2012-13 BUDGET MEASURE: FRAUD PREVENTION AND COMPLIANCE – INCREASED BILLING ASSURANCE FOR THE MEDICARE BENEFITS SCHEDULE

This measure will establish a new approach to compliance for large health practices

- The Department of Human Services is committed to ensuring the integrity and sustainability of the Medicare Program through its compliance activities.
- The Department is responsible for ensuring that Medicare Program benefits are paid only for eligible services.
- This measure is looking at the compliance challenges associated with the changing nature of health practice, from small owner-operated practices to larger business enterprises.
- The measure aims to establish a better understanding of the impact of practice business arrangements on health practitioner billing behaviours.
- There is concern that some health practitioners in practices, where a number of health practitioners are working, may be pressured to provide or refer services that are not medically necessary.
    - There is also concern about potential incorrect billing.
- The use of practice-based reviews in implementing this measure is a new compliance approach.
    - The reviews are being conducted where Medicare claims data identifies possible over-servicing by four or more medical practitioners at the one practice.
- By reviewing all health practitioners at a practice where some appear to be over-servicing, the Department may be able to identify systemic issues with the practice, and correct the behaviour of multiple practitioners.
- This measure is not just focused on conducting practice-based reviews.
    - The Department is also providing education for all health practitioners about their Medicare billing responsibilities.

BACKGROUND

- The measure aims to establish a new compliance approach using data collection, education and practice-based reviews to build an evidence-based body of knowledge about Medicare Program compliance by large practices.
  - This will enable the Department to better understand and model the potential influence of different business and commercial arrangements on individual health practitioner's billing behaviours.
- The budget measure will run over three financial years from 1 July 2012 to 30 June 2015 and will cost $7.6 million. It aims to achieve savings of $20.7 million.
- An education letter, 'Billing accurately under Medicare', will be provided to all health practitioners during 2013. The letter advises practitioners about their legal responsibilities and accountabilities when billing MBS items. An initial mail-out took place on 25 March 2013 and all mail-outs will be completed by 30 June 2013.
- A web page with information about billing responsibilities was published on 25 March 2013.
- Online learning modules and a vodcast will be available on the Department's website by 4 July 2013.
- Practice based reviews commenced 23 April 2013 and will continue to June 2014, with approximately s 37(1)(a) health practitioners interviewed under the Practitioner Review Program.
- Billing profiles of all practitioners at the practice will be reviewed. Where concerns are identified, practitioners will be interviewed under the Practitioner Review Program and, where necessary, the Department delegate will refer the practitioner to the Director of Professional Services Review.
- s 37(1)(a)

- Under the *Health Insurance Act 1973*, a general practitioner is deemed to have engaged in inappropriate practice (over-servicing) if they render 80 or more professional attendances on 20 or more days in a twelve month period.
  - This is known as the '80/20 rule'.
- The criteria for selecting a practice for review in this project are that:
  - there are four or more health practitioners in the practice; and
  - four or more general practitioners in the practice are approaching, or have breached, 80 or more professional attendances on 20 or more days in a twelve month period (80/20 rule).
- s 37(1)(a)

2012-13 Budget Measure: *Fraud prevention and compliance – Increased billing assurance for the Medicare Benefits Schedule*

This measure will establish a new approach to compliance for large practices

- The Department of Human Services is committed to ensuring the integrity and sustainability of the Medicare Program through its compliance activities.
- The Department is responsible for ensuring that Medicare Program benefits are paid only for eligible services.
- This measure is looking at the compliance challenges associated with the changing nature of health practice, from small owner-operated practices to larger business enterprises.
- The measure aims to establish a better understanding of the impact of practice business arrangements on health practitioner billing behaviours.
- There is concern that some health practitioners in practices, where a number of health practitioners are working, may be pressured to provide or refer services that are not medically necessary. There is also concern about potential incorrect billing.
- The use of practice-based reviews is a new compliance approach. These are being conducted where Medicare claims data identifies possible over-servicing by four or more medical practitioners at the one practice.
- By reviewing all health practitioners at a practice where some appear to be over-servicing, the Department may be able to identify systemic issues with the practice, and correct the behaviour of multiple practitioners within a shorter timeframe.
- This project is not just focused on conducting practice-based reviews. The Department is also providing education for all health practitioners about their Medicare billing responsibilities.

BACKGROUND

- The measure aims to establish a new compliance approach using data collection, education and practice based reviews to build an evidence-based body of knowledge about Medicare Program compliance by large practices.
  - This will enable the Department to better understand and model the potential influence of different business and commercial arrangements on individual health practitioner's billing behaviours.
- The Budget measure will run over three financial years from 1 July 2012 to 30 June 2015 and will cost $7.6 million; and aims to achieve savings of $20.7 million.
- An education letter, 'Billing accurately under Medicare', will be provided to all health practitioners during 2013. The letter advises practitioners about their legal responsibilities and accountabilities when billing MBS items. An initial mail-out took place on 25 March 2013.
- A web page with information about billing responsibilities was published on 25 March 2013.
- Online learning modules and a vodcast will be available on the Department's website by 30 June 2013.
- Practice based reviews commenced 23 April 2013 and will continue to June 2014, with approximately s 37(1)(a) general practitioners interviewed under the Practitioner Review Program.
- Billing profiles of all practitioners at the practice will be reviewed. Where concerns are identified, practitioners will be interviewed under the Practitioner Review Program, and where necessary, referred to the Director of Professional Services Review.
- s 37(1)(a)
- Under the *Health Insurance Act 1973*, a general practitioner is deemed to have engaged in inappropriate practice (over-servicing) if they render 80 or more professional attendances on 20 or more days in a twelve month period.
  - This is known as the '80/20 rule'.
- The criteria for selecting a practice for review in this project are that:
  - there are four or more health practitioners in the practice; and
  - four or more general practitioners in the practice are approaching, or have breached, 80 or more professional attendances on 20 or more days in a twelve month period (80/20 rule).
- In January 2013 a pilot practice-based review was conducted in New South Wales. s 37(1)(a)
-