



**Office of the
Health Complaints Commissioner
2007**

700-0601005 – 700-0601003 Case report - Investigation into the complaint against two private hospitals and a surgeon

s. 25 (1)(c) a health service provider acted unreasonably in the manner of providing a service – Report issued November 2006

A complaint was lodged under the *Health Complaints Act 1995* against two private hospital and a surgeon. The complaint against the surgeon was not substantiated. The complainant was admitted to the first private hospital for the treatment for injuries received following a cycling accident in October 2005, then transferred to the second private hospital that same day as the surgeon rarely operated at the first hospital. The complaint related primarily to administrative and billing matters at both hospitals, the delayed treatment received at the first hospital, and the circumstances relating to his transfer to the second hospital for treatment for his injuries.

The complainant had travel insurance (AIG) which included full medical cover and also private health international cover (BUPA International) and had these documents on him. Neither private hospital made a reasonable attempt to contact the complainant's insurer. In part this was due to phone and facsimile facilities with international coverage not being readily available after normal business hours and a policy of requiring an up-front payment prior to treatment.

With regard to the billing system at the second hospital the complainant objected to being presented with an invoice charging in excess of the estimated period of admission. The complainant stated that the orthopaedic surgeon estimated that he would require 2 days hospitalization and surgery on the wrist to fix the distal radial fracture, but the accounts person in administration approached him with an invoice that cited 4 nights hospitalization and 2 operations and was in excess of \$4,000 with the requirement that it be paid immediately or the surgery would not proceed. He contested the invoice amount, which was reduced to \$2,636.

The explanation provided by the hospital was that the initial invoice was for an estimation of the costs he would incur whilst an inpatient including two days accommodation, a private room supplement and a theatre fee. The initial estimation for the theatre fee was at Band 5, which was subsequently reduced to Band 1 following his surgery and confirmation of the procedure performed by the surgeon. The difference between the Band 5 and Band 1 theatre fees is \$710. The hospital stated that they take seriously their obligation of informed financial consent and that until a procedure has occurred the final invoice amount is not known. To assist in this process "quotes" or interim invoices are provided. Upon discharge, the final account adjustment resulted in the complainant being refunded \$710. The complainant maintained he had to insist on the refund at the date of his discharge rather than wait.

The complainant believed that the hospital ought to have contacted the insurer to arrange for these accounts to be met and to have assisted by forwarding the doctor's report as to his injuries and his treatment. In any insurance cover the insurer needs to be satisfied that the cover is activated and that they are liable to indemnify the insured. In this case BUPA International

needed a medical practitioner to provide a written report of the injuries requiring treatment before they would confirm their liability to meet the cost arising under the policy.

The hospital stated that at the time of the complainant's admission there had been no confirmation of acceptance of his hospital charges by his Health/Travel Insurance Agency, hence the provision of an interim account. They stated that it is their normal practice for Health Insurance Acceptance of Liability to be gained prior to the admission of patients, or acceptance of responsibility for the account by the patient for either the full cost of treatment or any gap costs prior to admission. For all "nil insured" patients, i.e. those for whom at the time of admission the insurer has not accepted responsibility for the account, payment for the estimated costs is required prior to admission.

The conclusion was that if the administrative system over the weekend and after hours was not able to facilitate such contact then the better approach would be for the hospital to adopt the practice of most hotels who impress the guest's credit card at reception and revise the amount charged when the guest is leaving. This would have allowed the complainant to be admitted, the medical report to be sent to the insurer and the charges accepted by the insurer prior to the patient being discharged. If such a practice had been in place, the initial credit card impression would have been destroyed and the complainant would not have had to meet the charges personally.

A recommendation was made that both hospitals consider adopting this practice. It was suggested to the administrators of both private hospitals that if a person seeking urgent admission presents with travel insurance documentation and the hospital is unable to facilitate contact with the insurer to ascertain acceptance of the charges, then the person's credit card be impressed pending this contact being made. If the contact is not made and the claim accepted prior to discharge then the final account can be debited against the card.