VOLUNTARY CODE OF PRACTICE FOR BILLING PRIVATE PATIENTS

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Introduction

The Association of Anaesthetists of Great Britain & Ireland (AAGBI) has produced this Voluntary Code of Practice for Billing Private Patients in response to requests from members and in order to guide members in matters relating to invoicing patients for private medical services. The private health market is experiencing change, and there is pressure for anaesthetists' fees to be paid directly by third parties as part of a treatment "package" or network. The AAGBI believes it important that the direct professional and contractual relationship between consultant anaesthetist and private patient be maintained. The guidance provided in this document underlines this relationship and gives advice on how to invoice patients. The idea behind this document is not to provide a mandatory method for managing financial issues in private practice but to offer a voluntary code of practice to which members can subscribe if they wish. Those who do may choose to indicate their compliance with this code in their invoices.

The AAGBI would welcome comments on this document from members, patients and PMIs.

Will Harrop-Griffiths
Honorary Secretary, for the Independent Practice Committee of the AAGBI

1.0 Summary of recommendations

1.1 Consultants set the fees that they charge their patients. Private Medical Insurers (PMIs) set benefit levels for their customers. There is no necessary correlation between fees and benefits.

1.2 Once a patient has agreed to the fee to be charged by the consultant for a procedure, there exists a contract under which the patient becomes liable for the payment of the fee, regardless of whether or not the patient holds private medical insurance.

1.3 Consultants should charge transparent and reasonable fees, and should make every effort to inform their patients of the fees before surgery.

1.4 Insured patients should be encouraged to check the benefit levels provided by their particular policy with their PMIs before undergoing surgery.

1.5 The fee charged should ideally include the totality of the care involved in the planned procedure. Any additional fees should be disclosed to the patient before surgery.

1.6 Consultants may send invoices to the patients, their PMIs or both. The AAGBI recommends that consultants always send the invoice to the patient. A copy of the invoice may also be sent to insured patients' PMIs.

2.0 General comments

2.1 When a consultant anaesthetist (henceforth "consultant") offers medical care to a private patient in return for a disclosed fee and the patient agrees to this arrangement, a contract is created in which the patient is wholly responsible for the payment of the consultant's fee.

2.2 This contract is not affected by the fact that the patient is a subscriber to a PMI; the patient remains ultimately responsible for payment of the fee but the PMI may pay some or all of the fee to the consultant on behalf of the patient.

2.3 Consultants set the level of the fees that they charge; PMIs set the benefit limits for their customers. The benefits provided by PMIs to their customers allow the payment of consultants' fees wholly or in part. There is thus no necessary correlation between the fees charged by consultants and the benefits paid by PMIs.

2.4 There exists no legally enforceable contract between a consultant and a PMI except where both parties enter willingly into such a contract.

2.5 Private patients will remain responsible for payment of a consultant's fee under the contract between them unless the consultant agrees to accept that the responsibility for payment should be confined to the PMI or other third party.

3.0 Before treatment

3.1 Whenever possible, the consultant should inform the patient before treatment of the likely fee[1] or explain how it will be determined unless he is prepared to limit his fee to whatever that patient's benefit maxima may happen to be[2]. Where, as often happens, patients take the decision to undergo an operation before they have spoken to their anaesthetist, they should be advised to contact the consultant anaesthetist if they wish to be told more about the fee that will be charged.

3.2 The scope of the fee quoted by the consultant should be explained. It may for example be a totalled fee for all the planned elements of the expected treatment process, such as:

3.2.1 Routine pre-operative evaluation whether performed shortly before surgery or some time in advance;

3.2.2 Intra-operative care, including payments to assistants or consultant colleagues for services provided during the treatment;

3.2.3 All drugs and equipment used in connection with the procedure;

3.2.4 Invasive monitoring lines used before, during or after surgery;

3.2.5 The performance of peripheral or neuraxial regional anaesthetic or analgesic techniques supplementary to or in place of general anaesthesia; and

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1 A sample letter is provided in Appendix 1

2 If the consultant is prepared to accept whatever benefit the PMI offers for the procedure, he need not warn the patient of his fee. If he does not warn the patient of the fee, he should not demand that the patient pay any shortfall if the PMI benefit is less than the fee charged.

3.2.6 Postoperative care, to include HDU and ICU care, and the management of continuous neuraxial of peripheral analgesic techniques.

3.3 If the fee quoted does not cover the totality of planned care, the consultant should tell the patient and clearly describe the additional fees that may be charged.

3.4 The patient should be warned that if the procedure and care differs from that planned, the fee may also vary, but that this variation will be fixed by the same means[3]. If any specific variations are envisaged these should be described at least in outline and the fee scales explained.

3.5 The consultant may choose to provide a separate estimate of HDU or ICU fees. This is advisable where it is less likely that these costs may be incurred.

3.6 The consultant should recommend that all patients check the benefit levels that are available for the treatment under the policy held with the PMI.

3.7 The patient should be told that he is ultimately responsible for the payment of the fee or the payment of any shortfall.

3.8 The consultant may wish to ask the patient to sign a financial agreement before the treatment in which the patient guarantees that the consultant's fee will be paid.

3.9 If the consultant chooses not to be paid directly by the PMI, the patient should be told as long before the planned treatment as possible.

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3 If the fee for the planned procedure is, for instance, 125% of the benefit maximum provided by the patient's PMI, then the fee for the procedure actually performed would be expected to be approximately 125% of the benefit maximum offered by the PMI for the actual procedure performed.

3.10 The consultant should tell the patient if he knows that he is not recognised for benefits by the patient's PMI.

3.11 The consultant should keep a record of the fee quoted to the patient.

3.12 It is acceptable for a consultant to request payment of fees in advance of treatment under certain circumstances.

3.13 Sometimes fees are in fact negotiated by a third party on behalf of the doctor. The fee set by the consultant anaesthetist may be agreed with the patient by the surgeon or by the surgeon's secretary or other agent. Sometimes it will be by a hospital administrator. Consultant anaesthetists must ensure that their agents have a clear, complete and up-to-date list of their charges and that they make a record of precisely what has been agreed.

3.14 Sometimes, particularly in emergencies or where there are linguistic problems, the patient's agreement will be given by an accompanying relative or other agent acting on their behalf. In all these circumstances it is vital to ensure that the representative has the authority of the principal they represent. Parents and spouses have ostensible authority to negotiate on behalf of their children and partners; in all other cases the doctor will be wise to ensure that there is a binding agreement with someone identifiable.

3.15 If separate charges are to be made by the consultant in respect of anaesthetic agents, other drugs or equipment, he should ensure that the patient appreciates this.

4.0 During treatment

4.1 If the consultant surgeon and anaesthetist plan to use a coding system, e.g. CCSD codes, when billing the patient, they should agree the code or codes relating to the procedure or procedures performed, and should ensure that members of the operating theatre staff are informed of these codes.

4.2 In choosing codes, the consultants should agree upon the code or codes that best describe the procedure or procedures performed, bearing in mind that some codes are specifically constructed so as to include the performance of more than one procedure. Consultants should not break up the elements of a single surgical or anaesthetic procedure into its constituent parts in order to maximise the benefit provided to the patient by his PMI.

5.0 After treatment

5.1 Accounts[4] should be sent to the patient, the patient's PMI or to both[5].

5.1.1 If the consultant agrees to set his fee within the PMI's benefit maxima, he can send an account only to the PMI if he so wishes. Alternatively, he can send an account to the patient and a copy to the PMI (or vice versa), making clear that he has done so.

5.1.2 If the consultant's fee is likely to be in excess of the PMI's benefit, he would be wise to send an account to the patient and, if he so wishes, a copy to the PMI (or vice versa). He should make clear to the patient whether he wishes the patient to forward the account to the PMI or whether he has sent a copy to the PMI.

5.1.3 If the patient does not hold private medical insurance or if the consultant does not wish to be paid directly by the PMI, the consultant should send an account to the patient and should ask to be paid directly by the patient. Under these circumstances, the consultant should offer to provide the patient with a receipt so that the patient can then claim benefits from his PMI if he has one.

5.1.4 If a consultant uses a billing service, he should consider himself responsible for the fees charged in the bills sent on his behalf and for the way in which the fees are collected.

5.2 Only one invoice (and copy if appropriate) should be sent for each discrete treatment episode.

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4 A sample invoice is provided in Appendix 2.

5 The AAGBI recommends that consultants always send the invoice to the patient. A copy of the invoice may also be sent to insured patients' PMIs.

5.6 Consultants are not obliged to put a CCSD code on their accounts, unless they have entered into an agreement with the patient or his PMI to do so, but may assist the patient if codes are included in the account.

5.7 The consultant may include a descriptive narrative of the procedures performed in the account in order to assist correct coding by the PMI but should not do so in order to maximise benefit payment.

5.8 The consultant should not normally allocate portions of his fee to particular codes or narratives. The fee should represent the whole amount payable for the entire treatment episode.

5.9 The consultant may, if it has been specified as a term of the contract, set a time limit for payment and should detail any penalties or additional payments that will be incurred by late payment.

6.0 Emergencies

6.1 Emergency treatment is more complex and carries more risk than elective treatment. It also frequently takes longer than elective treatment and is often more disruptive of the doctor's life, being conducted outside routine working hours. Thus the doctor will frequently feel it is appropriate to charge a higher fee.

6.2 Some procedures specified by CCSD codes are always performed as emergencies and the PMIs' benefit maxima associated with those procedures may take this into account.

6.3 Other procedures specified by CCSD codes are commonly performed electively so that benefit maxima are less likely to cover the fees consultants charge for acting in an emergency. Where the consultant charges a higher fee because of some factor particular to the case, such as the fact that it has been performed as an emergency, then this should be made clear to assist the patient in explaining the situation to the PMI.

6.4 The consultant should make every effort to warn the patient of his fee in advance of surgery but this may not be possible in an emergency, in which case the patient, or whoever has contracted on their behalf, will have incurred a liability to meet a fee that is reasonable in the circumstances.

6.5 The fee that will be reasonable in the circumstances will take into account the issues mentioned in 6.1 above. If the patient cannot be warned of the fee in advance of surgery, the fee that will be reasonable in the circumstances will be based on the appropriate fee for the equivalent elective procedure, with an additional proportion added to the extent that the factors described in paragraph 6.1 arise.

Appendix 1

PRO FORMA LETTER FROM SURGEON TO PATIENT IN ADVANCE OF SURGERY

<Date of letter>

<Patient name>
<Address>

Dear <patient name>,

I am writing to confirm that your admission has been arranged to the <name of hospital> on <day, date> at <time> for surgery that afternoon. It is essential you have nothing to eat after <time> on the morning of admission. You may drink clear fluids until <time> and the ward staff will then advise on fluid intake.

Mr <surgeon's name>'s fee for <procedure description and CCSD code(s)> will be approximately £<surgeon fee>. In addition, the approximate fee for the anaesthetist, Dr <anaesthetist name>, will be £<anaesthetist fee>.

If you wish to make a claim from your medical insurance company, please obtain a claim form, complete the subscriber's section and give it to the admissions officer on admission.

You are advised to check with your insurance company the level of your cover and the exact allowances to which you are entitled under the terms and conditions of your particular policy. Many insurance companies do settle the surgeon's and anaesthetist's fees in full but in some cases a shortfall occurs. Payment of any shortfall is your responsibility. If in doubt, I suggest that you send a copy of this letter to your insurance company, asking them to send you an agreement in writing as to of the above fees they will cover.

Yours sincerely,

<Name of secretary>
Secretary to <Name of surgeon>

Appendix 2

EXAMPLE OF AN INVOICE

Dr H Featherstone FRCA

Consultant Anaesthetist

21 Portland Place
London W1B 1PY

Tel: 020 7631 1650

PMI Ref: HF 04786
Provider Ref: 152320

To Mr A Patient
Address

For Professional Services

At the John Snow Hospital on 29/2/2008

Procedure: *Ectomy and refashioning*
CCSD Code: X2365

£325.00

Terms: payment within 30 days

Either: If you have insurance please forward this to your insurers

Or: A copy of this invoice has been forwarded to your insurers

With compliments

THE ASSOCIATION OF ANAESTHETISTS

of Great Britain & Ireland

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