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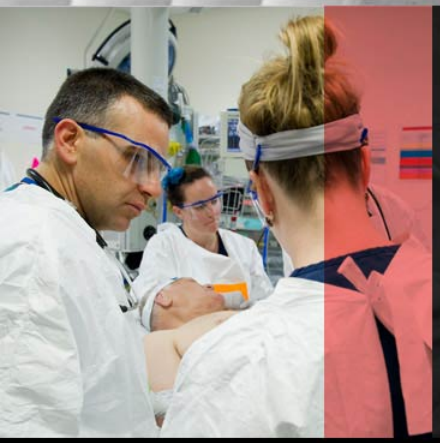

Fraud and Non-Compliance associated with Medicare

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Fraud and Non-Compliance Associated with Medicare

Overview

- Evolution of DHS and the compliance journey
- Legislative basis for compliance intervention and recovery of benefits
- Types of non-compliance
- Approach to management of non-compliance
- Challenges and opportunities
- Questions

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Evolution of DHS and the compliance journey - HIC

- **The Health Insurance Commission** (HIC)
  - 1974 - HIC created as a Commonwealth Statutory Authority
  - 1975 - Medibank
  - 1976 - 'Medibank Mark II'
  - 1983 - Medicare
  - 1998 - Medibank Private separated from HIC

- Compliance was managed by a Canberra-based General Manager, but state managers were fairly autonomous, determining their own intervention strategies, relying on local intelligence and the corporate knowledge of long-serving staff

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Evolution of DHS and the compliance journey – Medicare Australia

- 2005 – **Medicare Australia** established as a DHS agency
  - a higher level of legal responsibility, accountability and transparency as staff bound by the *Public Service Act 1999* as well as by the *Financial Management and Accountability Act 1997* (FMA Act).

- A national model of compliance was developed and managed along functional lines rather than geographical lines.
- Increased use of email saw the introduction of 'virtual teams', with compliance officers in different states working on the same taskforce.
- A greater emphasis on cost-effectiveness led to a more strategic approach of risk identification, treatment and recoveries.

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Evolution of DHS and the compliance journey – DHS

Department of Human Services (DHS)

2011 – The **Department of Human Services** was established in 2004 and became a single department in 2011 with the integration of Medicare Australia and Centrelink

- DHS is responsible for the development of service delivery policy and provides access to social, health and other payments and services.
- DHS has over 35,000 employees. It is the second largest department of state, comprising one quarter of the Australian public service.

- DHS employs over 3000 compliance staff nationally.
- The Recovery, Health and Business Compliance Division is responsible for Medicare program compliance and debt recovery, as well as the strategic fraud and non-compliance plan for the whole department .

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Department of Human Services - roles

DHS administers the Medicare program, including PBS, and ensures that:

- correct benefits are paid
- to eligible patients
- for eligible services
- by eligible health care professionals
- in accordance with the *Health Insurance Act 1973* (Medicare) and the *National Health Act 1953* (PBS)

For 2011-2012

Medicare Program

Persons enrolled	23 million
Medicare services processed	332 million
Medicare benefits paid	$ 17.7 billion
PBS Benefits	$ 9.7 billion

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Department of Human Services - roles

Minister for Health and Ageing

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Department of Health and Ageing

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- Health program policy
- Sets fees
- Drafts legislation
- Publishes MBS and PBS

Minister for Human Services

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Department of Human Services

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- Health program administration
- Makes payments
- Provides information
- Compliance & debt recovery

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Legislative basis for compliance intervention

Legislation has developed over many years. It is amended to manage new risks, including legal challenges to compliance administration.

- ***Crimes Act 1914*** – offences in general eg forgery; aiding or abetting
- ***National Health Act 1953*** – rules for Pharmaceutical Benefits
- ***Health Insurance Act 1973*** – rules for Medicare Benefits
- ***Human Services (Medicare) Act 1973*** – where reasonable grounds for believing that a relevant offence has been or is being committed, allows DHS to:
  - issue a notice requiring a person to give information or produce documents
  - enter premises with the consent of the occupier and conduct a search
  - enter premises, conduct searches and seize evidential material under warrant

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Legislative basis for compliance intervention

- ***Health Insurance Amendment (Compliance) Act 2011*** allows DHS to:
  - require health professionals or a third party to produce documents to substantiate their Medicare claiming when audited
  - impose a financial penalty 20% value of incorrect payments for health professionals who do not substantiate claims or whose incorrect claims are above $2500.
  - No penalty or reduced penalty if *Voluntary Acknowledgement*

- ***Health Insurance (Professional Services Review) Amendment Act 2012***
  - 'Prescribed pattern of services' 80/20 *deemed* inappropriate practice
  - Allows for review of allied health professionals
  - Allows for review of those causing or permitting inappropriate practice eg employers/corporate entities

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Legislative basis for recovery of benefits

Health Insurance Act 1973

- Section 129AC - where, as a result of the making of a false or misleading statement (incorrect claim), an amount paid exceeds the amount that should have been paid, the amount of the excess is recoverable as a debt due to the Commonwealth.

***Financial Management and Accountability Act 1997* (FMA Act)**

- Section 47 provides that the Secretary must pursue recovery of each debt and that the Secretary is responsible for debts owing to the Commonwealth.
- A debt arises for the purposes of section 47 of the FMA Act at the point that there is an amount which is:
  - ascertainable and certain;
  - capable of recovery in action for debt; and
  - due for payment (as of the day that it was incorrectly paid)

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DHS compliance model

The core elements of DHS' philosophy are:

- **helping** health practitioners and the Australian public to understand their rights and obligations
- **making it as easy** as possible for them to meet their obligations when making claims for benefits
- **supporting** people who want to do the right thing
- **actively pursuing** those who seek to opportunistically or deliberately exploit the programs we administer.

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Risk management

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Recovery of benefits where a debt is identified
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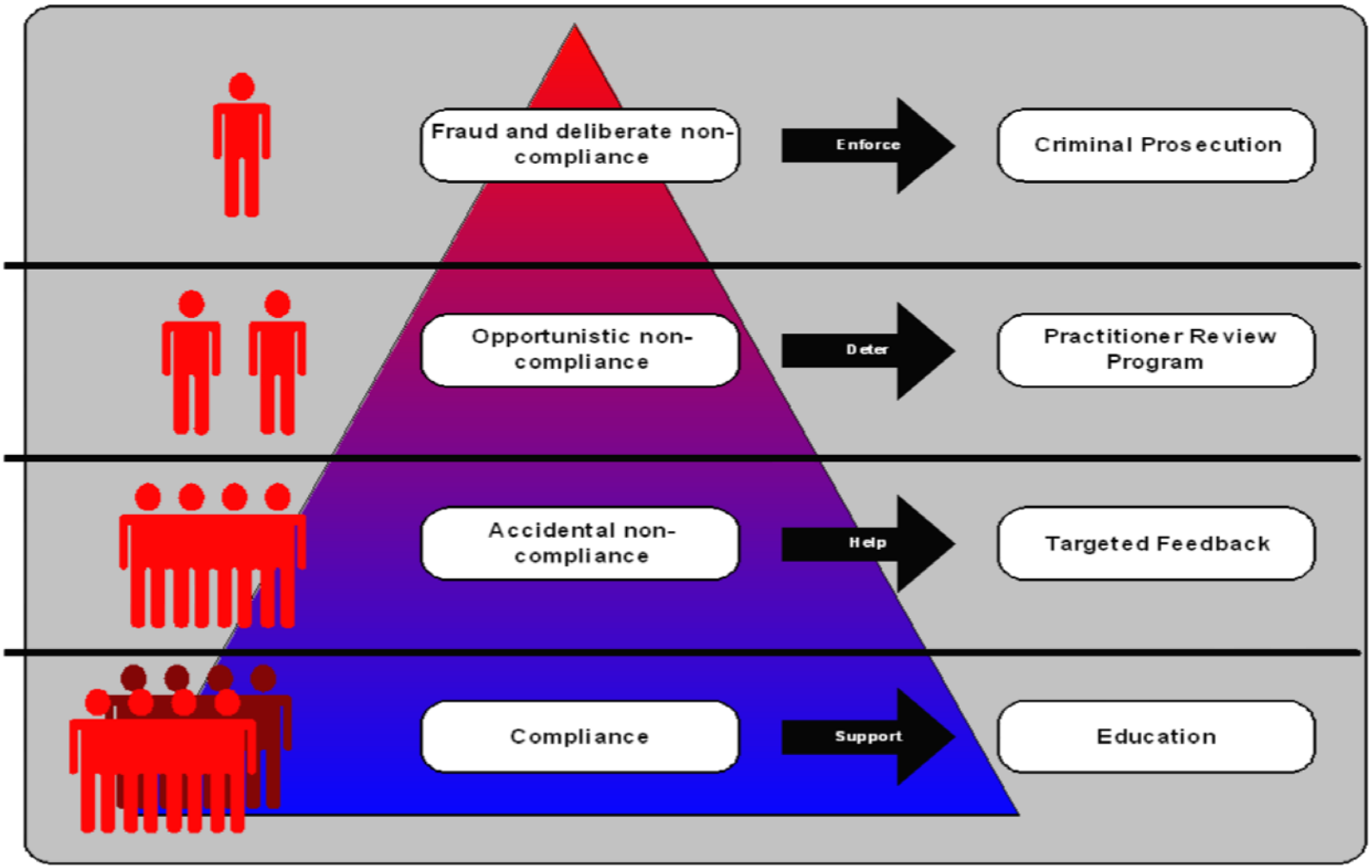

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Identification of non-compliance

Identification of possible fraud or misuse through:

- **Environmental scanning** – Annually invite health industry groups and policy department to advise what they think are emerging risks.

- **Data** analysis – <u>Strategic analysis:</u>
  - **Policy factors** – growth of MBS items and health professionals
  - **Economic factors** – growth of corporatisation of health practices
  - **Social factors** – community demand; ageing population
  - **Technological** – eBusiness impacts
  - **Legal factors** – complexity of legislative requirements

  – <u>Health practitioner analysis</u>:
  - Of individuals or like groups or specialties
  - Practice profile; growth in item usage; 'outlier analysis'; MBS item associations; geospatial analysis;
  - GP Risk Assessment System vs Specialist RAS

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Identification of non-compliance

The **TOP 100** report - by item or specialty, nationally or in a state

- Is a very useful tool in identifying practitioners of concern.
- If listed for multiple items, this is an indicator of possible inappropriate practice rather than being a billing error.
- Especially for those who render any item 2 or more times greater than the next highest renderer.

It is especially useful for identifying specialists. Some may be:

- up-coding by routinely using the most complex and expensive item eg arthroplasty item 49533;
- using an item that is unusual for that specialty, often for a new procedure with no MBS item eg radiologists or cardiologists claiming open surgery items for a percutaneous procedure; or
- adding on items to increase the benefit, either routinely, or to recompense for a procedure that took longer than normal eg laparoscopic division of adhesions item 30393.

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Identification of non-compliance

Identification of possible fraud or misuse through:

- **Intelligence**
  - Tip-offs from claims payment staff, patients, peers, practice managers, Dept. of Health and Ageing, other regulatory bodies
  - Approximately 1500 Medicare-related tip-offs per year
- **Audit**
  - Planned - as part of the annual strategic plan – audit specific item numbers used by any specialty; or of specific item numbers used by a specific specialty.
  - Responsive – audit a group or individual in response to intelligence or other imperative.
- **Investigation**
  - As part of an investigation for suspected fraud

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Types of non-compliance

The key risks to the integrity of the programs we administer are:

- **Inappropriate practice** = conduct in the rendering or initiating of Medicare services or in prescribing under the PBS that would be unacceptable to the general body of members of the profession.

- **Incorrect claiming** = failure to meet requirements of Medicare Benefits Schedule.

- **Fraud =** benefit is obtained by *knowingly* making false or misleading statement, in connection with a claim for benefit.

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Types of non-compliance – Inappropriate practice

- By practitioner or employer
- Due to one or more of:
  - over-servicing
  - MBS descriptors not met
  - inadequate clinical input
  - services not clinically relevant
- *80/20 Rule* = *deeming provision*
  = 80 or more professional services on 20 or more days in 12 month period

Practitioner Review Program (PRP)

- Interviewed by a DHS Medical Adviser; given period to change behaviour; otherwise delegate sends a request to the Director of Professional Services Review (PSR)
- Inappropriate practice is determined by *peers*, not DHS

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Types of non-compliance – Inappropriate practice

PRP dataset – no. and % of all Medicare services and PBS drugs compared in most recent 12 months to previous 12 months.

	Total services		Weekly patterns
	Total benefits		Item associations
	Peer percentiles		CDM items
	% change		Specialist referrals
	Patient age/sex		Family servicing
	Services per patient		Pathology top 20/ %ile/SPP
	Patient frequency		Imaging top 20/ %ile/SPP
	Services per day		PBS drugs / volume /scripts per patient

- Approximately 10% of those reviewed under the DHS' PRP fail to address our concerns and are referred to PSR.
- Repay benefits and/or disqualification from Medicare for up to 5 years
- **In 2011-2012:**
  - **328** Practitioner Review Program reviews
  - **30** requests to the Director of Professional Services Review

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Types of non-compliance – Inappropriate practice

Inappropriate Practice Case: **Dr AAA, Chiropractor**

- Dr AAA had higher number than peers of initiation of diagnostic imaging – multiple level and repeated imaging per patient, including teenagers.
- Concerns that services that may not have been clinically necessary.
- Dr AAA's rationale for frequent testing was to monitor the progress of patients during a regime of regular chiropractic care.

Outcome: A Committee of three chiropractors found that in 90 % of the examined services, Dr AAA failed to establish essential clinical criteria, such as evidence of trauma, deterioration of presenting condition or suspicion of new pathology.

The Committee concluded that this conduct would be unacceptable to the general body of chiropractors. Dr AAA was reprimanded and counselled.

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Types of non-compliance – Inappropriate practice

Inappropriate Practice Case: **Dr YYY, ENT surgeon**

- A review of Plastic and Reconstructive Surgery items identified Dr YYY as the only one to use item 45632 (rhinoplasty, alar cartilages) with items 41671 (septoplasty), 41716 (intranasal antrum op), 41737 (intranasal op on frontal sinus) and 41764 (nasendoscopy).
- Above 99th%ile for item 45632 and was no. 1 in Australia, despite being in a rural area.
- Family servicing - to more than one family member on the same day on 35 occasions in 12 months.
- 'New radical sinus surgery' for which there was no MBS item.

Outcome: PSR Committee found services were not medically necessary, had insufficient clinical input and medical records were deficient. Dr YYY was counselled, reprimanded, ordered to repay over $14,000 and was disqualified from billing item 45362 for 6 months.

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Types of non-compliance: Incorrect claiming

Incorrect claiming

- Failing to fulfil requirements of Medicare Benefits Schedule, for example
  - billing a higher specialist fee without a valid referral
  - billing a more expensive item when a cheaper item should have been used for the service that was performed eg using an MBS item for removal of a skin cancer when the pathology result showed it was a benign lesion.

- If a debt is not established, then treatment may include **targeted feedback letter**.

- **Audit -** now with powers to compel documents to substantiate claims made to Medicare.
  - if incorrect payment of benefits is confirmed, a debt is established and **recovery** of benefits will be sought.

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Types of non-compliance: Incorrect claiming

Incorrect claiming case: Anaesthetists

Tip-off from private sector that anaesthetists were claiming longer than expected times for short procedures - endoscopies and cataract removals. Data showed some billed 16 or more hours in anaesthetic time units each day.

The audit found anaesthetists had managed more than one patient at a time, so that simultaneous accrual of time units made it look like services were provided for more hours than there were in a usual work-day.

About $100,000 was recovered for the incorrectly billing of time unit items where the anaesthetists did not provide exclusive and continuous care.

There were additional recoveries of $9,000 for other concerns identified:

- Claiming anaesthetic emergency modifier items where an emergency situation did not exist; and
- Claiming anaesthetic items as out-patient services when in fact the services were performed as admitted patient services.

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Types of non-compliance: Incorrect claiming

Incorrect claiming case: Medical Practice

A patient was identified as having a high number of emergency after-hours consultations.

A further review revealed 12 different practitioners at the one practice had seen this patient.

A review of the practice identified concerns with their billing. When advised the practice found an error with their software, resulting in double-billing.

Approximately $200,000 in incorrect payments were recovered.

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Types of non-compliance: Fraud

- By patient, practice manager, practitioner, corporate, DHS claims processing staff.
- *Intent*ional dishonest act, or omission.
- Most public fraud is
  - identified by **tip-offs** from staff, colleagues or friends
  - committed by members of the **public**
  - by faking receipts or prescriptions
  - adding zeroes to doctors' accounts to claim extra cash
  - identity fraud eg overseas patient assumes identity of a relative and uses relative's Medicare card to access health care in Australia
  - Medicare card fraud eg patient uses false card to access health care in Australia.
- Practitioner fraud usually by deliberately claiming for services which were not performed.
- Pharmacist fraud by claiming pharmaceutical benefits when PBS medications have not been supplied; or claiming for the same benefit on multiple occasions.

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Types of non-compliance: Fraud

- Cases are investigated and managed by qualified compliance officers
- Criminal standard of proof based on evidence
  - witness statements, seize records, computer forensics
- Referral to Commonwealth Director of Public Prosecution.
- If convicted, may receive:
  - criminal record
  - fine
  - imprisonment
  - health practitioners - de-registered by AHPRA
    - disqualified from Medicare

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Types of non-compliance: Fraud

Fraud case

Practice manager

- A practice manager made a duplicate image of accounts of several doctors in the practice.
- He lodged 1,282 false claims to the value of $924,090 over 17 months.
- The fraud was detected when a claim was lodged for a deceased patient.
- Data of a number of practitioners analysed.
- The case was referred to the CDPP and successfully prosecuted
- He was sentenced to nine years imprisonment with a non-parole period of three years.

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Types of non-compliance: Fraud

Fraud case

Practitioner – Online Claiming

- Several members of the public reported anomalies on their history statements from the Medicare Online Services website.
- Further investigation found that while the patients received some of the services, others appeared to be falsely claimed by the practitioner.
- The matter was referred to the CDPP and successfully prosecuted
- The practitioner was ordered to repay $123,000 to the Department, and was convicted and sentenced to 4 years imprisonment.

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Voluntary compliance - provider percentile charts

Practitioners can request a report of the MBS items they have provided in a 12 month period.

Percentile charts are available online for practitioners to compare their servicing to that of their peers.

Percentile reports are available for common MBS item numbers for

- attendance items;
- health assessment, care plan, Domiciliary Medication Management Review;
- GP mental health treatment;
- optometrical services;
- allied health;
- practice nurse;
- psychological therapy and focused psychological strategy;
- midwifery, nurse practitioner; and
- dental services.

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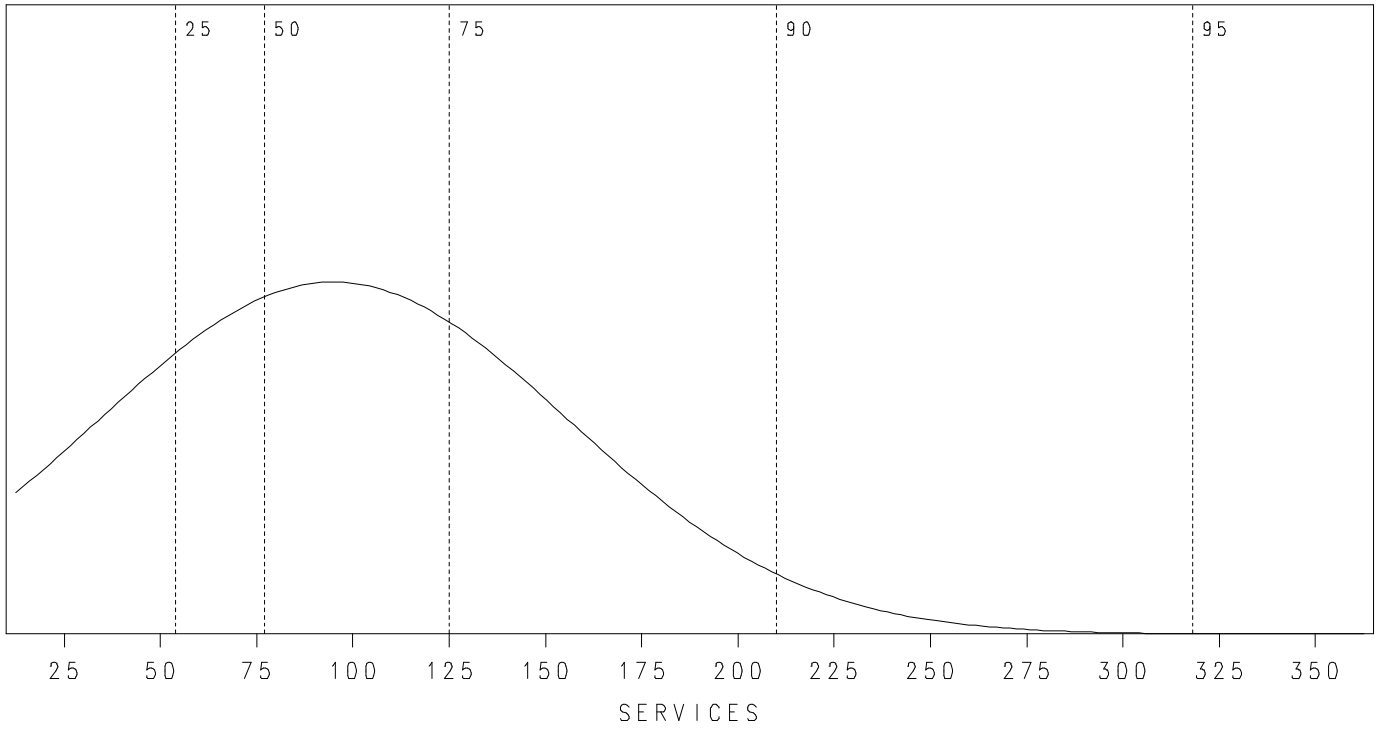
Voluntary compliance - provider percentile charts

Item 10966 percentile chart – osteopathy service after a care plan referral

Percentile	25th	50th	75th	90th	95th
Services	54	77	125	210	318



Data table for the Item 10966 percentile chart

95 per cent of health professionals have claimed less than or equal to 318 services.
This means that only 5 per cent of health professionals have claimed more than 318 services.

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Pre-payment risk management

1. Administrative systems: processing flags

2. Claims approval process: Medicare Claims Review Panel

- MBS item descriptor *states, '…where it can be demonstrated…'*

*…by….*sufficient clinical &/or photographic evidence to enable the Panel to determine

  - that a clinical requirement is satisfied; and
  - that the service meets the MBS item descriptor.

- MBS Explanatory Notes may have additional requirements
  - eg breast ptosis - photographs including an anterolateral view.

- Also for prospective approval of proposed surgery - for informed financial consent.

- Patient or provider able to appeal to the Panel for review of decision.

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Pre-payment risk management - Medicare Claims Review Panel

- In 2011-12, a total of **2321** applications were received.
- Of these, 35% were for computerised perimetry services.

Item	*Description*	*No of services*
11222	Computerised perimetry	804
45558	Breast ptosis correction (bilateral)	465
45585	Liposuction to 1 regional area	338
45019	Full face chemical peel for severe sun damaged skin	175
45528	Mammaplasty, augmentation	147
45588	Meloplasty (bilateral)	37

- Most of the applications for liposuction were for treatment of gynaecomastia. Note: no benefits payable after 1 Nov 2012.
- There were 31 appeals (1% of applications) lodged, with decisions overturned in 9, including after additional information was provided by the practitioner.

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Challenges

Health is a complex environment

- Privacy
- Legislation
- Policy

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Opportunities

- To better understanding of each other's environment, risks, expectations and constraints
- To work together to identify risks and emerging trends
- Co-design of analysis techniques, patterns of recognition or useful flags
- Joint approach to risks that affect both the department and the private health industry

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Fraud and Non-Compliance Associated with Medicare

Questions?

Thank you