PROFESSIONAL
SERVICES REVIEW

DIRECTOR
Dr Tony Webber

Dear Dr Holland,

Professional Services Review's submission to the Senate Community Affairs Inquiry

Please find attached the Professional Services Review (PSR) Agency's submission to the Senate Community Affairs Committee and associated relevant attachments.

PSR was established in July 1994 as an Agency within the Health Portfolio to protect the integrity of Medicare and the Pharmaceutical Benefits Scheme. Through the performance of its statutory role, PSR protects patients and the community from the risks associated with inappropriate practice, and protects the Commonwealth from having to meet the cost of health services provided as a result of inappropriate practice.

Throughout 2011 PSR has been working with key stakeholders, particularly the Department of Health and Ageing, Medicare Australia and the Australian Medical Association, to enhance the administration of the Scheme. Substantial improvements have been discussed through the PSR Advisory Committee, and this work is ongoing.

Some of the major activities in 2011 include:

i. publishing a resource guide to assist practitioners who come before the Scheme entitled "*Your guide to the PSR Process*"(Appendix A to our submission)
ii. agreeing to "*Guidelines for the Appointment of Medical Practitioners as Panel Members, Deputy Directors and Consultants to Professional Services Review Matters*" to formalise the criteria and process for future appointments (Appendix B to our submission)
iii. developing Guidelines on selecting specific Committee Members to sit on a peer review panel
iv. amending the review meeting process and invitation to provide greater clarity on the purpose of the meeting and its role in assisting the Director during his or her review
v. agreeing to work with the profession to develop a new format for the *'Report to the Professions'*.

It is of some significance that I make this submission on my final day after six and a half years as the Director of PSR. As of Monday a new Director will be in the role.

I would like to advise that I am available to appear before the Committee and answer any questions the Committee may have.

Yours sincerely,

Dr Tony Webber
Director
12 August 2011

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Australian Government

Professional Services Review

Submission to the Senate Community Affairs Committee for the Inquiry into the Professional Services Review Scheme

August 2011

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Background

On 6 July 2011 the Senate referred the following matter to the Senate Community Affairs Committee for inquiry and report:

> *A review of the Professional Services Review (PSR) Scheme provided for under the Health Insurance Act 1973 (the Act) which is responsible for reviewing and investigating the provision of Medicare or Pharmaceutical Benefits Scheme services by health professionals, with particular reference to:*
>
> *(a) the structure and composition of the PSR, including:*
> - *(i) criteria for selection of the executive and constituent members encompassing their experience in administrative review proceedings,*
> - *(ii) the role of specialist health professionals in assisting in cases where members lack relevant specialist expertise, and*
> - *(iii) accountability of all parties under the Act;*

> *(b) current operating procedures and processes used to guide Committees in reviewing cases;*
> *(c) procedures for investigating alleged breaches under the Act;*
> *(d) pathways available to practitioners or health professionals under review to respond to any alleged breach;*
> *(e) the appropriateness of the appeals process; and*
> *(f) any other related matter.*

On 28 July 2011 Dr Ian Holland, Secretary to the Community Affairs Committee invited the Director of PSR, Dr Tony Webber to provide a written submission to the Committee addressing the terms of reference for the Inquiry. PSR is pleased to provide the below submission on the PSR Scheme to assist the Committee in its Inquiry.

The PSR Scheme

Context

1. Through the Medicare program and Pharmaceutical Benefits Scheme (PBS) the Commonwealth provides access to subsidised health services to assist Australians meet the costs of specified medical, optometric, dental, surgical, and allied health services and listed pharmaceuticals.
2. The Medicare and Pharmaceutical Benefit programs set out the financial amount (benefits) that the Australian Government is prepared to reimburse patients for specified medical services (MBS items) and to contribute to the costs of prescription drugs (PBS items).
3. To access the Medicare program practitioners self-determine which service they have provided in light of the MBS items and consequently what benefit they or their patient is entitled to receive.
4. Similarly when providing a prescription for a pharmaceutical item covered by the PBS, practitioners self-determine that the patient is entitled to receive the medicine and that the Commonwealth is consequently liable for the relevant PBS benefit amount.
5. Whilst the vast majority of practitioners comply with the rules of Medicare and the PBS, there is a risk that a small minority may seek to provide unwarranted or unnecessary medical services or prescriptions to patients. Similarly some practitioners may provide a reduced or limited level of health service than would otherwise be expected of a practitioner claiming that specific health service item. These two risks can lead to:
    i. The Commonwealth funding, and patients being exposed to, unnecessary and unjustified medical services

    and

    ii. The Commonwealth funding, and patients being exposed to, inadequate medical services.

Establishment of the PSR Scheme

6. In July 1994 the Professional Services Review (PSR) Scheme was established by amendment to the *Health Insurance Act 1973* (the Act) after close consultation with the medical profession.
7. The PSR Scheme is part of a strong regulatory regime to ensure that clinically appropriate services are delivered through the Medicare and PBS programs.
8. As a key player in the protection of Medicare and the PBS, PSR shares responsibility for protecting the integrity of a significant quantum of Commonwealth funds. In the 2010-11 financial year:
    i. 319.1 million MBS claims valued at $16.4 billion were made and processed through the Medicare system
    ii. 201.5 million PBS claims valued at $8.4 billion were made and processed through the PBS system.
9. The number of practitioners accessing Medicare and the PBS continues to grow. At 30 June 2011 Medicare Australia was reporting that 94,853 practitioners were accessing the Medicare Program.

Financial Year	2005-06	2006-07	2007-08	2008- 09	2009-10	2010-11
MBS services processed	247.4m	257.9m	278.7m	294m	308.4m	319.1m
MBS benefits paid	$10.9b	$11.8b	$13.1b	$14.3b	$15.4b	$16.4b
PBS services processed	183.3m	183.1m	185.3m	196m	197.7m	201.5m
PBS benefits paid	$6.3b	$6.5b	$7.0b	$7.7b	$8.3b	$8.4b

Figures taken from Medicare Australia Annual Reports 2005-06 to 2009-10 and figures provided by Medicare Australia for 2010-11

10. The Australian Government, through PSR, aims to safeguard the public against the risks and costs of inappropriate practices by practitioners. The role and functions of PSR are set out in Part VAA of *the Health Insurance Act 1973*, which establishes the PSR Scheme. It states at section 79A that:

> *"The object of this Part is to protect the integrity of the Commonwealth Medicare benefits and pharmaceutical benefits programs and, in doing so:*
>
> *(a) protect patients and the community in general from the risks associated with inappropriate practice; and*
>
> *(b) protect the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice"*

11. The Act provides the legislative framework within which:
    i. the Director of PSR reviews a practitioners rendering or initiation of MBS and PBS services upon request from Medicare Australia
    ii. a peer review Committee reviews the provision of services by a practitioner for inappropriate practice
    iii. the Determining Authority applies sanctions in instances where a practitioner is found to have engaged in inappropriate practice.

12. Under the PSR Scheme there is a two-pronged approach to safeguarding the integrity of the Medicare and Pharmaceutical Benefits programs. These are to:
    i. protect the public from inappropriate practice by ensuring that the Commonwealth funded services delivered by practitioners are medically necessary and clinically relevant.
    ii. 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 – specifically that the service that has been provided is adequate in light of the associated requirements for the payment claimed.

13. The compliance activities within Medicare Australia cannot fully identify and address compliance matters that require the use of medical professional judgement. This is because Medicare Australia does not have the authority or expertise to determine the clinical relevance or appropriateness of MBS or PBS services that have been claimed.
14. Whilst Medicare Australia's compliance audit process can assess the factual accuracy of a claim (i.e. whether a patient attended, or a test was performed) it cannot make the same professional judgements that a Committee of peers authorised within the PSR Scheme can (i.e. whether the patient received an adequate service, or that the service performed was required).
15. Medicare Australia's role in monitoring and managing inappropriate practice is the identification and referral of potential inappropriate practice to the Director of PSR under section 86 of the Act.

The PSR Process

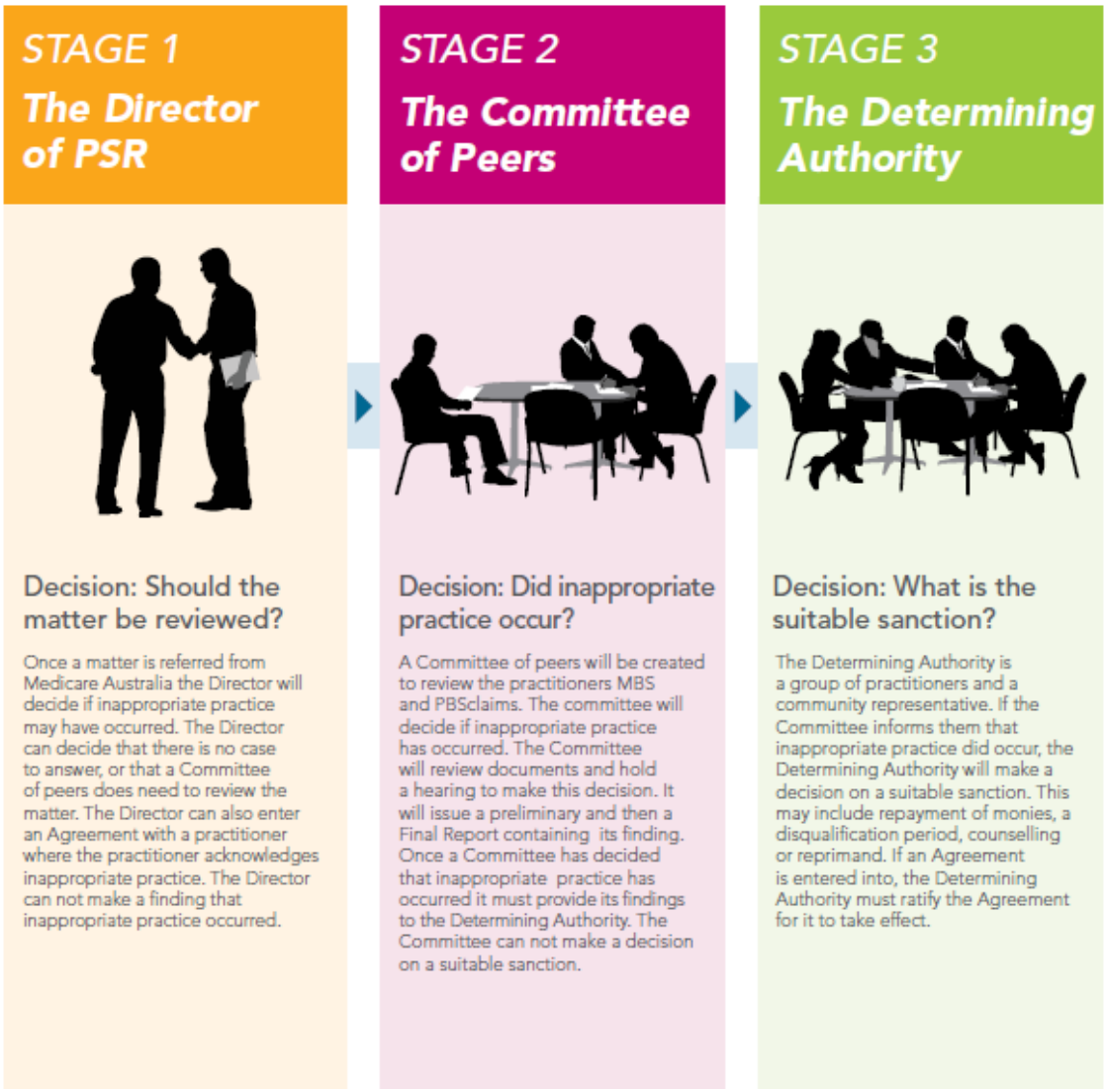
16. The PSR Scheme has continued to evolve since its inception. Legislative amendments were made in 1997, 1999, 2002 and 2006 to strengthen and clarify the professional review process and address evidentiary difficulties. Comprehensive reviews conducted in 1999 and 2006 by Government and key stakeholders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

17. The PSR Scheme provides for the separation of the three elements of the decision-making process and is comprised of three main stages.

    1. The first stage involves the consideration by the Director of PSR of whether there is sufficient evidence that would enable a Committee of peers to determine if inappropriate practice may have occurred. Alternatively, if the practitioner is willing to acknowledge inappropriate practice, the practitioner and the Director may seek to negotiate an Agreement.

    2. The second stage is a peer review process by a PSR Committee (Committee) to determine if inappropriate practice has occurred.

    3. The third and final stage involves the consideration and setting of an appropriate outcome by the Determining Authority.



Information about the PSR Scheme

18. PSR recognises that the PSR process set out in Part VAA of the Act has the potential to be confusing to some practitioners who are referred into the Scheme. Two out of three practitioners who come before the PSR Scheme have a legal adviser to assist them through the process and PSR actively encourages practitioners to seek advice and assistance throughout the process.

19. Throughout 2011 PSR has worked closely with the medical profession to increase the information it provides on the Scheme. This led the Agency to publish a 66 page resource guide on the PSR process titled *Your Guide to the PSR Process* on 7 July 2011.

20. *Your Guide to the PSR Process* is intended to be a comprehensive support tool for practitioners and other stakeholders to understand the Scheme and was produced in collaboration with the Australian Medical Association (AMA) following advice from the PSR Advisory Committee.

21. The resource guide provides practitioners under review with a detailed explanation of each step in the PSR process so that they know what to expect when they are reviewed by PSR.

22. It includes information in response to commonly asked questions as well as general guidance. The document also contains information on each of the three key stages that make up the PSR Scheme including:

    i. the key decisions that are made in relation to a matter throughout the various stages of the process

    ii. a practitioners rights and responsibilities during each stage of the process

    and

    iii. when and how a practitioner will have opportunities to present their case.

23. PSR has commenced the process of providing a hardcopy version of the Guide to practitioners upon their referral to PSR, and has also made the book publicly available on our website.

24. It is envisaged that this document will be reviewed regularly to meet the changing needs of practitioners and other stakeholders and to maintain its relevance. PSR intends to review the resource guide before the end of 2011 to include any further feedback provided on the document.

25. *Your Guide to the PSR Process* is attached as **Appendix A** to this submission.

Referrals to the Director of PSR

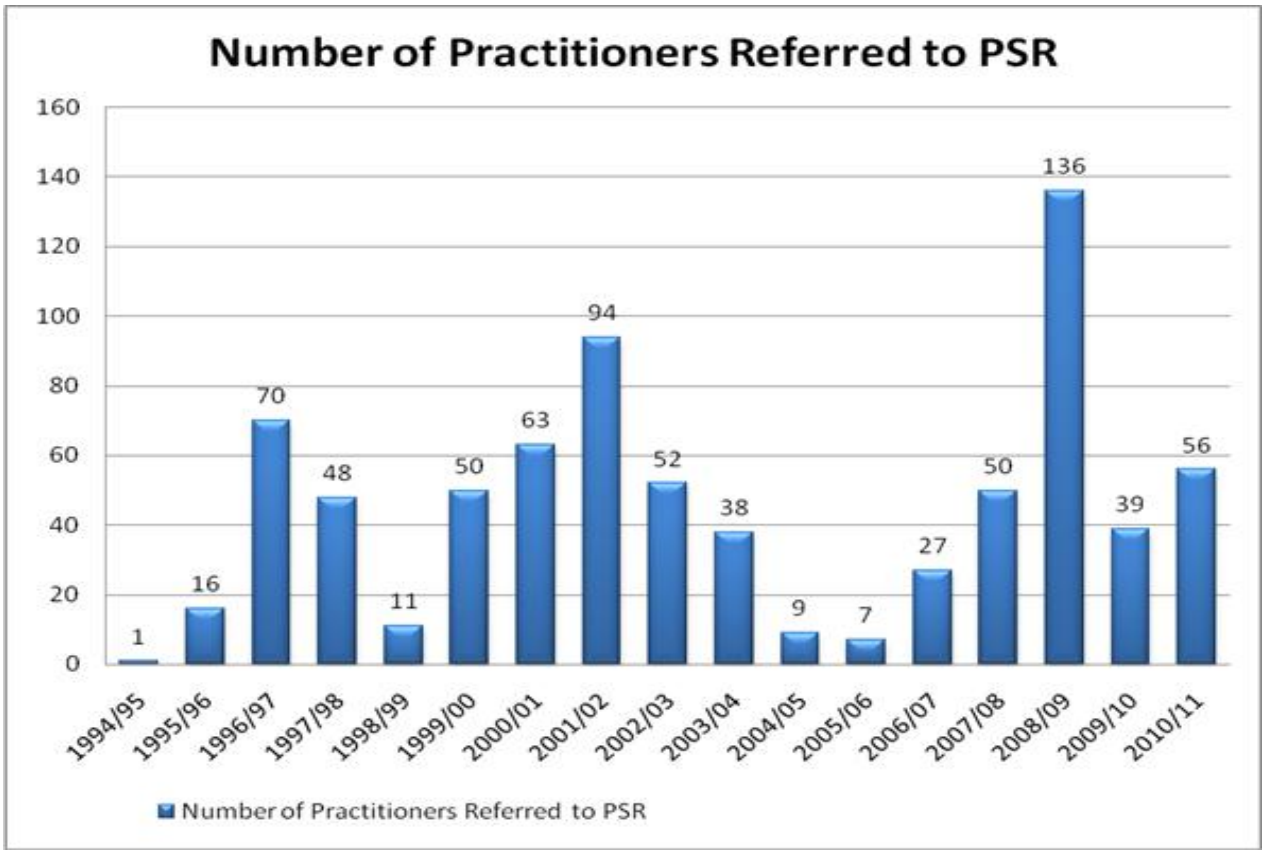
26. The PSR process begins when Medicare Australia requests the Director to undertake a review of the provision of services by a practitioner over a specified period.

27. Under section 81 of the Act persons reviewed and investigated by the Scheme can be practitioners engaged in one of the following professions:

    (a) medicine
    (b) dentistry
    (c) optometry
    (ca) midwifery
    (cb) the practice of a nurse practitioner
    (d) chiropractic
    (e) physiotherapy
    (f) podiatry
    (g) osteopathy.

28. The practitioners reviewed by PSR must all be referred to the Director by Medicare Australia. PSR cannot identify or select practitioners for review.

29. Since the establishment of the PSR Scheme, Medicare Australia has referred 767 practitioners to the Director for possible review. Despite some significant fluctuations in the referrals across years, the long term average is 45 practitioners referred per annum.



Figures taken from PSR Annual Reports 1994-95 to 2009-10 and internal case monitoring for 2010-11

30. Practitioners come to PSR after being identified through statistical analysis and being reviewed by Medicare Australia as part of its Practitioner Review Program.

31. It is important to note that the small number of practitioners referred to PSR are generally operating at the top end of Medicare servicing and PBS prescribing (either in total or for specific types of funded services) and the appropriateness of this claiming requires consideration by the practitioners peers. Since establishment and after investigation, 33 per cent of completed matters are dismissed as not being of concern.

32. Practitioners referred to PSR generally have a claiming profile which is anomalous or has distinct outlying features when compared to their peers. Examples of the types of concerns which Medicare Australia refers to PSR include:

    i. high volume of total services per patient when compared to the practitioners peers

    ii. disproportionate amount of MBS services or PBS prescriptions compared to professional attendances

    iii. disproportionate amount of prescriptions for drugs of dependence compared to professional attendances

    iv. disproportionate amount of pathology or diagnostic imaging services initiated compared to professional attendances

    v. overall pattern of MBS items claimed is distinctly different from the practitioners peers.

Review by the Director of PSR

33. When the Director receives a request from Medicare Australia, he or she must decide whether to conduct a Review within one month. At this stage of the process the Director is making a decision of whether or not the referral is valid and the statistical information provided by Medicare Australia indicates that a review is required.

34. If the Director decides to undertake a review of the practitioners rendering or initiation of MBS services or PBS prescribing he or she may review all services that the practitioner has provided in the review period or may make a decision based on a selected sample. The Director's review is

not limited to the services listed in the referral by Medicare Australia however, only services provided during the review period can be considered.

35. The purpose of the Director's review is to determine if there is sufficient evidence for a peer review Committee to conduct an inquiry into the practitioners rendering or initiation of MBS services or prescribing of PBS medicines.
36. The Director has no legal ability to make a determination that a practitioner has engaged in inappropriate practice.
37. If the Director decides to review a practitioner he or she will request the production of clinical records relating to the services being reviewed by issuing a legal instrument referred to as a 'Notice to Produce' on the practitioner or another third party under section 89B of the Act. The production of documents listed is a legal requirement, and failure to produce documents requested in a valid notice can result in disqualification from Medicare. The practitioner will be given a due date for supplying the clinical records which must be at least 14 days after the day the practitioner receives the Notice.
38. Once the Director has received the medical records he or she may then seek to meet with the practitioner at a review meeting designed to facilitate an exchange of information on the reasons for the review and the Director's initial view on the clinical records. The meeting is an opportunity for the practitioner to provide a verbal explanation of their practice to the Director prior to any decision being made.
39. In revised processes recently endorsed by the AMA, PSR has agreed to alter the meeting invitation that is sent to practitioners to include more detailed information on the Director's preliminary views following the review of the practitioner's clinical records.
40. The Director uses the practitioner's clinical records and information provided by the practitioner in the review meeting to prepare an 89C report containing his or her preliminary decision on how the case should proceed. The options available to the Director are to:
    i. take no further action
    ii. seek to negotiate an Agreement under section 92 of the Act

        or

    iii. refer the practitioner to a peer review Committee.
41. Practitioners have one month from the date of receiving the Report to send their submission to the Director, and following receipt of the submission the Director will make a decision on the appropriate course of action in the case.
42. If the Director decides to take no further action, the matter will be closed.

Negotiated Agreements under Section 92

43. The entering of a Negotiated Agreement between the practitioner and the Director under section 92 of the Act can only be used when the practitioner is prepared to acknowledge that he or she has engaged in inappropriate practice in relation to specific MBS or PBS items.
44. There is no obligation for any practitioner to enter into a Negotiated Agreement with the Director.
45. The Negotiated Agreement is a binding decision containing the acknowledgement of specific instances of inappropriate practice and what sanctions will apply in relation to the matter (ranging from reprimand, repayment of benefits, full or partial disqualification from Medicare or removal of the practitioners authority to prescribe or dispense PBS medicines for an agreed period of no more than three years).
46. As a part of the Negotiated Agreement process, practitioners have the opportunity to negotiate with the Director on what they consider to be suitable terms of the agreement in their case.
47. If an Agreement cannot be reached or if the practitioner does not believe that he or she has engaged in inappropriate practice, the matter will be referred to a peer review Committee for consideration.

48. If the practitioner and Director do reach a Negotiated Agreement it is signed by both parties and sent to the Determining Authority for ratification.

Review by a Committee of Peers under section 93

49. If the Director considers that the conduct of the practitioner requires investigation or a Negotiated Agreement cannot be reached, a Committee of the practitioner's peers will be established to make a decision on whether the practitioner engaged in inappropriate practice.

50. A PSR peer review Committee is the only body that can determine that a practitioner engaged in inappropriate practice. To do this the Committee will consider whether the practitioner's clinical decisions in providing MBS and PBS services were appropriate for the patient and whether they meet the requirements of the Medicare item descriptor and or any PBS restrictions as well as assessing the adequacy of clinical records.

51. In making appointments of Panel members and Deputy Directors to a Committee the Director must comply with the requirements of section 95 of the Act outlined at paragraph 113 of this submission.

52. When appointing a PSR Committee the Director follows a number of guiding principles, for example where possible, the Director seeks to appoint a Committee Chair and Members who are:

    i. from the same specialty as the practitioner

    ii. from the same State

    iii. able to balance the gender, cultural diversity and experience of the Committee in light of the practitioner's own background

    and

    iv. able to advise that they are free from any known possibility of bias or conflict of interest.

53. PSR and the AMA are currently developing Guidelines for the selection of specific Panel members and Deputy Directors to PSR Committees to guide future appointment processes. This is further detailed at paragraph 107 of this submission.

54. Once a Committee has been formed the practitioner is advised of the identity of each of the Committee members and has the opportunity to challenge the appointment of any Committee member on the grounds of bias.

55. Once the Committee has been established, it will meet to decide if a hearing is warranted and which Medicare services and PBS items it will examine. The Committee will then request clinical records for a sample of services the practitioner provided or initiated during the review period under section 105A of the Act.

56. If, after considering the information provided, the Committee forms a preliminary view that the practitioner may have engaged in inappropriate practice, a hearing will be held.

57. The hearing provides the practitioner with the opportunity to present both oral and written evidence to support their case. All conversations and statements made during a Committee Hearing are recorded.

58. The Committee's role during the hearing is to collect information that will assist it to determine whether the practitioners conduct in connection with the rendering or initiation of services would be unacceptable to the general body of the practitioner's peers.

59. The majority of a PSR peer review Committee hearing involves the Committee members questioning the practitioner about specific services he or she has provided, and the clinical records that have been reviewed. The purpose of the questioning is to obtain evidence relevant to the Committee's investigation on whether the services provided were justified and appropriate in light of the Medicare item descriptor and / or PBS requirements, as well as assessing the adequacy of the practitioners clinical records.

60. Under section 103 there are a number of rights practitioners have during the Committee hearing, including the right to:

    i. be accompanied by a lawyer or another adviser

ii. call witnesses to give evidence (other than evidence providing reference to the practitioner's character)

iii. produce written statements providing reference to the practitioner's character

iv. question a person giving evidence at the hearing

v. address the Committee on questions of law arising during the hearing

vi. after the conclusion of the taking of evidence, make a final address to the Committee on questions of law, the conduct of the hearing and the merits of the matters to which the hearing relates. This includes addressing the Committee on questions of clinical practice.

61. The practitioner's legal adviser or other adviser also has rights including the right to:

i. provide the practitioner with advice during the hearing

ii. address the Committee on questions of law that may arise during the hearing (if they are a legal adviser)

iii. after the conclusion of the taking of evidence, make a final address to the Committee on questions of law (if they are a legal adviser), the conduct of the hearing and the merits of the matters to which the hearing relates.

62. After the hearing is completed the Committee will produce a Draft Report containing its preliminary findings on the practitioners conduct. The Draft Report will contain:

i. a summary of the case to date

ii. details of the information and evidence the Committee has considered

iii. reasons for the Committee's decision to reject or give weight to some evidence

iv. the Committee's findings and reasoning regarding where it has or has not found inappropriate practice.

63. If the Committee finds no inappropriate practice the Draft Report becomes the Final Report and the case will be closed. If the Committee finds that inappropriate practice has occurred, the practitioner will receive an invitation to make a submission on the Draft Report. The invitation to make a submission provides the practitioner with an opportunity to suggest changes to the Draft Report including providing additional information or correcting any matter where he or she feels the Committee has failed to take into account relevant evidence, made an incorrect conclusion or any other matter.

64. The Committee will consider any submission the practitioner makes in response to the Draft Report, and produce a Final Report containing its final decision. The Final Report will include an explanation of how the practitioner's submissions were considered.

65. Once it is made the Committee will send the Final Report to the practitioner and provide the practitioner one month in which they may seek judicial review.

66. Following this one month period the Committee will send the Final Report to the Determining Authority. The Determining Authority will then decide what sanctions will apply in the case.

Determining Authority

67. The Determining Authority is an independent body within the Professional Services Review Scheme. The Determining Authority has two main functions, which are to:

i. decide whether to ratify section 92 Negotiated Agreements reached between the Director of PSR and a practitioner

and

ii. determine what sanctions to apply whenever practitioners have been found to have engaged in inappropriate practice by a Peer review Committee.

68. The Determining Authority consists of a minimum of three members including:

i. a Chair, who is a medical practitioner

ii. a member who is not a practitioner (i.e. is a member of the public)

and

iii. a member who is a practitioner in the same profession as the practitioner.

69. Meetings of the Determining Authority are held in private and decisions of the Determining Authority are reached by majority vote.

70. The Determining Authority has one month to make a decision to ratify a section 92 Negotiated Agreement after it has been referred. To make this decision the Determining Authority will consider if the terms of a Negotiated Agreement are fair and consistent with similar past cases. Part of the Determining Authority's role is to ensure that neither the practitioner, nor the Director, have made an unfair Agreement and that the outcome is suitable. Based on their assessment the Determining Authority will decide to either ratify or refuse to ratify the Agreement and will advise the practitioner, and the Director, in writing of its decision within 7 days.

71. When a Committee makes a finding of inappropriate practice against a practitioner, the Determining Authority will invite submissions from the practitioner on the sanctions it should impose. The Determining Authority will then make a Draft Determination which includes:

i. the preliminary decision on the sanctions that should apply

ii. the reasons for the decision

and

iii. details of the material the Determining Authority has relied on in making its decision.

72. The Determining Authority must impose one or more of the following sanctions set out in section 106U of the Act:

i. a reprimand

ii. counselling

iii. partial disqualification from claiming a Medicare benefit for no more than 3 years

iv. full disqualification from claiming a Medicare benefit for no more than 3 years

v. an order for repayment of any Medicare benefits for services provided in the review period which have been found as being provided inappropriately

vi. a full disqualification from the PBS for no more than 3 years.

73. Practitioners are given an opportunity to make written submissions on the Draft Determination. The Determining Authority will consider this submission and then make a Final Determination. The Final Determination will include:

i. the Determining Authority's final decision on the sanctions that should be applied

ii. the reasons for the decision

iii. details of the material the Determining Authority relied on in making its decision including any submissions the practitioner made.

Appeal Process

74. At any time in the PSR process the practitioner being reviewed can seek judicial intervention or review in the Federal Court or the Federal Magistrates Court, in accordance with the *Administrative Decisions (Judicial Review) Act 1977* (ADJR Act).

75. The grounds of review, set out in the ADJR Act, include that:

i. the decision was not authorised by the *Health Insurance Act 1973*

ii. the decision involved an error of law

iii. that a breach of the rules of procedural fairness/natural justice occurred

iv. that the procedures required by law were not observed

v. that irrelevant considerations were taken into account or there was a failure to take relevant considerations into account

vi. that the exercise of power by the decision maker was so unreasonable that no reasonable person could have so exercised it.

76. The rules of procedural fairness are that:

i. there must be no actual or apparent bias in the decision-making process, i.e. the process must operate with complete impartiality and must be seen as not involving any element of prejudgment

and

ii. when a decision is to be made which may deprive a person of some right or interest or lead to loss of reputation or livelihood, the person is entitled to know the case against him or her and must be given an opportunity of replying to it.

77. The remedies the court may grant in judicial review include:

i. granting an injunction to stay proceedings

ii. setting a decision aside

iii. remitting the case to the Committee or to a new Committee for re-consideration

iv. declaring the rights of parties.

78. Over the last 5 years there have been 14 Federal Court appeals.

Outcomes and Effectiveness of the PSR Scheme

79. Since 2004-05 PSR has received 324 requests to review from Medicare Australia and has completed 339 matters (some carried over from previous financial years).

80. Outcomes from 2004-05 to 2010-11 include:

i. Decision to take no further action taken in 70 matters (21 per cent of matters)

ii. Negotiated and entered into 166 Agreements in which a practitioner acknowledged inappropriate practice (49 per cent of matters)

iii. Made 103 final determinations in which a practitioner was found to have engaged in inappropriate practice by a Committee of their peers (30 per cent of matters).

Year	No Further Action	Negotiated Agreement	Final Determination following Peer Review Committee	Completed Cases
2004/05	15	11	26	52
2005/06	0	8	14	22
2006/07	1	6	14	21
2007/08	7	27	6	40
2008/09	19	33	9	61
2009/10	17	49	28	94
2010/11	11	32	6	49
TOTAL	**70**	**166**	**103**	**339**

Figures taken from PSR Annual Reports 2004-05 to -2009-10 and internal case monitoring for 2010-11

81. Since establishment, 33 per cent of completed matters have been dismissed as not being of concern, 37 per cent have resulted in a Negotiated Agreement and 30 per cent of matters have resulted in a final determination following review by a Committee of peers.

Repayments

82. From 2004-05 to 2010-11 PSR ordered repayments of inappropriately rendered or initiated services or inappropriately prescribed PBS medicines totalling $15.9 million. This comprised:
    i. Negotiated Agreements - $8,959,551.46
    ii. Final determinations following a Committee finding - $7,007,585.69.

Disqualifications and Suspensions

83. From 2004-05 to 2010-11, 191 practitioners were suspended from access to Medicare and / or the PBS (approximately 56 per cent of all completed matters) as a result of coming before PSR. 125 (approximately 65 per cent) of these suspensions were a result of Negotiated Agreements and 66 (approximately 35 per cent) were the result of a finding of inappropriate practice by a Committee.
84. Not all practitioners receive a suspension. Of the 269 findings or acknowledgements of inappropriate practice 78 matters (29 per cent) did not result in any suspension being applied.

Reprimand and Counsel

85. From 2004-05 to 2010-11 PSR reprimanded or counselled 249 practitioners regarding their behaviour in rendering or initiating Medicare services or PBS prescribing. 93 per cent of inappropriate practice findings result in a reprimand or counsel. Broken down:
    i. 155 of these reprimands were a result of Negotiated Agreements
    ii. 94 of these reprimands and counsels related to a finding of inappropriate practice by a Committee.

Deterrence

86. The sanctions imposed through the PSR Scheme have a deterrent impact. These include changing the future claiming behaviour of those practitioners that are reviewed and deterring broader inappropriate practice across the profession.
87. In early 2011 PSR asked Medicare Australia to provide statistics on the practitioners whose PSR cases had been completed in the 2009-10 financial year. The purpose of this request was to enable PSR to establish the impact it was having on the claiming behaviour of the practitioners that had been reviewed.
88. Constraints within the *Health Insurance Act 1973* and the *Privacy Act 1988* prevent Medicare Australia from providing any specific claims data however, it was able to advise that for the 49 practitioners who entered into a Negotiated Agreement in 2009-10, on average:
    i. there was a 35 per cent reduction in MBS services rendered and a 19 per cent reduction in average monthly MBS benefits claimed
    ii. there was a 34 per cent reduction in PBS prescriptions rendered and a 31 per cent reduction in PBS benefits generated.
89. Specifically Medicare Australia advised that:
    i. 80 per cent of the 49 practitioners who entered into a Negotiated Agreement in 2009-10 reduced the number MBS services they provided, and reduced their average monthly benefits claimed by an average of 36%

    and

    ii. 86 per cent of the 49 practitioners who entered into a Negotiated Agreement in 2009-10 reduced the number PBS prescriptions they rendered by an average of 33 per cent.

PSR Decision Makers

90. The main individuals involved in the case process under the PSR Scheme are:

i. **The Director of PSR -** who is a medical practitioner appointed by the Minister for Health and Ageing with the agreement of the AMA.

ii. **The PSR Panel -** which comprises medical and other health care practitioners, who are appointed by the Minister for Health and Ageing after consultation with the AMA.

iii. **A specific PSR Committee -** which comprise members of the PSR Panel (typically 2 Panel members in addition to one Deputy-Director who is the chair) and are established by the Director on a case-by-case basis to consider the conduct of a specific referred practitioner.

iv. **The Determining Authority -** comprising a medical practitioner as Chair, a layperson and a member of the relevant profession appointed by the Minister.

The Director

91. The PSR Scheme is managed by the Director who is an independent statutory officer appointed by the Commonwealth Minister for Health and Ageing under section 83 of the Act. Under this section the Director's appointment is subject to the agreement of the AMA.

92. Section 106Y provides that the Director can be appointed for a 3 year term and is eligible for reappointment.

93. Under Schedule 1 to the *Financial Management and Accountability Regulations 1997*, PSR is prescribed as an Agency for the purposes of the *Financial Management and Accountability Act 1997*. The Director is prescribed as the Agency's Chief Executive for the purposes of that Act and its responsibilities relating to the proper use of Commonwealth resources.

94. In addition to conducting the reviews in line with the powers and functions set out in the Act, section 106ZM states that the Director and the APS employees assisting the Director together constitute a Statutory Agency and that the Director is the Head of that Statutory Agency for the purposes of the *Public Service Act 1999*.

95. Section 106ZPL also requires the Director to arrange for the provision of services to every Committee and to the Determining Authority for the purpose of the performance of the functions or the exercise of the powers of the Committee or Authority under the Act.

96. The current Director, Dr Tony Webber, was first appointed by the Minister for Health and Ageing for a three year term commencing on 14th February 2005. He was reappointed on 14 May 2008 for a second three year term until 13 May 2011 and was consequently extended for a further 3 month period ending on 13 August 2011.

97. The Director of PSR prior to Dr Webber was Dr John Holmes who served in the role from the establishment of PSR on 27 July 1994 through to 25 February 2005.

98. The Department of Health and Ageing has managed the selection process for the new Director of PSR currently anticipated to commence in the role from 14 August 2011.

The PSR Panel and Deputy Directors

99. The Professional Services Review Panel is established under subsection 84(1) of the Act and provides members who are available for appointment to a Committee Panel.

100. The Panel consists of practitioners who are appointed by the Minister after consultation with the AMA (in the case of medical practitioners) or other appropriate professional organisations for a period not exceeding 5 years.

101. Panel members and Deputy Directors must be currently practicing and have sufficient experience in, and knowledge of, current clinical practice to be able to represent their body of peers. In addition, they need to be recognised as an appropriate member of their profession and specialty to represent their peers on a Committee. They must also be both willing and

available to sit in Committee hearings and make proper enquires into the appropriateness of practice of one of their peers.

102. Former Panel members and Deputy Directors include highly respected and qualified members of the medical profession including:

- Board Members and Chairs of Professional Standards Committees of State RACGP
- Chair and Members of Health & Professional Standards Committees
- Chairpersons and Directors of State Medical Boards
- Peer reviewers for Health Care Complaints Council
- Directors, Board Members and Examiners for the Royal Australian College of General Practitioners Clinical and Fellowship examinations
- Chairman, Directors, Presidents, Medical Secretaries and Fellows of State AMA bodies
- Chairman, Board Members and Secretary's of Divisions of General Practice and Australian Association of General Practitioners
- Contributors to Therapeutic Guidelines
- Members of State RACGP Faculty Boards
- Directors of GP Networks
- Chairman and Board members of medical research and education foundations.

103. On 1 January 2010 there were 92 Panel Members available to serve on Committees.

104. From the appointed panel member the Minister appoints Deputy Directors who Chair PSR Committees under section 85 of the Act.

105. On 1 January 2010 there were 23 Deputy Directors of PSR available to serve as Chairpersons of Committees.

106. On 27 October 2010 the Director of PSR responded to potential issues with the 2009 appointment of Panel members and Deputy Directors by requesting that all current Panel members and Deputy Directors resign. This was a precautionary measure taken to put any concerns beyond doubt.

107. On 16 March 2010 the AMA and PSR agreed to *Guidelines for the Appointment of Medical Practitioners as Panel Members, Deputy Directors and Consultants to Professional Services Review Matters*. This document is **Appendix B**.

108. The Guidelines agreed with the AMA include the criteria for selecting Panel members and Deputy-Directors and the process to consult on their appointment.

109. The criteria for PSR Panel members and Deputy Directors, as formalised in the Guidelines are set out in clauses 2.2 and 3.2. These clauses state:

Qualifications of Panel members

In order to be appointed to the Panel, a provider must:

a) be a currently registered provider within the meaning of the Act;
b) be currently practicing (at least on a part time basis);
c) have sufficient experience in, and knowledge of, current medical practice in his or her specialty as to be able to represent their body of peers, usually demonstrated by at least 15 years FTE practice experience;
d) be both willing and available to sit in Committee hearings and make proper enquiries into the appropriateness of practice of one of their peers;
e) be willing to participate in training that will enable them to participate in the legal orientated processes associated with sitting on a Committee;
f) be recognised as a suitable member of their profession and specialty to represent their peers on a Committee;
g) be willing to sign a declaration of interest document prior to their name being submitted to the Minister; and

h) *be willing to enter a deed of confidentiality in relation to the information they will obtain as Panel and Committee members.*

Qualifications of Deputy Directors

In order to be appointed as a Deputy Director, a provider must:

a) *be a currently registered provider within the meaning of the Act;*
b) *be currently practicing (at least on a part time basis);*
c) *be a current Panel member appointed by the Minister under Section 84 of the Act, or able to be so appointed prior to appointment as a Deputy Director;*
d) *have sufficient experience in, and knowledge of, current medical practice in his or her specialty as to be able to represent their body of peers, usually demonstrated by at least 15 years experience;*
e) *have experience in the PSR Committee process, usually demonstrated by having previously served as a Committee member on more than 2 Committees;*
f) *have demonstrated ability to manage the conduct of a PSR hearing;*
g) *be both willing and available to be the chairperson of the Committee and make proper enquiries into the appropriateness of practice of one of their peers;*
h) *have demonstrated ability to participate and control the legal orientated processes associated with chairing a Committee;*
i) *be recognised as an appropriate member of their profession and sub-specialty to represent their peers on a Committee.*
j) *enter a deed of confidentiality in relation to the information they will obtain as a Deputy-Director, Panel and Committee member.*

110. Within the Guidelines PSR and the AMA have also agreed to a biennial recruitment process to identify and select practitioners for future appointment to the panel. This is set out at 2.4 and includes PSR contacting the AMA, relevant colleges and other relevant organisations to identify specialties and recognised special interest areas from which future Panel members need to be obtained. The process to conduct a biennial recruitment process as agreed requires the Director to:

a) *seek the view of the AMA, the Colleges and Relevant Organisations to obtain a list of specialties and recognised special interest areas from which Panel members need to be obtained;*
b) *write to the AMA, the Colleges and Relevant Organisations to advertise to practitioners the recruitment process and invite practitioners to make an application directly to the PSR;*
c) *seek applications from practitioners by making an open call in appropriate public forums (including advertisements in relevant press and other such actions).*

111. The first public recruitment round will occur in the final quarter of 2011.

Committees

112. To create a Committee of peers the Director selects from the Professional Services Review Panel and appoints a Professional Services Review Committee comprising at least three practitioners (two Panel members and a Deputy Director) under section 93 of the Act.

113. A new peer review Committee is established for each practitioner under review. PSR Committees can comprise medical, optometry, dental, physiotherapy, podiatry, chiropractic, osteopathic, midwife or nurse practitioners, dependant on the specialty and profession of the Practitioner under review.

"95 Constitution of Committees

(1) A Committee set up under section 93 in connection with a referral consists of the following members appointed by the Director:

(a) a Chairperson who is a Deputy Director; and

(b) 2 other Panel members; and

(c) if subsection (6) applies—not more than 2 additional Panel members.

(1A) If the person under review is not the practitioner who rendered or initiated all of the referred services, the Panel members referred to in paragraph (1)(b) must be members of professions or

specialties relevant to the field or fields of practice of the practitioner or practitioners who rendered or initiated the referred services.

(2) If the person under review is the practitioner who rendered or initiated all of the referred services, the Chairperson, and the other Panel members referred to in paragraph (1)(b), must be practitioners who belong to the profession in which the practitioner was practising when the services were rendered or initiated.

(3) If the practitioner was at that time a consultant physician in relation to a particular specialty, the other Panel members referred to in paragraph (1)(b) must also be consultant physicians in relation to that specialty.

(4) If the practitioner was at that time a specialist in relation to a particular specialty, the other Panel members referred to in paragraph (1)(b) must also be specialists in relation to that specialty.

(5) If the practitioner was at that time a general practitioner, the other Panel members referred to in paragraph (1)(b) must also be general practitioners.

(6) The Director may appoint an additional Panel member or additional Panel members referred to in paragraph (1)(c) if the Director thinks it is desirable to do so in order to give the Committee a wider range of clinical expertise, having regard to the services specified in the referral.

(7) An additional Panel member must be a member of a profession or a specialty relevant to a field of practice of the practitioner, or any of the practitioners, who rendered or initiated the referred services.

(8) Any Panel member whom the Director consulted under section 90 in relation to the referral must not be appointed as a member of the Committee."

114. Over the last three years, ten practitioners (18.8% of those referred to a Committee) have claimed to be practising in a special interest or sub-speciality area.

115. In four of these cases the Director recognised the sub-specialities of the medical profession and consequently appointed Panel members to the peer review Committee who were also specialists in relation to those sub-specialities.

116. In the six other instances the practitioners claimed they were practising:

    i. phlebology
    ii. hormone replacement therapy and myofascial medicine
    iii. nutritional and environmental medicine
    iv. non-malignant pain therapy, laser therapy and complementary medicine
    v. fatigue management
    vi. thyroid and hormonal medicine.

117. In these instances the Director did not consider the claimed specialities were sub-specialties of general practice and appointed Panel members to the Professional Services Review Committees who were general practitioners.

118. This decision aligns with advice received by the Professional Services Review Advisory Committee from the Royal Australian College of General Practitioners in April 2011 that only a specific interest group with Chapter status should be recognised for the purposes of peer review (that is, a Fellow of the Chapter should be peer reviewed from other Fellows of the Chapter).

119. To provide greater transparency and certainty on this matter PSR is working with the AMA to create guidelines to clarify the recognition of subspecialties within the professions and specialty areas used when forming peer review Committees. These guidelines have been drafted and discussed with the AMA throughout 2011, and will require the Director of PSR to:

    "periodically, and prior to each biennial panel member recruitment process, ...approach the relevant professional organisations set out in guidelines to confirm the details of all special interest or sub-specialty areas that are recognised by that relevant professional organisation".

120. The proposed Guidelines will also stipulate that:

    "When forming a Committee the Director of PSR will seek to select members from the Panel who:

a) *are able to run an effective Committee process that follows the principles of natural justice and procedural fairness;*
b) *are able to facilitate an efficient Committee process that minimises delay and protraction of the PSR process;*
c) *are a member of the same special interest or sub-specialty area as the person under review when that special interest or sub-specialty area is recognised by the relevant professional organisation ;*
d) *are able to relate to the experiences of the person under review in terms of other areas of their background (for example culture, gender, mode of practice, and area of study);*
e) *are able to represent the interests of the profession, Commonwealth and Australian public in their role as Committee members."*

121. The practitioner may challenge the appointment of a member of a Committee, on the basis that one of the appointed Panel members is biased, may be biased, or might reasonably be thought to be biased. If the Director of PSR decides that the challenge is valid, another person is appointed to the peer review Committee.

Determining Authority

122. The Determining Authority is an independent body within the Professional Services Review Scheme and is established by section 106Q of the Act. It has two main roles:

i. The first is to decide whether or not to ratify Negotiated Agreements reached between the Director of PSR and a practitioner on the sanctions to apply where both parties agree that inappropriate practice has occurred.

ii. The second is to determine the sanctions to apply whenever practitioners have been found by a Professional Services Review Committee to have engaged in inappropriate practice.

123. The Determining Authority comprises a permanent Chair (medical practitioner), a permanent lay person and a member who represents the profession of the practitioner (section 106ZPA). The Minister for Health and Ageing appoints the Chair and members after consultation with the AMA and the relevant professions.

124. The current appointments for each of these Determining Authority Members are for a three year term expiring on 21 May 2013.

Consultants and other individuals

125. Section 90 states that the Director may consult on decisions. Specifically the section states:

"In order to obtain assistance in making his or her decision on a review, the Director may consult one or both of the following:

(a) a Panel member;

(b) any consultant or learned professional body that the Director considers appropriate".

126. To formalise the process for selecting and appointing consultants to assist the Director, the AMA and PSR recently agreed to Guidelines in relation to the appointment and use of consultants.

127. These guidelines, signed on 16 March 2010, and attached at **Appendix B**, state that:

"The Director will generally exercise their discretion to engage a consultant when:
a) *the medical practice under review requires clinical or technical expertise that is outside of the Director's past experience and current knowledge (either as a practitioner, or as the Director);*
b) *the matter under review relates to a new or emerging medical practice, or alternative medical practice or technologies, or is otherwise a new or unique matter not previously reviewed under the PSR Scheme;*
c) *the Director otherwise believes that a consultant will be able to assist in the decision making process during a review, and provide feedback to the Director on the conduct of the matter."*

128. The Guidelines also make clear that the *"the Director of the PSR is responsible for ensuring that only suitably qualified practitioners, with appropriate experience and knowledge are engaged as consultants for the purposes of conducting a review".*

129. The process for selecting consultants agreed with the AMA is that the Director will:

    a) *develop a role statement outlining the role requirements, and key deliverables that will be sought for through the consultancy contract;*
    b) *if necessary, seek input and advice from the AMA, Colleges or another organisation to source practitioners with the required skill, knowledge and/or experience; and*
    c) *engage a practitioner or relevant individual, known to have the required skills, knowledge and/or experience to meet the requirements of the role and produce the key deliverables contained within the consultancy contract.*

130. The Guidelines also confirm PSRs expectations that a consultant will enter a deed of confidentiality in relation to the information he or she will obtain in assisting the Director with a review and also make a declaration of any possible conflict of interest before appointment.

Operating Procedures and Guidance for Decision Makers

131. PSR Committee members have immediate access to legal advice during the course of a hearing, and receive training in legal and administrative procedures.

132. Upon appointment Panel members receive *The PSR Committee Handbook*, which details the PSR process and is intended to be a resource guide for Committee Members. The latest version of the PSR Committee Handbook is attached at **Appendix C**.

133. In addition to receiving the Committee Handbook, both Panel members and Deputy-Directors are expected to attend training sessions offered by PSR.

134. The last Panel member training day was held on 13 February 2010 and covered topics including:

    i. overview of the PSR Scheme, the role of Committee members and key issues
    ii. overview of the Committee Process, Logistics and Commitments required
    iii. expectations of Part Time holders of Public Office, including the APS Values and Code of conduct
    iv. processes leading up to a Request to Review
    v. legal considerations and the Committee Handbook.

135. The last Deputy Director training day was held on 28 May 2010 and covered topics including:

    i. the perspective of the practitioner under review (presented by a legal firm that commonly represents practitioners)
    ii. updates from Medicare Australia, the Department of Health and Ageing and PSR
    iii. electronic records.