About us

The Department of Human Services, delivers services for the Australian Government.

Our vision is excellence in providing government services to every Australian.

We are responsible for developing service delivery policy and providing access to social, health and other payments and services through:

- Medicare
- Centrelink
- Child Support

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Presentation outline

At the end of this presentation you will have a better understanding of the Human Services MBS compliance audit requirements and processes that will assist in minimising the risk of noncompliant practices.

Tonight's plan:

- provide a brief overview of the requirements for the items you use
- discuss your responsibilities when claiming through the MBS
- explain the audit process
- discuss some common potential mistakes
- answer questions

APS Australian Psychological Society

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The Medicare Benefits Schedule (MBS)

- outlines Medicare eligible professional services
- lists an item number, a descriptor and schedule fee for each service
- schedule fee's are determined by Government in consultation with relevant health professions

MBS Online

- contains the latest MBS information
- includes explanatory notes which can be accessed by hyperlink from the relevant item number

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MBS Online Website

mbsonline.gov.au

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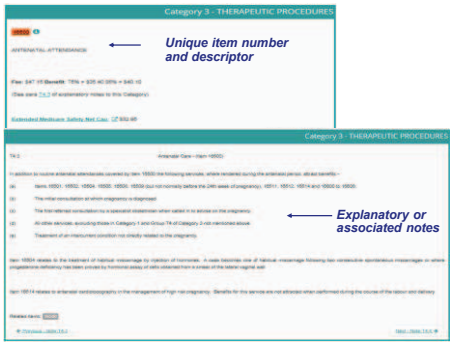
MBS Online - Example

MBS Online – Unique Item number and explanatory notes



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Better Access MBS items			
If you are an eligible	**You can provide**	**MBS Individual Services**	**MBS Group Services**
Clinical Psychologist	**Psychological therapy services**	**80000 – 80015**	**80020**
Psychologist	**Focussed psychological strategies (FPS) services**	**80100 – 80115**	**80120**
Occupational Therapist	Focussed psychological strategies (FPS) services	80125 – 80140	80145
Social Worker	Focussed psychological strategies (FPS) services	80150 – 80165	80170

For full item descriptions, please refer to mbsonline.gov.au

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Provider eligibility requirements

Clinical Psychologists (Psychological Therapy Services)

- registered in the health profession of psychology under the applicable law in force in the State or Territory in which the service is provided and who is:
  - endorsed by the Psychology Board of Australia to practice in clinical psychology.

Registered Psychologists (Focussed Psychological Strategies Services)

- must hold general registration in the health profession of psychology under the applicable law in force in the State or Territory in which the service is provided.

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Eligible patients

A patient must be assessed as having a mental disorder and referred by:

- a general practitioner who is managing the patient under a GP Mental Health Treatment Plan or under a referred psychiatrist assessment and management plan;
- a psychiatrist; or
- a paediatrician.

You can see patients who do not meet the eligibility criteria but Medicare benefits are not payable for these services.

Note: there is no approved referral form to access Better Access psychology services – a referral letter will suffice.

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Calendar year limits

In a calendar year patients can receive psychological therapy services and/or focussed psychological strategies services up to the limit of:

10 individual services and

10 group services

Note: a calendar year is the period from 1 January to 31 December.

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Valid referrals

Psychological therapy and focussed psychological strategy (FPS) services are not eligible for Medicare benefits without a valid referral.

Referral requirements

- The referring practitioner should specify the number of services to be provided per course of treatment (up to a maximum of 6 services in any 1 referral).
- A course of treatment means up to 6 services per referral, or the number of services specified on the referral.
- There may be 2 or more courses of treatment within a patient's entitlement of up to 10 services per calendar year. A second referral is required after the first course of treatment (6 services) has been completed.

Note: allied mental health professionals should not claim Medicare benefits in excess of the patient's entitlement or in excess of the number stated on a referral.

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Course of treatment

Within the maximum service allocation of 10 services, the allied mental health professional can provide 1 or more courses of treatment.

For the purposes of these services, a course of treatment consists of the number of services stated in the patient's referral *(up to a maximum of 6 in any 1 referral).*

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Reporting requirements

- After completing a course of treatment you must provide a written report to the referring medical practitioner.
- Your report must include information that allows them to assess the patient's need for more services and include:
  - assessments carried out on the patient
  - where relevant, the progress made
  - all treatments provided
  - recommendations on future management of the patient's disorder

Note: you don't need to use an approved form to write your reports.

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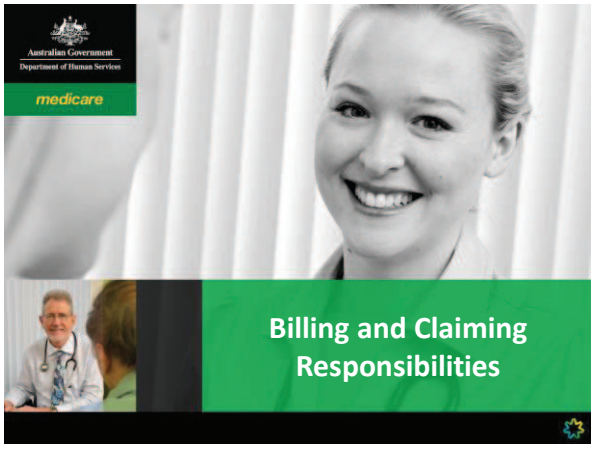

Billing and claiming responsibilities

- An eligible health professional is legally responsible for services billed under their provider number or in their name.
- All services billed must fulfil the requirements in the MBS.
- If incorrect claims are made, the eligible health professional:
  - will be responsible for the repayment of the full amount of incorrect benefits that were paid, and
  - may be required to pay an administrative penalty.
- Advising DHS early of incorrect payments through voluntary acknowledgement will reduce any applicable administrative penalties.

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Consequences of noncompliance

All services billed must fulfil the **requirements** in the MBS. If an eligible health professional is found to have incorrectly claimed benefits:

- they will be responsible for the repayment of the full amount of incorrect benefits that were paid and
- they may be required to pay an administrative penalty

Note: advising Human Services early of incorrect payments may reduce any applicable administrative penalties.

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Good record keeping practices

It is important for health professionals to have good record keeping practices to:

- ensure accurate and secure patient information
- provide transparent reporting
- substantiate claims when participating in Medicare compliance audits

Note: poor record keeping increases risk of incorrect claims and may expose the practice to potential fraud.

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Accurate patient information

For claiming purposes, the Individual Reference Number (IRN) uniquely identifies each individual person on a Medicare card. It appears to the left of the patient's name on their Medicare card.

The IRN is used to assign a service to a patient's Medicare history and approve the payment of the submitted claim. When billing and claiming, it is critical that the IRN selected accurately matches the patient the service was provided to.

When submitting claims you must clearly identify the patient by:

- using the correct IRN when submitting claims via Medicare Easyclaim or Medicare Online and/or
- recording the correct IRN in the 'PATIENT REF. No.' field on the Medicare bulk bill (assignment of benefit) form when manually bulk billing.

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Consequences of using the incorrect IRN

Accurate billing and claiming is your legal responsibility. Incorrectly using an IRN to identify a patient can have consequences for both you as the health professional and for the patient.

Identifying an incorrect IRN on a claim can lead to:

- an incorrectly paid service
- a service being assigned to an incorrect person and
- future Medicare services for a patient not accepted due to a prerequisite item not being correctly billed against the right IRN

Note: under the *Health Insurance Act 1973*, submitting a claim using an incorrect IRN, regardless of intent, is considered making a false or misleading statement, and therefore recovery of paid benefits can be pursued from the provider regardless of who the benefit was paid to.

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More information on billing and claiming responsibilities

For more information refer to the following resources on the Department of Human Services site

- Billing accurately under Medicare
- Medicare billing assurance toolkit
- Administrative record keeping guidelines

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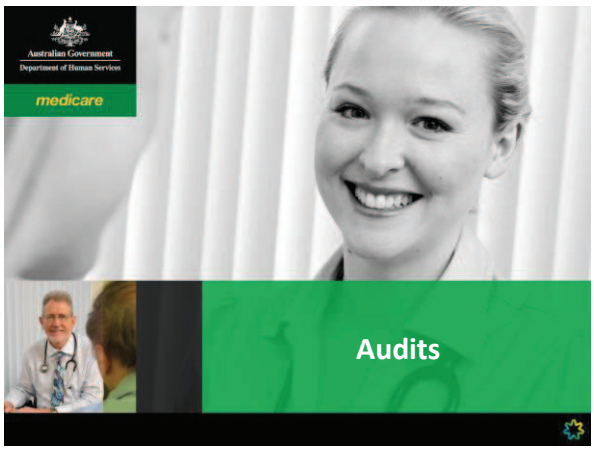

Why does Health Compliance conduct audits?

Health compliance has a key responsibility to protect Medicare payment integrity.

We do this by addressing incorrect claiming as a result of error, abuse or fraud.

To do this we undertake the following four activities:

- **Education and engagement**
- **Audits and reviews**
- **Review of decision / objections**
- **Referrals and prosecutions**

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Our Health Compliance Model

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When do audits happen?

Audits are commenced in situations where the department believes there is a compliance risk.

A compliance risk may be identified through:

- Routine audits conducted on a regular basis
- Data analytics and routine risk assessment processes
- Tip-offs provided to the department

Who do we audit?

You can be asked to participate in an audit if you are a health professional claiming services listed on the MBS.

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What is an audit?

An audit is the department checking to see that claims made under your provider number met legislative requirements. This means that

- You were an eligible provider for the service on the date of service.
- The patient was eligible on the date of service.
- The department paid the benefit claimed.
- The service provided met all legislative requirements of the MBS item claimed.
- You can provide evidence to demonstrate that the service was provided.

If we suspect you are either claiming or billing fraudulently the matter will be investigated and may be referred to the Commonwealth Director of Public Prosecutions.

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Who conducts our audits?

As the decision makers in the audit process, our Compliance Officers are trained and required to apply the principles and rules of natural justice, that is:

- inform any person whose interests may be adversely affected about the decision;
- provide the person affected by the decision with a reasonable opportunity to present their case;
- act fairly and without bias in making decisions
- make reasonable inquiries;
- conduct inquiries or address an issue without undue delay.

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What are common noncompliance issues?

The most common noncompliance issues identified by MBS compliance audits are:

- providers not meeting all of the requirements of the MBS item claimed
- poor record keeping that prevents a health professional from substantiating their claims

What type of information do you need to provide?

The following resources on the Department of Human Services site will assist:

- Medicare billing assurance toolkit
- Guideline for substantiating valid individual Allied Health Services were provided. This addresses MBS items 10968 and 10956
- Guideline for substantiating that a valid Allied Mental Health service has been provided. This addresses MBS items 80000 to 80170 under the Better Access program

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Can patient's clinical information be provided?

- You can provide any document that you feel provides proof that bills issued and claims made under your provider number are correct.
- We don't expect you to supply clinical information unless it's the only way you can substantiate your claim.
- You can censor all information in the documents that is not relevant to substantiating your claim or have the document reviewed by a medical adviser.

Note: you can legally provide clinical information to us. The *Privacy Act 1998* authorises disclosure as required or authorised by law.

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Case Study

Psychologist John Citizen receives a referral from Dr Smith for his new patient Craig.

The referral consists of a copy of the GP Mental Health Treatment Plan and a letter from Dr Smith asking John to see Craig for 10 services.

John sees Craig for 10 services and then sends Dr Smith a written report.

Is John compliant or noncompliant?

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How are you notified of an audit?

We use one of three methods to conduct our audits:

- letter only
- telephone and letter
- telephone, face to face meeting and letter

What won't happen during an audit?

We **won't**:

- arrive at your practice unannounced;
- attend your practice and go through your medical files without your permission;
- ask you to close your practice to conduct an audit.

Exception: Only during a criminal investigation would we arrive at your practice unannounced and if needed, with the authority of a search warrant to seize records/files.

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What if you choose not to provide the information we ask for?

We can issue you with a formal notice to produce documents under section 129AAD of the *Health Insurance Act 1973* for any services rendered on or after 9 April 2011.

Upon receipt of the notice you'll get at least 21 days to respond by providing us with documents to substantiate your services.

What if you choose not to respond to formal notice to produce documents?

If you choose not to respond to a formal notice to produce documents all benefits received for the services on the schedule will be recoverable. Penalties will also apply for any amount owed over $2,500.

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What happens if you are found noncompliant?

If you are found noncompliant during an audit you will receive a notice of decision letter advising

- Which services were found noncompliant and why (e.g. incorrect payment or unsubstantiated service)
- That amounts are recoverable for the noncompliant services
- Whether or not administrative penalties will apply and why
- Your review of decision rights

If you don't respond or apply for a review of decision within 28 days we will send you a debt notification letter that will include any penalties payable.

For more information about administrative and civil penalties refer to the following resource on the Department of Human Services site

- Medicare compliance audits and reviews

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What if you want a decision reviewed?

To apply for a review of decision you must:

- have undergone a compliance audit
- have a letter from the department issued within the past 28 days stating that the amounts are recoverable as a result of a compliance audit
- be seeking a review of decision to recover amounts
- not had the decision reviewed previously
- be able to submit new and additional information with the application to support your claim that the amounts that have been paid are correct, and
- complete the approved Review of Decision form

The approved Review of Decision form can be found on the Department of Human Services site under the title - Application to Review Compliance Audit Decision form.

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What preparation should you do?

The best preparation you can do is make sure you meet the requirements of the MBS before you claim.

We also recommend you maintain good administrative record keeping standards within your practice.

If you know you've met the MBS item requirements and have the appropriate records to substantiate the claim then you'll always be prepared if you're asked to participate in a Medicare compliance audit.

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How to report suspected fraud:

Calling:

13 15 24* - *(Mon to Fri between 9.00am - 5.00pm AEST)*

Printing the Reporting Suspected Fraud form and faxing it to:

1300 657 239*

Printing the Reporting Suspected Fraud form and mailing it to:

Customer Compliance Branch
Business Integrity
GPO Box 9822
Sydney NSW 2001.

Forms available from: www.humanservices.gov.au/customer/information/fraud-and-security

**Call charges may apply*

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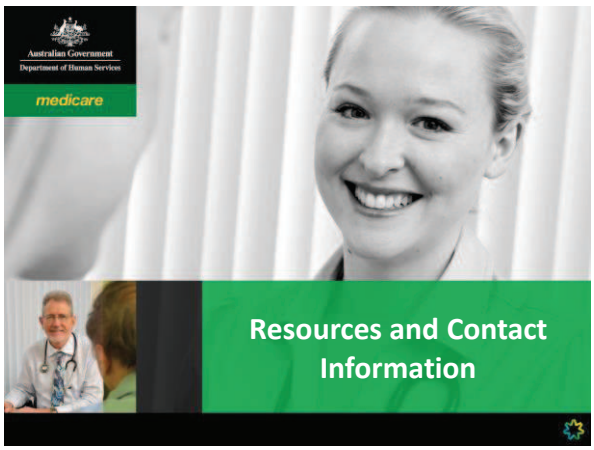
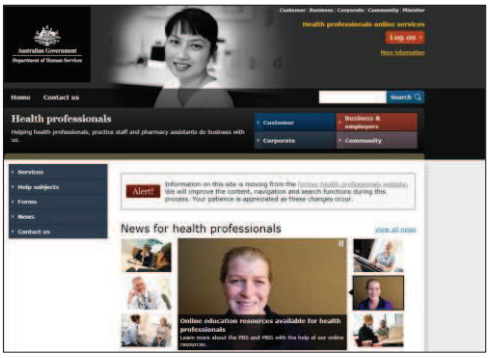
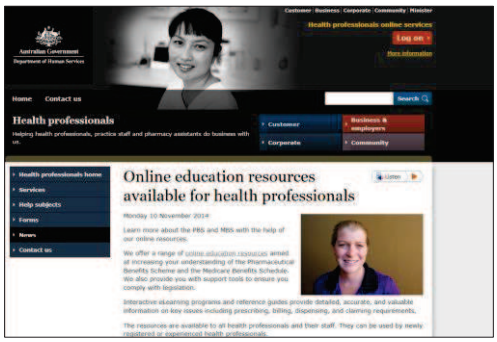


Compliance within Medicare – eLearning program

Medicare for health professionals



Online education services



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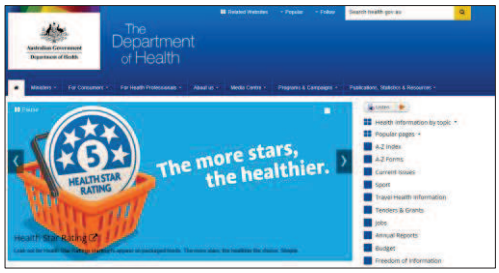
Department of Health



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For more information

*Phone **132 150** Medicare provider enquiries, call charges may apply*

humanservices.gov.au website

Education resources at humanservices.gov.au/hpeducation

Post to:
Department of Human Services
PO Box 9822
[Your capital city]

Email askMBS@humanservices.gov.au for questions on
MBS item interpretation

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Disclaimer

The information in this presentation is intended for guidance only.

The health programs administered by the Department of Human Services are regulated by Commonwealth legislation and/or policy guidelines.

As a health professional, you need to determine how this information applies to your particular circumstances.

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