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Medicare Australia National Compliance Program

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Foreword

Each year Medicare Australia processes about 500 million transactions and pays more than $30 billion in benefits to providers and the Australian public. Through Medicare and the Pharmaceutical Benefits Scheme, Medicare Australia has a connection with almost every provider and Australian resident, as well as members of the health care sector and professional bodies.

Our research tells us that providers and the Australian public value choice and convenience in accessing our products and services. In recognition of this, we are focused on providing great service, convenience and flexibility by offering a choice of channels and an expanded range of services. Medicare Australia is changing to better serve the needs of providers, the public and the Australian Government.

An important part of providing great service is protecting the integrity of the programs we administer.

We want to make sure that:

The right person receives the right payment at the right time—no more, no less.

We work hard to gain community confidence by being provider and public focused as well as transparent in our operations. The *National Compliance Program 2008–09* is intended to inform providers and the wider community, in an open and constructive way, what they can expect from Medicare Australia and where we will focus our compliance efforts.

We have developed three key strategies that form the core of our business direction and the foundation for delivering the Australian Government's service reform agenda in 2008–09 and beyond:

- the Provider Strategy
- the Public Strategy
- the People Strategy.

These strategies place providers, the Australian public and Medicare Australia staff at the centre of our business thinking.

The Provider and the Public Strategies in particular, address increasing access to and convenience in, the programs that we administer. Program integrity is captured in these strategies as fundamental to our service delivery. Our National Compliance Program is crucial to achieving that integrity and elementary to our business.

This National Compliance Program details our compliance approach, which includes an appropriate mix of education, support, deterrence and enforcement in order to encourage maximum levels of voluntary compliance. The program outlines what risks we will focus on, how we will manage and treat these risks and what compliance activities we have planned to address them for the coming 12 months.

In developing this program we carried out extensive stakeholder consultation to ensure that we understand the issues and circumstances facing providers and we have identified the strategic risks impacting on compliance as:

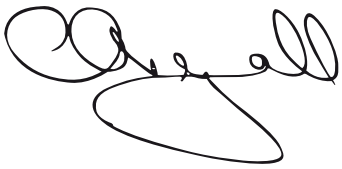
- increasing complexity
- growth in health care items and provider groups
- changes in practice affecting the provision of health services
- eBusiness impacts
- community demand.

This year we will continue to actively support and promote voluntary compliance because we understand that most people want to do the right thing. We will make it easy for people to get it right by delivering choice, convenience and improved access to high quality information and education.

We recognise that there are a small number of people who will seek to deliberately exploit our programs and we will take an appropriate and proportionate response in these circumstances. Our responses can include recovering benefits paid incorrectly, suspension from Medicare and the Pharmaceutical Benefits Scheme and criminal prosecution.

Our program is designed to be balanced and to promote voluntary compliance by helping individuals understand our compliance activities and informing the wider community of our compliance approach.

I am pleased to introduce Medicare Australia's *National Compliance Program 2008–09*.



Catherine Argall PSM
Chief Executive Officer
Medicare Australia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Program integrity

Medicare Australia's goal is to provide great service to the Australian community by providing services and making payments that are quick, efficient and effective. An inherent part of our great service is managing integrity in the delivery of the government programs we administer.

Our payment services are designed to require minimal up front verification without claiming complexity. Our focus is to take a post-payment approach using risk management techniques to monitor and confirm payment accuracy and integrity. As part of this approach we contact providers and members of the public in a range of circumstances—not based on a 'suspicion' of noncompliance but rather as part of our general approach to confirm payment accuracy.

We know that ensuring program integrity is broader than focusing on compliance management. We must first understand the requirements of the programs and the needs and preferences of providers and the public. This means designing and implementing reliable and accessible business systems and providing high quality, timely products and services. It also requires actively supporting voluntary compliance with information on the requirements of the programs and taking appropriate and proportionate action to deal with noncompliance.

We understand the importance of a strong corporate governance framework in ensuring program integrity. Medicare Australia is committed to transparent financial management and upholding our service charter and values.

Program integrity requires a 'whole of organisation' approach to make sure we provide great service, effectively manage compliance and our own commitments and obligations. The areas we will focus on to improve our great service and our corporate governance for 2008–09 are set out in more detail in our *National Business Plan*.

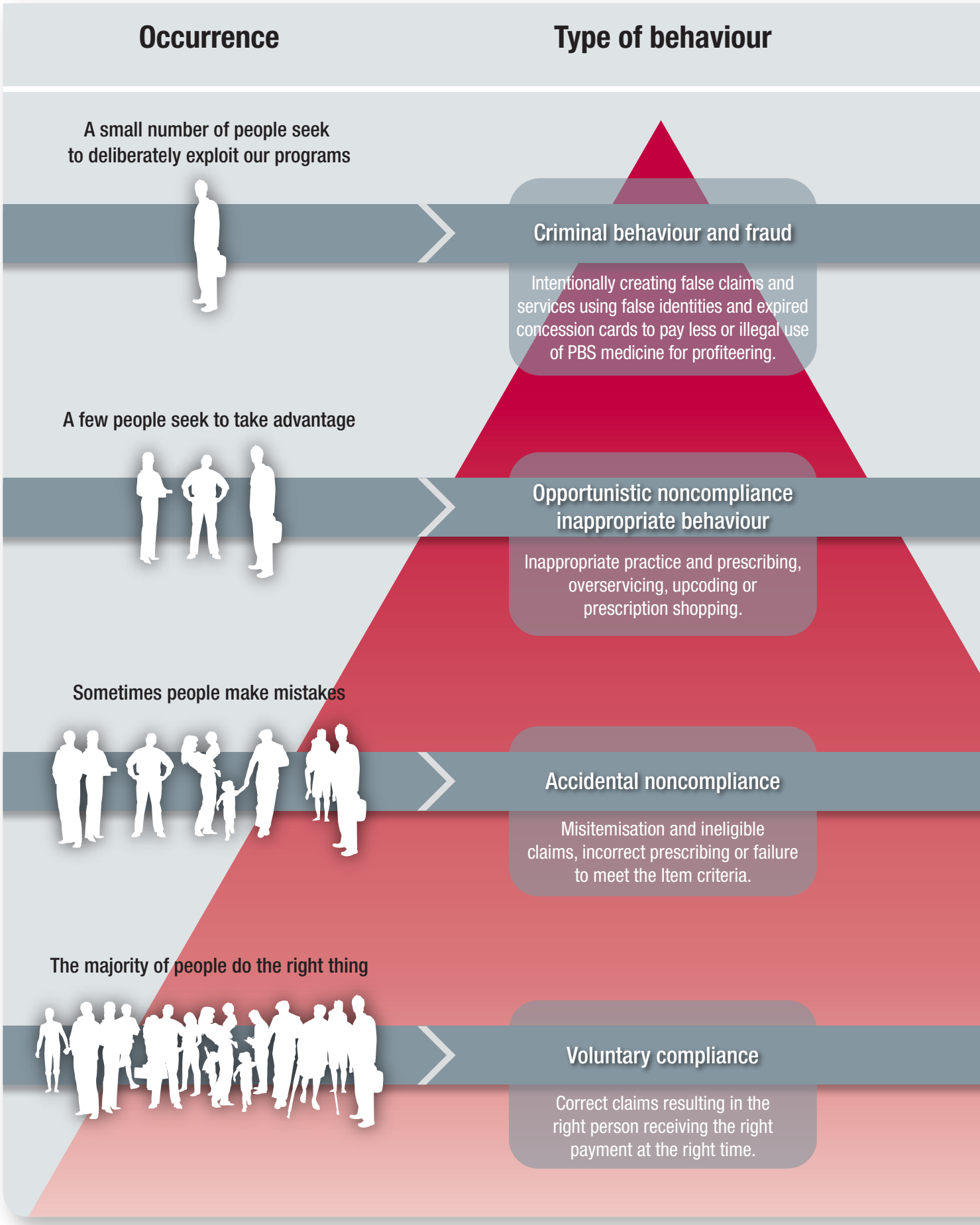
Our compliance philosophy

Our philosophy for managing compliance is about encouraging people to voluntarily comply and dealing with noncompliance and fraud appropriately. The core elements of our philosophy are:

- helping providers and the Australian public to understand their rights and obligations
- making it as easy as possible for them to meet their obligations when making claims for benefits
- supporting people who want to do the right thing
- actively pursuing those who seek to opportunistically or deliberately exploit the programs we administer.

The intent is to maximise the number of people who voluntarily comply with their obligations and minimise noncompliance. To do this we must understand the drivers of noncompliance so that our response can address the systemic problems as well as the particular circumstance we encounter.

Our compliance model



Our response

Enforce the law

We have an obligation to identify deliberate noncompliance and deal with this behaviour using the full force of the law. We will examine all instances of suspected fraud and, where necessary, we will refer matters for criminal prosecution.

Correct behaviour

There will always be a small number of people who seek to gain a benefit or advantage that they are not entitled to. If we find someone has purposely sought to gain an inappropriate benefit, we will seek recovery of the payment and may consider referring the matter for professional peer review.

Counsel and provide feedback

We recognise that sometimes people make mistakes and we will seek to help them avoid future errors. Through targeted information we will explain the issues we have identified, giving reasonable opportunity to respond. In circumstances where money has been obtained incorrectly we may seek to recover those payments.

Help and support

We support the majority of the community who voluntarily comply. We want to make it easy for providers and the public to do the right thing and we do this by providing a wide range of fast and reliable payment services together with high quality, accessible information and education support.

Encouraging a culture of voluntary compliance

Medicare Australia is committed to building a culture of voluntary compliance by actively encouraging the public and health care providers to meet their obligations.

We have identified four key areas which we will improve to encourage and assist compliance:

To enhance involvement, cooperation and commitment with stakeholder groups, we will:

- implement our comprehensive *Provider Strategy* focusing on services and products that make it easier for providers to comply
- enhance our relationships with stakeholders to enable us to better identify compliance risks and co-design practical and appropriate mitigation strategies
- work with stakeholders to understand the impacts of new legislative changes and identify opportunities for effective compliance activities
- enhance communication strategies through increased audience segmentation and better targeting.

To strengthen our information strategies and education program, we will:

- further develop our education program and the range and quality of the education products we offer
- continue to improve our processes for engaging and collaborating with stakeholders to design and deliver education
- continue to inform providers and the public about their responsibilities and entitlements.

To reduce complexity and red tape by streamlining processes, we will:

- further refine our risk assessment tools as part of a program integrity framework that has a provider and public focus
- always aim to increase certainty, enhance national consistency and deliver quality when designing new business systems
- improve the timeliness, consistency and accessibility of our advice when providers and the public ask us for information
- continue to work with policy agencies to develop and influence the design of government policy and legislation to make it easy for people to comply.

To refine our post payment review processes and compliance responses, we will:

- refine our post payment verification systems to detect and deter accidental, opportunistic and deliberate noncompliance
- continue to deliver a compliance program based on education and support
- further strengthen partnerships with other law enforcement agencies and participate in cross-agency intelligence operations.

Our compliance commitments

- **Make it easy for providers and the public** to meet their obligations by providing timely advice and information and seeking new and improved ways to deliver our programs.
- **Be genuinely interested in providers and the public** and take their circumstances into account when conducting our compliance activities.
- **Respect the rights of providers and the public** by explaining our processes and concerns and treating everyone with respect, dignity and courtesy.
- **Get it right** for the Australian community by delivering our compliance program with precision and professionalism to protect the integrity of the programs we administer.

Our strategic compliance risks

Medicare Australia encounters many different forms of noncompliance within the programs we administer and each year we undertake a broad range of activities to identify the strategic risks driving this noncompliance. By understanding these drivers we are in a better position to address any systemic issues and root causes of noncompliance.

This year we undertook environmental scanning and consulted with our stakeholders to better understand the pressures affecting compliance. From this work we have confirmed that the strategic risks identified in last year's National Compliance Program largely remain the same, and form the basis of this year's five key strategic risks impacting on the integrity of the programs we administer.

Strategic risk—increasing complexity

The number and range of items, as well as the complexity of both Medicare and the Pharmaceutical Benefits Scheme may result in misinterpretation or misuse of the schedules.

Medicare and the Pharmaceutical Benefits Scheme (PBS) are the primary programs we administer and account for the majority of benefits we pay.

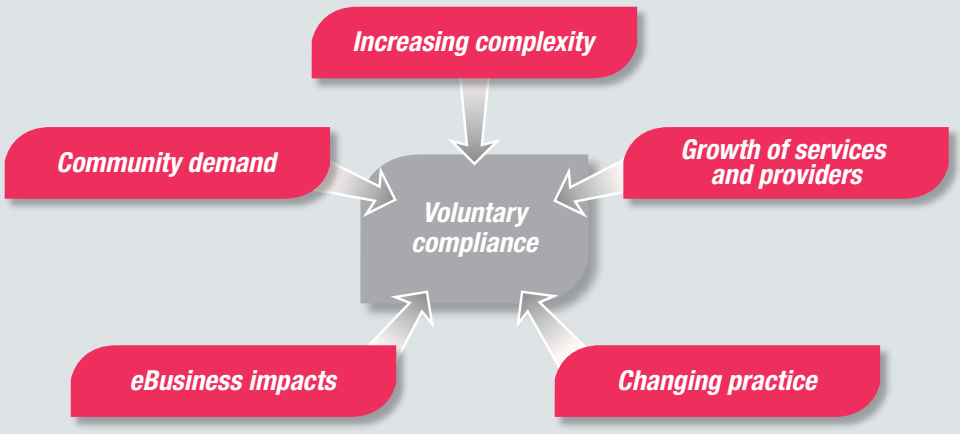
The various ways in which services can be provided, billed and prescribed can generate ambiguity, misinterpretation or opportunistic interpretation of the rules. Developments in health services and medicine also continue to lead to increasingly complex Medicare Benefits Schedule (MBS) items and PBS listings, which may be open to more than one interpretation. This increased complexity creates the potential for accidental noncompliance by innocent mistakes, the provision of services not clinically necessary by failing to meet Item requirements or descriptors, and also opens up opportunities for abuse.

We understand the need to provide practical support and timely advice on MBS and PBS items, legislation and regulatory requirements.

Strategic response—increasing complexity

We will continue to explore opportunities for new products and services to improve the timeliness, relevance and accessibility of our advice, as well as the availability of education products to deal with complexity across all sectors of the provider community.

Five key strategic risks—the pressures on voluntary compliance



Strategic risk—growth in services and provider groups

New Item types on the MBS and PBS as well as new provider groups such as allied health professionals and practice nurses accessing the items increases the potential for noncompliance.

Over the last five years:

- the number of MBS items has grown by 23 per cent
- the number of individual practitioners has grown by 15 per cent
- MBS transactions have increased by 17 per cent
- there are new types of provider groups becoming part of the claiming process, such as allied health professionals and practice nurses.

Growth in provider groups can result in increased misunderstanding and misinterpretation of the schedules leading to incorrect claims.

From a compliance perspective this rate of growth in MBS and PBS items can:

- place pressure on the knowledge of providers, especially new groups of providers dealing with the MBS, PBS and other programs for the first time
- add complexity to the scheme because it requires providers to increase their awareness of items relating to their work
- lead those who have failed to keep up with changes, to claim items no longer relevant or appropriate for their work
- lead to claims that fail to meet Item requirements.

Strategic response—growth in services and provider groups

We will have a greater focus on education and the provision of consistent advice tailored to particular provider groups. We will improve the access and availability of information to support providers when billing or claiming for services.

Strategic risk—changes in business practices affecting the provision of health services

Evolving delivery technologies, business management and service delivery methods all continue to place pressure on correct claiming and appropriate practice.

Business practices within the health industry continue to change. The developments we identified last year are still the major themes of change in health care delivery. In particular we continue to see:

- a shift from small practices to larger group practices or commercial companies
- an increase in casual workforce in general practice
- more specialised services
- rapid uptake of new medical technologies and procedures
- greater emphasis on Aged Care and simplifying medical delivery systems to older patients
- further emphasis on preventative medicine
- increasing complexity in pharmacy ownership.

From stakeholder consultation, research and observation of the health sector, we are concerned that these developments may lead to incorrect claims and/or inappropriate practice. Mainly we are concerned that these changes can place pressure on providers to:

- overservice
- request unnecessary services
- incorrectly prescribe or supply PBS drugs.

We have also observed that there is significant growth in the number of practice staff interpreting the schedules and making claims.

We expect these changes to continue as they are being driven by demand and developments in health practice. We recognise the positive impacts on compliance that the changing health business is driving, including:

- many corporate health entities are increasing the scrutiny, consistency and integrity of their employees' claiming behaviour
- corporate structures provide Medicare Australia with one contact point for compliance concerns
- timely provision of education and training to a corporate entity can have improved compliance impacts.

Strategic response—changes in business practices affecting the provision of health services

We will focus our compliance activities towards the areas of most concern with targeted programs of information, education and enforcement. We will do more to work with stakeholders to develop appropriate responses to noncompliance linked to these changes.

Strategic risk—eBusiness impacts

Increasing use of technology for claiming and service delivery can present new threats to compliance.

eBusiness continues to evolve in the health care sector, creating new business channels and transaction formats. These changes are likely to continue to develop and improve the efficiency and convenience of health care, impacting on:

- the provision of medical services, billing and claiming
- the prescribing of medicine
- record keeping requirements.

While we recognise this will streamline claiming and billing and improve compliance in some areas, we also acknowledge it may lead to greater opportunities for noncompliance in other areas.

Strategic response—eBusiness impacts

We will support developments that improve the health system while increasing our compliance focus in this area. We will be extending our monitoring of claiming and billing practices to target 'at risk' claims for post payment review and potentially audit, including a random selection of MBS and PBS claims. This will include contacting providers and/or members of the public in a range of circumstances after a benefit has been paid.

Strategic risk—community demand

Patients demanding health services and medicine beyond clinical need.

Our stakeholders continue to identify concerns with patients demanding services beyond clinical need. This growth in patient demand can be attributed to a range of factors such as:

- the increase in expectations for preventative care, better detection and management of chronic illness
- increased access to self-diagnosis tools (mostly internet based)
- aggressive advertising, which may also be contributing to this demand.

The outcome of these pressures could include:

- unnecessary tests being performed
- over-prescribing and overservicing
- mis-itemisation of services in the interest of the patient
- the supply of PBS subsidised medicine without an appropriate prescription and in circumstances where the patient may not be eligible.

Strategic response—community demand

We will focus on items showing significant unexplained growth in claims, particularly those connected with substantial advertising. For example, we will closely monitor areas associated with preventative medicine that could lead to medically unnecessary tests or advertised services not covered by Medicare.

Our compliance activities 2008–09

Through our environmental scanning and risk assessment work we have identified a number of specific areas within each of the key risks that we will pay attention to in 2008–09.

Set out below under each strategic risk are the specific issues and behaviours that we will examine over the next 12 months. Our actions may vary based on a proportional response to the compliance threat and the individual's circumstances.

Strategic risk—increasing complexity

The number and range of items, as well as the complexity of both Medicare and the Pharmaceutical Benefits Scheme may result in increased opportunity for misuse and misinterpretation of the schedules.

Area of focus	Our response
Specialist attendances	We will use a range of techniques and processes to test compliance in relation to specialist attendances. This will include the analysis of claiming data to identify noncompliance, provision of targeted information and conducting a range of audits. We intend to focus on: • time-based attendance items at risk of upcoding, including consultant physician and neurosurgery items • the billing of any specialist services without a valid referral or request.
Routine billing of long general practitioner consultations in association with other services	We will conduct an analysis of claiming patterns to detect irregular claiming behaviour and address these through provider reviews and compliance audits. Detected noncompliance will lead to targeted information, with the potential for recovery action and possible referral to the Director of Professional Services Review.
Incentives payments	We will audit 10 per cent of all practices receiving payments through the Practice Incentive Program (PIP). We will conduct a mix of desk and field audits to determine compliance on other incentive programs.
Items at risk of upcoding where the provider will bill for a more complex and more expensive Item than the service provided	Specific attention will be paid to: • skin lesions, excisions, flap repairs • time-based items including attendance items • deep and superficial wounds • general practitioner consultations routinely claimed with practice nurse items. We will continue to support providers to meet their obligations through the delivery of a structured education program that offers a combination of standardised basic Medicare Australia program information and tailored education reinforcing appropriate billing. We will also continue to target high risk areas of the MBS and providers of concern through a series of audits and provider reviews.
Incorrect claiming and payment under the Private Health Insurance Rebate Scheme (PHIR)	We will conduct a number of field audits to determine compliance with the PHIR claiming requirements including instances where claims are made for individuals who are ineligible.
High risk providers who continue to practice and bill inappropriately outside the intent of Medicare and the PBS	We will target high risk providers and apply more stringent measures to change behaviour and maximise compliance.
Teen dental health initiative	As this is a new initiative our focus will be to support the community and providers through delivering effective information services. We will analyse trends of claiming in the first 12 months with a more stringent compliance activity in subsequent years, once the risks are fully understood.

Case study

Not understanding an Item can be costly

The removal of skin lesions is one group of MBS items medical practitioners have had difficulty interpreting.

During 2007 Medicare Australia identified a medical practitioner who had claimed for high volumes of skin lesion removals. We found that although 346 medical services had been performed, the medical practitioner did not understand or meet the requirements outlined in the MBS for the Item that they had claimed. The claims were therefore not valid for payment and we took action to educate the medical practitioner on the correct use of skin lesion items and recovered incorrect payments of $35 205.

Strategic risk—growth in services and provider groups

New Item types that may create ambiguity and new provider groups accessing the MBS and PBS, such as allied health professionals and practice nurses.

Area of focus	Our response
Care plans—management plans and health checks	We will focus our compliance activities on instances where the provider has not met all the requirements of the MBS Item. We will conduct a range of data analyses and desk audits to test the veracity of claims for these items. Specifically we will focus on care plans being claimed when patients have had only one or no previous visits with a provider. Activities will include education, targeted information and more serious interventions if deliberate or extensive noncompliance is found.
Allied health professionals	We will conduct statistical and data reviews to understand allied health professional trends and patterns, and will focus compliance activities on allied health professionals who appear to have a claiming pattern that is different to their peers. We will provide targeted information on compliance issues of concern, and conduct desk and field audits and allied health professional reviews where specific concerns need to be investigated. We will also work with allied health providers to identify and develop information and education products tailored to their needs.
International medical graduates	We will continue to work with stakeholder groups to gain a shared understanding of the issues facing international medical graduates and develop tailored education and information that will support them in 'getting it right'.
Providers who are new to the MBS and PBS	We will provide face to face and online education to support providers new to the MBS and PBS.
Areas of unexplained growth	We will monitor the claiming volumes of MBS and PBS items and conduct risk assessments and intelligence reports on items, providers or groups of items that experience unexplained growth. When unexplained growth is identified, Medicare Australia will conduct an intervention that is proportionate to the noncompliant behaviour.

Case study

Pay attention to new Item types

Medicare Australia identified a medical practitioner whose claiming patterns were substantially different to peers. These claiming patterns were reviewed under the Practitioner Review Program.

During the review, Medicare Australia found that the medical practitioner had incorrectly claimed MBS benefits for 3487 services relating to wound treatment carried out by a practice nurse over a 12 month period. We recovered $45 712 but took no further action as we were satisfied that the errors had resulted from the practitioner's innocent misunderstanding.

Strategic risk—changes in business practices affecting the provision of health services

Evolving delivery technologies, business management and service delivery methods continue to place pressure on correct claiming and appropriate practice.

Area of focus	Our response
The impact of corporate entities on providers and pharmacy behaviour	We will undertake a national project to gain a detailed understanding of the compliance issues in the corporate health care sector. We will research possible noncompliance concerns such as opportunistic billing outside the intent of Medicare which results in incorrect use of items, and incorrect billing including overservicing and mis-itemisation. This will involve a range of research, stakeholder engagement and audit activities.
Inappropriate practice in niche areas where we see significant growth in items, potentially as a result of advertising	We will monitor claiming to identify emerging trends and behaviours of concern in special interest clinics. These special interest areas include heart, skin, allergy clinics and illnesses affecting the digestive system, eyesight or hearing. Audits including provider reviews designed to change provider behaviour and maximise compliance will also be conducted.
Unexplained growth in after hours items	We will analyse growth trends through a series of research and audit activities to better understand drivers affecting compliance in this area. In particular we will review any structural changes made by a practice to gain advantages not intended by legislation.
Supply of medicine for prescriptions where the patient is deceased	We will cross-match data in relation to ongoing claiming of prescriptions after a patient is deceased. This will involve a range of targeted information and audit activities.
Commercial arrangements that lead to increased services particularly diagnostic imaging and pathology tests	We will closely monitor practices to ensure that changes are being implemented to align with legislative requirements. This will involve a range of targeted information and audit activities.

Case study

Corporate advertising for MBS items can lead to overservicing

In 2006 there was considerable advertising of heart screening services by corporate entities. This advertising included claims that these services were eligible for Medicare benefits. As a result, claiming for relevant Medicare benefits grew from $0.54 million in 2005 to $10 million in 2006.

Medicare Australia took a broad approach to clarify the eligibility of such services for Medicare benefits, together with an increased focus on individual practitioners with high levels of these services. Medicare Australia identified 43 medical practitioners whose claiming patterns were substantially different to peers and initiated reviews under our Practitioner Review Program.

Since commencement of this strategy:

- Claiming for one of the key MBS items has decreased with claims submitted in December 2007 returning to approximately the same level as the monthly average claiming in 2005.
- Current advertising for these tests no longer suggests that they are funded by Medicare.

We will continue to monitor these and similar items closely in 2008–09.

Strategic risk—eBusiness impacts

Increasing use of technology for claiming and service delivery can present new threats to compliance.

Area of focus	Our response
Automation of processes relating to clinical decision making that has the potential to affect compliant prescribing and dispensing	We will engage with key stakeholders and software vendors to communicate issues affecting compliance and provide input into the design of 'upfront' controls to reduce risks associated with overriding MBS warnings and PBS restrictions.
Review electronic Medicare claiming to reduce administrative errors and other noncompliant behaviour	We will monitor and analyse eClaiming channels and provide targeted information on common problems and areas of concern. We will focus our payment accuracy reviews and desk based audits on areas of concern.
Technology which changes the nature of practice in ways not predicted by the MBS and PBS	We will monitor providers' use of these technologies, in particular teleradiology and telepsychiatry. This will involve a range of targeted information and audit activities.

Did you know...?

Medicare Australia regularly conducts Multiple Payment Reviews to identify when pharmacies have claimed for the same prescription on more than one occasion.

In 2007-08 Medicare Australia finalised its fourth PBS Multiple Payment Review. As a part of this audit, we reviewed the claims of 324 pharmacies and identified 26 480 multiple claims worth a total of $1.1 million. This amount was recovered from the pharmacies.

This was the fourth Multiple Payment Review conducted by Medicare Australia since January 2003. Over the course of these four audits, the claims of over 1300 pharmacies were reviewed by Medicare Australia and more than $5.3 million in incorrect PBS benefits was recovered.

Multiple payments happen in a number of different ways but it generally occurs when more than one claim is made for the same authorised supply of a PBS Item (i.e. the same prescription is claimed for twice). Specifically, Multiple payments can include:

- **Regenerated repeats**—result in breaches of Regulations 25 (1) and 26 (1A) of the *National Health (Pharmaceutical Benefits) Regulations 1960*.
- **Same day originals**—dispensing these constitutes a breach of Regulation 25 (3) (a) and (4) (a) of the *National Health (Pharmaceutical Benefits) Regulations 1960*.
- **Missing scripts**—constitutes a breach of the Rules under subsection 99AAA(8) of the *National Health Act 1953*, specifically rule 3(g).

Strategic risk—community demand

Patients demanding health services and medicine beyond clinical need.

Area of focus	Our response
Prescribing medicine outside PBS restrictions and authority requirements	We will undertake a combination of targeted information and desk and field audits in relation to noncompliant prescribing. In 2008–09 we plan to review around 10 high risk/high cost groups of medicine, including Esomeprazole, Opioids, Lipid lowering drugs (C10A, C10B), Androgens, Antipsychotics (Quetiapine Fumarate and Olanzapine) and drugs affecting bone structure and mineralisation.
The initiation and billing of diagnostic imaging and pathology services that are not clinically necessary	This will be a focus of our practitioner reviews, targeted information and field audit activities. We will continue to place emphasis on changing the behaviour of those who appear to be responding to community pressures by over-initiating diagnostic imaging and pathology tests through the provision of targeted information and field audits.
Members of the public obtaining more PBS medicine than needed	We will monitor individuals who are suspected of obtaining more PBS medicine than needed through our Prescription Shopping Program and alert prescribers and patients when they meet set criteria. We will provide information services to providers and the public on various topics of concern, including oversupply.
Misuse of identity to obtain benefits not entitled Misrepresentation of concessional entitlements Payment of concessional benefits to those not entitled	We will continue to conduct concession validation reviews across our payment services and potentially run a combination of desk and field audits to identify misuse. We will also work closely with stakeholders to support efforts in checking entitlements and continue to inform the community about how to avoid becoming a victim of identity crime. Our response will include using the full force of the law to deal with identity crime.
Overseas Drug Diversion Program (ODDP)	We will continue to provide information and targeted education to inform the community about the laws on exporting PBS subsidised medicine. In addition, we will continue to participate in joint agency taskforces particularly with the Australian Federal Police and the Australian Customs Service to deter, monitor and deal with potential overseas drug diversion.
Regulation 25 dispensing	We will monitor pharmacies that have a high proportion or volume of Regulation 25 supplies (i.e. where supply occurs inside the 4 and 20 day rule) and we will intervene with pharmacies through a proportionate education and audit program.

Case study

Inappropriate prescribing

Medicare Australia was concerned that a medical practitioner's prescribing of Cox-2 drugs and narcotics to patients may not have been clinically appropriate and that their level of services to patients may have been inappropriate.

Medicare Australia referred the case to the Director of the Professional Services Review (DPSR) who examined a sample of the records. The DPSR found that the PBS guidelines for prescribing Cox-2 drugs had not been followed and uncovered records to suggest some patients were addicted to the narcotics being prescribed. The general practitioner acknowledged practicing inappropriately and admitted to finding many of the patients' demands for medication intimidating. The general practitioner repaid $60 000 in benefits and was fully suspended from prescribing narcotic medications for nine weeks.

Did you know...?

Medicare Australia's Prescription Shopping Information Service (PSIS) helps prescribers make more informed prescribing decisions about patients who may be risking their health by accessing too much prescription medicine.

Once registered they can call the PSIS 24 hours a day, seven days a week on **1800 631 181**** to find out if their patient has been identified under the Prescription Shopping Program. If identified, a near real-time report on the patient's prescribing history is available.

In 2007–08:

- we received over 20 900 calls to the PSIS
- we sent more than 4650 patient reports to prescribers
- we contacted prescribers to discuss more than 3320 patients and sent almost 7700 letters to prescribers.

Overseas Drug Diversion Program information and resources

In 2007–08:

- we received over 5200 calls to the Travelling with PBS Medicine enquiry line
- we received almost 10 800 hits to the website.

For more information, visit the Medicare Australia website to download the:

- patient travel letter template
- medicine export declaration form
- resource material reorder form.

Travelling with PBS Medicine enquiry line: **1800 500 147****

Email: **odd@medicareaustralia.gov.au**

Major initiatives 2008–09

Implement standardised processes to support national consistency

Medicare Australia continues to respond to stakeholder feedback. Part of our focus is to standardise internal processes around the correct interpretation of MBS and PBS items to support providers to get it right when using Medicare Australia programs.

We have introduced the concept of the 'One Medicare View' to offer simple, accurate and consistent information on ambiguous issues or questions that arise regarding an Item descriptor or legislation.

Enhancing and extending the provision of online education

Medicare Australia's second major initiative to support and address compliance issues is to increase the provision of learning and information tools for providers.

Specifically Medicare Australia will enhance its flagship online learning tools—Medicare and PBS e-Learning for new health care professionals, Medicare online learning for rural and remote health care professionals and online PBS education for experienced health care professionals.

We are committed to enhancing online education and information services and recognise that timely, useful and relevant education helps providers to voluntarily comply.

Enhancing compliance through increased MBS audits

As part of the 2008–09 Budget the Australian Government announced that it is moving to further protect the integrity of Medicare by boosting Medicare compliance activities.

Under the *Increased MBS Compliance Audits* initiative the Government will increase the number of audits on MBS services to ensure that providers are fulfilling the requirements of relevant MBS item descriptors. Audits on MBS claims will increase from less than one per cent to over four per cent of the active provider population.

The Government is also proposing to increase the powers of Medicare Australia to compel the production of records substantiating MBS claims and introduce new administrative penalties for individuals who are found to be claiming incorrectly. The exact nature and details of both of these legislation changes will be determined by Parliament in 2008–09 and the Government will work closely with stakeholders and health care professionals throughout the design of the new legislation.

Under the initiative increased auditing will commence from January 2009. More information will be made available as this initiative progresses.

Undertaking compliance activities

The first element of our compliance approach is to help people meet their requirements. However, we must also respond to those who do not meet their obligations either unintentionally or deliberately.

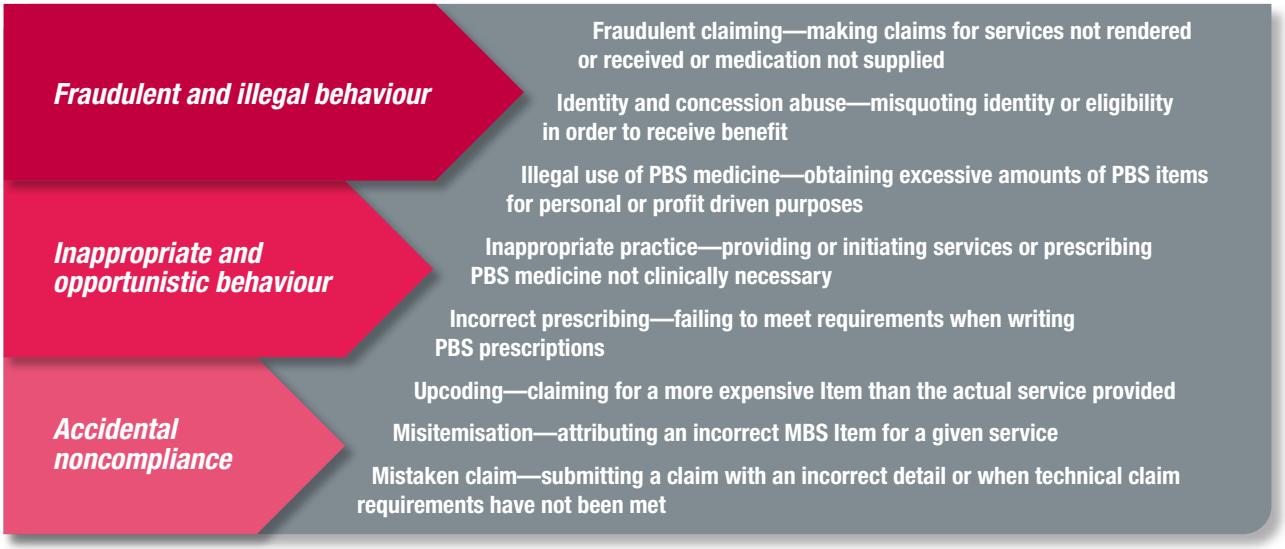
We contact providers and members of the public in a range of circumstances generally after a benefit has been paid. We undertake a range of specific activities to verify compliance including sophisticated data analysis and intelligence gathering, audits, reviews and investigations.

We seek to deal with noncompliance by effectively correcting the immediate issue and establishing ongoing compliance. Our compliance activities and our responses are graduated, ranging from education and counselling through to recovery of incorrect benefits and prosecution.

In dealing with a potential compliance issue, we may:

- contact you by phone to confirm the accuracy and details of a claim
- remind you by letter of the requirements to meet specific requirements and claim certain items
- alert you by phone or letter when we have a concern and need to verify your compliance, or clarify matters with you where we believe there may have been an unintentional mistake
- give you the opportunity to provide an explanation and/or confirmation of your claim when we have a concern
- recover benefits when appropriate for any incorrect or reckless claims
- assess all allegations of fraud and criminal behaviour and pursue appropriate cases to the full extent of the law, including criminal prosecution.

Typical forms of noncompliance



How we detect noncompliance

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

Data analysis and mining activities include:

- assessing tip-offs and referrals from members of the public, our own staff and other Australian Government departments and agencies
- monitoring the practice profiles of medical practitioners to identify outliers and abnormal claiming patterns
- monitoring MBS processing data for unusual trends or patterns and reviewing providers who rank within the top 100 claimants of key items
- monitoring unusual growth in an MBS Item to identify medical practitioners with high or unusual claims for that Item
- mapping of relationships and transactions between patients, medical practitioners and specialists to identify unusual patterns or trends
- developing patterns and profiles from previous case results.

Using targeted information to support providers

Targeted information involves identifying an issue or concern with a provider's claiming history and contacting them to ensure that they understand the rules and requirements. This approach is used when we do not believe that stricter compliance actions are warranted.

In 2007–08 we undertook a wide range of targeted information activities, including mail outs to:

- 3300 medical practitioners who claimed items 721 and 723 in conjunction with a consultation
- 2600 consultant physicians about items 132 and 133
- 1422 medical practitioners about their MBS claiming
- 529 patients about the amount of PBS items they were obtaining
- 7700 prescribers about the PBS items received by their patients
- all practitioners and pathology and diagnostic imaging providers about the new legislation, which took effect in March 2008.

Enhancing compliance through a graduated audit program

We take a graduated approach to auditing. The spectrum ranges from random audits conducted to promote continuous improvement at one end, to targeted audits examining an issue of concern at the other. Both random and targeted audits are a process to check that the right payments have been made to the right person at the right time—no more, no less.

All 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 obtained incorrectly the usual outcome is to recover these payments.

In 2008–09, Medicare Australia will conduct a range of targeted desk and field audits to verify claims that practitioners and pharmacists have made. 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 to confirm the claiming facts.

Criminal behaviour will not be tolerated

Medicare Australia is aware of the temptations and opportunities that the programs we administer can provide. The MBS and PBS are high volume and high value programs and this can sometimes motivate individuals to obtain money through fraudulent and criminal means. In some cases individuals with minimal prior contact will be attracted by the ease of claiming that Medicare Australia provides. In other cases a health care professional with ongoing access to our claiming channels may be tempted to submit fraudulent claims.

The value of medical services and medicine provided in Australia, and the subsidies associated with those services, also attracts interest in borrowing, creating and stealing identities to gain access to benefits and concession status.

Given the seriousness of the consequences of fraud to the integrity of our systems we have a highly detailed process for monitoring, detecting, and pursuing criminal actions.

Fraud and other forms of criminal behaviour are unacceptable in any system. We assess every allegation of fraud or criminal behaviour and will use the full force of the law to deal with this type of behaviour.

As part of our approach to addressing criminal threats to our programs we manage the Australian Government Fraud Hotline, which can be contacted on **131 524***.

In 2008-09 we will continue to investigate allegations of intentional noncompliance and pursue criminal behaviour through the courts. In particular we will strengthen our relationships with the Australian Federal Police, the Australian Customs Service, state police and other Australian Government departments and agencies to identify, investigate and respond to criminal behaviour.

Case study

Medical practitioner suspended from Medicare for fraud

In 2007 Medicare Australia identified a medical practitioner who had fraudulently claimed MBS services not provided over an 18 month period. The medical practitioner pleaded guilty to 64 charges of making a false statement and was sentenced to 100 hours of community service, placed on a good behaviour bond for three years and ordered to repay Medicare Australia.

Following conviction, Medicare Australia referred the case to the Medicare Participation Review Committee that suspended the medical practitioner from all access to Medicare for a period of six months.

Case study

Pharmacist jailed for PBS fraud

A pharmacist was sentenced to four and a half years in jail for deliberately defrauding the PBS.

The pharmacist pleaded guilty to fraudulently obtaining $400 000 worth of PBS benefits he was not entitled to.

A Medicare Australia investigation found that over a four year period the pharmacist claimed PBS benefits for prescriptions not supplied. His fraudulent activities included submitting false scripts, using his parents' names and directing his pharmacy assistants to falsify signatures on prescriptions not supplied. He also admitted to using recently deceased peoples' identities to submit false PBS claims.

He received two sentences of four and half years' imprisonment to be served concurrently, with a non-parole period of 12 months.

Case study

Mother and daughter jailed for defrauding Medicare

In April 2008 a mother and daughter were each sentenced to 18 months in jail for fraudulently claiming benefits for Medicare services which did not occur. Medicare Australia identified irregularities in 2006 when claims were being submitted. Further investigations revealed the mother, while employed as a medical receptionist, together with her daughter, submitted fraudulent claims for services not provided. The women were also ordered to repay a combined total of $32 252.85 Medicare benefits as being fraudulently obtained.

Case study

Medical practitioner suspended for three years for upcoding

After analysing data, Medicare Australia was concerned that a medical practitioner working in a skin cancer clinic may have been billing skin lesion items at a higher level of benefit than was warranted by the size of the lesion.

We referred the case to the Director of the Professional Services Review Scheme. From examination of the medical practitioner's medical records it appeared that the patients received inappropriate and unnecessary treatments. In some instances the medical practitioner had upcoded the MBS Item to obtain a higher benefit. The medical practitioner acknowledged their inappropriate practice and agreed to repay $400 000 in Medicare benefits and be disqualified from using MBS items related to skin cancer for three years.

Conclusion

By being open, accountable and proactive in our compliance efforts, we aim to strengthen provider and public confidence in the integrity of the programs we deliver.

This *National Compliance Program 2008–09* sets out the mix of education, support, deterrence and enforcement activities we will undertake to encourage voluntary compliance and deal with noncompliance. The results of our 2008–09 activities will inform the way we tailor future compliance efforts. The results will be published in our annual report.

In order to increase voluntary compliance and raise awareness of our compliance program we recognise the need to build and maintain open dialogue with stakeholders.

To ensure the sustainability of the health payments system we must assure the government, providers and the wider community that the taxpayer-funded programs we deliver are protected by a robust and comprehensive compliance system. We believe that the *National Compliance Program 2008–09* provides just that.

We welcome your feedback. To provide comments on our *National Compliance Program 2008–09*, please write to:

General Manager
Program Review Division
Medicare Australia
PO Box 1001
TUGGERANONG DC ACT 2901

or email us at: **compliance.feedback@medicareaustralia.gov.au**

Compliance snapshot 2007–08

Our achievements	
Education	
Face to face	We have provided face to face education to more than 2200 new medical practitioners and more than 2700 others in the health care industry. 180 participants have completed 1063 online PrimeEd PBS education units and 18 participants have completed online MBS education through the Australian College of Rural and Remote Medicine website.
	We have provided face to face education to almost 3700 pharmacy students.
	Two new online Medicare education products are available and a re-developed Medicare component of education for new providers was piloted. We delivered two workshops to practice staff at the 2007 Australian Association of Practice Managers Conference.
Travelling with PBS Medicine enquiry line	We have received over 5200 calls to the Travelling with PBS Medicine enquiry line and almost 10 800 hits to the website.
Prescription Shopping Program	We have received over 20 900 calls to the Prescription Shopping Information Service and have sent more than 4650 patient reports to medical practitioners.
	We have contacted almost 630 prescribers to discuss more than 3320 patients and sent more than 7700 letters to prescribers.
Communications	*Mediguide* was sent to all practice managers, is available online and was distributed in CD form to rural and remote medical practitioners. Articles have been published in *Forum*, *Bulletin Board*, *Practice Incentive Program* (PIP) quarterly newsletters, *AusDoc*, *Medical Observer* and *Medical Director*.
Research and analysis	
Fraud Tip-off Line	We have received more than 2230 contacts, all of which have been reviewed.
Data analysis	We have completed assessments of claiming data in relation to 12 MBS items and 10 PBS areas. A further three assessments have been commenced and will be finalised in 2008–09.
	We have completed assessments of heart screening and ePrescribing to understand program integrity risks and emerging noncompliance. We commenced assessments in relation to corporations, paperless claiming and skin screening. The latter will be finalised in 2008–09.
Intervention and action	
Audits	We have audited more than 560 Practice Incentive Program practices. The fourth Multiple Payment Review has been finalised. 324 pharmacies were audited and 26 480 incorrect claims with a total value of $1.1 million were identified.
Practice Review Program	We have completed reviewing 329 medical practitioners under the Practitioner Review Program and are currently reviewing a further 336 medical practitioners. We have requested the Director of the Professional Service Review (DPSR) to review 50 practitioners.
Overseas Drug Diversion Program	Five airport operations have been conducted and a total of 26 detentions of PBS subsidised medicine has occurred at airports and international mail exchanges.
Investigations	We have finalised almost 600 investigation cases, including cases relating to 223 medical practitioners, 42 pharmacists and 330 members of the public. We are currently investigating suspected fraud by 209 individuals and have referred 74 individuals to the Commonwealth Director of Public Prosecutions (CDPP) for criminal prosecution.
Outcomes	
Prosecutions	The CDPP has successfully finalised prosecution of 51 individuals, including one medical practitioner, four pharmacists and 46 members of the public.
Director, Professional Services Review	The DPSR has issued 34 findings with associated orders to repay Medicare Australia a total of $1.64 million.
Recoveries	We have identified $6.82 million in incorrect payments for recovery from 513 individuals or organisations.

How to report suspected noncompliance

Anyone can make reports about suspected noncompliance by phoning the Fraud Tip-off Line: **131 524***
(Monday to Friday between 9.00am–4.45pm local time)

You can also make reports by filling out an online form at **medicareaustralia.gov.au/about/fraud.jsp**

Or by mailing the form to:

Medicare Australia
PRD compliance program
GPO Box 9822
Adelaide SA 5001

For more information

Online **medicareaustralia.gov.au** then go to **For health professionals** > **Doing business with Medicare Australia** > **Audits & Compliance** > **National Compliance Program**

Email **medicare@medicareaustralia.gov.au**

Call **132 011***

TTY **1800 552 152** ** (Hearing and speech impaired)

TIS **131 450*** (Translating and interpreting service)

* Call charges apply

** Call charges apply for mobiles and pay phones only

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