Australasian College of
Skin Cancer Medicine

SKIN CANCER COLLEGE of
AUSTRALIA & NEW ZEALAND

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

RE: PROFESSIONAL SERVICES REVIEW (PSR) SCHEME

We appreciate the opportunity to provide our submission in relation to the present inquiry of the Professional Services Review Scheme.

Australasian College of Skin Cancer Medicine (ACSCM) and Skin Cancer College of Australia and New Zealand (SCCANZ) are two separate colleges undergoing a merger process. Together, we represent about 600 members. We are completely funded by our members receiving no government funding. Most of our members are full time GP's practicing skin cancer on a full time basis. The other component of our member's spend substantial periods of their working hours practicing skin cancer medicine. The two colleges also educate our members through workshops, annual scientific meetings, research, and also offer an examination pathway leading to a Fellowship. In combination, these two colleges would have provided education to about 2000 GP's within the past 4-5 years, both colleges are RACGP and ACRRM accredited to provide education. ACSCM tends to be more procedurally based and focused on assisting rural and remote GP's practicing skin cancer medicine. SCCANZ tends to be more metropolitan based on GP's practising skin cancer medicine, training extensively in dermoscopy skills for the early detection of skin cancer, which is essentially saving the health system money in the long term.

Background:
Australia is unique in the setting of skin cancer. Australians have the highest incidence of skin cancer in the whole world. Of the deadliest variety – Melanoma; United Kingdom has an incidence of about 16 per 100 000 (Cancer Research UK 2010 – reference 1). Australia has an incidence of 49 per 100 000 (Weedon, D – reference 2). The incidence of melanoma in the USA is around one third of the rates in Australia and the UK has one quarter of the incidence rate (NHMRC 2008 – reference 3). Skin cancer is a combination of having susceptible fair skin, sunlight (ultraviolet light) intensity and also prolonged exposure to sunlight. The majority of Australians are from the Anglo-Celtic descent with skin type that is highly susceptible to skin cancer. The combination of susceptible fair skin type and the high incidence of sun exposure is an explosive combination in causing skin cancers.

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Australia is also unique due to its vast geography. The small population is sparsely distributed. Populations are concentrated around coastal areas. Dermatologists are eminently qualified to treat skin cancer. Unfortunately there are only about 360 dermatologist spread throughout Australia. The population of Australia is 22 million. About one dermatologist to 61,000 patients. In Austria, there are about 900 dermatologists to a population of 8 million (Reference 4). About one dermatologist to 8,800 patients. Australia does not have adequate number of dermatologists to treat all the skin cancer patients.

There are about 28,000 general practitioners in Australia (AIHW – reference 5). A lot of the general practitioners have undergone further education and training to provide a service to their patients to treat skin cancer. These general practitioners have undertaken extra education and training at their own personal expense. There is no government funding for skin cancer education.

These GPs then used their acquired training and education to treat patients with skin cancer. These GPs access and bill Medicare for these services. Medicare has correspondingly noticed a huge funding increase of skin cancer treatment item numbers. Medicare forms a flawed conclusion that doctors must be gouging the Medicare system. The PSR's argument that the parameters for effective and efficient treatment of disease is gauged through an amount billed to Medicare, with high amounts billed being equated with inappropriate practice and small amounts billed equaling appropriate clinical practice is a very blunt policy instrument.

The total amounts billed by a skin cancer doctor is the real reason for audits being initiated by Medicare and / or PSR involvement. The details and minutiae of issues like contemporaneous notes, inappropriate practices are just technical language used to blur and justify this process. The operation of the PSR investigations represent a complete denial to the principles of natural justice.

Medicare and PSR should not be viewed as two distinct separate entities. Though claiming independence, PSR and Medicare are deeply intertwined. One could not exist without the other. Medicare and its neural network triggers an "audit". The triggers are not presented in a transparent manner. If Medicare was transparent, some of the issues relating to natural justice and due process would not percolate at the PSR level. If the trigger is a financial trigger, the Senate should review the potential overall costs savings of skin cancer treated by general practitioners versus specialist practitioners and hospital care for procedures.

Medicare / PSR denials of Natural Justice:

1. Respondents are presumed to be practicing inappropriate medicine and are not afforded the presumption of innocence until proven otherwise. Practitioners are usually presented with a letter of demand to repay Medicare for inappropriate practice and practitioners are then meant to prove their innocence to avoid paying the PSR demanded amount. The review processes are merely mechanisms to present a façade of transparency. This has been made even worse with the *Health Insurance Amendment (Compliance) Act 2011.* Under this Act, an audit for whatever reason is triggered leading to the recovery of funds unless substantiated. There are no reasons given for the audit trigger and also no understanding of what constitutes substantiation.

2. The PSR uses the reason of poor medical records as a strong argument to sustain views that a medical practitioner has practiced inappropriate medicine. However, there are 2 issues with this argument. Firstly, some of these doctors accused of having poor medical records work in General Practices that has been AGPAL accredited. One of the criteria for a General Practice to acquire accreditation is demonstration of satisfactory medical records. In the cases of doctors found by PSR to have poor medical records but yet found to be satisfactory by AGPAL, a clear conflict arises, especially when the government provides Practice Incentive Payments to accredited practices. Secondly, PSR claims that poor medical records puts a patient at risk of harm. If such a risk exists, the Director of

PSR has a mandatory duty to notify the peak regulating body: Australian Health Practitioner Regulation Authority (AHPRA) and the corresponding Medical Board. Again, this is deficient and not practised systematically by the Director of PSR. Clause (d) within AHPRA states:

"(d) placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards."

There is duplication of red tape and governance roles. AHPRA, Medical Boards and AGPAL have accredited doctors, practices and their medical records as being satisfactory. Whereas, PSR refutes the roles of these established organizations and authorities.

3. Medicare and PSR do not recognize any subspecialties within General Practice. This practice is arcane and not progressive. The data pool whereby our skin cancer members are compared against is that of the average general practitioner. Medicare and PSR have repeatedly refused to accept sub specialty practices within General Practice. Yet, the peak authority of General Practice – Royal College of General Practitioners – recognizes, acknowledges and promotes subspecialties. *The RACGP submission to the Medical Board of Australia of 10 February 2010* supports the term "Specialist general practitioner". Comparing a profile of a full time skin cancer doctor with a full time general practitioner is a denial of natural justice. This practice also extends to the selection of peers. PSR does not recognize and as a result does not provide a doctor under review with equivalent peers. Peers that practice skin cancer medicine.

4. Cost in terms of billings generated by a doctor is the clearest and strongest indication of triggering a Medicare audit and then leading to PSR. Certainly, a doctor who is generating billings significantly below average does not trigger an audit. In our experience within the Colleges, doctors who trigger a Medicare Audit and then PSR are always doctors who have higher than average billings generated during a 12-month period. In our experience, no doctor earning less than $100 000 in a 12-month period has ever triggered an audit. Cost is a blunt instrument. It is also a denial of natural justice. There are other forms of methodology that are more transparent and certainly more sophisticated: for example - Numbers needed to treat (NNT). Reliance on cost alone as a trigger factor and refusal to see the broader picture is certainly myopic and a denial of natural justice.

5. The assertion that the Medicare / PSR mechanism is merely a façade to disguise a cost saving exercise is demonstrated by the proportions of general practitioners versus medical specialists submitted to PSR and having an adverse outcome together with moneys repaid and restriction of Medicare item numbers used. The proportion of general practitioners to specialist medical practitioners is about 55:45. However, the proportions of general practitioners to specialist medical practitioners submitted to PSR is not 55:45. (*Australian Institute of Health and Welfare 2009. General practitioner 25, 707 versus specialist medical practitioner 24, 290. – reference 6)*

6. The denial of natural justice must be further asserted when there is alarming evidence demonstrating that PSR staff obtain performance bonus commensurate with the number of doctors who enter into a Negotiated Settlement. This is blatantly a cost savings maneuver on the part of PSR.

7. Medicare Benefits Schedule (MBS). The MBS is the definitive written authority for both Medicare and PSR to interpret, apply and enforce. Unfortunately repeated oral and written attempts to seek clarification from Medicare has always been denied or eluded answering the questions. If Medicare is indeed transparent and promotes natural justice, simple matters of providing resources towards educating GP's through seminars, presentations or workshops would suffice. Unfortunately, these have never

been available. Some of the specifics within the MBS that causes confusion amongst skin cancer GP's :

- Skin Flap Item Number 45200 and 45203. Medicare has never been able to clarify the differences between a "simple" versus "complex" flap. Similarly, what constitutes a "small" versus "large" flap. There has been various opinions of a personal nature expressed by Medicare advisers eg " a complex flap can only be performed in an operating theatre " There is not however any such corroborating suggestion in the MBS.

- Medicare item numbers 30196, 30197, 30202 and 30203. These items require proven histology of malignancy before they can be used. There is no clarity as to the time duration of which the proven histology of malignancy within the specified site could be used. A Western Australian Medicare adviser quoted 6 months. In Queensland, an adviser quoted 12 months and in Tasmania, it was quoted as 3 months.

- When confronted with two confusing Medicare item number, the usual Medicare response is (sic) "the cheaper item number is the correct item number"

- There is no agreement of whether certain item numbers eg 30071 has an aftercare component.

- Probably the most interesting comment was from the previous Director of Professional Services Review who commented that the MBS is (sic) " a dog's breakfast ". He also believed that the MBS could never be clarified. However, Dr Weber acknowledges that Medicare is targeting the medical provider who regularly uses the "expensive" Medicare item numbers.

- Our members have been accused of "upcoding" a lesion size. This relates to claiming a benefit based upon size of the lesion but using the larger billing size rather than the actual billing size. Part of this complexity lies in the inability of Medicare to explain and enunciate what is an acceptable "shrinkage" component. "Shrinkage "refers to skin / tissue which undergoes shrinkage made smaller due to formalin processing. Commonly quoted and acceptable shrinkage rates range from 10% to 60%. Again, Medicare is indeterminate. When faced with a decision, Medicare / PSR uses the percentage that is most convenient to confront a doctor on their inaccurate billings.

- Full skin checks especially using techniques like serial sequential digital monitoring (Scott Menzies BJD 2009 – reference 7) and also total body monitoring (Kelly, J Arch Dermatol 2005 – reference 8) consumes an inordinate amounts of time. An average total body monitoring takes up at least 30 – 45 minutes. These procedures justifies a Level C and sometimes a Level D consultation. Medicare adopts the view that the majority of consultations by skin cancer GP's must be a level B. They apply their own arbitrary 80 – 20 rule. Whereby 80% of the consultations should be billed as Level B and only a maximum of 20% of consults to be billed as Level C or even Level D

The previous Director of PSR compares Medicare to the Australian Tax Office (ATO) when he presented a lecture recently. He alluded that Medicare has substantial powers to investigate similarly to the ATO. This is wrong. The Australian Tax Office's charter is substantially different from Medicare. Medicare is an Insurance organization chartered to administered funds collected by the ATO towards the provision of medical care to the Australian community.

Funding dichotomy

Within this medical – Medicare funding landscape, an oxymoron appears. Politically, it is viewed to be desirable and expedient to promote and fund GPs in procedural medicine. Especially when there is a clear separation between rural and metropolitan communities in accessing doctors with procedural skills. The Government provides funding and resource incentives for doctor to migrate to rural and remote communities. One of the easier and more essential skills within a rural and remote community setting is the ability to perform minor skin surgery. It seems that GP's who pursue the path of up-skilling are then unfairly penalized by Medicare, because they practice these acquired skills on the community. And most of these GP's have acquired these skills at their own expense. Government funds encourages GPs to migrate to rural and remote communities. Medicare penalizes and triggers audits leading to PSR in attempts to reduce the billings by the doctors in rural and remote communities.

Privacy and Confidentiality.

Recent amendments to the Medicare Act - *Health Insurance Amendment (Compliance) Act 2011.* – provides bureaucrats with the opportunity to access patient's private and confidential files. Some of the troubling issues: issues of seeking consent of patients by bureaucrats to access files have never been delineated, patient's confidentiality, destruction of files upon audit completion and that this new legislation is in conflict with *Good Medical Practice – A code of conduct for doctors in Australia.* This document was developed by the Medical Board of Australia. One of our members have even complained that bureaucrats have actually telephoned their patients seeking to verify and authenticate certain medical services that has been performed.

The patient-doctor relationship is based upon trust and goodwill. This trust and goodwill is easily eroded when a bureaucrat telephones a patient, queries the patient about his/her treating doctor. It diminishes the patient-doctor relationship as the bureaucrat's telephone conversation will sow seeds of doubt in the patient's mind. This is of particular concern when our members are dealing with the emotionally sensitive issue of cancer.

Case Example

I was the medical director of a group of skin cancer clinics. There were 26 clinics throughout Australia. We had about 80 doctors practicing skin cancer medicine. Some on a full time, some on a part time basis. By the year 2007, this group had a patient database of about 600, 000 patients. About 20% of the annual melanomas (a deadly form of skin cancer) within Australia was diagnosed by this group of skin cancer clinics. We had a certain doctor who had worked with the company for years. This doctor practiced in Brisbane, Queensland. Within our group, this doctor consistently diagnosed the highest amounts of melanoma every year. Consistently. One year he was awarded a company medal of having diagnosed 100 cases of melanoma in a period of only a few years. The average GP would diagnoses 3-10 melanoma in a 5 year period. I presented him with that 100 melanoma diagnosis award. Within a few months of receiving that award, Medicare performed an audit and referred him to PSR. I provided advocacy on his behalf. This doctor engaged a reputable team consisting of a lawyer and barrister with significant Medicare experience to represent him. During the discussions between his lawyers and PSR, his barrister rang to inform myself that PSR would not accept any arguments proposed on his billings because he was one of the highest earning GPs over the past few years. Upon this information, the doctor lost all hope and felt he was coerced into a negotiated settlement of about $400 000 and also was banned from using Medicare skin cancer related item numbers for three years. The other reason that this doctor lost all faith in the system was the information from his lawyers and barristers that the only way to obtain natural justice was through the Australian courts. Most likely involving the High Court of Australia. Furthermore, they also reinforced in this doctor's mind that natural justice would not prevail with PSR. The option was to stand and mount a defence, which could take years and at a huge cost. Or enter into a negotiated settlement, repay an amount of $400 000 and accept

the ban on using Medicare skin cancer related item numbers for three years. This doctor opted for the later to reduce the stress and the cost to defend his integrity.

At no stage did the PSR process require this doctor to give evidence on his number needed to treat (NNT), that is for how many benign cases excised was a malignancy found. Otherwise the PSR may have discovered that this doctor was actually providing a superior service, with superior clinical & diagnostic skills in the early detection of skin cancer. This certainly is opposition to the idea put forward by the former Director of the PSR Tony Webber in the 2008-9 review / report that there is an "increasing sophistication in detecting possible inappropriate practice"

Conclusion:
We as the Presidents of the represented skin cancer colleges implore and petition the Senate Committee to consider our submissions. That a grave denial of natural justice has occurred when Medicare / PSR uses cost as a blunt instrument in determining efficiency and outcomes. They are other methods which are more transparent and accords natural justice, such as observing the record of accreditation and looking at the NNT of a given skin cancer practitioner. In addition to making this submission we would like to be afforded the opportunity to present to the committee hearing, we strongly believe that the PSR could take on board a number of proactive recommendations to ensure the integrity of how practitioners can bill and maintain the integrity of Medicare / PSR.

Thank you

Yours faithfully

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President ACSCM

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President SCCANZ

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