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Can private health insurers decide that a patient does not need treatment in hospital?

Paying Type C claims: observations of the private health insurance industry

COMMONWEALTH OMBUDSMAN

PRIVATE HEALTH INSURANCE

Helping people, improving government

Introduction

This issue paper outlines the Private Health Insurance Ombudsman's observations of and concerns about industry practices for assessing private health insurance claims requiring 'Type C certification'. It also provides best practice guidance for stakeholders when handling these claims.

Insurers do not have the authority to challenge a Type C certificate issued by a qualified medical practitioner, provided it meets the requirements under the *Private Health Insurance (Benefit Requirements) Rules 2011*.

If an insurer holds genuine concerns about a medical certificate, and they are unable to resolve these with the hospital or certifying medical practitioner, they should contact the Department of Health and Aged Care.

The role of the Private Health Insurance Ombudsman

The Office of the Commonwealth Ombudsman (the Office), in its role as the Private Health Insurance Ombudsman, protects the interests of private health insurance consumers. We do this in many ways, including:

- assisting health insurance consumers to resolve complaints through our independent complaint handling service
- identifying underlying problems with private health insurers or health care providers
- reporting and providing advice and recommendations to industry and government about private health insurance, including the performance of the sector and the nature of complaints

- managing PrivateHealth.gov.au, a comprehensive source of independent information about private health insurance for consumers.

Background

Type C procedures are those which normally take place outside of a hospital setting, such as in a doctor's rooms or health clinic. This means they are usually not eligible for private health insurance benefits.

However, in cases where a medical practitioner certifies that a patient requires hospital admission for a Type C procedure, a health insurer must pay benefits in accordance with the *Private Health Insurance (Benefit Requirements) Rules 2011* (the Rules).

Schedule 3, Rule 7 provides that *the medical practitioner providing the professional service must certify in writing that due to the medical condition of the patient or because of the special circumstances specified, it would be contrary to accepted medical practice to provide the procedure to the patient except in a hospital.* The certification provided by the medical practitioner in these cases is known as a Type C certificate.

Clinicians must complete certification documents in line with the rules and, before paying benefits, private health insurers will check that certification documents meet the requirements.

In July 2023, following a run of complaints about the handling of claims supported by Type C certificates, the Office surveyed all private health insurers to gain a better understanding of industry practices for these claims. All insurers provided a response.

It is important to note that the Office is not the health insurance regulator, and this paper does not address compliance issues or endorse specific processes. The Department of Health and Aged Care (the Department) is responsible for administering private health insurance legislation and regulating the industry. It has issued guidance for insurers and health care providers on the application of the rules relating to Type C

certification in PHI Circular 37/17 Clarification of Roles in the Certification Process[1] (the Circular).

This issues paper shares our observations of industry practices, based on the complaints we have received and the results of the survey. It also includes best practice guidance for stakeholders on areas we identified for improvement. The guidance is aimed at assisting in improving processes and communication between insurers and hospitals, which in turn can improve the consumer experience.

Issues

Type C complaints

During 2022 and 2023, the Office received complaints about several insurers declining Type C hospital claims, purportedly on the grounds that they contained insufficient information. In many of the complaints, the insurer questioned whether the clinical procedure was necessary but did not decline the claim outright, effectively leaving the claim in limbo – and in some cases the patient was left out of pocket. In some cases, the insurer simply advised the hospital that the claim could not be processed without further information but did not make it clear what information was missing.

We also observed some insurers refusing Type C claims on grounds we considered unreasonable. For example, an insurer considered a Type C certificate was invalid because, although it provided details of the medical condition requiring hospital admission, the certificate did not list any special circumstances. In our view, this is inconsistent with the Rules and Circular, which state that the Type C certificate must contain details of the patient's medical condition *or* special circumstances, explaining why hospital admission is required to avoid contravening accepted medical practice. They do not require the Type C certificate to include *both* details of a medical condition and special circumstances. .

[1] PHI Circular 37/17 Clarification of Roles in the Certification Process: https://webarchive.nla.gov.au/awa/20201115002640/https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-phicircular2017-37 (accessed 13 December 2023)

Case study

Rejection of multiple claims on the basis of insufficient information

Our Office investigated a complaint from a consumer about an insurer's non-payment of claims for inpatient Type C admissions at an accredited hospital facility. The hospital provided Exercise Medicine for oncology patients in the form of exercise programs and medical consultations. These were offered both as outpatient appointments and, in certain cases when extra medical supervision was required to manage critical medical risks, as inpatient hospital treatments.

The hospital considered the inpatient treatments to be valid Type C admissions and provided insurers with a Type C certificate for associated day admissions. However, the complainant's insurer disputed the clinical necessity of the inpatient procedure.

In total, we received 19 complaints about various insurers which refused to pay Type C claims associated with this hospital because they believed the claims did not meet the certification requirements. In the examples we saw, the insurers did not provide sufficiently clear reasons why claims should not be paid based on the documents the hospital provided.

Our Office engaged directly with insurers to progress outcomes to individual complaints and, given the involvement of multiple insurers, also discussed our concerns with the Department. The Department wrote to the insurers involved to clarify their obligations under the legislation. As a result, the complaints were resolved with some insurers immediately agreeing to pay the claims. Others agreed to pay the claims only after further discussions with our Office.

Case study

Rejection of claim on the basis of generic information

A hospital contacted our Office about a patient with Hyperemesis Gravidarum, a severe type of nausea and vomiting, in the early stages of pregnancy. The patient was previously admitted overnight for treatment including IV fluids and antiemetics, and their insurer paid the claim in full.

Due to the patient having a small child at home to look after, their treating obstetrician made the decision for them to be admitted for the same treatment, but on a same day basis.

The Type C documentation stated the patient required admission and treatment for Hyperemesis Gravidarum in the form of intravenous fluids and medications, and their baby required ongoing monitoring from maternity specialty clinicians while admitted, in the hope of preventing further ongoing or extended admissions.

The insurer rejected several claims for the same treatment on the basis that the documentation did not meet Type C requirements. It considered the doctor had provided a generic rationale on each certificate. It referred to the Circular, which states that the monitoring of a patient for adverse reactions does not meet the Type C requirements.

The hospital provided further information from the patient's doctor, advising that the admissions were required in order to break the cycle of severe vomiting and allow the patient to return home between admissions to care for their young child. Even with the additional information, the insurer advised it remained of the view that the certificates did not meet the Type C requirements.

In our view, it was not open to the insurer to refuse to pay these claims: the Type C documentation contained sufficient information to meet the minimum requirements under Schedule 3, Rule 7, including adequate information to identify the patient, details of the patient's medical condition and a signed medical statement from the

treating medical practitioner that it would be contrary to provide the treatment outside of a hospital setting as part of a day admission.

We also sought advice from the Department, which supported our view that the Type C certificates in this case met the certification requirements. On this basis, we asked the insurer to reconsider its decision not to pay the claims.

The insurer acknowledged it had taken a narrow interpretation of the Circular and agreed to pay all claims for this patient. It also advised it would change its processes to ensure that Type C claims were assessed appropriately in future.

Findings from the insurer survey

The insurer survey we conducted included a range of questions on the processes used by health insurers when handling Type C claims.

The survey results revealed a range of inconsistencies in the way insurers across the industry manage Type C claims. This is concerning, not least because it may disadvantage and confuse consumers and delay processing claims for hospitals.

The information required on a Type C certificate

We asked respondents to outline the minimum amount of information they look for on a Type C certificate to approve a claim. The sample of responses in Table 1 below demonstrates there is considerable inconsistency across the industry.

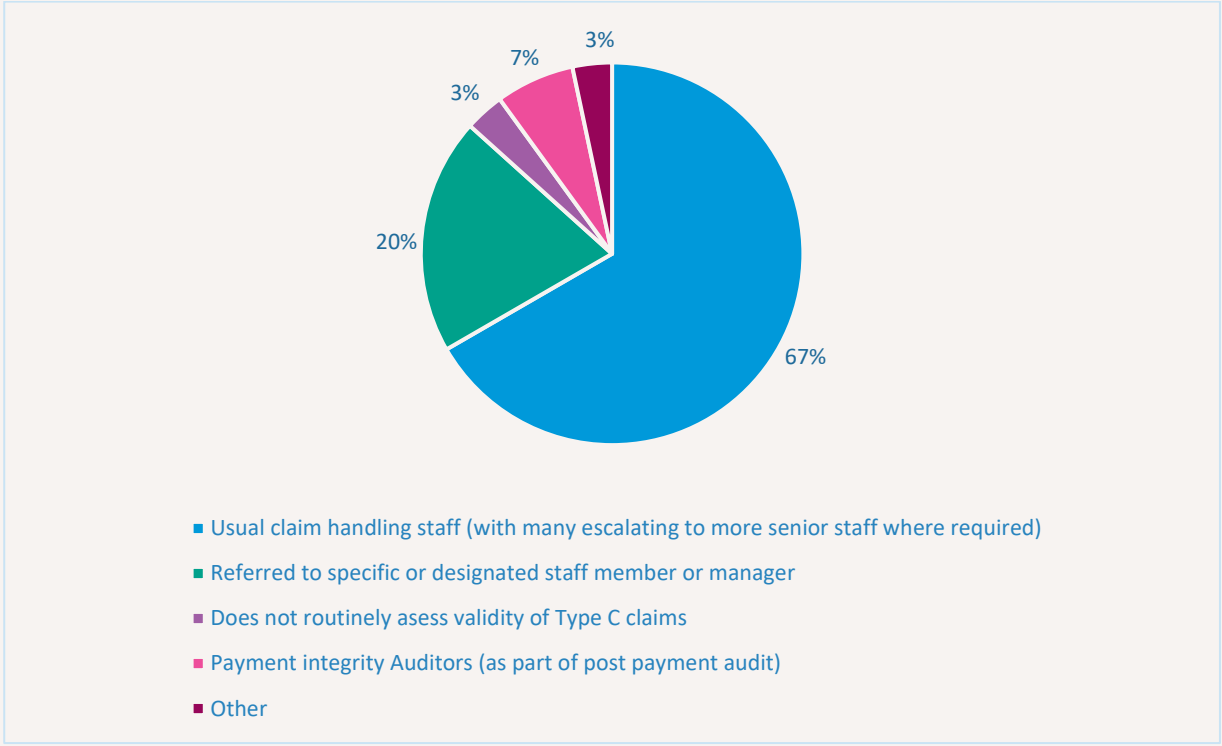
Table 1: Information insurers ask for to approve a Type C claim – selected insurer responses

Minimal requirements	Moderate requirements	High requirements
Provided the Type C certificate is submitted by the provider, no specific details are required.	Claims are approved, provided the reason for admission meets the criteria in the insurer's matrix of valid and invalid reasons.	The Type C certificate must include a description that validates the admission. If the Type C certificate only describes the nature of the condition the insurer may ask for supporting documentation.
Type C certificates are audited for completion via a post payment audit process, but payments are not withheld based on the certificate.	Certificate is checked for completion of every field, and to ensure it contains details specifying the medical condition of the patient requiring admission OR special circumstances.	A treating doctor must provide evidence that the patient's special circumstances justify the hospital admission. This evidence must be documented in the patient's medical record.
Type C certificates are not routinely reviewed; if reviewed, it is expected that there are clinical or other circumstances that support payment of the claim in accordance with the list in the Benefit Requirements Rules.	Claims approved if they meet Type C procedure guidelines as advised by health insurer management services company or hospital contracting service.	If the insurer is unable to identify the Medicare Benefits Schedule (MBS) item of the procedure being certified, the insurer will seek to confirm the MBS item number with the hospital. The insurer will consider rejecting the claim where that information is not supplied in a reasonable timeframe.

Who assesses Type C claims

We asked insurers who in their organisation was responsible for assessing Type C claims. The majority advised their usual claim handling staff assess these claims, with many escalating to more senior staff where required. A small number of insurers also indicated that they refer Type C claims for review by clinical or medical advisors where necessary.

Figure 1: Who assesses Type C claims



What happens when there is insufficient information on the Type C certificate

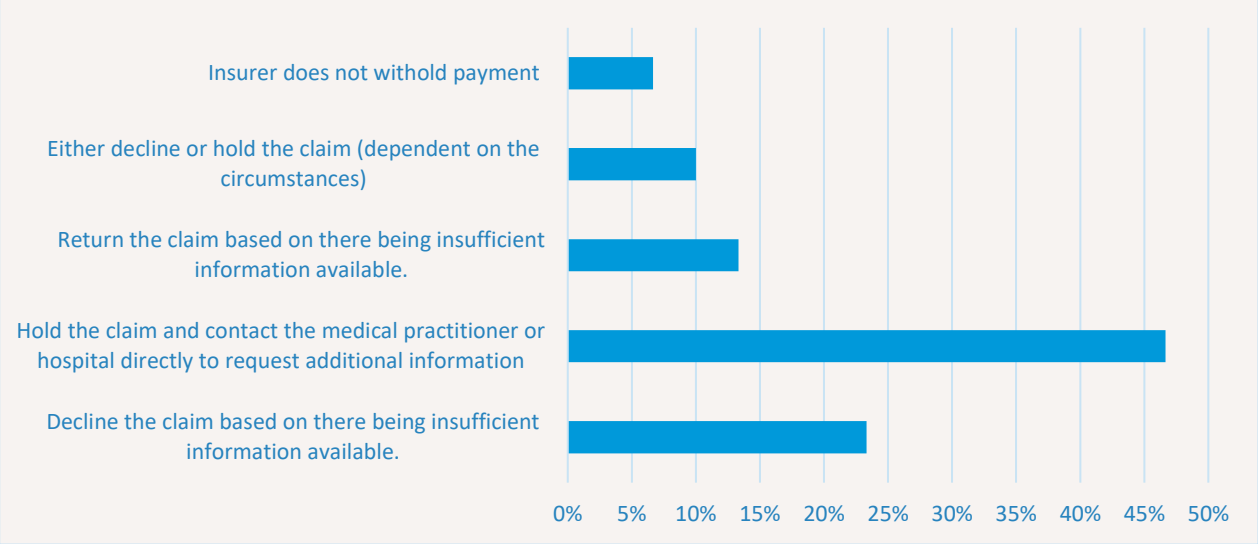
Where insurers consider the Type C certificate does not contain sufficient information to assess the claim, just under half of insurers advised that they hold the claim and contact the medical practitioner or hospital directly to seek further information. Some advised that the claim is cancelled after a certain period if all the required information is not received. The timing for this cancellation approach ranged from 5 days to 2 years, with some indicating that they do not have a cut off time for completing the claim.

Approximately a quarter of insurers advised they will decline the claim in the absence of what they regard as sufficient information, without asking the hospital for more

information. However, most indicated that declining the claim does not mean the hospital is unable to resubmit the claim with further information.

Other insurers advised that their decision to decline the claim or hold the claim will depend on the extent to which the information is insufficient. For example, one insurer stated where the certificate is submitted unsigned or incomplete, the claim will be declined, but if there is insufficient information about the medical condition or special circumstances, the insurer will hold the claim and seek further information from the hospital.

Figure 2: Action taken by insurers when there is insufficient information to assess a Type C claim



The avenues available for patients to seek a review of a Type C claim outcome also varied between insurers. Most indicated that the process is between the insurer and the hospital, and that they do not involve the patient. Others advised that where the patient requests it, they will provide information about the claim outcome and complaints policy.

The survey results revealed a range of inconsistencies in the way insurers across the industry manage Type C claims. This is concerning, not least because it may disadvantage and confuse consumers and delay processing claims for hospitals. We acknowledge that, by their nature, different insurers will use different operating models to run their business and that these may create some variance in procedure and processing arrangements. However, noting the Rules make clear and legally binding

provision for the payment of benefits for Type C procedures where the certification requirements are met, we do not accept that these different operating models should produce such different consumer experiences and outcomes. There is a legal obligation to pay a Type C claim that meets the requirements set out in the Rules and insurers do not have the ability to vary or impose additional requirements. We are concerned that in some instances this obligation is not being met.

The Office has explained health insurer obligations to pay Type C claims in a number of individual complaints. Although we offer guidance below, it is ultimately a health insurer's responsibility to ensure it understands and complies with legal obligations to pay benefits. It is then the Department's role to monitor compliance by insurers.

Best practice guidance on Type C processes

Insurers should apply the following best practice principles when handling Type C claims to ensure consumers are provided with timely and consistent outcomes. These are also principles the Office will have in mind when handling complaints.

1. **Insurers must not defer or refuse a claim because it does not include information outside what is required in the Rules (as clarified by PHI 37/17 Circular). Where an insurer considers a Type C claim does not include sufficient information to meet the certification requirements, they should clearly outline the specific information that is required to approve the claim and provide an opportunity for the medical practitioner or hospital to give this additional information.**

The Rules and PHI 37/17 Circular state that, at a minimum, a Type C certificate should include:

- *"Sufficient information to identify the patient, the certifying practitioner and the specific medical procedure being certified*
- *details of the patient's medical condition,* ***or*** [emphasis added] *the special circumstances relevant to the specific procedure, that the medical practitioner is certifying require it to be performed in a hospital, and*
- *a signed statement with wording to the effect that the medical practitioner certifies that it would be contrary to accepted medical practice to provide the procedure unless the patient is given hospital treatment that … does not include … part of an overnight stay."*

We acknowledge that, for a range of reasons, insurers may prefer to receive more detailed information in support of a Type C claim than is set out above. Nonetheless, in our view, it is neither lawful, nor fair or reasonable for insurers to delay decision on, or refuse a claim that, on an objective reading, includes this standard information.

2. **Type C claims should not be considered on a clinical basis and there is no requirement for Type C assessors to be clinical staff.**

Insurers do not have authority to challenge a Type C certificate issued by a qualified medical practitioner. The insurer's role is simply to assess whether the Type C certificate meets the requirements set out in the Rules.

If an insurer holds genuine concerns about a medical certificate, and they are unable to resolve these with hospital or certifying medical practitioner, they should contact the Department.

3. **Where there is disagreement over whether a Type C claim should be paid, the insurer should work together with the hospital to resolve the issue and minimise any impact on the consumer.**

In many cases, Type C complaints are made to us by consumers who are caught between an insurer and a hospital who are unwilling or unable to resolve the matter between them.

Type C claims are highly technical and in almost every case, only the insurer and/or the hospital will have the information and expertise to progress an outcome. In our view, it is unfair and unreasonable to expect a consumer to pay hospital bills without any assurance their claim will be covered, or to require them to pursue a reconsideration by their insurer.

As a rule of thumb, consumers should be involved only as a last resort, and only after the insurer and hospital have made concerted efforts to resolve any issues between them. This is even more the case when the insurer is choosing not to comply with the law, by not paying a claim involving a Type C certificate that provides the information Schedule 3, Rule 7 requires.

Hospitals should not advise patients they are being charged upfront for a service for which they may previously have had no or minimal out of pocket costs, on the basis that their insurer may not accept Type C certificates. This is unhelpful and misleading to patients. Hospitals should instead explain the Type C process and why issues may sometimes arise.

4. **Claims should be considered in a timely manner and if the insurer believes there is insufficient information or does not agree the claim meets Type C criteria, the hospital should be informed and asked to provide additional information within 2 months of the insurer receiving the claim. If further information is not received, the insurer should decline the claim within 1 month of the request for additional information being made.**

It is apparent that timeframes for assessing Type C claims vary across the industry, with some insurers indicating they do not have a cut-off time for completion of the claim. We have observed some insurers pausing their consideration of Type C claims until the hospital or patient provides any additional information that is outstanding.

Insurers should also implement a clear timeframe in which they will decline a Type C claim if required information is not supplied and this should be clearly communicated to the hospital. We suggest that in most cases, 1 month after requesting additional information is an appropriate period. By setting a timeframe in which claims are automatically refused, insurers ensure that hospitals and consumers are provided a clear point at which they may seek a review or lodge a complaint about the outcome. This avoids the risk of claims being held 'in limbo' indefinitely.

Dispute resolution

If an insurer and hospital are unable to reach an agreement regarding the outcome of a claim, they can contact the Office of the Private Health Insurance Ombudsman for further assistance. The Office would consider the complaint through its usual process.

For more information visit ombudsman.gov.au or call 1300 362 072