Professional Services Review

REPORT to the PROFESSIONS

2006–07
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3. Glossary
The 2006–07 Report to the Professions provides details of Professional Services Review's (PSR's) activities for the year. It includes summaries of individual cases finalised and vignettes describing areas of concern to PSR.

In the 12 months this report covers, PSR experienced a significant increase in caseload. Medicare Australia referred 27 cases compared to seven the previous year. Present indications are that PSR will receive more than 50 cases in 2007–08. PSR has also investigated a greater variety of practitioners, including specialists, optometrists and other allied health providers. In the past PSR has attracted criticism for only investigating general practitioners; this is no longer the case.

Medicare Australia's revised procedures have resulted in PSR investigating practitioners with abnormal billing profiles sooner. Practitioners who have been referred to PSR in the past are now 'fast-tracked' if they again raise Medicare Australia's concerns. In the last 12 months PSR has witnessed an increase in the number of repeat referrals. I remind practitioners that a second adverse determination by a PSR Committee puts them at risk of disqualification from Medicare and the Pharmaceutical Benefits scheme for up to five years.

The Department of Health and Ageing's 2006 Review of the Professional Services Review Scheme has been completed and all its recommendations have been accepted.

During 2008 the Advisory Committee
recommended by the review will oversee work to implement the remaining recommendations. This may result in PSR's activities increasing to include coverage of medical practitioners' services to Department of Veterans' Affairs' clients as well as coverage of allied health providers, such as psychologists and dieticians, not currently within PSR's remit. The full review report can be found at <www.psr.gov.au>.

PSR's internal processes are also being reviewed to reduce the time a practitioner is involved in the process. Peer review committees will investigate and report on inappropriate practice expeditiously, so a practitioner is able to resume appropriate practice as soon as possible. An unnecessarily prolonged investigation can increase the strain on an already stressed practitioner; PSR aims to avoid this wherever possible.

The lessons learned from the cases described in this Report to the Professions can be applied in many practice settings. The most salient lesson to learn is to always make contemporaneous and comprehensive notes in all clinical encounters.

Tony Webber
Director
Agency overview

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Agency overview

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

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

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

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

A person who is an officer of a body corporate engages in inappropriate practice if the person causes or permits a practitioner employed by the person or body corporate to engage in inappropriate practice.
The essential features of the PSR Scheme are:

- Director of PSR, who is a medical practitioner appointed ministerially and able to engage staff and consultants, to investigate requests to review from Medicare Australia. The Minister for Health and Ageing appointed Dr Anthony David Webber Director of Professional Services Review from 14 February 2005 for a three-year period.

- PSR Panel, comprising medical and other health-related practitioners, who are appointed ministerially. At 30 June 2007, 133 members were 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.

- Committees, comprising practitioners from the PSR Panel, established by the Director on a case-by-case basis to consider the conduct of practitioners.

- Determining Authority comprising a medical practitioner as Chair, a layperson and a member of the relevant profession who are appointed ministerially. The Determining Authority's role is to decide on sanctions for practitioners found by Committees to have engaged in inappropriate practice and to consider whether to ratify agreements entered into by the Director and the person under review.

At every major point in the process the practitioner is given the opportunity to make submissions that could influence the outcomes.

**Medicare Australia requests to review**

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

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

- Prescribed pattern of services
- High volume of services
- High number of services per patient
- High prescribing of PBS drugs
- Inadequate clinical input
- MBS item not satisfied
- Services not medically necessary.

**Professional Services Review's process**

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

- decide to take no further action
- enter into an agreement, or
- establish and make a referral to a peer review Committee.
No further action
Where the Director decides to take no further action, the Director writes to the person under review and Medicare Australia informing them of the outcome of the review.

Agreement
The Director may enter into a negotiated agreement with a practitioner. Both parties sign a document containing an acknowledgement by the practitioner that he or she has engaged in inappropriate practice. It may also contain an agreement for repayment of Medicare benefits and partial or full disqualification from Medicare. The Determining Authority must ratify this agreement. While the name of the practitioner remains confidential, the details of the inappropriate practice are published.

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

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

Determining Authority
The Determining Authority is a separate body whose role is to determine the sanctions to be applied in cases of inappropriate practice.

On receipt of a Committee’s final report containing findings that the person under review has engaged in inappropriate practice the Determining Authority must invite written submissions on any sanctions that may be applied, issue a draft determination, seek comments from the person under review on the draft determination and issue a final determination containing sanctions.

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

Medicare Participation Review Committee
When a practitioner has had two effective final determinations the Director must provide a written notice to the Medicare Participation Review Committee. This Committee 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.

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

PSR has working relationships with Medicare Australia, the Department of Health and Ageing and health registration boards nationwide. In addition PSR fosters good relationships with its wider stakeholders, including the Australian Medical Association, the various Royal colleges and many other professional bodies and organisations.

Medicare Australia

Medicare Australia, which administers the MBS and PBS, can ask the Director to review the 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. PSR is an active participant in these activities.

Health registration boards

The Act requires the Director to refer practitioners 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.

Development of the PSR Scheme legislation

The PSR Scheme was established by the Health Legislation (Professional Services Review) Amendment Act 1993 which amended the Health Insurance Act 1973, and came into effect on 1 July 1994.

The Act was substantially amended in 1999 following a comprehensive review of the scheme. An adverse decision by the Federal Court in November 2001 (Prodhon 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), which substantially agreed with the way PSR characterised its role. However, further amendment to the Act was needed to address the Federal Court’s concerns.

Parliament passed the Health Insurance Amendment (Professional Services Review and Other Matters) Act 2002 in December 2002. This new Act made a number of amendments to the existing Act, specifically to:

- clarify the roles and responsibilities of Medicare Australia, the Director of PSR and Committees
- enhance procedural fairness processes
- validate a number of referrals (that may otherwise have been found to be invalid on the basis of the Prodhon decision).

The Department of Health and Ageing developed the Act in consultation with the Director of PSR, Medicare Australia and the Australian Medical Association.
Management and accountability

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

An Executive Officer and three Unit Managers and their staff 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 documentation for referrals of practitioners to Committees and the agreements sent to the Determining Authority following negotiations. The Committees Unit provides secretariat services to PSR Committees. The Corporate Unit provides financial and human resources and information technology services and support for the whole organisation.

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

Figure 1: Organisation chart
Audit Committee
The Audit Committee was established in 2004-05.
The objective of the Audit Committee is to provide independent assurance and assistance to the Director on PSR's risk, control and compliance framework and its external accountability responsibilities.

Management Committee
The Management Committee, comprising the Director, the Executive Officer and the Unit Managers, meets monthly to consider relevant issues. The committee’s agenda varies depending on current issues but regularly covers:
- operational issues
- policy maintenance and development
- corporate governance issues
- internal audit and audit committee activities
- finances
- human resources
- occupational health and safety.

Human Resources
In 2006-07 PSR employed 15 staff under the Public Service Act 1999.
The Director of PSR is a holder of full time public office whose remuneration and other benefits are set by the Remuneration Tribunal.

As at 30 June 2007, 133 PSR Panel Members including 21 Deputy Directors and 10 members of the Determining Authority were holders of part time public office. The Remuneration Tribunal sets the remuneration and benefits for panel members and Determining Authority members as it does for the Director.
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SECTION: TWO
Report on performance

Performance
PSR has achieved strong support from the profession during the year due to an increased profile resulting from publication of the second annual Report to the Professions, and media interest in a range of PSR and Medicare Australia related issues. PSR has strengthened its ties with Medicare Australia and with the Department of Health and Ageing to develop a stronger and more integrated approach to compliance activities to protect the integrity of the Medicare and pharmaceutical benefits programs.

Medicare Australia sent 27 requests for review to PSR this year (see Table 1). The Director dismissed one case during the review process following the death of the practitioner. The Determining Authority ratified six negotiated agreements. In 10 additional cases the Determining Authority made a final determination following a Committee report, two of which were subject to applications to the Federal Court and were not effective as at 30 June 2007. Six new Committees were established during the year.

At 30 June 2007, 18 cases were under review by the Director and 22 referrals were in various stages of the Committee process. In addition, 13 cases were with the Determining Authority, 11 of these were in the Federal Court.

It took an average of 156 days (208 days in 2005-06) to complete those seven cases leading to a negotiated agreement to the stage when they were referred to the Determining Authority against a legislative timeframe of 13 months for completion.
### Table 1: Workload statistics

<table>
<thead>
<tr>
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</tr>
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<td>Requests withdrawn or lapsed</td>
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<td>- Findings of inappropriate practice</td>
<td>8</td>
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<td>- Findings of no inappropriate practice</td>
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</tr>
<tr>
<td>Referrals to medical boards</td>
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</tr>
<tr>
<td>Negotiated agreements ratified</td>
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<td>8</td>
</tr>
<tr>
<td>Final determinations made</td>
<td>10</td>
<td>5</td>
</tr>
</tbody>
</table>

#### Committee reports

The Director made six referrals to Committees during the year. Eight Committees reported findings of inappropriate practice; and 13 Committee reports were sent to the Determining Authority.

The average time taken for Committees to report findings on 13 cases was 549 days (829 in 2005-06).

#### Determining Authority activities

The Determining Authority received 20 cases this year.

#### Negotiated Agreements

The Determining Authority ratified five negotiated agreements on first presentation; a sixth was not ratified by the Determining Authority, in the first instance. A new negotiated agreement addressing the Determining Authority's concerns was subsequently ratified.

Sanctions agreed as part of the ratified agreements were that:
- six practitioners be reprimanded
- four practitioners be partially disqualified from Medicare for a total of 63 months
- six practitioners agreed to make repayments totalling $594,887 (from $14,887 to $400,000).

The six negotiated agreements were ratified in an average of 16 days (22 in 2005-06) against a legislated timeframe of one month.

#### Determinations

Nine draft determinations and 10 final determinations were issued from findings in Committee reports.

The Determining Authority took an average of 148 days (164 in 2005-06) to make the nine draft determinations and an average of 118 days to issue the 10 final determinations.
Federal Court action caused delays in issuing the final determinations in two cases. During the year 14 final determinations came into effect. The sanctions imposed by these effective final determinations included:

- reprimand and counselling
- repayment in 10 determinations totalling $1,155,980.84
- full disqualification periods in four cases from six weeks to three years totalling three years six months and two weeks
- partial disqualification periods in eight cases from three months to two years totalling 10 years six months
- full suspension of the authority to dispense PBS pharmaceuticals.

Referrals to Medical Boards
The Director referred seven practitioners to the relevant state medical registration board. In five cases the Director or the Committee concerned formed the opinion that the practitioners had caused, were causing, or were likely to cause a significant threat to the life or health of patients. In two cases the practitioners were referred because the Director or the Committee formed the opinion that the practitioners had failed to comply with professional standards.

Re-referrals
In 2006-07 there were four requests for re-review of a practitioner whom Medicare Australia had previously sent for review.

Negotiated agreements ratified by the Determining Authority

*Dr A, General practitioner
Queensland*

Medicare Australia referred Dr A because it was concerned that his rendering of management plans (MBS items 721 and 725) might have constituted inappropriate practice. Medicare Australia was also concerned about Dr A's daily servicing and the extent of his family servicing.

During the review period Dr A provided 13,087 MBS services, which placed him at the 98th percentile compared to all vocationally registered general practitioners in Australia. Additionally Dr A rendered GP management plan services above the 97th percentile.

Dr A's clinical records were examined. It was considered that 80 per cent of Dr A's GP management plans were inappropriate. It appeared that the entries in the data fields of the plans were populated by Dr A's software, and that these entries were identical in many instances. There did not appear to be any clinical judgement applied to many management plans, as they were not individualised for a particular patient's conditions. Many of the plans appeared to have been for relatively minor conditions. All of Dr A's management plan reviews were considered inappropriate. There was no attempt to evaluate the care given over the preceding six months and there was no comment on the progress toward treatment goals or changes to the management plan. Dr A's management plans would not have contributed to an improvement in his patients' health.

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1 MBS item 721 is a GP management plan, item 725 is a review of a GP management plan.
Case Study One

Consultations claimed with procedures and Chronic Disease Management items

The fee structure for a procedural item or an investigation item in the MBS contains a component for the time taken to undertake the procedure. A PSR Committee may consider it inappropriate practice to charge a consultation item if there is no clinical need for the service in the following circumstances:

- In association with a skin excision item, particularly if the patient had been booked specifically for the procedure.
- Billing a long consultation in association with a diagnostic procedure (for example, an ECG or respiratory function testing) if the doctor's clinical interaction with the patient would not justify the item claimed.
- A surgeon billing a consultation item to a patient in the anaesthetic bay before surgery where no clinical interaction took place.
- Billing a consultation item in association with an Enhanced Primary Care item (MBS items 700 to 719) or Chronic Disease Management item (MBS items 721 to 880), if no separate medical problem was dealt with at the same patient attendance.

If a practitioner does choose to bill Medicare for one of these examples, the medical record should indicate the clinical need for the service.
Dr A was visited in his surgery and the Director's concerns were discussed. Dr A had started to change his practice to satisfy Medicare Australia's concerns. As it appeared that Dr A was making a genuine effort to change his practice profile a negotiated agreement was signed. Dr A acknowledged that he had practiced inappropriately and he agreed to repay $35,000 and be disqualified from the provision of MBS items 721 and 725 for a period of six months.

Dr A's case highlights the fact that GP management plans are designed to improve the quality of patient care and need to be done thoughtfully with adequate clinical input that seeks to improve a patient's health outcome.

Dr B, General practitioner Victoria

Medicare Australia was concerned that Dr B's level C consultations and her initiation of pathology may have been inappropriate. Medicare Australia had first identified Dr B in 2003. Dr B rendered 2313 level C consultations and only 926 level B consultations in the 12 months July 2004 to June 2005. This is a very unusual pattern for a general practitioner. Dr B's ratio of level B to level C consultations was 1:2.49 for the review period compared to that rendered by general practitioners nationally on average being 7:1.1. Dr B's total rendering of level C consultations was above the 99th percentile.

Medicare Australia's other concern was in relation to her ordering of pathology. During the review period Dr B's ordering of hormone assays and homocysteine was significantly above the 99th percentile. Dr B's total patient numbers were on the 32nd percentile.

Dr B was visited in her practice and a sample of her clinical records was examined. Dr B appeared to have a 'niche' practice where she treats patients with obesity, hormone imbalances, and osteoporosis and to whom she offers lifestyle counselling. There is a DEXA bone density scanner in her rooms.

Dr B's records were handwritten, disorganised and barely legible. Dr B's use of abbreviations and idiosyncratic symbols was confusing and would preclude another doctor effectively continuing the care of her patients using her clinical records.

Dr B's records did not support the level C consultations she had claimed. There was no evidence of a detailed history or the recording of an extensive physical examination. It appeared that a level C consultation was billed on a time basis only, without regard to the content requirement of the item descriptor.

It became apparent from the records that nearly every patient had a significant number of pathology tests requested. Justification for these investigations was rarely found in the notes. It was also clear that the majority of tests would have had little contribution to patient management. Dr B appeared to order a battery of similar tests for each patient without regard to the clinical situation.

A further concern was her extensive use of DEXA scanning for bone mineral density estimation. A consultant endocrinologist reviewed the clinical notes of patients who had undergone a DEXA scan and, in his opinion, these scans...
were being ordered unnecessarily and without justifiable medical indications. In addition, he was concerned that many young women whom Dr B had labelled as having a 'hormone imbalance' were being scanned. The Director formed the opinion that Dr B had failed to comply with professional standards in her use of DEXA scanning and she was referred to the Medical Board of Victoria.

Dr B acknowledged that she had engaged in inappropriate practice in relation to MBS level C consultations and her ordering of pathology tests. The Director considered that her inappropriate conduct could be satisfactorily addressed by a negotiated agreement. She agreed to repay $70,000 in Medicare benefits.

Practitioners should always be thoughtful in their ordering of pathology and limit any investigations to those required by the clinical situation. It is unwise and not good practice to have a 'standard' list of tests for every patient.

**Dr C, General practitioner, Western Australia**

Medicare Australia referred Dr C because it was concerned about his level of initiation of both diagnostic imaging and pathology. Dr C had first come to the attention of Medicare Australia in 1995. Following Medicare Australia's intervention at that time he had modified his pathology and radiology ordering practices. However a similarly concerning pattern of behaviour had reappeared in 2001 and 2004.

During the review period Dr C provided 5715 services (63rd percentile) to 1332 patients (41st percentile). However Dr C was at the 98th percentile for initiation of diagnostic imaging compared to all other general practitioners. Similarly Dr C was initiating pathology at the 97th percentile.

Dr C's practice demographics did not account for this discrepancy.

Samples of Dr C's records were examined. His records in relation to provision of level C consultations did not justify the item claimed. Specifically it appeared that when he had treated a number of minor conditions at the same time, he had billed for a level C consultation. These consultations did not contain the level of complexity the item descriptor requires.

In addition, there was evidence of frequent pathology and radiology initiation without adequate clinical justification.

The Director met with Dr C and the findings were discussed. Dr C explained that he had a large Southern European patient base, and that his patients expected frequent investigations. The Director pointed out that it is the treating doctor's responsibility to determine any investigations, based on clinical need. Dr C was also made aware that his peers would not consider it appropriate to acquiesce to patient demands or expectations for unnecessary investigations.

Dr C demonstrated that he had considerable insight into his inappropriate pathology and radiology ordering. The Director considered that Dr C's matter could be the subject of a negotiated agreement. Dr C acknowledged that he had practised inappropriately and agreed to repay $14,887.

Many practitioners who come before PSR find themselves in difficulty when they practice medicine dictated by their patients' request for either investigations or drug treatment without a sound clinical basis for these decisions.
PSR Committees have been critical of some practitioners' pattern of pathology ordering. In some disturbing cases pathology has been ordered as the sole route to a diagnosis; history and examination having been accorded scant regard. This has been particularly evident in a high volume practice. Doctors are reminded that 'adequate clinical input' implies that a relevant history and examination have been performed and recorded. Pathology and diagnostic imaging are expensive tools and should never be used as substitutes for the practitioner's clinical input. PSR Committees have also highlighted inappropriate frequent ordering of pathology particularly when the results have been normal and the patient's condition has not warranted a repeat test.

It also appears that when some GPs decide to investigate a patient they have adopted the practice of ordering the same large bank of tests for all patients, regardless of their clinical condition. For example, ordering B12 and iron studies before receiving the results of a full blood count results in many unnecessary investigations being charged to Medicare. PSR Committees view this as inappropriate practice.

GPs are reminded that if they have been found to have practiced inappropriately by initiating unnecessary pathology and diagnostic imaging they may be required to repay the cost of these investigations to Medicare Australia.

Example of frequent repetition of pathology

<table>
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<tr>
<th>Date</th>
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<th>Lab No</th>
<th>Total Cholesterol</th>
<th>Triglycerides</th>
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<tr>
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<td>22/09/04</td>
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<td>16/11/04</td>
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<tr>
<td>10/11/05</td>
<td>00:00</td>
<td>1270002</td>
<td>5.6 mmol/L</td>
<td></td>
</tr>
</tbody>
</table>

This patient had had three tests for cholesterol and triglycerides within three months. There was no clinical indication for the repetition. Doctors should be mindful of any previous results available for a patient. Previous results may have been ordered by another doctor within the practice or may be available from a hospital or specialist. A doctor who repeats pathology or diagnostic imaging without a clinical indication may be found to have practiced inappropriately. An optometrist who repeats computerised perimetry without clinical justification may also be found to have practiced inappropriately.
Report on performance

Dr D, General practitioner
Queensland

Dr D worked in a Queensland skin clinic. Medicare Australia referred him over several concerns. During the review period Dr D received $765,101.85 in Medicare benefits, which is at the 100th percentile. Medicare data demonstrated that Dr D was the second highest renderer of items 30192 and 30213. Lesions treated under MBS item 30213 must be visible from four meters. Given the volume of these services Dr D rendered, his peers may consider it unlikely that so many patients with these lesions would present to one practitioner.

Medicare Australia was also concerned by the high number of skin flap items Dr D had claimed as being needed for wound closure. During the review period Dr D was above the 99th percentile for his rendering of skin flap services. Medicare Australia was concerned that many of his skin excision items may have been billed at a higher level of benefit than was warranted by the size of the lesion.

A large number of Dr D’s records were examined. It was considered that Dr D had claimed skin flap items for closure of wounds in which the histopathology revealed the original lesion to be very small. In one instance Dr D had claimed that two skin flaps were needed to close a wound following excision of a two millimetre lesion from the back of a hand. The Director was of the view that Dr D’s peers would consider this an inappropriate use of skin flap items.

Dr D appeared to have claimed for malignant lesion removal where the histopathology revealed that the lesions were benign and therefore did not justify the benefit claimed. The difference between the benefit for a benign lesion and a malignant one can be more than $60. The impression gained, from examination of Dr D’s medical records, was that his patients received inappropriate and unnecessary treatments. It also appeared that in some instances Dr D ‘up-coded’ the MBS item to obtain a higher benefit.

When confronted with the Director’s findings Dr D acknowledged that he had practiced inappropriately. He agreed to repay $400,000 in Medicare benefits and to be disqualified from using MBS items related to skin cancer medicine for three years.

Dr D’s conduct should remind practitioners that it is essential to pay scrupulous attention to the requirement of the MBS descriptor and to practice in an appropriate manner when billing for skin cancer services.

Dr E, General practitioner
New South Wales

Dr E was referred to PSR as Medicare Australia was concerned that her prescribing of Cox-2 drugs and narcotics may have been inappropriate. In addition they were concerned that the level of services to patients may also have been inappropriate. Dr E’s individual patient numbers (1420) was on the 45th percentile, however her level of services per patient was on the 92nd percentile.

Dr E issued 731 prescriptions for celecoxib and 434 prescriptions for meloxicam, a combined volume of 1165 prescriptions, 838 of which were for patients under the age of 50. The requirements of the PBS Schedule state that these drugs are not to be used for acute pain, soft tissue injury or arthrosis without an inflammatory component. Medicare Australia was concerned that Dr E’s prescribing may have been outside the PBS guidelines.

4 MBS item 30192 is removal of pre-malignant skin lesions and MBS item 30213 is removal of telangiectases.
During the review period Dr E issued 919 prescriptions for opium alkaloids and 625 prescriptions for benzodiazepine derivatives. Medicare Australia was concerned that this level of prescribing may not have been clinically appropriate.

The Director met with Dr E in her surgery and examined a sample of her records. Dr E practiced in an isolated region as a solo general practitioner. She had also been granted dispensing rights, as there was a considerable distance to the nearest pharmacy.

Dr E's records relating to her level B consultations were brief and poorly documented with minimal or no written histories or details of examination findings. Similarly many of her level C services lacked the clinical complexity to justify the item claimed. The records related to Medicare Australia's prescribing concerns were also poorly documented. There was little evidence that the PBS guidelines for prescribing Cox-2 drugs had been followed. Contrary to the requirements of the PBS Schedule, the records showed that Dr E had prescribed Cox-2 drugs for soft tissue injury and lower back pain without evidence of inflammation.

Dr E's prescribing of narcotics in many instances was also considered inappropriate. She paid little attention to drug interactions and did not record accepted pain management principles. It appeared that Dr E allowed her patients to dictate treatment beyond what her peers would consider reasonable. Several records suggested that her patients were addicted to the medication being prescribed.

During the Director’s visit to her surgery, additional causes for concern were found. Dr E had made inadequate provision for vaccines and had no proper cold chain for either storage or transportation. Concerns were also held for Dr E's stock control. The dispensary was housed in the staff kitchen and was easily accessible to patients. There did not appear to be any security measures in place to prevent theft.

After a further meeting with Dr E she acknowledged that she had practiced inappropriately. She stated that she felt isolated and found many of the patients' demands for medication intimidating. She felt an obligation to the community; however, she did acknowledge that in some instances her drug dependant patients were manipulating her.

She agreed to repay $60,000 in Medicare benefits, be fully suspended from prescribing narcotic medications for nine weeks, and that her authority to dispense pharmaceutical benefits be suspended for three years. As a result of these sanctions, Dr E moved her practice to an area where she would gain peer support and would not require dispensing rights.

Dr F, General practitioner
Western Australia

Medicare Australia referred Dr F as it was concerned that his level of ordering of cerebral perfusion studies, also known as SPECT scanning (MBS item 61402), may have been in excess of clinical requirements. SPECT scanning is an item predominantly used clinically by psychiatrists and neurologists. In addition, Medicare Australia was concerned with Dr F's itemisation of level C consultations.

Dr F, a vocationally registered general practitioner, saw only 470 individual patients during the review period, (7th percentile). However, he ordered 117 item 61402 perfusion studies. Dr F was above the 99th percentile for his initiation of this item when compared to all active general practitioners and all active psychiatrists in Australia during the review period.
Family servicing

PSR frequently receives requests from Medicare to investigate a practitioner's family servicing. Family servicing is defined as seeing more than one family member on the same Medicare card on the same day.

While on most occasions this will be quite legitimate, there have been cases where, for example, a parent or guardian may bring in a child who is ill and after seeing that child the parent or guardian says: "the other kids seem OK but could you check them while we're here?" This can be a minefield for the doctor as it may be difficult to refuse such a request. However, if there is no clinical reason for the other children to present to the doctor, a Medicare rebatable fee cannot be charged.

The other trap for a practitioner is the elderly couple that always attends the surgery together. If one of the pair is attending merely to accompany the other and does not require a medical consultation, even if they have booked an appointment, they cannot be billed under Medicare.

These issues can be largely resolved if the practice has a clearly enunciated policy about multiple consultations in the one time slot.
Dr F rendered 41 per cent of his consultations as level C and 40 per cent as level B. Medicare Australia was concerned that Dr F's rendering of level C consultations may not have fulfilled the MBS descriptor on each occasion or may not have been clinically relevant.

Dr F's records were examined in relation to MBS item 36 and 44 services. Dr F's records revealed that he had recorded exhaustive histories, detailed notes, management plans and counselling notes. It appeared that Dr F would have spent the time with the patients as required by the MBS item descriptor. However, following examination of his records, a new concern emerged. The records examined showed a referral pattern of Dr F's patients to a psychiatrist who issued a prescription of dexamphetamine and authorised Dr F to be a 'co-prescriber' of the medication. In many records examined there was little evidence that dexamphetamine was the best first treatment option.

The Director met with Dr F to discuss these issues. Dr F acknowledged that he had practiced inappropriately and agreed to repay $15,000 and be disqualified from using item 61402 for 18 months.

Final determinations made by the Determining Authority

Dr Ameen Ahmed Bham
General practitioner
Morley, Western Australia

Medicare Australia referred Dr Bham because he rendered high numbers of services, particularly MBS items 53, 54, 11506 and 11700. Dr Bham claimed 17,103 total services during the review period.

The Director's investigation revealed that for both MBS item 53 and 54 services, the clinical content of the services often appeared insufficient to have occupied the time allegedly spent with the patient. In other instances, Dr Bham raised additional accounts for what appeared to be normal aftercare where normal aftercare was included in the original procedural item.

Dr Bham was referred to a Committee and it found that in respect of MBS items 53 and 54 he engaged in inappropriate practice because he:
- prescribed antibiotics where there was no indication of bacterial infection
- lacked the knowledge of the use of a range of common drugs
- failed to make an adequate examination of his patients
- managed a number of common conditions poorly, including depression, asthma and respiratory infections

5 Level D consultations (item 44) are defined as 'an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations...to one or more complex problems and lasting at least 40 minutes.'

6 MBS item 53 is a standard consultation, 54 a long consultation, 11506 a measurement of respiratory function, and 11700 an ECG trace and report.
used MBS item 54 for workers compensation or third party injuries, regardless of the time spent with the patient
used MBS items for time not spent in face-to-face contact with the patient
included time spent on procedural items in the consultation time.

In respect to MBS item 11506 he:
- failed to conduct the test before and after a bronchodilator
- failed to keep a permanent record of the tracing
- used the test as a substitute for taking a history
- lacked the knowledge to interpret the reports.

In respect of MBS item 11700 he:
- conducted the test when it was not clinically indicated
- used the test as a substitute for history taking and physical examination.

Committee questioning revealed Dr Bham had less than an elementary grasp of asthma management. Dr Bham admitted that he did not understand the readings generated by his respiratory function testing machine.

As the Committee was concerned that Dr Bham’s conduct in several areas of his practice had caused, was causing, or was likely to cause, a significant threat to the life or health of the patients under his care it made a statement to the Director who referred the matter to the Medical Board of Western Australia for further action.

The Determining Authority directed that Dr Bham:
- be reprimanded and counselled by the Director or his nominee
- repay $284,278.12 in Medicare benefits
- be fully disqualified from access to Medicare for two months
- be disqualified for 12 months from access to MBS items 11506 and 11700.

**Dr Mina Mounir Fahmy Moussa**
General practitioner
Cloverdale, Western Australia

Medicare Australia referred Dr Moussa to the Director because it was concerned about his high volume of total rendered services; in particular, his rendering of MBS items 11700, 30061 and 42644. Medicare Australia was also concerned about Dr Moussa’s level of prescribing tramadol hydrochloride.

The Director considered that the medical records he examined relating to MBS items 23 and 36 were brief and lacking in clinical detail. Frequently the records only contained diagnoses or presenting symptoms, and references to examination and management were brief. In some circumstances the entries consisted of only five or six words. Level C consultations were used for seemingly straightforward conditions, such as removal of sutures, minor respiratory infections and repeat prescriptions.

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7 MBS item 30061 is superficial removal of a foreign body from the eye, MBS item 42644 is removal of an embedded foreign body from a cornea or sclera.

8 MBS item 23 is a level B GP consultation lasting less than 20 minutes and item 36 is a level C consultation lasting longer than 20 minutes.
There has been a dramatic increase in the number of practitioners offering minor skin excision procedures, both in the context of a standard general practice and in dedicated skin clinics, in the last five years.

Medicare has asked PSR to investigate a number of practitioners and their use of skin excision items. PSR investigations are consistently finding certain forms of inappropriate practice. They are:

- Failing to obtain histological proof of malignancy (items 30196 to 30205). Despite an accurate clinical diagnosis, a practitioner who is not a specialist must obtain histological proof before claiming this item.

- Failure to claim the correct size or depth of a lesion removed (items 31200 to 31335). It is evident when records are examined that many of the doctors PSR sees have claimed for lesions that were much smaller than the item claimed would suggest. Pathology fixation may cause some shrinkage, however it is not credible that a 3 mm lesion was more than 20 mm in diameter before excision. A practitioner's best defence is to document the lesion accurately in situ in the clinical notes and if possible to photograph it before removal.

- PSR Committees have considered that many of the high numbers of benign lesions practitioners have removed by excision should have been diagnosed clinically as benign and either left alone or treated in a less invasive manner.

- Use of flap repairs (items 45200 to 45207). In several cases in 2006-07 it appeared that use of flaps would have been of marginal clinical benefit to the patient. As the use of flap closure of wounds requires a high degree of skill to ensure optimal cosmetic and functional results, practitioners without extensive training or supervision should not attempt it. PSR will continue to review cases involving use of skin flaps very carefully.
Examples of inappropriate use of skin excision items

MBS item 31215: cyst, ulcer or scar ... more than 20 mm in diameter, removal by surgical excision ...

Pathology report
Specimen: skin lesion R upper arm
Clinical details: dark mole
Macroscopic: The specimen consists of a skin ellipse with attached subcutaneous tissue and that measuring 44 x 22 x 15 mm. On the skin surface is a pale greyish pink irregularly shaped smooth papule measuring 4 mm in diameter.
Microscopic: The sections reveal a benign cavernous haemangioma. Excision margins appear to be clear.

The doctor who claimed MBS item 31215 for removal of this lesion was found to have practiced inappropriately because the evidence from the pathology report shows the lesion to be only 4 mm in diameter. Even allowing for shrinkage this lesion was never more than 20 mm in diameter.

CLINICAL NOTES

Ex SCC R face.

MACROSCOPIC EXAMINATION

Specimen container is labelled R face. An ellipse of skin 24x8mm with a central T piece 10x5mm. Centrally there is a poorly defined slightly thickened scaly lesion 7mm in maximum. 4T. sol/bb/pp

MICROSCOPIC EXAMINATION

The sections showed an actinic keratosis with several keratin plugged dilated pores and areas of sebaceous glandular hyperplasia. Patchy areas of chronic inflammation could also be seen. There is no evidence of any malignant change.

SUMMARY

MBS item 45200: Single stage local flap ... indicated to repair 1 defect ...

A PSR Committee judged this service an inappropriate use of a skin flap. The clinical photos provided indicated that this lesion could have been readily removed by a simple elliptical excision resulting in a better long-term cosmetic result. Doctors who use flap surgery in their practice should ensure a flap repair is in the best interest of their patients. The doctor in this case was required to repay benefits for most of his flap repairs.
Dr Moussa was then referred to a Committee. The Committee found that 42 per cent of Dr Moussa's item 36 services demonstrated inappropriate practice. Dr Moussa failed to take detailed histories or perform examinations of multiple systems. The medical records lacked essential clinical information, such as presenting complaints, patient histories, examinations, diagnoses and management plans.

Dr Moussa also failed to keep adequate records about his provision of ECGs and foreign body removal from the eye.

Dr Moussa inappropriately prescribed tramadol hydrochloride in a number of instances. Dr Moussa was not able to effectively monitor the quantity prescribed or the amount the patient was consuming. Prescriptions appeared to have been written on patient demand rather than on clinical indications.

The Determining Authority directed Dr Moussa be reprimanded and counselled, repay $18,415.43 in Medicare benefits and be fully disqualified from access to Medicare for three months.

Dr Peter Wayne Snodgrass
Chiropractor
Norwood, South Australia

Medicare Australia referred Dr Snodgrass because of concerns that he may have initiated diagnostic imaging services that may not have been necessary.

A Committee, consisting of three chiropractors, investigated Dr Snodgrass. The Committee reviewed a sample of medical records for patients for whom Dr Snodgrass initiated diagnostic imaging services. The Committee found that in 90 per cent of the examined services Dr Snodgrass failed to establish essential clinical criteria, such as evidence of trauma, deterioration of presenting condition or suspicion of new pathology. The Committee found that Dr Snodgrass’ failure to do this would be unacceptable to the general body of chiropractors.

For example, Dr Snodgrass initiated diagnostic imaging of the pelvic region for two female patients of child-bearing age and one teenager without adequate clinical justification.

Dr Snodgrass’ rationale for frequent testing was to monitor the progress of patients during a regime of regular chiropractic care. The Committee did not agree with Dr Snodgrass’ rationale and concluded that his conduct would be unacceptable to the general body of chiropractors.

The Determining Authority, which also included a chiropractor, directed that Dr Snodgrass be reprimanded and counselled by the Director or his nominee.

Dr Gias Swid
General practitioner
Fairfield, New South Wales

Medicare Australia was concerned that Dr Swid’s billing statistics may have indicated that he had engaged in inappropriate practice. During the review period Dr Swid rendered 19,769 services for a total benefit of $364,142.35. This was above the 99th percentile for all active medical practitioners in Australia. Medicare Australia was also concerned about Dr Swid’s prescribing of Cox-2 drugs under the PBS.

Following the Director’s review Dr Swid was referred to a Committee. The Committee examined a random sample of Dr Swid’s standard consultations (MBS item 53) and found that he had failed to provide an appropriate level of clinical input in that presenting complaints
of patients were dealt with superficially, often with no attempt to investigate the underlying causes. The Committee also found that Dr Swid's routine practice of asking patients if they felt hot instead of using a thermometer would be unacceptable to his peers.

The Committee described Dr Swid's medical records as 'rudimentary', which reflected the lack of clinical input in his consultations. The Committee also found that Dr Swid recycled pages from other (older) patient records. This was confusing at best and had the potential to breach patient confidentiality and compromise the quality of care. Of the 36 records the Committee examined, 35 per cent were found to have involved significant inappropriate practice.

The Determining Authority directed that Dr Swid be reprimanded and counselled by the Director, repay $117,209.34 in Medicare benefits, and that he be fully disqualified from Medicare for six weeks.

Dr Patrick Glen McCabe
General practitioner
Southport, Queensland

Medicare Australia referred Dr McCabe because of his unusual ratio of long and prolonged consultations. During the review period Dr McCabe's ratio of long (MBS item 54) to standard consultations (MBS item 53) was 1:0.55 when the average ratio for general practitioners was 1:4.17. The disparity with Dr McCabe's peers was even more striking for prolonged (MBS item 57) to standard consultations; 1:1.97 compared to 1:52.75. Medicare Australia also had concerns about Dr McCabe's services per patient and his initiation of pathology.

Following an investigation by the Director, Dr McCabe was referred to a Committee to consider his conduct. The Committee found that 90 per cent of Dr McCabe's long consultations (MBS item 54) involved inappropriate practice. Dr McCabe stated his patient base consisted of chronic disease and cancer patients. He offered treatment in molecular medicine, which he described as treatment focused on diet and supplements to 'invigorate molecular function'. Dr McCabe also offered his patients immunotherapy described as consisting of 'various ingredients which are known to be helpful in invigorating immune function...they consist of antioxidants, minerals and enzyme cofactors'. These treatments were administered by intravenous infusion.

The Committee found that Dr McCabe did not provide an appropriate level of clinical input and he failed to investigate presenting complaints and implement treatment. In three services patients reported shortness of breath; however Dr McCabe did not initiate investigation or treatment. Dr McCabe did not examine the abdomen, despite the patient having colon cancer. Dr McCabe explained his behaviour by saying 'if he had some complaint about abdominal pain or something like that, I would have looked at it'. The Committee was alarmed that Dr McCabe relied on the patient to report any changes in such a significant condition.

Dr McCabe's medical records were insufficient to contribute to the quality and continuity of patient care. Typically absent clinical information included presenting complaints, histories, examinations performed, findings, diagnoses, details of medications prescribed and management plans. Dr McCabe's response, when the Committee challenged him about his records, was that he does 'not interrupt interviews with patients to write notes'. Seven records reviewed revealed no notes of a consultation at all.
Misunderstanding of level C and D consultations

Over the last few years PSR has discovered considerable confusion in the general practice community as to how to use level C and level D consultation items.

These items were originally introduced for vocationally registered general practitioners (VR-GPs) to use; access has subsequently been extended to other medical practitioners working in designated areas. VR-GPs may not be aware that they are unable to use the older Group A2 items. Level C and D items recognise that to provide a high quality of medical care for patients with complex health needs requires not only more time, but also a higher degree of clinical input to justify the higher Medicare benefit.

Level C and D consultations require that the doctor spend the prescribed time with the patient, (20 minutes for a level C, 40 minutes for a level D). In addition, it is a requirement that the doctor fulfil the item descriptor pertaining to the content of the item claimed. In the case of a level C consultation, the MBS item descriptor requires 'taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more problems. The consultation must be adequately documented to reflect these requirements. A level D consultation is similarly worded, but also requires an exhaustive history and comprehensive examination.

These items are not intended to be used for a string of minor conditions that may have met the time but not the content requirement. For example, a patient seen for a repeat script for a stable condition, an ear syringe and a blood pressure measurement would not qualify as a level C consultation even if the consultation lasted more than 20 minutes. Doctors should be sure they have met the item descriptor before billing for a level C or D consultation.

Examples of level C or D consultations incorrectly claimed

MBS item 36: professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan lasting at least 20 minutes.
A PSR Committee found this service to be inappropriate, as the practitioner had recorded inadequate history and details of examination. The Committee found that recording the results of a breast exam and a pap smear as 'N' was completely lacking in the required clinical detail.

MBS item 36: professional attendance involving taking a detailed history, an examination of multiple systems arranging any necessary investigations and implementing a management plan ... lasting at least 20 minutes.

A PSR Committee regarded this item 36 service as inappropriate as recording 'domestic problems' was inadequate for another doctor reading the notes to understand the nature of the problems discussed. Doctors are reminded that recording the essential elements of a patient's problems is equally important when it is a psychological issue as when it is a purely physical issue.

MBS item 44: professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan ... lasting at least 40 minutes

A PSR Committee found no evidence of an exhaustive history, or a comprehensive examination of multiple systems in this record. An item 44 record requires sufficient clinical content to meet the item descriptor.

MBS item 23: ... professional attendance involving taking a selective history, examination ... with the implementation of a management plan in relation to one or more problems, OR a professional attendance of less than 20 minutes

Saturday March 18 2006 16:14:30
Dr M
Reason for visit: NIDDM

A PSR Committee found that a statement of the presenting complaint is insufficient to constitute the medical record for this encounter.
The Determining Authority directed that Dr McCabe be reprimanded and counselled by the Director and that he repay $25,391.20 in Medicare benefits. The Determining Authority further directed that Dr McCabe be fully disqualified from Medicare for three years. These sanctions represent the maximum that could be applied in Dr McCabe’s case.

Dr Nihal Jayantha Hewa
General practitioner
Flemington, Victoria

Medicare Australia referred Dr Hewa as his volume of MBS item 2 services was well above the 99th percentile. Dr Hewa rendered 950 MBS item 2 services during the review period. The 99th percentile for general practitioners at that time was 69.

The Director’s initial review suggested that the majority of the claims for MBS item 2 did not meet the MBS descriptor because the patients’ conditions did not appear to warrant immediate treatment.

Dr Hewa was referred to a Committee that found 18 per cent of MBS item 2 services he had rendered involved inappropriate practice. The Committee was of the opinion that Dr Hewa did not provide an appropriate level of clinical input to the services examined in that he:

- did not take an adequate history for the presenting complaint
- did not perform adequate examinations
- prescribed drugs without providing advice on adverse effects

Medicare Australia referred Dr Saddik for a number of reasons. During the review period Dr Saddik rendered 10,493 services to 2070 patients for a total benefit of $356,851.65. Dr Saddik’s average of 5.07 services per patient was above the 93rd percentile of all general practitioners.

Dr Saddik was above the 99th percentile for rendering enhanced primary care items 720, 724 and 740. Medicare Australia was concerned that Dr Saddik’s use of chronic disease management items may have been inappropriate considering the profile of his patient base; 5.8 per cent of Dr Saddik’s patients were over 65 years.

Medicare Australia was also concerned about Dr Saddik’s rendering of skin sensitivity testing, skin excision items and initiation of pathology, in particular, his ordering of iron studies.

The Director’s review revealed that Dr Saddik may have ordered iron studies inappropriately in some circumstances. Similarly, the Director found that the majority of MBS items 720, 724 and 740 services did not satisfy the MBS item descriptor and did not appear to be medically necessary. As well, there did not appear to be clinical

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9 MBS item 2 is a ‘professional attendance at consulting rooms...where the patient’s medical condition requires immediate treatment and where it is necessary for the doctor to return to and open consulting rooms... attendance... between 11 pm and 7 am, on a public holiday, on a Sunday, before 8 am or after 1 pm on a Saturday.’

10 MBS item 720 is a community care plan, MBS item 724 is a review of a community care plan and MBS item 740 is a community case conference.
indications for 50 per cent of the MBS item 12003 (allergy skin testing) services examined. The Director referred Dr Saddik to a Committee. The Committee found that all of MBS item 724 (review of a multidisciplinary community care plan) services involved inappropriate practice and 83 per cent of MBS item 740 services were inappropriate.

The Committee found that Dr Saddik's care plans did not identify all care providers. In addition, the Committee heard evidence from a patient's pharmacist who stated that despite being named in the care plans he had not received any documentation from Dr Saddik about the services in question. The Committee found that Dr Saddik did not provide an appropriate level of clinical input into the care plan reviews examined, and that he failed to review issues identified in the original care plans.

Dr Saddik's failure to maintain adequate and legible records of care plan reviews would make it difficult for members of the care team, or another practitioner, to understand and effectively contribute to the care of these patients.

The Committee also found that Dr Saddik failed to satisfy the requirements for MBS item 740 services in that he failed to distribute copies of the case conference summaries to other participants and patients. Dr Saddik failed, on many occasions, to ensure sufficient participants attended and failed to obtain patient consent for case conferences to take place. The Committee found that some case conferences were not medically necessary.

The Determining Authority directed Dr Saddik be reprimanded and counselled by the Director, that he repay $3986.15 in Medicare benefits, and be disqualified from Medicare for three months in relation to all case conference items. Dr Elizabeth Aileen Molnar Psychiatrist Brisbane, Queensland Medicare Australia was concerned that Dr Molnar's practice profile, which reflected many days with more than 10 hours consulting, may have involved inappropriate practice. During the review period Dr Molnar provided 3518 services to 327 patients for a total benefit of $352,667.80. Dr Molnar was above the 98th percentile for rendering MBS item 324, above the 99th percentile for rendering MBS item 32612 and above the 99th percentile for MBS item 32813 when compared to all active consultant psychiatrists in Australia during the review period. The Director engaged a consultant psychiatrist to review Dr Molnar's records. The consultant's view was that her clinical notes were 'at best erratic, more frequently downright poor and occasionally entirely absent.' The consultant was also of the opinion that the only way to gain an understanding of the clinical content of her practice was for her to be investigated by a panel of her peers.

A Committee, including two consultant psychiatrists, was established. The Committee found that Dr Molnar's conduct in connection with providing 60 per cent of MBS item 306 services examined would be unacceptable to the general body of consultant psychiatrists.

Dr Molnar's records lacked essential clinical information such as current medications.

11 MBS item 324 is an attendance by a psychiatrist of more than 30 minutes but not more than 45 minutes at hospital.
12 MBS item 326 is an attendance by a psychiatrist of more than 45 minutes but not more than 75 minutes at hospital.
13 MBS item 328 is an attendance by a psychiatrist of more than 75 minutes at hospital.
14 MBS item 306 is an attendance by a psychiatrist of more than 45 minutes but not more than 75 minutes at consulting rooms.
If a general practitioner or other medical practitioner renders more than 80 professional attendances on each of 20 or more days in a 12-month period he or she is taken to have practiced inappropriately unless there are exceptional circumstances.

The 80/20 rule came into operation on 1 January 2000. The number of attendances per day was set at 80 as it was the opinion of practitioners the Department of Health and Ageing and the AMA consulted that to render more than 80 attendances per day would be unsustainable and inconsistent with provision of a high standard of care. At the time, 80 consultations per day was thought to be an extreme number, as most GPs were seeing between 30 and 45 patients per day.

Most doctors in general practice are fully aware of the 80/20 rule and take steps to avoid breaking it. However, the 80/20 rule should not be regarded as a speed limit. GPs will put themselves at risk of closer scrutiny if they consistently see large numbers of patients. GPs often ask ‘what is the number of patients I can see and not trigger an investigation?’ The answer is; there isn’t such a number. A GP has an obligation to ensure all the attendances he or she renders in any one day have the appropriate level of clinical input, are relevant for the patient’s condition and meet the MBS item descriptor. A doctor consistently seeing more than 50 to 60 patients a day may find it difficult to provide a sustained high level of care.

A GP may find him or herself under investigation for a consistently abnormal pattern of services well below the 80/20 rule. Doctors should also remember that enhanced primary care and chronic disease management items and after hours consultations all count toward the 80/20 rule.
side effects, dosage and reasons for alteration, mental state examinations and management plans. Additionally, hospital discharge records and referral documentation were often absent from the records. In defence of her notes, Dr Molnar submitted that she had been advised by a senior professional colleague to 'make very extensive notes or you make very short notes'. In the Committee's opinion, the general body of consultant psychiatrists would expect that medical records should contain objective clinical details of mental state examinations, medication reviews, details of professional care provided and management plans.

The Determining Authority considered the inappropriate practice disclosed in the Committee's report to be of a very serious nature and directed that Dr Molnar be reprimanded and counselled, repay $98,215.17 in Medicare benefits and that she be disqualified from Medicare for six months in relation to providing psychiatric MBS items.

External review of actions
The person under review can seek judicial review in the Federal Court. Administrative decisions can be reviewed in the Administrative Appeals Tribunal (see Table 2).

Federal Court
Dr Hugo Huu Hiep Ho and 
Dr Hien Than Do 
General practitioners 
Merrylands, New South Wales 

Dr Ho and Dr Do practiced in partnership. On 13 December 2001 the then Health Insurance Commission (HIC) referred each to PSR because Dr Ho had rendered 80 or more professional attendances on 24 occasions between 1 January and 6 November 2000 and Dr Do had done so on 56 occasions between 1 January and 23 June 2000. Independent PSR Committees considered each referral and ultimately reported that their subjects had engaged in inappropriate practice for the purposes of section 108KA (prescribed pattern of services).

The Committee examining Dr Ho's referral found that exceptional circumstances did not affect the rendering of the services in question. Some circumstances were outside the referral period; others were part of a long-term and ongoing practice. The partners should have adjusted their patient load to maintain quality of service.

The Committee examining Dr Do's referral also found no exceptional circumstances. The practice generally provided high numbers of services and

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<th>Table 2: Court/tribunal actions</th>
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the days of 80 or more were simply part of that pattern. There were then about 50 other medical providers in the area, including some surgeries with extended opening hours that might have taken overflow patients. Further, some of the circumstances had been foreseeable; yet there was no evidence of an action plan (such as triage, appointments or locum) to manage numbers of patients seen.

The doctors each commenced judicial review proceedings in the Federal Court. In preliminary proceedings, Jacobson J had ordered, based on an agreement between the parties, that the outcome of their proceedings (and of similar proceedings brought by several other doctors) would ultimately turn on the result of one test case concerning section 106KA issues and separate consideration of Constitutional issues by the Federal and High Courts. In that test case, challenges to the investigative and adjudicative referrals were dismissed but the Committee was found to have erred in its understanding of the 'exceptional circumstances' provisions in section 106KA(2) and regulation 11(b) and to have wrongly had regard to whether the alleged exceptional circumstances had been foreseeable. As a result of that test case, Jacobson J ruled on 19 April 2006 that unless Drs Ho and Do could show they should be taken to have relied on regulation 11(b) this was the end of their matters.

Drs Ho and Do successfully appealed to the Full Court which held that their review applications should not have been formally tied to the outcome of the test case and, moreover, that the 'agreement' was 'of uncertain meaning and could not bind the Court. The doctors were free to pursue their original applications for judicial review.

In considering their substantive review applications, Rares J noted that a previous partnership of Drs Ho and Do and a third doctor had dissolved in 1999 with Drs Ho and Do as new partners retaining over 10,000 case files. They had submitted to their respective PSR Committees that exceptional circumstances had affected their rendering of services. These included the high case load inherited from the previous partnership, stress (including litigation) resulting from the dissolution, inability (despite efforts) to engage a third full-time doctor to replace the previous partner, high numbers of patients presenting after weekends and public holidays and during winter, and the occasional absence of either of the two doctors due to illness or other reasons.

Rares J examined the provisions of section 106KA and regulation 11 and previous decisions. He concluded that the term 'exceptional circumstances' in section 106KA(2) required consideration of all the circumstances - it could be a single circumstance or a combination. The circumstances did not have to be unexpected, unpredictable or one-off. He held that regulation 11 added circumstances, which might or might not fall within, but could not restrict, the terms of section 106KA(2).

He considered that the Committee had wrongly limited the scope of 'exceptional circumstances' by reference to regulation 11 and the 1999 Report of the Review of the PSR Scheme by concentrating on 'intermittent or episodic' circumstances rather than the combination of circumstances relied on by Drs Ho and Do. Further, a Committee must consider whether there were exceptional circumstances as defined in any of section 106KA(2) and regulations 11(a) and 11(b).

16 Ho v Grigor; Do v Wilcock [2006] FCAFC 72.
17 Ho v PSR Committee No 285; Do v PSR Committee No 283 [2007] FCA 388.
Clinical notes and computerisation of medical records

Australian GPs have enthusiastically embraced computer technology. The improvement in clinical care when information technology systems are used effectively has been well documented in both hospital- and office-based practice published studies.

Health professionals have varying keyboard skills; some are highly competent touch typists but many are still at the 'hunt and peck' two-finger level. This has implications for the quality of the medical record produced. Doctors who once wrote comprehensive notes in longhand are now sometimes reduced to a few lines of tortured text. The requirement for good recording has not changed. Doctors need to ensure their keyboard skills are sufficient for the task before adopting the new technology.

PSR Committee scrutiny of computerised medical records has often found examples of extensive 'cut and paste' in the medical record. Patients are individuals; their records should reflect an individual and tailored approach. When a practitioner's GP Management Plans, mental health items, or health assessments contain the same information for most patients, the practitioner will need to explain to a PSR Committee why his or her patients are all carbon copies of each other.

Computerised medical records?

This doctor started using a computer for writing prescriptions in 2005. From that date he neglected to record clinical notes in either hand written or computer form. He stated that he did not have time to do both.
In this case, the doctors had raised circumstances which were arguably exceptional in terms of regulation 11(a); for example, on 4 January 2000 when the new partnership commenced after a difficult dissolution and public holidays with only two doctors to service 90 per cent of the patients previously serviced by three doctors. Similarly, when Dr Do went home sick on two occasions, was this 'an unusual occurrence creating an unusual level of need for professional attendances' by Dr Ho? The Committees should have specifically addressed such issues.

The Full Court had indicated in Orel that a Committee should determine whether circumstances were 'exceptional', in the general meaning of that word under section 106KA(2), having regard to the usual operation of a medical practice, and practice management might be considered in that context. However, Rares J noted, the Full Court had also held that practice management was not relevant where the focus was on patient needs, not management skills. Rares J concluded that the two Committees had misconstrued or failed to apply the tests for exceptional circumstances. He ordered that the members of those Committees be prohibited from further constituting those Committees, primarily because the Committees had taken an active role in defending their decisions in the litigation, which might raise an apprehension of bias. It was left for the Director of PSR to decide whether to reconstitute the Committees with new members.

Appeals against both these decisions were lodged with the Full Federal Court on 16 May 2007.

Dr Lynette Bellamy
Medical practitioner
Edgecliff, New South Wales

Between 8 and 15 August 2006 Dr Bellamy was served with a Notice under section 102 to appear before PSR Committee 345 at 9 am on 22 September 2006 and to give evidence as required. On 19 September she informed the Committee of pre-existing arrangements for her to attend and speak at a conference elsewhere during 20 to 22 September and advised that she would not attend the hearing until 2.15 pm on 22 September. As the Committee declined to change its existing arrangements and commencement time, she asked that the respondent Committee be restrained from commencing at 9 am and that commencement be deferred to 2.15 pm.

Justice Graham held:

No reason whatsoever is advanced as to why it would be unjust for the Review Committee to proceed with the hearing at the appointed time in circumstances where the applicant has had over a month's notice of the intended hearing time. In my opinion, the application has no merit and should be dismissed with costs.

Dr Lam Quoc Phan
General practitioner
Cabramatta, New South Wales

The HIC referred Dr Phan to PSR on 29 June 2000 in respect of all services provided during 1999 because he had rendered 18,165 services, including 17,970 level B services in that year. A Committee investigated and its final report on 28 October 2004 was that Dr Phan had engaged in inappropriate practice in rendering 47 of 80 services examined. It identified deficiencies in his patient histories, examinations, management plans and prescribing.

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19 Ho v PSR Committee No 295 [No 2]; Do v PSR Committee No 293 [No 2] [2007] FCA 603.
20 Bellamy v PSR Committee No 345 [2006] FCA 1283.
On 7 December 2004 Dr Phan sought judicial review by the Federal Court. First, Dr Phan said the Director failed to proceed fairly because adverse reports from two medical advisers, which he considered in making the referral to the Committee, were not disclosed to Dr Phan and he was therefore not able to comment on them. The reports were not mentioned in that referral or conveyed to the Committee. Tamberlin J noted legal authorities that procedural fairness must be considered in the overall context of a statutory scheme and that there may be no entitlement to be heard at the first stage, particularly if there is a right at a later stage. In this case, the two reports were not before the Committee, which could not have been "infected" or "poisoned" by them, and he was satisfied that procedural fairness regarding the Director's decision was afforded by the overall process.

Second, Dr Phan said the lists of services and patient files referred to the Committee were not a proper sample, having been examined and found deficient by the Director. This must have skewed the sample and adversely affected Committee deliberations. Tamberlin J accepted the view of the Committee's statistical adviser that, from a statistical point of view, it was irrelevant that the Committee looked at the same random samples and services as the Director. The Committee, not the Director, had the authority to decide whether the sample disclosed inappropriate practice.

Third, Dr Phan said, relying on the decision in Mathews, the sample had not been randomly drawn from the preliminary random sample as required by the relevant sampling Determination. Tamberlin J distinguished the Mathews decision and held that the Committee had been entitled, under section 106K(4), to use an alternative sampling methodology advised by an accredited statistician to be statistically valid. Furthermore, previous examination by the Director did not affect the random character of the sample.

Fourth, Dr Phan said the Committee had not complied with the sampling determination, but had changed its methodology in accordance with undisclosed advice from an accredited statistician. His Honour held that the Committee had not been obliged to disclose its advice, so long as it had been obtained, and had it been entitled under section 106K(4) to adopt the alternative methodology. Further, the statutory scheme provided adequate opportunity for Dr Phan to meet the substantive case against him.

Finally, Dr Phan objected on grounds of the Committee's 'judicial immunity' to certain evidence from the statistician based on material said to have been before the Committee. It was argued that this waived the Committee's immunity and the whole Committee file should be discoverable. Tamberlin J rejected these arguments. The immunity protects the freedom of the decision-making process. The statistician's report was not itself part of the Committee's own deliberations. Further, the statistician was an independent consultant, not protected by the immunity. Nor was he an agent of the Committee, able to waive its immunity.

Accordingly, having failed on all grounds, the judicial review application was dismissed. Dr Phan did not appeal to the Full Court.

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21 Phan v Kelly [2007] FCA 269.
24 Conferred under section 106F(1).
Before GP Management Plans and Team Care Arrangements (GPMP/TCAs) were introduced, many patients were unable to access allied health services in the community due to cost. GPs have supported GPMP/TCAs and patients have welcomed them.

PSR has been concerned that some practitioners have made inappropriate choices when selecting patients to refer for allied health services. Referrals should always be based on clinical need. Practitioners are reminded that this item (723) is for patients with a chronic or terminal condition who need ongoing care from a multidisciplinary team of their GP and at least two other health care providers.

PSR Committees will look critically at the indications a practitioner has used to initiate a TCA item. If the patient's condition could have easily been managed in the course of normal GP care, practitioners may be found to have practiced inappropriately. Adding a pharmacist to a TCA for a patient's stable blood pressure condition to 'make up the numbers' is considered an example of inappropriate practice. The Department of Health and Ageing's website states that if the pharmacist is not providing ongoing treatment or services to a patient (other than routine dispensing) they would not comprise one of the minimum members of the team.

Allied health practitioners who create in a patient's mind the expectation that their GP will 'do the paperwork' so the allied health service will be free of charge at the point of service are doing their patients and their profession a disservice. Practitioners who retrospectively backdate GPMP/TCAs are acting illegally. If a practitioner feels the patient does not have a chronic or terminal condition for which a TCA is appropriate they should not agree to a patient's request for referral to an allied health practitioner.

Case Study Eight

Allied health providers and team care arrangements

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MBS item 721: preparation ... of a GP Management Plan for a patient

Task
- Specialist referral
- Community Nurse
- Counseling

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GPM Plan Summary
This page must go to the patient and other team members as appropriate.

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- Specialist referral
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Smoking cessation and a stable surgical condition are not sufficient reasons for a GPMP. This plan was undertaken simply to enable the patient to claim Medicare benefits for sessions with a psychologist. In a number of similar cases practitioners completed the GPMP/TCAs because the allied health provider had suggested to the patient that their treatment would be 'free' if the practitioner backdated the paperwork. This may constitute a false or misleading statement, which under the legislation may carry a serious penalty. Practitioners should not allow themselves to be manipulated in this way.
On 28 June 2002 the HIC asked the Director of PSR to review Dr Carrick’s provision of services because she was rendering a high number of certain services compared with her peers; Dr Carrick’s practice predominantly involves use of endoscopies. A Committee investigated and found that her conduct would be unacceptable to the general body of medical practitioners in connection with 28 of the 30 MBS item 30487 services it examined. Dr Carrick sought judicial review by the Federal Court.  

Branson J dismissed the application on all grounds other than Constitutional issues reserved for separate consideration.

First, the judicial review challenge to the investigative referral failed. Branson J distinguished the decisions in Daniel as the HIC had clearly appreciated that the referral was discretionary, correspondence with Dr Carrick made plain that there were significant unresolved issues at the time of referral, there had been no undertaking not to refer, the HIC had correctly declined to advise on her professional practice, and her Honour had found no consideration not identified in the referral which the HIC was bound to take into account. A further claim that an HIC counsellor had misled Dr Carrick was not supported in her submissions to the Court or her personal evidence. Branson J did not accept that Dr Carrick had not had the opportunity to act on the counsellor’s advice.

Second, the challenge to the adjudicative referral failed. Dr Carrick argued that, by including with that referral medical materials that had been examined and found sufficiently deficient to cause the referral, the Director had impermissibly skewed the exploratory sample results for the Committee’s deliberations. After referring to the failure of this argument in Phan, Branson J likewise rejected it because section 93(6) required the Director to give written reasons for his referral, and relevant Guidelines28 permitted him to include any relevant information or material.

Third, attachment to the adjudicative referral of a report to the Director by a consultant gastroenterologist who was also a Deputy Director of PSR did not invalidate the Committee report. It had been attached as the basis for the Director’s referral, not as a basis for the Committee’s decisions. The Committee appeared to have applied its own expertise and had not referred to the report of the consultant gastroenterologist in support of its findings. Dr Carrick had not sought that the consultant gastroenterologist be available for cross-examination, so there was no substance to the claim that his report could not be tested.

Finally, regarding application of the sampling methodology, her Honour held, following Mathews and Phan, that the Committee was not required to, itself, select a random sample of services from the preliminary random sample and that the Act did not require the Committee to look at evidence ‘truly independent’ of that considered by the Director.
As previously reported, Dr Saint was referred to PSR in 2000, was reported by the Investigating Committee to have engaged in inappropriate practice, and sought judicial review. Having been only partially successful with discovery applications to the court, he applied under the Freedom of Information Act 1982 (FOI Act) for copies of various documents created in the course of the Committee investigation. PSR provided some documents to him; others were claimed to be exempt from freedom of information disclosure. He sought review by the Administrative Appeals Tribunal of the latter decisions.

On 30 October 2006, the Tribunal affirmed the PSR decisions. The documents were broadly working notes and drafts of Committee members and/or their support staff (secretariat and lawyer) and included comments on medical services provided by Dr Saint, drafts of/for their report and its appendices, comments thereon, preliminary findings, comments on submissions by Dr Saint, and legal advice. PSR had based its exemption decisions on section 36 of the FOI Act (internal working documents), section 40 (adverse effect on agency operations) and section 42 (legal professional privilege).

The Tribunal was satisfied that the Committee was an agency, for freedom of information purposes, and that most of the documents were deliberative in nature so that section 36(1)(a) applied. Exemption also requires that section 36(1)(b) be satisfied, namely that disclosure would 'be contrary to the public interest'. The Tribunal accepted PSR submissions that this would be so because section 106ZR makes it a criminal offence to disclose Committee deliberations, findings, information or evidence unless the Health Insurance Act 1973 otherwise provides for disclosure; because that Act requires a Committee to give the person under review an opportunity to comment on a draft of their report and Committee members would be severely inhibited in their task if preliminary materials were disclosed; and because the Committee had judicial immunity under section 106F(1) which would be undermined if their deliberations were disclosed by other processes.

Of the remaining documents, all but one were conceded to be exempt under section 42 of the FOI Act. The Tribunal held that remaining document to be exempt as it was created by a lawyer (employed by a law firm, not PSR) for the dominant purpose of providing legal advice to PSR and would be privileged from production in legal proceedings. The Tribunal found that this privilege had not been waived by publication in a PSR Annual Report of legal advice by another lawyer relating to the same general matter as the document in contention.

The Tribunal did not need to consider the application of section 40 of the FOI Act.
Inappropriate use of non VR-GP MBS items

MBS item 54: long consultation of more than 25 minutes duration but not more than 45 minutes duration

Tuesday November 8 2005
Dr. G
Management: discussed x-ray results
Actions:
Pathology requested: GTT (2hr); FBE; E/LFTs; LIPIDSIHDL (fasting)

A PSR Committee found that use of item 54 for this service was inappropriate as there was no clinical content recorded in the notes. The Committee found that for a consultation that was claimed to have lasted at least 25 minutes the lack of detail in this record was unacceptable.

While there is adequate clinical detail in this record, this was a simple clinical encounter, common in general practice and it was the opinion of peers that this clinical situation should not have taken more than 25 minutes to manage. A PSR Committee found, therefore, that it was inappropriate to bill this encounter as an item 54.
Constitutional challenge

As previously reported, several practitioners under review have challenged the constitutional validity of the P5R Scheme in relation to 'civil conscription' and 'judicial power' (sections 51(xxiiiA) and 71 respectively of the Constitution). Some 14 cases are now awaiting resolution of those issues. Stone J dismissed one such challenge, involving Dr Selim, in 2006. That decision has been appealed to the Full Federal Court. Meanwhile, two applications (Drs Dimian and Wong) direct to the High Court on constitutional grounds were remitted to the Full Federal Court. The Full Federal Court heard these matters, together with the Selim appeal, on 5-6 March 2007. At the time of writing the decision is awaited.

Outcomes

The preliminary decisions in Ho and Do highlight the dangers in tying outcomes to other undecided cases - even though it was a genuine attempt to expedite resolution of several closely related proceedings.

Being subject to appeal, the substantive decisions in Ho and Do are not final. Nevertheless, they are important steps in the explication of the 'exceptional circumstances' provisions in section 106KA(2) and regulation 11 and indicate the level of detailed reasoning the courts expect of PSR Committees.

The decision in Bellamy makes clear that medical practitioners must heed the lawful directions of PSR Committees.

The decision in Phan confirms that it is the overall provision of procedural fairness that is important in the PSR process. This does not necessarily require the person under review to be able to comment at every possible stage, which will help avoid some possible delays.

Phan also resolves some doubts about the statistical sampling procedures, particularly where the methodology is varied on advice from an accredited statistician. Finally, Phan also reinforces the earlier decisions in Mathews, Do and Ho that Committee documents are not generally discoverable in judicial proceedings.

Corrick indicates limits to the application of Daniel, which will help to avoid nebulous and wide-ranging challenges to referrals based on alleged undertakings, understandings or disregard of relevant considerations. Corrick also approves and applies decisions in Mathews and Phan regarding the random selection of services and assertions that the Director's actions and report may bias Committee deliberations or skew sampling procedures. These decisions will give greater certainty to the overall PSR processes.

The AAT decision in Saint shows that refusal of discovery of Committee documents in judicial proceedings cannot be bypassed using the FOI Act. This reinforces the protections for deliberative processes of Committees (and, by analogy, of the Director and Determining Authority).

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## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AAT</td>
<td>Administrative Appeals Tribunal</td>
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<tr>
<td>AMA</td>
<td>Australian Medical Association</td>
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<tr>
<td>Committee</td>
<td>A Professional Services Review Committee established by the Director in accordance with section 93 of the Act to examine a case of apparent 'inappropriate practice' referred by Medicare Australia</td>
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<tr>
<td>Cox-2</td>
<td>A selective inhibitor – the newest of the non-steroidal anti-inflammatory drugs</td>
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<tr>
<td>Determining Authority</td>
<td>A three-person panel responsible for determining the sanction following an adverse PSR Committee finding</td>
</tr>
<tr>
<td>Director</td>
<td>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</td>
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<tr>
<td>disqualification</td>
<td>Exclusion (partial or complete) from eligibility for the practitioner’s services to attract Medicare benefits</td>
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<tr>
<td>FOI</td>
<td>freedom of information</td>
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<tr>
<td>inappropriate practice</td>
<td>Conduct in connection with rendering or initiating services for which a Medicare benefit was payable, and which a committee of peers could reasonably consider would be unacceptable to the general body of the peer group (section 82 of the Act)</td>
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<tr>
<td>MBS</td>
<td>Medicare Benefits Schedule</td>
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<tr>
<td>Minister</td>
<td>Minister for Health and Ageing</td>
</tr>
<tr>
<td>OHS</td>
<td>occupational health and safety</td>
</tr>
<tr>
<td>Panel</td>
<td>PSR Panel consisting of medical practitioners, dentists, optometrists, chiropractors, physiotherapists, osteopaths and podiatrists appointed by the Minister following consultation with the relevant professional organisations</td>
</tr>
<tr>
<td>Prescribed pattern of services</td>
<td>A prescribed pattern of services is also known as the 80/20 rule, whereby a practitioner is deemed to have practiced inappropriately if he or she renders 80 or more services on 20 or more days in a 12-month period</td>
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<tr>
<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
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<tr>
<td>PSR</td>
<td>Professional Services Review</td>
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<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 Medicare Australia asking the Director to review the provision of services and containing Medicare Australia’s concerns and the reasons it considers a practitioner or other person may have engaged in inappropriate practice in the terms of section 82 of the Act.</td>
</tr>
<tr>
<td>80/20 rule</td>
<td>see prescribed pattern of services</td>
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