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WRITTEN QUESTION TO THE MINISTER FOR SOCIAL SECURITY
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ANSWER TO BE TABLED ON TUESDAY 20th NOVEMBER 2012

Question

1. How many rebates were claimed by GPs for the year 31st October 2011 until 31st October 2012 and at what cost?

2. How much of the cost was associated to referral letters?

3. What checks and measures were made to ensure only legally allowable claims were made? How frequently have these checks been made in the last 10 years and in what form? Has evidence of other practices been looked for or found? If so, what action was taken?

4. How many, if any, were found to be incorrect claims (e.g. requesting X-rays or "telephone consultations", etc) during the period October 2011 to October 2012?.

5. Are there any other doubtful claims for rebate payments being made? For example are two claims (one for the prescription and to administer it) being made to give one flu vaccine? If this has happened, what has been the cost to the Health Insurance Fund in total and per signature rebates? What action has been taken?

6. What measures have been taken in relation to false claims and what monies have been recovered?

7. If evidence is found that false claims have been made what action will be taken against such claimants?

Answer

Information has been provided for the period 1 October 2011 to 30 September 2012. Whereas most rebate claims from GPs are submitted and paid within a few weeks of the consultation, a time period of up to six months is allowed for these claims to be submitted. The figures reported below represent rebates that have been processed up to the date of the data extract, and will be subject to change as additional claims are processed.

The rate of medical benefit between 1 October 2011 and 26 June 2012 was £19.59. Since 27 June 2012, the value of the benefit has been £20.28.

Currently, 409,000 claims have been paid at a cost of £8.06 million for the year to 30 September 2012

Of this total, the total costs associated with medical benefits provided for letters of referral was £0.99 million.

Claims are checked automatically using embedded business rules within the Department's IT system before processing and invalid claims are rejected, according to those business rules. These rules include automatically rejecting multiple claims for the same consultation and alerting the Department if a patient has more than one visit/claim within 24 hours from a single surgery. In the latter scenario, payment is not made unless the surgery can confirm that it is a genuine instance of 2 separate claims. When claims are rejected, this information is provided to the GP, as each batch of claims is paid.

In addition to these automatic checks which are applied to every claim submitted, the Department undertakes periodic random checks on claims by confirming details with the individual patient, by either letter or phone call. The Department also writes directly to surgeries, again on a random basis, to confirm details of claims. Checks are also specifically undertaken in respect of patients with high numbers of consultations.

A Medical Director has recently been appointed to lead the Primary Care Governance Unit and he has already undertaken a number of visits to local practices to ensure that best practice is being followed and has initially focussed upon practices with high levels of consultation or referral letters

Between 1 October 2011 and 30 September 2012 2,438 claims were disallowed.

The claims submitted by GPs include information on the identity of each patient and the date and time of their consultation. If a GP were to falsify claims, this might amount to fraud and could be referred to the Police for investigation accordingly.