SIRA responses to questions on notice from Law & Justice

1. Work status metric

The Hon. ANTHONY D'ADAM: Ms Donnelly, I wanted to come back to this question about return-to-work rates and the shift to return-to-work ratio that was based on work status. When did that shift actually occur? When did you implement that change in methodology?

Ms DONNELLY: I might need to check but I think it would be the 2016 review of this Committee—of workers compensation—that made recommendations that we were to improve the way that we were measuring return to work. I can very easily check and come back to you on notice but it has been in that past three- to four-year period.

Response

In response to a recommendation of the Legislative Council Standing Committee on Law and Justice in the Report *First Review of the Workers Compensation Scheme* March 2017, the NSW Government committed in October 2017 that SIRA would develop:

"…*a multi-layered approach to measure system-wide return to work performance that will provide more consistent and complete analysis and reporting of return to work outcomes."*

Since 2017, SIRA has worked to collect clearer and more comprehensive data on return to work. SIRA now uses a range of measures and is continuing to develop improved multi-layered lead and lag indicators of return to work.

In 2017, SIRA increased use of an existing supplementary return to work performance measure based on "work status" which records the work status of a worker at a point in time (after 4, 13, 26 and 52 weeks).

In increasing the use of the work status measure SIRA was particularly responding to an observation in the March 2017 Committee Report *First Review of the Workers Compensation Scheme* on page 28 section 2.71:

"As for measuring return to work rates, the committee believes this metric should be refined so that it does not capture workers who have returned to work for an hour, or who are classified as having returned to work because they no longer received workers compensation payments. Instead, a worker should be considered as 'returned to work' in circumstances where the injured worker and their employer are both satisfied with the new working conditions."

The work status measure data is reported by insurers to SIRA and it requires a case manager to collect evidence and document whether or not a worker has actually returned to work. It includes information on whether a worker has returned to work in either suitable work or pre-injury work or has not returned to work and payments have ceased for other reasons such as retirement.

Prior to this change "cessation of benefits" was the primary return to work metric used by the former WorkCover Authority and, initially, by SIRA, with work status code used as a supplementary measure.

Work status replaced cessation of weekly payments as SIRA's primary return to work measure in late 2017. The shift was reflected in the 2016/2017 Workers Compensation Annual Performance Review published in March 2018.

Insurers, including the Nominal Insurer, have been required to collect and provide "work status" data for approximately 20 years. The definition and coding requirements for the measure have been substantially consistent since at least 2008. These data requirements are communicated to all insurers through the Claims Technical Manual on the SIRA website which is issued under section 40b and 40c of the *Workplace Injury Management and Workers Compensation Act 1998.*

SIRA, as the regulator, is empowered under section 23(m) of the *Workplace Injury Management and Workers Compensation Act 1998* to collect, analyse and publish data and statistics, as the Authority considers appropriate.

As SIRA implemented improvements in return to work measurement in line with the Government response to the Law and Justice recommendations, SIRA also increased oversight, engagement and feedback to insurers about the quality of data related to return to work - including the quality of their "work status code" data.

In December 2019, SIRA commenced a public consultation to seek input on its current return to work measures and how these may be strengthened. A summary of this consultation and further subsequent return to work roundtable discussions will be published by the end of the year.

2. Return to work rates

The Hon. DANIEL MOOKHEY: On a slightly unrelated matter, you said earlier that it was deteriorating and then it plateaued.

Ms DONNELLY: Yes.

The Hon. DANIEL MOOKHEY: To be clear, it was deteriorating in financial year 2018-19. That is correct?

Ms DONNELLY: Yes.

The Hon. DANIEL MOOKHEY: When did you say that it started to plateau?

Ms DONNELLY: I do not have all the data in front of me. But if I look at January through to this year, notwithstanding the impact of COVID it has been fairly stable. I will take that on notice, if you like.

The Hon. DANIEL MOOKHEY: But it is very clear it was still deteriorating in 2018-19 and in the first half of 2019-20?

Ms DONNELLY: That is my recollection. I am happy to confirm it on notice.

Response

Return to work rates began to plateau at four, 13 and 26 weeks in December 2019 following a significant deterioration in 2018/19.

System-wide return to work rates at 52 weeks have not stabilised and continue to show a slight decline. Similarly, other return to work measures that can be used to monitor scheme performance continue to deteriorate. For example, there has been an increase in weekly payments as a proportion of total payments compared to previous years. In July 2018, weekly payments made up 30.6 per cent of total payments compared to 41.5 per cent in July 2020.

Return to work data as at 11 September 2019 has been provided in Tab A. SIRA also publishes return to work performance on its open data portal to provide transparency into the performance of the workers compensation system. The portal provides a breakdown of return to work measures for the system as a whole, by insurer type, industry and return to work period.

3. Synapse presentation

The Hon. DANIEL MOOKHEY: With your prescience you may have anticipated this particular question. Can we have a copy of the report?

Ms DONNELLY: I am happy to take that on notice and certainly provide it. I do not think I have a copy with me.

The Hon. TREVOR KHAN: Does that mean that you will provide it?

Ms DONNELLY: Can I just say that it is not a report. It is a presentation that was part of that pilot going back to the insurers showing them what we found.

The Hon. DANIEL MOOKHEY: Can we have the presentation?

Ms DONNELLY: Yes.

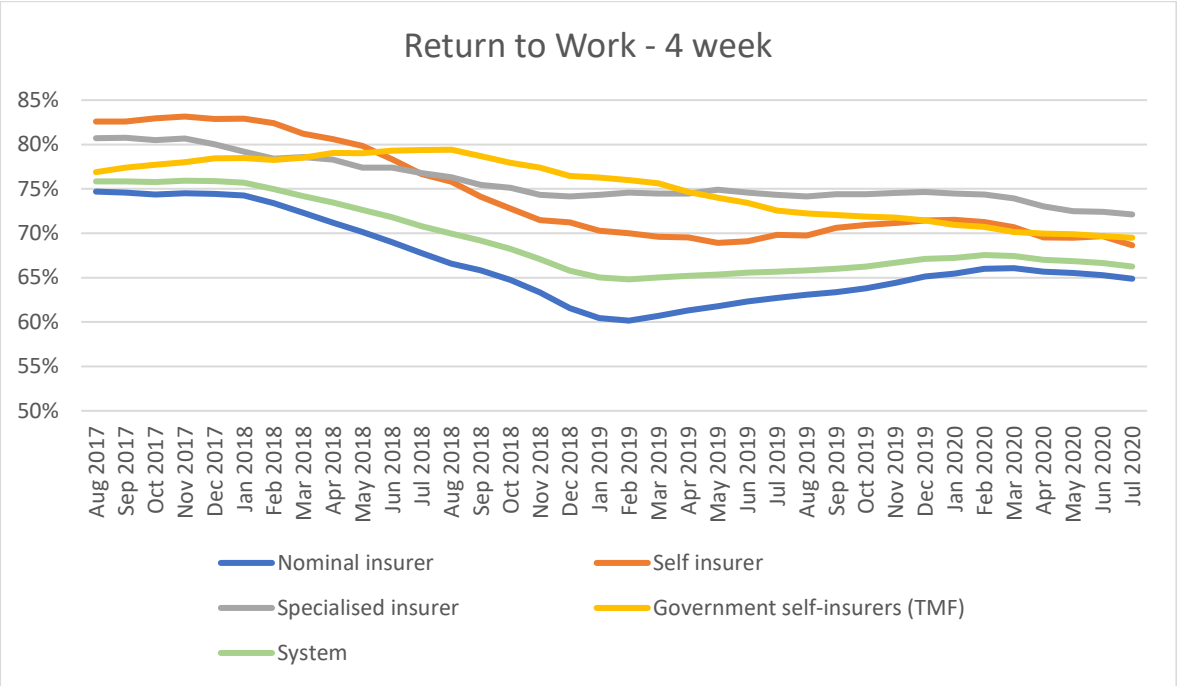
Response

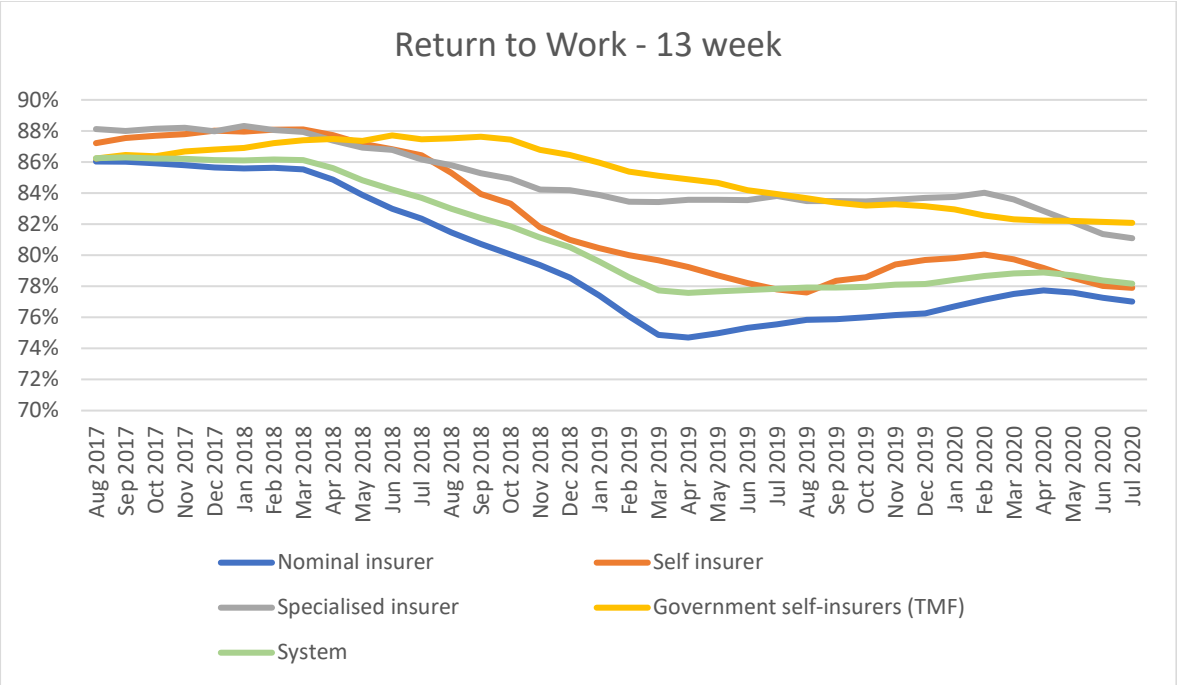
Please see attached Synapse presentation for industry at Tab B and icare at Tab C.

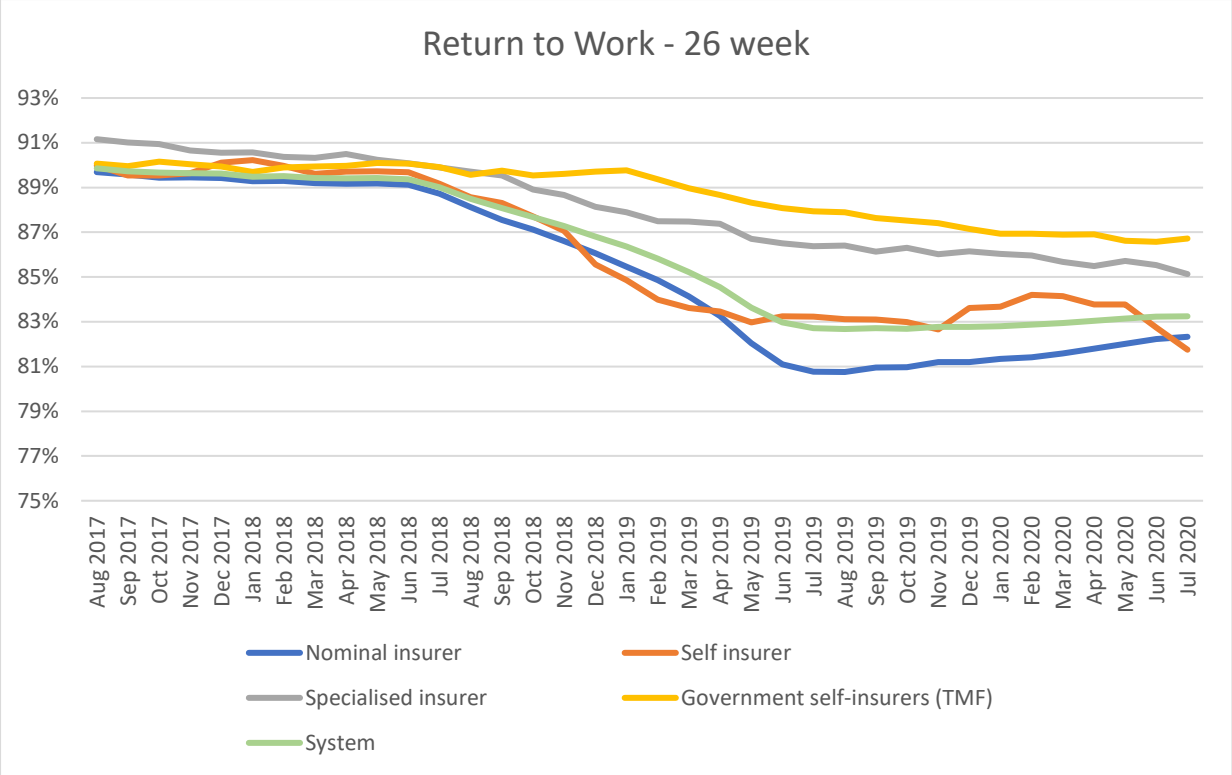
SIRA commissioned Synapse Medical Services to undertake an initial review of 1000 claims to identify health practitioners who were not adhering to SIRA's regulated payment rules and rates, and insurers who were paying invoices contrary to billing rules. This review forms part of a larger ***Review of Regulatory Requirements for Healthcare Arrangements*** in the NSW workers compensation and CTP schemes. The review will result in improved regulatory and fee setting approaches to ensure injured people have access to the right healthcare at the right time for optimal recovery and return to work, and so the schemes provide value-based care.

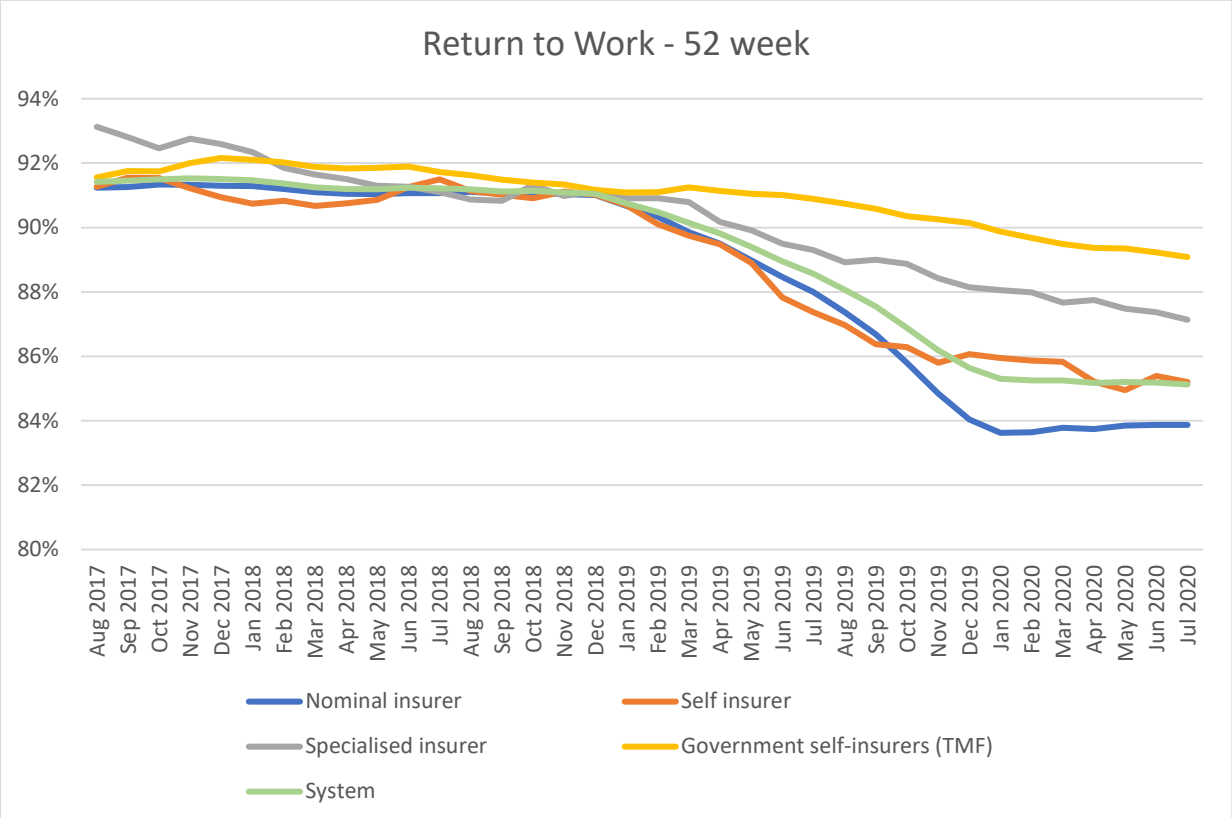
Tab A – Return to work data as at 11 September 2020

Return to work by insurer type (monthly view)






Return to Work - 26 week
93%
91%
89%
87%
85%
83%
81%
79%
77%
75%
Aug 2017
Sep 2017
Oct 2017
Nov 2017
Dec 2017
Jan 2018
Feb 2018
Mar 2018
Apr 2018
May 2018
Jun 2018
Jul 2018
Aug 2018
Sep 2018
Oct 2018
Nov 2018
Dec 2018
Jan 2019
Feb 2019
Mar 2019
Apr 2019
May 2019
Jun 2019
Jul 2019
Aug 2019
Sep 2019
Oct 2019
Nov 2019
Dec 2019
Jan 2020
Feb 2020
Mar 2020
Apr 2020
May 2020
Jun 2020
Jul 2020
Nominal insurer
Self insurer
Specialised insurer
Government self-insurers (TMF)
System


Return to Work - 52 week
94%
92%
90%
88%
86%
84%
82%
80%
Aug 2017
Sep 2017
Oct 2017
Nov 2017
Dec 2017
Jan 2018
Feb 2018
Mar 2018
Apr 2018
May 2018
Jun 2018
Jul 2018
Aug 2018
Sep 2018
Oct 2018
Nov 2018
Dec 2018
Jan 2019
Feb 2019
Mar 2019
Apr 2019
May 2019
Jun 2019
Jul 2019
Aug 2019
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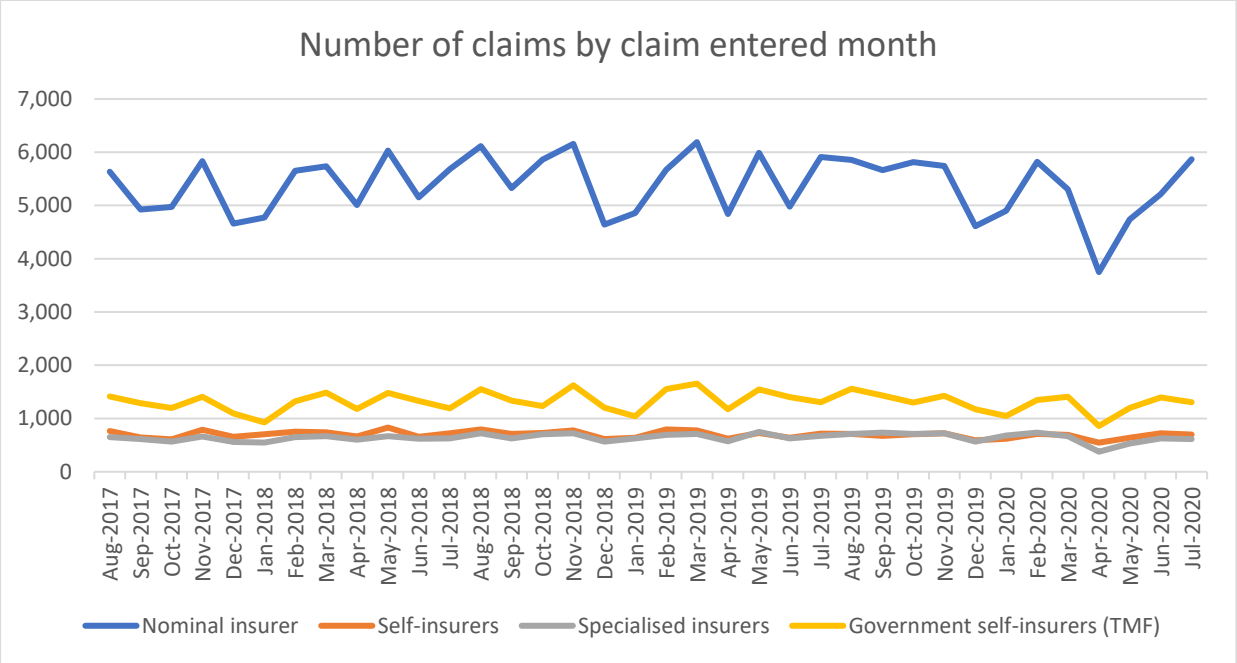
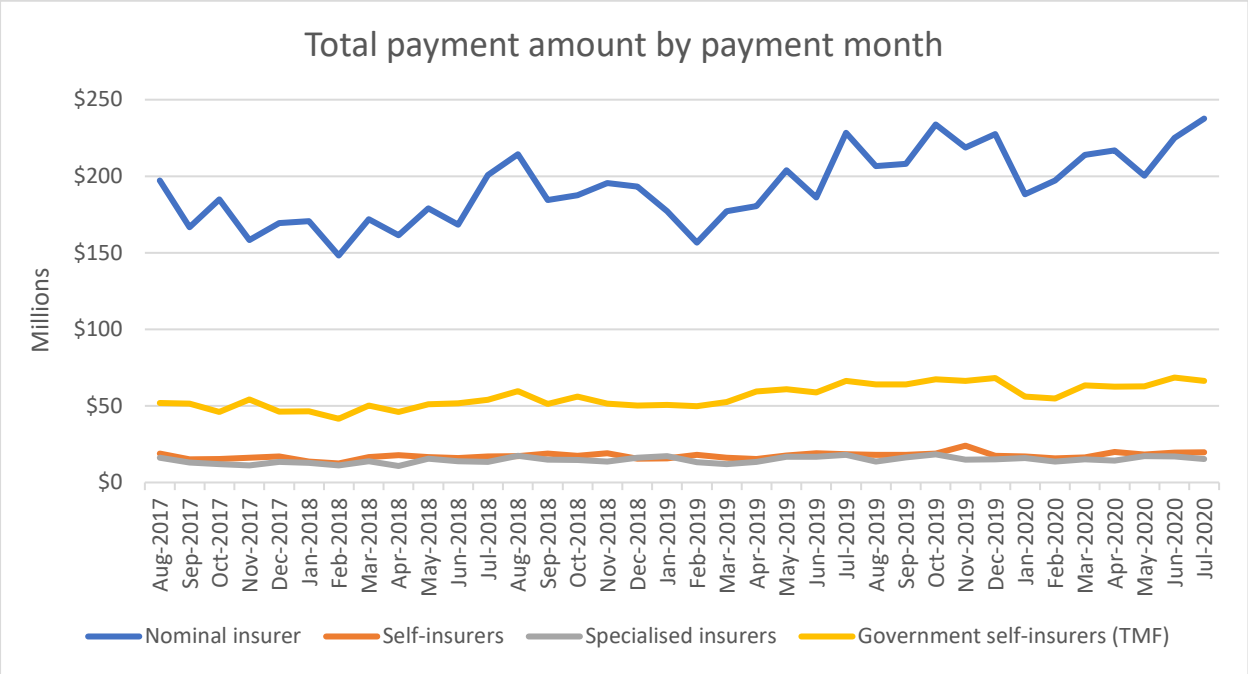
Nov 2019
Dec 2019
Jan 2020
Feb 2020
Mar 2020
Apr 2020
May 2020
Jun 2020
Jul 2020
Nominal insurer
Self insurer
Specialised insurer
Government self-insurers (TMF)
System

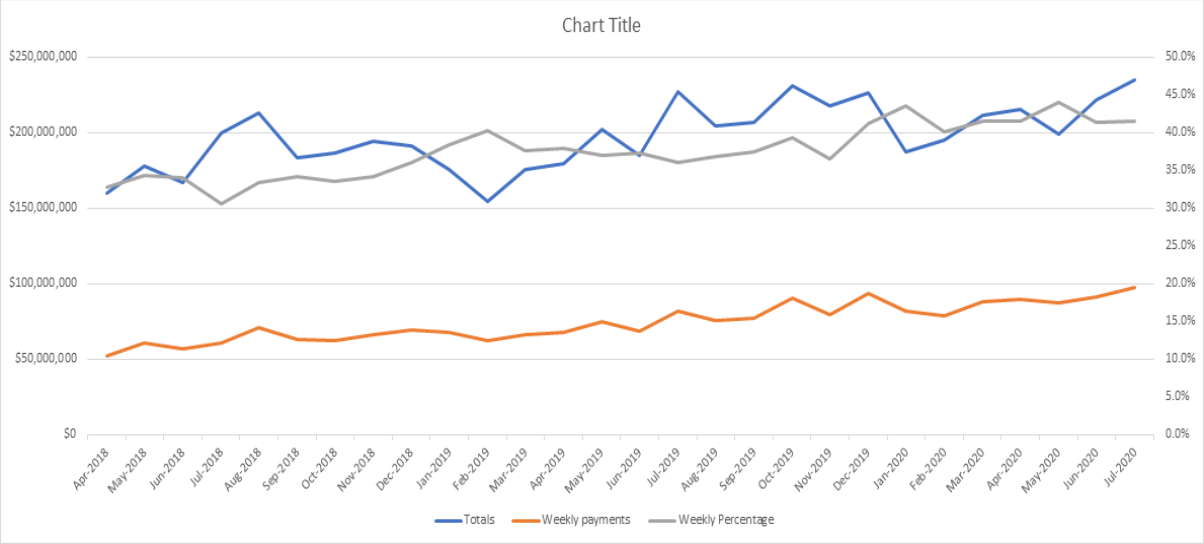
Number of claims by insurer type (monthly view)



Total payment amount by insurer type (monthly view)



Weekly payments as a percentage of total payment (July 2018 – July 2020)



Synapse | SIRA Industry Presentation

10, 11 and 12 June 2020

Contents

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Billing
Coding
Transcription
Consulting
Education

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INTERNAL MEDICINE JOURNAL

No payments, copayments and faux payments: are medical practitioners adequately equipped to manage Medicare claiming and compliance?

M. A. Faux, J. L. Wardle and J. Adams

Faculty of Health, University of Technology, Sydney, New South Wales, Australia

Journal of Law and Medicine

Informed discourse at the interface between law and health

Medicare Billing, Law and Practice: Complex, Incomprehensible and Beginning to Unravel

Margaret Faux, Jonathan Wardle and Jon Adams*

Australia's Medicare is still widely considered one of the world's best health systems. However, continual political tinkering for 40 years has led to a medical billing and payment system that has become labyrinthine in its complexity and is more vulnerable to abuse now, from all stakeholders, than when first introduced. Continuing to make alterations to Medicare without addressing underlying structural issues, may compound Australia's health reform challenges, increase the incidence of non-compliance and expenditure and thwart necessary reforms to develop a modern, data-driven, digitally informed health system. For the medical practitioners who are required to navigate the increasing complexity and relentless change, they will remain at high risk of investigation and prosecution in what has become an anarchic operating environment that they cannot avoid, but do not understand.

Open access Research

BMJ Open

Who teaches medical billing? A national cross-sectional survey of Australian medical education stakeholders

Margaret Faux,[1] Jonathan Wardle,[1,2,3] Angelica G Thompson-Butel,[4] Jon Adams[1]

To cite: Faux M, Wardle J, Thompson-Butel AG, *et al*. Who teaches medical billing? A national cross-sectional survey of Australian medical education stakeholders. *BMJ Open* 2018;**8**:e020712. doi:10.1136/bmjopen-2017-020712

ABSTRACT

Importance Billing errors and healthcare fraud have been described by the WHO as 'the last great unreduced health-care cost'. Estimates suggest that 7% of global health expenditure (US$487 billion) is wasted from this phenomenon. Irrespective of different payment models, challenges exist at the interface of medical billing and medical practice across the globe. Medical billing

Strengths and limitations of this study

- Despite medical billing errors and fraud being a significant problem, and education having been proven as an effective preventative strategy, to our knowledge this is the first study which has attempted to systematically map medical billing education of Australian medical practitioners

BMJ Open: first published as 10.1136/bmjopen-2017-020

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Comment on this paper

Wading through Molasses: A qualitative examination of the experiences, perceptions, attitudes, and knowledge of Australian medical practitioners regarding medical billing

Margaret Faux, Jon Adams, Simran Dahiya, Jon Wardle

doi: https://doi.org/10.1101/2020.05.26.20113324

Background and Context

SIRA approached Synapse in August 2019 to discuss areas of shared interest and explore potential opportunities to collaborate in the area of medical practitioner billing integrity and claims management.

SIRA's legislated objectives in the *State Insurance and Care Governance Act 2015* include:

- minimising the cost to the community of injuries arising from workplace or motor vehicle crashes
- promoting efficient, effective and viable personnel injury schemes
- Effectively supervising claims handling and disputes

The total annual payments made by SIRA are in the order of $1 billion for all health service providers (including hospitals), primarily managed through public and privately underwritten insurers.

After discussions, a proof of concept project was agreed wherein Synapse would analyse medical practitioner invoices (excluding GPs) for 1000 workers compensation claims. The claimants were identified by SIRA as having higher utilisation of medical practitioner services.

Dates & Deliverables

12 December 2019	-	The approved dataset was provided to Synapse
21 January 2020	-	Interim report and presentation
21 February 2020	-	Final presentation

Overview of the Dataset

Categories	Line count	$Value
Anaesthetic Claims	9543	$5,860,772.97
Surgical Operations	4926	$15,149,522.56
Assistance at operation	1324	$2,088,146.90
Diagnostic Imaging Service	5909	$2,931,277.14
MRI	2032	$1,427,116.25
Injections and Neurotomies	668	$625,921.68
Pain Leads and stimulators	73	$145,423.19
Pain Procedures	242	$433,330.19
Miscellaneous Diagnostic Procedures And Investigations	697	$165,085.37
Miscellaneous Therapeutic Procedures	987	$431,361.34
Pathology Services	5608	$278,182.35
Grand Total	**32009**	**$29,536,139.94**

Executive Summary

7% - Global average health system leakage caused by billing errors and fraud [1]

Total Incorrect Payments	$9,812,778.86 (33%)

Categories	Number of lines of not payable either by AMA or by MBS Rules	$ value of not payable claims either by AMA or by MBS Rules	Number of claims paid at incorrect rates	$ value of claims paid at incorrect rates
Anaesthetic Claims	9543	$ 4,877,310.64	9543	$ 148,427.06
Surgical Operations	4926	$ 1,590,401.82	4926	$ 1,904,619.17
Assistance at operation	1324	$ 123,271.33	1324	$ 106,861.55
Diagnostic Imaging Service	5909	$ 244,008.55	5909	$ 156,757.33
MRI	2032	$ 66,017.05	2032	$ 127,819.77
Injections and Neurotomies	668	$ -	668	$ 182,139.94
Pain Procedures	242	$ -	242	$ 183,579.87
Pain Leads and stimulators	73	$ 8,708.75	73	$ 46,062.39
Miscellaneous Diagnostic Procedures And Investigations	697	$ 585.00	697	$ 3,538.80
Miscellaneous Therapeutic Procedures	2	$ 1,295.00	987	$ 26,072.60
Pathology Services	96	$ 4,202.98	5608	$ 11,099.26
Grand Total	**25512**	**$ 6,915,801.12**	**32009**	**$ 2,896,977.74**

Ref 1: Gee J and Button M. The Financial Cost of Healthcare fraud 2014: What Data from Around the World Shows

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Resources and Notes

Human resources used for this project

- Margaret Faux (CEO)
- One Senior Analyst
- Six Analysts / Medical Billers
- One Project Manager
- Chief Medical Officer

Manual resources used

- AMA Fee Schedule 2016
- Medicare Benefits Schedule (MBS)
- Workers Compensation (Medical Practitioner Fees) Order 2019
- Workers Compensation (Surgeon Fees) Order 2019
- Workers Compensation (Orthopaedic Surgeon Fees) Order 2019

Notes

- We only stated something as an overpayment if it was greater than $50 above the AMA 2016 rate
- We split the original data file into worksheets with each worksheet corresponding to slides in this deck

Methods

1. Initial data sorting and filtering
2. We then ran the claims through our Medical Billing Rules Engine (MBRE)
3. Based on the initial results we did further sorting and filtering to draw out issues identified in the first run
4. Our medical billing specialists undertook a detailed manual analysis of issues identified, as well as issues that would not be picked up by the MBRE
5. We drew on our vast experience of how doctors behave when they bill to Medicare vs when they bill to a WC insurer, and used decades of claims data as a comparator/logic check

Limitations

1. We did not know the doctors' specialties.
2. We did not know how many different doctors billed the services for each patient.
3. We used one AMA schedule (2016) for the sake of expedience and to ensure our calculations of over payments were conservative.
4. We used the 2019 Workers Compensation Fee Orders also for the sake of expediency.
5. Without knowing the doctor's specialties, we could not determine issues around dual qualified specialists.
6. We did not have information about referrals.

Surgery – Multiple Services Rules

- ✓ Multiple Operation Rule: The Schedule fees for two or more operations performed on a patient on the one occasion are calculated by the following rule:- 100% for the item with the greatest Schedule fee, plus 50% for the item with the next greatest Schedule fee, plus 25% for each other item. – (Ref MBS Book page 471)

- ✓ AMA follows the Medicare multi-op rules. “Where the operation comprises a combination of procedures, which are commonly performed together and for which a specific combined item is provided in the List, it is recommended that it be regarded as the one item of service in applying the multiple operation rule.” (Ref AMA fee schedule 2016 Page 23)

NOTE: As per Fee Order 2019 we used 150% for the highest paying item and 112.5% for the other items.

Findings:- The overpaid value of claims noncompliant with the above rule was $1,904,619.17
(Ref sheet “Surgery” Column K)

Surgery – Multiple Services Rules - examples

EXAMPLE 1
claim was **overpaid $16,965** stepdown rules not applied.

ID	Service date	Type	Payment classification Group	MBS Codes	2016 AMA Rate	Multiple Service Rule (MSR)	After applying MSR	Total Payment Amount ($)
CLM-300	1/06/2018	Surgical Operations	MH600	45485	$2,380.00	x1.5	$3,570.00	$14,550.10
CLM-300	1/06/2018	Surgical Operations	MH610	45486	$1,720.00	x1.125	$1,935.00	$7,897.60
CLM-300	1/06/2018	Surgical Operations	MH680	45493	$1,125.00	x1.125	$1,265.63	$1,288.15
					Total		**$6,770.63**	**$23,735.85**

EXAMPLE 2
claim was **overpaid $14,668** stepdown rules not applied.

ID	Service date	Type	Payment classification Group	MBS Codes	2016 AMA Rate	Multiple Service Rule(MSR)	After applying MSR	Total Payment Amount ($)
CLM-480	9/11/2018	Surgical Operations	MJ050	45504	$4,655.00	x1.5	$6,982.50	$7,117.50
CLM-480	9/11/2018	Surgical Operations	MJ240	45562	$3,120.00	x1.125	$3,510.00	$3,577.50
CLM-480	9/11/2018	Surgical Operations	MR640	48242	$1,785.00	x1.125	$2,008.13	$2,730.00
CLM-480	9/11/2018	Surgical Operations	MP335	47393	$1,590.00	x1.125	$1,788.75	$3,645.00
CLM-480	9/11/2018	Surgical Operations	ML445	46426	$1,030.00	x1.125	$1,158.75	$10,930.95
CLM-480	9/11/2018	Surgical Operations	MS025	48406	$960.00	x1.125	$1,080.00	$1,102.50
CLM-480	9/11/2018	Surgical Operations	EA075	30023	$855.00	x1.125	$961.88	$3,043.10
CLM-480	9/11/2018	Surgical Operations	MN100	47027	$510.00	x1.125	$573.75	$585.00
					Total		**$18,063.75**	**$32,731.55**

EXAMPLE 3
claim was **overpaid $22,697** stepdown rules not applied.

ID	Service date	Type	Payment classification Group	MBS Codes	2016 AMA Rate	Multiple Service Rule(MSR)	After applying MSR	Total Payment Amount ($)
CLM-605	10/11/2017	Surgical Operations	MJ025	45500	$2,900.00	x1.5	$4,350.00	$23,925.00
CLM-605	10/11/2017	Surgical Operations	MP096	47316	$1,850.00	x1.125	$2,081.25	$2,081.25
CLM-605	10/11/2017	Surgical Operations	ML605	46468	$1,185.00	x1.125	$1,333.13	$1,185.00
CLM-605	10/11/2017	Surgical Operations	MP076	47310	$960.00	x1.125	$1,080.00	$1,080.00
CLM-605	10/11/2017	Surgical Operations	EA075	30023	$855.00	x1.125	$961.88	$3,512.00
CLM-605	10/11/2017	Surgical Operations	ML425	46420	$640.00	x1.125	$720.00	$1,440.00
					Total		**$10,526.25**	**$33,223.25**

Surgical Operations – mismatches and other rules not applied

- Item numbers that were removed w.e.f Nov 2018 in MBS schedule were still billed and processed by payers. This was **valued at $946K**. (Refer "Deleted MBS item" Column H)
- Description Injury Mismatch: Injury location was compared with the actual item numbers claimed and we found mismatches. This was **valued at $100K**. (Refer "Description Injury Mismatch" Column H)

- WCO 2019 : A few item numbers that cannot be paid under Workers Compensation Order 2019 rule were paid. This was **valued at $69K**. (See screenshot)

AMA/MBS item number	Descriptor	Reason for decline
MH480/45445	FREE GRAFTING (split skin) as inlay graft to 1 defect including elective dissection using a mould (including insertion of and removal of mould)	The appropriate item is MH490/45448.
MR170/47954	TENDON, repair of, not being a service to which another item in this Group applies	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.

- As per WCO 2019, a few item numbers are "Flagged" in combination with any item numbers. See Example below. **This is valued at $185K**. (Refer sheet "Flagged" column H)

AMA/MBS item number	Descriptor	Clinical indication
LN810/39330	Neurolysis by open operation without transposition	Not being a service associated with a service to which item LN740/39312 applies. Can be used in combination with elbow surgery (eg: MS045/48412 if performing an ulna nerve release with medial epicondylectomy or MR020/47903 lateral or medial epicondylitis debridement). Not to be used in combination with item MT760/48948. **Flag if used in combination with any item codes for shoulder surgery or in acute trauma.**

Surgical Operations – questionable claims

- "Independent procedures" claimed with additional surgical item numbers.
  See example:- **192 claims with value $300K**
  (Refer "Independent Procedure" Column H)

ID	Service dat	Payment classification Group	MBS Code	MBS Description
CLM-304	24/07/2018	MT790	48957	Shoulder, arthroscopic stabilisation of, for recurrent instability including la bral repair or reattachment when performed - not being a service associated wit h any other arthroscopic procedure of the shoulder region (Assist.) (Anaes.)
CLM-304	24/07/2018	MR210	47966	Tendon or ligament transfer, as an independent procedure (Assist.) (Anaes.)

- Consecutive item numbers claimed together. **This was valued at $265K** (See Screenshot)

LN790 $840.00	NEURECTOMY, NEUROTOMY or removal of tumour from superficial peripheral nerve, by open operation	39324
LN800 $1,430.00	NEURECTOMY, NEUROTOMY or removal of tumour from deep peripheral nerve, by open operation	39327

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Anaesthetics – inappropriate claims under both AMA and MBS rules

- Independent block procedures can generally not be claimed with general anaesthesia under AMA rules, which aligns with Medicare.
- Two initiation items are not payable for same date of service. (Ref AMA fee schedule 2016 page 136)
- Two anaesthesia consultation items are not payable for same date of service. (Ref "main sheet for review" rows 121-124)

The combined value of claims noncompliant with the above rules was $141K (Ref sheet "Anaesthetic claims" Column J)

ID	Service date	Type	Payment classification Group	MBS Codes	No Of Units	Per unit rate as per 2016 AMA rate	2016 AMA Rate	Total Payment Amount ($)	MBS Description
CLM-117	15/03/2019	Anaesthetic	CS912	21912	5	$83.00	$415.00	$946.00	Initiation of management of anaesthesia for injection procedure for discography : lumbar or thoracic (005) (basic units)
CLM-117	15/03/2019	Anaesthetic	CE690	20690	5	$83.00	$415.00	$430.00	Initiation of management of anaesthesia for percutaneous spinal procedures, not being a service to which another item in this subgroup applies (005) (basic un its)
CLM-117	15/03/2019	Anaesthetic	CA002	17610 / 17640	2	$83.00	$166.00	$172.00	#N/A

Anaesthetics

- Time items are mandatory under the MBS but not under the AMA. (Ref MBS Book page 475). ***There were therefore no time items in the sample data***. If Medicare rules had been applied 100% of the anaesthetic claims would have been rejected at a value of **$3.7M** (ref sheet "Anaesthetic no time items" Column J)
- Item CV009 would not be paid under MBS rules - A total of **$1.2M** - (ref sheet "Non MBS item" Column K)
- Item CA045 would not be paid and does not exist under MBS rules. All claims for this service are questionable, total **value of $100K**
- The below example shows 23 units but additional 99 units possibly overpaid and it an operation that would normally take 2 hours and the patient was an otherwise healthy 51 year old male

ID	Service date	Type	Payment classification Group	MBS Codes	No Of Units	Per unit rate as per 2016 AMA rate	2016 AMA Rate (units x unit rate)	Total Payment Amount ($)	Description	Age at injury	Gender	Injury Location 3d	Injury Nature Division 1d
CLM-464	8/04/2019	Anaesthetic Claims	CM484	21484	5	$83.00	$415.00	$8,342.00	CM484: - osteotomy or osteoplasty of the tibia and fibula	51	M	540. Lower Leg	B. Fractures
CLM-464	8/04/2019	Anaesthetic Claims	CV083		5	$83.00	$415.00	$430.00	CV083: MAJOR PERIPHERAL NERVE BLOCK, performed peri-operatively, with the introduction of a catheter to allow continuous nerve blockade to provide post-operative pain relief	51	M	540. Lower Leg	B. Fractures
CLM-464	8/04/2019	Anaesthetic Claims	CA004	17615 / 17645	4	$83.00	$332.00	$344.00	CA004: - an attendance of more than 15 minutes but not more than 30 minutes duration	51	M	540. Lower Leg	B. Fractures
CLM-464	8/04/2019	Anaesthetic Claims	CV125	18222	3	$83.00	$249.00	$258.00	CV125: SUBSEQUENT INJECTION (or revision of infusion) of a therapeutic substance to maintain regional anaesthesia or analgesia where the period of continuous medical practitioner attendance is 15 minutes or less	51	M	540. Lower Leg	B. Fractures
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				Total unit	23	Total	$1,909.00	$10,148.00					

Pain Procedures

- Over claiming for programming of Pain Stimulators was valued at **$8K** (Ref sheet “Pain Procedures” Column H)
- In the below example, the fee for item 39130 includes the programming and calibration of the stimulator. The two items will never be paid together on the same DOS under Medicare rules. Some doctors will move the item 39131 to the next day but do not attend the patient, the programming typically being done by a technician working for the stimulator company. The supervision rules of Medicare do not allow for this to be claimed.

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CLM-563	8/01/2019	Pain Leads and stimulators	LN550	39131	$1,800.00	Electrodes, epidural or peripheral nerve, management of patient and adjustment or reprogramming of neurostimulator by a medical practitioner, for the manageme nt of chronic intractable neuropathic pain or pain from refractory angina pecto ris - each day

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Diagnostic Imaging – Inappropriate claims under both AMA and MBS rules

"There are several rules that may apply when calculating Medicare benefits payable when multiple diagnostic imaging services are provided to a patient at the same attendance (same day). These rules were developed in association with the diagnostic imaging profession representative organisations and reflect that there are efficiencies to the provider when these services are performed on the same occasion. Unless there are clinical reasons for doing 916 so, they should be provided to the patient at the one attendance and the efficiencies from doing this reflected in the overall fee charged".(Ref MBS book page 915)

6 claims with TWO MRI's on same DOS with value of **$5.5k** - The below item OP210 for 3 regions covers the item for 1 region. The 2 are never paid on the same DOS under MBS rules nor under AMA rules.

ID	Service dat	Type	Payment classification Group	2016 AMA Rate	Multiple Service Ru	Total Payment Amount ($	Description
CLM-123	13/04/2018	MRI	OP210	$1,050.00	NA	$1,050.00	OP210: Magnetic Resonance Study of three or more contiguous regions of the body or two or more separate regions of the body
CLM-123	13/04/2018	MRI	OP200	$700.00	NA	$700.00	OP200: Magnetic Resonance Study of one region of the body or two contiguous regions of the body

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Diagnostic Imaging – questionable claims

- Questionable x-ray | ultrasound | CT | MRI combinations on same body part on same day. Valued at **$310K** (Ref sheet "Diagnostic imaging" Column H)
- A total of 78 MRI valued at **$57K** were claimed within the period of 2 months for a patient (some within 1-2 days), doctors would not risk claiming this under MBS. See below example.
- Under Medicare billing rules the term NK and K services are differentiated to identify the age of the machine used. This determines the rebate amount. Also, Medicare uses LSPNs to validate such claims. AMA does not.

ID	Service dat	Type	Payment classification Group	2016 AMA Rate	Total Payment Amount ($)	Description
CLM-680	22/08/2018	MRI	OP200	$700.00	$2,800.00	OP200: Magnetic Resonance Study of one region of the body or two contiguous regions of the body
CLM-680	23/08/2018	MRI	OP200	$700.00	$2,800.00	OP200: Magnetic Resonance Study of one region of the body or two contiguous regions of the body

Injury/Procedure mismatches & ECGs

- There were several mismatches between the injury location in the body and the procedure claimed. We note this could be due to incorrect coding in some instances.
  - Item claimed for procedure of the shoulder region. But the injury relates to knee (see below screenshot)
  - Caesarean anaesthetic item claimed for a male patient (Refer claimed ID CLM-1 , CLM-263 , CLM-360 & CLM-457)

ID	Service date	Payment classification Group	MBS Codes	Total Payment Amount ($)	Description	Date of Injury	Age at injury	Gender	Injury Location 3d	Injury Nature 3d	Mechanism Sub Group 2d
CLM-54	17/09/2019	MT770	48951	$4,072.50	MT770: SHOULDER, arthroscopic division of coraco-acromial ligament including acromionplasty - not being a service associated with any other arthroscopic procedure of the shoulder region	13/11/2017	52	F	800. Psychological System in General	707. Reaction to Stressors - Other, Multiple or not Specified	86. Other Mental Stress Factors
CLM-203	7/05/2019	MT800	48960	$4,290.00	MT800: SHOULDER, reconstruction or repair of, including repair of rotator cuff by arthroscopic, arthroscopic assisted or mini open means; arthroscopic acromioplasty; or resection of acromioclavicular joint by separate approach when performed- not being a service associated with any other procedure of the shoulder region	20/03/2018	54	M	530. Knee	218. Trauma to Joints and Ligaments, not Elsewhere Classified	02. Falls on the same Level
CLM-457	9/05/2019	MZ910		$555.00	MZ910: Assistance at a series or combination of operations, one of which is a birth involving Caesarean section - FEE = 20% of the total fee or $570.00, whichever is the greater	05/10/2018	45	M	311. Lower Back	422. Disc Displacement, Prolapse, Degeneration or Hernia	41. Muscular Stress While Lifting, Carrying, or Putting Down Objects

ECGs - cannot claim item 11712 with 11709 or 11700 with 11701 (ref “main sheet for review” row 24485 & 24486)

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Incorrect AMA fees paid

- Incorrect fees were paid not only for surgical services but across many services.
- The total value of claims paid at incorrect rates was **$3M** (Ref sheet “Incorrect AMA fee” Column O).

ID	Service date	Type	Payment classification Group	MBS Codes	No Of Units	Per unit rate as per 2016 AMA rate	2016 AMA Rate	Total Payment Amount ($)
CLM-781	3/11/2017	Anaesthesia Consultation	CA002	17610 / 17640	2	$83.00	$166.00	$4,482.00
CLM-39	29/04/2019	Assistant At operation	MZ900				$2,115.25	$25,164.05
CLM-463	21/03/2019	Injections and Neurotomis	CV240	18274	7	$83.00	$581.00	$5,766.52
CLM-574	11/12/2017	Pathology Services	PA005	65060			$20.00	$848.00

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Probable causes of the substantial leakage found

- ✓ Poor visibility – Payers can't see the breakdown of units for anaesthetics due to having adopted AMA vs MBS system. We perceive a significant issue with claims being artificially inflated, evidenced by too many modifiers and / or long anaesthetics
- ✓ Poor controls – Payers are often paying at incorrect rates and for erroneous item combinations.
- ✓ Demonstrably low billing literacy amongst claims processers / case managers
- ✓ Low billing literacy amongst medical practitioners
- ✓ No billing rules being applied
- ✓ Confusion about AMA vs MBS vs WC Fee Orders vs ASA RVG Guide (anaesthetists) rules
- ✓ Up-coding appears to be a significant issue

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The big picture

- ✓ The relationships between the MBS | AMA | WC Fee Orders | ASA Guide are opaque at best
- ✓ Empirical evidence has proven that doctors' legal literacy of medical billing is extremely low. In Australia, the only resource some doctors use occasionally is the MBS. Most rely on colleagues and other third parties for information about billing, the quality of which is variable
- ✓ There is no national curriculum on medical billing and never has been. Everyone is making it up!
- ✓ Doctors will continue to plead ignorance when under investigation for non-compliant billing (excluding clear cases of fraud), because they can
- ✓ Doctors did not study medicine to become medical billing experts. They will only ever manage one rule book.
- ✓ The MBS and ACHIs are becoming increasingly divergent, though both are likely to stick. AMA codes will become increasingly more difficult to cross match against hospital claims
- ✓ The system has become byzantine over 40 years. Aligning fee schedules and systems will benefit payers, patients and providers nationally.

Thank you

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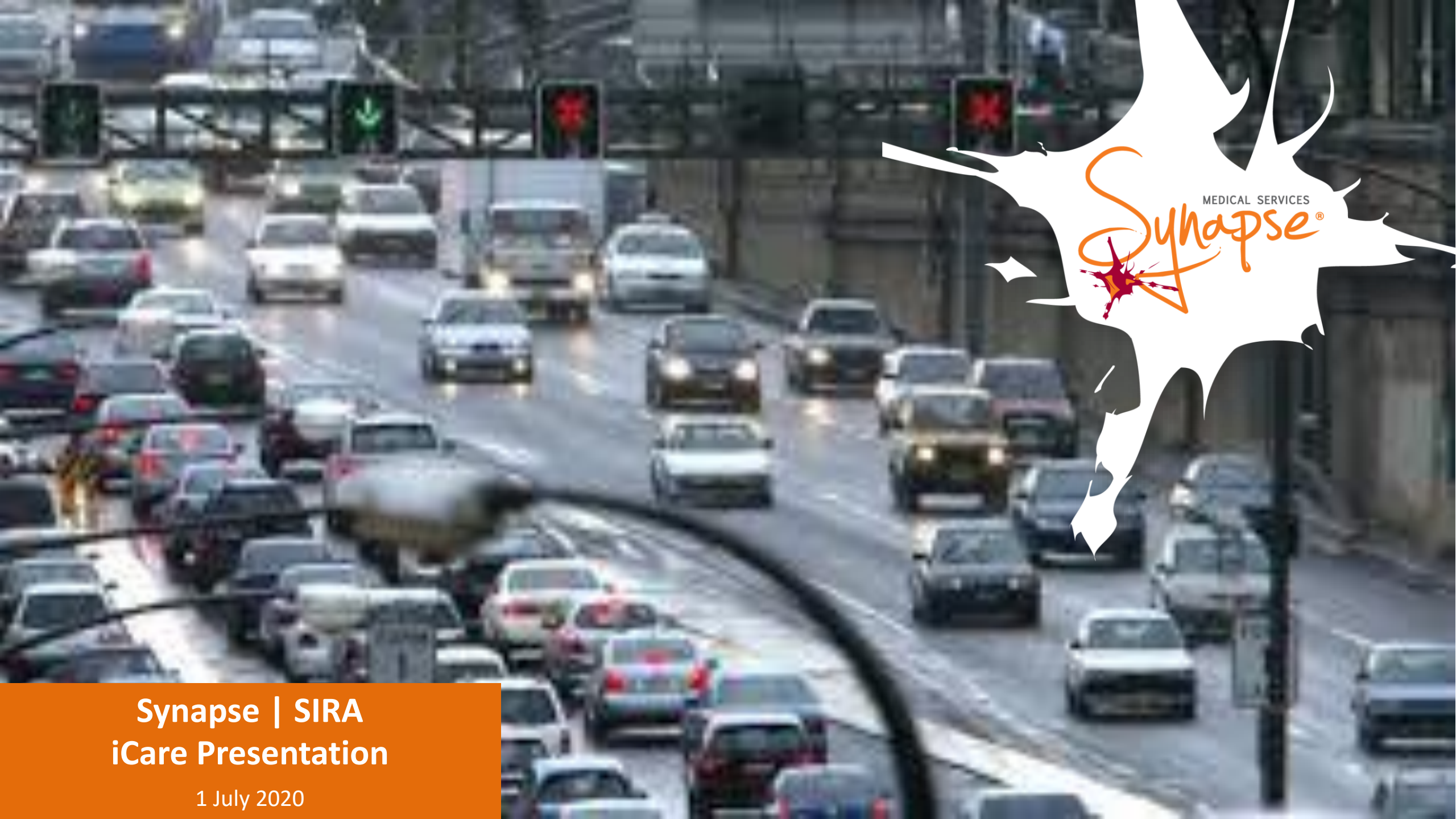
aimactraining.com



Synapse | SIRA iCare Presentation

1 July 2020

Contents

Overview of the Dataset

Categories	Line count	$Value
Anaesthetic Claims	9543	$5,860,772.97
Surgical Operations	4926	$15,149,522.56
Assistance at operation	1324	$2,088,146.90
Diagnostic Imaging Service	5909	$2,931,277.14
MRI	2032	$1,427,116.25
Injections and Neurotomies	668	$625,921.68
Pain Leads and stimulators	73	$145,423.19
Pain Procedures	242	$433,330.19
Miscellaneous Diagnostic Procedures And Investigations	697	$165,085.37
Miscellaneous Therapeutic Procedures	987	$431,361.34
Pathology Services	5608	$278,182.35
Grand Total	**32009**	**$29,536,139.94**

Executive Summary

7% - Global average health system leakage caused by billing errors and fraud [1]

Total Incorrect Payments	$9,812,778.86 (33%)

Categories	Number of lines of not payable either by AMA or by MBS Rules	$ value of not payable claims either by AMA or by MBS Rules	Number of claims paid at incorrect rates	$ value of claims paid at incorrect rates
Anaesthetic Claims	9543	$ 4,877,310.64	9543	$ 148,427.06
Surgical Operations	4926	$ 1,590,401.82	4926	$ 1,904,619.17
Assistance at operation	1324	$ 123,271.33	1324	$ 106,861.55
Diagnostic Imaging Service	5909	$ 244,008.55	5909	$ 156,757.33
MRI	2032	$ 66,017.05	2032	$ 127,819.77
Injections and Neurotomies	668	$ -	668	$ 182,139.94
Pain Procedures	242	$ -	242	$ 183,579.87
Pain Leads and stimulators	73	$ 8,708.75	73	$ 46,062.39
Miscellaneous Diagnostic Procedures And Investigations	697	$ 585.00	697	$ 3,538.80
Miscellaneous Therapeutic Procedures	2	$ 1,295.00	987	$ 26,072.60
Pathology Services	96	$ 4,202.98	5608	$ 11,099.26
Grand Total	**25512**	**$ 6,915,801.12**	**32009**	**$ 2,896,977.74**

Ref 1: Gee J and Button M. The Financial Cost of Healthcare fraud 2014: What Data from Around the World Shows

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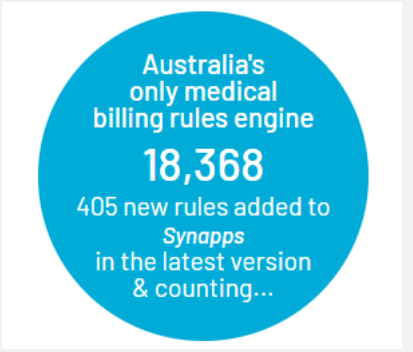
Methods

1. Initial data sorting and filtering
2. We then ran the claims through our Medical Billing Rules Engine (MBRE)
3. Based on the initial results we did further sorting and filtering to draw out issues identified in the first run
4. Our medical billing specialists undertook a detailed manual analysis of issues identified, as well as issues that would not be picked up by the MBRE
5. We drew on our vast experience of how doctors behave when they bill to Medicare vs when they bill to a WC insurer and used decades of claims data as a comparator/logic check.



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Limitations

1. We did not know the doctors' specialties.
2. We did not know how many different doctors billed the services for each patient.
3. We used one AMA schedule (2016) for the sake of expedience and to ensure our calculations of over payments were conservative.
4. We used the 2019 Workers Compensation Fee Orders also for the sake of expediency.
5. Without knowing the doctor's specialties, we could not determine issues around dual qualified specialists.
6. We did not have information about referrals.

Surgery – Multiple Services Rules - examples

EXAMPLE 1
claim was **overpaid $16,965** stepdown rules not applied.

ID	Service date	Type	Payment classification Group	MBS Codes	2016 AMA Rate	Multiple Service Rule (MSR)	After applying MSR	Total Payment Amount ($)
CLM-300	1/06/2018	Surgical Operations	MH600	45485	$2,380.00	x1.5	$3,570.00	$14,550.10
CLM-300	1/06/2018	Surgical Operations	MH610	45486	$1,720.00	x1.125	$1,935.00	$7,897.60
CLM-300	1/06/2018	Surgical Operations	MH680	45493	$1,125.00	x1.125	$1,265.63	$1,288.15
					Total		**$6,770.63**	**$23,735.85**

EXAMPLE 2
claim was **overpaid $14,668** stepdown rules not applied.

ID	Service date	Type	Payment classification Group	MBS Codes	2016 AMA Rate	Multiple Service Rule(MSR)	After applying MSR	Total Payment Amount ($)
CLM-480	9/11/2018	Surgical Operations	MJ050	45504	$4,655.00	x1.5	$6,982.50	$7,117.50
CLM-480	9/11/2018	Surgical Operations	MJ240	45562	$3,120.00	x1.125	$3,510.00	$3,577.50
CLM-480	9/11/2018	Surgical Operations	MR640	48242	$1,785.00	x1.125	$2,008.13	$2,730.00
CLM-480	9/11/2018	Surgical Operations	MP335	47393	$1,590.00	x1.125	$1,788.75	$3,645.00
CLM-480	9/11/2018	Surgical Operations	ML445	46426	$1,030.00	x1.125	$1,158.75	$10,930.95
CLM-480	9/11/2018	Surgical Operations	MS025	48406	$960.00	x1.125	$1,080.00	$1,102.50
CLM-480	9/11/2018	Surgical Operations	EA075	30023	$855.00	x1.125	$961.88	$3,043.10
CLM-480	9/11/2018	Surgical Operations	MN100	47027	$510.00	x1.125	$573.75	$585.00
					Total		**$18,063.75**	**$32,731.55**

EXAMPLE 3
claim was **overpaid $22,697** stepdown rules not applied.

ID	Service date	Type	Payment classification Group	MBS Codes	2016 AMA Rate	Multiple Service Rule(MSR)	After applying MSR	Total Payment Amount ($)
CLM-605	10/11/2017	Surgical Operations	MJ025	45500	$2,900.00	x1.5	$4,350.00	$23,925.00
CLM-605	10/11/2017	Surgical Operations	MP096	47316	$1,850.00	x1.125	$2,081.25	$2,081.25
CLM-605	10/11/2017	Surgical Operations	ML605	46468	$1,185.00	x1.125	$1,333.13	$1,185.00
CLM-605	10/11/2017	Surgical Operations	MP076	47310	$960.00	x1.125	$1,080.00	$1,080.00
CLM-605	10/11/2017	Surgical Operations	EA075	30023	$855.00	x1.125	$961.88	$3,512.00
CLM-605	10/11/2017	Surgical Operations	ML425	46420	$640.00	x1.125	$720.00	$1,440.00
					Total		**$10,526.25**	**$33,223.25**

Surgical Operations – mismatches and other rules not applied

- Item numbers that were removed w.e.f Nov 2018 in MBS schedule were still billed and processed by payers. This was **valued at $946K**. (Refer "Deleted MBS item" Column H)
- Description Injury Mismatch: Injury location was compared with the actual item numbers claimed and we found mismatches. This was **valued at $100K**. (Refer "Description Injury Mismatch" Column H)

- WCO 2019 : A few item numbers that cannot be paid under Workers Compensation Order 2019 rule were paid. This was **valued at $69K**. (See screenshot)

AMA/MBS item number	Descriptor	Reason for decline
MH480/45445	FREE GRAFTING (split skin) as inlay graft to 1 defect including elective dissection using a mould (including insertion of and removal of mould)	The appropriate item is MH490/45448.
MR170/47954	TENDON, repair of, not being a service to which another item in this Group applies	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.

- As per WCO 2019, a few item numbers are "Flagged" in combination with any item numbers. See Example below. **This is valued at $185K**. (Refer sheet "Flagged" column H)

AMA/MBS item number	Descriptor	Clinical indication
LN810/39330	Neurolysis by open operation without transposition	Not being a service associated with a service to which item LN740/39312 applies. Can be used in combination with elbow surgery (eg: MS045/48412 if performing an ulna nerve release with medial epicondylectomy or MR020/47903 lateral or medial epicondylitis debridement). Not to be used in combination with item MT760/48948. **Flag if used in combination with any item codes for shoulder surgery or in acute trauma.**

Surgical Operations – questionable claims

- "Independent procedures" claimed with additional surgical item numbers.
  See example:- **192 claims with value $300K**
  (Refer "Independent Procedure" Column H)

ID	Service dat	Payment classification Group	MBS Code	MBS Description
CLM-304	24/07/2018	MT790	48957	Shoulder, arthroscopic stabilisation of, for recurrent instability including la bral repair or reattachment when performed - not being a service associated wit h any other arthroscopic procedure of the shoulder region (Assist.) (Anaes.)
CLM-304	24/07/2018	MR210	47966	Tendon or ligament transfer, as an independent procedure (Assist.) (Anaes.)

- Consecutive item numbers claimed together. **This was valued at $265K** (See Screenshot)

LN790 $840.00	NEURECTOMY, NEUROTOMY or removal of tumour from superficial peripheral nerve, by open operation	39324
LN800 $1,430.00	NEURECTOMY, NEUROTOMY or removal of tumour from deep peripheral nerve, by open operation	39327

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Anaesthetics

- Time items are mandatory under the MBS but not under the AMA. (Ref MBS Book page 475). ***There were therefore no time items in the sample data***. If Medicare rules had been applied 100% of the anaesthetic claims would have been rejected at a value of **$3.7M** (ref sheet "Anaesthetic no time items" Column J)
- Item CV009 would not be paid under MBS rules - A total of **$1.2M** - (ref sheet "Non MBS item" Column K)
- Item CA045 would not be paid and does not exist under MBS rules. All claims for this service are questionable, total **value of $100K**
- The below example shows 23 units but additional 99 units possibly overpaid for an operation that would normally take 2 hours and the patient was an otherwise healthy 51 year old male

ID	Service date	Type	Payment classification Group	MBS Codes	No Of Units	Per unit rate as per 2016 AMA rate	2016 AMA Rate (units x unit rate)	Total Payment Amount ($)	Description	Age at injury	Gender	Injury Location 3d	Injury Nature Division 1d
CLM-464	8/04/2019	Anaesthetic Claims	CM484	21484	5	$83.00	$415.00	$8,342.00	CM484: - osteotomy or osteoplasty of the tibia and fibula	51	M	540. Lower Leg	B. Fractures
CLM-464	8/04/2019	Anaesthetic Claims	CV083		5	$83.00	$415.00	$430.00	CV083: MAJOR PERIPHERAL NERVE BLOCK, performed peri-operatively, with the introduction of a catheter to allow continuous nerve blockade to provide post-operative pain relief	51	M	540. Lower Leg	B. Fractures
CLM-464	8/04/2019	Anaesthetic Claims	CA004	17615 / 17645	4	$83.00	$332.00	$344.00	CA004: - an attendance of more than 15 minutes but not more than 30 minutes duration	51	M	540. Lower Leg	B. Fractures
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				Total unit	**23**	**Total**	**$1,909.00**	**$10,148.00**					

Anaesthetics – inappropriate claims under both AMA and MBS rules

- Independent block procedures can generally not be claimed with general anaesthesia under AMA rules, which aligns with Medicare.
- Two initiation items are not payable for same date of service. (Ref AMA fee schedule 2016 page 136)
- Two anaesthesia consultation items are not payable for same date of service. (Ref "main sheet for review" rows 121-124)

The combined value of claims noncompliant with the above rules was $141K (Ref sheet "Anaesthetic claims" Column J)

ID	Service date	Type	Payment classification Group	MBS Codes	No Of Units	Per unit rate as per 2016 AMA rate	2016 AMA Rate	Total Payment Amount ($)	MBS Description
CLM-117	15/03/2019	Anaesthetic	CS912	21912	5	$83.00	$415.00	$946.00	Initiation of management of anaesthesia for injection procedure for discography : lumbar or thoracic (005) (basic units)
CLM-117	15/03/2019	Anaesthetic	CE690	20690	5	$83.00	$415.00	$430.00	Initiation of management of anaesthesia for percutaneous spinal procedures, not being a service to which another item in this subgroup applies (005) (basic un its)
CLM-117	15/03/2019	Anaesthetic	CA002	17610 / 17640	2	$83.00	$166.00	$172.00	#N/A

Pain Procedures

- Over claiming for programming of Pain Stimulators was valued at **$8K** (Ref sheet “Pain Procedures” Column H)
- In the below example, the fee for item 39130 includes the programming and calibration of the stimulator. The two items will never be paid together on the same DOS under Medicare rules. Some doctors will move the item 39131 to the next day but do not attend the patient, the programming typically being done by a technician working for the stimulator company. The supervision rules of Medicare do not allow for this to be claimed.

ID	Service date	Type	Payment classification Group	MBS Codes	Total Payment Amount ($)	MBS Description
CLM-563	8/01/2019	Pain Leads and stimulators	LN540	39130	$2,850.00	Epidural lead, percutaneous placement of, including intraoperative test stimula tion, for the management of chronic intractable neuropathic pain or pain from r efractory angina pectoris, to a maximum of 4 leads (Anaes.)
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Diagnostic Imaging – Inappropriate claims under both AMA and MBS rules

"There are several rules that may apply when calculating Medicare benefits payable when multiple diagnostic imaging services are provided to a patient at the same attendance (same day). These rules were developed in association with the diagnostic imaging profession representative organisations and reflect that there are efficiencies to the provider when these services are performed on the same occasion. Unless there are clinical reasons for doing 916 so, they should be provided to the patient at the one attendance and the efficiencies from doing this reflected in the overall fee charged".(Ref MBS book page 915)

6 claims with TWO MRI's on same DOS with value of **$5.5k** - The below item OP210 for 3 regions covers the item for 1 region. The 2 are never paid on the same DOS under MBS rules nor under AMA rules.

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CLM-123	13/04/2018	MRI	OP210	$1,050.00	NA	$1,050.00	OP210: Magnetic Resonance Study of three or more contiguous regions of the body or two or more separate regions of the body
CLM-123	13/04/2018	MRI	OP200	$700.00	NA	$700.00	OP200: Magnetic Resonance Study of one region of the body or two contiguous regions of the body

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Diagnostic Imaging – questionable claims

- Questionable x-ray | ultrasound | CT | MRI combinations on same body part on same day. Valued at **$310K** (Ref sheet "Diagnostic imaging" Column H)
- A total of 78 MRI valued at **$57K** were claimed within the period of 2 months for a patient (some within 1-2 days), doctors would not risk claiming this under MBS. See below example.
- Under Medicare billing rules the term NK and K services are differentiated to identify the age of the machine used. This determines the rebate amount. Also, Medicare uses LSPNs to validate such claims. AMA does not.

ID	Service dat	Type	Payment classification Group	2016 AMA Rate	Total Payment Amount ($)	Description
CLM-680	22/08/2018	MRI	OP200	$700.00	$2,800.00	OP200: Magnetic Resonance Study of one region of the body or two contiguous regions of the body
CLM-680	23/08/2018	MRI	OP200	$700.00	$2,800.00	OP200: Magnetic Resonance Study of one region of the body or two contiguous regions of the body

Injury/Procedure mismatches & ECGs

- There were several mismatches between the injury location in the body and the procedure claimed. We note this could be due to incorrect coding in some instances.
  - Item claimed for procedure of the shoulder region. But the injury relates to knee (see below screenshot)
  - Caesarean anaesthetic item claimed for a male patient (Refer claimed ID CLM-1 , CLM-263 , CLM-360 & CLM-457)

ID	Service date	Payment classification Group	MBS Codes	Total Payment Amount ($)	Description	Date of Injury	Age at injury	Gender	Injury Location 3d	Injury Nature 3d	Mechanism Sub Group 2d
CLM-54	17/09/2019	MT770	48951	$4,072.50	MT770: SHOULDER, arthroscopic division of coraco-acromial ligament including acromionplasty - not being a service associated with any other arthroscopic procedure of the shoulder region	13/11/2017	52	F	800. Psychological System in General	707. Reaction to Stressors - Other, Multiple or not Specified	86. Other Mental Stress Factors
CLM-203	7/05/2019	MT800	48960	$4,290.00	MT800: SHOULDER, reconstruction or repair of, including repair of rotator cuff by arthroscopic, arthroscopic assisted or mini open means; arthroscopic acromioplasty; or resection of acromioclavicular joint by separate approach when performed- not being a service associated with any other procedure of the shoulder region	20/03/2018	54	M	530. Knee	218. Trauma to Joints and Ligaments, not Elsewhere Classified	02. Falls on the same Level
CLM-457	9/05/2019	MZ910		$555.00	MZ910: Assistance at a series or combination of operations, one of which is a birth involving Caesarean section - FEE = 20% of the total fee or $570.00, whichever is the greater	05/10/2018	45	M	311. Lower Back	422. Disc Displacement, Prolapse, Degeneration or Hernia	41. Muscular Stress While Lifting, Carrying, or Putting Down Objects

ECGs - cannot claim item 11712 with 11709 or 11700 with 11701 (ref “main sheet for review” row 24485 & 24486)

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Incorrect AMA fees paid

- Incorrect fees were paid not only for surgical services but across many services.
- The total value of claims paid at incorrect rates was **$3M** (Ref sheet “Incorrect AMA fee” Column O).

ID	Service date	Type	Payment classification Group	MBS Codes	No Of Units	Per unit rate as per 2016 AMA rate	2016 AMA Rate	Total Payment Amount ($)
CLM-781	3/11/2017	Anaesthesia Consultation	CA002	17610 / 17640	2	$83.00	$166.00	$4,482.00
CLM-39	29/04/2019	Assistant At operation	MZ900				$2,115.25	$25,164.05
CLM-463	21/03/2019	Injections and Neurotomis	CV240	18274	7	$83.00	$581.00	$5,766.52
CLM-574	11/12/2017	Pathology Services	PA005	65060			$20.00	$848.00

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Probable causes of the substantial leakage found

- ✓ Poor visibility – Payers can't see the breakdown of units for anaesthetics due to having adopted AMA vs MBS system. We perceive a significant issue with claims being artificially inflated, evidenced by too many modifiers and / or long anaesthetics
- ✓ Poor controls – Payers are often paying at incorrect rates and for erroneous item combinations.
- ✓ Demonstrably low billing literacy amongst claims processers / case managers
- ✓ Low billing literacy amongst medical practitioners
- ✓ No billing rules being applied
- ✓ Confusion about AMA vs MBS vs WC Fee Orders vs ASA RVG Guide (anaesthetists) rules
- ✓ Up-coding appears to be a significant issue

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The big picture

- ✓ The relationships between the MBS | AMA | WC Fee Orders | ASA Guide are opaque at best
- ✓ Empirical evidence has proven that doctors' legal literacy of medical billing is extremely low. In Australia, the only resource some doctors use occasionally is the MBS. Most rely on colleagues and other third parties for information about billing, the quality of which is variable
- ✓ There is no national curriculum on medical billing and never has been. Everyone is making it up!
- ✓ Doctors will continue to plead ignorance when under investigation for non-compliant billing (excluding clear cases of fraud), because they can
- ✓ Doctors did not study medicine to become medical billing experts. They will only ever manage one rule book.
- ✓ The MBS and ACHIs are becoming increasingly divergent, though both are likely to stick. AMA codes will become increasingly more difficult to cross match against hospital claims
- ✓ The system has become byzantine over 40 years. Aligning fee schedules and systems will benefit payers, patients and providers nationally.

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