Rights of Private Practice – Rights/Obligations, Cost Shifting and Billing

The Association has recently received a number of queries regarding rights and obligations for State Public Sector full time, 0.8 and sessional salaried practitioners operating under Arrangement A and sets out updated general advice hereunder for your information.

As a consequence of incorrect advice being given by some managers’ additional advice sought and received from Medicare relating to supervision requirements for procedural trainees services to bona fide private patients to attract Medicare benefits is also included. Separate advice in respect to retrospective billing is also provided.

Private Practice - In or using the employer’s facilities
The AMA Industrial Agreements provide, a medical practitioner with the right to private practice shall at the time of being appointed be granted a right of private practice subject to the conditions of the Agreement. (Clause 27 (2)) “A practitioner may elect to relinquish all private practice income retention rights” “in or using the hospitals”\(^1\) facilities, assign such private practice income to the employer and receive the Arrangement A allowance in lieu as shown hereunder.

<table>
<thead>
<tr>
<th>Position</th>
<th>1-Oct 10</th>
<th>1-Oct-11</th>
<th>1-Oct-12</th>
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</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>$86,722</td>
<td>$90,243</td>
<td>$94,304</td>
</tr>
<tr>
<td>Health Service Medical Practitioner</td>
<td>$58,669</td>
<td>$61,015</td>
<td>$63,761</td>
</tr>
<tr>
<td>Non Specialist Qualified Medical Administrator</td>
<td>$64,751</td>
<td>$67,341</td>
<td>$70,372</td>
</tr>
<tr>
<td>Snr Medical Practitioner</td>
<td>$64,751</td>
<td>$67,341</td>
<td>$70,372</td>
</tr>
<tr>
<td>Medical Administrator</td>
<td>$86,722</td>
<td>$90,243</td>
<td>$94,304</td>
</tr>
<tr>
<td>Vocationally Registered General Practitioner</td>
<td>$64,751</td>
<td>$67,341</td>
<td>$70,372</td>
</tr>
</tbody>
</table>

\(^1\)Hospital in this context refers to the employer and also includes Health Services and the Health Department itself.

Relevant provisions from the AMA Industrial Agreements relating to Arrangement A clinicians include:

Clause 28(2) prescribes:
“A practitioner who assigns to the Employer private practice income generated from all work, whether publicly or privately funded, carried out on behalf of the Employer shall:

(a) be paid the applicable Private Practice Income Allowance;
(b) authorise the employer to render accounts in the Practitioner’s name; and
(c) on each occasion the opportunity to exercise private practice rights arises, assess the fee to be charged and advise the Employer so that an account can be rendered by the Employer”. i.e. the practitioner determines the fee he or she will charge for the service provided.
Clause 27(4) prescribes:
“A practitioner shall, to the fullest extent permissible by law, exercise rights of private practice in any public teaching hospital or in any other public sector health care facility in which the practitioner works”.

Under these arrangements the practitioner receives, on a fortnightly basis, a private practice income allowance as set out in the above table.

Clause 27(5) prescribes:
“The hospital shall provide to the practitioner a copy of the Patient Election form or other evidence of an election to be a private patient which would satisfy Medicare Australia or other applicable health insurers of the election to be a private patient for those private patients admitted under the care of the practitioner.”

Clause 27(6) prescribes:
“A Practitioner who does not comply with the terms and conditions under which facilities are made available to the practitioner for the purpose of engaging in private practice forfeits the ability to exercise rights of private practice” i.e. As a quid pro quo for receipt of the allowance the practitioner is obliged to seek to maximise their rights of private practice within the hospital and assign that consequent income to the employer.

In accordance with the Agreement, if the employer determines the practitioner is not exercising rights of private practice to the fullest extent permissible by law in the context of their specialty/role, the employer can seek to withdraw the exercise of rights of private practice in which case the practitioner would not qualify for the Arrangement A allowance. Such a decision however, may be challenged pursuant to Clause 27(8) and Clause 55. - Dispute Settling Procedures may be invoked. In accordance with sub-clause 55(5), the status quo that existed prior to the dispute arising must remain in place whilst such procedures are followed. i.e. Arrangement A should continue. Note: In some cases e.g. Emergency Medicine, the capacity to earn private income is minimal. The amount earned is irrelevant to the right to elect Arrangement A.

The failure by the hospital to provide patient election forms and properly administer their obligations does not affect the practitioner’s rights to Arrangement A.

Personal Responsibility not assigned
It should be noted the practitioner still retains (and cannot assign) their personal medico-legal responsibility under the Federal Health Insurance Act for ensuring, where applicable, the proper referral is in place and determining the correct item number(s). The practitioner is also responsible for determining the individual fee(s) he or she wishes to charge a particular patient as set out in Clause 28(2)(c) above.

Employer Responsibilities – Doctors should Request Quarterly Statements
Clause 28(3) prescribes:
“The employer in acting as agent for the practitioner shall ensure that no account is rendered which could place the practitioner in breach of the Health Insurance Act 1973 (Cwth). The employer shall, if requested, provide to the practitioner on a quarterly basis a statement detailing total amount of accounts rendered and amounts collected (exclusive of GST) in the practitioner’s name.”
Unfortunately as has been demonstrated previously, the Employer has not always ensured that doctors have not been exposed legally.

The AMA strongly advises practitioners to ensure all facets of this advice is complied with. The Association would strongly advocate that the practitioners insist on receiving a quarterly statement as provided for in Clause 28(3) so that they can reconcile their activity to ensure that bills are not being sent out in their name which do not comply with the requirements of the Health Insurance Act. There have for example been instances where items relating to a different specialty have been raised in the doctor’s name.

Indemnity
Salaried practitioners under Arrangement A are covered by Government Indemnity in relation to medical negligence claims for both public and private patients. Practitioners employed in the metropolitan area under Arrangement B are not covered by the State for private patients. The scope and quality of that indemnity was substantially improved a few years ago as a consequence of strong lobbying by the AMA. That indemnity does not however, cover inquiries or investigations by for example the Health Insurance Commission, Coroners Court or the Medical Board. Doctors are advised to maintain additional complimentary private M.D.O. cover for such purposes and for access to independent legal advice when required. The Professional Development and Expense Allowance secured by the AMA which is payable fortnightly and, as at 1/10/11 in metropolitan Perth, equates to $23,468 is designed to assist in meeting such costs (as well as AMA subscriptions).

Tax Issues
It should be noted that the ATO has issued a number of rulings in the Eastern States indicating that any income raised in the practitioners name needs to be declared on their tax returns and providing that where that is assigned to the hospital pursuant to a contractual obligation that a corresponding offset can also be claimed. It is likely that the principles underpinning such rulings will similarly apply in W.A. It is, however, important that practitioners consult their own accountants regarding taxation requirements.

Trade Practices Considerations
It should also be noted that under the Trade Practices Act (now called the Competition and Consumer Act 2010), individual clinicians cannot be dictated to in terms of the fees that they charge their private patients. Doctors not in a legal partnership of natural persons should not collectively agree on fees to be charged nor should a hospital direct a practitioner as to what the practitioner should charge. An individual doctor must determine their own general fee and should instruct the employer as to what their fee will be, generally in the absence of the doctor determining a different fee for the individual patient. i.e. A standing instruction could be issued to the employer by the individual. A copy of the standing instruction should be retained and confirmation from the employer should also be sought that the employer will comply with the doctor’s instructions.

Concerns could also arise if the hospitals sought to develop initiatives which unfairly competed with external Private Practice which could offend the anti competitive provisions of the Act.

Health Insurance Act
It is emphasised that the practitioner remains fully accountable under the Health Insurance Act and must ensure where relevant, a valid arms length referral exists and the correct item numbers are used to ensure that the Commonwealth is not paying Medicare benefits when they should not be. All practitioners are urged to become familiar with referral /itemisation requirements if they are not already and should consult both the CMBS and AMA List of Medical Services and Fees for further information.
Further details regarding Industrial Rights and Obligations are set out in Clauses 27 & 28 of the AMA Industrial Agreement. Practitioners who are operating under Arrangement B should also refer to Clause 29 of the AMA Industrial Agreement.

Cost Shifting and or Privatisation
Any proposals to change the manner in which services are provided in public hospitals which might involve increasing private activity or privatising existing public activity needs to be very carefully considered and if appropriate, legal advice sought. The Association has previously provided detailed advice in relation to the Ambulatory Surgery Initiative (ASI) and Privately Referred Non In-patients (PRNI) and secured a commitment to improved additional indemnity coverage for such initiatives. Given previous adverse publicity and investigations by external authorities in the past the Association would urge practitioners to exercise due diligence, and seek appropriate advice from the Association and their Medical Defence Organisation in relation to any information provided by the hospital before considering participating in any such initiatives.

Medical practitioners should be wary, for example, of management which seeks to insist there is an obligation to participate in arrangements in order to maintain access to Arrangement A, where what is being proposed is a change in traditional private practice activities for the Department, eligible patients are not being given a free choice to elect to be treated free as public patients and there is a lack of independent external confirmation of the lawfulness or otherwise of what is being proposed. Whilst the Association strongly supports clinicians and hospitals legitimately maximising income, great care needs to be taken to not replicate problems that have arisen in the past, by over enthusiastic or naive management embarking upon schemes which subsequently result in significant adverse publicity, investigation and emotional distress, such as occurred a few years ago in relation to a trust fund enquiry at one of our major hospitals.

Personal Provision for Consultations and Direct Personal Supervision of Procedural Trainees

Following recent concerns and incorrect advice being given by Health management over supervision requirements the following advice is provided:

1. THE CMBS Notes for Guidance state:

   Consultations:
   The Federal Health Insurance Act 1973 specifies that other than for a narrow group of services that may be rendered by or “on behalf of “ that medical benefits will only be payable if they have been personally performed by the billing practitioner” e.g. Consultation items. For exceptions refer to the CMBS Notes for Guidance (G.12 .1-2).
   Specialist and Physician Consultation items for example should be personally provided by that consultant even though a trainee might participate

2. Procedures undertaken by Trainees.

   Attached is detailed advice published in February 2012 Medicus from Medicare (replicated in full) which emphasises that for procedural services to bona fide private patients undertaken by procedural trainees the supervising practitioner must be “present at all times while the specialist trainee provides a medical service”. 
Supervising practitioners in whose name bills are raised should ensure that all the requirements detailed in the Medicus article are met.

Request by HCN for previous Patient Billing Information
The Association is aware that practitioners have been requested by HCN or the Hospital to assist in issuing bills for patients treated years previously which raises a number of concerns for the Association. The Association has prepared the following simple check list to ensure that you do not expose yourself to potential fraudulent activities arising from the employer failing to seek such information as required in a timely manner in 2008, 2009, 2010, and 2011.

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<tbody>
<tr>
<td>1</td>
<td>Has the patient been given the choice to be public or private and if private have you cited the election form or other complying evidence of private election?</td>
</tr>
<tr>
<td>2</td>
<td>Has the Patient received informed financial consent?</td>
</tr>
<tr>
<td>3</td>
<td>Are you as the billing practitioner satisfied there is a valid referral in place</td>
</tr>
<tr>
<td>4</td>
<td>Did you as the practitioner personally perform the consultation and determine the item number?</td>
</tr>
<tr>
<td>5</td>
<td>Did you either personally perform the procedure or anaesthetic being proposed to be billed in your name or provide constant and personal in theatre supervision of the trainee throughout the procedure?</td>
</tr>
<tr>
<td>6</td>
<td>Did you as the practitioner providing the service have the opportunity of assessing and notifying HCN of the fee to be charged?</td>
</tr>
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If you answer NO to any of the above questions decline to complete billing form or ask HCN for more details.

In short
Practitioners exercising rights of private practice have an obligation to exercise that right to the fullest extent permissible by law. Appropriate income maximisation is supported but to be lawful:

1. A Patient has to have freely been given choice between public and private.
2. Be seen in accordance with clinical need.
3. There needs to be a Valid referral (see CMBS –Section G.6.1.for full details).
4. The Hospital needs to provide the Doctor with patient election form (or other acceptable evidence) (Clause 27 (5)).
5. Consultative services must be provided personally whilst procedural service performed by trainees to be eligible for Medicare benefits MUST in addition to these criteria be personally and continuously supervised in theatre by the Consultant.
6. There needs to be informed financial consent. Only you can determine the fee in each instance. You cannot be directed by anyone as to the fee you determine either generally or in a particular case.
7. Remember YOU remain medico legally liable. You are only assigning income/billing not any potential liability. The Indemnity referred to above is exactly that.
8. Action by Employer seeking to induce illegitimate cost shifting could result in misconduct and/ or fraud investigations.
9. If in doubt, seek independent written advice.

This advice is general in nature. The full provisions are set out in the AMA Industrial Agreement available on the AMA (WA) website at www.amamwa.com.au Members with any queries should not hesitate to consult the Association, their IHLC Representative or Medical Defence Association if they have any concerns.
Membership

The AMA reiterates that it is only able to assist financial members of the Association should issues arise in the workplace. Like insurance companies membership provides you with advice and assistance for issues that arise during your membership. Therefore practitioners are strongly advised to join the AMA to ensure that the Association can assist with your future issues. The membership application form on the subsequent page can be completed and sent back to the AMA at 14 Stirling Highway, NEDLANDS WA 6009 or alternatively you can join on-line via www.amawa.com.au.

Support the Association that Supports You!
Become a Member now!

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MEMBERSHIP APPLICATION

Given Names________________________ Surname________________________

hereby applies to be elected a member of the Australian Medical Association and the Australian Medical Association (WA) Inc.

Signature__________________________ Date ___/___/___

Preferred Name____________________ Date of Birth ___/___/___ M F

Correspondence

To Home          To Practice

Address________________________________________________________

Tel______________________Mobile_______________Email__________________

Practice Address___________________________

tel______________________Mobile_______________Email__________________

Type of Practice

Specialist Specialty/Specialties______________ Registrar Speciality_____

Sub Specialty/Specialties___________ Level:

General Practitioner Specialty/Specialties___________ RMO/ Intern_________

Other (please give details)_____________ Level:

Mail to AMA PO Box 133 Nedlands WA 6909, or fax to (08) 9273 3073 or email membership@amawa.com.au or join online: www.amawa.com.au. We will send a tax invoice and further membership information upon receipt of your completed application form.
Following queries by members, AMA (WA) sought advice from Medicare on the situations described below. The answers have been replicated in full. They have also been forwarded to the WA Health Department Chief Executive and HCN, to seek to ensure that all involved parties are aware of their respective obligations in providing and billing private patient services, and that doctors are not exposed to investigation with potentially serious consequences for non-compliance.

Q1. Private Hospital

a. Surgical registrar performs surgery on a consenting private patient physically supervised by the consultant surgeon.

Question:
Is a surgical rebate payable?
Is an anaesthetic rebate payable?

b. As above, but the surgeon is not physically present but is available by telephone.

Is a surgical rebate payable?
Is an anaesthetic rebate payable?

Health Professional Branch response

Division 2.36 of the Health Insurance (General Medical Services Table) Regulations 2011 (the Regulations) outlines certain principles around provision of medical services by specialist trainees. I am copying the salient rules in full below as they are relatively straightforward.

Rule 2.36.1
Definition
In this division:
Specialist trainee under the supervision of a medical practitioner means a medical practitioner who is:
(a) Enrolled in and undertaking a training program with a medical college; and
(b) Supervised by a medical practitioner who is present at all times while specialist trainee provides a medical service.

Rule 2.36.2 Medical services that may be provided by medical practitioner or specialist trainee medical services – items

(1) A medical service set out in the following items may be provided by a medical practitioner or a specialist trainee under the supervision of a medical practitioner:
(a) Items 13015 to 16018;
(b) Items 16600 to 16636;
(c) Items 18213 to 18298;
(d) Items 20100 to 51318.

Medical services taken to be provided by supervising medical practitioner

(2) If a medical service set out in an item mentioned in paragraph (1) (a) to (d) is provided by a specialist trainee under the supervision of a medical practitioner, the medical service is taken to have been provided by the supervising medical practitioner.

The above provisions clearly indicate that the supervising practitioner must be “present at all times while the specialist trainee provides a medical service”.

Therefore, a surgical service provided by the specialist trainee where the supervising surgeon is available by telephone, but is not physically present, is not a service for which a Medicare rebate is payable.

The Health Insurance Act 1973 and the Regulations provide that where the relevant surgical service:
• Reflects an item in the General Medical Services Table which attracts anaesthetic; and
• Is a clinically relevant service; and
• Is provided by a registered medical practitioner;
an associated anaesthetic rebate may be payable.

The payment of an anaesthetic rebate is not dependent on a rebate being paid for the surgical service. The fact that the surgery is provided by a surgical trainee without immediate supervision prevents the payment of a surgical rebate but does not, in itself, prevent payment of an anaesthetic rebate. It is sufficient that the surgical trainee is a registered medical practitioner providing a clinically relevant service. As is the case with any MBS item, the relevant anaesthetic item descriptor must be met for any rebate to be payable.

Q2. Public Hospital

Patient has been admitted via ED with a referral generated by a registrar in ED to a surgeon. Patient initially came in as a public patient and after discussion agrees to elect to be private on a no gap basis.

or

Patient has initially been referred into outpatients by an outside practitioner;

either

1. an outside practitioner has provided a referral to a name Dr or
2. Hospital Dr. e.g. registrar in outpatients provides a referral to a named Dr. e.g. his/her consultant and
   a. Surgical registrar performs surgery with either:  
      i. A specialist anaesthetist
      ii. An anaesthetic registrar under physical supervision.
      iii. An anaesthetic registrar under indirect supervision with a consultant anaesthetist in the next theatre.

Does it make any difference if the hospital has waived the bed fees as the patient is not privately insured but has agreed to be private on the basis they will not be out of pocket?

**Health Professional Branch response**

Each of the referral mechanisms described may represent a valid referral, viz:

- Referral by an emergency department registrar to surgeon.
- Referral by an external medical practitioner to a named doctor in a public hospital outpatients department.
- Referral by a hospital registrar to a named doctor in a public hospital outpatients department.

For the referral to be valid:

- The referring medical practitioner must consider the need for the referral;
- The referral must be written, signed by the referring practitioner and dated; and
- The referral must contain any information about the patient’s condition that the referring practitioner considers necessary.

For the services provided as a result of the referral to attract Medicare rebates:

- The specialist or consultant physician to whom the patient is referred must be exercising a right to private practice within the public hospital;
- The patient must have elected to be treated as a private patient, and that election must be on the basis of informed financial consent;
- Any services provided must be clinically relevant services; and
- Relevant item descriptors must have been met.

As indicated previously, a surgical service provided by a specialist trainee will attract a Medicare rebate only where the supervising practitioner is “present at all times” while the specialist trainee provides a medical service”. Where supervision is provided remotely, including from within the hospital or by telephone, no rebate is payable.

   As indicated previously, the fact that the surgery is provided by a surgical trainee without immediate supervision prevents the payments of a surgical rebate but does not, in itself, prevent payment of an anaesthetic rebate.

   However, where provision of the anaesthetic is by an anaesthetic registrar (or specialist trainee) the same supervision requirements that apply to the surgical service apply to the anaesthetic service. That is, provided the supervising anaesthetist is “present at all times” while the specialist anaesthetic trainee provides a medical service, an anaesthetic rebate may be payable. Where the anaesthetist supervises the anaesthetic registrar remotely, including from the next theatre, no rebate is payable for the anaesthetic service.

   Whether or not the hospital elects to waive bed fees for the patient is a choice to be made by the hospital. Whether or not a specialist or consultant physician elects to bill in a way that reduces the patient’s out of pocket costs is a private matter between the treating doctor and the patient. However, hospitals are reminded that financial arrangements that constitute cost shifting from the public hospital system to the MBS may breach the Health Insurance Act and may breach the National Healthcare Agreement between the Commonwealth and each State/Territory.

**Q3: Clarification**

I take it from the advice that in the scenario where, for example, a surgical trainee operating on a patient who has elected to be private is not directly supervised by a specialist but the anaesthetic trainee is directly supervised and all other criteria are satisfied, that Medicare benefits are not payable for the surgical service but are payable for the anaesthetic service. Similarly, if the reverse is the case they are payable for the surgical component but not the anaesthetic component. I also assume that eligibility for Medicare benefits for related services to the private patient provided during the episode of care/hospital stay e.g. radiology, pathology and other medical services would not be affected by the surgical or anaesthetic services eligibility and would be assessed as to whether they complied with their individual eligibility criteria.

**Health Professional Branch response**

The conclusions in the above paragraph are correct.

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Members with any queries should contact AMA (WA)Deputy Executive Director, Mr Peter Jennings, on 9273 3000