Recent NCAT decision reinforces need for care around billing practices

***Health Care Complaints Commission v Kolos* [2022] NSWCATOD 46**

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AT A GLANCE

- The NCAT recently heard a complaint against a medical practitioner which involved – among other things – allegations of excessive billing practices in breach of specific conditions on the practitioner's registration.
- A Medicare audit informed this aspect of the proceedings.
- This case provides a timely reminder to all practitioners about Medicare compliance requirements which continue to be a focus of the Medicare Professional Services Review (PSR) program.

It is a requirement of the Medical Benefits Schedule (MBS) that all practitioners who provide a service for which a Medicare benefit is payable need to maintain accurate and contemporaneous health records.

These must demonstrate how the practitioner has met the requirements of the MBS item descriptor. In particular, there are obligations around records being adequate and contemporaneous, similar to the requirements in the Board's code.

MEDICARE AUDITS

Since 2018, there has been a sustained increase in audit activity by the Medicare Professional Services Review (PSR) program. During the 2018/2019 year, there was an increase of approximately $9 million of recoveries from the PSR ($29,196,203 compared to $20,845,546 in 2017/2018), according to the 2018-2019 Annual Report.

The Department of Health's Practitioner Review Program (PRP) routinely monitors the claiming of MBS items and will review and contact a doctor if their billing profile identifies statistical outliers when compared to their peers. Common examples are rendering a statistically abnormal volume of total and daily services.

The PSR predominantly resolves inappropriate billing through negotiated agreement. An agreement generally states the amount of money to be repaid and may include a partial amount, a total amount, and even disqualification from participating in the MBS and Pharmaceutical Benefits Scheme (PBS). In 2019-20, the PSR partially disqualified 59 practitioners and made full disqualifications of two practitioners.

In addition to repayment orders or other actions, the PSR can refer practitioners to the regulatory body to assess patient safety concerns and concerns over non-compliance with professional standards.

INAPPROPRIATE PRACTICE

Inappropriate practice relates to conduct by practitioners or corporate entities. It is defined in the Health Insurance Act 1973 (Cth) and refers to:

- the conduct of a practitioner regarding provided services that attract a Medicare or pharmaceutical benefit, which would be unacceptable to the general body of that practitioner's professional peers
- situations where 80 or more services are provided on 20 or more days in a 12 month period (the 80/20 rule), and
- situations where a person (including an individual, a practitioner, a body corporate, and officer of a body corporate), has knowingly, recklessly or negligently caused, or permitted a practitioner to engage in, conduct that constitutes inappropriate practice.

> Practitioners can minimise the risk of Medicare concerns, which can lead to a Medicare or PRP review or investigation

PRACTITIONER REVIEW PROGRAM

The Medicare Professional Services Review process can be stressful, onerous and time-consuming. PRPs may result in the Chief Executive Medicare or their delegate making a request to the Director to review the relevant services over a period of up to two years from the date of the request. If the Chief Executive Medicare becomes aware of a prescribed pattern of services, they must make a request to the Director.

As part of the PRP, a practitioner may be given an opportunity to provide a written submission or additional information relating to concerns about claiming or prescribing. If that happens, practitioners should first contact their medical defence organisation for guidance.

WAYS TO MINIMISE THE RISK

Practitioners can minimise the risk of Medicare concerns, which can lead to a Medicare or PRP review or investigation, by:

- having a clear clinical justification for management decisions, including referrals and prescriptions that accords with generally accepted, competent professional practice
- making legible notes containing sufficient detail of history taken, examinations, investigation results, diagnosis and management plans to allow another practitioner to provide ongoing care
- ensuring there is sufficient information documented to justify why the claim was appropriate for less common Medicare items
- being aware of the Medicare 80/20 rule
- keeping up-to-date with item descriptors, as these can change
- monitoring compliance with all Medicare requirements, and
- contacting Medicare for clarification.

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