

ama simplified billing kit

Two major criticisms levelled at the medical profession in the current private health insurance debate are 'unexpected' patient gaps and the number of bills patients receive for private episodes of care. These are not the most important issues affecting private health insurance, but there is room for the medical profession to improve its record in these two areas.

The AMA has developed this kit to inform doctors of the options available to improve how we advise our patients about the costs of their treatment and how we bill patients. If we can improve our performance in these areas, we will help patients and remove some of the impetus for contracting.

If successful, we will keep the focus of the debate where it should be - on the funds and the Government to introduce sensible reform to private health.

What does the AMA propose

The AMA believes that the medical profession can assist in improving the current private health system by:

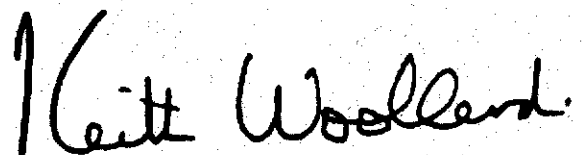
- resisting contracts but working cooperatively with Government and funds to find effective long-term solutions to the decline in private health insurance;
- introducing simplified billing and payment procedures;
- making sure that patients are informed of any possible gap payments before they agree to the episode of care; and
- helping to address utilisation costs.

The AMA has put forward options to the Government for reform including:

- The early introduction of Unfunded Lifetime Community Rating.
- Means testing on public hospitals or some other device to relieve pressure on public hospitals and shift demand to the private sector.
- Greater private contributions through long-term savings strategies.
- Specific Government action for areas such as Obstetrics and Anaesthesia where there are large gaps because of inadequate rebates causing patient dissatisfaction.

If the medical profession retains its independence from funds and private hospitals, we can continue to be strong advocates for our patients, our profession and for the entire health system. Without this independence outside commercial interests will override our professionalism and our care.

I hope that you find this kit useful. Please contact the AMA on (02) 6270 5400 if you have questions about any part of this kit.



*Keith Woollard
Federal President*

simplified billing - What does it mean?

Simplified billing is the process of coordinating patient bills for an episode of care. It streamlines the billing process for patients, and in the process should eliminate 'unexpected' patient gaps and streamline payments to the doctor.

It involves obtaining financial consent from a patient for an in-patient episode of care, and coordinating all medical bills related to the episode of care such that the patient receives the bills in one or two stages, within a reasonable time after the episode of care.

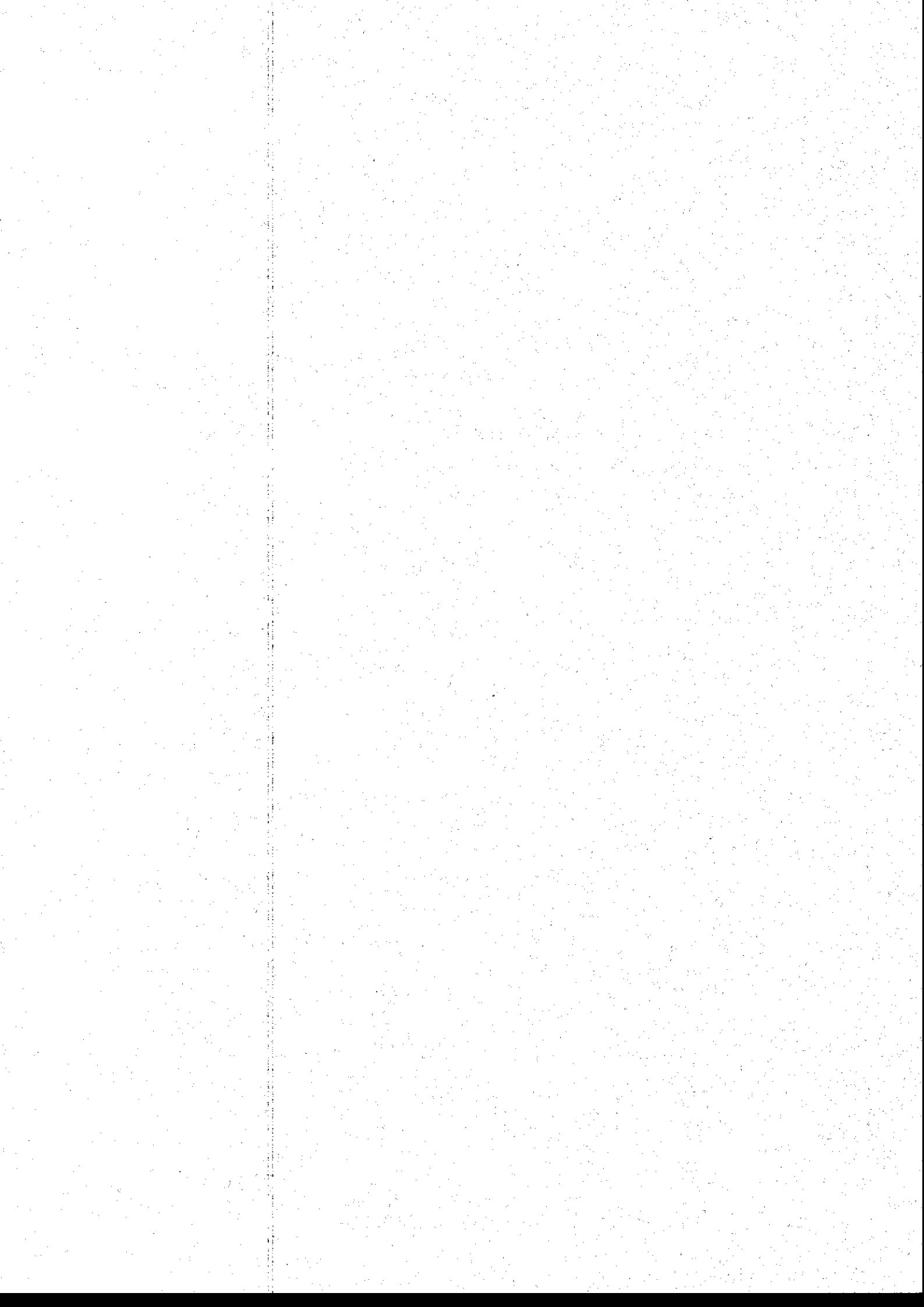
The AMA estimates that, on average, the number of medical accounts patients receive per private hospital admission is 6.4. However, this is only the average. In many cases the number can be substantially more.

Key principles

The AMA recommends doctors look for the following attributes in any simplified billing arrangement:

- The doctor/patient relationship should not be compromised by any agreement involving a third party, eg a doctor-fund or doctor-hospital contract.
- Participation must be voluntary and doctors completely free to opt in and out of the system.
- Doctors must retain their independence to charge individual patients, individually determined fees as appropriate for each patient.
- Wherever possible, financial consent should be discussed prior to patient admission.
- Dispatch of accounts to patients should be prompt and coordinated for each episode of care, collated and presented to the patient at time of discharge or mailed to the patient with a summary enclosed.
- The payment process should be simplified with collection of Medicare and health fund contributions facilitated and all payments directed to one address.
- There should be an acceptable agreement in place outlining how the agency coordinating the billing will handle moneys and information held on behalf of participating doctors and patients.
- The agency agreement should provide for payment to the doctor within a reasonable period of time, with an upper limit of 90 days.
- The agency should have professional indemnity cover that ensures payment to all concerned.
- The agency's accounting mechanisms should comply with government regulations (when promulgated).
- Arrangements which use electronic funds transfer technology will assist in achieving administrative simplicity and efficiency.





simplified billing

The Objective

The objective of simplified billing is to streamline the billing process for patients and, in the process, eliminate "unexpected" patient gaps and streamline payments to doctors.

The Benefits of Simplified Billing

For the medical practitioner:

Simplified billing should improve the service for patients, may save on administrative time and reduce the delay in receipt of patient payments and possibly the number of bad debts. (The Health Insurance Commission estimates that the average delay between a patient leaving hospital and lodging a Medicare claim form is 40 days). There will be some administrative cost of participating in such a service, but it is expected any costs will be outweighed by the benefits.

For the patient:

It reduces the trouble and confusion they experience in dealing with multiple bills and in obtaining rebates from their fund and Medicare. They receive a simplified bill on one occasion from medical practitioners, and their claims to Medicare and fund benefits are made for them.

Simplified Billing Agencies

There are currently four types of simplified billing agency structures being used to coordinate the billing process. The AMA is opposed to the fourth type, which is fund controlled.

1. Doctor controlled agency
A group of doctors agree to operate their own billing agency.
2. Third Party agency
An independent external organisation acts as an agency to undertake the process.
3. Hospital-based agency
A hospital may agree to establish a unit which acts as an agent to coordinate all bills.
4. Fund Controlled - the AMA is opposed to this type of agency, as it will normally involve a medical practitioner agreement (contract) between the doctor and fund.

Some of these models are being trialed as part of the Government's Simplified Billing Trials which will be evaluated in June/July 1998. The AMA and Australian Private Hospitals' Association both support these trials and are represented on the Steering Committee.



Assignment of Medicare Benefits to Billing Agents

The Parliament has approved changes to the law to enable patients to assign their Medicare benefits to a simplified billing agent registered with the Private Health Insurance Administration Council (PHIAC).

Doctors will still be allowed to charge a patient moiety, but instead of the Medicare rebate going to the patient to forward to the doctor, the rebate will go to the billing agent to forward to the doctor.

Under the new law, PHIAC will administer guidelines which will require billing agents to meet a range of criteria, possibly including:

- A requirement that they operate trust accounts for the receipt and disbursement of moneys held on behalf of the doctor.
- An upper limit of 90 days for payment to be made to the doctor.
- Appropriate mechanisms in place to ensure patient confidentiality.
- Holding adequate professional indemnity insurance.

The criteria will be designed to protect doctors and patients participating in simplified billing arrangements by ensuring accountability for all money flowing through the arrangements.

Patients will be able to assign the Medicare benefit to the simplified billing agent. But, they will not be able to do this in cases where their Medicare benefit is automatically assigned to a health fund. That is in cases where:

- the doctor is directly contracted to the fund through a medical purchaser-provider agreement, or
- the hospital has a purchaser-provider agreement in place with the fund and the hospital has a practitioner agreement with the doctor.

Medical practitioners using the simplified billing arrangement will need to assign to the billing agent all amounts they are owed in relation to the service (including amounts covered by a fund contribution and patient moiety) to enable the billing agent to collect the moneys on their behalf.

the simplified billing process

Establishing a Billing Agent

Step 1: Agree on the type of Billing Agency

Get doctors together to agree on the preferred method of management of simplified billing arrangements:

1. Doctor controlled agency; or
2. Third party agency; or
3. Hospital-based agency.

Where the agreed arrangements do not involve a hospital-based agency, it is recommended that the doctors involved inform their hospital(s) of their new billing arrangements.

Step 2 - If necessary, create the body that will act as the simplified billing agency.

Agree to allow this agency to act as your agent and to collect moneys on your behalf.

Agency law provides a basic guarantee that moneys collected by the agent on your behalf remain your property at all times. However, you should seek legal advice to define the scope of what the agent may do with the money collected for and on your behalf. The agent will also have to comply with any government regulations regarding trust accounts, professional indemnity, etc.

You will also need to agree on how the cost of the service will be met and how much time the billing and payment process should take (eg will the Billing Agent charge fees and/or be able to invest the money on the short-term money market for a set period of time?).

It is also important to make sure that there is an appropriate confidentiality agreement in place with the Billing Agent - so that confidential information cannot be passed on to a third party.

If the Billing Agent is being created, it will need to establish mechanisms to receive and coordinate bills. This could involve electronic transfers between Medicare and health funds.

Step 3 - The Billing Agent will have to obtain approval to receive Medicare Benefits directly.

As mentioned earlier in this kit, under the recent changes to the law, Billing Agents will have to apply to the Private Health Insurance Administration Council (PHIAC) for approval to operate as a billing agency. Approved Billing Agents are able to receive assignments of Medicare benefits from patients. This will involve meeting a number of criteria which are currently being determined by the Government (see section 3 of this kit for an explanation of the changes to the law).

Step 4 - Financial Consent Form

Agree on a financial consent form and process which all participating doctors will use (see section 5 for information on this).

Step 5 - Organise your Practice

Establish mechanisms within the medical practice and, where relevant, the hospital, to forward bills to the Billing Agent.

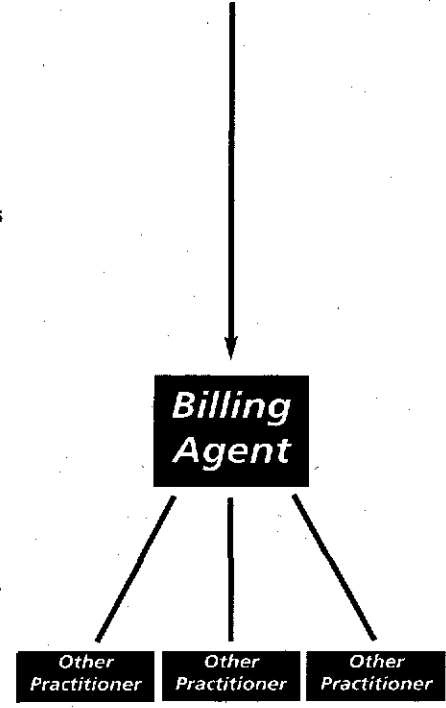
The Principal Medical Practitioner (PMP) advises the patient about the simplified billing process at the consultation, prior to hospital admission, and discusses costs.

The patient and PMP complete:

- Financial Consent form - acknowledging that the patient is aware of the costs involved in the proposed procedure.
- Medicare Claim form - whereby the patient assigns their Medicare benefit (and possibly the health fund benefit) directly to the Billing Agent. This form should be available from the Health Insurance Commission or Billing Agent.

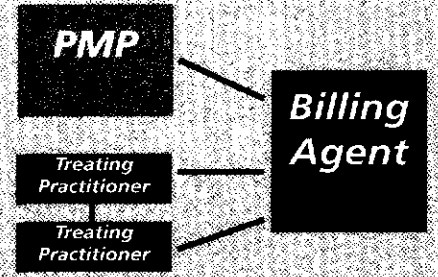
The PMP sends both forms to the Billing Agent, advising them that the patient will be using the simplified billing process.

On receipt of the two forms, the Billing Agent informs the other practitioners involved in the episode of care that it will be coordinating the patient's bills.



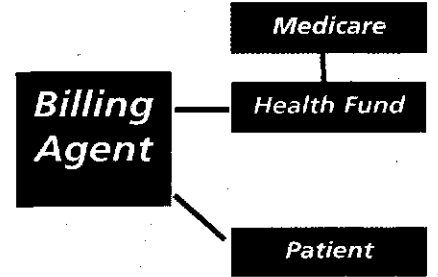
Step 2 - Patient discharged from hospital

PMP and other treating practitioners send accounts to the Billing Agent.



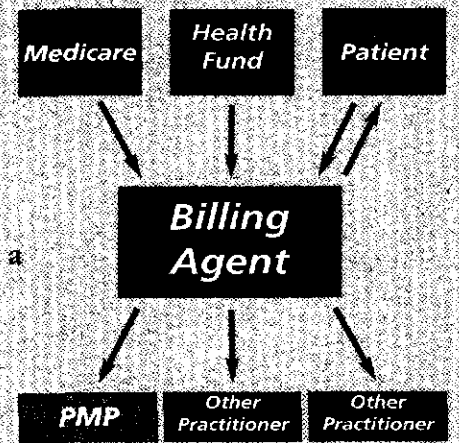
Step 3 - Billing Agent coordinates accounts

The Billing Agent makes claims to Medicare, the health fund and sends an account to the patient.



Step 4 - Accounts Paid

The Billing Agent receives payments from Medicare, the health fund and patient, and forwards payments to all practitioners involved. Payments should be passed on as received or within a reasonable time as agreed between the practitioners and the Billing Agent. A receipt for payment is issued to the patient.



the financial consent process

Wherever possible, the doctor should give the patient sufficient information regarding his or her likely fees and the associated rebates so that the patient is able to make an informed financial decision prior to the provision of medical services

(AMA Resolution 32/96)

A copy of an AMA endorsed financial consent form is attached. This form is also available electronically via the AMA's website (<http://www.ama.com.au>) and may be personalised by individual practices.

Suggested financial consent process:

During the consultation prior to hospital admission, the Principal Medical Practitioner completes the form and discusses the estimated costs and out of pocket expenses with the patient. This form should include best possible estimates.

The principal practitioner should advise the patient that they have only estimated the fees of other practitioners involved in the episode of care and that it is the patient's responsibility to confirm these costs with each of the practitioners involved.

It is important to advise the patient that you are providing an estimate only and that due to unforeseen circumstances the procedure may need to be varied, or the doctors involved may vary, and hence fees may change.

The patient signs the form, indicating that the doctor has explained the costs to them and that they understand the costs involved.



Notes

- 1. Medicare Benefit**
The Medicare Benefit is the amount which the Commonwealth Government will contribute to the cost of the procedure.
- 2. Health Fund Benefit**
If the patient is a member of a health insurance fund, the fund may also contribute to the cost of the medical service. The figure included in this column is an estimate only, patients should speak to their particular fund about the percentage of the medical charge which the fund will cover.
- 3. Patient Gap Payment**
Medicare and health insurance funds will not always cover the entire cost of the medical service. The "Patient Gap Payment" represents the part of the cost of the medical service which is not covered by Medicare or the health insurance fund and which you, the patient, will have to cover from your own pocket.
- 4. Names of Practitioners - Others**
Your doctor has only provided an estimate of the fees which the other medical practitioners may charge for the procedure. If you would like to confirm the fees of other practitioners you should contact each doctor involved. Please note that sometimes due to unforeseen circumstances there may need to be a change in the practitioners involved.

Patient/Guardian to complete:

I acknowledge that I have discussed the estimated costs of my in-hospital procedure with my doctor. I agree that the costs above are an estimate only and subject to variation. I understand I must pay the charges incurred. I understand I do not have to proceed with the procedure even though I sign this form.

Patient/Guardian's Signature		Date	/ /
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IF YOU HAVE ANY QUESTIONS, SPEAK TO YOUR DOCTOR OR THE FOLLOWING CONTACT AT THE HOSPITAL.

Hospital Contact: _____

Telephone: _____

examples of simplified billing agents

The Government is currently supporting nine trials of simplified billing processes around Australia. The trials are running for six months and will be evaluated in June/July 1998.

Eight of the nine trials are hospital-based. One trial involves a third-party billing agency. An example of a hospital-based billing process and the third-party billing agency process are outlined here.

1. Third Party Agent

This is a preferred model, because it involves an independent agent collecting fees on behalf of the doctor and hence does not affect the doctor/patient relationship or the level of fee that a doctor can charge.

Example: UniBill

Pannell Kerr Forster is currently trialing UniBill, a third party simplified billing service in Brisbane, as part of the Government sponsored trials. UniBill is an incorporated private company which acts as an agent for medical practitioners to coordinate bills and collect payments from patients. It is the only third party billing service taking part in the Government sponsored trials and has had considerable interest from doctors in Brisbane.

Under the UniBill billing process, the doctor enters an agreement with UniBill to provide the service. The service is initiated when the doctor forwards a patient's financial consent form to UniBill.

At consultation prior to hospital admission, the Principal Medical Practitioner and patient complete a financial consent form as well as a form agreeing to allow UniBill to receive Medicare and health fund rebates on their behalf. The financial consent form is forwarded to UniBill, which informs the other medical providers that the patient is using the UniBill simplified billing system.

When the patient is released from hospital, the providers fax their accounts (including any adjustments) to UniBill. UniBill then coordinates the processing and dispatch of accounts to patients, the collection of Medicare, health fund and patient contributions, and pays the providers.

UniBill has obtained legal advice which indicates that the fees that it collects on behalf of a doctor remain the property of the doctor at all times.

Benefits identified by UniBill:

- The UniBill service is only involved in the collection of fees, it does not interfere in the doctor-patient relationship or the level of fees set by the doctor. Any inquiries in relation to the patient's medical condition or procedures are directed to the doctor.
- Provided UniBill receives the doctor's account within five days of the patient's release from hospital they undertake to pay the doctor's account within 45 days of the patient's release from hospital.
- They will also negotiate payment terms with patients who may be experiencing difficulties in meeting accounts. The account is turned over to the doctor after 45 days.



- money market (with the doctor's authority); and
- A handling fee of 0.195% of funds handled on behalf of the doctor.

2. The Hospital Model

The benefit of the Hospital Model is the potential for all bills for the patient's episode of care to be coordinated. The main issue which needs to be considered in using this model, is that the administration costs of the scheme must be met by the doctors/hospital. This model does not involve contracting. The level of fees is purely a matter between the doctor and patient.

Example: St Andrews War Memorial Hospital

St Andrew's War Memorial Hospital and St Andrew's Heart Institute are currently operating a simplified billing process as part of the Government's trials. Their trial developed from a pilot the hospital initiated in 1996, with cardiac surgical patients. It was extended to meet demands from patients and some specialists who had heard of the service.

Participation is optional for the patient. The hospital ascertains the patient's willingness to participate on admission or at pre-admission clinics. If the patient chooses to use the service, they sign a consent form to allow the agency to coordinate their bills and to claim the Medicare and health fund rebates on behalf of the patient.

The agency advises participating providers of the patients who have opted to use the service and they send their fee accounts directly to the billing coordinator instead of the patient.

Patients are given self-addressed envelopes to forward any accounts to the service, which may have been sent directly to the patients (ie by providers who do not yet participate in the scheme).

The service obtains the Medicare and health fund benefits on behalf of the patients and forwards these to the doctors involved. The service forwards an account to the patient for any patient gap. The patient returns their payment to the service which is then forwarded on to the doctor. The patient receives a receipt for the total payment.

Benefits:

- The system is significantly reducing payment time, with Medicare rebate cheques being returned in less than eight days.
- There is increased patient satisfaction with their perception of hospital services and reduced stress for the patient or carer.
- Ease of / improved liaison between the HIC and health fund over payments.

The Cost of the Service:

- St Andrew's has indicated that a funding mechanism will need to be implemented between providers and the hospital to sustain the system in the long-term.

patient gaps - Why they exist

Why is there a difference between the Medicare Benefit and doctors' fees ?

Patients often have difficulty appreciating why doctors charge more than the government's Medicare rebate.

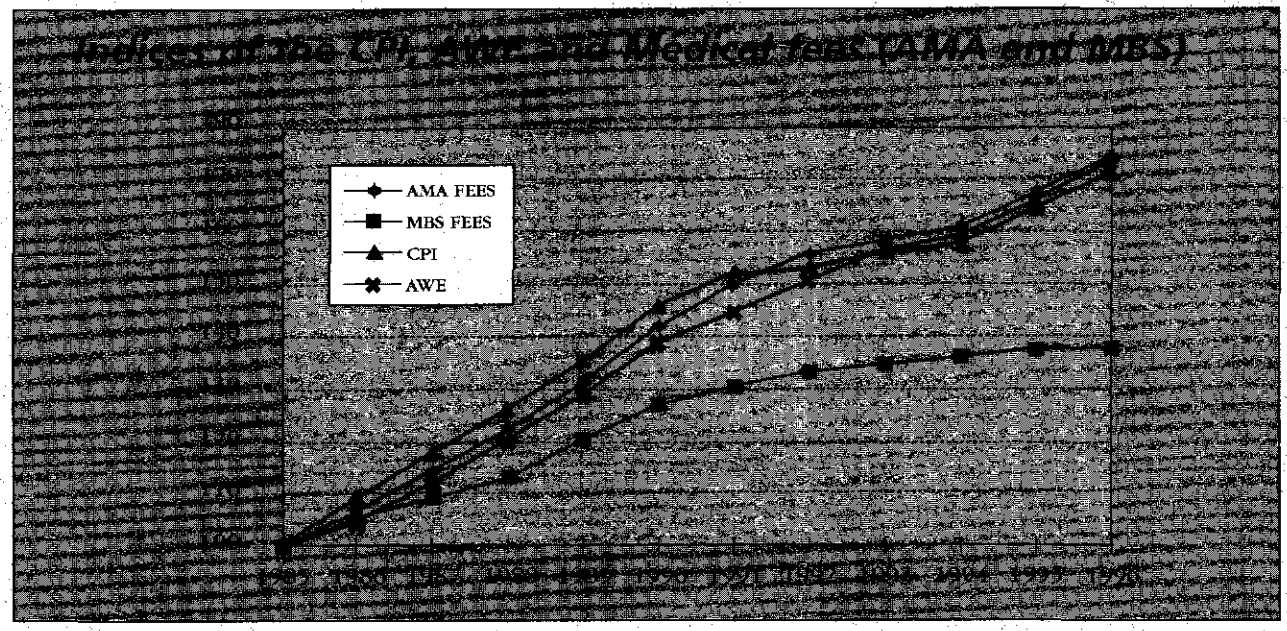
The AMA estimates that the average medical gap for an episode of private hospital care was \$88 in 1994/95. This is only an average. We know that in a lot of cases medical practitioners do not charge a gap, while in other cases the gap is very significant.

The Medicare Benefit

The Commonwealth Auditor-General has stated that fees in the Medicare Benefits Schedule (MBS) "simply represent the amount that the government, having regard to budgetary and economic considerations, is willing to pay (*Auditor General Report No 32 1990-91*)."

The MBS shows the amounts on which the Commonwealth government bases the payment of Medicare rebates. It is not described as a list of fair and reasonable fees, nor does it suggest that the fees are adequate to cover costs. Since 1985 MBS rebates have not kept pace with the rising costs of providing quality medical services.

The failure of the MBS to keep pace with inflation is illustrated in the graph below, which shows changes in prices and wages compared with the annual adjustments to the fees in the AMA List of Medical Services and Fees and the MBS.



(Consumer Price Index (CPI) and Average Weekly Earnings (AWE))

Because of its failure to keep pace with rising costs, the fees in the MBS no longer adequately reflect the costs incurred by doctors or adequately compensate patients for the cost of their medical services.

The Government's legislation currently prevents privately insured patients from insuring for medical charges above 100% of the MBS fee unless the doctor has a contract with a health fund or a hospital.

The AMA is opposed to such contracts because they invite interference in the care of patients by parties other than the doctor and the patient, as well as interference in the level of fees a doctor may charge.

Eliminating 'unexpected' patient gaps

'Unexpected' gaps are a real source of patient dissatisfaction and are something which the profession needs to address through the financial consent process outlined earlier in this kit.

The AMA believes that, wherever possible, doctors should advise their patients of the fees that are likely to apply to any medical service and the likely rebates, so that: (i) patients are aware of any gaps and (ii) they are able to make an informed financial decision about proceeding with the service.

It is vital that the medical profession informs patients of possible gap payments prior to the service, so that there can be no criticism of doctors for 'unexpected' patient gaps.