Rise in Medicare Audits and PSR Oversight

Reading time:
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The Department of Health has increased its random auditing process and government resources to ensure Medicare is not misused by patients or providers. Sophisticated methods for detecting inappropriate practice or incorrect claims have been developed including monitoring and comparing claim profiles and/or habits of healthcare professionals to identify inconsistencies.

Amid broader scrutiny on how healthcare practitioners use rebates, Medicare's enforcement arm, the Professional Services Review (PSR), has increased its capacity to respond to inappropriate practice and billing. Investigations into healthcare practitioners misusing the Medicare Benefit Schedule (MBS) rose by 40% in the last financial year, with practitioners ordered to repay more than $4 million worth of benefits claimed.

Recently, the cost of after-hours doctor subsidies reached $245 million as 10 doctors were referred for investigation. The federal Health Department is pursuing doctors to repay $30 million in erroneous or fraudulent Medicare claims, a jump of nearly 60% from a year before, after ramping up its compliance regime in the year to June. The $30 million in debts 'raised' during 2016-17 showed a sharp increase from the $18.8 million in the previous year.

As well as random screening, Medicare also looks at the potential irregularities in healthcare service patterns. If your services are outside the norm of your peers, you are likely to be investigated.

Under the PSR Scheme 'inappropriate practice' is deemed practice that is NOT medically necessary and clinically relevant. Clinically relevant service refers to 'a service rendered by a medical or dental practitioner that is generally accepted in the medical or dental profession as being necessary for the appropriate treatment of the patient to whom it is rendered'.

How does Medicare monitor?

Some methods Medicare use to monitor include:

- algorithms to monitor and compare the claiming profiles of health professionals to identify inconsistencies
- identifying unusual patterns of item usage and item combinations
- identifying and applying patterns learned from previous cases of non-compliance
- investigating or following up tip-offs

Did you know that you are legally responsible for services billed to Medicare under your Medicare provider number OR in your name?

Avoid inappropriate practice by remembering you are responsible whenever your provider number is used. It comes down to you to ensure you are aware and approve of how your practice, employer or hospital uses your number.

In order to claim with Medicare, a service must not be an excluded service such as cosmetic, it must have been medically necessary, must be supported by evidence in the notes of sufficient medical input. Also, ensure notes are contemporaneous and adequate and they must demonstrate that the conditions of the items number were met.

Legislative requirements (PSR)

An adequate record

All patient records must be clearly identifiable with a separate entry for each attendance. Provide adequate clinical information to explain the service you provide as well as adequate contemporaneous records to enable another practitioner to easily take over.

A contemporaneous record

These must be completed at the time the practitioner renders or initiates service and/or as soon as practicable after rendered/initiated service.

Some common problems

Over-servicing – providing unnecessary or excessive services. Medicare might be charged where there is no or perhaps a questionable need and this, occurs on a regular basis

Billing – item numbers are incorrect or item number descriptor not met. Billing for services without a Medicare benefit. Eg cosmetic procedures and tattoo removal

Clinical – inappropriate prescribing, inadequate history of presenting problem or adequate clinical examination. Failing to address the underlying medical problem such as back pain, providing pain relief, but no treatment framework. Treatment that is unacceptable by your peers or is alternative in nature or outdated will most likely be questioned.

In MIPS' experience members with Medicare issues generally fall into 4 groups:

1. Specialist interest groups
2. Genuinely unaware of transgression
3. Healthcare practitioners 'working the system'
4. Fraudulent

How can MIPS assist?

For qualifying notifications MIPS provides you with clinico-legal advice and/or legal representation/legal defence costs in relation to Medicare audits. However, there will be no membership coverage where Medicare determines that an amount is to be repaid by you or for any allegations concerning/involving fraud or dishonesty.

Some tips

- Committees look more favourably on contemporaneous electronic records and full disclosure (no missing records).
- Urgency rating of consultation must be determined after seeing the patient. Urgency must be demonstrated via active treatment.
- Keep updated with Medicare changes by monitoring relevant industry media channels
- Visit Medicare website regularly to educate yourself and your practice. Control claims made in your name.
- Notify MIPS immediately if contacted by Medicare and remember to always maintain professionalism. Their compliance checks are common and increasing. MIPS can assist you to explain your practice and method of claiming so ensure you are clear and concise. The priority will be seek advice from MIPS' legal representatives and mitigate outcomes.

For further advice visit mips.com.au or call 1800 061 113

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