Senate Standing Committee on Finance and Public Administration

BUDGET ESTIMATES – 27 MAY 2010
ANSWER TO QUESTION ON NOTICE

Human Services Portfolio

Topic: Fraud detection

Question reference number: HS57

Senator: FIFIELD
Type of question: Written
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Question:

a) Could you advise on what measures are in place to detect fraud?

b) Has Medicare initiated legal action or referred matters to law enforcement agencies relating to fraud allegations?
- Of any of those matters referred, how many have led to legal action or criminal proceedings?
- How many cases of fraud were detected or suspected and/or referred in 2007 or 2007-08 and in 2008 or in 2008-09 (calendar or financial years)?

c) How many staff are directly engaged in compliance and fraud prevention and or/detection?
- How many were employed in that area in 2007?

Answer:

a) Medicare Australia uses a sophisticated range of data mining and analysis techniques to detect and identify fraud and non-compliance within the programs it administers. These techniques include the use of artificial intelligence to identify concerns and regular data reviews looking for anomalous claiming behaviour and patterns.

Activities to detect non-compliance within programs administered by Medicare Australia include:

- assessing tip-offs and referrals from members of the public, Medicare Australia staff, and other government departments and agencies;
- monitoring the practice profiles of providers and suppliers to identify abnormal claiming;
- monitoring Medicare Benefits Schedule claiming for unusual trends or patterns and reviewing providers who rank within the top 100 claimants of key items;

- monitoring unusual growth in a Medicare Benefits Schedule item to identify providers with high or unusual claiming of that item;
- monitoring claiming against Pharmaceutical Benefits Scheme items to identify unusual trends by individuals obtaining Pharmaceutical Benefits Scheme items;
- mapping relationships and transactions between patients and providers to identify unusual patterns or trends; and
- developing patterns and profiles from previous cases and results.

Medicare Australia also operates the Government Fraud Tip-off Line – 13 15 24. This service allows providers and the general public to report suspected activities that could compromise the integrity of the programs administered by Medicare Australia.

Each call is processed and assessed by a compliance officer and where appropriate referred for compliance action.

b) Medicare Australia has a responsibility to protect the integrity of programs it administers. For those individuals who deliberately seek to exploit these programs, Medicare Australia will undertake formal investigations and, where appropriate, refer cases to the Commonwealth Director of Public Prosecutions.

A breakdown of investigation cases, referrals to the Commonwealth Director of Public Prosecutions, and completed prosecution cases for the 2007-08, 2008-09 and 2009-10 financial years is as follows:

Financial Year	Referrals to CDPP	Prosecutions
2007-08	74	51
2008-09	32	48
2009-10 FYTD*	6	11

*As at 31 May 2010

During the 2008–09 financial year, Medicare Australia moved to a strengthened risk based approach to compliance by focussing on those areas of highest risk. The change in approach means that most low value compliance cases are now resolved by audit processes.

c) The number of staff directly engaged in compliance activities, including fraud prevention and detection for the 2007–08, and 2009–10 financial years are as follows:

Financial Year	Compliance Officers
2007-2008 (1)	199.45 FTE
2009-2010 (2)	250.90 FTE

Notes:
(1) Compliance officer figure for 2007–08 is as at 30 June 2008.
(2) Compliance officer figure for 2009–10 is as at 31 May 2010.