The Hon. Tony Abbott MHR
Minister for Health and Ageing
Parliament House
Canberra ACT 2600

Dear Minister


This report has been prepared in accordance with the Requirements for Annual Reports approved on behalf of the Parliament by the Joint Committee of Public Accounts and Audit under section 63 of the Public Service Act 1999.

Yours sincerely

Tony Webber
5th October 2005
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Director’s report
Director’s report

The eleven years since the passage of Part VAA of the Health Insurance Act 1973 establishing Professional Services Review (PSR) have seen widespread changes in the way medicine is practiced in Australia. Over the last decade more doctors have started practicing in large, vertically integrated medical centres. This phenomenon, once confined to large cities, is now spreading into regional areas. Allied to this trend is the growing popularity of part-time medical practice; many doctors now consider their leisure and family time as important as their work. The benefits of a computerised practice have also become widely accepted. Doctors now regard an Internet connection as essential as a stethoscope. General practice seems to have embraced computers more extensively than the specialist community.

The community has also changed. The public is now better educated and informed regarding their own and their family’s health.

There is a greater community expectation of quality care when accessing health services. Consumers are less willing to accept medical advice uncritically. The increasing use of alternative medicine and other therapies has provided the community with at times a bewildering choice of health options.

The challenges for medical regulators and governments around Australia in this new environment are considerable. Professional Services Review is not immune from this change. To maintain both Parliamentary and professional support for the PSR process we are reviewing all our current processes with the aim of keeping pace with change.

In June all PSR staff attended a two-day workshop at Bowral NSW where our mission statement and key performance indicators were reviewed and rewritten. This has given us a clearer focus for the future. It has also been an excellent preparation for a review of the PSR scheme to be completed around the end of December 2005.
It is my intention to bring to PSR the principle of continuous quality management to ensure we are able to keep pace with the environment in which we work.

The robustness of the PSR scheme has been tested in the Federal Court on many occasions. PSR has been found to have consistently applied the legislation with due regard to fair process and equity. The scheme depends for its success on the commitment of the members of the PSR panel. Clinicians in active practice who apply peer standards to evaluating their colleagues, give the scheme its legitimacy and its widespread support. I would like to thank all those members of the panel who have given of their time to sit on committees.

Committee members require particular skills in questioning and report writing. New panel members often feel they have learnt these skills from their practice of medicine. Experience has taught us that to achieve a robust result, members require training to acquire the necessary skills. Professional Services Review runs training workshops regularly for new and existing members. The last training workshop was held at Werribee in Victoria. PSR staff and our consultants, including two current and one retired Justices of State Courts, conducted the training. Members of the panel invariably come away with a new-found respect for their legal colleagues.

I would also like to particularly thank the 21 panel members who are appointed as Deputy Directors and as the Chairs of Committees. The Deputy Directors are senior members of their professional groups. Committee work for a Chair requires considerable dedication both in time and effort. I am very appreciative of the support the Deputy Directors have given me since my appointment on 14 February 2005.

The Professional Services Review scheme is a highly litigious area. In general, practitioners who are investigated by the scheme are well resourced and are defending their livelihood. Many practitioners take full advantage of seeking judicial relief. As at 30 June 2005 there were 27 Federal Court actions either active or pending. The challenges to the integrity of the process range from issues of procedural fairness to invoking the Constitution. I am pleased to report that to date PSR has won almost all of these actions, although some have been taken on appeal to the Full Court of the Federal Court. We have been greatly assisted in this by the exceptional service offered by our solicitors Minter Ellison and the very able counsel engaged.

The Professional Services Review Tribunal finished its role this year with its last decision. I would like to pay tribute to work done by the Tribunal and in particular to thank the Hon. Alan Neaves for his unstinting dedication as the Presiding Officer.

The Determining Authority is now the only decision-making body that determines sanctions. It is only at the Determining Authority stage where there is any direct consumer input into the PSR process. In carrying out its function the Determining Authority must decide, inter alia, on the possible impact on the community if a particular practitioner is excluded from the Medicare arrangements for a length of time. The consumer representative’s input is germane to these assessments.

In August 2004 Professional Services Review moved to its new home, in the Brindabella Business Park at the Canberra Airport. Despite some initial misgivings, staff are happy with PSR’s new home. Bright colours and light airy spaces make for a very pleasant working environment.
Dr John Holmes, PSR's foundation director retired in February 2005. Dr Holmes has had a long and distinguished career with public health administration spanning 18 years. Dr Holmes started PSR with a staff of three and over the last 10 years guided the organisation through many difficult times including several serious court challenges and changes of legislation. Dr Holmes's single-minded determination to keep PSR as an independent organisation has resulted in the high esteem PSR commands within the profession. PSR's processes are accepted as being fair and transparent to those practitioners who are investigated. Dr John Holmes can rightly claim credit for this legacy.

The year has not been without its problems. Professional Services Review depends entirely for its workload on requests from the Health Insurance Commission. In previous years this has been in the range of 40–50 requests per year. In the 2004–05 reporting period this dropped to just nine. This has caused severe dislocation within PSR, particularly as the organisation had no prior warning that this was to occur. The Health Insurance Commission changed its internal processes nationally and the process of change resulted in a significant decrease in requests for review. We have been assured that this is a temporary aberration. However, it has had a profound effect on PSR. We have had to downsize our organisation by offering voluntary redundancies to almost 30 per cent of staff. This has been a very traumatic and disruptive experience for a small organisation.

The change in the Health Insurance Commission's procedures has resulted in much more thoroughly worked-up requests. As a result, I believe it will now be less likely for the conduct of practitioners referred to PSR to be dismissed.

Since the Medical Indemnity industry has offered insurance cover most medical practitioners who come before PSR are legally represented. Generally lawyers who work in this area have sufficient experience to give timely and helpful advice to their clients. Experienced lawyers acting for a practitioner can greatly assist the committee process and in general keep their clients from making unwise decisions. It is also noteworthy that many more practitioners are wishing to enter a negotiated agreement under section 92. I believe this is also due to their having legal advice available.

The next five years will see a widening gap in the demand for services and the supply of practitioners in Australia. With a finite Health Budget this creates an imperative for governments to require that the quality of the services it funds be of the highest order. In the past more emphasis has been placed on accounting for expenditure than on quality outcomes. We are at a crossroad in health care and decisions made now will affect the health of Australians and how it is funded for decades to come. I believe Professional Services Review has a role to play in shaping this agenda and I look forward to the year ahead.

Tony Webber
Director
2004–05 Key events at a glance
### 2004–05 Key events at a glance

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 July</td>
<td>Dr John Howard GREY, Victoria—The Professional Services Review Tribunal affirmed the determination made by the Determining Officer.</td>
</tr>
<tr>
<td>1 July</td>
<td>Dr Nicholas SEVDALIS, Victoria—The Professional Services Review Tribunal set aside the determination of the Determining Officer and made a new determination.</td>
</tr>
<tr>
<td>7 July</td>
<td>Drs Zelko OREB, Boguslaw BARTOS, Hugo Huu Hiep HO, Hien Thanh DO and Sou Kao LY, all of New South Wales—The Federal Court dismissed a notice of motion by each of the five applicants seeking orders for discovery.</td>
</tr>
<tr>
<td>28 October</td>
<td>Dr Zelko OREB, New South Wales—The Federal Court orders that the hearing on the non-constitutional issues proceed before the (new) constitutional challenge.</td>
</tr>
<tr>
<td>30 November</td>
<td>Dr Zelko OREB, New South Wales—The Federal Court set aside the findings by the committee.</td>
</tr>
<tr>
<td>30 November</td>
<td>Dr Donald HATCHER, Queensland—The Federal Court set aside the sanctions of the Determining Authority and the findings by the committee.</td>
</tr>
<tr>
<td>8 December</td>
<td>Dr Rifaat DIMIAN, New South Wales—The Federal Court dismissed an appeal by Dr Dimian.</td>
</tr>
<tr>
<td>22 December</td>
<td>Dr Jack FREEMAN, Victoria—The Full Court of the Federal Court dismissed an appeal by Dr Freeman from a single judge of the Federal Court.</td>
</tr>
<tr>
<td>23 December</td>
<td>Dr Peter Thomas TISDALL, Victoria—The Professional Services Review Tribunal set aside the determination of the Determining Officer and made a new determination.</td>
</tr>
<tr>
<td>7 February</td>
<td>Dr Ashrat Thabit SELIM, New South Wales—The Federal Court dismissed an appeal by Dr Selim.</td>
</tr>
<tr>
<td>7 February</td>
<td>Dr Il Song LEE, New South Wales—In two decisions, the Federal Court set aside separate committee findings.</td>
</tr>
<tr>
<td>14 February</td>
<td>Dr Anthony David WEBBER appointed Director on Dr John HOLMES retirement.</td>
</tr>
<tr>
<td>8 April</td>
<td>Dr Peter Thomas TISDALL, Victoria—The Federal Court dismissed an appeal by Dr Tisdall.</td>
</tr>
</tbody>
</table>
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1. Agency overview

The object of the Professional Services Review (PSR) scheme is to protect the integrity of the Medicare and Pharmaceutical Benefits Schemes by:

- protecting patients and the community in general from the risks associated with inappropriate practices
- protecting the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice.

The role and function of PSR is to administer Part VAA of the *Health Insurance Act 1973* (the Act). The current scheme, effective 1 January 2003, is an avenue for review and investigation of cases of suspected inappropriate practice by practitioners who render or initiate services attracting a Medicare benefit or who prescribe under the Pharmaceutical Benefits Scheme (see Appendix 3). After undertaking a review, the Director must decide to either take no further action, or provide the practitioner with a written report and invite submissions on any further action.

After time for submissions, the Director must:

- decide to take no further action
- enter into an agreement, or
- establish and make a referral to a peer review committee.
No further action

Where the Director decides to take no further action, the Director writes to the person under review informing them of the outcome of the review.

Agreement

If the person under review enters into an agreement with the Director, a formal document is drawn up for signature by both parties and given to the Determining Authority to decide whether or not ratification is appropriate. The name of the person under review remains confidential.

Peer review

Where the Director determines the conduct of the person under review needs further investigation, a PSR committee is established. The committee comprises members drawn from a panel appointed by the Minister for Health and Ageing. The committee conducts a hearing where the person under review can provide both oral and written evidence in support of their case. The Act allows for them to be accompanied by a lawyer or another adviser but limits a lawyer's role to providing advice to the person under review, addressing the committee on questions of law and making a final address on the merits of the matter. After considering all the evidence and taking into account any submissions received, the committee produces a draft report containing findings on the conduct of the person under review. After the person under review has been given time to make submissions on the draft report, a final report is forwarded to the Determining Authority.

Determining Authority

In cases where the committee finds that the person under review has engaged in inappropriate practice the Determining Authority must invite written submissions on any sanctions that may be applied, issue a draft determination, seek comments from the person under review, and issue a final determination containing sanctions.

When a final determination comes into effect the Director can publish certain details, including practitioners’ names and addresses, profession or specialty, the nature of the unacceptable conduct and the sanctions imposed.

Federal Court

At any stage in the process the person under review may seek judicial review in the Federal Court.

Natural justice

There is strong process of natural justice throughout the PSR scheme that was further built on by the 2002 amendments to the Act.

Legislation—August 1999 to December 2002

The essential differences under the post 1 August 1999 to 31 December 2002 legislation are as follows:

- the Health Insurance Commission (the Commission) referred a person to the Director for investigation
- following an investigation, the Director could dismiss a referral
- the Director was not required, following an investigation, to give a person a notice of intention to refer the person to a committee
- the Determining Authority was not required to seek submissions from a person before making a draft determination.
Legislation—Pre 1 August 1999
The essential differences under the pre 1 August 1999 legislation are as follows:

- the Director did not have the same powers of investigation
- a Determining Officer determined the sanctions
- the person under review could take their case to a Professional Services Review Tribunal after the sanctions were established.

As at 30 June 2005, there was one pre 1 August 1999 case under appeal to the Federal Court.

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

Our mission
Examination of health practitioners’ conduct to ascertain whether or not the practitioner has practiced inappropriately in relation to services which attract Medicare or pharmaceutical 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
- show timeliness.

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

- review requests expeditiously and effectively to enable courses of action to be decided
- provide support services to PSR committees 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
- provide effective and efficient human resource management, financial management and corporate planning services
- ensure PSR legislation remains relevant.

Our relationships
The PSR has working relationships with the Health Insurance Commission, the Department of Health and Ageing, the Professional Services Review Tribunals and health registration boards nationwide.

Health Insurance Commission
Professional Services Review’s workload is dependent on requests sent by the Commission. The Commission, which administers the Medicare and Pharmaceutical Benefits Schemes, can request the Director to review provision of services by a practitioner for suspected inappropriate practice.

Cases of possible fraud identified during the PSR process are referred back to the Commission for action.
Department of Health and Ageing

The Department of Health and Ageing has policy responsibility for providing advice to the Minister on development and maintenance of the PSR scheme. The Department liaises with stakeholders in the scheme and performs the broader tasks of policy review and development of legislation.

The Minister has appointed a senior officer of the Department, the First Assistant Secretary, Medical and Pharmaceutical Services Division, to the position of Determining Officer for cases referred to PSR prior to 1 August 1999. There are no referrals made before that date outstanding for completion by the Determining Officer. The role of Determining Officer will cease to exist once the last case currently before the Federal Court has been finalised. (The Determining Authority has an expanded role to that of the Determining Officer for cases referred after 1 August 1999.)

Professional Services Review Tribunals

The Health Insurance Amendment (Professional Services Review) Act 1999 preserves the right of practitioners to seek a review of determinations made by the Determining Officer in relation to matters referred by the Commission before that legislation came into effect in August 1999. Once the last case currently before the Federal Court is finalised, the Tribunals will cease to function. The Tribunals are not, however, empowered to review decisions of the Determining Authority, which took over the role of the Determining Officer for cases referred after August 1999.

Health registration boards

The Act allows PSR to refer a person under review to appropriate bodies when a significant threat to the life or health of a patient is identified or where the person under review has failed to comply with professional standards.
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Report on performance

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## 2. Report on performance

### Outcome and output structure

PSR contributes to the Health and Ageing Portfolio Outcome 2—Access to Medicare. The PSR scheme is funded to ensure that any requests by the Health Insurance Commission of suspected cases of inappropriate practice are reviewed and, if necessary, investigated by a committee of the practitioner’s peers. Regulatory activity is the only output for PSR.

The PSR output specified in the Portfolio Budget Statement 2004–05 was:

<table>
<thead>
<tr>
<th>Output Groups</th>
<th>Performance Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Program Management</td>
<td><strong>Quality:</strong> Court challenges made in regard to committee processes, findings and Determining Authority determinations are resolved successfully. Rate of re-referral against a target of zero.</td>
</tr>
<tr>
<td></td>
<td><strong>Quantity:</strong> Approximately 50 referrals received from the Commission. Approximate 60 referrals finalised.</td>
</tr>
<tr>
<td></td>
<td><strong>Price:</strong> $7.764 million</td>
</tr>
</tbody>
</table>

Examination of health practitioners’ conduct to ascertain whether or not the practitioner has practiced inappropriately in relation to services which attract Medicare or pharmaceutical benefits.
Performance assessment

Table 1—2004–05 Achievements at a glance

<table>
<thead>
<tr>
<th>Target Outcome</th>
<th>Target</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Court challenges resolved successfully</td>
<td>100%</td>
<td>61.5%*</td>
</tr>
<tr>
<td>Rate of re-referral</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Requests from the Commission</td>
<td>50</td>
<td>9</td>
</tr>
<tr>
<td>Requests/referrals finalised</td>
<td>60</td>
<td>54</td>
</tr>
</tbody>
</table>

* Four applications to the Federal Court by practitioners were settled with the applications being dismissed by consent. In addition, there were two other preliminary decisions in one case where, firstly, the group of practitioners failed in an attempt to obtain an order for discovery and, secondly, it was ordered that an appeal on non-constitutional grounds proceed rather than be delayed as sought by the practitioner.

Court challenges

This year, the dominating cases have been those involving challenges against the prescribed pattern of services—the so called ‘80/20’ cases. It was always expected practitioners would challenge findings where committees decided there were no exceptional circumstances to warrant the practitioner exceeding 80 or more attendances on 20 or more days in the specified period. This has been the case this year with the Federal Court handing down six decisions in 80/20 cases. Two judges handed down four separate decisions in favour of practitioners (*Oreb, Hatcher* and two in *Lee*) indicating that the various committees had applied the wrong test when making findings about what constituted exceptional circumstances. It is interesting to note that in the next decision handed down (*Tisdall*), Gray J totally disagreed with the reasoning of his fellow judges in the earlier decisions, indicating that, in his opinion, their reasoning was fundamentally wrong in relation to their approach to the issue of exceptional circumstances. All these cases are now subject of appeal in the Full Federal Court. A number have had hearings and decisions reserved. Most should have been decided for next year’s report.

At 30 June 2005, 27 cases were outstanding in the Federal and Full Federal Court.2

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1. A full report is given on all these cases later in this chapter.
2. These are listed at the end of this chapter under Federal Court and Full Federal Court.
Table 2—Court actions

<table>
<thead>
<tr>
<th></th>
<th>2004–05</th>
<th>2003–04</th>
</tr>
</thead>
<tbody>
<tr>
<td>Court applications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Committees</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Determining Authority</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Determining Officer</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Professional Services Review Tribunal</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Federal and Full Federal Court hearings held</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>Federal and Full Federal Court decisions handed down in favour of the person under review</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Federal Court decisions handed down in favour of PSR</td>
<td>8*</td>
<td>5</td>
</tr>
<tr>
<td>High Court applications</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>High Court decisions in favour of PSR</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

* Four applications to the Federal Court by practitioners were settled with the applications being dismissed by consent. In addition, there were two other preliminary decisions in one case where, firstly, the group of practitioners failed in an attempt to obtain an order for discovery and, secondly, it was ordered that an appeal on non-constitutional grounds proceed rather than be delayed as sought by the practitioner.

Re-referrals

The Commission sent no second (or subsequent) requests for review in this reporting period—last year it sent four.

Requests for review from the Health Insurance Commission

The Commission sent nine requests for review to PSR this year. The Director dismissed 15 requests after conducting a review as he considered there would be insufficient grounds on which a committee could reasonably find the practitioner had engaged in inappropriate practice. The Director negotiated 11 agreements with practitioners where he was not satisfied a committee would not find the practitioner had engaged in inappropriate practice. Another 11 cases were sent to committees for further investigation and there were eight cases under review at the end of the year (see Table 3).

The Director referred one practitioner to the relevant state medical registration board because he formed the opinion the practitioner had caused, is causing or was likely to cause a significant threat to the life or health of patients. The Director believed there was a possibility the practitioner was treating non-malignant lesions with superficial radiotherapy not supported by histopathological studies before undertaking the procedures. He was also treating, by superficial radiology and cryotherapy, what appeared to the referring doctor, to be multiple solar keratosis conditions.
Soon after the Director initiated his review, the practitioner moved overseas and has not been able to be contacted since. The practitioner is no longer registered to practice in Australia.

For those referrals the Director dismissed, it took an average of 253 days to carry out the review (211 days in 2003–04) and an average of 313 days (247 days in 2003–04) to review a request that ended with a negotiated agreement, both against a legislative time frame of 13 months for completion.

<table>
<thead>
<tr>
<th></th>
<th>2004–05</th>
<th>2003–04</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requests received from the Commission</td>
<td>9</td>
<td>38</td>
</tr>
<tr>
<td>Requests dismissed</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>Agreements negotiated</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Requests withdrawn or lapsed</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Re-referrals</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Committees established</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Referrals to medical boards initiated by the Director</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Disqualifications from Medicare for failing to produce documents</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Suspected fraud</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Table 3—Requests from the Commission**

**Referrals to committees**

The Director made 11 referrals to committees during the year (see Table 4). Twenty-three committees reported findings of inappropriate practice to the Determining Authority. One committee reported to the Determining Officer that it was unable to complete its investigation. The practitioner concerned had been disqualified from Medicare since July 1998 for failing to produce medical records to the committee. He has not been registered with the local medical board for some years.

Following an investigation, one committee found that the practitioner had not practiced inappropriately.

Eighteen referrals remained in various stages of the process at the time of reporting.

With the exception of the prescribed pattern of services cases before committees during the year, most committees have used a sampling method to help quantify levels of inappropriate practice and allow for extrapolation of repayment should the Determining Authority choose this as a sanction.

One committee referred a practitioner to the relevant state medical registration board because it formed the opinion the practitioner had caused, is causing or was likely to cause a significant threat to the life or health of patients. The committee believed the practitioner demonstrated a gross lack of clinical knowledge, lack of competence and use of unacceptable treatments. The committee was of the opinion the practitioner incorrectly diagnosed respiratory tract infection as vasomotor rhinitis for which he routinely used
parenteral corticosteroids as a first-line treatment instead of considering more conventional and less risky treatments. He also claimed to deliver the steroids via intra-articular injection to the hip joint. The committee believed the injection could not have been more than parenteral.

The average time taken for the 23 committees to report to the Determining Authority was 920 days (532 days in 2003–04).

Table 4—Referrals to committees

<table>
<thead>
<tr>
<th></th>
<th>2004–05</th>
<th>2003–04</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals sent to committees</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Committee sessions held</td>
<td>55</td>
<td>70</td>
</tr>
<tr>
<td>Draft reports being prepared as at 30 June 2005</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Draft reports with person under review as at 30 June 2005</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Submissions received on draft reports</td>
<td>18</td>
<td>33</td>
</tr>
<tr>
<td>Final reports with person under review as at 30 June 2005</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Final reports sent to the Determining Authority</td>
<td>23</td>
<td>32</td>
</tr>
<tr>
<td>Final reports sent to the Determining Officer</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Adverse findings</td>
<td>23</td>
<td>37</td>
</tr>
<tr>
<td>Practitioner cleared</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Investigation impossible</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Hearings in progress</td>
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<tr>
<td>Referrals to medical boards initiated by committees</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>Disqualifications from Medicare for failing to produce documents or attend hearings</td>
<td>0</td>
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<tr>
<td>Suspected fraud</td>
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Determining Authority

Twenty-seven cases were sent to the Determining Authority this year. The four negotiated agreements received were ratified, as were seven other agreements outstanding at the end of last year. Twenty-six final determinations were issued from findings in committee reports. The Determining Authority had 27 cases under consideration at the end of June 2005, with a significant number of these in the Federal Court (see Table 5).
The Determining Authority took an average of 144 days (76 days in 2003–04) to issue a draft determination and another 186 days (134 days in 2003–04) to issue the final determination. This is against a legislated timeframe of one month for a draft determination and 28 days for a final determination (including the 14 days for the practitioner to make submissions). All time limits on the Determining Authority have an exemption clause.

Agreements
The 11 negotiated agreements were ratified in an average of 13 days (18 days in 2003–04) against a legislated timeframe of one month.

A failure by the Determining Authority to ratify an agreement within the one-month limit means the agreement is taken to have been ratified.

Sanctions agreed as part of the negotiations were that:

- all 11 practitioners were reprimanded
- four practitioners were partially disqualified from Medicare for a total of four years and 11 months (from 5 months to three years)
- eight practitioners agreed to make repayments totaling $197,500 (from $7500 to $70,000 and averaging $17,954.55 per agreement).
A brief description of the 11 negotiated agreements that came into effect is given below.

**Dr A, General Practitioner, Sydney NSW**

The Commission was concerned this practitioner was providing a high volume of total services (15,986 services to 4,987 patients), high daily servicing (168 days of 60 or more services) and rendering of MBS items 30038, 30041, 30045 and 30048, wound repair items and that his conduct in connection with the provision of those services, may constitute inappropriate practice.

During review, the Director found Dr A’s medical records were generally hard to read and contained limited details of the clinical input provided.

In particular, the clinical notes lacked an adequate history and frequently did not contain a provisional diagnosis or management plan. In some instances, Dr A might have prescribed antibiotics where they were not clinically indicated. For example, Dr A recorded a diagnosis of ‘bronchitis/pharyngitis’ and prescribed antibiotics but did not record any indication of a bacterial infection.

From the medical records, the Director formed the opinion that Dr A was not itemising the wound repair services correctly. (For example, two-year-old with ‘laceration chin—7.5 cm deep’; and 12-year-old with ‘5 cm wound on little finger.’) Dr A acknowledged his conduct had constituted inappropriate practice and negotiated an agreement involving a reprimand.

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**Service examined by a Committee – Case 1**

**Service claimed**

MBS item 54 – a long consultation of more than 25 minutes but not more than 45 minutes

**Record entry**

20/6/03 Collage + Pedicure Focus

**Explanation**

Committee – What did she come to see you about?

Practitioner – She was on the program of immunotherapy and she was coming twice a week. She may have come at extra times if she had been in trouble.
Dr B, General Practitioner, Melbourne Vic

The Commission was concerned that Dr B was the 3rd and 20th highest renderer of items 14100 and 14106 respectively; both laser photocoagulation items, in Australia. In addition, Dr B rendered a higher proportion of level C and D services than the average for all active general practitioners in Australia. Dr B works as a medical assistant to a dermatologist.

Following a review, the Director was concerned that Dr B’s item 44 services (level C) were for imaging and photographic documentation of patients’ naevi or for procedures such as hair removal or cosmetic procedures (Botox or other filler substance injections) at the same time. The Director was also concerned that the item 14100/14106 services did not appear to be for patients with haemangiomas as required by the item description. It was likely many services were provided as part of an overall cosmetic rather than therapeutic treatment.

Dr B acknowledged after discussion and submissions, that the conduct had constituted inappropriate practice by failing to maintain adequate and contemporaneous medical records to substantiate the services claimed. Dr B agreed to repay $7500 in Medicare benefits and to be reprimanded.

Dr C, General Practitioner, Sydney NSW

The Commission requested the Director to review the rendered services and daily servicing ($467 086 Medicare benefits for 5.58 services per patient with 31 occasions of 60 or more services per day), the high number of level C surgery consultations (3091) and home visits (697), the initiation of pathology (6.13 services for 39 per cent of total patients) and services to two or more patients on the same Medicare card on the same day (528 occasions).

After reviewing the records provided by Dr C, the Director was of the opinion that Dr C may have practiced inappropriately in that he kept records deficient in content and quality. Many services had no notes, lacked sufficient clinical input or appeared to have recorded only that a prescription had been issued. The records did not justify the services claimed.

Dr C acknowledged his conduct constituted inappropriate practice and expressed intent to significantly change his practice. Dr C agreed to be reprimanded, repay Medicare benefits of $50 000 and be disqualified from Group A1 (vocationally registered general practice) items for five months.

Dr D, Consultant Physician in Gastroenterology

The reasons the Commission gave for making this request were the overall number of rendered services and daily servicing by Dr D (13 602 services at a Medicare benefit of $1 507 595 and 60 or more services a day on 33 occasions) and the level of consultations in association with procedural items on the same day.

After conducting his review, that included obtaining advice from a senior consultant physician in gastroenterology, the Director formed the view that Dr D did not receive a proper referral to a consultant physician to justify a claim for an MBS item 110 (initial consultation) nor did Dr D document that he had rendered a service that justified an item 110 consultation. The Director was of the view that the request Dr D received was for a procedural item rather than a referral to a consultant physician for management of a patient’s problem. Dr D’s medical records focused on a history of the gastrointestinal problem but there was no evidence of any history...
taken of other problems or of the general health of the patient. It was apparent from the request documentation that some patients had significant medical problems. Also, there was no evidence that a physical examination was made prior to the procedure. On advice provided by Dr D, he allows five minutes for the consultation and 10 minutes for the procedure.

Following much discussion, Dr D agreed that his conduct constituted inappropriate practice, that the ‘request’ to perform a procedural item was not a valid referral (as required by the legislation), agreed to be reprimanded and to repay $70 000 in Medicare benefits.

Dr E, General Practitioner,
Sydney NSW

The Commission was concerned that Dr E was in the top percentile of all active general practitioners for the number of services he was providing (14 958 for a Medicare benefit of $378 332) and his itemisation of a number of minor procedural items (84 12-lead electrocardiography, 19 removal of foreign body from cornea, 11 treatments of fracture of metacarpal and 20 edge resection of in-growing toenail—total of $6253). Dr E provided 60 or more services on 62 days in the request period.

Following review of a number of medical records provided by Dr E, the Director formed the view Dr E’s conduct may have constituted inappropriate practice because the records revealed little clinical information. Many of the records were lacking in adequate histories, physical examination and findings sufficient to justify the items claimed. Evidence of investigations and medications prescribed was scarce. Of the 18 records examined relating to toenail wedge resections, almost all were viewed as inadequate as no details of the procedure or anaesthetic were recorded.

In addition, Dr E appeared to have provided these services on very busy days and the Director was concerned, under the circumstances, about his capacity to perform unhurried elective surgery.

In discussion with the Director, Dr E admitted he had failed to maintain adequate medical records to support the high volume of consultations and other procedural items claimed and that rendering such a high volume of services regularly was conduct that constituted inappropriate practice. Dr E agreed to be reprimanded, repay Medicare benefits of $15 000 and be disqualified from Group A1 services (vocationally registered general practitioner) items for 12 months.

Dr F, General Practitioner,
country NSW

The Commission requested the Director review Dr F’s prescribing and the high number of services per patient he provided. Dr F wrote 1886 prescriptions to 10 patients. The Director reviewed a number of medical records provided by Dr F. These records lacked sufficient clinical input and legibility in that many had no entry on or for dates on which a service was claimed. Many records showed issue of a prescription only, a pattern of prescribing narcotic medication early in treatment, and that Dr F failed to adequately monitor the health effects of drugs with a high risk of dependency.

In submissions and discussions with the Director, Dr F put forward arguments about the number of patients that required pain management in the area. He had taken a number of steps to alter the situation including discussions with the local area health service.

Dr F acknowledged that his conduct during the review period, in connection with the provision of the services, constituted inappropriate practice. Dr F agreed to be reprimanded.
Service examined by a Committee – Case 2

Service claimed  MBS item 54 – a long consultation of more than 25 minutes but not more than 45 minutes

Record entry  18/2/03  15:50 - 16:30

Explanation

Committee - Can you give us any indication as to why the patient presented on that particular day?

Practitioner – She would have been in for a check up, as I look at the record here.

Committee - Yes, a check up for?

Practitioner – Well, she was - oh, she had a variety of things but she was hypertensive.

Committee - So, she was in for a blood pressure check?

Practitioner – No, she was in for a check on the problem of hypertension. That's all. You just don't take the blood pressure. You go into a discussion of, you know, all the possible things that can be affecting her blood pressure, her lifestyle. I notice here that a month before that I'd made a note when she came in that she was a very unhappy lady in her domestic affairs and that was the - something new or recurrent in her life.

Committee - Apart from your presumption that you're reviewing her hypertension, was there any other constituent of that consultation?

Practitioner – Well, she had had immediately - previous - in December she'd had severe pain in her legs which I considered were a soft tissue origin.
Dr G, General Practitioner, country NSW

The reasons the Commission gave for making this request for a review to the Director, were that Dr G was rendering a high number of total services and daily services (16,507 total services for a Medicare benefit of $427,633 and providing 60 or more services per day on 102 days in the review period), rendering 25 wedge resections of in-growing toenail, prescribing 30,611 items at a cost of $813,485 (1,151 scripts for paracetamol amongst others) and providing services to two or more people on the same Medicare card on the same day on 376 occasions.

The Director ordered Dr G to produce 75 medical records for examination as part of the review. After examining the records, the Director was concerned that consultation items were often illegible or difficult to read and contained brief notes and a very brief history dealing with the immediate symptom with no evidence of assessment of long-term management of chronic conditions. The records for the wedge resections often just showed ‘wedge resection of nail’ as the initial treatment of an in-growing toenail. There was no evidence of a simpler procedure being performed and no details of the anaesthetic given.

Dr G admitted that his conduct in connection with the provision of certain services constituted engaging in inappropriate practice. He admitted to a failure to maintain adequate and contemporaneous medical records to support the claims for Medicare benefits. Further, Dr G submitted that he had reduced the opening hours of his surgery, was working about 11 hours less per week and had instigated a process to ensure he kept better medical records. Dr G made an agreement to be reprimanded and repay $15,000 in Medicare benefits.

Dr H, General Practitioner, Melbourne Vic

The Commission’s concerns about Dr H were about his itemisation of out-of-surgery consultation services, care plan items, joint or synovial cavity injections and prescribing of benzodiazepines. The Director ordered Dr H to produce about 100 records so a review of his practice could be carried out.

The result of the review was that the Director was concerned the majority of the medical records of consultations at residential aged care facilities contained no clinical notes for the date of service. In addition, the claim for care plan items were not able to be justified on the records kept. Documentation was poor, lacking sufficient clinical input and giving no clear indication of other team members. The records generally were not adequate and contemporaneous.

Dr H acknowledged his conduct in connection with the provision of certain services constituted inappropriate practice in that he failed to keep adequate and contemporaneous medical records supporting the claims for Medicare benefits. Dr H was reprimanded.

Dr K, General Practitioner, Melbourne Vic

The Commission was concerned at the high volume of services Dr K rendered, (14,802) including providing 60 or more services on 73 days in the review period. Dr K was required to produce 39 medical records for the Director’s review.

The Director’s examination of the records showed them to be brief and barely legible. Recording of clinical input was deficient in detail especially of the long-term patients with chronic illness. The clinical notes lacked important details such as patient history and management of diagnosed conditions. For example, in records
that showed a diagnosis of diabetes, there was no evidence of regular monitoring of blood glucose levels or physical examinations.

Dr K agreed he had failed to maintain adequate and contemporaneous medical records to support the Medicare benefits claimed. Dr K agreed to be reprimanded, repay $10,000 in Medicare benefits and to be disqualified from Group A1 (vocationally registered general practitioner) items for six months.

Dr L, General Practitioner, Melbourne Vic

The Commission requested the Director to review Dr L’s ratio of level B, C and D surgery consultations, and initiation of certain pathology services. Only 2.6 per cent of consultations by Dr L were level B, 56.6 per cent were level C and 39 per cent were level D. The percentages for all active general practitioners in Australia was level B—81.4 per cent, level C—10.7 per cent and level D—1 per cent. Dr L was the third ranked requester in Australia of pathology tests for the quantitation of copper, manganese, selenium or zinc and for tests involving the quantitation of serum zinc in a patient receiving intravenous alimentation.

Dr L was required to produce about 75 medical records to the Director. The records indicated that, while new patients had a detailed history of the particular presenting problem and nutritional history, there was a lack of detail of the patient’s physical condition, past or present. There was no evidence that a general systemic history was taken and this raised concerns that patients with complicated medical histories appeared to have received little attention for more mundane problems. It also appeared Dr L routinely requested a wide variety of uncommon tests on the initial consultation without performing any physical examination. There appeared to be no correlation between the clinical notes and the tests ordered and it was difficult to avoid the impression that tests were used as a routine health screen. Such tests were often repeated even when the results were persistently normal.

Dr L acknowledged her conduct in connection with the services constituted engaging in inappropriate practice in that she had failed to maintain medical records that adequately documented the patient’s history, examination findings, management and progress and the rationale for the pathology tests ordered. Further, certain of the pathology tests ordered would be regarded as inappropriate in the clinical situation of individual patients as demonstrated in the records. Dr L agreed to be reprimanded and repay $15,000 in Medicare benefits.

Dr M, Specialist Radiation Oncologist/ Medical Practitioner, capital city

Dr M was employed as a radiation oncologist at a large public hospital during the week and on some weekends provided services as a medical practitioner at a suburban medical practice. It was services from this latter practice that the Commissions requested the Director to review. The Commission was concerned about the comparative number of long consultations (MBS item 54) Dr M rendered and his high prescribing, including of addictive medicines.

A review of some 60 medical records for standard (item 53) and long (item 54) consultations showed entries to have few symptoms recorded, scanty findings and little evidence of management planning. In addition, many of the records on the long consultations did not contain entries for the date of service, many patients appeared to have straight-forward conditions such as ‘flu’ and upper respiratory tract infections, or had presented for repeat prescriptions or blood pressure checks. These records were extremely brief.
Service examined by a Committee – Case 3

Service claimed  MBS item 44 – an attendance involving an exhaustive history, a comprehensive examination of multiple systems, arranging necessary investigations and implementing a management plan for 1 or more complex problems, and lasting at least 40 minutes

Record entry

Explanation  Committee - What was the patient's reason for consultation on this day?

Practitioner – I do not know because it is not recorded and I have had hundreds, well, not hundreds but tens of visits with this patient over the years and obviously it was so involved that I never got around to writing the notes up. And perhaps we went out to do acupuncture or some other treatment on her. A vitamin injection and I never came back to the notes and I omitted to write them up, which is most unusual because my receptionist is obsessive and she often comes to me at the end of the day and says: you did not write up these three patients and then I sit down and I write up these three patients accordingly.

This was one very rare occasion that she would have missed that and not brought the file to me at 9:30 in the evening, saying: please write these up, because you tell me you must write up your notes. So I would have scribbled the two items that I would have written on a prescription for her and she always had multiple prescriptions and multiple problems.
Dr M only produced five of the 11 medical records ordered in relation to his prescribing. These again contained scanty notes with the diagnoses not obvious. There was a lack of management planning with little evidence of counselling or active psychotherapy for patients receiving long-term benzodiazepines or narcotics. One patient had 240 prescriptions; 237 of which were for benzodiazepines. Another had 174 prescriptions for morphine compounds out of 367 prescriptions. Both patients’ records had no supporting notes and related to a 12-month period. Dr M was his own third top patient for prescribing.

In submissions, Dr M advised he suffers from a range of medical conditions that limit his mobility and extend the time it takes to properly review patients. He further claimed his conditions make it difficult for him to access clinics and has therefore tended to treat himself. He claimed he conducted a proper workup on all patients.

The Director met with Dr M (as he does with all practitioners when negotiating an agreement) and at the conclusion of the meeting Dr M conceded his conduct in the provision of the consultations and prescribing at the suburban medical practice constituted inappropriate practice in that he did not keep medical records to support the services claimed or the prescriptions written. Dr M agreed to be reprimanded and disqualified from all consultation services as a (general) medical practitioner for three years.

Final determinations

During the reporting period, 26 final determinations were issued, 26 became effective and the sanctions imposed as part of the effective final determinations included:

- reprimand and counselling on all 26 determinations
- repayment across 22 determinations totalling $1,626,909.24 (from $983.21 to $269,499.24 and averaging $62,573.31 per determination)
- full disqualification periods from two months to one year totalling 6.4 years over 12 determinations
- partial disqualification periods from one month to two years and nine months totalling 5.5 years over 10 determinations.

When a practitioner has had two effective final determinations the Director must provide a written notice to the Medicare Participation Review Committee (MPRC). Pursuant to section 106X of the Act the Director wrote to the Chairperson of the MPRC in March 2005 providing information relating to a recent effective determination against a practitioner and an earlier effective determination from October 1998. The MPRC has a discretionary range of options available — from taking no further action against the practitioner to counselling and reprimand and full or partial disqualification from participation in the Medicare benefits arrangements for up to five years. As required under the Act the practitioner was notified of the correspondence to the MPRC.

As the Director is able to publish certain information on practitioners where a final determination comes into effect, details of those in date-of-effect order are given below:
Dr John Chung-Tsang Lai, General Practitioner, Bendigo Vic

Dr Lai was reviewed for his high level of prescribing under the Pharmaceutical Benefits Scheme. During the referral period Dr Lai wrote a total of 1003 prescriptions for benzodiazepines that comprised 28.9 per cent of his total prescribing.

The Committee examined Dr Lai’s item 54 surgery consultations and his item 173 acupuncture items. The Committee found Dr Lai had engaged in inappropriate practice in 100 per cent of consultations examined. The Committee’s findings included that Dr Lai:

- failed to use accepted medical criteria for selecting patients to whom antibiotic drugs were prescribed
- failed to monitor the quantities of drugs being supplied to patients
- failed to take an adequate history or make a proper physical examination
- failed to keep medical records that contained essential clinical information
- did not formulate clinically sound management plans for his patients.

In relation to Dr Lai’s use of acupuncture, the committee found he subjected patients to more treatments than were necessary.

The Committee formed the opinion that Dr Lai’s conduct was likely to cause a significant threat to the life or health of his patients. The Director referred Dr Lai to the Medical Practitioners Board of Victoria.

The Determining Authority directed that Dr Lai repay $65 483.41 in Medicare benefits and be fully disqualified from Medicare for three months.

Dr Anthony Tsamoglou, General Practitioner, Kogarah NSW

The Commission requested the Director to review Dr Tsamoglou’s practice for three reasons: his high average number of services per patient (6.58) which was above the 98th percentile, his high volume of level C consultations (2253) which was between the 95th and 99th percentile, and his high level of initiation of pathology.

Dr Tsamoglou initiated more pathology services per patient (4.12) than 99 per cent of all active general practitioners in Australia.

The Director found, in relation to MBS item 24 (level B home visit) and MBS item 37 (level C home visit), that Dr Tsamoglou engaged in inappropriate practice in all services examined as he did not keep medical records containing all essential clinical information.

When examining many of Dr Tsamoglou’s level C surgery consultations, the committee again found Dr Tsamoglou’s record keeping deficient in essential information. In particular there was ‘little or no documented evidence of counselling, which Dr Tsamoglou stated occurred’. The committee considered that, ‘good clinical records of psychological consultations in a general practice form part of proper clinical care, assist in tracking key issues between consultations and also with the management of recurring difficulties in the long term’.

Another aspect of Dr Tsamoglou’s practice that caused the committee concern was his use of MBS items 18274 and 18276 (paravertebral, cervical, thoracic, lumbar or coccygeal nerves, injection of an anaesthetic agent). Based on the evidence, both oral and written, the committee concluded that Dr Tsamoglou injected soft tissue trigger points rather than performing nerve blocks. The Committee was of the opinion that this conduct would have been unacceptable to the general body of general practitioners.
Service examined by a Committee – Case 4

Service claimed  MBS item 36 – an attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing of a management plan for 1 or more problems, and lasting at least 20 minutes

Record entry

Explanation  Committee – Why did the patient attend this day?

Practitioner  He was – he needed a repeat. He’d run out of Murelax.
The Determining Authority found that Dr Tsamoglou’s conduct constituted inappropriate practice. It directed that Dr Tsamoglou repay to the Commonwealth $12 762.58, and be disqualified for a period of three months from all services provided as a vocationally registered general practitioner.

Dr Frederico John Facchini, Medical Practitioner, Kogarah NSW

The Commission requested Dr Facchini be reviewed for his high services per patient (10.67) and the high volume of long and prolonged consultations: 68 per cent of all Dr Facchini’s consultations were long surgery consultations, and 21 per cent were prolonged. During the referral period Dr Facchini received $120 245 in Medicare benefits.

During the hearing Dr Facchini told the committee that he ran a ‘walk-in practice’ and that he did not have a receptionist nor did he keep a diary or a daybook.

The Committee found that 96 per cent of Dr Facchini’s item 54 services were inappropriate. Dr Facchini was found not to have taken an adequate history and/or made an adequate physical examination and/or formulated an adequate management plan. Dr Facchini was found to have rendered services not medically necessary and to have kept records deficient in essential clinical information.

Eighteen of the 30 randomly-sampled services under examination involved issuing of a prescription for methadone. Dr Facchini repeatedly justified his failure to follow up clinical aspects of presenting complaints amongst his patients because he was a ‘methadone doctor’. The Committee did not accept this as an excuse.

The Determining Authority noted that, in relation to most services, the clinical input was deficient and Dr Facchini’s medical records adversely impacted Dr Facchini’s ability to provide care to his patient. The Authority directed Dr Facchini to repay to the Commonwealth $24 444.64 and to be fully disqualified from Medicare for one month.

Dr David Michael Gillman, Medical Practitioner, Airlie Beach Qld

Dr Gillman’s practice was reviewed on request by the Commission for his level of prescribing methadone, codeine phosphate and pethidine. Dr Gillman prescribed 7275 items under the PBS at a net cost of $143 375.93. Of the total number of prescriptions issued, 26.91 per cent were for narcotics or benzodiazepines.

The Committee was ‘very concerned regarding the overall quality of Dr Gillman’s medical records’. During the hearing the committee became concerned regarding Dr Gillman’s management of pigmented lesions some of which he had treated without histological conformation of their nature. It is possible that some of Dr Gillman’s patients received inadequate care as a result of his management.

The Committee expressed its concern regarding Dr Gillman’s prescribing of narcotics for non-clinically valid reasons, for not using accepted medical criteria for selecting patients to whom drugs were prescribed, and for not giving proper warning of the addictive properties of some drugs.

The Committee found that Dr Gillman’s conduct constituted inappropriate practice in relation to 79 per cent of the class of MBS item 44 services and 15 per cent of the class of MBS item 30195 services.

The Determining Authority directed Dr Gillman to repay $11 640 to the Commonwealth and be disqualified from Medicare for six months from all services provided as a vocationally registered general practitioner.
Dr Wan Kum Chan,  
General Practitioner, Kingsford NSW

The Commission requested Dr Chan be reviewed for her high level of services. During the referral period Dr Chan provided 16 331 services to 5075 patients which put her well above the 99th percentile compared to all active general practitioners in Australia. Dr Chan gained benefits of $347 083.25 for these services.

The Committee concluded that all the 30 randomly sampled services would be considered unacceptable to the general body of general practitioners and would therefore constitute inappropriate practice.

Dr Chan’s medical records were found to be deficient in essential clinical information and, in all instances, the committee found Dr Chan had recorded information that was indecipherable. The Committee was not satisfied, by the oral and written evidence, that Dr Chan formulated and/or implemented an adequate management plan for a diagnosed complaint.

The Determining Authority directed Dr Chan to repay $101 382.71 and be disqualified for six months from Medicare for all services provided as a vocationally registered general practitioner.

Dr Jerzy Cywinski,  
General Practitioner, Bonnyrigg/Austral NSW

See summary under Federal Court and Full Federal Court, decisions handed down, later in this chapter.

Dr Peter Andrianakis,  
Medical Practitioner, Yarraville/East Kew Vic.

See summary under Federal Court and Full Federal Court, decisions handed down, later in this chapter.

Dr Kim Fatt Chan,  
General Practitioner, Reservoir Vic.

The Commission requested Dr Chan be reviewed for his high level of daily servicing and his overall high number of rendered services. During the referral period Dr Chan rendered 20 947 services to 5950 patients. This was well above the 99th percentile (15 915) for all active general practitioners in Australia. During the referral period Dr Chan rendered services for a total of $463 114.05 in Medicare benefits.

In almost every record examined, the committee noted that Dr Chan's writing was mostly illegible. Dr Chan repeated information in patients’ records that he had obtained previously which made it difficult for him or any other treating practitioner to understand what had actually occurred during that particular consultation.

The Committee examined 61 MBS item 36 services and found that Dr Chan had engaged in inappropriate practice in 40 of the 61 services. Dr Chan was found not to have taken an adequate history, had failed to make an adequate examination, had failed to arrange necessary investigations and had failed to implement an adequate management plan in relation to one or more problems.

The Determining Authority required Dr Chan to repay to the Commonwealth benefits in the amount of $20 992.95 and be fully disqualified for two months from Medicare.

This was Dr Chan’s second referral to Professional Services Review. He had had an adverse determination in 1998 wherein he was required to repay $8255.90 and be disqualified for one month. As a result of the second adverse finding he was automatically referred to the Medicare Review Participation Committee.
Service examined by a Committee – Case 5

Service claimed  
**MBS item 23** – an attendance involving taking a selective history, an examination and implementing a management plan in relation to 1 or more problems

Record entry

Explanation  
**Committee** – What was the clinical reason for this consultation?

**Practitioner** – He has mild underlying asthma and he presented with a prolonged lower respiratory bronchitis infection which I diagnosed as viral, and 2 October, 6 November, so I – he saw me first and I – on the previous day, with cough which is lingering for nearly a month now. So when he came back again saying the cough is bad and he needs some relief, after assessing him again to make sure, I started him on seretide, thinking that it’s one of these post-viral bronchitis cough, query hyperactive airway that something like seretide will give him some relief.
Dr Jonathon Robert Turtle,  
General Practitioner, Deakin ACT

The Commission requested that Dr Turtle be reviewed for his rendering of a high proportion of long and prolonged consultations compared to standard consultations (1367 level B, 2458 level C and 502 level D). In addition, Dr Turtle’s rate of referral for pathology was above the 99th percentile for all active general practitioners in Australia ($61 524.70 in total pathology benefits).

The PSR committee found that Dr Turtle failed to collect and record an adequate history, failed to perform an examination of multiple systems, failed to arrange necessary investigations, and/or failed to implement a management plan.

The committee was of the opinion that, in some cases, Dr Turtle performed an examination that was inadequate for the presenting complaint. In other cases Dr Turtle failed to arrange the necessary investigations for the presenting complaint. This could have led to a misdiagnosis, resulting in the wrong treatment.

The committee's conclusion was that Dr Turtle's conduct would be unacceptable to the general body of general practitioners in connection with the services examined.

The Determining Authority found Dr Turtle's inappropriate practice to be significant, and that it was of a serious nature. In light of submissions from Dr Turtle on the draft determination, the Authority reduced the severity of the sanctions because of Dr Turtle's willingness to change and his acknowledgement that his records were inadequate.

The final determination directed that Dr Turtle repay to the Commonwealth Medicare benefits in the amount of $57 082.12. In addition, he was disqualified for six months from all services provided as a vocationally registered general practitioner.

Dr Chris Siamidis,  
Medical Practitioner, Brunswick Vic.

See summary under Federal Court and Full Federal Court, decisions handed down, later in this chapter.

Dr Mario Marchesani,  
General Practitioner, Geelong Vic.

Dr Marchesani was reviewed on request because of the high number of services per patient he rendered and the number of his level C consultations and home visits. Dr Marchesani rendered 338 level C home visits during the referral period — well above the 99th percentile (170).

The committee examined Dr Marchesani’s long surgery (item 36) and long home visits (item 37). Dr Marchesani was found to have engaged in inappropriate practice because he failed to take a detailed history, failed to provide an adequate level of clinical input and kept medical records that were deficient in essential clinical information. Dr Marchesani visited patients with relatively straightforward single system problems, the committee considered these visits not clinically necessary. Dr Marchesani believed the time spent making specialist appointments for patients could be included when calculating the length of time of a consultation. The committee did not agree.

Dr Marchesani rendered many home visits to patients well known to him, sometimes at the request of the patient and sometimes on his own initiative. The committee found, in almost every instance, no evidence of any condition or new illness that would require Dr Marchesani to spend in excess of 20 minutes with the patient. The committee found that 100 per cent of Dr Marchesani’s long home visits were inappropriate.

The Determining Authority considered that Dr Marchesani failed to provide adequate clinical input to the services he provided.
The Authority directed that he repay to the Commonwealth $21,154.32 and be disqualified for a period of six months from all services provided as a vocationally registered general practitioner.

**Dr William Crow Lyon, General Practitioner, McCrae Vic.**

The Commission requested a review of Dr Lyon because of his excessive prescribing of benzodiazepines and codeine-containing compounds. In the referral period, Dr Lyon wrote 1431 prescriptions for benzodiazepines and 566 codeine compound analgesics to 274 patients.

The committee found that Dr Lyon ‘gave little or no consideration to whether some of his patients were drug dependent. He issued frequent repeat benzodiazepine prescriptions to patients, with little or no other clinical input’. The committee found a number of instances where Dr Lyon prescribed two benzodiazepines to patients during a consultation. When asked why he prescribed them in combination, Dr Lyon stated: ‘I don’t know why I do it really, to be honest with you’. He acknowledged that he sometimes prescribed drugs because the patient wanted them.

Dr Lyon’s progress notes generally consisted of single-line entries, with no history or evidence of an examination. The committee formed an opinion that Dr Lyon’s conduct was causing or was likely to cause a significant threat to the life or health of his patients. As a consequence he was referred to the Medical Practitioners Board of Victoria.

The Determining Authority directed that Dr Lyon be reprimanded and counselled and repay to the Commonwealth $1436.67. The Authority took into account that Dr Lyon was the subject of conditional registration supervised by the Medical Practitioners Board of Victoria.

**Dr Jonathon Brent Sutton, General Practitioner, Doncaster/Fitzroy North Vic.**

The Commission requested that Dr Sutton be reviewed because of his high level of services per patient (10.36 services per patient, total benefits $226,059.80), and the number of level C and D surgery consultations. Dr Sutton was above the 90th percentile for level C surgery consultations and above the 99th percentile for level D surgery consultations. He was also reviewed for the level of home visits and initiation of pathology and radiology. Dr Sutton’s total home visits made up 30 per cent of his total consultations compared with all active general practitioners in Australia (2.25%).

The committee found that, in those services it examined, Dr Sutton’s treatment ‘could not be described as accepted practice and was at best often superficial if not bizarre. Given the patients’ ailments his treatment also often appeared to be illogical, too frequent and without a sound clinical basis.’

The committee was concerned also that ‘Dr Sutton’s treatment of family members for psychiatric problems which, in the circumstances described, was inappropriate and demonstrated a lack of insight on his part. The number of visits and consultations to his family members was extraordinary—85 to one and 45 to another.

The Determining Authority noted that Dr Sutton’s inappropriate practice was of a serious nature. It also noted that the Authority imposed lesser directions on Dr Sutton than it otherwise would have, because the Medical Practitioner’s Board of Victoria was dealing with him. The Authority based its decision on only the 19 services the committee had examined and did not extrapolate. The Authority directed that Dr Sutton repay $983.21 and be fully disqualified for six months.
Service examined by a Committee – Case 6

Service claimed  MBS item 44 – an attendance involving an exhaustive history, a comprehensive examination of multiple systems, arranging necessary investigations and implementing a management plan for 1 or more complex problems, and lasting at least 40 minutes

Record entry  

Explanation  Committee – And this particular consultation?

Practitioner - Perhaps not quite so well, but you know, in basic things, yes. He had been complaining of urinary tract problems, was worried about those and I had done some tests at that time looking at renal things and I had actually referred him on to Professor Aaaa who is a renal specialist and I had hoped that he would stay with Professor Aaaa and not come back to me, but unfortunately he came back like a bad penny a little while later.

I have not seen him for some time, which is very, very good, but at that stage the etcetera, etcetera was just my frustration at saying ‘look, this guy is driving me bananas with what he is doing. As I say, he complained of some symptoms and that I thought needed checking. I actually did some tests on him at the time and I also referred him on to Dr Bbbb as well for examination but that was later on that I sent him to see Dr Bbbb. That was in ’03.
Dr Ian Gordon Falconer,  
General Practitioner, Croydon South Vic.  
The Commission requested a review of Dr Falconer due to his very high services per patient.  
During the referral period Dr Falconer had an average of 13.14 services per patient and rendered 1932 services to 147 patients. Despite having a very small patient base Dr Falconer was above the 99th percentile for emergency attendance after hours.  
The committee found that Dr Falconer had engaged in inappropriate practice by failing to provide adequate clinical input into services, rendering services that were not necessary, managing chronic pain in a clinically unacceptable way, and prescribing narcotics and benzodiazepines when they were not clinically indicated.  
During the hearing the committee became concerned that, due to Dr Falconer’s health and mental state, he was unfit to continue participating in the proceedings. Dr Falconer was referred to a consultant physician for an opinion. The physician advised that Dr Falconer was not fit to continue in practice. The committee was concerned that Dr Falconer’s conduct was causing or was likely to cause a significant threat to the life or health of his patients. The Director was advised of the committee’s concerns and Dr Falconer was referred to the Medical Practitioner’s Board of Victoria.  
The Determining Authority directed that Dr Falconer be reprimanded and counselled by the Director. Dr Falconer agreed to retire from medical practice.  

Dr Ian Lester Rafter,  
General Practitioner, Sydney NSW  
The Commission requested that Dr Rafter be reviewed because of his high level of pathology initiation. In the review period Dr Rafter referred 939 patients for a total of 7290 pathology services at a total benefit of $164,684.20—this was 968 services above the 99th percentile for all active general practitioners in Australia.  
The committee found Dr Rafter had initiated pathology services that were not medically necessary. In addition, the committee found that many of Dr Rafter’s initiated pathology services were for health screening, as defined in the MBS book. Dr Rafter ordered significant amounts of pathology in all consultations examined. The committee concluded that ‘many of the pathology tests initiated had no role in the diagnosis or management of patient symptoms’. Pathology services were often repeated within short intervals. Dr Rafter used pathology services to explore patient symptoms without conducting a physical examination. Additionally, Dr Rafter initiated some pathology services to explore patient symptoms based on the assertions of unproven literature and theory. The Determining Authority considered that a reprimand and counselling were both necessary and appropriate sanctions in Dr Rafter’s case.  

Dr Lawrence Matthew Finley,  
General Practitioner, Culburra Beach NSW  
The Commission requested that Dr Finley be reviewed for his high level of total services (16,710) and his prescribing of benzodiazepines. With a patient base of 4438 patients, Dr Finley prescribed 27,579 items under the PBS at a net cost of $512,494.95. On 1936 occasions he prescribed benzodiazepines (7.01 per cent of total prescriptions). The committee found that 100 per cent of the sampled item 23 services were inappropriate. In particular the committee found that Dr Finley had failed to provide adequate clinical input into the services, had prescribed benzodiazepines when these were not clinically indicated, and failed...
to keep adequate and contemporaneous records. Dr Finley’s records were generally illegible.

The committee also examined Dr Finley’s conduct in relation to rendering items 18216 (intrathecal or epidural injection), 18242 (greater occipital nerve injection of an anaesthetic agent) and 39115 (percutaneous neurotomy). All of these services rendered by Dr Finley were found to be inappropriate. In particular the committee was very concerned about Dr Finley’s inadequate sterilisation methods. Dr Finley told the committee he had not used an autoclave for 10 years. Dr Finley initially asserted he had an autoclave until his wife reminded him he had given it away many years ago. He also told the committee it was his routine practice to reuse the same blade for (on average) 10 consecutive patients. The committee communicated their concerns to the Director who referred Dr Finley to the NSW Health Care Complaints Commission.

In view of the serious nature of Dr Finley’s inappropriate practice the Determining Authority directed that Dr Finley repay $269,499.24 and be disqualified for 12 months from all services provided as a vocationally registered general practitioner.

Dr Guy Claude Delcourt,
General Practitioner, Mill Park Vic

The Commission requested that Dr Delcourt be reviewed because of concerns regarding his itemisation of deep skin repair. During the referral period Dr Delcourt rendered many more deep wound repairs than superficial repairs. Dr Delcourt’s profile was higher than the 99th percentile for these items than for all other vocationally registered general practitioners in Australia.

In addition to the Commission’s concerns, the Director was also concerned that Dr Delcourt’s conduct in rendering MBS item 36 services may have constituted inappropriate practice. The committee investigated Dr Delcourt’s item 36 services and found that 100 per cent of the sampled services were inappropriate.

The committee then examined Dr Delcourt’s conduct in relation to deep wound repair (MBS item 30029). All of Dr Delcourt’s item 30029 and 30035 services were also found to be inappropriate. In particular he had not recorded essential clinical information as to wound location, tissue layer involved and tetanus immunisation status. The committee found Dr Delcourt had acted on his incorrect belief that if subcutaneous tissue was involved in any location it constituted a deep laceration, whether or not sutures were used. The committee also disagreed with Dr Delcourt’s opinion that a laceration on the fingertip constituted a deep laceration. On occasions Dr Delcourt used Steri Strips to treat wounds and claimed to have repaired a deep laceration.

The Determining Authority directed that Dr Delcourt be counselled and reprimanded by the Director and repay $16,435.26 in Medicare benefits.

Dr Neville Arthur Breitkreutz,
General Practitioner, Biggera Waters Qld

The Commission requested that Dr Breitkreutz be reviewed because of his prescribing of benzodiazepines, narcotics and codeine compounds. During the referral period Dr Breitkreutz wrote 727 prescriptions for benzodiazepines, 268 for codeine compounds and 397 for narcotics. The Commission was also concerned that many doctor-shopping patients were attending Dr Breitkreutz’s practice.

The committee was concerned that Dr Breitkreutz prescribed drugs to his patients without adequate clinical indications. The committee concluded that he prescribed drugs of addiction to patients on demand. In the case of a patient suffering from spinal stenosis Dr Breitkreutz...
continued to prescribe large quantities of narcotics and benzodiazepines. For another patient suffering from back pain Dr Breitkreutz prescribed Physeptone (methadone) 10 mg tablets (pack of 20) every three days. The committee concluded that he failed to record an adequate history or formulate an adequate management plan. Dr Breitkreutz’s records at times consisted of only single-line entries.

The committee regarded Dr Breitkreutz’s disregard of Department of Health and Ageing advice that temazepam capsules should not be prescribed (due to the risk that addicts may inject the contents) as a serious threat to his patient. If injected into an artery, temazepam can cause tissue damage and gangrene.

The Determining Authority directed that Dr Breitkreutz be reprimanded and counselled by the Director. In his submission to the Determining Authority Dr Breitkreutz advised that he had retired from practice.

Dr Jack Freeman,
General Practitioner, Nth Melbourne Vic.
See summary under Federal Court and Full Federal Court, decisions handed down, later in this chapter.

Dr Constantinos Perkoulidis,
Medical Practitioner, Brunswick Vic.
See summary under Federal Court and Full Federal Court, decisions handed down, later in this chapter.

Dr Phillip John Chapman,
General Practitioner, South Broken Hill NSW

The Commission requested that Dr Chapman be reviewed for his high level of services. Dr Chapman provided 16,521 services for a total benefit of $408,054.80; this put Dr Chapman above the 99th percentile when compared to all active general practitioners in Australia. Dr Chapman was also reviewed for prescribing under the Pharmaceutical Benefits Scheme. Dr Chapman prescribed 44,174 items at a net cost of $974,046.52.

The committee found inappropriate practice in 52 per cent of the exploratory sample of services. The committee found that Dr Chapman ‘did not provide an appropriate level of clinical input into the services and failed to satisfy the requirement of MBS item 23’. Dr Chapman’s medical records ‘were not sufficient to contribute to the quality and continuity of care received by patients’.

The committee found ‘there was no documented or oral evidence that Dr Chapman employed clinical management plans or strategies designed to provide comprehensive and continuing whole-patient care to patients who presented with long term chronic conditions’.

The Determining Authority considered that Dr Chapman’s inappropriate practice was serious and considerable. Applying the sampling methodology, 5,189 MBS item 23 services involved inappropriate practice. The Authority directed Dr Chapman to repay $116,305.56 and be fully disqualified for three months and be disqualified for 12 months from all services provided as a vocationally registered general practitioner (concurrent with the full disqualification).

Dr Mohammed Amjad Hussain,
General Practitioner, Airport West Vic.

The Commission requested a review of Dr Hussain because he had rendered 80 or more attendances on 22 occasions during the referral period.

The committee reached a finding that Dr Hussain had engaged in inappropriate practice by rendering 80 or more attendances on 22 days and that there was no suitably persuasive evidence of exceptional circumstances on any of the 22 days.

In his submission, Dr Hussain claimed there were exceptional circumstances that had led him to
be unable to render less than 80 attendances on the 22 days. His submission contained, inter alia, the following reasons:

- a relative shortage of GPs in the western suburbs of Melbourne
- Dr Hussain’s partner was unavailable during the referral period
- migrant groups comprise a loyal patient base
- all patients were bulk billed, while surrounding practices had reduced bulk billing
- no other clinics in the shopping area in which the practice was situated.

The committee considered these ‘reasons’ and rejected all of them as an explanation for Dr Hussain’s conduct. The committee was of the opinion that a practitioner should be able to proactively manage his practice so as to avoid a situation where he sees very large numbers of patients.

The Determining Authority directed Dr Hussain to repay to the Commonwealth $42 124.45.

Dr Khalid Aziz Qidwai, General Practitioner, Ashfield NSW

The Commission requested a review of Dr Qidwai because of his high level of rendering a level C consultation item with a procedural item. During the review period Dr Qidwai claimed 936 level C consultations and 919 procedural items.

The committee examined Dr Qidwai’s conduct in respect of 40 randomly sampled services and concluded that his conduct in connection with 36 of these services would be considered unacceptable to the general body of general practitioners. In particular 33 services were not medically necessary and the records of 35 services examined were considered to be deficient in essential clinical information and of a very poor standard.

During the hearing the committee became concerned that Dr Qidwai’s conduct was causing or was likely to cause a significant threat to the life or health of his patients for the following reasons:

- lack of understanding of autoclaving techniques
- lack of understanding of resuscitation facilities
- inadequately trained surgery assistants
- inadequate medical records
- inaccurate reading and assessment of histopathology reports
- lack of understanding of legal requirements for termination of pregnancies.

The committee communicated its concerns to the Director who was obliged to notify the Medical Board of New South Wales.

The Determining Authority viewed Dr Qidwai’s inappropriate practice as considerable. It determined that he repay $10 512.56, be fully disqualified for two months and be disqualified for four months from all services provided as a vocationally registered general practitioner (concurrent with the full disqualification).

Dr Michael Levenda, General Practitioner, Caulfield North Vic.

The Commission requested that Dr Levenda be reviewed for rendering of level C surgery consultations (item 36), for minor skin excisions, and use of nasendoscopy item 41764.

Dr Levenda was above the 99th percentile for his level C consultations, skin biopsy item 30071, and nasendoscopy.

The committee found that Dr Levenda had engaged in inappropriate practice in all of the item 36 and item 41764 services examined. In addition, 10 of the 11 skin biopsy services the committee examined involved inappropriate practice.
The committee found numerous examples of Dr Levenda failing to provide adequate input: failure to determine the cause of a patient’s frequent falls, failure to consider the significance of the symptom of ‘numb toes’ in a diabetic patient, and failure to establish the source of infection prior to prescribing Doryx.

Dr Levenda’s use of a nasendoscope displayed grossly inappropriate conduct. He had used the instrument to examine simple problems such as a blocked nose, cough and allergic rhinitis. In some instances he failed to institute other, more appropriate investigations, such as X-ray, for a possible fractured nose.

Dr Levenda’s medical records were also found to be inadequate. The committee concluded that in all cases examined Dr Levenda’s records were not sufficiently clear and detailed so that another practitioner could safely and effectively undertake the patient’s ongoing care.

The Determining Authority found that Dr Levenda’s inappropriate practice was of a serious nature. The Authority directed that Dr Levenda repay $69,172.87 and be disqualified for six months from all services provided as a vocationally registered general practitioner.

Dr Albert Gerald Galea,  
General Practitioner, Liverpool NSW

Dr Galea was reviewed, on request by the Commission, because his total services were above the 99th percentile—17,416 services to 2974 patients for a total benefit of $406,739.30. He was also referred for his high level of diagnostic imaging that was also above the 99th percentile.

The committee found that 25 of 30 randomly sampled services Dr Galea rendered were inappropriate. Dr Galea’s records were deficient in essential clinical information and there was generally a lack of appropriate clinical input.

With respect to diagnostic imaging, the committee found that Dr Galea initiated services that were not necessary and failed to take an adequate history or carry out an adequate examination before initiating these services.

The committee also formed the view that Dr Galea’s conduct was causing or was likely to cause a significant threat to life or health of his patients. The reasons for this view included his inadequate pharmacological management and high prescribing levels and his poor patient management. The committee communicated its concerns to the Director who referred Dr Galea to the New South Wales Health Care Complaints Commission.

The Determining Authority agreed with the committee that Dr Galea had engaged in inappropriate practice in a large number of services (11,743 item 23 services). It directed Dr Galea to repay $267,547.50 and be disqualified for three months from all services provided as a vocationally registered general practitioner.

Dr Paul Joseph Ameisen,  
General Practitioner, Edgecliff NSW

The Commission requested a review of Dr Ameisen for his high level of services per patient. Dr Ameisen rendered 8751 services to 1402 patients (6.24 services per patient) for a total benefit of $263,733.50. He was also referred for the level of his initiation of pathology, his high level of prescribing Pethidine injections and benzodiazepines. Dr Ameisen was also above the 95th percentile in his rendering of level D surgery consultations.

The committee found that Dr Ameisen generally did not take detailed histories of patient’s presenting complaints and on several occasions did not examine the patient.
On the occasions Dr Ameisen did undertake an examination it was brief and was not of multiple systems, as required by the MBS descriptor. In all but two of the services examined, the clinical component of the service did not warrant use of MBS item 36. The entries in the medical records were generally insufficient to contribute to the quality and continuity of patient care.

On occasion, Dr Ameisen relied on results from a Lis Ten test, (a form of computerised electrodermal screening performed by another person who was not a medical practitioner), rather than the evaluation of clinical indications. In one example Dr Ameisen ‘intended to base the management plan for this patient, who had a history of chemical exposure, on the Lis Ten test rather than history and examination findings.’

The Determining Authority found that Dr Ameisen’s inappropriate practice was significant: ‘Dr Ameisen’s conduct in respect of 25 out of 26 MBS item 36 services sampled and 23 of the 25 MBS item 44 services sampled would be unacceptable to the general body of general practitioners.’

In most instances Dr Ameisen did not satisfy the requirements of the Medical Benefits Schedule, his clinical input was deficient, and his medical records adversely impacted his ability to provide care to his patients.

The Determining Authority directed Dr Ameisen to repay $63,525.20 in benefits and be disqualified for six months from all services provided as a vocationally registered general practitioner.

**Determining Officer**

The Determining Officer’s role applies to all cases referred by the Commission before 1 August 1999. (For cases referred after that date, the Determining Authority takes the role.) The First Assistant Secretary, Medical and Pharmaceutical Services Division in the Department of Health and Ageing currently holds the position and was appointed ministerially. The Determining Officer makes determinations about practitioners who have been found, by a committee of their peers, to have engaged in inappropriate practice.

In making any determination, the Determining Officer essentially has the same sanctions available to it as the Determining Authority.

During the year, the Determining Officer received the last of the committee reports relating to referrals made by the Commission prior to 1 August 1999. However, as the committee could not complete its investigation, the Determining Officer took no action. (The practitioner had been disqualified from Medicare since July 1998 for failing to produce medical records to the committee. The practitioner has not been registered with the local medical board for a number of years.)

<table>
<thead>
<tr>
<th>Table 6—Determining Officer cases</th>
<th>2004–05</th>
<th>2003–04</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committee reports received</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Draft determinations issued</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Final determinations issued</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Request for review to PSR Tribunal</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>
Professional Services Review Tribunal

Practitioners, about whom the Determining Officer has made a final determination, may ask the Minister for Health and Ageing to refer the determination to a Tribunal for review. A Tribunal 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 legal technicality as a proper consideration of the matter permits. Unlike proceedings before committees, the person under review may be legally represented.

PSR Tribunals are not empowered to review decisions of the Determining Authority, which takes over the role of the Determining Officer for cases referred after 1 August 1999.

There was one request to the Minister for review of a final determination during the year. The Tribunal conducted two hearings in this matter and handed down decisions in three cases. In one case (Grey) the Tribunal affirmed the final determination, and affirmed the committee findings in the other two (Sevdalis and Tisdall) but made a different determination to that of the Determining Officer. One of these cases (Tisdall) has been appealed to the Full Federal Court. These cases are discussed in full later in this chapter.

The PSR Tribunal has no more cases to consider.

Table 7—Professional Services Review Tribunal cases

<table>
<thead>
<tr>
<th></th>
<th>2004–05</th>
<th>2003–04</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requests for Review received</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Hearings held</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Decisions handed down</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Appeal withdrawn</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Reasons for requests and referrals

Commission requests for review

The reasons the Commission requests a review of the provision of services by a practitioner generally fall within select and distinctive categories. As the Commission only has access to claims data and any information elicited by a medical adviser during a visit, the categories are limited to the results of statistical interrogation. Requests generally fall into one or more of the following categories:

- prescribed pattern of services
- high volume of services
- high number of services per patient
- high prescribing of Pharmaceutical Benefits Scheme drugs
- high ordering of pathology and diagnostic imaging tests.

3 A prescribed pattern of services also forms a reason for a referral from the Director to a committee.
Table 8—Types of concerns in Commission requests

<table>
<thead>
<tr>
<th>Concern</th>
<th>2004–05</th>
<th>2003–04</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribed pattern of services</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>High volume of services</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>High Medicare Benefits Schedule level C and/or D services</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>High services per patient</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>High ordering of pathology and diagnostic imaging</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>High Pharmaceutical Benefits Scheme prescribing</td>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>18</td>
</tr>
</tbody>
</table>

Note: some referrals contained more than one of the above concerns.

Committee referrals
When the Director makes a decision to review, he has the power to obtain patient records and other relevant documents that are examined by appropriately qualified and experienced practitioners. This gives a greater insight into the particular practitioner’s behaviour than was available to the Commission.

Consequently, issues become apparent following a review and may form part of the following reasons for referral to a committee:

- inadequate clinical input
- Medicare Benefits Schedule item descriptor not satisfied
- services not medically necessary
- particular services or types of services
- inadequate medical records.

Table 9—Types of services referred to committees

<table>
<thead>
<tr>
<th>Service</th>
<th>2004–05</th>
<th>2003–04</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribed pattern of services</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Standard consultations</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Long consultations</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Prolonged consultations</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Other Medicare Benefits Schedule items</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Pharmaceutical Benefits Scheme prescribing</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Pathology and/or Diagnostic Imaging</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Note: some referrals contained more than one type of service.
Table 10—Reasons for referral to committees

<table>
<thead>
<tr>
<th>Reason for Referral</th>
<th>2004–05</th>
<th>2003–04</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate clinical input</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Inadequate medical records</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Services not medically necessary</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Medicare Benefits Schedule not satisfied</td>
<td>8</td>
<td>4</td>
</tr>
</tbody>
</table>

Note: all referrals contained more than one reason.

Other types of concerns

There are three other areas of concern that can become apparent during an investigation or during a committee process. These are:

- professional isolation
- unusual medical practice
- alteration of documents.

A discussion of the different types of concerns in Commission referrals, reasons for referral to committees and other types of concerns follows.

Prescribed pattern of services

Following a 1999 review of the scheme by the Australian Medical Association (AMA), the Commission, the Department of Health and Ageing and PSR4 legislative changes were made to include a method of examining the conduct of practitioners who have high volumes of services. The legislation came into effect for services rendered after 1 January 2000, and the first wave of these referrals was received in 2002–03.

In a significant departure from other types of referrals, a practitioner who performs a nominated number of services in a particular period is deemed by the legislation to have practiced inappropriately, unless they can provide evidence that exceptional circumstances existed. That is, the onus of proof is on the practitioner to demonstrate that he or she did not practice inappropriately.

Although a prescribed pattern of services can be applied to any medical specialty or type of service, so far the regulations5 only apply to general practitioners and other medical practitioners rendering professional attendances. Professional attendances are essentially consultations and do not include other services, such as procedural items.

The 1999 review committee, in consultation with the AMA Federal Council, the AMA Council of General Practice, the Royal Australian College of General Practitioners, the Rural Doctors’ Association of Australia and the Australian Divisions of General Practice, devised the formula of a combination of 80 or more professional attendances on 20 or more days in a 12-month period as indicative of inappropriate practice. In general, the profession accepted that practitioners providing such high

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volumes of services could not possibly be providing adequate clinical care for their patients.

The Director has limited power in respect of these referrals and although he can receive and consider submissions from the person under review, it is a committee that hears any claims of exceptional circumstances.

The regulations provide guidance—they declare exceptional circumstances to be:

‘an unusual occurrence causing an unusual level of need for professional attendances, and an absence of other medical services for patients of the person under review during the relevant period, having regard to the location of the practice and the characteristics of the patients.’

Of course, committees are not limited to these circumstances and are free to use their combined professional judgment in deciding what is an exceptional circumstance.

The review committee was firmly of the view that a high level of skill, competence and organisational arrangements were important for practitioners. But while these factors may have a great effect on a practitioner’s ability to provide 50, rather than 20, consultations regularly per day, the review committee indicated skill, competence and organisational arrangements would have little effect on the practitioner’s ability to provide 80 or more attendances per day.

The Federal Court has recently begun to give direction on interpreting the Act and the particular regulation. (See discussions on Oreb, Hatcher and Tisdall under Federal Court and Full Federal Court later in this chapter.)

High volume of services

It is important to appreciate that the prescribed pattern of services is not a ‘speed limit’ below which it is ‘safe’ and avoids investigation.

Apart from those practitioners referred under this concern, there is a small number who regularly provide a high number of services at or above the 99th percentile of approximately 14,200 services per annum. Rendering services at a level below that of a prescribed pattern of services does not prevent a practitioner being asked to justify their conduct.

The majority of general practitioners have great difficulty understanding how such large numbers of patients can be seen on a regular basis and still be provided with proper medical care. Proper medical care requires a range of activities by the treating practitioner, such as:

- 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, which may involve arranging for relevant diagnostic tests (pathology and/or diagnostic imaging tests)
- a diagnosis
- implementation of a management plan that may include prescribing drugs, referral for consultant advice, or treatment and explanation of the management plan to the patient.

All of this takes time and no step can be omitted without jeopardising the patient’s health and/or increasing the risk of patient harm.

It may be financially rewarding for a practitioner to see high volumes of patients, but this style of practice generally only allows time for addressing the presenting symptom or complaint and is of little overall benefit to the patient. So far, committees have not accepted arguments that excessively high throughputs can be explained by claims of superior ability and organisation or vast experience.
High number of services per patient
Practitioners who provide, on average, a higher number of services per patient than their peers sometimes try to explain it by claiming to have a smaller and older (and ‘sicker’ with multiple pathology) patient base. However, committees have often found such behaviour to be the result of a practitioner acceding too easily to patient demands without due regard to the medical or clinical necessity for the frequency of service. These practitioners usually also have high unexplainable prescribing rates.

High prescribing of Pharmaceutical Benefits Scheme drugs
A high volume of prescribing under the Pharmaceutical Benefits Scheme often leads to a Commission referral. Many of these referrals involve prescribing of addictive pharmaceuticals, such as benzodiazepines, painkillers and narcotics. This year one referral expressed concern about prescribing. The Director was concerned the practitioner was prescribing drugs without naming the specific analgesic, dose or quantity (many entries merely had ‘pain killers’ recorded) and writing multiple scripts for the same medication on the same day. It seems, from evidence committees gathered, that on occasions, high prescribing is again a result of the practitioner acceding to patient demand or as a way for the practitioner to end the consultation.

Inadequate medical records
Ten of the Director’s referrals (other than referrals concerning prescribed pattern of services) to committees contained a concern that the practitioner had failed to keep adequate and contemporaneous medical records.

This is more than 90 per cent of referrals. This must be of major concern to the profession, particularly because of the effort it has exerted in educating practitioners in recent times.

In addition, in every one of the 26 effective determinations and 11 negotiated agreements concluded during the year, there was a conclusion that each practitioner had failed to keep adequate and contemporaneous health records.

A good record is an important element to justify the service initiated or rendered. In cases where the Director has dismissed a referral, or a committee has not made an adverse finding, the medical records have been such that they supported the practitioner’s conduct and claims. This highlights the importance of maintaining, not comprehensive or ‘gold standard’ records, but at the very least, adequate and contemporaneous medical records.

From 1 January 2000, Commonwealth legislation requires a committee, in consideration of a referral, to have regard to whether a practitioner has kept adequate and contemporaneous medical records. The committee is further required to take this into account when making decisions on whether the practitioner has engaged in inappropriate practice.

The Commonwealth’s requirement for patient records is broad and not as onerous as some state and territory legislation. For a record to be adequate, it must:
- clearly identify the patient
- contain a separate entry for each attendance
- provide clinical information to explain the service/s rendered or initiated
- be sufficiently comprehensible so another practitioner can undertake ongoing care of the patient.
- To be contemporaneous, the record must be completed at the time of the service or as soon as is practicable afterwards.
The extent that the practitioners referred for a prescribed pattern of services kept adequate or inadequate records is unknown because the Director does not need to order production of records in these cases. However, if previous experience with the records of other practitioners rendering high volumes of services is an indication, it is suspected that these practitioners' records would also be significantly deficient.

**Inadequate clinical input**
Six referrals to committees this year concerned possible inadequate clinical input. During the Director’s review of the request, examination of medical records sometimes suggests the practitioner may not have provided adequate clinical input when treating patients. When there is little or no detail in the record, it is difficult to determine what service has been rendered.

The Act defines a professional service on which a Medicare benefit is paid, but leaves the decision of the clinical relevance of that service to what is generally accepted by practitioners’ peers as the appropriate treatment for patients.

**Medicare Benefits Schedule item not satisfied**
In eight cases referred to committees this year it appeared to the Director that the item of service the practitioner claimed may not have actually been provided at the appropriate level. In most cases, following review of the request and examination of patient records and practitioner submissions, the Director was of the view the practitioner may have claimed a Medicare Benefits Schedule item of greater value than the records or submissions demonstrated. Once again, when there is little or no detail in the record, it is difficult to determine what service has been rendered.

Common examples involved claiming a long, rather than a standard, consultation or claiming for suturing a deep wound, rather than a superficial wound. 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, after a lapse of time, of proving intent to defraud.

The other common type of ‘error’ occurs where a practitioner regularly includes the time for procedural services as part of the overall time spent with the patient and hence itemises a longer consultation than actually took place. Some practitioners claim to be unaware that by billing a separate benefit for procedural services they are not entitled to add the time taken to the consultation component.

**Services not medically necessary**
This year eight referrals to committees contained the concern of services not being medically necessary. When a patient consults a practitioner for a particular problem the expectation is that they are going to be treated for that complaint, but it appears that some practitioners also perform services that are not clinically indicated and therefore not medically necessary.

This situation is often revealed upon review of medical records that show the patient’s presenting complaint and the resulting treatment. At times there appeared to be no correlation between the complaint and some of the treatment.

**Particular services or types of services**
Once the Director has completed a review (by examining patient records and practitioner submissions) of the broadly framed initial request from the Commission, it becomes more apparent where the concerns lie.
The Director is then able to focus the referral, for specific attention by a committee, on concerns within a particular Medicare Benefits Schedule item or items. Often this will lead to a referral of, for example, all Medicare Benefits Schedule item 36 or 44 services. Sometimes the referral will be for a particular procedural or diagnostic service. Questioning in the committee hearing often reveals there was no proper clinical indication for the procedure; the conclusion to be reached is that the indication for the procedure was only because the practitioner had access to the necessary equipment.

Professional isolation
Practitioners the Commission refers are often professionally isolated. They have little contact with professional colleagues and/or fail to keep their professional knowledge up-to-date. Others are manipulated by more senior practitioners or ‘employers’, or have deluded themselves. In the course of hearings, committees sometimes find impaired practitioners, mainly due to illness or substance abuse, and have referred these practitioners to the relevant Medical Board.

A number of practitioners who work as independent contractors or employees in medical centres have claimed that office staff are responsible for itemisation on documents for Medicare benefit. This defence has been accorded little weight because the practitioner alone is responsible for the accuracy of the information provided for the purposes of a Medicare claim and this responsibility cannot be delegated or abdicated.

Unusual medical practice
It is important for practitioners to remember that the PSR scheme applies to services rendered or initiated under the Medicare benefits arrangements and medications prescribed under the Pharmaceutical Benefits Scheme. Within the legislation encompassing both schemes there are strict criteria for benefit eligibility.

Practitioners providing medicine that can be characterised as alternative or complementary need to be aware that, for their services to be eligible for a benefit, they must still meet the prescribed criteria.

The most important point is that the service must be clinically relevant. That is, the service must be generally accepted by the medical profession as being necessary for the appropriate treatment of the patient.

Alteration of documents
On a number of occasions, during both the initial review and at committee investigation, suspicion has been raised that the medical records produced have been altered subsequent to the notice ordering their production. This is an offence under Commonwealth legislation and arrangements are in place to enable prosecution of cases involving such fraudulent activity. State and territory medical boards are also concerned by such conduct and have significant penalties at their disposal.

Professional Services Review Tribunal cases
Full copies of PSR Tribunal decisions are available on the PSR web site at <www.psr.gov.au>.

Dr John Howard Grey,
General Practitioner of Frankston, Vic. (PSR 126)
The Commission referred Dr Grey in November 1997 because it was concerned he could not maintain an appropriate level of clinical input at his high servicing (24 774) rate on a regular and continuing basis. The period referred was 1 January 1996 to 31 December 1996.

In October 2000 the committee provided Dr Grey with a draft report for comment. Dr Grey instituted (ultimately unsuccessful) proceedings in the Federal
Court that culminated in a refusal of special leave by the High Court in February 2003. The Full Court of the Federal Court decision was of particular importance for the PSR scheme as it returned the focus to investigation of inappropriate practice safeguarded by procedural fairness. Details were provided in the Annual Reports for 2000–2001, 2001–2002 and 2002–2003.

The committee reported in May 2003 that Dr Grey had engaged in inappropriate practice in connection with rendering MBS item 36 and 44 services. In all cases examined, there was insufficient clinical input to meet the needs of the patient and/or warrant use of the item. Other issues included provision of some consultations by a nurse rather than Dr Grey personally, initiation of unnecessary screening tests, and inappropriate prescribing or treatment.

In November 2003, the Determining Officer directed that Dr Grey be reprimanded and counselled, repay Medicare benefits totalling $16,132, be fully disqualified from Medicare for three months and partially disqualified for six months. Dr Grey sought review by the PSR Tribunal.

On 1 July 2004 the Tribunal affirmed the determination. With respect to the period of disqualification the Tribunal stated that no useful analogy, as suggested by Dr Grey, could be drawn between the circumstances to which guidelines issued for Medicare Participation Review Committees relate and the circumstances that give rise to the questions before the Tribunal.

It further stated that the PSR committee’s findings disclose a systematic departure by Dr Grey from standards that would be acceptable to the general body of general practitioners and they disclose matters of serious concern. The Tribunal also stated that it agreed with the committee’s comments that it ‘considers that the accreditation of the practice in which Dr Grey works has no relevance to the consideration of his conduct in respect of services rendered during the referral period.

The Tribunal took the lengthy period elapsed since the referral period into account, but noted the absence of evidence that Dr Grey had since made his style of practice more acceptable. Dr Grey did not appeal the Tribunal decision.

Dr Nicholas Sevdalis, Medical Practitioner of Fairfield, Vic. (PSR 120/120A)

The Commission referred Dr Sevdalis in November 1997 for his high average number of services per patient, high level of long consultations, prolonged consultations and home visits, and high level of prescribing.

A committee was established and held a hearing, but one member resigned before it reported. Dr Sevdalis preferred a new committee to be established, rather than the two remaining members completing the report. As Dr Sevdalis failed to produce medical records to this second committee he was disqualified from Medicare arrangements until, in 2002, he agreed to provide the second committee with copies of records originally provided to the first committee.

The second committee reported in September 2003 that Dr Sevdalis had engaged in inappropriate practice in rendering certain MBS item 57 and 65 services. It found that his prescribing was not based on clinical indications or scientific evidence, excessive doses were prescribed, some prescribing did not comply with PBS requirements, and some issues could have been dealt with in less than the time required for these MBS items. Although no formal finding was made in this regard, poor medical records were also a concern to the committee.
In February 2004, the Determining Officer directed that Dr Sevdalis be reprimanded, counselled, and fully disqualified from Medicare for one month. Dr Sevdalis sought review by the PSR Tribunal.

On 1 July 2004 the Tribunal made a fresh determination that Dr Sevdalis be reprimanded and counselled. The Tribunal had regard to the circumstances of the disqualification of Dr Sevdalis for failing to produce records to the committee, the nature of the conduct criticised by the committee, the investigation of only 20 services, lack of evidence that these were representative of his general standard of practice, and the length of time elapsed.

The Tribunal nevertheless indicated that it took a serious view of the applicant’s conduct, particularly regarding prescribing. It strongly recommended that, after the counselling and unless the Commission was convinced Dr Sevdalis had changed his pattern of practice to accord with what would be acceptable to the general body of general practitioners, a more extensive investigation be undertaken to reassess his practice. Dr Sevdalis did not appeal the Tribunal decision.

Dr Peter Tisdall, General Practitioner, Kyabram, Vic. (PSR 106)

Dr Tisdall was referred because the Commission was concerned about his high total services, services per patient, and prescribing. The committee hearings were punctuated by the Federal Court litigation noted in the Director’s 2002–03 and 2003–04 reports.

The committee found he had engaged in inappropriate practice in rendering a sample of item 23 services, largely because of inadequate clinical input and inadequate management of specific problems. Dr Tisdall’s management of specific problems (such as asthma) was clinically inadequate and there was concern about his use of drugs, especially broad-spectrum antibiotics. The committee also found his records to be seriously deficient in important, often critical, information, particularly clinical findings.

The Determining Officer directed that Dr Tisdall be reprimanded and counselled, repay Medicare benefits totalling $141,086.85, and be fully disqualified for one year and partially disqualified for two years. On 12 July 2004 Dr Tisdall requested a review by a Professional Services Review Tribunal. On 23 December 2004, the Tribunal upheld the determination except for a small reduction in the Medicare repayment.

The Court had previously rebutted Dr Tisdall’s argument that the committee had not been fair when it did not give him notice of reasons for rejecting certain affidavit evidence from specialists, saying the committee was entitled to rely on its own expertise without declaring it. The Tribunal rejected a similar argument that the committee should, for procedural fairness, have told Dr Tisdall why the affidavits were regarded as insufficient to displace its tentative findings in the draft report or afforded him yet another opportunity to put further material before it.

The Tribunal agreed with the committee that Dr Tisdall’s clinical notes were totally inadequate—one possible explanation was the pressure of time resulting from the applicant rendering such a high number of services per day. Nevertheless, the quality of the records did not dominate the committee’s decisions. The Tribunal was also satisfied:

- with the committee’s findings that Dr Tisdall misunderstood the clinical input necessary to satisfy the differing requirements of the levels of MBS surgery consultations
- that the committee had given appropriate weight to Dr Tisdall’s evidence of his ‘usual practice’ where he had not adequately recorded and could not remember a consultation
that, for a range of reasons, the specialist affidavits were of limited use in assessing the committee's findings.

with the committee's concern about prescription of antibiotics for uncomplicated upper respiratory tract infections was not clinically indicated.

The Tribunal said the findings of inappropriate practice reflected very serious concerns as to Dr Tisdall’s conduct but he had not generally accepted the findings. He failed to acknowledge any shortcomings in his clinical input, in his prescription of drugs, or any deficiencies in his clinical notes. The Tribunal regarded this as a very important factor militating against any reduction in the periods of disqualification in the absence of any evidence that Dr Tisdall had made significant changes to his pattern of practice. There was also no commitment to change his style of practice in the future. Nothing had convinced the Tribunal that it should vary the periods of disqualification.

The Tribunal did, however, consider that the committee had incorrectly found one service unacceptable and a small reduction in the repayment of Medicare benefits resulted.

Dr Tisdall has appealed the Tribunal decision to the Full Federal Court. (A hearing on the appeal was held on 10 August 2005 before Justices Heerey, Sundberg and North with the Court reserving its decision.)

Federal Court and Full Federal Court cases

Decisions handed down

Full copies of Federal and Full Federal Court decisions are available on the PSR web site at <www.psr.gov.au>.

Dr Zelco Oreb, medical practitioner, Newtown NSW

The Commission referred Dr Oreb on 13 December 2001 to determine whether he had engaged in inappropriate practice in connection with rendering services constituting a prescribed pattern. During the referral period of 24 January 2000 to 8 August 2000 inclusive the Commission’s data showed that Dr Oreb had rendered 80 or more professional attendances per day on 33 occasions.

A committee was established and found Dr Oreb had engaged in inappropriate practice in rendering a prescribed pattern of services during the period referred and that no exceptional circumstances existed on any of the 33 days in question. Dr Oreb appealed to the Federal Court on whether exceptional circumstances existed, whether the investigative and adjudicative referrals were invalid on grounds established in the Daniel decisions,6 and whether the ‘prescribed pattern’ provisions constituted ‘civil conscription’ in contravention of the Australian Constitution.

In a preliminary decision on 7 July 2004, Jacobson J rejected orders sought by Dr Oreb7 for discovery of various classes of documents broadly relevant to the decisions made.

6 Which concerned relevant considerations in making referrals and the obligations of the Director regarding agreements under s.92 of the Act—see summaries in the 2003–04 PSR Annual Report.

7 His Honour’s decision also refused discovery orders sought by other applicants—Drs Bartos, Do, Ho and Ly.
His Honour generally considered that discovery was irrelevant or unnecessary where reasons for decisions were given. In a second preliminary decision on 28 October 2004, Jacobson J ordered that the hearing on non-constitutional issues proceed ahead of the constitutional issue (which had been raised by the applicant at a late stage).

On 30 November 2004, Jacobson J rejected the Daniel-based arguments as there was no evidence that, following counselling, the Commission had decided not to refer Dr Oreb to PSR and there was evidence that the possibility of a s.92 agreement had been drawn to Dr Oreb’s attention in correspondence and pamphlets.

Dr Oreb had based his claims of exceptional circumstances on high patient demand, the fact that many were refugees from former Yugoslavia with whom he could communicate because of his ethnicity and language skills, lack of alternative medical services, and his work patterns. The committee rejected these claims as the factors were relatively static and could have been managed to bring attendance rates down to acceptable levels such that proper clinical care could be provided to all patients. There was no evidence Dr Oreb had attempted to do this.

Jacobson J held that the committee had wrongly concluded, after reference to extrinsic material, that exceptional circumstances would ordinarily be intermittent and that it would be ‘difficult to justify’ circumstances of an ongoing nature. His Honour ordered that the matter be remitted to the Director to consider whether a fresh referral should be made to another, differently constituted, committee.

Dr Oreb appealed the decision of Jacobson J concerning the offer of a s.92 agreement and PSR cross appealed on the exceptional circumstances issue. On 10 May 2005 the Full Court heard an appeal by Dr Oreb about the validity of the referrals and a cross-appeal by the committee on the meaning of ‘exceptional circumstances’. On 14–15 June 2005, Jacobson J heard argument on the constitutional issue. Decisions have been reserved.

Dr Jerzy Cywinski, General Practitioner, Bonnyrigg/Austral NSW

The Commission referred Dr Cywinski because it was concerned about his high number of total services (16 448), his use of long consultations with procedural items, and his high rate of initiation of pathology and diagnostic imaging.

In examining Dr Cywinski’s MBS item 23 services, the committee found he had engaged in inappropriate practice in 48 per cent of these services. The inappropriate practice included: failure to collect and record an adequate history or make a proper examination, prescribed drugs that were not clinically indicated, prescribed narcotic or codeine compound analgesics without clinical indication and without regard to the potential habituating properties of these drugs, billing Medicare for services not personally rendered by him, and keeping records that were deficient in essential clinical material.

The committee made similar findings in relation to Dr Cywinski’s item 36 services. The Determining Authority directed Dr Cywinski to repay $55 327.82 and be fully disqualified for two months and be disqualified for 12 months from all services provided as a vocationally registered general practitioner (concurrent with the full disqualification).

In May 2004, Dr Cywinski appealed to the Federal Court for a review of the determination and penalty imposed by the Determining Authority. Dr Cywinski withdrew his application and on 6 October 2004, the Federal Court dismissed his appeal.
Dr Peter Andrianakis,  
Medical Practitioner, Yarraville/East Kew Vic.

The Commission referred Dr Andrianakis because of his high level of rendered services. During the review period he provided 17,004 services to 5,797 patients. Most of these services (16,204) were standard (item 53) consultations.

The committee examined Dr Andrianakis’s long consultations (item 54), and his home visits (item 59).

The committee found that Dr Andrianakis claimed an item 54 when the presenting problem could and should have been dealt with in less than 25 minutes. Dr Andrianakis was also found not to have taken and recorded sufficient history, not to have made an adequate examination, nor to have formulated an adequate management plan. The committee considered this behaviour would not be acceptable to the general body of medical practitioners.

In relation to his item 59 home visits, the committee found that Dr Andrianakis rendered home visit services when the presenting problem and the patient’s medical condition were such that a home visit was not medically necessary. The committee also found that Dr Andrianakis failed to keep adequate medical records. The Determining Authority directed that, in addition to being reprimanded and counselled by the Director, Dr Andrianakis be fully disqualified for two months from Medicare.

Dr Andrianakis appealed to the Federal Court on the issue of whether the committee and the Determining Authority erred in their decisions in relation to the inadequacy of his patient medical records. Dr Andrianakis appealed before the Federal Court in July 2004 and the final determination came into effect in September 2004.

Dr Donald Hatcher,  
General Practitioner, Roma Qld

The Commission referred Dr Hatcher on 13 December 2001 to determine whether he had engaged in inappropriate practice in connection with rendering services constituting a prescribed pattern. During the referral period of 1 January 2000 to 6 November 2000 inclusive the Commission’s data showed that Dr Hatcher had rendered 80 or more professional attendances per day on 37 occasions.

A committee was established, a hearing held and a final report, with an adverse outcome, produced. The Determining Authority directed that Dr Hatcher be reprimanded, counselled, repay $67,796.75 and be fully disqualified for four weeks. Dr Hatcher appealed to the Federal Court on the issues of whether exceptional circumstances existed, and the validity of the Investigative Referral and of the Determining Authority’s decisions.

Dr Hatcher based his claims of exceptional circumstances on an ongoing shortage of doctors in Roma and the surrounding rural area, a high number of disadvantaged, unemployed and Aboriginal people, certain periodic factors, his bulk billing policy, and his practice organisation. Although he had reduced his appointments to 70 per day he said he was still legally obliged to see emergency cases above that number.

The committee rejected these claims as the factors were relatively static and could have been managed to bring attendance rates down to acceptable levels.

Kiefel J held that the Investigative Referral was valid—unlike the Daniel situation, there were no relevant circumstances the Commission had overlooked and the possibility of exceptional circumstances during the referral period was a matter for the committee to decide. Her Honour also held that the Determining
Authority was entitled to require repayment of Medicare benefits for all services on all days with 80 or more attendances where exceptional circumstances did not exist.

Kiefel J further held that exceptional circumstances did not refer to matters within a practitioner’s control and were not subject to a time limit. She said the committee had not considered whether the combination of a need for medical services for disadvantaged, unemployed and Aboriginal people and Dr Hatcher’s willingness to bulk bill all patients amounted to an exceptional circumstance. Her Honour accordingly set aside the determination and ordered that the matter be remitted to the Director to consider whether a fresh referral should be made to another, differently constituted, committee.

The committee has appealed the decision about the meaning of ‘exceptional circumstances’ and the order to refer to a new committee. The appeal was heard on 18 May 2005 before Black CJ Wilcox and Lander JJ. The decision has been reserved.

Dr Dimian appealed to the Federal Court on constitutional grounds, alleged failure to offer a s.92 agreement, and alleged lack of procedural fairness in the preparation of the committee report through failure to warn him that his credibility was an issue. The constitutional issues have yet to be decided; Jacobson J found that the s.92 possibility had been adequately brought to Dr Dimian’s notice both by letter and pamphlet; and his Honour held, having regard to the adjudicative referral, the hearing and the draft report, that Dr Dimian was not left in the dark about the possibility his evidence might not be accepted.

Dr Dimian appealed to the Full Federal Court on the s.92 issue. A hearing was held before Black CJ, Wilcox and Lander JJ on 10 May 2005. The decision has been reserved.

Dr Jack Freeman, General Practitioner, North Melbourne Vic.

The Commission referred Dr Freeman for rendering 80 or more attendances per day on 92 occasions during the referral period of slightly less than six months.

Dr Freeman did not contest the Commission’s evidence as to the number of professional attendances. Dr Freeman’s legal representative made submissions to the fact that Dr Freeman would forego his right to lead evidence and argue that exceptional circumstances existed on the 92 days.

The Determining Authority directed Dr Freeman to repay $225 377.50 and be fully disqualified for two years and nine months.

Dr Freeman appealed to the Federal Court on the grounds that the investigative referral was invalid for the same reasons as in *Pradhan v Holmes* [2001] FCA 1560 (essentially lack of specificity); that the determination failed to take into account Dr Freeman’s belief that the committee
investigation had been resolved on an agreed basis; and that the Commission erroneously believed the Health Insurance Act required it to make an investigative referral once it had identified a prescribed pattern of services, without regard to the merits of the particular case.

On 19 April 2004, North J dismissed the appeal. He held that the referral was distinguishable from Pradhan because it clearly stated the conduct referred. As the determination set out the applicant’s contentions as to the committee’s resolution of the matter, and the process of reasoning adopted by the Determining Authority, it was clear it had had regard to those contentions when coming to its conclusion.

On 10 May 2004, Dr Freeman appealed to the Full Federal Court against the decision of North J. On 22 December 2004, the Full Federal Court rejected all the arguments put by Dr Freeman and dismissed his appeal. The determination took effect in January 2005.

Dr Ashraf Selim, General Practitioner, Punchbowl NSW
The Commission referred Dr Selim on 18 December 2001 because it was concerned he may have engaged in inappropriate practice through a high level of rendered services and high daily servicing during the referral period of 1 January 2000 to 31 December 2000 inclusive. The Director conducted a review and decided a committee should further investigate Dr Selim’s conduct.

A committee was established, a hearing held and a final report produced with a finding that he had engaged in inappropriate practice, largely because of poor clinical records and unsatisfactory evidence of clinical input to services. There were also instances of inappropriate prescribing and ordering of tests that were not clinically indicated.

Dr Selim appealed to the Federal Court on the basis that none of the PSR ‘decision making’ bodies considered his services over the whole two years immediately preceding the Investigative Referral, but instead looked at a 12-month period that fell within those two years. He also alleged that the committee did not inform him of its concerns before producing its draft report and that it applied the wrong test, comparing his conduct to an optimal level rather than to a range of conduct that would be considered acceptable.

On 28 October 2004, Jacobson J ordered the constitutional issues be severed for separate hearing.

On 7 February 2005 Jacobson J held there was no error on the Director’s part regarding the possibility of a s.92 agreement. This had been adequately brought to Dr Selim’s notice by letter and pamphlet, and Dr Selim had neither responded nor approached the Director. Other grounds of appeal mentioned in our 2003-04 Annual Report were not pursued. Jacobson J dismissed the appeal on the judicial review ground. Dr Selim has appealed that to the Full Federal Court—no date for hearing has yet been set.

Stone J heard Dr Selim’s challenge on the constitutional issue on 14 June 2005 with a decision reserved.

Dr Il Song Lee, General Practitioner, Eastwood NSW—Case 1
The Commission referred Dr Lee on 3 June 2002 to determine whether he had engaged in inappropriate practice in connection with rendering services constituting a prescribed pattern. During the referral period of 8 January 2001 to 12 October 2001 inclusive the Commission’s data showed Dr Lee had rendered 80 or more professional attendances per day on 37 occasions.
A committee was established, a hearing held and a final report, finding Dr Lee engaged in inappropriate practice, produced. Dr Lee has appealed to the Federal Court on the issues of whether exceptional circumstances existed, the referral decisions were invalid on the same grounds as in *Daniel v Kelly*, and the ‘prescribed pattern of services’ constitutes civil conscription.

On 28 October 2004, Jacobson J ordered the constitutional issues be severed for separate hearing. This has yet to occur.

On 7 February 2005 Jacobson J held that the Director was not in error regarding the possibility of a s.92 agreement. This had been squarely brought to Dr Lee’s notice by letter and Dr Lee had neither responded nor approached the Director. However, his Honour considered that the committee had wrongly applied the ‘exceptional circumstances’ test. He said Dr Lee’s claim was, in substance, that Korean patients demanded a Korean doctor and this was outside his control as there was at most only one other Korean doctor available in the area. Although the committee found there were 30 other doctors in the area, it did not consider, as provided by regulation 11(b), the ethnic characteristics of Korean patients—particularly whether they were prepared and able to see non-Korean speaking doctors. Further, the committee’s perception of a need for patients to integrate within the wider community was an irrelevant consideration. Accordingly, his Honour ordered the committee’s finding set aside and the matter be remitted to the Director to consider whether a fresh referral should be made to another, differently constituted, committee.

A committee was established, a hearing held and a final report, finding Dr Lee engaged in inappropriate practice, produced. Dr Lee appealed to the Federal Court on the issues of whether:

- the Commission made an automatic referral
- the Director failed to consider how to investigate Dr Lee’s conduct unconstrained by section 106KA of the Act
- the committee wrongly thought exceptional circumstances could not arise from events that affected rendering services throughout the referral period
- the ‘prescribed pattern of services’ constitutes civil conscription.

On 27 October 2004, Jacobson J ordered the constitutional issues be severed for separate hearing. This has yet to occur.

On 7 February 2005 Jacobson J held that the Director was not in error regarding the possibility of a s.92 agreement. This had been adequately brought to Dr Lee’s notice by letter and Dr Lee had neither responded nor approached the Director. However, his Honour considered the committee had wrongly applied the ‘exceptional circumstances’ test. He said Dr Lee’s claim was, in substance, that Korean patients demanded a Korean doctor and this was outside his control as there was at most
only one other Korean doctor available in the area. Although the committee found that other culturally appropriate and accessible services were available for Korean patients, it did not consider, as provided by regulation 11(b), their ethnic characteristics—particularly whether they were prepared and able to see such service providers. Further, the committee's perception of a need for patients to integrate within the wider community was an irrelevant consideration. Accordingly, his Honour ordered the committee's finding set aside and the matter be remitted to the Director to consider whether a fresh referral should be made to another, differently constituted, committee.

An appeal was lodged with the Full Federal Court and heard before Black CJ, Wilcox and Lander JJ on 2 August 2005 with the decision reserved.

Dr Sou Kao Ly,
General Practitioner, Cabramatta NSW

The Commission referred Dr Ly on 13 December 2001 to determine whether he had engaged in inappropriate practice in connection with rendering services constituting a prescribed pattern. During the referral period of 1 January 2000 to 9 April 2000 inclusive the Commission’s data showed that Dr Ly had rendered 80 or more professional attendances per day on 28 occasions.

A committee was established, a hearing held and a final report, finding Dr Ly had engaged in inappropriate practice and that no exceptional circumstances existed on any of the 28 days, produced. The Determining Authority made a determination that Dr Ly be reprimanded, counselled, repay $58,334.45 to Medicare, and be fully disqualified from Medicare for two months and partially for six months.

Dr Ly appealed to the Federal Court on the issues of whether:

- the respondents erroneously construed the Act as establishing a separate procedure for 80/20 Investigative Referrals
- the Commission was required to make an Investigative Referral once it identified a prescribed pattern of services
- the committee adequately considered the services provided in the relevant period
- exceptional circumstances existed.

As part of the Federal Court process, it was recognised there were certain facts that put this matter directly on a par with Kelly v Daniel. Consequently, on 18 October 2004, consent orders were made to declare void and set aside the investigative referral, the adjudicative referral, the committee’s report and the final determination.

Dr Peter Thomas Tisdall,
General Practitioner, Kyabram Vic.

The Commission requested a review of Dr Tisdall’s practice because it believed he had engaged in inappropriate practice by rendering a prescribed pattern of services during the period 5 January 2000 to 21 August 2000. The committee found Dr Tisdall had rendered 80 or more services on 35 days and that no exceptional circumstances existed on any of the days. This was a reduction in the number of days from 66 days because Dr Tisdall was able to demonstrate that he did not provide some of the services from the nominated addresses in the request. Dr Tisdall appealed to the Federal Court.

On 8 April 2005, Gray J dismissed the appeal. Although it appeared that Dr Tisdall had rendered 80 or more services on 66 days in that period, some of the services were for MBS items rendered away from his surgery. Further, there was evidence that other services claimed under his surgery provider
number had in fact been rendered to outpatients at the local hospital. Gray J held that, because the referrals specified services rendered at his surgery, services rendered elsewhere could not be counted even when the Commission had no way of knowing where they were rendered. Nevertheless the committee had validly found, after allowing for such services, there was a residue of 35 days each with 80 or more services rendered.

Gray J also adopted the reasoning in *Crowley, Oreb, Dimian, Selim*, and *Lee v Kelly* in rejecting Dr Tisdall’s assertions that the Acting Director denied him procedural fairness by failing to inform him that an ‘agreement pursuant to s.92 would not be possible unless the applicant requested such an agreement and was prepared to admit to having engaged in inappropriate practice. His Honour noted that Dr Tisdall knew a s.92 agreement was an option and had legal advice at all times. There was no obligation on the Acting Director to initiate discussions.

When it came to interpreting regulation 11b*8* (what constitutes an exceptional circumstance), Gray J took a completely different approach to that of Kiefel J in *Hatcher* and Jacobson J in *Oreb* (and later in the two *Lee* cases). Justice Gray viewed both their approaches, although slightly different in each decision, in considering exceptional circumstances as ‘fundamentally wrong’.

Dr Tisdall has appealed to the Full Federal Court and no date has yet been set for hearing.

**Dr Anthony Joseph,**
**Medical Practitioner, Lithgow NSW**

In August 2000, the Commission requested the Director review Dr Joseph for his rendering of item 53 (standard surgery consultation—5221) and item 59 services (standard home visit—11 802). Dr Joseph provided 17 660 services to 1846 patients with a Medicare benefit of $417 777.10. On 21 January 2004, the committee found Dr Joseph had engaged in inappropriate practice during the referral period 1 January to 31 December 1999 in relation to 70 per cent of the item 53 services and 86 per cent of the item 59 services. The committee found Dr Joseph had, in relation to the item 53 services:

- failed to take an adequate history and make an adequate examination; lacked knowledge of the proper management of a range of medical conditions
- prescribed a number of drugs including antibiotics, benzodiazepines, narcotics and codeine where there were no clinical indications despite evidence of undesirable side effects or interactions
- kept medical records that were deficient in essential clinical information.

In relation to the item 59 services, the committee found Dr Joseph, in addition to the findings on item 53 services, had:

- rendered home visits that were not medically necessary
- facilitated drug dependence in a patient.

Dr Joseph told the committee he did not keep a record of any home visits prior to mid 1999 because he ‘understood that it didn’t come in legally to keep records at that stage’ and that ‘I just didn’t keep a record because I didn’t—I would not have had time to write all the home visits down myself’.

The committee formed the view that Dr Joseph had caused, was causing or was likely to cause a threat to the life or health of patients and took steps to refer him to the relevant state medical board. The committee established, among other concerns,
that Dr Joseph prescribed medication to two patients without seeing them and he posted prescriptions to the patients in response to letters requesting the particular drugs.

On 9 August 2004, the Determining Authority directed Dr Joseph be reprimanded, counselled, disqualified from Medicare for three years and repay Medicare benefits of $267,999.47.

On 3 September 2004 Dr Joseph applied to the Federal Court for review on grounds including the sampling procedure, failure to take into account relevant considerations, and failure to hold a hearing after legislation changes. Branson J heard the application on 30–31 May 2005. On 29 July 2005, Dr Joseph’s application was dismissed in its entirety and the determination came into effect shortly after.

Dr Constantinos Perkoulidis,  
Medical Practitioner, Brunswick Vic.

Dr Perkoulidis was reviewed by request from the Commission because of the high proportion of his long surgery consultations and his long and prolonged home visits compared to all other active medical practitioners in Australia. Dr Perkoulidis’ rendering of long consultations (item 54) was above the 95th percentile, his long home visits (item 60) was above the 99th percentile, and his prolonged home visits (item 65) was above the 95th percentile. The Director conducted a review and decided a committee should further investigate Dr Perkoulidis’ conduct.

The committee found that Dr Perkoulidis provided long consultations when the patient’s problems could have been adequately addressed in shorter consultations. Examples of these straightforward problems included an influenza vaccination, rhinitis, and otitis media.

Dr Perkoulidis’ medical records were of very poor quality; medical summaries were not filled in or kept up-to-date and the progress notes were brief and missing aspects of essential information. There were many loose-leaf pages of medical records that did not have any identification to indicate to whom the record belonged. Dr Perkoulidis’ handwriting was difficult to read.

Dr Perkoulidis said that approximately 40 per cent of the patients to whom he rendered home visits asked that he not record any information about the visit. Coincidently, the majority of these patients were related to him. The committee found this conduct would be unacceptable to the general body of medical practitioners. The committee found that 29 out of 30 home visits examined were unacceptable.

The Determining Authority directed that Dr Perkoulidis be reprimanded, counselled, repay $88,718.67 of Medicare benefits and be fully disqualified for two months.

Dr Perkoulidis applied for Federal Court review of whether the penalties were appropriate and adequate reasons were provided. Before hearing, the matter was settled. Dr Perkoulidis agreed to the determination and also agreed to pay the respondent’s costs of $25,000, both by 24 equal monthly instalments. The determination came into effect on 1 April 2005.

Dr Chris Siamidis,  
Medical Practitioner, North Fitzroy Vic.

The Commission requested a review of Dr Siamidis practice on 2 June 2000 because it was concerned he may have engaged in inappropriate practice through rendering a high volume of home visits (6748 to 863 patients) and services per patient,
both of which were above the 99th percentile when compared to all active medical practitioners in Australia, during the referral period of 1 July 1998 to 30 June 1999. The Director conducted a review and decided a committee should further investigate Dr Siamidis’ conduct.

Dr Siamidis told the committee he had a unique practice, whereby he attended patients at their home rather than in a surgery. Dr Siamidis also told the committee he did not keep day-to-day medical records when visiting patients. He told the committee he made rough notes on the back of Medicare forms and re-wrote these afterwards. There was no evidence to support his contention. There was no evidence to suggest that Dr Siamidis liaised with other general practitioners about patient care.

The committee considered that, to assess a patient’s progress, a medical practitioner would need to make a written record of:

- relevant medical history
- examination
- differential diagnosis
- management plan
- medications
- evaluation of the patient at each presentation.

Dr Siamidis failed to record any of this information. The Determining Authority viewed Dr Siamidis’ inappropriate practice as extreme and directed him to be reprimanded, counselled, repay $75 000 in Medicare benefits and be fully disqualified for 12 months.

Dr Siamidis appealed to the Federal Court on the basis of whether the committee and the Determining Authority had erred in their decisions in relation to the inadequacy of the patient records he provided to the Director. The application was subsequently dismissed by consent on 8 November 2004, with Dr Siamidis being ordered to pay the respondents’ costs ($53 788) as assessed by the Court.

Other appeals lodged and under consideration by the courts

Dr Boguslaw Stanislaw Bartos,
General Practitioner, Green Valley NSW
PSR 290, Federal Court N1341 of 2002,
—decision reserved.

Dr Lynette Maree Bellamy,
Medical Practitioner, Edgecliff NSW
PSR 345, Federal Court NSD897 of 2005,
no hearing date set.

Dr Ameen Ahmed Bham,
Medical Practitioner, Rockingham WA
PSR 187, Federal Court WAD23-2005,
no hearing date set.

Dr Jane Carrick,
Medical Practitioner, Auburn NSW
PSR 352, Federal Court NSD322 of 2005,
no hearing date set.

Dr Paul David Crowley,
General Practitioner, Lowood Qld
PSR 366, Federal Court V273 of 2003,
no hearing date set.
Dr Hien Thahn Do,
General Practitioner, Merrylands NSW
PSR 293, Federal Court N1321 of 2002, hearing before Jacobson J on 14 June 2005 on constitutional issues—decision reserved.

Dr Hugo Huu Hiep Ho,
General Practitioner, Merrylands NSW

Dr George Maragoudakis,
General Practitioner, Parkdale Vic.
PSR 323, Federal Court V182 of 2003, hearing before Weinberg J on 18 July 2005—decision reserved.

Dr John William Mathews,
General Practitioner, Campbelltown NSW

Dr Malcolm Stuart Nyst,
General Practitioner, East Brisbane Qld
PSR 353, Federal Court Qld 136 of 2005, no hearing date set.

Dr Lam Quoc Phan,
General Practitioner, Cabramatta NSW
PSR 190, Federal Court N1818 of 2004, no hearing date set.

Dr John Warren Piesse,
General Practitioner, Kew Vic.
PSR 308, V870 of 2002 and V1161 of 2004, no hearing date set.

Dr Charles Rupert Russell-Smith,
General Practitioner, Kwinana WA
PSR 291, Federal Court W7 of 2003, no hearing date set.

Dr Charles Rupert Russell-Smith,
General Practitioner, Kwinana WA
PSR 369, Federal Court W73 of 2005, no hearing date set.

Dr Warren John Saint,
General Practitioner, Bassendean WA

Dr Peter Thomas Tisdall,
General Practitioner, Kyabram Vic.
PSR 375, Federal Court V1115 of 2004, no hearing date set.

Dr Chan Kan Kenneth Wong,
General Practitioner, Merrylands and Parramatta NSW
PSR 339, Federal Court N141 of 2004, no hearing date set.
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3. Management and accountability

Structure and organisation chart
The Director, Dr Anthony David Webber, is a statutory officer appointed by the Minister for Health and Ageing (with agreement from the AMA) to manage the PSR process. Dr Webber was appointed Director from 14 February 2005 following the retirement of the inaugural Director, Dr Alan John Holmes. The Director reports directly to the Minister and his actions are governed by the Act.

An Executive Officer, Mr John Jenner, three Unit Managers and their staff and legal counsel support the Director in his role (see Figure 1).

The Executive Officer reports to the Director and has a leadership role in achieving organisational objectives through management of operational matters, financial and human resources, policy development and provision of governance advice.

The Review Unit assists the Director with the review of requests received from the Commission. It also produces the agreements sent to the Determining Authority following negotiations and the documentation for referral of practitioners to committees.

The Committees Unit provides secretariat support to committees. The Corporate Unit provides financial and human resources and information technology services and support for the whole organisation.
General legal assistance is outsourced to the Minter Ellison law firm. A Minter Ellison legal officer was outposted to PSR on a full-time basis and Minter Ellison lawyers in each state provide assistance at committee hearings.

In addition, secretariat support for the Determining Authority is located within PSR’s offices.

Legal support is provided to the Determining Authority by the Clayton Utz law firm.

PSR operates two standing committees—an Audit Committee and a Management Committee.

**Audit Committee**

The Audit Committee was established late in 2004–05 and comprises three members: Ms Glenys Roper, independent chairperson, Mr Peter Hoefer, independent member and Mr John Jenner, Executive Officer at PSR. The committee met for the first time in June 2005. A representative from the Australian National Audit Office attended as an invited observer.

The objective of the Audit Committee is to provide independent assurance and assistance to the Director on PSR’s risk, control and compliance framework and its external accountability responsibilities.

As part of the overall management and control responsibilities, PSR has appointed a respected Canberra audit and governance service provider, Ascent, to provide internal audit services.
Management Committee

The Management Committee, comprising the Director, the Executive Officer and the Unit Managers, meet monthly to consider relevant issues. The committee’s agenda varies depending on current issues but it regularly discusses:

- operational issues
- policy maintenance and development
- corporate governance issues
- finances
- human resources
- occupational health and safety
- productivity.

The committee also meets weekly to discuss issues for the coming week.

Risk management

A draft risk management and fraud control plan was prepared for 1 July 2003 to 30 June 2004. The draft plan covered activities in the planning, monitoring and controlling of actions that would address the threats and problems identified as part of the analysis of risk process and the likelihood of PSR as an organisation achieving its stated objectives.

A review of the draft plan conducted by PSR Management in May and November 2004 included:

- updating the risk register by conducting a revised risk analysis (identifying new risks, updating the assessment of risks, removing now irrelevant risks)
- updating action plans to address the risks for new key risks
- identifying new action plans.

The Risk Management Plan is inclusive of the outcomes of the review and incorporates subsequent follow-up action needed to ensure PSR’s risk management is responsive to the organisation’s changing needs. The review has enabled a revised PSR Risk Management and Fraud Control Plan to be developed for 2004–05. (Following the first meeting of the Audit Committee in June 2005, PSR has undertaken to further refine the Plan early in 2005–06 and develop a stand-alone fraud control plan.)

To date, PSR has only lodged one minor insurance claim and is confident that all significant risks are being managed effectively.

External scrutiny

During the year the PSR scheme was scrutinised in a number of cases before PSR Tribunals and/or the Courts. This report contains summaries of those cases, the impact of which is discussed in the Report on Performance.

Management of human resources

All staff, except the Director, were employed under the Public Service Act 1999 and all but two ongoing staff were employed on a permanent full-time basis. Two staff members were employed on a part-time basis.

Due to the significant downturn in the number of requests the Commission sent to PSR this year, seven staff in the Committee Unit accepted redundancy packages with four retiring in 2004–05 and three early in 2005–06. Another staff member accepted a redundancy package after a recruitment action resulted in a position upgrade. As well, one staff member transferred permanently to the Department of Transport and Communications and one resigned to join the ACT Public Service.

Tables 11 and 12 show the actual permanent staffing levels against the staffing budget and the classification levels of all staff.
Table 11—Staffing budget and levels

<table>
<thead>
<tr>
<th></th>
<th>2004–05 Budget</th>
<th>2004–05 Actual</th>
<th>2003–04 Actual</th>
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<tr>
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<tr>
<td></td>
<td>35</td>
<td>19</td>
<td>30</td>
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</table>

Table 12—Staff classification levels as at 30 June 2005

<table>
<thead>
<tr>
<th>Classification</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statutory Office Holder</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>SES 1</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>EL 2</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>EL 1</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>APS 6</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>APS 5</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>APS 4</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>APS 3</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>APS 2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>9</td>
<td>19</td>
</tr>
</tbody>
</table>

SES = Senior Executive Service
EL = Executive Level Officer
APS = Australian Public Service

Twenty-two per cent of staff are from non English-speaking backgrounds, and there are no staff of Aboriginal or Torres Strait Islander origin nor do any have a disability.

Training and development

Staff training needs were identified through PSR’s performance development scheme, which allowed the Human Resources Manager to develop a training schedule of external and internal courses. The training schedule developed included courses in:

- Leadership
- Teamwork
- Writing skills
- Planning IT architecture
- Occupational health and safety.

Two staff members are currently studying for formal qualifications under the Studybank scheme and two other staff members were helped with studies during the year.

The expenditure devoted to training in 2004–05 was 3.2 per cent. This figure does not include training provided to staff through the memorandum of understanding with the Department of Health and Ageing.

There is strong management commitment to developing staff and committee members so they are better able to perform their duties.
Deputy Directors’ conference
A two-day conference for Deputy Directors (committee chairpersons) was held in Canberra on 9–11 March 2005. The 17 Deputy Directors attending reviewed the past year’s activities and were:

- informed about the status of completed and current PSR Tribunal and Federal Court cases, including the constitutional challenges
- addressed by the Hon. Mr Alan Neaves, President of the PSR Tribunal on experiences over the last two years
- addressed by Dr Andrew Pesce and Ms Pam Burton from the AMA on the current situation for medical indemnity insurance and how it affects the PSR process
- informed about the approach the Determining Authority takes in setting sanctions following a committee report of inappropriate practice
- addressed by Ms Jane Halton, Secretary of the Department of Health and Ageing on Australian Health into the Future.

Training workshop for PSR panel members
A training workshop was held for 12 panel (committee) members at Werribee Park in Victoria on 1–3 April 2005. The theme of the training was to give Panel members ideas and techniques to cope with the demands of hearings and report preparation.

Staff team building and planning day
PSR staff attended a team building and planning workshop at Bowral on 20–21 June 2005. The organisation, under the new Director, set out its plan for the future with the support and commitment of all staff.

External conferences attended by PSR staff
During 2004–05 PSR staff attended:

- the 2nd Australasian Conference on Safety and Quality in Health Care in Canberra on 9–11 August 2004
- the Planning and Implementing Service-Oriented Architecture Conference in Sydney on 15–17 March 2005
Ethical standards
The Australian Public Service values are promoted to staff and, as shown in the Agency Overview, PSR has developed values specific to the organisation. As part of its review of the Corporate Plan undertaken at the Bowral workshop, PSR is reviewing its agency-specific values.

Certified Agreement and Australian Workplace Agreements
PSR staff were covered by the third Certified Agreement with a nominal expiry date of 31 December 2005. The Remuneration Tribunal sets the Director’s salary and conditions. Australian Workplace Agreements covered PSR’s Executive Officer, plus an additional 10 staff.

Some of the major features of the Certified Agreement include:
- salary adjustments in July 2003 (average increase of 1.5 per cent) a 3.5 per cent pay rise in January 2004, and a 4 per cent pay rise in January 2005
- an enhanced performance development scheme
- formation of a Policy Review Committee
- higher duties allowance of more than five days paid from the first day and paid after aggregation of five days in a calendar year
- two weeks paid paternity leave
- revised travel time arrangements
- school holiday family care subsidy
- expanded study assistance through Studybank
- Australian Workplace Agreements available for all staff.

The salary ranges for Australian Public Service employees covered by the Certified Agreement are set out in Table 13.

<table>
<thead>
<tr>
<th>APS classification</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>APS 1</td>
<td>$31 278</td>
<td>$35 122</td>
</tr>
<tr>
<td>APS 2</td>
<td>$36 555</td>
<td>$39 915</td>
</tr>
<tr>
<td>APS 3</td>
<td>$42 137</td>
<td>$46 605</td>
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<tr>
<td>APS 4</td>
<td>$47 646</td>
<td>$50 459</td>
</tr>
<tr>
<td>APS 5</td>
<td>$51 843</td>
<td>$54 834</td>
</tr>
<tr>
<td>APS 6</td>
<td>$57 428</td>
<td>$64 568</td>
</tr>
<tr>
<td>EL 1</td>
<td>$70 360</td>
<td>$77 429</td>
</tr>
<tr>
<td>EL 2</td>
<td>$80 205</td>
<td>$95 353</td>
</tr>
</tbody>
</table>

APS = Australian Public Service EL = Executive Level
Performance pay
Guidelines for performance pay are contained in individual Australian Workplace Agreements. This year PSR paid a total of $35,345.20 in performance pay to five staff.

Occupational health and safety
In recognition of the legal responsibility to safeguard the health of its employees while they work, the agency provides and maintains occupational health and safety (OHS) standards in relation to its offices and equipment. The OHS Committee met on a quarterly basis during the year. The OHS Committee regularly makes recommendations to the PSR Management Committee for consideration. In all cases PSR Management has supported the OHS Committee’s recommendations.

During the year, the PSR office relocated from Yarralumla to Brindabella Business Park at Canberra International Airport. During this relocation, extensive consultation was undertaken with staff and the health and safety representatives regarding fit-out of the office and relocation activities. The health and safety representative carried out an OHS inspection of the new office before staff relocated. Another more extensive OHS inspection was undertaken following relocation and staff settling in to the new premises. PSR Management was guided by the recommendations of the OHS Committee to rectify potential OHS hazards identified in the office.

If required, policy advice relating to OHS is given by the specialist area in the Department of Health and Ageing as an element of the memorandum of understanding. Also included in the memorandum of understanding is access for staff and/or their immediate families to counselling services by trained professionals, using an employee assistance program.

Four OHS incident reports were submitted in 2004–05 one of which resulted in a claim to Comcare. Two of these incidents related to trips in the workplace, one work-related back injury and one to a fall outside the workplace. No notices were issued or received under any of the relevant sections of the OHS Act during the year.

Workplace diversity
In its commitment to workplace diversity PSR ensures all staff are treated fairly and without direct, indirect or systemic discrimination. All staff have equal access to employment, career and development opportunities and PSR encourages appropriate representation from the target groups specified in workplace diversity policies.

Because of its size, PSR has no separate workplace diversity plan but has embraced that of the Department of Health and Ageing.

Industrial democracy
Staff were consulted on all major issues during the year. Staff meetings are held within Units and information is channelled to and from management meetings.

As mentioned in last year’s report, PSR decided to relocate its office to Brindabella Business Park at Canberra International Airport. Staff were taken on visits to prospective premises and staff meetings were held to gain and evaluate opinions as part of the decision-making process. Staff were also consulted on the floor plan, outfitting and furniture.

Commonwealth Disability Strategy
Our programs and services are not delivered to the general public and, to date, we have not had any person under review claim a disability. If the need arose, PSR considers it would be able to satisfactorily cater to any circumstance.
The PSR website <www.psr.gov.au> contains public information about the scheme and meets the Government Online minimum standards with regard to accessible formats for people with disabilities.

With regard to contract tendering, we have adopted the purchasing policies of the Department of Health and Ageing which encompass the Commonwealth Disability Strategy.

There are currently no staff with a disability employed at PSR. However, our employment policies, procedures and practices comply with the requirements of the *Disability Discrimination Act 1992*.

**Finance**

The 2004–05 budget appropriation was $7.764 million and received an additional $8000 for the United States Free Trade Agreement at the mid-year Additional Estimates resulting in a final Budget appropriation of $7.772 million.

Late in the financial year, PSR returned $5 million to the Department of Finance and Administration because it had no need for the level of cash reserves that had accumulated. The level of cash reserve is a result of the PSR scheme being so litigious with approximately one-third of our cases going to Federal Court action. While PSR has won the vast majority of cases in the courts, the few that have been lost have had a great effect, halting and disrupting, progress on other cases. The adverse effects of Pradhan and then Daniel have had a big impact on PSR being able to progress its core business.

PSR has not been able to work through a full year cycle without legal obstacles blocking progress to some extent. As a consequence of these Federal Court decisions and prudent financial management, PSR had accumulated considerable cash reserves.

In March, PSR moved its general ledger and budget control processes in-house to the Great Plains Financial Information Management System software. This has given PSR greater control over its finances, especially in the payment of accounts.

During 2004–05 PSR continued to assess payroll functions provided through the Department of Health and Ageing’s SAP system. A decision was taken late in the financial year to move to an outsourced payroll arrangement provided by a national solutions company, Ross Logic.

Ascent has been appointed to rewrite PSR’s Chief Executive Instructions and Procedural Rules following the change of these internal processes.

The Australian National Audit Office’s report on our 2004–05 financial statements was unqualified and was signed on 16 September 2005 (see Appendix 1).

**Purchasing**

For most of the year, PSR purchased services such as payment of accounts, personnel functions, library, registry, training and coverage for programs including workplace diversity, occupational health and safety and industrial democracy, through a memorandum of understanding with the Department of Health and Ageing. An agreed annual fee is paid for these services. PSR adopts the Department of Health and Ageing’s purchasing policies and participates in joint purchasing arrangements for such things as travel, banking and office supplies.

**Asset management**

All PSR assets are securely housed at our premises within the Brindabella Business Park. PSR maintains an asset register and we undertake an asset stocktake annually. All assets loaned to staff are signed for in a register.
Consultants and competitive tendering and contracting

There was no activity relating to contracting out of delivery of government activities, previously performed by a Commonwealth agency, to another organisation.

In accordance with Senate Orders on government contracts (the Murray Motion), all PSR contracts in excess of $100 000 are displayed on the PSR web site. Any other contracts or purchases in excess of $10 000 are recorded in the Commonwealth Purchasing and Disposal Gazette.

The total amount paid to one consultant in 2004–05 was $52 975.

Ecologically sustainable development and environmental performance

On account of its small size, PSR has no formal method of reporting its environmental performance, but has endeavoured to reduce its energy costs and encourages ecologically sustainable practices, such as paper recycling.

To aid a gradual transition from paper records to electronic record keeping, PSR has been using the Tower Records Information Management (TRIM) system since 2002. The TRIM system enables PSR to reduce its paper usage because most documents created internally will only be produced electronically and documents received electronically are stored electronically and need not be printed.

Information technology

First-level IT support is provided in-house. An external provider, Infront Systems, continued to provide routine maintenance and second- and third-level IT support. During the year, LNB Computing provided continual support and upgrades to MALCOLM (a customised database for tracking and reporting all stages of referrals).

Publications

One new publication was produced this year: the 2003–04 Annual Report. This and past reports are available on the PSR web site at <www.psr.gov.au>. See Appendix 2 for a list of publications held by PSR.
Appendixes

Appendix 1: Financial statements

INDEPENDENT AUDIT REPORT

To the Minister for Health and Ageing

Scope

The financial statements comprise:

- Statement by the Chief Executive and Chief Finance Officer;
- Schedules of Commitments and Contingencies; and
- Notes to and forming part of the Financial Statements

of the Professional Services Review Scheme for the year ended 30 June 2005.

The Professional Services Review’s Chief Executive is responsible for the preparation and true and fair presentation of the financial statements in accordance with the Finance Minister’s Orders. This includes responsibility for the maintenance of adequate accounting records and internal controls that are designed to prevent and detect fraud and error, and for the accounting policies and accounting estimates inherent in the financial statements.

Audit approach

I have conducted an independent audit in order to express an opinion to you. My audit has been conducted in accordance with the Australian National Audit Office Auditing Standards, which incorporate the Australian Auditing and Assurance Standards, in order to provide reasonable assurance as to whether the financial statements are free of material misstatement. The nature of an audit is influenced by factors such as the use of professional judgement, selective testing, the inherent limitations of internal control, and the availability of persuasive, rather than conclusive, evidence. Therefore, an audit cannot guarantee that all material misstatements have been detected.

While the effectiveness of management’s internal controls over financial reporting was considered when determining the nature and extent of audit procedures, the audit was not designed to provide assurance on internal controls.

The audit did not involve an analysis of the prudence of business decisions made by the Chief Executive or management.

Procedures were performed to assess whether, in all material respects, the financial statements present fairly, in accordance with the Finance Minister’s Orders made under the Financial Management and Accountability Act 1997, Accounting Standards and other mandatory financial...
reporting requirements in Australia, a view which is consistent with my understanding of the Professional Services Review’s performance as represented by the statements of financial performance, financial position and cash flows.

The audit opinion is formed on the basis of these procedures, which included:

- examining, on a test basis, information to provide evidence supporting the amounts and disclosures in the financial statements; and
- assessing the appropriateness of the accounting policies and disclosures used, and the reasonableness of significant accounting estimates made by the Chief Executive.

**Independence**

In conducting the audit, I have followed the independence requirements of the ANAO, which incorporate Australian professional ethical pronouncements.

**Audit Opinion**

In my opinion, the financial statements:

(i) have been prepared in accordance with Finance Minister’s Orders made under the Financial Management and Accountability Act 1997 and applicable Accounting Standards; and

(ii) give a true and fair view, of the matters required by applicable Accounting Standards and other mandatory professional reporting requirements in Australia, and the Finance Minister’s Orders, of the financial position of the Professional Services Review as at 30 June 2005, and its financial performance and cash flows for the year then ended.

**Australian National Audit Office**

Richard Rundle
Executive Director

Delegate of the Auditor-General
Canberra
19 September 2005
Statement by the Chief Executive Officer

In our opinion, the attached financial statements for the year ended 30 June 2005 are based on properly maintained financial records and give a true and fair view of the matters required by the Finance Minister’s Orders made under the Financial Management and Accountability Act 1997.

Signed
Dr Tony Webber
Director
Professional Services Review
16 September 2005

Signed
Dean Browne
Chief Finance Officer
Professional Services Review
16 September 2005
# Statement of Financial Performance for the Year Ended 30 June 2005

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<thead>
<tr>
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<tbody>
<tr>
<td>Revenues from ordinary activities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenues from Government</td>
<td>4A</td>
<td>7,772,000</td>
<td>7,598,000</td>
</tr>
<tr>
<td>Sales of goods and services</td>
<td>4B</td>
<td>2,309</td>
<td>2,531</td>
</tr>
<tr>
<td>Revenue from sale of assets</td>
<td>4C</td>
<td>18,571</td>
<td>–</td>
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<tr>
<td>Other revenues</td>
<td>4D</td>
<td>223,336</td>
<td>6,200</td>
</tr>
<tr>
<td>Prior period prepayment adjustment</td>
<td>4E</td>
<td>–</td>
<td>210,000</td>
</tr>
<tr>
<td><strong>Total revenues from ordinary activities</strong></td>
<td></td>
<td><strong>8,016,216</strong></td>
<td><strong>7,816,731</strong></td>
</tr>
<tr>
<td>Expenses from ordinary activities (excluding borrowing costs expense)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employees expenses</td>
<td>5A</td>
<td>2,710,486</td>
<td>2,382,640</td>
</tr>
<tr>
<td>Suppliers expenses</td>
<td>5B</td>
<td>4,153,988</td>
<td>4,365,395</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>5C</td>
<td>261,866</td>
<td>180,638</td>
</tr>
<tr>
<td>Write-down and impairment of assets</td>
<td>5D</td>
<td>33,714</td>
<td>81,619</td>
</tr>
<tr>
<td>Value of assets sold</td>
<td>4C</td>
<td>17,272</td>
<td>–</td>
</tr>
<tr>
<td><strong>Total expenses from ordinary activities (excluding borrowing costs expense)</strong></td>
<td></td>
<td><strong>7,177,326</strong></td>
<td><strong>7,010,292</strong></td>
</tr>
<tr>
<td><strong>Net operating surplus (deficit) from ordinary activities</strong></td>
<td>10A</td>
<td>838,890</td>
<td>806,439</td>
</tr>
<tr>
<td>Net credit (debit) to asset revaluation reserve</td>
<td>10A</td>
<td>(7,491)</td>
<td>–</td>
</tr>
<tr>
<td><strong>Total Revenues, Expenses and Valuation Adjustments Attributable to Members of the Parent Entity and Recognised Directly in Equity</strong></td>
<td></td>
<td>(7,491)</td>
<td>–</td>
</tr>
<tr>
<td><strong>Total Changes in Equity other than those resulting from transactions with Owners as Owners</strong></td>
<td></td>
<td>831,399</td>
<td>806,439</td>
</tr>
</tbody>
</table>

The above statement should be read in conjunction with the accompanying notes.
Statement of Financial Position as at 30 June 2005

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial assets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash</td>
<td>6A</td>
<td>1,216,697</td>
<td>5,710,817</td>
</tr>
<tr>
<td>Receivables</td>
<td>6B</td>
<td>5,243,462</td>
<td>160,137</td>
</tr>
<tr>
<td><strong>Total financial assets</strong></td>
<td></td>
<td>6,460,159</td>
<td>5,870,955</td>
</tr>
<tr>
<td>Non-financial assets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Land and buildings</td>
<td>7A, 7D</td>
<td>346,174</td>
<td>12,886</td>
</tr>
<tr>
<td>Infrastructure, plant and equipment</td>
<td>7B, 7D</td>
<td>262,321</td>
<td>239,150</td>
</tr>
<tr>
<td>Intangibles</td>
<td>7C, 7D</td>
<td>276,684</td>
<td>295,188</td>
</tr>
<tr>
<td>Other non-financial assets</td>
<td>7E</td>
<td>19,028</td>
<td>651,629</td>
</tr>
<tr>
<td><strong>Total non-financial assets</strong></td>
<td></td>
<td>904,207</td>
<td>1,198,853</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td></td>
<td>7,364,366</td>
<td>7,069,808</td>
</tr>
<tr>
<td><strong>Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employees</td>
<td>8A</td>
<td>558,935</td>
<td>783,537</td>
</tr>
<tr>
<td><strong>Total provisions</strong></td>
<td></td>
<td>558,935</td>
<td>783,537</td>
</tr>
<tr>
<td>Payables</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suppliers</td>
<td>9A</td>
<td>119,330</td>
<td>431,568</td>
</tr>
<tr>
<td><strong>Total payables</strong></td>
<td></td>
<td>119,330</td>
<td>431,568</td>
</tr>
<tr>
<td><strong>Total liabilities</strong></td>
<td></td>
<td>678,265</td>
<td>1,215,105</td>
</tr>
<tr>
<td><strong>Equity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributed equity</td>
<td>10A</td>
<td>700,000</td>
<td>700,000</td>
</tr>
<tr>
<td>Reserves</td>
<td>10A</td>
<td>22,832</td>
<td>30,324</td>
</tr>
<tr>
<td>Retained surpluses/(Accumulated deficits)</td>
<td>10A</td>
<td>5,963,269</td>
<td>5,124,379</td>
</tr>
<tr>
<td><strong>Total equity</strong></td>
<td></td>
<td>6,686,101</td>
<td>5,854,703</td>
</tr>
<tr>
<td><strong>Total liabilities and equity</strong></td>
<td></td>
<td>7,364,366</td>
<td>7,069,808</td>
</tr>
<tr>
<td>Current liabilities</td>
<td></td>
<td>527,151</td>
<td>661,709</td>
</tr>
<tr>
<td>Non-current liabilities</td>
<td></td>
<td>151,114</td>
<td>553,396</td>
</tr>
<tr>
<td>Current assets</td>
<td></td>
<td>6,479,187</td>
<td>6,522,584</td>
</tr>
<tr>
<td>Non-current assets</td>
<td></td>
<td>885,179</td>
<td>547,224</td>
</tr>
</tbody>
</table>

The above statement should be read in conjunction with the accompanying notes.
Statement of Cash Flows for the Year Ended 30 June 2005

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Operating Activities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cash Received</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goods and services</td>
<td></td>
<td>2,309</td>
<td>2,664</td>
</tr>
<tr>
<td>Appropriations</td>
<td></td>
<td>7,727,000</td>
<td>7,616,000</td>
</tr>
<tr>
<td>Other revenues</td>
<td></td>
<td>223,336</td>
<td>-</td>
</tr>
<tr>
<td>Net GST received from ATO</td>
<td></td>
<td>-</td>
<td>296,118</td>
</tr>
<tr>
<td><strong>Total Cash Received</strong></td>
<td></td>
<td>7,952,645</td>
<td>7,914,782</td>
</tr>
<tr>
<td><strong>Cash Used</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employees</td>
<td></td>
<td>2,935,088</td>
<td>2,368,035</td>
</tr>
<tr>
<td>Suppliers</td>
<td></td>
<td>3,833,626</td>
<td>3,508,032</td>
</tr>
<tr>
<td>Net GST paid to ATO</td>
<td></td>
<td>38,325</td>
<td>314,502</td>
</tr>
<tr>
<td><strong>Total Cash Used</strong></td>
<td></td>
<td>6,807,039</td>
<td>6,190,569</td>
</tr>
<tr>
<td><strong>Net Cash From or (Used By) Operating Activities</strong></td>
<td></td>
<td>1,145,606</td>
<td>1,724,213</td>
</tr>
<tr>
<td><strong>Investing Activities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cash Received</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proceeds from sales of property, plant and equipment</td>
<td></td>
<td>18,571</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Cash Received</strong></td>
<td></td>
<td>18,571</td>
<td>-</td>
</tr>
<tr>
<td><strong>Cash Used</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchase of property, plant and equipment</td>
<td></td>
<td>605,201</td>
<td>38,064</td>
</tr>
<tr>
<td>Purchase of intangibles</td>
<td></td>
<td>53,098</td>
<td>121,316</td>
</tr>
<tr>
<td><strong>Total Cash Used</strong></td>
<td></td>
<td>658,299</td>
<td>159,380</td>
</tr>
<tr>
<td><strong>Net Cash From or (Used By) Investing Activities</strong></td>
<td></td>
<td>(639,728)</td>
<td>(159,380)</td>
</tr>
<tr>
<td><strong>Financing Activities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cash Received</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriations – contributed equity</td>
<td></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Cash Received</strong></td>
<td></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Cash Used</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Return of contributed equity</td>
<td></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Cash to the OPA</td>
<td></td>
<td>5,000,000</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Cash Used</strong></td>
<td></td>
<td>5,000,000</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net Cash From or (Used By) Financing Activities</strong></td>
<td></td>
<td>(5,000,000)</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net Increase or (Decrease) in Cash Held</strong></td>
<td></td>
<td>(4,494,122)</td>
<td>1,564,833</td>
</tr>
<tr>
<td>Cash at the beginning of the reporting period</td>
<td></td>
<td>5,710,818</td>
<td>4,145,985</td>
</tr>
<tr>
<td><strong>Cash at the End of the Reporting Period</strong></td>
<td>6A</td>
<td>1,216,697</td>
<td>5,710,818</td>
</tr>
</tbody>
</table>

The above statement should be read in conjunction with the accompanying notes.
**Schedule of Commitments as at 30 June 2005**

<table>
<thead>
<tr>
<th>By Type</th>
<th>Notes</th>
<th>2004–2005 $</th>
<th>2003–2004 $</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Capital commitments</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Land and buildings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infrastructure, plant and equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Capital Commitments</strong></td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td><strong>Other Commitments</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating leases</td>
<td></td>
<td>1,202,290</td>
<td>47,029</td>
</tr>
<tr>
<td><strong>Total Other Commitments</strong></td>
<td></td>
<td>1,202,290</td>
<td>47,029</td>
</tr>
<tr>
<td>Commitments Receivable</td>
<td></td>
<td>(109,299)</td>
<td>1,698</td>
</tr>
<tr>
<td><strong>Net Commitments by Type</strong></td>
<td></td>
<td>1,092,991</td>
<td>45,331</td>
</tr>
<tr>
<td><strong>By Maturity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital Commitments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One year or less</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>From one to five years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over five years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Capital Commitments</strong></td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Operating Lease Commitments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One year or less</td>
<td></td>
<td>311,828</td>
<td>47,029</td>
</tr>
<tr>
<td>From one to five years</td>
<td></td>
<td>890,462</td>
<td>-</td>
</tr>
<tr>
<td>Over five years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Operating Lease Commitments</strong></td>
<td></td>
<td>1,202,290</td>
<td>47,029</td>
</tr>
<tr>
<td>Commitments Receivable</td>
<td></td>
<td>(109,299)</td>
<td>1,698</td>
</tr>
<tr>
<td><strong>Net Commitments by Maturity</strong></td>
<td></td>
<td>1,092,991</td>
<td>45,331</td>
</tr>
</tbody>
</table>

NB: Commitments are GST inclusive where relevant.
Schedule of Commitments as at 30 June 2005 continued

1 Operating leases included are effectively non-cancellable and comprise:

<table>
<thead>
<tr>
<th>Nature of lease</th>
<th>General description of leasing arrangement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leases for office accommodation</td>
<td>Lease payments are subject to annual increases. The term of the lease for the Brindabella Park office is for 5 years and commenced on 1 August 2004.</td>
</tr>
<tr>
<td>Agreements for the provision of motor vehicles to senior executive officers</td>
<td>No contingent rentals exist. There are no renewal or purchase options available to Professional Services Review.</td>
</tr>
<tr>
<td>A lease in relation to computer equipment held as at 30 June 2005.</td>
<td>The lessor provides all computer equipment and software designated as necessary in the supply contract for 3 years. The initial equipment has on average a useful life of 3 years from the commencement of the contract. Professional Services Review may vary its originally designated requirement, subject to giving 3 months notice, at no penalty.</td>
</tr>
</tbody>
</table>

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

Schedule of Contingencies as at 30 June 2005

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance from previous period</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>New</td>
<td>35,760</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>35,760</td>
<td>-</td>
</tr>
<tr>
<td>Re-measurement</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Liabilities crystallised</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Obligations expired</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Contingent Liabilities</strong></td>
<td><strong>35,760</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td><strong>35,760</strong></td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance from previous period</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>New</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Re-measurement</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Assets crystallised</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Expired</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Contingent Assets</strong></td>
<td><strong>-</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td><strong>-</strong></td>
<td><strong>-</strong></td>
</tr>
</tbody>
</table>

| Net Contingencies      | 35,760            | -                 | -                             | -                             | 35,760       | -            |

Details of each class of contingent liabilities and assets, including those not included above because they cannot be quantified or are considered remote, are disclosed in Note 12: Contingent Liabilities and Assets.

The above statement should be read in conjunction with the accompanying notes.
Notes to and Forming Part of the Financial Statements as at 30 June 2005

INDEX

<table>
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<tr>
<th>Note No.</th>
<th>Description</th>
</tr>
</thead>
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<td>1</td>
<td>Summary of Significant Accounting Policies</td>
</tr>
<tr>
<td>2</td>
<td>Adoption of Australian Equivalents to International Financial Reporting Standards from 2005-2006</td>
</tr>
<tr>
<td>3</td>
<td>Events Occurring after Reporting Date</td>
</tr>
<tr>
<td>4</td>
<td>Operating Revenues</td>
</tr>
<tr>
<td>5</td>
<td>Operating Expenses</td>
</tr>
<tr>
<td>6</td>
<td>Financial Assets</td>
</tr>
<tr>
<td>7</td>
<td>Non-Financial Assets</td>
</tr>
<tr>
<td>8</td>
<td>Provisions</td>
</tr>
<tr>
<td>9</td>
<td>Payables</td>
</tr>
<tr>
<td>10</td>
<td>Equity</td>
</tr>
<tr>
<td>11</td>
<td>Cash Flow Reconciliation</td>
</tr>
<tr>
<td>12</td>
<td>Contingent Liabilities and Assets</td>
</tr>
<tr>
<td>13</td>
<td>Executive Remuneration</td>
</tr>
<tr>
<td>14</td>
<td>Remuneration of Auditors</td>
</tr>
<tr>
<td>15</td>
<td>Average Staffing Levels</td>
</tr>
<tr>
<td>16</td>
<td>Financial Instruments</td>
</tr>
<tr>
<td>17</td>
<td>Appropriations</td>
</tr>
<tr>
<td>18</td>
<td>Specific Payment Disclosures</td>
</tr>
<tr>
<td>19</td>
<td>Reporting of Outcomes</td>
</tr>
</tbody>
</table>
Note 1—Summary of Significant Accounting Policies

1.1 Objectives of Professional Services Review
The objective of Professional Services Review 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 Pharmaceutical Benefits Schedule.

The continued existence of Professional Services Review in its present form and with its present programs is dependent on Government policy and on continuing appropriations by Parliament for Professional Services Review’s administration and programs.

1.2 Basis of Accounting
The financial statements are required by section 49 of the Financial Management and Accountability Act 1997 and are a general-purpose financial report.

The statements have been prepared in accordance with:

- Finance Minister’s Orders (or FMOs, being the Financial Management and Accountability Orders (Financial Statements for reporting periods ending on or after 30 June 2005));
- Australian Accounting Standards and Accounting Interpretations issued by the Australian Accounting Standards Board; and
- Consensus Views of the Urgent Issues Group.

The Statements of Financial Performance and Financial Position have been prepared on an accrual basis and are in accordance with historical cost convention, except for certain assets, which, as noted, are at valuation. Except where stated, no allowance is made for the effect of changing prices on the results or the financial position.

Assets and liabilities are recognised in the Statement of Financial Position when and only when it is probable that future economic benefits will flow and the amounts of the assets or liabilities can be reliably measured. However, assets and liabilities arising under agreements equally proportionately unperformed are not recognised unless required by an Accounting Standard. Liabilities and assets that are unrecognised are reported in the Schedule of Commitments and the Schedule of Contingencies (other than unquantifiable or remote contingencies, which are reported at Note 12).

Revenues and expenses are recognised in the Statement of Financial Performance when and only when the flow or consumption or loss of economic benefits has occurred and can be reliably measured.

1.3 Revenue

(a) Revenues from Government
Amounts appropriated for agency outputs appropriations for the year (adjusted for any formal additions and reductions) are recognised as revenue, except for certain amounts that relate to activities that are reciprocal in nature, in which case revenue is recognised only when it has been earned.

(b) Resources Received Free of Charge
Services received free of charge are recognised as revenue when and only when a fair value can be reliably determined and the services would have been purchased if they had not been donated. Use of those resources is recognised as an expense.

Contributions of assets at no cost of acquisition or for nominal consideration are recognised as revenue at their fair value when the asset qualifies for recognition, unless received from another government agency as a consequence of a restructuring of administrative arrangements (Refer to Note 1.4).
(c) Other Revenue

Revenue from the sale of goods is recognised upon the delivery of goods to customers.

Revenue from rendering of services is recognised by reference to the stage of completion of contracts or other agreements to provide services. The stage of completion is determined according to the proportion that costs incurred to date bear to the estimated total costs of the transaction.

Receivables for goods and services are recognised at the nominal amounts due less any provision for bad and doubtful debts. Collectability of debts is reviewed at balance date. Provisions are made when collectability of the debt is judged to be less rather than more likely.

Interest revenue is recognised on a time proportionate basis that takes into account the effective yield on the relevant asset.

Revenue from disposal of non-current assets is recognised when control of the asset has passed to the buyer.

1.4 Transactions with the Government as Owner

(a) Equity injections

Amounts appropriated which are designated as 'equity injections' for a year (less any savings offered up in Portfolio Additional Estimates Statements) are recognised directly in Contributed Equity in that year.

(b) Restructuring of Administrative Arrangements

Net assets received from or relinquished to another Commonwealth agency or authority under a restructuring of administrative arrangements are adjusted at their book value directly against contributed equity.

1.5 Employee Benefits

Liabilities for services rendered by employees are recognised at the reporting date to the extent that they have not been settled.

Liabilities for wages and salaries (including non-monetary benefits), annual leave and sick leave are measured at their nominal amounts. Other employee benefits expected to be settled within 12 months of the reporting date are also measured at their nominal amounts.

The nominal amount is calculated with regard to the rates expected to be paid on settlement of the liability.

All other employee benefit liabilities are measured as the present value of the estimated future cash outflows to be made in respect of services provided by employees up to the reporting date.

(a) Leave

The liability for employee benefits includes provision for annual leave and long service leave. No provision has been made for sick leave as all sick leave is non-vesting and the average sick leave taken in future years by employees of Professional Services Review estimated to be less than the annual entitlement for sick leave.

The leave liabilities are calculated on the basis of employees' remuneration, including Professional Services Review employer superannuation contribution rates to the extent that the leave is likely to be taken during service rather than paid out on termination.

The liability for long service leave has been determined by reference to the work of an actuary as at 30 June 2005. The estimate of the present value of the liability takes into account attrition rates and pay increases through promotion and inflation.
(b) Separation and Redundancy
Provision is made for separation and redundancy benefit payments. Professional Services Review has developed a detailed formal plan for the terminations and has informed those employees affected that it will carry out the terminations.

(c) Superannuation
Professional Services Review staff are members of the Commonwealth Superannuation Scheme and the Public Sector Superannuation Scheme. The liability for their superannuation benefits is recognised in the financial statements of the Australian Government and is settled by the Australian Government in due course.

Professional Services Review makes employer contributions to the Australian Government at rates determined by an actuary to be sufficient to meet the cost to the Government of the superannuation entitlements of Professional Services Review's employees.

The liability for superannuation recognised as at 30 June represents outstanding contributions for the final fortnight of the year.

1.6 Leases
A distinction is made between finance leases and operating leases. Finance leases effectively transfer from the lessor to the lessee substantially all the risks and benefits incidental to ownership of leased non-current assets. In operating leases, the lessor effectively retains substantially all such risks and benefits.

Where a non-current asset is acquired by means of a finance lease, the asset is capitalised at the present value of minimum lease payments at the beginning of the lease term and a liability recognised at the same time and for the same amount. The discount rate used is the interest rate implicit in the lease. Leased assets are amortised over the period of the lease. Lease payments are allocated between the principal component and the interest expense.

Operating lease payments are expensed on a basis that is representative of the pattern of benefits derived from the leased assets. The net present value of future net outlays in respect of surplus space under non-cancelable lease agreements is expensed in the period in which the space becomes surplus.

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

1.7 Cash
Cash means notes and coins held and any deposits held at call with a bank or financial institution. Cash is recognised at its nominal amount.

1.8 Other Financial Instruments
Government loans are carried at the balance yet to be repaid. Interest is expensed as it accrues unless it is directly attributable to a qualifying asset.

(a) Trade Creditors
Trade 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).

(b) Contingent Liabilities and Contingent Assets
Contingent liabilities (assets) are not recognised in the Statement of Financial Position but are discussed in the relevant schedules and notes. They may arise from uncertainty as to the existence of a liability (asset), or represent an existing liability (asset) in respect of which settlement is not probable or the amount
cannot be reliably measured. Remote contingencies are part of this disclosure. Where settlement becomes probable, a liability (asset) is recognised. A liability (asset) is recognised when its existence is confirmed by a future event, settlement becomes probable or reliable measurement becomes possible.

1.9 Acquisition of Assets

Assets are recorded at cost on acquisition except as stated below. The cost of acquisition includes the fair value of assets transferred in exchange and liabilities undertaken.

Assets acquired at no cost, or for nominal consideration, are initially recognised as assets and revenues at their fair value at the date of acquisition, unless acquired as a consequence of restructuring of administrative arrangements. In the latter case, assets are initially recognised as contributions by owners at the amounts at which they were recognised in the transferor agency’s accounts immediately prior to the restructuring.

1.10 Property, Plant and Equipment (PP&e)

(a) Asset Recognition Threshold

Purchases of property, plant and equipment are recognised initially at cost in the Statement of Financial Position, except for purchases costing less than $2,000, which are expensed in the year of acquisition (other than where they form part of a group of similar items which are significant in total).

(b) Revaluations

(i) Basis

Land, buildings, plant and equipment are carried at valuation, being revalued annually with sufficient frequency such that the carrying amount of each asset class is not materially different, at reporting date, from its fair value. Valuations were undertaken in as at 30 June 2005.

(ii) Depreciation

Depreciable property plant and equipment assets are written-off to their estimated residual values over their estimated useful lives to the Agency using, in all cases, the straight-line method of depreciation. Leasehold improvements are depreciated on a straight-line basis over the lesser of the estimated useful life of the improvements or the unexpired period of the lease.

Depreciation rates (useful lives) and methods are reviewed at each reporting date and necessary adjustments are recognised in the current, or current and future reporting periods, as appropriate. Residual values are re-estimated for a change in prices only when assets are revalued.

Depreciation rates applying to each class of depreciable asset are based on the following useful lives:

<table>
<thead>
<tr>
<th>Asset class</th>
<th>Fair value measured at:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leasehold improvements</td>
<td>Depreciated replacement cost</td>
</tr>
<tr>
<td>Plant &amp; equipment</td>
<td>Market selling price</td>
</tr>
</tbody>
</table>

The aggregate amount of depreciation allocated for each class of asset during the reporting period is disclosed in Note 5C.

1.11 Impairment of Non-Current Assets

Non-current assets carried at up to date fair value at the reporting date are not subject to impairment testing.
1.12 Intangibles

Professional Services Review’s intangibles comprise purchased software which is carried at cost.

Software is amortised on a straight-line basis over its anticipated useful life. The useful lives of Professional Services Review software is 5 years (2003–04: 5 years).

1.13 Inventories

No inventories were held for resale at Professional Services Review during 2004–05.

1.14 Taxation/Competitive Neutrality

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

Revenues, expenses and assets are recognised net of GST:

- except where the amount of GST incurred is not recoverable from the Australian Taxation Office; and
- except for receivables and payables.

Competitive Neutrality

Professional Services Review did not provide services on a for-profit basis in 2004–05.

Note 2–Adoption of Australian Equivalents to International Financial Reporting Standards from 2005–2006

The Australian Accounting Standards Board has issued replacement Australian Accounting Standards to apply from 2005–06. The new standards are the Australian Equivalents to International Financial Reporting Standards (AEIFRS). The International Financial Reporting Standards are issued by the International Accounting Standards Board. The new standards cannot be adopted early. The standards being replaced are to be withdrawn with effect from 2005–06, but continue to apply in the meantime, including reporting periods ending on 30 June 2005.

The purpose of issuing AEIFRS is to enable Australian reporting entities reporting under the Corporations Act 2001 to be able to more readily access overseas capital markets by preparing their financial reports according to accounting standards more widely used overseas.

For-profit entities complying with AEIFRS will be able to make an explicit and unreserved statement of compliance with International Financial Reporting Standards (IFRS) as well as a statement that the financial report has been prepared in accordance with Australian Accounting Standards.

AEIFRS contain certain additional provisions that will apply to not-for-profit entities, including Australian Government agencies. Some of these provisions are in conflict with IFRS, and therefore Professional Services Review will only be able to assert that the financial report has been prepared in accordance with Australian Accounting Standards.

AAS 29 Financial Reporting by Government Departments will continue to apply under AEIFRS.

Accounting Standard AASB 1047 Disclosing the Impacts of Adopting Australian Equivalents to International Financial Reporting Standards requires that the financial statements for 2004–05 disclose:

- an explanation of how the transition to AEIFRS is being managed;
- narrative explanations of the key policy differences arising from the adoption of AEIFRS;
- any known or reliably estimable information about the impacts on the financial report had it been prepared using AEIFRS; and
- if the impacts of the above are not known or reliably estimable, a statement to that effect.

Where an entity is not able to make a reliable estimate, or where quantitative information is not known, the entity should update the narrative
disclosures of the key differences in accounting policies that are expected to arise from the adoption of AEIFRS.

The purpose of this Note is to make these disclosures.

Management of the transition to AEIFRS

Professional Services Review has taken the following steps for the preparation towards the implementation of AEIFRS:

- Professional Services Review’s Audit Committee is tasked with oversight of the transition to and implementation of AEIFRS. The Chief Finance Officer is formally responsible for the project and reports regularly to the Audit Committee on progress against the formal plan approved by the Committee.

- The plan requires the following key steps to be undertaken and sets deadlines for their achievement:
  - All major accounting policy differences between current AASB standards and AEIFRS were identified.
  - System changes necessary to be able to report under the AEIFRS, including those necessary to capture data under both sets of rules for 2004–05 were completed. This included the testing and implementation of those changes.
  - A transitional balance sheet as at 1 July 2004 under AEIFRS was completed and presented to the Audit Committee.
  - An AEIFRS compliant balance sheet as at 30 June 2005 was also prepared during the preparation of the 2004–05 statutory financial reports.
  - The 2004–05 Balance Sheet under AEIFRS will be reported to the Department of Finance and Administration in line with their reporting deadlines.

- The plan also addresses the risks to successful achievement of the above objectives and includes strategies to keep implementation on track to meet deadlines.

- Consultants were engaged where necessary to assist with each of the above steps.

Major changes in accounting policy

Professional Services Review believes that the first financial report prepared under AEIFRS i.e. at 30 June 2006, will be prepared on the basis that Professional Services Review will be a first time adopter under AASB 1 First-time Adoption of Australian Equivalents to International Financial Reporting Standards. Changes in accounting policies under AEIFRS are applied retrospectively i.e. as if the new policy had always applied except in relation to the exemptions available and prohibitions under AASB 1. This means that an AEIFRS compliant balance sheet has to be prepared as at 1 July 2004. This will enable the 2005–06 financial statements to report comparatives under AEIFRS.

A first time adopter of AEIFRS may elect to use exemptions under paragraphs 13 to 25E. When developing the accounting policies applicable to the preparation of the 1 July opening balance sheet, no exemptions were applied by Professional Services Review.

The results of Professional Services Review’s analysis of the impact of AEIFRS policies found that there were no accounting policy changes that would have a material impact on the 2004–05 Balance Sheet. The most significant change as a result of the implementation of AEIFRS was in relation to employee entitlements and is detailed below.
1. **Employee Entitlements**
The 2003–04 financial report noted that the AEIFRS standards may require the market yield on corporate bonds to be used. The AASB has decided that a deep market in high quality corporate bonds does not exist and therefore national government bonds will be referenced.

AEIFRS require that annual leave that is not expected to be taken within 12 months of balance date is to be discounted. After assessing the staff leave profile, Professional Services Review have estimated the financial impact of discounting the non current portion of annual leave to be $500. This is not considered to be material and hence, the balances recorded for employee entitlements within the 2004–05 financial year will not be changed as a result of the implementation of AEIFRS.

2. **Impairment of Intangibles and Property, Plant and Equipment**

Professional Services Review’s policy on impairment of non-current assets is at Note 1.11.

Under AEIFRS these assets will be subject to assessment for impairment and, if there are indications of impairment, an assessment of the degree of impairment. (Impairment measurement must also be done, irrespective of any indications of impairment, for intangible assets not yet available for use). The impairment test is that the carrying amount of an asset must not exceed the greater of (a) its fair value less costs to sell and (b) its value in use. 'Value in use' is the net present value of net cash inflows for cash generating units of Professional Services Review and depreciated replacement cost for other assets which would be replaced if Professional Services Review were deprived of them.

The most significant changes are that, for Professional Services Review’s cash generating units, the recoverable amount is only generally to be measured where there is an indication of impairment. Previously all assets’ recoverable amount was tested.

However, an impairment assessment of the agency’s assets indicated that no adjustments will be required.

3. **Financial Instruments**

AEIFRS include an option for entities not to restate comparative information in respect of financial instruments in the first AEIFRS report. It is expected that Finance Minister’s Orders will require entities to use this option. Therefore, the amounts for financial instruments presented in the Professional Services Review’s 2004–05 primary financial statements are not expected to change as a result of the adoption of AEIFRS.

Professional Services Review will be required by AEIFRS to review the carrying amounts of financial instruments at 1 July 2005 to ensure they align with the accounting policies required by AEIFRS. It is expected that the carrying amounts of financial instruments held by Professional Services Review will not materially change as a result of this process.

**Reconciliation of Impacts – AGAAP to AEIFRS**

As a result of the implementation of AEIFRS no material changes have been identified to the financial statements that Professional Services Review is reporting under Australian Accounting Standards for 30 June 2005. Consequently, a table which reconciles the balances under Australian Accounting Standards to those that will be utilised under AEIFRS has not been provided as no differences exist.

**Note 3–Events Occurring after Reporting Date**

There are no events occurring after balance date that effect the 2005 financial statements.
### Note 4–Operating Revenues

#### Note 4A–Revenues from Government

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriations for outputs</td>
<td>7,772,000</td>
<td>7,598,000</td>
</tr>
<tr>
<td><strong>Total Revenues from Government</strong></td>
<td>7,772,000</td>
<td>7,598,000</td>
</tr>
</tbody>
</table>

#### Note 4B–Sales of goods and services

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Goods</td>
<td>2,309</td>
<td>2,531</td>
</tr>
<tr>
<td>Services</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td><strong>Total Sales of goods and services</strong></td>
<td>2,309</td>
<td>2,531</td>
</tr>
<tr>
<td>Provision of goods to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related entities</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>External entities</td>
<td>2,309</td>
<td>2,531</td>
</tr>
<tr>
<td><strong>Total sales of goods</strong></td>
<td>2,309</td>
<td>2,531</td>
</tr>
<tr>
<td>Costs of sales of goods</td>
<td>2,309</td>
<td>2,531</td>
</tr>
</tbody>
</table>

#### Note 4C–Revenue from sale of assets

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Infrastructure, plant and equipment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proceeds from disposal</td>
<td>18,571</td>
<td>–</td>
</tr>
<tr>
<td>Less: Net book value of assets disposed</td>
<td>17,272</td>
<td>–</td>
</tr>
<tr>
<td>Less: Write-offs of assets</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td><strong>Net gain/(loss) from disposal of infrastructure, plant and equipment</strong></td>
<td>1,299</td>
<td>–</td>
</tr>
<tr>
<td>Total revenue from sale of assets</td>
<td>18,571</td>
<td>–</td>
</tr>
<tr>
<td>Total value of assets disposed</td>
<td>17,272</td>
<td>–</td>
</tr>
<tr>
<td><strong>Total Net gain/(loss) from disposal of assets</strong></td>
<td>1,299</td>
<td>–</td>
</tr>
</tbody>
</table>
Note 4D–Other revenues

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Other revenue</td>
<td>15,132</td>
<td>-</td>
</tr>
<tr>
<td>Court costs recovered from persons under review</td>
<td>200,954</td>
<td>-</td>
</tr>
<tr>
<td>Resources received free of charge</td>
<td>7,250</td>
<td>6,200</td>
</tr>
<tr>
<td>Total Other revenues</td>
<td>223,336</td>
<td>6,200</td>
</tr>
</tbody>
</table>

Note 4E–Prior period prepayment adjustment

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior period prepayment adjustment</td>
<td>-</td>
<td>210,000</td>
</tr>
<tr>
<td>Total Prior period prepayment adjustment</td>
<td>-</td>
<td>210,000</td>
</tr>
</tbody>
</table>

During 2003–04 it was identified that in previous financial years Professional Services Review has understated prepaid expenses. In 2000–01 Professional Services Review expensed an amount of $420,000 that represented a prepayment to the Department of Health and Ageing for SAP maintenance for 6 years, to be expensed at $70,000 per year.

The result of this error has had an impact on each of the subsequent years accounts. In 2000–01 there was an overstatement of expenses and understatement of prepaid expenses to the extent of $350,000. Subsequent years expenses have been understated by $70,000 per year, with a corresponding understatement of prepaid expenses. The balance of the prepaid expense to be recognised at 30 June 2004 is $210,000.

Note 5–Operating Expenses

Note 5A–Employee expenses

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee benefits expense:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wages and Salaries</td>
<td>1,454,227</td>
<td>1,651,735</td>
</tr>
<tr>
<td>Superannuation</td>
<td>290,661</td>
<td>337,071</td>
</tr>
<tr>
<td>Leave and other entitlements</td>
<td>207,037</td>
<td>295,468</td>
</tr>
<tr>
<td>Separation and redundancies</td>
<td>392,848</td>
<td>-</td>
</tr>
<tr>
<td>Other employee expenses</td>
<td>343,635</td>
<td>80,721</td>
</tr>
<tr>
<td>Total Employee benefits expense</td>
<td>2,688,408</td>
<td>2,364,995</td>
</tr>
<tr>
<td>Worker compensation premiums</td>
<td>22,078</td>
<td>17,645</td>
</tr>
<tr>
<td>Total Employee expenses</td>
<td>2,710,486</td>
<td>2,382,640</td>
</tr>
</tbody>
</table>
### Note 5B–Suppliers expenses

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Goods from related entities</td>
<td>-</td>
<td>10,222</td>
</tr>
<tr>
<td>Goods from external entities</td>
<td>265,315</td>
<td>90,133</td>
</tr>
<tr>
<td>Services from related entities</td>
<td>539,448</td>
<td>1,251,014</td>
</tr>
<tr>
<td>Services from external entities</td>
<td>3,062,985</td>
<td>2,777,449</td>
</tr>
<tr>
<td>Operating lease rentals</td>
<td>286,240</td>
<td>236,577</td>
</tr>
<tr>
<td><strong>Total Suppliers expenses</strong></td>
<td><strong>4,153,988</strong></td>
<td><strong>4,365,395</strong></td>
</tr>
</tbody>
</table>

1 These comprise minimum lease payments only.

* During 2003–2004 an amount of $1,606 remained in a clearing account as at 30 June 2004. An erroneous journal was posted overstating suppliers expenses and GST receivable by $1,460 and $146 respectively and cash was understated by $1,606. Consequently, the comparative figures for cash, GST receivables and supplier expenses have been adjusted to reflect the correct balances.

### Note 5C–Depreciation and amortisation

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Depreciation:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leasehold improvements</td>
<td>90,115</td>
<td>32,503</td>
</tr>
<tr>
<td>Infrastructure, plant and equipment</td>
<td>81,202</td>
<td>76,541</td>
</tr>
<tr>
<td><strong>Total Depreciation</strong></td>
<td><strong>171,317</strong></td>
<td><strong>109,044</strong></td>
</tr>
<tr>
<td>Amortisation:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intangibles – computer software</td>
<td>90,548</td>
<td>71,594</td>
</tr>
<tr>
<td><strong>Total Amortisation</strong></td>
<td><strong>90,548</strong></td>
<td><strong>71,594</strong></td>
</tr>
</tbody>
</table>

The aggregate amounts of depreciation or amortisation expensed during the reporting period for each class of depreciable asset are as follows:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Leasehold improvements</td>
<td>90,115</td>
<td>32,503</td>
</tr>
<tr>
<td>Infrastructure, plant and equipment</td>
<td>81,202</td>
<td>76,541</td>
</tr>
<tr>
<td>Intangibles – computer software</td>
<td>90,548</td>
<td>71,594</td>
</tr>
<tr>
<td><strong>Total Depreciation and amortisation</strong></td>
<td><strong>261,865</strong></td>
<td><strong>180,638</strong></td>
</tr>
</tbody>
</table>

No depreciation or amortisation was allocated to the carrying amounts of other assets.
Note 5D–Write-down of assets

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-financial assets:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leasehold improvements – revaluation decrement</td>
<td>-</td>
<td>59,606</td>
</tr>
<tr>
<td>Infrastructure, plant &amp; equipment – revaluation decrement</td>
<td>33,714</td>
<td>22,013</td>
</tr>
<tr>
<td><strong>Total Write-down of non-financial assets</strong></td>
<td><strong>33,714</strong></td>
<td><strong>81,619</strong></td>
</tr>
<tr>
<td>Total Write-down of assets</td>
<td>33,714</td>
<td>81,619</td>
</tr>
</tbody>
</table>

Note 6–Financial Assets

Note 6A–Cash

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Departmental (other than special accounts)*</td>
<td>1,216,697</td>
<td>5,710,818</td>
</tr>
<tr>
<td><strong>Total Cash</strong></td>
<td>1,216,697</td>
<td>5,710,818</td>
</tr>
</tbody>
</table>

* During 2003-2004 an amount of $1,806 remained in a clearing account as at 30 June 2004. An erroneous journal was posted overstating suppliers expenses and GST receivable by $1,460 and $146 respectively and cash was understated by $1,606. Consequently, the comparative figures for cash, GST receivables and supplier expenses have been adjusted to reflect the correct balances.
### Note 6B—Receivables

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goods and services</strong></td>
<td></td>
<td>8,492</td>
</tr>
<tr>
<td><strong>Less: Provision for doubtful debts</strong></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>GST receivable from the Australian Taxation Office</strong> *</td>
<td>198,462</td>
<td>151,645</td>
</tr>
<tr>
<td><strong>Appropriations receivable:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- for additional outputs</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>- undrawn</td>
<td>5,045,000</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Receivables (Net)</strong></td>
<td>5,243,462</td>
<td>160,137</td>
</tr>
</tbody>
</table>

**Receivables is represented by:**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current</strong></td>
<td>5,243,462</td>
<td>160,137</td>
</tr>
<tr>
<td><strong>Non-current</strong></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Receivables (Net)</strong></td>
<td>5,243,462</td>
<td>160,137</td>
</tr>
</tbody>
</table>

All receivables are with entities external to the Commonwealth. Credit terms are net 30 days (2004: 30 days).

**Receivables (gross) are aged as follows:**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current</strong></td>
<td>5,243,462</td>
<td>160,137</td>
</tr>
<tr>
<td><strong>Overdue by:</strong></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Less than 30 days</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>30 to 60 days</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>61 to 90 days</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>More than 90 days</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total receivables (gross)</strong></td>
<td>5,243,462</td>
<td>160,137</td>
</tr>
</tbody>
</table>

**The provision for doubtful debts is aged as follows:**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current</strong></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Overdue by:</strong></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Less than 30 days</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>30 to 60 days</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>61 to 90 days</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>More than 90 days</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total provision for doubtful debts</strong></td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

*During 2003-2004 an amount of $1,606 remained in a clearing account as at 30 June 2004. An erroneous journal was posted overstating suppliers expenses and GST receivable by $1,460 and $146 respectively and cash was understated by $1,606. Consequently, the comparative figures for cash, GST receivables and supplier expenses have been adjusted to reflect the correct balances.
### Note 7–Non-Financial Assets

#### Note 7A–Land and buildings

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Leasehold improvements:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leasehold improvements at cost</td>
<td>423,404</td>
<td>-</td>
</tr>
<tr>
<td><strong>Less: Leasehold improvements at cost – accumulated depreciation</strong></td>
<td>(77,230)</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>346,174</td>
<td>-</td>
</tr>
<tr>
<td>Leasehold improvements at fair value (2003–04)</td>
<td>-</td>
<td>1,364</td>
</tr>
<tr>
<td><strong>Less: Leasehold improvements at fair value – accumulated depreciation (2003–04)</strong></td>
<td>-</td>
<td>(1,364)</td>
</tr>
<tr>
<td>Leasehold improvements at fair value (2002–03)</td>
<td>-</td>
<td>18,093</td>
</tr>
<tr>
<td><strong>Less: Leasehold improvements at fair value – accumulated depreciation (2002–03)</strong></td>
<td>-</td>
<td>(5,207)</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>12,886</td>
</tr>
<tr>
<td>Leasehold improvements at deprival value (2001–02)</td>
<td>-</td>
<td>220,056</td>
</tr>
<tr>
<td><strong>Less: Leasehold improvements at deprival value – accumulated depreciation (2001–02)</strong></td>
<td>-</td>
<td>(220,056)</td>
</tr>
<tr>
<td><strong>Total Leasehold improvements</strong></td>
<td>346,174</td>
<td>12,886</td>
</tr>
<tr>
<td><strong>Total Land and buildings</strong></td>
<td>346,174</td>
<td>12,886</td>
</tr>
</tbody>
</table>

All revaluations are independent and are conducted in accordance with the revaluation policy stated in Note 1. All valuations have been performed by the Australian Valuation Office.

No revaluation increments or decrements were made against Land and Buildings for 2005 (2004: $59,606 was expensed).
Note 7B–Infrastructure, plant and equipment

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Infrastructure, plant and equipment at cost</td>
<td>250,956</td>
<td>189,452</td>
</tr>
<tr>
<td>Infrastructure, plant and equipment at cost – accumulated depreciation</td>
<td>(34,620)</td>
<td>(17,730)</td>
</tr>
<tr>
<td></td>
<td>216,336</td>
<td>171,722</td>
</tr>
<tr>
<td>Infrastructure, plant and equipment at fair value (2004–05)</td>
<td>45,985</td>
<td>-</td>
</tr>
<tr>
<td>Less: Infrastructure, plant and equipment at fair value – accumulated depreciation (2004–05)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>45,985</td>
<td>-</td>
</tr>
<tr>
<td>Infrastructure, plant and equipment at fair value (2002-03)</td>
<td>-</td>
<td>36,495</td>
</tr>
<tr>
<td>Less: Infrastructure, plant and equipment at fair value – accumulated depreciation (2002-03)</td>
<td>-</td>
<td>(6,883)</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>29,612</td>
</tr>
<tr>
<td>Infrastructure, plant and equipment at deprival value (2001-02)</td>
<td>-</td>
<td>245,473</td>
</tr>
<tr>
<td>Less: Infrastructure, plant and equipment at deprival value – accumulated depreciation (2001-02)</td>
<td>-</td>
<td>(207,657)</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>37,816</td>
</tr>
<tr>
<td>Total Infrastructure, plant and equipment</td>
<td>262,321</td>
<td>239,150</td>
</tr>
</tbody>
</table>

All revaluations are independent and are conducted in accordance with the revaluation policy stated in Note 1. All valuations have been performed by the Australian Valuation Office.

A revaluation decrement of $7,492 was made against the asset revaluation reserve (2004: $0) and a decrement of $33,714 was expensed (2004: $22,013).

Note 7C–Intangibles

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Computer Software:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Computer Software at Cost</td>
<td>544,839</td>
<td>471,394</td>
</tr>
<tr>
<td>Computer Software at Cost–accumulated amortisation</td>
<td>(268,155)</td>
<td>(176,206)</td>
</tr>
<tr>
<td><strong>Total Computer Software</strong></td>
<td>276,684</td>
<td>295,188</td>
</tr>
<tr>
<td>Total Intangibles</td>
<td>276,684</td>
<td>295,188</td>
</tr>
</tbody>
</table>
### Note 7D—Analysis of Property, Plant and Equipment

#### A) Asset Movement Summary

<table>
<thead>
<tr>
<th>Item</th>
<th>Land $</th>
<th>Buildings—leasehold improvements $</th>
<th>Total land and buildings $</th>
<th>Total infrastructure, plant and equipment $</th>
<th>Computer software $</th>
<th>Other intangibles $</th>
<th>Total intangibles $</th>
<th>Total $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross value as at 1 July 2004</td>
<td>-</td>
<td>239,512</td>
<td>239,512</td>
<td>471,420</td>
<td>471,394</td>
<td>-</td>
<td>471,394</td>
<td>1,182,326</td>
</tr>
<tr>
<td>Accumulated Depreciation/Amortisation as at 1 July 2004</td>
<td>-</td>
<td>(226,626)</td>
<td>(226,626)</td>
<td>(232,270)</td>
<td>(176,206)</td>
<td>-</td>
<td>(176,206)</td>
<td>(635,102)</td>
</tr>
<tr>
<td>Net book value as at 1 July 2004</td>
<td>-</td>
<td>12,886</td>
<td>12,886</td>
<td>239,150</td>
<td>295,188</td>
<td>-</td>
<td>295,188</td>
<td>547,224</td>
</tr>
<tr>
<td>Additions:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchase of assets</td>
<td>-</td>
<td>423,404</td>
<td>423,404</td>
<td>181,797</td>
<td>53,097</td>
<td>-</td>
<td>53,097</td>
<td>658,298</td>
</tr>
<tr>
<td>From acquisition of operations (including restructuring)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net revaluation increment/decrement</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(41,205)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(41,205)</td>
</tr>
<tr>
<td>Depreciation/amortisation expense</td>
<td>-</td>
<td>(90,115)</td>
<td>(90,115)</td>
<td>(81,202)</td>
<td>(90,548)</td>
<td>-</td>
<td>(90,548)</td>
<td>(261,865)</td>
</tr>
<tr>
<td>Reclassifications</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(18,947)</td>
<td>18,947</td>
<td>-</td>
<td>18,947</td>
<td>-</td>
</tr>
<tr>
<td>Write-offs/downs</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Disposals:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>From disposal of operations</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other disposals</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(17,272)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(17,272)</td>
</tr>
<tr>
<td>Gross value as at 30 June 2005</td>
<td>-</td>
<td>423,404</td>
<td>423,404</td>
<td>399,467</td>
<td>544,839</td>
<td>-</td>
<td>544,839</td>
<td>1,367,710</td>
</tr>
<tr>
<td>Accumulated Depreciation/Amortisation as at 30 June 2005</td>
<td>-</td>
<td>(77,230)</td>
<td>(77,230)</td>
<td>(137,146)</td>
<td>(268,155)</td>
<td>-</td>
<td>(268,155)</td>
<td>(482,531)</td>
</tr>
</tbody>
</table>
### B) Land and buildings

<table>
<thead>
<tr>
<th>Item</th>
<th>Land $</th>
<th>Buildings - leasehold improvements $</th>
<th>Total land and buildings $</th>
<th>Total Infrastructure, plant and equipment $</th>
<th>Computer software $</th>
<th>Other intangibles $</th>
<th>Total intangibles $</th>
<th>Total $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross value as at 30 June 2005</td>
<td></td>
<td></td>
<td></td>
<td>45,985</td>
<td></td>
<td></td>
<td></td>
<td>45,985</td>
</tr>
<tr>
<td>Accumulated Depreciation/ Amortisation as at 30 June 2005</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net book value as at 30 June 2005</td>
<td></td>
<td></td>
<td></td>
<td>45,985</td>
<td></td>
<td></td>
<td></td>
<td>45,985</td>
</tr>
<tr>
<td>Gross value as at 1 July 2004</td>
<td></td>
<td></td>
<td></td>
<td>239,513</td>
<td></td>
<td></td>
<td></td>
<td>521,481</td>
</tr>
<tr>
<td>Accumulated Depreciation/ Amortisation as at 1 July 2004</td>
<td></td>
<td></td>
<td></td>
<td>(226,627)</td>
<td></td>
<td></td>
<td></td>
<td>(441,167)</td>
</tr>
<tr>
<td>Net book value as at 1 July 2004</td>
<td></td>
<td></td>
<td></td>
<td>12,886</td>
<td></td>
<td></td>
<td></td>
<td>80,314</td>
</tr>
</tbody>
</table>

### C) Assets under Construction

<table>
<thead>
<tr>
<th>Item</th>
<th>Land $</th>
<th>Buildings - leasehold improvements $</th>
<th>Total land and buildings $</th>
<th>Total Infrastructure, plant and equipment $</th>
<th>Computer software $</th>
<th>Other intangibles $</th>
<th>Total intangibles $</th>
<th>Total $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross value as at 30 June 2005</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross value as at 1 July 2004</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross value as at 1 July 2004</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Note 7E–Other non-financial assets

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepayments</td>
<td>19,028</td>
<td>651,629</td>
</tr>
<tr>
<td>Total Other non-financial assets</td>
<td>19,028</td>
<td>651,629</td>
</tr>
</tbody>
</table>

### Note 8–Provisions

#### Note 8A–Employee provisions

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and wages</td>
<td>27,649</td>
<td>43,049</td>
</tr>
<tr>
<td>Leave</td>
<td>402,411</td>
<td>666,953</td>
</tr>
<tr>
<td>Superannuation</td>
<td>942</td>
<td>73,535</td>
</tr>
<tr>
<td>Separations and redundancies</td>
<td>127,933</td>
<td>-</td>
</tr>
<tr>
<td>Other employee provisions</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total employee provisions</strong></td>
<td><strong>558,935</strong></td>
<td><strong>783,537</strong></td>
</tr>
<tr>
<td>Workers’ compensation</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total employee provisions and related on-costs</strong></td>
<td><strong>558,935</strong></td>
<td><strong>783,537</strong></td>
</tr>
<tr>
<td>Employee provisions are represented by:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current</td>
<td>407,821</td>
<td>230,141</td>
</tr>
<tr>
<td>Non-current</td>
<td>151,114</td>
<td>553,396</td>
</tr>
<tr>
<td><strong>Total employee provisions</strong></td>
<td><strong>558,935</strong></td>
<td><strong>783,537</strong></td>
</tr>
</tbody>
</table>

### Note 9–Payables

#### Note 9A–Suppliers payable

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trade creditors</td>
<td>119,330</td>
<td>429,878</td>
</tr>
<tr>
<td>Operating lease rentals</td>
<td>-</td>
<td>1,690</td>
</tr>
<tr>
<td><strong>Total Suppliers payable</strong></td>
<td><strong>119,330</strong></td>
<td><strong>431,568</strong></td>
</tr>
<tr>
<td>Suppliers payable are represented by:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current</td>
<td>119,330</td>
<td>431,568</td>
</tr>
<tr>
<td>Non-current</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total suppliers payable</strong></td>
<td><strong>119,330</strong></td>
<td><strong>431,568</strong></td>
</tr>
</tbody>
</table>

Settlement is usually made net 30 days.
**Note 10–Equity**

**Note 10A–Analysis of Equity**

<table>
<thead>
<tr>
<th>Item</th>
<th>Accumulated Results</th>
<th>Asset Revaluation Reserves</th>
<th>Contributed Equity</th>
<th>Total Equity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening balance as at 1 July</td>
<td>5,124,379</td>
<td>4,317,940</td>
<td>30,324</td>
<td>30,324</td>
</tr>
<tr>
<td>Net surplus/deficit</td>
<td>801,890</td>
<td>806,439</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net revaluation increment/(decrement)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transactions with owner:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distributions to owner:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Returns on capital</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Dividends</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Returns of capital</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Returns of contributed equity</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Contributions by owner:</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Appropriations (equity injections)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Restructuring</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfers to/(from)/between reserves</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Closing balance as at 30 June</td>
<td>5,926,269</td>
<td>5,124,379</td>
<td>22,832</td>
<td>30,324</td>
</tr>
</tbody>
</table>
### Note 11–Cash Flow Reconciliation

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Reconciliation of cash per Statement of Financial Position to Statement of Cash Flows</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash at year end per Statement of Cash Flows</td>
<td>1,216,697</td>
<td>5,710,818</td>
</tr>
<tr>
<td>Statement of Financial Position items comprising above cash:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>‘Financial Asset – Cash’ [Note 6A]</td>
<td>1,216,697</td>
<td>5,710,818</td>
</tr>
<tr>
<td>Reconciliation of net surplus to net cash from operating activities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net surplus (deficit)</td>
<td>838,890</td>
<td>806,439</td>
</tr>
<tr>
<td>Depreciation/amortisation</td>
<td>261,865</td>
<td>180,638</td>
</tr>
<tr>
<td>Net write down of non-financial assets</td>
<td>33,714</td>
<td>81,619</td>
</tr>
<tr>
<td>Gain on disposal of assets</td>
<td>(1,298)</td>
<td>-</td>
</tr>
<tr>
<td>(Increase)/decrease in net receivables</td>
<td>(83,325)</td>
<td>(8,742)</td>
</tr>
<tr>
<td>(Increase)/decrease in prepayments</td>
<td>632,601</td>
<td>697,287</td>
</tr>
<tr>
<td>Increase/(decrease) in employee provisions</td>
<td>(224,602)</td>
<td>23,095</td>
</tr>
<tr>
<td>Increase/(decrease) in supplier payables</td>
<td>(312,239)</td>
<td>25,350</td>
</tr>
<tr>
<td>Net cash from/(used by) operating activities</td>
<td>1,145,606</td>
<td>1,805,686</td>
</tr>
</tbody>
</table>

### Note 12–Contingent Liabilities and Assets

**Quantifiable Contingencies**

As at 30 June 2005, Professional Services Review has identified a single contingency in relation to the potential for Professional Services Review to make good at the end of the lease on the current office premises. Professional Services Review have estimated the cost of restoring the office premises to the original condition as $35,760.

**Unquantifiable Contingencies**

As at 30 June 2005, Professional Services Review has been awarded costs in a number of legal cases in respect to its successful investigations into inappropriate practice. The amounts owing are yet to be quantified by the Courts.

**Remote Contingencies**

As at 30 June 2005, Professional Services Review has no remote contingencies.
### Note 13–Executive Remuneration

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$160,001 to $170,000</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>$170,001 to $180,000</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>$180,001 to $190,000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>$190,001 to $200,000</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>$200,001 to $210,000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>$210,001 to $220,000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>$220,001 to $230,000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>$230,001 to $240,000</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total number of executives</strong></td>
<td><strong>2</strong></td>
<td><strong>2</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The aggregate amount of total remuneration of executives shown above.</td>
<td>370,472</td>
</tr>
<tr>
<td>The aggregate amount of separation and redundancy/termination benefit payments during the year to executives shown above.</td>
<td>-</td>
</tr>
</tbody>
</table>

### Note 14–Remuneration of Auditors

Financial statement audit services are provided free of charge to Professional Services Review by the Australian National Audit Office.

The fair value of the services provided was:

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7,250</td>
<td>6,200</td>
</tr>
</tbody>
</table>

No other services were provided by the Auditor-General.

### Note 15–Average Staffing Levels

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The average staffing levels for Professional Services Review during the year were:</td>
<td>27</td>
</tr>
</tbody>
</table>
### Note 16–Financial Instruments

#### Note 16A–Interest rate risk

<table>
<thead>
<tr>
<th>Financial Instrument</th>
<th>Notes</th>
<th>Non-Interest Bearing</th>
<th>Total</th>
<th>Weighted Average Effective Interest Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2005 $</td>
<td>2004 $</td>
<td>2005 $</td>
</tr>
<tr>
<td><strong>Financial Assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash</td>
<td>6A</td>
<td>1,216,697</td>
<td>5,709,212</td>
<td>1,216,697</td>
</tr>
<tr>
<td>Receivables for goods and services (gross)</td>
<td>6B</td>
<td>-</td>
<td>8,492</td>
<td>-</td>
</tr>
<tr>
<td>GST Receivable</td>
<td>6B</td>
<td>198,462</td>
<td>151,645</td>
<td>198,462</td>
</tr>
<tr>
<td>Appropriations receivable</td>
<td>6B</td>
<td>5,045,000</td>
<td>-</td>
<td>5,008,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>6,460,159</td>
<td>5,869,349</td>
<td>6,423,159</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>7,327,366</td>
<td>7,069,808</td>
<td></td>
</tr>
<tr>
<td><strong>Financial Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade creditors</td>
<td>9A</td>
<td>119,330</td>
<td>431,568</td>
<td>119,330</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>119,330</td>
<td>431,568</td>
<td>119,330</td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>678,265</td>
<td>1,215,105</td>
<td></td>
</tr>
<tr>
<td><strong>Liabilities Not Recognised</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Makegood provision</td>
<td>12</td>
<td>35,760</td>
<td>-</td>
<td>35,760</td>
</tr>
<tr>
<td>Other guarantee</td>
<td>12</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>35,760</td>
<td>-</td>
<td>35,760</td>
</tr>
<tr>
<td><strong>Total Liabilities not recognised</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Note 16B–Net fair value of financial assets and liabilities

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Total Carrying Amount $</td>
<td>Aggregate Net Fair Value $</td>
</tr>
<tr>
<td>Financial Assets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash</td>
<td>6A</td>
<td>1,216,697</td>
<td>1,216,697</td>
</tr>
<tr>
<td>Receivables for goods and services (net)</td>
<td>6B</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>GST receivable</td>
<td>6B</td>
<td>198,462</td>
<td>198,462</td>
</tr>
<tr>
<td>Appropriations receivable</td>
<td>6B</td>
<td>5,045,000</td>
<td>5,045,000</td>
</tr>
<tr>
<td>Total Financial Assets</td>
<td></td>
<td>6,460,159</td>
<td>6,460,159</td>
</tr>
<tr>
<td>Financial Liabilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade creditors</td>
<td>9A</td>
<td>119,330</td>
<td>119,330</td>
</tr>
<tr>
<td>Total Financial Liabilities</td>
<td></td>
<td>119,330</td>
<td>119,330</td>
</tr>
<tr>
<td>Liabilities Not Recognised</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Makegood provision</td>
<td>12</td>
<td>35,760</td>
<td>35,760</td>
</tr>
<tr>
<td>Other Guarantee</td>
<td>12</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Total Liabilities Not Recognised</td>
<td></td>
<td>35,760</td>
<td>35,760</td>
</tr>
</tbody>
</table>

The net fair values of cash and non-interest-bearing monetary financial assets approximate their carrying amounts.
The net fair values for trade creditors are approximated by their carrying amounts.

Note 16–Financial Instruments

Note 16C–Credit Risk Exposure

Professional Services Review's maximum exposures to credit risk at reporting date in relation to each class of recognised financial assets is the carrying amount of those assets as indicated in the Statement of Financial Performance.

Professional Service Review has no significant exposures to any concentrations of credit risk.

All figures for credit risk referred to do not take into account the value of any collateral or other security.
### Note 17–Appropriations

**Note 17A–Acquittal of authority to draw cash from the Consolidated Revenue Fund (CRF) from Act 1 and Act 3 (Appropriations)**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Year ended 30 June 2005</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance carried from previous year</td>
<td>5,825,577</td>
<td>4,236,968</td>
</tr>
<tr>
<td>Reductions of appropriations (prior years)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Adjusted Balance carried for previous period</td>
<td>5,825,577</td>
<td>4,236,968</td>
</tr>
<tr>
<td>Appropriation Act (No.1) 2004–2005</td>
<td>7,764,000</td>
<td>7,531,000</td>
</tr>
<tr>
<td>Appropriation Act (No.3) 2004–2005</td>
<td>8,000</td>
<td>67,000</td>
</tr>
<tr>
<td>Agency Adjustments by the Finance Minister (Appropriation Acts)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Comcover receipts (Appropriation Act s13)</td>
<td>3,771</td>
<td>-</td>
</tr>
<tr>
<td>Advance to the Finance Minister</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Adjustment of appropriations on change of entity function (FMA Act s32)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Refunds credited (FMA Act s30)</td>
<td>449,192</td>
<td>378,984</td>
</tr>
<tr>
<td>Appropriation reduced by section 9 determinations (current year)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sub-total 2004–05 Annual Appropriation</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Appropriations to take account of recoverable GST (FMAA s30A)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Annotations to ‘net appropriations’ (FMA Act s31)</td>
<td>240,445</td>
<td>2,664</td>
</tr>
<tr>
<td>Total appropriations available for payments</td>
<td>14,290,985</td>
<td>12,216,616</td>
</tr>
<tr>
<td>Cash payments made during the year (GST inclusive)</td>
<td>(7,830,826)</td>
<td>(6,390,893)</td>
</tr>
<tr>
<td>Appropriations credited to Special Accounts (excluding GST)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Balance of Authority to Draw Cash from the CRF for Ordinary Annual Services Appropriations</td>
<td>6,460,159</td>
<td>5,825,723</td>
</tr>
<tr>
<td>Represented by:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash</td>
<td>1,216,697</td>
<td>5,710,818</td>
</tr>
<tr>
<td>Receivable–appropriations</td>
<td>5,045,000</td>
<td>-</td>
</tr>
<tr>
<td>Receivables – GST receivable from the ATO</td>
<td>198,462</td>
<td>151,645</td>
</tr>
<tr>
<td>Payables – GST payable</td>
<td>-</td>
<td>(36,886)</td>
</tr>
<tr>
<td>Total</td>
<td>6,460,159</td>
<td>5,825,577</td>
</tr>
</tbody>
</table>
**Note 18–Specific Payment Disclosures**
Professional Services Review did not make “Act of Grace”, ex-gratia or any other payments that should be disclosed under this Note, or waiver amounts owing during 2004–05

**Note 19–Reporting of Outcomes**
Professional Services Review operates under only one outcome:
Access through Medicare to cost-effective medical services, medicines and acute health care for all Australians.

**Note 19A–Net Cost of Outcome Delivery**

<table>
<thead>
<tr>
<th>Outcome 1</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2005 $</td>
</tr>
<tr>
<td>Operating expenditure</td>
<td></td>
</tr>
<tr>
<td>Departmental expenses</td>
<td>7,177,326</td>
</tr>
<tr>
<td><strong>Total operating expenditure</strong></td>
<td></td>
</tr>
<tr>
<td>Costs recovered from provision of goods and services to the non-government sector</td>
<td></td>
</tr>
<tr>
<td>Departmental sales of goods and services</td>
<td>2,309</td>
</tr>
<tr>
<td><strong>Total costs recovered</strong></td>
<td>2,309</td>
</tr>
<tr>
<td>Other external revenues</td>
<td></td>
</tr>
<tr>
<td>Revenue from disposal of assets</td>
<td>18,571</td>
</tr>
<tr>
<td>Goods and services revenue from related entities</td>
<td>-</td>
</tr>
<tr>
<td>Other</td>
<td>223,336</td>
</tr>
<tr>
<td><strong>Total other external revenues</strong></td>
<td>241,907</td>
</tr>
<tr>
<td>Net cost/(contribution) of outcome</td>
<td></td>
</tr>
</tbody>
</table>

Outcome 1 is described in Note 1.1. Net costs shown include intra-government costs that are eliminated in calculating the actual Budget Outcome.
### Note 19B–Major Classes of Departmental Revenues and Expenses by Output Group

<table>
<thead>
<tr>
<th>Outcome 1</th>
<th>Output Group 1.1</th>
<th>Outcome 1 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2005 $</td>
<td>2004 $</td>
</tr>
<tr>
<td>Departmental expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employees</td>
<td>2,710,486</td>
<td>2,382,640</td>
</tr>
<tr>
<td>Suppliers</td>
<td>4,153,988</td>
<td>4,365,395</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>261,866</td>
<td>180,638</td>
</tr>
<tr>
<td>Other expenses</td>
<td>50,986</td>
<td>81,619</td>
</tr>
<tr>
<td><strong>Total Departmental expenses</strong></td>
<td>7,177,326</td>
<td>7,010,292</td>
</tr>
<tr>
<td>Funded by:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenues from Government</td>
<td>7,772,000</td>
<td>7,598,000</td>
</tr>
<tr>
<td>Sales of goods and services</td>
<td>2,309</td>
<td>2,531</td>
</tr>
<tr>
<td>Revenue from the sale of assets</td>
<td>18,571</td>
<td>-</td>
</tr>
<tr>
<td>Other revenues</td>
<td>223,336</td>
<td>216,200</td>
</tr>
<tr>
<td><strong>Total Departmental revenues</strong></td>
<td>8,016,216</td>
<td>7,816,731</td>
</tr>
</tbody>
</table>
Appendix 2: Freedom of information statement

Four requests for access to documents under provisions of the Freedom of Information Act 1982 were received during 2004–05. Three were completed and one request remains partly complete.

Contact officer

All freedom of information requests should be directed to:

The Executive Officer
Professional Services Review
PO Box 7152
Canberra Business Centre
Fyshwick ACT 2610

Documents

The types of documents PSR holds are:

- referrals, requests for review and related documents from the Commission pursuant to section 86 of the Health Insurance Act 1973 regarding the conduct of a person the Commission considers may have engaged in inappropriate practice in connection with rendering or initiating services
- reports of, and related documents regarding, reviews carried out by PSR
- lists of panel members to sit on committees
- reports of committees
- administrative files
- memorandum of understanding and other agreements
- finance and accounting records
- legal advices
- computer records
- consultancy reports and databases
- contracts
- minutes of various meetings
- 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:

Appendix 3: Legislative overview

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

The Act was substantially amended in 1999 following a comprehensive review of the scheme. An adverse decision by the Federal Court in November 2001 (Pradhan v Holmes & Others) raised concerns that the 1999 amendments to the Act may not have the effect intended. The Full Court of the Federal Court in May 2002 handed down a decision (Health Insurance Commission v Grey) that substantially agreed with the way PSR characterises its role. However, further amendment to the Act was needed to address the Federal Court's concerns.

The Health Insurance Amendment (Professional Services Review and Other Matters) Act 2002 was passed by Parliament in December 2002. The majority of the amendments came into effect on 1 January 2003 with the remainder on Royal Assent on 18 December 2002. This new Act makes a number of amendments to the existing Act, specifically to:

- clarify the roles and responsibilities of the Commission, the Director of PSR and PSR committees
- enhance procedural fairness processes
- validate a number of referrals (that may otherwise have been found to be invalid on the basis of Pradhan) which are currently before committees.

The Act was been developed in consultation with the Director of PSR, the Commission, the AMA and the Department of Health and Ageing.

The Director

The Minister for Health and Ageing, the Hon. Tony Abbott, appointed Dr Anthony David Webber Director of Professional Services Review from 14 February 2005 for a three-year period. Dr John Holmes was the inaugural Director from 1 July 1994 until Dr Webber's appointment.

At 30 June 2005, there were 154 members appointed by the Minister as panel members to serve on committees. Of these, 21 were also appointed as Deputy Directors of PSR to serve as chairpersons. The Minister appointed one new member during the year.

Background

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

The essential features of the review structure are:

- a Director of PSR, who is a medical practitioner, appointed ministerially and able to engage staff and consultants
- a PSR panel, comprising medical and other health related practitioners, who are appointed ministerially
- committees, comprising practitioners from the PSR panel appointed by the Director on a case-by-case basis to consider the conduct of practitioners referred by the Director for investigation
- a Determining Authority comprising a medical practitioner as Chair, a lay person and a member of the relevant profession. The Determining Authority's role is to decide on the sanctions for practitioners found by committees to have engaged in inappropriate practice and to consider whether to ratify agreements entered into by the Director and the person under review.
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 (that is, general practitioner, specialist or consultant physician) in which the practitioner was practicing when he or she rendered or initiated the services, or
- in the case of a dental practitioner, optometrist, chiropractor, physiotherapist or podiatrist—the conduct would be unacceptable to the general body of the members of the profession in which the practitioner was practicing 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 PSR scheme

The PSR scheme gives health professionals 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:

- review of a request from the Commission
- committee hearings and findings
- determination of any penalty.
Glossary
Glossary

**Act**  

**adjudicative referral**  
A case prepared by the Director, instituting a referral to a PSR committee, after an investigation of the concerns contained in an investigative referral. (From 1 January 2003 the Director makes a referral to a PSR committee to investigate concerns.)

**AMA**  
Australian Medical Association

**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 Health Insurance Commission

**deeming**  
A prescribed pattern of services under section 106KA of the Act that is deemed to be inappropriate practice

**Determining Authority**  
A three-person panel responsible for determining the sanction following an adverse PSR committee finding

**Determining Officer**  
An officer appointed by the Minister to determine an appropriate sanction to apply where a PSR committee finds a person under review has engaged in inappropriate practice, as defined in the Act

**Director**  
The Director of Professional Services Review is an independent statutory officer appointed by the Minister—the occupant must be a medical practitioner and the AMA must agree to the appointment

**disqualification**  
Exclusion (partial or complete) from eligibility for the practitioner’s services to attract Medicare benefits

**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)

**investigative referral**  
A case prepared by the Health Insurance Commission and referred to the Director, containing the Commission’s concerns and the reasons it considers a practitioner or other person may have engaged in inappropriate practice in the terms of section 82 of the Act. (From 1 January 2003, the Commission asks the Director to review the provision of services by a practitioner.)

**MBS**  
Medicare Benefits Schedule

**MPRC**  
Medicare Participation Review Committee
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minister</td>
<td>Minister for Health and Ageing</td>
</tr>
<tr>
<td>panel</td>
<td>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</td>
</tr>
<tr>
<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
</tr>
<tr>
<td>PSR</td>
<td>Professional Services Review</td>
</tr>
<tr>
<td>referral</td>
<td>A case prepared by the Director and referred to a PSR committee for investigation, detailing the concerns and the reasons a practitioner or other person may have engaged in 'inappropriate practice' in the terms of section 82 of the Act</td>
</tr>
<tr>
<td>request for review</td>
<td>A case prepared by the Commission asking the Director to review the provision of services and containing the Commission's concerns and the reasons it considers a practitioner or other person may have engaged in inappropriate practice in the terms of section 82 of the Act. (Applies from 1 January 2003)</td>
</tr>
<tr>
<td>80/20 rule</td>
<td>A prescribed pattern of services applying to practitioners providing 80 or more professional attendances on 20 or more days in a 12-month period</td>
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