The Australian Psychological Society Ltd

Senate Community Affairs Committee

A Supplementary Submission To The Inquiry into Medicare Audit Legislation

from the Australian Psychological Society

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Inquiry into Medicare Audit Legislation

Introduction

The purpose of this supplementary submission is to comment specifically on the Privacy Impact Assessment (PIA) released by Medicare on May 2. As this was released following the close of submissions to this Inquiry, interested bodies and societies were invited to make a supplementary submission.

Prior to a detailed analysis of the PIA, the Australian Psychological Society (APS) would like to make some general comments that were prompted by the discussions at the Senate Inquiry's public hearing and by submissions made by other bodies on that occasion.

Variation and Complexity

Both the proposed Bill and the PIA appear to treat all providers as if a homogenous group when clearly they are not. Not only are GP processes quite distinctly different to Specialist's, but even Specialists differ among themselves. Allied Health Professionals are another group again. Their specific and marked differences are that not only do they require a GP referral, their sessions are capped and they are generally unable to refer to other services. The general failure to acknowledge and accommodate these differences tends to disenfranchise, if not alienate, the very group of new providers that DoHA and Medicare should be engaging with and educating.

The variation and complexity between provider groups is found not just in the procedures and types of interventions for which there are Medicare item numbers, but also in the differing clinical presentations and the subsequent variations in clinical records produced by this diversity. As a consequence, it is almost impossible for a piece of legislation to enunciate general principles and procedures that are going to be able to match, and effectively manage, all clinical situations. It is clear that this is the origin of some of the confusion, anxiety and even intense concern, that this proposed legislation (and the PIA) has generated. It may also be fair to conclude that Medicare has not grasped this range of differences between providers despite them all being part of ther Medicare system. It will certainly be necessary for the legislation to be reviewed, if not fundamentally changed, to meet this amount of variation. It may even be necessary to accommodate that variation by the creation of number of sets of procedures which differ for the varying clinical and provider settings.

A Need for Greater Detail

One of the difficulties that all professional bodies and their members have encountered with this proposed legislation and the PIA is the lack of explicit detail regarding the purpose, process and information required of the audit procedure. If Medicare would make explicit the sort of information that it requires for a successful audit process, why it needs it and for what purpose, it would make a resolution of the compliance debate so much easier. That would have had at least three benefits:

- health practitioners would understand what information needs to be collected at the time of service provision;
- it would enable health practitioners (and their professional associations) to immediately understand whether such a process does threaten patient privacy and confidentiality and then recommend the appropriate course of action;

- it would enable professional bodies to develop suggested procedures/*pro formas*/ software programs that they could recommend to members.

A Clear Separation of Processes

Given that so many professional bodies interpreted the legislation and the PIA as proposing a violation of patient privacy, interference in the patient/provider relationship and undermining of the crucial ingredient of confidentiality in therapeutic interventions, this needs considerable effort by Medicare to either remove such possibilities or to clarify their communication.

The Society argued before the Senate Committee that a distinction between administrative and clinical file content needs to be made. This was referred to by the AMA as a distinction between "technical" and "personal", and may even constitute something like what was referred to by Dr Roger Clarke (Australian Privacy Foundation) as the notion of '*two files'.*

It may well be that distinguishing between administrative and clinical (or technical and personal) may be slightly different for each health professional situation. It is clear that issues such as diagnosis, or even differential diagnoses may be revealed when practitioners are referring for specialist or other practitioner opinions. Such information does cross the boundaries between administrative and clinical domains and may well be available, or inferred, by specific referrals. In other provider settings, such as with Allied Health - who tend to be end providers and rarely initiate referrals that have relevance to Medicare - such "violations" of patient information would rarely be seen to occur. In any case such "violations" are already potentially available to Medicare through the information already collected via specific Item numbers.

What does need repeating is that if Medicare was explicit about the type of information that it will be seeking as part of its audit, there will be less need for anxiety about that violation of confidentiality and it will ensure providers can take steps to ensure that separation of information from clinical information. In fact, it appeared to the APS that had this clarity been forthcoming even prior to the PIA, much of the PIA content and detailed explanation would have been unnecessary. Furthermore, it would not only enable the legislation to more clearly articulate the role that Medicare wishes to exercise through this audit process but also have clarified the demarcation between the audit and the responsibilities and appropriate functions of the Professional Services Review (PSR). This is vital in protecting confidential patient information from the non-clinical personnel associated with the Medicare audit.

It will hopefully then be clear that the audit process is focused on 'Who received a service?' 'Did they receive a service?' 'When did they receive a service?' and 'What kind of service did they receive?' All other questions of 'Why did they receive a service?' and 'Was it the appropriate service?' would then be the domain of the PSR. It may also then become evident that the violation of privacy that has become the focus of this inquiry may not actually be inherent in the audit and that the need for Medicare to consult "clinical records" in the sense that most professional bodies interpreted it never existed. That is at least the Society's hope if not its conviction.

Specific Issues Raised by the PIA

1 **Terminology.** The three labels: 'health information', 'clinical information' and 'personal information' were all defined but not distinguished from each other. Why were three terms needed when they all seemed to be referring to the same thing? All three refer to areas of the professional record that include material that is sensitive and private. It would be helpful to confine discussion to one term and one definition unless there is real purpose in having three different terms? Not surprisingly, this only added to confusion rather than increasing clarity. It is suggested that a section of the proposed Bill that provides a set of precise definitions would be very useful to both Medicare and the providers.

2 **Explanation of the Audit Process**. As noted above, at no point does the paper set out to provide a clear rationale and defence of the audit process that gives the reader a chance to understand what Medicare specifically wants and why. Such a precise and clearly defined argument would have removed so much of the hit and miss responses that has characterised the content of most submissions. It is not that the submissions were not well argued and focused, but that they were not clear regarding which aspects of the audit process they were objecting to. What many agreed with was opposition to the blanket access to the clinical record by the CEO of Medicare Australia (whether it was "clinical information", "health information" or "personal information") and that such a liberty was just not acceptable. This may not have occurred had the procedure been more precisely defined. However, the APS can assure the Senate Committee that its members would be in extremely unsettled if any access to the clinical record was permitted, or even inferred, in this legislation.

3 **Need for Clear Requirements.** Despite a considerable number of Points that relate to the question of file access, and the extensiveness of the PIA, it is not clear what the "requirements" (Point 72) are that Medicare needs for its audit. In Points 63 and 64, Medicare is quite explicit about the personal information that it already collects and receives through the Medicare reporting system. But it then fails to go on to say what additional information is absolutely crucial to its audit program.

At point number 76 it makes reference "to produce documents in respect of a service" and then goes on to talk about the need to access health information without any explanation of why. For many practitioners, the documents in respect of a service are administrative and clerical in nature and have little to do with detailed (and crucial) client health information or client clinical information. There are some attempts at grappling with this issue in Points 82, 85, 88 and 90. But if 85 and 90, particularly, are taken at face value, then the purview of the audit is administrative detail and does not need access to what is commonly understood by 'health', 'clinical' or 'personal' information.

With some modicum of guess work, it is possible to infer from the above points what is being required and so the Society will attempt that inferential process. Point 90 suggests that Medicare wants clear and available documents that provide:

- item numbers for each service specified;
- date that service was provided;
- Medicare numbers of clients seen for that service.

Point 85 suggests that the sort of documents appropriate are:

- appointment books

- receipts
- referrals

and goes on to say '*that excerpts from patient medical records will not be relevant to audits'.*

4 **Possible Superfluity in the PIA.** There is considerable effort put into large sections of the document to expand on the protection of clients, practitioners and, particularly, Medicare from accusations of invasion of privacy and violation of Privacy Principles. If the assumptions made above are correct, then Medicare only wants clear evidence of when, to whom, on what referral and which service was provided; or was a referral made, and for whom, when and for what. If so, the all the elaborations to be found in Points 86 to 94 to 102 and most of 108 to 194 seem unnecessary and superfluous.

To be able to provide the information specified above requires no access to the private clinical information beyond client name, Medicare number, service providers, referring practitioner, actual referral document and item numbers. None of this goes *significantly* beyond what has already been reported to Medicare from which it is possible, anyway, to infer the likely diagnoses and health conditions. But this is vastly different from invading the client's file and the reports on, or notes of, detailed assessments, differential diagnoses, clinical sessions, intimate family details or even third party personal information.

5 **Patient/Client Informing Processes.** Once again, if the assumptions above are correct and there is no invasion of patient/client records beyond the administrative detail noted above, the need to potentially distress clients with specific notification that their case is included in an audit is unnecessary. Certainly, a general public information campaign (Recommendation 2) would be important, but it needs to convey very clearly what is being asked under the audit (as set out above) and that nothing shared confidentially or as part of therapy is under threat.

A Way Forward

The APS sets out below what it sees as a relevant process for its members. It is stressed that it is only applicable to its members as acknowledgment of what was said earlier in the document about the range of service providers and the variations in clinical processes. It also would repeat the proposal that it may be necessary for Medicare to enunciate different audit processes for differing groups and that one process may not fit all – a likely cause of much of the uproar produced. What follows, then, is suited to psychologists and maybe other end-providers.

So for psychologists in private practice, the following, it would appear, needs to be available (or even stored separately) for the purposes of audit:

- a paper or electronic appointment book that can be copied (after removal of other client appointments not specified in the audit) and viewed by Medicare staff;
- a clear date, client name and/or Medicare number relating to a service provided;
- an item number that was the basis of claim for that service and the time length of that service;
- an account for that service if needed as added evidence of service;
- a copy of the referral from the GP or specialist for that client.

That would seem to answer the questions raised in general terms by the audit documents and by the specific document requests mentioned at Point 90 in the PIA. The second recommendation is that Medicare Australia engages with professional bodies, particularly those in Allied Health due to their recent provider status, to assist with the education of members on their rights and responsibilities as a Medicare Provider. Such educational sessions could be packaged as part of professional development and attract CPD points or even be a requirement for Provider Registration to assist with the quality assurance process. Above all, such sessions would assist with clear communication with all Providers thereby reducing misunderstandings and additionally enhance collaborative relationships and shared objectives.