UPDATE IN A NUTSHELL

Medical Billing Summer 2018/19

With legislative changes, proposed changes to surgical remuneration arrangements, debt recovery changes and escalating Medicare claw-backs of funds from doctors over the last few months, the world of medical billing warrants increased attention. With the increased focus on compliance by the Department of Health, it is imperative to be up to date with your medical billing requirements. **Loryn Einstein** outlines what you need to know about the most recent changes…

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Medicare Benefits Schedule (MBS) Review – Proposed Changes To Remuneration Arrangements For Surgical Assistants

The MBS Review Taskforce's Principles and Rules Committee (PRC) have formulated draft recommendations for changes to the current arrangements by which surgical assistants are remunerated. At Medical Billing Experts we care about our clients and their patients, so we are taking the potential impact of these changes very seriously.

The recommendations by the MBS Review Taskforce are:

1. *That current arrangements under which surgical assistants bill patients separately from the primary surgeon, and have access to MBS items for their specific services, be discontinued; and*
2. *That new arrangements be introduced under which the primary surgeon pays the assistant directly for their services.*

The proposal involves the surgeon having full responsibility for the billing of both the primary procedure and any assistance service. The surgeon would co-claim a new assistance item which would have a variable fee, derived from the fee/s for the surgery item/s and set at a fixed percentage (say, 15 percent) of the total, which would dictate the amount of the patient benefit."

This proposal would eliminate MBS item numbers for surgical assistant fees including items 51300, 51303, 51306, 51309, 51312, 51315, and 51318 and would reduce compensation of surgical assistants from 20% of the primary surgeon's fee to 15%. **This is a 25% reduction in remuneration to surgical assistants.**

This proposal not only puts a **larger administrative burden on the primary surgeons**, it changes the relationship between the surgeon and the surgical assistant by **making surgeons financially responsible for the remuneration of their assistants**.

Patients are likely to incur an increase in out-of-pocket expenses due to both the increased administrative burden on primary surgeons and the need for surgeons to properly remunerate their assistants.

At present, the majority of surgical assistants charge little or no gap and the bulk of the assistant fees come directly from the health funds. If the primary surgeon and assistant surgeon must be billed together where the primary surgeon does not participate in the "no gap" scheme, BOTH the primary surgeon's fees AND the surgical assistant's fees will need to be collected directly from the patient (and rebated at 100% of schedule fee if the patient is insured) even if the surgical assistant is not receiving a gap amount. This results in far higher out-of-pocket costs for the patient as the entire transaction becomes a gap transaction, not just the primary surgeon's portion of the fees as would happen under the current billing regime.

To illustrate the impact of the proposed change, consider below the example of a hysterectomy billed at AMA rates.

COMPARISON OF CURRENT AND PROPOSED SCHEME

	PRIMARY SURGEON	ASSISTANT
CURRENT BILLING RULES		
Paid directly by patient	$3,920.00	**nil**
Paid to Dr. by Medibank	0	$391.89
Rebate to patient at Schedule Fee	$1,317.80	n/a
Patient out of pocket	$2,602.20	**nil**
PROPOSED BILLING RULES		
Paid directly by patient	$3,920.00	$391.89
Paid to Dr. by Medibank	0	0
Rebate to patient at Schedule Fee	$1,317.80	$197.67
Patient out of pocket	$2,602.20	**$194.22**

Under the current billing rules, if the surgical assistant can be fully paid by Medibank at the no-gap rate then there is no additional cost to the patient for the surgical assistant.

Under the proposed scheme, the Primary Surgeon is responsible for billing for both their own fees and the fees for their surgical assistant. The Primary Surgeon has to negotiate an agreement with their surgical assistant as to how the surgical assistant will be compensated.

What is likely to happen is that the Primary Surgeon will choose to keep their billing as streamlined as possible by billing both their own fee and the fee for their Surgical Assistant at AMA rate. Therefore, they would simply calculate the surgical assistant's fee as 15% of the Primary Surgeon fee. This would result in a larger out of pocket costs for the patient of $194.22 as shown in the table above.

It is noteworthy that there is no guarantee of any amount of compensation for the surgical assistant. This is left as a matter to be negotiated between the Primary Surgeon and the surgical assistant.

HOW DOES THIS IMPACT YOUR BILLING?

As this is currently a proposal, there is no current impact on your billing, HOWEVER, if this proposal becomes a reality

- Surgical assistants will have no ability to invoice patients or health funds directly for the services that they render as the assist fees in the Medicare Benefits Schedule will cease to exist
- Surgeons will be responsible for billing patients and health funds for the work performed by their surgical assistants
- Surgeons will need to put payment arrangements in place to compensate the surgical assistants that work with them in theatre

Improved Medicare Compliance Changes To Legislation For Health Professionals

As at 1 July 2018, the Department of Health introduced amendments to sections of the *Health Insurance Act 1973*, the *Dental Benefits Act 2008* and the *National Health Act*. The noteworthy changes are set out below.

1. Changes to the length of time records must be kept

The legislative change increases the length of time that referrals must be retained from 18 months to two years.

Current Law	New Law
Specialists and consultant physicians are required to keep copies of referrals for 18 months	Specialists and consultant physicians are required to keep copies of referrals for two years
Pathologists and radiologists are required to keep copies of referrals for 18 months	Pathologists and radiologists are required to keep copies of referrals for two years
There is no requirement for allied health practitioners to keep copies of referrals	Allied health practitioners are required to keep copies of referrals for two years
The payment of a rebate for a professional service may be conditional on the creation of a document, but there is no requirement for a practitioner to keep a copy of the document	If a document is specifically mentioned in an item (such as a GP Health Assessment), and is created by the practitioner, then the practitioner must keep a copy for two years

2. Financial penalties for failure to produce documents

Not only are all health professionals required to retain referral documents, they are also required to retain any documents that substantiate the MBS items that they claim. This includes clinical notes that show that the clinical care delivered fully complies with all criteria spelled out in the MBS item number and all other relevant records that support billing of the particular item number(s).

Financial penalties can occur if a debt to Medicare exceeds $2,500 and the health professional fails to substantiate the items that have been claimed. The financial penalties in these circumstances will be a base rate of 20% of the total debt, and will increase if the health professional fails to respond to a notice to produce documents in the specified time period.

3. Debt Recovery Mechanisms

If a health professional owes money to the Department of Health as a result of compliance activity, they must pay the total amount within 28 days of the invoice date. If they fail to pay the Department of Health by this deadline and a repayment plan is not agreed to within 90 days, the department can now retain 20% of bulk billed benefits claimed and/or garnish the doctor's bank account or other assets.

4. Shared Debt Recovery Scheme

The Shared Debt Recovery Scheme will commence on 1 July 2019 to allow time for consultation with peak bodies regarding how the Scheme will operate.

Under this new Scheme, where a practice or corporate entity or hospital plays a role in the billing of MBS items on behalf of individual practitioners, debts arising from improper billing can be shared between the medical practitioner and the medical practice that performed the billing on their behalf. To ensure the integrity of the MBS billing performed, medical practitioners will continue to be held responsible for ensuring that claims made under their provider number, are compliant with the MBS requirements. Additionally, medical practices will have a responsibility to ensure that the medical practitioners working in the practice are claiming MBS items correctly.

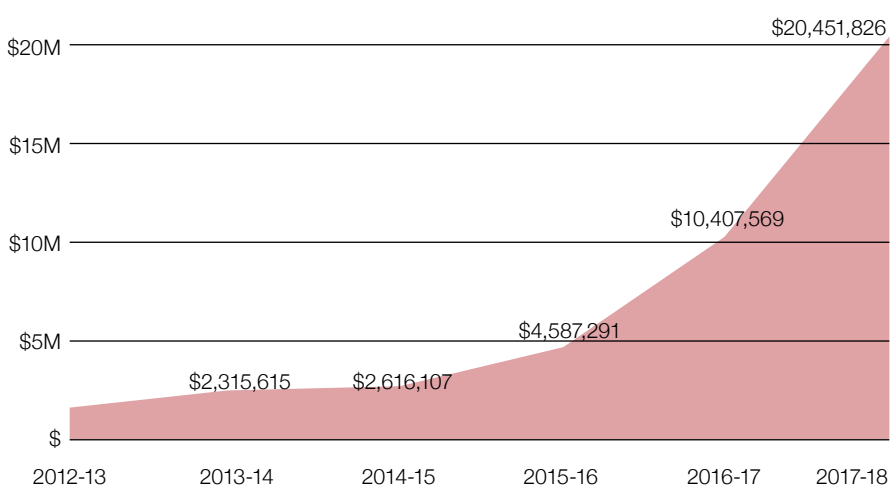
In preparation for the implementation of the Scheme in 2019, as at 1 July 2018 health practitioners applying for a new provider number are required to produce information regarding their employer(s). This includes medical practices, corporate providers, hospitals and any other entities the health professional is engaged with to provide health services.

This chart below shows the increase in funds recovered by the PSR from 2012 to the end of the 2018 financial year due to improper billing performed by medical practitioners. The recoveries have increased nearly 20 times from 2013 to 2018.

During the 2012/13 financial year, before compliance became a focus for the Department of Health, the PSR recovered $1.5 million dollars relating to inappropriate billing by doctors. As the focus shifted to billing compliance, billing audits and clawbacks of funds, this recovery quickly escalated to $10.5 million in the 2016/17 financial year and then doubled in a period of one year to over $20 million in the 2017/18 financial year.

The amounts in the above chart only capture the funds recovered by the PSR. The $20 million in funds recovered for inappropriate billing do not include the millions of dollars recovered by Medicare itself

PSR RECOVERIES FROM IMPROPER MEDICARE BILLING



for cases that were resolved and payment arrangements that were made with doctors without a referral to the PSR.

For example, thousands of specialists and surgeons received letters from the Department of Health in April and May this year alleging that the doctors had inappropriately billed initial consultations in instances where they should have billed subsequent consultations. Most of the doctors receiving these letters voluntarily paid back the funds for these claims to avoid fines, interest and a possible referral to the PSR. This clawback of funds does not appear on the chart although it was in the millions of dollars as these funds were recovered without the involvement of the PSR.

It is noteworthy that in the first three months of the 2018/19 financial year, the PSR has already recovered over $5 million in funds from medical practitioners. This highlights the fact that billing compliance, audit and clawback of funds is an increasing focus of the Department of Health.

Now more than ever, I cannot stress enough the importance of medical billing compliance. With escalating audit and clawback activities by the Department of Health, it is critical to stay compliant.

Stay on top of medical billing

Keep an eye out for the next Medical Billing Experts article to make sure that you stay up to date with new insurance regulations, medical billing news and updates, and if you have questions about your medical billing, **contact us** for an introduction to **Loryn Einstein**.