# Professional Services Review Update

Dr Scott Masters

Local Medical Association

Sunshine Coast, Qld

Article in mthly newsletter, Jan 2011 – with graphs

The Professional Services Review (PSR) has recently undergone a major shake-up. After a meeting with the AMA and the Department of Health and Ageing, Dr Tony Webber admitted that current PSR committee members had not been appointed to their positions through the recommended process and have all been asked to resign and reapply for their positions.

This major oversight now puts in jeopardy all decisions made by the current panel and has put a stop on 40 cases currently before the committee. Dr Steve Hambleton from the AMA had become increasingly concerned about the operation of the PSR after multiple complaints from members about the lack of natural justice in the system. One common complaint has been that the PSR committee, which is supposed to be made up of peers, was not adequately representing the profession. At closer inspection, it became obvious that the AMA had not been consulted over appointments which contravene current legislative requirements. One of the irregularities related to the appointment of 2 deputy directors to the PSR panel.

It has been put to the AMA by concerned members that better representation at the PSR is urgently needed. Some suggestions include

- No one should be "selected" to the panel- as in, appointed for a few years to do the job as an employee. They should be "peers" - and true peers are people who have been working for years at the coalface and understand the realities of general practice
- Random selection of GP's with at least 5 years experience (with provider numbers between two standard deviations of mean turnover ). A selected GP can refuse to serve, or their selection can be objected to by a relevant party.
- A committee of randomly selected GP's would constitute a genuine jury of peers, just like juries selected for criminal trials - a 1,000 year old system that has stood the test of time.
- They should be minimally compensated for their work and appointed for a short term - eg, a year. Under no circumstances should the members be in any way beholden to Medicare. They would be expected to remain firmly footed in the real world and to return to it once their service is discharged.

- A commissioner can oversee the proceedings and make final rulings, but the presence of 12 impartial members of the profession will stop dead any star-chamber proceedings. Medicare will be satisfied that the people investigated are not simply shielded by an AMA posse. The profession will be satisfied that GP's with unusual patterns are not simply crucified by a kangaroo court.
- At least 1 GP on the committee should be from the ""Dr under review"" immediate peer group eg a rural GP should have at least 1 rural GP amongst the 12, similarly for a special interest GP

Under the previous Director of the PSR, Dr John Holmes, being on the PSR panel was a sign of seniority within the profession. The above system would help return this status.

Now would be a perfect opportunity for some rationalisation of the MBS and the PSR. We need both schemes operating well to optimise health care in this country. Some pragmatic suggestions for improvement include:

• A dedicated response line for GPs who have queries regarding interpretation of the MBS. There are multiple phone and email inquiry lines available but reliable quick responses are rare.

• A PSR that sticks to its role of policing correct use of the MBS instead of commenting on clinical practice, as it has recently with regard to antibiotic and opioid prescribing, pathology requests and CT ordering. Unilateral proclamations that there is over-prescribing and over-ordering of investigations undermines patient confidence and frustrates doctors trying to do their best in often difficult clinical circumstances.

• Spreading audits to all Medicare providers not just GPs. For example, specialists are responsible for more than 50% of Medicare expenditure yet account for less than 5% of referrals to the PSR.

• Increased transparency in the Medicare audit process, with more debate about the assumptions used in the audit process, especially that all GPs are the same.

• Improved transparency of the PSR referral process. Medical defence organisations consider the current process unpredictable.

• Procedural fairness — currently there is no practical appeal mechanism.

• Individual determinations from Medicare/PSR for doctors who are not sure if they are practising appropriately. The Australian Taxation Office provides this service for taxpayers so it would be reasonable to expect Medicare/PSR to do the same, as penalties for failure are severe.

Dr Scott Masters – LMA Medicare Compliance Officer

# Medicare/PSR Survey

For Local Medical Association

Sunshine Coast, Qld

The results of the survey are in and I am happy to say we ended up with over 200 replies from doctors around Australia. The sources were our own LMA, the Medical Observer website and the Oz-eDocs group. The results suggest that doctors have major concerns about the current Medicare/PSR system and how it is operating. Further enquiry would seem mandatory and an urgent review into implementing long suggested changes to the system. Recently the MJA highlighted research that has shown "audit anxiety" is one of the major reasons for a drop in level C and D consultations in preference of the shorter level A and B consults (MJA 2010; 193 (2): 80-83). **One million less long consultations** occurred due to Drs concerns about being targeted by the PSR – this does not bode well for people with chronic health problems. This goes directly against health minister Nicola Roxon's stated aim of increasing the length of consultation time with patients

Anecdotally, there is evidence of rural practitioners cutting back on working hours and doctors decreasing bulk billing due to recent increases in PSR activity. The most urgent priorities seem to be:

1) A simplified MBS schedule and reduction in bureaucratic red tape
2) Increased transparency of the Medicare/PSR audit system with attention to providing Natural Justice ( eg If the dental care EPC's are found to be inappropriate, it's the GP who is currently liable to pay the 4000 back to Medicare)
3) A dedicated Medicare/PSR response to queries on appropriate item number use. A 24-48 hr response time with binding answers (rather than the current 6 week upwards non-binding responses)

Many interesting comments were put in by our local members:

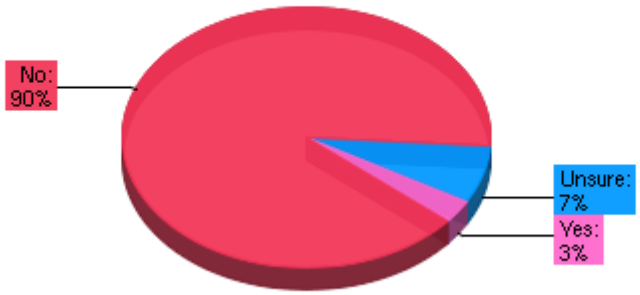
1) About time audits extended to allied health
2) Much confusion abounds with conflicting information from different Medicare phone advisors
3) Anything to do with EPC items, I have no confidence
4) Phoned up for an interpretation of an item number – they just read out the MBS descriptor verbatim – not much use
5) Should change its name to Moneycare
6) Any organisation doing its own reviews with no accountability – what the !*#?

The results below will be forwarded on to the federal AMA Vice-President and the RACGP President who have both taken up this issue with Medicare/PSR

Summary Report - Jul/26/2010

Survey:Medicare PSR Satisfaction Survey

## Do you have confidence that the current Medicare process will provide natural justice?

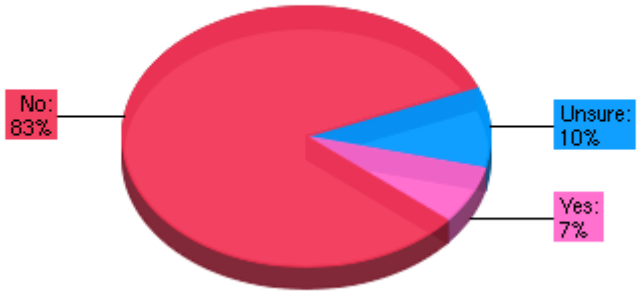



| Value | Count | Percent % |
|---|---|---|
| No | 188 | 90% |
| Unsure | 15 | 7.2% |
| Yes | 6 | 2.9% |

**Statistics**

Total Responses 209

## Has Medicare/PSR responded adequately to most of your queries on interpretation of the Medicare schedule?

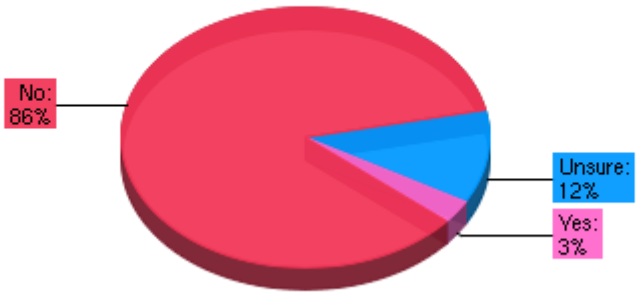



| Value | Count | Percent % |
|---|---|---|
| No | 171 | 82.6% |
| Unsure | 21 | 10.1% |
| Yes | 15 | 7.2% |

**Statistics**

| Value | Count | Percent % |
|---|---|---|
| Total Responses | 207 | |

## Do you have confidence in the Director of the PSR?

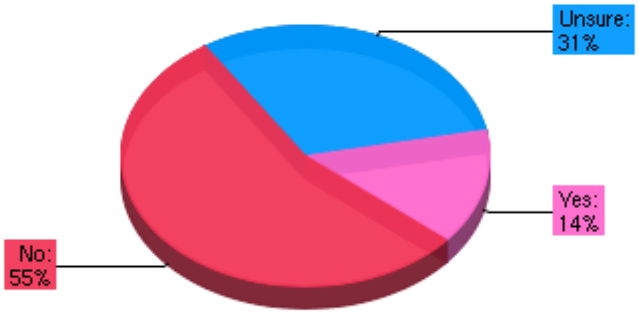



| Value | Count | Percent % |
|---|---|---|
| No | 177 | 85.5% |
| Unsure | 24 | 11.6% |
| Yes | 6 | 2.9% |

**Statistics**

| | |
|---|---|
| Total Responses | 207 |

## If you use the EPC items. do you have confidence you would pass a compliance audit on these items?

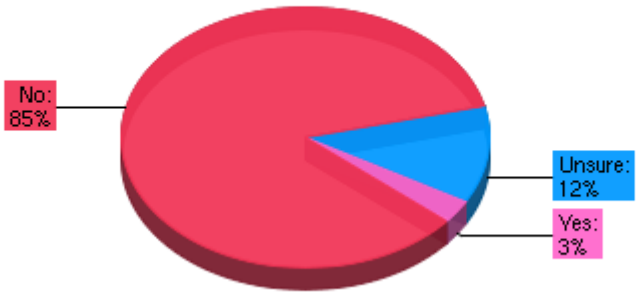



| Value | Count | Percent % |
|---|---|---|
| No | 115 | 54.8% |
| Unsure | 65 | 31% |
| Yes | 30 | 14.3% |

**Statistics**

| | |
|---|---|
| Total Responses | 210 |

# If you were found to have inappropiately billed Medicare by the audit process, would you feel confident that Natural Justice would prevail at the PSR committee process?




| Value | Count | Percent % |
|---|---|---|
| No | 175 | 85% |
| Unsure | 25 | 12.1% |
| Yes | 6 | 2.9% |

**Statistics**

| | |
|---|---|
| Total Responses | 206 |

This was published late last year. This is a summary of the concerns of the profession regarding the current way the Medicare/PSR audit system operates.

# Audit Anxiety and General Practice – Dr Scott Masters

## **MJA Insight –** 29/11/10

http://www.mjainsight.com.au/view?post=scott-masters-medicare-needs-an-audit&post_id=1872&cat=comment

Taylor et al[1] in their recent MJA article "Decline with a capital D" highlighted the current bipolar attitude the federal health department has towards managing complex patients in general practice. As discussed in the article, there is a worrying trend of declining long consultations in general practice that has occurred in tandem with a 400% increase in the number of audits performed by Medicare.. This is occurring despite the federal health minister indicating a preference for GPs to spend more time with patients to deal with multiple health problems and provide valuable preventative care[2]. "Audit anxiety" has been postulated to be responsible for around 1 million less long consultations. This decline in long consultations and rise in brief level A consultations has not been offset by the use of special medical benefits scheme item numbers such as for health assessments and care plans. For people with complex health needs, this is very bad news.

It would seem that Medicare and the Professional Services Review have created a climate of confusion and mistrust out in the frontlines of primary practice. A recent survey[3] showed over 90% of GPs did not have confidence that the Medicare auditing and compliance process provides natural justice. A further 80% did not feel certain they would pass a compliance audit on the use of enhanced primary care (EPC) item numbers. Combine this with the recent proclamations from the PSR over issues such as pathology ordering, CT scan requests and Medicare dental item numbers and it is no wonder that many GPs feel confused, exposed and considering early retirement.

Now would be a perfect opportunity for some rationalisation of the Medical Benefits Scheme and the PSR. We need both schemes operating well to optimise health care in this country. Some pragmatic suggestions for improvement include

- A dedicated response line for GPs who have queries regarding interpretation of the MBS. At present there are multiple phone and email enquiry lines but reliable quick responses are rare.

- A PSR that sticks to its role of policing correct use of Medicare Benefits Schedule instead of commenting on clinical practice. Recent examples are antibiotic and opioid prescribing, pathology requests and CT ordering. If the Director has concerns he should address them to the appropriate colleges such as RACGP, ACCRM, RANZR etc. His unilateral proclamations that there is over prescribing and over ordering of investigations just leads to an undermining of patient confidence and frustration from the majority of doctors trying to do their best in often difficult clinical circumstances

- Spreading audits to all Medicare providers not just GPs. Specialists are responsible for over 50% of Medicare expenditure yet account for less than 5% of referrals to the PSR. Comparable data for allied health is not easy to find and we are yet to know how the Nurse Practitioners will fare. GPs should not have to bear the brunt of audits

- Increased transparency in the Medicare audit process. What triggers a Medicare audit in the first place? Is it based purely on volume i.e. being above the 95% for a certain item number? Are rural GPs compared with urban GPs? Are the hours worked by the GP taken into account? How are GPs with special interests handled? What are the expectations after the initial audit? There needs to be more debate about the assumptions Medicare use throughout the audit process, especially the assumption that GPs are all the same.

- Improved transparency of the PSR referral process. The Director of the PSR can choose to dismiss claims, offer Drs a negotiated agreement or refer Drs on to the PSR committee. Once referred to the PSR committee, no appeal on medical fact is allowed, only an appeal on legal process. The Director and the committee often disagree on what is inappropriate practice. This has led to medical defence organisations advising Drs to accept settlements with the Director rather than face the PSR committee. They consider the PSR committee unpredictable and acknowledge there is no practical appeal mechanism. The High Court has ruled that boat people must be treated with procedural fairness. Why, in the case of the PSR, does a lesser standard apply to doctors?

- Individual determinations from Medicare/ PSR for doctors unsure if they are practicing appropriately. This would involve submitting case notes for an

opinion. The tax office supplies this service for tax payers, it would be reasonable to expect Medicare/PSR to do the same as penalties for failure are severe.

Increased co-operation of Medicare/PSR with Drs and their professional bodies will benefit the community and lead to an improved health system. Current signs indicate this needs to happen immediately or those most vulnerable in our health system will suffer.

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Taylor MJ, Horey D,Livingstone C et al. Decline with a capital D. MJA 2010; 193 (2): 80-83
Roxon N, Minister for Health and Ageing. Medicare red tape slashed [media release]. 14 Dec 2009. Canberra: DoHA, 2009. http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr09-nr-nr234.htm (accessed OCT 2010).