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Submission to the Senate Inquiry into the Health Legislation Amendment (Medicare Compliance and Other Measures) Bill 2021 [Provisions]

By email to: community.affairs.sen@aph.gov.au; seniorclerk.committees.sen@aph.gov.au

Thank you for giving me the opportunity to provide this submission.

INTRODUCTION AND BACKGROUND

I am a Solicitor admitted to practice in the Supreme Court of NSW and the High Court of Australia, and have practiced law for over two decades. I am also an academic scholar of Medicare and health insurance law, and I have recently completed a PhD on the topic of Medicare claiming and compliance. I have been a health system administrator since Medicare began, am a Registered Nurse, and the founder and CEO of global MedTech company, Synapse Medical, which provides medical billing and clinical coding solutions globally. I contribute widely to the national health reform debate with over 100 publications (both peer reviewed and popular media) which are available here.

I offer the following submissions in my personal capacity as a health system lawyer, academic and administrator with 38 years' experience processing Medicare bills, and the only Australian to have a doctorate on Medicare claiming and compliance.

I note the terms of reference seek submissions related only to one aspect of this Bill, namely proposed subsections 105AA(2) and (5), however, my submissions extend beyond that scope for reasons that will become apparent. I thank the committee for considering them.

I oppose the introduction of this Bill in its entirety for the following reasons.

SUBMISSIONS

1. I am concerned about the accuracy of a statement made by the relevant Minister when this Bill was read a second time. The relevant second reading speech is available at this link https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22chamber%2Fhansardr%2F25165%2F0024%22 and the concerning statement is the following:

   > *"The department supports practitioners, healthcare organisations and peak bodies to correctly claim health payments with a clear focus on education, engagement and consultation."*

2. Available evidence suggests the opposite is true and the department has no focus on education at all. In fact, empirical evidence on this precise topic appears to have been overlooked. Specifically, the following five peer reviewed articles, all of which were in the public domain prior to the second

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reading speech of this Bill, make clear that there is little or no education on Medicare billing and never has been, and that educational efforts by the department are sporadic and inadequate.

i. ***No payments, copayments and faux payments: are medical practitioners adequately equipped to manage Medicare claiming and compliance?*** Margaret Faux, Jonathan Wardle and Jon Adams. Internal Medicine Journal 2015 https://doi.org/10.1111/imj.12665

ii. ***Educational needs of medical practitioners about medical billing: a scoping review of the literature.*** Faux, M., Adams, J. & Wardle, J. Educational needs of medical practitioners about medical billing: a scoping review of the literature. *Hum Resour Health* 19, 84 (2021). https://doi.org/10.1186/s12960-021-00631-x

iii. ***Who teaches medical billing? A national cross-sectional survey of Australian medical educational stakeholders.*** Margaret Faux, Jonathan Wardle, Angelica G Thompson-Butel, Jon Adams. BMJ Open 2018 https://bmjopen.bmj.com/content/8/7/e020712.abstract

iv. ***Medicare billing, law and practice: complex, incomprehensible and beginning to unravel*.** Margaret Faux, Jonathan Wardle and Jon Adams, Journal of Law and Medicine 2019 https://opus.lib.uts.edu.au/handle/10453/136958

v. ***Frenetic law making during the COVID-19 pandemic: the impact on doctors, patients and the Medicare system.*** Margaret Faux. AUSPUBLAW (24 April 2020) https://auspublaw.org/2020/04/frenetic-law-making-during-the-covid-19-pandemic-the-impact-on-doctors-patients-and-the-medicare-system

3. One additional academic article was published more recently (see link below). It presents qualitative research results, which expand on the above works and is the first study of its kind ever undertaken in Australia. In that study, direct quotes from the medical practitioner participants clearly describe a complete absence of education or support in relation to Medicare billing, which is profoundly complex and difficult to understand. One participant even described being led into medical billing error by what appears to have been a botched departmental audit.

   i. ***Wading through molasses: a qualitative examination of the experiences, perceptions, attitudes and knowledge of Australian medical practitioners regarding medical billing.*** Margaret Faux, Jon Adams, Simran Dahiya, Jon Wardle. Published in *PLoS One* in January 2022. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0262211

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4. In 1993, The Hon. Darryl Williams QC, delivered a blistering attack on the proposed new Professional Services Review Agency (PSR)[1], describing it as making a mockery of the principals of natural justice. Many of the concerns raised by Mr Williams persist, and evidence presented in my thesis suggests the PSR system is falling well short of meeting its objectives of upholding the integrity of Medicare payments and delivering value to the public. Its crude methods of investigation and prosecution target doctors who would almost all bill better/differently if they had access to reliable education and support and the MBS item descriptions made sense. Instead, these doctors are subjected to extremely distressing, drawn out, PSR investigations (conducted in secret without public scrutiny), while rogue practitioners like those seen in the recent ABC 4 Corners program *"Cosmetic Cowboys"* unlawfully bill services to Medicare but fly under the audit radar.

5. There is a common view that Medicare billing is easy. However, the irrefutable evidence presented in my thesis shows that Medicare billing is profoundly complex. This has developed mostly over the last 20 years. There is now layer upon layer of widely dispersed, opaque and impenetrable legal instruments, which has created rule of law problems because medical practitioners cannot always find the laws that apply to them, and their legal advisors cannot find them either.

6. For clarity, my research found that the multitude of instruments regulating Medicare billing extrapolate out to well over 7,300 pages of Acts, Regulations, Determinations, Rules, Directions, Terms and Conditions, Schedules, Website Pages and Guides. Noting this *excludes* all of the Private Health Insurance medical fee schedules (which contain further rules), all of the State and Territory Health Acts, Policies and Enterprise and Right of Private Practice Agreements, the entire content of the MBS Online website (with the exception of the MBS book), all content on the Department of Health website (which overlaps with the MBS online website and is sometimes inconsistent with it), a file comprising over 6000 lines being the medical fee schedule located on the Victorian Transport Accident Commission website (which includes another set of bespoke rules), relevant content from the Independent Hospitals Pricing Authority and Australian Health Practitioner Regulation Agency websites, and every Covid related instrument. If all of the excluded materials were added, I conservatively estimate that the total number of pages of important medical billing content that medical practitioners are expected to know, or at least be familiar with, would exceed 20,000.

7. In 2020 alone, 255 statutory instruments were added to the Federal Register of Legislation which included the words 'Health Insurance' in the title, and only 53 of those were Covid-19 related. Therefore 202 statutory instruments relating to 'Health Insurance' were enacted in one year alone, all of which impacted medical practitioner billing compliance in some way.

8. By comparison, the *Corporations Act 2001 (Cth)* has a relatively modest 3,000 plus pages, and in New South Wales (NSW), the NSW State Register of Legislation, records just five statutory

[1] Mr Williams, Health Legislation (Professional Services Review) Amendment Bill 1993, Second Reading https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;db=CHAMBER;id=chamber%2Fhansardr%2F1993-10-21%2F0101;query=Id%3A%22chamber%2Fhansardr%2F1993-10-21%2F0105%22

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instruments made under the *Road Transport Act 2013*, setting out road transport and road rules in NSW, comprising 911 pages, which includes the Principal Act.

9. Medical practitioner participants of my research demonstrated confusion about even the most basic elements of correct Medicare billing, there was no legally reliable advice and support available to them, and they felt powerless to address these issues. The evidence also suggests that the government is equally confused about what is or is not a complaint medical bill, and effective management of scheme integrity is therefore wanting. Further, that recent reforms, such as through the MBS Review Taskforce, may have exacerbated existing challenges.

10. There can be no lingering doubt that a nationally consistent, regulated, educational response to Medicare compliance is required, but evidence suggests it cannot be introduced until indecipherable Medicare laws have first been fixed.

11. I contribute a regular fortnightly column to a key industry publication, The Medical Republic[2]. Two recent articles may assist the committee because they demonstrate the profound complexity and mercurial nature of Medicare billing arrangements, as well as government confusion. The first provides numerous examples of the incomprehensibility of the scheme[3], and the second sets out a recent change to Medicare billing requirements made by the department that was/is literally impossible for medical practitioners to comply with[4]. In addition to the footnotes, I have ***attached*** these two articles to assist the committee.

12. The available evidence suggests that the PSR already operates in the manner of a Star Chamber, a sentiment echoed by a Federal Court Judge last year[5]. To now tighten its grip further through the introduction of this Bill, without addressing underlying structural issues and in the context of no education or reliable support being available is, in my opinion, unconscionable. It also obfuscates the need to address underlying system issues. My research concluded that a principal cause of Medicare non-compliance is system issues rather than deliberate abuse by medical practitioners.

13. This Bill will not solve Medicare payment integrity problems, but will worsen them. Practitioners are already describing Medicare audit anxiety more and more, and I am observing that many medical practitioners are effectively opting out of engaging with Medicare completely because they are too scared of billing incorrectly despite best intentions, which pushes consumer out-of-pocket medical costs up.

14. This Bill will have adverse impacts on health providers who are practicing legitimately. The weight of evidence makes clear that medical practitioners who are billing correctly for the services they

[2] https://medicalrepublic.com.au/
[3] Margaret Faux, Medical Billing is Full of Reasonable Doubts. https://medicalrepublic.com.au/medical-billing-is-full-of-reasonable-doubts/54973
[4] Margaret Faux, BREAKING: The Government Doesn't Know How Medicare Works. https://medicalrepublic.com.au/breaking-government-doesnt-know-how-medicare-works/61025
[5] Jeremy Knibbs, No, Professor Quinlivan, The PSR IS Like a Star Chamber. https://medicalrepublic.com.au/no-ms-quinlivan-the-psr-is-like-a-star-chamber/50873

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provide are often unable to escape the PSR. Two recent examples of medical practitioners who have reached out to me while involved in PSR matters demonstrate this:

a) A bulk billing GP who was treating a large cohort of Aboriginal and Torres Strait Islander people was at the highest percentile of GPs billing the MBS item for removal of foreign bodies, and was therefore automatically referred to the PSR by the department. The extraordinarily wide powers of the PSR of course meant that his investigation was far reaching and included other services. But the reason for him billing unusually high volumes of the foreign body service was that his patient population don't wear shoes. They therefore get more foreign bodies in their feet than most. He was practising and billing legitimately. The trauma of the PSR process has caused him to stop practicing as a GP completely. He now works solely in a hospital setting and informed me that he will never return to private general practice.

b) A bulk billing surgeon who practices in a similarly niche area and provides certain high volumes of imaging, was investigated by the PSR. He was required to repay a considerable sum. When practitioners are required to make repayments, they have no option other than to admit that they engaged in inappropriate practice. This doctor confirmed to me he does not believe that he engaged in inappropriate practice but had no option other than to effectively give a false confession to the PSR. His story is sobering. At all times he had sought advice from the department to ensure he was billing correctly. But worse, he will definitely be re-investigated by the PSR and is aware of that. The reasons are simple - he is billing legitimately for the necessary services he provides. But he will always be at the highest percentile for his MBS items because of his niche area of practice. He will therefore be recaptured by the departments' 'robodebt' system. So, his options now, as he described them to me, are to either stop providing the services his patients need (making them less safe), or provide the services but not bill to Medicare and charge the patients instead. So, no more bulk billing and no more Medicare rebates for his patients. Instead, they will pay in full, and he will give them a receipted invoice without an MBS item on it, meaning his Medicare entitled taxpaying patients will no longer be able to receive the Medicare rebates they are legitimately entitled to. He has no other option if he wants to keep his patients safe, be paid for his work and not live in fear of another PSR investigation.

15. While researching how other countries manage medical payment integrity, I did not find any other country seeking to emulate the PSR model. In fact, I found the opposite. Emerging health systems are adopting new, digital approaches to the problem of financial leakage, recognising that by leveraging technology and data analytics, incorrect payments can be prevented before they happen. A balance between some inevitable post-payment policing and increased pre-payment visibility is becoming a recognised approach to the prevention of improper payments.

16. Unfortunately, the Australian government appears to be doggedly following the failed US approach to medical payment compliance, which even the US is pivoting away from. This shift by the US

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government began after the US Department of Health and Human Services conceded the Medicare appeals system was broken, and it would take more than 11 years to clear the backlog of appeals awaiting hearing by an Administrative Law Judge, over half of which providers were likely to win[6].

17. I have made 27 recommendations for reform in my PhD. The recommendations are not intended to solve all of Medicare's problems, but rather, to address and quickly alleviate many of the issues identified and discussed in the thesis. Based on the evidence, one of the recommendations is to phase out the PSR and replace it with a more modern, balanced system of managing Medicare compliance, which is less punitive and less expensive.

18. The current approach of the government, which is to give more power to the PSR, is the wrong approach to addressing problems related to Medicare payment integrity, and is not in the public interest. The available evidence suggests the introduction of this Bill will worsen existing challenges across the Medicare payment environment, including causing already intolerable out-of-pocket medical costs to rise. Urgent structural reform of Medicare is required.

Accordingly, I oppose this Bill in its entirety.

I would be happy to discuss these submissions with the committee if required.

Yours sincerely

Dr Margaret Faux

[6] Greer Donley, The Broken Medicare Appeals System: Failed Regulatory Solutions and the Promise of Federal Litigation https://scholarship.law.pitt.edu/cgi/viewcontent.cgi?article=1088&context=fac_articles