Health Insurance Amendment (Professional Services Review) Bill 2012

Dr Rhonda Jolly
Social Policy Section

Contents

Purpose ............................................................................................................................................. 3
Background ..................................................................................................................................... 3
Evolution of the PSR ..................................................................................................................... 3
   Amendments .................................................................................................................................. 5
   1997 amendments ...................................................................................................................... 5
   1999 amendments ...................................................................................................................... 5
   2002 amendments ..................................................................................................................... 6
   2006 amendments to regulations ............................................................................................. 7
Review 2006–07 ........................................................................................................................... 7
   Response by Labor .................................................................................................................... 8
   2010 Bill ...................................................................................................................................... 8
   This Bill ....................................................................................................................................... 9
Description of the Professional Services Review Scheme ............................................................. 10
Committee consideration .............................................................................................................. 10
   PSR structure and composition ............................................................................................... 10
   Operating procedures and processes ....................................................................................... 13
   Procedures for investigation .................................................................................................... 14
   Pathways for practitioners ........................................................................................................ 14
   Appeals process ........................................................................................................................ 15
   Other issues ............................................................................................................................... 16
   Senate report ............................................................................................................................. 17
Financial Implications ............................................................................................................ 19

Main issues and key provisions .......................................................................................... 20
  Validation of certain acts .................................................................................................... 20
    Issue ................................................................................................................................. 20
    Provisions ......................................................................................................................... 21
  Prescribed pattern of services ........................................................................................... 22
    Issue ................................................................................................................................. 22
    Provisions ......................................................................................................................... 24
    Comments ......................................................................................................................... 24
  Allied health practitioners ................................................................................................. 26
    Issue ................................................................................................................................. 26
    Provisions ......................................................................................................................... 26
  Other amendments ........................................................................................................... 27
    Meaning of service .......................................................................................................... 27
    Extensions of time ............................................................................................................. 27
    No further action in certain circumstances ...................................................................... 28
    Disqualified practitioners ............................................................................................... 29
    Patient referrals ............................................................................................................... 29
    Legislative instruments .................................................................................................... 29
  Concluding comments ...................................................................................................... 29

Appendix A: PSR Review process ..................................................................................... 31

Appendix B: Number of practitioners referred to the PSR ................................................. 34
Health Insurance Amendment (Professional Services Review) Bill 2012

Date introduced: 9 May 2012

House: House of Representatives

Portfolio: Health and Ageing

Commencement: Sections 1 to 3 and Schedule 1 on Royal Assent; Schedule 3 is the day after Royal Assent and Schedule 2 on a single day to be fixed by Proclamation however, if Schedule 2 does not commence within the period of six months after Royal Assent, it commences on the day after the end of that period.

Links: The links to the Bill, its Explanatory Memorandum and second reading speech can be found on the Bill’s home page, or through http://www.aph.gov.au/Parliamentary_Business/Bills_Legislation. When Bills have been passed and have received Royal Assent, they become Acts, which can be found at http://www.comlaw.gov.au/.

Purpose

The Health Insurance Amendment (Professional Services Review) Bill 2012 (the Bill) proposes to amend provisions for the Professional Services Review (PSR) Scheme and the Medicare Participation Review Committee (MPRC) processes in the Health Insurance Act 1973 (the Act). It is intended that these amendments will strengthen the ability of the Professional Services Review to protect the integrity of Medicare, improve administration and clarify issues raised in judicial decisions.

Background

Evolution of the PSR

Medical Services Committees of Inquiry (MSCI) were established under the Act ‘to determine whether services rendered to patients were reasonably necessary for the adequate medical care of the patients’. In effect, MSCI were to determine if medical practitioners were ‘overservicing patients’.


Warning: All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.
A 1982 audit report on the MSCI system found, however, that approximately seven per cent of Medicare benefits funding was lost to fraud and overservicing, whereas only 51 medical practitioners had been penalised for fraud or overservicing in seven years. The report blamed ‘cumbersome, time-consuming and ineffective’ MSCI procedures for this situation. Some remedial measures, including a restructure of the Department of Health, were taken to address problems with the system, but a further audit done a decade later by the Australian National Audit Office (ANAO) found that the ‘basic mechanisms’ of the MSCI system had changed only marginally. The ANAO made a number of recommendations, such as increasing penalties for overservicing and providing MSCIs with more power to access medical records.

In response to the ANAO’s report, the Keating Labor Government established a joint task force from the Department of Health, the Health Insurance Commission (HIC) and the Australian Medical Association (AMA) to investigate the option of a peer review scheme which could be given powers to investigate medical practitioners suspected of fraud or overservicing as well as the capacity to apply effective penalties if overservicing were to be identified.

Funding was provided in the 1994 Budget and legislation was passed later in that year to create the statutory body, the Professional Services Review (PSR or the Scheme) Scheme. The PSR encompassed a number of significant changes to the existing system, including the introduction of the concept of ‘inappropriate practice’. This concept was seen to take ‘investigative practice well beyond mere excessive servicing’ to include practices such as providing insufficient medical care or inadequate medical record keeping. The Scheme provided for a number of disciplinary options, ranging from counseling, through repayment of Medicare benefits to full disqualification and revocation of prescribing rights for a period up to six months. At the same time, there were mechanisms built in to the system which were intended to ensure that persons under review were treated fairly. The PSR applied to a number of professions, but it was linked to those professions which claimed Commonwealth benefits.

---

7. Note: there is a difference between fraud and inappropriate practice. For fraud to occur 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.
9. It covered medical practitioners, dentists, optometrists, chiropractors, physiotherapists and podiatrists. The PSR Scheme did not cover hospital treatment of public patients because medical benefits are not paid for this care. Fraud and inappropriate practice in public hospitals are the responsibility of state and territory governments.

Warning: All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.
Amendments

To date, the PSR has been amended three times since it was introduced. This has been with the intention of refining its operation or in response to judicial decisions. These amendments took place in 1997, 1999 and 2002. Changes to the PSR regulation were also undertaken in 2006.

1997 amendments

In 1997, amendments to the Act were made to refine the Scheme by strengthening and clarifying the professional review process and removing administrative anomalies. Changes included increasing the maximum disqualification penalty for practitioners to three years and providing a PSR Review Committee with power to require persons, including those under review, to provide the Committee with such documents as it may specify prior to a hearing. The 1997 amendments were supported by the AMA.10

1999 amendments

A comprehensive review of the PSR Scheme was undertaken in 1999 in response to Federal Court decisions in relation to accusations of inappropriate medical practice by Dr Steven Yung (the Yung case). Dr Yung was investigated after statistical information indicated that between 1 January 1994 to 31 December 1994 he had provided 17 331 services.11

The HIC argued in the Yung case that an appropriate level of clinical input could not be maintained on a regular and continuing basis during the long hours worked by Dr Yung. However, the Federal Court did not accept that counting the number of hours worked could be readily translated into allegations of inappropriate practice.12 Nor could the number of patients Dr Yung saw provide a basis for concluding that he delivered inadequate care.13 In addition, the Federal Court was satisfied that particular instances of inappropriate practice needed to be identified from a sample of services, rather than extrapolated from general statistics as had occurred. In effect, in 1997, the Federal Court found a number of deficiencies in the PSR process. The findings of the Full Federal Court on appeal iterated this opinion.14

12. Ibid.
13. Ibid.

Warning: All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.
Following the 1999 Review, the PSR Scheme was substantially amended by the *Health Insurance Amendment (Professional Services Review) Act 1999* to address procedural and evidentiary deficiencies and to refine its effectiveness in dealing with possible instances of inappropriate practice. The 1999 amendments contained, for example, a new deeming provision, using the concept of a 'prescribed pattern of services'. This pattern involved the rendering of 80 or more services a day during 20 or more days in a given year. The pattern was developed by the PSR Review Committee based on HIC data and in consultation with peak bodies.

### 2002 amendments

Consistent with the recommendations of the 1999 Review, the PSR was modified further in 2002, to clarify the intended object and operation of the Scheme and to address issues identified by the Federal Court in the case of Dr Jagjit Singh Pradhan (the *Pradhan case*).

As in earlier cases relating to the PSR, the key issue in the *Pradhan* case was that there were design and administration deficiencies in PSR processes. Dr Pradhan submitted to the court that PSR referrals were too broad and matters raised in a PSR adjudicative referral were different to those raised in an investigative referral. Justice Finn concluded that the 1999 amendments had had no material impact upon these issues and that if Parliament had intended ‘to mandate a roving commission into past service provision by medical and other practitioners ... it would - and should - have done so in language having far greater clarity and aptness for that purpose than that of the 1999 amendments’.

Legislative amendments to address the issues raised in the *Pradhan* case were made in 2002 and were supported by all key stakeholders. The amendments to the Act emphasised the public protective aim of the Scheme and replaced an investigative referral process with a request from Medicare Australia for examination of Medicare services rendered or initiated by a practitioner for whom a Medicare benefit had been claimed during a particular period. This process was not restricted by reference to Medicare Australia’s reasons for the request and was seen to have the

---

16. Ibid.
17. Ibid.
19. Ibid.

*Warning: All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.*
objective of enhancing procedural fairness opportunities at various stages of the Scheme’s review process.\textsuperscript{21}

2006 amendments to regulations

Two amendments were made in July 2006 to the Health Insurance (Professional Services Review) Regulations 1999.

The first amendment updated the list of ‘professional attendances’ that could be provided by medical practitioners under the Medicare Benefits Schedule (MBS).

Consistent with the public protective role intended for the Scheme, the second amendment specified bodies to whom a person under review must be referred (under section 106XB of the Act) if it is considered by the Director of the PSR, or a PSR committee advises the Director, that the person may have failed to comply with professional standards.\textsuperscript{22}

Review 2006–07

A review of the PSR Scheme was conducted in 2006–07 by a Steering Committee comprising representatives from the Department of Health and Ageing (DoHA), Medicare Australia, the AMA and the PSR, who provided a co-opted representative (the 2006–07 Review).\textsuperscript{23} The 2006–07 Review confirmed continued support for the PSR Scheme and the concept of peer review and made a number of recommendations for improvements including:

- formation of an advisory committee to oversee the Scheme’s performance and provide ongoing guidance for its effective operation. The 2006–07 Review suggested a number of roles for this advisory committee, such as developing parameters for identifying possible inappropriate practice by specialists and allied health professionals and
- streamlining of the Scheme’s review process while maintaining natural justice for persons under review.\textsuperscript{24}

The 2006–07 Review also favoured broadening the definition of ‘practitioner’ so that all health professionals who provide services which attract Medicare benefits would come under the purview of the Scheme.

\textsuperscript{24}. Ibid.
Upon the release of the review report in May 2007, the Minister for Health and Ageing, Tony Abbott, commented:

A review of the Professional Services Review (PSR) Scheme has found that it continues to provide a safeguard for patients against inappropriate medical practice. The PSR plays an important role in protecting the integrity of Medicare and the Pharmaceutical Benefits Scheme. While the vast majority of health practitioners provide appropriate services to patients, the PSR investigates instances where inappropriate practices may have occurred, and may impose sanctions on those found to have practised inappropriately... The review found that the scheme continues to have the support of the health sector. The report recommends retaining the scheme, including the concept of ‘peer review’ that underpins it. On the matter of governance and coverage, the review has recommended the appointment of an advisory committee, and broadening the scheme to include allied health practitioner services eligible for Medicare benefits. It also recommends that the scheme’s processes be streamlined and its administration improved through consultation with professional colleges and medical bodies... The recommendations will be implemented in consultation with the health sector.  

The Coalition Government was not able to fulfil its promise to consult with the health sector and introduce legislation to implement the recommendations in the 2006–07 Review prior to the November 2007 federal election.

Response by Labor

2010 Bill

It was not until 16 June 2010, that the Rudd Labor Government moved to address the matters raised by the 2006–07 Review. The Health Insurance Amendment (Professional Services Review) Bill 2010 (the 2010 Bill) was introduced into the House of Representatives on 17 June 2010. However, the 2010 Bill lapsed when the Parliament was prorogued on 19 July 2010.

The release of an exposure draft of the Government’s proposed changes to the PSR in March 2010 caused some concern to stakeholders. Both the Royal Australian College of General Practitioners (RACGP) and the AMA raised objections to a requirement which would have compelled persons under review to ‘produce objects’ as requested by a PSR committee. The doctors’ groups were alarmed that medical practitioners would face up to 12 months in gaol if they failed to do so. They

---

26. The Bill's home page for Health Insurance Amendment (Professional Services Review) Bill 2010 can be viewed at: http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query%3DId%3A%22legislation%2Fbillhome%2Fr4326%22;rec%3D0

**Warning:** All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.
were also concerned that changes to legislation would require doctors disqualified from Medicare to display signs to that effect.\textsuperscript{27}

The AMA noted its support for the recommendation by the 2006–07 Review that the Determining Authority should be given the power to enforce relevant sanctions equivalent to those available to the MPRC.\textsuperscript{28} However, it sought clarification of a number of the provisions in the Bill including the proposals which it believed might have allowed the Director and the Determining Authority to disqualify for up to five years only practitioners with an effective determination of inappropriate practice on two or more separate occasions.\textsuperscript{29}

The RACGP was also concerned about a number of other issues in the 2010 Bill. In particular, the RACGP complained that ‘prescribed patterns of services’, as described by regulation 10 in the Health Insurance (Professional Services Review) Regulations 1999, applied primarily to general practitioners. It saw no reason why regulation 10 did not apply to all medical specialties.\textsuperscript{30}

This Bill

There appears to be little opposition to this Bill. The Opposition noting for example in the House of Representatives that it did not intend to oppose any provisions in the Bill.\textsuperscript{31} This is hardly surprising, given that the Leader of the Opposition, Tony Abbott, in his past capacity as the Coalition Government’s Health Minister, was one of the Ministers who failed to consult with the AMA on PSR panel appointments.\textsuperscript{32} In addition, the Bill proposes amendments to the PSR recommended by a review set up by the previous government and fully supported by Mr Abbott.

\begin{itemize}
\item \textsuperscript{28} The Determining Authority is an independent body within the PSR. The Determining Authority has two main functions: to decide whether to ratify section 92 Negotiated Agreements reached between the Director of PSR and a practitioner and to determine what sanctions apply when practitioners have been found to have engaged in inappropriate practice by a Committee.
\item \textsuperscript{29} AMA exposure draft submission, op. cit
\item \textsuperscript{30} RACGP exposure draft submission, op. cit.
\item \textsuperscript{32} This issue is addressed by Schedule 1 to the Bill.
\end{itemize}

\textbf{Warning:} All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.
Description of the Professional Services Review Scheme

The PSR, which is established under Part VAA of the Act, is made up of three separate elements: the Director, the committee of peers and the Determining Authority.

The Director’s main role is to decide whether a case against a person under review should proceed, or whether it is appropriate to enter into an agreement with a practitioner.33 An agreement may include repaying some or all Medicare benefits received by that practitioner. Agreements have to be ratified or rejected by the Determining Authority.

If the Director does not consider an agreement to be appropriate, or one cannot be reached, he/she will refer the case to the committee of peers. This panel will then examine the case in detail with the practitioner and report to the Determining Authority. If inappropriate practice is found to have occurred, the Determining Authority will decide on appropriate sanctions.34

Committee consideration

Prior to the introduction of this Bill, PSR issues were the subject of a review by the Senate Community Affairs References Committee (the Senate Committee).35 Terms of reference for the inquiry, which was referred to the Senate Committee on 6 July 2011, required investigation of:

- the structure and composition of the PSR
- operating procedures and processes used to guide committees in reviewing cases
- procedures for investigating alleged breaches of the Act
- pathways for practitioners under review to respond to alleged breaches
- the appropriateness of the appeals process and
- any other relevant matters.36

The Senate Committee asked for submissions and undertook public hearings before producing its report on 25 October 2011. The matters raised in those submissions are discussed below.

PSR structure and composition

The structure and composition of PSR Committees was the subject of a considerable number of submissions to the Senate Committee. Stakeholders such as MDA National, a provider of medical

---

35. Ibid.
36. Ibid.

*Warning: All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.*
defence and medico legal advocacy services, noted support for a peer review process to determine whether instances of inappropriate practice may have occurred, but added that ‘any peer review process must involve genuine peers’. 37 According to MDA National:

... as at 30 June 2009, there were 158 members who were available to serve on PSR Committees and we understand that there may be fewer members currently available to serve on these committees. General practice, in particular, is a very diverse specialty, with significant differences associated with the geographical location of the practice, patient demographics and GPs who work full-time or part-time and with different sub-specialty expertise. It is essential that practitioners under review are provided with appropriate peer review. For example, MDA National is aware of one case where a plastic surgeon was involved in the review of a GP who was performing skin cancer work, and another case where a dual specialty qualified practitioner did not have a similarly qualified peer on the PSR Committee. Importantly, the peers must apply an appropriate standard with respect to their assessment of the clinical relevance and adequacy of the services provided by the practitioner and not a ‘gold standard’. 38

MDA National submitted that an increased use of independent medical experts who could provide reports and/or give evidence before the Director or a PSR Committee may assist in providing more appropriate peer review. Guidelines could be developed to provide advice on the admissibility of expert evidence and how the evidence should be considered and used. Consideration could also be given to having the PSR Committees chaired by a legally qualified person with experience in administrative review proceedings. 39

Other organisations made similar points. These included the Australasian Podiatry Council’s call for PSR Committees reviewing members of its profession to be composed of members of their state based member association 40 and the Health and Life organisation’s suggestion that panels be appointed by relevant accredited colleges responsible for the training of a particular profession. 41

Submissions from some who had experienced the PSR process also argued that the selection processes for PSR Committees were flawed. Professor Robert Allen claimed that in late 2004 he was ‘attacked’ by a PSR Committee supposedly consisting of his peers, but in effect comprising three

37. MDA, submission, op. cit.
38. Ibid.
39. Ibid.

Warning: All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.
practitioners with no experience or expertise in his area of nutritional and environmental medicine. These practitioners forced him to provide his patient notes, were not interested in outcomes of his practice and expressed pre-conceived ideas about what should occur at consultations.42 A number of other submissions by medical practitioners put similar arguments, including that practitioners’ lives and livelihoods can be ruined by judgements delivered by PSR Committees that did not have relevant experience and credentials.43 The Australasian College of Nutritional and Environmental Medicine saw the solution for practitioners such as Professor Allen as amending the structure and composition of the PSR to represent more broadly the whole population of medical practitioners; including specialists and sub-specialist general practitioners to ensure that those who practice in areas of specialty or sub-speciality are not marginalised.44

Lawyer Allen Williamson submitted detailed comments that noted PSR Committee appointments needed to reflect similar circumstances of practice and that this did not necessarily occur.45 Williamson was also not alone in criticising the Director of the PSR. He claimed that as the Director influenced the selection of Committee members and Deputy Directors, the people chosen for these positions possibly reflected the Director’s view of the appropriate operation of the Medicare scheme.46 Medical defence organisation, Avant, also raised the issue of the powers of the Director, concluding that there were insufficient checks and balances currently in place.47 There appeared also to be particular concern about the approach of ex-Director Dr Tony Webber, which some viewed as inflexible and insensitive to the subtleties requirements for various practices.48

In contrast, former PSR Committee members considered the composition of the PSR Committees was “both sound and made up of well regarded medical practitioners who have a broad breadth of

46. Ibid.
48. See for example evidence from M Watt, Paralegal Adviser, Australian Doctors Union, evidence to Senate Community Affairs References Committee, Review of the Professional Services Review (PSR) Scheme, op. cit.

Warning: All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.
clinical experience’ and that the system as it exists was fairer than having a legal practitioner (or some other person) determining whether a medical practitioner was practising in a clinically appropriate manner.\textsuperscript{49}

Operating procedures and processes

With regards to PSR ‘operating procedures’, Avant considered that it was essential for the proper functioning of the PSR Scheme for PSR Committees to be seen to be independent of the PSR Director. In Avant’s view, the Director and Committees were perhaps too closely interlinked.\textsuperscript{50}

Dr Richard Waluk complained about what he called ‘fishing expeditions’ and ‘fault finding missions’ undertaken by the PSR. Dr Waluk saw these as an escalation of an audit process in order ‘to find implicating evidence at all cost’.\textsuperscript{51}

In the AMA’s view, its advocacy for publicly available guidelines regarding the selection and appointment of panel members and the PSR’s response in agreeing to produce these documents had addressed concerns about the appointment of practising, appropriately qualified and experienced PSR Committees. It could be added that perhaps the controversy regarding the selection of PSR Committees which first surfaced in late 2010 (and which is discussed in more detail later in this Digest) was also a contributing factor in the development of these guidelines.

Further, the AMA argued that it had secured changes to the system by negotiation which would enable persons under review to prepare better for meetings with the PSR Director and for those persons to receive more details about investigations prior to those meetings. Further, to lessen any perception of intimidation, the meetings were no longer to be held in the offices of the PSR’s legal representatives.\textsuperscript{52} The AMA also noted that it was in discussion with DoHA and the PSR about the development of guidelines governing the conduct of the Director’s investigation:

The PSR scheme could be strengthened by the inclusion of requirements for the Director and the Committees to provide a statement in writing setting out their findings on material questions of


\textsuperscript{50} Avant, submission, op. cit.


Warning: All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.
fact, referring to the evidence or other material on which those findings were based and giving the reasons for the decision. The AMA is currently in discussions with the Department of Health and Ageing and the PSR about the best way to ensure that this fundamental aspect of administrative law principles is guaranteed in the operation of the PSR scheme.

Dr Paul Hanson, a former PSR Committee member, believed PSR processes are both fair and reasonable to all concerned because before persons under review are subject to PSR Committee investigation they have been offered a number of chances to consider changing their practices.

Procedures for investigation

In Health and Life’s view, however, the PSR appeared subjective in determining whether a breach had occurred basing its conclusions ‘on statistical analysis rather than actual evidence’. Professor Allen also saw a problem with a number of criteria used to determine whether an alleged breach of the Act had occurred. Allen considered that the current system left it to individuals to determine what the general body of medical practitioners would do in assessing what constitutes a breach. So too, in insisting that practitioner’s notes are used as evidence in investigating alleged breaches, it is not taken into consideration that it may be unrealistic to expect that notes will fully reflect all of a consultation.

Pathways for practitioners

In Paul Hanson’s view, the PSR gives persons under review ample opportunity to explain why they practice the way they do; they have the opportunity after PSR Committee hearings to offer further submissions and these are taken in to account in the final reports of those Committees. In addition, persons under review are able to appeal findings to the Federal Court. Dr Gerard Ingham, also a former PSR Committee member, agrees. Dr Ingham adds that the current process also affords persons under review the opportunity to come to an arrangement with the Director of the PSR and avoid a hearing.

Avant argues, however, that persons under review are not legally represented. This creates significant barriers for people who are also nervous, inexperienced and often fatigued by adversarial, repetitive questioning that can continue for days. Consultations with persons under review have led

---

53. Ibid.
54. Hanson, submission, op. cit.
55. Health and Life, submission, op. cit.
56. Allen, submission, op. cit.
57. Hanson, submission, op. cit.

**Warning:** All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.
Avant to conclude that these practitioners are often left wondering exactly what conduct Committee members actually believe is inappropriate. Moreover, the practitioners are only told ‘with any degree of particularity’ what the case is against them when the PSR Committee produces a draft report.\(^5\) During public hearings Dr John Caska from the ADU agreed with Avant’s view that persons under investigation are presumed to be guilty.\(^6\)

In Professor Allen’s view, practitioners under review must be entitled to legal or similar representation to both represent and speak on their behalf and entitled to mitigate the financial consequences of a breach where it can be demonstrated that it was unintentional rather than fraudulent.\(^6\)

In contrast, Dr Tony Webber, in a private capacity as former Director of the PSR, argued before the Senate Committee at public hearings, that the process of investigation was not a legal process because the PSR Committee focuses on the clinical relevance of the behaviour of medical practitioners. Dr Webber noted, however, that there is nothing preventing doctors being reviewed from being accompanied by a legal person, and this person ‘is certainly able to comment on points of law or procedure, or procedural fairness, but because they are not medical practitioners they do not have the ability to talk to the problem at hand’.\(^6\)

### Appeals process

There was considerable criticism of the appeals process. The Australasian Integrative Medicine Association (AIMA) argued ‘there is no practical appeal mechanism’.\(^6\) Health and Life acknowledged that while there may be a process, it takes too long and it is too difficult and expensive for practitioners to defend themselves.\(^6\) Professor Allen argued that the appeals process needed to be ‘outside the domain of the PSR’.\(^6\)

On the other hand the PSR argued that there is ample opportunity for persons under review to appeal decisions during the investigation process:

---

59. Avant, submission, op. cit.
61. Allen, submission, op. cit.
64. Health and Life, submission, op. cit.
65. Allen, submission, op. cit.

**Warning:** All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.
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). 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.  

The PSR added that since 2004—05 it had received 324 requests for review of practitioners from Medicare Australia. In 21 per cent of those cases there had been a decision not to take further action and in only 30 per cent had there been final determinations made of inappropriate practice. The PSR noted also however, that 49 per cent of cases had resulted in section 92 agreements under which a practitioner acknowledges inappropriate practice.

Other issues

Other issues which were raised before the Senate Committee included how Medicare item descriptors may contribute to adverse findings against practitioners. The College of Nutritional Medicine remarked for example:

> The PSR’s interpretation of the Medicare descriptor items should be based on the agreed positions of the organisations concerned. Medicare item descriptors may be problematic and open to individual interpretation. Medical consultations take many forms that do not necessarily fit current Medicare item descriptors, e.g., counselling during a consultation does not necessarily require a physical examination, yet the descriptor includes/requires a physical examination.  

---


67. Ibid.

68. A 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 practitioner’s authority to prescribe or dispense PBS medicines for an agreed period of (currently) no more than three years).

69. For example, Watt, op. cit.

70. College of Nutritional Medicine, submission, op. cit.

**Warning:** All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.
Dr Waluk also argued for review of Medicare descriptors so that they were made non-ambiguous and their meaning adequately communicated. Waluk believed introduction of time only (not content) based consultation charging may simplify audits.\textsuperscript{71} MDA National believed there should be greater consultation with the medical profession in developing item descriptors and associated explanatory notes.\textsuperscript{72}

Waluk also argued for adoption of a different approach to Medicare statistical targeting; one which could be calibrated against the practice demographics and specialisation. This would mean that current practices, such as those of comparing the referral patterns of an urban medical practitioner with those of a rural colleague are replaced with a requirement to compare like with like. The findings of the Senate Committee tentatively suggest that this could be one means to improve operation of the PSR without recourse to further legislative change.

Dr Browning from the Medical Indemnity Protection Society submitted that the Senate review was an opportunity to recast the PSR Act and processes so that it better reflected the aim of the Scheme to protect patients from inappropriate practice than what Browning saw was an emphasis on cost recovery. Browning suggested that this could be achieved if the Australian Health Practitioner Regulation Agency was installed as the body to determine if an investigation was warranted.\textsuperscript{73}

Senate report

The Senate Committee made some obvious statements about Medicare Australia making more effort to communicate its auditing methodology to the medical community and agencies involved in health policy regularly updating online information about regulations and policies. It also made a series of recommendations in response to some of the matters which had been raised by stakeholders including:

- that the ways in which official lists of professions, specialties and sub-specialties are constructed is simplified (Recommendation 3)
- that guidelines agreed by the PSR and the AMA in March 2011 for the appointment of Panel Members and Deputy Directors were reviewed one year after their implementation and that this was done in consultation with stakeholders (Recommendation 4)
- that the Government liaise with stakeholders to ascertain the desirability for a legally qualified person to be involved in the PSR process (Recommendation 5)

\textsuperscript{71}. Waluk, submission, op. cit.
\textsuperscript{72}. Dr A Browning, Medical Indemnity Protection Society, evidence to Senate Community Affairs References Committee, \textit{Review}, op. cit.

\textbf{Warning:} All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.
that the Government review the legislation to allow the Determining Authority greater flexibility in its sanctions with regard to PBS items (Recommendation 6) and

that the Government review the PSR’s enabling legislation, to ensure that the PSR can effectively pursue abuse of the MBS or PBS systems, regardless of the structure of employment of the person under review (Recommendation 7).

As none of these recommendations as they stand would need to be addressed by legislative means, none have been addressed in this Bill. However they serve to acknowledge some of the ongoing disquiet in the medical profession in relation to the operation and effectiveness of the PSR Scheme and provide context to some of the amendments in the Bill.

The Senate Committee made a number of observations about how processes could be further improved without recourse to legislative change. For example, arguments that the PSR Committees are not comprised of true peers and therefore they cannot provide natural justice, could be addressed, in the Senate Committee’s view, by improving the pool of potential panel members and strengthening requirements to have peers on each panel.

Additional comments from the Coalition Senators on the Senate Committee are also worth noting:

Coalition Senators acknowledge those of the medical profession who were sufficiently courageous to expose some of the limitations of the Professional Services Review process... But for the courageous advocacy by some and their willingness to litigate many of the deficiencies would not have been so widely exposed.

Coalition Senators urge the soon to be appointed personnel of the PSR to take a more consultative approach in the performance of their functions and ascertain methodologies whereby fairness to all can be transparently observed. This is especially important for those in the emerging areas of speciality. This will go a long way to restoring confidence by the profession in the operations of the PSR.

The Government response to the Senate Committee report, tabled in the Senate on 13 March 2012, accepted all the recommendations which had been made.

On 9 May 2012, the Senate Selection of Bills Committee determined not to refer this Bill to a Committee for further inquiry. Given that the Senate had recently investigated issues pertaining to the PSR, this was not unexpected.

---

75. Ibid.

Warning: All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.
Financial Implications

According to the Explanatory Memorandum the amendments in this Bill will have no financial implications for the Commonwealth.

However, it should be noted that there are clear financial implications if the amendments contained in Schedule 1 to the Bill were to fail to pass. Benefits paid under the PBS and Medicare were approximately $25 billion in 2010–11 and the amounts paid back to these schemes by practitioners deemed to have practiced inappropriately is minimal in comparison. Nevertheless, as the table below shows the amounts over time cannot be dismissed. Therefore, if amendments which validate past PSR Committee findings are not confirmed, then those practitioners previously deemed to have practised inappropriately may be entitled to reclaim for services.

Table 7 - Funds recovered from PUR’s

<table>
<thead>
<tr>
<th>Year</th>
<th>Negotiated Agreements</th>
<th>Final Determinations</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004-05</td>
<td>197,500</td>
<td>1,626,990</td>
<td>1,824,490</td>
</tr>
<tr>
<td>2005-06</td>
<td>509,984</td>
<td>817,392</td>
<td>1,327,376</td>
</tr>
<tr>
<td>2006-07</td>
<td>594,097</td>
<td>1,455,901</td>
<td>1,749,998</td>
</tr>
<tr>
<td>2007-08</td>
<td>1,130,793</td>
<td>530,011</td>
<td>1,660,804</td>
</tr>
<tr>
<td>2008-09</td>
<td>1,206,872</td>
<td>405,083</td>
<td>1,611,955</td>
</tr>
<tr>
<td>2009-10</td>
<td>3,099,621</td>
<td>2,085,510</td>
<td>5,185,131</td>
</tr>
<tr>
<td>2010-11</td>
<td>1,813,894</td>
<td>386,750</td>
<td>2,200,644</td>
</tr>
<tr>
<td>Total</td>
<td>8,959,551</td>
<td>7,007,583</td>
<td>15,967,136</td>
</tr>
</tbody>
</table>

Source: PSR


Warning: All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.
Main issues and key provisions

Validation of certain acts

Issue

Schedule 1 to the Bill is a legislative response to the decision of the Full Court of the Federal Court in the *Kutlu* case, which is outlined below.

*Kutlu v Director of PSR [2011] FCAFC 94*

Section 84 of the Act requires the Minister for Health and Ageing to consult with the AMA before making appointments to the PSR Panel. Members of the PSR Panel are drawn upon to constitute PSR Committees which investigate instances of alleged inappropriate practice by medical practitioners.

In November 2010, a number of concerns were raised about the validity of the appointments of medical practitioners to the PSR Panel. In the *Kutlu* case, the Full Court of the Federal Court considered whether a failure to follow the legislative requirement that the Minister consult with the AMA prior to making statutory appointments to the PSR Panel had the effect of invalidating the appointments. 80 *Kutlu* concerned five separate PSR Committees, each of which was constituted by members of the PSR Panel who were appointed by two successive Ministers without consulting the AMA.

The Court held that the requirement to consult was a mandatory requirement and that consultation could not be seen as a mere technicality or formality.

The Commonwealth argued in *Kutlu* that a finding of invalidity would create significant public inconvenience—but the Court dismissed the argument. Justices Rares and Katzmann said that ‘the inconvenience resulting from a finding of invalidity of the various impugned appointments is likely to be significant. However, the scale of both Ministers’ failures to obey simple legislative commands to consult the AMA ... is not likely to have been a matter that the Parliament anticipated.’ In a separate judgment, Justice Flick agreed, stating that ‘Any public inconvenience is an inconvenience for which the Minister alone must remain accountable.’ 81

In August 2011 the Federal Government filed an application to appeal the *Kutlu* decision in the High Court. However, the Government abandoned its intention to appeal in the week prior to the hearing

---


**Warning:** All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.
in the High Court, in conjunction with the introduction of the ‘retrospective’ legislation contained in this Bill.

The decision in *Kutlu* is critical for a number of practitioners who have commenced proceedings in the Federal Court of Australia seeking judicial review of decisions of PSR Committees which had made findings adverse to the practitioners. It has been noted that the decision ‘potentially permits practitioners who have been the subject of an adverse finding by a PSR Committee—which considered their matter after the 2005 appointments—to now seek to challenge those decisions’.  

A report in the Medical Observer commented that 40 doctors whose cases had been deliberated upon by PSR committees between 2005 and 2009 could possibly challenge findings against them. These doctors had been required to repay $3.3 million in Medicare rebates.

Provisions

Schedule 1 to the Bill validates certain actions done under Part VAA, VB or VII of the Act any time before the commencement of the Schedule. These parts of the Act relate to the PSR, MPRC and various miscellaneous matters.

Item 1 of Schedule 1 retrospectively validates actions taken by PSR panels and the Deputy Director at any time before the item commences; that is, acts that may be invalid because a person was not validly appointed as a panel member or a Deputy Director.

The Parliament has the power to pass legislation retrospectively. Generally though, governments must justify the need for retrospective operation and ensure that the legislation does not unduly impinge on a person’s rights or responsibilities. The retrospective operation of this amendment is intended to ratify previous decisions made by the PSR and to ‘ensure that action taken to protect the integrity of services provided under Medicare may be relied on’.

In addition, sub item 1(4) provides that the retrospective operation of Schedule 1 to the Bill does not affect the rights of those persons who have been granted leave to appeal to the High Court, if the valid appointment of a panel member or a Deputy Director is an issue in the proceedings. Item 3 of Schedule 1 provides for payment of compensation in circumstances where the retrospective operation of Schedule 1 to the Bill results in an acquisition of property from a person otherwise than on just terms.

---

82. Unsworth Legal, op. cit.
84. The constitutional validity of retrospective legislation was affirmed by the High Court in *Polyukhovich v Commonwealth* (1991) 172 CLR 501.

**Warning:** All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.
This is a standard type of provision\(^{86}\) that is designed to preserve the law from a challenge based on section 51(xxxi) of the Constitution, which provides that Parliament has power to make laws with respect to ‘the acquisition of property on just terms from any State or person for any purpose in respect of which the Parliament has power to make laws’.

Interestingly, Health Minister Tanya Plibersek has stated:

> The practitioners who have been found to have engaged in inappropriate practices by their peers, and have successfully challenged a Professional Services Review process on the grounds of irregularity in the appointment process, may be re-referred to a new PSR Committee for investigation if the Director decides to do so.\(^{87}\)

**Item 2** of Schedule 1 to the Bill will allow the PSR to re-examine the cases of the four doctors who have successfully challenged the PSR appointment process in the *Kutlu* case.

The Explanatory Memorandum describes the reasons for this provision:

> By allowing a new PSR Committee to examine the range of services for matters that have been successfully challenged by a practitioner on the grounds of irregularities in the appointment process of Panel members and Deputy Directors, item 2 will allow a Committee of the practitioner’s peers to ensure that the practitioner’s provision of those services was appropriate. This will ensure the integrity of the MBS and PBS is maintained and not undermined by an irregularity in the appointment process.\(^{88}\)

### Prescribed pattern of services

**Issue**

The Explanatory Memorandum to the 2010 Bill argued that changes to the Act introduced by its provisions would ensure that the PSR Scheme continued to operate ‘effectively’ to prevent Commonwealth funds being paid for services provided by practitioners who engaged in inappropriate practice.\(^{89}\) It could be suggested however, that this Bill and the current proposals reflect what has become a commonplace response to the issue of defining, and dealing with,

---

86. For example, equivalent provisions are: section 300 of the *Carbon Credits (Carbon Farming Initiative) Act 2011*; subsections 68(2) and (3) of the *Tertiary Education Quality and Standards Agency Act 2011*; and section 152ELD of the *Competition and Consumer Act 2010*.


**Warning:** All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.
'inappropriate practice' through the PSR process—legislative amendment as a reaction to practitioners’ perceptions of injustice. Indeed, this Bill can be seen as yet another attempt to achieve balance between treating practitioners fairly and reducing incidents of inappropriate practice.

Amendments in Part 1 of Schedule 2 to the Bill arise as a result of the judgments in the Daniel cases.

---


Section 106KA of the Act was introduced under the 1999 amendments to the PSR to expedite investigation of instances of overservicing. According to an assessment by legal analyst Robin Bell, section 106KA and regulations 7–10 read together, ‘provide that a medical practitioner who provides 80 or more professional attendances on 20 or more days in a 12-month period is deemed to have engaged in ‘inappropriate practice’ (what is commonly referred to as the 80/20 rule or the overservicing rule).’

On 8 May 2001, a representative of the Health Insurance Commission (HIC) wrote to Dr Stephen Daniel stating that his servicing pattern appeared to have reached the prescribed level which may result in automatic referral to the Director of Professional Services Review (the Director). Dr Daniel was counselled by another HIC representative from the Victorian office and told that he may be referred to a PSR Committee if concerns about his servicing continued. At first it appeared that HIC did not intend to formally investigate Dr Daniel. The Victorian office of the HIC subsequently wrote to Dr Daniel advising that a reduction in his practice statistics since he had received counselling had convinced that office that such a referral was not necessary.

In the meantime, the Canberra office of the HIC referred Dr Daniel to the PSR in December 2001 on account of his 80/20 practice statistics and in February 2002, the Director referred him to a PSR Committee. The conduct alleged was that Dr Daniel had engaged in ‘inappropriate practice’ in relation to the provision of services between 13 August 2000 and 7 January 2001.

Dr Daniel then sought judicial review of, among other things, the decision to refer him to the Director for breach of the 80/20 rule. The Federal Court, and then on appeal, the Full Court of the Federal Court found:

- the Act did not bind the HIC or the Director to make a referral merely because the relevant statistical conditions were satisfied—that is, a referral was not automatic
- the investigative referral to the Director was invalid because it did not take into account Dr Daniel’s prior counselling history and
- the adjudicative referral of Dr Daniel to a PSR Committee was invalid in that it lacked procedural fairness.

---


**Warning:** All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.
Amendments in this Bill revisit the Government’s earlier attempt (through the 2010 Bill) to address the issues raised in the Daniel judgements in relation to what comprises ‘inappropriate practice’.

Provisions

Existing paragraph 82(1)(a) of the Act defines inappropriate practice by a general practitioner as conduct in connection with rendering or initiating services that a PSR Committee could reasonably conclude would be unacceptable to the general body of general practitioners. Similar definitions of inappropriate practices apply to practitioners of other professions regulated by the PSR Scheme as set out in section 81.

Item 3 of Part 1 of Schedule 2 to the Bill inserts proposed subsections 82(1A)–(1D) into the Act. In particular, proposed subsection 82(1A) provides that a practitioner engages in inappropriate practice in rendering or initiating services during a period if some or all of the services constitute a ‘prescribed pattern of services’. Proposed subsection 82(1B) is an exception to the rule where the inappropriate practice in rendering or initiating services on a particular day arose due to exceptional circumstances.91

The Explanatory Memorandum for the Bill describes the purpose of Part 1 of Schedule 2 to the Bill as making it clear that the Chief Executive Medicare must request the Director of the PSR to review the provision of services by a person during a specified period if the Medicare CEO becomes aware ‘that the circumstances in which the services were rendered or initiated by a person constitute a ‘prescribed pattern of services’’.92

Item 6 of Schedule 2 inserts proposed subsection 82A into the Act to provide a definition of prescribed pattern of services as those which are prescribed by regulations and may include ‘the rendering or initiation of more than a specified number of services of a particular kind, on each of more than a specified number of days during a period of a specified duration’: proposed subsection 82A(3).

Comments

This change may serve to inflame some who have already been subject to existing PSR processes. For example, Dr Masters claimed in evidence to the recent Senate inquiry into the PSR that auditing of the medical profession had become unbalanced:

... such that there is no capacity for people who are audited or who are put up to the Professional Services Review to have their case heard in a natural justice situation. It is very difficult if you disagree with anybody in the PSR process to actually state your case and have the ability to cross-examine them about what they actually want.

91. Proposed subsection 82(1D) provides that regulations may prescribe those circumstances which are exceptional.
92. Emphasis not in original, Explanatory Memorandum, p. 15.

Warning: All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.
I see the big problem here is at the very first step. When the audit starts from Medicare, there is no actual guide from Medicare that you have done anything wrong. It is just a repeated line of, ‘We notice that you are a statistical outlier, so you are different from your colleagues; therefore, we have got concerns.’ When you ask them, ‘What exactly is your concern?’ they say, ‘We’re just letting you know that you’re in this five or 10 per cent of people who do,’ for instance, ‘more long consultations than other doctors.’ Then you might say back to them, ‘How many would you like me to do? They say, ‘No. That’s not a problem. Just what your peers would find acceptable.’

I have never had complaint from my peers, and all the people whom I have spoken to who have been through this process have not actually had complaints from their peers. The only complaint they have had is from Medicare. So there lies the problem: what is a peer; how do we access our peers; how do Medicare relate to peers? As you can probably see from what I have outlined before, I am actively involved with peers every day, and I have never had a complaint about my practice, except that I am a statistical anomaly. I think Medicare are suggesting to us that they would be very happy if we had this bell curve and there was a straight line right down the middle. They do not seem to like anybody on the end of the bell curve and they seem to want to interrogate them. Probably our main concern is that. And then there is the actual process itself. So we are putting forward that we need something more like an administrative tribunal to look at these cases.  

It appears from this and other evidence given to the Senate inquiry that, to date, assessment of patterns of practice has not been sympathetic to unusual or different circumstances. It remains to be seen to what extent this will be taken into account in regulations made for the purpose of proposed section 82A. Certainly, the indication is that Medicare is convinced that its ‘sophisticated’ and ‘adaptive’ profiling techniques take into account a number of factors when reaching decisions. Medicare identifies four broad situations in which a provider’s claims may be recognised for audit. These are when:

- a provider has used an item with a medium to high risk of non-compliance
- a provider’s individual claiming statistics appear to be unusual or irregular
- a provider’s claiming statistics are significantly different to their peers or
- a provider has been identified through ‘tip-offs’ and information received.

Medicare adds:

In each of these situations, Medicare Australia recognises there are often many acceptable reasons for claiming behaviour. Medicare Australia’s approach is not to assume an incorrect claim but to raise the concern with the provider and allow the provider the opportunity to explain their situation.

---


**Warning:** All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.
The Senate committee acknowledged the complexity of this issue, but accepted the premise that focussing on statistical outliers would be the best way to identify inappropriate practice. Nevertheless, it encouraged Medicare to try to develop techniques that have the capacity to uncover inappropriate practices ‘other than those identified as statistical outliers using current methods’.  

There is the possibility that this issue can be addressed more comprehensively and sympathetically through non legislative means and that future iterations of the regulations could reflect revised approaches to what constitutes prescribed patterns of service.

**Allied health practitioners**

**Issue**

Certain recommendations of the 2006–07 Review were dealt with in the proposed 2010 Bill and are now reflected in this Bill. These included:

- a determination could be made that a health professional was a practitioner for the purposes of the PSR Scheme and the MPRC. One reason for this amendment was that health professionals not covered by the PSR and MPRC review provided 3.6 million services at a cost to Medicare of $350 million in the calendar year 2009 and
- removing the requirement for the Director of PSR to refer to the MPRC those practitioners who have been found to have engaged in inappropriate practice on two or more occasions. This amendment provided that the Director and the Determining Authority of the PSR could apply a disqualification period of up to five years to those practitioners. This was equivalent to the sanction available to the MPRC and separated a review of inappropriate practice under a PSR process from the review of a practitioner by an MPRC (practitioners under this process are seen to have committed a civil or criminal offence).

**Provisions**

This Bill proposes in *items 16—18* of Schedule 2 to broaden the definitions of ‘practitioner’ and ‘profession’ in existing subsection 81(1) of the Act so that the Minister is able to determine new categories of health professionals providing health services within the meaning of subsection 3C(8)

---

96. Recommendations 4, 9 and 12.
97. See footnote 28 for information on the Determining Authority.

*Warning: All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.*
of the Act. Health professionals who currently provide services within the meaning of subsection 3C(8) include mental health nurses, social workers, clinical psychologists and Aboriginal health workers. This will have the effect of bringing any new categories of health professional within the scope of the PSR Scheme. Items 25–27 of Schedule 2 similarly broaden the definition of ‘practitioner’ in existing subsection 124B(1) to bring those practitioners within the scope of MPRCs in Part VB of the Act.

Other amendments

The Bill also includes provisions to streamline the administration of the Scheme.

Meaning of service

Items 31 and 32 in Part 3 of Schedule 2 to the Bill make clear that the PSR Scheme applies to a Medicare ‘service’ which has been requested, as well as to a service that has been rendered. The Explanatory Memorandum provides an example of how this amendment would apply in considering whether a practitioner had engaged in inappropriate practice:

For example, a chiropractor may advertise that every new patient for the month of March will receive ‘a free set of spinal x-rays’ at the first consultation. The chiropractor may then refer each new patient for a service for which a medicare [sic] benefit would be payable if rendered e.g. an x-ray. If the chiropractor is subsequently a person under review, his or her conduct in initiating such services may be taken into account in forming a view about inappropriate practice even though the initiated services may not have been rendered (or may never be rendered). This is because the chiropractor has initiated services which, if rendered, would result in the expenditure of public revenue for services that may not be clinically relevant.  

Extensions of time

Part 4 of Schedule 2 to the Bill provides for a number of instances in which an extension of time may be provided to a PSR Committee to deliver its final report. These are shown below and are described in item 33 of Part 4 of Schedule 2 to the Bill:

---

98. Explanatory Memorandum, p. 22.

**Warning:** All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.
### Extension of period for giving final report

<table>
<thead>
<tr>
<th>Item</th>
<th>Column 1</th>
<th>Column 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The person under review is unable because of ill health to attend an</td>
<td>The period during which the person under review is unable to attend the</td>
</tr>
<tr>
<td></td>
<td>hearing being conducted by the Committee</td>
<td>hearing</td>
</tr>
<tr>
<td>2</td>
<td>The person under review is fully disqualified under section 105</td>
<td>The period during which the person under review is fully disqualified</td>
</tr>
<tr>
<td>3</td>
<td>A notice is given to a person</td>
<td>The period during which the person to whom the notice is given fails</td>
</tr>
<tr>
<td></td>
<td>under subsection 105A(2) and the person fails to comply with a</td>
<td>to comply with the requirement</td>
</tr>
<tr>
<td></td>
<td>requirement of the notice</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>The Committee’s consideration of an order</td>
<td>The period for which the Committee’s consideration of the referral</td>
</tr>
<tr>
<td></td>
<td>is suspended under paragraph 106N(2)(b) or because of an injunction or</td>
<td>is suspended</td>
</tr>
<tr>
<td></td>
<td>order</td>
<td></td>
</tr>
</tbody>
</table>

**Item 35** of this part mirrors the proposal in the 2010 legislation to allow the Director of PSR to give information about a person to the Determining Authority only once and that the Director must not give information to the Determining Authority after the Authority has made a draft determination.

As already stated, where a person is referred to a PSR Committee for inappropriate practice, the PSR Committee examines the case and then reports to the Determining Authority. If inappropriate practice has been found, it is for the Determining Authority to determine the appropriate sanction.

**Items 36–40** set out the processes to be followed and the time limits to be complied with by the Determining Authority prior to making its final determination about the sanctions to be imposed where inappropriate practice has been found. They will ensure that at every step in the process the practitioner is informed and has ample opportunity to provide input. **Item 41** inserts **proposed section 1067B** into the Act, which is about how time periods for doing an act are affected if an injunction or other court order operates.

**No further action in certain circumstances**

**Item 44** inserts **proposed section 106GA** into the Act, which empowers the Director to advise a PSR Committee in writing that he or she is satisfied that circumstances exist that make a proper investigation impossible. Similarly, **item 46** inserts **proposed sections 106QA and 106QB** into the Act to empower the Director to advise the Determining Authority in writing that he or she is satisfied that circumstances exist that would make it impossible for the terms of an agreement under section 92 of the Act to take effect.

**Items 52–74** in Part 7 of Schedule 2 to the Bill propose to remove the obligation for the Director PSR to refer to the MPRC any practitioners who have been found to have engaged in inappropriate practice.

*Warning: All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.*
practice more than twice. These items will allow the Director (in relation to agreements made under section 92) and the Determining Authority (under determinations made under section 106TA) to impose sanctions of five years disqualification. These sanctions are equivalent to those that can be imposed by an MPRC.

Disqualified practitioners

The proposal in the 2010 legislation to require disqualified practitioners to provide patients with some form of notification regarding disqualification conditions is also replicated in this Bill. Item 83 in Part 9 of Schedule 2 to the Bill amends subsection 19D(1) of the Act so that practitioners disqualified under section 106ZPM will be subject to the notification requirements. Although it should be added that the failure to comply with this requirement is not onerous; according to subsection 19D(2), a fine of only $100 applies.

Patient referrals

Part 10 of Schedule 2 to the Bill proposes to amend the Act by repealing subsection 133(2), which currently provides only for regulations to be made in relation to referrals made to consultant physicians or specialists. A new section 132A will be inserted with the intention, as the Explanatory Memorandum points out, to allow for regulations to be made ‘to prescribe the manner in which patients are referred for a Medicare service by a referring practitioner to another practitioner.’

This will accommodate referrals such as those from a nurse practitioner for example to a general practitioner or a general practitioner to a clinical psychologist.

Legislative instruments

Technical amendments in the 2010 Bill are also included in this Bill with the intention of ensuring that certain provisions are legislative instruments for the purposes of the Legislative Instruments Act 2003. These amendments are contained in Schedule 3 to the Bill.

Concluding comments

The fundamental issue with regards to the PSR has always been how to find a balance between legislative and administrative means which in turn balance the twin objectives of the Scheme. These have been to protect patients and the community in general from the risks associated with inappropriate practice and to protect the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice.

The provisions in this Bill are yet another reaction to issues which appear to have been raised consistently since the PSR was introduced. Each of a number of iterations appears to address some aspects of the imbalance noted above, but none has satisfactorily resolved the concerns of a relatively small, but disgruntled group of practitioners.

Recent recommendations from a PricewaterhouseCoopers Review of the operation of the PSR have added yet another dimension to the debate about the need for improvement of the Scheme, and ways in which to achieve it. PricewaterhouseCoopers findings were that there is indeed scope to improve procedural and evidentiary practices of the PSR, and as such, the report confirms some of the findings of the 2011 Senate Committee inquiry. However, both reviews, as well as past findings, indicate that legislative change is not necessarily required in order to deliver outcomes that better achieve the dual purposes of the PSR. Introduction of new guidelines agreed to by the AMA and the PSR are one example of such non legislative improvements which are likely to improve operation of the PSR and which will be more readily adaptable than legislation.

Alternative means to improve the operation and effectiveness of the PSR aside, clearly this Bill makes no fundamental changes to the current system. Apart from the change to validate decisions made by PSR committees as the result of a failure to consult, as is required under the Act, changes in the Bill will have only a minor effect on the way the PSR functions. While these changes will most likely improve the efficiency of the system, as will non legislative changes, there remains within the PSR system the potential for dispute. This is perhaps inevitable given that the PSR is set up to investigate inappropriate practice, and as such it must establish limits by which that practice can be defined and investigated. Some may unfairly fall outside those limits, regardless of how carefully they are constructed.
Appendix A: PSR Review process

**STAGE 1**
The Director of PSR

Decision: Should the matter be reviewed?

Once a matter is referred from Medicare Australia the Director will decide if inappropriate practice may have occurred. The Director can decide that there is no case to answer, or that a Committee of peers does need to review the matter. The Director can also enter an Agreement with a practitioner where the practitioner acknowledges inappropriate practice. The Director can not make a finding that inappropriate practice occurred.

**STAGE 2**
The Committee of Peers

Decision: Did inappropriate practice occur?

A Committee of peers will be created to review the practitioners’ MBS and PBS claims. The committee will decide if inappropriate practice has occurred. The Committee will review documents and hold a hearing to make this decision. It will issue a preliminary and then a Final Report containing its finding. Once a Committee has decided that inappropriate practice has occurred it must provide its findings to the Determining Authority. The Committee can not make a decision on a suitable sanction.

**STAGE 3**
The Determining Authority

Decision: What is the suitable sanction?

The Determining Authority is a group of practitioners and a community representative. If the Committee informs them that inappropriate practice did occur, the Determining Authority will make a decision on a suitable sanction. This may include repayment of money, a disqualification period, counselling or reprimand. If an Agreement is entered into, the Determining Authority must ratify the Agreement for it to take effect.

Warning: All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.
SUMMARY OF STAGE 1 – Review by the Director

Decision on whether the matter should be reviewed

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

A review must be undertaken if, after considering the DHS request, the Director forms the opinion that the practitioner may have engaged in inappropriate practice.

The Director undertakes a review of the data received from DHS, and may also direct the practitioner to produce complete and original patient records. After the records are examined, the Director may meet with the practitioner. A report on the findings is made and any submission received from the practitioner is considered. The Director must then decide to:

1. take no further action
2. negotiate an Agreement under section 92 of the Act or
3. refer the practitioner to a peer review Committee.

SUMMARY OF STAGE 2 – Review by a Committee

Decision on whether inappropriate practice occurred

If the Director considers that the conduct of the practitioner needs further investigation, or the practitioner chooses not to enter a Negotiated Agreement, a Committee of the practitioner’s peers is established. Members are drawn from the Panel appointed by the Minister.

The Committee determines whether the practitioner’s conduct in connection with the rendering or initiation of services would be acceptable to the general body of their peers. The Committee uses clinical records and any other material provided by the practitioner to make this decision.

If, after considering the information provided, the Committee forms a preliminary view that the practitioner may have engaged in inappropriate practice, a hearing is held. The hearing provides the practitioner with the opportunity to present both oral and written evidence to support their case. After considering all the evidence, the Committee produces a draft report containing its findings and provides a copy to the practitioner.

If the Committee finds that no inappropriate practice has occurred, the matter is closed. If the Committee finds that inappropriate practice has occurred, the practitioner is given time to make submissions on the draft report. The Committee then considers the practitioner’s submissions and may or may not change their findings. The Committee then issues a final report to the practitioner and the Determining Authority.

**Warning:** All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.
SUMMARY OF STAGE 3 – Determining Authority

Decision on a suitable sanction

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

- decide whether to ratify Negotiated Agreements reached between the Director and a practitioner and
- determine what sanctions to apply when a Committee finds that a practitioner has engaged in inappropriate practice.

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 prepare a Draft Determination, including the sanctions it intends to impose.

The Determining Authority must impose one or more of the following sanctions:

- a reprimand
- counselling
- partial disqualification from claiming a Medicare benefit for no more than three years
- full disqualification from claiming a Medicare benefit for no more than three years
- an order for repayment of any Medicare benefits for services provided in the review period that have been found as being provided inappropriately and
- a full disqualification from the PBS for no more than three years.

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 contains the final decision of PSR and is the end of the PSR process, unless the practitioner appeals to the Federal Court or Federal Magistrates Court.

Source: PSR 100

---


Warning: All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.
Appendix B: Number of practitioners referred to the PSR

![Number of Practitioners Referred to PSR](image)

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

**Source:** PSR\(^{101}\)

---

101. PSR, submission, op. cit.

**Warning:** All viewers of this digest are advised to visit the disclaimer appearing at the end of this document. The disclaimer sets out the status and purpose of the digest.