

Key findings

VMO claims for payment

Inadequate processes for verifying VMO claims

VMO contracts are with individual local health districts, and VMOs submit claims for payment to hospitals for work they perform on public patients. Each hospital's staff verifies its own VMO claims, which are then sent to NSW Health Support Services (HSS) for data entry and submission for payment.

Exhibit 8: Verification of VMO claims for payment



Source: Audit Office

VMO claims for payment are hard copy

Interviews with hospital staff revealed numerous problems with VMO claims verification and processing.

All claims for payment from VMOs are in hard copy, and some are even handwritten.

Exhibit 9: A handwritten VMO claim

HEALTH SUPPORT SERVICES NSW HEALTH		Author: Vmosey ISO Working Party Email: QualityAssurance.ServiceCentres@nsw.health.nsw.gov.au Approved by: Director Operations & Business Support		Document ID: 2009-VMO008 Version: 1 Modified: 23/7/09 Published Date: 23/7/09		OFFICE USE ONLY Claim Form No: Entered: Checked:					
SESSIONAL VMO CLAIM FORM Separate claim forms to be completed for each month Please refer to VMO Hintsheet for completing this Claim Form											
Health Service: AREA HEALTH SERVICE		Facility Name: HOSPITAL		Facility Code:		VMO Name: D		Specialty: PHYSICIAN		Month Worked:	
Routine Hours Only											
HSSC use only	Service Type & Committee Meetings	Start Date	Start Time 24hr clock (HH:MM)	Finish Date	Finish Time 24hr clock (HH:MM)	Hours worked (HH:MM)	Hours deducted (HH:MM)	No. Patients Attended	Total Payable hours (HH:MM)	No. of reads (Radio.vmo only)	Cost Centre (Enter Cost Centre if different to the designated Cost Centre provided by your Health Service)
	MS	22/9/10	1630	22/9/10	2100	2w 30'	-	-	2w 30'		
	MS	23/9/10	0830	23/9/10	0900	30'	-	-	30'		
	R	23/9/10	0900	23/9/10	1000	1hr	-	1	1hr		
	MS	23/9/10	1000	23/9/10	1045	45'	-	-	45'		
	R	23/9/10	1100	23/9/10	1530	4w 30'	-	8	4w 30'		
	MS	23/9/10	1600	23/9/10	1730	1w 30'	-	-	1w 30'		
	R	23/9/10	1700	23/9/10	1745	45'	-	2	45'		
	R	24/9/10	0800	24/9/10	2245	14w 45'	-	23	14w 45'		
	R	25/9/10	1200	25/9/10	2000	8hr	-	11	8hr		
	R	26/9/10	1100	26/9/10	1845	7w 45'	-	13	7w 45'		
	R	23/9/10	0900	23/9/10	1545	6w 45'	-	12	6w 45'		
	R	24/9/10	0900	24/9/10	1300	4hr	-	6	4hr		
Service Types: M1= Routine; M2= Theatre; M3= Meetings; M4= Committee Meetings; M5= Clinical Practice; M6= Administration of a Dept; M7= Peer Review; M8= Hospital Patient Management; M9= Agreed Committee & Post Graduate Education - Please complete Agreed Committee & Post Graduate Education Form HSSC: R= Out Patient; MS= Consult											
Please complete VMO Doctor's Plans, Medicare Patients forms for all routine hours claimed Certification: I certify that the information provided (including the patient's details) is a true and accurate record for the period and that no claims are made for "Rostered On-Call" hours provided at the same time at another hospital.											
Doctors Name: (Please Print Name) D						Doctors Signature:			Date: 30/9/10		
CLAIM RECEIVED BY: (Please Print Name)						Date:					
CLAIM CHECKED AND PAYMENT APPROVED											
Authorised By: (Please Print Name)						Authorised Signature:			Date:		

Source: NSW Health and Audit Office research

NSW Health has no state wide policy or guidelines for verification of VMO claims, and relies on the integrity and effectiveness of local processes.

Some hospitals rigorously verify VMO claims for payment. Staff check them against hospital and operating theatre rosters, electronic medical records and the patient administration system. We saw examples of VMO claims in which every particular – date, patient name, whether public or private, procedure carried out – had been checked and verified. We saw examples of advice to VMOs rejecting or correcting some claims for reasons such as:

- more than one consultation had been charged on the same day for the same person
- the payment claimed for aftercare is already included in payment for the initial consultation
- the patient was not in the hospital on the day claimed
- the claim had already been paid.

However, several hospitals acknowledged that they could perform only minimal checks on VMO claims for payment because of the tight deadline for submitting VMO claims to HSS, lack of resources and difficulty of accessing information against which to verify claims.

Verification is labour-intensive, with claims being checked against other hard copy records to confirm that the service claimed for was actually delivered. Electronic claims and the ability of other systems to communicate would offer opportunities to automate and speed up verification.

Some doctors submit claims for payment irregularly or late, sometimes 12 months late or longer. While hospitals can in theory accrue for these, receiving an unexpected claim for several hundred thousand dollars strains cash flow. NSW Health has advised that the VMO determination contains a deadline for submission of claims for payment, but it is unclear whether this deadline is enforceable.

The audit team had access to relevant internal audit reports during planning for the audit. While these had identified and in some cases rectified problems, we found that many still existed. We also saw differing approaches and levels of activity by different VMOs.

Exhibit 10: Internal audit findings on VMO claims verification (2010 and later)

Weak and inconsistent processes for verifying VMO claims

Hospitals reviewed employed different processes for verifying claims for payment by VMOs, with some less effective than others. There were numerous examples of inaccurate or inappropriate claims found.

Lack of adequate approval of payments

Some claims were not signed by the VMO. Checking and approval by hospital staff was not clearly separated and was sometimes ineffective.

Lateness in VMOs submitting claims

One VMO had not submitted a claim since 2009, and the hospital accrues an estimated amount monthly. The amount owed to the VMO probably exceeds \$800,000.

Failure to comply with policy

VMOs at a principal referral hospital are remunerated under fee for service arrangements despite a NSW Health Policy Directive that sessional contracts apply. This has been in place for over a decade but there is no documentation on the terms of the agreement and no history on how it was authorised. Excess costs are estimated as at least \$150,000 per annum.

Source: NSW Health and Audit Office research

Inadequate
verification of
VMO claims

Some doctors
submit claims
irregularly or late

Recommendations

We recommend that NSW Health:

- develops consistent guidelines and procedures for verifying VMO claims for payment
- ensures that there is more effective scrutiny of VMO payments to ensure that they are being made in accordance with NSW Health Policy Directives.

We recommend that NSW Health, after appropriate consultation with the Australian Medical Association, amend the model VMO contracts to impose stricter controls over the submission of VMO claims. This could include making a failure to submit claims within a certain time limit mean that the claims are discounted or ultimately need not be paid.

Problems with processing of VMO claims for payment

After verification, VMO claims for payment are entered into the VMoney system operated by HSS.

HSS has two independent centres at Parramatta and at Newcastle. These two centres have different VMoney systems, and hence development and maintenance costs are duplicated.

VMO claims for Parramatta are sent by courier in hard copy for data entry. Hospital staff within Hunter New England Local Health District enter VMO claims directly into VMoney. Manual data entry represents a significant workload and would be expected to generate errors.

VMoney calculates each VMO's fees from his or her claims based on a set of rules related to when and where VMOs work. These rules are applied by the system which sends this as payment data to NSW Health's finance system.

Some hospital staff complained about availability of management reports to assist them in verifying VMO claims for payment.

NSW Health has advised that it is developing improvements to the VMoney system. These are intended to include a web-based portal for data entry which will eliminate some manual processes and interface with other systems to facilitate verifying patient details. A pilot system is planned for the fourth quarter of 2011, and the final phase will integrate the new VMO payment system with the automated rostering system in 2014.

Exhibit 11: Risks of losses with inadequate verification of VMO claims for payment

The risk to the hospital of inadequate verification is that they may be paying for services they did not receive. As NSW Health pays VMOs over \$500 million per annum the financial impact of inadequate verification can be significant.

We attempted to estimate the risk of inadequate verification. Hospitals checking VMO claims thoroughly found and rectified errors in between ten per cent and 18 per cent of all claims processed. It is likely that this error rate would also apply in hospitals which are unable to thoroughly check VMO claims.

Many of the local health districts visited had difficulties adequately verifying VMO claims for payment. One of the benefits of the VMoney improvements should be an enhanced capability to deal with VMO overpayments. The business case noted this, but did not quantify any resultant cost savings. NSW Health maintains that it would be difficult to do so.

Source: NSW Health and Audit Office research

HSS branches
have different
VMoney
systems

Errors found in
ten to 18 per
cent of VMO
claims for
payment

Recommendations

We recommend that NSW Health expedites current improvements in VMoney and related systems to:

- eliminate manual data entry
- improve access by hospital staff to VMO payment management reports.

Inconsistencies in VMO numbers

The number of VMO accounts processed by HSS Parramatta was found to exceed the number of VMOs by around 30 per cent because some VMOs have contracts with multiple hospitals. In addition some VMO code numbers were found to be shared by several VMOs.

With so many multiple contracts for an individual VMO it is difficult to verify that a VMO has not claimed payment from different hospitals for overlapping services, such as being on call at multiple hospitals at the same time.

Recommendations

We recommend that NSW Health assign unique identifiers to VMOs to ensure that there are no overpayments for duplicated services.

Analysis of treatment and VMO billing patterns

Hospital staff observed that some VMOs claimed different payments for what appeared to be similar patient treatments. One hospital noted that some VMOs were claiming for an unusually high number of emergency caesarean sections, while others did not. VMOs are paid \$780.35 for a normal caesarean and \$1,567.60 for an emergency caesarean. Staff at that hospital were able to extract data to show that while most doctors claimed about half of their caesareans as emergencies, a few claimed that 100 per cent were emergency. It is possible that some normal caesarean sections were being billed as the higher cost emergency procedure.

Some hospitals appeared to use such analysis of data to explore apparent inconsistencies in practice, while others did not demonstrate this capability.

Exhibit 12: Anomalies in rates of surgery

The management of an area health service found that an unexpectedly high number of patients required a particular surgical procedure.

A study compared the rate of surgery in the local government area of the hospital in question with others using indirect age standardisation. This technique is used in health research for valid comparisons of rates in different populations, such as incidence rates, prevalence rates, mortality rates and health service utilisation rates.

The study revealed that while indirect age standardisation predicted that 335 procedures would have been expected at the hospital in question, 530 procedures had actually been performed. The statistical significance was such that there was only one chance in a thousand that this could have happened by coincidence. The study concluded that the rate of surgery for the particular procedure performed in the hospital's local government area was very significantly different to the rates observed in the rest of the area health service.

This anomaly had been detected and rectified before this audit commenced.

Source: NSW Health and Audit Office research

Difficult to verify
that VMOs
have not
submitted
overlapping
claims

Exhibit 13: Inconsistent priorities

Problems with priorities

The management of an area health service found that an unexpectedly high proportion of private patients awaiting a particular procedure were being given the highest clinical priority. The area's management analysed priorities given to public and private patients in public hospitals, and this revealed that one VMO had given higher clinical priority to his/her private patients than to public ones.

While 69 per cent of the VMO's public patients would have waited for a year to have surgery, only six per cent of his or her private patients would have waited that long. This inconsistency had been detected and rectified before this audit commenced.

Source: NSW Health and Audit Office research

Only a small number of hospitals we visited used analysis of rates of surgery or comparisons of clinical priorities to detect anomalies. It would be advantageous if such analysis were more widely used.

Recommendations

We recommend that NSW Health develops the use of benchmarking studies and analysis to assist local health districts to detect inconsistent VMO claims for payment or anomalies in clinical priorities allocated to patients.

Need for clinical expertise

Some hospital staff mentioned the absence of directors of medical services as a key reason for their inability to ensure that procedures conducted by VMOs were clinically appropriate. Some staff who were not doctors claimed that they lacked the requisite expertise and experience necessary for discussing clinical-related issues with doctors, whereas a director of medical services, who is a doctor trained in administration and management, is much better able to do so.

Shortage of directors of medical services

Few of the hospitals in our sample had a director of medical services. Some had been unable to fill director of medical services positions for long periods. NSW Health does not maintain records of such vacancies and was unable to quantify the shortages.

Directors of medical services can play an important role not just in verifying VMO claims for payment, but more generally in communicating with the medical staff on clinically related issues and in managing, and ensuring the efficient provision of services by, the medical workforce. To fill medical administrator vacancies, NSW Health needs to promote medical administration as an attractive career option in comparison with other medical specialities.

To provide an enhanced career structure for medical administrators, and to provide high level assistance to Chief Executives and Boards in respect of medical administration, NSW Health could consider establishing a senior level, district wide medical administrator position in local health districts which includes among its responsibilities managing the medical workforce.

Recommendations

We recommend that NSW Health builds director of medical services capacity by encouraging doctors to choose medical administration as a career path, such as by training through the Royal Australasian College of Medical Administrators.

Staff specialist availability

No systems to measure time spent by staff specialists on different activities

No hospital visited was able to provide any estimate of the proportion of time staff specialists are expected to spend on different activities. There are no systems by which the time spent on different activities by staff specialists can be measured.

Neither the staff specialists (State) Award nor the staff specialists determination give any indication of what duties staff specialists are expected to undertake or the time which they would be expected to allocate to them.

The Garling Report also referred to the difficulty of knowing in what activities staff specialists were engaged:

[S]ome staff specialists overexploit their right to treat private patients and are not sufficiently available to carry out public patient work.

The award requires each staff specialist to provide a signed monthly return showing any leave taken in the previous month. This has to be certified by the relevant hospital executive.

Both the award and determination are silent on the need to complete timesheets. According to the award, staff specialist performance agreements should include the nature of work to be performed during normal duties (clinical, teaching, administrative, research, quality improvement etc) and the amount of time that staff specialists will be released to undertake college and other professional association activities.

In addition to rights to engage in private practice as part of their employment, the award entitles full time staff specialists to engage in medical practice, paid employment or other business activities outside their employment with the approval of the employer. These activities by staff specialists are generally known as outside practice. Some hospitals have part time staff specialists, and they are required to notify the employer of any outside practice they conduct.

Involvement in outside practice if not properly supervised has the potential to conflict with staff specialist obligations to the employer. Some hospital staff interviewed claimed that at those times when a staff specialist should be on site, he or she may be unavailable, apparently due to carrying out outside practice activities. This was a particular concern with public hospitals situated next to co-located private hospitals where staff specialists are involved in outside practice.

The proposed rostering system being developed by NSW Health offers an opportunity to more clearly specify the duties of staff specialists, what they will be doing, where they should be and at what time. Better rostering of doctors would also assist local health districts to meet national health reform requirements.

Recommendations

We recommend that NSW Health uses the provisions of the staff specialist award to develop performance agreements for each staff specialist to describe their activities in detail.

Lack of clarity of VMO private practice entitlements

Staff at many hospitals emphasised the importance of private patient income to their budgets. NSW Health's private patient fee income in 2009–10 was \$359 million, which represents 16 per cent of total non-government revenue.

Despite the importance of income from private patients to the public health system, the VMO determinations and model contracts provide no guidance on arrangements for VMO private practice in public hospitals, in contrast to the staff specialists determination. VMO determinations only mention private patients in the context of professional indemnity insurance, and VMO contracts do not include the word private.

VMO contracts in other jurisdictions, e.g. the ACT, give some details on treatment of private patients in the public health system and emphasise its importance:

[T]he Territory may make available for use of the VMO facilities for the care of his or her private patients, and encourages the VMO to participate in Territory programs aimed at increasing the use of private insurance by patients being admitted to Territory facilities.

More clarity in contracts between NSW Health and its VMOs would improve governance. This could include details of proposed private practice commitments, its location, working times, duration of work, any conflict with arrangements for public patients, charges for use of any public hospital facilities, reporting of private patient activities (if appropriate) etc.

Some staff specialists may not be available when needed

Internal audit
revealed
significant
problems with the
TESL approval

Poor
record-keeping
of TESL
entitlements or
actual leave taken

Recommendations

We recommend that NSW Health provides a more explicit basis for VMO entitlements to treat private patients in public hospitals.

Burdensome training, education and study leave processes

Staff specialists also are provided with a training, education and study leave allowance (TESL) under their determination. Staff specialists are entitled to claim up to \$29,400 in TESL expenses and 25 calendar days of leave per year with pro rata entitlements for those working part time. Depending upon their private practice arrangements, some are directly paid by NSW Health and others draw their TESL allowance from trust funds derived from private practice earnings.

NSW Health staff advised that not all staff specialists take all of their TESL entitlement. While NSW Health was unable to provide any estimate of actual leave taken or the cost of TESL, total expenditure may be as much as \$60 million per annum.

Many hospitals visited complained about the amount of paperwork in administering this leave, including verifying appropriateness of courses and ensuring that individuals' TESL entitlements are not exceeded.

Internal audit reports by two area health services revealed significant problems with the TESL approval processes.

Exhibit 14: Internal Audit reports on training, education and study leave

Inconsistent TESL administration processes

Hospitals reviewed employed different processes relating to the processing and management of TESL.

Inconsistent interpretation of TESL policy

Differences in the interpretation of the policy were noted. For instance while some hospitals would not allow staff specialists to attend conferences outside their speciality, others did not reject a TESL application on this basis.

Lack of records or incomplete records

The records of TESL days and funding balances maintained by the hospitals vary, both in terms of actual records kept and the timeliness of the information. One hospital did not maintain any central records for the TESL funding taken by staff specialists, but relied on a senior member of staff maintaining a mental record.

Risk of leave taken exceeding entitlements

With the manual systems in place, errors in spreadsheet formulas and the lack of accurate and timely records held at these hospitals, there is an opportunity for staff specialists to obtain greater TESL entitlements. One area health service found that some staff specialists had negative TESL leave balances and/or funding entitlements, and estimated the potential over accrual by its staff specialists at 677 TESL days and \$740,000.

Inadequate approval of TESL applications

Some applications were found to be incomplete. In some the actual application was missing a conflict of interest declaration or appropriate sign off, and in others the application did not have an appropriate quote for travel costs. In all instances these applications were approved. Some TESL leave applications were not signed off by the appropriately delegated officer, and some applicants had approved their own applications.

Source: NSW Health Internal Audit reports

The TESL application and approval process utilised in the Illawarra Shoalhaven Local Health District was found in an internal audit to have strong controls compared to other hospitals. It was recommended as a significant improvement by senior management interviewed in other local health districts.

Other jurisdictions use different approaches to training, education and study leave. In Queensland, for example, staff specialists receive their entitlements in cash and self-manage their study requirements.

Recommendations

We recommend that NSW Health seeks improvements to reduce administration costs of staff specialists' TESL.

Some observations on Internal Audit

Internal Audit reports for the local health districts included in the sample for this audit had all identified deficiencies in processes for verifying VMO claims for payment. All had given examples of possible overpayments. Internal Audit reports provided by other local health districts also noted deficiencies leading to risk of overpayment of VMOs.

The document *Future Arrangements for Governance of NSW Health* does not mention the role of internal audit, nor does it give any indication of how NSW Health's Internal Audit function, formerly meeting the needs of eight area health services, will be able to provide an adequate level of service to the 15 local health districts.

The quality of internal audit reports made available during this audit has provided a reminder of the importance of this function to good governance. An internal audit framework for VMOs, developed in 2009 by NSW Health's Internal Audit Working Party, has given support and direction to local internal audit teams. The framework also offers an opportunity for some comparisons and benchmarking between practices and findings of internal audit teams.

The success of internal audit in addressing sensitive issues such as overcharging will depend on their ability to build strong relationships with local health district staff with the knowledge to identify potential problems that internal audit teams can then investigate. The benchmarking and analysis skills that some hospital staff used to identify anomalies could also be of significant assistance to local internal audit teams.

It is therefore most important that NSW Health continues to support local health district internal audit teams throughout the current change processes. The operation of Audit and Risk Committees and internal audit in local health districts will be of continuing interest to the Audit Office.