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Medicare Australia and the Professional Services Review Scheme

Case histories are based on actual medical negligence claims or medicolegal referrals; however certain facts have been omitted or changed by the author to ensure the anonymity of the parties involved.

Medicare Australia's Practitioner Review Program and the Professional Services Review (PSR) Scheme aim to protect the integrity of Medicare and pharmaceutical benefits programs by protecting patients and the community from the risks associated with 'inappropriate practice' and also protecting the Commonwealth Government from having to meet the cost of services provided as a result of inappropriate practice. This article outlines the operation of the Practitioner Review Program and PSR.

Case history

The general practitioner received a letter from a Medicare Australia medical adviser inviting him to participate in an interview. The GP had received a Medicare Australia Practitioner Review Program Report 1 and the report noted that Medicare Australia had concerns in relation to his:

- rendered services – services per patient, and
- rendered services – Level C and D consultations.

The report included a number of tables that compared his billing practices over a 2 year period with those of all active vocationally registered GPs in Australia. The GP was placed above the 98th percentile for the items noted to be of concern by Medicare Australia. The GP agreed to the interview. The medical adviser met with the GP to find out more about his practice and to discuss Medicare Australia's concerns. Some weeks after the interview, the GP received a letter from Medicare Australia informing him that the case management committee (CMC) had considered the information in relation to his practice profile and the interview, and that concerns remained

about his rendered services – Level C and D consultations. The letter noted that the CMC would review his practice profile in 6 months to consider whether the concerns had been addressed, or if any new concerns had been identified. If this occurred, the GP was informed that Medicare Australia's Medical Director would be invited by the CMC to participate in a review of his practice profile.

The GP was very concerned that Medicare Australia had not accepted his explanation for the reason why his practice profile differed from that of his peers. He felt that the nature of his practice had not been taken into account. He sent a detailed letter to the Medical Director of Medicare Australia outlining the specific nature of his practice. He also noted that he was very familiar with the Medicare Benefits Schedule (MBS) descriptors for Level C and D consultations, and described the circumstances in which he would itemise Level C and D consultations. One month later, the GP received a letter from Medicare Australia stating that this additional information had been considered and, as a consequence, Medicare Australia's concerns with his practice had been addressed.

■ **The Professional Services Review Report to the Professions 2006–2007 states that: 'over the last few years PSR has discovered considerable confusion in the general practice community as to how to use Level C and D consultation items'.¹ The report notes 'Level C and D consultations require that the doctor spend the prescribed time with the patient (20 minutes for a Level C, 40 minutes for a Level D). In addition, it is a requirement that the doctor fulfil the item descriptor pertaining to the content of the item claimed. In the case of a Level C consultation, the MBS item descriptor requires taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or**

more problems. The consultation must be adequately documented to reflect these requirements. A Level D consultation is similarly worded, but also requires an exhaustive history and comprehensive examination'. The report goes on to state that: 'these items are not intended to be used for a string of minor conditions that may have met the time but not the content requirement. For example, a patient seen for a repeat script for a stable condition, an ear syringe and a blood pressure measurement would not qualify as a Level C consultation even if the consultation lasted more than 20 minutes. Doctors should be sure they have met the item descriptor before billing for a Level C or D consultation'. The implication is that the billing by GPs of level C and D consultations may not be appropriate.

These comments have raised significant concern among the profession. Some medical groups have strongly disputed the assertion that GPs are 'confused' about the use of Level C and D consultations.^{2,3} It has been noted that there are 22 000 general practitioners in Australia and only 27 cases were referred to the PSR during 2006–2007, and not all of these cases involved GPs. Further, a recent analysis of Medicare billing by GPs concluded that consultations charged as Level C are more complex than those charged as Level B, and GPs use both time and content when choosing item numbers, rather than simply relying on specified time thresholds.⁴

Risk management strategies

It is important that GPs are familiar with the MBS item descriptors and understand the processes by which Medicare Australia and the PSR determine if a GP has engaged in 'inappropriate practice'.

Medicare Australia's Practitioner Review Program commenced on 1 November 2006. The stated purpose of the program is to protect patients and the community from the risks and costs of inappropriate practice. Under the program, Medicare Australia identifies medical practitioners where Medicare and/or the Pharmaceutical Benefits Scheme (PBS) data indicates that the practitioner's rendering, initiating or prescribing practice profile appears different when compared with their peers. While this may reflect the nature of the medical practitioner's practice, it may also indicate 'inappropriate practice'. Inappropriate practice can be defined as conduct in connection with rendering or initiating services that would be unacceptable to the general body of members of that profession. In addition, the *Health Insurance Act*, 1973 specifies that a GP is deemed to have practised inappropriately if he or she has rendered 80 or more professional attendances on each of 20 or more days in a 12 month period. Importantly, in determining whether a medical practitioner has engaged in inappropriate practice, regard is given to whether the practitioner has kept adequate and contemporaneous medical records.

Medicare Australia's Practitioner Review Program consists of one or more of the following steps:

- an interview with one of Medicare Australia's medical advisers to discuss the concerns of Medicare Australia
- a period of time to enable the practitioner to review their practice, and
- a review by Medicare Australia's Medical Director to determine if a request for review should be made to the Director of the PSR.

In considering making a request to the Director of PSR for review of a practitioner's provision of services, Medicare Australia will take into consideration whether the:

- practitioner responds to Medicare Australia's attempts to contact them
- practitioner participates in an interview with a medical adviser
- practitioner asks Medicare Australia to request a review by the Director of PSR
- practitioner addresses Medicare Australia's concerns at the completion of a period of review and no new concerns have been identified
- practitioner has previously undergone a period of review by Medicare Australia for the same concern, or
- practitioner has previously been determined by PSR to have engaged in inappropriate practice.

The medical practitioner is provided with an opportunity to make a submission for consideration by Medicare Australia before a request is made to the Director of PSR.

The PSR Scheme is the process used for investigating and reviewing whether a practitioner has engaged in inappropriate practice. It was introduced in 1994 and has undergone a number of reviews and amendments since its introduction. Referrals to the PSR are made by Medicare Australia. The PSR Scheme exists to protect the integrity of Medicare and the PBS. The PSR Director undertakes a review of the data received from Medicare Australia and may also require a person under review to produce documents, including medical records of services delivered.

After completion of a review, the PSR Director must:

- decide to take no further action
- negotiate or enter into an agreement with the practitioner which must be ratified by the Determining Authority (the agreement may include repayment of Medicare benefits and partial or full disqualification from Medicare), or
- establish and make a referral to a peer review Professional Services Review Committee.

Any findings of inappropriate practice by a PSR Committee must be reviewed by the Determining Authority, which determines the sanctions to be applied. These may include:

- reprimand and counselling by the PSR Director
- repayment of Medicare benefits, and
- partial or full disqualification from Medicare for a maximum of 3 years.

The PSR Director or PSR Committee may also refer a medical practitioner to the Medical Board, if they form the opinion that

there is a significant threat to the life or health of patients arising from the practitioner's conduct and/or the noncompliance with professional standards. Cases of possible fraud are referred back to Medicare Australia for action.

General practitioners are encouraged to seek advice from their medical indemnity insurer, or other adviser, before participating in an interview with one of Medicare Australia's medical advisers. Appropriate, early advice will assist the GP in dealing with the Medicare Australia and PSR processes. In the event of a review by Medicare Australia or the PSR, the importance of contemporaneous and adequate medical records that reflect the content of the consultation cannot be overemphasised.

Conflict of interest: none declared.

References

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