Senate Standing Committee on Community Affairs

BUDGET ESTIMATES - 2 JUNE 2011
ANSWER TO QUESTION ON NOTICE

Human Services Portfolio

Topic: Medicare – Fraud Prevention / Protection

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Senator: Fifield
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Question:

a) **Senator FIFIELD:** How much did Medicare spend on fraud prevention and fraud detection in the financial year to date?

Mr Bridge: I do not have the exact figure with me, so I will take it on notice. Medicare spends around $30 million per annum on its compliance program, which includes fraud investigations, our reviews for the PSR and our general audit programs. That has been fairly consistent for a number of years.

Senator FIFIELD: Similar amounts in previous years. How many staff are directly deployed on those roles at the moment in Medicare?

Mr Bridge: Again, that is around 300.

Senator FIFIELD: How many cases of fraud have been detected in the year to date?

Mr Bridge: By way of explanation, there is fraud in the criminal sense and more directly in incorrect claims. By far the majority of the work that we do is around the incorrect claims rather than outright criminal fraud. In the programs we undertake we tend to find very small instances of outright criminal fraud, which is largely due to the nature of the programs and how they work together. On average, we would take on board around 3,500 cases per annum. That is the both the professional services review beforehand and general audit cases.

b) **Senator FIFIELD:** How many of those would you deem to be fraud as opposed to errors?

Mr Bridge: The number varies dramatically all the time. I can take on notice the actual number of cases out of the work to date and our actual audits. For example, I can give you the 2009-10 figure.

Senator FIFIELD: Thank you.

c) **Mr Bridge:** It was 3,594 across all of our programs. That includes health professionals, pharmacists and members of the public. That is the number audited. In those different groups there are different levels of the number of cases where we have found incorrect claims. I can give you a detailed breakdown of that on notice.

Senator FIFIELD: On notice is fine. How many successful prosecutions of fraud have there been?

Mr Bridge: Again, it is a very small number. For the 2010-11 year to date it is 10, of which nine were members of the public and one was a medical professional.

d) **Senator FIFIELD:** How many tip-offs has Medicare received year to date in relation to fraud?

Mr Bridge: It is around 2,500. Again, that number is reasonably steady over the years.

Senator FIFIELD: Can you break those up between medical professionals and customers?

Mr Bridge: I will take that on notice.

Senator FIFIELD: Of those 2,500 tip-offs, how many ended up being substantiated?

Mr Bridge: Again, that 2,500 is all forms of tip-offs that we might get, so it could be potential PSR cases, as we said before, and fraud investigations. I will take that on notice to give you actual detailed data around the numbers.

Answer:

a) Medicare Australia's compliance program includes investigations of potential fraud as well as audits of incorrect claiming and inappropriate practice. In the 2010–11 financial year (as at 30 April 2011), the total operational costs of the compliance program at Medicare Australia was $32.36 million. Medicare Australia is not able to provide a breakdown of the operational costs directly associated with fraud activities.

b) In the 2009–10 financial year, Medicare Australia completed 3,594 audits and review cases. Of these, eight were referred to the Commonwealth Director of Public Prosecutions for criminal prosecution in relation to potential fraud.

This financial year (as at 30 April 2011), Medicare Australia has completed 1,933 audits and review cases. Of these, 18 were referred to the Commonwealth Director of Public Prosecutions for criminal prosecution in relation to potential fraud.

The 1,933 figure refers to audits and review cases completed of the Medicare Benefits Schedule, the Pharmaceutical Benefits Scheme, Health Support Programs, Aged Care and members of the public.

c) In the 2009–10 financial year Medicare Australia completed 3,594 audits and review cases, of which 619 were found to have claimed Medicare benefits incorrectly. The below table shows a detailed breakdown of this by group:

Audited group	Number Audited	Individuals/entities for the recovery of benefits incorrectly paid
Medical practitioners	**2,365**	**477**
Pharmacies / pharmacists	**273**	**100**
Patients / members of the public	**468**	**25**
Practice Incentive Program recipients, medical practices and other	**488**	**17**
Total	**3,594**	**619**

d) For this financial year (as at 30 April 2011), Medicare Australia had received 2,445 tip-offs and referrals.

Tip-offs and referrals can be received through a variety of channels by telephoning the Australian Government Services Fraud Tip-Off Line or online though the Medicare Australia website. Medicare Australia also receives tip-offs about potential fraud cases via fax, mail and email.

Of those tip-offs and referrals, 1,782 were identified for further investigation.

Medicare Australia is not able to provide how many of these were substantiated or a breakdown of this figure between health professionals and members of the public.