

FLORAL
CREST
HERE

**PROFESSIONAL
SERVICES REVIEW**

**ANNUAL REPORT
1996-97**

© Commonwealth of Australia 1997

ISSN 1327-6514

This work is copyright. Apart from any use as permitted under the Copyright Act 1968, no part may be reproduced by any process without prior written permission from the Australian Government Publishing Service. Requests and inquiries concerning reproduction rights should be directed to the Manager, Commonwealth Information Services, Australian Government Publishing Service, GPO Box 84, Canberra ACT 2601.

Copies of this report and further information can be obtained from:

The Executive Officer
Professional Services Review
Telephone: 02 6285 1651
Facsimile: 02 6285 1762

PO Box 136 Yarralumla 2600
16 Bentham Street Yarralumla 2600
TEL: (02) 6285 1431 FAX: (02) 6285 1762

CONTENTS

	Page No.
OBJECTIVE	1
DIRECTOR'S REPORT	2
DETERMINING OFFICER'S REPORT	17
CHANGES TO THE LEGISLATION	21
CASE SUMMARIES	23
CORPORATE OVERVIEW	33
APPENDIX 1: Financial Statements	40
APPENDIX 2: Summary Table of Resources	57
APPENDIX 3: Financial and Staffing Resources Summary	58
APPENDIX 4: Freedom of Information Statement	59
APPENDIX 5: Legislative Overview	61
APPENDIX 6: Process	64
APPENDIX 7: Glossary	70
APPENDIX 8: Abbreviations	71
COMPLIANCE INDEX	72

INTRODUCTION

The Director of Professional Services Review is a statutory officer appointed by the Minister for Health and Family Services to manage the process whereby the conduct of a person, who is involved in rendering or initiating services which attract a Medicare rebate, can be examined to ascertain whether *inappropriate practice* is involved.

- Inappropriate practice is defined in the *Health Insurance Act 1973* as conduct that is unacceptable to the general body of the members of the profession or speciality in which the practitioner was practising when he or she rendered or initiated the services in question.

The Director's caseload is dependent upon the Health Insurance Commission investigating instances of suspected inappropriate practice, preparing the case and referring it to the Director for consideration. If the Director decides the person does have a case to answer, a peer review process is initiated. This peer review is conducted by committees with membership drawn from a panel comprising nominees of relevant professions who are appointed by the Minister.

The Professional Services Review was established as a prescribed authority to assist the Director to carry out the functions which are detailed in Part VAA of the Professional Services Review Scheme in the *Health Insurance Act 1973*.

OBJECTIVE

To examine, impartially and expeditiously, cases of suspected inappropriate practice referred by the Health Insurance Commission.

DIRECTOR'S REPORT

In its third year the Professional Services Review (PSR) experienced an increasing caseload referred by the Health Insurance Commission (HIC).

I remain of the belief that the PSR Scheme has continued to build on the promising start noted in last year's Annual Report. I am further encouraged by the activities and results of the past year and the commitment and support of the process by the professional members of the PSR Panel.

I am convinced that the PSR Scheme is performing the function envisaged, by the Parliament, at its establishment.

There is increasing support for the Scheme from the wider professional community as a fuller understanding and appreciation of the process and its aims spreads. Invitations have been accepted to address various professional groups on issues relevant to the PSR process where concerns can be expressed and questions answered. Such activity ensures the process becomes more transparent and accepted.

The requirements for privacy and confidentiality are well understood and practiced by all involved and this limits the extent, to date, of wider publicity. It is only when a practitioner appeals to the Professional Services Review Tribunal (PSRT) or the Federal Court that the name of the referred practitioner can be made public. In the past year considerable publicity occurred when the PSRT issued Determinations resulting from the hearing of appeals by two practitioners against whom adverse findings had been made by Professional Services Review Committees (PSRCs).

The HIC continues to advise that the PSR Scheme and the publicity generated to date have acted to encourage positive changes in the behaviour of practitioners following counselling visits by its medical advisers.

In the year to 30 June 1997, the HIC referred the conduct of 70 practitioners to the Director of Professional Services Review. PSRCs were established in 30 cases under s.93 of the Act, three referrals were dismissed

PSR Caseload

Table 1 shows the increase in the number of referrals received from the HIC over the past year with 50 out of 70 received in the six months from January to June 1997. This increased workload has obvious effects on the capacity of the PSR process to deal expeditiously with the cases referred.

The Act, under which the PSR operates, currently has a limit of 15 Deputy Directors who may be appointed by the Minister—there is currently a full complement, of whom 10 are medical practitioners. The PSR Panel currently comprises 152 members (exclusive of the Deputy Directors) and, of these, 53 are general medical practitioners.

It is vital for the credibility of such a peer review process that these Deputy Directors and Panel members should be engaged in clinical practice. Therefore, they have constraints on the time available to devote to interests other than their professional clinical activities. The time commitment of the Deputy Directors is even more substantial than that of the other Committee members.

Many Deputy Directors and Panel members have indicated they would not be available to serve on more than four or five PSRCs in any one year. Indeed, some members would be unable to give that time commitment. It thus becomes obvious that, with the current number of Deputy Directors, there is a limit to the number of cases that can be dealt with in any one year—approximately 50 to 60.

A similar constraint exists with the secretariat but this can be more easily overcome by engaging additional personnel either on a permanent or, more likely, a temporary/contract basis. Agreement has been reached with the Department of Finance regarding this arrangement.

It is important, therefore, to appreciate that the availability of professional members is the limiting factor to the number of cases that can be addressed. All involved in the PSR process are cognisant of Parliament's intent that referred cases be handled expeditiously so early resolution of perceived concerns can occur.

However, even during the period of the hearings, members of the PSRC often have professional and personal commitments so delays do occur and it has been found difficult, in many cases, to maintain the time periods as provided for in the legislation.

All but one of the referrals received up to 30 June 1997 have involved services performed by medical practitioners engaged in general medical practice.

One referral was received regarding services performed by an optometrist but this referral was subsequently dismissed under s.91 of the Act. Shortly after 30 June 1997, a referral was received regarding the conduct of a specialist medical practitioner.

No referrals have been received which involve services of the other professional groupings covered by the PSR Scheme, namely, dentistry, physiotherapy, chiropractic or podiatry.

Section 91 Dismissal

Section 91 of the Act allows the Director to dismiss the referral if 'he or she is satisfied that there are insufficient grounds on which a Committee could reasonably find that the person under review has engaged in inappropriate practice in connection with the referred services'.

When a referral is forwarded to the person under review by the HIC it is accompanied by a copy of the relevant section of the legislation and a notice inviting the practitioner to forward a written submission to the Director addressing the reasons the Director should dismiss the referral without setting up a PSRC. This is often the first real opportunity the practitioner has to address the clinical issues as distinct from the statistical concerns raised previously by the HIC. Section 91 gives the Director a very significant discretion and power which is not exercised lightly.

Following consideration of the practitioner's submission, consultation with a Panel member or consultant occurs. The consultant is usually nominated by a learned professional body, such as one of the Royal Colleges or speciality groups, as allowed for by the Act. In most instances, a visit to the

practitioner's practice is made to ensure the submission reflects the reality and to ensure the clinical records support the statements made in the submission.

Following such a visit and assessment, it is usual practice to further consult a Panel member, invariably a Deputy Director, and obtain an endorsement of the belief that it would be unlikely that a Committee would find inappropriate conduct in such a case.

It is only following such a procedure, as detailed, that a referral is dismissed under the legislation. As required, the reasons for the decision to dismiss the referral are forwarded to the HIC.

Section 92 Dismissal

Section 92 of the Act gives the Director the discretion and power to dismiss a referral if, in short, the referred practitioner agrees to a period of partial disqualification. Accepting such a sanction allows the practitioner to avoid the stress and time of a PSR Committee hearing and also ensures no adverse finding is recorded. The significance of this latter effect relates to s.106X which mandates the referral of a practitioner with two adverse findings to a Medicare Participation Review Committee (MPRC). Such referrals can have serious consequences for a practitioner, including disqualification from the Medicare arrangements for a period of up to five years.

In the past year, a number of practitioners or their legal advisers have made such an offer under s.92 but only four have been accepted. Before considering such an offer, the Director must be convinced the practitioner understands and accepts the manner in which the practice is inappropriate and has instituted, or is committed to instituting, changes to their practice such that it would no longer be unacceptable. The difficulties inherent in balancing the requirement for some punitive sanction for past behaviour with the positive outcome of behavioural reform is recognised and one which is obviously considered in all cases.

In those cases where partial disqualification has been accepted, I am confident the professional behaviour will show a permanent change and the practitioner will not come to the notice of the HIC again.

Section 93 - Professional Services Review Committee Hearings

Thirty PSRCs were established in the year whilst a number set up in 1995–96 completed hearings and finalised reports. No complaints were received regarding the administrative arrangements made for the hearings in the various capital cities.

A representative selection of case summaries can be found on page 23. The majority of referrals involved a very rapid throughput of patients with the provision of a high number of services. The graph on page 23 relates to the services performed by vocationally registered general practitioners.

The PSRCs have difficulty accepting arguments of increased efficiency, vast experience and superior competence which practitioners often advanced especially when the medical record or evidence at a hearing does not support such claims. Failure to allow adequate time for the patient: to obtain a relevant history; perform a physical examination; formulate and implement a management plan; and provide an explanation to the patient, must increase the risk of error and the potential of harm for the patient. The majority of practitioners accept that proper practice requires time be available and spent with each patient.

Workforce issues do not appear to give a rational explanation for this style of practice which often occurs in areas where there are adequate numbers of practitioners. The outcome for the patient is that only the presenting problem or symptom is addressed in the rapid consultation and no effort is made to engage in whole-person care.

Medical Records

The experience of another year has confirmed the importance of, and need for, adequate and contemporaneous records both for the proper conduct of professional practice and for the defence of any legal claim or question of

accountability such as posed in the PSR Scheme. Committees have been unable to accept the frequently advanced proposition that the practitioner has a memory such that recall of all patient details is possible, especially when this involves several thousand patients over a period of years.

In this regard it is worth noting that Australian Medical Boards are now formulating and even issuing guidelines as to what they, as regulatory bodies, regard as essential medical records for proper professional practice. This is to satisfy their charter to ensure the safety of the public.

In most of the cases considered over the past year, where adverse findings have been made, the records have been found to be sparse, inadequate and even non-existent. Invariably in the cases where the PSRC has found the conduct of the referred practitioner to be 'not unacceptable', the medical record has supported the practitioner's claims.

PSRCs remain of the opinion that the minimum requirements for a medical record are that it should show:

- presenting complaint and history,
- result of examination, including relevant negative findings,
- management of presenting complaint,
- justification for any tests or referral,
and should also record, in a reviewable format;
- past history,
- drug allergies,
- current treatment, if any, and
- immunisation history, social history and habits where appropriate.

It is appreciated and accepted that all records may not meet this criteria but would be required for the management of long-term patients and those with significant medical conditions. As other bodies have stated, the record must be capable of being used by another practitioner in the care of the patient.

Alteration of Records

It was noted in last year's report that some PSRCs were concerned that medical records and other documentation provided to a Committee, as required by the Act, may have been altered or amended subsequent to its initial production and following its request by a Committee. The Act makes it an offence to produce a false or misleading document and significant financial penalties apply. Again this year several Committees have been suspicious that alterations may have been made.

The HIC is instituting procedures to enable a PSRC to refer such concerns to it for investigation and possible prosecution. Such investigations may include forensic examinations of the records. Practitioners should also be well aware that regulatory bodies such as the State Medical Boards, are very concerned by such behaviour.

Extended Hours Clinics

Several practitioners who have been the subject of PSRC hearings have worked in extended hours clinics; their relationships with the owners of the facilities are usually that of independent contractors rather than employees. The clinic usually provides the facilities and administrative support the practitioner needs in return for a percentage of the fees billed by the practitioner. This facility fee, payable to the clinic management, ranges from 40 per cent to 60 per cent with the usual figure being 55 per cent to 60 per cent. Such an arrangement renders s.82(2) of the Act of little consequence and not able to be invoked against the owners of such clinics should it be considered their conduct would otherwise be within the ambit of the Act.

Among the advantages claimed for medical centre practice is an improvement in administrative processes and management such that the medical practitioner is not distracted from the clinical role. In many of the cases involving medical centre practitioners this advantage was not evident. Evidence in such cases frequently revealed a number of problems. These problems included: inadequate record systems, no recall system for dealing with abnormal results or at-risk patients, and often no alert markers

on the medical files. In addition, systems were frequently organised in such a way that the practitioner had little knowledge or control of the financial billing for which they were ultimately responsible.

There was usually a failure to encourage appropriate continuing medical education or professional training and in many cases no effort to monitor or limit the hours of duty required of a practitioner so that patients were not put at risk.

Hours of duty

Many practitioners appearing before PSRCs claim extended hours of work and it is often impossible to verify such claims. However, there can be no doubt some practitioners do work apparently excessive hours. At a time when professional groups and industrial organisations are moving to ensure doctors, in hospitals or training situations, are not required to work excessive periods it would seem appropriate that professional organisations review this situation and consider developing some guidelines. The community recognises that there should be limits on the hours of duty for various groups where fatigue at work could pose significant risk to public safety and it seems hard to argue that medical and health care practitioners should not have a similar code of behaviour in this regard. The exigencies of medical practice are acknowledged but emergencies and epidemics are not occurring all the time.

Regulatory Bodies

Discussions have been held with most State and Territory regulatory bodies especially those dealing with medical practitioners. These various Medical Boards are now fully cognisant of the scope of the Act as regards inappropriate practice and are all supportive of the PSRC's role.

Several PSRCs have been concerned during hearings as to the clinical competence of the practitioner and this year the conduct of another practitioner was referred to the relevant State Medical Board. Among the proposed changes to the Act is one that strengthens this provision enabling PSRCs to refer relevant concerns to such bodies.

Medical Boards are more and more seeking cooperation and a sharing of relevant information where this is authorised by legislation. It is interesting to note that a number of the Australian Medical Boards are currently considering ways they can put in place methods and legislation by which they can monitor and assess the continuing competence and performance of their registrants. The General Medical Council in the United Kingdom has recently initiated such a process.

Late in 1996 I attended the 2nd International Conference of Medical Regulatory Bodies held in Melbourne. Representatives of regulatory authorities from around the world were in attendance. This was a fascinating and interesting meeting which clearly demonstrated that similar problems were shared in all jurisdictions.

In June/July 1996 the opportunity arose to have discussions with regulatory bodies, Government organisations and professional bodies in Canada, the United States of America and the United Kingdom about their management of the problems the PSR was established to address. Although these countries have different health care financing systems to Australia it was interesting to find a similar concern regarding aberrant professional behaviour and much was learnt of their processes. Recently, discussions were held with the General Medical Council in the United Kingdom which, in September 1997, intends implementing a process to monitor professional performance and competence within its jurisdiction. It will be interesting and instructive to observe the progress of this initiative which may well have significant lessons for Australian practice.

Legal Processes

At the time of reporting, two appeals have been dealt with by a PSR Tribunal. The Tribunal supported the finding of inappropriate practice in both appeals and has varied the determination. In the appeal by Dr S Yung the determination was lessened with no repayment of Medicare benefit required ;and in that of Dr J Tankey, the Tribunal increased the determination and substituted repayment of all benefit to that amount proposed by the Determining Officer.

Both practitioners appealed to the Federal Court on matters of law. The first appeal, in the case of Dr Yung, has been heard and the judgment is reserved. Dr Tankey's appeal is yet to be listed.

As at 30 June 1997, only one case referred for hearing by a PSRC has reached a final decision in that the Final Determination has taken effect.

Two cases seeking injunctions to halt PSRC hearings have been heard in the Federal Court and both were unsuccessful. One case confirmed that the HIC could refer cases to the Director where the evidence was mainly statistical. The other case, which alleged bias on the part of all members of a PSRC on the basis of their membership of one professional organisation, also failed. Other issues raised by the plaintiffs in these actions, including a challenge to the legislation based on the Constitution, remain to be litigated in court.

As this is a new legislative Scheme it is obvious that challenges will occur concerning various legal issues until the law is clarified and a body of legal precedent established.

PSR Panel

Membership of the PSR Panel carries the likelihood of being required to serve on a PSRC. This is a difficult and responsible task and can indeed be very stressful, especially as it is often a task with which many practitioners have had little experience. However, those members asked to serve have carried out the task responsibly, competently and always with respect and consideration to the colleague appearing before them. Their contribution and commitment is very much appreciated.

The Deputy Directors whose task is to chair the committees have the added onerous responsibility of coordinating the process and ensuring the process is conducted with fairness and regard to all involved. This process involves a considerable commitment of time from the Panel members who all have a continuing involvement in full-time professional practice.

Dr Nicolas Radford who served as a Deputy Director resigned from the PSR Panel during the year. He was subsequently appointed by the Minister as a

medical member of the PSRT. Acknowledgment is made of his contribution to the PSR Scheme and previously to the Medical Services Committees of Inquiry. He will take that experience to the Tribunal. Dr Dana Wainwright, who was a Panel Member, resigned and has also been appointed to the PSRT. I congratulate both of them on their appointments.

Ethnic and Cultural Differences

The argument that different ethnic communities need and expect a different standard of care to the remainder of the Australian community is often raised in PSRC hearings and was mentioned in last year's report. Over the past year, discussions have been held with leaders of various ethnically-based professional bodies. Invariably they have supported the position that in the treatment of Australian citizens, by practitioners registered by Australian regulatory bodies, in a health care system financially underwritten by the Australian taxpayer, Australian medical standards apply.

Indeed, these groups are often disappointed by the realisation that some of their members exploit their community.

With their support, nominations have been sought from these groups for appointment by the Minister to the PSR Panel. Some appointments have already been made and more will follow. This will ensure a broader cross-section of the profession is represented on the Panel.

Timeliness

When the Act was passed by Parliament, timeframes were written into the legislative scheme with the clear intent of minimising the delays encountered in the previous process. These timeframes have been difficult to maintain due to the reasons mentioned elsewhere in this report. It is appreciated that all practitioners appointed to PSRCs have endeavoured to meet these time requirements.

Administration

No major problems have been encountered this year in the administrative arrangements in place for establishing and conducting PSRC hearings.

Hearings, which are stressful to all involved, are conducted with the minimum of formality having regard to the need for fairness and confidentiality. Auscript continues to provide a very efficient and timely service in the provision of hearing transcripts. Our legal arrangements, with most legal advice being sourced from Minter Ellison Canberra, have been effective with prompt responses to our legal needs.

Deputy Directors' Workshop

A workshop was held in Canberra in April for the Medical Deputy Directors at which the previous years' activities were reviewed. As the review process is based on legislation, several sessions were held with legal advisers to ensure the procedures during PSRC hearings were soundly based. This was, as before, a most useful and informative exercise.

Determining Officer's Report

The Determining Officer, Dr Louise Morauta, has forwarded a report on the role and activities of the Determining Officer for inclusion in this Annual Report on the PSR Scheme. The report is on page 17.

Advice to Practitioners

Even with the benefit of another year of experience of the PSR Scheme I would repeat the advice given in the 1995–96 report so practitioners can reduce the possibility and risk of being asked to justify their conduct to a committee of their professional colleagues.

Keep good records: these are the most vital tool in any defence in a justification proceeding.

Listen to the HIC Medical Adviser: the HIC concerns are detailed to the practitioner.

Discussion with professional colleagues: there may be other professional views on long or strongly held beliefs.

I am most grateful for the efforts of a dedicated and committed staff and the contribution of those members of the PSR Panel who have served on PSRCs. In an era of accountability, the task is vital for the professions and helps to ensure the Australian patient and public has a health care system of value in all senses of that term.

Dr John Holmes
Director of Professional Services Review

DETERMINING OFFICER'S REPORT

Following the departure of the Scheme's original Determining Officer, Dr Anthony Adams, at the beginning of 1997, the Minister appointed as new Determining Officer, the person holding the position of First Assistant Secretary, Health Benefits Division, Department of Health and Family Services. Ms Gail Batman acted in this position until early May 1997 when Dr Louise Morauta took up duty.

Making Determinations

There were some delays in issuing determinations during this year. For the most part these delays arose from difficulties in applying the legislative provisions relating to the powers of the Determining Officer. There was some doubt about whether, in applying certain sanctions in s.106U of the Health Insurance Act 1973, the Determining Officer may have been exercising judicial rather than administrative powers. Consequently, the Government decided to remove any doubt on the matter by amending the legislative basis of the PSR Scheme. The Health Insurance Amendment Bill (No.1) 1997 was introduced into the House of Representatives on 26 March 1997. The Bill passed to the Senate following debate in June 1997.

In making determinations, the challenge has been to maintain some consistency. The Determining Officer must consider each case on its individual merits while at the same time being aware of previous cases. This was more difficult in the early stages of the Scheme, with few Committee reports coming before the Determining Officer. The process is now clearer with ten draft Determinations and five final Determinations issued.

Another guiding factor for the Determining Officer can be decisions made by PSR Tribunals following reviews of determinations. With only two decisions by PSR Tribunals in the latter part of the year, Tribunal reviews were of limited assistance to the Determining Officer during the period.

PSR Tribunal Decisions

PSRTs handed down two decisions in the year following reviews of Determinations. These were for Dr Stephen Yung (New South Wales) and Dr James Tankey (Queensland)—both general practitioners.

Dr Yung

Dr Yung was referred by the HIC to the Director of PSR in May 1995 for all services rendered during the 1994 calendar year. In that period, Dr Yung provided 17 331 services to 8 575 patients at a Medicare benefit cost of \$373 512. This number of services was beyond that of the 99th percentile of all general practitioners billing under Medicare in 1994. Dr Yung rendered the vast bulk of these services when working three and a half days a week.

In August 1995, the PSR Committee found that Dr Yung's practice environment was of poor quality, the emphasis in the practice being one where financial motivation took a higher profile than the concept of professionalism. The Committee found Dr Yung to have practised episodic care rather than continuing care with little demonstration of preventive care and that his medical records were of very poor quality. The Committee concluded that Dr Yung's conduct would not have been acceptable to his peers.

The Determining Officer made a determination against Dr Yung that he be counselled, he repay \$42 130.60, and he be fully disqualified from Medicare for six months and partially disqualified for nine months.

Following a hearing by PSR Tribunal No.1, the Tribunal set aside the original determination and decided that Dr Yung be fully disqualified for six months. The Tribunal concluded that, although the decision of the Committee was the correct one, it did not necessarily mean they agreed with all aspects of the Committee proceedings or its report on its findings.

Dr Tankey

Dr Tankey was referred by the HIC to the Director of PSR on 26 July 1995 for all services rendered and initiated in the 1994 calendar year. In that period, Dr Tankey provided 27 048 services to 5 556 patients at a Medicare benefit cost of \$580 576. This number of services was well above the 99th percentile of all general practitioners billing under Medicare in 1994. Dr Tankey saw over 120 patients daily on 74 days of the year.

In January 1996 the PSR Committee found Dr Tankey's practice to be characterised by a consistent pattern of extremely high and rapid throughput of patients with insufficient consultation time being allocated to allow for appropriate practice. Dr Tankey's medical records were found to be inadequate, major diagnoses were not recorded and he displayed a poor attitude to preventive medicine and the psycho-social requirements of his patients.

The Determining Officer made a Determination that Dr Tankey be counselled, that he repay \$258 277.45 (being the amount equivalent to the benefits paid for 50 per cent of all his consultation items), and he be fully disqualified from Medicare for six months and partially disqualified for 12 months.

The Determining Officer's decision was reviewed by PSR Tribunal No. 7, which held a hearing in April 1997. The Tribunal set aside the original determination and issued a new determination to the effect that Dr Tankey be counselled, he repay \$580 576.00 (being the amount equivalent to all Medicare benefits paid during the period), and he be fully disqualified for six months and partially disqualified for 12 months.

The Tribunal agreed with the findings of the PSR Committee, believing it was not possible for Dr Tankey to have been practising appropriately with such rapid throughout.

Both Dr Yung and Dr Tankey have since appealed the PSR Tribunal's decisions to the Federal Court.

Table 3 shows the actions on cases by the Determining Officer and a Professional Services Review Tribunal in 1996–97.

Table 3	
PSRC Reports to the Determining Officer	18*
PSRC Reports sent to Persons Under Review	17
PSRC Reports indicating the Person Under Review was not practising inappropriately	1
Draft determinations issued by the Determining Officer	10
Submissions made to the Determining Officer on draft determinations	11
Final determinations issued by the Determining Officer	5
Requests to the Minister for a review by a Professional Services Review Tribunal of the final determination	4
Reviews conducted by Professional Services Review Tribunals	2
Appeals made to the Federal Court on reviews by Professional Services Review Tribunals	2

* *The discrepancy in this figure compared with the figure in Table 1 is due to 3 Reports from PSRCS to the Determining Officer being in transit on 30 June 1997.*

CHANGES TO THE LEGISLATION

As mentioned above, legislative amendments to the PSR Scheme were introduced into Parliament during the year. The main motivation for the Bill was to ensure judicial powers were not being exercised by the executive under the Scheme by removing the ability to recover an amount in addition to any Medicare benefits paid.

Other major amendments are designed to:

- define the classes of practitioners so they are consistent with other parts of the Act, enabling a better test to be applied in terms of a practitioner's conduct and, as a consequence, clarify the test under which a PSR Committee reports on the conduct of the practitioner;
- remove the statistical sampling provisions which have proved unworkable in practice; and
- increase the periods of partial and full disqualification from access to Medicare up to a maximum of three years in both cases.

The other amendments contained in the Bill are minor changes to improve the administration of the Scheme.

CASE SUMMARIES

The then Minister, at the time of the passage of the legislation, formally advised the Senate Standing Committee on Community Affairs that the Director of Professional Services Review would be required, in his Annual Report, to provide in a narrative style appropriate examples of cases having resulted in findings of inappropriate practice.

The following brief summaries are provided in accordance with that undertaking. The cases selected are examples of various problems considered over the past year and illustrate the range of issues involved in the referrals received. For ease of reading, many of the figures have been rounded and for reasons of brevity, not all issues raised and discussed in the hearings are detailed.

For comparison purposes regarding the case summaries, Graph 1 shows the distribution curve for the number of medical services provided by general practitioners for the calendar year 1996. The shape of the graph in relation to the number of services has altered little over the years.



CASE A—High level of servicing

A 1975 graduate who spent three years working in the hospital system, then three months as an assistant in a group practice before entering solo general practice in an outer suburban area situated in a lower socio-economic area.

The referral data showed approximately 23 000 services for a Medicare benefit cost of \$546 000. Not only was the number of services above the 99th percentile for Australian general practitioners, the practitioner was also above the 90th percentile in services per patient. The doctor claimed for 2100 home visits in the year of the referral as well as considerable procedure work, mainly excisions of skin lesions.

Following the hearing the Committee, in its Report, expressed concern about the practitioner's clinical competence and considered the doctor's clinical knowledge was no longer current and little effort had been made to keep up-to-date. They considered the evidence showed the practitioner did not allow enough time to adequately perform the clinical services for which the doctor was claiming.

The Committee considered there was little clinical justification for many of the home visits claimed and were also concerned that frequently a high number of patients were seen at the one place. The manner in which surgical procedures were undertaken also attracted the Committee's concern. They were very worried by the doctor's practice as regards sterility and the importance of this. Very few of the lesions excised were submitted for pathological examination.

The medical records were of poor standard and did not give any justification to the claims made. No evidence could be elicited of any useful continuing medical education (CME). The Committee was also concerned by the practitioner's prescribing, in particular, large quantities of benzodiazepines and an inappropriate use of antibiotics.

In summary, the Committee was greatly concerned in the hearing of the referral by its perception of the practitioner's competence in many areas and a lack of insight into the problem.

A finding of inappropriate practice was made.

Case B—A highly serviced practice

An overseas graduate, the practitioner migrated to Australia in 1974 and was initially involved in hospital and psychiatric institutions until commencing in solo suburban practice 15 years ago.

The HIC referral outlined the concerns regarding high patient services and high services per patient. The practice profile showed 14 495 services for 2 329 patients (giving a Medicare benefit payment of \$320 000). There were 397 home visits. The servicing pattern was beyond the 96 percentile at 6.22.

Following the hearing, the Committee found inappropriate practice due to maintaining a workload which would not allow time for adequate clinical input to consultations. The Committee also found that many of the home visits appeared to be for social reasons rather than genuine medical necessity.

This case was reported in the 1995–96 Annual Report. The practitioner has accepted the Final Determination of the Determining Officer that the practitioner be counselled and be fully disqualified from the Medicare arrangements for two months.

Case C—Stretching the time

The practitioner graduated in 1968 and, after considerable hospital experience, commenced in a general practice partnership in suburbia. After 20 years, the partnership ended and the practitioner commenced in another practice with an associate.

The referral related to HIC concerns regarding clinical justification for the high volume of Level C and D consultations (5 627 or 49 per cent of the 10 800 services rendered). The practice statistics showed 1 700 patients.

The practitioner claimed a patient base which consisted of a considerable number of elderly patients and others with complex medical conditions. It was also claimed that very long hours were worked. The practitioner stated that the high volume of Level C and D consultations was related to counselling (although the practitioner had no formal training in this area). The PSRC had difficulty accepting this claim.

The PSRC found that the clinical notes examined and oral evidence given did not support the practitioner's contentions. The PSRC reached the conclusion that the claims for Level C and D consultations would be considered inappropriate by the general body of general medical practitioners. On further examination, it became apparent that the practitioner's patient population was not dissimilar to the peer group.

A similar result followed its examination of those claims for Level C and D services rendered in nursing homes and hospitals. Again, during the hearing, the PSRC found the medical records to be inadequate (including those for hospitalised patients) and incapable of supporting the complexity involved in the claimed consultations.

Case D—Rapid throughput of patients

Graduating in 1959, this practitioner subsequently gained extensive experience in hospitals, some specialist post-graduate training and general practice experience before joining an extended hours clinic in 1991. The practitioner was an independent contractor at the clinic rendering medical services. Administrative support was provided by the clinic.

The HIC referral related to the high volume of claimed services—28 000 in the year of referral (the 99th percentile was 17 000) of which 25 000 were claimed as Level B consultations. An average of 90 services was provided to 80 patients per day. The practitioner claimed to work long hours six days per week.

The evidence confirmed that episodic care and symptom management were undertaken and no attempt was made to provide continuous whole-person care. The medical records were inadequate and would not assist any practitioner with such a rapid throughput approach to patient management. The records were considered to be of such poor quality that they would not assist a locum or indeed other practitioners in the same clinic. The practitioner claimed an ability to remember patient details but the PSRC was unable to accept this assertion given the 12 000 patient contacts during the period of referral.

The administrative arrangements of the clinic, with regard to Medicare direct billing, was flawed. The PSRC noted frequent errors in Medicare billing and commented that it was the practitioner's responsibility to ensure Medicare claims in their names were correctly itemised.

Other concerns the PSRC held related to the lack of home visits, the long hours of work undertaken and the inability of the practitioner to perform adequately over such a time period.

Case E—A rapid throughput of patients

This practitioner graduated from an overseas university followed by several years hospital experience before migrating to Australia. Medical studies were repeated at an Australian university followed by a further 18 months hospital experience. Prior to setting up a solo general practice, the practitioner did not have any general practice training or experience. The practitioner expressed a special interest in gynaecology.

The HIC concerns related to over 24 000 services claimed for the year of referral which was well above the 99th percentile (17 000 services). The practitioner claimed long working hours seven days per week. Patients were mainly from one ethnic group.

The Committee held concerns about several aspects of the practice and was unable to reconcile the extraordinarily high number of services rendered with the claimed clinical content and the stated hours worked. The medical records examined failed to support the practitioner's claims despite making allowances for a supposed ability to remember all details of patient histories. The records would be of little use to a locum in the management of the patients.

Other serious concerns, which emerged during the hearing, included:

- incorrect itemisation of Medicare services;
- performance of operative procedures especially outside normal hours (without qualified assistance and the necessary resuscitation equipment in case of emergencies);
- failure to adequately document the operative procedure; and

- a cavalier approach to the disposal of clinical waste and ‘sharps’.

The Committee considered the practitioner demonstrated a lack of understanding of its concerns, which related to an inappropriate response to patient demand. This could also be regarded as exploitation of what was claimed to be a socially and economically deprived ethnic community.

Case F—High number of services

An overseas graduate spent three years as a hospital Resident Medical Officer and a year as a locum in general practice before commencing in solo practice in an outer metropolitan area.

The HIC referred the practitioner because of its concerns about the extremely high volume of services rendered which was in the region of 24 000 (the 99th percentile was 17 000). For the year under review, 20 000 services were claimed as Level B consultations. The practitioner averaged 85 services per day.

Following the hearing, the PSRC was concerned about the low level of professional input into consultations rendered. The evidence confirmed episodic care with the practitioner treating symptoms and presenting complaints to the exclusion of the underlying cause.

The medical records examined were inadequate and did not support the practitioner’s account of what was claimed to have been done during the consultations. The practitioner was found to be medically isolated with little, if any, professional interaction with colleagues. The practitioner also demonstrated a lack of awareness of current medical concepts and treatments. Other concerns of the Committee related to:

- security of the patient records;
- management of blood spills; and
- maintenance of records such as the Dangerous Drug Register; and preparation of Medicare assignment forms.

The PSRC found the conduct of the practitioner was unacceptable to the general body of general medical practitioners.

Case G—Dangerous practice

Graduating from an overseas university in 1977, the practitioner subsequently passed the Australian Medical Council examination and spent two years in hospital posts. After completion of Family Medicine Program training, the practitioner commenced in solo suburban general practice in 1980. Five years later he returned to his homeland on several occasions and undertook further training including a limited time - seven weeks of unstructured and unrecognised training in nerve block procedures.

The concerns of the HIC related to the high number of Level C and D consultations, the high average number of services per patient and the high number of regional or field nerve block procedures performed.

The PSRC elicited the fact that many of the extended consultations were for multi-vitamin injections as the practitioner claimed the patients needed counselling and such claims were often for courses of injections. Other Level C and D consultations related to daily 'physiotherapy' usually involving ultrasound. Often the Level C and D consultations were incorrectly claimed in association with a procedural service.

The PSRC's major concern related to the practitioner's use of nerve block procedures which included:

MBS item 18252 - Cervical Plexus, injection of an anaesthetic agent

Claims for this procedure were seven times the number of the second ranked practitioner in Australia.

MBS item 18276 - Paravertebral Nerves, injection of an anaesthetic agent

This was claimed on 48 occasions.

MBS item 18286 - Lumbar or Thoracic Nerves, injection of an anaesthetic agent

Claims for this item were 10 times that of the second ranked practitioner in Australia.

MBS item 8290 - Cranial Nerve other than Trigeminal, destruction by a neurolytic agent

Claims were double that of the second ranked practitioner.

The PSRC took evidence from two recognised experts in this field and concluded that the practitioner's conduct in performing regional and nerve blocks without adequate training, in an inappropriate environment, without proper equipment such as image intensification, and without trained assistance was unacceptable to the general body of general medical practitioners.

Indeed the PSRC determined that the conduct was such that referral to the State Medical Board was warranted and took this action under s.106P(1) of the Act.

Case H—Inappropriate prescribing

Following graduation in 1989 from an Australian university, this practitioner worked in several public hospitals and as a locum in general practice.

The concerns related to the practitioner's activities in a medical practice in a deprived socio-economic area. One patient was a heavy user of pethidine injections (200 mg per injection usually) for management of chronic pain which related to several previous operations. The practitioner entered into a contract with the patient to endeavour to wean the patient from the high dosage (up to 1 600 mgs per day) which the patient obtained from many different practitioners without any supervisory control.

This was obviously a very difficult patient who required extra prescriptions because of many spontaneously broken ampoules (which were tendered to the practitioner). The patient also claimed that many injections by other practitioners into scar tissue were ineffectual.

When the prescriptions dispensed were tallied against a diary kept by the patient there were considerable discrepancies. The practitioner was counselled by the State unit responsible for monitoring drugs of dependence and was advised that pethidine should not be prescribed for chronic pain and oral medication should be used. Subsequent to this, HIC medical and

pharmaceutical advisers counselled the practitioner regarding the Pharmaceutical Benefit Scheme (PBS) restrictions on pethidine. The practitioner then ceased treating the above patient but shortly thereafter began a similar treatment regime for another patient.

During the course of the PSRC proceedings it became apparent that many of the prescriptions were forgeries written on prescription forms which were stolen from the practitioner. Suspicion fell on the first mentioned patient as many of the entries in the treatment diary were also falsified.

The PSRC was concerned that the practitioner showed a lack of appreciation of the essentials of management of chronic pain coupled with a failure to heed expert advice, even when given in the context of counselling. The practitioner continued to maintain that the treatment of these difficult patients was correct. The PSRC found that the practitioner had breached the legal requirements of the PBS and had failed to monitor the treatment regime undertaken. The PSRC found that the conduct of the practitioner was inappropriate.

The final Determination, effective after 30 June 1997, was that the practitioner be reprimanded, counselled and fully disqualified from the Medicare arrangements for one month.

Case I—A manipulated practice

Following an overseas graduation in 1966, the practitioner worked in many countries and in military service before commencing in a group general practice in an outer suburban area. The practitioner commenced in solo practice three years prior to referral.

The HIC concerns related to the high proportion of long consultations, the high number of home visits and the high services per patient.

The PSRC noted a marked change in practice style following the move from group to solo practice, namely, more services to less patients, and postulated that a target income might explain this change.

The ‘need for counselling’ was the rationale given by the practitioner for the long consultations. The practitioner had no formal training in this area

and the 'counselling' referred to consisted of passive listening and social chat. The PSRC considered such counselling of limited value and did not justify the claims for Medicare benefits. The PSRC also considered the practitioner encouraged dependence in patients, particularly those depressed, lonely, inadequate or addicted. There was no evidence of rational management plans for the patients.

Another concern was with regular claims for home visits to a family who lived at and ran the local tavern.

This practitioner was totally professionally isolated, with no collegiate interaction whatsoever. The practitioner had no involvement with or interest in continuing medical education. A further worry related to inappropriate prescribing of drugs which also encouraged interdependency to an undesirable degree.

The PSRC considered the practitioner had little insight into the reasons for these concerns and had serious reservations as to whether any change in behaviour was likely.

CORPORATE OVERVIEW

Objective

To provide effective and efficient human resource management, financial management and corporate planning services which will better enable the PSR to achieve its objective.

Strategies

- Provide the information necessary to enable management to make effective, efficient and timely decisions on finance, staffing and resource issues
- Secure and maintain adequate financial resources and manage those resources efficiently through the provision of high quality financial and resource management advice
- Provide and manage accommodation, facilities, stores and office services to enable efficient and cost effective usage
- Obtain, develop, involve and retain quality staff
- Ensure full compliance with all statutory and administrative requirements

Performance indicators

- Corporate costs as a portion of total costs
- Monthly cashflow projections provided to management within seven days of the end of the month
- Maintenance of Committee costs in real terms
- Number of functions that have been through the Competitive Tendering and Contracting (CTC) processes
- Percentage of funds spent on training

- Degree to which externally imposed deadlines and compliance requirements are met

Financial and Staffing Summary

Table 4

	Actual 1995–96	Budget 1996–97	Actual 1996–97
	(\$'000)	(\$'000)	(\$'000)
Appropriation	750	1 129*	1 129
Staffing	5.4	6**	7**

* Budget figure amended to include additional estimates.

** Includes one contractor

Finance

The original budget estimate for the PSR in 1996–97 was \$1.226 million. In the leadup to the 1996–97 Budget, the PSR offered up \$300 000 in savings because earlier projections, as to the number of cases to be referred from the HIC, were unlikely to be realised. However, two caveats were placed on these savings. Firstly, the uncertainty as to the number and complexity of the referrals sent to the PSR made it very difficult to estimate expenditure. Secondly, the PSR estimates did not make allowance for any considerable legal costs that might be encountered.

The PSR's Budget allocation was set at \$926 000. However, it became evident mid year that the PSR was going to receive a higher than anticipated number of referrals and, as a result, all expenditure components were critically reviewed and the cashflow projections revised. The review established that the current budget appropriation would be insufficient for the PSR to operate to its full capacity for the whole of the year.

The PSR received an additional \$203 000 at Additional Estimates (bringing the total appropriation to \$1.129 million) to fund the increased number and complexity of cases and to engage specialist legal advice. There is an ongoing need to obtain expert advice on legal issues.

Specific detail related to the PSR's allocation and expenditure for 1996–97 is presented in the Financial Statements at page 40 of this report.

ANAO's audit report on the PSR's 1996–97 financial statements was unqualified and signed on 14 October 1997.

Forward Estimates Funding

The volume of referrals the HIC will send in a year is unpredictable and the costs associated with each referral are considerable. Costs include those associated with a PSRC hearing as well as the staffing resources to meet the increased workloads. In 1997–98 the number of referrals from the HIC is expected to almost double.

The PSR has negotiated with the Department of Finance an agreed minimum funding and staffing level. In addition to this, agreement has been reached on a workload formula which is driven by the number of referrals the PSR receives from the HIC. This workload agreement caters for both staffing resources and financial funding.

Administration

A Memorandum of Understanding (MOU) and a Service Level Agreement which were developed in 1994–95 with the then Department of Human Services and Health remained in force during this reporting period. The Department of Health and Family Services, as it is now, provides services such as payment of accounts, personnel, preparation of Financial Statements, internal audit, library, registry facilities and coverage for programs including Equal Employment Opportunity, Occupational Health and Safety and Industrial Democracy for which the PSR pays an agreed annual amount.

Links with other agencies have been continued during this reporting period. Staff have attended forums such as COMNET to discuss and exchange information on current human resource management issues. In addition, the PSR receives all the information from central agencies that is made available to the larger government agencies.

Personnel

At 30 June 1997 the PSR had a staffing level of seven (including one contractor) plus the statutory officer position of Director of Professional Services Review. This represents an increase of two over the staffing level for 1995–96 and is the direct result of an increasing caseload for the agency. Two full-time positions were created in a rationalisation of the organisation's structure to meet with the increased caseload. The staff comprised five males and three females. The position profile by gender at 30 June 1997 was:

Position	Local designation	Gender
Statutory Office Holder		
Director	Director	male
Staff		
Senior Officer B	Executive Officer	male
Senior Officer C	Resource Manager	male
Admin Services Officer 6	Committee Secretary	female
Admin Services Officer 6	Committee Secretary	male
Admin Services Officer 5	Administrative Assistant	female
Admin Services Officer 4	Administrative Support Officer	male
Contractor	Committee Secretary	female

The Director of Professional Services Review is employed under the *Health Insurance Act 1973*. All other staff (except the contractor) were employed under the *Public Service Act 1922*. Six staff are full-time permanent and one is full-time temporary.

A contractor was employed for the last seven months of the year, to assist with the increased caseload. The contractor has considerable experience with the Professional Services Review Scheme.

None of the staff come from non-English-speaking backgrounds, are of Aboriginal or Torres Strait Islander origin or have a disability.

Staff Development and Training

During the year a number of PSR staff attended training and development courses. These included courses in computer software applications and legal issues. Also the Department of Health and Family Services provided training on financial issues, resource management and computer applications.

On-going training is scheduled for 1997-98 based on the identified needs of the organisation. All staff had the opportunity to participate in information technology training which was specified in the agreement with the service provider mentioned on page 38 of this report.

Workplace Reform

Given its small size the PSR has chosen to participate in the workplace reform discussions (Certified Agreements and Australian Workplace Agreements) within the Department of Health and Family Services. Workplace reform issues are again covered by the PSR's MOU with the Department. The PSR has commenced discussion with staff on the workplace reform issues and will participate in focus groups developing a certified agreement for the Department of Health and Family Services. The PSR cannot form part of the certified agreement of the Department, but is likely to model its own agreement(s) on the Department's model.

Occupational Health and Safety

Professional Services Review recognises that it has a legal responsibility to safeguard the health of its employees while they work. The agency provides and maintains OH&S standards in relation to its offices and its equipment. Office environment aspects relating to OH&S were incorporated by Interiors Australia in the design and fit-out of the additional office space (see page 38). For ongoing elements, because of its limited resources, the PSR has endorsed the Department's OH&S Plan and follows the procedures outlined therein. Where required, the Department, as party to the MOU, will provide policy advice relating to OH&S.

There were no OH&S incidents in 1996–97 nor were any notices issued or received under any of the relevant sections of the OH&S Act. In accordance with the Act a health and safety officer has been appointed.

Equal Employment Opportunity

Professional Services Review is committed to the principles of equal employment opportunity, which require that all staff be treated fairly and without direct, indirect or systematic discrimination. EEO requires all staff to have equal access to employment, career and development opportunities and encourages appropriate representation of the target groups specified in EEO policies.

Because of its small size, PSR has no EEO plan of its own, instead it is encompassed within Department's EEO program.

Industrial Democracy

Weekly and ad hoc meetings are held with all staff to discuss ongoing business and management issues, such as the future directions of the agency, proposed legislative changes, proposed staffing structure and additional office accommodation.

Information Technology

The Technology Partnership Agreement (TPA) with Logical Solutions, whereby software, hardware, maintenance support and on-going training are provided for a single cost, remained in place in 1996–97. Professional Services Review continues to be satisfied with the agreement which has one further year to run. In addition to the TPA, the PSR has purchased hardware and software outright to accommodate the additional staff it has recruited. This was done after a careful cost benefit analysis of the purchase versus leasing options.

Additional Accommodation

The PSR's accommodation was insufficient to house the additional staff recruited to meet the increased caseload. Initiatives were undertaken during the year to reduce the pressure on the PSR's accommodation.

Additional office space was secured across the road from the current premises. The new premises were designed and fitted out by Interiors Australia, to a standard consistent with the rest of the PSR's accommodation. The move occurred with very little disruption except for the considerable teething problems with both the telephone and computer links.

Ministerial or Senate Inquiries

All target dates for budget estimates, responses to estimate committee questions, Ministerial briefings, Ministerials, Department of Finance returns and financial statements were met.

Stationery and Publications

No new publications were produced in 1996–97 with the exception of the agency's 1995–96 Annual Report.

APPENDIX 1:
FINANCIAL STATEMENTS

AUDIT OFFICE LETTER

CRC

INDEPENDENT AUDIT REPORT

CRC

INDEPENDENT AUDIT REPORT
(2ND PAGE)

CRC

STATEMENT BY THE
DIRECTOR AND
RESOURCE MANAGER

CRC

DEPARTMENTAL
REVENUES AND
EXPENSES

CRC

DEPARTMENTAL ASSETS
AND LIABILITIES

CRC

DEPARTMENTAL
CASH FLOW

CRC

STATEMENT OF
TRANSACTIONS BY
FUND

CRC

SCHEDULE OF
COMMITMENTS

CRC

NOTES TO
AND FORMING

CRC

NOTES TO
AND FORMING
(Con't)

CRC

APPENDIX 2:
SUMMARY TABLE OF RESOURCES

SUMMARY TABLE OF
RESOURCES

CRC

APPENDIX 3:
FINANCIAL AND STAFFING
RESOURCES SUMMARY

FINANCIAL AND
STAFFING
RESOURCES
SUMMARY

CRC

APPENDIX 4: FREEDOM OF INFORMATION STATEMENT

During the year ended 30 June 1997, the Professional Services Review received nil requests for access to documents under the provisions of the *Freedom of Information Act 1982*.

Contact Officer

All freedom of information requests should be directed to:

The Executive Officer
Professional Services Review
PO Box 136
YARRALUMLA ACT 2600
Telephone: 02 6285 1651

Documents

The types of documents held by the PSR are listed below.

- referrals and related documents from the HIC pursuant to s.86 of the *Health Insurance Act 1973* regarding the conduct of a person the Commission considers may have engaged in inappropriate practice in connection with rendering or initiating services;
- lists of Panel members to sit on Professional Services Review Committees;
- reports of Professional Services Review Committees;
- administrative files;
- Memorandum of Understanding and other agreements;
- finance and accounting records;
- legal advisings;

- computer records;
- consultancy reports and databases;
- contracts;
- minutes of various meetings; and
- general correspondence.

In respect of section 9 of the *Freedom of Information Act 1982*, this agency has the following document that is provided for the use of, or is used by, the agency or its officers in making decisions or recommendations, under or for the purposes of an enactment or scheme administered by the agency:

- Procedure Guide for Professional Services Review Committees.

APPENDIX 5: LEGISLATIVE OVERVIEW

The Professional Services Review Scheme was established by the *Health Legislation (Professional Services Review) Amendment Act 1993* which amended the *Health Insurance Act 1973*, and came into effect from 1 July 1994.

Dr A J (John) Holmes was appointed Director of Professional Services Review by the then Minister for Human Services and Health (now Health and Family Services) on 21 July 1994 for a three year period.

Since establishment of the PSR Scheme, 152 practitioners nominated by the relevant professions have been appointed as members of the Professional Services Review Panel and their appointments expire on 24 January 2000. Fifteen of the Panel Members have been appointed as Deputy Directors of Professional Services Review. The Deputy Directors serve as Chairpersons of the PSRCs.

Background

The legislation was developed in 1994–95 with the aim of providing an effective peer review mechanism to deal quickly and fairly with concerns about inappropriate practice.

The essential features of the review structure are:

- a Director of Professional Services Review (PSR), who is a medical practitioner, appointed ministerially and able to engage staff and consultants;
- a Professional Services Review Panel (PSRP), comprising medical practitioners, who are appointed ministerially;
- Professional Services Review Committees (PSRCs), comprising practitioners from the PSRP appointed by the Director of PSR on a case-by-case basis to investigate practitioners referred by the Director for review; and

- a Determining Officer, who must be a public office holder, appointed ministerially, and whose role it is to decide on the penalty for practitioners found by a PSRC to have practiced inappropriately.

The whole review process is based on the principle of peer review and will be instigated only in instances where prior counselling of practitioners by the HIC has been considered to have been in vain.

Inappropriate Practice

A practitioner engages in inappropriate practice if the practitioner's conduct, in connection with rendering or initiating services, is such that a Committee of his or her peers could reasonably conclude that:

in the case of a **medical practitioner**—the conduct would be unacceptable to the general body of the members of the specialty (general medical practice is taken to be a specialty) in which the practitioner was practicing when he or she rendered or initiated the services; or

in the case of a **dental practitioner, optometrist, chiropractor, physio-therapist or podiatrist**—the conduct would be unacceptable to the general body of the members of the profession in which the practitioner was practising when he or she rendered or initiated the services.

A person (including a practitioner) or a person who is an officer of a body corporate engages in inappropriate practice if the person knowingly, recklessly or negligently causes or permits, a practitioner employed by the person or body corporate to engage in conduct that constitutes inappropriate practice by the practitioner.

Benefits of the Professional Services Review Scheme

The Scheme gives the profession substantial autonomy in reaching findings on inappropriate practice. At the same time, proper care has been taken to ensure the practitioner under review receives natural justice. At every major point in the review process the practitioner is given the opportunity to make submissions that could influence the review process and outcome.

The scheme provides for the separation of the three elements of the decision making processes which are:

- the referral for review
- the review hearings and findings; and
- the determination of any penalty.

The HIC prepares and refers a case for review to the Director of the Professional Services Review who decides whether to empanel a PSRC.

The Review Committee reports on its findings and, if the findings are adverse to the practitioner under review, a Determining Officer, who must be a person holding an office or appointment under the Public Service Act, must determine one or more of the following courses of action:

- a reprimand;
- counselling;
- repayment of benefits to the Commonwealth;
- payment of a penalty to the Commonwealth; and/or
- complete or partial disqualification from the Medicare scheme.

The Determining Officer is required to provide the practitioner under review with a draft Determination on which the practitioner will have the opportunity to make submissions before it becomes final.

A practitioner who is subject to an adverse finding may request a review by the PSRT. An appeal may also be made to the Federal Court on a question of law only.

APPENDIX 6: PROCESS

The following material combines legislative requirements and administrative procedures and summarises them to give an overview of what happens after the HIC decides it has concerns of inappropriate practice which should be referred to the Director of Professional Services Review. Information on HIC procedures leading to the referral of a case to the Director should be sought from the Commission.

Referral

When the HIC refers a case for review to the Director of PSR, it must, *within 48 hours*, send a copy of the referral to the person under review and invite that person to make a written submission to the Director *within 14 days*, stating why the Director should dismiss the referral.

Director's decision

The Director must, *within 28 days* of receiving the referral, decide whether to establish a PSRC to consider whether the practitioner has engaged in inappropriate practice, as defined in s.82 of the Act. In reaching this decision, the Director may take advice from appropriate consultants. If the practitioner has taken the opportunity to make a submission to the Director, it is taken into consideration at this stage.

The Director may dismiss the referral, without establishing a PSRC, only if satisfied there are insufficient grounds for a PSRC to find the practitioner had engaged in inappropriate practice or if the practitioner has entered into a written arrangement with the Director agreeing to a partial disqualification from Medicare.

Establishing a PSRC

The Director will select a Deputy Director to chair a Committee and at least two other members from the Professional Services Review Panel who must be members of the profession or medical specialty in which the practitioner

was practising when he or she performed or initiated the services which are believed to have been inappropriate. Where the Director considers it desirable to give the Committee a wider range of clinical expertise, up to two further Panel members from a relevant profession or specialty may be appointed to the Committee.

The Director must notify the person under review and the HIC of the decision, in writing, *within 7 days* of the decision. If the decision is to proceed with the establishment of a PSRC, the notification is to include the proposed membership of the Committee. If the decision is to dismiss the referral, the Director must give the reasons for that decision.

The person under review may challenge the appointment of a Committee member on the grounds of actual or perceived bias.

Committee process

The Committee must meet *within 14 days* after appointment to consider the case. Meetings are held in private.

If the Committee believes the person under review may have engaged in inappropriate practice, it must hold a hearing. The person under review must be given particulars of the matters giving rise to the hearing and *at least 14 days'* notice of the date and place of the hearing. The person is required to appear at the hearing to give evidence and/or to produce documents and to attend to identify those documents specified in the notice.

Hearings

The person under review is entitled to be accompanied by a lawyer or other adviser; to question any person giving evidence to the Committee; and to address the Committee. The Committee may allow an adviser *other than a lawyer* to ask questions or to address the Committee on the person's behalf.

While a PSRC has legal powers such as the power to summon witnesses and to require persons to answer questions, it is intended that hearings be conducted in as informal a way as possible. Evidence may be taken on oath or affirmation.

If a practitioner fails to attend a hearing or refuses to answer questions or to produce documents, the Committee may fix another day *at least 28 days later* for the hearing and give the person notice of that hearing. If the person again fails to appear or fails to answer, the Director must disqualify the practitioner from access to Medicare benefits and so advise the HIC. If the practitioner subsequently complies with the Committee's requirements, the disqualification is lifted.

A PSRC may inform itself on matters before it as it sees fit. With the approval of the Director, it may engage people with suitable qualifications and experience as consultants for this purpose.

The legislation provides for penalties:

- in the event of a person under review or a witness knowingly giving an answer or producing a document which is false or misleading to the Committee; and
- for the failure or refusal of a witness to attend a hearing, to be sworn or to make an affirmation, to answer a question or to produce a document as required by the Committee.

Statistical Sampling

One of the inadequacies of the previous (MSCI) arrangements was that over-servicing could be found to have occurred only in relation to individual services. Every service provided or initiated by the practitioner over an extended period had to be examined to establish the extent of over-servicing and then recovery of Medicare benefits and a penalty could be imposed only in relation to those services actually determined to be excessive.

A significant aspect of the PSR Scheme is that the Act provides that the Minister may issue directions which are tabled in Parliament on the production, issue and use of samples. As a result, a PSRC may, from a statistically valid sample of services rendered or initiated by the practitioner, apply the findings to the whole class of services that is of concern. In order for the HIC to utilise this provision, the referral must relate to one or more of the following:

- services of a specified class,
- services provided to a specified class of persons, and
- services at a specified location.

Findings in relation to the sample may then be applied to the other services in the specified class, etc. The statistical procedure for making the necessary calculations has been developed by the Australian Bureau of Statistics.

Reporting

The Committee must give to the Determining Officer a written report setting out its findings on whether the person under review's conduct in relation to the referred services was, in the Committee's opinion, unacceptable to the general body of the members of the profession or speciality involved.

Employers can also be found to have acted inappropriately.

The report should refer to the evidence or other material on which those findings were based. It should provide the Determining Officer with sufficient information to assist that officer in drafting a Determination.

If the PSRC members are not unanimous in their findings, an additional minority report may be given to the Determining Officer.

A PSRC must report its findings to the Determining Officer *within 90 days* of its being set up. However, the Chairperson of the PSRC may, before the deadline for reporting, apply in writing to the Director for an extension of time. If the Director is satisfied with the reasons given for requiring the extension, he may grant an extension of up to 30 days. The Chairperson is not prevented from seeking further extensions of up to 30 days.

Suspension of Proceedings

The PSR Scheme has been established to examine professional practices in relation to Medicare and aspects of the Pharmaceutical Benefits Scheme only. If a PSRC, in the course of its examination of a referral, comes to the view that the person under review may have committed fraud, the Committee must report on its concerns to the HIC and suspend its consideration of the referral. The Commission may subsequently return the

referral, possibly modified, to the PSRC, in which case the Committee would recommence its consideration of the referral.

If a PSRC thinks that material before it indicates that action should be taken against the person under review ‘in order to lessen a serious and imminent threat to the life or health of any person’, it must report its concerns to the relevant regulatory body, for example, a State Medical Board, without suspending its consideration of the referral.

The Determining Officer

The Determining Officer is a person holding an office or appointment under the Public Service Act 1922 and who is appointed by the Minister for the purpose. The present appointee is the Chief Medical Advisor of the Department of Health and Family Services.

The Determining Officer must, *within 7 days* of receiving the report of a PSRC, give a copy to the person under review. *Within 14 days* of receiving the report, the Determining Officer must give the person under review and the Director copies of a draft determination in relation to the report.

If the report of the PSRC is adverse to the person under review, the draft determination will include one or more of the following courses of action:

- a reprimand;
- counselling;
- repayment of benefits to the Commonwealth;
- payment of a penalty to the Commonwealth; and/or
- complete or partial disqualification from the Medicare scheme.

The person under review is given *14 days* in which to make written suggestions for changes to the draft determination.

At the end of the 14 days and *within 35 days* of receiving the report of the PSRC, the Determining Officer must give the person under review a final determination in relation to the report from the PSRC. In the absence of any appeal against the determination, it takes effect *28 days* after it is delivered to the person under review.

Further appeal

A practitioner who is the subject of a Determination may request a review by a Professional Services Review Tribunal (PSRT). On a question of law, appeal is to the Federal Court.

Essential features

The legislation provides a review mechanism which is characterised by:

- **impartiality:** the Director and his staff are independent of the HIC, which develops cases for review, and the Panel members who conduct reviews are from the specialty/profession of the person under review;
 - there is provision for appeal or review of every significant decision in the process;
- **privacy:** the deliberations, findings, information and evidence given to a PSRC remain confidential and may only be disclosed in circumstances prescribed by the Act, for example, in the case of an appeal to a Tribunal or to the Federal Court;
- **competence:** cases are examined by experienced members of the relevant professions; and
- **timeliness:** the legislation imposes timelines which ensure cases will not drag on or be unnecessarily delayed by any party.

APPENDIX 7: GLOSSARY

Act	the <i>Health Insurance Act 1973</i> , as amended by the <i>Health Legislation (Professional Services Review) Amendment Act 1994</i> .
Commission	the Health Insurance Commission (also HIC).
Committee	a Professional Services Review Committee established by the Director in accordance with s.93 of the Act to examine a case of apparent inappropriate practice referred by the HIC.
Determining Officer	an officer appointed by the Minister to determine an appropriate penalty to apply where a PSRC finds that a person under review has engaged in inappropriate practice, as defined in the Act.
Director	the Director of Professional Services Review is an independent statutory officer appointed by the Minister. The occupant must be a medical practitioner and the AMA must agree to the appointment.
Disqualification	(partial or complete) exclusion from eligibility to receive Medicare benefits.
Inappropriate practice	defined fully in s.82 of the Act, but could briefly be described as professional conduct in relation to Medicare which a committee of peers would reasonably consider would be unacceptable to the general body of the members of the specialty or profession.
Minister	the Minister for Human Services and Health.
Panel	the PSR Panel consists of medical practitioners, dentists, optometrists, chiropractors, physiotherapists and podiatrists nominated by the relevant professional organisations and who have been appointed by the Minister.
Referral	a case prepared by the Commission and referred to the Director, detailing the Commission's concerns and the reasons it considers that a practitioner or other person has engaged in inappropriate practice in the terms of s.82 of the Act.

APPENDIX 8: ABBREVIATIONS

ASL	Average Staffing Level
AMA	Australian Medical Association
ANAO	Australian National Audit Office
CME	Continuing Medical Education
HIA	Health Insurance Act 1973
HIC	Health Insurance Commission
H&FS	Commonwealth Department of Health and Family Services
MPRC	Medicare Participation Review Committee
MSCI	Medical Services Committee(s) of Inquiry. Sometimes used broadly to include certain other committees with similar functions, such as the Optometrical Services Committee of Inquiry.
PBS	Pharmaceutical Benefits Scheme
POE	Property Operating Expenses
PSR	Professional Services Review
PSRC	Professional Services Review Committee
PSRT	Professional Services Review Tribunal
QA	Quality Assurance
RACGP	Royal Australian College of General Practitioners

COMPLIANCE INDEX

	Page
Abbreviations,	71
Contact details for further information,	ii
Corporate overview,	33
Director's report,	2
Financial statements,	40
Freedom of information statement,	59
Glossary,	70
Introduction,	1
Letter of transmission,	iii
Objective,	1
Summary table of resources,	57
Table of contents,	v