UPDATE IN A NUTSHELL

Medical Billing Winter 2018

Winter 2018 has brought a number of changes that doctors, and medical administrators need be aware of. As these changes are likely to directly or indirectly affect the entire industry, **Loryn Einstein** dives in with the update.

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"CONTRACTED FACILITY" REINS TIGHTENED BY BUPA

Perhaps the largest recent shift on the health fund landscape has been the publication of the revised Bupa benefits commencing 1 August 2018.

In February, Bupa faced concerns voiced by industry bodies after announcing that their gap cover scheme would only pay benefits if patients were treated at a Bupa-contracted facility. In the first iteration of the change which is scheduled to take effect on 1 August 2018, Bupa also 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.

After fierce opposition to this plan, Bupa reviewed their proposed 1 August 2018 change to provider benefits which prevented patients admitted to public hospitals on an emergency or unplanned basis from accessing 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 continued until July.

After an information release to providers in mid-July, Bupa rolled out a further modified policy change which came into effect on 1 August 2018. The 1 August 2018 changes included:

- Bupa Scheme benefits were increased for most operation and anaesthetic items from 1 August 2018.
- The higher Scheme benefits apply to patients being treated in a Bupa Members First, Network or Fee agreement Hospital or Day Hospital.
- Bupa will only pay benefits up to 100% of the MBS Schedule fee for patients treated in facilities that do not have an agreement with Bupa (including registered Second Tier facilities)
- Bupa implemented a new **Public Hospital Medical Gap Scheme** starting 1 August 2018 which provides the following benefits to gap scheme providers:
  - When a patient is admitted on an emergency or unplanned basis, the Public Hospital Medical Gap Scheme applies on a **No Gap** basis only
  - When a patient is admitted for a planned or pre-booked admission (defined as an admission where the Hospital performs an electronic eligibility check to Bupa at least 2 days prior to the admission), the Public Hospital Medical Gap Scheme allows for either a **No Gap** or **Known Gap** option for providers
- To be eligible for **Known Gap** cover under the Public Hospital Medical Gap Scheme, doctors must be registered for the Public Hospital Known Gap Scheme.
- After 1 August 2018, Bupa requires that all Eclipse and Manual claims to include both the Facility ID and name of the facility of where the treatment took place. Failure to provide this information will result in rejection of your claim.
- From 1 August 2018, Bupa Scheme providers will no longer be able to opt out of being promoted to Bupa customers.

In Bupa's 19 July 2018 emails and letters to providers, Bupa stated that it has automatically enrolled doctors in the Public Hospital Scheme based on their current enrolment in the existing Bupa Scheme (i.e. based on each doctors' registration as either a No Gap or Known Gap provider under the current Bupa Scheme).

As of the third week of July 2018 Bupa has not published the new fee schedules, batch headers or an updated Medical Gap Scheme Practitioner's Guide on their website. The list of Bupa Member's First, Network and Fixed Fee facilities is available **online**.

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 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.

Recommended actions to take to ensure Bupa billing is in line with the new Schemes:

- Ensure that Bupa pricing in your software is updated on 1 August 2018
- Check the Bupa Hospital Listing to see if the facilities where you practice are to be billed at Scheme rates or at 100% of the MBS Schedule fee
- Check your current enrolment with Bupa and if needed, adjust your registration as a No Gap or a Know Gap provider
- Ensure that all Bupa billing after 1 August 2018 includes the Facility Id and the name of the facility where the service took place
- As all Scheme providers will be promoted on the Bupa website, check your details **HERE** and lodge a Change of Details form if any of the information needs updating

HBF CHANGES: WHAT YOU NEED TO KNOW

West Australian based HBF and East Australian based HCF not-for-profit insurers have announced that their planned merger will not be proceeding. In a joint statement in early June 2018, HBF and HCF said that *"it would not be in the best interests of our members to proceed"*.

As HBF was seeking to position itself as a major competitor for Bupa and Medibank through its merger with HCF, it is likely that HBF will be seeking an alternative to the failed HCF merger.

In an unrelated move, HBF updated their Medical Gap Agreement on 1 July 2018. The updated agreement is available on their website at www.hbf.com.au/about-hbf/for-providers. The key change to the Medical Gap Agreement is regarding the HBF privacy collection policy regarding how HBF may use and disclose doctors' personal information when they participate in the medical gap arrangement. This means that doctors' correspondence and/or billing address may be disclosed.

Also noteworthy are a number of cuts to patient cover for some HBF policies that took effect on 1 July 2018. The HBF policies impacted where:

- Young Saver Hospital cover no longer covers obesity surgery, dialysis, insulin pumps cochlear implants or sterility reversal
- Mid Hospital cover no longer covers obesity surgery or dialysis and psychiatric care is only covered in public hospitals
- Young Singles Saver Twin Pack cover no longer covers obesity surgery, dialysis, insulin pumps, sterility reversal or cochlear implants
- Smart Saver Twin Pack cover no longer covers obesity surgery, dialysis, insulin pumps or cochlear implants
- Mid Family Cover no longer covers dialysis and psychiatric care is only covered in public hospitals.

What this means for your billing

Whilst HBF and HCF have cancelled their merger, keep an eye on HBF as they seek to identify an alternative fund to merge with as this may result in future changes to benefits schedules or fund rules.

With increased policy restrictions which commenced on 1 July, review your HBF rejections carefully and encourage your patients to check if upcoming procedures are covered by their policy.

PRIVATE HEALTH INSURANCE REFORMS – GOLD/SILVER/BRONZE/ BASIC PRODUCT TIERS

The Turnbull government passed legislation in June 2018 requiring a four-tier health cover rollout by all health funds in 2019. To remain compliant, health funds will be restricted to offering a maximum of four levels of cover, marketed as 'Gold, Silver, Bronze or Basic'. The minimum cover requirements in each category were finalised recently with the new product categorization taking effect from April 2019.

What this means for your billing

The new Hospital Treatment Product Tiers will simplify your administrative processes by providing an easy way to identify what treatments patient's health fund cover includes.

Hospital Treatment Product Tiers – Gold, Silver, Bronze and Basic

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	RCP	✓	✓	✓
Eye	RCP	✓	✓	✓
Ear, nose and throat	RCP	✓	✓	✓
Tonsils, adenoids and grommets	RCP	✓	✓	✓
Bone, joint and muscle	RCP	✓	✓	✓
Joint reconstructions	RCP	✓	✓	✓
Kidney and bladder	RCP	✓	✓	✓
Male reproductive system	RCP	✓	✓	✓
Digestive system	RCP	✓	✓	✓
Hernia and appendix	RCP	✓	✓	✓
Gastrointestinal endoscopy	RCP	✓	✓	✓
Gynaecology	RCP	✓	✓	✓
Miscarriage and termination of pregnancy	RCP	✓	✓	✓
Chemotherapy, radiotherapy and immunotherapy for cancer	RCP	✓	✓	✓
Skin	RCP	✓	✓	✓
Breast surgery (medically necessary)	RCP	✓	✓	✓
Diabetes	RCP	✓	✓	✓
Heart, lung and vascular system	RCP		✓	✓
Blood	RCP		✓	✓
Back, neck and spine	RCP		✓	✓
Plastic and reconstructive surgery (medically necessary)	RCP		✓	✓
Dental surgery	RCP		✓	✓
Podiatric surgery (provided by an accredited podiatric surgeon)	RCP		✓	✓
Implantation of hearing devices	RCP		✓	✓
Cataracts	RCP			✓
Joint replacements and spinal fusion	RCP			✓
Dialysis for chronic kidney disease	RCP			✓
Pregnancy, birth and neonates	RCP			✓
Assisted reproductive services	RCP			✓
Weight loss surgery	RCP			✓
Insulin pumps	RCP			✓
Chronic pain	RCP			✓
Sleep studies	RCP			✓

✓

Indicates the treatment/ service is a minimum requirement of the product category. The service must be covered on an unrestricted basis.

✓R

Indicates the treatment/ service is a minimum requirement of the product category. The service may be offered on a restricted cover basis in Basic, Bronze and Silver product tiers only.

RCP

Restricted cover permitted: indicates the treatment/service is not a minimum requirement of the product category. Insurers may choose to offer these as additional services on a restricted or unrestricted basis.

Indicates the treatment/ service is not a minimum requirement of the product category. Insurers may choose to offer these as additional services; however, it must be on an unrestricted basis.

PRIVATE HEALTH INSURANCE REFORMS – OUT-OF-POCKET COSTS

In early 2018, the Minister for Health announced the establishment of a Ministerial Advisory Committee on Out-of-Pocket Costs. This Advisory Committee has been tasked with:

- Developing the best way to make information regarding out-of-pocket costs more transparent to consumers
- Identifying and resolving legislative and regulatory barriers to consumer transparency of out-of-pocket medical costs
- Implementation of best practice models

It is expected that the Committee will meet four times in 2017-18 and twice in 2018-19.

What this means for your billing

To date there are no noteworthy outcomes from the Committee. Information regarding the outcomes of the work performed by this Committee will be included in future articles when relevant information becomes available.

MEDICARE REBATES TO BE REDUCED FOR NON-VR DOCTORS

As part of the Stronger Rural Health Strategy announced in the 2018-19 Budget, a new Medicare fee structure will commence on 1 July 2018 for standard and non-standard attendances performed by medical practitioners who are not vocationally-recognised and who are new entrants to general practice after 1 July 2018. The resulting changes include:

- New medical practitioners providing services in a metropolitan area who are not vocationally-recognised will be paid at a rate that is 80% of the benefit for most equivalent GP items
- New medical practitioners providing services in a regional or remote area who are not vocationally-recognised will be paid at a rate that is 80% of the benefit for the equivalent GP items for all types of services
- Items for general consultations and attendances associated with PIP incentive payments performed by new non-VR medical practitioners in metropolitan areas will be paid the equivalent other medical practitioner (OMP) items for these services (Group A2 and A19 of the Medicare Benefits Schedule)
- Urgent after-hours items in Medicare Benefits Schedule Group A11 are not impacted by this change

The changes for currently practicing non-VR doctors will be phased in over the next five years. Medical practitioners currently participating in an OMP Program will be able to claim the higher specialist GP rates until 1 July 2023. Access to the OMP Programs will be closed to new applicants as of late 2018. The OMP programs impacted include:

- The Rural Other Medical Practitioners Program
- The Outer-Metropolitan Other Medical Practitioners Program
- The MedicarePlus for Other Medical Practitioners Program
- The After-Hours Other Medical Practitioners Program

A range of existing GP items were amended as at 1 July 2018 to restrict their use by new entrant non-VR practitioners. The items that were amended are: 160, 161, 163, 164, 170, 171, 172, 701, 703, 705, 707, 715, 721, 723, 729, 731, 732, 735, 739, 743, 747, 750, 758, 871, 872, 900, 903, 2125, 2138, 2179, 2220, 2700, 2701, 2712, 2713, 2715, 2717, 2721, 2723, 2725, 2727, and 4001.

As at 1 July 2018, a number of item numbers were added to the Medicare Benefits Schedule to reflect the changes in benefits for non-VR practitioners. The new items are all in Group A7 and are:
Subgroup 2: 179, 181, 183, 185, 187, 188, 189, 191, 202, 203, 206, 212
Subgroup 3: 214, 215, 218, 219, 220
Subgroup 4: 221, 222, 223
Subgroup 5: 224, 225, 226, 227, 228
Subgroup 6: 229, 230, 231, 232, 233, 235, 236, 237, 238, 239, 240, 243, 244
Subgroup 7: 245, 249
Subgroup 8: 251, 252, 253, 254, 255, 256, 257, 259, 260, 261, 262, 263, 264, 265, 266, 268, 269, 270, 271
Subgroup 9: 272, 276, 277, 279, 281, 282, 283, 285, 286, 287
Subgroup 10: 733, 737, 741, 745, 761, 763, 766, 769, 772, 776, 788, 789
Subgroup 11: 792
Subgroup 12: 812, 827, 829, 867, 868, 869, 873, 876, 881, 885, 891, 892

What this means for your billing

With these changes to benefits, GP's should ensure that they are listed as a "specialist" in general practice on the AHPRA register as this will now have an impact on their billing.

AND LAST BUT NOT LEAST... AN IMPORTANT UPDATE ON MEDICARE COMPLIANCE AUDITS

AUDIT ALERT

Many providers have received urgent action requests from Medicare over the last few months to justify initial items billed over the last few years. These audits have been caused by numerous billing errors including:

- **Billing more than one initial consultation under the same referral**
- **Billing more than one initial consultation under and indefinite referral**
- **Billing more than one initial consultation for a single course of treatment**
- **Billing frequency of initial consultation for individual patients**

If you are not clear on the rules surrounding initial versus subsequent consultations, it is critical that you update your knowledge immediately. The Government has budgeted a further $9.5 million to continue to improve Medicare compliance and debt recovery. **Just because items that you billed in the past were paid to you does not mean that they were billed properly AND does not mean that the billing performed will not be audited and "clawed back" in future.**

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.

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.

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