EASY AND AFFORDABLE ACCESS TO HEALTHCARE FOR THE WHOLE FAMILY…IT'S JUST A WALK IN THE PARK.

04

Medicare

MEDICARE

Key business results

In 2002–03, HIC processed 221.4 million services, representing $8,115.5 million in Medicare benefits.

At a glance

Medicare expenditure 2001–02 and 2002–03

At 30 June	2001–02	2002–03	% change
Total benefits (includes adjustments to provisions for outstanding claims)	$7,832.0 million	$8,174.5 million	4.4% increase
Radiation oncology health program grants	$23.0 million	$36.0 million	56.5% increase

Medicare enrolments, claims and benefits 1998–99 to 2002–03

As at 30 June	Units	1998–99	1999–00	2000–01	2001–02	2002–03
Enrolment						
Persons enrolled*	Million	19.4	19.7	20.1	20.4	20.6
Active cards	Million	10.8	11.0	11.3	11.5	11.7
Claims						
Services processed	Million	206.3	209.6	213.9	220.7	221.4
Benefits						
Benefits processed	$million	6,669	6,945	7,327	7,830	8,116
Average benefit per service	$	32.32	33.14	34.25	35.48	36.65
Average period service to lodgement	Days†	15.1	15.3	15.7	16.5	16.3
Average period lodgement to processing	Days††	5.1	5.7	6.1	5.1	4.4

*Medicare enrollees include some people who are not Australian residents (e.g. long-term visitors greater than six months and eligible short-term visitors).
†Time between date of a medical service and lodgement of a Medicare claim.
††Time between date of lodgement and processing of a Medicare claim.

Overview

Medicare is Australia's universal health insurance scheme. Introduced in 1984, its objectives are to:

- make health care affordable for all Australians;
- provide all Australians with access to health care services, with priority according to clinical need; and
- provide a high quality of care.

Medicare provides access to:

- free treatment as a public (Medicare) patient in a public hospital; and
- free or subsidised treatment by medical practitioners including general practitioners, specialists, participating optometrists or dentists (specified services only).

The Australian Government funds health care through:

- grants to State and Territory governments for the operation of public hospitals through Australian Health Care Agreements;
- access to medical benefits offering eligible patient rebates on fees paid to eligible medical practitioners; and
- grants to government and non-government medical practitioners for a range of other services, such as screening programs to meet special needs.

HIC's responsibilities

HIC's responsibilities primarily relate to:

- ensuring Medicare benefits are paid for services to eligible health care consumers by eligible medical practitioners;
- assessing and paying Medicare benefits for a range of medical services, whether provided in or out of hospital, based on the *Medicare Benefits Schedule* (MBS) fees set by the Australian Government on advice from expert committees; and
- protecting the integrity of the programs it administers through the prevention, detection and investigation of fraud and abuse.

Medicare Benefits Schedule

The Department of Health and Ageing has primary responsibility for the MBS and advises HIC on any changes. HIC is responsible for the day-to-day operation of the MBS, and also monitors and analyses the operation and performance of service item usage under Medicare to identify trends in specific item usage, broad types of service, costs and future audit topics.

Medicare levy

The Medicare levy was established on the principle that all Australians should contribute to the cost of health care, according to their ability to pay through taxation revenue and a levy on taxable income.

Medicare Safety Net

The Medicare Safety Net is designed to protect people who have high medical expenses. When an individual or registered family that pays 'gap' amounts reaches the Medicare Safety Net threshold in a calendar year ($319.70 from 1 January 2003, for individuals or families — indexed annually from 1 January), Medicare benefits increase to 100 per cent of the MBS fee for any further services that are not bulk billed in that year. 'Gap' amounts are the difference between the Medicare rebate and MBS fee.

To be eligible for the Medicare Safety Net using combined gap amounts, families and couples need to complete a Medicare Safety Net registration form (even where its members are listed on a single Medicare card). Individuals do not need to register.

Medicare eligibility

People who reside in Australia are eligible for Medicare if they:

- hold Australian citizenship; or
- have been issued with a permanent visa; or
- hold New Zealand citizenship; or
- have applied for a permanent visa (restrictions apply to persons who have applied for a parent visa — other requirements apply).

Australian citizens who have resided overseas for more than five years will be required to demonstrate their intention to permanently reside in Australia before a Medicare card is granted. A blue interim Medicare card was introduced in September 2000 for people eligible for Medicare benefits based on their application for permanent residency. An interim Medicare card helps medical practitioners and their staff to identify people with limited Medicare eligibility.

Medicare cards and Medicare levy exemptions 2001–02 and 2002–03

Medicare	2001–02	2002–03	% change
Cards			
Total cards issued*	3.43 million	3.03 million	11.6% decrease
Reciprocal health care cards	51,373	46,932	8.6% decrease
Medicare levy exemption			
Total applications	24,458	19,994	18.25% decrease
Accepted applications	24,317	18,500	23.92% decrease
Rejected applications	141	488	246.10% increase

*Includes reciprocal health care cards issued under agreements

Customising services for Indigenous Australians

As an ongoing response to recommendations in the 1997 Keys Young report, HIC continued to make significant progress in ensuring Indigenous Australians have access to Medicare, the PBS and other HIC programs.

Key initiatives during 2002–03 included:

- support to program changes and policy initiatives with the Department of Health and Ageing such as payments for pathology services;
- introduction of a voluntary Indigenous identifier on the Medicare enrolment file;
- provision and enhancement of outreach services to Indigenous communities and providing advice and support to Aboriginal Health Services;
- continued sponsorship of Indigenous events, such as Croc Festivals and the National 3-on-3 Basketball Challenge, and providing information about HIC programs at these events; and
- launch and implementation of the Indigenous Communication Strategy (see page 50).

HIC continues to work in partnership with the Department of Health and Ageing, including the Office of Aboriginal and Torres Strait Islander Health, the Department of Immigration and Multicultural and Indigenous Affairs, and to develop working relationships with other key organisations such as the National Aboriginal Community Controlled Health Organisations (NACCHO) and the Aboriginal and Torres Strait Islander Commission (ATSIC).

Liaison Officers for Indigenous access in each State and Territory work closely with Aboriginal Health Services and Aboriginal Health Workers in community health services, providing outreach services. These include conducting on-the-ground promotion and education about HIC's programs for Indigenous Australians and their health service providers. For example, through Medicare enrolment drives, visitations, training, and building relationships at local community events.

Relationships between Aboriginal Health Services and their local Medicare offices continue to be fostered, based on the success of reducing rejected claims and improving enrolment data in areas where these relationships exist. The introduction in 2002 of a national free call 1800 number specifically for Aboriginal and Torres Strait Islander customers and their health service providers has proved to be extremely effective in providing additional support for enrolment, claiming and general advice. Approximately 20,500 calls were answered during 2002–03.

The voluntary Indigenous identifier is an initiative that aims to enable HIC to improve service delivery to Indigenous customers, research Indigenous health data and measure performance. It was a commitment of the Minister for Health and Ageing and a recommendation of the Keys Young report.

HIC continues to provide cross-cultural awareness training for staff, and is committed to improving HIC staff understanding and appreciation of Indigenous culture.

With the support of NACCHO, the Office of Aboriginal and Torres Strait Islander Health and an Indigenous communications consultant, HIC developed a communication strategy in 2002–03 for Indigenous customers and their service providers. Its aim is to effectively provide information to Indigenous people and their service providers about HIC programs and how to access them. As part of the communication strategy, a toolkit for Aboriginal Health Services was developed to assist Aboriginal Health Service staff with Medicare billing and enrolment. For further information see page 50.

HIC will continue to work with authorities, medical practitioners and communities to improve the accuracy of immunisation data for Indigenous Australian children.

The Northern Territory District Medical Officers Project is a partnership between HIC, the Department of Health and Ageing and Northern Territory Health which has provided a further 60 Indigenous communities and health services with approval to claim Medicare benefits for medical services provided to community members.

Aboriginal health service practice data

To improve access to Medicare benefits for customers of nominated Aboriginal and Torres Strait Islander Health Services, the Minister for Health and Ageing directed (in accordance with existing section 19(2) orders under the Health Insurance Act) that Medicare benefits be paid to these health services. Medicare benefits are not payable where a health service is funded from another source unless the Minister otherwise directs.

HIC collects information on medical practitioners providing services at 168 Aboriginal and Torres Strait Islander Health Services. This information enables the identification of Medicare payments provided to these Aboriginal and Torres Strait Islander health services.

Memorandums of understanding signed

HIC supports a number of Indigenous health projects involving the Tiwi Health Board, Katherine West Health Board and Maari Ma Health Aboriginal Corporation (Wilcannia, NSW). HIC's responsibilities include verification of Medicare eligibility of project participants, enrolment of new Medicare applicants, and the addition to/withdrawal of participants from the projects. HIC also provides fortnightly aggregated financial Medicare and PBS usage information to help in identifying funds to be reimbursed to the Australian Government.

To ensure its obligations under the Privacy Act are met, HIC entered into memorandums of understanding with each of the project fundholders where they agreed to:

- provide relevant Medicare information for each new participant to enable HIC to establish their Medicare and PBS entitlement and to enable linking back to the fund holder for billing purposes; and
- advise HIC of any participant who is to be withdrawn from the project.

Improved services for immigrants

HIC and the Department of Immigration and Multicultural and Indigenous Affairs continue to work together through the electronic transmission of information with an aim to:

- improve service delivery for people who have applied for, or been granted, permanent residency status in Australia;
- reduce administrative burdens associated with establishing Medicare eligibility; and
- simplify Medicare enrolment.

HIC staff also work closely with Migrant Resource Centres and volunteer groups working with migrants to provide information regarding Medicare requirements.

Visitors to Australia

The Australian Government has signed Reciprocal Health Care Agreements with some countries, which entitles residents of these countries to restricted access to health cover while visiting Australia. Currently, these are Finland, Ireland, Italy, Malta, New Zealand, Sweden, The Netherlands and the United Kingdom.

Provider eligibility and registration

Medical practitioners must satisfy the eligibility requirements of the Health Insurance Act before Medicare benefits are payable for professional services. They may apply to HIC for a provider number at each location at which they practice by completing an application form and attaching relevant documentation.

Services provided by a medical practitioner who does not satisfy the eligibility requirements will not attract a Medicare benefit. However, this may not affect the practitioner's ability to prescribe pharmaceutical benefits, or refer or order pathology and diagnostic imaging services.

Committees

HIC is represented on a number of MBS related, inter-departmental and inter-professional committees including:

- Medicare Benefits Consultative Committee;
- Diagnostic Imaging Management Committee;
- Pathology Services Table Committee;
- Pathology Consultative Committee;
- Optometrical Benefits Consultative Committee; and
- Medicare Claims Review Panel.

HIC also provides administrative support for expert committees under the Medicare program. The Minister for Health and Ageing appoints committee members from panels of nominees put forward by the relevant professional bodies and colleges. The committees are:

- General Practice Recognition Eligibility Committee;
- General Practice Recognition Appeal Committee;
- Medical Benefits (Dental Practitioner) Advisory Committee;
- Medical Benefits (Dental Practitioner) Appeal Committee;
- Overseas Specialist Advisory Committees;
- Overseas Specialist Appeal Committee;
- Specialist Recognition Advisory Committees; and
- Specialist Recognition Appeal Committee.

Location specific practice registration

The *Health Insurance Amendment (Diagnostic Imaging, Radiation Oncology and Other Measures) Act 2003* requires all practice sites and bases for mobile equipment where diagnostic imaging and radiation oncology services are undertaken, to be registered with HIC in order to claim Medicare benefits.

The main purpose of this amendment is to provide a mechanism to collect information about the rendering of diagnostic imaging and radiation oncology services. This assists the Government and the diagnostic imaging industry to monitor the nature of services provided and assess compliance for benefits by ensuring equipment used in relation to a Medicare claim meets the eligibility requirements. The information will also allow the development of future programs to maintain and improve patient access to high quality services.

As at 30 June 2003, 2,544 diagnostic imaging or radiation oncology premises or mobile bases have registered with HIC and been allocated a unique location specific practice number (LSPN). Under the new legislation, from 1 July 2003 Medicare benefits will not be payable to practice sites for diagnostic imaging or radiation oncology items unless a LSPN is quoted on patient accounts, receipts, or bulk billing assignment forms.

To assist doctors in identifying registered practices eligible for Medicare benefits, a list of LSPN registered practice sites and mobile facilities have been published on HIC's website **www.hic.gov.au**

Pathology

The Pathology quality and outlays agreement 1999–2004 between the Minister for Health and Ageing, the Royal College of Pathologists Australasia and the Australian Association of Pathology Practices, provides the basis for developing an improved regulatory environment in the health sector with potential benefits to all parties.

Approved collection centre listings are now available on HIC's website **www.hic.gov.au**

Medicare Claiming

Bulk bill claims

Bulk billing occurs when the patient's right to a Medicare benefit is assigned by the patient to the medical practitioner who rendered the service. The medical practitioner accepts 85 per cent of the MBS fee as full payment for the medical service and bills HIC directly.

In 2002–03, there were 150.1 million services bulk billed, accounting for 67.8 per cent of all services by all categories of medical practitioners. Additional statistical information is available in the electronic version of HIC's annual report **www.hic.gov.au**

HIC Online

As at 30 June 2003, 69 sites were transmitting claims to HIC via HIC Online. A total of 326,902 bulk bill claims have been processed since the system was introduced.

Medclaims

The proportion of bulk bill services made electronically using Medclaims increased to 75.4 per cent with the number of sites transmitting claims decreasing from 6,957 at 30 June 2002 to 6,231 at 30 June 2003.

Scanning and document imaging system

HIC continues to use a generic imaging system for scanning. In 2002–03, some 15 per cent of bulk bill services were processed using this system.

Patient claims

Recognising that consumers of health services have different preferences when it comes to accessing Medicare benefits, HIC has developed a range of benefit claiming options. The challenge for HIC is to maintain an efficient service that is responsive to unique customer groups and provides ongoing innovation in claiming and related services, while further broadening information service provision.

Paid accounts

Where the medical practitioner does not bulk bill, and the patient pays the account in full at the time of service, a Medicare benefit may be claimed from HIC by the patient.

Unpaid accounts

Where the medical practitioner gives the patient an account, the patient may choose to lodge an unpaid account with HIC. A cheque for the Medicare benefit made payable to the medical practitioner will be sent to the patient who gives the cheque to the medical practitioner plus any additional amount owing.

Medicare office claiming

HIC's network of 226 Medicare offices throughout Australia is supported by its national computing and communications infrastructure. All Medicare offices provide a full range of Medicare services including processing of enrolments and registrations, and cash, cheque and electronic funds transfer (EFT) payments. They also accept lodgement of participating health fund claims under Medicare two-way arrangements, and process claims for the Federal Government 30% Health Insurance Rebate and benefits for the PBS. Medicare offices also provide Family Assistance Office services. Medicare office address details are available at **www.hic.gov.au/yourhealth/where_to_find_us/index.htm**

Medicare claims can be made in person by submitting a claim over the counter or via a drop box at a Medicare office. Innovations, such as formless cash claiming and EFT payment of Medicare benefits directly into the patient's bank or credit union account, are an important part of customer-focused service in Medicare offices. EFT payment is offered to people lodging claims by post and through Medicare easyclaim facilities as an alternative to payment by cheque.

Medicare easyclaim

There have been 990,281 Medicare claims since the Medicare easyclaim project commenced, providing an alternative Medicare claiming option for people living in rural and remote areas around Australia who do not have direct access to Medicare offices.

At 30 June 2003, 501 facsimile devices and 562 telephone booths were operating in Rural Transaction Centres, State Government agencies, post offices, pharmacies and many other locally based shops and services. The locations of Medicare easyclaim devices are available at HIC's website **www.hic.gov.au**

Medicare mail claiming

Medicare claims can still be made by posting the claim form and account or receipt to HIC.

Two-way lodgement of Medicare claims

Medicare Two-Way Agency allows people to lodge Medicare claims at their health fund or health fund claims at Medicare offices. A total of 730,329 in-hospital gap claims were lodged under the two-way agency arrangements and there was a total of 37 participating health funds in 2002–03.

Simplified billing

The simplified billing initiative is designed to simplify medical billing and payment arrangements for private patients for in-hospital care. It reduces:

- the number of separate accounts sent to the patient;
- delays in patient billing;
- administration costs for accounts; and
- the level of bad debts as providers have evidence that the claim has been lodged.

There are four major simplified billing models currently in use.

Medical Purchaser Provider Agreement (MPPA) — where a health fund can make an agreement to pay provider benefits above the *Medicare Benefits Schedule* fee. Legislation was introduced prohibiting any health fund from interfering with the clinical freedom of medical practitioners. This addresses any concerns a medical practitioner may have with entering into such an agreement with a health fund. The patient need not be involved unless there is an agreed out-of-pocket expense.

Hospital purchaser provider agreement/Practitioner agreement (HPPA/PA) — where a medical practitioner need not deal directly with health funds if submitting claims for simplified billing. The agreement is a combination of agreements between medical practitioners and hospitals and between hospitals and health funds.

Approved billing agency model — where a billing agent acts on behalf of the patient to claim Medicare benefits and health insurance medical benefits. The maximum amount of benefits a billing agent can collect on the patient's behalf is equal to 100 per cent of the schedule fee.

Registration of simplified billing agents — on 8 October 2002 the *Health Legislation Amendment (Private Health Industry Measures) Act 2002* (the Amending Act) transferred responsibility for the registration of billing agents from the Private Health Insurance Administration Council (PHIAC) to HIC effective from 8 April 2003.

Between 8 April and 30 June 2003, HIC received and approved one new application for registration as a Public body simplified billing agent. Two previously registered simplified billing agents renewed their registrations, one as a public body and one a body corporate.

Gap cover schemes — where the purpose is to enable a health fund to offer insurance coverage for the cost of hospital treatment and associated professional attention for the person insured. This can apply where;

- the cost of the treatment is greater than the schedule fee;
- there is no other form of agreement between the health fund and the provider; and
- the person insured pays a specified amount or percentage under a known gap policy or the full cost of treatment is covered under a no-gap policy.

Simplified billing claims have increased from 65.9% to 69.5% of all Medicare in-hospital services in 12 months. Twenty-five billing agents were registered to coordinate claims for medical accounts under simplified billing arrangements at 30 June 2003. Eight were transmitting claims electronically and 17 were lodging claims manually. Forty health funds also transmitted simplified billing claims electronically to HIC.

Of the claims transmitted from health funds and billing agents, 97% were transmitted electronically and 3% manually.

Balimed

In recognition of the extreme difficulties faced by those injured in the Bali bombings, the Australian Government agreed to cover all out-of-pocket expenses, incurred in Australia, for the treatment of injuries received. The scheme covers Australian residents and eligible overseas nationals.

A Balimed Steering Committee was established in order to generate and oversee guidelines and procedures. The committee includes representatives from the Department of Health and Ageing, the Department of Family and Community Services, the Department of Finance and Administration and HIC.

A Bali special health care benefits hotline has been established 1800 660 026.

The scheme covers eligible persons until 12 October 2005 and HIC has the discretion to terminate coverage of a person on reasonable grounds, on a case-by-case basis. It will cover costs faced by eligible patients for the following kinds of goods and services:

- Medical — gap payments between normal Medicare benefits and the fee charged by the doctor, to the extent that the amount is not covered by private health insurance;
- Hospital — costs not otherwise covered by public patient arrangements or private insurance;
- Pharmaceutical — the full cost of pharmaceuticals covered by the Pharmaceutical Benefits Scheme; and
- Allied Health — costs of services such as physiotherapy, speech therapy and occupational therapy, less any amounts covered by private health insurance.

As at 30 June 2003, 141 victims were registered with HIC to receive assistance and $111,811 has been paid to 84 victims.

Professional Services Review Scheme

Established under the Health Insurance Act, the Professional Services Review Scheme came into effect on 1 July 1994 and applies to health professionals who provide or initiate services under Medicare or the Pharmaceutical Benefits Scheme. These include medical practitioners, optometrists, dentists, podiatrists, chiropractors, physiotherapists and practice proprietors.

The Professional Services Review Scheme provides a system of peer review to determine whether a practitioner is inappropriately rendering or initiating services under Medicare, or inappropriately prescribing under the Pharmaceutical Benefits Scheme.

The Director of Professional Services Review, the Professional Services Review Committees and the determining authority are independent of HIC. Their role is to report on the question of inappropriate practice. If a Committee makes a finding of inappropriate practice against a medical practitioner, the determining authority will decide the sanction to be imposed.

During the year ending 30 June 2003, 52 practitioners were referred to the Director of Professional Services Review. Of those referred, 47 were general practitioners and five were specialists.

Prescribed pattern of service (80/20 rule)

In 2002–03, nine practitioners who had a prescribed pattern of service were referred to the Director of Professional Services Review. A ‘prescribed pattern of service’ occurs when a medical practitioner renders 80 or more professional services on each of 20 or more days in a 12-month period.

Recoveries under the Professional Services Review Scheme

In 2002–03, $150,155.40 was recovered from 10 practitioners pursuant to agreements and final determinations under the Professional Services Review Scheme.

Inappropriate practice

'Inappropriate practice', as defined by section 82 of the Health Insurance Act, occurs where a Professional Services Review Committee could reasonably conclude that a medical practitioner's conduct in relation to rendering or initiating a service would be unacceptable to their general body of peers. For this purpose, a service is either one for which a Medicare benefit was payable or a prescription was written for supply of medication under the Pharmaceutical Benefits Scheme (or supplied by a health care provider).

HIC identifies medical practitioners whose statistics with respect to rendering or initiating services appears abnormal when compared with their peers. HIC's State Case Management Committees review patterns of practice and decide when medical practitioners should be interviewed.

HIC medical, pharmaceutical or optometrical advisers may meet with the medical practitioners for further information and discussion. The interview, also referred to as an intervention, provides the opportunity for the medical practitioner to discuss particular issues with the adviser and explain possible reasons for the pattern of practice.

Following the meeting, any concerns are reconsidered by the State Case Management Committee. In the majority of cases no further action is required.

If after this review, the medical practitioner's servicing remains a concern, a request will be made by HIC to the Director of Professional Services Review to review the provision of services by the practitioner. The Director may decide to:

- dismiss the request;
- enter into an agreement with the medical practitioner to repay Medicare benefits; undertake a period of disqualification from Medicare, or revoke or suspend the authority to prescribe items under the PBS; or
- set up a Professional Services Review Committee comprising the medical practitioner's peers to determine if the medical practitioner has engaged in inappropriate practice.

Summary of counselling undertaken 2002–03

Specialty	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	Total
General practice	212	140	56	67	31	16	0	5	527
Specialists	20	17	8	5	3	2	0	0	55
Optometrists	22	11	7	9	1	1	0	0	51
Total	254	168	71	81	35	19	0	5	633

Compliance audits

HIC monitors payments on claims paid for Medicare through a program of audits.

Post payment audits

HIC conducts an annual program of post payment audits to monitor and evaluate legislative compliance with claiming and payment of claims by HIC. To support the post payment audit process for Medicare, purpose based and source based audits are conducted throughout the year.

Purpose based audits

Purpose based audits are specific, in-depth reviews designed to confirm compliance with the applicable legislation and the MBS. They complement other HIC activities used to address risks to, or abuse of, Medicare. HIC conducts purpose based audits throughout the year; however, the audit results are reported only in the year in which they are completed.

Medicare purpose based audits undertaken during the year involved 188 medical practitioners and 9,277 services. Various levels of non-compliance were found and the total amount of identified recoveries was approximately $0.25 million.

State and National Office audit officers conduct the audits, supported by Medical Advisers within HIC. National consistency is achieved through regular conferences with State audit staff and a common methodology.

Source based audits

Source based audits are a post payment review process used by HIC. Their principal objective is to determine high-risk areas within the Medicare program by verifying all aspects of the claimed service with documents and parties relevant to the transaction, including patients, medical practitioners and HIC processing areas.

A secondary objective is to identify administrative errors; these errors generally do not affect the amount of benefit paid.

Source based audits are used to identify the errors in services examined and to quantify the amount of improper payments made in relation to those services. In the audits conducted in 2002–03, there were no improper payments identified, however, errors without payment implications were identified in the claims examined. This resulted in providers being advised of the errors and counselled where appropriate. Examples included dates of services provided not being advised and tick boxes not checked.

Fraud investigations

HIC uses a participative approach to ensure uniform and consistent guidelines to fraud investigations are implemented nationally and conform with Government best practices.

This is done through the National Central Coordinating Committee which consists of representatives from the Australian Federal Police, Department of Health and Ageing, Department of Veterans' Affairs, the Office of the Director of Public Prosecutions and HIC.

Summary of investigations into fraud 2002–03

Investigations	Total
Public fraud* investigations started (all programs)	112
Public fraud investigations finished (all programs)	122
Practitioner fraud investigations started (all programs)	104
Practitioner fraud investigations finished (all programs)	164
Receptionist fraud investigations started (all programs)	4
Receptionist fraud investigations finished (all programs)	2
Public/provider/receptionist/pharmacist fraud referred to Australian Federal Police (all programs)	1
Public/provider/receptionist fraud referred to State Police	46
Public/provider investigation briefs-of-evidence referred to Director of Public Prosecutions	28

*'Public fraud' refers to patients and members of the public who unlawfully seek to obtain health benefits.

Of Medicare related investigations in 2002–03 the following stand out:

Provider fraud

- In March 2003 in Victoria, Dr Jack Freeman pleaded guilty in the County Court to one charge of defrauding the Commonwealth in relation to approximately $680,000 of fraudulent Medicare claims.
- In April 2003 in Victoria, Dr Michelle Wielicki pleaded guilty to three charges under section 128B of the *Health Insurance Act 1973* relating to the submission of fraudulent Medicare claims.

Public fraud

- In July 2002 in South Australia, Miss D Kennedy was forging accounts/receipts and using them to obtain cash benefits from Medicare. The charges were proved and Miss Kennedy received a three-month suspended sentence and ordered to repay the money.
- In November 2002 in Victoria, Susan Green, a person working for a medical stationery supplier, manufactured false invoices and receipts on which fraudulent payments were obtained from HIC. As a result the offender was sentenced to 12 months imprisonment and ordered to repay the money.

Internal

In October 2002, Sandra Di Filippo, a former HIC customer service operator from Queensland, was sentenced to three years imprisonment with a minimum sentence to serve of four months for defrauding HIC. The money defrauded by the employee was repaid before the the trial.

Provider investigations (PBS)

In September 2002 in Victoria, a major pharmacy investigation was concluded with the sentencing of Thi Xuan Phoung Le to three years imprisonment and an order to repay $350,000.

Training

All HIC investigators will hold Certificate IV Fraud Control (Investigation) qualifications and relevant investigation managers will meet the Commonwealth Fraud Control Guidelines issued by the Attorney-General's Department.

Program Review (PR) desktop

The PR desktop is a national system that supports all aspects of Program Review work in the States and National Office. It is used to record, manage and report on all activities arising from program integrity work.

Medicare Participation Review Committee

Practitioners convicted of offences against Medicare must be referred to the Medicare Participation Review Committee (MPRC) for review of their future involvement in the Medicare scheme. The MPRC can determine if a person, including where relevant, a body corporate, has breached an Approved Pathology Practitioner (APP) or Approved Pathology Authority (APA) undertaking, or has engaged in a prohibited diagnostic imaging practice. Medical practitioners with two final determinations of inappropriate practice under the Professional Services Review Scheme also come before the MPRC.

The Health Insurance Act requires that the MPRC include a legally qualified chairperson and, depending on the matter being considered, two to four members drawn from a pool of medical, optometrical or dental practitioners. The MPRC is administratively supported by HIC but is an independent statutory body.

An MPRC determination can result in five years total disqualification from professional participation in the Medicare Scheme and further action by State and Territory registration bodies. During 2002–03, six cases were referred to an MPRC and three determinations were made. There is a time lag between referral and determination and, as a consequence, matters may span more than one financial year.

Cases referred to the Medicare Participation Review Committee 2002–03

Type of practitioner	No.	Reason
General practitioner	2	Convicted or found guilty of Medicare offences
Pathology company	1	Potential breach of APA undertaking

Determinations by the Medicare Participation Review Committee 2002–03

Determination	No.
Total disqualification for one year and six months	1
Revocation of APA undertaking for three months	1
Reprimanded	1
Dismissed due to out of time appeal by practitioner referred	1

Risk management developments

HIC has developed new Artificial Intelligence (AI) tools to detect anomalies in a number of areas. All systems for diagnostic imaging and general practice were field tested in August 2002 and November 2002 respectively. Initial in-house testing was very promising.

Education and promotion

Community

Medicare information revamped in 2002–03 included: *Medicare — your questions answered*, *Health care for visitors to Australia*, *The Safety Net helps protect you from high medical costs*, the *Medicare Two-way Agency* information sheet and poster, *One easy step to enrol your new baby in Medicare*, and *Welcome to Australia — How to use your Medicare card*.

Your Health Matters continues to provide consumers with information relating to Medicare, including how to claim benefits and the importance of keeping card details up-to-date.

Medical practitioners

Education and information activities for medical practitioners and practice staff included quarterly production of HIC's newsletters *Forum*, *Pathology Notes* and *Health Industry News* — an electronic newsletter developed specifically for private health fund operators, billing agents, software vendors and other interested parties. An upgrade of *Mediguide — a guide to the Medicare claiming system and other health programs administered by HIC* was completed. HIC representatives attended conferences, seminars and presentations for medical practitioners and practice managers.

Communication to medical practitioners on HIC Online occurred through *Forum*, the reference publication *Mediguide*, articles and media releases, national and local conference participation and workshops with Divisions of General Practice. Information kits including sheets and booklets were also produced for medical practitioners and practice managers on the HIC Online claiming channel. An HIC Online helpdesk enquiry line is also in place to answer HIC Online enquiries.

Software vendors

Communication to medical software vendors on HIC Online occurred through the Software Vendor helpdesk, information booklets and guides, consultation with the Medical Software Industry Association and electronic updates.

Customer research

Ninety-three per cent of health consumers indicated they were satisfied with HIC service for Medicare. Ninety-three per cent of consumers who recently visited a Medicare office were satisfied with the experience.

Seventy-three per cent of general practitioners were satisfied with claiming and receiving Medicare payments. Practitioners were also satisfied with HIC's phone services and believe that HIC customer service staff do a good job administering Medicare, PBS and other programs given the growing complexity of the health system.