

2007-08

Professional Services Review



REPORT TO THE PROFESSIONS

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DIRECTOR'S REPORT





Director's report

Professional Services Review's workload increased to 50 cases in 2007–08, compared to 27 cases in 2006–07. Medicare Australia's revised initial investigative processes have been responsible for this increase. Medicare Australia expects to ask PSR to investigate over 100 cases in 2008–09.

The increasing workload has necessitated continual scrutiny of our internal processes to ensure practitioners are reviewed expediently and fairly. I would like to record my thanks to my staff in Canberra and the practitioners on the PSR Panel around Australia for their willingness to respond to the increasing numbers of practitioners referred for investigation.

The mix of practitioners we have seen is changing. In 2007–08 and the first half of 2008–09 Medicare Australia asked PSR to investigate

five optometrists and 11 medical specialists. The optometrists have mainly been referred for excessive claims involving perimetry. The medical specialties involved include neurology, cardiology, gastroenterology, ophthalmology, sports medicine, plastic surgery and psychiatry.

Practitioners working in general practice continue to make up the majority of referrals. Many of these referrals have exhibited a number of common features. In particular, I am concerned by the number of practitioners referred for inappropriate prescribing of narcotic analgesics and benzodiazepine drugs. Doctors who prescribe up to five different benzodiazepine drugs in addition to narcotics for known illicit drug users are simply fuelling the growing black market for prescription drugs. This behaviour is anathema to accepted medical practice. Doctors found to prescribe these drugs recklessly have been referred to state medical boards for further action.

Antibiotic prescribing has also been highlighted in a number of referrals. General practitioners treating simple upper respiratory infections with either amoxicillin or amoxicillin with clavulanic acid have commonly been found to have practiced inappropriately. Practitioners are reminded that there are many readily available sources of information that detail evidence-based prescribing information. Practitioners should not base their prescribing decisions solely on the recommendations of drug company representatives.

Excessive pathology ordering continues to generate referrals to PSR. Doctors are reminded that extensive pathology or diagnostic imaging is not a substitute for obtaining a detailed history and making a physical examination. Practitioners who order investigations without clinical relevance will be found to have practiced inappropriately and will be required to repay the Medicare benefits for any unnecessary investigations.

There are still some practitioners who are reluctant to seek advice from their medical defence organisation early in a Medicare Australia investigation. I encourage any practitioner contacted by Medicare Australia to seek advice early, as timely resolution of Medicare Australia's concerns may prevent referral to PSR.

Poor clinical notes are a weakness in many of the medical records PSR reviewed. Increasing use of computers is to be encouraged in medical practice, however care must be exercised to ensure clinical notes are individualised. The same 'cut and paste' seen throughout a doctor's notes is not convincing evidence of appropriate clinical practice.

I would like to reassure the professions that a referral to PSR does not always result in a finding of inappropriate practice. Following a detailed

examination of clinical notes and meeting with a doctor I am able to dismiss about 15 per cent of practitioners sent for investigation.

However, it is clear from discussion that many doctors are unable to achieve an appropriate balance between their work and their private lives. Life is too short to neglect family and friends.



Tony Webber
Director





SECTION ONE



Agency overview



Agency overview

The PSR Scheme

The object of the PSR Scheme is to protect the integrity of the Medicare benefits and pharmaceutical benefits programs by:

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

The PSR Scheme was developed to provide an effective peer review mechanism to deal quickly and fairly with concerns about possible inappropriate practice.

A practitioner engages in inappropriate practice if his or her conduct, in connection with rendering or initiating services, is such that the conduct would be unacceptable to the general body of the group (that is, medical practitioner, dentist, optometrist, chiropractor, physiotherapist, osteopath or podiatrist) in which the practitioner was practising.

A person who is an officer of a body corporate engages in inappropriate practice if the person causes or permits an employee to engage in inappropriate practice.

Key players in the PSR Scheme are:

- The Director of PSR, who is a medical practitioner appointed by the Minister for Health and Ageing with the agreement of the Australian Medical Association (AMA). Dr Anthony Webber was appointed Director of PSR on 14 February 2005 for a three-year period. Dr Webber's appointment was extended for a further three-year term from 14 May 2008.
- The PSR Panel, comprising medical and other health care practitioners, who are appointed by the minister. At 30 June 2008, 165 members of the panel were available to serve on Committees. Of these, 21 were also appointed as Deputy Directors of PSR to serve as chairpersons of Committees.
- PSR Committees, comprising members of the PSR Panel, established by the Director on a case-by-case basis to consider the conduct of practitioners.

- The Determining Authority, comprising a medical practitioner as Chair, a layperson and a member of the relevant profession who are appointed by the minister. The Determining Authority's role is to decide on 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.
- Medicare Australia that makes requests to the Director of PSR to review the provision of services by practitioners.
- The Australian Government Department of Health and Ageing that has responsibility for legislation and policy relating to the PSR Scheme.

Medicare Australia requests to review

Medicare Australia asks the Director of PSR to review a practitioner's provision of services if it considers he or she may have provided those services inappropriately based on statistical data and other information.

Medicare Australia has access to claims data and any information elicited by a medical adviser during a visit to a practitioner or from a practitioner's written submissions. The reasons Medicare Australia seeks review of the provision of services generally fall within distinct categories, including:

- prescribed pattern of services
- high volume of services
- high number of services per patient
- high prescribing of Pharmaceutical Benefits Scheme (PBS) drugs
- inadequate clinical input
- Medicare Benefits Schedule (MBS) item not satisfied
- services not medically necessary.

Table 4 page 12 summarises the issues PSR has identified in requests to review this year.

Cases of possible fraud PSR identifies in the course of its investigations are referred back to Medicare Australia for action.

Professional Services Review's process

The Director undertakes a review of the data received from Medicare Australia and may also direct the practitioner to produce a sample of medical records. Following examination of the medical records, a report to the practitioner and consideration of any submission received from the practitioner, 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 and Medicare Australia informing them of the outcome of the review.

Agreement

The Director may enter into a negotiated agreement with the person under review. Both parties sign a document containing an acknowledgement by the practitioner that he or she has engaged in inappropriate practice.

It may also contain an agreement for repayment of Medicare benefits and partial or full disqualification from Medicare. The Determining Authority must ratify the agreement for it to have effect. While the name of the practitioner remains confidential, the details of the inappropriate practice are published.

Committee

Where the Director considers the conduct of the person under review needs further

investigation, a Committee is established. The Committee comprises members drawn from the panel appointed by the Minister for Health and Ageing. The Committee may conduct a hearing where the practitioner can provide both oral and written evidence in support of their case.

After considering all the evidence, the Committee produces a draft report containing findings on the practitioner's conduct. Where the Committee finds that the person under review has not practised inappropriately, the matter concludes. Where the findings are of inappropriate practice, the person under review is given time to make submissions on the draft report. After considering those further submissions a final report of any inappropriate practice is then forwarded to the person under review and the Determining Authority.

Determining Authority

The Determining Authority's role is to determine the sanctions to be applied in cases of inappropriate practice.

On receipt of a Committee's final report containing findings of 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 on the draft determination and issue a final determination containing sanctions.

The sanctions may include reprimand and counselling by the Director, repayment of Medicare benefits and partial or full disqualification from Medicare for a maximum of three years. When a final determination comes into effect the Director can publish certain details, including the practitioner's name and address, profession or specialty, nature of the inappropriate practice and sanctions imposed.

Medicare Participation Review Committees

When a practitioner has attracted two effective final determinations the Director must provide a written notice to the Chairperson of the Medicare Participation Review Committees. Such committees have a discretionary range of options available, from taking no further action to counselling and reprimand and full or partial disqualification from participation in the Medicare benefits arrangements for up to five years.

Federal Court

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

PSR's relationships

As well as ongoing working relationships with Medicare Australia and the Department of Health and Ageing, PSR fosters good relationships with its wider stakeholders, including the AMA, medical boards, the various Royal colleges and many other professional bodies and organisations.

Structure and organisation

The Director, Dr Tony Webber, is a statutory officer appointed by the Minister for Health and Ageing (with agreement from the AMA) to manage the PSR process. The Director reports to the Minister and his actions are governed by the *Health Insurance Act 1973*.

An Executive Officer, Ms Alison Leonard, reports to the Director and has a leadership role in achieving organisational objectives through overseeing management of operational and corporate matters, governance and policy advice.

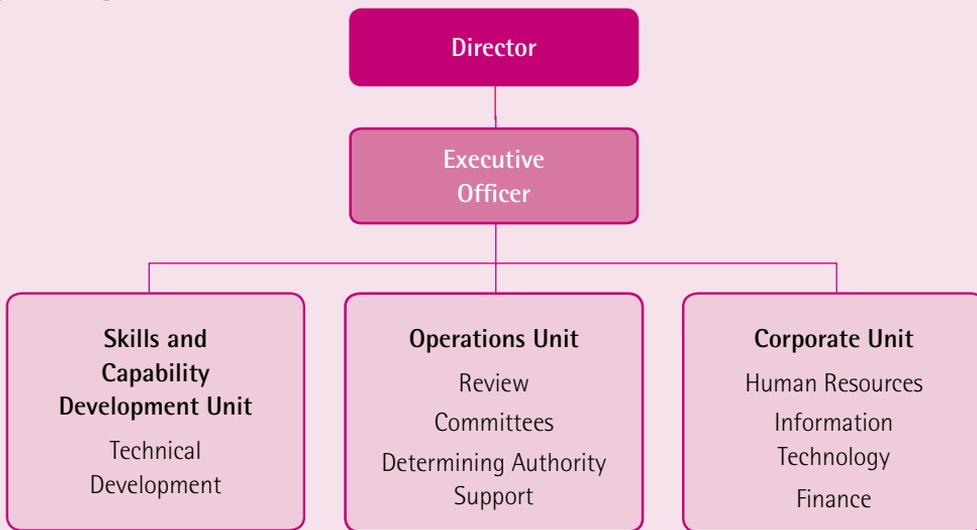
During the year PSR reviewed its organisational structure to reflect its growing workload and the expected impact of the 2006 Review of the PSR Scheme. The revised structure includes an Operations Unit with responsibility for managing all PSR's business processes, a Corporate Unit providing corporate services, and a Skills and Capability Development Unit providing technical development and training for operational staff and Deputy Directors, Panel members and members of the Determining Authority (see Figure 1).

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

Audit Committee

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

Figure 1: Organisation chart



Management Committee

The Management Committee, comprising the Director, the Executive Officer and the unit managers, meets monthly.

As PSR is a small agency, its Management Committee performs a range of roles that might be performed by specialist committees in larger organisations. The committee's agenda varies depending on current issues but regularly covers:

- business planning and monitoring
- corporate governance
- finances
- human resources
- internal audit and audit committee activities
- occupational health and safety
- operational issues
- stakeholder management.

Human resources

The increase in PSR's workload during 2007–08 and the change program resulting from PSR's review of its business processes and organisational structure gave rise to a range of human resource management challenges.

At 30 June 2008 PSR employed 25 staff – an increase of 40 per cent since 30 June 2007.

The Director of PSR is a holder of full-time public office whose remuneration and benefits are set by the Remuneration Tribunal each year.

As at 30 June 2008, 165 panel members, including 21 Deputy Directors, and nine members of the Determining Authority were holders of part-time public office (see Table 1). The Remuneration Tribunal sets the remuneration and benefits for panel members and Determining Authority members each year.

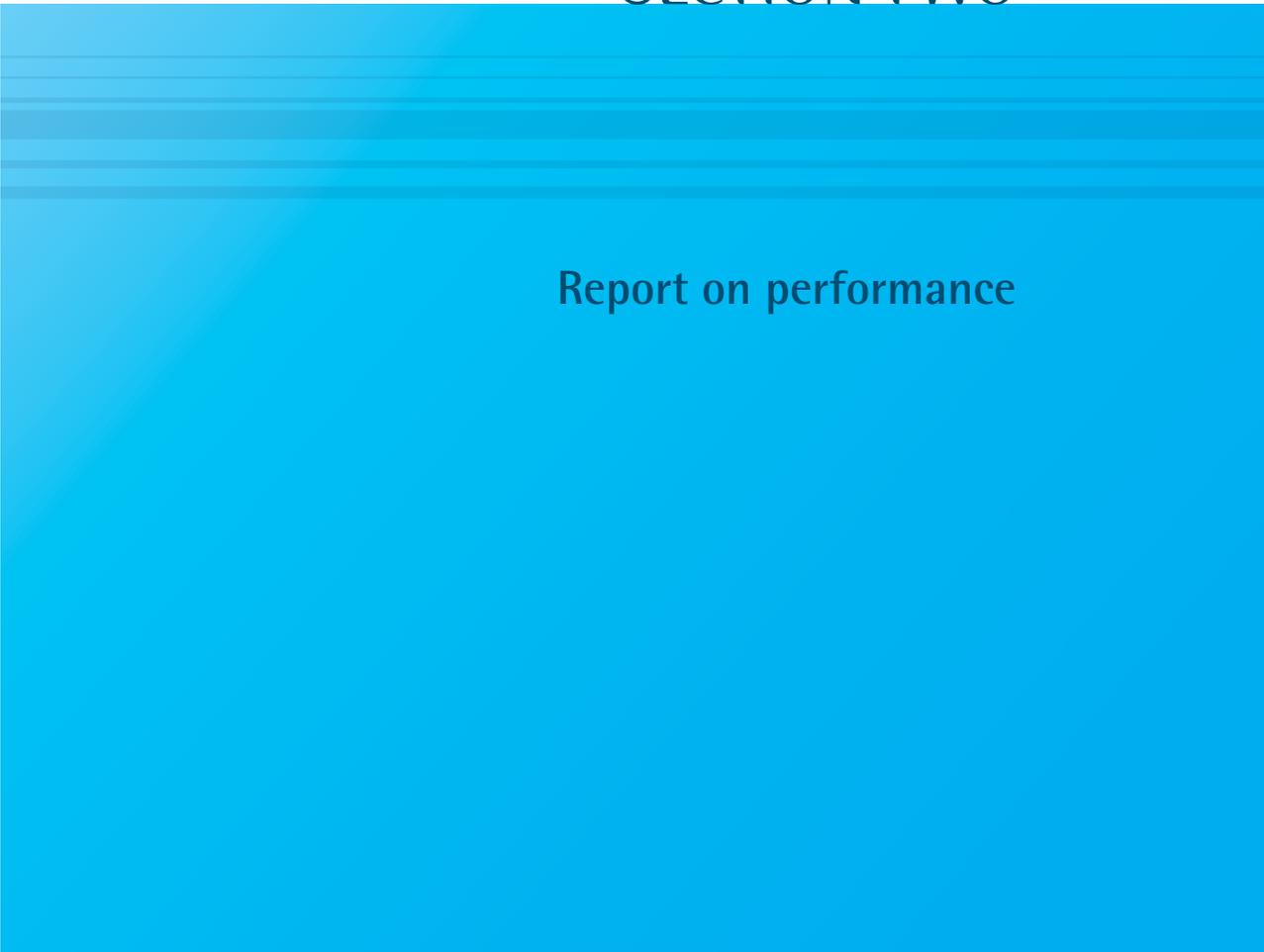
Panel members are appointed in locations across Australia to provide a broad pool of knowledge and experience to the peer review process.

Table 1: Panel members by location and gender, as at 30 June 2008

Location	Male	Female	Total
New South Wales	43	8	51
Victoria	30	6	36
Queensland	23	8	31
Western Australia	10	5	15
South Australia	14	3	17
Tasmania	7	2	9
Northern Territory	1	1	2
Australian Capital Territory	3	1	4
Total	131	34	165



SECTION TWO



Report on performance



Report on performance

Medicare Australia sent 50 requests for review to PSR this year (see Table 2). This represents a return to normal workload input for PSR.

As most of PSR's business processes take more than a year to conclude, workload data cannot be reconciled within a 12-month period. The following discussion of performance relates to activities undertaken during 2007–08.

Table 2: Requests received from Medicare Australia, 2002–03 to 2007–08

2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
52	38	9	7	27	50



Deputy Directors' conference, May 2008

Table 3: Workload statistics, 2005–06 to 2007–08

	2005–06	2006–07	2007–08
Requests received from Medicare Australia	7	27	50
– Requests by Medicare Australia to review a practitioner for a second or subsequent time	1	4	19
No further action	0	1	7
Requests withdrawn or lapsed	0	1	0
Referrals from the Director to new Committees	2	6	15
Committees in progress ^a	1	4	11
Committee reports finalised	6	13	7
– Reports finding inappropriate practice	6	8	7
– Reports finding no inappropriate practice	0	5	0
Referrals to medical boards	0	7	4
Referrals to MPRCs	1	0	6
Referrals to other bodies	0	0	1
Negotiated agreements ratified	8	6	27
Final determinations made	5	10	6
Cases on hand, as at 30 June ^b	5	18	19

Notes: a Established prior to 1 July 2007 and yet to report at 30 June 2008
 b Director's decision on no further action, negotiated agreement or referral to Committee yet to be made
 MPRCs = Medicare Participation Review Committees
 Workload data cannot be reconciled within a 12-month period

Issues identified

The issues identified in PSR cases this year generally related to:

- inappropriate use of MBS attendance items
- inappropriate use of diagnostic imaging or pathology

- inappropriate use of MBS procedural items
- inappropriate prescribing

More detail on these issues can be found in Table 4.

Case Study One

Inappropriate use of 'cut and paste' in computer medical records

Patient A

Presenting complaint: Headaches

Examination: Not clinically anaemic; not jaundiced; no spider naevi; no abnormal bruising; no thinning of skin.

Respiratory: No respiratory distress. No recession. Not using accessory muscles. No wheeze. Not peripherally cyanosed. Not centrally cyanosed. No finger clubbing. No nicotine stains. Normal air entry on Left. Normal air entry on Right. No creps. No rhonchi.

CNS: No Left upper Facial nerve palsy. No Right upper Facial nerve palsy. No Left lower Facial nerve palsy. No Right lower Facial nerve palsy. No Left ptosis. No Right ptosis. Normal Left corneal reflex. Normal Right corneal reflex. No nystagmus to Left. No nystagmus to Right. Normal Finger–Nose test on Left. Normal Finger–Nose test on Right. Normal Heel–Knee test on Left. Normal Heel–Knee test on Right. No dysdiadochokinesis on Left. No dysdiadochokinesis on Right. No Left foot drop. No Right foot drop. Normal gag reflex. Romberg's sign negative. No tremor. No cogwheel rigidity. No involuntary movements.

Reason for visit: Migraine

Management: Fluids, rest Panadol, warmth



Patient B

Presenting complaint: Index finger pain

Examination: Not clinically anaemic. Not centrally cyanosed. Not peripherally cyanosed. Not jaundiced. No finger clubbing. No spider naevi. No abnormal bruising. No thinning of skin.

CNS: No Left upper Facial nerve palsy. No Right upper Facial nerve palsy. No Left lower Facial nerve palsy. No Right lower Facial nerve palsy. No Left ptosis. No Right ptosis. Normal Left corneal reflex. Normal Right corneal reflex. No nystagmus to Left. No nystagmus to Right. Normal Finger–Nose test on Left. Normal Finger–Nose test on Right. Normal Heel–Knee test on Left. Normal Heel–Knee test on Right. No dysdiadochokinesis on Left. No dysdiadochokinesis on Right. No Left foot drop. No Right foot drop. Normal gag reflex. Romberg’s sign negative. No tremor. No cogwheel rigidity. No involuntary movements.

Diagnosis: Bruised right index finger

Management: rub heat, massage, physio, rest

These records were typical examples from this GP. It is beyond credibility that a patient presenting with a sore finger required a full neurological examination. The same examination results are recorded in many different consultations irrespective of the presenting complaint. This practice devalues all of this doctor’s medical records.

GP Management Plans also need to demonstrate an individual assessment of the needs of a particular patient. Carbon copy GP Management Plans for all diabetics in a practice, for example, may suggest that an inadequate level of clinical input has been put into these Management Plans.



Table 4: Issues identified in PSR cases, 2007–08

Inappropriate use of MBS attendance items	<ul style="list-style-type: none"> • Up-coding of consultation items • Inappropriate use of chronic disease management items • Inappropriate referrals to allied health providers using team care arrangement items
Inappropriate use of diagnostic imaging or pathology	<ul style="list-style-type: none"> • CT scans without clinical justification • Unnecessary repeated pathology testing, including frequent blood lipid levels • Unusual and expensive blood tests without clinical justification
Inappropriate use of MBS procedural items	<ul style="list-style-type: none"> • Up-coding of skin cancer removal items • Up-coding of laceration repair items • Excessive use of skin flap items when treating skin lesions • Inappropriate use of vascular diagnostic items • Up-coding of fracture items
Inappropriate prescribing	<ul style="list-style-type: none"> • Excessive prescription of lipid lowering drugs • Excessive prescription of narcotic and benzodiazepine drugs • Unnecessary use of antibiotics • Inappropriate choice of antibiotics • Prescription of anti-inflammatory and H2 blocking drugs against the PBS guidelines

No further action

The Director decided to take no further action in seven cases involving five GPs, one GP/general surgeon and one optometrist. These practitioners were from Victoria, New South Wales and Queensland. Descriptions of these cases are on pages 20–21, 25–28.

Negotiated agreements

The Determining Authority ratified 27 agreements between the Director and practitioners. The practitioners concerned were GPs and Vocationally Recognised General Practitioners (VRGPs: 22), medical practitioners (four) and one optometrist. They were from New South Wales (18), Tasmania (one), Queensland (five) and Victoria (three). Descriptions of these cases are on pages 28–35, 40–50.

Sanctions forming part of these agreements were that:

- 27 practitioners be reprimanded
- one practitioner be partially disqualified from Medicare for three years
- 24 practitioners be fully disqualified from Medicare for between two and 18 months
- 24 practitioners to make repayments of Medicare benefits from \$3500 to \$165,000; totalling \$1,130,793.

Committees

Seven Committees concluded their investigations and all made findings of inappropriate practice. The Committee findings related to five GPs and two medical practitioners, from Victoria (three), New South Wales (two) and Queensland (two).

The Director referred a further 15 new cases to Committees during the year.

Determining Authority

The Determining Authority made five draft determinations and six final determinations from findings in Committee reports. Federal Court action caused delay in issuing the final determination in one case.

During the year seven final determinations came into effect. The sanctions imposed by these effective final determinations were:

- reprimand and counselling in all cases
- three practitioners were fully disqualified from Medicare for between one and six months
- four practitioners were partially disqualified from Medicare for between three and 12 months
- six practitioners were required to repay Medicare benefits from \$32,082 to \$188,256; totalling \$530,011
- one practitioner's authority to dispense PBS pharmaceuticals was fully suspended for six months.

Referrals to medical boards and other bodies

The Act requires the Director to refer practitioners 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.

The Director referred four practitioners to the relevant state medical registration board because the Director, the Committee concerned or the Determining Authority formed the opinion that the practitioners had caused, were causing or were likely to cause a significant threat to the life or health of patients. The Director referred one further case to another body because of

concerns that the practitioner had failed to comply with professional standards.

Six cases were notified to the Chairperson of the Medicare Participation Review Committees because a second or subsequent final determination was made.

Re-referrals

In late 2006 Medicare Australia revised its procedures for managing concerns with practitioners who have previously been referred to PSR. The revised process means that in certain circumstances practitioners are not offered a further period of review before Medicare Australia decides to refer the case to PSR.

Implementation of this revised process saw an increase in the number of requests to PSR in 2007–08 for practitioners Medicare Australia had previously referred. The 19 cases concerned included 17 GPs and two other medical practitioners, who have collectively been referred to PSR 25 times. These cases had previously resulted in four decisions to take no further action, six negotiated agreements and 15 Committee findings of inappropriate practice. Sanctions included reprimand by the Director, repayment of Medicare benefits of between \$9000 and \$316,373, and full or partial disqualification from Medicare for from one month to one year.

The 19 cases received in 2007–08 have resulted in one decision to take no further action, seven negotiated agreements and six referrals to Committees. At 30 June 2008 five cases were still under review.

PSR is working with Medicare Australia to analyse the claiming behaviour of practitioners whose practice continues to cause concern after they have been through the PSR process.

Case Study Two

Inappropriate prescription of benzodiazepines and narcotics

Patient A

This record for a 40-year-old woman illustrates the inappropriate use of narcotics for tension headache in addition to long-term oxazepam use. There was no evidence this patient received any counselling for her drug usage, many of the entries only detailed a repeat supply of either narcotics or oxazepam.

Handwritten notes on lined paper:

- 10/2/08 Type depressed anxious → Gen addicted to cannabis
- do of headaches → treatment type - severe at times
- PP 17/12 Occipital area tender - C1 N10
- 26/3/08 Serenipin 30/1/12 (12) neck muscle tension type → Binaural
- 2/4/08 Hip hemostase free shoes 107
- 17/4/08 Rubae Sr (12) (12)
- 2/5/08 Serenipin (12) 13/1/08 Clonix tabs - Considered to cause smoking
- 13/6/08 PM Serenipin (12) (12)
- 30/7/08 PM Serenipin (12) (12)

Patient B

This patient, seen initially in 2006, was given narcotics for migraine; two years and many prescriptions later she was still being given narcotics and diazepam. There was no record of a more appropriate Management Plan. There was evidence in the notes of drug seeking behaviour, which the GP ignored or did not understand.

Wednesday September 13 2006 17:39:29

migraine headache for two days
no vomit BP and temp ok
hist of seizures so no tramal
try Oxynorm

Actions:

Prescriptions printed:
VALIUM TABLET 5mg 1 t.i.d. a.c.
Prescription added: OXYNORM CAPSULE 10mg 1 t.i.d. p.r.n.
Prescriptions printed:
OXYNORM CAPSULE 10mg 1 t.i.d. p.r.n.

Friday August 8 2008 14:08:27

migraine looks unwell

Actions:

Prescriptions printed:
OXYCONTIN SR TABLET 40mg 1 t.i.d. p.r.n. x10
Prescriptions printed:
VALIUM TABLET 5mg 1 b.d.

Patient C

This patient was given diazepam and paracetamol and codeine tablets on request, allegedly for headaches. Headache is a very common presentation in general practice and the management of some patients is a complex problem for the GP. Patients who present frequently requesting these drugs are either already dependant or at high risk of becoming so. It is incumbent upon the clinician to manage these patients to minimise an adverse outcome. The majority of practitioners regard merely dispensing drugs, which have a high potential for abuse, as both inappropriate and unprofessional. A doctor investigated by PSR practising in this manner will be referred to the appropriate state medical board for further action.

	Headaches.	Antenax or
29.9.05	—	Paralidone Forte Paralidone Forte (20) (Microtab)
10.10.05	—	Antenax 5mg. (Microtab)
1.11.05	—	Paralidone Forte (20); Antenax 5mg (50), 1-2D



External review of actions

In 2007–08 no matters were referred to the Administrative Appeals Tribunal.

Practitioners involved in the PSR process can seek judicial review in the Federal Court. In 2007–08 three decisions on PSR matters were in the Federal Court and five were in the Full

Federal Court. A further decision was made in the Federal Court on 4 July 2008. Currently, 15 cases involved in the constitutional challenge are in the High Court (see Table 5). Two new applications to Court were made during 2007–08 but both were discontinued by the applicants.

Court cases decided during the year are described on pages 59–68.

Table 5: Court actions, 2007–08

Court actions	No.
New court applications	2 ^a
Cases currently before the courts	
– Federal Court	–
– Full Federal Court	–
– High Court	15
Court decisions	
– Federal Court	4 ^b
– Full Federal Court	5
– High Court	0

Note: a Both were discontinued by the applicants
 b Includes *Saint v Holmes* [2008] FCA 987 (4 July 2008)

Case Study Three

Inappropriate choice of antibiotic for upper respiratory infections

Patient A

Consultation Not Coded

sore throat.
says has had on tonsill been remove.

afeb. red/inflamamed pharynx

a.pharyngitis

Script Written - Amoxil Capsules 500 mg

m/c 30/10

Patient B

Consultation Not Coded

sore throat 1/7

t.red/inflamed tonsillitis

chest clear

a.tonsillitis

Script Written - Amoxil Syrup Forte Sugar Free 250 mg/5 mL 100 mL

panadol a/d

Patient C

Consultation Not Coded

sore throat, feels has a lump in r.sided neck. very concernse.

red /inflamed pharynx. palpable cn.chest clear

pharyngitis

explanation.

Radiology Requested (MIA) - Ultrasound - Neck [palpable lump? r.sided neck; cervical gland?]

Script Written - Augmentin Duo Tablets

Patient D

Consultation Not Coded

bp 130/85

sore throat. blocked r.ear, red/inflmad pharynx. chest clear.

a.pharyngitis

Script Written - Augmentin Duo Tablets

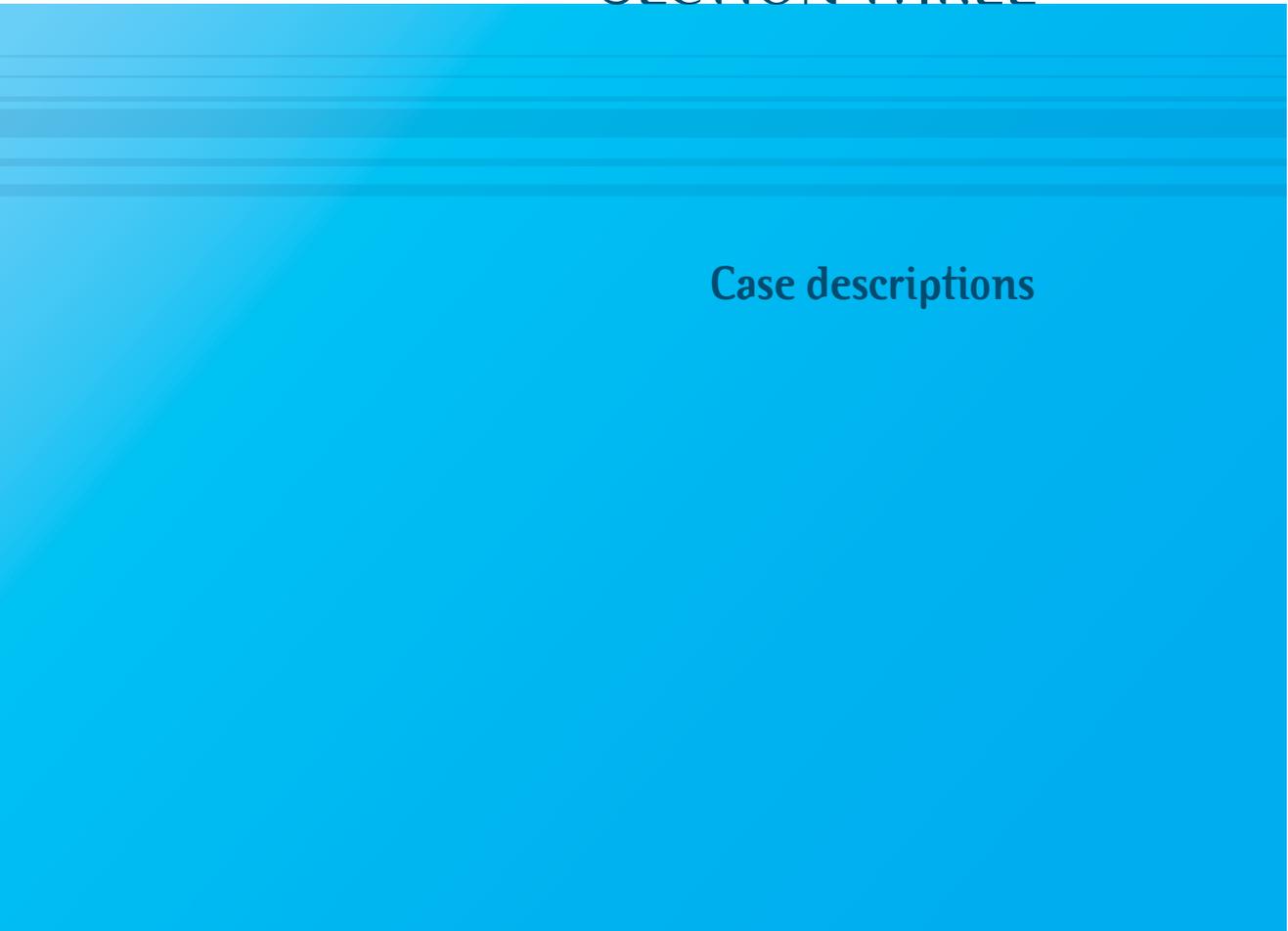
These four patient records illustrate the inappropriate use of amoxicillin and amoxicillin with clavulanic acid. The majority of pharyngitis presenting to GPs is viral, however bacterial infections are important to recognise and treat appropriately. *Streptococcus pyogenes* is the most likely causative organism and remains sensitive to penicillin. The Therapeutic Guidelines¹ recommend phenoxymethylpenicillin orally or roxithromycin for patients hypersensitive to penicillin. Amoxicillin alone or in combination with clavulanic acid offers no advantage, is associated with a greater risk of side effects and is a more expensive alternative.

1 eTG complete November 2008 update, Respiratory tract infections: pharyngitis and/or tonsillitis.





SECTION THREE



Case descriptions



Case descriptions

In seven instances during 2007–08 the Director decided to take no further action against a person Medicare Australia referred (section 91 of the *Health Insurance Act 1973*); he made an agreement with the person under review (section 92) on 27 occasions; and, pursuant to section 93, established seven PSR Committees to further investigate the person under review.

Decision to take no further action

Under section 91 of the *Health Insurance Act 1973* the Director may decide to take no further action in relation to a review if he is satisfied that:

- there are insufficient grounds on which a Committee could reasonably find that the person under review has engaged in inappropriate practice in providing services during the review period, or

- circumstances exist that would make a proper investigation by a Committee impossible.

Dr AA
General practitioner
Victoria

Medicare Australia was concerned that Dr AA may have been practicing inappropriately because of his high levels of prescribing, rendered services and daily services.

Medicare Australia's statistics showed that Dr AA was in the 99th percentile for rendered services, and in the 94th percentile for prescribing.

Based on the material Medicare Australia provided, the Director decided to review Dr AA's provision of MBS item 23, 36, 721¹ and 50124² services, and Dr AA's prescribing of diazepam, olanzapine and tramadol during the review period.

Upon reviewing Dr AA's records, the Director considered that his rendering of MBS items 23, 36, 721, 50124 and his prescribing of olanzapine

¹ MBS item 721 is a GP Management Plan

² MBS item 50124 is an intra-articular injection

were not inappropriate. The medical records were well documented and detailed. Dr AA's care plans were not inappropriate in the records examined. The Director initially had some concerns about Dr AA's prescribing of tramadol and diazepam, as there was little evidence in the medical records of management planning or consideration of drug interactions.

Dr AA provided an extensive written submission to the Director addressing the specific concerns. The Director also met with Dr AA as part of his review. Dr AA advised that he had a special interest in treating substance abuse patients, with over half of his patient base being drug and alcohol related. The Drugs and Poisons Unit of the Victorian Department of Health strongly supports Dr AA in this area of practice. Dr AA's strong involvement with the local community has extended to having helped set up the mobile integrated health service in the area.

It was the Director's opinion that Dr AA was a caring and competent doctor dealing with a demanding patient base. No further action was taken under section 91 of the *Health Insurance Act 1973*.

Dr AB
General practitioner
New South Wales

Dr AB was previously referred to PSR in 2001 as Medicare Australia had held concerns about his high volume of daily services and his rendering of MBS item 23, 36, 37,³ 44⁴ and 47⁵ services. No further action was taken, as a possibility existed that Medicare Australia's referral to PSR may have been invalid.

In June 2007 Medicare Australia held further concerns about Dr AB's rendering of services per patient and MBS item 11700,⁶ 11712⁷ and 11708⁸ services.

Dr AB was in the 95th percentile for services per patient, in the 98th percentile for MBS item 11700, and the 99th percentile for MBS items 11708 and 11712.

The Director decided to review Dr AB's provision of MBS item 23, 36, 37, 44, 11700 and 41764 services, and his prescribing of temazepam and nitrazepam during the review period.

From examination of the records, the Director considered that most services met the MBS requirements and he held no concerns about Dr AB's prescribing of temazepam and nitrazepam during the review period. The Director noted, however, that in some cases entries in the medical records were illegible due to Dr AB's poor handwriting.

Through discussions with Dr AB about Medicare Australia's concerns the Director learned that Dr AB regularly attends conferences to maintain his continuing education; has a very low referral rate to specialists – he has, for example, an interest in cardiovascular conditions and performs electrocardiograms (ECGs), Holter monitors and exercise stress tests, thereby reducing the need to refer patients to specialists for these investigations; deals with his patients' conditions in an in-depth manner; undertakes intensive investigations on behalf of patients; and provides follow-up care.

Although Dr AB's medical records were full and detailed, his poor handwriting made assessment of some consultation items difficult. At the meeting the Director gave Dr AB the opportunity to read from some patient records his recording of the consultation. It became clear that Dr AB had undertaken these services appropriately.

It was the Director's opinion that Dr AB was a competent doctor who needed to improve his handwriting. Dr AB was advised to improve

3 MBS item 37 is a level C home visit
4 MBS item 44 is a level D GP consultation
5 MBS item 47 is a level D home visit

6 MBS item 11700 is a 12-lead electrocardiograph and report
7 MBS item 11712 is multi channel ECG
8 MBS item 11708 is ECG recording

Reducing the harms from prescribing psychoactive drugs

The benzodiazepines were a great advance on the barbiturates which had previously been widely prescribed for sedation. There is no doubt that the barbiturates were much more likely to result in complications including the development of dependence, withdrawal seizures and fatal and non-fatal drug overdose. It took some time to work out that while the benzodiazepines were less harmful than the barbiturates, they were not innocuous. Benzodiazepines are commonly consumed by several groups in our community.

The elderly are the largest population of long term benzodiazepine consumers in our community where they are mainly prescribed for nocturnal sedation. Though the risk of harm per individual is relatively small in the short-term, with so many tens of thousands of elderly taking benzodiazepines for many years, problems resulting from benzodiazepine in the elderly are commonly seen. These include confusion, withdrawal seizures and drug dependence. Prevention involves only prescribing benzodiazepine to the elderly for nocturnal sedation for a few days at a time. Where patients are encountered who have been taking benzodiazepine for a long period, doctors should try to encourage these patients to slowly reduce the dose to zero over four to six weeks. Many patients will resist such attempts but it is worth persisting with repeated attempts to slowly wean these patients from their benzodiazepines.

Benzodiazepines are also often prescribed to middle aged patients with severe chronic medical conditions or mental health problems. These patients often take multiple other medications. Regular review of these patients should include attempting to reduce the number of medications by eliminating drugs which are no longer necessary. Again, doctors should try to encourage these patients to slowly reduce the dose of their benzodiazepines to zero over four to six weeks. Prevention involves trying to find non-pharmacological means of alleviating the patient's distress. If that is not achievable, only prescribe a short course of a low dose and avoid prescribing short-acting benzodiazepines.

Benzodiazepines are also often taken by younger poly drug users. Benzodiazepines which have rapid onset and a short half life are more likely to be attractive in this population and are also more likely to be associated with problems. Many patients who take illicit drugs also consume benzodiazepines. Those who also take benzodiazepines have a poorer prognosis and are more likely to experience problems. While attempts to reduce or even eliminate all benzodiazepine consumption in this population are understandable, doctors face a difficult judgment as some patients denied legal access to benzodiazepines will then obtain and consume benzodiazepines or more dangerous psychoactive drugs from the black market.

The advent of orally well-absorbed, sustained-release prescription opioids in Australia in the early 1990s was also a major advance. This allowed better treatment of malignant and chronic non-malignant pain by avoiding the sharp peaks and low troughs associated with short acting opioids which were often injected. The brief peaks were associated with euphoria and near complete analgesia while the troughs were associated with opioid withdrawal symptoms and a return of severe pain. These cycles increased the likelihood of drug-seeking behaviour and the

Reducing the harms from prescribing psychoactive drugs...cont'd

development of drug dependence. There is no case these days for commencing a patient with chronic non-malignant pain on frequent injections of morphine.

Consumption of oxycodone and morphine-based sustained-release prescription opioids in Australia has been increasing rapidly over the last decade and a half. While this has enabled the partial withdrawal of obsolete pethidine, the increasing prescribing of sustained-release prescription opioids does also cause some concern. Australia is close to consuming quantities of these drugs which were associated with major problems in the USA. Since the early 2000s, drug overdose deaths from sustained-release prescription opioids in the USA have exceeded deaths from heroin. Requests for treatment of heroin dependence have been declining in the last decade in the USA but requests for treatment of prescription opioid dependence have been increasing rapidly. In Australia, diversion of sustained-release prescription opioids to the black market has increased in the last decade since the commencement of a heroin shortage. This has been exacerbated by an increase in unmet demand for methadone and buprenorphine treatment for heroin dependence.

The markets for sustained-release prescription opioids for malignant pain, chronic non-malignant pain and heroin dependence overlap. Doctors prescribing sustained-release prescription opioids to patients with these conditions need to constantly weigh up the benefits and risks of prescribing. A cardinal rule in clinical pharmacology is that the correct dose of any medication is the smallest dose for the shortest period capable of achieving the desired clinical objectives. In some cases, it may turn out that the required dose is substantial and that this dose may be required for the indefinite future. But it may also turn out that pharmacological treatment is not required as non-pharmacological means can overcome the patient's problem. Treatment begins with a thorough assessment. A bio-psycho-social framework is far preferable to a more limited bio-medical approach. Many good guidelines for prescribing for chronic non-malignant pain are available on the internet.

Doctors should be mindful that the prescribing of psychoactive drugs is carefully regulated. Reckless prescribing carries a risk of detection, investigation and severe penalties. These penalties may possibly include withdrawal of prescribing rights or even the temporary or permanent loss of medical registration. The best protection from these risks is the practice of good medicine. This includes taking a proper history, conducting a thorough examination, keeping excellent records, making a diagnosis, considering differential diagnoses, seeking advice if uncertain and consulting or referring the patient to more experienced colleagues if the diagnosis or management is more difficult than expected. Long term prescribing of drugs of dependence to known drug dependent patients requires approval from state or territory departments of health. If such prescribing is carried out without official approval and is detected, severe sanctions may follow. Drug dependent patients can be referred to alcohol and drug treatment services. Doctors can readily obtain advice regarding the management of such patients from alcohol and drug treatment services. When faced with requests from patients

Consultant's Report

Reducing the harms from prescribing psychoactive drugs...cont'd

which make you feel uncomfortable, make sure that you try to help the patient. If you are not sure what to do, refer the patient to a nearby alcohol and drug treatment service.

*Dr. Alex Wodak
Director, Alcohol and Drug Service
St. Vincent's Hospital*

*Chair, Report on Prescription Opioids and Chronic Non-Malignant Pain
Royal Australasian College of Physicians*

NSW Health Pharmaceutical Services Branch.
Guidelines For The Management Of Patients With Chronic Non-Cancer Pain
http://www.health.nsw.gov.au/resources/publichealth/pharmaceutical/pdf/chronic_pain.pdf



his handwriting, as patient care could suffer if another practitioner needed to take care of his patients.

The Director considered that no further action was required and the matter was resolved under section 91 of the *Health Insurance Act 1973*.

Dr AC
General practitioner
New South Wales

Dr AC was previously referred to PSR in 2001 having infringed the 80/20 deeming rule. The Determining Authority made a final determination in relation to that matter. Dr AC was reprimanded by the Director, repaid the sum of \$58,839.50 in Medicare benefits and was disqualified for a period of four months.

Medicare Australia's new concerns related to Dr AC's rendered services – procedures and daily servicing. Dr AC was in the 78th percentile for rendered services and on or above the 97th percentile for rendered services – procedures.

The Director decided to examine a sample of medical records in relation to various MBS items including MBS item 23, 36, 5020, skin excision items and flap surgery services. The records examined raised no concerns; they were computer generated, well documented and met the MBS criteria.

In a meeting with the Director, Dr AC explained he worked for eight months of the year as a locum throughout Queensland and Western Australia and regularly attends conferences to maintain his continuing education. Dr AC advised that he would be cutting down on his current practice to pursue other interests. The Director considered Dr AC a well-trained and experienced general practitioner.

The Director decided to take no further action in relation to this matter and dismissed the case under section 91 of the *Health Insurance Act 1973*.

Dr AD
General practitioner
Victoria

Medicare Australia was concerned that Dr AD may have practiced inappropriately in relation to initiation of pathology, diagnostic imaging and prescribing under the PBS. Dr AD was in the 99th percentile for diagnostic imaging and pathology services and in the 91st percentile for prescribing.

The Director reviewed Dr AD's records to determine if inappropriate practice had occurred.

The Director considered records relating to MBS item 721, 723,⁹ 2710,¹⁰ 58100¹¹ and prescribing of lipid lowering drugs to be not inappropriate.

Most records relating to MBS item 23 and 36 services were considered to be not inappropriate although some records contained very limited clinical notes. In relation to MBS item 44 services, several records lacked sufficient evidence of adequate history and other clinical detail. Dr AD's initiation of pathology items, particularly B12, folate, thyroid function and iron studies, often lacked relevant clinical indications.

In a meeting with the Director, Dr AD, a solo practitioner, stated that he had trouble finding another practitioner to join him. Dr AD works 12 hours a day to keep up with patient demand. He explained that since the review, he had changed many aspects of his practice.

He stated that he improved his record keeping and made adjustments to his computer system. He was now more careful when ordering pathology and said he avoided a 'shotgun

⁹ MBS item 723 is team care arrangements
¹⁰ MBS item 2710 is a GP mental health plan

¹¹ MBS item 58100 is diagnostic imaging of the lumbosacral spine

approach! He further explained that he had started to implement enhanced primary care (EPC) items instead of using MBS item 44 services, and has employed a psychologist and another practitioner.

The Director considered that Dr AD was a caring conscientious doctor who would not cause concern in the future. The Director decided that the most appropriate action was to dismiss the case under section 91 of the *Health Insurance Act 1973*.

*Dr AE
General practitioner/General surgeon
Victoria*

Dr AE practiced in a rural area of need where he was the only general surgeon in the local district. He was also on call for the accident and emergency department at the local hospital.

Medicare Australia was concerned that Dr AE's rendered services, daily servicing, initiation of pathology, diagnostic imaging and prescribing under the PBS may have involved inappropriate practice. During the review period Dr AE provided 17,488 services to 6331 patients for total benefits of \$665,241.65. Dr AE was above the 99th percentile for total services rendered when compared to his peers.

The Director reviewed a large sample of Dr AE's medical records and considered there were no concerns about MBS item 23, 104,¹² 31325, 31270, 30061, 31200, 31255, 47369 services.¹³ The Director was concerned, however, that Dr E may not have met the MBS item descriptor for MBS item 1.¹⁴

According to Medicare statistics Dr AE performed complicated procedures (MBS items 32003¹⁵ and 31518¹⁶) only once during the review period. The Director and a surgical

consultant agreed that in performing a minimal number of these procedures, Dr AE might not have maintained the minimum level of competence required.

The Director met with Dr AE at his surgery to discuss Medicare Australia's concerns. Dr AE advised that he had worked in his current practice for 26 years and that he worked seven days a week starting at 5.30 am and finishing at 10.30 pm with no breaks. Dr AE said he had trouble turning patients away and had always worked long hours. Dr AE explained that he was called upon to do most operations in the hospital and, after nightly rounds, he attended patients in the accident and emergency department.

While visiting with Dr AE the Director was invited to speak to hospital staff about Dr AE's provision of MBS item 1 services. After these discussions and after consulting the Department of Health and Ageing the Director was satisfied that Dr AE had not engaged in inappropriate practice in providing MBS item 1 services during the review period.

Dr AE's practice manager provided the Director with a copy of the hospital audit report detailing the total operations Dr AE had performed over the past three months. The Director was satisfied that Dr AE was fully competent to perform the major surgery he provided during the review period. Many of the operations Dr AE performed were for public patients and had therefore not appeared on Medicare Australia's statistics. This circumstance had given the false impression that Dr AE did not undertake sufficient numbers of procedures to remain competent.

The Director considered that Dr AE was a hard working and competent practitioner, held in high esteem by his colleagues, staff and the local community.

12 MBS item 104 is a specialist consultation
13 MBS items 30061, 31325, 31270, 31200, 31255 and 47369 are minor surgical items

14 MBS item 1 is an emergency after hours attendance at a place other than consulting rooms

15 MBS item 32003 is for resection of the large intestine
16 MBS item 31518 is a total mastectomy

At a further meeting with the Director, Dr AE outlined his plans for his future retirement from Australian practice. The Director considered it appropriate to resolve this matter under section 91 of the *Health Insurance Act 1973* and took no further action.

Mr AF
Optometrist
New South Wales

Mr AF was identified as the 3rd highest user nationally of MBS item 10913¹⁷ for the period 1 October 2003 to 30 September 2004.

Mr AF was referred to PSR because Medicare Australia was concerned about his rendered services and daily servicing.

During the review period Mr AF rendered 1403 MBS item 10918¹⁸ services and more than 20 services per day on 65 days. Mr AF was at the 99th percentile for his total services and between the 98th and 99th percentile for total patients.

The Director engaged an optometrical adviser to assist him with this matter. Medical records relating to MBS item 10900,¹⁹ 10916²⁰ and 10918 were produced and examined; the clinical notes contained relevant and adequate information.

The optometrical adviser provided a written report to the Director. It was the adviser's opinion that a committee, if established, would not be able to make a finding of inappropriate practice in this matter.

Based on the information before him the Director resolved the matter under section 91 of the *Health Insurance Act 1973*.

Dr AG
General practitioner
Queensland

Dr AG was referred to PSR as Medicare Australia held concerns about his level C and level D²¹ consultations and his prescribing of drugs of dependence.

During the review period Dr AG provided 612 services to 173 patients for total benefits of \$41,352.70. Most services Dr AG provided were level C and D consultations, comprising 89 per cent of total surgery consultations.

The Director asked Dr AG to produce medical records relating to MBS item 36 and 44 services and the medical records of patients to whom Dr AG provided prescriptions for diazepam and temazepam.

Dr AG advised that he was longer practising and was preparing to sell his previous practice. He further advised that due to ill health he was unable to provide the medical records in the required timeframe. Dr AG was given numerous extensions of time to produce the medical records. Due to his non-compliance in producing medical records for examination, the Director advised Medicare Australia to cease all benefits payable for services Dr AG rendered.

During the review it became known that the Queensland Medical Board had suspended Dr AG from practice. The Director also received a letter

17 MBS item 10913 is a professional attendance of more than 15 minutes duration ... where the patient has new signs or symptoms

18 MBS item 10918 is a professional attendance being the second or subsequent in a course of attention

19 MBS item 10900 is a professional attendance of more than 15 minutes duration, being the first in a course of attention

20 MBS item 10916 is a professional attendance, being the first in a course of attention, of not more than 15 minutes duration

21 A **level C service** is defined as a 'professional attendance involving taking a detailed history, an examination of multiple systems, arranging and necessary investigations and implementing a management plan in relation to one or more problems and lasting at least 20 minutes'. A **level D service** is defined as a 'professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more complex problems, and lasting at least 40 minutes'.

from Dr AG's psychologist advising of his current medical condition.

Based on the evidence before him, namely confirmation that Dr AG is mentally incapacitated and is currently suspended from practice by the Queensland Medical Board, the Director was satisfied that it would be impossible for a committee to conduct a proper investigation into this matter.

As a result, the Director decided that, in accordance with section 91 of the *Health Insurance Act 1973*, no further action would be taken in this matter.

Agreement entered into between Director and person under review

Section 92 of the *Health Insurance Act 1973* refers to cases where the Director has made an agreement with the person under review.

Dr A Medical practitioner New South Wales

Dr A is a medical practitioner working exclusively in a skin cancer clinic. Dr A has a postgraduate in dermatology and undertakes annual training with the Skin Cancer Society. Dr A also has a Masters of Medicine.

Medicare Australia referred Dr A to PSR due to his level of EPC items, in particular MBS items 721 and 725²² and his itemisation of skin excision services. Medicare Australia's data suggested that Dr A was not managing chronic and complex medical conditions; therefore, he may have rendered EPC items that were not clinically relevant. Medicare Australia's data also showed that an unusually high proportion (84 per cent) of lesions Dr A had excised were itemised as over 10 mm in diameter, with as

many lesions of more than 20 mm as there were lesions less than 10 mm. Consequently, Dr A's medical records relating to skin excision items were examined.

Dr A's clinical notes suggested that the tumours were considerably smaller than those claimed, or the diagnosis did not meet MBS requirements. Even allowing for artifactual shrinkage the pathology indicated that the lesion was initially smaller than the item claimed would indicate.

The Director was also concerned that Dr A appeared to use skin flaps in inappropriate circumstances where wound closure could have been effected by direct closure.

Dr A's rendering of EPC items was also considered inappropriate. As Dr A worked exclusively in skin cancer medicine the management plans, as recorded, would not have added any value to the patients' care. These plans covered items that should have been provided in the framework of a normal consultation.

As part of the review the Director met with Dr A at his practice location. Dr A practises in a low socioeconomic area and bulk bills all patients.

Given Dr A's involvement with the local and surrounding communities' health services and his willingness to acknowledge his inappropriate practice, the Director decided to resolve this matter through a negotiated agreement. Dr A agreed to be reprimanded by the Director and to repay \$27,412 in Medicare benefits.

This case illustrates that waiting for the pathology report before billing the patient would resolve some of the issues. Dr A's inappropriate use of GP Management Plans should remind practitioners that conditions that could be easily managed in the course of normal general practice do not warrant a management plan.

²² MBS item 725 is a care plan review

Dr B

General practitioner

Rural/Remote New South Wales

Dr B is an overseas trained practitioner. After completing further studies in Australia Dr B was invited to participate in the Rural Recruitment Program in New South Wales. During the review period Dr B practised in a remote rural community in mid western New South Wales.

Dr B was referred to PSR as Medicare Australia was concerned that his rendering of level C and level D consultations and procedural items along with his initiation of pathology and his prescribing under the PBS might have constituted inappropriate practice.

During the review period Dr B rendered 464 level C and 414 level D consultations placing him at the 99th percentile for these services compared to all active vocationally registered general practitioners in Australia.

During the review period Dr B performed a wide variety and number of procedural services. Dr B's three most commonly initiated pathology investigations were iron studies, malignancy associated antigens and thyroid function tests.

Medicare Australia was also concerned with Dr B's prescribing of clopidogrel and lipid lowering drugs during the review period.

Dr B's clinical records were examined. No concerns were raised about his provision of MBS item 23 services or his prescribing under the PBS during the review period. It was found however that his medical records relating to level C and D consultations did not justify the MBS item claimed. Specifically, it appeared that patients presented with minor conditions that would not have required the 20 or 40 minutes recorded for these consultations.

Records were examined in relation to Dr B's provision of MBS item 721. No evidence could

be found in the records examined that a plan had either been initiated or recorded.

The Director examined records about procedural items and considered that Dr B had mis-itemised many of these services. Records examined relating to Dr B's initiation of iron studies and malignancy-associated antigens did not contain the clinical evidence to justify these types of investigations.

In his submission, Dr B advised that many of his patients presented with drug and alcohol problems, mental health issues, sexual and physical assault and domestic violence, and also chronic cardiac and respiratory conditions. These presentations are common in most rural and remote communities and do not excuse inappropriate practice.

Since the review period, Dr B had moved from New South Wales to practise in Victoria. Medicare Australia statistics showed that Dr B had made considerable changes to his practice profile.

Dr B acknowledged that he had engaged in inappropriate practice during the review period in his provision of MBS items 36, 44, 721 services and procedural items.

During a second interview Dr B was contrite and admitted his previous errors. Dr B had shown insight into his behaviour and current Medicare Australia statistics did show a more normal pattern of billing. In addition, Dr B was now working in a more supported practice with peers on hand at all times. He was aware that Medicare Australia would act upon any further transgressions promptly and that a second referral to PSR could result in disqualification for up to five years. A negotiated agreement was considered appropriate. Dr B agreed to be reprimanded by the Director, repay \$165,000 in Medicare benefits and to be disqualified from provision of MBS item 36 and 44 services for 12 months. The repayment was substantial and would act as a deterrent to a repeat referral.

Dr C
General practitioner
New South Wales

Medicare Australia referred Dr C because it was concerned about his daily servicing and initiation of pathology, which were above the 95th percentile during the review period.

Dr C's records were examined but his poor handwriting made interpretation difficult. Most contained incomplete health summary sheets, and those examined in relation to item 36 services were found to be brief and lacking in clinical detail. Clinical notes recorded only a limited history and in many cases examination results were not recorded.

During the review period Dr C rendered 166 ECGs. In half the records examined the notes did not clinically support the need for an ECG. Indeed, it appeared from one record examined that Dr C provided an ECG after the patient presented with abdominal pain and flatulence.

Examination of medical records relating to MBS pathology item 66596²³ services revealed a lack of clinical indications recorded in the patient notes to justify this type of investigation. The patient's presenting conditions would not have required this type of initial investigation.

A meeting with Dr C took place in which the review was discussed. Dr C displayed some insight into his behaviour during the review period, and since the Director's review he had taken steps to improve his practice. He had curbed his ordering of inappropriate pathology and was using computer software to record his notes. Since the review Dr C had increased his level A²⁴ consultations and decreased his rendering of level C consultations.

Dr C acknowledged the deficiencies in his practice during the review period and agreed he had practised inappropriately. The Director considered it appropriate to enter into a negotiated agreement to resolve this matter. Dr C agreed to be reprimanded by the Director and to repay \$27,000 in Medicare benefits.

Dr C's case highlights the importance of keeping up-to-date legible clinical notes, and the importance of ordering only clinically relevant pathology.

Dr D
General practitioner
Tasmania

Medicare Australia was concerned that Dr D's level C and level D consultations and his initiation of pathology may have been inappropriate. Medicare Australia first identified Dr D in 2003.

During the review period Dr D rendered:

- 1742 level B surgery consultations²⁵
- 1033 level C surgery consultations
- 144 level D surgery consultations.

During the review period Dr D initiated 3522 pathology services for 363 pathology patients equalling 9.70 pathology services per pathology patient.

Dr D's notes on level C and D consultations were difficult to read; they lacked sufficient evidence in relation to complexity levels, detailed history, examination of multiple systems and management planning. Notes examined relating to Dr D's ordering of iron studies contained no evidence to justify the investigation; indeed, many of these patients had had a recent normal full blood count.

²³ MBS item 66596 is an iron study

²⁴ A **level A service** is defined as a 'professional attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management'

²⁵ A **level B service** is defined as a 'professional attendance involving taking a selective history, examination of the patient with implementation of a management plan'

The Director met with Dr D to discuss the issues discovered in his medical records. Dr D acknowledged that his note taking was inadequate and agreed that his practice was driven by patient demand and that he had trouble controlling this aspect of his practice.

The Director acknowledged that Dr D was a hard working practitioner who kept up to date with his continuing medical education. However, it appeared that he did not allocate sufficient time to adequately record detailed notes.

The Director considered that the level of inappropriate practice could be satisfactorily addressed by a negotiated agreement. Dr D agreed to be reprimanded by the Director, repay \$40,000 in Medicare benefits and to be disqualified from providing MBS item 36 and 44 services for two months.

Dr E
General practitioner
Queensland

Medicare Australia referred Dr E for a variety of concerns including his provision of rendered services, services per patient, initiation of pathology, itemisation of skin lesion excisions, consultations in the after care period, and prescribing of lipid lowering drugs and drugs of potential dependence.

Medicare Australia's statistics showed that Dr E rendered 12,513 services to 2123 patients for total Medicare benefits of \$412,407.65. Dr E was above the 97th percentile for total services rendered when compared to his peers. Dr E initiated 6888 pathology services for 884 patients. Dr E was above the 97th percentile for skin excision items.

The drug Dr E most frequently prescribed during the review period was pravastatin sodium; he

was above the 99th percentile in issuing 491 prescriptions for this medication.

Dr E's medical records were examined. Records relating to MBS item 36 services lacked sufficient detail to justify the claim. Although the consultations did occasionally deal with more than one problem, conditions treated were often straightforward and should have been billed using a different MBS item.

The Director found insufficient evidence in the medical record to justify a claim for MBS item 30192.²⁶ It appeared from the notes that Dr E was claiming this item for removal of warts or removal of less than the required 10 or more lesions. The records dealing with excision of tumours suggested that even allowing for shrinkage the histopathology suggested that the tumours were considerably smaller than the MBS requirements.

The Director's review of Dr E's medical records revealed evidence of excessive pathology ordering, as the investigations initiated had no role in the diagnosis or management of patients' symptoms.

The records revealed that Dr E did not meet the PBS criteria for prescribing pravastatin. Dr E readily provided multiple prescriptions of temazepam and oxazepam but there was no evidence that patients had been advised of the drugs' habituating properties.

After a meeting with the Director where these concerns were discussed Dr E made a written submission. Dr E acknowledged that his medical records were lacking in clinical detail and he had begun to address this concern. Dr E's submission supported his claim that he was addressing the excessive initiation of pathologies that arose from his aggressive and proactive approach to the significant lifestyle problems his patients

26 MBS item 30192 is premalignant skin lesions, 10 or more lesions treated by non-surgical means

suffered. He further outlined the steps he would be implementing to address the Director's concerns.

Dr E is a solo practitioner who operates in a depressed area with patients from a low socioeconomic demographic who have few health care alternatives. Dr E welcomed the Director's review as an opportunity to reflect upon his manner of practice and gain insight into the matters that were of concern.

The Director considered that this matter could appropriately be resolved by a negotiated agreement. Dr E agreed to be reprimanded by the Director, repay \$60,000 in Medicare benefits and to be disqualified from providing MBS item 31210, 31215, 31285 and 30192 services²⁷ for 12 months.

Dr F
General practitioner
New South Wales

Dr F practised in a rural community during the review period. He has specialist training and holds fellowships with colleges of surgeons and physicians overseas. He has a special interest in cardiology and is involved in teaching medical students and overseas trained doctors.

Dr F was previously counselled under the PSR scheme in 1998 over the rate of services per patient and the proportion of level C and D consultations. He again came to Medicare Australia's attention in 2004 at which time they were concerned that Dr F's level of rendered and daily services and services per patient may have been inappropriate.

During the review period Dr F rendered 17,360 services to 2518 patients. Dr F claimed a total of \$692,298.61 in Medicare benefits in this

period. A sample of Dr F's medical records was examined and found to be generally detailed and well documented.

The Director noted, however, that a small number of skin excision records and records relating to removal of foreign bodies did not contain sufficient evidence to meet the MBS item descriptor.

At a meeting with the Director, Dr F readily conceded that he might not have fully complied with the MBS item number descriptor relating to a number of services he had provided during the review period.

Given the amount of inappropriate conduct found and Dr F's open acknowledgement of the deficiencies of some of his medical records, the Director decided it was appropriate to resolve the matter with a negotiated agreement. Dr F also indicated that he would soon be leaving general practice to take up a teaching role at a university.

Dr F agreed to be reprimanded by the Director, repay \$27,000 in Medicare benefits and be disqualified from providing MBS item 30067,²⁸ 31275 and 31277²⁹ services for 12 months.

Dr G
General practitioner
Victoria

Medicare Australia asked the Director to review Dr G's provision of MBS item 45200³⁰ and 14221³¹ services, and deep wound repairs. Medicare Australia was also concerned with Dr G's level of prescribing of drugs of dependence.

Dr G has been practising in Victoria as a solo practitioner for 32 years. During the review period Dr G provided 7143 services to 1641

27 MBS items 31210, 31215, 31285 and 30192 relate to excision of skin lesions

28 MBS item 30067 is removal of a foreign body in muscle, tendon or other deep tissue

29 MBS items 31275 and 31277 relate to removal of skin cancers

30 MBS item 45200 is for a skin flap repair of a defect in skin

31 MBS item 14221 is implanting a device for delivery of therapeutic agents

patients for a total Medicare benefit of \$252,065.60.

Medicare Australia statistics showed that Dr G provided MBS item 45200 on 23 occasions during the review period. Dr G considered this a receptionist clerical error as he had only performed this item twice.

The medical records Dr G provided for review consisted of a mixture of computer generated and handwritten notes. The Director raised no concerns about Dr G's documenting of MBS item 14221.

However, while it appeared that Dr G used his computer to record the prescriptions written, little or no other details of other consultations were recorded. Many patients appeared to have been prescribed large doses of Valium, often in conjunction with other benzodiazepines or other psychoactive drugs. The notes did not contain Dr G's rationale for prescribing such large doses of Valium to his patients. There was a lack of management planning and little evidence of counselling or active psychotherapy for patients receiving long-term benzodiazepines.

At the Director's review meeting Dr G acknowledged that his note taking was grossly inadequate. Dr G said he was unaware that the need to keep adequate and contemporaneous notes had been a requirement since 1999. Dr G said that having to produce his records for PSR allowed him to see how bad his note taking was. He has now taken the necessary steps to improve his record keeping.

In his submission to the Director, Dr G acknowledged that he had erred in his clinical judgement in prescribing Panadeine Forte® and tramadol. Dr G conceded that his peers might consider his prescribing under the PBS

inappropriate due to his poor record keeping. Dr G further outlined the steps he has taken to address the Director's concerns. He showed considerable insight into his behaviour during the review period and was remorseful.

The Director entered into a negotiated agreement with Dr G who agreed to be reprimanded by the Director and to repay \$65,000 in Medicare benefits.

*Dr H
Medical practitioner
Queensland*

Dr H works exclusively in a skin cancer clinic in Queensland. Medicare Australia referred Dr H because of concerns over his itemisation of skin flap and skin graft services, itemisation of skin excision services, cryotherapy and family servicing.

Medicare Australia's statistics showed that Dr H's itemisation of MBS item 30203 and itemisation of skin flap and skin graft services were above the 99th percentile. The proportion of benign to malignant excisions differed markedly from all active medical practitioners in Australia during the review period.

Dr H's medical records were reviewed to determine whether inappropriate practice had occurred. It was considered that the medical records examined in relation to Dr H's skin excision items would comply with the standard for an 'adequate record' as prescribed by regulation. The medical records examined for MBS items 53 and 54³² services lacked history and examination details. The patient summary sheet was an information questionnaire completed by the patient. The Director considered this summary sheet did not contain sufficient information to provide the patient's

32 MBS item 53 is a standard consultation lasting up to 25 minutes; item 54 is a long consultation lasting more than 25 minutes but less than 45 minutes

complete past, family or social history. There was no record of any follow-up on clinically significant responses to questions on this sheet.

The records were difficult to assess with respect to flap surgery and free grafting, as there was little detail about the site or size of the lesion. In addition, the family servicing notes were poorly documented. It appeared that Dr H would examine families with children as young as seven for skin cancer. This was considered inappropriate.

At a meeting with the Director, Dr H provided an example of photos taken during a patient's procedure. He also advised that he had stopped recording family history if he deemed it irrelevant to skin cancer. The Director advised that most peers would expect significant past/family history to be recorded whether it was relevant to skin cancer work or not.

In his submission to the Director, Dr H conceded the shortcomings in his recorded notes. PSR's review of his services had alerted him to the need to record in more detail the size and location of lesions, not only for adequate patient care, but to ensure his note keeping is of the highest standard. Dr H agreed that he had practiced inappropriately during the review period.

The Director considered this matter could be resolved by a negotiated agreement. Dr H agreed to be reprimanded by the Director, to repay \$51,850 in Medicare benefits and to be disqualified from MBS items 45200, 45203, 45206 and 45451³³ for six months.

Dr I

Other medical practitioner New South Wales

Dr I is a participant in MedicarePlus.³⁴ Medicare Australia was concerned that Dr I's

practice profile was at variance to his peers in relation to:

- level C and D surgery consultations
- rendered services – EPC items
- services per patient
- initiation of pathology
- prescribing under the PBS – lipid modifying agents.

Dr I's patient base of 825 was at the 19th percentile while his rendering of MBS item 36 services was at the 98th percentile when compared to his peers.

During the review period, 91 per cent of Dr I's patients received level C or D consultations; 612 patients (74 per cent of total patients) received an EPC service, but a specialist, physician or psychiatrist reviewed only 24 per cent.

Samples of Dr I's records were examined. The medical records were computer generated and most consultation items and prescribing were detailed and well documented. However, the medical records examined in relation to EPC services and mental health care plans lacked sufficient detail to justify implementing these plans. Many plans appeared to have been for relatively minor conditions and would not have contributed to improvements in the patient's health.

From the records examined, it appeared that Dr I may have initiated the same battery of tests for every patient; there seemed to be no individual discrimination in his pathology initiation.

The Director met with Dr I as part of his review.

Dr I is a solo practitioner and a significant proportion of his patients are either pensioners or health card holders. Dr I advised that his care

33 MBS items 45200, 45203, 45206 and 45451 are for skin flap repairs and skin grafting

34 Under the MedicarePlus Program, medical practitioners who are registered with the program are deemed to be general

practitioners for the purposes of the General Medical Services Table. As a result, a medical practitioner is entitled to render services ordinarily reserved for vocationally registered general practitioners (VRGPs) and attract higher benefits for their services.

plans are computer generated and he uses his local Division of General Practice format.

Since the review he has decreased the number of care plans he provides. Dr I stated that he sees many mentally ill patients and they all have chronic and complex conditions. He feels it necessary to implement a care plan to ensure these patients have access to the services they require.

In his written submission to the Director Dr I conceded that some of his consultations might not have been fully documented. Dr I agreed he had practised inappropriately with regard to his rendering of MBS item 721 and 2710 services and his initiation of pathology.

The Director considered that Dr I's inappropriate conduct could be satisfactorily addressed by a negotiated agreement. Dr I agreed to be reprimanded by the Director, repay \$25,000 in Medicare benefits and to be disqualified from providing MBS item 721 and 2710 services for three months.

Dr J
General practitioner
New South Wales

Medicare Australia requested a review of Dr J's provision of services due to concerns over his daily servicing, rendered MBS item 11506³⁵ and 11700 services and EPC services.

Dr J's patient numbers were in the 80th percentile and benefits were in the 99th percentile; he was in the 99th percentile for rendering item 11506 and in the 98th percentile for rendering item 11700. During the review period Dr J rendered twice as many EPC services as the previous year.

The medical records reviewed contained a number of inadequacies that raised concerns.

Records examined in relation to MBS item 2710 contained no evidence of an assessment of suicide risk being undertaken, and there was no evidence of an outcome tool used, as required by MBS. The Director considered approximately 40 per cent of MBS item 721 services were not medically necessary. Finally, there was no evidence of a meaningful review or changes to patient needs and goals in the records examined for item 725.

The records examined in relation to item 11506 contained no evidence as to the clinical relevance of this test being undertaken. The result of the tests did not appear to alter the treatment of any patient, nor add any benefit to the patients' care. The records examined in relation to MBS item 11700 contained little clinical justification for this test being performed.

The Director met with Dr J to discuss the review. Dr J is a solo practitioner with a special interest in mental health. He had been practising for 25 years and is the only practitioner in his area providing home visits. His patients were well known to him. He acknowledged that he had not included details in his written notes of his provision of cognitive behaviour or relaxation therapy.

Dr J stated, in a written submission to the Director, that he has begun a comprehensive review of his files to address deficiencies. Dr J further advised that as a result of the Director's review he would be liaising with his local Division of General Practice and the Royal Australian College of General Practitioners to ensure selection criteria and documentation requirements are always followed for GP management items. He also undertook to seek appropriate assistance to improve his documentation and record keeping.

³⁵ MBS item 11506 is measurement of respiratory function

Principles for the use of antibiotics in people if we want to maintain the best long term benefits

Summary of principles.

1. Antibiotics that are 'critically important' or 'last resort' in the treatment of serious human infections should not be used to treat infections, when other simpler and narrower spectrum antibiotics would be equally clinically effective.
2. Use of antibiotics for prophylactic purposes should be kept to a minimum. The use of methods (other than antibiotics eg vaccines) to prevent infection should be further expanded and developed.
3. Antibiotics should only be used where antibiotics are of more benefit than placebo and benefits are clinically significant.
4. Antibiotics should not be used for purposes other than to prevent or treat bacterial infections (eg not for anti-inflammatory purposes).

Antibiotic resistance is an ever-increasing problem. In some areas of the world the bacteria causing even common community onset infections (eg *E.coli*) can be resistant to almost all available antibiotics. In Australia we have lower resistance rates than most other countries, but we are still seeing a rise in resistance to many common bacteria including *Staphylococcus aureus* and *E.coli*.

Resistance is driven by the total amounts of antibiotics we use. The resistance rates are accelerated when we use broad-spectrum antibiotics rather than narrow spectrum agents. If we then also have poor hygiene, infection control etc, then these resistant bacteria can rapidly spread more widely.

Antibiotics that are 'critically important' or 'last resort' in the treatment of serious human infections should not be used to treat infections when other simpler and narrower spectrum antibiotics would have been equally clinically effective.

There are many serious infections in humans where there are few or no alternative antibiotics can be used and antibiotic resistance develops. They can therefore be classified as 'critically important'. Examples of such antibiotics include:

Class of antibiotic	Examples
glycopeptides	vancomycin, teicoplanin
3rd and 4th generation cephalosporins	cefotaxime, ceftriaxone, ceftazadime, cefpirome, cefepime
anti tuberculosis drugs	rifampicin, isoniazid, pyrazinamide
fluoroquinolones	ciprofloxacin, norfloxacin, moxifloxacin
carbapenems	imipenem, meropenem
some anti-staphylococcal antibiotics	rifampicin, fusidic acid, pristinamycin,

Principles for the use of antibiotics in people if we want to maintain the best long term benefits...cont'd

It is essential that these 'critical' or 'last line' antibiotics not be used if simpler agents would have been as efficacious. Examples of where these agents can commonly be overused or misused is the use of 3rd generation cephalosporins (such as ceftriaxone), to treat community acquired pneumonia where pneumococcus is likely to be the causative organism and where penicillin or ampicillin would be equally efficacious. Another example is the use of agents such as norfloxacin to treat urinary tract infections if simpler agents such as amoxicillin/clavulanate or oral 1st generation cephalosporin (eg cephalexin) would have eradicated the infection.

Most of these 'critically important' antibiotics are also broad spectrum. Therefore if resistance develops to these agents there will be little or no alternative therapeutic agents available.

In some cases even if bacteria are present antibiotic therapy is of little or no benefit. An example is bronchitis. Most cases are probably viral in aetiology but some can be associated with a pneumococcal infection. In most studies there has been no clear evidence that antibiotics have much clinical benefit compared to placebo (as measured by rate of patient improvement or decrease in temperature etc.). Antibiotics (either narrow or broad spectrum) should not be used for treatment unless there is clearly significant improvement that benefits the individual patient by the use of these antibiotics and preferably shown in appropriate clinical trials.

Use of antibiotics for prophylactic purposes should be kept to a minimum. The use of methods (other than antibiotics eg vaccines) to prevent infection should be further expanded and developed.

Some surgical operations are associated with a high risk of infection and prophylactic antibiotics have been shown to significantly decrease secondary infections, eg colorectal surgery. It is clear however that one or two doses of an antibiotic are as effective as long courses if they are given at the appropriate time (that is the first dose reaching peak concentration at the time of the first skin incision).

It is also well shown that changing improving surgical techniques (eg minimising tissue necrosis and tying off small bleeding vessels) is associated with lower infection rates.

Antibiotics should not be used as prophylactic agents to prevent bacterial infections unless there are clear studies that show there is a benefit (eg using antibiotics to try and prevent secondary bacterial sinusitis when a patient has a viral upper respiratory tract infection has not been shown to be of any benefit).

Many antibiotics are given to patients to treat infections where it is very likely that a virus is the causative organism. Antibiotics in this situation are likely to have little or no benefit, but promote side effects in the patient and in society as a whole (through the development of antibiotic resistant bacteria that spread from person to person). Antibiotics therefore should not be used unless there is a high likelihood of a bacterial infection being present and that it will improve with this therapy.

Principles for the use of antibiotics in people if we want to maintain the best long term benefits...cont'd

Matters of public hygiene, eg separating the water supply from faecal contamination, are of major benefit in preventing antibiotic resistant infections such as E.coli and salmonella. The introduction of an effective vaccine against Haemophilus influenzae (Hib) has almost eliminated these antibiotic resistant bacteria as a cause of major infections in children. In hospitals good infection control practices, as well as improved patient accommodation, decreases the chance of spread of resistant bacteria from patient-to-patient and therefore the need for subsequent antibiotics.

Antibiotics should not be used for purposes other than to prevent or treat bacterial infections (eg for anti-inflammatory purposes).

Acne, where appropriate, should be treated with topical agents or other therapies rather than long-term macrolides or tetracyclines (orally or topically).

Antibiotics should not be used for purposes other than to treat or prevent bacterial infections. Some antibiotics have in-vitro anti-inflammatory activities. Macrolides and tetracyclines are examples of this, and they have been used or proposed for use to treat inflammatory conditions. There have been suggestions that macrolides should be used for their anti-inflammatory properties in asthma. However, because antibiotic use is associated with the development of resistance in bacteria, antibiotics should not be used as anti-inflammatory or other properties. If these properties are shown to be of clinical benefit, research and development should occur to find or develop similar molecules that have this anti inflammatory property but do not have any antibacterial activity, and do not contribute to cross resistance to known bacteria.

Conclusion.

Antibiotic resistance is increasing in nearly every species of bacteria that causes infections in humans. This rate of resistance is occurring faster than we have new classes of antibiotics being developed. Antibiotics are unique among pharmaceutical agents in that they are non-renewable resources. In addition, if resistance develops in bacteria, not only is this problematic for the patient who took the antibiotic that may have induced or amplified this resistance, but also to those around them and the rest of society because these bacteria strains go from person to person and from country to country. There are increasing examples of bacteria causing serious infection for which we may have limited or in some cases no antibiotics to effectively treat threatening infections. Examples include vancomycin resistant enterococcus (VRE), vancomycin intermediate resistant Staph. aureus (VISA), multi resistant Pseudomonas aeruginosa, multi resistant Acinetobacter, multi resistant E.coli and multi resistant Mycobacterium tuberculosis. Even bacteria that until relatively recently was sensitive to many antibiotics can now be very difficult to treat in certain situations (eg penicillin resistant pneumococcus causing meningitis).

It is essential that we use the antibiotics that we have wisely, in particular use narrow spectrum antibiotics when they would give good clinical outcome to the patients with

Consultant's Report

Principles for the use of antibiotics in people if we want to maintain the best long term benefits...cont'd

bacterial infections. We must reserve 'critically important' or 'last line' antibiotics only for those conditions when there are little or few alternatives available.

Peter Collignon

Infectious Diseases Physician and Microbiologist

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Professor, School of Clinical Medicine, Australian National University.



It was the Director's opinion that the seriousness of the identified concerns was such that a negotiated agreement would be appropriate.

Dr J agreed to be reprimanded by the Director, repay \$16,800 in Medicare benefits, and be disqualified from items 11700 and 11506 for six months.

*Dr K
Medical practitioner
New South Wales*

Medicare Australia previously referred Dr K to PSR in 2000 over concerns about high volume of daily services and total high volume of rendered services. The outcome of that review was a negotiated agreement ratified by the Determining Authority in 2001.

Dr K was later registered for the MedicarePlus Program entitling him to render vocationally recognised general practitioner (VRGP) consultation items.

Dr K came to Medicare Australia's attention again in 2004 in relation to prescribing of Cox-2 inhibitor drugs. Medicare Australia asked PSR to review Dr K's provision of services in relation to chronic disease management services. During the review period Dr K rendered 227 item 721, an increase of 363.27 per cent from the previous year and 239 item 723, an increase of 670.97 per cent from the previous year.

Dr K's patient demographic revealed he now had a younger population base and his previously large elderly population of patients had declined.

Samples of Dr K's medical records were reviewed; they were difficult to read, contained no health summary sheets and contained limited clinical detail. Records examined relating to MBS item 36 noted simple presentations that would not have had the complexity required to meet the MBS criteria. The chronic disease

management services did not fulfil the item descriptors and in many cases were considered not medically necessary for the patient's care.

Records examined in relation to item 2710 contained no recorded evidence of a risk assessment or mental state exam.

The Director met with Dr K to discuss his review. Dr K indicated that he had misunderstood the MBS criteria in relation to some items. Dr K stated that an adviser of his local Division had told him that patients should have a care plan if they had a chronic condition without qualification. The Director discussed with Dr K the appropriateness of providing care plans.

Dr K agreed that he had practised inappropriately. He agreed to be reprimanded by the Director and to repay \$40,000 in Medicare benefits. Once the Determining Authority had ratified the agreement it became the second adverse finding for Dr K under the PSR Scheme. This mandated a referral to the Chairperson of the Medicare Participation Review Committees.

*Dr L
General practitioner
New South Wales*

Medicare Australia was concerned that Dr L may have practiced inappropriately because of his high level of total rendered services, daily servicing, services per patient and after hours consultations.

Medicare Australia's statistics indicated that Dr L was in the 97th percentile for total rendered services and after hours attendances and in the 98th percentile for services per patient.

Dr L's records were reviewed and it was found that only one record for MBS item 1 provided evidence that the consultation had taken place. There was no recorded evidence for 5023 home visit items. It was also found that the records for

items 23, 36, 44 and 5040³⁶ were brief, lacking in clinical detail, and the records did not justify long consultations.

At a meeting with the Director, Dr L said he had a very busy practice and, after five practitioners had retired from the practice, found it difficult to attract doctors to meet patient demand. Dr L believed he had to pick up the balance of work and acknowledged that he finds it hard to say 'no' to patients.

During the review period Dr L was working between two practice locations, undertaking home visits, nursing home visits and after hours consultations.

In a written submission to the Director, Dr L acknowledged that his record keeping did not always contain sufficient clinical information to satisfy the relevant MBS item descriptor for the service rendered and that he had begun to institute a system to improve his record keeping. Dr L understood and accepted the Director's criticisms and listed further changes to his practice he intended to make.

The Director decided that the most appropriate way to resolve the matter was through a negotiated agreement. Dr L agreed to be reprimanded by the Director, to repay \$160,000 of Medicare benefits and to be disqualified from items 36 to 51 (inclusive) for nine months.

Dr M
General practitioner
Queensland

Medicare Australia was concerned that Dr M may have been inappropriately prescribing drugs of dependence. Dr M's statistics indicated that his prescribing of benzodiazepine derivatives had increased when patient numbers had decreased.

The records examined in relation to Dr M's prescribing under the PBS indicated his reliance on drugs to treat symptoms. Dr M provided multiple prescriptions with no evidence that patients had been advised of the drugs' habituating properties and without apparent regard to the dangers of polypharmacy.

It appeared Dr M made little or no effort to reduce dosages of benzodiazepines or narcotics prescribed to his patients. His records revealed a lack of management planning, with little evidence of counselling for patients receiving long-term benzodiazepines and/or narcotics. The impression gained from the records was that Dr M might have allowed patients to dictate treatment.

In conjunction with the Director's review of the medical records a meeting was arranged with Dr M to discuss the Director's concerns. Dr M's clinic is in a low socioeconomic area.

After the meeting Dr M made a written submission to the Director in which he advised that he had taken the Director's comments very seriously and outlined the steps he had taken to reduce the number of patients he sees who are on Schedule 8 drugs. He had ceased prescribing Schedule 4 drugs to some patients and had weaned a number of patients off these drugs. Dr M acknowledged that he would benefit from further education with respect to prescribing drugs of potential dependence and outlined the educational sessions in his area he intended to undertake.

In view of Dr M's submission a further meeting was arranged. At this meeting Dr M acknowledged the need to change his practice management and to make changes to his current work style. At this meeting the Director agreed to delay making his final decision to enable Dr M time to re-educate

³⁶ MBS item 5040 is a level C attendance on a Sunday, public holiday or after 1 pm on a Saturday

himself with respect to prescribing drugs of potential dependence and to address practice management issues.

The Director obtained Dr M's current practice statistics from Medicare Australia.

These statistics showed a considerable decrease in the prescription of drugs of dependence. Dr M provided proof of the further education he had undertaken and advised that these courses had been beneficial to him and had improved his understanding of the rationale for prescribing narcotics.

Dr M stated that he had had time to reflect on his previous conduct and had made improvements to his practice management. He no longer runs a patient-driven practice and practises in a more responsible manner.

The Director was satisfied that Dr M had fulfilled the commitments detailed in his submission and considered the most appropriate action in resolving this matter was to enter into a negotiated agreement. Dr M agreed that he had practiced inappropriately during the review period in his prescribing under the PBS and was reprimanded by the Director.

Dr N *General practitioner* *Victoria*

Medicare Australia referred Dr N because of concerns that his prescribing under the PBS, in particular drugs of dependence may have been inappropriate.

Dr N, an elderly general practitioner, had been before PSR for similar concerns in 2003. That matter was resolved by a negotiated agreement that was ratified by the Determining Authority in 2004.

Dr N was in the 83rd percentile for prescribing drugs of dependence. Most of his patients were

drug dependent, had chronic pain and were involved with multiple substance abuses.

From Dr N's records it was apparent that he did not monitor the quantities of prescriptions or try to reduce the dosages of benzodiazepines. There was no evidence of a physical examination taking place before prescribing of the drugs, nor were there any warnings about the addictive nature of the drugs being prescribed. In addition Dr N prescribed a large number of many different medications to his patients without regard to the dangers of polypharmacy. Dr N's behaviour was clearly not acceptable and it became apparent that Dr N might have submitted to patient demand for drugs.

In the meeting with Dr N, he stated that many patients were referred to him with existing substance abuse problems and were referred with multiple prescriptions for drugs of dependence. He explained that he experienced pressure from patients to prescribe the drugs in question. The Director advised that he considered Dr N's conduct unacceptable and inappropriate.

Given the level of inappropriate conduct, the associated costs of establishing a committee, and the public interest in resolving this matter quickly, the Director entered into a negotiated agreement with Dr N. This agreement effectively retired Dr N from practice.

Dr N agreed to be reprimanded by the Director, his Part V11 authority to be suspended for three years and to be fully disqualified from provision of all MBS services for three years. As this agreement was Dr N's second adverse finding under the PSR Scheme this action mandated referral to the Chairperson of the Medicare Participation Review Committees.

Given that Dr N's prescribing had caused or was likely to cause a significant threat to the life or health of his patients, the Director referred him

to the Medical Board of Victoria. The Medical Board advised that Dr N had entered into an agreement with them not to engage in any form of medical practice including but not limited to remunerated or unremunerated consultations or procedures, writing prescriptions and referrals and signing documents requiring the exercise of knowledge and skills of a medical practitioner.

Dr O
General practitioner
Queensland

Dr O had previously been referred to PSR in 1996. The Determining Authority made a final determination in 1997. Dr O again came to Medicare Australia's attention in August 2006.

Medicare Australia asked PSR to undertake a review of Dr O's provision of services, in particular skin excision items, family servicing and prescribing of antibiotics and Cox-2 inhibitors. Medicare Australia's statistics indicated that Dr O was in the 99th percentile for rendered services and he was in the 89th percentile for PBS prescribing.

Dr O's records were reviewed to determine if inappropriate practice had occurred. Most of Dr O's medical records did not raise concerns; however, the records for MBS item 36 services were found to be brief and lacking in clinical detail. Notes recorded simple presentation with no complex history or examination. The recorded notes did not support the consultation lasting more than 20 minutes.

The Director met with Dr O to discuss the review. Dr O noted that he had an increase in patient demand because other practices in the area had stopped bulk billing. Since the review, Dr O stated that he applied the criteria for an MBS item 36 service and improved his record keeping.

Dr O acknowledged that he had practiced inappropriately in relation to MBS item 36

services during the review period. He agreed to be reprimanded by the Director, to repay \$20,000 in Medicare benefits and to be disqualified from provision of MBS item 36 services for three months.

As this was Dr O's second adverse finding under the PSR Scheme this action mandated a referral to the Chairperson of the Medicare Participation Review Committees.

Dr P
General practitioner
New South Wales

Medicare Australia's concerns about Dr P were his initiation of pathology, daily servicing and rendered services, services per patient, family servicing and prescribing of Cox-2 inhibiting drugs. Medicare Australia's statistics indicated that Dr P was in the 95th percentile for total pathology services and in the 97th percentile for rendered services. In addition, he was in the 92nd percentile for services per patient and in the 91st percentile for prescribing under the PBS.

Samples of Dr P's medical records were produced for the Director's examination but poor handwriting made them difficult to assess. The clinical notes in relation to MBS item 23, 36 and 5020³⁷ services were brief, at times consisting of only single line, or two word entries with minimal or no history or details of findings on examination. There was no recording of allergies, family history or current medication. For item 11712, the Director found that 20 per cent of the records did not contain sufficient clinical information to justify this type of investigation; as well, 90 per cent of Dr P's GP Management Plans did not satisfy the item descriptor or were considered not medically necessary for the care of the patient.

Dr P's prescribing of meloxicam did not satisfy the item descriptor in 60 per cent of records.

³⁷ MBS item 5020 is a professional attendance on a Sunday, public holiday or after 1 pm on a Saturday

PBS criteria restrict the use of meloxicam to treatment of osteoarthritis; Dr P had used it for acute soft tissue injury. In many cases, pathology tests Dr P ordered did not appear to be clinically relevant.

Dr P stated in his meeting with the Director that since the review period he had moved to a new practice. As a result, his workload was greatly reduced and he was using computerised notes and taking better notes.

Dr P agreed to be reprimanded by the Director, to repay \$90,000 in Medicare benefits and to be disqualified from provision of MBS item 721, 723 and 5020 services for three months.

*Ms Q
Optometrist
New South Wales*

Medicare Australia's concerns over Ms Q were with regard to rendered servicing – item 10916 and daily servicing. Medicare Australia's statistics showed that Ms Q was in the 99th percentile for total patients, total services and for item 10916. From information contained in Medicare Australia's request it became apparent that Ms Q did not provide routine slit lamp examinations.

The Director and an optometrical adviser met with Ms Q to discuss Medicare Australia's request before deciding to seek clinical records for examination.

At the meeting Ms Q advised that she works seven days a week in two different practices. The optometrical adviser raised concerns that Ms Q does not routinely perform a slit lamp examination, saying that Ms Q would find herself at variance with her peers, as they would consider it inappropriate not to perform this test.

Furthermore, it was concluded that the number of patients Ms Q was servicing might make it difficult for her to provide adequate care to all

her patients. Ms Q encouraged her patients to be reviewed every year; this would also be out of step with most optometrists, as it is common practice to have an examination every two years.

At the meeting Ms Q acknowledged that her conduct during the review period was inappropriate and indicated she would like to resolve this matter by way of a negotiated agreement. The Director considered this matter could be resolved expeditiously by entering into a negotiated agreement. Ms Q agreed to be reprimanded by the Director and to repay \$40,000 in Medicare benefits.

*Dr R
General practitioner
New South Wales*

PSR reviewed Dr R's behaviour, as Medicare Australia was concerned with his prescribing of benzodiazepines; he was in the 97th percentile.

Dr R produced samples of his medical records for review. The records examined in relation to MBS item 36 services were found to be brief and lacking in clinical detail. The notes lacked sufficient evidence about complexity levels, detailed history, examination of multiple systems and management planning to justify the item claimed. Notes recorded simple presentation and did not support the consultation lasting more than 20 minutes.

Dr R's prescribing of diazepam was considered inappropriate. The Director held concerns about the other addictive medications also being prescribed to some patients. There appeared to be a lack of management planning, with little evidence of counselling recorded in the notes for patients receiving long-term benzodiazepine. Notes for many consultations for these patients only recorded prescriptions written.

As part of his review the Director met with Dr R to discuss his concerns. Dr R is a general

practitioner who has worked in rural New South Wales since 1971. Dr R provides regular nursing home and home visits.

Dr R advised that during the review period he had merged his solo practice with a local medical centre. The merger had involved a variety of significant changes to his practice and as a consequence his note taking had suffered. Dr R assured the Director that he had taken steps to reduce his prescribing of benzodiazepine.

The Director considered this matter was appropriate to resolve by negotiated agreement. Dr R agreed to be reprimanded by the Director and to repay \$17,908 in Medicare benefits.

Dr S
General practitioner
New South Wales

Medicare Australia was concerned that Dr S's rendered services, daily services and EPC services may have involved inappropriate practice. Medicare Australia had similar concerns in a previous request in 2002. A section 92 agreement that the Determining Authority ratified in 2002 had resolved the previous matter.

Dr S was in the 99th percentile for rendered services; there was an increase in the number of days when 80 to 89 services were rendered. Dr S was in the 97th percentile for EPC services.

Upon review of Dr S's records the Director found that half his notes relating to item 36 services were brief and lacked clinical detail. The presentations were simple and would not have the complexity level to justify an item 36 claim. In most cases his GP Management Plans were found not medically necessary. Dr S's prescribing of simvastatin did not satisfy the qualifying criteria for use of this medication under the PBS.

The Director met with Dr S to discuss the review. Dr S said he had not initiated the prescribing of simvastatin, as patients had come to him after being prescribed the drug by either a specialist or another general practitioner; the Director accepted Dr S's explanation.

The Director decided that the most appropriate action was to enter into a negotiated agreement. Dr S agreed to be reprimanded by the Director, to repay \$67,810 in Medicare benefits and to be disqualified from provision of items 36 and 721 for two months.

As this was Dr S's second adverse finding under the PSR Scheme, he was referred to the Chairperson of the Medicare Participation Review Committees for review of his continuation in the Medicare arrangements.

Dr T
General practitioner
New South Wales

Medicare Australia was concerned that Dr T's daily servicing and rendered services may have involved inappropriate practice. Medicare Australia's statistics showed that Dr T was in the 98th percentile for rendered services, and at or above the 98th percentile for EPC and chronic disease management services. Dr T also breached the 80/20 rule by rendering 80 or more attendances on 21 days during the review period.

The Director reviewed Dr T's medical records to determine if inappropriate practice had taken place. The examination raised little or no concerns.

In the Director's meeting with Dr T to discuss his review findings he noted that Dr T had breached the 80/20 rule. Dr T said he had misunderstood the 80/20 rule due to an article he had read in a medical magazine. Dr T said that Medicare Australia had not advised him that he was

close to breaching the 80/20 rule and therefore he was not given the opportunity to correct the situation. He further stated that he had decreased his level of servicing by 20 per cent over the previous three months.

Dr T acknowledged that he had practiced inappropriately, and was willing to enter into a negotiated agreement. Under the circumstances, the Director considered this the most appropriate action. Dr T agreed to be reprimanded by the Director.

Dr U
General practitioner
New South Wales

Medicare Australia had concerns about Dr U's level C consultations and skin excision items. Dr U worked exclusively in skin cancer medicine. Medicare Australia statistics showed that Dr U was in the 99th percentile for item 30192, and his ratio of level B and C consultations was different from his peers. He was in the 98th percentile for item 30202 and in the 99th percentile for item 30203.³⁸ Dr U frequently billed consultations with procedures during the review period.

Dr U's records were examined. The Director had no major concerns over MBS items 23, 30192, 30196, 30202, 30203, 31230, 31260, 31270 and 31290;³⁹ however, 40 per cent of Dr U's item 36 services did not meet the standard for adequate record, as there was not sufficient detail or complexity to justify the item. As well, many of the lesions Dr U treated, and for which he claimed against MBS item 31275,⁴⁰ were less than the 20 mm required by that item descriptor.

Dr U's skin flap services raised major concerns. Some skin flaps were not performed in the area specified by the MBS item descriptor, and many were not generous enough when sutured

in position. There was also no evidence of adhesive strips being used while sutures were in position, and no evidence of a pressure dressing to decrease swelling. Dr U had provided colour photographs of the lesions before excision, the skin markings for the use of a flap and the short- and longer-term results. A plastic surgeon reviewed these photographs and clinical notes and was very critical of the way Dr U had used skin flaps; many of Dr U's flaps resulted in wound breakdown, as the flap was often not large enough to avoid undue tension in the suture line. The photographs revealed very poor long-term cosmetic results.

In his meeting with the Director, Dr U stated that he had changed his practice since the review to address Medicare Australia's concerns. He had started to use light therapy for extensive lesions in place of skin flaps and no longer charged for double flaps. He stated he was now making more detailed notes. At a second meeting with Dr U, he explained that he was documenting management plans and had started using scales in all photos of lesions to ensure the lesions were the right size for the item number claimed. Dr U acknowledged the Director's criticisms where skin flaps were concerned.

The Director decided that a negotiated agreement would be the most appropriate way to resolve the matter. Dr U agreed to be reprimanded by the Director, to repay \$15,000 in Medicare benefits and to be disqualified from provision of items 45200 and 45206 for 18 months.

Dr V
General practitioner
New South Wales

Medicare Australia was concerned that Dr V's rendered services, daily attendances, and

38 MBS items 30192, 30202 and 30203 relate to skin lesions treated by non-surgical means

39 MBS item 31290 is excision of basal cell or squamous cell

carcinoma more than 20 mm

40 MBS item 31275 is excision of basal cell or squamous cell carcinoma from skin of face, neck or lower leg of more than 20mm in diameter

prescribing under the PBS may have involved inappropriate practice.

Dr V was a solo practitioner with a busy practice treating over 7000 patients. He rendered over 18,000 services during the review period.

The Director reviewed a sample of medical records and determined that Dr V's management plans and medical records were inappropriate. For MBS item 23, Dr V's records were inadequate as they were brief and lacking in clinical details and contained little evidence of history and examination. His obesity management was poor, with no evidence of recorded body mass index or weight goals. He appeared to rely only on drugs to address obesity. Dr V's prescribing of rabeprazole only for management of ulcer disease was inappropriate as there was no evidence in the records examined that he excluded helicobacter infection.

During the review the Director meet with Dr V. Discussions revealed that Dr V never claimed level C or D consultations; he said that if a consultation warranted such a claim he only ever charged for an item 23. Dr V did not have an appointment system and he felt obliged to see all patients who presented to the practice; he worked seven days a week. Since the review Dr V had tried implementing an appointment system with limited success, as patients still dropped in and expected to be seen. Dr V said he had reduced his consultations to 50 patients per day, and was willing to make further changes. He acknowledged that his records were poor and said he would undertake to change his record keeping techniques.

Dr V showed insight into Medicare Australia's concerns, and expressed his willingness to change. The Director found it appropriate to enter into a negotiated agreement to resolve this matter. Dr V agreed to be reprimanded by

the Director and to repay \$85,000 in Medicare benefits.

Dr W Vocationally Recognised General Practitioner New South Wales

Dr W came to Medicare Australia's attention because of his high number of rendered services, services per patient and his prescribing under the PBS. He had a previous referral to PSR in 1997, and the Determining Authority made a final determination in 1999.

Dr W's statistics showed that he was in the 99th percentile for rendered services, the 97th percentile for services per patient and the 99th percentile for prescribing under the PBS.

Dr W provided a sample of medical records for review. The Director noted that Dr W prescribed diazepam to a small number of patients who were long-term benzodiazepine users being treated for insomnia or chronic anxiety. While the Director considered that diazepam might not have been the best choice of drug for these conditions, Dr W's use of this drug did reflect his peer's usage.

The Director considered that Dr W may have engaged in inappropriate practice in his provision of some MBS item 36 and 2710 services as the recorded notes did not meet the MBS item descriptor or lacked sufficient clinical detail to explain the nature of the service provided.

The Director met with Dr W to discuss his concerns. During the meeting Dr W said he sees many nursing home patients, as many other general practitioners no longer undertake this role. Dr W is a solo practitioner working on average 60+ hours per week. He admitted that being a solo practitioner is tough and conceded he could understand why his statistics would alarm Medicare Australia. Since the review Dr

W has adopted an appointment system and his practice is now more structured.

The Director considered it appropriate to enter into a negotiated agreement to resolve this matter.

Dr W acknowledged that during the review period he had failed to maintain adequate and contemporaneous medical records in connection with some MBS item 36 and 2710 services. He agreed to be reprimanded by the Director and to repay \$10,000 in Medicare benefits.

As this was Dr W's second adverse finding under the PSR Scheme, this mandated a referral to the Chairperson of the Medicare Participation Review Committees for further investigation.

Dr X
General practitioner
Victoria

Medicare Australia had previously referred Dr X to PSR in 2003. Dr X had a niche practice, in which he treated patients with drug and alcohol addiction. The previous Director of PSR subsequently dismissed that matter.

Medicare Australia referred Dr X to PSR again in 2007 due to concerns over his rendered services, daily services, rendering of skin excision items, and prescribing under the PBS – in particular total PBS items and drugs of dependence. Medicare Australia's statistics showed that Dr X was in the 99th percentile for rendered services and total benefits. His patient numbers were in the 92nd percentile, and his total PBS statistics were in the 97th percentile.

In addition, Dr X was at or above the 96th percentile for prescribing drugs of dependence.

The Director reviewed a sample of Dr X's medical records. During the course of his review the Director meet with Dr X to discuss concerns

about his prescribing of lactulose, diclofenace, diazepam, fentanyl and buprenorphine during the review period. Discussion also centred on his lack of recording of clinical detail in a minority of medical records in relation to MBS item 36, and skin excision item services.

Dr X acknowledged that during the review period he had failed to have due regard to the restrictions applying to prescribing lactulose and diclofenace under the PBS. Through his discussions with Dr X and a subsequent written submission the Director's concerns were largely addressed.

Dr X impressed as a competent practitioner dealing with a difficult and demanding patient base. The Director considered it appropriate to enter into an agreement to resolve this matter.

Dr X agreed to be reprimanded by the Director and to repay \$3500 in Medicare benefits that related to those consultations in which he had inappropriately prescribed lactulose and diclofenace outside PBS restrictions.

Dr Y
General practitioner
Queensland

Medicare Australia was concerned about Dr Y's services per patient, level C consultations, vascular and cardiovascular MBS items, EPC items, initiation of pathology, initiation of diagnostic imaging, and rendering of MBS item 10993.⁴¹ Dr Y had a previous final determination from PSR in 2003.

Medicare Australia's statistics showed that Dr Y was in the 99th percentile for services per patient, vascular and cardiovascular MBS items and EPC items; in the 98th percentile for initiation of pathology and the 78th percentile for initiation of diagnostic imaging; and above the 93rd percentile for MBS item 10993.

41 MBS item 10993 is an immunisation service provided by a nurse

Samples of Dr Y's medical records were produced for examination. The Director was not concerned about Dr Y's provision of MBS item 23, 721, 723, 725, 10993, 55114, 55113 services or his prescribing of atorvastatin. It was clear from the records, however, that Dr Y used a cut and paste method for his notes on MBS item 36 services; and his notes did not meet the MBS criteria for item 700⁴² services. Examination of records relating to diagnostic procedures and investigation items 11506 and 11610⁴³ revealed a lack of clinical indications recorded for these types of investigations. Dr Y initiated frequent and repeated tests when results were normal for pathology items 66515 and 66536.⁴⁴

The Director met with Dr Y to discuss his concerns. Dr Y said his is not a normal practice as he specialised in cardiovascular risk management and his services had increased due to an ageing patient base. He further explained that he uses the cut and paste technique for item 36 only as a reminder and that he individualises them according to the patient. Dr Y said he was trying to ensure MBS criteria were met and that he had made continual improvements to his note taking.

The Director considered it appropriate to enter into a negotiated agreement. Dr Y agreed to be reprimanded by the Director, to repay \$25,000 in Medicare benefits and to be disqualified from provision of MBS item 11610 for 18 months.

As this was Dr Y's second finding of inappropriate practice, he was referred to the Chairperson of the Medicare Participation Review Committees for further investigation.

Dr Z

General practitioner New South Wales

Medicare Australia was concerned that Dr Z's skin flap items, rendering consultations with

procedures, rendering consultations in the aftercare period, and skin excision items may have involved inappropriate practice. Dr Z's statistics showed that he was at or above the 99th percentile for flap items, at or above the 98th percentile for skin excision times and at the 85th percentile for total rendered services.

The Director reviewed Dr Z's medical records to determine if inappropriate practice had occurred. Over half (52 per cent) of the medical records examined relating to MBS item 23 services lacked sufficient clinical detail. The Director was particularly concerned that Dr Z appeared to use skin flaps in inappropriate circumstances where, because of the size of the lesion and the area on the body the lesion was positioned, wound closure could have been achieved by direct closure. The records did not provide evidence to support use of the flap for adequate wound closure. It also appeared that Dr Z had claimed MBS item 45207,⁴⁵ where lesions were removed from patients' leg, back, chest or chin and therefore did not meet the MBS criteria.

At the Director's meeting with Dr Z it became clear that Dr Z has a special interest in skin cancer and sports medicine and predominately works in skin cancer medicine. Dr Z could not explain why there was a difference in his records in the size for re-excision lesions compared to the histopathology reports. He said in future he would not claim skin excision items until the histology results were known.

Dr Z acknowledged that his conduct in rendering some MBS item 23 services was inappropriate.

Dr Z agreed to be reprimanded by the Director, to repay \$51,513.12 in Medicare benefits and to be disqualified from provision of MBS items 45200 and 45207 for six months.

42 MBS item 700 is a health assessment for a patient over 75 years of age

43 MBS item 11610 is measurement of ankle – waveform

analysis 44 MBS items 66515 and 66536 are used for blood lipid levels

45 MBS item 45207 is for skin flap repairs

Dr ZZ
Medical practitioner
New South Wales

Dr ZZ is participating in the MedicarePlus Program qualifying him to claim VRGP items.

Medicare Australia was concerned that Dr ZZ may have practiced inappropriately because of his high rendering of MBS items 47003⁴⁶ and 47633,⁴⁷ and MBS item 30192. Dr ZZ's statistics showed that for items 47003 to 47633, he was at or above the 97th percentile. He rendered item 30192 on 100 occasions to 79 patients. Dr ZZ's total benefits were in the 98th percentile.

The Director reviewed a sample of Dr ZZ's medical records. He considered that the records relating to MBS item 36 services reflected inadequate detail and did not justify the item claimed. He also found that one-third of item 47003 and 47633 services might have been mis-itemised.

The Director met with Dr ZZ to discuss his findings. During the review period Dr ZZ saw many patients on weekends with acute sporting injuries. He also indicated that billing might have been an administrative error although he was unable to prove it at the time because the previous practice denied him access to patient files.

Since the review period Dr ZZ has changed his practice location and has not seen any fracture or sporting injuries in his new practice; he felt this was because he was now located in a shopping centre. Dr ZZ advised that the new practice used electronic documentation and provided much more support. Included in his written submission, Dr ZZ provided samples of his current medical records, which showed considerable improvement from the clinical notes recorded during the review period.

Given Dr ZZ's change of practice location, improvements made in his record keeping and the nature of the identified concerns the Director considered it appropriate to enter into a negotiated agreement. Dr ZZ agreed to be reprimanded by the Director and repay \$40,000 in Medicare benefits.

Referral to a Committee

Section 93 of the *Health Insurance Act 1973* refers to cases where the Director has established a PSR Committee to further investigate the person under review.

Dr George Maragoudakis
Medical practitioner
Frankston Victoria

Dr Maragoudakis participates in the MedicarePlus Program entitling him to claim VRGP consultation items.

Medicare Australia was concerned that Dr Maragoudakis may have practiced inappropriately as he rendered 80 or more attendances on 31 days during the review period. The Medicare benefits for the attendances that fell under the 80/20 rule amounted to \$50,850.40. Dr Maragoudakis was brought to PSR's attention in December 2001.

Dr Maragoudakis was invited to make submissions to the Director. In his submission Dr Maragoudakis claimed that his rendering of services was due to exceptional circumstances and should be dismissed by the Director. He stated his practice was in a low socioeconomic area and treated many unemployed and disabled patients. He explained that these patients needed more frequent and urgent care than most in the general population. Dr Maragoudakis also stated that there was a shortage of practitioners in the area, and it was difficult to get locums. His practice was

46 MBS item 47003 is treatment of a dislocated clavicle

47 MBS item 47633 is for treatment of a fractured metatarsal

one of three bulk billing practices in the area, and he worked 80 hours a week to meet patient demand.

A Professional Services Review Committee was established. The Committee unanimously found that Dr Maragoudakis had engaged in inappropriate practice. It concluded that Dr Maragoudakis' conduct in providing services amounted to a prescribed pattern of services and that exceptional circumstances did not affect his provision of services during the referral period.

The Determining Authority, having considered the age of the referral and the changes Dr Maragoudakis has made to his practice since the review period, made a final determination that Dr Maragoudakis be reprimanded and counselled by the Director, and that he be disqualified from provision of general practitioner attendance services for three months.

Dr Robert Bruce Allen
General practitioner
Donvale Victoria

Medicare Australia asked the Director to review Dr Allen's provision of services relating to the ratio of level C to level D surgery consultations and his initiation of pathology. During the review period Dr Allen rendered 2391 services to 582 patients for a total Medicare benefit of \$98,879. Dr Allen was above the 95th percentile for level D surgery consultations when compared to his peers; 23.31 per cent of his total consultations were level D surgery consultations and 29.54 per cent were level C.

During the review period Dr Allen initiated 3434 pathology services to 408 of his 582 patients for a total Medicare benefit of \$82,649.95. Dr Allen's pathology service, per pathology patient, was at the 99th percentile when compared to his peers.

Dr Allen was asked to provide medical records to the Director for examination. The records examined in relation to item 36 and 44 services revealed Dr Allen's recording of clinical input during the consultation was deficient in detail. There was limited evidence of a history, examination or implementation of a management plan in the clinical records. Many patients appeared to have emotional, personality or psychiatric problems but there was no evidence in the notes that these problems were addressed.

It became clear from the records that Dr Allen had ordered a significant number of pathology tests for nearly every patient, for which justification was rarely apparent in the notes. It also became clear from the results available that most tests would have contributed little to patient management as the results were within normal parameters.

The matter was referred to a Professional Services Review Committee for further investigation. The Committee reported that Dr Allen had engaged in inappropriate practice in connection with 90 per cent of MBS item 36 and 44 services. Dr Allen had failed to provide an adequate level of clinical input into his services, failed to satisfy the MBS requirements for most services, on occasions ordered pathology where it was not reasonably necessary for managing the patient and failed to keep adequate medical records.

The Determining Authority made a determination that Dr Allen be reprimanded and counselled by the Director, repay \$32,082.10 in Medicare benefits, and be disqualified from provision of MBS item 36 and 44 services for three months.

*Dr Andreas Henco
Medical practitioner
Cairns Queensland*

Medicare Australia was concerned that Dr Henco may have practised inappropriately in relation to:

- rendered services
- volume of daily servicing constituting a prescribed pattern of servicing (80/20 deeming provision)
- initiation of pathology and diagnostic imaging
- prescribing of antibiotics
- use of Regulation 24.⁴⁸

Dr Henco rendered 80 or more professional attendances per day on 24 occasions.

The Director reviewed Dr Henco's medical records and had no major concerns about MBS items 53, 698,⁴⁹ 5020 or his prescribing of amoxicillin/clavulanic acid tablets. For MBS item 54 services, however, the Director found that the conditions treated were straightforward and would not have taken the time needed to meet the MBS item descriptor. Dr Henco's prescribing of cefaclor was considered inappropriate, as the conditions being treated were minor viral respiratory tract infections. The Director concluded that Dr Henco may have 'up coded' many of his consultations, provided services not medically necessary, failed to keep adequate and contemporaneous records, and failed to provide an appropriate level of clinical input to his services and prescribing.

A Professional Services Review Committee was established. The Committee found that Dr Henco had practised inappropriately in 83 per cent of MBS item 54 services. The Committee examined 15 occasions where Dr Henco prescribed cefaclor and found that he practised inappropriately on

eight of those occasions. The Committee found 80 per cent of Dr Henco's use of CT scanning of the lumbar spine inappropriate and his claimed use of an operating microscope to perform 'ear toilet' inappropriate in all instances.

Dr Henco returned to Germany at the time Medicare Australia referred him to PSR. This did not inhibit the investigation as medical records were sourced from the practice at which he had worked. As provided for in the Act, the Committee met and considered the evidence in Dr Henco's absence.

The Determining Authority made a Determination that Dr Henco be reprimanded and counselled by the Director, repay \$84,338 in Medicare benefits, be suspended for six months and be disqualified from providing services to which an item in Group A2 of the General Medical Services Table relates for six months.

Although Dr Henco did not return from Germany he promptly repaid Medicare benefits as required by the Determining Authority.

*Dr Mark Mitchelson
General practitioner
Cairns Queensland*

Medicare Australia was concerned that Dr Mitchelson's prescribing under the PBS and his percentage and ratio of level B and level C surgery consultations may have been inappropriate. During the review period Dr Mitchelson rendered 9012 services generating \$258,131.10 in Medicare benefits.

Dr Mitchelson was required to produce a sample of medical records for the Director to examine. The records were brief; they showed a high level of prescribing of narcotics with frequent failure to document the rationale and proposed management of patients on long-term

48 Regulation 24 allows a pharmacist to dispense repeat prescriptions with the original supply

49 MBS item 698 is a professional attendance at consulting rooms between 11 pm and 7 am

narcotic therapy. Given the lack of history and examination findings the Director considered that another practitioner would experience difficulty in providing ongoing care for Dr Mitchelson's patients.

A Professional Services Review Committee was established. The Committee found that Dr Mitchelson had engaged in inappropriate practice in 73 per cent of his MBS item 23 services and 83 per cent of his MBS item 36 services. The Committee found that Dr Mitchelson failed to satisfy the requirements of the relevant MBS item number, provided insufficient clinical input in connection with managing patients who were prescribed drugs of addiction, and initiated investigations in the absence of relevant clinical indicators.

During the course of its investigation, the Committee formed the opinion that Dr Mitchelson's conduct had caused, was causing, or was likely to cause a significant threat to the life or health of a person. It therefore made a referral to the Queensland Medical Board in 2006 for further investigation.

The Determining Authority made a determination that Dr Mitchelson be reprimanded and counselled by the Director, repay \$188,256.79 of Medicare benefits, be fully disqualified for six months and be suspended from prescribing under the PBS for six months.

Dr Mitchelson filed an appeal in the Federal Court. This motion was dismissed and PSR was awarded indemnity costs.

Dr Poh Boon Eric Choo
General practitioner
Doncaster Victoria

Dr Choo was referred to PSR due to Medicare Australia's concerns over his services per patient,

home visits, nursing home consultations, and MBS item 50124 services.

During the review period Dr Choo rendered 11,622 services to 1680 patients – an average of 6.92 services per patient – that was above the 98th percentile when compared with all active general practitioners in Australia.

Dr Choo rendered MBS item 50124 services on 1816 occasions to 634 patients; 1349 level B home visits to 111 patients, an average of 12.1 visits to each patient; and 1596 level B nursing home visits to 77 patients, an average of 20.7 services for each patient.

The Director considered, after examining Dr Choo's medical records, that he rendered frequent attendances to his patients with no apparent need for that frequency.

Dr Choo's conduct was referred to a Committee for further investigation. The Committee found that 62 per cent of MBS item 24⁵⁰ services and 78 per cent of item 50124 services would be unacceptable to the general body of general practitioners. The Committee's summarised views were as follows:

- Many services to elderly patients were made by the calendar, once a week or more, when there was no medical necessity for such frequent visits.
- On many occasions when Dr Choo was called out to a home visit he did not provide sufficient clinical input concerning the patient's presenting complaint.
- Dr Choo in some instances used injection of steroids to treat what he diagnosed as vasomotor rhinitis when the symptoms were indicative of respiratory tract infections.
- Dr Choo kept inadequate medical records.

50 MBS item 24 is a level B standard home visit

The Determining Authority made a determination that Dr Choo be reprimanded and counselled by the Director, repay \$56,543.65 in Medicare benefits, be disqualified from Group A1 services for four months and be disqualified from MBS item 50124 services for 12 months.

Dr Choo applied for an order of review in the Federal Court on 29 November 2006; the Federal Court dismissed the proceeding on 23 August 2007.

Dr John Frederick McKenzie
General practitioner
Matraville New South Wales

Medicare Australia asked PSR to review Dr McKenzie's provision of services in relation to level C and level D surgery consultations, initiation of pathology, initiation of diagnostic imaging, and prescribing under the PBS.

During the review period Dr McKenzie rendered 3673 services to 782 patients for \$160,372.95 in Medicare benefits.

The Director considered that the medical records he examined were brief and lacking in clinical detail. They did not contain adequate health summary sheets and the brevity of the clinical notes would create difficulties in providing ongoing care of the patient by another practitioner. The records also reflected frequent prescribing of oral steroids and nandrolone decanoate with frequent failure to document the diagnosis, rationale and proposed management.

Dr McKenzie was referred to a Committee for further investigation. The Committee found Dr McKenzie engaged in inappropriate practice in connection to 73 per cent of MBS item 36 services and 73 per cent of MBS item 44 services. The nature of the Committee's findings and views were that Dr McKenzie:

- failed to provide an appropriate level of clinical input to the services because he failed to perform adequate examination or assessments with respect to presenting complaints, failed to implement adequate management plans and failed to take detailed patient histories to explain the reasons the patient presented for treatment
- did not satisfy MBS requirements for the rendered services
- used MBS item 36 and 44 in circumstances when the clinical content and the time required to address patients' presenting complaints did not warrant their use
- on some occasions did not satisfy the requirements for prescribing pharmaceutical benefits under the PBS
- on some occasions provided pathology services that were not necessary
- failed to keep adequate and contemporaneous records as required by section 82(3) of the Act.

During the course of its investigation the Committee formed the opinion that Dr McKenzie's conduct had caused, was causing, or was likely to cause a significant threat to the life or health of a person. Dr McKenzie's conduct was therefore referred to the New South Wales Medical Board in 2005.

The Determining Authority directed that Dr McKenzie be reprimanded and counselled by the Director, repay \$36,831.83 in Medicare benefits and be fully disqualified for one month.

Dr John MacPherson
General practitioner
Brookvale New South Wales

Medicare Australia's request to review noted concerns about Dr MacPherson's:

- volume of services and daily services
- wound repair (deep tissue)
- removal of foreign bodies from the eye
- prescribing of benzodiazepines and codeine phosphate compounds
- level A attendances
- EPC items.

During the review period Dr MacPherson rendered 16,880 services for total Medicare benefits of \$488,621.20.

From the sample of medical records Dr MacPherson produced for examination, the Director considered that the prescribing of codeine phosphate with paracetamol tabs and diazepam may have been inappropriate because the clinical notes reflected little evidence of management planning for chronic conditions or of consideration being given to drug interactions. The Director was also concerned about the excessive doses of addictive medications being prescribed.

The Director believed the clinical notes about wound repair items and EPC services did not satisfy the relevant MBS item descriptors or did not appear to be medically necessary. It also appeared that Dr MacPherson would routinely

initiate an MBS item 720⁵¹ service in the management of patients with simple obesity.

This matter was referred to a Professional Services Review Committee. The Committee found that Dr MacPherson engaged in inappropriate practice in connection with:

- 90 per cent of MBS item 700 services
- 90 per cent of MBS item 720 services
- 34 per cent of MBS item 23 services
- all 32 MBS item 30029⁵² services examined by the Committee
- all 15 MBS item 30041⁵³ services examined by the Committee.

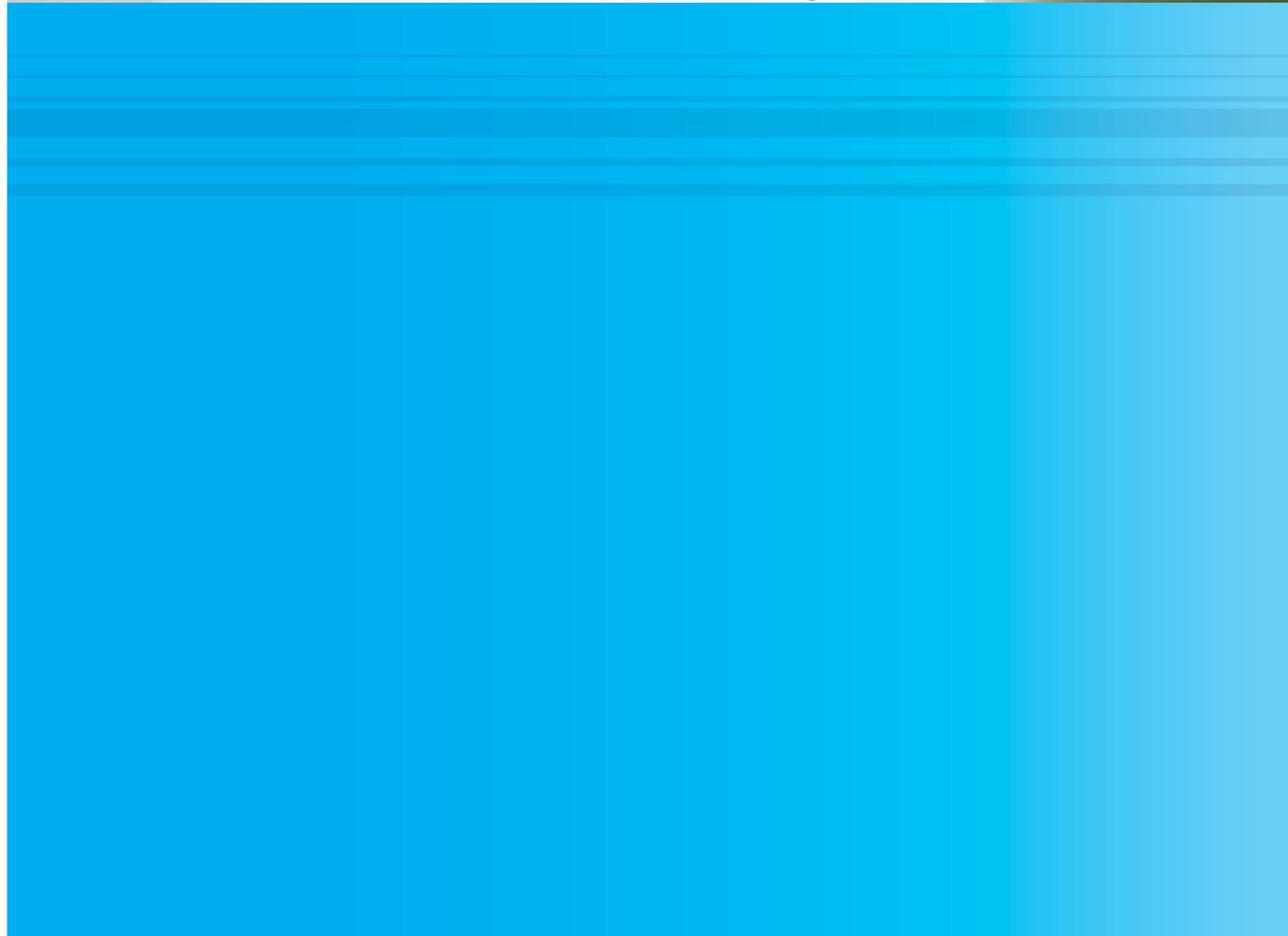
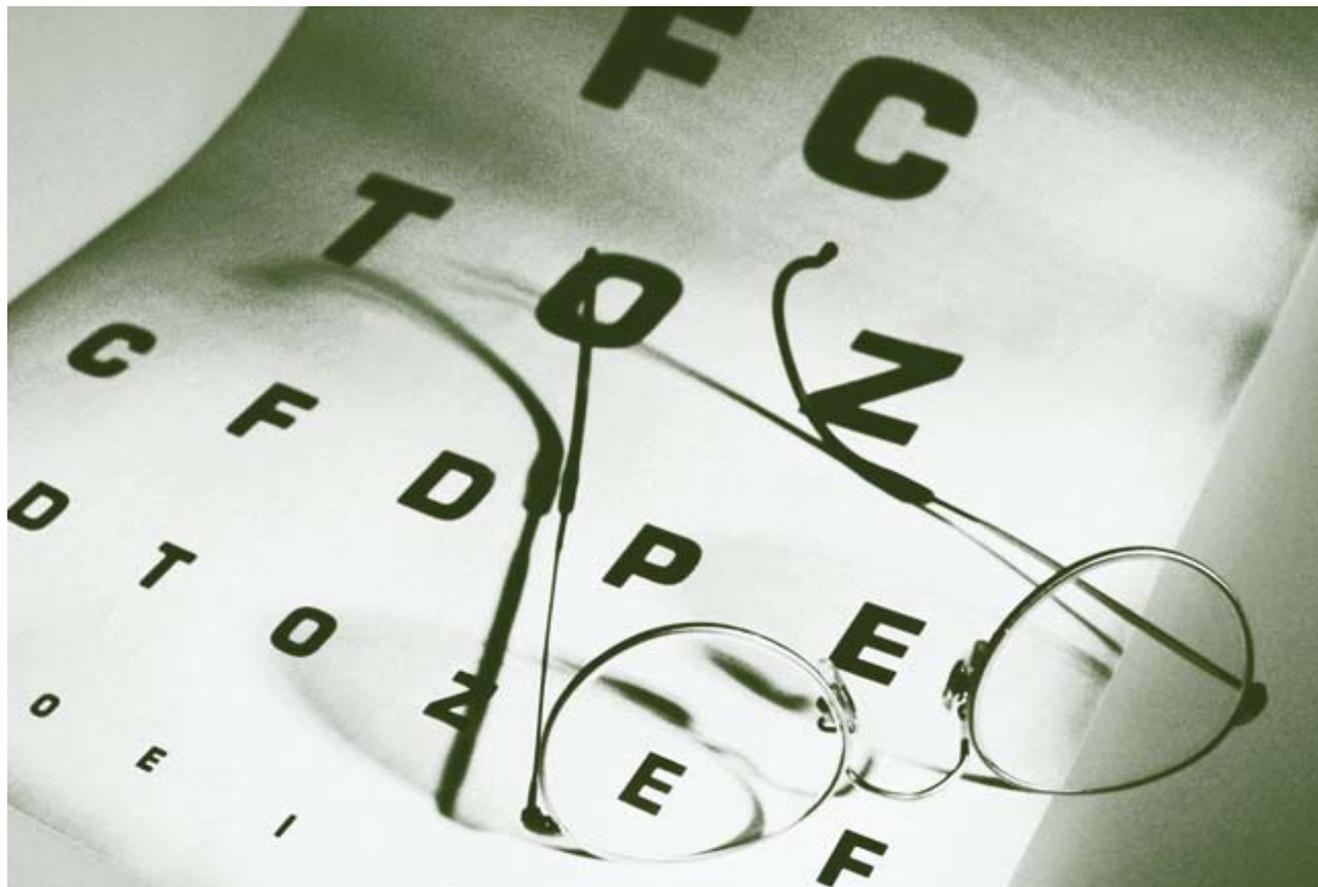
The Committee found that Dr MacPherson failed to satisfy the MBS requirements, failed to provide an appropriate level of clinical input, rendered services that were not medically necessary, failed to keep adequate medical records and did not perform an adequate physical examination.

The Determining Authority made a determination that Dr MacPherson be reprimanded and counselled by the Director, repay \$131,958.65 of Medicare benefits, and be disqualified from provision of services in Group A14 and Group A15 for three months.

51 MBS item 720 is a GP care plan

52 MBS item 30029 is repair of a laceration involving deeper tissues

53 MBS item 30041 is repair of a laceration involving deeper tissue more than 7 cm long





REPORT TO THE PROFESSIONS

Legal cases



Legal cases

Nine Federal Court decisions have involved PSR cases this year.

The status of these court cases, many of which have been discussed in earlier PSR Annual Reports, is reported below.

No new applications have been made to the Federal Court in relation to cases referred to PSR in the last four years. This may reflect the growing certainty about the legal operation of the PSR Scheme as a result both of amendments to legislation and legal decisions to date. The reduced number of requests from Medicare Australia during 2004–05 and 2005–06 may also have had an impact.

Fourteen PSR court cases are currently on hold (voluntarily or by consent order) pending High Court resolution of the constitutional challenge in *Selim*.⁵⁴

Outcomes

Subject to any successful appeal to the High Court, the decision of the Full Federal Court in *Selim* and *Wong* seems to have settled that, within the broader context of Medicare, the PSR Scheme does not involve civil conscription and is not thereby constitutionally invalid. Once the decision of the High Court of Australia is received the other 14 court applications raising the constitutional question should be resolved.

The Federal Court decision in *Selim* confirmed that the Determining Authority is not invalidly exercising the judicial power of the Commonwealth in breach of the Constitution. At the hearing of the Special Leave Application the applicants confirmed that they would not be pursuing the issue of judicial power.

Thoo confirms that the Director may refer all services by a practitioner in a referral period, whatever the reasons for Medicare Australia's request and whatever his reasons for asking a Committee to investigate.

⁵⁴ The High Court heard the Application for Special Leave lodged by Doctors Selim and Wong on 1 August 2008. At this

hearing the High Court granted the Request for Leave to Appeal. It is expected that this matter will be heard over two days in November 2008.

Thoo also confirms that, where a Medicare Australia request and the Director's referral are based on a suspected prescribed pattern of services, a Committee may nevertheless make findings without considering a prescribed pattern of services and may use sampling for this purpose.

In *Do* and *Ho* the Full Federal Court reversed a finding that the Committees had wrongly excluded 'exceptional circumstances' of an ongoing nature as a defence for a prescribed pattern of services. This has implications for several other cases. The Court also took a robust view of 'unusual' in the context of Health Insurance (Professional Services Review) Regulations 1999 Regulation 11(a), holding that public holidays, practitioner illness, and staffing changes were not unusual occurrences and their consequences should be manageable. This too will affect other cases.

Saint involved a large number of evidentiary issues each of which the court considered in detail. Importantly, the court upheld the immunity and confidentiality of Committee processes. Thus discovery of Committee documents was limited to evidence before it and its internal reasoning could not be examined beyond what it gave in its report. The court also dismissed a large number of assertions (for example, of unfair procedures) that were tenuous or not supported by clear evidence.

Thoo and *Mitchelson* both indicate that courts will not condone excessive delay. It was not a denial of procedural fairness when a Committee refused Dr Thoo a late adjournment to obtain legal advice because he had had ample prior opportunity to do so. Not only was Dr Mitchelson's case struck out, but also he was further penalised with indemnity costs because of severely inadequate pleadings, excessive delay, and ignoring court orders.

Nevertheless *Mitchelson* also shows that the court will make every endeavour to identify and address the real issues in an application, so that justice can be done notwithstanding poor drafting and delay by an applicant.

Cases

Dr Ashraf Thabit Selim General practitioner Punchbowl, NSW

The (then) Health Insurance Commission referred Dr Selim in 2001 because of his high number of rendered services and high daily servicing during 2000. A Committee found that he had engaged in inappropriate practice.⁵⁵ Dr Selim appealed to the Federal Court on both judicial review and constitutional grounds.

On 28 October 2004, Jacobson J ordered that the constitutional issues be severed for separate hearing. Some judicial review grounds were subsequently dropped and on 7 February 2005 Jacobson J dismissed the appeal on the remaining judicial review grounds.⁵⁶

Dr Selim appealed that decision to the Full Federal Court. It was agreed that no further action would be taken pending decisions in *Oreb* and *Dimian*.

Stone J heard Dr Selim's constitutional claim that the PSR Scheme contravened section 51(xxiiiA) of the Australian Constitution, which provides that the Commonwealth parliament may make laws with respect to, among other things, provision of medical and dental services (but not so as to authorise any form of civil conscription).

On 23 February 2006, her Honour dismissed that challenge.⁵⁷

Dr Selim appealed to the Full Federal Court. The hearing was initially adjourned pending the outcome of applications to the High

55 *PSR Annual Report 2003-04* p. 57; *PSR Annual Report 2004-05* p. 55
56 *Selim v Lele* [2005] FCA 24

57 *Selim v Lele* [2006] FCA 126; see also *PSR Annual Report 2005-06* pp. 48-50

Court in the *Dimian* and *Wong* cases, and also on constitutional grounds.⁵⁸ However, the High Court remitted those cases to the Full Federal Court and all three were ultimately considered together. An additional argument was also raised, namely that the PSR legislation impermissibly conferred the Commonwealth's judicial power on the Determining Authority.

Because of the potential impact of an adverse constitutional finding on the whole Medicare scheme, the Australian Government intervened; the Solicitor-General and the Australian Government Solicitor managed the Commonwealth case.

Only two High Court cases have been about civil conscription in relation to provision of medical and dental services. *The BMA Case*⁵⁹ concerned a provision of the *Pharmaceutical Benefits Act 1944* requiring any doctor prescribing any medicine listed in the Commonwealth Pharmaceutical Formulary⁶⁰ to use a prescribed form regardless of whether the medicine was to be obtained free. There was a practical requirement for doctors to prescribe from the Formulary, but the requirement to use the form was not related to receiving any benefit. The provision was held to be invalid because it imposed a form of civil conscription.

However, in the *General Practitioners Society Case*,⁶¹ the High Court upheld provisions of the *Health Insurance Act 1973* and regulations which provided that a medical benefit would be payable with respect to certain pathology services only if the service was performed by or on behalf of an approved pathology practitioner. Approval required doctors to provide an undertaking and agree to adhere to a code of conduct. Certain conditions, such as that a pathology service be requested in writing and the request be retained for 18

months, also applied. These were to ensure the Commonwealth did not pay for unnecessary or excessive pathology services.

In *Selim*, the Full Federal Court analysed both the above cases as well as relevant official explanatory materials published before the 1946 referendum that resulted in the addition of section 51 (xxiiiA) to the Constitution. It accepted evidence that the *Health Insurance Act 1973* imposed a practical compulsion on doctors who wished to be general practitioners in private practice to participate in the Medicare scheme. They therefore should not do anything unacceptable to the general body of general practitioners in providing Medicare services.

Nevertheless, sections 10, 20 and 20A of the *Health Insurance Act 1973* do not require a practitioner to provide a professional service or render an account. Rather, if an eligible person incurs expense in receiving a professional service, a Medicare benefit would be payable to the person (or, if unpaid, the practitioner). According to Black CJ, Finn and Lander JJ:

The purpose of Part VAA is to preserve the integrity of the Medicare Benefits Scheme not to require medical practitioners to perform professional services. It does no more than regulate the way in which medical practitioners should render their medical services where they have first chosen to render those services.⁶²

Thus, even given a practical compulsion to participate in Medicare, sections 10, 20 and 20A of the *Health Insurance Act 1973* only regulated the manner of providing services and this did not amount to civil conscription.

The Full Court also considered submissions that the Determining Authority was unconstitutionally exercising the judicial power of the Commonwealth.

58 *PSR Annual Report 2005–06* pp. 50–51

59 *Federal Council of the British Medical Association in Australia v Commonwealth* (1949) 79 CLR 201

60 The Commonwealth Pharmaceutical Formulary listed medicines obtainable free of charge under a government scheme

61 *General Practitioners Society v Commonwealth* (1980) 145 CLR 532

62 *Selim v Lele* [2008] FCAFC 13, paragraph 48

It was argued that previous decisions⁶³ that PSR Committees, the former Determining Officer and the former PSR Tribunal were not unconstitutional should be reconsidered in the light of a High Court observation⁶⁴ that a distinction between so-called 'protective' and 'punitive' powers might not be valid. It is generally accepted that disciplinary sanctions of the kind in the PSR Scheme exist to protect its beneficiaries, whereas powers under the criminal law are to punish criminal behaviour. Only courts may do the latter. However, the Full Court considered that the protective/punitive distinction was only one minor factor in considering the powers of the Determining Authority and it held that, like the other PSR authorities, it was not exercising judicial power.

On 27 February 2008 the Full Court dismissed the appeals.⁶⁵ On 28 March 2008 Dr Selim sought special leave to appeal to the High Court.⁶⁶

Dr Kenneth Wong
General practitioner
Merrylands, NSW

The (then) Health Insurance Commission referred Dr Wong on 10 May 2001 because it was concerned about his rendered services and daily servicing between 1 July 2000 and 30 June 2001. A Committee reported that Dr Wong had engaged in inappropriate practice, largely because he failed to provide adequate clinical input and/or provided services that were not clinically necessary.

On 11 February 2004, Dr Wong appealed to the Federal Court, alleging that the Director had failed to offer an agreement to him under section 92. On 3 December 2004, Jacobson J

made a consent order that the outcome turn solely on the result of the appeal in *Oreb v Willcock*, which was dismissed on 16 September 2005. The non-constitutional aspects of *Wong* were accordingly then dismissed.⁶⁷

On 3 May 2006 Dr Wong (with Dr Rifaat Dimian) filed a Writ of Summons in the High Court claiming that various provisions of the *Health Insurance Act 1973* were not within the Commonwealth's powers under the Constitution.⁶⁸ The High Court remitted this case to the Federal Court, and the Full Court decided to consider the cases of Doctors Selim, Dimian and Wong together.

On 27 February 2008 the Full Court dismissed the constitutional appeals,⁶⁹ and on 28 March 2008 Dr Wong (with Dr Selim) sought special leave to appeal to the High Court.⁷⁰

Dr Rifaat Dimian
Medical practitioner
Merrylands, NSW

The (then) Health Insurance Commission referred Dr Dimian on 17 May 2000 because it was concerned that he might have engaged in inappropriate practice through high daily servicing and a high volume of rendered services between 1 July 1998 and 30 June 1999. A Committee reported that Dr Dimian had engaged in inappropriate practice, largely because of lack of clinical input and poor clinical records.

Dr Dimian appealed to the Federal Court on constitutional grounds and two others: failure to offer a section 92 agreement and lack of procedural fairness in preparation of the Committee report.

63 *Tankey v Adams* [2000] 104 FCR 152; *Health Insurance Commission v Grey* [2002] 120 FCR 470

64 *Rich v Australian Securities and Investments Commission* [2004] 220 CLR 129

65 *Selim v Lele* [2008] FCAFC 13

66 See note 54

67 *PSR Annual Report 2005–06* pp. 47–48

68 *PSR Annual Report 2007–08* pp. 47

69 *Selim v Lele* [2008] FCAFC 13; *PSR Annual Report 2007–08* pp.45

70 See note 54

A single judge dismissed the appeals on non-constitutional grounds on 8 December 2004,⁷¹ and the Full Court dismissed them on 16 September 2005.⁷²

On 3 May 2006 Dr Dimian (with Dr Kenneth Wong) filed a Writ of Summons in the High Court, which claimed that various provisions of the Act were constitutionally invalid because:

- on a practical matter, they amounted to 'civil conscription' within the meaning of section 51(xxiiiA) of the Constitution
- contrary to section 71 of the Constitution, they purported to confer part of the judicial power of the Commonwealth on people who had not been appointed pursuant to section 72 of the Constitution.

The High Court remitted this case to the Federal Court, and the Full Court decided to consider the cases of Doctors Selim, Dimian and Wong together.

On 27 February 2008 the Full Court dismissed the constitutional appeals.⁷³ The Determining Authority has agreed not to proceed until the outcome of the applications to the High Court by Doctors Selim and Wong is known.⁷⁴

Dr Dimian did not seek special leave to appeal to the High Court.

Dr Jane Carrick
Medical practitioner
Auburn, NSW

The (then) Health Insurance Commission referred Dr Carrick to PSR in 2002 because she was rendering a high number of certain endoscopy-related services. A PSR Committee found that her conduct would be unacceptable to the general body of medical practitioners in

connection with 28 of 30 MBS item 30487⁷⁵ services. As reported last year,⁷⁶ the Federal Court dismissed⁷⁷ a judicial review application by Dr Carrick on all grounds except a constitutional issue to be resolved in the litigation regarding Dr Selim.⁷⁸

Dr Mark Leslie Mitchelson
General practitioner
Cairns, Qld

On 6 December 2004, the (then) Health Insurance Commission asked the Director to review the provision of services by Dr Mitchelson. On 22 July 2006 a Committee was established and ultimately reported that Dr Mitchelson had engaged in inappropriate practice in connection with 73 per cent of MBS item 23⁷⁹ services and 83 per cent of item 36⁸⁰ services examined using sampling methodology. On 5 April 2007 the Determining Authority made a final determination that Dr Mitchelson be reprimanded and counselled, repay to the Commonwealth \$137,660.95 and \$50,595.84 in respect of item 23 and 36 services, be suspended from PBS prescribing for six months and be fully disqualified from Medicare for six months.

Dr Mitchelson sought to have the Federal Court review this determination, but a number of procedural or legal errors were made which resulted in three hearings. He first lodged a Notice of Appeal on 8 May 2007 and was ordered, at a Directions hearing on 12 July 2007, to file an amended Notice by 30 July 2007, but failed to follow up until the respondents filed a Notice of Motion on 3 August 2007 seeking dismissal of the Appeal as incompetent. Dr Mitchelson then filed an Amended Application for Order of Review on 24 August 2007 and sought to amend the original Notice of Appeal.

71 *Dimian v HIC* [2004] FCA 1615; *PSR Annual Report 2004–05* p. 54

72 *Dimian v HIC* [2005] FCAFC 200; *PSR Annual Report 2005–06* p. 50

73 *Selim v Lele* [2008] FCAFC 13; pp. *PSR Annual Report 2007–08* pp.45

74 See note 54

75 MBS item 30487 is a small bowel intubation with biopsy

76 *PSR Annual Report 2006–07* pp. 31–32

77 *Carrick v Health Insurance Commission* [2007] FCA 984

78 See note 54

79 MBS item 23 is a level B GP consultation

80 MBS item 36 is a level C GP consultation

The grounds in these documents were, broadly, denial of natural justice as the Committee comprised only metropolitan practitioners, but should have included a regional practitioner; the sample of only 30 out of 7499 cases was too small; the Committee did not consult with any patients; and the nature of his regional client base should have been considered.

On 4 September 2007, Justice Greenwood explained⁸¹ that the original Notice of Appeal entirely failed, as the court had no jurisdiction under section 19 of the *Federal Court of Australia Act 1976* to hear an appeal from a determination of the Determining Authority. Although misdescribed and misconceived, it seemed the doctor was attempting to obtain review of the Determining Authority's decision under the *Administrative Decisions (Judicial Review) Act 1977*, at least on the ground of improper exercise of power.

Federal Court Rules empowered the court to amend, or have amended, any document 'for the purpose of determining the real questions raised by...or of correcting any defect or error in...or of avoiding multiplicity of proceedings'. The power was remedial. Clearly the doctor wanted an Order of Review based on the grounds in section 5 of the *Administrative Decisions (Judicial Review) Act 1977*. His Honour directed that an appropriate application with identified grounds and particulars, and an identified decision, for *Administrative Decisions (Judicial Review) Act 1977* purposes, be filed for hearing on 18 September 2007.

Later the same day, having regard to the inadequate formulation of the Notice of Appeal and the delays, his Honour ordered that Dr Mitchelson pay the respondent's indemnity costs for their 'quite proper' Notice of Motion on 3 August.⁸²

On 25 September 2007, Justice Greenwood delivered his substantive decision.⁸³ He held there was no denial of natural justice where (under section 95 of the *Health Insurance Act 1973*) the Director appointed the Committee of a Deputy Director and two panel members (sections 85 and 84 of the *Health Insurance Act 1973*). There was no want of power in so doing, nor any statutory obligation to appoint a regional practitioner.⁸⁴

There was no contention that the Committee acted beyond power in adopting a sampling methodology advised to be valid by an accredited statistician. Section 106K of the *Health Insurance Act 1973* expressly provides for reliance on sampling, which could lead to a serious order under section 106U. Prima facie the Committee acted reasonably and Dr Mitchelson had not sought to demonstrate any failure, such as incorrect inferences, indefinite testimony or inexactness. Nor did he plead any facts demonstrating that the methodology adopted was unreasonable or invalid, or seek to demonstrate that Committee findings were unsupported by evidence.

Having regard to the deficiencies in the pleadings and the extensive delays by the applicant, His Honour refused leave to amend the original Notice of Appeal and dismissed it, with indemnity costs.

*Dr Hien Thahn Do and
Dr Hugo Huu Hiep Ho
General practitioners
Merrylands, NSW*

Dr Do and Dr Ho practiced in partnership. On 13 December 2001 the (then) Health Insurance Commission referred each to PSR because some of their professional attendances during 2000 may have constituted a prescribed pattern

81 *Mitchelson v HIC* [2007] FCA 1372

82 *Mitchelson v HIC* (No.2) [2007] FCA 1396

83 *Mitchelson v HIC* (No.3) [2007] FCA 1491

84 Note also *McFarlane v Batman* [2000] FCA 1663 where a similar claim was dismissed

of services. Independent PSR Committees considered each referral and each ultimately reported that their subject had engaged in inappropriate practice.

Neither Committee found that exceptional circumstances affected the rendering of the services in question. Doctors Do and Ho appealed to the Federal Court on constitutional grounds (still awaiting resolution in Dr Selim's litigation) and on application of the 'exceptional circumstances' tests in section 106KA(2) of the *Health Insurance Act 1973* and regulations 11(a) and 11(b) of the Health Insurance (Professional Services) Regulations 1999. After a number of legal proceedings, Rares J held that both Committees had misconstrued or failed to apply the tests for exceptional circumstances. It was left to the Director of PSR to decide whether to reconstitute the Committees with new members.⁸⁵

Appeals against both decisions were lodged with the Full Federal Court that on 29 February 2008 allowed the appeals.⁸⁶

The Full Court held that 'standard' material in the two reports did not assert an unbending rule, but sought to explain what circumstances would most likely be regarded as exceptional, and only expressed a qualified view that they were likely to be intermittent or episodic. This did not indicate an erroneous approach by the Committees.

Doctors Do and Ho contended the Committees had failed to expressly consider regulation 11(a) that required an unusual level of need for professional attendances caused by an unusual occurrence. But the circumstances the doctors relied on did not meet these criteria. Public holidays were not unusual and were known well in advance. Absences due to illness, while not predictable, were not unusual.

There was no contrary evidence, nor was there evidence that the level of attendances following such illness or holidays was unusual. The departure of a partner was not an exceptional circumstance. There was no evidence it led to an unusual level of need for attendances – rather, that was a consequence of their decision to keep all the patients previously serviced by three doctors. The court concluded that the evidence did not support application of regulation 11(a). One judge also noted indirect evidence that the regulation had been considered.

In focusing on practice management the Committees were only expressing views that the consequences of public holidays, illness and practice changes were not unusual and could be managed.

Given the Full Court's decision, new Committees were not required.

Dr James Chee Min Thoo
General practitioner
Sanctuary Point, NSW

The (then) Health Insurance Commission referred Dr Thoo on 23 December 2004 because some of his professional attendances during 2003 may have constituted a prescribed pattern of services. A Committee investigated and on 29 June 2007 reported that Dr Thoo had engaged in inappropriate practice in provision of item 23 and 36 services.

On 6 August 2007, Dr Thoo appealed to the Federal Court on grounds that the Committee:

- was not legally authorised to inquire into and report concerning the services it did
- had denied him procedural fairness by refusing his request for adjournment of a hearing.

85 See *PSR Annual Report 2006–07* pp. 27–29 for details of the decisions

86 *Willcock v Do* [2008] FCAFC 15, incorporating *Willcock v Ho*

On 4 June 2008, Justice Lindgren dismissed the appeal on both grounds.⁸⁷

Dr Thoo had submitted that the Committee was only authorised to investigate and report on the question of a prescribed pattern of services, evidence for which had been the reason given in the Director's report for his referral to the Committee. The Court noted that the Director had nevertheless referred to the Committee all services provided by Dr Thoo during 2003. While section 103H(1) of the *Health Insurance Act 1973* provided that the Committee should only make findings in respect of the referred services, section 103H(3) made clear that its investigation was not limited by anything in the Director's report to the Committee, nor by anything in the Commission's request under section 86 that the Director investigate provision of services. Further, section 106K permits a Committee to rely on a sample of services.⁸⁸ Finally, section 106KA(7) makes it clear that section 106KA did not prevent a Committee making findings without considering a prescribed pattern of circumstances.

Dr Thoo also submitted that the Committee was wrong to proceed with its third hearing on 3 February 2006 when Dr Thoo had withdrawn after being refused an adjournment to obtain legal advice. The Court noted evidence that Dr Thoo had only sought legal advice two days earlier and had not brought a lawyer with him. The Committee Secretary had advised him by letter dated 30 March 2005 of the scope of the investigation, and by letter dated 15 November 2005 that the Committee would not give him legal advice but he was entitled to bring a lawyer to hearings. The first hearing had been on 31 August 2005 but Dr Thoo did not challenge the Committee's validity until 10 November 2005, just eight days before attending the second hearing. Furthermore, section 106(4)

empowered the Chair to adjourn a hearing, but did not require that any requested adjournment be granted, and section 106(1) gave the Chair discretion in conducting proceedings. Finally, the Committee had been entitled to adjourn to get legal advice and was not obliged to disclose that to Dr Thoo. In all the circumstances, Dr Thoo had not been denied procedural fairness.

*Dr Warren John Saint
General practitioner
Kwinana, WA*

The (then) Health Insurance Commission referred Dr Saint on 21 August 2000 because it was concerned about his rendered services and daily servicing.

A Committee was established on 18 May 2001. Following investigations using sampling methodology, it reported on 7 June 2004 that 20 per cent of Dr Saint's item 36 services involved conduct which would be unacceptable to the general body of general practitioners.

The Determining Authority has delayed making a determination pending resolution of a judicial review application by Dr Saint to the Federal Court on 5 July 2004. Resolution of that matter was delayed by a number of other proceedings, namely:

- In the Federal Court, Dr Saint sought discovery of many Health Insurance Commission, PSR Director and Committee documents. On 22 August 2005, French J ordered discovery of documents of an evidentiary character that were before or considered by the Committee. Discovery of other documents was refused on grounds of irrelevance and/or because of Committee protection and immunity under section 106F.⁸⁹

⁸⁷ *Thoo v Professional Services Committee No 446* [2008] FCA 830

⁸⁸ Although apparently not argued, section 93(7B) permits the Director to refer any or all services provided during the review period and section 93(7C) protects this from any limitation by material in his report under section 89C(1)(b)(i)

⁸⁹ *Saint v Holmes (No 1)* [2005] FCA 1057; *PSR Annual Report 2005–06* p. 56

- From 13 March 2005, Dr Saint made freedom of information requests for a wide range of documents relating to the Committee and its investigation of his referral, including relevant correspondence with the Director and the Health Insurance Commission and relevant policies and guidelines. PSR provided copies of most documents, but some exemptions were claimed.⁹⁰
- Dr Saint sought Administrative Appeals Tribunal review of PSR's exemption decisions. On 30 October 2006, the Tribunal affirmed the PSR decisions.⁹¹

Justice Siopsis dismissed Dr Saint's review application⁹² regarding the Health Insurance Commission's investigative referral:

- The Full Court had dismissed a claim of constitutional invalidity in Dr Selim's case⁹³ and the present parties had no further submissions to make.
- Dr Saint sought to introduce a large amount of documentary evidence, such as Committee correspondence, largely obtained through freedom of information. Most was refused because, for judicial review, new evidence is generally not permitted unless it relates to making good a legal contention. Much was irrelevant. Some was protected by Committee immunity under section 106F. His Honour did admit affidavits by three expert witnesses.
- Dr Saint claimed the Commission had denied him procedural fairness as he had not been counselled and given an opportunity to adjust his practice to meet the Commission's concerns before referral to PSR. The Commission had undertaken to do so in a 1995 newsletter about PSR. Further, statements by two Commission

officers had led him to believe he was not being asked to cut back services and a referral decision would only be made after reviewing his statistics for the first quarter of 2000. Siopsis J considered that Dr Saint had been counselled on 18 January 2000 and given to the end of March 2000 to meet the concerns, and that the Commission had complied with its advised procedure.

- Even if this was incorrect, Dr Saint had not suffered any practical unfairness. His submission that the Commission should have reviewed his servicing in the second quarter of 2000 was not supported by claims or evidence of improvement. Assertions he had received multiple or repeated counselling when in fact it was only twice did not matter as the 1995 newsletter had only referred to having one counselling before referral. The evidence did not support Dr Saint's claim he had not known the referral was based on first, not second, quarter servicing statistics.
- Dr Saint alleged that, when making the investigative referral to PSR, the Commission failed to take into account his explanation of servicing levels. His Honour noted that the delegate's reasons referred to an explanation having been sought and that Dr Saint's explanation was set out in attachments to the reasons. He was satisfied that the delegate was aware of the explanation and took it into account. In addition, it was clear from section 86(4)(b) that the Commission only had to explain why there may have been inappropriate practice (to identify matters for the Director) rather than reasons for making the referral. The Commission's reasons were appropriate for this purpose.

90 *PSR Annual Report 2005–06* p. 56

91 *Saint v Director of Professional Services Review* [2006] AATA

92 *Saint v Holmes* [2008] FCA 987 (4 July 2008)

93 *Selim v Lele* [2008] FCAFC 13 929; *PSR Annual Report 2006–07* p. 32–33

- Dr Saint said the Commission needed to be 'comfortably satisfied' by sufficiently cogent evidence before referral but had taken into account disputed statistics and counselling. His Honour noted that the legal authority cited related to determining a serious charge, whereas the Commission was only posing a question for investigation.
- Dr Saint said the conduct referred was 'unspecified and unlimited' like that held invalid in *Pradhan*.⁹⁴ *Siopsis J* followed the Full Court decisions in *Grey*⁹⁵ and *Freeman*⁹⁶ in rejecting this argument.
- Dr Saint claimed that, although compliance with MBS descriptors had not been referred, the Committee had wrongly considered the duration of his patient consultations and this had infected its report. His Honour rejected this as there was no mention of consultation times in the final report and any evidence of the Committee's decision processes was inadmissible.
- Dr Saint contended that the Committee should have met to perform certain functions (discussing services, considering draft report and his submissions, considering the final report). *Siopsis J* noted that section 97(1) required a first meeting of the Committee but there was no other express requirement for meeting, which indicated it did not have to meet to perform other functions. Furthermore, any evidence of how it went about its task was inadmissible.

Justice *Siopsis* also dismissed Dr Saint's submissions about the Director's adjudicative referral:

- Dr Saint argued that, because he wrongly believed the Commission delegate had considered his service statistics for the second quarter of 2000, he was denied procedural fairness in making submissions that the Director should dismiss the referral under section 91. His Honour found that there was no contemporary evidence to support this claim and in fact Table 5 in the referral made no reference to second quarter statistics.
 - Dr Saint contended there was no evidence to support the Director's finding about clinically inappropriate use of drugs. In fact the Director had examined Dr Saint's clinical notes and his report referred to the range of drugs and level of prescribing, and expressed concern about apparent clinically inappropriate use. For the purposes of referral the Director's professional opinion was sufficient evidence.
 - Dr Saint said the Committee had failed to apply the statutory test for keeping adequate and contemporaneous patient records applicable from 1 November 1999 because it wrongly believed they did not apply to records made before that date. His Honour noted that the Committee said the statutory test codified preexisting standards and it had in fact applied those. Accordingly, even if it had made an error of law, this made no difference to the outcome and he would exercise his discretion to withhold relief.
 - Dr Saint said the Committee had failed to distinguish failing to provide adequate clinical input from failing to record what input there was. *Siopsis J* said he had examined the services found inappropriate solely based on inadequate records and was satisfied that the Committee appreciated the distinction.
- And Justice *Siopsis* dismissed Dr Saint's submissions about the Committee report:

94 *Pradhan v Holmes* [2001] FCA 1560

95 *Grey v Health Insurance Commission* [2001] FCA 1257

96 *Freeman v HIC* [2004] FCAFC 335

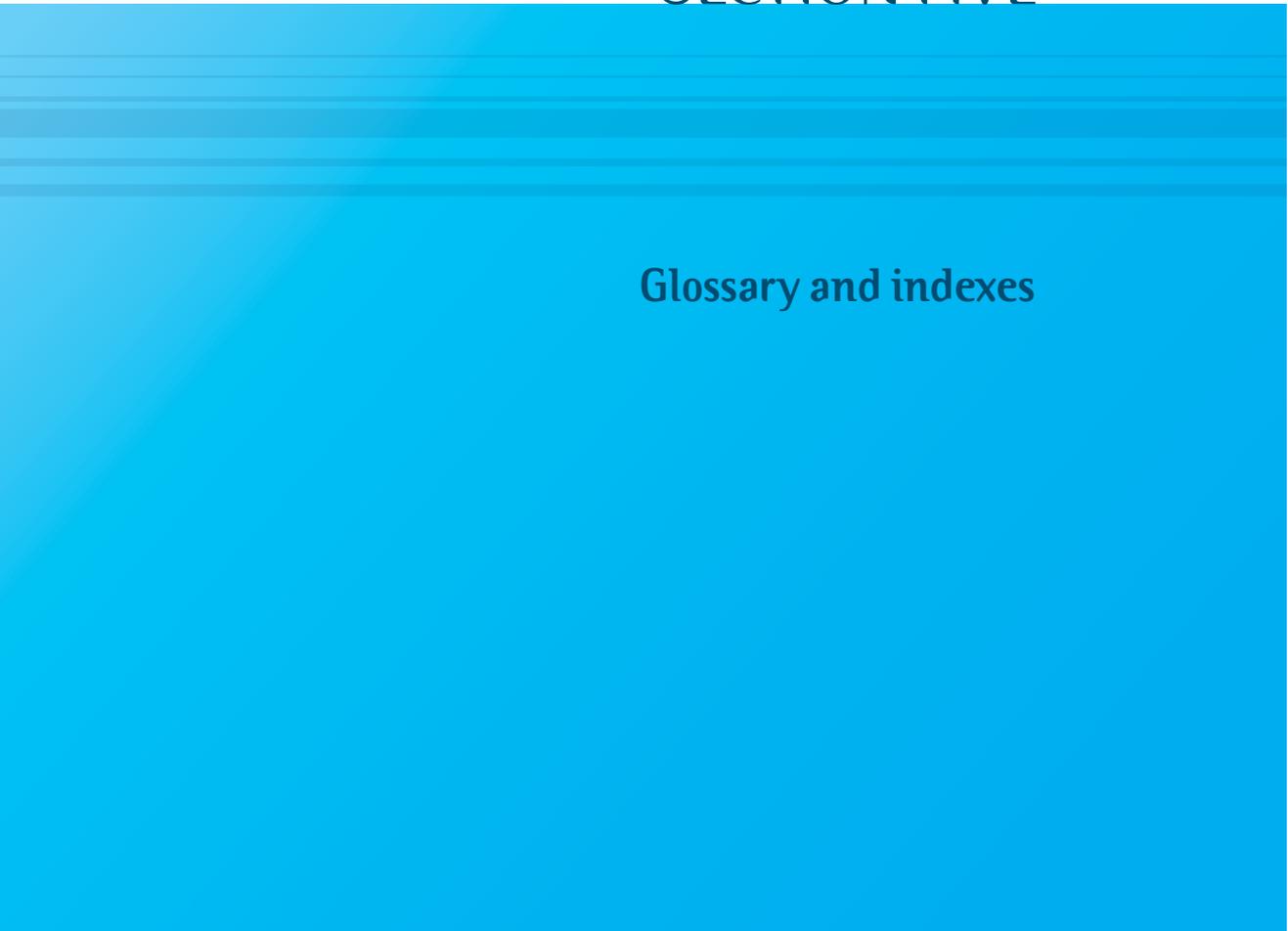
- It was submitted that adverse findings could not be based solely on inadequate record keeping. His Honour noted that section 82(3) emphasised the importance of clinical records.
- The Committee did not sample Dr Saint's services in accordance with the methodology determined by the minister. Dr Saint submitted that advice given by Professor Nicholls, a statistician accredited by the Statistical Society of Australia, did not certify the Committee's sampling methodology as a whole, but addressed only its conclusion. His Honour noted that section 106K(4) contemplated use of alternative methodologies and that Professor Nicholls had said the Committee's 'approach' was valid. He noted *Phan*⁹⁷ where the words 'statistically valid to adopt the conclusion' were considered sufficient compliance with section 106K(4) and approved the procedure in this case.
- Finally, Dr Saint submitted that, as in *Mathews*,⁹⁸ the 'exploratory sample' had not been randomly drawn from the 'preliminary random sample' as required by the sampling determination. His Honour accepted evidence that examination of the Commission's computer file showed that the 'exploratory sample' had in fact been correctly drawn.

97 *Phan v Kelly* (2007) 158 FCR 75

98 *Mathews v HIC* (2006) 90 ALD 49



SECTION FIVE



Glossary and indexes

Glossary and indexes

Glossary

80/20 rule	see prescribed pattern of services
Act	<i>Health Insurance Act 1973</i> , as amended by the <i>Health Legislation (Professional Services Review) Amendment Act 1994</i> and subsequent amendments
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 Medicare Australia
Cox-2	A selective inhibitor – the newest of the non-steroidal anti-inflammatory drugs
Determining Authority	A three-person panel responsible for determining the sanction following an adverse PSR Committee finding
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
ECG	electrocardiogram
EPC	enhanced primary care
inappropriate practice	Conduct in connection with rendering or initiating services for which a Medicare benefit was payable, and which a committee of peers could reasonably consider would be unacceptable to the general body of the peer group (section 82 of the Act)
Level A service	A professional attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management.
Level B service	A professional attendance involving taking a selective history, examination of the patient with implementation of a management plan.
Level C service	A professional attendance involving taking a detailed history, an examination of multiple systems, arranging necessary investigations and implementing a management plan in relation to one or more problems and lasting at least 20 minutes.

Level D service	A professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more complex problems, and lasting at least 40 minutes.
MBS	Medicare Benefits Schedule
Minister	Minister for Health and Ageing
Panel	PSR Panel consisting of medical practitioners, dentists, optometrists, chiropractors, physiotherapists, osteopaths and podiatrists appointed by the minister following consultation with the relevant professional organisations
PBS	Pharmaceutical Benefits Scheme
Prescribed pattern of services	A prescribed pattern of services is also known as the 80/20 rule, whereby a practitioner is deemed to have practised inappropriately if he or she renders 80 or more services on 20 or more days in a 12-month period
PSR referral	Professional Services Review 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
request for review	A case prepared by Medicare Australia asking the Director to review the provision of services and containing Medicare Australia'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.
Schedule 4 drugs	Restricted drugs
Schedule 8 drugs	Drugs of addiction
VRGP	Vocationally Recognised General Practitioner

MBS items referred to in text

MBS item no. Service

1	an emergency after hours attendance at a place other than consulting rooms
23	a level B GP consultation
24	a level B standard home visit
36	a level C GP consultation
37	a level C home visit
44	a level D GP consultation
47	a level D home visit
53	a standard consultation lasting up to 25 minutes
54	a long consultation lasting more than 25 minutes but less than 45 minutes
104	a specialist consultation
698	a professional attendance at consulting rooms between 11 pm and 7 am
700	health assessment for a patient over 75 year of age
720	GP care plan
721	GP Management Plan
723	team care arrangements
725	a care plan review
2710	GP mental health plan
5020	a professional attendance on a Sunday, public holiday or after 1 pm on a Saturday
5040	a level C attendance on a Sunday, public holiday or after 1 pm on a Saturday
10900	a professional attendance of more than 15 minutes duration, being the first in a course of attention
10913	a professional attendance of more than 15 minutes duration ... where the patient has new signs or symptoms
10916	professional attendance, being the first in a course of attention, of not more than 15 minutes duration
10918	professional attendance being the second or subsequent in a course of attention
10993	an immunisation service provided by a nurse

11506	measurement of respiratory function
11610	a measurement of ankle – waveform analysis
11700	12-lead electrocardiograph and report
11708	ECG recording
11712	multi channel ECG
14221	implanting a device for delivery of therapeutic agents
30029	repair of a laceration involving deeper tissues
30041	repair of a laceration involving deeper tissue more than 7 cm long
30061	minor surgical item
30067	removal of a foreign body in muscle, tendon or other deep tissue
30192	pre-malignant skin lesions, 10 or more lesions treated by non surgical means
30196	confirmed malignant skin lesion removed by curettage or laser
30202	skin lesions treated by non surgical means
30203	more than 10 malignant skin lesions treated by non surgical means
30487	small bowel intubation with biopsy
31200	excision of skin tumour
31210	excision of skin lesion more than 10 mm but less than 20 mm in diameter
31215	excision of skin lesion more than 20 mm in diameter
31230	excision of skin lesion from nose, eyelid, lip, ear, digit or genitalia
31255	excision of basal cell or squamous cell carcinoma from skin from nose, eyelid, lip, ear, digit or genitalia up to and including 10 mm in diameter
31260	excision of basal cell or squamous cell carcinoma from skin from nose, eyelid, lip, ear, digit or genitalia more than 10 mm in diameter
31270	excision of basal cell or squamous cell carcinoma from skin from face, neck or lower leg more than 10 mm in diameter
31275	excision of basal cell or squamous cell carcinoma from skin from face, neck or lower leg more than 20 mm in diameter
31277	re-excision of basal cell or squamous cell carcinoma from skin from face, neck or lower leg more than 20 mm in diameter, performed by a practitioner other than the practitioner who provided the previous treatment

31285	excision of basal cell or squamous cell carcinoma more than 10 mm and up to 20 mm in diameter
31290	excision of basal cell or squamous cell carcinoma more than 20 mm
31325	a melanoma removal up to 10 mm in diameter
31518	total mastectomy
32003	resection of the large intestine
41764	endoscopic examination of nose, nasopharynx and larynx
45200	skin flap repair of a defect in skin
45203	skin flap repairs and skin grafting
45206	skin flap repair to eyelid, nose, lip, neck, hand, thumb, fingers or genitals
45207	skin flap
45451	skin flap repairs and skin grafting
47003	treatment of a dislocated clavicle
47369	minor surgical
47633	treatment of a fractured metatarsal
50124	intra-articular injection
58100	diagnostic imaging of the lumbosacral spine
66515	six or more pathology tests including lipid testing
66536	quantitation of high-density lipoprotein cholesterol
66596	iron studies