Royal Australasian College of Surgeons

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Private Health Strategy Branch
Australian Government Department of Health and Aged Care
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RE: Submission on the Proposed Simplified Billing Regulations and System Changes

Dear Private Health Strategy Branch,

The Royal Australasian College of Surgeons (RACS) is pleased to provide feedback on the draft simplified billing rules and system changes backing the *Health Insurance Legislation Amendment (Assignment of Medicare Benefits) Act 2024* to commence in January 2026.

Being the leading body that represents Australia and New Zealand's surgeons, RACS is dedicated to ensuring that Medicare billing process reforms uphold the highest standards of patient care, administrative efficiency, and fair access to surgical services. While we welcome the Department's effort to enhance billing processes, we seek to ensure that these reforms support the financial realities impacting both surgeons and their patients.

In our submission, RACS aims to answer to the 'Guidance Questions' provided by the Private Health Strategy Branch on pp.17-18 within the Consultation handout.

Introduction

The Royal Australasian College of Surgeons (RACS) values the importance of improving the Online Eligibility Check (OEC) web service to assist Australian surgeons more effectively in determining a patient's eligibility for coverage, particularly for complicated procedures. The current system is not fully aimed at providing for the complexities of surgical treatment, i.e., apportioning Medicare benefits correctly for follow-up or post-operative care. Bringing the OEC to include more detailed eligibility information, particularly for complex and multi-stage procedures, would improve claims adjudication speed and accuracy, reduce administrative burdens, and facilitate more efficient communication among surgeons, payers, and patients. As an example, major trauma surgery involves a team of general surgeons, neurosurgeons, vascular surgeons and orthopaedic surgeons and then at later stages, plastic surgeons. Providing complicated services such as this requires effective coordination of administrative and financial activities. [1] In Australia, fee-for-service funding model underpinning the MBS makes integrated care difficult, particularly for patients with complex chronic disorders and multiple problems who require multidisciplinary, coordinated care.[2] Additionally, the provision of all legislated clinical categories and a better insurer response system would make the claims and billing process more efficient and clearer for healthcare providers and patients alike.

For better compliance and fewer disputes, RACS highly recommends ongoing improvement in record-keeping practices. RACS supports the principle that all surgeons need to maintain precise, detailed records of patient consent, treatment plans, and financial disclosures to ensure smooth assignment of Medicare benefits and other related aspects. Uniform documentation procedures, particularly in terms of Informed Financial Consent (IFC), is the 'golden standard' and ideally should be used uniformly throughout all surgical services. Surgeons must take the initiative in providing IFC documentation to patients, ensuring that all aspects of their care, including the cost, are explained and fully understood.

However, it is not the responsibility of a surgeon to explain the health insurance policies of their patients, except for the information related to a specific procedure directly impacting the patient in question. RACS encourages

[1] 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-
[2] Angeles MR, Crosland P, Hensher M. Challenges for Medicare and universal health care in Australia since 2000. Med J Aust. 2023 Apr 17;218(7):322-9.

prompt and reliable claims processing among our members, with timely notification to patients and assignors regarding delays or outstanding balances. This transparency will encourage better understanding of financial responsibility and hence enhance patients' trust in our healthcare system and reduce administrative burdens to surgical practices. RACS has already taken the initiative to promote such practices as demonstrated on page 14 of our *Code of Conduct*,[3] and our position paper *Informed Financial Consent*.[4]

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 close to 8,000 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 main specialties: Cardiothoracic, General, Neurosurgery, Orthopaedic, Otolaryngology Head and Neck, Paediatric, Plastic and Reconstructive, Urology, and Vascular surgery.

RACS acknowledges the purpose of the *Health Insurance Legislation Amendment (Assignment of Medicare Benefits) Act 2024* to modernize billing practices, but we have some reservations about its implementation in the context of the surgical practice. While conversion to electronic assignment and direct payment may ease administrative burdens for others, it could enhance bureaucratic burdens on surgeons, particularly those in small private practices already overwhelmed by regulation. The possibility of insurers having greater control over fee levels is concerning as to whether this will lead to managed care arrangements. Should this occur, it would potentially undermine the independence of surgical decision-making and undermine the economic viability of high-complexity procedures. 'Managed care' was argument against in RACS's submission to the Australian Competition & Consumers Commission in relation to the *Honeysuckle Healthcare Pty Ltd* matter.[5]

Furthermore, in acute surgery emergencies where the patients are incapacitated, the problems of logistics regarding consent and authorization for payment persist. Under lax protection, these reforms can decrease access to specialist surgical care, heighten financial burdens on patients, and reinforce inequalities within the medical system. RACS urges the Private Health Strategy Branch to have a genuine approach to consulting with the surgical profession to reduce these risks and ensure that any legislative change strengthens, not weakens, the delivery of high-quality surgical care.

IFC restrictions are required for surgical services with separate information for other practitioners to enable patients to see their own IFC. Establish emergency situations where IFC is not feasible and scope variation in surgery that can render IFC invalid in the 'Implied' Assignment Pathway. Streamline billing to reduce administrative costs and patient out-of-pocket charges. Track ECLIPSE use for no-gap or identified-gap billing and document scope variations. Compensate for ECLIPSE's limitations by permitting over-charge billing beyond known-gap out-of-pocket (OOP), simplifying billing and preventing misapplied no-gap claims. Inform patients of any scope changes affecting IFC and enable flexible billing for scope changes to avert split billing.

Online Eligibility Check Web Services

The current inputs and outputs within the Online Eligibility Check (OEC) web service are limited for Australian surgeons to come up with a correct determination of a patient's coverage eligibility, especially for advanced procedures. The system provides rudimentary eligibility information but does not always include the nuances of surgery practice, such as the full coverage for post-op treatment or complicated procedures. Studies have identified that while surgical funding covers the costs of the initial hospitalisation, the ongoing costs of services after discharge including outpatient episodes, readmissions or post-acute care are poorly understood and not always accounted for, and that providing integrated care through the MBS is difficult.[6] For example, Medicare benefit assignment is deferred or undermined by insufficient information or unclear insurer policies. It would be simpler for surgeons to establish eligibility with certainty and insurers to be involved in informed discussions if the system were extensive and accurate. Proper Medicare benefit assignment for each service performed would thereby be guaranteed.

Additionally, the codes for reporting illness should comprise all clinically legislated categories to demonstrate the full range of surgical treatment in Australia. This would allow surgeons to coordinate their services more closely with the appropriate Medicare benefits and avoid mistakes or conflicts. Those sections for insurer feedback must be strengthened to potentially offer more accurate breakdowns of coverage, particularly when the surgery is complicated or is a follow-up procedure, as well as to guarantee that Medicare benefits are allotted properly.

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[3] https://www.surgeons.org/become-a-surgeon/About-specialist-surgeons/code-of-conduct
[4] https://www.surgeons.org/about-racs/position-papers/informed-financial-consent-2019
[5] https://www.surgeons.org/News/Advocacy/Submission-to-the-Australian-Competition-and-Consumers-Commission Determination
[6] Kaye DR, Luckenbaugh AN, Oerline M, Hollenbeck BK, Herrel LA, Dimick JB, et al. Understanding the Costs Associated With Surgical Care Delivery in the Medicare Population. Ann Surg. 2020 Jan;271(1):23-8.
Angeles MR, Crosland P, Hensher M. Challenges for Medicare and universal health care in Australia since 2000. Med J Aust. 2023 Apr 17;218(7):322-9.

These would allow for trouble-free billing, reduced administrative costs, and provide for easier exchange of information among insurers, surgeons, and patients.

RACS believes that assurances are required to ensure that the online eligibility check is limited to surgical services, i.e., surgeons, in order to allow the Independent Financial Contribution (IFC) information directly pertaining to surgical services. Information for other practitioners involved, such as anaesthetists, assistants, and pathology services, should be provided separately so that patients are able to receive the IFC independently from those services.

Assignment Declaration in Claim

The mandatory benefit declaration assignment may pose operating, financial, and technical problems to surgical practices. Operationally, it will introduce an additional administrative task for surgical practices, especially the smaller ones, which are already burdened with complex billing plans. Additional time and effort will be required to document patient consent, confirm eligibility, and process assignment of benefits. This may be particularly challenging in postoperative care, in which patients have been subjected to procedures involving multiple practitioners, such that it becomes hard to differentiate which services qualify for Medicare benefits. While current guidelines allow flexibility, not all MBS services allow for aftercare, and delegation of aftercare remains the responsibility of the initial specialist. A recent Australian study has identified that the ageing population is expected to increase the incidence of expensive postoperative complications which threatens the sustainability of essential surgical care. [7] Delay in payment processing, caused by the compulsory declaration, will further weigh on surgical practices, especially in situations where insurers challenge or delay the assignment of benefits.

Technically and economically, utilisation of required assignment statements will most probably lead to delayed payments and may increase billing disputes between surgeons, insurers, and patients. Claims and billing software will need to be adjusted to accommodate the new provisions, which can cause complications and defects if not done correctly. Practices can be subjected to higher financial strain when claims are rejected or delayed and would need additional technical investment in order to stay in sync with the transformations. The new system risks imposing additional administrative pressures on smaller practices along with risks of insurer control over surgical fees and reduced Medicare payment for surgical services. All of this during a politically recognized period of high cost of living which may see the closing down of private practices, and an increased surgical migration into the public sector or a delay of younger surgeons transitioning from public to private practice. Increasing costs of MBS services are leading to increasing patient out-of-pocket costs, reducing the affordability of private healthcare in Australia and reducing equity of access to surgical services. Australia still relies more heavily on patients contributing to the cost of their care, compared to similar countries.[8]

It must be remembered that there are exceptional emergency situations in which the IFC may not be possible. This must be made explicit in any assignment statements in claims, recording any exceptions where patients cannot receive an IFC due to the emergency nature of their treatment.

S20AAA(1) 'Implied' Assignment Pathway

Service providers to private hospital patients in public hospitals are typically under medical gap cover, purchaser-provider contracts, and other insurer agreements, subject to the specific agreements with the patient's insurer. While private patients in public hospitals may be covered by gap cover, subject to a suitable agreement with the hospital and the insurer, this may be made difficult for surgeons. The provider is required to negotiate the coordination of private insurance claims and Medicare benefits. The implicit assignment pathway (S20AAA(1)) may make billing easier but does nothing to solve the whole of the complexity of private health coverage in these situations.

From the surgeon's perspective, the reliance on inferred assignment of private patients in public hospitals can lead to delay or failure to receive payment. This is more likely to occur when the insurer has limited awareness of the patient's coverage or when there are multiple insurers involved. Due to the wide variations in these arrangements between insurers, open communication and amended agreements are necessary to ensure that surgeons are properly compensated for their services and the complexities of both Medicare and private insurance are managed well.

Clarification is required in that there are situations where surgery scope can be changed during the operation, resulting in the changing of item numbers, and thus the IFC will no longer be applicable. The 'Implied' Assignment

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[7] Australian Government. Aftercare or post-operative treatment. 2024 [cited 2025 8 April]; Available from: https://www.servicesaustralia.gov.au/mbs-billing-for-aftercare-or-post-operative-treatment?context=20.
Ludbrook GL. The Hidden Pandemic: the Cost of Postoperative Complications. Curr Anesthesiol Rep. 2022;12(1):1-9.
[8] Callander EJ. Out-of-pocket fees for health care in Australia: implications for equity. Med J Aust. 2023 Apr 17;218(7):294-7.
Grattan Institute. Not so universal. How to reduce out-of-pocket healthcare payments. 2022 [cited 2025 8 April]; Available from: https://grattan.edu.au/wp-content/uploads/2022/03/Not-so-universal-how-to-reduce-out-of-pocket-healthcare-payments-Grattan-Report.pdf.

Pathway should be able to accommodate such situations where surgery scope is changed so that billing for the patient accurately reflects the new scope and item numbers.

Regulations for s20AAA(3) 'Requested' Assignment Pathway

In the s20AAA(3) 'Requested' Assignment Pathway of care, there is a critical importance that IFC discussions should be done well at key moments in a patient's treatment journey. Surgeons, anaesthetists, pathologists, and radiologists generally have IFC discussions prior to procedures when the patients are informed of financial information, such as Medicare and private health insurance cover. However, when emergencies happen or services deviate from the initial plan of care, post-service IFC procedures become more complex. Surgeons and hospitals must adjust IFC contracts to include complications or emergent interventions, notifying patients of extra charges and alterations in their care.

The Medicare benefit assignment procedure ought to be clearly outlined in the request, complete with defined information of the services provided, i.e., MBS item numbers and treatment plan adjustments. Standardized terms for the assignment request should provide explanation of the exact procedures performed, and in the event that any unplanned services are required, these need to be documented and revised as such. Given the complexity of treatment by surgery, such as unforeseen complications, the procedure can involve sending multiple assignment requests so that all treatment stages are adequately addressed. Unforeseen complications will become more common with population-based increases in ageing and co-morbidities. Therefore effective strategies to plan and fund the end-to-end journey of the surgical episode of care is essential. This is also the case in other specialties such as interventional oncology, where technical and clinical activities are not matched by the reimbursement models and funding arrangements in Australia such as the MBS.[9] It will promote transparency, reduce bureaucracy, and ensure that patients are fully aware of how much they should pay for their treatment.

In relation to the 'Requested' assignment pathway, RACS notes that efficient billing procedures should be implemented to both patients and medical practices' advantages. Efficient billing should minimize administrative hassle as the existing system tends to increase patients' out-of-pocket costs due to the increased administrative burden in medical offices. The pathway should be made simpler by both parties' advantage without overloading the system.

Record-keeping

From an Australian surgical perspective, detailed and correct records are vital in the compliance with the *Health Insurance Legislation Amendment (Assignment of Medicare Benefits) Act 2024*. For both the "implied" and "requested" assignment pathways, there are critical records such as patient consent, treatment, billing, and insurer communication. These records should detail the services performed, the patient's awareness of any responsibility to pay, or lack thereof, and assignment of Medicare benefits, whether implied or directly requested. Electronic health records (EHR) can be helpful in streamlining this so that all necessary documentation is documented at the time it is performed and available for auditing when required. Issues of privacy protection must be considered as well.

Although the proposed set of records does encapsulate the needs in general, there ought to be flexibility within the system to enable variable practice in varying healthcare settings. Variations from care plans must be documented by surgeons, particularly in the event of complications or follow-up services provided post-surgery. The process becomes transparent in assignment and avoids billing inconsistencies. RACS supports a system that can provide openness within the process of allocation and reconcile the realities of surgical practice so that patient care and regulatory compliance are both preserved.

Maintain accurate records of cases where the ECLIPSE billing system is used, especially in instances that accommodates only no-gap or known-gap payments accommodated. It is also recommended to document any cases in which surgeons simplify billing, such as charging only the out-of-pocket (OOP) amount and using the schedule fee through ECLIPSE. Record-keeping should also track any modifications to the scope of surgery or changes in item numbers that may affect IFC validity.

Claims Payment

Prompt payment and claim processing from the surgical perspective are critical to a practice's financial health. Insurers make every effort to process claims in 30 days, but some claims are so complicated or require additional information, which will lead to delay. Administrative hold, disagreement over treatment details, or missing information can delay payments for more than six months. These delays can have a devastating impact on cash flow and overheads, particularly for small practices, and create uncertainty in reimbursement. Payers must make sure that they complete claims promptly, ideally within a 30-day cycle, to enable providers to continue care without

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[9] Ludbrook GL. The Hidden Pandemic: the Cost of Postoperative Complications. Curr Anesthesiol Rep. 2022;12(1):1-9. Brown N. Reimbursement of interventional oncology in Australia: How it works and how it does not. J Med Imaging Radiat Oncol. 2023 Dec;67(8):915-25.

interruption of funds. In the United States for instance there is a significant cost burden associated with the administration of healthcare costs.[10] While the Australian context is different, it is clear that the administrative tasks and payment systems should be effective and with limited impact on smaller private providers.

Additionally, the insurers should notify providers if there is a delay in a claim, stating the reason for the delay and the estimated time to resolve. The insurers should maintain effective communication in order to manage expectations and not impose any cost. Where the claims are delayed beyond the regular processing time, it should be necessary for insurers to take early action to notify providers so that they can make follow-up or submit further documents as required. Enhanced transparency and effectiveness in claims payments would assist in ensuring the surgical practices are able to concentrate on patient care without the burden of extended financial uncertainty. There has recently been an increase in complaints to private health insurers about delayed payments, lower benefits or non-payment which impacts both patients and the heathcare provider.[11]

The ECLIPSE system's current limitations, being restricted to no-gap or known-gap payments, must be addressed. Claims payment must have a mechanism that supports billing over the known-gap OOP component so that patients' bills are not complicated. Surgeons need to be paid the schedule fee by the government and insurers, free from the threat of inadvertently claiming the no-gap rate. This will make billing uncomplicated and split-billing practices minimized or eliminated.

Notification

Sufficient and understandable notice of claim handling is most important for making complete disclosures to assignors and patients regarding their status and Medicare benefit statuses, as well as outstanding funds that must be paid. The surgeon, being historically an interface between patient and insurers, knows the value of communication. Ideally, patients would be notified within 7-14 days by insurers and billing agents via physical mail or electronic communication depending on the patient's preference and availability. Easy to read and simple notifications will avoid confusion so patients can pay any outstanding balances or seek clarification as needed.

From a surgical practice perspective, it is crucial that the patient or assignor promptly receives the statement of benefits, either in writing or by electronic notification, ensuring the notice clearly details the services that has been paid and the remaining amount due. Healthcare providers do not usually work directly with the notice process, but they can facilitate notice to patients and help settle issues with the insurer. Proper and timely communication between all interested parties provides transparency that enables the patient's financial understanding as well as the practice's effectiveness of operation. 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. In Australia, the Informed Financial Consent Guide provides patients with the financial health literacy they need to have discussions with their doctor about their medical costs.[12]

Notice to patients should clearly state the potential for scope changes during a surgical procedure to affect the IFC. Notice should be provided timely to patients where the IFC cannot be provided in emergency situations or scope changes with information on how the final billing can differ from anticipated expectations.

IFC and Financial Disclosures

There is a need, from the point of view of the Australian surgeon, to post patients Informed Financial Consent (IFC) forms at all levels of treatment so that they are adequately informed and aware of what their out-of-pocket costs will be. This has to be done at the initial level and not at the request of the patient so that there is no misunderstanding or misinformation about out-of-pocket costs or Medicare coverage. Clear, well-written, and concise documentation allows the patients to make informed decisions about their treatment and funding, which is critical in building confidence and meeting the moral standards of medical practice.

Additionally, the stakeholders should ideally provide copies or templates of Medicare benefit assignment forms, benefit statements, or other equivalent monetary disclosures to the Department of Health and Aged Care. The forms must be standardized, legislative compliant, and patient-friendly. Standardization of financial disclosures renders all stakeholders aware of their obligations and entitlements, transparent, and avoids complexity in the claims process, ultimately to the advantage of healthcare providers and patients.

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[10] Sahni NR, Gupta P, Peterson M, Cutler DM. Active steps to reduce administrative spending associated with financial transactions in US health care. Health Aff Sch. 2023 Nov;1(5):qxad053.

[11] AMA. Private health insurance report card 2024. 2024 [cited 2025 8 April]; Available from: https://www.ama.com.au/sites/default/files/2025-02/AMA_Private_Health_Insurance_Report_Card_2024_0.pdf.

[12] 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.

AMA. Updated guide to help patients understand out-of-pocket medical costs. 2024 [cited 2025 8 April]; Available from: https://generalsurgeons.com.au/wp-content/uploads/2024/10/AMA-Media-Release_Informed-Financial-Consent-Guide.pdf.

Financial disclosure of IFC regarding IFC is required to prominently indicate that IFC only covers our services. Any change to the extent of surgery or item numbers that affect the IFC needs to be prominently disclosed to the patient. The system has to avoid incentives for surgeons in minimizing inappropriate billing due to limitations of ECLIPSE today. With the inclusion of the ability to charge over recognized-gap OOP costs within the ECLIPSE system, billing patient and claim billing for surgeons will be simple and precise to avoid the presence of split-billing.

Recommendations

- Ensure that IFC is only for our services, with separate details of other practitioners (e.g., anaesthetists, pathology) so that patients can locate IFC in their own right.
- Specify emergency situations when IFC cannot be performed and have this clearly noted on claims.
- Provide for scope variations in surgery and item numbers, which can make IFC void and null. This should be incorporated in the 'Implied' Assignment Pathway.
- Streamline billing to reduce administrative burden on patients and practices, reducing out-of-pocket expense.
- Track usage of ECLIPSE for no-gap or known-gap billings, for example where surgeons streamline billing, to ensure that records clearly document scope variations and number of items.
- Avoid the restrictions of ECLIPSE by providing for over-charge billing of known-gap OOP, to preserve streamlined billing and prevent misapplied no-gap claims.
- Alert patients to scope modifications during procedure that affect IFC and end-of-case billing
- Merely inform them that IFC should only be billed against our services, and bill flexibly to adjust for scope variations. Allow a facility within ECLIPSE to charge above known-gap OOP to streamline and avoid split billing.

Conclusion

In conclusion, the Royal Australasian College of Surgeons (RACS) recommends significant improvements to Medicare benefit assignment systems, primarily in the Online Eligibility Check (OEC) web service, claims processing, and Informed Financial Consent (IFC) processes. Refinements in the OEC system should be made to include more comprehensive coverage details, especially for follow-up and complex surgery, and the inclusion of all legislated clinical categories under presenting illness codes. In assignment procedures, clear and accurate documentation, including IFC and benefit assignment templates, must be maintained and distributed well to prevent opacity and administrative errors. Ensure IFC is limited to surgical services, with separate details for other practitioners, streamline billing to reduce costs, account for scope changes that affect IFC, and allow over-charge billing in ECLIPSE to simplify claims and avoid split-billing. RACS also urges timely processing of claims, where insurers provide clear notice in cases of delay, and urges the Department of Health and Aged Care to harmonize financial disclosures across stakeholders. All these improvements will reduce the financial cost to surgical practices, improve patient comprehension, and ease the provision of high-quality care.

Sincerely,

Associate Professor Kerin Fielding
RACS President

Professor Mark Frydenberg
Chair, Health Policy and Advocacy Committee