Review of the Professional Services Review Scheme

Report of the Steering Committee

May 2007
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# List of Acronyms

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<th>Description</th>
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<tr>
<td>AMA</td>
<td>Australian Medical Association</td>
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<td>ANAO</td>
<td>Australian National Audit Office</td>
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<tr>
<td>ANN</td>
<td>Artificial Neural Network</td>
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<td>BEACH</td>
<td>Bettering the Evaluation and Care of Health</td>
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<td>CEO</td>
<td>Chief Executive Officer</td>
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<td>CHF</td>
<td>Consumers Health Forum</td>
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<td>DA</td>
<td>Determining Authority</td>
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<td>DoHA</td>
<td>Department of Health and Ageing</td>
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<td>DPSR</td>
<td>Director Professional Services Review</td>
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<td>DVA</td>
<td>Department of Veterans’ Affairs</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>HIA</td>
<td>Health Insurance Act 1973</td>
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<td>HIC</td>
<td>Health Insurance Commission</td>
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<td>MA</td>
<td>Medicare Australia</td>
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<td>MBCC</td>
<td>Medicare Benefits Consultative Committee</td>
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<td>MBS</td>
<td>Medicare Benefits Schedule</td>
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<td>MPRC</td>
<td>Medicare Participation Review Committee</td>
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<td>MSAC</td>
<td>Medical Services Advisory Committee</td>
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<td>MSC1</td>
<td>Medical Services Committee of Inquiry</td>
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<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
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<td>PPR</td>
<td>Practice Profile Review</td>
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<td>PRP</td>
<td>Practitioner Review Program</td>
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<td>Professional Services Review</td>
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<td>PSRC</td>
<td>Professional Services Review Committee</td>
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<td>PUR</td>
<td>Person Under Review</td>
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Executive Summary

The 2006 Review of the Professional Services Review (PSR) Scheme was conducted by a Steering Committee comprising representatives from the Department of Health and Ageing (DoHA), Medicare Australia, the Australian Medical Association (AMA) and the PSR, who provided a co-opted representative. The Review considered the effectiveness of the current PSR Scheme and identified ways in which the Scheme could better meet emerging challenges to its future operation.

The key tenet of the PSR Scheme, which commenced in July 1994, is to protect the integrity of Medicare and the Pharmaceutical Benefits Scheme (PBS) and protect patients and the community in general from the risks associated with inappropriate practice. It does so by providing a peer review process for investigating those practitioners who may have engaged in inappropriate practice in the rendering or initiating of Medicare services or in prescribing under the PBS. The 2006 Review confirmed continued support for the PSR Scheme and the concept of peer review.

The PSR Scheme has continued to evolve since its inception. Legislative amendments were made in 1997, 1999, 2002 and 2006 to strengthen and clarify the professional review process and address evidentiary difficulties. A comprehensive review conducted in 1999 made recommendations to refine the administration of the Scheme to improve its legal effectiveness and transparency.

The 2006 Review examined the impact of the recommendations of the 1999 Review and the impact of the 1999 and 2002 legislative changes on the operation of the PSR Scheme. The Scheme operates within a changing healthcare environment and will increasingly need to respond in a flexible manner to new and emerging medical practices and technologies. The Steering Committee explored these issues to establish a clear view for the future operation of the Scheme.

Recommendations have been made which are designed to further improve the Scheme’s efficiency. Chief among these recommendations are the formation of an advisory committee which would oversee the PSR Scheme’s performance and provide ongoing guidance for its effective operation; and the streamlining of the Scheme’s review process while maintaining natural justice for the person under review.

The Steering Committee recommended that parameters for identifying possible inappropriate practice by specialists and allied health professionals be developed by DoHA, Medicare Australia and PSR in consultation with medical colleges and professional medical bodies. This will strengthen the capacity of the PSR Scheme to respond to instances of inappropriate practice by all health practitioners whose services are eligible for Medicare and PBS benefits. It was also noted that PSR may be able to assist in the provision of education and support to practitioners in the context of appropriate use of items listed in the Medicare Benefits Schedule (MBS) and best practice. Both these types of activities could be implemented and monitored under the supervision of the proposed advisory committee.

The Steering Committee has developed two key proposals which aim to ensure that the PSR Scheme is responsive to the Medicare and PBS environment. A proposal to broaden the definition of a ‘practitioner’ will ensure that all health professionals who provide services which attract Medicare benefits, including those from allied health, will come under the purview of the Scheme. Further, it is proposed that services claimed under the auspices of the
Department of Veterans’ Affairs (DVA) be taken into account in any investigation to determine whether a practitioner should be the subject of a request by Medicare Australia for review by PSR. This will provide greater protection for patients by preventing the anomaly where a practitioner who has been disqualified from providing services under Medicare for practising inappropriately can still provide services under DVA arrangements.

The Steering Committee considered that it is not proper that a medical practitioner found to have engaged in inappropriate practice on two separate occasions be dealt with by the Medicare Participation Review Committee (MPRC) which deals with persons convicted of a criminal offence. The Steering Committee recommends that such cases be directly referred to the Determining Authority (established under the PSR Scheme), which should be given the power to enforce relevant sanctions equivalent to those of the MPRC.

To reflect the emerging trend of the corporatisation of medical practices, the Steering Committee considers that systems to capture data on corporations should be developed. This will assist in monitoring any potential influence on individual practitioners. A range of suitable sanctions will also need to be developed for corporations found to be contributing to inappropriate practice.

The Steering Committee considers that many of the proposals contained in this report are best addressed by the proposed advisory committee, which can engage in the complexities of the issues raised in the PSR Scheme’s operation. Such proposals include improving the flow of information between Medicare Australia and the Director of PSR (DPSR); examining the effectiveness of current sanctions; and developing and monitoring performance indicators. The advisory committee would also be able to provide guidance in addressing new issues that arise in the future for the PSR Scheme.

The Steering Committee recommends that the PSR Scheme be re-evaluated in four years time to assess the effectiveness of the changes proposed in this report.

The 2006 Review provides the following recommendations:

**Supporting the continuation of the PSR Scheme and the concept of peer review**

*Recommendation 1:* The Professional Services Review Scheme be retained in its current form under the existing governance arrangements.

*Recommendation 2:* The existing review process based on ‘peer review’ as set out in Section 82 of the *Health Insurance Act 1973* be retained.

**Establishing a committee to provide cohesive oversight of the PSR Scheme**

*Recommendation 3:* A PSR advisory committee, comprising senior representation from DoHA, AMA, PSR and Medicare Australia, be established to maintain an overview of the PSR Scheme and provide ongoing guidance for its effective operation.

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1 The *Health Insurance Amendment (Professional Services Review and Other Matters) Act 2002* included the amendment to replace the investigative referral process with a request from Medicare Australia that the DPSR examine Medicare services rendered or initiated by a practitioner for whom a Medicare benefit had been claimed during a period (s.86). Throughout the report use of the terms ‘refer’ and ‘referral’ will connote the meaning outlined in s.86.
Streamlining the PSR Scheme’s processes

Recommendation 4: PSR Scheme processes and Medicare Australia’s process be streamlined to ensure the efficiency of the Scheme.

Retaining the ‘80/20 rule’

Recommendation 5: The current deeming provision as set out in Section 106KA of the Health Insurance Act 1973 and related regulations be retained.

Identifying inappropriate practice by specialists and allied health professionals

Recommendation 6: Parameters for identifying possible inappropriate practice by specialists and allied health professionals be developed by DoHA, Medicare Australia and PSR, in consultation with colleges and professional medical bodies. This process is to be overseen by the proposed advisory committee.

Improving the information flow between stakeholders

Recommendation 7: Proposals to enhance the flow of information between Medicare Australia and the Director of PSR be further investigated by the proposed advisory committee.

Examining the effectiveness of sanctions

Recommendation 8: The adequacy of the existing range of sanctions that can be imposed on practitioners found to have engaged in inappropriate practice be examined by the proposed advisory committee to ensure the continuing effectiveness of the Scheme.

Removing the need for Medicare Participation Review Committees for the PSR Scheme

Recommendation 9: PSR cases currently referred to the Medicare Participation Review Committee (MPRC) be directly referred to the Determining Authority (DA). The DA be given the power to enforce relevant sanctions equivalent to those currently available to the MPRC.

Developing ways to combat negative corporate influence

Recommendation 10: Systems to capture data on corporations be developed to better monitor the potential influence of corporations on individual practitioner behaviour.

Recommendation 11: A range of sanctions be developed and enacted that can be imposed on corporations found to be contributing to inappropriate practice by practitioners with whom they have a pecuniary relationship.

Broadening the PSR Scheme

Recommendation 12: Section 81 of the Health Insurance Act 1973, which lists the practitioners whose conduct may be examined under the PSR Scheme, be amended to include all allied health professional groups who initiate or render services that are eligible for payment of Medicare benefits now and in the future.
**Recommendation 13:** The Department of Veterans’ Affairs (DVA) claimed services be incorporated under the PSR Scheme as approved in principle by DVA. This is subject to further discussions with DVA and the provision of additional funding for Medicare Australia and PSR to implement this recommendation.

**Monitoring the performance of the PSR Scheme**

**Recommendation 14:** Agreed performance indicators be developed and monitored by the proposed advisory committee and reported on annually by the Director of PSR and Medicare Australia.

**Recommendation 15:** The PSR Scheme be reviewed in 2010.

A detailed discussion of the Steering Committee’s findings and recommendations are contained in chapters 3 and 4 of this report.
The 2006 PSR Scheme Review

1.1 Reasons for and Scope of the 2006 PSR Review

Following the first major review of the Professional Services Review (PSR) Scheme in 1999, a series of recommendations were set out in The Report of the Review Committee of the Professional Services Review Scheme which was presented to the then Minister for Health and Aged Care, Dr Michael Wooldridge. Recommendation 44 proposed that a review of the PSR Scheme be conducted no later than three years after the 1999 changes were implemented.²

The Australian Government provided the commitment, during the second reading of the Health Insurance Amendment (Professional Services Review) Bill 1999, to review the Scheme within twelve to eighteen months to monitor the effectiveness of the legislative amendments.³ However, the proposed review was delayed because there was insufficient case law to effectively evaluate the 1999 legislative amendments. When further refinements to the PSR Scheme were made in 2002 in response to the decision in the Pradhan⁴ case, the decision was made to postpone the review until such time as an adequate case law history could be developed to inform the process.

The 2006 Review of the PSR Scheme reviews the operation of the Scheme; assesses the extent to which the Scheme will be able to achieve its objectives in the future; and makes recommendations to the Minister for Health and Ageing on areas for improvement. The Steering Committee’s agreed Terms of Reference are outlined at Appendix 1.

The Steering Committee was established in March 2006, comprising representatives from the Australian Medical Association (AMA), Medicare Australia and the Department of Health and Ageing (DoHA). The Committee was chaired by DoHA and the Director of PSR was a co-opted member. During the course of the Review, it was agreed to establish a working group comprising line officers to further examine a number of issues that had arisen as part of the Review.

The Steering Committee noted that in accordance with the Terms of Reference, the Review would consider both Medicare Australia’s review processes which led to requests for review being forwarded to PSR, as well as PSR review processes.

Dr Bill Coote was engaged by DoHA to assist in providing qualitative analysis for the review of the PSR Scheme. As part of the Review, a broad range of stakeholders was consulted to gauge their views on the current PSR arrangements, the Scheme’s effectiveness, and constraints on its effectiveness to addressing emerging challenges to its future operation. Appendix 2 provides a list of organisations and individuals consulted through this process.

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The PSR Scheme

The PSR Scheme investigates the provision of services by a practitioner to determine whether the practitioner has engaged in inappropriate practice in providing Medicare services or in prescribing under the Pharmaceutical Benefits Scheme (PBS). The review process is based on the concept of ‘peer review’. This involves a committee of the practitioner’s peers determining if the rendering or initiating of services by the practitioner would be considered clinically relevant and appropriate to the general body of members of the profession. A description of the review process is at Appendix 3.

Medicare is one of the largest programs administered by the Federal Government at a cost of $10.8 billion in 2005-06. The PBS expended $6.2 billion in the same year. PSR works to protect the integrity of Medicare and the PBS and in doing so:

(i) protect patients and the community in general from the risks associated with inappropriate practice; and

(ii) protect the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice.

As set out in legislation, practitioners whose conduct may be examined under the PSR Scheme include medical, dental, optometric, chiropractic, physiotherapy, podiatry and osteopathic practitioners providing Medicare or PBS services.

The Scheme provides for the separation of the three elements of the decision-making process: referral for review by Medicare Australia to the Director of PSR; review hearings and findings undertaken by the PSR Committee; and the determination of sanctions to be imposed by the Determining Authority.

A practitioner found to have engaged in inappropriate practice can be reprimanded, counselled, required to repay Medicare benefits and/or be partially and/or fully disqualified from Medicare and the PBS for up to three years.

2.1 Roles and responsibilities

The PSR Scheme sits within a complex structure of regulatory bodies that underpin medical and other health practice in Australia. PSR roles operate together with a range of Commonwealth and State government entities and with the roles of autonomous professional bodies. These include:

5 Inappropriate practice is defined in s.82 of the Health Insurance Act 1973 (HIA) as conduct in the rendering or initiating of services that is considered ‘unacceptable to the general body of the members of the specialty (profession peers)’ as appropriate.

6 HIA 1973, Section 79A.

7 Section 82 of the Health Insurance Act 1973.

8 As outlined at 3.15, the practitioner can be disqualified for up to 5 years through a Medicare Participation Review Committee if found to have practised inappropriately a second time.
governments;
state medical boards;
the various State based entities that assess complaints against health practitioners;
employers such as public hospitals and medical corporations;
accreditation agencies;
medical schools and other educators and trainers;
professional colleges;
industrial associations; and
private health insurers.

The governance structure for the PSR Scheme is outlined below.

**Minister for Health and Ageing**
Ultimate policy responsibility for the PSR Scheme lies with the Minister for Health and Ageing. As set out in ss.83 to 85 of the *Health Insurance Act 1973* (HIA), the Minister may appoint:
- the Director of PSR (DPSR) for a period not exceeding three years following agreement with the Australian Medical Association (AMA); and
- PSR Panel members and Deputy Directors (who chair PSR committees) following consultation with the AMA (and other relevant organisations when appointing a practitioner other than a medical practitioner).

**Professional Services Review**
PSR administers Part VAA of the HIA which authorises the PSR Scheme. PSR was established in July 1994 as an independent agency within the Health Portfolio, reporting directly to the Minister for Health and Ageing. PSR examines possible cases of inappropriate practice referred by Medicare Australia.

**Medicare Australia**
Medicare Australia administers a wide range of health-related programs on behalf of the Australian Government, including Medicare and the Pharmaceutical Benefits Scheme (PBS). It is one of six service agencies which come under the umbrella of the Department of Human Services. Medicare Australia has a rigorous compliance and fraud detection function.

Through its Practice Profile Review (PPR) process, Medicare Australia also identifies practitioners who may be practising inappropriately and refers them to the PSR. Medicare Australia’s PPR process is independent of the fraud detection function.

The PSR cannot self-initiate a referral as Medicare Australia is the only body that may legally make referrals to the PSR under the HIA.

Cases of possible fraud identified during the PSR process are not dealt with by PSR but are referred back to Medicare Australia for action, in accordance with s.89A of the HIA.

Medicare Australia also undertakes compliance activities which aim to identify, educate and intervene with practitioners who are potentially prescribing PBS medicines inappropriately. These activities are undertaken by Medicare Australia as part of its general PBS compliance strategy.
When prescribing is different to peers and suspected to be outside of the restrictions or authority requirements a number of remedies may be chosen, from general education, magazine articles or general information sheets, targeted feedback letters or review under the Practitioner Review Program (PRP). If concerns are not adequately addressed through the PRP, Medicare Australia can request the DPSR to review the practitioners’ provision of services in relation to inappropriate prescribing.

**Department of Health and Ageing**
DoHA is responsible for providing policy advice to the Minister on the development and maintenance of the PSR Scheme. DoHA liaises with stakeholders and performs the broader tasks of policy review and development of legislation.

**The Australian Medical Association**
The AMA is the peak representative organisation for registered medical practitioners and medical students. It keeps its members informed about PSR Scheme guidelines and procedures. It has been consulted about PSR policy issues since the Scheme’s inception and must agree to the appointment of the DPSR and be consulted about the appointment of panel members and Deputy Directors.

These relationships can be illustrated in the following diagram:

**Figure 2.1**

**PSR Governance**
2.2 Evolution of the PSR Scheme 1994 – 2006

The PSR Scheme was introduced in 1994 to replace the previous Medical Services Committees of Inquiry (MSCI) arrangements. MSCIs were standing (as opposed to peer group) committees appointed by the Minister and dealt with excessive servicing by medical practitioners.

A 1992–93 Australian National Audit Office (ANAO) Report, Medifraud and excessive servicing: Health Insurance Commission, found that MSCIs did not combat overservicing effectively and should be reviewed. A key issue of concern was that the mechanisms for dealing with overservicing did little to discourage the provision or initiation of excessive servicing and the level of benefits recovered from practitioners was totally eclipsed by the level of overservicing that actually occurred. The ANAO Report considered that the minimum requirements needed in order to make MSCIs more effective were:

- increasing the amount of repayment and/or penalty to reflect more closely the amount of money defrauded from Medicare;
- providing the MSCIs with the power to access the medical records of those medical practitioners referred to the Committee;
- the appointment of additional MSCIs to help reduce time delays;
- follow-up counselling to be undertaken by the Chairperson of the relevant MSCI; and
- the appointment of a full time manager to oversee the MSCI operations.

In response, and in consultation with the medical profession, the Government agreed to develop new measures to combat overservicing and these came into effect through the establishment of the PSR Scheme in July 1994. Rather than retaining the MSCIs, the amending legislation provided for the establishment of PSR committees which would provide greater access to relevant experience and improved competency to deal with different types of practitioners.

The legislation also introduced the concept of ‘inappropriate practice,’ which was defined as conduct in rendering or initiating services that is unacceptable to a practitioner’s professional colleagues generally. The intention was to increase the autonomy of the medical profession to reach decisions on inappropriate practice while still according natural justice to a person under review (PUR).

The original intention for the PSR Scheme was:

- to be able to recover amounts of money and set sanctions commensurate with the nature and extent of the inappropriate practice identified;

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11 ANAO Audit Report No. 17, pages 6-7.
12 The Scheme was established by the Health Legislation (Professional Services Review) Amendment Act which amended the Health Insurance Act by inserting a new Part VAA – the Professional Review Scheme.
• to allow cases to be dealt with more quickly by building specific timeframes for particular steps into the PSR process and limiting the role of lawyers in the process; and
• to bring under the one umbrella several committees dealing separately with activities relating to the rendering and initiating of services and the prescription of pharmaceuticals.

Strengthening the original PSR Scheme: 1997 and 1999 Amendments

The PSR Scheme has been the subject of a high level of litigation. Approximately one third of its cases have resulted in Federal Court action. Since commencement in 1994, there have been over 60 applications to the courts by 44 individual practitioners out of a total 457 referrals (as at 30 June 2006). PSR has only lost in three challenges and a part of a fourth.14 The publicity in the medical press and other media attached to these decisions acts to promote the deterrent effect of the PSR Scheme.

While PSR has successfully defended the vast majority of cases in the courts, those few that have been lost have impacted on other cases and also resulted in the requirement for legislative change to achieve the Government's policy intent. Legislative amendments made to the PSR Scheme have increased its robustness and ability to withstand legal challenge.

1997 Amendments

The PSR Scheme was amended in 1997 to strengthen and clarify the professional review process and to remove administrative anomalies from the Scheme by:
• repealing the statistical sampling provisions which had proved cumbersome and unworkable in practice, though no objection was raised to sampling in principle;
• streamlining PSR committee procedures by requiring the production of documents prior to a committee hearing and introducing penalties for contempt of a committee;
• refining the directions that may be included in PSR determinations by providing a clearer approach to calculating the amounts of Medicare benefits to be repaid; and
• increasing the maximum full period of disqualification from 6 months to 3 years, and maximum partial period of disqualification from 12 months to 3 years.

1999 PSR Review

A comprehensive review of the PSR Scheme was undertaken in 1999 in response to Federal Court and Full Federal Court decisions (1997 and 1998, respectively) in the Yung case15 which had significant impact on the Scheme's administration.

The PSR Scheme was substantially amended following the 1999 Review and the legislative changes to the Scheme were authorised by amendments to the HIA contained in the Health Insurance Amendment (Professional Services Review) Act 1999.

Further information about the effectiveness of the 1999 PSR Review outcomes can be found at 3.1.

15 Steven Yung v Anthony Adams [1997] 1400 FCA.
Clarifying the objectives of the PSR Scheme: 2002 Amendments

Consistent with the recommendations of the 1999 Review as outlined in Appendix 5, the PSR Scheme was modified further in 2002, to clarify the intended object and operation of the Scheme and to address certain issues identified by the Federal Court in the Pradhan decision. The legislative amendments were made by the *Health Insurance Amendment (Professional Services Review and Other Matters) Act 2002*. All key stakeholders supported the amendments to the HIA, which came into effect on 1 January 2003.

The main amendments included:
- the inclusion of a new objects clause (s.79A of the HIA), emphasising the public protective aim of the Scheme as confirmed in *Grey*;\(^{16}\)
- the replacement of the investigative referral process with a request from Medicare Australia that the DPSR examine Medicare services rendered or initiated by a practitioner for whom a Medicare benefit had been claimed during a period (s.86). This amendment meant that the DPSR or a PSR committee was able to examine patient records relating to any or all specified services rendered or initiated by the practitioner during a specified period, and was not restricted by Medicare Australia’s reasons for the request;
- the validation of previous referrals potentially affected by the *Pradhan* decision (see Appendix 10); and
- enhanced procedural fairness opportunities at various stages of the Scheme’s review process.

Refining the PSR Scheme: 2006 Amendments

The operation of the PSR Scheme continues to evolve. For example, in July 2006, two amendments were made to the *Health Insurance (Professional Services Review) Regulations 1999*.

The first amendment updates the list of ‘professional attendances’ that can be provided by doctors under the Medicare Benefits Schedule (MBS). A wide range of medical services has been added to the MBS since the 1999 regulations were enacted, such as general practitioner after-hours attendances, general practitioner attendances associated with the Practice Incentives Program, and attendances for fitting contact lenses. These medical services are now considered ‘professional attendances’ for the purposes of establishing inappropriate practice.

Consistent with the public protective role of the Scheme, the second amendment specifies bodies to whom a PUR must be referred (s.106XB of the HIA) if the Director of PSR considers, or the DA or a PSR committee advises the Director of PSR, that the person has failed to comply with professional standards.\(^ {17}\)

The specific bodies include:
- medical boards in every state and territory;

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\(^{17}\) DPSR is also able to refer practitioners to medical boards and other specific bodies if the DPSR considers that a practitioner’s behaviour poses a significant threat to a person’s health or life.
• boards for chiropractors, osteopaths, optometrists, physiotherapists and dentists in every state and territory;
• podiatry boards in every state and territory except the Northern Territory;¹⁸
• the Royal Australian College of General Practitioners;
• the General Practice Recognition Appeal Committee;
• the General Practice Recognition Eligibility Committee;
• Australian General Practice Accreditation Limited;
• Quality Practice Accreditation Pty Ltd; and
• Medicare Australia.

At the time of writing, one referral has been made under this provision.

¹⁸ There is no podiatry registration board in the Northern Territory but podiatrists working in the Northern Territory are advised to register with the relevant board in Western Australia, South Australia or Queensland.
Effectiveness of the current PSR Scheme

In responding to the terms of reference, the Steering Committee considered the following key issues:

- the effectiveness of the 1999 PSR Review recommendations;
- the effectiveness of the 2002 legislative amendments;
- the performance of the Scheme against indicators;
- stakeholder views of effectiveness;
- governance arrangements;
- the concept of peer review;
- possible formal consultative mechanisms;
- the decline in the number of requests made by Medicare Australia to the Director of PSR (DPSR);
- the length of the Medicare Australia and PSR processes;
- court challenges to the PSR scheme;
- the application of the ‘deeming’ provision;
- identifying inappropriate practice among specialists;
- limitations on the exchange of information;
- the adequacy of existing sanctions;
- the management of Medicare Participation Review Committees (MPRCs); and
- the interpretation of Medicare Benefits Schedule item descriptors.

This section outlines the current situation, stakeholder feedback and the Steering Committee findings and recommendations in respect of each issue.

3.1 Effectiveness of the 1999 PSR Review recommendations

The Review was conducted in 1999 by the Australian Medical Association (AMA), PSR, the HIC (now Medicare Australia) and the then Department of Health and Aged Care. A broad range of stakeholders was consulted during the review process.

Findings of the 1999 PSR Review

The 1999 PSR Review found that both the Government and the profession supported the concept of a peer review-based PSR Scheme. The Review recognised that there was a need to implement legislative and administrative changes to improve the efficiency and effectiveness of the PSR Scheme by according natural justice to the practitioner under review; clarifying methods of investigating inappropriate practice; and addressing evidentiary difficulties as highlighted by the Full Federal Court in *Adams v Yung*.

The Review report contains 45 recommendations (see Appendix 5) which entail amendments to the *Health Insurance Act 1973* (HIA) to enhance the operation of the PSR Scheme. The main recommendations were structural and administrative improvements to the Scheme, improved patient safety controls through a referral mechanism to specified health regulatory
bodies, increased deterrence through publication of the names of practitioners practising inappropriately and the application of the deeming provision.

A major change made following recommendations by the 1999 Review was the provision for ‘deeming’ of inappropriate practice when defined levels of servicing are reached. The deeming provision applies where a general practitioner provided 80 or more consultation services on 20 or more days in a 12 month period, unless the practitioner can show that exceptional circumstances apply (Recommendations 3 – 7). This issue is further discussed in detail at 3.11.

The Report of the Review Committee of the Professional Services Review Scheme was tabled in Parliament on 2 June 1999 as part of amending legislation. The amending Act came into law on 1 August 1999.

Implementation of the 1999 PSR Review recommendations

The 1999-2000 Budget measure provided additional funding of $11.9 million over four years to implement the recommendations of the 1999 Review for the enhancement and restructure of the PSR agency and the creation of an independent Determining Authority (DA). Federal Court findings in November 2001 in Pradhan v Holmes & Others resulted in further legislative amendments to the PSR legislation to clarify the different stages in the PSR process. This led to the delay in the full implementation of the proposed enhancements to the PSR process.

All of the 1999 Review recommendations have been implemented, except for recommendations 6, 10, 16, 40 and 44, which are being addressed under this Review. An assessment of the effectiveness of each of the 1999 Review recommendations is summarised in Appendix 5.

Recommendation 6 has been partly implemented. It provides that deeming provisions, which are specialty and profession specific, be developed in consultation with relevant professional groups and be introduced into the regulations. A mechanism to identify inappropriate practice among specialists and consultant physicians has been considered under this Review and is discussed at 3.12.

Recommendation 10 has not been implemented. It provides that in cases of high volumes of attendances per day by general practitioners covered by the ‘deeming’ provisions, Ministerial guidelines should provide for substantial periods of suspension from Medicare. Ministerial guidelines regarding periods of disqualification have not yet been drafted as it was subsequently considered that any attempt at setting out guidelines could be seen to be proscriptive. Guidelines under the previous arrangements were not successful and it was decided to allow the DA to examine every case on individual merit and set sanctions according to the circumstances of each case and submissions.

Recommendation 16 has not been implemented. It recommends that a Standing Committee comprising representatives of the AMA and the then HIC be established to review counselling processes, review the Artificial Neural Network, explore initiatives and

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encourage the overall concept of good practice. Establishment of an advisory committee has been considered under this Review and is discussed at 3.7.

 Recommendation 40 has not been implemented. It recommends that all the time periods in the HIA for procedures under the PSR Scheme be examined jointly by the AMA and the Government to see whether they are appropriately and realistically set, taking into account the impact on the new PSR Agency of the proposed administrative arrangements. This Review has looked at the length of Medicare Australia and PSR review processes and developed a streamlined review process. This is further discussed at 3.9.

 The implementation of Recommendation 44, which recommends that the Government and the profession review the revised PSR Scheme no later than three years after it comes into effect, has been implemented by this Review.

 **Effectiveness of the 1999 PSR Review recommendations**

 In summary, the Steering Committee finds that, based on available information, the 1999 PSR Review recommendations have enhanced the PSR Scheme through:

- implementing structural and administrative improvements to the Scheme:
  - (a) replacing the Determining Officer with the three member Determining Authority (DA) (Recommendations 34 and 35) has achieved a more balanced, transparent and acceptable professional judgment process;
  - (b) the Director of PSR’s increased powers of review and ability to negotiate agreements with practitioners (Recommendations 17 – 22) have avoided the need, in 63 cases, to progress to the formal PSR committee hearing processes and avoided possible future litigation associated with a PSR committee or a DA decision. Recommendation 17 enables the Director of PSR and/or a PSR Committee under s.89B and s.105A respectively, to have access to patient records to establish whether the practitioner under review is practising inappropriately. Issues that could never become apparent from just examining claims data are often found;
  - (c) the introduction of the requirement in s.82(3) for PSR committees to have regard to whether the practitioner kept adequate and contemporaneous medical records (Recommendation 45) has greatly strengthened committee decisions;
  - (d) acceptance of the quality of the revised sampling methodology by tribunals and courts (Recommendation 2) has resulted in increases in recovery of Medicare benefits.

- improved patient safety controls through greater interaction with specified health regulatory bodies and referral to State Medical Boards (Recommendations 17 and 32);

- enabling publication of details of practitioners found to have engaged in inappropriate practice, except in cases where a negotiated settlement has been made (Recommendation 42), thereby deterring practitioners from adopting inappropriate practices; and

- application of the deeming provision (80/20 rule) which seems to have had a deterrent effect. The number of practitioners who have breached the deeming...
provision decreased from 30 in 2000, to 10 in 2001 and further to nil in 2004 and 2005. There was one such case in 2006.

### 3.2 Effectiveness of the 2002 legislative amendments

These amendments clarified the protective nature of the scheme in protecting both Commonwealth revenue and patients from inappropriate practice. The amendments also reinforced the ‘procedural fairness’ requirements necessary in the process, based on a strong system of peer review. The Steering Committee considers that these were important changes to ensure procedural fairness and protect the rights of the person under review (PUR).

The amendments validated 35 referrals previously put on hold following the Pradhan decision. This ensured that possible inappropriate practice was addressed in these cases. For future cases, the Steering Committee considers that amendments enabling the Director of PSR or a PSR committee to examine patient records relating to services rendered or initiated during a specified period, and not restricted by the then HIC’s reasons for the request, have allowed the referral process to be workable.

The Steering Committee considers overall that the 2002 legislative amendments have improved the Scheme, both for practitioners under review and for the public.

### 3.3 Performance of the Scheme against indicators

Indicators have been developed for the PSR Scheme and the Medicare Australia process leading to referral to PSR and are discussed in relevant annual reports. These are useful in indicating the effectiveness of the Scheme against key performance measures.

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</thead>
<tbody>
<tr>
<td>1. Requests from Medicare Australia</td>
<td>50</td>
<td>50</td>
<td>63</td>
<td>94</td>
<td>52</td>
<td>38</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>2. Rate of re-referral from MA to PSR</td>
<td>0</td>
<td>N/A</td>
<td>5</td>
<td>7</td>
<td>8</td>
<td>4</td>
<td>0</td>
<td>1</td>
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<tr>
<td>3. MA requests for review finalised</td>
<td>60</td>
<td>N/A</td>
<td>42</td>
<td>71</td>
<td>58</td>
<td>46</td>
<td>30</td>
<td>10</td>
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<tr>
<td>4. Committee reports issued</td>
<td>30</td>
<td>7</td>
<td>6</td>
<td>3</td>
<td>19</td>
<td>34</td>
<td>24</td>
<td>6</td>
</tr>
<tr>
<td>5. Final determinations issued</td>
<td>30</td>
<td>16</td>
<td>12</td>
<td>3</td>
<td>5</td>
<td>21</td>
<td>26</td>
<td>6</td>
</tr>
<tr>
<td>6. Effective final determinations(^{21}) issued</td>
<td>40</td>
<td>16</td>
<td>12</td>
<td>5</td>
<td>5</td>
<td>22</td>
<td>26</td>
<td>14</td>
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\(^{20}\) Indicators 1 to 3 were reported on in the 2004-05 PSR Annual Report and indicators 4 to 6 were reported on in the 2005-06 PSR Annual Report. Figures for other years are unpublished figures from PSR.

\(^{21}\) An ‘effective determination’ is when a final determination takes effect, as defined under section 106V of the HIA.
The performance indicators show that few practitioners are referred to the PSR more than once. However, the number of requests for review from Medicare Australia has decreased significantly since 2003-04. This issue is discussed at 3.8. As a consequence of the legal challenges and low number of referrals, many of the targets identified in the other performance measures have not been met over the years.

The issue of legal challenges to the Scheme is discussed at 3.10.

3.4 Stakeholder views of PSR Scheme effectiveness

Extensive consultations were held with a wide range of medical and other professional groups; regulatory bodies, such as the medical boards; medical defence organisations; the Consumers Health Forum; the inaugural Director of PSR and some individual lawyers with extensive experience with the PSR Scheme.

Other groups with less direct involvement in the PSR Scheme were approached in writing and asked for comments on broad aspects of the PSR Scheme. A list of organisations and individuals consulted is at Appendix 2.

Major issues raised during the consultation process

Positive views of the PSR Scheme
A distinctive feature of the Review consultation process has been the positive attitude towards and strong support for the PSR Scheme across all medical and non-medical clinical groups. No organisation or individual consulted raised fundamental issues that call into question the basis of the Scheme, and all stakeholders considered that the PSR Scheme should continue.

Support for current PSR governance arrangements
The Review consultations indicated strong support for the current PSR governance arrangements with PSR as an independent statutory body under the Minster for Health and Ageing. No organisation or individual consulted proposed alternate governance arrangements for the PSR Scheme radically different from the present one. A common point raised during consultations was that the distinct procedural roles of MA and PSR should be maintained.

The Steering Committee also noted the broad support expressed for the maintenance of the current status of the position of Director of PSR as a statutory position reporting directly to the Minister for Health and Ageing.

Support for the concept of peer review
The Review consultations indicated that there is broad strong support for the PSR peer review process and its continuation under the PSR Scheme. That is, ‘inappropriate practice’ is regarded as a useful concept and suspected inappropriate practice should be assessed by a committee of peers. This is further discussed at 3.6.

Other outcomes of the Review consultations are discussed under the relevant sections throughout the report.
3.5 Governance Arrangements

In accordance with Uhrig principles,\textsuperscript{22} the governance arrangements for the PSR Scheme are aligned with its primary purpose, which is to protect the integrity of the Medicare and Pharmaceutical Benefits programs. The regulatory and service delivery functions that serve to achieve this objective are described under the HIA and its subordinate legislation. The Minister for Health and Ageing is the responsible Minister.\textsuperscript{23}

There is a two-pronged approach to safeguarding the integrity of the Medicare and Pharmaceutical Benefits programs. Through the operation of the PSR Scheme, the first approach aims to protect the public from inappropriate practice by ensuring that the services delivered by health practitioners are medically necessary and clinically relevant. This ‘public protective’ role has been explicitly recognised by the Full Court of the Federal Court.\textsuperscript{24}

The second approach aims to protect the public from the consequences of inappropriate practice by ensuring that payments to claimants are made in accordance with the regulations for the Medicare and Pharmaceutical Benefit Schedules. The compliance activities within Medicare Australia support the achievement of this objective.

As noted above, during the Review’s consultations, stakeholders expressed strong support for continuing the current governance arrangements and for the distinct procedural roles of Medicare Australia and PSR to be maintained. There is a strong view amongst Medicare service providers that the statutory independence of the PSR and the PSR Scheme under the Minister for Health and Ageing should be maintained.

Nevertheless, the Steering Committee considers that some issues raised in consultations could be effectively addressed through enhancing the current governance arrangement by establishing an advisory committee. The issues that could be addressed are discussed at 3.8, 3.13 and 3.16 and include the decline in the number of requests made by Medicare Australia to the Director of PSR, limitations on the exchange of information and the interpretation of Medicare Benefits Schedule item descriptions. The establishment of an advisory committee to improve the operation of the PSR Scheme is discussed at 3.7.

Recommendation 1: The Professional Services Review Scheme be retained in its current form under the existing governance arrangements.

\textsuperscript{22} Mr John Uhrig AC was appointed in November 2002 by the Australian Government to conduct a review of the corporate governance of Commonwealth statutory authorities and office holders. The objective of the review was to identify issues surrounding existing governance arrangements and to provide options for Government to improve the performance and get the best from statutory authorities and office holders, and their accountability frameworks. Uhrig principles include considering the need to form a regulatory body, using existing departments or bodies and having a clear purpose for government bodies.

\textsuperscript{23} The roles and responsibilities of different groups of relevance to the PSR Scheme are outlined at 2.1.

\textsuperscript{24} In \textit{Health Insurance Commission v Grey} (2002) 120 FCR 470.
3.6 Concept of Peer Review

The PSR Scheme is based on the concept of peer review. Peer review involves a committee of the practitioner’s peers determining if the rendering or initiating of services\(^{25}\) by the practitioner under review would be considered clinically relevant and appropriate to the general body of members of the profession. Inappropriate practice is defined in the HIA as conduct that would be unacceptable to the general body of practitioners in that discipline.\(^{26}\)

Consultations with stakeholders indicated that there is broad support for the concept of peer review and its application in the PSR review process.

The Steering Committee notes that the Review consultations strongly indicated that stakeholders do not support Medicare Australia having access to patient records as this comes under the purview of peer review.\(^{27}\)

During consultations, it was suggested that the PSR committee process would be better served by including a legal representative as a member, rather than as an advisor, to each committee established by the Director of PSR. It was argued that a legally qualified member of a committee would provide a project management focus to consideration of each case and be able to quickly identify legal issues and provide professional assistance with the consideration of evidence.

The Steering Committee notes this suggestion and points out that since implementation of the 1999 Review recommendations, PSR committee members have immediate access to legal advice and receive training in legal and administrative procedures. The Steering Committee considers that having a legal member on PSR committees is difficult to reconcile with the underlying concept of peer review and may undermine the integrity of both the PSR committee and the peer review process.

The Steering Committee considers that the existing concept of peer review within the PSR preview process remains effective and acceptable to the medical profession and should be retained.

**Recommendation 2:** The existing review process based on ‘peer review’ as set out in Section 82 of the *Health Insurance Act 1973* be retained.

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\(^{25}\) Rendering or initiating services includes the prescribing of PBS medicines.

\(^{26}\) Section 82, HIA 1973.

\(^{27}\) Medicare Australia does not legally have powers to compel the practitioner identified to hand over patient records for review and therefore cannot assess the clinical necessity of the health service provided by the practitioner. Issues such as the level of clinical input to services provided can only be assessed by the PSR Director or a PSR committee, who do have access to patient records.
3.7 Formal Consultative Mechanisms

Establishment of an overarching Advisory Committee

Current situation
Currently, no regular or formal mechanism exists for discussion and feedback between the various stakeholders in relation to the Scheme’s performance and operational issues. Discussion occurs on an ad hoc basis in relation to particular issues.

Steering Committee findings
The Steering Committee considers that an advisory committee should be established which would oversee the operation of the PSR Scheme.

It is intended that the proposed advisory committee be a mechanism to ensure that those responsible for policy arrangements, and those responsible for administering the various parts of the PSR Scheme, are directly involved in identifying and resolving issues arising from time to time in relation to the operation of the Scheme.

The advisory committee would have the ability to make recommendations to the relevant bodies in relation to procedural or legislative changes. More specifically, the advisory committee would:

- assess and review, on an ongoing basis, the effectiveness of the PSR Scheme’s performance;
- inform policy review and development; and
- facilitate any agreed change to the PSR Scheme, whether such change is legislative or administrative in nature.

It would provide a forum at which the performance of the Scheme and emerging issues that may impact on the Scheme’s effectiveness can be discussed. The advisory committee would also have an important role in resolving issues that may emerge from time to time between PSR and Medicare Australia as a result of their different foci.

The Steering Committee notes that the establishment of an overarching advisory committee will facilitate addressing the major issues affecting the PSR Scheme that have become apparent during this 2006 review and the subsequent policy issues likely to impact on PSR over the next few years. This is in contrast to the 1999 Review which focused largely on procedural and legislative issues affecting the operations of PSR processes.

The advisory committee would comprise senior representation from DoHA, AMA, PSR and Medicare Australia as stakeholders in the PSR Scheme. In view of the responsibility for policy arrangements resting with the DoHA, the group would be chaired by the relevant Deputy Secretary from DoHA. Representatives from the allied health sector will be consulted regarding specific issues related to allied health.

An issue raised by the Consumers Health Forum (CHF) was that there should be consumer representation on the proposed advisory committee and other committees looking at broader policy issues likely to affect consumers’ access to medical services. The Steering Committee considered this issue and found that CHF membership on the proposed advisory committee
would not be appropriate as the proposed committee would have a policy advisory capacity and was not intended to be a consultative committee. However, the advisory committee would liaise with the CHF on matters relating to consumers’ concerns.

**Recommendation 3:** A PSR advisory committee, comprising senior representation from DoHA, AMA, PSR and Medicare Australia, be established to maintain an overview of the PSR Scheme and provide ongoing guidance for its effective operation.

### 3.8 Decline in the number of requests made by Medicare Australia to the Director of PSR

**Current situation**

The number of requests for review from Medicare Australia has decreased significantly since 2003-04.

On 1 June 2004, Medicare Australia implemented a two-stage process in relation to the identification of practitioners whose conduct might appropriately be the subject of a request to the Director of PSR. This two-stage process was implemented in response to a Federal Court decision in *Daniel v HIC*,\(^{28}\) to ensure national consistency and to address issues concerning procedural fairness and natural justice in the process of working up a request for review. The process provided practitioners with more opportunities to address Medicare Australia’s concerns but considerably slowed down the process of requests being made to the Director of PSR. Around this time, the number of requests made under subsection 86(1) of the HIA greatly declined.

Table 3.2 indicates the decline in requests from Medicare Australia to the Director of PSR in recent years:

**Table 3.2: Number of Requests from Medicare Australia to the Director, PSR**

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<tr>
<td></td>
<td>50</td>
<td>63</td>
<td>94</td>
<td>52</td>
<td>38</td>
<td>9</td>
<td>7</td>
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</table>

Source: PSR data unpublished

Figure 3.1 indicates the consequent decline in findings of inappropriate practice and in PSR dismissed cases:\(^{29}\)

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\(^{28}\) [2003] FCA 772.

\(^{29}\) It should be noted that the large increase in referrals from Medicare Australia in 2001-02 was due to the decision by the Federal Court in 2001 in *Pradhan v Holmes* [1999] FCA 758 regarding the wording of the referral from Medicare Australia. This had implications for 30 cases which were withdrawn by the then HIC and subsequently re-referred with different wording in the referral. Bell, R. *Protecting Medicare Services: Trials of a peer review scheme*. 2005: 105.
Steering Committee findings

It is difficult to identify with certainty the causes of the reduction in requests from Medicare Australia to PSR as there are many factors that could contribute, including a deterrent effect of PSR cases and their associated publicity or a change in Medicare Australia’s review procedures. The Steering Committee considers that there are several approaches that can significantly contribute to ensuring that cases of possible inappropriate practice are appropriately investigated. These include the following:

Streamlining Medicare Australia’s review processes
During the course of the PSR Review, revised procedures to reduce the length of the review process were developed by Medicare Australia, considered by the PSR Working Group and endorsed by the Steering Committee. It is anticipated that the number of requests for review from Medicare Australia to the Director of PSR will increase as a consequence of the implementation of these revised procedures. The proposed revised procedures for both Medicare Australia and PSR are discussed in detail at 3.9.

Coverage of the PSR Scheme
The Steering Committee considers that there are opportunities for expanding and incorporating under-represented medical professional groups in the PSR Scheme and those currently outside the Scheme.  

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30 Practitioners whose conduct may be examined under the PSR Scheme are medical, dental, optometric, chiropractic, physiotherapy, podiatry and osteopathic practitioners (s.81, HIA).
(i) Better identifying inappropriate practice by specialists and allied health groups
Since 1999, less than five per cent of the practitioners referred to PSR have been specialists. The Steering Committee notes in this regard that the application of a specific ‘deeming’ provision\(^{31}\) for specialists would be too difficult to identify and implement and would not be supported by the medical profession. A proposed mechanism for identifying inappropriate practice among these medical groups is discussed at 3.12.

In addition, there is currently no mechanism within Medicare Australia to review those allied health practitioners who may have engaged in inappropriate practice if they are not listed in Section 81 of the HIA. This issue is discussed at 4.2. The Steering Committee considers that this represents a considerable and growing segment of the health workforce which is not being adequately captured in the PSR process.

A way forward would be to extend the concept of peer review to include capacity for recognised specialty groups and allied health groups to peruse, in an orderly process, de-identified claims data relating to all members of that professional group. This could be done in consultation with the colleges and professional medical bodies. The aim would be for these groups to identify patterns of practice and item utilisation that would be worthy of further review by Medicare Australia, with possible referral to the Director of PSR. This is discussed in detail at 3.12.

The Steering Committee envisages that the proposed advisory committee would over-sight this process and assess the outcomes of such collaboration.

(ii) Incorporation of relevant DVA processes under the PSR Scheme arrangements
The Department of Veterans’ Affairs (DVA) assists the Repatriation Commission and the Military Rehabilitation and Compensation Commission in contracting with service providers to arrange for the provision of treatment services to eligible persons. Medicare Australia currently processes the majority of claims for payment for these service providers\(^{32}\) on behalf of the two Commissions.

The Steering Committee supports a system whereby both Medicare and repatriation medical services are taken into account in a review under the Medicare Australia PPR process to determine whether a provider should be referred to PSR. This matter is further discussed at 4.3.

\(^{31}\) i.e as for general practitioners, where services above a certain volume are ‘deemed’ to be inappropriate unless exceptional circumstances can be demonstrated.

\(^{32}\) Service providers include medical practitioners, pharmacists, and a wide range of other allied health providers including dentists, optometrists, physiotherapists, chiropractors, community nurses, audiologists, occupational therapists, orthoptists, podiatrists, psychologists and counsellors.
3.9 Length of Medicare Australia and PSR Processes

Proposed streamlined review procedural arrangements

Current situation

The Steering Committee considers that while maintaining procedural fairness and natural justice provisions, processes at Medicare Australia’s Practice Profile Request stage and the PSR Review stage should be shortened to enhance efficiency.

As illustrated in figures 3.2 and 3.3, cases going to court take much longer to be resolved, but even without court challenges, the complete PSR process is still long. The perception that PSR cases take a long time to be resolved arose repeatedly during consultations and was considered a major drawback of the Scheme. A long PSR process is not optimal for the PUR or the PSR Scheme as a whole.

Note: Data for cases prior to the 1999 review was recorded retrospectively so some may be incomplete or inaccurate
At the time of the Review, the time required for Medicare Australia to manage and assess cases was on average approximately 39 months. The time required for PSR processes was on average approximately 40 months, including initial assessment, committee hearings, and DA decision. Hence the combined Medicare Australia and PSR stages make the complete process an average of 79 months in total.

All stages of the process contribute to the timeframes, and many of these stages are legislatively prescribed with the aim of providing procedural fairness. Table 3.4 illustrates average durations for each stage:

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<tr>
<th></th>
<th>pre 99</th>
<th>post 99</th>
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<tr>
<td>To court</td>
<td>881</td>
<td>810</td>
</tr>
<tr>
<td>Court days</td>
<td>493</td>
<td>616</td>
</tr>
<tr>
<td>Initial PSR</td>
<td>223</td>
<td>219</td>
</tr>
<tr>
<td>Negotiation</td>
<td>125</td>
<td>260</td>
</tr>
<tr>
<td>In committee</td>
<td>383</td>
<td>1098</td>
</tr>
<tr>
<td>Determining Authority</td>
<td>335</td>
<td>167</td>
</tr>
</tbody>
</table>


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33 Note that the table and charts only show completed cases. For example, if a case has been referred to a committee but the committee has not completed its investigation, the committee process will not be included. If a case involves a court process, the days to court is calculated from the date the case was referred to PSR. This is because the transfer to court can take place at any point in the review process.

34 The extended time taken in relation to post 1999 committee matters (1098 days) is partly a consequence of the Federal Court decision *in Pradhan v Holmes* requiring relevant referrals to be dismissed and returned to Medicare Australia for reconsideration and, if appropriate, subsequent referral.
**Steering Committee response**

As part of the Review, a proposal was considered to streamline the PSR Scheme’s processes and Medicare Australia’s Practice Profile Review (PPR) process and to provide opportunities for the person under review (PUR) to be fast tracked through the review process. These revised procedures would effectively:

- reduce the two stage process, which takes approximately 39 months within Medicare Australia, to a single stage process taking approximately 14 -20 months, whilst still meeting the principles of procedural fairness and natural justice; and
- reduce the time taken for that part of the PSR Scheme process which occurs within PSR itself from approximately 40 months to approximately 18 months. The shortened process would cover the initial assessment stage, committee hearing stage and DA stage. This estimate is subject to the time required for obtaining Medicare Australia data, obtaining medical records and the production of submissions by the PUR.

The Steering Committee notes that, in response to the initial findings of the Review that the Medicare Australia and PSR review processes were too lengthy, Medicare Australia implemented a streamlined Practitioner Review Program (PRP) as of 1 November 2006.

It was also proposed to streamline the review processes through provisions to fast track the provider/PUR through the new PPR and PSR processes. Implications would be:

1. At the PPRP stage:
   (i) providers have the option to be fast tracked at any stage of the PPR process to Medicare Australia’s Medical Director for s.86 referral to the Director of PSR;
   (ii) providers previously determined by PSR as having engaged in inappropriate practice will be fast tracked to Medicare Australia’s Medical Director with no review period; and
   (iii) providers who present more than once with the same concern will be fast tracked to Medicare Australia’s Medical Director with no review period.

2. At the Initial Review by PSR process stage:
   (i) the PUR be given the option by the Director of PSR to be fast tracked to a PSR committee.

A detailed outline of the streamlining process can be found at Appendices 6, 7 and 8.

The Steering Committee agrees in principle to the proposed streamlining of procedural arrangements under the PSR Scheme, as well as Medicare Australia’s procedural arrangements and the provision of opportunities to fast track a practitioner in both the PRP and PSR review processes.

**Recommendation 4:** PSR Scheme processes and Medicare Australia’s process be streamlined to ensure the efficiency of the Scheme.
3.10 Court challenges to the PSR Scheme

The PSR scheme has been subject to a significant amount of legal challenge. Since the scheme’s beginning, there have been 63 legal challenges out of 457 requests for review from Medicare Australia to the Director of PSR. The status of these cases is at Appendix 9. These court challenges have significantly lengthened the PSR process, as illustrated in table 3.4.

Factors contributing to the high level of litigation

As noted by Bell,35 given the high stakes for practitioners referred to the Director of PSR, it is not surprising that there is a high level of litigation associated with the PSR scheme. The sanctions are far more effective than for the MSCI scheme because Medicare repayments ordered can be very substantial and there may be long periods of disqualification. Many referred practitioners have very large incomes from the Medicare Benefits Scheme through assignment of benefits under s.20A(1) of the HIA, so that every delay helps to maintain this income, which may well exceed legal costs. Health practitioners may not be required to pay their own court costs as some legal challenges are funded by medical defence organisations.

Other broader contributing factors to the high level of litigation include parallel increases of litigation in the wider field of regulation of health practitioners. In addition, it is common for a new administrative scheme to take some time to bed down with established procedures, experienced administration and settled law.

Key legal challenges

Many of the court decisions relating to the PSR scheme have been useful in illuminating aspects of the legislation; confirming the applicability of established legal principles; or identifying areas requiring clarification, improved administration, or further training of those administering the legislation. The key court decisions that have impacted on the PSR Scheme are summarised at Appendix 10.36

The most significant legal challenge to date is a challenge to the constitutional validity of Medicare and the PSR Scheme which has been launched by some doctors. The doctors allege that the PSR legislation and parts of the Medicare legislation are unconstitutional in that they breach the prohibition on civil conscription in the Constitution and are an invalid exercise of judicial power. This case is unlikely to be resolved before this Review is finalised. Its implications for PSR and Medicare will depend on the findings and reasoning of the court.

In conclusion, the Steering Committee notes that as the scheme becomes more established and court cases produce more precedents, it is anticipated that the PSR Scheme’s high levels of litigation will reduce somewhat over time.

36 This summary is based on Bell, R. Protecting Medicare Services: Trials of a peer review scheme. 2005: 34. 35, and 44.
3.11 Application of the ‘deeming’ provision

A general practitioner is deemed to have engaged in inappropriate practice if 80 or more professional attendances are rendered on each of 20 or more days in a 12 month period, unless exceptional circumstances applied (as defined in the HIA and regulations). This is known as the ‘80/20’ rule.

This provision was developed following extensive stakeholder consultation in response to the 1999 PSR Review. The Review noted that the medical profession generally accepts that high volume provision of services by a practitioner prohibits adequate clinical input.

There has been extensive litigation around the 80/20 rule, many court judgments and a large amount of commentary. Nearly all practitioners faced with an 80/20 referral have claimed that exceptional circumstances affected their provision of the relevant services. Courts have interpreted ‘exceptional circumstances’ in ways that tend to be sympathetic towards rural doctors and doctors who provide services to particular cultural and linguistic groups, which could be seen as undermining the policy intent of the provision. However the number of providers who have been the subject of a request to the Director of PSR involving the application of the deeming provision has dramatically decreased from 30 in 2000, to 10 in 2001 and further to nil in 2004 and 2005. There was one such case in 2006. Application of

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37 The ‘exceptional circumstances’ exception is contained in section 106KA of the Health Insurance Act 1973 (HIA), and regulation 11 of the Health Insurance (Professional Services Review) Regulations 1999 (the Regulations).

Subsections 106KA(2) and (5) of the HIA provide as follows:

“(2) If the person under review satisfies the Committee that, on a particular day or particular days during the relevant period, exceptional circumstances existed that affected the rendering or initiating of services provided by the person, the person is not taken by subsection (1) to have engaged in inappropriate practice on that day or those days.”

“(5) The circumstances that constitute exceptional circumstances for the purposes of subsection (2) include, but are not limited to, circumstances that are declared by the regulations to be exceptional circumstances.”

Regulation 11 of the Regulations provide as follows:

Regulation 11 provides that for subsection 106KA(5) of the HIA, the following circumstances are declared as constituting exceptional circumstances:

(a) an unusual occurrence causing an unusual level of need for professional attendances;
(b) an absence of other medical services, for patients of the person under review during the relevant period, having regard to:
   (i) the location of the practice of the person under review; and
   (ii) characteristics of the patients of the person under review.”

40 There are 41 cases that have included the 80/20 rule as one of the reasons for referral since the 1999 Review. Of these, 16 are incomplete, with 10 of these cases returned to PSR following court consideration, 4 being in court and one each being in PSR and in court. Of the 25 completed cases, 11 were dismissed, 10 were considered by a committee (with sanctions imposed for 6 cases and the remaining 4 cases being found to not involve inappropriate practice by reason of exceptional circumstances), 2 were resolved by an agreement and 2 by no further action in court. Of the 11 cases completed by way of dismissal, 10 followed the Federal Court decision in Pradhan. The eleventh case (referred to PSR in 2006) was not proceeded with under the 80/20 rule
the deeming provision is now a rare event, suggesting a deterrent effect but also leading to concerns that doctors may be ‘playing the system.’ The issue has also been raised of expanding the rule to include specialists and other providers.

The deeming provision has been an issue of great concern and interest to those interviewed during the Review consultations, though there was little consensus on whether the provision should be amended, removed or left as it is. The Steering Committee has considered these issues and the outcomes of stakeholder consultations and does not consider that the current arrangements should be changed, because of the low numbers of 80/20 referrals, the fact that providers below the 80/20 threshold are being monitored and an 80/20 equivalent for specialists would be difficult to define.

**Approaching 80/20**

In relation to the concern that 80/20 cases have dropped to zero because doctors might be providing services just below this threshold, this may be an issue for part-time doctors but does not seem to be for full-time doctors. Medicare Australia produces monthly data analysis reports that list practitioners who have reached 80/20 or are approaching the 80/20 threshold, that is, those who have rendered 70 to 79 professional attendances on 20 or more days. These practitioners are contacted and advised of Medicare Australia’s concerns and offered the opportunity to have an interview with a medical adviser regarding their practice profile.

According to Medicare Australia, there also does not appear to have been a significant growth in the number of providers who render volumes of services just under the 80/20 threshold. Between 1 January 2005 and 31 December 2005, 62 providers rendered 70 or more professional attendances on 20 or more days. All are currently under review as part of Medicare Australia’s practice profile review process. However, data about time trends in high volume servicing just below the 80/20 threshold is not available, and without this, it is difficult to ascertain whether the current low number of 80/20 referrals is due to a deterrent effect. A proposed indicator for this is at 4.4.

It was also suggested that given that the deeming provision has not been invoked in recent years, a lower threshold could be developed, such as 70/30. In response, the Steering Committee considers that this seems a rather arbitrary parameter, and that it is likely that GP organisations would resist a reduction of the level at which deeming would apply.

*A deeming provision for specialists and other providers*

An issue raised by stakeholders was the possibility of extending the deeming provision to include medical specialists and other providers for whom no deeming provision currently applies. The broad consensus view was that such criteria, at least in most areas of specialist medical practice, may be difficult or impossible to define because of the diversity of specialist practice. Stakeholders seemed more amenable at this stage to a process that explores the parameters of inappropriate practice generally and identifies defined ‘triggers’ that would warrant a review by Medicare Australia, with possible referral to the PSR.

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(but was investigated having regard to other concerns) because of the interpretation by the courts of the term “exceptional circumstances” contained in Regulation 11 of the *Health Insurance (Professional Services Review) Regulations 1999*. Apart from the issues associated with the court interpretation of “exceptional circumstances” it is difficult to draw implications from these statistics given that 16 of these cases are incomplete, and a further 10 were dismissed because of the failure to accord procedural fairness as determined by the *Pradhan* case.
The Steering Committee notes that Medicare Australia periodically employs consultant specialists, recommended by the AMA and the Colleges, to identify outlying behaviours from de-identified data. This issue is further discussed in the next section.

In conclusion, the Steering Committee considers that as a matter of policy, the deeming provision ought to be retained in its current form. Arguments for retention of the provision for general practitioners include the probable strong deterrent effect judging from available claiming data, the fact that the provision is now rarely invoked, and that there is no guarantee that any amendments would protect the provision from further legal challenge.

The Steering Committee recommends retention of the current deeming provision.

** Recommendation 5: **The current deeming provision as set out in Section 106KA of the *Health Insurance Act 1973* and related regulations be retained.

### 3.12 Identifying inappropriate practice among specialists

A key statistic arising from the analysis of PSR Scheme data is the low number of specialists who historically have been referred to the Director of PSR. Since 1999, only 16 of the 321 practitioners referred to the PSR have been specialist practitioners.

<table>
<thead>
<tr>
<th>Practitioner Type</th>
<th>Pre 99</th>
<th>Post 99</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractor</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Osteopath</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dental practitioner</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Optometrist</td>
<td>1</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Podiatrist</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>General practitioner</td>
<td>N.A</td>
<td>239</td>
<td>239</td>
</tr>
<tr>
<td>Non VR (OMP)(^{43})</td>
<td>N.A</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>Specialist</td>
<td>N.A</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Medical undefined</td>
<td>135</td>
<td>16</td>
<td>151</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>136</td>
<td>321</td>
<td>457</td>
</tr>
</tbody>
</table>

Source: PSR data (unpublished)

This is despite there being over 24,500 specialists who provide MBS consultations that account for over 50 per cent of Government’s expenditure on Medicare.

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\(^{41}\) Prior to the 1999 Review, the type of medical practitioner was not distinguished.

\(^{42}\) Note: Prior to the 1999 Review, the type of medical practitioner was not distinguished.

\(^{43}\) Some non VR (OMP)’s doctors were ‘grandfathered’ following the introduction of the vocational register of general practitioners in 1989.
The constraints associated with successfully identifying inappropriate practice by specialty groups as compared with general practice were raised regularly during consultations. While it has been noted in the previous section that modifying the deeming provisions (as was mooted during the 1999 Review) to include specialists is not feasible and would not be supported by the medical profession, the Steering Committee investigated ways in which Medicare Australia and PSR could work collaboratively to identify instances of possible inappropriate practice within specialist medical practice.

As part of its National Compliance Program, Medicare Australia utilises various methods to detect possible inappropriate practice by practitioners, including specialists, such as: advanced data analysis; professional risk assessment and intelligence services; strategic risk assessments; and audits. If a practitioner’s MBS or PBS data indicates that their rendering, initiating or prescribing practices appear different when compared with their peers, Medicare Australia may decide to examine that practitioner through its Practice Profile Review process.

The Steering Committee considered that Medicare Australia’s ability to determine clinical necessity or appropriateness of services by specialty groups through claims data only was constrained. This is because there are varying interpretations of some procedural items in the MBS used by specialists; and Medicare Australia can only look narrowly at the item descriptor, rather than at patient records which may justify apparently unusual billing practices. Hence a pattern of practice may satisfy the MBS descriptor, but may not reflect appropriate clinical practice as assessed by peers. This means that Medicare Australia must use other methods to detect possible inappropriate practice by specialists and consultant physicians, including growth charts, outliers, and intelligence about irregular billing practices.

The Steering Committee looked at ways in which peer assessment could be utilised to assist Medicare Australia’s identification process. The Steering Committee considers that a process should be established whereby specialty and allied health groups examine de-identified data to possibly identify appropriate and inappropriate patterns of practice. The aim of this process would be to assess the feasibility of specialty groups being able to identify patterns of practice and item utilisation that should trigger review by Medicare Australia with possible referral to the Director of PSR.

During the consultation process, specialty groups were asked about assisting in the identification of ‘normal’ and ‘abnormal’ patterns of practice using de-identified claims data. There was in-principle support for this process, however, groups stressed that their participation would be for the purposes of enhancing quality practice only.

The Steering Committee also recommends that this process be overseen by the proposed advisory committee.

**Recommendation 6:** Parameters for identifying possible inappropriate practice by specialists and allied health professionals be developed by DoHA, Medicare Australia and PSR in consultation with colleges and professional bodies. This process is to be overseen by the advisory committee.

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3.13 Limitations on the exchange of information

Enhancing the flow of information

The Steering Committee considered increasing the flow of information between Medicare Australia, PSR and medical boards to a greater degree, to facilitate a more efficient and effective review process.

Medicare Australia legally does not have legislated powers to compel the production of medical records and needs to rely solely on data in assessing a possible request to PSR. During consultations, stakeholders consistently advised that they do not support Medicare Australia having access to patient records, mainly because Medicare Australia is not seen as an independent peer-review organisation.

Medicare Australia is able to provide information to state medical boards in certain circumstances. This may commonly include provision of information by Medicare Australia in response to a request from a state medical board, or rarely, if a delegate of Medicare Australia determines that there may be a threat to life or limb of a practitioner or his/her patient.

Medicare Australia must give PSR information if requested, about any or all services provided by the PUR during the review period. PSR can seek relevant documents from anyone, for example a PUR, or any committee or body of persons such as a medical board (whether incorporated or unincorporated), as long as they are covered under the HIA. This means that PSR and PSR committees can assess the level of clinical input provided to services through the perusal of patient records.

PSR may now refer practitioners to specified medical boards and colleges following an amendment made to the Health Insurance (Professional Services Review) Regulations 1999 in 2006 to specify bodies to which a PUR must be referred if the person has failed to comply with professional standards (s.106XB). A similar provision applies where a PUR is considered to cause, or is likely to cause, a significant threat to the life or health of another person (s.106XA).

In conclusion, the Steering Committee considered that existing provisions already allow the sharing of relevant information to some degree. Any changes could be considered by the proposed Advisory Committee if required.

The PSR Director having access to data outside the Review period

The Steering Committee considered the proposal that the PSR Director would benefit from having access to data outside the review period for counselling purposes, to be able to ascertain whether improvements in performance had been made since the person had been under review.

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The Steering Committee noted the preliminary legal advice that, assessed on a case-by-case basis, such access may be legally available, although there may be limitations under the legal principle of natural justice. However, the Steering Committee has been advised that if consent of a PUR is obtained, there would be no legal impediment to the access of such information.

The Steering Committee considers that this issue should be addressed by the proposed advisory committee.

**Consumer issues**

The Consumers Health Forum (CHF) raised issues with those parts of the PSR process that allow access to patient records. The CHF’s view was that people had an expectation that they would know when their patient records are being accessed by an agency and the purpose of that access. The CHF indicated that they would like the opportunity to better understand how access to records assists the PSR process and the procedures and conditions under which patient records are accessed and used during PSR proceedings.

The Steering Committee considers that CHF concerns may be addressed by the advisory committee in the course of monitoring data exchange issues.

In conclusion, the Steering Committee considers that the issue of changes to current provisions in relation to the exchange of information needs further investigation. The Steering Committee recommends that data exchange be monitored by the proposed advisory committee.

**Recommendation 7:** Proposals to enhance the flow of information between Medicare Australia and the Director of PSR be further investigated by the proposed advisory committee.

### 3.14 Adequacy of Existing Sanctions

To be effective, sanctions must act as a deterrent to practitioners from engaging in inappropriate practice and encourage the provision of clinically relevant services and appropriate prescribing of PBS medicines. The sanctions must be commensurate with the level of inappropriate practice and must be imposed consistently and fairly.

In determining the adequacy and effectiveness of the range of sanctions, regard must also be given to:

- community expectations and perceptions that the sanctions imposed are effective in deterring inappropriate practice and protecting patients and the community in general from such practices; and
- protecting Commonwealth revenue under Medicare and the PBS against having to meet the cost of services provided as a result of inappropriate practice.
Given this, the Steering Committee considers that any proposed changes to the range of sanctions to be imposed under the PSR Scheme\textsuperscript{47} will need to be developed in consultation with and be supported by the medical profession.

Under s.106ZPR of the HIA, the Director of PSR is allowed to publish certain details, including the practitioner’s name and his/her conduct, when a final determination of the DA has come into effect. The PSR publishes these details annually in the PSR Annual Report and PSR’s ‘Report to the Professions’. However, practitioners who enter into an agreement with the Director of PSR have their name withheld from publication. Although the publication of these details is not a sanction in its strict sense, rather a deterrent, in effect it does serve as a sanction and may influence the decision of a PUR to enter into an agreement with the PSR Director to avoid public exposure and censure.

Currently, PURs who have had a second effective determination are referred to the MPRC, which has the power to impose disqualification from participation in Medicare for up to five years. Transferring the role of the MPRC to the DA is under review (refer to 3.15). If this function is transferred to the DA, consideration would need to be given to enabling the DA to impose disqualifications equivalent to those of the MPRC.

The Steering Committee notes the complexities posed in recovering benefits from practitioners who have engaged in inappropriate prescribing of PBS medicines and the limitations on imposing sanctions on corporate practices.

Through the current PSR process, only limited sanctions can be placed on practitioners for inappropriate prescribing of PBS medicines. These include reprimands, counselling and suspension from prescribing PBS medicines (generally only for those medicines which have been inappropriately prescribed). Extension of the current sanctions to include the recovery of benefits from practitioners who have engaged in inappropriate prescribing of PBS medicines will require legislative amendments but may be an effective means of deterring inappropriate prescribing.

**Effect of the 1999 PSR Review outcomes on sanctions**

The recommendations of the 1999 PSR Review touched on the range of sanctions available under the PSR Scheme; sanctions applicable under the deeming provision; the process of negotiating and determining sanctions to be imposed; and the powers of the PSR Director to negotiate sanctions. This is discussed in detail at recommendations 9, 10, 20 and 37 respectively at Appendix 5.

**Effectiveness of the current sanctions**

Table 3.5 sets out the sanctions imposed on practitioners found to have engaged in inappropriate practice since the 1999 PSR Review.

\textsuperscript{47} Sanctions are described at Appendix 3.
Table 3.5 Summary of sanctions, completed cases, post the 1999 PSR Review

<table>
<thead>
<tr>
<th></th>
<th>Agreement</th>
<th>Committee inappropriate</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases</td>
<td>63</td>
<td>48</td>
<td>111</td>
</tr>
<tr>
<td>Number counselled</td>
<td>See note 2</td>
<td>48</td>
<td>48</td>
</tr>
<tr>
<td>Number reprimanded</td>
<td>61</td>
<td>47</td>
<td>108</td>
</tr>
<tr>
<td>Number repayment required</td>
<td>42</td>
<td>42</td>
<td>84</td>
</tr>
<tr>
<td>Ave repayment amount</td>
<td>$28,039</td>
<td>$70,497</td>
<td>$49,268</td>
</tr>
<tr>
<td>Number full MBS disqualification</td>
<td>5</td>
<td>24</td>
<td>29</td>
</tr>
<tr>
<td>Ave disqualification (months)</td>
<td>15.5</td>
<td>10.3</td>
<td>11.2</td>
</tr>
<tr>
<td>Number part MBS disqualification</td>
<td>11</td>
<td>20</td>
<td>32</td>
</tr>
<tr>
<td>Ave disqualification (months)</td>
<td>na</td>
<td>1.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Number PBS Suspension</td>
<td>1</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

Source: PSR data (unpublished)

Note 1: Multiple sanctions are generally imposed and cases are included in each relevant sanction.
Note 2: While counselling is not available as a sanction in relation to agreements under s92, all practitioners with whom a s.92 agreement is reached are counselled as part of the agreement process.

Repeat practitioners in Medicare Australia’s practice profile reviews

Table 3.6 sets out the incidence of practitioners who have undergone a second Medicare Australia practice profile review.

Table 3.6 Medicare Australia practice profile reviews

<table>
<thead>
<tr>
<th>Year</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) No. of practitioners with practice profile review</td>
<td>561</td>
<td>636</td>
<td>584</td>
<td>566</td>
<td>415</td>
<td>383</td>
</tr>
<tr>
<td>(b) No. of repeat practitioners</td>
<td>4</td>
<td>13</td>
<td>39</td>
<td>74</td>
<td>51</td>
<td>61</td>
</tr>
<tr>
<td>% of repeat practitioners</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>13</td>
<td>12</td>
<td>16</td>
</tr>
</tbody>
</table>

Source: Medicare Australia data (unpublished)

From 2000 to 2005 inclusive, a total of 3,145 practitioners have undergone a Medicare Australia practice profile review (PPR), of which a total of 242 practitioners (8 per cent) have undergone a second practice profile review. Of those who entered their second review, 33 per cent (82 practitioners) did not address Medicare Australia’s concerns and were referred to Director of PSR for review.

Re-referral of practitioners from Medicare Australia to the Director of PSR

Table 3.7 Rate of referral from Medicare Australia to Director PSR for review

<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>50</td>
<td>63</td>
<td>94</td>
<td>52</td>
<td>38</td>
<td>9</td>
<td>7</td>
</tr>
</tbody>
</table>

Source: PSR data (unpublished)
As indicated in table 3.7, for the period 2000-01 to 2005-06, there was a total of 263 requests from Medicare Australia to the Director of PSR. Of these, there were 238 referrals accepted and 25 re-referrals. The rate of re-referral to the Director of PSR for the period was 10.5 per cent.

The rate of practitioners who have undergone a second review under Medicare Australia’s PPR process (8 per cent) of which almost a third were referred to the Director of PSR, and the rate of re-referral from Medicare Australia to the Director of PSR (10.5 per cent) suggests that in these cases, sanctions have had little deterrent effect and/or have not been effective in changing practitioner behaviour.

The Steering Committee found that the adequacy of the sanctions warrants closer scrutiny with regard to their deterrent to inappropriate practice, the range of sanctions that can be imposed, and limitations on the recovery of benefits from practitioners under the present arrangements. The Steering Committee considers that the proposed advisory committee could further examine the issue of sanctions.

**Recommendation 8:** The adequacy of the existing range of sanctions that can be imposed on practitioners found to have engaged in inappropriate practice be examined by the proposed advisory committee to ensure the continuing effectiveness of the Scheme.

### 3.15 Management of Medicare Participation Review Committee process

The MPRC is an independent statutory body which reviews medical practitioners convicted of offences against Medicare to determine their future participation in Medicare. The MPRC has the power to reprimand, counsel or disqualify medical practitioners from participating in the Medicare Scheme for up to five years.

In relation to the PSR Scheme, a practitioner with an effective determination of inappropriate practice on two separate occasions is referred by the Director of PSR to the MPRC. An MPRC determination can lead to disqualification from participation in Medicare for up to five years.

The Steering Committee considered alternative processes for dealing with practitioners found to have engaged in inappropriate practice on two separate occasions under the PSR Scheme. The Steering Committee is of the view that it is not proper that a person who has been found to have engaged in inappropriate practice by a committee of peers should be dealt with by the same body that deals with persons convicted of a criminal offence. The Steering Committee
considers that it is more consistent and appropriate that, as part of the concept of peer assessment, practitioners found to have engaged in inappropriate practice on two separate occasions be sanctioned by the DA, which is an integral part of the PSR Scheme. In addition, the Steering Committee considers that referral of only second determinations to the MPRC seems to result in duplication in roles and an unnecessarily lengthened review process as reference to the MPRC adds to the time that a practitioner spends being subjected to a formal regulatory system.

The Steering Committee has been advised that there are no legal impediments to removing MPRCs from the PSR process.

In conclusion, the Steering Committee recommends that PSR cases currently referred to the MPRC should be directly referred to the DA and the DA should be given increased sanctioning powers of being able to disqualify a practitioner for up to five years in line with current MPRC sanctions. Implementation of this recommendation would require legislative change.

**Recommendation 9:** PSR cases currently referred to the Medicare Participation Review Committee (MPRC) be directly referred to the Determining Authority (DA). The DA be given the power to enforce relevant sanctions equivalent to those currently available to the MPRC.

### 3.16 Interpretation of Medicare Benefits Schedule item descriptors

Medicare benefits are payable for all clinically relevant services that are listed on the Medicare Benefits Schedule (MBS). A description of the services that are eligible for a Medicare benefit is contained in the MBS book. The MBS book released on 1 November 2006 lists over 5000 items divided into eight categories. Each listed professional service is allocated a unique item number and associated Schedule fee and Medicare benefit.

Many of the items in the MBS book have associated explanatory notes, however, situations arise where the item description does not neatly fit the service performed. DoHA, Medicare Australia and the AMA work closely together to ensure that possible issues surrounding MBS item descriptions are identified and clarified in a timely manner.

Practitioners are encouraged to contact Medicare Australia about matters of interpretation of Schedule items. Inquiries may range from simple clarifications around the meaning of items to the application for prospective approval of proposed surgery. Matters of interpretation that require further clarification are referred by Medicare Australia to DoHA. Additionally, several fora exist to deal with the different aspects of defining Medicare benefit Schedule items. These are listed in Appendix 11.

The Steering Committee found that clear and unambiguous MBS Schedule item descriptions are essential for promoting appropriate practice in the context of the PSR Scheme. It acknowledged the work being done by DoHA, Medicare Australia and the AMA in developing a process to address issues of concern regarding the appropriate application of Medicare benefits. The Steering Committee also supported the direct provision to the PSR Director of information about the intent of MBS Schedule item descriptions, including Minutes from Medical Services Advisory Committee (MSAC) meetings (these are also available at www.msac.gov.au).
Future challenges to the PSR Scheme

4.1 Emerging medical practice trends

The Steering Committee recognises that the changing nature of medicine will alter the way in which medical services are accessed in the future. While noting that it was not within the Review’s terms of reference to attempt to predict the future of medical practice, consideration was given to the possible impacts of some emerging medical practice trends on the PSR Scheme.

Corporatisation and vertical integration of medical practice

An emerging change in medical practice is the development of corporate entities in the general practice area. Medical centres that are owned or leased by a corporate entity are established and general practitioners are co-located or linked with other health practitioners, such as diagnostic imaging and pathology services, clinical specialists, and pharmacy, in what is referred to as corporate vertical integration. Of concern is the potential of such corporate practices to impact on clinical autonomy, high volume servicing and inappropriate referral.

Many stakeholder groups consulted referred to the corporatisation of general practice and the potential of such corporations to influence GP referral practices and encourage overservicing through remuneration schemes, including bonuses and performance pay. A frequent point raised during the consultations was whether corporate practices do or might lead to new forms of inappropriate practice.

Currently, most information on corporate practices relies on anecdotal evidence as there is no formal system of data collection within Medicare Australia to identify and monitor corporate entities involved in providing medical services. There is also no system to track corporate practices or monitor billing and referral patterns of general practitioners working in corporate practices.

Subsection 82(2) of the Health Insurance Act 1973 (HIA) pertains only to those persons, including an officer of a corporation, who cause or permit a practitioner in their employ to engage in inappropriate practice. Many corporate practices therefore do not engage medical practitioners as employees, but rather as contractors. This enables corporate business owners to exert influence on contracted individual practitioners whilst remaining at arms length from any compliance intervention. Where a corporate entity can be identified, there are only limited sanctions that can be imposed by the Determining Authority (DA) if the person under review (PUR) is a corporate entity.

Refer to 3.4 Stakeholder views of effectiveness.
The Steering Committee considers that the potential impact of corporate practice ownership and conduct on medical practice needs to be monitored and strong deterrents to corporate-induced inappropriate practice be introduced through:

- the development of systems to capture data on corporations; and
- the introduction of legislation that enables sanctions to be imposed on corporations found to be contributing to inappropriate practice by practitioners with whom they have a pecuniary relationship.

**Recommendation 10:** Systems to capture data on corporations be developed to better monitor the potential influence of corporations on individual practitioner behaviour.

**Recommendation 11:** A range of sanctions be developed and enacted that can be imposed on corporations found to be contributing to inappropriate practice by practitioners with whom they have a pecuniary relationship.

**Safety Net issues**

The Australian Government is responsible for setting MBS fees for the purpose of establishing Medicare rebates associated with MBS services and for the payment of Medicare benefits, however it has no role in determining how practitioners charge for their own services.

The advent of the Australian Government’s new extended Safety Net program has provided additional protection from high out-of-pocket expenses for all Australians for Medicare-claimable services provided outside of hospital. The Government has signalled its expectations that medical practitioners act responsibly in ensuring patients receive appropriate medical care and that they do not raise their fees unreasonably in order to shift the extra cost on to the Government via the safety net. It has also advised that it will continue to monitor the level of benefits paid and any changes in billing practices.

**Special interest practices**

There has been a growing emergence of special interest practices over the last five years. Many general practitioners are now undertaking extra training which enables them to specialise in certain procedures and they have joined practices which only provide such services. Clinics specialising in such areas as skin care or impotence and which can be now found in metropolitan or larger rural areas, are examples of this growing trend.

The Review highlighted the difficulties in identifying inappropriate practice across special interest groups due to the different work practices often employed by such groups. It was proposed that de-identified data from these groups be examined in a similar way to that of specialty craft groups (see section 3.12).
Quality in Health Care

During the Review consultations, there was frequent reference to the desirability of somehow linking PSR activities to other processes which aim to increase the quality of medical and other health practice. For example, the Royal Australian College of General Practitioners (RACGP) commented:

The RACGP would like to enhance its involvement with the Scheme by becoming more active in identifying new challenges in Australian medicine and engaging in the development of appropriate responses….the RACGP supports the use of high quality evidence in decisions affecting Australian general practice and the future of the PSR.49

The Review also identified the need to promote understanding of the role that quality focussed entities such as the recently established Australian Commission on Safety and Quality in Health Care and the Australian General Practice Network can play in ensuring the efficient and appropriate payment of medical benefits through Medicare.

The Role of PSR in Education

The Review noted that changes to government health policy have the potential to impact on the operation of the PSR Scheme. The Steering Committee agreed that it was important to standardise and strengthen education programs for practitioners to ensure that there was a heightened awareness of the appropriate use of Medicare items within the context of emerging medical practice trends. It considered that PSR is in a unique position to play an increased role in education to support medical practitioners found to be in need of remedial training, to provide best practice care.

4.2 Inclusion of allied health providers under the PSR Scheme

There are around 450 000 paid health professionals in Australia, of whom just over 350 000 are currently employed in health service industries. Allied health professionals account for nine per cent of the workforce.50 Between 1996 and 2001, the overall health workforce increased by over 11 per cent, nearly double the population growth of six per cent. Over that period, the numbers of allied and complementary health workers grew by more than 25 per cent.51

The 2005-06 BEACH survey, which captures information on general practice activity in Australia, shows that referrals made to allied health professionals accounted for 23.9 per cent of all GP referrals in 2005-06. Almost 40 per cent of such referrals were to physiotherapists, followed by psychologists (9.7 per cent), podiatrists/chiropodists (8.0 per cent) and dieticians/nutritionists (7.9 per cent).52 With the growing shortage in the medical workforce, new patterns of practice involving team care are emerging that provide opportunities to make use of a growing health resource provided by allied health workers and other providers.

49 Consultant’s Report, page 33.
50 Productivity Commission 2005, Australia’s Health Workforce, Research Report, Canberra, p.XIV.
51 Ibid p.10.
Two initiatives promoting such patterns have recently extended Medicare benefits to services provided by other allied health practitioners: the Medicare Allied Health and Dental Care initiative and the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (MBS). However there is currently no mechanism for allied health professionals participating in these programs to be reviewed under the PSR Scheme, with the exception of chiropractors, physiotherapists, podiatrists, optometrists and osteopaths.

During the Review consultations, stakeholders highlighted the need to include all allied health practitioners under the PSR Scheme and for the concept of ‘inappropriate practice’ to be extended to take account of the new patterns of practice now available under the new initiatives. Concerns were also expressed regarding the potential for new forms of inappropriate practice under these new arrangements, including referral of patients to an allied health practitioner with whom the GP may have some prior arrangement.

The Steering Committee considers that parameters for identifying possible inappropriate practice by allied health professionals be developed as recommended for specialists in Recommendation 7. The recommended process is outlined at 3.12.

The Review Steering Committee also considers that s.81 of the HIA be amended to include other allied health practitioners for whom Medicare benefits are payable for their services.

**Recommendation 12:** Section 81 of the *Health Insurance Act 1973*, which lists the practitioners whose conduct may be examined under the PSR Scheme, be amended to include all allied health professional groups who initiate or render services that are eligible for payment of Medicare benefits now and in the future.

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53 These initiatives and the practitioners involved are described at Appendix 12.
54 These professional groups are included under practitioners whose conduct may be examined under the PSR Scheme, as detailed in s.81 of the HIA. Dental practitioners are also covered by the PSR Scheme in accordance with s.82 of the HIA.
55 Under Section 82(1) of the *Health Insurance Act 1973*, a practitioner engages in inappropriate practice if their conduct in connection with rendering or initiating services would be unacceptable to the general body of practitioners in that speciality. ‘Initiate or render services’ also includes prescribing PBS medicines. Dentists are already able to prescribe certain PBS medicines, and it may be the case that some allied health practitioners will be able to do this in the future.
4.3 Incorporation of the Department of Veterans’ Affairs claimed services under the PSR Scheme

The Review considered the possibility of the Department of Veterans’ Affairs (DVA) review arrangements for claimed services being consolidated under the PSR Scheme. This has in-principle support of DVA.

Currently, Medicare Australia processes the majority of payment claims from service providers to eligible veterans and their families. However, DVA has its own quality and compliance mechanisms for these claimed services and Medicare Australia does not have access to the relevant DVA data. There appears to be some logic in having a single system in place for dealing with both Medicare and DVA payments and review arrangements. This would facilitate DVA claimed services being accounted for under the PSR Scheme.

The Steering Committee’s preference is for a system whereby both Medicare and DVA claimed services are taken into account in any review to determine whether a practitioner should be referred to the Director of PSR (DPSR) by Medicare Australia. It would also ensure that if a practitioner is disqualified or restricted from providing services under Medicare, that practitioner would automatically be disqualified or restricted from providing services under DVA processes.

If this is not possible, the Steering Committee considers that DVA-provider data should be reviewed at the PSR review stage. Hence, if a practitioner is referred by Medicare Australia to the Director of PSR because of possible inappropriate practice in relation to Medicare, DVA claimed services would also be considered and taken into account at the PSR review stage.

DVA’s approach to providing services through contracting with service providers is in the process of being changed to a statutory-based regime and both parties agree that work in relation to incorporating DVA review arrangements under the PSR Scheme would be best managed as part of this exercise. It is anticipated that complex legislative change will be required. The Steering Committee considers that this is an issue that the proposed advisory committee keep under review.

The Steering Committee notes that the proposed arrangements are under discussion and recommends DVA claimed services be incorporated under the PSR Scheme.

The Steering Committee recommends that additional funding be provided for Medicare Australia and PSR to implement this recommendation.

**Recommendation 13:** The Department of Veterans’ Affairs (DVA) claimed services be incorporated under the PSR Scheme as approved in principle by DVA. This is subject to further discussions with DVA and the provision of additional funding for Medicare Australia and PSR to implement this recommendation.

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56 Eligible persons include veterans, war widows and widowers, serving and former members of the Australian Defence Force, eligible Australian Federal Police members with overseas service and their dependants and carers.
4.4 Performance indicators for the future

The PSR Scheme’s performance against current performance indicators are outlined at 3.3 and include:

- requests from Medicare Australia;
- rate of re-referral;
- Medicare Australia requests for review finalised;
- Committee reports issued;
- final determinations issued; and
- effective final determinations issued.

Well defined performance indicators are important tools for objectively measuring the success of a program. While the current performance indicators do illustrate some important components of the program’s effectiveness, more process indicators could be used in conjunction with these, to identify specific areas of improvement. Process indicators were proposed during the Review, including for matters at the Medicare Australia stage of the PSR process. These were:

**Medicare Australia stage**

- the numbers of practitioners at various levels within the Medicare Australia Practitioner Review Program;
- the number of practitioners against whom no further action is to be taken and at which level of the Medicare Australia process such decision was made;
- the time taken at various stages of the Medicare Australia process, including time taken to implement final determinations made by the Determining Authority;
- changes in individual practitioners' claiming behaviour associated with Medicare Australia interventions;\(^{57}\)
- numbers of practitioners reviewed over time by reason the practitioner attracted attention and outcome and any trends over time in these figures; and
- data on possible impacts of the '80/20' rule, for example, systematic trend data on whether GPs are providing services just below this threshold to avoid '80/20' referrals to PSR, and an indicator measuring high volume services for part-time providers.

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\(^{57}\) This proposed performance indicator and the two following were sought from Medicare Australia for the Review, but were not available. It is difficult without this data to draw any conclusions regarding the impact of Medicare Australia’s processes on practitioner behaviour. Therefore, this Review has not been able to assess the impact of Medicare Australia’s internal processes on the effectiveness of the Scheme. This is significant as fewer than 10 referrals were made to PSR in the last financial year, so currently, a large proportion of the ‘PSR’ process (broadly defined) is occurring at the Medicare Australia stage.
Medicare Australia and PSR stages

- the number of reviews undertaken in relation to each practitioner identified.

PSR stage

- the number of cases where the PSR Director decides not to undertake a review (s. 88A);
- the number of cases where the PSR Director decides to take no further action (s.91);
- the number of cases where an agreement has been reached between the PSR Director and the PUR (s.92);
- aggregate data of sanctions imposed under s.92;
- number of cases referred to the PSR Committee (s.93);
- outcomes of final determinations made by the DA; and
- time taken at various stages of the PSR process.

The proposed indicators may be too numerous to succinctly indicate the Scheme’s effectiveness, and some may need further refining. The Steering Committee recommends that the current performance indicators and those proposed during consultations be considered by the proposed advisory committee, with the aim of developing a small number of key performance indicators against which the PSR Scheme be monitored. Since the performance indicators are subject to significant external factors outside of the influence of PSR, such as court decisions or Medicare Australia actions, the Scheme’s effectiveness is a shared responsibility between Medicare Australia, PSR and DoHA, and all three have a role in ensuring that performance measures are met.

Recommendation 14: Agreed performance indicators be developed and monitored by the proposed advisory committee and reported on annually by the Director of PSR and Medicare Australia.

4.5 Future Review of the PSR Scheme

The Steering Committee recommends that the Government and the medical profession review the PSR Scheme by 2010 to evaluate the effectiveness of the revised arrangements and the ability of the Scheme to meet future challenges.

Recommendation 15: The PSR Scheme be reviewed in 2010.
Appendix 1 – Terms of Reference

Review of the Professional Services Review Scheme

1. Review the operation of the Professional Services Review (PSR) Scheme, with a particular focus on the impact of the 1999 and 2002 legislative changes, and identify achievements and barriers to the Scheme meeting its objectives.

2. Assess the extent to which the PSR Scheme will be able to achieve its objectives in the future, taking into account the roles and responsibilities of stakeholder organisations (including but not limited to the Department of Health and Ageing, Medicare Australia and the Australian Medical Association) and related Commonwealth compliance activities (i.e. Medicare Participation Review Committees).

3. Make recommendations to the Minister for Health and Ageing on areas for improvements of the Scheme, including structure and operation of the PSR and related activities, impact of proposed changes on legislation and administrative arrangements, and mechanisms for ongoing monitoring and reporting to government, the profession and the public.
Appendix 2 – Organisations and individuals consulted

Consumers
Consumers' Health Forum of Australia

Australian Medical Association (AMA)
Federal Office
AMA Council of General Practice
Australian Medical Association (NSW) Ltd
Australian Medical Association Victoria
Australian Medical Association Queensland

Colleges
Australasian College for Emergency Medicine
Australian and New Zealand College of Anaesthetists
Australian College of Dermatologists
Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Royal Australian and New Zealand College of Ophthalmologists
Royal Australian and New Zealand College of Psychiatrists
Royal Australian and New Zealand College of Radiologists
Royal Australian College of General Practitioners
Royal Australian College of Medical Administrators
The Royal College of Pathologists of Australasia
Royal Australasian College of Physicians
Royal Australasian College of Surgeons
Australian College of Rural and Remote Medicine
University of Melbourne

Medical Associations
Australian Association of Pathology Practices
Australian Diagnostic Imaging Association
Australian Society of Anaesthetists Ltd
National Association of Specialist Obstetricians and Gynaecologists
Australian Orthopaedic Association

GP Groups
Australian Divisions of General Practice
Rural Doctors Association of Australia
(RACGP - See above)

(AMA Council of General Practice - See AMA)
GP Special Interest Groups
Skin Cancer Society of Australia
Travel Medicine
Women's Health Australia
Impotence Australia
Complementary Medicine Association
Australian Acupuncture and Chinese Medicine Association

Allied Health
Allied Health Professions Australia
Peak Body covers:
- Audiologists
- Podiatrists
- Social Workers
- Radiographers
- Orthotic Prosthetic providers
- Psychologists
- Dieticians
- Orthoptics
- Occupational Therapists
- Physiotherapists
- Speech Pathologists
Chiropractors' Association of Australia
Optometrists Association Australia
Australian Dental Association Inc

Medical Boards
Medical Board of Queensland
NSW Medical Board
Medical Practitioners Board of Victoria

Medical Defence
Medical Indemnity Industry Association of Australia
United Medical Protection
Medical Indemnity Protection Society
Other Medical Defence Organisations - teleconference with CEOs

Health Complaints Offices
ACT Health Services Complaints Commissioner
Health & Community Services Complaints - Adelaide
Health and Community Services Complaints Commission - Darwin
Health Care Complaints Commission - NSW
Health Complaints Commissioner - Tasmania
Health Quality and Complaints Commission - Brisbane
Health Services Commissioner - Melbourne
The Office of Health Review - Perth

**Others**
AMC meeting covering all States and Territories
Australian Association of Practice Managers
Deputy Directors of PSR
Corporations who signed the Corporate Code of Conduct for corporations involved in the provision of management and administrative services in medical centres in Australia
Dr John Holmes, former Director PSR
TressCox Lawyers
Minter Ellison Lawyers
Law Institute of Victoria
Department of Veterans’ Affairs
Rhonda Henderson, Barrister
Appendix 3 – Description of the PSR Scheme Processes

Medicare Australia Processes

Medicare Australia identifies practitioners whose Medicare or PBS data indicates their rendering, initiating or prescribing practice profiles appear different in comparison with their peers. Under s.86 of the HIA, Medicare Australia may request the Director PSR (DPSR) to review the provision of services by a person during the period specified in the request. Practitioners’ claiming patterns are monitored through the methods outlined at 3.12.

Request by Medicare Australia to Director of PSR

Between June 2004 and November 2006, Medicare Australia had a two-stage approach to its practice profile review process. The Medicare Australia and PSR processes are represented in simplified form at Appendix 4.

PSR Scheme Processes

Following Medicare Australia’s practice profile review process, Medicare Australia may request the PSR Director to review a practitioner. There are several phases in the PSR review process and these are outlined below.

Phase 1 – Investigation by the Director of PSR

If, having received a request to review from Medicare Australia, the DPSR decides (s.88A of the HIA) to undertake such review, the Director of PSR must provide a written notice of that decision to the person under review (PUR) and Medicare Australia. The scope of the PSR Director’s review is set out in s.88B of the HIA. The DPSR may review any or all of the services provided by the PUR during the review period, may undertake the review in such manner as the Director of PSR thinks appropriate and is not limited by the reasons included in the request from Medicare Australia. The DPSR has the power to require the production of documents or the giving of information relevant to the review. The DPSR invites written submissions from the PUR. After considering any submissions, the DPSR can either:

- dismiss the request (s.91);
- enter into an agreement with the PUR (s.92); or
- make a referral to a PSR Committee to consider whether the PUR has engaged in appropriate practice (s.93). The referral must set out the reasons for making the referral and the DPSR must provide to the PSR committee a copy of the report of the investigation.\(^58\)

\(^58\) The Director of PSR can also refer a person under review to a relevant regulatory body, if they form the opinion that the person has caused, is causing or is likely to cause a significant threat to the life or health of patients. This power of referral is also available to the PSR Committee and the Determining Authority via the Director.
Phase 2 – Examination by a PSR Committee

PSR committees are established under the HIA and their function is to examine referrals made by the DPSR. A committee is comprised of a Deputy Director (appointed by the Minister for Health and Ageing under s.85 of the HIA) and two other panel members from the profession or specialty as the practitioner under review. The membership of each PSR committee is decided by the Director of PSR.

Where the DPSR makes a referral to a PSR committee, the committee conducts hearings, makes findings in respect of the ‘referred services’ and prepares a report setting out its findings on whether the practitioner has, in the committee’s opinion, engaged in inappropriate practice in the rendering or initiating of some or all of the ‘referred services’.

The PSR committee is required to prepare a draft report, on which the practitioner is able to make submissions, and a final report having regard to any submissions made. The final report is provided to the practitioner, the DPSR and the Determining Authority (DA).

Phase 3 – The Determining Authority

The DA is an independent body established under the HIA. The function of the DA is to ratify agreements between the DPSR and the PUR and to make draft and final determinations, in which directions are imposed on the PUR, following receipt of a final report from a PSR committee.

If the committee finds that inappropriate practice has not occurred, the committee is not required to provide its final report to the DA and must advise the practitioner, the DPSR and Medicare Australia accordingly (ss.106L(3) and (5) of the HIA).

If the Committee finds that inappropriate practice has occurred, the DA must firstly give the PUR the opportunity to make submissions to the DA about the directions the DA should impose (s.106SA of the HIA) and, having taken those submissions into account, must make a draft determination, on which the practitioner may make further submissions, and a final determination having regard to any submissions made by the practitioner on the draft determination. The draft and final determination must contain one or more of the following directions:

- the practitioner be reprimanded and/or counselled;
- the practitioner repay Commonwealth Medicare benefits; and/or
- the practitioner be fully and/or partially disqualified from Medicare and/or suspension from the PBS for up to three years.

The practitioner has the right to access legal advice and to apply to the court if they are dissatisfied with the final determination of the DA.

Medicare Participation Review Committee

In cases where a practitioner has engaged in inappropriate practice on two separate occasions, the practitioner is referred to the Medicare Participation Review Committee (MPRC).59

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59 The HIA was amended by the Health Legislation Amendment Act (No.2) 1985 (‘the 1985 amendment’) to introduce Part VB which relates to MPRCs.
The Steering Committee has considered alternate arrangements for dealing with PSR cases that currently are referred to the MPRC for determination. This is further discussed at 3.15.
Appendix 4 – PSR Scheme Process Map

Medicare Australia Identifies inappropriate practice via analysis of Medicare and PBS Data and other information

First Stage Review
(includes review of practice operation, reference to a Case Management Committee and opportunity for practitioner to respond to concerns)

Are Medicare Australia concerns addressed?

Yes
Matter is closed

No
Refer matter back to the Case Management Committee (may include recommendation to recommence second stage)

Make a request to the Director of PSR

Second Stage Review
(includes reference to a Case Management Committee, an interview with a Medicare Australia Advisor and opportunity for practitioner to make written submissions in response to interview report)

Are Medicare Australia concerns addressed?

Yes
Matter is closed

No

Or

3. Determining Authority ratifies Agreement

2. PSR Director investigates request

No Further Action

Enter into an Agreement with Person Under Review

Refer matter to PSR Committee

Matter is closed

2. PSR Committee investigates Referral

Practice is not inappropriate

No Further Action

Inappropriate Practice

3. Determining Authority imposes sanctions through Draft and Final Determinations

Medicare Participation Review Committee

The PSR Director refers the practitioner to the MPRC after a second finding of inappropriate practice

Professional Services Review processes

No Medicare Australia concerns addressed?

Yes

No

Refer matter back to the Case Management Committee (may include recommendation to recommence second stage)

Make a request to the Director of PSR
## Appendix 5 – Review of the effectiveness of the 1999 PSR Review recommendations

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Implementation</th>
<th>Effectiveness</th>
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<tbody>
<tr>
<td><strong>Recommendation 1:</strong> The general definition of inappropriate practice in the HIA be maintained as conduct unacceptable to the general body of the practitioner’s peers.</td>
<td>n/a</td>
<td>n/a</td>
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<tr>
<td><strong>Recommendation 2:</strong> Act be amended to provide for the application of sampling and for Ministerial directions for a range of sampling methodologies to be used by PSRCs in relation to particular identifiable services.</td>
<td>s.106K HI (PSR) Amendment Act 1999</td>
<td>Of requests to DPSR since 1 August 1999, the DA has made 53 final determinations - 30 used sampling methodology resulting in total sanctions for repayment of $2,207,985.50. The sampling methodology has been challenged in a number of matters - <em>Saint</em> (yet to be heard) and <em>Matthews</em>. Court did not criticise sampling methodology but found that PSRC did not follow the procedures set out in the relevant Determination.</td>
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<td><strong>Recommendation 3:</strong> Act to be amended to provide a deeming provision in respect of high volume servicing per day. Once pattern of servicing specified in regulations is reached, practitioner deemed to have engaged in inappropriate practice unless exceptional circumstances have occurred.</td>
<td>s.106KA HI (PSR) Amendment Act 1999 – amended by Health Legislation Amendment Act (No. 3) 1999 Reg 11 HI (PSR) Regulations 1999 – Prescribed pattern of services</td>
<td>Based on data provided by Medicare Australia, the report of the 1999 Review Committee identified 100 practitioners with 80 or more attendances per day on 20 or more days in a 12 month period. Since the relevant legislative changes took effect on 1 August 1999, Medicare Australia has referred 23 practitioners (involving 30 matters) to DPSR for review. Of those requests, 2 matters have been resolved under s.92 (full disqualification for 6 weeks each and total repayment of $135,000.00). The DA has made final determinations in 7 matters - 5 full disqualifications totalling 44.5 months, 1 partial disqualification for 6 months and repayments totalling $531,378.40. Two matters are at PSRC hearing stage and 18 are affected by the decision in <em>Oreb</em>. One matter was dismissed at PSRC hearing stage as proper investigation was not possible due to inaccurate data provided by Medicare Australia.</td>
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<td><strong>Recommendation 4:</strong> Deeming provision will apply when practitioner provides 80 or more consultation services on 20 or more days of a year – general practice only</td>
<td>s.106KA HI (PSR) Amendment Act 1999 – amended by Health Legislation Amendment Act (No. 3) 1999 Reg 11 HI (PSR) Regulations 1999 – pattern of services</td>
<td></td>
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<tr>
<td><strong>Recommendation 5:</strong> Exceptional circumstances may relate, but not be limited to, the availability of alternative medical services or unusual occurrences.</td>
<td>s.106KA HI (PSR) Amendment Act 1999 – amended by Health Legislation Amendment Act (No. 3) 1999 Reg 11 HI (PSR) Regulations 1999 – Prescribed pattern of services</td>
<td>The 1999 Review Committee clearly considered that high levels of skill, competence and organisational arrangements would have little effect on a practitioner’s ability to practice appropriately when providing 80 or more consultation services for 20 or more days in a 12 month period (see pages 19 and 20 of that report). It was only in relation to ‘an exceptional event or a very extreme geographic circumstance’ that a practitioner might be considered to practice appropriately while rendering such a high number of services. The Courts have applied a more liberal approach to the interpretation of s.106KA and Regulation 11 and hence the original intent of the deeming provisions has not been met.</td>
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<tr>
<td>1999 Review Recommendation</td>
<td>Implementation</td>
<td>Effectiveness</td>
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<tr>
<td><strong>Recommendation 6:</strong> Deeming provisions will be specialty- and profession specific, be developed in consultation with relevant professional groups and be introduced in regulations.</td>
<td>Implemented in relation to general practice in consultation with AMA. Reg 11 HI (PSR) Regulations 1999 – Prescribed pattern of services</td>
<td>Deeming rules have been developed for practitioners practising in general practice. A mechanism to identify inappropriate practice among specialists and consultant physicians has been considered under this 2006 Review.</td>
</tr>
<tr>
<td><strong>Recommendation 7:</strong> If a GP is deemed to have engaged in inappropriate practice, quantum to be defined in terms of all consultation services on every day on which 80 or more consultation services were rendered, and where exceptional circumstances cannot be demonstrated.</td>
<td>s.106KA HI (PSR) Amendment Act 1999 – amended by Health Legislation Amendment Act (No. 3) 1999</td>
<td>In 8 of the 9 matters resolved under the deeming provision the full Medicare benefit paid in relation to each day on which 80 or more consultation services were rendered has been determined or agreed to be repaid in full.</td>
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<tr>
<td><strong>Recommendation 8:</strong> Act be amended so that a PSRC can make a finding of inappropriate practice in broad terms without identifying specific services or a number of services when:</td>
<td>s.106KB HI (PSR) Amendment Act 1999</td>
<td>This provision was introduced as a result of a specific case; however, there has not been any subsequent case in which a PSRC has needed to rely on this provision. Nonetheless, the provision identifies a set of circumstances which may occur in the future.</td>
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<td>- there are no clinical records or the records cannot be used; and</td>
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<td>- the finding is based on HIC data and evidence taken at the hearing; and</td>
<td></td>
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<td>- The finding focuses on particular categories of services.</td>
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**DETERMINATIONS**

<p>| <strong>Recommendation 9:</strong> Existing sanctions (counselling, reprimand, repayment of some or all of Medicare benefits and suspension from Medicare) be retained. | s.106U Health Legislation (PSR) Amendment Act 1994 s.106U HI Amendment Act (No. 1) 1997 | Of requests to DPSR since 1 August 1999, the Determining Authority has made 53 final determinations, all of which contain reprimand and counselling sanctions, 44 of those final determinations contain disqualification sanctions (totalling 180 months partial disqualification in 24 cases, 237 months full disqualification in 26 cases, no disqualification in 9 cases and one partial disqualification for 3 months under PBS). Total repayments of $3 120 471.65 were applied in 47 cases. Repayment was not imposed in 6 cases. |</p>
<table>
<thead>
<tr>
<th>1999 Review Recommendation</th>
<th>Implementation</th>
<th>Effectiveness</th>
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<tbody>
<tr>
<td><strong>Recommendation 10:</strong> In cases of high volumes of attendances per day by general practitioners and covered by the deeming provisions, Ministerial guidelines (see Recommendation 39) should provide for substantial periods of suspension from Medicare (e.g. periods of two years or more).</td>
<td>s.106Q(3) <em>Health Insurance Amendment (Professional Services Review) Act 1999</em></td>
<td>Disqualification sanction included in ss.106U(2A), (3) and (4) as being up to 3 years. Ministerial guidelines regarding periods of disqualification not yet drafted. This is because it was subsequently considered that any attempt at setting out guidelines could be seen to be proscriptive. Guidelines under the previous arrangements were not successful and it was decided to allow the DA to examine every case on individual merit and set sanctions according to the circumstances of each case and submissions.</td>
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<tr>
<td><strong>Recommendation 11:</strong> When a general finding is made as outlined in Recommendation 8, the sanctions must be limited to counselling, reprimand and/or suspension.</td>
<td>s.106U (particularly sub-para 106U(1)(ca)(ii)) <em>HI Amendment (Professional Services Review) Act 1999</em></td>
<td>There has not been any case in which a PSRC has needed to rely on this provision. See s.106KB and sub paragraph 106U(1)(ca)(ii).</td>
</tr>
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</table>

**EXPANDED AGENCY**

<table>
<thead>
<tr>
<th>Recommendation 12: The PSR Agency be expanded to include the functions of investigation, case preparation and administrative support for the proposed Determining Panel (DP).</th>
<th>Approval given for staff increases.</th>
<th>Staffing occurred as follows;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Year</td>
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<tr>
<td></td>
<td></td>
<td>ASL (funded)</td>
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<td></td>
<td></td>
<td>ASL (actual)</td>
</tr>
<tr>
<td>Recommendation 13: Additional funding be provided to permit the new PSR Agency to perform efficiently and effectively</td>
<td>Additional funding provided.</td>
<td>Funding has been sufficient to meet all requirements.</td>
</tr>
</tbody>
</table>
**Recommendation 14:** The process of referral be redefined in the HIA as a progressive action starting with a notification of a concern or concerns issued by the HIC to the DPSR and, after investigation, a formal referral from the DPSR to a PSRC.

**s.81 HI Amendment (PSR & Other Matters) Act 2002** – definition of ‘investigative referral’ repealed & definition of ‘referral’ amended

**Highly effective – process considerably simplified.**

**Recommendation 15:** A PSRC be able to raise new concerns which may become an additional referral by the DPSR provided that the PUR is given adequate notice and time to consider his or her responses.

**s.106J HI Amendment (Professional Services Review and Other Matters) Act 2002**

**There have not been any relevant cases.**

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

**More effective on-going processes involving Medicare Australia and professional groups is recommended following the 2006 PSR review.**

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**DIRECTOR OF PROFESSIONAL SERVICES REVIEW (DPSR)**

**Recommendation 17:** The HIA be amended to give the DPSR the power to require production of documents, and the power to refer concerns about a practitioner’s professional conduct to State and Territory Registration Boards.

**Production of Documents – s.89B HI Amendment (Professional Services Review) Act 1994**

**Power to refer professional conduct concerns – see Recommendation 32.**

S89B used in every case reviewed by DPSR. The power to disqualify from Medicare has been used on three occasions where the PUR has refused or failed to produce documents.

**Recommendation 18:** The DPSR be able to engage case officers, including clinical practitioner advisors, to perform the detailed examination of clinical records and other tasks for the effective work-up of a case for referral to a PSRC.

**s.90 Health Legislation (PSR) Act 1994**

**s.106ZM**

**Clinical practitioner advisers have been used since the changes were introduced. However, with reduced requests from Medicare Australia over the last 18 months there has not been any need to continue to use part time or full time clinical practitioner advisers.**

Eight trained, experienced staff (30% of PSR workforce) were retrenched in May – June 2005 due to lack of requests for review from Medicare Australia.

**Recommendation 19:** The HIA be amended to give the DPSR an option not to action HIC concerns, with the proviso that if the same practitioner is the subject of subsequent HIC concerns, the DPSR must action those subsequent concerns.

**s.88A & s.89 HI Amendment (PSR & Other Matters) Act 2002**

**There have not been any cases in this category.**

**Recommendation 20:** The HIA be amended to increase the powers of the DPSR to negotiate, but not approve,

**s.92 & s.106R HI Amendment (PSR) Act 1999, amended 2002 to delete para 92(1)(c)**

**Of requests to DPSR since 1 August 1999, 63 have been subject of s.92 agreements with repayments totalling $1 177 649.00 in respect of 41 matters. In 10 matters partial disqualification totalling 94**
<table>
<thead>
<tr>
<th>Recommendation 21:</th>
<th>Where a PUR acknowledges inappropriate practice and negotiates a settlement.</th>
<th>and enact s.92A</th>
<th>months was imposed and, in four matters, full disqualification totalling 42 months was imposed. In 18 matters reprimand alone was imposed. The DA has ratified all but one case resolved under s.92. That case was referred to a PSRC under s.93 with the resultant finding of no inappropriate practice. The ability of DPSR to require repayment of Medicare benefits as part of a s.92 agreement was not previously available. This was a new initiative introduced by the HI Amendment (PSR) Act 1999. Monies recovered by way of this initiative would not otherwise have been repaid.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendation 22:</td>
<td>The HIA be amended to specify that a negotiated settlement, once implemented, is considered to be a final determination for the purposes of s.106X of the HIA.</td>
<td>Para 92(4)(f) HI Amendment (PSR) Act 1999</td>
<td>All s.92 agreements include advice to this extent.</td>
</tr>
<tr>
<td><strong>ENHANCED LEGAL ASSISTANCE AND PROCESSES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommendation 23:</td>
<td>Legal case officers will assist the DPSR, the PSRCs and the DP. However, the same legal officer cannot be involved in more than one stage of a case (the stages being investigation, Committee and Determining Panel).</td>
<td>s.106ZM &amp; s.106ZPL HI Amendment (PSR) Act 1999, amended 2002 Act re ‘review’</td>
<td>This provision has been applied and is operating effectively.</td>
</tr>
<tr>
<td>Recommendation 24:</td>
<td>The PSRC and PUR be permitted to bring witnesses, other than character witnesses, who would be able to be questioned, subject to the discretion of the Committee, in relation to their evidence.</td>
<td>s.103 HI Amendment (PSR) Act 1999</td>
<td>Although rarely used, this provision is operating effectively.</td>
</tr>
<tr>
<td>Recommendation 25:</td>
<td>The PSRCs be provided with assistance from a legal adviser who will be available to the PSRC and attend PSRC hearings, but not take part in any decision making process.</td>
<td>s.81 Definitions &amp; s.106ZPL HI Amendment (PSR) Act 1999, amended 2002 Act re ‘review’</td>
<td>This provision is operating effectively.</td>
</tr>
<tr>
<td>Recommendation 26:</td>
<td>Members of PSRCs receive training in natural justice and other relevant legal issues.</td>
<td></td>
<td>Since 1999, nine 2-3 day training workshops have been held which were attended by 185 Panel members. Training included topics such as natural justice, questioning techniques, report preparation, report writing and decision making.</td>
</tr>
<tr>
<td>Recommendation 27:</td>
<td>Comprehensive procedural guidelines and operational protocols be developed for PSRCs.</td>
<td></td>
<td>Handbook for Committee members was developed in August 2000 and was revised in May 2003. Notes for Guidance relevant to PSR staff engaged on Committee work is in place.</td>
</tr>
<tr>
<td>Recommendation 28:</td>
<td>The legal adviser to the PUR be given the right to address the</td>
<td>s.103 HI Amendment (PSR) Act 1999</td>
<td>PUR legal advisers are utilising this change.</td>
</tr>
<tr>
<td><strong>PSRC</strong> on legal issues during the hearing and on the merits of the case as well as matters of law in a final address.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Recommendation 29:</strong> The PUR be given a copy of the draft PSRC report and be invited to make formal written submissions.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>s.106KD HI Amendment (PSR) Act 1999, amended 2002 Act re ‘1 month’</td>
<td></td>
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<tr>
<td>On all but rare occasions, submissions are being made by the PUR on receipt of the draft report.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Recommendation 30:</strong> The PSRC be required to take the submissions by the PUR into account in making its final report.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>s.106L(1) HI Amendment (PSR) Act 1999, amended 2002 Act re ‘1 month’ and to insert s.106L(1A)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The factual question of whether submissions were taken into account has been challenged in the Courts – see the response of Gray J in Piesse.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Recommendation 31:</strong> The final report of the PSRC be sent to the PUR and to the DP. The report will be sent to the DP not earlier than 28 days after it has been sent to the PUR to allow the PUR to exercise a right of appeal to the Federal Court on matters of law.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>s.106L(3) HI Amendment (PSR &amp; Other Matters) Act 2002 – legislated as ‘not earlier than 1 month’</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This provision is being complied with. The period of one month prior to a PSRC final report being sent to the DA is adversely impacting on the effectiveness and efficiency of the PSR Scheme by delaying finalisation of the case. Holding a report for one month serves no real purpose and simply delays the process by this period of time. S.106L(3) could be replaced with a requirement that, should the PUR apply to the Courts for review of a PSRC final determination which has been sent to the DA, then the DA process is suspended pending the outcome of that application and any subsequent appeals. There would then be no adverse impact on the appeal rights of the PUR.</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### REFERRAL OF PROFESSIONAL ISSUES

| **Recommendation 32:** The HIA be amended to empower the DPSR, PSRCs and the DP to refer concerns relating to significant threats to the life or health of persons to State/Territory registration bodies, and matters relating to the practitioner’s compliance with professional standards to relevant bodies. |
| s.106XA & s.106XB HI Amendment (PSR) Act 1999, amended 2002 Act re ‘review’ |
| Of requests to DPSR since 1 August 1999, 21 referrals concerning the conduct of 18 practitioners have been referred to relevant State or Territory registration bodies or medical boards in relation to concerns relating to possible significant threats to life or health of persons – s.106XA. Section106XB relates to the power to refer matters to a regulatory body concerning non-compliance by a practitioner with professional standards. The Regulations to specify those bodies is in the process of being introduced. |

| **Recommendation 33:** The HIA be amended to empower PSRCs to notify the HIC of matters of concern arising out of an inquiry, such as instances of doctor shopping. |
| s.106N HI Amendment (PSR) Act 1999 re fraud |
| One matter has been referred to Medicare Australia for suspected fraud. |

### DETERMINING PANEL (DP)

| **Recommendation 34:** The position of the Determining Officer (DO) be replaced by an independent DP serviced by an expanded PSR Agency. |
| s.106Q HI Amendment (PSR) Act 1999 |
| Determining Authority (DA) in place. |

| **Recommendation 35:** The DP comprises a permanent chair (medical practitioner), a |
| Division 5 Subdivision D, ss.106ZPA to 106ZPK |
| DA members appointed in 2000. Re-appointments completed in 2005 for five-year terms. Legal Counsel to DA has been re-tendered and... |
permanent lay person and a
third member who is a
representative of the profession
of the PUR, with a lawyer to
assist the Panel. Members to be
appointed by the Minister in
consultation with the AMA or
relevant bodies.

**Recommendation 36:** The
same DP be used for all cases
appropriate to the profession of
the PUR with allowances being
made for replacements in the
event of illness or other such
reasons.

**Recommendation 37:** The
PUR be given a draft
determination and be invited to
make formal written
submissions addressing
sanctions contained in the draft.

**Recommendation 38:** The DP
be required to take the
submissions of the PUR into
account in making a final
determination.

**Recommendation 39:** The HIA
t be amended to provide that the
Minister may, in writing, make
guidelines for the DP and that
decisions by the DP be
consistent with these guidelines.

**Recommendation 40:** All the
time periods contained in the
HIA for procedures under the
PSR Scheme be examined
jointly by the AMA and the

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**REVIEWED TIME PERIODS**

**Recommendation 40:** All the
time periods contained in the
HIA for procedures under the
PSR Scheme be examined
jointly by the AMA and the

---

**HI Amendment (PSR) Act 1999, amended 2002 Act re ‘agreement’ and ‘report’**

This provision is operating effectively. There have been few occasions where there has been a need to involve other medical members of the DA due to the unavailability of the member who usually attends. This has been kept to a minimum due to flexibility in meeting dates.

**s.106ZPH HI Amendment (PSR) Act 1999**

This provision is operating effectively. There have been few occasions where there has been a need to involve other medical members of the DA due to the unavailability of the member who usually attends. This has been kept to a minimum due to flexibility in meeting dates.

**s.106T HI Amendment (PSR) Act 1999, amended 2002 Act by inserting s.106SA (invite submissions before making draft determination) and consequential amendments to s.106T(1)**

Since the enactment of s.106SA in 2002 it is necessary for the DA, within month of receiving a PSRC report, to seek submissions from the PUR regarding sanctions which may be imposed. Those submissions are taken into account when making a draft determination at which later stage the PUR is again invited to make submissions regarding the proposed sanctions imposed in the draft determination – s.106T. Those further submissions are taken into account when making a final determination. Unfailingly, submissions provided in both instances, focus on the finding of the PSRC and complaints about that part of the Scheme.

Having been found by a PSRC to have engaged in inappropriate practice, it is proper and fair that the PUR should be given an opportunity to submit pleas in mitigation as to sanctions to be imposed as is provided by s.106SA. However, the additional need to invite submissions as imposed by s.106T is superfluous and simply adds delay to the process. Either s.106SA or s.106T should be repealed.

The right of the PUR to apply to the Courts, if dissatisfied with the DA final determination, is retained.

**s.106T(1) HI Amendment (PSR & Other Matters) Act 2002**

This provision is operating effectively.

**s.106Q(3) HI Amendment (PSR) Act 1999**

Ministerial guidelines not yet drafted.

The time required by Medicare Australia to work a matter to the point of making a request to review to DPSR is, on average, approximately 39 months. Similarly, the time required by PSR processes, including initial assessment, committee hearings and
<table>
<thead>
<tr>
<th>Recommendation 41:</th>
<th>The PSRT to be discontinued. However, review rights by the Federal Court on matters of law be maintained.</th>
<th>s.63 HI Amendment (PSR) Act 1999 repealed Part VA HI Act 1973 relating to PSR Tribunals</th>
<th>PSRT has been discontinued.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REVIEW RIGHTS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OTHER MATTERS</strong></td>
<td></td>
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</tr>
<tr>
<td>Recommendation 42:</td>
<td>Details of PSRC reports and DP decisions may be published, including names of the practitioners involved, when a final determination has been made, excluding cases where a negotiated settlement has been made.</td>
<td>s.106ZPR HI Amendment (PSR) Act 1999, amended 2002 Act to remove reference to ‘referred services’</td>
<td>Relevant details are published in DPSR Annual Report and the medical press. Publication has been shown to have a considerable deterrent effect. DPSR is also preparing a media release on conclusion of significant cases. A summary report has been sent to members of the profession shortly and may be produced annually.</td>
</tr>
<tr>
<td>Recommendation 43:</td>
<td>In all cases already within the PSR system on the date the revised legislation takes effect, transitional arrangements should be such as not to disadvantage the PURs in those cases.</td>
<td>s.118 HI Amendment (PSR &amp; Other Matters) Act 2002</td>
<td>This provision has operated effectively.</td>
</tr>
<tr>
<td>Recommendation 44:</td>
<td>The Government and the profession review the revised PSR Scheme no later than three years after it comes into effect.</td>
<td></td>
<td>Review now being undertaken. The Minister gave an undertaking to review after three years. Circumstances (court decisions and further legislative amendments) warranted this be delayed until now to enable proper examination of cases and proper assessment of the effects of legislative changes.</td>
</tr>
<tr>
<td>Recommendation 45:</td>
<td>The maintenance of adequate and contemporaneous medical records be a legislative requirement for the payment of Medicare benefits from 1 November 1999. The nature of this requirement will be the subject of further discussions between the profession and the Government.</td>
<td>s.82(3), s.81 Definitions HI Amendment (PSR) Act 1999 and Regulation 6 HI(PSR) Regulations 1999</td>
<td>Rather than impose a legal requirement for payment of benefits (a matter which Medicare Australia cannot ascertain at the point of payment) the legislation requires that a PSRC must have regard to this provision when making a finding of inappropriate practice – see s.82(3) and Regulation 6. Medical records are a clear indication of the quality of clinical practice and, along with other matters, this provision has been of great assistance to DPSR and PSRCs in determining inappropriate practice.</td>
</tr>
</tbody>
</table>

Government to see whether they are appropriately and realistically set taking into account the impact on the new PSR Agency of the proposed administrative arrangements.

DA decision averaged approximately 40 months. The detail of the processes within both Medicare Australia and PSR is being examined as part of the 2006 Review. Also, see comments regarding s.106SA at Recommendation 37.
Appendix 6 – Proposed revised Medicare Australia Practice Profile Review (PPR) process and PSR procedural arrangements

The Steering Committee agreed in principle that:

- It endorse the proposed revised Medicare Australia PPR process with one stage only (refer to figure below). Under the proposed new Practitioner Review Program (PRP), the current two stage process which takes approximately 39 months within Medicare Australia would be reduced to a single stage process taking approximately 14 -20 months. The following considerations are to be taken into account:

  - Providers have the option to be fast tracked at any stage of the PPR process to Medicare Australia’s Medical Director for s.86 referral to the Director PSR (DPSR).
  - Providers previously determined by PSR as having engaged in inappropriate practice will be fast tracked to Medicare Australia’s Medical Director with no review period.
  - Providers who present more than once with the same concern, for example, initiation of pathology or diagnostic imaging, or consultations rendered, will be fast tracked to Medicare Australia’s Medical Director with no review period.
  - The review period may be terminated at any time and the provider referred to Medicare Australia’s Medical Director if Medicare Australia has reason to believe that the concern(s) is/are escalating, for example, a data profile is becoming more different to peers or intelligence or complaints are received.

- In the transition to the new process, the current practitioner under review in the second stage is not to go back to the start of the assessment process.

- In future, Medicare Australia-captured data regarding the PRP process will be made available to the DoHA for relevant discussion purposes. DoHA to provide Medicare Australia with the reporting requirements for this data.

- Medicare Australia has advised that it has implemented the PRP one stage process as of 1 November 2006. The implementation of such a process is an internal administrative issue within Medicare Australia not requiring any legislative change.

Proposed revised procedural arrangements under the PSR Scheme

The Steering Committee agreed in principle that:

- It approve the proposed revised internal PSR process outlined below. The time taken for the proposed process, including initial assessment stage, committee hearing stage and Determining Authority (DA) stage, be reduced from approximately 40 months under the current process to approximately 18 months under the proposed arrangements.
A. Initial Review by PSR Process

Initial Review by PSR of general practitioners, specialists and other non-general practitioners follow the same reviewed procedural arrangements with the following considerations to be taken into account:

- The initial review of a GP by the DPSR is always going to be different and shorter than for a specialist or paramedical practitioner.
- In the case of a GP, the DPSR will usually undertake the review himself and form a view.
- When dealing with a specialist, or other non-GP practitioner, or where the DPSR otherwise considers it appropriate, the DPSR will retain the discretion to use a consultant and this may lengthen the process by several weeks.
- The option for a PUR to be fast tracked to a PSR committee be emphasised during the review process.
- In order to reduce the time required for the review process, PSR is to investigate further the proposal that the DPSR look at a small random sample of records sufficient to decide if a committee would be likely to find inappropriate practice. If the DPSR decides to refer the PUR to a committee, the committee may consider an appropriate random sample of records (see Tamberlin, J in Phan v Kelly [2007] FCA 269).

B. PSR Committee Process

- There is to be no change to current arrangements at PSR committees.

C. Determining Authority Process–

(i) Determining Authority (DA) process – s.92 agreement

- Due to Medicare Australia’s shift in portfolio responsibility to the Minister for Human Services, there is currently no mechanism to advise the Minister for Health and Ageing of a disqualification. PSR to add an additional box to the process chart indicating that PSR advises the Minister for Health and Ageing of a disqualification under s.19D once a relevant final determination takes effect.

(ii) Determining Authority process – PSR committee report

- There is merit in reducing the number of submissions a PUR can make to the DA from two to one as proposed in the revised DA process in order to reduce the DA process by at least 28 days. The following considerations are to be taken into account:
  - The PUR be able to provide a submission to the DA only on the draft determination.
  - DA to provide the PUR with a basic outline of a submission to assist them in writing their submission.

The Steering Committee notes that the only legislative change required would be the removal of the right of a PUR to make submissions prior to the DA’s draft determination (i.e. repeal s.106SA of the HIA). This change would be subject to legal advice as to the risk of successful legal challenges to the final determination.
Provider and concerns identified

CMC approves PPRP intervention

PPRP intervention: Letter → Interview (1 month) → Report prepared (1 month)

CMC considers report

Concerns addressed

Concerns remain Refer to Medical Director

Concerns remain: CMC approves review period → review period (6 to 12 months) → Report prepared (2 months)

CMC considers report

Concerns addressed

Medical Director Report prepared (1 month) Provider submission (1 month) MD considers [Total 2 months]

Concerns remain Request to Director PSR

Concerns addressed Matter closed

SINGLE STAGE
CONTINUED FROM PREVIOUS PAGE

Pre-hearing meeting → Hearing → Transcript received → Draft report prepared

Make draft determination. Send to PUR & seek submissions

PSRC report received by Determining Authority

Final report to PUR and Determining Authority

Submission received and considered

Draft report to PUR – seek submissions

Consider submissions, make final determination and send to PUR

Advise MA & DPSR of final determination and date of effect

Date of effect of final determination. S.19D advice to Minister by DPSR

Legend:
- DPSR Review Process
- PSR Committee Process
- Determining Authority Process
### Appendix 9 – Summary of outcomes (estimated)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Pre 99</th>
<th>Post 99</th>
<th>Subtotal</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Court</td>
<td>No court</td>
<td>Court</td>
</tr>
<tr>
<td><strong>Incomplete</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- In PSR</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- In committee</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- In court</td>
<td>1</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>- Court returned to PSR</td>
<td>0</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td><strong>Total incomplete</strong></td>
<td>1</td>
<td>0</td>
<td>26</td>
</tr>
<tr>
<td><strong>Complete</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Dismissed DPSR</td>
<td>0</td>
<td>42</td>
<td>0</td>
</tr>
<tr>
<td>- Agreement</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>- Committee inappropriate</td>
<td>24</td>
<td>46</td>
<td>7</td>
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<tr>
<td>- Committee NIP</td>
<td>1</td>
<td>17</td>
<td>1</td>
</tr>
<tr>
<td>- Dismissed by court</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total complete</strong></td>
<td>25</td>
<td>110</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>26</td>
<td>110</td>
<td>37</td>
</tr>
</tbody>
</table>

Appendix 10 – Key PSR legal cases

Yung v Adams

The first PSR referral, of Dr Yung, led to an examination of the new PSR Scheme by the Federal Court. The main issues raised were:

- Procedural deficiencies: The PUR was not afforded natural justice because the Professional Services Review Committee (PSRC) failed to indicate the adverse conclusions that might be reached. In addition, PSR and the PSR Tribunal (PSRT) had regard to matters outside the scope of the referral. PSRC did not particularise the case for the person under review (PUR) to answer.
- Evidentiary deficiencies: The PSRC was found to be in error by not relating its findings to identified services, and not undertaking a detailed consideration of individual services. The Full Court made it clear that a PSRC must reach an ultimate conclusion about some or all of the services specified in the referral.

The 1999 PSR Review recommended changes to the PSR Scheme in response to this case. All of these recommendations were implemented.

Mercado v Holmes

This case set boundaries to the Director PSR’s and the committee’s investigations. *Mercado v Holmes* held that a committee could not investigate the conduct of the PUR in providing services unless the conduct has been identified in the adjudicative referral (i.e. the referral from the Director of PSR (DPSR) to a committee). This severely limited the PSR Scheme as, for practical reasons, it was often not possible for the then HIC or the DPSR to identify conduct of concern ahead of the committee investigation.

Pradhan v Holmes

In response to *Mercado v Holmes*, all types of conduct were left open for investigation. This was held invalid in *Pradhan v Holmes* as the PUR could not know in advance the case to be met.

The decisions in *Mercado* and *Pradhan* prompted further refinements to the PSR Scheme such as those contained in the *Health Insurance Amendment (Professional Services Review and Other Matters) Act 2002*, Act No. 130 0f 2002, whereby:

(a) the Director of PSR:
- was empowered to review any or all of the services provided by the person under review during the review period;
- was empowered to undertake the review in such manner as the Director thinks fit; and
- was not limited by the reasons in the request from Medicare Australia.

(b) a PSR committee:
- was required to make findings only in respect of the ‘referred services’;
- was not required to have regard to conduct in connection with rendering or initiating all of the ‘referred services’ but may do so if the committee considered it appropriate; and

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60 *Yung v Adams* (1997) 80 FCR 453.
was not limited in its investigation of the ‘referred services’ by the reasons given in the Director’s report to the committee or by anything else in that report.63

As a result of this case, 30 referrals were dismissed and returned to Medicare Australia for reconsideration.64

*Health Insurance Commission v Grey*65

In this case, the court turned the focus to procedural fairness and the objectives of the PSR Scheme. It concluded that at all stages of the process, the legislation ensures that the practitioner is afforded procedural fairness and, in particular, is given an adequate opportunity to meet any concerns that may be raised.66 The case also confirmed that the PSR Scheme, while disciplinary in form, is not in the tradition of professional self-regulation but is public protective, with the objects of protecting patients and the Commonwealth from abuse of the system.

In response to the judgement, the 2002 legislative amendments enhanced procedural fairness options for the PUR and introduced an objects clause. Subsequent court decisions mostly seem to have reflected the Full Court’s approach to making the PSR Scheme more workable and fairer.

*Daniel v Health Insurance Commission*67

In terms of procedural fairness, *Daniel v Health Insurance Commission* found that s.106KA did not bind the then HIC or the DPSR to make a referral merely because the relevant statistical conditions were satisfied. Hence ‘80/20’ referrals should not be automatic and any other relevant considerations need to be taken into account.

Discussion about the 80/20 rule and court cases relating to its interpretation is found in section 3.11.

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63 See sections 88B and 106H(3) of the HIA.
## Appendix 11 – Bodies involved with Medicare benefit items

<table>
<thead>
<tr>
<th>Group</th>
<th>Membership</th>
<th>Description of duties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Benefits Consultative Committee</td>
<td>Representatives from DoHA, Medicare Australia, AMA and relevant craft groups.</td>
<td>Provides a forum for discussion on and review of particular services within the MBS.</td>
</tr>
<tr>
<td>(MBCC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Services Advisory Committee (MSAC)</td>
<td>The membership of MSAC comprises a mix of clinical expertise covering pathology, surgery, specialist medicine and general practice, plus clinical epidemiology and clinical trials, health economics, consumers, and health administration and planning.</td>
<td>Advises the Minister on the safety, effectiveness and cost effectiveness of new and emerging medical services and technologies and under what circumstances funding by Medicare should be supported.</td>
</tr>
<tr>
<td>Medicare Claims Review Panel</td>
<td>Representatives from Medicare Australia and DoHA.</td>
<td>Reviews claims for services requiring a demonstrated clinical need before Medicare benefits are payable. The Panel does not have any discretion under the HIA to permit payment for services that do not accurately fulfil the item descriptor.</td>
</tr>
</tbody>
</table>
Appendix 12 – Recent initiatives extending MBS eligibility

Medicare Allied Health and Dental Care initiative
The Medicare Allied Health and Dental Care initiative commenced on 1 July 2004. It provides for Medicare benefits to be paid for certain services provided to people with chronic conditions and complex care needs by eligible allied health professionals, dentists and dental specialists. These services are available to people who are being managed by their general practitioner under an Enhanced Primary Care (EPC) plan. Eligible patients are entitled to five allied health services per year and/or three dental services per year.

Under this initiative, eligible allied health services can be paid a Medicare benefit under certain items. Allied health professional groups whose services are eligible for payment of Medicare benefits are:

- Aboriginal health workers;
- audiologists;
- chiropodists;
- chiropractors;
- diabetes educators;
- dieticians;
- exercise physiologists;
- mental health workers, including mental health nurses and social workers;
- osteopaths;
- physiotherapists;
- podiatrists;
- psychologists;
- occupational therapists; and
- speech pathologists.68

Eligible dental services can be paid a Medicare benefit under MBS Group M4, Items 10975-10977. In 2005-06, approximately 536,000 allied health and dental services were provided under these arrangements, with total benefits of around $25 million being paid through Medicare.69

Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (MBS) initiative
This initiative introduced new Medicare services on 1 November 2006 to provide increased community access to mental health professionals and team-based mental health care.

The GP Mental Health Care items provide a structured framework for GPs to undertake early intervention, assessment and management of patients with mental disorders, and provide new referral pathways to clinical psychologists and other allied mental health service providers. A new GP Mental Health Care Consultation item is also available for GPs to provide continuing management of patients with mental disorders. The GP items are available to medical

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68 The arrangements under the Medicare Allied Health and Dental Care initiative are outlined in Medicare Benefits Schedule Allied Health and Dental Services Effective 1 November 2006.

practitioners (including general practitioners, but not including specialists or consultant physicians).

Under the Better Access initiative, patients with an assessed mental disorder may be referred for up to 12 individual and/or 12 group allied mental health services per calendar year by:
• a medical practitioner managing the patient under a GP Mental Health Care Plan or under a psychiatrist assessment and management plan; or
• a psychiatrist or paediatrician.

Allied mental health services under this initiative include psychological assessment and therapy provided by eligible clinical psychologists and focussed psychological strategies provided by eligible psychologists, social workers and occupational therapists.
Appendix 13 - Membership of the Steering Committee

Mr David Learmonth (Chair)
Deputy Secretary
Department of Health and Ageing

Dr Robyn Mason
Secretary General
Australian Medical Association

Ms Philippa Godwin
Deputy Chief Executive Officer
Government Relations and Program Integrity

Dr Tony Webber (co-opted member)
Director
Professional Services Review

Consultant

Dr W Coote

Secretariat

MBS Policy Implementation Branch
Department of Health and Ageing