Australian Government
Professional Services Review

Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600
Australia

Dear Dr Holland,

Further information requested by the Senate Standing Committee on Community Affairs

Please find attached the Professional Services Review (PSR) Agency's response to questions taken on notice during our appearance at the Senate Standing Committee on Community Affairs inquiry into Professional Services Review on 23 September 2011.

I would like to thank the Committee for their time, and the opportunity they provided PSR to respond to the Committee's questions.

Yours sincerely

Dr Bill Coote
Acting Director
Professional Services Review
29 September 2011

Response to the main concerns:

- A concern raised in a number of submissions to the committee is that practitioners who appear before PSR committees are not always confident that the committee members are properly their peers. The Australian Doctors Union in its testimony to the committee discussed the issue of "determining medical subspecialties" and stated that despite the "PSR/AMA memorandum of understanding" there was "no obvious pathway for individuals or groups of doctors to move up to chapter status". (Draft transcript provided to PSR by Committee Secretary). The Submission to the Senate from the Australian College of Skin Cancer Medicine states (p3) "Medicare and PSR do not recognize any subspecialties within General Practice. This practice is arcane and not progressive."

- In accordance with section 95 of the *Health Insurance Act 1973*, titled 'Constitution of Committees', PSR appoints deputy-directors who are from the same profession and two committee members who are from the same speciality that the person under review was practising in when the services under review were rendered or initiated. This was set out at paragraph 113 of our submission.

- It is important the Committee appreciates that recognition of emerging medical specialties is not the role of PSR. This is a role for the Australian Medical Council (AMC). The AMC website states: "In 2002 in response to an invitation from the Commonwealth Minister for Health and Ageing, the AMC took on the responsibility for advising the minister on which disciplines of medical practice should be recognised as medical specialties in Australia". In assessing submissions for recognition as a speciality the AMC assesses matters such as the "standards of the specialist education, training programs and continuing professional development programs available for the medical speciality".

- There are established processes that any medical discipline can pursue in seeking the addition or amendment of items in the Medicare Benefits Schedule (MBS) in order to better reflect contemporary medical practice, including the emergence of a new medical specialty. Evidence relating to the safety, clinical effectiveness and cost-effectiveness of any proposed amendment to the MBS is appraised by the Medical Services Advisory Committee (MSAC), an independent expert committee appointed by the Minister for Health and Ageing. MSAC provides advice to the Minister for Health and Ageing in relation to the strength of the available evidence, and on the circumstances under which public funding should be supported. However, any decision to amend the MBS remains the prerogative of Government.

What is the process for ensuring there are sufficient specialists on the panel and has the 'just in time' appointment process been used previously?

- To prevent specialists being unnecessarily appointed to the panel PSR has historically used a 'just in time' appointment process to appoint specialists only when they are likely to be required (i.e. because someone in that specialty has been referred to the Director).

- This process was recently formalised in the Guidelines agreed with the Australian Medical Association on 16 March 2011, but has been a process utilised by the Agency throughout its history.

- Since 2000/2001 PSR has requested the Minister to appoint the following practitioners through a 'just in time' appointment process:
  - 4 Radiologists (9 Jul 2010)
  - 1 Dermatologist (23 Oct 2009)
  - 1 Geriatrician (20 Jul 2009)
  - 2 Psychoanalysts (20 Jul 2009)
  - 1 Sports Physician (3 Mar 2009)
  - 1 Sports Physician (25 Nov 2008)
  - 3 ENT surgeons (14 Oct 2008)
  - 1 Sports Physician (14 Oct 2008)
  - 3 Ophthalmologists (13 Aug 2008)
  - 1 Anaesthetist (3 Mar 2008)
  - 1 Chest Physician (3 Mar 2008)
  - 1 Dermatologist (25 Sep 2007)
  - 2 Psychiatrists, (5 Sep 2005)
  - 4 Physiotherapists (5 Sep 2005)
  - 1 Chiropractor (5 Sep 2005)
  - 3 ENT surgeons (14 Oct 2002)
  - 1 Colorectal surgeon (14 Oct 2002)
  - 1 Urological surgeon (14 Oct 2002)
  - 1 Paediatric Physician (14 Oct 2002)
  - 8 Surgeons and 7 Physicians (1 Oct 2001).

Selection process for entry into Medicare Australia's Practitioner Review Program and potential referral to PSR

- Medicare Australia outlines the process of the Practitioner Review Program (that can lead to a referral to PSR) on its website at: http://www.medicareaustralia.gov.au/provider/business/audits/prp.jsp

- Medicare Australia's National Compliance Program 2010-11 states that "Where [Medicare Australia] identify concerns relating to possible inappropriate practice by a practitioner, a compliance medical officer (a qualified medial practitioner) will review the information. Where concerns are identified, the officer will arrange an interview with the practitioner to explain the concerns and offer them an opportunity to respond. If concerns remain after a period of review Medicare Australia may request the Director of PSR to examine the practitioner's provision of services".

- A practitioner's total financial claiming volume is not the sole or main identification process leading to a referral to PSR. PSR routinely receive referrals based on individual items, or concerns that do not go to the total volume or financial income of the practitioner. For example, PSR has had referrals relating to practitioners who:
    - only rendered a total of 888 services (6th percentile) to 116 patients (0 percentile) in a year. The reason for the referral was that the practitioner could not satisfy Medicare Australia's concerns that there was a clinical need to render approximately 7.66 services per patient.
    - rendered only 1,299 services (5th percentile) to 649 patients (8th percentile) in a year. The reason for the referral was that the practitioner could not adequately explain to Medicare Australia why they initiated 7,303 pathology services (99th percentile) to such a low number of patients (i.e. at an average of 11.25 pathology services per patient).
    - rendered 6,962 services (77th percentile) to 1,334 patients (42nd percentile) in a year. This practitioner was referred to PSR because they could not adequately explain to Medicare Australia why they had prescribed an average of 17.8 prescriptions per patient and why seven of their top 20 PBS items were drugs of dependence. This practitioner could not satisfy Medicare Australia as to why they prescribed codeine phosphate with paracetamol, temazepam and oxycodone tablets on the same date, to the same patient, on 65 occasions.

Are practitioners provided with sufficient information about the matter being reviewed?

- The primary purpose of the PSR process is to conduct a review of a practitioner's rendering and initiation of services that attract Medicare or pharmaceutical benefits. To perform this role both the Director's review meeting and the Committee hearing are essential mechanisms to gain information to enable an assessment to be performed on whether there are legitimate concerns or not.

- Providing the practitioner with the findings prior to the hearing or meeting would require both the Director and Committee to pre-judge the case, based on the clinical records and claiming statistics alone, and without hearing from the practitioner concerned.

- A practitioner referred to PSR receives numerous and detailed documents relating to the reasons for their referral to, and the concerns that are to be considered by, the PSR. The practitioner is fully informed ahead of the committee hearing of the specific services and clinical records that will be considered and discussed.

- Chronologically the documents that a practitioner receives that detail the concerns to be reviewed include:
    1. Medicare's 'Request to Review' document is sent to PSR and to the practitioner. This document includes:
        - A paragraph 'Summary of Concerns' in the cover letter to the Director;
        - An executive summary containing a table of concerns linked to the relevant data attachments;
        - A chronological history, including a table for each meeting and item of correspondence in Medicare's Practitioner Review Program, and the specifics of the concerns detailed in that meeting or letter;

- A one to three page detailed reasoning for each specific concern, setting out the data tables demonstrating the concern, the findings of fact made by Medicare Australia from their analysis, and two to five paragraphs detailing the ongoing reasons for the concern.

2. Once the Director determines to undertake a review, a notice of this decision is sent to the practitioner. This letter contains a paragraph or list, under the heading "Decision to Undertake a Review" that details the concerns that may suggest that inappropriate practice may have occurred.
3. The Directors Review meeting invitation outlines to the PUR that the purpose of the meeting is to discuss the reasons for the practitioner's referral to PSR and the findings of the Director's review of medical records. In changes introduced in 2011 this letter now also contains excerpts of the practitioner's clinical records, that the Director has reviewed and may demonstrate the nature of the concerns.
4. Following the review meeting the practitioner receives an 89C Report which details the concerns that remain following the review of the medical records and the review meeting. These concerns are set out in relation to each specific MBS or PBS item and generally ranges from 2 to 5 pages in length. The 89C report specifically details the Director's preliminary findings and invites the practitioner to respond to these findings.
5. If the matter is referred to a Committee, the Director must produce a section 93 report and provide it to the practitioner. This report details the reasons why the Director thinks the practitioner may have engaged in inappropriate practice. Under the heading "Discussion and Findings" the Director details the findings of concern that has resulted in the committee referral. These are further spelled out in a following section headed "Reasons for making the Referral" which contains a list of concerns that the Director is referring to the Committee.
6. At least 4 weeks prior to the Committee hearing the practitioner will receive a copy of their clinical records that the Committee is intending to review. This copy, produced by PSR, is separated by items of concern, details the MBS item requirements, lists the records that will be reviewed, and then attaches each clinical record, with a flag attached to indicate the specific service that will be considered and discussed at the hearing.
7. At the commencement of the committee hearing the Deputy-Director (who chairs the committee) explains the items and associated records that will be reviewed by the committee. At the close of each day of hearing, the practitioner is advised of the specific items and records that will be reviewed the following day.
8. Following the hearing the practitioner receives the Committees draft report detailing their preliminary view on the concerns that may be valid. This detailed report, generally ranging from 100 to 300 pages in length, contains:
   - An executive summary detailing the concerns that the Committee considers to have been found;
   - A detailed assessment of each individual service, and associated clinical record, arranged by concern, and containing the Committees specific findings in relation to the concerns found for that service.

   The practitioner is then invited to respond to this preliminary finding in written submissions addressing the Committee prior to the making of a final report.

Opportunity to respond to concerns

- There are 4 separate decision making stages in the PSR process. These are Medicare Australia's Practitioner Review Program, the Director of PSR, the Committee of Peers and the Determining Authority. At each stage the practitioner receives details of the concerns that has led to their referral and is given an opportunity to explain or address those concerns.

- A practitioner who goes through the full PSR process will have at least eight opportunities to make submissions and explain their practice in light of the concerns that have been identified. These are:
    1. A written submission and interview process through Medicare Australia's practitioner review program
    2. A verbal submission at the Director's review meeting
    3. A written submission on the Director's findings contained in the s89C report
    4. Written submissions prior to the committee hearing
    5. Verbal and written submissions at the Committee hearing and written submissions following the hearing
    6. A written submission on the Committee's Draft Report
    7. A written submission on Committee's Final Report
    8. A written submission on the Determining Authority's Draft Determination

Is it true that PSR has reviewed a practitioner's use of Pap Smears, leading to the closure of a clinic?

- There are 18 pap-smear specific item numbers in the Medicare Benefits Schedule. A search of the PSR case management system returned no finding of a referral to PSR from Medicare Australia in relation to concerns around these Pap-smear items.

- PSR has no record of any of these items ever being reviewed by PSR for any practitioner.

Can PSR respond to claims by Mr Brazenor that his expertise was not taken into account?

Replaced with revised answer, received 11 October 2011 (last page)

Please provide details on the number of overseas trained doctors referred to PSR?

- Since July 2008 PSR has received 80 referrals from Medicare Australia in relation to overseas trained doctors. Over the same period there have been a total of 235 total referrals. PSR was unable to identify the training location of 17 of these practitioners.

Please provide details on the experience of panel members in relation to rural practice?

- The last 60 practitioners referred to PSR involved 43 practicing in capital cities, 14 practicing in regional areas, and 3 practicing in rural areas.

- Of the 92 panel members available to serve on Committees as at 1 January 2010 there were 72 located in city/metropolitan areas, 15 in regional areas and 5 in rural areas. Amongst these panel members were 9 general practitioners who listed their experience as including:
  1. 36 years as rural GP in NSW and past Chairman AMA Rural Reference Group/ Rural Medicine Committee (2005-2010)
  2. 37 years as a rural GP in SA and Fellow of the Australian College of Rural and Remote Medicine
  3. 35 years in rural practice in WA and representative on AMA GP Rural Reference Group
  4. 11 years experience working in a rural general practice in Tasmania
  5. 14 years experience as rural GP in Tasmania
  6. 20 years experience as a GP in particular as a rural GP in Victoria
  7. 10 years experience working in isolated remote communities in NSW, SA, NT and QLD
  8. 10 years remote medical work in NT and 17 years experience in rural QLD
  9. 7 years experience working in country NSW.

Do witnesses think that doctors are more extensively and vigorously audited now more than previously? If so, what have been the primary drivers in this approach?"

- PSR receives all of its matters from Medicare Australia. Despite some fluctuation across financial years, the average number of cases since commencement of PSR in 1994 is roughly 45 to 50 per annum. This long term average has not dramatically increased or changed in the last few years despite significant growth in the number of providers accessing the Medicare program, and overall growth in MSB and PBS expenditure.

Does the PSR provide, or input to any education practices and processes to combat ambiguity?

- Medicare Australia's provides education and information services on MBS and PBS matters. PSR has been consulted on the design and content of some of these information products as a relevant stakeholder.

- PSR works closely with the profession, through the Colleges and other relevant organisations, to explain and inform practitioners on the definition of inappropriate practice, the details of recent findings of inappropriate practice and the importance of keeping records that meet the requirements in the *Health Insurance Act 1973*.

What is the remuneration for Committee members and the Determining Authority?

- Committee and Determining Authority members are part time office holders and are not salaried members of PSR.
- Under section 106ZL of the *Health Insurance Act 1973*, and in accordance with the *Remuneration Tribunal Act 1973*, the Commonwealth Remuneration Tribunal sets the fees and allowances for Professional Service Review panel members, deputy-directors and Determining Authority members.
- All members of Committees and the Determining Authority receive reimbursement only for hours worked on specific cases and are not entitled to any bonus payments.
- In 2011-12 the Remuneration Tribunal has set the follow rates for PSR decision makers:

	Fee	Nature of Payment
Deputy Director and Chair of Determining Authority	$1,273	Daily fee for +3 consecutive hours
Panel Member and Determining Authority Members	$1,130	Daily fee for +3 consecutive hours

How many 80/20 matters does PSR receive?

- Between 2006/07 and 2010/11 PSR completed ten 80/20 matters.

What is PSR's current appropriation?

- PSR received a Departmental appropriation of $6,667,000 for the 2011-12 financial year.

Dr Ruse's submission and previous evidence suggests a lack of consultation of professional bodies in the drafting of MBS item descriptors - do you have any comments on that?

- There are established processes that any medical discipline can pursue in seeking the addition or amendment of items in the Medicare Benefits Schedule (MBS) in order to better reflect contemporary medical practice, including the emergence of a new medical specialty. Evidence relating to the safety, clinical effectiveness and cost-effectiveness of any proposed amendment to the MBS is appraised by the Medical Services Advisory Committee (MSAC), an independent expert committee appointed by the Minister for Health and Ageing. MSAC provides advice to the Minister for Health and Ageing in relation to the strength of the available evidence, and on the circumstances under which public funding should be supported. However, any decision to amend the MBS remains the prerogative of Government.

How many occasions have there been when outside experts have been called on?

- Section 90 of the *Health Insurance Act 1973* enables the Director to engage a consultant "to obtain assistance in making his or her decision on a review". Between 2008-09 and 2010-11the Director has engaged a consultant to assist in 37 reviews.

- Subsection 95(6) of the *Health Insurance Act 1973* enables the Director to appoint an additional member to a peer review committee to "give the committee a wider range of expertise, having regard to the services specified in the referral". Since 1994 there have been 8 committees with an additional member appointed.

Who are the other bodies that the Minister consults with (other than the AMA) in the appointment of the DA?

- Under Section 106ZPB of the *Health Insurance Act 1973* the Minister must consult the Australian Medical Association about the appointment of members to the Determining Authority.

- The section also requires the Minister to consult with other organisations or associations, when appointing members from professions that are not medical practitioners. This requirement extends to any member of the Determining Authority practicing as dental practitioners, optometrists, midwifes, nurse practitioners, chiropractors, physiotherapists, podiatrists and osteopaths.

- Organisations that have been approached in relation to the appointment of panel members and/or Determining Authority members include:
  - Optometrists Association of Australia
  - Chiropractors Association of Australia
  - Australian Physiotherapy Association
  - Australian Dental Association
  - Australian Podiatry Council

- The appointment of the non-medical practitioner to the Determining Authority is also discussed with the Consumers Health Forum.

Can PSR respond to claims by Mr Brazenor that his expertise was not taken into account?

Matter 1:

- PSR records show that Mr Brazenor wrote a character reference for a practitioner who was subject to review by the Director on 7 July 2004. In this matter, and after meeting with the practitioner, the Director determined that there was no case to answer. The matter did not proceed to the committee stage and the Director wrote to the practitioner on 22 December 2004 advising that the case had been dismissed under section 91 of the Act.

Matter 2:

- PSR has been advised that Mr Brazenor was in attendance at a meeting held on 15 February 2011 between the Director of PSR and another practitioner who was under review.

- In this matter the Director held concerns that the records did not contain sufficient clinical detail to support the billing of the MBS items, and that the records did not contain adequate clinical indication to support the ordering of diagnostic imaging tests. These concerns were set out in the section 89C Report sent to the practitioner on 2 March 2011 with an invitation for the practitioner to make a written submission.

- In a written submission dated 1 April 2011 the practitioner's legal representative advised the Director that the practitioner:
  - "is prepared to enter into an agreement with you pursuant to section 92";
  - "will admit that he practised inappropriately during the referral period in that in some instances he failed to make adequate records first in respect of his Item 36 and 44 consultations and secondly in respect of the clinical indications for his referring patients for CT scans";
  - had "sought specific input from the President of the Australian Spine Society, Mr Graeme Brazenor, neurosurgeon, to address Medicare concerns in relation to [CT items] with special emphasis on clinical indicators and relevant data recording"; and
  - "will undertake appropriate training with the President of the Spine Society, Mr Brazenor, in order to upskill regarding the appropriate ordering of CT scans".

- A section 92 agreement was entered between the practitioner and the Director on 8 June 2011. The Agreement was ratified by the Determining Authority on 12 July 2011.

Dr Bill Coote,
Acting Director
Professional Services Review
// October 2011