



Australian Government

Medicare Australia

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The Secretary  
Senate Community Affairs Committee  
PO Box 6100  
Parliament House  
CANBERRA ACT 2600

Dear Mr Humphery,

**Medicare Australia's submission to the Senate Community Affairs inquiry into the Compliance Audits on Medicare Benefits**

Thank you for your letter dated 25 March 2009 inviting Medicare Australia to provide a written submission addressing the issues which may be of relevance to the Committee in regards to the proposed amendments to the Health Insurance Act 1973.

Medicare Australia, within the Human Services Portfolio under the responsibility of the Minister for Human Services, Senator the Hon Joe Ludwig, is a prescribed agency under the *Financial Management and Accountability Act 1997* and a statutory agency under the *Public Service Act 1999*. Medicare Australia has responsibility for the delivery of the Medicare program on behalf of the Australian Government.

Please find attached the following information for the Committee's perusal:

*Attachment A- Medicare Australia's written submission*

*Attachment B- Medicare Australia's National Compliance Program*

In addition to the written submission, I would like to advise of Medicare Australia's willingness to appear before the Committee to answer any questions the Committee may have.

Once again, I thank you for inviting Medicare Australia to make a written submission to the Committee. I trust our submission will be of assistance.

Yours sincerely,

Philippa Godwin  
A/g Chief Executive Officer

24 April 2009



**Australian Government**

**Medicare Australia**

Submission  
to the Community Affairs Committee  
on

# Compliance Audits on Medicare Benefits

April 2009

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## Executive summary

1. Medicare Australia, within the Human Services Portfolio under the responsibility of the Minister for Human Services, Senator the Hon Joe Ludwig, is a prescribed agency under the *Financial Management and Accountability Act 1997* and a statutory agency under the *Public Service Act 1999*.
2. Medicare Australia has responsibility for the delivery of the Medicare program. A key component of that delivery is to ensure that the right person receives the right payment at the right time—no more, no less.
3. On a day-to-day basis, Medicare Australia ensures that payments for services set out in the Medicare Benefits Schedule (MBS) are made to both providers and the public in accordance with the relevant legislation. There are currently 81,224 providers generating nearly 280 million MBS services on an annual basis.
4. In 2007–08, expenditure on the Medicare program was over \$13 billion. In the first six months of the 2008–09 financial year MBS expenditure was \$7.14 billion.<sup>1</sup>
5. Proportionally MBS expenditure equates to roughly \$160,000 per provider per annum, and if Allied Health providers and expenditure is excluded, it equates to roughly \$200,000 per provider per annum.
6. Like many other administrative payment systems, the Medicare program is a 'self assessment' system. That is, it relies on providers to correctly determine and claim or bill for the MBS item which corresponds to the service they have provided.<sup>2</sup>
7. As a consequence, Medicare Australia undertakes a broad based compliance program to manage the integrity of payments which involves a combination of help and support services together with audit and review activity.
8. The balance of compliance activity is heavily weighted towards helping and supporting providers to correctly claim rather than on enforcement activity. For example, less than 4 per cent of providers are subject to audit each year whereas more than 25 per cent of providers would be provided with some form of education or information to assist correct claiming.
9. Medicare Australia undertakes a range of data analysis and assessment processes which can lead to risk based compliance activities such as increased education and support and/or Medicare compliance audits of specified concerns.
10. Medicare Australia has an extensive range of help and support services for providers which includes: - a provider enquiry line; learning guides and e-learning services; reference guides; targeted information and face to face education.

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<sup>1</sup> MBS statistics website shows from 1 July to 31 December 2008 MBS expenditure was \$7,139,486,909.

<sup>2</sup> A provider generates a Medicare payment either by claiming the item through Medicare Australia (i.e. bulk bill) or by billing Medicare by issuing a patient receipt that can then be used by a patient to claim a rebate at a Medicare office. In either case the provider indicates the service that has been provided, and consequently the benefit that is payable. For clarity this document occasionally uses the terms claim, claims and claiming in the broad sense, covering all methods by which a provider generates a payment under Medicare.

11. Medicare Australia's audit and review activity involves a combination of upfront controls and a post-payment audit and review program in order to mitigate against claiming behaviour that may impinge on the effective use of the health care budget.
12. The upfront controls involve an initial assessment of claims to ensure that clearly wrong payments are not made. The post payment audit and review program focuses on verifying compliance in higher risk claims.
13. Medicare Australia publishes an annual Compliance Program which sets out the identified compliance risks and the areas of focus of compliance activity.
14. As the population ages and health spending increases, it becomes increasingly important to ensure the validity of taxpayer funded expenditure.
15. The post-payment activity involves two levels of review, a program of random payment accuracy reviews and a risk based audit program.
16. A Medicare compliance audit is a check conducted by Medicare Australia to ensure that a Medicare benefit amount has been paid correctly. This includes checking that the provider was eligible to provide the service, that the service was provided, and that the service met the requirements of the MBS item that was claimed.
17. Currently, except in very limited circumstances or in matters involving a criminal act, there is no requirement for a provider to substantiate their Medicare claiming and billing, nor is there a penalty system to deter non-compliance.
18. The proposed legislative changes to the *Health Insurance Act 1973* will address these issues by requiring providers to substantiate their claims when requested to do so and provide for the imposition of financial penalties on providers in certain circumstances.
19. The proposed changes will enable Medicare Australia to provide greater levels of assurance that Medicare claims are being correctly made.
20. The proposed changes will more closely align the information gathering powers available to Medicare Australia with those of other key Commonwealth administrative agencies, and provide a more modern and efficient compliance and penalty framework to deal with incorrect claims.
21. There are three distinct areas of incorrect claim risks to the Medicare program. These are:
  - **fraud** – where an individual seeks to obtain a MBS benefit by intentionally falsifying facts and/or documents;
  - **incorrect claims** – where the facts provided in the claim do not match the reality of what occurred (either through misunderstanding, error, innocent mistake, carelessness or recklessness); and
  - **inappropriate practice** – where a Medicare claim is made for a health service that would not be acceptable to a general body of a provider's peers as clinically necessary or suitable for the treatment of the patient.
22. Whilst the *Health Insurance Act 1973* and *Medicare Australia Act 1973* provide for schemes and powers to manage fraud and inappropriate practice, there is no comparable legislative mechanism to deal with incorrect claiming.

23. In the absence of a requirement for providers to give information to substantiate Medicare payments Medicare Australia's general compliance activities primarily rely on a provider volunteering information to demonstrate that they have claimed for Medicare payments correctly.
24. Medicare Australia's experience has been that in a range of cases, including those involving significant compliance risks, providers refuse to make the necessary substantiating information available. On average this occurs in 20% of compliance activities. As a consequence Medicare Australia cannot confirm the accuracy of Medicare claims or ensure that Medicare payments were made in accordance with legislative requirements.
25. As a result Medicare Australia's ability to detect and manage incorrect claims is limited and contrasts with the powers afforded to other Government departments and agencies (for example Centrelink and the Australia Taxation Office), which are able to require substantiating documentation for verification purposes and to protect the public revenue.
26. The proposed legislation seeks to address this serious shortcoming. The legislation will enable the Medicare Australia CEO to serve a notice on a provider, or another person, requiring them to produce any document or excerpt that is relevant to substantiating the accuracy of a Medicare payment.
27. Requiring providers to verify their claims for Medicare-eligible services, especially when there are specific concerns about the claims, is a reasonable and responsible way of protecting the public revenue.
28. The proposed changes are limited to substantiating Medicare claims and do not provide a general power to Medicare Australia to seek or obtain broader information.
29. Similarly, existing legislation makes no provision for the application of penalties where the provider's MBS billing or claiming is incorrect, except in the case of the commission of a criminal act.
30. Medicare Australia's experience is that there is not a significant level of criminal activity by providers but that incorrect claims through misunderstanding, error, innocent mistake, carelessness or recklessness are more common.
31. The consequence of not having a penalty system for 'non-criminal' acts resulting in incorrect claims is that providers can repeatedly make incorrect claims with little or no adverse outcome, other than possibly having to repay monies that are specifically identified as being incorrectly received.
32. The proposed legislation will introduce a financial penalty of 20% which will apply to any debts for incorrect claims over \$2500 (or a higher amount prescribed in legislation). This threshold ensures that providers who make one-off minor inadvertent errors are not penalised.
33. Medicare Australia believes that imposing financial sanctions on providers in certain circumstances will be an effective means to encourage compliance and ensure the integrity of the Medicare program.
34. The proposed legislation will have wide ranging benefits for the administration of the Medicare program. Specifically the proposed legislation will:
  - benefit Australian taxpayers by further protecting the integrity of the Medicare program, and reducing financial leakage that may divert health funding from the management of legitimate health issues;

- benefit providers by clarifying their rights and obligations when their claims are audited; and
  - benefit the Australian Government by enabling Medicare Australia to provide assurance that health expenditure is correct, and that Medicare claims can be adequately monitored.
35. Medicare Australia believes the proposed legislative changes include appropriate checks and balances which will significantly improve the integrity of the Medicare program while at the same time providing appropriate protections for individual patients and providers. For instance:
- Medicare Australia will be able to require a person to produce documents, including documents containing health information — however, this power can only be used if the document is necessary to substantiate a Medicare payment for which there is a reasonable concern. The requirement to produce information only applies to those parts of documents or records, such as those containing a patient's clinical information, that confirm factual matters relevant to substantiating a payment.
  - Providers will be subject to penalties—but the penalties have been limited to situations where incorrect claiming is over a \$2500 threshold. Furthermore if a provider has received an incorrect amount and acknowledges this:
    - prior to any compliance contact, no penalty will be imposed;
    - prior to a formal written notice being issued, the penalty will be reduced by 50 per cent; or
    - prior to completion of the audit, the penalty will be reduced by 25 per cent.
  - Furthermore Medicare Australia will not be able to:
    - access complete patient files;
    - request documents for MBS claims where there is no reasonable concern that the payment exceeds the amount that should have been paid;
    - view or use any information (including patient histories or personal information) that is not relevant to the claim being audited;
    - self determine which documents it will access (the decision is made by the person being audited or the person on whom the notice is served);
    - use the information collected for any purpose other than confirming the Medicare payment; or
    - store or pass on the information to any other person or agency (unless authorised under the Privacy Act 1988 (i.e. when there is threat to life).
36. To support voluntary compliance the community needs to have confidence that Government programs are effective and not being exploited. Medicare Australia is therefore very conscious of the need to adequately protect both individual privacy and taxpayer's funds.
37. All information collected by Medicare Australia for the purpose of its compliance functions is protected by the provisions of the *Privacy Act 1988*. In addition to this, any disclosure of information collected by Medicare Australia is subject to the secrecy provisions of the *Health Insurance Act 1973* which prohibits Medicare Australia staff from releasing patient and other information to third parties except in the performance of their statutory duties, and provides criminal penalties for any breach of these obligations.

38. Medicare Australia supports the proposed legislation in that:
- it will address existing deficiencies in Medicare Australia's ability to identify and deter incorrect Medicare claims by providers;
  - it clarifies the rights and obligations of both Medicare Australia and providers in relation to the substantiation of Medicare claims; and
  - it provides a clear administrative penalty system that will be an effective deterrent, efficient in application, and unlikely to strain the resources of providers.
39. Medicare Australia considers the proposed legislation to be essential to improve its ability to manage the integrity of the Medicare program.



# 1. Introduction

## 1.1 *The Committee's Terms of Reference*

1. On 19 March 2009 the Senate referred the following matter to the Community Affairs Committee for inquiry and report by 15 May 2009:

*Any Government proposal to implement the Government's announced 2008-09 Budget measure to increase compliance audits on Medicare benefits by increasing the audit powers to Medicare Australia to access the patient records supporting Medicare billing and to apply sanctions on providers.<sup>3</sup>*

2. On 25 March 2009 the Chief Executive Officer (CEO) of Medicare Australia received a written invitation from Mr Elton Humphery, Secretary of the Community Affairs Committee, to "provide a written submission addressing the issues which may be of relevance" to the Committee.
3. The Committee's terms of reference are based on the 2008-09 Budget measure announced on 14 May 2008 titled "Protecting the Integrity of Medicare through Increased Compliance Activity".<sup>4</sup>
4. The Portfolio Budget Statement for this budget measure, stated:

*During 2008-09, Medicare Australia and the Department [of Health and Ageing], on the Australian Government's behalf, will work with the medical profession and other stakeholders to develop a more strategic focus on MBS compliance through implementation of the Increased MBS Compliance Audits Initiative. This initiative will enhance Medicare Australia's ability to detect and treat non-compliance by increasing audit activity on Medicare services to ensure that providers are fulfilling the requirements of relevant MBS item descriptors. Medicare Australia will conduct an additional 2,000 audits each year on Medicare providers who have been identified as having unusual billing practices. At the same time, the Government will introduce legislation to increase the powers of Medicare Australia, so that when auditing providers and services are identified as being at medium to high-risk of incorrect claiming, providers will be compelled to produce evidence, where appropriate, to substantiate Medicare billing. The initiative also introduces financial sanctions for providers who are billing Medicare inappropriately.*

5. Based on the above motion and subsequent invitation, Medicare Australia's written submission to the Committee contained within this document, is separated into four distinct parts:
  - an overview of the Medicare program and existing compliance program – Part 2 (page 9)
  - the Medicare compliance audit program – Part 3 (page 16)
  - the proposal to increase Medicare Australia's powers to access information – Part 4 (page 18)
  - the proposal to apply sanctions on providers – Part 5 (page 25).

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<sup>3</sup> Australia, Senate Hansard, Thursday, 19 March 2009.

<sup>4</sup> Portfolio Budget Statements 2008-09, Budget Related Paper No. 1.10, Health and Ageing Portfolio

## 2. The Medicare Program

6. Introduced in 1984, the Medicare program is Australia's universal health care system which provides eligible Australian residents with affordable, accessible and high-quality health care.
7. Medicare was established on the understanding that all Australians should contribute to the cost of health care according to their ability to pay. It is financed through progressive income tax and an income-related Medicare levy.
8. Through the Medicare program the Australian Government provides access to free or subsidised health services to assist Australians to meet the costs of specified medical, optometric, dental, surgical, and allied health services.
9. The Medicare program achieves its goal by setting out the financial amount (Medicare benefit) that the Australian Government is prepared to pay for specified services. The list of health services which the government is prepared to fund, the actual benefit amount the government will contribute, and the conditions on the use and provision of the specified services are set out in the Medicare Benefits Schedule (MBS).
10. The schedule fees for MBS items are uniform across Australia and are determined by the Department of Health and Ageing in consultation with professional bodies. This decision making process has led to the MBS containing a series of items with detailed rules and eligibility requirements for each of those services.

### 2.1 *The Medicare benefit claim and payment system*

11. The Medicare scheme is provided for in the *Health Insurance Act 1973* and the various regulations made under that Act.
12. Entitlement to a Medicare benefit is provided for in section 10 of the *Health Insurance Act 1973*. Generally, Medicare benefits are payable where medical expenses are incurred in respect of a professional service (as defined in section 3) rendered in Australia to an eligible person. The person entitled to the Medicare benefit is the person who incurred the medical expenses (section 20), but that person may assign the benefit to the person who rendered the service or on whose behalf it was rendered (section 20A).<sup>5</sup>
13. The professional services in respect of which Medicare benefits are payable are those set out in tables prescribed in regulations made under sections 4, 4A and 4AA of the *Health Insurance Act 1973*, and under Ministerial determinations made under section 3C. These regulations and determinations effectively:
  - describe the professional services (often referred to as items) in respect of which Medicare benefits are payable;
  - set out the fees payable in relation to those services; and
  - provide rules of interpretation which are to be applied to specific items.

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<sup>5</sup> Various other sections of the *Health Insurance Act 1973* place conditions on the nature of a service that may be eligible for benefit. In addition the MBS item descriptors set out conditions and requirements that must be met for the service to be eligible for a benefit. An eligible provider is a person who qualifies to provide MBS services under relevant statutory provisions. These will vary depending on the nature of the service being provided.

14. The payment of a Medicare benefit is subject to various requirements in the *Health Insurance Act 1973* and regulations made under it, including a requirement in subsection 19(6) that the prescribed particulars are recorded on the account or receipt for fees in respect of the service, or where an assignment or agreement has been made under section 20A, on the form of assignment or agreement. Regulation 13 of the *Health Insurance Regulations 1975* prescribes the relevant particulars.

## ***2.2 The role of a provider within the Medicare payment system***

15. To generate a Medicare benefit payment a provider must identify:

- themselves (by name and address or by provider number);
- the service that the patient has received (by stating the relevant MBS item number or providing such detailed description as to allow the MBS item to be identified);
- the date of the service; and
- the amount charged.

16. When a Medicare claim is lodged, the claimant makes a declaration that the information in the claim is true and correct and that they understand that it is an offence under the *Health Insurance Act 1973* to make a false statement relating to Medicare benefits.

17. Medicare providers self-determine which service they have provided and consequently what benefit they or their patient is entitled to receive. Through the claiming system, providers are not required to substantiate the correctness of their claims (i.e. provide documentary evidence prior to receiving payment).

18. Medicare Australia checks key requirements such as patient eligibility and provider details, and then makes payments accordingly. This offers convenience for both providers and patients, and does not require the significant resources that would be required if all claims were checked pre-payment.

19. Medicare Australia conducts post-payment audits to confirm that claims and payments are correct.

## ***2.3 The Medicare program in 2009***

20. Key features of the Medicare program include its overall size and continued growth.

21. In the 2007-08 financial year:

- \$13.1 billion was claimed and paid through the Medicare system - a \$1.3 billion (11 per cent) increase on the previous year;
- 21.4 million individuals were eligible for Medicare services;
- 278.7 million MBS claims were made and processed;
- 81,224 active providers<sup>6</sup> claimed Medicare benefits.

22. MBS expenditure in the first six months of this financial year was \$7.14 billion.<sup>7</sup>

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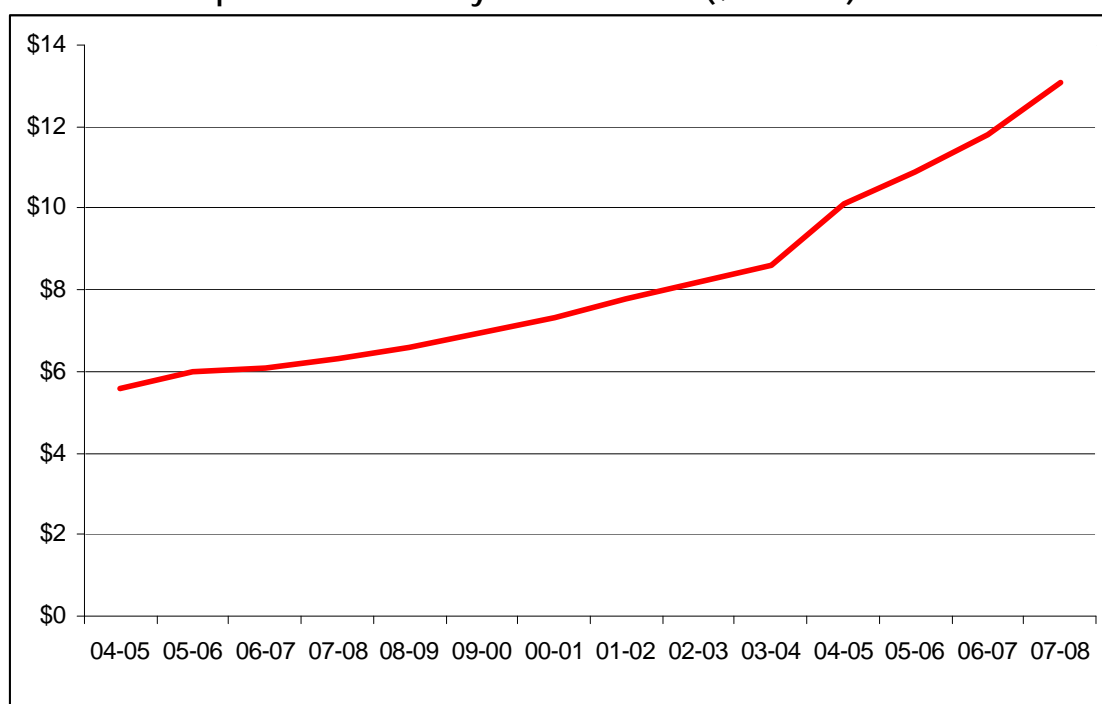
<sup>6</sup> An "active provider" is defined as any provider who has claimed or billed a Medicare benefit within the previous 12 months.

<sup>7</sup> MBS statistics website shows from 1 July to 31 December 2008 MBS expenditure was \$7,139,486,909.

23. In the past ten years the Medicare scheme has undergone significant growth and expansion. Changes include:

- expenditure has doubled from \$6.3 billion in 1997-98 to \$13.1 billion in 2007-08;
- the number of providers who can provide Medicare services has increased from 44,500 to 81,224 (82.5 per cent);
- the total annual number of services claimed has grown from 202 million to nearly 278.7 million (37.9 per cent); and
- the number of MBS items increased from 3903 to 5765 (47.7 per cent).

Figure 1 – MBS expenditure annually since 1994-95 (\$ billions)



## 2.4 Medicare Australia's compliance program and philosophy

24. One of Medicare Australia's major roles is to assure the Government, providers and the wider community that the taxpayer funded Medicare program is protected by a robust and comprehensive compliance program which ensures money is accurately and correctly spent.
25. Medicare Australia has the authority to conduct certain compliance activities under the *Medicare Australia Act 1973* and the *Medicare Australia (Functions of the Chief Executive Officer) Direction 2005*.<sup>8</sup>
26. Medicare Australia considers that the largest threat to the Medicare program is expenditure on incorrect Medicare claims (i.e. claims that are not eligible for payment under Medicare).

<sup>8</sup> Sections 5 and 6, and Part IID of the *Medicare Australia Act 1973*; section 4 of the *Medicare Australia (Functions of the Chief Executive Officer) Direction 2005*.

27. A report by the Australian National Audit Office in 1996–97, found that non-compliant MBS payments equated to around 1.3 to 2.3 per cent of expenditure.<sup>9</sup> Bearing in mind the substantial growth in expenditure and MBS items since this report it would suggest that at current levels, annual non-compliant payments could be around at least \$170–\$300m per annum.<sup>10</sup>
28. The Medicare program is a self-assessment system, in which providers select the MBS item that corresponds to the work they have performed. It is therefore important to have an adequate program of activity to support providers in making this selection and in confirming after the event that the correct decision was made.
29. Medicare Australia's philosophy for managing compliance is to encourage people to voluntarily comply and deal with non-compliance and fraud appropriately. The core elements of its philosophy involves:
- helping providers and the Australian public to understand their rights and obligations;
  - making it as easy as possible for individuals to meet their obligations when making claims for benefits;
  - supporting people who want to do the right thing; and
  - actively pursuing those who seek to opportunistically or deliberately exploit the programs we administer.
30. Medicare Australia's compliance philosophy is aimed at ensuring the right person receives the right benefit - no more, no less. This philosophy is well founded in compliance theory and is based on a common '*compliance model*' which is currently adopted by many Commonwealth departments and agencies, and is evident in their fraud control and compliance plans (see for example the Australian Taxation Office and Australian Customs Service). A copy of Medicare Australia's compliance model is provided at **Attachment 1**.
31. Each year Medicare Australia publishes a *National Compliance Program*<sup>11</sup> to explain the mix of education, support, deterrence and audit activities it will undertake to encourage voluntary compliance. The publication of this program is part of the open and transparent manner in which Medicare Australia conducts and designs its compliance activities.
32. Medicare Australia's main focus is supporting providers to make correct claiming decisions. Activities to support providers reach a very high proportion of providers and at far greater levels than the audit program. This financial year the number of providers who are expected to participate in an education activity or receive targeted compliance information will be more than 12 times the amount intended to be audited.<sup>12</sup>
33. Prior to the budget measure more than 99 per cent of providers were not subject to audit. Despite the increased audit levels approximately 96 per cent of providers will still not be subject to a compliance audit.

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<sup>9</sup> Medicare Fraud and Inappropriate Practice, Australian National Audit Office, 1996-97.

<sup>10</sup> Based on annual MBS expenditure of \$13 billion.

<sup>11</sup> See Medicare Australia's 2008-09 *National Compliance Program* at <http://www.medicareaustralia.gov.au/provider/business/audits/ncp/index.jsp>

<sup>12</sup> Already this financial year over 20,000 providers have received some form of targeted information, attended face to face training sessions, or completed online education e-learning modules.

## ***2.5 Assisting providers to get it right***

34. A vital part of Medicare Australia's compliance philosophy is the provision of accurate information and education to assist providers to 'get it right'.
35. Information and support services that Medicare Australia currently provides to encourage correct claiming includes:
- a Medicare Provider Enquiry line;<sup>13</sup>
  - Administrative Position Statements<sup>14</sup>;
  - e-learning services;<sup>15</sup>
  - Learning guides;
  - Quick reference guides and targeted information;<sup>16</sup>
  - Provider percentile charts<sup>17</sup>; and
  - Face to face education.<sup>18</sup>
36. Medicare Australia will continue its efforts and ongoing commitment to education and information to support providers. However, these activities need to be balanced with action to deter incorrect billing and claiming behaviour. Education is, and must be an integral part of promoting voluntary compliance and is a core element of Medicare Australia's compliance approach; however, without an active deterrent element, some providers may not engage with the free education, or appropriately monitor their claims.

## ***2.6 A risk based approach to compliance***

37. Medicare Australia takes a risk based approach to managing compliance concerns which is a common and recognised method of compliance management. A risk based approach recognises that:
- 1) It would be cumbersome and costly to undertake a highly invasive or unfocused compliance program seeking to check all claims for Medicare and it is unnecessary to do so.
  - 2) Medicare Australia has limited resources which need to be focused in the most effective manner to support compliance and payment integrity. Targeted compliance activity also ensures that the time and resources of providers is not wasted confirming claims about which there is no concern.

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<sup>13</sup> Last financial year 1,609,852 calls were handled, with an average call time of 159 seconds.

<sup>14</sup> An Administrative Position Statement (APS) is an authorised and documented position held by Medicare Australia in relation to the interpretation of a specific Medicare Benefit Schedule (MBS) item or in relation to the administration of the MBS, Pharmaceutical Benefits Scheme (PBS) or associated government program, in particular, where there is ambiguity.

<sup>15</sup> Already this financial year 3360 individuals have accessed online MBS education, and the product has been mailed to over 70,000 providers along with the electronic copy of the Medicare Benefits Schedule.

<sup>16</sup> Already in this financial year, information has been provided to 11,133 allied health professionals and 6,151 general providers in relation to MBS items.

<sup>17</sup> Provider percentile charts show the number of services billed by peer groups for selected MBS items. These can be used by providers to compare their billing data with peers.

<sup>18</sup> This financial year Medicare Australia has already provided face to face education to 1920 health professionals (including 720 new providers).

- 3) Targeting compliance activity to situations where there is a real concern is justifiable, yields stronger compliance outcomes, and allows Medicare Australia to select the most appropriate form of activity (i.e. education, counselling, audit, review, investigation) to address the nature of the risk.
38. Medicare Australia undertakes extensive environmental scanning and consultation to identify risks including receiving submissions and ideas from the health industry on the emerging risks and issues affecting MBS compliance.
39. Medicare Australia uses a sophisticated range of data mining and analysis techniques to detect and identify providers and services at risk of non-compliance. There are four broad situations in which a provider's claims may be identified for audit. These are when:
  - a provider has used an item with a medium to high risk of non-compliance;
  - a provider's individual claiming statistics appear to be unusual or irregular;
  - a provider's claiming statistics are significantly different to their peers; or
  - a provider has been identified through 'tip-offs' and information received.
40. In each of these situations, Medicare Australia recognises there are often many acceptable reasons for claiming behaviour. Medicare Australia's approach is not to assume an incorrect claim but to raise the concern with the provider and allow the provider the opportunity to explain their situation.

## ***2.7 Outline of Medicare Australia's options to manage non-compliance***

41. There are three distinct areas of incorrect claim risks to the Medicare program. These are:
  - 1) **fraud** – where an individual seeks to obtain a Medicare benefit by intentionally falsifying facts and/or documents;
  - 2) **inappropriate practice** – where Medicare servicing would not be acceptable to a general body of a provider's peers as clinically necessary or suitable for the treatment of the patient; and
  - 3) **incorrect claims** – where the facts provided in the claim do not match the reality of what occurred (either through misunderstanding, error, innocent mistake, carelessness or recklessness) and this leads to a Medicare payment being made when the legislative requirements were not met.

### **Fraud**

42. Medicare Australia has an active fraud control program to manage criminal threats to the Medicare system.
43. In 1993 Parliament amended the *Medicare Australia Act 1973* to provide Medicare Australia with the ability to investigate criminal threats to the programs it administers. This included enabling authorised Medicare Australia employees to conduct searches and seize documents (including clinical records) under a warrant issued by a magistrate, when there is a reasonable suspicion that a fraud or some other criminal act has been committed.
44. Medicare Australia's experience has been that the incidence of fraud by providers is not high. Last financial year the Commonwealth Director of Public Prosecutions successfully prosecuted 51

individuals referred by Medicare Australia. This included 46 members of the public, 4 pharmacists and 1 provider.<sup>19</sup>

45. When a provider is convicted of fraud against Medicare, the CEO must refer the provider to the Medicare Participation Review Committee (MPRC).<sup>20</sup> The MPRC has the power to disqualify a convicted provider from the Medicare program for a period of up to 5 years.
46. The current Government proposal to implement the announced 2008-09 Budget measure does not involve any alteration or addition to Medicare Australia's existing criminal investigation role, or the role of the MPRC.

### **Inappropriate practice.**

47. Inappropriate practice is addressed through a peer review process conducted by the Director of the Professional Services Review (PSR). The Director of the PSR may convene a committee of the provider's peers to determine if the rendering or initiating of Medicare services by the provider is considered appropriate.
48. The Director of the PSR has a range of powers to assist in reviews, including obtaining clinical notes and records.
49. Where there is a determination that inappropriate practice has occurred there are a range of sanctions available to the Director of the PSR including requiring a provider to repay Medicare benefits and disqualifying a provider from the Medicare program for a period of up to three years.
50. Medicare Australia's only role in monitoring and managing inappropriate practice is the identification and referral of potential inappropriate practice to the Director of the PSR.
51. Medicare Australia employs a range of data analysis techniques to identify providers where Medicare data indicates that their practice profile, (for billing or claiming Medicare benefits), appears significantly different when compared with their peers.
52. When Medicare Australia identifies concerns with a provider's billing or claims, the first step is to give the provider the opportunity to respond to those concerns. If there is no reasonable explanation to resolve the concerns and the matter does not show incorrect or fraudulent claims, there may be a further concern that inappropriate practice has occurred.
53. If this is the case Medicare Australia can refer the provider to the Director of the PSR for review.
54. This financial year 118 providers have been referred to the Director of the PSR.
55. Medicare Australia does not determine the clinical relevance or appropriateness of a MBS services. This will not change under the proposed legislation, which explicitly separates Medicare Australia's compliance audit process from the PSR process by prohibiting the use of documents collected in an audit from being used directly or indirectly as evidence in a PSR matter.
56. This proposed legislation will not alter or change the role of PSR in reviewing providers who may have engaged in inappropriate practice. Medicare Australia will continue to refer potential matters of inappropriate practice to the Director of the PSR.

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<sup>19</sup> This financial year there have been 3 successful prosecutions of providers.

<sup>20</sup> Part VB of the *Health Insurance Act 1973*



## Incorrect claims

57. An incorrect claim occurs when there is a false or misleading statement, not involving an intentional fraud, that results in a Medicare payment being made that is greater than the entitled benefit.
58. An incorrect claim can be categorised into four main types. These are:
- 1) **An ineligible claim** – which includes:
    - failure to meet the requirements of the MBS item;
    - failure of either the patient or provider to meet Medicare eligibility requirements;
    - failure of the equipment used in the service to meet Medicare eligibility requirements; or
    - a claim for a service which is explicitly excluded from eligibility for a Medicare benefit (for example, claims for a medical examination provided for the purpose of life insurance, superannuation, admission of membership of a friendly society, or for employment purposes).
  - 2) **A mis-itemised claim** – which involves claiming an item number for a service other than the one actually provided.
  - 3) **An up-coded claim** – which is a form of mis-itemisation but involves claiming an item similar to the one provided but of a higher value than the actual service provided (i.e. some MBS items are scaled in value depending on complexity, time or size requirements).
  - 4) **A duplicate claim** – making multiple claims for the same service.
59. Medicare Australia's only recourse when it identifies an incorrect claim is to request repayment of the amount that has been overpaid, and if a repayment is not forthcoming, to initiate legal proceedings to recover the amount from the person who caused the loss.
60. In 2007-08 Medicare Australia raised debts in relation to incorrect claims with a value of \$3.48 million from 213 providers. This was a 105 per cent increase in the value of incorrect claiming debts raised in the previous financial year.
61. In the first half of this financial year Medicare Australia has already raised debts totalling \$1.86 million in incorrectly paid benefits from 139 providers.
62. The relatively low level of recovery of incorrect claims under Medicare Australia's compliance program is influenced by the fact that providers generally cannot be required to provide evidence to substantiate their billing or claiming. Consequently, it can be practically difficult for Medicare Australia to establish that an incorrect claim has been made and recover the monies which were incorrectly paid.

## 3. Medicare Australia's compliance audit program

### 3.1 *The existing Medicare audit program*

63. Each year over \$13 billion in benefits are paid as part of the Medicare program. To safeguard this expenditure and maintain the integrity of Medicare, a small percentage of providers are asked to verify their claims through an audit program.

64. MBS compliance audits are designed to check that the provider and patient were eligible for Medicare benefits and that the service was provided and met the MBS item requirements. These are all questions of fact and do not question either the clinical appropriateness or adequacy of the MBS service, or the clinical decision making of the provider.
65. Medicare Australia's current ability to monitor and manage incorrect claims is severely limited. The current legislation does not contain provisions which require providers to substantiate their Medicare claims, and unless the claiming data reveals contradicting facts, or elements that would generate a concern, there is limited ability to establish that an incorrect claim has been made (without the provider volunteering the information).
66. Currently, when conducting post-payment audits, Medicare Australia requests an explanation, relevant information or documents from providers to substantiate the facts of a service in relation to which a Medicare claim has been made. By way of example, if a provider claims an MBS item that:
- requires a particular test to be done - Medicare Australia may ask for evidence that the test was done;
  - requires a referral - Medicare Australia may ask for a copy of the referral; and
  - requires a patient to have a certain characteristic (age, sex, pre-existing condition) - Medicare Australia may ask for evidence that the required characteristic existed.
67. The response rates, outcomes and types of documents produced vary considerably across different audit topics. In general:
- around 21 per cent of providers approached during compliance activities do not respond, or decide not to take part; and
  - around 10 per cent of the providers who do respond give Medicare Australia some form of health information about their patients – to reiterate – 10 percent of providers already give to Medicare Australia voluntarily the confidential patient material that is the subject of this legislation.
68. Medicare Australia's general audit process is outlined in the diagram at **Attachment 2**.
69. Information collected as part of a compliance audit process is retained by Medicare Australia only until the purpose for which it was collected (checking MBS claiming accuracy) has been met. All information received during an audit is handled and managed in accordance with:
- the Commonwealth Protective Security Manual (PSM);
  - the *Privacy Act 1988*;
  - the secrecy provisions in the *Health Insurance Act 1973*;<sup>21</sup>
  - the Australian Government Information and Communications Technology Security Manual;
  - the Australian Government e-Authentication Framework (AGAF);
  - the Gatekeeper Public Key Infrastructure (PKI) Framework; and
  - other Australian Government and international security standards.
70. Personal information collected through audits is only accessed by specifically authorised and trained Medicare Australia staff and there are security safeguards in place to prevent and detect unauthorised access.

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<sup>21</sup> Section 130 of the *Health Insurance Act 1973*.

71. Once the compliance activity has been fully concluded any documents produced are disposed of by Medicare Australia.<sup>22</sup> This destruction occurs in accordance with current legislative requirements in a manner which prevents recognition or reconstruction of the information. For example, paper based information is shredded or pulped and electronic or removable media will be physically damaged to the point of inoperability, (eg. via shredding, degaussing, melting, etc).<sup>23</sup>
72. Medicare Australia's compliance activities are subject to existing requirements of procedural fairness and natural justice. Medicare Australia has an internal complaint and review process that gives individuals the ability to have Medicare Australia's actions and decisions reviewed by an independent officer.

### ***3.2 Increased audits of the Medicare program***

73. Prior to 2009 Medicare Australia's active Medicare compliance activities covered around 0.7 per cent of the active provider population. Proportionately this would equate to each provider being audited once every 143 years.<sup>24</sup> Medicare Australia's advice to Government was that this audit coverage was inadequate to provide the necessary assurance that Medicare benefits were being correctly claimed.
74. The decision by the Government to fund an increase in the number of compliance audits in the Medicare program has allowed Medicare Australia to establish a more viable program covering a wider range of health providers. For example, prior to the increase Medicare Australia had limited capacity to audit specialists and virtually no capacity to audit allied health providers.
75. Whilst the expanded audit program provides for a greater number of audits and a higher level of assurance to Government of the integrity of Medicare payments, over 96 per cent of health providers will not be subject to the program and proportionately audits may still be a once in a lifetime event (i.e. once every 25 years).

## **4. Access to information during a Medicare compliance audit**

76. Medicare Australia has no general power to require a person to provide information or documents for the purposes of verifying the validity of a claim for Medicare benefits. However, there are limited coercive information gathering powers available to Medicare Australia (discussed further below).
77. Consequently, a provider can simply refuse to comply with a request made by Medicare Australia for information or documents to verify claims.
78. Currently there is also no explicit or specific legal framework to set out either Medicare Australia's rights to request documents, or the provider's obligation to produce documents to substantiate

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<sup>22</sup> If the document is required for legal purposes (i.e. recovery or enforcement of penalty) the record will be kept securely until any legal proceedings are completed. It should also be noted that the compliance case management system may continue to contain a history of the case, in line with Commonwealth record keeping requirements.

<sup>23</sup> Medicare Australia disposal of personal information occurs in accordance with the Archives Act, the PSM, Medicare Australia's Disposal & Destruction of Classified Information Policy, and other relevant policies.

<sup>24</sup> This is strictly statistical. Due to the risk based approach adopted by Medicare Australia some providers may be audited more than once, and some may never be audited.

Medicare claims.<sup>25</sup> There is therefore a lack of clarity for providers when they are approached as part of a Medicare compliance audit and this ambiguity causes some providers to refuse to participate, and others to provide too much and unnecessary information.

79. The current lack of a substantiation requirement limits the scope of Medicare Australia's audit program. For example, Medicare Australia often does not seek to audit services that would specifically require information contained in clinical notes. This effectively places some MBS items outside any active compliance program and prevents Medicare Australia from determining whether large segments of Commonwealth expenditure are being made correctly.
80. This is an unsatisfactory outcome from a compliance perspective, as it gives providers who may be billing incorrectly with an easy means to avoid detection. This can have a negative impact on the public revenue.
81. Medicare Australia has legitimate compliance concerns about those providers who refuse to participate in audits and these concerns cannot currently be addressed.

#### ***4.1 Medicare Australia's existing powers to compel the production of documents***

82. There is currently an information and document gathering power set out in section 8P of the *Medicare Australia Act 1973*. However, that power can only be exercised where there are reasonable grounds for believing that particular criminal offences have been committed or particular civil contraventions have occurred. Consequently, the power under section 8P cannot be utilised to conduct general audit activities, where no clear basis for suspecting criminal conduct exists.
83. The power under section 8P cannot be used to obtain the clinical records of patients from providers or other persons, although a patient can be required to provide their own clinical records – subsections 8P(3) and 8P(4).
84. Under section 8Y of the *Medicare Australia Act 1973*, Medicare Australia may also exercise search and seizure powers under a warrant issued by a magistrate to obtain documents, including patient records, where criminal activity or civil contraventions are suspected. The exercise of these powers is very limited and involves providing statements under oath to a Magistrate that an authorised officer suspects on reasonable grounds that there is evidential material relating to a relevant criminal offence.
85. There are also a number of existing provisions within the *Health Insurance Act 1973* which require persons to produce specific documents or other information to Medicare Australia on request. This extends to clinical information in limited circumstances. The relevant provisions of the *Health Insurance Act 1973* require:
  - specialists and consultant physicians to retain and (if requested) produce referrals, or information about services rendered without a referral – section 20BA;
  - approved pathology providers and approved pathology authorities to retain and (if requested) produce written requests, or written confirmation of requests, for pathology services – section 23DK;

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<sup>25</sup> The *Privacy Act 1988* would allow the audit activity to occur, in that disclosure of information by a provider to Medicare Australia is authorised by NPP 2, and the laws and principles within that Act cover how Medicare Australia may generally deal with the information collected.

- approved pathology authorities to retain and (if requested) produce records of pathology services – section 23DKA and regulation 16A of the *Health Insurance Regulations 1975*;
- providers to retain and (if requested) produce written requests for diagnostic imaging services – section 23DR; and
- providers to retain and (if requested) produce records of diagnostic imaging services – section 23DS and regulation 20 of the *Health Insurance Regulations 1975*.

## 4.2 *The powers of other Government agencies to compel the production of documents*

86. The proposed legislative changes will bring the Medicare program more closely into line with other Government programs which involve the collection or payment of public monies, such as those in the areas of taxation, child support and social welfare.

87. For example:

- 1) Under the *Income Tax Assessment Act 1936*, the Commissioner of the Australian Taxation Office (ATO) has very broad powers to compel the production of documents and information to ascertain the correctness of tax claims.

Specifically section 263 gives the Commissioner or any authorised officer the power to have "*full and free access to all buildings, places, books, documents and other papers for any of the purposes of this Act, and for that purpose may make extracts from or copies of any such books, documents or papers*".

Section 264 gives the Commissioner the power to issue written notices requiring "*any person, whether a taxpayer or not, including any officer employed in or in connexion with any department of a Government or by any public authority: to furnish him with such information as he may require; and to attend and give evidence before him or before any officer authorized by him in that behalf concerning his or any other person's income or assessment, and may require him to produce all books, documents and other papers whatever in his custody or under his control relating thereto*".

- 2) Under the *Social Security (Administration) Act 1999*, Centrelink, another agency within the Department of Human Services Portfolio, has broad powers to require persons to produce documents or provide information for the purpose of verifying social security payments.

For example, section 192 allows the Secretary to "*require a person to give information, or produce a document that is in the person's custody or under the person's control, to the Department if the Secretary considers that the information or document may be relevant*" to a person's entitlement to social security payments.

Similarly, section 195 allows the Secretary to require a person to give information about a class of persons to the Department to detect cases in which social security payments should not have been made, or to verify the eligibility of persons who receive those payments.

88. The *Health Insurance Act 1973* confers broad powers on the Director of the PSR to access relevant documents, including complete clinical notes. Under section 89B, the Director may "*by written notice given to the person under review; or any other person whom the Director believes to have possession, custody or control of, or to be able to obtain, relevant documents*" require the person "*to*

*produce to the Director, or to a person nominated by the Director, such relevant documents as are referred to in the notice'.*

89. Under the proposed legislation, Medicare Australia will not have the same broad powers of access to clinical records as the Director of the PSR. The proposed powers will not enable Medicare Australia to require providers to produce complete patient notes. Further, Medicare Australia will have no need to see, and providers will not be required to produce, any documents which contain clinical information about a patient unless that document is essential to confirming a particular fact directly related to the making of a Medicare claim. For example, Medicare Australia could require a provider to produce documentary evidence that a patient had diabetes if the MBS item that was claimed is only payable if the patient has diabetes, but Medicare Australia could not require any further details about that patient's medical condition.
90. Under the proposed regime, Medicare Australia's ability to access documents will still be less comprehensive than those possessed by either Centrelink or the ATO. Specifically Medicare Australia's powers will be confined to requiring providers to produce only those documents (or extracts of those documents) to the extent that they are necessary to substantiate a particular payment under Medicare.
91. Medicare Australia will not have the power to access documents or files, and will only be able to receive documents that a provider chooses to submit in response to a substantiation request.

### ***4.3 Proposed requirement to substantiate Medicare claims***

92. The proposed legislation enables the Medicare Australia CEO to request, and requires providers to produce, relevant documents to substantiate that a payment under Medicare was correct.
93. Providers are already under certain legal, professional and other obligations to keep and retain records relating to their treatment of patients and the rendering and claiming of Medicare Benefits. This proposal does not introduce any new record making or retention requirements.
94. The proposed amendments will allow the Medicare Australia CEO, or the CEO's delegate, to give a person a written notice requiring them to produce documents which are relevant to determining the correctness of a payment under Medicare.
95. The ability to request a provider to substantiate their Medicare claims has an inbuilt relevance test which ensures that any information which is not relevant to the claim being audited cannot be requested by Medicare Australia and should not be provided.
96. The ability to request documents is also specifically limited to producing documents relevant to payments made in relation to services:
  - 1) rendered within the two years prior to the receipt of the notice;
  - 2) which are clearly identified; and
  - 3) for which there is a reasonable concern that a Medicare payment exceeds the amount that should have been paid.
97. The requirement is further limited to requiring relevant documents, or parts of documents, which would enable Medicare Australia to determine the factual accuracy of a Medicare payment which was made and cannot be used for any other purpose.
98. Limiting the power to specified services, where there are reasonable concerns about payments made in relation to those services, will prevent the use of the power on a random basis, and will

- enhance requirements for Medicare Australia to have documented decisions on why an individual notice was issued.
99. The Medicare Australia CEO will delegate the power to issue written notices to selected and trained compliance auditors (for example, those with enhanced privacy and security awareness training).
  100. It is anticipated that those delegated officers will only issue a written notice in situations where a provider has failed to voluntarily respond to a request for substantiating documentation in the course of an audit. It is not proposed that Medicare Australia will use this power as the first step within an audit process (i.e. Medicare Australia expects that the vast majority of providers will continue to cooperate and produce documents voluntarily).
  101. Documents produced by a provider will only be accessed by Medicare Australia employees who are directly involved in the audit. All audit records are contained within a secure business system that only compliance officers can access. Furthermore the collection and use of the documents obtained during an audit are protected by the *Privacy Act 1988* and the secrecy provisions within the *Health Insurance Act 1973* which includes criminal offences for misuse of information.<sup>26</sup>
  102. The proposed legislation does not require the notice to list the actual documents being sought. Providers will be given the opportunity to select the document that is most convenient to their individual mode of practice. Medicare Australia is proposing that delegated compliance officers will indicate the types of documents that may satisfy the specific concerns, and may also offer examples. The actual decision on what to produce to substantiate a payment will rest with the provider.
  103. Under the proposed amendments, a notice to produce documents will be able to issued to a person other than the provider (with the exception of the patient or their representative) if that person has possession, custody or control of documents which are relevant to substantiating a Medicare payment. There may be circumstances where providers cannot access relevant documents because they are in the possession of corporations or other entities (for example, medical practices and private hospitals).
  104. The proposed legislation will enable Medicare Australia to obtain copies of the relevant documents from those other persons. This will overcome situations where providers could otherwise avoid liability by passing control of documents to corporate entities or other organisations, and ensures that providers will not be held liable for failing to comply with a notice due to circumstances beyond their control.
  105. Ultimately a failure to respond to a written notice within the specified time (at least 21 days) will result in an automatic outcome where the Medicare benefits paid for the services are disallowed and become a debt due to the Commonwealth. The proposed legislation enables Medicare Australia to extend this deadline where the provider or their representative provides valid reasons.
  106. Consistent with current practice and legal requirements, information will be stored securely and either returned or destroyed once the audit has been finalised.

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<sup>26</sup> Section 130 Health Insurance Act 1973

#### ***4.4 Issues directly relating to clinical information***

107. In the course of conducting its current audit activities, Medicare Australia can and does receive health information about patients from providers for the purpose of validating Medicare payments.
108. However, Medicare Australia recognises that this proposal has a potential privacy impact because it may, in certain circumstances, require providers to disclose limited clinical information about their patients to Medicare Australia for verification purposes. Of course, as noted above, some of this same type of information is already volunteered to Medicare Australia by providers.
109. The proposed legislation will effectively require a provider to verify the statement they made which led to the making of a Medicare payment by providing supporting evidence. Medicare Australia will not have any authority to request or use documents that are not relevant to determining the factual accuracy of a Medicare payment.
110. A provider already identifies a patient, the service that the patient has received, and in some cases, the condition that they have as a part of the Medicare billing process. A provider does this by using a valid Medicare Card number and a valid item number from the MBS.
111. For example:
  - if a provider bills or claims item 2622 then they are asserting that the patient has diabetes;
  - if a provider bills or claims item 2668 then they are asserting that the patient has asthma;
  - if a provider bills or claims item 16590 then they are asserting that the patient is more than 20 weeks pregnant; and
  - if a provider bills or claims item 31210 then they are asserting that the patient had a skin lesion greater than 10mm in size removed.
112. Consequently a compliance audit request, if properly complied with, will not reveal to Medicare Australia any information it cannot already infer from claiming information. A Medicare compliance audit therefore does not require a provider to disclose new health information about a patient, but is merely aimed at substantiating the facts that have already been asserted through the making of a claim under Medicare.
113. There are now an increasing number of MBS items where an aspect of item requirement includes the presence of a clinical condition, or the performance of a clinical test. The main way that a provider could substantiate adherence to these item requirements would be to produce to Medicare Australia an extract of the relevant clinical record, to confirm that the service included the required features. This will not require any clinical interpretation by Medicare Australia, just the verification of a matter of fact.
114. The proposed legislative amendment represents a change to the existing voluntary basis of the Medicare compliance audit program. During Medicare Australia's current audit processes, clinical information is sometimes disclosed to Medicare Australia (for example when it is provided voluntarily by the provider).
115. In one audit project conducted in 2008-09, Medicare Australia calculated that it received clinical information in roughly 10 per cent of the audit cases. This clinical information included references and notes about the patient's treatment, injury and/or medical condition.
116. Medicare Australia only seeks clinical information to confirm that the legal requirements of the MBS item which has been claimed have been met. Consequently, in most cases, only limited excerpts of



- a patient's clinical notes would be required, and there would be no situations where Medicare Australia would, for example, require access to the whole of a patient's clinical file or patient history.
117. This limitation to substantiating the facts of an MBS claim effectively places some sensitive information outside the scope of a Medicare compliance audit. By way of example, if a provider claims an MBS item that:
- 1) requires a particular test to be done – Medicare Australia may ask for evidence that the test was done – but would not need to know what the test result was;
  - 2) requires a referral – Medicare Australia may ask for a copy of the referral – but would not need to see why the referral was made; and
  - 3) requires a patient to have a certain characteristic (i.e. a pre-existing condition) – Medicare Australia may ask for evidence that the required characteristic existed – but would not need to see how the condition originated, or how it manifests.
118. Medicare Australia recognises that confidentiality is an important part of a provider-patient relationship. Without confidentiality and its ensuing trust, patients may be reluctant to provide the health information a provider requires for their effective treatment. There is a need to balance this confidentiality with the need to ensure the accurate expenditure of Medicare payments. Medicare Australia is therefore committed to the protection of the health information it obtains, both now and under any new provisions, to ensure that members of the public maintain their confidence in the Medicare program.
119. In this context, it is appropriate to reiterate that the proposed legislation will simply require a provider to verify a statement they have already made in a Medicare invoice or claim by providing supporting evidence. The proposed legislation will not give Medicare Australia the authority to require a provider to produce documents that are not relevant to determining the factual accuracy of a specific Medicare payment, nor does it allow Medicare Australia to access complete records.
120. Medicare Australia takes the privacy and confidentiality of information it handles very seriously. It already receives and manages a considerable amount of health and other sensitive personal information relating to both patients and providers, and maintains the highest standards of professionalism in protecting the privacy of this information.
121. Medicare Australia's commitment to incorporating best privacy practice has been recognised at the inaugural Australian Privacy Awards in 2008, where it was the winner of the Grand Award for the most outstanding nominee from any category.

#### ***4.5 Patient Notification when information collected***

122. Medicare Australia and the Department of Health and Ageing have given careful consideration, and consulted stakeholders on, the issue of whether a patient should be advised when a provider gives Medicare Australia any of their health related information.
123. Based on the stakeholder comments received, and Medicare Australia's experience with notifications required under section 8ZN of the *Medicare Australia Act 1973*, Medicare Australia believes that the proposed legislation should not contain any patient notification requirement. This is based on the position that the provider is only being asked to substantiate details which they have already provided to Medicare Australia when a claim is made.

124. Under section 8ZN of the *Medicare Australia Act 1973*, Medicare Australia is currently required to notify patients if it seizes their clinical records through the exercise of its criminal investigation powers. Medicare Australia's experience is that this causes considerable angst amongst patients who do not understand the process or reasons why the records are being examined. Some patients erroneously assume that it is the quality of clinical care that is under review and become concerned about having a continued relationship with the provider.
125. Patient notification therefore has the potential to compromise the privacy of the provider, and may lead patients to worry that their provider has behaved inappropriately or illegally in circumstances where no problem is ultimately identified. A number of provider groups have indicated that patient notification would be unreasonable and would have potentially adverse and inappropriate impacts on their reputation and ability to serve their patients.
126. Patient notification is inconsistent with present practice. The current power of the Director of the PSR to access clinical records under section 89 of the *Health Insurance Act 1973* does not require patient notification.
127. Likewise the existing, though limited, information gathering powers in the *Health Insurance Act 1973* which allow Medicare Australia to require providers to produce documents containing clinical information do not require patient notification to occur (see for example, 23DS, 23DKA).
128. The Information Privacy Principles in the *Privacy Act 1988* do not require Medicare Australia to notify patients whose personal information is being disclosed to Medicare Australia as part of an audit.<sup>27</sup> This would not change as a result of the proposed legislation changes.
129. Finally, it is important to note that the information obtained in conducting audits will not be used in making any decisions affecting the patient, and can only impact on the provider.
130. Medicare Australia is considering a broader information campaign for patients to raise awareness that their health information may potentially be accessed for a compliance audit. In doing this Medicare Australia will undertake consultation with affected stakeholders.

## 5. Sanctions

### 5.1 Existing Penalties and Sanctions for incorrect Medicare claiming and billing

131. Criminal sanctions may apply if a provider (or another person) makes a false or misleading statement which leads to an incorrect payment under the Medicare program.<sup>28</sup> However, criminal prosecutions are rare and occur in the most serious cases, usually where conduct is intentional and repeated. Where incorrect claiming occurs as a result of a misunderstanding, an administrative error or mistake, or through carelessness or recklessness, Medicare Australia's only realistic response is to recover the monies from the person who caused the loss.<sup>29</sup>
132. Prosecutions are time consuming and costly and depend on the collection of enough evidence to establish the commission of a criminal offence. Even when successful, prosecutions do not always

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<sup>27</sup> IPP2 of the *Privacy Act 1988* requires a privacy note only when information is solicited from the individual concerned – during an audit the information is solicited from the provider, not the patient.

<sup>28</sup> Sections 128A and 128B of the *Health Insurance Act 1973*

<sup>29</sup> Section 129AC

- result in the imposition of serious sanctions. Therefore there is often little public interest in seeking the prosecution of providers except in very serious cases.
133. The absence of more streamlined penalties addressing minor incorrect claiming is considered by Medicare Australia to be a current restriction on effective compliance management.
134. The issue of deterrence is fundamental to the ongoing integrity of the Medicare Scheme. Compliance management within the Medicare program depends on encouraging voluntary compliance and deterring incorrect claiming. An audit coverage that results in 96% of providers not being audited only increases the need for broader deterrence.
135. Medicare Australia believes that the current system - where only a small proportion of claims by a small proportion of providers are scrutinised, and a small portion of incorrect claims are recovered without sanction - does not provide adequate deterrence to providers to 'get it right'.
136. Medicare Australia often encounters situations where a provider is willing to make an immediate payment knowing that they can continue to claim and there has been no real cost to them. Indeed they have effectively had a 'free' loan and use of Commonwealth funds.
137. From a compliance perspective the lack of any effective mechanism to deal with providers who bill or claim incorrectly is a major shortcoming of the *Health Insurance Act 1973*. Medicare Australia considers that there would be a much greater incentive for providers to ensure that their billing or claiming is error free if those providers were subject to a simple administrative for any incorrect billing or claiming.

## ***5.2 Sanctions for Incorrect claims available to other Government Agencies***

138. In looking at precedents for an administrative penalty, Medicare Australia considered other Commonwealth Law, the Australian Law Reform Commission (ALRC) Report: '*Principled Regulation: Federal Civil & Administrative Penalties in Australia*', and the Attorney-General's Department '*Guide to Framing Commonwealth Offences, Civil Penalties and Enforcement Powers*'.
139. The ALRC report, *Principled Regulation*, supports Administrative penalties in high-volume, low culpability situations where the regulator and individual have ongoing and repeated interactions.<sup>30</sup>
140. There are other Commonwealth programs which include administrative penalties as a deterrent. These include:
- 1) Customs legislation, which enables 100% administrative penalties on custom duties in set circumstances;<sup>31</sup>
  - 2) the *Fisheries Management Act 1991* which provides for 20% administrative penalties for specific breaches (particularly relating to levies);<sup>32</sup>
  - 3) the *Social Security Act 1991* and the *Social Security (Administration) Act 1999* which provides for administrative penalties in the form of reduced benefit payments when breaches occur;<sup>33</sup> and

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<sup>30</sup> ALRC Report 95: *Principled Regulation: Federal Civil and Administrative Penalties in Australia*, 2002.

<sup>31</sup> See for example section 4 of the *Customs Undertakings (Penalties) Act 1981*, and section 4 of the *Customs Securities (Penalties) Act 1981*.

<sup>32</sup> Section 112, *Fisheries Management Act 1991*

- 4) the *Taxation Administration Act 1953*, which has a range of administrative penalties that apply to overpayments and the making of false statements. This legislation includes increased penalties for higher culpability events<sup>34</sup>, and reductions in penalties for cooperation and other supporting behaviour.<sup>35</sup>
141. The ATO's penalty system was considered to be a good example of how an administrative penalty system could apply to providers because of the self-assessment aspect of the tax regime – that the balance of taxpayers having the right to self-assess their tax liability is that they have a duty to get it right and substantiate their claims when concerns arise. One of the incentives to get it right – and thus protect the public revenue so that monies are available to be applied for future public advantage – is that a small penalty is attracted when an overpayment is made.
142. The Medicare program is a similar self-assessment system with self-classification of the services provided by providers. There is also the similar role for Medicare Australia in seeking to protect the public revenue – and specifically to protect the health spending for future public advantage.
143. Based on the research across other compliance programs within Australia, Medicare Australia and the Department of Health and Ageing advised the Government that administrative penalties would be an appropriate and effective means of managing incorrect Medicare claiming for the following reasons:
- the bulk of the incorrect claiming within the Medicare is non-criminal in nature and is not committed with a pre-meditated intent to receive unwarranted amounts;
  - the seriousness of the majority of incorrect claiming would rarely warrant court action (either civil or criminal);
  - a simple deterrent system would support Medicare Australia's aim to encourage voluntary compliance rather than taking a strict, strong-handed, technical and/or inflexible approach to enforcement;
  - criminal prosecution has potentially long-lasting impacts on an individual, their reputation, and their business, that would often be unwarranted for billing or claiming mistakes; and
  - administrative penalties are effective and efficient, and unlikely to strain the resources of the provider concerned.
144. The proposed administrative penalty system for providers who make incorrect claims has consequently been designed after consideration of the existing penalty schemes, and taking into account what would be appropriate within the Health system. Specifically the penalty amounts, audit coverage, and the available reductions in penalty are based on the existing Medicare compliance program and voluntary compliance model.

### ***5.3 Proposed Penalties and Sanctions***

145. The proposed legislation will introduce an administrative penalty whenever a debt in excess of a specified threshold has arisen through incorrect Medicare payments. The penalties will apply automatically. Consequently, there is no decision making by Medicare Australia officers, and this will ensure consistency in the application of audit outcomes (i.e. incorrect claiming of the same value will cause a penalty of the same value).

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<sup>33</sup> For example automatically reduced or removed benefit payments following participation failures under sections 500ZB, 550B, 576A, 626, 742 of the *Social Security Act 1991*.

<sup>34</sup> Section 284-90 *Taxation Administration Act 1953*.

<sup>35</sup> Section 284-225 *Taxation Administration Act 1953*.

146. The proposed penalty amount is 20 per cent of the amount of the debt owed by the provider. Medicare Australia supports the calculation of a financial penalty based on a percentage of the incorrect claim. This ensures that the penalty system has an inbuilt level of proportionality.
147. The proposed penalty amount of 20 per cent should have sufficient weight to deter incorrect billing and claiming and compensate the Commonwealth for the loss of use of public funds, whilst remaining both proportional and appropriate to the circumstance. In 2004 a review of Medicare sanctions, conducted by Philips Fox on behalf of Medicare Australia, recommended a 100 per cent administrative penalty for incorrect claims.<sup>36</sup>
148. Other Australian administrative penalty systems generally set a higher rate of penalty than 20 per cent. Medicare Australia feels that any penalty amount less than 20 per cent would lose the deterrent impact on the wider health provider community.
149. The proposed legislation will include a threshold below which penalties do not apply. This threshold is \$2,500 or a higher amount prescribed by regulation. The intent of the threshold is to ensure that innocent or more minor mistakes are not penalised. Medicare Australia believes that \$2,500 is a suitable threshold amount. Based on 2007–08 recovery cases, 64 per cent of providers were required to make repayments below this threshold amount (i.e. would not pay a penalty).
150. Medicare Australia believes the current penalty and threshold amounts will provide an appropriate level of deterrence, and that any penalties that are applied will be proportionate and fair. The total annual penalties that Medicare would have recovered last financial year (assuming the 20 per cent base penalty applied in all situations without discount) would have been less than \$280,000.

#### ***5.4 Reductions and Increases in the Penalty***

151. The proposed penalty system will provide incentives for voluntary compliance behaviour. For instance, if a provider acknowledges that an incorrect payment has been made:
  - prior to any compliance contact, no penalty will be imposed;
  - prior to a formal written notice being issued, the penalty will be reduced by 50 per cent; or
  - prior to completion of the audit, the penalty will be reduced by 25 per cent.
152. Medicare Australia considers an administrative penalty system of this nature is likely to increase voluntary compliance. Under the existing Medicare compliance program, Medicare Australia occasionally has providers self-declare their mistakes. Medicare Australia believes this measure will increase this occurrence, particularly when Medicare Australia promotes its upcoming areas of compliance interest (i.e. through the publication of its National Compliance Program, or within its quarterly newsletters to providers).
153. Medicare Australia will support this element of the legislation by introducing easy processes through which a provider can self-declare an incorrect payment. This will ensure that providers are able to take advantage of the incentives provided within the legislation when they have caused an incorrect payment.
154. The proposed model also provides for additional penalties to be imposed on providers who seek to obstruct an audit. Specifically, if a provider completely fails to respond to a written notice, the full amount of the services identified in that notice will become a debt due to the Commonwealth, and the total penalty payable will be increased by 25 per cent.

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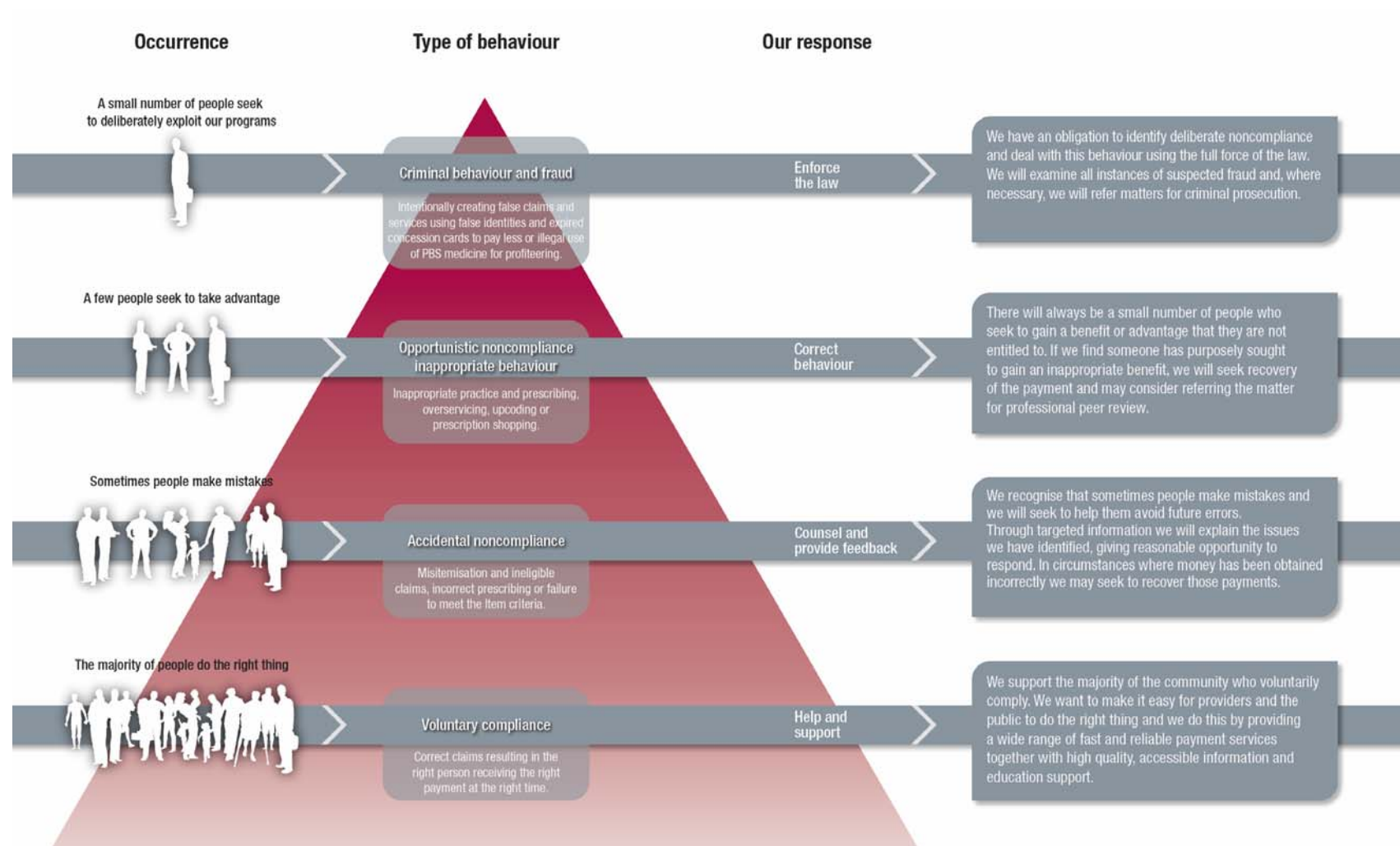
<sup>36</sup> MBS Sanctions Review – Preferred Options Report, Phillips Fox, 2004. Pg 58.

155. Medicare Australia does not believe that this will occur frequently, as the provision only applies to total failure. Medicare Australia does believe, however, that a provider who completely fails to respond to a notice should receive a higher penalty than someone who has sought to respond to an audit.
156. The proposed legislation also targets recidivist behaviour (habitual non-compliance) by increasing penalty amounts by 50 per cent if the provider has in the past two years paid a previous penalty amount over \$30,000. Medicare Australia does not believe that this provision will be applied frequently, but considers it important to deal with a very small proportion of providers whose billing and claiming behaviour continues to be found to be non-compliant.
157. Medicare Australia believes that the penalty system proposed in the legislation will contribute significantly to a voluntary compliance approach. It will do this by encouraging providers to self-monitor their claims, and come forward about mistakes before they are repeated or become habitual. Applied appropriately, administrative penalties will discourage non-compliance by encouraging providers to exercise appropriate care and diligence when claiming and billing for Medicare services.

## 6. Conclusion

158. Medicare Australia supports the proposed legislation for the following reasons:
- 1) it will address existing deficiencies in Medicare Australia's ability to identify and deter incorrect Medicare billing and claiming by providers;
  - 2) it will assist in clarifying the rights and obligations of both Medicare Australia and providers in relation to the substantiation of Medicare payments; and
  - 3) it will introduce a simple and fair administrative penalty system which will be an effective deterrent, be efficient in its application, and is unlikely to strain the resources of providers.
159. Medicare Australia considers the proposed legislation to be essential to improve its ability to manage the integrity of the Medicare program.

## Attachment 1 – Medicare Australia’s compliance model



Attachment 2 – Medicare Australia’s Generic Audit Process

