Professional Services Review
Report to the Professions
2004–2005
# Contents

**Director’s report** 6

**2004–05 Key events at a glance** 10

**1. Agency and scheme overview** 11

- Objective 12
- Background 13
- Inappropriate practice 13
- Benefits of the PSR scheme 13
- The Director 13
- Our vision 14
- Our mission 14
- Our values 14
- Our strategies 14
- Our relationships 14
  - Medicare Australia 14
  - Department of Health and Ageing 14
  - Health registration boards 14
- The process 15
- The organisation 17

**2. Report on performance** 19

- Court challenges 20
- Re-referrals 21
- Requests for review from the Health Insurance Commission 21
- Referrals to committees 22
- Determining Authority 23
- Agreements 24
  - Dr A, General Practitioner, Sydney NSW 24
  - Dr B, General Practitioner, Melbourne Vic 25
  - Dr C, General Practitioner, Sydney NSW 26
  - Dr D, Consultant Physician in Gastroenterology 26
  - Dr E, General Practitioner, Sydney NSW 26
  - Dr F, General Practitioner, country NSW 27
Final determinations

Dr G, General Practitioner, country NSW 27
Dr H, General Practitioner, Melbourne Vic 29
Dr K, General Practitioner, Melbourne Vic 29
Dr L, General Practitioner, Melbourne Vic 29
Dr M, Specialist Radiation Oncologist/Medical Practitioner, capital city 30

Dr John Chung-Tsang Lai, General Practitioner, Bendigo Vic 31
Dr Anthony Tsamoglou, General Practitioner, Kogarah NSW 33
Dr Frederico John Facchini, Medical Practitioner, Kogarah NSW 33
Dr David Michael Gillman, Medical Practitioner, Airlie Beach Qld 35
Dr Wan Kum Chan, General Practitioner, Kingsford NSW 35
Dr Jerzy Cywinski, General Practitioner, Bonnyrigg/Austral NSW 35
Dr Peter Andrianakis, Medical Practitioner, Yarraville/East Kew Vic. 35
Dr Kim Fatt Chan, General Practitioner, Reservoir Vic. 36
Dr Jonathon Robert Turtle, General Practitioner, Deakin ACT 36
Dr Chris Siamidis, Medical Practitioner, Brunswick Vic. 37
Dr Mario Marchesani, General Practitioner, Geelong Vic. 38
Dr William Crow Lyon, General Practitioner, McCrae Vic. 38
Dr Jonathon Brent Sutton, General Practitioner, Doncaster/Fitzroy North Vic. 39
Dr Ian Gordon Falconer, General Practitioner, Croydon South Vic. 39
Dr Ian Lester Rafter, General Practitioner, Sydney NSW 39
Dr Lawrence Matthew Finley, General Practitioner, Culburra Beach NSW 41
Dr Guy Claude Delcourt, General Practitioner, Mill Park Vic 41
Dr Neville Arthur Breitkreutz, General Practitioner, Biggera Waters Qld 42
Dr Jack Freeman, General Practitioner, Nth Melbourne Vic. 42
Dr Constantinos Perkoulidis, Medical Practitioner, Brunswick Vic. 42
Dr Phillip John Chapman, General Practitioner, South Broken Hill NSW 42
Dr Mohammed Amjad Hussain, General Practitioner, Airport West Vic. 43
Dr Khalid Aziz Qidwai, General Practitioner, Ashfield NSW 43
Dr Michael Levenda, General Practitioner, Caulfield North Vic. 44
Dr Albert Gerald Galea, General Practitioner, Liverpool NSW 44
Dr Paul Joseph Ameisen, General Practitioner, Edgecliff NSW 45

Reasons for requests and referrals

Commission requests for review
Committee referrals 46
Other types of concerns 47
Prescribed pattern of services – the "80/20 rule" 47
High volume of services 48
High number of services per patient 49
High prescribing of Pharmaceutical Benefits Scheme drugs 49
Inadequate medical records 49
Inadequate clinical input 50
Medicare Benefits Schedule item not satisfied 50
Services not medically necessary 51
Particular services or types of services 51
Professional isolation 51
Unusual medical practice 51
Alteration of documents 52
Federal Court and Full Federal Court decisions 52
Dr Zelco Oreb, medical practitioner, Newtown NSW 52
Dr Jerzy Cywinski, General Practitioner, Bonnyrigg/Austral NSW 53
Dr Peter Andrianakis, Medical Practitioner, Yarraville/East Kew Vic. 53
Dr Donald Hatcher, General Practitioner, Roma Qld 54
Dr Rifaat Dimian, Medical Practitioner, Merrylands NSW 55
Dr Jack Freeman, General Practitioner, North Melbourne Vic. 55
Dr Ashraf Selim, General Practitioner, Punchbowl NSW 56
Dr Il Song Lee, General Practitioner, Eastwood NSW—Case 1 57
Dr Il Song Lee, General Practitioner, Eastwood NSW—Case 2 57
Dr Sou Kao Ly, General Practitioner, Cabramatta NSW 58
Dr Peter Thomas Tisdall, General Practitioner, Kyabram Vic. 58
Dr Anthony Joseph, Medical Practitioner, Lithgow NSW 59
Dr Constantinos Perkoulidis, Medical Practitioner, Brunswick Vic. 60
Dr Chris Siamidis, Medical Practitioner, North Fitzroy Vic. 61

Glossary 64
**Director’s report**

Professional Services Review (PSR) has been established for 12 years, during which time it has been a ‘low profile’ organisation. Many practitioners have not known of its existence. At the same time the practice of medicine has changed considerably. There is a need for health professionals to be aware of their obligations to the public when using Medicare and the PBS, and a need to be aware of the regulatory environment. Hence the reason for this publication.

More practitioners are now practicing in large, vertically integrated medical centres. This phenomenon, once confined to large cities, is now spreading into regional areas. Allied to this trend is the growing popularity of part-time medical practice with many doctors regarding their leisure and family time as important as their working life. The benefits of a computerised practice have also become widely accepted. Many doctors now regard an internet connection as essential as a stethoscope. General practice seems to have embraced computers more extensively than the specialist community.

The general community has changed at the same time. The public is better educated and better informed regarding their own and their family’s health. There is greater community expectation of quality when accessing health care, and consumers are less willing to accept medical advice uncritically. The increasing use of alternative medicine and other therapies has provided our patients with a bewildering choice of health options.

The challenges for health regulators and governments around Australia in this new environment are considerable. Professional Services Review is an integral part of health regulation in Australia. PSR is not only involved with the medical profession, but also chiropractors, dentists, physiotherapists, podiatrists and optometrists who use Medicare. The next five years will see a widening gap in the demand for services and the supply...
of practitioners in Australia. With a finite Health Budget this creates an imperative for governments to require that the quality of the services it funds to be of the highest order.

Medicare Australia maintains the data base on all practitioners in Australia registered to use Medicare. Anomalous patterns of services and claiming are identified from this data base. In the first instance a Medicare Australia medical officer will investigate the circumstances and may interview the practitioner. The practitioner is given an opportunity to explain and if necessary change behaviour. If there has not been sufficient behaviour change, and there is a suggestion that the practitioner may have engaged in inappropriate practice, Medicare Australia makes a request to me to review the provision of his/her medical services.

As part of my review, medical records for a sample of services are sought from the practitioner. On review of the records I can decide to take no further action, enter into an agreement with the practitioner, which usually involves the repayment of benefits, or refer the practitioner to a committee of peers. The peer review committee consists of a chair, and at least two other practitioners of the same discipline as the doctor being reviewed. The Committee's task is to examine a sample of services, with the doctor, and the medical records. If inappropriate practice is found the Committee's report is sent to the Determining Authority to determine sanctions, which could include reprimand, counselling, repayment of benefits and disqualification from Medicare and/or PBS for up to 3 years. It is only at the Determining Authority stage where there is any consumer input into the PSR process. In carrying out its function the Determining Authority must decide, inter alia, on the possible impact on the community if a particular practitioner is excluded from the Medicare arrangements for a length of time.

The Professional Services Review Scheme is a highly litigious area. In general, practitioners who are investigated by the Scheme are well resourced and are defending their livelihood. Many practitioners take full advantage of seeking judicial relief. The challenges to the integrity of the process range from issues of procedural fairness to invoking the Constitution. To date PSR has won almost all of these actions.

PSR has been found to have consistently applied the legislation with due regard to fair process and equity. The Scheme depends for its success on the commitment of the members of the PSR Panel, those who serve on the committees. Clinicians in active practice who apply peer standards to the evaluation of their colleagues, give the Scheme its legitimacy and its wide spread support.

Since the Medical Indemnity industry has offered insurance cover, most medical practitioners who come before PSR are legally represented. Generally, lawyers who work in this area have sufficient experience to give timely and helpful advice to their clients. Experienced lawyers acting for a practitioner can greatly assist the Committee process and in general keep their clients from making unwise decisions.

The range of professional activities seen by PSR is wide. Some of the recent cases concern inappropriate use of skin excision items and Extended Primary Care items. The astounding growth in skin cancer clinics throughout Australia has prompted close scrutiny of excision and skin flap items. This has led to redesigning MBS skin flap item numbers by the Department of Health and Ageing to limit inappropriate practice. Practitioners using Extended Primary Care items,
including care plans and health assessments must ensure that the clinical content is relevant and appropriate for each particular patient, and not generated generically by computer.

The most important advice I can offer is that no matter in what health discipline you practice always make adequate and contemporaneous clinical notes. This advice is not new, however it still surprises me how often it is ignored.

This booklet is designed to raise awareness of the role of Professional Services Review and Medicare regulation generally. It also illustrates a little of the range of inappropriate practice seen by PSR in just one year.

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

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

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

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

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

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

Further amendments were passed by Parliament in December 2002, coming into effect on 1 January 2003.

The role and function of PSR is to administer Part VAA of the Health Insurance Act 1973 (the Act). The current scheme is an avenue for review and investigation of cases of suspected inappropriate practice by practitioners who render or initiate services attracting a Medicare benefit or who prescribe under the Pharmaceutical Benefits Scheme.
Background

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

The essential features of the review structure are:

- a Director of PSR, who is a medical practitioner, appointed ministerially and able to engage staff and consultants
- a PSR panel, comprising medical and other health related practitioners, who are appointed ministerially
- committees, comprising practitioners from the PSR panel appointed by the Director on a case-by-case basis to consider the conduct of practitioners referred by the Director for investigation
- a Determining Authority comprising a medical practitioner as Chair, a lay person and a member of the relevant profession. The Determining Authority’s role is to decide on the sanctions for practitioners found by committees to have engaged in inappropriate practice and to consider whether to ratify agreements entered into by the Director and the person under review.

Inappropriate practice

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

- in the case of a medical practitioner— the conduct would be unacceptable to the general body of the members of the group (that is, general practitioner, specialist or consultant physician) in which the practitioner was practicing when he or she rendered or initiated the services, or
- in the case of a dental practitioner, optometrist, chiropractor, physiotherapist, osteopath or podiatrist—the conduct would be unacceptable to the general body of the members of the profession in which the practitioner was practicing when he or she rendered or initiated the services.

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

Benefits of the PSR scheme

The PSR scheme gives health professionals substantial autonomy in reaching findings on inappropriate practice. At the same time, proper care has been taken to ensure the practitioner under review receives natural justice. At every major point in the review process the practitioner is given the opportunity to make submissions that could influence the review process and outcome. The scheme provides for separation of the three elements of the decision-making processes, which are:

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

The Director

The Minister for Health and Ageing, the Hon. Tony Abbott, appointed Dr Anthony David Webber Director of Professional Services Review from 14 February 2005 for a three-year period.

At 30 June 2005, there were 154 members appointed by the Minister as panel members to serve on committees. Of these, 21 were also appointed as Deputy Directors of PSR to serve as chairpersons.
Our vision
As an independent authority, PSR contributes to ensuring access through Medicare to cost-effective medical services, medicines and health care for all Australians.

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

Our values
In doing our job, all members of PSR will:
- act with fairness, consistency, impartiality and integrity
- demonstrate dedication and commitment
- act with professionalism
- value and respect each other and work as a team
- show timeliness.

Our strategies
The strategies we employ to achieve our mission and values are to:
- review requests expeditiously and effectively to enable courses of action to be decided
- provide support services to PSR committees to enable them to carry out the PSR mission
- provide support to the Determining Authority to enable it to function
- manage relationships with stakeholders to maintain and enhance credibility of, and provide information about, the PSR scheme
- provide effective and efficient human resource management, financial management and corporate planning services
- ensure PSR legislation remains relevant.

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

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

Cases of possible fraud identified during the PSR process are referred back to Medicare Australia for action.

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

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

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1 Medicare Australia was known as the Health Insurance Commission until 30 September 2005. As the Report on Performance was prepared when Medicare Australia was know as the Health Insurance Commission, reference remains in that chapter to the Health Insurance Commission.
The process

The Professional Services Review Panel consists of medical practitioners and other health practitioners appointed by the Minister after consultation with the AMA or appropriate professional organisations.

From the Panel, the Minister appoints Deputy Directors, who chair Professional Services Review Committees (PSRCs). A PSRC includes a Deputy Director and two other Panel members from the same profession or specialty as the practitioner under review. One or two more Panel members may be included to give the PSRC a wider range of clinical expertise.

The Determining Authority comprises a medical practitioner as Chair, plus a layperson and a member of the relevant profession. These are appointed by the Minister after consultation with the appropriate professions.

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

Counselling: Medicare Australia generally identifies potential inappropriate practice on the basis of a practitioner’s service statistics. Medicare Australia advises a practitioner of its concerns. The practitioner’s conduct is subsequently reviewed, and if concerns remain unaddressed, Medicare Australia may request the Director to review the practitioner’s conduct.

Request for review: Medicare Australia can request the Director to review the provision of services by the practitioner during a specified period. A copy of the request is sent to the practitioner. The Director must decide within 1 month whether to undertake a review.

Review: The Director may review any services provided by the practitioner and is not restricted to Medicare Australia’s reasons for requesting the review. The Director can require the practitioner to produce documents and can penalise non-compliance. Case officers may be appointed to help the Director conduct the review.

Following the review: After the review, the Director must decide to either take no further action, or to provide the practitioner with a written report and invite submissions on any further action. After time for submissions, the Director must:

- decide to take no further action
- negotiate and enter into an agreement, or
- establish a PSRC and make a referral to it.

No further action: The Director may decide to take no further action if a PSRC could not reasonably find inappropriate practice.

Negotiating an agreement: The Director may negotiate a conclusion if the practitioner admits inappropriate practice and accepts sanctions. The agreement becomes effective if ratified by the Determining Authority.

Establishing a PSRC: The Director must establish a PSRC unless he/she decides to take no further action or the Determining Authority has ratified an agreement.

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

Hearings: A PSRC meets in private in State capital cities. The practitioner is given notice of the time and place of the hearing and must appear to give evidence. A PSRC may require the practitioner or someone else to produce documents. A lawyer usually assists a PSRC.
Failure to comply: If the practitioner fails to give evidence or to produce the requested documents, a PSRC may notify the Director who will fully disqualify the practitioner from Medicare until the practitioner complies.

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

Medical records: A PSRC must consider whether the practitioner kept adequate and contemporaneous clinical records. A PSRC may find the practitioner’s practice inappropriate despite the absence, deficiency or illegibility of health records.

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

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

PSRC report: A PSRC will send a draft report to the practitioner inviting a submission on its preliminary findings. The PSRC must consider any submission from the practitioner before finalising its report to the Determining Authority.

Determination: If the PSRC makes a finding of inappropriate practice against the practitioner, the Determining Authority will invite submissions from the practitioner on the sanctions it should impose. The Determining Authority will then draft a determination, including the sanctions it intends to impose, upon which the practitioner may make further submissions. The Determining Authority will consider any further submissions in finalising the determination.

Sanctions: The Determining Authority must impose one or more of the following:
- a reprimand
- counselling
- repayment of Medicare benefits, and/or
- complete and/or partial disqualification from the Medicare scheme and/or PBS for up to three years.

Natural justice: The Scheme has safeguards to ensure the practitioner is treated fairly. At every major step the practitioner is invited to make submissions – especially on draft findings.

Confidentiality: The information and evidence presented to the PSRC, its deliberations and its findings remain confidential and may not be disclosed unless specifically authorised by the Act or on appeal. However, the Director may publish the name and address of any practitioner when the Determining Authority’s decisions become effective.

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

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

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

Annual report: The Director’s annual report to the Minister outlines the types of behaviour which led to findings of inappropriate practice and guides the professions as to their peers’ understanding of inappropriate practice. Practitioner’s names, an outline of their inappropriate practice, and the sanctions imposed are published in the annual
The organisation

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

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

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

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

The Committees Unit provides secretariat support to committees. The Corporate Unit provides financial and human resources and information technology services and support for the whole organisation.

General legal assistance is outsourced to the Minter Ellison law firm. A Minter Ellison legal officer is outposted to PSR on a part-time basis and Minter Ellison lawyers in each state provide assistance at committee hearings.

In addition, secretariat support for the Determining Authority is located within PSR’s offices. Legal support is provided to the Determining Authority by Phillips Fox.

Figure 1: Organisation chart
2. Report on performance

Court challenges

This year, the dominating cases have been those involving challenges against the prescribed pattern of services—the so called ‘80/20’ cases. It was always expected practitioners would challenge findings where committees decided there were no exceptional circumstances to warrant the practitioner exceeding 80 or more attendances on 20 or more days in the specified period. This has been the case this year with the Federal Court handing down six decisions in 80/20 cases. Two judges handed down four separate decisions in favour of practitioners (Oreb, Hatcher and two in Lee) indicating that the various committees had applied the wrong test when making findings about what constituted exceptional circumstances.

It is interesting to note that in the next decision handed down (Tisdall), Gray J totally disagreed with the reasoning of his fellow judges in the earlier decisions, indicating that, in his opinion, their reasoning was fundamentally wrong in relation to their approach to the issue of exceptional circumstances. All these cases are now subject of appeal in the Full Federal Court. A number have had hearings and decisions reserved. Most should have been decided for next year’s report.

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

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2. A full report is given on all these cases later in this chapter.
Table 1—Court actions

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<tr>
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<tbody>
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<td>Review</td>
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<tr>
<td>Committees</td>
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<td>6</td>
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<td>Determining Authority</td>
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<td>Federal and Full Federal Court hearings held</td>
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<td>Federal Court decisions handed down in favour of PSR</td>
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<td>High Court applications</td>
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<tr>
<td>High Court decisions in favour of PSR</td>
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* Four applications to the Federal Court by practitioners were settled with the applications being dismissed by consent. In addition, there were two other preliminary decisions in one case where, firstly, the group of practitioners failed in an attempt to obtain an order for discovery and, secondly, it was ordered that an appeal on non-constitutional grounds proceed rather than be delayed as sought by the practitioner.

Re-referrals

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

Requests for review from the Health Insurance Commission

The Commission sent nine requests for review to PSR this year. The Director dismissed 15 requests after conducting a review as he considered there would be insufficient grounds on which a committee could reasonably find the practitioner had engaged in inappropriate practice. The Director negotiated 11 agreements with practitioners where he was not satisfied a committee would not find the practitioner had engaged in inappropriate practice.

Another 11 cases were sent to committees for further investigation and there were eight cases under review at the end of the year (see Table 2).

The Director referred one practitioner to the relevant state medical registration board because he formed the opinion the practitioner had caused, is causing or was likely to cause a significant threat to the life or health of patients. The Director believed there was a possibility the practitioner was treating non-malignant lesions with superficial radiotherapy not supported by histopathological studies before undertaking the procedures. He was also treating, by superficial radiology and cryotherapy, what appeared to the referring doctor, to be multiple solar keratosis conditions. Soon after the Director initiated his review, the practitioner moved overseas and has not been able to be contacted since. The practitioner is no longer registered to practice in Australia.
Table 2—Requests from the Commission

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

Referrals to committees

The Director made 11 referrals to committees during the year (see Table 3). Twenty-three committees reported findings of inappropriate practice to the Determining Authority. One committee reported to the Determining Officer that it was unable to complete its investigation. The practitioner concerned had been disqualified from Medicare since July 1998 for failing to produce medical records to the committee. He has not been registered with the local medical board for some years.

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

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

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

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

The average time taken for the 23 committees to report to the Determining Authority was 920 days (532 days in 2003–04).
### Table 3—Referrals to committees

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

### Determining Authority

Twenty-seven cases were sent to the Determining Authority this year. The four negotiated agreements received were ratified, as were seven other agreements outstanding at the end of last year.

### Table 4—Determining Authority cases

<table>
<thead>
<tr>
<th></th>
<th>2004–05</th>
<th>2003–04</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negotiated agreements received</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Negotiated agreements ratified</td>
<td>11</td>
<td>7</td>
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<tr>
<td>Negotiated agreements not ratified</td>
<td>0</td>
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<tr>
<td>Committee reports received</td>
<td>23</td>
<td>33</td>
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<tr>
<td>Final determinations issued</td>
<td>26</td>
<td>18</td>
</tr>
<tr>
<td>Effective final determinations</td>
<td>26</td>
<td>11</td>
</tr>
<tr>
<td>Medical Board referrals</td>
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</table>

Twenty-six final determinations were issued from findings in committee reports. The Determining Authority had 27 cases under consideration at the end of June 2005, with a significant number of these in the Federal Court (see Table 4).
The Determining Authority took an average of 144 days (76 days in 2003–04) to issue a draft determination and another 186 days (134 days in 2003–04) to issue the final determination. This is against a legislated timeframe of one month for a draft determination and 28 days for a final determination (including the 14 days for the practitioner to make submissions). All time limits on the Determining Authority have an exemption clause.

Agreements

The 11 negotiated agreements were ratified in an average of 13 days (18 days in 2003–04) against a legislated timeframe of one month. A failure by the Determining Authority to ratify an agreement within the one-month limit means the agreement is taken to have been ratified.

Sanctions agreed as part of the negotiations were that:

- all 11 practitioners were reprimanded
- four practitioners were partially disqualified from Medicare for a total of four years and 11 months (from 5 months to three years)
- eight practitioners agreed to make repayments totaling $197,500 (from $7,500 to $70,000 and averaging $17,954.55 per agreement).

A brief description of the 11 negotiated agreements that came into effect is given below.

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

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

During review, the Director found Dr A’s medical records were generally hard to read and contained limited details of the clinical input provided. In particular, the clinical notes lacked an adequate history and frequently did not contain a provisional diagnosis or management plan. In some instances, Dr A might have prescribed antibiotics where they were not clinically indicated. For example, Dr A recorded a diagnosis of ‘bronchitis/pharyngitis’ and prescribed antibiotics but did not record any indication of a bacterial infection.

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

**Dr B, General Practitioner, Melbourne Vic**

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

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

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

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

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

**Record entry**

20/6/03 Collogue + Medical Focus

**Explanation**  
Committee – What did she come to see you about?  
Practitioner – She was on the program of immunotherapy and she was coming twice a week. She may have come at extra times if she had been in trouble.
Dr C, General Practitioner, Sydney NSW

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

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

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

Dr D, Consultant Physician in Gastroenterology

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

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

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

Dr E, General Practitioner, Sydney NSW

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

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

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

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

**Dr F, General Practitioner, country NSW**

The Commission requested the Director review Dr F’s prescribing and the high number of services per patient he provided. Dr F wrote 1886 prescriptions to 10 patients. The Director reviewed a number of medical records provided by Dr F.

These records lacked sufficient clinical input and legibility in that many had no entry on or for dates on which a service was claimed. Many records showed issue of a prescription only, a pattern of prescribing narcotic medication early in treatment, and that Dr F failed to adequately monitor the health effects of drugs with a high risk of dependency.

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

Dr F acknowledged that his conduct during the review period, in connection with the provision of the services, constituted inappropriate practice. Dr F agreed to be reprimanded.

**Dr G, General Practitioner, country NSW**

The reasons the Commission gave for making this request for a review to the Director, were that Dr G was rendering a high number of total services and daily services (16 507 total services for a Medicare benefit of $427 633 and providing 60 or more services per day on 102 days in the review period), rendering 25 wedge resections of in-growing toenail, prescribing 30 611 items at a cost of $813 485 (1151 scripts for paracetamol amongst others) and providing services to two or more people on the same Medicare card on the same day on 376 occasions.

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

Dr G admitted that his conduct in connection with the provision of certain services constituted engaging in inappropriate practice. He admitted to a failure to maintain adequate and contemporaneous medical records to support
<table>
<thead>
<tr>
<th>Service examined by a Committee – Case 2</th>
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</thead>
<tbody>
<tr>
<td><strong>Service claimed</strong></td>
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<tr>
<td><strong>Record entry</strong></td>
</tr>
<tr>
<td><strong>Explanation</strong></td>
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<tr>
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| | Practitioner – Well, she had had immediately - previous - in December she’d had severe pain in her legs which I considered were a soft tissue origin.
the claims for Medicare benefits. Further, Dr G submitted that he had reduced the opening hours of his surgery, was working about 11 hours less per week and had instigated a process to ensure he kept better medical records. Dr G made an agreement to be reprimanded and repay $15 000 in Medicare benefits.

Dr H, General Practitioner, Melbourne Vic

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

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

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

Dr K, General Practitioner, Melbourne Vic

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

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

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

Dr L, General Practitioner, Melbourne Vic

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

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

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

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

Dr M was employed as a radiation oncologist at a large public hospital during the week and on some weekends provided services as a medical practitioner at a suburban medical practice. It was services from this latter practice that the Commissions requested the Director to review. The Commission was concerned about the comparative number of long consultations (MBS item 54) Dr M rendered and his high prescribing, including of addictive medicines. A review of some 60 medical records for standard (item 53) and long (item 54) consultations showed entries to have few symptoms recorded, scanty findings and little evidence of management planning. In addition, many of the records on the long consultations did not contain entries for the date of service, many patients appeared to have straight-forward conditions such as ‘flu’ and upper respiratory tract infections, or had presented for repeat prescriptions or blood pressure checks. These records were extremely brief.

Dr M only produced five of the 11 medical records ordered in relation to his prescribing. These again contained scanty notes with the diagnoses not obvious. There was a lack of management planning with little evidence of counselling or active psychotherapy for patients receiving long-term benzodiazepines or narcotics. One patient had 240 prescriptions; 237 of which were for benzodiazepines. Another had 174 prescriptions for morphine compounds out of 367 prescriptions. Both patients’ records had no supporting notes and related to a 12-month period. Dr M was his own third top patient for prescribing.

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

The Director met with Dr M (as he does with all practitioners when negotiating an agreement) and at the conclusion of the meeting Dr M conceded his conduct in the provision of the consultations and prescribing at the suburban medical practice constituted inappropriate practice in that he did not keep medical records to support the services claimed or the prescriptions written. Dr M agreed to be reprimanded and disqualified from all consultation services as a (general) medical practitioner for three years.
Service examined by a Committee – Case 3

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

Record entry

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

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

This was one very rare occasion that she would have missed that and not brought the file to me at 9.30 in the evening, saying: please write these up, because you tell me you must write up your notes. So I would have scribbled the two items that I would have written on a prescription for her and she always had multiple prescriptions and multiple problems.
Final determinations

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

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

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

As required under the Act the practitioner was notified of the correspondence to the MPRC.

As the Director is able to publish certain information on practitioners where a final determination comes into effect, details of those in date-of-effect order are given below:

**Dr John Chung-Tsang Lai, General Practitioner, Bendigo Vic**

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

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

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

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

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

The Determining Authority directed that Dr Lai repay $65,483.41 in Medicare benefits and be fully disqualified from Medicare for three months.
Dr Anthony Tsamoglou, General Practitioner, Kogarah NSW

The Commission requested the Director to review Dr Tsamoglou’s practice for three reasons: his high average number of services per patient (6.58) which was above the 98th percentile, his high volume of level C consultations (2253) which was between the 95th and 99th percentile, and his high level of initiation of pathology. Dr Tsamoglou initiated more pathology services per patient (4.12) than 99 per cent of all active general practitioners in Australia.

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

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

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

The Determining Authority found that Dr Tsamoglou’s conduct constituted inappropriate practice. It directed that Dr Tsamoglou repay to the Commonwealth $12 762.58, and be disqualified for a period of three months from all services provided as a vocationally registered general practitioner.

Dr Frederico John Facchini, Medical Practitioner, Kogarah NSW

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

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

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

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

The Determining Authority noted that, in relation to most services, the clinical input was deficient and Dr Facchini’s medical records adversely impacted Dr Facchini’s ability to provide care to his patient.
Service examined by a Committee – Case 4

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

**Record entry**  

**Explanation**  
Committee – Why did the patient attend this day?

Practitioner – He was – he needed a repeat. He’d run out of Murelax.
The Authority directed Dr Facchini to repay to the Commonwealth $24,444.64 and to be fully disqualified from Medicare for one month.

Dr David Michael Gillman, Medical Practitioner, Airlie Beach Qld

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

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

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

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

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

Dr Wan Kum Chan, General Practitioner, Kingsford NSW

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

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

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

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

Dr Jerzy Cywinski, General Practitioner, Bonnyrigg/Austral NSW

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

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

See summary under Federal Court and Full Federal Court, decisions handed down, later in this chapter.
Dr Kim Fatt Chan,
General Practitioner, Reservoir Vic.

The Commission requested Dr Chan be reviewed for his high level of daily servicing and his overall high number of rendered services. During the referral period Dr Chan rendered 20,947 services to 5,950 patients. This was well above the 99th percentile (15,515) for all active general practitioners in Australia. During the referral period Dr Chan rendered services for a total of $463,114.05 in Medicare benefits.

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

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

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

This was Dr Chan’s second referral to Professional Services Review. He had had an adverse determination in 1998 wherein he was required to repay $8,255.90 and be disqualified for one month. As a result of the second adverse finding he was automatically referred to the Medicare Review Participation Committee.

Dr Jonathon Robert Turtle,
General Practitioner, Deakin ACT

The Commission requested that Dr Turtle be reviewed for his rendering of a high proportion of long and prolonged consultations compared to standard consultations (1,367 level B, 2,458 level C and 502 level D). In addition, Dr Turtle’s rate of referral for pathology was above the 99th percentile for all active general practitioners in Australia ($61,524.70 in total pathology benefits).

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

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

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

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

The final determination directed that Dr Turtle repay to the Commonwealth Medicare benefits in the amount of $57,082.12. In addition, he was disqualified for six months from all services provided as a vocationally registered general practitioner.
Service examined by a Committee – Case 5

Service claimed

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

Record entry

[Handwritten note: 7 Nov 200...]

Explanation

Committee – What was the clinical reason for this consultation?

Practitioner – He has mild underlying asthma and he presented with a prolonged lower respiratory bronchitis infection which I diagnosed as viral, and 2 October, 6 November, so I saw him first and I – on the previous day, with cough which is lingering for nearly a month now. So when he came back again saying the cough is bad and he needs some relief, after assessing him again to make sure, I started him on seretide, thinking that it’s one of these post-viral bronchitis cough, query hyperactive airway that something like seretide will give him some relief.
Dr Chris Siamidis,
Medical Practitioner, Brunswick Vic.
See summary under Federal Court and Full Federal Court, decisions handed down, later in this chapter.

Dr Mario Marchesani,
General Practitioner, Geelong Vic.
Dr Marchesani was reviewed on request because of the high number of services per patient he rendered and the number of his level C consultations and home visits. Dr Marchesani rendered 338 level C home visits during the referral period—well above the 99th percentile (170).
The committee examined Dr Marchesani’s long surgery (item 36) and long home visits (item 37). Dr Marchesani was found to have engaged in inappropriate practice because he failed to take a detailed history, failed to provide an adequate level of clinical input and kept medical records that were deficient in essential clinical information. Dr Marchesani visited patients with relatively straightforward single system problems, the committee considered these visits not clinically necessary. Dr Marchesani believed the time spent making specialist appointments for patients could be included when calculating the length of time of a consultation. The committee did not agree.
Dr Marchesani rendered many home visits to patients well known to him, sometimes at the request of the patient and sometimes on his own initiative. The committee found, in almost every instance, no evidence of any condition or new illness that would require Dr Marchesani to spend in excess of 20 minutes with the patient. The committee found that 100 per cent of Dr Marchesani’s long home visits were inappropriate.
The Determining Authority considered that Dr Marchesani failed to provide adequate clinical input to the services he provided.

The Authority directed that he repay to the Commonwealth $21 154.32 and be disqualified for a period of six months from all services provided as a vocationally registered general practitioner.

Dr William Crow Lyon,
General Practitioner, McCrae Vic.
The Commission requested a review of Dr Lyon because of his excessive prescribing of benzodiazepines and codeine-containing compounds. In the referral period, Dr Lyon wrote 1431 prescriptions for benzodiazepines and 566 codeine compound analgesics to 274 patients.
The committee found that Dr Lyon ‘gave little or no consideration to whether some of his patients were drug dependent. He issued frequent repeat benzodiazepine prescriptions to patients, with little or no other clinical input’. The committee found a number of instances where Dr Lyon prescribed two benzodiazepines to patients during a consultation. When asked why he prescribed them in combination, Dr Lyon stated: ‘I don’t know why I do it really, to be honest with you’. He acknowledged that he sometimes prescribed drugs because the patient wanted them.
Dr Lyon’s progress notes generally consisted of single-line entries, with no history or evidence of an examination. The committee formed an opinion that Dr Lyon’s conduct was causing or was likely to cause a significant threat to the life or health of his patients. As a consequence he was referred to the Medical Practitioners Board of Victoria.
The Determining Authority directed that Dr Lyon be reprimanded and counselled and repay to the Commonwealth $1436.67. The Authority took into account that Dr Lyon was the subject of conditional registration supervised by the Medical Practitioner’s Board of Victoria.
Dr Jonathon Brent Sutton,  
General Practitioner,  
Doncaster/Fitzroy North Vic.

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

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

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

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

Dr Ian Gordon Falconer,  
General Practitioner, Croydon South Vic.

The Commission requested a review of Dr Falconer due to his very high services per patient. During the referral period Dr Falconer had an average of 13.14 services per patient and rendered 1932 services to 147 patients. Despite having a very small patient base Dr Falconer was above the 99th percentile for emergency attendance after hours.

The committee found that Dr Falconer had engaged in inappropriate practice by failing to provide adequate clinical input into services, rendering services that were not necessary, managing chronic pain in a clinically unacceptable way, and prescribing narcotics and benzodiazepines when they were not clinically indicated.

During the hearing the committee became concerned that, due to Dr Falconer's health and mental state, he was unfit to continue participating in the proceedings. Dr Falconer was referred to a consultant physician for an opinion. The physician advised that Dr Falconer was not fit to continue in practice. The committee was concerned that Dr Falconer's conduct was causing or was likely to cause a significant threat to the life or health of his patients. The Director was advised of the committee's concerns and Dr Falconer was referred to the Medical Practitioner's Board of Victoria.

The Determining Authority directed that Dr Falconer be reprimanded and counselled by the Director. Dr Falconer agreed to retire from medical practice.

Dr Ian Lester Rafter,  
General Practitioner, Sydney NSW

The Commission requested that Dr Rafter be reviewed because of his high level of pathology initiation. In the review period Dr Rafter referred 939 patients for a total of 7290 pathology services.
Service examined by a Committee – Case 6

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

Record entry  

Explanation  Committee – And this particular consultation?

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

I have not seen him for some time, which is very, very good, but at that stage the etcetera, etcetera was just my frustration at saying look, this guy is driving me bananas with what he is doing. As I say, he complained of some symptoms and that I thought needed checking. I actually did some tests on him at the time and I also referred him on to Dr Bbbb as well for examination but that was later on that I sent him to see Dr Bbbb. That was in '03.
at a total benefit of $164,684.20—this was 968 services above the 99th percentile for all active general practitioners in Australia.

The committee found Dr Rafter had initiated pathology services that were not medically necessary. In addition, the committee found that many of Dr Rafter’s initiated pathology services were for health screening, as defined in the MBS book.

Dr Rafter ordered significant amounts of pathology in all consultations examined. The committee concluded that ‘many of the pathology tests initiated had no role in the diagnosis or management of patient symptoms.' Pathology services were often repeated within short intervals.

Dr Rafter used pathology services to explore patient symptoms without conducting a physical examination. Additionally, Dr Rafter initiated some pathology services to explore patient symptoms based on the assertions of unproven literature and theory.

The Determining Authority considered that a reprimand and counselling were both necessary and appropriate sanctions in Dr Rafter’s case.

**Dr Lawrence Matthew Finley, General Practitioner, Culburra Beach NSW**

The Commission requested that Dr Finley be reviewed for his high level of total services (16,710) and his prescribing of benzodiazepines. With a patient base of 4438 patients, Dr Finley prescribed 27,579 items under the PBS at a net cost of $512,494.95. On 1936 occasions he prescribed benzodiazepines (7.01 per cent of total prescriptions).

The committee found that 100 per cent of the sampled item 23 services were inappropriate. In particular the committee found that Dr Finley had failed to provide adequate clinical input into the services, had prescribed benzodiazepines when these were not clinically indicated, and failed to keep adequate and contemporaneous records. Dr Finley’s records were generally illegible.

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

The committee communicated their concerns to the Director who referred Dr Finley to the NSW Health Care Complaints Commission.

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

**Dr Guy Claude Delcourt, General Practitioner, Mill Park Vic**

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

In addition to the Commission’s concerns, the Director was also concerned that Dr Delcourt’s
conduct in rendering MBS item 36 services may have constituted inappropriate practice.

The committee investigated Dr Delcourt’s item 36 services and found that 100 per cent of the sampled services were inappropriate.

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

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

Dr Neville Arthur Breitkreutz, General Practitioner, Biggera Waters Qld

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

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

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

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

Dr Jack Freeman, General Practitioner, Nth Melbourne Vic.

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

Dr Constantinos Perkoulidis, Medical Practitioner, Brunswick Vic.

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

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

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

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

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

The Determining Authority considered that Dr Chapman’s inappropriate practice was serious and considerable. Applying the sampling methodology, 5189 MBS item 23 services involved inappropriate practice. The Authority directed Dr Chapman to repay $116,305.56 and be fully disqualified for three months and be disqualified for 12 months from all services provided as a vocationally registered general practitioner (concurrent with the full disqualification).

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

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

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

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

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

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

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

Dr Khalid Aziz Qidwai,
General Practitioner, Ashfield NSW

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

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

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

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

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

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

Dr Michael Levenda,
General Practitioner, Caulfield North Vic.

The Commission requested that Dr Levenda be reviewed for rendering of level C surgery consultations (item 36), for minor skin excisions, and use of nasendoscopy item 41764. Dr Levenda was above the 99th percentile for his level C consultations, skin biopsy item 30071, and nasendoscopy.

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

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

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

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

Dr Albert Gerald Galea,
General Practitioner, Liverpool NSW

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

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

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The committee considered that 25 of 30 randomly sampled services Dr Galea rendered were inappropriate. Dr Galea’s records were deficient in essential clinical information and there was generally a lack of appropriate clinical input.
With respect to diagnostic imaging, the committee found that Dr Galea initiated services that were not necessary and failed to take an adequate history or carry out an adequate examination before initiating these services.

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

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

Dr Paul Joseph Ameisen,
General Practitioner, Edgecliff NSW

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

The committee found that Dr Ameisen generally did not take detailed histories of patient’s presenting complaints and on several occasions did not examine the patient.

On the occasions Dr Ameisen did undertake an examination it was brief and was not of multiple systems, as required by the MBS descriptor. In all but two of the services examined, the clinical component of the service did not warrant use of MBS item 36. The entries in the medical records were generally insufficient to contribute to the quality and continuity of patient care.

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

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

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

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

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

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

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

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

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

Table 5—Types of concerns in Commission requests

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

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

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4 A prescribed pattern of services also forms a reason for a referral from the Director to a committee.
Table 6—Types of services referred to committees

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

Note: some referrals contained more than one type of service.

Table 7—Reasons for referral to committees

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

Note: all referrals contained more than one reason.

Other types of concerns

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

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

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

Prescribed pattern of services – the “80/20 rule”

Following a 1999 review of the scheme by the Australian Medical Association (AMA), the Commission, the Department of Health and Ageing and PSR5 legislative changes were made to include a method of examining the conduct of practitioners who have high volumes of services. The legislation came into effect for services rendered after 1 January 2000, and the first wave of these referrals was received in 2002–03.

In a significant departure from other types of referrals, a practitioner who performs a nominated number of services in a particular period is deemed

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by the legislation to have practiced inappropriately, unless they can provide evidence that exceptional circumstances existed. That is, the onus of proof is on the practitioner to demonstrate that he or she did not practice inappropriately.

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

The 1999 review committee, in consultation with the AMA Federal Council, the AMA Council of General Practice, the Royal Australian College of General Practitioners, the Rural Doctors’ Association of Australia and the Australian Divisions of General Practice, devised the formula of a combination of 80 or more professional attendances on 20 or more days in a 12-month period as indicative of inappropriate practice. In general, the profession accepted that practitioners providing such high volumes of services could not possibly be providing adequate clinical care for their patients.

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

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

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

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

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

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

**High volume of services**

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

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

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

- obtaining the history of the presenting complaint and, on occasions, a family and past history from the patient
- an appropriate examination, even if a focused examination, which may involve arranging for relevant diagnostic tests (pathology and/or diagnostic imaging tests)
- a diagnosis
- implementation of a management plan that may include prescribing drugs, referral for consultant advice, or treatment and explanation of the management plan to the patient.

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

It may be financially rewarding for a practitioner to see high volumes of patients, but this style of practice generally only allows time for addressing the presenting symptom or complaint and is of little overall benefit to the patient. So far, committees have not accepted arguments that excessively high throughputs can be explained by claims of superior ability and organisation or vast experience.

High number of services per patient

Practitioners who provide, on average, a higher number of services per patient than their peers sometimes try to explain it by claiming to have a smaller and older (and ‘sicker’ with multiple pathology) patient base. However, committees have often found such behaviour to be the result of a practitioner acceding too easily to patient demands without due regard to the medical or clinical necessity for the frequency of service. These practitioners usually also have high unexplainable prescribing rates.

High prescribing of Pharmaceutical Benefits Scheme drugs

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

Inadequate medical records

Ten of the Director’s referrals (other than referrals concerning prescribed pattern of services) to committees contained a concern that the practitioner had failed to keep adequate and contemporaneous medical records. This is more than 90 per cent of referrals. This must be of major concern to the profession, particularly because of the effort it has exerted in educating practitioners in recent times.

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

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

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

The Commonwealth’s requirement for patient records is broad and not as onerous as some state and territory legislation. For a record to be adequate, it must:

- clearly identify the patient
- contain a separate entry for each attendance
- provide clinical information to explain the service/s rendered or initiated
- be sufficiently comprehensible so another practitioner can undertake ongoing care of the patient.
- To be contemporaneous, the record must be completed at the time of the service or as soon as is practicable afterwards.

The extent that the practitioners referred for a prescribed pattern of services kept adequate or inadequate records is unknown because the Director does not need to order production of records in these cases. However, if previous experience with the records of other practitioners rendering high volumes of services is an indication, it is suspected that these practitioners’ records would also be significantly deficient.

Inadequate clinical input

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

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

Medicare Benefits Schedule item not satisfied

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

Common examples involved claiming a long, rather than a standard, consultation or claiming for suturing a deep wound, rather than a superficial wound. Although this could be considered a fraudulent claim, it would be difficult, if not impossible, to have such a finding upheld in an Australian court because of the difficulty, after a lapse of time, of proving intent to defraud.

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

**Services not medically necessary**

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

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

**Particular services or types of services**

Once the Director has completed a review (by examining patient records and practitioner submissions) of the broadly framed initial request from the Commission, it becomes more apparent where the concerns lie.

The Director is then able to focus the referral, for specific attention by a committee, on concerns within a particular Medicare Benefits Schedule item or items. Often this will lead to a referral of, for example, all Medicare Benefits Schedule item 36 or 44 services. Sometimes the referral will be for a particular procedural or diagnostic service. Questioning in the committee hearing often reveals there was no proper clinical indication for the procedure; the conclusion to be reached is that the indication for the procedure was only because the practitioner had access to the necessary equipment.

**Professional isolation**

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

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

**Unusual medical practice**

It is important for practitioners to remember that the PSR scheme applies to services rendered or initiated under the Medicare benefits arrangements and medications prescribed under the Pharmaceutical Benefits Scheme.

Within the legislation encompassing both schemes there are strict criteria for benefit eligibility.

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

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

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

Federal Court and Full Federal Court decisions

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

Dr Zelco Oreb, medical practitioner, Newtown NSW

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

A committee was established and found Dr Oreb had engaged in inappropriate practice in rendering a prescribed pattern of services during the period referred and that no exceptional circumstances existed on any of the 33 days in question. Dr Oreb appealed to the Federal Court on whether exceptional circumstances existed, whether the investigative and adjudicative referrals were invalid on grounds established in the Daniel decisions, which concerned relevant considerations in making referrals and the obligations of the Director regarding agreements under s.92 of the Act—see summaries in the 2003–04 PSR Annual Report. Jacobson J also refused discovery orders sought by other applicants—Drs Bartos, Do, Ho and Ly.

His Honour generally considered that discovery was irrelevant or unnecessary where reasons for decisions were given. In a second preliminary decision on 28 October 2004, Jacobson J ordered that the hearing on non-constitutional issues
proceed ahead of the constitutional issue (which had been raised by the applicant at a late stage).

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

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

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

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

Dr Jerzy Cywinski, General Practitioner, Bonnyrigg/Austral NSW

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

In examining Dr Cywinski's MBS item 23 services, the committee found he had engaged in inappropriate practice in 48 per cent of these services. The inappropriate practice included: failure to collect and record an adequate history or make a proper examination, prescribed drugs that were not clinically indicated, prescribed narcotic or codeine compound analgesics without clinical indication and without regard to the potential habituating properties of these drugs, billing Medicare for services not personally rendered by him, and keeping records that were deficient in essential clinical material. The committee made similar findings in relation to Dr Cywinski's item 36 services. The Determining Authority directed Dr Cywinski to repay $55 327.82 and be fully disqualified for two months and be disqualified for 12 months from all services provided as a vocationally registered general practitioner (concurrent with the full disqualification).

In May 2004, Dr Cywinski appealed to the Federal Court for a review of the determination and penalty imposed by the Determining Authority. Dr Cywinski withdrew his application and on 6 October 2004, the Federal Court dismissed his appeal.

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

The Commission referred Dr Andrianakis because of his high level of rendered services. During the review period he provided 17 004 services to 5797 patients. Most of these services (16 204) were standard (item 53) consultations.
The committee examined Dr Andrianakis’s long consultations (item 54), and his home visits (item 59).

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

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

Dr Andrianakis appealed to the Federal Court on the issue of whether the committee and the Determining Authority erred in their decisions in relation to the inadequacy of his patient medical records. The Determining Authority directed that, in addition to being reprimanded and counselled by the Director, Dr Andrianakis be fully disqualified for two months from Medicare.

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

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

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

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

Dr Rifaat Dimian,  
Medical Practitioner, Merrylands NSW

The Commission referred Dr Dimian on 17 May 2000 because it was concerned that he may have engaged in inappropriate practice through high daily servicing and a high volume of rendered services (19 870) during the referral period of 1 July 1998 to 30 June 1999 inclusive. The Director conducted a review and decided a committee should further investigate Dr Dimian’s conduct.

A committee was established, held a hearing and produced a final report with a finding that he had engaged in inappropriate practice, largely because of lack of clinical input into, and poor clinical records of, services.

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

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

Dr Jack Freeman,  
General Practitioner, North Melbourne Vic.

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

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

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

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

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

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

Dr Ashraf Selim,
General Practitioner, Punchbowl NSW

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

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

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

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

On 7 February 2005 Jacobson J held there was no error on the Director’s part regarding the possibility of a s.92 agreement. This had been adequately brought to Dr Selim’s notice by letter and pamphlet, and Dr Selim had neither responded nor approached the Director. Other grounds of appeal mentioned in our 2003-04 Annual Report were not pursued. Jacobson J dismissed the appeal on the judicial review ground. Dr Selim has appealed that to the Full Federal Court—no date for hearing has yet been set.
Stone J heard Dr Selim’s challenge on the constitutional issue on 14 June 2005 with a decision reserved.

Dr Il Song Lee, General Practitioner, Eastwood NSW—Case 1

The Commission referred Dr Lee on 3 June 2002 to determine whether he had engaged in inappropriate practice in connection with rendering services constituting a prescribed pattern. During the referral period of 8 January 2001 to 12 October 2001 inclusive the Commission’s data showed Dr Lee had rendered 80 or more professional attendances per day on 37 occasions.

A committee was established, a hearing held and a final report, finding Dr Lee engaged in inappropriate practice, produced. Dr Lee has appealed to the Federal Court on the issues of whether exceptional circumstances existed, the referral decisions were invalid on the same grounds as in Daniel v Kelly, and the ‘prescribed pattern of services’ constitutes civil conscription.

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

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

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

Dr Il Song Lee, General Practitioner, Eastwood NSW—Case 2

The Commission referred Dr Lee on 13 December 2001 to determine whether he had engaged in inappropriate practice in connection with rendering services constituting a prescribed pattern. During the referral period of 1 January 2000 to 25 September 2000 inclusive the Commission’s data showed Dr Lee had rendered 80 or more professional attendances per day on 37 occasions.

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

- the Commission made an automatic referral
- the Director failed to consider how to investigate Dr Lee’s conduct unconstrained by section 106KA of the Act
- the committee wrongly thought exceptional circumstances could not arise from events that affected rendering services throughout the referral period
- the ‘prescribed pattern of services’ constitutes civil conscription.
On 27 October 2004, Jacobson J ordered the constitutional issues be severed for separate hearing. This has yet to occur.

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

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

Dr Sou Kao Ly, 
General Practitioner, Cabramatta NSW

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

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

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

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

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

Dr Peter Thomas Tisdall, 
General Practitioner, Kyabram Vic.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr Constantinos Perkoulidis, Medical Practitioner, Brunswick Vic.

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

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

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

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

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

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

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

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

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

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

Dr Siamidis failed to record any of this information.

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

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

Act  

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

AMA  
Australian Medical Association

committee  
A Professional Services Review committee established by the Director in accordance with section 93 of the Act to examine a case of apparent ‘inappropriate practice’ referred by the Health Insurance Commission

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

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

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

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

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

inappropriate practice  
Professional conduct in relation to Medicare which a committee of peers would reasonably consider would be unacceptable to the general body of the peer group (section 82)

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

MBS  
Medicare Benefits Schedule

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