# The rules on referrals

Worried about whether your referrals would stand up to scrutiny in a Medicare audit? In the interest of clearing up your concerns, **Margaret Faux** undertakes the forensics on this complex subject.

We always seem to get stuck at the referral slide. Typically, about 15 minutes into our presentations for The Private Practice, Steven Macarounas is forced to politely interject to end the barrage of questions from the specialists in the room. The questions tend to run along the same lines:

- If the GP doesn't stipulate to whom in our practice the referral is for, can we simply circle the name of the doctor or 'fill in the blank'?
- I have a colleague who is booked up for four months. Sometimes he sends patients who have been referred to him by their GP to me, as they can get in to see me quicker. Is it okay for me to 'take over' the referral?
- If I am seeing a person with problem X and am then asked to see the same person at 4am for a new problem (Y), can I bill an initial assessment 110 (though technically there is no referring doctor for the Y problem) because the patient is already under my care?
- If the patient goes to acute care for a period then comes back, does that start another 'period' with a 110, new referring doctor, or just continue with the 116 because one is basically continuing care for the same problem?
- A sound business model builds the practice as a saleable asset, as opposed to the individual doctors within it. How can we achieve this when Medicare requires that referrals name the individual doctor?

**Margaret Faux is Managing Director of Synapse Medical Services.**

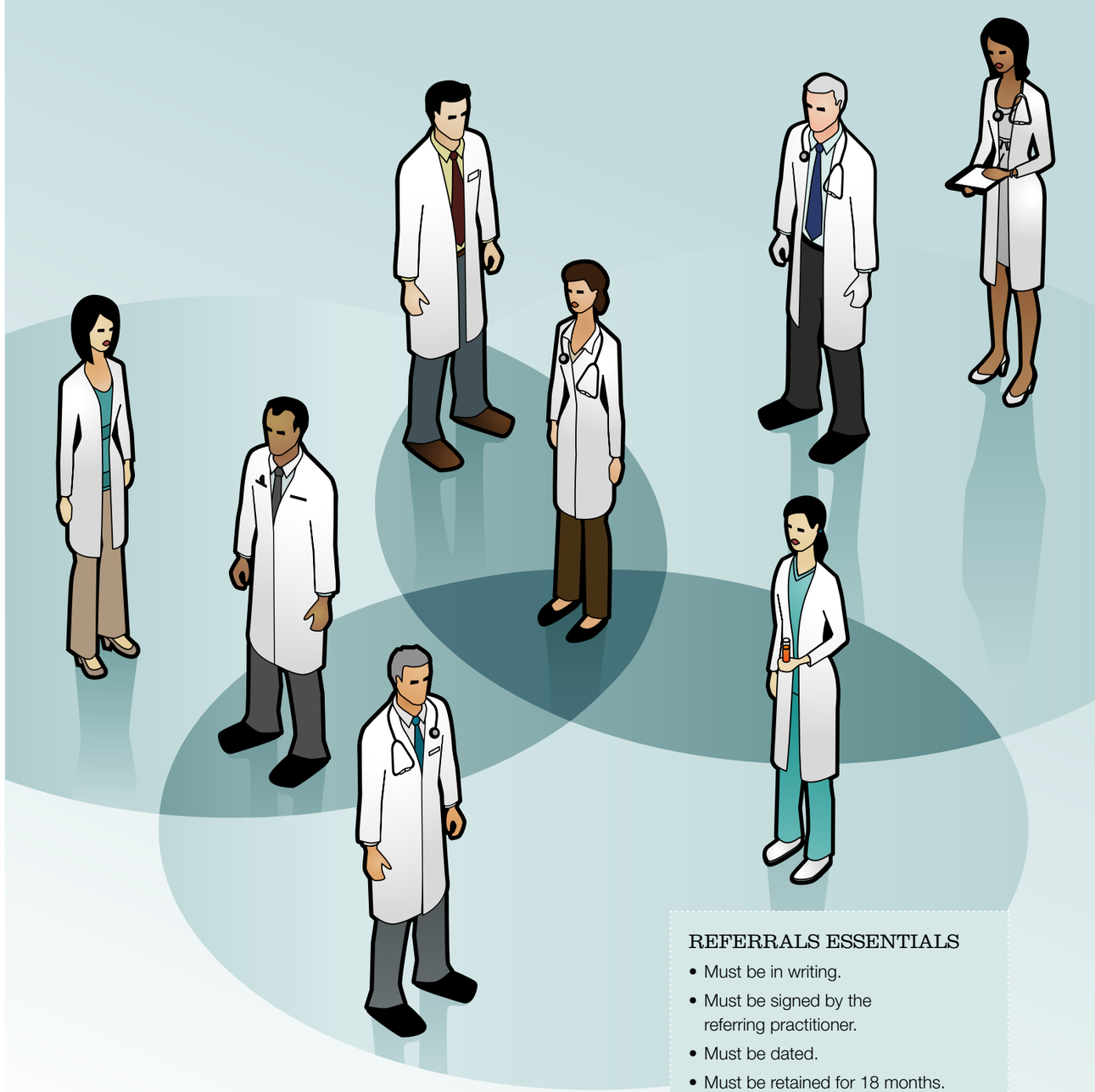
Although referrals should be one of the simplest components of Medicare, this is not the case. Indeed, it's a topic that is neither well understood nor easily or briefly explained, yet referrals are an important and deeply embedded component of our national health scheme. So, let me answer those questions.

## The legal requirements

All legal requirements relating to referrals can be found in section 20BA of the *Health Insurance Act 1973*, and regulations 29, 30 and 31 of the *Health Insurance Regulations 1975* – neither of which provide absolute clarity as to whether a referral must be to a named specialist or not, and this is the cause of much of the confusion. But it's not so much what the legislation says, it's what it doesn't say that provides some answers.

The language of both the Act and Regulations clearly refers to individuals rather than practices, and uses the singular rather than plural. This is seen in the use of phrases such as:

*– 'referral to a consultant physician or specialist'*
*– 'a patient is to be referred by a referring practitioner to another practitioner'*
*– 'in the practice of his or her specialty'*



### REFERRALS ESSENTIALS

- Must be in writing.
- Must be signed by the referring practitioner.
- Must be dated.
- Must be retained for 18 months.
- Must specify a service to be rendered by the specialist.
- Must give the specialist necessary information about the patient's condition.
- The referral must be received before the service is provided.
- Referrals do not need to be in writing in a medical emergency.

If you give the words their plain-English meaning, which is a key principal of statutory interpretation, one would conclude the intention is that patients are referred to a person not a practice. But what the legislation doesn't say is also relevant.

Both the Act and Regulations are silent as to whether the referral must specifically name the specialist to whom the patient is being referred and, in the absence of such direction, it must be assumed that this is not a Medicare requirement.

The legislative requirement is that the patient is referred 'to another practitioner', but nowhere is there a further requirement to address the other practitioner by name. What is required is that the patient is referred to 'a single' specialist as opposed to everyone in the specialist practice – all of whom could theoretically charge an initial consultation for that patient, which is clearly not the policy's intention.

It is therefore accepted medical practice, as opposed to a legislative requirement, that referrals address a specialist by name where possible. But the reality is that sometimes, for very good reasons, referrals arrive addressed to 'Dear Cardiology Practice'. Interestingly, this is something GP software facilitates but most specialist software does not. That notwithstanding, what should you do in these circumstances?

Many practice managers will call the referrer and request a revised referral naming the specialist. If a referral pad has been used, some will circle the name of the specialist who sees the patient on the day, while others will simply insert a name or 'fill in the blank'. For those whose personalities border on the edge of OCD, the most sensible preference is option one, which offers indisputable certainty.

But the correct response is that as long as all other requirements concerning the need for the referral and the content of the referral have been satisfied, and the referral is taken up by one specialist only, then the legal requirements have been met and the referral is valid. Put simply, there is no Medicare requirement whereby a referral must address a specialist by name.

## Can you 'take over' a referral?

An often-asked question is what to do in circumstances where an otherwise valid referral does name a particular specialist but that specialist is not available to see the patient.

Firstly, always keep in mind the GP who made the initial referral and the reasons for that referral. Sometimes a GP will refer to a specific specialist because the GP is of the view that a particular practitioner will best meet the medical needs of the patient. But it's also true that sometimes the GP simply wants their patient seen ASAP, and any specialist will do.

There is nothing in the legislation to prevent another specialist from 'taking over' a referral on a permanent basis and claiming the relevant specialist-referred MBS items. Though, of course, it would be prudent for someone to communicate the change of specialist and the reasons for the change to the referrer.

In circumstances where the named specialist – the principal – is not available and a locum is covering, the locum tenens provisions of the MBS provide the solution. The patient does not have to be seen by the principal and can be seen under that referral, by a locum. A new referral is not required as it is accepted medical practice that the original referral applies to the locum.

In these circumstances Medicare benefits are determined based on the qualifications of the locum, not the principal. And it should be noted that an initial consultation can only be claimed once, by either the locum or the principal – whoever first saw the patient under that referral.

## Emergencies and new conditions

In circumstances where one is seeing a person with problem X and is then asked to see them at 4am for a new problem when there's clearly no ability to obtain a new referral, there are a few options. A second initial consultation can be claimed under the original referral when the patient presents with a new condition, unrelated to the first condition. In my work we see this very often and it will usually be necessary to add the words 'not duplicate service' and 'new condition' to the claim to ensure it is paid.

The Medicare website provides a useful example of a patient who is regularly reviewed for glaucoma who then develops a pterygium. This would commence a new episode of care and a new initial consultation item would be payable. And as long as the original referral was worded broadly enough, there is no requirement contained anywhere in the legislation specifically indicating that a new referral must be issued in these circumstances – and sometimes it's just not possible.

However, if the original referral specifically requested only the treatment and management of glaucoma, then you'll need a new referral for the pterygium.

Alternatively, if the treatment is an emergency situation or occurs in a hospital and it is not possible to obtain a referral, you can obviously proceed and treat the patient without a referral. The detailed records you will include in the hospital file will be all that's required should the claim ever need to be substantiated.

## What is a course of treatment?

Often questions about referrals come down to the definition of a single course of treatment and determining when one course of treatment ends and another begins. This is not always easy. Medicare describes a single course of treatment by a specialist as including an initial consultation and the continuing management and treatment of the patient up to the point where the patient is referred back to the care of the GP, as well as any subsequent follow-ups of the same condition.

Often patients will spend a period of time in acute care during the course of an admission, and this doesn't always occur at the start of that admission. An episode in acute care does not necessarily commence a new course of treatment, for which a new initial consultation would be payable. The patient can go to intensive care or theatre, or even be discharged home and return, and still be receiving care for the same problem under the same referral.

Of course, sometimes a referral will expire during the course of treatment and a new referral will be required – and this does not automatically commence a new course of treatment. If you are managing the same condition then an initial consultation should not be claimed again. The new referral simply ensures claims are paid at the specialist rate.

### What is the referral asking you to do?

Implementing the precise request contained in the referral should not be overlooked. This Professional Standards Review case is a cautionary tale:

*PSR annual reports* – 2004-2005
Dr D, Consultant Physician in Gastroenterology

The reasons the Commission gave for making this request were the overall number of rendered services and daily servicing by Dr D (13,602 services at a Medicare benefit of $1,507,595 and 60 or more services a day on 33 occasions) and the level of consultations in association with procedural items on the same day.

After conducting his review, which included obtaining advice from a senior consultant physician in gastroenterology, the Director formed the view that Dr D did not receive a proper referral to a consultant physician to justify a claim for an MBS item 110 (initial consultation), nor did Dr D document that he had rendered a service that justified an item 110 consultation.

The Director was of the view that the request Dr D received was for a procedural item (endoscopy etc.) rather than a referral to a consultant physician for management of a patient's problem. Dr D's medical records focused on a history of the gastrointestinal problem but there was no evidence of any history taken of other problems or of the general health of the patient.

It was apparent from the request documentation that some patients had significant medical problems. Also, there was no evidence that a physical examination was made prior to the procedure. On advice provided by Dr D, he allows five minutes for the consultation and 10 minutes for the procedure.

Following much discussion, Dr D agreed that his conduct constituted inappropriate practice, that the 'request' to perform a procedural item was not a valid referral (as required by the legislation), and agreed to be reprimanded and to repay $70,000 in Medicare benefits.

Aspects of this case are difficult to reconcile with the fundamental nature of specialist physician practice, as the PSR found that the request received by the gastroenterologist was valid for the procedure only and not for any consultation. If that was the case, it seems to have reduced the gastroenterologist to being little more than a technician.

Nonetheless, the example provides a clear message to medical practitioners to exercise caution in rendering services not specifically articulated in the referral document, and to keep a thorough record of services provided.

## Period of validity

GP referrals are usually valid for 12 months and specialist referrals three months, although GPs can state the length of the referral to be something other than 12 months if they so choose. The start date is the date of the first consultation covered by that referral, not the date of the referral itself.

When an admitted patient is referred to a specialist, the referral is valid for three months or the duration of the admission, whichever is longer. The referral in this instance does not need to be a separate letter or document. Regulation 30 provides that a signed referral contained in and forming part of the patient's hospital file is sufficient.

Indefinite referrals are intended to be just that – indefinite – but most of you will know this is simply not the case.

Medicare even provides written material on its website advising specialists not to request a new referral and advising GPs not to issue a new referral unless a new condition arises. Yet, anecdotally, doctors and practice managers will tell you that indefinite referrals seem to 'expire' in an arbitrary fashion.

Usually, practices become aware of this when their claims suddenly start rejecting. Then, having called Medicare, they are informed that the referral has expired, despite protests that it was indefinite. Only one option remains – get a new referral. If you don't you cannot claim the specialist-referred items. This remains a peculiarity of the system.

Backdating referrals is illegal and serious penalties apply for breaches. But how do you manage the situation where you thought you had a valid referral prior to your first consultation with the patient but it turns out you didn't?

The first indication is usually when your claim is rejected with one of the 'something's up with the referral' rejection codes. In a medical-billing company where we submit thousands of claims daily, problems with the referral is one of the most common causes of rejected claims. Often, once the data has been carefully checked to ensure name and provider number were correctly entered and phone calls have been made, it turns out that an intern or resident – whose provider number does not yet allow them to refer – has written the original referral.

Interns, residents and some registrars working in public hospitals do not have a provider number that allows them to refer to private clinicians outside of the hospital. They are able to write a referral on behalf of their supervising consultant, as long as the consultant signs the referral. The privilege of referring comes with their qualifications, a little later in their careers.

The original referral in this scenario therefore contained an error, in that it named the wrong referring doctor and provider number, and until this is fixed, the claim will not be paid. But the question here is whether you should revert to claiming the non-referred items until such time as you have a valid referral, or whether a genuine error can be corrected.

It's one of those grey areas on which the legislation is silent. It's not a lost, stolen or destroyed referral and so those provisions cannot apply. It's simply an honest mistake usually made by a well-meaning junior

Indefinite referrals are intended to be just that – indefinite – but most of you will know this is simply not the case.

clinician taking the load off the consultant, but it's the consultant who should have been named as the referring doctor.

Medicare accommodates genuine errors and states that an invoice can only be reissued if a genuine error has occurred. This example can therefore be viewed as falling within that category and, as such, the most sensible course of action is to call the hospital – which you will inevitably have to do anyway – negotiate being put through to the consultant, explain to him or her what has occurred and seek confirmation that the referral was issued on the relevant date by him or her. Then correct your claim and resubmit.

If your efforts reveal the patient came to you via the emergency department, the correct referring doctor will usually be the director of the department or, in the case of a larger emergency department, one of the staff specialists.

## Miscellaneous requirements

On a final note, there are specific requirements for some items – such as the Geriatrician services covered by items 141-147. These must be GP referred and are very specific regarding reporting back to the GP. Always check the MBS if you are unsure.

Referrals can now be electronic, consistent with the provisions of the Electronic Transactions Act 1999. Importantly, referrals for outpatient services in public hospitals are covered by the National Healthcare Agreement and, as such, are not the subject of this article.

As a reader of *The Private Practice eZine*, you'll already be switched on to the concept of building your practice as a business asset. And now you have been assured that there is no Medicare requirement to specifically name the specialist to whom the patient is being referred, this no longer needs to be viewed as an impediment to building your practice for sale.

While referrals are a complex but largely comprehensible aspect of the Medicare scheme, their role in state-run, public-hospital clinics is unimaginably labyrinthine in comparison. As many of us struggle to reconcile the federal legislation and the National Healthcare agreement – in the context of regularly changing national-partnership agreements, contentious Council of Australian Governments conferences held by health ministers and the potential impact of the National Disability Insurance Scheme – perhaps we should be thankful private-sector referrals are fairly straightforward!