The Senate

Community Affairs Legislation Committee

Compliance audits on Medicare benefits

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42nd Parliament

from 14 May 2009

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Senator Catryna Bilyk	ALP, Tasmania
Senator Mitch Fifield	LP, Victoria
Senator Gary Humphries	LP, Australian Capital Territory

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Senator Mark Furner	ALP, Queensland
Senator Gary Humphries	LP, Australian Capital Territory

Substitute Members for this inquiry

Senator Fifield to replace Senator Bernardi in place of Senator Adams from 10 March to 12 May 2009

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INTRODUCTION

Terms of reference

1.1 On 19 March 2009, on the motion of Senator the Hon Joe Ludwig, Minister for Human Services, the Senate referred the matter of compliance audits on Medicare benefits to the Community Affairs Committee[1] for inquiry and report by 15 May 2009 (extended to 10 June 2009 and later to 17 June 2009). The terms of reference required the Committee to examine:

> 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.

Conduct of the inquiry

1.2 The Committee advertised the inquiry in *The Australian* and on its website. It wrote to many organisations and individuals inviting submissions to the inquiry. The Committee received 25 public submissions which are listed at Appendix 1. The Committee held a public hearing in Canberra on 6 May 2009 and details of the hearing are referred to in Appendix 2. The submissions and Hansard transcript of evidence may be accessed through the Committee's website at http://www.aph.gov.au/senate_ca.

1.3 On 9 April 2009 the Department of Health and Ageing released the Exposure Draft of the Health Insurance Amendment (Compliance) Bill 2009 (the Exposure Draft) and associated Explanatory Material. On 1 May 2009 the Privacy Impact Assessment *Ensuing the Integrity of Medicare: Increased MBS Compliance Audits* was also released. To allow sufficient time for submitters to provide additional comments regarding the Privacy Impact Assessment (PIA), the reporting date of the inquiry was extended. The Exposure Draft is attached at Appendix 3 and the PIA is attached at Appendix 4.

Acknowledgments

1.4 The Committee acknowledges and thanks all those who assisted with its inquiry, by making submissions, attending hearings and giving evidence, providing additional information and other forms of assistance.

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1 Following the restructuring of Senate Committees on 13 May 2009, the inquiry was continued by the Senate Community Affairs Legislation Committee.

Background

1.5 Compliance audits of Medicare services are checks conducted by administrative staff of Medicare Australia to confirm that a medical practitioner was eligible to provide a Medicare service, that the service was actually provided and that the service met the requirements of the Medicare item paid in respect of the service. The Explanatory Material to the Exposure Draft note that Medicare audits have been conducted since the program was introduced in 1984 and that there has been little change to Medicare Australia's compliance program in the past decade despite significant expansions of the Medicare scheme.[2]

1.6 As part of the Federal Budget 2008-09, the Commonwealth Government announced the Increased MBS Compliance Audit Initiative (the Initiative), a plan to enhance the compliance program of Medicare benefits by Medicare Australia. The Minister for Health and Ageing, the Hon Nicola Roxon MP and the Minister for Human Services, Senator the Hon Joe Ludwig indicated that under the Initiative Medicare Australia will increase the number of audits from 500 to 2500 each year on practitioners who provide Medicare-eligible services to ensure that doctors are fulfilling the requirements of relevant MBS item descriptors.[3] The Explanatory Material note that the increase in audits, which do not require legislative amendment, started on 1 January 2009 and are expected to cover around 3.2 per cent of the practitioner population.[4]

1.7 The other announced measures were 'increasing the powers of Medicare Australia to compel doctors to produce evidence when asked to substantiate their Medicare billing' and changes to 'impose sanctions on practitioners who are billing inappropriately, but whose practice does not warrant referral to the Professional Services Review or for criminal investigation'.[5] The Exposure Draft outlines the proposed legislative amendments to the *Health Insurance Act 1973* in these two areas: provisions to enable the Chief Executive Officer (CEO) of Medicare Australia to give notices to a practitioner (or another person) to produce documents relating to Medicare benefit; and provisions to establish administrative penalties to be imposed on a practitioner in certain circumstances.

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2 Explanatory Material, pp. 5-8.

3 Minister for Health and Ageing, the Hon Nicola Roxon MP and the Minister for Human Services, Senator the Hon Joe Ludwig, 'Ensuring the Integrity of Medicare: Increased MBS Compliance Audits', *Media Release*, 13 May 2008, p. 1.

4 Explanatory Material, p. 5.

5 Minister for Health and Ageing, the Hon Nicola Roxon MP and the Minister for Human Services, Senator the Hon Joe Ludwig, 'Ensuring the Integrity of Medicare: Increased MBS Compliance Audits', *Media Release*, 13 May 2008, p. 1.

1.8 The implementation of the Initiative is estimated to provide savings of $147.2 million over four years and will cost $76.9 million to administer, leading to net savings of $70.3 million over four years.[6]

Key Provisions of the Exposure Draft

Notice to produce documents

1.9 If the CEO of Medicare Australia has a reasonable concern that an amount paid in respect of a professional service exceeds the amount that should have been paid, he or she may give a notice to produce documents to the practitioner who rendered the service. If the CEO believes on reasonable grounds that another person has custody, control or possession of documents relevant to ascertaining whether the amount paid in respect of the professional service should have been paid, a notice may be given to that person.

1.10 The notice to produce documents must include: the item number of each service specified in the notice; the date each service was rendered; the Medicare number of the patient for each service; the reason(s) for the CEO's concern; how the documents can be produced; and the period within which and the place at which the documents can be produced. The period within which the document can be produced must be at least 21 days after the day the notice is given.[7]

1.11 The Medicare Australia CEO may inspect, copy and retain documents produced under a notice 'for such a reasonable period as he or she thinks fit'. The Explanatory Material note that the authority to require a person to produce documents includes the power to require the production of documents containing health information about an individual. In some circumstances, practitioners will be required to produce documents, or extracts of documents, which contain clinical information about a patient to substantiate a Medicare benefit paid in respect of a professional service. However the Explanatory Material also note that clinical information will only need to be provided if that information is necessary to verify that a payment was properly made.[8]

1.12 If the practitioner who rendered the service fails to comply with the notice within the set period the amount paid is recoverable as a debt due to the Commonwealth from that person. If the practitioner complies with a notice to produce a document in respect of a service but the information in the document does not substantiate the Medicare benefit amount paid in respect of the service, the amount which cannot be substantiated is recoverable as a debt due to the Commonwealth from the practitioner.[9]

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6 Explanatory Material, p. 5.

7 Explanatory Material, pp. 17-18.

8 Explanatory Material, p. 19.

9 Explanatory Material, pp. 22-24.

Administrative penalty

1.13 Under the proposed changes a person may be liable for an administrative penalty of 20 per cent if the Medicare Australia CEO serves a notice on the person for an amount as debt due to the Commonwealth and the total amount is $2,500 or higher.

1.14 The proposed changes provide that this base penalty amount may be reduced in certain circumstances. If a practitioner voluntarily admits that an incorrect amount has been paid in respect of a professional service prior to being contacted by Medicare Australia, there is a 100 per cent reduction in the penalty. If a practitioner admits that an incorrect amount has been paid in respect of the service before a notice to produce documents is issued, the penalty is reduced by 50 per cent. If a practitioner admits that an incorrect amount has been paid in respect of the service after they have received a notice to produce but before the audit is completed, the base penalty amount is reduced by 25 per cent.[10]

1.15 The proposed changes provide that the base penalty amount may also be increased in certain circumstances. If a practitioner does not produce any documents relating to any of the services specified in a notice to produce, the full amount of the services identified in the notice become repayable and the base penalty amount is increased by 25 per cent. If a practitioner in the previous 24 months has been unable to substantiate an amount paid in respect of services specified in a notice to produce documents under the proposed changes and the total they repaid was more than $30,000, the penalty which is being recovered is increased by 50 per cent.[11]

Privacy Impact Assessment

1.16 A PIA is an analysis of the personal information flows and potential privacy risks and impacts of a project. The flow of personal information is evaluated against the Information Privacy Principles (IPPs) in section 14 of the *Privacy Act 1988* which governs the manner in which personal information is handled within government agencies.

1.17 The PIA released by the Department of Health and Ageing focused on the proposed changes allowing Medicare Australia to give a notice to produce documents to persons to substantiate a Medicare benefit and made a number of recommendations. Medicare Australia has subsequently advised the Committee that it accepts and will adopt each of the recommendations made in the PIA.[12] The recommendations were:

10 Explanatory Material, pp. 31-32.

11 Explanatory Material, p. 33.

12 Medicare Australia, *Supplementary submission dated 26 May 2009*, p. 19.

Recommendation 1

The PIA should continue to be updated throughout the implementation and ongoing management of the IMCA [Increased Medicare Compliance Audits] initiative.

Recommendation 2

An information campaign for the public on the need for Medicare compliance audits and the potential for their clinical information to be accessed to confirm payment accuracy should be considered. Alternatively Medicare Australia should explore what information it can make available to patients (on new or existing forms, or through new or existing channels) on the potential for excerpts from their medical records to be provided to Medicare Australia during compliance audits.

Recommendation 3

Audits of internal Medicare Australia staff accessing information collected during a compliance audit should be undertaken by Medicare Australia on a regular basis, to ensure early detection of inappropriate access and potential misuse of data.

Recommendation 4

The notice to produce documents given by Medicare Australia to the practitioner should clearly state that the information being collected may only be used for the purposes of the compliance audit. The notice should also note any secondary purpose the information may be used for as required or authorised by or under law, such as in relation to offences under the HIA [*Health Insurance Act 1973*] or *Criminal Code Act 1995* relating to false and misleading statements made in respect of Medicare services (IPP 10.1(c) 'use of the information for that other purpose is required or authorised by or under law').

Recommendation 5

Details on what constitutes an authorised disclosure of health information collected as part of a compliance audit should be made clear and accessible to the public.

Recommendation 6

To increase compliance with the openness and transparency requirements of privacy best practice, Medicare Australia should review the information available on its website about the type of personal information held by Medicare Australia and the purpose for which that information is held.

Recommendation 7

Medicare Australia and the Department of Health and Ageing should use existing relationships with peak practitioner groups, health consumer and privacy groups to review and, if appropriate, change their accreditation requirements and Privacy Policies in relation to notices displayed in practices.

Recommendation 8

To provide clarity and transparency, Medicare Australia should establish and publish a clear set of guidelines covering the relevant retention and destruction policies relating to documents collected through the proposed legislation.

Recommendation 9

Audits of the records management of health information should be undertaken, to ensure compliance with retention and destruction guidelines and policies.

Recommendation 10

Consideration should be given to reporting on the frequency and nature of Medicare Australia's access to clinical notes and reviewing the initiative after implementation, including a privacy audit to assess the privacy impacts, once the new procedures have been operational for a period of time.[13]

ISSUES

Privacy and the doctor/ patient relationship

1.18 Many medical and other groups noted their concern that because of the proposed changes patients will withhold information from doctors if there is a possibility their personal health information could be provided to third parties other than for medical care.[14] For example the Australian Medical Association stated:

> If patients' know their personal health information could be viewed by Medicare Australia officers this could well be a barrier to patients telling doctors everything they need to know in order to provide the best quality care. This will have profound consequences for individuals and for health across the country.[15]

1.19 A number of submitters highlighted that patient clinical records often contained personal information of a highly sensitive nature, sometimes relating to other persons.[16] The Australian Society for HIV Medicine stressed the importance of confidentiality in the doctor/patient relationship, and noted that the consultations doctors have with patients '…often contain information that is extremely intimate and personal concerning sexual behaviour, emotional feelings and sexuality'. They stated:

> Patients may not disclose sensitive or confidential information about their sexual life if that information can be released to a third party without their

13 Department of Health and Ageing, *Privacy Impact Assessment, 2008-09 Budget Initiative, Ensuring the Integrity of Medicare: Increased MBS Compliance Audits*, 28 April 2009.

14 For example Australian Medical Association, *Submission* 11, pp. 2 & 5.

15 Australian Medical Association, *Submission* 11, p. 10.

16 For example Office of the Privacy Commissioner, *Submission* 20, p. 9.

> permission. Many patients insist on checking first that their information will remain confidential…Does this mean that we must warn patients that anything they say may be read by a non-medical third party in the future to check that a doctor has claimed the appropriate Medicare benefit?[17]

1.20 In the area of mental health several professional and consumer groups emphasised the importance of the confidentiality of patient medical records.[18] In particular, they noted that the development of an ongoing trusting therapeutic relationship between the practitioner and the patient in the mental health sector made the confidentiality of clinical records vital. The Royal Australian and New Zealand College of Psychiatrists stated:

> Breaches of this confidentiality produce particularly serious consequences for the psychiatrically impaired, due to the widespread and pernicious stigma accorded to mental illness, and the particular vulnerability of psychiatric patients due to their conditions. Under these circumstances, a breach of confidentiality can be extremely traumatising, and potentially devastating.[19]

1.21 The Office of the Privacy Commissioner suggested further clarification was needed to the proposed changes to give providers a clearer understanding of whether they were required to produce clinical records and to prevent requests for clinical records when other information is sufficient.[20] The Office of the Privacy Commissioner made a number of suggestions to improve the protection of patient privacy. These included:

- a tailored approach to Medicare items and information considered particularly sensitive, such as, records dealing with HIV status, mental health, reproductive and sexual health issues;
- that Medicare Australia consider the cost and practicality of broadening of role of the medical advisors in handling clinical information obtained during audits;
- further investigation be made into using de-identified information to minimise the association of names and medical details;
- reporting and review requirements for Medicare Australia on aspects of the initiative, such as the proportion of audits which collect clinical records and the additional amount of public saving achieved. [21]

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17 Australian Society of HIV Medicine, *Submission* 6, p. 2.

18 Australian Psychological Society, *Submission* 8, p. 2; Royal Australian and New Zealand College of Psychiatrists, *Submission* 13, p. 4; Private Mental Health Consumer Carer Network, *Submission* 14, p. 1.

19 Royal Australian and New Zealand College of Psychiatrists, *Submission* 13, p. 4.

20 Office of the Privacy Commissioner, *Submission* 20, p. 9.

21 Office of the Privacy Commissioner, *Submission* 20, pp. 13 -14.

1.22 Similarly the Public Interest Advocacy Centre recommended that: accessing patient records should not become a routine part of every compliance audit; the process should be multi-stage to ensure a separate decision is made in order to access clinical information; personal information should be de-identified if possible; patients should be notified regarding access to their records as early as possible; and if a patient objects to access to their records, the decision to access records should be subject to an internal review.[22]

1.23 Medicare Australia responded that their audits were multi-step processes and highlighted a diagram setting out the stages of the proposed compliance audit process.[23] However the audit process as outlined by Medicare Australia does not create separate steps for access to patient clinical records as opposed to other administrative records. It is left to providers to decide which records will substantiate a Medicare claim.[24]

1.24 Medicare Australia also highlighted problems with the efficacy of de-identifying patient records. They noted:

> Medicare Australia needs to confirm a specific service that a specific patient has received… a provider already identifies the patient and the MBS service they have received as part of the claiming process… In conducting an audit Medicare Australia therefore does not generally divulge any more information than has already been provided through the MBS claim.[25]

Access to clinical records and substantiation of claims

1.25 Some submitters and witnesses were concerned that there was little clarity regarding the threshold circumstances for the CEO of Medicare Australia to issue notices to produce documents under the proposed legislation.[26] Under the Exposure Draft the Medicare Australia CEO must have a 'reasonable concern' that an amount paid, in respect of a professional service may exceed the amount that should have been paid before a notice may be issued. The Department of Health and Ageing indicated that the term 'reasonable concern' had been used in designing the proposed legislation in order to provide a degree of flexibility. Ms Samantha Robertson of the Department of Health and Ageing stated:

> I think it is very hard for us to be able to define what is a reasonable concern. The reasonable concern is actually going to be very different depending on the type of audit that is undertaken… The more you get into defining what is a reasonable concern, the more you might lock things

22 Public Interest Advocacy Centre, *Submission* 19, p. 8.

23 Medicare Australia, *Supplementary submission dated 26 May 2009*, p. 16.

24 Medicare Australia, *Submission* 16, p. 22.

25 Medicare Australia, *Supplementary submission dated 26 May 2009*, p. 10.

26 For example Mr William Rowlings, Civil Liberties Australia, *Proof Committee Hansard*, 6 May 2009, p. 16.

> down to have unintended consequences and a concern that is quite genuine but outside the definition.[27]

1.26 Many groups were concerned about what information would be considered sufficient to substantiate a claim and how this would affect the confidentiality of patient clinical records. For example the Australian Psychological Society questioned the 'lack of clear guidelines outlining what constitutes substantiating information…'. The Society highlighted that the proposed scheme places the onus of proof wholly on providers to demonstrate they have not defrauded and the judgement as to what is a substantiated claim rests entirely with Medicare Australia. They noted that practitioners, concerned about under-substantiating claims, may be driven 'to produce excessive information, including sensitive, private and confidential information'.[28] Furthermore they argued that the changes treated practitioners as a homogenous group when there was 'variation and complexity between provider groups' and '…subsequent variations in clinical records produced by this diversity'.[29]

1.27 The Medical Indemnity Industry Association of Australia (MIIAA) was also concerned with the lack of any requirement that Medicare Australia specify the documents or the classes of documents sought in the notice. They submitted that '…the exercise of coercive powers in such a vague and unspecified manner is unfair to the recipient of the notice…'.[30]

1.28 The Department of Health and Ageing stressed there was no power to compel the release of clinical records to Medicare Australia in the proposed changes and emphasised it was left to the person given the notice to determine what sort of information was available to substantiate a Medicare claim. They noted that documents have not been specified in order to make it as easy as possible for providers to comply with notices. The Department also stated that specifying the different kinds of information and documents that a practitioner might use to substantiate a Medicare benefit paid in respect of a service, would create additional red tape for practitioners.[31]

1.29 The Australian Medical Association argued that in the majority of cases compliance audits will require the production of patient clinical records in order to substantiate a Medicare claim, rather than other administrative records held by a practitioner. In particular, Dr Rosanna Capolingua, President of the Australian Medical Association highlighted that some administrative records, such as the

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27 Ms Samantha Robertson, Department of Health and Ageing, *Proof Committee Hansard*, 6 May 2009, pp.101-102.

28 Australian Psychological Society, *Submission 8*, p. 3.

29 Australian Psychological Society, *Supplementary submission 29 May 2009*, p. 2.

30 Medical Indemnity Industry Association of Australia, *Submission 4*, p. 5.

31 Department of Health and Ageing, *Submission* 21, p. 12.

appointment book or diary of a medical practice, would not reflect the patients actually seen by a practitioner as these records are not amended retrospectively.[32]

1.30 The Royal Australian and New Zealand College of Psychiatrists noted there needed to be a balance between Medicare requirements, practitioners' requirements for medical records, and the patient's need for confidentiality. They were concerned that there is no consensus as to what are considered appropriate clinical notes and recommended clearer guidelines should be developed on how to meet record making requirements.[33]

1.31 Medicare Australia stated that the proposal does not introduce any new record making or retention requirement but that providers are already under 'legal, professional and other obligations to keep and retain records relating to the treatment of patients...'. They argued that the proposed changes would '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'. It noted that Medicare Australia's ability to access documents will still be less comprehensive than Centrelink or the Australian Tax Office because they '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'.[34]

1.32 Medicare Australia highlighted that the proposed changes did not provide any additional power to seize documents. Ms Philippa Godwin, Acting Chief Executive Officer of Medicare Australia, stated:

> The measure before us would give us an additional power such that, if during that process of voluntary engagement there has still not been adequate substantiation—and that is effectively what we are talking about: a substantiation power—then the proposed legislation would enable us to issue a notice asking for documents that go to substantiation. If the practitioner refuses to supply those documents, there is no further power in the legislation that enables us to go in and seize documents.[35]

1.33 However, should a practitioner choose not to comply with a notice to produce documents substantiating a claim, the claim is disallowed and becomes a debt to the Commonwealth, and may attract an administrative penalty if it is over the threshold of $2,500.[36]

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32 Dr Rosanna Capolingua, Australian Medical Association, *Proof Committee Hansard*, 6 May 2009, p. 70.

33 Royal Australian and New Zealand College of Psychiatrists, *Submission* 13, pp. 6-7.

34 Medicare Australia, *Submission* 16, pp. 20-21.

35 Ms Philippa Godwin, Medicare Australia, *Proof Committee Hansard*, 6 May 2009, p. 92.

36 Medicare Australia, *Submission* 16, p. 22.

Patient notification and consent

1.34 A number of medical organisations raised their concerns that the proposed changes would alter existing guidelines that medical practitioners were not permitted to disclose patient records without seeking the patient's approval. The Royal Australian College of General Practitioners noted that current guidelines required medical practitioners dealing with patient health information to treat the consent of the patient as the guiding principle.[37] The Royal College of Pathologists of Australia also noted:

> …[the change proposed] represents a significant departure from the way patient information has been managed to date and would be a cause for alarm for many patients.[38]

1.35 Others argued that patient consent should be required before clinical records are released for the purposes of a compliance audit. The Australian Medical Association argued that Medicare Australia should be responsible for obtaining patient consent for medical records to be provided and that this should be 'both broadly through public information campaigns that also explain why it is necessary to see medical records as well as contemporaneously from individual patients whose doctors are the subject of audits'.[39]

1.36 Some witnesses and submitters argued that patients had a right to be notified that some or all of their clinical records were being provided to Medicare Australia as part of a compliance audit. The Royal Australian and New Zealand College of Psychiatrists, while recognising that notification may risk the special relationship between patients and psychiatrists, believed that on balance 'patients have a right to know that their file is being accessed'. However they recommended that precautions be put in place to limit the release of sensitive confidential information and that guidelines be developed on how to inform patients of psychiatrists when their records are accessed.[40]

1.37 Similarly the Private Mental Health Consumer Carer Network also was of the view 'that all Australians have the right to be informed of any access of their clinical records'. It recommended that Medicare Australia and peak mental health groups should 'develop clear protocols around the best way of conveying this information to patients in a manner which continues to the retention of the therapeutic relationship'.[41]

1.38 The Public Interest Advocacy Centre recognised that there were situations where it would be problematic to advise patients that their records had been accessed

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37 Royal Australian College of General Practitioners, *Submission* 22, p. 5.

38 Royal College of Pathologists of Australia, *Submission* 10, p. 1.

39 Australian Medical Association, *Submission* 11, p. 11.

40 Royal Australian and New Zealand College of Psychiatrists, *Submission* 13, p. 5.

41 Private Mental Health Consumers Carer Network, *Submission* 14, p. 3.

for audit purposes, but submitted that, in the normal course of events, all patients should be notified. However they did not support the proposition that patient consent should be required before access was allowed for an audit. The Centre noted there would be practical difficulties with contacting patients and requests for consent could cause distress to patients, particularly those with disabilities or the elderly. They also stated:

> …there is a real danger that if unscrupulous health professionals were aware that an audit could not go ahead if there was not consent to patient access, then they may well apply pressure on patients not to consent.[42]

1.39 Medicare Australia advised that careful consideration had been given to the issue of patient notification. From their experience with the seizure of clinical records in criminal investigations they believed that proposed legislation should not contain a patient notification requirement. They stated:

> 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.
>
> 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.[43]

1.40 The Department of Health and Ageing acknowledged that the issue of patient notification and consent was complex but they had taken into account the significant potential risks to patient privacy of notification and undermining the doctor/patient relationship. However the Department also noted there were mixed views on this issue and the proposed changes did not prevent a practitioner from informing individual patients that information from their medical record has been provided to Medicare Australia during a compliance audit.[44]

Medicare Australia staff and processes

1.41 A number of witnesses and submitters considered that Medicare Australia staff were not suitably qualified to interpret clinical records provided during a compliance audit. For example the Medical Indemnity Industry Association of Australia believed that administrators without medical qualifications would be called

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42 Public Interest Advocacy Centre, *Submission* 19, p. 7.

43 Medicare Australia, *Submission* 16, p. 25.

44 Department of Health and Ageing, *Submission* 21, p. 12; Mr David Learmonth, Department of Health and Ageing, *Proof Committee Hansard*, 6 May 2009, p. 110.

to make determinations which 'clearly require medical expertise and experience'. They did not agree with the statement in the Explanatory Material that the question of whether the service the practitioner provided met the requirements of the Medicare item was 'a question of fact which does not require any clinical assessment of the service'. The Association submitted that:

> …the interpretation of medical records or other records of clinical care should be performed by persons with professional qualifications and experience in the relevant discipline.[45]

1.42 Similarly Dr Roger Clarke of the Australian Privacy Foundation argued a major problem with the proposed scheme was access by people without appropriate qualifications to clinical data which was 'extraordinarily easy to misinterpret'. He stated that when 'there are sufficient grounds for access as part of an audit process then the individual who inspects the record should be a person with appropriate medical qualifications'.[46] The Australian Medical Association also stated that Medicare Australia administrative auditors would not have the insight of a doctor in understanding clinical notes in order to determine whether the requirements of an MBS item had been claimed appropriately.[47]

1.43 However the Department of Health and Ageing reaffirmed the purpose of the initiative was to seek evidence of compliance with the administrative requirements of the MBS in order to claim a particular item, such as preconditions, time and tests. Mr Learmonth of the Department of Health and Ageing stated:

> We are not looking at making professional judgements or clinical judgements; this is about administrative requirements for claiming payments.[48]

1.44 Medicare Australia did not accept the argument that compliance audit staff required medical qualifications. It emphasised that the compliance audits were assessing the facts of a Medicare service and did not involve making clinical judgements. However Medicare Australia also indicated that it employs a range of health professionals who may be accessed by audit staff.[49]

1.45 The capacity of Medicare Australia to protect the confidentiality of patient clinical records was also raised during the inquiry. For example the Australian Privacy Foundation raised concerns regarding how gathered audit information will be stored and secured. They highlighted research which indicated that many staff in

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45 Medical Indemnity Industry Association of Australia, *Submission* 4, p. 4.

46 Dr Roger Clarke, Australian Privacy Foundation, *Proof Committee Hansard*, 6 May 2009, pp. 45- 47.

47 Australian Medical Association, *Submission* 11, p. 6.

48 Mr David Learmonth, Department of Health and Ageing, *Proof Committee Hansard*, 6 May 2009, p. 88.

49 Medicare Australia, *Supplementary submission dated 26 May 2009*, p. 10.

organisations are not adequately trained in handling secure information and can avoid security measures if they interfere with productivity.[50]

1.46 Medicare Australia noted that staff involved in compliance audits are subject to provisions of the *Health Insurance Act 1973* which provides increased protection for information collected by Medicare Australia and includes criminal penalties for those who misuse this information. Medicare Australia also emphasised the expertise and training of staff in relation to Medicare issues, audit techniques and privacy issues.[51]

1.47 The Committee also received information from the Australian Public Service Commissioner, Ms Lynelle Briggs about the privacy protections of the *Public Service Act 1999* which would also apply to Medicare Australia staff. She advised that all Australian Public Service (APS) employees were obliged to follow the APS Values and Code of Conduct. A failure to comply with the *Privacy Act 1988* could be considered a breach of the Code and could result in sanctions including termination of employment, reduction in classification, transfer, reduction in salary or a fine. Ms Briggs also noted that Public Service Regulation 2.1 prohibits APS employees from disclosing information that was received in confidence by the government from a person or persons outside the government. A suspected breach of this regulation could be also investigated under s.70 of the *Crimes Act 1914*.[52]

1.48 Medicare Australia also addressed concerns raised regarding the storage and security of compliance data. It noted that the case management system used is only accessible by compliance officers, that all access is logged and monitored and the system is not connected to the internet. Furthermore it noted that a planned new case management system 'will be specifically designed to meet Commonwealth security and privacy requirements for compliance activities'.[53]

Compliance audits, professional services review and fraud

1.49 Some witnesses and submitters suggested that the proposed compliance audits to be conducted by Medicare Australia unnecessarily duplicated or extended into the jurisdiction of the Professional Services Review (the PSR). The PSR has authority to investigate whether health practitioners have engaged in inappropriate practice when providing Medicare services or when prescribing medication. The PSR Committee consists of medical practitioners and other health practitioners appointed by the Minister for Health after consultation with appropriate professional organisations.

1.50 Civil Liberties Australia questioned the need to duplicate the role of the PSR and highlighted that reviewing medical services is best done by medical practitioners

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50 Australian Privacy Foundation, *Submission* 3, p. 2.

51 Medicare Australia, *Supplementary submission dated 26 May 2009*, pp. 9-10.

52 Australian Public Service Commissioner, *Submission* 24, pp. 1-2.

53 Medicare Australia, *Supplementary submission dated 26 May 2009*, p. 13.

rather than others.[54] Mr William Rowlings of Civil Liberties Australia stated that Medicare Australia was seeking to extend jurisdiction over a compliance area which was the responsibility of the PSR. He suggested the PSR was the appropriate agency to receive additional resources to undertake compliance auditing.[55] The Australian Psychological Society also noted that the most serious concern it had with the Exposure Draft was the blurring of the lines between the proposed compliance audit process and the existing PSR process.[56]

1.51 The Medical Indemnity Industry Association of Australia emphasised that a range of accountability mechanisms already exist for medical professionals. They stated:

> The present mechanisms can and do result in the repayment of incorrectly claimed benefits, findings of inappropriate practice, the reprimand of practitioners and partial or full disqualification of practitioners from the Medicare system for periods of up to 5 years…
>
> Practitioner Review Program and Professional Services Review already operate to provide a comprehensive system to investigate anomalous Medicare billing - including by the examination of patients' medical records. However, such examination of patients' private medical information in these processes is appropriately confined to the professional peers of the person under review.[57]

1.52 The Department of Health and Ageing clarified the differences between the three main areas of risk in relation to Medicare (fraud, inappropriate practice and incorrect Medicare payments) and the relevant compliance approaches to each of these risks.[58] In the case of fraud, where a person seeks to obtain a Medicare benefit by intentionally falsifying facts and/or documents, Medicare Australia has broad powers to investigate. In the case of inappropriate practice, Medicare Australia can refer suspected cases to the PSR.

1.53 The proposed changes are directed to incorrect Medicare payments, when a practitioner makes an unintentional false or misleading statement that results in a Medicare benefit payment being paid incorrectly. The Department emphasised that under the current arrangements Medicare Australia has no power to require a practitioner to cooperate with an audit request. They noted:

> If a practitioner refuses to respond or cooperate voluntarily, Medicare Australia is not able to proceed with the audit and is unable to verify the Medicare benefit amount paid in respect of the service.

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54 Civil Liberties Australia, *Submission* 9, pp. 6-7.

55 Mr William Rowlings, Civil Liberties Australia, *Proof Committee Hansard*, 6 May 2009, p. 15.

56 Australian Psychological Society, *Submission* 8, p. 2.

57 Medical Indemnity Industry Association of Australia, *Submission* 4, p. 3.

58 Department of Health and Ageing, *Submission* 21, pp. 6-8.

1.54 Medicare Australia suggested that several submissions to the inquiry had confused the function of the PSR with the role of compliance audits in identifying incorrect claims. They highlighted that compliance audits were administrative checks and did not relate to clinical appropriateness or professional adequacy.[59]

Complexity and simplification

1.55 The complexity of both the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme was raised by a number of witnesses. The Royal Australian College of General Practitioners was concerned the complexity of the MBS increased the likelihood that practitioners will make unavoidable errors when submitting to audits.[60] The Medical Indemnity Industry Association of Australia argued that the Medicare system was highly regulated and had become 'increasingly complex at an alarming rate'. They stated:

> The expanding administrative demands on practitioners and medical practices caused by that complexity have left the individual practitioners increasingly vulnerable to personal liability for any administrative errors in claims made under the practitioner's Medicare provider number.[61]

1.56 Some witnesses and submitters also suggested that the simplification of the MBS and additional investment in the education of practitioners was a better approach to non-compliance than the changes proposed in the Exposure Draft.[62] The Department of Health and Ageing noted that a review looking at simplifying the MBS was under way and their engagement with the medical profession through the Medicare Benefits Consultative Committee. Medicare Australia also referred to a range of education programs it provides in relation to the MBS that are designed to assist practitioners including reference guides and an administrative practice statement.[63]

Impact on practitioners

1.57 The Explanatory Material to the Exposure Draft note that the compliance cost for the new measures was assessed as medium as any Medicare service provided by a health practitioner could be audited.[64] Medicare Australia acknowledged that any form of audit is an impost on the party being audited, but stated efforts were made to

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59 Medicare Australia, *Supplementary submission dated 26 May 2009*, p. 8.

60 Royal Australian College of General Practitioners, *Submission* 22, p. 3.

61 Medical Indemnity Industry Association of Australia, *Submission* 4, p. 3.

62 Dr Karen Flegg, Royal Australian College of General Practitioners, *Proof Committee Hansard*, 6 May 2009, p. 3; Dr Rosanna Capolingua, *Proof Committee Hansard*, 6 May 2009, p. 74.

63 Mr David Learmonth, Department of Health and Ageing, *Proof Committee Hansard*, 6 May 2009, p. 112; Mr Colin Bridge, Medicare Australia, *Proof Committee Hansard*, 6 May 2009, p. 112.

64 Explanatory Materials, p. 4.

ensure the impact on practitioners was as low as possible.[65] They suggested the impact on providers would be marginal with the majority of their compliance activities continuing to be focused on information services, education and training to support providers to complete accurate claims. They stated:

> 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.[66]

1.58 The Department of Health and Ageing also argued there was a targeted approach to auditing the administrative requirements of Medicare items. Mr Learmonth stated:

> We have a very sophisticated way of saying, 'Here we think is significant risk; here are some particular items that we think are a concern'—and we will narrow and limit our scope of attention to those particular items and thus minimise the footprint, if you like, or the impact on the provider… this is really crunched down to the absolute minimum of what is required to substantiate a payment, in a targeted way.[67]

1.59 However some witnesses and submitters suggested the additional administrative burden on practitioners may negatively affect patient outcomes and access to a suitable number of qualified clinicians.[68] Civil Liberties Australia suggested the estimated financial impact of the proposed measures was incorrect as it did not correctly take into account the 'extra costs to be borne by doctors and society' resulting in a 'sub-optimal outcome for Australia'.[69]

1.60 The Australian Medical Association highlighted an example of where a compliance audit was a considerable burden on the time of a practitioner with only minor incorrect claims being discovered. Dr Rosanna Capolingua, President of the Association, questioned the projected savings of the measures:

> The only certainty is that it will cost $76.9 million…. The real net gain is likely to be far less. The projected savings of $147.2 million over four years are, by their own admission, a best guess. The total cost of each audit is $9,600 and each must recoup on average $18,400 to achieve this level of savings.[70]

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65 Mr Colin Bridge, Medicare Australia, *Proof Committee Hansard*, 6 May 2009, p. 99.

66 Medicare Australia, *Submission* 16, p. 12.

67 Mr David Learmonth, Department of Health and Ageing, *Proof Committee Hansard*, 6 May 2009, p. 97.

68 For example Australian Privacy Foundation, *Submission* 3, p. 3.

69 Civil Liberties Australia, *Submission* 9, p. 5.

70 Dr Rosanna Capolingua, Australian Medical Association, *Proof Committee Hansard*, 6 May 2009, pp. 65-66.

1.61 The role of practitioners in de-identifying patient information from records provided to Medicare Australia was also discussed during the inquiry. The Royal Australian College of General Practitioners argued that de-identification of clinical records would be additional burden on practitioners.[71] However Mr Peter Dodd of the Public Interest Advocacy Centre suggested this was a question of balance and noted the additional cost of the process would reduce the potential for patient information being inappropriately disclosed.[72]

Integrity of Medicare

1.62 Medicare Australia and the Department of Health and Ageing highlighted that the size and scope of the Medicare program has undergone significant growth and expansion in the last decade. In 2007-08 expenditure was over $13 billion with 81,224 providers generating nearly 280 million MBS services.[73] New groups of practitioners such as allied health practitioners may now provide Medicare-eligible services.[74]

1.63 The *Health Insurance Act 1973* currently does not provide Medicare Australia with the authority to require practitioners to provide verifying documents during a compliance audit. When a practitioner does not respond or refuses to cooperate with a compliance audit, the process is effectively halted as no further action is able to be taken. Medicare Australia advised that:

> 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.[75]

1.64 In the absence of a requirement for providers to give information to substantiate Medicare payments, Medicare Australia's compliance activities rely on providers volunteering information to demonstrate claims have been made correctly. Medicare Australia noted that 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. They argued this suggested at current levels 'annual non-compliant payments could be around at least $170-300m per annum'.[76] Medicare Australia argued that requiring providers to verify their claims, when there are specific concerns

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71 Dr Karen Flegg, Royal Australian College of General Practitioners, *Proof Committee Hansard*, 6 May 2009, p. 4.

72 Mr Peter Dodd, Public Interest Advocacy Centre, *Proof Committee Hansard*, 6 May 2009, pp. 40 -41.

73 Medicare Australia, *Submission* 16, p. 3.

74 Department of Health and Ageing, *Submission* 21, p. 5.

75 Medicare Australia, *Submission* 16, p. 5.

76 Medicare Australia, *Submission* 16, p. 12.

about the claims, is a reasonable and responsible way of protecting the public revenue. They stated:

> 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.[77]

1.65 Similarly the Department of Health and Ageing argued that the proposed changes were 'concerned with the minority of practitioners who do not take appropriate care when billing Medicare-eligible services and/or do not voluntarily comply with compliance audit requests'. They stated:

> This draft Bill addresses the current weakness in activities designed to address key risks to the integrity of the Medicare scheme by establishing a simple, cost effective administrative mechanism to deal with incorrect Medicare payments which constitute a substantial risk to Medicare expenditure.[78]

1.66 The Australian Health Insurance Association also supported the proposed changes as important to ensuring the integrity of the Medicare system and indicated they would like to see further measures to address inappropriate billing and fraudulent activity within the broader health system. They noted that the detection of inappropriate claiming within the public system can also assist in preventing inappropriate practices in the private sector, enhancing the integrity and affordability of private health cover.[79]

1.67 The Public Interest Advocacy Centre suggested that the proposed changes raise two potentially competing public interest principles. These were the public interest of Medicare consumers in the maintenance and integrity of Australia's universal health scheme and the public interest in the confidentiality of communications in the doctor/patient relationship recorded in the medical records of patients. The Centre concluded that, with some amendments, the proposed changes and the existing privacy protections, 'appropriately balances the public interest in the integrity of Medicare and the public interest in the maintenance of patient confidentiality and privacy of health records'. The Centre stated that the proposed amendment:

> …does not represent a significant change from the long-existing practice that health records can be accessed, in the public interest, in certain controlled circumstances by bodies exercising investigative powers.[80]

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77 Medicare Australia, *Submission* 16, p. 5.

78 Department of Health and Ageing, *Submission* 21, p. 21.

79 Australian Health Insurance Association, *Submission* 15, pp. 1-2.

80 Public Interest Advocacy Centre, *Submission* 19, p. 8.

1.68 However medical and privacy groups argued that the proposed changes were unnecessarily intrusive of patient privacy and disproportionate to the perceived problem of incorrect Medicare claims. For example the Australian Medical Association argued that the costs of the changes proposed were not proportionate with the 'low level concerns Medicare Australia has with the use of the MBS'. The AMA asserted that:

> The cost that this legislation incurs in undermining the trust that patients have in their doctors to maintain the confidentiality of their medical record will result in a fundamental alteration of the community's confidence in the security of their private and personal information and is too high a price to pay….
>
> Public probity concerns to protect government expenditure are important, but in a scale of importance, they rank lower than the protection of personal health information that risks undermining the ongoing health care of individuals.[81]

1.69 Dr Roger Clarke of the Australian Privacy Foundation stated the proposed amendments did not reflect the value that the Australian people place on privacy. He commented:

> It is quite extreme of the agency to be suggesting that all forms of infringement and all forms of suspicions about even accidental overservicing are sufficient to justify substantial invasions of privacy in relation to sensitive data…[82]

1.70 However the Consumers Health Forum of Australia stated that it understood that privacy will not be compromised under the proposed changes and supported the measure. They argued:

> Consumers are fully aware of the need to ensure a sustainable health system that has checks and balances in place. It is entirely in the public interest for the new MBS compliance procedures to be implemented.[83]

Administrative penalty and appeals

1.71 A number of separate issues were raised by submitters and witnesses in relation to the scheme of administrative penalties proposed and the opportunity to appeal decisions.

1.72 The Medical Indemnity Industry Association of Australia argued that the scheme lacked an opportunity for practitioners to dispute decisions by Medicare Australia compliance auditors. Furthermore they argued that any decision 'must be

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81 Australian Medical Association, *Submission* 11, pp. 2 & 5.

82 Mr Roger Clarke, Australian Privacy Foundation, *Proof Committee Hansard*, 6 May 2009, p. 55.

83 Consumers Health Forum of Australia, *Submission* 7, p. 1.

amenable to external merits review' and that the Administrative Appeals Tribunal was the appropriate body to conduct such a review.[84] They also suggested that there should be a further opportunity for practitioners to respond where Medicare Australia proposes to decide there has been non-compliance with a notice to produce. This would be an opportunity for the person who would be adversely affected by such a decision to 'show cause' why such a decision should not be made.[85]

1.73 The Commonwealth Ombudsman, Professor John McMillan also notified the Committee regarding his Office's recent investigation of a case relating to the interpretation of the MBS. He noted that changes in medical practice and terminology will always result in a certain level of uncertainty over what is or is not covered by a particular MBS item and that the compliance process should accommodate the possibilities of genuine confusion, dispute or honest mistake. He recommended the inclusion of an initial written warning to practitioners before any penalty can be imposed and a mechanism by which merits review could be sought regarding the meaning of MBS items and whether a claim has been properly substantiated.[86]

1.74 The Commonwealth Ombudsman also raised concerns with the proposed automatic penalty regime, with reductions which vary depending on when a practitioner advises Medicare Australia an amount has been incorrectly claimed. He suggested this limited 'the resolution of genuine disputes about the meaning of items' and created a disincentive to seeking review of decisions.[87]

1.75 The issue of procedural fairness was also raised by the Australian Medical Association. The Association stated:

> There do not appear to be any provisions in the Bill for a doctor to argue mitigating circumstances before the decision is made, or to seek administrative review of the decision after it is made. As we understand it, the only avenue of recourse the doctor will have is through the Federal Court under the *Administrative Decisions (Judicial Review) Act 1977*. This is a time consuming and expensive process…[88]

1.76 The Office of the Privacy Commissioner emphasised it was important that the administrative penalty for amounts not properly substantiated does not result in practitioners providing additional and unnecessary patient information 'to avoid the possibility of a fine'. They suggested it may be appropriate to include protection for providers who in good faith give Medicare insufficient information and are subsequently required to provide further information to substantiate a claim.[89]

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84 Medical Indemnity Industry Association of Australia, *Submission* 4, p. 5.

85 Medical Indemnity Industry Association of Australia, *Submission* 4, p. 5.

86 Commonwealth Ombudsman, *Submission* 25, p. 2.

87 Commonwealth Ombudsman, *Submission* 25, p. 2.

88 Australian Medical Association, *Submission* 11, p. 13.

89 Office of the Privacy Commissioner, *Submission* 20, p. 9.

1.77 The Australian Psychological Society was concerned that practitioners could be made liable for administrative errors made by Medicare under the proposed scheme. They highlighted the situation of overpayments to practitioners and stated they believed 'administrative errors by Medicare Australia should be rectified by Medicare Australia'.[90] Similarly the Australian Physiotherapy Association stated that minor claims errors were just as likely to favour Medicare Australia as they were the individual practitioner and recommended that a mechanism be included to reimburse practitioners where Medicare Australia has been the beneficiary of an error.

1.78 Medicare Australia did not agree that providers would, or could be held liable for administrative errors and argued that compliance audits were intended to ensure payments were correct. It also noted that a process exists whereby providers can re-submit claims if they find they have under-claimed, which will then be adjusted and paid by Medicare Australia.[91]

1.79 The Department of Health and Ageing has previously indicated that the introduction of administrative penalties may be accompanied by additional formal appeal rights for providers.[92] The Department noted that there are a number of avenues of appeal under existing arrangements including independent internal review by Medicare Australia and formal judicial review of administrative decisions or review under legislation such as the *Freedom of Information Act 1982* or the *Ombudsman Act 1976*. They noted that once the proposed legislation is passed Medicare Australia will include information on how practitioners may make complaints about a compliance audit when a notice to produce documents is issued. They also noted:

> Under the HIA, review by the Administrative Appeals Tribunal is generally restricted to those decisions which impact on a practitioner's ability to provide Medicare services. That is, where the sanction imposed may involve disqualification from participation in Medicare and /or the Pharmaceutical Benefits Scheme for a period of time.[93]

1.80 The size of the administrative penalty and the threshold was also discussed in submissions. One submission argued that the administrative penalties in the Exposure Draft were 'inadequate in relation to the seriousness of the illegal activities' and that a 'more appropriate penalty regime would be based on recent Australian Taxation Office convictions for fraud'.[94] The Australian Physiotherapy Association agreed the $2,500

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90 Australian Psychological Society, *Submission* 8, p. 3.

91 Medicare Australia, *Supplementary submission dated 26 May 2009*, p. 13.

92 Department of Health and Ageing, *Submission* 21, Attachment 5, *Increased MBS Compliance Audits, Information Sheet*, p. 4.

93 Department of Health and Ageing, Submission 21, Attachment 8, *Answers to Questions on Notice – Question 2*, p. 2.

94 Name withheld, *Submission* 2, p. 1.

threshold was appropriate but sought reassurance that this amount would be indexed annually.[95]

1.81 The Department of Health and Ageing commented that the proposed administrative penalties would provide an incentive for practitioners 'to ensure that the Medicare services they provide comply with the relevant legislative requirements'. The Department noted that the penalties are structured to encourage compliant behaviour, for example, if a practitioner admits to causing an incorrect Medicare payment to be made prior to any Medicare Australia compliance contact, no additional penalty amount is payable.[96] The Department also noted that the $2,500 threshold will mean that practitioners who owe a small amount of money will not be subject to a financial sanction. They stated:

> The $2,500 threshold is based on an analysis of Medicare Australia data which indicates that this is the point at which mistaken claims may become routine, or reflective of poor administration or decision making. In 2007-08 only 36% of practitioners who were required to repay money, repaid an amount of more than $2,500.[97]

1.82 Medicare Australia argued that the threshold will ensure that providers who make 'one-off minor inadvertent errors' are not penalised and that the 20 per cent penalty was proportionate and fair. They stated:

> 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… Medicare Australia feels that any penalty amount less than 20 per cent would lose the deterrent impact on the wider health provider community.[98]

Privacy Impact Assessment

1.83 On the whole those medical and privacy groups which provided supplementary submissions did not consider that the PIA addressed their concerns in relation to the proposed changes.[99] However, there were differing levels of support for the PIA recommendations in relation to ongoing assessment of the Medicare Australia

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95 Australian Physiotherapy Association, *Submission* 18, pp. 1-2.

96 Department of Health and Ageing, *Submission* 21, p. 14.

97 Department of Health and Ageing, *Submission* 21, p. 14.

98 Medicare Australia, *Submission* 16, pp. 5 & 28.

99 Royal Australian and New Zealand College of Psychiatrists, *Supplementary submission dated 15 May 2009*, p. 1; Australian Privacy Foundation, *Supplementary submission dated 22 May 2009*, p. 1; Australian Medical Association, *Supplementary submission dated 25 May 2009*, p. 1; Australasian Society for HIV Medicine, *Supplementary submission dated 26 May 2009*, p. 1; Royal Australian College of General Practitioners, *Supplementary submission dated 28 May 2009*, p. 2.

compliance program, consultation with peak groups, and providing information to medical practitioners and patients about the measures.

1.84 A number of practitioner groups highlighted that the PIA had not dealt with criticisms of the measures outlined in their original submissions. For example the Australian Medical Association stated the PIA maintained the incorrect premise that administrative documents will satisfy compliance concerns. They argued that the privacy impact of the proposed measure could not be properly assessed until the information that will be required to substantiate Medicare benefits is listed by Medicare Australia. The Association also objected to the assertion that 'practitioners would attempt to convince patients to withhold their consent to the release of the personal information to Medicare Australia'.[100]

1.85 The Australian Privacy Foundation argued that because the PIA 'was conducted behind closed doors… far better balanced design features and amelioration measures could have been devised' to achieve the aims without substantial privacy breaches.[101] The Royal Australian College of General Practitioners submitted that some of the recommendations in the PIA relating to ongoing quality assurance of the privacy aspects of compliance program were 'a clear admission that it is not possible for Medicare Australia to create a safe and reliable system for managing sensitive patient information'.[102]

1.86 Medicare Australia also made a supplementary submission which noted that it accepted and would adopt all recommendations made in the PIA. However they also restated their support for the measures in the Exposure Draft and argued that 'the proposed legislation is essential in order to improve its ability to manage the integrity of the Medicare program'.[103]

Conclusion

1.87 The issues dealt with in this inquiry represent an area where two public interests overlap. On one hand there is the interest of patients to have their clinical records kept confidential by medical practitioners. On the other, there is the interest of tax-payers, who fund Medicare and are entitled to expect reasonable checks are made to ensure those public funds are being expended appropriately. While the Committee appreciates the issues and concerns raised by medical, privacy and other organisations regarding the treatment of patient clinical records, it considers that the proposed changes, as outlined in the Exposure Draft, represent a good balance between these overlapping public interests.

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100 Australian Medical Association, *Supplementary submission dated 25 May 2009*, pp. 1-2.

101 Australian Privacy Foundation, *Supplementary submission dated 6 May 2009*, p.1.

102 Royal Australian College of General Practitioners, *Supplementary submission dated 28 May 2009*, p. 6.

103 Medicare Australia, *Supplementary submission dated 26 May 2009*, p. 17.

1.88 However there was one area of the proposed compliance audit process which concerned the Committee. The Committee is sympathetic to the suggestion made in some submissions, such as the Office of the Privacy Commissioner, that a more tailored approach be applied to accessing sensitive health information during the compliance audit process. Proposals to include a multi-stage audit process to enhance the privacy protection of patient clinical records were also persuasive. This would mean that an additional step or decision would be required before patient clinical records would be accepted by Medicare Australia as part of a compliance audit. This would assist in limiting the accessing of patient clinical records to situations where other administrative records held by providers are not sufficient to substantiate a claim.

1.89 The Committee understands that these suggested changes to the compliance audit process may not be practically convenient to include in the draft legislation and may be more appropriate as part of the regulations and as an administrative practice of Medicare Australia. Nonetheless, the Committee considers they would provide an additional privacy protection for patient clinical records and should be clearly stated.

1.90 The Committee notes that Medicare Australia and the Department of Health and Ageing have undertaken considerable consultation with relevant stakeholders in developing the initiative, including working closely with the Office of the Privacy Commissioner. The Department's statement that the Privacy Impact Assessment will be updated throughout the implementation and ongoing management of the Initiative is an encouraging sign that important patient privacy issues will not be forgotten as the compliance audit program continues.[104] The Committee is also gratified that Medicare Australia has accepted and will adopt all the recommendations made in the PIA.

1.91 The Committee also notes that Medicare Australia has been receptive to the recommendation made by the Australian Medical Association for clarification regarding what constitutes 'reasonable record keeping and information arrangements' for providers.[105] The Committee believes clarification in this area will assist to limit the impact on practitioners of compliance audits and protect patient privacy by restricting the need for Medicare Australia to access clinical records in order to substantiate claims.

104 Department of Health and Ageing, *Submission* 21, pp. 12-13.

105 Medicare Australia, *Supplementary submission dated 26 May 2009*, p. 12.

Recommendation

1.92 The Committee recommends that the Department of Health and Ageing and Medicare Australia ensure that as part of the Medicare compliance audit process specific measures are detailed in the regulations to ensure that patient clinical records are only required to be accessed where necessary.

Senator Claire Moore

Chair

June 2009

MINORITY REPORTY BY COALITION SENATORS

HEALTH INSURANCE AMENDMENT (COMPLIANCE) BILL 2009

1.1 Coalition Senators support an enhanced and expanded audit process to protect the integrity of the Medicare system and minimise inappropriate or inaccurate Medicare claims. We agree with the need to protect the interests of tax-payers and ensure that public funds be expended appropriately.

1.2 Getting the balance right between the privacy of the patient and ensuring that public funds are appropriated properly should be the paramount consideration in this Inquiry.

1.3 Coalition Senators believe that the Government has not achieved that balance in the *Exposure Draft of the Health Insurance Amendment (compliance) Bill 2009* released on 9 April 2009 by the Department of Health and Ageing and we do not agree with the Majority Report by the Chair of the Community Affairs Committee, Senator Claire Moore.

1.4 In addition, Senators and submitters were forced to rely upon the exposure draft only without the benefit of access to the full legislation and regulations underpinning it.

1.5 The primacy of the principle of doctor/patient confidentially has always been an important part of our health system. Coalition Senators believe that any attempt to weaken this principle should be only as a last resort and subject to strict mandatory protocols. We do not support the provisions contained in the exposure draft legislation that would provide the CEO of Medicare or his/her delegate with the authority to access patient records.

1.6 Coalition Senators agree with evidence provided to the Committee that significant savings could be achieved if some of the expenditure was invested in educational and training measures. This could provide the desired savings and deliver value for the taxpayer without compromising patient record confidentiality.

1.7 We believe that any proposed reforms to compliance auditing of Medicare benefits should include a training or educational component targeted at health

professionals to assist them in achieving greater accuracy in their billing processes, thus reducing inadvertent or unintended claim errors.

PRIVACY

2.1 A considerable number of witnesses and submissions to the Inquiry raised the issue of patient records being reviewed by Medicare Australia investigators during the proposed Medicare Audit process. Patient records contain the personal medical history of an individual and under the current system, they remain strictly confidential between the patient and their medical practitioner. The information contained in these records is often extremely sensitive and the comprehensiveness and accuracy of this information is usually critical to the provision of the highest levels of care. If patients believe that a third person may have access to their confidential medical records without their permission, there is a real risk that they may not provide all the relevant information to their medical practitioner.

2.2 In their submission to the committee the Australasian Society for HIV Medicine (NSW) stated:

> I have worked in general practice for 20 years. In the early days, we kept clinical notes with special codes to hide sensitive information like sexuality from prying eyes. These kinds of special codes impeded the flow of necessary and proper flow of information between professions. Let us not return to those days, just when electronic records are starting to bridge the gap between different sectors of the health workforce.[1]

2.3 The implications of disclosure of private patient information in the area of mental health should also not be underestimated. As mentioned in the Majority Report, the Royal Australian and New Zealand College of Psychiatrists warned the Committee about the "serious consequences for the psychiatrically impaired" from a breach of confidentiality and that any breach could have "extremely traumatising and potentially devastating."[2]

2.4 In that context, Coalition Senators believe that patient clinical records should only be accessed by a third party as a last resort and under strictly enforced mandatory protocols.

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1 Australasian Society for HIV Medicine (NSW) Submission, p.2.

2.5 The Government claims that there is a need to review patient records to confirm that a patient was eligible for a specific Medicare scheduled item. The Department of Health and Ageing stated that:

> We are not looking at making professional judgements or clinical judgements; this is about administrative requirements for claiming payments.[3]

2.6 Paragraph 1.40 of the Majority Report raises the issue of the qualifications of Medicare audit staff to review patient records. In particular, it notes questions of adequate staff qualifications to interpret clinical records when conducting compliance audits.

2.7 In reviewing patient records to ascertain if a particular Medicare scheduled item was appropriate, Medicare administrative investigators will be required to make professional or clinical judgements that they are unqualified to make about the clinical necessity for that service or procedure.

2.8 Under the Government's proposed, Medicare administrative investigators must have "reasonable concern" that a fee for a medical service exceeds the amount that should have been paid before requesting access to patient records.

2.9 A number of submitters were concerned at the lack of definition of "reasonable concern and the exact type of information considered to substantiate access to the private data of patients. The Medical Indemnity Association of Australia stated that "the exercise of coercive powers in such a vague and unspecified manner is unfair to the recipient of the notice."[4] Similarly, the Australian Medical Association felt that, "we are sacrificing the threshold issue of the privacy of the patient record, " if an administrator's reasonable concern were all that was required.[5]

2.10 Coalition Senators are concerned about the access to the private records of Patients through such means. There are already a number of administrative avenues that can be pursued to ascertain if a particular service or procedure

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[2] Royal Australian and New Zealand College of Psychiatrists (VIC) Submission, p.3.

[3] Mr David Learmonth, Department of Health and Ageing, *Proof Committee Hansard*, 6 May 2009, p. 88.

[4] Medical Indemnity Industry Association of Australia, *Submission 4*, p. 5.

[5] Dr Rosanna Capolingua, Australian Medical Association, *Proof Committee Hansard*, 6 May 2009, p. 71.

was claimed and performed without the need to access personal clinical records.

These include:

- Provider's certification or other legal declaration that the patient was eligible for the service rendered.
- Tests - Medicare Australia could ask for evidence that the test was done;
- Referrals - Medicare Australia could ask to see the referral;
- Time spent with a patient, or the service performed at a particular time – Medicare Australia could ask for evidence that those time requirements had been met;[6]
- Pre-existing condition – Medicare Australia could ask for evidence that the pre-existing condition existed.[7]

PROFESSIONAL SERVICES REVIEW BOARD

3.1 Where serious concerns are raised concerning a medical provider's practices, there are already proven avenues that can be pursued to investigate the conduct. In the event that the CEO of Medicare is not satisfied with the evidence provided by a medical professional under investigation and believes that reviewing a patient's records may be required then this matter should be referred to the Professional Services Review Board (PSR) for investigation.

3.2 The PSR is comprised of relevant medical professionals appointed by the Minister for Health and Ageing who are qualified to interpret clinical records and make recommendations about the conduct of medical practitioners to the CEO of Medicare Australia.

3.3 Coalition Senators believe that existing processes already provide for sufficient access to confidential patient records by third parties in limited circumstances. Any further expansion of access to these records in order to prosecute serious fraudulent Medicare claiming activity must be subject to strict mandatory protocols to protect the privacy of the individual.

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6 *Exposure Draft of the Health Insurance Amendment (Compliance) Bill 2009 Explanatory Material*

7 *Exposure Draft of the Health Insurance Amendment (Compliance) Bill 2009 Explanatory Material*

INCORRECT BILLING

4.1 The government has increased the number of annual Medicare Audits from 500 to 2500. Coalition Senators support this increase as it recognises the increase in Medicare provider numbers issued to health professionals and the associated increase in Medicare claims.

4.2 Evidence was provided to the committee that errors and incorrect Medicare claims were responsible for a significant proportion of inappropriate claims rather than deliberate fraud. The committee heard suggestions from a number of witnesses as to how the savings desired by government could be realised without invasive audits or compromising patient records.

4.3 Dr Flegg from the Royal Australian College of General Practitioners stated:

> I think confusion by the schedule is another important point to make. The MBS is complex and amazingly confusing. Medicare itself gives conflicting advice at times about how to bill properly. Even excellent doctors with really good intentions can make mistakes. The college thinks that the MBS needs revision with a view to simplification and that that money would be better spent on an activity such as that, plus education. We believe the end result would be the same.[8]

4.4 Dr Flegg asserted that if the money proposed by the government on the audit process were redirected to initiatives such as education, training and simplification of the MBS then significant savings to the tax-payer could be realised.

> We feel that incorrect claiming or mistakes in claiming could be better addressed by investing in the education of general practitioners specifically in the area of billing practices, particularly of new GPs who may be confused by the schedule.[9]

4.5 Dr Capolingua, former President of the AMA further argued in her evidence to the committee:

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[8] Dr Flegg RACGP, Proof Committee Hansard 6 May 2009, p.CA3.

[9] Dr Flegg RACGP, Proof Committee Hansard 6 May 2009, p.CA3.

> All this, when government already openly admits that the biggest hurdle to compliance is red tape, and helping doctors to understand and comply with an increasingly complex system will deliver far greater, long-term benefits than sacrificing the privacy of all Australians to catch a handful of doctors and a few honest mistakes.[10]

4.6 The Government has indicated that the Increased Medicare Compliance Audit initiative will provide savings of $147.2 million over four years and will cost $76.9 million to administer, leading to net savings of $70.3 million over four years.

4.7 Given the significant administrative costs of the measure, Coalition Senators believe that the Government should redirect some of this expenditure into education and training measures to achieve similar savings without compromising patient privacy.

CONCLUSION

5.1 Coalition senators support enhanced Medicare Audit measures designed to protect the integrity of the Medicare claims scheme and to ensure the appropriate expenditure of tax-payer funds.

5.2 Coalition Senators do not believe that access to patient records should be extended to the CEO of Medicare or his/her delegate. The confidentiality of patient records must be preserved by limiting access to these records to necessary medical professionals, or in very limited cases and under strict protocols, to the Professional Services Review Board.

5.3 We acknowledge the concerns raised by a number of witnesses during the committee process that the complexity of the Medicare schedule may lead to incorrect claims lodged by Medical professionals and that a number of incorrect claims may be the result of error caused by confusion with the system rather that deliberate fraud.

5.4 A review of the Medicare Schedule as well as an educational program for Medicare Professionals must be conducted to reduce inadvertent or honest mistakes being made when lodging Medicare claims.

5.5 The Office of the Privacy Commissioner should be consulted during the development of regulations, guidelines or protocols that will protect patient record confidentiality during any Medicare audit

[10] Dr Capolingua AMA. Proof Committee Hansard 6 May 2009, p. CA66.

investigation that may be referred to the Professional Services Review Board.

RECOMMENDATIONS

Recommendation 1

The Government conduct a review of the Medicare Benefits Schedule with the view to rationalising or simplifying individual schedule items.

Recommendation 2

The Government develop a training/information program in consultation with relevant professional associations to improve the accuracy of Medicare billing practices among health care professionals.

Recommendation 3

If the Medicare CEO remains unsatisfied with the responses of the medical provider or has further questions that the CEO believes may only be resolved through reviewing a patient's record, then the matter should be referred to the Professional Services Review Board to be reviewed by a committee of the practitioner's peers. A report prepared by the Professional Services Review Board could then be submitted to the Medicare CEO for consideration.

Recommendation 4

The Office of the Privacy Commissioner should be consulted to develop protocols and guidelines for the protection of patient history record confidentiality during any Medicare compliance audit activity.

Senator Sue Boyce
LP, Senator for Queensland

Senator Judith Adams
LP, Senator for Western Australia

Senator Gary Humphries
LP, Senator for the Australian Capital Territory

Additional Comments

Australian Greens

The Australian Greens support the Committee recommendation that further measures

are adopted to ensure that patient clinical records are only required to be accessed where necessary in the Medicare compliance audit process and that the specific measures are detailed in the regulations.

The primary aim of the new measures is to minimise the need to access clinical records in the Medicare audit process. The Greens propose a two stage process to achieve this by first, introducing a mandatory electronic data collection mechanism as part of every patient consultation and second, outlining a process to determine when clinical records must be accessed and then provide maximum protection for patient confidentiality once it is determined that access is necessary.

The first stage measure to enable the provision of more accurate detail of patient consultations as a matter of course would require doctors to complete an electronic form for each consultation which would provide the basic details relevant to the Medicare audit process such as length of time, purpose, referrals etc in a tick a box format. This would completed on line during the consultation as a matter of course.

The second stage measure is the multi-staged review process which includes proposals outlined in submissions from PIAC and the Privacy Commissioner to the Committee. This process ensures that any decision to assess clinical information is made separately from the routine audit process and follows a number of steps to ensure sensitive information is handled with due care and confidentiality.

1. Medical advisers have oversight of all audits involving clinical information;

2. Provision of a clear definition of what constitutes "a reasonable concern" to conduct a review of the health provider against which a determination is made;

3. The decision to investigate patient records is made by senior officers delegated by the Medicare CEO, with oversight by medical advisers;

4. If it is decided 'reasonable concern' exists, a Privacy Impact Assessment is made to justify accessing patient records including that there is no other way to obtain the necessary information and that the investigation is in the public interest;

5. The PIA will include assessment of whether the necessary information can be gained by de-identified records without undermining the integrity of the audit process;

6. The patients, or their authorised decision maker, should be advised that their personal health record is to be accessed for the purpose of a compliance audit.

7. That if the patient or their authorised decision maker objects to the use of their personal medical record and provides reasons, the decision to access information is subject to an internal review, and the patient is provided with written reasons for the decision.

Senator Rachel Siewert
Australian Greens

APPENDIX 1

LIST OF PUBLIC SUBMISSIONS, TABLED DOCUMENTS AND ADDITIONAL INFORMATION AUTHORISED FOR PUBLICATION BY THE COMMITTEE

1 Australian Society of Anaesthetists (NSW)

2 Name withheld

3 Australian Privacy Foundation (APF) (NSW)

Supplementary information

- Supplementary submission provided at hearing 6.5.09
- Supplementary submission relating to the PIA Report,dated 22.5.09

4 Medical Indemnity Industry Association of Australia (SA)

Supplementary information

- Additional information following hearing 6.5.09, dated 28.5.08

5 Australian General Practice Network (ACT)

6 Australasian Society for HIV Medicine (NSW)

Supplementary information

- Supplementary submission commenting on Privacy Impact Assessment, dated 26.5.09

7 Consumers Health Forum of Australia (ACT)

8 Australian Psychological Society (VIC)

Supplementary information

- Supplementary submission commenting on Privacy Impact Assessment, dated 29.5.09

9 Civil Liberties Australia (ACT)

Supplementary information

- Response to a question arising from the hearing 6.5.09, received 11.5.09

10 Royal College of Pathologists of Australasia (NSW)

11 Australian Medical Association (ACT)

Supplementary information

- Additional information provided following hearing 6.5.09 relating to the text of a petition, received 7.5.09
- Comments on the Privacy Impact Assessment, dated 25.5.09

12 Royal Australasian College of Surgeons (VIC)

13 Royal Australian and New Zealand College of Psychiatrists (VIC)

Supplementary information

- Supplementary submission commenting on Privacy Impact Assessment, dated 15.5.09

14 Private Mental Health Consumer Carer Network (Australia) (SA)

15 Australian Health Insurance Association (ACT)

16 Medicare Australia (ACT)

Supplementary information

- Supplementary submission responding to information requested at the hearing 6.5.09, dated 26.5.09
- Copies of privacy and security training material, received 29.5.09

17 Australian Association of Social Workers (ACT)

18 Australian Physiotherapy Association (VIC)

19 Public Interest Advocacy Centre Ltd (PIAC) (NSW)

20 Office of the Privacy Commissioner (Commonwealth)

21 Department of Health and Ageing (ACT)

Supplementary information

- Responses to questions on notice arising from the hearing 6.5.09, received 10.6.09

22 Royal Australian College of General Practitioners (VIC)

Supplementary information

- Supplementary submission commenting on the Privacy Impact Assessment, dated 25.5.09

23 Copley, Mr Robert (ACT)

24 Australian Public Service Commission (ACT)

25 Commonwealth Ombudsman (ACT)

APPENDIX 2

WITNESSES WHO APPEARED BEFORE THE COMMITTEE AT PUBLIC HEARINGS

Wednesday, 6 May 2009
Parliament House, Canberra

Committee Members in attendance

Senator Claire Moore (Chair)
Senator Rachel Siewert (Deputy Chair)
Senator Catryna Bilyk
Senator Sue Boyce
Senator Mark Furner
Senator Gary Humphries

Witnesses

Royal Australian College of General Practitioners
Dr Karen Flegg, Fellow of the College
Ms Lauren Cordwell, Acting Manager, General Practice Advocacy and Support

Civil Liberties Australia (via teleconference)
Mr Bill Rowlings, Chief Executive Officer

Royal Australian and New Zealand College of Psychiatrists
Dr Maria Tomasic, Honorary Secretary

Australian Psychological Society
Mr David Stokes, Senior Manager, Professional Practice

Public Interest Advocacy Centre Ltd (via teleconference)
Mr Peter Dodd, Solicitor, Health Policy and Advocacy

Australian Privacy Foundation
Dr Roger Clarke, Chair
Dr Juanita Fernando, Chair, Health Sub Committee

Medical Indemnity Industry Association of Australia (via teleconference)
Ms Ellen Edmonds-Wilson, Chief Executive Officer

Australian Medical Association
Dr Rosanna Capolingua, President
Mr Francis Sullivan, Secretary General

Medicare Australia

Ms Philippa Godwin, Acting Chief Executive Officer

Mr Mark Jackson, Acting Deputy Chief Executive Officer

Mr Colin Bridge, General Manager Program Review Division

Department of Health and Ageing

Mr David Learmonth, Deputy Secretary

Mr Tony Kingdon, First Assistant Secretary, Medical Benefits Division

Ms Samantha Robertson, Assistant Secretary, Medicare Benefits Branch

APPENDIX 3

EXPOSURE DRAFT

Health Insurance Amendment (Compliance) Bill 2009

EXPOSURE DRAFT

2008-2009

The Parliament of the
Commonwealth of Australia

HOUSE OF REPRESENTATIVES/THE SENATE

EXPOSURE DRAFT

Health Insurance Amendment (Compliance) Bill 2009

No. , 2009

(Health and Ageing)

A Bill for an Act to amend the *Health Insurance Act 1973*, and for related purposes

Contents

A Bill for an Act to amend the *Health Insurance Act 1973*, and for related purposes

The Parliament of Australia enacts:

1 Short title

This Act may be cited as the *Health Insurance Amendment (Compliance) Act 2009*.

2 Commencement

This Act commences on 1 July 2009.

3 Schedule(s)

Each Act that is specified in a Schedule to this Act is amended or repealed as set out in the applicable items in the Schedule

concerned, and any other item in a Schedule to this Act has effect according to its terms.

Schedule 1—Amendment of the Health Insurance Act 1973

1 Subsection 3(1)

Insert:

medicare number has the same meaning as in subsection 84(1) of the *National Health Act 1953*.

2 After section 129AAC

Insert:

@129AAD Notice to produce documents

When section applies

(1) This section applies if the Medicare Australia CEO has a reasonable concern that an amount paid, purportedly by way of benefit or payment under this Act, in respect of one or more professional services may exceed the amount (if any) that should have been paid.

Note: The Medicare CEO may, for example, have a reasonable concern about benefits or payments made in respect of:

(a) professional services rendered by individual practitioners; or

(b) professional services rendered by particular kinds of practitioners; or

(c) the rendering of services to which specific items, or groups of items, relate.

CEO may require person to produce document etc.

(2) If the CEO believes on reasonable grounds that:

(a) a person who rendered a professional service, or on whose behalf a professional service was rendered; or

(b) subject to subsection (5), another person;

has possession, custody or control of one or more documents relevant to ascertaining whether the amount paid in respect of the professional service should have been paid, the CEO may, by

written notice given to the person, require the person to do any or all of the things mentioned in subsection (4).

(3) However, a notice may only be given in respect of a professional service that was rendered in the period of 2 years immediately before the notice is given.

(4) The CEO may require the person, in relation to each professional service specified in the notice:

(a) to produce to the CEO any document, or extract of any document, that is relevant for the purpose set out in subsection (2); or

(b) to make a copy of any such document or extract and to produce to the CEO that copy.

Note: For a person referred to in paragraph (2)(a), failure to comply with a notice may lead to recovery action (see section 129AC) and an administrative penalty may be applied (see sections @129AEA, @129AEB and @129AEC). For a person referred to in paragraph (2)(b), failure to comply with a notice may lead to a civil penalty (see section @129AAE).

CEO not to give notice to certain persons

(5) A person referred to in paragraph (2)(b) does not include:

(a) the person in respect of whom the professional service was rendered; or

(b) the person who incurred the medical expenses in respect of the service.

Content of notice

(6) The notice must specify:

(a) details of each professional service (including the item, date on which the service was rendered and medicare number of the person in respect of whom the service was rendered) that is the subject of the CEO's concern; and

(b) the reason or reasons for the CEO's concern; and

(c) how the document, extract or copy is to be produced; and

(d) the period within which, and place at which, the document, extract or copy is to be produced.

The period specified under paragraph (d) must be a period ending at least 21 days after the day on which the notice is given.

Health information

(7) The power under this section to require a document, extract or copy to be produced includes the power to require the production of a document, extract or copy containing health information (within the meaning of the *Privacy Act 1988*) about an individual.

Section not limited

(8) This section is not limited by:

(a) any other provision of this Act; or

(b) any provision of the *Medicare Australia Act 1973* or any other Act;

that relates to the powers of the Medicare Australia CEO to require the production of documents.

@129AAE Civil penalty—failure to comply with requirement in notice

(1) A person referred to in paragraph @129AAD(2)(b) contravenes this section if:

(a) the person is given a notice under section @129AAD requiring the person to do something in respect of a professional service; and

(b) the person fails to comply with the requirement within the period specified in the notice; and

Civil penalty:

(a) for an individual—20 penalty units; and

(b) for a body corporate—100 penalty units.

(2) It is a defence to subsection (1) if:

(a) the failure to comply is brought about by another person over whom the person has no control or by a non-human act or event over which the person has no control; and

(b) the person could not reasonably be expected to guard against the failure.

Note: The defendant bears the onus of proving the matters necessary to establish the defence.

@129AAF Self-incrimination etc.

(1) A person is not excused from producing a document, extract or copy when required to do so under section @129AAD on the ground that doing so would tend to incriminate the person or expose the person to a penalty.

(2) However, the production of the document, extract or copy, and any information obtained as a direct or indirect result of the production of the document, extract or copy, are not admissible in evidence against the person in:

(a) any criminal proceedings, other than:

(i) proceedings for an offence against this Act dealing with false or misleading information or documents; and

(ii) proceedings for an offence against section 137.1 or 137.2 of the *Criminal Code* (which deals with false or misleading information or documents) that relates to this Act; or

(b) any civil proceedings, other than a civil proceeding arising under Part VIA or this Part.

@129AAG Medicare Australia CEO may deal with documents etc. produced

(1) If a document, extract or copy has been produced under section @129AAD in respect of a professional service, the Medicare Australia CEO may do all or any of the things mentioned in subsection (2) for the purpose of ascertaining whether the information contained in the document, extract or copy properly substantiates an amount paid, purportedly by way of benefit or payment under this Act, in respect of the service.

Note: If the information does not properly substantiate the amount, recovery action may be taken (see section 129AC) and an administrative penalty may be applied (see sections @129AEA, @129AEB and @129AEC).

(2) The Medicare Australia CEO may:

(a) inspect the document, extract or copy; and

(b) make a copy of, or take an extract from, such a document or extract; and

(c) retain the document, extract or copy in his or her possession for such reasonable period as he or she thinks fit.

(3) The person otherwise entitled to possession of the document or extract is entitled to be supplied, as soon as practicable, with a copy certified by the Medicare Australia CEO to be a true copy.

(4) The certified copy must be received in all courts and tribunals as evidence as if it were the original.

(5) Until a certified copy is supplied, the Medicare Australia CEO must, at such times and places as he or she thinks appropriate, permit the person otherwise entitled to possession of the document or extract, or a person authorised by that person, to inspect and make copies of, or take extracts from, the document or extract.

(6) This section is not limited by:

(a) any other provision of this Act; or

(b) any provision of the *Medicare Australia Act 1973* or any other Act;

that relates to the powers of the Medicare Australia CEO to deal with a document, extract or copy as described in subsection (2) of this section.

3 Application

Section @129AAD of the *Health Insurance Act 1973* applies in respect of a professional service that is rendered on or after the commencement of that section.

4 After subsection 129AC(1)

Insert:

Failure to produce document

(1A) Subject to subsection (1B), if:

(a) a person referred to in paragraph @129AAD(2)(a) is required, by a notice given under section @129AAD, to produce a document, extract or copy in respect of a professional service; and

(b) the person does not comply with the requirement within the period set out in the notice;

the amount paid in respect of the service, purportedly by way of benefit or payment under this Act, is recoverable as a debt due to the Commonwealth from the person, or the estate of the person, whether or not the amount was paid to the person.

(1B) Subsection (1A) does not apply if the person concerned satisfies the Medicare Australia CEO that the person's non-compliance is due to circumstances beyond the person's control.

Amount not properly substantiated—notice to person referred to in paragraph @129AAD(2)(a)

(1C) Subject to subsection (1D), if:

(a) a person referred to in paragraph @129AAD(2)(a) is required, by a notice given under section @129AAD, to produce a document, extract or copy in respect of a professional service; and

(b) the person complies with the requirement within the period set out in the notice; and

(c) the information contained in the document, extract or copy does not properly substantiate (wholly or partly) the amount paid, purportedly by way of benefit or payment under this Act, in respect of the service;

then, to the extent that the amount is not properly substantiated, the amount is recoverable as a debt due to the Commonwealth from the person, or the estate of the person, whether or not the amount was paid to the person.

(1D) Subsection (1C) does not apply if the person concerned satisfies the Medicare Australia CEO that the reason that the information contained in the document, extract or copy does not properly substantiate the amount is due to circumstances beyond the person's control.

Amount not properly substantiated—notice to person referred to in paragraph @129AAD(2)(b)

(1E) Subject to subsection (1F), if:

(a) a person (the ***notice recipient***) referred to in paragraph @129AAD(2)(b) is required, by a notice given under section @129AAD, to produce a document, extract or copy in respect of a professional service; and

(b) the notice recipient complies with the requirement within the period set out in the notice; and

(c) the information contained in the document, extract or copy does not properly substantiate (wholly or partly) the amount

paid, purportedly by way of benefit or payment under this Act, in respect of the service;

then, to the extent that the amount is not properly substantiated, the amount is recoverable as a debt due to the Commonwealth from:

(d) the person who rendered the service, or on whose behalf the service was rendered; or

(e) the estate of that person;

whether or not the amount was paid to that person.

(1F) Subsection (1E) does not apply if the person from whom the amount concerned is recoverable satisfies the Medicare Australia CEO that the reason that the information contained in the document, extract or copy does not properly substantiate the amount is due to circumstances beyond the control of the person and the notice recipient.

Administrative penalty

(1G) If:

(a) a person is given a notice under section @129AEC of the person's liability to pay an administrative penalty; and

(b) the person does not pay the penalty by the day set out in the notice as the day by which the penalty becomes due for payment;

the amount set out in the notice is recoverable as a debt due to the Commonwealth from the person or the estate of the person.

Recovery once only

(1H) To avoid doubt, an amount paid purportedly by way of benefit or payment under this Act is recoverable under this section once only.

Note 1: The heading to section 129AC is replaced by the heading "**Recovery of amounts overpaid etc. and administrative penalties**".

Note 2: The following heading to subsection 129AC(1) is inserted "*False or misleading statements*".

5 At the end of paragraph 129AC(2)(a)

Add ", (1A), (1C), (1E) or (1G)".

Note: The following heading to subsection 129AC(2) is inserted "*Interest on amounts*".

6 At the end of paragraph 129AC(2)(a)

Add "and".

7 Subsection 129AC(4)

Repeal the subsection, substitute:

Set-off

(4) Despite any other provision of this Act, if:

(a) an amount (the ***recoverable amount***) is recoverable from a person under subsection (1), (1A), (1C), (1E) or (1G); and

(b) an amount (the ***later amount***) of benefit or payment later becomes payable to the person under this Act; and

(c) the person so agrees;

the Medicare Australia CEO may, on behalf of the Commonwealth, set off all or a part of the recoverable amount against all or a part of the later amount.

8 Application and saving

(1) Subsection 129AC(4) of the *Health Insurance Act 1973* as amended by this Act applies in relation to amounts recoverable under subsection 129AC(1) of that Act before, on or after the commencement of this item.

(2) If a person's agreement referred to subsection 129AC(4) of the *Health Insurance Act 1973* is in force, in relation to an amount, immediately before the commencement of this item, that agreement is taken to be in force for the purposes of:

(a) that amount; and

(b) that subsection as in force immediately after that commencement.

(3) Subitem (2) does not prevent the person withdrawing the agreement.

9 After section 129AE

Insert:

@129AEA Liability for administrative penalty

Subsection 129AC(1) applies

(1) A person is liable for an administrative penalty in respect of a professional service rendered by, or on behalf of, the person if:

(a) the Medicare Australia CEO has served a notice on the person claiming an amount (the ***total amount***) as a debt due to the Commonwealth under subsection 129AC(1); and

(b) the total amount consists of, or includes, an amount (the ***recoverable amount***) in respect of the service; and

(c) no part of the total amount became due more than 2 years before the notice was served; and

(d) the total amount is more than:

(i) $2,500; or

(ii) if a higher amount is prescribed by the regulations—that higher amount.

Subsection 129AC(1A) or (1C) applies

(2) A person is liable for an administrative penalty in respect of a particular professional service if:

(a) a notice was given to the person under section @129AAD requiring the person to produce a document, extract or copy relevant to the particular professional service; and

(b) subsection 129AC(1A) or (1C) applies to the person and the particular professional service; and

(c) if the notice specifies one or more other professional services—either or both of subsections 129AC(1A) and (1C) apply to the person and any other professional service specified in the notice; and

(d) the sum of the amounts that may be recovered from the person under those subsections in respect of the particular professional service, and any other professional service that is specified in the notice, is more than:

(i) $2,500; or

(ii) if a higher amount is prescribed by the regulations—that higher amount.

(3) If subsection (2) applies, the ***recoverable amount*** in respect of the particular professional service is:

(a) if subsection 129AC(1A) applies to the particular professional service—the amount that may be recovered from the person under that subsection in respect of the service; and

(b) if subsection 129AC(1C) applies to the particular professional service—the amount that may be recovered from the person under that subsection in respect of the service.

Subsection 129AC(1E) applies

(4) A person (the ***practitioner***) who rendered a particular professional service, or on whose behalf a particular professional service was rendered, is liable for an administrative penalty in respect of the service if:

(a) a notice was given to another person under section @129AAD requiring the person to produce a document, extract or copy relevant to the particular professional service; and

(b) subsection 129AC(1E) applies to the practitioner and the particular professional service; and

(c) if the notice specifies one or more other professional services—subsection 129AC(1E) applies to the practitioner and any other professional service specified in the notice; and

(d) the sum of the amounts that may be recovered from the practitioner under that subsection in respect of the particular professional service, and any other professional service that is specified in the notice, is more than:

(i) $2,500; or

(ii) if a higher amount is prescribed by the regulations—that higher amount.

(5) If subsection (4) applies, the ***recoverable amount*** in respect of the particular professional service is the amount that may be recovered from the practitioner under subsection 129AC(1E) in respect of the service.

@129AEB Amount of administrative penalty

(1) The amount of the administrative penalty in respect of a professional service is worked out in accordance with this section.

Base penalty amount

(2) Subject to subsections (3), (4), (5) and (6), the amount (the ***base penalty amount***) of the administrative penalty is 20% of whichever of the following applies in respect of the professional service:

(a) the recoverable amount referred to in @129AEA(1)(b);

(b) the recoverable amount referred to in paragraph @129AEA(3)(a) or (b);

(c) the recoverable amount referred to in subsection @129AEA(5).

Reductions in base penalty amount

(3) A person's base penalty amount for a professional service is reduced in accordance with the table.

Reductions of base penalty amount

Item	If ...	the base penalty amount is reduced by ...
1	before the Medicare Australia CEO contacts the person (whether by notice under section @129AAD or otherwise) about the professional service, the person voluntarily tells the Medicare Australia CEO, in the approved form, that an amount paid, purportedly by way of benefit or payment under this Act, in respect of the service exceeds the amount (if any) that should have been paid	100%
2	(a) after the Medicare Australia CEO contacts the person about the service; and (b) before the CEO gives a notice to the person under section @129AAD that specifies the service; the person voluntarily tells the CEO, in the approved form, that an amount paid, purportedly by way of benefit or payment under this Act, in respect of the service exceeds the amount (if any) that should have been paid	50%
3	(a) after the Medicare Australia CEO gives a notice to the person under section @129AAD that specifies the service; and	25%

Reductions of base penalty amount		
Item	**If ...**	**the base penalty amount is reduced by ...**
	(b) before the end of the period specified in the notice; the person tells the CEO, in the approved form, that an amount paid, purportedly by way of benefit or payment under this Act, in respect of the service exceeds the amount (if any) that should have been paid	

Increases in base penalty amount

(4) A person's base penalty amount for a professional service is increased by 25% if:

(a) the Medicare Australia CEO gives a notice to the person under section @129AAD that specifies the service; and

(b) the person does not comply with the notice in respect of the professional service, or any other professional service specified in the notice, within the period specified in the notice.

(5) A person's (the ***practitioner***) base penalty amount for a professional service (the ***latest professional service***) rendered by, or on behalf of, the practitioner is increased by 50% if:

(a) any of the following apply:

(i) the Medicare Australia CEO gives a notice to the practitioner under section @129AAD that specifies the latest professional service;

(ii) the Medicare Australia CEO serves a notice on the practitioner claiming an amount as a debt due to the Commonwealth under subsection 129AC(1) and that amount consists of, or includes, an amount in respect of the latest professional service;

(iii) the Medicare Australia CEO gives a notice to another person under section @129AAD that specifies the latest professional service; and

(b) any of the following apply:

(i) in the 24 months immediately before the notice is given or served, the Medicare Australia CEO has given to the

practitioner one or more other notices under section @129AAD specifying other professional services rendered by, or on behalf of, the practitioner;

(ii) in the 24 months immediately before the notice is given or served, the Medicare Australia CEO has served on the practitioner one or more other notices claiming an amount as a debt due to the Commonwealth under subsection 129AC(1) consisting of, or including, other professional services rendered by, or on behalf of, the practitioner;

(iii) in the 24 months immediately before the notice is given or served, the Medicare Australia CEO has given to another person one or more other notices under section @129AAD specifying other professional services that were rendered by, or on behalf of, the practitioner; and

(c) the total of:

(i) the sum of the recoverable amounts (see subsection (2)) in respect of each other professional service; and

(ii) the sum of the base penalty amounts for each other professional service as reduced or increased in accordance with this section (if relevant);

is more than:

(iii) $30,000; or

(iv) if a higher amount is prescribed by the regulations—that higher amount.

(6) If both subsections (4) and (5) apply in relation to a professional service, apply subsection (4) and then subsection (5). In applying subsection (5) in that case, the base penalty amount is that amount as increased under subsection (4).

Interaction between reduction and increase

(7) If a base penalty amount is subject to both a reduction and an increase, apply the reduction first.

@129AEC Notice of administrative penalty

The Medicare Australia CEO must give to a person who is liable for an administrative penalty written notice of the following:

(a) the person's liability to pay an administrative penalty in respect of one or more professional services;

(b) the professional service to which each administrative penalty relates;

(c) if there is more than one professional service—the total of the administrative penalties;

(d) the day by which the penalty becomes due for payment (which must be at least 14 days after the day on which the notice is given);

(e) the fact that the notice is given under this section.

The notice may also deal with a debt due to the Commonwealth under section 129AC arising in relation to the professional service.

10 Application

Sections @129AEA, @129AEB and @129AEC of the *Health Insurance Act 1973* apply in respect of a professional service that is rendered on or after the commencement of those sections.

APPENDIX 4

PRIVACY IMPACT ASSESSMENT (PIA)

2008-09 Budget Initiative

Ensuring the Integrity of Medicare: Increased MBS Compliance Audits

Privacy Impact Assessment (PIA)

2008-09 Budget Initiative

Ensuring the Integrity of Medicare: Increased MBS Compliance Audits

as at 28 April 2009

Contents

Terminology used in this PIA

CEO	Chief Executive Officer of Medicare Australia
Clinical information	information from a practitioner's record that contains clinical details relating to a patient
Direction	*Medicare Australia (Functions of Chief Executive Officer) Direction 2005*
DoHA	Department of Health and Ageing
FOI Act	*Freedom of Information Act 1982*
health information	as defined in the *Privacy Act 1988*: "(a) information or an opinion about: (i) the health or a disability (at any time) of an individual; or (ii) an individual's expressed wishes about the future provision of health services to him or her; or (iii) a health service provided, or to be provided, to an individual; that is also personal information; or (b) other personal information collected to provide, or in providing, a health service; or (c) other personal information about an individual collected in connection with the donation, or intended donation, by the individual of his or her body parts, organs or body substances; or (d) genetic information about an individual in a form that is, or could be, predictive of the health of the individual or a genetic relative of the individual."
HIA	*Health Insurance Act 1973*
IPP	Information Privacy Principle (Section 14 of the *Privacy Act 1988*)
Medicare Australia Act	*Medicare Australia Act 1973*
MBS	Medicare Benefits Schedule. The table of medical services prescribed in the regulations is published annually as the MBS and is provided free of cost to practitioners on a CD and is available online at www.mbsonline.gov.au. Practitioners may also purchase hard copies of the MBS.
Medicare number	As defined in subsection 84(1) of the *National Health Act 1953*
NCP	Medicare Australia's National Compliance Program 2008-09
NHA	*National Health Act 1953*
NPP	National Privacy Principle (Schedule 3 of the *Privacy Act 1988*)
OPC	Office of the Privacy Commissioner
Other person	A person who is not the practitioner or the patient who has documents relevant to substantiating a Medicare benefit amount paid in respect of a service
personal information	as defined in the *Privacy Act 1988*: "…information or an opinion (including information or an opinion forming part of a database), whether true or not, and whether recorded in material form or not, about an individual whose identity is apparent, or can reasonably be ascertained, from the information or opinion." (Note - this definition relates to a "natural" (living) person)
PIA	Privacy Impact Assessment
practitioner	Any medical or health practitioner who renders a professional service for which a Medicare benefit amount is paid
Privacy Act	*Privacy Act 1988*
protected information	as defined in the *Health Insurance Act 1973*:

	"… information about a person that is held in the records of the Department"
PRD	Program Review Division of Medicare Australia
PSR	Professional Services Review
ROI	Release of Information
sensitive information	as defined in the *Privacy Act 1988* "(a) information or an opinion about an individual's: (i) racial or ethnic origin; or (ii) political opinions; or (iii) membership of a political association; or (iv) religious beliefs or affiliations; or (v) philosophical beliefs; or (vi) membership of a professional or trade association; or (vii) membership of a trade union; or (viii) sexual preferences or practices; or (ix) criminal record; that is also personal information; or (b) health information about an individual; or (c) genetic information about an individual that is not otherwise health information."
service	A service to which an item relates, being a clinically relevant service that is rendered by or on behalf of a medical practitioner. A clinically relevant service is a service rendered by a medical or a dental practitioner or optometrist that is generally accepted as being necessary for the appropriate treatment of the patient to whom it is rendered (see section 3 of the HIA).

Part A—Background Information

What is a Privacy Impact Assessment?

1. A Privacy Impact Assessment (PIA) is a detailed analysis of the personal information flows and potential privacy risks and impacts of a project. The purpose of conducting a PIA is to add value to projects that handle personal information by mitigating privacy risks and impacts, ensuring compliance with legal obligations and building best privacy practice into a project.

2. The essential stages of a PIA involve describing the project, mapping the flow of personal information in the project, identifying and analysing any privacy impacts and then making recommendations about the best way forward to manage the identified privacy impacts.

3. To ensure compliance with relevant privacy legislation, the flow of personal information is evaluated against the Information Privacy Principles (IPPs). The IPPs are outlined in section 14 of the Commonwealth *Privacy Act 1988* and govern the manner in which personal information is handled within government agencies.

Background

4. In the 2008 Budget the Australian Government announced the 'Ensuring the Integrity of Medicare: Increased Medicare Benefits Schedule (MBS) Compliance Audits' (IMCA) initiative.

5. Under Medicare Australia's existing compliance program for the Medicare scheme, compliance audits are conducted to confirm that Medicare benefits paid in respect of services have been paid correctly.

6. A compliance audit is a check conducted by administrative staff to confirm that the service met the requirements of the Medicare item paid in respect of the service.

7. The IMCA initiative aims to protect the integrity of the Medicare scheme by enhancing the existing compliance program.

8. The initiative consists of three related components:

   - Part One involves an increase in the number of compliance audits undertaken each year from 500 to 2,500.
   - Part Two introduces a legislative requirement for practitioners and other specified persons to produce documents to substantiate Medicare benefits paid in respect of services when audited by Medicare Australia. At present, practitioners are under no legal obligation to produce such evidence.
   - Part Three provides for a financial administrative penalty for certain practitioners who cannot substantiate a Medicare benefit paid in respect of a service. Under current arrangements, although Medicare benefits which are incorrectly paid in respect of a service can be recovered from the practitioner who caused the incorrect payment to be made, no additional penalty applies.

9. This PIA contains an analysis of the information flows and potential privacy impacts for the changes relating to Part Two of the initiative.

10. The proposed amendments will have a privacy impact because they will provide Medicare Australia with authority to give a notice to produce documents to persons to substantiate a Medicare benefit paid in respect of a service and the person will be required to comply.

11. This may involve the disclosure of information from a patient medical record to Medicare Australia.

12. This PIA is based on policy and procedural information available up to the time of writing.

13. The PIA is an iterative document which will continue to be updated regularly to reflect privacy issues arising from this initiative.

14. This approach is in keeping with the view of the Office of the Privacy Commissioner (OPC).

Audit Process

15. Medicare Australia's *National Compliance Program 2008-09* (NCP)promotes compliance through a mix of education, support, deterrence and enforcement activities to encourage voluntary compliance and to deal with non-compliance. The NCP provides details of the key strategic risks identified for 2008-09 and indicates the areas of focus for upcoming compliance activities.

16. The NCP is published to ensure that practitioners are aware of the risks to the integrity of the Medicare scheme and the areas that Medicare Australia's compliance activities will be targeting.

17. Medicare Australia uses a sophisticated range of data mining and analysis techniques to detect and identify non-compliance. This includes the use of artificial intelligence to identify targets for detection activities and regular data reviews looking for anomalous claiming behaviour and patterns.

18. Data analysis and mining activities include:

    - assessing tip-offs and referrals from members of the public, Medicare Australia staff and other Australian government departments and agencies
    - comparing the practice profiles of individual practitioners to their peer group to identify abnormal claiming patterns
    - detecting unusual trends or patterns and reviewing practitioners who rank within the top 100 claimants of key Medicare items
    - monitoring unusual growth in the use of a particular Medicare item (or group of items) to identify practitioners with high or unusual usage of that item(s).

19. This analysis means that Medicare Australia can target its compliance activities towards services and/or practitioners which are identified as being a potential risk to the integrity of the Medicare scheme.

20. When this occurs Medicare Australia contacts the rendering practitioner and requests that they provide documents or information to substantiate the Medicare benefits which were paid in respect of the service(s).

21. Internally, Medicare Australia's audit processes follow two specific processes consisting of either a desk, or a field, audit.

22. A desk audit involves Medicare Australia making enquiries over the telephone or through correspondence, while a field audit involves a Medicare Australia compliance officer attending a place of business in person at a pre-arranged time to confirm the claiming facts.

23. Medicare Australia audits are designed to be a quick and easy process for the individuals concerned. When an audit confirms Australian Government money has been paid incorrectly the usual outcome is to recover the amount.

24. Medicare Australia's current audit program is based largely on voluntary compliance, as there is no general requirement on practitioners to provide documents supporting a Medicare benefit paid in respect of a service.

The Need for Change

25. There has been little change to Medicare Australia's compliance program for the Medicare scheme in the past decade despite significant growth and expansion:

    - expenditure has more than doubled (from $6 billion in 1997-98 to over $13 billion in 2007-08);

- the number of services claimed has grown from 202 million to nearly 280 million annually;
- the number of practitioners who can provide Medicare services has increased from 44,500 to over 80,000; and
- new groups of practitioners may now provide Medicare services.

26. Existing provisions in the HIA and other legislation which seeks to protect the integrity of the Medicare scheme largely focus on inappropriate practice (Part VAA of the HIA) or criminal activity (sections 128A, 128B and 129 of the HIA relating to false and misleading statements and Part IID of the *Medicare Australia Act 1973*).

27. The HIA does not currently include a general requirement for practitioners to provide verifying documents during a compliance audit.

28. While many practitioners cooperate voluntarily with requests from Medicare Australia during a compliance audit, some do not respond or refuse to cooperate with a request.

29. Across a range of audits conducted during 2006-07, this non-response rate ranged from 4% to 70%. The average non-response rate for compliance audits of Medicare services during this period was around 20%.

30. When a practitioner does not respond or refuses to cooperate with an audit request Medicare Australia does not currently have the authority to require the production of the relevant information.

31. As a result the audit is effectively halted as no further action is able to be taken, unless Medicare Australia considers there are grounds for referral to PSR or for criminal investigation. This is an unsatisfactory outcome from a compliance perspective, as it means that Medicare Australia is unable to confirm that some Medicare benefits paid in respect of services were paid correctly, allowing some practitioners to avoid detection. This can have a negative impact on public revenue.

32. There are some exceptions to this. The HIA currently requires some practitioners to provide specified health information, including information contained in patient medical records in response to a request from Medicare Australia.

33. Sections 23DKA and 23DS of the HIA provide that clinical information relating to diagnostic imaging or pathology services must be produced (following a request) to a Medicare Australia employee who is a medical practitioner.

34. Medicare Australia may also request copies of specialist referrals from a specialist or consultant physician under section 20BA of the HIA, and diagnostic imaging and pathology requests from providers of diagnostic imaging services and approved pathology practitioners under sections 23DK and 23DR of the HIA.

35. Although the *Privacy Act 1988* allows personal information to be disclosed to bodies such as Medicare Australia where that disclosure is reasonably necessary to protect public revenue, many practitioners remain unclear about their obligations[1].

36. Part IID of the *Medicare Australia Act 1973* provides Medicare Australia with the power to require a person to provide information or produce documents where there are reasonable grounds for believing the information or documents may be relevant to the commission of a criminal offence or civil contravention.

37. Part IID also gives Medicare Australia powers of search and seizure (which extend to clinical records) where criminal offences or civil contraventions are suspected

Project Description

38. The project involves amending the HIA to enable the CEO of Medicare Australia to give a written notice requiring the production of documents to substantiate whether a

[1] National Privacy Principles No.2 h(iii)

Medicare benefit amount paid in respect of a professional service should have been paid.

39. The CEO of Medicare Australia can give the notice to the practitioner who rendered the service and/or to another person who has custody, control or possession of documents which are relevant to the service.

40. The CEO cannot give a notice to produce documents to the patient (the person to whom the professional service was rendered) or the person who incurred the medical expense in relation to the professional service (such as a parent or guardian).

41. The CEO can only issue a notice to produce when there is a reasonable concern that the Medicare benefit paid in respect of one or more professional services may exceed the amount that should have been paid.

42. In practice, practitioners and services audited under this project will be identified through Medicare Australia's risk assessment process where there is found to be a medium to high risk that the Medicare benefits paid may exceed the amount that should have been paid.

43. Practitioners suspected of fraud or inappropriate practice will not be the subject of compliance audits. These matters will continue to be referred for criminal investigation or Professional Services Review.

44. The project will have a privacy impact because the proposed changes will provide Medicare Australia with authority to give a notice to produce documents to persons to substantiate a Medicare benefit paid in respect of a service and the person will be required to comply.

45. This includes the disclosure of health information (as defined in the Privacy Act 1988) and does not exclude excerpts from a patient's medical record where they are relevant to substantiating the benefit paid.

46. Health information which is provided to Medicare Australia during compliance audits under this project is protected under existing legislation.

47. Medicare Australia already manages a significant amount of health information about individuals including patients and practitioners.

48. The use of information collected for the purposes of the Medicare scheme is governed by section 130 of the HIA and by the *Privacy Act 1988*.

49. Section 130 of the HIA prohibits Medicare Australia staff from giving out personal information to any other person, except in the performance of their statutory duties and functions or where the individual has authorised the release of that information.

50. The project represents an incremental change because it adds an additional power to an existing process.

51. The existing process is the compliance program for the Medicare scheme and the additional power is the legislative changes which will require practitioners to comply with a notice to produce documents.

52. It is also incremental in the sense that many practitioners already voluntarily provide health information, including patient medical records, during compliance audits.

53. One of the aims of the project is to formalise existing compliance processes so that practitioners are clear about their obligations during a Medicare Australia compliance audit.

54. Individual practitioners will be able to select the documents which they consider most aptly substantiates the service from the range of information available to them.

55. This means that the practitioner (or specified person) is responsible for deciding which documents address the compliance concern.

56. The project also clarifies Medicare Australia's powers to request, receive, use and disclose the information it currently receives voluntarily. For example, the proposed legislation sets out the circumstances under which Medicare Australia may issue a notice to produce documents.

Stakeholder Consultation

57. The Department of Health and Ageing and Medicare Australia have consulted with stakeholders on the design of the IMCA initiative, including the legislative amendments.

58. A letter was despatched to stakeholders on 14 May 2008. A copy of this correspondence can be found at Attachment A.

59. Two information sheets have been issued to stakeholders (17 October 2008 and 24 February 2009) (Attachments B and C).

60. The Department and Medicare Australia have also met with and/or received written submissions from a range of stakeholders including:

Allied Health Professions Australia
Australian General Practice Network
Australasian College of Dermatologists
Australian Association of Pathology Practices
Australian Medical Association
Australian Orthopaedic Association
Australian Privacy Foundation
Australian Society of Anaesthetists
AVANT
Consumer's Health Forum of Australia
National Association of Obstetricians and Gynaecologists
Occupational Therapists Australia
Optometrists Association of Australia
Royal Australian and New Zealand College of Obstetrics and Gynaecologists
Royal Australian and New Zealand College of Ophthalmologists
Royal Australian and New Zealand College of Psychiatrists
Royal Australian College of General Practitioners
Royal Australian College of Pathologists
Royal Australian College of Physicians - Australasian Chapter of Sexual Health Medicine
Royal Australian College of Physicians - Australian Faculty of Rehabilitation Medicine
Royal Australian College of Physicians – Paediatrics and Child Health Division
Royal College of Surgeons
Rural Doctors Association of Australia
Western Australian Health Consumers Council

Feedback from stakeholders has been used to assist the design of the IMCA initiative, in the drafting of proposed legislative amendments and the development of this PIA.

Part B—Privacy Analysis

61. The sections in this part of the document describe and map the flows of personal information in Part Two of the IMCA initiative project – that is, introducing a legislative requirement for practitioners and other specified persons to produce documents to substantiate Medicare benefits paid in respect of services when audited by Medicare Australia

62. The privacy impacts of these elements of the initiative are assessed on the basis of good privacy practice and compliance with the Information Privacy Principles in the *Privacy Act 1988*. A copy of the IPPs can be found at Attachment D.

Collection

63. Under existing legislation Medicare Australia collects a range of personal information about practitioners and patients.

64. When a claim for a Medicare benefit is lodged, Medicare Australia receives information about the identity and qualifications of the person who provided the service (through a provider number), the identity of the person who received the service (through a Medicare number) and the service that the patient received (through an Medicare item number or description of the service).

65. There are over 5,700 individual Medicare items which are set out in existing legislation. Each item describes a particular medical service which is available under the Medicare scheme and the schedule fee for that service.

66. Some Medicare items identify the medical service the patient has received. For example:

- if Medicare item 2622 is paid in respect of a service, the practitioner is asserting that the patient has diabetes;
- if Medicare item 2668 is paid in respect of a service, the practitioner is asserting that the patient has asthma;
- if Medicare item 16590 is paid in respect of a service, the practitioner is asserting that the patient is more than 20 weeks pregnant; and
- if Medicare item 31210 is paid in respect of a service, the practitioner is asserting that the patient had a skin lesion greater than 10mm in size removed.

67. Some items also specify certain clinical actions which the practitioner must provide to the patient during the service for the item to be used. One example of this is Medicare item 2620 (cycle of care for diabetes) which requires the practitioner to conduct a range of activities during the service including a blood pressure reading and a weight, height and BMI calculation.

68. There are a number of conditions set out in the HIA which must be met before a person can receive a Medicare benefit for a medical service including:

- both the practitioner providing the service and the patient must be Medicare eligible;
- there must be a relevant item for the service available under the Medicare scheme;
- the medical service must be clinically relevant;
- all the components described for that item must be provided during the service; and
- the practitioner must identify the Medicare item relevant to the service provided on the account or bulk-billing form. The practitioner may do this by using the item number or by providing a description of the service.

69. In identifying the relevant Medicare item and providing an account or bulk-billing form which complies with the legislative requirements the practitioner is effectively

assessing the service they provided against the criteria set out in legislation and making a declaration that the assessment of the service is correct.

70. It is an offence under the HIA to make a false statement relating to Medicare benefits.

71. This reliance on self-assessment means that patients and practitioners can access Medicare payments quickly with little up-front verification. However as a consequence it is important to have a reasonable level of post-payment verification activity to ensure that public revenue is being expended appropriately.

72. The IMCA initiative does not introduce any additional record keeping requirements. Under existing Health Insurance (General Medical Services Table) Regulations one of the elements of a professional attendance is the recording of the clinical details of the service provided to the patient. Many practitioners are also required to keep adequate records as part of their registration requirements under State and Territory legislation.

73. At present many practitioners voluntarily provide health information, including patient medical records, to Medicare Australia during compliance audits.

74. The provision of this information is covered by the National Privacy Principles (NPPs) in the *Privacy Act 1988* which permit personal information to be disclosed to enforcement bodies where that disclosure is reasonably necessary for the protection of public revenue. However where such a disclosure occurs, NPP 2.2 requires a practitioner to make a written note of the use or disclosure.

75. In addition, existing legislation enables Medicare Australia to compel the provision of:

- referrals received by specialist or consultant physicians;
- pathology requests from pathology practitioners;
- diagnostic imaging requests from medical practitioners; and
- other reports (records) held by diagnostic imaging and pathology providers.

These powers are contained in sections 20BA, 23DK, 232DKA, 23DS, 23DR, respectively, of the HIA.

76. The proposed legislative amendments will enable the CEO of Medicare Australia to require a practitioner or another person to produce documents in respect of a service to substantiate a Medicare benefit paid in respect of that service. This will include the power to require production of documents containing health information about an individual.

77. The definition of health information which applies to the proposed legislative amendments is that contained in section 6 of the *Privacy Act 1988*. It includes information from a patient medical record.

78. Consideration was given to defining the requirement so that information contained in patient medical records might only be provided when there was ‘no other alternative’. However this restriction presents difficulties in that it could lead to situations where there may be alternative means to obtain the relevant information but those alternatives are impractical or operationally unrealistic (for example, it could be argued that an alternative to exercising the power might be to interview all the individual patients about their medical condition or servicing history, however this could alert patients unnecessarily that there may be concerns about their doctor or the service provided).

79. The alternative which has been adopted is to include a power in the proposed legislation which is restricted by the concern being audited and the relevance of the documents to the concern.

80. The requirement for the CEO of Medicare Australia to have a reasonable concern before a notice to produce documents can be given to a person limits the extent of this power.

81. The proposed legislation places a requirement on practitioners to produce documents to address the compliance concern being audited. It does not provide Medicare Australia with complete and unjustified access to patient medical records. Medicare Australia will only be able to require that a practitioner provide documents that are relevant to substantiating the Medicare service.

82. This effectively places most of the health information which may be contained in a patient medical record outside the scope of a Medicare compliance audit. By way of example, if a practitioner is given a notice to produce documents in relation to a Medicare item that:

- requires a particular test to be done – Medicare Australia will require evidence that the test was done – but would not need to know what the test result was;
- requires a referral – Medicare Australia will require a copy of the referral – but would not need to see why the referral was made; and
- requires a patient to have a pre-existing medical condition (such as diabetes) – Medicare Australia may require evidence that the pre-existing medical condition existed – but would not need to see how the condition originated, or how it manifests.

83. If the practitioner identifies that an excerpt of a patient medical record is the most appropriate document to address the audit concern, they will be able to censor the excerpt so that only the relevant information is provided Medicare Australia.

84. Medicare Australia will contact the practitioner about the compliance concern in relation to specific services before a notice to produce documents is issued.

85. It is expected that compliance audits will require the production of documents such as appointment books, receipts and referrals and that excerpts from patient medical records will not be relevant to audits conducted in relation to some Medicare services.

86. The evidence required would depend upon the nature of the review being conducted and would vary considerably on a case by case basis. For example Medicare item 16590 is only payable for the planning and management of a pregnancy that has progressed beyond 20 weeks so a practitioner may be asked to present evidence to confirm that the patient met this requirement. The practitioner may do this by providing documents relating to a diagnostic imaging test result or may provide an excerpt from a medical record to verify that the pregnancy had progressed beyond 20 weeks.

87. This will not require any clinical assessment by the compliance auditor at Medicare Australia, just the verification of a matter of fact already supplied.

88. Medicare Australia will have appropriate protections in place to manage the accessing, handling and use of that information:

- authorised persons will undertake additional dedicated privacy training on their obligations with respect to the collection, use, storage and disclosure of personal and protected information;
- Medicare Australia will only be able to exercise the power when there is a reasonable concern about a Medicare benefit paid in respect of a service;
- Medicare Australia will only be able to seek information that verifies the specified service and will be restricted in using the information solely for that purpose; and
- the practitioner will decide what documents and information to provide in response to the audit request.

89. Some stakeholders have also asked whether information provided during a compliance audit could be de-identified. One of the difficulties with this is that when Medicare Australia identifies a risk to the integrity of the Medicare scheme, they do so in relation to concerns about specific services provided to specific individuals (even where the risk identified may be a group of Medicare items or a particular type of practitioner). Once a concern is identified, Medicare Australia contacts the

practitioner to discuss the concern in relation to the specific service provided to an individual.

90. The proposed legislation formalises the process that Medicare Australia uses at present when making requests to practitioners during compliance audits by providing that a notice to produce documents must include:

- the item number of each service specified in the notice;
- the date each service was rendered;
- the Medicare number of the patient for each service;
- the reason(s) for the CEO's concern;
- how the documents can be produced; and
- the period within which, and the place at which the documents can be produced.

91. The proposed legislation does not require Medicare Australia to include the name of the person in the notice. This was discussed with a number of stakeholders who indicated it was a reasonable compromise.

92. One stakeholder organisation has recently indicated that some practitioners can only track patient records through a name and not a Medicare number. Consequently, if a practitioner is not able to identify records using the information provided in the notice, they will be able to contact the compliance auditor at Medicare Australia for additional details.

93. When a notice to produce documents is given to a practitioner, they will also receive a Privacy Notice detailing the reasons the information is being collected, how it will be used, who it could be disclosed to and how it will be stored. As required by IPP 2(d) and consistent with good privacy practice, this notice will also reference Medicare Australia's legal authority for the collection, use and disclosure of the information.

Notification

94. Patient notification has been an important issued raised by many stakeholders during consultations. Some stakeholders support individual patient notification, while others support indirect notification through notices in medical practices and/or on Medicare forms.

95. At present Medicare Australia is not required to notify patients whose personal information is disclosed voluntarily by a practitioner during a compliance audit. IPP2 requires a privacy note only when information is solicited from the individual concerned. This would not change as a result of this project.

96. However, Medicare Australia is required to notify patients when records are seized under a search warrant during criminal investigations. It should be noted that the seizing of records during criminal investigations generally involves whole patient files. This is quite different to what is being proposed in the IMCA initiative.

97. The potential benefits of notifying individual patients that information from their medical records has been provided to Medicare Australia during a compliance audit are that the individual would be aware of where their personal information is being held. It is also possible that the individual patient might receive some limited information about why their information was provided to Medicare Australia. However this would depend of the legislative arrangement and consideration of the individual practitioner's right to privacy.

98. The most common benefit of individual notification occurs when an individual is able to choose whether to release their personal information. However, the proposed legislation does not provide the patient with the ability to opt out of having their information used for a compliance audit. Therefore the main benefits of an individual notification policy would not apply for this project.

99. The potential negative impacts associated with notifying individual patients that information from their medical records has been provided to Medicare Australia during a compliance audit have also been identified based on discussions with stakeholders and Medicare Australia's experience during criminal investigations.

100. The potential negative impacts of individual notification include:

- notification may unintentionally compromise the patient's privacy (for example, where a letter of notification from Medicare Australia alerts someone in the patient's household that they have seen a practitioner where the patient did not want this to occur);
- notification may cause anxiety to some patients (a patient may think that the medical care their practitioner is providing is not appropriate);
- notification may disrupt the therapeutic relationship (a patient may lose confidence in the practitioner); and
- notification may compromise the practitioner's privacy.

101. The privacy rights of the patient must be balanced against those of the practitioner. In considering the potential impact of individual notification one of the concerns has been to avoid the situation which currently occurs during criminal investigations. At present Medicare Australia obtains patient medical records during criminal investigations of practitioners, they are required to individually notify every patient. However, Medicare Australia is also required to protect the privacy of the practitioner, so cannot disclose any detailed information to the patients. This means that patients may receive a notice which does not identify the practitioner, the nature of the investigation or any details about the outcome.

102. In this situation, notification causes considerable concern to patients who worry that a service they have received may have been compromised.

103. However all of these impacts could adversely impact on a practitioner's reputation, business and financial situation. The negatives of notification are therefore substantial in comparison to the benefits and may diminish the privacy of both patients and practitioners.

104. It should be noted that under current arrangements where documents, including patient medical records, are supplied during Professional Services Review processes (under section 105A of the HIA), patients are not notified that their records have been provided for this purpose.

105. An alternative option to individual notification could be:

- for practitioners to note in the patient medical record details regarding which elements of the record have been provided to Medicare Australia during a compliance audit. This would have the benefit of leaving a 'paper trail' should an individual have cause to access their medical record;
- for the Medicare Australia compliance case management system to indicate when a patient medical record has been provided during a compliance audit. This would enable Medicare Australia to report on the frequency and nature of the provision of information from patient medical records during compliance audits either in the annual report or directly to the Office of the Privacy Commissioner.

106. A number of stakeholders suggested a broader information campaign for patients to raise awareness that excerpts of their medical records may potentially be provided to Medicare Australia during a compliance audit.

107. Medicare Australia is currently considering the practicality of providing practitioners with notices to put up in their medical practices and of placing information in Medicare Australia offices on assignment of benefit forms and patient receipts.

Patient Confidentiality

108. Confidentiality is an important part of a practitioner patient relationship. Without confidentiality and trust patients may be reluctant to provide the health information a practitioner requires to treat their patient.

109. The patient confidentiality concept is straight forward; patients have the right to feel safe in providing health information to their practitioner because they know their practitioner is obliged to keep their medical records confidential.

110. There are, however, legislated 'public interest' exceptions to the duty of confidentiality, where practitioners are bound to disclose confidential patient information to a third party, such as in the case of suspected child abuse or notifiable diseases.

111. There are also other situations where institutions and organisations may access patient medical records sometimes without patient knowledge. These include:

    - State or Federal Police Departments
    - State/Federal/Commonwealth Courts (e.g. Coroners Court)
    - Medical Boards

112. For the purposes of this project, the public interest is that of maintaining the integrity of the Medicare scheme. The Medicare scheme provides an undisputed public good that has strong support from the majority of Australians.

113. An important distinction of this project from other public interest disclosures currently required of practitioners is that the disclosure will impact on the practitioner not the patient. Accordingly a patient could feel safe in providing health information to their practitioner as a result of this project because they can be reassured that it will not have any detrimental impact upon them receiving the medical services they require.

114. It is important to note that the concept of patient confidentiality is not intended to be used by practitioners to protect their own interests.

115. Furthermore, Medicare Australia has a long history of securely handling personal information and is active in ensuring high standards of privacy protection so patients can have confidence in relation to the risk of unauthorised or incidental breaches of personal privacy. Notably, Medicare Australia won the inaugural Australian Grand Award for Privacy in 2008. In announcing the award, the Australian Privacy Commissioner noted that "Medicare Australia's dedication to protecting the privacy of its customers is a model for other government agencies and for the Australian marketplace as a whole".

116. Some stakeholders have suggested that if information from a patient medical record is supplied during a compliance audit, it should only be viewed by medical advisers within Medicare Australia. This suggestion was not adopted in the proposed legislation.

117. Under current arrangements, Medicare Australia's medical advisers sometimes review the clinical content of information provided by practitioners where it is required to assess the eligibility of claims for payments of benefits, or to assess concerns about possible inappropriate practice.

118. The compliance audits being conducted as part of the IMCA initiative are administrative checks to substantiate the Medicare benefits paid in respect of services. Compliance auditors will not be assessing whether a particular service was clinically relevant or appropriate.

119. The compliance audit process requires all Medicare Australia compliance officers to have special training in the collection, use, storage and disclosure of personal and protected information; as well as an understanding of administrative processes in respect of the Medicare scheme.

Privacy Impact Analysis—Collection (Information Privacy Principles 1-3)

120. The proposed legislation will comply with the requirements of IPPs 1 to 3.

121. In regard to IPP1, the personal information will be collected for a lawful purpose that is directly related to Medicare Australia functions and activities. This project will amend legislation to allow Medicare Australia to require practitioners to produce documents, including information from a patient medical record when necessary, to substantiate a Medicare benefit paid in respect of a service.

122. The health information being sought from practitioners under this project will enhance Medicare Australia's ability to undertake compliance activities for the Medicare scheme. Compliance activities are an integral part of Medicare Australia's responsibility in carrying out its functions under the *Medicare Australia Act 1973*.

123. IPP2 is not applicable to the collection of a patient's information as part of a Medicare Australia audit, as the project does not involve asking a patient for their personal information directly. However, the issue of notification is discussed elsewhere in this PIA.

124. As indicated above, practitioners will receive a privacy notice when personal information is collected detailing the reasons the information is being collected, how it will be used, who it could be disclosed to and how it will be stored. As required by IPP 2(d) and consistent with good privacy practice, this notice will also reference Medicare Australia's legal authority for the collection, use and disclosure of the information.

125. IPP3 protections are intended to be applied because processes will be established to ensure that only the minimum amount of personal information is collected to substantiate the Medicare benefit paid in respect of a service. These processes will also ensure the completeness of information collected, given the purpose it is being collected for, and minimise the intrusiveness of the collection. The audit process allows the practitioner the opportunity to discuss and explain any inconsistencies found in relation to documents used to substantiate services.

126. A notice to produce documents may only be given when the CEO of Medicare Australia has a reasonable concern that the benefit paid in respect of a service may have exceeded the amount which should have been paid. This means that information will only be collected when there is an identified compliance concern.

127. An assessment has been made that the proposed collection will not be unreasonably intrusive having considered the following:

- the information is not solicited directly from the patient;
- specific notice is not given to patients by Medicare Australia (for the reasons outlined in paragraphs 93-104);
- the information is sensitive information that is also subject to practitioners' duty of confidentiality;
- Medicare Australia can compel production of the information; and
- patients do not have a choice about the use of their information in an audit (for the reasons listed at paragraph 132).

Recommendation 1

128. The PIA should continue to be updated throughout the implementation and ongoing management of the IMCA initiative.

Recommendation 2

129. An information campaign for the public on the need for Medicare compliance audits and the potential for their clinical information to be accessed to confirm payment accuracy should be considered. Alternatively Medicare Australia should explore what information it can make available to patients (on new or existing forms, or through new or existing channels) on the potential for excerpts from their medical records to be provided to Medicare Australia during compliance audits.

Use

130. The information collected under the proposed legislation is only to be used within Medicare Australia during a compliance audit for the purpose of substantiating a Medicare benefit paid in respect of a service.

131. There is to be no data matching or linking of the information collected beyond the reconciling of the specified Medicare service as an intrinsic part of the audit process.

132. Documents and information collected under the new legislation will not be able to be used as the basis for referral to PSR or for other criminal and civil proceedings except for those relating to offences under the HIA or *Criminal Code Act 1995* relating to false and misleading statements made in respect of Medicare services.

133. Upon completion of the compliance audit and closing of the case, documents will either be returned to the practitioner or destroyed in accordance with legislative requirements.

Consent

134. It is not being proposed that patients should have a choice about whether their personal information is used as part of a Medicare Australia audit of a practitioner.

135. The main reasons for this are that:

- access to the necessary information would not be complete if there was an opt out provision; and
- access to the necessary information could be prevented by a practitioner who was able to convince patients to withhold their consent.

136. This is consistent with existing provisions relating to patient medical records provided under the Professional Services Review scheme provisions of the HIA where patient consent is not required for relevant documents provided during investigations of inappropriate practice (sections 89B and 105A of the HIA).

137. Another important consideration from the patient's perspective is that none of the information obtained will be used in making a decision affecting the patient, rather the decision affects the practitioner.

138. The issue of patient consent from the practitioner's viewpoint is different to that of Commonwealth Agencies because practitioners are subject to the NPPs, not the IPPs. The creation of a law requiring practitioners to disclose clinical information for this project means that practitioners are able to do so by virtue of NPP 2.1(g), which allows a private organisation to release personal information for a secondary purpose when authorised or required to do so by law.

Unauthorised Access

139. There are a number of safeguards implemented within Medicare Australia to prevent inappropriate access to information. These are detailed in the Security / Storage section of this document.

140. Medicare Australia also has processes in place for detecting unauthorised access. Given the extra sensitivities around information from patient medical records, it is recommended that access to that information be scheduled for regular internal audits, to ensure early detection of patterns and behaviours which would indicate inappropriate access to and use of data.

Privacy Impact Analysis—Use—Information Privacy Principles 9 and 10

141. The assessment of the privacy impacts is that the proposed legislation will facilitate compliance with IPPs 9 and 10.

142. IPP9 will be complied with because Medicare Australia will use the personal information collected under this project only for a purpose to which the information is relevant, that is the substantiation of Medicare benefits paid in respect of services.

143. IPP10 will be complied with because Medicare Australia does not intend to use the information collected for any purposes other than those for which the information was collected. It should be noted that these primary purposes may include the imposing of a pecuniary penalty and to protect the public revenue.

Recommendation 3

144. Audits of internal Medicare Australia staff accessing information collected during a compliance audit should be undertaken by Medicare Australia on a regular basis, to ensure early detection of inappropriate access and potential misuse of data.

Recommendation 4

145. The notice to produce documents given by Medicare Australia to the practitioner should clearly state that the information being collected may only be used for the purposes of the compliance audit. The notice should also note any secondary purpose the information may be used for as required or authorised by or under law, such as in relation to offences under the HIA or *Criminal Code Act 1995* relating to false and misleading statements made in respect of Medicare services (IPP 10.1(c) 'use of the information for that other purpose is required or authorised by or under law').

Disclosure

146. Disclosure of information collected under a notice to produce documents given under the proposed legislation is subject to the secrecy provisions of the HIA. The secrecy provisions are contained in section 130 of the HIA. Section 130(1) states that:

> A person shall not, directly or indirectly, except in the performance of his or her duties, or in the exercise of his or her powers or functions, under this Act or for the purpose of enabling a person to perform functions under the *Medicare Australia Act 1973, the Dental Benefits Act 2008* or the medical indemnity legislation, and while he or she is, or after he or she ceases to be, an officer, make a record of, or divulge or communicate to any person, any information with respect to the affairs of another person acquired by him or her in the performance of his or her duties, or in the exercise of his or her powers or functions, under this Act.

147. The secrecy provisions prohibit Medicare Australia staff from releasing an individual's information to a third party, unless one of the specified exceptions applies.

148. It is envisioned that disclosures of health information supplied during a compliance audit would only be made by relevant Medicare Australia staff in the exercise/performance of their powers or functions, which would therefore be authorised under s130(1).

149. The majority of the other exceptions in section 130 require authorisation by a specified delegate before information can be disclosed.

150. For any personal information collected outside of the secrecy provisions, disclosure of that information to a third party must be in accordance with IPP 11 of the Privacy Act.

Privacy Impact Analysis—Disclosure—Information Privacy Principle 11

151. Health information currently collected by Medicare Australia is protected under the secrecy provisions of the HIA, and disclosures are governed by those secrecy provisions. Any release of information under those provisions therefore meets the criteria of IPP11.1(d) ['disclosure is required or authorised by or under law'].

Recommendation 5

152. Details on what constitutes an authorised disclosure of health information collected as part of a compliance audit should be made clear and accessible to the public.

Access / Correction

153. Information is available on the Medicare Australia website advising the public on information handing practices within the agency, and on how they can request access to their personal information.

154. An individual may request access to their personal information from Medicare Australia by phone, face to face in a Medicare office, or in writing. Some personal information can also be accessed via the Medicare Australia Online Services channel.

155. An individual can view their Medicare claims history via Medicare Australia Online Services. If an individual believes there are errors in those records, there are avenues by which the individual can request that their Medicare claims history be corrected.

156. Individuals may apply for the correction of their personal information held by Medicare Australia by providing details of the information they consider to be inaccurate. A request for correction may be made in accordance with IPP 7 of the Privacy Act or section 48 of the *Freedom of Information Act 1982*.

157. Where an individual considers the personal information about them held by Medicare Australia is incorrect, out of date or misleading, they may request that Medicare Australia make the appropriate corrections, deletions and additions to ensure that the record is accurate. In the case of Medicare claims details, these can be corrected if necessary by way of a 'latter day adjustment' which would provide correction of the recorded information.

158. Medicare Australia would not correct the information contained in an excerpt of a patient medical record provided during a compliance audit – that information is used only to substantiate the service and is not retained beyond the timeframe required to complete the compliance audit. Any corrections would be made to the individual's claims history held within Medicare Australia records and systems.

159. Medicare Australia will not automatically release updated details to agencies or organisations who have received authorised disclosures of Medicare claims data. If there are exceptional circumstances (eg serious and imminent threat to the life or health of the individual), there are processes within the Medicare Australia Release of Information (ROI) system that would enable a proactive release of the new information.

160. If an individual wanted to alter their medical records held by the practitioner, they would need to make that request to the practitioner.

Openness

161. A recommendation has been made that Medicare Australia review its privacy policies and processes to ensure that people are adequately informed about the types of

personal information that Medicare Australia holds. This could include making more information available on the Medicare Australia website about the nature of the records of personal information held by Medicare Australia and the purpose for which that information is held.

162. Likewise, a recommendation has been made that peak bodies for practitioner groups review and, if appropriate, advise their members of changes that may be needed to Privacy Policies which may be displayed in practices.

Recommendation 6

163. To increase compliance with the openness and transparency requirements of privacy best practice, Medicare Australia should review the information available on its website about the type of personal information held by Medicare Australia and the purpose for which that information is held.

Recommendation 7

164. Medicare Australia and the Department of Health and Ageing should use existing relationships with peak practitioner groups, health consumer and privacy groups to review and, if appropriate, change their accreditation requirements and Privacy Policies in relation to notices displayed in practices.

Privacy Impact Analysis—Access / Correction—Information Privacy Principles 5-7

165. In regard to IPP5, Medicare Australia has some details on its website about the personal information held and how this can be accessed. Medicare Australia also maintains a Personal Information Digest (PID), which is submitted to the Privacy Commissioner on an annual basis. Compliance with IPP5 could however be improved by implementing the action in Recommendation 6, to include more information on the Medicare Australia website rather than relying on the OPC to publish the PID on their website.

166. Medicare Australia complies with IPP6 in that it has a range of access processes in place. These processes include that requests can be made under Freedom of Information legislation or ROI legislation and policies.

167. In terms of IPP7, the nature of the project means that the information collected relates to a specific point in time so it is not consistent with the purpose of the collection to update the health information held. The health information collected for a compliance audit is disposed of once the review is complete (when it is no longer relevant for the purpose for which it was collected).

Data Quality

168. Consistent with current practice, Medicare Australia will take all reasonable steps to ensure that the information supplied by a practitioner as part of a compliance audit is the most accurate, up-to-date and complete information to the extent required to satisfy that a Medicare benefit has been paid correctly.

169. The auditing process is seeking to substantiate a Medicare benefit paid in respect of a service.

170. The auditing process allows the practitioner the opportunity to discuss and explain any inconsistencies found in relation to documents provided to substantiate services.

Privacy Impact Analysis—Data Quality—Information Privacy Principle 8

171. The assessment of the privacy impacts is that there are processes in place to ensure that the information used for the purposes of the compliance audit is accurate, up-to-date and complete to the extent required to satisfy that a Medicare benefit has been paid correctly. These processes therefore would comply with the requirements of IPP 8.

Security / Storage

172. Personal information collected under this project will be protected by the security safeguards that are currently in place in Medicare Australia. Those safeguards are in place both to prevent and to detect unauthorised access. They cover the facets of personnel security, physical security and IT security.

173. The safeguards implemented within Medicare Australia to protect personal information include:

- access rights are issued on the basis of staff requiring this in the performance of their duties,
- application of existing Medicare Australia policies and procedures (eg security, privacy, unauthorised access policies), and
- application of existing Medicare Australia security processes for authentication and authorisation of staff accessing records.

174. Medicare Australia complies with requirements specified in documents including:

- the Commonwealth Protective Security Manual (PSM);
- the *Privacy Act 1988*;
- secrecy provisions in the HIA and the NHA;
- the Australian Government Information and Communications Technology Security Manual (ACSI 33);
- the Australian Government e-Authentication Framework (AGAF);
- the Gatekeeper Public Key Infrastructure (PKI) Framework; and
- other Australian Government and international security standards.

175. Existing Medicare Australia procedures will be used to authorise staff access to premises and systems. Users of IT systems will require a logon and password, access to physical areas and material will require security passes and keys. Audits trails will be maintained and can be used to detect behaviours which may indicate unauthorised access.

176. Existing Medicare Australia processes will be used for reporting of security and privacy breaches. Medicare Australia staff are obligated to report any security and/or privacy incidents for appropriate follow-up.

177. Under current compliance audit processes, access to documents drawn from patient medical records provided voluntarily by practitioners to Medicare Australia is limited to specifically trained and authorised Medicare Australia staff.

178. Only select authorised Medicare Australia staff will be allowed to give a notice to produce documents to a practitioner. These authorised staff will be given additional training in the use and storage of sensitive information.

Privacy Impact Analysis—Security—Information Privacy Principle 4

179. On the basis of the information available regarding current procedures and the proposed legislative amendments, the assessment of the privacy impacts is that the measures in place are designed to ensure personal information can be accessed by authorised personnel only, and include audit activities to detect and identify inappropriate access. These processes comply with the requirements of IPP4.

Retention / Destruction

180. Medicare Australia has implemented records management policies to ensure compliance with statutory recordkeeping obligations, including those in the following legislation:

- *Medicare Australia Act 1973*
- *Archives Act 1983*
- *Evidence Act 1995*
- *Freedom of Information Act 1982*
- *Crimes Act 1914*
- *Financial Management and Accountability Act 1997*
- *Electronic Transactions Act 1999*
- *Ombudsman's Act 1976*
- *Administrative Appeals Act 1975*

181. Personal information collected as part of the compliance audit process is retained by Medicare Australia only until the purpose for which it was collected has been effectively met. The information is disposed of by Medicare Australia once the compliance activity has been fully concluded.

182. If the information is required for legal purposes, recovery or enforcement of penalty, the file is kept securely until any legal proceedings are completed.

183. Once the information is no longer required it is either returned to the practitioner or destroyed in accordance with current legislative requirements.

184. Medicare Australia complies with the requirements of the Archives Act, the PSM, Medicare Australia's Disposal & Destruction of Classified Information Policy, and other relevant legislation and policies when disposing of personal information.

185. These government policies governing destruction of sensitive and classified information require the information be destroyed in a manner which prevents recognition or reconstruction. For example, paper based information should be shredded or pulped. Electronic or removable media should be physically damaged to the point of inoperability, (eg. via shredding, degaussing, melting, or other such methods) before disposal of the media.

Recommendation 8

186. To provide clarity and transparency, Medicare Australia should establish and publish a clear set of guidelines covering the relevant retention and destruction policies relating to documents collected through the proposed legislation.

Recommendation 9

187. Audits of the records management of health information should be undertaken, to ensure compliance with retention and destruction guidelines and policies.

Privacy Management

188. The project recognises the importance the community places on the privacy of its health information. Policies and processes outlined in this document will continue to be developed in conjunction with any new policies arising (eg, from stakeholder feedback) to keep the need for information from patient medical records to be provided

during compliance audits to the minimum necessary to substantiate the Medicare benefit paid in respect of the service.

189. Medicare Australia is already active in ensuring high standards of privacy protection and has an extensive range of privacy protection activities which support the relevant legislation and best privacy practice.

190. These activities include:

- induction training for new staff and follow up training on identified privacy issues relevant to staff in different business areas (including for example, training on the secrecy provisions of the HIA);
- privacy impact assessments of new initiatives involving the collection, use or disclosure of personal information;
- audits of access to personal information to identify any unauthorised access by Medicare Australia staff;
- provision of specialist privacy advice to all business units to encourage the identification and resolution of any privacy issues as they arise;
- reviews of customer complaints and staff reports of possible privacy breaches to ensure action is taken to address any ongoing risks; and
- specific processes for the release of personal information to any other agency or person (personal information is only disclosed in line with privacy requirements)

191. Under current arrangements, all personal information collected by Medicare Australia must be managed in accordance with the *Privacy Act 1988*. Most personal information is subject to additional privacy requirements specified in "secrecy provisions" included in the *Health Insurance Act 1973* and the *National Health Act 1953*. These provisions make it an offence for information to be divulged other than in narrowly specified circumstances.

192. Additional privacy protection is provided by:

- the APS Values and Code of Conduct, based on the *Public Service Act 1999*
- the *Archives Act 1983*
- in the case of health service providers and contractors who do business with Medicare Australia, the private sector provisions of the *Privacy Act 1988*.

193. In addition to the extensive privacy safeguards already operating, the following are some of the safeguards currently proposed for the project:

- a notice to produce documents may only be given when Medicare Australia has a reasonable concern that a Medicare benefit paid in respect of a service may exceed the amount that should have been paid;
- Medicare Australia may only require a practitioner to produce information relevant to substantiate the service;
- processes will be established to ensure that only the minimum amount of health information is collected to substantiate the service/s; ;
- where information from a patient medical record is required it will only be viewed by an authorised person (note - an authorised person will be defined in a policy document which could be made available to the public);
- existing staff will receive refresher privacy training;
- staff performing the function of an "authorised person" will undertake additional dedicated privacy training on their obligations with respect to the collection, use, storage and disclosure of personal and protected information (this will be incorporated into internal policy);
- documents and information collected will not be able to be used as the basis for referral to PSR or for other criminal and civil proceedings except for those relating to offences under the HIA or *Criminal Code Act 1995* relating to false and

misleading statements made in respect of Medicare Services (proposed in the draft legislation);

- Medicare Australia will conduct regular internal audits to ensure early detection of patterns and behaviours which would indicate inappropriate access to and use of data (see PIA recommendation 3);
- consideration will be given to reporting on the frequency and nature of the provision of information from patient medical records to Medicare Australia during compliance audits; and
- conducting a post implementation review of the initiative including a privacy audit to assess the ongoing privacy impacts (see PIA recommendation 10).

194. Further safeguards may be identified from feedback received as part of the ongoing consultation and from the implementation process.

Recommendation 10

195. Consideration should be given to reporting on the frequency and nature of Medicare Australia's access to clinical notes and reviewing the initiative after implementation, including a privacy audit to assess the privacy impacts, once the new procedures have been operational for a period of time.

Summary of recommendations

Recommendation 1

The PIA should continue to be updated throughout the implementation and ongoing management of the IMCA initiative.

Recommendation 2

An information campaign for the public on the need for Medicare compliance audits and the potential for their clinical information to be accessed to confirm payment accuracy should be considered. Alternatively Medicare Australia should explore what information it can make available to patients (on new or existing forms, or through new or existing channels) on the potential for excerpts from their medical records to be provided to Medicare Australia during compliance audits.

Recommendation 3

Audits of internal Medicare Australia staff accessing information collected during a compliance audit should be undertaken by Medicare Australia on a regular basis, to ensure early detection of inappropriate access and potential misuse of data.

Recommendation 4

The notice to produce documents given by Medicare Australia to the practitioner should clearly state that the information being collected may only be used for the purposes of the compliance audit. The notice should also note any secondary purpose the information may be used for as required or authorised by or under law, such as in relation to offences under the HIA or *Criminal Code Act 1995* relating to false and misleading statements made in respect of Medicare services (IPP 10.1(c) 'use of the information for that other purpose is required or authorised by or under law').

Recommendation 5

Details on what constitutes an authorised disclosure of health information collected as part of a compliance audit should be made clear and accessible to the public.

Recommendation 6

To increase compliance with the openness and transparency requirements of privacy best practice, Medicare Australia should review the information available on its website about the type of personal information held by Medicare Australia and the purpose for which that information is held.

Recommendation 7

Medicare Australia and the Department of Health and Ageing should use existing relationships with peak practitioner groups, health consumer and privacy groups to review and, if appropriate, change their accreditation requirements and Privacy Policies in relation to notices displayed in practices.

Recommendation 8

To provide clarity and transparency, Medicare Australia should establish and publish a clear set of guidelines covering the relevant retention and destruction policies relating to documents collected through the proposed legislation.

Recommendation 9

Audits of the records management of health information should be undertaken, to ensure compliance with retention and destruction guidelines and policies.

Recommendation 10

Consideration should be given to reporting on the frequency and nature of Medicare Australia's access to clinical notes and reviewing the initiative after implementation, including a privacy audit to assess the privacy impacts, once the new procedures have been operational for a period of time.

Attachment A

14 May 2008

Dear <>

Commonwealth Budget – Increased MBS Compliance Audits

The Commonwealth Government has announced that it is moving to further protect the integrity of Medicare by boosting its Medicare compliance program. I am writing to provide you with further information on this budget announcement.

Summary of the Initiative
The efficient and appropriate allocation of resources is a core element of the Government's health reform initiatives. Commonwealth spending on Medicare benefits is currently around $13 billion per annum (2007-08) and the Commonwealth Government needs to ensure that this expenditure provides the best value for money. A program as large as the Medicare Scheme requires a reasonable level of compliance activity to ensure that payments are only being made for eligible claims. The Government has decided that the current level of MBS compliance activity may not have kept up with growth in the Medicare program over recent years.

Under the '*Increasing MBS Compliance*' initiative the Government will increase audits on Medicare Benefits Schedule (MBS) services to ensure that providers are fulfilling the requirements of relevant MBS item descriptors.

The Government will also increase the powers of Medicare Australia to compel the production of records substantiating MBS billing and claiming, and introduce new administrative penalties for individuals who are found to be claiming MBS benefits incorrectly.

Increased Audits
Commencing in January 2009 Medicare Australia will be funded to undertake an additional 2000 MBS compliance audits each financial year. Under this increased audit program providers will be asked to justify their MBS claiming by providing explanations and supporting documentation.

An audit will generally involve Medicare Australia notifying a provider that a concern has been identified, and asking them to produce evidence supporting their claims or billing. For those that are selected for audit there will be some limited work in collecting the necessary evidence to substantiate their MBS Claims. This work will generally involve showing Medicare Australia relevant documents relating to limited and specified services. Medicare Australia does not expect that responding to a desk audit would be an onerous task for practitioners who keep adequate records.

Access to a Broader Range of Records
When requested, providers will be required to produce records that show compliance with the claiming requirements contained in the MBS. Requiring practitioners to verify their claims for Medicare eligible services when audited is a reasonable and responsible way of ensuring that taxpayer funds are spent appropriately. This initiative will include giving Medicare Australia access, in certain limited circumstances when there is no other alternative, to relevant excerpts of a provider's clinical notes.

Health Professionals are already under legal obligations to keep and retain records relating to their treatment of patients and the rendering and claiming of Medicare Benefits. This proposal will not introduce any new record making or retention requirements. The proposal will also reduce the current uncertainty around what a provider can provide to Medicare Australia as part of an audit.

In drafting the new legislation the Government will work closely with key stakeholder groups and the Office of the Privacy Commissioner, to ensure that the legislation properly protects the privacy of both the provider who is being audited, and the consumer whose medical services may be subject to review.

A New Financial Penalty System

The Government has also announced its intention to introduce financial penalties for practitioners who have caused the Commonwealth to pay Medicare Benefits incorrectly. These financial penalties will provide a simple and transparent system to address non-compliance and create an additional incentive for providers to ensure they are compliant with MBS requirements.

The Government believes that practitioners who occasionally make incorrect claims will be better addressed by paying financial penalties, rather than being pursued in the criminal courts, or being suspended by a body of peers. Paying a financial penalty will encourage these practitioners to change their behaviour, and repay the taxpayer for the money that has been taken, without any permanent or significant damage being done to their professional reputation or standing.

Actual penalty amounts will be set in consultation with key stakeholders, and will be based on established legal principles including fairness, proportionality, natural justice and equity.

Consultation
During 2008-09 Medicare Australia, and the Department of Health and Ageing, will undertake significant consultation with the medical profession and other stakeholders about the changes to the compliance program.

If you have any questions about the 'Increased MBS Compliance' initiative you can find more information on the Department of Health and Ageing website, http://www.health.gov.au/, or otherwise call **Luke Twyford** on **(02) 612 47376**.

Medicare Australia looks forward to working with you and your organisation on this important initiative.

Yours Sincerely

Catherine Argall PSM
CEO
Medicare Australia

Attachment B

18 October 2008

Dear <Stakeholder>

Please find enclosed an information sheet on the Increased MBS Compliance Audits initiative (Attachment A). The Department of Health and Ageing (DOHA), in conjunction with Medicare Australia, is seeking your views on how these changes should be operate.

Background
The Medicare scheme is funded by taxpayers and the Government has a responsibility to ensure that these funds are expended appropriately. As part of the 2008 Budget, the Government announced the first significant increase to compliance activities for the Medicare scheme in over ten years. The Increased MBS Compliance Audits initiative will:

- significantly increase the number of audits conducted each year by Medicare Australia;
- expand the program to include allied health professionals; and
- provide better coverage of specialists.

The Government also intends to amend legislation to:

- require Medicare providers to produce evidence to verify their Medicare claims when audited by Medicare Australia; and
- introduce financial penalties for those Medicare providers who repeatedly bill Medicare incorrectly.

These changes build on Medicare Australia's current compliance activities and complement the work of the Professional Services Review.

Consultation process
DOHA, in conjunction with Medicare Australia, is consulting with organisations representing the medical profession, allied health professionals and health consumers, as well as with the Office of the Privacy Commissioner.

It is anticipated that consultation will be an iterative process which will occur throughout the development of these components of the initiative.

The views of stakeholders will be used to inform how the production of evidence and administrative penalties will work in practice, and will be incorporated into the draft legislation during December 2008 and January 2009.

Stakeholders will be provided with progress reports on the Initiative as matters progress. At present, it is anticipated that the Bill will be included on the legislation program for the Autumn 2009 Parliamentary sitting.

Senior representatives from DOHA and Medicare Australia will also meet with organisations representing key stakeholders during October 2008 to discuss the development of this package. While the main focus of these discussions will be the development of the legislation they will also present an opportunity to address any issues in relation to the increased audit activity.

If you would like to provide feedback or arrange a meeting to discuss these changes you should contact:

Rose Ross
Director (a/g) Medicare Integrity Section
Medicare Benefits Branch
Department of Health and Ageing
GPO Box 9848
Canberra ACT 2601
email: rosemund.ross@health.gov.au

I trust this information is of assistance and look forward to receiving your feedback on the initiative.

Yours sincerely,
<Sender details>

Increased MBS Compliance Audits
Information Sheet

What has been announced?

In the 2008–09 Federal Budget the Australian Government announced its plan to refine and enhance the MBS audit process undertaken by Medicare Australia.

The Increased MBS Compliance Audits initiative has three components:

1. increasing the number of audits undertaken by Medicare Australia;
2. compelling Medicare providers to produce evidence to verify their claiming when audited; and
3. introducing administrative sanctions for Medicare providers who claim incorrectly.

For the purposes of this initiative a Medicare provider is any person who renders or initiates a service for which a Medicare benefit is payable.

Why are these changes being made?

In 2007–08, expenditure on the Medicare scheme was over $13 billion and there were 280 million transactions generated by over 60,000 Medicare providers. This initiative is the first significant investment in the Medicare compliance program in over ten years. In the last five years alone, Medicare expenditure has increased by 43% and there has been considerable growth in both the number of items (23%) and the number of individual providers (15%).

The Government recognises that most Medicare providers try to do the right thing and Medicare benefits are currently paid with minimal up-front verification so that individuals can receive their rebates quickly. As part of ensuring the integrity of the system, a small percentage of providers will occasionally be asked to verify their claims.

What is proposed under the increased audit component?

Commencing in January 2009 the coverage of Medicare Australia's audit program for the Medicare scheme will increase from 0.7% to 4% of the total active provider population. This means that the number of audits conducted each year will increase from 500 to 2,500.

The program will also be expanded to include allied health providers, and increase the proportion of specialists audited. This is important because to date, the audit program has predominantly focused on GPs, although they only comprise around one-third of the total active provider population.

The audits conducted by Medicare Australia under this initiative will be a simple administrative check to ensure that providers are fulfilling the MBS item requirements for which a Medicare benefit has been paid. Medicare Australia's current risk assessment processes, incorporating the use of artificial intelligence and data reviews to identify anomalous claiming patterns, will continue to be used to identify claims for audit.

Medicare Australia will continue to focus on the provision of information as its primary response to compliance concerns and has announced that it is both increasing and enhancing the provision of information, support and education to providers.

What is proposed under the access to evidence component?

The Government intends to amend legislation to introduce a general obligation on Medicare providers to respond to a Medicare Australia audit request.

Why does Medicare Australia need this new authority?

Medicare providers currently self-determine which service they have supplied and what payment their patients are entitled to receive. When a provider itemises an MBS item they are effectively stating that the conditions of the indicated item have been met. The Government trusts providers to get these details right – and whilst key requirements such as patient eligibility and provider details are checked – payments are made quickly without additional verification of the claim details. This offers convenience for both providers and patients. To balance this Medicare Australia needs to conduct post-payment audits to confirm that claims and payments are correct in order to give some level of assurance that government expenditure is directed appropriately.

There is currently no legal framework to set out either Medicare Australia's or the practitioner's rights and responsibilities in relation to the provision of information to Medicare Australia. It is not clear what Medicare Australia can ask for or what practitioners are obliged to provide in response to a Medicare Australia request. Whilst most practitioners respond co-operatively to Medicare Australia's requests for information some do engage in protracted negotiations with Medicare Australia through Medical defence unions, industry bodies, and legal firms. In some circumstances practitioners have provided Medicare Australia with too much information, the wrong type of documents or not all the information necessary to confirm the accuracy of the claims.

This is particularly relevant to those issues which can only be confirmed by reference to clinical information. The intent of this new authority is to make it clear what information can be requested and what a practitioner's obligations are in responding to Medicare Australia requests.

This initiative will give practitioners and Medicare Australia greater certainty by providing a legislative framework about practitioner rights and obligations in verifying MBS billing. This will reduce unnecessary drains on the resources of both the practitioner and Medicare Australia.

What power will Medicare Australia have to access information?

In most cases Medicare providers will be able to verify their claims using documents such as referrals and requests, appointment books, and receipts. However, some MBS items may require information from a clinical record to confirm that the content requirements have been met. For example Item 2622 is only payable for consultations for a patient with diabetes, Item 2668 is only payable for consultations with a patient with asthma, and Item 16590 is only payable for the planning and management of a pregnancy that has progressed beyond 20 weeks. Item 2517 requires a practitioner to demonstrate that they have completed a range of checks (eg. HbA1c, weight, height, BMI, blood pressure etc). In these cases a provider may be asked to present evidence to confirm that the patient meets these conditions or that the tests were performed. This will not require any clinical interpretation by Medicare Australia, just the verification of a matter of fact already supplied.

In these situations Medicare Australia will only have the ability to request the relevant excerpt that substantiates the claim and Medicare Australia will not have unfettered access to complete patient records or files. It is also envisaged that the authority to access relevant excerpts from a clinical record during an audit would only be exercised infrequently, and in circumstances where there is no other method of verifying the claim.

Medicare Australia already receives and manages a considerable amount of sensitive information relating to both patients and providers and maintains the highest standards of professionalism in protecting the privacy of this information. The Australian Privacy Commissioner, in announcing Medicare Australia as the first recipient of the Grand Award for Privacy, noted that "Medicare Australia's dedication to protecting the privacy of its customers is a model for other government agencies and for the Australian marketplace as a whole."

How will the Government protect privacy and patient-doctor confidentiality?
The legislative amendments will include appropriate safeguards on the collection and use of health information. These safeguards will be developed in consultation with the Privacy Commissioner and stakeholders and will be governed by both the *Privacy Act 1988*, and section 130 of the *Health Insurance Act 1973*. As a starting point it is proposed that the legislation require that:

- only a few select authorised staff will be given the power to request clinical information;
- these authorised staff will be given additional training in the use and storage of sensitive information; and
- Medicare Australia will only be able to seek information that verifies the details of an identified claim and will be restricted in using the information solely for that purpose.

Isn't this more red tape on providers?
No. The Government does not anticipate introducing any new record keeping or document retention requirements. Medicare providers are already required to keep adequate and contemporaneous records under section 82(3) of the *Health Insurance Act 1973*. Records that meet this requirement should suffice for the purposes of this initiative.

How does this affect the role of the Professional Services Review (PSR)?
PSR exists to protect the integrity of Medicare and the PBS and in doing so:

- protect patients and the community in general from the risks associated with inappropriate practice; and
- protect the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice[1].

It does this through a peer review process which investigates practitioners who may have engaged in inappropriate practice in relation to Medicare or the PBS schemes. Broadly, this involves a committee of the practitioner's peers determining if the rendering or initiating of Medicare or PBS services by the practitioner would be considered clinically relevant and appropriate by the general body of members of the profession.

This initiative will not alter or change the role of PSR in reviewing practitioners who may have engaged in inappropriate practice. Medicare Australia will continue to refer matters relating to inappropriate practice to the Director of PSR. Medicare Australia will not be determining the clinical relevance or appropriateness of services that a practitioner provides.

What is proposed under the administrative penalties component?

The Government has indicated that Medicare providers found to be repeatedly billing items incorrectly will receive education to assist them claim MBS items correctly. In addition, under certain circumstances, providers found to be claiming incorrectly may be subject to administrative penalties. The penalties are intended to act as an additional incentive to encourage providers and their staff to be vigilant about complying with the MBS requirements.

While providers who make one-off mistakes will not be penalised, it is envisaged that those who repeatedly bill Medicare services incorrectly will be subject to a financial penalty. It is envisaged that the financial penalty will be an additional percentage of the amount to be recovered.

The exact nature of the penalty and the actual penalty amounts will be developed following stakeholder consultation. However, in cases of genuine misunderstanding or inadvertent error it may be possible to provide the Medicare CEO with the authority to remit the full amount of the penalty. Alternatively, the penalty could be described so that it would not apply to any amount below a threshold amount.

It is also possible to include 'discounts' to the penalty for self disclosure before or during an audit.

[1] Inappropriate practice is defined in s.82 of the Health Insurance Act 1973 (HIA) as conduct in the rendering or initiating of services that is considered 'unacceptable to the general body of the members of the specialty (profession peers)'.

Why are administrative penalties being introduced?
Making factually incorrect claims through carelessness is against the law. Administrative penalties are appropriate for managing this type of non-compliant behaviour because:

1. the bulk of the non-compliance within the MBS is non-criminal in nature;
2. the seriousness of the majority of breaches rarely warrants court action (either civil or criminal);
3. the Government wants to encourage voluntary compliance rather than taking a strict, strong-handed, technical and/or inflexible approach to enforcement; and
4. administrative penalties are effective and efficient, reduce the court's workload and do not strain the resources of the provider concerned.

At present providers audited by Medicare Australia do not have formal rights to have the merits of their case reviewed by an independent authority. They may apply to the Federal Court or Federal Magistrates Court for a review under the *Administrative Decisions (Judicial Review) Act 1977.* However, this review is limited to ensuring that the decision maker used the correct legal reasoning or followed the correct legal procedures.

It is anticipated that the introduction of administrative penalties will be accompanied by the provision of additional formal appeal rights for providers. This will be developed following stakeholder consultation, but is likely to enable providers to appeal both the assessment of a claim and any penalty notice through cost effective mechanisms such as an independent reviewer with Medicare Australia and the Administrative Appeals Tribunal. The current rights of appeal to the ADJR and Ombudsman will remain.

What legislation changes will be required?

Changes to the *Health Insurance Act 1973* will be required to introduce the obligation to provide evidence and create the administrative penalties.

What consultation is proposed?

The Government will be consulting with organisations representing the medical profession, allied health professionals and health consumers throughout the development of this package. Further discussions will also be conducted with the Office of the Privacy Commissioner.

The Government is now seeking your views on how these changes should operate. Stakeholders are invited to write to the Department of Health and Ageing (DOHA) with their views on how the changes should be implemented. Senior representatives from DOHA and Medicare Australia will also meet with organisations representing key stakeholders during October 2008 to discuss the development of this package. If you would like to provide feedback or arrange a meeting to discuss these changes you should contact:

Rose Ross
Director (a/g) Medicare Integrity Section
Medicare Benefits Branch
Department of Health and Ageing
GPO Box 9848
Canberra ACT 2601
email: rosemund.ross@health.gov.au

The views of stakeholders will be used to design how the production of evidence and administrative penalties will work in practice, and will be incorporated into the draft legislation during December 2008 and January 2009.

It is anticipated that this consultation process will be ongoing with key stakeholders being contacted regularly up until the Bill for these legislative amendments is introduced into the Parliament. At this stage, it is expected that this will occur during the Autumn 2009 sitting.

Attachment C

THE INCREASED MBS COMPLIANCE AUDIT INITIATIVE

YOUR QUESTIONS ANSWERED

What has been announced?

In the 2008–09 Budget the Australian Government announced the Increased MBS Compliance Audit initiative which:

4. increases the number of audits undertaken by Medicare Australia;
5. expands the audit program to include allied health providers and to allow better coverage of specialists;
6. requires providers to produce evidence to verify their Medicare claiming when audited; and
7. introduces a financial penalty for Medicare providers whose incorrect claims cross a specified threshold.

In October 2008 the Department of Health and Ageing (DoHA) and Medicare Australia issued an information sheet about the initiative and invited stakeholder comments. Organisations representing providers, consumers and privacy groups have provided submissions and/or met with the DoHA and Medicare Australia to discuss their input.

This information sheet provides further details on how the proposed legislative changes will operate.

Why are these changes being made?

In 2007–08, expenditure on the Medicare scheme was over $13 billion and there were nearly 280 million transactions generated by around 65,000 Medicare providers. This initiative is the first significant investment in the Medicare compliance program in over ten years. In the last five years alone, Medicare expenditure has increased by 43% and there has been considerable growth in both the number of items (23%) and the number of individual providers (15%).

The Government recognises that most Medicare providers try to do the right thing and Medicare benefits are currently paid with minimal up-front verification so that individuals can receive their rebates quickly. A small percentage of claims identified through Medicare Australia's risk assessment processes as being of medium to high risk of incorrect claiming are audited to ensure their individual accuracy and the overall integrity of the Medicare scheme.

When do these changes take effect?

The increase in the number of MBS compliance audits, and the expansion of the program to include allied health professionals and better coverage of specialists, began on 1 January 2009.

The legislative amendments to the *Health Insurance Act 1973* (the Act) required to give effect to the changes for the production of evidence and the financial penalties will take effect from 1 July 2009, subject to the passage of legislation. The requirement to produce evidence and the financial penalties will not be retrospective. These new powers will only apply to Medicare services provided after the commencement of the legislation.

What is the Government doing to assist Medicare providers to comply with MBS requirements?

The Government recognises that the MBS, particularly the primary care elements, can be complex and is in the process of simplifying the primary care MBS items. This process is being undertaken in consultation with providers and the changes to the MBS will commence on 1 July 2009.

It is usual for reviews of MBS items to be undertaken in consultation with stakeholders. In fact, the relevant craft groups are consulted during the drafting of all item descriptors, and those descriptors are usually agreed with the profession before they are introduced.

In addition, the Medicare Benefits Consultative Committee (MBCC) may review items to ensure that the MBS continues to reflect appropriate clinical practice. The MBCC consists of the DoHA, Medicare Australia, the Australian Medical Association (AMA) and representatives of the relevant craft group. The MBCC may propose changes to MBS items for consideration by the Minister for Health and Ageing. Providers seeking changes to items should consult the relevant craft group which can pursue the matter with the AMA and the DoHA.

Medicare Australia offers a range of resources specially developed for providers on how to correctly claim MBS items. This support is delivered both online and in face-to-face sessions. It is intended that these resources will be updated as required to reflect issues that arise during compliance audits. More details about these resources are attached to this information sheet.

What will be in the legislation?

Notice to produce documents

Currently providers are under no legal obligation to substantiate their MBS claims, unless being investigated for fraud. This means that noncompliant providers can essentially choose not to be audited.

It is proposed that these amendments will authorise Medicare Australia's Chief Executive Officer, or delegate, to issue a written notice under the Act requiring a provider to produce documents that are relevant to determining the validity of an MBS claim. This power will be limited to claims providers have made within the two years prior to the receipt of the notice and will only apply to services provided after the commencement of the legislation.

The legislation will provide that Medicare Australia can only issue a notice where there is a reasonable concern that an MBS payment may not have been claimed correctly. This will prevent the use of the power without a valid justification, and addresses stakeholder concerns that it could be used to over-burden providers.

The legislation will require Medicare Australia to identify the specific service that is being audited and the nature of the compliance concern as is currently the case. Medicare Australia will not specify the document the provider needs to produce, as this will give providers the opportunity to select the document that is most convenient to their individual mode of practice. A contact number will be included so that providers can discuss their individual situation with a Medicare Australia auditor.

The issue of minimising the impact on providers' time has been raised in most stakeholder meetings. Industry representatives have highlighted that individual providers have very different methods for recording their services and that the requests for substantiation need to allow for flexibility.

A failure to respond to a notice to produce evidence issued under the Act would result in a finding the services identified within the notice were incorrectly claimed.

Repayments

The legislation will provide that when an MBS claim has been made incorrectly it will automatically become a debt owed to the Commonwealth which a provider will be required to repay. The debt amount will be calculated as the difference between what was claimed and what should have been claimed for the service that was provided.

Financial Penalties

It is proposed that a financial penalty of 20% will be applied to debts in excess of $2,500[1]. This threshold will ensure that providers who make one-off mistakes are not penalised. Medicare

Australia's data on providers who repaid monies in 2007–08, shows that 64% had a repayment amount of ***less than*** $2,500[2]. Almost half of all recoveries during this period were below $1,000.

The proposed model includes incentives for voluntary admission and cooperation. For instance the penalty would be:

- removed if a provider admits to receiving an incorrect amount prior to any Medicare Australia compliance contact;
- reduced by 50% if a provider admits making an incorrect claim before a notice to produce evidence is issued;
- reduced by 25% if the provider admits making an incorrect claim before completion of the audit.

The proposed model also provides that where a provider completely fails to respond to a notice to produce evidence the full amount of the services identified in the notice becomes a debt and the total penalty payable increases by 25%.

If, within a 24 months period, a provider is found to have made a second (or further) incorrect claim and the total they repaid for the previous claim was more than $30,000, it is proposed that the penalty amount be increased by 50%.

Why does Medicare Australia conduct MBS audits?

The aim of an MBS compliance audit is to check that the provider and patient were eligible for Medicare benefits and the service was provided and met the MBS item requirements. These are all questions of fact and do not impose on either the clinical appropriateness or adequacy of the MBS service. By way of example if a provider claims an MBS item that:

- requires a particular test to be done - Medicare Australia will ask for evidence that the test was done;
- requires a referral - Medicare Australia will ask for a copy of the referral;
- requires a certain amount of time to be spent with the patient, or the service to be performed at a particular time – Medicare Australia will ask for evidence that those time requirements have been met;
- requires a pre-existing condition – Medicare Australia will ask for evidence that the pre-existing condition existed.

During an MBS compliance audit, Medicare Australia will not be authorised to question the clinical appropriateness of the service or item nor the provider's professional decision making. Medicare Australia will only be authorised to test the facts of the service to ensure that they match the claim that has been made.

How are providers selected for MBS compliance audits?

Medicare Australia recognises there are often many acceptable reasons for shifts or changes in claiming behaviour and always gives a provider the opportunity to explain their situation. The four processes through which a provider's claims may be identified for audit are:

1. A provider has used an item/s with a medium to high risk of non-compliance;
2. A provider's claiming statistics appear to be unusual or irregular;
3. A provider's claiming statistics are different to their peers; or
4. Items or individuals identified through tip-offs.

- Further information on how a provider may be selected for a compliance audit is attached to this information sheet.

How will the audit process change?

The new audit process will be largely unchanged. In line with current practice, a provider will be notified that there is an issue with an MBS claim that Medicare Australia is seeking to confirm and asked to produce evidence to verify specified claims. Medicare Australia will specify the reason(s) for the request, the item number of each professional service included in the request, the Medicare

1. In 2007-08, 49% of all recoveries were below $1,000, and 26% were below $200. 22% of recoveries were between $2,500-$10,000; 9% between $10,000-$50,000; 2% between $50,000-$100,000; and 2% were over $100,000

number of the patient(s), and the date the service(s) was provided. The provider will also receive a privacy notice detailing the reasons why the information is being sought, who it will be viewed by, and how it will be used and stored.

How will providers respond to an audit request?

Medicare Australia can receive documents in either hard copy or electronically and will give providers a choice of what is most convenient to them. If a provider prefers, it may also be possible for a Medicare Australia officer to meet with them to view or copy relevant documents. The actual documents a provider might decide to send to Medicare Australia will depend on the MBS item and the specific concern being audited. Further information on how providers can respond to the request will be included in the audit letter. Providers will also be able to discuss the type of information required with a compliance officer.

How will Medicare Australia minimise the impact on a provider's time and business?

Those providers who are audited can expect Medicare Australia to minimise the business impacts of the audit process. Specifically Medicare Australia will be required to be very clear about the services it is auditing, the concerns that need to be addressed and the timeframe a provider has to respond. Medicare Australia will be flexible about the delivery of the evidence, and will work with providers to find the most convenient means of examining documents.

What information will I need to provide?

What type of records should a provider keep?

This initiative will not introduce any new record making or retention requirements for Medicare providers[3]. A provider's medical practice should already have source documents (including receipts and appointment books) and clinical records that:

- clearly identify the patient (by name, reference or Medicare number);
- contain a separate entry for each attendance by the patient and the date on which the service was rendered;
- provide information adequate to verify the administrative details of the service rendered;
- are sufficiently comprehensive to communicate the details of the service provided (i.e. tests performed and ordered, results of examinations).

What records will a provider be required to produce?

The proposed legislation will not specify the kind of document a provider should produce. Instead the provider will be able to choose which documentary evidence they have that confirms the relevant elements of the MBS claims being audited. The kind of evidence required will depend on the risk identified by Medicare Australia. ie. The reason the audit is being conducted. This will be explained in the letter the provider receives.

The legislation will clearly state that Medicare Australia can only ask for and accept documents relevant to substantiating the MBS item/s of concern. Medicare Australia will not be authorised to request whole patient files. It is anticipated that where clinical notes are provided to Medicare Australia to verify a particular claim, they may be censored so that only the details relevant to the audit are legible.

What will happen to the documents collected by Medicare Australia?

Documentation forwarded to Medicare Australia will be viewed by a limited number of specifically trained and authorised staff. These authorised staff will be located in central and state or territory offices rather than local branches. Medicare Australia already has a 'conflict of interest' policy that prohibits staff members from being involved in compliance activities when they are acquainted with the individual connected with the items being audited. If a document substantiates an MBS claim it is likely that only one individual (the auditor) would need to see the document.

Information will be stored in accordance with relevant legislation and current policies that safeguard personal information. Personal information collected during a compliance audit will be protected by the security safeguards that are currently in place in Medicare Australia. Those safeguards prevent

[3] Regulation 9(1) of the Health Insurance (General Medical Services Table) Regulations describes the elements of a professional attendance for a broad range of Medicare attendance items. Recording the clinical details of the service provided to the patient is one element of the professional attendance.

and detect unauthorised access. They cover the facets of personnel security, physical security and IT security. Medicare Australia currently complies with Government requirements including:

- the Commonwealth Protective Security Manual (PSM);
- the *Privacy Act 1988*;
- secrecy provisions in the *Health Insurance Act 1973* (s130);
- the Australian Government Information and Communications Technology Security Manual (ACSI 33);
- the Australian Government e-Authentication Framework (AGAF);
- the Gatekeeper Public Key Infrastructure (PKI) Framework; and
- other Australian Government and international security standards.

It is anticipated that the legislation will prevent documents collected through the audit process from being used for other purposes including Professional Services Review matters. However the documents will be able to be used in criminal matters where a provider has defrauded the Commonwealth.

How does this apply to clinical information?

One of the intents of this legislation is to formalise existing voluntary compliance audit processes where clinical information is already disclosed to Medicare Australia. Currently during an audit Medicare Australia can and does receive health information from providers to validate claims they have made.

Information relevant to payment verification – including some clinical information – is routinely provided voluntarily by some providers during an audit. The *Privacy Act 1988* allows personal information to be disclosed to bodies such as Medicare Australia where that disclosure is reasonably necessary to protect the public revenue. However, at present there is not a clear legal framework which sets out either Medicare Australia's or the provider's rights and responsibilities in relation to the provision of clinical information except in certain limited circumstances (such as fraud). Accordingly, it is not currently clear what Medicare Australia can ask for or what providers are obliged to provide. The proposed legislation will address this ambiguity.

Will patients know that a service they have received is being audited?

It is unlikely that the legislation will require either Medicare Australia or providers to advise individual patients that an MBS service they have received is being audited. A number of stakeholders have indicated that notifying patients may compromise the provider's privacy because it will advise patients that their doctor is being audited by Medicare Australia and cause unnecessary anxiety to some patients.

Where can I find out more?

The draft bill giving effect to the proposed legislation details is expected to be publicly available in March 2009. Both Medicare Australia and the Department of Health and Ageing are continuing to discuss issues relating to the legislative amendments with key stakeholders. As more details become available we will update our website. Visit **www.medicareaustralia.gov.au** then go to **For health professionals**.

Medicare Australia's Resources for Providers

Information and support services that Medicare Australia currently provides to encourage correct claiming include:

- **Enquiry lines**

  Medicare Australia runs a designated Medicare enquiry line for providers who have questions about MBS claiming or interpretation. Providers can contact the Medicare provider enquiry line on **132 150** (local call rate) or via email **medicare.prov@medicareaustralia.gov.au**

- **Administrative Position Statements**

  An Administrative Position Statement (APS) is a Medicare Australia authorised interpretation of an area of the MBS where there is potential claiming ambiguity. These statements aim to provide clarity and reduce uncertainty for providers to make it easier for them to comply with requirements of the MBS and PBS. This should save time and effort and provide peace of mind, especially in the event of an audit where an APS sets the baseline against which compliance is assessed. Visit **www.medicareaustralia.gov.au** then go to **For health professionals** > **Doing business with Medicare Australia > Administrative Position Statements (APS)**

- **eLearning services**

  Medicare Australia's eLearning programs are designed to help providers better understand Medicare requirements. There are currently three MBS related eLearning products covering new providers, rural and remote providers, and dentists. These online education products are easy to use, interactive and free of charge. Visit **www.medicareaustralia.gov.au** then go to **For health professionals** > **Doing business with Medicare Australia** > **Education** for a full list of current eLearning products.

- **Learning guides**

  Learning guides are an alternative if providers are unable to access eLearning. They are designed to help new providers acquire the essential skills needed to access Medicare and the PBS correctly.

- **Quick reference guides and targeted information**

  Quick reference guides are designed to provide clarity on complex areas within the MBS and PBS. The guides focus on topics identified in Medicare Australia's National Compliance Program. Both quick reference guides and targeted information are Medicare Australia's process for providing advice on single issues to people who need them. They are distributed to relevant providers and are also made available on our website. Already in 2008–09, information has been provided to 11,133 allied health professionals and 6,151 general providers in relation to MBS items.

- **Provider percentile charts**

  Provider percentile charts have recently been made available on the Medicare Australia website. The charts show the number of services billed by peer groups for selected MBS items. The charts allow providers to assess their own claiming patterns in relation to others. They have been introduced in response to feedback from providers who told us it would be a valuable tool. Charts on the current website include common attendance items and chronic disease management items. Medicare Australia will update the website on a quarterly basis.

- **Face to face education**

  This financial year Medicare Australia has delivered face to face education sessions on a wide range of topics to support better access to and correct use of the MBS for both new and experienced providers. In the last six months Medicare Australia has provided face to face education to 1408 professionals.

- **Other resources**

  A range of printed handbooks and other resources on Medicare and the PBS are also available. These include prescription writing guides and dispensing and claiming checklists to help providers correctly prescribe PBS medicine within private practice or public hospital settings.

Where can I find out more?

Visit **www.medicareaustralia.gov.au** then go to **For health professionals** > **Doing business with Medicare Australia** > **Education**

How are providers selected for MBS Compliance audits?

There are four broad processes through which a provider's claims may be identified for audit. In each of these processes, Medicare Australia recognises there are often many acceptable reasons for shifts or changes in claiming behaviour and always gives a provider the chance to explain their situation. Our risk identification process takes into account past audit outcomes. This ensures that previously addressed concerns are not re-examined.

The four processes that may identify a provider for audit are:

1. **A provider has used an item/s with a medium to high risk of non-compliance**

   To ensure compliance activities focus on the items and types of services which are most likely to be incorrectly claimed, Medicare Australia undertakes significant analysis to identify items where there is a higher risk of incorrect claims. A significant part of this process includes receiving submissions and ideas from the health industry on the emerging risks and issues affecting MBS compliance. Based on this analysis Medicare Australia selects a number of individuals who have used this item for audit. In this situation a provider may be chosen because they belong to an industry or specialist group involved in areas of high risk billing or may have used a high risk item.

2. **A provider's claiming statistics appear to be unusual or irregular**

   Medicare Australia runs regular reports on the use of MBS items to monitor possible non-compliance. Some of the indicators which may lead to a provider being identified for audit include:
   - claims for an individual item are extremely high;
   - claims for specific items increase dramatically or significantly without any clear or identifiable reason;
   - claims over a specified period are higher than what would be expected;
   - claiming of items appears to be outside a provider's specialty or area of practice;
   - items appear to be claimed without required prerequisites (e.g. no pathology test appears to have been performed for the patient despite the MBS item requiring one);
   - patient billing appears to be abnormal or inconsistent (e.g. provider has claimed for a patient that has seen another doctor on the same day or the items claimed do not appear to meet the demographics of a provider's area).

3. **A provider's claiming statistics are different to their peers**

   From the claiming data it receives Medicare Australia can build a profile of usual claiming behaviour for each provider group and compare an individual's profile to this. This can identify individuals whose use of an item significantly exceeds that of their peers, or whose proportional use of graduated items (e.g. time, size or complexity based items) appears different. Medicare Australia uses sophisticated technology to compare factors including total benefits, services, patient demographics and prescribing of pharmaceuticals. The profiling system is adaptive and takes into account factors such as number of days worked and area of practice.

4. **Items or individuals identified through tip-offs**

   Medicare Australia regularly receives reports about claiming behaviour from members of the public, practice staff and other providers. Sometimes this information relates to poor claiming practice, and possible incorrect claiming. If a provider is identified for audit through this process, Medicare Australia will generally seek information that confirms or disproves the information we have received from the tip-off.

Where can I find out more?

Visit **www.medicareaustralia.gov.au** then go to **For health professionals > Doing business with Medicare Australia Audits and Compliance > National Compliance Program**

Attachment D

Privacy Act 1988—Information Privacy Principles

Principle 1 - Manner and purpose of collection of personal information

1. Personal information shall not be collected by a collector for inclusion in a record or in a generally available publication unless:
   (a) the information is collected for a purpose that is a lawful purpose directly related to a function or activity of the collector; and
   (b) the collection of the information is necessary for or directly related to that purpose.

2. Personal information shall not be collected by a collector by unlawful or unfair means.

Principle 2 - Solicitation of personal information from individual concerned

Where:

(a) a collector collects personal information for inclusion in a record or in a generally available publication; and
(b) the information is solicited by the collector from the individual concerned;
the collector shall take such steps (if any) as are, in the circumstances, reasonable to ensure that, before the information is collected or, if that is not practicable, as soon as practicable after the information is collected, the individual concerned is generally aware of:
(c) the purpose for which the information is being collected;
(d) if the collection of the information is authorised or required by or under law - the fact that the collection of the information is so authorised or required; and
(e) any person to whom, or any body or agency to which, it is the collector's usual practice to disclose personal information of the kind so collected, and (if known by the collector) any person to whom, or any body or agency to which, it is the usual practice of that first mentioned person, body or agency to pass on that information.

Principle 3 - Solicitation of personal information generally

Where:

(a) a collector collects personal information for inclusion in a record or in a generally available publication; and
(b) the information is solicited by the collector:
the collector shall take such steps (if any) as are, in the circumstances, reasonable to ensure that, having regard to the purpose for which the information is collected:
(c) the information collected is relevant to that purpose and is up to date and complete; and
(d) the collection of the information does not intrude to an unreasonable extent upon the personal affairs of the individual concerned.

Principle 4 - Storage and security of personal information

A record-keeper who has possession or control of a record that contains personal information shall ensure:

(a) that the record is protected, by such security safeguards as it is reasonable in the circumstances to take, against loss, against unauthorised access, use, modification or disclosure, and against other misuse; and
(b) that if it is necessary for the record to be given to a person in connection with the provision of a service to the record-keeper, everything reasonably within the power of the record-keeper is done to prevent unauthorised use or disclosure of information contained in the record.

Principle 5 - Information relating to records kept by record-keeper

1. A record-keeper who has possession or control of records that contain personal information shall, subject to clause 2 of this Principle, take such steps as are, in the circumstances, reasonable to enable any person to ascertain:
   (a) whether the record-keeper has possession or control of any records that contain personal information; and
   (b) if the record-keeper has possession or control of a record that contains such information:
      (i) the nature of that information;

(ii) the main purposes for which that information is used; and
(iii) the steps that the person should take if the person wishes to obtain access to the record.

2. A record-keeper is not required under clause 1 of this Principle to give a person information if the record-keeper is required or authorised to refuse to give that information to the person under the applicable provisions of any law of the Commonwealth that provides for access by persons to documents.

3. A record-keeper shall maintain a record setting out:
   (a) the nature of the records of personal information kept by or on behalf of the record-keeper;
   (b) the purpose for which each type of record is kept;
   (c) the classes of individuals about whom records are kept;
   (d) the period for which each type of record is kept;
   (e) the persons who are entitled to have access to personal information contained in the records and the conditions under which they are entitled to have that access; and
   (f) the steps that should be taken by persons wishing to obtain access to that information.

4. A record-keeper shall:
   (a) make the record maintained under clause 3 of this Principle available for inspection by members of the public; and
   (b) give the Commissioner, in the month of June in each year, a copy of the record so maintained.

Principle 6 - Access to records containing personal information

Where a record-keeper has possession or control of a record that contains personal information, the individual concerned shall be entitled to have access to that record, except to the extent that the record-keeper is required or authorised to refuse to provide the individual with access to that record under the applicable provisions of any law of the Commonwealth that provides for access by persons to documents.

Principle 7 - Alteration of records containing personal information

1. A record-keeper who has possession or control of a record that contains personal information shall take such steps (if any), by way of making appropriate corrections, deletions and additions as are, in the circumstances, reasonable to ensure that the record:
   (a) is accurate; and
   (b) is, having regard to the purpose for which the information was collected or is to be used and to any purpose that is directly related to that purpose, relevant, up to date, complete and not misleading.

2. The obligation imposed on a record-keeper by clause 1 is subject to any applicable limitation in a law of the Commonwealth that provides a right to require the correction or amendment of documents.

3. Where:
   (a) the record-keeper of a record containing personal information is not willing to amend that record, by making a correction, deletion or addition, in accordance with a request by the individual concerned; and
   (b) no decision or recommendation to the effect that the record should be amended wholly or partly in accordance with that request has been made under the applicable provisions of a law of the Commonwealth;

   the record-keeper shall, if so requested by the individual concerned, take such steps (if any) as are reasonable in the circumstances to attach to the record any statement provided by that individual of the correction, deletion or addition sought.

Principle 8 - Record-keeper to check accuracy etc of personal information before use

A record-keeper who has possession or control of a record that contains personal information shall not use that information without taking such steps (if any) as are, in the circumstances, reasonable to ensure that, having regard to the purpose for which the information is proposed to be used, the information is accurate, up to date and complete.

Principle 9 - Personal information to be used only for relevant purposes

A record-keeper who has possession or control of a record that contains personal information shall not use the information except for a purpose to which the information is relevant.

Principle 10 - Limits on use of personal information

1. A record-keeper who has possession or control of a record that contains personal information that was obtained for a particular purpose shall not use the information for any other purpose unless:

(a) the individual concerned has consented to use of the information for that other purpose;
(b) the record-keeper believes on reasonable grounds that use of the information for that other purpose is necessary to prevent or lessen a serious and imminent threat to the life or health of the individual concerned or another person;
(c) use of the information for that other purpose is required or authorised by or under law;
(d) use of the information for that other purpose is reasonably necessary for enforcement of the criminal law or of a law imposing a pecuniary penalty, or for the protection of the public revenue; or
(e) the purpose for which the information is used is directly related to the purpose for which the information was obtained.

2. Where personal information is used for enforcement of the criminal law or of a law imposing a pecuniary penalty, or for the protection of the public revenue, the record-keeper shall include in the record containing that information a note of that use.

Principle 11 - Limits on disclosure of personal information

1. A record-keeper who has possession or control of a record that contains personal information shall not disclose the information to a person, body or agency (other than the individual concerned) unless:
   (a) the individual concerned is reasonably likely to have been aware, or made aware under Principle 2, that information of that kind is usually passed to that person, body or agency;
   (b) the individual concerned has consented to the disclosure;
   (c) the record-keeper believes on reasonable grounds that the disclosure is necessary to prevent or lessen a serious and imminent threat to the life or health of the individual concerned or of another person;
   (d) the disclosure is required or authorised by or under law; or
   (e) the disclosure is reasonably necessary for the enforcement of the criminal law or of a law imposing a pecuniary penalty, or for the protection of the public revenue.

2. Where personal information is disclosed for the purposes of enforcement of the criminal law or of a law imposing a pecuniary penalty, or for the purpose of the protection of the public revenue, the record-keeper shall include in the record containing that information a note of the disclosure.

3. A person, body or agency to whom personal information is disclosed under clause 1 of this Principle shall not use or disclose the information for a purpose other than the purpose for which the information was given to the person, body or agency.