Special Commission of Inquiry into Healthcare Funding

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Introduction

Thank you for giving me the opportunity to provide this submission to the NSW Health Funding Inquiry 2023. This introduction summarises my professional experience and background. I will then address three key areas of relevance to the inquiry namely, problems at the interface of state and federal laws, fraud and waste, and the pressing need for health system education.

1. I am currently employed as the chief executive officer of a company that runs one of the largest medical billing services in Australia, Synapse Medical Services (**Synapse**). Synapse administers all types of medical bills for individual medical practitioners (**MP**) across every medical speciality, as well as providing medical billing solutions, and services to public and private hospitals, large corporate organisations, and government agencies. Synapse also provides clinical coding, transcription, and consulting services, which includes undertaking special projects such as medical billing compliance audits. Synapse provides all these services to NSW public hospitals.

2. I am also a solicitor and the principal of my law firm, Margaret Faux, Solicitor, which operates exclusively as an online service, providing answers to complex medical billing and health system questions submitted by medical practitioners and other health professionals.[1]

[1] The website to my law firm can be accessed at this link: https://mbsanswers.com.au/

3. In late 2020 I was awarded a PhD on Medicare claiming and compliance. My research examined the Medicare billing system (including its application in public hospitals) through a legal, administrative and system lens, using a mixed methods design. The thesis is publicly available in the UTS online thesis collection.[2]

4. Prior to studying law, I qualified and practised as a registered nurse for 13 years, which included working in NSW public hospitals. I now maintain non-practising registered nurse status with the Australian Health Practitioner Regulation Agency. My nursing background provides clinical context and understanding to my work.

5. In my capacity as a solicitor, clinician, and Medicare compliance expert, I regularly receive instructions from law firms to act as an expert witness in legal proceedings, both civil and criminal, concerning the operation of Medicare and Australia's broader health financing arrangements. This has included providing my expert opinion on the very complex commonwealth/state funding arrangements that currently apply in public hospital outpatient departments, and whether double-dipping occurs.

6. Synapse operates in international markets doing the same work (medical billing, clinical coding, and health financing consulting) and has various projects in the Middle East as well as an office in Dubai. I am currently leading a team who are developing the non-admitted casemix classification for the Kingdom of Saudi Arabia.

7. I am regularly asked to comment in the media on the topic of health regulation. This has included featuring in the Sydney Morning Herald, The Age, The Guardian, Channel 9, 60 Minutes, and the ABC's 7.30 and 4 Corners.

[2] Medicare claiming and compliance, UTS thesis collection: https://opus.lib.uts.edu.au/handle/10453/155387

8. I have published over 150 articles, both peer reviewed and popular media, on the topic of Medicare and private health insurance law and billing and contribute widely to Australia's health reform debate.[3]

9. I have an adjunct research appointment at Southern Cross University, New South Wales. My research interests are focused on enabling equitable access to well-functioning Universal Health Coverage systems. My specific areas of interest are directly connected to my four decades of industry experience which has spanned health system financing, payment integrity, codes and classifications, regulation, and digital enablement.

10. I have deep knowledge of the "realities of the street" in terms of how the health financing arrangements in NSW are actually administered, informed by my work as the CEO of Synapse.

Executive Summary

11. The National Health Reform Agreement and Medicare regulations contain irreconcilable differences which contribute to public hospital access problems for NSW consumers. This issue has been identified by the Australian National Audit Office, the Victorian Auditor General, the South Australian Independent Commission Against Corruption, and me (in my PhD). Remedying this central, long-standing structural flaw will have a positive impact on health funding in NSW by reducing perverse incentives and improving payment integrity.

12. Based on evidence and experience, there can be no doubt that fraud and waste are rampant, not only in the NSW health system, but Australia wide.

13. No one has ever conducted a statistically valid measurement of the rates of fraud and waste in the Medicare system, and desktop analysis is never sufficient to

[3] My consolidated articles and media appearances are available at this link: https://synapsemedical.com.au/news/category/publications/

uncover fraud. We need urgently to accurately measure the size of this problem and implement controls to improve payment integrity.

14. The health funding arrangements in NSW are extremely complex and inextricably linked with commonwealth health funding arrangements. A complex regulatory "spaghetti junction" has evolved over many decades, such that it is currently beyond the full comprehension of anyone. NSW (and Australian) health regulation requires a complete overhaul, which cannot be affected without the support and cooperation of the commonwealth government.

15. Evidence suggests that NSW medical practitioners do not receive education about NSW health funding arrangements prior to being required to work within the system and being the ultimate custodians of NSW health funds. An educational response is urgently required.

The National Health Reform Agreement in collision with the Health Insurance Act 1973

16. A major problem impacting public hospital funding arrangements in all states, including NSW, derives from the fact that National Health Reform Agreement (**NHRA**)[4] and provisions of Medicare's enabling legislation, the *Health Insurance Act 1973* (**HIA**)[5], are not aligned. An important area of focus for this inquiry must inevitably be this interface, where state and federal funding arrangements have irreconcilable provisions that have created perverse incentives, compromised payment integrity, and caused access problems for consumers.

17. The NHRA enables state-run public hospitals to bill using the MBS and Private Health Insurance (**PHI**) schemes, the latter, usually under gapcover arrangements. The practical application of these arrangements is to require publicly practicing MP to bill under their individual Right of Private Practice Agreements (**ROPP**) for patients who elect to be treated privately. This is

[4] https://www.health.gov.au/our-work/2020-25-national-health-reform-agreement-nhra
[5] https://www.legislation.gov.au/Details/C2023C00455

implemented mostly, but not exclusively, in public hospital outpatient (**OP**) departments. Under these arrangements the hospital will retain some or all the revenue collected for salaried MP, but contracted MP often retain all their MBS and PHI billing revenue, particularly when it is their sole revenue source (which happens in NSW). The arrangements are different in every state and territory.

18. An overarching but often poorly understood concept related to Medicare billing is that the MBS applies exclusively to private patients. The MBS list of fees subsidises the private fees that private patients incur on a fee-for-service basis. Therefore, a public patient who attends a public hospital OP department and agrees to be bulk billed is no longer public – that patient immediately become private. This is the case even though most of these patients do not have PHI and therefore do not understand how they can be categorised as private.

19. It is commonly believed that bulk billing Medicare for these public hospital OPs is illegal and causes double dipping because a parallel Activity Based Funding (**ABF**) stream exists. However, based on findings from my research, there is no illegality if all required conditions are met, nor may there be any payment duplication at the relevant point in time. Or, in the alternative if there is duplication, it is unlikely to involve the MBS billing.

20. ABF was formally introduced in Australian public hospitals in 2011. The principal focus of ABF was admitted patient care. The OP component of ABF is known as the Tier 2 Classification which essentially counts rather than codes patient encounters resulting in poor visibility over service delivery and imprecise costing. By retrofitting the Tier 2 model into the pre-existing MBS framework, (the MBS pre-dated ABF by almost 30 years), payment duplication and other problems were inevitable.

21. The following section copied from my PhD may assist the inquiry with context around a critically important section of the HIA insofar as payment duplication and ROPP arrangements are concerned. The relevant section is 19(2):

"While section 19(2) of the HIA provides that a Medicare benefit is not payable when a medical service is provided 'by, or on behalf of, or under an arrangement with the Commonwealth', the current arrangement between the States and the Commonwealth expressly provides that Medicare benefits are payable subject to certain strict criteria being met. Section 19(2) of the HIA has therefore been interpreted as enabling MP to undertake private practice in public hospitals pursuant to certain provision of the NHRA, and claim through the MBS (Victorian Auditor-General 2019). This is because when an MP provides a service to a patient who has elected to be treated privately, that service is not provided 'by or on behalf of, or under an arrangement with the Commonwealth', but pursuant to a private contract between the MP and patient (State Government of Victoria 2011; "Health Insurance Commission v Peverill [1994] HCA 8"). The s 96 agreements operating between 2003-2008 went so far as to describe patients who elected to be treated privately in a public hospital outpatient department, as not being patients of the hospital (see below):

'Note: An eligible person who has been referred to receive outpatient services from a medical specialist exercising a right of private practice under the terms of employment or a contract with a hospital which provides public hospital services, <u>is not a patient of the hospital</u>.' (Commonwealth Government 2003: 15)

The Victorian Auditor-General has suggested a ROPP can only be exercised in the context of a 'broader employment arrangement with the public health service' (Victorian Auditor-General 2019), a position echoed by the Independent Commissioner Against Corruption in South Australia (SA), who stated 'A ROPP permits a salaried specialist to treat a private patient in a public hospital' (Lander 2019).

The Victorian Audit Report expressed concern that some MP working in public facilities in the State of Victoria may be engaged in non-compliant billing because they were billing to Medicare when supposedly exercising a ROPP, but were

independent contractors rather than salaried employees and therefore could not legitimately exercise a ROPP (Victorian Auditor-General 2019). However, in the State of New South Wales (NSW), MP are expressly advised an opposite interpretation of a ROPP, which is inconsistent with the narrow interpretation adopted in Victoria and SA. The NSW Department of Health, informs MP who are '…clinical academics, visiting medical officers and honorary medical officers' that they are permitted to exercise a ROPP and bill to Medicare, even though they are not employees (NSW Government 2021a).

This lack of definitional clarity around what a ROPP is and which category of MP can exercise a ROPP may be caused by a drafting inconsistency in the NHRA where Clause G17 includes the word 'contract' in the context of ROPP provisions - <u>a medical specialist exercising a right of private practice under the terms of employment or a contract with a hospital</u>; but the subsequent clause G19 does not make reference to a contract - <u>a named medical specialist who is exercising a right of private practice</u> and the patient chooses to be treated as a private patient.'(Australian Government 2020-2025)

Inclusion of the word 'contract' in Clause G17 of the NHRA may support the current wide interpretation of a ROPP adopted in NSW, but ultimately, it is the interpretive ambiguity that may expose MP to medical billing compliance risk caused by genuine ignorance around whether they are permitted to exercise a ROPP and therefore bill a patient who has consented to be bulk billed in a public hospital outpatient setting. Given the various State authorities appear not to agree on what a ROPP is, it is reasonable to suggest that MP have little option other than to follow the directions of appropriate managers of ROPP arrangements in the state-run facilities where they provide public hospital services, even though such directions may be incorrect, exposing MP to legal liability for possible breaches of s 19(2) of the HIA. The SA Commissioner noted:

'...it should be observed that a lack of formal direction about when and how ROPP is to be exercised contributes to the ambiguity surrounding the discharge of salaried specialists' public duties and creates a risk of misconduct and maladministration which contributes to the risk of corruption.'(Lander 2019)

Compounding the confusion around the threshold issue of which MP can legitimately exercise a ROPP, the signatories to the NHRA are the State Premiers, Territory Government Chief Ministers, and the Prime Minister. Therefore, the entire NHRA does not directly bind MP basis a fundamental principal of contract law known as privity of contract which provides 'A person who is not a party to a contract can neither enforce the contract nor incur any obligation under it.' (Paterson, Robertson, and Duke 2012: 255) However, contracts between MP and state operated public hospitals would usually create binding obligations on MP to adhere to applicable departmental policies, procedures and directions, though MP have no practical ability to know whether such directions are correct, particularly in view of a finding from this research described in chapter six, that MP may not know the NHRA exists."

22. In addition to there being no national consensus around what a ROPP is and therefore who can exercise one, to understand whether double dipping occurs, it is necessary to consider legal 'ownership' of the Medicare rebate, and who is legally able to facilitate its release from the commonwealth government's consolidated revenue fund to a MP or hospital's bank account.

23. Throughout the HIA is reference to an 'eligible person'. An eligible person is a patient, not a MP. As such, it is the patient who is the legal beneficiary of the Medicare rebate. Under bulk billing arrangements, the patient can agree to assign their Medicare entitlement to a MP.

24. The High Court has confirmed that the relationship between a MP and patient is a contract governed by general principles of contract law, and bulk billing requires

the consent of both parties before the patient's Medicare rebate can be assigned to the MP.[6] This is facilitated by the patient signing a consent to bulk bill, which is legally required each time a service is provided. Put another way, it is illegal to obtain global consent for future bulk billing, though such practice occurs commonly and is an open secret across the health sector including in NSW public hospitals.

25. Public hospitals around the country have been bulk billing OPs since at least 1994, long before ABF was introduced.[7]

26. My research found that the original legal advice enabling the bulk billing of public hospital OPs was that when a MP provided a service to a public OP who elected to be treated privately, that service was not provided 'by or on behalf of, or under an arrangement with the Commonwealth' in breach of section 19(2), but pursuant to a private contract between the MP and patient.[8]

27. It is also noteworthy that if a private OP requires admission on the day of their OP appointment, they are entitled to continue to elect to be treated as a private patient once they have been admitted to the hospital. When this happens, the patient's assigned Medicare benefit is passed to either a MP or the hospital as part of a bundled payment, usually under PHI gapcover arrangements. It is therefore not open to suggest that patients cannot assign their Medicare benefit when they are OPs but can when they are admitted. The Medicare benefit 'travels' with the patient always and relevant provisions of the HIA enable patients to assign their Medicare benefit both when they elect to be a private inpatient *and* when they elect to be a private outpatient.

[6] Wong v Commonwealth of Australia [2009] HCA 3 https://eresources.hcourt.gov.au/showCase/2009/HCA/3
[7] "Doctors face jail over billing" Alicia Larriera, Sydney Morning Herald Archive, 20 October 1994
[8] State Government of Victoria. 2011. "Specialists clinics in Victorian public hospitals. A resource kit for MBS-billed services."

28. Returning to the alleged double dipping issue, a condition precedent to bulk billing under the NHRA is that the patient has a *named* referral, and the treating specialist is exercising a ROPP. It should be noted the HIA, and associated regulations do not expressly require a named referral.[9]

29. There is well known hostility between some general practitioners (**GP**) and public hospitals on this issue, with some GPs refusing to provide the named referrals that the NHRA requires, and public hospitals turning patients away if they don't have one. Both parties have legitimate grievances. GPs feel burdened by interruptions to their day from public hospitals demanding a named referral on the spot. Public hospitals are legitimately able to ask for a named referral to enable MBS billing. However, both parties appear not to understand that neither has a right to control the passage of a Medicare benefit because it does not belong to them. Patients are very much caught in the middle of this long-standing impasse, the locus of which is not patient centred.

30. In the context of a typical OP appointment where a patient has consented to be bulk billed, if all other requirements have been met including the patient having a named referral, and the MP is legitimately exercising a ROPP, there does not appear to be any illegality about the patient being bulk billed at the moment in time when the patient is at the reception desk following their appointment. At that precise moment, evidence suggests the commonwealth government has not already paid for that service via an ABF payment.

31. ABF operates on a 'payment in arrears' model. Each year a legal instrument known as the *Federal Financial Relations (National Health Reform Payments) Determination* appears on the federal register of legislation.[10] This instrument and relevant provisions of the NHRA repeatedly refer to estimates based on activity in the previous year, with an allowance for anticipated growth. State health

[9] Health Insurance regulations 2018 https://www.legislation.gov.au/Details/F2023C01017
[10] See for example: Federal Financial Relations (National Health Reform Payments for 2019-2020) Determination 2021 https://www.legislation.gov.au/Details/F2021L00474/Explanatory%20Statement/Text

departments then pass relevant budget allocations to public hospitals within their jurisdiction, based on each hospital's reported activity from the previous year.

32. In my experience, because hospitals are paid for activity in the previous year, MP who work in public hospitals report that it is incumbent upon them to ensure they meet their annual activity targets to prevent funding cuts in the following year.

33. Accordingly, in the context of an immediately bulk billed claim for an OP, it is difficult to see how the commonwealth has paid for the service, and where any alleged duplication has occurred. The fact is that the patient's appointment will only be reported as ABF activity *after the patient leaves* and will be included in the following year's ABF allocation. For clarity, the commonwealth will not pay for that appointment until the following year. This suggests that any duplication is more likely to be caused by any subsequent ABF claim made by the hospital, rather than MBS claims made by MPs. The only time when duplication may be caused by the MBS claim, would be if that claim was submitted at a much later point in time. This would generally be an exception rather than the rule.

34. It should also be noted that an adjustment should be made to offset the MBS billing against the ABF payment but in practice, this is poorly administered. The Commonwealth Auditor General has reported concerns in this area and estimated the size of potential non-compliance very conservatively at over $300 million annually.[11]

35. My research found that irreconcilable differences at the interface of the HIA, NHRA, ROPPs and other legal instruments are the root cause of these problems, and without reform, the double dipping and non-compliance debates will continue, despite there being no clear evidence that double dipping occurs.

[11] https://www.anao.gov.au/work/performance-audit/australian-government-funding-public-hospital-services-risk-management-data-monitoring-and-reporting

36. It should also be noted that the Independent Hospitals and Aged Care Pricing Authority (**IHACPA**) is currently engaged in a program of work to create a new casemix classification for public hospital OPs. This will replace the current Tier 2 model. However, this will inevitably continue to operate in parallel with the MBS and may exacerbate rather than alleviate current funding challenges.

37. The Commonwealth Auditor General,[12] the Victorian Auditor General,[13] the South Australian Independent Commission Against Corruption[14] and I (in my PhD) have all identified this issue as a major problem requiring priority reform, yet inaction persists.

Solutions:

a) This is a problem the NSW government cannot solve alone. It requires the support of the commonwealth government and all states and territories who must come together and align referral law as between the NHRA and the HIA. I offer my proposals (from my PhD) as one possible solution to address this crippling issue. See **Annexure A**.

b) Public hospitals require education on correct bulk billing, which must be rigorously enforced. This is legal education *not* clinical education and as such, it must be taught by legal educators, such as university law schools (see **Annexure B**). As a side note but one that may be of interest to the inquiry, the commonwealth Department of Health and Aged Care (**DOHAC**) has recently announced plans to modernise the "Assignment of Benefit" process. This is a major reform that has the potential to be a game changer insofar as payment integrity is concerned, including in NSW public hospitals.

[12] https://www.anao.gov.au/work/performance-audit/australian-government-funding-public-hospital-services-risk-management-data-monitoring-and-reporting
[13] https://www.audit.vic.gov.au/report/managing-private-medical-practice-public-hospitals
[14] https://www.icac.sa.gov.au/publications/published-reports/troubling-ambiguity-governance-sa-health

c) I have led projects in a number of NSW public hospital OP departments where I have heard reception staff say to patients: *"Now, if you don't come back with this named referral signed, next time we'll have to charge you."* And, in response to a patient asking what they were signing another receptionist said *"It's a Medicare form. And if you don't sign it, we'll have to put you in as a non-Medicare patient and then we'll charge you."* This type of manipulative communication has become commonplace and is embedded in business processes in some NSW public hospitals. The only way to stop it and protect vulnerable consumers will be to mandate signage, firmly affixed, very visibly in public hospital OP departments with words to the effect:

a. You cannot be turned away from this clinic under any circumstances. If you are please call XXXX and report the hospital.

b. This clinic is not permitted to force you to obtain a named referral from your GP before you attend or make your appointment conditional upon you having one. You can come without a referral and the clinic must see you.

The normalisation of fraud and waste

38. Based on my extensive experience over many decades, most of the fraud and waste (which includes overservicing) occurring in the Australian health system is invisible and therefore extremely difficult to detect.

39. A common phrase I use to explain why medical fraud is so hard to detect is this: "As long as you bill your lies correctly you won't get caught". Put another way, one cannot rely on clinical or billing records as the source of truth, because those records can contain lies or be completely fake. The recent ABC 7:30 report by Adele Ferguson and Laura Francis called *"Podiatrist's questionable business practices expose the health payment system"*[15] serves to illustrate this point. I was

[15] https://www.abc.net.au/news/2023-10-24/questionable-business-practices-in-podiatry-revealed-730/103009694

involved in that program where we uncovered a number of questionable practices. The work we undertook was comprehensive, aligning with the gold standard approach to medical fraud investigations (see **Annexure C** for details of the gold standard). Most importantly, the clinical and billing records alone only tell part of the story and if we had relied solely on those records, we would not have uncovered what we did. This is because the billing records appeared correct. While there were high volumes of some services, it was not impossible that all those services had been provided. It was only by digging deeper and obtaining copies of relevant referrals, and most importantly, having numerous detailed conversations with the patients, were we able to be certain that referrals were fake, face-to-face attendances were impossible (one patient lived in WA and the podiatrist was based in NSW) and the patients confirmed that most services had not been provided at all.

40. The above example demonstrates why desktop analysis like that undertaken recently by Deloitte[16] is never sufficient to uncover fraud, and the implausibly low estimates coming from such reports do little more than embolden criminals.

41. Mere mention of the term "medical fraud" evokes an emotive response. It is an area where unconscious bias is common, and euphemisms are frequently used to describe criminal behaviour. Common euphemisms are: overservicing, overcharging, inappropriate practice, rorting, and unsatisfactory professional conduct. Fraud is a criminal offence involving obtaining a financial benefit by deception. The reality is that much of what we, in Australia, describe using euphemisms, is fraud. The former Director of the Professional Services Review Agency (the Medicare watchdog) has confirmed this when she said:

> *"Then there are doctors who are billing for patients who are not physically present, or services not physically performed. Really, it's fraud, but it's very difficult. Sometimes we speak to the police and the Department of Health*

[16] https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/independent-review-into-medicare-compliance

about whether we make these criminal investigations or just administrative. But the current line has been a large majority of the cases has stayed with the PSR for administrative inappropriate practice."[17]

42. A good example demonstrating how deep we have descended into the normalisation of fraud is found in an article from Sydney University which was published in April 2023.[18] The article described 29.6% of GPs dishonestly billing Medicare for longer services than those they provided "at least once". The correct legal description of this conduct is fraud, but the authors euphemistically called it overcharging. The authors then proceeded to argue that dishonestly stealing from the government was acceptable for GPs, because by not being dishonest other times, they provided a net benefit to the community. The arguments were as outrageous as they were breathtakingly ignorant of the law. It is not open under Australian law to argue for example, that 30% of people speed, but because those same people drive under the speed limit other times, they provide a net benefit to road users and shouldn't get speeding tickets. We cannot argue that we *mostly* don't steal to avoid going to jail. When a GP (or any Medicare provider) is found guilty of billing for services longer than those provided, the law requires they repay the full amount. There is no ability to put forward reckless arguments like those proffered by the Sydney University authors and do a net benefit calculation to reduce the amount they repay, nor should there be. Such arguments undermine the rule of law by suggesting doctors (in this case GPs) are above it. But not only were these arguments published, they were celebrated.

43. The trivialisation of fraud was again on display in an article by the Sydney Morning Herald in December 2022. The SMH wrote: *"GPs are sharing tactics for maximising Medicare billing on doctors-only Facebook groups, including sharing a list of so-called "little frauds" and techniques for "packing and stacking" their billing so*

[17] Siobhan Calafiore. Doctors are better off with the PSR than the police: watchdog director. Australian Doctor News. 9 June 2022.
[18] Under or Over? GP charging of Medicare. https://www1.racgp.org.au/ajgp/2023/april/general-practitioner-charging-of-medicare

multiple services are billed from single patient attendances. Medicare billing "cheat sheets", tips on avoiding audits and raising gap fees without patients noticing."[19]

44. In NSW public hospitals the most common types of fraud I have witnessed are billing for fictitious services, creating fake referrals and up-coding (where a more complex or longer MBS service is billed). Below are some examples of conduct I have directly observed from Synapse projects:

    a. A NSW public hospital OP department had (an likely still has) a modus operandi whereby they bill for longer and more complex services than those provided for *every* patient. Also, if a patient doesn't have a referral (which is common), they insert fake referral information into the Medicare online system before transmission. For reasons already explained this is impossible to detect at the other end because everything looks correct. At this site, Synapse formed the view that approximately 90% of the MBS claims submitted were fraudulent.

    b. In another NSW public hospital, Synapse uncovered an entrenched practice whereby all of the day admissions were illegally bulk billed to Medicare because the MPs said they thought the patients were OP and could therefore be bulk billed. These patients were public patients admitted to NSW public hospitals at the relevant point in time, making it illegal to bill them to Medicare. It should be noted that when I explained that this was not permitted the MPs were horrified. They had been doing it for years.

    c. I have also directly observed NSW public hospital OP departments billing to Medicare for patients who didn't turn up for their appointment.

    d. All the above 3 fraud types remain invisible.

[19] https://www.smh.com.au/politics/federal/little-frauds-debated-on-doctors-only-facebook-groups-20221111-p5bxku.html

45. In addition to the MBS billing, the most common ways in which I am aware ABF is abused are as follows:

    a. Up-coding - This is the practice of allocating an ICD/ACHI code for a more complex treatment than provided. For example, clinical coders interpret the Australian Coding Standards (**ACS**) differently. I have witnessed a coder incorrectly coding from nursing records outside of the nurse's scope of practice – this breaches the ACS, but generates more activity and therefore more revenue for the hospital. Another example that leads to up-coding is to increase comorbidities as follows.

    b. Increase comorbidities – This is the practice of documenting fake diagnoses. For example, a patient is given steroids to treat condition A and that causes their blood sugar to go up enabling a diagnosis of diabetes to be documented, which the patient doesn't really have. Another example is a patient becoming a bit dehydrated causing their creatinine level to rise, which enables a diagnosis of acute kidney injury. The more comorbidities the more activity, and the more revenue.

    c. Type changing – This is the practice of bouncing the patient around care types to keep them longer. For example, every time a patient becomes a little unwell in a sub-acute setting, they are type changed to be 'acute' again, but they are really not acute and are continuing their sub-acute care. This enables the patient to stay in the hospital longer generating more activity and revenue.

46. I offer the following short video featuring one of the world's leading experts in healthcare fraud, Professor Malcolm Sparrow from the John F Kennedy School of Government at Harvard University. It may assist the inquiry to better understand the nature of healthcare fraud which is characterised by high volumes of low value crimes, many of which appear to be perfectly normal and correct:

https://scholar.harvard.edu/msparrow/files/fox_business-healthcare_fraud-8-18-2009-edited.wmv.

47. Following from the above video I advise that I now have a decade of experience administering the U.S medical bills Professor Sparrow is referring to and can confirm that the risks and frauds I see in both the Australian MBS system and the U.S billing system are basically the same, because of our common fee-for-service payment structure. However, the U.S manages fraud better than we do, so, whatever the U.S fraud figure is, ours is higher.

48. The truth is that nobody has ever conducted a statistically valid measurement of the rates of fraud, abuse, waste, error, and overpayments within the Australian Medicare program, and it is time for us to move beyond the battle of competing but inevitably rough estimates. Instead, we need to measure the scale of the problem in a reliable and systematic way. We know how to do that—using rigorous audits of random samples and asking patients what happened at their medical appointments—but there has never been the political will to conduct such measurements and reveal the true scope of the issue. Only when unambiguous facts about loss rates are put on the table can the debate progress beyond the ultimately pointless "who's estimate is better" and of course the persistent attempts by vested interests to pretend "this is not really serious". We need urgently to move on to "what to do about it". Because when no-one knows how much is being lost, no-one knows how much to spend on tackling the problem, nor how aggressive an approach to take in protecting public funds.

Solutions:

a) This is a difficult problem to solve and is another that requires extensive cooperation from the commonwealth. However, NSW could consider establishing an independent health payment integrity institute (**HPII**), loosely modelled on the U.S Centres for Medicare and Medicaid integrity institute

(**MII**).[20] Like the U.S model, the work of the HPII would involve law enforcement, fraud control and policing and as such, would ideally be positioned within the NSW Attorney General's portfolio.

b) The stated mission of the U.S MII is as follows:

> *"The mission of the Medicaid Integrity Institute (MII) is to provide effective training tailored to meet the ongoing needs of state Medicaid employees responsible for protecting the integrity of the Medicaid program, with the goal of raising national program integrity performance standards and professionalism, at no cost to states. By embracing and utilizing sound learning methodology and instructional design, coupled with progressive technology, the MII endeavors to provide outstanding professional education to states. The MII curriculum includes various aspects of Medicaid program integrity, including fraud investigations, data mining and analysis, provider enrollment, managed care oversight, emerging trends, and case development."*

c) Suggested responsibilities for a potential NSW HPII might be:

I. Education and training of law enforcement officers on fraud control, MBS and ABF data mining and analysis, emerging trends, and case management.

II. Educating consumers about their rights when attending public hospitals.

III. Fostering initiatives to change the language of this discourse from euphemisms to calling out fraud correctly.

IV. Trialling systems where consumers can benefit financially from blowing the whistle, in certain, clearly defined circumstances.

V. Introducing and maintaining a watch website where consumers can anonymously report fraud and see it counted on the website.

[20] Medicaid Integrity Institute: https://www.cms.gov/medicaid-chip/medicare-coordination/integrity-institute

VI. Making policy recommendations around pre-payment controls and plugging regulatory gaps that prevent effective prosecution.

The massive national knowledge deficit

49. In the quantitative phase of my doctoral studies, I conducted a survey of all organisations who had any involvement in teaching MPs about medical billing, from their first day as medical students to the end of their careers. The study was published in the BMJ Open.[21] In essence, I asked four questions:

a) Do you teach medical billing?
b) Have you ever taught medical billing?
c) Do you think medical billing should be taught?
d) If you think medical billing should be taught, who do you think should teach it?

The results were basically that no-one teaches it, everyone thinks it should be taught, and everyone thinks it is someone else's job to teach it.

50. In the subsequent qualitative phase of my PhD, I interviewed two groups of MPs about their knowledge of medical billing. One group was salaried medical officers working in NSW public hospitals. Most of these MP were very senior, including department heads. The study was published in PLOS ONE.[22] Below are sample quotes from the MP concerning billing under ROPPs in NSW public hospital OP departments.

> *"Um trial and error, there was no formal introduction, no formal training as you go through… there was no mention of billing…so you navigate it by the skin of your teeth."*

[21] Who teaches medical billing? https://bmjopen.bmj.com/content/8/7/e020712
[22] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0262211

"I had no idea how Medicare kind of worked …no one taught me how to bill…I had no idea what it meant to Medicare bill, what gaps were, what scheduled fee was, all the different rates of things were, so it made no sense…there is absolutely no training."

"…when you are a Registrar and when you finish you then realise, oh, there is Medicare. Now what have I been taught about Medicare? Essentially nothing…you realise you are supposed to bill, but still have no inkling how to do it."

"[billing in the public hospital is] *a minefield. My understanding is that for outpatient services in a privatised clinic like this it's quite within our rights to charge a gap,"* though when quizzed about the source of that information he said, *"Look I do not know the precise details of that; this is just something I have been told."*

"I just feel dumb at these things, I need someone to explain it really in very basic terms to me. The area of private practice billing [in public hospitals] *really baffles me."*

"…billing under my name in the public hospital in the outpatient department…I cannot see. I could not tell you if anyone did it fraudulently or inappropriately."

"…I trust my colleagues but at the end of the day I have no idea."

"I have no control over claiming so I feel very uneasy with the whole process."

51. It is not just MP who do not understand medical billing and the operation of Australia's broader health financing arrangements. It is a system of such

complexity that it is presently beyond the full comprehension of anyone. Some examples of poor legal literacy follow:

a. IHACPA (formerly IHPA) has implemented rules that directly conflict with and cannot coexist with laws under the HIA.[23]

b. I have observed clinical coders making changes to MBS claims for private patients in NSW public hospitals exposing the MP to fraud (the coder thought they knew better than the MP what service had been provided).

c. I have been on a DOHAC (formerly DOH) training webinar for MP where the department provided incorrect legal advice about certain MBS billing to the MP participants on the call. The incorrect legal advice would have applied to private patients in NSW public hospitals under private health insurance (**PHI**) gapcover schemes. It was later retracted after I complained and reported it.

d. I have many examples of the DOHAC @askMBS service providing incorrect legal advice to MP. I also have examples where two MP have submitted the same question to @askMBS and received two entirely different and conflicting answers.

e. GPs mistakenly believe that bulk billing in public hospital OP departments is illegal.

f. Some NSW public hospitals force patients to attend a GP that they cannot afford to obtain a named referral as a condition of attending a public hospital OP department. Anecdotally, patients attending NSW public hospital OP departments ask MPs to load them up with scripts for regular

[23] https://www.audit.vic.gov.au/report/managing-private-medical-practice-public-hospitals

medications while they are there so they don't have to go back to their GP when their scripts run out – because they can't afford the GP visits.

g. The many payment systems we have (the NDIS, Medicare, the PHIs, the department of veteran's affairs, workers compensation and compulsory third-party insurers) are all used or are relevant in NSW public hospitals. These systems overlap and intersect such that it has become very easy to bill the same service to multiple payers. I have seen evidence of triple dipping where the same service has been billed simultaneously through the MBS, the PHI, and a patient payment.

h. I have also seen many examples where incorrect legal and accounting advice about MBS billing has landed MP in serious trouble, including in the context of a private entity co-located on the grounds of a NSW public hospital.

52. A person wishing to study health insurance, or health financing law and practice, is currently unable to do so anywhere in the world. While the discipline of health economics deals with the architecture of health financing arrangements, currently lacking are any experts with specific skills and training on how to implement the objectives and design put forward by health economists and other health policy professionals, using law. It is a new area of legal scholarship already recognised by the WHO.[24]

Solutions:

53. The evidence suggests we do not teach MP the operation of the health system before they are required to work within it. In fact, there is no education available to anyone on the complex operation of Australia's health system and the granular

[24] https://www.who.int/health-topics/health-law#tab=tab_1

details of our health financing arrangements. Education is therefore a vital component of ensuring a sustainable health system for NSW into the future.

54. I offer a suggested education framework from my PhD, which aligns with current evidence. The key point to note is that this is legal education *not* clinical education and, as such, it needs to be positioned within university law schools and made available across faculties to reach a wide audience beyond MP. See **Annexure C.**

Thank you again for giving me the opportunity to make this submission. I would be happy to offer any further assistance to the inquiry as required.

Dated 13 December 2023

Dr Margaret Faux

Annexure A[25]

Recommendation 9 – Reform referral law

Rationale

The difference in referral provisions between the NHRA and HIA (discussed throughout this thesis) is a significant contributor to non-compliant billing in public hospital OPD. Even though GP will commonly name specialists on the referral letters they write, relevant provisions of the HIA have always been ambiguous as to whether this is a legal requirement. As a result, sometimes GP write referrals to a clinic rather than a named specialist. Some examples are:

1. A public hospital outpatient referral letter may commence with the words 'Dear Fracture Clinic' or 'Dear Gastroenterologist'.
2. A referral letter from a public hospital to a small private hospital that only provides rehabilitation services may commence with 'Dear Rehabilitation Private Hospital'.
3. A referral written on the template referral pad of a private clinic, which has the names of all the specialists working in the clinic on the template, may commence with 'Dear Oncologist', and when presented, someone (often an administrator) will circle the name of one of the oncologists on the template, who will take up that referral, and
4. It is also common for names to be crossed out on referrals and new names substituted.

Compliant billing in public hospital OPD can never be achieved until referral provisions are consistent between the NHRA and HIA. However, the potential downstream consequences of changes to referral laws are considerable. Therefore, changes should be carefully implemented to protect MP, uphold good clinical practice, ensure GP remain the centre of care coordination and provide consumers with ultimate control of the process. Further research looking at potential options for reform in this area would be appropriate. But to protect medical practitioners from further confusion and unintentional errors, a single, clear

[25] Faux, M, Ibid at 363

law applicable across the entire medical billing landscape must be found. One option is as follows:

1. That all referrals name the specialist the patient is being referred to, with penalties introduced for providing or accepting an unnamed (and therefore invalid) referral.
2. That a specialist of the same specialty should be able to take over a referral, but only in certain clearly defined circumstances.
3. Relevant provisions of the NHRA be redrafted to align with the revised provisions of the HIA (recommendation 10), and
4. A system of fines be trialled for un-named referrals, including qui tam penalties.

Implementation

Amend section 20BA of the HIA as follows:

20BA Confirmation of referral to a consultant physician or specialist

(1) If:

(a) a person refers a patient, in writing, to a named consultant physician or a specialist; and

(b) the named physician or specialist receives the referral; and

(c) the named physician or specialist renders a specialist medical service to the patient as a consequence of the referral;

the named physician or specialist must:

(d) retain the referral for the period of 2 years beginning on the day on which the service was rendered to the patient; and

(e) produce the referral, if asked to do so by the Chief Executive Medicare, to a medical practitioner who is a Departmental employee (within the meaning of the Human Services (Medicare) Act 1973) within 7 days after receiving the request; and

(f) not substitute him or herself as the named physician or specialist the patient has been referred to unless:

(i) the named physician or specialist is unable to render specialist medical services to the patient as a consequence of the referral and the substitute physician or

specialist is of the same medical specialty as the physician or specialist named on the referral; or

(ii) a patient has presented the referral to a substitute physician or specialist who is of the same medical specialty as the physician or specialist named on the referral to avoid paying out of pocket medical expenses.

Amend Regulation 58 (2) as follows:

58 Services provided upon referral

(2) Subject to subsections (3) to (5), the following particulars are prescribed:

(a) the name of the referring practitioner;

(b) the address of the place of practice, or the provider number in respect of the place of practice, of the referring practitioner;

(c) the date on which the patient was referred by the referring practitioner to the consultant physician or specialist;

(d) the period of validity of the referral under section 102; and

(e) the name of the consultant physician or specialist the referring practitioner is referring the patient to.

Communicating changes to MP and patients

Communication material for consumers should be included on the repurposed medical cost website (recommendation 27), explaining to patients they can re-use a digital copy of a specialist referral to avoid paying OOP medical expenses, but not because they did not like the medical advice they received from the MP. It is important this provision does not inadvertently enable poor health choices or 'doctor shopping'. Patients should also be advised they do not need to return to their GP or pay an online telehealth service for a new referral.

Penalties for providing or accepting an invalid referral should be imposed on MP

Suggest a trial of a five-penalty unit strict liability offence, actively enforced by DOH and communicated clearly to MP and consumers, who should be encouraged to call the existing DOH tip-off phone number to report and provide photographic evidence of a breach such as:

- a photo of a referral from a GP lacking the name of the specialist, or

- a photo of an unnamed referral in a patient's file at a public hospital or private specialist clinic after benefits for referred Medicare services have been claimed.

Swift and decisive issuing of fines must follow, similar to existing processes for speeding and parking fines, where the fine is automatically issued based on photographic evidence.

Penalties for breaches of the substitution provisions should be imposed on MP

Suggest a trial of a 10-penalty unit strict liability qui tam offence with 20% of the recovery benefitting the whistle-blower. The most likely whistle-blower under this provision would be a specialist who has had a referral taken by a colleague; the incentive to report would therefore be strong. This provision must also be actively enforced by DOH and communicated clearly to MP and consumers, who should be encouraged to call the existing DOH tip-off phone number to report and provide photographic evidence of the breach. Swift and decisive issuing of fines must again follow.

Penalties for patient breaches of substitution provisions

It is suggested DOH monitors patient claiming on the back end of the Electronic Claim Lodgement and Information Processing Service Environment (ECLIPSE) system initially, with a view to managing any 'doctor-shopping' behaviour by rejecting claims for reimbursement, rather than issuing fines.

Recommendation 10 – Prevent duplicate billing in public hospital OPD

Rationale

Irreconcilable provisions at the interface of the NHRA, HIA, enterprise, ROPP and other agreements suggests a decision must be made concerning which of ABF or Commonwealth MBS funding should continue in public hospital OPD. The two cannot continue to coexist. While ABF funding for admitted services has been effective, tier 2 clinics have had less success, evidenced by the previously discussed ANAO estimate of over $300 million in duplicated payments. It is therefore suggested serious consideration be given to abandoning tier 2 arrangements altogether and replacing them with the MBS/SNOMED-CT combination proposed elsewhere in this study. This would create a single, unified national approach to all

non-admitted care, irrespective of the specific setting. The alternative is to remove MBS funding, however the impact on public hospitals if that were removed would likely be catastrophic, because many public hospital OPD are heavily reliant on contracted MP. Clarity around the charging of gaps to public patients is also required.

Implementation

The HIA

A simple but important change to the HIA is required. Current use of the word 'in' in section 128C suggests applicability to admitted patients only, rather than also encompassing outpatients.

Amend Section 128C of the HIA as follows:

128C Charging of fees for provision of public hospital services to public patients

(1) A person mentioned in subsection (2) must not, in circumstances set out in the regulations:

- (a) charge a fee for the provision of a public hospital service; or
- (b) receive any payment or other consideration from anyone in respect of the provision of a public hospital service;

if the person knows that the person to whom the service is, or is to be, provided is, or intends to be, a public patient at the hospital.

Given MP are not signatories to the NHRA, the amended section 128C will provide a prosecution option for the Federal Government directly with MP rather than through provisions of the NHRA. This would address the charging of unlawful gaps in both inpatient and outpatient settings in public hospitals, and it is suggested a 20-penalty unit strict liability qui tam offence be introduced as the relevant penalty, which would be vigorously pursued by the DOH.

The NHRA

On the basis tier 2 funding is discontinued as suggested, numerous provisions of the NHRA will require subsequent amendment. It is also important that the language of the NHRA is

aligned with consumer understanding. Consumers currently do not understand how they can elect to be a 'private' patient when receiving services in a public hospital OPD if they do not have PHI. The terminology is therefore important and should be revised to the term 'bulk bill', which all Australians understand. It is also suggested that the purpose and definition of ROPPs be reviewed, because if all MP (including MP who are *not* employees) are permitted to claim Medicare benefits and bill private patients in public hospitals outpatient departments, as is the case in NSW, then it is unclear what purpose the ROPP title actually serves. Potential changes are as follows:

G16. Where care is directly related to an episode of admitted patient care and is part of a single course of treatment, it should be provided as a bulk billed service with no out of pocket expenses charged to the patient, regardless of whether it is provided at the hospital, or in private rooms.

G17. Services provided to public patients should not generate charges against the Commonwealth MBS:

a. except where there is a third-party payment arrangement with the hospital or the State, emergency department patients cannot be referred to an outpatient department to receive services from a medical specialist; or ~~exercising a right of private practice under the terms of employment or a contract with a hospital which provides public hospital services;~~

b. ~~referral pathways must not be controlled so as to deny access to free public hospital services;~~ except where a public patient has been advised to return to the outpatient department of a public hospital for follow up care after discharge, without first returning to their general practitioner (GP), however the only services permitted to be bulk billed to the Commonwealth MBS in the absence of a GP referral are the unreferred services in the range of items 52-57.

NB: Proposed clause G17(b) will overcome the current problem of some referrals not being provided at arm's length, and will incentivise hospital MP to return patients to the GP post-discharge, but will also retain a modest funding source of lower-paying Medicare items (in the absence of tier 2) when returning a patient to their GP is neither practical nor possible.

Medicare can easily implement policing of this clause by rejecting all claims for referred specialist services linked to MP public hospital provider numbers if no GP referral is recorded on the claim.

G19. Subject to G17, an eligible patient presenting at a public hospital outpatient department will be treated free of charge as a public patient unless:

a. there is a third party payment arrangement with the hospital or the State or Territory to pay for such services; or
b. the patient has been referred to a named medical specialist by a general practitioner ~~exercising a right of private practice~~ and the patient agrees to be bulk billed ~~treated as a private patient~~. For the avoidance of doubt, subject to the provisions of G22, general practitioners, nurse practitioners and allied health professionals are not permitted to bulk bill or charge fees to patients anywhere on the street address of a public hospital under any circumstances.

G19A. A patient who has agreed to be bulk billed in a public hospital outpatient department shall not be charged out of pocket medical expenses under any circumstances.

Separately: The DOH should revoke MBS claiming rights (retaining the ability to request and refer) on all GP, nurse practitioner and allied health provider numbers linked to the street address of every public hospital not being subject to a section 19(2) exemption.

Ensure public and private patients receive the same treatment for non-admitted care

The fastest and most effective way to eliminate some of the high-cost duplicate payments in public hospital OPD is to remove the 85% rebate for all procedures for which patients would be admitted if they had PHI. Many items in the Medicare scheme attract a 75% rebate only, recognising it may be unsafe to provide some procedures in an outpatient setting. For example, many of the neurosurgical services, including some minor procedures, attract an inpatient benefit only, such as the below example:

"39600

Group T8 - Surgical Operations – Subgroup - 7 – Neurosurgical Subheading - 5 - Cranio-Cerebral Injuries

INTRACRANIAL HAEMORRHAGE, burr-hole craniotomy for - including burr-holes

Fee: $488.45 Benefit: 75% = $366.35"

By removing Medicare outpatient (85%) rebates from common procedures performed in public hospital OPD, such as cardiac angiography and stenting, endoscopies and colonoscopies, all patients will thereafter be admitted for these procedures because the sole source of revenue will be ABF. The common colonoscopy item described below is one example:

"32226

Group T8 - Surgical Operations – Subgroup - 2 - Colorectal

Endoscopic examination of the colon to the caecum by colonoscopy, for a patient with a high risk of colorectal cancer due to:

(a) a known or suspected familial condition, such as familial adenomatous polyposis, Lynch syndrome or serrated polyposis syndrome; or

(b) a genetic mutation associated with hereditary colorectal cancer

Applicable only once in any 12 month period

Fee: $344.80 Benefit: 75% = $258.60 ~~*85% = $293.10"*~~

NB: It is not recommended that cancer services have the 85% rebate removed, because this would likely incentivise unnecessary admissions for patients receiving chemotherapy, similar to that described in chapter 7 around the introduction of item 13950. This recommendation should therefore be carefully restricted and applied only to procedures that cannot ever be safely performed outside an operating theatre or angiography suite.

Annexure B[26]

8.3 Educational reform

Curriculum development can begin while regulatory reform is in progress, but delivery of educational content can only begin once a cohesive regulatory framework is in place.

Recommendation 20 – Health financing law and practice curriculum development

A single university health/law faculty should take ownership of curriculum development and examinations (including the MP test), possibly following a competitive bidding process. The new discipline of Health Financing Law and Practice (HFLP) is suited to a graduate program, and will also require a simpler Certificate IV qualification for third-party billers, who will become Registered Medical Billing Agents (RMBA; similar to Registered Tax and BAS Agents). Graduates of these programs will achieve legitimacy as 'experts' in Medicare billing and health financing law following successful completion of a rigorous course of study and will be certified under a professional scheme. It is recommended that the first individuals for whom the graduate program should be mandatorily required is government employees working in the Medicare Benefits Division of the DOH. Specific subjects within the graduate program should also be made available as electives for medical students. In addition to graduate program students completing the following core legal subjects - *The Australian Legal System*, *Contract Law* (with a heavy emphasis on *Insurance Contracts*) and *Administrative Law*, suggested program inclusions are:

Graduate program in health financing law and practice

- Detailed analysis of all relevant statutes, regulations, agreements and policies in **Figure 5**;
- introduction to health economics;
- introduction to international clinical code systems including ICD, CPT, ACHI, SNOMED-CT and Logical Observation Identifiers Names and Codes;

[26] Ibid at 381

- introduction to health informatics and health data governance;
- comparative health systems;
- medical billing ethics; and
- the law of informed financial consent.

Certificate IV in health financing law and practice

- Overview of all relevant Statutes, Regulations, Agreements and Policies in **Figure 5**;
- medical billing ethics;
- informed financial consent;
- medical billing from the provider perspective; and
- regulation of RMBA.

Biennial online MP Medicare billing test administered by DOH

This test should be equivalent to a learner driver test, including both generic and specialty-specific questions. The test *must* be exclusively written by the law faculty owner, to ensure questions link directly to new summary offences which will be codified in the HIA.

Recommendation 21 – Commence biennial Medicare billing test for medical practitioners

Rationale

Drawing from the findings in this thesis, MP desire education on medical billing, but not too much. With trained experts around them (**Figure 19**), in time, better control of compliance will be achieved. However, MP will always retain primary legal responsibility for the bills they submit, and should therefore be required to undertake a basic learner driver-level test biennially, linked not only to the renewal of their provider numbers, but to new summary offences and fines.

Implementation

As soon as the law faculty owner has finalised the MP test it should be made available online exclusively via the DOH website (noting it is in the interest of DOH to administer this program because the DOH issues and maintains provider numbers). Cancellation of MP provider

numbers should be attached to the six-digit provider number stem rather than the eight-digit location-specific numbers, to ensure all of the MP's provider numbers are cancelled at the same time. The first provider number stems should begin to expire within 18 months. Once an initial cohort of MP have successfully completed the online test, DOH should commence monitoring their compliance with the written rulings and begin issuing fines.

Recommendation 22 – Link rebate increases and MDO premiums to certified billers

Rationale

All participants in this study intended to continue using third parties to administer their medical billing. Much of the future compliance onus will therefore fall to these new professionals who will hold a minimum Certificate IV qualification, and who will be answerable to their own professional organisation (described in recommendation 23).

Implementation

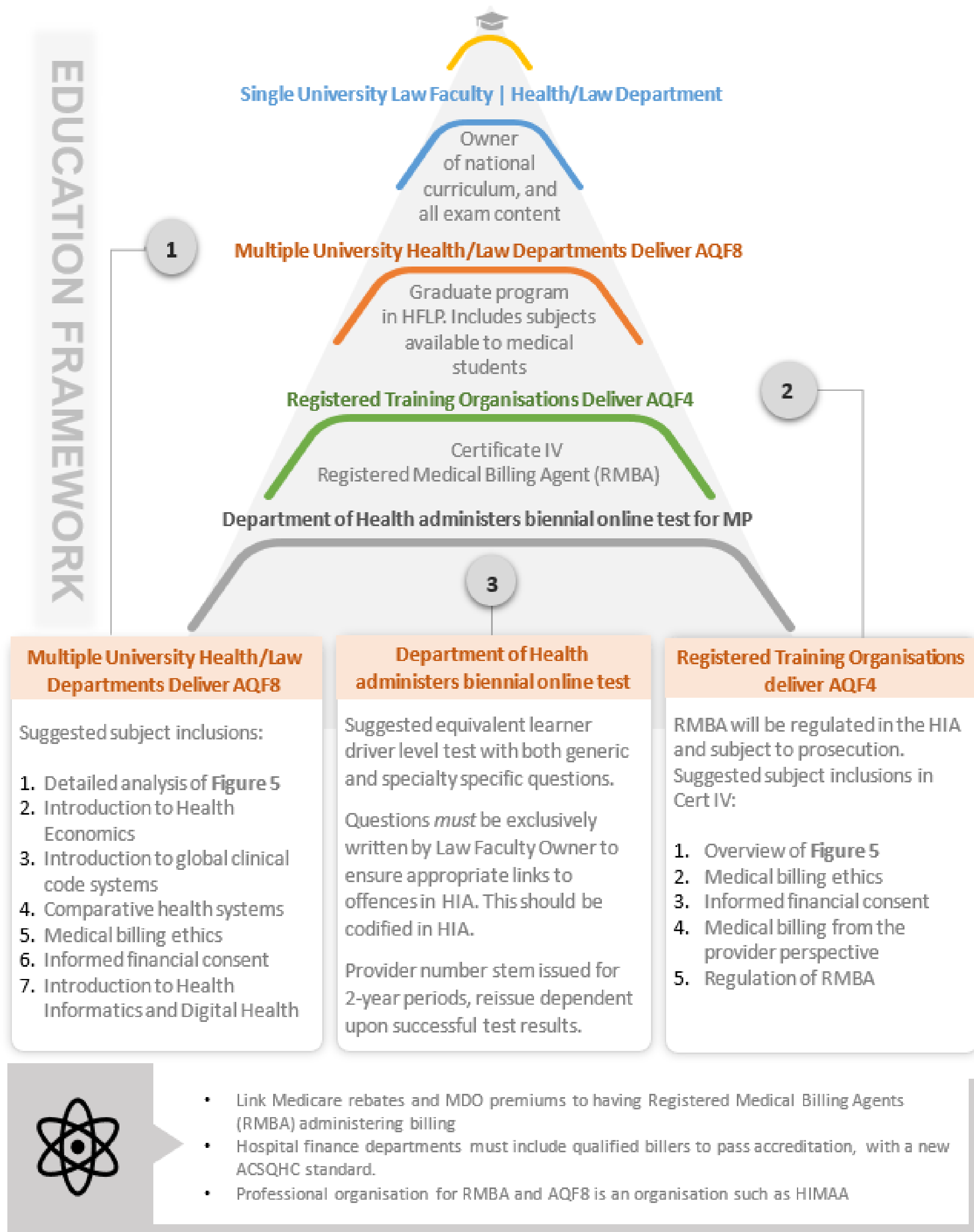
By mid-2024, commence linking annual Medicare rebate increases to MP who can demonstrate that approved RMBA administer *all* of their billing. In addition, it is suggested the MDO should consider increasing annual medical indemnity premiums for MP who do not use RMBA to administer their medical billing or decrease premiums for those who do.

Recommendation 23 – Establish a professional organisation for certified billers

A plethora of fragmented professional organisations exist within the health sector. As such, positioning RMBA within an existing organisation rather than creating a new one appears most appropriate. An organisation such as the Health Information Management Association of Australia (HIMAA), which is the current professional organisation for clinical coders seems well suited to this purpose. However, for this to occur, HIMAA would need to develop a separate professional stream for the new discipline, within a robust framework, which would need a new code of ethics for billers.

A diagrammatic representation of this entire education framework is set out in **Figure 19.**

Figure 1 - Education framework



Annexure C

The Gold Standard approach to Healthcare Fraud Investigations

The gold standard methodology for investigating healthcare fraud is set out by one of the world's leading experts in this area, Professor Malcolm Sparrow from the John F. Kennedy School of Government at Harvard, in his book *License to Steal: How Fraud Bleeds America's Health Care System*.[27]

Professor Sparrow describes a typical, inadequate medical claims audit, which involves capturing statistical outliers, then requesting medical records, then further correspondence with the provider. This mirrors the current approach in Australia.

By contrast, the below gold standard approach is much more comprehensive.

"A fraud audit should include at least the following four types of inquiry, preferably conducted in the order shown here, and rather soon after the date of the claimed services so that patients have a reasonably good chance of recalling the details of the encounter.

*1. **Claims examination**, focusing on all the normal issues of medical orthodoxy, policy coverage and price. Also focusing on anything else unusual or suspicious, for example, signs of deception and patterns reflective of scams known through intelligence reports.*

*2. **Contextual data analysis**, examining the claim within its broader data context. In particular, examining,*

- *The provider's aggregate billing behaviours and billing profile*
- *The patient's aggregate treatment patterns and profile*
- *Duplicate, similar, or related claims o Referral patterns, coincidences, clusters, or structures in surrounding billings*
- *Business relationships between providers and referring physicians, ownership arrangements, potential kickbacks, etc.*

*3. **Patient interview**, preferably in person, otherwise by telephone. To verify the relationship with the provider, the diagnosis, and the treatment provided. May require contact with relatives in some instances.*

4. Then, if the steps above indicate grounds for suspicion, an unannounced visit to the provider by investigators, to examine the medical and billing records. If the above three steps indicate nothing abnormal, then less intrusive record review techniques can be applied at this stage."

[27] Malcolm K Sparrow, License to Steal: How Fraud Bleeds America's Health Care System Westview Press, Updated Ed, 2000, p157