Australia's Medicare billing is a problem, but researchers find many more GPs undercharge

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Australia's Medicare billing system is overly complicated, bureaucratic and not meeting the needs of a modern health service, potentially leaking billions of dollars. But claims this loss is mostly due to fraudulent billing

practices by GPs are inaccurate.

In October, the ABC's 7.30 program and the Nine newspapers raised concerns about an estimated A$8 billion in Medicare waste, caused by a mixture of doctors' errors, over-servicing and outright fraud. The examples given, however, were almost exclusively intentional fraud, mainly in general practice. This promoted health minister Mark Butler to commission an independent review, led by Dr. Pradeep Philip.

The Philip review, released earlier this month, was highly critical of the current Medicare system and found non-compliance and fraud accounted for $1.5 to $3 billion of Medicare waste.

Our research team analyzed GP activity recorded during almost 90,000 patient encounters to assess how GPs were billing for the services they provided.

We found GPs undercharged at 11.8% of encounters and overcharged at 1.6%. This suggests GPs aren't routinely defrauding Medicare, and in fact have saved the system equivalent to $351 million in the 2021-22 financial year.

However, we agree the current billing system needs to be urgently reformed.

How does Medicare billing work?

GPs claim a fee for service, called a rebate, which is a fixed amount ascribed on the Medicare Benefits Schedule (MBS), based on the type of service provided.

There are nearly 6,000 MBS item numbers. GPs can charge for one or more MBS items for a patient service.

Around 90% of MBS items claimed by GPs are considered standard consultation items (surgery, residential aged care facility visits, home visits and so on), that are in four levels (A, B, C and D) which increase in length.

The cost associated increases with each level. An example of an error would be a GP accidentally charging for a Level C consultation (requires 20 minutes or longer; $76.95 rebate) when the visit only met the criteria for a Level B (less than 20 minutes; rebate of $39.75). An example of under-billing is when a GP is entitled to claim for a Level C but charges only a Level B.

An example of over-servicing is a pathology test for blood glucose level being repeated for the same patient at consecutive visits, where the patient's condition did not warrant the second test.

An example of fraud would be claiming for a service that had not been provided.

Examining doctors' billing in the real world

The data we analyzed in our peer-reviewed study were collected between 2013-2016 from nationally representative samples of GPs during 89,765 real-time encounters with their patients. The GPs recorded the start and finish time for each visit.

The Philip review did not try to quantify the amount of underbilling.

We decided to examine the billing data following the 7.30 Report/Nine news investigation, but the participants could not have been influenced by these reports as the data we used were collected prior to the ABC/Nine publications.

Why would doctors undercharge?

We theorized GPs were likely undercharging Medicare for two reasons:

1) while time is the predominant measure, GPs are likely to still consider content and complexity when billing standard Medicare items, rather than just billing according to the time spent with the patient

2) fear of triggering a professional services review (PSR) of their billing.

A professional services review can be triggered for a variety of reasons, for example, a GP has a higher proportion of longer consultations than might be expected. A professional services review involves an audit of the GP's billing. It can potentially lead to a decision that can prevent the GP from being able to bill Medicare.

Last week, HealthED, a health education company, included three post-webinar questions on this topic in an online survey of 1,852 GPs from across Australia. Answering these questions was not compulsory.

The results showed most (83.3%) GPs consider the length and complexity of the consultation when billing Level C and D items, even though increased complexity is no longer required (since 2011).

More than half (60.3%) intentionally under-billed Medicare in the previous week.

The most common reasons for under-billing were:

- they did not feel that the content of the consultation justified a higher MBS item (41.9%)
- fear of triggering a professional services review alert (33.5%)

- confusion around Medicare schedule criteria (30.8%).

These responses correlate with the findings from our nationally representative sample, which suggests GPs predominantly act with integrity, but also based on fear and confusion.

Time to reform Medicare billing

A simplification of the current very complex Medicare billing system would resolve a lot of waste through unintended errors. Reducing low value and unnecessary care is not a simple task as these are difficult to define, and often rely on situational judgment. When systems are no longer fit for purpose, they should be reviewed and revised, as the Philip review has recommended.

There are bad actors in every profession and those who "game" Medicare should be called out. However, the claims of widespread fraud have not been supported by our work or the Philip review.

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