Australian Government
Professional Services Review

PSR PANEL NEWSLETTER

August 2018

COMMUNICATION WITH THE PROFESSION

Regular newsletters have been sent to Professional Services Review (**PSR**) Panel members since 2016. Following a meeting with medical indemnity, private hospital and private insurance officers, I have decided to make these newsletters public. They will now be available on our website.

This measure adds to our communication engagement strategy, which includes:

- regular meetings with stakeholders
- speaking at conferences
- regular meetings with the Australian Medical Association and Medicare Compliance staff
- publishing case outcomes and
- providing formal feedback in the agency's annual report tabled in Parliament.

I am also in the process of amending the PSR website (www.psr.gov.au). Publishing case outcomes was a new initiative last year to inform the profession about cases resolved by PSR. To highlight this initiative, the case outcomes will now be more accessible from the main interface of the website. New tabs on the main interface will also delineate advice on procedural issues for practitioners as opposed to employers/ corporations who are referred to PSR.

We have also revised the practitioner guide booklet to make it simpler and shorter, and are developing an employer/corporation booklet to assist non-practitioners referred to PSR.

CORPORATE REFERRALS LEGISLATIVE AMENDMENTS

Amending legislation has now passed both Houses of Parliament making minor changes to PSR's powers surrounding the review of employers and/or corporate practices. These amendments came into effect on 1 July 2018.

TRAINING DAYS

Thank you to the Panel members who were able to attend the training days for PSR Panel members in the last quarter. These were held in Sydney and Melbourne and most members attended. Issues covered included an update on privacy awareness, topical matters arising in PSR matters, and procedural issues in Committee hearings.

DETERMINING AUTHORITY

Following an advertised recruitment process, the Minister for Health appointed new Determining Authority Members and a new Chair in May 2018. These appointees bring experience in both rural and metropolitan general practice, as well as psychiatry, community health and veteran's health. A training day for these appointees has been held and the Determining Authority has already held several meetings.

CLARIFICATION OF AUTHORSHIP OF LETTERS TO PRACTITIONERS FROM MEDICARE

Recently, the Medicare Compliance division sent a large volume of letters to practitioners in relation to prescribing Schedule 8 drugs and the rendering of selected MBS item numbers. A number of people have contacted me about this. PSR is separate from the Medicare Compliance division and had no role or input into those letters.

URGENT AFTER HOURS

There are now a number of finalised cases relating to practitioners whose provision of urgent after hours items was referred to PSR. Some common themes have emerged from those cases. These include that inappropriate practice may be found if one or more of the following are present:

- A poor history (this includes findings over failure to document smoking status, allergies, relevant comorbidity, current medications, and to identify the red flags specifically excluded in the presentation)
- A poor examination (this includes findings over failure to examine key systems involved in the presentation and specifically exclude serious concerns)
- Failure to make a diagnosis or list a differential diagnosis (this includes findings over merely repeating the presenting symptom such as a sore wrist, a painful shoulder, a sore back, a cough or abdominal pain, without making a diagnosis)
- Inappropriate management (this includes findings over prescribing second tier antibiotics when there is no evidence of antibiotic resistance and/or where doing so is contrary to Australian antibiotic guidelines, or prescribing strong analgesic medication or benzodiazepines without clear cause)
- Treatment was not required urgently and could have been deferred to the next in hours period. This includes findings that consultations involving:
    - ◊ upper respiratory tract infections in patients with no underlying respiratory comorbidity
    - ◊ viral gastroenteritis
    - ◊ rashes
    - ◊ medical certificates
    - ◊ otitis externa or interna in patients with no underlying ENT comorbidity or
    - ◊ filling prescriptions for patients who have run out of medication

may not be urgent.

Any finding of inappropriate practice, however, depends on the unique situation of each consultation and the particular conduct of the person under review.

CONDUCTING A FAIR AND EFFECTIVE HEARING

I recently attended the 2018 Administrative Appeals Tribunal Annual Conference. A paper presented at that conference by Ms Anne Britton titled 'Conducting a fair and effective hearing' provides useful advice. The paper outlines the habits of effective tribunal members as well as principles, red flags and tips for effective questioning. I commend the paper to you, which is attached to the email circulating this newsletter.

APPROPRIATE PRESCRIBING AND LOW BACK PAIN

I would like to draw your attention towards the outcome of Choosing Wisely in respect to the management of low back pain and prescribing. Please find an extract summarising the key recommendations about the management of back pain on the following page.

Professor Julie Quinlivan
Director, Professional Services Review

EXTRACT FROM 'CHOOSING WISELY':

1. Avoid prescribing opioids (particularly long-acting opioids) as first-line or monotherapy for chronic non-cancer pain (CNCP)

The true place of opioids in chronic non-cancer pain (CNCP) is unknown. Most trials of their efficacy have been of less than twelve weeks duration and have shown only modest effects. By contrast opioid use in CNCP has been associated with increased distress, poorer self-rated health, inactivity during leisure, unemployment, higher healthcare utilisation and lower quality of life, suggesting failure to appreciate the complex nature of these conditions.

Opioids should not be used alone or as analgesics of first choice in patients with CNCP. A trial of opioid may be indicated in some patients, according to published guidance. If such an opioid trial is undertaken, then a long-acting preparation should be prescribed, in conjunction with non-drug therapies – physical, behavioural and cognitive – that promote functional restoration, reduce distress and potentially lower pain intensity.

2. Do not continue opioid prescription for chronic non-cancer pain (CNCP) without ongoing demonstration of functional benefit, periodic attempts at dose reduction and screening for long-term harms

Comprehensive assessment of patients with CNCP is essential before prescribing an opioid. An opioid 'contract' should describe the purpose of the prescription and would include agreed criteria for functional improvement, risks and side-effects of opioid analgesics, and ground rules regarding their use and cessation. There should be a single prescriber (and a deputy) to take responsibility for opioid prescription, in accordance with the regulatory requirements of the relevant jurisdiction.

3. Avoid prescribing pregabalin and gabapentin for pain which does not fulfil the criteria for neuropathic pain

The IASP definition of neuropathic pain (2011) requires demonstration of a lesion or disease of the somatosensory system. In effect, that means demonstration of neurological signs. Descriptors that may suggest the pain may be neuropathic, such as burning, painful cold, electric shock-like etc., on their own do not meet this criterion.

Pregabalin has a restricted PBS authority for 'neuropathic pain'. Although the definition being applied is not stated in the PBS Authority listing, use of the 2011 IASP definition is recommended. As with any pharmacotherapy used in pain medicine, the outcome of a trial of pregabalin or of gabapentin should be judged by improvement in everyday physical, emotional and cognitive functioning, including activity, sleep, absence of adverse effects, and improvement in quality of life.

4. Do not prescribe benzodiazepines for low back pain

Lifetime prevalence of low back pain in Australia is reported to be as high as 80% with one in ten experiencing significant activity limitation.

Although benzodiazepines continue to be commonly prescribed as 'muscle relaxants' for low back pain (LBP), there is an absolute lack of evidence of benefit for this indication. Only one RCT has been conducted on diazepam in acute LBP during the last 40 years, and it showed no additional benefit when added to NSAID therapy alone. A recent systematic review found no additional studies to support the use of benzodiazepines in treating acute or chronic back pain.

Well-described risks are associated with benzodiazepine usage, including abuse, addiction, tolerance and overdose. Accidental death from pharmaceutical benzodiazepines in Australia were highest in the 40-49 and 30-39 year age groups. The number of deaths in the older age groups also remains high.

There is no place for use of benzodiazepine for low back pain.

5. Do not refer axial lower lumbar back pain for spinal fusion surgery