

Bulletin



August 2019

Anti-Social media

A palliative care inquest
Making the best care, better

Victorian Voluntary Assisted Dying legislation
What does it mean?

Medicare Shared Debt Recovery Scheme

Good workplace = good outcomes

Everyone, including doctors, midwives and other healthcare professionals need a good workplace environment.

Where you practise can have significant effects on the care you can provide to your patients and your own well-being. Excessive workloads, unreasonable expectations, inadequate resources and lack of support can place extraordinary pressures on you.

A workplace with any of these problems makes it much harder for you to give the best care to your patients, can compromise your mental health, lead to burnout and make you dread going to work.

Workplaces with professionals stretched beyond their limits can pose significant risks of conflict, which can lead to communication breakdowns, cultures of blame and issues of bullying.

Doctors' personal health and well-being can be areas of concern in a well-functioning workplace. Imagine what happens to the doctor suffering health issues when the workplace is dysfunctional.

Adverse patient outcomes in a poor workplace can leave the individual bearing the weight of what happened, even when systemic issues made it hard to prevent. They can also be singled out, however unfairly, for investigative or disciplinary scrutiny.

MIGA is conscious its members and clients can face significant challenges in hospitals, practices and other workplaces across Australia. We see this on a

recurring basis in calls for advice, medico-legal matters, in our risk education discussions and other engagement with our members, clients and the broader healthcare profession.

These concerns drive our advocacy for healthy workplaces, covering issues such as bullying¹, unacceptable workloads, doctors' health and well-being², and investigative and complaints processes³.

We lobby governments and regulators, work with colleges and professional associations, contribute to inquiries, consultations and reviews, and raise awareness through presentations, workshops and other forums.

Over the last couple of months MIGA has contributed to:

- Development of a national framework for doctor and medical student mental health by Everymind
- A South Australian parliamentary inquiry into workplace fatigue and bullying in hospitals and health services.

We have used these opportunities to explain the relationship between healthy doctors, healthy workplaces and healthy patients.

We have placed emphasis and priority on:

- System change to prevent fatigue and burnout
- Safe and inclusive training and work environments
- Proper processes and support for dealing with bullying
- Assisting doctors manage their health issues.



Welcome to the August edition of the Bulletin. In this issue you will find some interesting articles on neonatal palliative care, social media pitfalls and new Voluntary Assisted Dying legislation enacted in Victoria.

With the commencement of our 2019/2020 Risk Education year, we also highlight Medicare's focus on inappropriate billing and its increased audit activity. While this has potential consequences for doctors, the recent introduction of Medicare's Shared Debt Recovery Scheme also raises the stakes for practices employing doctors and billing on their behalf. If you find the information on this topic intriguing or even worrying, we encourage you to attend a Risk Management Conference and participate in our hypothetical: 'Medicare – Does your dawg bite?'

I encourage you to continue, or consider participating in, our Risk Education this year. Besides earning CPD Points, you can take away a better understanding of the risks in your practice, how they present and tips for proactively managing them.

I hope you enjoy this issue and look forward to meeting you at an education event over the coming months.

Keryn Hendrick
Risk Education Manager

Good workplace = good outcomes

(Continued from front cover)

Ideally a whole of system approach is needed, covering issues such as workplace culture, communication between professionals, shared understandings and perspectives, clinical workloads and staffing, and trusted, fair and meaningful processes for dealing with concerns. But in reality all workplaces have their differences.

MIGA's work on the importance of healthy workplaces and healthy professionals continues, and we encourage you to be a part of the change you want to see. Think about and constructively discuss how your work environment could change for the better. Starting the conversation is the first step in finding solutions.

We encourage our members and clients with a particular interest in these issues or questions about our advocacy efforts to contact us.

Mandy Anderson

CEO and Managing Director

- 1 See for example MIGA's submission to a Federal Senate inquiry around bullying and harassment in the medical profession - www.aph.gov.au/DocumentStore.ashx?id=4dfc2f35-9b69-4e5e-9736-aa8526c48b71&subId=460052
- 2 For more information, see www.migabulletin.com.au/article/doctors-health-gaining-traction - MIGA's hearing evidence and submission to the parliamentary inquiry considering national treating practitioner mandatory reporting reforms is available at www.migabulletin.com.au/article/two-very-different-ms-which-affect-you
- 3 More information about MIGA's work around investigative and complaints processes is available at www.migabulletin.com.au/article/goodness-me-could-this-be-medico-legal-disease and www.migabulletin.com.au/article/advocating-on-medical-board-ahpra-changes

Queen's Birthday Honours

We would like to acknowledge the following doctors who received Queen's Birthday Honours and extend our congratulations to them.

Dr Jonathon Clark (AM)

Member of the Order of Australia

For significant service to medicine as a head and neck surgeon.

Dr Douglas Lingard (AM)

Member of the Order of Australia

For significant service to medicine as a radiologist, and to community health.

Assoc Prof Leo Pinczewski (AM)

Member of the Order of Australia

For significant service to medicine, particularly to the advancement of knee surgery.

Dr Joseph Reich (AM)

Member of the Order of Australia

For significant service to ophthalmology.

Dr Robert Stunden (OAM)

Medal of the Order of Australia

For service to medicine in the field of paediatric surgery.

Dr Vida Viliunas (OAM)

Medal of the Order of Australia

For service to medicine in the field of anaesthesiology.

eHealth

Making it helpful and practical

eHealth has become an increasingly significant part of healthcare. Starting with electronic records and emails, moving onto video consultations and secure messaging, and into apps and artificial intelligence, eHealth is ever evolving. It is often seen as a way of making healthcare better, safer and more efficient.

It can do all those things, but only if done right. This is where important issues of usability, practicality, clinical usefulness and reasonable expectations come into play.

This is why MIGA advocates on eHealth, most recently in the Australian Digital Health Agency's consultation on a national health interoperability roadmap. We have argued for augmenting and connecting existing eHealth systems to improve their operation, usefulness and uptake, and recognising the central role of doctors and other health professionals in eHealth design and development.

The scale of ambition, scope and purpose of an eHealth initiative can be an issue and potentially detract from important benefits it offers. For example, My Health Record has inherent limitations, but can make some important clinical information more easily available¹.

What might seem relatively simple and limited initiatives can be important ones. Granting Queensland online access to key public hospital records, an initiative supported by MIGA², allowed many GPs to access important information quickly³.

Real-time prescribing systems are an important part of managing high risk medications, particularly opioids⁴. However it is imperative the systems are practical and easy to use, without unfair penalties for doctors who make mistakes using them. These are issues we recently raised in a Queensland inquiry into prescription medication reforms⁵.

The South Australian EPAS public hospital eHealth system is a recent example of challenges MIGA has seen its members face with eHealth record systems. To the EPAS review we highlighted concerns with navigation, time burdens, record availability and communication, explaining the medico-legal and safety issues these can cause.

We appreciate the huge gains that can be made in eHealth and understand the risks that can surround these projects. Our advocacy work on eHealth will continue and if you would like to know more, we encourage you to contact us.

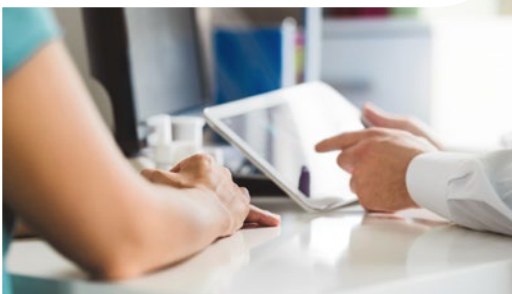
1 For more information on issues around My Health Record, MIGA's submission to the Senate My Health Record inquiry is available at www.aph.gov.au/DocumentStore.ashx?id=594cd7f3-31f5-46f0-b21c-7099a14ac496&subId=659834

2 MIGA's submission to a parliamentary inquiry considering this issue is available at www.parliament.qld.gov.au/documents/committees/LACSC/2016/21-HealthOLAB16/submissions/006.pdf

3 "GP Access to The Viewer a 'game-changer' for Queensland GPs", Pulse+IT, 7 December 2017 - available at www.pulseitmagazine.com.au/australian-ehealth/4107-gp-access-to-the-viewer-a-game-changer-for-queensland-gps

4 See MIGA's submission to the TGA consultation on opioid use and misuse - www.tga.gov.au/sites/default/files/submissions-received-prescription-strong-schedule-8-opioid-use-and-misuse-in-australia-mig.pdf

5 See MIGA's submission (www.parliament.qld.gov.au/documents/committees/SDNRAIDC/2019/MAPB2019/submissions/018.pdf) and inquiry evidence (www.parliament.qld.gov.au/documents/committees/SDNRAIDC/2019/MAPB2019/trns-20/June2019-PH-MAPB2019.pdf)



MIGA 120th Anniversary Charity Gala Ball

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*Celebrating 120 years of service to the medical and healthcare professions, our Charity Gala Ball will be held at the Adelaide Convention Centre on **Saturday, 7 December 2019.***

Help us celebrate this incredible milestone by joining us for a night of fun, entertainment, food and great company.

Funds raised from the event will support **Beyond Blue**. Mental health is an issue across the community, but we acknowledge its particular importance for healthcare professionals where the highs, lows and emotion associated with their work can be extreme. Help us support their vital work in this complex and growing area.

Tickets are available at a cost of \$185pp, or book a table of 10 for \$1,700.

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This event is only possible because of the significant financial and other support we have received from our sponsors. We gratefully acknowledge their commitment and support of our Charity Gala Ball.

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Case Study

A palliative care inquest Making the best care, better

Marie-Clare Elder
Senior Solicitor – Claims & Legal Services

A recent coronial decision has provided reassurance to clinicians that the inquisitorial system has the capacity to highlight good clinical care.

When an inquest concerning treatment provided in a hospital is announced, staff at all levels feel anxious and apprehensive about the care they have provided being subjected to such public scrutiny. Frequently the Coroner is critical of systemic failures, lack of documentation and errors in judgement that may cause or contribute to a patient's death. It is intended that these criticisms and the recommendations for change improve healthcare delivery and patient outcomes. For the clinician involved it can sometimes be hard to recognise this intent.

This case, however, is an example of exemplary care provided in extremely distressing circumstances – the tragic loss of an infant. It is unique as the focus is on the management of an inevitable outcome, as opposed to how the death may have been prevented. Inquests centring on palliative care are rare. These findings demonstrate why.

Facts

Jaxon McGrorery-Smith was born on 20 October 2011. Shortly after his delivery, Jaxon began experiencing seizures and respiratory distress. Investigations revealed a profound hypoxic brain injury and following consultation with specialist teams, his parents made the very difficult decision to withdraw life sustaining treatment.

Jaxon was transferred to the palliative care team on 22 October 2011. He died at home on 18 November 2011. It was the lengthy 27 days between the withdrawal of treatment and his death that led to the Coroner's inquiry.

Issues for the Coroner

The inquest examined the following¹:

- a. In relation to end-of-life care decision-making:
 1. Were Jaxon's parents provided with adequate time and opportunity for discussion and reflection?
 2. Were Jaxon's parents provided with the opportunity to review their decisions, once made?
- b. Did the cessation of intensive care, including the cessation of anti-convulsant medication, food and fluids, amount to appropriate palliative care?
- c. Were NSW Health Guidelines regarding end-of-life care and decision making appropriately followed? Ought the Guidelines be reviewed and updated following any findings from the inquest?²

Time and opportunity

It is widely acknowledged that care of the palliative patient is equally focused on the care of the palliative patient's loved ones. Certainly, a devastating diagnosis takes time to process. Families and loved ones commonly have many questions and sometimes there is confusion when coming to terms with such news. Clinicians are trained to be patient and provide support, and additional input from other staff such as social workers and specialist nurses is frequently provided.

The evidence in this case demonstrated (and ultimately the findings supported) that there were multiple discussions with Jaxon's parents from the time his brain injury was realised until his death. There are numerous references to the well documented discussions with intensive care, palliative care and social work professionals.

Importantly, Professor Dominic Wilkinson, the Coroner's expert neonatologist and Professor of Medical Ethics opined that sufficient time had been afforded to Jaxon's parents for them to make the decision to move Jaxon to palliative care, acknowledging that such serious decisions carried some degree of urgency, in terms of not prolonging the likelihood of death. The Coroner also concluded that the contemporaneous records demonstrated that the implications of Jaxon's condition were adequately explained to his parents and that they were given sufficient time to make what was clearly a distressing and difficult decision. Professor Wilkinson was also of the view that the records documented regular contact with Jaxon's treating neonatologist, Dr Wright, and given that there was no neurological improvement or change in Jaxon's condition and the parents' decision to palliate, there was no basis on which the decision to withdraw intensive care should have been reviewed, although he noted that there was ample opportunity to do so.

Appropriate palliative care and within guidelines

The Coroner examined the 2005 NSW Health End-of-Life Care Guidelines² when reviewing Jaxon's palliation. Dr Campbell, an expert consultant neonatologist assisting the Coroner, expressed the view that although appropriate, the withdrawal of hydration and nutrition up until 18 November 2011 seemed to be "at the extreme limit of palliative care guidelines". This view was supported by the other experts.

Professor Wilkinson quoted a Canadian study which provided evidence that the average time between withdrawal of artificial nutrition and hydration and death in neonates was 16 days with the range being from 2 to 37 days. He stated that this was consistent with his own experience as a neonatologist.

It was noted by another expert that decisions surrounding feeding and hydration in end-of-life care are difficult and ethically challenging.

The Coroner reviewed the care provided to Jaxon, including the medications he was prescribed and concluded that the "end of life care provided to Jaxon was consistent with the principles set out in the NSW Guidelines".

Conclusion

This case, undoubtedly tragic, is an example of careful, compassionate and thorough delivery of care to a palliative neonate and his family. It is apparent from the findings that staff members from the multidisciplinary teams were totally engaged and professional and documented the numerous discussions that took place with the family during Jaxon's life. Clinical planning and decision making often takes precedence in medical notes but the meeting entries provided vital evidence of the holistic approach the team took in caring for Jaxon and his family. It is pleasing that the findings recommended further enhancements to end-of-life care in NSW and shone a light on the excellent care the hospital and staff provided to Jaxon and his parents.

The full article was published in the Health Law Bulletin 2019 Volume 27 No. 3 page 45.

¹ *Inquest into the death of Jaxon McGrorery-Smith* (Coroners Court NSW, 14 November 2018) at paragraph 13.1
² NSW Health End-of-Life Care and Decision-Making – Guidelines (GL2005_057), published 22 March 2005



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Advocacy





Case Study

Victorian Voluntary Assisted Dying Legislation What does it mean?

Timothy Bowen
Senior Solicitor – Advocacy, Claims
and Education



On 19 June 2019, voluntary assisted dying became legal in Victoria. This regime permits Victorian adults with terminal conditions to seek medical assistance with ending their life in limited circumstances.

It is the first time in over 20 years that such a regime has been legal anywhere in Australia. It follows multiple unsuccessful attempts to introduce such a regime in different parts of Australia.

The Western Australian Government intends to introduce legislation into parliament to permit voluntary assisted dying. Both South Australia and Queensland are undertaking parliamentary inquiries into end of life issues, including voluntary assisted dying.

What does this mean for doctors, nurses, other healthcare professionals and organisations? MIGA is conscious our members and clients hold a range of moral, ethical and professional views about voluntary assisted dying. We have no position on whether such regimes should be legal or not. These are matters for the profession and broader community.

Whatever one's position, a voluntary assisted dying regime poses a range of medico-legal and other practical issues which doctors, other healthcare professionals and organisations may be confronted with if they have patients asking about voluntary assisted dying, irrespective of whether or not they are willing and able to participate in such a process.

Conscious of this, and as part of its commitment to sensible, practical and fair regulation, MIGA is involved in advocacy around the practicalities of voluntary assisted dying regimes. Our focus is on how they would work if legalised, any uncertainties and risks created, and issues requiring further work or clarification¹. In doing

so, we have in mind the interests of health professionals who might be involved, those who would object to being involved and those uncertain about what they would do.

What you should know

Some features of the recently commenced Victorian voluntary assisted dying regime include:

- **Conscientious objection**
 - There is no obligation to participate, provide information or refer to a doctor who may assist²
- **Do not initiate discussions about voluntary assisted dying**
 - Voluntary assisted dying can only be discussed with a patient when they raise it in clear and unambiguous terms
- **Multiple doctors involved**
 - Two doctors must be involved in the process – a co-ordinating medical practitioner and a consulting medical practitioner
 - Certain specialists can be consulted for further opinions, such as on condition eligibility and patient capacity - there is a mandatory referral to assess prognosis for neurodegenerative conditions
- **Compulsory training and necessary qualifications and experience**
 - A doctor cannot take a co-ordinating or consulting practitioner role until they have undergone compulsory training
 - Both practitioners must have particular levels of qualification and experience
- **Patient eligibility – patients must**
 - Have decision-making capacity throughout the process
 - Be an Australian citizen or resident, ordinarily resident in Victoria for 12 months
 - Have an incurable, advanced and progressive disease, illness or condition

- causing intolerable suffering and expecting death within 12 months for degenerative neurological conditions, or 6 months for other terminal conditions
- **Timeframes and information**
 - Normally at least 9 days between initial and final requests by a patient
 - There are specific requirements on information to be given to patients, including treatment and palliative care options, risks and ability to withdraw anytime
- **Documentation, reporting and approval**
 - There are detailed documentation requirements
 - Throughout the process reports must be given to the Voluntary Assisted Dying Board
 - A permit is required before a medication prescription can be made
- **Medication**
 - Provided by a statewide pharmacy service (at The Alfred Hospital in Melbourne)
- **Implications of getting it wrong**
 - Initiating discussion about voluntary assisted dying unless on explicit patient request is grounds for disciplinary action and mandatory reporting
 - There are penalties for not lodging required forms
 - There are serious criminal offences arising from administering substances not in accordance with the regime, or inducing a person to access the regime.

Comprehensive information, including a guide for medical and other health practitioners, has been produced by the Victorian Department of Health and Human Services³. The Guide is available at www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying/health-practitioner-information.

We encourage any doctor considering involvement to familiarise themselves with this material in order to understand the regime's detailed obligations.

Key matters for Victorian doctors to consider include:

- How you will respond to patients requesting access to voluntary assisted dying, whatever your willingness and ability to be involved
- If willing and able to be involved, the need for you to take the time to fully understand the regime requirements, and whether you can put appropriate procedures in place
- MIGA expects those overseeing the regime will interpret its requirements strictly
- The potential emotional and other personal impact involvement may have on you.

¹ See for example the Western Australian Ministerial Expert Panel on Voluntary Assisted Dying, which has just produced its final report, and MIGA contributed to the panel's consultation - ww2.health.wa.gov.au/Articles/U_Z/Voluntary-assisted-dying

² The expectations of clause 2.4 of the Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia* continue to apply, which include informing your patients and, if relevant, colleagues, of your objection, not using your objection to impede access to treatments that are legal and not allowing your moral or religious views to deny patients access to medical care (see www.medicalboard.gov.au/codes-guidelines-policies/code-of-conduct.aspx)

³ See www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying

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Anti-Social Media

This article was originally published on the Panetta McGrath Lawyers Health Blog.

The ability for information shared on social media to be published immediately and disseminated widely means that caution should be exercised before any content is shared online.

A doctor has been reprimanded and suspended for his comments in online forums promoting violence against woman and racism.

The doctor, who was employed in the public health system in two States, has also been asked to step down from his position while the health district completes its own separate investigation.

The doctor was found to have made a number of inappropriate and offensive comments in online forums in which he was readily identifiable as a medical practitioner, including stating that "some women deserve to be raped".

The case demonstrates the increasingly porous boundaries between professional and personal conduct. The Tribunal stated that although the online posts were not made in the course of practising medicine and were posted after hours, there was nevertheless a clear nexus between the posts and the doctor's profession, as he identified himself as a medical practitioner on multiple occasions.

Whilst the case represents the extreme end of the spectrum, the ability for information shared on social media to be published immediately and disseminated widely means that caution should be exercised before any content is shared online.

AHPRA has a social media policy (www.medicalboard.gov.au/Codes-Guidelines-Policies/Social-media-policy.aspx) requiring practitioners to remain cognisant of the National Law, the National Board's code of conduct and the guidelines for advertising regulated health services when using social media.

Here are some of the common social media pitfalls and how best to avoid them:

Social media can colour personal and professional reputations

Personal Facebook pages can reveal a detailed account of someone's personal life. For example, it is easy to see that patients might question a practitioner's professional competency if they were to find online embarrassing photographs of the practitioner, such as being intoxicated.

Other material that would be considered inappropriate or unprofessional if posted would be use of drugs, crime, nudity, sexual content or innuendo, patient information and criticism of others.

Therefore, be circumspect about the content you create and post online in order to ensure that you do not skew patients' perceptions of the profession or the level of care they expect to be given.

Friending patients on Facebook

Practitioners who allow patients access to their personal information online (by either accepting a patient's request to connect or extending a request to connect to a patient) risk a variety of repercussions.

There is a risk of blurring the boundaries between a practitioner's personal and professional life, which may complicate or change the nature of the relationship between a practitioner and patient.

By interacting with patients online, you may expose yourself to scrutiny of your personal life. Facebook profiles can feature some highly personal information, such as photographs, details of friends and family in your network and comments both written by and received from others. A patient's access to your personal information could undermine the practitioner-patient relationship.

It is recommended that you politely decline any friend requests from patients on Facebook, to avoid the risk of blurring boundaries. You could send a polite message to the patient, or should the matter be raised in a later consultation, just politely explain that you cannot 'friend' your patients because of the importance of maintaining a strictly professional relationship.

Patient privacy and confidentiality

It is also important to consider patient confidentiality in a social media world, particularly in terms of photographs and videos that are uploaded.

The usual standards of patient privacy and confidentiality apply online, so refrain from posting identifiable patient information. Even de-identified photos may be identifiable with reference to piercings or tattoos.

Clinical images are "health information" and must be treated with the same privacy and confidentiality as any other health record or information. They should only be taken with appropriate consent, stored securely, and only disclosed in accordance with the consent given, or if there is a legal obligation to do so.

Using clinical images for any purpose other than that for which consent has been obtained, or sharing them in a non-professional context, is inappropriate and risks you being the subject of a complaint to AHPRA or legal action.

Key tips

- Pause and reflect before you post a comment or photo in any context
- The content should be scrutinised in terms of appropriateness as well as who may have access to that information. Check and update your security settings
- Use common-sense and do not comment about patients, cases or colleagues
- Politely decline any friend requests from patients.

Prudence Campbell

Solicitor - Panetta McGrath Lawyers



Mandatory reporting Clear the confusion



For more information
email us reo@miga.com.au



If you need advice
please call 1800 839 280



Mandatory reporting obligations relate to a wide range of circumstances including; child protection, elder abuse, domestic violence, as well as patient risk related to driving, flying, possession of firearms, to name a few.

Reporting requirements vary across States and Territories, and importantly, changes have recently been announced.

Understanding these regimes and the impact of changes can be tricky. Build your confidence at a workshop that we will be running at locations around the country. You can participate at:

GP 19 in Adelaide on 24, October, register at gp19.com.au

RMA 19 on the Gold Coast, 25 October register at rma.acrrm.org.au

MIGA's Risk Management Conferences in Adelaide, Brisbane, Melbourne or Sydney
MIGA workshops in Darwin and Perth, register at reo.miga.com.au

The bill you don't want to pay

Doctor Joe entered into a service agreement with a practice company whereby 40% of his billings were retained by that entity for nursing, administration and other support services.

He contacted MIGA soon after he received a letter from the Provider Benefits Integrity Division of Department of Health advising Dr Joe his billings had been the subject of a Medicare audit. The Department's analysis raised a number of concerns in relation to Dr Joe's billing practices, in particular:

- The level of billing rendered for various items were far in excess of most of his peers (>95th centile), and that his peers may not consider the level of services rendered or initiated to be clinically appropriate
- Whether all MBS item requirements were met for every service.

The letter from the Department contained a spreadsheet of over 25 pages detailing two years of benefits paid that were the subject of the audit.

Doctor Joe was invited to attend a formal interview within 2 weeks to discuss the audit and the Medicare claims he had made. He was also invited to make voluntary acknowledgement and repayment of any services identified as incorrectly claimed, whether they be the subject of the audit or outside the audit.

MIGA's claims team advised Dr Joe, in preparing for the interview, to review all the MBS item requirements and the patient health records that were the subject of the audit to ensure that they documented adequately that the MBS item requirements were met.

Doctor Joe spent many hours doing this task within the short time frame provided. It became apparent that for a considerable number of billings there were issues including:

- The health record was poorly documented and could not substantiate the service provided and/or the duration of the consultation
- Incorrect MBS item numbers had been used either by him or practice staff
- Claims had been made by the practice staff using his provider number in relation to services provided by others, such as visiting locums and trainees who had not yet received a provider number
- Incidents where services provided to one patient on the same day were claimed over subsequent days to obtain greater benefit.

Doctor Joe attended the interview and voluntary acknowledgements were made in relation to incorrect billings.

The Department was still not satisfied in relation to certain billing practices and referred the matter to the Delegate of the Chief Executive Medicare for referral to the Professional Services Review (PSR).

The doctor was then subjected to interviews by the Director of the PSR and subsequently a hearing before a PSR panel which lasted for a number of days.

The end result for Dr Joe was:

- He was considered responsible for all billings claimed under his provider number notwithstanding that 40% of the billings went to the practice entity and its staff had been part of the incorrect billing practices¹
- Repayments he was required to make in relation to incorrect or inappropriate billings were in the hundreds of thousands of dollars
- His ability to claim certain MBS item numbers was suspended for a period of time
- The practice entity terminated his service agreement on the basis of a significant breach of contract in failing to keep proper health records that comprehensively documented the service provided to each patient.

How does a doctor find themselves in this situation? What is Medicare's investigative process and what does it mean for me? Surely the employer is partly to blame and held accountable by Medicare?

Find out all this and more at MIGA's new claims hypothetical '**Medicare – Does your dawg bite?**' We will explore these issues and many more in an interactive, entertaining and enlightening session.



You literally can't afford to miss this one!
Book to attend the Hypothetical via REO

Keryn Hendrick
Risk Education Manager

¹ Legislation has introduced a Shared Debt Recovery Scheme operative from 1 July 2019



Medicare Shared Debt Recovery Scheme

Over the last few years Medicare has been increasing its audit activity where it suspects practitioners of inappropriate billing. Medicare has had recent success in recovering over payment of Medicare benefits from practitioners and we expect that its audit activity will continue and is likely to be expanded.

While some inappropriate billing may be inadvertent, the reality is that responsibility for correct claiming rests with the practitioner.

Medicare billing is often delegated to non-practitioners and can be administered through centralised billing areas that can be influenced by organisational processes and policies.

We are aware of situations where inappropriate billing has occurred at the practice administration level, the doctor themselves being unaware. However, following an audit the doctor (as the holder of the provider number) has been held responsible for the full repayment of the overpaid benefits, despite the doctor and the practice having jointly benefitted from the overpayment. In at least one incident the practice also terminated the doctor's employment for a 'breach of professional standards'.

In response to the way billing may be conducted within practices and in acknowledgement that corporatised practices may benefit from and/or contribute to inappropriate billing, on 1 July 2019 Medicare introduced the Shared Debt Recovery Scheme. The Scheme enables Medicare to make a shared debt determination and apportion the debt recovery between the doctor and practice entity.

Medicare's intent in introducing the Scheme is to encourage practitioners and the practice organisation to work together to ensure billing is correct, improve response to Medicare audits and promptly repay any debts that may arise.

Access to advice and support is an important additional benefit of insuring with MIGA and we encourage you to utilise our expertise where you receive notification of a Medicare audit. We encourage both individual policyholders and practices holding Professional Indemnity insurance with MIGA to contact our Claims & Legal Services team for advice and support on these issues and we encourage early notification to enable us time to assist you.

A more detailed fact sheet outlining the operation of the Shared Debt Recovery Scheme is available from the Department of Health's website at www.health.gov.au/internet/main/publishing.nsf/Content/shared-debt-recovery-scheme-fact-sheet.

Suspected inappropriate billing identified by Medicare follows an escalation process through Medicare and the PSR. Our Team can provide advice and assistance to help you understand and navigate this process.

Our new claims hypothetical, '**Medicare – Does your dawg bite?**' presented at our Risk Management Conferences provides insight to the process and our panelists have first-hand experience.



Join our interactive and entertaining discussion!
Book to attend the Hypothetical via REO

Maurie Corsini
National Manager - Underwriting

Midwives snapshot

The essentials of follow-up

Fulfilling the duty of care for 'follow-up' is primarily a matter of communication supported by good systems.

A time may come when you need to demonstrate that there were adequate and reliable systems in place to ensure that your clients are followed up appropriately, particularly where there may be a likelihood of a potentially serious adverse outcome.

You must generally follow up investigations or advice notwithstanding the failure of the client, or indeed a hospital or pathology laboratory, to follow advice or normally accepted procedures.

The list opposite shows the essentials you need to consider to ensure that, in the event your practise is scrutinised, you have all the 'boxes ticked'.

Across the healthcare community, follow-up is a critical component of the provision of care. Unfortunately, all too often, we see the tragic and avoidable consequences for the patient and practitioner of poor, or incomplete follow-up systems.

If you need help or advice in relation to the follow-up process within your midwifery practice please contact our Risk Management Team, we would be happy to help you.

Liz Fitzgerald
National Manager - Risk Services



✓ In your discussion with the woman ensure you:

- Detail why the recommendation is being made
- Give time frames indicating urgency
- Explain why a test or referral is needed
- Explain the degree of urgency (time frames)
- Explain the consequences of choosing not to have a test or attend for specialist advice
- Document this discussion in the woman's notes.

✓ Within your practice establish a robust system for tracking:

- When tests are ordered
- When results are received
- When results are communicated
- When a referral is made to another health practitioner
- That the woman has attended an appointment post referral.

✓ If your recommendation is to 'wait and see' ensure you:

- Provide a clear end time frame when action or review should occur
- Give clear instructions on when to return or in what circumstances to seek help in the interim
- Make enquiry when the woman next attends
- Document the plan and the outcome clearly in the woman's notes.

✓ Your documentation is critical in your delivery of care and evidence of the standard of care you provide. It needs to include:

- The reason for any tests or referral
- Details of your discussions with the woman
- Document any advice you give to the woman
- Documentary evidence of all your attempts to contact the woman.

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