PROFESSIONAL SERVICES REVIEW

ANNUAL REPORT 1999–2000

ISSN 1327-6514

Copies of this report can be obtained from:

The Professional Services Review
PO Box 136
Yarralumla ACT 2600

Telephone: 02 6281 9100
Facsimile: 02 6281 9199
Internet: www.psr.gov.au

Further information can be obtained from:

The Executive Officer
Professional Services Review
Telephone: 02 6281 9100
Facsimile: 02 6281 9199

Edited by PenUltimate, Canberra

Cover design by SpinCreative, Canberra 2016

Printed by Paragon Printers Australasia, Canberra

PROFESSIONAL SERVICES REVIEW

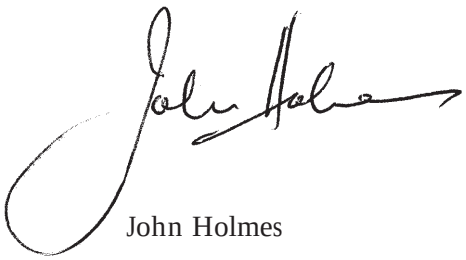
The Hon. Dr Michael Wooldridge, MP
Minister for Health and Aged Care
Parliament House
CANBERRA ACT 2600

Dear Minister

In accordance with section 106 ZQ of the Health Insurance Act 1973, I present the sixth annual report on the Professional Services Review Scheme.

You are required to cause a copy of this report to be laid before each House of the Parliament on or before 31 October in the year in which the report is given.

Yours sincerely



John Holmes

25 September 2000

CONTENTS

INTRODUCTION

The Director of Professional Services Review (DPSR) is a statutory officer appointed by the Minister for Health and Aged Care to manage the process whereby the conduct of a person, who is involved in rendering or initiating services which attract a Medicare rebate or has prescribed under the Pharmaceutical Benefits Scheme, can be examined to ascertain whether inappropriate practice is involved.

Inappropriate practice is defined in section 82 of the *Health Insurance Act 1973* (the Act) essentially as conduct that is unacceptable to the general body of the members of the peer group 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 (HIC), which administers Medicare, referring instances of suspected inappropriate practice to the Director for investigation. If the Director decides the person has a case to answer, and a negotiated settlement is not reached or not considered appropriate, 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. If a committee makes a finding of inappropriate practice against the practitioner, the Determining Authority (DA) decides the sanction(s) to be imposed from a range of sanctions detailed in the Act.

The Professional Services Review (PSR) was established as a prescribed authority to help the Director carry out the functions which are detailed in Part VAA – Professional Services Review Scheme – in the Act.

Under section 106ZQ of the Act, the Director must prepare and give to the Minister a report on the operation of the Professional Services Review Scheme during the past financial year.

Corporate Plan

Due to the expanded role provided for this organisation in the Act from 1 August 1999, the PSR adopted a new corporate plan late in the year. PSR will be reporting against this plan in next year's Annual Report. The Corporate Plan is as follows:

Our Vision

As an independent authority, PSR contributes to ensuring access through Medicare to cost-effective medical services, medicines and acute health care for all Australians.

Our Mission

Examination of health practitioners' conduct to ascertain whether or not the practitioner has practised inappropriately in relation to services which attract Medicare benefits.

Our Values

In doing our job all members of PSR will:

- act with fairness, consistency, impartiality and integrity;
- demonstrate dedication and commitment;
- act with professionalism;
- value and respect each other and work as a team; and
- show timeliness.

Our Strategies

The strategies we employ to achieve our mission and values are to:

- investigate referrals expeditiously and effectively to enable courses of action to be decided;
- provide support services to PSRCs to enable them to carry out the PSR mission;
- provide support to the Determining Authority to enable it to function;
- manage relationships with stakeholders to maintain and enhance credibility of, and provide information about, the PSR Scheme; and
- provide effective and efficient human resource management, financial management and corporate planning services.

DIRECTOR'S REPORT

On 29 June 1999 the Federal Parliament passed the *Health Insurance Amendment (Professional Services Review) Act 1999*. This Act implemented the changes recommended by the Review Committee of the Professional Services Review Scheme in its report of March 1999. That Committee had been established in 1998 by the Minister for Health and Aged Care, the Hon. Dr Michael Wooldridge following an adverse decision of the Full Federal Court handed down in May 1998 in the case of *Adams v Yung and Ors* [1998] 83 FCR 248 (the Yung case). This was the first case referred to the Director of Professional Services Review by the Health Insurance Commission in 1995.

The amended legislation came into effect on 1 August 1999. Cases referred by the HIC before 1 August 1999 continue to be dealt with under the legislation current at the time of the referral. Relevant regulations required by the amendments to the Act have been tabled in Federal Parliament since 1 August 1999 and are now in effect. These regulations cover:

- the content of referrals – both the investigative and the adjudicative referral;
- the methods of statistical sampling – these regulations have been formulated following advice from expert statisticians and the Australian Bureau of Statistics; and
- the requirement for an adequate and contemporaneous record of services attracting a Medicare benefit.

In my Annual Report for 1998–99, I highlighted a number of the issues which I believed to be particularly relevant and which addressed concerns raised by the Federal Court about the PSR Scheme before those legislative changes were introduced. We also developed a 'plain English' brochure outlining the PSR Scheme which is reproduced at Appendix 1. The brochure was designed to provide an easy-to-understand outline of the PSR process. It has been well received and is useful in providing such information to professional organisations, individual practitioners and the public.

The most significant operational change to the process is the requirement for the Director to investigate the HIC referral. The Director now has extensive

powers, the most significant of which is the ability to examine medical records and other relevant documentation by means of a 'notice to produce'. Failure to comply with such a notice can lead to suspension from the Medicare program. This prevents the payment of Medicare benefits for the services rendered by the suspended practitioner.

It is the Director's responsibility to consider:

- the HIC investigative referral,
- any submissions from the referred practitioner,
- the documentation obtained (including medical records), and
- advice from professional associations or experts,

and to determine whether:

- the referral should be dismissed,
- an agreement should be entered into with the practitioner, or
- a Professional Services Review Committee (PSRC) should be established.

This change to the process has required very significant organisational change. As a consequence of the legislative amendments, the PSR agency has increased in size and has a very different organisational structure. These changes include the need for medical and legal sections along with a substantial increase in the secretariat support unit. The medical section has two full-time medical officer positions with scope for part-time assistance from relevant medical and other health care practitioners. The legal section currently comprises one lawyer but it is recognised that further legal personnel may be required with increasing caseload and possible consequent litigation. The increasing workload generated by the change in process has necessitated the recruitment of administrative support staff. It is fortunate that high quality staff have been attracted to these interesting and challenging positions in such a small agency.

Training

The Review Committee report recommended that training be provided for members who served on PSRCs. Considerable consultation took place regarding the curriculum for such training. Weekend training workshops took place in four States, Queensland, New South Wales, Victoria and South Australia. Members of the PSR panel from Tasmania, Western Australia and the Northern Territory were able to attend the workshop closest to them.

These workshops were held during September, October and November 1999.

As panel members are all in full-time professional practice, the workshops were held on weekends and at out-of-city locations to minimise professional distractions. Ms Felicity Hampel, QC of the Melbourne Bar led the training. She was supported by Mr Hugh Selby, a barrister of Canberra for three of the courses and for the other course by Ms Fiona McLeod, a barrister of Melbourne and Mr Justice George Hampel of Victoria. The format of the weekends was based on mock hearings based on 'real life' situations encountered by PSRCs at hearings. The format proved very successful and the improvement in performance of those attending was noticeable and significant. The intent was not to teach doctors and other health care practitioners to be 'lawyers' but to enable them to deal with hearings so future legal risk to their proceedings and decisions might be minimised.

A major outcome of the workshops was the realisation that questions needed to be asked and reports written in a manner that later allowed a judge to understand the reasoning behind the professional decision. The workshops also stressed the importance of showing the practitioner under review procedural fairness. From the perspective of the PSR and from participant feedback, these workshops were so successful we intend holding small follow-up sessions. Subsequent to attendance at the weekends the benefits have been demonstrated by the way PSRC members now conduct hearings.

PSR caseload

The caseload statistics for the PSR are shown in Table 1. Fifty new referrals were received in the past 12 months with all being received from the HIC in the past seven months. Those referrals are now in the investigative phase. Four referrals have been dismissed under section 91 and a number of negotiations to reach an agreement under section 92 are in progress, but not yet finalised.

Seven PSRCs have been established in the past year, all to hear cases under previous legislation. Seven finalised reports have been forwarded to the Determining Officer. The changes to Committee process required by the Federal Court decisions have caused an increased workload for Committees.

I have received an increased number of draft and final determinations made by the Determining Officer.

Table 1: PSR caseload

	1994–95	1995–96	1996–97	1997–98	1998–99	1999–00	Total
HIC referrals received by DPSR	1	16	70	48	11	50	196
Referrals dismissed under section 91		1	3	11	26	4	43
Referrals dismissed under section 92			2	3			5
PSRCs established by DPSR	1	15	30	35	5	7	93
PSRC Reports to Determining Officer		8	21	22	20	7	78
Draft Determination received by DPSR		2	10	24	1	21	58
Final Determination			1	29	2	23	55

Investigative process

Following consideration of the investigative referral received from the HIC and any submission received from the practitioner, the usual practice is to seek medical records and any other relevant documentation from the practitioner. The HIC is asked to provide a random listing of services in the areas of concern. The person under review is then given a notice to produce records for the patients for whom these services were provided.

The PSR's medical staff examine these records and I seek further medical or other professional advice as is appropriate to help me decide whether or not the practitioner may have engaged in inappropriate practice. The confidentiality and privacy provisions of the Act affect all people involved in this process and these requirements are made very clear to outside consultants and experts when advice is sought.

I then consider the appropriate course of action, being one of the following:

- dismissing the referral section 91
- negotiating an agreement section 92
- establishing a PSRC section 93

Section 91 dismissal

If the investigation suggests there are insufficient grounds for a PSRC to make a finding of 'inappropriate practice', the Director may dismiss the referral. Such dismissal of the referral has not, to now, been made without a visit to the practitioner's practice to ascertain that the submission and records examined accurately reflect the actual situation. Acceptance of these visits is voluntary on the part of the practitioner but all have willingly acceded to date. The visits are an opportunity for a professional discussion on the Medicare and PSR Schemes and are often extremely useful from a collegiate viewpoint.

Some practitioners have commented that the referral had caused them to critically review their activities and to change their professional behaviour. Such statements were supported by HIC statistical data on the practitioner. A number of practitioners also commented that such change in behaviour had markedly improved their professional satisfaction and personal and family life. However, it is a sad reflection that some probably will be referred to the PSR again, despite assurances to the contrary for changed behaviour.

Section 92 negotiated agreement

The amendments to the Act allow the Director to reach a negotiated agreement on a referral with the practitioner. The terms of the settlement must include an acknowledgement that there has been 'inappropriate conduct' and the agreement can include:

- a reprimand,
- repayment of Medicare benefits, and/or
- total or partial disqualification for up to three years.

Any such agreement must be submitted for ratification to the Determining Authority which may reject the agreement. As a section 92 agreement is regarded as an adverse finding, a second adverse finding automatically requires referral to the Medicare Participation Review Committee (MPRC). Agreements are confidential and the practitioner is not publicly identified.

With the new referrals received, subsequent to the amendments to the Act, a number of practitioners and/or their legal advisers have indicated they wish to consider entering such an agreement. At the time of this report no agreements have been reached. One practitioner attempted to make an agreement but was not prepared to agree to any sanction involving repayment or a period of disqualification from the Medicare arrangements, which I found unsatisfactory.

It is anticipated that a number of these section 92 agreements will be reported next year.

Section 93 PSRC hearings

During the year, seven new PSRCs were established and those set up in the previous year continued with hearings and a number finalised their reports. The administrative arrangements for PSRC hearings have not led to any complaints and are working satisfactorily. Even before the legislative amendments, it had become the practice to forward the PSRC draft report to the practitioner under review seeking further submissions addressing the proposed findings. The PSRC, on receipt of such a submission, considered it before forwarding its report to the Determining Officer. In the past year, seven finalised reports have been forwarded to the Determining Officer.

The outcomes from the PSRC hearings since the Scheme commenced are listed in Table 2.

Table 2: Outcomes of PSRC hearings

PSRC established	96
adverse findings	64
cleared	14
suspended	3
current	15

In 64 cases a PSRC made a finding of inappropriate practice and in 14 cases they reached a conclusion that no inappropriate practice occurred. These statistics do much to address any perception that a PSRC hearing is in the nature of a 'kangaroo court' and that the referred practitioner is adjudged as guilty before a hearing even commences.

There are currently three cases where the hearing has been suspended. In two cases the practitioners' rendered services are not eligible to attract Medicare benefits because they failed to comply with notices to give evidence or to produce documents. The other relates to a practitioner with a significant medical condition.

Brief synopses of some cases PSRCs have considered, and the relevant findings, are on pages 22–29.

Fraud

Under the old legislation, a PSRC suspended its hearing when it suspected fraud and returned the whole referral to the HIC for investigation and prosecution if a case could be made. Since the beginning of the Scheme, PSRCs thought six cases were possibly fraudulent and were referred to the HIC. Following investigation, some of these cases were subsequently referred to the Director of Public Prosecutions (DPP) to consider prosecution in a Court. The DPP declined to proceed and all the cases have been returned to the PSRC to resume its hearing of the referral.

The revised legislation requires that only the suspected fraudulent conduct be referred to the HIC and the Committee should continue with its hearing. It is evident that substantial difficulties can be experienced in obtaining evidence adequate to use in Court when the matters occurred some years previously.

Reasons for referral

Although many and varied, the reasons for referral can be categorised into five distinct types. Many referrals involve more than one of these categories:

- high volume of services;
- high number of services per patient;
- 'up-coding' and 'co-coding;
- particular services; and
- unusual medical practice.

High volume of services

A small number of practitioners regularly claim for providing a very high number of services on a regular basis. Most general practitioners have great

difficulty in understanding how such large numbers of patients can be seen in the available time. Proper medical practice requires a number of activities:

- obtaining the history of the presenting complaint and, on occasions, a family and past history from the patient;
- an appropriate examination, even if a focused examination;
- development of a diagnosis; and
- implementation of a management plan which may involve arranging for diagnostic tests, prescribing treatment, such as drugs, and explaining the management to the patient.

All of this takes time and no step can be omitted without greatly increasing the risk of patient harm.

Seeing many patients quickly certainly may be financially rewarding for the practitioner but, if this style of practice only allows time for addressing the presenting symptom or problem, it is of little overall benefit to the patient. In medical practice, sins of omission are as important as sins of commission. To date, PSRCs have not accepted arguments that excessively high through-puts can be explained by claims of superior ability and organisation or vast experience. As noted in previous reports, workforce issues generally do not provide a rationale for such conduct.

In the revised Scheme a provision has been inserted by which practitioners who exceed a prescribed pattern of services will be deemed to have been engaged in inappropriate practice unless a PSRC accepts that there were exceptional circumstances. During the review of the PSR Scheme the profession endorsed this proposal.

The pattern of services is prescribed in regulations. Currently, for general practitioners, the prescribed pattern is constituted when 80 or more professional attendances are rendered on each of 20 or more days in a 12-month period. It is important to appreciate that this is not a 'speed limit' but a reversal of 'onus of proof'. Servicing at a level below that prescribed pattern does not prevent a practitioner from being asked to justify their conduct in the PSR process.

It has been well reported that there is increasing corporatisation of medicine, particularly in the diagnostic areas of pathology and radiology, but now rapidly extending into general practice. The experience of the past five years has been that a number of referrals have come from such corporatised practices. It has

been obvious that pressure, overt or covert, is put on practitioners to see as many patients as possible and suspicion has been aroused that requesting pathology and diagnostic imaging tests is being encouraged. The rationale for this is often a perceived need to practise 'defensive medicine'. Operators of such practices should ensure the practitioner is free to carry out their professional activities with no restriction on their professional autonomy.

High number of services per patient

This category involves practitioners who provide, on average, a higher number of services per patient than their peers. Sometimes, it is explained by the practitioner having a small and older patient base. However, it is often the result of a practitioner acceding too readily to patient demands without having regard to the medical or clinical necessity for the service. Enquiry by a PSRC often reveals a very large number of prescriptions for narcotics or benzodiazapines are being issued.

'Up-coding' and 'co-coding'

'Up-coding' is a euphemism for claiming for payment of a service attracting a higher Medicare benefit than the service actually performed. Although this could be considered a fraudulent claim, it would be difficult, if not impossible, to have such a finding upheld in an Australian court because of the difficulty of proving intent to defraud.

'Co-coding' describes the situation where a practitioner regularly submits claims for one or more services in the Medicare Benefits Schedule in association with another discrete service. The situation may be that the lesser service could be expected to be part of the major claimed service. Another example is the claim for provision of an unnecessary extra service in association with the appropriate service, for example, an additional consultation at the time of a pre-arranged minor surgical procedure.

Particular services

Experience has shown that some practitioners are submitting very high numbers of claims for investigative, diagnostic or therapeutic procedures. Questioning in the PSRC hearing often reveals there was no proper clinical indication for the procedure. It is hard to escape the conclusion that the

indication for the procedure was simply that the practitioner had access to the equipment necessary for that procedure. In such situations as indeed in many others, it is evident that patients are not able to audit the indications for the procedure or the subsequent claims on Medicare.

Unusual medical practice

Practitioners who engage in practice that can be characterised as alternative or complementary must be prepared to justify their practice and their claims against Medicare in light of the legislative requirements that services attracting a Medicare benefit be 'clinically relevant'. This is even more relevant in the prevailing climate of Evidence Based Medicine.

Practitioners referred

A common factor among practitioners referred by the HIC is that they are professionally isolated and have little contact with professional colleagues. Also, practitioners who fail to keep their professional knowledge up-to-date are more likely to be referred. Others are manipulated by more senior practitioners, 'employers' or have deluded themselves. Another category could be defined as being disabled, due mainly to illness or substance abuse. There is no denying that a common cause of this behaviour is dishonesty, with greed as the major motivator. As mentioned previously, it is extremely difficult to secure evidence for successful prosecution for fraud in these matters.

Medical records

The importance of the medical record has again been demonstrated at hearings. Maintaining good records is an important element in justifying the service in the PSR process, as it is in any justification procedure in other jurisdictions. This importance has been reinforced by the requirement of the legislation that an adequate and contemporaneous record be required for any service which attracts a Medicare Benefit payment. A PSRC is now required to have regard to whether the practitioner has kept adequate and contemporaneous medical records in its consideration of an adjudicative referral and to take this matter into account when making decisions on whether a practitioner engaged in inappropriate practice.

State and Territory Medical Boards are now issuing their registrants with guidelines for the medical records required for safe professional practice. The required standard is usually stated as a record that would enable another practitioner to take over the care of a patient so the care of that patient is not compromised. The professional view of the medical record is that it is a record of the patient's health care over a period of time. In cases where a PSRC has not made an adverse finding, the medical records have been such that they supported the practitioner's conduct.

As noted previously, regulations under the Act regarding 'adequate and contemporaneous records' have been made.

Alteration of documentation

A number of PSRCs have had the strong impression that the medical records produced have been altered subsequent to the notice requiring their production. This is an offence under the Act and arrangements are now in place to enable prosecution of cases involving such fraudulent alterations. State and Territory Medical Boards are also very concerned by such conduct and have significant penalties at their disposal.

Regulatory bodies

The interest of the State and Territory Medical Boards in the PSR process continues. With the amendments to the Act, the Director and the Determining Authority now have the ability to refer significant relevant concerns to medical boards and professional regulatory bodies, and to other organisations as defined in the regulations. The concerns that would lead to a referral to a medical board are those related to ensuring the safety of the public.

The investigative process, as outlined above, which gives access to direct clinical information allows an assessment to be made as to whether there could be a concern meriting the attention of a medical board. Three medical practitioners were referred to the relevant State Medical Boards, two by a PSRC under the old legislation and one by the Director under the new.

The concerns leading to referrals related to impairment of a practitioner and practitioners appearing to be dangerously supplying drugs.

In April 2000, I attended the Annual Meeting of the Federation of State Medical Boards of the United States of America held in Dallas, Texas. This was again a most interesting and stimulating meeting and included representatives from countries other than the USA. Many of the sessions were very relevant to the conduct of the PSR process and I gained valuable information and made interesting contacts.

I took the opportunity to visit and hold discussions with the College des Medicines du Quebec and the College of Physicians and Surgeons of Ontario which have similar responsibilities to the PSR in the Canadian system as well as their standard regulatory activities. In Toronto I also met with the President and Executive Director of the Ontario Medical Association. It was pleasing to realise that the OMA strongly supported the professional accountability processes run by the College in Ontario.

Australian professional organisations

Opportunities to outline the PSR process to relevant professional organisations are gladly taken. In the past year I continued to accept invitations to address medical professional gatherings and medico-legal meetings. Such speaking engagements have included the Annual Scientific meeting of the Australasian College of Dermatologists, Divisions of General Practice and several meetings of the associations of ethnic medical practitioners. These include the Australian Arabic Medical Association, Australian Chinese Medical Association, Australian Vietnamese Medical Association and the Overseas Medical Graduates Association.

I have found these meetings to be extremely worthwhile, eliciting an interest in, and an appreciation of the rationale for the PSR Scheme. After a full explanation is given, strong professional support is evident.

A visit to Darwin, on an unrelated matter, allowed me the opportunity to meet with the local leaders of the profession. At this meeting were representatives of the Medical Board of the Northern Territory, the Australian Medical Association, the Royal Australian College of General Practitioners and the Top End Division of General Practice.

I also attended the Annual Scientific meeting of the Royal Australian College of General Practitioners held in Adelaide in October 1999 and am pleased to record that I will be making a presentation on the Professional Services

Review Scheme at that College's Annual Scientific Meeting in Townsville in October this year.

I again accepted the invitation to give a lecture to the students of the graduate medical course at the Medical School of the University of Queensland. The lecture was on accountability processes and requirements of professional medical practice. The lecture provoked some interesting questions and discussions. We are endeavouring to determine if it is possible to expand this activity to other medical schools.

Determining Authority

The legislative amendments established a Determining Authority and this replaced the Determining Officer under the previous Scheme. The Determining Authority is required to make determinations from a range of sanctions laid down in the Act following a finding of 'inappropriate practice' by a PSRC. The Authority is a three-person panel. The chair must be a medical practitioner, the second member must be a layperson and the third member must be of the same profession as the practitioner against whom the adverse finding has been made.

The range of sanctions available to the Determining Authority has not altered from the previous Scheme. They include:

- reprimand;
- counselling by Director or nominee;
- repayment of Medicare benefit payments; and
- disqualification – total or in part – from the Medicare arrangements for periods of up to three years.

The Minister appointed the members of the Authority on 22 May 2000 following consultation, as required by the Act, with the Australian Medical Association and the relevant professional organisations for the other health care professionals. The appointments have been made in such a way that substitutes are available should one or other member be unavailable for any reason. Experience has shown the need for such an arrangement.

The Director is responsible for administrative, legal and secretariat support for the Determining Authority. Given the requirements of the legislation, a secretariat unit has been established with its own independent facilities to

provide support to the Determining Authority. We have also made arrangements for independent legal counsel.

It is intended that the Determining Authority, as constituted for considering cases involving medical practitioners and optometrists, convene in the near future to gain an understanding of the legislation and the task they are required to perform.[1]

Administration

The administrative arrangements in place for conducting PSRC hearings operated smoothly throughout the year. I thank the Administrative Appeals Tribunal and the Industrial Relations Commission for the use of their hearing rooms. Hearings are audio-recorded and Auscript provides a transcript. I also thank Auscript which has always provided services to the satisfaction of the PSRCs and secretariat. The need to have a hard copy of documents tendered and considered in PSRC hearings gives rise to a very resource-intensive commitment. We are, therefore, considering the increased use of computer technology in hearings.

Workshop for Deputy Directors

Once again the Deputy Directors who chaired PSRCs met in Canberra in March 2000 to review the past year's activities and to consider the future in the light of the significant changes to the PSR procedures made by the 1999 amendments to the Act. With increased legal involvement in the Scheme, a major focus was on the legal issues which lawyers may raise in hearings and which the Chair of the PSRC needs to address. Mr Hugh Selby, who had been a trainer in the workshops held for panel members, facilitated a very productive session on the first day of the workshop.

These workshops are most important in ensuring uniform standards and maintenance of procedural fairness across all PSRCs whatever the State in which they are held.

---

1. The first meeting of the Determining Authority was held in Melbourne on 18 August 2000. The discussions covered the reasons for, the history of, and the current processes of the PSR scheme. Practical experience was gained by considering a dummy report and formulating a draft determiniation.

As in previous years, I was impressed by the commitment shown by the Deputy Directors who fully understand both the community and professional responsibilities involved in their difficult roles.

Litigation

In the past year we have had an interest in two cases in the Federal Court: Tankey v Adams and Mercado v Holmes. A brief discussion of each is below.

Tankey v Adams [1999] Q185 of 1999

Dr Tankey appealed against a decision in the Federal Court by Mr Justice Einfeld which allowed in part an appeal by Dr Tankey against a decision of a PSRC.

Dr Tankey had carried out 27 048 services in 1994 at a cost to Medicare of $580 576. There were more than 140 services on 26 days. His conduct was referred to PSR by the HIC which believed 'that the appropriate level of clinical input may not be able to be maintained at this servicing rate on a regular and continuing basis'. The doctor also initiated 10 266 pathology services, 3 183 diagnostic imaging services and 1 306 patient referrals to consultant physicians or specialists. The HIC believed these services or referrals were not reasonably medically necessary or appropriate for the care of the patients.

The Committee found that Dr Tankey had developed a consistent pattern of extremely high and rapid throughput of patients and had abdicated from the professional responsibility to allocate enough time to elucidate and address patients' problems and record a proper medical history. It also found fault with the pathology and imaging requests and the referrals. It concluded that his conduct was unacceptable to the general body of vocationally registered general practitioners.

The Determining Officer directed counselling, repayment of $258 277.45 of Medicare benefits, and substantial periods of disqualification. On review, the PSR Tribunal increased the repayment, but this was reversed by the Federal Court.

Dr Tankey appealed to the Full Federal Court and the hearing of the appeal was held in Brisbane on 22–23 November 1999 before Ryan, O'Connor and Weinberg JJ. At the end of the reporting period judgment had not been handed down.

I observed, in my 1998–99 report, that in Federal Court action based on the core professional review aspects of the process, the score card read three judges split each way. It is hoped that a decision in Tankey, when handed down, will resolve some of the outstanding legal issues.

This case certainly highlights the problem of introducing a new or revised legislative Scheme as it has taken five years from the initial referral to this time without resolution. The possibility still exists of issues being argued and an appeal to the High Court of Australia.[2]

Mercado v Holmes [2000] FCA 620

This Federal Court decision considered issues as to the scope of a referral and the effect of apprehended bias. The HIC had referred Dr Mercado's conduct to PSR expressing concern that, in light of the high volume of services rendered by him, it believed 'that the appropriate level of clinical input may not be able to be maintained at this servicing rate on a regular and continuing basis'. The practitioner's total services in the referral period exceeded the 98th percentile of all medical practitioners in Australia and he rendered more than 60 services per day on 93 occasions and more than 80 services on nine occasions.

Included with the referral papers was a copy of a counselling report in relation to an earlier period which alleged that Dr Mercado had admitted that his peers may find inappropriate his long hours of work in relation to his high volume of services. Dr Mercado had been sent a copy of the report but had not contested the allegation at the time.

---

2. The full bench of the Federal Court (handed down on 10 August 2000) unanimously found for the Commonwealth on every ground of appeal. In particular it held that the PSR process was constitutionally valid, it upheld the peer review process and considered that peer assessment would generally be reliable. It said the case against Dr Tankey was quite overwhelming and it would defy common sense to suggest that the strength of the evidence may not be taken into account.

The Court applied the High Court view that reasons given by statutory decision-makers should not be overzealously scrutinised for legal errors, it said that testimonials and patient surveys were of little weight in a peer review of professional conduct and, importantly, it held the process was procedurally fair. In this regard the Committee had identified and particularised matters of concern which came to its attention during the proceedings, communicated these to Dr Tankey, and invited him to make submissions on them. The Committee had provided a comprehensive list of the adverse matters and Dr Tankey had made no complaint about lack of particulars until the matter first went to court.

Dr Tankey did not seek leave to appeal to the High Court

The PSR Committee's letter to Dr Mercado stated that it was concerned about whether he was able to provide an appropriate level of clinical input, and also whether the services were reasonably medically necessary. Justice Heerey held, following previous decisions of the court, that this second concern could not be considered by the committee because it was distinct from the issues relating to high volume of servicing and had not been specified as a concern by the HIC.

The judge also held it was reasonable to think that the (non-lawyer) Committee could be biased by the alleged admissions of inappropriate practice of the very kind under review, particularly as the information came from a credible source. He believed this despite the Committee acknowledging the irrelevance of the alleged admissions to the current hearing and stating that it would ignore them.

The court ordered a permanent injunction to restrain further hearings. An appeal has been lodged on the bias issue.

Appeals to the Professional Services Review Tribunals

Table 3 gives a statistical overview of the appeal activity under the PSR Scheme since its inception. The table covers the cases in which an appeal is made by a practitioner against a Final Determination by the Determining Officer. Appeals to the Federal Court on machinery and administrative process matters are not included.

Table 3: Appeals to PSRT and Federal Court

	Lodged	Hearing	Judgment
PSR Tribunal	22	14	14
Federal Court	4	3	3
Full Federal Court	2	2	1

In appeals to the Professional Services Review Tribunals, the applicant withdrew the appeal on two occasions and in four other cases resolution was reached without a formal hearing. Two cases remain outstanding.

In the Federal Court, Dr Jean McFarlane had appealed against a PSRT decision. As the appeal grounds were similar to those of Dr Tankey, the matter has been held over until the Tankey decision is handed down by the full bench of the Federal Court.

Report of Determining Officer

A report provided by the Determining Officer on the role and activities of that position for the year is on pages 30–31.

Department of Health and Aged Care

With responsibility for the policy parameters of the PSR Scheme, the Department has submitted its comments on the Report of the Review Committee. This appears on pages 32–34.

Formal counselling

One of the sanctions available for inclusion in a determination is that the Director or nominee counsel the practitioner. I carried out eight formal counsellings throughout the year. It is a common component of most determinations. It has proven to be a most valuable exercise and I have been pleased by the manner in which counselling has been received.

Following most counselling it has been my impression that the hearing process and judgment by a peer group has been a salutary experience as well as an educational process. It is unlikely that most of the counselled practitioners will again be the subject of an adverse finding by a PSRC. The effect of such a second finding, with mandatory referral to an MPRC, is stressed at counselling.

Advice to practitioners

Based on the experience of six years of the PSR Scheme, I repeat my annual advice to practitioners to help them reduce the possibility and risk of being asked to justify their conduct to a committee of their peers. My advice remains as given in all previous reports:

- listen to the HIC Medical Adviser when HIC concerns are explained. Such visits should make practitioners review their conduct and even seek advice from colleagues and their professional associations. The HIC Medical Advisers and support staff are available to answer queries regarding Medicare and the interpretation of Medicare Benefit Schedule items. It is essential that such advice be documented.
- discuss problems with professional colleagues – there may be other professional views on long- or strongly-held beliefs. Medicine is a

collegiate profession: professional associations and colleagues are only too pleased to offer guidance but advice can only be relevant if they know all the facts.

- keep good records as they are a vital element in any defence in a justification proceeding. This is now an essential element of practice under the amended legislation.

PSR Committees

I acknowledge with gratitude the contribution and commitment of PSRC members. This difficult and onerous task can be stressful on the member and demanding on time. All members who have served in this role have carried out their duties responsibly, carefully and with consideration for the colleague upon whom they are required to make a judgment.

A special tribute must be made to the Deputy Directors whose role it is to chair the Committees, coordinate and manage the hearing process and prepare the report to the Determining Officer, and now the Determining Authority. All have carried out these responsibilities effectively. With the revised arrangements they will have an increased responsibility.

It is pleasing to record that the Remuneration Tribunal responded favourably to a submission from the Department of Health and Aged Care on the sitting fees and allowances to be paid to those involved in the PSR Scheme: members of the PSR Panel, Professional Services Review Tribunal and the Determining Authority.

PSR staff

I thank my staff for the competent manner in which they provided the secretariat and other support functions. It is always pleasing, as frequently happens, to receive commendations and laudatory remarks on the performance of the PSR personnel. I am most grateful for their efforts and their support.

Medical support

The organisational structure now has a medical section with two full-time positions. It is fortunate that one of these holds both medical and legal qualifications. We have also used the services of part-time medical practitioners in the office in Canberra in the examination of medical records in the investigative

process. It is obvious that only medical practitioners have the ability to assess these records. Advice has also been sought from consultants on particular issues and these are both medical and optometrical practitioners.

Legal support

Operating in a legalistic environment it is essential to have access to, and confidence in, first-class legal advice. Our legal support is provided by the Canberra office of Minter Ellison Lawyers who have provided a lawyer who is outposted to the PSR office. This is proving to be a most successful arrangement.

Statistical sampling

The regulations to the Act covering statistical sampling have been gazetted and are now in force. Expert statisticians were used to give advice and support in this area. Cases currently underway are being examined based on the use of a sampling methodology. This appears to be satisfactory in practice and we are confident the methodology used will survive legal challenge. The Act provides the ability to use different methodologies to that prescribed in the appropriate circumstances. Such different methodologies must be valid statistically and be from a statistician accredited by the Statistical Society of Australia. Professor Des Nicholls, Head of the Department of Statistics and Econometrics at the Australian National University is the main source for this advice.

Conclusion

The past year has been a year of significant change with major legislative amendments impacting on the Scheme. Management of these changes is progressing satisfactorily and the outcome would appear to be a better focus on the problems presented in the referrals.

In the professional arena, the PSR Scheme continues to have very strong support, especially from those who have been involved in any way. I am pleased to record that no member of the panel who has served on a PSRC has raised any objection as to the fairness, balance and professionalism given by colleagues to this difficult task. Full explanation of the Scheme to professional groups always evinces support for the PSR process.

While I have never underestimated the challenges in establishing a fair and effective professional peer review system, I believe that the efforts in putting

such a system in place have the support and encouragement of the government, the general public and the vast majority of the profession. The new PSR arrangements described in this report give me great confidence that, with the continued cooperation of the profession, we will be able to change the practice behaviour of those few people who practise in ways that their peers are unable to support and contribute to ensuring that the Australian public receives the quality professional care it deserves. It also ensures the use of community resources has transparent accountability.

Dr John Holmes
Director
Professional Services Review
25 October 2000

CASE SUMMARIES

When the legislation establishing the PSR Scheme was first introduced into Parliament, the then Minister formally advised the Senate Standing Committee on Community Affairs that the Director would, in his annual report, provide, in a narrative style, examples of cases which resulted in findings of 'inappropriate practice'.

The following summaries are provided in accordance with that undertaking. Experience has shown that these cases are of interest to the profession. Often the existence of such behaviour is not even suspected by the majority of practitioners who are unaware of the deviant activities of some of their colleagues. It is not unusual for a practitioner to be unaware of what the neighbourhood practitioners are doing – this situation can even occur in the confines of a partnership or group practice.

These illustrative cases are abbreviated and not all the issues involved in an individual case are detailed. For ease of reading, the numbers given are usually rounded.

Case AB

This vocationally registered general practitioner mainly worked at two metropolitan extended hours medical centres.

The HIC's referral focused on the practitioner's very high number of services (28 000) for 11 600 patients claimed in the referral year attracting Medicare benefits of $576 000. Of those services, 20 500 were level B (item 23) consultations.

The Committee found that the practitioner practised symptom-oriented medicine characterised by an initiation of treatment with no effort to follow-up with patients, monitor their progress or adjust medication when necessary. It found numerous deficiencies in the standard of the practitioner's medical records, noting also that the practitioner neither maintained an appropriate recall system, nor could demonstrate that tests were appropriately followed up.

Of great concern to the Committee was the practitioner's conduct in treating patients suffering from hepatitis C, multiple sclerosis and cancer with lithium,

a drug used in the treatment of manic depression but unproven in the treatment of these conditions. The Committee noted that the practitioner did not explain the toxic side effects of lithium to the patients, therefore did not obtain their informed consent. It considered that the practitioner was engaging in experimental treatment in an unethical manner that was of no value to the actual clinical management of these patients. Because of the threat to the life or health of these patients, the Committee referred this aspect of the practice to the State Medical Board.

Case CD

This practitioner worked in a medical clinic in an inner metropolitan area, the clientele of which consisted mainly of pensioners and health care card holders from the local area. More than half the practitioner's patients were aged under 30 years of age. The practitioner advised an interest in drug and alcohol related problems and Aboriginal health and had a number of methadone patients. Over an 11-month period, the practitioner provided 23 300 services (the 99th percentile being 17 000 services) at a Medicare benefits cost of $560 000.

The Committee's inquiry extended over three days of hearing. It found that the clinical input into many consultations was lacking and considered the practitioner's treatment of some frequently-seen patients to, at times, constitute reckless management coupled with a lack of concern for their welfare. Other criticisms related to the practitioner's use of benzodiazepines for methadone patients, finding that these prescriptions were neither appropriately written nor condoned by drug and alcohol units or detoxification programs.

Case EF

This practitioner, who worked in a large metropolitan city extended hours centre, had previously spent 11 years working as a solo general practitioner. The practitioner was a self confessed workaholic, working between 10 and 12 hours a day on the five week days, between 8 and 9 hours on Sundays as well as taking on extra shifts if staff shortages occurred, including night shifts.

Of the 18 000 services provided in the 12 months referral period, 3 700 (22 per cent of all consultations) were level C (complex and >20 minute) consultations and almost 1 000 (6 per cent of all consultations) were level D (complex and >40 minute) consultations. The practitioner's use of these items

substantially exceeded the 99th percentile and Medicare benefits paid exceeded $500 000.

The Committee found that, for many of these longer-attendance items, the practitioner had acted more as a social worker and that the related clinical notes failed to support the charging of many of these items. In one case, the practitioner had seen the patient 125 times during the 12 months, 97 times charging for level C attendances and nine times for level D attendances. In another case, the practitioner saw a patient 98 times and charged a level B attendance for what essentially was cleaning and dressing leg ulcers, many of which had been done by the nursing staff. The Committee also found examples of inadequate clinical input to services rendered, mis-itemisation of certain procedures and failure to adequately and appropriately institute a management plan for the treatment of some patients.

Case GH

This practitioner, who had post graduate training in acupuncture and Chinese medicine, worked from two practice addresses in a large regional centre. Time spent at the practices averaged 14 hours per day on week days with an additional six hours on Saturdays. Outside these normal working hours, the practitioner periodically spent additional time preparing herbal medicines, third party and workers compensation reports and practice management duties.

During the referral period, the practitioner rendered 19 000 services to 3 400 patients, the 99th percentile being 15 600 services. Of these services, 12 200 were level B (item 23) consultations and 7 000 were acupuncture services (item 173). On 190 occasions, the practitioner provided more than 60 services per day.

The Committee found that the practitioner provided episodic care, kept extremely poor clinical records, practised outdated acupuncture techniques and, although having the correct equipment, had a flawed technique for ensuring the sterility of the acupuncture needles, the use of which placed patients in danger of serious infection. Other Committee concerns focused on the practitioner's prescribing antibiotics for viral infections, the use of steroids and non-steroidal anti-inflammatory drugs coupled with acupuncture and an apparent failure to monitor the liver function of patients treated with herbal medicines.

Case IJ

This general practitioner was referred by the HIC because of concerns about high average number of services per patient and high levels of prescribing. Of the 4 000 services provided (to 700 patients at a cost to Medicare of $135 000) in the 12-month referral period, 1 100 were regional or field nerve blocks and 150 were procedures for pain relief. The practitioner's prescribing of morphine sulphate and oxycodone suppositories exceeded the 99th percentile for both prescriptions.

The Committee noted the practitioner's admission to not having any formal training in psychological medicine, counselling, or in 'pain management', but agreed that a medical practitioner may acquire skills through less formal means.

It accepted that the practitioner's desire to help patients with back pain was genuine and acknowledged the existence of unmet need with respect to services available to people who suffer from all forms of chronic pain. It also accepted that a medical practitioner who practised in the area of chronic back pain was likely to see such patients more frequently and over longer periods of time that a practitioner might with patients with other complaints.

However, its inquiry revealed that the practitioner prescribed narcotics repeatedly in response to patient pressure rather than on the basis of a sound therapeutic strategy. Accordingly, the Committee found that this conduct would be unacceptable to the general body of general practitioners.

Case KL

After graduation, this practitioner worked overseas, primarily as a surgeon but also in general medicine, before returning to Australia to enter private general practice. The practice locations included a private hospital, owned by the practitioner.

HIC concerns related to both in-patient and out-patient services, high levels of rendered and initiated services (including pathology and diagnostic imaging), the clinical relevance of rendered and initiated services and the adequacy of clinical input. The practitioner's level of services per patient of 9.16 far exceeded the 99th percentile (7.56) as did the ratios of pathology services and diagnostic imaging services per patient. The practitioner's five highest serviced patients received 175, 152, 145, 133 and 129 services respectively in the referral period.

The Committee found the practitioner demonstrated deficiencies in medical knowledge and practised in a style which engendered excessive servicing. It discovered a pattern of prolonged hospital admissions with daily attendances by doctors in circumstances where clinical relevance could not be demonstrated. While many patients were seen by other doctors while hospitalised under the care of the practitioner under review, no entries could be found in the practitioner's practice or hospital records regarding these other attendances and the practitioner was unable to enlighten the Committee as to their clinical necessity.

The Committee was highly critical of the practitioner's initiation of pathology tests, which were mainly for in-patients. It also found instances of inappropriate initiation of diagnostic imaging tests that were not clinically relevant and tests for health screening (for which payment of Medicare benefits is precluded). The Committee also found that the practitioner had failed to initiate diagnostic imaging tests in critical situations.

Medical records were found to be almost uniformly inadequate because of handwriting so illegible that even the practitioner had difficulty reading and interpreting the notes. The notes rarely stated reasons for hospital admissions and contained minimal details of medical and/or social histories. Investigations and/or subsequent test results were seldom recorded and were arranged in a haphazard manner, making it a complicated, error-prone and time-consuming task to access and assess information.

The Committee was so concerned about the potential danger to patients' lives that it referred the practitioner's conduct to the Medical Board in the particular State.

Case MN

This overseas graduate practised as a solo general practitioner from a suburban location in a major capital city for over 20 years. The HIC's concerns related to the high average number of services per patient (8 000 services to 1 200 patients) and the high proportion of long and prolonged consultations and home visits that comprised in excess of 50 per cent of all services.

Following consideration of all the material before it, the Committee formed the opinion that, in approximately 80 to 90 per cent of these services, the

practitioner had not provided an acceptable level of clinical input or had failed to demonstrate the clinical relevance of the service.

Another area of concern for the Committee was the practitioner's use of injectable antibiotics. The Committee could not accept the practitioner's indication for giving such injections, that is, it was the patients' cultural belief that they could only get better if they were given an injection.

The Committee was also concerned about the quality of the medical records and found them to be clinically inadequate, lacking important information and, in some instances, they did not accurately reflect what actually had occurred during the consultation or visit. Furthermore, in respect of more than 30 per cent of attendances examined by the Committee, the practitioner had failed to even record the encounter.

Case OP

This practitioner had been in private medical practice for over 30 years and had spent the last 14 years working in 'a private primary care allergy unit'. The HIC's referral concerns related mainly to the high average number of services per patient.

The Committee found that the practitioner's most highly serviced patient received a total of 490 services in the year covering the referral, of which 480 were either long or prolonged home visits. On 134 occasions, one patient received both a long and a prolonged home visit on the same day. On 244 days during the referral period the practitioner saw two or more members of this patient's family. However, during a school holiday period of 10 days, no services were rendered by the practitioner (or any other practitioner) to any member of this family. On the day before this 10-day period, the practitioner attended all eight members of the family unit and on the day following the 10-day period, the practitioner attended seven members of the family.

Although the Committee asked the practitioner to produce 159 patient records to help in its examination of the practitioner's conduct, no records were produced. The practitioner initially claimed the records could not be produced because they were the property of her employing company and that the director of the company (the practitioner's daughter) had refused to release them. After the Committee issued a notice to produce the documents to the

daughter (which she ignored), the practitioner ultimately produced computer-generated information (provided by the daughter) in respect of each of the 159 patients. Beyond showing the names and addresses of the patients, there was not a single clinical entry for any of the patients. All clinical information was claimed to have been lost because of computer crashes. It was also claimed that the practitioner's handwritten clinical notes had been destroyed after they were scanned into the computer.

During the hearing the practitioner repeatedly asserted that it was not possible to comment on the condition of any patient without access to the clinical records. The practitioner refused to offer any insight into the condition of any patient on the basis of personal recollection, including the condition/s of the most heavily serviced patient.

The Committee found it difficult to give any credence to the claims made by the practitioner. The Committee concluded that the practitioner deliberately withheld clinical records and deliberately refused to comment on patient clinical conditions in order to avoid professional accountability.

Notwithstanding the practitioner's non-cooperation, the Committee concluded that the practitioner had engaged in inappropriate practice by virtue of encouraging patient dependency. It also referred to the State Medical Board two matters relating to its concerns about possible threats to the health of some of the practitioner's patients.

Case QR

This vocationally-registered general practitioner was the principal of a suburban medical centre in a major city. The HIC's referral concerns were that the practitioner was rendering a high volume of services and that his initiating of pathology and diagnostic imaging services was inappropriately high. In proceeding with an examination of the practitioner's conduct, the Committee followed an approved sampling methodology.

The significance of the sampling methodology was that it allowed the Committee to consider random samples of the practitioner's services and to extrapolate any findings of inappropriate practice to all the services in each area of concern. The Committee examined six areas of concern, namely:

- rendering of level B surgery consultations (item 23);

- rendering of level C surgery consultations (item 36) when these consultations were rendered with another service on the same day;
- rendering of level C surgery consultations without any other service being rendered on the same day;
- rendering of Holter ECG monitoring services (item 11709);
- rendering of ECG exercise monitoring (item 11712); and
- initiation of diagnostic imaging services.

The concerns related to consultation items, particularly level C consultations, level C consultations when rendered in association with a diagnostic test, and the use of and indication for cardiac tests, namely stress testing and Holter monitoring.

The Committee found that many of the tests were performed without an appropriate clinical indication, that the time involved in the procedure was also claimed as a consultation item and that an appropriate level of clinical input was lacking for many of the consultations.

The use of the sampling methodology in the report of the hearing will help the Determining Officer quantify the level of sanction in the determination.

DETERMINING OFFICER'S REPORT

Overview

The role of the Determining Officer within the Professional Services Review Scheme focuses on making determinations in respect of practitioners who have been found, by Committees of their peers, to have engaged in inappropriate practice.

Under revised arrangements authorised by the *Health Insurance Amendment (Professional Services Review) Act 1999*, a Determining Authority will take over the role of the Determining Officer. The Determining Authority's role will apply to all cases referred by the Health Insurance Commission after August 1999. The Determining Officer continues to be responsible for cases referred before the relevant provisions of the amending legislation came into effect in August 1999.

In making a determination, the Determining Officer is required to apply one or more of the directions specified in section 106U of the Act. These include requiring the practitioner to be reprimanded and/or counselled by the Director of Professional Services Review or his nominee, repaying to the Commonwealth the whole or part of the Medicare benefit paid for services in connection with which the practitioner was found to have engaged in inappropriate practice and full or partial disqualification from Medicare for periods of up to three years.

The Determining Officer also defends requests for reviews of determinations in Professional Services Review Tribunals (PSRTs).

Determinations

During the year, the Determining Officer received seven reports from Professional Services Review Committees, all of which contained findings that the person under review had engaged in inappropriate practice. Due to the Determining Officer's resources being directed almost exclusively during 1998–99 to reviewing the PSR Scheme, consideration of a number of reports, forwarded from Committees in 1998–99, remained outstanding at the beginning of 1999–2000. Notwithstanding that, in the early part of the year, the Determining Officer's resources continued to be directed to reviewing the PSR Scheme, 21 draft determinations and 18 final determinations were issued.

The recipients of 15 final determinations accepted those determinations without seeking any further review. Sanctions in respect of these determinations include repayment of $24 263.85.

Professional Services Review Tribunal Decisions

Practitioners in respect of whom the Determining Officer has made a final determination may ask the Minister for Health and Aged Care to refer the determination to a PSRT for review. A PSRT comprises a President, who is a former judicial office holder, and two members of the same profession as the person under review. Proceedings before a Tribunal are conducted with as little formality and technicality as a proper consideration of the matter permits. Unlike proceedings before Professional Services Review Committees, the person under review may be legally represented.

No PSRT hearings took place in 1999–2000. At 30 June 2000 there were two cases awaiting a hearing by a PSRT.

Federal Court Decisions

A decision on the appeal in the Federal Court in the *Tankey v Adams* case is pending.

Determining Officer Activities

The following table shows the Determining Officer's actions on cases in 1999–2000.

PSRC reports to Determining Officer	7
PSRC reports sent to persons under review	7
PSRC reports indicating the person under review was not practising inappropriately	0
Draft determinations issued	21
Submissions made to Determining Officer on draft determinations	12
Final determinations issued	18
Final determinations accepted without appeal	15
Requests to the Minister for a review by a PSRT	3
Applications for review withdrawn prior to hearing	5
Reviews conducted by a PSRT	0
Decisions handed down by a PSRT	0

Department of Health and Aged Care Report

Overview

The Department of Health and Aged Care assumes overarching policy responsibilities for advice to the Minister on development and maintenance of the PSR Scheme. This role requires the Department to constantly liaise with the respective stakeholders in the Scheme and perform the broader tasks of reviewing policy and developing legislation. The Minister has appointed a senior officer of the Department, the First Assistant Secretary, Health Access and Financing Division, to the position of Determining Officer under the Scheme. The Determining Officer's role and report for 1999–2000 is on pages 30–31.

Other more specific tasks falling to the Department include overseeing the operation of the Professional Services Review Tribunals and the appointment of Presidents and members of those Tribunals. In addition, the Department provides legal and administrative assistance to the Determining Officer in preparing determinations and responding to challenges to determinations to Tribunals or the Federal Court. The Department also renewed its Memorandum of Understanding (MoU) with the Administrative Appeals Tribunal (AAT) whereby the AAT acts as Registrar to the various PSRTs.

Legislation

The operation of the PSR Scheme is governed by legislation contained in the Act.

A comprehensive review of the PSR Scheme recommended a series of amendments to the Act to enhance the operation of the Scheme.

These recommendations are detailed in the *Report of the Review Committee of the Professional Services Review Scheme*, March 1999, and include:

- re-defining the process by which a practitioner's conduct is referred for consideration into a more progressive action where new concerns can be raised;
- increasing the investigation, case preparation and negotiation powers for the Director of Professional Services Review;

- increasing the legal support and more comprehensive training and operating protocols for the PSR Committees;
- clarifying how PSR Committees can investigate and quantify inappropriate practice;
- providing greater legal support for the person under review;
- replacing the Determining Officer (currently in the Department of Health and Aged Care) with a Determining Authority comprising a permanent chair (medical practitioner), a permanent lay person and a third member who is a representative of the profession of the person under review; and
- removing the PSR Tribunals from the process whilst retaining the right of review on points of law.

To amend the Act and give effect to these recommendations, the *Health Insurance Amendment (Professional Services Review) Act (No.95) 1999* was introduced from 1 August 1999. It specifies that the new PSR arrangements apply in respect of matters referred to the Director of PSR by the Health Insurance Commission after this date. Several minor legislative revisions were subsequently needed, and a follow-up amendment to the Act was passed as part of the *Health Legislation Amendment Act (No.159) 1999*, which received Royal Assent in December 1999.

In addition, several subordinate legislative instruments were introduced to provide more detail on the operation of specific aspects of the enhanced PSR Scheme. These are:

- new guidelines in respect of referrals – the Health Insurance (Professional Services Review – Content of Investigative Referrals Guidelines 1999 and the Health Insurance (Professional Services Review – Content and Form of Adjudicative Referrals) Guidelines 1999;
- a new sampling methodology for a PSR Committee to apply in identifying and quantifying inappropriate practice – the Health Insurance (Professional Services Review – Sampling Methodology) Determination 2000 (No.1); and
- new consolidated regulations that specify the circumstances which constitute a prescribed pattern of services for Part VAA of the Act, and set out the standards to be met in order that a practitioner's medical records are adequate and contemporaneous – the Health Insurance (Professional Services Review) Regulations 1999 No.258 as amended.

Professional Services Review Tribunals (PSRT)

The *Health Insurance Amendment (Professional Services Review) Act 1999* preserves the right for practitioners to request a review of determinations made by the Determining Officer for matters referred by the HIC prior to that legislation coming into effect in August 1999. PSRTs are not empowered to review decisions of the Determining Authority which takes over the role of the Determining Officer for cases referred after August 1999.

CORPORATE OVERVIEW

Strategies

- To provide effective and efficient human resource management, financial management and corporate planning services which will enable the PSR to achieve its mission.
- 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 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 cash flow projections provided to management within seven days of the end of the month.
- Percentage of funds spent on training.
- Degree to which externally imposed deadlines and compliance requirements are met.

Performance assessment

This financial year saw a marginal decrease in the corporate costs percentage, 90.01 per cent of total costs, compared to 91.14 per cent in 1998–99. This percentage should further improve over time as the organisation processes more referrals under the amended legislation.

The amended legislation, which came into force on 1 August 1999, greatly expanded the role of the agency and resulted in a major recruitment campaign to obtain medical, legal and administrative support to carry out the new investigative function and to service the Determining Authority. Because the

supporting regulations where not finalised until 1 November 1999, referrals under the new legislation were not received from the HIC until 23 December 1999. As a consequence, in the first half of the financial year particularly, a significant amount of staff effort and resources were channelled into recruitment, training, and developing procedures and practices while the hearings into current referrals continued.

Monthly cash flow projections were produced for management within seven days of the end of the month for 12 out of the 12 months.

As indicated in last year's report there was an identified need to provide more training for the PSRC members and staff. PSR followed through on this commitment and increased expenditure on staff training to 7.69 per cent from 1.95 per cent in 1998–99. This percentage does not include the training provided to PSR staff through the MoU with the Department of Health and Aged Care.

All externally imposed deadlines and compliance requirements were met 100 per cent of the time.

Finance

PSR's 1999–2000 budget appropriation was $3.330 million. In addition, PSR received an equity injection of $700 000 to fitout the expanded organisation. This was PSR's first year of a four-year funding arrangement to cover the expansion of the organisation. PSR was able to secure adequate accommodation in its current building to house staff of the expanded organisation. Stage one of the equity-funded fitout was completed early in the financial year with stage two commencing late in the year.

As mentioned, there were delays in finalising the legislation and associated regulations and, as a result, only 11 cases were finalised. As a consequence PSR returned $500 000 to the Department of Finance and Administration. However, we received 50 new referrals from the HIC between 23 December 1999 and the end of the financial year and investigations into these referrals commenced. In 2000–01, PSR's budget appropriation of $4.896 million, incorporates funding for an increase in staffing levels from 20 to 30 staff and an increased workload.

The Australian National Audit Office's report on the PSR's 1999–00 financial statements was unqualified and was signed on 15 September 2000 (see Appendixes 2, 3 and 4).

Administration

A MoU with the Department of Health and Aged Care, remained in force during this reporting period. The Department provides services, such as payment of accounts, personnel functions, library, registry and coverage for programs including workplace diversity, occupational health and safety and industrial democracy for which the PSR pays an agreed annual fee.

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

Staff figures

1999–2000 Budget	1999–2000 Actual ASL	1998–99 Actual
20	18	10

Classification Levels as at 30 June 2000	Male	Female	Total
Statutory Office Holder	1		1
SES	1		1
Medical Officers Level 4			
Executive Officer Level 2	2		2
Executive Officer Level 1	4	2	6
APS 6	1	2	3
APS 4	2	1	3
APS 3		2	2
Contractor	1	1	2
Total	12	8	20

The Director of Professional Services Review is employed under the *Health Insurance Act 1973*. All other staff (except the contractors) were employed under the *Public Service Act 1922*. All staff were employed on a permanent full-time basis.

Ten per cent of staff come from non–English-speaking backgrounds, and no staff are of Aboriginal or Torres Strait Islander origin nor do they have a disability. No performance–based payments were made during the year.

Staff development and training

As mentioned there was a major focus on training in 1999–2000. All active medical and optometrical members of the PSR Panel received training on the new legislation and participated in workshops to develop their questioning skills. The majority of PSR staff members also attended these sessions. Through the PSR performance development scheme, staff training needs were clearly identified. This allowed the human resources manager to target courses for particular individuals or coordinate internally-run courses.

On-going training is scheduled for 2000–01 based on the organisation's and individuals' identified needs.

Workplace reform

PSR staff enjoyed the flexibility of working within the Professional Services Review Certified Agreement 1999. This agreement is due to expire on 31 December 2000. Initial discussions commenced about the form of the new agreement and staff representation on the negotiation team. A number of senior management staff signed Australian Workplace Agreements during the year.

Occupational health and safety

PSR recognises that it has a legal responsibility to safeguard the health of its employees while they work. The agency provides and maintains occupational health and safety (OH&S) standards in relation to its offices and its equipment. For ongoing elements, because of its limited resources, the PSR has endorsed the Department's OH&S plan and follows the procedures outlined therein. PSR formed an OH&S Committee during the year, comprising the human resources manager and three staff. Three of the four members of this

committee attended a one-week OH&S course to ensure they understood their role on this committee. The fourth person will attend this course early in the next financial year. If required, policy advice relating to OH&S will be provided by the specialist area in the Department of Health and Aged Care as an element of the MoU. Also included in the MoU is access for PSR staff and/or their immediate families to counselling services by trained professionals.

There were no OH&S incidents in 1999–2000 nor were any notices issued or received under any of the relevant sections of the OH&S Act.

Workplace diversity

PSR is committed to the principles of workplace diversity, which require that all staff be treated fairly and without direct, indirect or systemic discrimination. Workplace diversity requires all staff to have equal access to employment, career and development opportunities and encourages appropriate representation of the target groups specified in workplace diversity policies.

Because of its small size, PSR has no workplace diversity plan of its own, instead it has embraced that of the Department of Health and Aged Care.

Industrial democracy

In this financial year the organisation has doubled in size. Due to this it has no longer been feasible to have regular all-staff meetings to discuss core business issues. As a result, a management Committee which meets fortnightly has been formed. Minutes of these meetings are circulated to all staff. Staff meetings are held within their units and information is channelled up and down the line to the management meetings. Meetings of all PSR staff take place when desirable, such as discussions on the certified agreement.

Information technology

Early in 1999–2000 PSR changed its IT platform from Macintosh to PCs. PSR has leased 21 computers and entered into an agreement with Allied Networks to provide routine maintenance and 2nd and 3rd level support. First level support is provided in-house. At the end of the financial year PSR was about to go to tender to contract development of a workflow and tracking database for the tracking and reporting of committee and investigation data.

Publications

The only new publications produced in 1999–2000 were the Annual Report and an updated version of the PSR information brochure which incorporated the amended legislative provisions (the text of which is at Appendix 1). A revised procedure manual for the use of the PSRCs is currently in preparation.

APPENDIX 1: BROCHURE: THE PROFESSIONAL SERVICES REVIEW SCHEME

The PSR Scheme authorises examination of health practitioners' conduct to ascertain whether or not they have practised inappropriately in relation to services which attract Medicare rebates or have prescribed inappropriately under the Pharmaceutical Benefits Scheme.

Inappropriate practice

'Inappropriate practice' means professional conduct that a committee of the practitioner's peers would reasonably consider unacceptable to the general body of the peer group.

Scheme participants

Health practitioners are medical and dental practitioners, optometrists, chiropractors, physiotherapists and podiatrists.

The Health Insurance Commission (HIC) administers Medicare and refers alleged cases of inappropriate practice to the Director of PSR (Director) for investigation.

The Scheme is managed by the Director of PSR who is an independent statutory officer appointed, subject to Australian Medical Association (AMA) agreement, by the Minister for Health and Aged Care.

The Professional Services Review Panel (PSRP) consists of medical practitioners appointed by the Minister after consultation with the AMA; and of dentists, optometrists, chiropractors, physiotherapists and podiatrists appointed by the Minister after consultation with appropriate professional organisations. From the Panel, the Minister appoints Deputy Directors, who chair the Committees.

A Professional Services Review Committee (PSRC) consists of a Deputy Director and generally two other Panel members from the same peer group or profession as the practitioner under review. Where the Director considers it

desirable to give the Committee a wider range of clinical expertise, up to two more Panel members may be included.

The Determining Authority comprises a medical practitioner as Chair, a lay person and a member of the relevant profession. Members are appointed by the Minister following consultation with the appropriate profession.

A Medicare Participation Review Committee (MPRC) can disqualify the practitioner, against whom two adverse determinations have been made, from the Medicare program for up to five years.

The Federal Court can, at any stage in the process, hear applications and appeals from practitioners.

The process

Counselling: Before referral to the Director, the HIC may offer the practitioner under review counselling and the opportunity to rectify the situation before formal action is initiated.

Referral: The HIC prepares an investigative referral to the Director. A copy is sent to the practitioner, with an invitation to make a written submission to the Director within 14 days.

Investigation: The Director may appoint case officers to investigate the referral. They may enquire into services not included in the HIC's reasons for referral. The Director has the power to require documents to be produced: there are penalties for non-compliance. After an investigation, the Director may:

- dismiss a referral;
- negotiate an agreement; or
- establish a PSRC.

Dismissing a referral: The Director may dismiss a referral if satisfied that a PSRC would not make a finding of inappropriate practice.

Negotiating an agreement: The practitioner may approach the Director to negotiate a conclusion of the matter. The Determining Authority must approve any agreement for it to become effective.

Establishing a PSRC: Unless satisfied that there are insufficient grounds for a finding of inappropriate practice or unless the Determining Authority has approved a negotiated agreement, the Director must establish a PSRC.

Challenging PSRC members: The practitioner may challenge the appointment of a PSRC member on the grounds of perceived bias.

Hearings: A PSRC meets in private in State capital cities. The practitioner is given notice of the time and place of the hearing and must appear to give evidence. A PSRC may require the practitioner or someone else to produce documents. A legal officer may assist a PSRC.

Failure to comply: If the practitioner fails to give evidence or to produce the requested documents, a PSRC may notify the Director who will fully disqualify the practitioner from Medicare until he or she complies.

PSRC process: A PSRC must accord the practitioner natural justice, may inform itself in any manner it thinks fit, and is not bound by the rules of evidence.

Medical records: A PSRC must consider whether adequate and contemporaneous records support the practitioner's claims. A PSRC may find the practitioner's practice inappropriate despite the absence, deficiency or illegibility of medical records.

Practitioner's rights at hearings: The practitioner may address a PSRC and question any witness and may be accompanied, but not represented, by a legal or other adviser. A legal adviser may address a PSRC on points of law, and make a final address on the merits of the case. A non-legal adviser may address a PSRC and question witnesses.

Professional concerns: If the Director, a PSRC or the Determining Authority suspects a significant threat to the life or health of any person, or failure to comply with professional standards or fraudulent activity, they must report this to the relevant authority.

PSRC report: A PSRC will send a draft report to the practitioner seeking a submission on its intended findings. A PSRC must consider any responding submission before forwarding its report to the Determining Authority.

Determination: If the PSRC makes a finding of inappropriate practice against the practitioner, the Determining Authority will decide the sanction to be imposed and will prepare a draft determination, upon which the practitioner may make further submission.

The sanctions

The Determining Authority must impose one or more of the following:

- a reprimand;
- counselling;
- repayment of Medicare benefits; and/or
- complete or partial disqualification from the Medicare scheme of up to three years.

Rights and responsibilities

Natural justice: The Scheme has safeguards to ensure the practitioner receives natural justice. At every major point in the process the practitioner is offered opportunities to make submissions.

Confidentiality: The information and evidence presented to the PSRC, its deliberations and findings remain confidential and may not be disclosed unless specifically authorised by the Act or on appeal. By contrast, the Determining Authority's decisions may be published, when effective.

Appeal rights: The practitioner may, at any stage, seek judicial review in the Federal Court.

Legal protection: Members of PSRCs, the Determining Authority and their consultants, witnesses and those appearing on behalf of practitioners are immune from civil or criminal actions.

Professional autonomy: The Scheme recognises the professional autonomy of the PSRCs in reaching findings of inappropriate practice.

Annual report: The Director's annual report to the Minister outlines the types of behaviour which led to findings of inappropriate practice and guides the professions as to their peers' understanding of inappropriate practice. The report is tabled in Parliament.

More information

Contact the Professional Services Review at PO Box 136 Yarralumla, ACT 2600 or on phone 02 6281 9100; fax 02 6281 9199; or on the Internet at www.psr.gov.au.

The authority for this Scheme is the *Health Insurance Act 1973* as amended. Copies of the Act can be obtained from a Government Info Shop. This is a general guide only and is not a legal document. It is published by the Professional Services Review, October 1999.

Appendix 2:
Financial Statements

Australian National
Audit Office

INDEPENDENT AUDIT REPORT

To the Minister for Health and Aged Care

Scope

I have audited the financial statements of Professional Services Review Scheme for the year ended 30 June 2000. The financial statements comprise:

- Statement by the Director and Resources Manager;
- Agency Operating Statement, Balance Sheet, Statement of Cashflows, Schedule of Commitments and Schedule of Contingencies; and
- Notes to and forming part of the Financial Statements.

The Director and the Resources Manager are responsible for the preparation and presentation of the financial statements and the information they contain. I have conducted an independent audit of the financial statements in order to express an opinion on them to you.

The audit has been conducted in accordance with the Australian National Audit Office Auditing Standards, which incorporate the Australian Auditing Standards, to provide reasonable assurance as to whether the financial statements are free of material misstatement. Audit procedures included examination, on a test basis, of evidence supporting the amounts and other disclosures in the financial statements, and the evaluation of accounting policies and significant accounting estimates. These procedures have been undertaken to form an opinion as to whether, in all material respects, the financial statements are presented fairly in accordance with Australian Accounting Standards, other mandatory professional reporting requirements and statutory requirements in Australia so as to present a view of the Scheme which is consistent with my understanding of its financial position, its operations and its cash flows.

The audit opinion expressed in this report has been formed on the above basis.

GPO Box 707 CANBERRA ACT 2601
Centenary House 19 National Circuit
BARTON ACT
Phone (02) 6203 7300 Fax (02) 6203 7777

Audit Opinion

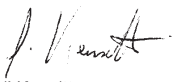
In my opinion,

(i) the financial statements have been prepared in accordance with Schedule 2 of the Finance Minister's Orders;

(ii) the financial statements give a true and fair view, in accordance with applicable Accounting Standards, other mandatory professional reporting requirements and Schedule 2 of the Finance Minister's Orders, of:

- the financial position of the Professional Services Review Scheme as at 30 June 2000 and the results of its operations and its cash flows for the year then ended; and
- the Commonwealth assets and liabilities as at 30 June 2000 and the revenue, expenses and cash flows of the Commonwealth for the year then ended, which have been administered by the Scheme.

Australian National Audit Office



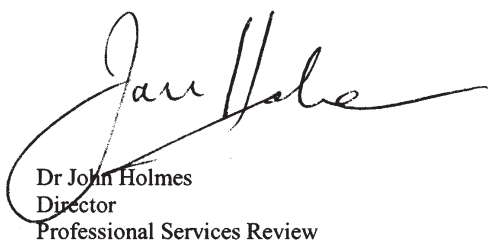
Gil Kensitt
A/g Executive Director

Delegate of the Auditor-General
Canberra

15 September 2000

Statement by the Director and Resources Manager

In our opinion, the attached financial statements give a true and fair view of the matters required by Schedule 2 to the Finance Minister's Orders made under section 63 of the *Financial Management and Accountability Act 1997.*



Dr John Holmes
Director
Professional Services Review

15 September 2000

Dean Browne
Resources Manager
Professional Services Review

15 September 2000

AGENCY OPERATING STATEMENT
for the period ended 30 June 2000

	Notes	1999-00 $	1998-99 $
Operating revenues			
Revenues from government	24	**2,830,000**	1,258,496
Revenues from independent sources		**41,683**	-
Resources received free of charge	17	**6,840**	77,813
Total operating revenues		**2,878,523**	1,336,309
Operating expenses			
Employees	4	**1,190,080**	424,364
Suppliers	5	**1,705,400**	847,810
Depreciation and amortisation	8	**80,356**	65,569
Write-down of assets	6	**-**	5,242
Net losses from asset sales	7	**214**	-
Total operating expenses		**2,976,050**	**1,342,985**
Operating surplus (deficit) before extraordinary items		**(97,527)**	**(6,676)**
Gain on extraordinary items	18	**-**	51,685
Net surplus or deficit after extraordinary items		**(97,527)**	45,009
Net deficit attributable to the Commonwealth			
Accumulated surpluses or deficits at the beginning of reporting period	23	**43,544**	(1,465)
Adjustment for Superannuation/Leave on cost		**(12,852)**	-
Total available for appropriation		**(66,835)**	43,544
Capital use provided for or paid		**(75,980)**	-
Accumulated surpluses at end of reporting period		**(142,815)**	43,544

The above statement should be read in conjunction with the accompanying notes

PROFESSIONAL SERVICES REVIEW
AGENCY BALANCE SHEET
As at 30 June 2000

	Notes	1999-00 $	1998-99 $
ASSETS			
Financial Assets			
Cash		**894,924**	236
Receivables	14	**17,631**	-
Total financial assets		**912,555**	236
Non-financial assets			
Land and buildings		**-**	-
Infrastructure, plant and equipment	11,12	**178,089**	89,988
Inventories		**-**	-
Intangibles	13	**33,393**	33,051
Other	15	**18,026**	83,251
Total non-financial assets		**229,508**	206,290
Total assets		**1,142,063**	**206,526**
LIABILITIES			
Provisions and payables			
Capital use charge		**75,980**	-
Employees	9	**451,753**	162,127
Suppliers	10	**57,146**	855
Other		**-**	-
Total provisions and payables		**584,879**	162,982
Total liabilities		**584,879**	162,982
EQUITY			
Capital		**700,000**	-
Reserves		**-**	-
Accumulated surpluses		**(142,815)**	43,544
Total equity	23	**557,185**	43,544
Total Liabilities and Equity		**1,142,064**	**206,526**
Current Liabilities		**279,654**	136,552
Non-Current liabilities		**305,225**	26,430
Current assets		**930,581**	83,487
Non-Current assets		**211,481**	123,039

The above statements should be read in conjunction with the accompanying notes

PROFESSIONAL SERVICES REVIEW
STATEMENT OF CASH FLOWS
for the period ended 30 June 2000

	Notes	1999-00 $	1998-99 $
OPERATING ACTIVITIES			
Cash received			
Appropriations for outputs	24	**2,830,000**	1,258,496
Interest		**24,877**	0
Total cash received		**2,854,877**	1,258,496
Cash used			
Employees		**(913,305)**	(430,128)
Other		**(1,577,870)**	(826,582)
Total cash used		**(2,491,175)**	(1,256,710)
Net cash from operating activities	16	**363,702**	1,786
INVESTING ACTIVITIES			
Cash used			
Purchase of property, plant and equipment		**(169,015)**	(2,550)
Total cash used		**(169,015)**	(2,550)
Net cash from investing activities		**(169,015)**	**(2,550)**
FINANCING ACTIVITIES			
Cash received			
Equity Injection		**700,000**	-
Total cash received		**700,000**	-
Net cash from (used by) financing activities		**700,000**	-
Net increase in cash held		**894,687**	**(764)**
Cash at the beginning of the reporting period		**236**	1,000
Cash at the end of the reporting period	25	**894,923**	236

The above statement should be read in conjunction with the accompanying notes

PROFESSIONAL SERVICES REVIEW
SCHEDULE OF COMMITMENTS
as at 30 June 2000

	Note	**1999-00** $	1998-99 $
BY TYPE			
OTHER COMMITMENTS			
Operating leases 1		**163,907**	351,550
Other commitments		**130,492**	-
Total other commitments		**294,399**	351,550
COMMITMENTS RECEIVABLE		-	-
Net commitments		**294,399**	351,550
BY MATURITY			
All net commitments			
One year or less		**240,446**	297,551
From one to two years		**53,953**	54,000
From two to five years		-	-
Over five years		-	-
Net commitments		**294,399**	351,551
Operating Lease Commitments			
One year or less		**109,954**	93,113
From one to five years		**53,953**	54,000
Over five years		-	-
Net commitments		**163,907**	147,113

NB: All 1999-00 commitments are GST inclusive where relevant. The comparatives have not been adjusted to reflect GST.

1 Operating leases included are effectively non-cancellable and comprise:
- leases for office accommodation;
- agreements for the provision of motor vehicles to senior executive officers; and
- a lease in relation to computer equipment held as at 30 June 1999 which was sold and leased back on 1 July 1999

The above schedule should be read in conjunction with the accompanying notes

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
for the year ended 30 June 2000

Note 1 - Objectives of Professional Services Review

The Objective of the PSR Scheme is to examine health practitioners conduct to ascertain whether or not they have practiced inappropriately in relation to services, which attract Medicare rebates or have prescribed inappropriately under the Pharmaceuticals Benefits Scheme.

Note 2 - Summary of Significant Accounting Policies

The objectives of Professional Services Review are enclosed in the corporate overview.

(a) Basis of Accounting:

The financial statements are required by section 49 of *the Financial and Accountability Act 1997* (section 50 of the *Audit Act 1901)* and are a general purpose financial report. The financial statements have been prepared in accordance with *Schedule 2 to the Financial Management and Accountability (FMA) Orders* made by the Minister for Finance and Administration. Schedule 2 requires that financial statements be prepared in compliance with Australian Accounting Standards, Accounting Guidance Releases and Urgent Issues Group consensus views, and having regard to Statements of Accounting Concepts.

The financial statements have been prepared on an accrual basis and are in accordance with the historical cost convention, or unless otherwise stated.

The continued existence of Professional Services Review in its present form is dependent on Government policy and on continuing appropriations by Parliament.

(b) Cash:

For purposes of the statement of cash flows, cash includes cash on hand and cash equivalents which are readily convertible to cash on hand.

(c) Infrastructure, Plant and Equipment:

Property, plant and equipment are capitalised in the year of acquisition where their value is $2,000 or over, except for information technology equipment and leasehold improvements for which the minimum threshold values are $500 and $50,000 respectively.

The carrying amount of fixed assets recognised in the Statement of Departmental Assets and Liabilities reflects the remaining service potential of those assets and equates to their written down value as at 30 June 2000.

Note 2 (cont'd)

The financial effect of the move to progressive charges is that the carrying amounts of assets will reflect current values and that depreciation charges will reflect the current cost of the services potential consumed in each period.

All variations have been performed by officers of the Department of Health and Aged Care and have been reviewed by Australian Valuation Office.

(d) Depreciation of Infrastructure, Plant and Equipment:

All infrastructure, plant and equipment and intangibles are depreciated using the straight line method, at rates based on expected useful economic life. Leasehold improvement is depreciated over the unexpired period of the lease.

(e) Employee Entitlements:

The employee entitlements provision includes entitlements for long service leave and recreation leave. Provision for recreation leave is measured as the amount unpaid at 30 June 2000. The provision for long service leave reflects the present value of the estimated future cash flows to be made in respect of all employees at 30 June 2000. In determining the present value of the liability, Professional Services Review has taken into account attrition rates and pay increases through promotion and inflation.

No provision has been made for sick leave as the average leave taken by Professional Services Review employees is estimated to be less than sick leave annually accrued.

(f) Superannuation:

Staff of Professional Services Review contribute to the Commonwealth Superannuation Scheme and the Public Sector Superannuation Scheme. Employer contributions in relation to these schemes have been expensed in the financial statements

(g) Leases:

All operating leases are recognised in accordance with Australian Accounting Standard AAS17, 'Accounting for Leases'. Property leases are accounted for as non-cancellable operating leases.

Professional Services Review had no finance leases as at 30 June 2000.

Note 2 (cont'd)

(h) Taxation:

Professional Services Review is exempt from all forms of taxation except fringe benefits tax and goods and services tax.

(i) Insurance:

In accordance with Commonwealth Government policy, assets are not insured and losses are expensed as they are incurred.

(j) Resources Received Free of Charge:

Resources received free of charge are recognised in the Agency Revenue and Expenses as revenue where the amounts can be reliably measured. Use of those resources is recognised in the Net Cost of Services or where there is a long term benefit an asset is recognised.

(k) Comparative Figures:

Where necessary, comparative figures have been adjusted to conform with changes in the presentation of the financial statements.

Comparatives are not presented in notes dealing with the reporting on outcomes, due to 1999-2000 being the first year of the implementation of accrual budgeting.

(l) Lease Incentives:

Lease incentives taking the form of rent free periods are recognised as liabilities. These liabilities are reduced by allocating lease payments between rental expense and reduction of the liability.

(m) Capital Usage Charge:

A capital usage charge on 12% is imposed by the Commonwealth on the net departmental assets of the agency. The charge is adjusted to take into account of asset gifts and revaluation increments during the financial year.

		1999-00	1998-99
		$	$
Note 3	**Operating Revenues**		
	Appropriations for outputs	**2,830,000**	1,258,496
	Resources received free of charge	**6,840**	77,813
	Interest	**41,683**	-
	Total Operating Revenues	**2,878,523**	1,336,309
Note 4	**Employee Expenses**		
	Remuneration and other employee expenses	**1,190,080**	424,364
	Total employee remuneration	**1,190,080**	424,364
Note 5	**Supplier Expense**		
	Supply of goods and services	**1,571,920**	758,830
	Operating lease expenses	**133,480**	88,978
	Total Suppliers' Expenses	**1,705,400**	847,810
Note 6	**Write down of assets**		
	Non-financial assets	**-**	5,242
	Total write down of assets	**-**	**5,242**
Note 7	**Net losses from asset sales**		
	Infrasructure, plant and equipment	**214**	-
	Total net losses from asset sales	**214**	-

	1999-00	1998-99
	$	$
Note 8 Depreciation and Amortisation		
Depreciation - infrastructure, plant & equipment	**68,947**	56,330
Amortisation - intangible assets	**11,409**	9,239
Total depreciation and amortisation expenses	**80,356**	65,569
Note 9 Provisions and payables - Employees		
Salaries and wages	**28,256**	6,273
Leave	**419,369**	155,478
Superannuation	**4,128**	376
Total employee liabilities	**451,753**	162,127
Note 10 Provisions and payables - Trade Creditors		
Trade creditors	**57,146**	855
Total suppliers	**57,146**	855
Note 11 Infrastructure, Plant and Equipment		
at historic cost	**127,505**	84,802
accummulated depreciation	**(54,293)**	(39,654)
	73,212	45,148
Fitout and leasehold improvements at cost	**319,590**	211,798
accumulated depreciation	**(214,713)**	(166,958)
	104,877	44,840
Total infrastructure, plant and equipment	**178,089**	89,988

Note 12 Analysis of Property, Plant, Equipment and Intangible Assets

Movement summary 1999-00 for all assets irrespective of valuation basis

Item	Infrastructure, Plant and Equipment $	Intangible Assets $	Total $
Gross value as at 1 July 1999	**296,600**	**60,053**	**356,653**
Additions	158,263	11,751	170,014
Disposals	(7,768)	-	(7,768)
Adjustments for revaluations	-	-	-
Gross value as at 30 June 2000	**447,095**	**71,804**	**518,899**
Accumulated depreciation/amortisation as at 1 July 1999	206,612	27,002	233,614
Depreciation/amortisation charge for assets held 1 July 1999	46,788	8,958	55,746
Depreciation/amortisation charge for additions	22,159	2,451	24,610
Adjustment for disposals	(6,554)	-	(6,554)
Adjustment for Revaluations	-	-	-
Accumulated depreciation/amortisation as at 30 June 2000	**269,005**	**38,411**	**307,416**
Net book value as at 30 June 2000	**178,090**	**33,393**	**211,483**
Net book value as at 1 July 1999	**89,988**	**33,051**	**123,039**

	1999-00 $	1998-99 $
Note 13 Intangibles		
Software at cost	**71,804**	60,053
accumulated amortisation	**(38,411)**	(27,002)
Total intangibles	**33,393**	33,051
Note 14 Receivables		
Revenues from independent sources	**17,631**	-
Total net receivables	17,631	-
Receivables (gross) are aged as follows:		
Overdue By:		
. Not overdue	**17,219**	-
. 90 Plus days	**412**	
Total net receivables	17,631	-
Note 15 Other Non-Financial Assets		
Prepayments	**18,026**	83,251
Total other non-financial assets	**18,026**	**83,251**

	1999-00	1998-99
	$	$

Note 16 Cash Flow Reconciliation

Net Cost of Services - gain/(loss)	**(2,934,368)**	(1,291,300)
Revenue from Government	**2,836,840**	1,336,309
Operating Result	**(97,528)**	45,009
Depreciation and amortisation	**80,356**	65,569
Loss on sale of assets	**214**	-
Asset revaluation	-	1,491
Asset write-offs	-	3,751
Capital usage charge	**(75,980)**	-
Changes in assets and liabilities:		
Increase (decrease) in suppliers' liability	**56,291**	(29,804)
Increase (decrease) in employee liabilities	**289,626**	(57,449)
Increase (decrease) for Superannuation on costs	**(12,852)**	-
Increase (decrease) in other liabilities	**75,980**	-
(Increase) decrease in receivables	**(17,631)**	15,700
(Increase) decrease in prepayments	**65,225**	(42,481)
Net cash provided (used) by operating activities	**363,702**	1,786

Note 17 Resources Received Free of Charge

The following resources received free of charge from other departments and entities have been recognised in the Departmental Revenues and Expenses:

Australian National Audit Office		
Provision of audit services	**6,840**	6,200
Department of Finance and Administration		
Comcover Premium	**-**	71,613
Total Resources Received Free of Charge	**6,840**	77,813

Note 18 Abnormal Revenue

Write back of superannuation liability	-	51,685
	-	51,685

	1999-00	1998-99
	$	$

Note 19 Executive Remuneration

The number of executive officers whose total fixed remuneration and performance pay, received and/or receivable for this reporting period, in excess of $100,000 is as follows:

	Number	Number
Salary range		
$140,001 to $150,000	1	1
$100,000 to $110,000	1	
	$	$
Aggregate fixed remuneration received by the officer.	254,620	157,736

Note 20 Appropriation for Future Reporting Periods

Appropriations relating to future reporting periods at 30 June 2000 under the 2000-01 Appropriation Bill (No. 1) totalled $4,956,000 (1999-00: $3,330,000).

Note 21 Contingencies

The Professional Service Review is not aware of any contingent gains or losses as at 30 June 2000 (1998-99: Nil).

Note 22 Average Staffing Levels

The average staffing level for PSR in 1999-00 was 18 (6 for 1998-99)

Note 23 Equity

Item	Capital $	Accumulated results $	TOTAL EQUITY $
Balance 1 July 1999		43,544	**43,544**
Operating Result		(97,528)	**(97,528)**
Equity injection	700,000		**700,000**
Capital use charge		(75,980)	**(75,980)**
Adjustment to equity		(12,852)	**(12,852)**
Balance 30 June 2000	**700,000**	(142,816)	**557,184**

Note 24 Expenditure from Annual Appropriations

	1999-00 Actual $	1999-00 Appropriation $	1998-99 Actual $
APPROPRIATION ACT Nos 1 and 3			
Division 347 PROFESSIONAL SERVICES REVIEW SCHEME			
1. Professional Services Review Scheme	**2,830,000**	3,330,000	**1,258,496**

Note 25 Financial Instruments

a) Terms, conditions and accounting policies

Financial Instrument	**Notes**	**Accounting Policies and Methods (including recognition criteria and measurement basis)**	**Nature of underlying instrument (including significant terms and conditions affecting the amount, timing and certainty of cash flows**
Financial Assets		Financial assets are recognised when control over future economic benefits is established and the amount of the benefit can be reliably measured.	
Receivables for goods and services	14	These receivables are recognised at the nominal amounts due less any provision for bad and doubtful debts. Collectibility of debts is reviewed at balance date. Provisions are made when collection of the debt is judged to be less rather than more likely.	All receivables are with entities external to the Commonwealth. Credit terms are net 30 days
Financial liabilities		Financial liabilities are recognised when a present obligation to another party is entered into and the amount of the liability can be reliably measured.	
Trade Creditors	10	Creditors and accruals are recognised at their nominal amounts, being the amounts at which the liabilities will be settled. Liabilities are recognised to the extent that the goods or services have been received (and irrespective of having been invoiced).	All creditors are entities that are not part of the Commonwealth legal entity. Settlement is usually made net 30 days.

Note 25 Financial Instruments (cont'd)

b) Interest Rate Risk

Financial Instrument	Notes	Non-Interest Bearing		Total		Weighted Average Effective Interest Rate	
		99-00	98-99	**99-00**	98-99	**99-00**	98-99
						%	%
Financial Assets							
Cash		**894,924**	236	**894,924**	236	n/a	n/a
Receivables for goods and services	14	**17,631**	-	**17,631**	-	n/a	n/a
Total Financial Assets (Recognised)		**912,555**	236	**912,555**	236		
Financial Liabilities							
Trade creditors	10	**57,146**	855	**57,146**	855	n/a	n/a
Other Liabilities		-	-	-	-	n/a	n/a
Total Financial Liabilities (Recognised)		**57,146**	**855**	**57,146**	**855**		

APPENDIX 3:
SUMMARY TABLE OF RESOURCES

PROFESSIONAL SERVICES REVIEW

Note 26 SUMMARY TABLE OF RESOURCES
Reconciliation of programs and appropriation elements for 1999-00

Program	Approp Bills 1 & 3 $	Approp Bills 2 & 4 $	Special Approps $	Annotated Approps $	**Program Approps** $	Less Adjustments $	**Program Outlays** $
Professional Services Review	3,330,000	-	-	-	3,330,000	(500,000)	2,830,000
TOTAL	3,330,000	-	-	-	3,330,000	(500,000)	2,830,000

NOTES:

Figures in tables and generally in the text have been rounded. Discrepancies in tables between totals and sums of components are due to rounding.

APPENDIX 4:
FINANCIAL AND STAFFING RESOURCES SUMMARY

PROFESSIONAL SERVICES REVIEW

Note 27 FINANCIAL AND STAFFING RESOURCES SUMMARY

	1999-00 Actual $	1999-00 Appropriation $	1998-99 Actual $
BUDGETARY (CASH) BASIS			
Components of Appropriations			
Running Costs	**2,830,000**	3,330,000	1,258,496
Program Costs (excluding Running Costs)	**-**	-	-
Total Outlays	**2,830,000**	3,330,000	1,258,496
Total Revenue	**-**		-
ACCRUAL BASIS			
Net cost of service delivery	**2,934,368**		1,291,300
Total assets	**1,142,062**		206,526
Total liabilities	**584,879**		162,982

	1999-00 Actual	1998-99 Actual

APPENDIX 5: FREEDOM OF INFORMATION STATEMENT

During the year ended 30 June 2000, the Professional Services Review received no 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 6281 9127

Documents

The types of documents the PSR holds are:

- referrals and related documents from the HIC pursuant to section 86 of the *Health Insurance Act 1973* regarding the conduct of a person the HIC considers may have engaged in inappropriate practice in connection with rendering or initiating services;
- reports of, and related documents regarding investigations carried out by the PSR;
- 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 advice;
- 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 6: 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 AJ (John) Holmes was appointed Director of Professional Services Review by the then Minister for Human Services and Health (now Health and Aged Care) on 21 July 1994 for a three-year period. Dr Holmes was subsequently re-appointed for a further three years.

During the period from the establishment of the PSR Scheme until 24 January 2000 when all appointments expired, 197 practitioners nominated by the relevant professions had been appointed as members of the Professional Services Review Panel. Many members agreed to serve a further term.
At 30 June 2000, 103 medical and optometrical members had been appointed by the Minister for a five-year period. Of these, 15 were also appointed as Deputy Directors of Professional Services Review. The Deputy Directors serve as Chairpersons of the PSRCs. Further nominations for appointment to the Panel are in the pipeline.

Background

The legislation was developed in 1993–94 with the aim of providing an effective peer review mechanism to deal quickly and fairly with concerns about inappropriate practice. Legislative amendments to the PSR Scheme came into effect on 6 November 1997. Further amendments became effective from 1 August 1999.

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 on a case-by-case basis to investigate practitioners referred by the Director for review; and

- a Determining Authority comprising a medical practitioner as Chair, a lay person and a member of the relevant profession, whose role it is to decide on the sanctions for practitioners found by a PSRC to have practised inappropriately and to consider agreements entered into between the Director and the person under review for ratification.

(The Determining Authority replaces the Determining Officer, who must be a public office holder, appointed ministerially, and whose role it is to decide on the sanctions for practitioners found by a PSRC to have practised inappropriately in relation to referrals to the Director before 1 August 1999.)

The review process is based on the principle of peer review and is instigated only in instances where prior counselling of practitioners by the HIC has been offered.

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 group (ie general practitioner, specialist or consultant physician) in which the practitioner was practising when he or she rendered or initiated the services; or
- in the case of a dental practitioner, optometrist, chiropractor, physiotherapist 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) 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 separation of the three elements of the decision-making processes which are:

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

The HIC prepares and refers a case for review to the Director of Professional Services Review who conducts an investigation. The Director has the power to require documents to be produced which then provides the first opportunity under the PSR Scheme for an examination of the records. After an investigation, the Director may:

- dismiss a referral;
- negotiate an agreement (which needs to be ratified by the Determining Authority to become effective); or
- establish a PSRC.

The PSRC reports on its findings and, if the findings are adverse to the practitioner under review, the Determining Authority must determine one or more of the following courses of action:

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

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

The practitioner may, at any time, seek judicial review in the Federal Court.

APPENDIX 7: 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 (Director). Information on HIC procedures leading to the referral of a case to the Director should be sought from the HIC.

Legislative changes

Following a comprehensive review by the Government and the AMA, extensive changes were made to the PSR Scheme with effect from 1 August 1999. These changes provided for improvements to the Scheme's administration, in the form of:

- increasing the investigation, case preparation and negotiating powers of the Director;
- providing legal support to the peer review committees and introducing more comprehensive training and operating protocols;
- allowing greater legal support to the person under review;
- replacing the Determining Officer with a Determining Authority comprising a permanent chair (medical practitioner), a permanent layperson and a third member who would be a representative of the profession of the person under review; and
- removing the PSR Tribunals from the process while retaining the right of review on points of law.

Other changes to the PSR Scheme included:

- providing for different methods of investigating inappropriate practice, including the introduction of deeming provisions in respect of high volume servicing per day, sampling methodologies and generic findings; and
- introducing a requirement from 1 November 1999 that a practitioner keep adequate and contemporaneous clinical records.

PSR Committees are to have regard to whether a practitioner keeps adequate and contemporaneous records of the rendering and initiation of services in determining whether that practitioner's conduct was appropriate.

Investigative referral

A referral by the HIC to the Director is known as an investigative referral.

When the HIC makes an investigative referral to the Director, 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.

Should the Director request further information on services contained in the referral, the HIC must comply with that request to the extent that it is able.

Action by director

On receipt of an investigative referral, the Director conducts an investigation into the referred services. For that purpose, the Director may require the person under review or any other person to produce patient records and other documents.

The Director may dismiss the investigative referral if satisfied that there are insufficient grounds on which a Committee could reasonably find that the person under review has engaged in inappropriate practice.

The Director and the person under review may enter into a written agreement under which that person and the Director agree to a sanction against the person. Any such agreement must be ratified by the Determining Authority. If an agreement is entered into, the Director must dismiss the referral.

The Director may set up a PSR Committee and make a referral, known as an adjudicative referral to the Committee, to consider whether the person under review's conduct constituted engaging in inappropriate practice.

In reaching a decision as to which course of action to pursue, 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 has nine months in which to refer the matter to a Committee, enter into an agreement with the person under review or dismiss the referral. If none of those steps is taken within those nine months, the referral lapses.

Adjudicative referral

The content and form of an adjudicative referral must comply with any guidelines made by the Minister.

The referral must be accompanied by a written report by the Director giving the reasons the Director thinks that conduct by the person under review may have constituted engaging in inappropriate practice.

Establishing a PSRC

The Director selects a Deputy Director to chair a Committee and at least two other members from the Professional Services Review Panel who must be peers. 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 person under review may challenge the appointment of a Committee member on the grounds of 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 written notice of particulars of the matters giving rise to the hearing and the date and place of the hearing at least 14 days prior to 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

Subject to any reasonable limitations or restrictions the Committee may impose, the person under review may:

- attend the hearing;
- be accompanied by a lawyer or another adviser;
- call witnesses to give evidence (other than evidence as to his or her character);
- produce written statements as to his or her character;
- question a person giving evidence at the hearing;
- address the Committee on questions of law arising during the hearing;
- make a final address to the Committee on questions of law, the conduct of the hearing and the merits of the matters to which the hearing relates.

If a lawyer accompanies the person under review, the lawyer may, subject to any reasonable limitations or restrictions that the Committee may impose:

- give advice to the person under review;
- address the Committee on questions of law arising during the hearing; and
- make a final address to the Committee on questions of law, the conduct of the hearing and the merits of the matters to which the hearing relates.

While a Committee has legal powers, such as the power to summon witnesses and to require persons to answer questions, it is intended that hearings be conducted without undue formality. Evidence may be taken on oath or affirmation.

Obligations of person under review

The notice of hearing given to the person under review must require that person to appear at the hearing and give evidence to a Committee. If the person under review fails to appear at the hearing, or appears but refuses or fails to give evidence or to answer a question that he or she is asked by a Committee member in the course of the hearing, the Committee may fix another day, at least 28 days later, for the taking of evidence from the person under review. Alternatively, the Committee may proceed with the hearing even if the person under review fails to appear.

If the person under review fails to appear or appears but refuses or fails to give evidence or to answer questions, the Chairperson must notify the Director of the failure or refusal. When such a notice is given to the Director, he or she must disqualify the person under review from Medicare and notify the HIC accordingly. If the person under review subsequently appears at a hearing and gives evidence and answers questions, the Chairperson must inform the Director and, as soon as practicable after being so informed, the Director must revoke the disqualification and give the HIC notice of the revocation.

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.

Committee to inform itself

A Committee 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.

Production of records

A Committee may, at any time before or during a hearing, give a notice to the person under review or to any other person whom the Committee believes to have possession, custody or control of patient records or other documents, requiring him or her to produce them to the Committee. The notice must give the person to whom it is addressed at least 14 days in which to comply. When documents are produced, the Committee may inspect them, retain them for a reasonable period and make copies of them.

Procedure at hearings

Procedure at hearings is within the discretion of the presiding member. The Committee is not bound by rules of evidence and may inform itself on any matter in any way it thinks appropriate.

The Committee may issue a summons to a person other than the person under review requiring that person to appear at the hearing to give evidence and produce documents.

A person, other than the person under review, who appears as a witness at a hearing may be prosecuted for refusing or failing to be sworn or to make an affirmation, for refusing or failing to answer a question that he or she is required by a Committee member to answer or for refusing or failing to produce a document that he or she is required to produce.

A person who obstructs or hinders the Committee or disrupts a hearing may be prosecuted for an offence.

A Committee member has the same protection and immunity as a Justice of the High Court. This means a Committee member cannot be sued or prosecuted for things that he or she says in the proper performance of his or her duties as a Committee member.

Findings of committee

The Committee must only make findings in respect of services that are specified in the adjudicative referral. The Committee is not, however, required to have regard to conduct in connection with the rendering or initiation of all of the referred services.

One of the possible approaches the Committee may take in determining whether or not inappropriate practice has occurred is to apply a sampling methodology. The Committee may sample services included in a particular class of referred services, make findings about specific services in the sample and extrapolate the results to a larger number of similar services in the referral. The sampling methodology the Committee uses must be either specified in a determination by the Minister or approved by an accredited statistician.

Another way the Committee may proceed is by relying on the deeming provision in section 106KA of the *Health Insurance Act 1973*. This provision is designed to assist in cases where the person under review has rendered high volumes of services per day over a minimum number of days in a year. If the number of referred services rendered over a prescribed number of days exceed those specified in the regulations, the burden falls on the person under review to satisfy the Committee that services rendered on those days were rendered appropriately.

If the clinical or practice records of the person under review are absent, deficient or illegible, making it impossible for the Committee to conduct an inquiry based on statistical sampling or patterns of services, the Committee may make a generic finding of inappropriate practice based on information supplied in the adjudicative referral, contained in the report by the Director or given in evidence at hearings held by the Committee.

Reporting

The Committee prepares a draft report of its preliminary findings and gives a copy to the person under review. That person may, within 21 days of receiving the draft report, make submissions in relation to the draft report. The Committee must consider any such submissions.

A final report is then prepared by the Committee and sent to the person under review and the Director. The person under review has 28 days in which to seek judicial review in the Federal Court should he or she wish to do so.

After the expiration of the 28 days, the final report is sent to the Determining Authority. The Committee must ensure the final report is given to the Determining Authority within six months of the day on which it receives the adjudicative referral. That period is, by force of the legislation, extended for any period during which the person under review is unable, because of illness, to attend a hearing of the Committee or during any period during which that person or another person fails to comply with a notice to produce documents. Also, at the request of the Chairperson or, if the Chairperson is not available, another member of the Committee may, before the deadline for reporting, apply to the Director for an extension of time not exceeding one month or further periods not exceeding one month in each case.

The report should refer to the evidence or other material on which those findings were based. It should provide the Determining Authority with sufficient information to assist it in drafting a Determination. If the Committee members are not unanimous in their findings, the report must set out the findings of the Committee members.

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 Committee, in the course of examining a referral, comes to the view that the person under review may have committed fraud, the Committee may send the material, or a copy of the material, which is the cause of its concern to the HIC with a statement of the matters it thinks may have constituted the offence. The Committee may then either continue with its consideration of the referral or suspend its consideration of the referral for such a period as it thinks appropriate.

If a Committee concludes that conduct by a person under review has caused, is causing, or is likely to cause a significant threat to the life or health of another person, it must give the Director a written statement of its concerns, together with the material or copies of the material on which its opinion is based.

If the person under review is a practitioner and if the Committee concludes that he or she has failed to comply with professional standards, the Committee must give the Director a written statement of its concerns, together with the material or copies of the material on which its opinion is based.

Determining Authority

The Determining Authority is an independent body within the PSR Scheme established by section 106Q of the Act.

It comprises a permanent Chairman, who must be a medical practitioner, a permanent lay person who must not be a member of any of the professions to which the provisions of the PSR Scheme apply, and a panel of persons representative of the professions to which the person under review may belong, eg medicine, dentistry, optometry, physiotherapy, chiropractic or podiatry.

Members are appointed by the Minister on a part-time basis for periods of up to five years after consultation with the AMA and the relevant professions. The Minister can also make acting appointments to the Authority should a member be unable to perform his or her duties for any reason or in the event of a vacancy in that office.

For any specific determination, the Authority is constituted by the Chair, the lay person and the representative of the person under review's profession. Meetings are held in private and any question arising for decision is decided by majority vote of members present. Authority members are accorded the same protection and immunities as a Justice of the High Court in the performance of their duties.

The Director is required to provide all necessary support to the Authority to enable it to perform its functions and to exercise its powers. However, in doing so, the Director must ensure no-one who has provided investigative services, legal or professional advice at any stage of the inquiry process also provides similar services to the Authority.

Role of determining authority

The Authority has two main roles. The first is to determine the level of sanctions to apply when a Committee has found a practitioner to have engaged in inappropriate practice and to express those decisions in formal determinations. The second is to decide whether or not to ratify agreements reached between the Director and a person under review on the level of sanctions to apply when both parties agree that inappropriate practice has occurred.

The Authority must confine its considerations to determining what are appropriate sanctions for the inappropriate practice identified by a Committee and must have regard only to such evidence as is relevant to this task.

Ratified agreements

Upon receipt of an agreement entered into between the Director and person under review, the Authority must make a decision either ratifying or refusing to ratify it within one month after the day the agreement was received. Failure to make a decision within this period means the agreement is deemed to have been ratified with effect from the end of that period.

The Authority must notify the Director and person under review in writing of its decision within seven days of its having been made or taken to have been made. Refusal to ratify decisions must be accompanied by statements of reasons.

Committee reports – finding of inappropriate practice

Where a Committee report contains a finding that the person under review engaged in inappropriate practice, or if a majority report contains such a finding, the Authority must, within one month after the day on which it receives the report, make a draft determination and give copies to the person under review and the Director.

The draft determination must contain one or more of the directions set out in section 106U of the Act.

The draft determination must be accompanied by an invitation to the person under review to make submissions, within 14 days after the day on which he or she receives the draft determination, suggesting changes to the directions contained in the draft determination. The Authority must take any submissions received into account in making its final determination.

Having made a draft determination, the Authority must, within one month after the end of the 14 day period permitted for making submissions, make a final determination. The determination must contain one or more of the directions set out in section 106U of the Act.

Content of draft and final determinations

The Authority may direct that the person under review be:

- reprimanded by the Director or the Director's nominee;
- counselled by the Director or the Director's nominee;
- required to pay the whole or part of the Medicare benefit paid for any service he or she rendered or initiated and in respect of which he or she was found to have engaged in inappropriate practice;
- required to pay the whole or part of the Medicare benefit paid for all or a proportion of any class of services he or she rendered or initiated in respect of which he or she was found to have engaged in inappropriate practice; and
- fully disqualified or partially disqualified from Medicare for periods of up to three years.

Other directions the Authority may make include:

- fully or partially revoking a participating optometrist's undertaking under section 23 of the Act; and
- revoking or suspending a doctor's or dentist's authority to prescribe or dispense a pharmaceutical benefit.

Date when final determination takes effect

Subject to any appeals, the final determination takes effect on the 35th day after the day on which the Authority gives a copy to the person under review.

Notification of final determination

The Authority must give copies of the final determination to the person under review and the Director as soon as practicable after making the final determination. It must also give copies of the final determination, in the form in which it takes effect, to the Director and the HIC as soon as practicable after the final determination takes effect.

Referral of professional issues to regulatory and other bodies

If the Authority concludes that conduct by a person under review has caused, is causing, or is likely to cause a significant threat to the life or health of another person, it must give the Director a written statement of its concerns, together with the material or copies of the material on which its opinion is based.

If the person under review is a practitioner and if the Authority concludes that he or she has failed to comply with professional standards, the Committee must give the Director a written statement of its concerns, together with the material or copies of the material on which its opinion is based.

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; Panel members who conduct reviews are active members of the specialty or profession of the person under review; and the Determining Authority which decides the level and scope of sanctions is also independent;
- appeal rights: there is provision for appeal or review of every significant decision in the process;
- privacy: the deliberations, findings, information and evidence given to a Committee remain confidential and may only be disclosed in circumstances prescribed by the Act, for example, in the case of an appeal 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.

GLOSSARY

AAT	Administrative Appeals Tribunal
Act	*Health Insurance Act 1973*, as amended by the *Health Legislation (Professional Services Review) Amendment Act 1994* and subsequent amendments
AMA	Australian Medical Association Limited
ASL	Average Staffing Level
Committee	A Professional Services Review Committee established by the Director in accordance with section 93 of the Act to examine a case of apparent 'inappropriate practice' referred by the HIC
COMNET	Corporate Management Network
DA	Determining Authority
Determining Authority	A three-person panel responsible for determining the sanction following an adverse PSRC finding
DO	Determining Officer
Determining Officer	An officer appointed by the Minister to determine an appropriate sanction to apply where a PSRC finds a person under review has engaged in inappropriate practice, as defined in the Act
Director (DPSR)	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	Exclusion (partial or complete) from eligibility for the practitioner's services to attract Medicare benefits
DPP	Director of Public Prosecutions
DPSR	Director of Professional Services Review

EEO	Equal Employment Opportunity
HIC	Health Insurance Commission
Inappropriate practice	Professional conduct in relation to Medicare which a committee of peers would reasonably consider would be unacceptable to the general body of the peer group (section 82)
IT	Information Technology
Minister	Minister for Health and Aged Care
MoU	Memorandum of Understanding
MPRC	Medicare Participation Review Committee
OH&S	Occupational Health and Safety
OMA	Ontario Medical Association
Panel	PSR Panel consisting of medical practitioners, dentists, optometrists, chiropractors, physiotherapists and podiatrists nominated by the relevant professional organisations and who have been appointed by the Minister
PSR	Professional Services Review
PSRC	Professional Services Review Committee
PSRP	Professional Services Review Panel
PSRT	Professional Services Review Tribunal
Referral	A case prepared by the HIC and referred to the DPSR, detailing the HIC's concerns and the reasons it considers a practitioner or other person has engaged in 'inappropriate practice' in the terms of section 82 of the Act

Compliance Index

INDEX