Consultation 4: Applying greater rigour to certification for hospital admission

Bupa Submission

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Context

To meet government's desire to keep health insurance sustainable and affordable for all Australians, it is essential that Private Health Insurers ("PHIs") can ensure the integrity of the benefits we are paying for health services on behalf of our customers.

Currently, the way in which compulsory payments from PHIs are triggered under the *Private Health Insurance (Benefit Requirements) Rules 2011* (the Rules) for hospital treatment is encouraging low value care, impeding expansion of services in out of hospital settings, and inviting wasteful and potentially fraudulent claims, all of which have an inflationary impact on premiums.

There are a small number of providers who routinely admit patients for services that do not, under any reasonable assessment of the services to be delivered, require an inpatient admission and, in fact, are identical to services received by non-admitted patients treated by other providers. In-patient art therapy for psychiatric patients and in-patient physiotherapy for cancer patients are two examples of which Bupa is aware.

Providers of such services appear to have built business models that exploit Type C certificates in an unusual and improper manner. While the volume of such cases is currently small, improved accountability is essential to ensure they do not proliferate or extend into the normal billing practices of other providers.

Problem definition

The categorisation of MBS items into Type A, Type C and Type B was introduced to define the specific services that do normally require hospitalisation and those that do not, with an allowance for exceptions on a case by case basis through the certification process. Our system of healthcare delivery is a combination of both inpatient and non-inpatient service delivery. The difference between these is not that there are some services delivered within a hospital precinct and others that are not. Hospitals have delivered outpatient and non-inpatient care for decades. Further, in the delivery of non-inpatient and outpatient care there is a diversity of locations and facilities that are not all the same.

Type C and Type B certification recognises that for some patients, due to their individual circumstances, there is a requirement for technology, facility or multidisciplinary care, that cannot be reasonably or safely delivered other than in an inpatient setting and, for Type B, as an overnight admission.

Since the introduction of *PHI Circular 37/17, 17 July 2017, Clarification of roles in the certification process* ("Circular 37/17") was introduced, the determination of suitability has shifted from a logical clinical justification to a simple clinician attestation that does not actually necessitate consideration of whether the requirements for technology, facility or multidisciplinary care to an individual patient's circumstances have been met.

Incorrect information and insufficient detail being provided by hospitals and medical practitioners to insurers occurs in two main areas:

1. What are the unique clinical circumstances that require a particular patient to be admitted in order to receive the intervention or procedure on that particular occasion?
2. How is the care provided to the admitted patient during the intervention or procedure differentiated from that which would normally be provided to a non-admitted patient receiving the same intervention or procedure?

In some cases, this is due to confusion and lack of awareness of certification requirements. In other cases, it could be argued that the current requirements allow improper and fraudulent activity.

A sense of the impact Circular 37/17 has had on invalidly claimed Type C services is demonstrated in the table below comparing the amounts Bupa recovered from Type C claims in 2016, prior to Circular 37/17, with those we recovered from Type C claims after Circular 37/17 in 2019.

Amounts recovered from Type C claims in 2016 (prior to Circular 37/17)	Amounts recovered from Type C claims in 2019 (post Circular 37/17)
$12,396 in PICC flushes incorrectly billed	$28,831 in PICC flushes incorrectly billed
$25,763 in Type C incorrectly billed	$2,789 in Type C incorrectly billed
$486,666 in subcutaneous injections	$687,568 in subcut injections (would include some intramuscular injections too)
$7899 in intramuscular injections	$289,230 in Trial of Void
	$21,744 in voluntary refunds from hospitals
Total $532,724	**Total $1,030,162**

The total amount recovered from invalidly claimed Type C services in 2019 is more than double the total amount recovered in 2016. This suggests that Circular 37/17 has resulted in significantly increasing overbilling and invalid claim activity. Further, we believe there were significantly more invalidly claimed Type C services than what we recovered which reinforces the magnitude of this issue.

Circular 37/17 does not provide for any clinical assessment by insurers of the medical conditions/special circumstances certified, nor does it require documentary validation by the provider, as part of checking the validity of the certification and ensuring it meets the requirements of the Rules. This results in insurers being obliged to pay for claims, even where they believe in good faith that the certification provided is improper or fraudulent. Our preferred approach outlined below addresses this directly.

Our preferred approach

Affordability and sustainability of private health insurance requires the Benefit Rules promote the right care in the right setting and do not incentivise low value care through over servicing and unnecessary hospital admissions. It is appropriate that insurers, as payors on behalf of their customers/members, can undertake clinical assessment and verification of the medical conditions or special clinical circumstances that mean a hospital admission is required for that member on that occasion.

For clarity, we are not suggesting insurers should have the ability to question the appropriateness of the care directed by a clinician, only that insurers should have the ability to ensure additional costs being passed onto members are justified by the provision of extra services or care needed because of the individual's special circumstances.

The only way for this matter to be effectively addressed is to rescind Circular 37/17 and reinstate the principle that exceptions – certified through Type B and Type C – must be justified appropriately.

A more appropriate circular would be assisted by amendments to the *Private Health Insurance (Benefit Requirements) Rules 2011* ("Rules") that would introduce a requirement for a medical practitioner appointed by the insurer to agree that having regard to:

a) the medical condition of the patient specified in the certificate; or

b) because of the special circumstances specified in the certificate

it would be contrary to accepted medical practice to provide the procedure to the patient unless the patient is admitted to hospital for a period that does (Type B), or does not (Type C) include part of an overnight stay. Despite the flaws in Circular 37/17, its operation would also be improved by these proposed amendments to the Rules.

This role for a medical practitioner appointed by the insurer would be similar to the role they perform in assessing and determining pre-existing conditions. Please see suggested amendments as an example in Appendix 1.

An independent clinical review mechanism, via a self-regulated industry panel or other body could also be incorporated where providers disagree with the assessment and decision of the medical practitioner appointed by the insurer.

Insurers would need to commit to assessment being undertaken with a strictly clinical rationale, as with pre-existing condition assessment, and on a case by case basis. However, the starting point is that a Type C procedure has been classified as such because an expert group has determined that in normal circumstances, the additional facilities and services to warrant inpatient care do not apply, so the procedure can be provided in a non-inpatient setting.

Response to proposed policy

Part one:

We do not believe the establishment of a self-regulated industry mediation panel to review and examine possible inappropriate certifications by medical practitioners can be effective at resolving disputes without better guidance and terms of reference than is currently provided by *Circular 37/17*. This must be rescinded with appropriate alternative guidance offered as a first priority.

Part two:

We agree that the development of guidelines is desirable, whether Circular 37/17 continues or is replaced with something more appropriate. We do not support the proposal that medical colleges undertake this work. Instead, we recommend it be undertaken by a small working group of clinical representatives from both payors and providers, with access to expert advice from the relevant professional bodies as needed, and from experts in payment structures between insurers and providers in both the public and private sectors.

Part three:

We agree that expanding the PSR's authority and functions to review alleged irregular practices associated with certification by both medical practitioners and associated hospitals who often have significant involvement in patient care decisions, may provide a deterrent and appropriate escalation and resolution point.

However, the timeframes and thresholds for PSR review, the standards of evidence and the familiarity of the PSR with funding models in private health care suggest that the PSR is not the ideal mediator and would become relevant only where there were clear cases of fraud or inappropriate care.

It may be possible for the PSR to establish a subsidiary body to deal with issues of contention relating to certification, but disputes over what comprises usual care or generally accepted care do not currently fit into the PSR's purview.

If PSR was to be given greater scope, we recommend timely responses and communication to insurers and other parties who refer cases, complaints or disputes to it, outlining for example:

- acceptance of the case, complaint or dispute for investigation
- the expected timeline of the investigation
- the findings and outcome of the investigation upon conclusion
- what action has been taken as a result, and what, if any penalty has been imposed on the medical provider or hospital.

TABLE 1: CONSULTATION QUESTIONS REFERENCE SUMMARY	
1. Should an industry mediation panel be established to resolve hospital certification disputes?	We do not believe the establishment of a self-regulated industry mediation panel to review and examine possible inappropriate certifications by medical practitioners can be effective at resolving disputes unless *Circular 37/17* is rescinded, and the principle that exceptions – certified through Type B and Type C – must be justified appropriately, is reinstated.
2. If an industry mediation panel is established, what process should be undertaken to establish it, including determining membership?	As per our response to question 1, we do not believe this would be the appropriate path. However, should the Government proceed with the establishment of such a body, it would need to represent payors as well as providers and have regard to the objective PHI's have to provide affordable and sustainable health insurance.
3. What parties should be involved in the development of advice on the appropriate criteria for certification?	Any such group should be small and include clinical representatives from both payors and providers, with access to expert advice from the relevant professional bodies as needed, and from experts in payment structures between insurers and providers in both the public and private sectors.
4. Should PSR, or another regulatory body, provide a regulated and enforceable process for reviewing Type C certification?	The timeframes and thresholds for PSR review, the standards of evidence and the familiarity or lack thereof of the PSR with funding models in private health care suggest that the PSR is not, the ideal mediator and would become relevant only where there were clear cases of fraud or inappropriate care. PSR would require additional expertise in order to undertake this function. It may be possible for PSR to establish a subsidiary body to deal with issues of contention relating to certification, but disputes over what comprises usual care or generally accepted care do not currently fit into the PSR's normal purview.
5. Should there be a specified list of 'special circumstances' allowable for Type C certificates?	The starting point is that a Type C procedure has been classified as such because an expert group has determined that in normal circumstances, the additional facilities and services to warrant inpatient care do not apply and the procedure can be provided in a non-inpatient setting. The special circumstances appropriate to exception of Type C certificates are a requirement for technology, facility or multidisciplinary care that, due to an individual patient's clinical circumstances, cannot be reasonably or safely delivered other than in the inpatient setting. Justification for such special circumstances should rest with the provider.
6. Should hospitals be potentially liable for Type C certificate statements, and if so, in what circumstances?	Yes. Hospitals should potentially be vicariously liable for improper or fraudulent Type C certificate statements where they have a relationship with the medical practitioner and may exercise involvement in patient care decisions; or where there is a pattern of regular or routine exploitation of Type C certificates.

7. What is the likely impact upon premiums of this proposal?	The proposal as it stands will have an inflationary impact as it does not effectively address the low value care and fraudulent activity that drives claims growth and consequently premiums. The alternative put forward by Bupa would address these issues more substantially.
8. What is the likely impact on the number of people and/or policies covered of this proposal?	The proposal as it stands will have an inflationary impact as it does not effectively address the low value care and fraudulent activity that drives claims growth and consequently premiums. Increasing premiums will drive further discontinuance.
9. What are appropriate metrics for measuring the impact of this proposal?	Volume of invalid Type C and Type B claims and recovery amounts. Volume of disputes.
10. What is the regulatory burden associated with this proposal?	The proposal as it stands has a high regulatory burden as industry will need to invest resources in establishing the self-regulated panel that will be ineffectual at resolving disputes or providing appropriate precedents. Circular 37/17 has resulted in significantly increased overbilling and invalid claim activity. Disputing invalid claims and recovering member funds is burdensome administration that can and should be addressed by rescinding Circular 37/17 and reinstating the principle that exceptions – certified through Type B and Type C – must be justified appropriately.
11. Are there any other reform options that should be considered?	The alternative put forward by Bupa would address these issues more substantially.

Appendix 1 – Type C suggested amendments to Benefit Requirement Rules

7. Certified Type C procedure

Note: Type C procedures are procedures that do not normally require hospital treatment.

(1) Benefits for day-only accommodation are payable for patients receiving a Type C procedure only if certification under subclause (2) is provided a medical practitioner appointed by the insurer agrees with the and certification provided under subclause (2), in accordance with subclauses (3) and (4).

(2) Certification must be provided as follows, the medical practitioner providing the professional service must certify in writing that:

(a) because of the medical condition of the patient specified in the certificate; or

(b) because of the special circumstances specified in the certificate,

it would be contrary to accepted medical practice to provide the procedure to the patient unless the patient is given hospital treatment at the hospital for a period that does not include part of an overnight stay.

(3) Following receipt of certification provided in subclause (2) a medical practitioner appointed by the insurer will form an opinion as to whether they agree that:

(a) because of the medical condition of the patient specified in the certificate; or

(b) because of the special circumstances specified in the certificate,

it would be contrary to accepted medical practice to provide the procedure to the patient unless the patient is given hospital treatment at the hospital for a period that does not include part of an overnight stay.

(4) In forming an opinion, in accordance with subclause (3), the medical practitioner appointed by the insurer will have regard to the certification provided in accordance with subclause (2) and any information provided by the medical practitioner providing the certification in subclause (2).