UPDATE IN A NUTSHELL

Medical Billing Early 2018

Loryn Einstein updates us on the latest changes in the 'billing' landscape.

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With health funds merging, insurers changing policy inclusions, new insurance regulations around the corner and new procedures for handling data breaches, there are plenty of things specialists, practitioners and medical administrators need to remain aware of in the industry right now. As the changes are likely to directly or indirectly affect the entire industry, let's dive in with the update.

HBF & HCF MERGER: What You Need to Know

West Australian based HBF and East Australian based HCF not-for-profit insurers have announced a merger to position themselves as a major competitor for Bupa and Medibank. Once the merge is complete, they will have 2.5 million policyholders and $4 billion in assets.

The merger needs to be approved by HBF's 22 elected and appointed councillors as well as by their counterparts at Sydney based HCF. The HBF councillors are expected to vote on the merger by the end of April. If approved, the merger is expected to be completed by the middle of 2018.

The initial press releases have stated that HBF and HCF will retain their existing fee schedules. Between HBF and HCF, there are several price schedules currently in use:

- Since HBF joined AHSA last year, HBF uses the AHSA fee schedule and gap rules for every state except WA
- HBF WA uses the historical HBF schedule and gap rules
- HCF has a no-gap fee schedule and a separate known-gap fee schedule

How fee schedules will be managed in the long term is not yet known. Almost every other fund merger in recent history have held their independent fee schedules for approximately six months before making major shifts. The question is whether these two companies will follow the status quo or do something different.

What this means for your billing
Whilst HBF and HCF have expressed an intent to keep their current fee schedules, keep an eye on announcements made during and after the proposed merger to ensure that you are billing HBF and HCF patients using the correct fee schedule.

Shifts in Minimum Cover

The Turnbull government is requiring a three-tier health cover rollout by all health funds in 2019. To remain compliant, health funds will be restricted to offering a maximum of three levels of cover, marketed as 'Bronze, Silver or Gold'. The minimum cover requirements in each category will be finalized sometime this year with the new product categorization taking effect from April 2019. In anticipation of these changes, we have seen some shifts to the more basic health insurance offerings.

Bupa have found themselves with somewhat of a mass exodus after announcing reductions in their basic cover. From 1 July 2018, Bupa's minimum benefits are being downgraded with hip and knee replacement, cataract and eye lens procedures, renal dialysis for chronic renal failure, pregnancy and birth related services, IVF and assisted reproductive services, and obesity related procedures and surgeries all to be classified as exclusions.

According to The Sydney Morning Herald in an article published on the 7th of March 2018, insurance comparison site iSelect reported 6,400 Bupa policy holders searched for alternative funds in the seven days following the Bupa announcement. iSelect Chief Executive Officer Scott Wilson also claimed that nearly a thousand of these people actually switched health funds away from Bupa over the seven day period.

Within days of Bupa's announcement, Western Australian fund HBF announced they would also be increasing exclusions on their basic policies and will not be covering weight loss surgery, dialysis, psychiatric care, insulin pumps and other items on those basic policies. Chief Executive Officer, John Van der Wielen said "We believe it is fairer to ask for those members who need to claim for certain services to move to that next level of cover" and that the company was trying to limit future premium increases as affordability is a major concern.

What this means for your billing
Changes in minimum covers will have an increasing impact on health fund claim rejections. Make sure that your informed financial consent process includes agreement by patients to pay claims that are not covered by their insurer. Also encourage patients to check whether procedures or surgeries are covered prior to booking.

"Contracted Facility" Reins Tightened by Bupa

In the firing line again, Bupa has faced concerns voiced by industry bodies regarding Bupa's scheduled changes as they announced that their gap cover scheme would only pay benefits if they were treated at a Bupa-contracted facility. Bupa will still pay 25% of schedule fee for patients treated in non-Bupa contracted facilities. This will result in doctors in these facilities being paid schedule fee instead of the higher Bupa Medical Gap Scheme amount.

In the first iteration of the 1st August 2018 change, Bupa announced that private patients who are treated in a public hospital would not be covered by their Bupa Medical Gap Scheme as no public hospitals are Bupa-contracted facilities. Changes like this have been in private health industry debate since it was revealed that billing health insurers generated $1.136 billion for public hospitals in 2015 to 2016.

After fierce opposition to this plan, Bupa modified their 1st August 2018 policy change to allow patients admitted to public hospitals on a planned basis to access their Bupa Medical Gap Scheme. As a large proportion of admissions to public hospitals are on an emergency basis, the debate on this particular issue may be far from over.

What this means for your billing
If Bupa commences this change on 1st August 2018 without further revisions, doctors working in day hospitals (many of which do not have a Bupa contract) or who see private patients in public hospitals will experience a large reduction in their income. The Bupa benefit for these patients (including the Medicare contribution) will be 100% of schedule fee instead of the Bupa Medical Gap Scheme amount.

1st March 2018 MBS Changes to urgent after-hours item numbers

A review of urgent after-hours item numbers by the MBS Review Taskforce noted that the use of urgent after-hours items had increase by 157

percent between the 2011 financial year and the 2017 financial year with no identifiable clinical explanation for the increase. Instead, the task force identified corporate advertising as the driver for the rapid increase in the usage of these item numbers.

On 1 March 2018, two urgent after-hours item numbers were removed from the Medicare Benefits Schedule (items 597 and 598) and four new urgent after-care item numbers were introduced:

585	Professional attendance by a general practitioner on one patient on one occasion—each attendance (other than an attendance in unsociable hours) in an after-hours period 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 **Fee:** $129.80 **Benefit:** 75% = $97.35 100% = $129.80 Replaces item 597
588	Professional attendance by a medical practitioner (other than a general practitioner) on one patient on one occasion—each attendance (other than an attendance in unsociable hours) in an after-hours period 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) the attendance is in an after-hours rural area; and (d) 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 **Fee:** $129.80 **Benefit:** 75% = $97.35 100% = $129.80 To be billed in Regional areas and can be billed by doctors without vocational registration or vocational recognition.
591	Professional attendance by a medical practitioner (other than a general practitioner) on one patient on one occasion—each attendance (other than an attendance in unsociable hours) in an after-hours period 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) the attendance is not in an after-hours rural area; and (d) 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 **Fee:** $100.00 **Benefit:** 75% = $75.00 100% = $100.00 To be billed by doctors in metropolitan areas who do not hold either vocational registration or vocational recognition and are not working as GP registrars.
594	Professional attendance by a medical practitioner—each additional patient at an attendance that qualifies for item 585, 588 or 591 in relation to the first patient (See para AN.0.9, AN.0.19 of explanatory notes to this Category) **Fee:** $41.95 **Benefit:** 75% = $31.50 100% = $41.95

Whilst previously urgent after-hours services could be organized two hours before the after-hours period commenced, the two-hour booking option has been removed from items 585, 588, 591, 594, 599 and 600.

Changes to Colonoscopy Services Description/Item Numbers

The changes to colonoscopy item numbers that were scheduled to commence on 1st March 2018 have been postponed. Existing MBS items (32090 and 32093) should be used until further notice.

Notifiable Data Breaches Scheme – is your data breach response plan in place?

From 22nd February 2018, under the Privacy Act 1988 all doctors and medical practices will be required to comply with the Notifiable Data Breach Scheme. This means that doctors and medical practices must notify individuals whose personal information is involved in any data breach that is likely to result in serious harm. The notification must include recommendations of the steps individuals should take in response to a breach.

Not all data breaches are notifiable as only those data breaches that are an "eligible data breach" require notification. An eligible data breach arises only when the following three criteria are satisfied:

1. There is unauthorized access to or unauthorized disclosure of personal information, or loss of personal information that an entity holds;
2. This is likely to result in serious harm to one or more individuals; and
3. The entity has not been able to prevent the likely risk of serious harm with remedial action.

In addition to the individuals whose personal information was involved in a data breach, the Commissioner must also be notified as soon as possible through a statement including:

- The identity and contact details of the organization
- A description of the data breach
- The kinds of information concerned and;
- Recommendations about the steps individuals should take in response to the data breach.

What this means for your billing
It is highly recommended that all medical practices have a data breach response plan to ensure that if something were to occur, it is addressed as quickly as possible and in compliance with the Act to ensure minimal impact.

Victorian Transport Accident Commission makes positive changes for service providers

The Victorian TAC rolled out administrative changes on 14th February 2018 that have streamlined the claims process. A number of treatments and services are now pre-approved and reports and clinical notes are no longer required unless the TAC specifically request them. These changes will bring the TAC in alignment with most other state motor accident bodies who require no more than standard payee, client and service details to be provided when invoicing.

In addition to these changes and in contrast to most other state bodies, patients are no longer required to pay a medical excess prior to treatment as the TAC will cover the cost with no out-of-pocket expenses.

Quality Improvement PIP Delayed Again

Department of Health has delayed the Practice Incentive Program Quality Improvement Incentive (PIP QI) for another year to allow practices adequate time to prepare. It will not begin until May 2019. The five incentives originally planned to cease on 1st May this year (asthma, quality prescribing, cervical screening, diabetes and GP aged care access) will now continue until the new QI incentive commences.

Keep an eye out for the next Medical Billing Experts article to make sure that you stay up to date with medical billing news and updates. Ⓟ

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