Australian Government
Medicare Australia

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The Secretary
Senate Community Affairs Committee
PO Box 6100
Parliament House
CANBERRA ACT 2600

Dear Mr Humphery,

Supplementary Submission to the Senate Community Affairs Committee inquiry into Compliance Audits on Medicare Benefits

Thank you for giving Medicare Australia the opportunity to appear before the Senate Community Affairs Committee's inquiry into Compliance Audits on Medicare Benefits.

Please find attached *Medicare Australia's Supplementary Submission* in response to requests for information made at the Committee hearing on 6 May 2009.

The Government pays out a very substantial amount of taxpayer money under the Medicare program each year. Over $13 billion was paid out the Medicare in 2007-08, and expenditure is growing at over $1 billion per annum.

There is no question that the vast majority of providers who bill and claim services under Medicare do so appropriately. However, given the sheer size of the Medicare program, it is critical that there are rigorous and effective compliance measures in place to deal with the small minority of providers who do not comply with applicable legislative requirements, whether that non-compliance is accidental, careless or deliberate.

Compliance audits are critical to verifying that taxpayer money paid out under the Medicare program has been properly spent. Last financial year, Medicare Australia's compliance program produced over $25 million in Medicare savings. In the same period, the value of recoveries of incorrect claims rose 105% to nearly $3.5 million.

Recent audits of GP Management plans identified a non-compliance rate of 36%, whilst an audit of the domiciliary medications management item identified a 28% non-compliance rate. Those outcomes suggest that, in some areas, there is a significant level of incorrect billing and claiming occurring under Medicare.

However, under the current legislative regime, providers who bill or claim incorrectly under Medicare are under no legal obligation to provide information for compliance audit purposes, and can simply choose not to cooperate with Medicare Australia, without experiencing any adverse consequences.

On average, 20% of providers do not respond to requests for information in relation to such audits. Medicare Australia submits that this represents a real and significant threat to the integrity

of the Medicare program, which the *Health Insurance Amendment (Compliance) Bill 2009* (the Bill) seeks to address.

The Bill includes provisions which will require providers to produce documents to substantiate Medicare payments made in relation to services they have rendered. Where the legislation makes a payment contingent on a patient having a particular medical condition or receiving a particular procedure, providers may need to produce documents which confirm those matters for substantiation purposes.

Submissions made by some stakeholders to the Committee have described the effect of the Bill in quite alarmist terms. In particular, it has been suggested that the Bill will provide Medicare Australia officers with unfettered access to providers' patient files (which may contain some highly sensitive information which is of no direct relevance to Medicare payments). This view is misconceived.

The Bill will not give Medicare Australia officers unfettered access to patient files. In fact the Bill will not confer on Medicare Australia any new powers of access, search or seizure at all. The Bill will merely require providers to produce sufficient documentation to substantiate Medicare payments made in respect of specific services, which will be identified in a written notice issued to the provider.

What documents a provider chooses to provide to Medicare Australia to substantiate a payment will be a matter entirely for them. Any patient information which a provider might need to provide to substantiate a payment will simply confirm factual matters already asserted by the provider in making the Medicare claim.

A provider who fails to produce relevant documents, or who cannot otherwise substantiate a payment, will simply be required to repay the unsubstantiated amount (and possibly pay an additional administrative penalty). There will be no scope for a provider to be sent to jail if they do not comply with a request for documents. In fact, the Bill does not contain any new criminal offence provisions.

Medicare Australia submits that the Bill is a reasonable, responsible and targeted measure which will enhance the integrity of the Medicare program, whilst maintaining the strong protection of personal information for which Medicare Australia is renowned.

In addition to the supplementary written submission, Medicare Australia will be submitting its privacy training material, as requested, under the cover of a separate letter to the Committee.

Once again, I thank you for inviting Medicare Australia to make a supplementary written submission to the Committee.

Yours sincerely,

Philippa Godwin
A/g Chief Executive Officer
26 May 2009

Australian Government

Medicare Australia

Supplementary Submission
to the Community Affairs Committee
on

Compliance Audits on Medicare Benefits

May 2009

Table of Contents

1) Introduction

1. On 6 May 2009 the Senate Community Affairs Committee (the Committee) held a public inquiry into Compliance Audits on Medicare Benefits.
2. At the hearing Medicare Australia appeared with the Department of Health and Ageing (DoHA) and spoke to the contents of its submission to the Committee which was submitted on 24 April 2009.
3. During Medicare Australia's appearance the Committee requested additional information and invited Medicare Australia to respond to the written submissions provided by other stakeholders, and specifically the Privacy Impact Assessment (PIA).
4. Medicare Australia has reviewed the additional 19 public submissions[1] made to the Committee, the proof Hansard of the public hearing, and the published version of the PIA. The following document contains Medicare Australia's response to some of the claims and recommendations that have been made.
5. The comments within this document reiterate and add to the information Medicare Australia and DoHA have already circulated in relation to the Increased Medicare Benefits Schedule (MBS) Compliance Audits Initiative.

[1] http://www.aph.gov.au/senate/committee/clac_ctte/medicare_benefits_compliance_audits/submissions/sublist.htm
The public submissions that Medicare Australia has reviewed include those made by: - Australian Medical Association (AMA); Office of the Privacy Commissioner (OPC); Australian Privacy Foundation (APF); Australian General Practice Network (AGPN); Consumer Health Forum (CHF); Australian Physiotherapy Association (APA); Australian Association of Social workers (AASW); Australian Health Insurance Association; Royal Australasian College of Surgeons; The Royal College of Pathologists of Australasia; The Royal Australian and New Zealand College of Psychiatrists (RANZCP); Private Mental Health Consumer Carer Network; Public Interest Advocacy Centre; Australian Society of Anaesthetists (ASA); Medical Indemnity Industry Association of Australia; Australian Psychological Society; Australasian Society for HIV Medicine; and Civil Liberties Australia.

2) The Privacy Impact Assessment and consultation

6. Medicare Australia was involved in the preparation of the PIA, and engaged with the Office of the Privacy Commissioner (OPC) and DoHA on its contents.
7. Medicare Australia accepts and will adopt each of the 10 recommendations within the Privacy Impact Assessment.
8. During the development of the draft Bill, and the Privacy Impact Assessment both DoHA and Medicare Australia engaged with stakeholders through a variety of means.
9. On 14 May 2008, the day following the budget announcement, the Medicare Australia CEO wrote to all major Medicare Australia stakeholders within its MBS stakeholder directory explaining the details of the initiative. This letter included information about upcoming consultation and included an offer to provide more details upon request.
10. Between May and September 2008, Medicare Australia and DoHA met with several stakeholders including the Office of the Privacy Commissioner on the initiative.
11. On 16 October 2008 DoHA and Medicare Australia issued an information sheet on the possible form of the legislation changes, under cover of a letter from both agencies. The information sheet was also published on the Medicare Australia website, and issued to industry media outlets.
12. Between October 2008 and January 2009, Medicare Australia and DoHA undertook a series of stakeholder engagement meetings to discuss the initiative.
13. On 24 February 2009 DoHA and Medicare Australia issued a second information sheet to respond to the feedback it was receiving in these stakeholder meetings. The second information sheet was circulated to all major Medicare stakeholder groups, placed on the Medicare Australia website, and released to industry press.
14. The second information sheet led to further stakeholder meetings and correspondence from several stakeholder groups.
15. Between October 2008 and April 2009 the following 41 stakeholders provided comment into the consultation process:

    - Allied Health Professions Australia
    - Audiological Society Australia
    - Australia College of Emergency Medicine
    - Australian Association of Pathology Practices
    - Australian Association of Practice Managers
    - Australian College of Rural and Remote Medicine
    - Australian General Practice Network
    - Australian Medical Association
    - Australian Orthopaedic Association
    - Australian Privacy Foundation
    - Australian Private Hospitals Association
    - Australian Society of Anaesthetists
    - AVANT Lawyers
    - b Consulting
    - Capital Pathology
    - Cardiac Society of Australia and New Zealand
    - College of Pathologists
    - Consumer Health Forum of Australia
    - Faculty of Medicine, Monash University

- Health Issues Centre
- Medicare Australia's Stakeholder Consultative Group
- Medicare Australia's Consumer Consultative Group
- National Australian Society of Obstetricians and Gynaecologists
- National Rural Health Alliance
- Northern Sydney General Practice Network
- Occupational Therapists Australia
- Office of Parliamentary Counsel
- Office of the Privacy Commissioner
- Optometrists Association of Australia
- Professional Services Review
- Royal Australasian College of Surgeons
- Royal Australian and New Zealand College of Obstetricians 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 Physicians - *Australasian Chapter of Sexual Health Medicine*
- Royal Australian College of Physicians - *Australian Faculty of Rehabilitation Medicine*
- Royal Australian College of Physicians – *Paediatrics & Child health Division*
- Rural Doctors Association of Australia
- Speech Pathology Australia
- WA Health Consumers Council

16. Following this consultation, on 9 April 2009 the Department of Health and Ageing released an exposure draft of the *Health Insurance Amendment (Compliance) Bill 2009*, and an associated *Explanatory Material* document.

17. On 1 May 2009 the latest iteration of the *Privacy Impact Assessment* was distributed to all stakeholders, and submitted to the Senate Committee.

3) Issues covered by the Privacy Impact Assessment which were raised in more than one public submission

18. Within the Privacy Impact Assessment (PIA) and throughout the 19 public submissions and proof Hansard of the Committee hearing there are seven recurring issues. These issues are:
    1) Doctor-patient confidentiality;
    2) Extent of the access to clinical records and sensitive health issues;
    3) Patient notification and consent;
    4) Role of the Professional Services Review (PSR) and clinical decision making;
    5) Limiting clinical records to Medicare Australia staff with medical degrees;
    6) De-identification of personal data; and
    7) Future reviews, and reporting on the use of the new provisions.

19. Medicare Australia addresses these recurring issues below.

3.1 Doctor-patient confidentiality

20. Some submissions to the Senate Committee questioned the impact of the proposed legislation on the doctor-patient relationship. The Australian Medical Association (AMA), Australian Privacy Foundation (APF), Australasian Society for HIV Medicine, and Civil Liberties Australia raised concerns that as a result of the proposal, patients will not provide full information when seeking medical treatment and doctors may not record full patient histories or clinical health details within patient records.

21. Medicare Australia addressed the issue of doctor-patient confidentiality in paragraphs 107 to 121 of its written submission.

22. The issue was also covered in paragraphs 108 to 115 of the PIA.

23. To reiterate the key points within these documents, Medicare Australia will not have any authority to request whole medical records or use documents that are not relevant to determining the factual accuracy of a Medicare payment. Consequently Medicare Australia will not have the level of access to the sensitive health information (patient histories etc) that these stakeholders suggested. This is further addressed under heading 3.2 below.

24. The proposed legislation does not require a provider to disclose new health information about a patient; it is merely aimed at substantiating the facts that have already been asserted through the making of a claim under Medicare, and specifically at responding to a Medicare Australia concern about whether the factual requirements have been met.

25. Under Section 129AAD of the Bill, Medicare Australia can only seek information (which may include clinical information) to confirm that the legal requirements of the MBS Item which has been claimed have been met. This limitation operates as a result of the requirement for there to be a reasonable concern that an MBS benefit amount exceeds the amount that should have been paid, and that only information relevant to resolving this concern can be requested.

26. To reiterate the point made within paragraphs 15, 110 and 111 of Medicare Australia's written submission, a provider already identifies a patient, the service that the patient has received, and in some cases, the condition that they have as a part of the Medicare billing process. A provider does this by using a valid Medicare Card number and a valid item number from the MBS.

3.2 Extent of access to clinical records and sensitive health issues

27. Much of the content within the public submissions to the Committee focussed on the level of detail from clinical records that would be available to Medicare Australia's compliance officers. For example, a number of submissions raised concerns about voyeuristic auditors trawling through patient files, looking at medical and sexual histories, and passing judgement on intimate personal details.

28. Within their public submissions, and during their evidence at the hearing, several stakeholders used examples of general consultation MBS Items (level A, B, C and D Items) to suggest that Medicare Australia would collect detailed patient histories and access sensitive health information.

29. Medicare Australia does not agree that the proposal would result in Medicare Australia having access to any of this information.

30. These item requirements involve clinical descriptors requiring professional judgment rather than simple matters of fact and are outside the scope of a compliance audit. The only fact that could be substantiated for general consultation items is that the consultation actually occurred. For these items Medicare Australia would not need to access clinical records, and would only need to see a patient receipt or similar record to confirm that the service occurred.

31. This is true of many of the consultation items, including psychiatric, psychological and sexual health consultations – where the only factual tests contained within the MBS item requirements are that a patient attended the surgery.

32. Matters of concern dealing with clinical descriptors including professional judgement remain matters for consideration by the Professional Services Review.

33. An important point that needs to be re-emphasised, is that Medicare Australia can only request information when it has a reasonable concern that an MBS item requirement has not been met. Referring to the actual MBS item requirements for these examples is therefore critical – and

demonstrates that Medicare Australia could not request access to the sensitive details that some stakeholders suggested in their hypothetical examples.

34. The Public Interest Advocacy Centre addressed this issue when it noted in its conclusion (page 8) that it was concerned that:

> "Much of the public debate surrounding the matters that are the subject of this Inquiry has been misdirected and often verging on the hysterical".

35. The Public Interest Advocacy Centre also noted that:

> "Contrary to some of the commentary about the Bill, the proposal if enacted should not be 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. PIAC is far more concerned with the adequacy of current legislation to protect personal health information held by the private sector".

36. Medicare Australia wishes to reiterate that the proposed legislation does not give Medicare Australia compliance officers the power to peruse patient records. The proposed legislation does not contain an access power under which Medicare Australia could demand patient files.

37. The proposed legislation introduces a requirement on a provider who is served a notice by Medicare Australia to produce evidence substantiating the MBS claims specified in the notice. In all situations the provider will determine which parts of documents, if any, they will produce to meet this obligation.

38. Even where a provider chooses to provide more information than is necessary, Medicare Australia will only be authorised to use the parts of a document that substantiate the facts that are of concern, and the subject of the substantiation notice.

39. If a provider were to refuse to produce a document then there is nothing Medicare Australia can do to access or view any information within that document.

40. Medicare Australia will provide advice to guide providers and reduce the risk of unnecessary information being produced in response to an audit request. This was a commitment made in Information Sheet two, and a recommendation of the Privacy Impact Assessment.

41. Medicare Australia and DoHA set out the limitations on the power to request documents within the PIA in paragraphs 63 to 93 and in paragraphs 120 to 127.

42. Medicare Australia also explained the limitations on the proposed power within its written submission to the Committee in paragraphs 94 to 99 and in paragraphs 109 to 117.

43. The OPC also provided a description of the limitations on the power in its written submission to the Senate Committee in paragraphs 29 to 38 and paragraph 55. Specifically, at paragraph 38, the OPC comments that the relevance test created by s.129AAD(1) and (6) of the Bill is "a welcome measure and should help ensure that only relevant information will be exchanged".

3.3 Patient notification and consent

44. From the outset this proposal has attracted a variety of opinions in relation to a patient's right to know that information relating to a health service would be accessed for a compliance audit.

45. Medicare Australia and DoHA proactively engaged with stakeholders on this issue (see page 4 of the '*Increased MBS Compliance Audits Initiative Information Sheet 2- your questions answered*').

46. The PIA discusses the issues of patient notification at paragraphs 94 to 107. The specific issue of consent is discussed in paragraphs 134 to 138.

47. Medicare Australia's written submission addresses this issue in paragraphs 122 to 130.

48. OPC's written submission recognises the issue of patient notification in paragraphs 44 to 46.

49. The question of patient notification is not straight forward. It requires that a balance be found between the privacy rights of a patient, and the privacy rights of a provider.

50. The position arrived at by the PIA (Recommendation 2) is that patient notification should be addressed through a broader information campaign rather than specific patient notification.

51. Medicare Australia supports this position and to this end draws attention to the submission of the Consumer Health Forum which states:

    "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."

3.4 Role of the Professional Services Review and clinical decision making

52. Several submissions confused the function of the Professional Services Review (PSR) with Medicare Australia's role in identifying incorrect claims.

53. Since the announcement of this Budget measure, both Medicare Australia and DoHA have sought to explain that the proposal does not alter the role of the PSR or its power to manage inappropriate practice. This was specifically stated and explained in the:
    - Increased MBS Compliance Audit Information Sheet 1 (information sheet 1) page 3;
    - Information Sheet 2 page 3;
    - the explanatory material accompanying the Bill paragraph 2.56;
    - Medicare Australia's written submission paragraphs 47 to 56; and
    - the PIA paragraph 43.

54. Medicare Australia set out the role of the PSR, and its role in the audit process, in paragraphs 47 to 56 of its written submission. The PSR's legal ability to require the production of documents was also referenced in paragraphs 88, 89, and 126.

55. A Medicare compliance audit is an administrative check that ensures the provider and patient were eligible for the Medicare benefits already received; the service was provided and that it met the MBS item requirements which correspond to the claim that has been made. These are all questions of fact and do not relate to either the clinical appropriateness or professional adequacy of the MBS service.

56. Under existing provisions within the Health Insurance Act 1973, which will not be altered or amended, the PSR considers the appropriateness of MBS services through a peer review process.

57. This proposal does not introduce any ability for Medicare Australia to review, address or determine the clinical appropriateness of a Medicare service. This is and will continue to be, the role of the PSR.

3.5 Limiting clinical records to Medicare Australia staff with medical degrees

58. Several submissions to the Committee expressed opinions that clinical information should only be obtained and viewed by Medicare Australia staff who are qualified medical practitioners. These views appear to be based on the inference that medically trained individuals provide better privacy protection to sensitive information than individuals with other qualifications.

59. At the Committee hearing, Senators sought information in relation to these statements and requested specific information on the legal protections covering the information collected during audits and the penalties for staff that misuse audit information.

60. The PIA addresses the protections afforded to the information collected during an audit throughout, but specifically at paragraphs 130 to 133, 139 to 140 and 172 to 179.

61. The *Health Insurance Act 1973,* specifically section 130 provides increased protection for the information collected by Medicare Australia and includes criminal penalties for staff who:

    "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….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 of function, under this Act."

62. A person who misuses information would also be subject to the provisions of the *Public Service Act 1999*, which could lead to further sanctions and result in termination of employment (section 29), and potentially limit any future employment opportunities within the Australian public service.

63. Medicare Australia would like to draw the Committee's attention to page 5 of the Public Interest Advocacy Group's submission which states that the privacy safeguards within the Bill to cover Medicare Australia's compliance audits:

    "…provide a higher level of protection to the privacy and confidentiality of personal health information held by Medicare Australia than the protection afforded similar information held by the private sector."

    This is an important and significant point and serves to further highlight the legal protections and restrictions on Medicare Australia staff, including criminal penalties and loss of employment, that are not matched by protections and restrictions on practice staff.

64. Medicare Australia's storage and security arrangement for the information collected during audits were set out at paragraphs 172 to 185 of the Privacy Impact Assessment. Importantly, Medicare Australia's compliance case management system is only accessible to compliance officers with designated security clearance, and all access to the system is logged and monitored by the organisation.

65. Medicare Australia also does not accept that only qualified medical practitioners could understand and conduct an MBS compliance audit.

66. Medicare Australia's audit staff are trained and experienced in MBS issues, and audit techniques. Many audit staff have worked in Medical offices, pharmacies and other health-related areas prior to their employment. Others have a background in Medicare Australia branch offices and enquiry lines where they have gained extensive knowledge in the use and requirements of MBS items.

67. Once working within the compliance audit area, Medicare Australia's staff have daily experience discussing, analysing and reviewing MBS items, discussing correct claiming with internal experts and providers, and reviewing the decisions and conclusions of their colleagues. There is therefore a significant level of content knowledge and MBS expertise within our audit teams.

68. It should be noted that currently Medicare Australia does employ a range of health professionals. Audit staff have access to doctors, pharmacists and other experts in the conduct of their compliance activities. Furthermore, all Medicare Australia compliance audit topics and procedures are designed in consultation with qualified medical advisers and approved by senior managers. However, because audits are assessing the facts of a MBS service, and do not involve making clinical judgments, there is no need for all audit staff to have medical qualifications.

69. If auditors need assistance in assessing matters of fact by confirming the content of a record, ample advice is available from health professionals employed by Medicare Australia. As the Office of the Privacy Commissioner (OPC) recognises at paragraph 61 of its written submission that "Medicare Australia auditors currently have access to medical advisers". Medical Advisers in this process are available for expert advice and guidance (to both the auditor and the individual provider subject to the audit), and Medicare Australia is recruiting additional professional staff because of the increased number of audits it is funded to undertake.

70. A specified legislated requirement dictating the role of medical advisers during an audit is not necessary, as it would add no further legal protection (over and above that already provided by legislation) and would add additional and unnecessary costs to the audit process. The use of medically trained individuals as advisers in audit design, target selection, and audit processes is a far more beneficial and efficient approach and is consistent with Medicare Australia's current compliance approach.

3.6 De-identification of personal data

71. Several submissions to the Senate Committee discussed the need to de-identify the information used in audits.

72. Medicare Australia and DoHA set out at paragraphs 91 and 92 of the PIA how the issue of de-identified data would be addressed. The OPC also provided a good summary of the issue of de-identification at paragraph 62 of its written submission.

73. Specifically, de-identification of the information responding to a audit request would not substantiate an identified claim. Medicare Australia needs to confirm a specific service that a specific patient has received. As indicated earlier, a provider already identifies the patient and the MBS service they have received as part of the claiming process.

74. Medicare Australia's audit letters and other communications are based on the principle that sufficient de-identification can be achieved through coded numbers (i.e. the patient can be identified by Medicare number rather than name, and the service can be identified by the MBS item number rather than a description of the service). In conducting an audit Medicare Australia therefore does not generally divulge any more information than has already been provided through the MBS claim.

75. In summary, Medicare Australia needs to identify the patient in order to confirm the specific service that is subject to audit. However we agree with the privacy policies and suggestions of stakeholders that wherever possible the names of patients should not be associated with a description of the service they have received, or a condition that they purportedly have.

3.7 Future reviews, and reporting on the use of the new provisions

76. Some stakeholders suggested that the use of the powers should be subject to reporting requirements in the Medicare Australia annual report, and that use of the legislation should be reviewed.

77. In response to this issue, the PIA recommended that Medicare Australia and DoHA report on the use of the power (Recommendation 10). This recommendation is accepted by Medicare Australia.

4) Specific response to individual submissions

78. There were a number of specific issues raised in the submissions and at the public hearing that Medicare Australia wishes to address.

Use of MBS item numbers

79. At page 6 in the Australian Medical Association's (AMA) submission, the AMA contends that:

> "Doctors are actually under no obligation to include MBS item numbers on their accounts. Doctors could choose to use words to describe the professional service sufficient for government officials to identify the actual MBS item number that relates to the professional service. It is an important administrative convenience for patients and the government that doctors enable processing of MBS claims by interpreting the item descriptors and then including the relevant MBS item numbers on their account".

80. Medicare Australia also made this point at paragraph 15 of its written submission, and the AMA's statement serves to highlight the fact that providers currently supply Medicare Australia with detailed information on the service they have provided to an identified patient through the MBS claiming process – either by using an MBS item, or describing the professional service.

81. If a provider chose to make MBS claims by describing the service they would necessarily have to provide sufficient information and clinical detail to enable Medicare assessing staff to determine the payable benefit. The details provided would, by necessity, have to list the services that were performed that match corresponding MBS requirements (e.g. they would need to specifically state that the patient was 20 weeks pregnant, and that a health check and consultation were performed). This would ultimately be a statement of fact that the provider could be held accountable for, and is ultimately no different to using a MBS item.

Adequacy of existing powers

82. At page 3 of its submission the AMA contends that the auditing powers that Medicare currently has are enough, and that "Medicare Australia have previously identified and prosecuted a number of doctors who have acted inappropriately in terms of Medicare rules and requirements". This statement confuses three distinct threats to the Medicare program: fraud which is prosecuted, inappropriate practice which is referred to the PSR, and incorrect claiming which is addressed through audit and recovery.

83. Medicare Australia addressed these issues in Part 4 of its written submission, commencing at page 18. Specifically Medicare Australia wishes to reiterate the point made at paragraph 26, that "the largest threat to the Medicare program is expenditure on incorrect Medicare claims" and paragraphs 76 and 77 where it is explained that there is "no general power to require a person to provide information or documents for the purpose of verifying the validity of a claim" and that consequently "a provider can simply refuse to comply with a request".

84. The 20% non-response rate to audit requests demonstrates that existing powers to address incorrect claims are inadequate, and the inability to require a provider to substantiate their claims leaves the Medicare Program exposed to a considerable degree of risk.

Transparency in audit selection

85. The AMA recommends at page 16 that "As part of formulating its compliance strategy, Medicare Australia should identify the high-risk services it has evidence require auditing".

86. Medicare Australia already does this on an annual basis when it produces a National Compliance Program. The preparation of this document is the result of significant environmental scanning, data analysis and stakeholder engagement. The National Compliance Program sets out the areas of compliance focus for the upcoming 12 months, including the areas and items within the Medicare program that are considered to be a compliance risk.

87. Medicare Australia discussed its National Compliance Program at sub-heading 2.4 of its written submission, and the 2008-09 National Compliance Program was submitted to the Committee.

Record-keeping requirements

88. Within its written submission the AMA recommends that Medicare Australia "should work with the profession to agree on what would constitute reasonable record keeping and information arrangements for these services that won't compromise patient care or introduce unnecessary additional red tape".

89. Medicare Australia supports this recommendation, and has already commenced work with some stakeholders and other Government agencies to consider what role it could play in making further record keeping information available.

Published policies and guidance for providers

90. At paragraph 8 of its submission, the Office of the Privacy Commissioner (OPC) suggests that "additional Medicare Australia policies should:

    - give providers who are subject to an audit a clearer understanding of whether or not clinical information is required; and
    - prevent requests for information drawn from clinical records when other information is sufficient (such as billing or attendance records)."

91. Medicare Australia accepts this recommendation, and would welcome the input of the OPC and other stakeholders into the design of these policies. It was always Medicare Australia's intention, as stated in Information Sheet 2, to provide additional advice to providers being audited to clarify what information was being sought and how the provider could respond. This was also specified at paragraph 2.28 of the Explanatory Material.

92. Medicare Australia also accepts the OPC recommendations at paragraph 9 to introduce published policies specifying how it will:

    - tailor "collection and information handling methods for particularly sensitive Medicare items and information";
    - give "additional oversight or participation of medical advisers in audits that involve clinical information"; and
    - limit "the degree of association between patient names and medical conditions where practicable during audits".

Security of stored information

93. At paragraph 3 of its submission the Australian Privacy Foundation (APF) seeks assurance that "all audit data will not be stored in a single database… connected to the internet…robust access control and security policies will be implemented…and audit data will be routinely encrypted". The Privacy Impact Assessment set out the system security and access limitations placed on information collected during compliance audits.

94. Medicare Australia has a case management system that is only accessible by compliance officers, and which has graduated access levels corresponding to position requirements. All access to the compliance case management system is logged and monitored. The case management system is not connected to the internet.

95. As part of the Increased MBS Compliance Audit Initiative Medicare Australia received capital funding for a new case management system, which is currently being sourced. This system will be specifically designed to meet Commonwealth security and privacy requirements for compliance activities.

Threshold for penalties and readjustment of claims

96. At page 1 of its submission, the Australian Physiotherapy Association (APA) states that "some margin of error must be allowed to ensure that health practitioners are not unduly penalised for honest mistakes". Medicare Australia agrees with this statement and notes that the "APA feels that the rate of $2500 prior to the imposition of the penalty fee (in addition to the requirement to pay back the incorrect amount claimed) is reasonable".

97. At page 2 the APA states that "Minor claim errors are just as likely to favour Medicare as they are the individual practitioner, and the APA recommends that some mechanism be built into auditing practice that allows for the reimbursement of practitioners". Medicare Australia agrees and already has in place a process where providers can re-submit MBS claims if they discover that they have under-claimed. Staff in Medicare Australia's processing section are able to make the requested adjustments to claims, and arrange for the corrected amount to be paid.

98. At subheading 3, the Australian Psychological Society (APS) states concerns that "providers will be made liable for administrative errors of Medicare Australia". Medicare Australia does not agree that providers would, or could be held liable for administrative errors. The reason for conducting MBS audits is to ensure that MBS claims and payments are correct. To this end we agree with APS that "the compliance audit process is an essential component of Medicare to ensure the scheme's integrity and accountability" (page 2).

Training for Compliance Officers

99. At page 1 of its submission, the Australian Association of Social Workers states that "Medicare Australia staff carrying out the audits will receive additional training to enable them to properly conduct the audits".

100. Medicare Australia has publicly stated that it will review its internal staff development program and training material based on any legislation changes. Offers to stakeholders to be included in the re-design of this material have also been made.

101. Medicare Australia already requires all new staff to sign a confidentiality undertaking and attend a privacy training session during the mandatory induction process. New staff are also required to complete an elearning package which aims to introduce privacy principles to new starters and explain the importance of privacy at Medicare Australia.

102. Topics covered within the privacy elearning package include:
    1) Introduction to privacy
    2) Privacy legislative framework
    3) Privacy principles
    4) Disclosure of information
    5) Unauthorised access.

103. In winning the 2008 Grand Privacy Award from the Office of the Privacy Commissioner Medicare Australia was assessed on a number of criteria, including the level of privacy consideration and consultation undertaken in planning and implementation as well as success in communicating the privacy related elements of its activities. The award noted that Medicare Australia has displayed progressive leadership through the development of a comprehensive training support package which includes an innovative DVD and workbook to support its people in understanding how to ensure the highest level of privacy protection while delivering great service.

104. A copy of the privacy training module will be provided to the Senate Committee.

105. The protection of personal information is outlined as corporate policy in the *Medicare Australia (Functions of Chief Executive Officer) Direction 2005*, Instruction 9.5, which states that all staff must complete the Privacy and Security Training Module as a condition of their employment.

106. Medicare Australia also has a compliance officer training module, in addition to the corporate training package. This includes a reinforcement of the privacy training that staff will have already received.

Access to records by private health insurance companies

107. Medicare Australia notes the submission by the Australian Health Insurance Association, and its confirmation that "As a condition of payment for a private health claim, an insured patient signs a claim form which permits the patient's health fund to audit the medical records or any other substantiating information related to the claim".

108. Based on this advice Medicare Australia has reviewed the claims forms of several Private Health companies.

- The Australian Unity Application claim form states:
  I [the member patient] *agree to assist Australian Unity to obtain all information relevant to this claim, authorise the doctors, practitioners or other relevant authorities to provide access to any records relevant to this ailment/injury to Australian Unity (including date, type of service and relevant clinical information), and consent to the release of all relevant information to a medical referee, as determined necessary by Australian Unity, for the purpose of assessment of this claim.*

- The ACA Health claim form states:
  I authorise the provider or any other authorities concerned with my or my dependants injury, disease or ailment, or treatment or diagnosis, to supply all relevant information to the fund, including for the purposes of audit, if required by the fund.

- The MBF claim form states:
  I authorise MBF to obtain information from the provider for any service claimed.

- The HCF claim form states:

I acknowledge that HCF may need to disclose details of this claim to third parties to establish the correct benefit entitlement and I authorise HCF to contact the provider and to access any information needed to verify and process this claim.

109. Medicare Australia is aware that the President of the AMA disagreed that private health insurance companies access clinical records to perform compliance checks.

110. Medicare Australia has been advised by the AHIA that "through the authority gained on the claim forms, health funds do conduct audits". The purpose of these audits "is to clarify medical information to substantiate a private health insurance claim".

111. The AHIA specifically advised Medicare Australia that "Doctors must release information (patient has already given consent through the claim form), including patient records" and that "this extends to GP's for the purpose of clarifying medical information to substantiate a private health insurance claim. Funds also get patient records from hospitals and specialists."

112. Medicare Australia is aware that private health insurance companies perform a variety of compliance audits, mainly within hospital settings, and generally obtain access to more than 100 clinical records per hospital audit.

113. Medicare Australia is aware of companies, such as *Healthcare Management Advisors Pty Ltd* (HMA) and *Bupa Australia*, which are actively engaged in compliance audits and activities in relation to private health insurance and do specifically access clinical records.

Power to seize information

114. The Royal Australasian College of Surgeons (RACS) recommends that "seized evidence pertaining to patient care should be copied and returned to the practitioner within 24hrs in order that ongoing or future care of that patient is not compromised".

115. Medicare Australia wishes to emphasise that under this proposal documents cannot be seized. If a provider chooses not to produce a document, then there is nothing Medicare Australia can do to access it.

116. Medicare Australia does however support the spirit of the RACS recommendation (that original records should not be removed from practice sites). Medicare Australia's current practice and ongoing preference would be to receive copies rather than the original documents in the course of a compliance audit.

Information to support claiming

117. RACS also recommends that Medicare Australia should establish an easily accessible "hotline" to enable medical practitioners to resolve item number concerns. Medicare Australia already has a provider enquiry line that receives over 1.6 million calls from providers per annum. Details of the provider enquiry line were included in paragraph 35 of Medicare Australia's written submission.

118. At page 2 of its submission, the Medical Indemnity Industry Association of Australia (MIIA) states that "there is no specific or general educational or preventative component to the measures proposed by the Bill". In response Medicare Australia reiterates the point made in paragraph 8 of Medicare Australia's written submission, that already more than 25% of providers take part in, or receive, some form of education or targeted information from Medicare Australia relating to their MBS claiming.

119. Already this financial year over 28,000 of the 81,224 active providers have received some form of targeted information or education. This figure of 28,000 includes:
    - 7,400 providers who have accessed online MBS eduction
    - 11,133 allied Health Workers who received targeted information on specific claiming issues
    - 6,151 providers who received targeted information on their claims; and
    - 3,500 providers who attended face to face education sessions provided by Medicare Australia.

    The figure of 28,000 does not include:
    - the more than 1.5 million calls made by providers to the provider enquiry line;
    - the more than 2,000 providers who have accessed the APS website to view our administrative position statements; or
    - the more than 70,000 providers who received the MBS Online education product on CD-Rom as part of a mail-out.

120. As Medicare Australia set out at paragraph 36 of its submission, education is an integral part of promoting voluntary compliance and is a core element of Medicare Australia's approach; however without an active deterrent element, some providers may not engage with the free education, or appropriately monitor their claims.

A defined multi-step audit process

121. At page 8 of its submission, the Public Interest Advocacy Centre submits that the audit process "should be a multi-step process that ensures that a separate decision is made to determine whether the collection of clinical information is necessary". Medicare Australia's audits are a multi-step process, with relevant decision making and review points along the way. Flow charts of the audit process were included in Information Sheet 2, and at the end of Medicare Australia's written submission.

Privacy Protection

122. The Australasian Society for HIV Medicine states, at paragraph 2, that "There is nothing in the amendments that speaks to the protection of that data within Medicare Australia". The Privacy Impact Assessment sets out the existing protections covering the information collected during a compliance audit. It is important to note that compliance audits currently occur, and that there are already many extensive and legislation protections for the information. New provisions are therefore not necessary.

Audit coverage of Allied Health Workers

123. At page 5 of its submission, Civil Liberties Australia (CLA) states that Medicare Australia has a hit list of allied health workers. This is not the case. The paragraph at 1.11 of the explanatory material is an example of the types of allied health workers who currently access Medicare. The CLA may not be aware of long-standing stakeholder criticisms that compliance activities have disproportionately focussed on general practitioners, and that the extension of the audit program to specialists and allied health workers is widely seen as a positive move – even by the professional groups within those fields.

5) Conclusion

124. Medicare Australia has reviewed the 19 public submissions made to the Committee prior to 6 May 2009, the proof Hansard of the public hearing, and the published version of the PIA.

125. In response Medicare Australia reiterates that the proposed legislation does not provide Medicare Australia with open, unfettered access to documents or information, nor does it allow Medicare Australia to search premises or seize documents as part of an audit.

126. Medicare Australia's audits are designed and limited, to testing the factual accuracy of claims made through the MBS claim system. Under the proposed legislation providers can only be requested to substantiate claims for which there is a reasonable concern about the accuracy of the payment.

127. All information collected for the purpose of a compliance function is bound by the secrecy provisions within the *Health Insurance Act 1973,* as well as the provisions of the *Privacy Act 1988* relating to protecting the information from unauthorised use or access, as well as the prohibitions on the disclosure of information.

128. Medicare Australia is committed to supporting providers with a solid educational framework. The efforts to support and encourage voluntary compliance far outweigh audit activity. Currently, more than 30% of all providers will have contact with Medicare Australia's help and support programs each year, whereas less than 4% will be requested to substantiate a claim.

129. Medicare Australia accepts and will adopt each of the 10 recommendations within the Privacy Impact Assessment.

130. Medicare Australia stands by the conclusion to its original written submission, that the proposed legislation is essential in order to improve its ability to manage the integrity of the Medicare program.

131. Specifically, Medicare Australia supports the proposed legislation because:

    1) it will address existing deficiencies in Medicare Australia's ability to identify and deter incorrect Medicare billing and claiming by providers;

    2) it will assist in clarifying the rights and obligations of both Medicare Australia and providers in relation to the substantiation of Medicare claims; and

    3) it will introduce a simple and fair administrative penalty system which will be an effective deterrent, be efficient in its application, and is unlikely to strain the resources of providers.