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To	Department of Health PHI Consultation
Topic	SVHA Response – Private Health Insurance Reforms – second wave
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Consultation 4: Applying Greater Rigour to Certification for Hospital Admission

SVHA supports the overall review of the current process for certification of Type B and C admissions as the system as it stands is currently administratively onerous and is leaving many patients out of pocket for admissions that are clinically appropriate.

SVHA does not believe that there is widespread "inappropriate practice by medical practitioners" and believe that certification is confusing for doctors and their patients are being left to question the value of the PHI when they can receive these services at no cost in the public sector.

There is a significant risk that there will be further reductions in PHI membership if legitimate overnight medical admissions continue to be included in targeted review processes by funds as this is a direct contradiction of the Private Health Insurance Act 2007.

Proposed policy part on: Establishment of a self-regulated industry panel to manage disputes.

The Department refers to the National Procedure Banding Committee as a comparison of self-regulation however the NPBC does not mediate disputes.

The paper refers to the need to "…examine possible inappropriate practice by medical practitioners…" which infers that there is systematic and deliberate behavior aimed at rorting the private health insurance sector. Commentary that certification has been "improper" or "fraudulent" has been used by funders and that this is both inflammatory and an incorrect evaluation of the private hospital sector as a whole.

If inappropriate practice is occurring surely this is an issue for Medicare to investigate.

Hospitals have a differing view point and experience as they are often left being unable to receive payment for admissions due to health funds questioning the certification and rejecting it for many reasons including

Doctors often do not know what documentation will constitute 'valid' certification and believe that having to justify admissions confusing as currently health funds have a varying response to certification.

It is also unclear as to the volume of disputes that the panel would need to adjudicate as SVHA has high numbers of rejected Type C and Type B certificates both at the time of treatment as well as at audit some time later.

Proposed policy part two: Encouraging the development of clinical guidelines for Type C procedures requiring hospitalisation by medical colleges

SVHA supports measures to engage with the medical colleges to set up guidelines or more appropriately – rules to determine which Type B and C admissions to hospital are medically appropriate.

We are aware of the Society of Plastic Surgeons – Criteria for Type C Banding Certification but it is unclear as to how widespread this has been implemented and whether health funds routinely accept the certification.

If guidelines/rules are to be developed, it would need to be agreed by health funds to accept the documentation as many of the reasons listed in the abovementioned guidelines would not be accepted by funds currently.

In order for the guidelines/rules to work, they need to be accepted across the board so as to avoid the situation where some funds accept them and others don't.

Proposed policy part three: Escalation of disputes or severe breaches to the Professional Services Review for decision

The PSR has no jurisdiction over hospitals currently and would be considered a major and possibly unnecessary step to extend their authority to do this.

The reasons for this in the consultation paper suggest that the health funds would then "…have an enforceable mechanism to challenge the use of Type C certificates…"

Health funds already have mechanisms within HPPA's to reject claims or then audit and demand refunds all within the context of continuing to pay the medical practitioner for their services.

This proposal does not protect hospitals to hold insurers accountable for unreasonable conduct where they may reject claims and excessive auditing practices to recoup costs.

If the guidelines/rules are implemented, then the need for escalation of disputes should diminish.

SVHA response to questions included in the Consultation paper

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

It is important to understand the extent of the problem and what type of dispute the panel would be required to resolve.

- Inappropriate Practice by medical practitioners?
- Rejection of certification by insurers who judge the validity of an admission?
- Application of certification to hospital admission for overnight Medical admissions due to doctor billing for consultation item numbers?

The consultation paper refers to "inappropriate practice by medical practitioners" but it is unclear how widespread this issue is as the paper suggests that this is a systemic issue, but this is not how hospitals view the problems with certification.

Hospitals believe the issues lie more with funds not accepting reasons for Type C admissions and medical staff being unclear as to why they are being asked to certify admissions that they believe constitute "accepted medical practice".

Contrary to the PHI Circular 37/7 where it discusses the role of insurers, Health Funds routinely reject certification based on their clinical assessment of the circumstances relating to an admission when the Rules state that they cannot.

Regarding medical admissions, most doctors would be unaware that lodging a consultation item number with a fund or Medicare would mean that they could potentially have to provide additional Type C certification to justify why they had admitted a patient.

This is absolutely contrary to the Private Health Insurance Act 2007 (section 121-5(3)) that defines hospital treatment to include medical treatment.

This is also despite the fact that HCP data would clearly indicate the validity of the admission. Hospitals (and doctors) should not need to justify medical admissions for patients with conditions such as pneumonia, and this is one example of where the administration is becoming overly burdensome.

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

Again, this would depend on what the role of the mediation panel is. Mediation is a specialized and costly process – who will fund this?

If a panel is established, there would need to be representation from all parties – private hospitals, insurers and medical practitioner

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

This should be clinician led because the criteria are clinical not funding. There should be medical representatives included as they are clearly best placed to determine what would be accepted medical practice.

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

The PSR has a place if there are examples of systemic misuse of the system by doctors but SVHA do not believe it is the right use of the PSR to determine the outcome of disputes between hospitals and funds.

Please see commentary above

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

Yes

The first consideration to be undertaken is whether a patient is insured for their condition – not where the treatment is provided.

There are a number of procedures that are routinely provided in hospitals for chronic conditions or other reasons where certification is consistently being rejected by funds because the reasons for admission are 'generic'.

In many circumstances the reason for admission is because the patient *may* develop complications, but funds will only pay *if* the patient has a complication despite the fact that the outcome of an appropriate admission may be the lack of complications.

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

It is unclear what is meant by this question.

Are you suggesting that hospitals (rather than doctors) complete the Type C certification? This would potentially be a better solution if there are standardised reasons or circumstances for admission as many doctors' report that they are paid for the services they provide whether the hospitals are paid or not.

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

This is unclear and would need to be modelled.

What is clear that consumers expect to be covered for treatment if their doctor wants to admit them to hospital (bearing in mind their level of cover). There would be a higher sense

of satisfaction and value of PHI if there was not perceived to be a "he said – she said" battle between hospitals and funds every time a patient needs to have an infusion for example.

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

This is difficult to predict but it would be fair to say that if a patient can receive treatment for a condition such as Crohn's disease or cancer at no out of pocket cost in the public sector – but take out private insurance to be treated by the doctor of their choice but then have to pay for their treatment surely resolving this issue will enhance the value of PHI where it is currently seen by members who experience this situation as having little value to them.

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

There should be a reduction in disputes over time if there is greater certainty over certification and the associated guidelines/rules being adhered to by all parties.

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

Should the department investigate setting a minimum benefit for uncertified Type C procedures?

Currently health funds cross reference doctor billing against hospital billing and hold hospitals to account for any discrepancy. This is particularly evident if item numbers provided by doctors to the hospital vary in a way that means that the fund can reduce payment to the hospital, and this is now even more apparent by the increase in medical admissions being rejected by funds due to the consultation MBS Items.

Apart from contacting doctors on a case by case basis, hospitals have no access to doctor billing to corroborate what is submitted to the fund or Medicare matches what has been provided to the hospital.

Hospitals know that funds focus on billing that will result in a refund being paid to a fund from a hospital – not the other way around.

The Department should look a mechanism to provide greater transparency of billing across the board so that the hospitals can be assured of being paid correctly for the care that has been provided.

Examples of 'rejected' certification

- Patient with ascites needing insertion of drain in order to drain up to 8 litres of fluid. Overnight Type B certification rejected as the fund "could see no evidence of additional complications or care being needed"

- Patient with febrile neutropaenia (with a background of Merkell Cell Carcinoma) admitted for investigation to identify the cause. Reviewed by Haematologist and Oncologist who determined after a number of investigations that the patient could be discharged home on oral antibiotics and followed up in rooms. Health fund rejected medical claim at audit stating that admission was a Type C (no procedures undertaken).

- Example of communication from a fund to a patient regarding rejecting claims for Infliximab infusions (despite other funds who do cover these types of admissions).

> *Whilst I appreciate Type C admissions can be very confusing and frustrating, xxx and all health funds are required to abide by the same legislation. How another fund process these accounts is not a matter I can comment on.*
> *I've spoken with my contracting team and can confirm a discussion has occurred with the hospital regarding the Type C requirements. Unfortunately, the certification is something that is beyond the control of xxx. A type C procedure can only be certified if it meets legislated requirements, not because of it being filled out generically. The hospital is correct in charging you, if the admission is not certified correctly by your treating doctor.*
> *All private health insurers are required to pay benefits towards Type C admission as set out by the Department of Health if a valid Type C certificate is provided. To date xxx have not received a valid Type C certificate for the rejected accounts associated with some of your admissions – monitoring for potential allergic reaction does not meet the requirements set out by the Department of Health. Each admission needs to have a valid Type C certificate completed after the admission to advise the fund why the patient needed to be admitted for that specific infusion. If the certificate meets the criteria as set out in the attached Circular then benefits will be paid according to the contract between the hospital and the fund. Unfortunately there is no way to guarantee that a Type C admission will be paid on prior to the admission, as it is based on the specific medical reasons on the particular day of the infusion that the Type C certificate is based on.*
> *Whilst I understand this is not your desired outcome and not what you were hoping to hear, but I do hope that I have gone some way in assuring you that I have exhausted all options in reviewing your case. xxx must remain fair and consistent to all members and can only pay benefits as per Private Health Insurance legislation and I am unable to assist you further relating to this matter – I would encourage you to speak with your treating doctor about the Type C certification for your past and expected admissions.*