Medbill

Billing Compliance & Revenue Cycle Management Solutions for Australian Private Health Providers




# Plugging the Leaks

## Maximising Practice Revenue for Specialists through Medicare Compliance

Brendan Homann | General Manager

"You trained to be a doctor, not a billing department. But in private practice, billing is the engine that funds everything."

- Billing Compliance & Audit
- Medical Billing Services
- Revenue Cycle Management

Introduction

# How not to lose over $2m over your career...

"Medical Billing — how hard can it really be?"

**PUBLIC SYSTEM**

You delivered care — someone else handled the Item Codes, the billing, and the revenue collection

**PRIVATE PRACTICE**

The claim rejection lands on YOUR desk — and nobody knows why.

You have provided the medical service – but you have zero funds in your bank account.

**TODAY'S GOAL**

Build a practice that is fully compliant & maximises it billing and never has to chase its own revenue...

**TLDR: Save me $2m over my career!**

WELCOME TO A DIFFERENT WORLD!

# From Shift Worker to Business Owner

## PUBLIC SYSTEM

- Salary paid regardless of the billing outcomes
- Revenue managed by the institution
- Coding & compliance someone else's problem
- Managing debts, rejections and cash flow someone else's problem
- Payer relationships handled centrally

- Clinical excellence = job done



## PRIVATE PRACTICE

- Revenue flows only when billing is correct
- YOU are the institution — all functions are yours
- Coding errors = your financial and legal exposure
- Every payer relationship must be managed
- Cash flow is the life blood of your business & your ability to meet your financial obligations (staff costs, rent, your salary etc)

- Clinical excellence is necessary - but not sufficient

WELCOME TO A DIFFERENT WORLD!

# The Payer Ecosystem

Unlike a hospital salary, no two payers work the same way — and none are designed to make it easy for you.

### Private Health Insurers

Multiple funds, varied schedules, own gap policies & benefit limits.
28-30 different private insurers across Australia

### Medicare

MBS schedule sets codes & pricing, strict item rules, co-claiming restrictions, bulk billing rules

### DVA

Separate fee schedules & approval requirements for veteran patients

### Third Party Insurers

State-based, employer liability claims, prior approval often required.
Eg WorkCover, 3rd Party Motor

### Self-Pay Patients

Fee transparency obligations (eg Informed Financial Consent), gap payment collection (Pre or Post), hardship discount policies

### The Key Point

The payer landscape shifts constantly — rules, schedules & denial rates change every year

WELCOME TO A DIFFERENT WORLD

# Pricing Policy & Billing Codes

## YOUR FEE POSITION — A REVENUE STRATEGY DECISION

### No Gap

Bill at insurer schedule fee. Patient pays nothing. High volume, capped ceiling.

### Known Gap

Charge above schedule. Gap disclosed upfront. Balances access with revenue.

### Gap - AMA Rates or Your Own Fee

Set your own fee schedule. Maximum revenue potential. Requires strong patient comms & payment collection processes.

⚠ **Inconsistency in fee position & discount policy implementation is one of the most costly early mistakes.**

## BILLING CODES — NOT OPTIONAL KNOWLEDGE

- **Item numbers are specialty-specific** and updated regularly by Medicare.
- **Get it wrong:** undercharge, overbill, or trigger a compliance audit.
- **MBS bundling, co-claiming & modifier rules** are not intuitive - they require ongoing education.
- **Most in-house billing errors trace back to the doctor,** not admin - because the clinical decision drives the billing codes.
- **Coding compliance** is a continuous professional obligation with direct financial and legal consequences.

REVENUE VS CASH FLOW

# Two Numbers — One Critical Gap

## REVENUE / BILLING

What you are entitled to earn
from the health services delivered

**Determined by:**

- Fee position chosen
- Billing codes submitted
- Services actually delivered

≠

## CASH FLOW

What actually lands
in your bank account — and when

**Determined by:**

- Claim accuracy & timeliness
- Payer processing & approval
- Denial management process, follow-up & patient collection discipline

The gap between revenue and cash flow is where billing lives — and where practices thrive or struggle.
Cash Flow pays the bills and keeps your practice running.

REVENUE VS CASH FLOW

# Revenue Cycle Management — Closing the Gap

**10–20%**

of ‘earned revenue’ unrecovered annually by practices with poor RCM

That’s 1-2 months a year that you are ‘working for free’

1

### Pre-Visit

Eligibility check, referral confirmation, correct item numbers identified

2

### At Point of Care

Accurate documentation, correct & complete code selection by the clinician for all services

3

### Claim Submission

Clean claims submitted promptly to correct payers with right modifiers

4

### Payer Processing

Monitor claim status, respond to requests for information quickly. Follow up unpaid patient debt

5

### Denial Management

Review, appeal and resubmit rejected claims — don't leave money behind

6

### Reconciliation

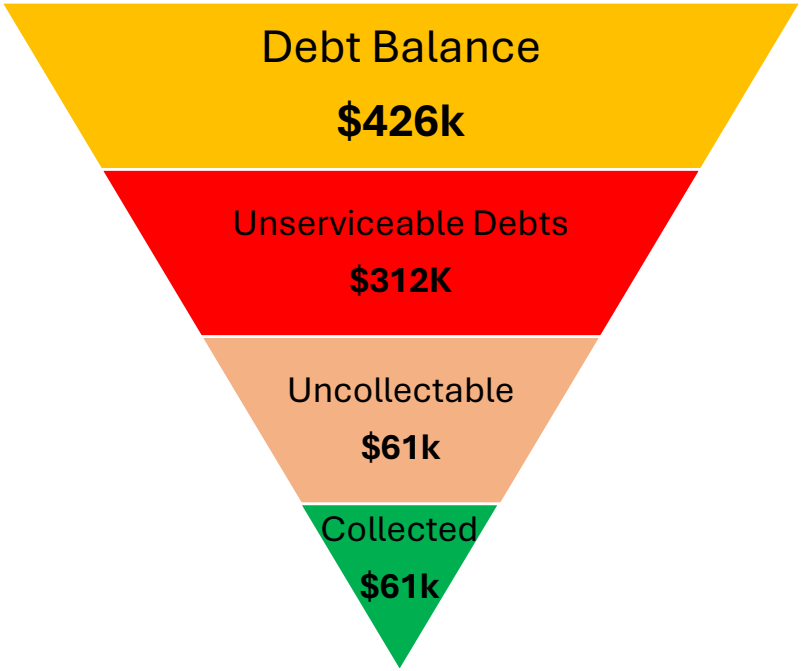
Payment posted, gaps collected, account closed — cycle complete

**Strong RCM = predictable revenue = a practice you can plan, invest in, and grow.**

REVENUE VS CASH FLOW

# Case Study – Debt not managed over time

## Surgeon Sydney - own PMS + own Admin team




### Key Failure Points:

- No regular reporting or review of financial performance with the PM and Accountant
- Failing to pivot patient debt to Medicare Bulk Bill
- Failing to reconcile Invoice to Cash (Bank Rec)
- Failing to identify and correct Disputed Claims (in time).
- Failure to bill correct items, locations, inpatient/outpatient.
- Failure to align to schemes/agreements.

**Failure to manage debt correctly for over a decade actually cost this provider $373k!**

REVENUE VS CASH FLOW

# The “Leaky Bucket”



**Average Lost Revenue per annum**

**10% - 20%**

**Lifetime lost earnings at risk**

**$2m ++**

**Close your Loops from the start!**

WHAT BILLING ACTUALLY INVOLVES

# The Full Billing Operation

Most doctors don't know what they don't know. Billing is not something that you are taught in your medical training.
Here is what 'billing' actually requires:

### Qualified Staff

Medical billing specialists — not general admin — with specialty-specific coding knowledge

### Compliance & Financial Oversight

MBS audit readiness, documentation standards, AHPRA and ATO obligations. Clear responsibilities & separation of duties for key financial tasks to manage fraud risks

### Credentialing

Ensuring provider numbers are active and correctly assigned per payer

### MBS Billing Updates

Continuous training as MBS schedules, item numbers, timing limits and rules as they change

### Billing Software & Payment Gateways

Practice management platforms with strong billing capabilities with ongoing licensing, updates & integration costs

### Payer Contracting

Registering and establishing and maintaining agreements with major funds (eg Known Gap) for all Provider Numbers

### Claim Appeals

Systematic review and resubmission of every denial — time-intensive and specialist skills required

### Revenue Reporting

Dashboards that tell you where revenue is, what's outstanding, and what's at risk. Regular and ongoing review with key staff and your Accountant / Financial Advisor

WHAT BILLING ACTUALLY INVOLVES

# The Billing Engine Room...




**Provider Numbers**
Registration per place you work with Medicare.

**Health Funds**
Registration per Health fund prior to providing services.

**Patient Demographics**
Accurate Patient Demographics Name, DOB, Fund, Medicare, DVA

**Accurate & Compliant Item Codes & Details**
Ensuring you have collected Referral, Procedure, Times, Locations, Item Codes, Additional Details as required.

**Timely**
Ensuring you submit claims on time to avoid unserviceability windows, don't delay, do it consistently each week.

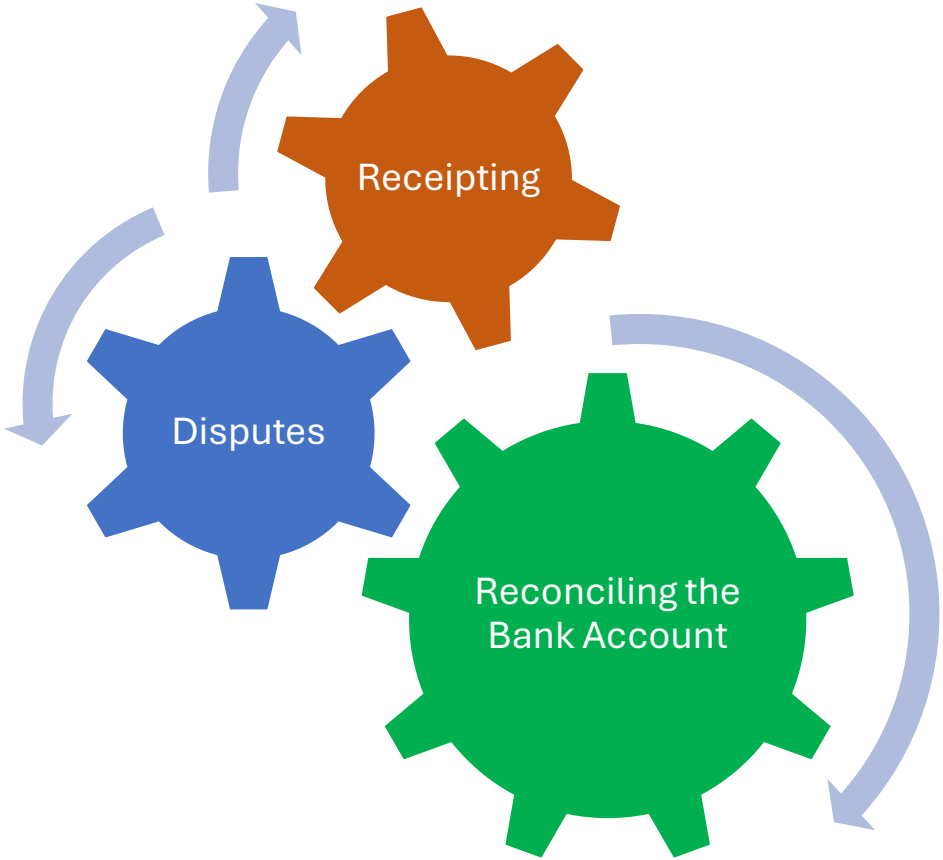
**Priced Correctly**
Ensuring pricing aligns to IFC, AMA Rates, Bulk Billing, Agreements

**Close your Gaps**
Have a way to ensure you bill for every Patient seen, every appointment held, every follow up, checks and balances.

**Cont...**

WHAT BILLING ACTUALLY INVOLVES

# The Billing Engine Room...




**Receipting**
Ensuring items that are “paid” are marked as paid whether letter, email, or digital.

**Identify Disputed or Unpaid Claims**
These may be strategically underpaid, rejected with reasons or without.

**Follow the Dispute Resolution Workflow**
Noting it varies for the type of dispute, Funder, rejection reasons and more.

**Call / Email / Mailout to Funders**
30+ minute hold time + 5 questions max per call.

**Chase Unpaid Patient Debt**
Rapid and systematic follow up of patient debt is critical. Pre Payment is becoming more common for Gap collection

**Did the money hit your account?**
For every receipted claim, are you sure it hit your account in full?

**If not, why not?**
Does the funder have the right details, did they forget to make payment, is it just a timing issue.

WHAT BILLING ACTUALLY INVOLVES

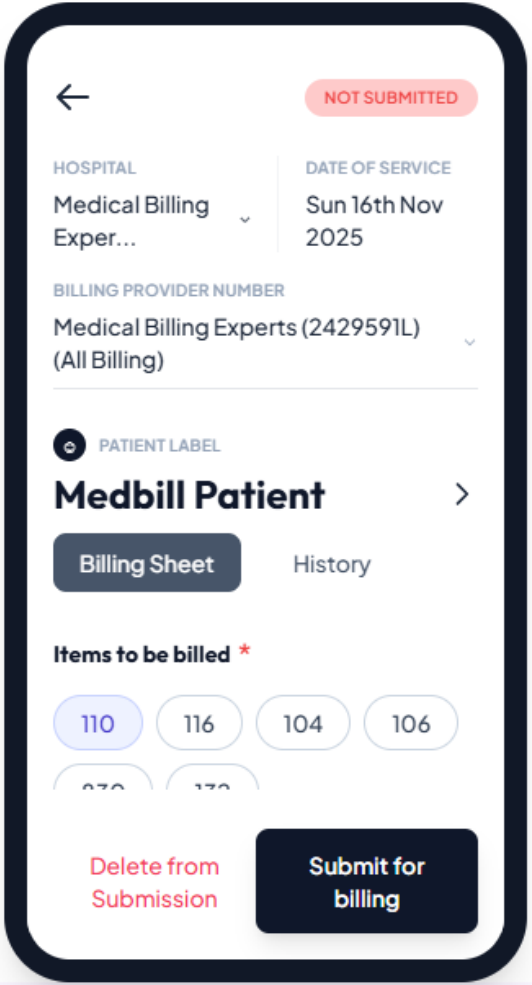
# Close the Loops

## Your Top 3 End of Month reports

### 1. Un-invoiced Appointments
Ensure you have invoiced every patient you saw.

### 2. Aged Debt
Rigour around tracking your Aged Debt within your Practice

### 3. Banking Report
Compare Bank Statement to Receipted Funds



# DOHAC is very clear where their billing compliance focus lies in 2025-2030.

Australian Government
Department of Health and Aged Care

## Health Provider Compliance Priorities 2025

### Bulk billing

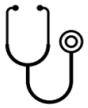
Access to affordable health care for all Australians is a high priority. When a health professional chooses to bulk bill a service, they accept the relevant Medicare benefit as full payment for the service.

Charging a co-payment or membership fee is a breach of the *Health Insurance Act 1973*. Where we find that a health professional has charged a co-payment or membership fee for a bulk-billed service, we take compliance action.

### Specialist and consultant physician claiming of attendance items and management plans

Professional attendance services are the largest contributor to Medicare Benefits Schedule (MBS) expenditure. Our data shows specialist and consultant physician attendance items drove the growth of attendance services in financial year 2023-24. This includes management plans such as MBS items 132 and 133.

Our focus is ensuring providers understand how to claim correctly to protect the sustainability of Medicare.



### Claiming MBS services while overseas

Medicare benefits are only payable where the service is performed in Australia to an eligible patient.

We take compliance action where a provider performs and claims MBS services while overseas.

### Suspected fraud

We are committed to tackling illegal activity and behaviour of concern to protect the integrity of Medicare.

### Duplicate payments

Medicare benefits are only payable where a service has not already been paid for through another funding arrangement. Duplicate payments breach Section 19 of the *Health Insurance Act 1973*. This requirement ensures the sustainability of Australia's healthcare system.



We take compliance action where we find duplicate payments.

### Opportunistic billing and emerging business models

In an environment of rising costs, technology advancements and innovation in healthcare delivery, there is increasing risk of business models prioritising revenue generation over clinically relevant patient care.

The integrity of Australian Government health program payments is impacted where:

- arrangements between an organisation and a health professional remove health provider control over their claiming, or
- a practitioner's clinical independence is undermined by corporate billing requirements.

We take compliance action to address inappropriate practice and mitigate the potential for patient harm.

### Inappropriate claiming of high-cost PBS medicines

The Pharmaceutical Benefits Scheme (PBS) provides patients with access to safe, proven and cost-effective medicines. Ensuring PBS compliance safeguards the sustainability of the PBS.

When a pharmacist supplies an invalid prescription, patient care can be impacted. In some cases, it can result in health program benefits being obtained fraudulently. We take compliance action where:

- PBS supplies are more than what was prescribed or clinically needed
- PBS medicines are claimed without a prescription.



### Open and uncertified PBS claims

We have identified an increasing number of PBS claims where the supply of pharmaceutical benefits was not certified, and the claim closed. This breaches the Claims Rules made under the *National Health Act 1953*.

Collaborating with Services Australia, our focus is on:

- supporting approved suppliers understand their claiming obligations, and
- implementing up-front controls to ensure future compliance.

WHAT HAPPENS IF I GET IT WRONG?

# The Australian Compliance Framework



Australian Government
Department of Health

7 February 2019

Our reference: [redacted]

[redacted]

REVIEW & ACT NOW

Dear Dr [redacted]

The Department of Health (the department) is responsible for compliance activities relating to health programs. Information held by the department indicates that some providers may not be meeting the Medicare Benefits Schedule (MBS) requirements for patient consultant physician treatment and management plan items (MBS Items 132 and 133).

You have been identified as a health provider that has claimed at or above the 90th percentile compared to your peers that claim MBS Item 132 and/or 133.

To satisfy the requirements under the *Health Insurance Act 1973* (Cth) and the instruments made under it, the claiming of item 132 or 133 must meet the MBS Item requirements outlined in the attached document.

Between 1 May 2017 and 30 April 2018, you claimed services relating to MBS Item 132 and/or 133 on 770 occasions.

To assist you in reviewing your claims, please find your schedule of claims attached for this period. If you identify any MBS payments that you were not entitled to receive, these must be repaid to the department. If you are unsure if you have met the requirements to claim MBS Item 132 or 133, you can seek clarification through the Department of Human Services at askMBS@humanservices.gov.au or call on 13 21 50.

**What you need to do**

**Review** the attached schedule of claims. Each claim needs to meet the item requirement outlined in the attached document.

If required, **fill out** the attached *Voluntary Acknowledgment of Incorrect Payments* form for any claims you were not entitled to receive.

Where required, **return** the completed *Voluntary Acknowledgment of Incorrect Payments* form, containing your completed schedule of claims.

If you are completing and returning a *Voluntary Acknowledgment of Incorrect Payments* form, please return by **7 March 2019**.

## Non-Linear Process

The entire process we are about to discuss is not Linear

## Selection for Targeted "Education"

The DoH regularly selects providers who's claims fall within certain parameters (ie 90th Percentile).

## Advise your Insurer

Your first step should be to notify your insurer.

## Respond

You will need to review each of the Claims, justifying why each is correct, agreeing to amend and repay or adjust the amounts.

- Clinical Notes VS Billing Details

## Big Data & Algorithms at Work

Note the government has huge volumes of data, and teams to analyse everything from:

- The detail included in your claims (referrals, item codes).
- How your claims stood out differently to your peers.
- Your overseas travel overlapping claiming.

# The Australian Compliance Framework

Targeted Campaign

DoH Audit

Response

## Referral to the PSR

**STAGE 1**
***The Director of PSR***



Decision: Should the matter be reviewed?

**STAGE 2**
***The Committee of Peers***



Decision: Did inappropriate practice occur?

**STAGE 3**
***The Determining Authority***



Decision: What is the suitable sanction?

**Plea Bargain**
**S192 Agreement**

- Repay funds
- Agree not bill certain Items

**Committee of Peers**
18-24 months process of

Intensive review of Clinical Files
Items, Clinical Notes, Behaviours

WHAT BILLING ACTUALLY INVOLVES

# The Hidden Costs — and the Compounding Burden

## WHAT YOU SEE

- Staff salary × 1–2 FTE
- Practice management software subscription

## WHAT'S HIDING BELOW

- Recruitment & turnover cost when your admin leaves
- Training time for coding updates & compliance changes
- Timing gaps for holidays, sick leave etc
- Invoice Write offs or deletions you never see
- Revenue lost during knowledge gaps and staff transitions
- Compliance exposure — audits, penalties, write-backs
- Your time: managing, supervising, fixing billing issues

## THE BILLING BURDEN COMPOUNDS

More patients ≠ more of the same.
More patients = more payers, more codes, more denials, more patient debt, more compliance risk, more management time.

- Every new procedure adds new item number complexity
- Every new payer adds a new set of rules to manage
- Every staff gap creates a revenue recovery backlog
- Every coding error compounds into a compliance pattern

**Every failure point in the billing cycle is a direct leak in your revenue cycle.**

# Case Study – Key Person Risk Management

## ER Dr Group – Own Single Admin Person




**Key Failure Points:**

- Mitigate the key person risk.
- What checks & balances are in place on this person.

**Failure to manage debt correctly for over a decade actually cost this provider $373k!**

THE DECISION

# The Fork in the Road

Every doctor entering private practice reaches this decision — most make it too quickly, based on instinct rather than analysis.

## INSOURCE

Hire experienced billing staff
Understand & Own the process
Keep it in-house

**At first glance:**

- Feels like control and visibility
- Staff on-site and accessible
- Familiar to hospital-trained mindset

OR

## OUTSOURCE

Engage a specialist
Hand off the submission & cash collection function
Focus on medicine & patient care

**At first glance:**

- Specialist expertise from day one
- No staffing, training or turnover risk
- Scalable as your practice grows
- Alignment of incentives with your billing partner

**This decision deserves more than a gut feel. Let's look at what it really means to insource.**

# Before You Decide — Answer These Questions Honestly

1

**Do I have the expertise in-house to manage a complex, compliance-heavy revenue cycle?**

Specialty coding, payer rules, MBS changes, consumer law, appeals — all of it.

2

**Can I absorb the cost and disruption if my billing operation underperforms or breaks down?**

Staff turnover or knowledge gaps, revenue gaps (debt), compliance exposure — what's your tolerance?

3

**Is building a billing department the best use of my capital and attention at this stage of my practice?**

Your time, focus and money are finite. What do you want to build? What do your staff prefer spend their time doing – dealing with patients or ringing insurers to manage rejections and collecting outstanding debts?

Most new practice owners' answer: No. No. No.

THE INSOURCING ILLUSION

# Why Insourcing Feels Safe — But Isn't

## THE ILLUSION

- "I can see it and manage it"
- "I trust my own staff more"
- "It's cheaper than outsourcing"
- "I have direct control over the process"
- "I'll know if something goes wrong“
- This is what the previous generation of doctors do

## THE REALITY

- Staff turnover is the #1 threat to RCM — your revenue cycle walks out when your biller or PM does
- In-house staff rarely have deep specialty-specific coding expertise
- True cost (salary, super, training, software, recruitment) often exceeds outsourcing
- Compliance errors carry personal liability for the practice principal
- No alignment of financial incentives with your staff - rejected claims or unpaid patient bills do not impact them
- Revenue leaks are often invisible until significant damage is done

"Do you want to build a billing department — or a medical practice?"

THE INSOURCING ILLUSION

# 2026: The Stakes Have Never Been Higher

The billing environment in 2026 is fundamentally more demanding than even 3 years ago.

### AI-Driven & Algorithmic Denial & Compliance Engines

Medicare & Insurers now deploy AI & data matching to identify claim anomalies and auto-deny at scale. In-house billers without specialist tools and knowledge are outgunned from the start.

### Real-Time Claims Processing Demands

Payers expect faster, cleaner claims. Delays and errors that were tolerated previously now trigger automatic rejection, requiring rapid re-submission capability.

### Increasing Audit Activity

Medicare and private funds have significantly increased audit frequency. Patterns of incorrect coding — even inadvertent — now attract formal investigation.

### Patient Contribution – & associated debt – is growing

Patients are paying more Gaps than ever before due to Medicare rebates not being indexed.
This is unlikely to change – so patient debt exposure for many Doctors is growing at a rapid rate each year.

WHAT BEST PRACTICE LOOKS LIKE

# What a Best-in-Class RCM Operation Delivers

1

### Clean Claim Rate Above Benchmark

95%+ first-pass acceptance — fewer rejections, faster payment, less rework

2

### Systematic Denial Management

Every denial reviewed, appealed and tracked — no revenue left behind

3

### Specialty-Specific Coding Expertise

Deep knowledge of your area's MBS codes, bundling rules and billing nuances — kept current

4

### Active Payer Relationship Management

Proactive engagement with funds, schemes and Medicare to resolve issues before they become patterns

5

### Real-Time Revenue Reporting

You know where your revenue is, what's outstanding, what's at risk — at all times

6

### Compliance Assurance

Audit-ready documentation, correct coding, and protection of the practice principal from personal liability

Could I build this in-house — and should I?

# Build the Practice You Intended

The doctors who thrive in private practice protect two things fiercely:

**Their Clinical Time**

**Their Revenue Cycle**

"What is one hour of my time worth —
and how many hours a week will a poorly run revenue cycle cost me?"

Medbill

Billing Compliance & Revenue Cycle Management
Solutions for Australian Private Health Providers

If you want to see what a well-run revenue cycle looks like in practice, Medbill would love to show you.

Scan the QR code and fill out the contact form and a Medbill Team member will be in touch in 24 hours to discuss your requirements