AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T I 61 2 6270 5400
F I 61 2 6270 5499
E I ama@ama.com.au
W I www.ama.com.au
39 Brisbane Ave Barton ACT 2600
PO Box 6090 Kingston ACT 2604

SUBMISSION

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AMA submission – Assignment of Benefits for Simplified Billing 2025

Via email: AssignmentofBenefit@health.gov.au

Introduction

The AMA is supportive of some of the proposed changes, which constitute the next stage in aligning Assignment of Benefit (AoB) rules under the Health Insurance Act with modern practices, however some aspects will be impractical and unworkable. We have supported the changes on the basis that they should be flexible and simple and should not impose additional bureaucratic burdens on patients, clinicians, hospitals, or insurers. As such, we are strongly supportive of prospective AoB through a robust informed financial consent (IFC) process, but we oppose any requirements to amend or change AoB after the procedure. This will create administrative nightmares for doctors to the detriment of patients and the system more broadly.

We will also need the Department to ensure there is a stronger focus on digital health solutions that can be integrated into workflows but will still allow other methods of communication to ensure no patients are excluded. The proposed changes should facilitate building enhanced IFC into clinical software systems.

We also note that once proposed changes are finalised the AMA will need to update the informed financial consent guide, a process that will take some months as it requires consultation with all cosignatories to the resource.

Proposed changes

The AMA supports the intent of the changes, noting some details require further attention and clarification. We recommend the department work with stakeholders to develop standardised forms and processes that will achieve the objective of minimising administrative burdens while enhancing consumer understanding.

The AMA support preauthorisation during the IFC process for private hospitals with mandatory field changes to electronic claim lodgement, as suggested by the department. The proposed changes do not impose a significant administrative burden on practices, as they only require minor adjustments to existing forms. However, we are concerned the requirement for practitioners or practice managers to tick off every MBS item in the OEC is far too onerous. We recommend a single box is sufficient to indicate that assignment has been done for all MBS items included in the claim.

The AMA opposes the statement in table 2 (p5): "If required, the medical practitioner needs to modify the request to cover complications or unplanned treatment." This is impractical and unrealistic. We do not support the requirement for further patient consent to permit billing of codes not specified in the IFC documentation.

Many circumstances can result in making changes to the item numbers billed during surgery, and the IFC for a procedure should cover anything associated with that occasion of service. If required, the medical practitioner needs to modify the request to cover complications or unplanned treatment. This needs to be forward-looking.

Patients are not in a position to determine which codes should be used and may be unable to engage after surgery, such as in the unfortunate event of a patient's death during the procedure. In such cases, the procedure might require different items than initially agreed upon. While the patient cannot assign these items, the practitioner should still be able to claim them. The auditing process and record retention requirements should facilitate this.

Additionally, it may be impractical to contact the patient immediately. Patients typically do not need to engage until a post-surgery check-up, which can be up to a month later. It is unreasonable to withhold the practitioner's payment during this waiting period. As such, we suggest altering this requirement.

If the process is too complex for surgeries where it is more likely additional items will need to be claimed, i.e. for more complex patients, it creates perverse disincentives for surgeons or anaesthetists to treat the patient when a simpler billing process will exist for straightforward procedures.

Prepayment verification for specialists

We disagree with the argument against prepayment verification for specialists. The OEC is online, and there are usually a few days between seeing the specialist and needing to be admitted, unless the patient is already hospitalised. Therefore, prepayment verification is not a significant issue for specialists.

We do not necessarily agree with the argument that patients will not comply with the AoB process for specialists. The process for specialists typically involves sending information to the patient via letter, email or application (app) to complete the IFC. Most patients with private health insurance are not in remote areas without reliable internet access, so this may not be a significant issue.

Insurance coverage

Determining whether a patient is adequately insured remains problematic, for example in orthopaedics. Patients often believe they are insured but are not, especially regarding specific coverage — such as that for joint replacement versus joint reconstruction. In public hospitals, practitioners have no control over IFC processes and are often not informed when a patient elects to use PHI. The proposed requirements would be unworkable in these settings. Additionally, in trauma or emergency surgery situations, formal IFC is not possible, and this should not preclude billing these patients.

A free and simple mechanism to confirm a patient's insurance status would be beneficial, akin to the *Thelma service* some practices use to check PHI eligibility.

Record Keeping

This will be a significant change for many practitioners and will require extensive communication. Introducing penalties for non-compliance with the new requirements could also further complicate the process. Clear guidelines regarding format of retained records, and the duration for which they should be retained, will be essential. We also strongly recommend a grace period on compliance once the new arrangements have been introduced.

The changes will make the process more complex for specialists who are not registered with insurers, or when the doctor's fee is above the known gap limit. Implementation of these changes should ensure instances of patients carrying the burden of pursuing Medicare rebates and PHI contributions are minimised.

Under the current no gap or known gap arrangements, the practice bills the insurer and receives the insurer's fee, which includes the Medicare component and does not need to bill Medicare directly. Any new arrangements should remain simple, avoiding direct communication with Medicare for the rebate when the insurer is paying the rest.

Contact

president@ama.com.au