REPORT ON REVIEW OF SECTION 92 OF THE HEALTH INSURANCE ACT 1973 (Cth)

for Department of Health and Aged Care

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List of Abbreviations

Ahpra	Australian Health Practitioner Registration Authority
AMA	Australian Medical Association
CDBS	Child Dental Benefits Schedule
CEM	Chief Executive Medicare
DA	Determining Authority
DPSR	Director, Professional Services Review
DVA	Department of Veterans' Affairs
EOFY	End of the Financial Year
EY	Ernst and Young
GP	General practitioner
HIC	Health Insurance Commission
MBS	Medicare Benefits Schedule
MA	Medical Adviser
PA	Professional Adviser
PBS	Pharmaceutical Benefits Scheme
PRP	Practitioner Review Program
PSR	Professional Services Review agency
PSR Committee	Professional Services Review Committee
PUR	Person under Review
RACGP	Royal Australian College of General Practitioners
SMA	Senior Medical Advisor

Executive Summary

The Australian Government provides healthcare support, notably under Medicare, the universal health scheme. This provides access to services under the Medicare Benefits Schedule (MBS), rebates under the Pharmaceutical Benefits Scheme (PBS), and to a lesser extent, the Child Dental Benefits Scheme (CDBS). Collectively these schemes provide for financial and other assistance designed to reduce the financial burden and sustain the health of Australians. This framework governing healthcare provision in Australia is designed to safeguard the public against the risks of costs of inappropriate practices, while at the same time protecting the integrity of, those schemes. The Professional Services Review (PSR), an independent agency, was set up as a key component for ensuring compliance with that framework.

The role of the PSR scheme is to investigate those health and medical professionals who may have engaged in inappropriate practice, that is, services involving inadequate record-keeping or other behaviour amounting to conduct which would not be acceptable to the general body of practitioners in the relevant medical or allied health profession, and inappropriate billing under the healthcare support schemes.

The PSR agency was set up in the 1990s as an independent body to regulate the role of practitioners and increasingly, corporate health and medical practices. The role of the PSR is set out in the *Health Insurance Act 1973* (Cth) (Act). That role is activated by a request by a delegate of the Chief Executive Medicare to the Director, PSR, to review the services provided by a practitioner or a corporate practice. This follows procedures within the Department which identify practitioners or those within corporate practices who may have engaged in, or instigated services that amount to inappropriate practice justifying a referral for review by the PSR.

If the Director decides to undertake a review, there are two principal avenues for this to occur: referral to a Committee of the PSR, a formal merit review hearing process under section 93 of the Act; or a private agreement negotiated between the Director and the practitioner under section 92 of the Act. Both process 'require a decision by the Determining Authority, either ratification of an agreement, or the determination of sanctions in light of the Committee's findings.'

For negotiated outcomes under section 92 of the Act, the Determining Authority will ratify the agreement if it considers the actions contained within it are fair and reasonable. Available sanctions commonly include, repayment of funds billed under the MBS and CDBS, partial disqualification from the MBS and CDBS or full disqualification for all three schemes. The sanctions may only be imposed if the practitioner has acknowledged their engagement in inappropriate practice.

Background to review

There has not previously been a review targeted solely on the end-to-end processes under section 92. This review has undertaken that task. As the negotiated outcome is the preferred option of nine out of ten practitioners involved in the PSR processes, the review is timely. The review was established following disquiet about the section 92 aspects of the regulatory scheme. Regulating the multiplicity of expertise and practices within the medical and allied health professionals is complex. It is not surprising that there is a lack of understanding about aspects of the scheme and dissatisfaction with some elements of its operation.

The review has been assisted by submissions from practitioner organisations and key individuals, by interviews conducted with relevant officers of the Department of Health and Aged Care (Department), the Australian Medical Association (AMA), the former Director PSR, the Executive Officer and Legal Counsel of the PSR, and of a legal practitioner involved regularly in representing practitioners under the scheme. The review has benefited from and reflects the insights and information provided by the submissions and interviews.

It is a truism that compliance by those being regulated depends on understandings of the purposes of the regulatory scheme which in turn leads to trust in the processes of the regulator.

The submissions indicated the transparency issues, together with concerns about some of the practices involved in the operation of the scheme, indicated a lack of trust. That deficit has the capacity to undermine a primary goal of the scheme, namely, behavioural change by practitioners involved in inappropriate practice. Many of the suggestions in the submissions are reflected in the recommendations in the review.

Transparency

The PSR scheme is described as a peer review scheme and the negotiated settlement conducted by the Director, PSR, is designed to ensure a more speedy outcome than is available under the formal hearing required by a decision under section 93. Several submissions acknowledged the importance of the PSR's role. Nonetheless, with one exception, all the submissions made suggestions for improvements. Lack of transparency in the processes was a key theme.

Specific concerns included the use by the PSR Director of a report by consultants, who it was perceived might not be a peer of the person under review, and whose report was not available to that person; the absence of known criteria adopted by the Director for deciding whether to accept a request for a negotiated settlement, as compared with a hearing; an absence of indicators which guide the Determining Authority's willingness to ratify an agreement; and the inability to obtain a definitive interpretation of items being billed under the government's healthcare schemes.

Disagreements about definitional issues leading to potential findings of inappropriate practice was another major theme of submissions. The second and third items are dealt with under 'Other deficits in information', below. Concerns about interpretive issues are the subject of observations and see 'Education' below.

Related concerns were that the pool of persons from which the PSR Director is appointed be expanded from its present restriction to medical practitioners and that the statutory criteria for appointment of consultants also be expanded. The first has not been supported by the review, given the predominance of medical practitioners which come before the PSR. It was also strongly opposed by the Australian Medical Association (AMA). The concern was that such an appointment might lead to a loss of trust in the scheme if the Director were perceived as not having qualifications appropriate for the bulk of its work. The review has, however, recommended that the AMA consult representatives of allied health bodies about the appointment of a Director prior to its report to the Minister, a step not at present required.

Currently, the only statutory guidance for appointment of consultants is that the person be 'appropriate'. It is envisaged in the Act that the Minister may issue Guidelines about criteria for consultants. That to date has not been effected. The review has recommended that the statutory power to issue Guidelines be activated. The Guidelines need to specify that there be no conflict of interest between a consultant and the person under review and that, to the extent possible, the consultant has the qualifications and experience appropriate for the case for which they provide advice. Allied with this recommendation is that publicly available material on websites and other sources be expanded to include information about the role, qualifications and experience of consultants and that appropriate detail about the consultant be included in the section 89C report provided by the Director to the practitioner under review.

Other deficits in information

Submissions suggested there is a need for better education and more information by the Department, the PSR and the Determining Authority, the final decision-maker, on statistical information about the scheme, including the outcomes of the section 92 agreement, and the practices of the Director in relation to its processes. Accordingly, there were suggestions that the PSR update its publication *Your Guide to the Professional Review Process* (*Guide*) and their website concerning these section 92 issues of concern.

The review recommends that the further information should include information on its website about the reasons the Director does/does not accept a request for a negotiated settlement and similarly when the Determining Authority will/will not ratify an agreement. The review also endorsed a suggestion that the Department ensure that the tone of its letters to practitioners is appropriate, taking into account the range of responses and recipients.

A suggestion prominent in many submissions was for the legislative removal of the requirement for an acknowledgement of inappropriate practice by a practitioner. The review did not accede to that suggestion. The acknowledgement is a pre-requisite to use of the section 92 process. The raising and recovery of a debt by the Commonwealth for amounts billed inappropriately could not legally be effected without that acknowledgement. Better publicisation of the requirement would clarify the reasons for this aspect of the process.

Another concern is reflected in the suggestion that the requirement for acknowledgement of inappropriate practice and actions taken by the PSR Director when seeking evidence from practitioners is coercive in nature. This was said to mean any acknowledgement of inappropriate practice was not obtained voluntarily.

This concern about the Director's approach to information gathering indicates misunderstanding of the Director's role. The Director is the sole person authorised to conduct the negotiated settlement process. The questioning by the Director of those involved in order to make a recommendation report is an inquisitorial process. Such an investigative style can be interpreted as coercive but use of the process is inevitable given that the Director is the only person conducting the section 92 process. Inquisitorial modes of questioning do not detract from the voluntariness of the information obtained.

Other concerns related to the nature of the sanctions imposed under the scheme. It was suggested that the impact of the enforcement of sanctions led to service reduction of practitioners and detracted from the clinical needs and health outcomes of patients. Notwithstanding, the sanctions are authorised by the Act, are proportionate, and are legally defensible. A related concern was an apparent failure of the Director to discount amounts owed in recognition of mitigating circumstances. Evidence from the PSR satisfied the review that mitigation of sanctions does take place. This has caused the review to recommend that more information be publicly provided to assuage such concerns.

There are two gaps in the sanctions which the Director can recommend: the Director is not able to undertake counselling and education of the practitioner; and is able only to recommend that a section 92 agreement in relation to PBS services results in disqualification from prescribing **all** PBS medicines or a reprimand. A more proportionate sanction would enable a sanction targeting only the specific prescriptions inappropriately prescribed. The first deficiency was to be rectified in legislation which lapsed following the calling of the 2022 election. The review has recommended that the Department advise the Minister that the legislation be resurrected, and that its amendments authorise both suggestions relating to sanctions.

Other suggested legislative changes were that: the consultant's report be provided to the practitioner; the Act enshrine the popular practice of the in-person meeting of the Director with the person under review, which would include the consultant; the Act list the criteria relied on by the Director when deciding to accept a request for a negotiated settlement; timelines for the practitioner to provide documents be extended; the factors influencing the Determining Authority when deciding whether to ratify the agreement should be included in the Act; and information sharing between the Director, Ahpra, and State and Territory regulatory bodies be permitted provided it is in the public interest to do so.

Legislative authorisation opens the way for disputes often ending up in courts and inevitably extending the process. For the most part these suggestions have not been accepted. As one of the key advantages of the negotiated settlement process is that it is quicker than any dispute resolution process in a tribunal or court, this intention would be undermined by legislative incorporation. The suggestion could also counter the aim to ensure a more efficient and effective

system. The review has suggested instead that more information be made publicly available to meet these concerns.

More detailed legislative amendments suggested included a change to the statutory definition of inappropriate practice including an amendment to the 'prescribed pattern of services' definition; and a broadening of the number of allied health practitioners who can be part of the scheme.

The existing definitions are long-standing and have been endorsed by the courts as appropriate. There are, however, no legislative criteria for a 'prescribed pattern of services' for specialists and allied health professionals as was recommended by a review of the PSR scheme in 2007. This review has endorsed this recommendation. Otherwise, the review has not suggested changes to existing definitions.

The list of allied health practitioner organisations who can bill under Medicare or other schemes are regularly updated in legislation.

Education

Enhancement of training and accreditation of bodies to conduct training courses on billing and other elements of the compliance program is the subject of observations in this review. The Department is best placed to undertake that further education given there is little focus to these elements of the healthcare scheme in universities or in the allied health or medical community.

Appointment of a delegate for the PSR Director

An important suggestion for legislative change which has been endorsed by the review is that the Director should be able to delegate key functions confined at present to the Director. The functions assigned to the Director under the Act and the practices adopted by succeeding Directors, particularly in relation to in-person meetings with practitioners throughout Australia which involves a punishing travel schedule, are demanding. When added to the practice of regular meetings with peak medical and health organisations and colleges, the administration of the agency, interactions with the Determining Authority, the Department and the Minister, together with the obligation to make public presentations at seminars and conferences, it is apparent that the workload is excessive. For that reason, the review has recommended that there be legislative provision for there to be a delegate who can relieve the Director of some of that load, not including the final decision-making role under section 92.

Stress engendered by process

Significant concern was expressed about the stress on practitioners involved in the scheme. There is no doubt that referral to PSR is a stressful process for the person under review and their family. The potential financial, professional and personal consequences are understandably anxiety-producing.

Some of that anxiety is due to lack of knowledge and understanding of the processes. For that reason, the review has made several recommendations about ways to improve the publicly available information to reduce that cause of stress. Equally the review has resisted suggestions that timelines for the processes be expanded. Extending the time involved only maintains the level of anxiety for longer and is undesirable. The detailed information about the end-to-end process in the report of this review is also part of the attempt to better educate practitioners.

The AMA has recently been funded by the Commonwealth Government to provide telehealth mental support for practitioners. The service is free and publicity for the new service is being rolled out. The review has also encouraged better information be provided by medical defence organisations and legal representatives as part of the improvement to information available.

Ultimately, it is for the practitioner to inform themselves of what is involved, to prepare for interviews and the collection of information required for the process, and to make changes to practices identified as inappropriate for mitigation of potential sanctions. In that context it is noted that practitioners are often granted a grace period within the Practitioner Review Program which precedes referral to the PSR to demonstrate improved behaviour. Taking advantage of

these options can assist in reducing the inevitable stress involved in the preliminary departmental and PSR scheme processes.

Recommendations

Recommendation 1: Legislation be re-introduced into the Parliament along the lines of the Health Legislation Amendment (Medicare Compliance and Other Measures) Bill 2021 to ensure the reforms proposed for section 92 be implemented. These include that the PSR Director has the full range of options relating to sanctions that may be imposed by the Determining Authority: [3.41]-[3.43].

Recommendation 2: The Professional Services Review (PSR) should publish in the *Guide* and on the website information in broad terms as to the reasons for, and the processes by which, calculations of repayment amounts are made: [3.44]-[3.53].

Recommendation 3: The PSR should update the hard copy of the *Guide* and its website to include indicative information about the duration of the review processes. The timeline should run from the time of the CEM's 'Request to Review' to the PSR Director till the coming into force of the section 92 agreement following ratification by the Determining Authority: [3.57]-[3.63].

Recommendation 4: The Department, in consultation with the peak bodies for specialists and allied health professionals, take steps to finalise the legislative criteria for a 'prescribed pattern of services' for specialists and allied health professionals in light of the recommendation made in the 2007 Review: [3.64]-[3.75].

Recommendation 5:

a. The Act be amended to permit delegation by the PSR Director of functions other than the decision-making function.

b. Assuming the recommendation is accepted, the Act be amended to provide for the qualifications of the delegate and for consultation with appropriate bodies about the appointment:{4.16]-[4.26].

Recommendation 6: The Act be amended to permit the PSR Director to release information to Ahpra and to State and Territory regulatory bodies following a section 92 process but only if it is in the public interest to do so: [4.35]-[4.40].

Recommendation 7: The Act be amended to provide in section 84 that the AMA consult allied health practitioners and organisations prior to the appointment of the Director: [5.5]-[5.12].

Recommendation 8:

a. The Department provide to the Minister a proposal for 'guidelines setting out the terms and conditions upon which consultants may be engaged under section 106ZP(4) of the Act'. The guidelines should reflect the current practice which is that the person appointed not have a conflict of interest and to the extent possible have qualifications and experience appropriate for the case on which advice is sought.

b. The *Guide* and other material on the PSR website be updated to contain information at a broad level as to:

   i statutory criteria for, and steps taken, to identify an appropriate consultant or professional organisation appointed under section 90 to advise the PSR Director, taking into account the need to ensure the independence and objectivity of the person; and

   ii that a consultant appointed under section 90 is a professional whose qualifications and experience should, as closely as possible, match the experience and qualifications of the practitioner under review but is not necessarily a direct 'peer' of the practitioner member: [5.13]-[5.24].

Recommendation 9: The PSR include in the *Guide* and other material on the PSR website information on the Director's practice of summarising in the section 89C report relevant elements

of the consultant's advice that the Director accepts, the qualifications and, as appropriate, experience of the consultant, and the absence of conflicts of interest: [5.25]-[5.35].

Recommendation 10:

The PSR should:

a. update the *Guide* to expand the information relating to the section 92 agreement process taking into account the suggestions in this review.

b. include a flow-chart of the process under section 92, updated as necessary: [5.36]-[5.57].

Recommendation 11: The PSR should:

a. regularly review its website design to ensure the information published is consistent with the Australian Government Digital Service Standards; and

b. ensure that its content on section 92 processes is enhanced by webinars and podcasts supplemented by other appropriate hard copy and online sources: [5.58]-[5.67].

Recommendation 12: To combat misperceptions about the scheme, professional associations, the AMA, the PSR, and the Department, should regularly update their websites to include statistics about compliance outcomes of reviews under section 92: [5.68]-[5.70].

Recommendation 13: The PSR include in the *Guide* and on other material on the website indicative examples of criteria used by:

a. the Director:

   i when not accepting a request for a section 92 agreement; and

   ii the kinds of clinical practices or conduct when deciding to negotiate an agreement.

b. the Determining Authority:

   i when not ratifying an agreement;

   ii for ratifying an agreement: [5.71]-[5.77].

Recommendation 14: The Department should:

a. expand the information on the Practitioner Review Program on its website;

b. undertake an examination of its letters to practitioners in consultation with the AMA or appropriate College to ensure they are appropriate for the range of responses and recipients: [6.14]-[6.19].

Observations

Observation 1:

The Department should:

(a) Continue regularly to update MBS online and records of responses to questions in AskMBS under the supervisions of a Senior Medical adviser, assisted by Medical Advisors.

(b) Ensure that MBS online and AskMBS reflect any changes needed following PSR Committee findings or Federal Court decisions which overrule or alter information in MBS online or records of responses in AskMBS.

(c) Display prominently on its website advisories and targeted newsletters featuring changes to key items in the MBS;

(d) Continue regularly to conduct seminars on items or discussions on changes to MBS or items which cause difficulties of interpretation for practitioners, after consultation with the PSR, the AMA and other peak health bodies about which items to feature. [6.25]-[6.41]

Observation 2:

(a) Training on billing and on the compliance program in Part VAA in the Act should be undertaken by the peak professional medical and allied health organisations and be required at least every three years as a matter of continuing professional development for practitioners with provider numbers or who intend to obtain one.

(b) Such training should include the development of templates for courses which could be populated for training purposes by smaller health organisations.

(c) The Department should coordinate discussions with the AMA, peak health and medical organisations, and the PSR on what training is required.

(d) Accreditation of training courses should be undertaken by the Department. [6.50]-[6.54]

Chapter 1. Objectives of the Review

1.2 The review is to assess how effectively the Professional Services Review (PSR) agency has operationalised its use of section 92 of the *Health Insurance Act 1973* (Cth) (Act) Part VAA as a key compliance tool. The objectives are reflected in the Terms of the Review (Appendix 1: Terms of Reference for Review) which are to assess:

- the end-to-end process flow from the perspective of the person under review;
- the extent of transparency of the process to the person under review, noting that the integrity of the Professional Services Review (PSR) scheme must be maintained;
- the quality of information available to persons under review about the section 92 process;

and by

- capturing relevant and contemporary feedback from consultation with the Department of Health and Aged Care (Department), the Professional Services Review, the Australian Medical Association (AMA) and other peak bodies.

1.3 There have been previous reviews of the PSR scheme.[1] None has focused exclusively on section 92, a key provision in the compliance framework for those rendering professional health services. This inquiry has enabled a more searching examination of the operation of the section.

1.4 The review is focused on the operation of section 92. The processes commence within the Department with the Department's Practitioner Review Program (PRP) which, in a limited number of cases, culminates in the request to the Director, PSR (Director) to undertake a review.

1.5 Following a request to the Director to review, the Director must make a threshold decision of whether or not to undertake a review (section 88A). Having decided to undertake a review the Director's options are:

- to take no further action (section 91);
- to reach an agreement with the practitioner[2] through a negotiated settlement (section 92); or
- referral for consideration by a PSR Committee (section 93).

An agreement or a determination by a PSR Committee must be ratified by the Determining Authority (DA) and implemented by the Department.

[1] Australian Medical Association (AMA), Health and Aged Care, Health Insurance Commission, Professional Services Review *The Report of the Review Committee of the Professional Services Review Scheme* (1999) (*PSR 1999 Report*); Department of Health and Ageing *Report of the Steering Committee Review of the Professional Services Review Scheme* (2007) (*Department of Health and Ageing 2007 Report*); Parliament of Australian Senate Community Affairs References Committee *Review of the Professional Services Review (PSR) Scheme* (2011) (*Senate Committee 2011 Report*); Ernst and Young Global Ltd *PSR Functional Review: Professional Services Review* (2018) (*EY Review*).

[2] This term is used throughout the review to include corporate practices. The term is used in its generic sense, not as defined in the Act section 3 as a 'medical practitioner or a dental practitioner'.

1.6 In cases in which patient safety is involved the process involves referral to the Australian Health Practitioners Review Authority (Ahpra). These may arise at any stage and does not stop PSR action. The infrequency of referrals by the Director, PSR to Ahpra (a total of 86 in 5 years[3]) does not justify consideration in this review. Referrals for fraud may also be made at any stage but are rare.

1.7 This review is of section 92 in the context of the scheme as a whole. Section 92 is the avenue within the PSR most commonly relied on for an assessment of whether the conduct of health practitioners amounts to inappropriate practice. The aim of the scheme is to encourage behavioural change to rectify the conduct which led to the practitioner being involved in inappropriate practice. Although those subject to review are predominantly individual practitioners, corporate medical and health practices may also come before the PSR if they have 'knowingly, recklessly or negligently caused or permitted a practitioner employed or otherwise engaged by them to engage in inappropriate practice'.

Role of regulator

1.8 Any regulator must meet the expectations of the role if it is to maintain compliance. As Miller notes: '[R]egulation is a relational activity and knowing your regulator provides the respect, trust and shared understanding necessary for a productive relationship'.[4] If there is doubt that those involved in their regulatory roles under the Act sufficiently understand the organisation and operation of the regulatory scheme, the regulator will forfeit respect and trust.

1.9 To avoid that outcome the regulator must understand the standards, practices and norms of the industries being regulated. That understanding is more demanding when the scheme involves expertise and practices within multiple disciplines as it does within the health professions.[5]

1.10 These principles underscore this review, are apparent in submissions to the review, and are relevant to suggestions made for changes to the regulatory scheme to assist it more efficiently and effectively to achieve the intended compliance outcomes.

Calls for change

1.11 The review was set up following some disquiet about practitioners' understanding of the processes adopted by the PSR when an agreement is negotiated under section 92. Another concern related to the requirement under section 92 to recover funds, often of substantial amounts, billed by practitioners under the Medicare Benefits Schedule (MBS\Medicare) or the Child Dental Benefits Schedule (CDBS).[6] The basis of that concern was described in one submission as follows:

[3] Information from PSR, 9 May 2022.
[4] Katie Miller 'Know your industry: know your regulator' (2022) 104 *AIAL Forum* 37..
[5] Id 42.
[6] The MBS is located in the *Health Insurance (General Medical Services Table) Regulation 2021* (Cth).

the problem with Medicare: there are no fixed, written standards for appropriate use of a highly interpretable legal instrument; doctors are never trained in how to apply it; and there is no-one whose job or qualification it is to education them.[7]

1.12 Others were concerned that section 92 processes were 'coercive' and were being used to lower 'the costs of the Medicare system by enforcing service reduction on medical practitioners', an approach which ignored 'the clinical needs and necessary health outcomes of their patients'.[8] Significant concerns were also expressed in relation to the stress of the process, and whether the advice received by the Director was provided by a true peer of the practitioner.

1.13 The former Director welcomed the review, noting that the legislation for the PSR is twenty-five years old, and there have been significant changes to practices. Another development to which the former Director referred is that 'the role of corporate [medical providers] in influencing the individual behaviour [of doctors] is a really important thing. It is a significantly corporatised process now, there is a lot of offshore ownership'.[9]

1.14 Following discussions and concerns raised by the Australian Medical Association, the government agreed 'to a targeted review of the procedures and processes involved in section 92 agreements.

Conduct of inquiry

1.15 The Department finalised the terms of review in late October 2021. Written submissions against the scope of the review were invited from some 50 key stakeholder professional health and medical organisations: Submissions were due by Friday, 10 December 2021. Over twenty submissions were received: Appendix 3. The Reviewer conducted interviews with a number of key personnel in the Department, the PSR, the AMA and a representative of medical defence organisations, and a Medical Advisor to the Department: Appendix 4.

1.16 The themes emerging from the submissions are grouped under the individual items in the terms of reference.

Previous reports on the PSR scheme

1.17 The first inquiry, the 1999 *Report of the Review Committee of the Professional Services Review Scheme* examined how the scheme was operating since it was established in 1994. The recommendations were designed to improve the legal effectiveness and transparency of the scheme. All but one of the recommendations relevant to this review (recommendations 2, 4-6, 19- 21 and 32) have been implemented.[10] The exception was recommendation 6, that deeming provisions for other health or medical specialties be included in the *Health Insurance (Professional Services Review) Regulations 1999* (Cth). There is no 80/20 rule or

[7] Penny Durham 'New PSR Bill won't fix a draconian system' *Medical Republic* Cloud Healthcare Webinar series, 1.
[8] Rick Morton 'Exclusive: Government 'star chamber' targets doctors' *The Saturday Paper* No 376, November 20-26, 2021, 3.
[9] Id 5.
[10] Sections 106K (Rec 2), 106KA. See also *Health Insurance (PSR) Regulations 1999* (Cth) reg 11 (recs 4, 5).

equivalents for specialists and allied health professionals but the development is under active consideration.[11]

1.18 The Department of Health and Ageing *Report of the Steering Committee Review of the Professional Services Review Scheme* (2007) recommended the establishment of a PSR Advisory Committee comprising representatives from the Department, the AMA, the PSR and Medicare. The Committee was:

- to provide ongoing guidance for the effective operations of the scheme (recommendation 3);
- to ensure increased efficiency of processes (recommendation 4);
- to develop parameters other than the 80/20 rule for identifying inappropriate practice by specialists and allied health professionals (recommendation 6);
- to advise on the adequacy of existing sanctions (recommendation 8); and
- to develop means to combat the adverse effects of corporate influence (recommendations 10 and 11).

The Advisory Committee has been created and has implemented reforms in some of the areas identified in the report.[12]

1.19 There has been better implementation of the 2011 report *Review of the Professional Services Review (PSR) Scheme* by the Senate Community Affairs References Committee. The government accepted and has implemented the recommendations concerning increased flexibility for the DA when imposing sanctions (recommendation 6); and that the legislation be amended to ensure that the PSR can effectively pursue abuse of the MBS/PBS systems, regardless of the structure of employment of the person under review (recommendation 7).

1.20 Finally, the EY *PSR Functional Review* in 2018 was principally focused on organisational aspects of the PSR's operations. EY reported positively on the Director's practice of meeting with the practitioner; recommended the practice, since implemented, of publishing de-identified information from reviews to educate the health practitioner community;[13] and suggested there needed to be better integration and information sharing between the Department and the PSR. This too has been implemented. The Department and the PSR have a practice of holding meetings roughly every six weeks.[14]

[11] Department, communications 28 March 2022.
[12] Department, communications 28 March 2022.
[13] Former PSR Director's monthly 'Updates' report.
[14] Interview with former PSR Director, 23 November 2021.

Chapter 2. Section 92 in context of PSR Scheme

2.1 This chapter provides in some detail the processes involved in section 92 of the Act. This provision is a significant element of the tools used in PSR's operations. The detail is included to respond to apparent misperceptions and misunderstanding of the scheme.

2.2 The PSR scheme was set up to ensure compliance by health practitioners with the objectives of the Act. These are to protect the public against practices which harm, not benefit, patients and to maintain the viability of government schemes subsidising health care in Australia. The three schemes are the Medicare Benefits Schedule (MBS), the universal health insurance scheme in Australia under which governments provide a rebate to patients, and the Pharmaceutical Benefits Scheme (PBS) which reduces the cost of medical prescriptions and the Child Dental Benefits Schedule (CDBS) which provides benefits for some basic dental services for eligible children aged 0-17 years. The schemes ensure that when practitioners claim for a benefit under the MBS, a dental benefit under the CDBS or prescribe listed medicines covered by the PBS,[15] the services are medically necessary and clinically relevant, and that the conduct of practitioners is appropriate.

2.3 Underpinning the scheme is the need to protect the health and safety of the public and to maintain the financial viability of Australia's government-funded health care system. These objectives are captured in section 79A of the Act.

> 79A The object of this Part [VAA] is to protect the integrity of the Commonwealth Medicare benefits, dental benefits and pharmaceutical benefits programs and in doing so:
>
> - Protect patients and the community in general from the risks associated with inappropriate practice; and
> - Protect the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice.

'Inappropriate practice'

2.4 The PSR scheme was established in 1994 by Part VAA of the *Health Insurance Act 1973* (Cth) (Act) to investigate whether a member of a health profession has engaged in 'inappropriate practice'. The expression 'inappropriate practice' is defined in section 82 and is the litmus test used at all the stages of the scheme outlined in this report. It is 'a professional evaluative, not an objective, standard'.[16]

> 82 Definitions of inappropriate practice
>
> **Unacceptable conduct**
>
> (1) A practitioner engages in inappropriate practice if the practitioner's conduct in connection with rendering or initiating services (other than a service of a kind referred to in paragraph (c) of the definition of service in subsection 81(1)) is such that a Committee could reasonably conclude that:

[15] *Health Insurance Act 1973* (Cth) (hereafter only section numbers will be referred to when they relate to the Act) section 81, as expanded under regulations by the Minister.
[16] *Karmakar v Minister for Health (No 2)* [2021] FCA 916 at [52] per Logan J.

a. if the practitioner rendered or initiated the services as a general practitioner—the conduct would be unacceptable to the general body of general practitioners; or

b. if the practitioner rendered or initiated the services as a specialist (other than a consultant physician) in a particular specialty—the conduct would be unacceptable to the general body of specialists in that specialty; or

c. if the practitioner rendered or initiated the services as a consultant physician in a particular specialty—the conduct would be unacceptable to the general body of consultant physicians in that specialty; or

d. if the practitioner rendered or initiated the services as neither a general practitioner nor a specialist but as a member of a particular profession—the conduct would be unacceptable to the general body of the members of that profession.

Prescribed pattern of service

(1A) Subject to subsections (1B) and (1C), a practitioner engages in **inappropriate practice** in rendering or initiating services during a particular period (the **relevant period**)[17] if the circumstances in which some or all of the services were rendered or initiated constitute a prescribed pattern of services. …

(2) A person (including a practitioner) engages in ***inappropriate practice*** if the person:

a. knowingly, recklessly or negligently causes, or knowingly, recklessly or negligently permits, a practitioner employed or otherwise engaged by the person to engage in conduct that constitutes inappropriate practice by the practitioner under subsection (1) or (1A); or

b. is an officer of a body corporate and knowingly, recklessly or negligently causes, or knowingly, recklessly or negligently permits, a practitioner employed or otherwise engaged by the body corporate to engage in conduct that constitutes inappropriate practice by the practitioner under subsection (1) or (1A).

Matters to which Committee must have regard

(3) A Committee must, in determining whether a practitioner's conduct in connection with rendering or initiating services was inappropriate practice, have regard to (as well as to other relevant matters) whether or not the practitioner kept adequate and contemporaneous records of the rendering or initiation of the services.

Health Insurance (Professional Services Review Scheme) Regulations 2019 (Cth)

Part 2—Prescribed matters for definitions

6 **Standards for adequate and contemporaneous records**

For the purposes of the definition of *adequate and contemporaneous records* in subsection 81(1) of the Act, the standards for a record of the rendering or initiation of services to a patient by a practitioner are that:

a. the record must include the name of the patient; and

b. the record must contain a separate entry for each attendance by the patient for a service; and

c. each separate entry for a service must:

[17] The 'relevant period' is described in section 86 as the period specified by the CEM in the 'Request to Review '

i include the date on which the service was rendered or initiated; and

ii provide sufficient clinical information to explain the service; and

iii be completed at the time, or as soon as practicable after, the service was rendered or initiated; and

d. the record must be sufficiently comprehensible to enable another practitioner to effectively undertake the patient's ongoing care in reliance on the record. …

8 Circumstances for medical practitioners for prescribed pattern of services

For the purposes of section 82A of the Act, circumstances in which services rendered or initiated by a medical practitioner constitute a *prescribed pattern of services* are that:

a. the medical practitioner renders or initiates 80 or more relevant services on each of 20 or more days in a 12 month period; or

b. the medical practitioner renders or initiates 30 or more relevant phone services on each of 20 or more days in a 12 month period.

2.5 Typical examples of unacceptable conduct are:

- doubts that claimed services have actually been performed;
- doubts that the service was clinically necessary;
- the clinical record is either missing, inadequate or not contemporaneous;[18] or
- there was inadequate and inappropriate clinical input.[19]

2.6 Section 82A spells out what is a 'prescribed pattern of service'. A 'prescribed pattern of services' arises when the practitioner's conduct meets the following criteria: 'the practitioner 'renders or initiates 80 or more relevant services on each of 20 or more days in a 12 month period'.[20] The provision does not apply to allied health body corporates. The '80/20 rule' aims to address consistently high volumes of rendered services by medical practitioners. Proof that a practitioner has rendered or initiated attendances which breach the 80/20 rule is *prima facie* evidence that the practitioner has engaged in inappropriate practice. However, there is an 'exceptional circumstances' exemption applied to a prescribed pattern of services, that is, the 80/20 rule.[21]

2.7 The key elements of 'inappropriate practice' are: unacceptable conduct, that is conduct in connection with rendering or initiating a service that could reasonably be concluded (an objective test) would be unacceptable to the general body of the health practitioner's profession; or rendering or initiating services in breach of the 80/20 rule. The prescribed pattern of services is deemed to be inappropriate practice unless there are 'exceptional circumstances'.[22]

[18] Section 82(3); *Health Insurance (Professional Services Review Scheme) Regulations 2019* (Cth) reg 6.
[19] PSR role in compliance and s 92 agreements, former PSR Director's presentation slides.
[20] Section 82A; *Health Insurance (Professional Services Review Scheme) Regulations 2019* (Cth) reg 8.
[21] *Health Insurance (Professional Services Review Scheme) Regulations 2019* (Cth) reg 7.
[22] *Health Insurance (Professional Services Review Scheme) Regulations 2019* (Cth) reg 7.

Exceptional circumstances exemption

2.8 The practitioner becomes vulnerable to disciplinary action under the Act for breaching the 'inappropriate practice' provision relating to the prescribed pattern of services unless there are 'exceptional circumstances' for the behaviour.[23] 'Exceptional circumstances' are defined, as follows in the regulations:

> 7 **Exceptional circumstances in relation to inappropriate practice**
>
> For the purposes of subsection 82(1D) of the Act, each of the following circumstances are exceptional circumstances for a particular day for a practitioner:
>
> a. an unusual occurrence causing an unusual level of need for relevant services on the day;
>
> b. an absence, on the day, of other medical services for the practitioner's patients, having regard to:
>
> i the location of the practitioner's practice; and
>
> ii the characteristics of the practitioner's patients.[24]

2.9 The exemption is commonly sought for services in regional areas in particular when the practitioner is affected by floods, isolation, or is providing services to people within a particular demographic.

Administration and ambit of the PSR scheme

2.10 The PSR, an independent statutory agency, administers three elements of the health compliance scheme when a case is referred by the CEM. These are:

- a draft agreement, including recommended sanctions, between the Director and the practitioner, negotiated under section 92 of the Act, following an acknowledgement of conduct amounting to inappropriate practice by the practitioner.
- a final report by a Professional Services Review Committee (PSR Committee) under section 106L of the Act following a merits review hearing resulting in a finding that the practitioner has engaged in inappropriate practice.
- ratification of the negotiated agreement or the making of a final determination[25] by the Determining Authority (DA), an independent statutory body administered by the PSR.

2.11 For the most part, this review does not consider the PSR Committee process, other than when it is an alternative to the agreement process. The review focuses on the other elements of the compliance framework, including the preliminary processes by the Department leading to a recommended referral to the PSR, the role of the PSR to negotiate agreements under section 92, and of the DA ratifying the section 92 agreements. Given the relatively small numbers that are referred to the regulatory agency Ahpra and that these referrals do not stop PSR action, the review does not consider the role and operational efficiency of that aspect of the scheme.

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[23] Section 82(1), (1B), (1C), (1D).
[24] *Health Insurance (Professional Services Review Scheme) Regulations 2019* (Cth) reg 7.
[25] Part VAA Div 5 and section 106Q.

2.12 The scheme applies to a wide variety of medical and allied health practitioners. The list includes medical practitioners (general practitioners and specialists[26]), dentists, optometrists, midwives, nurse practitioners, chiropractors, physiotherapists, podiatrists and osteopaths, audiologists, diabetes educators, dieticians, exercise physiologists, mental health nurses, occupational therapists, psychologists, social workers, speech pathologists, Aboriginal and Torres Strait islander health practitioners, Aboriginal health workers, or orthoptists. The list of health practitioners is progressively expanded as other practitioners become eligible to render services which attract a Medicare benefit.

2.13 The PSR processes extend to employers or officers of corporate health or medical practices (corporates) if the employer or officer causes or permits a practitioner employee or 'person otherwise engaged', to 'knowingly, recklessly or negligently' to engage in conduct amounting to 'inappropriate practice'.[27] Currently, the Director can only refer a corporate practice to a PSR Committee if there is possible inappropriate practice (s 93) and cannot negotiate an agreement: section 92. That omission may be rectified if the Health Legislation Amendment (Medicare Compliance and Other Measures) Bill 2021 (Bill) is eventually passed. Item 8 of the Bill inserts new paragraph 92(2)(aa) which will authorise the Director to offer a section 92 agreement to corporate practices. The Bill was before the Parliament but was not passed before the 2022 federal election and has lapsed.

2.14 The PSR scheme is described in PSR publicly available material as a system of review by peers.[28] That reflects the participation of appropriately qualified practitioners at each stage in the PSR process and is discussed later in this report. Submissions indicated concern about the accuracy of the description in relation to advice provided to the Director during the section 92 process.

Section 92 in context

2.15 The section 92 processes are the principal focus of this review. In order to appreciate the scope of the processes, they need to be seen in the context of the framework of the health practitioner compliance processes as a whole. Accordingly, the following are the three phases that are relevant to this review:

- Phase 1: Identification by the Department of practitioners where there are concerns of potential inappropriate practice that are unable to be resolved under the Practitioner Review Program leading to a request by a delegate of the CEM to the Director for review.
- Phase 2: Review by the Director to decide whether the practitioner has possibly engaged in inappropriate practice. The Director has several options:
  - decline the request to undertake a review;
  - decide to take no further action (section 91)
  - accept a request for a negotiated agreement (section 92);
  - refer the practitioner to a PSR Committee (section 93); or,

[26] Section 82(1) and *Health Insurance (Professional Services Review – Allied Health and Others) Determination 2012* (Cth).
[27] Sections 81(2), 82(2). See also *National Home Doctor Service Pty Ltd v Director Professional Services Review* (*National Home Doctor Service*) [2020] FCA 1381.
[28] Professional Service Review *Your Guide to the Professional Services Review Process* (2018) (*Guide*) 7.

- in more serious cases, the PSR may also refer the matter to another regulatory agency such as the Australian Health Practitioners Review Authority (Ahpra), a Medical Board, or a peak body of which the practitioner is a member for their separate consideration. These referrals do not stop the PSR process.[29]

- Phase 3: Ratification or refusal of ratification by the Determining Authority (DA) of the agreement reached under section 92.

2.16 The scheme, within the compliance context, has been crafted carefully to ensure a distinct role for each stage of the process. The statutory 'inappropriate practice' test is applied at all stages. The information obtained by the Department is triggered by a review of data during a set period of Medicare billing, including the practitioner's profile, factors such as specialisation, patient profile and demographics, as well as PBS prescribing patterns together with any information provided by the practitioner during the Practitioner Review Program,[30] The material is considered by the Department's qualified health professionals, that is, its Professional Advisors (PAs).

2.17 The Director builds on that information by obtaining Medicare records from the Department, and patient records from the practitioner, as well as possible professional advice. This enables the Director to offer an agreement to a practitioner, or to refer the matter to a PSR Committee which involves more searching analysis of records during the detailed review. The final decision-maker, the Determining Authority, then assesses either: the draft agreement under section 92 and ratifies it (or sends it back for re-negotiation); or the final report by a PSR Committee under section 93 and makes a determination.

2.18 There are graduated levels of formality and speed, at different stages. The section 92 process is intended to be an expedited process as compared to the PSR Committee and DA processes. Partly for this reason, when offered the choice of either a negotiated settlement or a PSR Committee review the section 92 agreement is the preferred avenue by over 90 per cent of practitioners who come before the PSR: **Table 4**.

Phase 1: Identification of practitioners of concern

2.19 As part of its compliance regulatory function the Department routinely monitors MBS and CDBS billing, and PBS prescribing practices to identify practitioners whose servicing behaviour varies from their peers.[31] The Department identifies practitioners with high or unusual billing or prescribing patterns and decides on the appropriate treatment. Where the variance to peers could be due to possible inappropriate practice, the practitioner is reviewed under the PRP. Some 40 per cent of cases reviewed under the PRP come from 'tip-off's.

[29] Sections 106XA and 106XB.

[30] The Department considers potential non-compliance, including incorrect claiming, inappropriate practice and fraud. Under the PRP, other information is also considered. Where the practitioner provides additional information such as at interview or through written submissions, this is also considered. While the Australian Health Practitioners Regulation Agency (Ahpra) considers conduct (from the perspective of public safety), the Department also looks at conduct issues. These may be intertwined and matters that go to the PSR may be brought to the attention of Ahpra. While patient safety issues may also be uncovered during PRP and PSR reviews, this is not the main function of these reviews. The Department's tip-off form on the website and the instructions makes it clear that concerns about patient safety should be addressed to Ahpra.

[31] Department of Health and Aged Care (Department) *Completed Cases figures as reported in the EOFY Compliance Executive Dashboard.*

Tips offs come from a variety of sources for examples; people view their MyGov digital health records and if there are discrepancies with their known services, they report it to the Department.[32]

2.20 Typical situations were identified in the Senate Committee 2011 report.

'There are four broad situations in which a provider's claims may be identified for audit. These are:

- 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'.[33]

2.21 The PRP identifies and intervenes with practitioners and corporate entities whose activity under the MBS, the PBS and the CDBS may indicate possible inappropriate practice. The function of the PRP is to review MBS and CDBS servicing and PBS prescribing behaviour to determine whether a request should be made to the Director of the PSR to review. Practitioners are only referred where concerns are unable to be resolved under the PRP.

2.22 The concerns of possible inappropriate practice are commonly identified through monitoring the patterns evident in the provision or initiation of MBS or CDBS services and the prescription of PBS items by individual practitioners. Data of practitioners in Australia who bill under Medicare is considered as part of the analysis to identify practitioners whose patterns are at variance to their peers. Other relevant information is also considered as part of the review. This includes the location of the practitioner, patient profile/demographics, specialisation or special interests, additional training, clinical relevance.

2.23 Where concerns that the practitioner may be engaging in inappropriate practice are unable to be resolved under the PRP, a delegate of the CEM may request the Director of the PSR to review the provision of services of the practitioner or corporate entity. All relevant information, including all information provided by practitioners throughout the PRP process, is considered by the delegate prior to making the request.

2.24 In determining the level of inappropriate practice, PAs and the delegate of the CEM will consider factors such as:

- The degree of variance from peers in a range of parameters, such as total services, daily services, or the rendering or initiating of individual services. These practitioners will often be among the practitioners with the highest rate of such services, or will vary from peers in either rendering or initiating of MBS or CDBS items or PBS prescribing.
- Whether MBS/CDBS/PBS requirements have been met, including the MBS item descriptors and PBS restrictions and authority requirements.

[32] Department *Practitioner Review Program* presentation slides.
[33] Senate Committee 2011 report 2.12, citing Medicare.

- Whether services were clinically relevant. A ‘clinically relevant service is one that is generally accepted by the relevant profession as needed for the appropriate treatment of the patient.

All practitioners who are accepted into the PRP are reviewed for suitability by a PA who is a qualified health professional.

2.25 How a case progresses through the PRP depends on several factors, including:

- Previous compliance history;
- The level of concerns about the nature or extent of possible inappropriate practice;
- If the 80/20 rule has been breached; and
- Whether the practitioner chooses to engage in any of the processes under the Program.

2.26 Most practitioners will be offered an interview. Among the cases reviewed annually in the PRP, certain cases are referred directly to the delegate of the CEM. The categories are:

- Breaches of the 80/20 rule; and
- Corporate practice.

Where concerns for patient safety are found, PRP cases are referred to Ahpra. The PRP will continue where there are concerns of potential inappropriate practice. These cases are a small proportion of the cases identified by the Department: see Table 1.

2.27 The majority of cases (about 80 per cent) accepted for the PRP will progress to interview after review by a PA due to concerns of potential inappropriate practice. Approximately 20 per cent will be closed prior to interview. A PA reviews the case and offers the practitioner an opportunity to attend an interview. Practitioners are contacted by telephone to arrange a time for an interview. The letter confirming the interview is accompanied by lists of concerns and the practitioner’s relevant MBS, CDBS and PBS servicing data. At the interview, the PA details the identified concerns and provides the practitioner the opportunity to provide information that may explain their servicing profile and the variance to peers in their claiming data.

2.28 After the interview, the PA considers all the available information, including any information provided at the interview and writes a report. The possible outcomes after interview include:

- All concerns are addressed, no further action is required and the matter is closed (about 7 per cent of those examined).
- Some or all of the concerns remain and the practitioner will be offered a six month period of review
- The matter is referred to a delegate of the CEM to consider whether to make a request to the Director without undergoing a six-month review.

2.29 For those offered a review period, the practitioner receives a letter explaining they have been offered a six-month review and an explanation of the remaining concerns is provided. The practitioner is given 6 months to consider their MBS/CDBS/PBS servicing behaviour and

make any changes they think are required. After the six-month review period ends, a PA will examine the practitioner's MBS/CDBS servicing and PBS prescribing data from that time, although the review will likely occur approximately eight months later to allow for the data to become available. Possible outcomes include:

- all concerns are addressed, and no further action is required, so the matter is closed
- some or all of the concerns remain, or new concerns are identified, and the matter is referred to a delegate of the CEM to consider whether to make a request to the Director of the PSR.

2.30 If the Department still has concerns the practitioner's servicing behaviour may indicate possible inappropriate practice, the relevant PA refers the cases to a delegate. The practitioner will receive a letter notifying them they have been referred to a delegate with an explanation of the remaining concerns. The delegate undertakes an independent review of all the relevant information available. If the delegate considers a request should not be made to the PSR Director, the case will be closed. If the delegate has concerns about the data, the practitioner may be invited to make a written submission to the delegate.[34] After consideration of any submissions received, the delegate may make a decision to close the case or make a request to the Director to review the services of the practitioner.[35] If the practitioner is identified under PRP a second time for concerns about possible inappropriate practice, the review period of six months may not be offered.

2.31 The process is illustrated in Table 1.

Table 1: Relevant Completed Cases figures as reported in the EOFY Compliance Exec Dashboards

Financial Year	Requests to PSR	Professional Review (PRP)
2016/17	81	454
2017/18	109	421
2018/19	101	457
2019/20	127	628
2020/21	73	335
Total	**523**	**2467**

** Cases to 30 June 2021*

2.32 The number of cases with a request to the Director PSR to review varies. In 2018-19, the number was 101.[36] In 2018-2019, 19.8 per cent of cases where the practitioner was interviewed were referred to the PSR. In 2020, the number of requests comprised 121

[34] *National Home Doctor Service* at [67] per Griffiths J.
[35] Section 86.
[36] Interview with Catherine Riordan, Director, Professional Review Section, Benefits Integrity and Digital Health Division, Department of Health and Aged Care, 3 November 2021.

practitioners and six corporate providers of medical or health services.[3738] As **Table 1** indicates a referral to the PSR occurs in only a small proportion (up to 20 per cent) of PRP review cases (based on the complete cases rate).[39]

2.33 The Department does not lightly refer to the PSR.[40] There has been a decrease in referrals to the PSR when the total number of those identified by the Department for potential to be included in the PRP is taken into account.

Phase 2: Consideration by the Director of the PSR

2.34 Consideration by the PSR is triggered by the referral to the PSR by the delegate of the CEM.[41] The CEM issues the Director with a Request for Review to examine the conduct of a practitioner. The majority of cases concern possible inappropriate practice from professional conduct rather than a specific breach of the 80/20 rule. The documentation accompanying the request includes the practitioner's submission, if made, and data relevant to the request.[42]

2.35 The CEM's referral request is couched as 'I request that you review [Dr/other health professional; named practitioner]'s provision of services for the purpose of considering whether they may have engaged in inappropriate practice within the meaning of section 82 of the Act' during a 'specified period'.[43] That period must be a period within the 2 years prior to the date of the request.[44] The letter shows the dates for the 'review period', details particular 'concerns' and the 'reasons for the concern'.[45] Within 7 days of making the referral, the CEM must notify the practitioner that they have been referred for review.[46]

2.36 From this point, the Director has discretion about how the process unfolds.[47] The section 92 agreement process is detailed in Table 3. The Director must make a decision whether to review and is given one month to do so. The test is whether there is a 'possibility' of inappropriate practice.[48] The Director makes the decision to review based on the material provided by the CEM, including the data of all the billing during the review period and the year prior to the review period, as well as the correspondence between the Department and the person under review during the PRP. When the decision is made, the Director notifies the CEM and the practitioner accordingly.[49]

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[37] Ibid.
[38] Interview with Deputy Secretary, and relevant First Assistant Secretary, Department of Health and Aged Care, 12 November 2021.
[39] *PSR role in compliance and s 92 agreements*, former PSR Director's presentation slides.
[40] Interview with Deputy Secretary, and relevant First Assistant Secretary, Department of Health and Aged Care, 12 November 2021.
[41] Section 80(3).
[42] Template, Department's 'Request to Review' letter.
[43] Template Departmental 'Request to Review' letter.
[44] Section 86(2).
[45] Template Department's 'Request to Review' letter.
[46] Section 87(1).
[47] Section 88B.
[48] Section 88A(2)
[49] Section 88A(4).

2.37 After deciding to undertake a review, the Director examines a sample (generally 10-50) of the services identified in the Request for Review.[50] The Director issues Notices to Produce to the practitioner and/or the practices at which the medical or allied health records are held, for the complete patient record for each patient to whom the sampled services were provided. The Director may also obtain other relevant information.[51]

2.38 If the Director decides not to undertake a review the case is closed (section 88(A(1)) by formally deciding to take no further action. However, if the Director decides to undertake review, there has to be a decision whether to:

- enter into an agreement under section 92; or
- refer the matter to a PSR Committee under section 93.[52]

2.39 A decision to take no further action (that is, to discontinue the review) under section 91 may be made at any point in the section 92 process, including prior to the Director receiving any records. This also includes, as the following material discusses, after:

- the Director's initial consideration of the records provided in the random cases selected by the Director;[53]
- receiving those records and a consultant(s) report or advice from a professional organisation on the records;[54] and/or
- receiving written submissions from the practitioner following receipt of the section 89C report.[55]

2.40 **Table 2** gives an indication of the demographic of practitioners who have opted for the section 92 agreement. Over two-thirds are doctors. Their training is not predominantly outside Australia, 44 per cent being overseas trained, as compared with 56 per cent who were trained in Australia. **Table 2** illustrates that the highest number of persons participating in PSR section 92 review processes are those who have practised for between five to ten years or those who have been in practice for more than twenty years. The large cohort of longer serving practitioners suggests that either keeping up with current developments or the onset of declining faculties may be issues of concern.

[50] Section 88B.
[51] Section 88A(2); *National Home Doctor Service* at [34].
[52] Section 80(4).
[53] Section 88A(8).
[54] Section 89C(1)(a).
[55] Sections 89C(2), 91. See also *National Home Doctor Service* at [39].

Table 2: Demographic outcomes from interviews with 77 consecutive 'people' interviewed by DPSR during a Director review. The compilation was provided by the PSR.

Variable	N=72 (%)
Gender	
Male	46 (64%)
Female	26 (36%)
State	
NSW	38 (53%)
Vic	10 (14%)
Qld	14 (19%)
SA	4 (5%)
WA	5 (7%)
Other	1 (1%)
Discipline	
GP specialist	27 (38%)
Doctor with no specialist qualification	20 (28%)
Other Specialist doctor	18 (25%)
Other healthcare professional	7 (10%)
Country of primary degree	
Australia	40 (56%)
Overseas	32 (44%)
Years billing MBS before PRP	
0-2	0 (0%)
2-5	7 (10%)
5-10	29 (40%)
10-20	4 (6%)
20+	32 (44%)
Years billing MBS before PSR	
0-2	0 (0%)
2-5	1 (1%)
5-10	32 (44%)
10-20	7 (10%)
20+	32 (44%)
Location of practice	
Metropolitan	59 (82%)
Rural	13 (12%)
Remote	0 (0%)

** Five 'people' were corporations, and demographic details were not relevant in those cases. Accordingly, the relevant sample is 72 people.*

**Rounding error may apply to percentages so percentages add up to 99% or 101%*

Summary: The practitioners referred to PSR by the Department of Health and Aged Care were more likely to be male, from NSW, have a basic medical qualification but no further specialty GP or other specialist qualification, have a primary degree from Australia and have 5-10 or 20+ years of billing history under the MBS, compared to the background demographics of the healthcare professions in Australia. The figures indicate that 90 per cent of those referred were medical practitioners, while 10 per cent were allied health professionals.

2.41 At all stages of the PSR process, if the Director forms the opinion, or is advised by a PSR Committee or by the DA that patient health or safety is at risk - 'egregious malpractice' cases[56]- or that a practitioner has failed to meet professional standards, the Director must refer the matter to Ahpra or other disciplinary bodies. The referral must be accompanied by a written notice of the concerns.[57]

2.42 In cases of suspected fraud, or suspected commission of a civil contravention of an Act, the Director may refer the matter to the CEM which may investigate and take appropriate action.[58] Despite the referral, the Director may continue the review or suspend the case until the CEM has responded.[59] The DA must also refer such cases to the Director to take action.[60] The Director takes into account examples of any serious breaches of inappropriate practice or conduct that the general body of the profession or specialty would regard as 'failing to comply with professional standards' or 'a significant threat to the life or health of any person'. If it is unclear from the information and the material what has led to the possible inappropriate practice the Director will not offer an agreement but instead refer the case to a PSR Committee.

2.43 If a review is to be held, the Director informs the practitioner of the concerns justifying the review and sends a 'Decision to Undertake a Review' notification letter.[61] The letter details the concerns suggesting that 'inappropriate practice' may have occurred.[62]

2.44 The notification is usually through the practitioner's legal or other representative. The person under review is represented in over 90 per cent of cases, generally through a legal representative provided by the practitioner's medical indemnity insurer.[63] If the person is not legally represented the Director takes special steps to ensure the practitioner understands the process.[64] The PSR strongly advises practitioners to be represented.[65]

2.45 The Director notifies the practitioner in a 'Notice to Produce' letter that they must produce the complete 'clinical or practice records of services rendered or initiated during the review

[56] *EY Functional Review*, 3.
[57] Sections 106XA (significant threat to life or health) or 106XB (non-compliance with professional standards'); *Health Insurance (Professional Services Review) Regulations* 1999 (Cth) regs 12, 13, Sch 1 Pts 1, 2 (definition of 'appropriate person or body' for a person under review in the Act): ss 106XA(4), 106XB (3).
[58] Section 89A.
[59] Section 89A(2).
[60] Sections 106UAA, 106XA, 206XB.
[61] Section 88A(4).
[62] 2011 Review [4.18].
[63] *PSR role in compliance and s 92 agreements*, former PSR Director's presentation slides.
[64] *PSR role in compliance and s 92 agreements*, former PSR Director's presentation slides.
[65] *Guide,* 2.

period' for the randomly selected services.[66] The records are the complete patient file, including those the practitioner is required to keep as the 'adequate and contemporaneous records of the rendering or initiation of the services'[67] as defined in the relevant regulations.[68] The time limit for provision of the material is within 'at least 14 days', from the date of the notice, but may be extended.[69] There are penalties for non-compliance with the notice.[70]

2.46 The Director generally appoints a 'suitably qualified' consultant or consultants, or relevant professional body,[71] to provide a report on the material.[72] The Director may also seek other information, including from PSR Committee reports on items similar to those arising in the referral or for the interpretation of ambiguous items in the Schedules.[73] Once the report and other material is analysed, the Director may decide to take no further action.[74]

2.47 The Director offers to meet with the practitioner, often at their workplace, to discuss the concerns outlined in the letter.[75] Occasionally this meeting is with another currently practising medical practitioner whom the Director has asked to perform this role on their behalf. At that meeting the Director (or their representative) discusses:

- the practitioner's background and training;
- the Director's preliminary views of the records that were provided to the PSR (outlined in a 'Decision to Undertake a Review' letter sent ahead of the meeting);
- billing statistics during the review period; and
- any other matters relevant to the review such as the special reasons for outlier results.[76]

2.48 Based on the information provided by the practitioner or representative, together with the material from other sources, the Director drafts a report, the section 89C report, provided to the practitioner and representative.[77] If the Director has continuing concerns, the letter outlines several PSR pathways: dismissal under section 91, a negotiated agreement under section 92, or a PSR Committee process under section 93. The letter invites the practitioner to make a submission about which of the review options the practitioner prefers.[78] The practitioner is usually given several weeks to respond.[79]

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[66] Sections 89B. The Director sends a Notice to the practitioner and representative requesting the production of documents or giving of information. There is a penalty for non-compliance: section 106ZPN.
[67] Section 81(1).
[68] *Health Insurance (Professional Services Review) Regulations 1999* (Cth) regs 5, 6.
[69] Section 89B(4).
[70] Sections 106ZPM, 106ZPN.
[71] Section 106ZP(1).
[72] Sections 90, 106ZP.
[73] Section 90.
[74] Section 91.
[75] *Guide,* 5.
[76] *Guide*, 6.
[77] Section 89C.
[78] Section 89C(1).
[79] Evidence provided by PSR, 8 March 2022.

2.49 The practitioner is encouraged make a written submission on the report,[80] about which option they prefer, including as to mitigating circumstances for the Director to consider if seeking a section 92 agreement or exceptional circumstances, if the 80/20 rule applies.[81] If the practitioner chooses the section 92 route, a pre-requisite is acknowledgement by the practitioner that their conduct in connection with providing services amounted to 'inappropriate practice'.[82] If there is no acknowledgement, the Director refers the matter to a PSR Committee.[83] 'No acknowledgement' cases are rare.

Mitigating circumstances

2.50 Mitigating circumstances are taken into account during negotiation of an agreement.[84] Examples of mitigating circumstances provided by practitioners are:

- evidence of a change in conduct; and
- proof of having undertaken relevant continuing medical education courses.

Exceptional circumstances

2.51 Exceptional circumstances are rarely raised (3-4 per annum) as they are only relevant to matters involving a prescribed pattern of services. At the same time, in relation to patient records, there are certain obligations on practices and practitioners. Practitioners have an obligation to keep adequate and contemporaneous records of services provided. They are also required to transfer their records to another practice if the practice holding the records is closed. A prudent practice will have off-site backups as promoted by the major medical indemnity insurers on their websites.[85] The practice to back up their patient records is also encouraged by the Royal Australian College of General Practitioners (RACGP) and other medical or allied health Colleges.[86]

Negotiation of agreement

2.52 Following receipt of the submissions, the Director proceeds to negotiate the terms of an agreement, including the sanctions,[87] following negotiations conducted with the legal or other representative, and/or the practitioner. The practitioner is encouraged to participate.[88] The sanctions which may be negotiated are one or more of the following:

- a reprimand by the Director;
- an order for repayment of any Medicare or PBS benefits for services in the review period which have been found to be provided inappropriately;

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[80] Section 89C(1). *PSR role in compliance and s 92 agreements*, former PSR Director's presentation slides.
[81] Section 82(1B), (1D); *Health Insurance (Professional Services Review) Regulations 2019* (Cth) reg 7.
[82] Section 92(1).
[83] Interview with former Director, PSR, 23 November 2021.
[84] Information by PSR, April 2022.
[85] For example, https://avant.org.au/resources
[86] Codes of conduct on organisation websites.
[87] Section 92(2).
[88] *Guide,* 6.

- a full or partial disqualification from claiming a Medicare benefit on one or more items for no more than 3 years; [89]
- a full disqualification from billing for PBS services;[90]
- a full or partial disqualification from claiming a Medicare benefit on one or more items for no more than 5 years if the practitioner has previously entered into an agreement.[91]

2.53 There are significant omissions in the current list of sanctions by the Director, namely:

(a) an inability to order counselling or further education;

(b) an inability to partially disqualify a practitioner from prescribing a medicine which attracts a pharmaceutical benefit; and

(c) no option to permit a section 92 negotiated agreement by a corporate practice.[92]

2.54 Omissions (a) and (c) are rectified in the Health Legislation Amendment (Medicare Compliance and Other Measures) Bill 2021 (Bill) which was before the Parliament. The Bill lapsed with the calling of the 2022 election.

2.55 During the negotiations, the Director commonly takes account of mitigating circumstances and the practitioner's submissions. On rare occasions (3-4 pa) exceptional circumstances for the purposes of the 80/20 rule are also taken into account.[93] Typical arguments raised by practitioners in mitigation of sanction are undertakings to:

- reduce the daily number of patients/services;
- undertake courses such as on mental health management skills, medical recordkeeping, understanding how to make MBS/PBS claims, or prescribing drugs of addiction; or
- reduce working hours per week.[94]

2.56 The Director drafts a decision containing the negotiated terms. In reaching a decision, the Director considers what a hypothetical PSR Committee might decide when making a finding of inappropriate practice, bearing in mind that this is not subject to merits review, as would apply before a PSR Committee, but one to be established only to the level of 'possibility' level.[95]

2.57 The practitioner or representative may either accept or reject the 'decision' or make a counter-offer. Once the terms appear to be settled, the Director drafts the agreement for signature. If the Director has not made a decision within 12 months after the Director has made the decision to review, it is deemed that the decision is to take no further action in

[89] Section 92(2).
[90] Section 92(2)(e).
[91] Section 92(2)(f),(2A).
[92] Information by PSR, April 2022.
[93] Information by PSR, April 2022.
[94] *PSR role in compliance and s 92 agreements*, former PSR Director's presentation slides.
[95] Interview with former Director PSR, 23 November 2021.

relation to the review.[96] This time limit is one of the indicators that the section 92 agreement process is intended to be expeditious.

2.58 The draft agreement as finally negotiated must be approved by the Determining Authority (DA).[97] The agreement is confidential.[98] If the draft agreement is not ratified by the DA, the agreement is returned to the Director to attempt to reach agreement on a redraft. If successful, the draft is again sent to the DA. If no agreement can be reached within three months of the refusal of ratification, or if no decision has been made to take no further action or to refer the case to a PSR Committee, the matter must be referred to a Committee.[99]

Phase 3: Ratification by the Determining Authority

2.59 If a draft agreement is reached, the terms of the agreement must be ratified by the Determining Authority (DA).[100] The DA is an independent statutory body[101] set up to make the final decision on practitioner compliance cases which come before the PSR.[102] The members are appointed by the Minister after consultation with the AMA. The DA generally meets once a month, in private.[103]

2.60 The members of a panel are the Chair, who is a medical practitioner;[104] a member of the public who is not a practitioner;[105] and another member or members from the profession of the practitioner whose decision is under consideration.[106] The Director provides material to the DA to assist with its decision but does not appear at the meeting.[107]

2.61 The role of the DA is to ratify the section 92 agreement, taking account of the material provided by the Director.[108] The material provided by the Director generally comprises:

- the CEM's 'Request to Review', including the documentation provided to the Director with the 'Request to Review';
- the report of the Director under section 89C following the decision to conduct a section 92 review;
- the submissions of the practitioner;
- the signed section 92 agreement; and

[96] Section 94.
[97] Sections 92(3), 106R.
[98] Section 92(6).
[99] Section 92A.
[100] Section 80(5).
[101] Part VAA Div 5.
[102] Section 106Q.
[103] Section 106ZPK(2).
[104] Section 106ZPA(1)(a).
[105] Section 106ZPA(1)(b).
[106] Section 106ZPA(1)(c). These provisions are to be amended if the Health Legislation Amendment (Medicare Compliance and Other Measures) Bill 2021 becomes law.
[107] Section 106ZPK.
[108] Section 106ZPK.

- a covering letter from the Director explaining the circumstances leading to the agreement.[109]

2.62 There is a time limit of one month for the DA to ratify an agreement.[110] The DA must notify the practitioner and the Director of the decision.[111] The notification to the practitioner includes only that the DA has agreed to the draft agreement, giving brief reasons. If the DA fails to ratify an agreement, as happens on occasion,[112] the Director must either negotiate a more acceptable agreement, decide to take no further action or refer the practitioner to a PSR Committee.[113]

2.63 Refusal to ratify occurs in about 8-9 per cent of agreements.[114] The DA must provide detailed reasons to the Director for a refusal to ratify.[115] The refusal may be because the DA considers a term of the agreement cannot be effected,[116] or because the terms are too lenient, not fair or unreasonable from the perspective of the practitioner or the Commonwealth.[117] The Director will then attempt to negotiate another agreement with the practitioner. If successful, the draft is again submitted to the DA for acceptance.[118]

2.64 In deciding whether to ratify agreements, the DA considers:

- whether the agreement contains sanctions within the range in the Act;
- the practitioner has acknowledged their inappropriate conduct; and
- the circumstances of the practitioner.[119]

The practitioner is given a copy of the covering letter and the signed section 92 agreement and already has all the other documents given to the DA.

2.65 The agreement comes into effect on the date specified in the agreement, or by default, the fourteenth day after the ratification.[120] The Department has one month before the terms are activated.[121] If the agreement contains a sanction of repayment, the amounts are a debt to the Commonwealth and recovery action is taken by the Department.[122] The Department is also responsible for implementing any disqualification from billing Medicare in the final agreement.[123]

2.66 In matters that proceed to a PSR Committee which makes a finding of inappropriate practice, the Director may also be directed by the DA to issue a reprimand or counsel the

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[109] Table 3: PSR *s 92 Agreement Process* chart; information by the PSR, April 2022.
[110] Section 106R(1).
[111] Section 106R; information provided by the PSR, April 2022.
[112] Section 106R(4).
[113] Section 93.
[114] Interview with Deputy Secretary, and relevant First Assistant Secretary, 12 November 2021.
[115] Section 106R(4).
[116] Section 106QB.
[117] Interview with former Director, PSR, 23 November 2021; *Guide*, 13.
[118] Section 92(5).
[119] Information provided by PSR, 8 March 2022.
[120] Section 92(4).
[121] *PSR role in compliance and s 92 agreements*, former PSR Director's presentation slides.
[122] Section 92(4)(e).
[123] *Guide*, 15.

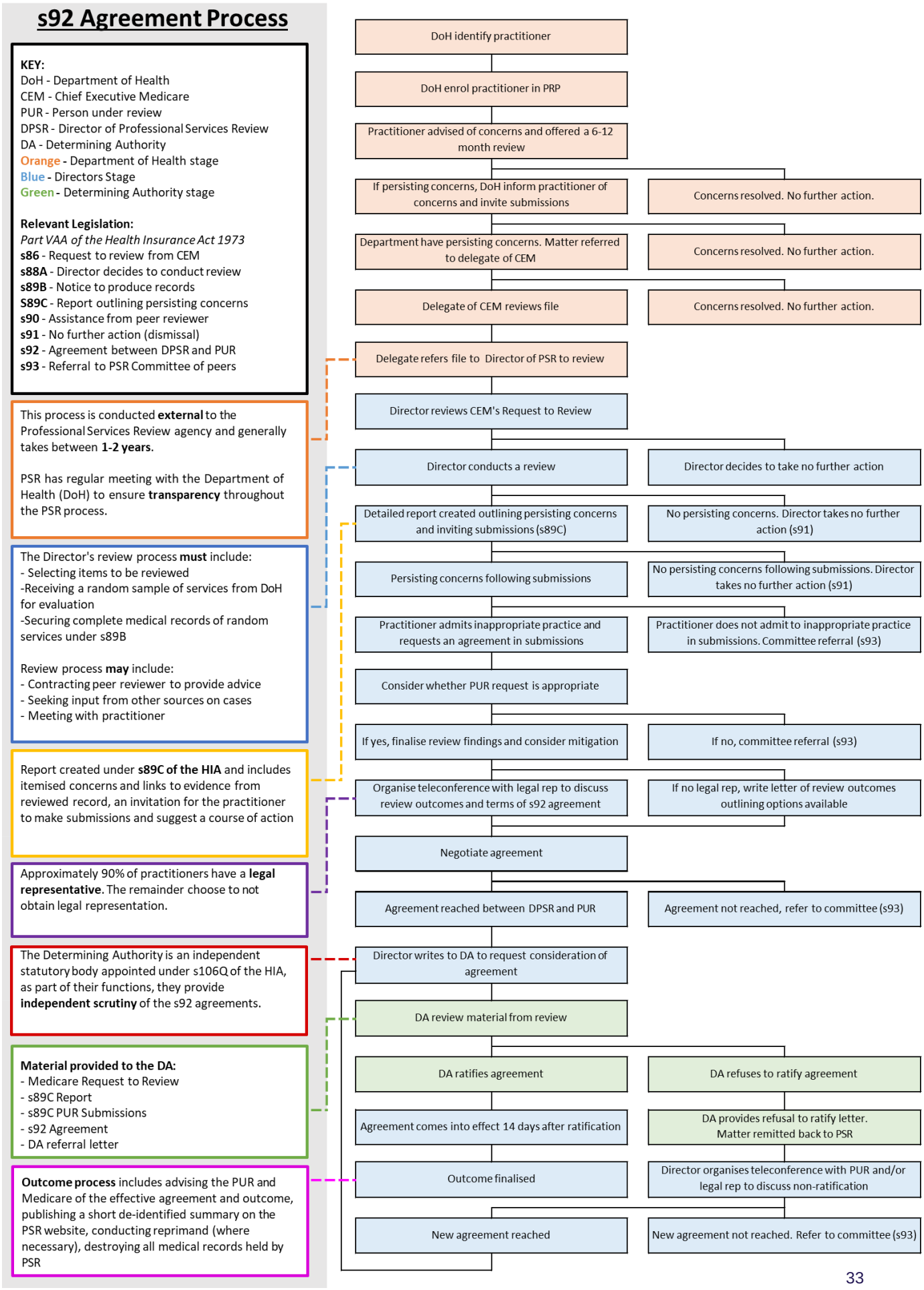
practitioner. The counselling takes the form of a letter outlining sources of assistance and further education to help the practitioner avoid the inappropriate practice in the future. The PSR also has an obligation to send the agreement to the relevant sections of the Department responsible for the implementation of its terms.[124]

2.67 If conduct involves a significant threat to life or health, the DA must advise peak regulatory bodies such as Medical Boards for doctors, Ahpra and the relevant professional association for practitioners in an allied health profession.[125] Equally these bodies must be notified of conduct amounting to breach of professional standards.[126]

2.68 A helpful flow chart of the stages of a section 92 process is outlined in **Table 3**. The flow chart was developed by PSR for the purposes of the review.

[124] Section 92(4)(d).
[125] *Health Insurance (Professional Services Review) Regulations 1999* (Cth) (*PSR Regulations*) reg 10(3).
[126] Section 91(2).

Table 3: Flow chart of the process indicating the stages of a section 92 process



2.69 As part of the review, the Department provided data regarding section 92 agreements reached between PSR and practitioners that had been referred to PSR. The data provided covers the past five (5) financial years 2016/2017 – 2020/2021 and the current financial year, 2021-2022, to 30 April 2022. The data includes the number of referrals made to PSR, the breakdown of outcome types reached and recovery values. In addition, the number of providers referred by the PSR to the Medical Boards or the Australian Health Practitioner Regulation Agency (Ahpra) under sections 106XA or 106XB has also been detailed using figures from PSR Annual Reports.

Table 4 illustrates the breakdown of PSR outcomes since the 2016/2017 financial year. The majority of PSR outcomes have been section 92 agreements. From 2016/2017 to 2020/2021, there have been 439 PSR outcomes of which, 83 per cent (365 cases) of PSR have been section 92 agreements, 11 per cent (48 cases) were referred to a PSR Committee under section 93 and 5 per cent (23 cases) were section 91 outcomes, that is, no further action after review.

Table 4: Breakdown of PSR outcomes since the 2016/2017 financial year

	PSR Outcomes				Outcome Values		Number of Referrals: To PSR			To Ahpra
Financial Year	S91	S92	S93	S106RB	S92	S93	Referral to PSR	80/20	Referral Not Accepted by PSR	Referral to Medical Boards/ Ahpra
2016/17	10	58	3	1	$8,660,983	$357,860.99	81	6	0	15
2017/18	1	49	16	0	$16,188,558	$4,560,620.28	109	4	0	14
2018/19	2	90	8	1	$26,411,680	$2,784,521.03	101	3	0	11
2019/20	4	79	12	1	$21,316,275	$6,362,627.64	127	1	0	20
2020/21	6	89	9	0	$21,296,121	$3,480,383.23	73	2	0	22
Total	**23**	**365**	**48**	**3**	**$93,873,617**	**$17,540,013.17**	**491**	**16**	**0**	**82**

*The breakdown of cases shows subsequent outcomes since 2016/2017 financial year to June 2021. The data shows that since the 2016/2017 financial year the average value per PSR outcome is, greater for cases referred to a PSR Committee under section 93. The average recovery amount for section 92 agreements was $257,188 per case while for cases referred to a PSR Committee under section 93, it was $365,542 per case.

In total, 491 cases have been referred to the PSR since the 2016/2017 financial year. Of these, 3.25 per cent of referrals (16 cases) to the PSR were 80/20 breaches. All referrals to the Director PSR were accepted for review and 23 had a decision of no further action (s 91) after the Director's review. Referrals to PSR do not necessarily result in an outcome in the same financial year, meaning that the outcomes may correlate to requests made in a previous financial year. 82 cases were referred to Ahpra in this period.

Chapter 3. End to end process flow from the perspective of the person under review

3.1 This chapter deals with the end-to-end process flow by considering the submissions made by practitioners or their organisations. The principal themes identified in the submissions are referred to in this and the following chapters. The themes are grouped loosely according to the terms of reference of the review. There is a degree of overlap in the terms of reference and as a consequence location of a theme to chapters is, to an extent, a matter of choice.

3.2 Several submissions voiced strong support for the PSR agency and its compliance role. This recognises that section 92 agreements are an effective, simple, and efficient approach to resolve concerns about inappropriate billings. For example:

- 'MIGA supports the legislative mechanism to permit persons under review (PUR) to enter into an agreement with the PSR Director to resolve issues of 'inappropriate practice' under s 92 of the HIA'.127
- 'In principle, the RACGP supports measures aimed at preserving the integrity of Medicare and the role of the Professional Services Review (PSR) in investigating inappropriate practice'.128
- 'We [ACNP] concur with the Professional Services Review Agency (PSR) scheme's goals to safeguard the public against the risks and of costs of inappropriate practices of practitioners as well as protecting the integrity of the Medical Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS) to ensure appropriate and cost-effective clinical services'.129
- 'RANZCO considers the PSR an important organisation as part of maintaining our overall health funding system, and we support the work that it does'.[130]

3.3 These submissions acknowledge that the processes adopted are important if there is to be a thorough and in the case of the PSR Committee authoritative finding especially in relation to MBS or PBS interpretation issues: see Chapter 6. They are also essential for protection of patient safety and to maintain the integrity of the Medicare system.

3.4 Nevertheless, there is room for improvement. The review has taken into account the many suggestions to this end from the helpful submissions.

Meetings with Director

3.5 The practice of recent Directors is to have an in-person meeting with the practitioner, often at their workplace, as part of the initial review process. This meeting is to understand better the circumstances of the practitioner, and to encourage the practitioner to respond with explanations or mitigating circumstances. The Director can discuss the concerns first-hand in a location familiar to the practitioner, thus reducing the stress involved. Other

127 Medical Insurance Group Australia Pty Ltd (MIGA), 1.
128 Royal Australian College of General Practitioners (RACGP), 1.
129 Australian College of Nurse Practitioners (ACNP), 1.
130 Royal Australian and New Zealand College of Ophthalmologists (RANZCO), 1.

advantages are that it speeds up the process and better enables an assessment of the credibility and competence to practise of the person under review.[131]

3.6 Several submissions expressed strong approval for the practice and advocated that the practice be included in the Act, while leaving open a discretion in cases where the practice would be inappropriate. Legislative inclusion it was argued would ensure the practice continues. As one submission put it:

> 'Although … already informally available at the Director's discretion in individual circumstances, the importance [of the practice] in ensuring procedural fairness and transparency, together with the inevitable risks of varying approaches by differing decision-makers over time, mean they should be required by legislation'.[132]

3.7 The review accepts that the practice is invaluable. The evidence is that meetings occur in about 95 per cent of cases.[133] Notwithstanding, there are potential difficulties associated with including the requirement in the Act. They are illustrated by the recent COVID-related restrictions on travel, the step imposes a heavy burden of time and travel on the Director, travel may not be feasible to some remote locations, an in-person meeting may not be needed in some cases and is not sought by all practitioners, and in other cases may not be appropriate. The review does not recommend that the step be included in the legislation as it would open the way for litigation if a statutorily required meeting did not occur.

3.8 An option is to include a discretionary step in the Act. The review also does not support this option either. Legislative requirements raise identification of criteria and also increase the possibility of litigation. The suggestion, if implemented, would undermine the intended expedition of the section 92 process. It is preferable for the step to be given more prominence in the PSR publication, *Your Guide to the Professional Review Process* (*Guide*) and other publicly available material, rather than in a legislative form.

Information available for meeting

3.9 Several submissions suggested specific information for the practitioner relating to the Director's concerns should be made available prior to the meeting. Complaints were variously:

- 'This [absence of information] hampers practitioners' ability to appropriately engage with the process and makes it difficult to prepare for any meeting with the PSR Director. Practitioners have also reported that there is insufficient time allocated to the meeting … to answer questions in a considered manner.[134]
- 'Solutions that promote fairness and transparency could be … providing preliminary reports to practitioners who agree to attend a meeting with the Director'.[135]

[131] *EY Functional Review*, 7.
[132] MIGA, 1.
[133] Interview with former Director and General Counsel, PSR, 8 February 2022.
[134] RACGP, 2.
[135] RACGP, 2.

- New issues are raised at the interview, often because of further disclosure by the practitioner.[136]

3.10 The evidence to the review was that the 'Notice to Undertake a Review' letter requesting the production of patient records does itemise the Director's concerns on the items selected from those provided by the Department.[137] The itemisation includes the billing records for those items chosen by the Director for consideration and any other information provided by the Department. Following the production of those records, their analysis by a consultant or information from a professional organisation and other sources, an interview is generally conducted with the practitioner.

3.11 It would be premature to send a preliminary draft prior to that interview. As **Table 3** indicates the meeting precedes one of the Director's decision-points. The information gleaned at that meeting, particularly from the discussion with the practitioner, the observation of the environment in which the practitioner works and the circumstances of their practice, may assuage the Director's concerns leading to a decision to take no further action. Prior to the meeting, that information was not available and such a decision could not be made. There can be no advance identification of such issues.

3.12 The review considers there is no need for a recommendation in response to the issues identified in these submissions.

New issues at interview

3.13 A further matter raised in submissions is that new issues arise at the meeting with the Director and practitioners have insufficient warning and time to respond adequately to them at the meeting.

3.14 It is inevitable that new issues emerge on such occasions. That is an inherent and often valuable element of such occasions. The interview provides an opportunity to tease out mitigating circumstances not considered by a practitioner, or to refute the basis of a possible issue raised by the pre-existing information to the benefit of the practitioner. The information is only elicited at the interview and is a key reason for the interview process. Additional questions cannot be anticipated prior to the interview and no recommendation can or should prevent this occurring.

3.15 One submission complained of the inquisitorial approach of the Director at the meeting. The reviewer has not attended in-person meetings and is not in a position to judge the correctness or otherwise of the complaint. Nevertheless, an interview process at which one person is eliciting information from another is, by its nature, inquisitorial in style. That is the correct description for such a meeting.

[136] Medical Indemnity Protection Society (MIPS), 5.

[137] Interview with former Director and General Counsel, PSR, 8 February 2022.

3.16 The review considers no recommendation is warranted on these submissions. If the practitioner has concerns about the style of the interview this can be raised by their legal or other representative.

Difficulties for practitioner in complying with 'Notice to Produce' patient records

3.17 Failure to comply with the notice requiring the production of patient records relevant to the concerns may result in a monetary penalty[138] or disqualification from billing Medicare[139], and/or result in the referral of the review to a PSR Committee, denying the more advantageous agreement process.

3.18 Several submissions raised concerns about practical impediments to the production of patient records.[140] Difficulties specified arose:

- when a practitioner is no longer employed or contracted to the practice holding the patient records;
- the practice at which the records were located has closed; or
- for other reasons the practitioner no longer has access to the patient records.[141]

3.19 Problems of these kinds can arise. The obstacles, however, at least in part, have been anticipated in the Act. The 'Notice to Produce' letter issued by the Director indicates that if the practitioner has difficulty accessing records, the practitioner should notify the PSR of the identity of the person or practice at which the records are located.[142] That notification opens the way for the PSR to seek the information directly from the person or practice. It is then the individual or practice which faces a penalty for failure to comply.[143]

3.20 In cases in which the practice has closed or the records are no longer available for other reasons, the circumstances are investigated. If they are beyond the practitioner's control, the Director considers whether the investigation should be conducted, or a more limited one undertaken. Such matters are taken into account by the Director when negotiating an agreement.[144]

Timeline difficulties

3.21 An associated difficulty is a statutory timeline of 14 days within which to provide the records. It was suggested that a recommendation be made to extend the timeline to 28 days. The Director regularly extends the 14-day time limit when requested.[145] At the same time, the Act states that if an extension is granted, the Director may add a commensurate number of days to the overall 12-month time frame for making a decision.[146] Although this

[138] Section 106ZPN.
[139] Section 106ZPM.
[140] For example, Royal Australian and New Zealand College of Radiologists (RANZCR), 1.
[141] ADA, 2.
[142] Section 89B(2)(d).
[143] Section 106ZPN.
[144] Information provided by PSR, March 2022.
[145] Section 94(2).
[146] Section 94(1).

may extend the overall time taken, the extension is fair and does not affect most practitioners.

3.22 For these reasons the review considers there is no need to extend the current statutory timeframe. The section 92 process is intended to be an expedited one and it would be inconsistent with that principle to do so when there is already a flexible exercise of the present limit.[147]

Employment consequences for practitioner if 'Notice to Produce' directed to employer

3.23 A related concern is that when 'Notices to Produce' are issued to practices, the notice may lead to an inference about the practitioner with adverse employment consequences.[148] This may be of concern particularly for those on contract or with a tenuous association with a practice. The PSR takes specific steps to not disclose the identity of the person under review when issuing notices to third parties.

3.24 At a practical level there is no alternative to disclosure. As the practice is only notified when records are unobtainable by the practitioner, the step may in fact benefit the practitioner in negotiations on a review as the discussion at [3.19]-[3.20] demonstrates. Alerting the practice to concerns may also be beneficial for employers or practice managers. The knowledge may prompt further training of practitioners or need for an internal audit of billing or change of clinical practice. Overall, such steps may benefit practitioners, patients, the corporate practice and assist in maintenance of the integrity of the Medicare system.

3.25 For these reasons the review considers no recommendation is needed.

Acknowledgement of inappropriate practice

3.26 Several submissions objected to the requirement that the practitioner acknowledge they have engaged in inappropriate practice and suggested it be removed from the Act. The requirement was argued to be a disincentive to practitioners considering an agreement[149] and to heighten feelings of being coerced. In turn that leads to dissatisfaction with and a lack of trust in the fairness of the process.

3.27 The review does not accept the suggestion. The law requires the acknowledgment. The repayment is included in the agreement because there has been an inappropriately billed Medicare item, claim for dental benefit, or PBS item. That inappropriately billed item raises a debt. Repayment of the debt 'is due by the person to the Commonwealth and is recoverable by action in any court of competent jurisdiction'.[150]

3.28 The Commonwealth as the provider of the funds involved is only entitled to be repaid when there is a decision that there is a debt. The acknowledgement that inappropriate practice has occurred is the basis on which that decision can be made. Without the

[147] Section 94(3).
[148] MIPS, 4.
[149] MIGA, 3.
[150] Section 92(4)(e).

acknowledgement there would be no legal basis for recovery action by the Commonwealth.[151] The repayment is conditional on a decision to raise the debt and without it the decision to recover the debt would be unlawful.

3.29 Not only would the removal of the requirement lead to possible unlawful action by the Commonwealth, but to remove the requirement would also be contrary to one of the objectives of the PSR scheme, namely, to preserve the integrity of Medicare.

3.30 The review considers no recommendation should be made in response to this suggestion.

Whether agreement voluntary

3.31 A number of submissions indicated that practitioners feel coerced into entering into an agreement following their acknowledgement of their 'inappropriate practice', not least because they did not accept their conduct warranted sanction.[152] The consequences, it was submitted, negated the voluntariness of the agreement and contributed to a perception of unfairness about the process.[153] The point is illustrated in the following extract:

> While it is acknowledged that practitioners choose to enter into a section 92 agreement, feedback suggests they do not always feel empowered in this decision, in part because they are being asked to make a voluntary acknowledgment of inappropriate activity without always understanding how they are at fault.[154]

3.32 The practitioner's inability to accept they had been involved in wrongdoing was only one reason for the expressions of concern about feeling coerced by the process. There were others. The Skin Cancer Council of Australasia (SCCA) observed:

> In reality, section 92 agreements are perceived by medical practitioners as an admission of guilt gained under coercion and duress. PURs [Person under Review] tell of being made to feel pressured to sign such agreements or face 'trial by committee' resulting in prolonged stress, further time out-of-practice and significantly higher legal fees. We believe most PURs enter into a section 92 agreement as a risk mitigation strategy to avoid higher financial penalties and other costs.[155]

Optometry Australia (OA) also noted:

> Often the decision to settle at this point is dictated more by other factors (eg weighing up the cost of closing a private practice for up to a week to 'fight' the decision at a panel hearing of PSR or for other personal reasons). We have previously been told by more than one member that it was simply easier to 'pay up and move on with their lives' rather than drag out the process further and fight on.[156]

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[151] *Prygodicz v Commonwealth (No 2)* [2021] FCA 634 (Robodebt). The case graphically demonstrates the consequences including cost of unlawful conduct.
[152] Australian Diagnostic Imaging Association (ADIA), 34-35; MIGA, 3.
[153] MIGA, 3; AMA, 4; Avant, 3.
[154] RACGP, 11.
[155] RACGP, 11.
[156] Submission of Optometry Australia (OA), 1.

The AMA reported:

> Administrative law is complex and it is not obvious to practitioners that they have avenues for review outside the Act. Without this information some PURs feel that they are being given a 'choice' between signing a S92 agreement and embarking on a process where PURs have a historically low rate of success and no rights of appeal.[157]

3.33 Coercion was also suggested to arise from the notification in the initial 'Decision to Undertake a Review' letter. The letter warns that the processes within the PSR could mean expansion of the inquiry into areas of practitioner billing not included in the referral from the Department. Additional suggested pressures came from the power imbalance between the Director and the practitioner, and that the Director was the sole decision-maker in the negotiated settlement process. The short time-frames for negotiating the terms of the agreement were also said to add to the coercion experienced by the practition.

3.34 It is understandable that the choice between a PSR Committee process or a negotiated outcome may result in the practitioner feeling pressured to adopt an agreement. People commonly face choices of that kind. Such choices often involve a degree of stress. Against that, there are reasons other than coercion for the choice by the practitioner of section 92.

- The extra time, stress and cost involved in the PSR Committee as compared with the section 92 process. (See *Length of and timelines for process*, later).
- The confidentiality of the process protects the practitioner's reputation and hence business.[158]
- The avoidance for the practitioner of the embarrassment of appearing before their peers at the Committee process.[159]
- The ability to negotiate and the certainty of the outcome.[160]
- The result for the practitioner is generally less harsh or severe than the PSR Committee process: **Table 4**.

Together these reasons indicate the advantages of a negotiated, confidential, less time-consuming process. The benefits of these advantages are illustrated in the figures in **Table 4**.

3.35 Despite the suggestions of coercion, the reality is that when faced with this choice over 90 per cent of practitioners choose an agreement: see **Table 4**. That choice is supported by a survey by the PSR of cases of practitioners who had either rejected an agreement or opted instead to attend a PSR Committee hearing. The number of cases identified was small – only 15 – but the results are indicative of the advantages of the operation of section 92. The survey commentary which is not included with Table 5 found: 'practitioners referred to a Committee were significantly less likely to submit that they would make a change in clinical practice [or to undergo further training] as a result of the review (36%) compared to those practitioners where the review outcome was a s92

[157] AMA, 2.
[158] ADIA, 34-35.
[159] Interview with Department official, 3 November 2021.
[160] Interview with Mr Andrew Davey, Director, Unsworth Legal, 12 April 2022.

agreement (90%)'.[161] That is, a negotiated outcome is more likely to result in behavioural change by practitioners: **Table 5**: Audit 2.

3.36 The results also indicated that in 67 per cent of the cases, the outcome for the practitioner at the Committee review was less favourable than the proposed terms of the agreement, and equally favourable in another 20 per cent of cases. The more beneficial outcome under section 92 is a strong incentive to adopt the agreement option: **Table 5**: Audit 3.

Table 5: Audit of PSR Outcomes

Audit 1: Outcomes of Director Reviews*

Practitioner request in submissions (N=111)	Actual Director state outcome (N=111)		
	S91	S92	S93
S91 (N=2)	0	0	2
S91 or s92 (N=10)	0	8	2
S92 (N=99)	0	92	7
S93 (N=0)	0	0	0

* *Excludes s91 cases*

Audit 2: Submissions from practitioners

Submissions	S92	S93	P-value
Reduce number of patients/services per day (aim for <70)	41%	9%	0.04
Course to improve mental health management skills	15%	0%	0.35
Course in medical recordkeeping	48%	0%	0.002
Course in understanding MBS	23%	0%	0.12
Course in prescribing drugs of addiction	11%	0%	0.60
Reduce working hours to less than 50/week	39%	9%	0.09

[161] PSR *An audit of the changes made to practice as a result of a PSR Director's review* (2019), 2.

Audit 3: s92 versus eventual s93 outcome*

	N=15 (%)
S92 terms were worse than eventual Committee/DA terms	2 (13%)
S92 terms were similar to eventual Committee/DA terms (+/- 10%)	3 (20%)
S92 terms were better than eventual Committee/DA terms	10 (67%)

** This audit only includes those practitioners who were offered a s92 and settlement was not achieved and they subsequently had a Committee and Determining Authority outcome. This audit does not include practitioners where a s92 offer was not made.*

3.37 There are other responses to the concerns in submissions. The section 92 process is intended as a less formal and more expeditious process. It is inevitably inquisitorial in style, given that the Director alone is eliciting information from the practitioner at the interview. That process also involves speedier decision-making which requires timely provision of information and decisions. Fairness is preserved because most practitioners are represented and the practitioner is given multiple opportunities to explain their practices. The speedier outcome is a trade-off between the section 92 procedures and the more comprehensive, time-consuming and thorough PSR Committee reviews. The style of the section 92 process is an intrinsic feature of its expedited nature.

3.38 The suggestion that any broadening of the review by the Director is threatening is negated by the legislation. Under section 88B of the Act, once the Director has decided to undertake a review, the Director is able to review any or all services provided by the practitioner during the review period. The information gathered during the review may be broader and more informed than that identified in the CEM's initial request for review. The advice provided by the Director to the practitioner when seeking the patient records that the scope of the review may be broader than the request from the CEM is an element of the fairness required when new information is taken into account by a decision-maker, here the Director.

3.39 On balance, the evidence as to the overwhelming support for an agreement, the inherent elements of the inquisitorial elements of the process and the steps taken by the former Director to enable a less stressful and time-consuming agreement process, as well as the benefits for behavioural change, indicate there is no need for a recommendation on these submissions.

Sanctions and suggested discounts

Sanctions

3.40 The statutory sanctions which may be included in a draft section 92 agreement were described in Chapter 2. Typically, a practitioner may be required to repay money for specific services billed inappropriately, there may be a period of partial or full

disqualification from claiming under the MBS/CDBS and/or full disqualification for prescribing medicines covered by the PBS, and a reprimand from the Director.[162]

3.41 As mentioned in Chapter 2, there are deficiencies in the sanctions which can be recommended by the Director in a section 92 agreement. The Director cannot initiate and undertake counselling and further sources of education for the practitioner. As one submission suggested: '[A]ll PURs [should] be offered counselling and education at the end of the process'.[163] This matter is rectified in the Health Legislation Amendment (Medicare Compliance and Other Measures) Bill 2021. The Bill was presented to the parliament but lapsed on the calling of the 2022 federal election.

3.42 Another deficiency in the sanctions which may be imposed under section 92 is that an agreement finding inappropriate practice in relation to PBS services can only result in disqualification from prescribing all PBS medicines. This unnecessarily restricts patients' access to care and as a result is rarely used. It is more appropriate 'to implement a targeted and proportionate sanction, being a disqualification from the specific class of medication'.[164]

3.43 The Director has seen the patient records, often visited the practice in which the practitioner operates. The Director has also considered the oral and written submissions of the practitioner. Accordingly, the Director has comprehensive information about the practitioner and their conduct and, as a consequence, is best equipped to undertake the counselling role.[165] When directed by the DA to undertake counselling, the PSR at present only writes to the practitioner referring the person to resources to assist with education, behavioural change and self-improvement.[166] An ability to offer counselling by teleconference or in person would be both valuable and preferable.

Recommendation 1:
Legislation be re-introduced into the Parliament along the lines of the Health Legislation Amendment (Medicare Compliance and Other Measures) Bill 2021 to ensure the reforms proposed for section 92 be implemented, including that the PSR Director has the full range of options that may be imposed by the Determining Authority.

Discounting

3.44 Submissions suggested there needed to be a documented and transparent discounting guide. It was said this would best act as 'an incentive for practitioners to engage in

[162] PSR *Review by the Director: Overview of the Director's review of your provision of services,* 2; de-identified example of reprimand and counselling letter. See also PSR Director's monthly 'Updates'.
[163] MIPS, 5.
[164] PSR submission, 4. This was recommendation 6 of the Senate Committee 2011 report.
[165] Evidence by PSR, 8 March 2022; de-identified section 89C notification; de-identified file note of teleconference at which the final section 92 agreement was put to the practitioner at which the practitioner itemised the behavioural changes for improved provision of services.
[166] De-identified copy of a reprimand letter, provided by the PSR, January 2022.

education and to make improvements to their practice'.[167] The suggestion is supported by the rounding of figures for repayments under section 92, as compared with the greater precision in amounts imposed by the Determining Authority following a PSR Committee investigation and final report.

3.45 In addition, there were suggestions that there is a need for more consistency in interpretation and for some leniency to be granted in consequence of possible alternative interpretation of items under scrutiny. These factors are reflected in the number of submissions advocating adjustment to, or discounts for amounts of repayment imposed in relation to items for which inconsistent interpretations are possible.[168]

3.46 Submissions provided examples of the current opacity of the process for estimating amounts owed.

- 'Whilst there are many good lessons along the way, many PURs still feel uncertain about the interpretation of some Medicare item numbers and the decision making of the PSR (for example, when the PSR indicates it considers 70% of the services to be inappropriate – the PUR wants to know why some were considered inappropriate and others not to ensure they practice appropriately going forward)'.[169]
- 'Uncertainty about the process of applying discounts to reflect Medicare rules such as the coning rules (which limit benefits for multiple services)'. [170]

3.47 Other points made in submissions were:

- '[T]here [should] be a statutory limit on repayment where the sole or main criticism is the quality of the medical record as opposed to the clinical content of the service, of 50% of the value of the service'.[171]
- '[I]f agreements are reached early discounts on amounts that may be payable ought be given'.[172]
- '[T]he PSR needs to publish information to assist PURs to better understand the calculation of repayment amounts'.[173]
- '"PURs" comparative level of understanding of MBS items and experience in claiming' and 'discounts, including for insight, education, changes to practice and sampling error' should be made.[174]

3.48 If there is an alternative billing item with a different threshold for the rebate, the current position of the Director is not to take the alternative into account. The concern is that it would encourage practitioners to bill the more expensive item because they would only have to pay back the difference if they are caught by the PSR. There should be a substantial consequence for conduct that is regarded by their peers as unacceptable.

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[167] Avant, 4.
[168] AHSS, MIDA, Avant; ASSCA; Royal College of Australian and New Zealand Radiologists (RCANZR).
[169] MIPS, 4.
[170] MIPS, 5.
[171] Avant, 4.
[172] AIDA, 20.
[173] MIPS, 4.
[174] MIGA, 4.

3.49 There are explanations for the rounding processes adopted for agreements. The *Guide* states that the 'volume of inappropriate practice cases is reduced by those days on which exceptional circumstances are found to have existed'.[175] However, this is only applicable when a practitioner has rendered a prescribed pattern of services and it is determined that exceptional circumstances exist.

3.50 Further, the agreement process is not as searching or extensive as the processes of a PSR Committee, so the Director's figures take this into account. Other circumstances, such as conflicting advice are also a factor affecting the figure.[176] The evidence to the review indicated that the Director does consider ignorance, minor errors, and disputed interpretation of items billed. These may lead to mitigation of sanctions or dropping an item from review.[177] Early payment of amounts owed is not a reason for discounting. The debt is owed.

3.51 At the telephone conference at which an offer of an agreement is made, the Director provides information about how the percentages are calculated. The percentages are itemised in telephone conversation with the practitioner or their representative and recorded by the PSR.[178] When explained by legal representatives, that information should be understood by practitioners. If the practitioner is not represented, the Director emails the practitioner with the information. What is missing is how the Director arrived at that percentage discount.

3.52 Providing even a rough guide to the discounting process is difficult. The process involves weighing up the limited number of services examined, the nature of the clinical records, the likely percentage of inappropriate practice within the services under review, possible statistical error given the sample size, mitigating or exceptional circumstances, as well as a repayment figure or disqualification period likely to be acceptable to the practitioner and considered reasonable by the DA. The number of variables indicates the difficulty of the task of itemisation of a discount. The figure can only ever be a matter of impression and will vary with each case. Judgement is required. This supports the need for a flexible approach.

3.53 The review considers that indicative guidelines are, however, feasible. Information relating to the factors taken into account in the discounting process could be similar in scope to sentencing guidelines in the criminal law. They would necessarily be broad. Factors such as willingness of the practitioner to change behaviour, to undergo retraining, and to make reparation to the Commonwealth, and other typical mitigating factors could be among those listed. The review has recommended accordingly.

[175] *Guide,* 18. See also sections 82(1A)-(1C).
[176] Information by PSR, April 2022.
[177] Id.
[178] De-identified Information provided by the PSR of the details outlined in the telephone call from the former Director to the practitioner's legal representative.

Recommendation 2:
The PSR should publish in the *Guide* and on the website information in broad terms as to the reasons for, and the processes by which, calculations of repayment amounts are made.

Increased amounts imposed in the last five or so years

3.54 There has been a noticeable increase in the amounts recovered from practitioners since 2016/2017 as compared with the amounts repaid prior to that year. In the previous five-year period, the amounts were roughly $1.3m per annum. By contrast, the amount was over $18m per annum in the most recent five-year period.[179] This was suggested to raise an inference that the current Director was more interested in meeting the cost-recovery element objective at the expense of the patient protective objectives of the Act.

3.55 The evidence does not support the inference. There are reasons which explain the increase in amounts recovered from practitioners under section 92 agreements. Better governance by the Department in recent years has resulted in an increase in the number of cases identified for possible compliance processes. This has been due in part to improved data analytics within the Department. In addition, more specialists are being referred to the PSR which, given pricing of specialist services, has resulted in higher amounts being recovered.[180]

3.56 In light of these factors which explain the increased amounts being recommended by the former Director, there is no need for a recommendation on this issue.

Length of and timelines for the overall process

3.57 Several submissions bemoaned the length of the process noting that this contributed significantly to the stress suffered by practitioners.[181] Submissions stated:

- '[T]here does not appear to be any publicly available documentation that outlines what the PUR could expect with respect to the specific timing and opportunities to respond.[182]
- 'Section 92 agreements are offered late in the review process'.[183]
- 'There is a need for more time at meetings with the Director properly to answer questions.'[184]

3.58 Notwithstanding the general absence of knowledge, one submission quoted from PSR's website setting out standard timelines as follows:

1. If the Director undertakes a review and decides to take no further action – 5 months from Medicare Australia's letter to the Director referring your matter to the PSR.

[179] MIPS, 2.
[180] Interview with Departmental officials, 21 January 2022.
[181] ADIA, 30.
[182] AMA, 2.
[183] ADIA, 20.
[184] RACGP, 2.

2. If the Director undertakes a review and decides to enter into a negotiated agreement with you that is then ratified by the Determining authority – 8 months from Medicare Australia's letter to the Director referring your matter to the PSR.
3. If the Director undertakes a review and refers your matter to a committee, which then conducts a review and refers its finding [?] to the Determining Authority which makes a final determination – 2.5 years from Medicare Australia's letter to the Director referring your matter to the PSR.[185]

3.59 These timelines do not include the time taken at the departmental stage of the process. That is likely to be up to and in some cases exceed 12 months if the practitioner has been given a review period under the Professional Review Program.

3.60 In general, there were calls for increased timeliness in aspects of the process. Examples were the suggestion that a practitioner should 'be notified immediately and given the opportunity to explain their use of the billing codes',[186] and that 'the PUR ought [to] have an opportunity to enter into a section 92 agreement at the earliest possible time'.[187] The inference from the first submission is that an explanation would nullify any compliance processes. Neither submission made a concrete suggestion about how the process could be shortened.

3.61 The existing timeframes for reaching an agreement are deliberately short. That is designed to limit the time spent on the process. As discussed earlier at [3.9]-[3.12], it is also not until the Director has acquired the information needed to draft the section 89C report, that the Director is in a position to estimate amounts of repayments. After the section 89C report is drafted, negotiations commence for the agreement. In practice, there is no earlier time at which agreements could be offered and accepted, or the terms quantified and agreed. Fairness requires all the preliminary steps be taken. Prior to this point, the amounts cannot be calculated.

3.62 Another concern raised was that the PSR process provides limited opportunities for negotiation and there was minimal interaction with the practitioner to resolve issues. The points at which the practitioner is offered the opportunity to resolve issues are outlined at [5.58]-[5.60]. The review notes that the criticism in the submissions may relate to the practitioner's understanding of what is required as they progress through the system. Practitioners should take note of those opportunities and use them to their advantage. Reliance on legal representatives is no excuse.

3.63 The review considers that the timelines for the process should be published in the hard copy version of the *Guide* but there is no need for recommendations on ways to shorten the process.

[185] ADIA, 15; *Guide*, 22 (online version).
[186] Australian Hand Surgery Society (AHSS), 1.
[187] ADIA, 20.

Recommendation 3:
The PSR should update the hard copy version of the *Guide* and its website to include indicative information about the duration of the review processes from the time of the CEM's 'Request to Review' to the PSR Director till the coming into force of the section 92 agreement following ratification by the Determining Authority.

Suggestions for legislative change

3.64 There is discussion elsewhere in this report of suggestions for legislative changes These related to:

- the removal of the requirement for acknowledgement of inappropriate practice;
- a requirement to provide the practitioner with the consultant's report;
- the in-person meeting by the Director with the practitioner;
- the presence at that meeting of the consultant;
- the legislative proposals expanding options for sanctions by the PSR Director;
- the criteria against which the Director decides to accept a request for review under section 92; and
- the broad factors used by the Determining Authority when deciding whether to ratify the agreement.

The justification for these suggestions for legislative prescription was not only fair process and transparency, but 'the inevitable risks of varying approaches by differing decision-makers over time' if the implementation is solely by a change to administrative practices.[188]

3.65 There were other submissions for legislative change, the first three of which are discussed in more detail under this heading. The data sharing issue is considered under 'Privacy' in Chapter 6. The suggestions included:

- changing the definition of 'Inappropriate practice';
- varying the 80/20 rule for different specialties; and
- broadening the scope of entities that can be subject to PSR review.

'Inappropriate practice'

3.66 One submission argued strongly that the definition needs to be clarified. The argument was based on the definition of inappropriate practice which refers to 'rendering or initiating services' of such a nature that a PSR Committee could reasonably conclude the conduct would be unacceptable to the general body of the practitioner's peers.[189] The argument is that the definition is hypothetical at two points: a Committee could … conclude; and the conduct would be unacceptable to peers.

[188] MIGA, 1.
[189] Section 82.

3.67 The thrust of the criticism was that tests comprising 'could' and 'would' are based on 'supposition upon supposition', are necessarily hypothetical and inherently unclear. A consequence, it was suggested, is that the measure is wholly dependent on the judgement of the PSR Director when assessing each case. This makes it impossible for a practitioner to know in advance the standard against which to judge their conduct.[190]

3.68 There was firm opposition to the suggested change from the AMA[191] and the PSR agency. The PSR pointed out that 'inappropriate practice':

> … 'is well understood by members of Committees and by the profession at large'. … [I]t has its origins in the tests applied by medical and other professional disciplinary bodies since the 19th century' and was upheld by the High Court.
>
> The High Court referred approvingly to the reasons for the test in these terms: [192]
>
> [64] The essential question in such cases is whether 'the practitioner was in such breach of the written or unwritten rules of the profession as would reasonably incur the strong reprobation of professional brethren of good repute and competence. …
>
> [65] A legislative scheme for the provision of medical services supported by appropriation of the Consolidated Revenue Fund established under s 81 of the *Constitution*, by requiring the professional activities of medical practitioners to conform to … norms [is] calculated to ensure that the activities be professional rather than unprofessional in character.

3.69 Inappropriate practice is a multi-faceted concept. It comprises billing processes and professional conduct. These are legislatively defined at a broad level. Part of the test relies on professional standards or codes of conduct for each health and medical professional organisation developed for the guidance of its members. As an element of their professional obligation, members should be aware of the standards in those codes and are enjoined to follow them. The behaviour expected of practitioners and their adherence to their legal and ethical obligations supplies content to the statutory inappropriate practice test by indicating the 'norms calculated to ensure that the activities be professional rather than unprofessional in character'.

3.70 The Director consults the professional organisations if there is an issue of conduct or clinical practice for which the codes and the practices of the organisation may be relevant. In addition, the Director relies on decisions of the PSR Committee and the Federal Court on the standards for services provided by practitioners in particular medical or health fields. The Director may also seek the advice of reputable Panel Members or consultants if there is no pertinent Committee finding or for 'hypothetical' or 'unclear' aspects of conduct or meaning.[193] Legal representatives should also be in a position to advise their clients.

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[190] ADIA, 11.
[191] Interview with Warwick Hough, General Manager, Nicholas Elmitt, Senior Policy Advisor, AMA, together with Dr Christopher Lee, Director, Policy and Legislation, Compliance Assessment Branch, Benefits Integrity and Digital Health Division, Australian Government Department of Health and Aged Care, 4 March 2022.
[192] *Wong v Commonwealth* (2009) 236 CLR 573 at [64]-[65].
[193] Evidence from PSR, 8 March 2022.

3.71 The review accepts that basing a test for conduct which amounts to what a PSR Committee could reasonably conclude is inappropriate practice has a weakness if no prior Committee or Federal Court decision on comparable conduct is available. But that is not the sole indication of the application of the test as the discussion in the previous paragraphs indicates. Alternative sources of advice are relied on. The outcomes of this advice cannot be known in advance as, of necessity, the issues are particular to the case at hand.

3.72 The legal position denying the need for change is as outlined in the passage from the High Court at [3.68]. There are also practical reasons for maintaining the status quo. The concerns not only relate to the particular circumstances of the practitioner but may be on technical or adequacy of records issues. It is generally the records rather than interpretation of items which cause the Director concern. Whether a record is adequate is a question of clinical judgement and the Director can rely on experience from other cases to assist in that evaluation. Ultimately, if the Director considers further guidance is needed the Director refers the review to a PSR Committee.

3.73 Overall, the settled law and practice, the existence of conduct codes and guides in the health and medical professions, appropriate advice from the practitioner's legal representative, and the Director's experience obviate the need for legislative change.

The 80/20 rule

3.74 The Act prescribes what the 'prescribed pattern of services' or 80/20 rule requires.[194] Rendering or initiating services falls within 'inappropriate practice' if the services amount to a 'prescribed pattern of services', namely, the 80/20 rule. This test is applied at all stages of the PSR process to medical practitioners referred on that basis. Some submissions suggested that the rule needed revisiting because it was inappropriate for certain health practices such as dentistry.[195] However, the prescribed pattern of services test does not currently apply to dentistry.

3.75 Recommendation 6 of the 2007 Review stated**:**

> Criteria for inappropriate practice by specialists and allied health professionals should be designed by DoH, AMA, DPSR in consultation with colleges and peak organisations.
>
> There is currently no 80/20 rule, or similar, for specialists or allied health professionals but the Department has acknowledged that development of such criteria remains under consideration.[196] The review supports the timely conclusion of that consideration.

[194] Section 82A; *Health Insurance (Professional Services Review) Regulations 2019* (Cth) reg 8.
[195] The example provided by ADA was inappropriate as the 80/20 rule does not apply to dentists.
[196] Interview with Departmental officials, 21 January 2022.

Recommendation 4:
The Department, in consultation with the peak bodies for specialists and allied health professionals take steps to finalise the legislative criteria for a 'prescribed pattern of services' for specialists and allied health professionals in light of the recommendation made in the 2007 Review.

Broadening the scope of entities that can be subject to PSR review

3.76 There is no need for a recommendation on this issue. Expansion of the list of entities occurs regularly by legislative instrument. The issue is practical. The medical or health entity needs to establish an entitlement to bill the MBS or CDBS or prescribe PBS medicines. Once that entity is recognised for this purpose, legislation can follow. These are matters for each entity on a case-by-case basis.

Chapter 4. Other issues from the perspective of the person under review and relevant to the section 92 process

Stress occasioned by process

4.1 A feature of the submissions was the concern about the stress the PSR process imposes on practitioners and their families. The review accepts that this is the case. Evidence in support undoubtedly arises as the submissions indicate. Samples of relevant submissions are:

- 'A referral to PSR is a period of enormous stress to a PUR'.[197]
- 'The process at present takes too long and this has a serious impact on the mental health and practice of the PUR which can "force" a section 92 settlement'.[198]
- 'The current process can be considered intimidating for a PUR'.[199]
- '[M]ost doctors who have experienced the PSR process tell of being extremely reluctant to seek support for fear of being shamed, viewed with suspicion, being denied the presumption of innocence, or subjected to scrutiny. Many also tell of severe mental health issues including depression, anxiety, loss of self-worth, PTSD and suicidal ideation'.[200]
- 'The lack of relevant resources makes the process opaque, confusing, and stressful for practitioners. Practitioners also want to know who is reviewing their records for the purposes of the review'.[201]
- 'The PSR Director's review process and section 92 agreements are regarded by most medical practitioners as opaque, unjust and harshly punitive. A culture of fear surrounds all aspects of the PSR'.[202]
- 'AMA members have complained about the adversarial and inquisition style of investigation of the PSR Director which causes undue stress and pressure on the PUR. These investigations have taken a significant toll on the health of PURs which can and has contributed to practitioners accepting an s92 agreement despite not believing that they had in fact acted inappropriately regarding their MBS billing practices'.[203]
- 'A referral to PSR is a period of enormous stress to a PUR. The processes of PSR are not like any other legal system a person is likely to have previously encountered or about which they have real understanding. PURs are commonly fearful and can even express thoughts of self-harm at times. Dismissal under s 91 is commonly not a realistic option. The PUR therefore has a relatively short time period to come to accept the deficiencies identified by the Director or face the frightening prospect of a hearing at which they will give evidence for 6 or 8 days'.[204]
- 'The current process can be considered intimidating for a PUR'.[205]

[197] Avant, 2.
[198] ADIA, 16.
[199] Australian College of Dermatologists (ACD), 1.
[200] SSCCA, 4.
[201] AMA, 2.
[202] SCCA,1.
[203] AMA, 4.
[204] Avant, 2.
[205] ACD, 1.

- ‘Referral to PSR is a highly stressful process for the PUR and the PUR’s family. The PUR is called upon to reflect on criticisms of their practice which are intrinsically personal in nature. Even the term ‘inappropriate practice’ … is thought by many to connote conduct of a highly disreputable nature such as sexual misconduct or the like. Invariably the PUR feels confronted and a defensive reaction to that is understandable’.[206]
- ‘…the process adopted is the reason for the perception that a section 92 agreement “reduce[s] the cost of Medicare by terrorising doctors” rather than properly protecting the community and Medicare from “inappropriate practice”’.[207]

4.2 The thrust of these concerns leading to stress can be summarised as follows:

- The lack of information about the process;
- The length of time taken to reach an outcome;
- The short amount of time to respond to requests for information;
- The impact on the person and their families due to the potential for adverse reputational and financial consequences, and the emotional stress of participation in the process; and
- The perception that sanctions are focused on protecting Commonwealth funding rather than patient protection.

4.3 As a Federal Court judge commented in the comparable context of a court hearing: ‘It is well known that personal litigants are likely to feel stress and strain from being engaged in litigation’.[208]

4.4 There is an inevitability about the stress involved in an investigative process which may result in fines, findings that records did not support clinical decisions, and potential loss of revenue. Such matters inevitably impact on the practitioner and their family. Stress is a normal reaction to such threats. When challenges to professional competence are added to these issues it is not surprising that the investigation can have significant impacts on those involved.

4.5 There are, however, some positive and practical developments in response to the significant stress reactions of some practitioners. The AMA pointed out that it has recently been funded by the Commonwealth Government to provide telehealth mental health support for practitioners. The support is provided by Doctors’ Health Services Ltd (https://www.ama.com.au\gp-network-news/new-free-confidential-mental-health-counselling-service). The service is free, and steps are being taken to publicise the service. Practitioners who are experiencing stress symptoms may take advantage of this new service.

4.6 The review had made suggestions elsewhere in this review which, if implemented, should minimise some of the causes of this distress. These include recommendations relating to more and better information about the section 92 process, greater transparency, and

[206] Avant, 5.
[207] ADIA, 9.
[208] *Croker v Department of Families, Housing, Community Services and Indigenous Affairs* [2010] FCA 1136 per Rares J at [21].

improvements to education, training and resourcing for those involved. The review has also resisted suggestions that deadlines should be extended as this would impede the intention that the section 92 process is an expedited one, and add to practitioners' stress. These and other recommendations and information in the review address misperceptions, and if implemented should improve understanding. Otherwise, the review does not consider there is need for another recommendation at this point.

Fairness of the process

4.7 It has long been recognised that persons affected by adjudication, even when findings go against them, are not so concerned about the outcome provided they perceive the process as fair.[209] Fair process requires that the practitioner, as the person or corporate body affected by review of their practices, be given an opportunity to comment on adverse information that is credible, relevant and significant.[210] The need for fair process was a constant theme in previous reports into the operations of the PSR.[211] Those concerns were muted by amendments to the Act in 2002 which introduced changes to meet many of the earlier identified issues and by the practices of the PSR which annually trains its staff and those involved in its processes in procedural fairness obligations.[212]

4.8 The review notes that the Senate Committee 2011 report rejected similar claims of failure to offer fair process for the reasons replicated in this review, namely, that a practitioner now has multiple opportunities to provide information to counter suggestions of possible inappropriate practice.[213]

4.9 Notwithstanding, the absence of fair process has again been a complaint about the process made to this review. The complaints, however, have been more specifically focused than the customary inability to be heard. The suggestions to this review related to the following issues:

- PURs could not prepare adequately for the Director's investigation because they were not informed about what services were being investigated and why;
- PURs were not given a clear explanation of the review process and their rights at the beginning of an investigation;
- the initial meeting between the PUR and the Director was intimidating. Further, the AMA identified a lack of consistency in the procedures followed at these meetings;
- written decisions made by the Director or Committee did not appear to consider evidence the PUR had provided during the review, or explain how the evidence was considered, or why it was dismissed; and
- written decisions did not actually explain the reasons for the decision of the Director or Committee.

[209] R Moorhead, M Sefton and L Scanlan 'What Drives Public and Participant Satisfaction with Courts and Tribunals – A Review of Recent Evidence' (Ministry of Justice, Research Series 5/08) (2008).
[210] *Applicant VEAL of 2002 v Minister for Immigration and Multicultural and Indigenous Affairs* (2005) 225 CLR 88.
[211] 2007 Review rec 4; 2011 Senate Committee Review Ch 4.
[212] Former PSR Director, presentation slides on the scheme.
[213] Senate Committee 2011 report [4.16]-[4.19], [4.21].

4.10 The general responses to these fairness issues have been dealt with in earlier recommendations in this review. As noted, there are several points during the processes before the Department, the Director, and the Determining Authority (DA) at which concerns are identified and outlined in notices and reports and practitioners have an opportunity to respond.[214] Other concerns about fairness were absence of information about who was responsible for decisions or recommendations and the consequences of choices by the practitioner. These too have been responded to elsewhere in this review.

4.11 Common complaints to this review related to the lack of consistency in interpretation of disputed items in the MBS. The suggestions for improvements, it was argued, would increase trust in the fairness of the process and improve overall compliance. This review has received submissions which support the recommendations in earlier reviews that there should be better, more informative online material on the MBS which should be regularly updated. The review has also highlighted the need for more consistency in decisions.[215]

4.12 The concerns underpinning the submissions warrant consideration. As one submission put it, 'It is important that those under review are treated fairly'.[216] One of those submissions was that the Director and/or consultant(s) might be biased. No evidence was provided in submissions to substantiate this possibility. Samples of submissions were:

- '[The] 'driving' of the process by the Director alone has the capacity to instil a Director's personal bias as a measure for 'inappropriate practice' which could be contrary to what is required under the 'parliamentary standard' [the definition of 'inappropriate practice']'.
- 'Such bias may infect the entire review process such that patterns may emerge on decisions in the Review process which vitiate the process and any section 92 agreement that is part of it'.[217]
- 'The current practice allows some PURs to entertain reasonable concerns about the veracity and reliability of the opinions which inform the Director. Such concerns may be able to be assuaged quite quickly with greater transparency. Eliminating concerns of unfair criticism is likely to result in a proportion of PURs concentrating more on the substance of the criticisms of their practice rather than their own misgivings about the source of the criticisms.'[218]
- '[I]f there is some genuine reason why the Director should not take advice from a particular source, it is appropriate that the PUR have the opportunity to bring that to the attention of the Director so that she may take that into account in discharging her functions.'[219]

4.13 Other suggestions were that the process adopted by the former Director led to a lack of fairness. In the absence of examples of bias on the part of the former Director which

[214] *National Home Doctor Service* at [67] per Griffiths J.
[215] Senate Committee 2011 report, recommendation 2.
[216] Royal Australian College of Australia and New Zealand Ophthalmologists (RANZCO),
[217] ADIA, 23.
[218] Avant, 3.
[219] Avant, 3.

affected an outcome, the review does not consider a recommendation is required on this issue.

4.14 The concerns about potential bias on the part of consultants have been dealt with under discussion of the consultant(s) at 'Criteria for appointment of a consultant' in Chapter 5. The concern may not be warranted given, as the review has noted, the consultant is not a decision-maker and the consultant's advice on some or all of the areas of concern may not be taken into account by the Director. Further, as mentioned earlier, the elements of the consultant's advice relied on by the Director are summarised in the section 89C report and can be complained about by the practitioner upon receipt of that report.

4.15 The Director's role as the sole decision-maker is required by the Act. The statutory intention is that the section 92 process conducted by the Director should not be dilatory.[220] That explains why the conduct of the agreement process is solely for the Director so that it will be undertaken with reasonable celerity. That feature of the section 92 process coupled with the need for practitioners to respond to PSR notices within statutory timeframes, contribute to a speedier outcome. If these requirements are perceived as coercive that cannot be avoided. The review sees no need to recommend a change.

Whether Director should be able to delegate functions

4.16 The Director has no power under the Act to delegate statutory functions. The ability to delegate in the Act is restricted to the Minister, the Secretary, or the Chief Executive Medicare.[221] The review considers this needs rectification.

4.17 The PSR has a small, dedicated staff including the recent appointment of a Medical Officer position who undertakes some interviews on behalf of the Director. The Medical Officer cannot make the decisions required to be made by the Director. The Act does provide for Deputy Directors, but their role as chairing PSR Committees is limited.[222] They are not empowered to take on other functions.

4.18 The workload of the Director is punishing. The Director personally meets with over 95 per cent of the practitioners being reviewed under section 92. This involves often extensive and time-consuming travel. The Director also must liaise with the Minister, the Department, peak medical and health organisations and colleges, as well as administer the PSR agency.

4.19 The decision-making role under section 92 requires the Director to analyse often copious material. This occurs at multiple points in the decision-making role. The Director also has statutory obligations to notify findings to the CEM, Ahpra, Medical Boards and other Colleges and key regulatory bodies, often within strict timelines.

[220] Section 94(1)(b); *National Home Doctor Service* at [56].
[221] Section 131.
[222] Section 85.

4.20 The Director's functions and, as relevant, the statutory timelines within which those functions must be concluded, are also demanding. The review notes the overall 12-month deadline for a section 92 agreement to be reached.[223] These are:

- after the initial referral by the CEM (one month);[224]
- to notify the CEM and practitioner of whether there is to be a review (seven days), and if not, to give reasons to the CEM;[225]
- to find a consultant or professional organisation appropriate for each referral;
- to analyse and make a decision on the information provided by the CEM as well as other material (including the advice of a consultant or professional organisation) in order to decide whether to refer the case for a PSR hearing, or to offer a negotiated agreement;
- to assess whether the material involves a suspected offence, civil contravention, or other offence in order to refer the case to the appropriate authority; [226]
- to draft and issue a Notice to obtain material from the practitioner or corporatised practice, (fourteen days);[227]
- to conduct an interview, usually in person, with the practitioner;
- to invite the practitioner or corporatised practice to nominate their choice of an agreement or a PSR Committee review (one month);[228]
- if no review is to be held to notify the practitioner and the CEM with reasons (seven days);[229]
- to draft the extensive reasons in the section 89C report;
- to negotiate the final draft section 92 agreement (within twelve months);
- to submit the agreement and relevant information for approval by the DA;
- to provide the DA and the practitioner with any further information requested by the DA;[230]
- to attempt to renegotiate agreements rejected by the DA (three months);[231]
- to assess whether there should be a referral, with reasons, to Medical Boards or other regulatory bodies in cases where the practitioner's conduct may involve a 'significant threat to the life or health of any person' or has 'failed to comply with professional standards';[232] and
- to implement elements of the final agreement such as a reprimand counselling if requested by the DA.[233]

[223] Section 94(1)(b).
[224] Section 88A.
[225] Section 88A(4)(5).
[226] Section 89A.
[227] Section 89B.
[228] Section 89C(b)(ii).
[229] Section 91(2)
[230] Section 106S.
[231] Section 92A(c).
[232] Sections 106XA, 106XB.
[233] Section 106U.

4.21 Authority to delegate would lighten this burden and have another advantage. When the Director alone can remake the agreement or attempt to re-negotiate an agreement, there is a potential for a perception of apprehended bias, given the role of the Director in the original decision. This could be avoided if a delegate was available.

4.22 Similar, but less demanding steps arise for a referral to a PSR Committee. These steps include constituting the panel for a hearing, training panel members, reprimanding and counselling the practitioner following a PSR Committee finding and a determination by the DA and the steps required to manage an appeal against a section 93 finding.

4.23 As evidenced earlier in this review in Tables 1 and 3, PSR case-loads (COVID-years excepted) have increased. This follows the more searching analytics conducted by the Department, and the increased numbers of medical specialists and corporates referred to the PSR. A delegate could shoulder specified elements of the workload without detracting from the final decision-making role of the Director.

4.24 Sharing the load would enable more time for discussion with practitioners being reviewed under section 92 and increase the time available for reading and analysing the written material. The appointment would also open the possibility of supplementing the expertise and experience of the Director by appointment of someone with qualifications which differ from those of the Director. This would meet another of the concerns aired in the submissions to this review.

4.25 If the many functions allocated personally to the Director could be delegated it would alleviate some of the work-load pressures. The review considers these reasons support the recommendation that the Director should be able to delegate some of the statutory and practical functions of the role. The review does not specify which functions could or should be delegated, given the statutory discretion allocated to the Director.

4.26 If the recommendation is accepted a formal delegation power will need to be included in the Act. The Delegate could be appointed as a part-time office-holder. The AMA would need to approve the appointment and if **Recommendation 5** is accepted, the AMA would need to consult not only its own members but also representatives of other peak allied health organisations about the appointment.

Recommendation 5:
(a) The Act be amended to permit delegation by the PSR Director of functions other than the decision-making function.
(b) Assuming the recommendation is accepted, the Act be amended to provide for the qualifications of the delegate and for consultation with appropriate bodies about the appointment.

Role of Medical Defence Organisations (MDOs) and representatives for practitioners

4.27 The legal or other representatives for practitioners provided by MDOs play a pivotal role in the PSR's compliance processes. That is recognised by the strong suggestion highlighted at the commencement of the *Guide* that upon referral to the PSR: 'You should

engage your medical defence organisation or a legal representative as early as possible to assist you through the process'.[234] That advice is strongly supported by this review.

4.28 The legal or other representative, whether chosen by an MDO, or independently engaged by a practitioner, performs a pivotal role in the section 92 process. They are responsible for advising the practitioner on the complex provisions in the Act, the choice of review options available, draft submissions in support of an agreement, provide arguments in mitigation of sanctions, negotiate the terms of the agreement, and make any further submissions to the DA.

4.29 The representative is generally the point of contact for the Director when notifying the practitioner of the PSR review, for the receipt of the draft agreement, and the final decision of the Director. These roles indicate that the advice provided by the legal or other representative is critical to achieve the best outcome for the practitioner.

4.30 Evidence to the review indicates that many legal or other representatives appointed by MDOs are well-established, understand the process and impart their understanding to their practitioner clients.[235] Inevitably there will be some representatives who do not meet these standards.

4.31 A submission was critical of MDOs and the role they play principally on grounds of self-interest. As it stated: 'The representative has a strong incentive to encourage the practitioner to 'settle'. As the timelines indicate, early settlement reduces ongoing administrative and legal costs to the MDO'.

The submission explained, MDOs do not have an incentive to:

- Challenge requests for documents and other information;
- Challenge interpretations of MBS items by the Director or a Committee;
- Negotiate for the disputed item (eg an after-hours MBS item or specialist MBS item) to be replaced with a lower cost item; or
- Alert PURs to the ability to appeal decisions.[236]

4.32 Representatives are beholden to their client, the insurer (MDO), as well as the client. In practice, unless they are employed by the insurer, they may also need to take into account the interests of their own employer, be it a legal firm or other business. The legal or other employer may have an incentive to extend the negotiation processes to increase returns to the business, cancelling out the assumed interest of the insurer in minimising administrative and legal costs.

4.33 Despite these conflicting pressures, the evidence to the review suggested that most legal or other representatives perform their representative task ethically, balancing the interests

[234] *Guide*, 2.
[235] Andrew Davey, Director Unsworth Legal, 12 April 2022.
[236] AMA, 2.

of all those involved.[237] Nonetheless, some representatives may need to improve the performance of their important functions.

4.34 The responsibility for ensuring improvement in the conduct of representatives does not rest with the Department, the PSR or the AMA. To the extent that the representative is legally qualified their investigation and discipline is in the hands of the local law society or barristers board. For organisations involved, including MDOs, sanctioning poor performance is to be undertaken by their relevant mentoring and disciplinary body, and should be pursued by practitioners. In light of these alternative and appropriate options, there is no need for the review to make a recommendation on these issues.

Privacy

4.35 Unless permitted to be exchanged under the legislation, there are limitations on sharing information between key agencies in the compliance program.[238] These limitations arise between the PSR, Ahpra and State and Territory disciplinary bodies. PSR must refer concerns as to possible fraud cases to the CEM.[239] The Director and the Determining Authority must also refer to State or Territory regulatory bodies or to Ahpra any significant threats to a patient's life or health,[240] or any failure to comply with professional standards.[241] These requirements are consistent with the objectives of the scheme.

4.36 The Determining Authority may also seek relevant information from the Director when making a determination[242] but this does not generally include information about the negotiations with the practitioner.[243] This is because the Determining Authority may comprise of some Panel members and the provisions in section 92(6) explicitly prevent the Director from disclosing to any Panel member the content of any communications relating to the negotiation process. Where there is no overlap between the Determining Authority and Panel members, in some cases, information about negotiations may be shared. Beyond these exceptions, the Director and the Determining Authority are inhibited by privacy rules from sharing information.

4.37 PSR suggested it would:

> … welcome a power to enable more efficient and effective information sharing with regulatory agencies in appropriate cases. A pathway to achieving this could be to enable the Director of PSR to issue public interest certificates, similar to the Secretary or Chief Executive Medicare. This option would build on existing legislative provisions that are well understood.[244]

[237] Andrew Davey, Director Unsworth legal, 12 April 2022.
[238] Section 130(1).
[239] Section 89A.
[240] Section 106XA.
[241] Section 106XB
[242] Section 106S.
[243] Information provided by PSR, 8 February 2022.
[244] PSR submission, 5.

There is also potential for a greater degree of disclosure as a further deterrent to increases in inappropriate practice.[245]

4.38 The Secretary of the Department of Health and Aged Care or the CEM may release information if the Minister certifies it is in the public interest to do so.[246] Neither the Director, nor the Determining Authority has such authority.

4.39 The confidentiality inherent in the section 92 processes is an incentive for practitioners to accept an offer of a negotiated settlement. The fact of the referral and the outcome is confidential thus protecting the professional reputation of the practitioner and avoiding concern on the part of the patients of the practitioner. The impact on patients from such disclosures and the likely financial and reputational consequences for a practitioner suggest maintenance of the status quo. Against that, is the need to protect the community by notifying it of practitioners whose behaviour creates risks for patient health and safely and for Commonwealth revenue, thereby jeopardising Medicare.[247]

4.40 A balance must be struck. The review considers that the balance is met by a suggestion that the Director be given a public interest power, akin to those of the Secretary of the Department or the CEM. The interpretations of 'public interest' indicate that it is a discretionary power limited only by criteria for its exercise discernible in the legislation granting the statutory power.[248] The review considers this strikes the right balance for the competing concerns. Legal advice is available to the Director from the PSR's General Counsel, or from the Department, to ensure the circumstances fall within the 'public interest' exemption.

Recommendation 6:
The Act be amended to permit the PSR Director to release information to Ahpra and to State and Territory regulatory bodies following a section 92 process but only if it is in the public interest to do so.

[245] Interview with departmental officials, 21 January 2022.
[246] Section 130(3).
[247] Section 79A.
[248] *Plaintiff S79 of 2012 v Minister for Immigration and Citizenship* [2013] HCA 24; *Plaintiff S10* [2012] HCA 31 at [99Iv)].

Chapter 5. The extent of transparency of the process to the person under review, noting that the integrity of the professional services review (PSR) scheme must be maintained

5.1 Transparency for government agencies requires that their actions are open and evidenced by information about their processes. The transparency of the process to the practitioner is a product of two factors: their perception overall of the independence of the scheme; and sufficient information to enable them to trust in the openness and to understand the specific processes of the scheme.

5.2 The perception of independence depends on institutional arrangements. The scheme, although managed by a statutory agency, the PSR, within the Health portfolio,[249] is a statutory agency. This should assuage any concerns about the independence of the body.

5.3 That comfort is supported by the Director and other key members of the PSR being appointed by entities outside the compliance framework bodies, including the Minister with the advice of an industry body, namely, the AMA. Nonetheless, as submissions raised several issues relating to the transparency of appointments for the Director and consultants, and the criteria used in the decision-making process, this chapter considers those issues.

5.4 The transparency of the operation of the section 92 process is the second element of the scheme essential to the maintenance of trust. If practitioners know what to expect from the section 92 process they are more likely to comply with its requirements.[250] Many of the recommendations in this review concern steps to improve that understanding.

Appointment of Director

5.5 The Director, however well qualified, is an individual and cannot reflect the qualifications and experiences of the multiple specialties and sub-specialties of the health and medical practitioners who may come before the PSR. The statutory solution is for the Director, who must under the Act be a medical professional, to seek the assistance of 'any consultant or learned professional body' to supplement the Director's skills and experience.[251]

5.6 The concern about the appointment of a medical practitioner as the Director is that the Director is the sole decision-maker under section 92, albeit with the benefit of advice from health professionals. Submissions referred to the fact that the Director may not be a 'peer' of the practitioner, may be biased, or may misunderstand the difficulties in interpretation or clinical practice leading to the conduct being examined.

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[249] Section 106ZM.
[250] Andrew Edgar 'Administrative Regulation-Making: Contrasting Parliamentary and Deliberative Legitimacy' (2016) 40 *University of Melbourne Law Review*, 738, 740.
[251] Section 90(1)(b).

5.7 Allied with these submissions were suggestions that the AMA not be the only professional health and medical organisation which approved the person to be appointed as Director. Currently, the Act requires that the Director of the PSR be a medical practitioner and the appointment, prior to being made by the Minister, must be agreed by the AMA.[252]

5.8 The argument in favour of the current process is based on a number of factors. These include the predominant representation of those with medical qualification reviewed by the PSR: **Table 2**. Not only are medical practitioners the largest cohort before the PSR, but the MBS Schedule/PBS Scheme is more significant for them. Billing by allied health practitioners is only possible after a referral from a medical practitioner, and allied health practitioners have far fewer items which may be billed under the MBS. Arguably these features mean the medical profession has a stronger claim for involvement with the decision to appoint the Director than other health practitioners.

5.9 The AMA also suggested that if a Director was appointed from among allied health professionals, there could be a loss of confidence in the PSR scheme.[253] That is a possible outcome if the section 92 findings by the Director are made by someone from an allied health profession who lacks the professional experience and knowledge of a medical practitioner.

5.10 As the introduction notes, the experience and qualifications of the Director can never replicate the multiple areas of health and medical specialisms. Nonetheless, an intermediate solution is possible in response to the concerns of allied health professionals. It is modelled on a process already contained in the Act. The Act provides:

> 84 (3) Before appointing a medical practitioner to be a Panel member, the Minister must consult the AMA. The Minister must make an arrangement with the AMA under which the AMA consults other specified organisations and associations before advising the Minister on the appointment.[254] (Emphasis added).

5.11 The Act already requires consultation with allied health practitioners and organisations about the proposed appointment of a medically qualified Panel member. A similar approach is adopted for appointment of Panel members as Deputy Directors.[255]

5.12 A suggested adaptation of section 84(3) is that the AMA also consults the peak organisations for allied health practitioners about the appointment of a Director and report the outcome to the Minister. The addition of such a provision would give allied health bodies an opportunity to express a view on which medical member should be appointed. Having been consulted, such bodies have had their interests in the appointment taken into account. The review favours this approach.

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[252] Section 83.
[253] Interview with Warwick Hough, General Manager, Nicholas Elmitt, Senior Policy Advisor, AMA, together with Dr Christopher Lee, Director, Policy and Legislation, Compliance Assessment Branch, Benefits Integrity and Digital Health Division, Australian Government Department of Health and Aged Care, 4 March 2022.
[254] Section 84(3).
[255] Section 85.

Recommendation 7:
The Act be amended to provide in section 84 that the AMA consult allied health practitioners and organisations prior to the appointment of the Director.

Criteria for appointment as a consultant

5.13 Another issue of predominant concern in the submissions was a lack of transparency about the role and qualifications of the consultant. Many needed reassurance that the consultant was a 'peer' of the practitioner, given the description of the process in PSR literature as a 'peer review process'.[256] The essence of that concern is the absence of information to reassure practitioners that the consultant is a 'peer' and appropriately qualified and experienced to provide a report fairly assessing the patient records and other information of the practitioner. Underlying concerns are that the consultant may be biased or have 'idiosyncratic views'.[257]

5.14 That assistance has special significance in relation to an agreement negotiated under section 92. The decision to permit an agreement is the outcome adopted for most practitioners referred to the PSR and is made by the Director alone who takes into account, among other matters, advice provided by consultants or appropriate professional bodies. That advice supplements the Director's experience and qualifications when needed.

5.15 Examples of submissions are:

- The Director is only one person … Those reviewed come from all specialties and sub-specialties of the profession.
- … a peer of a medical professional [should be defined] as a person with the same scope of practice and who is practising in the same clinical setting.[258]
- [I]t would assist if the PUR understood …. whether all records produced were reviewed by a practitioner that holds the same or equivalent qualification as the PUR. The provision of written information [to that effect] would reduce doubt and the propensity for mistrust.[259]
- [T]he process should clearly articulate that the consultation is with a practitioner in the same division or registration category as the PUR.[260]
- [T]rue peers of a PUR in cosmetic medical practice are medical colleagues also engaged in that scope of practice.[261]
- We ask that in the … investigation of an [Integrative Medicine] doctor [should] be reviewed by a true integrative medicine peer'.[262]

[256] *Guide* 7.
[257] *Karmakar v Minister for Health (No 2)* [2021] FCA 916 at [49].
[258] SCCA, 1.
[259] MIPS, 4.
[260] ADA, 3.
[261] Australasian College of Cosmetic Surgery and Medicine (ACCSM), 8.
[262] Australasian Integrative Medicine Association (AIMA), 3.

- [A]ny peer review process must involve genuine peers.[263]
- [I]t would assist if the PUR understood whether all records produced were reviewed, whether they were reviewed by more than one person, and whether they were reviewed by a practitioner that holds the same or equivalent qualification as the PUR. The provision of such written information would reduce doubt and the propensity for mistrust.[264]

5.16 The description of a 'peer' on the PSR website is:

> A peer is defined as a member of the PSR Panel who has been appointed, after consultation with their relevant professional association, to represent the general body of their profession'.[265]
>
> The AMA's stated expectations for appointment of a peer to a PSR Panel are that the person is:

- Engaged in current clinical practice;
- Minimum 10 years' experience as a Fellow of their College;
- Bill and prescribe using the MBS and PBS;
- Have a social media screen that indicates they have 'no unusual views' in regard to MBS or PBS;
- Have experience in either representing the profession, teaching or research;
- Are approved by the relevant College and AMA as being a suitable PSR Panel member;
- No prior adverse regulatory history.[266]

5.17 These criteria for a 'peer' are for Panel members. Such members are appointed for hearings by PSR Committees. These requirements do not apply to consultants.[267] There are no statutory criteria for being a 'consultant' other than that the person be 'appropriate'.[268] There is authority for the Minister to 'make guidelines setting out the terms and conditions upon which consultants may be engaged'.[269] No guidelines have been made.

5.18 There is no necessity for consultants to be required to meet the same criteria as are applied for the appointment of PSR Panel members. Panel members are decision-makers; consultants are advisors only. The concern about reliance on the report of the consultant(s) is understandable if the decision was that of the consultant. It is not. The decision is that of the Director alone, weighing up and taking into account all the information available, not just the input of the consultant(s) or professional organisation.

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[263] Australian College of Nurse Practitioners (ACNP), 1.
[264] MIPS, 4.
[265] PSR website, 'Peer Review - The role of peers in the PSR Scheme', accessed on 25 February 2022.
[266] *PSR role in compliance and s92 agreements* former PSR Director's presentation slides.
[267] https://www.psr.gov.au/about-the-psr-scheme at Peer Review - The role of peers in the PSR Scheme
[268] Section 90.
[269] Section 106ZP(4).

5.19 That still leaves open the need for the Director to seek assistance from someone with experience and qualifications appropriate to assist with the case under review. The Director's decision is based on advice from several sources. These may include more than one consultant, information from the Colleges or other professional health and medical bodies, previous PSR Committee decisions and the Director's experience of comparable cases. Not all the advice will be accepted. Not all the concerns are shared by both the Director and the consultant.

5.20 The Act's description of a consultant as being 'appropriate' indicates the Director is intended to have discretion as to the choice. That discretion is needed given the multiplicity of specialties potentially granted the right to seek an agreement under section 92. The issue is whether that discretion should be better defined. As the AMA pointed out there is a need for more visibility of relevant skills and experience relating to the selection of consultants as compared with the choice of panel members.[270]

5.21 The review supports that suggestion. It would be helpful to have more guidance on the ambit of 'appropriate'. That would not preclude the retention by the Director of the ability to choose a person as consultant who is capable of assessing billing practices and recording of clinical outcomes in the circumstances of each case. The information may assuage concerns about the expertise and experience of the consultant when performing their role.

5.22 Appointment of someone closely matching the qualifications of the practitioner who is practising in the same clinical setting is often impractical, especially in smaller health professions or highly specialised areas such as nuclear medicine, skin medicine, or orthopaedics where specialisation may be restricted to a single part of the body.[271] Qualifications earned at one point in time may not be replicated in the constantly changing professional accreditation world. The practitioner may be the sole practitioner with those qualifications or experience. The concerns do not take into account the practical difficulty of finding a sufficiently qualified professional whose expertise and practice experience closely matches that of the person under review.

5.23 The compromise suggested by the review is that the Director's discretion to appoint someone who is 'appropriate' be retained. At the same time some guidance can be provided by the Minister if guidelines were to be issued which contain some broad criteria for consultants. These should at least include that any suggested consultant not to have a conflict of interest and should as closely as practicable, match the experience and qualifications of the practitioner under review.

5.24 A further suggestion is that the PSR publication, the *Guide,* be updated to include this information. Regulators can facilitate understanding through publication of more transparent information about qualifications.

[270] AMA, 3.
[271] Interview with former Director and General Counsel, PSR, 8 February 2022.

Recommendation 8:
(a) The Department provide to the Minister a proposal for 'guidelines setting out the terms and conditions upon which consultants may be engaged under section 106ZP(4) of the Act'. The guidelines should reflect current practice that the person appointed not have a conflict of interest and to the extent possible has qualifications and experience appropriate for the case on which advice is sought.

(b) The *Guide* and other material on the PSR website be updated to contain information at a broad level as to:

(i) statutory criteria for, and steps taken, to identify an appropriate consultant or professional organisation appointed under section 90 to advise the PSR Director, taking into account the need to ensure the independence and objectivity of the person; and

(ii) that a consultant appointed under section 90 is a professional whose qualifications and experience should, as closely as possible, match the qualifications and experience of the practitioner under review but is not necessarily a direct 'peer' of the practitioner member: [5.13]-[5.24].

Disclosure to a practitioner of consultant's report

5.25 Submissions suggested that as a matter of transparency and fairness the consultant's report should be available to the practitioner or legal representative so the practitioner could respond to it, and that this should be a statutory requirement. As a minimum as one submission put it: 'there is no compelling reasons why such opinions/advice [of consultants] should not be available as a default position on a de-identified basis'.[272]

5.26 The suggestion that the report of the consultant be disclosed is met by the content included in the section 89C report. The review also notes that the right not to disclose the consultant's report has been upheld by the Federal Court which found no unfairness in the practice.[273] There is evidence that in exceptional cases the Director will release the report.[274]

5.27 The practices of the Director relating to the section 89C report meet these concerns. The report is extensive to enable the practitioner to understand the Director's concerns and the consequences of entering into an agreement.[275] The evidence to the review indicates that the report summarises the evidence, including from consultants or organisations, and outlines the reasons for findings on the critical issues.[276] Typically, reports are about 11

[272]MIGA, 6.
[273] *Karmakar v Minister for Health (No 2)* [2021] FCA 916 at [50] (*Karmakar*).
[274] Andrew Davey, Director Unsworth Legal, 12 April 2022; Miga, 3.
[275] Id at [49].
[276] De-identified copy of typical section 89C agreement provided to the review by the PSR. See also Andrew Davey, Director Unsworth Legal, 12 April 2022.

pages in length with a range of from 5 to 60 pages.[277] The practitioner is given the opportunity to make submissions on that report and on any evident errors, idiosyncrasies or biases. If the practitioner has concerns arising from the Director's report, the practitioner can also indicate they would prefer the PSR Committee process.

5.28 An issue is whether the Director's practice should be mandated. The review considers there are practical reasons for not doing so. The consultant's report is provided at an early stage in the process. To disclose it, fails to recognise that information obtained after it is provided to the Director, including during the negotiation process, may be influential in the outcome. In addition, any requirement to disclose the whole report opens the way for significant lengthening of the process and runs counter to the intended expedited nature of the section 92 process. Another reason for non-disclosure is that the Director does not rely on a consultant's report in all cases.

5.29 The Director is chosen for an ability to exercise professional judgement and that judgement has to take into account multiple sources of information and advice. In limited numbers of cases, if the Director is not comfortable about the level of information, or there is a genuine and novel ambiguity about an issue raised concerning inappropriate practice, the Director can refer the matter to a PSR Committee.[278] That step may not be welcomed due to the extension of time and cost for the practitioner. The referral to a PSR Committee is not taken lightly.[279]

The consultants' role at the meeting between the practitioner and the Director

5.30 Some submissions suggested that the consultant should attend the meeting with the Director and the practitioner. [280] Others recommended that the name of the person should be disclosed. A related suggestion was that there should at least be disclosure of the qualifications of the consultant or consultants. The apparent concerns are that the evidence on which the Director's judgement is based may be tainted by a report of a consultant with idiosyncratic views or who may be biased.

5.31 It is not appropriate to require the presence of the consultant at the meeting with the Director. Protecting the privacy of the consultant is important, not least in those cases where the qualifications or experience of that person is in short supply. That privacy would inevitably be breached if the consultant attended meetings. To so require also gives undue prominence to the role of the consultant.

5.32 Some submissions acknowledge these difficulties:

- '… on the basis that this may contribute to reluctance by consultants to provide their services, particularly in small professional craft groups';[281]

[277] De-identified report provided to the reviewers; email on 8 March 2022 from the Executive Officer and General Counsel of the PSR confirming that the report was chosen at random and was an example of average length.
[278] *Kew v Director, PSR* [2021] FCA 1607'; *Hamor v Commonwealth* [2020] FCA 1748.
[279] Interview with former Director and General Counsel, PSR, 8 February 2022.
[280] It is not uncommon for there to be more than one consultant for an investigation. Use of 'consultant' includes all consultants for a particular matter.
[281] MIGA, 3. See also *Re Raiz and Professional Services Review* [2021] AATA 4360 at [109]-[111[.

- ‘Craft groups within some specialties in Australia are small and, sometimes, highly professionally and commercially competitive. … [T]he small pool of prospective reviewers available to comment on the practice of some PURS makes it all the more important for the success of the s 92 process that the PUR have the opportunity to satisfy themselves of the objectivity of their detractor or to raise any concern about that with the Director’.[282]

5.33 These and other submission recognise that identification of the consultant, either by publishing their qualifications and experience, or by their presence at the meeting between the Director and the practitioner was unjustified on privacy and practicality grounds. Nor is it required as a matter of fairness.[283]

5.34 A compromise suggestion was that only the qualifications of the consultant be disclosed, and that those parts of their reports which could identify them be withheld. The review considers that the suggestion concerning the qualifications of the consultant is sensible. However, on privacy and practicality grounds details which could identify the person ought not be revealed. Disclosure of extensive parts of the review is unnecessary.

5.35 The practice of the Director is to nominate the qualifications of the consultant in the report and to summarise those elements of the report relied on. The review considers that these practices meet the concerns expressed and should be referred to in information provided by the PSR including on its website.

Recommendation 9:
The PSR include in the *Guide* and other material on the PSR website information on the Director’s practice of summarising in the section 89C report relevant elements of the consultant’s advice that the Director accepts, the qualifications and, as appropriate, experience of the consultant, and the absence of conflicts of interest.

Criteria used by Director for accepting a request for a section 92 agreement

5.36 A number of submissions raised issues concerning the criteria used by the Director in deciding to agree to the practitioner’s choice of review under section 92. As one submission put it:

> The SCCA recommends very strongly that the PUR must have access to the standards or criteria against which they are assessed. The PSR Director can send a PUR a ‘Notice to Produce’ documents. However, no detail is provided of the standards or criteria against which the PSR Director evaluates these documents, which are in most cases clinical records. Transparency will be greatly improved by providing this information.[284]

5.37 A starting point is the indicative criteria for *rejecting* the request for an agreement. The Director refers cases to the PSR Committee in the following circumstances:

[282] Avant, 3.
[283] *Karmakar v Minister for Health (No 2)* [2021] FCA 916 at [49].
[284] SCCA,4.

- Suspected harm to patients;
- Where there is divergence in views of the practitioner under review versus those of the consultant and Director;
- New items not previously reviewed by a Committee;
- Repeat referral;
- New area of law.[285]

Added to this list should be cases in which no agreement can be reached following rejection by the DA.

5.38 The Director has emphasised that 'the central legal question is whether a person engaged in "inappropriate practice"'.[286] In turn that involves 'conduct in connection with rendering or initiating an MBS or PBS service that would be unacceptable to the general body of practitioners in the profession or specialty' of the practitioner'.[287] These tests capture the legislative standards. They are expressed in necessarily broad terms.

5.39 Examples of typical questions considered by the Director which suggest clinical practices that would be unacceptable involve questions such as:

- Was the service actually performed?
- Was the service clinically necessary for patient management?
- Was the clinical record adequate and contemporaneous?
- Was there adequate and appropriate clinical input?
- Has the MBS item descriptor been met?[288]

5.40 The PSR website states:

- The Director will evaluate the records provided to PSR. The Director may seek advice and assistance from consultants or professional bodies in relation to the review. … [These records] may raise issues such as:
- your compliance with regulatory requirements and professional expectations;
- the quality and adequacy of your records and other documentation;
- the clinical relevance of your service provision; and
- your clinical input and decision making.

5.41 The professional association for each medical and allied body has a code of conduct for the behaviour that would be unacceptable to the general body of its members. Although expressed in terms of principle, the Codes illustrate the standards of clinical practice expected to be adhered to by practitioners and are relied on the purposes of deciding what is 'inappropriate practice'.

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[285] *PSR role in compliance and s92 agreements*, former PSR Director's presentation slides. Additional information by PSR April 2022.
[286] Interview with former PSR Director, 23 November 2021.
[287] *PSR role in compliance and s92 agreements*, former PSR Director's presentation slides.
[288] Ibid.

5.42 If an issue concerning conduct arises which is not covered by a Code, the Director may seek advice from a person in authority in the relevant College. On occasion, the Director may also discuss an issue with PSR Panel Members holding offices on a disciplinary Board under Ahpra.[289] The Director exercises clinical judgement about what conduct would breach those measures. The *PSR Director's Monthly Update* publication gives examples of the conduct that commonly falls within the statutory test and does refer to the area of practice of the practitioner the subject of the agreement.

5.43 There is also regular contact between professional peak bodies and the Director about any changes to clinical standards and professional conduct evident in the Codes.[290] These communications are necessary due to the significant variations between the Codes catering for the variations in practices as between health and medical professionals. No listing in legislation or even on the PSR website could capture these changes. It would be unworkable to itemise legislative standards for all the professions covered by Part VAA. The Director inevitably has to exercise a degree of judgement, based on experience and knowledge when making decisions concerning conduct or clinical practice.

5.44 Given the necessary breadth of expression of the legislative standards and the variations in practices across the medical and allied health fields and in individual cases, it would be inappropriate to attempt a more prescriptive legislative standard. Words, however well drafted, cannot capture all the factors which lie behind the exercise of judgement.

5.45 As the PSR pointed out:

> It would not be feasible to specify standards of conduct as each case depends on its particular circumstances. Conduct that might be unacceptable in one case might not be in another.[291] The flexibility provided by the broad legislative standard is necessary given that a review needs to take account of 'particular individual services, … what the PUR says actually happened on that day, for that patient, for each occasion of service'[s] that are the subject of the Director's concerns.[292]

5.46 The review accepts that this is an area in which the Director must continue to exercise judgement based on experience and understanding of the scheme. Nonetheless, there is scope to add to the information on the PSR website and other publications such as the *Guide* indicative examples of the kind listed in the typical questions considered by the Director relating to clinical practices: see **Recommendation 8**.

Insufficient information on section 92 review processes within the PSR

5.47 Many submissions indicated that the general information available to practitioners about the section 92 processes is inadequate. It was suggested this meant practitioners lack understanding about specific steps associated with section 92 agreements, including their ability to participate, particularly if they have legal representation. The suggestions were also that practitioners have limited understanding of the impact of choice of an agreement

[289] Information by PSR, April 2022l
[290] Interview with former PSR Director, 23 November 2021.
[291] Evidence from the PSR in response to questions, 9 March 2022.
[292] Ibid.

or a PSR Committee hearing. The outcomes were that the processes did not improve practitioners' level of compliance and led to a lack of trust.[293] The absence of information about the choice of an agreement or a hearing was also suggested to contribute to practitioners' observations about feeling coerced and of lack of fairness. [294] This was dealt with earlier in this review at [3.12]-[3.39].

5.48 A pertinent observation on these concerns is that:

> Given the potential implications of the PSR process, both financial and for clinical practice, it is imperative that a PUR[295] has a clearer scope to respond to the PSR Director's concerns than is presently required to be given. It is insufficient that it be left to the Director's discretion alone to determine the appropriate level of information to provide to a PUR. [296]

As other submissions noted, improvements to the information provided would enable a practitioner better to reflect the Director's 'concerns' and 'to make an appropriately well-informed decision about whether to seek to negotiate a s 92 agreement'.[297]

5.49 At the same time, the PSR submission pointed out that in addition to detailed information on its website:

When a decision to conduct a review is made, PURs and their lawyers are provided with written information about the section 92 process. When the Director meets with the PUR, the process is again explained and the opportunity provided for PURs to ask questions about the process.[298] In addition, the legal representatives of the practitioner have a responsibility to outline what to expect during the process.

5.50 At one level these concerns are surprising given the information which has been given to practitioners. The documentation comprising the CEM's 'Request for Review', and any submissions made during the departmental processes have been provided to the practitioner at the time of referral to the PSR. The Director's 'Decision to Undertake a Review' letter informs the practitioner of the reasons for the decision and is accompanied by a list of the Director's concerns. In addition, the PSR's website contains information on PSR processes and is succinctly captured in the PSR's publication, the *Guide*.

Your Guide to the Professional Services Review Process: A resource for practitioners who are referred to Professional Services Review (Guide).

5.51 The submissions suggest that some professional health and medical organisations and practitioners appear to be unaware of the *Guide.* It is available on the PSR website and is provided to every practitioner with the Director's 'Decision to Undertake a Review' letter. The *Guide* contains a simplified but helpful overview of the scheme, the steps the practitioner should take if referred, the role of the Director under section 92 and of the DA

[293] RACGP, 1, 3.
[294] AMA, 2.
[295] 'PUR' is the acronym for 'person under review'. It is in general use but is not in the Act. This review avoids use of the acronym and in preference uses the generic term 'practitioner'.
[296] MIGA 2.
[297] Avant, 5.
[298] PSR submission, 2.

as the final decision-maker. Although the account needs updating, it is a valuable overview of the process.

5.52 Notwithstanding the PSR view, as one submission noted of the *Guide*:

> The information is clear but necessarily brief. Given the stress that a PUR understandably experiences once being informed of a referral to the PSR, the review recommends that the PSR create other content for the website such as fact sheets, videos and podcasts explaining the process in greater detail with case studies (similar to the approach taken by Ahpra in recent times).[299]

5.53 The review notes that the Guide was last updated in 2018. Its information is general in nature and focuses more heavily on the PSR Committee, not the section 92, process. As nine out of ten practitioners choose to negotiate an agreement under section 92, there is value in providing more detail about the agreement process. The legislative scheme is complex and copious and the regular amendments have added to the difficulty for practitioners and their representatives of navigating the Act and related legislation.

5.54 Despite the existence of the *Guide* and the other sources of advice about the process, the review accepts that more detailed information is required to improve the transparency and understanding by the practitioner of their rights. The process can be difficult to comprehend given that practitioners have no or limited experience of how the PSR operates. They may also be reluctant to seek advice from colleagues as this may alert others to their being under review.[300] The system, notably avenues for review, is particularly opaque even for practitioners trained in Australia, let alone those trained overseas. The paucity of information is experienced particularly by allied health professionals who rarely come before the PSR: **Table 2**.

5.55 The AMA summed up the complaints:

> Given the proportion of cases resolved via section 92 agreement, the reported issues and the impact on clinical practice, it is important that the section 92 process is better understood by the general practice community, and that there is trust in the system.[301]

5.56 Specific suggestions for additions to the *Guide* are that it include:

- '[P]ublicly available documentation that outlines what the PUR could expect with respect to the specific timing and opportunities to respond;[302] and 'a guide as to anticipated time frame, taking into account the complexity of the case';[303]
- '[C]lear information on the Section 92 agreement negotiation phase and the short and long term impacts of entering into a Section 92 agreement';[304]

[299] MIPS, 3.
[300] AMA, 1; MIPS, 4.
[301] AMA covering letter, 13 December 2021.
[302] AMA, 1.
[303] ACD, 1.
[304] RANZCR, 1.

- ‘All processes leading up to and during the review must be clear and transparent. This includes the processes undertaken ahead of the referral to the PSR, the initial review, findings and qualifications of the peer reviewer, and the scope and process of a PST Committee review should the PUR opt for that instead of an S92’.[305]
- ‘[T]hat a PUR can attend the teleconference with the PSR Director and legal representatives to hear the Director’s oral decision of the section 92 agreement’;[306]
- ‘All options for a PUR, including appeal options available to them under administrative law, must be clearly and immediately provided upon notification that they have been referred to the PSR’;[307]
- Advice as to use of consultants, their qualifications, and whether their advice is taken into account by the Director;[308]
- ‘A map of the process with clear statement of the potential outcomes’;[309]
- ‘[P]ractitioners have advised that they were not informed of who had reviewed their case, and what their experiences/qualifications were’.[310]
- ‘A framework setting out the scope of investigations … and greater transparency in relation to requests for advice from experts, including the advice received.[311]
- ‘[Information prior to signing an agreement so that] practitioners [are] aware of their rights to challenge decisions by … Determining Authorities and in the Federal Court.
- ‘[B]efore they sign an S92 agreement practitioners should be made aware of their rights to challenge decisions by … Determining Authorities in the Federal Court’.[312]
- The circumstances in which the practitioner may face referral to Ahpra or other professional disciplinary organisations.[313]

The review has already suggested in **Recommendation 9** that the Director should include in the *Guide* the practice of the Director of summarising in the section 89C report key elements of the consultant’s advice, the qualifications and, as appropriate, the experience and absence of conflict of interest of the consultant(s).

5.57 In light of these submissions and the evidence, the review recommends that the PSR upgrade its available information, particularly the *Guide*, specifically focusing on the section 92 processes. The list should also include information relating to the practice of the Director of having an in-person interview with the practitioner unless inappropriate.

[305] AMA, 4 .
[306] RACGP, 3.
[307] AMA, 4.
[308] Several submissions.
[309] ACD, 1.
[310] RACGP, 2.
[311] AMA, 2.
[312] AMA, 2 .
[313] ADIA, 35.

Recommendation 10:
The PSR should:

(a) update the *Guide* to expand the information relating to the section 92 agreement process taking into account the suggestions identified in this review.
(b) to include a flow-chart of the process under section 92, updated as necessary.

Transparency of other information on section 92

5.58 A consistent criticism in the submissions was the absence of information for the practitioner as to which of their services have been 'inappropriate'. The criticism fails to take into account the multiple opportunities provided during the departmental and PSR processes for explanations to be sought and answers provided to those questions.

5.59 Practitioners who appear before the PSR have generally been through the PRP processes. The departmental processes have offered opportunities on up to three occasions for information about the services which appear to have breached the inappropriate practice rules. Those occasions are:

- when offered an opportunity to make a submission to the MA after being advised they have been identified for investigation; at an interview with the MA;
- during the PRP program; and
- to the SMA when deciding whether to recommend review by the PSR.

These steps in the process have alerted the practitioner that their services are under consideration, and provided an opportunity to learn about the processes, including before the PSR, and to raise any concerns or understandings.

5.60 Upon referral to the PSR, the practitioner has again been notified of the services under consideration and offered advice and explanation at another four points in the process. These are:

- when the practitioner is notified that their services are to be reviewed and their patient records are required;
- during an in-person interview with the Director;
- when a submission is requested from the practitioner after receiving the section 89C report; and
- during the subsequent negotiations on the proposed agreement.

The practitioner is almost always represented by legal representatives who again provide advice as to the steps in the process and the reasons for the review.

5.61 In the face of these multiple opportunities to learn about the steps in the compliance procedures, claims of ignorance of the processes lack credibility. Practitioners have a personal responsibility to use the existing resources on websites and in other forums to discover such processes. They are also able to seek information at the multiple stages at

which they have opportunities during the compliance processes discussed in this review. Their legal or other representatives are also able to advise.

5.62 The PSR submission confirmed these multiple opportunities. The submission stated that it provides detailed information at each stage of the review process, and the information on the website is regularly reviewed to ensure it is useful. In terms of requests for use of other possible avenues, the submission noted the PSR is not funded to produce a short video demonstrating the process but would be happy to do so if funds were available. It would do so, so the submission noted, 'in consultation with the MDOs in order that the PUR's perspective of the process is adequately reflected'.[314]

5.63 The review accepts that there is much useful information on the PSR's website covering relevant points in the process. The Director also provides regular presentations at conferences and has consultations with professional health and medical organisations. Nonetheless, busy practitioners may have limited time to explore existing sources. Information in plain language which is easily accessible is advantageous. Further information on the section 92 process should be provided taking account of the suggestions made in this review. Assistance is available from the aids to website enhancement by the Australian Government Digital Service Standards available at: https://www.dta.gov.au. It would also be useful to test information sources with a target audience focusing on the role of the practitioner at each stage of the process.

5.64 Despite these multiple sources and opportunities, the review agrees that more information can be provided about the processes and has made recommendations accordingly. The review also agrees that to enable better understanding by practitioners of their compliance failings, and to assist with closure of what has been a stressful process, counselling by PSR at the end of the process would be valuable. In particular, that counselling and education should focus on what the practitioner should have done to avoid being reviewed by the PSR. The proposed legislative change will permit the PSR to fulfil this role to a more satisfactory extent: see **Recommendation 1**.

5.65 The information should be more detailed than is presently provided including an explanation of how the person under review came to be referred to the PSR, their rights in the process, the role and qualifications of consultants, a map of the process with possible outcomes at relevant points, the consequences of not complying with requests, and rights to review the agreement. The PSR should also publish and update regularly on its website current average processing timeframes for review under sections 92 and 93, in addition to the information presently in the online version of the *Guide*, noting such timeframes may be subject to the complexity of the case. These suggestions are dealt with in **Recommendation 3**.

5.66 As negotiation of an agreement is clearly the preferred form of review, there would be value in supplementing that information with fact sheets, podcasts, webinars and other forms of social media. These types of information are relatively inexpensive to provide and the PSR website will often be the first location relied on. It is a truism that having

[314] PSR, 1-2.

multiple avenues of information is essential to ensure that information is received by those to whom it is directed. This justifies more and better information about how the section 92 process unfolds and what consequences may follow. The suggestions would respond to requests for more information about the process from its inception. Legal representatives new to the area would also find such aids helpful.

5.67 The review notes that the Royal Australian and New College of Psychiatrists (RANZCP) has offered its support to the PSR in relation to the production of a webinar. The PSR would also find it valuable to couch its online services in accordance with the advice provided by the Australian Government Digital Service.

Recommendation 11:
The PSR should:

(a). regularly review its website design to ensure the information published is consistent with the Australian Government Digital Service Standards; and
(b). ensure that its content on section 92 processes is enhanced by webinars and podcasts supplemented by other appropriate hard copy and online sources.

Misperceptions of process

5.68 Allied with the lack of information the submissions indicated that there are common misperceptions about the process. One such misperception is that the Director has a 100 per cent record of finding that the conduct of practitioners involves inappropriate process resulting in either a section 92 agreement or referral to a PSR Committee. The insidious impact of such wrongful belief was captured in the comment in the submissions that rightly or wrongly 'perception informs belief'.[315]

5.69 **Table 4** indicates that the present figures, not including those for 2021-2022, suggest the perception is incorrect. Information provided by the Department indicates that overall in about one per cent of cases no outcome is possible, for example, because the practitioner has died, and that in five per cent of cases to date, the Director did decide to take no further action.[316] The outcomes following a referral to the Director are not surprising given the significant filtering of cases which occurs prior to the referral.

5.70 Combating misperceptions of this kind is never easy. The responsibility to do so must be shared. The professional associations, the PSR, the AMA and the Department need to counter such perceptions with more and better information. That should be done using the range of available hard copy and online resources. The recommendations to the PSR for improvements to publicly available information would be an element of that agency's actions in response. The AMA and the Department should also take similar steps by

[315] Skin Cancer College of Australasia (SCCA), 5.
[316] Information provided by the Department, July 2022.

providing and regularly updating on their websites statistically correct figures concerning the role and findings of the PSR.

Recommendation 12:
To combat misperceptions of practitioners, peak professional associations, the AMA, the PSR, and the Department should regularly update their websites to include statistics about compliance outcomes of reviews under section 92.

Transparency and the Determining Authority

5.71 A concern expressed in some submissions was that not all the documents given to the DA were also provided to the practitioner. It was argued that this disclosure was necessary if the objectives of the process are to be realised. Additional concerns were that the reasons of the DA for rejection of an agreement were inadequate to produce behavioural change of practitioners and do not meet the standards for the content of reasons when required by an Act, unless excluded.[317] There is no exclusion in the Act.

5.72 Despite the concern about paucity of reasons, the evidence is that the reasons provided by the DA are generally 2 to 3 pages long, and explain the concerns listed in the terms of the agreement with some specificity. In addition, if the decision is not to ratify the agreement the detail is to enable the practitioner and the Director to renegotiate an agreement that is more likely to be ratified next time around.[318]

5.73 The review is satisfied that the DA's reasons are sufficient to inform the practitioner and other parties why the DA has ratified the agreement.[319] In addition, the section 89C report as forwarded to the DA, together with its accompanying documents, contains the essential information for informing the practitioner about the concerns relating to their inappropriate practice. The review considers there is no call for the DA to provide more and better information to the practitioner.

5.74 A related issue involves practitioners' uncertainty as to the matters taken into account when the DA is deciding whether to ratify a section 92 agreement. The DA is governed by the same legislative standards as apply to the Director and PSR Committees.

5.75 Chapter 2 referred briefly to the reasons the DA rejects draft agreements. The standards are broad, such as the proposed sanctions cannot be effected, the terms are too lenient, not fair or unreasonable. Otherwise, the Act provides limited information about the measures used by the DA when making the decision to ratify an agreement.

5.76 For the same reasons that apply when the Director negotiates an agreement, the review considers it is not feasible for the DA to provide more prescriptive legislative information. Each case turns on its own facts and must be considered against criteria applicable not

[317] *Acts Interpretation Act 1901* (Cth) s 25D.
[318] For example, Andrew Davey, Director Unsworth Legal, 12 April 2022.
[319] Ibid.

only in legislation but also by the relevant professional organisation. The evidence to the review indicated that the reasons of the DA are sufficient to explain to the practitioner why it considers the terms of the agreement were unsatisfactory.[320]

5.77 Again, however, there would be value in the *Guide* and other information on the PSR website containing more detail about the ratification role and, at a broad level, what criteria the DA uses for the purposes of ratification.

Recommendation 13:
The PSR include in the *Guide* and on other material on the website indicative examples of criteria used by:
(a) the *Director*:
(i) when not accepting a request for a section 92 agreement; and
(ii) the kinds of clinical practices or conduct when deciding to negotiate an agreement.
(b) the *Determining Authority*:
(i) when not ratifying an agreement;
(ii) for ratifying an agreement.[321]

[320] Andrew Davey, Director, Unsworth Legal, 12 April 2022.
[321] MIPS, 5.

Chapter 6. The quality of information about the section 92 process available to the person under review

6.1 The quality of information about the scheme is dependent on having adequate knowledge and understanding of the scheme. The understanding may need elaboration of the available information and better access to that information. Achieving these aims involves both education and training. As Miller noted: 'The most significant work of a regulator [is] education and engagement'.[322] If the quality of the information is inadequate or fails to meet the needs and expectations of intended recipients, improvements to the content, accessibility and methods of training is required.

6.2 Education can take multiple forms. Consultations, formal and informal, seminars and conferences provide occasions for interaction between practitioners and the regulatory bodies. They provide opportunities for suggestions to improve the available forms of guidance, the development of statutory rules to reflect industry practice and the operation of the regulatory framework. An earlier example in this review has been the in-person meeting between the Director and practitioner under review. Such interchanges provide significant insights and on-the-spot feedback about the compliance of the practitioner.

6.3 Training requires development of courses, continuing education programs, regular induction programs, and opportunities for development or improvement of skills.

Submissions: compliance scheme - better education and training

6.4 Much of the criticism in the submissions concerned the need for better information on online sources. A substantial proportion of other submissions involved complaints about conflicting interpretations of items in the MBS. It was suggested this led to a sense of unfairness and distrust of the process. As one submission expressed it:

> Where there is such a degree of reliance on samples of Medicare services and clinical records by the PSR, it is imperative that there be clear and detailed articulation of the perceived deficiencies or non-compliance in MBS services claimed by a PUR to allow meaningful responses, procedural fairness and transparency.[323]

6.5 The responsibility for educating and training practitioners in order that they keep up-to-date with information about compliance processes under section 92, and have a clear understanding of the twin components of the inappropriate practice - appropriate billing, and accurate record-keeping - is not borne solely by the PSR, the AMA, the Department, or peak professional health and medical bodies. As the Senate Committee concluded in 2011:

> While the committee agrees that it is the practitioner's responsibility to make clinical judgements and decisions in relation to MBS items, we are of the view that as much advice and information as possible should be accessible to the practitioners. The production of quick reference guides and factsheets are particularly useful … .. The committee suggests

[322] See note 4, 42.
[323] MIGA, 2.

that the department, in consultation with practitioner representative bodies keep a watching brief on the accessibility and currency of information sources.[324]

The extent to which this exhortation has been heeded is a major focus of this chapter.

Submissions

6.6 Submissions expressed concern not only about the MBS but also the inadequacy of education in general.

Typical complaints were:

- 'The quality of education available to doctors to help them interpret MBS item numbers, submit appropriate billing and thus avoid the PSR process requires improvement'.[325]
- 'Although Services Australia does provide MBS education resources … for health professionals these are not highly regarded. The information is either too basic – i.e. does not adequately cater for the very wide variation in clinical scenarios, particularly in a primary care setting, or the information is ambiguous and confusing'.[326]
- 'The clarity and specificity of education provided by Services Australia [should be] greatly improved to help practitioners accurately interpret MBS item numbers, submit appropriate billing and thus avoid the PSR process.'[327]
- 'The inconsistent interpretation of MBS rules by the PSR and the Department of Health (through AskMBS) is a widespread concern. There have … been reported instances of conflicting advice provided by AskMBS and PSR communications. As a result, some GPs have no confidence in the interpretation of an MBS rule or requirement until it is tested through the PSR … Consistency in interpretation of MBS rules by the PSR and the Department of Health would increase trust in the overall compliance process.'[328]
- '[There is] inadequate knowledge of the Medicare requirements generally. Practitioners do not receive education or instruction on Medicare billing whilst unregistered and there is a paucity of quality education for practitioners once registered. … [T]here is a compelling argument that Medicare provider numbers should not be issued until a practitioner satisfactorily completes an assessable course provided by the DoH [now Department of Health and Aged Care].'[329]
- 'There is evidence that judgements made by the PSR Director are not always in accordance with accepted medical guidelines or best practice. For example, in early 2019, GPs were required to pay back Medicare under Section 92 for claims made using MBS item 30196. This was due to what was regarded by the Skin Cancer College of Australasia as a clinically incorrect interpretation by the PSR Director that Intra-epidermal Carcinoma (IEC) also known as squamous cell carcinoma (SCC) in situ, or Bowens disease, is not a skin malignancy and that there is no Medicare item number claimable for its treatment'.[330]

[324] Senate Committee 2011 report [2.30].
[325] ASSCA, 6.
[326] ASSCA, 6.
[327] ASSCA, 2.
[328] RACGP, 3.
[329] MIPS [6.1] (a).
[330] SCCA, 5.

- ‘The RANZCP said it would be ‘supportive of the PSR providing training for clinicians, in the form of a webinar for example, to increase the understanding of MBS audits and investigations’.[331]
- ‘Clinicians also report that advice received via the AskMBS service is often:
  - A repetition of the item descriptor(s) included in the MBS Schedule which clinicians can easily access for themselves;
  - Not clinically relevant/valid and appears to be provided by someone who is not clinically qualified;
  - Ambiguous or confusing; and
  - Inconsistent ie clinicians report receiving different answers from AskMBS to the same question.’[332]

6.7 These submissions do not always distinguish between education of health professionals in general and education on billing. Although specific concerns referred to interpretation of MBS items, the reality is that it is record-keeping that is more prominent among the concerns of the PSR Director.[333]

6.8 In summary, the submissions suggest that those involved in the compliance program, the Department, the PSR, and the DA should:

- Undertake regular consultations with peak bodies and professional associations, as well as with the Department for discussion of interpretation issues
- Provide better information on definitions of key terms in the Act
- improve education on the general compliance processes overall
- make available more information on the departmental website on the PRP scheme and the benefits of taking advantage of that scheme; and
- improve its education on record-keeping.

Education and the Department

6.9 Submissions made several specific suggestions about areas of improvement to available education by the Department. The Department indicated that it supports the need for more and better education.[334] The willingness of the Department to improve its website by providing more content about the compliance program, including the PSR component, is welcome.[335]

6.10 More generally, the Benefits Integrity and Digital Health Division (BIDHD) of the Department issues Advisories available on the Department’s website. An example was the recent advisory on telehealth billing.[336] The Department’s website contains multiple guides, advisories, checklists, flyers and fact sheets on specific items and on ways to

[331] Royal Australian & New Zealand College of Psychiatrists (RANZCP), covering letter to submission.
[332] SCCA, 6.
[333] Email from PSR, 8 March 2022.
[334] Discussions with departmental officers, 21 January 2022.
[335] Interview with departmental officials, 17 January 2022.
[336] Existing fact sheets provide general information about items. These may not be specific to compliance-related activities.

substantiate claims. Nonetheless, the Department conceded it could include more information online to assist practitioners.[337]

6.11 Specific suggestions in the submissions were the absence of adequate information by the Department for the practitioner at the initial stage of the section 92 process. The submissions itemised:

- need for a peer review system within the Department;
- the failure to take account of exceptional circumstances;
- the need for procedural fairness;
- the absence of the option for judicial review; [338]
- the provision of a copy of the referral and reasons for the referral to the practitioner with the 'Request to Review' notice to the PSR;
- confusion by some MAs of the psychiatric process for referral, assessment and treatment leading to inappropriate audits;[339] and
- the inappropriate tone of some letters.

Peer review

6.12 The suggestions that the departmental process should require peer review involve a misunderstanding of the different functions under the scheme allocated to the Department, the PSR and the DA. A level of peer review is provided during departmental processes through professional advisors who interview the practitioner, assess the medical records and make recommendations to the delegate of the CEM, a Senior Medical Advisor. The advisors are medically trained and do not necessarily claim to be peers of allied health professionals. A more closely allied 'peer review' process is reserved for the PSR and the DA, not the Department.

'Mitigating circumstances'

6.13 The suggestion that mitigating circumstances are not taken into account during the departmental processes is not supported by the evidence. The figures in Table 1 indicate that significant filtering occurs during those processes. Medically trained departmental advisors have a general understanding of the clinical issues faced by all health professionals. They are aware at a broad level of mitigating circumstances factors and take them into account in filtering cases. During the departmental processes there is also an opportunity for practitioners to explain the circumstances leading to the inclusion of the practitioner in an audit. In many cases these explanations mean the practitioner is excused from any further compliance action.

6.14 To require more would unnecessarily duplicate the role of the PSR, undermine the carefully graduated structure of the compliance scheme in Part VAA of the Act, and ignore the limited amount of information available at the departmental stage. To the extent that

[337] Interview with departmental officials, 21 January 2022.
[338] Australian Dental Industry Association (ADIA), 17.
[339] RANZCP, 3.

the medical advisors have no in-depth knowledge of clinical and other issues facing allied health professionals, increased levels of knowledge on the part of the MAs is generally unnecessary given the relatively small number of allied health practitioners identified for the PRP, or can be called for if required: see **Table 2**. Meeting these suggestions at the departmental stage to any greater extent, would also not have the benefit of the independent scrutiny provided by the PSR agency and would be premature given the preliminary nature of departmental functions.

6.15 At the same time, the review considers there is scope for the Department to increase the information about the Practitioner Review Program (PRP) on its website, fact sheets and other sources of information. The Program is a key element of the steps taken in the compliance program to achieve behavioural change among medical and allied health professionals and deserves greater attention. In particular, the Department should point out that a practitioner's willingness to participate in and to benefit from the program as evidenced by demonstrated change of behaviour, is an opportunity to avoid further compliance action such as referral to the PSR.

Fair process

6.16 The concern about absence of procedural fairness fails to take account of the processes adopted by the Department. These include the offer of an interview by a MA with its opportunity for the practitioner to explain apparently aberrant figures, the ability to better understand the billing system and to amend practices during the PRP, and for a further explanatory submission to the SMA delegate. Collectively, these steps provide fair process for the practitioner.

Judicial review

6.17 Judicial review of the PRP is not an option since it would be premature. The filtering which occurs within the Department excludes those practitioners who can satisfactorily explain the figures which led to their inclusion in the audit. Even for practitioners referred to the PSR, the departmental processes leading to that referral are based on no more than a 'possibility' if inappropriate practice.[340] No decision relating to 'inappropriate practice' is made. In relation to practitioners who during the PSR process negotiate an agreement, there are no adverse impacts under the Part VAA processes until the DA makes a decision to ratify that agreement. Consequently, the pre-requisite to judicial review that there be a decision having adverse consequences for the practitioner is absent until that point is reached.[341]

Documents accompanying CEM's 'Request to Review'

6.18 The evidence to the review establishes that a copy of the referral to the PSR containing the information on which the notification is based, together with the accompanying documents, is provided to the practitioner when the 'Request to Review' notice is sent to the Director, PSR.

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[340] Ibid.
[341] *Australian Broadcasting Tribunal v Bond* (1990) 170 CLR 321.

Department's letters

6.19 The suggestion in one submission that the tone in departmental letters was inappropriate was not supported by evidence. The issue of how best to devise letters which are appropriate for a range of responses while promoting efficiency by use of template letters is common for government agencies. In the absence of specifics, the review does no more than recommend that the letters to practitioners be examined with that issue in mind.

6.20 The Department's website contains multiple guides, advisories, checklists, flyers and fact sheets on specific items and on ways to substantiate claims. Nonetheless, it has conceded it could include more information online to assist practitioners.[342]

Recommendation 14:
The Department should:

(a) expand the information on the Practitioner Review Program on its website;
(b) undertake an examination of its letters to practitioners, in consultation with the AMA or appropriate College, to ensure they are appropriate for the range of responses and recipients.

[342] Interview with departmental officials, 21 January 2022.

Observations

Specific departmental services: MBS online, and AskMBS

6.21 Many of the concerns in the submissions focused on the quality of information provided by the MBS online and AskMBS services. AskMBS as an inquiry-based service that supplements MBS online. The review notes that there is information about the PBS on the Department's PBS information service at pbs@health.gov.au or 1800 020 613. The focus in this section is otherwise on MBS online and AskMBS.

6.22 MBS online contains the complete MBS listed in the general medical services table, pathology services table and diagnostic imaging services table as prescribed under the Act, as well as any determinations made under s 3C of the Act: see www.mbsonline.gov.au.[343] The service is used generally by the medical profession and others for information and guidance about Medicare service items prescribed under the Act. The legislation is detailed and complex and legal advice about content is advisable for busy practitioners.

6.23 MBS online primarily sets out item numbers and descriptors and a key element is the explanatory notes. The explanatory notes bring together information relating to the requirements in regulation and provide guidance material for the use of items. This is to assist providers with general MBS information, and an interpretation of billing issues. MBS Online is the most significant source of information for providers. The service is updated whenever changes are made to the MBS.

6.24 AskMBS is an online inquiry service hosted by the Department. The service has a dual operation: an online email advice service, and it publishes AskMBS Advisories. The email advice service is said to provide: 'policy-based information' to 'health professionals, practice managers and others to understand their Medicare Benefits Schedule (MBS) billing requirements [and] answers to queries on the interpretation of MBS items, explanatory notes and related legislation'. The AskMBS advisories summarise 'responses to frequently asked questions on specific subject areas'.

6.25 As the official description from the AskMBS fact sheet states:

> AskMBS responds to enquiries from providers of services on the Medicare Benefits Schedule (MBS) seeking advice on interpretation of MBS items (including those for dental, pathology and diagnostic imaging), explanatory notes and associated legislation. This advice is intended primarily to assist health professionals, practice managers and others to understand and comply with MBS billing requirements: (https://www.health.gov.au/sites/default/files/documents/2021/06/askmbs-email-advice-service_3.pdf.

[343] Currently the relevant regulations are the *Health Insurance (General Medical Services Table) Regulations 2021* (Cth), *Health Insurance (Pathology Services Table) Regulations 2020* (Cth), and the *Health Insurance (Diagnostic Imaging Services Table) Regulations (No 2) 2020* (Cth).

The advice provided is general in nature and cannot be used to make clinical decisions, which are a matter for professional judgement.

6.26 Where enquirer confusion is apparent AskMBS clarifies that it 'has no involvement in the administration of the Medicare program, including claims processing, the payment of Medicare benefits and provider eligibility, which is the responsibility of Services Australia.

6.27 The AskMBS service is located within BIDHD. The Division consults with the Medical Benefits Division (MBD) which is responsible for updating the MBS and adding new items/deleting superseded items. The Department took over the AskMBS service in 2019.

6.28 The role of the Department in in-person advising on interpretation issues relating to billing is otherwise limited. Audits are about satisfying the Department that the service rendered met the item descriptor for the MBS item number specified by the provider in a bulk billed claim or on a patient receipt. During the PRP processes there is an opportunity for practitioners to discuss interpretation and conduct issues with the departmental medical advisors. Medical Advisors and other officials also provide answers to interpretation issues which arise during the analysis, PRP and subsequent departmental processes. For the most part, information is not about clinical content, which is a matter for the PSR.

6.29 There is a need for increased consistency in interpretation issues. The small number of cases at the PSR Committee and even fewer at the Federal Court[344] indicate that the precedential value of any findings on items is limited. The Committee is a merits review body which looks in depth at the evidence of how particular items have been interpreted, applied, and recorded, measured against the 'inappropriate practice' standard, and its findings are relied on by practitioners, advisors, and professional associations.

6.30 The Court has a limited role and can only consider issues of law.[345] The test of what is 'inappropriate practice' is spelled out in the legislation, but interpreting the legislation and available sources including MBS online explanatory notes remains within the Court's jurisdiction.[346] Although technically the Court may not provide advice on clinical judgements and decisions, given that many of the complaints relate to interpretation issues, and the findings of the Court in individual case, including on clinical practices are authoritative, the decisions are of significance for those providing advice.

6.31 Regular updating of the information in MBS online is critical to supplement such findings. If a PSR Committee, or the Federal Court has made findings on an item which are different from information in the explanatory notes in MBS online, the Department responds promptly by updating MBS online.

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[344] *Kew v Director of Professional Services Review* [2021] FCA 1607; *Hamor v Commonwealth* [2020] FCA 1748; *Nithianantha v Commonwealth* [2018] FCA 2063; *Bupa HI Pty Ltd v Andrew Chang Services Pty Ltd* [2018] FCA 2033; *Sevdalis v Director of Professional Services Review* [2017] FCAFC 9; *Sevdalis v Director of Professional Services Review (No 2)* [2016] FCA 433.
[345] Creyke, Groves, McMillan and Smyth *Control of Government Action* (6th edn, 2022, LexisNexis) 15.4.1-15.4.14 The Jurisdictional (or Objective) Fact Concept.
[346] See n 218.

6.32 MBS online and AskMBS are the most authoritative source of information on the MBS, subject only to findings by a PSR Committee or the Federal Court. MBS online provides an interpretive guide on ambiguous or open-to-interpretation explanations of items in MBS in the notes to each item. Accordingly, MBS online is the default guide on the changes to, and with AskMBS interpretation of, MBS items. This is not to cross the threshold into individual clinical judgement which is the role of the PSR.

6.33 The PSR can update the Department at its six-weekly meetings on PSR Committee or Federal Court decisions at odds with information as described earlier on MBS online or in response to queries to AskMBS.

6.34 Departmental officials also talk to professional health and medical organisations about issues relating to MBS and what interpretation is 'reasonable'. There are two kinds of contacts: for discussions by policy areas for example to explain new items or restructures of existing items; and those related to compliance. Despite these contacts, and although AskMBS is now better resourced, as the submissions indicate issues remain concerning the accuracy of MBS online.

6.35 The review considers steps could be taken partly to alleviate these issues by using a Senior Medical Adviser, assisted by Medical Advisers, to ensure the accuracy and currency of the updating.[347]

Observation 1

Observation 1:
The Department should:

(a) Continue regularly to update MBS online and records of responses to questions in AskMBS under the supervisions of a Senior Medical adviser, assisted by Medical Advisors.
(b) Ensure that MBS online and AskMBS reflect any changes needed following PSR Committee findings or Federal Court decisions which overrule or alter information in MBS online or records of responses in AskMBS.
(c) Display prominently on its website newsletter, advisories and targeted newsletters featuring changes to key items in the MBS.
(d) Continue regularly to conduct seminars on items or discussions on changes to MBS or items which cause difficulties of interpretation for practitioners, after consultation with the PSR, the AMA and other peak health bodies about which items to feature.

[347] Andrew Davey, Director Unsworth Legal, 12 April 2022.

Training: topics, who should conduct and who should accredit training?

6.36 Changes to practitioners' behaviour indicate a need for further training. Key topics identified in the submissions were record keeping and billing.

6.37 The Senate Committee 2011 report suggested the Department of Human Services (DHS) had a series of self-paced e-learning programs on its website including ones on Medicare.[348] No submissions referred to them, suggesting they may no longer be available.

6.38 On the Department's website there are training modules developed in connection with the Doctor Portal learning and the AMA.[349] The introductory module provides medical professionals with information on: the role of compliance in the Medicare system; relevant regulations and legislation; obligations with regards to claiming under Medicare; and processes and procedures should an incorrect claim be identified.

6.39 These could be supplemented with selected courses formerly provided by DHS. The review notes that the Department is attempting to address information deficits and it would be useful if it introduced comparable programs.

6.40 Although the PSR Director provides regular seminars to key organisations and is well placed to be advised of specific difficulties facing the organisations, the PSR is not funded to provide such training and education. The improvement to the PSR's information resources that the review recommends will contribute to the better understanding of its processes that has been called for in submissions. Given funding difficulties for the PSR, the review notes the offer of RANZCP that it would be 'would be supportive of the PSR providing training to clinicians, in the form of a webinar for example, to increase the understanding'.[350] The College may be willing to assist the PSR with funds for this purpose.

Record-keeping

6.41 In relation to the PSR, it is the Director who considers whether the provider exercised appropriate clinical input to justify charging for a particular MBS item, whether it was clinically relevant to deliver such a service, and whether, when rendering the service, the provider made adequate and contemporaneous clinical notes which would allow another practitioner to take over the care of the patient. A 'clinically relevant service' is defined as a service that is generally accepted in the 'medical, dental or optometrical profession … as being necessary for the appropriate treatment of the patient to whom it is rendered'.[351]

6.42 Whether a service is clinically relevant is decided by the practitioner. The practitioner is likely to be the only person present during a consultation, is the only one aware of the patient's presentation, and what service was provided. Further, the assessment and choice of treatment, and whether a service has been correctly described is ultimately a

[348] Senate Committee 2011 report [2.26].
[349] https://www.dplearning.com.au/cpd-learning/medicare-billing-compliance.
[350] RANZCP, covering letter.
[351] Section 3.

matter of clinical judgement by the practitioner. If there is insufficient evidence in the client record to satisfy the PSR that the service was justified, their role is to query the entry.

6.43 If the practitioner fails to satisfy the Director that the circumstances warranted the service, the practitioner should accept that their clinical judgement cannot be substantiated, and their record-keeping may need improvement if their professional conduct is to avoid question in the future.

6.44 This is an area of long-standing interest having been the subject of recommendations in the earlier reports.[352] In addition, evidence from the Director's *Monthly Updates*, PSR Committee and Federal Court decisions is that record-keeping is a prominent feature of PSR reviews. Better education in this area, taking into account time and other pressures for practitioners, is a critical step to improve clinical practice.[353]

Billing

6.45 Submissions specifically referred to billing training to improve performance and avoid referral to the PSR.

6.46 The suggestion that approval of a MBS provider number should be contingent on billing training was not supported by the AMA on the ground that it would be a barrier to practice and involve unnecessary delay, particularly for overseas-trained health and medical specialists. The review accepted that advice. Nonetheless, the need for that training is particularly important for medical practitioners and allied health practitioners whose qualifications and subsequent practical experience were obtained outside Australia.

6.47 The review considers that a more appropriate solution is for continuing professional development training (CPD) on billing of those seeking or wishing to maintain provider accreditation. Such accreditation would need to be regular, at least every three years given the frequency of changes to the MBS. That raises the question to whom should that training be directed?

6.48 Practitioners are responsible for all items billed under their provider number, therefore the targeted group should be practitioners who hold provider numbers and those who are billing on the practitioner's behalf. In corporate and larger practices, it is the practice manager who undertakes the billing role. The AMA suggested practice managers too should be targeted for training given their significant influence and practical assistance to meet billing targets.[354]

6.49 Although it is the practitioner who bears the primary responsibility for billing, general training of practice managers is sensible. Practice managers are host to the clinical notes and information provided by practitioners. Training would enable the managers to be more

[352] *Department of Health and Ageing 2007 Report* recommendation 4; *Senate Committee 2011 Report*, recommendation 2.
[353] Medical Board of Australia *Good Medical Practice: A Code of Conduct for Doctors in Australia*.
[354] Interview with Warwick Hough, General Manager, Nicholas Elmitt, Senior Policy Advisor, AMA, together with Dr Christopher Lee, Director, Policy and Legislation, Compliance Assessment Branch, Benefits Integrity and Digital Health Division, Australian Government Department of Health and Aged Care, 4 March 2022.

knowledgeable about MBS/PBS requirements and in turn may encourage further internal training and better record-keeping practices by their practitioners.

Conduct and accreditation of training

6.50 Undertaking training requires identification of the training provider. The review does not accept suggestions that the health and medical schools in Australian universities should include training on Medicare or record-keeping except at a general level. The syllabus is already crowded and not all those studying will go into practice or obtain provider qualifications. A similar argument applies to training institutions for allied health practitioners. Although submissions emphasised issues relating to interpretation of items in the MBS, more commonly as mentioned earlier, it is record-keeping - lack of notes and inadequate detail or clinical support in the record, that is the focus of concern at the PSR.

6.51 Who should undertake the training? The AMA has done general training in the past and this could continue. Generally, however, the peak professional health and medical organisations should provide such training. There are issues specific to particular areas or specialties and these organisations are best able to place a specialty lens on the information needed for members. The peak organisations should identify what training is needed for their specialty and how best to deliver the outcomes to their members.

6.52 Designing courses is best undertaken by the larger professional health and medical bodies. These include the Australian College of Remote and Rural Medicine (ACCRM) and the Royal Australian College of General Practitioners (RACGP). These bodies could design training courses or provide templates of such courses to be filled in and used by smaller bodies.[355] Active consideration should be given to offering courses online in the form of webinars or blogs, as these may be more accessible for busy practitioners. The review accepts that smaller professional health and medical organisations are insufficiently funded to undertake the design and provider role without assistance. The review recommends that the AMA, the larger health and medical organisations, and the Department assist these organisations in this regard.

6.53 The Australian Medical Council (AMC) is a regulatory and education body for Australian and New Zealand medical practitioners. It conducts clinical examinations but at present these do not include billing questions in the written clinical exam. Every healthcare professional must pass some specific tests in their training, but none on billing prior to accreditation. Some Medicare courses cover similar training, but these are not required, accredited or centralised.[356] The AMC, although set up to regulate and provide education to the medical profession, would be an obvious body to be involved.

6.54 There would need to be a national accreditation body for final approval of courses. That should be the Commonwealth. The Commonwealth, specifically the Department would also need to fund the cost of accreditation and conduct general training. The larger health

[355] Bodies have provided such template courses in other specific areas of practical knowledge.
[356] Interview with former Director and General Counsel, PSR, 8 February 2022.

and medical organisations could levy their members so that they could conduct more specific training for their members.

Observation 2

Observation 2:

(a) Training on billing and on the compliance program in Part VAA in the Act should be undertaken by the peak professional medical and allied health organisations and be required at least every three years as a matter of continuing professional development for practitioners with provider numbers or who intend to obtain one.
(b) Such training should include the development of templates for courses which could be populated for training purposes by smaller health organisations.
(c) The Department should coordinate discussions with the AMA, peak health and medical organisations, the PSR [and the AMC] on what training is required on the Part
(d) Accreditation of training courses should be undertaken by the Department.

Appendix 1: Terms of Reference for Review

Terms of Review
Review of s 92, *Health Insurance Act 1973*

Purpose

The purpose of the Review is to assess how section 92 of the *Health Insurance Act 1973* (the Act) is being operationalised by the Professional Services Review Agency (PSR).

Background

The PSR is a key contributor to the compliance and regulatory framework that governs healthcare provision in Australia. The PSR scheme was introduced in 1994 by the Australian Government to safeguard the public against the risks of costs of inappropriate practices of practitioners as well as protecting the integrity of Medicare and the Pharmaceutical Benefits Scheme (PBS). The role and functions of PSR are set out in the *Health Insurance Act 1973* (the Act).

PSR is part of a strong regulatory regime that ensures that appropriate and cost-effective clinical services are delivered through Medicare and the PBS. PSR provides the legislative framework within which services provided by a practitioner may be peer reviewed in response to a request from the Department of Health (under delegation from the Chief Executive Medicare).

PSR covers medical practitioners, dentists, optometrists, midwives, nurse practitioners, chiropractors, physiotherapists, podiatrists and osteopaths who use Medicare and the PBS.

PSR Corporate governance

PSR operates as an Australian Government agency within the Commonwealth legislative framework. The operations of PSR are governed by the *Public Governance, Performance and Accountability Act 2013* and the *Public Service Act 1999.*

Current Process

The PSR process begins when a delegate of the Chief Executive Medicare requests the Director to undertake a review of a services provided by the person under review (PUR) during a specified period (the review period). The Director must undertake a review if, after considering that request and any other relevant material, it appears that there is a possibility that a PUR has engaged in inappropriate practice ('inappropriate practice' is conduct in connection with rendering or initiating services that a Committee of peers could reasonably conclude was unacceptable to the general body of the PUR's profession or, if applicable, medical specialty).

Rendering a 'prescribed pattern of services' (which means rendering 80 or more professional attendance services by a general practitioner on 20 or more days during a 12 month period) is also deemed to constitute inappropriate practice, except where this has occurred because of exceptional circumstances.

The Director obtains details of a random sample of services that were billed or that relate to particular Medicare Benefits Schedule items and/or PBS items. The Director then requests medical records corresponding to this sample of services. Following a review of those records, the Director may seek to meet with the PUR before preparing a report.

The PUR will have the opportunity to make submissions on this report. The Director may decide to take no further action, may seek to enter into an agreement under section 92 of the Act (which needs to be ratified by the Determining Authority), or may refer the matter to a Committee. The majority of matters referred to the Director are currently concluded through an agreement under section 92. Over 90 per cent of PURs are represented by lawyers throughout the agreement negotiation process. Most of these lawyers are provided to PURs through their medical indemnity insurer.

The Department will:

- provide these terms of reference to the reviewer (see Scope below)
- manage the review process in accordance with Commonwealth Procurement Rules and other established best practices
- engage an independent external contractor (referred to as the Reviewer) to conduct the review in line with the defined scope
- will consult and engage with the Australian Medical Association (the AMA) and the PSR during this review process, including providing the AMA with an opportunity to comment on a draft of the review document before it is finalised
- provide the Reviewer with access to documentation/information required for the conduct of the review.

The Reviewer will:

- be required to sign a confidentiality and privacy agreement before commencement of work
- discuss any issues relating to the review with, and provide regular updates to the Department of Health as the contract manager
- be required, from time to time and where practicable, to be on site at the PSR, the AMA or the Department to examine documents and conduct interviews with relevant staff
- consult with, and be assisted by, a medical adviser selected by the Department from nominations provided by the AMA
- take into account any comments provided by the AMA on behalf of its members and participate in any conversations with practitioners or other bodies, including lawyers who are experienced in representing PURs in negotiations, which may have constructive suggestions, that are facilitated by the AMA
- provide the Department with draft review documentation detailing their consultation process including who was interviewed, findings and recommendations
- finalise the review report taking into account feedback from the Department, informed by any comments from the AMA on the draft
- not require access to individual PSR cases and will not require security clearances as any information provided will be de-identified.

Scope of the review

The reviewer will conduct an assessment of how section 92 of the Act is operationalised by the PSR including the:

- end to end process flow from the perspective of the PUR
- extent of transparency of the process to the PUR, noting that the integrity of the PSR must be maintained
- quality of information available to PURs about the section 92 process
- capturing relevant and contemporary feedback from consultation with the Department, PSR and AMA.

Possible recommendations

The reviewer may make recommendations about process changes that may improve the experience for PURs and further the objective below.

Objective/Outcome

That PURs are treated fairly and have access to clear, transparent and comprehensive information about how the PSR Director review and section 92 agreement negotiation phase operates.

Appendix 2: Invitees to make a submission to the review

Australasian College of Sports and Exercise Physicians
Australasian Integrative Medicine Association Inc.
Australasian Podiatry Association
Australasian Sleep Association
Australia and New Zealand Gastric & Oesophageal Surgery Association
Australian and New Zealand Association of Neurologists
Australian and New Zealand Association of Oral & Maxillofacial Surgeons
Urological Society of Australian and New Zealand
Australian and New Zealand College of Anaesthetists
Australian and New Zealand Society for Geriatric Medicine
Australian Association of Social Workers Ltd.
Australian College of Clinical Psychologists
Australian College of Midwives
Australian College of Nurse Practitioners
Australian College of Rural and Remote Medicine
Australian Dental Association Inc
Australian Diagnostic Imaging Association
Australian Hand Surgery Society
Midwives Australia
Australian Society of Anaesthetists
Australian Society of Orthopaedic Surgeons
Australian Society of Plastic Surgeons
Gastroenterological Society of Australia
Optometry Australia
Royal Australasian College of Surgeons
Australia College of Nursing
Rural Doctors Association of Australia
The Australasian College of Cosmetic Surgery
The Australasian College of Dermatologists
The Australasian College of Phlebology
The Australian Psychological Society Ltd
The Australian Society of Otolaryngology Head and Neck Surgery Limited
The Cardiac Society of Australia and New Zealand
The Royal Australasian College of Dental Surgeons
The Royal Australasian College of Physicians

The Royal Australian and New Zealand College of Obstetricians & Gynaecologists
The Royal Australian and New Zealand College of Ophthalmologists
The Royal Australian and New Zealand College of Psychiatrists
The Royal Australian and New Zealand College of Radiologists
The Royal Australian College of General Practitioners
The Royal College of Pathologists of Australasia
The Thoracic Society of Australia and New Zealand
Skin Cancer College Australia
Australasian College of Nutritional and Environmental Medicine
Avant Mutual Group Ltd
MDA National
Medical Indemnity Protection Society (MIPS)
Australian Pathology
Australian Orthopaedic Association

Appendix 3: Submissions received

Australasian Integrative Medicine Association Inc.

Australian College of Nurse Practitioners

Australian Dental Association Inc

Australian Diagnostic Imaging Association

Australian Hand Surgery Society

Gastroenterological Society of Australia

Optometry Australia

The Australasian College of Cosmetic Surgery and Medicine

The Australasian College of Dermatologists

The Royal Australian and New Zealand College of Ophthalmologists

The Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Radiologists

The Royal Australian College of General Practitioners

Skin Cancer College Australia

Avant Mutual Group Ltd.

Medical Indemnity Protection Society (MIPS)

MIGA – Medical Defence Association of South Australia

Healius

Australian Medical Association

Professional Services Review

Appendix 4: Consultations conducted by reviewer

- 19 October 2021: Sean Lane, Assistant Secretary, and Anthony Henry, Assistant Director, Compliance Assessment Branch, Department of Health
- 28 October 2021: Warwick Hough, General Manager, and Pham Vo, a senior official AMA.
- 3 November 2021: Catherine Riordan, Director, Professional Review Section, Compliance Enforcement and Professional Review Branch, Department of Health
- 12 November 2021: Penny Shakespeare, Deputy Secretary, Deputy Secretary, Health Resourcing Group and Daniel MCCABE, First Assistant Secretary, Benefits Integrity and Digital Health Division, Department of Health
- 23 November 2021: Professor Quinlivan, Director, PSR
- 6 December 2021: Bruce Topperwein, Executive Officer and General Counsel, PSR
- 17 January 2022: Sean Lane, Anthony Henry.
- 8 February 2022: Professor Quinlivan and Bruce Topperwein
- 4 March 2022: Warwick Hough, General Manager, Nicholas Elmitt, Senior Policy Advisor, AMA, together with Dr Christopher Lee, Director, Policy and Legislation, Compliance Assessment Branch, Benefits Integrity and Digital Health Division, Australian Government Department of Health
- 12 April 2022: Andrew Davey Director Unsworth Legal.
- 9 May 2022: Dr Di Dio, Medical Advisor, Professional Services Review

Appendix 5: Information concerning Reviewer and Dr Dhupelia

Robin Creyke AO, FAAL, Emeritus Professor, ANU, Doctor of Law *Honoris Causa*

LLB (Hons), (University of Western Australia), LLM (Australian National University), Grad Dip Communications (University of Western Sydney, Barrister (Queensland Supreme Court), Barrister & Solicitor (ACT Supreme Court)

Present positions:

- Chair, National Customs Brokers Licensing Advisory Committee
- Expert Consultant, Proximity Legal
- Emeritus Professor, ANU
- Member of ATO Independent Panel for assessing complex compensation claims under the Compensation for Detriment due to Defective Administration (CDDA) scheme
- Senior (sessional) Member, ACT Civil and Administrative Tribunal
- Independent reviewer, Australian Advertising Standards Board

Former positions:

- (Executive) Senior Member, Administrative Appeals Tribunal
- Integrity Adviser, Australian Taxation Office
- Commissioner, ACT Independent Competition & Regulatory Commission
- Member, Administrative Review Council
- Member (sessional) Social Security Appeals Tribunal
- Special Counsel, Government & Corporate Group, Phillips Fox Lawyers
- Member (sessional) Nursing Homes and Hostels Review Tribunal
- Academic, Faculty of Law, Australian National University
- Officer, Department of Trade & Industry, Canberra

Current or recent Board Memberships:

- Deputy Chair, Act Ministerial Advisory Council on Ageing
- Member, Law Council of Australia, Administrative Law Committee
- Member, Law Council of Australia, Integrity Working Group
- Member, Law Council of Australia/Administrative Appeals Tribunal Liaison Committee
- Member, Advisory Board, ANU's Centre for Military Justice and Security Law
- Chair, Editorial Board, *AIAL Forum*, the journal of the Australian Institute of Administrative Law (AIAL)
- Australian Institute of Administrative Law, Founding Member (1989)/Officer, National Executive (1995-), National President (2004-2006)

Dr Dilip Dhupelia, LRCPS (IRE); DIP OBST ACOG; FRACGP; FARGP; FAICD; AFRACMA

Current positions:

- AMAQ Foundation Chair and Director
- AMAQ Councillor (Immediate Past President)
- AMA Federal Council (Queensland Area Rep)
- Member of Federal AMA Council of Rural Doctors
- Member of AMAQ Council of General Practitioners
- Chair of AMA Qld Nominations and Remuneration Committee
- Board Director and Chair of Finance, General Practice Training Queensland
- Director of Medical and Clinical Services, Queensland Country Practice, Queensland Rural Medical Service, Darling Downs Hospital and Health Service
- Part Time General Practitioner at Toowong
- Member of the Clinical Advisory Group of Brisbane North PHN

Previous positions:

- State President and Board Director Australian Medical Association Qld
- Senior Medical Adviser for Medicare Australia, Department of Human Services
- Member of the Professional Conduct Tribunal of the Institute of Chartered Accountants in Australia
- Executive Member on Federal AMA Council of General Practice
- Chair of the Board of Directors of CheckUP Australia (formerly General Practice Queensland, GPQ)
- GP Obstetrician in Toowoomba
- Medical Director of University of Southern Queensland
- President of GP Connections (Toowoomba Division of General Practice)
- Treasurer and then President of Toowoomba LMA of AMAQ
- Medical Superintendent at Milmerran Hospital
- Member of Management Advisory Committee of the UQ Rural Clinical Division of the Medical School
- GP Supervisor for Registrars and Medical Students

Additional skills and experience:

- Governance and Strategy
- Rural and Remote Policy
- Medical Education