Royal Australasian College of Surgeons

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250–290 Spring Street
East Melbourne VIC 3002 Australia
Telephone +61 3 9249 1200
www.surgeons.org
ABN 29 004 167 766

Ms Apolline Kohen
Acting Secretary
Senate Standing Committee on Community Affairs, Legislative Committee
Australian Commonwealth Government
PO Box 6100,
Parliament House
CANBERRA ACT 2600

Email: community.affairs.sen@aph.gov.au

Dear Ms Kohen

RE: Inquiry into the Health Insurance Amendment (Compliance Administration) Bill 2020

The Royal Australasian College of Surgeons (RACS) welcomes the invite to provide a submission on behalf of our Fellows to this inquiry. RACS is the leading institution for the training of surgical practice for more than 7,000 surgeons and 1,300 surgical trainees and International Medical Graduates.

RACS acknowledges and accepts the Government's previous announcement during their 2017-2018 Budget as to the introduction of legislative amendments that will help improve Medicare compliance.[i] During the announcement of that budget in May 2017[ii] it was shown that only 20% of Medicare debts raised were ever recovered. By December 2018 the Government claimed that debt recovery rose to 40% and that stronger powers were still needed "so that the Government could recover more of the funds overpaid due to incorrect claiming, inappropriate practice and fraud."[iii] We understand the context and the need for such changes.

However, input from our Fellows were that individual medical practitioners have been unfairly held 100% responsible for Medicare debts incurred in the past and have been subject to punitive actions as a result. Errors by administrative staff in both private and public practice will inevitably occur often without the practitioner's knowledge, and this must not be perceived as deliberately misleading, leading to unfair litigation and reputational damage.

Contractual arrangements with practitioners' medical practices and hospitals with respect to the billing arrangements have been subject to Medicare audits with differing results. Services claimed are subject to relevant employment, and contractual or financial agreements which have led to a surgeon's service provider number becoming vulnerable to incorrectly perceived misuses.

The Bill and its amendments resulting in section 129AC(1) and section 129ACA(1) (the amendments) of the *Health Insurance Act 1973* (the Act), appear to revolve around omitting 'statement' and substituting the word with 'information' in relation to 'false or misleading.' The end result being "that a Medicare benefit or payment can be recovered as a debt due to the Commonwealth in circumstances where an incorrect amount is paid (purportedly by way of Medicare benefit or payment) as a result of a person giving false or misleading information."[iv]

But there is an absence of any real authoritative guidelines here. This creates undue Medicare audit anxieties, especially when the Chief Executive of Medicare does not seem to be required to identify the details of the allegations to the alleged practitioner.

RACS is concerned about two basic elements absent in the Bill and the legislative instrument of enforcement. These being:

1. Procedural Fairness and the Right to an Appeal
2. Errors Misconstrued as False or Deliberately Misleading

Procedural Fairness and the Right to an Appeal

The Government's Explanatory Memorandum[v] explicitly states that the Chief Executive of Medicare does not have to identify the false and misleading statement made by the practitioner in question. This immediately raises the question of procedural fairness and the right to an appeal. Natural justice would ensure that the misleading claim should be completely transparent, and the evidence made available behind the request from government for a reimbursement.

RACS understands the Minister for Population, Cities and Urban Infrastructure the Hon. Alan Edward Tudge's explanation for this Bill in the Second Reading in that there may be "a possible misunderstanding about the operation of the act" due to technological advances in Medicare claiming and the requirement to creative more legislative "flexibility".[vi] RACS' concern is that the debate between what is deemed as 'information' as opposed to the previous usage of the term 'statement' reduces the issue to mere semantics at the cost of procedural fairness.

Minister Tudge stated the following in the Second Reading for the Bill:

> "The vast majority of practitioners do the right thing—only a small proportion of Medicare services are claimed incorrectly…"

Minister for Health Greg Hunt has made similar comments:

> "The overwhelming majority of healthcare providers claim MBS, PBS and Child Dental Benefits appropriately… Unfortunately, we know that a very small proportion do not."[vii]

RACS concurs with both of these statements, but this only raises the question as to why there is a sudden shift whereby the Chief Executive of Medicare does not have to identify the false and misleading 'information' made by the practitioner. There is confusion as to why Government thinks that this should be the new normative approach.

Another pitfall to avoid is the re-creation of a litigious regime, which will prove costly to the government. Historically it has been shown that doctors "fight vigorously" to defend their reputation against fraud charges with the assistance of their medical defence organisations. It has been reported that the Professional Services Review scheme (PSR) established in 1994 under the Act, have great power, among them being:

- to investigate a medical practitioner,
- the requisition of medical records,
- and to "compel answers under oath in a formal hearing and recommend a range of sanctions which include prosecution."

However, in its earlier manifestation, the PSR reported that between 1994 to 2005 they had 447 referrals where actions were taken. To resolve each action the PSR scheme cost on average $70,000 per referral[viii] or $31,290,000 in total.

Error Misconstrued as False or Deliberately Misleading

Laws under the *Health Practitioner Regulation National Law* s136 already exist so as to deter external influences from corporate directors or managers to direct or incite their registered health practitioner employees to practise in ways that would constitute unprofessional conduct or professional misconduct.[ix] RACS' concern is whether there is a necessity for this Bill in becoming an unnecessary blunt punitive instrument where an electronic error was made. Such errors may find itself among numerous online and mobile processing systems which would encompass a bank's EFTPOS terminal or Easyclaim within a medical practice.

Hence, any use of an inappropriate or misleading MBS code requires a mechanism for reimbursement, but if this did occur in error by either the medical practitioner or their practice staff, assurances need to be made for such an act not to be deemed as an offence, or leading to a charge laid on either or both parties, nor the medical practice. A non-confrontational mechanism is required to deal with circumstances where irregularities occur infrequently with adequate protections for our Fellows and their practice. This has not been clearly stated by the Government.

In a recent Public Hospital Compliance meeting between RACS and the Provider Benefits Integrity Division, Health Financing Group, Compliance Operations Branch, Commonwealth Department of Health last August, the issue of potential duplication of Medicare payments in public hospitals where a patient with private health insurance (PHI) has been admitted was discussed. RACS spoke from their Fellows' experience that many hospital contracts have in their agreement the need to access a medical practitioner's provider number for billing purposes. Privatised surgery or outpatients in a public hospital present a potential problem, as practitioners rarely have control of the billings made by the hospital under their provider number. Practitioners can receive from the hospital at the year's end a notification of their billing total with the explanation that money collected is 'donated' back to the hospital for taxation purposes.

Importantly, instances can occur when the head of a unit's provider number is used for Medicare claiming, simply because their name is prominent on every patient's health chart in their department.

The impression RACS received from Government was that there needs to be more transparency and education with state and territory hospital administrations when it comes to this form of billing. On face value an error with respect to an individual service provider number could be deemed as false, resulting in an unfair and excessive reimbursement request by the Government. This would need to be directed to the public hospital and not to the practitioner, as the practitioner never receives the funds that are direct to public hospitals' special purpose funds.

When accusations of false and misleading information are made, damage to a practitioner's reputation and their subsequent mental wellbeing may transpire. Litigation is another avenue often pursued when legislation evolves into a perceived blunt punitive instrument. RACS encourages Government to provide more specific authoritative guidelines with a supportive education campaign and a right to an appeal process in case an error was made.

More work is also needed with various jurisdictions (states and territories) for public hospitals and private hospitals, as well as for private patients being cared for in public hospitals. To avoid any confusion, private and public hospitals should be encouraged to provide weekly reports to doctors as to how their provider numbers are being used in this context.

RACS is happy to assist Government with their messaging to surgeons provided an information package is developed for RACS to promote changes to our fellowship for educational purposes

both from a Commonwealth standpoint as well as a state and territory perspective where needed. RACS is open to working closely with Government to warn our Fellows of any related up and coming future audits.

Conclusion

RACS' Code of Conduct explicitly opposes any form of false or misleading behaviour resulting in financial gain. As stipulated:

> "I will abide by the Code of Conduct of this College, and will never allow considerations of financial reward, career advancement, or reputation to compromise my judgement or the care I provide."[x]

Considering this, RACS also believes in the core value of natural justice or *audi alteram partem*, "let the other side be heard as well". What appears to be lacking is a set of clear guidelines for the rippling after-effect these amendments will have on our profession. The following are in summary RACS' primary concerns regarding this Bill and the consequences expressed in its explanatory memorandum.

- The principle of reimbursement is reasonable if an error has been made
- The principle of Medicare not having to notify the practitioner what the error is, is not acceptable from a procedural fairness viewpoint
- Right of objection/appeal needs to be part of this legislation and within the parameters of the Exploratory Memorandum
- Clear distinction needs to be made of an error requiring reimbursement, from a deliberate act of fraud as an honest error could be made inadvertently by the practitioner, practice staff or public hospital staff
- Errors identified should be disclosed to practitioners and a request for reimbursement made that is not associated with litigation, punitive or unfair damage to reputation
- Repeated errors leading to suspicion of fraudulent behaviour may require a different framework to what is being proposed within the parameters of the Exploratory Memorandum

We look forward to receiving your response.

Yours sincerely

Dr Anthony Sparnon
President

Office of the President

[i] Department of Health Commonwealth., 'Guaranteeing Medicare – improving safety and quality through stronger compliance' 8 May 2018
http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2018-factsheet04.htm

[ii] Parliament of Australia '2017-2018 Budget Estimates'
https://www.aph.gov.au/Parliamentary_Business/Senate_Estimates/ca/2017-18_Budget_estimates

[iii] Department of Health Commonwealth., 'Shared Debt Recovery Scheme - public consultation'
https://consultations.health.gov.au/compliance-systems/sdrs-consultation/

[iv] House of Representatives, Health Insurance Amendment (Compliance Administration) Bill 2020 Explanatory Memorandum 2019-2020, *The Parliament of The Commonwealth of Australia*, p.1

https://parlinfo.aph.gov.au/parlInfo/download/legislation/ems/r6620_ems_1f75a640-48a2-4fea-bfeb-ac5c3f541843/upload_pdf/JC000297.pdf;fileType=application%2Fpdf

[v] House of Representatives, Health Insurance Amendment (Compliance Administration) Bill 2020 Explanatory Memorandum 2019-2020, *The Parliament of The Commonwealth of Australia*, p.1

https://parlinfo.aph.gov.au/parlInfo/download/legislation/ems/r6620_ems_1f75a640-48a2-4fea-bfeb-ac5c3f541843/upload_pdf/JC000297.pdf;fileType=application%2Fpdf

[vi] Health Insurance Amendment (Compliance Administration) Bill 2020, Second Reading, Thursday, 29 October 2020 *The Parliament of The Commonwealth of Australia*
https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansardr%2F401a8e85-65d0-4704-8cfc-ef351b7cb8b6%2F0009%22

[vii] Paola, Sheshtyn., "New Legislation to better detect PBS fraud", *AJP.com*, 4 December 2019
https://ajp.com.au/news/new-legislation-to-better-detect-pbs-fraud/

[viii] Healy, Judith (editor)., *Improving Health Care Safety and Quality, Reluctant Regulators,* Chapter 8 "Regulation by Enforcement: Laws, Money and Monitoring" Publishers Taylor & Francis, 2016 pp.266-267

[ix] *Health Practitioner Regulation National Law (Victoria) Act 2009*, s136 Directing or inciting unprofessional conduct or professional misconduct
http://classic.austlii.edu.au/au/legis/nsw/consol_act/hprnl460/s136.html

[x] Royal Australasian College of Surgeons (RACS), Code of Conduct, p .5
https://www.surgeons.org/en/become-a-surgeon/about-specialist-surgeons/code-of-conduct