Appendix 3
Health Provider Compliance Report

Machinery of Government change

On 30 September 2015, the Prime Minister, the Hon Malcolm Turnbull MP, announced that a Machinery of Government transfer would occur, with responsibility for the Medicare Provider Compliance function transferring from the Department of Human Services to the Department of Health. The transfer was recommended by the Health Functional and Efficiency Review.

Achievements

The Department of Health continues to achieve results with several matters referred to the Commonwealth Director of Public Prosecutions. The following three cases, amongst others, were finalised in the courts during 2015-16:

- 13 November 2015, a health professional was convicted and sentenced to three years imprisonment for fraudulently obtaining Medicare benefits of $854,188. The health professional had submitted false claims for over 14,000 services that were not provided to patients in Victoria between December 2006 and September 2013.
- 15 January 2016, a former medical receptionist was convicted and sentenced to three years imprisonment for fraudulently obtaining Medicare benefits of $189,316. The medical receptionist had submitted 771 false claims for services which were not provided to patients at two medical practices in Queensland between May 2011 and November 2012.
- 22 March 2016, a former medical receptionist was convicted and sentenced to six months imprisonment for fraudulently obtaining Medicare benefits of $44,134. The former medical receptionist had submitted 345 false claims for services not provided to patients at a medical centre in New South Wales between December 2008 and May 2013.

Improve billing practices within public hospitals

The *Fraud Prevention and Compliance — improve billing practices within public hospitals* measure, which concluded in 2015-16, identified further areas for education about Medicare billing practices within public hospitals. Information was published on the Department's website to help health professionals and hospital administrators understand their legal responsibilities and requirements when billing under Medicare in public hospitals.

Looking ahead

Enhanced compliance Budget measure

The *Healthier Medicare — enhanced Medicare compliance program* will enhance health provider compliance with funding of $48 million over four years. Efficiencies will be achieved by introducing an advanced data analytics capability to better target providers who make Medicare claims that are inconsistent with existing rules and introducing changes to improve low rates of debt recovery from providers. The savings of $66.2 million over four years from this measure will be redirected by the Government to fund Health policy priorities.

Education and stakeholder engagement

Education and engagement assists health professionals meet their compliance obligations through a range of activities and information.

General education and targeted feedback letters

In 2015-16, 417 general education and targeted feedback letters were sent to health professionals covering a range of issues, such as checking concession entitlement of patients when claiming bulk bill incentive items.

Health Professional Guidelines

Developed in consultation with peak bodies, Health Professional Guidelines (HPGs) help educate regarding the documents that can be used to substantiate services. At 30 June 2016 there were 19 HPGs published on the Department of Health website.

Health compliance professionalism survey

The professionalism survey invites health professionals to provide feedback about their experience during Health Provider Compliance audits. The survey is sent following the completion of an audit and feedback guides training initiatives and improvements to business processes. In 2015-16 the Department received completed surveys from 409 health professionals, showing an overall satisfaction level of 91.1 per cent.

Audit and review activities

Audits and reviews are planned compliance activities on individuals or businesses that support payment integrity. They include general audits, practitioner review or criminal investigation.

Table 1: Completed health compliance audits and reviews

Programs/groups	2015-16
Medicare Benefits Schedule	3,399
Pharmaceutical Benefits Scheme	291
Health support programs	66
Child Dental Benefits Schedule	156
Total	3,912

The 2015-16 work program focussed on priority risks in the following areas:

Pharmaceutical Benefits Scheme (PBS)

- **Unapproved pharmacies:** reviewed claims from approved pharmacies when allegations were made that they had claimed for medicines supplied by another pharmacy not approved to supply under the PBS.
- **Multiple payments:** reviewed approved suppliers when claims are made more than once for the same authorised supply of a PBS medicine or when claims are made for the supply of two identical prescriptions where only one is valid for PBS subsidy.

Medicare Benefits Schedule (MBS)

- **GPs bulk billing incentive payments:** recovered benefits from GPs who continued to claim incorrectly after receiving targeted letters in 2014-15 about claiming for patients who did not have a valid concession card on the date of service.
- **Specialists-referred consultations:** audited specialists' claiming of referred consultations to determine if they had a valid referral before claiming the consultation.
- **Specialists-assisted reproductive technology:** audited specialists to determine if they have incorrectly claimed Medicare benefits for services related to Assisted Reproductive Technology) treatment cycles.
- **Pathology services:** carried out an end-to-end audit of selected approved pathology authorities to ensure that pathology tests/services requested were the tests performed and claimed by the approved pathology practitioner.
- **Diagnostic imaging:** audited computed tomography and/or diagnostic radiology services to ensure that the services requested were performed and claimed by the billing practitioner.

Incentive programs

- **Practice Incentives Program and Practice Nurse Incentive Program:** activities in 2015-16 focused on redrafting of the guidelines for the programs to provide increased clarity for practices and better support for future compliance activity.

Child Dental Benefit Schedule (CDBS)

- **Targeted audits:** identified dental practitioners for audit through analysis of CDBS claims data to ensure all requirements for payment of benefits had been met.
- **Education:** provided education material to all dental practitioners eligible to claim under the CDBS.
- **Voluntary acknowledgements:** processed repayments of debts from incorrect claiming that were acknowledged voluntarily by dental practitioners.
- **Monitoring:** reviewed the claims data of all dental practitioners who provided services under the CDBS.

Practitioner Review Program

The Department monitors Medicare claims to identify medical practitioners whose servicing or ordering of tests, or prescribing under the PBS, appears abnormal when compared with their peers. Whilst this may reflect the nature of the practice, it may also indicate inappropriate practice. When the Department has concerns about a practitioner's Medicare claims the practitioner is reviewed under the Department's Practitioner Review Program. At interview with one of the Department's health professional advisers, the practitioner is provided with an opportunity to explain why their profile is different to that of their peers. If concerns remain, including after a possible period of review, the Department may request the Director of

Professional Services Review (PSR) to review the practitioner's provision of services.

During 2015-16, 80 such requests were made to the Director of PSR.

During 2015-16, issues discussed during practitioner interviews included, but were not limited to:

- daily servicing;
- prescribing of drugs of addiction under the PBS; and
- initiation of pathology or diagnostic imaging.

During 2015-16, 472 practitioners were interviewed by professional advisers.

Under the *Health Insurance Act 1973* (the Act) general practitioners or other medical practitioners who render 80 or more professional attendances on 20 or more days in a 12 month period (a prescribed pattern of services) are deemed to have engaged in inappropriate practice (the 80/20 rule) and must be reviewed by the Director of PSR. During 2015-16, the Director of PSR was requested to review the provision of services of five practitioners who breached the 80/20 rule.

Practitioners identified as approaching the 80/20 service level without yet breaching the rule were reminded of their obligations by letter, or at a Practitioner Review Program interview. During 2015-16, 77 practitioners were advised in writing to review their Medicare servicing levels.

Internal reviews

In 2015-16, the Department completed 69 reviews of decisions, including 44 legislative reviews and 25 administrative reviews. The original decision was upheld in approximately 39 per cent of cases. Of those cases where the original decision was varied or revoked, 85 per cent involved consideration of new evidence.

Table 2: Health internal reviews

	2015-16	2014-15	2013-14
Allied health providers	4	6	12
Pharmacies	1	1	0
Dentists	6	2	2
General practitioners and specialists	39	42	9
Incentive payments	19	12	3
Total	69	63	26

Debts

Health programs debt

In 2015-16, the Department worked with the Department of Human Services to raise debts of more than $18.6 million in incorrect MBS and other health support payments. This was through:

- identifying recoverable amounts from audits and investigations;
- practitioners acknowledging incorrect billing at a Practitioner Review Program interview or during an audit;
- payment orders resulting from successful prosecutions or from determinations under the Professional Services Review scheme; and
- penalties, including civil, criminal and administrative.

Table 3: Debts raised for recovery of benefits incorrectly paid

Program	2015-16		2014-15		2013-14	
	Number	$ million	Number	$ million	Number	$ million
Medicare Benefits Schedule	1,924	16.3	1,760	61.4	970	9.8
Pharmaceutical Benefits Scheme	222	1.6	211	1.2	146	0.7
Health support programs	39	0.74	39	1.3	35	0.2
Total	2,185	18.6	2,010	64.0[110]	1,151	10.7

Fraud

Fraud investigations

The Department investigates fraud and refers matters to the Commonwealth Director of Public Prosecutions (CDPP) where appropriate relating to PBS, MBS, and other Health support programs. The Department's fraud control processes are deliberately focused on the most serious cases of non-compliance, not on people making honest mistakes.

In 2015-16, the Department conducted 190 investigations into fraud compared to 169 investigations in 2014-15.

[110] Total has been rounded to the nearest decimal point.

Tip-offs

In February 2016, the Department launched the Health Provider Compliance Hotline. Previously tip-offs associated with claiming by health providers were managed through the Australian Government Fraud Tip-off Line in the Department of Human Services. Since February 2016, the Department has received approximately 850 tip-offs from members of the public and health providers about potential provider non-compliance or fraud. Tip-offs can be lodged by:

- telephoning the Provider Compliance Hotline on 1800 314 808;
- email at health.provider.compliance@health.gov.au; and
- web form under the 'reporting suspected fraud' quick link on the home page of the Department's website: www.health.gov.au

Referrals

Medicare Participation Review Committees

Medicare Participation Review Committees (MPRCs) are independent statutory committees established on a case-by-case basis under Part VB of the *Health Insurance Act 1973.* They make determinations about whether to disqualify practitioners from participating in the Medicare program for a period up to five years.

Practitioners are referred to MPRCs following: the making of pecuniary penalty orders in respect of civil contraventions of the legislation; the commission of relevant criminal offences; or, breaches of a pathology undertaking. No practitioners were referred to MPRCs in 2015-16.

Table 4: Cases referred to MPRCs

	2015-16	2014-15	2013-14[111]
Open matters at start of year	0	1	7
Matters referred	0	0	0
Determinations finalised	0	1	6
Open matters at end of year	0	0	1
Hearings conducted	0	0	6

Commonwealth Director of Public Prosecutions

The Department and the Commonwealth Director of Public Prosecutions (CDPP) continued to work together to respond to fraud against health programs. The Department detects and investigates potential fraud and refers matters involving criminal offences relating to the MBS, PBS, or other related Health support programs to the CDPP, which decides whether to prosecute in line with the Prosecution Policy of the Commonwealth.

In 2015-16, the Department referred 35 matters to the CDPP including:

- 3 matters relating to health professionals;
- 1 matter relating to pharmacists; and

[111] Since December 2013, practitioners who have been referred to the Director of Professional Services Review on two or more occasions are no longer referred to MPRCs.

- 31[112] matters relating to corporate entities/employers, employees (such as receptionists), or their associates.

This compares to 94 such matters referred to the CDPP in 2014-15.

- 46[113] cases had a successful prosecution outcome during 2015-16. These outcomes included:
  - 36 reparation orders for the repayment of $1,462,706 in funds;
  - 12 custodial sentences ranging from one month to three years;
  - 24 orders relating to good behaviour and community service; and
  - 10 fines issued by the court.

[112] This includes two matters that were referred to the CDPP prior to Machinery of Government changes that have since been referred to the Department of Human Services, Business Integrity Branch for management.

[113] This includes eight public fraud matters that were finalised by the CDPP prior to Machinery of Government changes.