Australian Government
Professional Services Review

PSR PANEL NEWSLETTER

April 2019

SUBMISSION TO AGED CARE ROYAL COMMISSION

PSR has made a submission to the Aged Care Royal Commission in relation to the need for standards in respect to nursing home notes. Recent PSR Committees have experienced difficulty where a nursing home has an inadequate system for storing medical records and the practitioner cannot be held responsible for poor or missing nursing home notes.

EXTERNAL AGENCY REVIEW

The external agency review has been completed and PSR management are implanting recommendations. Overall the report was extremely positive and no major issues were identified.

DEMOGRAPHICS OF PSR PANEL MEMBERS

In the past two years there has been a significant attempt to broaden the membership of the PSR Panel. The Panel sunk to a low of only 28% female membership in 2016 and had limited diversity in terms of rural practice and overseas born members. I am pleased to report that following an attempt to broaden membership, the PSR Panel is now one of the most balanced and diverse in the Health portfolio. A summary table is presented opposite.

Gender	
Female	43%
Male	57%
Place of Birth	
Australia	73%
Overseas	27%
Areas ever practised	
Inner metropolitan areas	43%
Outer metropolitan areas	68%
Rural areas	65%

FEDERAL COURT UPDATE

Nithianantha v Commonwealth of Australia & PSR Committee No. 936 [2018] FCA 2063

Dr Nithianantha sought judicial review of certain aspects of the Final Report of a PSR Committee, which, among other things, had found that he had breached the 80/20 rule in rendering 80 or more attendance services on each of 28 days in a 12 month period, and had engaged in inappropriate practice in billing MBS item 597 (urgent after-hours attendances) when the patients he attended had not actually required urgent treatment.

The 80/20 rule

Regulation 11(b) of the *Health Insurance (Professional Services Review) Regulations 1999* provides that the absence of other medical services for a practitioner's patients is deemed to be an exceptional circumstance for the purposes of the 80/20 rule.

Dr Nithianantha had put the case to the Committee that there was an absence of other medical services for his patients in the remote rural town in which he practised, and that this constituted an exceptional circumstance. The Committee had rejected that case on the basis of oral evidence given by the practice manager of the only other general practice in that town.

In Court, Dr Nithianantha submitted that the Committee had failed to consider whether the services of the other practice were a readily and reasonably available alternative for Dr Nithianantha's patients; that it could not make that inference from the practice manager's evidence; and that it had failed to consider whether another medical practitioner was available on each of the 28 days on which he claimed exceptional circumstances. The Court rejected each of these submissions.

The Court held that the Committee was correct in its view that once the evidence establishes that the practitioner had rendered 80 or more attendance services on 20 or more days in a 12 month period, there

is a practical onus on the practitioner to establish that there was an absence of alternative medical services for the practitioner's patients on any of those days if that is the exception to the 80/20 rule relied on by the practitioner.

Dr Nithianantha had put his case on the basis that there was an absence of other medical services for his patients on each and every day in the 12 month review period. The evidence of the practice manager contradicted the evidence given by Dr Nithianantha, and the Court held that it was open to the Committee to prefer the evidence of the practice manager as she had direct knowledge of her practice's staffing and willingness to accept patients from Dr Nithianantha's practice during the review period. The Court said:

'As the evidence stood and having regard to how Dr Nithianantha put his case, it did not require speculation, assumption or guesswork on the part of the Committee to conclude that there was not an absence of medical services for the applicant's patients during the review period for the purposes of reg 11(b). That finding was founded on cogent evidence from a person in a better position to give it than either Dr Nithianantha or Mr Cracknell [a local government councillor, who had made a statement in support of Dr Nithianantha].'

In its Final Report, the Committee did not specifically make a finding with respect to whether there were exceptional circumstances on each of the individual 28 days, but made a finding in respect of the review period as a whole. The Court rejected Dr Nithianantha's submission that the Committee had erred. The Court noted an observation by Greenwood J in *Tisdall v Webber* (2011) 193 FCR 260 that it is likely that a practitioner who seeks to rely on reg 11(b) will adopt the course of attempting to show that the exceptional circumstances existed throughout the whole of the relevant period because it is likely to be forensically difficult to satisfy a committee that there was an absence of medical services for the practitioner's patients on individual days. This was the approach that Dr Nithianantha had taken before the Committee.

The Court said that where a practitioner relies only on reg 11(b), it is only if exceptional circumstances are made out by evidence which allows the Committee to conclude that reg 11(b) is satisfied that it is possible to move to the next step. The next step is the determination of whether the Committee could reasonably conclude that those exceptional circumstances existed on some or all of the days on which 80 or more professional attendances were rendered *and* that they affected the rendering of those services by the practitioner. In this case, in which the Committee had found that there were no exceptional circumstances on the basis of the evidence before it, it was not required to seek out further evidence in respect of any of the 28 days.

In submissions in response to the Committee's Draft Report, it was suggested that on 11 of the 28 days, Dr Nithianantha had rendered urgent after hours services, which took him over the 80 services. In response, the Committee made the comment in its Final Report that on each day where Dr Nithianantha had provided 80 or more attendance services, he had billed health assessment items or chronic disease management items, and that it was not correct for Dr Nithianantha to claim that he rendered more than 80 services on those days simply because he rendered after-hours consultations on certain days.

The Court noted that whether or not Dr Nithianantha could have better organised his practice is an irrelevant consideration for the purposes of establishing 'exceptional circumstances' under reg 11(b). Nevertheless, the Court said that the Committee had already found that there were no exceptional circumstances, and that it did not need to establish that doctors from the other practice were in fact in the town and available on the 11 days referred to in the submission. Dr Nithianantha's lawyer had the opportunity to cross examine the practice manager at the hearing on that issue but did not do so, and did not address this issue in submissions after the hearing.

Urgent after-hours attendance – MBS item 597

It was submitted by Dr Nithianantha that the Committee had misinterpreted the requirements of MBS item 597 in relation to the time at which 'urgency' is to be assessed. He submitted that it is enough if, when he formed the opinion that urgent treatment was required, that opinion would have been acceptable to his peers 'in the circumstances that existed and on the information available when the opinion was formed', even if it turns out that the patient requires treatment for a different, non-urgent condition which is diagnosed during the consultation.

The Court rejected that approach, and said that the term 'requires' where used in the item and in reg 2.15.1(1)(a) is not susceptible of meaning 'might require'. The Court said that before the consultation, the practitioner can only form a view, having regard to the circumstances which have been conveyed to him or her by someone who may not be the patient. The best the practitioner can do at that point is form a view of what might be required at that time, not what is required. What is required can only be determined following consultation which can, if necessary, include examination.

The Court noted that it is true that the doctor must, at the time he or she receives a call requesting an attendance, make the decision whether to provide the attendance. While there would be a plain unfairness if the practitioner were not to be remunerated at all for after-hours effort, that is not the effect of the scheme of regulations. This is reflected in the different after-hours period rates in Group A11 and Group A22 of the MBS.

The Court also rejected an argument that the existence of a debate among practitioners regarding the time at which the urgency test is to be determined meant that it was not open to the Committee to find that Dr Nithianantha's conduct in billing the item would be unacceptable to the general body of general practitioners. The Court noted that the Committee, who were also general practitioners, was in a position to form a view of whether the claims made by Dr Nithianantha under MBS item 597 would be acceptable to the general body of members of that profession having regard to their interpretation of that item, and reg 2.15.1, notwithstanding that some practitioners may have a different view.

Dr Nithianantha's application for judicial review was dismissed.

NEW PSR REGULATIONS

The last newsletter advised of new *Health Insurance Regulations 2018* replacing the *Health Insurance Regulations 1975*. Consistent with the recent legislative requirement that all regulations must either lapse or be renewed at least every ten years, the PSR Regulations have also been updated. On 23 February 2019, The *Health Insurance (Professional Services Review) Regulations 1999* were replaced by the *Health Insurance (Professional Services Review Scheme) Regulations 2019* (the **PSR Regs**). The PSR Regs contain:

- the definition of 'adequate and contemporaneous record'
- the '80/20 rule'
- the circumstances that are deemed to be 'exceptional' for the purposes of the '80/20 rule'
- the allowances payable for witnesses at PSR Committee hearings
- the regulatory and other bodies to which the Director can make a referral.

The standards for 'adequate and contemporaneous records' have not essentially changed, but have been clarified. Formerly, there was some confusion with the use of the words 'entry' and 'record'. The new regulation more clearly indicates that 'record' refers to the whole patient record, and 'entry' refers to the entry made in respect of a particular service. The new regulation states:

6 Standards for adequate and contemporaneous records

For the purposes of the definition of adequate and contemporaneous records in subsection 81(1) of the Act, the standards for a record of the rendering or initiation of services to a patient by a practitioner are that:

(a) the record must include the name of the patient; and

(b) the record must contain a separate entry for each attendance by the patient for a service; and

(c) each separate entry for a service must:

(i) include the date on which the service was rendered or initiated; and

(ii) provide sufficient clinical information to explain the service; and

(iii) be completed at the time, or as soon as practicable after, the service was rendered or initiated; and

(d) the record must be sufficiently comprehensible to enable another practitioner to effectively undertake the patient's ongoing care in reliance on the record.

While the new legislation applies to all matters to be decided by Committees on and from 23 February 2019, Committees that are assessing the conduct of practitioners that occurred before that date should *also* consider whether the result might be any different if the previous regulations were applied. If it could be said that a person under review had an accrued right to have the previous law apply to them and they would benefit from the application of the prior law, they should be given that benefit. While there was no intention to change the law by the rewriting of the regulations, there might be a different nuance in the language that could possibly affect the outcome in a particular case.

Similarly, in relation to the 80/20 rule and the deemed exceptional circumstances, while the text has slightly altered, the intention of the new PSR Regs was to make the meaning clearer rather than change it.

YEAR TO DATE CASES AND RECOVERIES

In the period 1 July 2018 to 31 March 2019:

- PSR received 74 new requests
- 66 agreements between the practitioner and the Director
- 6 final determinations
- 2 s 91 'no further action' outcomes
- $21.1M in total repayment directions resulting from the resolved matters
- 47 of the resulted matters involving some form of disqualification

TRAINING DAYS

Training was held for new PSR Panel members on Saturday 9 February 2019. Training covered legislation, procedural matters, privacy requirements, administration and mock hearings.

Training days for established PSR Panel members will be held on 4 and 11 May 2019.

The Saturday 4 May session is being held in Melbourne at the Stamford Plaza Melbourne, 111 Little Collins Street from 9:00-3:00pm.

The Saturday 11 May session is being held in Sydney at the Stamford Plaza Sydney Airport, Corner of Robey and O'Riordan Street from 9:00-3:00pm.

The agenda will be distributed soon and will include an update on PSR processes and a guest speaker discussing interviewing techniques.

POLICY ON NAMING PUR

The PSR is reviewing its policy on naming of practitioners. It is seeking input from multiple parties. If you wish to have input please send an email to Madeleine at madeleine.roberts@psr.gov.au by 30 April 2019 and I will view collated responses and finalise the policy at that time.

PUBLIC SERVICE REVIEW

A major review of the public service was implemented in 2018 and a series of recommendations developed. The PSR have reviewed these and determined that 23 of the 52 recommendations impact on the PSR. The PSR Management Committee have developed a work plan to implement these recommendations over the next 12 months.

PRIVATE HEALTH AUSTRALIA (PHA) LOW VALUE INTERVENTIONS ANALYSIS

PHA has undertaken a prevalence analysis of interventions agreed to be of low value by international clinical experts. This work aligns with that performed by the Choosing Wisely initiative which has been operating in Australia since 2015, supported by 37 medical professional groups. The root cause of low value care was found to be multi-factorial. Some of the causative factors were:

- Health system design issues which make it difficult to provide the appropriate care in the right setting, or which create a perverse incentive which drives low-value care. For example, referring a patient to hospital because the more appropriate outpatient setting would generate a co-payment;
- Gaps in training and feedback where clinicians have not changed their practice or upgraded their skills in light of the best available evidence.

PSR Committees are tasked to consider whether a service is clinically indicated as part of the evaluation of inappropriate practice, and consideration of low value intervention and service frequency may be relevant considerations.

TRAMADOL – A WARNING

PSR Committees are often tasked with reviewing prescribing. Yet another large study has warned of the increased risk of death with inappropriate prescribing of Tramadol. PSR Committees should note these reports in considering whether practice is inappropriate.

A large cohort study of 88 902 patients with osteoarthritis found that initial prescription of tramadol was associated with a significantly increased risk of mortality over 1 year compared with initial prescription of naproxen (hazard ratio [HR], 1.71), diclofenac (HR, 1.88), celecoxib (HR, 1.70), and etoricoxib (HR, 2.04), but not compared with codeine (HR, 0.94).

The authors concluded that Tramadol prescription may be associated with increased all-cause mortality compared with commonly prescribed nonsteroidal anti-inflammatory drugs.

USE OF OPERATING MICROSCOPE IN EAR SURGERY 41647

A number of general practitioners and OMPs have purchased a microscope and have started to bill item 41647 for removing ear wax. This items reads:

EAR TOILET requiring use of operating microscope and microinspection of tympanic membrane with or without general anaesthesia.

I have taken advice from several sources including ENT specialists and MBS advisory committee members and I am advised this item is only for billing in association with ENT surgery and hence the anaesthetic affixation to indicate an anaesthetic can be billed with the use of the item. I am advised it is for the purpose of pathology involving middle ear and tympanic membrane and erosive otitis externa. The item is for use when it is necessary to extract debris from around the perforated tympanic membrane without causing damage to middle ear structures or to assist in clearing debris when operatively managing tumours or erosive infections.

It is not for use in association with ear syringing for wax in the rooms.

Given this advice was uniform and clear cut, and the PSR is now applying this at the Director stage review, I thought I would pass it on to members.

SCOPE OF PRACTICE CONSIDERATIONS

A number of general practitioners and OMPs have begun billing for extensive flap repairs, skin grafting and removal of underlying bone or cartilage and surgical management of invasive melanoma.

Quality and safety are important components to consideration of inappropriate practice and one key role of the PSR is to protect patients from the harm of inappropriate practice. As Director I take this role very seriously.

In considering whether it is appropriate practice, Committees might consider whether the training and qualifications of a practitioner under review are equivalent to those that would apply to practitioners who perform equivalent procedures in a public hospital setting.

If the answer is that the practitioner under review is unlikely to receive accreditation to perform these procedures in public hospitals on public patients, then consideration should be given as to whether the performance of such procedures represents inappropriate practice because a practitioner is practising outside the general body of the professions understanding of appropriate scope of practice.

Safety comes first.