THE INCREASED MBS COMPLIANCE AUDIT INITIATIVE

INFORMATION SHEET 2 -YOUR QUESTIONS ANSWERED

What has been announced?

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

1. increases the number of audits undertaken by Medicare Australia;
2. expands the audit program to include allied health providers and to allow better coverage of specialists;
3. requires providers to produce evidence to verify their Medicare claiming when audited; and
4. introduces a financial penalty for Medicare providers whose incorrect claims are above a certain amount.

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

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

Why are these changes being made?

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

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

When do these changes take effect?

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

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

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

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

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

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

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

What is being proposed as part of the legislative amendments?

Proposed changes - Notice to produce documents

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

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

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

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

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

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

Proposed changes - Repayments

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

Proposed changes - Financial Penalties

It is proposed that a financial penalty of 20% will be applied to debts above a certain dollar amount – a specified threshold. It is proposed that this threshold be $2,500. The threshold will ensure that providers who make one-off mistakes are not penalised. Medicare Australia's data on providers who repaid monies in 2007–08, shows that 64% had a repayment amount of ***less than*** $2,500[1]. Almost half of all recoveries during this period were below $1,000.

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

- removed if a provider admits to receiving an incorrect amount prior to any Medicare Australia compliance contact;
- reduced by 50% if a provider admits making an incorrect claim before a notice to produce evidence is issued;
- reduced by 25% if the provider admits making an incorrect claim before completion of the audit.

The proposed model also provides that where a provider completely fails to respond to a notice to produce evidence the full amount of the services identified in the notice becomes a debt and the total penalty payable increases by 25%.

If, within a 24 months period, a provider is found to have made a second (or further) incorrect claim and the total they repaid for the previous claim was more than $30,000, it is proposed that the penalty amount be increased by 50%.

Why does Medicare Australia conduct MBS audits?

The aim of an MBS compliance audit is to check that the provider and patient were eligible for Medicare benefits and the service was provided and met the MBS item requirements. These are all questions of fact and do not impose on either the clinical appropriateness or adequacy of the MBS service. By way of example if a provider claims an MBS item that:

- requires a particular test to be done - Medicare Australia will ask for evidence that the test was done;
- requires a referral - Medicare Australia will ask for a copy of the referral;
- requires a certain amount of time to be spent with the patient, or the service to be performed at a particular time – Medicare Australia will ask for evidence that those time requirements have been met;
- requires a pre-existing condition – Medicare Australia will ask for evidence that the pre-existing condition existed.

[1] In 2007-08, 49% of all recoveries were below $1,000, and 26% were below $200. 22% of recoveries were between $2,500-$10,000; 9% between $10,000-$50,000; 2% between $50,000-$100,000; and 2% were over $100,000.

During an MBS compliance audit, Medicare Australia will not be authorised to question the clinical appropriateness of the service or item nor the provider's professional decision making. Medicare Australia will only be authorised to test the facts of the service to ensure that they match the claim that has been made.

How are providers selected for MBS compliance audits?

Medicare Australia recognises there are often many acceptable reasons for shifts or changes in claiming behaviour and always gives a provider the opportunity to explain their situation. The four processes through which a provider's claims may be identified for audit are:

1. A provider has used an item/s with a medium to high risk of non-compliance;
2. A provider's claiming statistics appear to be unusual or irregular;
3. A provider's claiming statistics are different to their peers; or
4. Items or individuals identified through tip-offs.

Further information on how a provider may be selected for a compliance audit is attached to this information sheet.

How will the audit process change?

The new audit process will be largely unchanged. In line with current practice, a provider will be notified that there is an issue with an MBS claim that Medicare Australia is seeking to confirm and asked to produce evidence to verify specified claims. Medicare Australia will specify the reason(s) for the request, the item number of each professional service included in the request, the Medicare number of the patient(s), and the date the service(s) was provided. The provider will also receive a privacy notice detailing the reasons why the information is being sought, who it will be viewed by, and how it will be used and stored.

How will providers respond to an audit request?

Medicare Australia can receive documents in either hard copy or electronically whichever is more convenient to the provider. If a provider prefers, it may also be possible for a Medicare Australia officer to meet with them to view or copy relevant documents. The documents a provider might decide to send to Medicare Australia will depend on the MBS item and the specific concern being audited. Information on how providers can respond to the request will be included in the audit letter. Providers will also be able to discuss tthe kind of information required with a compliance officer.

How will Medicare Australia minimise the impact on a provider's time and business?

Those providers who are audited can expect Medicare Australia to minimise the business impacts of the audit process. Specifically Medicare Australia will be required to be very clear about the services it is auditing, the concerns that need to be addressed and the timeframe a provider has to respond. Medicare Australia will be flexible about the delivery of the evidence, and will work with providers to find the most convenient means of transmitting documents.

What information will I need to provide?

What type of records should a provider keep?

This initiative will not introduce any new record making or retention requirements for Medicare providers[2]. A provider's medical practice should already have source documents (including receipts and appointment books) and clinical records that:

- clearly identify the patient (by name, reference or Medicare number)
- contain a separate entry for each attendance by the patient and the date on which the service was rendered
- provide information adequate to verify the administrative details of service rendered
- are sufficiently comprehensive to communicate the details of the service provided (i.e. tests performed and ordered, results of examinations).

What records will a provider be required to produce?

The proposed legislation will not specify the kind of document a provider should produce. Instead the provider will be able to choose the documentary evidence that confirms the relevant elements of the MBS claims being audited. The kind of evidence required will depend on the risk identified by Medicare Australia, that is, the reason the audit is being conducted. This will be explained in the letter the provider receives.

The legislation will clearly state that Medicare Australia can only ask for and accept documents relevant to substantiating the MBS item they are concerned about. Medicare Australia will not be authorised to request whole patient files. It is

[2] Regulation 9(1) of the Health Insurance (General Medical Services Table) Regulations describes the elements of a professional attendance for a broad range of Medicare attendance items. Recording the clinical details of the service provided to the patient is one element of the professional attendance.

anticipated that where clinical notes are provided to Medicare Australia to verify a particular claim, they may be censored so that only the details relevant to the audit are legible.

What will happen to the documents collected by Medicare Australia?

Documentation forwarded to Medicare Australia will be viewed by a limited number of specifically trained and authorised staff. These authorised staff will be located in central and state or territory offices rather than local branches. Medicare Australia already has a 'conflict of interest' policy that prohibits staff members from being involved in compliance activities when they are acquainted with the individual connected with the items being audited. If a document substantiates an MBS claim, it is likely that only one individual (the auditor) would need to see the document.

Information will be stored in accordance with relevant legislation and current policies that safeguard personal information. Personal information collected during a compliance audit will be protected by the security safeguards that are currently in place in Medicare Australia. Those safeguards prevent and detect unauthorised access. They cover the facets of personnel security, physical security and IT security. Medicare Australia currently complies with Government requirements including:

- the Commonwealth Protective Security Manual (PSM);
- the *Privacy Act 1988*;
- secrecy provisions in the *Health Insurance Act 1973* (s130);
- the Australian Government Information and Communications Technology Security Manual (ACSI 33);
- the Australian Government e-Authentication Framework (AGAF);
- the Gatekeeper Public Key Infrastructure (PKI) Framework; and
- other Australian Government and international security standards.

It is anticipated that the legislation will prevent documents collected through the audit process from being used for other purposes including Professional Services Review matters. However the documents will be able to be used in criminal matters where a provider has defrauded the Commonwealth.

How does this apply to clinical information?

One of the intents of this legislation is to formalise existing voluntary compliance audit processes where clinical information is already disclosed to Medicare Australia. Currently during an audit Medicare Australia can and does receive health information from providers to validate claims they have made.

Information relevant to payment verification – including some clinical information – is routinely provided voluntarily by some providers during an audit. The *Privacy Act 1988* allows personal information to be disclosed to bodies such as Medicare Australia where that disclosure is reasonably necessary to protect the public revenue. However, at present there is not a clear legal framework which sets out either Medicare Australia's or the provider's rights and responsibilities in relation to the provision of clinical information except in certain limited circumstances (such as fraud). Accordingly, it is not currently clear what Medicare Australia can ask for or what providers are obliged to provide. The proposed legislation will address this ambiguity. The proposed legislative changes will mean that all Medicare providers will be required by law to produce evidence to verify a claim if audited by Medicare Australia.

Will patients know that a service they have received is being audited?

It is unlikely that the legislation will require either Medicare Australia or providers to advise individual patients that an MBS service they have received is being audited. A number of stakeholders have indicated that notifying patients may compromise the provider's privacy because patients will know that their doctor is being audited by Medicare Australia and this may cause unnecessary anxiety to some patients.

Where can I find out more?

The bill giving effect to the proposed legislation details is still being drafted and has not yet been finalised. It is expected to introduced into Parliament in March 2009. Both Medicare Australia and the Department of Health and Ageing are continuing to discuss the legislative amendments with key stakeholders. If you wish to provide further feedback you should email it to medicareintegrity@health.gov.au. As more details become available Medicare Australia will update the website. Visit **www.medicareaustralia.gov.au** then go to **For health professionals**.

Medicare Australia's Resources for Providers

Information and support services that Medicare Australia currently provides to encourage correct claiming include:

- **Enquiry lines**
  Medicare Australia runs a designated Medicare enquiry line for providers who have questions about MBS claiming or interpretation. Providers can contact the Medicare provider enquiry line on **132 150** (local call rate) or via email **medicare.prov@medicareaustralia.gov.au**

- **Administrative Position Statements**
  An Administrative Position Statement (APS) is a Medicare Australia authorised interpretation of an area of the MBS where there is potential claiming ambiguity. These statements aim to provide clarity and reduce uncertainty for providers to make it easier for them to comply with requirements of the MBS and PBS. This should save time and effort and provide peace of mind, especially in the event of an audit where an APS sets the baseline against which compliance is assessed. Visit **www.medicareaustralia.gov.au** then go to **For health professionals** > **Doing business with Medicare Australia > Administrative Position Statements (APS)**

- **eLearning services**
  Medicare Australia's eLearning programs are designed to help providers better understand Medicare requirements. There are currently three MBS related eLearning products covering new providers, rural and remote providers, and dentists. These online education products are easy to use, interactive and free of charge. Visit **www.medicareaustralia.gov.au** then go to **For health professionals** > **Doing business with Medicare Australia** > **Education** for a full list of current eLearning products.

- **Learning guides**
  Learning guides are an alternative if providers are unable to access eLearning. They are designed to help new providers acquire the essential skills needed to access Medicare and the PBS correctly.

- **Quick reference guides and targeted information**
  Quick reference guides are designed to provide clarity on complex areas within the MBS and PBS. The guides focus on topics identified in Medicare Australia's National Compliance Program. Both quick reference guides and targeted information are Medicare Australia's process for providing advice on single issues to people who need them. They are distributed to relevant providers and are also made available on our website. Already in 2008–09, information has been provided to 11,133 allied health professionals and 6,151 general providers in relation to MBS items.

- **Face to face education**
  This financial year Medicare Australia has delivered face to face education sessions on a wide range of topics to support better access to and correct use of the MBS for both new and experienced providers. In the last 6 months Medicare Australia has provided face to face education to 1408 professionals.

- **Other resources**
  A range of printed handbooks and other resources on Medicare and the PBS are also available. These include prescription writing guides and dispensing and claiming checklists to help providers correctly prescribe PBS medicine within private practice or public hospital settings.

Where can I find out more?

Visit **www.medicareaustralia.gov.au** then go to **For health professionals** > **Doing business with Medicare Australia** > **Education**

How are providers selected for MBS Compliance audits?

There are four broad processes through which a provider's claims may be identified for audit. In each of these processes, Medicare Australia recognises there are often many acceptable reasons for shifts or changes in claiming behaviour and always gives a provider the chance to explain their situation. The four processes that may identify a provider for audit are:

1. **A provider has used an item/s with a medium to high risk of non-compliance**

   To ensure compliance activities focus on the items and types of services which are most likely to be incorrectly claimed, Medicare Australia undertakes significant analysis to identify items where there is a higher risk of incorrect claims. A significant part of this process includes receiving submissions and ideas from the health industry on the emerging risks and issues effecting MBS compliance. Based on this analysis Medicare Australia selects a number of individuals who have used this item for audit. In this situation a provider may be chosen because they belong to an industry or specialist group involved in areas of high risk billing or may have used a high risk item.

2. **A provider's claiming statistics appear to be unusual or irregular**

   Medicare Australia runs regular reports on the use of MBS items to monitor possible non-compliance. Some of the indicators which may lead to a provider being identified for audit include:
   - claims for an individual item are extremely high
   - claims for specific items increase dramatically or significantly without any clear or identifiable reason
   - claims over a specified period are higher than what would be expected
   - claiming of items appears to be outside a provider's specialty or area of practice
   - items appear to be claimed without required prerequisites (e.g. no pathology test appears to have been performed for the patient despite the MBS item requiring one)
   - patient billing appears to be abnormal or inconsistent (e.g. provider has claimed for a patient that has seen another doctor on the same day or the items claimed do not appear to meet the demographics of a provider's area).

3. **A provider's claiming statistics are different to their peers**

   From the claiming data it receives Medicare Australia can build a profile of usual claiming behaviour for each provider group and compare an individual's profile to this. This can identify individuals whose use of an item significantly exceeds that of their peers, or whose proportional use of graduated items (e.g. time, size or complexity based items) appears different. Medicare Australia uses sophisticated technology to compare factors including total benefits, services, patient demographics and prescribing of pharmaceuticals. The profiling system is adaptive and takes into account factors such as number of days worked and area of practice.

4. **Items or individuals identified through tip-offs**

   Medicare Australia regularly receives reports about claiming behaviour from members of the public, practice staff and other providers. Sometimes this information relates to poor claiming practice, and possible incorrect claiming. If a provider is identified for audit through this process, Medicare Australia will generally seek information that confirms or disproves the information we have received from the tip-off.

Where can I find out more?

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

The New MBS Audit Process - As proposed in the Draft Legislation

Medicare Australia makes a range of information and support tools available about correct claiming - Medicare Australia is transparent about its audit program

Provider may choose to come forward about noncompliance

NEW STEP: any penalty that should be paid is completely removed

Through data analysis Medicare Australia develops a reasonable concern that an MBS benefit may have been incorrectly claimed

Medicare Australia will make an enquiry detailing the nature of the concern and specifying the claims which require confirmation

Provider may admit to incorrect claims

NEW STEP: any penalty that should be paid is reduced by 50%

Audit closed

Provider may submit documents in response to audit

Based on response Medicare Australia will determine the audit outcome

NEW STEP: any incorrect claims above the threshold will attract the base penalty amount (no increase or reduction)

Audit closed

Provider may either fail or refuse to respond to the audit

NEW STEPS

Medicare Australia issues a written notice requiring production of documents within 21 days

Provider may choose to admit to incorrect claims - any penalty they should have paid is reduced by 25%

Audit closed

Provider may submit documents in response to the notice

Based on response Medicare Australia will determine the audit outcome
- incorrect claims above the threshold will attract the base penalty amount (no increase or reduction)

Audit closed

Provider may completely fail or refuse to respond to the audit letter

All claims identified in the notice (the total amount) will attract the base penalty amount plus an additional 25%

Audit closed

Medicare Australia issues debt and penalty notice as one complete invoice*

***NEW STEP**
if the practitioner has previously been issued a penalty/debt notice in the preceding 24 months and repaid more than $30,000 - the penalty amount is increased by 50%.