Australian Government

Office of the Privacy Commissioner


# Increased MBS Compliance Audits Initiative

## Submission to the Senate Standing Committee on Community Affairs Inquiry

April 2009

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# Executive Summary

1. The Office of the Privacy Commissioner's submission deals with the privacy and information-handling aspects of the Increased MBS Compliance Audits initiative ('the initiative'), and the Health Insurance Amendment (Compliance) Bill 2009 ('the Bill').[1] In particular, it addresses the proposed addition to Medicare Australia's audit powers to compel providers to disclose patient information, in limited circumstances, in order to verify MBS claims.
2. This submission examines the privacy safeguards that are proposed to apply to the initiative. It also highlights some issues that may warrant further consideration in the interests of good privacy practice and to ensure information handling that accords with the *Privacy Act 1988* (Cth).
3. The Office of the Privacy Commissioner ('the Office') believes there is a need to maintain high levels of public trust and confidence in agencies' handling of personal information. Medicare Australia appears highly conscious of the sensitivity of the personal information it currently holds, as the agency's existing practices and service standards demonstrate. Medicare Australia has indicated its intention that these standards be reflected in the initiative.
4. The Office welcomes the focus on privacy issues so far – through Medicare Australia and the Department of Health and Ageing's joint privacy impact assessment, and ongoing consultation with professional, consumer and privacy groups, as well as our Office. It is understood that the privacy impact assessment will be an ongoing process that will guide implementation, and the Office supports this approach.
5. It is important that adequate safeguards are in place to protect personal health information collected under the initiative. Existing safeguards include protections under the Privacy Act (the Information Privacy Principles) and the Health Insurance Act. Some specific additional protections are also warranted, including those proposed in the Bill for issuing notices to providers.
6. Internal Medicare Australia policies, auditor training and provider education are also likely to play an important role in limiting the disclosure of clinical information from medical records to what is necessary.
7. The Office 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).
8. In reviewing and developing additional internal policies for MBS audits, the Office submits that the following options should also be considered:

[1] See www.health.gov.au/internet/main/publishing.nsf/Content/exp-draft-HIA-bill2009.

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

9. The Office also suggests introducing reporting and review requirements for ongoing accountability and evaluation of the initiative.
10. In the Office's view, the opportunity to consider and address these and other issues raised in the Senate Committee process will enhance the initiative's development. The Office looks forward to further engagement with relevant agencies and stakeholders, to ensure privacy continues to be protected and respected while maintaining the integrity of the Medicare Benefits Schedule ('MBS').

# The Office of the Privacy Commissioner

11. The Office of the Privacy Commissioner ('the Office') is an independent statutory body responsible for promoting an Australian culture that respects privacy. The Office, established under the *Privacy Act 1988* (Cth) ('the Privacy Act'), has responsibilities for the protection of individuals' personal information held by:

    - Australian and ACT government agencies, and
    - all private sector health service providers, large private sector organisations and some small businesses.

    The Office also has responsibilities under the Privacy Act in relation to credit worthiness information held by credit reporting agencies and credit providers, and personal tax file numbers used by individuals and organisations.

# Introduction

12. The Office welcomes the opportunity to comment on the Increased MBS Compliance Audits initiative ('the initiative') and the Health Insurance Amendment (Compliance) Bill 2009 ('the Bill').[2] The Office's comments deal with the privacy and personal information-handling aspects of the initiative, particularly the proposed addition to Medicare Australia's audit powers. These additional powers would permit Medicare Australia to compel providers to disclose patient information in limited circumstances (including clinical information) to verify the accuracy of providers' Medicare claims.
13. The Explanatory Material ('EM') to the Bill provides the rationale for the compulsory collection of patient information under the initiative. Reasons include the large amount of public money involved in the Medicare Benefits Schedule ('MBS'), the widely acknowledged value of MBS services, and the significant expansion of the MBS over the past decade.[3]
14. In the Office's view, it is important to minimise impacts on privacy by design, legislation, and policy protections. This is particularly relevant to health and other sensitive information because of the special significance of that information in the eyes of the community.[4]
15. This submission comments on existing and additional privacy safeguards that are proposed to apply to the initiative. It also highlights issues that may warrant further consideration in the interests of good privacy practice,

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[2] See www.health.gov.au/internet/main/publishing.nsf/Content/exp-draft-HIA-bill2009.

[3] See, eg, *Explanatory Material to the Exposure Draft – Health Insurance Amendment (Compliance) Bill 2009* ('EM to the Bill'), from para 1.36.

[4] See, for example, the Hon Daryl Williams QC (then Attorney-General), Second Reading Speech for the Privacy Amendment (Private Sector) Bill 2000, http://parlinfo.aph.gov.au/parlInfo/genpdf/chamber/hansardr/2000-11-08/0008/hansard_frag.pdf;fileType=application%2Fpdf, at p 2.

and to ensure personal information-handling that accords with the *Privacy Act 1988* (Cth) ('Privacy Act').

16. In assessing the initiative, the Office believes there is a need to maintain high levels of public trust and confidence in government agencies' handling of personal information. Recent Community Attitudes Surveys conducted by the Office suggest an increase in public trust in government agencies.[5] Medicare Australia appears highly conscious of the sensitivity of the personal information it currently holds, and the need to meet the Australian community's high expectations for information-handling.[6] For example, Medicare Australia's service charter states, "We will: Respect the privacy and the confidentiality of your personal information". The Office would expect these service standards to inform the initiative's development.

# Background and context of the initiative

## Stakeholder engagement and consultation

17. The Minister for Human Services has emphasised the need to work with key stakeholders, including the Privacy Commissioner, in developing the necessary changes that will give effect to the initiative, which was a 2008-09 budgetary measure. The Department of Health and Ageing ('DOHA') and Medicare Australia have sought the Office of the Privacy Commissioner's advice at various stages since the initiative was put forward. This includes advice under the Office's ongoing Memorandum of Understanding with Medicare Australia.

18. The Office is committed to assisting Medicare Australia with a view to minimising the initiative's privacy impacts through an effective range of safeguards. It is important to note that these safeguards will include the information security requirements that already apply to Medicare Australia, through the Information Privacy Principles ('IPPs') under the Privacy Act and the 'secrecy provisions' under the *Health Insurance Act 1973* ('Health Insurance Act').

19. The Office welcomes the consultation so far undertaken with other relevant stakeholders, including opportunities for input by professional, consumer and privacy groups. In the Office's view, the ongoing involvement of these stakeholders and the Privacy Commissioner will assist the initiative's implementation.

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[5] Respondents who trusted government agencies' handling of personal information increased from 58% in 2001, 64% in 2004 to 73% in 2007. The Office of the Privacy Commissioner's Community Attitudes Surveys are available at www.privacy.gov.au/business/research/index.html.

[6] See, eg, DoHA/Medicare Australia, *Increased MBS Compliance Audits Information Sheet*, November 2008 ('MBS Infosheet A'), 'What power will Medicare Australia have to access information?'

## Privacy Impact Assessment (PIA)

20. A privacy impact assessment can be an important tool to identify and address the potential privacy impacts of a project that involves personal information handling. PIAs can inform the design and implementation of such projects, to ensure that sound personal information-handling practices are 'built in' rather than 'bolted on'. In 2006 the Privacy Commissioner released a Privacy Impact Assessment Guide to assist Australian and ACT Government agencies to integrate privacy into such projects.[7]

21. The Office welcomes the attention paid to privacy issues so far through Medicare Australia and DOHA's joint PIA. This process, and public information about the initiative, refer to a range of safeguards intended to minimise privacy impacts. Such protections need to be adequate, effective and enforceable. In addition, the protections should:

    - ensure legal compliance and good privacy practice
    - promote public and stakeholder confidence in agency policies, and
    - reflect Medicare Australia's responsibilities and reputation for sound personal information-handling practices.

22. Good privacy practice is important because the Bill would require or authorise certain activities 'by or under law' – thereby satisfying relevant Privacy Act requirements regarding use and disclosure. For example, the Bill may authorise a provider's disclosure, and Medicare Australia's use of the information for legally authorised purposes relating to verifying MBS claims. Ensuring these authorised activities are carried out in a manner consistent with good privacy practice can improve the overall handling of personal information under the initiative.

23. The Office also understands that a further PIA will be conducted to guide Medicare Australia's implementation of the initiative, and welcomes this intention. This reflects the Office's view that privacy impact assessment is often an iterative process – one that is ongoing as a project progresses to new stages.

## Medicare Australia's current approach to MBS compliance audits

24. The Office understands that currently Medicare Australia's audits follow a risk-based assessment model, focussing on providers and services with a

[7] The Office's PIA Guide is available at www.privacy.gov.au/publications/pia06/index.html. It includes working through some practical steps that:

- identify and define the project scope and aims
- describe and map the flows of personal information within the project
- identify and analyse how the project may impact on privacy, and
- consider options to improve privacy outcomes.

Once this analysis is complete a PIA report can be produced summarising the information and making recommendations about how the privacy impacts and project aims can be successfully managed.

medium to high risk of non-compliance.[8] The Office believes this is an appropriate approach, and may also assist in ensuring that collection of personal information is necessary and relevant under Information Privacy Principles 1 and 3.

25. Being the subject of an MBS audit should not imply a practitioner is deliberately or necessarily doing anything wrong. It is understood that current audit procedures give providers an opportunity to explain anomalies in MBS claiming patterns without requests for further clinical details or patient information, and that audits can be closed if a satisfactory explanation is given. The Office supports the continuation of this staged audit approach, as one method of limiting when patient information will be sought under the initiative.

26. At present, the Office understands that patient information, including some clinical information, is provided voluntarily by some audited providers.[9] The key difference under this initiative is that the Bill would give Medicare Australia limited additional powers to require such information to be produced.

## Scope of proposed reform to MBS audit procedures

27. It is understood that the initiative as proposed consists of three main elements:

    i) an increase in the number of audits undertaken by Medicare Australia[10]

    ii) a requirement that practitioners must produce evidence to verify their claiming when requested during an audit

    iii) introducing a financial penalty for Medicare practitioners who make incorrect claims.[11]

28. The Office's particular focus is on the second aspect, particularly with regard to personal information handling and scrutiny of clinical records. The Bill's proposed changes need to be assessed in the context of Medicare Australia's existing role in conducting MBS audits (to oversee the appropriate spending of public money), and the secrecy provisions that currently regulate these activities.

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[8] See, eg, EM to the Bill, paras 2.5-2.7. See also *The Increased MBS Compliance Audit Initiative – Your Questions Answered*, February 2009 ('MBS Infosheet B') 'How are providers selected for MBS compliance audits?', p 3, www.medicare.gov.au/files/increased-mbs-compliance-audits-info-sheet-No2.pdf.

[9] Eg, MBS Infosheet A, 'Why does Medicare Australia need this new authority?', www.medicare.gov.au/provider/incentives/files/minister-approved-information-sheet.pdf.

[10] From 500 to 2500 audits each year, or from 0.7% to about 3.2% of Medicare providers, with a broader focus to include allied health providers and more specialists as well as GPs.

[11] EM to Bill, para 1.5. See also MBS Infosheet A.

# General comments and suggestions

29. This initiative has fostered some public discussion around the relationship of confidentiality between practitioners and patients. It has been noted that patients rely on this relationship of trust and confidentiality in providing full and frank information to their doctor. At the same time, existing 'public interest' exceptions to confidentiality have also been noted, along with voluntary disclosures of patient information by providers in current MBS audits.[12]

30. Proposals relating to public revenue protection that may impact on patient privacy should be carefully considered on their individual merits and, taking a whole-of-government perspective, on their cumulative impact. Striking the right balance can avoid unwarranted impacts on individual privacy and community confidence in the protection of personal information.

31. The privacy protections which are proposed to apply to this initiative come from a range of sources. These include the Bill, the Privacy Act, the Health Insurance Act, Medicare Australia policies (existing or proposed), and provider education programs. In some cases, policy statements have been made about information-handling under the initiative, although it is not clear that all of these intentions are enforceable (for example, see para 35 below). While the policy statements are welcome, the Office suggests that further detail is needed to demonstrate how these statements will be given practical effect, and how the various privacy safeguards will interoperate.

## Safeguards for handling personal health information under the initiative

32. Any personal information held by MBS providers is likely to be 'health information' under the Privacy Act. 'Health information' is a subcategory of 'sensitive information', which is generally ascribed higher protections under the Privacy Act.[13] This includes express, additional protections under the National Privacy Principles ('NPPs') that apply to all private sector health service providers.[14]

33. As an Australian Government agency, Medicare Australia is bound by the Information Privacy Principles ('IPPs'), which do not include the same express references to health and sensitive information. Nevertheless, it is important to ensure that adequate safeguards will protect personal information collected under the initiative. This should include existing protections under the IPPs in the Privacy Act, secrecy provisions under the Health Insurance Act, and some specific additional protections.

34. Examples of necessary safeguards for the initiative include:

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[12] See, eg, EM to the Bill, para 1.40.

[13] Health information and sensitive information are defined under section 6 of the Privacy Act.

[14] Eg, NPP 10 generally requires an organisation to obtain an individual's consent before their health information may be collected, unless another NPP 10 exception applies.

- specifying limits around the kind of personal information that needs to be collected
- restricting its further use for other purposes
- prescribing the type of officers who may view this information
- providing additional training to those officers, and
- ensuring sanctions are in place for misuse of patients' information.

The Office understands that measures are already in place for the last four points above, through existing legislative protections or (in relation to authorised officers and training) additional policies that will be adopted for the initiative.[15] In relation to the first point above, the Bill also contains some limitations on what kind of information can be requested. This issue is discussed in more detail below.

## Limitations on collection of clinical information

35. The EM to the Bill states that the disclosure and collection of *clinical* information will not be necessary or relevant in "most compliance audits".[16] The intention is that clinical information would only be requested where other documentation such as appointment or billing records are not sufficient to verify claims. An information sheet on the initiative also states that "Medicare Australia will not be authorised to request whole patient files",[17] but that relevant excerpts from medical records can be required to substantiate a given claim.

36. The Office supports such limitations, provided they are enforceable – either through clear limitations in the Bill, or in binding policies that apply to Medicare Australia. (See also, 'Tailored policies for handling clinical information', from para 58 below.)

### Proposed limitations

37. As the Office understands it, the Bill contains two key measures to limit the circumstances in which Medicare Australia can compel providers to produce patient information (clinical or otherwise) to verify MBS claims:

    i) Medicare Australia must have a "reasonable concern" that a claim has been made incorrectly.[18]

    This is an appropriate safeguard in the legislation. It may be useful to further clarify the standard of 'reasonable concern'.[19]

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[15] See, eg, EM to the Bill, para 1.50, 'Protection of information provided during compliance audits'. See also MBS Infosheet A, 'How will the Government protect privacy and patient-doctor confidentiality?'

[16] Eg, EM to Bill, para 2.34. See also MBS Infosheet A, 'What power will Medicare Australia have to access information?'.

[17] MBS Infosheet B, 'What records will a provider be required to produce?', p 4.

[18] Clause @129AAD of the Bill ('Notice to produce documents').

[19] For example, is this intended to be equivalent to 'reasonable suspicion', or a higher threshold, such as 'reasonable belief'?

ii) "The legislation will clearly state that Medicare Australia can only ask for and accept documents relevant to substantiating the MBS item/s of concern."[20]

The Office understands this refers to subclauses @129AAD(1) and (6) of the Bill. This is a welcome measure and should help to ensure that only relevant information will be exchanged.

**Additional suggestions**

38. In addition to the above, the Office suggests further clarification in the Bill, or in internal Medicare Australia policies, should:

- give providers a clearer understanding of whether or not they are required to produce information from *clinical records* in a given audit, and
- prevent requests for information drawn from clinical records when other information is sufficient (such as billing or attendance records).

39. These suggestions recognise the need to maintain sufficient flexibility in the Bill for providers to comply.[21] It is submitted that the above measures would align with:

- the initiative's intent to "address [the current] ambiguity",[22] and
- professional bodies' calls for limits on collection of clinical information.[23]

40. In the absence of additional legislative clarification, it appears that internal Medicare Australia policies, auditor training and provider education will be important in limiting the disclosure of clinical information to what is necessary.[24] Internal information-handling policies could be publicised in a clear and accessible way, for example, in privacy policies on Medicare Australia's website, summarised on claim forms, and in other documentation about the initiative.

41. The Bill also proposes to introduce fines that will apply to providers who produce insufficient documentation during an audit.[25] It is important that those measures do not result in additional and unnecessary patient information being provided to avoid the possibility of a fine. The Office suggests it may be appropriate for the Bill to provide additional protection to providers who (in good faith) produce information that they believe is sufficient, but are subsequently required to produce further information to verify MBS claims (and agree to do so).[26]

[20] MBS Information Sheet B, 'What records will a provider be required to produce?'
[21] EM to the Bill, paras 2.27-2.29.
[22] MBS Infosheet B, 'How does this apply to clinical information?'
[23] See, eg, *Australian Medicine*, "Increased MBS Compliance Audits: penalties for doctors, invasion of privacy for patients", 16 February 2009.
[24] An example is that "A contact number will be included so that providers can discuss their individual situation with a Medicare Australia auditor." MBS Infosheet B, 'What will be in the legislation? – Notice to produce documents'.
[25] Clause 129AC(1C) of the Bill ('Amount not properly substantiated...').
[26] Such additional protection may be appropriate in relation to clause 129AC(1C).

## Notice about information collected for MBS audits

### Notice to patients

42. It is generally a Privacy Act requirement, and good practice, to notify individuals when their personal information is being collected, why it is collected, and how it may be used or disclosed. Indeed, the collection of *health* information by a business generally requires an individual's consent, although this requirement does not apply to Australian Government agencies.[27]

43. However, as patient information is collected from providers being audited under the initiative, not from patients themselves, Medicare Australia's usual notice requirements under Information Privacy Principle 2 (IPP 2) do not apply. Nevertheless, the compulsory collection of health information, including from clinical records, introduces a new element to Medicare Australia's audit powers. The issue of patient notification is therefore of interest to the Office.

44. The Office understands that Medicare Australia and DoHA have given substantial consideration to notification options and good practice through the PIA process. A range of positive and negative considerations have been weighed up, following consultation with key stakeholders.

45. In particular the Office notes the arguments against specific notice include the potential for compromising provider privacy, and the likelihood of potential alarm or harm to patients. It is understood that a number of professional groups raised these concerns.[28] The Office also understands that existing MBS audit practices do not generally involve notice to individual patients (in contrast to fraud investigations, for example).

46. Following the consideration of various options, the proposed policy for the initiative remains that individual patients will not be notified if their records are disclosed in an audit. The Office understands that Medicare Australia and DOHA are instead considering options for raising public awareness of the initiative and the role of MBS audits. This may include a more general information campaign. The Office would support such awareness-raising activities.

### Notice to providers

47. Medicare Australia will still be required to give notice to practitioners, in accordance with IPP 2, when the agency collects information about practitioners themselves. The Office suggests that privacy notices to providers outline the handling of the practitioner's personal information *and* that of their patients. This seems appropriate because:

[27] National Privacy Principle 10 requires a business to get an individual's consent to collect health and other sensitive information, unless another exception applies (eg, where collection is required by law or is necessary to prevent or lessen a serious and imminent threat where an individual is incapacitated). Under Information Privacy Principles (IPPs) 1-3, collection by an agency must be relevant, and necessary for (or directly related to) a lawful purpose, that is directly related to an agency function or activity. Collection must not unreasonably intrude on an individual's personal affairs.

[28] MBS Infosheet B, p 4, 'How does this apply to clinical information?'

- patient information is subject to duties of doctor-patient confidentiality
- the records are generally the practitioner's intellectual property, and
- the practitioner can inform their patients of certain facts if they deem this appropriate (without replacing Medicare Australia's role in informing patients more generally about its audit and information handling practices).

48. Privacy notices to providers should also state if there is a legal requirement or authorisation for the collection, as required by IPP 2(d).

### Review of privacy policies and notice procedures

49. The Office understands that Medicare Australia and DOHA are considering further discussions with health professions, consumers and privacy groups, to review existing privacy policies and notice procedures in relation to MBS audits. The Office would support such a review.

50. The Office also has a number of Information Sheets which may be useful reference points in this regard. For example, Private Sector Information Sheet 23 discusses patients' reasonable expectations about information-handling for the management of a health service, such as for safety and quality assurance purposes.[29] The Office's Information Sheet 3 also gives an introductory overview of NPP 5 obligations on Openness in the private sector.[30]

## Ensuring collection isn't unreasonably intrusive (IPP 3)

51. Information Privacy Principle 3 requires an agency to take reasonable steps to ensure that "the collection of the information does not intrude to an unreasonable extent upon the personal affairs of the individual concerned." Some stakeholders have expressed a view that the initiative may be considerably intrusive on patient privacy.[31]

52. These concerns about potential intrusiveness generally relate to:
    - the type of information involved (as it is sensitive 'health information' under the Privacy Act, is ordinarily subject to practitioners' duty of confidentiality, and may be of a particularly personal nature)
    - the way the information is collected (the major change being that Medicare Australia would be able to compel production of the information, which providers may currently supply voluntarily).

53. The Office's *Plain English Guidelines to IPPs 1 – 3* provide further advice on assessing whether collection is unreasonable intrusive. For example:

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[29] Private Sector Information Sheet 23 – *Use and disclosure of health information for management, funding and monitoring of a health service* (2008), www.privacy.gov.au/publications/IS23_08.html.

[30] See www.privacy.gov.au/publications/IS3_01.html.

[31] See, eg, Australian Financial Review, "Doctors attack proposal to access medical records", 16 April 2009. See also *Australian Medicine*, "Increased MBS Compliance Audits: penalties for doctors, invasion of privacy for patients", 16 February 2009.

> *Whether an intrusive method of collecting personal information is likely to be reasonable depends on things like:*
>
> - *whether the information is important to the agency's purpose of collection*
> - *the importance of, and public interest in, the agency's purpose of collection*
> - *the extent to which the agency intrudes on a person's privacy to collect the information*
> - *whether the law specifically authorises the agency to use that method of collecting information*
> - *whether people have a free choice in whether or not to provide the information – if they do it is much less likely to be unreasonably intrusive.*[32]

54. It is important for Medicare Australia to demonstrate that, having regard to the purpose of collection:
    - the collection is necessary for or directly related to that purpose (IPP 1) and
    - the agency has taken any steps that are reasonable to ensure the collection of clinical information is not *unreasonably intrusive* (IPP 3).

55. The information sheets on the initiative, and the EM to the Bill, explain that efforts will be made to minimise the intrusiveness of personal information collection under the initiative. For example:
    i) access to clinical information will be sought only where other information won't suffice[33] (however, it is not clear how this will be ensured in practice – the Office suggests further policy development on this aspect – with some further suggestions in the next section)
    ii) the legislation will state that only information relating to specifically identified items can be requested and accepted[34] (this intent is given effect by subclause @129AAD(6) of the Bill, 'Content of notice')
    iii) relevant excerpts of clinical information will be sought or required, and collection of whole records will not be authorised by the legislation[35] (however, the Bill does not appear to *prevent* the collection of whole records, if this is the intent – see, eg, clause @129AAD of the Bill)
    iv) to issue a notice to produce, Medicare Australia must have a "reasonable concern" that an MBS payment may not have been claimed correctly[36] (required by clause @129AAD(1) of the Bill)
    v) the handling of clinical information will be restricted to specifically trained and authorised Medicare Australia staff[37] (as an internal policy)

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[32] See in particular Guideline 21 – www.privacy.gov.au/publications/HRC_PRIVACY_PUBLICATION.word_file.p6_4_14.4.doc, pp 24-25.
[33] MBS Infosheet A, 'What power will Medicare Australia have to access information?'
[34] MBS Infosheet B, 'What records will a provider be required to produce'.
[35] MBS Infosheet B, 'What records will a provider be required to produce'. See also MBS Infosheet A, 'What power will Medicare Australia have to access information?'
[36] Clause @129AAD(1) of the Bill.

vi) it is understood that Medicare Australia and DoHA intend to improve community awareness of the role of MBS audits.

56. Taken together, these are important safeguards, and make the collection of patient information less intrusive than it would otherwise be. However, the Office believes such steps should be as binding and enforceable as practicable. As noted, it is not clear how some of these proposed protections will be implemented or enforced – for example, i) and iii) above.

57. The Office believes that minimising requests and compulsory acquisition of clinical notes (by relying on other evidence) should remain a key privacy driver and benchmark for the initiative. This may also assist in ensuring Medicare Australia's high privacy standards are maintained.

# Specific comments and suggestions for further consideration

## Tailored policies for handling clinical information

58. The Office welcomes the current risk-based approach to MBS audits, and suggests that where there is a lower risk of non-compliance, there may be less imperative to require that clinical information be produced.

59. This submission has suggested that Medicare Australia review and develop additional policies for requesting or requiring patient information under the proposed new powers. In particular, production of *clinical* information should only be requested or required where it is necessary (see above, from para 35). As part of that policy development process, the Office suggests the following matters should also be considered.

### Particularly sensitive items and information

60. The Office suggests that a tailored approach be applied for Medicare items and information that may be considered particularly sensitive – for example, records dealing with HIV status, mental health, reproductive and sexual health issues. The Office recognises that sensitivities vary between individuals, and that practitioners may identify other highly-sensitive procedures or conditions in particular communities. Staff audit training could emphasise these tailored approaches. This would reflect the intent to limit the handling of clinical information and minimise intrusiveness of collection.

### Medical practitioner oversight

61. The Office understands Medicare Australia auditors currently have access to medical advisers, who have a role in handling clinical information in seized records. Medicare Australia could weigh the cost and practicality of broadening medical advisers' role in handling clinical information obtained

[37] See, eg, EM to the Bill, para 1.57.

in MBS audits alongside any likely privacy benefits. The views of consumers and health professions may also be instructive on this matter.

### Degree of patient identification required

62. The Office understands that using de-identified information may be impractical for MBS audit purposes, as records could not be reconciled without considerable additional technical processes. However, methods for minimising Medicare Australia's association of names and sensitive medical details could be further investigated. For example, greater reliance on the Medicare number to refer to records (depending on practicalities for providers).

## Reporting and review requirements

63. Reporting and review requirements can be a useful accountability mechanism, and can assist in assessing a policy's effectiveness. The Office suggests a requirement in the legislation or elsewhere that Medicare Australia report regularly on aspects of the initiative, such as in its annual report. Reporting requirements could include:
    - the frequency of, and reasons for, reliance on powers conferred by the Bill
    - the proportion of audits in which collection of clinical notes or excerpts occurs, and the approximate number of medical records involved, and
    - the additional amount of public savings achieved as a result of the initiative (if practicable, with particular reference to 'notices to produce').
64. The Office would also support a post-implementation review of the changes, which could draw on the above data.

## Secondary use restrictions

65. The Office understands that the policy intent is that secondary uses of information collected to verify MBS claims (including data-matching or other linking) will not be allowed. An exception is in the event of false or misleading statements pertaining to Medicare services or the Health Insurance Act.[38] It is understood that existing use or disclosure exceptions under the Privacy Act (IPPs) and the Health Insurance Act (secrecy provisions) will continue to apply.[39] However, the Office welcomes the intent that secondary uses will not generally occur. The Office also understands that Medicare Australia will conduct audits of internal uses as a further precaution against unauthorised viewing or use of this information.

[38] EM to Bill para 1.80 refers to limited use for criminal proceedings relating to misleading statements.

[39] Eg, IPP 11 permits disclosure for secondary purposes with consent; to prevent a serious and imminent threat to life or health; where required or authorised by law; or where necessary for criminal enforcement or public revenue protection.