Royal Australasian College of Surgeons

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Ms Hayley Petrie
A/g First Assistant Secretary
Benefits Integrity Division
Department of Health and Aged Care
GPO Box 9848
Canberra ACT 2601

Subject: Consultation on Proposed Amendments to the *Health Insurance Act 1973* to Improve Medicare Integrity

Dear Ms Petrie,

The Royal Australasian College of Surgeons (RACS) would like to take this opportunity to provide feedback on the Australian Department of Health and Aged Care's consultation regarding amendments to the *Health Insurance Act 1973*. RACS recognises the importance of these proposed amendments. However, concerns exist as to any unforeseen obstructive impact caused by legislative change affecting surgeons and their patients. On closer examination, the *Health Legislation Amendment (Improved Medicare Integrity and Other Measures) Bill 2024* aim to enhance Medicare by strengthening their compliance processes. This would result in improving regulatory oversight. These changes were highlighted in the *Independent Review of Medicare Integrity and Compliance*. The Review emphasized the necessity for such reforms, particularly in relation to administrative inquiries and recoveries, as well as the use of information in health regulatory proceedings. RACS' focus is on the minutia and the need for more detailed explanation, especially when considering any alleged regulatory contraventions.

Introduction

It is paramount to ensure the sustainability and integrity of Medicare. RACS supports all efforts towards improving Medicare compliance to prevent fraudulent activities. But any amendments must take into consideration the possibility of error and miscalculations. A balance is needed between robust oversight and the protection of a surgeon's autonomy to run their practice effectively, as well as patient rights. Natural justice and procedural fairness are necessities to allow a surgeon to stand their case if the evidence can be put into question. Systemic mechanisms that increase administrative oversight, broaden information-sharing powers, and refine Medicare compliance measures appears to be the goal of these amendments. But caution must be exercised in how clinicians would be impacted by any possible regulatory overreach. Beneficial and fit for purpose provisions to protect and defend both patients and surgeons are needed.

Surgically for whatever type of compliance measures, it is necessary to consider the special clinical procedural circumstances that exist for all surgical specialties. Unlike general practice, where the Medicare claims involve lower-cost, high-frequency items, surgical procedures may differ when considering cost and frequency of interventions. Take, for instance, spinal surgery and bariatric surgery, both surgeries have rigorous clinical guidelines requiring nuance assessments. For low back pain, local Clinical Care Standards from the Australian Commission on Safety and Quality in Health Care explain the activities, including referral for specialist review including surgery. This guideline included input from the Australian Orthopaedic Association. International guidelines provide further detail for surgery, for example for lumbar spinal stenosis, a common indication for age-related lower back pain. For bariatric surgery, local guidelines step out best practice before surgery is considered, while international guidelines provide further detail on surgical approaches.[1] Broad compliance

[1] Anderson DB, Beard DJ, Rannou F, Hunter DJ, Suri P, Chen L, et al. Clinical assessment and management of lumbar spinal stenosis: clinical dilemmas and considerations for surgical referral. Lancet Rheumatol. 2024 Oct;6(10):e727-e32. Australian Commission on Safety and Quality in Health Care. Low back pain. Clinical care standard. 2022 [cited 2025 11 Mar]; Available from: https://www.safetyandquality.gov.au/sites/default/files/2022-08/low_back_pain_clinical_care_standard.pdf

measures may result in undue restrictions leading to unjustified audits and payment restatements. If sufficient protective measures are not put in place, there is a danger that valid surgical procedures will be regarded as being non-compliant and could be inappropriately flagged which may ultimately harm the patients' much needed access to clinical care attention.

RACS's submission will analyze critically these draft amendments and their likely impact on surgical practice, regulatory accountability, and cost transparency. RACS will identify the main areas that need more clarification and suggests actions to enhance the legislative framework without undermining trust and efficiency in Australia's healthcare. Our discussion takes into account of the wider implications of the changes, including their effects on professional responsibilities, compliance costs, and the increasing role of insurers in Medicare administration. RACS is happy to work with the Department to make sure the amendments have the desired effect without causing any adverse unintended impacts on the surgical profession and on patient care.

Background

The Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical standards, professionalism, and education in Australia and Aotearoa New Zealand. It represents over 8,300 surgeons and 1,300 surgical trainees and Specialist International Medical Graduates (SIMGs). As a not-for-profit organization, RACS funds surgical research, supports healthcare, and provides surgical education in the Indo-Pacific. The College trains surgeons in nine specialties: Cardiothoracic, General, Neurosurgery, Orthopaedic, Otolaryngology Head and Neck, Paediatric, Plastic and Reconstructive, Urology, and Vascular surgery.

Operations are a significant component of Medicare expenditures, and high-cost procedures such as joint replacement, cardiac surgery, and cancer resections are under rigorous regulatory constraints. RACS has sought a balance between accountability mechanisms and ensuring that patient's access to care is not hindered by administrative barriers. This submission builds on earlier submissions presented by RACS, particularly those to the MBS Review Taskforce, and is consistent with our continued commitment to enable evidence-based policy in the regulation of surgical practice.

Proposed Changes – Administrative enquiries and recoveries

The Independent Review of Medicare Integrity concluded that existing compliance mechanisms are not sufficient to detect, prevent, and rectify improper payments and thereby compromise Medicare integrity and public trust. Proposed reforms aim to enhance payment accuracy, notably by enhancing information collection from third parties and reinforcing reclamation mechanisms for non-compliant payments.

Changes will create new Medicare compliance measures to allow requests for relevant payment information from individuals such as practice staff or other practitioners. If evidence suggests a payment did not meet requirements, recovery may occur following natural justice, such as when a practitioner lacks the necessary qualifications for a Medicare service.

The revised sections and subsectionswithin 'Administrative enquiries and recoveries' must include compliance issues, regulatory evaluation, recovery of payments, and responsibilities pertaining to assignment of Medicare benefits. Section 127 is particularly pertinent in that it encompasses provisions pertaining to notices, conformity with regulations, and the authority to impose civil penalties.

Below are sections and subsections which may have implications for surgeons in relation to administrative enquiries and recoveries. These are as follows:

- **Section 20A(6) – Regulations:** This allows for regulations prescribing requirements related to Medicare benefit assignment agreements, including compliance obligations.
- **Section 20AAA(2) – Assignment of Medicare Benefits:** Automatic assignment ('right to the payment') of Medicare benefits under specific conditions. Its impact relevant to administrative tracking and recoveries.
- **Subsection 127(1), (3), (4), (5), and (6):** These subsections appear to mandate professionals (by means of contravention and penalties), insurers, or billing agents to provide notifications essential for auditing and administrative recoveries. Subsection 127(6) includes a civil penalty provision, highlighting enforcement measures related to compliance.

Rousing R, Jensen RK, Fruensgaard S, Strøm J, Brøgger HA, Degn JDM, et al. Danish national clinical guidelines for surgical and nonsurgical treatment of patients with lumbar spinal stenosis. Eur Spine J. 2019 Jun;28(6):1386-96.
Eisenberg D, Shikora SA, Aarts E, Aminian A, Angrisani L, Cohen RV, et al. 2022 American Society for Metabolic and Bariatric Surgery (ASMBS) and International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO): Indications for Metabolic and Bariatric Surgery. Surg Obes Relat Dis. 2022 Dec;18(12):1345-56.
Markovic TP, Proietto J, Dixon JB, Rigas G, Deed G, Hamdorf JM, et al. The Australian Obesity Management Algorithm: A simple tool to guide the management of obesity in primary care. Obes Res Clin Pract. 2022 Sep-Oct;16(5):353-63.

Critique to Proposed Changes – Administrative enquiries and recoveries

The objective of the *Health Insurance Legislation Amendment (Assignment of Medicare Benefits) Act 2024* is to facilitate Medicare benefit assignments and eliminate complex regulatory and financial problems. The 'assignment of benefits' is an agreement for example between the practitioner and the patient. The main challenge is the transference of responsibility for billing to insurers and billing agents also known as Sections 20A and 20AAA **with no clear recovery mechanisms for wrong enquiries**. Further to this, insurers should give feedback to assignors or policy holders within six months, notwithstanding, if there is no punishment for non-compliance this may increase the risk of disputes, especially in the cases which are urgent.

The amendments made to bulk billing (Section 20A) are based on the principle of automatic allocation of Medicare benefits without the patient's consent. The delegation of regulatory details could result in more frequent, yet arbitrary, policy changes. Section 20AAA explicitly permits payers to engage in direct negotiation with healthcare providers (the surgeon) but will this give rise to a more draconian managed care scenario whereby treatment models become driven by the payers, at the expense of clinical autonomy. The legal vagueness in Sections 20A and 20AAA regarding Medicare benefit claims may cause confusion with **no clear process to resolve disputes, more litigation, and more complicated administrative functions**.

To address these risks, the law should include explicit recovery facilities, enhance patient consent requirements, reign in insurer overreach, and set a more streamlined way of settling disputes. Without these provisions, the amendments may subject providers to financial losses and also interfere with patient autonomy leading towards the establishment of more regulatory ambiguities and uncertainties.

Legislative Context and Surgical Impact

New Medicare compliance measures will enable requests for relevant payment information from practice staff or other practitioners. If evidence indicates non-compliance, an investigation may lead to payment recovery, such as when a practitioner lacks the required qualifications for a Medicare service. Surgical professionals may be the most affected by such a policy due to the fact that billing affairs are usually quite complicated and involve more than one type of discipline and specialty. Take for example, orthopaedic trauma surgery, which is a case in point when examining the composition of a surgical team necessary for particular procedure, and the use of multiple specialists such as an orthopaedic surgeon, plastic surgeon, anaesthetist, etc.

For example, trauma care is an interdisciplinary surgical sub-speciality wherein all disciplines are equally valuable and play crucial roles in taking care of patients of polytrauma. Thoraco-abdominal trauma is handled by general surgeons, head injuries and spine by neurosurgeons and orthopaedic surgeons, while vascular surgeons treat trauma of significant blood vessels for limb and organ perfusion to be kept up. Orthopaedic surgeons deal with musculoskeletal injuries including fractures and joint dislocation. Plastic surgeons also aid in soft tissue reconstruction and complicated wound care. As major trauma centres expand, cooperation among such specialties is critical to delivering broad-spectrum, multi-disciplinary treatment.[2] The lack of clear guidance on multi-provider billing scenarios could lead to disputes and retrospective claims denials, impacting hospital and private practice operations.

Another area of concern is the area of "routine post-operative care". Due to the poor definitions and inadequate construction of the provision of post-operative care and its payment in the early days of Medicare, we are already seeing restrictions on Medicare payments to patients if they have had any surgery in the recent past. There are many situations:

1. Patient is seeing the practitioner who performed the surgery, but the care provided is not "routine post-operative care", and therefore should attract a Medicare rebate. There is poor definition of what constitutes "not normal aftercare".
2. Patient is seeing a different practitioner to the one who performed the surgery, and is receiving what should be normal post-operative care, but it is not visible to Medicare.
3. Patient is seeing a different practitioner to the one who performed the surgery, and is providing care which is NOT routine postoperative care, and in many cases has nothing to do with the operation or post-operative care at all.

We are seeing Medicare rejecting payments already and we anticipate that these new powers and regulations concerning incorrect payments will only increase the difficulties for patients and doctors in this already confused area.

Proposed change – Information in regulatory proceedings

The Independent Review of Medicare Integrity underscored the necessity of enhancing health service safety, quality, and accessibility. Even though the Director of Professional Services Review (PSR) is obligated to report serious threats or professional non-conformity to regulators, legal barriers might inhibit the application of this

[2] BMJ. The complete guide to becoming a trauma surgeon. 2021 [cited 2025 7 March]; Available from: https://www.bmj.com/careers/article/the-complete-guide-to-becoming-a-trauma-surgeon-

information in proceedings and, therefore, limit regulators from upholding professional standards and patient safety.

Amendments to information referred by the Director of the PSR in connection with serious threats or professional non-compliance can be enforced in National Law proceedings and for the initiation of regulatory investigation. Regulators like Australian Health Practitioner Regulation Agency (Ahpra) and its Boards can enforce such information in legal proceedings. Information from PSR processes can be received in corresponding compliance proceedings as well, e.g., enforcing document production or repayment orders.

The amendments related to 'Information in regulatory proceedings' would be under the following sections:

- **Subsection 127(1) and (2) (referenced under Note 1 and Note 2 of section 20A and section 20AAA):** These subsections provide provisions regarding requirements for providing information and notices ('copy', 'notification'), which are to apply in regulatory proceedings.
- **Regulations under Subsection 20A(6):** This subsection explicitly states that regulations may prescribe requirements in relation to information to be furnished, how and in what manner it must be furnished, and notices before or at the time of entering into agreements.
- **Notifications under Section 127(3), (4), and (5):** These sections require specified parties (insurers, hospitals, professionals) to furnish assignors with notices ('notification') of Medicare benefit assignments within specified time frames.

Critique to Proposed Changes – Information in regulatory proceedings

Amendment (Assignment of Medicare Benefits) Act 2024 introduce additional regulatory frameworks to Medicare benefit assignments but possibly generate new uncertainties and risks. Although the reforms are more transparent on assignment, they do not address **disclosure requirements in regulatory hearings**. Sections 20A and 20AAA impose further responsibilities on practitioners and insurers but lack specific provisions on disclosure in audits, litigation, or compliance reviews, which could potentially create legal uncertainty.

The blanket payment of Medicare benefits under section 20A(2) also **poses issues of informed financial consent**. Patients' rights might be unfamiliar to them, and there may be controversies regarding consent. Informed financial consent has several ethical, legal and practical difficulties and involves stakeholders beyond the medical practitioner. As stated by Attinger et al., 2024, there should be a "multi-faceted approach to financial communication that acknowledges the influence of non-clinical providers and other structural forces…" to enable informed financial decision-making.[3]

In addition, the increased role of private insurers under section 20AAA can cause Medicare's administration to incline towards managed care, which can undermine the independence of doctors in fee-setting and generate potential conflicts of interest. Managed care, common in the United States, places barriers to care based on specific and sometimes rigid medical insurance requirements, rather than clinical indication. This includes the need for pre-authorisation and can limit patient choice, while having a detrimental impact on professional autonomy and career satisfaction.[4]

New section 127 compliance and notice requirements may impose administrative burdens on practitioners. Civil sanctions for non-compliance threaten to expose medical practitioners to criminal prosecution, distracting them from care. Reforms are insufficient to protect patients' rights because there appears to be no strict obligation to seek consent before distributing benefits specifically, leading to financial disclosure gaps. While these amendments streamline procedures, they may also risk making compliance more complex. Stricter regulatory control, more clearly defined practitioners, and insurers' requirements, and greater patient protections need to be implemented to prevent undesirable side effects.

Implications for Surgical Practice

Enhanced information-sharing provisions enacted can have unintended repercussions for surgical procedures. Surgeons are already subject to stringent regulatory and peer-review mechanisms, including public and private hospital credentialing procedures. Any PSR referrals in a regulatory hearing but in absence of natural justice and a fair process can result in reputational damage and administrative sanctions against surgeons who may ultimately be found to have acted in good faith.

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[3] Attinger SA, Kerridge I, Stewart C, Karpin I, Gallagher S, Norman RJ, et al. Money matters: a critique of 'informed financial consent'. Med Law Rev. 2024 Aug 1;32(3):356-72.

[4] InsightPlus MJA. Managed care: coming to Australia earlier than we thought? 2021 [cited 2025 7 Mar]; Available from: https://insightplus.mja.com.au/2021/24/managed-care-coming-to-australia-earlier-than-thought/
Stoddard JJ, Hargraves JL, Reed M, Vratil A. Managed care, professional autonomy, and income: effects on physician career satisfaction. J Gen Intern Med. 2001 Oct;16(10):675-84.

For example, for cases of complex cancer surgery, there are clinical decision variations due to the nuanced nature of oncologic intervention. A surgeon may choose a more aggressive approach based on deliberation by the multidisciplinary team, but if brought to the limelight as an outlier in Medicare, they will have to suffer unnecessary regulatory scrutiny. The analysis of any potential outlier from a dataset needs to involve a number of stages of data verification as well as understanding of the surgical activity including patient selection and local review. All published examples of surgical outliers from clinical quality registries show issues related to surgical systems (for examples, see National Bowel Cancer Audit and National Prostate Cancer Audits outlier reports), not problems associated with individual surgeons, as noted in the RACS response to the draft Framework for Australian Clinical Quality Registries.[5]

Risk of Unintended Compliance Outcomes

An important point to highlight is the risk of unintended compliance issues. The following presents hypotheticals and anecdotal concerns from our Fellowship on the ground. Many Medicare claims are submitted by third parties, such as hospital finance teams (for private patients in public hospitals) or practice staff, which can result in errors unrelated to practitioner fraud. For example, in private-in-public cases, where funds get directed to a Special Purpose Fund (SPF) rather than the doctor, and staff often assign the Medicare benefit to the head of the unit rather than the actual treating surgeon.

Similarly, in private practice, a surgeon may allocate an MBS item number correctly, only for practice staff to submit it incorrectly. The Department and PSR must implement clear mechanisms to identify system errors and seek reimbursement for overpayments, rather than initiating a formal PSR investigation unless major fraud is suspected. In any dispute, natural justice should be practice allowing a defendant to present their side in camera or a closed hearing.[6]

Conclusion

The Royal Australasian College of Surgeons (RACS) appreciates the Australian Government's initiative to strengthen Medicare integrity by introducing the amendments to the *Health Insurance Act 1973*. Maintaining public confidence in the system and ensuring Medicare sustainability are key aims. But while the *Health Legislation Amendment (Improved Medicare Integrity and Other Measures) Bill 2024* is imposing radical changes to deal with non-compliance and fraud, it may also create issues relating to regulatory oversight, fiscal prudence, patient consent, and administrative burden on surgeons.

Particularly, administrative inquiry and recovery reforms must implement enforceable and transparent means for holding insurers and billing agents responsible for compliance as well, particularly in the case of erroneous payments and claims denials. Otherwise, such reforms would impose legal and financial uncertainty upon providers without requiring insurers to be accountable for non-compliance. Changes to tighten the compliance may also hurt patients who do not understand the complex rules and may not necessarily discover those who are improperly claiming.

Similarly, the proposed amendments for using information in regulation proceedings must balance against one another the need for transparency and accountability, and patient and practitioner protection. While increasing information-sharing for compliance investigations is called for, the provisions are unclear regarding legal responsibilities in audits, litigation, and compliance reviews. Second, the trend toward insurer-initiated arrangements and Medicare benefit assignments without action by providers and patients diminishes patient and fee-setting practitioner control over benefit arrangements and heightens the prospect of creeping managed care in the Australian healthcare environment.

To limit and mitigate these risks, RACS suggests:

- **Reinforcing regulatory monitoring** so insurers and billing agents are brought into line to be responsible for compliance requirements and payment recoveries, and patient financial consent prior to Medicare benefit assignments.
- **Improving patient consent conditions** before Medicare benefit awards to allow fiscal accountability and make well-informed decisions.
- **Including a conflict resolution process** in order to preclude unnecessary litigations and administrative burden upon practitioners.

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[5] National Bowel Cancer Audit. Outlier responses 2021. 2021 [cited 2025 11 Mar]; Available from: https://www.nboca.org.uk/reports/outlier_responses_2021/
National Prostate Cancer Audits. Annual report 2020, outlier communications [cited 2025 5 Mar]; Available from: https://www.npca.org.uk/wp-content/uploads/2021/01/NPCA-Annual-Report-2020_Outlier-Communications-140121.pdf
Royal Australasian College of Surgeons. RACS submission in response to the ACSQHC consultation regarding: the Framework for Australian Clinical Quality Registries – 2nd edition. 2023 [cited 2025 5 Mar]; Available from: https://www.surgeons.org/News/Advocacy/Framework-for-Australian-clinical-quality-registries

[6] Confidential membership feedback via our Health Policy and Advocacy Committee, 2025

- **Determining information disclosure obligations in statutory cases** to eradicate juridical uncertainty for multi-disciplinary surgery teams.
- **Ensuring procedural fairness in regulatory action**, particularly among surgical specialists in managing complicated matters.
- **Simplify a complex process:** Especially in light of a patient's understanding and not place the burden solely on the back of the medical practitioner, in our case the surgeon.

With these safeguards removed, the amendments threaten to expose providers to unforeseen administrative and financial burdens, erode patient protections, and create uncertainty in the Medicare regulatory environment. RACS urges the Australian Government to revise these legislative amendments so that Medicare integrity is maintained without compromising clinical autonomy, the financial sustainability of medical practice, or patients' rights.

RACS would welcome ongoing consideration of these critical issues and is happy to work with the Department of Health and Aged Care to ensure that Medicare reforms achieve a balance of compliance, accountability, and quality surgical care in Australia.

Sincerely,

Professor Mark Frydenberg
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Committed to
Indigenous health