THE REPORT OF THE REVIEW COMMITTEE OF THE PROFESSIONAL SERVICES REVIEW SCHEME

AMA
PROFESSIONAL SERVICES REVIEW
HEALTH INSURANCE COMMISSION
Health and Aged Care

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4 March 1999

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

Dear Minister

We, the members of the Review Committee of the Professional Services Review (PSR) Scheme, have pleasure in presenting our final report to you. It has been prepared with the assistance of a Working Group.

The report responds to your request for advice regarding any legislative and administrative changes necessary to ensure the effectiveness of the PSR Scheme.

A number of interested parties were consulted during the review process, including the PSR Deputy Directors, the PSR Tribunal Presidents and members, the AMA's Federal and Executive Councils, the AMA Council of General Practice and the RACGP.

The Review Committee is unanimous in its support for a peer-review based PSR Scheme. It recognises the need however to improve the administration of the PSR process, to accord natural justice to the practitioner under review, clarify methods of investigating inappropriate practice, and address evidentiary difficulties.

The Review Committee makes a number of recommendations to achieve these outcomes and these are set out in this report. We trust that the implementation of the legislative and administrative changes proposed will provide for a more efficient and effective PSR Scheme and encourage good practice within all the professions subject to the PSR Scheme.

Yours sincerely

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Contents

1 Overview

1.1 Executive Summary

The review process confirmed that both the Government and the profession support a peer review-based Professional Services Review (PSR) Scheme, and share a common interest in developing a range of methods to encourage good practice within the medical profession. These include continuing medical education, accreditation, and practice incentives payments.

The Review Committee considered the procedural and evidentiary difficulties in the present PSR Scheme highlighted by the Full Federal Court in *Adams v Yun*g. It found that the general definition of inappropriate practice in the *Health Insurance Act 1973* (the Act), as conduct unacceptable to the general body of practitioner's peers, could be retained.

However, it identified the need to distinguish between the different categories of inappropriate practice, and recommends that specific provision should be made for how each category of inappropriate practice be approached by a PSR committee.

Conduct identified by Professional Services Review Committees (PSRC) as unacceptable and involving inappropriate practice falls broadly into the following categories:

- general professional issues (including physical or mental impairment);
- particular identifiable unacceptable practice (including high number of services per patient, inappropriate prescribing, inappropriate ordering of diagnostic imaging and pathology); and
- high volume of services per day.

The Review Committee proposes that the following approaches be used to address the different categories of inappropriate practice:

- for general professional issues, matters should be referred to appropriate bodies such as Medical Boards;
- for particular identifiable unacceptable practice, either the particular services should be identified, or a sample of services examined and extrapolated to the total services of that type within a referral period; and
- for high volume of services per day, a deeming provision should be applied or a sampling approach adopted where the deeming provision is not appropriate. The deeming provision will apply where a practitioner reaches or exceeds a specified volume of services (set at a level agreed with the profession for that specialty/profession). Once this occurs, a practitioner will be deemed to be practising inappropriately unless he or she can demonstrate exceptional circumstances to the satisfaction of the PSRC.

The Review also identified changes necessary to improve the administration of the PSR process to meet the needs for legal effectiveness, transparency and natural justice, and to ensure the peer review process is maintained. These proposed changes include:

- consolidating the existing PSR functions into a single agency with increased funding to support its expanded investigative and administrative functions;
- providing legal support to the peer review committees through a legal adviser who will assist the committee on matters of law, and by introducing comprehensive training and operating protocols for committee members;
- allowing greater legal support to the practitioner under review (PUR) so that his or her legal adviser has the right to address the committee throughout the hearing on matters of law and a right to a final address to the committee on the merits of the case as well as matters of law;
- replacing the Determining Officer (currently in the Department of Health and Aged Care) with a Determining Panel (comprising a permanent medical practitioner chair, a permanent lay person and a third member who is a representative of the profession of the PUR) also to be serviced by the new agency;
- structuring the Agency so that support (including legal support) for investigations, committees and determining panels will be clearly separated; and
- removing the PSR Tribunal from the process in recognition that review on the merits of the final determination is not appropriate in a scheme in which the key judgment is a professional judgment by the practitioner's peers about the practitioner's conduct. The right of review on points of law by the courts will, of course, be retained.

The Review Committee recommends that the profession and the Government review the new PSR arrangements at anytime where circumstances require, but not later than three years after coming into effect.

1.2 Reasons for the Review

The PSR Scheme provides for a system of peer review focusing on a practitioner's conduct to determine whether a practitioner has inappropriately rendered or initiated services which attract a Medicare benefit, or has inappropriately prescribed under the Pharmaceutical Benefits Scheme (PBS).

Decisions in the *Yung* case by the Federal Court in December 1997 and the Full Federal Court in May 1998 highlighted deficiencies in the legislation and in the operation of the Professional Services Review Scheme, and necessitated a comprehensive review of the Scheme.

In accepting the substance of the Federal Court's findings, the Review Committee acknowledges the difficulties encountered by the PSRC in conducting this first inquiry under a new Scheme. In the *Yung* case, the PSRC relied on the legislative definition of inappropriate practice being conduct unacceptable to the general body of the profession. Consequently, the PSRC inquiry focussed on the general pattern of conduct, not on the provision of excessive services to individual patients as required by the previous Medical Services Committees of Inquiry (MSCI) process.

The Federal Court concerns about the PSR process fall within two broad categories:

- procedural deficiencies—the PUR was not afforded natural justice through the PSRC's failure to particularise various matters against the doctor in respect of inappropriate practice and to indicate the adverse conclusions that might be reached. In addition, the PSRC and the PSR Tribunal (PSRT) had regard to matters outside the scope of the referral. The PSRC did not particularise the case for the person under review to answer; and
- evidentiary deficiencies—the PSRC was found to be in error by not relating its findings to identified services, and not undertaking a detailed consideration of individual services. The Full Court made it clear that a PSRC must reach an ultimate conclusion about some or all of the services specified in the referral.

To address the deficiencies identified by the Court and to clarify the legislative intention of the Scheme to focus on professional conduct, the Minister for Health and Aged Care, the Hon Dr Michael Wooldridge, agreed on 31 July 1998 to a comprehensive review of the PSR Scheme.

1.3 Review Process

The review was undertaken by a Review Committee comprising the Australian Medical Association (AMA) (Chair), the Health Insurance Commission (HIC), the Director of Professional Services Review (DPSR) and the Department of Health and Aged Care (Health). A working group supported the Review Committee.

The objectives of the review, agreed between the AMA and the Minister for Health and Aged Care, were to:

- consider the implications of the recent Federal Court decisions and experience with the Scheme to date for current administrative arrangements;
- consider and make recommendations for changes to the administrative arrangements underpinning the Scheme to ensure its continuing effectiveness in line with the requirements of the courts;
- consider specific arrangements which enhance the Scheme, with such consideration to encompass, but not be limited to, the location of the role of the Determining Officer and additional administrative and other support for the peer review process;
- consider and make recommendations regarding any legislative changes necessary to guarantee an effective Scheme; and
- advise on any other matters considered necessary to enhance the effectiveness of the process.

The Review Committee was to report to the Minister for Health and Aged Care by the end of October 1998. This was subsequently revised to facilitate the broad consultation required as part of the review process.

A number of interested parties were consulted during the review process, including the PSR Deputy Directors (that is, chairs of the PSRCs); the PSRT Presidents and members; State and Territory medical boards; professional bodies and colleges; major medical defence organisations; and the AMA's Executive Council, Federal Council and Council of General

Practice.

Legal advice was sought from several Senior Counsel on aspects of the proposed changes to the Scheme. Expert advice was also sought from Professor Des Nicholls, Department of Statistics and Econometrics, Australian National University, on appropriate sampling methodologies, and considered by the Review Committee. Consultations with the AMA Federal Council and the AMA Council of General Practice were critical to the review process.

The Review Committee identified the need for several changes to the PSR Scheme to improve the administration of the process, clarify the methods of investigating inappropriate practice, and address evidentiary difficulties.

1.4 Recommendations

A detailed discussion of the Review Committee's recommendations is contained in parts 3 and 4 of this report. The specific recommendations of the Review Committee are as follows:

Definition of Inappropriate Practice

- **Recommendation 1:** The general definition of inappropriate practice in the *Health Insurance Act 1973* be maintained as conduct unacceptable to the general body of the practitioner's peers.

Processes to Arrive at Findings

- **Recommendation 2:** The Act be amended to provide the authority for the application of sampling and for Ministerial directions to be made to provide for a range of sampling methodologies to be used by PSRCs to make findings in relation to the provision of particular identifiable services.

- **Recommendation 3:** The Act be amended to provide the authority for the application of a deeming provision in respect of high volume servicing per day. Once the pattern of services specified in regulations under this provision is reached, a practitioner will be deemed to have engaged in inappropriate practice unless he or she can demonstrate to the satisfaction of the PSRC that exceptional circumstances have occurred.

- **Recommendation 4**: With respect to general practice, the deeming provision will apply when a practitioner provides 80 or more consultation services on 20 or more days of a year. If the Committee has concerns about the accuracy of the HIC data such that the threshold limits may not have been met, the Committee may decide not to rely on the deeming provision.

- **Recommendation 5**: With respect to general practice, exceptional circumstances may relate, but not be limited to, the availability of alternative medical services or unusual occurrences.

- **Recommendation 6:** Deeming provisions in respect of high volume services per day will be specialty- and profession-specific, be developed in consultation with relevant groups within the professions, and be introduced in regulations.

- **Recommendation 7**: If a general practitioner is deemed to have engaged in inappropriate practice, the quantum of inappropriate practice be defined in terms of all consultation services on every day on which 80 or more consultation services were rendered, and where exceptional circumstances cannot be demonstrated to the satisfaction of the PSRC.
- **Recommendation 8**: The Act be amended so that a PSRC can make a finding of inappropriate practice in broad terms without identifying specific services or a number of services when:
  - there are no clinical records or the records cannot be used; and
  - the finding is based on HIC data and evidence taken at the hearing; and
  - the finding focuses on particular categories of services.

Determinations

- **Recommendation 9**: The existing range of sanctions should be retained in the Act, namely counselling, reprimand, repayment of some or all of the Medicare benefits and/or suspension from Medicare.
- **Recommendation 10**: In cases of high volumes of attendances per day by general practitioners and covered by the deeming provisions, Ministerial guidelines (see Recommendation 39) should provide for substantial periods of suspension from Medicare (eg periods of 2 years or more).
- **Recommendation 11**: When a general finding is made as outlined in Recommendation 8, the sanctions must be limited to counselling, reprimand and/or suspension.

Expanded Agency

- **Recommendation 12:** The PSR Agency be expanded to include the functions of investigation, case preparation and administrative support for the proposed Determining Panel (DP).
- **Recommendation 13:** Additional funding be provided to permit the new PSR Agency to perform efficiently and effectively.

Health Insurance Commission and Referral Processes

- **Recommendation 14:** The process of referral be redefined in the Act as a progressive action starting with a notification of a concern or concerns issued by the HIC to the DPSR and, after investigation, a formal referral from the DPSR to a PSRC.
- **Recommendation 15:** A PSRC be able to raise new concerns which may become an additional referral by the DPSR provided that the PUR is given adequate notice and time to consider his or her responses.

- **Recommendation 16:** A Standing Committee comprising representatives of the AMA and HIC be established to review counselling processes, review the Artificial Neural Network (ANN), explore initiatives and encourage the overall concept of good practice.

Director of Professional Services Review (DPSR)

- **Recommendation 17:** The Act be amended to give the DPSR the power to require production of documents, and the power to refer concerns about a practitioner's professional conduct to State and Territory Registration Boards.
- **Recommendation 18:** The DPSR be able to engage case officers, including clinical practitioner advisers, to perform the detailed examination of clinical records and other tasks for the effective work-up of a case for referral to a PSRC.
- **Recommendation 19:** The Act be amended to give the DPSR an option not to action HIC concerns, with the proviso that if the same practitioner is the subject of subsequent HIC concerns, the DPSR must action those subsequent concerns.
- **Recommendation 20:** The Act be amended to increase the powers of the DPSR to negotiate, but not approve, suspension (full or partial) and repayment of Medicare benefits, where a PUR acknowledges inappropriate practice and negotiates a settlement.
- **Recommendation 21:** Where a PUR acknowledges inappropriate practice and negotiates a settlement with the DPSR, the recommended settlement will not be implemented by the DPSR but instead be referred to a DP for concurrence.
- **Recommendation 22:** The Act be amended to specify that a negotiated settlement, once implemented, is considered to be a final determination for the purposes of Section 106X of the Act.

Enhanced Legal Assistance and Processes

- **Recommendation 23:** Legal case officers will assist the DPSR, the PSRCs and the DP. However, the same legal adviser cannot be involved in more than one stage of a case (the stages being investigation, Committee and Determining Panel).
- **Recommendation 24:** The PSRC and PUR be permitted to bring witnesses, other than character witnesses, who would be able to be questioned, subject to the discretion of the Committee, in relation to their evidence.
- **Recommendation 25:** The PSRCs be provided with assistance from a legal adviser who will be available to the PSRC and attend PSRC hearings, but not take part in any decision making process.
- **Recommendation 26:** Members of PSRCs receive training in natural justice and other relevant legal issues.
- **Recommendation 27:** Comprehensive procedural guidelines and operational protocols be developed for PSRCs.

- **Recommendation 28:** The legal adviser to the PUR be given the right to address the PSRC on legal issues during the hearing and on the merits of the case as well as matters of law in a final address.
- **Recommendation 29:** The PUR be given a copy of the draft PSRC report and be invited to make formal written submissions.
- **Recommendation 30:** The PSRC be required to take the submissions by the PUR into account in making its final report.
- **Recommendation 31:** The final report of the PSRC be sent to the PUR and to the DP. The report will be sent to the DP not earlier than 28 days after it has been sent to the PUR to allow the PUR to exercise a right of appeal to the Federal Court on matters of law.

Referral of Professional Issues

- **Recommendation 32**: The Act be amended to empower the DPSR, PSRCs and the DP to refer concerns relating to significant threats to the life or health of persons to State/ Territory registration bodies, and matters relating to the practitioner's compliance with professional standards to relevant bodies.
- **Recommendation 33:** The Act be amended to empower PSRCs to notify the HIC of matters of concern arising out of an inquiry, such as instances of doctor shopping.

Determining Panel (DP)

- **Recommendation 34:** The position of the Determining Officer (DO) be replaced by an independent DP serviced by an expanded PSR Agency.
- **Recommendation 35:** The DP comprise a permanent chair (medical practitioner), a permanent lay person and a third member who is a representative of the profession of the PUR, with a lawyer to assist the Panel. Members to be appointed by the Minister in consultation with the AMA or relevant bodies.
- **Recommendation 36:** The same DP be used for all cases appropriate to the profession of the PUR with allowances being made for replacements in the event of illness or other such reasons.
- **Recommendation 37:** The PUR be given a draft determination and be invited to make formal written submissions addressing the sanctions contained in the draft.
- **Recommendation 38:** The DP be required to take the submissions of the PUR into account in making a final determination.
- **Recommendation 39:** The Act be amended to provide that the Minister may, in writing, make guidelines for the DP and that decisions by the DP be consistent with these guidelines.

Revised Time Periods

- **Recommendation 40:** All the time periods contained in the Act for procedures under the PSR Scheme be examined jointly by the AMA and the Government to see whether they are appropriately and realistically set taking into account the impact on the new PSR Agency of the proposed administrative arrangements.

Review Rights

- **Recommendation 41**: The PSRTs be discontinued. However, review rights by the Federal Court on matters of law be maintained.

Other Matters

- **Recommendation 42**: Details of PSRC reports and DP decisions may be published, including names of the practitioners involved, when a final determination has been made, excluding cases where a negotiated settlement has been made.
- **Recommendation 43:** In all cases already within the PSR system on the date the revised legislation takes effect, transitional arrangements should be such as not to disadvantage the PURs in those cases.
- **Recommendation 44**: The Government and the profession review the revised PSR Scheme no later than three years after it comes into effect.
- **Recommendation 45:** The maintenance of adequate and contemporaneous medical records be a legislative requirement for payment of Medicare benefits from 1 November 1999. The nature of this requirement will be the subject of further discussions between the profession and the Government.

2 Background

2.1 Introduction of the PSR Scheme

The PSR Scheme was introduced in 1994 to replace the previous Medical Services Committees of Inquiry (MSCI) scheme. A report by the Australian National Audit Office (ANAO) in 1992-93, entitled *Medifraud and excessive servicing: Health Insurance Commission*, found that MSCIs were not operating satisfactorily and needed to be strengthened.

A major complaint in the ANAO report was that the MSCI process did little to discourage the provision or initiation of excessive services. The MSCIs did not provide an effective deterrent because, in many instances, the level of benefits recovered from practitioners was totally eclipsed by the level of overservicing that had actually occurred.

The inability to impose penalties commensurate with the extent of a practitioner's overservicing was largely due to a lack of power to make decisions on the extent of overservicing on the basis of generalised evidence. MSCI judgements about overservicing could only be made on the basis of individual services—that is, benefit recovery and penalties could only be made in respect of the identified excessive services.

2.2 Description of the PSR Scheme

The PSR Scheme is established by Part VAA (sections 80–106ZR) of *the Health Insurance Act 1973* (the Act). Part VA (sections 107–124A) of the Act concerns PSRTs and appeals to the Federal Court.

The PSR Scheme is concerned with the conduct of health professionals—medical practitioners, dentists, optometrists, chiropractors, physiotherapists and podiatrists (sections 81–82). It provides for the examination of an individual health practitioner's conduct by a committee of peers to ascertain whether inappropriate practice under Medicare is involved and, if so, to provide for action to be taken.

The PSR Scheme seeks to address the shortcomings of the MSCI process identified by the ANAO. It replaced the concept of excessive servicing with the broader concept of inappropriate practice. This is defined in the Act as conduct in connection with the rendering or initiating of services that is 'unacceptable to the general body of the members of the specialty' (or the profession) as appropriate (section 82).

The PSR scheme originally enabled a PSRC to apply the findings from a sample of services rendered or initiated by the PUR to the whole class of services of concern. It was envisaged that 'sampling' would result in far greater benefit repayments than was achieved under the MSCI process.

These provisions were repealed in November 1997 as the sampling procedures proved to be administratively complex and cumbersome and unworkable in practice for PSRCs.

In broad terms, the PSR process provided for under the legislation involves the following stages:

- The HIC monitors the Medicare claiming patterns of health practitioners. The HIC identifies and counsels practitioners with atypical behaviour for which a reasonable explanation was not apparent. Where no or insufficient change in behaviour occurs following counselling, the HIC prepares and refers cases to the DPSR.
- The DPSR must dismiss a referral or establish a PSRC (the members of which are selected from the practitioners on the Professional Services Review Panel) to consider whether the practitioner concerned has engaged in inappropriate practice.
- The PSR Scheme examines professional practices in relation to Medicare and aspects of the Pharmaceutical Benefits Scheme (PBS). If a PSRC, in the course of its examination of a referral, comes to the view that the PUR may have committed fraud, it must report its concerns to the HIC and suspend its consideration of the referral. The HIC may subsequently return the referral, possibly modified, to the PSRC, and it would recommence consideration of the referral.
- If a PSRC thinks that the material before it indicates that action should be taken against the PUR 'in order to lessen a serious threat to the life or health of any person', it must report its concerns to the relevant regulatory body, for example, a State Medical Board, without suspending its consideration of the referral (s.106P).
- The PSRC conducts hearings, makes findings and prepares a report setting out its findings on whether the practitioner has, in its opinion, engaged in inappropriate practice.
- A report is given to the Determining Officer (DO) and, if the report makes a finding that the practitioner has engaged in inappropriate practice, the DO must make a draft determination. This must be given to the practitioner to enable him or her to make submissions in response.
- The DO must then make a final determination containing one or more directions of the kind set out in section 106U(1), for example, that the practitioner be reprimanded, counselled, repay to the Commonwealth an amount equivalent to any Medicare benefit paid for inappropriate services, or that the practitioner be suspended (or disqualified) for periods up to three years in respect of the provision of Medicare services.
- If the practitioner is aggrieved by the final determination, he or she has a right of appeal to the PSRT. A practitioner can be legally represented at a Tribunal.
- A PSRT has power to review a determination. The Act provides a PSRT's decision is final, subject to the Constitution, and except for an appeal to the Federal Court on a question of law only, or an appeal brought in accordance with the *Federal Court of Australia Act 1976*.
- Section 106X of the Act mandates that a practitioner with two effective final determinations must be referred to a Medicare Participation Review Committee (MPRC). Such referrals can have serious consequences for a practitioner, including suspension from the Medicare arrangement for a period up to five years.

2.3 Overview of PSR Activities

The PSR process begins with the monitoring and counselling activities of the HIC.

The HIC monitors the claiming patterns of all practitioners and identifies those with behaviour that is atypical. It uses Artificial Neural Network (ANN) technology to identify practitioners with high-risk profiles. It refers them to State Case Management Committees (CMCs) to determine if further action is warranted.

These ANNs are computer systems which have been developed to classify the servicing patterns of practitioners. The classification system aims to identify those practitioners who may be practising inappropriately based on their Medicare servicing profiles. The classifications are based on the interaction of a number of indicators, such as the number of services or, for example, the ratio of deep to superficial lacerations repaired. Individual practitioners are then categorised into those of considerable concern to those of no concern.

Only about one third of practitioners identified are counselled. The vast majority of practitioners provide sufficient additional information to show that their practice is quite appropriate, or they agree to modify their behaviour. It is only after counselling and a further period of review that the HIC will refer a practitioner to the DPSR for possible investigation if his/her servicing continues to be of concern.

The numbers of practitioners referred by the HIC to the DPSR for consideration of possible inappropriate practice is quite small in comparison to those identified in the first instance. For example, in 1997-98, there were 1,890 medical practitioners identified with behaviour as atypical, while only 43 were referred to the DPSR. The activities undertaken by the HIC since the inception of the PSR are summarised below.

Table A: HIC Activities

	1994-5	1995-6	1996-7	1997-8
GPs				
– Identified by ANN	1,695	1,846	1,876	1,890
– Counselled by HIC	155	456	588	666
Specialists				
– Counselled by HIC	6	8	40	113
Total Practitioners Counselled	161	464	628	779
Total Referrals to PSR	1	18	73	43

(Source: HIC)

Since 1994 the HIC has identified 7,307 instances where practitioners' claiming practice patterns vary significantly from that of their peers. HIC medical advisers counselled some 2,032 practitioners (1,865 general practitioners and 167 specialists).

HIC counselling activities, and the publicity generated to date, have encouraged positive changes in the behaviour of practitioners. The HIC data provided at Table B shows significant reductions in the average annual cost per practitioner in the two years after counselling, for example, the average annual cost change for Medicare per practitioner is $34,930.

Table B: Financial impact of counselling by HIC medical advisers

	PBS	Medicare	DI initiated	Pathology initiated
Average per practitioner for the 2 years following counselling	$8,234	$34,930	$9,159	$7,251

(Source: HIC)

A total of 135 practitioners, which represents less than 7 per cent of all practitioners counselled since 1994, was subsequently referred to the DPSR.

The DPSR is an independent statutory position created by the *Health Legislation (Professional Services Review) Amendment Act 1993.* The DPSR's responsibilities include considering HIC referrals for review of a practitioner's conduct and, deciding whether to set up a PSRC. PSRC members are drawn from a Professional Services Review Panel.

The DPSR also has the power to dismiss a referral, including the power to impose, but only with the consent of a practitioner whose conduct is under review, a partial suspension from Medicare.

Table C: Summary of PSR activities

	1994-5	1995-6	1996-7	1997-8	Total
HIC referrals received by DPSR	1	16	70	48	135
Referrals dismissed:					
– Insufficient grounds s.91		1	3	11	15
– Partial suspension s.92			2	3	5
PSRCs established by DPSR	1	15	30	35	81
PSRC reports to Determining Officer		8	21	22	51
Draft Determination Received by DPSR		2	10	24	36
Final Determination			1	29	30

(Source: PSR Annual Report 1997-98)

The first case the HIC referred to the DPSR concerned the conduct of Dr S.Yung, a vocationally registered general practitioner who rendered 19,622 services in the year, 1 January to 31 December 1994. Dr Yung appealed to the Federal Court against a PSRT decision that he be fully suspended from Medicare for six months.

In December 1997, Justice Davies of the Federal Court ordered that the decision of the PSRT be set aside and the proceeding be remitted to a differently constituted Tribunal.

The DO appealed Justice Davies' decision to the full Federal Court. In May 1998, the Full Court by majority (Burchett and Hill JJ with Beaumont J dissenting) substantially dismissed the appeal.

2.4 Implications of Federal Court decisions

Since the adverse findings in the *Yung* matter in the Full Federal Court, several general practitioners have succeeded in having PSRT determinations set aside. The determinations were set aside either on application by both parties or by the decision of the PSRT that, essentially, there was no difference between each of these later cases and that of the *Yung* case.

Table D: Appeal Activity

	Lodged	Decisions
PSR Tribunal	19	15
Federal Court	4	2
Full Federal Court	1	1

(Source: Department of Health and Aged Care—data as at 22 Feb 1999)

The Federal Court decision in *Yung* highlighted deficiencies in the PSR Scheme. The impact of these findings on the PSR process are that a PSRC:

- may only investigate and make findings on those aspects of the doctor's conduct that are specifically set out in the referral as matters of concern to the HIC; and
- must base its findings only on identified or specified services.

The Court also held that:

- the practitioner's Vocational Registration status and the Royal Australian College of General Practitioners (RACGP) standards were irrelevant, as the legislation provides for a test related to the body of general practitioners generally;
- the PSRC could only take into consideration what the doctor did and not what he or she did not do; and
- the PSRC did not afford natural justice in that it failed to particularise various matters against the doctor in respect of conclusions it reached, and it failed to indicate adverse conclusions which might be reached.

The Court also commented on the PSRT process. It held that it is open to the PSRT to take a different view from the PSRC on the issues that were before the PSRC.

As a result of the *Yung* decision, all aspects of the PSR Scheme need to be examined in light of the errors of law identified. Accordingly, the Minister for Health and Aged Care, the Hon Dr Michael Wooldridge established a Review Committee to consider the effects of the Court judgement and make recommendations on any legislative amendments and administrative changes that may be required.

The Federal Court subsequently handed down a decision in relation to an appeal by Dr Retnaraja against a PSRT decision. The practitioner had been found by a PSRC to have engaged in inappropriate conduct. The final determination, which directed that Dr Retnaraja be suspended from Medicare and repay an amount of benefit, had been affirmed by a PSRT. The Federal Court set aside the repayment of benefit but otherwise upheld the PSRT decision.

The Review Committee noted that as part of its decision, the Court was satisfied that Dr Retnaraja was accorded natural justice in that he had been made aware of the HIC and PSRC concerns and given every opportunity to respond. The Court also found the PSRC was entitled to adopt a less formal sampling procedure, provided that the sample used was sufficiently broad to justify the ultimate conclusion that a practitioner had engaged in inappropriate conduct. However, the Court held that repayment is only possible where the volume of inappropriate practice was precisely identified, and this was not done in the case of Dr Retnaraja.

3 Peer Review

3.1 Introduction

Under the current Act, inappropriate practice is defined as conduct in connection with rendering or initiating services, which would be 'unacceptable to the general body' of peers of general practitioners, specialists, consultant physicians, or the relevant profession (s. 82).

The role of the PSRCs to date has been to determine if the practitioner's conduct amounts to inappropriate practice. In coming to that opinion, it is required to test the practitioner's conduct against what is unacceptable to the general body of the practitioner's peers.

A PSRC finding of inappropriate practice results in a sanction being determined by the DO. The determination is made in the form of directions (s.106U). These provide for a practitioner to be: reprimanded; counselled; required to pay the whole or part of Medicare benefits paid by the Commonwealth in respect of the services; and/or be suspended from Medicare, either partially or fully, for up to 3 years.

3.2 Definition of Inappropriate Practice

The professional organisations consulted during the review urged that 'peer review' remain as the cornerstone of the PSR Scheme. The Review Committee therefore proposes no change to the current definition of inappropriate practice in the legislation.

Recommendation 1

The general definition of inappropriate practice in the *Health Insurance Act 1973* be maintained as conduct unacceptable to the general body of that practitioner's peers.

The Review Committee did, however, seek to address the difficulties identified by the Federal Court in *Adams v Yung*—specifically that the PSRC findings were not based on any detailed consideration of individual services.

The Court noted that the PSRC did not attempt to undertake a sample analysis or base its findings on a detailed consideration of individual services. The full Court also made it clear that even though sampling permits necessary extrapolation from the sample to the referred services, a PSRC must nevertheless reach an ultimate conclusion about some or all of the services specified in the referral. This is particularly important if sanctions are to be imposed.

Accordingly, the Review Committee examined the different types of inappropriate practice and proposes various methods to identify and quantify inappropriate practice.

3.3 Types of Inappropriate Practice

The Review Committee examined the conduct identified by PSRCs to date as unacceptable and which involved inappropriate practice. It found these types of conduct fell broadly into the following categories:

(a) General professional issues

In the course of a hearing into a referral, PSRCs have found issues of professional concern in relation to clinical competence and performance; aberrant professional behaviour or beliefs; lack of meaningful continuing medical education; physical or mental impairment; and substance abuse. Organisational issues which affect patient safety, such as equipment and staffing deficiencies, are also sometimes evident.

The Review Committee agreed that PSRCs should only comment on general professional issues where they are directly relevant to a particular Medicare service in question (see Recommendation 32, Section 4, Revised PSR Arrangements).

(b) Particular identifiable unacceptable conduct

These concern particular identifiable types of conduct such as: high number of services per patient; unusual incidence of specific types of services; inappropriate prescribing; inappropriate ordering of diagnostic imaging and pathology; and inappropriate use of Medicare item numbers when making claims.

(c) High volume services per day

A large number of the cases brought before PSRCs involve general practitioners providing high numbers of services per day with low rates of consultation services per patient. An extreme case was a practitioner who rendered 240 services in one day. There are other practitioners who regularly provided 100–120 services per day.

3.4 Methods for making a finding of Inappropriate Practice

When PSRC members make their professional judgment on 'inappropriate practice' a range of issues can be, and are, considered. As well as medical records, consideration may be given to the practitioner's professional education and experience; the practice organisation; the practice location; the availability of other medical services in the locale; and the demography of the practice population.

However, in order to satisfy the evidentiary requirements raised by the Court in *Adams v Yung*, a PSRC needs to identify the extent of inappropriate practice by relating this to some or all of the services specified in the referral.

There are several ways this can be done—by examining the individual identified services, or by examining a sample of the services and extrapolating these to the services within the referral period.

An examination of individual services may be appropriate if the total number of services is small, but can become time consuming for a PSRC if a large number of services is involved (a Committee must explore the issues relating to a service with the PUR in order to ensure fair judgments are made about these services).

(a) Sampling

It is feasible for a PSRC to sample services to make findings about specific services in the sample, and to extrapolate the results to a larger number of similar services within the referral, as long as the methodology is statistically sound.

If, for example, it was thought that particular procedures undertaken by a doctor might be inappropriate, a sample of those procedures may be undertaken and the proportion of the sample found to be inappropriate may be extrapolated to all such like procedures.

Similarly, a 'group' of potentially over-serviced patients could be defined (for example, those with 40 or more visits a year), a sample could be drawn and inspected, and the results of that sampling extrapolated to this group.

The Review Committee obtained confirmation of this from a statistical expert, Professor Des Nicholls, of the Department of Statistics and Econometrics, Australian National University. Professor Nicholls said that:'As long as the sample size is reasonable (greater than 20 but preferably 30 or more) for a given class size, sample size and proportion of units (items or patients) in the sample of interest which are suspected as inappropriate it will be possible to compute the length of the confidence interval and hence the lower boundary of that interval which is taken as the appropriate measure of inappropriate practice'. (Source: p.10 November 1998 Report by Professor Nicholls—*The Detection of Inappropriate Practice*). He subsequently advised that the 'exploratory' sample size should preferably be 30 but not less than 25. In cases where a selected service cannot be successfully matched with the PUR's records, that service should be excluded from the analysis. The minimum 'exploratory' sample size must be no less than 25.

Sampling and investigation of consultation services in this way could result in a sustainable finding of inappropriate practice by a PSRC and would allow a DP to impose more fitting sanctions—counselling, reprimand, suspension and repayment of benefits—as appropriate (see Section 3.5—Determining Sanctions).

The original PSR legislation attempted to do this, but had subsequently been repealed because the methodology provided had been too administratively complex and cumbersome to apply.

The Review Committee agreed that with expert statistical advice it was possible to develop appropriate statistical methodologies for PSRCs to apply in respect of particular identified practice. It recommended that these methodologies should be set out in Ministerial directions.

The Act should be amended to provide the authority for the application of sampling and that generic methodologies will be set out by Ministerial Direction as well as the option of using a statistically valid and logically defensible alternative where the generic methodology is not suitable.

Recommendation 2

The Act be amended to provide the authority for the application of sampling and for Ministerial directions to be made to provide for a range of sampling methodologies to be used by PSRCs to make findings in relation to the provision of particular identifiable services.

(b) Deeming Provisions

The medical profession generally accepts that high volume provision of services by a practitioner prohibits adequate clinical input.

The Review Committee examined data from the HIC on differing practice patterns and considered the number of consultations and frequency necessary to identify at what point a prima facie case of inappropriate practice in relation to high volume servicing per day might be suspected.

Data on the average consultations per year and the standard deviation for Vocationally Registered (VR) practitioners and Other Medical Practitioners (OMP) in 1997–98 by geographic location are shown for practitioners with 80 or more attendances per day on 20 or more days in a 12 month period.

HIC data for VR general and OMP consultations 1997-98 financial year

Consultations	Location	Number of Providers	Average Consultations per year	Standard deviation
80 for 20 days	Capital	81	15,886	3,519
80 for 20 days	Metro-other	6	16,775	1,628
80 for 20 days	Rural-large	5	15,106	2,950
80 for 20 days	Rural-small	2	16,605	2,572
80 for 20 days	Rural-other	5	18,157	5,494
80 for 20 days	Remote-central	1	16,369	-
80 for 20 days	Remote-other	0	-	-
	Total	100		

Sampling requires each and every service in an initial sample to be put to the PUR. In order to judge the question of appropriateness of the service, the peer committee has to be able to make a judgement on the individual services.

In cases of extremely high volume servicing, it could be time consuming and thus impractical to examine a sufficient number of individual services to arrive at a conclusion that would sustain a viable and worthwhile level of sanction. This was one of the major criticisms of the former MSCI process.

The only way to tackle high volume cases on the basis of patterns of services is to be in a position to establish in a court a process whereby a PSRC can establish what volume of services is unacceptable generally to the practitioner's peers. There are at present no standards on volumes of services that are generally accepted. Obviously, individual PSRCs can not apply a standard when it does not exist.

The Review Committee agreed to introduce a deeming provision (developed in consultation with the profession) whereby once a specified number of services per day is reached, the practitioner must justify to a PSRC the provision of such a high volume of services. The deeming provision triggers a shift in the evidentiary burden.

It was agreed that the Act should provide the authority with respect to any group of practitioners for the process of dealing with high volume services per day and provide for the introduction, in regulations, of the specific details of the deeming provisions and how they will apply.

The provisions in the Act authorising regulations for the deeming provision (as well as the sampling methodologies) will need to state that nothing in the regulations would prevent a committee from making a finding of inappropriate practice on services less than the deeming provision set out in the regulations.

Recommendation 3

The Act be amended to provide the authority for the application of a deeming provision in respect of high volume servicing per day. Once the pattern of services specified in regulations under this provision is reached, a practitioner will be deemed to have engaged in inappropriate practice unless he or she can demonstrate to the satisfaction of the PSRC that exceptional circumstances have occurred.

To establish the point at which deeming would occur for general practitioners, the Review Committee consulted with the AMA Federal Council and the AMA Council of General Practice (AMACGP) as well as with representatives from the Royal Australian College of General Practitioners (RACGP), the Rural Doctors Association of Australia (RDAA) and the Australian Divisions of General Practice (ADGP).

Based on HIC data, the Review Committee considered the practice patterns of general practitioners. It discussed with the AMA CGP several points at which the volume of servicing per day by a GP over a 12-month period should be deemed to be inappropriate.

The preference of the AMA CGP was for a single deeming provision. This was considered to be where a general practitioner performed 80 or more consultation services on 20 or more days in a year. Such a practitioner would be deemed to be practising inappropriately, unless he or she can show exceptional circumstances, which allow them to practice appropriately while rendering such a high number of services.

The Review Committee acknowledges that there could be occasions where a PUR could demonstrate that inaccuracies in the HIC data placed that practitioner incorrectly in the deeming provision range. Should a PSRC be concerned about the accuracy of the HIC data such that the practitioner may not have met the threshold limits, the PSRC can decide not to rely on the deeming provision and treat the case by sampling or by direct consideration of the clinical records.

Recommendation 4

With respect to general practice the deeming provision will apply where a practitioner provides 80 or more consultation services on 20 or more days a year. If the Committee has concerns about the accuracy of the HIC data such that the threshold limits may not have been met, the Committee may decide not to rely on the deeming provision.

A claim of exceptional circumstances will be based on general evidence (not on an examination of individual patient records). The exceptional circumstances will need to be well defined in the legislation (eg to be either an exceptional event or a very extreme geographic circumstance).

The Review Committee believes high levels of skill, competence and organisational arrangements are worthwhile and important. However, while they may have a great effect in a practitioner's ability to provide 50 rather than 20 consultation services regularly in a day, they

have little effect at the 80 consultation services a day mark. It is, therefore, expected that argument that a practitioner's ability or organisation provides an exceptional circumstance is unlikely to be sustained.

Recommendation 5

With respect to general practice exceptional circumstances may relate, but not be limited to, the availability of alternative medical services or unusual occurrences.

If necessary, the Act would also set out mandatory processes, which need to be complied with before a regulation is made, for example, there must be consultations with the AMA and the relevant parts of the medical profession.

Rather than delay the implementation of the new arrangements, the Review Committee proposed that the deeming provision for general practitioners be introduced. Specific deeming provisions for other than general practitioners will be subsequently developed in consultations with those relevant groups within the profession.

Recommendation 6

Deeming provisions in respect of high volume services per day be specialty- and profession-specific, be developed in consultation with relevant groups within the professions, and be introduced in regulations.

The deeming provisions would be applied to all consultation services on all days where the services exceed the number set out in the regulation where exceptional circumstances have not been demonstrated. For example, if a practitioner has been referred to a PSRC for inquiry because he or she has rendered 80 or more consultation services on 35 days, and is able to demonstrate exceptional circumstances for seven of those days, repayment would be for all services rendered on those other 28 days.

Recommendation 7

If a general practitioner is deemed to have engaged in inappropriate practice, the quantum of inappropriate practice be defined in terms of all consultation services on all days on which 80 or more consultation services were rendered, and where exceptional circumstances cannot be demonstrated to the satisfaction of the Committee.

It is important to note that the deeming provision in no way acknowledges that conduct below 80 consultation services on less than 20 days a year is automatically acceptable. Such cases would be addressed through sampling. The intent of the deeming provision is to provide a simpler means of tackling high volume servicing per day rather than a time consuming sampling methodology.

The deeming provision for general practitioners and OMPs will apply to consultations rather than all services and apply to all types of consultations. Services other than consultations will not be subject to the deeming provision criteria. They will need to be dealt with separately (for example, sampling), if they are the subject of a referral.

A draft regulation, which illustrates what might be contained in such a regulation, is set out below.

Illustrative Draft Regulation

Deeming provision

(1) A practitioner's conduct in connection with the rendering of consultation services is deemed to be unacceptable if 80 or more consultation services were provided on 20 or more days in any 12-month period.

(2) The services in connection with which the practitioner's conduct is deemed by subsection (1) to be unacceptable are all consultation services rendered on all days in that twelve month period on which the practitioner rendered 80 or more consultations.

(3) If a practitioner is able to demonstrate that there were exceptional circumstances which rendered that practitioner's conduct not to be unacceptable, the Committee may conclude that the practitioner's conduct is not unacceptable, or is not unacceptable except in connection with certain services.

(4) Where a Committee concludes that a practitioner's conduct in connection with the rendering of consultation services is not unacceptable except in connection with certain services the Committee must specify those services as:

(a) a stated number of consultation services of a particular type or types; or
(b) a stated proportion of consultation services or a stated proportion of consultation services of a particular type or types;

and the practitioner's conduct in connection with the services so specified is deemed to be unacceptable.

(5) In assessing whether there are exceptional circumstances, the Committee may have regard to, but is not limited to:

(a) the availability of alternative medical services to the practitioner's patients; and
(b) unusual occurrences causing unusual levels of need for consultation services.

(6) For the avoidance of doubt, in reaching a conclusion under this regulation that a practitioner's conduct in connection with the rendering of services is unacceptable, it is not necessary for the Committee to identify the particular consultation services in connection with which a practitioner's conduct is said to be unacceptable.

(7) In this regulation, "consultation services" means the items included in group A1 and group A2 of Part 2 of the table of medical services prescribed under section 4 of this Act from time to time.

3.5 Generic findings

In some instances, a PSRC may be confident a practitioner has engaged in inappropriate conduct, but may for various reasons be unable to identify the specific services involved, or even the number or proportion of services involved. This may arise in circumstances such as:

- the records have been lost or misplaced or the practitioner has given the records to another practitioner or to the patient;

- the records are deficient in the requisite information and the practitioner is unable to recall the detail of the consultations;
- the practitioner has failed to keep a record;
- the record is illegible or kept in a form intelligible only to the practitioner; and
- initiated services where, because of difficulties identifying either the patient or the date on which the service was rendered, sampling is impracticable.

In such instances a Committee may be confident that the practitioner has been practising inappropriately by virtue of HIC or prescribing data, and by general questioning, but is unable to precisely identify or quantify the relevant services.

A PSRC should be able to make a finding of inappropriate practice in a general sense in such cases. Clearly it would not be able to quantify the services for the purposes of calculating a repayment.

Recommendation 8

The Act be amended so that a PSRC can make a finding of inappropriate practice in broad terms without identifying specific services or a number of services when:

– there are no clinical records or the records cannot be used; and

– the finding is based on HIC data and evidence taken at the hearing; and

– the finding focuses on particular categories of services.

3.6 Determining Sanctions

The Review Committee agreed that maintaining the existing sanctions was essential to ensure the continuing effectiveness of the PSR Scheme.

Recommendation 9

The existing range of determinations be retained in the Act, namely counselling, reprimand, repayment of some or all of the Medicare benefits and suspension from Medicare.

To provide an effective deterrent to other practitioners, the level of sanction imposed needs to be sufficient to match the level of inappropriate practice. Whilst counselling certainly has an extremely important role to play in tempering and modifying practitioner behaviour, it clearly is not a significant sanction for gross cases of inappropriate practice.

The only real deterrents are proportionately large repayment of Medicare benefits and/or considerable periods of suspension from Medicare. (Short periods of suspension have demonstrably done nothing more than provide the practitioner with a holiday.) Maximum periods of suspension imposed to date have been in the order of 6 months full and 12 months partial.

The AMA views high volume provision of services, on a sustained and consistent basis, very seriously. It is the view of the AMA that this type of conduct should be subject to severe sanctions which clearly indicate that this type of professional conduct is unacceptable to the medical profession. The AMA's view is that the most appropriate form of sanction for very high volume practitioners is a substantial period of suspension from Medicare.

The Commonwealth also has a responsibility in terms of the appropriate expenditure of public monies. The Review Committee noted the ANAO report findings and the need for the level of benefit recovered from a practitioner to be commensurate with the level of over servicing actually engaged in. There is also a strong need to satisfy community perceptions that the level of sanction imposed matches the level of inappropriate practice.

The Review Committee noted the views of the AMA and the Commonwealth, and agreed that substantial periods of suspension from Medicare and the recovery of Medicare benefits were appropriate for practitioners found to have rendered high volumes of services per day.

Recommendation 10

In cases of high volumes of attendances per day by general practitioners and covered by the deeming provisions, Ministerial guidelines (see Recommendation 39) should provide for substantial periods of suspension from Medicare (eg periods of 2 years or more).

It should be recognised that suspension from Medicare does not affect a practitioner's medical board registration nor does it deprive a practitioner of an ability to earn a livelihood.

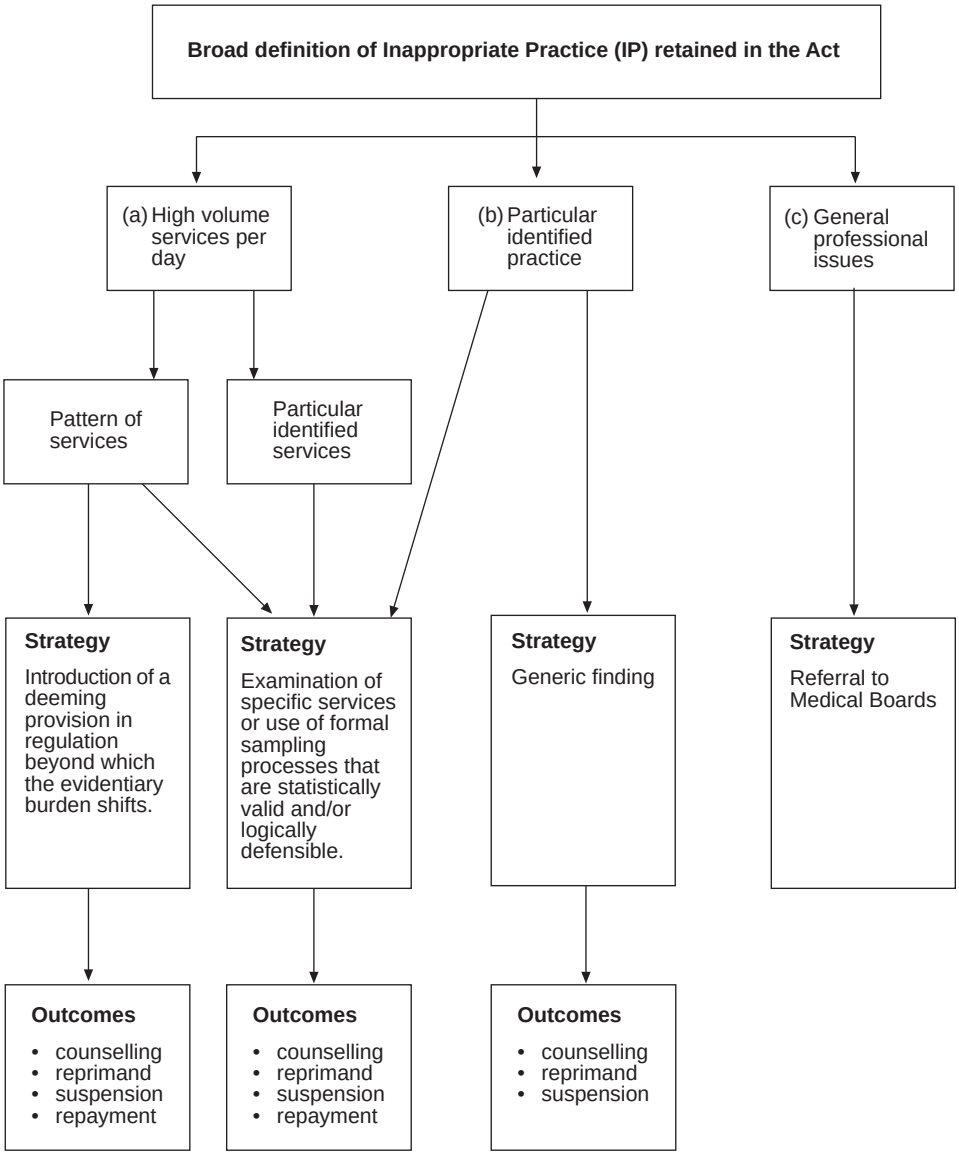
Application of the deeming provision will allow a PSRC to define the quantum of inappropriate practice. It will also allow the full range of currently available sanctions—that is, reprimand, counselling, repayment of Medicare benefits and both partial and full suspension periods—to be applied by a Determining Panel.

In relation to a general finding of inappropriate practice, where specific services or a number of services are not identified, the Review Committee acknowledged that the available sanctions would be limited to counselling, reprimand and/or suspension.

Recommendation 11

When a general finding is made as outlined in Recommendation 8, the sanctions must be limited to counselling, reprimand and/or suspension.

The following diagram illustrates the subsequent approaches recommended by the Review Committee for PSRCs to deal with different types of inappropriate practice.


Broad definition of Inappropriate Practice (IP) retained in the Act
(a) High volume services per day
(b) Particular identified practice
(c) General professional issues
Pattern of services
Particular identified services
Strategy
Introduction of a deeming provision in regulation beyond which the evidentiary burden shifts.
Strategy
Examination of specific services or use of formal sampling processes that are statistically valid and/or logically defensible.
Strategy
Generic finding
Strategy
Referral to Medical Boards
Outcomes
• counselling
• reprimand
• suspension
• repayment
Outcomes
• counselling
• reprimand
• suspension
• repayment
Outcomes
• counselling
• reprimand
• suspension

4 Revised PSR arrangements

4.1 Introduction

The current PSR arrangements involve four separate agencies, each of which operates at 'arms-length' from each other. These agencies are the HIC, DPSR, the DO in the Department of Health and Aged Care (Health) and the PSR.

A firmly held view arising out of the Review is that these fragmented arrangements have mitigated against the PSR scheme's success. The separation of powers can be seen as constituting too many layers in the process.

To achieve a more seamless exercise of responsibilities, the Review Committee recommends that a number of the scheme's responsibilities be consolidated within a single expanded Professional Services Review Agency.

However, it is intended that the different stages of the PSR process (investigation, committee proceedings, determination of sanctions) remain discrete and independent.

Recommendation 12

The PSR Agency be expanded to include the functions of investigation, case preparation and administrative support for the proposed Determining Panel.

4.2 Expansion of PSR Agency and Financial Implications

The measures detailed below will greatly add to the scope of the PSR Agency functions. The Agency would need additional resources for these functions to be efficiently and effectively performed. It is proposed that legal personnel, medical officers and administrative staff be engaged to act as case officers for specific referrals from the HIC, as well as perform management roles.

Increased administrative support staff would carry out the Agency's day to day management functions and public relations/public reporting functions, as well as provide the more general case officer support to the DPSR, PSRCs and the new Determining Panel.

Additional funding will be needed to put these arrangements into place. These additional resources will, to some extent, be balanced by a reduction in resource needs in Health and by the proposed removal of the PSRT process.

With the transfer of the DO (now a Determining Panel) function to the PSR Agency and the removal of the PSRTs, Health's role will contract to that of policy oversight of the Scheme. The impact of these changes on the HIC is expected to be negligible.

There will be some off-setting savings accruing from PSR cases no longer being contested in PSRTs. The more rigorous approach taken in processing PSR cases should also minimise the number of judicial review applications appeals by practitioners to the Federal Court.

On balance, the adoption of these measures by Government and the profession constitute a cost-effective way of addressing the demonstrated deficiencies of the current scheme.

Recommendation 13

Additional funding be provided to permit the new expanded PSR Agency to perform efficiently and effectively.

4.3 Health Insurance Commission (HIC)

The Review Committee noted the preventive success of the HIC counselling process and recommends that HIC Medical Advisers continue to counsel practitioners where appropriate. While the Review Committee agreed that counselling prior to referral is desirable, it did not recommend mandatory counselling.

At present, the HIC referral sets the boundaries within which a practitioner's professional conduct may be examined by a PSRC. The Review Committee recommends the process of referral be re-defined in the Act in terms of a progressive action.

Its starting point will be the initial concerns of the HIC to the DPSR and will include issues arising in the investigation process or in the PSRC peer review process itself. The DPSR will make the formal referral of a practitioner to a PSRC. This will follow an investigation of the basic concerns expressed by the HIC.

Recommendation 14

The process of referral be redefined in the Act as a progressive action starting with a notification of a concern or concerns issued by the HIC to the DPSR and, after investigation, a formal referral from the DPSR to the PSRC.

Where a PSRC identifies issues of concern that are not part of the referral by the DPSR, the PSRC should be able to ask the DPSR to investigate these concerns more fully. If this investigation shows there may be a case for the PUR to answer, the DPSR should make a further referral to the PSRC for consideration. The practitioner must be given adequate notice and time to consider this additionally referred matter.

Recommendation 15

A PSRC be able to raise new concerns which may become an additional referral by the DPSR provided that the PUR is given adequate notice and time to consider his or her responses.

During consultations with the AMA Council of General Practice, the Review Committee found concerns amongst the profession about possible inconsistencies in the identification, counselling and referral processes carried out by the HIC in different States.

To address these concerns, the Review Committee recommends the setting up of a joint Standing Committee, comprising representatives of the AMA and HIC, to review counselling processes (including how practitioners are identified), review the Artificial Neural Network, explore a range of other initiatives, and encourage the overall concept of good practice.

Recommendation 16

A Standing Committee comprising representatives of the AMA and HIC be established to review counselling processes, review the Artificial Neural Network, explore initiatives and encourage the overall concept of good practice.

4.4 Director of Professional Services Review (DPSR)

It is envisaged that the new PSR Agency will receive and investigate concerns from the HIC. If the investigation demonstrates that inappropriate practice may have taken place, the DPSR will refer that practitioner to a committee of his or her peers for review (ie, a PSRC).

The DPSR investigation process needs to be able to examine medical records and other practice documents. The effect of this may well mean referral to a PSRC becomes unnecessary. Alternatively, it will provide a PSRC with sufficient information for a more comprehensive hearing, and maximise the use of their time and resources.

It is proposed that the DPSR's powers be increased to include the power to require the production of documents by a PUR, including medical records, practice and other relevant documents. In addition, the DPSR should be given the power to refer concerns about a practitioner's professional conduct to State and Territory Registration Boards.

Recommendation 17

The Act be amended to give the DPSR the power to require the production of documents, and the power to refer concerns about a practitioner's professional conduct to State and Territory Registration Boards.

To complement this recommendation, and to enhance the investigative role of the Agency, it is proposed that the DPSR be assisted by case officers, including clinical practitioner advisers, who would perform the detailed examination of clinical records and other tasks necessary for the effective work-up of a case for referral to a PSRC. The current ability of the DPSR to use consultants as required would remain unchanged. (Case Officers are discussed further under Section 4.6.)

Recommendation 18

The DPSR be able to engage case officers, including clinical practitioner advisers, to perform the detailed examination of clinical records and other tasks for the effective work-up of a case for referral to a PSRC.

Under the existing legislation, where the HIC refers a practitioner to the DPSR, the DPSR must, within 28 days of the notification, either dismiss the referral (under either s.91 or s.92 of the Act) or establish a PSRC to consider whether the practitioner concerned has engaged in inappropriate practice.

Under the revised arrangements, the HIC will notify the DPSR of concerns relating to a practitioner's conduct and, after investigation, a formal referral may be issued by the DPSR to a PSRC. Even with additional resources provided to the expanded PSR Agency, PSR Panel members are a limited resource and may put constrains on the number of PSRCs available to deal with all concerns sent to the DPSR.

Consequently it is recommended that the Act be amended to give the DPSR the option of not taking action in response to the notification of concerns by the HIC. The Act would be amended to require the DPSR, within six months of notification of concerns by the HIC, to advise the practitioner that:

- the notification of concerns has been dismissed; or
- the DPSR intends to establish a PSRC. The DPSR is not necessarily required to establish a PSRC within that six month period, particularly where ongoing investigations may be required or resources constrain the setting up of a PSRC; or
- the DPSR does not intend to take action on this occasion. However, should the HIC send concerns about the same practitioner a second time, the DPSR must take action on these subsequent concerns.

If the DPSR takes no action on HIC concerns within the six-month period the referral will be taken to have lapsed.

Recommendation 19

The Act be amended to give the DPSR an option not to action HIC concerns, with the proviso that if the same practitioner is the subject of subsequent HIC concerns, the DPSR must action those subsequent concerns.

The current arrangements also provide for the DPSR to enter into a written arrangement with the PUR whereby that person agrees to partial suspension from Medicare for up to 12 months. The DPSR exercised this power on two occasions in 1996–97 and three occasions in 1997–98 (See Table C Section 2).

The Review Committee recommends that the DPSR be given increased powers to negotiate, but not approve, suspension (full or partial) and repayment of benefits. These negotiated settlements would also be referred to the Determining Panel for approval.

Recommendation 20

The Act be amended to increase the powers of the DPSR to negotiate, but not approve, suspension(full or partial) and repayment of Medicare benefits, where a PUR acknowledges inappropriate practice and negotiates a settlement.

Where the PUR acknowledges inappropriate practice and negotiates a settlement with the DPSR, the Review Committee agreed that the recommended settlement be referred to a DP for approval. If the DP does not approve the recommended settlement it can refer the matter back to the DPSR for further negotiation with the PUR. As with the current scheme, no PSRC would be convened if the practitioner agreed to a negotiated settlement.

Recommendation 21

Where a PUR acknowledges inappropriate practice and negotiates a settlement with the DPSR, the recommended settlement not be implemented by the DPSR but instead be referred to a Determining Panel for concurrence.

The amendment to the legislation should also require the DPSR to provide the DP with a written report setting out the details of the settlement proposed. Where a DP approves a negotiated settlement, it should also be treated as a final determination for the purposes of Section 106X of the current Act.

That is, if a practitioner has two effective final determinations he or she is automatically referred to a Medicare Participation Review Committee (MPRC).

Recommendation 22

The Act be amended to specify that a negotiated settlement, once implemented, is considered a final determination for the purposes of s.106X of the Act.

4.5 Case Officers

To ensure PSRC time and expertise is used most effectively, and to improve a PSRC's ability to focus on issues relevant to inappropriate practice, it is proposed that the DPSR be given a greater investigatory role in cases identified for further inquiry by the HIC.

It is proposed that the DPSR be assisted by case officers comprising administrative, clinical, statistical, legal and other appropriate personnel as required. Case officers would only operate as assistants to, and be under the direction of, the DPSR.

Case officers would not have powers relating to entry, search, or seizure. With the consent of the PUR, it may be appropriate for a clinical practitioner adviser to interview the practitioner as part of the investigations.

Case officer functions will vary. At the investigatory stage, the DPSR will primarily employ medically qualified case officers, who will undertake the detailed examination of medical records and review of appointment books as they relate to the services of concern. Care must be taken to ensure that the case officers do not investigate areas under the jurisdiction of the relevant Medical Boards, unless it is pertinent to the Medicare services under consideration. Administrative case officers may also be used in the subsequent preparation of a formal document setting out the specific areas of concern. This detailed investigation report will form the DPSR referral to the PSRC and will be provided to the PUR.

Legal case officers will only have a minor involvement at the investigatory stage, such as in the preparation of any necessary legal documents for the DPSR, (ie, to require the production of medical records). The legal case officers will mostly be involved in providing advice during the PSRC proceedings and to the Determining Panel. (Discussed in more detail at Section 4.6 (b)). To avoid any potential concerns about bias, the Review Committee recommends that the same legal adviser cannot be involved in more than one stage of a case (the stages being investigation, Committee and Determining Panel).

Recommendation 23

Legal advisers will assist the DPSR, the PSRCs and the Determining Panel. However, the same legal adviser cannot be involved in more than one stage of a case (the stages being investigation, Committee and Determining Panel).

4.6 Professional Services Review Committees (PSRC)

Form and Content of Powers

The PSRC process, as it currently stands, is an investigative arrangement. A PSRC comprises a Deputy Director as the Chair and members of the same specialty or profession as the PUR. It considers and reports to the DO on the question of inappropriate practice in connection with the rendering and initiation of services and prescribing.

The PSRC report contains the committee's opinion, or finding, on the question of inappropriate practice and may, with the written consent of the PUR, include recommendations for suspension, and about the nature and period of suspension from Medicare. The PSRC has power to require the production of medical records; to compel attendance at a Committee hearing; to engage consultants; and to refer to Registration Boards if it thinks action should be taken against a PUR in order to lessen a serious threat to the life or health of any person (s.106P).

The revised arrangements would see the process continuing to remain firmly one of peer review with the composition of PSRCs remaining unchanged. PSRCs would be able to identify matters in addition to the *referral* and send these matters back to the DPSR for further investigation. If warranted, these matters may be added to the *referral* after an adjournment to enable the PUR to respond. The PSRC power to refer patient management matters to relevant Medical Boards, or other registration authorities, would be maintained and strengthened.

The Act does not specifically entitle the PUR to call witnesses. The PSRC decides whether it should hear a witness at a hearing, or summon a person to appear as a witness. In the interest of procedural fairness, it is proposed that the Act be amended to enable both the PSRC and the PUR to bring witnesses, other than character witnesses, for questioning. Only written character references will be acceptable.

Recommendation 24

The PSRC and PUR be permitted to bring witnesses, other than character witnesses, who would be able to be questioned, subject to the discretion of the Committee in relation to their evidence.

Support for PSRCs—Legal Support and Training

The Review Committee considered the concerns raised by the Court in *Yung* in relation to the operation of the PSRCs (See Section 2).

The Court held the PSRC did not afford natural justice to the PUR because it did not particularise various matters in respect of conclusions it reached, and that it also failed to indicate adverse conclusions, which might be reached. Accordingly, the Review Committee proposes that PSRCs receive assistance from a legal adviser who will be available to the Committee and who will attend hearings. As well, PSRCs should receive increased administrative support.

The legal adviser would assist the Committee to help ensure that the PUR is afforded natural justice. This may involve general advice on procedural issues, and on specific legal questions as they arise.

The functions of the legal adviser could include:

- providing advice on any obvious legal problems before a hearing begins (by examining the material that will be before the PSRC, including any submissions made by the PUR);
- providing advice during the hearing sought by the PSRC or on their own initiative by private conference;
- providing advice to the PSRC on legal points made by the PUR or his/her legal advisers; and
- checking the legal aspects of the PSRC report (both draft and final).

The Review Committee was concerned to ensure that the legal adviser to the PSRC should not in any way be a party to the decision making process of the DP.

Recommendation 25

The PSRCs be provided with assistance from a legal adviser who will be available to the PSRC and attend PSRC hearings, but not take part in any decision making process.

The Review Committee also recommends that all PSRC members receive appropriate training to undertake their roles effectively and draw on the expertise of the proposed legal adviser. Such training could involve basic administrative law, including natural justice issues, the questioning of the PUR, and the handling of witnesses and the legal advisers to the PUR during the hearing.

Recommendation 26

Members of PSRCs receive training in natural justice and other relevant legal issues.

To complement this training, and to assist with the implementation of the proposed new administrative arrangements, it is recommended that comprehensive rules of procedure and operating protocols be introduced for the PSRC process.

These procedural rules and operational protocols would provide guidance on conduct for PSRC inquiries and the hearing, as well as guidance on how to address submissions from the PUR and prepare the PSRC report. The availability of such detailed procedures would also assist the PUR and address natural justice concerns.

Recommendation 27

Comprehensive procedural rules and operational protocols be developed for PSRCs.

Legal Support for PUR

It is proposed that a PUR, can be accompanied and advised, but not represented, by a legal adviser, as is the situation at present. However, it is recommended that the PUR's legal adviser be given the right to address the PSRC throughout the hearing on legal points, and on the merits of the case in a final address. The final address may encompass all matters relevant to the decision concerning inappropriate practice, as well as issues going to the conduct of the inquiry.

This level of legal representation seeks to balance the need for fair and legally defensible procedures with the desire to maintain the 'peer review' focus of the scheme by avoiding legalistic procedures.

Recommendation 28

The legal adviser to the PUR be given the right to address the PSRC on legal issues during the hearing and on the merits of the case as well as matters of law in a final address.

Reporting

Under the current arrangements, a PSRC provides the DO and the DPSR with a report on its findings. The DO then forwards that report to the PUR.

To provide the PUR with every opportunity to respond to peer concerns, it is proposed that the PSRC prepare a draft report with assistance from a legal officer (on points of law), and provide a copy of it to the PUR.

The PUR will be invited to make submissions in relation to the draft report which will then be considered by the PSRC before it makes a final report.

Recommendation 29

The PUR be given a copy of the draft PSRC report and be invited to make formal written submissions.

Recommendation 30

The PSRC be required to take the submissions by the PUR into account before making its final report.

The final report of the PSRC will then be presented to the PUR and the Determining Panel (to replace the existing Determining Officer—See Section 4.7) for the making of a determination if the report contains a finding of inappropriate practice.

Recommendation 31

The final report of the PSRC be sent to the PUR and to the Determining Panel. The report will be sent to the Determining Panel not earlier than 28 days after it has been sent to the PUR to exercise a right of appeal to the Federal Court on matters of law.

Professional Issues—Referrals

PSRCs have identified various professional issues in relation to clinical competence and performance; aberrant professional behaviour or beliefs; lack of meaningful continuing medical education; physical or mental impairment; and substance abuse. Organisational issues that can affect patient safety, such as equipment and staffing deficiencies, are also sometimes evident.

These issues are relevant for professional practice but, in light of the Federal Court's decision in *Adams v Yung*, are not necessarily relevant to the issue of inappropriate practice relating to the provision of services that attract a Medicare benefit.

Currently PSRCs must refer concerns about possible serious threats to the life or health of persons to State/Territory registration bodies. Matters relating to a practitioner's compliance with professional standards (for example, compliance with conditions for vocational registration) can only be referred by the DO to other bodies such as a General Practice Recognition Eligibility Committee and a Specialist Recognition Advisory Committee.

The Review recommends that with the creation of a consolidated PSR Agency, the legislation be amended so that the DPSR, PSRCs and the DP can, at any stage of the process, refer concerns relating to significant threats to the life or health of persons to State/Territory registration bodies, and refer matters relating to the practitioner's compliance with professional standards to relevant bodies.

Recommendation 32

The Act be amended to empower the DPSR, PSRCs and the Determining Panel to refer concerns relating to significant threats to the life or health of persons to State/Territory registration bodies, and matters relating to the practitioner's compliance with professional standards to relevant bodies.

In addition the Review Committee also recommended that PSRCs be empowered by legislation to notify the HIC of matters of concern arising out of an inquiry, such as incidences of doctor shopping, (ie patients visiting numerous medical practitioners for purposes such as obtaining multiple prescriptions).

Recommendation 33

The Act be amended to empower PSRCs to notify the HIC of matters of concern arising out of an inquiry, such as instances of doctor shopping.

4.7 Determining Panel

Composition

Currently, the DO is a senior officer of the Department of Health and Aged Care whose function is to determine the sanction(s) to be applied following a PSRC finding of inappropriate practice.

Unless a PUR challenges a decision under the *Administrative Decisions (Judicial Review) Act 1977*, challenges to the PSRT or the Federal Court are made only on the DO Determination and not the PSRC findings.

The DPSR currently oversights the peer review until a PSRC report is issued. Thus the DPSR has not formally been a party to any of the legal challenges.

In order to address this deficiency, it is recommended that the DO be replaced by an independent Determining Panel (DP), not located in Health, and serviced by the expanded PSR Agency.

Recommendation 34

The position of the Determining Officer be replaced by an independent Determining Panel serviced by an expanded PSR Agency.

It is proposed that the DP comprise a permanent chair (a medical practitioner), a permanent lay person and third member who will be a representative of the profession of the PUR (eg medical practitioner, optometrist, etc), with a lawyer assisting the Panel. The Review Committee was concerned to ensure that the legal adviser to the DP should not in any way be a party to the decision making process of the PSRC. Members of the DP will be appointed by the Minister, in consultation with the AMA or other relevant organisations as appropriate.

Recommendation 35

The Determining Panel comprise a permanent chair (medical practitioner), a permanent lay person and a third member who is a representative of the profession of the PUR with a lawyer to assist the Panel. Members will be appointed by the Minister in consultation with the AMA or relevant bodies.

To ensure consistency of determinations, the same DP would be used for all cases appropriate to the profession of the PUR with allowances being made for replacements in the event of unavailability, leave, illness, etc.

Recommendation 36

The same Determining Panel be used for all cases appropriate to the profession of the PUR with allowances being made for replacements in the event of illness or other such reasons.

Determinations/Sanctions

As with the DO under the current scheme, the DP should make a draft determination and forward that draft to the PUR. The practitioner will be invited to make submissions addressing the sanctions contained in that draft determination. In effect, the practitioner will be invited to raise circumstances that warrant a lesser sanction.

Recommendation 37

The PUR be given a draft determination and be invited to make formal written submissions addressing the sanctions contained in the draft.

All of the sanctions contained in the current arrangements, namely counselling, reprimand, repayment of some or all of the Medicare benefits and suspension from Medicare, should remain available to the DP in the new scheme.

Following consideration of any submissions, the DP could make and forward to the PUR a final determination after which no further submissions will be considered.

Recommendation 38

The Determining Panel be required to take the submissions of the PUR into account in making a final determination.

To assist the DP, the Review Committee recommends that guidelines be introduced and that decisions by the DP be consistent with these guidelines.

Recommendation 39

The Act be amended to provide that the Minister may, in writing, make guidelines for the Determining Panel and that decisions by the Determining Panel be consistent with these guidelines.

4.8 Time Periods

The current Scheme imposes time constraints upon all parties to the PSR. Times vary from two days (the HIC must send a copy of the referral to the PUR within 48 hours of sending the referral to the DPSR) to the 120 days given to a PSRC to give the DO its report.

A breach of some time periods, for example, the 14 days provided to the DO to provide the PUR with a draft determination, does not affect the validity of the particular process. However, a breach of others introduces uncertainty as to the practical impact of such a breach. For example, the Act offers no extension of the 14 day period given to the PUR to make written submissions concerning a draft determination, but does not articulate the consequences that arise if that time period is exceeded.

The expanded role proposed for the DPSR under the revised scheme would introduce new procedures and processes. Rather than simply attaching time constraints to these new processes, and adding them to the existing set of time limited processes, it is proposed that all of the time periods should be examined to see whether they were appropriately and realistically set. The Review Committee agreed that should be done jointly by the AMA and the Government.

Recommendation 40

All the time periods contained in the Act for procedures under the PSR Scheme be examined jointly by the AMA and the Government to see whether they are appropriately and realistically set, taking into account the impact on the new PSR Agency of the proposed administrative arrangements.

4.9 Appeal rights

Under the current arrangements, the role of the PSRT is to review final determinations made by the DO.

As mentioned above, the present PSR process allows for a PSRT to review a determination (not the PSRC findings) on its merits. In view of the changes proposed to the scheme, it is recommended that there not be an avenue of review by a PSRT.

The particular changes which justify removing this request for review are as following:

- the practitioner is to be given greater support at the PSRC stage because his or her legal adviser has a right to address the PSRC throughout the hearing on matters of law and a right to make a final address on the merits of the case and on matters of law;

- the practitioner is to be given an opportunity to make submissions on the draft report of the PSRC before it is sent to the DP; and
- the DO is to be replaced with a three member DP, which will give the practitioner an opportunity to make submissions on a draft determination before a final determination is made.

The practitioner will thus be given extensive opportunities to respond to peer concerns about the appropriateness of his or her conduct.

Removal of the PSRT from the process also recognises that review on the merits of the final determination is not appropriate in a scheme in which the key judgement is a professional judgement by the practitioner's peers about the practitioner's conduct. The PUR will, of course, have full rights to seek judicial review at any stage of the process.

Recommendation 41

The PSRTs be discontinued. However, review rights by the Federal Court on matters of law be maintained.

Under the current arrangements PSRC proceedings are held in private. Once a matter goes to a PSRT it becomes public. Publication of a practitioner's name was seen as a major deterrent of the Scheme. To maintain this deterrent effect, it is proposed that the DPSR be able to publish names of all PURs where a determination has been implemented (excluding a negotiated settlement).

Recommendation 42

Details of PSRC reports and Determining Panel decisions may be published, including names of the practitioners involved, when a final determination has been made, excluding cases where a negotiated settlement has been made.

4.10 Transitional Arrangements

Should the recommendations in this report be accepted, amendments are needed to the *Health Insurance Act 1973* and would take effect on a date to be fixed, or by the granting of Royal Assent, whichever is the later.

In all cases transiting the new arrangements, the Review Committee recommends the PUR should not be disadvantaged. Where such changes have the potential to disadvantage a PUR, and it is intended these changes could apply to periods prior to the amended Act taking effect, then the Review Committee recommends warning must be given to this effect.

The Review Committee recommends the following should apply:

- where a referral has been made by the HIC to the DPSR under the existing legislation and a PSRC has been established, then the inquiry should be conducted and concluded through to finality under the existing legislation (including availability to review of a final determination by a PSRT);

- where a referral has been made by the HIC to the DPSR under the existing legislation, but no PSRC has been established, then the revised approach being recommended in this Report should apply to the PUR (and the referral by the HIC becomes open to the DPSR to expand on referral to a PSRC); and
- notwithstanding the approach to be taken in the first dot point above, every consideration should be given to ensure that a PUR is afforded the maximum level of enhanced administrative provisions during the inquiry, for example, increased legal support, draft reports by PSRCs, etc.

Recommendation 43

In all cases already within the PSR system on the date the revised legislation takes effect, transitional arrangements should be such as not to disadvantage the PURs in those cases.

4.11 Future Review of Scheme

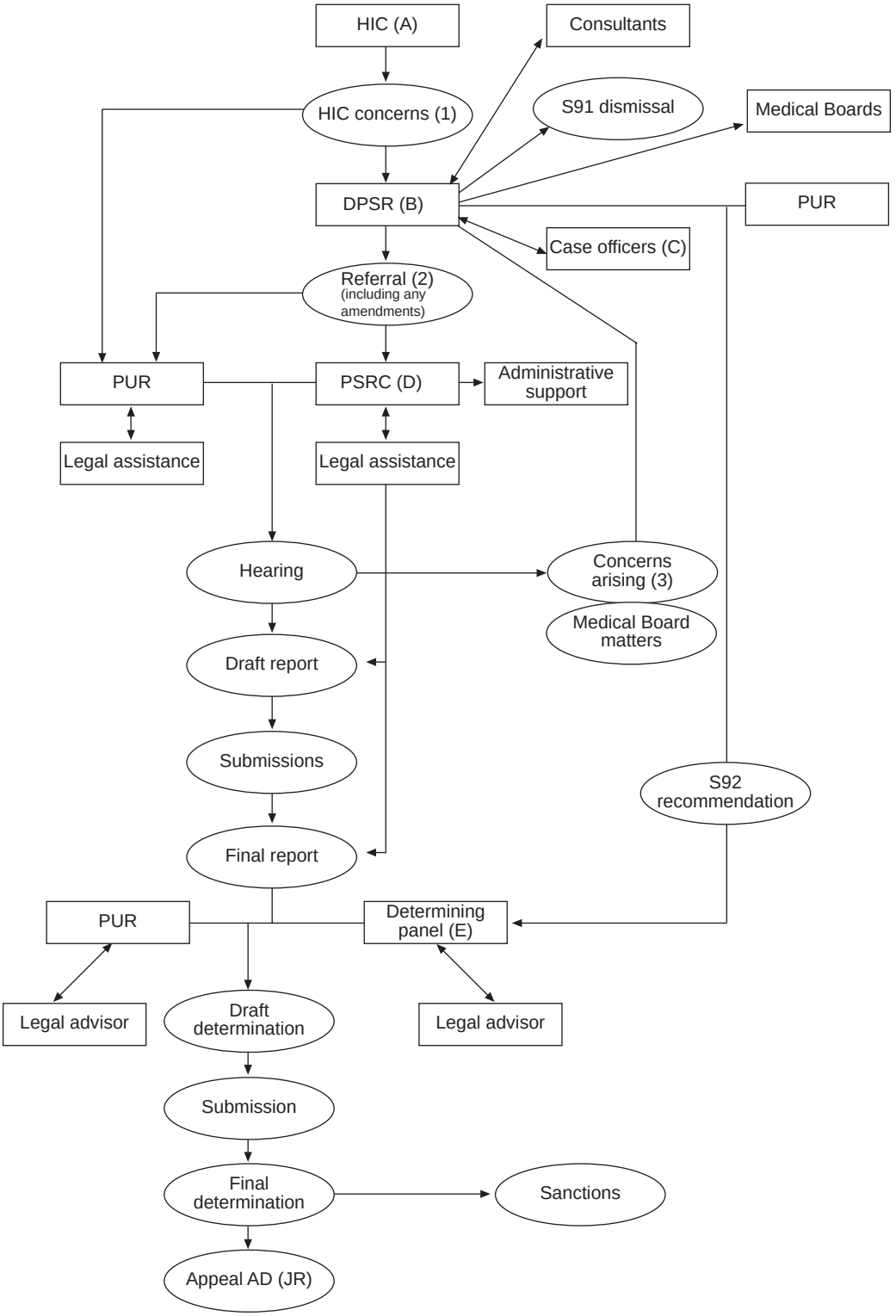
In recognition of possible concerns of the profession that the new arrangements be reviewable, it is proposed that the Government and the profession can review the revised Scheme at any time, but not later than three years after it comes into effect.

Recommendation 44

The Government and the profession review the revised PSR Scheme no later than three years after it comes into effect.

4.12 Flow Chart

The following Flow Chart describes the proposed arrangements for the PSR Scheme.


HIC (A)
Consultants
HIC concerns (1)
S91 dismissal
Medical Boards
DPSR (B)
PUR
Case officers (C)
Referral (2)
(including any amendments)
PUR
PSRC (D)
Administrative support
Legal assistance
Legal assistance
Hearing
Concerns arising (3)
Medical Board matters
Draft report
Submissions
S92 recommendation
Final report
PUR
Determining panel (E)
Legal advisor
Draft determination
Legal advisor
Submission
Final determination
Sanctions
Appeal AD (JR)

5 *Related Issues*

5.1 Medical Records

Many of the practitioners under PSRC consideration were found to have extremely poor records, making it difficult to establish whether services were or were not appropriate.

The Review Committee strongly supported the requirement that practitioners maintain adequate and contemporaneous medical records. These are essential to the provision of quality and to ensure continuity of care. Such a medical record will also provide a level of accountability for the type of service rendered.

Following further consultation with the profession about content, the Review Committee recommends that the requirement to keep adequate and contemporaneous medical records be a legislative requirement from 1 November 1999.

This will assist the PSRC in the identification of inappropriate practice as it will be able to find that what is not recorded was not performed, or at least that the records are inadequate.

The introduction of this requirement will not change the situation regarding confidentiality of such records through existing legal structures.

Recommendation 45

The maintenance of adequate and contemporaneous medical records be a legislative requirement for payment of Medicare benefits from 1 November 1999. The nature of this requirement will be the subject of further discussions between the profession and the Government.

Glossary of terms

Adams v Yung	Dr Tony Adams, Determining Officer in Dr Stephen Yung case
ADGP	Australian Divisions of General Practice
AMA	Australian Medical Association
AMACGP	Australian Medical Association Council of General Practitioners
ANAO	Australian National Audit Office
ANN	Artificial Neural Network
CMC	Case Management Committee
DO	Determining Officer
DP	Determining Panel
DPSR	Director of Professional Services Review
Health	Commonwealth Department of Health and Aged Care
HIC	Health Insurance Commission
MPRC	Medicare Participation Review Committee
MSCI	Medical Services Committee of Inquiry
OMP	Other Medical Practitioner
PBS	Pharmaceutical Benefits Scheme
PSR	Professional Services Review
PSRC	Professional Services Review Committee
PSRT	Professional Services Review Tribunal
PUR	Person under Review
RACGP	Royal Australian College of General Practitioners
RDAA	Rural Doctors Association of Australia
The Act	Health Insurance Act 1973
VR	Vocationally Registered (General Practitioner)