Health Insurance Amendment (Professional Services Review and Other Matters) Bill 2002
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Date Introduced: 27 June 2002
House: House of Representatives
Portfolio: Health and Ageing
Commencement: Most provisions commence a month and a day after Royal Assent.

Purpose
To amend the Health Insurance Act 1973 to:

- clarify the operation of the Professional Services Review Scheme, a scheme regulating fraud and inappropriate practice (overservicing) in relation to medical services; and
- extend the medicare eligibility for cleft lip and cleft palate sufferers who have been certified before their 22\textsuperscript{nd} birthday, allowing them to claim until their 28\textsuperscript{th} birthday.

Background
Professional Services Review (PSR)

Schedule 1 amends Part VAA of the Health Insurance Act 1973 (the Act). Part VAA deals with the Professional Services Review Scheme (the PSR Scheme).

The PSR Scheme
The PSR Scheme commenced on 1 July 1994, having been established by the Health Legislation (Professional Services Review) Amendment Act 1993. The aim of the PSR Scheme is to deal quickly and fairly with inappropriate practice under Medicare\textsuperscript{1}. It replaced the Medical Services Committees of Inquiry which previously had responsibility for policing overservicing under Medicare. The effectiveness of these Committees in dealing with overservicing had been questioned by the Australian National Audit Office (ANAO) in its report Medicare and excessive servicing: Health Insurance Commission\textsuperscript{2}.

Warning:
This Digest was prepared for debate. It reflects the legislation as introduced and does not canvass subsequent amendments.
This Digest does not have any official legal status. Other sources should be consulted to determine the subsequent official status of the Bill.
A major focus of the PSR Scheme is to prevent, detect and investigate fraud and inappropriate practice in regard to medical services for which a benefit has been paid under Medicare. For fraud to have occurred a person must have obtained a payment to which he or she is not entitled and the payment must have been obtained by the person supplying false or misleading information. For a person to engage in 'inappropriate practice' they must have engaged in conduct, in relation to rendering or initiating a medical service, that could reasonably viewed as being unacceptable to their general body of peers.

**Excessive Servicing v. Inappropriate Practice**

In introducing the PSR Scheme, it was said that '[a] significant change in the bill is the replacement of the concept of excessive servicing with one of inappropriate practice':

> Whereas excessive servicing is currently defined as the rendering or initiation of services not reasonably necessary for the adequate care of the patient, the concept of inappropriate practice goes further. It covers ... conduct in connection with the rendering or initiating of services that is unacceptable to his or her ... colleagues.³

**Statistics**

The incidence of (medicare) servicing is illustrated by the distribution curve in the figure below which is reproduced from the PSR Annual Report 1997–98. It was noted that '[t]he shape of the graph in relation to the number of services has altered little over the years'.⁴
The Four Tiers of the PSR Scheme

The PSR Scheme has been said to have four 'tiers': '[t]he first three relate to determining whether … a medical practitioner has engaged in "inappropriate practice" … [t]he fourth tier or step involves the imposition of a sanction'. The key focus is on the first three tiers which involve the identification of possible inappropriate practice by the Health Insurance Commission (HIC), the referral of matters for investigation by the Director of Professional Services Review and adjudication by a Professional Services Review Committee (PSRC).

The first tier involves the identification of possible inappropriate practice and counselling. Essentially, this process is prompted by statistical abnormalities in servicing patterns. As the HIC itself states, it first 'identifies medical practitioners whose servicing, ordering or prescribing appears abnormal when compared with their peers'. It then uses a committee to 'review patterns of practice and decide when medical practitioners should be interviewed'.

Following the committee process, specialist advisers meet with the practitioner for 'counselling' or an opportunity to comment on abnormalities in the pattern of practice. The outcome may be a referral to the Director of Professional Services Review (the Director).

The second tier involves 'investigative referrals'. Under section 86 of the Act, the HIC may refer a matter to the Director for investigation of inappropriate practice. It may relate to the rendering and/or the initiation of any or all services but only within a maximum 2 year referral period. It must contain 'particulars of all services rendered or initiated' and set out the reasons why it is thought that the person may have engaged in inappropriate practice.

Critically, under section 87, the referral must specify whether it relates to (a) specified services, (b) services of a specified class, to a specified class of person, or in a specified location, and/or (c) services within a specific period. At the same time, under section 89, the Director may investigate any of the 'referred services' 'including services not dealt with in the reasons' listed pursuant to section 86. Section 88 contains notice requirements.

The third tier involves 'adjudicative referrals'. Section 93 empowers the Director to set up a Committee (PSRC) to further consider the issue of inappropriate practice. PSRCs are made up of persons who are professional peers of the practitioner. The referral may relate to any of the services listed in the 'particulars of all services' in the investigative referral and is not limited by any of the reasons given in the investigative referral. Like the investigative referral, the Director must provide a report giving the PSRC reasons why it is thought that the person may have engaged in inappropriate practice.

The third tier also contains a loop between adjudicative and investigative referrals. While the PSRC may only make findings as to the services particularised in the referral, it may, if it considers that there may have been inappropriate practice in respect of other services, make an investigative referral of those matters back to the Director. The Director may then return those matters to the PSRC via an adjudicative referral.

Essentially, the PSR Scheme contemplates a staged investigation process in which statistically high servicing is progressively translated into clinically inappropriate practice. Moreover, in the translation, it envisages a process which ultimately identifies for
assessment specific conduct in relation to an instance, class or circumstance of services. The key issue for present purposes is the point at which the specific conduct is identified. This has considerable implications for the jurisdictional width of the investigation and adjudication processes and the extent of procedural fairness protections for practitioners.

Amendments in 1997 and 1999

In 1997 the PSR Scheme was amended by the *Health Insurance Amendment Act (No. 1) 1997*. These amendments were prompted in part by a report of the Australian National Audit Office, *Medifraud and Inappropriate Practice: Health Insurance Commission*.15

In 1999 the PSR Scheme was amended by the *Health Insurance Amendment (Professional Services Review) Act 1999*. These amendments were prompted by decisions of the Federal Court in *Yung v. Adams* (1997) 150 ALR 436 and its appeal in *Adams v. Yung* (1998) 83 FCR 248. In the initial application Davies J found a number of deficiencies in the PSR process including a denial of natural justice to the practitioner under review. An appeal was then made to the Full Federal Court which also found against the PSR Scheme.16

After *Yung*, a comprehensive review of the PSR Scheme was undertaken by a committee comprising representatives of the HIC, the Director, the Commonwealth Department of Health and Aged Care and the Australian Medical Association (AMA) (the PSR Review). The PSR Review gave its recommendations for amendments in a report *The Report of the Review Committee of the Professional Services Review Scheme* in March 1999.

Yung

One of the issues in *Yung v. Adams* was the problem of translating servicing statistics into clinically inappropriate practice. In the initial application, Davies J criticised the HIC:

> The concern of [HIC] that the appropriate level of clinical input could not be maintained on a regular and continuing basis for the long hours worked by Dr Yung could not readily be translated into an allegation of ‘inappropriate practice’ … The fact that Dr Yung saw what was considered to be an excessive number of patients a day was not a basis for concluding that Dr Yung gave inadequate care and attention to all his patients, to any particular proportion of his patients or to any particular patients.17

Moreover, he criticised their open ended approach to identifying inappropriate practice:

> Because the proceedings are of a disciplinary nature, it clearly would not be appropriate for a decision-maker merely to conclude that the medical practitioner engaged in inappropriate practice some time during the period which is specified in relation to some of the referred services. The services in respect of which the finding of inappropriate practice is made must be identified … [W]hat must be done is to examine at least an appropriate sample of services in detail to identify the elements of ‘inappropriate practice’ arising from the services in that sample and to apply the findings statistically to the whole of the referred services, provided … it be … valid.18
Put simply, Davies J held that conduct must be particularised in the investigative and adjudicative referrals and that this confined the jurisdiction of the Director and the PSRCs. His conclusion was a product of at least two factors: (a) the language of the Act and its reference to 'conduct' in relation to 'specified services' and (b) the requirements of natural justice in the context of an investigation and discipline process. This view was reiterated in comments by Burchett and Hill JJ in the Full Court decision of Adams v. Yung.19

The referral while expressed to be of conduct is not conduct in isolation. It is conduct relating to the issue whether the person has engaged in inappropriate practice in connection with the rendering of services … While those services may include all or some services within the referral period, the reference is not intended to open for consideration … any aspect at all of the [practitioner's] conduct in the referral period.

Similarly, in Mercado v. Holmes [2000] FCA 600, Heerey J said a referral must 'identify the conduct being referred and the alleged inappropriate practice relevant to the specified services and contain sufficient detail to make the Committee review process workable'.20

The Amendments

The 1999 amendments were an attempt to resolve the issues in these cases in three ways. First, they effected a clearer distinction between the second and third tiers by establishing the distinct 'adjudicative review'. Second, they expanded the power in those hearings to obtain information regarding services not canvassed in the investigative referral. Third, they strengthened procedural fairness requirements protecting practitioners under review.

Two areas of interest related to statistical sampling and deeming provisions. The original PSR Scheme included provisions allowing PSRCs to make findings based on statistically significant samples of services. In this way, findings as to conduct in specific instances could be extrapolated into findings as to conduct in relation to specific services, or, after later amendments, other services. These provisions were repealed as they had become 'unworkable in practice'21 or 'too administratively complex and cumbersome to apply'.22 However, the PSR Review thought that 'with expert statistical advice it was possible to develop appropriate statistical methodologies for PSRCs to apply in respect of particular identified practice'. The 1999 amendments contained new statistical sampling provisions.

Another recommendation of the PSR Review was that the Act 'provide the authority for the application of a deeming provision in respect of high volume servicing per day'. The rationale for a deeming provision seemed to be related to the issues in Yung and Mercado. In cases where there had been an extremely high volume of servicing, while sampling might assist, the sample size needed to be substantial in order to be statistically significant. The solution was to introduce a provision 'whereby once a specified number of services per day is reached, the practitioner must justify to a PSRC the provision of such a high volume of services'. In effect, this 'triggers a shift in the evidentiary burden'.23

The 1999 amendments contained the new deeming provision, using the concept of a 'prescribed pattern of services'.24 The prescribed pattern involves the rendering of 80 or
more services a day during 20 or more days in a given year.\textsuperscript{25} The pattern was developed by the PSR Review Committee based on HIC data and consultation with peak bodies.\textsuperscript{26}

A more extensive background is available in the relevant 1999 Bills Digest.\textsuperscript{27}

**Pradhan**

As the Explanatory Memorandum notes, the amendments in **Schedule 1** were prompted by a decision of the Federal Court in *Pradhan v. Holmes & Others* [2001] FCA 1\textsuperscript{560}.

As in the earlier cases, a key issue in *Pradhan v. Holmes* was the need to identify conduct. The case was '[a] legal challenge to one of the first referrals following the amendments to the [PSR] Scheme [in 1999]'.\textsuperscript{28} Indeed, it was 'designed to expose the limitations of the amended [PSR] scheme itself, or else deficiencies in the manner of its administration'.\textsuperscript{29}

Dr Pradhan's basic submissions were that the referrals were too broad and that the matters raised in the adjudicative referral were different to the matters raised in the investigative referral. The issue in the investigative referral was the high volume of services.\textsuperscript{30} The adjudicative referral raised new concerns. In both referrals, the particularisation of conduct was hedged either by a caveat that the attached information was not 'in intended in any way to limit the conduct referred' (investigative referral) or a catch-all reference to conduct 'that otherwise constituted engaging in inappropriate practice' (adjudicative referral).

Put simply, the HIC submission was that the amendments were intended to reduce the need to particularise conduct in the investigative and adjudicative referrals. They said that while services had to be specified, there was a wide jurisdiction to identify a range of conduct from which to assess inappropriate practice: 'the parameters of each level of investigation is governed by the services, not by the conduct'.\textsuperscript{31} This conclusion was said to be reflected by the increased jurisdiction of the Director and PSRCs to stray beyond the services in the referral and the improved procedural fairness protections to practitioners.

Finn J's response was that the 1999 amendments had no material impact upon these issues:

If Parliament had intended to mandate a roving commission into past service provision by medical and other practitioners … circumscribed only by time limitations (2 years) and by the capacity of the Director to whittle down the services worthy of examination, it would - and should - have done so in language having far greater clarity and aptness for that purpose than that of the 1999 amendments.

Essentially, Finn J considered that, while the 1999 amendments allowed greater discretion for the Director and PSRCs to consider various services, they did not provide any greater discretion in the particularisation of conduct. There should be no 'fishing expeditions'.

**The Problem in a Nutshell**

To an observer it might seem perverse that a case involving a comparatively high volume of services, which, as the stakeholders and statute agree, implies inappropriate practice,
cannot be dealt with purely on the basis of the volume of those services. The problem is the need to particularise conduct in the investigatory and adjudicative referrals, a product of the ambiguous reference to 'conduct' in the referral provisions of the Act, exacerbated by the disciplinary nature of the process and the various procedural fairness obligations.

The annual services provided by Dr Pradhan (around 17,000) and Dr Yung (17,331) placed them beyond the 99th percentile. While Dr Yung's case preceded the 1999 amendments, one might ask why Dr Pradhan's case was not dealt with under the deeming provisions? The answer may be that the deeming provision did not address (a) the need to particularise conduct in the referrals or (b) the problem of 'changing conduct midstream'.

Main Provisions

Professional Services Review

As the Explanatory Memorandum indicates '[g]iven the complexity of the [PSR] Scheme, the amendments to Part VAA are extensive'. It identifies five main areas which relate to:

- objects and outline clauses;
- replacement of the investigative referral process with a request process;
- inclusion of a formal review stage following the (investigative referral) request;
- clarification of the need to particularise conduct and its effect on jurisdiction; and
- increased procedural fairness protections at various stages.

These amendments essentially attempt to reduce the need to specify conduct by measures that underscore a wide jurisdiction within the second and third tiers and other measures that elaborate upon the statutory procedural fairness requirements.

Proposed sections 79A and 80 replace the present 'outline' provision with an objects clause and a 'main features' clause. The former expresses in blunt terms the purpose of Part VAA is to 'protect the integrity of ... medicare benefits ... and, in doing so protect patients and the community in general from the risks associated with inappropriate practice and protect the Commonwealth from having to meet the cost of services provided as a result'. The latter emphasises, in relation to the (second tier) request, that the PSRC 'can investigate any aspect of the provision of the referred services and its investigation is not limited by any reasons given in a request for review'. It also emphasises the procedural fairness protections which are 'made throughout the scheme for the person under review'.

Second Tier

In proposed new sections 86 to 89 the investigative referral becomes a request for review.
Proposed section 86 empowers the HIC to request the Director to review the provision of services by a person. Whereas the form and content of the investigative referral is currently governed by the Act and the Guidelines, these matters are all left to be determined almost solely by the latter which continue to be disallowable instruments.

Significantly, there is no reference to 'conduct' and there is no statutory requirement to specify the services rendered or initiated as is presently the case in sections 86 and 87.

Proposed section 88A inserts a formal decision making stage in which the Director must decide whether or not to undertake a review requested by the HIC. He or she must do so if in the Director's opinion 'there is a possibility that the person has engaged in inappropriate practice'. He or she must make a decision regarding the review within 1 month or else give the practitioner a report and an opportunity to make submissions (proposed section 89C). In conducting the review, he or she is not limited to the services specified or the reasons given in the request (proposed section 88B). The Director may decide to take no further action if satisfied that there are insufficient grounds for a PSRC to reasonably find that the person has engaged in inappropriate practice, as is presently the case, or that a proper investigation by a PSRC would be impossible (proposed section 91). The Director must prepare a report which must be provided to the HIC and the practitioner.

Third Tier
In the amendments, the adjudicative referral becomes a referral per se.

The Director may decide to refer a matter to a PSRC. The referral is not limited by the services specified or terms of the report (proposed new subsections 93(7B) and (7C)). While the PSRC may only make findings in respect of referred services, it is not limited by the reasons given in the request or in the referral (proposed section 106H).

As is presently the case, the PSRC 'is not required to have regard to conduct in connection with rendering or initiating all of the referred services but may do so if the PSRC considers it appropriate in the circumstances' (proposed subsection 106H(2)).

Saving, Transitional and Validation
The amendments above do not apply retrospectively to old referrals (item 118). However, any old referrals that contained the form of hedging present in Pradhan v. Holmes are validated by removing any caveat that attached information is not 'intended in any way to limit the conduct referred' (investigative referral) or a catch-all reference to conduct 'that otherwise constituted engaging in inappropriate practice' (adjudicative referral) (item 119).

It might be noted that while the validation provisions deal with a failure to particularise conduct they do not deal with 'changing conduct midstream'. Whether this will be an issue in the future probably depends on the strength of the statutory procedural fairness regime.
Cleft Lip and Cleft Palate

Schedule 2 amends the provisions in the Act which deal with 'prescribed dental patients'. Presently, a 'prescribed dental patient' is a person under 22 years who suffers from a cleft lip or cleft palate condition that has been certified by an approved doctor or dentist. It is also any person who suffers from another condition that has been certified by an approved doctor or dentist that has been determined by the Minister to fall within these provisions.\(^{35}\)

**Proposed section 3BA** would extend the definition to include persons under 28 years who have been certified as suffering cleft lip or cleft palate condition before their 22\(^{nd}\) birthday. The extension to 28 years would not apply to other conditions prescribed by the Minister.

According to the Explanatory Memorandum accompanying the Bill, the Department has consulted with the Australian Dental Association (ADA) and the Australian Centre for Dental Specialists about the extension of the age limit for access to the Cleft Lip and Palate Scheme. Extension of the age limit to 28 will enable the program to cover the period in which the jaw continues to grow.

However, further consultation with the ADA indicates that while they support the extension of the age limit to 28 for the above clinical reasons, the ADA also supports the extension of access to the scheme throughout life. This corresponds with the position of CleftPals, a volunteer non-profit organisation that supports people who are involved with cleft lips and/or palates. CleftPals maintains that access to treatment over the life span more accurately reflects the clinical needs of people born with cleft lip and/or cleft palate. This position is informed by the need for some people with cleft lip and/or palate to continue to receive treatment after the age of 28 for their condition.

Additionally, CleftPals argues that those people who initially received treatment many years ago are unable to access more advanced clinical procedures because of the age cut off. An extension of this cut off period to the age of 28 will not significantly help those people who have been unable to access more advanced clinical procedures because of age.

**Endnotes**


The referral period may be up to 2 years.

Subsection 86(4).

Subsection 87(1).

Subsection 95(2).

Subsection 93(7).

Subsection 93(6).

Subsection 106H(2).

Subsection 93(2).


Ibid at p. 443 (emphasis added).


*Mercado v. Holmes* [2000] FCA 600 at [70].


Section 106KA.

Health Insurance (Professional Services Review) Regulations 1999, r. 11.


*Pradhan v. Holmes & Others* [2001] FCA 1560 at [1].

The concern was that 'his high average number of services per patient meant some of the services rendered by Dr Pradhan might not be reasonably medically necessary for the care of his patients': Professional Services Review, *Annual Report 2000-01*, p. 18.

*Pradhan v. Holmes & Others* [2001] FCA 1560 at [101].
34 Section 91.
35 Section 3, definition of 'prescribed dental patient'.