nib health funds limited
Head Office
22 Honeysuckle Drive
Newcastle NSW 2300
abn 83 000 124 381

t 13 14 63
f 02 4925 1900

e nib@nib.com.au
w nib.com.au

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Department of Health
Via email: phiconsultation@health.gov.au

nib's Response to Consultation 4: Applying Greater Rigour to Certification for Hospital Admission

nib health funds (nib) support reforms to provide clear guidance on the requirements for hospital admission certification. This will reduce potential disputes with hospitals and allow nib members greater certainty about their cover when booking planned admissions.

We also support a proposed self-regulated industry panel, clinical guidelines and clear escalation process covering disputes and material breaches of established guidelines.

In summary:

- The self-regulated body should be funded on a cost recovery model from the healthcare industry
- The key question for all certified Type C claims is what changed in the delivery of a Type C procedure for the relevant patient that needed a hospital admission rather than a hospital service?
- Regulation of the escalation process to the PSR, if implemented, must be open and transparent to health funds
- A review of the legislation should provide a benefit for a hospital service, outpatient, emergency department, primary care and diagnostics. This would address the historic context of the certification process and eliminate the need for Type C certifications.

Context

The Department of Health (DOH) provides a problem definition[1] on certifications and the actions taken in 2017, as described in the release of *PHI Circular 37/7, 17 July 2017, Clarification of roles in the certification process*. As historical context, when the requirement to 'occupy a bed' to receive a benefit for Hospital Treatment was removed, there was a concern procedures performed at hospital that didn't need a bed, such as outpatient, emergency department or non-admitted minor surgery or diagnostic procedures, might claim a benefit.

On 7 November 1991, Mr Peter Staples, the then Minister for Aged, Family and Health Services, addressed the parliament and stated:

> "…In an effort to ensure that the growth of day surgery did not emanate from treatment that was performed in doctors' rooms, or treatment that was traditionally provided in hospitals as outpatients, my Department produced a type C-exclusion

[1] DOH 2020 (1) p. 23.

list-professional attention list. This exclusion list-a list of Medicare benefits schedule procedures not normally done in hospital on a day-only basis prevents hospitals and day hospital facilities from receiving an accommodation benefit if a procedure on the list is undertaken on a day-only basis."[2] .

Mr Staples then went on to describe the certification process and how it would be extended from overnight hospitals to day facilities. The fundamental issue is treatment based not on clinical need, but on the accommodation benefit obtained. If the patient is treated as an outpatient, or under non-admitted service terms, the benefit is not available. These services are covered under their applicable MBS rebate and as such they are reimbursed by Medicare rather than private health insurance.

The discussion should focus on the following principle: *"the right care, in the right setting, by the right provider and at the right price."*[3] Whilst "unnecessary and wasteful services…..are not a widespread problem,"[4] it is disappointing some providers have private health insurance pay admitted inpatient service benefits with no meaningful clinical rationale for the same services funded as hospital outpatient or community treatments by other providers. Rather than continuing with a broken system, a full review that allows for the provision of a benefit for hospital services such as outpatient treatment and primary care would eliminate the need for the certification process.

QUESTIONS FOR ALL STAKEHOLDERS: CERTIFICATION FOR HOSPITAL ADMISSION

1. ***Should an industry mediation panel be established to resolve hospital certification disputes?***

   Yes. This is not a widespread problem but one that requires education and consistent messaging. Only a small percentage of claims require certification to verify hospital treatment. The industry, through the panel, should provide that education through mediation and information dissemination.

2. ***If an industry mediation panel is established, what process should be undertaken to establish it, including determining membership?***

   The National Procedure Banding Committee (NPBC), dating back to the 1980s, works as a forum to provide guidance to the industry. It is a balanced group of funds and hospitals that review and resolve issues related to theatre payments. It could be used as a model for a mediation panel. Determining membership and powers of authority are described in subsequent questions.

3. ***What parties should be involved in the development of advice on the appropriate criteria for certification?***

   The driving success of the NPBC is that it is a balanced group of nine hospital and nine health fund representatives with neither group holding a deciding vote or power.

[2] Hansard 1991 pg. 2700
[3] AHIA, 2005.
[4] DOH 2020 (1) pg. 5.

Members are made up of clinical staff, registered health professionals, financial contractors, and others representing hospitals or health funds.

We recommend the industry mediation panel be the same, featuring people with a range of backgrounds such as billing clerks, doctors, nurses and consumers. Represented groups should be in equal numbers, therefore holding no deciding vote or power over the other.

4. ***Should PSR, or another regulatory body, provide a regulated and enforceable process for reviewing Type C certification?***

For the PSR to provide an enforceable process, it must be able to provide information to the health funds. This might require legislative change.

We agree that an escalation body is required in the proposal put forward. The PSR does not currently provide information to health funds on its activities or investigations. Legislative change is required to mandate the PSR to provide full disclosure of its review after failure to resolve issues at the self-regulated industry panel.

An alternative, which would not require legislative change, is that the office of the Ombudsman should be considered. When the *National Health Act 1953* removed clause 3B, there was concern there would be disputes between hospitals and health funds. The Ombudsman was appointed to settle disputes. There are still issues with acute care certifications, but these are largely resolved within industry and by the Ombudsman. No business revenue models are built on the Acute Care Certificate, which is different to a Type C certificate. However, the lessons from the Ombudsman's handling of the certifications can be applied.

5. ***Should there be a specified list of 'special circumstances' allowable for Type C certificates?***

No. There should not be a list. We saw this with the Colonoscopy MBS Review where providers "billed under a variety of 'best fit' items."[5] A list would replicate the issue where providers would try and find the *best fit* rather than the special circumstance.

The key question is - what changed in the delivery of the certified procedure due to a 'special circumstance' or 'medical condition' of the individual patient? If the procedure did not change from the standard practice to meet the Medicare Benefits Schedule, then it's likely it did not require an inpatient admission. The difference between a hospital service and Hospital Treatment should be made clear for providers who are unaware of the need and context of certifications. For example:

- A pharmacy located in a hospital licenced to dispense section 100 drugs is a hospital service and is not in and of itself Hospital Treatment
- Nursing staff, rather than a doctor, giving an intramuscular injection is a hospital service and is not necessarily a Hospital Treatment.

[5] CSCC 2019 pg. 90.

- Undertaking a diagnostic ultrasound is a hospital service and not Hospital Treatment.

It is the change in the delivery, or planned change, because of an issue with the individual patient, that means that these hospital services are Hospital Treatments. Each situation is unique to the patient and therefore a "list" should not be allowed.

Medical colleges and clinical guidelines document the standard operating procedures. However, it is the unusual circumstances that require an alteration of practices in these guidelines. The previous circular alludes to the change in procedure with examples of 'Haemophilia' and 'procedure on a young child' but does not articulate that the Type C procedure being certified was planned for or altered in implementation because of the special circumstance or medical condition.[6]

6. Should hospitals be potentially liable for Type C certificate statements, and if so, in what circumstances?

Hospitals that request mediation in Type C certification should contribute to the cost recovery of the mediation (see question 7). Importantly, to protect the patient regardless of the outcome, the hospital undertakes not to return to the patient for fiscal recompense.

It is the medical practitioner performing the procedure who decides and not the hospital. if there is any modification required that means it should be done as an admitted procedure rather than an outpatient in a hospital or clinic or community rooms.

An outpatient service "refers to any part of hospital, excluding the emergency department, that provides non-admitted patient care."[7] While this statement was made in regard to public hospitals, the same applies in the private sector. It is not the place but the procedure that is important in determining care.

7. What is the likely impact upon premiums of this proposal?

The industry mediation panel should be funded in a manner that minimises impact on premiums through a cost recovery model.

Revenue for the running of the NPBC is raised by Australian Private Hospitals Association (APHA) for their members to be part of the NPBC and provide some secretarial services to the broader committee through the copyrighted publication and distribution of the national procedure banding schedule.[2] The proposed mediation committee should also be self-funded.[8]

A cost recovery model could be based on the difference between various claimed costs. The cost of a review should be based on the difference between the MBS Schedule Fee

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[6] PHI Circular 37/17.
[7] DOH 2017.
[2] http://www.apha.org.au/wp-content/uploads/2009/07/Procedure-Banding-Schedule-Terms-of-Agreement-2010-2011.pdf http://www.apha.org.au/wp-content/uploads/2009/07/Procedure-Banding-Schedule-Terms-of-Agreement-2010-2011.pdf
[8] http://www.apha.org.au/wp-content/uploads/2009/07/Procedure-Banding-Schedule-Terms-of-Agreement-2010-2011.pdf

and the last published 'Private Hospital Data Bureau: Annual Report' for the service or the average contracted rate for accommodation Same-Day Band 1 rate. This represents the difference in benefit.

The advantage of a cost recovery model set on a case-by-case basis is that it ensures applications are measured and the financial implications for all parties are considered. For providers doing the right thing, the impact is small. This would mean fewer complaints requiring escalation. It would mean certainty for patients, as parties are not pursuing recompense, and a decrease in escalations to the Ombudsman and the Department of Health because there is a forum to discuss and mediate on case-by-case submissions.

Mediated outcomes should be published through the respective associations such as the APHA and Private Healthcare Australia (PHA), so that stakeholders know the correct certifications and accepted industry practice.

8. What is the likely impact on the number of people and/or policies covered of this proposal?

The impact should be negligible as patients should be receiving the right care in the right setting by the right provider and at the right price.

For those few providers and situations where the setting is purported to be more than delivered or required, such as outpatient rather than hospital service, then the procedure should still have clinically occurred; the impact is the difference in recompense from the outpatient to the admitted accommodation fee.

9. What are appropriate metrics for measuring the impact of this proposal?

The PHA has demonstrated that it is feasible to examine the Hospital Casemix Protocol (HCP) data to determine the rate of Type C certified admissions paid for under the current Private Health Insurance (PHI) Benefit Requirement Rules. There is not a log of the "incidence of disputes"[9] referred to in the consultation paper, so an alternative measure such as HCP monitoring should be employed.

However, the rates of Type C procedures paid for should be monitored by the hospital provider and publication of decisions should show a fall in disputes and increase in certainty for providers, funders and patients.

10. What is the regulatory burden associated with this proposal?

To use the Commonwealth's Professional Services Review (PSR) and require it to provide all information to a health fund will create implications for regulation. The panel proposed, being an industry one where deliberations were in the public domain, would have no regulatory requirement.

[9] DOH 2020 (1) pg. 5.

11. Are there any other reform options that should be considered?

The health system has seen "changes in models of care over time, with some procedures that previously required admission becoming available as outpatient services."[10] We suggest that it is time to reconsider the incentives that initially drove the creation of the Type C list by the Department of Health.

As described above, the original decision was to ensure "growth of day surgery did not emanate from treatment that was performed in doctors' rooms, or treatment that was traditionally provided in hospitals as outpatients"[11] but this means these treatments are not recompensed by private health insurance. Therefore, there is an incentive to ensure that regardless of the model of care, it needs to be an admission to seek a health fund benefit.

PHI that provides a benefit for admitted Hospital Treatment should fund non-admitted as "services provided by hospitals: in hospital outpatient clinics, in community-based clinics, in patients' homes."[12]

Perhaps, by adopting the Tier 2 Non-Admitted Services to PHI along with the admitted Hospital Treatment as per the PHI Benefit Rules, it would decrease the incentive to classify hospital services as admitted treatments as they would receive a fair benefit for the care provided. PHI should be able to provide a benefit for non-admitted services both where an MBS is applicable and for non-MBS eligible outpatient non-admitted services.

There should be a commitment to review PHI in providing a benefit for hospital services, outpatients, primary care and relevant clinical services needed by members and patients rather than continuing to create processes that encourage Hospital Treatment for the purposes of revenue. Without this commitment, as we have seen since the circular released in 2017, the situation will continue.

Please don't hesitate to contact me on 0428 903 824 or e.close@nib.com.au if you have any further questions.

Yours sincerely,

Ed Close
Chief Executive – Australian Residents Health Insurance

[10] AIHW, 2018.
[11] Handsard 1991 pg. 2700
[12] IHPA, 2019.