How Does Anaesthetic billing work?

The insurance and health care industry can be confusing, even for those who work within it. The information presented here will hopefully make things a little clearer, and includes examples to illustrate the broad stroke principles. While every effort has been made to be as accurate as possible, the examples and numbers below should be considered to be approximations and are not exact. If you require clarity about your insurance cover, please call your insurance company. Here is a link for insurance company contact details if you have specific questions.

Anaesthetists are not employed by the hospital, the insurance company, or the surgeon. The anaesthetist's fee is **entirely separate** to, and independent of, the surgeon and the hospital or day surgery facility. It important to appreciate that health funds DO NOT pay or employ doctors for medical services. Their role is to reimburse their customers for medical expenses. As such, insurance companies do not determine a doctor's fee, and doctors have no control, or ability to influence, what your insurer chooses to reimburse you.

How is your Anaesthetic Fee Determined?

The anaesthetic fee is generated via item numbers contained within the Medical Benefits Schedule (MBS). There are several components to an anaesthetic fee.

The pre-anaesthetic consultation, the time it took to review your case notes and preoperative investigations, the type and complexity of the surgical procedure, the time taken for the Anaesthetic care, age, medical complexity, as well as any specific procedures such as epidurals, nerve blocks, or invasive monitoring, all contribute to the fee. Each component above will have an item number assigned by the MBS. Each Item number will have a unit value. The total number of units is used to derive your fee.

On face value this may sound daunting. Thus, to simplify, let's look at a typical general surgical procedure and break down the item numbers. Assume you are having your gallbladder out as a planned operation (elective procedure – not emergency), you are fit and well, and the Anaesthetic care takes 90 minutes. The breakdown would be as follows:

- *Pre-operative Consultation of less than 15 minutes*
  - *MBS item number 17610*
  - *Unit Value 2*
- *Laparoscopic Cholecystectomy*
  - *MBS item number 20706*
  - *Unit Value 7*
- *Time 90 minutes*
  - *MBS item number 23065*
  - *Unit value 6*

The total unit value for this procedure is 15 units (2+7+6). This is multiplied by the monetary value assigned per unit to give the total fee. The current AMA schedule is

100 dollars per unit of anaesthesia - as such the fee for this procedure might be up to 15 units x 100 dollars per unit = $1500.

This example is based on a fit and well patient but there are many variables that may add additional units to the total fee. These include, but are not limited to, whether your procedure is an “emergency”, whether you, as a patient, are medically complex and require additional pre-anaesthetic review or additional intra-operative monitoring, or whether more components/procedures need to be added to the anaesthetic to assist in your safety and comfort post-procedure. To help understand how these modifiers affect an account let’s relook at the above example, but assume you were having the procedure as an emergency at 10 pm on a Saturday, and that you were very sick, medically complex with a history of extensive heart disease, and required additional intra-operative monitoring to keep you safe. The fee then might look a little like this*:*

- *Pre-operative consultation 25 mins (remember you are sicker, and it takes your anaesthetist longer to go through your current health)*
  - *MBS item number 17615*
  - *Unit value 4*
- *Laparoscopic Cholecystectomy*
  - *MBS item number 20706*
  - *Unit value 7*
- *Time 90 minutes*
  - *MBS item number 23065*
  - *Unit value 6*
- *Invasive Arterial Monitoring*
  - *MBS Item number 22012 + 22025*
  - *Unit value 7*
- *Emergency Modifier +50% as “out of hours”*
  - *25025*
  - *Unit value 6.5*

The total unit value for this procedure is now 30.5 units and the fee for this procedure would be 30.5 units x 100 dollars per unit = $3,050.

How does the Health Fund Rebate work?

Each health fund has its own rebate schedule and pays a different amount per unit.

By way of example, the AMA (Australian Medical Association) schedule is approximately $100 per unit. Typically, most insurance company schedules are about one third of this; in the region of $36 per unit (this includes the Medicare rebate, which is approximately $16.85 per unit). Thus, in broad stokes, the insurance company is contributing approximately $19.15 per unit.

This disparity between the AMA schedule and insurance company schedules is one of the reasons you may have a shortfall payment.

Let’s take a second look at our fit and well healthy patient having their gallbladder removed (as above). We calculated the total unit value for this procedure to be 15

units, based on item numbers in the MBS. The current AMA scheduled fee for this procedure is $1500. Were we to take the example of a non-specific health fund that pays 36 dollars per unit, their level of rebate would be in the region $540 dollars for this same procedure**.**

As can be seen, there is a significant difference between the two payments, and this is what may generate a shortfall payment.

Health funds and benefit reduction

Unfortunately, the health fund industry can be even more complex, and some insurance companies operate on a "benefit reduction" policy. In essence, this means that health funds significantly reduce their payout if a doctor is not 'contracted in' (i.e., the doctor agrees to be a 'preferred provider' and to be paid what the insurance company stipulates). If the doctor's fee exceeds (by any amount at all) the insurance company's unit price, then the fund reduces the rebate paid on your behalf. One large insurer in WA reduces its rebate down to the Medicare rebate (approx. $16.85/unit as per the example above) plus 25% (i.e. to a total of approximately $21.85 a unit) if a doctor is not 'contracted in'. This can result in a very significant shortfall as in this setting the fund is paying $5 a unit.

We suggest asking your individual health fund upfront if they operate a "benefit reduction" policy so they may clarify the level of rebate they may expect from their health fund after the application of anaesthetic fees.

In Summary:

- Your shortfall is the difference between what your fund and Medicare cover, and the total fee for the anaesthesia services. The shortfall will be your personal responsibility to pay. For administrative simplicity, this is usually required in advance.
- All anaesthetists are individual practitioners, and their fees will vary. By law, they are not allowed to set a specific unit fee for all anaesthetists.
- Where possible we will try to provide you with an estimate of cost a week prior to your procedure. This is sent via a secure link by text message or email. Please note that sometimes, for reasons beyond our control, this may be less than a week.
- The ASA has provided an information sheet with further information on fees, rebates and indexation.
- Should you have specific questions about your cover we would encourage you to contact your insurance company. Insurance company contact details can be found at this link.