BILLING COMPLIANCE IN A NUTSHELL

Loryn Einstein outlines pre and post-operative consultation billing compliance.

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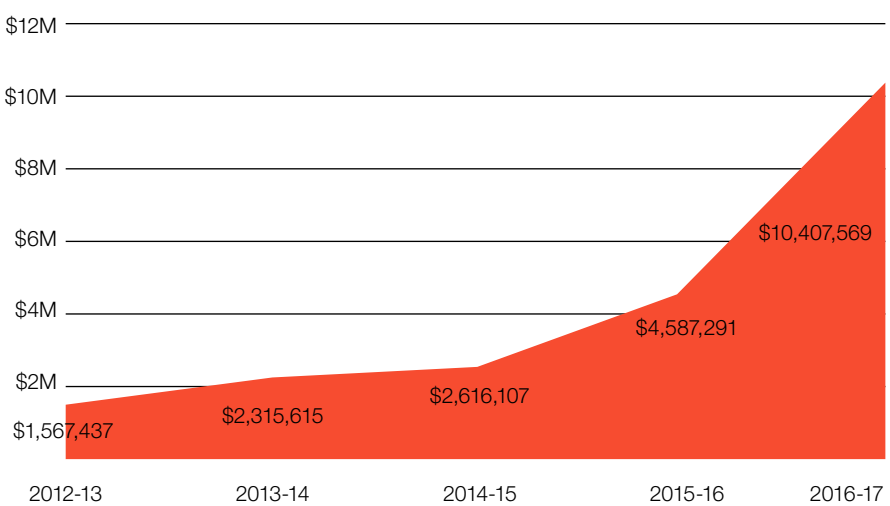
Inappropriate Medicare billing resulted in $29 million of debts against doctors and healthcare providers by the federal government last year. The 2017 Professional Services Review Annual Report showed that, for the first time since the inception of the PSR scheme, the PSR recovered more in funds than its Treasury appropriation. To avoid the serious ramifications to their practices of the PSR activities, doctors and healthcare providers need to be diligent and well informed with their billing compliance.

Treasury Appropriation and PSR Recoveries

Year	Treasury Appropriation	Total Recoveries $
2016–17	5,131,000	10,407,569
2015–16	5,528,000	4,587,291
2014–15	5,688,000	2,616,107
2013–14	5,740,000	2,315,615
2012–13	5,739,000	1,567,437

The increase in funds recovered from doctors and healthcare providers has increased significantly over the past five years, as shown in the chart below.

PSR Recoveries from Improper Medicare Billing



In addition to the ongoing referrals of General Practitioners to the PSR, there has also been a marked increase in specialists referred to the Professional Services Review by Medicare. Whilst only 13.7% of practitioners referred to the PSR in 2015-16 were specialists, this increased to 29.6% in 2016-17 with further increases expected in the future.

The improper billing by specialists that was recently referred to the PSR included specialists in radiology, neurology, ophthalmology, nuclear medicine, dermatology, otorhinolaryngology, psychiatry, and respiratory and sleep medicine. This included three large recoveries from specialists in September 2017:

- $1,100,000 recovered from a nuclear medicine physician for improper billing of items 12306, 12312, 12315 and 12323. **The practitioner was also disqualified from billing MBS item numbers 12306, 12312, 12315 and 12323 for 18 months**;
- $750,000 recovered from an ophthalmologist for improper billing of items 42702, 42740 and 42788; and
- $2,000,000 was recovered from a consultant sleep and respiratory physician for improper billing of 11503 and 12203. **The practitioner was also disqualified from billing items 11503 and 12203 for 3 years**.

In addition to financial recovery and disqualifying practitioners from billing item numbers, the PSR also referred three times the number of practitioners in 2016-17 to AHPRA than the previous year.

The PSR stated in their annual report that: *"In 2017–18, PSR will further strengthen the deterrent effect of the PSR Scheme by continuing to refer cases of practitioners who may pose a threat to the life or health of a patient to regulatory bodies for further action. The PSR will also refer to the major non-compliance unit any practitioner where a serious compliance concern is generated."*

To help doctors protect themselves from the impact of these increased compliance audits by Medicare and the PSR, **compliance and appropriate billing** will be the focus of my "In a Nutshell" articles as well as the lectures I will be delivering for The Private Practice in 2018. This includes lectures at The Private Practice ***Risk and Compliance 1 day workshops*** and lectures at the ***3 day Comprehensive*** courses at various locations across Australia.

The remainder of this article will focus on important changes to billing of pre and post-surgical consultations that took effect on 1 November 2017 as a result of the ongoing Medicare Benefits Schedule Review. Staying up to date with these changes as well as the numerous other changes to the MBS that have occurred over the last six months is critical for all doctors and medical practices.

CONSULTATIONS BILLED ON THE SAME DAY AS PROCEDURES

The Medicare rules for charging consultations on the same day as procedures or surgeries has changed effective from 1 November 2017.

The change was driven by a concern of the MBS Review Taskforce that attendance or consultation items were being billed the same day as procedures where no substantive attendance on the patient occurred. For many procedures, the taskforce was of the opinion that the consultation was "considered to be integral to the procedure and not a separate service".

The inconsistency in billing practices across different providers was also of concern to the MBS Review Taskforce. The data showed that some providers rarely or never billed consultations with procedures while other practitioners often or always billed consultations with procedures. The Taskforce appears to have been particularly concerned with the variance in billing of consultations with colonoscopies.

If ANY of the item numbers that you are billing in Group T8 (item numbers from 30001-50952) have an MBS schedule fee of $300 or more, you can no longer bill the following items on the same date of service
105 – Specialist subsequent attendance
116 – Consultant Physician subsequent attendance
119 – Consultant Physician minor subsequent attendance
386 – Occupational Physician subsequent attendance
2806 - Pain Medicine subsequent attendance
2814 - Pain Medicine subsequent minor attendance
3010 – Palliative Medicine subsequent attendance
3014 – Palliative Medicine subsequent minor attendance
6019 – Addiction Medicine subsequent attendance
6052 – Sexual Health Medicine subsequent attendance
16404 – Obstetrics subsequent attendance

Medicare has released three new consultation item numbers that can be billed from 1 November 2017. These new items can be billed on the same date of service that you are billing an item in Group T8 (item numbers from 30001-50952) ONLY IF the PROCEDURE IS URGENT AND NOT ABLE TO BE PREDICTED PRIOR TO THE COMMENCEMENT OF THE ATTENDANCE.

As such, Medicare has stated that: "It is expected that these items would be rarely required". This would indicate that frequent billing of the below item numbers may raise an audit flag so please bill with caution.

Item 111 - for use by specialists
Item 117 – for use by Consultant Physicians
Item 120 – for use by Consultant Physicians (minor attendance)

Please note that to bill any of the below item numbers you must meet all the criteria listed and per the above, bill with extreme caution.

111	Professional attendance at consulting rooms or in hospital **by a specialist** in the practice of his or her specialty following referral of the patient to him or her by a referring practitioner—an attendance after the first attendance in a single course of treatment, if: (a) during the attendance, the specialist determines the need to perform an operation on the patient that had not otherwise been scheduled; and (b) the specialist subsequently performs an operation on the patient, on the same day; and (c) the operation is a service to which an item in Group T8 applies; and (d) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $300 or more For any particular patient, once only on the same day. Fee: $43.00 Benefit: 75% = $32.25 85% = $36.55
117	Professional attendance at consulting rooms or in hospital, **by consultant physician** in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner – an attendance after the first attendance in a single course of treatment, if: (a) the attendance is **not a minor attendance**; and (b) during the attendance, the consultant physician determines the need to perform an operation on the patient that had not otherwise been scheduled; and (c) the consultant physician subsequently performs an operation on the patient, on the same day; and (d) the operation is a service to which an item in Group T8 applies; and (e) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $300 or more For any particular patient, once only on the same day. Fee: $75.50 Benefit: 75% = $56.65 85% = $64.20
120	Professional attendance at consulting rooms or in hospital **by a consultant physician** in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner – an attendance after the first attendance in a single course of treatment, if: (a) the attendance is **a minor attendance**; and (b) during the attendance, the consultant physician determines the need to perform an operation on the patient that had not otherwise been scheduled; and (c) the consultant physician subsequently performs an operation on the patient, on the same day; and (d) the operation is a service to which an item in Group T8 applies; and (e) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $300 or more For any particular patient, once only on the same day. Fee: $43.00 Benefit: 75% = $32.25 85% = $36.55

The information supplied by Medicare so far indicates that this rule only applies to subsequent attendances and that initial consultations can still be billed if appropriate.

AFTERCARE PROVIDED BY GENERAL PRACTITIONERS

Before the 1 November 2017 changes approved by the Medicare Benefits Schedule Review Taskforce, the Medicare benefit for the aftercare for most operations was included in benefits paid to the provider performing the procedure. In cases where it was more practical for the patient's aftercare to be managed by their GP, there was no Medicare benefit available to the GP as the specialist who performed the procedure had already been paid for the aftercare. Not only was this disadvantaging GP's financially, it also put an administrative burden on their practices to follow up rejections when patients were seen by the GP after procedures, whether or not the GP visit related to aftercare for the procedure itself.

As of 1 November 2017, General Practitioners can bill consultations for providing aftercare for patients who have had procedures. They can also treat patients for unrelated conditions without running the risk of unnecessary rejections by Medicare as "possible aftercare".

If aftercare is included in the Medicare benefit paid for the operation or procedure, the provider who performed the operation or procedure is still required to provide routine aftercare without billing the patient. The benefit for this aftercare is still included in the benefit paid for the surgical or procedural item number(s).

If the General Practitioner is the provider that performed the surgery or procedure, they also cannot bill for a consultation if aftercare was included in the original benefit paid for the surgery or procedure.

Both pre and post the 1 November 2017 changes, providers wishing to bill for consultations that do not meet the aftercare rules are only prohibited from billing Medicare and from billing the Health Funds (which contains a Medicare benefit component) for the consultation. Providers can bill these consultations privately which is a pure out of pocket expense for the patient which will not be subject to any Medicare or Health Fund rebate.

NOTE: When raising these invoices, providers must not list an MBS item number on the invoice as the consultation does not qualify for a Medicare rebate.

Now more than ever compliance needs to be of concern to every practitioner and medical practice. The Department of Health has quadrupled their audit staff this financial year, highlighting how crucial compliance with Medicare and DOH legislation and billing requirements is. Keep an eye out for my "In a Nutshell" publications, and take the opportunity to attend an upcoming ***Risk and Compliance Management Workshop*** for further billing compliance updates. Ⓟ

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