



**Australian Government**

**Medicare Australia**



***Medicare Australia's  
National Compliance Program  
2010–2011***

© Commonwealth of Australia 2010

This work is copyright. You may download, display, print and reproduce this material in unaltered form only (retaining this notice) for your personal, non-commercial use or use within your organisation. Apart from any use as permitted under the Copyright Act 1968, all other rights are reserved. Requests and inquiries concerning reproduction and rights should be addressed to Commonwealth Copyright Administration, Attorney General's Department, National Circuit, Barton ACT 2600 or posted at <http://www.ag.gov.au/cca>

## **Foreword**



I am pleased to present Medicare Australia's National Compliance Program for 2010–2011.

Our National Compliance Program sets out to inform both providers and the Australian public about how we will manage compliance and the issues we will address in the year ahead.

The program forms part of the Government's strategy for managing non-compliance and fraud in the delivery of social, health and welfare programs.

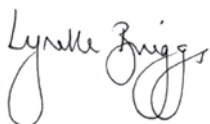
Medicare Australia pays claims quickly and effectively, and in this environment it is vital that we understand and support the approach to voluntary compliance. We recognise that most people want to do the right thing, so our National Compliance Program focuses on education and support to help providers and the public meet their obligations. This is complemented by a system of professional audits, reviews and where necessary, criminal investigations.

In 2009–2010 we worked in collaboration with our stakeholders to improve our education and support strategies.

In 2010–2011 we will focus on:

- continuing to develop resources to support providers, including new doctors and international medical graduates, to voluntarily meet their compliance obligations
- engaging with stakeholders including the co-design of our compliance initiatives
- completing our published work program; and
- working closely with other Human Services agencies to improve compliance and fraud management.

By supporting health professionals and the public to understand their voluntary compliance obligations, our aim is to ensure public funds are used appropriately, and to make sure the right person receives the right payment at the right time.












**Lynelle Briggs**

Chief Executive Officer  
Medicare Australia

# **Table of contents**

---

	<b>Introduction</b>	<b>1</b>
	<b>Our compliance philosophy</b>	<b>2</b>
	Our philosophy	2
	Our compliance commitment	2
	Mutual obligations	2
	Our commitment to privacy	2
	<b>Our compliance model</b>	<b>3</b>
	<b>Our compliance approach</b>	<b>6</b>
	Our stakeholders	6
	Risk detection	7
	Our education and support activities	8
	Our audit and investigation activities	8
	Payment accuracy reviews	9
	Compliance Professionalism Survey	10
	<b>Our key focus and priorities for 2010–2011</b>	<b>11</b>
	General practitioners	12
	Specialists	15
	Other providers	17
	Practice managers	19
	Pharmacists	20
	Aged Care Providers	21
	Health insurance funds	21
	Members of the public	21
	<b>More information</b>	<b>22</b>
	<b>Australian Government Services Fraud Tip-Off Line</b>	<b>23</b>
	<b>Acronyms</b>	<b>24</b>
	<b>Appendix A</b>	<b>26</b>

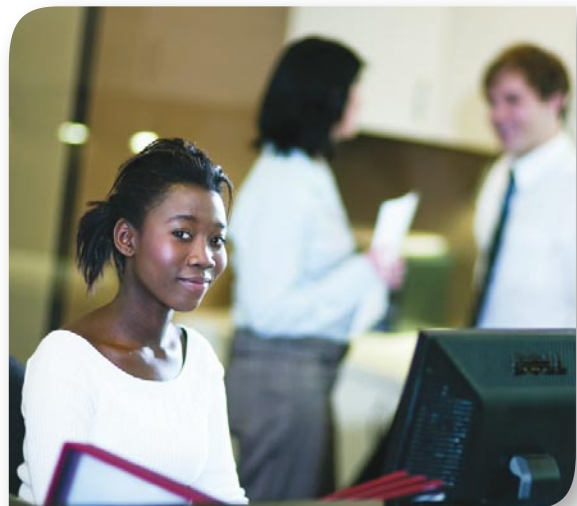
# Introduction

Medicare Australia is committed to 21st century service delivery. This means providing all Australians with convenient and efficient access to government information and payment services. An inherent part of this is to assure the Australian Government, health professionals and the wider community of the integrity of the programs we deliver. This includes developing and delivering a robust and comprehensive compliance program that ensures the right person receives the right payment at the right time—no more, no less.

Our payment systems rely on providers to correctly determine the claim or bill for the service they have provided or the pharmaceutical item they have prescribed or supplied. Our focus is to ensure providers have the information and support to do this correctly. We do this through a variety of means including engaging with stakeholders and conducting education activities, face-to-face and online, in a collaborative fashion. We then take a post payment approach using risk management techniques to monitor and confirm payment accuracy and program integrity.

Our National Compliance Program sets out our approach to compliance for 2010–2011. It again focuses on our key stakeholder groups. It highlights the key risks to the integrity of the programs we deliver and outlines our responses to these concerns. This program also outlines how we will be supporting each group to voluntarily comply.

As part of our compliance approach we collaborate with agencies across the Human Services Portfolio and with the Department of Health and Ageing (DoHA). Each year the Department of Human Services (DHS) prepares a Strategic Fraud and Non Compliance Plan identifying key strategic concerns across the portfolio. Medicare Australia's National Compliance Program supports this plan, identifying our approach to managing the compliance of health and aged care payment programs.



# **Our compliance philosophy**

## **Our philosophy**

The majority of people want to do the right thing and will comply if they understand their rights and obligations.

The core elements of our philosophy are to:

- support people who want to do the right thing and make it as easy as possible for them to meet their obligations
- educate those who make honest mistakes
- actively pursue those who seek to opportunistically or deliberately exploit the programs we administer.

Our intent is to maximise the number of people who voluntarily comply with their obligations and minimise non-compliance.

## **Our compliance commitment**

Our commitment for 2010–2011 is to deliver high quality compliance services, information and support to make it easier for health professionals to comply and for members of the public to understand their obligations.

In line with our service charter, during 2010–2011 we will:

- **make it easy** for people to meet their obligations by providing timely advice and information and seeking new and improved ways to deliver our compliance programs
- **be genuinely interested** and take people's individual circumstances into account when conducting our compliance activities
- **respect people's rights** by explaining our processes and concerns and treating everyone with respect, dignity and courtesy
- **get it right** for the Australian community by delivering our compliance program with precision and professionalism.

## **Mutual obligations**

You can expect us to:

- ensure the information you need is easily accessible to allow you to comply with program requirements
- be fair and reasonable
- be available to respond to questions in order to help you comply with program requirements
- take a professional approach to compliance activities.

We expect you to:

- be familiar with the requirements of Medicare Australia's programs
- work in accordance with these requirements
- understand your obligations under relevant legislation
- cooperate with Medicare Australia to verify compliance.

## **Our commitment to privacy**

Medicare Australia manages all personal information in accordance with the *Privacy Act 1988*. Most of that personal information is also subject to secrecy provisions included in the *Health Insurance Act 1973* and the *National Health Act 1953*. These provisions make it an offence for protected information to be divulged other than in narrowly specified circumstances.

We are committed to protecting the privacy and confidentiality of the information we hold about our providers and members of the public and take all matters in relation to privacy seriously.

# **Our compliance model**

The compliance model captures our philosophy and recognises that our activities and responses need to be appropriate for the nature of the issues we encounter.

Each year, we seek to expand our knowledge of the health environment including factors that affect how well providers and the Australian public comply with the programs we administer.

We conduct an annual environmental scan which involves consulting our stakeholders about trends and changes in their business and how these trends may impact compliance for the programs we administer.

We then examine this feedback using a well accepted risk identification framework known as PESTLe, and seek to understand the environmental factors that are driving non-compliance.

**Policy**—growth in volume of services and providers

**Economic**—changing ways of delivering health services

**Social**—community expectations and demand

**Technological**—the effect of eBusiness and other technologies

**Legal**—interpretation and application.

By understanding these factors we can work to remove the barriers to compliance, and focus on assisting providers and the public through our education and compliance activities.

**Diagram 1—The compliance model**

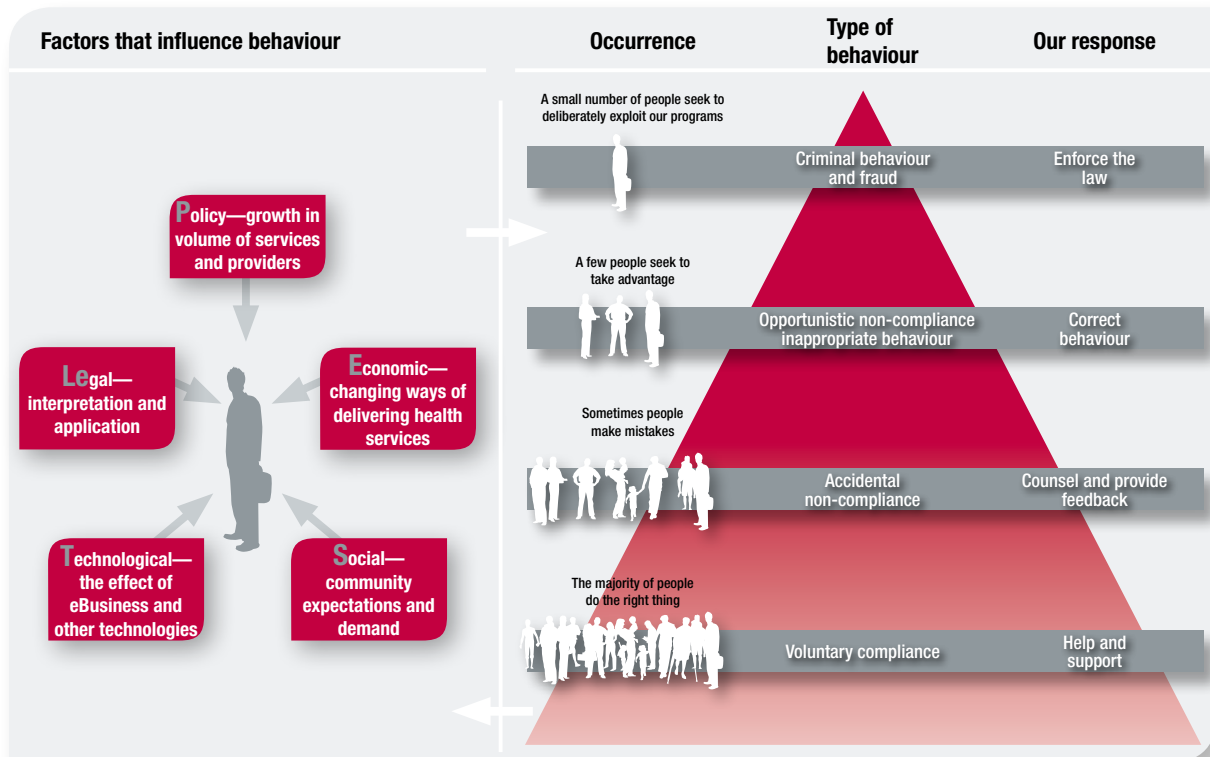


Diagram 1 illustrates the factors that influence behaviour (PESTLe framework) and the compliance triangle.

We recognise that individuals will behave in different ways. The diagram on page two identifies the following broad types of behaviour and our response to them:

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

**Accidental non-compliance:** We recognise that sometimes people make mistakes. For example, health professionals who mistakenly claim benefits using incorrect Medicare Benefits Schedule (MBS) item numbers (misitemisation) or unknowingly prescribe outside the Pharmaceutical Benefits Scheme (PBS) criteria.

When this is identified, we will seek to help health professionals avoid future errors by providing specific information explaining the suspected issue/s, giving reasonable opportunity to respond. In circumstances where payment has been obtained incorrectly we may seek to recover payment/s.

**Opportunistic non-compliance and inappropriate behaviour:** There will always be a small number of people who seek to gain a benefit or advantage to which they are not entitled. For example:

- health professionals who knowingly bill an item when not all requirements of the item have been met
- health professionals who provide services not clinically necessary
- members of the public who obtain more PBS medicines than they require.

If it has been determined that someone has intentionally sought to gain an incorrect or inappropriate benefit, we will seek recovery of the payment and where appropriate, consider referring the matter for professional peer review.

**Criminal behaviour and fraud:** A small number of people seek to deliberately exploit our programs. For example, health professionals who intentionally create false claims for services they did not provide or medicines they did not supply, or members of the public who create false claims using their own identity or that of someone else.

We have an obligation to identify potentially fraudulent activities and deal with this behaviour according to the law and, where necessary, we will refer matters for criminal prosecution.

The PESTLe framework illustrates external factors that can influence a person's behaviour as follows:

### **Policy—growth in volume of services and providers**

In the past 10 years the MBS and PBS have undergone significant expansion in response to changing health needs, workforce shortages and an ageing population. This change can be attributed to:

- encouraging general practitioner management of chronic disease
- initiatives to improve health outcomes, thereby reducing patient cost through better care management
- employing doctors from overseas.

Medicare claimable services are now delivered by general practitioners, practice nurses, dentists, allied health professionals, optometrists, and, from November 2010, by nurse practitioners and midwives with an increasing focus on team-based care.

### **Economic—changing ways of delivering health services**

There have been significant changes to the management of health businesses and the delivery of health services. The major themes include:

- a continued shortage of general practitioners (GPs) especially in regional and rural areas, and increased reliance on doctors from overseas. We are seeing a trend of GPs working fewer hours and younger doctors are seeking greater flexibility and less involvement in the administrative tasks involved in the management of a practice
- a shift from small practices to larger group practices and an increase in the consolidation and business restructure of health care organisations, with doctors more likely to be employees or contractors. Patients are likely to be seeing a number of different providers, both within the one practice and across practices
- an increase in the role of practice and pharmacy staff, where employees are likely to be responsible for direct interactions with Medicare Australia including interpreting schedules, managing the billing and claiming functions, and overall business management of the practice.

## **Social—community expectations and demand**

Consumers of health care today have greater access to information and seek greater control over their health treatment. They use the internet and other information sources to choose health professionals and self-diagnose.

This along with an increased focus on preventive medicine can lead to the billing of services not clinically necessary or not subsidised by Medicare or PBS. Examples may include:

- unnecessary referrals, tests and investigations
- cosmetic procedures billed to Medicare, either under Medicare Safety Net arrangements or without clinical necessity
- inappropriate prescribing of medicine, particularly of medicine subject to abuse
- prescribing of PBS listed medicines intended for illegal use by a patient's family or friends overseas.

Reasons for members of the public to consult a GP are also changing, with a trend toward more requests for services such as check-ups and prescriptions and away from symptom presentations.

Patients seeking state-of-the art technologies and medicines can place GPs under considerable pressure.

## **Technological—the effect of eBusiness and other technologies**

The automation of processes within the health care sector for claiming and service delivery functions is a growing enabler in our technology-driven environment. Our view is that software used to provide these automated services needs to support compliance and we are working with software developer groups to influence where we can.

Many of the claims processed by Medicare Australia are now processed electronically without any manual intervention.

## **Legal—interpretation and application**

The Australian government pays Medicare and PBS benefits to assist consumers with the cost of medical, optometrical and some dental and allied health services, and the cost of prescriptions. The breadth and range of services available reflects the comprehensive nature of the Medicare and the PBS programs. However, this large range of items adds complexity and may result in misinterpretation or misuse of the schedules.

Developments in health services and medicine also continue to lead to increasingly complex MBS items and PBS listings which may be open to more than one interpretation. This creates the potential for accidental and intentional non-compliance.

The complexity of health programs can be a particular challenge for doctors working in isolation or overseas trained doctors who may be unfamiliar with the systems and controls in place.

# Our compliance approach

Every year we review our approach to compliance. We consider our business strategy, input from our stakeholders, government requirements and policy changes in designing our compliance plan and activities. In 2010–2011 our approach to compliance will involve:

- providing information, advice and supporting education materials to assist understanding of program requirements
- working to improve our relationships and communication with stakeholders to better identify risks to compliance and opportunities for improvement
- continuing our program of risk detection and analysis to enhance our program integrity
- ensuring our audit and investigation work is understood, appropriate, and professional.

Our approach will continue to build on previous years' work in better understanding the experience of providers within the health system. This involves reviewing the experiences providers have in accessing our services and aligning our education and support with their information needs.

For example, in 2009–2010 we gave presentations at nine national health conferences on topics such as our online education model, compliance audits and billing specialised Medicare items. We surveyed 400 allied health professionals in late 2009 and the findings will inform our education and support strategy across this provider segment and inform the design of future compliance activity. We also ran a Google adwords campaign in early 2010 as part of the online education services communication strategy with the aim of increasing traffic to Medicare Australia's online education services.

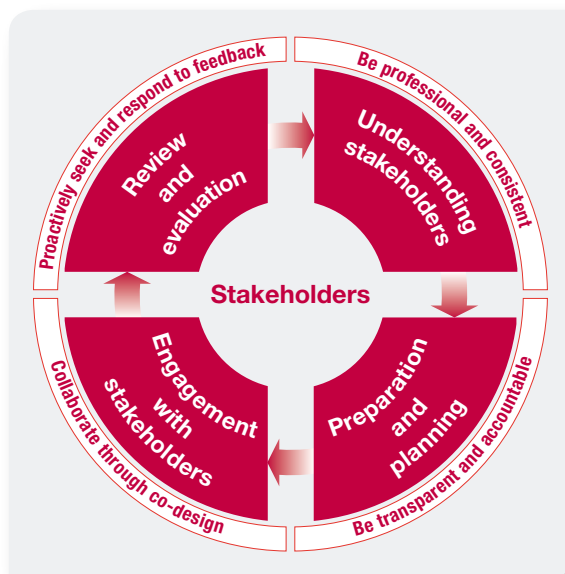
## Our stakeholders

In 2010–2011 we will continue to build on the co-design approach we adopted in recent years which forms part of our Stakeholder Engagement Framework. As diagram 2 represents, in partnering with stakeholders we will:

- **be professional and consistent.** We will seek to understand our stakeholders' priorities, responsibilities and capabilities

- **be transparent and accountable in our stakeholder engagement.** We will regularly engage with key stakeholders to identify and thoroughly understand any emerging risks to compliance. This engagement helps to determine appropriate measures and ways these can be implemented, particularly learning and support strategies
- **collaborate through co-design.** We will continue to co-design compliance strategies where appropriate and will continue to engage regularly with key stakeholders drawing on their expertise, knowledge and contacts
- **proactively seek and respond to feedback.** We will work with stakeholders to ensure there is a clear understanding of the audit process. We will continue to seek feedback through the Compliance Professionalism Survey<sup>1</sup>.

Diagram 2—Partnering with stakeholders



During 2010–2011 we will continue to work with stakeholders to improve the letters we use as part of compliance strategies.

We will continue our work to understand the experiences of providers as they interact with the health system—expanding our user pathways and developing new ways to better understand the learning and support needs as well as potential irritants or blockers to compliance.

<sup>1</sup>Results from the 2009–2010 survey are available on page 10.

## Risk detection

Risk detection includes identifying, assessing and prioritising risks to the integrity of the programs we administer.

### Risk identification

We use various information sources to identify compliance risks and issues. These include:

- seeking input from stakeholders through standing consultative committees and other meetings and workshops
- an annual compliance survey distributed to peak bodies and relevant government agencies
- feedback and learnings from previous compliance activities
- tip-offs and referrals from members of the public, our own people and other government departments and agencies
- monitoring of Medicare and PBS item usage over time, to identify unusual or unexplainable item growth
- media and literature reviews.

When a compliance risk or concern is identified, we conduct comprehensive research and analysis to understand any issues and contributing factors as well as the potential impact that may result.

### Risk Assessment

Information gathered through the research process is then assessed against additional criteria to assess the financial impact of the risk as well as the social and policy aspects.

Once a risk or concern is identified, we use a range of sophisticated data mining and analysis tools to identify individuals who may be non-compliant. Techniques used include artificial intelligence methodologies, rules-based analysis and regular data reviews.

To detect non-compliance, Medicare Australia's compliance risk and assessment area:

- monitors the claiming profiles of individuals (comparing claiming profiles against peers to identify outliers)
- reviews the top claimants by a range of fields including geographic, demographic and claim or service types
- monitors unusual growth in individual claim types
- monitors high risk items and claim types (for example high-cost claims)
- monitors processing data for unusual trends or patterns, (such as duplicate claims)
- examines patterns of cash, cheque and EFT payments to identify cases of possible fraud.

Based on the information obtained through the research and data analysis process, individual cases are assessed by experienced and specialist compliance officers and referred for further auditing as necessary.

### Risk prioritisation

At each stage of the risk detection process, work is prioritised, taking into account issues such as:

- the likely nature of the behaviour for example, accidental, opportunistic, inappropriate or fraudulent
- the impact of the behaviour
- whether a new risk is likely to grow unless addressed
- whether a risk is associated with a new provider group or can be attributed to a change under the PESTLe framework (see Diagram 1)
- potential policy changes.

Prioritising this work makes sure we focus on issues that have the most significant impact in our business.

### Compliance strategy design

Based on the outcomes of the risk detection process, we will co-design compliance strategies in consultation with internal and external stakeholders.

Compliance strategies detail the actions which will be taken to ensure non-compliance is monitored, detected and treated to support voluntary compliance. We will take a varied approach to designing educational and enforcement activities to ensure our response is proportional to the compliance risk.

## Our education and support activities

We provide a range of educational products and services designed to support voluntary compliance, including: eLearning products, quick reference guides, specific education resources/activities/programs, provider percentile charts and enquiry lines.

### Educational products

We develop educational products to assist both new and experienced health professionals understand and apply the requirements of the MBS and PBS. Through close collaboration with health professionals we have designed products for specific user groups to provide clarity on complex topics.

This includes the recent development of a number of eLearning modules to assist GPs and optometrists, including:

- *Medicare and You—Chronic Disease Management for GPs*
- *Medicare and You—treatment for skin lesions*
- *PBS and You—prescribing for optometrists.*

We also deliver workshops, presentations and face-to-face education sessions to pharmacy students.

To access the full range of our educational resources visit [www.medicareaustralia.gov.au](http://www.medicareaustralia.gov.au) then go to

**For health professionals > Doing business with Medicare Australia > Online education services.**

### Provider percentile charts

A range of provider percentile charts are available on our website, showing the number of services billed by peer groups for selected MBS items. The charts are updated quarterly and allow providers to assess their own billing patterns in relation to others.

Charts currently on the website include common attendance items, chronic disease management items, mental health items and a range of consultant and allied health items.

To access statistical information, visit [www.medicareaustralia.gov.au](http://www.medicareaustralia.gov.au) then go to **About Medicare Australia > Statistics > Provider percentile charts.**

### For more information

To contact dedicated Medicare Australia enquiry lines for health professionals:

- call the Medicare provider enquiry line on **132 150** (local call rate) or email [medicare.prov@medicareaustralia.gov.au](mailto:medicare.prov@medicareaustralia.gov.au)
- call the PBS enquiry line on **132 290** (local call rate) or email [pbs@medicareaustralia.gov.au](mailto:pbs@medicareaustralia.gov.au)

## Our audit and investigation activities

Whilst the focus of our compliance activities is heavily weighted towards educating and supporting providers, we also undertake audit and investigation activities when the facts of a case determine it is appropriate. We use various techniques and audit styles to verify compliance, ranging from simple telephone audits to formal criminal investigations for the purposes of prosecution.

To deal with the varying types of non-compliance, we have different levels of audit and investigation activities, as follows:

- compliance audits
- practitioner review program
- criminal investigations.

### Compliance audits

Medicare Australia conducts compliance audits with health professionals or general practices to verify the details of services where we identify a risk that payments may have been made incorrectly. Compliance audits are usually conducted by telephone, letter or face-to-face and we provide health professionals with the opportunity to respond before we take any action.

A compliance audit is designed to check that both the provider and patient were eligible for Medicare benefits and that the service was provided, meeting all item requirements. This audit is based on questions of fact—it does not question either the clinical appropriateness or adequacy of the MBS service, or the clinical decision-making of the provider. In regard to the health support programs, a compliance audit is designed to provide assurance that practices and health organisations receiving incentive payments were eligible for the incentive being claimed.

Where an incorrect payment is identified, we may seek to recover the incorrectly paid amount. We may also provide advice and educational material to the provider where this will support voluntary compliance.

We do not use compliance audits to investigate suspected fraud or criminal behaviour—or the clinical decision making, or quality of care provided by providers.

## Practitioner Review Program

The Practitioner Review Program deals with practitioners whose provision of services under Medicare and/or PBS prescribing data suggests that there may be inappropriate practice.

Inappropriate practice is defined as conduct in connection with rendering or initiating services that would be unacceptable to the general body of members of that profession.

Where we identify concerns relating to possible inappropriate practice by a practitioner, a compliance medical officer (a qualified medical practitioner) will review the information. Where concerns are identified, the officer will arrange an interview with the practitioner to explain the concerns and offer them an opportunity to respond.

If concerns remain after a period of review Medicare Australia may request the Director of Professional Services Review to examine the practitioner's provision of services. Professional Services Review is an agency independent of Medicare Australia.

For more information on Medicare Australia's Practitioner Review Program visit [www.medicareaustralia.gov.au](http://www.medicareaustralia.gov.au) then go to **For health professionals > Doing business with Medicare Australia > Compliance > Practitioner Review Program**. For more information about Professional Services Review visit [www.psr.gov.au](http://www.psr.gov.au)

## Criminal investigations

For the small number of individuals who seek to intentionally, recklessly or negligently defraud our programs and schemes, we conduct criminal investigations. If appropriate and necessary, we refer cases to the Commonwealth Director of Public Prosecutions (CDPP) for their consideration.

Medicare Australia conducts criminal investigations in accordance with the Australian Government Investigation Standards (AGIS) and the Commonwealth Fraud Control Guidelines. The criminal investigation process involves gathering evidence from external and internal sources including information held in the possession or control of Medicare Australia. From time to time, witnesses are interviewed and statements recorded. Part of the criminal investigation process includes providing the person suspected of fraudulent behaviour an opportunity to respond to the allegations made against them.

Recognising the seriousness of these matters, Medicare Australia employs experienced investigators trained to conduct criminal investigations. Investigators employed by Medicare Australia also hold necessary mandatory qualifications as articulated in the Commonwealth Fraud Control Guidelines and Australian Government Investigation Standards.

## Payment accuracy reviews

Medicare Australia conducts payment accuracy reviews to demonstrate that the MBS and PBS payment systems have made accurate payments in accordance with legislated requirements (the *Health Insurance Act 1973* and the *National Health Act 1953*).

Each year, results of these reviews are reported to the Australian National Audit Office and form part of their assessment of Medicare Australia's financial status.

Payment accuracy reviews are a post-payment process that focus on whether the service claimed was actually provided to a patient and whether our claims system processed the claiming data accurately. The review is designed as a statistical test of our payment system and as such the services reviewed are selected at random.

Payment accuracy reviews involve contact of patients and providers and are conducted by Medicare Australia Service Officers by telephone. They are therefore not considered to form part of Medicare Australia's active compliance program.



## Compliance Professionalism Survey

In January 2010 Medicare Australia announced the roll out of a new Compliance Professionalism Survey to monitor the professionalism of its compliance staff and audit processes. The survey asks health professionals who have been involved in compliance activities such as audits, to rate our performance against a variety of indicators. These include how well staff explained the reason for the activity, the outcome of the activity and the opportunity they were given to respond.

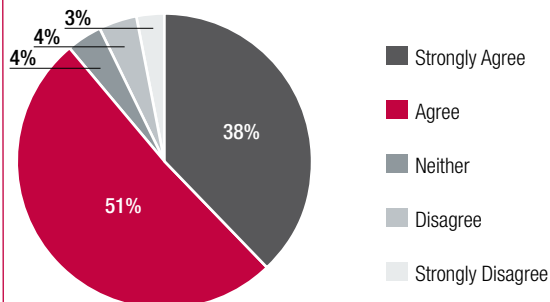
Medicare Australia is using feedback from the survey to identify areas for improvement and opportunities for further staff training and development.

The early results, involving feedback from 236 health professionals has been positive. Ninety three per cent agreed or strongly agreed that they were treated in a professional manner. Ninety two per cent agreed or strongly agreed that privacy was respected.

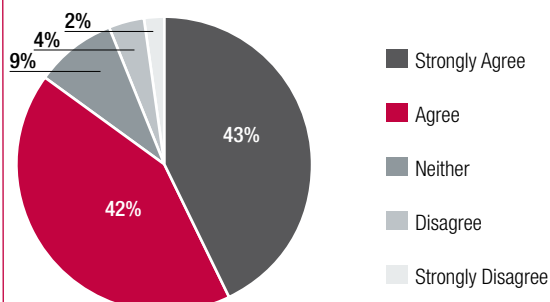
Note: Participation in the audit is voluntary and respondents can choose to remain anonymous.

The following charts outline some of the Compliance Professionalism Survey results as at 30 June 2010.

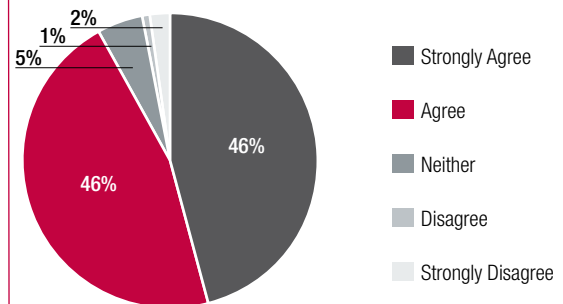
### The reason for the compliance activity was fully explained



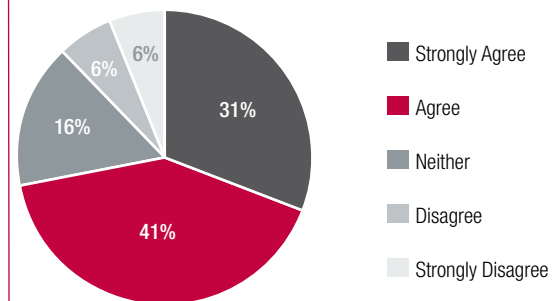
### Medicare Australia was flexible scheduling appointment(s) and/or deadlines



### I was given an opportunity to respond to Medicare Australia's concerns



### The information provided was helpful to me in understanding how to correctly use the MBS/PBS



## ***Our key focus and priorities for 2010–2011***

---

In line with our compliance philosophy, there are three main components to our compliance activities:

- research and monitoring
- education, information and support
- audits and enforcement.

Based on our research and the identified level of risk, we vary our compliance approach to ensure our response is proportional to the compliance risk and the individual's circumstances.

The number of health professionals participating in Medicare has increased from 94 721 in 2008–2009 to 101 413 in 2009–2010.

The total annual number of Medicare services claimed has grown from about 294 million to nearly 308.4 million (4.9 per cent).

The number of Medicare Benefits Schedule (MBS) items increased from 5747 to 5754 (0.1 per cent).

## General practitioners

In 2009–2010 there were approximately 27 700 general practitioners who billed Medicare benefits.

In 2009–2010 general practitioners billed more than 126.9 million MBS services, totalling more than \$5.5 billion in Medicare benefits.

The highest prescribed PBS medicine for 2009–2010 was Atorvastatin (lipid-lowering drug) at 6.2 per cent of the total PBS items prescribed by general practitioners.

In 2010–2011 we plan to continue our commitment to promoting voluntary compliance for general practitioners. We will focus on developing and reviewing our educational products and provide presentations to assist practitioners in understanding the MBS and PBS. We will also maintain contact with general practitioners and key general practice groups as part of our stakeholder engagement plan.

We are working with stakeholders, through the Health Professional Online Services and Provider Service Design External Stakeholder Committee, to identify areas where additional resources are required and to identify activities to be undertaken in 2010–2011. We are reviewing our new health professional strategy, and will work with stakeholder groups to identify any changes required to the current approach.

In 2009–2010 we published articles in *Forum* on chronic disease management and promoted quick reference guides and Medicare Australia's new improved online education services. We also placed advertisements for eLearning programs for MBS and PBS in *Forum*. In 2010–2011 we will continue to provide valuable updates in relation to important matters in *Forum*.

Areas of interest with general practitioners include:

- incorrect billing, for example:
  - billing for services not eligible for Medicare benefits
  - upcoding—billing a similar but more complex/expensive item than the service provided
- incorrect prescribing, such as prescribing PBS medicines to patients who do not meet the requirements.
- inappropriate ordering of pathology and diagnostic imaging services
- inappropriate practice (for example over servicing).

### Case study

Medicare Australia received a tip-off that a medical practitioner had been claiming for after hours consultations by way of remote access from his home to the Medicare Australia online claiming software at the medical practice.

We investigated the provider and uncovered suspected fraudulent activity amounting to over \$400 000. The case has been referred to the Commonwealth Director of Public Prosecutions.

### Case study

Following a tip-off from a health professional about a provider (who was not a specialist of gastroenterology) providing a high number of endoscopies, the provider was assessed under the Practitioner Review Program.

After completing the review process and interview with the provider, concerns remained about the practitioner's servicing. As a result, we requested a review of the provider's practice profile by the Director of the Professional Services Review.

The provider was reprimanded and counselled for inappropriate practice. The provider was ordered to repay Medicare Australia around \$167 000.

Particular areas of focus in 2010–2011 include (in alphabetical order):

### Bulk bill incentive items

We will examine payments for bulk bill incentive items to ensure these items are billed for eligible patients - in particular, we will examine the routine use of these items for patients over 16 years of age who do not have a health care card, pension concession card, or Commonwealth Senior's card. We will design a compliance strategy proportionate to the size and nature of this risk.

### Case study

Medicare Australia received information from several members of the public that a provider, who worked at an after hours locum service, had been claiming for services that were never rendered.

Investigations revealed that the practitioner had incorrectly claimed for over \$100 000 of services whilst overseas. The case has been referred to the Commonwealth Director of Public Prosecutions.

### Case study

We received a tip-off from a member of the public who was concerned about the items a practitioner had bulk-billed that were not discussed during their visit. Investigations commenced and revealed possible over-servicing and concerns with the itemisation of accounts.

We completed a Practitioner Review Program over 12 months to assess the practitioner's claiming and further concerns were identified. The practitioner was then referred to the Director of Professional Services Review.

The provider received a reprimand, a partial disqualification for 12 months from using three Medicare Benefits Schedule (MBS) item numbers, a full disqualification for six weeks from providing any MBS services and was ordered to repay over \$180 000.

### Care plans

We will examine payments for MBS care plan items to ensure these items are being used correctly. In 2009–2010 we commenced compliance activities to monitor instances where providers did not meet all of the requirements of the MBS items and where patients have had only one or no previous visits with a provider. In 2010–2011 we will complete the current compliance activities and then monitor the use of care plan items to inform future compliance strategies.

### Diagnostic imaging and pathology

We encourage the appropriate ordering of pathology and diagnostic imaging services. Where inappropriate ordering is identified we will refer the provider to the Director of Professional Services Review.

As well as focusing on potential pathology and diagnostic imaging inducements, we have concerns about pathology tests being ordered for health screening purposes, particularly routine ordering of vitamin D tests and routine ordering of sets of tests such as iron studies, folate, and thyroid stimulating hormone tests being ordered together. In 2010–2011, we will monitor pathology testing with a particular focus on these areas.

### Case study

Through a Practitioner Review Program interview, Medicare Australia noted some concerns with a provider's MBS itemisation in relation to select items and pathology initiation.

Following the interview, a six month review showed that the volume of services for the relevant MBS items and pathology services rendered resulted in a decrease of approximately \$65 000.

### Health Support Programs

Our compliance effort in 2010–2011 will focus on payments under Health Support Programs to ensure that participating practices are meeting eligibility requirements. These include:

- Practice Incentive Program (PIP) confirmation statements  
In 2009–2010 Medicare Australia sent confirmation statements to all PIP practices asking for confirmation of their ongoing eligibility for PIP and individual incentives being claimed. In 2010–2011, we will commence selected audits of practices that have not returned confirmation statements by the due date.
- PIP eHealth Incentive  
In 2009–2010 we commenced audits of practices claiming the PIP eHealth Incentive to ensure they were meeting eligibility requirements (for example, requirements for individual practitioner PKI certificates). In 2010–2011 we will complete the current audit activities and use audit findings to inform development of future compliance strategies.
- PIP Indigenous Health Incentive (IHI)  
In 2010–2011 we will monitor this new incentive to ensure payments are being claimed correctly.
- Mental Health Nurse Incentive Program (MHNIP)  
In 2009–2010 we audited organisations claiming MHNIP payments to ensure they were meeting eligibility requirements (for example, meeting insurance requirements). In 2010–2011 we will complete the current audit activities and use audit findings to inform future compliance strategies.
- General Practice Immunisation Incentive (GPPI) Program  
In 2010–2011 we will audit participating practices to ensure they meet new entry requirements that include:
  - meeting the Royal Australian College of General Practitioners (RACGP) definition of a general practice
  - having appropriate processes to handle and store vaccines
  - having current public liability insurance
  - having current professional indemnity cover for general practitioners.

## High risk providers

Our Practitioner Review Program will continue to focus on those GPs who are possibly practising, billing or prescribing outside the intent of the MBS and the PBS. We will continue to analyse our data to identify those providers whose billing or prescribing behaviour is significantly different from their peers. In particular, we look at the:

- number of services
- amount of benefits
- number of unique items
- number of services rendered per patient
- number of patients referred
- number of providers to whom patients have been referred
- number of pathology services
- number of diagnostic imaging services
- average number of services performed on a referred patient.

### Case study

Medicare Australia became concerned with a provider's total rendered services for Chronic Disease Management and allergy testing, resulting in a Practice Review Program intervention.

The profile was reviewed after 6 months and it was found that there was a decrease in billing for these items by approximately \$95 000.

## New health professionals including international medical graduates

In 2010–2011 we will continue to work on initiatives to support new GPs including international medical graduates. We will work with key stakeholders to gain a shared understanding of the challenges facing this group.

In 2009–2010 we trialled a pilot program of teletutorials<sup>2</sup> that aimed to provide a more efficient, flexible and accessible learning experience on the MBS for general practitioner registrars and international medical graduates. We also conducted a survey with regional training providers and general practitioner registrar supervisors to identify their learning and support needs. Results from this trial indicated that greater promotion of educational products for new health professionals is required.

In 2010–2011 a communication plan will be implemented to increase awareness of our education products and services in this area.

<sup>2</sup>Tutorials conducted over the telephone.

## Prescribing

Prescribing PBS medicines to patients who do not meet the requirements is one of the primary risks to the integrity of the PBS. Prescribers have an important role in deciding who is eligible to obtain PBS medicines, in particular restricted and authority medicines.

We will continue to research and monitor prescribing of PBS listed medicine, focusing on GPs who prescribe restricted and authority required medicines to patients that do not meet PBS requirements.

We will provide information to support prescribers to understand their obligations when prescribing PBS medicines through existing eLearning products and will develop new resources for prescribers as required. In exceptional circumstances, the Practitioner Review Program may review specific prescribing concerns that may be considered as potentially inappropriate.

The prescribing of drugs of addiction continues to be a concern and as a result is an area of focus for our compliance activities.

### Case study

Through routine claiming data analysis, we identified a provider who was writing a high number of prescriptions for pain relief medications.

We commenced a review of the provider's claiming and prescribing history which identified further concerns regarding the practice and prescribing profile. We referred the case to the Director of the Professional Services Review for peer review.

The provider was fully disqualified from prescribing PBS medications for three years and ordered to repay around \$45 000 to Medicare Australia.

## Skin lesions and associated items

We will continue current compliance activities (including audits, recovery and review under the Practitioner Review Program) associated with skin lesion excisions, wounds and cryotherapy.

In 2010–2011 we will develop and implement compliance strategies focussing on upcoding of skin lesion and flap repair items and billing an item that is not substantiated by the required histopathology test.

We released a new eLearning product in late 2009 covering consultation items and the treatment of skin lesions. We will monitor the need for additional education tools to address other aspects of billing for these services.

## Specialists

In 2009–2010 around 26 900 specialists billed Medicare benefits.

In 2009–2010, specialists billed more than \$8.1 billion in Medicare benefits. Of these, diagnostic imaging and pathology services amounted to \$3.8 billion.

There are a diverse range of specialists<sup>3</sup>—ranging from those who practice largely in hospitals such as anaesthetists, to those who practice largely in private practice such as dermatologists. In 2010–2011 we plan to continue our commitment to promote issues of importance to specialists.

We are working with stakeholders, including through the Health Professional Online Services and Provider Service Design External Stakeholder Committee to identify the information and education services required by this group of health professionals and to identify activities to be undertaken in 2010–2011.

In 2009–2010 we supported specialists by providing information in our *“Can I help you?”* and *Forum* publications including articles on Medicare e-claiming and how to access the MBS online. We also presented to the College of Dermatologists.

Our general interests with specialists include:

- billing for services not eligible for Medicare benefits, for example, cosmetic procedures that are not clinically relevant
- billing incorrect or inappropriate combinations of MBS items—more specifically, billing a set of items when one item covers a procedure
- billing consultations with procedures that include consultation time
- inappropriate ordering and incorrect use of pathology and diagnostic imaging services
- consultations billed without the required referral
- new referrals requested on top of an existing referral to allow the billing of another initial consultation
- inappropriate practice.

Particular areas of focus in 2010–2011 include (in alphabetical order):

### Gastroenterology

In 2009–2010 we identified suspected risks around gastroenterologists billing unusual combinations of MBS items.

In 2010–2011 we will design and implement a compliance strategy (likely to include audit and review under the Practitioner Review Program).

### Orthopaedic surgery

In 2009–2010 we identified suspected risks around orthopaedic surgeons billing unusual combinations of MBS items.

In 2010–2011 we will design and implement a compliance strategy (likely to include audit and review under the Practitioner Review Program).

### Prohibited practices

We have concerns about breaches of the prohibited practice legislation, such as commercial arrangements that may encourage unnecessary requests for pathology and diagnostic imaging services. We will continue to focus on leasing, rental arrangements and other commercial arrangements between requesters and providers of pathology and diagnostic imaging services.

### Simplified billing

In 2010–2011 we will review specialist claims submitted through simplified billing and electronic claiming channels. We will assess the high rate of claim rejections to help determine the need for additional training or education on billing requirements. Additionally, the accuracy of claims submitted by billing agents will be examined.

### Supervision and personal performance requirements

In 2010–2011 we will design and implement compliance strategies to address the following concerns:

- clinical services are being performed by a technician without the required supervision of the medical practitioner
- billing under the names of specialists and consultant physicians, including pathologists, who did not personally perform services or provide the required level of supervision.

<sup>3</sup> This term includes consultant physicians.

## Use of Extended Medicare Safety Net

Following recent changes to Extended Medicare Safety Net arrangements, we will monitor the impact on billing patterns—particularly the capping of obstetric and Assisted Reproductive Technology (ART) services and the effect on consultation fees.

Practitioners are required to bill the item that best describes the service provided—the fee specified on the account must match the amount charged for the service specified. This means any component for other goods or services not part of the MBS item being billed must not be included in the fee for that item.

### Case study

We received information that a specialist medical clinic was exploiting the Extended Medicare Safety Net by including the cost of airfares and accommodation for interstate patients in the billed cost for Medicare items.

When we contacted the providers to discuss the matter they clarified that non-medical costs were not being billed to Medicare. However, they agreed to amend the itemisation on their bills to ensure no further confusion would arise about which charges are being billed to Medicare.



## Other providers

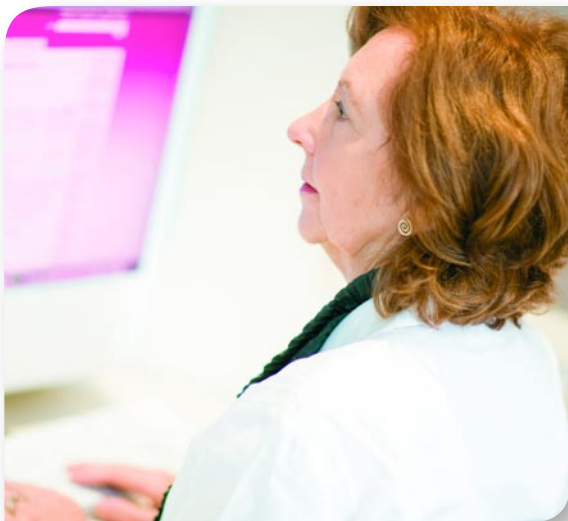
In 2009–2010 there were around 46 800 'other providers' who billed Medicare benefits, of these almost 30 000 were allied health professionals.

In 2009–2010 'other providers' billed more than 35 million MBS services and more than \$1.7 billion in Medicare benefits.

In 2009–2010 we engaged other health professionals in a survey of 400 allied health professionals. The findings from the survey will inform our education and support strategy across this provider segment and inform the design of future compliance activity.

We have also published online a number of quick reference guides and other resources on topics relevant to other provider groups, and continue to deliver presentations on topics of interest to allied health professionals at peak body conferences and other events. We are working with nurse practitioners and midwives to identify their support needs once they become eligible to provide Medicare services and prescribe PBS medicines.

We will be working with other stakeholders in this group to identify areas where additional resources are required and to identify activities to be undertaken in 2010–2011. We will in particular be working with allied health professional groups to identify channels for communication with their members about the resources which are available to them.



## Allied health professionals

Our audits in 2009–2010 identified the following as areas of concern:

- first and final reports were not provided to the referring practitioner
- referrals were backdated
- referrals were incomplete, unsigned or expired.

In 2010–2011 we will focus on educating allied health professionals to address these concerns.

### Case study

After analysing claims data, we identified an allied health professional whose billing pattern demonstrated an unusually high level of servicing.

When interviewed, the allied health professional admitted that they were unaware of the criteria for claiming services under Medicare.

We determined the allied health professional had billed for services that were provided without the required referral. The allied health professional acknowledged the error and agreed to repay the benefits claimed, totalling almost \$9000, to Medicare Australia.

### Case study

Whilst conducting an audit on allied health professionals, Medicare Australia identified a clinical psychologist had not been performing all services which had been claimed under their provider number personally.

The clinical psychologist was interviewed and it was established that intern clinical psychologists had been providing the services. As this did not satisfy the descriptors for items claimed, these services were required to be recovered and as a result, a debt of approximately \$246 000 was identified.

## Dentists

In 2009–2010, we commenced a compliance project to determine the level of compliance with the requirements of the Chronic Disease Dental Scheme (CDDS). This project included undertaking audits of a number of providers who have made claims for benefits under the CDDS Scheme. From the audits completed so far, we have identified the following concerns:

- some dental providers have failed to meet the requirements of Section 10 of the *Health Insurance (Dental Services) Determination 2007*. Section 10 requires a dental provider to provide a patient, in writing and prior to the commencement of treatment, details of the course of treatment along with a quotation for each dental service and each other service (if any). It also requires the provider to give a copy or written summary of the plan, prior to the commencement of treatment to the general practitioner who referred the patient for dental services.
- some dental providers have lodged claims for benefits prior to completing the services. Section 10 of the *Health Insurance Act 1973* provides that a Medicare benefit is payable only where a service has been rendered.

### Case study

We received notification that a patient's dental treatment was performed by a dental technician. The dental work was not completed but was claimed in full under the name of a dentist at the same practice. A bulk bill claim was also made before the dental treatment was completed. This also affected the patient's ability to claim further services when they opted to see a new dentist.

We investigated the issue and spoke to the providers involved. The dentist repaid Medicare Australia the incorrectly claimed amount and the patient's Medicare records were adjusted to correctly reflect their claims history.

### Case study

Following a complaint from a member of the public, we commenced a review of a dentist who had been claiming under the Chronic Disease Dental Scheme. The review showed that the dentist had been regularly billing multiple items for a single service when those items did not meet the item descriptor.

The dentist was interviewed and a debt for approximately \$21 400 was raised.

## Midwives and nurse practitioners

In 2009–2010 Medicare Australia commenced working with nurse practitioners and midwives to understand their work environment as a precursor to developing specific resources for these groups in 2010–2011. Workshops with nurse practitioners were conducted in June 2010.

We will continue to work with both nurse practitioners and midwives to identify the information and education services which will assist them in accessing Medicare and the PBS.

## Optometrists

In 2009–2010 we designed a compliance strategy focusing on optometrists:

- with an unusually high utilisation of the computerised perimetry items (MBS Items 10940 and 10941)
- with high daily services in aged care facilities or in general practice
- who have incorrectly billed MBS Item 10914 in place of MBS Item 10907
- who breach the optometrical 'Common Form of Undertaking' by charging more than the MBS scheduled fee.

In 2010–2011 we will implement this compliance strategy which will include a combination of targeted education letters, audits to verify services and reviews under the Practitioner Review Program.

### Case study

Through a routine data review, we identified an optometrist claiming a much larger number of optometry services than their peers.

We referred the provider for a review under the Practitioner Review Program.

Following the review, the provider was asked to repay almost \$100 000 to Medicare Australia.

## Practice managers

### Practice managers

We recognise the increasingly important role of practice managers in the administration of the Australian health care system. Education programs and services will be promoted to practice staff, including nurses and practice managers.

Medicare Australia encourages Practices to utilise eLearning programs, quick reference guides and other resources developed for the relevant health professional groups as part of their orientation programs for new staff.

We are working with the Australian Association of Practice Managers representative on the Health Professional Online Services and Provider Service Design External Stakeholder Committee to identify areas where additional resources are required and to identify activities to be undertaken in 2010–2011.

### Electronic claiming

As the use of electronic claiming increases there is also a potential risk of incorrect or fraudulent claiming by practice staff. We have processes in place to allow us to monitor claims and continue to identify patterns that may indicate fraud.

#### Case study

We received information from a member of the public that a provider had electronically bulk billed for services that were not provided. On investigation, we found that another member of the public on the same Medicare card as the complainant had been provided with similar services by the provider. Through interviews with the provider it was found that the original member of the public was not a patient of this provider and that the provider had claimed Medicare benefits against both parties for services provided to only one.

The provider repaid an amount of approximately \$4200 to Medicare Australia.

## Record keeping

In 2010–2011 we will continue our work towards delivering better record keeping support.

Medicare Australia has commenced a record keeping project that will deliver a range of useful administrative guidelines that will support good record keeping. These guidelines aim to be easy and applicable to all health professionals. These guidelines will assist practice managers in maintaining best practice and will ensure they are prepared if providers in their practice are ever asked to participate in an audit.

### Working with software vendors

We are committed to working with software vendors to better support health professionals and their practice staff in operating efficiently in an online claiming environment and meeting their compliance obligations. The majority of medical practices use some type of software to manage some or all of their record keeping responsibilities. There is a need to identify an ongoing process to influence enhancement in software development with a focus on providing input in the design of upfront controls of software used by medical practices.

In 2009–2010 we commenced the Software Vendor User Pathway Project to gain an understanding of how software is being developed in relation to practice management responsibility and requirements (e.g. changes to the MBS and PBS schedules). Our aim in 2010–2011 is to work in partnership with software vendors, enabling superior products and service to the medical industry when accessing health programs administered by Medicare Australia.

## Pharmacists

Around 5402 pharmacies are approved to supply medicines under the Pharmaceutical Benefits Scheme.

The number of PBS prescriptions dispensed has increased from 197.2 million in 2008–2009 to 198.9 million in 2009–2010 (0.9 per cent).

PBS expenditure has increased from \$7.5 billion in 2008–2009 to \$8 billion in 2009–2010.

On 1 July 2010, Medicare Australia launched its first eLearning program for pharmacists, *PBS and You – dispensing and claiming for pharmacists*. This program was developed in consultation with the Pharmacy Guild of Australia, the Pharmaceutical Society of Australia and the Australian Pharmacy Council.

Handbooks and other resources relating to the supply of PBS medicines, including the supply of Highly Specialised Drugs in participating hospitals and dispensing and claiming checklists for pharmacists are also available on the Medicare Australia website.

Medicare Australia also provides information and education support to pharmacy students and to intern pharmacists as part of the National Intern Training Program.

We will be working with pharmacy stakeholder groups to identify areas where additional resources are required and to identify activities to be undertaken in 2010–2011.

### Fifth Community Pharmacy Agreement

In 2010–2011 we will be working with stakeholders to incorporate our compliance approach into the development of new programs under the Fifth Community Pharmacy Agreement. We will also be monitoring the implementation of electronic prescribing to ensure pharmacists are claiming correctly.



## Incorrect supply

In 2010–2011 we will continue to focus on pharmacists who are supplying outside the intent of the PBS. We will analyse our data to identify those pharmacists whose dispensing behaviour is different from their peers and will be reviewing these pharmacists as part of our audit program.

We will provide education and support to assist community and hospital pharmacies to submit their PBS claims appropriately.

We will also focus on pharmacies with a high proportion of patients who appear to be stockpiling medicines in the PBS Safety Net period. We will be reviewing these pharmacies as part of our compliance program.

In previous years, we have identified concerns in relation to supply of PBS medicines after the death of the patient. In 2010–2011 we will continue to focus on reducing occurrences of this nature.

## Multiple payments

In 2010–2011 we will continue to focus on approved suppliers that have claimed the same prescription on more than one occasion. We will monitor these situations and will seek to recover the incorrect PBS payments where legislation has been breached.

### Case study

As the result of an audit, we found that a number of pharmacists had submitted PBS claims without valid prescriptions.

We notified the pharmacists involved of their incorrect claiming and they agreed to repay the amount they had incorrectly received back to Medicare Australia.

A similar audit was conducted three years later which revealed the same pharmacists had continued to submit PBS claims without prescription details.

All debts were acknowledged by the pharmacists involved, they received counselling and the benefits they had received amounting to approximately \$2000 were once again repaid to Medicare Australia.

## Aged Care Providers

In 2009–2010 Medicare Australia conducted a focussed review into the Residential Aged Care Program. A sample of aged care providers were randomly selected to participate in the review. The review showed a high level of compliance. Only a small percentage of under-claims and over-claims were identified in the review.

Medicare Australia plans to expand this review in 2010–2011 to include residential and community care services. The objective of the review is to determine the level of compliance and identify areas where Medicare Australia may be able to further support voluntary compliance.



## Health insurance funds

In 2010–2011 we will continue to audit health funds making payments under the Private Health Insurance Rebate program to ensure payments are correct and to identify any potential cases of fraud or incorrect payments.

## Members of the public

### PBS medicines

Our focus will be on members of the public who:

- obtain more PBS medicines than they require
- divert PBS medicines overseas illegally
- obtain PBS medicines for illegal purposes, such as reselling and remanufacturing.

In 2010–2011 we will continue to operate the national 'Travelling with PBS Medicine' enquiry line (**1800 500 147**). The function of the enquiry line is to explain people's rights and responsibilities when taking or sending PBS medicine overseas.

The national Prescription Shopping Information Service for providers (**1800 631 181**) will continue to provide information and targeted feedback to individuals and providers regarding patients who are at high risk of prescription shopping.

We will also continue to strengthen our Prescription Shopping Program and work with stakeholders where possible to improve the effectiveness of this program.

### Patient claiming fraud

We have ongoing concerns about individuals claiming benefits to which they are not entitled. In 2010–2011 we will continue to monitor patient claiming to identify and investigate cases of potential fraud.

### Case study

A Medicare Australia Service Officer became suspicious of a claim presented by a member of the public at a Medicare office. Further investigation found that whilst the person had received some services, other services appeared to have been falsely claimed.

We conducted a formal interview with the person who made a full admission that false claims were submitted in order to obtain the Medicare rebate. We referred the case to the Commonwealth Director of Public Prosecutions for prosecution.

The person was convicted, ordered to repay almost \$4000 and sentenced to a term of imprisonment.

## **More information**

---

We welcome your feedback.

To provide comments on our *National Compliance Program 2010–2011*, or to order additional copies:

Email [compliance.feedback@medicareaustralia.gov.au](mailto:compliance.feedback@medicareaustralia.gov.au)

Mail **Compliance feedback  
Customer Service Design and  
Compliance Division  
Medicare Australia  
PO Box 1001  
TUGGERANONG ACT 2901**



# **Australian Government Services Fraud Tip-Off Line**

Each year millions of dollars in taxpayers' money is lost due to fraud against social, health and welfare services and payments.

Most people are honest and use government services fairly. However, if you have information about someone who is misusing these services, or if you suspect a fraud against the Human Services Portfolio (including Centrelink, the Child Support Agency, the Department of Veterans' Affairs and Medicare Australia) call the Australian Government Services Fraud Tip-Off Line on **131 524**.



# **Acronyms**

<b>Acronym</b>	<b>Definition</b>
AGIS	Australian Government Investigation Standard
CDPP	Commonwealth Director of Public Prosecutions
DHS	Department of Human Services
DoHA	Department of Health and Ageing
EFT	Electronic Funds Transfer
MBS	Medicare Benefits Schedule
MHNIP	Mental Health Nurse Incentive Program
PBS	Pharmaceutical Benefits Scheme
PSR	Professional Services Review
RACGP	Royal Australian College of General Practitioners



# Appendix A

## Achievement against commitments in the 2009–2010 Medicare Australia National Compliance Program

### Face-to-face and online education

- We delivered face-to-face education to almost 3000 medical practitioners (including GPs, Medical interns and specialists), around 3300 pharmacy students and pharmacy interns, 100 medical students and almost 1000 others in the health care industry.
- We gave presentations at nine national health conferences on topics including our online education model for new health professionals, compliance audits and billing Medicare items including anaesthesia, chronic disease management, mental health, skin, and diabetes management items.
- We surveyed 400 allied health professionals in October/November 2009. The findings from the survey will inform our education and support strategy across this provider segment and inform the design of future compliance activity.
- We surveyed Regional Training Providers and GP registrars in November/December 2009 to seek their input on possible approaches to GP registrar reinforcement learning. We will use this information to inform future education strategies for this provider segment.
- We continued the development of learning tools to support the introduction of new arrangements for funding Highly Specialised Drugs in public hospitals.
- We developed education products to support the correct prescribing of Restricted, Authority Required and Authority Required (STREAMLINED) benefits.
- From July 2009 to June 2010, there were 34 070 'visits' to the education pages on the Medicare Australia website.
- We launched two new Medicare and You advanced eLearning modules for GPs:
  - MBS and You—Chronic Disease Management for GPs
  - MBS and You—treatment for skin lesions.
- We launched new PBS and You eLearning modules including:
  - PBS and You—for new health professionals
  - PBS and You—prescribing for optometrists
  - PBS and You—prescribing in public hospitals
  - PBS and You—prescribing in private practice
  - PBS and You—dispensing and claiming for pharmacists.

### Information services

- We have received over 3500 calls to the 'Travelling with PBS medicine' enquiry line and more than 30 000 hits to the website.
- We have received over 26 900 calls to the Prescription Shopping Information Service and have had over 10 300 website hits. We have sent over 5000 patient reports to providers.

### Communication

- We implemented an online education services communication strategy throughout 2009–2010. The strategy aimed to increase awareness of Medicare Australia's online education services and to ensure they were the first choice for health professionals as a resource tool for new information and continual learning.
- We ran a Google adwords campaign during February and March 2010 as part of the online education services communication strategy with the aim of increasing traffic to Medicare Australia's online education services.
- Following the mailout of the quick reference guide on Practice Nurse Medicare Items in June 2009 to 12 205 health professionals, an additional 2874 health professionals received a copy of the guide during January 2010. The guide is also available on our website.
- We distributed education material to 141 public hospitals. The package included the PBS and You manual plus checklists for PBS prescribers and pharmacists working in public hospitals participating in the PBS reforms.
- We published articles in *Forum* on chronic disease management and to promote quick reference guides, Medicare Australia's eLearning modules and new improved online education services. We also placed advertisements for eLearning programs for MBS and PBS in *Forum*.
- We published articles on new education resources for public hospitals, Medicare special numbers, and multiple payments and also promoted the PBS and You for new health professionals eLearning module in *Bulletin Board*.
- We updated our online education products to reflect Medicare primary care items from 1 May 2010.

## Achievement against commitments in the 2009–2010 Medicare Australia National Compliance Program

### Fraud Tip-off Line

- We have received 1864 tip-off calls through the Australian Government Services Fraud Tip-Off Line and 1011 tip-offs through other avenues.
- We have undertaken initial assessment on 1071 tip-offs.

### Data analysis

- We continue to monitor claiming against a range of issues to identify potential non-compliance.
- We completed risk assessments of claiming data in relation to:
  - potential fraud via eClaiming patient claims
  - specific purpose clinics
    - high charge attendances
    - erectile dysfunction
    - hair transplantation services
  - PBS supply after date of death
  - PBS prescribing after date of death
  - PBS prescribing patterns different to peers – particularly for benzodiazepines, narcotics and antibiotics
  - where s19(2) exemption not in place and MBS services being paid
  - figure head billing of non pathology items by pathology companies
  - optometrical MBS items 10940 and 10941 computerised perimetry not clinically relevant
  - patient eligibility for allied health services
  - anaesthetic time units.

### Audits

- We have completed:
  - audits on 414 Practice Incentive Payments (PIP) recipients
  - 1943 audits of medical practitioners, pharmacists and members of the public in relation to claiming for MBS or PBS benefits
  - 159 investigations of medical practitioners, pharmacists or members of the public for suspected fraudulent behaviour
  - reviews of 151 medical practitioners through our Practitioner Review Program.
- We made eight detentions of PBS medicines at airports and international mail exchanges.

### Prosecutions

- We have referred eight individuals to the Commonwealth Director of Public Prosecutions (CDPP) for criminal prosecution, including a medical practitioner.
- We assisted the CDPP to successfully prosecute 12 individuals, all members of the public.

### Professional Services Review

- We have requested the Director, Professional Services Review to review 36 medical practitioners for inappropriate practice.

### Incorrect payments identified for recovery action

- We identified more than \$10.29 million in incorrect payments to medical practitioners, pharmacists and members of the public.
- We have received repayments of more than \$7.94 million.

Research & Analysis

Intervention & Action

Outcomes

