RACGP

Medicare compliance

Frequently asked questions

General comments

The Royal Australian College of General Practitioners (RACGP) is not a statutory body and is unable to intervene in individual compliance cases. As with all specialist medical colleges, the RACGP has no legal authority to interpret Medicare Benefit Schedule (MBS) rules and regulations. It is the responsibility of the treating practitioner to ensure that any service billed to Medicare meets the item descriptor in the MBS and any eligibility requirements in full. You should maintain appropriate patient notes to demonstrate how you met the descriptor of any Medicare service billed.

We advise general practitioners (GPs) to contact their medical defence organisation (MDO) if they require support regarding their individual case. More information is available in our statement on Medicare interpretation and compliance (member login required).

The RACGP is in regular contact with the Department of Health and Aged Care (DoHAC) regarding a range of compliance issues. We provide de-identified examples to the DoHAC to highlight broad issues with compliance processes. We are also working with other peak professional organisations and MDOs to change the way compliance activities are undertaken.

The DoHAC has been asked to provide advice and input to this document. **For clarity, the RACGP views and positions on how compliance activities are conducted that are identified in this document do not represent the views of the DoHAC.**

The RACGP appreciates that Medicare compliance activities can be extremely stressful for GPs and very time consuming. We provide a support program for members who are experiencing any stress or similar difficulties:

- GP Support Program
- Self-care and mental health resources

The FAQs below are designed to help GPs better understand the different types of compliance activities and alleviate some of the fear and misconceptions that currently exist.

FAQs

What are the different types of compliance activities?

Targeted compliance letters	The DoHAC sends a variety of targeted compliance letters to educate and encourage providers to review their billing so they can ensure it is compliant and would be considered appropriate by peers. Depending on the nature of claiming patterns or billing discussed, the letters may be accompanied by a schedule of claims or contain a description of their billing to assist the review. While the process is voluntary, if you believe your billing is correct/appropriate following your review, you should consider providing an explanation to the DoHAC which you may wish to do in consultation with your MDO. If you identify incorrect claims during your review, early notification of these to the DoHAC will ensure the notified claims are not included in a future compliance activity.

<table>
<tr><td></td><td>It is important that you read the letters carefully to understand the concerns raised by the DoHAC and ensure any responses are received by the correct area in DoHAC promptly.</td></tr>
<tr><td>Audits</td><td>An audit may be undertaken where there is reasonable concern that a Medicare benefit has been paid which exceeds the amount (if any) that should have been paid. An audit is not a criminal investigation.

The audit process generally starts with a request for documents. You may be asked to provide documents to demonstrate that a Medicare benefit was payable for the services rendered.
Where you fail to respond or provide documents to substantiate the services, you may be issued a notice to produce documents. This requires you to supply documents within a specified timeframe. Failure to respond or provide all documents requested can lead to you being required to repay the Medicare benefits in question.
If you can substantiate your claiming the audit will be closed. Alternatively, you may be required to repay a debt and administrative penalty.

Detailed information on audits can be found at Our Medicare compliance approach - Audits | Australian Government Department of Health and Aged Care</td></tr>
<tr><td>Practitioner Review Program (PRP)</td><td>The PRP reviews a provider's Medicare and Child Dental Benefits Schedule (CDBS) servicing, and Pharmaceutical Benefits Scheme (PBS) prescribing data to identify possible inappropriate practice.

The PRP involves DoHAC professional advisers reviewing your Medicare servicing and PBS prescribing data and assessing variances from your peers. Where this variance could be due to possible inappropriate practice, you may be identified for review under the PRP.
Servicing/prescribing data is only the starting point for a PRP review. Other factors such as your location, patient demographics, special interests, additional training, and other potentially relevant matters are also considered.
How a case progresses through the PRP depends on the circumstances of the individual case.
You may be offered an interview with one of the DoHAC's professional advisers. The adviser will discuss their concerns with you, and you will have an opportunity to provide additional information.
Possible outcomes after an interview include:

All concerns are addressed and no further action is required with the matter closed.
Some or all of the concerns remain, and your data will be examined again following a six-month period of review.
The matter is referred to a delegate of the Chief Executive Medicare (delegate) to consider whether to make a request to the Director of the Professional Services Review (PSR), without undergoing a six-month review.

If concerns are not addressed under the PRP, this may result in a request being made by the delegate to the PSR Director to review your case.
If the delegate becomes aware you have rendered or initiated a prescribed pattern of services (known as the 80/20 and 30/20 rules), a request to the PSR Director must be made.

Detailed information on the PRP can be found at Practitioner Review Program | Australian Government Department of Health and Aged Care.</td></tr>
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Professional Services Review (PSR)	The delegate may request the PSR Director to review your provision of services or prescribing if concerns are unable to be resolved under the PRP. The PSR process has three main stages: 1. Consideration by the Director of whether there is sufficient evidence of inappropriate practice (or a negotiated agreement if the practitioner is willing to acknowledge inappropriate practice). 2. A peer review process by a PSR Committee. 3. Consideration and setting of an appropriate outcome. A finding of inappropriate practice can result in serious penalties such as repayments of Medicare benefits, a partial or full disqualification of billing certain MBS items or a full disqualification from prescribing under the PBS. PSR Committee members are drawn from a panel of practising health or medical practitioners. Some panel members are appointed as Deputy Directors who chair the Committee. A Committee includes a Deputy Director from your profession and two other panel members who are from your profession or, if applicable, medical specialty. One or two more panel members may also be appointed by the Director to give the Committee a wider range of expertise.

Is a targeted compliance letter a ‘nudge’ letter?

No, targeted compliance letters are not ‘nudge’ letters. These letters ask providers to review a list of claims made over a certain period and repay any incorrect claims to the DoHAC. ‘Nudge letter’ is often incorrectly used as a blanket term to describe all compliance letters.

I’ve received a targeted compliance letter. Am I being audited?

No, you are not being audited if you receive a targeted compliance letter.

How does the DoHAC decide who receives a targeted compliance letter?

The DoHAC’s Benefits Integrity Division sorts through data and billing trends before deciding on compliance interventions.

In some cases, letters are sent to providers with high levels of claiming certain MBS items where it is not clear to the DoHAC why this is occurring. The DoHAC also receives tip-offs from members of the public who have concerns about the services their GP has billed, which may prompt a letter or another compliance intervention.

The DoHAC may also invite key stakeholders to provide feedback on questionable billing trends that may be occurring and factors influencing these (eg location or providers, areas of special interest), however at this stage there is no guarantee that a compliance activity will be undertaken.

How will the DoHAC continue to monitor providers who receive a targeted compliance letter? What circumstances could trigger further compliance action (eg an audit) in future?

It is customary for the DoHAC to review the impact of a compliance activity and monitor billing trends for a certain period afterwards (usually, but not strictly, 18 months). They will then decide on further action as needed.

The DoHAC may intervene sooner with an audit in exceptional circumstances – for example, if a provider has an unusually high level of servicing in comparison to their peers that cannot be explained. However, you should note that audits account for a tiny percentage of all Medicare compliance interventions.

Is the DoHAC likely to retract targeted compliance letters once they have been sent?

No, targeted compliance letters are not retracted once they have been sent.

Do I need to respond to a targeted compliance letter?

Responding to targeted compliance letters is voluntary. These letters provide an opportunity for providers to self-reflect on their billing. If you receive a targeted compliance letter and do not respond, the DoHAC may elect to undertake further compliance activities in respect of the concern raised.

Providers are strongly encouraged to contact your MDO if you are unsure how to respond to the letter or what action to take. If you choose to identify incorrect claims in the list sent to you, you will need to repay any incorrect payments to the DoHAC by following the instructions in the letter. If you believe your claiming is correct, you should consider providing an explanation to the DoHAC.

Ultimately it is up to each individual GP to decide on the best course of action for them, and your MDO is best placed to assist you make this decision. You should be aware that the DoHAC will continue to monitor your claiming and may take further compliance action, including an audit, if concerns persist.

It is impossible for GPs to review claims made at practices/aged care facilities they no longer work at. What is the DoHAC's expectation in this scenario where it has issued a targeted compliance letter?

Targeted compliance letters are not audits and GPs are not required to produce documentation for the DoHAC to review.

Does the DoHAC provide a response to GPs when they send back their explanation of why they believe their claiming is correct after receiving a targeted compliance letter?

Yes, the DoHAC will respond if you provide an explanation of your claiming. If you do not receive a response, you can contact the DoHAC at the relevant email address on the letter you have received.

Why do GPs sometimes receive different replies from the DoHAC after responding to a targeted compliance letter?

When a GP contacts the DoHAC in response to receiving a targeted compliance letter, each response is reviewed independently and replied to accordingly. As such, responses can vary in terms of wording used.

The DoHAC is concerned with ensuring that patients receive the services that they are entitled to under Medicare and health practitioners comply with MBS claiming requirements. The DoHAC takes compliance action where concerns are identified that a practitioner may not have met the MBS requirements and benefits have been paid that should not have been paid.

I don't have enough time to review my list of claims attached to a targeted compliance letter. What should I do?

You can request an extension by emailing the address specified on the letter you have received.

Will the DoHAC take further action if I don't respond to a targeted compliance letter, or if I respond saying my claiming is correct?

The DoHAC will continue monitoring future billing after targeted compliance letters are sent. Where practitioners identify and correct non-compliant billing, and where changed billing behaviour is evident in data, there would generally not be a need for contact about the same compliance concern. However, the DoHAC may follow up with practitioners where a response has not been received, as a lack of response can indicate the letter was never received, and further action may be taken if it appears a potentially non-compliant behaviour is ongoing.

The DoHAC may also take further action even if you repay money after receiving a targeted compliance letter. This does not automatically preclude you from further compliance activity, particularly if you continue to demonstrate the same billing patterns.

You need to ensure that any service billed to Medicare is clinically relevant and meets the item descriptor in the MBS and any eligibility requirements in full. You should maintain appropriate patient notes to demonstrate how you meet the descriptor of any Medicare service billed.

Will I be referred to the PRP if I receive a targeted compliance letter?

The DoHAC routinely monitors MBS/CDBS claiming and PBS prescribing for all medical practitioners and may take compliance action where it raises concerns of potential incorrect claiming, inappropriate practice or fraud. Data of medical practitioners in Australia who bill under Medicare is analysed to identify practitioners who vary from their peers. Where the variance could be due to possible inappropriate practice, the DoHAC may review a practitioner's servicing under the PRP. Concerns of possible inappropriate practice are identified by a DoHAC professional adviser who is a qualified health professional.

The DoHAC considers a range of factors in determining possible inappropriate practice, including variance from peers across a range of parameters, whether MBS, CDBS or PBS requirements have been met, and whether services were clinically relevant.

How long do PRP cases take to resolve?

The anticipated timeframe to resolve a PRP review is between six and 12 months. The time taken to resolve a PRP review can be impacted by several factors including:

- the progression of a case through the PRP. For example, a practitioner may be offered a six-month period of review following an interview, or their case may progress to a delegate of the Chief Executive Medicare after interview due to the severity of concerns of potential inappropriate practice. If a case is closed immediately after interview, then the timeframe will usually be less than six months
- the complexity of the case
- if additional time is requested by the person under review at any stage during the review process
- if additional advice or input to assist the PRP review is required (for example, policy or legal advice).

The DoHAC endeavours to complete all cases in a timely fashion. Where additional time is required to complete a PRP review, this is to ensure the review is given appropriate consideration in light of the particular circumstances of an individual case.

What are the 80/20 and 30/20 rules?

A GP is deemed to have engaged in inappropriate practice where some or all of the services rendered or initiated constitute a prescribed pattern of services, unless exceptional circumstances apply. This includes:

- 80 or more relevant services on each of 20 or more days in a 12-month period (known as the 80/20 rule). Since 1 July 2022, telehealth services (telephone and video) have been included in the 80/20 rule
- 30 or more relevant phone services on each of 20 or more days in a 12-month period (known as the 30/20 rule). This rule was introduced on 1 October 2022.

The *Health Insurance Act 1973* requires a request to be made to the Director PSR if the Chief Executive Medicare becomes aware of a breach of the 80/20 or 30/20 rules.

What is the Online Compliance Platform?

The Online Compliance Platform (OCP) is a secure digital portal for health providers. If you are contacted by the DoHAC about certain Medicare compliance activities, they may also invite you to use the OCP. You can use it to self-review your Medicare claims, identify any potential errors and respond to the DoHAC online.

Using the OCP is voluntary. You can choose to receive a paper schedule and respond to the DoHAC by mail if you prefer. If you would like to use the OCP, you must give the DoHAC your email address and mobile phone number. This is to enable you to use the OCP privately and securely.

You can use the OCP to:

- search the schedule for a keyword
- filter the schedule by item number, service location, response, and selection

- select items individually or in groups to provide a single response where the services are compliant or non-compliant
- write comments and upload supporting documents with your response
- include feedback about your experience using the OCP.

Before you submit a response, the OCP will also confirm the amount of any incorrect payments.

FAQs about the OCP and supporting resources are available from the DoHAC's website.

Where can I find information and resources on Medicare compliance?

Visit the RACGP's Medicare resources webpage and click on the 'Compliance processes' tab.

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