) is at least 70 years old; or
>
> (c) if the person identifies as being of Aboriginal or Torres Strait Islander descent—is at least 50 years old; or
>
> (d) is pregnant; or
>
> (e) is the parent of a child aged under 12 months; or
>
> (f) is being treated for a chronic health condition; or
>
> (g) is immune compromised; or
>
> (h) meets the current national triage protocol criteria for suspected COVID-19 infection.

It was evident that subclause (b) brought large numbers of patients within scope and that geriatricians would be forced to bulk bill almost everyone. Subclause (g) had the same effect on oncologists and haematologists treating cancer patients, and subclause (f) was a catch-all that would apply to many patients and potentially all psychiatric patients, depending on the definition of 'chronic health condition'. Subclause (e) also raised questions about how every doctor would necessarily know their patient had a child under 12 months if there was no reason for that information to be shared.

A further Determination[24] commenced on 20 April 2020. This Determination finally scrapped mandatory bulk billing for all health workers except GP, who remain required to bulk bill COVID Medicare services for concession card holders, children under 16 and patients who are more vulnerable to COVID (in accordance with the above unchanged clause), at the time of writing. Further changes will no doubt be made.

The impact on doctors

Doctors are confused. And that is a problem for both doctors and the government. The latter may find itself unable to enforce or prosecute abuses of the Medicare scheme 18 months from now, in the post-COVID period.

Having been inundated with requests from doctors seeking clarity about mandatory bulk billing, I commenced a daily bulletin[25] on 16 March 2020 answering questions about the new COVID Medicare services. It serves to illustrate the high levels of confusion about Medicare billing compliance right now. Even the most basic elements of a bulk billing transaction, such as whether the patient still has to sign the assignment of benefit voucher and how that can be done over a phone call, have caused Medicare audit anxiety.

Medicare audit anxiety is an increasingly well-documented phenomenon that some commentators[26] have identified as contributing to doctor burnout and suicide. It stems from a long-standing problem of doctors not really understanding how Medicare works and worse, being randomly subjected to sometimes far reaching investigations by officials who also do not know how it works. There is not now, and has never been, a national curriculum on the law and practice of Medicare, so levels of knowledge are variable, including within the Federal Services Australia Department, which administers the scheme.

If you can imagine running a case in the Supreme Court having never been made aware of the Supreme Court Rules, that will give you a glimpse into the world doctors inhabit when it comes to Medicare. Astonishing though it may seem, Australian doctors are never taught how Medicare works or how to bill correctly at any point in their careers[27]. It is a central area of inquiry in my PhD on Medicare claiming and compliance.

Confusion about correct use of Medicare prevails even in non-COVID times, so to add to that burden by enacting laws so fast that the same billing decision might be illegal on 13 March, legal on the 31st, illegal again on 6 April, and legal again from 20 April, has increased anxiety

levels among doctors exponentially, but it is the longer-term fear of an investigation and audit that troubles them the most, and there is unfortunately no reliable resource that can assuage that fear completely.

In a recent post, Andrew Edgar[28] described one of the problems of rapid, unscrutinised law-making being legal uncertainty in circumstances where serious penalties may be imposed for breaches of laws unable to be found, because they are not on the register. Certainly, this phenomenon has occurred in relation to the Medicare Determinations. Not only has the MBS Online website[29] (detailing items of the Medicare Benefits Schedule) not kept pace with the frenetic changes, but neither that website, nor verbal or even written advice from the Department, can be relied upon by doctors in any event.

In *Stirling v Minister for Finance* [2017] FCA 874[30], Dr Stirling was a GP who recorded a telephone conversation he had with Medicare seeking advice about whether he was eligible to claim two Medicare services. The recorded telephone advice he received, which was later admitted into evidence, led him to believe he was so eligible, and he commenced regularly claiming the two services. He also confirmed the verbal advice in a letter to Medicare which informed the Department of his understanding and intentions. He successfully claimed the two uncontroversial services for the next five years before being audited by Medicare, which decided he was not eligible to claim them, had never been, and would be required to repay a debt of $332,541.30 to the Commonwealth. On the basis that relevant considerations had not been taken into account and the earlier decision was legally unreasonable, Dr Stirling successfully appealed a decision disallowing his application for waiver of the Commonwealth debt and the matter was remitted to the Minister for further consideration.

In addition to departmental desk audits, which can have catastrophic consequences for doctors such as Dr Stirling, billing concerns can also be investigated by the Professional Services Review Scheme (PSR), a scheme under Part VAA of the HIA. The PSR is a peer review scheme administered by lay people with a remit to protect the integrity of Medicare and the Pharmaceutical Benefits Scheme.

The PSR has been plagued by Federal Court challenges[31] since its inception in 1994, many of which have included an element of denial of procedural fairness. In addition, in the recent PSR matter of *Nithianantha v Commonwealth of Australia* [2018] FCA 2063[32], a quite breathtaking decision was made which effectively closed off the only remaining source of reliable information for doctors about Medicare billing. In that case, Dr Nithianantha attempted to rely on written advice from Medicare (*Nithianantha* [36(6) and [55]) to justify a medical billing decision but was unsuccessful because the PSR effectively said the written advice was wrong. Notably, the *Stirling* decision was not cited in *Nithianantha* and there appears to have been no consideration of any relevant precedent that may arguably have been set.

As a result of the *Nithianantha* decision, doctors have been left in a situation where it is no longer an exaggeration to say there is apparently nowhere they can go to obtain legally accurate, reliable information on Medicare billing. So, in the context of rapidly changing, complex, COVID Medicare billing arrangements, heightened fear of Medicare audits would seem well placed.

In addition to general confusion about what happens, for example, if a doctor decides not to bulk bill a COVID Medicare service (does the patient simply not receive their Medicare rebate or is a penalty imposed on the doctor?), the highly interpretive nature of the new service descriptions may very likely lead to costly appeals for the government. In *Suman Sood v R* [2006] NSWCCA 114[33], Adams J stated that requiring Dr Sood to have known in advance the legal meaning of 'in respect of' amounted to requiring her to provide an opinion concerning the interpretation of the law and its application to the facts which, as a medical practitioner, she had neither the skills nor the qualifications to do. Similarly, the system is now requiring doctors to predict what the legal interpretation of words such as 'chronic health condition' might be, which in turn, determines whether that service must be bulk billed or not. Doctors are therefore in a similar position to Dr Sood, where a not unreasonable interpretation of a COVID Medicare service may end up being wrong, but the only way to find out is when it's too late and the doctor has found herself before the PSR or a court.

The impact on patients

Ultimately, the greatest impact of the mandatory bulk billing decision will be felt by consumers, because the Medicare entitlement is theirs. However, it may not play out in the manner anticipated by the government and protect consumers from out of pocket costs. It may instead do the opposite.

In 1972, a few years before the introduction of the original scheme Medibank (later Medicare), then Health Minister, Bill Hayden, referring to the Constitutional caveat, correctly stated[34]:

> *"Doctors don't have to enter the scheme; we couldn't compel them to. They could just refuse to take part…Doctors aren't going to be conscripted…"*

In the 2009 High Court case of *Wong v Commonwealth*[13], Kirby J described the circumstances when doctors can bill outside of the Medicare scheme in the following terms:

> *"Whilst fully disqualified, a medical practitioner would not be prevented from rendering medical services for which no Medicare benefit was payable – such as … for those patients who are "prepared to pay the practitioner's fee without claiming on Medicare."*

While Kirby J's comments related to a disqualified doctor, they apply to all doctors and the practical effect is that there is no legal barrier to doctors charging patients private fees during COVID, as long as the patient does not claim on Medicare. This is easy for doctors to implement by not putting a Medicare item number on the relevant invoice. Anecdotal evidence[35] suggests that the combined effects of the fear of making billing errors despite best intentions and rapidly collapsing practices under mandatory bulk billing, has caused some doctors to start doing precisely this, meaning Medicare-eligible taxpayers are being denied Medicare rebates.

Conclusion

The current COVID item numbers in the Medicare schedule will sunset on 30 September 2020, though the government will no doubt be under pressure before then for their continuance. Medicare, as an honour system, relies heavily on the integrity of doctors to bill correctly. While evidence suggests most doctors do try to achieve compliance, it cannot be denied that telehealth will expose Medicare to new vulnerabilities and risks – how will the Department know if a phone call between a doctor and patient ever took place when the costs of auditing each single service outweigh the value of the claim?

Before telehealth becomes a permanent feature of Australia's health system, important structural weaknesses and educational deficits will need to be addressed to ensure the scheme's sustainability. However, mandatory bulk billing does not now and will never fit within the current legal structure of Medicare, not least because it is constitutionally impermissible, and the attempt to force it during COVID may end up being of rhetorical effect only, unable to be policed or prosecuted in any meaningful way.

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Post-Script - Covid-19 vaccinations

Since the above article was published, the government has embarked on a national roll out of the Covid-19 vaccination, and has again sought to nullify the substantive obligation codified in section 20A of the HIA (which makes bulk billing voluntary) by using secondary law to make it mandatory for GP who provide Covid-19 vaccinations. Some GP have already attempted to circumvent this requirement by charging patients $70 for a pre-vaccination assessment on a day prior to the day when patients are scheduled to receive the vaccine (Clun 2021).

It would be difficult to argue the new regulatory requirements around providing the Covid-19 vaccination would *not* create a legal compulsion. There is a clear, legal direction that MBS Covid-19 vaccine services must be bulk billed, and cannot be co-claimed with any other service, except in very tightly controlled circumstances (MBSOnline 2020). The approach of the government therefore seems to be that while legal compulsion has been imposed at the Covid-19 vaccine item number level, there is no legal compulsion to participate in the Covid-19 vaccine program more broadly. GP participation in the scheme is voluntary. A GP can therefore continue to provide usual primary health services to the general population, charging freely for those services, but if that same GP wishes to participate in the vaccine roll out, she must bulk bill the vaccine services.

The constitutional argument arising from this approach is therefore whether restricting legal compulsion to certain services only, may still intrude impermissibly into the private contractual relationship between a MP and patient. The answer to that question would likely be complicated presently, by an intersection between the *Constitution* and the *Biosecurity Act 2015 (Cwth)* (Government 2015a). The *Biosecurity Act 2015* has never been the subject of High Court deliberations because the first human biosecurity emergency in Australia falling within its powers is the ongoing Covid-19 Pandemic. However, absent a High Court decision, the answer to this complex legal question will likely remain moot, though it should be noted that potential legal arguments may not be confined to the *Constitution* and *Biosecurity Act 2015*. Other areas of public law may also be invoked, such as the rule of law principle of legality.

Recent legal discourse around the principle of legality (which requires laws to be accessible and comprehensible) has increased in the context of Australia's previously mentioned business laws, including discussion around the specific problem that arises when secondary law is used to contradict substantive obligations under the principal Act.

'The surfeit of law is not the only problem. Understanding individual sections can be vexed. Many definitions are used to turn on and off substantive obligations, rather than to clarify meaning, sometimes with counterintuitive results (e.g. a 'company' is defined, for some purposes, to include an unincorporated registrable body). The use of Russian-doll definitions sends one down a seemingly interminable rabbit-hole towards yet more "complex and prolix, if not labyrinthine, statutory definitions". Further, there is no clear legislative hierarchy; instead, Regulations and instruments regularly make substantive changes that render the primary law – on its face – highly misleading. For example, Part 7.6 of the Act requires certain persons to hold a financial services licence, but 46 separate legislative instruments provide exemptions and modifications…The result of all of this is…that parts of the Act fail to "operate as a reliable guide to conduct, readily ascertainable and capable of equally ready understanding … even for trained lawyers". There is a "real possibility of misunderstanding or misapplication of its provisions".'(Isdale and Ash 2021)

Similarly, section 20A of the HIA has always enabled optional bulk billing, despite secondary law now purporting to make it mandatory for 16 MBS items (this number was higher at the beginning of the Covid-19 pandemic and has continually fluctuated), with some of those items having prolix explanations spanning multiple pages.

Whether the government will continue along this path of forced bulk billing for some MBS items but not others, after the Covid-19 pandemic ends, is unknown. However, this thesis will argue that to do so would likely be futile; non-compliance caused by busy MP forgetting which services must be bulk billed would increase, and effective oversight would be impossible. This issue and the principle of legality will be discussed in more detail in chapter seven.

1.4 The Medicare billing system

Medicare provides health services to Australians in two ways. Firstly, underpinned by the CCC, the Medicare scheme subsidises the privately incurred healthcare costs of Australians when they visit a MP outside of hospital. At its most basic, medical billing in this setting follows one of two methods. A MP can either:

1. Charge a fee of their choosing after which the patient can claim a relevant rebate and will be left out-of-pocket for any difference between the amount paid and the rebate, or
2. Bulk bill the claim (as described in the preceding article) and accept the government rebate in full payment for the service provided.

Secondly, enabled by s 96 of the Australian Constitution, Medicare provides free services when public patients receive treatment anywhere in a public hospital. While one might think the basic premise of everything being free for public patients seeking treatment at a public hospital would be fairly straightforward, evidence suggests this is not the case. One clear example is found via a website describing regional MP services (not subject to any relevant exemption) who appear to charge patients for every visit to their local public hospital emergency service (Gawler GPInc 2020; Australian Government 2020-2025), despite an overarching government requirement that all public emergency services must be provided free of charge. Another similar regional public hospital appears to be planning to emulate the same model (Dawes 2020). Further, the Australian Auditor General conservatively estimates that over $300 million is incorrectly bulk billed annually in public hospitals (Australian Auditor-General 2019), suggesting that either wilful misconduct is worryingly prevalent, or the ‘rules’ around medical billing in public hospitals are unclear.

When visiting a MP outside of hospital, the CCC has the effect of enshrining the small business nature of Australian medical practice, whereby MP function like any business owner, all of whom are entitled to sell their products and services at prices they determine.

To circumvent the restrictive High Court interpretations of the CCC already discussed, the Whitlam government implemented a basic structure still in place today under which the government sets a rebate amount, the legal beneficiary of which is the patient, not the MP. Put simply, medical costs incurred by the patient outside of hospital are subsidised - the MP is not paid. This arrangement is governed by general principles of contract law, which is discussed in chapter four. It is also important to note that the Medicare scheme was never intended to subsidise the full costs incurred by patients, other than when they are admitted to a public hospital (Scotton and MacDonald 1993).

The media often report medical fee concerns using language that confuses these basic tenets of Medicare, such as by suggesting the Medicare rebate is a recommended fee, which it is not. The discourse in the Medicare billing arena is sometimes hyperbolic, declaring some surgeons charge 'ten times the Medicare fee' (Dunlevy 2016) or charge 'more than twice the official Medicare fee' (Willis and Bullen 2019). Irrespective of the amount of the fee charged, the fact is that the Australian government does not recommend or set official fees for medical services, and MP can charge as they wish. Further, the rebates set by the government bear little relationship to the actual costs of providing services, attributable to the fact that no science underpins the rebate setting process. This is discussed further in chapter four.

The Australian medical billing system utilises medical service codes commonly described as 'MBS items' or 'MBS codes', MBS being an acronym for the Medicare Benefits Schedule book, which has been published annually since 1974. The MBS book was originally provided to every MP each year in hard copy, but is now an online resource (MBSOnline 2020), where the approximately 6000 medical service descriptions and codes can be accessed. Further, while the patient is the legal beneficiary of the Medicare entitlement, the patient has no legal authority to select MBS codes relevant to their encounter with the MP. The law provides this task is the responsibility of the MP (Australian Government 1973a).

Australia's Medicare is an expansive UHC system that reimburses largely unrationed, clinically relevant services, with everything from the treatment of minor ailments to organ transplants

and complex cancer treatments being covered. Of note, from the outset, the government has had very little ability to determine whether the threshold requirement has been met – whether services being claimed and paid for by taxpayers were actually clinically relevant; indeed, without knowing the reason why a patient presented to a MP in the first place, it was impossible to know. A patient could easily undergo a non-clinically relevant operation, such as having a bilateral knee replacement when only one knee was painful, for which taxpayers would pay, with no questions asked. This was nothing more than a timing legacy; the system was introduced in the 1970s when the only proof of clinical relevance was on paper records held in medical practices inaccessible to the government. However, this has not been the case for at least the last 10 years (Jun Xu et al. 2013).

This historic disconnect between clinical and billing data has meant the government has had (and continues to have) very little visibility over the services it subsidises, but rather than addressing this legitimate concern using modern technological tools, the government has preferred to assume MP are deliberately abusing the system at alarmingly high rates, with little regard for relevant context, including the roles of the many actors (including software vendors) involved in Australian medical billing. A 360 degree view of a medical bill, incorporating the perspectives of each key actor, starting with the patient, may therefore assist us to understand the many different lenses through which a medical bill is viewed.

A medical bill from the patient's perspective

If a MP said to a patient, 'All you have to pay is $10. We will get the rest from Medicare.' The patient would not know that a crime was probably about to be committed.

Australian MP can either charge as they wish, or bulk bill, but not both simultaneously. This central feature of bulk billing is the lynchpin that keeps Medicare afloat and is discussed in more detail in chapter four. When bulk billing, MP effectively trade their constitutional right to charge any amount, in return for immediate reimbursement at a lower rate ("Health Insurance Commission v Peverill [1994] HCA 8").

In a 2006 Medicare fraud case ("Suman SOOD v Regina 2006 NSWCCA 114"), Dr Sood routinely bulk billed and charged a separate gap simultaneously, and was found guilty of 96 counts of criminal fraud. Dr Sood unsuccessfully argued that the additional fees she charged related to a separate service; not the service she bulk billed. However, the prosecution successfully argued the additional fee she charged was inextricably linked to the service she bulk billed, which constituted a criminal offence. The *Sood* case gave the government the legal authority it needed, and still draws upon, to send a very clear message to the medical profession that knowingly bulk billing and charging a gap at the same time, is a crime.

Returning to the $10 example, most patients would probably be pleased to have only been required to pay $10, rather than paying $50 and claiming $40 back from Medicare, and would not know, understand, or be interested in the process by which the MP would 'get the rest from Medicare.' In addition, a MP who has never been taught how to bill correctly may hold a genuine belief, like Dr Sood, that she is helping her patients by reducing the up-front fees they are required to pay at the point of service. Without having been taught how to bill and having a legal case such as *Sood* presented and explained in a learning context, it is understandable that an MP may hold a genuine but mistaken belief that helping patients pay less in this way could be a crime.

In addition to the patient having no ability to know whether the method of billing is correct, patients also have no ability to know whether the MBS item or items claimed under their Medicare card are correct. The hypothetical patient who paid $10 (say for a repeat prescription) would not know if another service had also been added to the bulk billed claim or whether a longer consultation than that actually provided was claimed. Even for the rare patients who may choose to login to their Medicare claims history via the available government portal to check their claiming history (Australian Government 2021a), most would still not know whether the claims they can see were accurate, because the law provides that relevant service descriptions must be 'sufficient to identify the item' (Australian Government 2018), but does not specify who it has to be sufficient for, though by inference, it is not the patient.

For example, a patient undergoing a relatively common, simple eye procedure in the MP's surgery under local anaesthetic, such as a conjunctival papilloma excision (removing a small, benign external growth from an eyelid), could see any of the following items on their invoice.

Table 1 - Example of papilloma excision items

Item	Full item description	Benefit (100%)
31206	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if: (a) the lesion size is not more than 10 mm in diameter; and (b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and (c) the specimen excised is sent for histological examination.	$98.45
52036	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, not being a service to which item 52039 applies.	$130.90
42677	Conjunctiva, cautery of, including treatment of pannus, each attendance at which treatment is given including any associated consultation.	$62.90

In addition to most patients not understanding or being particularly interested in the finer details of MBS item descriptions, most online billing software has a 50-character limit in the data field for the MBS service description, and it is the first 50 characters of each description that are typically displayed. This means that even for patients who may request a printed copy of their invoice, they will usually see truncated descriptions such as the following.

Table 2 - Example of truncated descriptions on a patient invoice

Item	50-character description included on patient invoice	Benefit (85% rebate)
31206	Tumour, cyst, ulcer or scar (other than a scar rem	$83.70
52036	Tumour, cyst, ulcer or scar (other than a scar rem	$111.30
42677	Conjunctiva, cautery of, including treatment of pa	$53.50

Cut off mid-sentence and often mid-word, these descriptions are meaningless to patients. In the above example, 50-character truncation, necessitated by medical billing having shifted to the online environment, has caused the first two descriptions to be identical for two very different services attracting different rebates. If the MP added another item for the time spent discussing the procedure with the patient, the final invoice would look something like this.

Table 3 - Example final patient invoice

Item	Description	Amount	Benefit (85% rebate)
105	Professional attendance by a specialist in the sp	$100	$38.25
31206	Tumour, cyst, ulcer or scar (other than a scar rem	$200	$83.70
Total		**$300**	**$121.95**

To the average patient, this invoice would cause no reason for concern, though it also does not provide any information sufficient to determine the accuracy or otherwise of the items listed - the patient would not know that item 31206 requires suturing and histology (which the patient may or may not have had), because neither word appears on their invoice.

A medical bill from the MP's perspective

MP are obviously able to read item descriptions and understand requirements if those requirements are clearly articulated. However, medical billing confusion does not always relate to *what* MBS item to bill. More often, confusion may relate to *how* to bill, *when* to bill, and sometimes *whether* to bill.

The majority of MP regularly bill only a small sub-set of the approximately 6000 MBS item numbers available, which suggests they would come to know how to bill their sub-set of items correctly. However, the evidence does not support this view. In the *Sood* case, evidence presented to the jury related to the billing of only one MBS item, and there was no concern that the item number Dr Sood chose was incorrect or that she had not provided the service she billed. Her error did not relate to *what* to bill, but *how* to bill the one MBS item she had correctly chosen.

In addition, most GP will routinely bill many more MBS items than the majority of specialists. A popular medical billing resource for GP is known as the 'MBS Quick Guide', which is produced monthly by a leading Australian GP media outlet, Australian Doctor (Kelso 2021). In April 2021, the MBS quick guide listed 88 MBS items able to be billed by GP (excluding Covid-19 telehealth items), whereas many specialist physicians regularly bill only the following four items:

1. Item 110 (standard initial consultation)
2. Item 116 (standard subsequent consultation)
3. Item 132 (complex initial consultation, 45 minutes)
4. Item 133 (complex subsequent consultation, 20 minutes)

All MP with a fellowship of the Royal Australasian College of Physicians (The Royal Australasian College of Physicians 2021) are able to bill these items including but not limited to neurologists, cardiologists, oncologists, gastroenterologists, haematologists, and endocrinologists. Some of these specialist physicians may also bill procedures such as cardiac

stents and colonoscopies, but even then, the total number of items a specialist physician would regularly bill is usually less than the number of items billed regularly by GP.

Even for surgeons, most would have a small sub-set of items they regularly bill, though there are of course notable exceptions. Dermatologists bill many more items due to the myriad skin lesions able to be biopsied and excised, anaesthetists bill using time increments and typically add many minor procedures such as arterial lines and monitoring to each anaesthetic, general surgeons bill a wider variety of procedures than specialist knee surgeons, radiologists perform a long list of diagnostic imaging services, and so on.

If we consider endocrinology for a moment, it is a specialty which has gradually become predominantly outpatient-based due to the management of chronic conditions like diabetes becoming better able to be managed in the community. From a billing perspective, this means not only do most endocrinologists bill just the above four item numbers, but they also bill them almost exclusively in what is arguably the easiest billing setting; outpatients, where there are less rules to grapple with.

However, knowing how to correctly bill even such a small number of MBS items has proven difficult for one endocrinologist. In January 2020, an endocrinologist was found to have engaged in inappropriate practice in relation to the billing of just three of the above four items. The reported concerns of the investigative body related to *how* to correctly bill those items, including the MP not meeting relevant time requirements (PSR Director 2020). However, a review of the descriptions of the items for which the endocrinologist was found to have erred (items 132 and 133) suggests there is an interpretive space around whether the time requirements refer to time *with the patient* (MBSOnline 2020). Perhaps the endocrinologist formed a genuine and not unreasonable but ultimately mistaken view that a 45-minute item can comprise 30 minutes with the patient and 15 minutes writing in the notes and making calls and arrangements for patient follow-up. Unfortunately, relevant reports of these types of matters are brief, making it impossible to know with certainty why this endocrinologist was punished for incorrectly billing these two MBS items. This lack of information and

transparency is in itself another problem that will be discussed in more detail throughout this work.

Every medical billing decision draws from the public purse and should therefore be a precision exercise. Yet examples of poorly described services potentially causing genuine MP confusion, like items 132 and 133, seem prevalent. Another example is the commonly billed GP 'Team Care Arrangements' item 723, which is arguably very easy to misinterpret (MBS Online 2020b). The item requires that two 'other' practitioners must be part of the treatment team and one may be another MP. But if both of the 'others' are allied health practitioners it is unclear whether the GP should split the permitted five referred allied health sessions between the two allied health practitioners, or whether all five sessions should be allocated to one practitioner and none to the other, or whether both of the allied health practitioners can avail five sessions each. Yet should the GP be found to have erred in her interpretation of how to bill item 723 correctly, the penalties imposed can be severe.

Appendix 1 provides an illuminating example of how the billing of a single case conference item and seeking assistance from Medicare to understand how to bill it correctly, can be perplexing. A case conference involves the coming together of a treatment team to discuss ongoing management of a patient, without the patient being present. It is a common service provided in areas such as chronic disease, disability, and oncology. Case conference item 838 clearly states the service must be provided *before* the patient is discharged from hospital, but the convoluted correspondence between the author and Medicare in **Appendix 1** concludes the item can only be claimed *after* the patient has been discharged. It should be noted that this has not changed since the date of the letters in **Appendix 1**.

Patients also suffer from intersecting pathologies such as concurrent pneumonia and heart failure, and do not always present with a single, simple problem that fits neatly into an MBS item description. Consider a patient who presents for treatment of a leg ulcer and leaves with a dressed and bandaged leg for which an item 23 (the most common item billed in the MBS schedule) was bulk billed. The patient returns the following week with a chest infection and

the GP prescribes antibiotics and intends to again bulk bill item 23. But on the way out to the reception desk, the nurse sees the patient and notices the leg dressing is falling off. He takes the patient to the treatment room, cares for the wound and provides a new bandage. Financial consent issues aside, can an additional charge for the bandage be levied in these circumstances even though the consultation is going to be bulk billed? Following the *Sood* reasoning, the answer would likely be no, because the bandage is inextricably linked to the bulk billed service, even though logic suggests the bandage bears no relationship to the patient's chest infection.

MP also receive information and advice that may not always be aligned with Medicare billing requirements. For example, MP treating Aboriginal and Torres Strait Islander (ATSI) people are expressly taught not to rush these patients so as to respect and accommodate their specific cultural norms including the concept of time, which operates quite differently when compared to the western concept of time:

'Explaining may take time because of narrative communication style or due to linguistic differences. In Western culture, emphasis is placed on time to meet deadlines and schedules. Time is perceived differently in Aboriginal and Torres Strait Islander cultures, as more value is placed on family responsibilities and community relationships. Consider allocating flexible consultation times. Take the time to explain and do not rush the person, and In Aboriginal and Torres Strait Islander cultures, extended periods of silence during conversations are considered the 'norm' and are valued'. (Queensland Government 2020)

The idea of not rushing and allowing extended periods of silence is antithetical to Medicare billing, where short, rushed consultations are the dominant operating model for GP, and high numbers of long consultations will automatically trigger a Medicare investigation (Services Australia 2020). Therefore, MP treating large cohorts of ATSI people may be presented with a unique problem. The question for them may become *whether* to bill for legitimate long consultations aware of the risks of becoming a statistical outlier, or choosing not to bill at all

or underbill (bill a shorter consultation of 20 minutes even though the MP spent an hour with the patient), to avoid unwanted attention by Medicare.

There are also circumstances when the law and Medicare's interpretation of the law are misaligned, causing even threshold decisions about *whether* to bill to be ambiguous. A recently added electrocardiograph (ECG) item 11714 is a good example. **Table 4** sets out the law (Australian Government 2020a):

Table 4 - Legal description of item 11714

11714	Twelve-lead electrocardiography, trace and clinical note, by a specialist or consultant physician, if the service is not associated with a service to which item 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable not more than twice on the same day	$25.00

Medicare interpretations of this provision, taken from the MBS are shown in **Figures 2 and 3**:

Figure 2 - Medicare's interpretation of item 11714 on 24 February 2021

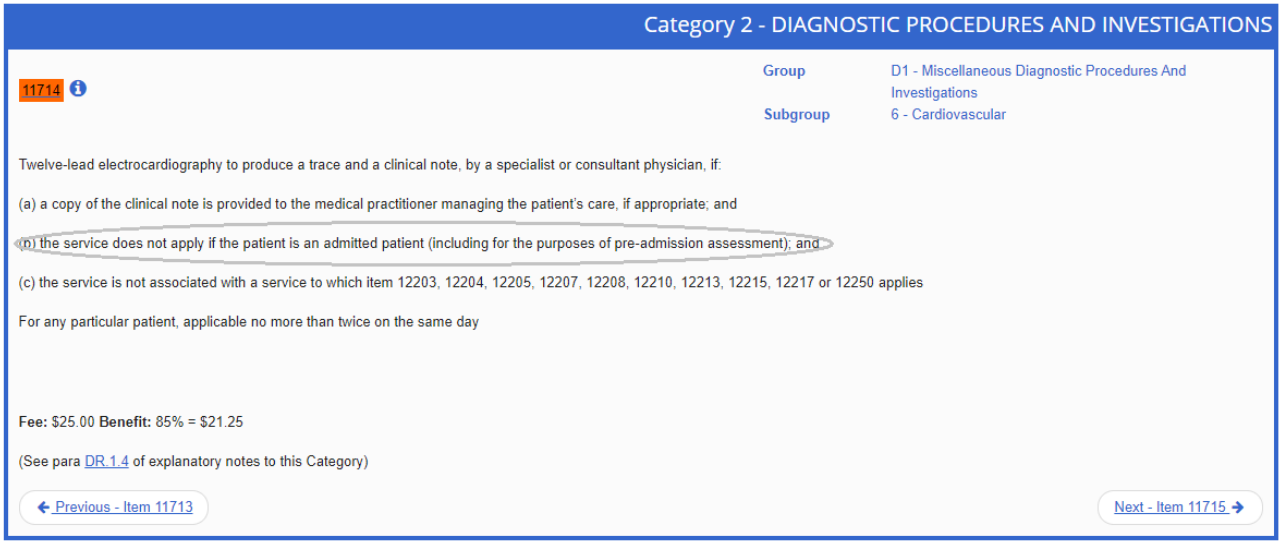
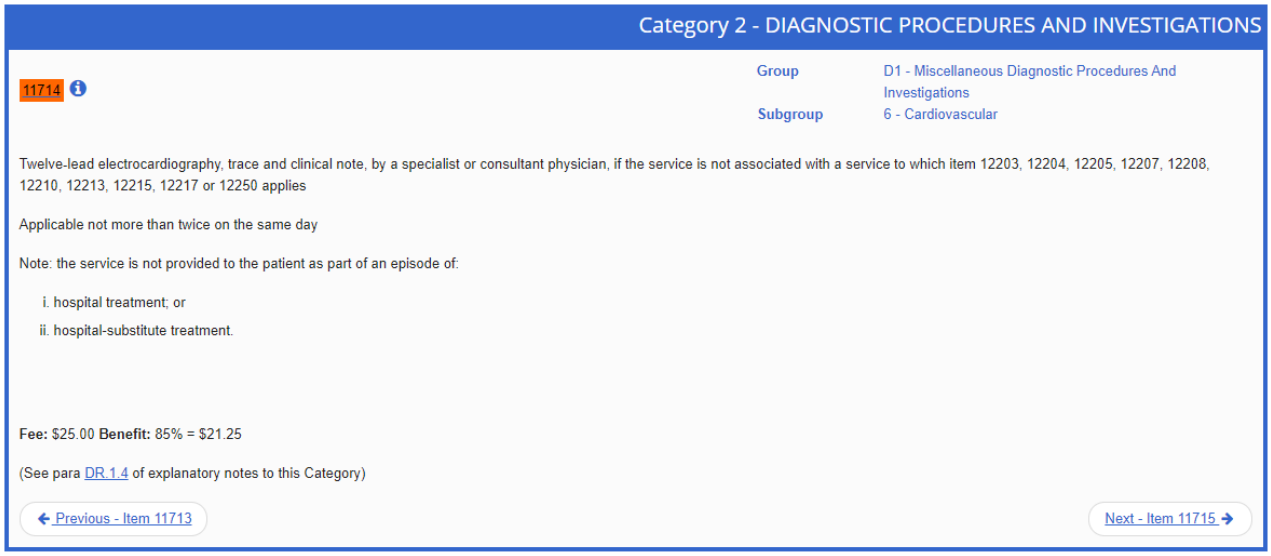


Figure 3 - Medicare's interpretation of item 11714 on 13 April 2021



In addition to Medicare's interpretation changing in a short time period, the most confusing part of these descriptions is the inclusion of references to 'admitted patient', 'pre-admission assessment' and 'hospital treatment'. The term 'hospital treatment', while recently added to the regulations (though in a separate regulation) (Australian Government 2021b), is nowhere defined.

The provision of an 85% rebate only, indicates the service cannot be claimed for inpatients. However, the earlier inclusion of the phrase 'pre-admission assessment' is worrying and suggests the government has adopted an interpretation of the service, that may not necessarily be clear to MP. Walking through the below process of logical reasoning for a patient attending a pre-admission clinic, a potential compliance trap for MP becomes evident.

1. Medicare reimburses clinically relevant services, which means the service must be 'necessary' for the treatment of the patient as judged by medical peers (Australian Government 1973a).

2. If an MP who is an anaesthetist is conducting a pre-admission assessment to determine a patient's suitability for a planned anaesthetic, and decides that item 11714 is

clinically relevant for the patient, the law appears to enable the service to be billed because the patient has not yet been admitted to hospital.

3. However, the words 'as part of an episode of hospital treatment', appears to be suggesting that billing item 11714 during a pre-admission assessment (if this is deemed 'part of an episode of hospital treatment') is never clinically relevant and should not be billed.

The problem from a compliance perspective is that it is currently impossible to know how a MP should approach the billing of item 11714, and with no case law to guide this decision making, it is also not possible for lawyers to confidently provide legal advice to MP on how to bill this service correctly. And as will be demonstrated, Medicare is an unreliable source of information and advice.

Even the threshold decision of determining the clinical relevance of an MBS item can present an insurmountable challenge requiring Herculean effort to navigate, because what a MP decides is 'necessary' for the treatment of two patients with the same medical problem can differ significantly based on an infinite array of variables, some clinical, others not. For example, if a service contract between a MP and a private hospital stipulates the MP is required to attend her admitted patients every day, what should the MP do if she deems daily visits are not necessary because her patients are stable? Her choices are a) breach Medicare requirements by billing for non-clinically relevant services, b) breach her contract with the hospital by not attending her patients daily, or c) attend her patients daily, not bill to Medicare, and not be paid.

Consider a hypothetical clinical scenario of a 50-year-old woman presenting with a two-day history of painful urination and fevers, and a past history of having had a kidney infection five years ago. It would be clinically relevant and necessary to take a urine sample for pathology testing. However, whilst not strictly necessary because the symptoms are most likely caused by a urinary tract infection (UTI) easily treated with antibiotics, the history also raises the

possibility of a more serious kidney infection for which a kidney scan might be necessary. It would obviously not be clinically relevant to order a brain scan. However, the decision of whether or not to order the kidney scan and its clinical relevance may ultimately depend on hindsight, because if the correct diagnosis was a simple UTI then arguably a scan was irrelevant and unnecessary. However, if the patient was admitted to hospital that night with a serious kidney infection and a kidney scan had not been ordered, the MP may be negligent. Multiple variables such as these, including the threat of litigation - when a MP may perceive a patient may become litigious if demands for treatment are not met - inform the many complex clinical decisions MP make for even the simplest patient presentations.

Of note, even the government appears to have experienced confusion around the meaning of clinical relevance and its correct application to compliance investigations. In the early years of the PSR, from 2000 to 2010, the Director continually referred to 'medical necessity' in the annual reports (Professional Services Review Agency 1995-2020) rather than 'clinical relevance', and may have incorrectly applied the non-applicable U.S standard of medical necessity in its investigations for a decade. Annual reports of the incoming PSR Director released after 2010 reverted to clinical relevance.

In addition to the central problem of determining clinical relevance and the government not being able to see or determine it anyway, myriad other standards have gradually made their way into the Medicare and medical billing landscape, and MP may struggle to know which standard applies to which MBS service. Sixteen of these standards are set out in **Table 15,** which are discussed later in this thesis.

Semantics can also be troublesome in the context of the MBS. The most common item number billed by surgeons for their first consultation with a patient is item 104, which has the following description:

'Professional attendance at consulting rooms or hospital by a specialist in the practice of the specialist's specialty after referral of the patient to the specialist-each attendance, other than

a second or subsequent attendance, in a single course of treatment, other than a service to which item 106, 109 or 16401 applies' (MBSOnline 2020)

The word 'attendance' is used multiple times, enabled by Section 3(4) of the *Health Insurance Act 1973 (Cwth)* (Australian Government 1973a) which defines 'attendance' as follows (my underlining):

"Unless the contrary intention appears, a reference in this Act to a professional attendance or to an attendance is a reference to an attendance by a medical practitioner on a patient, including an attendance at the medical practitioner's rooms or surgery."

The term 'attendance' throughout the MBS is therefore intended to refer to physical, personal attendance by a medical practitioner on a patient. However, over time, many confusing descriptions have been introduced into the MBS to the point where it has become sometimes very difficult to determine whether a '*contrary intention*' applies to a specific service. For example, it is not always clear whether:

(a) the intention is that a MP attends on a patient, in accordance with s 3(4) of the HIA, or
(b) the intention is that a patient attends to receive treatment by a MP.

The two are not the same.

One example where the difference between (a) and (b) above may cause confusion is the recent addition of oncology item 13950. Item 13950 is described as:

"Parenteral administration of one or more antineoplastic agents, including cytotoxic chemotherapy or monoclonal antibody therapy but not agents used in anti-resorptive bone therapy or hormonal therapy, by or on behalf of the specialist or consultant physician – attendance for one or more episodes of administration." (MBS Online 2020b)

Unlike item 104, this item confuses supervision with attendance. Use of the words 'by or on behalf of' suggest the MP is not required to personally attend the patient, but the later inclusion of the word 'attendance' suggests the opposite. A second possibility is that the concept of MP attendance versus patient attendance has been confused and clarity could be achieved by the final phrase being deleted. However, a third possibility is that the government has intentionally introduced a '*contrary intention*' being that the patient attends rather than the MP, though it is impossible to know.

What is already becoming apparent is that the size of the subset of MBS items regularly billed by an MP (whether four MBS items or 40) is of less importance in the overall compliance picture, than the context in which billing itemisation occurs. Even a MP who regularly bills only one MBS item could be innocently or deliberately billing it incorrectly all the time - by charging illegal gaps when bulk billing like Dr Sood, bulk billing without obtaining patient consent, billing without meeting time requirements (billing for 20 minutes but only taking 3 minutes) like the endocrinologist, billing when the service is not clinically relevant, or billing to Medicare when the patient attends for a work related matter, which is prohibited (Australian Government 1973a).

In the context of work injuries, entirely separate, State based arrangements come into play, adding another layer of complexity to daily medical billing decision-making. For example, the State Insurance Regulatory Authority in NSW adopts a hybrid mix of Medicare rules, Australian Medical Association rules, and its own rules, which are regulated in a resource known as a 'Fee Order' (State Insurance Regulatory Authority NSW 2020). However, this research will demonstrate that MP are unaware of the existence of the *Fee Order*, and are therefore unlikely to comply with it. Further, that work injury fee arrangements have become so convoluted that it is quite possible for a MP holding dual qualifications in anaesthesia and pain medicine to believe she can legitimately bill daily pre-anaesthetic consultations on a post-operative patient. This is described in more detail in chapter four.

When a medical bill is generated in a public hospital, more layers of complexity are introduced.

A medical bill in a public hospital from the MP's perspective

Public patients located anywhere in a public hospital are required to be treated free of charge, which also prohibits bulk billing to Medicare. MP are paid salaries or are contracted to treat public patients in public hospitals, though pursuant to the provisions of the current s 96 Agreement known as the *National Health Reform Agreement (NHRA)* (Australian Government 2020-2025), public patients can elect to be treated as private patients when receiving both inpatient and outpatient services in most Australian public hospitals (Victorian Auditor-General 2019; Queensland Auditor-General 2013; Lander 2019). Public hospitals must also provide emergency department treatment to all Medicare eligible patients completely free of charge (Australian Government 2020-2025).

While seemingly straightforward, gaining insights into the possible causes of allegedly high levels of non-compliant billing in public hospitals (Auditor-General 2019) becomes apparent when reviewing the many intertwined legal instruments governing these arrangements, primarily key provisions of the HIA and NHRA. Section 19(2) of the HIA provides:

'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:

(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.'

In addition, section 128C of the HIA prevents MP from charging fees to public patients in public hospitals in the following terms:

'(1) A person mentioned in subsection (2) must not, in circumstances set out in the regulations:
(a) charge a fee for the provision of a public hospital service; or
(b) receive any payment or other consideration from anyone in respect of the provision of a public hospital service;
if the person knows that the person to whom the service is, or is to be, provided is, or intends to be, a public patient in the hospital.'

While section 19(2) of the HIA provides that a Medicare benefit is *not* payable when a medical service is provided 'by, or on behalf of, or under an arrangement with the Commonwealth', the current arrangement between the States and the Commonwealth expressly provides that Medicare benefits *are* payable subject to certain strict criteria being met. Section 19(2) of the HIA has therefore been interpreted as enabling MP to undertake private practice in public hospitals pursuant to certain provision of the NHRA, and claim through the MBS (Victorian Auditor-General 2019). This is because when an MP provides a service to a patient who has elected to be treated privately, that service is not provided 'by or on behalf of, or under an arrangement with the Commonwealth', but pursuant to a private contract between the MP and patient (State Government of Victoria 2011; "Health Insurance Commission v Peverill [1994] HCA 8"). The s 96 agreements operating between 2003-2008 went so far as to describe patients who elected to be treated privately in a public hospital outpatient department, as not being patients of the hospital (see below):

'*Note: An eligible person who has been referred to receive outpatient services from a medical specialist exercising a right of private practice under the terms of employment or a contract with a hospital which provides public hospital services, <u>is not a patient of the hospital</u>*.' (Commonwealth Government 2003: 15)

When read together, section 128C and the provisions of the NHRA, convey a clear intention that private practice arrangements in public hospitals are based on the right of every Australian to choose to receive free services everywhere in a public health facility, including

refusing to be bulk billed (Australian Government 2020-2025: Clauses 1 f. and 8 a.). Private practice in public hospitals is therefore tightly restricted to certain MP, ensuring GP and other health practitioners such as allied health professionals and nurse practitioners, cannot provide services or bill to Medicare anywhere on the premises of a public health facility, unless the facility is subject to a specific remote location exemption.

However, from a MP compliance perspective, billing difficulties in this context may not relate to *what* MBS item to bill, but instead knowing *when* the MP is exercising a right of private practice (ROPP) and is permitted to bill.

The Victorian Auditor-General has suggested a ROPP can only be exercised in the context of a *'broader employment arrangement with the public health service' (Victorian Auditor-General 2019),* a position echoed by the Independent Commissioner Against Corruption in South Australia (SA), who stated *'A ROPP permits a salaried specialist to treat a private patient in a public hospital' (Lander 2019)*.

The Victorian Audit Report expressed concern that some MP working in public facilities in the State of Victoria may be engaged in non-compliant billing because they were billing to Medicare when supposedly exercising a ROPP, but were independent contractors rather than salaried employees and therefore could not legitimately exercise a ROPP (Victorian Auditor-General 2019). However, in the State of New South Wales (NSW), MP are expressly advised an opposite interpretation of a ROPP, which is inconsistent with the narrow interpretation adopted in Victoria and SA. The NSW Department of Health, informs MP who are '*…clinical academics, visiting medical officers and honorary medical officers'* that they are permitted to exercise a ROPP and bill to Medicare, even though they are *not* employees (NSW Government 2021a).

This lack of definitional clarity around what a ROPP is and which category of MP can exercise a ROPP may be caused by a drafting inconsistency in the NHRA where Clause G17 includes the word 'contract' in the context of ROPP provisions - *a medical specialist exercising a right of*

private practice under the terms of employment or a contract with a hospital; but the subsequent clause G19 does not make reference to a contract - *a named medical specialist who is exercising a right of private practice and the patient chooses to be treated as a private patient.'(Australian Government 2020-2025)*

Inclusion of the word 'contract' in Clause G17 of the NHRA may support the current wide interpretation of a ROPP adopted in NSW, but ultimately, it is the interpretive ambiguity that may expose MP to medical billing compliance risk caused by genuine ignorance around whether they are permitted to exercise a ROPP and therefore bill a patient who has consented to be bulk billed in a public hospital outpatient setting. Given the various State authorities appear not to agree on what a ROPP is, it is reasonable to suggest that MP have little option other than to follow the directions of appropriate managers of ROPP arrangements in the state-run facilities where they provide public hospital services, even though such directions may be incorrect, exposing MP to legal liability for possible breaches of s 19(2) of the HIA. The SA Commissioner noted:

'…it should be observed that a lack of formal direction about when and how ROPP is to be exercised contributes to the ambiguity surrounding the discharge of salaried specialists' public duties and creates a risk of misconduct and maladministration which contributes to the risk of corruption.'(Lander 2019)

Compounding the confusion around the threshold issue of which MP can legitimately exercise a ROPP, the signatories to the NHRA are the State Premiers, Territory Government Chief Ministers, and the Prime Minister. Therefore, the entire NHRA does not directly bind MP basis a fundamental principal of contract law known as *privity of contract* which provides 'A person who is not a party to a contract can neither enforce the contract nor incur any obligation under it.' (Paterson, Robertson, and Duke 2012: 255) However, contracts between MP and state operated public hospitals would usually create binding obligations on MP to adhere to applicable departmental policies, procedures and directions, though MP have no practical

ability to know whether such directions are correct, particularly in view of a finding from this research described in chapter six, that MP may not know the NHRA exists.

Apart from the threshold ROPP issue, another area where MP are vulnerable to making unintentional billing errors in public hospitals is day admissions. Patients in this category usually attend for a procedure or therapy for a period of approximately four hours and are formally admitted on arrival and discharged when they leave. From a medical billing perspective, a MP may mistakenly believe such patients have not been admitted, are outpatients, and are therefore able to be bulk billed to Medicare under clause G19 of the NHRA. This is particularly so when there is no requirement for the patient to wear a hospital gown, such as day rehabilitation patients who wear gym clothing, and day oncology patients who sit in a chair to receive an infusion wearing whatever they arrived in – these patients 'look like' outpatients. The potential billing error that may occur in this scenario is expensive. These patients may be incorrectly bulk billed to Medicare as outpatients when they are in fact public inpatients who should not be billed at all.

The preceding examples demonstrate just some of the unwieldy, entangled, morass of layers that may make medical billing in public hospitals extremely challenging for MP. There are many more examples - some public hospitals are subject to what are known as s 19(2) exemptions which means everything just described does not apply, and MP (and others) can bill everything to Medicare. There are also ambiguities around billing public patients in private hospitals (as opposed to private patients in public hospitals), and in the context of neonatal medicine, the law provides that a newborn with its mother is classified as an outpatient, however if that newborn is transferred to the intensive care nursery it becomes an inpatient; the first of a multiple birth is an outpatient, but the second and all subsequent babies are inpatients, and a mother with her newborn is an inpatient (Australian Government 1973a). If a MP practicing neonatal medicine errs and bills the wrong baby from a multiple birth or mistakenly bills an outpatient baby as an inpatient the potential penalties can be severe.

Media reporting of medical bills

Media headlines concerning rampant overservicing and Medicare rorting by MP sell well (Doran 2015; Evans 2018; Smith 2007; Sunrise TV 2018) and have therefore proven a powerful rhetorical tool. One area of medical billing where the media have reported incorrectly on alleged MP rorts is in the area of booking fees and split bills (Aubusson 2019) which, while possibly unethical, are rarely illegal.

While Medicare benefits are payable for clinically relevant services only, the fact that a service is not clinically relevant does not mean it cannot be provided, it just means there is currently no Medicare rebate for it. Common examples of non-clinically relevant services are cosmetic Botox injections and fillers, booking, membership or administration fees and some family meetings. There is usually no legal barrier to MP charging for these services (there is one exception which is discussed in chapter four), and in circumstances when a patient has a cosmetic Botox injection and a consultation for back pain during the same appointment, split bills are not only legal, but expressly required by Medicare. The Services Australia Department, which administers the Medicare scheme, has no legal authority to collect and process information that falls within the domain of income tax (Australian Government 1973b). This includes anything that does not attract a Medicare benefit, such as a cosmetic Botox injection. If Medicare were to collect this type of information, it would be acting outside its permitted legal functions. Medicare therefore advises MP as follows:

"Medicare benefits are claimable only for 'clinically relevant' services rendered by an appropriate health practitioner. … When a service is not clinically relevant, the fee and payment arrangements are a private matter between the practitioner and the patient."(MBS Online 2020b)

Further, even if a court deemed these variously named additional fees and split bills illegal, the CCC would enable MP to shift costs easily and legally to consumers in other ways. For example, the most common MBS item for an initial consultation by a surgeon is item 104.

Instead of charging $500 for the item 104 plus a $500 booking fee, a surgeon could simply instead legally charge $1000 for item 104. Or a GP charging an annual membership fee, could instead charge the equivalent of the membership fee as a one-time high cost service for a simple attendance such as item 23.

Another example of a no doubt well-intentioned, senior journalist, reporting erroneously in relation to Medicare billing occurred during the 2014 co-payment debate already mentioned (Sloan 2014). Notably, the many errors on this occasion related to the claiming of a common, single service using two item numbers – one for the base service plus another for an incentive. With the exception of the reporter's comment that the MBS was complex, little else pertaining to the Government's co-payment plan was correct. This is described in **Table 5**.

Table 5 - Example of journalistic errors when reporting on the MBS

Direct quote from the published article	Nature of error made
"In addition to being paid the standard consulting item fee, GPs also receive an additional payment for bulk-billing their patients."	GP do not, and did not receive an additional payment for bulk billing their patients unless they were concessional or a child under 16.
"This extra payment adds between $7.50 and $10.65 per visit, depending on the location of the GP."	The incentive items, which were (and still are) *only* paid when a GP bills a concession card holder or child under 16, are paid at 85% of the schedule fee not the 100% quoted by the journalist. The amounts added (which were current on 1 July 2014) were therefore $6.15 and $9.25, respectively.
"Doctors receive both the standard and the incentive payments when they bulk bill patients."	They do not.
"Clearly, the continuation of the bulk-billing incentive fee makes no sense if the government is seeking to impose co-payments. But rather than eliminate this item number from the schedule, the government will retain it (it will be called the low gap incentive) to compensate doctors who bulk bill concessional card holders and children who have been to the doctor 10 times in a year."	Here, the journalist displayed a fundamental misunderstanding of both the operation of the Medicare scheme and how bulk bill incentives work. The proposed new co-payments required the GP to *first* charge the concession card holder or child $7 adding it to the base attendance item (which cannot be known in advance of providing a service) *before* they would become eligible to claim the incentive.

"At the same time, the standard MBS fee is to be reduced by $5. Given the government's insistence that a minimum co-payment of $7 should be charged…."	The proposed $7 co-payment was a maximum not a minimum amount.
"A variation would have been to eliminate the incentive payment for adults who don't hold concession cards."	There were no incentive payments for adults who did not hold concession cards. This remains so today.

This journalist, a well-respected Professor of Economics, reporting in a leading Australian newspaper, had undoubtedly researched the operation of the MBS and the bulk billing incentive items, but was unable to understand how those items operated or how the proposed changes would work. This suggests that attempts to self-learn seemingly simple medical billing, (noting this article related to the most commonly billed item number in the MBS) may flummox even the brightest minds. Additional examples of incorrect and misleading media reporting around the topic of MP billing practices are described in chapter four, but for present purposes, what is relevant is that while highly capable journalists may be forgiven for finding medical billing difficult to understand, no such generosity is afforded MP should they experience similar confusion.

Medicare 'big data' - the government perspective of Medicare bills

Government announcements of high bulk billing rates are regularly celebrated as suggesting Medicare is functioning well and patients are not paying OOP (Department of Health 2020d). Due to the method of medical billing described in this chapter, it is not difficult to see why departmental bulk billing statistics have been challenged as misleading (RMIT ABC Fact Check and Ellen McCutchan 2019), and why they do not align with separately reported data suggesting Australians are paying very high OOP (Organization for Economic Cooperation and Develpoment 2017).

Further, in view of the fact that the national audit office has suggested that annual non-compliant bulk billing in public hospitals is valued at over $300 million (Auditor-General 2019), these allegedly high bulk billing rates reported by the government may actually indicate that Medicare is in trouble. For example, MP could be charging unlawful gaps for every bulk billed

encounter and the government would not know because those transactions are recorded on separate software systems invisible to the government; MP may also be repeatedly returning patients to their surgeries to enable more bulk billing rather than attending to multiple medical problems under one bulk billed claim, could be correctly bulk billing one MBS service and separately charging for a second service at the same time (this is usually permissible), and fictitious services may also be hidden in the bulk billing mix. All of these variables are currently underreported and therefore unknown.

Additionally, the Medicare billing data received by the government is stripped of the context presented thus far in this thesis. The data can therefore only provide basic information about use of the Medicare billing system and whether use is increasing, decreasing, or is stable. Medicare item data alone cannot provide important information concerning the experience of users at the point of service and the context in which billing itemisation occurred. In the previously mentioned Medicare 'robodebt' story, which aired on national television, a health policy expert described flaws in the government's approach to Medicare's analysis of statistical data anomalies stating:

"If you're outside the bell curve, it's not a matter of if — but when — you'll be hauled before the PSR,"

"It's the whole notion of garbage in, garbage out — we've seen this in things like Robodebt where you've got data that doesn't accurately reflect what happens."(Hartley 2021)

The Australian National Audit Office has also questioned the ability of Medicare itself to accurately determine whether a Medicare claim is or is not compliant, finding departmental staff have sometimes erred in this regard, stating:

"MBS billing arrangements can be complex and may vary significantly by MBS item. As a consequence, Medicare compliance audits can vary in their complexity, and there can be challenges in accurately calculating debts to be recovered from health professionals…in the sample of … compliance audits reviewed, different approaches were identified to calculating

debts for claimants whose billing was assessed as non-compliant. In some audit cases compliance officers made decisions with supporting evidence from health professionals, while others made decisions without documented evidence. In this context, there is a risk that some debts in the wider population of Medicare compliance activities are also calculated inconsistently and, therefore, inaccurately…Of the 359 completed Medicare audits, 33 (nine per cent) contained data inaccuracies that resulted in compliant claims being incorrectly recorded and reported as non-compliant."(Australian Auditor-General 2014)

Conclusion

This section of the introduction chapter has described the constitutional foundations of Medicare, and provided a basic overview of how the Medicare billing system works. It has also provided some evidence of possible MP confusion around correct Medicare billing, and has suggested that a proliferation of prolix Medicare law may be contributing to interpretive challenges impacting MP compliance. Logically therefore, if the system has become confusing for the MP who use it every day, it may also have become confusing for the government, who is on the receiving end of Medicare claims. It is the receiver who ultimately determines whether claims are paid or rejected, so consideration of potential system vulnerabilities or threats that may have been introduced as a result of a possible surfeit of confusing law, is where the narrative now shifts. The following section introduces the key government agencies with responsibilities to preserve the integrity of the millions of Medicare payments made every day.

1.5 Public governance, accountability, and the integrity of the Medicare scheme

Introduction to the Australian National Audit Office and the Joint Committee of Public Accounts and Audit

Since Federation in 1901, Section 81 of the Australian Constitution and the *Annual Appropriation Acts* have enabled the Commonwealth to collect and spend taxpayer's money through a consolidated revenue fund. Medicare revenue is derived from that fund.

Auditing the flow of money in and out of the fund was seen as fundamental to good government in Australia's new accountable, parliamentary democracy at the beginning of the new century, and the fourth piece of Commonwealth legislation enacted by parliament after Federation was the *Audit Act 1901*. This Act created the office of the Commonwealth Auditor General, an independent institution designed to protect the public by scrutinising government accounts. The *Audit Act 1901* was replaced by the *Auditor-General Act 1997*, and the Auditor-General is now an independent officer of the parliament, housed in the Australian National Audit Office (ANAO).

The ANAO conducts performance audits of Commonwealth entities such as the Department of Health (DOH), applying accepted Australian Auditing Standards issued by the Auditing and Assurance Standards Board (Australian Government). A further layer of oversight and scrutiny is provided by the Joint Committee of Public Accounts and Audit (JCPAA) enabled by the *Public Accounts and Audit Committee Act 1951.* The JCPAA undertakes its own enquiries, including further audits of those already undertaken by the ANAO.

The cornerstone legislative instrument governing the conduct of public officials is the *Public Governance, Performance and Accountability Act 2013 (Cth)* (PGPA). The PGPA provides a standard requiring 'proper' use and management of public money, with 'proper' being defined in Section 8 as 'efficient, effective, economical and ethical'. Under the provisions of the PGPA,

all Commonwealth entities are required to have both a risk management framework and a fraud control plan.

When Medibank was introduced, the enabling legislation, the HIA, included the MSCI, which was the independent policing arm of the new scheme, with a remit to investigate fraud and excessive servicing, which became known as overservicing. Appeals from the MSCI could be made to the Medical Services Review Tribunal and the courts, while suspected fraud was dealt with via usual criminal justice channels.

Historical records suggest that from the outset, the government assumed (and continues to assume), that MP would work out how to bill correctly largely on their own (Scotton and MacDonald 1993). Therefore, post-payment audits were deemed sufficient to manage compliance and scheme integrity. This mistaken view may have been the Achilles heel of entire scheme. Had the government had the foresight to introduce a national curriculum on the operation of the new Medibank scheme, the process of developing necessary expertise in the emergent field of health financing law and practice, would have begun. A simple initiative of this nature was arguably always within the government's grasp, but instead, MP were left (and are still left) to interpret and apply the scheme's increasingly complex legal requirements on their own, and non-compliance has been an intractable problem ever since.

By 1982, a progress report of the JCPAA (Commonwealth Government 1982) indicated the MSCI was failing, both in terms of cost and outcomes. Few MP were being investigated or prosecuted, largely because the FFS structure of the scheme made investigations inefficient and expensive. It would take days or weeks to obtain and scrutinise a single medical record to prove that a service valued at under $20 was unnecessary and therefore should not have been paid. There was no return on the government investment, and nor were MP adequately deterred by the MSCI, due to the low numbers of successful prosecutions and the ease with which they could avoid or frustrate an investigation.

In 1992, an Auditor-General's report titled 'Medifraud and Excessive Servicing: Health Insurance Commission' (Australian Auditor-General 1992-3) cited little improvement over the previous decade, numerous ongoing inadequacies and failures including inadequate policing, insufficient training for staff and regulatory gaps, and concluded that the level of Medicare fraud had increased significantly. This report became the catalyst for the introduction of the Professional Services Review Agency (PSR), which is discussed in more detail shortly.

The ANAO and the JCPAA conducted numerous audits of Medicare agencies prior to the introduction of the PSR. If their fundamental purpose was accountability to the public purse, this research found that both current and earlier Medicare audits have fallen well short of achieving that aim. This may be partially attributable to lax regulation, under which the ANAO has limited authority beyond auditing departmental performance, and can make recommendations but without power to enforce them. A performance audit, by its very nature and design, may be unable to achieve sufficiently high levels of specificity and scrutiny to determine whether Medicare transactions are correct.

Introduction to the Professional Services Review Agency (PSR)

The next layer of accountability down the compliance ladder with the specific remit of post-payment policing is the PSR, which is the principal government agency tasked with maintaining the integrity of the Medicare scheme.

Perhaps the most curious anomaly around the introduction of the PSR, which was designed with the full support and cooperation of the medical profession, is that it was built on a false premise – that MP understand how Medicare works. Though not formally documented, the concept of MP peers sitting in adjudication of their colleagues on Medicare billing compliance must have rested on an accepted assumption that there was a high level of legal literacy among MP about how to bill correctly. However, this study will show that assumption is and always was incorrect.

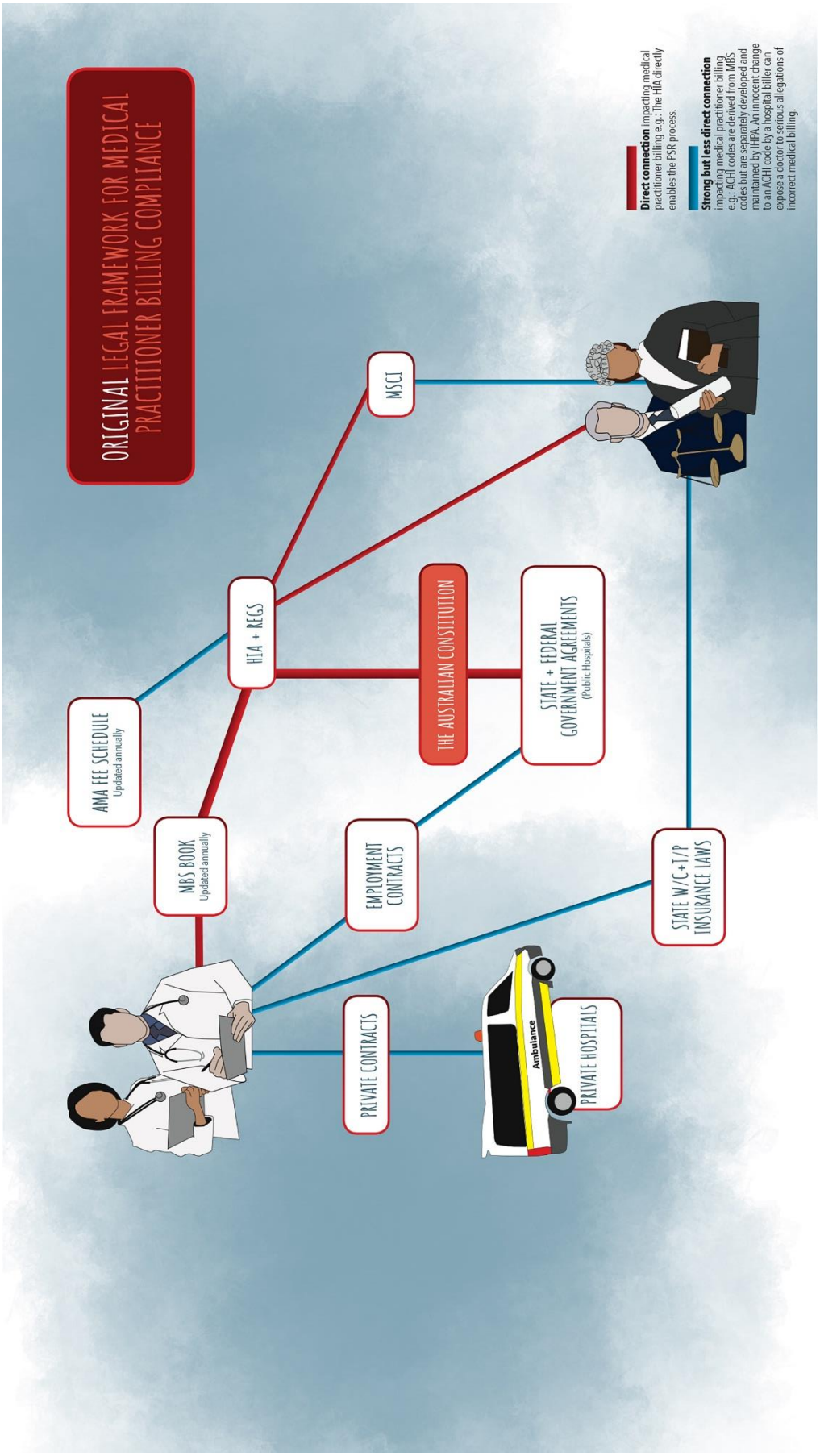
Evidence presented in this research suggests MP are not now and have never been taught how Medicare works or how to bill correctly, there is not now and has never been a national curriculum on the topic, and medical billing complexity has increased exponentially over many years. Therefore, the MP appointed to the PSR who sit in judgment of their colleagues, from the outset, would at best have had variable levels of self-taught knowledge about the very rules they would enforce. This raises the possibility of MP peers themselves having engaged in inappropriate practice prior to sitting on the PSR, and may have first become aware of their own erroneous billing conduct through learning gained on the PSR. Either way, MP peers were not (and are not) medical billing experts, because this research found that category of person does not exist in Australia. There also appears to be no legislated requirement that peers hold any relevant qualification that would demonstrate deep knowledge of the provisions of the HIA and the associated suite of interconnected legislation that might be thought a prerequisite for a PSR appointment.

An increasingly complex legislative landscape

In 1975, when Medibank was introduced, the regulatory landscape MP were required to navigate was relatively simple. The HIA introduced a schedule of services based on the AMA list of the most common fees, and the only other contracts and arrangements some MP would have encountered in their daily billing activities were the contracts with the hospitals where they worked, and possibly workers compensation (WC) insurers which have existed since the 1920s. Prosecution pathways were also relatively simple, with the only new element being the MSCI. This framework is represented in **Figure 4**.

To investigate or prosecute medical billing non-compliance, a reasonable assumption is that peers are able to demonstrate understanding of applicable regulatory complexity, for it is not possible to conduct an impartial, fully informed enquiry otherwise.

Figure 4 - Original MP medical billing compliance framework, 1975



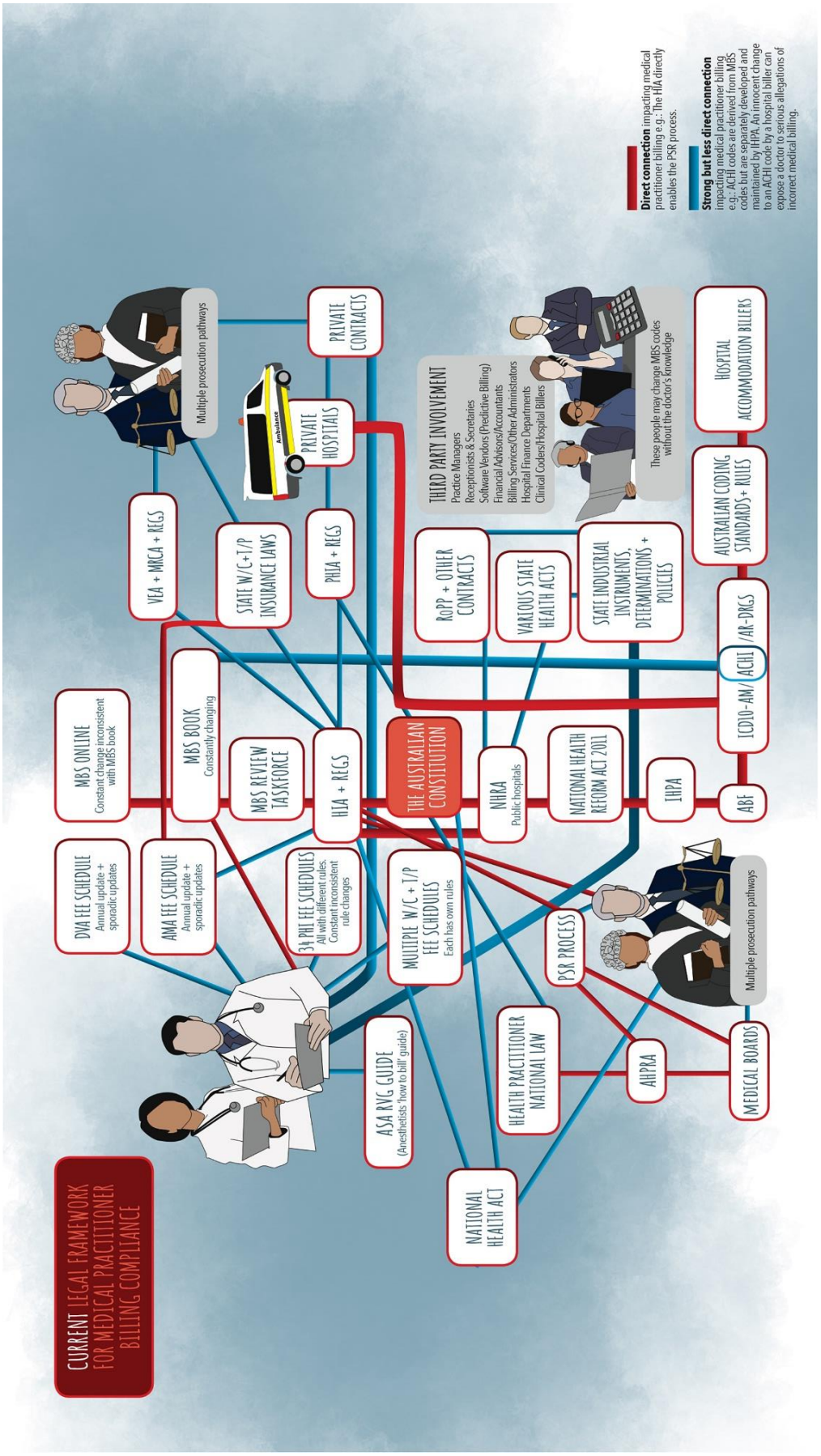
It is therefore helpful to visualise this complexity and the vast body of interconnected laws, agreements, and various other instruments that have been introduced by successive governments, mostly over the last 20 years. This has led to the current complex, tangled web of legal elements, now so convoluted, it is suggested it would be beyond the comprehension of anyone. This is represented in **Figure 5**.

Very few medical billing decisions involve one law. For example, in the common scenario of a salaried MP employed in a public hospital consulting a private patient, in order to confidently bill correctly, the MP requires some understanding of *each* of the following:

- relevant provisions of the HIA and Regulations;
- relevant provisions of the NHRA;
- private health insurance laws such as the Gap Cover legislation;
- the terms and conditions of the relevant PHI;
- the provisions of their ROPP Agreement;
- the provisions of relevant state health acts; and
- the item description in the MBS (which may be different to the underlying law).

Findings from this study will demonstrate that MP have scant knowledge of these legal instruments, and perhaps the most troubling aspect of this is that even if a rare MP is able to integrate and comprehend all relevant requirements, a well-meaning third party, such as a clinical coder who is far removed from the original MBS item allocation, may change the item without the knowledge of the MP. In addition, evidence to follow suggests the PSR has always struggled with this regulatory complexity, and has been a troubled agency since its inception. Being central to the topic of MP billing compliance in Australia, the PSR is the subject of focussed attention later in this thesis. However, it is first necessary to contextualise the FFS transaction type that the PSR oversees, and its place in global health systems. This is of particular importance because the constitutional structure of Medicare already discussed, suggests FFS payments will remain a feature of Australia's Medicare long into the future.

Figure 5 - Current MP medical billing compliance framework



1.6 Fee-for-service payments in the Australian context

During the half century after WWII, global recognition that investment in health pays the greatest dividends for economic prosperity increased. In 1948 the World Health Organization (WHO) declared health a fundamental human right (World Health Organization 1948), and the Alma Ata declaration at the International Conference of Primary Health Care in 1978 affirmed a Health for All agenda (World Health Organization 1978). By 2012, UHC was endorsed by the United Nations (UN) and on 25 September 2015, the UN adopted the target of UHC by 2030 for all member states as an agreed sustainable development goal (United Nations 2019).

Australia's predominantly FFS Medicare system is widely considered one of the best UHC systems in the world, both in terms of cost and health outcomes (The Commonwealth Fund 2020). Prior to its introduction, one in five Australians had no health insurance and the voluntary private market had become too complex for most people to understand (J.A. Nimmo 1969). An authoritative record of the introduction of Medibank noted**:**

"By the mid-1960s the limitations of Australia's voluntary health insurance scheme were starting to be felt. The financial growth of the health insurance funds contrasted with growing dissatisfaction with rising contribution rates and gaps in coverage. Though few were aware of it, the time was ripe for health insurance to become a major public issue." (Scotton and MacDonald 1993: 19)

A turbulent political period led to the abolition of Medibank on the 14th of April 1981 and a return to voluntary, private insurance for approximately two and a half years. A new government ushered in the rebranded Medicare scheme on the 1st of February 1984, which endures today.

Australia's health reformists are now actively advocating a shift away from FFS to new payment models which prefer value over volume; the core principle of VBC (Australian Healthcare and Hospitals Association 2020). However, dismantling FFS payments in Australia

will be difficult due to the constitutionally sanctioned contractual relationship between MP and patients. Further, without ever having attempted to remedy underlying structural problems, it is difficult to sustain a compelling argument that dismantling FFS payments or introducing new payment models is all that is needed to set Australia on the right path to a more fiscally accountable health system. The complexity and unique features of the health market demand a more detailed and considered approach to offset the multiple unique variables at play when paying for health, including asymmetric information (G.Palmer and S.Short 2010), the operation of the moral hazard (Einav and Finkelstein 2018), the impact of the social determinants of health (Marmot 2015), the realities of rationing and poor health system literacy.

The Australian FFS payment model has often been weaponised by governments who have vacillated between blaming MP or patients for increasing Medicare expenditure. When seeking to control the supply side of health expenditure, MP are the natural target, due to widespread understanding that FFS payments incentivise oversupply of unnecessary services.

However, on occasion, the government has shifted its focus to the demand side of health expenditure, in which patients become the problem. This typically takes the form of co-payment proposals suggesting patients require a price signal to curb their overuse of medical services (Parliament of Australia 2014).

While it is not surprising that a push to abandon FFS has garnered support among policymakers (Wright 2016; Australian Healthcare and Hospitals Association 2020) because it seems an obvious and tantalisingly simple solution to the oversupply problem, basic economic principles of supply and demand will never solve structural deficits in the Medicare system. Further, it is suggested that blaming cost blow-outs on the end users of any modern health system is deserving of criticism as an outdated and lazy approach, designed to do nothing more than obfuscate the shortcomings and maladministration of governments which have been slow to adapt their payment systems and compliance activities to the modern world.

1.7 Fee-for-service payments in the global context

The WHO has stated no health system will succeed without a strong health financing system supporting it, and that such systems require careful construction and design based on country specific socio-political considerations (World Health Organization 2010). Not all successful health financing systems are funded through taxation like Medicare. Another common source of UHC funding is employer/employee contributions, as seen in the U.S, Indonesia, and the United Arab Emirates. However, with over 100 years of collective global experience, a substantial body of knowledge is available to inform optimal, country-specific design, a basic requirement of which is the enablement of rapid payments through the health service supply chain irrespective of the funding source. If MP and hospital providers experience payment delays, they quickly shift the cost burden to consumers to offset disruptions to their cash flows, which causes OOP medical expenses to be incurred by patients at the point of need.

Effective UHC systems offer mandatory rather than voluntary coverage (World Health Organization 2010), strong community-based primary care triaging access to more expensive secondary and tertiary care (World Health Organization 2010), pre-payment and pooling of risk (World Health Organization 2010) and in competitive, private health insurance markets, some form of risk equalisation (Faux 2017). Some systems operate as a single public payer model (HP+/TNP2K. 2018), others are private (Scott 2020), and some, like Australia, have blended public/private payment arrangements. There is no clear international consensus on a ‘best’ model or MP payment type, but FFS payments remain common (World Health Organization 2010) and all health systems feature one or more of the payment types shown in **Figure 6**, each having well documented advantages and disadvantages (L.Guinness. and V.Wiseman. 2011).

Figure 6 - Advantages and disadvantages of the four main provider payment mechanisms

Payment	*Advantages*	*Drawbacks*
Fee-for-service	Provides a direct incentive to the doctor to increase effort (can be useful in some situations where there is an under-use of services)	Incentive to increase the provision of services beyond what is necessary (over-supply or supplier-induced demand); cost escalation
Capitation	No incentive to over-supply or induce the demand; strong incentive to improve efficiency of care delivery; improves continuity of care; ensures a good control of costs	Incentive to undersupply; increased efficiency may cause providers to sacrifice quality (however, not so much if patients are free to choose); 'cream-skimming' behaviours – doctors favour the enrolment of patients who are less sick
Salary	No incentive to over-supply or induce the demand; no incentive to compete for patients and/or select better-off and healthier patients; ensures a good control of costs	No incentive to improve efficiency; incentive to reduce services and/or quality of care
Performance-based payment	Increase the provision of specific (desired and targeted) services; increase the quality of care (when targeted)	'Gaming' behaviours (people trying to cheat by over-reporting); effort and attention is taken away from services that are not rewarded; potentially complicated system to monitor and enforce

*Source: Lorna Guinness & Virginia Wiseman: **Introduction to Health Economics**, second edition, 2011. McGraw-Hill Education, at page 156*

FFS is often criticised as being the least effective payment type (World Health Organization 2010), despite research suggesting other payment types have led to more worrying outcomes such as risks to human health. For example, the introduction of capitated managed care did not alleviate fraud and non-compliance in the U.S health system, but made it worse. Not only did non-compliance become more difficult to detect, it became more dangerous to patients when overservicing was replaced with underservicing (Sparrow 2000).

"…the trend…is to replace fee-for-service structures with some kind of standardized fee structure – Diagnosis Related Groups, Prospective Payment Systems, or even fully capitated managed care…it suggests there is no hope of ever managing a fee-for-service system properly; the only 'fix' available is to scrap it and replace it with something else…the

introduction of capitated or prospective payment systems carries with it an entirely new set of problems and new fraud types…" (Sparrow 2000: 52-53)

Other studies have found that the United Kingdom's capitation-model UHC system, the National Health Service (NHS) has some of the highest rates of non-compliance and fraud in the world (Gee and Button 2014); more recently, a study of alternative payment models reported potential negative impacts of value-based care (VBC) on vulnerable populations, who are unlikely to achieve the measurable outcomes VBC depends upon. The research suggested these new payment models may hurt rather than help, particularly for MP serving poor and disadvantaged communities (Joynt Maddox K. E 2018). Another commentator has expressed similar concerns around measurement of the nebulous concept of value under VBC (Rosenbaum 2017).

"…perhaps the most problematic is its [VBC's] reinforcement of illusions about value: that we know what it means and can measure it, that the same things matter to all patients, and that the effect of any intervention can be understood in isolation from countless others." (Rosenbaum 2017: 2396)

Returning to FFS payments momentarily, a recent publication in the *Journal of Medicine and Philosophy* (Heath J 2020) initiated an important discussion concerning the moral dimensions around compliant medical billing, suggesting creative billing practices should be stigmatized rather than celebrated from within the profession itself. The author described as a 'rather surprising oversight' that while medical ethics is a recognized component of medical education, the financial aspects of medical practice are almost never discussed and medical practitioners therefore receive little or no guidance in this important area. Further, that in FFS payment environments, MP have enormous latitude in regard to how they describe their services, with often very little effective oversight by payers. Therefore, the human temptation to misrepresent the services they provide can sometimes be significant, particularly where a seemingly small 'fiddle' to a service description can lead to higher reimbursement. The ethical challenges in navigating this are never taught nor even mentioned throughout medical

undergraduate or postgraduate training, yet the legal consequences when MP are found in breach of payment rules are usually very serious. The author argued that both medical schools and specialist colleges have failed in their duty to address this critical gap in learning and suggested some colleges may actually be cultivating the practice of questionable or borderline billing to 'maximise' or 'optimize' financial return. Moreover, that medical practitioners often fail to see the connection between their own poor billing conduct and the failure of the health system overall and that to address these challenges, both education and regulation are required. There is evidence that the practice of 'maximising' or 'optimising' medical billing to increase financial return may be prevalent in Australia, and is discussed in section 2.3.

Ultimately, the way we choose to pay MP in the future will continue to evolve. But irrespective of payment type, actual spending will continue to occur (either directly or indirectly) at the point of service, based on an encounter between a MP and a patient.

A principal focus of effective health financing system regulation must therefore always be to ensure the cost burden is not shifted too far to consumers (World Health Organization 2010). Unfortunately in Australia, OOP medical expenses are now some of the highest in the world (Organization for Economic Cooperation and Develpoment 2017) and voluntary PHI coverage is in rapid decline (Duckett 2019a). The many factors which have led to this situation extend well beyond egregious conduct by a few avaricious MP or Medicare's FFS structure, and solutions will require a fundamental rethink about how we modernise Medicare and manage system integrity into the future.

1.8 Are medical practitioners adequately equipped to comply with Medicare?

In early 2014, a report by the National Commission of Audit (NCA) (National Commission of Audit 2014) proposed that Medicare co-payments be introduced as a responsible and necessary health system reform with a stated purpose of sending a price signal to Australians who were apparently over utilising medical services, because they perceived them as 'free'. The report stated:

'medical practitioners who wish to bulk bill should not be able to waive the co-payment.'(National Commission of Audit 2014: 202)

It was quite extraordinary that a report produced at the highest levels of government appeared to have little understanding of the fact that the proposal, in its original form, would very likely have created a legal compulsion affecting Australia's principal cohort of primary healthcare providers, our GP. Had the powerful GP lobby been inclined to contest the initiative in the High Court, a case arguing the proposal offended the CCC, on its face, appeared strong.

Notably, a few months later when the federal budget was delivered on 13 May 2014, the proposal had been modified and was introduced in the following revised terms:

"Providers will still be able to set their own fees and will have discretion whether to charge the $7 patient contribution." (Commonwealth Government 2014: 10)

While the revised structure of the proposal may no longer have constituted legal compulsion, the question of whether it would have constituted practical compulsion remains unanswered. The design of the second iteration involved a minimum 13% revenue reduction for GP if they refused to participate (Faux 2014), however, it did not go ahead so was never tested.

In the period between release of the NCA report and the subsequent parliamentary debates, it appears the Prime Minister, the Honourable Tony Abbott MP, may have been briefed on the

operation of the CCC in relation to medical fee setting, evidenced by his specific use of the word 'compulsion' on 16 July 2014 (Hansard 2014). He stated:

'As the shadow minister well knows, there is no compulsion on any doctor to charge the co-payment.'

In the end, the co-payment proposal failed. Succumbing to the weight of heavy and sustained criticism, it was eventually scrapped, the Prime Minister declaring it *'dead buried and cremated'* on 3 March 2015 (Hansard 2015).

The following article, which forms the remainder of section 1.8, was published during the 2014 co-payment debate. The article introduces some of the complexity and challenges experienced by MP in regard to daily Medicare billing, and suggested the proposed co-payment initiative would have compounded existing difficulties around Medicare billing and compliance.

The publication was a personal viewpoint published article in the *Internal Medicine Journal* of the Royal Australasian College of Physicians in 2015**. No payments, copayments and faux payments: are medical practitioners adequately equipped to manage Medicare claiming and compliance?** Faux MA, Wardle JL, Adams J. DOI:10.1111/imj.12665. The article can also be accessed via this link https://pubmed.ncbi.nlm.nih.gov/25650538/

Abstract

The complexity of Medicare claiming means it is often beyond the comprehension of many, including medical practitioners who are required to interpret and apply Medicare every day. A single Medicare service can be the subject of 30 different payment rates, multiple claiming methods and a myriad of rules, with severe penalties for noncompliance, yet the administrative infrastructure and specialised human resourcing of Medicare may have decreased over time. As a result, medical practitioners experience difficulties accessing reliable information and support concerning their claiming and compliance obligations. Some commentators overlook the complexity of Medicare and suggest that deliberate misuse of the system by medical practitioners is a significant contributor to rising healthcare costs, although there is currently no empirical evidence to support this view. Quantifying the precise amount of leakage caused by inappropriate claiming has proven an impossible task, although current estimates are $1–3 billion annually. The current government's proposed copayment plan may cause increases in noncompliance and incorrect Medicare claiming, and a causal link has been demonstrated between medical practitioner access to Medicare education and significant costs savings. Medicare claiming is a component of almost every medical interaction in Australia, yet most education in this area currently occurs on an ad hoc basis. Research examining medical practitioner experiences and understanding regarding Medicare claiming and compliance is urgently required to responsibly adapt Medicare to our rapidly changing healthcare environment.

Introduction

In 1969 the Nimmo Report highlighted how "the operation of the health insurance scheme [was] unnecessarily complex and beyond the comprehension of many"[1] and the report became a catalyst for the 1975 introduction of Medibank, Australia's first national health insurance scheme. Medibank introduced subsidies for health care services on an unprecedented scale however complexities in the health insurance scheme appear to remain.

In its first year, the cost of Medibank (of which medical services were only one component) was $1.647 billion.[2] By 2009-2010 the cost of the medical services component alone, reimbursed under Medicare (Medibank's successor) had risen to $21.2 billion.[3] The decade 2000 to 2010 recorded an average medical services expenditure increase of 3.9% per annum[3] which, if continued, will see medical service costs rising to approximately $31 billion by 2020. Given these circumstances, it is not surprising that Medicare costs and the sustainability of the tax payer funded health insurance scheme have often been the focus of attempts to contain rising health care costs.

Deliberate misuse of the system by errant medical practitioners has been cited as contributing significantly to Medicare's financial pressures,[4 5] though quantifying the precise monetary value attributable to inappropriate claiming has proven an impossible task [5 6]. In 2004 minimum estimates were 10% [5] and current estimates, which are based solely on extrapolation and expert opinion, are between 5-15%, representing approximately $1 - $3 billion annually [4 6].

Despite this there has been little research exploring possible alternative explanations for erroneous claims beyond rorting, including institutionalised inefficiencies within Medicare itself. Nor has there been any empirical examination of medical practitioners' understanding of the Medicare scheme and its correct application at the point of service, or possible difficulties in adequately navigating what has become – despite the Nimmo report's findings forty-five years ago – a highly complex and often incomprehensible scheme.

This article summarises a selection of available literature on the topic of medical practitioners' understanding of Medicare and examines the complexity of day-to-day Medicare claiming. Without further examination of this important topic, proposed changes to Medicare (including the introduction of co-payments), may compound the compliance difficulties facing medical practitioners. Such empirical work is essential to responsibly adapt Medicare – or any institutionalised payment system – to the modern delivery of health care services.

Historical development and system complexity

The enabling legislation for Medibank (and subsequently Medicare) is the *Health Insurance Act 1973* (Cwth) and associated regulations, articulated in the Medicare Benefits Schedule (MBS). In the forty years since the *Health Insurance Act* was introduced, health financing has become more convoluted and now involves a web of legal statutes and agreements, regulations, policies and rules which impact the daily MBS claiming activity of medical practitioners who are heavily dependent on subsidised Medicare payments for their livelihoods (Table 1). This dependence has been the subject of deliberations by the High Court, which has confirmed the reliance of Australian medical practitioners on Medicare to ensure viability.[7]

Australia's national health insurance scheme has often been subject to political tinkering, including the previous introduction of co-payments by two governments, reforms which were subsequently repealed. The Medicare scheme has become increasingly complex, and now reimburses approximately 6000 professional services, compared to the original 1000 reimbursed by Medibank. The hard copy of the MBS has more than doubled in size since the first edition and comprises almost 900 A4 pages of service descriptions, complex cross referencing and rules.

In addition to MBS use by medical practitioners in private practice, cost sharing arrangements between States and the Commonwealth have enabled public hospitals to access MBS benefits to supplement Commonwealth grant funding.[8] In practical terms this is implemented by requiring salaried medical practitioners working in public hospitals to claim MBS benefits for private inpatients and referred outpatients, secured by way of individual Right of Private Practice (RoPP) agreements between medical practitioners and hospitals. MBS reimbursements collected under these arrangements may be retained by the medical practitioner, the hospital, or shared in various proportions. RoPP arrangements differ in every State and Territory, as do the arrangements for unsalaried medical practitioners, who may

also claim MBS reimbursement for private patients and referred outpatients in public hospitals.[9]

Table 1 Minimum legal literacy required by medical practitioners to claim correctly for medical services provided on a daily basis

	Private practice		Public hospital practice					
	IP	OP	Public IP	Private IP	Referred OP	Non-referred OP	Emergency department†	Comments
Health Insurance Act 1973	X	X	X	X	X	X	X	
General Medical Services Table	X	X		X	X			
Diagnostic Imaging Services Table	X	X		X	X			
Pathology Services Table	X	X		X	X			
Health Insurance Regulations 1975	X	X		X	X			
Medicare Benefits Schedule (MBS)	X	X		X	X			The MBS is a departmental interpretation of the first five statutes referred to in this table. It is updated regularly and is available as an online reference.
Veterans Entitlement Act 1986	X	X		X	X			Veterans' claims are administered by Medicare and use MBS item numbers.
Military Rehabilitation and Compensation Act 2004	X	X	X	X	X	X	X	Current defence personnel claims are administered by Garrison Health Services, a business line within Medibank Health Solutions.
National Health Reform Agreement			X	X	X	X	X	
Right of Private Practice agreements				X	X			
Employment/contractor agreements	X	X		X	X			
Private Health Insurance Act 2007	X			X				There are 34 registered private health funds‡
Workers compensation and third party insurance schemes in each state and territory§	X	X	X	X	X	X	X	Workers compensation and third party schemes derive medical services from the MBS.

†Non-admitted patients in public emergency departments are categorised differently from other public non-admitted patients (called outpatients) and can never have MBS charges raised against them. ‡http://www.phio.org.au/downloads/file/PublicationItems/SOHFR2013.pdf. The 34 registered private health funds have unique schemes, arrangements and fees for the same medical services. See Table 2. §All States except Victoria and Western Australia have now adopted the new national law http://www.safeworkaustralia.gov.au/sites/swa/model-whs-laws/pages/jurisdictional-progress-whs-laws. Victoria and Western Australia continue to operate under their respective Occupational Health and Safety schemes. Each State and Territory has unique third-party insurance arrangements and legislative frameworks. IP, inpatient; MBS, Medicare Benefits Schedule; OP, outpatient.

Reimbursement for medical services is also provided by other payers such as private health insurers, the Department of Veterans Affairs, workers compensation and compulsory third party insurance organisations all of which add further complexities to a system where a single service can now be the subject of thirty different payment rates, multiple claiming methods

and a myriad of rules (Table 2), with strict penalties for medical practitioners who claim incorrectly.

Medicare's administrative infrastructure

Despite greater complexity and substantial growth of the MBS since 1975, no corresponding rise in departmental infrastructure and expertise to manage this growth, or support the increased number of providers using the scheme is evident. Rather, even when accounting for efficiencies afforded by new and emerging technologies, there appears to have been a decrease in the administrative infrastructure and specialised human resourcing of Medicare.

Prior to the launch of Medibank in 1975 a nationwide administration system, unprecedented in size and scale, was implemented. A dedicated and highly skilled team was required and the Health Insurance Commission (HIC) was established for this purpose.[10] In what was described as a critically important decision by Medibank's founders, the HIC was created as a separate commission[10] with HIC staff employed outside of the *Public Service Act,* ensuring promotional opportunities lay exclusively within the Commission and essential expertise would not be lost with every round of promotions.[11] However, legislative reforms in 2005 dissolved the HIC as a separate commission and the original crucial safeguards, specifically designed to retain departmental Medicare expertise, were undone, dismantling the barriers designed to prevent Medicare staff from moving to other public service departments.

Reviews into Medicare claiming

By 2011, MBS claiming had become so complex it came under the scrutiny of a Senate Committee inquiry.[12] During the inquiry medical practitioners openly expressed their frustrations and difficulties accessing reliable information and support from Medicare regarding billing and compliance. This conflicted with institutional submissions from Medicare, which suggested ample resources and reliable support were available.[12]

Submissions to the inquiry from medical defence organisation (MDO) representatives suggested that processes should be in place to enable medical practitioners to obtain clarity about the use of the MBS, drawing a comparison between the advice and written rulings available from the Australian Taxation Office and the lack of similar information and advice from Medicare, suggesting that as a result medical practitioners often unknowingly fell into non-compliance.[12]

One personal submission from a medical practitioner (who had previously been investigated by the Professional Services Review [PSR]) was highlighted by the Committee to illustrate practitioner frustrations with the response of Medicare to requests for further information around claiming:

"…'[Medicare said] we cannot give you an answer... We suggest you contact the AMA and the college of GPs.' I contacted the AMA and the College of GPs…and they said: 'We are not here to interpret the Medicare schedule. That should be done by Medicare.' Medicare will not do it. The PSR will not do it. The AMA will not do it. The College of GPs will not do it. And we get fined."[12]

The MDO of this medical practitioner may also have provided limited assistance, as standard practice for MDOs is to refer members to Medicare to seek advice concerning MBS claiming in the first instance, and indemnity cover under the policies of some MDOs excludes fees charged, which are subsequently required to be repaid to Medicare, irrespective of whether the medical practitioner personally retained the fees in question.[13]

The Senate Committee concluded that, although it was the responsibility of medical practitioners to make clinical judgments, as much advice and information as possible should be available to them in relation to MBS itemisation, but fell short of clarifying or identifying who should provide such advice and information.[12]

Table 2 Current claiming options for MBS item 110 (a physician attendance)† All fees valid up to 30 June 2014

Insurer	Fee	Comments	Claiming method
Medicare schedule fee	150.90	The Australian Constitution s51 (xxiiiA) provides that doctors are free to set their own fees. Any fee can therefore be charged depending on the claiming method used and the context in which the service is provided. The schedule fee is the total patient rebate available for a private inpatient service. Medicare reimburses 75% of the schedule fee and the patients' private health fund, the additional 25%. If a gap cover scheme is selected by the doctor, different fees apply.	Claim usually sent to the patient to pay and then claim rebates. Three statutory claiming options are available.
Medicare outpatient rebate	128.30	Medicare reimburses 85% of the schedule fee for outpatients and 75% for inpatients if the claim is bulk billed.‡ When bulk billing, raising additional charges or copayments is illegal.§	Electronic or manual claim usually sent directly to the department. The patient is required to sign the assignment of benefit in the approved form.
Medicare inpatient rebate	113.20		
Medicare telehealth rebate	192.40	To claim item 110 as a telehealth service, it must be claimed together with item 112. Additional incentives are also payable but not simultaneously with the claim submission. There are complex requirements for obtaining the patients signature if bulk billing as the patient is not physically present. Gaps can be charged for telehealth services.	
Department of Veterans Affairs inpatient	208.15	Specific requirements concerning the charging of ex-servicemen and women are contained in the Veterans Entitlements Act 1986 which prevents Veterans being charged if the medical practitioner has accepted the Veterans card.	
Department of Veterans Affairs outpatient	203.75		
Australian Defence Force	195.20	Garrison Health Services is a new business line within Medibank Health Solutions now administering current serving member claims. Specific requirements exist concerning the charging of Defence personnel.	Manual claim sent to Garrison Health Services
HCF	193.65	Inpatient gap cover arrangements where the patient enters an agreement with their private health fund to assign their Medicare benefit to the fund. The patient is not required to sign the assignment of benefit form. No additional fee can lawfully be charged to the patient when using gap cover schemes unless a known gap scheme operates. — HCF does not operate a known gap scheme	ECLIPSE¶ agreement sent manually or electronically to the health fund
St Lukes Health	193.65	St Lukes Health operates a known gap scheme where an additional amount up to 10% of the St Lukes Schedule can be charged to the patient. Written informed financial consent (IFC) is a legal requirement under all known gap arrangements.	
Latrobe Health	188.63	Latrobe Health provides known gap cover under an MPPA	
HBF	195.20	HBF operates a known gap scheme where the patient can be charged up to 10% above the HBF schedule. IFC required.	
GMHBA	181.10	GMHBA operates a known gap scheme where an additional amount can be charged to the patient. This amount is unspecified. IFC required.	
BUPA NSW, QLD and ACT	181.15	Can charge an additional amount of $500 per episode under BUPAs known gap scheme which were expanded from Victoria and South Australia to all states on 1 July 2014. Restrictions to some practitioners apply. IFC required.	
BUPA VIC	212.15		
BUPA SA	209.10		
BUPA TAS	181.00		
BUPA WA	181.50		
BUPA NT	181.45		
AHSA†† NSW and QLD	178.00	AHSA operates a known gap scheme where an additional amount can be charged to the patient being the difference between the AHSA rate and the AMA rate up to a maximum of $400 per MBS item. IFC required.	ECLIPSE 'scheme' (additional requirements to the 'agreement' above) sent manually or electronically to the health fund
AHSA VIC	184.70		
AHSA SA, TAS and NT	183.50		
AHSA WA	162.50		
AHSA ACT	179.90		
Medibank Private and Australian Health Management (AHM)	195.20	Medibank Private and AHM operate a known gap scheme where an additional $500 amount per claim (as opposed to per MBS item) can be charged to the patient. IFC required. Specific rules for certain specialties.	
NIB	173.45	NIB does not operate a known gap scheme	
AMA recommended fee	300.00	The AMA fee is also the fee payable for workers compensation and third party claims not otherwise listed in this table.	Claim usually sent to the patient
Victorian Workcover	244.93	This is also the applicable rate for third party Transport Accident Commission claims in Victoria.	Manual claim sent either to the patient or to the insurer
Workcover SA	232.10		
Workcover WA consulting rooms	266.20	Includes the issue of a certificate if required	
Workcover WA hospital or home	318.80	Includes the issue of a certificate if required	

†Item 110 was chosen as it is a commonly claimed physician item for both inpatient and outpatient services. General practitioner (GP) items operate differently. The most commonly claimed GP service is item 23, which can only be claimed on an outpatient basis. The equivalent GP inpatient attendance is item 24 to which this entire table applies. However, item 24 is subject to additional complex rules as GPs are paid different amounts if more than one inpatient is consulted on the same day. A sliding fee scale applies. ‡GP non-referred services are paid at 100% of the schedule fee, but this does not apply to item 110, which is a specialist service. §s20A of the Health Insurance Act 1973 provides that when bulk billing, doctors must accept the assigned Medicare rebate in full payment for the service provided, the only exception being certain vaccines. ¶ECLIPSE Electronic Claim Lodgement and Information Processing Service Environment. Medicare's online claiming portal for inpatient services. ††AHSA Australian Health Service Alliance. Umbrella organisation for 25 registered health funds for which it facilitates claiming arrangements and fee schedules. AMA, Australian Medical Association; BUPA, British United Provident Association; GMHBA, Geelong Medical and Hospital Benefits Association; HBF, Hospitals Benefit Fund of Western Australia; HCF, Hospitals Contribution Fund of Australia; MPPA, Medical Purchaser Provider Agreement; NIB, Newcastle Industrial Benefits Hospital Fund.

A notable case

PSR decisions, unlike Medical Board decisions, are not publicly available and therefore offer little further guidance to medical practitioners concerning how to claim Medicare benefits correctly. Very occasionally, when incorrect Medicare claiming amounts to criminal activity, reported cases are found on the public record and it is in this context where the complexity of Medicare has proven a challenge for members of the legal profession.

In 2006 a case of Medicare fraud was appealed in the NSW Court of Criminal Appeal, [14] where the meaning of three ubiquitous words in the scheme - 'in respect of' - was considered [14]. A medical practitioner, who had been found guilty by a jury of 96 counts of fraud, maintained that the fees in question were not fees 'in respect of' the relevant MBS service. One of the three appeal court judges (Justice Adams) agreed.

The conduct for which the medical practitioner was found guilty was in bulk billing and also charging another amount to her patients on the same day. The medical practitioner had, in effect, charged her patients a co-payment, which was then and remains illegal.[7] [15]

Justice Adams commented that requiring the medical practitioner to have known in advance the legal meaning of 'in respect of' amounted to requiring her to interpret a point of law and apply it to the facts which, as a medical practitioner, she had neither the skills nor qualifications to do. Justice Adams pointed out that interpretation of the MBS will always be debatable and medical practitioners should not be rendered liable to criminal prosecution for making a 'not unreasonable' interpretation of it.[14]

Yet whilst even senior members of the Australian judiciary may not agree on issues of MBS interpretation, medical practitioners must make claiming decisions every day and remain personally responsible for every MBS service claimed. This is cited as a responsibility which can never be delegated or abrogated [16] as there is very limited scope for third parties to be held accountable for MBS claiming. As a result, hospital administrators, front desk staff and

other third parties who may direct or facilitate medical practitioner's MBS claims, will not themselves be held to account should that claiming be incorrect.

Government initiatives

Some commentators overlook the increasing complexity of Medicare, maintaining that incorrect claiming is due to widespread and wilful misuse of Medicare by medical practitioners.[4] The government's response to such claims has been to increase pressure on medical practitioners through expanding audit and compliance initiatives[17], but despite these initiatives, a recent report tabled in parliament indicated that Medicare compliance activity since 2008 has been largely unsuccessful.[6] Additionally, since its establishment, the PSR has consistently cited MBS claiming confusion by medical practitioners in its annual reports, referring to it as an ongoing problem.[18]

Other government initiatives, such as the current co-payment proposal (which would legalise concurrently charging a $7 co-payment whilst also bulk billing for the same service), necessitate amendments to the *Health Insurance Act.*[15] However for the medical practitioners who will be required to interpret and apply any such changed arrangements, new layers of complexity may further obfuscate an area of law, which in many respects is already unclear.

Medical practitioner support

Whilst most attention focuses on over-claiming, some medical practitioners have been caught in cost-shifting battles between State and Commonwealth provision of health services, and are pressured to increase their Medicare claiming. A Queensland Audit Office report revealed that RoPP schemes operating in Queensland public hospitals had cost the Queensland government at least $800 million despite being designed to be cost neutral. This was held to be due to under claiming of Medicare benefits by medical practitioners for privately insured patients, as it was a requirement that hospital salaried medical practitioners generate MBS claims for these patients (which had not occurred, affecting a net revenue loss to the State).[19]

The Queensland report provided a rare empirical investigation of medical practitioner support and knowledge for proper MBS claiming, with a questionnaire of medical practitioners (n=86) indicating 79% of respondents believed induction concerning which professional services were billable to Medicare or the private health funds was inadequate, 65% believed ongoing support in relation to MBS claiming was inadequate, and 62% were uncertain about what services could be billed under the MBS.[19]

The possible link between system complexity and erroneous claiming patterns has been raised previously. In 2007 the then Human Services Minister announced that by changing medical practitioner claiming and prescribing behaviour via an education and compliance program, $250 million in Medicare program savings had been achieved in the previous year.[20] This suggests that a significant cost reduction can be achieved without requiring Australians to pay the impost of a co-payment. However, despite the importance of Medicare in almost every medical interaction in Australia, most claiming and compliance education currently occurs on an adhoc basis, and there is no Australian Medical Council requirement for medical courses to provide such education to medical students.

Conclusion

Despite mounting pressure on medical practitioners to claim from Medicare correctly, no formal, systematic research has explored the factors associated with Medicare compliance, the level of Medicare knowledge among claimants, or the education needs of claimants. As such, the contemporary debate on Medicare claims compliance remains dominated by anecdotal and polemic commentary. This differs from other jurisdictions (such as the U.S) where medical practitioner claiming and compliance has been more comprehensively studied.[21-23]

The sustainability of Medicare is a stated objective of the current government [24] who has recently proposed co-payments as a solution to rising Medicare expenditure. However, in the absence of a detailed understanding of the utility and infrastructure of the Medicare system

and its application in practice, co-payments may do nothing more than increase the administrative complexity of Medicare, and further the potential impact of both wilful and inadvertent non-compliance.

It is reasonable for doctors and patients to expect that the government will base policy initiatives on a firm research base and give due consideration to possible internal inefficiencies before charging consumers more for the same services. However, the dearth of research in this area presents challenges for policy makers in developing appropriate system reform.

If we are to responsibly modernise Medicare in a rapidly changing health care environment, research in the crucial area of medical practitioner experiences, perceptions and understanding of Medicare claiming is urgently required.

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Post-Script – Changes to the MBS from 2015.

In 2015, soon after the previous article was published, the federal government handed reform of the entire MBS to MP. The new *MBS Review Taskforce (MBSRT)*, would consider *'how the more than 5,700 items on the MBS can be better aligned with contemporary clinical evidence and practice, and improve health outcomes for patients.'* (Health 2019a) The MBSRT took five years to complete and was almost exclusively the work of MP, led by an endocrinologist (Health 2019b).

Completed at the end of 2020, it is too soon to assess whether the MBSRT has achieved its stated objectives. However, some examples of changes made pursuant to recommendations of the MBSRT, which will be presented in this thesis, suggest that by adding more layers of complexity to an already broken system, some of the work of the MBSRT, particularly in areas outside of the clinical expertise of taskforce members, may have exacerbated existing compliance challenges and further eroded the government's ability to maintain scheme integrity.

Commencing with a review of the literature, this thesis will now continue on a journey which argues:

1. Medical billing is profoundly complex.
2. There are major problems with MP understanding of billing.
3. There is no education or reliable support for MP around billing.
4. The root causes of billing non-compliance are rule of law problems.
5. Government oversight of compliance and current policing strategies are ineffective.
6. Recent reform of Medicare may have exacerbated compliance problems.
7. Education will be a critical component of future solutions, though no-one currently has clear responsibility for education.
8. Education alone will not improve MP billing compliance and a national curriculum cannot be introduced until rule of law problems are first addressed.

CHAPTER 2: Literature Review

2.1 Background and context

The initial literature review for this thesis was undertaken during the early phases of the project in 2013/14. The search strategy was initially restricted to Australian databases, but very little directly relevant literature was found. At that time, only one empirical Australian study directly related to the research topic existed, and it makes only passing reference to education initiatives for medical practitioners in the context of combating Medicare fraud (Flynn 2004).

Given the original Australian searches revealed very little directly relevant empirical work, it was necessary to include commentaries and grey literature and broaden the search to include materials from other jurisdictions. This returned approximately 70 results, with most empirical studies being from the United States (U.S). The original search terms are shown in **Table 6.**

In early 2020, as this project was nearing completion, it was decided to run the search again. The topic of medical fraud and billing non-compliance had attracted increased global attention in the preceding six years, with more research outputs expected as a result. Therefore, a second comprehensive literature review was undertaken to ensure all current international literature was included. The search terms in **Table 6** were used again initially, but duplicate results were repeatedly returned.

A detailed process of refining search terms to maximise specificity led to a significantly reduced number of terms in the final academic publication, which was published later than some of the other articles included in this thesis. Consequently, some of the articles mentioned in section 2.2 are the contents of later chapters of this thesis.

Table 6 - Original literature review search terms

doctors and medicare and australia
doctors and medibank and australia
medical billing and medical education/filtered to published in last 10 years
medical billing and medical education and australia
medical billing and medical education and family physician
teach* and medicare and australia
doctors and professionalism
medical professionalism and medical billing and australia
medical professionalism and medical education and australia
medicare and doctor and educat*
medical curriculum and medicare/ and Australia (added for pubmed to reduce results)
medicare benefits schedule and educat*
medical fees and australia
medical providers and medicare/australia added
medical payments and australia
fee for service and education and australia
medical providers payments and australia
professional standards review and medicare and compliance
doctors and the MBS and australia
doctors and the PBS and australia
medical billing and australia
medical billing and medical curriculum and australia
medical billing and medical curriculum
health insurance and medical curriculum and australia
vocational training and medical billing
registrar and medical billing
physician and medical billing
surg* and medical billing
doctors and legal education / and australia added
doctors and business education
medical professionalism and australia

While numerous government reports were included in the review article inserted in section 2.2, the majority of reports published by the Australian National Audit Office (ANAO) were not included in that review. It was found that most ANAO reports did not contribute to an understanding of available education initiatives for MP in regards billing compliance other than to report a lack of education, or education not being a focus of the report. However,

content from ANAO reports in the area of Medicare billing and public hospital billing are referenced throughout this thesis where relevant, the ANAO website having been regularly reviewed for new reports tabled in parliament related to Medicare compliance.

This chapter is divided into two parts, firstly the scoping review, which synthesises current global literature, and secondly, a section titled 'legal case reviews.'

The legal case reviews are a selection of key Australian and U.S decisions across both civil and criminal jurisdictions, in which MP have either been investigated for alleged medical billing misconduct, or, in one case, have sued for defamation in the context of providing medical billing education. These cases inform the need for regulation of medical billing education providers who are becoming vertically integrated into corporate medical practices to 'maximise' Medicare revenue. In addition, the cases demonstrate the far-reaching investigations MP are subjected to during medical billing investigations, many of which escalate to contested legal proceedings. The arguments mounted by legal representatives who defend MP under investigation are also of relevance given their consistency across jurisdictions.

The U.S material is principally sourced from an important academic article summarising relevant case law in that jurisdiction, authored by a U.S lawyer. This section also introduces the concept of qui tam whistle-blower laws, which are widely used in the U.S to manage medical billing compliance. In addition, one criminal case from the U.S was found during manual searches, which has been included due to its proximity to the subject matter of this thesis and the consistency in the experience of a U.S MP who allegedly relied on erroneous advice from an untrained third party, and the serious consequences that flowed as a result.

2.2 Educational needs of medical practitioners about medical billing: A scoping review of the literature.

The material presented in section 2.2 was published in *Human Resources for Health* in July 2021 as **Educational needs of medical practitioners about medical billing: a scoping review of the literature**. Faux, M., Adams, J. & Wardle, J. Educational needs of medical practitioners about medical billing: a scoping review of the literature. *Hum Resour Health* 19, 84 (2021). The article can be accessed at this link https://doi.org/10.1186/s12960-021-00631-x.

Abstract

Keywords: Medical billing education; health care fraud and non-compliance; health system literacy; legal liability of medical practitioners; health insurance

Introduction: The World Health Organization has suggested the solution to health system waste caused by incorrect billing and fraud is policing and prosecution. However, a growing body of evidence suggests leakage may not always be fraudulent or corrupt, with researchers suggesting medical practitioners may sometimes struggle to understand increasingly complex legal requirements around health financing and billing transactions, which may be improved through education. To explore this phenomenon further, we undertook a scoping review of the literature to identify the medical billing education needs of medical practitioners and whether those needs are being met.

Methods: Eligible records included English language materials published between 1 January 2000 and 4 May 2020. Searches were conducted on MEDLINE, PubMed, Google Scholar, CINAHL, LexisNexis and Heinonline.

Results: We identified 74 records as directly relevant to the search criteria. Despite undertaking a comprehensive, English language search, with no country restrictions, studies meeting the inclusion criteria were limited to three countries (Australia, Canada, US),

indicating a need for further work internationally. The literature suggests the education needs of medical practitioners in relation to medical billing compliance are not being met and medical practitioners desire more education on this topic. Evidence suggests education may be effective in improving medical billing compliance and reducing waste in health systems. There is broad agreement amongst medical education stakeholders in multiple jurisdictions that medical billing should be viewed as a core competency of medical education, though there is an apparent inertia to include this competency in medical education curricula. Penalties for non-compliant medical billing are serious and medical practitioners are at risk of random audits and investigations for breaches of sometimes incomprehensible, and highly interpretive regulations they may never have been taught.

Conclusion: Despite acknowledged significance of waste in health systems due to poor practitioner knowledge of billing practices, there has been very little research to date on education interventions to improve health system efficiency at a practitioner level.

Introduction

The World Health Organization (WHO) has stated that "health-care systems haemorrhage money," citing ten causes of inefficiencies and remedies.[1] In the cited domain of waste attributable to fraud and corruption, the solutions proffered focus on measures to police and sanction wrong doers, such as medical practitioners who over-service in fee for service payment environments.[1] Notably absent is any suggestion that teaching medical practitioners how their health systems work and how to allocate health dollars correctly may improve their compliance and reduce waste. This is despite evidence from the US, Canada and Australia suggesting medical practitioners may have at best, only a cursory understanding of the complex financial and billing infrastructure in their health systems, which may be contributing to unintentional misuse and exposure to serious legal sanctions.[2]

In Australia, despite an overarching assumption that doctors have high legal literacy in relation to correct billing using Australia's national universal health system, Medicare,[2] a recent study

seeking to measure that experience, challenged that assumption, suggesting medical practitioners may instead be experiencing difficulties accessing reliable medical billing advice.[3] In 2016, the Government of the Netherlands acknowledged this educational gap by introducing a requirement that universities and medical specialist training colleges provide education to medical practitioners in relation to medical billing and the costs of providing care, the stated aim being to tackle billing mistakes and fraud through prevention, rather than solely through punitive post-payment policing.[4] While this intervention has been implemented, it does not appear to have been evaluated. However, the Dutch Healthcare Authority now details how consumers can report suspected healthcare fraud.[5] This may suggest that successful implementation of medical billing education has placed the Netherlands Government in a better position to prosecute deliberate misconduct when it is reported.

However, while medical billing education has been recognised as an effective measure to improve compliance, reduce incorrect billing and improve integrity of health financing systems,[6] formal education initiatives remain rare and many medical practitioners may have received no training whatsoever.[7]

To explore this phenomenon further, a scoping review of the literature was undertaken[8] to determine the extent to which focused examination has been undertaken of the educational needs of medical practitioners in relation to medical billing compliance and whether those needs are being met.

Methods

Search strategy and selection criteria

Inclusion criteria targeted literature that specifically cited teaching and education of medical practitioners in relation to medical billing, using combinations of keywords such as “medical billing and education”, “medical billing and curricul*”, “billing and coding education”, “physician medical billing”, “Medicare billing education”. The word “coding” was included in

the keywords because medical billing is referred to as medical coding in some jurisdictions. Materials dealing with individual health care system specifics and medical billing in the broad contexts of health economics, politics and health policy were deemed not relevant and excluded.

Grey, commentary materials and legal literature were included in the search strategy and manual searching was undertaken to review bibliographies and reference lists in the material originally sourced. No country restrictions were put in place.

As this is a novel topic and of interest to the general health, social sciences and legal communities, relevant databases in these areas were initially searched including MEDLINE, PubMed, Google Scholar, CINAHL, LexisNexis and Heinonline. We initially included the CINAHL nursing and allied health database, to capture possible results from multi-disciplinary billing settings such as Rehabilitation Medicine and Palliative Care. However, no relevant results were returned so CINAHL was later excluded. LexisNexis and Heinonline are important legal databases, which were included as they are likely repositories of law reports and articles dealing with medical practitioners who had been prosecuted for incorrect billing through law enforcement, as the WHO recommends. In countries where the rule of law is upheld, education about laws is usually made available prior to individuals being required to engage with those laws. We therefore searched these databases to determine whether medical practitioners had discussed educational needs in the context of policing and prosecution for incorrect billing. LexisNexis returned numerous irrelevant results which were unable to be reduced by refining search terms. All results found on LexisNexis were duplicates of those found on Heinonline and due to Heinonline enabling more granular refinement of search criteria, we excluded the LexisNexis database in final searches.

Due to the large number of initial search hits, numerous filtering strategies were applied, and criteria refined until sensitivity and specificity appeared to be optimised. This process identified 3022 records of materials published in the last 20 years. We undertook further

manual searching on Google Scholar to ensure any grey literature were found as well as again manually reviewing bibliographies and reference lists in the material originally sourced.

As this topic tends to divide opinion along partisan lines (i.e. “medical practitioners are deliberately committing fraud”, or, “are unintentionally making errors”), opinion pieces and grey literature had the potential to be very relevant in the evolving discussion on the causes of non compliant medical billing. To ensure we did not reject key insights numerous government reports were included. Only two empirical Australian studies directly related to the research topic were found.

Results

After removing duplicates and unrelated records, we screened the abstracts of the remaining 241 records, and excluded a further 155 records which did not meet inclusion criteria, because they did not specifically target educational needs of medical practitioners around medical billing. We also excluded a further 12 records which were legal cases concerning non-compliant medical billing and fraud, because they did not specifically address teaching and education of the medical practitioners who were the subject of those proceedings. An additional 44 records met the inclusion criteria as a result of manual processes. The majority of relevant results on medical billing in Australia were found in grey literature and commentary, which may therefore have an inherent bias. While in the US the topic appears to be more mature, with substantial numbers of empirical studies found. In Canada, only one empirical study and one commentary article met the inclusion criteria. Summary results of the search are presented in Fig 1. Although a comprehensive international, English language search with no country restrictions was conducted, results were limited to three countries (Australia, Canada, US). The final results were sorted into four categories, presented in Table 1.

Fig 1 Prisma Flow Diagram

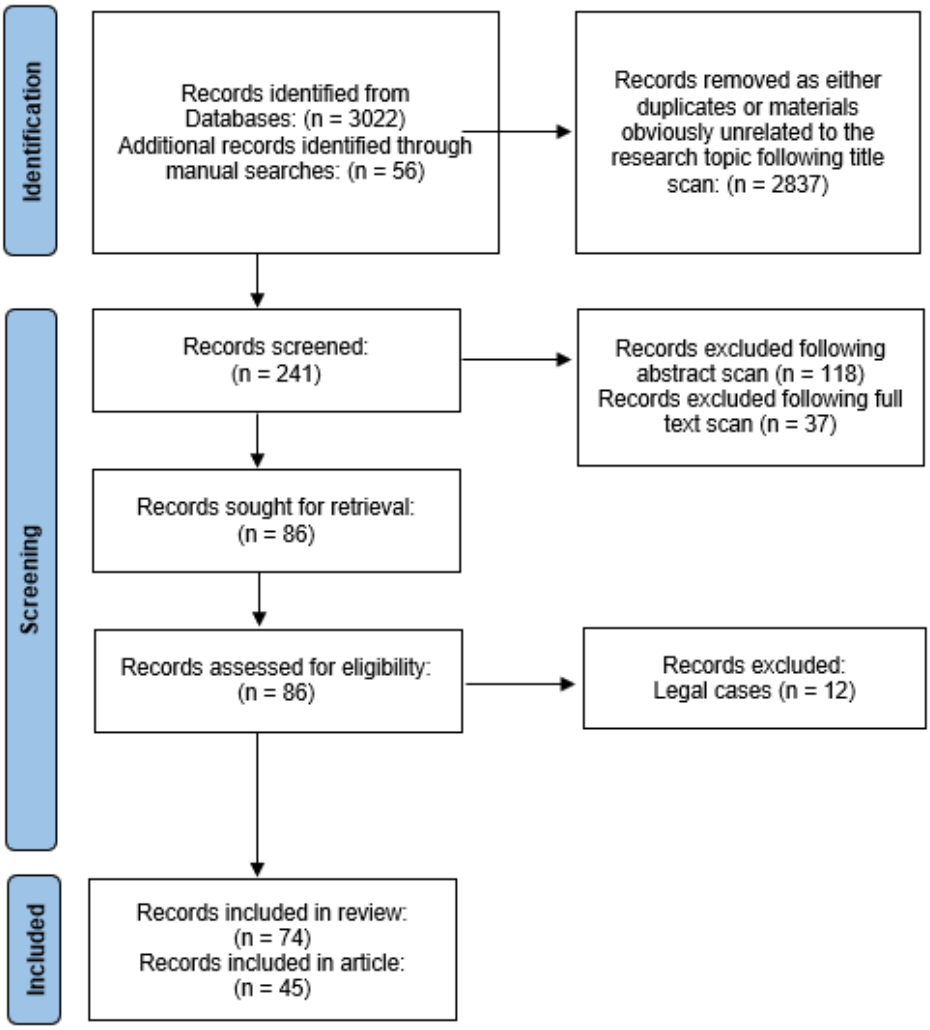

Table 1 Final Search Results

Category	Australia	US	Canada	Total
Empirical	2	28	1	31
Grey	37			37
Commentary/opinion	3	2	1	6
Total				74

For ease of reference, what follows is a stepwise presentation of the results in Table 1, commencing with empirical literature and ending with commentary and opinion pieces.

Empirical literature - Australia

A 2004 doctoral thesis on the topic of Medicare fraud and inappropriate practice provided a detailed analysis of how fraud and overserving allegedly became entrenched in Australia's health system between 1975 and 1996.[9] The study was "primarily an empirical study" which included over 59 qualitative interviews with politicians, leading stakeholder representatives, senior public servants, fraud investigators, journalists, and others who spoke on condition of anonymity. The study suggested the extent of non-compliant medical billing in Australia at the time may have been over 25% of the schemes' total cost, and definitely not under 10%. Precise quantification was not possible. Solutions to non-compliance were positioned through a criminal justice lens, with education only briefly mentioned as a weaker, less effective solution than regulation and policing. The thesis argued lax regulation and inadequate resourcing had led to a failure of necessary oversight and prosecution of errant medical practitioners. The study did not offer any explanation for non-compliant medical billing beyond deliberate abuse, and most interview participants appeared to share the view that medical practitioners "know how to bill correctly…" though subsequent research suggests this may not be the case.[3]

In a study of medical practitioner education stakeholders[3] the authors conducted a national cross-sectional survey which reported the first attempt to systematically map the ways Australian medical practitioners obtain education and understanding of medical billing, and explored the perceptions of medical education stakeholders on the topic. The results revealed little medical billing education was occurring with the majority of participants (70%, n=40) reporting they did not offer and had never offered medical billing education. However, 89% of participants thought medical billing education should be provided but there was no consensus on who should provide it or when it should occur. The study also found that most education in this area occurs on an ad hoc basis and is taught by medical practitioners who themselves have never been formally taught correct use of the Medicare scheme because no national, government approved curriculum has ever existed. The knowledge of those teaching the topic was therefore reported as variable, and the researchers reported this as being consistent with US findings, which suggest that rather than reliance on ad-hoc training,

development of a national medical billing curriculum should be encouraged to improve compliance, expedite judicial processes, and reduce waste.

Empirical literature - US and Canada

Our review found studies specifically seeking to measure an equivalent experience have been primarily undertaken in the US, where a different medical billing system to Australia's operates, and where the heterogeneity of service providers and payers may warrant additional focus on billing education. The Australian medical billing system is based on a unique schedule of service codes known as the Medicare Benefits Schedule (MBS), whereas the US uses the International Classification of Disease (ICD) and Current Procedural Terminology (CPT) codes. Canada uses different billing codes again, known as the Ontario Health Insurance Plan (OHIP) Schedule of Benefits and Fees.

However, an assessment of the differences between these code sets and the practical application of each suggests the challenges faced while undertaking medical billing in all three countries is similar because the cognitive process of matching clinical encounters to an administrative dataset is the same.

US research on the subject of medical billing and reimbursement is more advanced than in Australia due to increased recognition in that jurisdiction that medical billing is a component of every interaction between a patient and a medical practitioner.[7, 10-16] The US literature suggests that training in the area of medical billing should be viewed as a core competency and a national curriculum on the topic should be developed.[7] (Andreae MC 2009) However, despite the Accreditation Council for Graduate Medical Education in the US agreeing that education about practice management and economics forms part of the required core competencies for medical practitioners, teaching of those subjects is variable and no formal national curriculum exists. One of the recognised challenges identified in the US material is that of 'teaching the teachers.'[7] With no written curriculum on the topic of medical billing, researchers pointed out that teaching of the subject will be variable and will depend on the

expertise, experience and the confidence of senior mentors who may themselves have had little training in the area.

In one study involving a cross sectional, needs assessment survey of second year community and university based internal medicine residents from four US geographic regions,[10] (Adiga 2006) participants (n=133) completed a questionnaire which included 27 questions, and the findings indicated that medical practitioners rated their own knowledge of Medicare billing as low. Participants also strongly agreed that their training in medical billing was inadequate and that it was important and should be a requirement of residency training programs.

In a 2009 study examining the adequacy of training in the area of medical billing and coding as perceived by 2300 recently graduated paediatricians recruited from the American Board of Pediatrics database of recent graduates[7] less than 20% of respondents reported their training in medical billing and coding as adequate. The key points emanating were that medical billing and coding is not uniformly taught and should be included in the core competency requirements for medical residents. Further, that work needs to be done to develop and test a curriculum in medical billing and coding and that residency programs need to ensure they are equipped to practice.

In another descriptive study of 104 medical students examining attitudes to professionalism,[11] preferences in the importance of professional competencies, teaching preferences in professionalism and the egregiousness of 30 vignettes of professional misconduct (Hultman CS 2012), participants rated illegal billing as the second most egregious of 30 vignettes of misconduct. Substance abuse was reported as being the most serious misconduct (86.8%), followed by illegal billing (69.1%) which was rated higher than sexual misconduct (50%).

Since 2016, we found an increase in the number of US studies on this topic, where results have echoed earlier findings that the level of medical billing literacy amongst medical practitioners remains demonstrably low and may be improved by targeted education.[11-15] In one recent US study more than 70% of medical practitioner participants felt there was a need for medical

billing and coding to be included in the medical curriculum[16] and a 2019 study of senior residents and staff physicians in Ontario, Canada (n=33)[17] described the billing accuracy of the medical practitioner participants as poor overall, with billing errors and omissions causing substantial revenue losses. Participants in that study felt that current medical billing education was both insufficient and ineffective and desired more.

Grey Literature and Commentary

A review of policy and parliamentary papers uncovered numerous Australian government reports dealing with medical billing compliance, and a 2018 analysis and critique of the US government's approach to managing Medicare compliance mirrored many of the challenges being experienced in relation to medical billing compliance in contemporary Australia.

Government reports – Australia

The principal government reports uncovered were the Annual Reports of the Professional Services Review Scheme (PSR) in Australia.[18] The PSR was established in 1994 as a peer review scheme to investigate Medicare services billed by medical practitioners, with the objective of protecting the integrity of the scheme.

A review of 25 years of the annual reports reveals the PSR has been plagued by costly legal challenges by medical practitioners who have felt aggrieved by a lack of due process, flawed extrapolation methodologies and inadequate legal reasoning to support adverse findings against them. The annual reports also consistently cited medical practitioner confusion about correct billing practices. Unfortunately, full decisions of the PSR, which may assist practitioners to understand how to bill correctly have never been published due to codified secrecy provisions which protect the agency from public scrutiny.

The operation of the PSR was the subject of a Senate Enquiry in 2011.[19] During the enquiry, submissions from medical practitioners highlighted both the complexity of Medicare billing

and the inadequacies in the resources available to them concerning its proper use. This directly contradicted institutional submissions from Medicare suggesting that ample resources and reliable support were available. One submission by a medical defence union representative indicated that processes should be in place to enable medical practitioners to obtain clarity about the use of the MBS and another drew a comparison between the advice and written rulings available from the Australian Taxation Office and the lack of such information and advice from Medicare, suggesting that this meant medical practitioners could unknowingly fall into error. The Senate Committee concluded that, although it was the responsibility of medical practitioners to make clinical judgments, as much advice and information as possible should be available to them in relation to MBS itemisation. However, the committee was silent as to who should provide this advice and information.

In addition to the PSR reports and Senate Enquiry, manual searches revealed a departmental newsletter to the profession in February 2007 titled 'Education the Key to Compliance' in which the government announced that by changing medical practitioner claiming and prescribing behaviour through an education and compliance program, $250 million in Medicare program savings had been achieved in the previous year.[6]

Commentary on the Medicare appeals process - U.S

The challenges plaguing the Australian PSR appear similar to those reported in the U.S, where one commentator described the US Medicare appeals system as broken,[20] and a US court has pondered whether Medicare laws have become so byzantine that the government had lost control of them.[20] The combined effects of complex, constantly changing, opaque medical billing rules and the use of extrapolation techniques appear to be at the heart of the problem which may have rendered the U.S government unable to manage medical billing compliance under its fee-for-service Medicare scheme, to the point where it "seems unable to keep up with its own frenetic lawmaking."[20] Further, that the US Department of Health and Human Services conceded it would take more than 10 years to clear the backlog of Medicare appeals awaiting review by an Administrative Law Judge (ALJ) noting ALJs overturn decisions against

medical practitioners over half of the time.[20] This may suggest that like their Australian counterparts, US medical practitioners may be struggling to understand complex medical billing rules they have never been taught and appearing before an ALJ is the first time they are afforded a merit based, evidentiary hearing and benefit from due process before a truly independent arbiter.

Canadian commentary

A recent publication in the *Journal of Medicine and Philosophy* initiated an important discussion concerning the moral dimensions around compliant medical billing, suggesting creative billing practices should be stigmatized rather than celebrated from within the profession itself.[21] The author described as a 'rather surprising oversight' that while medical ethics is a recognized component of medical education, the financial aspects of medical practice are almost never discussed and medical practitioners therefore receive little or no guidance in this important area. Further, that in fee-for-service payment environments, medical practitioners have enormous latitude in regards how they describe their services, with often very little effective oversight by payers. Therefore, the human temptation to misrepresent the services they provide can sometimes be significant, particularly where a seemingly small 'fiddle' to a service description can lead to higher reimbursement. The related ethical challenges are never taught nor mentioned throughout medical undergraduate or postgraduate training, yet the legal consequences when medical practitioners are found in breach of payment rules are usually very serious. The author argued that both medical schools and specialist colleges have failed in their duty to address this critical gap in learning and suggested some colleges may actually be cultivating the practice of questionable or borderline billing to 'maximise' or 'optimize' financial return. Moreover, that medical practitioners often fail to see the connection between their own poor billing conduct and the failure of the health system overall and that to address these challenges, both education and regulation are required.

Australian government educational materials

We found a number of resources produced by Medicare described as 'Compliance Education for Health Professionals.'[22] These include a "Medicare Billing Assurance Toolkit" and various e-learning modules. A review of these resources found a heavy focus on penalties for non-compliance without providing comprehensive information on how to be compliant. The resources suggested an overarching departmental view that medical practitioners possess a high level of legal literacy regarding correct use of Medicare, though available evidence challenges this position.[3] The resources were found to be rudimentary, offering little more than directing medical practitioners to the MBS if they are unsure of billing requirements, which is unhelpful considering findings of a recent study suggested the MBS has become complex and incomprehensible.[2]

Where education does exist, it may not be directed to the relevant parties. During manual searching from the bibliographies and references lists in the preliminary searches, a training course was found that appears to be the only government accredited course in Australia dealing with the processing of medical accounts.[23] On review of the course materials, performance criteria and outcome measures, it was found that this was a basic certificate level course designed for medical receptionists who are not responsible for MBS billing, rather than being targeted at medical practitioners who are.

US government educational materials

We also reviewed educational materials available to US medical practitioners who we found are similarly required to self-learn the complexities of medical billing by reading a number of resources such as Explanation of Benefits Remittance Statements they receive when the claims they submit are denied, publications produced by intermediaries in the medical billing process who are contracted by the federal government (known as Medicare Administrative Contractors), and materials on the Centres for Medicare and Medicaid Services website.[23] However, evidence suggests medical billing literacy among US medical practitioners remains

low[7, 10-16] and the above resources are inadequate to prepare them to bill correctly and protect them from post-payment investigation.

Discussion

The legal machinery underpinning fiscal transactions in health systems is typically profoundly complex. We found that the paucity of available data on this important topic does not correlate well with the impact non-compliant billing has on global health systems. Irrespective of whether the cause of non-compliance is deliberate or accidental, the size of the problem, which has been reported as averaging 7% of total health expenditure,[25] is of sufficient magnitude to warrant focussed academic attention, particularly given the likely global economic slowdown caused by Covid-19. Waste caused by non-compliant medical billing in health systems can no longer be ignored. The fact that the scope and extent of this issue as a problem has been consistently identified as a major barrier to the efficiency of health systems, yet few studies have been conducted on initiatives that may help to address the issue, suggests that further research is warranted to ensure that stakeholders are able to make evidence-informed decisions when developing initiatives to combat medical billing non-compliance.

Although limited to three countries, the literature revealed a pervasive unified global view across those countries that medical practitioners obtain high levels of medical billing literacy through an osmotic process unsupported by the evidence. Unmet education needs were also evident throughout the literature across jurisdictions. Early reports[9] uncovered by our review mention short term success with education initiatives for medical practitioners in Australia, and the PSR consistently cited practitioner confusion as being an ongoing problem. However, from the outset, very little was published in the PSR annual reports concerning available assistance to medical practitioners concerning how to use the (Australian) Medicare system correctly. The first PSR Director repeatedly advised medical practitioners via these reports to 'read the MBS book each year' and suggested speaking with Medicare when unsure of correct itemisation. However, this is and was always an unrealistic and onerous requirement on

medical practitioners given the current printed version of the MBS comprises over 900 A4 pages of item numbers, explanatory notes, rules and cross references, many of which are difficult to comprehend, and a single medical service can be the subject of over 30 different payment rates and rules.[26] We also found no evidence of medical billing educational resources such as a 25 year body of precedent that might assist medical practitioners to understand how to bill correctly.

In the US, government maladministration was described as having far reaching consequences impacting the broader health system and ultimately consumers,[20] and we suggest the impacts identified would be applicable in any health system.

The first such impact is that medical practitioners, as small business owners, may not have the financial means to support lengthy investigations and repay large amounts, so may become insolvent or choose to stop practicing. This causes the health market to contract to the detriment of smaller providers and their patients, becoming consolidated by larger corporations with the liquidity to withstand long legal battles. Further, if small providers servicing remote communities are impacted, their absence may not be filled by larger corporates, potentially leaving such communities without medical services.

A second impact was cited as regulatory and administrative burdens causing some medical practitioners to stop treating Medicare patients completely. In Australia, where all citizens and many eligible residents are covered by Medicare, the practical expression of this type of pressure is seen when medical practitioners simply stop engaging with Medicare directly, requiring patients to instead pay full fees upfront and claim available rebates themselves. This practice is evident in the current out-of-pocket medical fees crisis in Australia.[26]

Another serious and potentially dangerous impact is that working under the constant threat of audits and investigation may cause some medical practitioners to under-service their patients. Others may continue to provide services but not bill and be reimbursed for them,

reducing government visibility over actual service delivery. A recent study in Australia described evidence of such practices among medical practitioners.[28]

Medical practitioners act as stewards for the integrity of their health systems through the bills they submit for each clinical encounter.[2] Further, medical billing is a component of every clinical encounter (whether directly or indirectly) and the penalties for non-compliance across jurisdictions are severe. Yet medical practitioners appear to receive little formal preparation in the proper use of the billing and payments systems they are required to engage with. Moreover, opaque and interpretive medical billing codes cause difficulties for medical practitioners in multiple jurisdictions, yet no research has ever sought to examine how, when and where medical practitioners obtain the high levels of medical billing literacy expected of them.

Successful health financing systems depend on the fast flow of payments between patients, payers and providers in a context of high volumes of small transactions, often sourced from public money. For this reason, a high level of scrutiny is required to ensure the integrity and sustainability of such schemes. However, in achieving this, a proportionately high level of precision must be maintained in the area of service descriptions and billing rules, to protect the providers who often have no option but to engage and claim reimbursements.

Limitations

A limitation of this review is the fact that results were drawn only from three countries, which may limit the generalisability of results. However, we view this as in important finding in-and-of itself, suggesting an urgent need for further work on this topic in other settings. The relatively large body of work from Australia may be reflective of the significant government role in Medicare, which is still reliant on fee-for-service provision by private providers, resulting in increased public accountability and interest in the topic in that country. Further work is required to examine the topic in other countries. Extensive investigation of informal,

ad hoc, and spontaneous educational initiatives that may exist in some jurisdictions were not captured by this review and may be deserving of focussed research attention.

Conclusion

Despite the increased research outputs on this topic in recent years there appears to remain a mistaken global view, unsupported by scientific evidence, that medical practitioners naturally know how their health systems work and how to bill correctly, and that punitive measures are therefore the sole solution to waste caused by non-compliant billing practices. This is despite a growing body of evidence suggesting education may be effective in addressing this problem.

Emerging health systems can learn from the experiences of the health systems reported in this study by prioritising curriculum development in health financing law and practice. Educating medical practitioners about the operation of their health financing systems and how to allocate scarce health dollars correctly protects them from exposure to potentially serious legal consequences for non-compliance, and may improve the efficient and equitable distribution of national health budgets.

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2.3 Legal case reviews

At its most serious, incorrect Medicare billing can result in charges of criminal fraud, though the high evidentiary burden of BRD ensures case numbers remain low. While civil proceedings are therefore more common in the area of Medicare non-compliance, examples of both criminal and civil prosecutions are reported in the following Australian and U.S decisions.

Case law – Australia

In the criminal case of Dr Sood previously mentioned ("Suman SOOD v Regina 2006 NSWCCA 114"), Dr Sood faced 96 counts of Medicare fraud for charging patients a counselling and theatre fee, and also bulk billing for a procedure on the same day. Throughout the jury trial Dr Sood repeatedly asserted she did not know her conduct was wrong. Evidence presented in support of this proposition was considerable and the trial judge even commented that at the relevant time, Dr Sood appeared to have had no appreciation that what she was doing was wrong. This notwithstanding, the jury returned a guilty verdict which Dr Sood subsequently appealed. During the appeal ("R v Suman SOOD 2007 NSWCCA 214"), the court was required to consider the meaning of three ubiquitous words in the Medicare scheme - 'in respect of'. Dr Sood had always maintained that the counselling and theatre fees she charged were not fees 'in respect of' the procedure she performed. In her mind, the procedure was completely separate to the ancillary services. One of the three appeal judges agreed with her.

In deliberations, Justice Adams said that requiring Dr Sood to have known in advance the legal meaning of 'in respect of' amounted to requiring her to provide an opinion concerning the interpretation of the law and its application to the facts which, as a MP, she had neither the skills nor qualifications to do. Although the appeal was ultimately allowed on the basis of a misdirection of the jury by the court of first instance, this case highlights the level of legal complexity MP may be forced to navigate in their daily billing practices.

In a more recent civil case ("Stirling v Minister for Finance [2017] FCA 874"), Dr Stirling was a GP and Phlebologist, who conducted certain ultrasound examinations on his patients. He had sought telephone advice from Medicare in 2005 concerning whether he was eligible to claim two relevant MBS ultrasound item numbers for the services he provided. The recorded telephone conversation which was later admitted into evidence led Dr Stirling to believe he was eligible to claim the two MBS items. For the avoidance of doubt, immediately following the phone conversation, Dr Stirling wrote a letter to Medicare confirming the contents of the recorded telephone conversation with a named Medicare representative, which was also later admitted into evidence. Dr Stirling's letter summarised the telephone conversation and informed Medicare he understood he was eligible to claim items 55246 and 55054 and intended to commence doing so. Dr Stirling billed and received Medicare benefits for these two uncontroversial services for the next five years. In 2010, Dr Stirling received a letter from Medicare informing him of its intention to audit his billing, and subsequently determined he was not eligible to claim items 55246 and 55054, had never been, and would be required to repay a debt of $332,541.30 to the Commonwealth. However, he successfully appealed, and the matter was remitted to the Minister for further consideration.

The *Stirling* decision is noteworthy because there was no suggestion Dr Stirling acted with deliberate intent to defraud, in fact the evidence indicated the opposite. Further, at the time of the 2005 telephone conversation, it is suggested the government ought to have been able to provide a definitive answer to what was a fairly straightforward question – was Dr Stirling eligible to claim the two items or not? The department itself was apparently unable to answer this question correctly, though Dr Stirling was expected to have known the answer. In addition, Medicare's conduct in paying Dr Stirling's claims for over five years may have ratified his belief that he was billing correctly, which was not unreasonable considering Medicare always had the ability to reject his claims if they were wrong.

Like the U.S Centres for Medicare and Medicaid Services, Australia's Medicare publishes a list of rejection codes it uses when rejecting non-payable claims (Services Australia 2021) and at the relevant time, the following common rejection codes were in use:

140 – Non Specialist Provider

141 – No benefit payable for services performed by this provider

704 – Provider not permitted to claim this item

Any of these rejection codes could have been applied to stop Dr Stirling's claims, and Medicare's decision not to invoke them to stop payment and prevent Dr Stirling engaging in unlawful conduct may have led him to form a genuine but ultimately mistaken belief that he was permitted to claim and receive reimbursement for the two services.

In another recent civil matter appealed from the PSR to the Federal Court ("Nithianantha v Commonwealth of Australia [2018] FCA 2063"), Dr Nithianantha sought to rely on email advice from Medicare, relating to when urgency is determined for an afterhours service – is it determined during initial contact when a patient calls requesting a home visit, or only later once the medical practitioner has attended and physically examined the patient? This was a critical point in the case. Of note, the Medicare email was not addressed to Dr Nithianantha but had been sourced from another medical practitioner. This fact caused this critical piece of written evidence to be disallowed, because the email was not addressed to Dr Nithianantha, had been provided at a time which put it outside the scope of the investigation, and in any case, according to the PSR, the advice was wrong.

Like *Stirling*, it is suggested the *Nithianantha* decision provides compelling evidence that the so called 'rules' of medical billing are unknown, even to the department who promulgates them. Further, that advice from Medicare cannot be relied upon, potentially rendering MP rudderless in a sea of arbitrarily applied 'rules' that can only ever be known when it's too late and the MP is under investigation. Both *Stirling* and *Nithianantha* may therefore represent symptoms of underlying structural weaknesses and possible administrative incompetence. Over time, MP confidence in the government's ability to understand how Medicare works and how to bill correctly appears to have been eroded to the point where MP live in fear of investigation (Baigent and Baigent 2018), aware that departmental staff will not be held to

account when the advice they provide is wrong. The *Nithianantha* decision is analysed in more detail in the discussion chapter of this thesis.

In an important recent decision, a legal dispute was centred around MBS billing education, and culminated in defamation proceedings between two GP ("Anand & Anor v Armstrong & Anor [2020] SADC 34" 2020). The plaintiff, Dr Anand, successfully sued Dr Armstrong for defamation and was awarded aggravated damages indicating the severity of the reputational damage he had suffered.

The facts of the case involved both parties seizing a market opportunity to commercialise MBS billing education. Dr Armstrong alleged Dr Anand had stolen her company's intellectual property in medical billing education materials via a Facebook post. The post erupted rapidly, becoming a melee of truculent insults and vituperative threats, which were visible to over 10,000 MP in the private Facebook group, all subsequently made public through the court proceedings.

During the proceedings, Dr Anand suggested the demand for this education was so great, he had secured a deal worth half a million dollars selling his newly devised MBS billing workshops (though the court found this deal had not, in fact, been secured). Dr Armstrong had been teaching MBS billing through her company 'Business for Doctors' for some years and had built a successful business which included selling workshops which encouraged MP to 'pack and stack' MBS item numbers, which Dr Armstrong referred to as 'combination billing'. The competing workshops of the parties essentially provided similar education, which taught GP how to cleverly craft 'safe' combinations of MBS item numbers to increase the revenue for each patient encounter. The evidence suggested Dr Anand's use of the word 'safe' referred to the design of each combination flying below Medicare's audit radar. The evidence also displayed Dr Armstrong's pride in her popular 'pack and stack' sessions, and she did not dispute Dr Anand's description of her approach, which included advising colleagues that 'the first one minute you should actually devote to the patient'.

In deliberations around the nature of publicly available MBS billing information, the court found that Dr Armstrong did not hold alleged intellectual property rights over such information or materials, nor did she have any legally enforceable monopoly over MBS billing education, the judge finding Dr Armstrong had acted with 'malice' and a purpose 'to advance her own personal interests…by seeking to extinguish the plaintiffs as competitors in the area of MBS education'. Importantly, the court did not accept that either party was an expert in the MBS billing system, though it was agreed MBS billing is complex, with one witness stating, 'people at every level struggled with the MBS.' ("Anand & Anor v Armstrong & Anor [2020] SADC 34" 2020: Para 163)

Being defamation proceedings, the court was not required to consider the legal accuracy of the medical billing methods and materials in dispute. However, the long and detailed judgement provides important insights into the ethical dimensions around medical billing, as well as clear evidence of the 'blind leading the blind' method through which MBS billing information is currently disseminated, the demand for this education caused by MBS complexity, and the low levels of legal literacy held by the MP who are currently teaching it.

In regard to the ethics of medical billing, the startling omission in the evidence of both parties was patient care. If the underlying purpose of 'combination billing' was genuinely patient focussed, one would have expected mention of the well-recognised practice where opportunistic offering of additional services represents good patient care (Breen K J 2010). An example might be a GP suggesting to a patient they have a general check-up 'while they are there', even though their reason for attending was a sprained ankle. A long hiatus since the patient's last visit may validate this type of preventative healthcare approach, which would usually lead to the billing of additional clinically relevant MBS items for that encounter.

However, good clinical practice of this nature was nowhere evident in these proceedings. Instead, both parties openly and enthusiastically described their undisputed focus on increasing revenue, by maximising the amount able to be extracted from the Medicare purse for every patient encounter. Unfortunately, the case also provided evidence that the

previously mentioned practice where *'some colleges may actually be cultivating the practice of questionable or borderline billing to 'maximise' or 'optimize' financial return'* (Heath J 2020) is active in Australia.

Dr Anand's course had successfully passed multiple audits by the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM), and had subsequently been accredited by the RACGP. This enabled MP participants to collect continuing professional development (CPD) points attached to their annual medical registration. Of note, her Honour remarked that the audit processes of the colleges appeared 'aimed at ascertaining whether the workshop met certain required guidelines, rather than addressing the technical accuracy of the content presented'. No evidence was presented concerning whether the colleges adopt the same approach when accrediting clinical course content.

The concept of medical colleges accrediting legal courses is troubling, and the alleged abrogation of responsibility for the technical content of such courses appears to be an attempt to mitigate their own legal risk, though this may not withstand legal scrutiny. Of further concern, a related media article has recently stated that Dr Armstrong's MBS billing workshops are still accredited (Knibbs 2021).

The alleged half a million-dollar deal described by Dr Anand involved an arrangement whereby Dr Anand would provide training to MP working for a corporate provider, focussed on teaching the MP how to generate 'significantly increased revenue per consultation'. If successful, the increased profits for the corporate provider would be applied to offset Dr Anand's course costs. This scheme essentially involved Medicare funding its own manipulation; participating corporate practices would increase their profits through increased Medicare billing, Dr Anand would sell more courses and build his half a million-dollar business, and the MP who had been taught by Dr Anand would increase their earnings by billing more to Medicare.

The *Anand v Armstrong* case is of great importance in the context of this research because it provides compelling primary evidence of MP ignorance around correct use of the Medicare scheme. Both Dr Anand and Dr Armstrong appeared to have held a genuine but mistaken belief that because certain combinations of MBS items *could* be legally billed, they *should* be billed for every patient, and MP lacking awareness of these combinations were somehow missing out on legitimate revenue. This approach is, of course, incorrect, and inconsistent with Medicare's purpose which is to subsidise the treatment costs of the clinical needs of patients, rather than to remunerate MP or maximise earnings. The failure of both GP to understand this, meant neither was able to explain the most basic element of correct MBS billing, which is that only clinically relevant services should ever be provided.

Of significance also, is the fact that the PSR consistently cites MP falling short on the clinical relevance standard when they come under investigation for incorrect billing (Professional Services Review Agency Case Outcomes). However, as has already been discussed, the decision around what is clinically relevant and therefore necessary for the treatment of each patient is not always straightforward and can often include subjective matters extending well beyond clinical considerations.

The problem, therefore, is not the complex legal and moral dimensions around this threshold decision itself, but that the public policy implications of these decisions may never be taught to MP within a legal or ethical learning framework. As a result of this educational gap, MP who falsely purport to have expertise in Medicare billing, appear to be innocently promulgating borderline billing practices through unregulated education initiatives. And worryingly, participants are being rewarded for learning borderline billing, by receiving CPD points. It is unknown whether any of the participants of these workshops have been investigated by the PSR, though it seems likely.

In the end, the *Anand v Armstrong* decision reflected poorly on both parties, and the medical profession more broadly, and may serve as a clarion call for the need to regulate nationally consistent MBS education.

Case law – U.S

Notable cases in the U.S highlight similar downstream impacts of incorrect medical billing advice, MP frustrations with government maladministration, the questionable use of extrapolation techniques, and a lack of clarity around correct interpretation of complex medical billing rules.

In a U.S case of Medicare fraud ("U.S v Semrau " 2012) the plaintiff, Dr Semrau was found guilty of a practice known as 'up-coding' where he routinely billed for a higher paying, more complex service, than that actually provided. The service codes used by Dr Semrau were the CPT (current procedural terminology) codes, which are the equivalent of MBS codes in the U.S. Like *Sood*, this case related to the billing of one service only. Dr Semrau maintained at all times that he did not know his conduct was wrong. The essence of his unsuccessful defence was that he did not deliberately abuse the system, but rather, did not understand the complex requirements of the U.S Medicare scheme and that the code he had billed was so similar in description to the lower paying code, that both could be correct. He described the opaque and interpretive nature of the service code he had allocated, suggesting that he had at all times made good faith attempts to bill correctly, but that the billing codes were confusing, and any impropriety was unintentional. Dr Semrau also provided evidence similar to that of Dr Stirling that he had relied on telephone advice from the payer (in this instance, a private payer), who had confirmed his billing decisions were legitimate. However, unlike Dr Stirling, Dr Semrau was unsuccessful in having relevant phone records admitted into evidence, despite his assertion that such records would have demonstrated his genuine reliance on ultimately erroneous advice from the payer, who would not be held to account for their actions.

In addition to criminal prosecutions like *Semrau*, the battle against Medicare fraud and non-compliance in the U.S is also fought through qui tam relator lawsuits under the U.S *False Claims Act* (FCA) (The United States Department of Justice 2021).

The words *qui tam* derive from a Latin phrase describing a person who commences legal action on behalf of the government as well as themselves. These cases are commonly referred to as 'whistleblower' actions, in which the qui tam individual is called the relator. The benefits of qui tam lawsuits are many. Relators can often provide the government with substantial evidence uncovering major frauds, the evidentiary burden is less onerous than the criminal burden - only requiring proof the defendant acted 'knowingly', and relators are incentivised by the promise of compensation of between 15 and 25 percent of any recovery if the government joins the proceedings, and more if the government decides not to intervene. (Centres for Medicare and Medicaid Services 2016). Qui tam cases typically involve billing irregularities such as up-coding like *Semrau*, billing for fictitious services, unlawful kickback schemes, and billing for services that may not have been medically necessary. As was mentioned in the introduction chapter, 'medical necessity' is the U.S equivalent of Australia's 'clinical relevance' standard. Somewhat surprisingly, 'medical necessity' is also one of the additional sixteen standards that have gradually made their way into Australia's medical billing landscape (**Table 15**), though it remains an anomaly which will be discussed in later sections of this thesis. During the last decade, over 600 qui tam actions were commenced every year in the U.S, over eighty percent of which related to health financing matters, many involving a 'medical necessity' allegation. (Garvey, Panariello, and Foley Hoag LLP 2021)

In a 2019 U.S qui tam lawsuit reported by a U.S law firm, the subjective nature of 'medical necessity' was highlighted, the court finding against the government's interests on the basis that a mere difference of medical opinion, on its own, does not constitute a false claim. (Garvey, Panariello, and Foley Hoag LLP 2021) The case involved a difference of medical opinion between the government's MP experts and the MP under investigation, around whether patients were 'terminally ill' and therefore eligible to receive hospice care. In deliberations the court remarked that the 'decision of whether a patient is terminally ill is fraught with speculation.' The authors commented on the courts findings as follows:

'Medical judgment can only be challenged when there is an objective falsehood. This can be established by showing, for example, that the physician never reviewed the record or familiarized himself with the patient's condition, or did not subjectively believe that the patient

was terminally ill before making such a certification. Finally, objective falsity can be established if no reasonable physician could have come to the same conclusion. A reasonable difference of medical opinion, however, can never rise to falsity under the FCA.'(Garvey, Panariello, and Foley Hoag LLP 2021)

Unlike in the U.S where qui tam cases are decided through judicial processes open to public scrutiny, Australian proceedings where serious similar findings of services not being 'clinically relevant' are made, are decided by the PSR (Professional Services Review Agency Case Outcomes), which is a non-expert agency where the decision-making process is hidden from public view. It is therefore not possible to know whether adverse findings of non-clinically relevant services having been provided by an Australian MP were based on any objective measure, or were mere differences of medical opinion. The impact of regulated secrecy around the operation of the PSR is considered in more detail in chapter seven.

The potential merits of introducing qui tam legislation in Australia have been the subject of academic attention (Faunce, Urbas, and Skillen 2011) and an extensive body of research, culminating in a Parliamentary Joint Committee Hearing in 2017 (Parliament of Australia 2017). The committee found that whistle-blower laws may be well suited to combatting fraud against the government in some key areas including Medicare compliance and enforcement.

Historically, U.S qui tam lawsuits have provided the U.S government with two options; the first is to watch – where the government does not intervene but instead observes the relator prosecute the case through to conclusion; the second is to join – where the government intervenes and takes over the running of the case. However, recent commentary has highlighted increasing abuse of qui tam lawsuits by relators themselves, leading to a third approach, in which the government actively seeks to dismiss escalating numbers of meritless claims.

'The ever-increasing number of qui tam actions does not reflect an increase in meritorious claims-if such were the case, we would expect to see a corresponding increase in the number of intervened cases. But the level of intervention has remained static while the number of qui

tam filings has skyrocketed, reflecting relators' abuse of the FCA…the number of dismissals has more than doubled as compared to the thirty-year period prior.'(Garvey, Panariello, and Foley Hoag LLP 2021)

Frivolous qui tam actions like those reported in the U.S may also become problematic in Australia given the opacity of Medicare billing rules. One example might be an Australian relator commencing a qui tam action targeting booking fees or split bills, which the relator may mistakenly believe are illegal. While speculative, it is not fanciful to suggest this may happen, given the polemic media commentary around this issue already discussed in the introduction chapter. That said, there may be other areas of Australian Medicare billing that are more suited to qui tam penalties, such as the important area of referral law, which will be discussed further in chapters six and seven. For example, a clear regulation stating a referral to a MP must name the MP the patient is being referred to, would be easy for consumers to understand and report. Referral law is also an area where government oversight is weak, and relators could therefore assist the government to find and prosecute abuses of referral requirements. This and other potential qui tam opportunities are discussed in chapter eight.

In addition to judicial proceedings, the U.S administers a complex system of appeals from Medicare payment determinations, which is not dissimilar to the Australian process of Medicare desk audits and their progression to PSR investigations. However, a key difference between the U.S and Australian administrative processes is that while waiting for appeals to be heard, the U.S government recoups payment from the MP as if they had already won (Donley 2018).

One example was a 2016 case where the court was scathing of the government's conduct and the situation it had placed the plaintiff in. The plaintiff in that case was an independent medical laboratory receiving Medicare payments for various services. The court stated the plaintiff has been placed in *"…a dire situation, one where a government contractor erroneously claims overpayment in an unreasonable amount, binds the provider in a seemingly endless*

administrative process, withholds 95% of the provider's income, and forces the provider out of business before it can receive its day in court."("D&G Holdings, LLC v. Burwell")

In Australia, MP are permitted to continue receiving payments from Medicare while under investigation, but extrapolation processes like those used during PSR investigations (discussed further in chapter seven), appear to cause similar problems in the U.S. On occasion, U.S MP have successfully obtained restraining orders against their government for the questionable exercise of extrapolation techniques. The evidence in one case alleged that an overpayment of $152,000 meant a staggering $8.6 million was immediately due and payable to the U.S government, the court noting the case was based on:

"(1) review of a sample of 100 claims for 95 beneficiaries for which there is an alleged overpayment of $152,000.00; and
(2) a questionable extrapolation across Hospice Savannah's universe of patient claims that Hospice Savannah owes CMS $8.6 million." ("Hospice Savannah. Inc. v Burwell" 2015)

In *Hospice Savannah*, the court also remarked that the plaintiff would be unlikely to receive a fair hearing for three to five years and had demonstrated it was likely to succeed on the merits.

Similarly, in Australia, this research will demonstrate that a sample of 30 records equating to an alleged incorrect payment of $8,817 may be extrapolated across an entire class of services resulting in a demand for repayment of $900,000, of which the MP would likely only have received a small percentage of total benefits paid[i].

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i: Extrapolation in Australia's Medicare is discussed in chapter seven. Also, see the first example in **Table 11** of a recent case where the MP was required to repay $900,000 for billing over 5000 item 12250s. The current outpatient rebate for item 12250 is $293.90, and assuming the PSR reviewed approximately 30 records of the MP, this equates to $8,817, yet the MP was required to repay $900,000. Working for a corporate sleep study provider, the MP would usually only have received a small percentage, say 20% of total benefits paid, for reporting the studies. We do not know whether this MP actually billed item 12250 incorrectly 5000 times, because only 30 records would have been reviewed, and PSR secrecy makes it impossible to research and examine this important area.

Conclusion

The literature review section of this thesis has illuminated the complex challenges involved in managing medical billing compliance in FFS payments schemes, but has also highlighted the shortcomings of purely punitive approaches to this problem, all of which appear to fail in some way. Later chapters of this thesis will explore these failures in more detail and consider evidence of what appears to be a global shift away from the 'pay and chase' approach to medical billing compliance. There is clear evidence that some countries, including the U.S, are beginning to recognise that maintaining payment integrity in complex health financing systems, requires a modern, digitally driven, multi-pronged approach.

This chapter has also provided evidence suggesting MP confusion around correct medical billing is a phenomenon that extends beyond Australian shores. In addition, the material suggests Australian MP receive little formal preparation and education in the proper use of Medicare and the MBS, and that no national curriculum on the subject exists or has ever existed. The review also revealed there has been no focused Australian study of the experiences of MP in relation to Medicare and their claiming and compliance obligations, and as a result we do not currently know how, when and where this learning occurs. Accordingly, the following research design chapter describes the methods used to investigate and explore these problems.

CHAPTER 3: Research Design

3.1 Research Aims and Objectives

The aim and objectives of this project were to provide the first detailed study of the interface between MP and the MBS, by examining the experiences and perceptions of MP in their practical application of the MBS, and analysing how they manage, research and investigate their medical billing obligations. Specifically, the study aims were to:

1. Provide the first critical examination of the experiences and perceptions of MP as they interact with Medicare and claim MBS reimbursements.
2. Identify perceived barriers to compliance.
3. Explore possible solutions to problems and deficiencies identified by participants.
4. Make recommendations for reform using a roadmap based on the doctrinal analysis and outcomes of this study.

3.2 Research Questions

The research questions were:

1. What are the experiences, perceptions, attitudes and knowledge of MP in relation to their claiming and compliance obligations under the MBS?
2. How do MP manage, research and investigate their MBS claiming and compliance obligations?
3. Where do MP access support and advice in relation to their Medicare claiming and compliance obligations, who provides this support and advice, and how do MP rate the quality of the support and advice?
4. What are the complexities in the Australian medical billing eco-system that may impact MP compliance with medical billing?

3.3 Significance of Research

Although some commentators have suggested that inefficiencies in billing may cost the Australian health system $1.2–3.6 billion annually (Webber 2012), this topic has escaped focused critical examination in Australia. While some commentators allege that these inefficiencies are related to deliberate defrauding of the national insurance scheme, other sources, including a 2011 Senate review (Senate Committee 2011) and MP representatives, have suggested that many of the inefficiencies are related to the lack of appropriate educational resources for MP, or MP confusion with the current billing scheme. However, despite the significant financial and clinical implications of this issue, there has been no formal research in this area.

A 2003 investigation of MP interaction with the Authority Prescribing System (Liaw S-T et al. March 2003), suggested that stated policy aims related to MP prescribing were not being met. A similar study of the MBS has obvious national benefit in contextualising the experiences of MP as they interact with the MBS, and exploring the perceptions of grassroots MP as they manage their obligations and integrate this administrative process into their clinical settings.

There is also a very real need for a deeper understanding of the effects of this area on MP themselves. Non-compliance imposes not only a significant cost on Australian taxpayers but can have a devastating impact on individual MP. Penalties for non-compliance are harsh, and in instances where non-compliance is the result of confusion rather than deliberate intent to defraud, the considerable community investment in training the MP may be jeopardised if the MP is unable to continue providing services to the public.

Additionally, if MP can develop clarity about their compliance obligations, their billing patterns are more likely to accurately reflect interactions between MP and their patients. This will not only improve the efficiency of billing procedures but will make those MP whose servicing has been fraudulently augmented more obvious as statistical outliers, resulting in more efficient targeting by government. Further, whether the MP interface with the MBS has an impact on

patient care is an important question. MP whom the PSR has found to have engaged in inappropriate practice have, by definition, provided non-clinically relevant services to their patients. This may pose risks to the healthcare of Australians and threaten the integrity of our national health scheme.

Finally, exploration of this area can assist policymakers to identify the amount of non-compliance that is due to confusion rather than deliberate exploitation, and to consider proposals for any necessary law reform, educating MP and revising billing procedures to reduce inefficiencies, excessive expenditure and possible injustices in the system.

3.4 Expected Outcomes

This study will be of national benefit by providing the first focused examination on medical billing understanding, information seeking and compliance by Australian MP. The findings will assist policymakers to ensure the efficient delivery of health care services under the Medicare scheme. Irrespective of any changes to the current scheme, medical billing is likely to continue to be problematic (as it is in the U.S and other jurisdictions), and will still require processes for the dissemination of information to MP, who will remain the end users.

3.5 Ethics

Before ethics approval for this study was sought, careful consideration was given to issues of consent, privacy, disclosure and participant autonomy. Participants in both the quantitative and qualitative phases of the study were able to withdraw consent after data collection had occurred, without repercussions, and all participants were provided with detailed information about the risks and benefits of the study (see **Appendices 2–5**). Participants were also given the opportunity to ask any questions, and all collected data was deidentified.

Participants in both phases were informed that they could request that their data be excluded from analysis at any stage. The survey questionnaire results were completely anonymised,

with no recording of names or contact details. Transcribed data from the interviews was identified only through a participant code number, with no direct identifiers listed with the analysed data. All data was encrypted and stored in a secure location and only the researcher and supervisors have access to it.

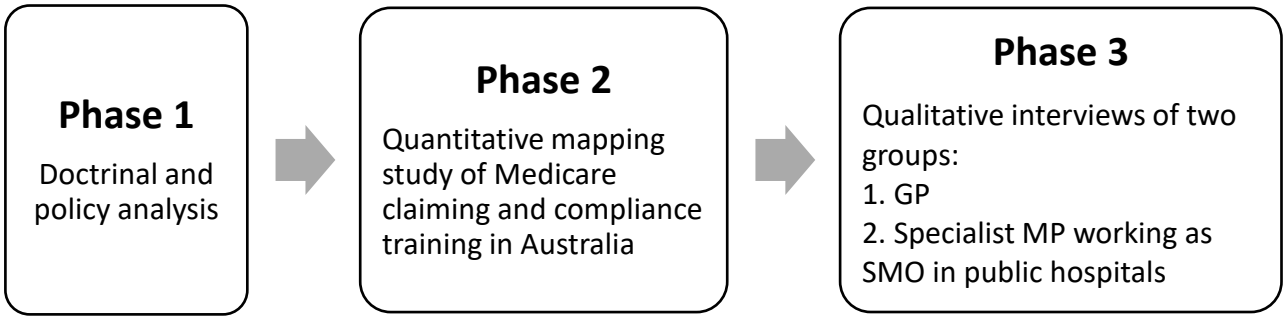
The ethical risk of the project was assessed as being low, but the initial submission to the ethics committee generated a request for further information concerning the recruitment of participants for phase three of the study. Once the requested information was provided, ethics approval was received for the study both from the Faculty of Health and via the University Ethics Committee (UTS HREC REF NO. 2014000060). A copy of the ethics approval can be viewed at **Appendix 6**.

3.6 Methodology and Study Design

This research employed a mixed methods design within a health services research conceptual framework.

Mixed methods research approaches are commonly employed in the areas of public health, health services and health policy (Mays 2006). The use of mixed methods in health services research is recognised as addressing some of the shortcomings of quantitative methods, by obtaining more detailed information and providing context to quantitative results (Mays 2006). Further, the pragmatic orientation of mixed methods research justifies the use of a pluralistic approach to derive deeper knowledge and understanding of the research problem (J.W Creswell 2014). This study traverses the disciplines of public health, health services research, law, health economics and policy, and both the research questions and research purpose were deemed to be best served by considered use of doctrinal analysis, followed by quantitative and qualitative methodologies. Consistent with established health service research methodology, a sequential mixed methods design was chosen, commencing with the doctrinal and policy analysis, followed by the quantitative mapping survey and qualitative semi-structured interviews. The research design is shown in **Figure 7**.

Figure 7 - Research phases



3.7 Phase one – Doctrinal and policy analysis

The study incorporates three distinct but interrelated phases of design. In order to first understand complexities that may be contributing to MP billing compliance, a detailed doctrinal analysis of key components of the underlying legal infrastructure and government policy was undertaken.

A bespoke approach was adopted to enable descriptive analysis of the evolution of Medicare's legal framework from 1975 through to today. This journey is also represented in **Figures 4 and 5**, where the Australian Constitution is the central hub of each diagram, and subsequent expansion of legal instruments extend outward from that point. **Figure 5** demonstrates where we are now - enveloped in a convoluted, morass of interconnected legal instruments, all of which impact daily medical billing compliance. Included in the analysis are important judicial decisions on certain provisions of these legal instruments. Examples are the cases of *Peverill*, which decided the essence of what a Medicare rebate is ("Health Insurance Commission v Peverill [1994] HCA 8"), and the two *Sood* cases, which enshrined the criminality of bulk billing and concurrently charging a gap ("R v Suman SOOD 2007 NSWCCA 214" ; "Suman SOOD v Regina 2006 NSWCCA 114").

The analysis was also intended to draw attention to pivotal government policy decisions which had a tangible impact on MP billing compliance. Most of these took place in the last twenty years. They include the introduction of Gapcover legislation in 2000, dismantling the Health

Insurance Commission in 2005, adding the Private Health Insurance Act in 2007 and introducing Activity Based Funding in 2011. Each of these major structural shifts and their impact on Medicare compliance are introduced through the doctrinal analysis. Findings from the analysis were then drawn upon to inform the design of the scientific sections which follow, specifically the quantitative survey questions, and the topics for exploration in the qualitative interviews with MP.

3.8 Phase two – Quantitative mapping survey

Introduction and rationale

Building on the literature review and doctrinal analysis, the quantitative survey enabled comprehensive mapping of the MBS information environment to determine availability of MBS resources available to MP. The survey was based on publicly available information drawn from universities, professional associations, registration bodies, disciplinary bodies, insurance organisations and Medicare.

Selection of participants

Purposive sampling was applied to invite each of the 66 major Australian institutional stakeholders directly then involved in educating MP in relation to their MBS claiming obligations to participate in a survey. The participants included:

- 18 accredited Australian medical schools,
- 16 specialist Australian medical colleges,
- 17 vocational education providers for Australian GP,
- 8 state and territory branches of the Australian Medical Association (AMA),
- 4 medical indemnity insurers,
- Medicare,

- The Australian Health Practitioner Registration Agency (representing eight state and territory Medical Boards), and
- The PSR.

The included participants represented all major institutions and professional and government organisations with a direct role in the transmission of information to MP concerning MBS claiming and compliance. The Australian Medical Council was excluded because its role is to set broad education standards as the accreditation authority for the medical profession under the Health Practitioner Regulation National Law, such standards being implemented by the other institutional stakeholders who were invited to participate (Australian Medical Council Limited 2020).

By surveying each of these participants, existing MBS resources available to MP were able to be mapped. The telephone survey was conducted between April 2014 and June 2015.

Survey design

Participants in the quantitative phase were required to participate in a telephone survey that took between two and five minutes of their time. The questionnaire included mostly closed questions to encourage a good response rate. A copy of the survey is found at **Appendix 7**.

Participants responded to a maximum of 15 questions with the final question being reserved for the government stakeholder group. This final question asked where medical practitioners who have been found to have breached Medicare's requirements are directed to learn how to bill correctly. The survey was designed as a telephone survey however the majority of stakeholders requested an emailed copy prior to agreeing to participate. Our study excluded divisions, faculties and chapters which exist under the umbrellas of the specialist medical colleges who were invited to participate. Some professional stakeholders were Australasian in nature (Australasia is a term for Australia, New Zealand and occasionally the Pacific Islands) and we excluded those organisations focussed primarily on New Zealand. The response rate

was 86% (n=57), with 32 respondents choosing to complete the survey manually by mail and email, and 25 were completed by telephone.

Data collection and analysis

Survey data was analysed using descriptive statistics via frequency distributions and cross-tabulations. Answers from the survey were subsequently drawn upon to help develop areas and themes for exploration in the phase three interviews.

Full details and the results of phase two are reported as a published academic journal article in chapter five of this thesis.

3.9 Phase three – Qualitative semi-structured interviews

Introduction and rationale

Given the detailed and ambitious nature of this project, its success was dependent upon the ability to collect and accurately record real experiences of MP in their day-to-day interactions with Medicare. Building directly upon and complementing the survey results described above, phase three was therefore designed to facilitate the collection of rich data through the use of semi-structured, qualitative interviews, in which the experiences of MP were recorded. Two pilot interviews were conducted to determine and refine appropriate themes to be explored during the interviews.

The collected data was analysed using an applied qualitative approach sometimes referred to as a 'framework approach' (Mays 2006). The framework approach is inductive and heavily focused on the observations and recorded accounts collected from study participants. A systematic approach to data analysis is used, which is designed to facilitate interpretation and analysis from people other than the primary researcher. This involves five broad stages of analysis: familiarisation, identifying a thematic framework, indexing, charting, and mapping and interpretation. (These stages are discussed in more detail below.) This approach is

consistent with the broad objective of this research which seeks to directly inform policymakers and health authorities rather than in developing theory (Mays 2006).

Recruitment of participants

For practical reasons, the source population for phase three was geographically restricted to New South Wales (NSW) based MP who claim MBS benefits daily. The first group in this phase was GP, who are the most often audited MP, and whose practice is almost exclusively private outpatients, and therefore heavily dependent on MBS reimbursements.

The second group of interviewees were Salaried Medical Officers (SMO) working in public hospitals, who are required to claim MBS reimbursements under their Right of Private Practice (ROPP) agreements. This group was of particular interest and relevance in the context of this study because they have been identified by Medicare as being the subject of more intense scrutiny in the context of ongoing departmental compliance and audit initiatives (Government 2011), but also because of the complexities of public hospital billing already described and the fact that many SMO receive no personal financial benefit from billing generated by the hospitals where they work.

Further information around this selection process is deserving of attention.

Appendix 8 shows the question guide for the qualitative interviews, which were designed to connect to the research questions, as well as draw from the prior quantitative study results. It is important to note that the questions did not relate to quantum of MP earnings, which is not the focus of this study. The focus of the questions sought to examine MP experiences, perceptions, attitudes, and knowledge of Medicare billing more broadly, rather than drilling down into earnings or knowledge of specific MBS item numbers. Further, given the HIA is federal legislation, it applies homogeneously to all MP. So, for example, the question of whether an MP is a GP, or a privately practicing orthopaedic surgeon is an irrelevant distinction for the purposes of this research, because the law is the same for both - a privately

practising GP bulk billing item 23 and a privately practising orthopaedic surgeon bulk billing item 104 are both required to comply with the same law. Furthermore, the work of GP (which is referred to as General Practice) is a recognised medical specialty in Australia, where GP are legally categorised as privately practising medical specialists (Australian Health Practitioner Regulation Agency). GP were therefore deemed to be representative of any medical specialist practicing privately outside of hospital. The prior quantitative results also found that GP received more education on MBS billing than non-GP specialists and were therefore arguably more informed about correct billing practices.

Having captured a nationally representative group of MP who bill predominantly in the outpatient setting, it was then necessary to include a second group of MP practising hospital-based medicine, where both PHI schemes and provisions of the NHRA intersect with provisions of the HIA. This is the most complex medical billing in Australia, and is outside the realm of GP, but squarely within the requirements of SMO billing. It should also be noted that the MBS item numbers that an SMO bills in a public hospital, are the same item numbers she bills if she practices privately. There is no distinction, and therefore, when some SMO participants made unprompted comments during interviews that they also practiced privately, this fact had no impact on their knowledge of how Medicare works or how to bill correctly.

For all of the above reasons, privately practising non-GP specialists, including Visiting Medical Officers (VMO), who are contracted to work in NSW public hospitals but not employed, were excluded from the study. And finally, it should be noted that the *Anand v Armstrong* decision, previously discussed, was handed down *after* phase three of this project had been completed. Therefore, while the case may have suggested some questionable MP conduct around billing, it did not inform any aspect of the scientific components of this study.

Interview procedure

Twenty-seven interviews were conducted, in line with thematic saturation estimates from previous health research (P Liamputtong, 2005). Saturation was reached after approximately

five interviews in each group, but the researcher continued interviewing in case new themes emerged. These interviews were divided fairly evenly between GP (12) and SMO working in public hospitals (15). MP participated in a face-to-face interview that lasted between 45 minutes and two hours. All interviews were audio-recorded for transcription and subsequent analysis. The interviews were conducted between July 2016 and May 2019.

Themes and interview questions

In order to explore the perceptions and understanding of MP and to build directly upon and draw from the phase two survey, input from MP stakeholders and the two pilot interviews, it was necessary to craft research questions based on related themes. While a preliminary interview topic guide and draft questions were developed to loosely guide the discussion, modifications were made as themes emerged from ongoing interview data that required further exploration. Participants were encouraged to talk about topics in their own terms in an informal environment (chosen by participants) to encourage free expression and natural dissemination of information. Throughout each interview, participants were encouraged to explore emergent themes by the use of probing questions aimed at obtaining further description and expansion of opinions, experiences, perceptions, and attitudes related to the research questions. The interview question guide can be found in **Appendix 8**.

Data analysis

In order to ensure quality during data analysis, quality assurance measures based upon systematic and self-conscious practice were implemented (P Liamputtong and Ezzy 2005). The process of data analysis included the five documented steps using the framework approach (Mays 2006) which can be broadly described as familiarisation, identification of framework, charting, mapping and interpretation.

Familiarisation is the process by which the qualitative researcher reviews transcripts. This process includes reading and re-reading the transcripts, organising the data for analysis,

visually scanning the transcripts, typing up field notes and beginning the process of sorting the data and considering its overall meaning. Identification of the framework involves the drawing out of key themes and issues from the text, around which the data is then organised. This is followed by indexing, in which identified themes are linked to text. Charting or coding begins to build up a picture of the data as a whole through the use of headings and sub-headings. At this point in the analysis the full range of perspectives on issues is brought together. Finally, mapping and interpretation are undertaken, whereby associations are clarified, and explanations worked towards. An example of the raw data analysis is shown in **Table 7**.

Table 7 - Example of raw data analysis

Raw Data	Theme
Bulk billing, I understand is where whatever Medicare says, so if … I treat the patient for say keeping on breathing machine let us say. Government says you can earn $50 a day for doing that and bulk bill would be if I say okay give me $50. If I charge $60, then I have charged a gap. [interviewer: when can you do that? SMO12 replied] No idea.	Poor legal literacy
[Interviewer asked SMO7 if education at various levels adequately equipped him to bill correctly] Not at all. It is purely through by necessity to understand it oneself and to understand the vagaries not only of billing, but how it works in the context of the staff specialist or ward arrangements, which are quite complex. [interviewer: 'any education on that either?'] No zero. Zip.	Inadequate induction
[interviewer]…so when it goes off into accounts, how confident are you about what happens next? [SMO14] I am confident because as the director, I have explored that, my colleagues would be somewhat less confident. [interviewer] With item numbers…? [SMO14] No just total numbers. Just money. Could have been anything. So, in fact, in reality I have no idea. [interviewer] So…you have got an idea of the total dollar amount that is billed, do you have an idea of the actual item numbers? [SMO14] No, not at all, not a jot, not one single solitary scintilla.	Absence of reliable advice and support
[GP3] We have a practice manager and we have asked her to contact Medicare about some…uncertain issues regarding Medicare…and she will get five different answers from five different people that she rings…that is a regular experience and I say "…there's no point in ringing Medicare about this" because I do not know who she is speaking to. I do not know whether she is speaking to a manager…or somebody who has recently started in Medicare who does not have much experience…and is just reading from one part of the manual but doesn't know the other parts…we've always had that experience if you ring up…the most recent example…charging through Medicare for overseas travel…she has spoken to several different people and received different answers from each one.	

Rigour

To demonstrate rigour in qualitative research, trustworthiness, authenticity and credibility must be maintained (J.W Creswell 2014). Creswell describes numerous strategies, some of which are more frequently adopted than others, to ensure analytical rigour (J.W Creswell 2014). Of these, triangulation was used in this study; other members of the research team, including an experienced qualitative researcher, separately analysed and interpreted the data including verifying the coding of responses and ensuring any disagreements were resolved. Any differences in researcher perspectives were then fed back into the analysis to crosscheck codes and themes and to develop an overall interpretation.

As has already been discussed, a descriptive technique, rich in detail, was used to convey the findings. Creswell described this technique as adding authenticity and validity to the findings (J.W Creswell 2014). A self-reflective, critical examination of potential bias was undertaken by the principal researcher, who spent prolonged time in the field engaging with the subject matter. Rigour was further enhanced by searching for negative cases in the codes and theme development, and peer debriefing enhanced the accuracy of the accounts (J.W Creswell 2014).

Full details, and the results of phase three, are set out in the academic publication that forms chapter six of this thesis.

CHAPTER 4: Doctrinal and Policy Analysis

4.1 Background and context

When Medibank was introduced in 1975 many of the reimbursed services provided by MP were largely supportive, treating symptoms rather than curing disease (Australia 1974). This was before the majority of the tests and treatments now available and reimbursed under Medicare existed and before the advent of the internet had fundamentally changed the way we live and work. Yet while the number of reimbursed services has increased sixfold over the past four decades, Medicare has arguably remained one of the most patient-centred health financing systems in the world, because the sole legal beneficiary of the Medicare rebate has always been the patient. However, in the process of intermingling our public and private payment arrangements across Medicare's FFS structure, the Medicare rebate has become buried deep in a chamber of secrets and labyrinthine complexity, such that the government has lost meaningful control of the scheme and compliance has become subjective and porous. Unfortunately, somewhere along that journey we appear to have lost sight of the scheme's focal point, which has always been the sole financial contributor to the Medicare funding pool – the patient (Australian Institute of Health and Welfare 2020).

The following detailed doctrinal and policy analysis of this evolutionary process includes commentary on pivotal legal decisions such as the High Court case of *Peverill*, which decided the essence of what a Medicare rebate is ("Health Insurance Commission v Peverill [1994] HCA 8"), and the two *Sood* cases, which enshrined the criminality of bulk billing and concurrently charging a gap ("R v Suman SOOD 2007 NSWCCA 214" ; "Suman SOOD v Regina 2006 NSWCCA 114"). Important structural changes made to the medical billing eco-system, predominantly between 2000 and 2020, which transitioned the law of medical billing from **Figure 4** to **Figure 5,** are also discussed.

4.2 Medicare billing law and practice: complex, incomprehensible and beginning to unravel

Chapter 4 was published in the *Journal of Law and Medicine* in 2019. **Medicare billing, law and practice: complex, incomprehensible and beginning to unravel**. Margaret Faux, Jonathan Wardle and Jon Adams (2019) 27 JLM 66. The article can also be accessed via this link https://pubmed.ncbi.nlm.nih.gov/31682343/

Abstract

Australia's Medicare is still widely considered one of the world's best health systems. However, continual political tinkering for 40 years has led to a medical billing and payment system that has become labyrinthine in its complexity and is more vulnerable to abuse now, from all stakeholders, than when first introduced. Continuing to make alterations to Medicare without addressing underlying structural issues, may compound Australia's health reform challenges, increase the incidence of non-compliance and expenditure and thwart necessary reforms to develop a modern, data-driven, digitally informed health system. For the medical practitioners who are required to navigate the increasing complexity and relentless change, they will remain at high risk of investigation and prosecution in what has become an anarchic operating environment that they cannot avoid, but do not understand.

Keywords*: Health care fraud and non-compliance; health system literacy; legal liability of medical practitioners; health insurance*

Introduction

The Nimmo report in 1969 described health insurance in Australia as "unnecessarily complex and beyond the comprehension of many," and the report became the catalyst for the introduction of Australia's first universal health coverage scheme, Medibank.[1] This paper

[1]Health Insurance, Report of the Commonwealth Committee of Enquiry, March 1969 https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id:%22library/lcatalog/10134931%22

suggests that Australia's current health insurance arrangements have again become so complex and incomprehensible that the system is beginning to unravel.

The authors have undertaken an extensive examination of core legal provisions of tax payer funded medical billing arrangements under Australia's public insurer, Medicare, and to the best of our knowledge this is the first time such a comprehensive review has been undertaken. It is suggested that continual political tinkering for forty years has created a medical billing and payment system that has become labyrinthine in its complexity and is more vulnerable to abuse now than when first introduced. Further, that continuing to make alterations to Medicare without addressing underlying structural issues, may compound Australia's health reform challenges, increase the incidence of non-compliance and expenditure, thwart necessary steps to develop a modern, data driven digitally informed health system, and risk destroying what is widely considered one of the best health systems in the world.[2]

Historical Context

Dr Frank Gaha was the only medical practitioner in the House of Representatives on the night of 9 April 1946[3] and to him the proposal to add eleven words into the Constitutional Amendment Bill represented little more than overzealous obsession on the part of the 'legal gentlemen'. A few months later, on 28 September 1946, one of the most successful referendums in Australian history led to the insertion of section 51(xxiiiA) into the Australian Constitution [4] including the verbiage which Gaha had thought redundant, *'but not so as to authorize any form of civil conscription*' (hereafter referred to as the 'CCC' meaning civil conscription caveat).[5]

[2] Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care https://interactives.commonwealthfund.org/2017/july/mirror-mirror/

[3] House of Representatives, Constitutional Alteration (Social Services) Bill 1946, Hansard https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;adv=yes;db=HANSARD80;id=hansard80%2Fhansardr80%2F1946-04-09%2F0151;orderBy=_fragment_number,doc_date-rev;page=3;query=Dataset%3Ahansardr,hansardr80%20Decade%3A%221940s%22%20Year%3A%221946%22;rec=3;resCount=Default

[4] The Social Services Referendum was passed nationally and in six States making it one of Australia's most successful Referendums https://www.electoralgeography.com/new/en/countries/a/australia/1946-referendum-australia.html

[5] An explanation by Robert Menzies, of the words "but not so as to authorize any form of civil conscription" which he successfully proposed be inserted into the Constitution can be read at this link

Far from redundant, the CCC became a foundation on which Australia's health system was built.[6] The CCC prevented the full implementation of the *National Health Service Acts of 1948,*[7] directly impacted many of the structural choices made by the Federal Government during the implementation of Australia's original universal health insurance scheme, Medibank,[8] and may be at the heart of many of the health reform challenges Australia is facing today.[9]

Almost seventy years later, 38 High Court judges have settled three points of law **(Table 1**) in relation to the interpretation of the CCC as follows:

1. The relationship between a medical practitioner and patient is a contract, governed by general principals of contract law;
2. Both legal and practical compulsion may offend the CCC, and
3. The CCC applies to medical and dental services only and not to other services described in Section 51(xxiiiA).

Table 1

Case Name	No. of Judges
British Medical Association v Commonwealth (1949) 79 CLR 201	6
General Practitioners Society of Australia v Commonwealth 145 CLR 532	7
Alexandra Private Geriatric Hospital Pty Ltd v Commonwealth (1987) 62 CLR 271	5
Health Insurance Commission v Peverill (1994) 179 CLR 226	7
Breen v Williams (1996) 186 CLR 71* **Breen* considered certain aspects the contractual relationship between doctor and patient, not s 51(xxiiiA) specifically	6
Wong v Commonwealth (2009) 236 CLR 573; [2009] HCA 3	7
Total	**38**

https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;adv=yes;db=HANSARD80;id=hansard80%2Fhansardr80%2F1946-04-09%2F0149;orderBy=_fragment_number,doc_date-rev;page=3;query=Dataset%3Ahansardr,hansardr80%20Decade%3A%221940s%22%20Year%3A%221946%22;rec=3;resCount=Default

[6] Medicare's enabling Legislation is the Health Insurance Act 1973 (Cwth). Despite it's name, it is not a law for Insurance (discussed in this paper) but a law enacted pursuant to the new Section 51(xxiiiA) of the Constitution, as a law for the provision of medical and dental services. From the outset, optometrical services were included.

[7] Anne-marie Boxall & James A. Gillespie, *Making Medicare: The Politics of Universal Health Care in Australia*, UNSW Press, Sydney, 2013, pages 28 and 29.

[8] Gough Whitlam, Curtin Memorial Lecture 1961, http://john.curtin.edu.au/jcmemlect/whitlam1961.html#anchor1597583

[9] Australia's current out-of-pocket medical costs crisis has been attributed to the practical impact of Section 51(xxiiiA) https://insidestory.org.au/healthcares-out-of-pocket-crisis/

Historical records suggest a political preference at the time of the introduction of Medibank to socialise medicine[10] but this was problematic for the government because the CCC prevented (and still prevents) the Federal Government from implementing an NHS[11] style of health system in which medical practitioners can be employed as public servants. This has effectively enshrined the small business nature of Australian medical practice enabling medical practitioners to set fees as they wish. More recently, the CCC was described by the High Court as a rare constitutional guarantee which benefits both parties equally by preserving freedom of choice for consumers, who cannot be forced to have a required relationship with a medical practitioner without their consent.[12]

Despite the seemingly impenetrable barrier imposed by the CCC, on 1 July 1975, the Federal Government successfully introduced Medibank (later Medicare), which provided health sector funding across two distinct domains, enabled by two separate sections of the Constitution:

1. The provision of free public hospital services via conditional federal grants made to State and Territory Governments under section 96,[13] and
2. Subsidised private services rendered by medical practitioners on a fee for service basis pursuant to laws made under Section 51(xxiiiA).

This structure, which endures today, has allowed the Federal Government to indirectly control State run public hospitals and subsidise out of pocket costs for consumers accessing private sector services.

Today, decisions concerning the interpretation of the CCC are being felt in the health reform space, where the need to control escalating federal health expenditure sits at odds with the unique position of power and privilege held by Australian medical practitioners who have

[10] Gough Whitlam (n 8)
[11] The National Health Service, known as the NHS, is the publicly funded Universal Health Coverage system in the United Kingdom. For more information visit this link https://www.nhs.uk/
[12] Wong v Commonwealth of Australia; Selim v Lele, Tan and Rivett constituting the professional Services Review Committee No 309 [2009] HCA 3 (2 February 2009) http://www.austlii.edu.au/cgi-bin/viewdoc/au/cases/cth/HCA/2009/3.html
[13] Gough Whitlam (n 8)

constitutional protection against excessive government intrusion into the private contractual arrangements they negotiate with their patients. In short, if available rebates (whether from the government or other payers) are perceived as insufficient by an individual medical practitioner, subject to any contractual barriers, the medical practitioner has a constitutional right to charge any amount.

The original scheme included approximately one thousand subsidised services.[14] Today there are almost six thousand, accessible by numerous providers and stakeholders beyond medical practitioners.[15] However, medical practitioners remain the largest group of Medicare eligible providers[16] and most are dependent on the scheme for their livelihoods.[17]

In the 40 years since the scheme was introduced, the daily business of matching increasingly complex clinical encounters to the scheme's administrative dataset has become much more difficult, and understanding the scheme's requirements can sometimes be challenging. Further, despite the CCC, there are numerous circumstances in daily practice when medical practitioners cannot set their fees as they wish, and when charges cannot lawfully be raised against their patients, though they may not know this. Examples are presented in this paper.

The Financial Impact of Non-Compliant Billing and Fraud

Health expenditure in Australia and internationally is outpacing Gross Domestic Product (GDP) growth[18] and the World Health Organization has stated that "Health systems haemorrhage money,"[19] citing ten categories of waste one being fraud and corruption.[20] Some

[14] The Medical benefits Schedule Book April 1974 with amendments to February 1975 http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/515793D58E889BD0CA257CD100033990/$File/1974%20Apr%20MBS%20-%20AUS.pdf
[15] April 2019 Medicare Benefits Schedule http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Downloads-201904
[16] April 2019 Medicare Benefits Schedule (n 15)
[17] Wong v Commonwealth of Australia (n 11)
[18] Public Spending on Health: A Closer Look at Global Trends. World Health Organization, https://www.who.int/health_financing/documents/health-expenditure-report-2018/en/
[19] Health systems financing: the path to universal coverage, World health Organization, https://www.who.int/whr/2010/en/
[20] Health systems financing (n 19)

commentators have suggested that irrespective of system design, no healthcare system is safe from fraud due to inevitable regulatory gaps where inappropriate extraction of money from health funding pools can occur.[21] In Australia, precise quantification of non-compliant Medicare billing has remained elusive, but one commentator has suggested deliberate misuse by medical practitioners costs taxpayers $2-3 billion annually or 10-15% of the schemes' total cost.[22]

In Australia, strategies to promote medical practitioner compliance have featured heavily in departmental reports,[23] the most common among them being education programs designed to encourage voluntary compliance. This is then augmented with post-payment audit activity.[24]

Australian popular media often refer to non-compliant Medicare billing as 'overservicing'[25] or 'rorting'[26] neither of which term has any legal meaning or relevance in this country. The term 'overservicing' was removed from Medicare's regulatory framework in 1994,[27] replaced with 'inappropriate practice'.[28]

The Medicare scheme is enabled by the *Health Insurance Act 1973 (Cth)* (HIA), which is a law within the scope of the Federal Governments Financial Accountability framework and

[21] Gee J et al, the financial cost of healthcare fraud, what data from around the world shows, file:///C:/Downloads/PKF%20Fraud_FINAL.PDF
[22] Webber T, What is wrong with Medicare? *MJA* 2012; 196(1): 18-9
[23] Australian National Audit Office. The Auditor-General, Audit report No.26 2013-14. Medicare Compliance Audits. Department of Human Services, https://www.anao.gov.au/work/performance-audit/medicare-compliance-audits
[24] Australian National Audit Office (n 23) In 2008-2009 the federal government announced an 'Increased Medicare Compliance Audit Initiative (IMCA)' which was designed to strengthen Medicare's audit capabilities. The IMCA provided additional funding to enable increased compliance audits from 500 to 2500 annually. The work had been expected to generate savings of $147.2 million over four years or $36.8 million per year. The net result was a $128.3 million shortfall in anticipated savings. These figures provide a useful basis from which to extrapolate a governmental approximation of $1.2 billion or approximately 6.8% of inappropriate Medicare claims annually.
[25] Medew, J, Too many patients receiving unnecessary medicine, doctors say, The Age, January 9, 2017 https://www.theage.com.au/national/victoria/too-many-patients-receiving-unnecessary-medicine-doctors-say-20170109-gtofmb.html
[26] Evans N, Medicare watchdog claims $21m back over medico rorts, Perth Now, 15 November 2018, https://www.perthnow.com.au/news/public-health/medicare-watchdog-claims-21m-back-over-medico-rorts-ng-b881022056z
[27] Bell R, Medicare Regulation through Professional Services Review – Lessons Learned, https://heinonline.org/HOL/LandingPage?handle=hein.journals/lwincntx23&div=21&id=&page=
[28] Health Insurance Act 1973 (Cwth) Section 80, https://www.legislation.gov.au/Details/C2018C00319

therefore, in addition to offences of inappropriate practice, offences under the HIA necessarily include sanctions under the *Criminal Code Act (Cwth)*[29] where criminal fraud may be prosecuted for serious breaches of the scheme's requirements.

Both civil and criminal offences have been consistently reported since the inception of the scheme,[30] and the majority of available commentary suggests that all incorrect claiming is fraudulent[31] implying the perpetrator has the necessary *mens rea* to act with deliberate intent to defraud. However, results of a recent study[32] which found that Australian medical practitioners may not know (and have never been formally taught) how to bill correctly using Medicare, challenges this assumption.

Irrespective of whether incorrect medical billing is intentional or not, in the current context of pressured health budgets and public expectations, the financial consequences of erroneous billing under Medicare has become a problem of sufficient magnitude that the question of how and why it is occurring can no longer be ignored.

Confusion Starts with the Language of the Law

Enforcement is only possible when concepts are clearly defined, either by the plain words and ordinary meaning of legislation or by judicial interpretation. Unfortunately, in the area of inappropriate practice and fraudulent breaches of the Medicare scheme, there is a relatively small body of case law and having never been judicially interpreted, some key terms within the scheme are therefore important to consider, as they may themselves be possible root causes of noncompliant medical billing by medical practitioners.

[29] Health Insurance Act 1973 (n 28) section 127, penalty for breach of Section 20A
[30] Bell R, Medicare Regulation through Professional Services Review (n 26)
[31] Webber (n 21) and Flynn K. Medical fraud and inappropriate practice in Medibank and Medicare, Australia 1975–1995. Doctor of Philosophy thesis, School of Social Sciences, Media and Communications, University of Wollongong, 2004.
[32] Faux M, Wardle J, Thompson-Butel AG*, et al* Who teaches medical billing? A national cross-sectional survey of Australian medical education stakeholders *BMJ Open* 2018;**8:**e020712. doi: 10.1136/bmjopen-2017-020712

Use of the term 'Health Insurance'

The original Medibank scheme was enabled by two Acts of Parliament: the *HIA* and the *Health Insurance Commission Act 1973.*[33] After major reforms to the Public Service sector in 2005, the *Health Insurance Commission Act 1973* was superseded and is now the *Human Services (Medicare) Act 1973,*[34] but the *HIA* remains. The *HIA* sets out eligibility criteria, billing rules and contains mechanical provisions which facilitate the operation of the Medicare scheme.

Despite its name, the *HIA* is not a law for the provision of insurance. The High Court has deemed it a law for the provision of medical and dental services pursuant to section 51(xxiiiA) of the *Constitution* rather than a law pursuant to the insurance head of power, section 51(xiv).[35] In contrast, the *Private Health Insurance Act 2007 (Cwth)*, defines 'insurance' as having the meaning to which paragraph 51(xiv) of the *Constitution* applies.[36]

Over time, Australia has significantly expanded the original public health funding arrangements and now operates within a complex blended system of both public and private health financing. However, use of the term "insurance" to describe both public and private funding arrangements may be a subtle contributor to confusion in relation to understanding contractual obligations surrounding individual medical billing transactions. This is so because Australia's public Medicare scheme cannot properly be described as a health insurance scheme as it does not carry out insurance business, a central feature of which is the issuing of contracts. Insurance law is in essence, the law of contract,[37] where a binding contract of insurance exists between relevant parties.

Consumer understanding of the term "insurance" is most relevant in areas such as motor vehicle insurance where common features of insurance contracts include; legal entitlement,

[33] Scotton RB and Macdonald CR, The Making of Medibank. University of New South Wales. School of Health Services Management, ASBN 0858320819
[34] Medicare Australia, Annual Report 2005-2006, https://www.humanservices.gov.au/sites/default/files/documents/medicare-annual-report-0506-complete.pdf
[35] Wong v Commonwealth of Australia (n 11)
[36] Private Health Insurance Act 2007 (Cwth) – Section 5.1
[37] Birds J, Birds modern insurance law, ninth edition, Sweet & Maxwell ISBN 978-0-414-02330-7

uncertainty, insurable interest, voluntariness, the provision of money's worth, no control by the party assuming the risk and the carrying out of insurance business which will usually include issuing premium and policy documents.[38] Whilst not an exhaustive list, it is evident that public health financing arrangements such as Medicare typically exclude some of these components, most obviously voluntariness.

In *Health Insurance Commission v Peverill,*[39] the Australian High Court settled certain key issues concerning the legal nature of the Medicare benefit including when the benefit becomes payable and who has contracts with whom in the context of a Medicare billing transaction involving three parties - a patient, a provider of professional services (usually a medical practitioner) and the government.

Legal entitlement to the Medicare Benefit

Peverill confirmed the existence of a contract between the medical practitioner and patient,[40] but the *HIA*[41] did not give rise to a contract between the patient and the government[42] nor between the medical practitioner and the government.[43] The Court characterised the Medicare benefit not as a proprietary right[44] but as a statutory gratuity payable to the patient,[45] and a chose in action that may be acquired by the medical practitioner.[46] Brennan J stated that Medicare benefits become payable immediately upon claims being both lodged and accepted,[47] but neither the patient nor the medical practitioner has a right to sue for unpaid Medicare benefits as no debt accrues to the benefit of either party. Further, payment of Medicare rebates is subject to government policy and the continuing will of the Parliament and may be altered or withdrawn any time.[48]

[38] Birds J, Birds modern insurance law (n 37) pages 10-12
[39] Health Insurance Commission v Peverill *[1994] HCA 8*
[40] Health Insurance Commission v Peverill (n 39)
[41] Health Insurance Commission v Peverill (n 39)
[42] Health Insurance Commission v Peverill (n 39)
[43] Health Insurance Commission v Peverill (n 39)
[44] Health Insurance Commission v Peverill (n 39)
[45] Health Insurance Commission v Peverill (n 39)
[46] Health Insurance Commission v Peverill (n 39)
[47] Health Insurance Commission v Peverill (n 39)
[48] Health Insurance Commission v Peverill (n 39)

Peverill also confirmed that the patient or "eligible person"[49] is the exclusive beneficiary of Medicare benefits[50] and that consent must be obtained from the eligible person before the benefit can be assigned to a provider of professional services.

Therefore, for practical purposes, whilst medical practitioners can charge as they wish under the contracts they enter with their patients, they cannot obtain the patient's Medicare benefit until agreement is reached and consent given. This important inbuilt compliance mechanism is the only step in a medical billing transaction directly involving the patient. By requiring the patient's signature to evidence consent, the billing of fictitious services and patient attendances is prevented and the patient is afforded an opportunity to review services itemised on the agreement.

Provided for in section 20B the assignor (the patient) must sign and retain a copy of the agreement,[51] and section 127 creates a strict liability offence if a copy of the signed agreement is not given to the patient.[52]

However, the patient consent requirement is also anachronistic because Medicare has evolved to include many reimbursed services where the patient is not required to be physically present.[53] Even when present, very few patients will today elect to retain paper copies of consent agreements, particularly as Medicare itself no longer requires practitioners to retain them either.[54]

By diluting the signature requirement in this way it is arguable the Commonwealth has undermined the provisions of section 20B and exposed Medicare to increased vulnerability

[49] Health Insurance Commission v Peverill (n 39)
[50] Health Insurance Commission v Peverill (n 39)
[51] Health Insurance Act 1973 (Cwth) Section 20B
[52] Health Insurance Act 1973 (n 51) – Section 127
[53] See for example the Medicare Benefits Schedule, Case Conferences by Consultant Physician – (items 820 to 838, 6029 to 6034 and 6064 to 6075)
http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=AN.0.51&qt=noteID&criteria=case%20conferences
[54] Department of Human Services, Assignment of benefit documents
https://www.humanservices.gov.au/organisations/health-professionals/services/medicare/medicare-online-health-professionals (accessed 31 March 2019)

and misuse. One example is the use of Medicare to recover bad debts. There is now nothing to prevent a medical practitioner submitting an electronic bill to Medicare for an overdue private patient debt without the patient's knowledge or consent, because neither party is required to retain the consent agreement. The medical record of the medical practitioner would usually provide evidence that the service took place but will provide no information concerning whether the billing was compliant.[55]

A myriad of similar transaction level decisions are made every day by medical practitioners as they go about their daily work, and whilst current government statistics suggest high rates of bulk billing[56] there is no mechanism available to test the veracity of the data because both intentional and unintentional misuse of bulk billing will usually not be visible.[57]

What is a 'Medical Service'?

During the 1946 Social Services Referendum the "YES" case put to Australians described the proposed constitutional change as applying to services provided by medical practitioners and dentists only.[58] However when Medibank was introduced almost thirty years later, a small number of optometry services were included. The optometry profession had initially proposed that their new Medibank eligible services be described as relating to 'specified conditions' rather than "medical conditions," but this was not acceded to on the basis that the correct description of all relevant subsidised services (noting the optometry services could also be provided by medically qualified ophthalmologists) under the new scheme was "medical conditions" which providers of medical services could provide. However, when the *HIA* was

[55] For example, it is illegal to obtain the patient's Medicare rebate and also charge a gap simultaneously (see the case of Sood below). But now, a patient could have paid $100 to the medical practitioner, still owe another $100, but because the patient has forgotten or has refused to pay the balance, the medical practitioner could simply unlawfully bill through Medicare to obtain the patient's Medicare rebate.

[56] The Hon Greg Hunt MP, Minister for Health, Highest bulk-billing rate on record, http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2018-hunt024.htm (accessed 31 March 2019)

[57] For example, a medical practitioner who mistakenly believes it is lawful to bulk bill a consultation and charge a separate $20 administration fee is unlikely to come to Medicare's attention even though the conduct is fraudulent. Medicare data will cite evidence of an electronic bulk billed service, which on its own would not trigger alerts of impropriety. Patients are also unlikely to complain in such circumstances because by bulk billing, the medical practitioner has reduced their out of pocket expenses, only requiring nominal payments which most would assume to be legal.

[58] Wong v Commonwealth of Australia (n 11) Kirby J

introduced, medical and dental services were grouped under a new term – "professional service" – though the reasons for this decision are unclear. One suggestion is that the inclusion of the optometrical services which were approved just 10 days before the scheme commenced necessitated a rushed decision regarding the need for an overarching term. The term "professional services" continues in use today, though it follows that the very fact of including optometrists from the outset means that providers of medical and dental services, described in s 51(xxiiiA), includes (and has always included) a wider class of persons than just medical practitioners and dentists, further, that a medical service itself has a wider meaning than being a service for treatment of a medical condition that only a medical practitioner can provide. Indeed today, the Medicare scheme subsidises 28 optometry services,[59] numerous services provided by a raft of allied health practitioners and nurses,[60] and many of the more recently added "professional services" are services that neither medical practitioners nor dentists have the training or skills to provide, such as exercise physiology, physiotherapy, chiropractic and dietetics services.

What is a 'Professional Service'?

Section 3 of the *HIA* defines "professional service" as being a "clinically relevant service" and the subsequent definition of "clinically relevant service" includes necessity as an element.

Interpretation of what constitutes a clinically relevant and necessary professional service is framed broadly to facilitate the art of medicine,[61] ensuring medical practitioners are free to exercise appropriate clinical discretion on a case by case basis. This approach also aligns with a guiding principle described in the Health Practitioner National Law to enable innovation in

[59] Medicare Benefits Schedule Category 1, Group A10 services http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/1BC94358D4F276D3CA257CCF0000AA73/$File/201904-MBS.pdf

[60] Medicare Benefits Schedule (n 59) Category 8 services

[61] The most famous author on the topic of the art of medicine was Sir William Osler, who was famously quoted as saying "The practice of medicine is an art not a trade: a calling, not a business: a calling in which your heart will be exercised equally with your head." See https://www.azquotes.com/author/11160-William_Osler The underlying principle posits that medical practitioners are guided by science, but treat patients as individuals.

service delivery.[62] However there may be a disconnect between the clinical skill set of medical practitioners and the administrative approach of Medicare, the ubiquitous effects of which permeate millions of decisions every day, ultimately impacting the corresponding billing transactions and health system spending. For medical practitioners, daily clinical decisions concerning whether a test or treatment is both clinically relevant and necessary will depend on numerous factors that may be poorly aligned with Medicare's approach, including non-clinical factors such as a perceived risk of subsequent litigation.[63]

The government has no ability to determine clinical relevance or necessity because it has no visibility over the reason why a patient attended a medical practitioner in the first place. Billing through Medicare requires the allocation of service codes only, which do not provide diagnostic information or describe presenting symptoms. This sits at odds with processes in some other countries where international disease codes are used at the start of the medical billing process to determine why the patient presented for medical treatment, which in turn provides necessary transparency for payers regarding the relevance and necessity of services rendered.[64]

In addition, a lack of clarity around the parameters of what is included in a professional service has caused disagreement at the highest levels of the Australian judiciary where in one case (discussed below) the Court did not reach consensus and the resulting judgement left open

[62] Health Practitioner Regulation National Law Act 2009, Section 2(f).
https://www.legislation.qld.gov.au/view/html/inforce/current/sl-2018-0168

[63] For example - in the circumstances of a 50 y.o woman presenting with a two day history of painful urination and fevers, and a past history of having had a kidney infection five years ago, it would be both clinically relevant and necessary to take a urine sample for pathology testing. However whilst not strictly necessary because the symptoms are most likely caused by a urinary tract infection (UTI) easily treated with antibiotics, the history would make it clinically relevant to also order a kidney scan as these symptoms are also consistent with a more serious kidney infection. It would not be clinically relevant to order a brain scan. However, the decision of whether or not to order the kidney scan and its relevance may ultimately depend on hindsight, because if the correct diagnosis was a simple UTI then arguably a scan was irrelevant and unnecessary. However, if the patient was admitted to hospital that night with a serious kidney infection and a kidney scan had not been undertaken, the medical practitioner may be negligent.

[64] In Australia, a patient who presents to a medical practitioner with a sprained ankle, could have an ECG and an asthma management plan billed, neither of which may be clinically relevant or necessary. In the U.S for example, the medical billing process commences with the allocation of an internationally recognised disease code prior to allocating billing codes. This enables the collection of data to determine clinical relevance but also acts as a barrier to the billing of codes which do not match an appropriate disease code. So in the above example, a sprained ankle presentation may be blocked from billing an ECG and asthma plan.

the question of where a professional service begins and ends.[65] This can be traced to the origins of the Medicare Benefits Schedule under which fees for professional services have always been arbitrarily allocated and do not relate to any formula or measure of work value where inclusions such as time taken, practice costs, consumables, cognitive and technical skill, physical effort and complexity might be defined. A large scale project seeking to address this important structural shortcoming was finalised by the Department of Health in 2000,[66] however its recommendations were never implemented.

A Notable Case

The case of *Sood v The Queen (Sood)*, demonstrates the potentially adverse impact that can follow when a medical practitioner is confused about the ambit of professional services and how to bill them correctly.

Dr Sood was a medical practitioner who was found guilty in an original jury trial of 96 counts of Medicare fraud for billing to Medicare and simultaneously charging additional fees.[67] On appeal the Court considered the meaning of three words in section 20A of the *HIA* – '*in respect of*' – and did not agree on the threshold issue of what came within the ambit of the professional service in that case.[68]

Section 20A of the *HIA* provides that once an agreement between the medical practitioner and patient to direct bill has been made, the government rebate constitutes "full payment" for whatever comes within the parameters of the professional service provided.[69] This would therefore preclude Dr Sood from charging additional fees.

[65] In Suman Sood v Regina [2006] NSWCCA 112 (12 April 2006), Dr Sood charged separate fees for counselling patients and for operating theatre costs, at the same time as billing directly to Medicare. The court found that the separate charges were illegal on the basis that counselling and operating theatre fees were included in the scope of the services Dr Sood had billed to Medicare. Dr Sood was found to have effectively double dipped, which was a crime.
[66] The Relative Value Study: http://www.health.gov.au/internet/main/publishing.nsf/Content/health-rvs-overview.htm
[67] *Suman Sood v Regina [2006] NSWCCA 114.* Dr Sood adopted a pattern of practice whereby she routinely bulk billed and charged a gap at the same time. Whilst she held that she was charging the gap for a separate service, the prosecution successfully argued the gap was part of the service that she bulk billed, which was a criminal offence.
[68] The appeal was ultimately allowed on the basis of misdirection of the jury by the court of first instance, but there was no consensus on this particular issue.
[69] Health Insurance Act 1973 (Cwth) - Section 20A

In the jury trial, counsel for Dr Sood argued that the additional fees Dr Sood charged (which she had described on the relevant invoices as "counselling and theatre fees"), were not fees *in respect of* the procedure she performed, but were instead fees *in respect of* separate professional services for which she was entitled to charge a fee. Dr Sood contended that there were up to four distinct services which might be provided to patients who attended her clinic each day: a consultation, counselling, theatre fees and a procedure. Having read the Medicare Benefits Schedule or MBS (discussed below), Dr Sood argued that she believed she was entitled to apply mixed billing arrangements across the four components, sometimes exercising her constitutional right to charge as she chose, and other times relinquishing it. This approach was (and remains) consistent with advice available for medical practitioners on Medicare's website.[70]

Section 20A of the *HIA* uses the singular 'service' as opposed to the plural 'services' in recognition of each Medicare service being unique and finite. Implicit in this construct is the ability for practitioners who provide more than one professional service to the same patient on the same day, to bill for those services using mixed billing arrangements, subject to certain exceptions.[71]

In *Sood* only one of the services the practitioner provided to each patient was subject to an exception and therefore it appeared open to her to direct bill the procedure, charge a private fee for the counselling and theatre fees and direct bill the consultation, as long as she accepted the government rebate 'in full payment' for the relevant direct billed services. However, the Crown contended that the manual billing method used by Dr Sood included a declaration that no payments had been sought *in respect of* the professional services she had direct billed. By charging additional counselling and theatre fees, the Crown successfully argued that Dr Sood had sought unlawful additional payments *in respect of* the direct billed procedure. This was

[70] Bulk billing and private billing together, Department of Human Services advice for medical practitioners, https://www.humanservices.gov.au/organisations/health-professionals/subjects/bulk-bill-payments-health-professionals#a4 (accessed 31 March 2019)
[71] Health Insurance Act 1973 (Cwth) - Section 15

enough for a jury to return a guilty verdict to 96 counts of dishonestly obtaining a financial benefit by deception contrary to section 134.2 of the *Criminal Code Act 1995 (Cth).*

The *Sood* decision highlights the complexities in what is widely considered a simple direct bill transaction, which most Australians know and refer to as "bulk billing". Numerous aspects of the decisions both at first instance and on appeal are troubling.

At the time of the jury trial, the costs of running operating theatres, which Dr Sood described as "theatre fees" had already been separated from medical practitioner fees in Australia for a decade.[72] Therefore if Dr Sood had provided the same service in a private hospital rather than a private clinic, there would have been no ability for the prosecution to mount its argument on this point because operating theatre fees were always billed separately by the facility.[73] Furthermore, the language of the service description which Dr Sood was found to have breached, made (and still makes) no mention of operating theatre costs as forming a component of the total rebate of $144.35.[74] The service description was this short phrase: "Evacuation of the contents of the gravid uterus by curettage or suction curettage." The authors suggest that both the court of first instance and appeal adopted an unsatisfactorily broad interpretation of this service and went so far as to suggest that counselling also formed part of the surgical procedure. This was even though it was accepted that some patients did not go ahead with the procedure after having had and paid for a separate counselling service.[75]

Dr Sood repeatedly stated during the jury trial that she did not know the conduct for which she stood accused was wrong. A recent study suggests there may have been some veracity to

[72] McDonald L, Healthcare funding from a private hospital perspective, HIM-INTERCHANGE Vol 2 No 2 2012 ISSN 1838-8620 (PRINT) ISSN 1838-8639 (ONLINE) http://www.himaa2.org.au/HIM-I/sites/default/files/HIM-I%202-2%20Report%20McDonald.pdf

[73] Accommodation and operating theatre fees are separately invoiced by Australian hospitals for payment either under activity based funding arrangements or by Private Health Insurers. Medical practitioners are entitled to the medical services described only in the MBS.

[74] The relevant description of the procedure which Dr Sood billed was "Item 35643 Evacuation of the contents of the gravid uterus by curettage or suction curettage not being a service to which Items 35639 or 35640 applies, including procedures to which Items 35626, 35627 or 35630 applies, where performed (Anaes. 17705=3B+2T)"

[75] Suman Sood v Regina (n 65)

this stance because recent evidence suggests medical practitioners do not have the high levels of legal literacy expected of them in relation to Medicare billing.[76]

This notwithstanding, the Commonwealth was successful in prosecuting Dr Sood and has since leveraged from this and similar decisions[77] by publishing a non-exhaustive list of what it considers to be included in the scope of a professional service. However, the *Sood* decision may in fact have weakened the government's ability to manage compliance by shrouding every MBS item number in an infinite array of possible inclusions which will only be known to medical practitioners who find themselves before a court.[78]

The appeal judgment of Adams J, who dissented strongly on this point, commented that there appeared to be no satisfactory interpretation of the scheme available and expressed his view on the issue of professional service parameters in the following terms:

"the Chief Justice is right to draw attention to the ubiquity in the Act of the phrase "in respect of a professional service". However, in each case the phrase could have substituted for it the word "for" without any loss of syntactical correctness. Is there a loss of referential meaning? The answer would be "yes" only if the underlying assumption is that more was intended to be covered than would be covered by the word "for". Aside from the phrase itself, the Act does not, in my respectful view, suggest the need for wider reference. The difficulty in accepting that the phrase itself is intended to reflect a wider reference is that it entails considerable uncertainty in a context where precision of scope is of considerable importance….The striking characteristic of the Table…is the clinical and minute precision in which each service…is described…Although the Regulations comprise a distinct statutory instrument, it forms part of a detailed, comprehensive scheme…the acceptance of the Crown submission would, in effect, surround each item with a penumbra of indeterminate meaning inconsistent with the structure of the legislative scheme and unfair to the medical practitioners attempting to work within its boundaries...I do not accept that the legislature intended to place doctors in the

[76] Faux M, Wardle J, Faux M, Wardle J, Thompson-Butel AG*, et al* (n 32)
[77] Dalima Pty Limited v Commonwealth of Australia Unreported, NSWSL, No 25304/87, 22 October 1987
[78] Faux M, Wardle J, Faux M, Wardle J, Thompson-Butel AG*, et al* (n 32)

position where a not unreasonable interpretation of the Act leads them to make a claim which *ex post facto* a judge (or, for that matter, a jury) will find to be wrong and render them liable to criminal prosecution…The question of interpretation is debatable and the fact that a doctor makes a claim, even if he or she thinks it *might* not be justifiable…should not render him or her liable to prosecution."[79]

It is noteworthy that whilst the majority of items and services listed in the Medicare scheme relate to specialist services, most discussion around fraudulent and non-compliant billing, as well as the majority of prosecutions, have focussed on general practitioners, such as Dr Sood.

The Medicare Benefits Schedule

To assist in understanding appropriate billing practices for professional services, Australian medical practitioners are referred to a resource known as the MBS, which utilises a schedule of fees originally developed in consultation with the Australian Medical Association (AMA) on a recommendation made in the Nimmo report.[80]

The MBS can best be described as a departmental compilation of the *HIA*, Regulations[81] and Tables.[82] However, it is not an instrument of Parliament and therefore does not have the force of law. Accordingly, interpretation of item descriptions, explanatory notes and commentary throughout the MBS is not correct statements of the law but rather interpretations as to how the government views the law, which are open to legal challenge. In the case of *Sood* just discussed, Dr Sood gave evidence that she had read the relevant sections of the MBS but its contents were insufficient to enable her to predict how three judges would later view the corresponding section of the legislation.

[79] Suman Sood v Regina (n 65)
[80] Health Insurance (n 1). Following the Nimmo Report, the federal assembly of the AMA passed a resolution in 1969 supporting the development of a list of the 'most common fees' to guide the determination of medical benefits and the subsequent list became the basis of the first MBS in 1975, which has continued to evolve for forty years.
[81] Health Insurance Regulations 2018
[82] Health Insurance (General Medical Services Table) Regulations 2018, Health Insurance (Pathology Services Table) Regulations 2018 and Health Insurance (Diagnostic Imaging Services Table) Regulations 2018

Indeed, it is common for interpretative statements contained in the MBS book to be inconsistent with the law beneath, with itself via the online version of the MBS, with the department's own online billing portal ECLIPSE (which every medical practice in the country is required to use) and with the linked funding systems that administer Australian hospital payment arrangements. Examples are described in **Table 2**.

Table 2

Brief Description of Issue	Details of the Discrepancy	Impact on Medical Practitioner (MP)
MBS book inconsistent with MBS online version	The MBS book states in TN.8.2 that the multiple operation rule applies to all items in T8 group, except items from subgroup 12. This would include item 44359. However, the MBS online version at http://www.mbsonline.gov.au version contradicts the MBS book by stating that the multiple operation rule applies to item 44359, which is confirmed as being part of T8 and subgroup 12. Section 15(4) of the *HIA* confirms the position taken in the MBS book but not the online version, the latter of which appears to be legally incorrect.	Reliance on MBS online will lead to underbilling for item 44359, if billing with other surgical services (which is usual). If Medicare applies the law correctly it will pay higher than the amount billed. This may put the MP in the position of believing an overpayment has occurred and the MP may be accused of rorting by not actioning a refund. Conversely, if Medicare applies the MBS online version, the MP may be accused of overcharging.
MBS online version is inconsistent with itself	The description of item 24 on MBS online http://www.mbsonline.gov.au implies the same fees are payable for each patient seen by a GP doing a ward round in a hospital, but in fact, when one clicks through to the ready reckoner it is apparent this is incorrect and a sliding scale applies, meaning the MP should not charge the same fee for each patient. Both sections of MBS online refer to the fee being the fee for item 23 plus another amount. However, this is potentially misleading because item 23 is paid at 100% of the Medicare Schedule Fee, whereas item 24 is paid at the lower inpatient rate of 75%.	MP may be accused of overcharging and rorting when the MP was in fact making a legitimate attempt to apply the convoluted and incomprehensible description provided on MBS online relating to legitimate services properly provided by the MP. The MP may be accused of attempting to rort the system if the claim finally submitted is incorrect.
Advice and information from government is inconsistent with the law and cannot be practically applied by MPs due to shortcomings of ECLIPSE online claiming platform	The MBS book states that an MP can either provide their provider number on each claim, or their name and the address where they provided the service. However, Medicare's online help page at this link https://www.humanservices.gov.au/organisations/health-professionals/services/medicare/hpos/resources/managing-provider-numbers implies this is not the case. It states MPs must have a provider number for each location where they work. However, in circumstances where Medicare refuses to issue an MP with a provider number the law provides than an MP can still claim by instead using their name and the address where the service was provided. This is provided in Div 5 of the *Health Insurance Regulations* Reg 51(2)(a) which provides that MPs can satisfy "prescribed particular" requirements by including their name and the address of the place where the service was provided, in lieu of a provider number.	However, irrespective of the legal requirement clearly articulated in Reg 51(2)(a), the government's online ECLIPSE platform which all MPs are required to use to submit electronic claims, does not include a data field for an address. Therefore, even if an MP wanted to submit a compliant electronic claim to Medicare using their name and the address where they provided the service, they are physically prevented from doing so. This may place an MP in the position of being unable to comply with legal requirements, for which the MP may be investigated and accused of deliberately attempting to rort the system.

MBS billing codes are inconsistent with the procedure codes used to reimburse Australian hospitals	The procedure codes used to reimburse Australian hospitals are known as ACHIs, or the Australian Classification of Health Interventions. ACHIs were originally derived from the MBS. There are now 6224 ACHIs which map to only 1363 MBS codes, meaning the MBS and ACHIs are no longer directly aligned or consistent, which can cause downstream problems for MPs. For example, an MP ophthalmologist performs a cataract operation and claims item 42702 which covers both the lens extraction and the insertion of the new intraocular lens. The claim is rejected because it is inconsistent with the claim submitted by the hospital. The hospital biller has changed the MPs item numbers from 42702 to 42701 (insertion of new lens) and 42698 (extraction of old lens) because item 42702 was removed from the ACHIs but not from the MBS. The hospital biller is therefore forced to change the MPs item numbers to generate the required bill from the hospital.	The MP is forced to change and bill two item numbers instead of one, costing Australian tax payers significantly more. The MP may be accused of rorting as a result of billing two services when one service, item 42702, was clearly appropriate in the circumstances. The MP has effectively been placed in a position of having no option other than to double code, because until she does, neither her claim nor the hospital's will be paid. Despite the MP being legally responsible for the MBS services claimed, a third party far downstream from the MP has changed the MPs item numbers without the MPs knowledge or consent, unknowingly potentially exposing the MP to criminal liability.

Daily Medicare Billing from the Medical Practitioner Perspective

Medical practitioners have no option but to engage with the Medicare scheme and comply with its requirements despite the fact that there is limited guidance as to how the scheme works and how to bill.[83] So convoluted has the scheme now become, that even threshold decisions create avenues for unintentional non-compliant billing to occur.

Provider numbers and the impact of electronic billing on compliance

Medical practitioners are required to bill using personal identifiers called "provider numbers," which are central to the integrity of the Medicare scheme. Collection of provider number data ensures the Health Department is able to track the identity of providers of professional services, analyse service delivery patterns and monitor compliance.[84] However, the law pertaining to provider numbers, though recently revised, has failed to accommodate the realities of electronic billing – now the main form of bill submission – which was introduced in 2002.

[83] Faux M, Wardle J, Faux M, Wardle J, Thompson-Butel AG*, et al* (n 32)

[84] About Medicare provider numbers, Department of Human Services https://www.humanservices.gov.au/organisations/health-professionals/services/medicare/medicare-benefits-health-professionals/apply-medicare-provider-number/about-medicare-provider-numbers (accessed 31 March 2019)

Section 19(6) of the *HIA* refers to prescribed particulars to be included on accounts and the newly revised 2018 Regulations describe those particulars as including the practitioner's name and practice address, or the practitioner's provider number.[85] In similar fashion to the definitions already described, the wording of the provider number definition adds further ambiguity to claiming hurdles which medical practitioners must navigate. The regulations state that a provider number *"…identifies the person and a place where the person practices the person's profession"*,[86] it does not state that a provider number *identifies the person and the place where the service was provided,* though this is the advice Medicare provides to medical practitioners, despite it often not being possible.[87]

The government facilitates electronic billing through its portal known as ECLIPSE,[88] which all medical practitioners are required to use, however, many of the shortcomings of this portal exacerbate billing challenges for medical practitioners. ECLIPSE only facilitates a provider number being linked to one software system and one bank account at a time despite this being misaligned with modern medical billing, where medical practitioners may be forced to bill from multiple different software systems at a single street address.[89] Currently, the only way to manage this scenario is to bill using multiple provider numbers for services provided at one address, which, applying Medicare's interpretation of the Regulations, would potentially represent a breach of the schemes requirements. However, any judicial determination would likely be focussed on whether the information provided to Medicare was false in a material

[85] Health Insurance Regulations 2018 – Regulation 51 https://www.legislation.gov.au/Details/F2019C00178 (accessed 31 March 2019)
[86] Health Insurance Regulations 2018 (n 85) Regulation 4
[87] Department of Human Services, eLearning Modules, What is a provider number? Slide 8 of 19 http://medicareaust.com/MODULES/MBS/MBSM11/index.html (accessed 31 March 2019)
[88] Department of Human Services, Simplified Billing and ECLIPSE, https://www.humanservices.gov.au/organisations/health-professionals/services/medicare/simplified-billing-and-eclipse (accessed 31 March 2019)
[89] A common example occurs when a medical practitioner has one provider number linked to Hospital A's address, but the hospital has co-located public and private hospitals and specialist consulting suites, all of which share the same street address. The medical practitioner can only have one provider number at that street address according to Medicare's current approach. However, the specialist suites may require that the medical practitioner bills through their software, the public hospital through theirs and the private hospital through a third software suite, with the revenue generated being legitimately directed into different bank accounts based on contractual arrangements. If Medicare refuses to issue additional provider numbers for the medical practitioner at the one street address, the only option is for the medical practitioner to use a different provider number for each of the three medical billing software suites.

particular.[90] The authors suggest this would be difficult to prove if a bill were otherwise correct.[91]

This notwithstanding, with no decided cases to assist, interpretations of the relevant regulations are speculative, including those of the government, which has itself acted inconsistently on this issue by sometimes arbitrarily allowing some medical practitioners to have two provider numbers at the same address and others not, and allowing the use of an existing provider number at an unrelated location on a temporary basis.[92]

The underlying provider number problem is that in the 40 years since the scheme began, a service location can now realistically be in a car with a laptop or mobile phone.[93] However the system remains designed for an era in which electronic services were not available. Failure to adapt the system to modern medical practice may therefore be encouraging unavoidable non-compliance by medical practitioners, but may have also rendered the Government unable to take any action when legitimate concerns about incorrect use of provider numbers do arise.

Contracting out of the Civil Conscription Caveat

There are many instances in daily practice where medical practitioners may have unknowingly contracted out of their constitutional freedom to set their fees. A common example is the *Veterans' Entitlement Act 1986 (Cwth)* (*VEA*) which is one of a suite of laws regulating entitlements for ex-servicemen and women, and current military personnel and their dependants.[94]

[90] Health Insurance Act 1973 – Section 128A
[91] If the only incorrect detail was the provider number suffix of 2 digits, but otherwise the claim was correct in every particular and the right amount of money was paid correctly for services correctly rendered and the medical practitioner provided additional details on the claim of the service location (which is mandatory data on all modern medical billing software) the authors suggest it would be extremely difficult to mount a a compelling prosecution case.
[92] Department of Human Services, eLearning Modules (n 85) Slide 13 of 19
[93] Telehealth services for medical specialists are included in the Medicare scheme and all that is required is an internet connection and video capability such as Skype. Therefore it is not fanciful for a medical specialist to pull over to the side of the road, power up a laptop (or even just use a mobile phone) and conduct a scheduled, Medicare claimable, online telehealth attendance from a car.
[94] Veterans' Entitlement Act 1986 (Cwth) and Safety, Rehabilitation and Compensation Act 1988 and Military Rehabilitation and Compensation Act 2004.

The Department of Veteran's Affairs (DVA) has a hybrid role as a publicly funded organisation with diverse portfolios. The *VEA* deals with what is described as "medical and other treatment"[95] (as opposed to "professional services") with section 90 enabling the preparation of written "Treatment Principles" designed to be legally binding on medical practitioners and articulated in a document called "LMO Notes".[96]

The *VEA* cross references the *HIA* in determining private patient principles[97] and reflects the constitutional freedom of DVA eligible patients to enter private arrangements if they wish. DVA has adopted the MBS for its subsidised medical services (though with different fees), and applies Medicare rules.[98] Since 1985 all DVA claims have been administered by Medicare.[99] However, the High Court has confirmed that the two schemes are completely separate, French CJ confirming that a medical practitioner unable to participate in the Medicare scheme could continue to provide services to entitled veterans.[100] Indeed one particular sub-class of entitled veterans who hold injury specific "white cards" may have no alternative other than to claim through both DVA and Medicare, though separately, in relation to the same visit to a medical practitioner.[101]

Information provided to eligible veterans via its website uses language suggestive of a prohibition against charges being levied by medical practitioners in any circumstances such as:

"If you are billed by your LMO or medical specialist, do not pay the account and advise DVA immediately."[102]

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[95] Veterans' Entitlement Act 1986 (Cwth) – Part V
[96] Australian Government, Department of Veteran's Affairs, Providers/Doctors, LMO notes https://www.dva.gov.au/providers/doctors#lmonotes (accessed 31 March 2019)
[97] Veterans' Entitlement Act 1986 (Cwth) – Section 90A
[98] Australian Government, Department of Veteran's Affairs, Providers/Doctors http://www.dva.gov.au/sites/default/files/files/providers/fee_schedules.pdf, notes for claiming DVA fees
[99] Scotton RB and Macdonald CR (n 33)
[100] Wong v Commonwealth of Australia (n 12)
[101] For example – A white card holder sees GP for leg injury (which is covered under the white card) as well as the flu, which is not. The claim for the leg must be made under the DVA white card but the claim for the flu cannot be because the flu is not covered under the card. The item 23 for the flu would have to be claimed under Medicare.
[102] Australian Government, Department of Veteran's Affairs Fact sheets for eligible Veterans https://www.dva.gov.au/factsheet-hsv80-local-medical -officer-and-medical -specialist-services (accessed 31 March 2019)

Statements such as this suggest that, in similar fashion to Medicare, medical practitioners are assumed to have knowledge of DVA requirements. However, available evidence suggests this is not the case.[103]

When medical practitioners register their provider numbers for electronic claims, they are automatically enrolled in the DVA scheme.[104] The enrolment process occurs without any active involvement on the part of the medical practitioner, effectively conscripting them into the DVA scheme without their knowledge or consent. Enrolling providers in this way under a false premise of consent may give rise to unintentional non-compliance and create tensions in managing the expectations of patients who have been led to believe all medical services under their DVA entitlements will not incur additional fees. It may also render vulnerable the integrity of the DVA scheme and the ability of the government to prosecute errant medical practitioners who were never afforded an opportunity to know in advance the terms and conditions of the DVA scheme prior to being involuntarily and unknowingly enrolled in it.

Similarly, workers compensation and third party claims can present challenges for medical practitioners who may hold an erroneous belief they are not permitted to raise fees against compensable patients beyond the gazetted rates referred to within the various State and Territory schemes. All such schemes derive the majority of services and fees from the MBS, with some additional services being found in the Australian Medical Association (AMA) schedule of fees.[105] Billing under these arrangements incorporates hybrid Medicare and AMA rules and fees, adding another layer of complexity for medical practitioners who may unknowingly levy incorrect charges in these circumstances. Whilst medical practitioners are expected to know and understand the requirements of each of these schemes, they have no training or skills which would enable them to make a decision about whether they are legally permitted to charge a workers compensation patient or not. State workers compensation legislation does not prevail over constitutional provisions and as such, medical practitioners

[103] Faux M (n 31)
[104] Australian Government, Department of Veteran's Affairs, Providers, Becoming a DVA service provider, https://www.dva.gov.au/providers/becoming-dva-service-provider (accessed 31 March 2019)
[105] AMA has maintained its separate schedule of medical fees, which is available only to AMA members or upon payment of a fee, https://ama.com.au/resources/fees-list (accessed 31 March 2019)

retain an overarching right to charge as they wish. State workers compensation provisions will typically limit insurer liability,[106] but this does not have an impact a medical practitioner's right to charge a compensable patient as he or she chooses, although it is unlikely a medical practitioner would know this.

Medicare Billing for Hospital Services

In addition to the basic billing framework presented thus far (being that medical practitioners either exercise their constitutional right to set fees as they please, or bill in accordance with other contractual arrangements), when a patient is admitted to an Australian hospital, multiple additional legal layers come into play, with overlapping and sometimes contradictory requirements depending on whether the patient is in a public or private facility.

Options for billing private inpatients under Medicare were expanded in 1998[107] and again in 2000,[108] when changes to the *National Health Act 1953* and the *HIA* introduced the ability for patients to assign Medicare benefits to private health insurers (PHIs), the central objective being to simplify billing processes and limit out of pocket costs for hospitalised patients.[109] On the back of a failed attempt by the government to encourage medical practitioners to contract out of their constitutional freedom and fix fee arrangements for in hospital billing,[110] the *Health Legislation Amendment (Gap Cover Schemes) Bill 2000* was introduced into parliament with the objective of controlling medical fees without contracted arrangements.[111]

[106] Workers Compensation Act 1987 No 70 http://www.legislation.nsw.gov.au/maintop/view/inforce/act+70+1987+cd+0+N Part 3 Division 3 Section 61 (accessed 31 March 2019)
[107] Danuta Mendelson, Devaluation of a Constitutional Guarantee: The History of Section 51 (xxiiiA) of the Commonwealth Constitution 23 Melb. U. L. Rev. 308 (1999)
[108] http://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/bd/Bd9900/2000bd134?print=1 (accessed 7 April 2019)
[109] http://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/bd/Bd9900/2000bd134?print=1 (n 108)
[110] Less than 100 medical practitioners across australia had signed up to the new Medical Purchaser Provider Agreements after two years of operation.
https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/1996-99/health/report/c03
[111] Then Federal Health Minister Michael Wooldridge said: *'This Bill amends the National Health Act 1953 (NHA) and the Health Insurance Act 1973 (HIA) to provide for gap cover schemes. The purpose of these schemes is to enable registered health benefits organisations to provide no gap and/or known gap private health insurance without the need for contracts.'*

Whilst referred to as "simplified" billing arrangements, a new medical billing industry quickly emerged to deal with the complexities of the new schemes, under which medical bills involved up to five parties, with various contracts and legal relationships that collectively determined the fate of the Medicare rebate at the heart of the transaction.[112] These schemes, often referred to as "gapcover schemes" remain in common use today. Practically, patients will typically have no involvement in a gapcover transaction though the legal basis for this is somewhat labyrinthine and porous.

Under these schemes, section 20A(2A) of the *HIA* provides that an eligible person may enter into an agreement to assign his or her right to the Medicare benefit to a PHI, an approved billing agent or another person.[113] Such assignment is subject to the provisions of section 20B, which provides that no signature is required in these circumstances.[114] The net effect being that a patient may unknowingly enter into an agreement with a PHI allowing the PHI to receive their Medicare benefit but without signing any agreement to that effect.

Where the agreement between the patient and the PHI exists is somewhat a mystery. Available policy documents of some PHIs are silent on the issue but nowhere does there appear to be a specific legal basis facilitating ongoing agreement for all inpatient Medicare benefit entitlements to be automatically assigned to the patient's PHI. This would seem to be quite an important omission.

Further, the wording of subsection (2A) refers to a singular 'benefit' which is consistent with the overarching provisions of the *HIA* already discussed. But a question then arises concerning when a patient is admitted to hospital and enters an unsigned agreement with a PHI to assign relevant Medicare benefits, does the PHI have a right to obtain all eligible Medicare benefits under some opaque grouping arrangements or is the PHI subject to the same onerous provisions as medical practitioners who receive assigned Medicare benefits? It would appear

[112] Including - a medical practitioner, a patient, the government, the private health insurer and possibly a billing agent.
[113] http://classic.austlii.edu.au/au/legis/cth/consol_act/hia1973164/s20a.html
[114] This is because the assignment of benefit takes place under subsection (2A) not subsection (1), the latter clause requiring the patient's signature

the same requirements which may expose a medical practitioner to risk of criminal liability for each individual professional service claimed do not apply to PHIs, because while medical practitioners are required to obtain the patient's consent every time they provide a service, it appears the PHIs have effectively been given an open and ongoing consent to collect public money, via the patient's Medicare benefit for every inpatient service.

Of further concern is the question of how long the PHI has to transfer Medicare benefits it receives from the government to the medical practitioner. In 1999 s 73AAG (n) and (o) of the *National Health Act 1953 (Cth)* provided that Medicare benefits must be passed to the medical practitioner within two months.[115] Further legislative tightening of this provision occurred in 2002.[116] However, in 2007 the gapcover schemes were completely subsumed into the *HIA* and the *Private Health Insurance Act 2007 (Cth)* and provisions relating to a specific time frame in which the transfer of public money from the health fund to the medical practitioner must take place were removed for PHIs but retained and moved into a new Deed Agreement for approved Billing Agents, who now have 90 days to pass benefits to a medical practitioner.[117]

Following the *Peverill* decision of the High Court, once a Medicare claim has been received and approved it becomes immediately payable. However, the original intention was that the immediate payment would be made to a provider of professional services (usually a medical practitioner) not a PHI. Billing agents are a further intermediary between the PHI and the medical practitioner who typically manage the billing process for medical practitioners for whom the task is too onerous and complex. Billing agents are often hospitals or medical billing companies who operate trust accounts into which medical billing revenue received from PHIs is paid before being distributed to medical practitioners. This convoluted passage of public

[115] Private health insurance circulars 1999, HBF 575 PH 336 http://webarchive.nla.gov.au/gov/20100307212147/http://www.health.gov.au/internet/main/publishing.nsf/Content/health-privatehealth-providers-circulars99-00-575_336.htm (accessed 8 April 2019)

[116] By the introduction of the *Health Legislation Amendment (Private Health Industry Measures) Act 2002*. The explanatory memorandum to the bill stated: 'Item 3 amends paragraph (o) of Schedule 1 [of the *National Health Act 1953]* to insert a reference to sub-section 20A(2AA) of the HIA. This amendment requires health funds to provide the Health Insurance Commission (HIC) with access to documents relating to Medicare benefits paid under a gap cover scheme, when requested to do so by the HIC. This will enable the HIC to access all necessary documents to audit the payment of Medicare benefits and ensure that public money has been properly directed.'

[117] Deed Agreement between the Federal Government and a Billing Agent, Clause 9 – Payment to an Assigning Practitioner – 90 day period https://www.humanservices.gov.au/sites/default/files/documents/deed-poll.pdf (accessed 7 April 2019)

money in the form of Medicare Benefits processed under gapcover arrangements is shown in **Table 3**.

Table 3

Patient ⇨	Medicare ⇨	PHI ⇨	Billing Agent ⇨	Medical practitioner
Privately insured patient unknowingly agrees to assign all relevant Medicare Benefits (MB) while in hospital to a PHI.	Applying the High Court decision in *Peverill,* Medicare must immediately release payment of the MB upon receipt and acceptance of claims. Accordingly, Medicare transfers 75% of the Medicare Schedule Fee to the patient's PHI straight away.	PHI receives 75% of the Medicare Schedule Fee for each claim and can retain it indefinitely. There is no mechanism or practical oversite of the PHIs handling of this payment of public money, particularly oversight of necessary refunds.	Pursuant to the terms of the Deed, a billing agent must pass the MB, plus any additional PHI component, to the medical practitioner within 90 days of receipt from the PHI.	The medical practitioner has no practical control or visibility over this entire process and can be prosecuted by Medicare and/or the PHI acting separately or together.

By adding additional parties to the transaction, specifically PHIs (who receive 75% of the Medicare schedule fee for each inpatient professional service billed), without sufficient regulatory safeguards, the government may have exposed public money to risk of misappropriation. The most common practical example occurs when PHIs use delaying tactics such as making payment to the medical practitioner contingent upon the happening of another event over which the medical practitioner has no control, such as proof of a corresponding hospital bill for the same service. While relevant contracts between the PHIs, medical practitioners and hospitals may lawfully enable delayed transfer of the PHI component of each payment, the Medicare component should either be immediately released to the medical practitioner or returned to consolidated revenue, which would better serve the

national interest. Unfortunately, lax regulation has meant that once the Medicare payment is in the hands of the PHI the government has little practical control over it.

The recent introduction of the Federal Governments new Gold, Silver and Bronze PHI products[118] may exacerbate gapcover billing challenges because until now, if Medicare approved a claim the PHI was required to also approve and pay it.[119] However, under the new products this will no longer be the case. All Australians will continue to be eligible for all services under Medicare but no longer under their PHI policies and it is unclear what will happen to Medicare Benefits paid to PHIs in circumstances where a patient's PHI policy does not cover a service which Medicare has approved and paid to the PHI. The critical mechanism to immediately return the Medicare Benefit to consolidated revenue is unclear.

If a patient disputes a gapcover bill they may direct concerns to all or any of the medical practitioner, the PHI and Medicare, whereas the medical practitioner cannot. The medical practitioner is only able to seek information in relation to a gapcover bill from the PHI, but can be investigated by both Medicare and the PHI, acting separately or together, in relation to a suspect bill.[120] Furthermore, an unintended consequence of these arrangements is that whilst bulk billing and charging a gap is a criminal offence as in the case of *Sood*,[121] once the same Medicare rebate is passed to a PHI under gapcover arrangements, what was once a criminal offence is effectively reduced to a lesser civil offence wherein a medical practitioner who generates a gapcover bill but also charges an unauthorised gap, may have simply breached a contract term with the PHI.

Gapcover billing has become so complex that even PHIs themselves have been unable to understand it. In 2011 Medibank Private (MBP) (then a government owned PHI) was the last of the major PHIs to commence online gapcover billing. Gapcover legislation provided that

[118] Private health insurance reforms: Gold/Silver/Bronze/Basic product tiers http://www.health.gov.au/internet/main/publishing.nsf/Content/private-health-insurance-reforms-fact-sheet-gold-gilver-bronze-basic-product-categories (accessed 8 April 2019)
[119] Private Health Insurance (Complying Product) Rules 2015
[120] Additionally, medical practitioners can be investigated by the Health Care Complaints Commission and / or the Medical Board of Australia if the patient complains.
[121] Suman Sood v Regina (n 65)

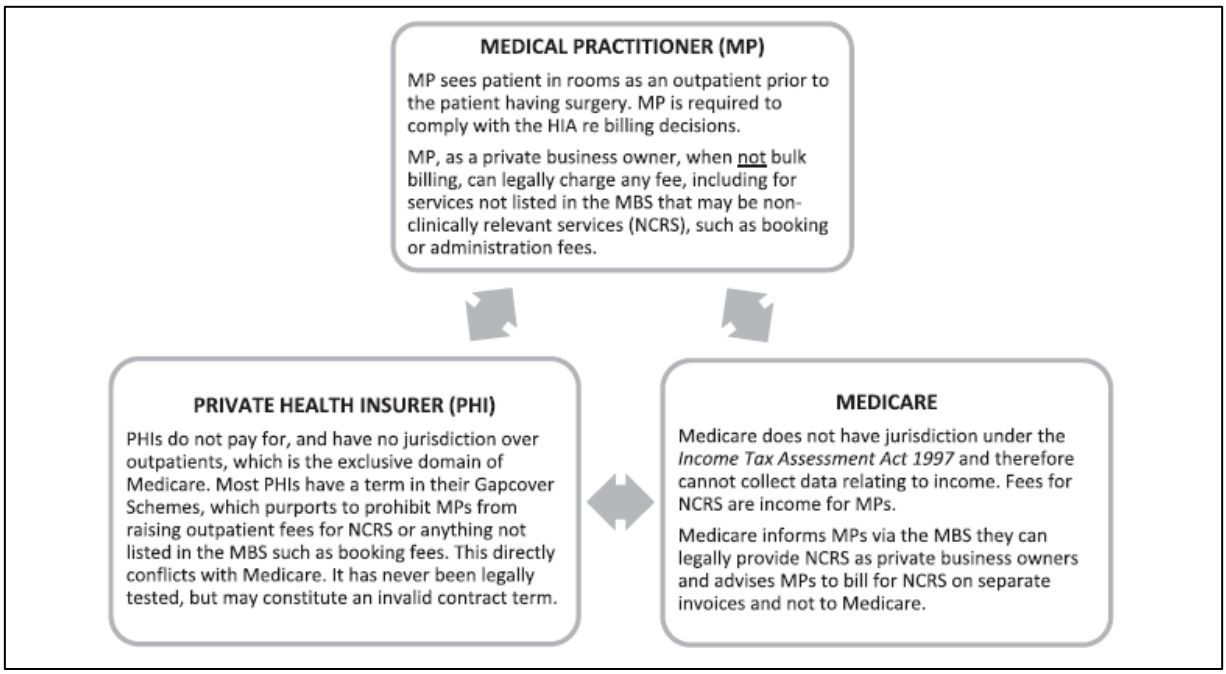
patients were to be given written informed financial consent detailing any likely gap payments before they went to hospital.[122] This provision was inserted to accommodate the hybrid "known gap" schemes where the patient would assign their Medicare benefit to the PHI and also pay another amount to the provider called a 'known gap'. When MBP commenced online billing, it failed to understand that no gap billing did not, by definition, involve gaps, and proceeded to create a requirement that all no gap bills submitted via its new online billing channel include a declaration that written informed financial consent had been obtained. This caused thousands of correct gapcover bills to be wrongly identified as being incorrect and placed clinicians in the invidious position of having to give a false declaration if they were to have any hope of being correctly paid for legitimate services correctly billed. Some months later MBP conceded its mistake, advising providers that after seeking internal clarity the issue had been rectified and the written consent requirement withdrawn.[123] It is once again apparent that for the medical practitioners who have to navigate the requirements of these complex schemes there is little support afforded them should they experience similar confusion and unintentionally err in relation to a bill they submit for payment.

In another recent example MBP appeared to again be unclear about its own complex known gap scheme when it was quoted in the media expressing concern about policy holders being charged $500 gaps which were administered by medical practitioners using split bills,[124] when this was in fact correct and compliant administration of the very rules MBP had put in place.[125] Inaccurate reporting such as this has unfortunately become widespread and is a symptom of a much bigger problem where the public (including the media) have become so confused about what is and isn't compliant medical billing they are prone to believing falsehoods which are difficult for medical practitioners to rebut, particularly when the medical practitioners themselves may be unsure about whether they are billing correctly.

[122] Health Legislation Amendment (Gap Cover Schemes) Act 2000, Section 73BDD(7)
[123] Medibank Private website: Informed Financial Consent and Eclipse Claims http://www.medibank.com.au/Health-Covers/Information-For-Health-Care-Providers/GapCover-Information/Article.aspx?Id=131 (accessed 8 April 2019)
[124] Patients being bled by specialists as out-of-pocket costs surge https://www.theaustralian.com.au/national-affairs/health/patients-being-bled-by-specialists-as-outofpocket-costs-surge/news-story/04720fe356186190de873461449aead2: Paywalled
[125] Medibank Private GapCover provider Guide https://www.medibank.com.au/content/dam/retail/providers/gap-cover/GapCover-booklet-2018.pdf (accessed 8 April 2019)

Perhaps the most concerning quite recent addition to the Gordian Knot that has become gapcover regulation, is that the terms and conditions of some PHI gapcover schemes[126] have the effect of making medical practitioner participation in their schemes contingent upon agreement to terms which may place the medical practitioner in breach of the Medicare scheme, in circumstances where the PHIs have questionable jurisdiction to purport to exercise such control. This is explained and presented in **Table 4**.

Table 4



Medicare Billing in Public Hospitals

Gapcover schemes are used in both private and public hospitals. In the latter, complex funding arrangements between State and federal governments enable State-run public hospitals to use the additional revenue to supplement annual grant funding. The practical application of these arrangements is to require publicly practicing, salaried medical officers to bill patients

[126] Bupa Medical Gap Scheme Terms and Conditions August 2018 https://www.bupa.com.au/staticfiles/BupaP3/For%20Providers%20Home/MediaFiles/PDF/bup16245-medical -gap-scheme-terms-and-conditions.pdf and Terms and Conditions of using the Medibank gapcover scheme https://www.medibank.com.au/content/dam/retail/providers/gap-cover/Revised_Terms_and_Conditions.pdf and NIB Medigap Terms and Conditions https://www.nib.com.au/docs/medigap-terms-and-conditions (all accessed 22 April 2019)

who elect to be treated privately. However, some PHIs pay a lesser amount than if the same services were provided in a private hospital, though the legal basis for this is somewhat opaque given the PHIs are required to pay under their Gapcover schemes at the rates approved by the Minister.[127]

Publicly practicing medical practitioners are required to bill under their individual Right of Private Practice Agreements (RoPP) for patients who elect to be treated privately. Under these arrangements the hospital will usually retain some or all of the revenue collected. The arrangements are different in every State and Territory as are the arrangements for Visiting Medical Officers (VMO), who may also use gapcover schemes for private patients in public hospitals, though all PHIs will reimburse VMOs at the gapcover rates as opposed to the Medicare schedule fee, representing another anomaly.

Facilitated by provisions of the National Health Reform Agreement (NHRA)[128] categories of patients in public hospitals were redefined and expanded beyond the two categories used by Medicare which are familiar to medical practitioners, inpatients and outpatients. The NHRA describes patients who are not admitted to a public hospital variously as "non-admitted patients", "outpatients" and "emergency department patients". Emergency department patients, from the medical practitioner perspective, may be thought of as "outpatients" in the sense they have not been formally admitted to the hospital, but such patients cannot legally be billed like other outpatients, although medical practitioners may not understand this. This adds another layer of legal complexity for medical practitioners because, in addition to understanding the provisions of the MBS, Workers Compensation and PHI schemes, they are assumed to also have a sound working knowledge of the NHRA and its interface with the *HIA*, for it is not possible to bill correctly otherwise.[129] However, the provisions of the NHRA and

[127] The Health Legislation Amendment (Gap Cover Schemes) Act 2000 https://www.legislation.gov.au/Details/C2004A00666 (accessed 22 April 2019) states the purpose of gapcover schemes is to pay above the Medicare schedule fee and all schemes must be approved by the Minister. It is therefore unclear the legal basis upon which the PHIs limit reimbursement to the Medicare schedule fee for private patients in public hospitals where a gapcover scheme applies.

[128] https://www.publichospitalfunding.gov.au/national-health-reform/agreement

[129] For example, a patient presenting to a public hospital emergency department may say to a treating medical practitioner that he/she has private health insurance and is happy to use it. The medical practitioner may then proceed to bill using the patient's PHI gapcover scheme for services provided, even though the NHRA prohibits it unless the patient was admitted.

the MBS sometimes collide[130] and it can be difficult to apply both correctly across the continuum of patient care in a public hospital setting.[131]

Quite apart from the complexity of gapcover schemes in Australia, the stated policy objective of reducing patient out-of-pocket costs when they go to hospital has failed.[132] It should be noted that much of this failure is ultimately a consequence of not understanding the practical impact of the CCC on Australian medical billing.

Third Party Involvement in Medicare Billing

In some respects Medicare operates like the Australian tax system in that taxpayers are personally responsible for the information they lodge with the Australian Tax Office irrespective of who prepared their tax return. Similarly, medical practitioners are prima facie responsible for every Medicare bill submitted in their name, even though someone else may have prepared and lodged the bill on their behalf.[133]

The impact of third party conduct in relation to MBS billing is of great significance because in contemporary practice most medical practitioners *do not* administer their own billing, this being traditionally delegated to office staff and other third parties. Until recently, medical practitioners had sole legal responsibility for medical billing with the exception of cases of criminal fraud.[134] However on 1 July 2018 section 82 of the HIA was amended with an expanded definition of inappropriate practice which brought corporate entities within the

[130] For example, telehealth services under Medicare can only be provided to outpatients. A medical practitioner may erroneously think emergency department patients are outpatients (because they have not been admitted) and unintentionally claim unlawfully to Medicare for telehealth services.
[131] For example, a rehabilitation physician may incorrectly assume she can bill to Medicare for outpatient case conferences after a public patient has been discharged home but is continuing to return to the public hospital for outpatient follow up. The MBS states: "All care directly related to a public in-patient's care should be provided free of charge. Where a patient has received in-patient treatment in a hospital as a public patient (as defined in Section 3(1) of the Health Insurance Act 1973), routine and non-routine aftercare directly related to that episode of admitted care will be provided free of charge as part of the public hospital service, regardless of where it is provided, on behalf of the state or territory as required by the National Healthcare Agreement. In this case no Medicare benefit is payable."
[132] https://insidestory.org.au/healthcares-out-of-pocket-crisis/
[133] The Health Insurance Act 1973, Section 81 http://www8.austlii.edu.au/cgi-bin/viewdoc/au/legis/cth/consol_act/hia1973164/s81.html (accessed 22 April 2019), defines persons able to be investigated, and describes a list of professionals who have eligibility to claim under the Medicare scheme.
[134] The Health Insurance Act 1973 (133)

purview of the Medicare watchdog, the Professional Services Review (PSR), which is discussed below. The purpose of the amendment was to enhance the PSR's ability to review third party involvement in Medicare billing.

This change to the law recognises that increasing corporatisation of medical practice could potentially be playing a role in the rising incidence of incorrect MBS billing, particularly in circumstances where employed or contracted medical practitioners are contractually bound or incentivised to meet targets or provide certain services to support the financial objectives of the corporate owner. Corporate owners and the Practice Managers they employ, may not necessarily be medically qualified and may have little understanding of Medicare billing requirements, focusing only on the value of each item in the schedule, rather than the important compliance provisions contained in the broader regulatory scheme.[135]

In addition to influence from corporate owners, medical practitioners seek and receive information concerning fees and billing from numerous other third parties one of which is the Australian Medical Association (AMA) which has maintained its own schedule of medical fees for over 40 years. The AMA schedule has its own codes, some of which map to the MBS and some of which do not, and has quasi-legal status in that it is the basis for the gazetted rates under many of the various State and Territory workers compensation schemes.[136]

However, inconsistencies between the AMA schedule and the MBS may further contribute to erroneous MBS billing by medical practitioners.[137]

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[135] For example, a corporate medical practice workflow may provide that all patients attending the practice will each have an electrocardiogram, a cardiac stress test and an echocardiogram before seeing a cardiologist. Whilst efficient operationally, it is arguable that none of these tests, which would draw a total of approximately $350 from the public purse, could properly be characterised as clinically relevant, when the patients have not seen a clinician (the cardiologist) prior to having them. This type of inappropriate billing may again be outside of the direct control of the medical practitioner, instead being directed and controlled by corporate business owners and other third parties, though the medical practitioner remains primarily responsible.

[136] The AMA schedule of fees is copyrighted to the AMA is not publicly available. It can only be accessed upon the payment of a licence fee for any medical practitioner who wishes to avail it. Services listed in the AMA schedule are a combination of all MBS services, together with additional services which do not correspond to the MBS but which the AMA has deemed as being legitimate, separately chargeable services.

[137] For example, the AMA permits charges to be raised for telephone consultations, whereas the MBS does not. Another example is the AMA is of the view that a separate item for the provision of a steroid injection is available to medical practitioners whereas Medicare disagrees and some years ago removed it from the MBS. However, for medical practitioners who may regularly refer to both schedules in relation to daily billing activity, this may cause an unintentionally

Adding further confusion is a third reference widely used by Australian anaesthetists, who are directed to the ASA Relative Value Guide (RVG) which was developed partly in response to the ambiguity and inconsistencies in many of the descriptions of unique anaesthetic services in the MBS.[138] However, a review of its contents reveals that it may create further confusion for medical practitioners. In some cases, descriptions relating to a single professional service are inconsistent as between the MBS, the AMA Schedule and the RVG.[139] Yet for Australian anaesthetists who will be held personally responsible should they choose the wrong interpretation, there appears to be nowhere to go to seek reliable advice and support when the three resources provide conflicting information in the context of a billing decision.

Another common third party involved in Medicare billing is public hospital finance departments, because RoPP agreements typically include clauses requiring medical practitioners to appoint the hospital as sole agent for all private Medicare billing as well as giving exclusive use of relevant provider numbers to the hospital to facilitate this activity. Entering into these arrangements is a condition of employment at the hospital, there being usually no option for the medical practitioner to negotiate the specific terms, which effectively hand over the entire administration of billing to hospital staff who themselves may have little knowledge or expertise in this area. Yet the medical practitioner retains personal responsibility for the veracity of submitted bills, though not the income, which is usually retained by the hospital.

More recently, over 20,000 medical practitioners seeking answers to the complexities of medical billing have formed a closed Facebook group in which the founder, a medical

fraudulent claim to be raised by a medical practitioner who incorrectly thinks that bulk billing an attendance and also charging separately for a steroid injection is permitted because the AMA suggests it is, whereas under Medicare, such practice would constitute a crime.

[138] Anaesthetic services are largely time based, with each unit of time having a dollar value. No other medical specialty in Australia claims in this way. The RVG is available exclusively to members in hardcopy, online PDF and as an App. Currently in its 19th edition, the RVG is heavily relied upon by Australian anaesthetists https://asa.org.au/wordpress/wp-content/uploads/Advertising/MediaPack2018RVG.pdf (accessed 22 April 2019).

[139] MBS item 17615 is an unreferred anaesthetic consultation involving complex assessment and management plan. The corresponding service in the AMA schedule is CA004 which the AMA describes as being equivalent to both of MBS items 17615 and 17645 but does not involve complexity or a management plan. The same service in the ASA (which borrows from both the MBS and the AMA) cross references the complexity in the MBS but is silent on referrals and management plan. Depending on which source is chosen, an anaesthetist could reasonably interpret the various provisions and claim daily pre-anaesthetic consultations on a post-operative patient without a referral or management plan.

practitioner, has self-declared as a medical billing expert.[140] The basis of this declaration appears to be that the medical practitioner has read the MBS and some provisions of the *HIA*. While commendable, it is somewhat concerning that having never been formally taught how to bill correctly, a medical practitioner is assuming expert status and providing potentially incorrect medical billing advice to other medical practitioners under a shroud of secrecy.[141] However, with nowhere to go to obtain reliable advice and support in relation to Medicare billing it is perhaps not surprising that groups such as this have appeared and that the government currently has no ability to intervene because there is no legal barrier to anyone declaring themselves a medical billing expert and providing education to others on how to extract public money from the Medicare purse. This is inconsistent with other areas of public financing such as taxation where only accountants, tax lawyers and as a bare minimum, registered tax agents, are permitted to hold themselves out as being experts in the area of taxation.

With no formal education on medical billing occurring throughout their medical training, medical practitioners are vulnerable to adopting direction from numerous third parties who declare themselves experts on the topic of medical billing. This may even extend to financial advisors and accountants, software vendors who may offer prompts or short cuts in the billing process such as predictive billing, as well as practice managers and receptionists who themselves have no formal training in this complex area.

Government Initiatives to Protect the Integrity of Medicare

The early days

Medicare's fee for service payment arrangements rely heavily on the honesty of medical practitioners to claim correctly. Aware of the inherent vulnerabilities of the new national insurance scheme, Medibank's founders established the Medical Services Committee of

[140] GP Loses court challenge on 80/20 https://www.ausdoc.com.au/news/gp-loses-court-challenge-8020-rule see in particular comments by one doctor who self proclaimed expert status.
[141] Business for Doctors https://www.facebook.com/businessfordoctors/

Inquiry (MSCI) which was charged with the task of monitoring services claimed under the new scheme and investigating possible breaches and referring potential cases of fraud.

By 1992, following an audit by the Australian National Audit Office, the MSCI had been found to be ineffective in deterring incorrect billing by medical practitioners[142] and was replaced by the PSR in 1994. The PSR was established as a peer review scheme to examine Medicare services claimed by medical practitioners and to determine whether claiming under the MBS constituted inappropriate practice. The PSR currently reviews between 50 and 100 practitioners annually.

The introduction and subsequent review of the PSR

The objective of the PSR is to protect the public interest in the standard of Medicare and Pharmaceutical Benefit Scheme services[143] and, in line with other health regulatory policy (e.g. practitioner regulation), the sanctions imposed are intended to be remedial rather than punitive. When findings of inappropriate practice are made by the PSR, the penalties imposed are onerous and can include disqualification from participating in the Medicare Scheme.

Unlike other regulated professions, where the names and details of reprimanded or disqualified persons are made public,[144] PSR decisions are not published, ostensibly to protect the anonymity of errant medical practitioners. Unfortunately, this means that PSR decisions do not contribute to a body of knowledge which might assist medical practitioners to better understand their compliance obligations and prevents the development of doctrinal precedent to inform future decision making and policy direction. Additionally, the PSR annual reports heavily redact case studies of investigated medical practitioners, making it possible for a medical practitioner to unknowingly learn medical billing from a colleague who has previously been investigated by the PSR.

[142] Bell R, Medicare Regulation through Professional Services Review (n 27)
[143] http://www8.austlii.edu.au/cgi-bin/viewdoc/au/legis/cth/consol_act/hia1973164/s79a.html (accessed 22 April 2019)
[144] See legal profession register at this link http://www.lawlink.nsw.gov.au/olsc/nswdr.nsf/webview and corporate directors and financial advisors at this link https://asic.gov.au/online-services/search-asics-registers/banned-and-disqualified/

The lack of transparency of the PSR is particularly concerning when its own annual reports routinely cite practitioner confusion as being a contributing factor in relation to poor MBS compliance.[145] During his six year period in the role of PSR Director Tony Webber actively engaged the PSR in Medicare compliance education programs for the profession via face to face seminars as well as annual reports to the profession,[146] both suggestive of an awareness of the prevalence of confusion and a need to address the issue. There is compelling evidence that high levels of confusion regarding correct Medicare billing remain prevalent.[147]

During a 2011 Senate Committee inquiry reviewing the PSR,[148] submissions from medical practitioners highlighted both the complexity of the Medicare billing system and the inadequacies in the resources available to them concerning its proper use. These submissions directly contradicted submissions from Medicare which suggested that ample resources and reliable support were available.[149] One submission indicated that processes should be in place to enable clinicians to obtain clarity about the use of the MBS and another drew a comparison between the advice and written rulings available from the Australian Taxation Office (ATO) and the lack of such information and advice from Medicare, suggesting that this meant medical practitioners could unknowingly fall into non-compliance.[150] The Senate Committee resolved that a "watching brief" should be kept to ensure that optimal educational material and information should always be available to practitioners though fell short of detailing who should fulfil this obligation.[151] It appears that informal, ad-hoc training and advice from unqualified individuals, such as the closed Facebook group already mentioned, have attempted to fill this void.

[145] https://www.psr.gov.au/sites/default/files/PSR_Annual_Report_2008-09.PDF?v=1478693046 (accessed 22 April 2019)
[146] http://www.psr.gov.au/publications-and-resources/other-publications (accessed 22 April 2019)
[147] GP Loses court challenge on 80/20 https://www.ausdoc.com.au/news/gp-loses-court-challenge-8020-rule see the 161 comments left by readers which demonstrate widespread confusion and one Doctor demonstrated a failure to understand the operation of the CCC (accessed 22 April 2019).
[148] Commonwealth of Australia, Community Affairs References Committee, Review of the Professional Services Review (PSR) Scheme, October 2011
[149] Commonwealth of Australia, Community Affairs References Committee (n 148)
[150] Commonwealth of Australia, Community Affairs References Committee (n 148)
[151] Commonwealth of Australia, Community Affairs References Committee (n 148)

Of major concern is a recent, unprecedented decision taken by the PSR in which it dismissed out of hand written advice from Medicare, which had been provided to a medical practitioner concerning the billing of a particular service. In its deliberations the PSR stated that Medicare's advice was incorrect[152] and in so doing, undermined the government as being the authority for correct Medicare billing advice. This decision may have effectively closed off the only remaining legitimate avenue of advice and support which medical practitioners might reasonably have expected to rely upon for medical billing decisions.

Government audits

In addition to the PSR, as part of the Increased Medicare Compliance Audit Initiative (IMCA), new legislation was enacted in 2011 which enhanced Medicare's audit capabilities.[153]

Activity under the new Act commenced in 2012.[154] However, a 2014 report by the Auditor General indicated that Medicare's compliance initiatives since 2008 had been largely unsuccessful.[155] The report acknowledged the complexity of Medicare billing,[156] highlighting the need for appropriately skilled departmental staff to undertake compliance audit work because the ability to correctly detect inaccurate claims requires prerequisite knowledge of accurate claims. However, the auditor found that rather than compliance management relying on specific policies or guidelines, the internal operating environment of the department consisted largely of unwritten "common knowledge",[157] inconsistency in approaches taken

[152] In Nithianantha v Commonwealth of Australia http://www8.austlii.edu.au/cgi-bin/viewdoc/au/cases/cth/FCA/2018/2063.html at para 193, the PSR Committee rejected written advice from the Provider Services Branch of the Department of Human Services that had been submitted in evidence, saying the advice was "not correct". The medical practitioner had attempted to rely on the written advice to justify a medical billing decision but was unsuccessful, because the PSR Committee effectively said the advice from Medicare was wrong. (accessed 1 June 2019)
[153] https://www.legislation.gov.au/Details/C2011A00010 In her second reading speech on 17 November 2010, then Health Minister Nicola Roxon said: "On average, 20 per cent of practitioners contacted by Medicare Australia do not respond to, or refuse to cooperate with, a request to substantiate a Medicare benefit paid for a service. When this occurs, Medicare Australia does not have any authority to require a practitioner to comply with the request. This means that there is no way to confirm that the Medicare benefit is correct. This legislation is intended to address that deficiency."
[154] Medicare annual report 2011-2012 https://www.humanservices.gov.au/organisations/about-us/annual-reports/annual-report-2011-12 (accessed 22 April 2019)
[155] Commonwealth of Australia 2014, Australian National Audit Office, Medicare Compliance Audits, Department of Human Services, Audit Report No. 26 2013-2014.
[156] Commonwealth of Australia 2014, Australian National Audit Office (n 155)
[157] Commonwealth of Australia 2014, Australian National Audit Office (n 155)

and interpretation of service requirements by audit staff,[158] accurate claims being falsely recorded as inaccurate,[159] Medicare debts being inaccurately calculated[160] and inappropriate reliance on "local knowledge and experience"[161] (rather than written, robust internal education programs) all of which was "expected to be addressed largely through on-the-job training".[162] It is worth noting that institutional protection of this nature suggests a possibly pervasive view within the department that medical practitioners have a higher level of legal literacy in regard to correct use of Medicare than Medicare's own staff, who themselves may sometimes not understand the requirements of the scheme, have no background or experience in health, and are not subject to penalties if their conduct is non-compliant.

Education initiatives

In 1985, one year after the revived Medibank scheme (renamed Medicare) was introduced, educating medical practitioners was again reported as an effective strategy in promoting voluntary compliance.[163] This was echoed in the Auditor General's report 30 years later in his general acknowledgment that the department's education initiatives were central to overall maintenance of system integrity.

Further evidence of the importance of medical practitioner education for improving billing compliance was seen in 2007, when the then Minister for Human Services announced education as being the key to compliance stating that $250 million in program savings had been achieved in the previous year through education initiatives which had changed the claiming patterns of practitioners.[164] Although the Department repeatedly states that

[158] Commonwealth of Australia 2014, Australian National Audit Office (n 155)
[159] Commonwealth of Australia 2014, Australian National Audit Office (n 155)
[160] Commonwealth of Australia 2014, Australian National Audit Office (n 155)
[161] Commonwealth of Australia 2014, Australian National Audit Office (n 155)
[162] Commonwealth of Australia 2014, Australian National Audit Office (n 155)
[163] Flynn, Kathryn. Medical Fraud and Inappropriate Practice in Medibank and Medicare, Australia 1975-1995. Doctor of Philosophy thesis, School of Social Sciences, Media and Communications, University of Wollongong, 2004. http://ro.uow.edu.au/theses/2071/ at page 270
[164] Medicare Forum spring 2007, Education Key to Compliance http://www.medicareaustralia.gov.au/provider/pubs/news/forum/files/spring-2007.pdf (accessed June 2014).

education is critical in managing billing compliance prospectively,[165] education initiatives have been generally short-lived, and a recent Australian study found that Australian medical practitioners do not now, and have never received formal education on correct billing under Medicare.[166]

Decreasing administrative support

Despite the combination of greater complexity, increased scope and the substantial growth in the number of available medical services and MBS claiming activity over the last 40 years, the administrative and support infrastructure of Medicare has declined considerably since its inception. The success of Medibank was dependent on the ability of the federal government to prove it could successfully process millions of claims from day 1. A dedicated team was established in the Health Insurance Commission (HIC) for this purpose.[167] The decision to create a separate commission was significant for two reasons. The first was to protect the Medibank levy from political whim,[168] and the second was a critically important structural component designed to establish and retain departmental expertise. HIC staff were employed outside of the *Public Service Act 1999 (Cth),* ensuring long-term retention of essential expert knowledge.[169] By establishing a dedicated authority comprising staff who were employed outside of the public service, it was predicted that expertise would not be lost with every round of promotions.[170]

However in 2005 the *Health Insurance Commission Act 1973 (Cth)* was renamed the *Medicare Australia Act 1973 (Cth)* and included reforms that dissolved the HIC as a separate commission and established it as an agency of the Department of Human Services. This had a twofold

[165] https://www.aph.gov.au/parliamentary_business/committees/senate/community_affairs/completed_inquiries/2008-10/medicare_benefits_compliance_audits/report/c01
[166] Faux M., Wardle J, Faux M, Wardle J, Thompson-Butel AG*, et al* (n 32)
[167] https://www.legislation.gov.au/Series/C2004A00100
[168] Anne-marie Boxall and James A Gillespie (n 8) "…the independence of the commission was closely associated with the idea of insulating the determination of the health insurance levy rate from short term political decisions."
[169] Anne-marie Boxall and James A Gillespie (n 8) "The ethos of the public service was that you get a job, and as soon as you get a job, you start looking through the notices and finding something one level above you."
[170] Anne-marie Boxall and James A Gillespie (n 8) "…promotional opportunities lay within the Commission so you build up a core of expertise…they didn't lose people. People spent their entire careers within the HIC."

effect: it facilitated increased ministerial control over the new agency; and it made all HIC staff employees of Medicare Australia under the *Public Service Act.* The original safeguards, specifically designed to retain departmental Medicare expertise, were permanently undone from the moment HIC employees became employees under the *Public Service Act*, because there were no longer any barriers to prevent Medicare staff from moving to other departments within the public service.

In a further dilution of expertise, in 2011, the largest overhaul in public service history was facilitated by legislative change which renamed the *Medicare Australia Act 1973 (Cth)* as the *Human Services (Medicare) Act 1973 (Cth)* and enabled the Department of Human Services to became a single government department integrating Centrelink, Medicare, the Child Support Agency and CRS Australia.

As a result, the necessary infrastructure to support the operation of Medicare (the fourth largest expenditure item in the federal budget)[171] is now so inadequate that neither compliance nor reform can be properly managed.

The MBS review taskforce

Medicare's founders anticipated the need for ongoing review and management of subsidised services in the scheme and established the Medicare Benefits Advisory Committee (MBAC) for this purpose. The functions of the MBAC are clearly set out in Part V of the *HIA*[172] and include considering the manner and the extent to which a particular service should be included in the Medicare scheme, including applicable fees. Composition of the MBAC describes a quorum of five, three of whom must be medical practitioners.[173] Of note, the role of the MBAC excludes making recommendations beyond clinical matters and fees. The committee operates at the professional service level and is not permitted to propose changes to the underlying legal structure.

[171] Australian National Audit Office (n 23)
[172] http://www6.austlii.edu.au/cgi-bin/viewdoc/au/legis/cth/consol_act/hia1973164/s67.html (accessed 22 April 2019)
[173] http://www6.austlii.edu.au/cgi-bin/viewdoc/au/legis/cth/consol_act/hia1973164/s75.html (accessed 22 April 2019)

This notwithstanding, in 2015 the Federal Government established a new body, called the MBS Review Taskforce (MBSRT). The stated purpose of the MBSRT is to align Medicare funded services with contemporary clinical evidence[174] and the work of the taskforce is nearing completion. The MBAC describes a point of differentiation between it and the MBSRT on its website stating its work is mostly prospective (assessing applications for new services to be included in the MBS) whilst the work of the MBSRT is largely retrospective,[175] though there appears to be some degree of overlap and duplication. The MBSRT terms of reference also permitted it to review the underlying legal structure and billing rules.[176]

On 1 November 2017, the government accepted sweeping changes to the MBS based on recommendations of the MBSRT which may have further obfuscated some of the already opaque legal principles discussed in this article. Specifically, rather than referring to the key tenets of clinical relevance and necessity, the MBSRT introduced a new concept, that of "reasonableness"[177] stating that it was reasonable for two common services to be billed together only if the higher paying service had a value under $300 but not if it had a value over $300. An unintended consequence of introducing reasonableness as a standard is that clinical relevance has effectively been undermined and avenues for the Government to prosecute breaches of the scheme may have been further eroded.[178] While the response of medical practitioners affected by this change is unknown, it would be a pyrrhic victory for the Government if this somewhat arbitrary $300 cap has been shifted to consumers in the form

[174] http://www.health.gov.au/internet/main/publishing.nsf/content/MBSR-tor (accessed 22 April 2019)
[175] http://www.msac.gov.au/internet/msac/publishing.nsf/Content/FAQ-01 (accessed 22 April 2019)
[176] https://www.health.gov.au/internet/main/publishing.nsf/Content/MBSR-tor (accessed 2 June 2019)
[177] The new rule provides that claiming an attendance item is not 'reasonable' if the associated procedure being claimed on the same occasion of service has a value equal to or greater than $300. However procedures under $300 are not affected because it is 'reasonable' to claim both an attendance and a cheaper procedure, one of the stated reasonings being to protect General Practitioners.
[178] http://www.health.gov.au/internet/main/publishing.nsf/Content/MBSR-addressing-variations-in-billing-of-medical - consultations (accessed 22 April 2019). The same attendance item cannot be clinically relevant for associated services with a value under $300 (with no questions asked), but not clinically relevant with procedures over $300. Following the reasoning in Dr Soods case, the prosecution case would surely now fail as demonstrated in the following hypothetical example: Dr X bulk bills colonoscopy item 32088 with a schedule fee of $334.35 and is now prevented from also billing attendance item 116 which has a value of $75.50. Dr X decides to charge the patient separately, in similar fashion to Dr Sood, a fee of $100 for the attendance, which the patient pays in cash and cannot claim. If one follows the reasoning in *Sood*, the attendance is inextricably linked to the procedure, cannot be billed separately under section 20A of the HIA, and may give rise to criminal liability. However, it would no longer be possible to succeed with the prosecution argument in Sood's case because the same attendance items are clearly separate in the schedule for other colonoscopy services such as item 32087 which has a fee of $204.70. One can no longer argue that all colonoscopies include an attendance component when those under $300 don't, but those over do.

of higher out of pocket costs or medical practitioners having simply adjusted their billing patterns to maintain their incomes.

Further, for medical practitioners who are required to navigate Medicare's changing rules, there is no clarity around the way the PHIs should apply such rules in a gapcover context. Medicare benefits make up approximately half or more of every claim made under a gapcover bill and with no interpretation of how such a change is to be applied in that context, there is nothing to prevent a PHI rejecting a claim for an attendance and a procedure claimed together when the procedure has a Medicare schedule fee of $250, on the basis that once the PHI component is added, the total amount payable is over $300. Despite the fact this may not be the intention, there is no practical ability for a medical practitioner to dispute such action. Further, the medical practitioner may unintentionally breach PHI scheme requirements unknowingly due to the arbitrary and inconsistent application of new Medicare rules by the PHIs.

It is widely accepted that the MBSRT has done good work in revising clinical descriptions of professional services, many of which have not been reviewed for decades. However, there has been less support when the MBSRT has ventured into the underlying legal structure and law reform. In a recent example, the MBSRT proposed that a certain category of medical practitioners be prevented from billing independently.[179] The response from industry was swift and brutal, and while the arguments put by industry responders (who included medical practitioners) were correct in pointing out the serious practical consequences of the proposed changes,[180] of more concern was an apparent failure to understand very basic structural elements of the regulatory scheme including the contractual nature of the relationship

[179] https://gallery.mailchimp.com/42742fbf9182f90c3f06a123c/files/91c9b261-9e76-48f2-bc59-d6f835689f3d/MBS_Review_Taskforce_Consultation_Surgical_Assistants_letter_to_stakeho..._1.pdf

[180] Response from the AMA https://ama.com.au/system/tdf/documents/Bartone%20to%20Grigg%20re%20changes%20to%20remuneration%20arrangements%20for%20surgical%20assistants.pdf?file=1&type=node&id=49361 response from the RACGP https://www1.racgp.org.au/newsgp/professional/racgp-rejects-proposed-cuts-to-surgical-assistance response from the Medical Surgical Assistants Society of Australia https://gallery.mailchimp.com/42742fbf9182f90c3f06a123c/files/01a0fe4e-ef0d-4bb6-a1f8-6b2e21c52f86/MSAS_letter_to_the_colleges.pdf and response from an affected Cardio-thoracic surgeon https://gallery.mailchimp.com/42742fbf9182f90c3f06a123c/files/65c8b00f-2ada-4d75-bdc3-57d24d84b707/Letter_to_Prof_Michael_Grigg.pdf

between a doctor and patient. Further it was apparent that the operation of the CCC had not been considered or understood because the proposed changes had the potential to expose the government to a High Court challenge based on a practical compulsion argument in breach of the CCC.

Conclusion

Medical billing in Australia has become so convoluted that we are beginning to see signs of the entire Medicare system unravelling. Lax regulation and constant tinkering at the system's periphery has led to Medicare being more vulnerable to abuse and non-compliance than 40 years ago.

Exacerbating the government's current challenges are the increasing numbers of organisations self-declaring as experts who are providing education to medical practitioners on everything from "maximising Medicare" to how to "pack and stack" Medicare item numbers.[181] In addition, one medical practitioner has successfully crowd funded an ongoing legal action against the government seeking declaratory relief against the PSR for procedural unfairness and a denial of natural justice.[182] The authors of an article published in the *Medical Journal of Australia*, specifically cited compliance with Medicare rules as being a contributing factor to medical practitioner burnout and suicide.[183]

The rapid pace of relentless change to services and billing rules proposed by the MBSRT and implemented by the government is not only inconsistent with international best practice standards,[184] but is also arguably rendering the Medicare scheme more vulnerable to abuse than ever before. The government has little ability to effectively deal with this because it has become almost impossible for medical practitioners to have certainty that they are using the

[181] Business for Doctors (n 141) and Medical Billing Experts, https://www.medical billingservices.com.au/
[182] PSR legal challenge gathers momentum http://medical republic.com.au/psr-legal-challenge-gathers-momentum/18099
[183] Michael Baigent and Ruth Baigent, Burnout in the medical profession: not a rite of passage, Med J Aust 2018; 208 (11): doi:10.5694/mja17.00891
[184] In all other countries medical payment and coding systems are updated no more than once per annum to enable all affected stakeholders including hospitals, medical practitioners, software vendors and others to make necessary changes to their systems and processes to be ready for new items and fees to commence on a set date. For example see: U.S transition to ICD 10 https://www.cdc.gov/nchs/icd/icd10cm_pcs_faq.htm and annual French system update for 2019 https://www.atih.sante.fr/sites/default/files/public/content/3502/cim-10_2019.pdf

Medicare scheme correctly from one day to the next. A service successfully billed and paid one day may be rejected the next due to a rule change the medical practitioner was unaware of and there is nowhere for the medical practitioner to go to obtain reliable advice and support. Yet medical practitioners are expected to know every nuance of the labyrinthine and constantly changing Medicare billing rules that they were never taught.[185]

Constant changes are also having unintended downstream negative consequences through the PHI legislation, workers compensation and other third party payer schemes, the Veterans Affairs legislation, all the way through to the complex payment arrangements and coding systems that deliver funding to Australian hospitals. The ultimate point of impact occurs when a service has been provided and a bill is required to be settled between a medical practitioner and a patient. This impact is increasingly taking the form of out-of-pocket costs, in a context where Australian consumers, who ultimately fund both Medicare and the PHI industry, have no ability to understand or question why they are paying again, when they have already paid via their taxes and PHI contributions.

Fifty years after the Nimmo report, the operation of our health payment arrangements has again become unnecessarily complex and beyond the comprehension of many. The levels of trust between medical practitioners, PHIs, Medicare, hospitals and patients, in relation to health financing transactions are at a record low, and there are no policy solutions in sight. While we continue to run up a down escalator in the area of meaningful health reform, ignoring structural weaknesses, the demand for health will continue apace, out-of-pocket costs will inevitably continue to rise as medical practitioners and hospitals circumvent reimbursement barriers and demand up-front payment, private health insurance coverage will likely continue to fall as a result (perceived as poor value by consumers) and the efficient, responsive and equitable modernisation of our excellent health system will remain elusive. For the medical practitioners required to navigate the increasing complexity, they will remain at risk of investigation and prosecution working in a system they cannot avoid, but do not understand.

[185] Faux M, Wardle J, Thompson-Butel AG *et al* (n 32)

CHAPTER 5: Quantitative Results

5.1 Background and Context

The quantitative phase of this study was carefully designed to capture any medical billing education that may have escaped the formal searches conducted in the literature review. While it was clear there was not, and had never been, a national curriculum on Medicare and medical billing, findings of high numbers of PSR investigations and Federal Court cases suggested that medical billing education must have been provided to MP somewhere in the course of their training. MP under investigation for billing errors are repeatedly reminded of their compliance obligations, which suggests prior knowledge acquisition, possibly obtained through informal channels. Further, in Australia's parliamentary democracy, citizens are made aware of laws that may adversely affect them; therefore, it was reasonable to assume that educational initiatives would have been made available to MP at some point in their training, particularly given the serious penalties flowing from adverse findings for breaches of Medicare laws.

5.2 Who teaches medical billing? A national cross-sectional survey of Australian medical education stakeholders

Section 5.2 was published in the *BMJ Open* in 2018 titled: **Who teaches medical billing? A national cross-sectional survey of Australian medical education stakeholders:** Faux M, et al. BMJ Open 2018; doi:10.1136/bmjopen-2017-020712. The article is also available at this link https://bmjopen.bmj.com/content/8/7/e020712

Abstract

*Importance: B*illing errors and healthcare fraud have been described by the WHO as 'the last great unreduced health-care cost'. Estimates suggest that 7% of global health expenditure (US$487 billion) is wasted from this phenomenon. Irrespective of different payment models, challenges exist at the interface of medical billing and medical practice across the globe. Medical billing education has been cited as an effective preventative strategy, with targeted education saving $A250 million in Australia in 1 year from an estimated $A1–3 billion of waste.

Objective: This study attempts to systematically map all avenues of medical practitioner education on medical billing in Australia and explores the perceptions of medical education stakeholders on this topic.

Design: National cross-sectional survey between April 2014 and June 2015. No patient or public involvement. Data analysis—descriptive statistics via frequency distributions.

Participants: All stakeholders who educate medical practitioners regarding clinical practice (n=66). 86% responded.

Results: There is little medical billing education occurring in Australia. The majority of stakeholders (70%, n=40) did not offer/have never offered a medical billing course. 89% thought medical billing should be taught, including 30% (n=17) who were already teaching it. There was no consensus on when medical billing education should occur.

Conclusions: To our knowledge, this is the first attempt of any country to map the ways doctors learn the complex legal and administrative infrastructure in which they work. Consistent with US findings, Australian doctors may not have expected legal and administrative literacy. Rather than reliance on ad hoc training, development of an Australian medical billing curriculum should be encouraged to improve compliance, expedite judicial processes and reduce waste. In the absence of adequate education, disciplinary bodies in all countries must consider pleas of ignorance by doctors under investigation, where appropriate, for incorrect medical billing.

Introduction

Reimbursement is a component of every encounter between a medical practitioner and a patient. From their first day of internship, medical practitioners have simultaneous and inextricably linked clinical and administrative responsibilities which form the basis upon which the license to practice medicine exists. The funding arrangements in the majority of countries which facilitate reimbursements to medical practitioners, employ some form of classification system which directly or indirectly links payments and resource allocation to patient interactions.[1]

The complexity of health classification systems, such as the international classification of diseases (ICD), while necessary to facilitate funding arrangements, may be a contributing factor to information asymmetries in the health care market. Whilst some initiatives and recommendations have attempted to minimise the specific impact of financial information asymmetry on healthcare costs, it remains a significant problem.[2,3] Most patients do not understand the clinical descriptions of services itemised on their medical bills, are not in a position to question the accuracy of procedural services performed on them while they were under general anaesthesia or unconscious in an intensive care unit, and will typically have no knowledge or understanding of ICD and billing codes which may operate in their jurisdictions. This places medical practitioners in a rare position of privilege when compared to other professionals and service providers with whom consumers may exercise more discernment and question anomalies on their bills. Patients have little option other than to trust medical practitioners will not only render clinically appropriate services and treatments, but also know how to correctly itemize those services on the relevant bills and claims for reimbursement. Ultimately, all decisions regarding the contents of medical bills are made unilaterally by the medical practitioner, in accordance with her determination of clinical need.

In 2014, measurable average losses caused by fraud and incorrect payments in the world's healthcare systems was estimated at 7% of total global health expenditure, or US$487 billion,[4] and the World Health Organization has identified financial leakage as one of the ten leading

causes of healthcare system waste globally.[1] In Australia, some commentators have suggested that incorrect billing and fraud costs Australia's tax payer funded healthcare system (Medicare) 10-15% of the scheme's total cost annually (A$2-3 billion).[5] However, the precise amount of deliberate versus unintentional misuse of the system has proven impossible to quantify in Australia. As such, the impact of alternative factors for incorrect billing beyond rorting - such as medical practitioners struggling to navigate the complex requirements of the Medicare system or inefficiencies that exist within the system itself – remains unknown. However, the lack of clarity around underpinning legislation and regulation has been identified by many medical practitioners as an important issue, one that often has significant professional consequences.[6,7]

Medical billing education has been recognised as an effective measure to improve compliance, reduce incorrect claiming and improve program integrity of health systems,[8,9] with countries such as the Netherlands recently introducing a requirement that universities and medical specialist training colleges provide education to medical practitioners in relation to medical billing and the costs of providing care.[10] However, such initiatives remain uncommon, with much of the available literature on the prevention of healthcare system waste and misuse largely ignoring education as a potentially preventive strategy. Instead, available literature focuses on sophisticated predictive modelling and data analytics, post-payment audit activity, recovery action and punitive measures, which may include disqualification from funding schemes and custodial sentences for providers.[4,6,11-13]

In both the U.S and Australia, evidence suggests that the medical profession itself takes a harsh view of colleagues who bill incorrectly.[8,14] One U.S study of 2300 paediatric graduates highlighted an 'acute and pervasive perception' that medical billing training was inadequate[15] and the medical student participants of another U.S study rated illegal billing as the second most egregious of 30 vignettes of misconduct, with substance abuse being reported as the most serious misconduct (86.8%), then illegal billing (69.1%), followed by sexual misconduct (50.0%).[16] Australian medical practitioners have also been highly critical of colleagues who bill incorrectly[14] and the Medical Board of Australia recognises the importance of medical billing

compliance by requiring certain medical practitioners to sign a legally binding declaration confirming the practitioner has taught key aspects of the operation of Australia's Medicare system, including funding arrangements, to colleagues, it thus being a requirement that assumes prior learning of the Medicare system by medical practitioners.[17] However, in Australia we currently do not know how, when or where this learning occurs.

The U.S federal government has adopted a view that publications produced by Medicare Administrative Contractors, the Centres for Medicare and Medicaid Services, and Explanation of Benefits Remittance Statements are adequate education for physicians.[18] However, a small body of international research on the topic (mostly undertaken in the U.S) suggests medical billing literacy amongst physicians is low.[15,19] This may provide some explanation as to why the financial cost of healthcare system misuse continues to be a pressing challenge in many countries.[1,4]

U.S research on the topic of medical practitioner knowledge of correct medical billing is generally more mature than other jurisdictions, and has resulted in suggestions that medical billing training should be viewed as a core competency of medical training, and a national medical billing curriculum should be developed.[19] Australian literature reveals no formal medical billing curriculum and, with the exception of a relatively small, rudimentary and non-mandatory selection of brief online learning materials,[20] only one government approved certificate course regarding medical billing exists.[21] However, this course is not designed for medical practitioners, but for medical receptionists, who are not legally responsible for the bills they submit on behalf of medical practitioners.[22]

There is increasing pressure on medical practitioners in relation to billing compliance internationally.[1,4,10,11] It has also been identified as an issue in Australia,[12,23] where the medical billing system is divorced from clinical designations (such as the ICD) and a single medical service can be the subject of over 30 different fees, rules and penalties.[7] There have been suggestions education may improve billing literacy,[9] yet there has been scant research attention on training medical practitioners regarding correct medical billing. In response to

the dearth of research in this area, this study attempts to systematically map all avenues of medical practitioner education on Medicare billing and compliance in Australia, and explores the perceptions of medical education stakeholders on the teaching of medical billing in Australia to inform appropriate policy and regulatory initiatives.

Methods

A national cross-sectional survey of all Australian organizational stakeholders (n=66) who play a role in the education of medical practitioners from their first day as medical students through to the end of their careers, in relation to clinical practice, was undertaken between April 2014 and June 2015. A copy of the survey is included as a supplementary file. The survey framed questions around the concept of a 'medical billing course', the definition of which was intentionally broad to include any content whatsoever on the specific topic of medical billing under Australia's unique classification system known as the Medicare Benefits Schedule (MBS). Unlike many other health systems, the MBS has no relationship with ICD codes.[i] The questions focused on course availability, as well as views on whether the topic should be taught and who should be responsible for delivery, the duration of courses offered, the qualifications of relevant teachers, whether courses were voluntary or mandatory, free or paid, and methods of assessment with regard to certification. Participants responded to a maximum of 15 questions with the final question being reserved for the government stakeholder group. This final question asked where medical practitioners who have been found to have breached Medicare's requirements are directed to learn how to bill correctly. The survey was designed as a telephone survey however the majority of stakeholders requested an emailed copy prior to agreeing to participate.

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i: The Medicare Benefits Schedule or MBS as it is known locally is Australia's unique classification system for professional services provided mostly by medical practitioners, but also by some allied health professionals. It was first introduced in 1975 (then known as the Medical Benefits Schedule). Unlike the majority of the world's health classification and medical billing systems, the MBS has no relationship with ICD codes and therefore there is no nexus at all between the work of Australian clinical coders and those who may process medical bills for Australian doctors. The MBS also has no relationship with Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), Systematized Nomenclature of Medicine (SNOMED), Logical Observation Identifiers Names and Codes (LOINC) or any other codes, and operates under its own legislative framework, separate to that which regulates clinical coding using ICD 10th Revision, Australian Modification in Australia.

Our study excluded divisions, faculties and chapters which exist under the umbrellas of the specialist medical colleges who were invited to participate. Some professional stakeholders were Australasian in nature (Australasia is a term for Australia, New Zealand and occasionally the Pacific Islands) and we excluded those organisations focussed primarily on New Zealand. Descriptive statistics via frequency distributions were used to analyse the data.

Patient and public involvement

No patients or members of the public were involved in this study.

Results

The response rate was 86% (n=57), with 32 respondents (who represented stakeholder organizations) choosing to complete the survey manually by mail and email, and 25 were completed by telephone. Characteristics of the stakeholders are presented in Table 1, together with the details of providers of medical billing courses in Australia.

Table 1 Characteristics and details of providers of medical billing course (MBC) in Australia

Stakeholder description	Invited	Responded	Offer MBC (% of respondents)	Do not offer MBC
Undergraduate education (university medical schools)	18	17	1 (6)	16
Postgraduate general practitioner education (vocational education providers)	17	15	12 (80)	3
Postgraduate specialist education (specialist medical colleges)	16	14	2 (14)	12
Representative professional organisations (state and territory branches of the Australian Medical Association (AMA))	8	5	0 (0)	5
Medical defence organisations (also known as medical indemnity insurers)	4	4	2 (50)	2
Government agencies and departments (Australian Health Practitioner Regulation Agency, Professional Services Review Agency and Medicare)	3	2	0 (0)	2
Total	n=66	n=57 (86%)	n=17 (30%)	n=40 (70%)

Medical billing course delivery and content

The majority of stakeholders (70%, n=40) did not offer, and have never offered, a medical billing course. Of those stakeholders who did provide courses regarding medical billing for medical practitioners (30%, n=17), the majority (71%, n=12) were vocational education providers facilitating postgraduate training exclusively to general practitioners (GPs). The majority of stakeholders who provided courses did so as a mandatory component of an induction and introduction program (76%, n=13). Most course providers reported a course duration of less than two hours (59%, n=10) and almost all providers of medical billing courses stated that the course was delivered by a person with medical qualifications, some of whom also had educational qualifications (94%, n=16). The majority of medical billing course providers did not include assessment as part of their course (82%, n=14) and almost all medical billing course providers provided the course free of charge (94%, n=16). These results are presented in table 2.

Two government agencies responded to question 15, which asked where medical practitioners who have been found to have breached Medicare's requirements are directed to learn how to bill correctly for their services. One stated that no direction is given to medical practitioners who have been found to have breached Medicare's requirements, and the other stated that medical practitioners who have been found to have breached Medicare's requirements would be referred to Medicare to further their learning in the area.

Table 2 Details of medical billing courses (MBCs) provided in Australia

MBC details	Who is MBC offered to?	When is MBC offered?	Mandatory or voluntary?	How many hours of duration?	How long has MBC been offered?	Qualifications of person delivering MBC	How is MBC examined?	Is MBC free or paid?
Undergraduate education (n=1) (university medical schools)	Medical students	In GP rotation (fourth year)	Mandatory	<4	5–10 years	MQ	Written examination, assignments/group projects	Free
Postgraduate general practitioner education (n=12) (vocational education providers)	GP registrars	(n=9) Component of induction and introduction programme (n=3) plus ongoing review during training	Mandatory	(n=7) <2 (n=3) 2–4 (n=1) >4 (n=1) varies	(n=8) 5–10 years (n=4) >10 years	(n=7) MQ (n=5) MQ plus education qualification	(n=10) Not examined (n=1) Informal quiz (n=1) Partially examined	Free
Postgraduate specialist education (n=2) (specialist medical colleges)	(n=1) Members of our organisation (n=1) Registrars	(n=1) annually in some states and biannually in others (n=1) at annual scientific congress	Voluntary	<2	(n=1) >10 years (n=1) <1 year	MQ	Not examined	(n=1) Pay (n=1) Free
Medical defence organisations (n=2) (also known as medical indemnity insurers)	Members of our organisation	(n=1) Articles in member publications (n=1) ad hoc	Voluntary	(n=1) Free reading (n=1) <2	(n=1) 5–10 years (n=1) <5 years	(n=1) Legal qualification (n=1) MQ	Not examined	Free
Total n=17	n=12 offered to GPs only	n=13 during orientation/induction	n=13 Mandatory	n=10 <2	n=10 5–10 years	(n=16) MQs	(n=14) Not examined	(n=16) Free

GP, general practitioner; MQ, medical qualification.

Perceptions on who should provide medical billing education

Table 3 shows stakeholder perceptions regarding medical billing courses. 89% of stakeholders thought that medical billing should be taught to medical practitioners, including 30% (n=17) who were already teaching it. Of the 40 stakeholders who did not offer a medical billing course, nearly three-quarters thought that someone should provide a medical billing course for medical practitioners (72%, n=29). Five respondents who stated that they did not think a medical billing course for medical practitioners was necessary nevertheless went on to suggest who they thought should deliver a medical billing course. The majority of respondents who did not think that a course was required were from undergraduate university medical schools and postgraduate specialist medical colleges. Most respondents who did not offer a medical billing course offered a view as to who should be responsible for teaching such a course (85%, n=34) and the majority stated Medicare (82% n=28).

Table 3 Stakeholder perceptions on who should provide medical billing education*

Suggested providers of medical billing courses	Those not teaching medical billing (n=40) who felt it *should* be taught (n=29) suggested the following stakeholders should teach it	Those not teaching medical billing who felt it *should not* be taught (n=11). 15% of these respondents (n=5) still suggested who should teach it	Total who responded (n=34)
Medicare	24	4	28
Australian Medical Association	6	1	7
Specialist colleges	5	1	6
Medical boards	4	0	4
Universities	3	0	3
Medical Defence Organisations	3	0	3
Vocational training providers	2	0	2
Private health funds	1	1	2
Total no of suggestions	48	7	55

*Thirty-four stakeholders who did not provide their own medical billing courses responded to this question. They comprise 29 positive responses to the question: "Do you think doctors should be taught medical billing?" and 5 negative responses who went on to suggest training providers. Many chose more than one stakeholder when responding.

Discussion

Our study identified broad agreement amongst medical education stakeholders that medical billing should be taught to medical practitioners at some point in their careers. However, there appears to be no consensus amongst the stakeholders on when this should occur.

Although most Australian medical education stakeholders in our study perceived the topic as important, most do not believe medical billing education falls within the scope of their own organizational responsibilities with respect to educating medical practitioners. All respondents suggested other parties should be responsible for delivering medical billing courses to medical practitioners. However, the stakeholder organizations who were nominated by other stakeholders as having responsibility for teaching medical billing to medical practitioners did not necessarily agree that this responsibility should fall with them. For example, the Australian Medical Association and the specialist colleges were among those most commonly selected to deliver courses, yet the nominated organizations themselves did not agree that this fell within their scope.

Undergraduate university medical schools and postgraduate specialist medical colleges were the major category of respondents who did not think that a specific course on medical billing was required. This finding directly contrasts with international views. The opposite view appears to be held by these two stakeholder groups in The Netherlands for example, where university medical schools and postgraduate specialist medical colleges have been tasked with providing training on medical billing and the costs of providing care to medical practitioners in that country.[10] University stakeholders reported a general consensus that Medicare billing was of no immediate relevance to undergraduate students, citing crowded curriculums and the need to prioritise clinical content over content concerning reimbursement after graduates join the workforce. Some specific postgraduate specialist colleges stated that any Medicare billing education should occur informally on an ad hoc basis during internship whenever relevant learning opportunities arise. However, we found that some postgraduate specialist colleges describe 'questionable' medical billing as unethical behaviour in their professionalism training modules,[24] yet training provided to their members may not include specific content on how to bill correctly.

The lack of qualified educators in this area is also potentially problematic. Our survey reveals that where medical billing education does exist in Australia, it is provided largely by medical practitioners, rather than educators with qualifications or expertise in the administrative and

legal aspects of Medicare. As such, our research suggests the training received by Australian medical practitioners regarding correct medical billing may be highly variable. One possible implication of this variability is that medical practitioners may be exposed to unnecessary risk of inadvertently falling into non-compliance with Medicare's requirements, for which possible sanctions can include criminal liability.[6] This is a finding that mirrors concerns raised in the U.S, where research has shown that teaching around medical billing to medical practitioners is highly variable and dependent on the expertise, experience and the confidence of senior mentors, many of whom may themselves have had little training in the area.[19]

Our study reveals some initiatives by independent organizations to create their own learning modules on medical billing for medical practitioners in lieu of more formal education. However significant gaps exist. For example, many vocational education providers described their medical billing courses as being practical 'on-the-job' training programs delivered during placement in GP practices. Yet such programs did not include specific curriculum content, learning outcomes or formal assessment of correct Medicare billing. The few courses which were offered by specialist medical colleges consisted of little more than voluntary attendance at a short presentation, and one stakeholder offered only optional reading of articles specific to Medicare billing. Whilst these efforts are commendable, the average course length of less than two hours is unlikely to achieve the high level of legal and administrative literacy that is expected of medical practitioners working within a complex system of nearly 6000 reimbursement items, over 900 A4 pages of service descriptions, complex cross-referencing, administrative permutations and rules. Whilst many medical practitioners may use only a small subset of these items, some have nevertheless been found guilty of fraud in relation to the billing of even these small subsets.[6] Others may be unaware of the myriad legal obligations applicable to each claim, particularly when a single medical service in Australia can be the subject of more than 30 payment rates, multiple rules, and strict penalties for non-compliance.[7]

Our analyses show most medical billing education initiatives tend to focus on general practice and educating GPs. Medical specialists - who represent both the majority of Australian

registered medical practitioners[25] and account for the majority of total Medicare expenditure[26] appear to receive almost no training in this area (with those few specialist organizations who do offer such content to their members offering it exclusively on a voluntary basis). This finding has particular significance given most specialists engage in hospital-based medical billing which, in Australia, has profound complexity.[22,27] It is also noteworthy that our research suggests medical practitioners who are found to have breached Medicare's requirements are given no guidance to help improve their medical billing compliance. One government stakeholder stated that offenders would be referred to Medicare to further their learning in this area, but it is not clear whether Medicare in fact offers remedial medical billing training. Lack of formal medical billing education for those who have already been found to have breached Medicare's requirements may increase the potential for recidivism. Further, the impact of incorrect medical billing on consumers in relation to out-of-pocket expenses (OOP) may be significant, because correct billing itemisation not only affects government expenditure, but may also determine whether consumers will be required to pay an OOP and the amount.

Examining the knowledge and educational needs of medical practitioners around medical billing is also important because medical practitioners may be investigated for incorrect billing in both civil and criminal jurisdictions, and relevant determinations in both settings reveal that medical practitioners under investigation will often state that they did not know the conduct for which they stand accused was wrong. [6,14,28] Whilst the defence of ignorance has been unsuccessful in preventing conviction both in Australia and the U.S,[6,28] the findings of our study suggest there may sometimes be veracity in such submissions, as the majority of Australian medical practitioners have never been taught how to bill correctly or at all. Until such time as governments can confidently assert and demonstrate that medical practitioners are fully cognizant of their medical billing responsibilities, procedural fairness for medical practitioners under investigation may be denied, and the defence of ignorance will always remain – at least theoretically – open.

The majority of medical education stakeholders in our study expressed the view that Australia's national universal insurer - Medicare - had sole responsibility for developing a standardised course and teaching correct medical billing to medical practitioners. Currently this is neither supported by the relevant legislation nor the administrative structure of Medicare.[22,29] The Department of Human Services (the administrator of Medicare payments in Australia) does have risk management responsibilities in order to protect the integrity of government payments, and under this component of its remit Medicare can and has already has adopted successful educational strategies as part of the departments' broader compliance initiatives.[9,12,23] However, Medicare cannot act as regulator, educator and prosecutor simultaneously due to inherent conflicts of interests, and in addition, it has specific legal obligations to conduct its activities within the parameters of the legislative scheme.[29] These obligations do not give Medicare responsibility for training medical practitioners. Rather, these are similar arrangements to those that exist with the Australian Taxation Office (ATO) in relation to tax law, where the ATO may provide support and advice in relation to taxation and also manages risk, but actual teaching of tax law and tax accounting is undertaken by external experts, typically inside academic institutions. A further unique feature of Australia's blended public/private health financing arrangements provides that Medicare has limited jurisdiction over Australia's private health insurance schemes[30] where many of the most complex medical billing arrangements are found. These schemes incorporate the entire regulatory framework of the MBS,[31] affect approximately 45% of the Australian population,[32] and represent the main form of medical billing for the majority of Australian medical specialists.[33]

Strengths and limitations

To our knowledge this is the first study which has attempted to systematically map all medical billing education of Australian medical practitioners. However, there are some limitations that need to be considered when interpreting our study findings. Multiple data collection methods (telephone, mail and email) may have elicited some response bias among participants, though this is likely to be negligible given the exploratory and descriptive nature of this study. Also, since this study, cost saving initiatives by the federal government in relation to the medical

education of GP's has reduced the number of vocational education providers from the 17 stakeholders included in our study to 11 stakeholders. Further, our study excluded divisions, faculties and chapters which exist under the umbrellas of the specialist medical colleges who were invited to participate. However, any impact upon our results is likely to be minimal due to the small numbers of medical practitioners involved and the focus of such divisions, faculties and chapters on clinical education, policy development and advocacy, rather than the administrative aspects of medical practice.

While this study focused on offerings by medical education stakeholders, further research is also required to explore whether medical practitioners are self-educating or sourcing non-traditional education on Medicare billing and compliance, thereby achieving the high expected levels of medical billing literacy expected of them.

This study reports findings from one country with a mixed public-private health system and a primarily fee-for-service reimbursement model and may therefore not be completely generalizable to other settings. Nevertheless, irrespective of whether health care systems are mature or emerging, challenges appear to exist at the interface of medical billing and payment system complexity, and medical practice across multiple health settings. Increasing private sector involvement in the 65-year-old, single public payer, capitation styled NHS of the United Kingdom has exposed compliance vulnerabilities,[4,34] and in a starkly different healthcare system with multiple, private payers, and a blend of capitation, fee-for-service and salary payment arrangements, the Netherlands has reported similar challenges.[10] Commentary on Indonesia's nascent universal healthcare system BPJS (Baden Penyelenggara Jaminan Sosial Kesehatan), which uses a mixed capitation and fee-for-service model has already described the challenges of medical practitioner compliance under the new scheme,[35] and some commentators have suggested that no healthcare system is exempt from billing errors and fraud.[4] As such our results may offer insights for regulators, policy-makers and practitioners beyond the Australian setting.

Conclusion

Our study suggests that very little proactive education aimed at improving medical billing compliance by medical practitioners is currently occurring or has ever occurred in Australia, and available medical billing education may be highly variable and may not deliver the level of expected legal and administrative literacy required to effectively and competently use the national insurance scheme and ensure program integrity. This is consistent with findings in the U.S where it has been suggested that clinicians need to be properly prepared to practice medicine beyond clinical encounters to reduce the incidence of potentially serious administrative errors. In the absence of adequate medical billing and payment system education for medical practitioners, relevant courts in all countries must give due consideration to pleas of ignorance made by medical practitioners facing criminal charges related to incorrect medical billing, which may sometimes be legitimate. Rather than reliance on ad-hoc training and education, development of a formal national medical billing curriculum for medical practitioners should be encouraged to improve billing compliance, expedite judicial processes, enhance program integrity and reduce wasted resources in the health system. Further research is required to determine the most effective design and delivery of any such curriculum.

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CHAPTER 6: Qualitative Results

6.1 Background and Context

The qualitative interviews with MP complemented and expanded the previous phases of this project. The two participant groups, previously described in chapter three, represented private specialists practising outpatient-based medicine, and a second group who practised public hospital-based medicine where Medicare billing is some of the most complex in the country. Collection of rich data about the lived experiences of these MP interacting with Medicare and medical billing in their day-to-day work enabled deeper exploration, reinforcement and contextualisation of the earlier findings of the study.

6.2 Wading through Molasses: A qualitative examination of the experiences, perceptions, attitudes, and knowledge of Australian medical practitioners regarding medical billing

The material in section 6.2 was published as an original research article in *PLoS One* in January 2022 as **Wading through Molasses: A qualitative examination of the experiences, perceptions, attitudes, and knowledge of Australian medical practitioners regarding medical billing.** Margaret Faux, Jon Adams, Simran Dahiya, Jon Wardle. It is available at this link https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0262211.

Wading through Molasses: A qualitative examination of the experiences, perceptions, attitudes, and knowledge of Australian medical practitioners regarding medical billing

Abstract

Background

Medical billing errors and fraud have been described as one of the last "great unreduced healthcare costs," with some commentators suggesting measurable average losses from this phenomenon are 7% of total health expenditure. In Australia, it has been estimated that leakage from Medicare caused by non-compliant medical billing may be 10-15% of the scheme's total cost. Despite a growing body of international research, mostly from the U.S, suggesting that rather than deliberately abusing the health financing systems they operate within, medical practitioners may be struggling to understand complex and highly interpretive medical billing rules, there is a lack of research in this area in Australia. The aim of this study was to address this research gap by examining the experiences of medical practitioners through the first qualitative study undertaken in Australia, which may have relevance in multiple jurisdictions.

Method

This study interviewed 27 specialist and general medical practitioners who claim Medicare reimbursements in their daily practice. Interviews were recorded, transcribed, and analysed using thematic analysis.

Results

The qualitative data revealed five themes including inadequate induction, poor legal literacy, absence of reliable advice and support, fear and deference, and unmet opportunities for improvement.

Conclusion

The qualitative data presented in this study suggest Australian medical practitioners are ill-equipped to manage their Medicare compliance obligations, have low levels of legal literacy and desire education, clarity and certainty around complex billing standards and rules. Non-compliant medical billing under Australia's Medicare scheme is a nuanced phenomenon that may be far more complex than previously thought and learnings from this study may offer important insights for other countries seeking solutions to the phenomenon of health system leakage. Strategies to address the barriers and deficiencies identified by participants in this study will require a multi-pronged approach. The data suggest that the current punitive system of ensuring compliance by Australian medical practitioners is not fit for purpose.

Introduction

Medical billing errors and fraud have been described as one of the last "great unreduced healthcare costs," with some commentators suggesting measurable average losses from this phenomenon are 7% of total health expenditure.[1] It is therefore central to the long-term economic viability of any health system that medical practitioners have clarity and certainty around relevant billing standards and rules. However, a growing body of international research, mostly from the U.S, suggests medical practitioners are ill equipped to understand the complexities of the health systems in which they work.

Like the reported experiences of their U.S colleagues, evidence suggest Australian medical practitioners may be experiencing difficulty navigating complex medical billing rules.[2] It has been suggested that the rate of non-compliant billing under Australia's Medicare caused by deliberate abuses by medical practitioners is between 10-15%.[3] However, how much non-compliant billing is deliberate is uncertain, as it rests in a spectrum with criminal fraud at one end and unintentional errors at the other and currently the precise quantum of each is unknown. This is largely because the problem is not what can be seen, but what cannot. Lax regulation, poor administration, system complexity and the fact that medical practitioners are never taught how to use the system correctly at any point in their careers have all been cited as factors contributing to this problem.[4] Increasing complexity has occurred in tangent with increased

penalties for non-compliance[5] and pressure on medical practitioners to bill correctly has reached the point where some authors have suggested that compliance with Medicare billing rules has become a contributing factor to medical practitioner burnout and suicide.[6] However, one area of activity that has been overlooked is improving user knowledge of the medical billing system.

Multiple recent U.S studies on the topic of medical billing literacy[7] have consistently reported demonstrably low literacy which may be improved by targeted educational initiatives, including by medical billing and coding education being a mandatory inclusion in the medical curriculum. However, an apparent inertia to act persists. In Australia, discussion around this topic is less mature, with very little similar research having been undertaken.

The aim of this study was therefore to address this research gap by examining the experiences of Australian medical practitioners in grass roots practice as they interact with Medicare and claim reimbursements under Australia's unique Medicare Benefits Schedule (MBS) codes.[8] This study will also explore medical practitioner knowledge of medical billing requirements, attitudes and perceptions to Medicare, and seek to identify any barriers to compliance as well as exploring possible solutions to deficiencies in current arrangements.

Methods

Between July 2016 and May 2019, semi structured interviews were conducted with specialist and general medical practitioners both of whom are required to claim Medicare reimbursements in their daily work. The study was geographically restricted to the State of New South Wales, was approved by the relevant Human Research Ethics Committee and consent was obtained from all participants. Participant information has been de-identified to preserve anonymity.

Participants

Twenty-seven interviews were conducted, twelve with General Practitioners (GP) and fifteen with Salaried Medical Officers (SMO), the latter of whom are specialists working in Australian public hospitals. Participants were recruited through advertising with their professional

associations, direct approaches and "snowballing". Participant demographics included 11 females and 16 males and a mix of overseas and Australian trained medical practitioners, who worked in both regional and city locations. The full spectrum of career stages was represented, including early career stage medical practitioners (defined as 0-7 years post-graduation) through to those who had practiced medicine for over 30 years. The SMO cohort included a variety of procedural and non-procedural specialists.

Data collection

Medical practitioners who responded to initial contact were sent an information sheet (S1 Fig.), consent form (S2 Fig.) and a short overview of the research via email, and those who participated signed the consent form prior to the interview.

Although every effort was made to identify participants who were not known to the principal researcher (first author), being someone who has worked in the medical billing industry for over 30 years it was likely that some participants would have a coexisting relationship. One GP and one SMO were personally known to the principal researcher, and another GP and SMO were professionally known. In addition, three SMOs were professional acquaintances. While this was unavoidable, it is not uncommon in qualitative research projects (for example a nurse questioning other nurses in their organisation as part of a project).

To ensure personal relationships (none of which were close) did not cloud data collection, the principal researcher continued to have regular discussions with other members of the research team adopting reflective practice to eliminate bias and ensure research integrity. Further, the third author listened to the audio recordings of all interviews and provided important insights when reviewing the draft paper to ensure data were accurately reflected and reported, with additional input from other authors as required.

To address possible conscious or unconscious bias, triangulation was used where an experienced qualitative researcher separately analysed and interpreted the data and any differences in researcher perspectives were cross checked to arrive at an overall interpretation.

By implementing these accepted methods rigour, trustworthiness, authenticity and credibility were addressed.[9]

As this study forms part of the doctoral thesis of the principal researcher, it was incumbent upon her to personally conduct as much of the work as possible. However, this project was at all times closely supervised by the last author, who is a senior researcher experienced in qualitative data collection. The principal researcher had ongoing discussions with the last author throughout the data collection phase and during the analysis and coding of the data.

Further, to ensure research integrity the last author directly sat in and supervised the first two interviews (including with the GP who had a personal relationship). Following approval of the first two interviews, the principal researcher continued and personally conducted all 27 interviews. Most of the interviews were conducted in person (n = 23) at a place and time convenient to the participants. Due to geographical barriers, some of the regional GP interviews were conducted by phone (n = 4).

Two listeners and two independent coders analysed the data in line with qualitative research norms. The third author listened to the audio recordings of all interviews and edited final transcripts to ensure accuracy. After discussion with the last author regarding emergent themes, the first and third authors worked together to code the data, with the other authors reviewing in areas that required resolution to disagreements.

The interviews were semi-structured, with a question sheet used to loosely guide questioning. A copy of the question guide is shown as S3 Fig**.** Participants were encouraged to speak freely and openly and were given unlimited time to enable full exploration of the topic. The interviews continued until theme saturation had been reached, the average interview length was one hour, and all participants consented to the interviews being recorded. The interviews were subsequently transcribed.

Data analysis

The process of data analysis included the five documented steps using the framework approach which is broadly described as familiarisation, identification of framework, charting, mapping and interpretation.[10]

The principal researcher reviewed the manuscripts to familiarise herself with the data including reading and re-reading the transcripts, relistening to the audio files, organising the data for analysis, visually scanning the transcripts and beginning the process of sorting the data to consider its overall meaning. Identification of the framework was then undertaken to draw out key themes and issues from the text around which the data were then organised. The data were then indexed to identify themes and finally, mapping and interpretation was undertaken, whereby associations were clarified, and explanations worked towards.

In order to ensure quality during data analysis, quality assurance measures based upon systematic and self-conscious practice were implemented.[9] A self-reflective, critical examination of potential bias was also undertaken by the principal researcher, who spent prolonged time in the field engaging with the subject matter.

Findings

Analysis of the qualitative data revealed five themes related to Medicare and MBS billing, including inadequate induction, poor legal literacy, absence of reliable advice and support, fear and deference, and unmet opportunities for improvement. Examples of raw data analysis and themes are shown in Table 1.

Table 1. Example of raw data analysis

Raw Data	Theme
[Interviewer asked SMO7 if education at various levels adequately equipped him to bill correctly] Not at all. It is purely through by necessity to understand it oneself and to understand the vagaries not only of billing, but how it works in the context of the staff specialist or ward arrangements, which are quite complex. [interviewer: 'any education on that either?'] No zero. Zip.	Inadequate induction
Bulk billing, I understand is where whatever Medicare says, so if … I treat the patient for say keeping on breathing machine let us say. Government says you can earn $50 a day for doing that and bulk bill would be if I say okay give me $50. If I charge $60, then I have charged a gap. [interviewer: when can you do that? SMO12 replied] No idea.	Poor legal literacy
[interviewer]…so when it goes off into accounts, how confident are you about what happens next? [SMO14] I am confident because as the director, I have explored that, my colleagues would be somewhat less confident. [interviewer] With item numbers…? [SMO14] No just total numbers. Just money. Could have been anything. So, in fact, in reality I have no idea. [interviewer] So…you have got an idea of the total dollar amount that is billed, do you have an idea of the actual item numbers? [SMO14] No, not at all, not a jot, not one single solitary scintilla.	Absence of reliable advice and support
[GP3] We have a practice manager and we have asked her to contact Medicare about some…uncertain issues regarding Medicare…and she will get five different answers from five different people that she rings…that is a regular experience and I say "…there's no point in ringing Medicare about this" because I do not know who she is speaking to. I do not know whether she is speaking to a manager…or somebody who has recently started in Medicare who does not have much experience…and is just reading from one part of the manual but doesn't know the other parts…we've always had that experience if you ring up…the most recent example…charging through Medicare for overseas travel…she has spoken to several different people and received different answers from each one.	
[GP2] I probably underbill…I'm just going to do what I know is safe.	Fear and Deference
[GP4] The threat of audit kind of hangs over…	
[SMO7] I do not order a lot of blood tests. I do not order a lot of scans. I am very interested in…evidence base, I am interested in doing what is needed, I try not to pander to anxiety, it's very difficult, it is much easier to give in and just order a million tests…It is an impost on the national health, so I think there is a responsibility.	
[GP8] Sending some more resources …for educating the doctors, by various means be it sending them letters like case examples, emails, having some conferences around, you know, correct Medicare billing etc and educating doctors the implications of incorrect charging particularly over-servicing and fraud, I think that is very important. Doctors just learn from their colleagues and others, you know, we are hearing stories, it is not something they are actively involved in, so there should be an education process and may be even attaching some category points…if the doctors understood Medicare and I think that is very important. The system is there but is not enough education about it.	Unmet opportunities for improvement

Inadequate induction into Medicare and MBS billing

All participants reported their first experience generating a medical bill, or claiming to Medicare, taking place in a knowledge vacuum, where they felt inadequately prepared. As the following quotes suggest, many respondents reported little – if any – training, and if training did occur it was usually brief, informal and taught by someone who may not necessarily have been qualified to teach it:

"…when I did my GP training we had a block of training prior to our very first day on the job…we basically just learnt you know your 23 and 36 item number [common time based attendances][11]*... there would have been question and answer time, but we hadn't practised yet so we wouldn't really have known what questions to ask."* (GP1)

"…in that induction program there was a guide to claiming, a very brief guide. I think my experience and a lot of other GP trainee's experience was that we had no idea, we were out there, kind of at the coal face, I had zero idea of what we were doing and…it was like walking through molasses, it was very hard to negotiate…It is so hard to understand, ridiculous…"(GP4)

" [I was] *totally naïve, I just believed what he said, thinking he is my senior guy and that was it, so I had no idea that there are legal implications, I had no idea."* (GP7)

While most GPs reported a brief induction process, SMOs reported having no induction at all, as explained by the following SMOs:

"Um trial and error, there was no formal introduction, no formal training as you go through… there was no mention of billing…so you navigate it by the skin of your teeth." (SMO11)

"I had no idea how Medicare kind of worked …no one taught me how to bill…I had no idea what it meant to Medicare bill, what gaps were, what scheduled fee was, all the different rates of things were, so it made no sense…there is absolutely no training." (SMO1)

"…when you are a Registrar and when you finish you then realise, oh, there is Medicare. Now what have I been taught about Medicare? Essentially nothing…you realise you are supposed to bill, but still have no inkling how to do it." (SMO10)

Poor legal literacy of Medicare and MBS billing

When participants were asked detailed questions about fundamental legal requirements to bill correctly, their levels of literacy were variable and some were confused in important areas, such as when it is permissible to charge a gap and what bulk billing was. Bulk billing is a common term in Australia, describing a transaction for a medical service wherein the patient does not pay any money because the medical practitioner chooses to accept the amount of the available government subsidy for that service.[12] The term 'gap' in the Australian context refers to a patient out-of-pocket payment which in many countries is described as a co-payment.

Both of the following quotes were from bulk billing doctors, one of whom did not know the process he was using was bulk billing and the other was unaware he could charge a gap if he wanted to.

"…bulk billing, we do not do bulk billing…really my understanding is it is something that happens in general practice…" (SMO9)

"I think a gap would only be payable if the patient is in hospital where…they have to pay the gap between the doctor's fee and the health fund rebate or gap between the specialist fee and the Medicare rebate, I am not entirely sure of this; I am just guessing from the limited amount of information that I have." (GP8)

When SMOs were asked their understanding of relevant law around bulk billing or charging gaps to patients in public hospital outpatient departments many of their responses highlighted a deep lack of knowledge.

"I think if we as the department decided to charge a gap, we can …there might be a specific rule, like you cannot charge a gap, but I am not sure, I have never asked questions, I have wondered about it though." (SMO3)

"Can a gap be charged? I actually do not know the answer to that question." (SMO4)

"[billing in the public hospital is] *a minefield. My understanding is that for outpatient services in a privatised clinic like this it's quite within our rights to charge a gap,"* though when quizzed about the source of that information he said, *"Look I do not know the precise details of that; this is just something I have been told."* (SMO6)

Confusion about the legalities of this area of public hospital billing extended to GPs, with one GP incorrectly asserting that bulk billing in public hospital outpatient departments is illegal.

"the states are fraudulently thriving on Medicare, in all public hospitals…the practice is frightening…they bulk bill you in the public hospital [outpatient department]*."* (GP5)

The majority of participants were also unclear about fundamental billing requirements. In Australia's gatekeeper model health system, patients usually require a valid referral from a general practitioner before seeking more specialised care. However, most participants did not know what constituted a valid referral. Other very basic requirements to bill correctly were also poorly understood by most participants such as specific rules around billing eligible war veterans, and whether any patient has to sign a form when the medical practitioner bulk bills the patient.

"Valid referrals, I do not know, I have no understanding of that. I am actually unsure." (GP9)

"…there seems to be at least as far as I am aware (but no one really knows) a practice that anyone who holds the Veterans Affairs Card will not be charged a gap. Whether that is true or not, I do not know." (SMO4)

"I am not really sure, to be honest…I am not sure if it is compulsory, [the bulk bill form] *needs to be signed by the patient. I do not really know."* (GP9)

When participants were asked how well they thought they complied with current standards some did not know what the standards were or whether such standards existed, and very few participants were aware of the penalties for noncompliance.

"I actually don't know that we would meet the criteria because I don't really know what they are." (SMO15)

"I don't really know…I mean I am sure they could make you pay back the money and there probably is jail time eventually at some point, but to be honest I don't really know what the penalties are." (GP1)

Absence of reliable advice and support

The majority of participants tended to describe their experiences seeking support and advice from Medicare in negative terms and preferred to direct medical billing questions to practice managers, colleagues, hospital finance departments, professional organisations and in one case, social media.

"…there was something recently that we actually called them up for and then it was some huge kerfuffle and…it kept going round and round….it was about this item number and they just kept reading the same thing we were reading, which was ambiguous. So, it was an utter waste of time." (GP12)

"I always felt like the advice was pretty good but if it got too technical, they were fudging it." (SMO15)

"We get three different answers literally, about the same thing." (GP5)

When asked what gave participants confidence in the medical billing expertise of others, their responses expressed blind faith, difficulties obtaining reliable advice and support and the need to trust someone, as the following quotes demonstrate.

"…the assumption is that…the secretarial staff would have done that before and they will be doing it for other doctors but whether they have had specific training in the rules and regulations around Medicare etc one never really knows…whether they had original training in what was actually required and what was not etc, I suppose it is not something that is very well regulated." (SMO4)

"Looks and appearance, she [the Practice Manager] *just appeared to know what she was doing, and I trusted her…I had to."* (GP6)

"the bottom line is it [MBS billing] *is not clear, and it is not easy to get clarity about some of those issues."* (GP3)

A private Facebook group had become the main source of Medicare billing information for one GP, who felt it was authentic and relying on it would protect her in the event of an audit.

"I do not have a choice but to rely on that because I do not think there is anything else and I realise the problem. If there are other things available, they're not made obvious to us, and I am someone actively seeking out this information. So, if I am looking for it and this is the best that I can find, what would a reasonable group of my peers do differently to what I am doing? Could I rely on that to be investigated? I have to, and I think that that is all I can do because I do not think there are other options…" (GP4)

SMOs reported a preference to seek support from inside the hospitals where they worked, even though some said they didn't know who to ask and others described the information they received as inherently unreliable. No SMO mentioned referencing the National Health Reform Agreement (NHRA),[13] which is the key agreement between the State and Federal Governments containing the rules for medical billing in public hospitals.

"I just feel dumb at these things, I need someone to explain it really in very basic terms to me. The area of private practice billing [in public hospitals] *really baffles me."* (SMO3)

"I knew nothing [about billing in public hospitals] *so they* [the hospital finance department] *had to know more than nothing,"* (SMO7)

All but one participant described education on medical billing throughout their careers in clear, unambiguous terms, summarised by the following typical response.

"[it was] *absolutely, totally, totally* [inadequate]. *Part of the problem, it is very interpretation based, there is no clarity on it. That's really poor and there isn't, to my knowledge, any kind of place that we can go, that in a succinct fashion, in a way that we need it to be, we can have very clear guidance about what we can or we cannot do and I strongly feel that I've had to wing this in terms of pulling stuff together, to make my own knowledge on it."* (GP4)

Most participants understood they were personally responsible for billing, but all had arrangements in place whereby third parties administered billing on their behalf. The advantage of this arrangement was reported as saving time, and the disadvantage was the inherent risk in having diminished control and visibility over the final item numbers submitted to Medicare. SMOs in particular were not confident that the item numbers they put on hospital forms were the same item numbers that were sent to Medicare, because they had very little control over medical billing activities undertaken in their name by the public hospitals where they work.

"…billing under my name in the public hospital in the outpatient department…I cannot see. I could not tell you if anyone did it fraudulently or inappropriately." (SMO7)

"As far as the data entry from my perspective, I know that the Medicare billing is correct because I put it in, so the question is two-pronged because one is my part of it and the second part is the part that I do not do…there is a gap there, so I do not know about the second part, because I have not checked." (SMO2)

"…I trust my colleagues but at the end of the day I have no idea." (SMO11)

"I have no control over claiming so I feel very uneasy with the whole process." (SMO10)

Many GPs also expressed concern that they ultimately did not know or have any visibility or control over what was being submitted to Medicare in their names.

"… I actually have no idea that they do what I ask them to do. I have to trust them, which I do of course. But they could be submitting all sorts of weird and wonderful things and I confess that I don't know what they're doing…you have got to trust someone." (GP3)

"There's that element of, I'm legally responsible for it and yet someone else is actually pressing the buttons, and maybe there is room for error there that I'm actually liable for, which I haven't even thought about, which is a bit disturbing." (GP2)

All participants described the unreliability of medical billing advice no matter who provided it, but perhaps the most startling example describing the unreliability of government advice was from a SMO who had been audited. This participant described her correct application of a locum billing rule, whereby when acting as a locum for a colleague, the medical practitioner is not permitted to claim an initial attendance item, but must instead claim a subsequent attendance item when a colleague has already reviewed the patient. The participant was subjected to what appears to have been a mishandled audit by Medicare, who appeared to have misunderstand the operation of the rule, which at all relevant times was clearly described in the MBS. As a result of the audit and Medicare's failure to explain to the SMO what she did wrong (which may have been nothing), the SMO changed her billing behaviour and is now billing incorrectly and costing Australian taxpayers more.

"I got audited… I then rang Medicare back and I said, "this was the logic for why I claimed 116 [a subsequent consultation]" *and I said, "Is this correct or not correct?" And they said, "we are not supposed to advise on the phone." And then I said, "So for me to get some advice, where can I go?" And they said, "you have to look at the MBS schedule." And I said, "I looked at the MBS schedule, I can't find the answers and I have asked my colleagues what they do and half of them do what I do and half of them put 110* [an initial consultation]." *So, I never got the right answer. They said they cannot provide any answers. It's pretty poor. I think there are*

answers that sometimes, you know, you're not quite sure, but don't really know who to ask except for your colleagues and sometimes I feel like the colleagues probably just make it up anyway because they probably don't know. [after the audit] *I did change my practice and now I use a 110 when I'm covering somebody else"* (SMO10)

Fear and deference

Most participants spoke positively about Medicare as a health system, describing its purpose as being to provide universal health coverage irrespective of ability to pay, and acknowledged the nexus between their billing and their responsibility for the national health budget. However, some participants commented on the shortcomings and inherent vulnerabilities in an honour-based scheme such as Medicare.

"I think we are the gatekeepers of it really, and the responsibility is on us as the doctors who are claiming. I think we need to be really quite careful about how we claim because I think if we are not claiming appropriately, then our health budget is not going to be able to sustain, you know, future healthcare." (GP9)

*"...you have rights to minimise cost to a country and then you have the rights to the patient in front of you, and sometimes that doesn't marry." (*GP12)

*"Well, the opportunity for cheating is as you can imagine endless. The way you describe your service is entirely up to you…I think most people are not dishonest and most doctors are not dishonest, but still as a taxpayer I do not like a system where you can endlessly plunder the public purse with relatively blunt scrutiny." (*GP10)

Most participants described billing defensively on occasions due to fear and anxiety of Medicare audits. One participant said she was initially scared of Medicare and recalled thinking when she first started practice, *"I will just stick to my 23s*[11] *and then I won't do anything wrong."* (GP1)

Under-billing was commonly reported, with many participants saying they would always contact Medicare to refund payments if they had made an over-billing mistake but would not correct under-billing errors. One respondent gave a typical response on this issue, *"If there is any doubt, I just do not claim it, it is as simple as that. I have a career of more than 20 years and I don't intend to end it prematurely."* (GP5)

Most participants also said they were not comfortable talking about money with their patients, so preferred to have the money handled by someone else and the majority expressed a disinterest in billing, with one respondent providing a typical response, *"I think no doctor wants to do their billing themselves, if I have to do billing myself, I probably would not do this."* (GP5)

Unmet opportunities for improvement

A prominent theme was a desire for the current educational deficit to be addressed. Participants had mixed views about the precise place and format of medical billing education with some suggesting a blended approach, whereby content would be provided both at the undergraduate level, and technical details taught later as required.

"I think if doctors in training have a very good understanding of how hospitals run, how Medicare works, how a private practice works, they will from the very beginning be much more engaged in trying to ensure that the funding is provided in an equitable manner and it is not trying to rort the system or do anything like that but is being aware of how things work…I think it is essential." (SMO4)

"[The educational deficit is a] *massive gap…if people are going to be working in the Australian Health System, they need to understand the remuneration and how it occurs in our health system, I think health economics is equally important and there is nothing taught about health economics."* (GP7)

"A lot of people would look at medicine and say, well look, people seem to get good salaries and a good lifestyle and that sort of thing…to understand that isn't just going, "so well, doctors

seem to be having a good time, but I don't really want to know the mechanism of it." I think understanding the mechanism is really important." (SMO1)

A common view about the practicalities of any future medical billing education suggested an applied learning approach would be more helpful than expecting medical practitioners to understand and interpret *"legal wording."* (GP8)

Discussion

General knowledge of medical billing and the impact of third parties

The qualitative data presented in this study suggest Australian medical practitioners are ill-equipped to manage their Medicare compliance obligations, have low levels of legal literacy and desire education, clarity and certainty around complex billing standards and rules. This is consistent with the results of prior survey findings in Australia[4] as well as findings in other countries such as the U.S and Canada.[14-16] This finding also aligns analysis of Australian medical billing policies which reported that a single Medicare service in Australia can be the subject of more than 30 different payment rates, multiple claiming methods and myriad rules.[17]

The data also suggest the current 'rules' of medical billing are confusing, and medical practitioners are struggling to understand and apply them in daily practice.

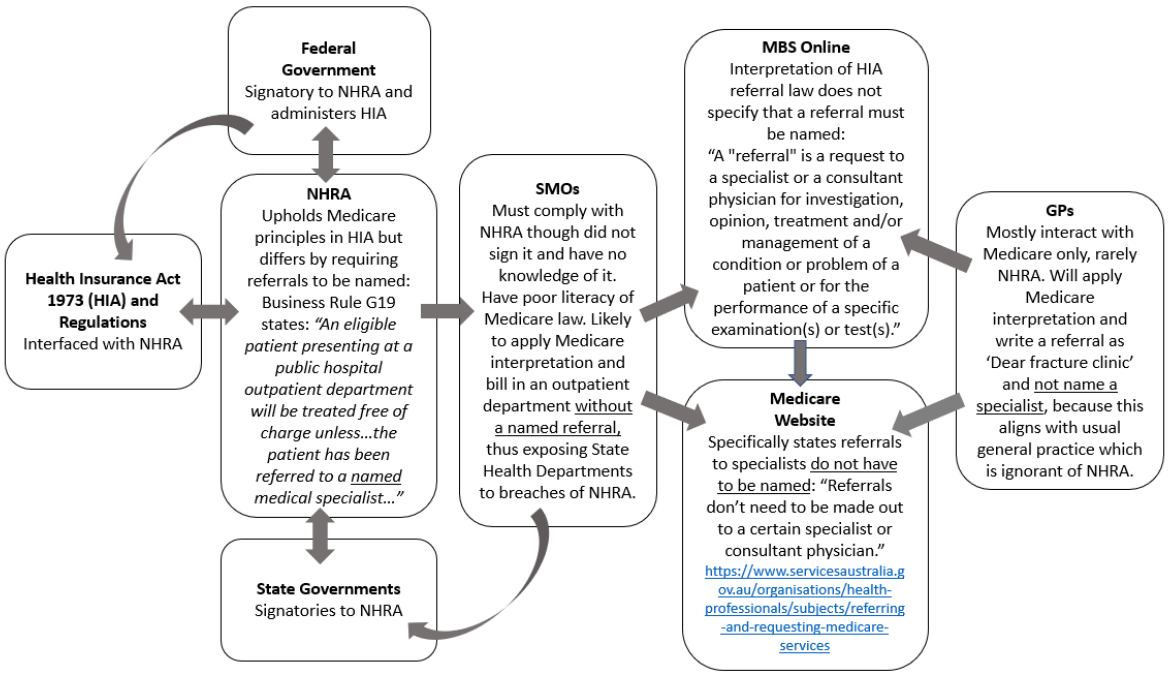
All participants commented on the potential negative impact of untrained third parties administering medical billing on their behalf. Participants described this common operating model as reducing the practical control and visibility they had over bills submitted to Medicare in their names, and was an area in which the law was out of step with the realities of modern medical practice management.

Risks to State and Federal Government relations and public hospital funding

Responses from participants suggested that while most medical practitioners have an awareness of the existence of the MBS (though many did not access or use it), they had no knowledge of the vast interconnected body of law that impacts their daily billing decisions, most notably the NHRA.[13] The apparent lack of awareness of the NHRA by SMOs combined with demonstrably poor understanding of some of the most basic elements of correct billing such as the components of a valid referral, may have serious repercussions extending beyond individual practitioners. Whilst SMOs are required to comply with the complex provisions of the NHRA, they are not parties to it, so cannot personally breach an agreement they did not sign. The relevant signatories to the NHRA are the Federal and State Governments, the latter of whom may be exposed to investigation and substantial repayments to the Commonwealth caused by incorrect billing by the SMOs in their employ. This risk was recently identified by both the Victorian Auditor General[18] and the Independent Commissioner Against Corruption in South Australia,[19] and was illuminated in this study.

This studies' data suggest SMOs may be unaware of the components of a valid referral despite this being a central component of a correct bill in a public hospital outpatient department. This finding, coupled with opaque legal drafting, inconsistent law making as between the NHRA and the *Health Insurance Act 1973 (Cwth)*, (which has been the subject of earlier critical analysis)[2] as well as inconsistent departmental interpretation of relevant legal provisions, may have extinguished any possibility of compliant billing in this important area. crippling the Federal Governments' ability to prosecute breaches when they occur. The mechanism of this process is shown in Fig 1.

Fig. 1 Referral law inconsistencies between Medicare and NHRA and potential impact.



Medicare audit anxiety and cognitive dissonance

Fear of Medicare audits was another issue highlighted by some participants, which appears to be contributing to overall feelings of anxiety and unease. This has the potential to impact patient care if medical practitioners make conservative treatment choices fuelled by fear of investigation, a potential sequela that has also been reported in the US.[20]

When asked about the connection between their billing patterns and their responsibility for the national health budget, participants acknowledged their responsibility to bill correctly and distribute finite resources prudently. However, this sat at odds with earlier responses around a preference by all participants to remain disconnected from billing administration, which they felt was not what they had studied medicine to do. This represented a striking cognitive dissonance in which the space between thought and action was occupied by ignorance from inadequate education, and indifference to having oversight of their own health budget spend.

Inadequate government support

This study found no evidence of the availability of reliable advice and support for billing questions, including from Medicare, with the main sources of information being medical

colleagues and administrative staff who themselves have never been formally taught how to bill correctly, but whom medical practitioners feel they have no option but to trust. Participants reported that the "the blind leading the blind" method by which medical billing information is disseminated may be perpetuating errors and myths. Further, the consistency in the experiences of the wide cross section of participants in this study supports a finding that extremely low levels of legal literacy in relation to medical billing may be creating a vortex of misinformation contributing to health system leakage.

Further, the data suggest that a lack of administrative resources and support provided by the Australian Government may have left medical practitioners with no place to go for legally accurate, reliable advice, meaning that despite due diligence, a medical practitioner may still fall foul of the law. In one case, a participant who described correct billing practices, appears to have been led into incorrect billing by the Australian Government who may not have the appropriate resources to provide accurate interpretations of its own rules to practitioners.

The participants of this study were clear that expecting medical practitioners to comply with complex and mercurial billing laws without relevant skills or training was unrealistic. Moreover, it is suggested that denying medical practitioners access to clear, reliable advice and training prior to imposing sometimes very serious sanctions is indefensible and may be inconsistent with common law principles of natural justice.[21]

Strengths and Limitations

Strengths of the study include the wide cross section of participants, information gathering in a non-punitive setting, and the diverse practice settings of participants including primary care and tertiary hospital-based care. The study also provides valuable insights into barriers to medical billing compliance and offers possible solutions for reform.

However, the qualitative data is contextually limited by the Australian context of a predominantly fee-for-service payment structure so the findings may not be generalisable, though the results are broadly comparable and consistent with reports of the same phenomenon in both the U.S and Canada.[14-16] Another limitation is the potential impact of selection bias

caused by the recruitment methods wherein a participant with high ethical standards was likely to work in a practice with others having the same standards. However, any impact would have been limited to the three GP practices where more than one GP was interviewed and possibly in the public hospitals where multiple SMOs were interviewed. However, any impact is likely minimal as all participants worked and billed independently day to day, and most did not know each other. Seven of the participants were known to the principal researcher either directly or indirectly, however, any impact is also likely minimal because the line of questioning was consistent across all participants and results were cross checked multiple times by multiple researchers using the recognised methods already discussed.

Conclusion

Non-compliant medical billing under Australia's Medicare scheme is a nuanced phenomenon that may be far more complex than previously thought. Therefore, many of the current punitive, post payment audit initiatives of the government are unlikely to succeed

Strategies to address the barriers and deficiencies identified by participants in this study will require a multi-pronged approach which may include the development of clear, legally binding medical billing rules, nationally consistent, accurate and accessible education, and structural reform to tighten and align the underlying regulatory framework.

This is the first Australian study to examine the lived experiences of Australian medical practitioners interacting with Medicare and medical billing. Some of the experiences are shared with international experiences, and may therefore offer learnings for other countries implementing universal health coverage systems, in which payment integrity and control of system leakage are of critical importance. The data suggest that the current system of ensuring compliance by medical practitioners in Australia is not fit for purpose.

Acknowledgments

The authors wish to thank the medical practitioners who shared their experiences with medical billing and Medicare.

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S1 Appendix

UNIVERSITY OF TECHNOLOGY SYDNEY

PARTICIPANT INFORMATION SHEET (Phase 2)

PROJECT TITLE

Claiming and compliance under the Medicare Benefits Schedule (MBS): a critical examination of attitudes, experiences, perceptions and knowledge of medical practitioners, UTS HREC REF NO. 2014000060.

WHO IS DOING THE RESEARCH?

My name is Margaret Faux and I am a PhD candidate at UTS. My supervisors are Jon Wardle and Jon Adams.

WHAT IS THIS RESEARCH ABOUT?

The aim of my research is to examine the experiences and perceptions of medical practitioners as they interact with Medicare and claim MBS reimbursements. The research also aims to identify any perceived barriers to compliance and to explore possible solutions to problems and deficiencies identified by participants.

IF I SAY YES, WHAT WILL IT INVOLVE?

I will ask you to participate in one face to face interview of between 30 minutes and one hour. You can choose the location and time of the interview.

ARE THERE ANY RISKS/INCONVENIENCE?

There are very few if any risks because the research has been carefully designed. Your privacy is of the highest importance and the data collected will be de-identified prior to being analysed and/or published.

WHY HAVE I BEEN ASKED?

You have been asked to participate because you are a medical practitioner who claims MBS reimbursements.

DO I HAVE TO SAY YES?

You don't have to say yes.

WHAT WILL HAPPEN IF I SAY NO?

Nothing. I will thank you for your time so far and won't contact you about this research again.

IF I SAY YES, CAN I CHANGE MY MIND LATER?

You can change your mind at any time and you don't have to say why. I will thank you for your time so far and won't contact you about this research again.

WHAT IF I HAVE CONCERNS OR A COMPLAINT?

If you have concerns about the research that you think I or my supervisor can help you with, please feel free to contact us on:

Margaret Faux: 0414 600 073
Margaret.A.Faux@student.uts.edu.au
Jon Wardle: Jon.Wardle@uts.edu.au
Jon Adams: Jon.Adams@uts.edu.au

If you would like to talk to someone who is not connected with the research, you may contact the Research Ethics Officer on 02 9514 9772, and quote this number UTS HREC REF NO. 2014000060.

S2 Appendix

UNIVERSITY OF TECHNOLOGY SYDNEY

Participant Consent Form (Phase 2)

I _____ *(participant's name)* agree to participate in the research project;

Claiming and compliance under the Medicare Benefits Schedule (MBS): a critical examination of attitudes, experiences, perceptions and knowledge of medical practitioners, UTS HREC REF NO. 2014000060.

The project is being conducted by Margaret Faux, email: Margaret.A.Faux@student.uts.edu.au telephone: 0414 600 073 of the University of Technology, Sydney, for her PhD.

I understand that the purpose of this study is to examine the experiences and perceptions of medical practitioners as they interact with Medicare and claim MBS reimbursements. The research also aims to identify any perceived barriers to compliance and to explore possible solutions to problems and deficiencies identified by participants.

I understand that I have been asked to participate in this research because I am a medical practitioner who claims MBS reimbursements in my daily work and that my participation in this research will involve between 30 minutes and one hour of my time being interviewed. There are no foreseeable risks to me above the risks of everyday living.

I am aware that I can contact Margaret Faux or her supervisors, Jon Wardle or Jon Adams, if I have any concerns about the research. I also understand that I am free to withdraw my participation from this research project at any time I wish, without consequences, and without giving a reason.

I agree that Margaret Faux has answered all my questions fully and clearly.

I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

_____ ____/____/____
Signature (participant)

_____ ____/____/____
Signature (researcher or delegate)

NOTE:
This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph: +61 2 9514 9772 Research.Ethics@uts.edu.au) and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

S3 Appendix

Appendix 1 - Qualitative Interview Question Guide

1. Do you recall your first experience billing your first MBS item? Can you tell me about that?
2. How did you initially learn to navigate the MBS?
3. Do you feel that your education, including undergraduate, post graduate and CME, has adequately equipped and informed you in relation to your MBS compliance obligations? If the answer identifies deficiencies: What do you perceive as being the nature of the deficiencies? Do you have any suggestions as to how the deficiencies might be addressed?
4. Have you ever encountered any problems or difficulties claiming MBS reimbursements that affected you personally? Have you ever encountered any problems or difficulties that affected your patients?
5. What do you understand as being the purpose of Medicare and having a provider number? How do you enact this understanding in day-to-day practice?
6. What do you view as your rights, obligations and responsibilities in relation to Medicare and the MBS?
7. Are you aware of possible repercussions for non-compliance with the MBS? Do you feel any concern about possible repercussions for non-compliance?
8. Do you manage your own MBS claims or do you outsource or delegate this task to third parties (such as practice managers or billing services)? If yes: What benefits do you perceive from doing this? What potential risks do you perceive from doing this?
9. What level of detail are you able to recall about your claiming patterns and practices?
10. Do you perceive differences between bulk billing transactions and other transactions? In what circumstances do you perceive you are able to charge additional fees to your patients?
11. Do you perceive any external pressure in relation to your claiming? What is the basis for this perception? (Note whether these are different in differing practice types e.g. corporate v. solo practice)
12. What do you perceive as being the relationship between your compliance obligations and patient care? Do you perceive that your billing patterns may impact patient care?
13. What types of support do you seek in relation to MBS billing? How often do you seek support in relation to your claiming? What do you perceive as being the quality of the support you receive? Where are you most likely to turn to for support in this area?
14. Do you perceive barriers or issues that prevent you from seeking or gaining assistance?
15. Do you perceive that your MBS claiming is compliant with current standards in your current practice setting? Why? Why not? Would you feel confident if you were audited by Medicare or the PSR? Why? Why not?
16. What do you understand about the aftercare claiming rules?
17. What do you understand as being the patient's role in a bulk billing transaction?
18. What do you understand about the rules around valid referrals?
19. What do you understand about the provider number rules and which one to use when?
20. What do you understand about the rules concerning the charging of Veterans, serving members and WC/TP patients?
21. What are your perceptions in relation to your claiming patterns and your responsibility for the national health budget?

CHAPTER 7: Discussion

7.1 A tangled, voluminous, morass of medical billing law

With the exception of the introduction of the PSR in 1994, not much changed in the Medicare billing system between 1975 and 2000. In hindsight, those years, before complexity crept in and then increased exponentially, were perhaps the perfect opportunity to introduce education for MP, and build curriculum content around Medicare billing law and practice. But, as has been demonstrated in the preceding chapters, there was no appetite for Medicare education initiatives at the time. Now unfortunately, it may be too late.

This discussion chapter dives deeper into the legal and administrative machine driving the Medicare payment and financing system, to examine and contextualise the many problems and experiences already identified. We will consider whether complexity itself is the core problem. After all, treating sick humans is complex and MP are easily able to integrate complex rules and systems into daily medical practice operations. Compliance within complexity should therefore be achievable within this cohort of highly intelligent individuals. That is of course, unless the complexity has become labyrinthine to the point where constructing a coherent curriculum would be impossible, or, like Australia's business laws, has become so convoluted that even highly intelligent, specialist corporate lawyers who have spent decades training to interpret and apply the laws, are struggling to navigate their opaque requirements (Butler 2021). A Gordian Knot of this magnitude, if it exists, would logically also impact the ability of government agencies to maintain control and oversight of the scheme.

Before proceeding, it is useful to revisit **Figure 5,** to hold in our minds a visual representation of just how much Medicare and medical billing law there is. The multitude of instruments included in that figure extrapolate out to well over 7,300 pages of Acts, Regulations, Determinations, Rules, Directions, Terms and Conditions, Schedules, Website Pages and

Guides. Noting this *excludes* all of the PHI medical fee schedules (which contain further rules), all of the State and Territory Health Acts, Policies and Enterprise and ROPP Agreements, the entire content of the MBS Online website (with the exception of the MBS book), all content on the DOH website (which overlaps with the MBS online website and is sometimes inconsistent with it), a file comprising over 6000 lines being the medical fee schedule located on the Victorian Transport Accident Commission website (which includes another set of bespoke rules), relevant content from the IHPA and AHPRA websites, and every Covid related instrument. If all of the excluded materials were added, it is conservatively estimated that the total number of pages of important medical billing content that MP are expected to know, or at least be familiar with, would exceed 20,000.

In 2020 alone, 255 statutory instruments were added to the Federal Register of Legislation which included the words 'Health Insurance' in the title, and only 53 of those were Covid-19 related. Therefore 202 statutory instruments relating to 'Health Insurance' were enacted in one year alone, all of which impacted MP billing compliance in some way.

By comparison, the *Corporations Act 2001 (Cth)* has a relatively modest 3,000 plus pages (Isdale and Ash 2021), and in Australia's most populous state, the State of New South Wales (NSW), the NSW State Register of Legislation, records just five statutory instruments made under the *Road Transport Act 2013* (NSW Government 2013), setting out road transport and road rules in NSW, comprising 911 pages, which includes the Principal Act.

7.2 Is effective oversight by the Australian National Audit Office even possible anymore?

Over many years, the inner workings of Medicare billing transactions appear to have become as complex and opaque as the darkest corners of the banking and finance sector, largely invisible to both the government and the public. As a result, effective oversight by the ANAO may no longer be possible for the simple reason that you cannot audit what you cannot see.

Millions of enigmatic Medicare billing rules

Monitoring the integrity of medical billing transactions requires deep understanding of myriad layers of different rule types, which to be effective, must be programmed into software systems designed to automatically assess and sometimes reject incoming claims. Dating back to the commencement of Medibank, software has been (and remains) a critical tool in the frontline management of medical payments integrity. However, unrelenting changes made to Medicare over many decades may have impacted the ANAO's ability to properly assess whether government software systems are fit for purpose.

It should also not be forgotten that there is a human element to software system management and maintenance. Though it is beyond the scope of this thesis to examine in detail, it seems likely that departmental software managers may also struggle to keep pace with the demands placed upon their teams to implement relentless change, and construct logical algorithms from opaque, poorly defined rules. In addition, the legacy software systems they administer may not even have the capabilities and sophistication necessary to enable integration of every new rule type, meaning some rules that may be critical in preventing incorrect distribution of public money, may not be programmed in time, or at all. Some of the common rule types currently found in the Australian Medicare system are set out in **Table 8**.

Table 8 - Non-exhaustive list of common types of Medicare billing rules

	Rule type	Examples / Details
1	Legal restriction	When bulk billing, doctors are not legally permitted to charge a gap. For example, administration or booking fees are illegal when bulk billing, but usually not otherwise.
2	Doctor-based item access rules	Only Fellows of the RACP can claim items 110 and 116. Only Fellows of the RACGP can claim items 23, 36 and 44. Only a cardiac surgeon can claim cardiac bypass surgery.
3	Doctor-based item claiming rules	A surgeon has access to request an MRI but cannot claim it. Only a radiologist can claim it.
4	Prerequisite not fulfilled	Eligible physicians cannot claim item 133 without having claimed a prior 132 for the same patient in the same year.
5	Other item numbers required	Cannot claim an anaesthetic initiation item without also claiming an anaesthetic time item.
6	Patient-based rules	Must bulk bill if patient is homeless or is the parent of a child under 12 months (GP Covid requirements).
7	Time of day restriction	Item can only be claimed after hours.
8	Length of time rule	Item 132 requires a minimum duration of 45 minutes. Item 23 requires a duration of between 6 and 20 minutes.
9	Frequency restriction	One item 880 per patient per week. Two item 133s per patient, per annum.
10	Setting rules (e.g. inpatient or outpatient clinic)	Inpatient (admitted to a hospital) or outpatient, such as the new electrocardiogram items introduced on 1 August 2020. Cardiac bypass surgery cannot be performed in an outpatient setting.
11	Modality rules	Whether face-to-face or telephone or video or a combination.
12	Group-based restriction	Items 170-172 for family group therapy. Specific rules for numbers of participants in the group and therapeutic outcomes. Case conference items list different types of participants who must be present for the group meeting.
13	Formula-based fee reduction (surgical/diagnostic imaging multiple service rule/surgical assisting rules)	Step down rules for surgical procedures. Highest paying item paid at 100% then 50% then 25% for other items. Reductions when diagnostic imaging provided with other services. Surgical assistant claims are formula driven and based on the item numbers the surgeon claims. Surgery discontinued on medical grounds calculated at 50% of the fee for the surgery had it proceeded as planned.

14	Should be bundled with other services	Shoulder reconstruction (item 48960) and tendon or ligament transfer (item 47966) should not routinely be unbundled and co-claimed.
15	Diagnosis based	Chemotherapy services not claimable in the absence of a cancer diagnosis.
16	Doctor hierarchy restriction	Junior registrars cannot claim public hospital outpatient services because they cannot exercise a right of private practice.
17	Correct referral pathway	Geriatrician item 141 must be referred by a GP and no-one else.
18	Multiple consulting doctors	Locum tenens rules prohibit multiple doctors each claiming an initial attendance for the same patient.
19	Patient-based restrictions under PHI	Claims by a cardiologist for an admitted bronze policy holder not automatically payable, even if patient develops cardiac symptoms.
20	Legal precedent	Federal Court *Nithianantha* decision holds urgency is decided only after attending the patient not during initial phone contact.
21	Contractual limitation e.g. Deed, NHRA	Referrals to public hospital outpatient departments must be named, pursuant to NHRA, whereas Medicare says the opposite.
22	Health fund flagged (e.g. cosmetic)	Rhinoplasty for purely cosmetic purposes not claimable but can be part cosmetic and part non-cosmetic. Requires splitting of operating and anaesthetic time.
23	PHI rules	Some PHIs allow doctors to choose no-gap or known-gap case by case. Others lock them in to one or the other.
24	Public hospital billing rules	Public patients who choose to remain public cannot be charged. Patients presenting to public hospital emergency department cannot be charged until after a decision to admit has been made.
25	Ineligible patient rules	Injured worker and motor vehicle accident patients are usually deemed ineligible and cannot be billed to Medicare.
26	Claim type (e.g. case based or per diem)	PHIs contract with private hospitals to bill some services as a bundled case payment and others are required to be expressed per diem. This relates to accommodation and theatre fees.
27	Not law but generally followed	Eligible veterans are usually not charged gaps even though there is no legal barrier to gaps being charged.
28	Age-based rules	Item 135 – child under 13 years Item 25014 – patient 75 years or more
29	Gender-based rules	Prostate tests and treatments on biological males Ovary and uterine tests and treatments on biological females

Table 8 is a non-exhaustive list of just some of the rationing rules that currently exist within the Medicare scheme. The application of these rules means that each individual item in the schedule can be the subject of literally hundreds of separate rules, as illustrated in the

example in **Table 9**, which is a very simple item number for the dressing of a localised burn - item 30003 (MBSOnline 2020).

Table 9 – Item 30003 description

Group T8—Surgical operations	
Column 1 **Item**	**Column 2** **Description**
Subgroup 1—General	
30003	Localised burns, dressing of, (not involving grafting)—each attendance at which the procedure is performed, including any associated consultation

Fee-for-service health systems transact high volumes of low-cost services such as item 30003, which currently attracts a rebate of approximately $30 depending on the context. This necessitates precision processing to ensure correct distribution of every dollar spent, and modern software systems used for this purpose require programmable logic. The complex logic required to program relevant billing rules for item 30003 alone would involve answers to the questions shown below in **Table 10**, and based on the answers (some of which are unclear and therefore unknown), implementation of the described logic as an algorithm.

In addition to what is conservatively estimated to be between 300 and 500 distinct rules for this one item (some rules may be able to be bundled into programmable logic, but the majority will be distinct), certain matters are unable to be programmed in a computerised system, such as whether an MP can claim the item if a nurse dresses the burn. In addition, these rules do not include payment rules and rebates which are layered over the top of these base rules, and which this research found number over 30 per item number (Faux, Wardle, and Adams 2015).

Extrapolating across the approximately 6000 item numbers in the schedule, it is conservatively estimated that an effective rules-based claims processing system for the MBS would require a minimum of two million algorithmically programmed rules. Without it, comprehensive oversight is impossible, and even with a rules-based system of this size and sophistication, some transactions will escape scrutiny.

Table 10 - Algorithm to program rules for MBS item 30003

Question	Algorithm depending on answer to question
Who can claim this service?	Allow if provider is Vocationally Registered (VR) general practitioner, non-VR general practitioner, dermatologist, plastic/reconstructive, hand surgeon or emergency physician. Flag if provider is any other provider type but do not hard block – send for human review.
Which graft services *can* be co-claimed?	Allow claiming with items having the prefix graft* if vascular, gynaecological, ENT, ophthalmology, spinal surgery, nerve, jejunal, mucosal or bone grafts. Disallow co-claim with certain burn graft items and some plastic/reconstructive and hand surgery items which may be associated with the burn. Total rules will be well in excess of 200 because there are well over 200 non-sequential items in the schedule with the word or prefix graft* (MBSOnline 2020)
Which 'associated' consultation items are restricted?	Block with items 104 and 105, 3-44 because provider most likely a surgeon or GP. Flag with items 110 and 116 because provider may be a physician and have reason to claim. Allow with all other attendances such as pre-anaesthetic attendances (item 17610) as patient may require general anaesthetic and item 17610 would be an appropriate co-claim.
Which items are hard blocked?	Block with 30006, 30010, 30014, 30017 and 30020.
Is it an inpatient or outpatient service or both?	Allow as both inpatient and outpatient claim.
Do diagnostic imaging multiple service rules (DIMSR) apply?	Apply all of DIMSR A, B and C to service.
Is an anaesthetic rebate applicable?	Disallow if claimed as a single service with all anaesthetic items. There are hundreds of anaesthetic items in the schedule. This would therefore add hundreds of separate rules.
Is an assistant rebate applicable?	Disallow with surgical assistant item numbers.
Can multiples be claimed?	Allow multiples on same day but require times and sites.
Public hospital ED?	Disallow if facility ID on claim is linked to public hospital.
Private hospital ED?	Allow if facility ID on claim is private hospital.
PHI rules if any. Which policies is this covered under?	Allow if online eligibility check shows patient policy is higher than basic. Skin is not covered under basic PHI policies.

Duplicate payments in public hospitals

In addition to service level rules, a previously mentioned ANAO report described deeply troubling issues relating to duplicate payments in public hospitals, and the Department of Health's (DOH) inability to determine whether such claims are compliant. The report highlighted a potentially significant cost of incorrect billing in this area, noting available estimates were likely conservative. **Figure 8** below (copied directly from the ANAO report) shows the estimated quantum of this public hospital problem (Auditor-General 2019).

Figure 8 - Estimates of duplicate payments for public hospital services

Table 2.5: Estimates of potential Australian Government duplicate payments for public hospital services

	2014–15	2015–16	2016–17
Total potential matched MBS payments paid excluding any MBS payment relating to day of admission and separation/discharge	$122m	$130m	$172m
Total potential matched MBS payments paid including any MBS payment relating to day of admission and separation/discharge	$249m	$272m	$332m

Note: Because of technical difficulties regarding matching of non-admitted care records, the above amounts likely underestimate potential duplicate payments for non-admitted care.

Source: ANAO analysis of Funding Body documentation.

The Auditor-General attributed the differences in the two rows of the table to difficulties establishing whether services were provided on the same day as the patient was an inpatient of the hospital and was therefore a true duplicate of a publicly funded service, or was a separate privately provided service. While the ANAO correctly stated that year-on-year increases in duplicate payments across the MBS and NHRA were a significant problem, it fell short of articulating specific details of alleged illegality other than to suggest an inconsistency with provisions of the NHRA.

Since the 1990s the MBS has been an important legally permissible source of funding for public hospital outpatient departments (OPD). In 2011, when the NHRA and Activity-Based Funding (ABF) were introduced, an alternate funding stream for OPD, known as 'tier 2 clinics', became available (Independent Hospitals Pricing Authority 2021), though the principal focus of ABF was admitted patient care based on diagnosis-related groups. This was enabled through the introduction of clinical coding of all inpatient episodes using ICD and ACHI codes. Coding of non-admitted patient episodes was never implemented for many legitimate reasons, including coding workforce shortages, the high labour costs associated with coding millions of daily encounters, legacy technical barriers caused by thousands of fragmented software and manual systems, split responsibilities between state and federal governments, and the entrenched, ubiquitous MBS itself.

Therefore, unlike other countries where all OPD encounters are coded, such as the U.S, which uses a combination of ICD and CPT codes, Australia does not now and has never formally coded non-admitted patient care. Instead, we report OPD activity using a confusing mix of tier 2 clinics, minimal use of a small sub-set of ICD codes (allocated without coding standards or rules), and the MBS. The ANAO report makes clear this is becoming increasingly problematic. Tier 2 clinics are administered differently between states, but generally provide funding based on imprecise metrics such as counts of occasions of service within broadly defined specialty areas (Independent Hospitals Pricing Authority 2020c). For example, all patients attending an orthopaedic fracture clinic are funded equally; however, what cannot be known without coding individual patient encounters is the specific details of why each patient attended. It is the very same problem that has plagued the MBS for 40 years. The government has no visibility over why each patient was there because the tier 2 model essentially counts rather than codes patients. The number of patients attending a clinic each day is known, but the granular detail of why each was there and what treatment was provided is not known. As a result, precision costing of services delivered to patients attending a public hospital OPD remains beyond reach. When coupled with parallel though distinct MBS funding, duplication is inevitable.

Analysis of the various legal requirements in this critical area of public hospital funding suggests the root cause of intractable and significant Medicare leakage in the OPD setting is once again, opaque, interpretive law. One example was well articulated by the Victorian Auditor-General in 2019 when he noted than a MP who complied with a direction issued by the Victorian Health Department could be in breach of the same provision if IHPA's interpretation was applied.

'[Victorian DOH] guidance states that procedures undertaken during a public specialist clinic appointment must be provided free of charge. However, IHPA's 2017 guidance on the NHRA differs from [Victorian DOH's] resource kit…IHPA's guidance notes that, for example, diagnostic imaging undertaken for review in a public clinic three days prior to an appointment is also included within the occasion of service and therefore cannot be separately claimed through MBS.'(Victorian Auditor-General 2019)

Analysis undertaken of relevant sections of the NHRA and its interface with the HIA suggest that duplicate sources of public and private funding for the same service may in many instances be legal, or at least not be clearly illegal.

Before presenting examples to illustrate this point, it should be noted that, as has already been explained in Chapters 1 and 4, ROPP arrangements differ across Australia, and there may therefore be some variance in the following examples in different Australian States and Territories. However, the overarching requirements of the NHRA apply nationally, and all ROPPs operate similarly, using one of the following three models:

1. 100% retention model, where the MP personally retains all billings
2. 100% donation model, where the MP donates all billings to the hospital
3. Blended arrangements with or without associated licences and fees, having enormous national variability

The following examples of a common patient journey through a public hospital for a straightforward colonoscopy procedure, are intended to assist in understanding where potential duplication is occurring, why it occurs and any areas where legal issues arise. To avoid over-complicating the following already very complex scenarios, the anaesthetist for each procedure, who could be subject to entirely different fee arrangements from the MP doing the colonoscopy, has intentionally been excluded, and all patients are assumed to be Medicare eligible.

Scenario 1 – *Patient is privately insured, and the treating MP is an employee*

A privately insured patient, who attends a public hospital for a simple colonoscopy, intending to go home the same day, will be formally admitted for the procedure, provided they elect to use their PHI. The hospital accommodation and operating theatre charges for the inpatient episode will be claimed through the patients PHI. The employed MP will usually exercise a ROPP and will also bill the patient's PHI using gapcover schemes, though the PHI may not honour scheme requirements (this is explained later in this chapter). Payment of the MP's claim will usually be deposited into one of the hospital's bank accounts, and the revenue will be used by the department in which the MP works, to employ staff, for research, purchasing equipment for the department and other related purposes. Duplicate payments are usually avoided in this scenario because of robust public hospital reporting requirements (Australian Government 2020-2025). The patient will typically spend a total of approximately four hours at the hospital before being discharged home.

Scenario 2 – *Patient is privately insured, and the treating MP is an independent contractor*

The main difference between this and scenario 1 is that the MP retains the entire medical fee payment from the PHI, which is deposited to a personal bank account of the MP. Duplication is usually well managed in this scenario due to the same robust public hospital reporting requirements and internal hospital administration processes, which should prevent the episode being counted twice. The contracted MP will usually pay a facility or licence fee to the

hospital for use of space, services, and equipment, often in the order of 20–30% of private billings.

Scenario 3 – *Patient is privately insured, and the treating MP is a level 2–5 employed MP in NSW*

The main difference in this scenario from scenario 2 is that there is no facility or licence fee paid to the hospital by the MP. Sliding scale arrangements operating in NSW give MP options to exercise different levels of ROPP, which enable gradual sacrifice of more of their salary in return for retention of a greater share of private billings. In NSW, at level 5, the MP retains all private billings, whereas a level 2 MP retains only 25%. Once again, because the patient is admitted, the risk of duplicated payments is reduced, though not eliminated.

Scenario 4 – *Patient is not privately insured, and the treating MP is an employee*

At the time of making their appointment, this patient will be asked to obtain a named referral, usually from a GP, and bring it with them to their appointment. On arrival, the patient will check-in at the very same reception desk where patients with PHI check-in, but will usually remain an outpatient, and be asked to consent to be bulk billed through the Commonwealth MBS. Practically, there is no difference at all in the clinical care provided to a privately insured patient wheeled out of the operating theatre and the MBS billed patient who is next in the queue. The difference is purely administrative, with one patient being formally admitted and the other not, of which most patients would not even be aware. In this scenario, the employed MP, who is legally entitled to exercise a ROPP, will bill through the MBS. There is no apparent unlawful conduct on the part of the MP in billing to the MBS in this context. The MP is not a signatory to the NHRA and therefore cannot be found in breach of it due to the principle of privity of contract (Paterson, Robertson, and Duke 2012), though it is possible the MP may have failed to comply with a direction from their state health department. If the hospital subsequently submits a duplicate claim to the Commonwealth through tier 2 arrangements for the same service, the duplication will represent a breach by the hospital, not the MP. When

this happens, the Commonwealth pays twice for the same service, firstly through MBS billing, and secondly through tier 2 arrangements, both payments being deposited into bank accounts of the hospital, albeit usually into two different accounts. The MP reimbursement will usually be deposited to the same hospital bank account described in scenario 1. An exception is that under the NSW sliding scale arrangements described in scenario 3, a level 5 MP would have directed the Medicare rebate to a personal bank account, not the hospital's, and the hospital would therefore only have been paid once, similar to scenario 5.

Scenario 5 – *Patient is not privately insured, and the treating MP is an independent contractor*

This patient will also be asked to bring a named referral and consent to be bulk billed through the MBS as an outpatient, as per scenario 4. The contracted MP will usually have a licence agreement with the hospital as per scenario 2. This complex scenario presents a high risk of duplication, though any illegality is again unclear. Like the MP in scenario 4, the independently contracted MP did not sign the NHRA and therefore cannot personally breach it. As already discussed, in NSW, these MP are permitted to exercise a ROPP and are expected to bill through the Commonwealth MBS as their principal source of income, with such revenue being deposited to their personal bank accounts, not the hospital's. This means the hospital is not paid at all for the service other than the modest 20-30% licence fee. If the hospital were to instead admit the patient, it will receive a significantly higher reimbursement through ABF, but this will cause the MP to be denied income because public admitted patients cannot be billed through the MBS at all. If the hospital subsequently submits a duplicate claim to the Commonwealth through tier 2 arrangements for the same service, the duplication will represent a breach by the hospital, not the MP. Unlike scenario 4, in this scenario the hospital will only be paid once for the service, as will the MP, though the Commonwealth will have paid twice. There is again no clear illegality on the part of the MP. In addition, Federal Government options to enforce repayment of alleged erroneous claims appear limited, on the basis of two threshold issues in any contested legal proceedings; the first - determining the offence or breach, and the second - knowing who to sue.

Scenario 6 – *MP is experiencing provider number problems*

Another confounding variable in this area relates to MP provider numbers. Medicare increasingly refuses to allocate provider numbers to MP, particularly attached to public hospital locations, where MP may sometimes need more than one provider number for legitimate reasons (discussed in chapter 4). When this occurs, the MP often has no option other than to bill to Medicare using a provider number which is not linked to the public hospital location. The government is unlikely to find claims processed in this way (noting such claims could be made by both employed and contracted MP), and such conduct does not clearly breach any particular law.

Issues of employed versus contracted MP and provider numbers aside, another consideration when examining the legality of ROPP administration relates to whether an MP was actually exercising a ROPP at the time the service was provided, though this has proven notoriously difficult to establish. For example, an employed MP with a 0.8 FTE position, theoretically has 0.2 FTE availability in which to exercise a ROPP. In practice, a typical day in the life of a public hospital MP involves seeing many patients on wards, in OPD and other parts of the hospital, with the MP constantly moving between settings where there are mixtures of public and private patients with no clear delineation between when the MP is or is not exercising a ROPP and the number of hours allocated to each patient category (Lander 2019).

What is apparent is the enormous complexity of ROPP arrangements, particularly in OPD settings. Deeply conflicted legal requirements at the intersection of the NHRA, HIA, State enterprise agreements, ROPP and contractor agreements appear to be the root cause of persistent payment duplication problems. MP participants of this study demonstrated extremely low levels of literacy in this area, clearly indicating they did not know what the relevant requirements were, felt they had nowhere to go for reliable support and advice, and had little control over billing submitted to Medicare under their name and provider number in the public hospitals where they worked. The hospitals had not provided any education or support to the MP in the area of Medicare billing, and the MP did not know the NHRA existed.

The ANAO report states (Australian Auditor-General 2019):

"…the terminology in the Business Rules for the NHRA regarding the use of Medicare in public hospitals has not been amended for clarity and consistency with the Health Insurance Act 1973."

It is both appropriate and necessary that certain provisions of the NHRA and HIA are aligned urgently. However, the problem of duplication will not be resolved through this process alone, because parallel ABF and MBS funding is fundamentally irreconcilable for non-admitted patient care. Solutions will require a new approach with impactful penalties (such as qui tam laws) and a complete rethink about how we count and measure ambulatory care in this country. Unfortunately, until such reform is undertaken, the government can expect duplicate payments in public hospitals to remain prevalent.

Inadequate controls and poor visibility

The ANAO may also be unable to effectively audit another important area already touched upon, which is determining whether the rules programmed into Medicare's software, if they exist at all, are correct. The *Stirling* case *("Stirling v Minister for Finance [2017] FCA 874"),* discussed in previous chapters, demonstrated they sometimes are not. Dr Stirling apparently should not have been permitted to claim items 55246 and 55054, but the government software system allowed him to claim and be reimbursed for both services for five years. It is unclear whether this system error has been rectified, or whether another GP with an interest in phlebology might find herself in a similar situation to Dr Stirling – being prosecuted for claiming items 55246 and 55054 when Medicare had permitted her to do so.

If we pause to consider the MP perspective around this issue, it should be remembered that a fundamental tenet of the MBS system is that if an MBS item number accurately describes a clinically relevant service an MP provides, there is prima facie no legal barrier to the MP claiming it. The schedule changes very often as we have seen, so there is nothing unusual

about a MP claiming new or different services as their clinical practices evolve. However, the question of whether a submitted claim will be paid or not is an entirely separate matter, which may be decided by the vagaries of rules programmed into the government software – if they exist. Some participants in the qualitative interviews of this study expressed heavy reliance on the government or other payers to reject their claims if they were wrong, equating payment with compliance. They held a strong belief that if a claim was paid it must be right. The experience of Dr Stirling makes clear MP are mistaken on this point.

To revisit some of the content in the introduction chapter around just how ambiguous this seemingly simple threshold decision can be for MP, item 14206 (MBSOnline 2020) is another good example. Item 14206 is described as 'HORMONE OR LIVING TISSUE IMPLANTATION by cannula' and is usually claimed in the context of assisted reproductive technology (ART). On the face of it therefore, it seems this service would not be ordinarily claimable by an oncologist, only by an MP qualified in the area of ART - usually an obstetrician/gynaecologist. However, oncologists do implant hormones for the treatment of cancer, as evidenced by content on the Cancer Australia website (Cancer Australia 2020). Further, item 14206 is positioned in a section of the MBS where miscellaneous procedures including item 14221 are found, which is an item oncologists commonly claim in the chemotherapy context. It is therefore arguable that it would be reasonable for an oncologist to form a view that she was eligible to claim item 14206 if that corresponds precisely to the service she has provided, just like Dr Stirling formed the view that he was able to claim items 55246 and 55054 because they were the services he provided.

Another example might be a GP with an interest and training in ear, nose and throat (ENT) surgery forming a view that she was eligible to claim item 41764, which is a nasendoscopy/sinoscopy (a simple outpatient procedure using a thin telescope about the diameter of a string of spaghetti to view the structures in the postnasal space and back of the throat), because that corresponds to the service she provides and is well within her capabilities and scope of practice. Item 41764 is positioned in the surgical, ENT section of the schedule, not the section where the majority of GP services are found, but this fact alone does

not necessarily preclude her from billing it. GP are able to bill the first item in this section of the schedule, which is item 41500 (removal of foreign body from the ear) and 41801 (removal of adenoids, which includes examination of the postnasal space). However, there is currently no certainty as to whether a GP is permitted to claim item 41764. Of more concern, should a GP decide to go ahead and successfully claim and receive payment for item 41764, that does not mean she is entitled to claim it. It could simply mean that the relevant rule blocking a GP from claiming that service has never been programmed into the government software, and the GP may be audited and required to repay possibly hundreds of thousands of dollars to Medicare after years of innocently thinking she was claiming correctly, like Dr Stirling. In addition, calling Medicare for advice prior to embarking on this course of action would seem pointless, given the advice Dr Stirling received was unreliable and wrong.

In addition to MP no longer knowing how to approach claiming and even how to manage threshold decisions concerning whether they should dare to claim an item number for a service legitimately provided, the evidence makes clear the government and its agencies have limited ability to detect non-compliant billing, other than in a few of the more obvious areas such as:

1. Whether claims were paid at incorrect rates, including whether there has been an incorrect application of applicable formulas.
2. High volumes of services by statistical outliers.
3. Instances where multiple doctors have claimed for services for the same patient outside of accepted clinical practice norms.
4. Instances where data matching reveals a service was provided when a MP was outside of Australia.
5. Some simple item level rules that may have failed in the software, such as item 132 only being payable once per year and 133 twice per year.
6. Gender and age-based rules.

One participant in phase three of this project reported her experience of a Medicare audit in which it appeared the government itself had erred in its understanding of its own rule, which

the MP had interpreted correctly. It is unclear to what extent such errors are visible to the ANAO when it conducts performance audits. However, the most recent ANAO report suggests a lack of awareness of serious problems such as this, when MP are falsely accused of breaches they did not commit. Further, not being experts in medical billing, it is possible that ANAO staff may not know what questions to ask the DOH during audit activity, and may therefore be unaware that over time, the list of what the DOH cannot see, and therefore the ANAO cannot audit, has unfortunately become much longer, including:

1. Services which should not be routinely co-claimed, such as a shoulder reconstruction (item 48960) and a tendon or ligament transfer (item 47966). Medicare will likely pay without question because these two items are from different parts of the schedule.
2. Services which do not match the specialty of the provider, such as Dr Stirling.
3. Services which appear to have been claimed more than they should, such as repeated x-rays of the same body part on many consecutive days.
4. Inflated anaesthetic units inconsistent with procedure type, patient health status and duration of procedure.
5. Whether referrals were named, to enable billing in a public hospital outpatient department in accordance with the NHRA.
6. Whether a valid referral existed at all for all specialist services.
7. Whether a public hospital OPD is erroneously claiming unreferred services in the belief that claiming without a named referral is permissible – because it is permissible under Medicare, but not under the NHRA.
8. Whether referrals to public hospital OPD after admitted care have been conducted at arm's length and meet referral law requirements.
9. Whether public hospital day patients (who are classified as inpatients) are being billed to Medicare mistakenly as outpatients because the MP believe a day patient is an outpatient.
10. Whether the MP billing the service actually provided the service or whether a locum provided the service under what both practitioners believed to be a compliant billing and revenue-sharing arrangement.

11. Whether the MP billing the service actually provided the service or whether an MP without a provider number delivered the service, but the hospital is continuing to bill the service using an open provider number of a different MP who no longer works there.
12. Whether other practitioners, such as nurse practitioners, are billing to the Commonwealth for services provided in metropolitan public hospitals in breach of the NHRA.
13. Whether a public patient admission has been delayed, enabling a billable outpatient visit.
14. Whether the decision to admit has been based on a patient's PHI status, such as for colonoscopies, angiography, or chemotherapy.
15. Whether unlawful gaps have been charged and recorded off books.
16. Whether diagnostic imaging has been provided on consecutive days to avoid the multi-service rule.
17. Whether services have been split and billed on consecutive dates of service to enable payment, whereas if billed on the one date of service when actually delivered, the claims would not have been payable due to the application of various restrictions.
18. Whether multiple diagnostic imaging services on the same patient, on the same day and for the same body part were clinically relevant.
19. Whether any service billed and paid was clinically relevant.
20. Whether services provided as part of funded academic research, are being unlawfully billed through the MBS.
21. Whether cosmetic treatments and procedures are unlawfully being billed through the MBS.
22. Whether dual-qualified providers such as pain specialists who are also qualified as rehabilitation physicians are allocating item numbers based on the available rebate rather than the service provided. For example, a pain specialist consultation item pays much less than a rehabilitation medicine item 132.
23. Fictitious services such as aged care facility visits to patients who may be cognitively impaired and have no ability to know or recall the alleged visit.

24. Whether surgical procedures have been up coded, such as claiming a complex caesarean when the operation was in fact straightforward.
25. Whether pathology claiming has been excessive, such as by conducting unnecessary tests on a single sample.

The most recent report by the ANAO into Medicare compliance was tabled in parliament on 23 November 2020 (Auditor-General 2020). The report cross references the previous 2014 audit already discussed, noting the approach of the DOH to compliance had completely changed since 2014 and there was therefore little utility in trying to measure success against it. The 2020 report found the new approach of DOH to MP compliance (which appears to have been largely based on recommendations made by an independent consulting organisation whose report is not accessible), had been partially successful.

Of concern, the estimated quantum of non-compliance in 2018-19 was reported as between $366 million and $2.2 billion (1-6% of a total expenditure of $36.6 billion across 4 programs, of which the MBS consumes 66% or $24.1 billion), apparently based on "a number of consultant reports commissioned by Health based on benchmarking with international comparators and applying research methodologies." (p. 22-23)

To suggest the incidence of non-compliance has reduced by more than 50% over the past eight years in the face of increasing complexity and no education or support for MP, is worrying. Further, the figures appear to be inconsistent with the Australian and international evidence reported in this thesis, and it is therefore suggested the reports upon which these estimates were based should be subjected to public scrutiny to enable detailed analysis of whether, for example, specific areas described in the preceding sections of this chapter, and the remainder of this thesis, have been identified, quantified, and included in the estimates. The dangers of underestimating the incidence of medical billing non-compliance are well documented such as in the U.S where one commentator wrote:

"In the absence of hard facts, estimates from investigative units are normally at least double or triple the size of corresponding estimates from paying agencies, and much energy is wasted squabbling over the truth. Investigative units, closer to the realities of the streets and short of resources, aim high. Paying agencies, defensive about their own control systems, eager not to offend their network of providers, and protective of their program's public image, aim low." (Sparrow 2000: 144)

"…senior administration officials have repeatedly asserted their success in "cutting the Medicare improper payments rate by 45% in just two years." Anyone hearing the administration's claim could be forgiven for imagining that things were looking up…within the Medicare program…They would be wrong on all counts." (Sparrow 2000: xiii)

Medical billing non-compliance by its very nature involves a large proportion of non-self-evident problems, many of which are country and system specific. It is therefore relatively easy to mislead consultants with no experience at the coal face or understanding of jurisdictional nuances administering medical bills, into thinking their methodologies are robust and have encompassed all relevant leakage. However, the client may well know this to be incorrect.

The ANAO report snapshot states, "In 2018-19, Health recovered $49.3 million in claims which should not have been paid." However, two basic flaws in the methodology underpinning the report suggest this statement is lacking an evidentiary basis. Firstly the report fails to distinguish administrative veracity from legal veracity, and secondly the report lacks tangible evidence to prove the $49.3 million of recoveries should not have been paid; the truthfulness of the claims in question do not appear to have been rigorously tested (such as by physical scrutiny of associated clinical and billing records or speaking with patients) and therefore it is equally possible that much of the $49.3 million *should* have been paid on the basis of clinically relevant services having been properly provided, but MP made voluntary repayments fearing they had breached a rule unknown to them and were experiencing Medicare audit anxiety. In these circumstances, MP may have made financial decisions based on the costs of legally

defending a largely incomprehensible and opaque demand being greater than the cost of the claim itself, causing them to acquiesce and pay the government's demand in order to close the matter or avoid being bullied or harassed by the government, which will be discussed further shortly.

In regard to administrative versus legal veracity, the fact the DOH states a claim should not have been paid does not make that position legally correct. In addition to evidence from participants in the qualitative phase of this study reporting departmental advice was unreliable and inconsistent, as will be discussed later in this chapter, the DOH is sometimes wrong in its interpretation of relevant laws and therefore a claim the DOH advises the ANAO should not have been paid, may have in fact been compliant. For example, two of the services which appear to have been included in the $49.3 million figure, are a GP attendance co-claimed with a mental health treatment plan. While the DOH may suggest these two services should not be routinely co-claimed the underpinning law permits it. Moreover, given research informs us that the three most common health concerns managed by GP are psychological, musculoskeletal and respiratory issues, and an estimated 50% of patients attending a GP have more than two diagnosed chronic conditions (Royal Australian College of General Practitioners 2019), it seems likely a significant proportion of the co-claiming of these services was correct, accurately reflecting the good work of GP in community practice, whose patients do not separate their physical and mental health problems, and bring a number of problems to a GP visit to have them dealt with simultaneously (Tokhi 2020).

Notably, the audit expressly excluded what it described as "passive compliance activities, such as education…" focussing again solely on punitive rather than supportive initiatives.

Unique problems in regional public hospitals

This research also found a number of examples of billing confusion leading to potentially worrying examples of system failure and payment duplication that may be affecting some of Australia's most impoverished postcodes, that may have escaped ANAO or DOH attention.

As has been previously explained, charging fees in public hospital emergency departments (ED) is illegal. However, this study found examples of this occurring openly, such as the following information located on a public website (Gawler GPInc 2020).

"Gawler GP Inc is contracted by Country Health SA to provide the Accident & Emergency service for Gawler Hospital…Conveniently Gawler GP Inc operates all its services from the Accident & Emergency Department of the Gawler Hospital (save and except for inpatient services which are carried out on the wards of the Hospital)…

Gawler GP Inc is a private after hours GP clinic and Accident & Emergency Department. As such a gap fee will be incurred for all doctor consultations.

"Gawler GP Inc charges a $35.00 gap fee for all doctor consultations. Cash, EFTPOS and Credit Card payment facilities are available during reception hours (9am – 10pm 7 days a week).

If you are experiencing payment difficulties, we can offer Centrepay or installment payment options to eligible patients."

Gawler Hospital is a public hospital (Department of Health 2020b) not the subject of a section 19(2) exemption (Department of Health 2020a), and it is therefore unclear why patients presenting to a public hospital ED are being charged $35, or how the ED has been turned into a 'private after hours GP clinic'. The only relevant provision of the NHRA applicable to this scenario appears to be Business Rule G21, which states:

"In those hospitals that rely on GPs for the provision of medical services (normally small rural hospitals), eligible patients may obtain non-admitted patient services as private patients where they request treatment by their own GP, either as part of continuing care or by prior arrangement with the doctor." (Commonwealth Government 2020)

The wording of the website does not appear to offer choice to patients in accordance with the above clause, though the clause itself is somewhat ambiguous. Relevant resources of the

South Australian Health Department provide further information describing these arrangements as a *'four-bay designated short stay unit, co-located within the ED…[providing]…assessment and/or therapy for select conditions'* (SA Health 2021), and a related service agreement describes the commonwealth funding arrangements pertaining to Gawler Hospital (Government of South Australia 2020-2021). While it is common to find separate legal entities operating within public hospitals, such as cafés, flower shops and other small businesses, operating a separate private ED raises many questions. The key question is whether patients can elect to be treated free of charge in the public section of the ED (if that exists), rather than paying in the separate private section. Additional questions arise around potential duplication of Federal and State funding because patients attending the 'private ED' appear to be being billed through the commonwealth MBS with a $35 gap, while the related service agreement just mentioned, indicates the provision of Commonwealth Activity Based Funding.

The conduct of private health insurers in relation to gapcover schemes

A further area that appears to have escaped the attention of government audit activity, where Medicare payments may be subject to exploitation, is the conduct of PHI in relation to simplified billing schemes, commonly referred to as gapcover schemes (discussed in Chapter 4). Most PHI now impose questionable restrictions in relation to the operation of their gapcover schemes for patients in public hospitals. Some refuse to pay above the Medicare schedule fee at all, and force public hospitals to revert to onerous manual claiming processes that existed in the 1990's (HCF 2020); others routinely delay legitimate payments, while others refuse to honour gapcover arrangements at all. For example, Medibank Private's Gap Cover terms and conditions (Medibank Private 2020) state:

"15. Benefits not payable. Benefits are not payable pursuant to the GapCover scheme – and no benefit may be payable at all under Fund Gap arrangements – in the following situations: …(h) if the service was performed by a salaried doctor at a public hospital (even if exercising rights of private practice);" (Medibank Private 2020)

Similar provisions with the same effect are found in the terms and conditions of HCF's gapcover scheme which states:

"'Private Practice' means services provided by a Recognised Provider operating in an independent and self-supporting basis either as a sole trader, partnership or group private practice but not employed or engaged by or subsidised by the Commonwealth or a State or Territory government for the provision of accommodation, facilities or other services. For the avoidance of doubt Private Practice does not include medical practitioners employed by or contracted to a public hospital or any other type of publicly funded facility even where they are undertaking the services as part of Private Practice arrangements." (HCF 2020)

Section 73BDDA of the *Health Legislation Amendment (Gap Cover Schemes) Act 2000* (the Act) expresses its purpose as enabling a registered organisation [a PHI] to "*offer insurance coverage for the cost of particular hospital treatment and associated professional attention for the person or persons insured…greater than the Schedule fee (within the meaning of Part II of the Health Insurance Act)…for the person or persons insured…*[where] *there is not a medical purchaser-provider agreement…and the person insured pays a specified amount or percentage under a known gap policy or the full cost of the treatment or attention is covered under a no gap policy*." (Australian Government 2000)

Central features of Section 73BDDA are:

- That both hospital and 'associated professional attention' or MP services are covered.
- That the benefits of gapcover schemes are intended to be afforded to policy holders (or patients) who enter insurance contracts with the PHI and pay relevant monthly premiums, and who also subsidise the PHI industry via their taxes (Stephen Duckett 2019).
- That no formal contract, such as a 'medical purchaser-provider agreement' is required as between the PHI and the MP.
- The amount payable under gapcover schemes must be 'greater than the Schedule fee'.

The terms and conditions of many PHI, including those already quoted, appear to be inconsistent not only with the spirit of the *Gap Cover Schemes Act*, but also with key requirements of Section 73BDDA. For example, if a privately insured patient is admitted to a public hospital and wishes to avail their PHI policy, the legal basis for the PHI honouring the requirement to cover the hospital treatment of that admission (this comprises accommodation and any operating theatre fees) but denying the associated MP treatment is nowhere apparent. The legislation states "*hospital treatment and associated professional attention for the person or persons insured…"* The statute does not use the conjunction *'or'* which it is suggested would have been included had that been the legislative intention.

Further, refusing to pay above the Medicare schedule fee presents a compelling, prima facie legal argument that some PHI may be acting contrary to the provisions of the Act. The Act also provides that gapcover schemes must be approved by the Minister and once approved, strictly adhered to, and the Minister cannot approve a gapcover scheme if it does not pay 'greater than' the Medicare schedule fee. It follows logically that if a PHI is not paying 'greater than' the Medicare schedule fee, it is non-compliant with its approved scheme.

The practical mechanism of this conduct occurs when the various MP who are treating a private patient in a public hospital are reimbursed differently for no apparent reason other than the PHIs being locked in battle with public hospitals, which they have long believed are competing for private patients (Kruger 2019). For example, if a surgeon operating on a patient is independently contracted to the public hospital, she may be entitled (under some PHI, but not all) to be reimbursed at gapcover rates, whereas if the anaesthetist for the very same operation on the same patient is a salaried employee, gapcover rates for her will be denied. The patient will have no knowledge that their PHI is denying one or more of the treating MP gapcover benefits, which the patient has paid for via their monthly premiums.

MP treatment represents on average 16% of the total cost of a hospital admission (Australian Medical Association 2020) and many patients admitted to public hospitals are either delivered there by ambulance or present with an acute unexpected illness or injury. When this occurs,

patients usually do not have the option of instead presenting at a private hospital because very few private hospitals have emergency departments in Australia. Therefore, preventing these patients from accessing the full benefit of their PHI policies, appears to be nothing more than a crude method of curtailing a legitimate public hospital revenue stream, effectively rendering PHI useless in public hospitals (where many younger policy holders may likely wish to use it), with complete disregard for patients and the law.

The recently revised NHRA (Commonwealth Government 2020) includes a new provision explicitly preventing PHI from delaying or refusing to pay eligible claims for private patients in public hospitals. However, the drafting of the clause is broad and vague (what is an eligible claim?) and is unlikely to have any deterrent effect on PHI anyway because like MP, the PHI are not signatories to the NHRA.

Most PHI also impose terms that may place MP in direct conflict with legal requirements under the HIA (discussed in Chapter 4), and despite the new provision in the NHRA, routinely delay payments. In this context the concern extends to the integrity of Medicare money transferred to the PHI under gapcover schemes (also discussed in chapter 4) but not passed to the MP. Such delays appear to be applied arbitrarily and differently by PHI, many of whom have established a modus operandi of making the passage of public money contingent upon proof of a corresponding hospital bill (for the accommodation and operating theatre fees, which have to be coded by clinical coders once the patient is discharged) over which MP have no control. Further, the impact of a global shortage of clinical coders (Shepheard J 2010) means long coding backlogs are common, and therefore corresponding delays passing public money to the legally entitled end beneficiary may extend for many months.

This research found that gapcover schemes have effectively become junk in the context of public hospital medical service delivery, through deliberate abuse of untested legal provisions, not by MP, but by the PHI. The original policy intention of these schemes; to simplify hospital billing and eliminate patient OOP, has failed, with gapcover insurance having become as pointless as motor accident insurance that only covers weekday accidents. Addressing these

important issues will require legislative tightening or litigation, though it is unclear to what extent the ANAO or DOH are aware of this significant problem.

In addition to gapcover schemes, the government's compliance challenges were further compounded with the recent introduction of tiered PHI policies (Department of Health 2020e), which may have created another blind spot in the passage of public money. Reports on the efficacy of this new system (which effectively requires patients to gamble with their health) have been unfavourable, describing increased rather than decreased consumer confusion (Engel 2019). This may not be surprising given the design was fundamentally misaligned with Medicare's structure. Creating tiered products under which Medicare would cover everything, but PHI would not, was arguably always unworkable. A summary of the new schemes taken from the DOH website (Department of Health 2020e) is provided in **Figure 9**.

Figure 9 - Tiered private health insurance arrangements

HOSPITAL TREATMENTS BY CLINICAL CATEGORY	BASIC	BRONZE	SILVER	GOLD
Rehabilitation	✓(R)	✓(R)	✓(R)	✓
Hospital psychiatric services	✓(R)	✓(R)	✓(R)	✓
Palliative care	✓(R)	✓(R)	✓(R)	✓
Brain and nervous system	O (R)	✓	✓	✓
Eye (not cataracts)	O (R)	✓	✓	✓
Ear, nose and throat	O (R)	✓	✓	✓
Tonsils, adenoids and grommets	O (R)	✓	✓	✓
Bone, joint and muscle	O (R)	✓	✓	✓
Joint reconstructions	O (R)	✓	✓	✓
Kidney and bladder	O (R)	✓	✓	✓
Male reproductive system	O (R)	✓	✓	✓
Digestive system	O (R)	✓	✓	✓
Hernia and appendix	O (R)	✓	✓	✓
Gastrointestinal endoscopy	O (R)	✓	✓	✓
Gynaecology	O (R)	✓	✓	✓
Miscarriage and termination of pregnancy	O (R)	✓	✓	✓
Chemotherapy, radiotherapy & immunotherapy for cancer	O (R)	✓	✓	✓
Pain management	O (R)	✓	✓	✓
Skin	O (R)	✓	✓	✓
Breast surgery (medically necessary)	O (R)	✓	✓	✓
Diabetes management (excluding insulin pumps)	O (R)	✓	✓	✓
Heart and vascular system	O (R)	O	✓	✓
Lung and chest	O (R)	O	✓	✓
Blood	O (R)	O	✓	✓
Back, neck and spine	O (R)	O	✓	✓
Plastic and reconstructive surgery (medically necessary)	O (R)	O	✓	✓
Dental surgery	O (R)	O	✓	✓
Podiatric surgery (provided by a registered podiatric surgeon)	O (R)	O	✓	✓
Implantation of hearing devices	O (R)	O	✓	✓
Cataracts	O (R)	O	O	✓
Joint replacements	O (R)	O	O	✓
Dialysis for chronic kidney failure	O (R)	O	O	✓
Pregnancy and birth	O (R)	O	O	✓
Assisted reproductive services	O (R)	O	O	✓
Weight loss surgery	O (R)	O	O	✓
Insulin pumps	O (R)	O	O	✓
Pain management with device	O (R)	O	O	✓
Sleep studies	O (R)	O	O	✓

✓ Minimum requirement of the product tier

(R) Insurers are allowed to offer cover for this clinical category on a restricted basis/with limited benefits

O Optional for insurer to include – not a minimum requirement of the product tier

Under these tiered arrangements, if a patient having neurosurgery experiences a post-operative cardiac event, depending on the policy tier, the PHI may refuse to pay for the required cardiac treatment. And, pursuant to a troublesome clause slipped into the enabling legislation, it is the PHI who effectively manage care in such scenarios, deciding whether to reimburse these types of common events or not, which creates yet another compliance problem for MP.

How was a U.S standard slipped into Australia's Medicare?

Managed care, in which payers are positioned between MP and their patients (Marcus 2000), has never been a major feature of Australia's health system. This is largely due to the protective nature of the CCC, which cocoons the intimate relationship between an MP and a patient in a private contract. However, managed care creep is beginning to appear, where payers (in Australia's case, the PHI) are beginning to ration services and shift control of clinical decision-making away from MP, and impose their own interpretations of compliant claims, separate to Medicare's. One example is the introduction of the U.S standard 'medical necessity', being strategically placed into the PHI regulations as follows:

Private Health Insurance (Complying Product) Rules 2015
(8) For subparagraph (2) (b) (ii), a hospital treatment is an associated unplanned treatment if it is:
(a) provided during an episode in which hospital treatment of a kind described in paragraph (2) (a) is being provided; and
(b) an unplanned treatment that:
(i) is provided as part of planned surgery performed during that episode; and
(ii) is, in the view of the MP who provides the unplanned treatment, <u>medically necessary and urgent</u> (Government 2015b).

It is the 'medically necessary and urgent' provision that enables PHI to deny the example of a neurosurgical patient needing cardiac care. While the regulation states the MP retains control of the decision-making process, the practical reality is that if a PHI refuses to pay, the administrative burdens imposed on MP to prove a service was both medically necessary (a standard not known to any Australian MP) and urgent, are so onerous and opaque that challenging a payment refusal would usually not be worth the effort. In such circumstances MP may find it easier to require the patient to pay up-front fees, but depending on the clinical setting and specific circumstances, this approach may be non-compliant with another law (Faux, Wardle, and Adams 2019).

One U.S study found 'The term medical necessity is rarely defined, largely unexamined, generally misunderstood, and idiosyncratically applied in medical and insurance' (Bergthold 1995). In addition to the recent U.S legal decision (discussed in chapter two) around mere differences of medical opinion no longer being sufficient to prove medical necessity, the term is defined differently by the U.S Medicaid and Medicare systems, differently again by U.S private insurers, and the American Medical Association has its own definition (FindLaw 2018). Further, medical necessity is the subject of much litigation in the U.S, where individual insurers may even use different internal definitions of the term when applying it to physicians, other providers, seniors and other adults (Cigna Insurance). In addition to 'medical necessity' having no settled definition in the U.S, a review of the definitions section of the *Private Health Insurance (Complying Product) Rules 2015 (Cwth)* found it is not defined there either.

Given this research found extremely low literacy among MP in relation to some of the most basic aspects of correct medical billing, adding another standard with a cavernous interpretive space around it, but nowhere defined, will almost certainly expose MP to increased compliance risk. As for the government, a billing compliance dispute for a single claim may now involve two conflicting standards – clinical relevance and medical necessity – and two funding sources - the government and the PHI. For example, a single $100 gapcover claim may now involve $75 (the government portion) being adjudicated under the standard of clinical relevance, and the remaining $25 (the PHI portion) being adjudicated under the separate standard of medical necessity.

Fees for no service

In 2000, when the PHI gapcover schemes were debated in the House of Representatives, only one politician was alive to the fact that the proposed changes to the HIA might have unforeseen consequences. He said:

'I believe that the amendments made to the Health Insurance Act 1973 to allow automatic assignment of a contributor's Medicare benefit to a registered organisation to facilitate

simplified billing and payment arrangements to be built into the gap cover scheme will mean yet one more way in which bulk-billing will be undermined.'(John Murphy - Hansard 2000)

The seemingly innocuous change referred to by Mr Murphy, did indeed undermine the integrity of public money, though the damage was not immediately apparent. Gapcover schemes were dependant on this change, which intermingled public and private money and twenty years later, it appears this may be another area where the ANAO has little practical ability to audit the passage of taxpayers money.

One of the strengths of Australia's blended public/private health system is that PHIs are not permitted to reimburse outpatient services. This ensures all Australians are equal at the 'front door' to our health system, the GP, and ensures Australian's do not see signs at GP clinics saying 'Medicare patients not accepted here', as happens in the U.S (Donley 2018). However, cost pressures are forcing the PHI to explore creative ways to reduce expenditure, and some are actively experimenting with out-of-hospital care by using available Hospital in the Home (HITH) and Hospital Substitute Treatment (HST) arrangements.

Under the HITH model, employed MP (and other clinicians) of a hospital, provide care in a patient's home as part of a hospital admission, and the hospital remains legally responsible for the patient throughout. This model is more likely to be seen in a public hospital where the incentive to reduce bed costs is strong, unlike private hospitals, where their principal source of revenue is derived from bed fees. Problems are therefore found less under the HITH model than under the HST model, where responsibility for the welfare of the patient becomes opaque, and Medicare compliance risks (as well as other legal risks) increase for MP. The legislative pathway enabling HST is set out in **Figure 10**.

Figure 10 – Legal pathway enabling hospital-substitute treatment

Legislative Instrument	Key Requirements
Private Health Insurance Act 2007 Section 69-10 defines HST	HST is General Treatment, and ○ Substitutes for an episode of hospital treatment, and ○ Includes nursing and pharmacological services or goods, and ○ Is not otherwise excluded
Private Health Insurance Act 2007 Section 121-10 defines General Treatment	General Treatment has the following exclusions: ○ General treatment *is not* hospital treatment ○ General treatment *does not include* any service for which a medicare benefit is payable
Private Health Insurance (Health Insurance Business) Rules 2018 Rule 10 links to the above Section 121-10 - General Treatment—and describes services for which a medicare benefit is payable but come within the definition of General Treatment	All services in Groups T1 to T11 of the general medical services table that: ○ Do not have the (H) symbol; or ○ Do not state in the item that the service must be performed in a hospital to attract a medicare benefit; and…services in the above classes must be provided as part of HST
Health Insurance (General Medical Services Table) Regulations (No. 2) 2020 The legal source of most MBS items including services in Groups T1 to T11	5.2.10 commences with the items in Group T1 which are miscellaneous therapeutic procedures, and subgroup 11 includes chemotherapy item 13950. Item 13950 does not include the symbol (H) and does not specifically state the service must be provided in hospital. Item 13950 can therefore be provided as HST.
Private Health Insurance (Benefit Requirements) Rules 2011 Defines a negotiated agreement	With the exception of psychiatric care, rehabilitation, and palliative care, the minimum benefit for treatment is the amount in the negotiated agreement. This amount can be below minimum benefit requirements.

The operation of HST schemes is essentially a convoluted sub-contracting arrangement, the starting point of which, is that a private home service provider must become approved by a PHI. The HCF website currently provides the following HST guidance for its policy holders (HCF 2021b):

'How does treatment at home get organised for me?

You should talk to your treatment team about at-home treatment options while you're in hospital.

We've sent hospitals a list of providers that HCF has contracts with to give treatment at home to members, so they're familiar with the types of treatment at home we'll cover eligible members for and can refer you straight to a provider.

There are no out-of-pocket costs for treatment at home through HCF-contracted HST providers.'

'We have contracts in place with a range of providers to give treatments at home to eligible members when we can make sure the treatment can be given safely and at the same, or better, quality than in hospital.'

The webpage listing HCF's contracted providers includes rehabilitation, intravenous antibiotics and wound care, and home chemotherapy providers (HCF 2021a). We will use home chemotherapy and the claiming of item 13950 to illustrate the compliance conundrum.

Despite contracts between PHIs like HCF, and home treatment providers being confidential, for HCF to make the above statement on its website concerning hospital grade safety and quality, it is reasonable to assume that onerous conditions and contract terms designed to keep patients safe, are imposed on the home providers. In the case of home chemotherapy, the home provider would usually be a Registered Nurse (RN) working within a corporate structure. RNs are regulated health professionals authorised to deliver nursing care, rather than diagnosing, prescribing, or treating patients, which is the domain of MP. Providing home chemotherapy therefore requires a direct professional relationship between the RN and an MP, the latter of whom is the only professional who has legal authority to prescribe the

chemotherapeutic drugs and take responsibility for the overall care of patients. The RN must therefore convince the treating MP that the chemotherapy treatment can be safely given in the patient's home, enter a sub-contract with the MP to that effect, and reassure the MP there will be no financial disadvantages – because if the same service was provided on an inpatient basis the MP would claim using gapcover schemes, but on an outpatient basis, only lower Medicare funding is available. The RN must also sub-contract with a pharmacy to provide the chemotherapeutic drugs and equipment. To solve the MP remuneration problem, and presumably to attract MP to these schemes, the PHIs permit MP to claim item 13950 for the home chemotherapy service under their gapcover schemes. However, the problem is that the MP provides no service, and the usual process of delivery by a RN in the patients home, makes it almost impossible for the MP to meet Medicare's supervision requirements.

Regulation 1.2.11 of the Health Insurance (General Medical Services Table) Regulations (No. 2) 2020, lists services that may be provided by persons other than medical practitioners, *'in accordance with accepted medical practice, [acting] under the supervision of a medical practitioner.'* A summary of services currently included on the list is discussed towards the end of this chapter and shown in **Figure 16**. Common examples of supervised services are blood transfusions and ECGs, where a MP will order the transfusion or test, but it is delivered by a RN under MP supervision, often from somewhere on the hospital grounds, though not always. Knowing how to satisfy these supervision arrangements has always been a grey area, and has become a recent target for the PSR.

Item 12250 is a supervised home sleep study service, and therefore a relevant comparator to item 13950, as both services can be provided in the patients home under MP supervision. **Table 11** shows three recent PSR agreements involving incorrect billing of item 12250 by respiratory and sleep physicians, which resulted in substantial repayments to Medicare.

Table 11 – Recent PSR findings relating to home sleep studies

PSR Section 92 Agreements with Respiratory and Sleep Physicians
June 2019 https://www.psr.gov.au/case-outcome/psr-directors-update-june-2019 The practitioner billed MBS item 12250 on more than 5000 occasions in the year under review and was required to repay $900,000 based on findings the practitioner: ▪ billed for services performed by other practitioners; ▪ did not always provide adequate clinical input into services; ▪ did not always comply with the requirements of MBS item 12250; and ▪ did not always document a clinical indication for the service.
Sept 2019 https://www.psr.gov.au/case-outcome/psr-directors-update-september-2019 The practitioner billed MBS item 12250 more than 2000 times during the year under review and was required to repay $200,000 based on findings that: ▪ MBS item requirements were not always complied with; ▪ services were not always clinically indicated; and ▪ the practitioner did not always provide adequate clinical input.
Oct 2019 https://www.psr.gov.au/case-outcome/psr-directors-update-october-2019 The practitioner billed MBS item 12250 on 2300 occasions (>97 centile compared to peers) and was required to repay $725,000 based on findings that: ▪ the practitioner did not always provide adequate clinical input into all services; ▪ appropriate quality assurance procedures were not in place with respect of the practitioner's rendering of sleep study services; ▪ the MBS requirements were not always met, including ensuring referrals were assessed prior to conducting the sleep study; and ▪ the practitioner provided services that were not always clinically indicated.

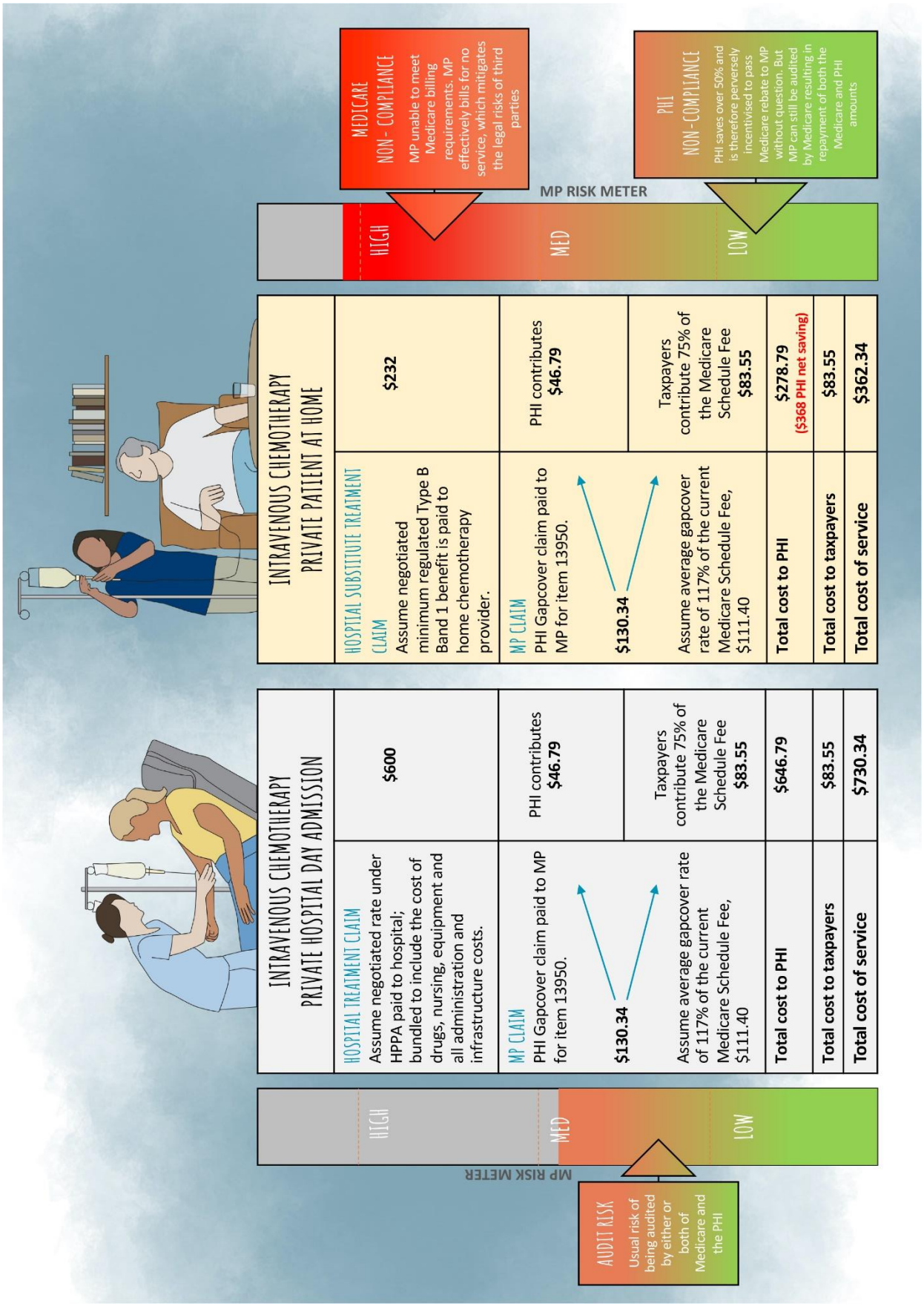
PSR secrecy means it is not possible to know the precise details of these decisions, and the comments of the Director are broad and vague. However, it may not be surprising that supervised home services should come under PSR scrutiny. The fact that significant parts of supervision items such as MBS item 13950 can be undertaken by other staff only serves to reinforce the importance of the MP adequately supervising the arrangements. And although the definition of supervision is vague, the MP must demonstrate some 'direct involvement' in the provision of the service (MBS Online 2020b), which is almost impossible to do. To evidence involvement the MP (not an RN) must enter adequate and contemporaneous records in the patient's file. But the MP is not present at the patient's home, and would be very unlikely to be in a position to make such an entry (having done nothing), and the file may not even be accessible. The only involvement of the MP in this scenario is writing the prescription for each day and dose of chemotherapy, but this alone does not meet Medicare requirements. Writing prescriptions is a core function of the work of all MP, and does not enable the claiming of a service where none was provided.

Without a MP claim for item 13950, both the RN and PHI have problems. Without this claim, there is no evidence of the service legitimately being a hospital-substitute service, supervised by a treating MP. This may put the RN in breach of contract requirements with the PHI relating to MP involvement and supervision, and the PHI in breach of legislated HST requirements. RN providers of home chemotherapy services may therefore pressure MP to bill item 13950 to mitigate their own medico-legal risk, while increasing that of the MP. However, the MP carries the full medico-legal burden in this scenario, both for the patient generally, but also in relation to Medicare billing, and if a MP falls foul of the supervision rules, substantial repayments may result, like those recently imposed on respiratory and sleep physicians. Additional medico-legal risks for the MP are caused by there being no provider location (a MP cannot have a provider number attached to a patient's home), no protection under a hospital's accreditation, and finally, because HST is essentially an outpatient service, the episodes are not coded, meaning no public health data is collected.

From the ANAO's perspective, what is most worrying about HST transactions is the handling of the taxpayer portion of every item 13950 claimed (currently $83.55). It is possible that the PHI may be less concerned about the integrity of these payments, and will pass them to MP without question, if to do so achieves a reduced benefit outlay for them. This is shown in **Figure 11**.

It is suggested that it would be very difficult for the ANAO to audit claims in this rapidly evolving area of Medicare billing, or even know what questions to ask of the DOH, who may themselves have limited awareness of the troubling mechanics of HST.

Figure 11 – Intravenous chemotherapy in hospital versus home



Honeysuckle Health Buying Group

In a very recent development, a joint venture company called Honeysuckle Health, which is part owned by one of the PHI, has applied to the Australian Competition and Consumer Commission (ACCC) for authorisation to establish a 'Health Buying Group'. The Honeysuckle Health Buying Group (HHBG) has a stated purpose of collectively negotiating and managing contracts with health providers, including MP (Australian Competition and Consumer Commission 2021). The application proposes to re-invigorate the previously unsuccessful Medical Purchaser Provider Agreements with MP, which were described in chapter 4. A draft determination by the ACCC dated 21 May 2021 has granted the application, finding that the public benefit would outweigh any likely detriment. The final determination is due by 1 October 2021.

Notably, the previously cited U.S organisation that applies the 'medical necessity' standard differently for different providers owns a 50% share of the HHBG (Cigna Insurance). The HHBG application specifically states there will be no boycotting of any MP. However, the application also provides that the HHBG will assess MP compliance including 'accuracy of claims' and 'excessive use of MBS items', and may make findings of 'fraudulent claims' and would share such findings with other payers participating in the HHBG. Of concern is the fact that despite its assertions to the contrary, the HHBG application seems likely to lead to collective boycotts of MP if for example the HHBG makes a unilateral finding of criminal fraud by an MP, and circulates that decision among group participants.

It is unclear how the HHBG purports to have legal authority to make findings of fraud outside of the criminal justice system, and nor does the HHBG have any demonstrated expertise in medical billing compliance. In fact, the HHBG application expressly demonstrates gaps in the medical billing literacy of the applicant such as by incorrectly stating that the Department of Veterans Affairs (DVA) maintains its own no-gap scheme, enabled by a process of individually contracting with MP, who then do not charge co-payments to DVA policyholders. Chapter 4 explained the inaccuracy of this information.

From the perspective of the ANAO, if this application proceeds to final approval, it is likely to further confound the ability of the ANAO to accurately quantify Medicare claims that should not have been paid, noting that 75% of the Medicare Schedule Fee will remain a component of every medical claim. This is due to the fact that in addition to the DOH, it seems the HHBG intends to exercise self-proclaimed authority to decide when claims should not be paid (based on unknown criteria), and may make demands for repayment from MP. It is unclear whether the HHBG will demand only its portion of such claims, or the Medicare portion as well, and how that process will be administered. Further, if an MP believes she has been falsely accused of fraud or 'excessive use of MBS items' (which is not defined in the application) by the HHBG, the only recourse would be expensive legal proceedings, during which there may be a possible boycott of the MP, preventing income earning ability to fund the legal proceedings. This approach echoes the failed U.S approach to compliance discussed in chapter 2.

The HHBG application has other worrying elements such as being opaque in its terminology around the definition of an 'episode of care' using vague terms such as 'hospital or health experience', and whether this includes outpatient services which are provided pre-and-post-operatively. Chapter 4 explained that MP are bound by the HIA in the outpatient setting, where the PHI have no jurisdiction. If the HHBG seeks to force MP into bulk billing outpatient services, MP may feel pressured to up-code in order to meet practice costs, and the question of whether such claims should or should not have been paid would represent another headache for the ANAO. For example, if a claim is compliant with the HIA but the HHBG suggests it should not have been paid, who is correct?

It also seems likely that an MP may be investigated twice in relation to the same claim, once by the HHBG and a second time by the government, the latter also having the potential to trigger a referral to the PSR. Like the proposed operation of the HHBG, which will operate completely autonomously, without any effective scrutiny insofar as Medicare compliance is concerned, the PSR is also devoid of public scrutiny.

7.3 Does the PSR uphold Medicare's integrity and deliver value to the public?

In addition to finding the ANAO may be limited in its ability to comprehensively monitor disbursement of public money via the Medicare scheme, the next level of scrutiny down the compliance ladder may also be wanting and not fit for purpose.

The PSR was troubled from the start

The enduring mystery around the establishment of the PSR was a lack of clarity on what 'mischief' the new offence of inappropriate practice was intended to remedy. The offence was not only vague by its title, but it expanded the PSR's remit beyond fraud and overservicing (which were the former MSCI offences) for no apparent reason.

The second reading speeches introducing the PSR Bill into parliament (Parliament of Australia 1993) shed no light on this important omission, which appears to have led to the creation of an initially rudderless organisation charged with prosecuting inappropriate practice, but with no benchmark for appropriate practice. This remains so today, with no clear indication of what is 'appropriate practice' or why the word 'practice' is used (implying clinical conduct), when the offences within the PSR's remit relate to financial conduct.

Late in 1993, the extraordinarily wide powers of the proposed new PSR came under criticism, with the former Federal Attorney-General describing them as draconian and profoundly deficient in the rule of law domain of natural justice and procedural fairness (Hon Williams D AM QC 1993). Mr Williams delivered a blistering attack on the proposed new scheme in his second reading speech to Parliament, expressing grave concerns around what he perceived as the scheme making a mockery of natural justice principles, specifically identifying the following components of the new scheme:

- the fact that a person under review (PUR) could be assessed by a general body of peers as opposed to a specific body.

- that statistical sampling could be applied to a whole class of services, meaning a PUR could be found guilty of an offence she/he did not commit.
- that the mechanisms around entering into secret agreements with the PSR director were tantamount to plea bargaining and not in the public interest.
- that full legal representation was not permitted and should be, especially given the serious penalties able to be imposed.
- that If a PUR fails to comply with certain directions, immediate and full disqualification from Medicare follows (he described these provisions as draconian);
- that the Determining Authority did not hear the evidence.
- that the rules of evidence do not apply.
- that the PSR can make findings of overservicing beyond cases specifically before the committee, which he described as 'extraordinary in a penalty proceeding'.
- that proceedings would be conducted in private, therefore avoiding public scrutiny.

His comments proved prescient and in closing remarks he stated:

"…This bill fudges the distinction between a prosecution on the one hand and an inquiry or investigation on the other hand. A review turns into a prosecution without the subject ever having been advised of that transformation or of the particular charge against the person being identified to him at the relevant time. That makes a mockery of the government's assertion that the proposed legislation meets the principles of natural justice and procedural fairness…" (Hon Williams D AM QC 1993)

An agency plagued by litigation

The PSR has been plagued by litigation, particularly in the area of natural justice since it began. Numerous MP have challenged the agency, which has averaged over 10 contested proceedings per year every year for the past 25 years. **Figure 12** sets out PSR activity taken from the annual reports (Professional Services Review Agency 1995-2020).

The agency has undergone significant change over the years, in response to various court decisions (Professional Services Review Agency 1995-2020), though not all have been positive. Many of the concerns expressed by Mr Williams appear to remain, and some may have worsened. For example, the PSR 'court room' where committee proceedings are heard, now typically has more people on the bench than below it, because PSR committee members are now provided full legal support and representation, whereas the PUR is still denied this basic human right. It is difficult to see how justice can be delivered in this environment and is arguably not the direction one might have expected the agency to have taken, given the sustained criticism it has been subjected to for many years.

MP who participated in the qualitative phase of this project were asked about their knowledge of penalties for non-compliant billing, and it might have been expected that the PSR would be mentioned in this context, but this was not the case. MP again fell short in this area of knowledge (discussed in Chapter 6) by not mentioning the PSR or its onerous extrapolation provisions, which applied to all of the GP participants. The extrapolation provisions are commonly referred to as the 80/20 rule.

Figure 12 - PSR 25-year summary

PSR Table	1994/95	1995/96	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	TOTAL
Referrals received (including re-referrals)	1	16	70	48	11	50	68	101	60	42	9	7	27	50	136	39	56	33	49	52	73	93	88	119	104		1401
Dismissed or lapsed		1	5	14	26	4	34	13	18	20	15	0	1	0	1	0	2	17	21	15	13	24	10	1	2		257
Committees established	1	15	30	35	5	7	30	31	17	6	11	2	6	11	47	41	3	0	8	9	10	19	18	23	31		416
PSRC reports to determining officer		8	21	22	20	7	6																				84
Draft determinations made		2	10	24	1	21									20	20	7	0	2	8	6	9	6	13			149
Final determinations (made and effective)			1	29	2	23						5	10	6	23	50	12	0	13	12	15	15	10	31	17		274
Agreements							16	0	21	14	4	8	6	27	75	49	32	19	20	24	18	18	61	49	90		551
Referrals to medical boards / AHPRA							5	0	1	0	1	0	7	4	7	17	6	0	3	4	5	5	15	14	15		109
Disqualifications from Medicare							0	1	1	0	0	0															2
Suspected fraud							0	0	0	0	0	0				1	1		0	0	0	0	4	1	2		9
Court applications (including PSR Tribunals)				28				10	22	13	18	0	6	2		8											107
Federal court hearings (single judge and full court)				19				5	14	3	17	19	8		1	8											94
Decisions handed down in favour of the person under review								3	1	2	5	17															28
Decisions handed down in favour of PSR								2	9	5	8	6															30
High court applications								1	1	1	0	2	0		0	0											5
High court decisions									2	1	0	1	2		2	0											8

The problems of extrapolation in a fee-for-service scheme

The 80/20 rule applies mostly to GP via an opaque technical provision likely unknown to the profession. Adverse findings of inappropriate practice by the PSR can lead to reprimands, orders for repayment of Medicare benefits, and partial or full disqualification from the scheme.

Under section 82(1A) of the HIA, a practitioner engages in inappropriate practice if services rendered or initiated constitute a 'prescribed pattern of services'. Circumstances constituting a prescribed pattern of service are set out in Part 2, Regulation 8 of the *Health Insurance (Professional Services Review Scheme) Regulations 2019 (Cth)*, which provides:

"For the purposes of section 82A of the Act, circumstances in which services rendered or initiated by a MP constitute a prescribed pattern of services are that the MP renders or initiates 80 or more relevant services on each of 20 or more days in a 12 month period."
(Australian Government 2019a)

'Relevant services' are defined as services in group A1, A2, A5, A6, A7, A9, A11, A13, A14, A15, A17, A18, A19, A20, A21, A22 or A23 of Part 2 of the general medical services table, which excludes the most commonly billed specialist attendance items 104, 105, 110 and 116. These services are located in the excluded groups A3 and A4, meaning that if a GP and a General Physician both consult more than 80 patients on 20 days in the same 12-month period, the GP would be found guilty of inappropriate practice, whereas the General Physician would not.

By creating deeming provisions (MP are deemed to have committed inappropriate practice once they provide 80 relevant services on 20 days) based on mathematical assumptions of probability and formulas crafted by actuaries, it is suggested the cornerstone of the Medicare scheme, clinical relevance, has been undermined. Logically, it is not possible for 80 services to be clinically relevant but the 81st not. It appears the extrapolation provisions within Medicare provide that MP should provide clinically relevant services, though not too many (even if they

are all clinically relevant), and as Mr Williams pointed out, adopting this type of blunt approach using statistical sampling may result in manifestly unjust results, such as being found guilty of an offence not committed.

More broadly, international experience suggests that the use of extrapolation in FFS schemes is fundamentally misaligned because it is a crude method of prediction based on probability, which will sometimes be wrong (Donley 2018). While deviation from an average may suggest questionable billing, it does not prove it. In addition, when adjudicators who may not have the same qualifications or experience as a medical practitioner under investigation second-guess clinical decision-making based solely on records and recall, more harm than good may be done if MP lose their livelihoods and patients end up without medical care. The practical expression of this phenomenon has been reported in both the US (Donley 2018) and Australia (O'Rourke 2019a), where the 80/20 rule appears to have affected clinical decision-making and good medical practice in some cases, potentially making patients less safe, such as when a MP chooses not to treat a patient fearing Medicare audit attention (Baigent and Baigent 2018).

The PSR has always maintained that the 80/20 rule is concerned with patient safety (Professional Services Review Agency 1995-2020), based on the premise it would be impossible to provide adequate clinical input when attending to more than 80 patients on one day. However, this is difficult to reconcile when considering common situations, such as salaried doctors working overnight in hospitals who may not see 80 patients but may be required to 'do things' for 80 patients in a single shift, such as writing up medications and other orders at the request of nurses, or a country GP attending a bus accident with numerous casualties delivered to the local ED. Would it be unsafe to immunise 300 school children on 21 consecutive days during a chickenpox outbreak, or test more than 80 asymptomatic patients for COVID-19 every day for many months during a global pandemic? Immunising all the elderly residents of an aged care facility against the flu during an outbreak, attending 100 inhabitants of a hotel during a diarrhoeal outbreak, operating a skin cancer clinic in a seaside town at the height of summer or a fly-in fly-out clinic organised specifically to see all of a

towns' sick people on one day, are common examples of the good work done in grassroots medical practice involving high volumes of services.

A question arises concerning whether safety is linked only to Medicare billing. In the examples given above, it appears the payment source determines safety, because if payment is derived outside of the Medicare scheme, such as through salaried arrangements or government grants, many of the above examples may not be deemed unsafe. It therefore appears that rendering or initiating services to 80 patients in a day is only unsafe if you bill to Medicare, but not if you don't. Additional flaws in the safety argument are that the rule renders 100 services safe on 19 days or 79 services safe on 30 days, and notably, physicians and surgeons, who are expressly excluded from the rule, are able to continue to claim more than 80 services on more than 20 days with no consequences.

Further, if safety relates to a perceived or actual risk to patient safety, it must be a dynamic concept because risk changes. For example, a decision to allow a sub-acute patient to have day leave from a hospital may be safe one week but not the following week, because a COVID cluster has emerged in the intervening period, and allowing a patient to have leave would expose the whole ward to the risk of COVID upon their return. The current COVID situation is in fact illustrative of the elastic nature of safety. With hundreds of patients having initially poured through the doors of hospitals every day, overwhelming MP, what was deemed safe in January 2020 shifted, and was not what was deemed safe a few months later.

The PSR may suggest an 'exceptional circumstances' provision in the regulations adequately deals with any shifting safety risk, but this argument does not withstand scrutiny following a recent decision of the Federal Court in the matter of *Nithianantha*.

A notable Federal Court appeal from the PSR

Dr Nithianantha was a GP working in the remote mining community of Blackwater at the height of the mining boom, who sought to invoke the 'exceptional circumstances' defence for

breaching the 80/20 rule. This defence is found in Part 2, Regulation 7 of the *Health Insurance (Professional Services Review Scheme) Regulations 2019 (Cth)*:

"For the purposes of subsection 82(1D) of the Act, each of the following circumstances are exceptional circumstances for a particular day for a practitioner:

(a) an unusual occurrence causing an unusual level of need for relevant services on the day;

(b) an absence, on the day, of other medical services for the practitioner's patients, having regard to:

(i) the location of the practitioner's practice; and

(ii) the characteristics of the practitioner's patients."

Legal counsel for Dr Nithianantha argued that he was the only accredited GP in the remote community of 5000–8000 people at the relevant time, and the local hospital was usually unattended by a MP. There was therefore an absence of other medical services available to patients, which would constitute exceptional circumstances. The argument was unsuccessful.

Following the case, Dr Nithianantha made public comments in response to intense media interest in his case, including the following:

"*The truth … is that for 4–6 months several years ago, there was a drastic shortage of locums due to the elimination of the rights of private practice. It left me as the only accredited GP in town with a hospital that had no doctor most of the time and another practice with two Level 1 conditional GPs."* (O'Rourke 2019a)

A review of the reasoning in the case suggests evidence of an alternative MP actually being available at the relevant times was flimsy. This notwithstanding, if Dr Nithianantha actually was the only accredited, full-time MP in a remote mining community at the peak of the mining season for 5000–8000 patients, and that fact did *not* give rise to exceptional circumstances, it is difficult to imagine what would constitute exceptional circumstances. Indeed, no

'exceptional circumstances' defence appears to have ever succeeded, and it is therefore suggested this regulatory provision may be largely factitious. Dr Nithianantha stated:

"Honestly, the fact that if 2 conditionally registered part time GPs were practicing in the area and I was the only accredited full time GP for 5000–8000 people, is why I lost, means I have no chance of justice..." (Lambert 2019)

As is the case in the majority of investigations into erroneous medical billing in Australia and internationally, Dr Nithianantha stated that he did not know that what he was doing was wrong. It is an oft-reported position, well supported by a growing body of global evidence (including from this study) that it may frequently be true. He said:

"I did what I thought was right and never said 'no' to anyone…I was unaware of an 80/20 rule and I paid the price for breaching it for 20-something days...I understand the PSR wanted this media article to make me an example to discourage other doctors appealing in federal court as they audit more doctors in the future." (Lambert 2019)

Ignorance and confusion about the 80/20 rule

Dr Nithianantha's statement above – that he was unaware of the 80/20 rule – is consistent with the findings of this study, but the study also found that even if Dr Nithianantha had wanted to inform himself about the rule, it would have been difficult. If a MP follows DOH instructions and visits the MBS website (MBSOnline 2020) and enters '80/20' into the search box, no results are returned. More effort and knowledge of the website is required, though this study found MP do not use the MBS Online website in their day-to-day practice nor are they ever formally taught of its existence. To compound matters, the website is not intuitive. To find basic information regarding the 80/20 rule, a MP would need to have an awareness of the legal description of the rule about a 'prescribed pattern of service', which this research found MP do not have.

The July 2020 version of the MBS online book (MBSOnline 2020), provides incorrect reference to the relevant regulation, stating:

"(a) Patterns of Services - The Health Insurance (Professional Services Review) Regulations 1999 specify that when a general practitioner or other MP reaches or exceeds 80 or more attendances on each of 20 or more days in a 12-month period, they are deemed to have practiced inappropriately."

Not only is this information out of date (the 1999 regulations were repealed on 23 February 2019, one and a half years prior to this search), but more concerningly, the 'translation' of the relevant legal provisions is misleading. The corresponding applicable regulation on 29 August 2020 provided the following:

"8 Circumstances for MP for prescribed pattern of services
For the purposes of section 82A of the Act, circumstances in which services rendered or initiated by a MP constitute a prescribed pattern of services are that the MP renders or initiates 80 or more relevant services on each of 20 or more days in a 12 month period."

As already mentioned, the 80/20 rule applies to GP only, and it is suggested this should be clarified. The current drafting in the online book may mislead GP into thinking the rule applies equally to their specialist colleagues, when it does not. More worrying is the use of the term 'attendances' rather than 'relevant services', which appears to be causing further confusion among GP, as evidenced by comments such as the following taken from the leading GP industry publication (Calafiore 2020).

"Professor Quinlivan added that breaches of the 80/20 rule were becoming less frequent". Indeed, this appears to be so. But there seem to be more comments in the PSR Monthly Reports about doctors seeing more than 60 patients. For example, in the June 2020 update "During the review period the practitioner rendered more than 60 professional attendances on more than 30 days, which was in excess of 99 percent of their peers." Is 60 the new 80? I cannot find 60

being mentioned in any Act, nor any "60/30" rule. Perhaps the PSR would be kind enough to clarify?"

This confusion is understandable given the vague description of the offence in the only online resource available to MP, who may not view many of the services they provide as 'attendances', even though such services are described as attendances for PSR purposes. For example, 'Taking Of A Cervical Smear From An Unscreened Or Significantly Underscreened Person' (MBSOnline 2020) is captured by the 80/20 rule, even though most GP would view this as a procedure, not an attendance, causing them to inadvertently breach the rule.

Does the PSR deliver value and protect the public?

Like the MSCI before it, the PSR's performance has been underwhelming. The agency has been mired in litigation and criticism, and the recoveries it achieved did not exceed its government appropriation for the first 20 years. A quiet change in this position deserves attention.

On 22 December 2016, a new Director was appointed to the PSR, and her first annual report celebrated a significant increase in recoveries (Professional Services Review Agency 1995-2020). It was the first time in the agency's history that recoveries outstripped appropriation. What is interesting about this is the sudden and dramatic increase from low historic returns, typically around $5M, to a substantial net gain.

It should be noted that the PSR does not have statutory permission to commence 'own motion' investigations; it can only act on referrals from the DOH. In addition, the PSR's budget is completely separate from the recoveries it settles, which the DOH manage. There is, therefore, no obvious incentive for the PSR to increase recoveries. However, the DOH does work to key performance metrics (Department of Health 2018/9) and it therefore appears possible the increased referrals from the DOH to the PSR are linked to internal DOH recovery targets. It is also possible the new Director felt pressured to demonstrate the financial value of the agency, which had not been evident prior to her appointment.

In the first year under new leadership, the Agency recovered $10.4M, $8.4M of which comprised s 92 agreements. Recoveries doubled the following year and have continued along the same trajectory, undoubtedly pleasing Federal Treasury. **Figure 13** sets out recoveries since the 2012–2013 financial year, noting the sudden increase in the 2016–2017 year under new leadership, and even greater results thereafter.

Figure 13 - PSR recoveries 2013-2019

Year	Treasury Appropriation	Recoveries from PSR Committees	Recoveries from Director s.92 agreements	Total recoveries $
2018-2019	6,946,000	2,784,522	26,411,681	29,196,203
2017-2018	5,518,000	4,656,988	16,188,558	20,845,546
2016-2017	5,131,000	1,940,685	8,466,884	10,407,569
2015-2016	5,528,000	2,957,291	1,630,000	4,587,291
2014-2015	5,688,000	1,047,763	1,568,344	2,616,107
2013-2014	5,740,000	712,524	1,603,092	2,315,615
2012-2013	5,739,000	477,164	1,090,272	1,567,437

Notably, while recoveries from committees have remained lower than appropriations, recoveries from s 92 Agreements have soared. Section 92 of the HIA includes the previously mentioned provisions which may force admissions of guilt as a form of plea bargain. Further, the Determining Authority who sanctions the agreements does not personally hear the evidence, and the entire process is shrouded in secrecy. Section 92 provides inter alia:

"92 Agreement entered into between Director and person under review

(1) If the person under review is a practitioner, the Director and the person may enter into a written agreement under which:

(a) the person acknowledges that the person engaged in inappropriate practice in connection with rendering or initiating specified services during the review period; and

(b) specified action in relation to the person (being action of a kind mentioned in subsection (2)) is to take effect.

(3) An agreement entered into between the Director and the person under review under subsection (1) does not take effect unless it is ratified by the Determining Authority.

(6) The Director must not disclose to any Panel member (other than a Panel member consulted by the Director under paragraph 90(1)(a) in relation to the referral):

(a) the content of any communications between the Director and the person under review in relation to proposals for an agreement under this section; or

(b) whether any such communications have taken place." (Australian Government 1973a)

If an agreement is not reached and the matter proceeds to a committee, those hearings are held in private, away from public scrutiny, and MP are prohibited from disclosing deliberations other than to their lawyers under a gag clause in Section 106ZR, which attracts a penalty of 12 months imprisonment if breached (Australian Government 1973a).

The principle of legality (discussed further below) encompasses a wide range of substantive presumptions, including the presumption that Parliament does not intend to limit fundamental rights, such as freedom of expression. The Australian Constitution does not explicitly protect this freedom. However, in addition to Australia being signatory to numerous human rights treaties which uphold the right to free speech, the High Court has inferred a right of freedom of political communication in Australia (Australian Human Rights Commission 2013). It is arguable that the essence of information discussed in PSR committee proceedings, which MP are unable to disclose pursuant to s 106ZR, is political. Australian courts and tribunals are well equipped to protect the identities of individuals who are the subject of proceedings, when required. There appears to therefore be no valid argument concerning

patient or MP privacy in the PSR context, both of which can be easily managed. PSR committees do not apply the rules of evidence, can bring any matter they choose within the scope of deliberations, are closed to the public, members hold no relevant qualifications, and PUR are not permitted full legal representation, yet serious, life-altering penalties can be imposed on MP. This takes place behind a veil of secrecy so thick, it is not unreasonable to suggest that the ongoing existence of s 106ZR serves no utility other than to stifle freedom of political expression, enabling the PSR to operate in the manner of a Star Chamber (Gruberg 2009).

The new Director has attributed her success to a greater focus on higher-paying specialist services, though a review of available monthly Director's updates (Professional Services Review Agency Case Outcomes) suggests this may be misleading. Monthly reports for the Director's first year in office are not available. However, in the 2017-2018 financial year, $5,340,000 (33%) related to agreements with specialists out of a reported total of $16,188,558. In the following year, agreements with specialists totalled just $2,550,000 (9.6%) out of a reported total of $26,411,681.

General practitioners have always been the principal target for the PSR. This is largely attributable to the fact that GP are easier to target because they receive funding almost solely from Medicare and bill high volumes of time-based services. Specialists, on the other hand, bill fewer time-based services and their reimbursement streams are complex as we have seen, sourced from mixed public and private funding arrangements. The complexity of these arrangements makes specialist billing harder to investigate and prosecute. In addition, applying the GP-focused 80/20 rule is a simple mathematical exercise.

Statistical sampling methodologies available to the PSR extend beyond the 80/20 rule enabled by s 106K, which also disproportionately affects GP. This extrapolation process is as follows:

"106K Committee may have regard to samples of services

(1) The Committee may, in investigating the provision of services included in a particular class of the referred services, have regard only to a sample of the services included in the class.

(2) If the Committee finds that a person has engaged in inappropriate practice in providing all, or a proportion, of the services included in the sample, then, the person under review is taken, for the purposes of this Part, to have engaged in inappropriate practice in the provision of all, or that proportion, as the case may be, of the services included in the class from which the sample is chosen.

(3) The Minister may, by legislative instrument, make determinations specifying the content and form of sampling methodologies that may be used by Committees for the purposes of subsection (1).

(4) The Committee may use a sampling methodology that is not specified in such a determination if, and only if, the Committee has been advised by a statistician accredited by the Statistical Society of Australia Inc that the sampling methodology is statistically valid."
(Australian Government 2019a)

A separate regulation known as the *Health Insurance (Professional Services Review-Sampling Methodology) Determination 2017* then comes into play, which provides that an MP can be found guilty and required to pay back payments made for an entire class of services, based on a sample size as small as 25 records.

"8 Sample

(1) Under this methodology, the Committee must have regard to a sample of no fewer than 25 provided services randomly drawn from a class of referred services being investigated.

9 Determining percentage of inappropriate practice in sample

(1) A Committee relying on subsection 106K (1) of the Act must work out, in accordance with subsection (2), the proportion of services in the sample in relation to the provision of which the person under review engaged in inappropriate practice.

(2) For subsection (1), the proportion is to be expressed as a percentage, as follows:

$$100 \times \left(d - \sqrt{\frac{4d \times (1-d) \times (N-s)}{N \times (s-1)}} \right)$$

d is the number of services in the sample that the Committee has determined are services in relation to the provision of which the person under review engaged in inappropriate practice, divided by s.

s is the number of services in the sample.

N is the number of services in the class." (Government 2017)

The PSR does not provide sufficient information in the short, monthly, case reports to understand or contextualise the circumstances of each case, such as the number of records on which each decision was based. However, General Legal Counsel for the PSR has stated publicly that the agency usually reviews approximately 30 records per MP (The Law Society of NSW 2020).

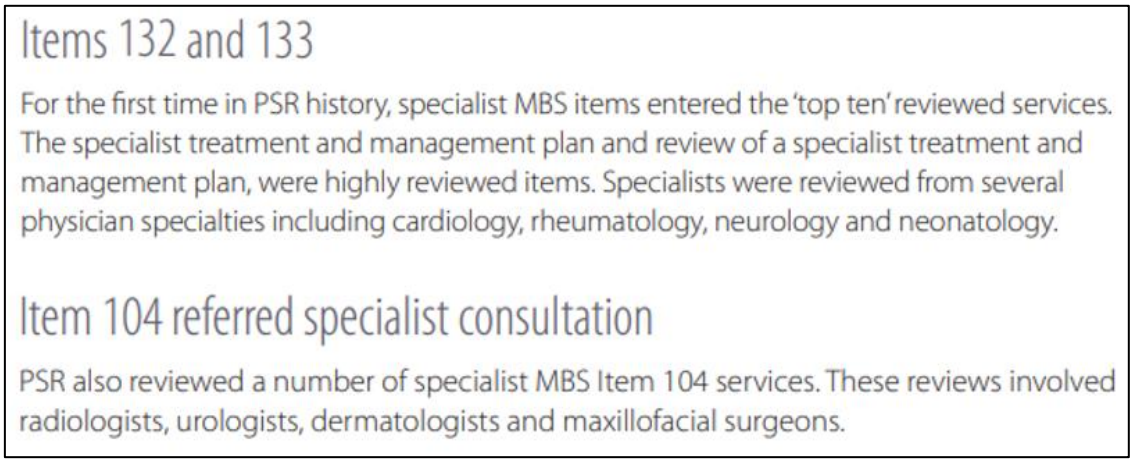
During the 2011 senate enquiry into the operation of the PSR (discussed in Chapter 1), a submission from the Australian Doctors Union stated:

"...it was a coercive process, with Dr Webber [then PSR Director] himself admitting, and again I am quoting: 'I informed them'—the person under review—'the process is long and very stressful'. How much free will have you got going into that? That is persuasive, intimidatory and threatening. You cannot voluntarily enter into an agreement if there is a threat hanging over your head." (Senate Committee 2011)

As a result of the PSR process remaining cloaked in high levels of regulated secrecy, it is not possible to know if the new Director or others involved in the PSR process are intimidating, threatening, and coercing MP, and whether MP are being bullied into entering s 92 agreements, forced into false confessions of guilt while under duress, considering this option a prudent risk mitigation strategy rather than being a genuine admission of wrongdoing.

Following the Senate enquiry, recommendations to ensure reliable information was readily available to MP in regard to medical billing were never implemented. This may explain why the PSR case reports demonstrate no progress at all has been made in assisting MP to understand how to bill correctly before they find themselves in trouble. Precedent is a cornerstone of our legal system that ensures everyone is treated fairly and equally before the law and after 25 years of operation, it is not unreasonable to think that a body of precedent might have been developed to assist MP to know how to bill correctly. Unfortunately, this is nowhere evident. Instead, the same issues are reported repeatedly, with the PSR making the same findings in relation to the same small handful of item numbers. Further, most of the blind spots of the ANAO are evidently also invisible to the PSR. The majority of adverse findings of the PSR continue to relate to the most simple and visible transgressions of GP services, even though the following recent statements made by the Director, shown in **Figure 14**, from the 2019-2020 annual report (Professional Services Review Agency 1995-2020), suggest otherwise.

Figure 14 – Statements by Director of PSR 2019-2020



Items 132 and 133

For the first time in PSR history, specialist MBS items entered the 'top ten' reviewed services. The specialist treatment and management plan and review of a specialist treatment and management plan, were highly reviewed items. Specialists were reviewed from several physician specialties including cardiology, rheumatology, neurology and neonatology.

Item 104 referred specialist consultation

PSR also reviewed a number of specialist MBS Item 104 services. These reviews involved radiologists, urologists, dermatologists and maxillofacial surgeons.

Despite implying the Agency had achieved another historic first, a review of the s 92 agreements reported in that financial year suggests the Director may have overstated this achievement. Out of the 78 agreements ratified, 67 (86%) related to usual GP services, precisely three (3.8%) actually related to items 132 and 133, and one (1.2%) related to item 104. Further, according to the case reports, agreements with specialists totalled $3,680,000

out of a total $21,566,275 (17%), and with the exception of one radiologist, any agreements entered into with 'cardiology, rheumatology, neurology and neonatology' or 'radiologists, urologists, dermatologists and maxillofacial surgeons' are not evident in the case reports. **Figure 15** sets out all s 92 Agreements in the 2019-2020 fiscal year abstracted from the case reports (Professional Services Review Agency Case Outcomes).

Figure 15 - PSR Section 92 Agreements 2019-2020

PSR Section 92 Agreements 2019-2020 fiscal year													
Item type	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March	Apr	May	June	**Total MP type**
GP/OMP items	0	10	4	5	3	9	5	8	7	0	12	4	**67**
Items 132 and 133	0	1	0	0	0	0	1	0	0	0	1	0	**3**
Item 104	0	0	0	0	0	0	1	0	0	0	0	0	**1**
Other specialist items	0	0	1	1	0	0	0	0	0	0	0	1	**3**
Other health practitioners	0	0	0	0	0	2	0	0	0	0	1	1	**4**
Total no. agreements	**0**	**11**	**5**	**6**	**3**	**11**	**7**	**8**	**7**	**0**	**14**	**6**	**78**

NB: OMP refers to MP known as 'other medical practitioners' who can claim certain GP items though not all GP items because they do not have vocational registration.

Irrespective of the fact that the same small handful of GP item numbers are demonstrably all that the PSR can and has ever been able to recover, the mere fact of PSR recoveries dramatically increasing rather than decreasing suggests erroneous billing is worsening rather than improving, and that the agency may not have made a dent in the incidence of non-compliance in 25 years.

In the 2018-2019 fiscal year, total Medicare expenditure was over $24 billion (Department of Health) and there were 118,996 registered MP in Australia (Agency 2018/9). Given the quantum of non-compliant Medicare billing is 5–15% of the schemes' total cost, non-compliance in that year was in the range of $1.2–$3.6 billion. It was reported as the PSR's most successful year in history, recovering $29,196,203, yet the agency investigated only 104 MP (0.08% of total registered MP) and collected less than 2.5% of total non-compliant medical bills, possibly less than 1%. Further, the Director herself has indicated she is mainly focused on clinical records, which can only ever provide a partial indication of a compliant bill, because the actual item number may have been altered by a third party, as this study demonstrated. The Director has publicly stated that the PSR is:

"…less interested in the volume of services provided by doctors than in ensuring doctors' notes showed the services were clinically relevant."(O'Rourke 2019b)

The problem with this approach is that a conscientious, diligent, honest MP, working under pressure, will be subject to the same fate as a dishonest colleague who has the time to deliberately abuse Medicare by auto filling the clinical record with sufficient 'notes' to have the PSR believe item requirements were met, even if they were not. The honest MP may have actually provided all services billed with a high level of clinical input and care but be found non-compliant due to poor notes, whereas a dishonest MP may pass PSR scrutiny with poor care but good fake notes. The previously discussed defamation case suggests this phenomenon may already be prevalent ("Anand & Anor v Armstrong & Anor [2020] SADC 34" 2020).

Another area of concern in relation to the PSR, is that the annual reports repeatedly indicate few findings of no inappropriate practice (Professional Services Review Agency 1995-2020), instead reporting a 100% (or near 100%) guilty rate. It is suggested that any jurisdiction seemingly unable to make findings of innocence may invoke legitimate concerns around bias, and in the context of the PSR, may suggest that once an MP is referred to the Agency, it is not possible to mount a successful defence. Again, the lack of public scrutiny and accountability of the PSR means research in this important area cannot be undertaken and the question of possible entrenched bias by the agency is unable to be rigorously tested or definitively answered.

This research found that for 25 years the PSR has failed to inform or educate MP on what conduct is expected of them and what constitutes appropriate practice. Further the Agency may have inadvertently created a new paradigm of *who* engages in inappropriate practice but gets away with it, potentially fuelling increases in a new type of egregious conduct by some, while apparently driving others to consider suicide (Baigent and Baigent 2018; O'Rourke 2019a: Comment "surrender was easier and less likely to lead to a fatal consequence, in order to continue on with my life.").

In addition to managing its own case load, the PSR refers potential criminal matters to the Department of Public Prosecutions (DPP). As a result of one such referral, a GP was found guilty, like Dr Sood ("Suman SOOD v Regina 2006 NSWCCA 114") of criminal fraud for allegedly billing while he was overseas and also for billing deceased patients. However, on 13 November 2020, the GP successfully appealed the decision and was released from jail after having served nine months of a four-year prison term. The court of appeal found the DPP had deliberately concealed an earlier report of the PSR which had found no wrongdoing by this GP and which may have exonerated him when the matter was before the court (O'Rourke 2020a). It appears that by deliberately excluding potentially exculpatory evidence the prosecution successfully projected a false impression to the jury of clear fraudulent conduct; the jury found the GP guilty after less than two hours of deliberation. The matter has now been set for a retrial.

Overall, it is difficult to see how the PSR facilitates justice or benefits MP or their taxpaying patients, in view of demonstrably poor financial and deterrent results. While precise figures are difficult to extract from ANAO, PSR and DOH reports for the same period, it appears that total MBS recoveries from combined PSR and DOH activities (noting this excludes PBS recoveries) in the 2018-2019 fiscal year totalled approximately $38 million, or 1-3% of estimated leakage (Department of Health 2018/9). This suggests that over 97% of non-compliant Medicare claims are never recovered. Compliance arrangements therefore appear to be weak and ineffective, and the government is unlikely to be meeting the required standard of 'proper' use and management of public money under the PGPA.

In another of the second reading speeches for the PSR Bill in 1993, another Member of Parliament made the following statement, suggesting that education rather than blunt force may represent a better use of taxpayers' money in this area:

"… I do have concerns. It could well be that education of both doctors and their patients could prove to be more effective than threats and wielding the big stick. Money the government devotes to these measures may be better spent working in partnership with various bodies to educate them as to what is appropriate and best for their patients." (Worth T 1993)

Confusion between the PSR and another government agency

In addition to potential criminal liability, following a PSR investigation MP can also be investigated again, for the same offence, by another government agency, the Australian Health Practitioner Regulation Agency (AHPRA), which has the following remit:

"The Australian Health Practitioner Regulation Agency (AHPRA) works with the 15 National Boards to help protect the public by regulating Australia's registered health practitioners. Together, our primary role is to protect the public and set standards and policies that all registered health practitioners must meet..." (Australian Health Practitioner Regulation Agency)

The distinction between AHPRA and the PSR is not clear in the area of Medicare billing, and has come under criticism from one medical defence organisation, which made the following submission to the Senate enquiry:

"...inappropriate practice, if it is a concern that should be addressed and considered for the benefit of the community, we believe that the body best able to do so is the Australian Health Practitioners Regulation Agency, AHPRA. That is their role: to protect the public from inappropriate practice. So, at the moment we have an unusual hybrid of an inappropriate practice that is really about appropriateness of billing for a service that is provided." (Senate Committee 2011)

The Department responded as follows:

"A lot of what is done [at PSR] is about ensuring the integrity of the MBS and that system, whereas AHPRA and the medical boards are there to ensure people are considered appropriate to continue practising. It is a different level of requirement and they are fulfilling very different roles." (Senate Committee 2011)

The Senate Committee was satisfied the two agencies had clear and distinct roles.

When the MSCI was dismantled in 1994, the offence of overservicing was removed, but in 2010, it was returned in the State of New South Wales (NSW). The *Health Practitioner Regulation National Law (NSW) No 86a* provides:

139B Meaning of "unsatisfactory professional conduct" of registered health practitioner generally [NSW]
(1) Unsatisfactory professional conduct of a registered health practitioner includes each of the following—…
(j) Engaging in overservicing… (Legislation)

Despite the Senate Committee finding clear distinctions between AHPRA and the PSR, there remains no clarity around what purpose the above section 139B(1)(j) has served and why the 80/20 rule (which is a prohibition against overservicing) does not come within the purview of AHPRA rather than the PSR. While currently restricted to NSW only, AHPRA may be the more appropriate agency to investigate and counsel MP about the 80/20 overservicing rule than the PSR, as was suggested during the senate enquiry. Under the current arrangements, it appears NSW-based MP can be guilty of both inappropriate practice under the PSR, and overservicing through AHPRA, for the same conduct, with no clear delineation between the two, and no clear benefit to the community.

Further, MP who have had billing restrictions imposed on them (such as through PSR decisions), or have been convicted of an offence which could include imprisonment, are required to notify AHPRA of the infraction pursuant to Section 130 of the *National Law.* In some instances, this may affect MP lives well beyond the practice of medicine. For example, if an MP should choose to change careers and seek entry to a new profession requiring a 'fit and proper person' declaration (such as accounting or law) entry may be denied.

It is suggested that clarity around the roles of the PSR versus AHPRA, and clinical versus financial conduct is currently lacking and the public interest may be better served by prosecuting each through appropriate and distinct channels. For example, a misdemeanour of 'non-compliant or incorrect billing', with a corresponding immediate fine, would be clearer and simpler for both MP and the community to understand, less expensive to administer, more efficient and possibly more effective in deterring recidivism. Whilst the HIA has always included fines for certain offences (Australian Government 1973a: for example s 127(2)), it is somewhat curious why the immediate imposition of a fine has been overlooked in the area of non-compliant billing, though it seems likely related to judicial versus administrative power.

Chapter III of the Australian Constitution prohibits the vesting of judicial powers in non-judicial bodies (Commonwealth Government 2012). Without legal qualifications, members of the PSR are therefore not permitted to exercise judicial power, and the administrative penalties they impose cannot exceed the Medicare rebates paid. The Federal Court has confirmed this position in a series of cases which definitively categorised the PSR as a non-judicial body basis its purpose being not to punish MP, but rather, to uphold administrative standards on the basis of professional judgement ("Tankey v Adams " 2000).

The current PSR Director has already commented on the increasing complexity of matters coming before the agency (Professional Services Review 2018-19). In the face of this, it is suggested that future compliance target areas, such as public hospital billing, will be beyond the capabilities of the PSR as a non-expert, non-court. It may therefore be timely for consideration to be given to a new system of prosecuting errant MP using immediate action (fines and penalty points), exercised with judicial power from within the existing legal system. A recent study found that immediate action against MP was rarely used and under-researched, but was a vital regulatory tool (Bradfield et al. 2020). Further research is required to test this approach, but some suggestions for immediate reform in this area are included in the following chapter.

7.4 The rule of law

In Australia, the rule of law rests on an accepted legal tradition that integrity and honesty in the way a government treats its citizens is a reasonable expectation. It is an umbrella term encompassing the following key legal principles:

'No one is above the law, there must be an independent judiciary to apply the law, the content of the law should be accessible, clear, and consistent, laws must be fair, rational and impartial and everyone must have a right to a fair trial including the presumption of innocence.'(Chaffey 2021)

It is vital that when legitimate expectations, rights and interests are affected by legislation, citizens have a right to know in advance what those laws are and should be able to trust an independent judiciary to adjudicate them fairly when contested. The concept of affording citizens the right to challenge government action via access to an impartial, merit-based hearings, is known as procedural fairness (sometimes also natural justice as previously cited in the PSR section). A condition precedent to procedural fairness is that the disputed laws were capable of being known in advance so that persons affected would have had opportunity to exercise choice and order their affairs around knowledge of those laws. An important and well-known legal doctrine flowing from the requirement that laws are accessible and clear, is that ignorance of those laws, excuses no one.

Ignorance of the law is no excuse

In addition to questionable exercise of procedural fairness by the PSR, across the Medicare scheme more broadly, there is little evidence that relevant laws are known or are capable of being known to MP before they fall into error. However, the Latin maxim *ignorantia juris non excusat* (ignorance of the law is no excuse) is upheld in Australia, and citizens can be found guilty even in circumstances when their mistake about a law was based on a genuinely held

and reasonable belief ("Ostrowski v Palmer [2004] HCA 30"), and even if the illegal action was based on erroneous advice from a government official.

In a 2004 High Court case ("Ostrowski v Palmer [2004] HCA 30"), Mr Palmer had obtained a commercial fishing licence and was found guilty of fishing in a certain prohibited location for rock lobsters. Prior to undertaking this course of action, Mr Palmer had first sought clarification from the relevant state government department, which provided information that led him to believe his intentions were legal and he proceeded to fish in the prohibited area based on this belief. Mr Palmer was unsuccessful in his defence, the court holding firm on the principle of ignorance being no excuse of compliance with law. In deliberations, the court stated:

“Ignorance of the legal consequences that flow from the existence of the facts that constitute an offence is ordinarily not a matter of exculpation, although it may be a matter of mitigation, and in some circumstances it may enliven a discretion not to prosecute…In a society in which many personal, social and commercial activities are closely regulated, and the schemes of regulation are frequently changed, the detail of regulation may be difficult for citizens and their lawyers to keep up with. Courts themselves normally require evidence of regulations as distinct from statutes.” ("Ostrowski v Palmer [2004] HCA 30": 2)

Under Australian law, a mistake of fact may constitute a defence for some offences, but Mr Palmer’s mistake was a mistake of law rather than of fact. The court held:

“Mr Palmer could not rely on the defence of mistake of fact under s 24. His mistake was one of law: he erroneously believed that no law prohibited him from fishing for rock lobster in that area. It is irrelevant that his belief was induced by the conduct of a Fisheries WA employee.” ("Ostrowski v Palmer [2004] HCA 30": 16)

In regard to the erroneous advice from a government official, the court continued:

"It is irrelevant that Mr Palmer's mistake was induced by the conduct of an employee of Fisheries WA. That conduct cannot convert a mistake as to the applicable law into a mistake of fact. If a defendant knows all the relevant facts that constitute the offence and acts on erroneous advice as to the legal effect of those facts, the defendant, like the adviser, has been mistaken as to the law, not the facts…Accordingly, the bare fact that the adviser or official may have been mistaken as to the state of the law does not convert the defendant's mistake into one of fact. Both the adviser or the official and the defendant operate under a mistake of law." ("Ostrowski v Palmer [2004] HCA 30": 59)

Participants in this study described advice from Medicare as unreliable and inconsistent and the Federal Court cases of *Stirling* and *Nithianantha* already discussed, together with the High Court decision in *Ostrowski*, make very clear that MP cannot rely on erroneous advice from Medicare as a defence in legal proceedings. It would therefore seem somewhat misleading for the government to be informing MP via its website that advice provided through the 'askMBS' email service is 'accurate, authoritative and up-to-date' (MBS Online 2020a) when High Court authority provides that any advice provided by a government official cannot be relied upon if it is wrong, unless it leads to a mistake of fact. Evidence from this research suggests the likelihood of a MP receiving incorrect advice from Medicare is high and would likely lead to a mistake of law, which would not enable an exculpatory defence in contested proceedings.

More recently, the High Court again considered ignorance of the law in certain cases involving Section 44 of the Constitution as it applied to parliamentarians with dual citizenship, many of whom stated they were unaware of the relevant law prior to breaching it. The Court again upheld the principle of ignorance not being an excuse and many politicians were dismissed as a result, but the court discussed a 'reasonable steps' exception that may apply if, for example:

"…the foreign country makes it impossible to renounce its citizenship, or imposes such onerous requirements or conditions that we find them unreasonable, then a person who has

done everything within their power to effect a renunciation will be thought to have done enough." (Morgan 2018)

While modern approaches to statutory interpretation in Australia are contextual and restrained, often focusing on underlying policy objectives, it is suggested that a 'reasonable steps' argument may be available to MP if Medicare billing law imposes such onerous requirements as to be unreasonable and effectively unable to be complied with.

Non-existent Medicare law

In some cases, Medicare appears to have enforced 'rules' without the rule having a corresponding regulation. One MP participant in the qualitative interviews appears to have been incorrectly investigated by Medicare for allegedly breaching a non-existent law, known as 'locum-tenens arrangements'.

MP provide medical cover for each other's patients during periods of leave, over weekends, or even at short notice for just a few hours. These arrangements are referred to amongst MP as locum arrangements, which are standard clinical practice, enabling periods of leave without disrupting patient care. However, there appears to be no relevant governing law applicable to these arrangements, even though the DOH audits breaches of them, such as the apparently falsely accused participant of this study, who had instinctively applied the locum requirements correctly. Hidden deep in the online version of the MBS book (MBSOnline 2020) is the following content relating to locum arrangements:

"*Locum-tenens Arrangements*
…Fresh referrals are not required for locum-tenens acting according to accepted medical practice for the principal of a practice ie referrals to the latter are accepted as applying to the former and benefit is not payable at the initial attendance rate for an attendance by a locum-tenens if the principal has already performed an initial attendance in respect of the particular instrument of referral." (MBSOnline 2020)

A close examination of the regulatory scheme on which the above statement is presumably based reveals the term 'locum tenens' is nowhere defined in the statute. Further, despite the DOH's stated position in the MBS, no law expressly prevents a locum from billing an initial consultation, as long as relevant referral requirements (which are also extremely confusing) are met. The only place the words 'locum tenens' appear anywhere in the regulatory scheme is at the item number level in the *Health Insurance (General Medical Services Table) Regulations 2018 (Cwth)* in relation to inconsequential notes on three item numbers (Australian Government 2020a).

MP have always been led to believe – and the government has propagated the belief – that the MBS book is the government's interpretation of the law. However, in this very common area of locum tenens arrangements, it appears the government may be enforcing laws that are either non-existent, unable to be found, or which impose such onerous requirements that they are impossible to comply with or comprehend.

The principle of legality

In addition to laws being accessible, the principle of legality requires that ordinary individuals should be able to understand the legal consequences flowing from clearly written legislation, so they can order their affairs accordingly. This important rule of law principle has been eloquently articulated in the following passage:

"The principle of legality cannot overcome dense or labyrinthine legislation. But it does ensure that fundamental rights and principles are not abrogated by general or ambiguous words. Lord Hoffmann noted in R v Secretary of State for the Home Department; Ex parte Simms that there is 'too great a risk' that the full implications of general or ambiguous words may be unclear on the face of the statute, and thereby pass 'unnoticed in the democratic process'. The principle of legality means that Parliament cannot lurk in the dark corners of a broad, vague power. It must bring any departure from the general system of law into the light of 'irresistible

clearness', so that people may look at the statute and know what legal consequences flow from it." (Rule of Law Education Centre 2016)

In the *Nithianantha* decision, one of the issues for determination was that of when urgency is determined – whether at the time of first contact over the phone, or later once the MP has attended the patient. Dr Nithianantha unsuccessfully sought to rely on an email passed to him from a colleague, though originating from Medicare, which stated that urgency was determined at the time of first contact. However, the court held that urgency can only be determined once a doctor actually attends and examines a patient. The court stated:

"Before the consultation, the practitioner can only form a view, having regard to the circumstances which have been conveyed to him or her by someone who may not be the patient. The best the practitioner can do at that point is form a view of what might be required at that time, not what is required. What is required can only be determined following consultation which can, if necessary, include examination." ("Nithianantha v Commonwealth of Australia [2018] FCA 2063")

Following the decision, and in recognition of the longstanding confusion and debate about the interpretation of the 'urgency' requirement, all relevant urgent after-hours item descriptions were amended. The PSR annual report stated:

"Since this matter was heard by the Court, the urgent after hours items were changed with the relevant phrase amended to 'requires urgent assessment', nevertheless, this still can be determined only following consultation with the patient and not before it." (Professional Services Review Agency 1995-2020)

One of the item numbers that underwent change following *Nithianantha* was item 599, which is identical to the item Dr Nithianantha breached, except the service must be provided in what is known as the 'unsociable' after-hours period, rather than just the standard after-hours period.

However, the COVID-19 pandemic may have exposed flaws in the *Nithianantha* reasoning, leaving MP vulnerable again to serious legal risk. Two of the new COVID telehealth items are the equivalent of item 599. These are set out in **Table 12**.

Table 12 - Urgent after-hours attendances

Urgent After Hours Attendance **Items introduced 30 March 2020**			
Brief description	Standard item	Video item	Phone item
Urgent attendance, unsociable after hours	599	92210	92216

The current legal position following the *Nithianantha* decision is that 'urgency' cannot be decided without personal attendance, but the new COVID item 599 equivalents expressly state the opposite – that urgency can be determined without personal attendance, via a video or phone call. Details of item 599 with its phone equivalent and identical text italicised are in **Table 13**.

Table 13 - Non-COVID versus COVID service

Non-COVID service Per *Nithianantha* – requires face-to-face attendance	**COVID service** Expressly excludes face-to-face attendance and requires the service is provided by phone
599 Professional *attendance by a general practitioner on not more than one patient on one occasion—each attendance in unsociable hours if:* *(a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and* *(b) the patient's medical condition requires urgent assessment*; and (c) if the attendance is at consulting rooms—it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance.	**92216** Phone *attendance by a general practitioner on not more than one patient on one occasion—each attendance in unsociable hours if:* *(a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and* *(b) the patient's medical condition requires urgent assessment*. NOTE: It is a legislative requirement that the service must be bulk billed where the service is provided to a concessional or vulnerable patient at the time the service is provided. For all other patients the service may be bulk billed.

The two regulations in Table 13 are irreconcilable. Identical except for the first word and some non-substantive content at the end of each, item 599 is able to have the *Nithianantha* reasoning applied, the COVID equivalent item 92216 cannot. If a MP bills item 92216, it appears she is immediately in breach of the current law by determining urgency on the phone. This demonstrates a prima facie failure of the principle of legality because it is not possible to read the statute and know the consequences flowing from it. Unfortunately, any suggestion that extraordinary circumstances caused by a global pandemic may have caused this legislative drafting slip are quickly overshadowed by the fact that similar inconsistencies are commonplace throughout the MBS.

Another example is item 13103, which is a service provided by renal physicians for patients undergoing renal dialysis. These patients are usually admitted to a day clinic and sit in a chair during their dialysis and return home the same day. The description of item 13103 provides:

"Supervision in hospital by a medical specialist of—haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, if the total attendance time on the patient by the supervising medical specialist does not exceed 45 minutes in one day." (MBSOnline 2020)

The MBS online book explains it further as follows:

"Item 13103 covers the supervision in hospital by a medical specialist for the management of dialysis, haemofiltration, haemoperfusion or peritoneal dialysis in a stabilised patient, or in the case of an unstabilised patient, where the total attendance time by the supervising medical specialist does not exceed 45 minutes." (MBSOnline 2020)

We have already discussed the way in which services in the Medicare scheme use specific words and phrases that are intended to convey consistent meaning such as 'attendance' and 'supervision'. The difficulty in interpreting item 13103 is it appears to be both a supervision and attendance item.

A common clinical scenario in relation to item 13103 is that dialysis patients will attend and be connected to dialysis equipment by nurses. The treating renal physician may not be physically present when this happens, though would have originally written up the required treatment in the patient's records for the nurses to follow. This is accepted clinical practice, and the renal physician will usually be working 'in the background' throughout each patient's dialysis treatment, responding to queries from the nursing staff and physically attending the patient when required. Confusion may therefore arise in answer to the legal question of whether a renal physician can legally claim item 13103 when patients are having their dialysis treatment, but the renal physician does not physically attend the patient on that day. The statute is unclear in this regard. Item 13103, the service is described as a supervision item rather than an attendance item. If it were the latter, it would be expected to commence with the words 'Professional attendance', like item 599.

In addition to uncertainty around whether it is the MP or the patient who is required to 'attend', item 13103 attracts an outpatient rebate, though it is unclear how an MP could supervise a patient 'in hospital' if the patient was not in hospital but was an outpatient. And if the patient is not in hospital, then presumably the MP would not need to be either.

If the statute requires a renal physician to physically attend a patient undergoing dialysis before claiming item 13103, it should say so. While it appears the item has been designed to acknowledge the reality of dialysis practice – that a renal physician would be working 'in the background' and may not attend the patient personally – the regulation is so opaque, it is impossible to be sure. Mandating physical attendance would also seem to make little sense because if a renal physician did physically attend, she would claim a relevant attendance item such as item 116. By mixing attendance and supervision concepts, MP may again be left exposed to investigation and prosecution for breaches of rules impossible to interpret.

Another recent example of incomprehensible drafting is found in the previously discussed MBS oncology item 13950, which commenced on 1 November 2020 following an MBSRT recommendation. This item is not only lacking in clarity, but more worryingly, the DOH's initial

advice provided to MP concerning its proper use appeared to be incorrect and inconsistent with current law[i].

Confusion around whether the commonly billed item 13950 requires MP attendance or patient attendance has already been discussed in the introduction chapter, and problems around its use in the HST setting have also been considered. This item enlivens still more problems.

A common scenario when item 13950 (which replaced a prior similar service) is billed, involves patients receiving three days of chemotherapy delivered via a pump. Typically, the patient will attend on day one and be admitted as a day patient for four hours while the pump is connected, loaded, and infused. The treating MP will rarely attend the patient on this day, or on any of the three days, the entire process being managed by nurses in accordance with accepted clinical practice. At the end of the first day of treatment the patient is discharged home for two nights, while the pump continues to deliver titrated dosages of chemotherapeutic agents. On day three, the patient returns for the pump to be disconnected, which takes just a few minutes, when the nurse disconnects it and flushes the cannula before sending the patient home again. The appropriate MBS service billable in this scenario is item 14221, which has the following description:

"LONG-TERM IMPLANTED DEVICE FOR DELIVERY OF THERAPEUTIC AGENTS, accessing of, not being a service associated with a service to which item 13950 applies" (MBSOnline 2020)

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i - The initial advice dated 20 October 2020 was accessed on 24 October 2020 and a copy of the downloaded document can be viewed at **Appendix 9**. The erroneous advice in the 20 October version was subsequently removed from the MBS Online website and replaced with updated advice dated 30 October 2020 available at this link (MBSOnline 2020) and as **Appendix 10**. It is unclear why the department did not use standard business practices of document version control when updating the document. Both documents are titled *information release #4*, when the later version should properly have been titled *information release #5* to protect MP who may have downloaded and relied upon the earlier version which contained incorrect legal advice that may have exposed MP to risk of a PSR investigation.

The initial DOH online information about the billing of item 13950 stated, inter alia, the following:

"…item 13950 may be claimed on the day where the pump or device is disconnected…"

Four months prior to the introduction of item 13950, the PSR found an oncologist had engaged in inappropriate practice for doing precisely what the department endorsed through the above phrase (Professional Services Review Agency Case Outcomes: see June 2020). In that matter, the PSR found that billing of the prior equivalent item to 13950 on day three was not permissible, given the same infuser was running and no new service had been provided other than to disconnect and flush the cannula. The MP was required to repay $135,000 to the DOH and was disqualified from certain MBS billing for 12 months. Four months later, that same MP may have achieved a successful outcome and avoided investigation altogether, because the department's initial online advice directly contradicted this recent quasi-legal finding of the PSR and the operation of the HIA, essentially endorsing billing for a service not provided.

The DOH's initial advice also informed MP they could *not* bill item 14221 on day three when the pump is disconnected, despite this being the item that most accurately reflects the service provided on that day.

Despite the updated departmental advice, serious concerns around the correct billing of this item, the potential cost to the public purse, as well as patient safety issues remain. The revised DOH advice includes the following statement (MBSOnline 2020):

"If, at the attendance to disconnect a pump or device, the practitioner further administers antineoplastic agents under a service described by item 13950, then item 13950 may be claimed for that episode of treatment."

Usual clinical practice is that the patient does not receive additional single doses of antineoplastic agents on day three of this regime. However, the DOH advice may have created

a perverse incentive for MP to prescribe an additional single dose of an antineoplastic agent, for administration by the nurse when the patient comes in on day three, which would enable the claiming of item 13950. In addition, it appears there may also now be a strong incentive to admit *all* patients requiring chemotherapy, rather than providing home-based or outpatient treatments.

The departmental advice suggests there is no barrier to billing item 13950 (which attracts a rebate of approximately $100) every day while a patient is having infused chemotherapy, without the MP ever being required to attend, as long as a nurse administers a 'top up' dose of an antineoplastic agent each day during the admission. Therefore, applying the department's advice, a seven-day course of infused chemotherapy for an admitted patient can attract the billing of item 13950 every day, drawing approximately $700 from the public purse (almost double if the services are billed through the patient's PHI), without the MP ever physically attending the patient, though if the MP *does* visit the patient, an additional attendance item is apparently also able to be billed.

It is suggested that even if the DOH's advice is found to be legally correct, this may set a worrying precedent inconsistent with the way the Medicare scheme has operated for almost 40 years, potentially making patients less safe and increasing government expenditure. Many admitted patients receive infusions of toxic and dangerous medications, and for the majority of MP the only service able to be billed to Medicare is an attendance when MP do their ward rounds and physically review patients under their care. There is nothing inherently special or difficult about a chemotherapy infusion versus myriad other infusions routinely provided by specialist MP to admitted patients. Enabling one group of MP to bill daily for 'supervising' delivery of a continuous infusion, without ever attending the patient, is akin to providing payment for no service and completely out of step with Medicare's most fundamental legal tenet. Not only does this create a potential slippery slope, in that other MP may demand the same, it could precipitate a legal precedent unfavourable to the government, by enabling MP to argue that while Medicare reimburses the provision of clinically relevant services, it also reimburses in the absence of the provision of a clinically relevant service.

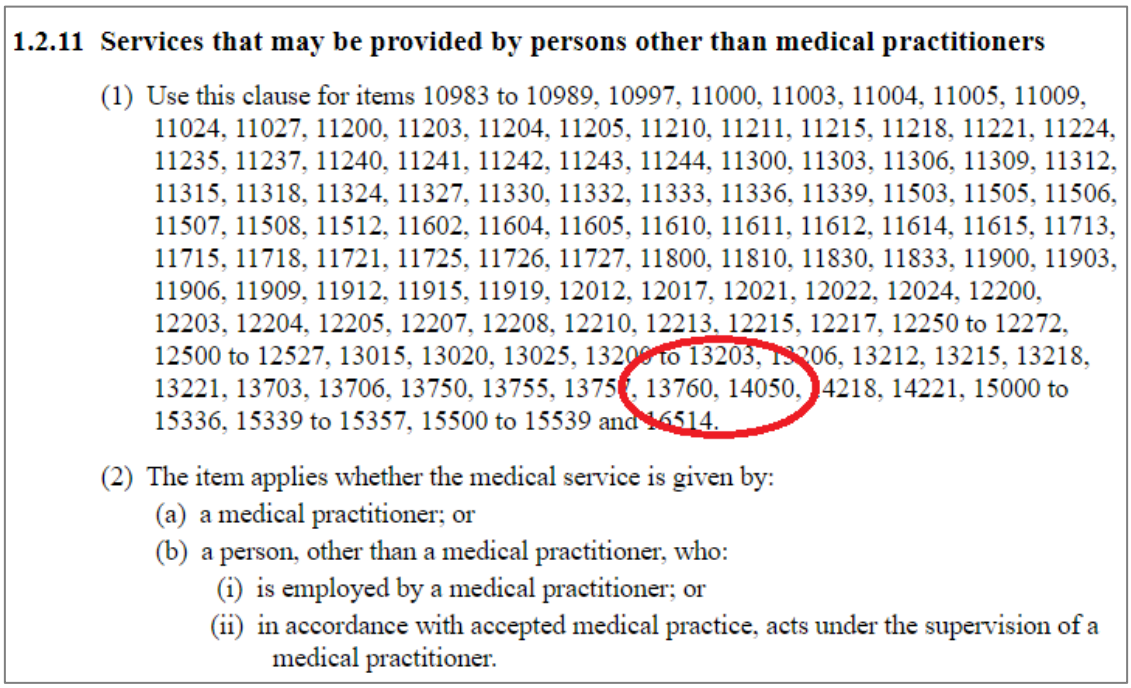
Three additional points of confusion in regard to item 13950 are:

1. The service has been classified as a Type B, Band 1 procedure meeting same-day accommodation requirements under the *Private Health Insurance Act (Cwth) 2007*, meaning the PHI will be required to reimburse it. However, the DOH's advice appears to have failed to understand that the PHI cannot reimburse the service on day three of a three-day pump, because the patient will not usually be admitted on day three, and the PHI cannot legally reimburse item 13950 in the absence of an admission, again circling back to the perverse incentive to admit.

2. The new item description of 14221 in the MBS states; *"…not being a service associated with a service to which 13950 applies."* However, item 13950 does not reciprocate, though it suggests the two services cannot be co-claimed by use of the phrase; *"Note: The fee for item 13950 contains a component which covers the accessing of a long-term drug delivery device."* It is therefore unclear whether the two services can ever be co-claimed, in what circumstances, and what additional information (such as the time of each service) may be required to substantiate such a claim, again leaving MP to second guess what a future legal interpretation might be.

3. Item 13950 has not been added to the list of items coming under what are known as the 'supervision rules' in the *Health Insurance (General Medical Services Table) Regulations (No.2) 2020*. This raises a serious legal question concerning whether item 13950 can be provided by someone other than a medical practitioner (such as a nurse) or whether the MP must physically attend and personally deliver the service. The words 'on behalf of' which have been included at the item description level may not override the operation of *Regulation 1.2.11* (Australian Government 2020a: Accessed 19 November 2020) (shown below in **Figure 16**) were interpretation of the correct use of this service be decided by a Court. This is another example of MP being potentially exposed to the risk of unintentional non-compliance, with no ability to rely on incorrect departmental advice should that advice be wrong.

Figure 16 – Services able to be provided under supervision



1.2.11 Services that may be provided by persons other than medical practitioners

(1) Use this clause for items 10983 to 10989, 10997, 11000, 11003, 11004, 11005, 11009, 11024, 11027, 11200, 11203, 11204, 11205, 11210, 11211, 11215, 11218, 11221, 11224, 11235, 11237, 11240, 11241, 11242, 11243, 11244, 11300, 11303, 11306, 11309, 11312, 11315, 11318, 11324, 11327, 11330, 11332, 11333, 11336, 11339, 11503, 11505, 11506, 11507, 11508, 11512, 11602, 11604, 11605, 11610, 11611, 11612, 11614, 11615, 11713, 11715, 11718, 11721, 11725, 11726, 11727, 11800, 11810, 11830, 11833, 11900, 11903, 11906, 11909, 11912, 11915, 11919, 12012, 12017, 12021, 12022, 12024, 12200, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217, 12250 to 12272, 12500 to 12527, 13015, 13020, 13025, 13200 to 13203, 13206, 13212, 13215, 13218, 13221, 13703, 13706, 13750, 13755, 13757, 13760, 14050, 14218, 14221, 15000 to 15336, 15339 to 15357, 15500 to 15539 and 16514.

(2) The item applies whether the medical service is given by:

(a) a medical practitioner; or

(b) a person, other than a medical practitioner, who:

(i) is employed by a medical practitioner; or

(ii) in accordance with accepted medical practice, acts under the supervision of a medical practitioner.

These types of codified and unfathomable inconsistencies are littered everywhere throughout the MBS. Item 14245 (MBSOnline 2020) is not clear about whether the MP who claims the item has to remain in attendance for two hours during an infusion with a risk of anaphylaxis and given the anaphylactic risk, whether the patient should be admitted and treated as an inpatient, and how that is possible given an adverse reaction does not satisfy relevant PHI admission rules, and nor does the short two hour infusion period (Australian Government 2011). Many of the case conference items (MBSOnline 2020) are unclear about whether the patient is required to be admitted at the time the conference takes place or whether it can be claimed after the patient is discharged but on the same day. Item 132 is unclear as to whether the 45-minute requirement is for face-to-face consultation with the patient or whether it can comprise face-to-face and administrative time. Items 4001 and 16500 should not be co-claimed, but this is not clearly stated anywhere, and on one not unreasonable interpretation the two items should always be co-claimed. Item 21070 describes initiation of anaesthesia for intraoral procedures and item 22900 describes initiation of anaesthesia for extraction of teeth; both items obviously relate to the mouth but there is no clarity around which should

be billed when, and an anaesthetist who regularly delivers anaesthetics for oral procedures could easily make the mistake of billing her usual item 21070 innocently assuming it would cover teeth. Item 47981 is in the orthopaedic surgery section of the schedule even though it is an operation a general surgeon may provide, and it is unclear whether a general surgeon (rather than an orthopaedic surgeon) can claim it.

Further, the new COVID telehealth equivalents of usual physician attendance services (MBSOnline 2020) had a time requirement trip wire added (which physicians would not have known about) when they were introduced, and in the highly specialised area of radiation oncology, at least three reasonable interpretations of a common item number combination are possible for a cancer patient receiving radiation treatment to two separate anatomical sites (such as their hip and spine) on the same day. These item combinations (shown in **Table 14**) will be paid or rejected arbitrarily, there being therefore no possibility of knowing which is right or wrong.

Table 14 - Common radiation oncology example

	Option 1	**Option 2**	**Option 3**
CT Simulation	15555 (Hip) 15555 (Spine)	15555 (Hip) 15555 (Spine)	15555 (Hip) 15550 (Spine)
Dosimetry	15565 (Hip) 15565 (Spine)	15565 (Hip) 15565 (Spine)	15565 (Hip) 15562 (Spine)
Each treatment attendance	15275 (Hip) 15275 (Spine) 15715 (Hip) 15715 (Spine)	15275 (inclusive of both disease sites) 15715 (inclusive of both disease sites as per TN.2.4 "*…once per attendance for treatment, irrespective of the number of treatment sites verified at that attendance*")(MBSOnline 2020)	15275 (Hip) 15257 (Spine) 15272 x 2 (Spine) (*as per TN.2.1 – Arc Therapy = three fields)* 15715 (inclusive of both disease sites as per TN.2.4)(MBSOnline 2020)

In addition, recently added electrocardiograph (ECG) items appear to have been drafted with complete disregard for well-established principles of good legal drafting, such as:

"…exactness, comprehensiveness and clarity, at the same time keeping in mind the brevity and simplicity which a skilled person can often attain without any sacrifice of accuracy or clearness." (J.K.Aitken 1991)

In *Piesse, The Elements of Drafting,* (J.K.Aitken 1991) the author describes the five basic rules of good legal drafting as follows:

1. the design of the whole instrument should be understood and incorporated;
2. nothing should be included or omitted at random;
3. the order of the draft should be strictly logical;
4. ordinary and accustomed forms of technical language should be used; and
5. legal language should be precise and accurate as far as possible.

This study found application of these rules, which are designed to enable consistent statutory interpretation thus facilitating MP compliance, are routinely overlooked by those who draft MBS items. All MP participants in this research reported challenges with MBS interpretation which they described as complex, 'highly interpretive' and 'ridiculous'.

Changes to the MBS implemented as a result of another tranche of MBSRT recommendations, included a raft of new cardiac services, including a simple ECG. The new ECG item 11707 was introduced with the following description:

"Twelve-lead electrocardiography to produce a trace only, by a medical practitioner, if the trace:

(a) is required to inform clinical decision making; and

(b) is reviewed in a clinically appropriate timeframe to identify potentially serious or life-threatening abnormalities; and

(c) does not need to be fully interpreted or reported on; and

(d) the service does not apply if:

(i) the patient is an admitted patient.

For any particular patient, applicable no more than twice on the same day." (MBSOnline 2020)

A consideration of the application of *Piesse's* principles is of benefit to weigh up potential downstream interpretive challenges relating to this common procedure.

Firstly, when considering the whole of the HIA, an overarching principle is that all services must be clinically relevant. Therefore, points (a) and (b) immediately present problems. Are the phrases 'required to inform clinical decision making' and 'a clinically appropriate timeframe' intended as new standards? If so, do they apply just to ECGs or does a MP have to apply these new standards in addition to the existing overarching standard of clinical relevance? If these are not new standards, they should be removed; if they are new standards, they should be clearly defined.

Secondly, the service includes the words 'produce a trace only…' but a review of point (b) imposes a second action, which is a review. Therefore, the term 'only' should be removed because it is incorrect and misleading. The regulation requires more than a 'trace', it requires a 'trace and review'.

Thirdly, the inclusion of negatives is unnecessary and confusing. If the service does not need to be 'fully interpreted or reported on' then this should be omitted. Further, if 'fully interpreted' is another new standard beyond the overarching standard of 'adequate and contemporaneous records' required throughout the MBS, it should also be comprehensively defined.

Fourthly, making the service inapplicable to admitted patients is superfluous. The government software is able to reject inpatient claims, so all that was necessary was to show an outpatient rebate only, and nothing else.

Fifthly and of significant concern, is an example of potential entrapment into guilt, similar to the urgent after-hours COVID attendance item 92216. The service requires the ECG 'is reviewed in a clinically appropriate timeframe to identify potentially serious or life-threatening abnormalities', so the question begs, what happens if the ECG does not identify potentially serious or life-threatening abnormalities? Is, like Dr Nithianantha, the MP guilty of an offence for determining urgency before examining the patient, when a court held this could only be determined afterwards? In the case of the ECG, if the test is performed on a patient complaining of chest pain but the pain turns out to be indigestion, which is not a serious or life-threatening abnormality, is the MP guilty of an offence?

Unclear drafting of this nature may expose MP to compliance risk. On one interpretation, only positive ECG results attract reimbursement, rendering the service unable to be complied with and MP guilty even before they attach the ECG leads to the patient's chest. However negative results are often of equal importance in eliminating differential diagnoses, and restricting an ECG in this way may make patients less safe if MP choose not to perform the test for fear of Medicare investigation.

Finally, a detailed examination of the relevant legislative instrument that introduced this and other cardiac items (Australian Government 2020a) reveals new standards have indeed been introduced, which may further undermine the overarching requirement of 'adequate and contemporaneous records' already mentioned. For ECGs and a few other cardiac items, a new requirement of 'clinical notes' and 'formal report' have been added. MP will have no knowledge of these new standards and will therefore be exposed to new compliance risks. But perhaps more worryingly, the requirements to bill this simple test have now become so onerous it will be impossible for the government to police, but relatively easy for GP to circumvent. For many GP, one obvious solution will be to continue to conduct ECGs when required, but rather than claim the ECG with an attendance separately – for example, as an item 23 (attendance) and an item 11700 (the old ECG item) – bundle the two and claim a single long attendance item 36 (provided other requirements of the item are met). This will cost the

government more and reduce visibility over service provision. The ECGs the government once saw may become hidden.

Overarching provisions of an Act of Parliament are not the only indicators of the purpose of particular provisions, such as the ECG provision. Sometimes, specific objects and overarching provisions do not sit well together and may be difficult to reconcile. However, it is a reasonable expectation that parliamentary drafters will draft the law mindful of the principle of legality. It is also reasonable to expect that drafters come from the ranks of experienced legal professionals who are subject matter experts with a strong grasp of the entire regulatory scheme within their purview. Evidence of poor drafting, such as ECG item 11707, might therefore give rise to the need for the responsible parliamentary drafters to be held to account. However, an examination of the original source of the drafting of the ECG regulation, found the item was enacted into law, almost completely unchanged, after having been drafted by a group of cardiologists (Department of Health 2019).

7.5 The slow erosion of clinical relevance

Section 82(3) of the HIA provides that a PSR Committee must have regard to whether the practitioner kept an 'adequate and contemporaneous record' of services under review, which goes to the central question of whether the service was clinically relevant. It is the only requirement the parliament states a PSR Committee *must* have regard to, indicating its importance. However, if a PSR Committee were to investigate a breach of the new ECG item just discussed, with its own separate record-keeping standard, it is unclear whether the PSR can consider the new standard, given it has no parliamentary direction to do so.

The initial decision of how an MP decides whether a Medicare service is clinically relevant has been discussed in various sections of this thesis. We will now consider the standard within the context of the broader regulatory framework to examine whether and to what extent the standard may have been eroded. This is important because as Medicare billing continues to evolve and new services are added to the scheme, if the base standard does not hold strong,

we may reach a point where lawyers acting for MP involved in disciplinary billing matters may be able to argue that clinical relevance is *not* a consistent or applicable threshold standard.

Impractical changes made to standards within the MBS, such as the ECG example, may also compound MP confusion around correct billing conduct, particularly if the boundaries of the various standards become blurred – what is the difference between 'adequate and contemporaneous' records versus 'clinical notes' versus 'formal report'?

The combined effects of constant government tinkering, the operation of the *Health Practitioner National Law* and other factors has led to the multitude of standards in **Table 15** applying across the Australian health payment landscape, all of which impact MP medical billing decisions and compliance.

Table 15 - Different standards across the health payment landscape

Standard	Source	Comments
Clinically relevant	Medicare	Overarching requirement to bill.
Required to inform clinical decision-making	Medicare	Required to bill cardiac services only. Unclear whether this is different or in addition to clinical relevance.
Clinically appropriate timeframe	Medicare	Required to bill cardiac services only. Unclear whether this is different or in addition to clinical relevance.
Medically necessary	PHI	No known definition. A U.S standard also without a settled definition in that country.
Reasonably necessary	SIRA‡	Applies for injured workers in NSW.
Reasonable and necessary	Compulsory third party (CTP)	Applies to injured motorists in NSW and is a higher standard than the SIRA standard.
Reasonably necessary for adequate treatment	MRCA* & VEA† Treatment Principles	Applies when treating eligible veterans and military personnel. 'Adequate treatment' is not defined.
Reasonableness	Medicare via an MBSRT recommendation	The rules committee decided a consultation was only clinically relevant if the associated procedure had a value under $300. Above that amount, a consultation was not clinically relevant because that was 'reasonable'.
Appropriateness	NPS Medicinewise, Choosing wisely	Advocates 'appropriateness' in its approach to decisions to treat. (Zadro et al. 2019)
Inappropriate practice	PSR	'Appropriate practice' is not defined.
Overservicing	AHPRA (NSW)	It is unclear how overservicing differs from inappropriate practice for billing matters.
Unsatisfactory professional conduct	AHPRA	Overservicing may lead to a finding of unsatisfactory professional conduct.
Professional misconduct	AHPRA	Professional misconduct is a more serious offence usually beyond billing transgressions.
Adequate and contemporaneous records	Medicare	Overarching record-keeping standard to support all billing decisions.
Medical records standard	AHPRA	Additional overarching standard imposed by 'Good medical practice – a code of conduct'.
Clinical notes standard	Medicare	Required when billing cardiac services only. Unclear whether this is different or in addition to adequate and contemporaneous records and the code of conduct.
Formal report	Medicare	Required when billing cardiac services only. Unclear whether this is different or in addition to adequate and contemporaneous records and the code of conduct.

‡ State Insurance Regulatory Authority

* *Military Rehabilitation and Compensation Act (Cwth) 2004*

† *Veterans Entitlements Act (Cwth) 1986*

Evidence from this study suggested that MP may be unaware of these standards, and given their ignorance of the law will likely be no excuse should they find themselves before a judge, it would appear quite an important omission that some form of prior warning system such as education is nowhere available. One possible explanation for this omission is an awareness by the government of the problems and limitations inherent in trying to create education programs around unclear laws.

By way of example, all of the MP participants in this research reported that their patient cohorts included war veterans and military personnel, though they had almost no understanding of the relevant law applicable to billing those patients, or the standard that applies (which is *not* clinical relevance). Treatment of these patients is regulated under separate legislation (discussed in Chapter 4) with a different threshold standard shown in **Table 15** of 'reasonably necessary for the adequate treatment of the patient', which is not defined. Further, MP stated they did not know whether they could charge a gap or even bill these patients in a public hospital. The answer to this question is tucked away in the Repatriation Private Patient Principles (Australian Government 2015), and nowhere explained on Medicare's website because it is not within Medicare's jurisdiction. This notwithstanding, the government brought the entire veterans and military personnel regulatory framework within the purview of the PSR in 2019, under the term 'relevant DVA law' (Australian Government 1973a) which was added and defined in the HIA. This has effectively given the PSR ability to investigate medical bills generated by MP under the Veterans Entitlements Act and Regulations, though it is unclear where MP sitting on PSR panels and committees will obtain the required legal skills to interpret and apply DVA laws which apply a different standard. Furthermore, the fact this critically important change was not communicated to the medical profession is of concern. Once MP become aware of the change, they may begin to vary their treatment of veterans such as by charging OOP medical expenses to mitigate the threat of PSR investigations, potentially having a detrimental impact on Australia's veteran community.

In another proposed change, a new item, called an enrolment fee, will soon be available to GP. The DOH has not yet provided details other than that the enrolment fee will be claimed through the MBS quarterly. The Health Minister has said (O'Rourke 2020b) the payments are intended to compensate GP for time spent giving advice over the phone or via email, as well as sending elderly patients reminders ahead of tests or immunisations, all of which is now reimbursed under COVID telehealth arrangements. The difficulty in trying to fit an enrolment fee into the MBS structure is that while the treatment of a patient may be clinically relevant, enrolling them in the practice never is. As a result, every patient presenting to a GP practice will likely have an enrolment fee billed. Under the current structure, some of these claims will be successfully reimbursed, others will not, but every GP will try because there can be no argument that billing an enrolment item is not clinically relevant, and a GP will never know whether the patient has already been enrolled somewhere else, the system operating fundamentally on a first come-first-served basis. Administrative components of clinically relevant services such as enrolling patients are more appropriately placed within the service itself rather than being unbundled and billed separately, or reimbursed outside of service code frameworks such as the MBS. However, having never properly defined the start and end point of professional services in the MBS and the inclusions and exclusions of each (discussed in Chapter 4), this problem repeats often, and short-sighted solutions such as adding separate enrolment fees to the MBS may expose public money to further vulnerabilities and increase compliance risk for MP.

Post-Script – Enrolment fees

In the days just prior to this thesis being finalised, the Federal Government released a consultation draft of its 10-year primary health care plan (Department of Health 2021b), which includes further details around this enrolment fee (renamed a registration fee). While beyond the scope of this thesis to discuss, the proposal makes patient access to telehealth MBS services contingent upon what is described as ‘voluntary patient registration’ with a GP practice. This is concerning and may give rise to constitutional issues. It appears that patients will have no realistic option other than to register with a practice if they wish to avail

telehealth, yet the GPs in that practice will remain at liberty to charge uncapped fees pursuant to the CCC.

MBSRT changes to electrocardiography services

The ECG changes already discussed, represent another manifestation of the clinical relevance visibility problem. Due to the fact that it is not possible for the government to know *why* an ECG was provided, it appears that an attempt has been made to insert possible reasons within the MBS item description itself. However, this reveals a lack of understanding that MBS codes are service codes and should therefore be drafted with a pure intent to do nothing more than describe the service itself, rather than trying to articulate all possible clinically relevant scenarios and circumstances which may cause the service to be delivered and billed. Recent legal commentary concerning proliferation of this type of approach to legal drafting in the context of business laws said:

'Delivering the Hamlyn Lectures in 2017, Burrows (now Lord Burrows) encouraged drafters to resist "the beguiling temptation to tie down all conceivable matters" because trying to do so "produces needlessly complex provisions and will in any event inevitably fail because tying everything down is an impossible goal".' (Isdale and Ash 2021)

Clinical relevance, or *why* the service was billed, is distinct from the service itself, and until the government has access to real-time clinical information about why a patient presented to an MP, clinical relevance can never be known in advance of payment. Further, attempts to delineate it in MBS regulations is largely pointless and an 'impossible goal' particularly given the reasons MP select MBS services are based on many years of medical training, endless human variation, and individual patient presentations.

Improving visibility over clinical services – the Australian hospital experience

Of note is the fact that Australia has successfully overcome the type of compliance and health expenditure challenges plaguing the MBS, in the area of hospital billing, where the various components of admitted episodes such as accommodation, operating theatre fees and prosthetics, are costed. Prior to the introduction of ABF, the Federal Government had poor control of expenditure within state-based public hospitals. ABF delivered successful cost containment in relation to admitted care (Independent Hospitals Pricing Authority 2020b), largely attributable to the introduction of coding, which gave the government – for the first time – visibility over what it was paying for by making providers more accountable.

Consistent representation of clinical conditions, treatment and issues is the foundation of all modern health systems and representation using codes that can be analysed and applied in digital systems underpin modern healthcare. Such codes are the tools we use to represent, count, and measure services, plan, monitor and pay.

Multiple code systems are in use worldwide. All are different and have different purposes. The most common types of codes found in most health systems are:

- disease codes;
- procedure codes;
- billing codes; and
- terminology or decision support codes.

MBS codes are billing codes. When ABF was introduced, the Australian health system added disease and procedure codes which enabled pre-payment visibility and bundling of hospital episode costs, achieving good fiscal control. Advancements in technology now present an opportunity for the government to adopt a similar approach to MBS billing and obtain real-time information about clinical relevance.

Designed in 1999, SNOMED-CT is a modern terminology code set in wide global use (SNOMED International 2020b). Designed to extract data directly from the clinical record in real time, with no extra effort required by MP, SNOMED-CT may offer an immediate solution to Medicare's clinical relevance problem by joining clinical and billing data in a single fiscal claim. Further, MP are unlikely to alter clinical records of actual treatment of their patients because these records represent their primary legal defence in medical negligence claims.

Pre-payment visibility is possible

The following short section (up to the commencement of section 7.6) is adapted from an opinion article (not peer reviewed) titled: **Telehealth is not quite the colt from old Regret, but it sure as hell has got away**. It was published in *Pulse+IT Magazine* on 18 May 2020 by Margaret Faux and Heather Grain, and is available at this link https://www.pulseitmagazine.com.au/news/australian-ehealth/5509-opinion-telehealth-is-not-quite-the-colt-from-old-regret-but-it-sure-as-hell-has-got-away

A basic rule of data can tame Medicare: collect data used to care for the patient at the point of care, not as a separate fiscal claim. In this way, administrative overheads are reduced and real data from the patient's care are used as the evidence for claiming.

SNOMED-CT are terminology codes already adopted by the Australian Digital Health Agency for Australia's digital health strategy and are the ideal coding system for this purpose. SNOMED-CT are designed for clinical use directly for patient care, and their level of specificity is high, numbering in the millions, and require no additional MP training or effort.

In the U.S health system, payers have better visibility over what they pay for than Australia because every non-admitted patient encounter is coded using disease and procedure codes. There is therefore nothing novel in this approach, with much of the world also coding non-admitted care. This is not to suggest the wholesale adoption of the U.S system of health data collection, because it has its own deep flaws and is burdensome, but rather, that we leverage

our progressive electronic health record systems to inform reimbursement policies and deliver a more accountable healthcare fiscal policy while not creating a clinical burden in data capture.

In the example of a non-compliant medical bill, extracting relevant SNOMED CT codes from the patient's record into the claim before it is submitted may not necessarily prevent egregious conduct. However, it may make MP think twice, because each additional cognitive step in the billing process allows for the entry of the conscience mind and ethical considerations.

If in the 'reason for attendance' data field of the clinical record, all that was entered was 'repeat script', SNOMED CT would return code 182918009 (repeated prescription (situation)). This enables the government to ask the right questions without having to issue expensive, time-consuming legal requests for clinical records when concerns arise. Questions such as: Why did a repeat script take over 20 minutes to issue? Additional reasons for a single attendance are of course common and easily accommodated by SNOMED CT.

Other benefits of SNOMED CT are that by giving the government what it sorely needs in terms of visibility over billing, it will have less need to restrict services in other ways, such as by allowing only one consult per patient per day or per week, which often does not align with appropriate clinical practice. It is not the number of claims that matters, but the reasons for those claims, and we must accept that, in the current context of a government paying blindly and non-compliant billing being a significant problem, the government has no option other than to impose restrictions of some sort.

Acknowledging and accepting there are multiple reasons for a patient to visit a doctor and symptoms are converted to a problem/diagnosis list, a SNOMED/MBS combination (the new SNOMED code providing the reason *why* a service was provided and the MBS code continuing to describe *what* service was provided and the fee) will enable the government to quickly identify outliers and combinations that just look odd. For example, if every patient presenting

to a particular clinic with the SNOMED code for ‘cough’ has MBS billing codes submitted for the removal of three moles, an ECG, a mental health treatment plan prepared, a 40-minute consult and a brain scan, then appropriate questions and requests for further information may be reasonable.

The introduction of SNOMED-CT codes alone will not solve all of Australia’s Medicare billing compliance challenges, but without it or another similar solution, the current intractable deadlock between MP demands for increased rebates and the government’s inability to account for expenditure, can never be reconciled.

7.6 The educational deficit

Despite occasional reports from the government about education being the 'key to compliance' (see **Appendix 11**), education has never been seriously considered as a strategy to combat non-compliance. Yet all participants in this study described the inadequacy of their training in this important area.

In whose interests is it to teach medical billing?

Despite having little interest in billing, all study participants desired more education on this topic, yet with the exception of non-expert businesses who appear to be promulgating erroneous advice ("Anand & Anor v Armstrong & Anor [2020] SADC 34" 2020), no government accredited organisation, such as the professional medical colleges, has ever conscientiously taken this up. While one might expect that a business opportunity of this size would usually not be missed in a free market, one possible explanation is the medical colleges instinctively know that Medicare is a legal system and, as professional scientists, they lack requisite qualifications to teach it. In addition to MP not having training or skills in this area, health financing law is not a recognised area of academic endeavour. The discipline of health financing law and practice does not currently exist in university schools of public health, health economics, insurance or law, and having escaped focused academic attention, the surrounding confusion of this topic may not be surprising.

Stakeholders with financial interests in teaching medical billing and health financing are typically payers, such as Medicare. By educating participating providers about the rules of any health payment scheme, probity and effective prosecution will usually increase by quashing the defence of ignorance. Unfortunately, Australia's complex blended public/private funding arrangements confound this norm. Medicare cannot act as educator, regulator and prosecutor simultaneously not only due to inherent conflicts of interests, but because many of our complex health funding arrangements are outside the government's jurisdictional scope, including much of the operation of the PHI and State WC schemes.

In the literature review section of this thesis, one international commentator (Heath J 2020) suggested medical billing education should be housed in university medical schools and specialist colleges, which he asserted, have failed in their duty to teach at least the ethics of medical billing to their students and members, noting that teaching general ethics is well recognised in the medical curriculum. However, the specialist colleges and medical schools who participated in this research did not see themselves as having responsibility in this area. The colleges felt their focus was safety, standards, advocacy and clinical education. University medical schools cited crowded curriculums as a barrier to teaching this content and suggested the subject matter was too distant from when it is required (discussed in Chapter 5). Further, the focus of university medical schools was, understandably, on graduating clinically safe interns. This study also found the AMA was not the appropriate educator, because its responsibilities are to its MP members rather than the broader health system.

All participants of this research intended to continue having third parties administer their Medicare billing, describing it as a somewhat disagreeable component of medical practice that they preferred not to discuss with patients. However, the potential negative consequences of uneducated and unaccountable third parties administering billing was an important theme in this project, and therefore education for third-party billers will be an essential consideration in addressing compliance into the future.

A comparison with other professions

Third-party administration of medical billing is similar to the way various areas of the financial services sector operate, such as taxation and financial planning. Additionally, the legal profession may offer parallel experience and transferable learning in the area of fiscal responsibility for their professional members.

Third-party administration of certain aspects of taxation in Australia is administered by a large workforce of professionals known as Tax and BAS Agents, who deliver valuable and reliable services to Australians in relation to the preparation of their tax returns. The Federal

Government has oversight of these professionals through the Tax Practitioners Board (Board 2020). The *Tax Agent Services Act 2009* regulates relevant curriculum requirements, including a primary academic qualification in bookkeeping or accounting at a minimum Australian Qualifications Framework level 4 (Australian Qualifications Framework 2020), which must be obtained through a registered training organisation or equivalent institution. The benefits to the community of using registered agents are nationally consistent qualifications, professional indemnity insurance and having met fit and proper person requirements.

The evolution of financial planning education is another area that potentially offers lessons which may benefit and inform future Medicare education strategies. Historically, accounting firms offered financial advice as an add-on to core accounting services. However, the accountants who provided this advice had no additional training or skills in financial planning, and often had conflicted interests in the products and service they were selling. This is not dissimilar to the position and interests often held by third-party billers such as hospital finance departments and corporate practice owners (discussed in Chapter 4). Following the previously mentioned Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (Hayne 2019a), regulation of those who called themselves Financial Planners would never again be in doubt. Financial Planners have since evolved from an industry to a regulated profession underpinned by standardised education requirements, a code of ethics, and government oversight by the Federal Financial Advisor Standards and Ethics Authority (Financial Advisor Standards and Ethics Authority 2020).

Education modelled along similar lines to accounting and financial planning may be appropriate for third-party medical billers, however this research found that any educational response will only succeed if MP are also required to participate, because ultimate legal responsibility under the HIA will continue to rest with them.

One MP participant in this study suggested that a program similar to that undertaken by trainee lawyers may offer pathways and opportunities for the medical profession to meet educational needs in relation to medical billing. To obtain a legal practising certificate and be

admitted to practice as a lawyer in Australia, all candidates must undertake a program known as the Graduate Diploma of Legal Practice (GDLP) (Legal Profession Admission Board 2020), which is designed to teach non-substantive areas of law and day-to-day 'lawyering'. A key competency in the GDLP, established by the Australasian Professional Legal Education Council for entry-level lawyers (Legal Profession Admission Board 2020), is a topic described as 'Trust and Office Accounting'. The topic aims to ensure that newly graduated lawyers properly understand the requirements of responsibly managing sometimes large sums of money they will hold in trust for clients. It is a compulsory subject requiring successful completion of an examination in order to pass the GDLP. It is suggested that whilst trust account money held by lawyers is private money (as opposed to Medicare, which is public money), there is an important parallel in that both professions have unfettered access to money which is not their own.

The legal profession has recognised this as an area of vulnerability for lawyers and has provided an educational response. The trust accounting module of the GDLP is the mechanism by which the legal profession discharges its duty to the Australian public to ensure all Australian lawyers know how to conduct themselves with propriety in this area. This, of course, does not prevent some lawyers from acting with impropriety and using monies held in trust inappropriately, but it does effectively close the defence of ignorance. Lawyers cannot ever say they 'did not know' that extracting money from a trust account in circumstances not directly related to providing legal services to a client was impermissible, and the profession itself stigmatises colleagues who err in this regard.

Medical practitioners, on the other hand, will often comment on the unfairness of investigations of their colleagues, stating the rules are too opaque and hard to follow. Findings from this study suggest this avenue of grievance should be closed via an educational response, and the experiences of the legal profession may be partially transferrable to the medical profession, though Medicare billing is considerably more complex than legal trust accounting and the relevant laws are currently incoherent.

It should, of course, never be forgotten that ultimate responsibility for the integrity of the Medicare purse rests with the Federal Government – the ultimate public custodian. It is the Federal Government which has an overarching duty to ensure entry-level MP, who will find themselves in the privileged position of being able to claim Medicare payments, are properly equipped to understand the legal requirements of claiming and compliance under the MBS from their first day on the job. This is currently not occurring, and in no other sector under our Westminster system of parliamentary democracy do we prosecute offenders so aggressively without the offender ever having been educated or even made aware of the rules prior to being required to use them. In the absence of this critical support, MP appear to have adopted a nihilistic and fatalistic approach to compliance risk, because they feel powerless in their ability to manage it (discussed in Chapter 6). MP don't know what to do beyond contacting their medical defence organisation (MDO) when Medicare billing situations arise, but their MDO generally provide minimal support in this area.

Medicare compliance will not be achieved until the cavernous educational gap identified in this research is filled. It is suggested that an appropriate place for this education, to ensure national consistency, independence and potentially make available professional indemnity insurance for graduating students, is within Australia's existing, world-class Australian Qualifications Framework (Australian Qualifications Framework 2020).

7.7 How the myth of Medicare literacy became entrenched

Health economists and MP have traditionally jostled for dominance as keepers of health system wisdom. In the early days of Medicare, when record-keeping was manual, data was not shared, funding was not blended and the legal structure was relatively simple (**Figure 4**), this was not problematic. The original scheme had been designed by two leading health economists (Scotton and MacDonald 1993), with the eventual co-operation of MP through the AMA, who provided the original fee schedule. As long as not too much changed, their collective understanding and wisdom about the new health system was deemed a sufficient knowledge base from which to draw should questions around the operation of the scheme arise.

Throughout the 20th century, additional health system 'experts' with qualifications in health administration, health system management, health service management and public health began increasing their participation in health policy development. However, these new health professionals typically focused on macro reform, general health leadership and hospital management, having little direct involvement in day-to-day health financing transactions, which remained the domain of clinicians (in Australia's case, mostly MP).

By 1994, when the PSR was introduced, MP dominance of the medical market was well established and the failure of the MSCI had strengthened that position. It appeared MP had a more detailed understanding of the operation of Medicare than the government. The messaging was simple – only we understand it and only we can fix it. However, in 2000, when simplified billing (or gapcover) schemes were introduced, complexity increased exponentially, heralding a new industry of medical billing companies who became 'experts' in managing the sudden influx of new requirements for dozens of PHI, all of which had different, constantly changing rules. The fatal flaw in gapcover schemes which sowed the seed of complexity, as we have seen, was taking the patient's Medicare rebate from them without their knowledge or consent. By assigning rebates automatically to PHI, an open chequebook of public money

was granted to the PHI in the context of a new, more complex regulatory environment, where public money could be buried in administration.

At around the same time, on the other side of the world, computer scientists were forging an exciting path as the newest health system 'experts' of the 21st century by developing a new field of endeavour which recognised that internet-based information models and data design would support the health systems of the future. These new professionals wasted no time developing training programs, including for sub-specialties within their field such as 'clinical terminologists' who had specific expertise in the understanding of ontologies and ways to represent clinical concepts within a domain. The discipline of health informatics was born (the Health Informatics Society of Australia (HISA) was established in 1993) (Australasian Institute of Digital Health 2020). The *Desiderata for Controlled Medical Vocabularies in the Twenty-First Century* (Cimino J J 1998), now famous among clinical terminologists, was published in 1998, introducing the concept of global standards for consistent, clearly expressed health data and medical service descriptions, stating:

"All too often…vocabularies change in ways that are for the convenience of the creators but wreak havoc with the users. For example, if the name of a concept is changed in such a way as to alter its meaning, what happens to the ability to aggregate patient data that are coded before and after the change? An important desideratum is that those charged with maintaining the vocabulary must accommodate graceful evolution of their content and structure. This can be accomplished through clear, detailed descriptions of what changes occur and why, so that good reasons for change (such as simple addition, refinement, precoordination, disambiguation, obsolescence, discovered redundancy, and minor name changes) can be understood and bad reasons (such as redundancy, major name changes, code reuse, and changed codes) can be avoided." (Cimino J J 1998)

In 2001 a second Australian digital health organisation, the Australasian College of Health Informatics (ACHI), was established (Australasian Institute of Digital Health 2020); the HISA

and ACHI merged in 2019 to become the current peak body for Australasian digital health – the Australasian Institute of Digital Health (Australasian Institute of Digital Health 2020).

In 2007, the international health informatics profession brought global clinical terminology and medical vocabulary experts together and established the Joint Initiative Council for Global Health Informatics Standardization (Joint Initiative Council for Global Health Informatics Standardization 2007), with a remit to establish standards to:

> *"1. Enable interoperability of information and processes across health domains;*
> *2. Support the timely, efficient delivery of safe, coordinated, accountable, high-quality health services to individuals, communities and populations;*
> *3. Facilitate effective global markets for health information systems." (Joint Initiative Council for Global Health Informatics Standardization 2007)*

Yet despite these advances in digital health and global acceptance that clinical terminology experts played a critically important role in developing interoperable, medical vocabularies, Australia continued to lag behind in the international e-health arena, with the MBS vocabulary remaining tightly controlled by MP.

By 2005, medical billing in Australia had become so convoluted, more and more aggrieved MP were challenging PSR decisions, and the need for better support and education for MP about how to bill correctly was becoming evident. However, in that year the government dismantled the Health Insurance Commission (HIC), and 30 years of corporate knowledge was dismantled with it. The government was also facing criticism around perceived ongoing failures to contain fraud and abuse (Flynn 2004), and in 2014 the ANAO again reported that Medicare compliance activity since 2008 had been largely unsuccessful (Australian Auditor-General 2014). Once again, this increased pressure on the DOH to improve its performance, but the DOH was by then hamstrung by a regulatory quagmire of inconsistent and overlapping provisions so deep it could do little more than double down and escalate investigations of GP through PSR referrals. However, with no improvements in education or departmental support following

the 2011 Senate Enquiry, MP were becoming increasingly anxious about Medicare compliance and were desperate for a central source of truth around correct use of the scheme.

Throughout this entire journey, Australians have continued to believe MP have deep knowledge about how Medicare works. It is, of course, a perfectly reasonable belief based on the simple premise that if MP interact and transact with Medicare every day, they must know how it works. Notably, MP have never actively opposed this misconception, which also drives ill-informed but understandable media reports of MP rorting. From the media's perspective, either MP know how Medicare works and are therefore deliberately rorting it, or MP are experiencing confusion (which has never been conceded) and are not rorting. There is no third explanation for non-compliant Medicare billing.

Amid global understanding and recognition that codes such as MBS codes were no longer confined to paper records, and serve equally important epidemiological, financial, clinical, and legal purposes for many stakeholders, in 2015 when the MBSRT was established, the government really had no option other than to ensure it would be led by MP. This was despite the fact that almost two decades earlier, the *Desiderata* had provided a prescient explanation of why single-stakeholder approaches to amending health data vocabularies, such as the MBS, was the wrong approach, stating:

"The intense focus previously directed at such issues as medical knowledge representation and patient care data models is now being redirected to the issue of developing and maintaining shareable, multipurpose, high-quality vocabularies." (Cimino J J 1998)

However, Australian MP, via various peak bodies such as the AMA, had spent two decades building their position as Medicare 'experts', so the task of rewriting Australia's critical health dataset would be theirs alone, even though this was unsupported by their scientific training and out of step with global trends. The terms of reference for the MBSRT were extremely wide as follows (Department of Health 2017):

"*2. Roles and responsibilities*

The Taskforce will undertake the following:

- *Review MBS items taking account of factors including concerns about safety, clinically unnecessary service provision and accepted clinical guidelines.*
- *Commission evidence-based reviews that rely on assessment of literature and data.*
- *Provide advice to the Minister, including advice on the evidence for services, appropriateness, best practice options, levels and frequency of support through the MBS.*
- *Advise on a structure for ongoing review of the MBS.*
- *Advise on a Departmental program of work that aims to update the Act and regulations (MBS Rules) that underpin MBS funding.*
- *Provide advice about the MBS and related health financing issues, including where the MBS funding model may not be the appropriate mechanism for providing patients with access to optimal care, as requested by the Minister.*
- *Engage with health consumers, medical professionals, peak bodies and other stakeholders to seek their views about appropriate review approaches and processes."*

With the exception of the first three bullet points and the last, it is arguable MP did not have the qualifications or skills to undertake this work, particularly; "*Advis[ing] on a Departmental program of work that aims to update the Act and regulations (MBS Rules) that underpin MBS funding*".

While there were undoubtedly many well-meaning MP involved in the MBSRT process, pluralistic ignorance may have been a factor in relation to some of their decisions to participate. Some MP may have innocently failed to understand that a major part of the process they were engaging in was law reform and therefore well outside their skill set, while others may have had some measure of contempt for the legal framework of Medicare. Evidence of the poor legal literacy of participants is becoming increasingly apparent such as the previous ECG example and another more damaging proposal - that GP should be permitted to charge separately for dressings when bulk billing – which was based on a failure to

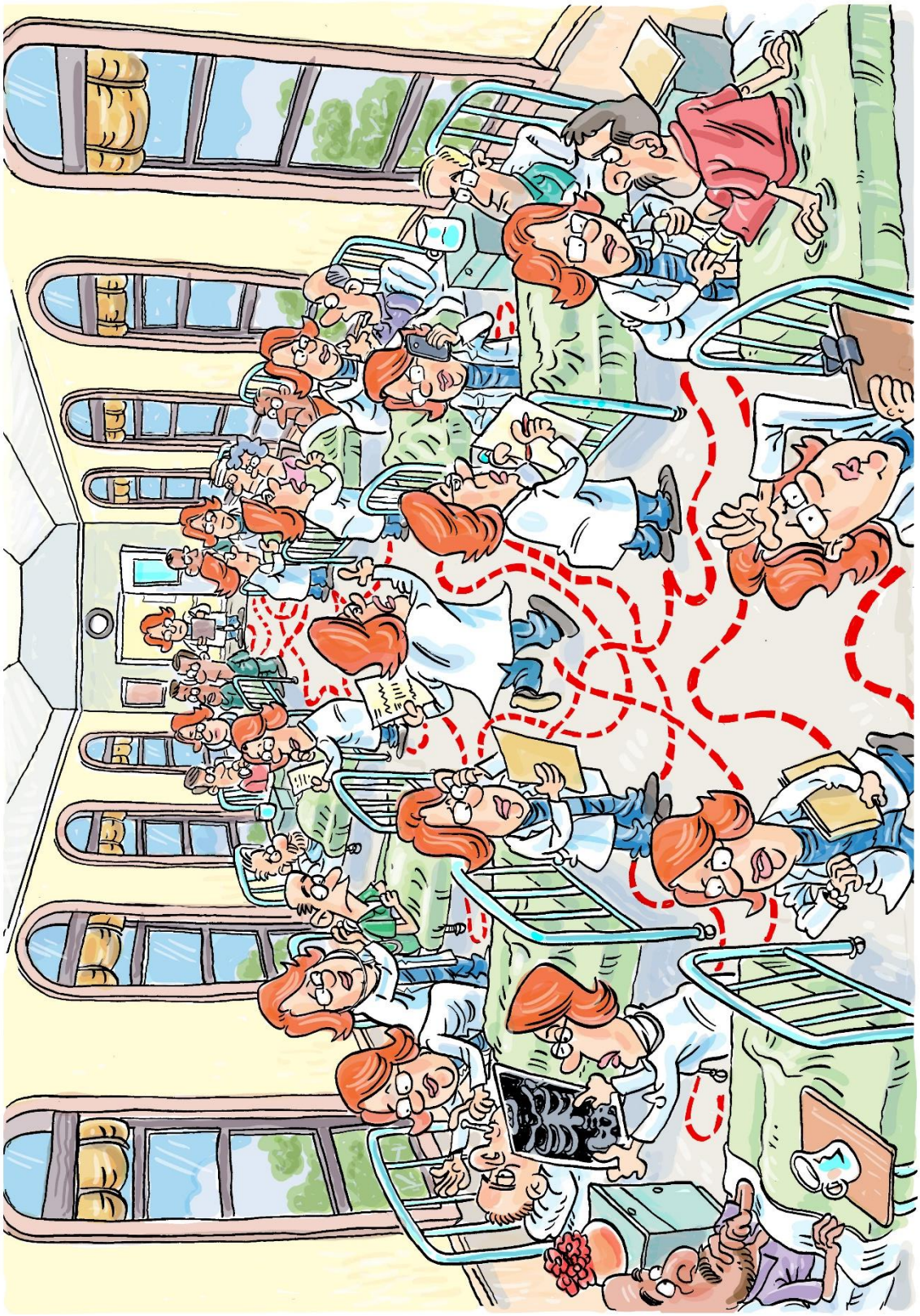
understand the application of the CCC (Faux and Grain 2021). The dressings proposal was immediately rejected by the government (Hunt 2021).

Another area of concern is found in the final report of the *Specialist and Consultant Physician Consultation Clinical Committee* which has suggested the solution to current problems around time-based attendance items, is to add more time-based attendance items into the MBS, this time for non-GP specialists (Department of Health 2020f). While it is appropriate that attendance items across all MP groups (including GP) be reviewed, there is no evidence this proposal will achieve its stated aim (which is unclear). In addition, the proposal will add more complexity to MBS billing, while being unworkable in the context of hospital-based medicine.

Time-based billing in environments where patients are seen sequentially is sometimes manageable. But hospital ward rounds rarely follow an orderly progression of linear time, instead being characterised by more chaotic zig zag time, with MP going back and forth between patients as new information comes to hand (e.g., pathology results), relatives arrive, patients forget questions and ask the MP to come back, nurses take down dressings, phone calls interrupt the flow, to name but a few examples. It is not an exaggeration to suggest that MP would require timekeepers with stop watches to manage time-based billing in this context were the MBSRT proposal to go ahead. This is illustrated in **Figure 17.** It is therefore suggested this represents another example of a poorly though out proposal, with no clear evidentiary basis or indication of what it seeks to achieve. A simpler solution would be to teach MP how to correctly bill the two current time-based services – items 132 and 133.

With no understanding of the interconnectedness of the MBS with almost every aspect of the health system (**Figure 5**), and no digital health experts or clinical terminologists on the committees to advise them, many MP on the MBSRT may also have been blinded to some of the downstream impacts of their work, such as exposing their own colleagues to new compliance risks like the ECG example in section 7.4, or preventing the hospitals who employ them from receiving timely payment from PHI because of mismatched ACHI and MBS codes.

Figure 17 – A typical hospital ward round



Software vendors have also been impacted by the unrelenting changes originating from the MBSRT (Kate McDonald 2020). These vendors import the MBS codes into the systems MP use to process billing. The International Organization for Standardization's Health Informatics Health Information Governance Standards Ad Hoc Group (ISO/TC215/AHG3 2020), whose work informs global health data governance standards in cooperation with the Joint Initiative Council for Global Health Informatics Standardization, has expressly included software vendors as stakeholders in health information, stating:

"Health information governance standards are relevant to a wide range of individuals, organisations, and governments.

- *Patients who depend on accurate, available, and secure data*
- *Clinicians and professional organizations who need accurate and accessible information, knowledge, and records*
- *Decision makers who need to know what is required and assured of appropriate governance*
- *Software vendors who need to be able to develop fiscally viable, safe and appropriate systems*
- *information governance practice implementors*
- *Regulators*
- *Health information and informatics professionals*
- *Governments*
- *Public health*
- *Population health*
- *Educators*
- *Researchers and analysts*
- *Health information custodians and similar organisations."* (ISO/TC215/AHG3 2020: full report available by request to Standards Australia)

In 2019 there were 495 changes to the MBS (MBSOnline 2020). Between 1 January and 20 September 2020, 635 changes were made (MBSOnline 2020), the majority of which were *not*

COVID related; note that every change can require alteration to thousands of rules. The recent ECG changes alone necessitated removal of over 400 rules and the addition of almost 600 new rules, all of which take software developers and Medicare time to program, and which affect the PHI and other payment systems across the country. When item 13950 was introduced on 1 November 2020, at least one major PHI still had not updated its fee schedule with the new item and associated rates three weeks later (NIB 2020), and anecdotal evidence suggests some hospital providers were still sorting out necessary contract changes with the PHI seven months later. It is MP who are caught in the middle of these processes, during which a compliant claim becomes a somewhat nebulous concept.

Sometimes changes are notified by Medicare and then retracted or revised within just a few days of each other, and other times a correction is advised multiple times in one day (MBS Online 2020b). Sometimes the email from the department attaching the updated MBS file has incorrect information which is never corrected (MBS Online 2020b). The net result of this chaos is that MP may inadvertently breach Medicare requirements, not because of intentional wrongdoing, but because their software vendor was unable to keep up with the relentless pace of change, and the MBS codes in the billing software were out of date. Details of the changes made to the MBS in 2019 and 2020 are set out in **Table 16**.

Table 16 - MBS item number changes 2019–2020

MBS item number changes 2019 and 2020					
2019					
Date	Added	Changed	Removed		
1/01/2019	1	7	0		
1/02/2019	1	1	0		
1/03/2019	22	1	12		
1/04/2019	3	1	0		
1/05/2019	12	1	0		
1/07/2019	8	13	0		
1/08/2019	0	2	0		
14/09/2019	7	0	0		
1/11/2019	104	263	36		
Sub-totals	**158**	**289**	**48**		
Total	**495**				
2020				Added-Covid	Changed-Covid
1/01/2020	36	77	0	0	0
17/03/2020	47	6	13	0	0
1/04/2020	0	3	1	0	0
6/04/2020	2	0	0	244	0
20/04/2020	2	3	0	28	0
28/05/2020	0	3	0	0	0
1/07/2020	7	20	0	1	8
1/08/2020	67	13	18	0	0
18/09/2020	6	30	0	0	0
Sub-totals	**167**	**155**	**32**	**273**	**8**
Total ex- Covid	**354**				
Total Covid	**281**				
Total	**635**				

In a speech defending the MBSRT's approach of being MP led and controlled, the Chair of the taskforce stated the review was his idea stating:

"The MBS not only had items on it that were redundant, but it had items on it where the descriptions were very poor…That led to a lot of confusion among practitioners as to what items they were meant to be using for certain things…It also provided some practitioners, whose ethics were perhaps rather dubious, opportunity for gaming the system, and we have certainly encountered a bit of that…Unfortunately, the 5–10% who use it inappropriately are

going to end up wrecking it for everyone unless they are made to pull their heads in…If we don't fix it, I can tell you, it is only going to take another five, maybe 10, years and government will come in and fix it itself. And it won't be to our liking." (O'Rourke 2019c)

Evidence from this study found that the MBSRT has increased rather than decreased the clarity of service descriptions in some areas and is unlikely to have made any improvement in the incidence of non-compliant billing, and may even have made it worse such as by sending ECGs underground. The comment that 5–10% of MP use Medicare inappropriately is unsupported by evidence. While the current best estimate of the incidence of non-compliant billing in Australia is 5–15% of the scheme's total cost, the distribution of that phenomenon across the more than 110,000 registered MP in Australia is not known.

The MBSRT being hailed as 'clinician led' was in many ways the pinnacle of the process of convincing Australians that MP understood the Medicare system sufficiently well not only to use and misuse it, but also to reform it. The fact that MP have retained a firm grip on 'Medicare expert' status on the basis of having a medical degree alone is quite astonishing, particularly given all MP participants of this study reported their principal focus was the practice of clinical medicine, they had little interest in Medicare billing, had always devolved the entire Medicare billing process to untrained third parties, and intended to continue doing so. However, the phenomenon of misunderstanding the limits of MP expertise is not uncommon. A recent example saw the former deputy chief medical officer describing some MP as undermining Covid-19 vaccine efforts by holding themselves out as vaccine experts when this was not the case.

'The fact that there are clinicians out there who want to have a voice is absolutely fine, but there is a big difference between someone who has a medical degree in a particular sub-specialty to our top vaccination experts. But from the public's perspective it's difficult to differentiate those voices.' (Aubusson and Clun 2021)

Similarly, any individual describing themselves as a 'Medicare expert' currently lacks any academic foundation or legitimacy, and this is also an area where it may be difficult for the public to differentiate competing voices. While MP have experience working with Medicare (as do many other health professionals), MP holding only medical qualifications cannot legitimately be described as 'Medicare experts', particularly given this research found most MP have never administered a single Medicare bill.

It is also unclear why the international standard for drafting clinical terminology was not referenced anywhere in the MBSRT. The preamble to *ISO/TS 22287:2019(en) Health informatics — Workforce roles and capabilities for terminology and terminology services in healthcare (term workforce)*, describes the importance of having experts involved in this work:

'The purpose of this document is to enable healthcare organizations and related supporting organizations that deploy HICT products to safely and effectively support semantic interoperability within systems and between systems locally, nationally, or globally. Semantic interoperability, the ability of computer systems to exchange data with unambiguous and shared meaning, is impacted by the generation, management and sharing of health-related data and information.

Implementation and operation of complex terminologies in healthcare organizations and related supporting organizations without proper knowledge and skills of personnel in those terminological resources is a contributing factor in the resulting failure to deliver expected care outcomes, in delays in Electronic Health Record (EHR) and Health Information Systems (HIS) implementations, and in some cases, in injury caused to patients.'(International Standards Organization 2019)

ISO Standard 22287:2019(en) describes in detail the skills required of personnel undertaking clinical terminology work, which are predominantly the skills of data scientists.

International medical associations such as the American Medical Association (American Medical Association 2021) and the World Organization of Family Doctors (Wonca 2021) have for many years recognised the work of expert clinical terminologists, by actively collaborating with them to align their code systems with international standards, including the U.S equivalent of the MBS - CPT codes.

'The American Medical Association (AMA) and SNOMED International have a collaborative agreement to coordinate on the design and development of their respective coding and terminology products.' (SNOMED International 2020a)

'In 2015, SNOMED International and WONCA (World Organization of Family Doctors) signed a refreshed Cooperation Agreement which was focused on delivering…General Practice/Family Practice (GP/FP) refset based on international requirements [and] With the development of ICPC-3 and planned implementation from 2021, the focus of discussions are now on identifying global requirements for linking SNOMED CT and ICPC-3.' (SNOMED International 2020a)

This important work of building internationally consistent health terminologies will also have flow on positive effects on MP compliance, because words, and descriptions of clinical services will have a single meaning in participating jurisdictions.

In Australia, the *Australian Digital Health Agency* (ADHA) is an independent statutory authority, and custodian of the national digital health strategy. (Australian Digital Health Agency 2021a) The ADHA has commented on the importance of harmonising Australia's health terminologies through strong data governance and standards stating, *"Evidence suggests that high-quality data requires both strong data governance and agreement on standards for terminology." (Australian Digital Health Agency 2021b)* The national digital health strategy is underpinned by the Australian modifications of SNOMED-CT codes (Australian Digital Health Agency 2021c). **Table 17** provides a hypothetical example of what MBS item 13950 might look like in the context of a common day admission for *'intravenous chemotherapy for adenocarcinoma of colon'* if it was aligned with other national codes.

Table 17 – Hypothetical example of MBS item 13950 aligned with Australia's other codes

Code set	MBS	ACHI	ICD-10 AM 11th Edition	SNOMED-AM
Purpose and use	Service codes with limited diagnostic information. Single use is billing. The only code set in Australia with dollar values attached to each code.	Procedure codes. Describe admitted patient services only. Derived from the MBS but with higher levels of specificity. Used in combination with ICD to inform DRG for ABF.	Disease codes. Represent reason for visit not services provided. Several purposes 1. ABF (combined with ACHI to inform DRG) 2. Public health monitoring 3. Epidemiology 4. Service planning	Terminology codes. Intended use is clinical. Represents meaning at whatever depth of specificity is relevant to the use case. Can show both the reason for visit and the service provided. Underpins Australia's digital health strategy.
Codes	13950	96199-00	C184 M81403	408645001 363688001 386358000
Descriptions attached to codes	New hypothetical description: Intravenous administration of one or more antineoplastic agents.	Intravenous administration of pharmacological agent antineoplastic	1. Malignant neoplasm of transverse colon 2. Adenocarcinoma Not Otherwise Specified	1. Adenocarcinoma of large intestine 2. Administration of antineoplastic agent (procedure) 3. Administration of drug or medicament via intravenous route (procedure)

In addition to the problems already discussed in relation to the new MBS item 13950, an additional issue is use of the term 'parenteral' in its current description (see page 49). The definition of parenteral is wide, encompassing anything 'not delivered via the intestinal tract' (MedicineNet 2021). **Table 17** demonstrates that the word is inconsistent with accepted terminology in other Australian codes used for the given clinical scenario. It is therefore unclear why it was chosen by the MBSRT and how item 13950 accommodates important differences in delivery modes encompassed under the umbrella term 'parenteral', such as the common difference between intravenous versus subcutaneous (under the skin)

administration. Subcutaneous delivery of any drug is less resource intensive than intravenous administration because it does not require someone trained and credentialled in intravenous access to do the work. Perhaps earlier discussion in this thesis around the fact that no science underpins the fee setting process of MBS items may have been a factor in this decision making, because the cost of subcutaneous versus intravenous administration of chemotherapy is not the same, yet the rebate has been set as if it is. Whether decisions such as this (which is linked to MBS fees not being pegged to any formula, and therefore not accurately reflecting the work involved) are linked to increased consumer OOP, is beyond the scope of this study to discuss, but is deserving of future academic attention.

The hypothetical item 13950 description in **Table 17** has all extraneous words removed and uses 'intravenous' to align with other codes. It is suggested that the word 'attendance' is also not required because once the item is added to the supervision rules already discussed, it is irrelevant whether an MP or someone else acting under the supervision of an MP attends to administer the treatment. It is further suggested that restricting access to item 13950 (such as only allowing oncologists and haematologists to bill it) should be a rules-based process where relevant provider numbers are blocked on the departmental software system, preventing erroneous claims such as those made by Dr Stirling. And finally, any remaining detail and examples may be better placed outside of the item description, such as in separate legally binding written rulings similar to the ATO rulings. A possible approach to written rulings is described in the following chapter. Clear and concise drafting of MBS items is also essential to ensure adherence to the rule of law principle of legality, as we have seen.

Ultimately, reform of Australia's critical health dataset (the MBS) may have been better led by the ADHA. The ADHA would have been well positioned to deploy appropriate experts such as those described in ISO Standard ISO/TS 22287:2019(en), ensure changes were aligned across all stakeholder groups and clinical classifications, uphold international standards for health data interoperability, while liaising with other departments on issues relating to the rule of law. The process of updating the Medicare schedule may now require significant rework.

7.8 The global shift away from 'pay and chase'

In addition to the global drive to standardise the language of health, emerging health systems are adopting new, digital approaches to the problem of financial leakage (Council of Cooperative Health Insurance - NPHIES 2020), recognising that by leveraging technology and data analytics, incorrect payments can be prevented before they happen. A balance between some inevitable post-payment policing and increased pre-payment visibility is becoming a recognised approach to the prevention of improper payments, and mature health systems are also realising the benefits of this more progressive approach.

In a 2018 report of the Centre for Medicare and Medicaid Services (CMS) (Centers for Medicare & Medicaid Services 2018), the US government emphasised a preventative focus, including providing education and assistance to MP. Around the same time, a legal commentator (Donley 2018) characterised the U.S Medicare appeals system as broken, with an 11-year backlog of matters awaiting review by an Administrative Law Judge (ALJ), more than half of which MP were likely to win.

By the following year, the CMS had developed a five-pillar program, which acknowledged its own shortcomings such as creating too many complex administrative requirements and not supporting MP to understand them. The tone of the new approach was mature, responsible, and modern:

"CMS has developed a five-pillar program integrity strategy to modernize the Agency's approach to reducing the improper payment rate while protecting its programs for future generations:

Stop Bad Actors. We work with law enforcement agencies to crack down on 'bad actors' who have defrauded federal health programs.

Prevent Fraud. Rather than the expensive and inefficient 'pay & chase' model, we are focused on preventing and eliminating fraud, waste and abuse on the front end and proactively strengthening vulnerabilities before they are exploited.

Mitigate Emerging Programmatic Risks. We are exploring ways to identify and reduce program integrity risks related to value-based payment programs by looking to experts in the healthcare community for lessons learned and best practices.

Reduce Provider Burden. We want to assist rather than punish providers who make good faith claim errors. To that end, we are we are reducing burden on providers by making coverage and payment rules more easily accessible to them, educating them in our programs, and reducing documentation requirements that are duplicative or unnecessary.

Leverage New Technology. We are working to modernize our program integrity efforts by exploring innovative technologies like artificial intelligence and machine learning, which could allow the Medicare program to review compliance on more claims with less burden on providers and less cost to taxpayers." (Centers for Medicare & Medicaid Services 2019)

Many years after available technology could have enabled the Australian government to begin to address its Medicare blind spots, it has instead continued to support ineffective and old-fashioned post-payment audits and policing. This is not to suggest that policing is no longer required. Working in cooperation with law enforcement agencies to manage fraud and non-compliance is a crucial component of any compliance strategy. However, a more modern and balanced approach is now within the grasp of every country dealing with this problem, and if implemented well, outliers and bad actors who maliciously plunder health funding pools will become more obvious and therefore easier to target, at less cost to taxpayers.

7.9 The ultimate point of impact – Australian consumers

MP participants of this research were asked whether they felt their billing decisions ever influenced patient care (**Appendix 8**). All participants said they had never put financial interests and billing opportunities before the clinical care of their patients. However, billing decisions do affect patients, whether directly or indirectly, because patients fund the entire health system.

The manifestation of patient impact appears to be linked to Medicare audit anxiety, which may be causing some MP to opt out of having direct contact with Medicare and other payers altogether. Instead, the current OOP crisis (Doggett 2018) may suggest more MP are choosing to charge patients upfront fees, perhaps perceiving this a less risky billing strategy. From the MP perspective, it is a safer option to direct available rebates to the patient's bank account rather than the MP's, because if the government or PHI seek to recoup payment, with few exceptions, their only option is to recover from the patient, which they are less likely to do. However, this introduces a raft of other problems affecting the wider health system, including a new legal problem relating to medical fee disclosures (Bupa 2018), and major challenges in the PHI industry (Duckett 2019a). Compounding these problems is the fact MP participants of this study reported being uncomfortable talking about money with their patients, describing those conversations as distasteful and compromising of the therapeutic relationship. In addition to never being taught how Medicare works and how to bill correctly, MP are also not taught the ethical and practical consequences of fee-setting decisions, or even how to approach pricing their services.

Medical practitioners charging egregious fees has been a prominent feature of recent Medicare discourse (Duckett 2019b; Bupa 2018; Ward 2018), and Australia has no specific law against it. Options for patients to contest medical bills are limited to misleading and deceptive conduct, unconscionable conduct, or other causes of action under contract law, although historically, patients rarely challenge medical bills. MP, on the other hand, appear to be less resistant to enforcing debts against patients, even when evidence of prior fee disclosure is

lacking. Disclosure of medical fees is referred to as Informed Financial Consent (IFC), though the concept is nowhere sharply defined, being referred to in various places such as the Code of Conduct (Medical Board 2013) and gapcover schemes legislation (Australian Government 2000). Recent debate has suggested MP should be forced to disclose their fees via IFC. However, forcing MP to disclose fees may unleash other problems.

The *Health Practitioner National Law* includes specific provisions controlling medical practice marketing, including a blanket ban on testimonials (Australian Health Practitioner Regulation Agency 2018). In countries with less robust regulatory provisions, MP may be more easily able to advertise in a way that falsely suggests superiority over colleagues such as by posting fake testimonials on websites that may lead consumers to make potentially dangerous healthcare decisions. Australian consumers are currently well protected from this type of predatory medical marketing. Forcing MP to disclose their fees may necessitate relaxation of these effective marketing restrictions because if an MP charges a high fee based on a belief their service is superior, like all businesses, the law would usually permit justification of those fees in the same way a luxury car dealer is permitted to explain why the cars it sells cost many times more than other vehicles. It is therefore suggested any benefits of a shift in this direction may be outweighed by increased risks to consumers.

In an attempt to address Australia's current OOP cost crisis, a government committee was recently established (Department of Health 2018), the outcome of which was the introduction of a voluntary medical fee transparency website (Australian Government 2020b). MP were invited to participate in this initiative, though very few did, and the project has failed to achieve its policy objective (Brodie 2020). Given the labyrinthine complexity and variability of rebates and medical fees described in this research, this failure may not be surprising given each MP would have required many pages of the website to explain and disclose their myriad fees linked to myriad PHI and other payer schemes, likely leading to more confusion among patients. It is therefore suggested an alternate approach to this problem is required, one that does not force fee disclosures.

Many professionals, including lawyers, are not required to disclose fees on their websites, although the *Legal Profession Uniform Law (NSW) No 16a of 2014 (the uniform law has been adopted by all States and territories)* requires lawyers to enter cost agreements with clients before commencing work. When a cost dispute arises, a protective mechanism prevents the lawyer commencing debt recovery proceedings against the client pending resolution of the dispute. A similar approach positioned within existing infrastructure may offer solutions agreeable to both patients and MP and is deserving of consideration. Instead of forcing MP to provide IFC, the law is easily able to provide that patients will not be required to pay their bills if they do not. A possible approach is outlined in the next chapter.

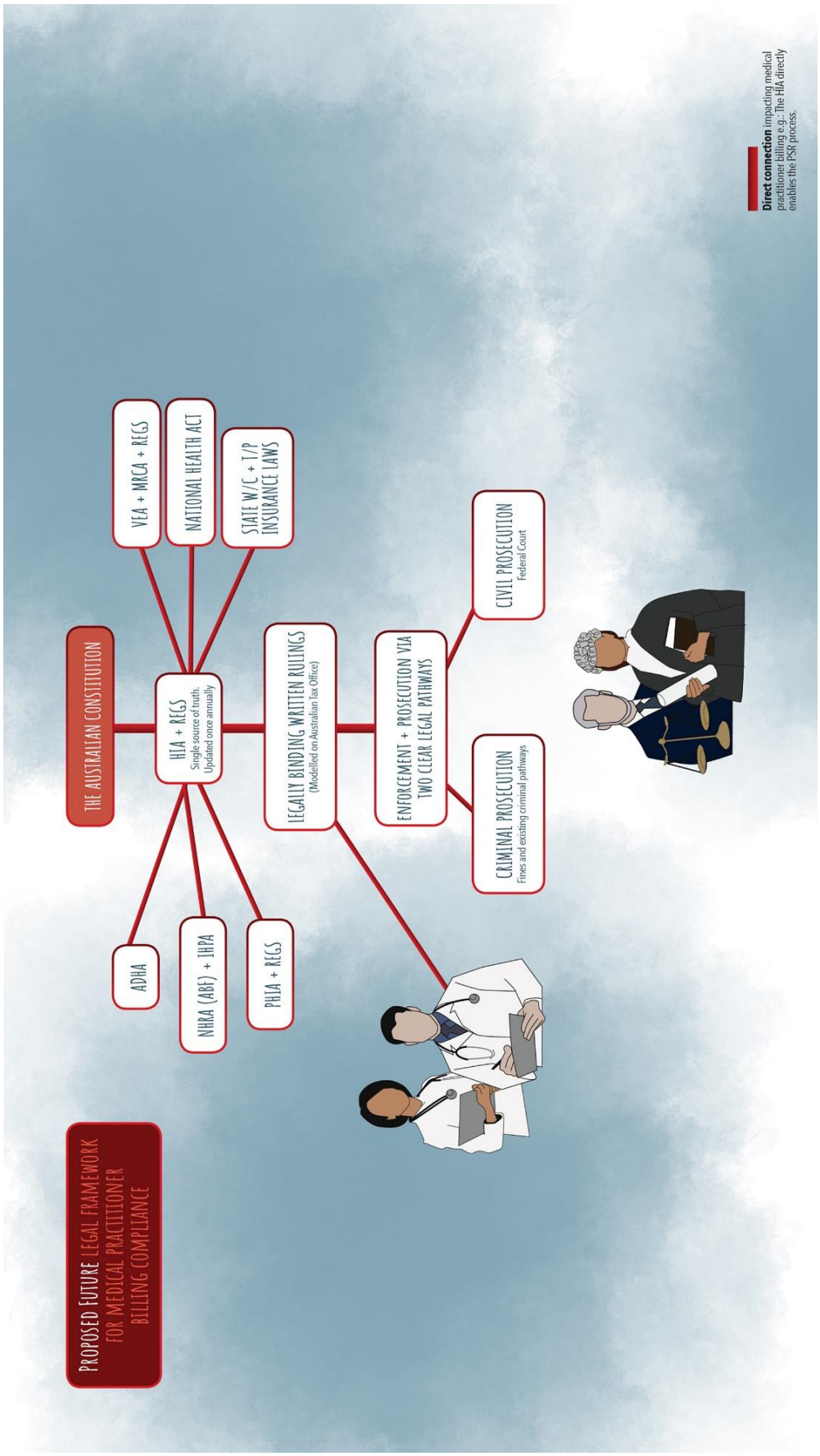
CHAPTER 8: Recommendations for Reform

8.1 Overview

It was inevitable that Medicare's payment arrangements would increase in complexity proportionate to increasing complexity in health service delivery over many decades. But without an overarching plan or policy, divergent codes, standards, and rules have become the norm, and individual actors within the health system (including the PHI, DVA, WC, and CTP insurers) have all created their own 'mini' health systems, that lean on Medicare for originating MBS codes, but administer them differently. On any given day, MP will typically be required to navigate them all. For example, a private surgical operating list of 15 patients, would usually include a mix of patients insured with BUPA, Medibank Private, HCF, at least four other PHI, one or two workers compensation patients, a few DVA patients, a self-insured patient, and sometimes overseas visitors with international insurance. If the HHBG application goes ahead, another layer will be added. The billing rules and rates are therefore different for every patient on the list, and it is unrealistic to expect MP to continue shouldering this burden with no assistance or support.

Therefore, while this research found there is a clear need and desire for MP education in medical billing, it also demonstrated that the shambolic state of Medicare's regulatory infrastructure does not lend itself to curriculum development at this time. Further, the operation of the shared debt recovery scheme (discussed in Chapter 6) and the current hostile PSR environment, suggests it is likely MP under investigation will increasingly seek to attribute blame to third parties where possible. As such, educational institutions themselves risk implication in PSR and Federal Court proceedings if medical billing education they develop leads MP into error. Law reform must therefore precede educational reform. A possible and achievable future legal framework, with all laws pointing to the central authority of the HIA, is represented in **Figure 18**.

Figure 18 - Proposed future MP medical billing compliance framework



Having taken over 40 years to reach the point of incomprehensibility, like Australia's business laws, returning Medicare's regulatory infrastructure to a cohesive whole, will likely take a decade. However, numerous, relatively easy to implement initiatives, can significantly improve non-compliant Medicare billing, potentially enabling more equitable sharing of the national health budget immediately.

The complexity and ambiguity of the scheme often results in multiple, sometimes incorrect interpretations, that ultimately impact medical practitioners. This chapter therefore offers recommendations for reform, which are designed to enable immediate, effective, and efficient solutions to many of the problems identified in this thesis, with most responsibilities positioned within existing agencies and institutions. The reforms are divided into three areas - regulation, education, and digitisation.

Before proceeding, it is worth noting that, in keeping with global trends (Batra, Davis, and Betts 2019; Walker 2016; Spinney 2021), Australia's increasingly digitised health system is likely to gradually shift to lower-cost, community-based care, and the importance of the MBS as the core data source in that transition will become dominant as the role of IHPA and ABF diminish. As less care is hospital based, the work of IHPA will reduce. IHPA is therefore not the appropriate agency to take ownership of the MBS, which is a system of laws invoking criminal liability. To protect MP and prevent a repeat slide into legal disarray, a law faculty should assume this role or a new Medicare Commissioner. It is therefore suggested that one option is that a single university law faculty owner assumes ultimate responsibility for the future Medicare written rulings proposed in **Recommendation 4**. This would be similar to the University of Sydney's former function as the single university owner of the ICD/ACHI framework through the National Centre for Classification in Health (Sydney 2020). Alternatively, a new Medicare Commissioner role could be established to assume this responsibility (see **Recommendations 3 and 5**). Moving forward, reimbursed Medicare services should be updated no more than biennially (unless circumstances such as a global pandemic arise), in alignment with the biennial updating of ACHI codes, both having a minimum six-month advance notice period communicated to all stakeholders.

8.2 Law reform

Please note: Red text below is intended to depict key components of recommended changes and a draft basis from which to design the final reform.

Recommendation 1 – Immediately freeze all changes to Medicare items*

Rationale

**There is one exception: In view of the ongoing COVID pandemic, research and reform in the area of telehealth services and SNOMED-CT should commence immediately, with implementation of evidence-based reforms proceeding where appropriate.*

While the government continues to change MBS items, responsible reform will not be possible, and further damage will be inflicted on the system. Accordingly, with the above italicised exception, all further changes to Medicare item numbers should be immediately frozen for an initial two-year period while active and rapid system repair is undertaken. Specifically, no further changes from the MBSRT should be implemented while the recommended rule of law 'principle of legality' impact process is undertaken, and SNOMED-CT trials are progressed. In any case, implementation of SNOMED-CT would likely necessitate redrafting of many poorly drafted MBS items to remove extraneous and inappropriate content, and given the size and cost of this project, it should be undertaken once. Therefore, holding further MBSRT changes pending SNOMED-CT trials will be more efficient and cost effective.

Recommendation 2 – Regulate visibility over clinical relevance

Rationale

Chapters 4 and 7 discussed the evidence supporting this reform, which is fundamental to improving compliance. Whether SNOMED-CT or another code set is employed, without a reform that directly links clinical and billing data, all other measures described below will have limited success.

In regard to privacy considerations, 90% of Australians have a My Health Record (Australian Digital Health Agency 2020) and have therefore already consented to their health record being coded to SNOMED-CT, which is used in the My Health Record system. As discussed in Chapters 4 and 7, clinical relevance is a core legal requirement of every Medicare bill, and the Australian Privacy Commissioner's position in relation to medical billing data states that it is able to be collected under relevant Australian privacy legislation as a 'reasonably expected and directly related secondary purpose' (Australian Government 2020c). Accordingly, there appear to be no privacy barriers to full implementation of SNOMED-CT, and most of the medical software industry is already SNOMED-CT enabled.

Implementation

The DOH should immediately commence research and trials of adding SNOMED-CT codes into every electronically submitted Medicare bill. This should commence with the new COVID telehealth items and, if successful, proceed to a broader roll-out. The new mandated SNOMED-CT code requirement for telehealth can initially be regulated at the item number level in similar fashion to the method recently used by the government to force bulk billing.

The government should set a short 18-month lead time, after which the inclusion of SNOMED-CT codes should be regulated as a prescribed particular for every Medicare claim in Australia, codified in the *Health Insurance Regulations 2018 Division 5-Particulars of professional services.* Payment will thereafter be denied without SNOMED-CT codes.

Recommendation 3 – Appoint an independent legal panel to review service descriptions

Rationale

Chapters 6 and 7 discussed troubling findings regarding the operation of the principle of legality as it applies to MP, who cannot know in advance the legal meaning of service descriptions due to the prevalence of unclear legal drafting.

Implementation

The Federal Government should appoint an independent legal panel or appoint a new Medicare Commissioner (see recommendation 5) to review the entire Medicare list of services, commencing with all changes made through the MBSRT and other known areas of concern highlighted in this thesis. This work could be undertaken in consultation with the Australian Law reform Commission (ALRC). The terms of reference should be restricted to assessing existing MBS items and rules only, for adherence to the rule of law principle of legality, ensuring 'irresistible clearness' (Rule of Law Education Centre 2016) of drafting such that each item, to the maximum extent possible, has a single consistent legal meaning within the context of the overarching legislative framework.

The panel should be chaired by a former Federal Court Judge or similar and comprise lawyers with experience in MBS interpretation in contested proceedings, a skilled parliamentary drafter, and one expert clinical terminologist with experience in international health data governance standards, to ensure changes made will not inadvertently reduce the quality of data flowing through the health system. This program of work should be supported by a new system of written rulings (see recommendation 5) similar to those provided by the Australian Taxation Office (ATO).

Recommendation 4 – Permanently discontinue the MBSRT and form a newly constituted MBAC

Rationale

Three separate committees and taskforces are currently involved in changes to the MBS, though the only statutory committee among them seems to be inactive. They are the:

- MBSRT (this committee completed its work at the end of 2020).
- A non-statutory Medical Services Advisory Committee (MSAC) (Department of Health 2020c).
- A legislated Medicare Benefits Advisory Committee (MBAC) (Australian Government 1973a), which appears to be constituted.

The composition of any committee tasked with Medicare service law reform should be regulated with such a structure already available in the HIA. It should be modernised and implemented.

Implementation

The MBSRT should be permanently discontinued. The MSAC should continue in its current form, though with a reduced remit around drafting of service descriptions, and with a newly constituted MBAC sitting above it through the following suggested amendments to section 66 of the HIA:

Section 66 Medicare Benefits Advisory Committee

(1) The Minister ~~may~~ shall establish a Medicare Benefits Advisory Committee consisting of ~~eight~~ five members, including: ~~at least five medical practitioners.~~

a) One registered health practitioner who represents the registered health practitioners who are or will be eligible to claim the Medicare benefit or benefits under consideration by the Committee;

b) One qualified Health Informatician, with relevant recent experience in international standards for health data governance;

c) One current employee of the Independent Hospitals Pricing Authority with relevant qualifications and recent experience in the current version of ICD/ACHI in use in Australia;

d) One clinical terminologist nominated by the Australian Digital Health Agency;

e) One Solicitor employed under the Commonwealth Public Service Act with relevant knowledge of the underlying legal architecture of the Australian Health System and this Act.

(2) The members of the Committee shall be appointed by the Minister. ~~and four of the members who are required to be medical practitioners shall be so appointed after consultation by the Minister with the Australian Medical Association and such other relevant~~

~~professional organizations and associations of each category of individual. as the Minister considers appropriate.~~

'Registered health practitioner' means a person listed on the Australian Health Practitioner Regulation Agency website at www.ahpra.gov.au.

The statutory responsibilities of the MBAC should be to settle final legal drafting of all Medicare services for enactment into law unchanged. The committee should work in cooperation with the existing MSAC, which will first determine whether a service should be included or removed from the Medicare scheme, based solely on clinical relevance. The MSAC should not be involved in the final draft of the service description. The MBAC should have the ability to reject any service unable to be classified as clinically relevant (such as a patient enrolment service). It would be expected that the legal representative on the MBAC would be from the Office of Parliamentary Counsel, which has responsibility for legislative drafting.

Prior to enactment into law, the MBAC should advise the single university law faculty owner or Medicare Commissioner (recommendation 5) who will prepare the relevant legally binding written rulings for new or amended services, and the rulings will be added to the repurposed medical fees website (recommendation 27) ahead of the go live date.

Recommendation 5 – Introduce legally binding written rulings

Rationale

The suggestion from the 2011 Senate Enquiry concerning a system of legally binding written rulings (similar to those that guide the ATO) should be implemented, creating a single source of truth for all Medicare services. Further, to prevent a repeat of the *Stirling* case, MP must be able to claim for services legitimately provided, without fear, and rely on the government to reject the claim if a barrier exists.

Implementation

Within 18 months, a new division of the HIA, adopting a similar format to Division 357 of the *Taxation Administration Act 1953 (Cwth)* (Australian Government 1953) should be introduced, with the rulings being derived from existing content (where coherent) from the MBS and the DOH website. To ensure independence, this task should be undertaken by the single university owner of the new national curriculum (recommendation 20), or a new independent agency such as an 'Office of the Medicare Services Commissioner' adopting a similar model to the current *Office of the Legal Services Commissioner* in NSW (NSW Government 2021b), which would sit under the portfolio of the Attorney-General *not* the Department of Health. Such an agency should work cooperatively with the ALRC, which is currently conducting similar reform to Australia's business laws and would therefore be well positioned to collaborate in the areas of rule of law considerations and implement principled legal drafting and statutory cohesion. The written rulings should address key challenges MP experience in relation to threshold billing decisions, many of which are described in this thesis, including but not limited to:

- Precise articulation of service parameters, such as whether non-clinical components like booking, administration, enrolment, and consumable fees are included or excluded.
- Preventing the government from seeking repayment of a claim that the government should have rejected.
- Preventing multiple, cross agency investigations in relation to the same claim.
- Clearly stating who can claim the service.

The suggested objectives of the new section in the HIA are as follows, noting the role of 'Chief Executive Medicare' may be replaced with 'Medicare Services Commissioner' depending on the model chosen.

What this Division is about

This Division sets out the object of this Part, and the common rules that apply to public and private rulings.

A ruling is an expression of the Chief Executive Medicare's opinion of the way in which a relevant provision applies, or would apply, to an eligible provider of Medicare services (you).

A ruling binds the Chief Executive Medicare if it applies to you and you act in accordance with it. If you do act in accordance with it and the law turns out to be less favourable to you than the ruling provides, you are protected by the ruling from any adverse consequences.

Object of the proposed new Part

(1) The object of this Part is to provide a way for eligible providers of Medicare services under the Health Insurance Act and Regulations to find out the Chief Executive Medicare's view about how certain laws administered by the Chief Executive Medicare apply to them so that the risks to them of uncertainty when allocating Medicare item numbers or determining how to use the Medicare scheme are reduced.

(2) This object is achieved by:

(a) making advice in the form of rulings by the Chief Executive Medicare available on a wide range of matters for any eligible provider of Medicare services;

(b) ensuring that the Chief Executive Medicare provides rulings in a timely manner;

(c) enabling the Chief Executive Medicare to obtain relevant information on which to base rulings;

(d) protecting eligible providers of Medicare services from investigation, prosecution and penalties when they rely on rulings; and

(e) limiting the ways the Chief Executive Medicare can alter rulings to the detriment of eligible providers of Medicare services.

Recommendation 6 – Discontinue the MBS

Rationale

The MBS contains incorrect information, is confusing, out of date, and appears to be contributing to non-compliant Medicare billing. Once the written rulings are implemented the MBS will serve no further purpose. The single source of reliable information will become the new, clearly expressed regulations, with one legally reliable interpretation in the form of written rulings.

Implementation

As soon as the written rulings are ready, the MBS book should be discontinued and removed from circulation permanently. Simultaneously, the mbsonline website should be decommissioned and all content moved to a repurposed version of the government's medical costs finder website (recommendation 27) available to both MP and consumers (Australian Government 2020b).

Recommendation 7 – Protect MP and patients using Australian Consumer Law

Rationale

Evidence from this study suggested MP may sometimes feel pressured by corporate practice owners to increase billings to meet the financial objectives of the owner. Further, MP were often unclear about whether they were permitted to charge OOP medical expenses, potentially leading to unexpected medical bills for patients.

Implementation

Unfair contract terms become void and unenforceable

The ACL, schedule 2, section 25(1)(n) enables the Governor-General to make regulations that render certain types of contract terms unfair (Australian Government 2021c). Section 25 (2) requires that before recommending such regulations to the Governor-General, the Federal Minister responsible for competition and consumer affairs must take into consideration detriment to consumers, business impact and the public interest.

As small business owners, MP enter contracts which will typically fall within the jurisdiction of the ACL. It is therefore suggested that rather than relying on common law decisions about unfair contract terms, which are most often initiated by the ACCC in the Federal Court, the government should consider activating section (25)(1)(n) and regulating that clauses in MP contracts which have the practical effect of setting Medicare billing targets or pressuring MP to increase billings, or in any way directing MP on how to bill and what MBS items to bill, are unfair contract terms under the ACL. This would render these common clauses void and unenforceable, protecting contracted MP from corporate pressure to bill, and better serving the public interest. This initiative would be of particular benefit to GP and may also reduce PSR matters concerning Medicare's Shared Debt Recovery Scheme. It would also protect non-GP specialists from contract clauses in MPPA's that seek to direct MBS billing itemisation.

Protecting consumers from unexpected medical fees

It is suggested the ACCC is the appropriate agency to corral relevant authorities to develop a simple medical fee disputes scheme, positioned within existing small claims tribunals, with the following key components:

1. The scheme should apply only to unpaid fees. If a fee has been paid some form of financial consent is implicit.
2. The patient lodges a simple, no cost, medical fee dispute notice, which will be based solely on an assertion that informed financial consent (IFC) was not provided prior to receiving the bill.
3. The MP is legally prohibited from enforcing a debt against the patient once the fee dispute notice is lodged.
4. The onus of proving that IFC was provided rests with the MP, who can adduce any form of evidence.
5. If the MP is successful, the patient pays the MP's bill plus an amount to cover costs (as a deterrent to vexatious claims).
6. If the MP is unsuccessful, no debt accrues for payment.
7. Legal representation is not permitted for either party.
8. The scheme will require reference in the Health Practitioner Regulation National Law and the Code of Conduct.

Protecting MP provider number use in public hospitals

Unfortunately, the ACL is unable to provide protection for SMO employed by public hospitals, because such arrangements are outside the jurisdictional scope of the ACL. It is therefore suggested the Australian Salaried Medical Officers Federation takes ownership of this problem and reviews all enterprise and ROPP agreements to ensure MP retain full control and visibility over their provider numbers when public hospitals conduct billing on their behalf. Recommendation 18, once implemented, will provide an additional layer of protection for SMO in this area.

Recommendation 8 – Align all laws to the single standard of clinical relevance

Rationale

Chapter 7 described the multitude of conflicting, ill-defined and therefore meaningless standards MP are required to comply with but are unaware of. All payers should align to the single, legally defined standard of clinical relevance. Recommendation 15 suggests tiered PHI be dismantled completely, but in the interim, the PHI should also align to clinical relevance.

Implementation

Amend the *Private Health Insurance (Complying Product) Rules 2015, Regulation Part 2B, 11F (8)(b)(ii)* as follows:

"…is, in the view of the medical practitioner who provides the unplanned treatment, clinically relevant in accordance with the provisions of the Health Insurance Act 1973 ~~medically necessary and urgent.~~ and payment shall not be denied in such circumstances."

Relevant provisions of the VEA and MRCA should also be redrafted to align to the clinical relevance standard.

Encourage non-federal and private agencies to align with clinical relevance

Even well-respected organisations such as *Choosing Wisely* should review the language they use to ensure their messaging to MP aligns will the single legal standard of clinical relevance, so as not to put MP at legal risk. States and Territories should also be encouraged to align their WC and CTP standards to clinical relevance, to improve compliance under their schemes.

Recommendation 9 – Reform referral law

Rationale

The difference in referral provisions between the NHRA and HIA (discussed throughout this thesis) is a significant contributor to non-compliant billing in public hospital OPD. Even though GP will commonly name specialists on the referral letters they write, relevant provisions of the HIA have always been ambiguous as to whether this is a legal requirement. As a result, sometimes GP write referrals to a clinic rather than a named specialist. Some examples are:

1. A public hospital outpatient referral letter may commence with the words 'Dear Fracture Clinic' or 'Dear Gastroenterologist'.
2. A referral letter from a public hospital to a small private hospital that only provides rehabilitation services may commence with 'Dear Rehabilitation Private Hospital'.
3. A referral written on the template referral pad of a private clinic, which has the names of all the specialists working in the clinic on the template, may commence with 'Dear Oncologist', and when presented, someone (often an administrator) will circle the name of one of the oncologists on the template, who will take up that referral, and
4. It is also common for names to be crossed out on referrals and new names substituted.

Compliant billing in public hospital OPD can never be achieved until referral provisions are consistent between the NHRA and HIA. However, the potential downstream consequences of changes to referral laws are considerable. Therefore, changes should be carefully implemented to protect MP, uphold good clinical practice, ensure GP remain the centre of care coordination and provide consumers with ultimate control of the process. Further research looking at potential options for reform in this area would be appropriate. But to

protect medical practitioners from further confusion and unintentional errors, a single, clear law applicable across the entire medical billing landscape must be found. One option is as follows:

1. That all referrals name the specialist the patient is being referred to, with penalties introduced for providing or accepting an unnamed (and therefore invalid) referral.
2. That a specialist of the same specialty should be able to take over a referral, but only in certain clearly defined circumstances.
3. Relevant provisions of the NHRA be redrafted to align with the revised provisions of the HIA (recommendation 10), and
4. A system of fines be trialled for un-named referrals, including qui tam penalties.

Implementation

Amend section 20BA of the HIA as follows:

20BA Confirmation of referral to a consultant physician or specialist

(1) If:

(a) a person refers a patient, in writing, to a named consultant physician or a specialist; and

(b) the named physician or specialist receives the referral; and

(c) the named physician or specialist renders a specialist medical service to the patient as a consequence of the referral;

the named physician or specialist must:

(d) retain the referral for the period of 2 years beginning on the day on which the service was rendered to the patient; and

(e) produce the referral, if asked to do so by the Chief Executive Medicare, to a medical practitioner who is a Departmental employee (within the meaning of the Human Services (Medicare) Act 1973) within 7 days after receiving the request; and

(f) not substitute him or herself as the named physician or specialist the patient has been referred to unless:

(i) the named physician or specialist is unable to render specialist medical services to the patient as a consequence of the referral and the substitute physician or specialist is of the same medical specialty as the physician or specialist named on the referral; or

(ii) a patient has presented the referral to a substitute physician or specialist who is of the same medical specialty as the physician or specialist named on the referral to avoid paying out of pocket medical expenses.

Amend Regulation 58 (2) as follows:

58 Services provided upon referral

(2) Subject to subsections (3) to (5), the following particulars are prescribed:

(a) the name of the referring practitioner;

(b) the address of the place of practice, or the provider number in respect of the place of practice, of the referring practitioner;

(c) the date on which the patient was referred by the referring practitioner to the consultant physician or specialist;

(d) the period of validity of the referral under section 102; and

(e) the name of the consultant physician or specialist the referring practitioner is referring the patient to.

Communicating changes to MP and patients

Communication material for consumers should be included on the repurposed medical cost website (recommendation 27), explaining to patients they can re-use a digital copy of a specialist referral to avoid paying OOP medical expenses, but not because they did not like the medical advice they received from the MP. It is important this provision does not inadvertently enable poor health choices or 'doctor shopping'. Patients should also be advised they do not need to return to their GP or pay an online telehealth service for a new referral.

Penalties for providing or accepting an invalid referral should be imposed on MP

Suggest a trial of a five-penalty unit strict liability offence, actively enforced by DOH and communicated clearly to MP and consumers, who should be encouraged to call the existing DOH tip-off phone number to report and provide photographic evidence of a breach such as:

- a photo of a referral from a GP lacking the name of the specialist, or
- a photo of an unnamed referral in a patient's file at a public hospital or private specialist clinic after benefits for referred Medicare services have been claimed.

Swift and decisive issuing of fines must follow, similar to existing processes for speeding and parking fines, where the fine is automatically issued based on photographic evidence.

Penalties for breaches of the substitution provisions should be imposed on MP

Suggest a trial of a 10-penalty unit strict liability qui tam offence with 20% of the recovery benefitting the whistle-blower. The most likely whistle-blower under this provision would be a specialist who has had a referral taken by a colleague; the incentive to report would therefore be strong. This provision must also be actively enforced by DOH and communicated clearly to MP and consumers, who should be encouraged to call the existing DOH tip-off phone number to report and provide photographic evidence of the breach. Swift and decisive issuing of fines must again follow.

Penalties for patient breaches of substitution provisions

It is suggested DOH monitors patient claiming on the back end of the Electronic Claim Lodgement and Information Processing Service Environment (ECLIPSE) system initially, with a view to managing any 'doctor-shopping' behaviour by rejecting claims for reimbursement, rather than issuing fines.

Recommendation 10 – Prevent duplicate billing in public hospital OPD

Rationale

Irreconcilable provisions at the interface of the NHRA, HIA, enterprise, ROPP and other agreements suggests a decision must be made concerning which of ABF or Commonwealth MBS funding should continue in public hospital OPD. The two cannot continue to coexist. While ABF funding for admitted services has been effective, tier 2 clinics have had less success, evidenced by the previously discussed ANAO estimate of over $300 million in duplicated payments. It is therefore suggested serious consideration be given to abandoning tier 2 arrangements altogether and replacing them with the MBS/SNOMED-CT combination proposed elsewhere in this study. This would create a single, unified national approach to all non-admitted care, irrespective of the specific setting. The alternative is to remove MBS funding, however the impact on public hospitals if that were removed would likely be catastrophic, because many public hospital OPD are heavily reliant on contracted MP. Clarity around the charging of gaps to public patients is also required.

Implementation

The HIA

A simple but important change to the HIA is required. Current use of the word 'in' in section 128C suggests applicability to admitted patients only, rather than also encompassing outpatients.

Amend Section 128C of the HIA as follows:

128C Charging of fees for provision of public hospital services to public patients

(1) A person mentioned in subsection (2) must not, in circumstances set out in the regulations:

(a) charge a fee for the provision of a public hospital service; or

(b) receive any payment or other consideration from anyone in respect of the provision of a public hospital service;

if the person knows that the person to whom the service is, or is to be, provided is, or intends to be, a public patient at the hospital.

Given MP are not signatories to the NHRA, the amended section 128C will provide a prosecution option for the Federal Government directly with MP rather than through provisions of the NHRA. This would address the charging of unlawful gaps in both inpatient and outpatient settings in public hospitals, and it is suggested a 20-penalty unit strict liability qui tam offence be introduced as the relevant penalty, which would be vigorously pursued by the DOH.

The NHRA

On the basis tier 2 funding is discontinued as suggested, numerous provisions of the NHRA will require subsequent amendment. It is also important that the language of the NHRA is aligned with consumer understanding. Consumers currently do not understand how they can elect to be a 'private' patient when receiving services in a public hospital OPD if they do not have PHI. The terminology is therefore important and should be revised to the term 'bulk bill', which all Australians understand. It is also suggested that the purpose and definition of ROPPs be reviewed, because if all MP (including MP who are *not* employees) are permitted to claim Medicare benefits and bill private patients in public hospitals outpatient departments, as is the case in NSW, then it is unclear what purpose the ROPP title actually serves. Potential changes are as follows:

G16. Where care is directly related to an episode of admitted patient care and is part of a single course of treatment, it should be provided as a bulk billed service with no out of pocket expenses charged to the patient, regardless of whether it is provided at the hospital, or in private rooms.

G17. Services provided to public patients should not generate charges against the Commonwealth MBS:

a. except where there is a third-party payment arrangement with the hospital or the State, emergency department patients cannot be referred to an outpatient department to receive services from a medical specialist; or ~~exercising a right of private practice under the terms of employment or a contract with a hospital which provides public hospital services;~~

b. ~~referral pathways must not be controlled so as to deny access to free public hospital services;~~ except where a public patient has been advised to return to the outpatient department of a public hospital for follow up care after discharge, without first returning to their general practitioner (GP), however the only services permitted to be bulk billed to the Commonwealth MBS in the absence of a GP referral are the unreferred services in the range of items 52-57.

NB: Proposed clause G17(b) will overcome the current problem of some referrals not being provided at arm's length, and will incentivise hospital MP to return patients to the GP post-discharge, but will also retain a modest funding source of lower-paying Medicare items (in the absence of tier 2) when returning a patient to their GP is neither practical nor possible. Medicare can easily implement policing of this clause by rejecting all claims for referred specialist services linked to MP public hospital provider numbers if no GP referral is recorded on the claim.

G19. Subject to G17, an eligible patient presenting at a public hospital outpatient department will be treated free of charge as a public patient unless:

a. there is a third party payment arrangement with the hospital or the State or Territory to pay for such services; or

b. the patient has been referred to a named medical specialist by a general practitioner ~~exercising a right of private practice~~ and the patient agrees to be bulk billed ~~treated as a private patient~~. For the avoidance of doubt, subject to the provisions of G22, general practitioners, nurse practitioners and allied health professionals are not permitted to bulk bill or charge fees to patients anywhere on the street address of a public hospital under any circumstances.

G19A. A patient who has agreed to be bulk billed in a public hospital outpatient department shall not be charged out of pocket medical expenses under any circumstances.

Separately: The DOH should revoke MBS claiming rights (retaining the ability to request and refer) on all GP, nurse practitioner and allied health provider numbers linked to the street address of every public hospital not being subject to a section 19(2) exemption.

Ensure public and private patients receive the same treatment for non-admitted care

The fastest and most effective way to eliminate some of the high-cost duplicate payments in public hospital OPD is to remove the 85% rebate for all procedures for which patients would be admitted if they had PHI. Many items in the Medicare scheme attract a 75% rebate only, recognising it may be unsafe to provide some procedures in an outpatient setting. For example, many of the neurosurgical services, including some minor procedures, attract an inpatient benefit only, such as the below example:

"39600
Group T8 - Surgical Operations – Subgroup - 7 – Neurosurgical Subheading - 5 - Cranio-Cerebral Injuries
INTRACRANIAL HAEMORRHAGE, burr-hole craniotomy for - including burr-holes
Fee: $488.45 Benefit: 75% = $366.35"

By removing Medicare outpatient (85%) rebates from common procedures performed in public hospital OPD, such as cardiac angiography and stenting, endoscopies and colonoscopies, all patients will thereafter be admitted for these procedures because the sole source of revenue will be ABF. The common colonoscopy item described below is one example:

"32226
Group T8 - Surgical Operations – Subgroup - 2 - Colorectal
Endoscopic examination of the colon to the caecum by colonoscopy, for a patient with a high risk of colorectal cancer due to:

(a) a known or suspected familial condition, such as familial adenomatous polyposis, Lynch syndrome or serrated polyposis syndrome; or

(b) a genetic mutation associated with hereditary colorectal cancer

Applicable only once in any 12 month period

Fee: $344.80 Benefit: 75% = $258.60 ~~85% = $293.10"~~

NB: It is not recommended that cancer services have the 85% rebate removed, because this would likely incentivise unnecessary admissions for patients receiving chemotherapy, similar to that described in chapter 7 around the introduction of item 13950. This recommendation should therefore be carefully restricted and applied only to procedures that cannot ever be safely performed outside an operating theatre or angiography suite.

Recommendation 11 – Redraft the NHRA to clarify rules in regional public hospitals

Rationale

Vulnerable populations in regional Australia appear to be experiencing unlawful gap charges in some public hospital OPD and ED.

Implementation

Amendments to the NHRA

G21. In those hospitals that rely on GPs for the provision of medical services (normally small rural hospitals), eligible patients may obtain non-admitted bulk billed services ~~as private patients~~ where they request treatment by their own GP, either as part of continuing care or by prior arrangement with the doctor. For the avoidance of doubt, a patient presenting anywhere on the street address of a public hospital to which this rule G21 applies, including but not limited to the emergency department, will not be charged any out of pocket medical expenses under any circumstances.

G22. States which have signed a Memorandum of Understanding with the Commonwealth for the COAG initiative "Improving Access to Primary Care Services in Rural and Remote Areas"

may bulk bill the MBS for eligible persons requiring primary health care services who present to approved facilities, but may not charge the patient any out of pocket medical expenses under any circumstances. Primary health care services for the purposes of this clause include reimbursed general practitioner, nurse practitioner and allied health MBS services.

Suggest a 20-penalty unit, strict liability, qui tam offence is trialled for a breach of these provisions under section 128C of the HIA (just discussed), actively pursued and enforced by the DOH. The likely whistle-blower in this scenario will be a patient who lives in a regional setting and has been charged an unlawful OOP fee. Such patients will have a strong incentive to report unlawful medical fees if their 20% portion of the recovery equates to $888, which will typically exceed the unlawful fee paid.

Recommendation 12 – Tighten existing bulk billing provisions

Rationale

Until a digital alternative is available, active patient involvement in all bulk billing transactions should be restored through the enforcement of existing provisions of the HIA. This should be communicated to consumers via the medical fee website in recommendation 27. This will restore the ability for the DOH to target non-compliance in known areas of vulnerability such as aged care facilities, where cognitively impaired residents may be bulk billed without a service having been provided. While section 20B of the HIA already regulates the signature requirement, it does not currently require that it be retained. Until suitable digital alternatives are widely available, retention of the signed bulk bill voucher should be regulated to align with the requirement to retain referrals for two years.

Implementation

Amend the following content on the Services Australia website (Services Australia 2020)

"Assignment of benefit documents

Assignment of benefit forms ~~no longer~~ need to be retained ~~at the practice if you are using Medicare Online~~ for 2 years.

~~If we need to confirm that the service was provided to a patient, we will seek alternative evidence from you that the service was provided. Evidence may include electronic billing information, notes in practice software appointment records, and, if the practice chooses to retain them, the copy of the assignment of benefit form.~~

The legislative requirements for the assignment of benefit are:

- an agreement must be made between the patient (assignor) and you for the assignment of benefit
- the agreement is evidenced through the use of the assignment of benefit form
- the patient is required to sign the form
- a copy of the agreement must be provided to the patient
- You must retain your copy of the signed form for 2 years."

Additional changes to align relevant provisions and tighten bulk billing arrangements:

1. Amend clause 9 of the provider online claiming agreement to align with the above (Australia 2020).
2. Decommission Medicare Easyclaim completely. Easyclaim is a significant point of vulnerability, enabling instant processing of claims without the patient's involvement and with no ability to know if the patient was present. All providers should be required to switch to the Medicare online channel, from which bulk bill forms can be printed.
3. Add the declaration that enabled prosecution of *Dr Sood* – "I have not sought any other payment etc" – to electronic bulk billed claims. This declaration will enable enforcement by the government against illegal gaps charged when bulk billing, thus protecting the public interest.

It is also suggested a 2-penalty unit strict liability offence be trialled, where a fine is issued for a failure to produce a digital copy of a signed bulk bill voucher within a very short time of the request being made. This process should be completely random. All MP and their practice staff who are billing correctly and obtaining the patient's signature should have no difficulty in producing a photo of a stored bulk bill voucher within minutes.

Recommendation 13 – Regulate natural justice in the PSR while it is phased out

Rationale

Once SNOMED-CT is in enabled, the DOH will have less need to issue legal notices requesting clinical information to support claims, because the gap between clinical and billing data will be filled and the government will already know why the patient was there, so will no longer need to ask. Therefore, in tandem with the introduction of SNOMED-CT and the other recommendations herein, it is recommended the PSR is dismantled via repeal of Part VAA of the HIA, and gradually replaced with a comprehensive system of summary offences, infringement notices, fines and penalty points, sensibly described as relating to incorrect or non-compliant billing. However, phasing out this agency will take time, so the natural justice issues presented in this study must be immediately addressed by implementing amendments to Part VAA of the HIA as a priority. This will not only protect MP but reduce legal challenges against the government.

NB: It is beyond the scope of this PhD to suggest whether the PSR should continue to operate in some reduced form, solely for PBS compliance.

Implementation

Prerequisite requirements for PSR members including the Director

Suggest the insertion of the following new requirements into Part VAA of the HIA:

(2) The Minister must not appoint any medical practitioner to the PSR in any capacity, including the Director, unless prior to such appointment:

a) an independent legal panel, appointed by General Legal Counsel of the PSR, has reviewed 30 randomly selected clinical records of the medical practitioner being considered for appointment, and extrapolated them across the entire class of services claimed by that medical practitioner, to ensure the medical practitioner has not engaged in inappropriate practice; and

b) the medical practitioner has demonstrated her or his detailed understanding and knowledge of Medicare billing law, including the provisions of this Act and regulations, by successfully passing the prescribed medical billing examination.

The 'prescribed medical billing examination' should be developed within three months.

End codified secrecy from the PSR

Amend Part VAA of the HIA to enable all of the following:

- a PUR shall be permitted to audio record all meetings between the PUR and the PSR from the first point of contact;
- a PUR shall be entitled to full legal representation throughout the PSR process;
- the rules of evidence shall apply in PSR committee hearings; and
- PSR committee hearings shall be conducted in public (this will render 106ZR redundant and it should be repealed).

Recommendation 14 – The Department of Veterans Affairs

Rationale

This study found MP are 'enrolled' into the DVA scheme without their knowledge or consent and have very low levels of knowledge about relevant DVA billing requirements.

Implementation

The DVA should be required to obtain signed consent from MP before enrolling them in the DVA scheme and no longer be permitted to 'piggyback' on MP Medicare enrolments. In addition, recent legislative changes which brought DVA within the purview of PSR (discussed in chapter 7) should be immediately repealed on the basis the PSR demonstrably lacks necessary skills to investigate billing anomalies under the ill-defined DVA standard of 'reasonably necessary' rather than the defined Medicare standard of 'clinically relevant'.

Recommendation 15 – The Private Health Insurers

Rationale

This research found that gapcover schemes are broken and should either be completely dismantled or immediately made robust to protect public money and the rights of consumers. There appear to be four options to achieve this end:

1. Dismantle gapcover schemes completely and revert to previous arrangements.
2. State governments consider litigating against the PHI for breach of relevant provisions of the gapcover legislation (discussed in chapter 7).
3. Enabled by section 73BDD(3) of the gapcover legislation, the ACCC consider legal proceedings against one or more of the PHI on the basis their conduct under gapcover schemes limits patient choice and is therefore anti-competitive.
4. The Federal Government tightens the drafting of key legal provisions of the gapcover legislation.

It is also recommended that the tiered PHI policies be dismantled, because the only policy of value is a gold policy, and our blended financing arrangements render the tiers unworkable.

Implementation

On the assumption gapcover schemes will continue to operate, the following legislative tightening is recommended:

Health Legislation Amendment (Gap Cover Schemes) Act 2000

(7) The Minister must not approve a gap cover scheme unless the scheme provides for the following:

(a) insured persons to be informed in writing, where the circumstances make it appropriate, of any amounts that the person can reasonably be expected to pay for treatment and the insured person acknowledges receipt of the advice; and

(b) insured persons are freely able to choose where they receive hospital treatment under a gap cover scheme, including in a public hospital; and

(c) the amount above the schedule fee payable under the gap cover scheme will be paid consistently regardless of where the patient chooses to be treated, including into the bank account of a public hospital under right of private practice arrangements. (NB: the last six words of clause (c) can be removed once ROPPs are repealed).

In addition, it is recommended the government reinstate the repealed statutory requirement that PHI pass the 75% Medicare rebate under gapcover schemes to the end beneficiary within a specified timeframe. The repealed section 73 AAF provided a 60-day period for this to occur, but it is suggested this be reduced to 30 days. Further, because no effective statutory authority exists to monitor PHI conduct, it is suggested qui tam penalty provisions be trialled to enforce these requirements as follows:

- a 20-penalty unit offence for not paying the full gapcover amount into a public hospital bank account; and
- a 20-penalty unit offence for not passing the 75% Medicare rebate to the end beneficiary within 30 days.

Numerous whistle-blowers, including public hospital finance departments, individual MP specialists and the PHI's own policy holders will be well incentivised to utilise these provisions.

Recommendation 16 – Align the National Health Reform Act with the HIA

Rationale

To align with recommendation 4, a reciprocal requirement should be codified into IHPA's enabling legislation to ensure IHPA always aligns its recommendations with the HIA, thus ensuring MBS codes always have an exactly matched ACHI code.

Implementation

The suggested positioning of this requirement is under the responsibilities of the jurisdictional advisory committee in section 196(1) of the *National Health Reform Act 2011*, by adding a function such as advising the Pricing Authority on "Maintaining alignment and consistency with the commonwealth Medicare billing system described in the *Health Insurance Act 1973* and Regulations."

Recommendation 17 – Introduce a new Australian coding standard

Rationale

This research reported the phenomenon of third parties such as clinical coders and hospital billers (the latter administer hospital billing rather than MBS billing) sometimes changing MBS item numbers previously allocated by MP without the MP's knowledge or consent. While not ill-intended (the individual is usually seeking to match the ACHI code the hospital has billed with the MBS code the MP has billed), this may expose the MP to serious legal consequences. In some hospitals, clinical coders and hospital billers are separate, but not always.

Implementation

A new Australian Coding Standard should be introduced that expressly prohibits coders from ever changing an MBS item number allocated by an MP without written consent of the MP.

Recommendation 18 – Introduce a new safety and quality standard

Rationale

Medical billing in public hospitals requires containment, but public hospitals are unlikely to improve their Medicare billing practices without a formal direction to do so. Currently, all public hospitals have mandated accreditation obligations. Accreditation is therefore an appropriate place to include a new Medicare and Medical Billing Compliance Standard, without which the hospital cannot operate, and all MP provider numbers attached to that facility will be blocked. This recommendation cannot be implemented until the education

framework below has been finalised, though once complete, the standard should require the hospital's medical billing team to include individuals who hold the new qualifications described in recommendation 20.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) is the regulated authority for national hospital accreditation standards. An important current standard of ACSQHC is the 'Partnering with Consumers Standard' which includes a requirement that organisations have effective processes in place to:

'Inform patients (and, if applicable, their carers and substitute decision-makers) about the risks, benefits and alternatives of a treatment, including any fees and charges associated with treatment and referrals.'(Australian Commission on Safety and Quality in Health Care 2021)

While ACSQHC describes Informed financial consent as 'an important but separate consent process', it is suggested this distinction is contradictory – it suggests consumers should be informed of fees and charges, but with no direction or standard relating to information around fees and charges – and should be corrected by the inclusion of this important information.

Implementation

ACSQHC should either introduce a new standard, possibly modelled on the Obamacare U.S Medicare compliance programs codified in the *US Affordable Care Act section 6401 (a)(7)*, or add a new action to the existing 'Partnering with Consumers Standard'. The new provision should be added to the existing standards in one of two possible places as follows:

1. "Clinical Governance Standard
2. Partnering with Consumers Standard (Option 1: add a new action 2.6 around Medicare literacy and medical billing governance.)
3. Preventing and Controlling Healthcare-associated Infection Standard
4. Medication Safety Standard
5. Comprehensive Care Standard

6. Communicating for Safety Standard
7. Blood Management Standard
8. Recognising and Responding to Acute Deterioration Standard"
9. Option 2: add a new Medicare Literacy and Medical Billing Governance Standard.

Recommendation 19 – Conduct a complete legislation review

Starting by comprehensively examining why the terms 'medical services' and 'professional services' continue to feature throughout the HIA and regulations, instead of the single constitutionally aligned term 'medical services', a complete review of Medicare's entire regulatory framework should be undertaken in cooperation with the ALRC, to align laws and improve clarity and navigability. The current approach of the ALRC should be adopted, which includes the following:

'… simple things, like the appropriate use of definitions (e.g. using them consistently, compiling them centrally, and tagging their usage), and the use of examples...also…considering the appropriate use of legislative hierarchy – that is, using subordinate legislation only to add detail where necessary, rather than to wholly amend or contradict primary law.'(Isdale and Ash 2021)

8.3 Educational reform

Curriculum development can begin while regulatory reform is in progress, but delivery of educational content can only begin once a cohesive regulatory framework is in place.

Recommendation 20 – Health financing law and practice curriculum development

A single university health/law faculty should take ownership of curriculum development and examinations (including the MP test), possibly following a competitive bidding process. The new discipline of Health Financing Law and Practice (HFLP) is suited to a graduate program, and will also require a simpler Certificate IV qualification for third-party billers, who will become Registered Medical Billing Agents (RMBA; similar to Registered Tax and BAS Agents). Graduates of these programs will achieve legitimacy as 'experts' in Medicare billing and health financing law following successful completion of a rigorous course of study and will be certified under a professional scheme. It is recommended that the first individuals for whom the graduate program should be mandatorily required is government employees working in the Medicare Benefits Division of the DOH. Specific subjects within the graduate program should also be made available as electives for medical students. In addition to graduate program students completing the following core legal subjects - *The Australian Legal System*, *Contract Law* (with a heavy emphasis on *Insurance Contracts*) and *Administrative Law*, suggested program inclusions are:

Graduate program in health financing law and practice

- Detailed analysis of all relevant statutes, regulations, agreements and policies in **Figure 5**;
- introduction to health economics;
- introduction to international clinical code systems including ICD, CPT, ACHI, SNOMED-CT and Logical Observation Identifiers Names and Codes;
- introduction to health informatics and health data governance;
- comparative health systems;

- medical billing ethics; and
- the law of informed financial consent.

Certificate IV in health financing law and practice

- Overview of all relevant Statutes, Regulations, Agreements and Policies in **Figure 5**;
- medical billing ethics;
- informed financial consent;
- medical billing from the provider perspective; and
- regulation of RMBA.

Biennial online MP Medicare billing test administered by DOH

This test should be equivalent to a learner driver test, including both generic and specialty-specific questions. The test *must* be exclusively written by the law faculty owner, to ensure questions link directly to new summary offences which will be codified in the HIA.

Recommendation 21 – Commence biennial Medicare billing test for medical practitioners

Rationale

Drawing from the findings in this thesis, MP desire education on medical billing, but not too much. With trained experts around them (**Figure 19**), in time, better control of compliance will be achieved. However, MP will always retain primary legal responsibility for the bills they submit, and should therefore be required to undertake a basic learner driver-level test biennially, linked not only to the renewal of their provider numbers, but to new summary offences and fines.

Implementation

As soon as the law faculty owner has finalised the MP test it should be made available online exclusively via the DOH website (noting it is in the interest of DOH to administer this program because the DOH issues and maintains provider numbers). Cancellation of MP provider numbers should be attached to the six-digit provider number stem rather than the eight-digit

location-specific numbers, to ensure all of the MP's provider numbers are cancelled at the same time. The first provider number stems should begin to expire within 18 months. Once an initial cohort of MP have successfully completed the online test, DOH should commence monitoring their compliance with the written rulings and begin issuing fines.

Recommendation 22 – Link rebate increases and MDO premiums to certified billers

Rationale

All participants in this study intended to continue using third parties to administer their medical billing. Much of the future compliance onus will therefore fall to these new professionals who will hold a minimum Certificate IV qualification, and who will be answerable to their own professional organisation (described in recommendation 23).

Implementation

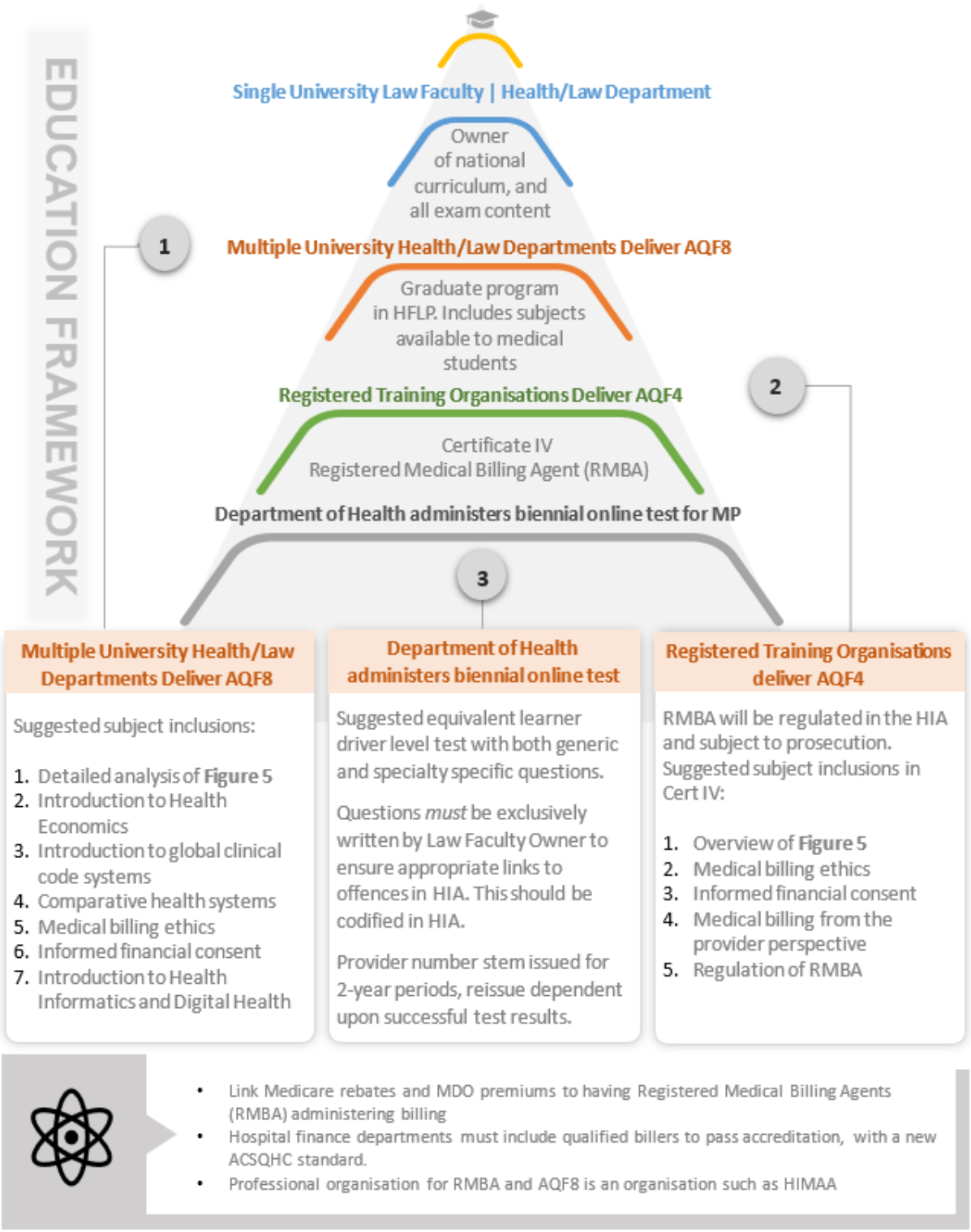
By mid-2024, commence linking annual Medicare rebate increases to MP who can demonstrate that approved RMBA administer *all* of their billing. In addition, it is suggested the MDO should consider increasing annual medical indemnity premiums for MP who do not use RMBA to administer their medical billing or decrease premiums for those who do.

Recommendation 23 – Establish a professional organisation for certified billers

A plethora of fragmented professional organisations exist within the health sector. As such, positioning RMBA within an existing organisation rather than creating a new one appears most appropriate. An organisation such as the Health Information Management Association of Australia (HIMAA), which is the current professional organisation for clinical coders seems well suited to this purpose. However, for this to occur, HIMAA would need to develop a separate professional stream for the new discipline, within a robust framework, which would need a new code of ethics for billers.

A diagrammatic representation of this entire education framework is set out in **Figure 19.**

Figure 19 - Education framework



8.4 Digital reform

Recommendation 24 – Incorporate SNOMED-CT into existing MBS claims

Concurrently with recommendation 2, the DOH and Services Australia should commence testing of submission of SNOMED-CT codes through the existing ECLIPSE channel.

Recommendation 25 – Decommission the mbsonline website

Simultaneously with recommendation 6, the mbsonline website should be decommissioned and selected content, able to be reused, should be moved to a repurposed version of the DOH's medical costs finder website described in recommendation 27.

Recommendation 26 – Repurpose the medical cost transparency website

Rationale

For many reasons (explained in this thesis), the government's current medical cost finder website (Australian Government 2020b) has poor prospects of success. However, the site can be repurposed to assist consumers to *understand* rather than *find* medical costs. It is recommended the written rulings be positioned on this website along with additional consumer information, all of which should be freely available to both MP and consumers.

Implementation

Suggested initial inclusions:

1. The written rulings in recommendation 5, which should mirror the design of the ATO's written rulings.
2. What to do if you receive an unexpected medical bill. Information at this link will flow from recommendation 7.
3. Avoid paying OOP by using your GP referral again. Information at this link will flow from recommendation 9.
4. Information about how bulk billing works in public hospital OPD.

5. Comprehensive information about electing to be a private patient in a public hospital.
6. The complete gapcover fee schedules and rules of every Australian PHI, displayed to clearly convey the myriad different rates and rules applicable to every MBS service.
7. Detailed information about which PHI *do not* honour gapcover schemes should the policy holder find themselves in a public hospital (until recommendation 15 is fully implemented).
8. Information about the whistle-blower provisions in these recommendations.

Recommendation 27 – Introduce a single health industry payment post office

Rationale

Full implementation of the preceding recommendations will significantly improve medical billing compliance in Australia, but consumer OOP will remain problematic for the following reasons:

1. There is no consolidated information on current OOP or total medical costs borne by consumers.
2. There is no system above Medicare's ECLIPSE system and other payment systems that can monitor total OOP on an ongoing basis.
3. MP largely ignore billing barriers and maintain their incomes by either adjusting their billing patterns or charging OOP, which the government may never see.

Comprehensive OOP information for any amount other than the Medicare rebate, gapcover or set fee amount cannot be transmitted to Medicare (discussed in chapter 4), and as a result, patient OOP often remain invisible. It is the lack of visibility rather than the legality of OOP that is the main problem. Complete patient cost information exists on practice management systems, hospital systems, accounting programs and paper records. In fact, thousands of systems hold the information the government requires, and obtaining access to these systems is not possible because it would require the cooperation of every clinician, allied health provider, hospital and software vendor, some of whom are not even present in Australia. More software vendors are entering the market all the time so the number of software applications on which OOP can remain hidden is continuing to rise.

A centralised, national medical billing platform would be an effective way to achieve full transparency over this final hidden element of billing data, and it is suggested Australia's relatively small population makes it a viable option. Such a system should not be mandatory, to avoid CCC issues, but should instead employ incentives such as faster payments, increased rebates, and audit amnesty to encourage uptake. This initiative would require a paradigm shift in thinking; rather than simply providing the back-end digital ECLIPSE interface for Medicare billing, the Federal Government would also operate the front end as a free, national medical billing service, in which clinical records and financial records are joined to the extent of requiring SNOMED-CT codes (maximising patient privacy) while achieving full OOP and billing transparency.

Implementation

The health industry payment post office (HIPPO) would sit above the government's existing ECLIPSE system and would become the only approved medical services invoice in Australia. HIPPO would be able to separate Medicare and non-Medicare components of the bill, and should be administered by DOH. In this way, the legal hurdle of 'Services Australia' not having jurisdiction to collect data related to income tax (previously discussed) would be overcome.

Key benefits of a free, government-operated, centralised billing platform such as HIPPO are numerous, including:

1. Real-time monitoring of total patient payments.
2. Centralised Medicare billing data, including OOP.
3. Enablement of a comprehensive rules engine to stop incorrect claims by preventing MP from transmitting incorrect claims.
4. The government would for the first time have visibility over third-party involvement in Medicare billing, including the PHI. Using HIPPO, the passage of the 75% Medicare rebate from the PHI to the end beneficiary under gap cover schemes will be immediately visible.
5. The data could be used to publish OOP.

6. A reduction in digital interface maintenance between the government and software vendors, who need only link patient demographic data. Software vendors do not compete on their ECLIPSE billing modules, which are all the same.
7. Non-compliant billing will become more visible and easier to target. For example, if a patient is bulk billed and charged an unlawful gap amount at the same time, this will be immediately visible to the government.

A diagrammatic overview of a possible HIPPO design is set out in **Figure 20**, and a five-year reform roadmap incorporating all of the preceding recommendations in **Figure 21**.

Figure 20 - HIPPO workflow

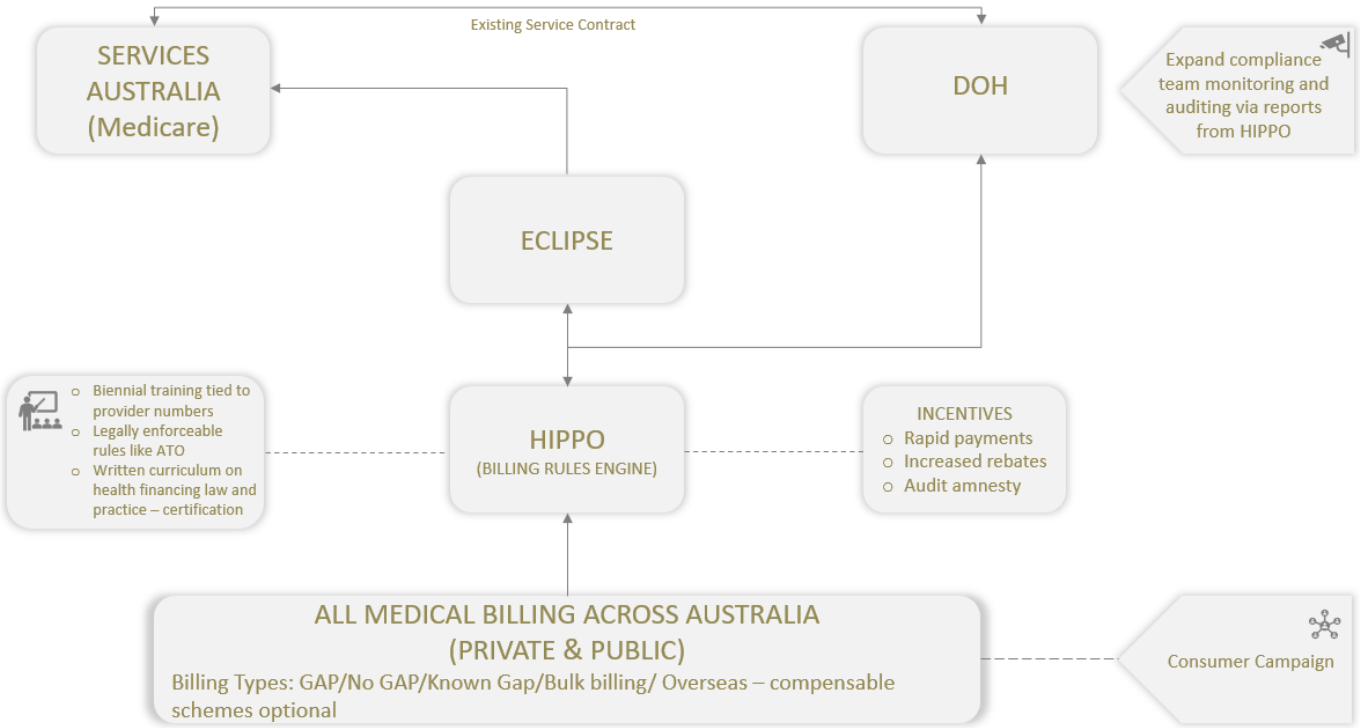
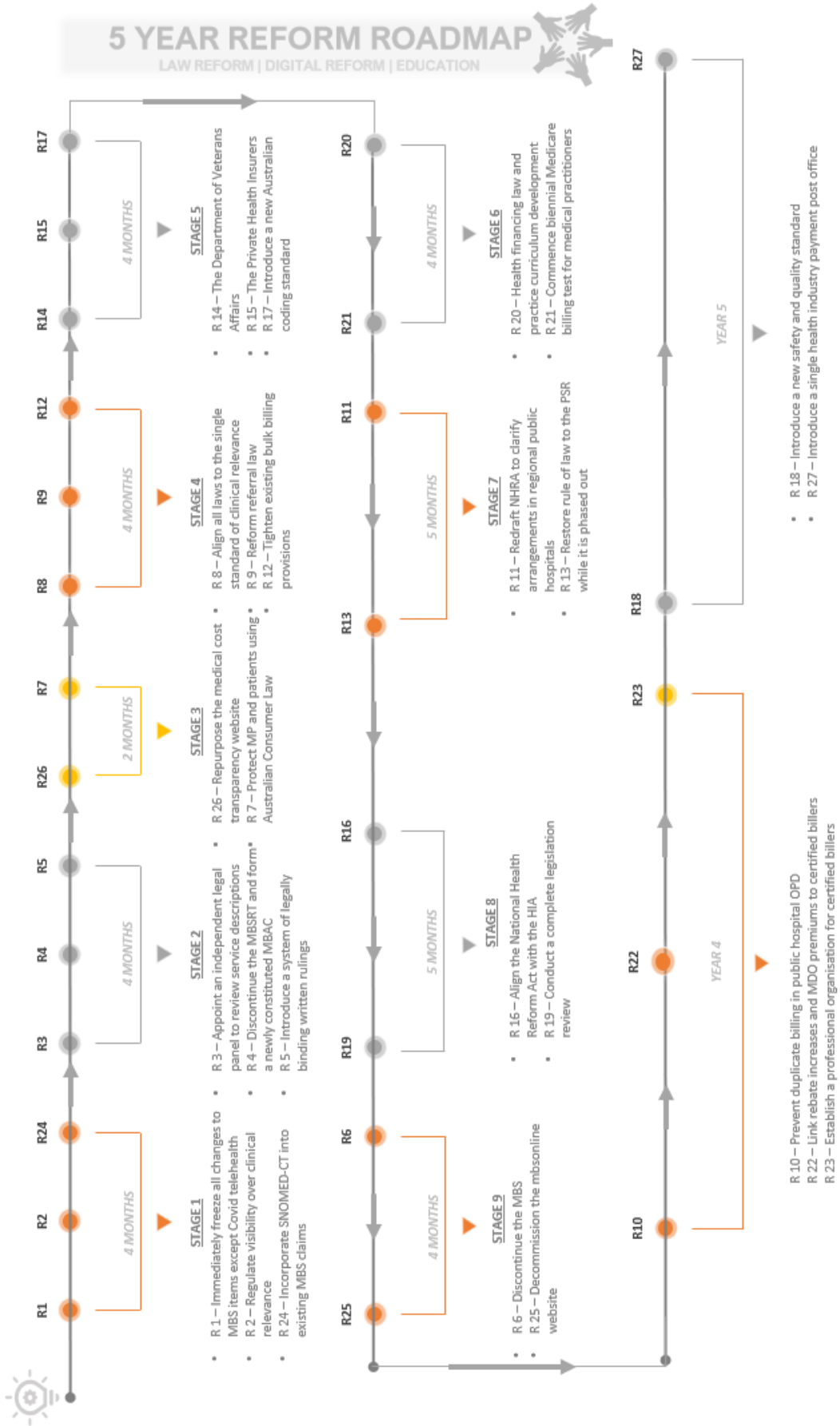


Figure 21 - Five-year reform roadmap



CHAPTER 9: Conclusion

9.1 Overview

Returning now to consider the research questions in chapter three, this thesis has examined the experiences, perceptions, attitudes and knowledge of MP in relation to their claiming and compliance obligations under the MBS, and found extremely poor legal literacy among MP in this area and no reliable sources of support. The study has also revealed that profound complexity exists within the medical billing eco-system, which is rooted in rule of law problems similar to those reported in the area of statutory corporations law.

'…we have aimed to illustrate how rule of law concerns arise in the particular context of statutory corporations law. However, we would be surprised if the problems we've identified are confined to that realm. Doubtless there are hundreds of other examples that can be drawn from our voluminous statute books.' (Isdale and Ash 2021)

Unfortunately, the government's penchant for adding more law shows no signs of abating, with a recent federal budget announcement indicating that over $700 million would be invested to make further changes to the MBS over the next four years (Department of Health 2021a). However, this will not make compliance easier but will likely worsen existing challenges because *'The more words, the more scope for dispute about meaning, the more chance of inconsistency and obscurity, the less likelihood of accommodation to change and the greater the risk of uncertainty and error.' (Isdale and Ash 2021)*

If the government wishes to control the medical billing behaviour of MP through law, the law must conform to certain minimum standards to enable it to be obeyed. This is currently lacking. Disciplined adherence to regulated law-making through parliamentary processes would serve this purpose, rather than departmental 'law-on-the-run' processes, which appear to be the dominant approach in the realm of Medicare law-making.

9.2 Principal findings

The introduction section of this thesis estimated the quantum of non-compliant billing in Australia at 5-15% of the scheme's total cost, though precise quantification was impossible. Precise quantification remains unknown for the many reasons articulated in this thesis, though with the weight of evidence suggesting the government exerts less control over compliance now than when prior research was undertaken (Flynn 2004), the incidence of non-compliance has likely increased proportionately, and may now been much higher than previous estimates. The size of the Medicare leakage problem is therefore an area where this research has reached consensus with previous work. The new learning and points of difference in this research relate to the causes of the problem.

Prior contributions to this area of research have suggested that non-compliance and fraud is solely attributable to deliberate malfeasance by errant MP, though this has been largely based on opinions rather than empirical evidence. This study challenges that assumption, suggesting that until the serious systemic problems described in this thesis are comprehensively addressed, and every Australian MP has been educated on the proper use of Medicare via a nationally consistent curriculum, current opinions suggesting Medicare leakage is principally attributable to MP misconduct and fraud can no longer be upheld. Even MP who appear to be actively and openly disseminating non-compliant approaches to billing may not be doing so deliberately. The evidence presented in chapter two suggests these education providers hold a genuine but mistaken belief they promote compliance.

Far from being simple, the irrefutable evidence shows that Medicare billing is profoundly complex. This has developed mostly over the last 20 years. There is now layer upon layer of widely dispersed, opaque and impenetrable legal instruments, which means MP cannot always find the laws that apply to them, and their legal advisors may also be struggling.

MP participants of this research demonstrated confusion about even the most basic elements of correct billing, there was no legally reliable advice and support available to them, and they

felt powerless to address these issues. The evidence also suggests that the government is equally confused about what is or is not a compliant medical bill, and without visibility over clinical relevance, effective management of scheme integrity is wanting. Further, recent reforms, such as through MBSRT initiatives, may have exacerbated some of these challenges.

There can be no lingering doubt that a nationally consistent, regulated, educational response to Medicare compliance is required, but this research found it cannot be introduced until rule of law problems are first addressed.

9.3 International application of this research

International standards and medical billing terminology workforce requirements

Every country requires medical billing codes to underpin their UHC systems, irrespective of payment model or system design. Billing versus procedure codes are sometimes differentiated such as in Australia where MBS codes are purely billing codes, and ACHI codes are our national procedure codes, which are not used directly for billing. There is currently no uniformity of billing codes across nations, and in mature health systems, the adopted billing codes tend to become quickly entrenched into systems and processes. For example, the U.S has for decades used CPT (for outpatients) as well as *The Healthcare Common Procedure Coding System* (HCPCS) and various others, Canada uses the *Ontario Health Insurance Plan* codes, France the *Classification Commune des Actes Médicaux* (CCAM) and so on. For countries with nascent UHC systems, the WHO is well advanced in the development of a single unified international medical procedure code set known as the 'ICHI' codes - the *International Classification of Health Interventions* – which will be available to member states free of charge (World Health Organization 2021b).

However, legitimate, country specific reasons will likely continue to cause some countries to prefer development of their own medical billing codes. One recent example is found in the Kingdom of Saudi Arabia (Council of Cooperative Health Insurance Saudi Arabia 2020). The

learnings from this research for such countries, is to ensure the right mix of skills are available to undertake this work so that codes are aligned to international standards.

Based on the evidence obtained in this thesis, the proposed team of people required to undertake this work in Australia was described in **Recommendation 4** under the structure of a new MBAC. The proposed MBAC structure is based on a skills matrix which includes a clinical terminologist, IHPA representative, an experienced legal drafter, a digital health expert and one relevant clinician. While this approach will work well in Australia, there would be benefits and therefore merit in developing a global standard for an optimally comprised medical billing code writing committee. It is suggested that the current ISO Health Informatics Health Information Governance Standards Ad Hoc Group (previously mentioned) has the appropriate expertise to undertake this work and build a methodology to develop a medical billing code writing standard. Once developed, all countries should regulate adoption of the standard into the legislative framework of their UHC systems.

Policy and law reform

Building and retaining expertise and corporate knowledge is essential for the long-term viability of UHC systems. Medibank's founders described this as a 'critically important' element of the original scheme (Scotton and MacDonald 1993), which proved to be correct. Once the HIC was dismantled, effective maintenance and control of Medicare quickly diminished and is now almost impossible. An optimal structure is a statutory authority, independent of government, with overarching responsibility for the health system, including overseeing research into evidence-based policy reform. A structural separation of powers is also recommended such that expert health lawyers are positioned within each countries' justice department, answerable to the first law officer, rather than the health minister. Then, with a regulatory mechanism in place directing that any changes to health system law must have final approval by these lawyers, legal chaos such as that demonstrated in this thesis, will be avoided, protecting MP from legal risk, and governments from wasting their precious health budgets fighting legal battles.

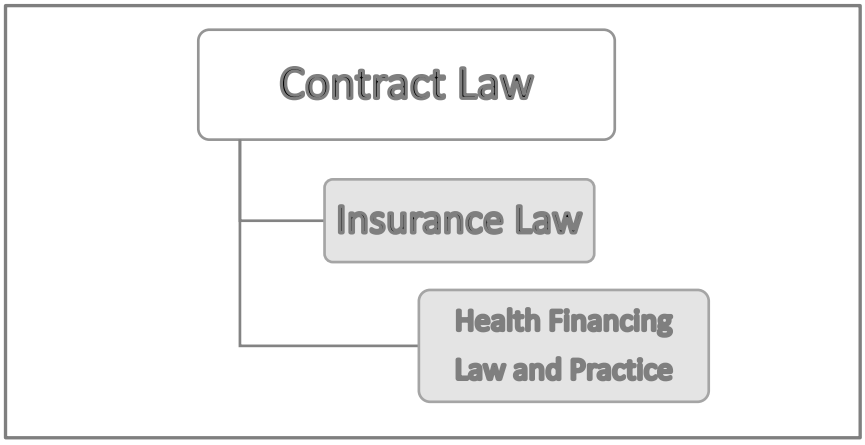
Ensuring the enabling legislation and broader regulatory framework of the system does not become disjointed and overly complex is another obvious learning from this study, that is relevant for all international health system lawyers. And finally, the need for all medical fees to be calculated by reference to an agreed mathematical formula, such as the RVG formula discussed in Chapter 4 (which was never implemented in Australia) is another important, transferrable learning from this research.

Medical and health professional education

A person wishing to study health insurance, or health financing law and practice, is currently unable to do so anywhere in the world. While the discipline of health economics deals with the architecture of health financing arrangements, currently lacking are any experts with specific skills and training on how to implement the objectives and design put forward by health economists and other health policy professionals, using law.

In the same way that macro-economists specialise in areas such as taxation, but the separate disciplines of tax accounting and tax law are well established. Similarly, complex health financing systems, require expert lawyers. This new, niche area of legal scholarship should be positioned as a sub-specialty of contract law, studied at master's level, focussing on applied health insurance law (noting use of the term 'financing' is preferable to 'insurance' to cover both public and private payment systems), This is shown in **Figure 22.**

Figure 22 – Health financing law and practice as a sub-specialty of contract law



The WHO already provides helpful information and guidance around effective laws for UHC systems (World health Organization 2021a), but lawyers tasked with drafting the HIA equivalent in their own countries, do not have specific training or skills in this area. These experts are critically important in every country building a UHC system, whether public or private, and must be able to ensure adherence to rule of law principles, draft effective compliance and integrity frameworks, understand codes and classifications, digital health, clinical terminologies, and the importance of precision legal drafting to avoid the types of devastating damage to MP, which have been demonstrated in this thesis.

All countries should also prioritise regulated education for MP on the operation of the health systems in which they are required to work.

9.4 Suggestions for further research

It is timely for research to now commence on whether the MBSRT has achieved its stated aims and objectives. In addition, examining SNOMED-CT as a clinical relevance tool, and alternatives to the PSR such as fines and penalty points, are both important areas deserving further focussed attention. The potential impacts of the increasing corporatisation of medicine has so far escaped the attention of researchers in Australia and should also be examined, particularly in the area of primary health care.

Another area of critical importance is to comprehensively reconsider how ambulatory care is counted and measured in this country. The evidence suggests tier 2 clinics may not be effective, and alternative models of recording outpatient care should therefore be explored.

Australian research should also examine whether Medicare reform beset by parochialism, may potentially be damaging Medicare's reputation as one of the world's best UHC systems thereby reducing substantial opportunities for international trade and research collaboration.

Eighteen countries have opted to implement a portion of Australia's health classification datasets, each currently holding a country licence for the ABF framework (Independent Hospitals Pricing Authority 2020a). While this is a great credit to our nation and testament to the success of ABF as an internationally recognised, successful system of controlling hospital expenditure, it is curious as to why more countries have not followed suit. The problem of ABF not being able to record granular detail of outpatient care (which constitutes the majority of health system activity) may be of concern to other countries. It is notable that no other country has adopted tier 2 clinics or the MBS, though some have trialled ABF but then switched to the U.S system (Independent Hospitals Pricing Authority 2020a: Malaysia is recorded as having a previous Australian licence but has adopted the U.S system). Others, such as Saudi Arabia, appear to have cobbled together a hybrid of ACHI and MBS codes to develop their own fee schedule for use in the outpatient setting (Council of Cooperative Health Insurance Saudi Arabia 2020). The U.S system of ICD and CPT codes is not only better aligned with international clinical terminology standards, but also enables every outpatient encounter to be coded to a high level of specificity, perhaps making it a more compelling option for countries developing their UHC systems.

Australia already subscribes to international standards such as the North Atlantic Treaty Organization (NATO) Standards (North Atlantic Treaty Organization 2020), recognising the importance of compatibility and interoperability in international military operations. We have also committed to the OECD's 2017 statement on health data governance, which recognises the importance of cross-border sharing of health data to improve health care quality, public health surveillance and inform the development of health systems and research.

"The Recommendation calls upon countries to develop and implement national health data governance frameworks according to twelve high level principles, setting the conditions for greater harmonisation so that more countries are able to benefit from statistical and research uses of data in which there is a public interest, and from international comparisons." (Organization for Economic Cooperation and Development 2017)

We do not appear to be upholding the OECD commitment in the area of health data, given MBS codes are critical health data.

Australia's ongoing failure to develop the MBS and code ambulatory care within a standardised, global e-health framework may therefore be limiting opportunities for the Australian government to export more of our health system to other countries. In a post Covid world where international trade will be key to Australia's economic recovery, this should be a priority.

International medical research collaboration may also be hampered by Australia's medical service descriptions being different to those in other countries. For example, international research relating to ECGs may be hampered because the new MBS description of an ECG is now misaligned with the description of the same test in most other countries, making it difficult for researchers to determine comparability.

9.5 Conclusion

Fifty years after Nimmo stated 'the operation of the health insurance scheme [was] unnecessarily complex and beyond the comprehension of many' (J.A. Nimmo 1969), the operation of the health insurance scheme is again in trouble, having become labyrinthine and beyond the comprehension of anyone. Medicare has become shrouded in a lawless operating environment over which the government exerts little control, in which compliance is nigh impossible, and the national knowledge deficit is of such magnitude that it is unable to be comprehensively remediated presently. Addressing rule of law problems via alignment of regulations and revision of poorly drafted laws will be required before national curriculum development and delivery can commence.

The fact that Australia's health system remains the envy of other countries (Schneider et al. 2017), despite its crumbling legal infrastructure, is evocative of the Churchillian phrase that it is 'a riddle, wrapped in a mystery, inside an enigma' (Churchill 1939). In reality, Medicare

continues to function as well as it does because of the dedicated MP and other health professionals who deliver care every day to millions of Australians, despite constantly burgeoning bureaucratic requirements in the Medicare storm that encircles them. But in the eye of that storm, where the two end users shelter, all is not well. Even for MP who would prefer not to impose OOP on their patients, that option appears to have become too dangerous, with MP regularly commenting on popular online forums that the only solution to avoid prosecution is *not* to bulk bill (O'Rourke 2019a; Lambert 2019). Bulk billing or engaging with gapcover schemes, both of which were specifically designed to eliminate patient OOP, therefore appear to be having the opposite effect. The convenience of immediate and direct payment to the MP may have been overtaken by the contrasting threat of prosecution for breaches of mercurial and unknown rules. Those who can flourish in this high-risk environment are large private sector organisations able to offer bulk-billed services and mitigate risk with capital reserves and legal teams, neither of which are available to smaller providers.

The current punitive approach of the government and private payers towards MP suggests both have lost sight of the fact that every new barrier they impose is calmly walked around by constitutionally protected MP, who quietly adjust their billing patterns or shift costs to consumers. An angry electorate is now paying for health everywhere – through taxes, PHI policies, at the GP, at the specialist and even sometimes in 'free' public hospitals. This has led to spiralling OOP, reduced visibility of actual service delivery, and continued decline of the PHI market, which is shown in **Figure 23**. In addition, the government may now find itself in the position of having to persist with aggressive recoveries through the PSR, *not* to combat non-compliant billing, but to fund increasing volumes of expensive litigation.

Figure 23 – Decline of the PHI market 2014 to 2020

Coverage of Hospital Treatment Tables
Offered by Health Benefits Funds by State
Insured Persons and Percentage of Population

Year ended 30 June			NSW	VIC	QLD	SA	WA	TAS	ACT	NT	Aust.
Jun	2014	Coverage ('000)	3,599	2,625	2,148	776	1,393	232	223	95	**11,091**
		% Population	47.9%	44.5%	45.5%	46.0%	55.3%	45.1%	57.4%	39.1%	**47.3%**
Jun	2015	Coverage ('000)	3,666	2,672	2,164	785	1,431	233	228	97	**11,276**
		% Population	48.1%	44.4%	45.3%	46.2%	56.3%	45.2%	57.5%	39.8%	**47.4%**
Jun	2016	Coverage ('000)	3,699	2,690	2,152	786	1,440	232	230	100	**11,329**
		% Population	47.8%	43.6%	44.4%	45.9%	56.4%	44.9%	57.0%	40.7%	**46.8%**
Jun	2017	Coverage ('000)	3,712	2,695	2,132	785	1,434	231	231	100	**11,319**
		% Population	47.2%	42.6%	43.3%	45.5%	55.7%	44.2%	56.0%	40.3%	**46.0%**
Jun	2018	Coverage ('000)	3,699	2,691	2,111	780	1,422	228	230	98	**11,259**
		% Population	46.4%	41.6%	42.1%	44.9%	54.8%	43.2%	54.7%	39.9%	**45.1%**
Jun	2019	Coverage ('000)	3,694	2,690	2,095	778	1,417	227	231	96	**11,228**
		% Population	45.7%	40.8%	41.1%	44.4%	54.0%	42.4%	54.2%	39.1%	**44.3%**
Jun	2020	Coverage ('000)	3,683	2,681	2,082	777	1,420	226	233	95	**11,197**
		% Population	45.1%	40.0%	40.2%	43.9%	53.3%	41.8%	53.9%	38.5%	**43.6%**

Source: Australian Prudential Regulation Authority https://www.apra.gov.au/quarterly-private-health-insurance-statistics

The regulatory Gordian Knot that has developed over many years has slowly led to the deep concealment of billing non-compliance, to the point where meaningful recoveries are almost impossible. It may not be surprising that the government has therefore resorted to extreme obscurantism in agencies such as the PSR, though evidence suggests this agency will eventually collapse under the weight of opposition. At the same time, MP organisations continue to advocate for increased remuneration via increased Medicare rebates, seemingly incognisant of the government's inability to responsibly accede to this request given non-compliance and poor transparency have created a financial void into which Medicare funding continues to pour at alarming rates.

However, it is not too late nor too difficult to learn from our errors and repair, strengthen and modernise Medicare for future generations. Medicare is a fundamentally good UHC system built on strong constitutional pillars which are unlikely to change. Australians will therefore need to accept that health system responsibilities will remain split between the state and

federal governments, with MP continuing to operate as small business owners. The key to joining this disparate structure, is data.

MBS codes will remain critical health data in Australia into the future. The MBS is already embedded within the scope of legislated definitions of health data (Australian Government 2020c). In fact, the MBS codes are of such high importance to the government, they attracted the involvement of the national security steward, The Australian Signals Directorate, when relevant cloud hosting standards for MBS data were introduced (Australian Government 2019b).

In the same way that the allocation of an ICD/CPT code combination, following an ambulatory patient encounter with an MP in the U.S (and other countries using the U.S classification system), triggers a data journey that flows right through the U.S health system, MBS codes will continue to serve the same purpose in this country. Whether SNOMED-CT codes are added to MBS claims as suggested in this thesis or not is less important than recognition of the fact that MBS codes are bedrock data, central to the operation of the entire health system. They must therefore be gracefully integrated into Australia's overarching digital health strategy to ensure all stakeholders benefit from future changes, rather than just a few.

Medicare billing will only increase in complexity in the coming decades as new tests and treatments become available and the health system shifts towards community-based, virtual care delivery (Batra, Davis, and Betts 2019; Walker 2016; Spinney 2021). Irrespective of whether future payment arrangements are FFS or something else, billing codes will always be required, as they are in every country with a UHC system. Further, Australia's legislated payment vehicle will likely continue to be the HIA.

Unless and until the legal defence of ignorance is eliminated to the maximum extent possible, control of compliance will remain patchy at best. This can only be achieved following repair and restoration of the legal infrastructure to an integrated whole, informed by an overarching data governance methodology. Education to nationally consistent standards can then follow.

Priority areas include addressing rule of law problems, educating MP and reducing their current compliance burdens, improving government enforcement and visibility, while protecting consumers.

Medicare was not born of a global mindset, but it needs to adopt one now or Australia will be left behind in important areas of international trade, cooperation and development in health. Standards-based interoperable, consistent, and clear health data, including the MBS, must be able to flow freely between digital systems to support international benchmarking, research collaborations and engagement. The future proofing of Medicare is therefore a matter of national importance that will benefit all Australians.

By demonstrating the significant complexity of medical billing and the wide-ranging knowledge deficit of MP in this area, this research concludes with a perhaps unpalatable truth, that a principal cause of non-compliant medical billing in Australia is system issues rather than deliberate abuse by MP. The need for immediate action to address the issues identified in this thesis is therefore pressing.

Without reform, the government can expect no improvement in leakage and increased litigation against the PSR by MP, who have no choice but to try and comply with a system they cannot avoid, do not understand, and feel powerless to change. Consumer OOP medical expenses will likely continue to rise as MP shift the cost burden to their patients, which may in turn accelerate contraction of the PHI market. An urgent correction to Medicare's billing system infrastructure is required, encompassing regulatory, educational, and digital reform.

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Appendices

Appendix 1 – Example Medicare determination of a single MBS item

29 September 2008

Medicare Australia
Assessing and Benefits
P.O Box 9822
Sydney NSW 2001

Dear Medicare

RE: Request for review and determination of item number 838

We request a formal review and determination of the above item number on behalf of Dr [redacted] provider number: [redacted]

Relevant background information

We submitted and Eclipse claim to [redacted] as follows:

Patient:	[redacted]
Medicare:	
Date of service:	28 February 2008
Item:	838
Amount of claim:	$243.20 (pursuant to the [redacted] Medigap scheme)

The claim was rejected. Advice from [redacted] was that Medicare rejected the claim.

We resubmitted the claim manually on 2nd April and it was again rejected. The rejection code indicated the problem lay with Mrs [redacted] status as either an inpatient or outpatient at the date of service.

We checked the admission and discharge details with both Dr [redacted] and the [redacted] Hospital to determine the patient's status at the date of service. Both confirmed that the patient was an inpatient at the date of service.

We then contacted [redacted] who also confirmed that their records indicated the patient was in hospital at the date of service, the discharge date being 3 March 2008. [redacted] advised us to resubmit the claim as item 838 was an inpatient item and was payable. Accordingly, we resubmitted the claim on 16 July 2008. It was again rejected.

On 25th July:

1. We spoke with [redacted] who advised that item 838 is included in their Medigap Schedule as the Medicare item descriptor clearly indicates it to be an inpatient item (in would not be included in their Medigap Schedule otherwise) but that Medicare considers it to be an outpatient only item and we therefore cannot bill it unless we bill it as an outpatient claim. This was clearly not an option in these circumstances as Mrs [redacted] was an inpatient.

2. We spoke with the Medicare Interpretations Department who advised that item 838 is marked as 'never' to be billed as an inpatient item and that the word 'participate' distinguishes this item from the other items 830, 832 and 834 and renders it an outpatient item. We were also advised that 'the Doctor' could have been outside of the hospital for this conference. We did not understand this information.

3. We spoke with Dr [redacted] regarding the above conversations and discussed other item numbers she might use instead of item 838. We have numerous clients who regularly bill items 830, 832 and 834, all of which are inpatient items, usually processed without problems. We discussed whether one of these items might be appropriate in this instance. Dr [redacted] said she would need to review the patient's medical records to determine whether she 'organised and coordinated' the conference (which would enable her to claim in the range of items 830 to 834) or whether she 'participated' in the conference (for which items 835, 837 and 838 are the appropriate items). Having reviewed the patient's medical records Dr [redacted] later advised us that she did not 'organise and coordinate' the conference but was asked by her colleague to 'participate' in it as a member of the treating team.

4. During a subsequent discussion with a representative of Medicare we were advised that we could write a letter requesting a determination but that it would be of no use as item 838 will 'never' be paid as an inpatient claim. This person was unable to explain why this was the case given the item description and the explanatory notes.

5. In the course of these and other conversations with both [redacted] and Medicare we have received various advices as to available options such as:

(a) claim using one of the items 830, 832 or 834. Point 3 above makes clear that this is not an option, and
(b) rebill the claim as an outpatient claim. We also cannot do this as Mrs [redacted] was an inpatient at the date of service.

The purpose of this letter therefore is to try to understand, in the context of the written descriptions and notes in the MBS, how item 838 can be an outpatient only item and, if it is, then what item should we bill on behalf of Dr [redacted] for the service she provided.

Item descriptor and explanatory notes in the MBS

The relevant item descriptor for item 838 is below (highlighting added by the writer). We have also copied the description for item 834 as it is a useful reference point. It appears that the two items operate together in circumstances where one Physician requests that another Physician participates in a discharge case conference.

> 838
> Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to PARTICIPATE **IN A DISCHARGE CASE CONFERENCE** of at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines
> *(See para A.34 of explanatory notes to this Category)*
> **Fee:** $197.55 **Benefit:** 75% = $148.20 85% = $167.95

834
Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to ORGANISE AND COORDINATE **A DISCHARGE CASE CONFERENCE** of at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines
(See para A.34 of explanatory notes to this Category)
Fee: $251.15 **Benefit:** 75% = $188.40 85% = $213.50

Item 834 is almost identical to item 838 other than the words 'participate' (item 838) and 'organise and coordinate' (item 834). The higher schedule fee of item 834 reflects the additional work required by the Physician who actually organises and coordinates the conference. Other than these differences it is difficult to understand why item 834 is always payable as an inpatient claim yet item 838 is apparently 'never' payable as such.

Dr [redacted] has confirmed that the service she provided to Mrs [redacted] on 28th February 2008 exactly meets the criteria of item 838 and that Mrs [redacted] conference was a very long and complex one that continued for well over an hour.

The explanatory notes copied below seem to add further support for the view that item 838 is an inpatient item:

> **A.34 Case Conferences by consultant physician (Items 820 to 838)**
>
> A.34.1 Items 820, 822, 823, 825, 826 and 828 apply to a community case conference (including a case conference conducted in a residential aged care facility) organised to discuss one patient in detail and applies only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and has complex needs requiring care from a multidisciplinary team. Items 820, 822, 823, 825, 826 and 828 do not apply to an in-patient of a hospital.
>
> A.34.2 For items 830, 832, 834, 835, 837 and 838, a discharge case conference is a case conference carried out in relation to a patient before the patient is discharged from a hospital. Items 830, 832, 834, 835, 837 and 838 are payable not more than once for each hospital admission.

The explanatory notes are very helpful in distinguishing the 'outpatient' nature of the items in the 820 to 828 range by use of the words:

> "…..do not apply to an in-patient of a hospital...."

and the 'inpatient' nature of the items in the 830 to 838 range by use of the words:

> "…….before the patient is discharged from a hospital....."

This is consistent with our experience billing items in this category. From 1 January this year to date we have billed more than 2,500 items in the range 820 to 838 (and including the weekly case conference item 880) for our physician clients.

In our experience the items 830, 832 and 834 are always processed without problem as inpatient claims, whilst the item 820 (being the most common item we see in that range of items) is always processed without problem as an outpatient claim. Of note is the fact that we have also experienced rejections when item 820 has been erroneously transmitted as an inpatient claim. The rejection code being 'outpatient item only' or words to that effect.

Notwithstanding the above descriptions and explanatory notes, if it is correct that item 838 is an outpatient item only then it would appear that Medicare has two identical items for the same outpatient service as follows (highlighting again added by the writer):

> 828
> Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **PARTICIPATE IN A COMMUNITY CASE CONFERENCE** (other than to organise and to coordinate the conference) of at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines
> *(See para A.34 of explanatory notes to this Category)*
> **Fee:** $197.55 **Benefit:** 75% = $148.20 85% = $167.95
>
> 838
> Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to **PARTICIPATE IN A DISCHARGE CASE CONFERENCE** of at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines
> *(See para A.34 of explanatory notes to this Category)*
> **Fee:** $197.55 **Benefit:** 75% = $148.20 85% = $167.95

The only difference being that item 828 uses the word 'community' whilst item 838 uses the word 'discharge'. The description is otherwise the same as is the fee and the relevant explanatory notes.

Given that item 828 refers to 'community' whilst item 838 refers to 'discharge' it is difficult to appreciate why one is not intended as an outpatient item and the other as an identical inpatient item.

We hope you can appreciate the difficulties we have had trying to understand the mysteries of item 838.

Could you please provide a written response which includes answers to the following questions?

1. Given that Mrs [redacted] was an inpatient on 28th February 2008, is the suggestion that we can bill the item as an outpatient claim correct? If yes, please explain why this is.
2. Given that Dr [redacted] only 'participated' in the discharge case conference but did not 'organise and coordinate' it, is the suggestion that we can bill item 834 correct? If yes, please explain why this is.
3. Given that the service provided by Dr [redacted] exactly meets the criteria of item 838 is there any circumstance under which the claim is payable as an inpatient claim?
4. If the answer to 3 is no, can you please advise which item is the correct item in the MBS for the service provided by Dr [redacted]?
5. If there is no service claimable by Dr [redacted] for the service she provided on 28th February 2008, is it therefore correct that there exists no current item in the MBS for a Consultant Physician who participates in a discharge case conference where the patient being discussed is an inpatient?
6. Is it correct that there are currently two items in the MBS for a Consultant Physician who participates in a case conference of more than 45 minutes where the patient is an outpatient, these being items 828 and 838?

Thank you in anticipation of your early attention to this request for a determination.

Please do not hesitate to contact the writer should you require any further information or clarification on any point.

Kind regards

Australian Government
Medicare Australia

If not delivered return to GPO Box 9822 in your capital city

RECEIVED
04 NOV 2008

Medicare

29 October 2008

Our Reference: [redacted]

Ms M Faux
[redacted]

Dear Ms Faux

[redacted]

Thank you for your enquiry regarding rejection of item 838 as an in-patient service, rendered by Dr [redacted] on 28 February 2008.

Medicare benefits are paid in accordance with the Medicare Benefits Schedule (MBS), which is administered by Medicare Australia on behalf of the Department of Health and Ageing (DoHA). In addition the interpretation of the rules and restrictions that govern the payment of benefits rest with DoHA.

A discharge case conference is for the care of an individual patient returning to the community after discharge from hospital.

The level of Medicare benefits payable for a discharge case conference depends on whether a service is an in-patient service or an out-of-hospital service.

To determine the appropriate Medicare rebates payable, case conferences have been separated into categories depending on the role of the medical practitioner's task at hand: These are:

- To organise and coordinate a discharge case conference; and
- To participate in a discharge case conference.

Since the introduction of these services, the only service considered to be an in-hospital service is "organising and coordinating a discharge case conference". Medicare benefits for this service are only available for private patients at 75% of the Schedule fee. The participation in a discharge case conference is considered to be an out-of-hospital service and therefore attracts payment of a Medicare rebate at 85% of the Schedule fee.

- The provider who organises and coordinates a discharge case conference is the provider who is responsible for the care of the patient's stay in hospital, therefore, the 'organising and coordinating a discharge case conference' items are claimed as in-hospital.

- The provider who participates in a discharge case conference should claim the 'participation in a discharge case conference' item as an out-of-hospital service, because the patient is not personally attended to by the participating provider.

In response to your questions:

Q. Given that Mrs [redacted] was an in-patient on 28th February 2008, is the suggestion that we bill for item as an out-patient claim correct? If yes, why this is?

A. Yes, that is correct. This service must be billed as an out-patient service because of the reasons outlined above.

Q. Given that Dr [redacted] only 'participated' in the discharge case conference but did not 'organise and coordinate' it, is the suggestion that we can bill item 834 correct? If yes, please explain why this is?

A. No, that is not correct. Provider has a responsibility to ensure that requirements of the item descriptor are fully met. If the provider has only 'participated in a case conference' the relevant item number must be claimed.

Q. Given that the service provided by Dr [redacted] exactly meet the criteria of item 838 is there any circumstance under which the claim is payable as an in-patient claim?

A. No

Q. If the answer to 3 is no, can you please advise which item is the correct item in the MBS for the service provided by Dr [redacted]?

A. Item 838

Q. If there is no service claimable by Dr [redacted] for the service she provided on 28th February 2008, is it therefore correct that there exists no current item number in the MBS for a Consultant Physician who participates in a discharge case conference where the patient being discussed as an in-patient?

A. Item number 838 is the correct item.

Q. Is it correct that there are currently tow items in the MBS for a Consultant Physician who participates in a case conference of more than 45 minutes where the patient is an outpatient, these being items 828 and 838?

A. Item 828 is for 'participation in a community case conference' whereas item 838 is for 'participation in a discharge case conference'.

I trust this information is of assistance.

If you have any questions, please call Medicare Assessing and Benefits on (02) 98953346.

Yours sincerely

[redacted]

Service Officer
Medicare Australia

Appendix 2 – Survey consent form

CONSENT FORM (Phase 1)
Telephone script

UNIVERSITY OF TECHNOLOGY SYDNEY

Hello, my name is Margaret Faux and I am a PhD Research student at UTS. Could you please put me through to the Dean/person responsible for delivering curriculum requirements to medical practitioners/medical students/education content for members/education of personnel deployed to provider liaison/provider interpretations/provider auditing/education for panel members involved in the discipline of medical practitioners for Medicare non-compliance.

Once the identity of the person has been established and noted:

Hello, my name is Margaret Faux and I am a PhD Research student at UTS. Do you have a few minutes to discuss my research project?

1. If yes, continue below
2. If no, but the participant is interested, I will determine a more convenient time to call back.
3. If no, I will thank them for their time and end the call.

The research project is called: *Claiming and compliance under the Medicare Benefits Schedule (MBS): a critical examination of attitudes, experiences, perceptions and knowledge of medical practitioners*. The purpose of this study is to examine the experiences and perceptions of medical practitioners as they interact with Medicare and claim MBS reimbursements.

I am asking you to participate because the organisation you represent plays a role in the education of medical practitioners/medical students. Your participation in this research will involve between 2 and 5 minutes of your time responding to a brief survey. The telephone survey will be conducted in accordance with privacy principles and will not be recorded. If you would like a copy of the consent form and information sheet, I will provide them to you.

You can contact me or my supervisors, Jon Wardle or Jon Adams, if you have any concerns about the research. I will provide you will my telephone number in a moment as well as that of the UTS research ethics officer. You are also free to withdraw your participation from this research project at any time you wish, including after the data has been collected, without consequences, and without giving a reason.

Do you have any questions? If yes, answer all questions and record responses given
Are you willing to continue? If yes, read and execute the below consent and commence survey

I _____ *(participant's name)* agree to participate in the research project *Claiming and compliance under the Medicare Benefits Schedule (MBS): a critical examination of attitudes, experiences, perceptions and knowledge of medical practitioners*. UTS HREC REF NO. 2014000060, *being* conducted by Margaret Faux email: Margaret.A.Faux@student.uts.edu.au telephone: 0414 600 073 of the University of Technology, Sydney for her degree, Doctor of Philosophy.

I agree that Margaret Faux has answered all my questions fully and clearly.
I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

_____ ____/____/____
Signature (participant – verbal consent)

_____ ____/____/____
Signature (Margaret Faux)

NOTE: This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph: +61 2 9514 9772 Research.Ethics@uts.edu.au) and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

Appendix 3 - Interview consent form

UNIVERSITY OF TECHNOLOGY SYDNEY

Participant Consent Form (Phase 2)

I _____ *(participant's name)* agree to participate in the research project;

Claiming and compliance under the Medicare Benefits Schedule (MBS): a critical examination of attitudes, experiences, perceptions and knowledge of medical practitioners, UTS HREC REF NO. 2014000060.

The project is being conducted by Margaret Faux, email: Margaret.A.Faux@student.uts.edu.au telephone: 0414 600 073 of the University of Technology, Sydney, for her PhD.

I understand that the purpose of this study is to examine the experiences and perceptions of medical practitioners as they interact with Medicare and claim MBS reimbursements. The research also aims to identify any perceived barriers to compliance and to explore possible solutions to problems and deficiencies identified by participants.

I understand that I have been asked to participate in this research because I am a medical practitioner who claims MBS reimbursements in my daily work and that my participation in this research will involve between 30 minutes and one hour of my time being interviewed. There are no foreseeable risks to me above the risks of everyday living.

I am aware that I can contact Margaret Faux or her supervisors, Jon Wardle or Jon Adams, if I have any concerns about the research. I also understand that I am free to withdraw my participation from this research project at any time I wish, without consequences, and without giving a reason.

I agree that Margaret Faux has answered all my questions fully and clearly.

I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

_____ ____/____/____
Signature (participant)

_____ ____/____/____
Signature (researcher or delegate)

NOTE:
This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph: +61 2 9514 9772 Research.Ethics@uts.edu.au) and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

Appendix 4 - Survey information sheet

UNIVERSITY OF TECHNOLOGY SYDNEY

PARTICIPANT INFORMATION SHEET (Phase 1)

PROJECT TITLE

Claiming and compliance under the Medicare Benefits Schedule (MBS): a critical examination of attitudes, experiences, perceptions and knowledge of medical practitioners, UTS HREC REF NO. 2014000060.

WHO IS DOING THE RESEARCH?

My name is Margaret Faux and I am a PhD student at UTS. My supervisors are Jon Wardle and Jon Adams.

WHAT IS THIS RESEARCH ABOUT?

The aim of my research is to examine the experiences and perceptions of medical practitioners as they interact with Medicare and claim MBS reimbursements.

IF I SAY YES, WHAT WILL IT INVOLVE?

I will ask you to participate in a short telephone survey that will take between 2 – 5 minutes of your time.

ARE THERE ANY RISKS/INCONVENIENCE?

There are very few if any risks because the research has been carefully designed. Your privacy and that of your organisation is of the highest importance and the data collected will be de-identified prior to being analysed and/or published.

WHY HAVE I BEEN ASKED?

You have been asked to participate because the organisation you represent plays a role in the education of medical practitioners/medical students.

DO I HAVE TO SAY YES?

You don't have to say yes.

WHAT WILL HAPPEN IF I SAY NO?

Nothing. I will thank you for your time so far and won't contact you about this research again.

IF I SAY YES, CAN I CHANGE MY MIND LATER?

You can change your mind at any time and you don't have to say why. I will thank you for your time so far and won't contact you about this research again.

WHAT IF I HAVE CONCERNS OR A COMPLAINT?

If you have concerns about the research that you think I or my supervisor can help you with, please feel free to contact us on:

Margaret Faux: 0414 600 073
Margaret.A.Faux@student.uts.edu.au
Jon Wardle: Jon.Wardle@uts.edu.au
Jon Adams: Jon.Adams@uts.edu.au

If you would like to talk to someone who is not connected with the research, you may contact the Research Ethics Officer on 02 9514 9772, and quote this number UTS HREC REF NO. 2014000060.

Appendix 5 - Interview information sheet

UNIVERSITY OF TECHNOLOGY SYDNEY

PARTICIPANT INFORMATION SHEET (Phase 2)

PROJECT TITLE

Claiming and compliance under the Medicare Benefits Schedule (MBS): a critical examination of attitudes, experiences, perceptions and knowledge of medical practitioners, UTS HREC REF NO. 2014000060.

WHO IS DOING THE RESEARCH?

My name is Margaret Faux and I am a PhD candidate at UTS. My supervisors are Jon Wardle and Jon Adams.

WHAT IS THIS RESEARCH ABOUT?

The aim of my research is to examine the experiences and perceptions of medical practitioners as they interact with Medicare and claim MBS reimbursements. The research also aims to identify any perceived barriers to compliance and to explore possible solutions to problems and deficiencies identified by participants.

IF I SAY YES, WHAT WILL IT INVOLVE?

I will ask you to participate in one face to face interview of between 30 minutes and one hour. You can choose the location and time of the interview.

ARE THERE ANY RISKS/INCONVENIENCE?

There are very few if any risks because the research has been carefully designed. Your privacy is of the highest importance and the data collected will be de-identified prior to being analysed and/or published.

WHY HAVE I BEEN ASKED?

You have been asked to participate because you are a medical practitioner who claims MBS reimbursements.

DO I HAVE TO SAY YES?

You don't have to say yes.

WHAT WILL HAPPEN IF I SAY NO?

Nothing. I will thank you for your time so far and won't contact you about this research again.

IF I SAY YES, CAN I CHANGE MY MIND LATER?

You can change your mind at any time and you don't have to say why. I will thank you for your time so far and won't contact you about this research again.

WHAT IF I HAVE CONCERNS OR A COMPLAINT?

If you have concerns about the research that you think I or my supervisor can help you with, please feel free to contact us on:

Margaret Faux: 0414 600 073
Margaret.A.Faux@student.uts.edu.au
Jon Wardle: Jon.Wardle@uts.edu.au
Jon Adams: Jon.Adams@uts.edu.au

If you would like to talk to someone who is not connected with the research, you may contact the Research Ethics Officer on 02 9514 9772, and quote this number UTS HREC REF NO. 2014000060.

Appendix 6 - Ethics approval

UTS HREC Approval email

Thu 6/11/2014 2:57 PM

Dear Applicant

UTS HREC REF NO. 2014000601

The UTS Human Research Ethics Expedited Review Committee reviewed your amendment application for your project titled, "Claiming and compliance under the Medicare Benefits Schedule (MBS): a critical examination of attitudes, experiences, perceptions and knowledge of medical practitioners (MPs)", and agreed that the amendments meet the requirements of the NHMRC National Statement on Ethical Conduct In Human Research (2007).

I am pleased to inform you that the Committee has approved your request to amend the protocol which requested to increase the number of participants by removing the 8 medical boards, adding the Australian Health Practitioner Regulation Agency (AHPRA) and also adding 17 vocational GP education providers. The new total number of participants will therefore be 66.

You should consider this your official letter of approval. If you require a hardcopy please contact the Research Ethics Officer (Research.Ethics@uts.edu.au).

To access this application, please follow the URLs below:
• if accessing within the UTS network: http://rmprod.itd.uts.edu.au/RMENet/HOM001N.aspx
• if accessing outside of UTS network: https://remote.uts.edu.au , and click on "RMENet - ResearchMaster Enterprise" after logging in.

We value your feedback on the online ethics process. If you would like to provide feedback please go to: http://surveys.uts.edu.au/surveys/onlineethics/index.cfm

If you wish to make any further changes to your research, please contact the Research Ethics Officer in the Research and Innovation Office, Ms Racheal Laugery on 02 9514 9772.

In the meantime I take this opportunity to wish you well with the remainder of your research.

Yours sincerely,

Professor Marion Haas
Chairperson
UTS Human Research Ethics Committee
C/- Research & Innovation Office
University of Technology, Sydney
T: (02) 9514 9645
F: (02) 9514 1244
E: Research.Ethics@uts.edu.au
I: http://www.research.uts.edu.au/policies/restricted/ethics.html
P: PO Box 123, BROADWAY NSW 2007
[Level 14, Building 1, Broadway Campus]
CB01.14.08.04

E:13

Appendix 7 - Quantitative survey

Claiming and compliance under the Medicare Benefits Schedule (MBS)

For the purposes of this survey:

1. The term "medical billing course" means:
Any form of training program, education program, lecture, syllabus, classes, seminar, workshop, subject or study program offered by your faculty/college/board/organisation/department* on the topic of claiming and compliance under the Medicare Benefits Schedule.

* The different participants will be addressed when surveyed using the following:
Medical schools = faculty
Royal Australian Colleges = college
Medical Boards and Professional Standards Review (PSR) Board = board / panel members
Medical Defense Organisations (MDO) and the Australian Medical Association (AMA) = organisation / employees / members
Medicare = department / employees

1. Does your faculty/college/board/organisation/department* offer a medical billing course to its students / medical practitioner trainees/ members / employees in provider liaison, provider interpretation and provider auditing* / personnel who make decisions on matters of medical practitioner compliance with the Medicare Benefits Schedule?**

- ◯ Yes (skip to question 7)
- ◯ No

2. Did your faculty/college/board/organisation/department* ever offer a medical billing course?

- ◯ Yes
- ◯ No (skip to question 5)

3. When was the medical billing course discontinued?

- ◯ 0-1 year ago
- ◯ 1-2 years ago
- ◯ 2-5 years ago
- ◯ more than 5 years ago

Claiming and compliance under the Medicare Benefits Schedule (MBS)

4. Which of the following best describes why the medical billing course was discontinued?

- ◯ No longer seen as important
- ◯ Insufficient space in the curriculum
- ◯ Lack of interest
- ◯ No-one to teach it

Other (please specify)

5. Do you think that medical practitioners/medical students should be required to attend a medical billing course?

- ◯ Yes
- ◯ No (end of survey)

6. Who do you think should be responsible for delivering a medical billing course? (end of survey)

- ☐ Medicare
- ☐ The AMA
- ☐ The colleges
- ☐ The medical defense organisations
- ☐ The universities
- ☐ The medicall boards

Other (please specify)

Claiming and compliance under the Medicare Benefits Schedule (MBS)

7. Which of the following best describes who the medical billing course is offered to?

- [ ] Medical students
- [ ] Post graduate students
- [ ] Alumni
- [ ] Members of our organisation
- [ ] Employees
- [ ] All medical practitioners

Other (please specify)

8. Please describe when the medical billing course is offered (eg: in the final year of the degree / in the first week of the induction program / courses are offered throughout the year)

9. Is the medical billing course mandatory or voluntary?

- ◯ Mandatory
- ◯ Voluntary

10. How many hours duration is the medical billing course?

- ◯ 0-1 hour
- ◯ 1-2 hours
- ◯ 2-4 hours
- ◯ more than 4 hours

Other (please specify)

11. How long has your faculty/college/board/organisation/department* been offering the medical billing course?

- ◯ 0-1 year
- ◯ 1-5 years
- ◯ 5-10 years
- ◯ More than 10 years

Claiming and compliance under the Medicare Benefits Schedule (MBS)

12. Which of the following best describes the qualifications of the person or people responsible for delivering the medical billing course?

- [ ] Legal qualification
- [ ] Education qualification
- [ ] Medical qualification
- [ ] Ethics qualification
- [ ] No formal qualifications

Other (please specify)

13. How is the medical billing course examined?

- [ ] Multiple choice examination
- [ ] Written answer examination
- [ ] Take home examination
- [ ] Assignments / group projects
- [ ] The course is not examined

Other (please specify)

14. Is the medical billing course offered as a free course or do participants have to pay?

- ◯ It is free
- ◯ Have to pay

The following question will be asked to Medicare, the Medical Boards and the PSR

15. Where are medical practitioners who have been found to have breached their Medicare compliance obligations directed to attend medical billing courses to further their learning?

- [ ] Medicare
- [ ] The AMA
- [ ] The colleges
- [ ] The Medical Defense Organisations
- [ ] No suggestions are made about where to access further learning on medical billing

Other (please specify)

Appendix 8 - Qualitative Interview Question Guide

1. Do you recall your first experience billing your first MBS item? Can you tell me about that?
2. How did you initially learn to navigate the MBS?
3. Do you feel that your education, including undergraduate, post graduate and CME, has adequately equipped and informed you in relation to your MBS compliance obligations? If the answer identifies deficiencies: What do you perceive as being the nature of the deficiencies? Do you have any suggestions as to how the deficiencies might be addressed?
4. Have you ever encountered any problems or difficulties claiming MBS reimbursements that affected you personally? Have you ever encountered any problems or difficulties that affected your patients?
5. What do you understand as being the purpose of Medicare and having a provider number? How do you enact this understanding in day-to-day practice?
6. What do you view as your rights, obligations and responsibilities in relation to Medicare and the MBS?
7. Are you aware of possible repercussions for non-compliance with the MBS? Do you feel any concern about possible repercussions for non-compliance?
8. Do you manage your own MBS claims or do you outsource or delegate this task to third parties (such as practice managers or billing services)? If yes: What benefits do you perceive from doing this? What potential risks do you perceive from doing this?
9. What level of detail are you able to recall about your claiming patterns and practices?
10. Do you perceive differences between bulk billing transactions and other transactions? In what circumstances do you perceive you are able to charge additional fees to your patients?
11. Do you perceive any external pressure in relation to your claiming? What is the basis for this perception? (Note whether these are different in differing practice types e.g. corporate v. solo practice)
12. What do you perceive as being the relationship between your compliance obligations and patient care? Do you perceive that your billing patterns may impact patient care?
13. What types of support do you seek in relation to MBS billing? How often do you seek support in relation to your claiming? What do you perceive as being the quality of the support you receive? Where are you most likely to turn to for support in this area?
14. Do you perceive barriers or issues that prevent you from seeking or gaining assistance?
15. Do you perceive that your MBS claiming is compliant with current standards in your current practice setting? Why? Why not? Would you feel confident if you were audited by Medicare or the PSR? Why? Why not?
16. What do you understand about the aftercare claiming rules?
17. What do you understand as being the patient's role in a bulk billing transaction?
18. What do you understand about the rules around valid referrals?
19. What do you understand about the provider number rules and which one to use when?
20. What do you understand about the rules concerning the charging of Veterans, serving members and WC/TP patients?
21. What are your perceptions in relation to your claiming patterns and your responsibility for the national health budget?

Appendix 9 – DOH Chemotherapy Information Release #4 dated 20 October 2020

Department of Health

Information Release #4
MBS Chemotherapeutic Procedures
Frequently Asked Questions

On 26 September 2020, the Department of Health presented a webinar on the changes that are to take effect on 1 November 2020 for chemotherapeutic procedures listed on the Medicare Benefits Schedule (MBS). Following the webinar, a broad range of stakeholders posed a variety of questions. The following explanatory statements are provided in response.

Parenteral Administration

Parenteral administration refers to the delivery of a therapeutic agent via injection, as opposed to administration via the alimentary tract or topically (e.g. application of creams or ointments).

Examples of suitable parenteral routes for the administration of cytotoxic chemotherapy and/or monoclonal antibody therapy include:

- intravascular;
- intramuscular;
- subcutaneous;
- intrathecal; or
- intracavitary.

Item 13950 provides for each attendance at which one or more antineoplastic agents are administered and can be claimed for each day where the service is provided in the course of treatment. The item covers the administration of one or more antineoplastic agents on the same occasion and it is not be expected that there would be multiple claims for item 13950 on one day.

Accessing long-term implanted delivery devices

From 1 November 2020, a new item - 13950 - will provide Medicare benefits for patients who undergo parenteral administration of antineoplastic agents (cytotoxic chemotherapy or monoclonal antibody therapy). Accessing a long-term implanted device, such as a peripherally inserted central catheter (PICC) line, for the purpose of administering the antineoplastic agent and at the time of administering the antineoplastic agent, is considered an integral component of this service, and therefore should not receive a separate MBS benefit. Item 14221 cannot be claimed in these circumstances.

Providers should note that the fee for item 13950 includes a component for accessing a long-term implanted drug delivery device when administering antineoplastic agents, and should be mindful of this when billing patients for services not specifically listed on the MBS. Note that billing against item 14221, for any reason (e.g. flushing or taking of bloods), is not permitted when the device is accessed during the attendance associated with 13950.

However, it is recognised that the clinical need for access to an implanted device exists beyond the administration of antineoplastic therapy, for example, flushing a long-term intravascular access device in order to maintain patency during prolonged periods of disuse or giving antibiotic therapy or transfusing blood products or taking a blood sample. Billing against item 14221, in these situations is considered clinically relevant and appropriate, so long as these services are not associated with an attendance for the administration of antineoplastic therapy under item 13950.

Where item 14221 is claimed on the same day as item 13950 for a separate and distinct clinically relevant service, the account for item 14221 must be annotated with 'separate attendance' or 'separate service' to enable the claim to be appropriately assessed. It would be expected that the account would be annotated with time of the attendances to demonstrate that separate services were provided to the patient.

Remote and Off-Site Supervision

The descriptor for item 13950 does not preclude remote or off-site administration of antineoplastic therapy. Billing of item 13950, where the administration of the antineoplastic agent or agents occurs at a location other than where the consultant physician or specialist is attending, is appropriate, so long as the claiming consultant physician or specialist is satisfied that the administration of the antineoplastic therapy is being performed with the level of supervision which is generally accepted by the profession as necessary for the appropriate treatment of the patient.

The specialist or consultant physician, who is undertaking or supervising the procedure, will bill the service using the provider number associated with the service location

Note that in order for a service to be claimed under item 13950 there must be an attendance on the patient by the specialist or consultant physician or the health professional providing the service on their behalf. Item 13950 cannot be claimed where the patient is receiving the infusion at home via

a pre-loaded pump or ambulatory delivery device and there has not been an attendance on the patient.

Pump and other devices

From 1 November 2020, the loading of pumps, reservoirs or ambulatory drug delivery devices can be billed under item 13950 (so long as the conditions described in the item descriptor are met). Item 13950, in these circumstances, can be billed once per attendance where the device is loaded with the antineoplastic agent or agents. Where appropriate, and where the item requirements have been met in full, including that there has been administration of an antineoplastic agent on that day, item 13950 may be claimed on the day where the pump or device is disconnected by the specialist or consultant physician or health professional providing the service on their behalf.

Therapies

Item 13950 covers the administration of antineoplastic agents for cytotoxic chemotherapy or monoclonal antibody therapy for the treatment of cancer. Other types of therapies, such as anti-resorptive bone therapy and hormonal therapy are not covered under item 13950. The supervision of these therapies is reimbursed on a consultation basis. Additionally, monoclonal antibody therapy for inflammatory conditions and multiple sclerosis are not covered by item 13950.

Administration of oral chemotherapy is not currently funded under the MBS. However, a recommendation of the MBS Review Taskforce is for the introduction of an MBS item to cover the administration of oral chemotherapy. This recommendation will be the subject of a Medical Services Advisory Committee (MSAC) application. Further information regarding the MSAC process can be found at www.msac.gov.au.

Private Health Insurance

From 1 November 2020, the private health insurance categorisation and classification for item 13950 will be:

- Procedure Type B Band 1 (same day accommodation); and
- Clinical category - Chemotherapy, radiotherapy and immunotherapy for cancer.

Under subsection 72-1(2) of the *Private Health Insurance Act 2007*, the minimum benefits an insurer must pay for covered hospital treatment, includes at least 25% of the MBS item Schedule

fee and the accommodation benefit as set out in the *Private Health Insurance (Benefit Requirements) Rules 2018*. Minimum benefits for private health insurance payments apply to the entirety of an MBS item, as written, including the full descriptor (i.e. there is no provision to pick and choose aspects of an item for any of the minimum benefits).

Use of Pharmaceuticals

From 1 November 2020, the parenteral administration of antineoplastic agents, including cytotoxic chemotherapy and monoclonal antibody therapy, can be claimed under item 13950.

Item 13950 cannot be used for claims related to the administration of pharmaceuticals used as part of hormonal therapy nor for the administration of colony-stimulating factors (such as filgrastim, pegfilgrastim, and plerixafor). Also, the administration of anti-resorptive bone therapy is not covered under item 13950.

The administration of pharmaceuticals given as part of a treatment regimen for a non-malignant disease cannot be claimed under item 13950. For example, item 13950 cannot be used for claims related to the treatment of multiple sclerosis (such as Natalizumab and Ocrelizumab) or for the treatment of arthritis (such as Rituximab or Tocilizumab).

Further information regarding the 1 November 2020 changes to the chemotherapeutic procedures listed on the MBS can be found at: www.mbsonline.gov.au.

Appendix 10 – DOH Chemotherapy Information Release #4 dated 30 October 2020

Department of Health

Information Release #4
MBS Chemotherapeutic Procedures
Frequently Asked Questions

On 26 September 2020, the Department of Health presented a webinar on the changes that are to take effect on 1 November 2020 for chemotherapeutic procedures listed on the Medicare Benefits Schedule (MBS). Following the webinar, a broad range of stakeholders posed a variety of questions. The following explanatory statements are provided in response.

Parenteral Administration

Parenteral administration refers to the delivery of a therapeutic agent via injection, as opposed to administration via the alimentary tract or topically (e.g. application of creams or ointments).

Examples of suitable parenteral routes for the administration of cytotoxic chemotherapy and/or monoclonal antibody therapy include:

- intravascular;
- intramuscular;
- subcutaneous;
- intrathecal; or
- intracavitary.

Item 13950 provides for each attendance at which one or more antineoplastic agents are administered and can be claimed for each day where the service is provided in the course of treatment. The item covers the administration of one or more antineoplastic agents on the same occasion and it is not be expected that there would be multiple claims for item 13950 on one day.

Accessing long-term implanted delivery devices

From 1 November 2020, a new item - 13950 - will provide Medicare benefits for patients who undergo parenteral administration of antineoplastic agents (cytotoxic chemotherapy or monoclonal antibody therapy). Accessing a long-term implanted device, such as a peripherally inserted central catheter (PICC) line, for the purpose of administering the antineoplastic agent and at the time of administering the antineoplastic agent, is considered an integral component of this service, and therefore should not receive a separate MBS benefit. Item 14221 cannot be claimed in these circumstances.

Department of Health

Information Release #4
MBS Chemotherapeutic Procedures
Frequently Asked Questions

On 26 September 2020, the Department of Health presented a webinar on the changes that are to take effect on 1 November 2020 for chemotherapeutic procedures listed on the Medicare Benefits Schedule (MBS). Following the webinar, a broad range of stakeholders posed a variety of questions. The following explanatory statements are provided in response.

Parenteral Administration

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Examples of suitable parenteral routes for the administration of cytotoxic chemotherapy and/or monoclonal antibody therapy include:

- intravascular;
- intramuscular;
- subcutaneous;
- intrathecal; or
- intracavitary.

Item 13950 provides for each attendance at which one or more antineoplastic agents are administered and can be claimed for each day where the service is provided in the course of treatment. The item covers the administration of one or more antineoplastic agents on the same occasion and it is not be expected that there would be multiple claims for item 13950 on one day.

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From 1 November 2020, a new item - 13950 - will provide Medicare benefits for patients who undergo parenteral administration of antineoplastic agents (cytotoxic chemotherapy or monoclonal antibody therapy). Accessing a long-term implanted device, such as a peripherally inserted central catheter (PICC) line, for the purpose of administering the antineoplastic agent and at the time of administering the antineoplastic agent, is considered an integral component of this service, and therefore should not receive a separate MBS benefit. Item 14221 cannot be claimed in these circumstances.

a pre-loaded pump or ambulatory delivery device and there has not been an attendance on the patient.

Pump and other devices

From 1 November 2020, the loading of pumps, reservoirs or ambulatory drug delivery devices can be billed under item 13950 (so long as the conditions described in the item descriptor are met). Item 13950, in these circumstances, can be billed once per attendance where the device is loaded with the antineoplastic agent or agents.

Under the MBS, there is no item that specifically covers the disconnection of a pump or device as part of or following the administration of antineoplastic agents.

From 1 November 2020, item 14221 is being amended to clarify that it cannot be claimed in association with the administration of antineoplastic agents for which item 13950 is being claimed, as the MBS fee for item 13950 contains a component to cover accessing of a long-term implanted device for delivery of therapeutic agents.

If, at the attendance to disconnect a pump or device, the practitioner further administers antineoplastic agents under a service described by item 13950, then item 13950 may be claimed for that episode of treatment. The administration of antineoplastic agents during the attendance to disconnect the pump or device is considered a separate attendance from the claim associated with the initial loading of the pump or device. Item 14221 cannot be claimed in these circumstances, as item 14221 cannot be claimed in association with a claim for item 13950.

Alternatively, if at the attendance to disconnect a pump or device there is no service provided under item 13950, then item 14221 may be claimed for a service associated with the accessing of a long-term implanted device for delivery of therapeutic agents, but only under circumstances where the long-term implanted device is accessed for the purpose of delivery of therapeutic agents (e.g. line maintenance for future access).

Therapies

Item 13950 covers the administration of antineoplastic agents for cytotoxic chemotherapy or monoclonal antibody therapy for the treatment of cancer. Other types of therapies, such as anti-resorptive bone therapy and hormonal therapy are not covered under item 13950. The supervision of these therapies is reimbursed on a consultation basis. Additionally, monoclonal antibody therapy for inflammatory conditions and multiple sclerosis are not covered by item 13950.

Administration of oral chemotherapy is not currently funded under the MBS. However, a recommendation of the MBS Review Taskforce is for the introduction of an MBS item to cover the administration of oral chemotherapy. This recommendation will be the subject of a Medical Services Advisory Committee (MSAC) application. Further information regarding the MSAC process can be found at www.msac.gov.au.

Private Health Insurance

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- Clinical category - Chemotherapy, radiotherapy and immunotherapy for cancer.

Under subsection 72-1(2) of the *Private Health Insurance Act 2007*, the minimum benefits an insurer must pay for covered hospital treatment, includes at least 25% of the MBS item Schedule fee and the accommodation benefit as set out in the *Private Health Insurance (Benefit Requirements) Rules 2018*. Minimum benefits for private health insurance payments apply to the entirety of an MBS item, as written, including the full descriptor (i.e. there is no provision to pick and choose aspects of an item for any of the minimum benefits).

Use of Pharmaceuticals

From 1 November 2020, the parenteral administration of antineoplastic agents, including cytotoxic chemotherapy and monoclonal antibody therapy, can be claimed under item 13950.

Item 13950 cannot be used for claims related to the administration of pharmaceuticals used as part of hormonal therapy nor for the administration of colony-stimulating factors (such as filgrastim, pegfilgrastim, and plerixafor). Also, the administration of anti-resorptive bone therapy is not covered under item 13950.

The administration of pharmaceuticals given as part of a treatment regimen for a non-malignant disease cannot be claimed under item 13950. For example, item 13950 cannot be used for claims related to the treatment of multiple sclerosis (such as Natalizumab and Ocrelizumab) or for the treatment of arthritis (such as Rituximab or Tocilizumab).

Further information regarding the 1 November 2020 changes to the chemotherapeutic procedures listed on the MBS can be found at: www.mbsonline.gov.au.

Appendix 11 – Medicare Forum Newsletter Spring 2007

Education key to compliance
Medicare Australia launch's its 2007-08 National Compliance Program
Page 2

Broadband for Health extended
How to get your practice online
Page 4

Indefinite referrals
When to write one
Page 5

Forum

SPRING 2007

Which claiming method is right for you?

	Availability	Less paper	EFT payment speed for practices	EFT payment speed for patients	Equipment required	DVA and ACIR	Software integration	Automatic reconciliation	Automatic concession verification	Security
Medicare Easyclaim (stand alone)	now	✓	next working day	almost immediately	EFTPOS terminal	✗	✗	✗	✓	triple DES^
Medicare Easyclaim (integrated)	under development	✓	next working day	almost immediately	EFTPOS terminal, PC, internet, practice software	✗	with Tyro/HCN†	available first half 2008	✓	triple DES^
Medicare Online (HIC Online)	now	✓	2-3 working days	2-3 working days	PC, internet, practice software	✓	✓	✓	not yet available	PKI
Paper claiming	now	✗	14 days	2-3 working days	✗	✓	✗	✗	✗	✗

†Other EFTPOS and software providers likely to offer integrated solutions over time.
^ Data Encryption Standard.

For more information on claiming solutions, visit www.australia.gov.au/easyclaim or call 1800 700 199.*

When Medicare began in 1984, there was one way for practices to lodge a claim—on paper.

Twenty three years on, a lot has changed. More than 50 per cent of all GP bulk bill claims are now made using Medicare Online, reducing payment times to practices from 14 days to two to three days, and cutting paperwork.

With the gradual rollout of another electronic claiming method, the EFTPOS-based Medicare Easyclaim, practices are being encouraged to take a closer look at all the options. Initially, Medicare Easyclaim is available as a stand-alone system but a version that is integrated with, that is, talks to practice management software is being developed.

'We realise how busy practices are, and that a conversation about claiming options may not be at the top of their list,' said Deputy CEO of Medicare Australia, Rona Mellor.

'But these are critical transactions for both the patient and the practice, and with the launch of Medicare Easyclaim we're asking practices to make an active decision about which system suits them best,' Ms Mellor said. ***More on page 3***

Medicare is listening

Medicare Australia recently conducted research with doctors and practice managers to gauge how we could improve our service to you.

You told us that you would like to be kept more informed of new or changing MBS and PBS items and new Medicare initiatives.

Practice managers also told us they wanted to be included in the distribution of Medicare Australia publications, including *Forum*. We have now expanded our distribution to all practice managers.

Please enjoy this Spring edition of *Forum*.

Australian Government
Medicare Australia

Education key to compliance

Education and support for health care providers are the focus of Medicare Australia's 2007–2008 National Compliance Program.

The program will see established providers receive phone and online support from Medicare Australia's professional advisers, while almost 4000 new providers will be educated on how to use Medicare and PBS over the next 12 months.

There will also be checks on whether certain MBS items are appropriately used, focusing on home medicine reviews, allied health, dental health and urgent after-hours care.

In launching the program, the Minister for Human Services, Senator Chris Ellison said Medicare's compliance activities were highly effective in ensuring the accountability expected by providers and the Australian public.

'Last year, the National Compliance Program enabled Medicare Australia to achieve program savings of $250 million, through changes to the claiming and prescribing behaviour of providers,' the Minister said.

'When honest errors occur, there will be a fair opportunity given to explain or rectify the mistake, however, those who deliberately misuse the system will face consequences.

'Medicare Australia will continue to examine all instances of fraud or criminal behaviour and, when appropriate, rigorously investigate with a view to criminal prosecution.'

Last year there were 79 referrals to the Commonwealth Director of Public Prosecutions and 56 successful prosecutions. This year Medicare Australia will continue to crack down on fraudulent claiming or billing, incorrect prescribing or supply of drugs, illegal or excessive use of some medicines and the abuse of incentives and other rebates.

The program can be found at Medicare Australia's website, **www.medicareaustralia.gov.au** and includes details of how health care providers can obtain further information and assistance.

Catherine Argall CEO of Medicare Australia speaking at the launch of the 2007-08 National Compliance Program

Also at the launch were: Australian Association of Practice Managers (AAPM) President NSW Branch, Gary Smith; APPM National Vice President, Marina Fulcher; APPM National President, Jan Chaffey; Australian General Practice Network Deputy Chief Executive Officer, Leisel Wett; Medicare Australia Manager Compliance Policy and Standards, Victoria Callioni

Important changes to Medclaims

Medicare Australia has formalised its plans to gradually wind down one of its older claiming channels, Medclaims, by ceasing to admit any new practices from 1 October 2007.

The Medclaims system is expected to close completely in mid-2008, almost 16 years after it was introduced. Medicare Australia is contacting practices still using Medclaims to help them transition to newer electronic claiming channels that are more secure, more efficient and more flexible.

The number of sites registered for Medclaims has dropped by 30 per cent over the past two years, with more than 1100 practices switching from Medclaims to Medicare Online (previously known as HIC Online).

Medclaims will operate as normal for existing users until mid-2008. All other Medicare Australia claiming methods remain unchanged.

For more information, visit **www.medicareaustralia.gov.au** or call **1800 700 199****.