Standing Committee on Law and Justice

2020 Review of the Workers Compensation Scheme

Questions on Notice from 24 August 2020 hearing

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The Hon. DANIEL MOOKHEY: Working through the group executives who received bonuses last year, is it the case that all of them received a bonus payment?

Mr BELL: Yes, it is.

The Hon. DANIEL MOOKHEY: That means that 11 of them received the bonus payments?

Mr BELL: No, I think it was eight, in fact—the eight who were there for the full period. It may well be 11 and I will have to take that question on notice.

Answer

There were eight Group Executives who received bonuses in 2018 – 2019. No bonuses were paid for 2019 – 2020.

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The Hon. DANIEL MOOKHEY: What is the total quantum of bonuses paid to all icare staff from the last three years?

Mr BELL: I would have to answer that question on notice. I do not have it to hand.

The Hon. DANIEL MOOKHEY: Do you have the last year in hand?

Mr BELL: I do not think I do, no.

Mr DAVID SHOEBRIDGE: To make that answer useful, if you could break it down by category and also by financial year—

Mr BELL: I can break it down by financial year and category on notice.

Answer

There were no performance payments paid for the Financial Year 2020.

Performance payments paid for the:

- For Financial Year 2019, 103 executives were paid a total of $3.08m for short term performance payments. Three executives were paid a total of $387k in relation to long term performance payments (for the three-year period from 1 July 2016 to 30 June 2019), which is the first and only long-term performance payment made in icare.
- For Financial Year 2018, 101 executives were paid a total of were $3.19m for short term performance payments. There were no long-term performance payments made in this financial year.

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Mr DAVID SHOEBRIDGE: That is right. How much was his wife's contract?

Mr CARAPIET: I do not know. She was a contingent worker. She had been there for a while. She had an original term of, I think, 12 months. That was subsequently extended a couple of times. I do not know what she was paid but I will take it on notice and get back to you.

Answer

Mirren Palmer (Mr Nagle's wife) was a contingent worker at icare from 1 February 2016 until 31 March 2019.

The Project Stanley investigation report from May 2019 that was provided to the Board indicates that Ms Palmer's contract with icare was initially for a day rate of $700 per day plus on-costs and superannuation. There was one rate adjustment effective 1 January 2018 when her rate was increased to $725 per day plus on-costs and superannuation. The total contract value for the period 1 February 2016 to 31 March 2019 was $772,524.

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The Hon. DANIEL MOOKHEY: When the corruption allegations that Mr McCann was investigating reaches the audit and risk committee—we have heard from Mr Carapiet and Mr Bell, to be fair, that internal investigations were launched, external investigations were launched and matters were referred to ICAC. Can you tell us when that happened and who particularly was the external investigator?

Mr PLUMB: The matters that were involved occurred, in my understanding, around about June 2018, after Mr McCann had left work, and arose in the context of his issues. They were referred to ICAC et cetera, and there was internal work done and responses were issued back directly to the board on those matters in late 2018.

The Hon. DANIEL MOOKHEY: Can you table or, on notice, provide us with the responses that you just referred to, which were received back as a result of that investigation?

Mr PLUMB: Yes, I can.

Answer

In June 2018 an information request was received from the ICAC pertaining to:

- Contract Matters

1. Businesses related to Chris Pescott;
2. RSA Archer and/or related entities;
3. Capgemini and / or related entities;

- Matters concerning theft of icare property
- Matters pertaining to a former contractor employed by icare

The Board received a confidential summary on the contract matters on 29 October 2018. This included a chronology of the correspondence (and further information requests) that had passed between the ICAC and icare between June 2018 and October 2018.

On 16 November 2018, the ICAC advised that it had decided not to make any further enquiries into the matter(s) or commence a formal investigation.

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Mr CARAPIET: That is the first thing. The other thing is that there are differences in legislation between New South Wales and Victoria that make it harder to police medical costs. The Victorian and Queensland systems have a test of "reasonable and necessary", where in New South Wales it is "reasonably necessary". icare still has a lot of responsibility to make sure that our part of medical costs are managed better.

The Hon. SCOTT FARLOW: Effectively what you are putting forward here is that this is a concern you have had in terms of the regulator's schedule of costs. What action have you taken with the regulator to express those concerns?

Mr CARAPIET: We have made a detailed submission and our expectation is that the regulator will make a decision on that within a few months. We are looking forward to that decision. They have been working hard at it and we have been working cooperatively with them on it.

The Hon. SCOTT FARLOW: Do you believe that this impost of costs has affected the scheme's long-term viability?

Mr CARAPIET: It has not affected the viability but it is a big element of the cost. If we just had to look at changing the schedule of rates to what they pay in Victoria, that would improve the liability profile we estimate by hundreds of millions of dollars. If the Parliament felt fit to change that one item in the legislation—

The Hon. SCOTT FARLOW: So this is from "reasonable and necessary" to "reasonably necessary"?

Mr CARAPIET: No, from "reasonably necessary" to "reasonable and necessary".

The Hon. SCOTT FARLOW: Apologies, yes.

Mr CARAPIET: That would bring us into line with Queensland and Victoria. They have said that they both have that test, I understand. That also is several hundred million dollars.

The Hon. CATHERINE CUSACK: Are those costs benchmarked against other States in your submission?

Mr CARAPIET: Yes, this is apples and apples.

The Hon. CATHERINE CUSACK: Is the submission something you could share with the Committee?

Mr CARAPIET: Absolutely.

Answer

icare's submission to the State Insurance Regulatory Authority's (SIRA) review of the NSW Workers Compensation and the Compulsory Third Party (CTP) schemes is provided at **Tab A**.

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The Hon. DANIEL MOOKHEY: Was he one of the 200 executives at icare who is eligible for a bonus?

Mr BELL: I do not know but I doubt it.

The Hon. DANIEL MOOKHEY: Why do you doubt it?

Mr BELL: Because I do not recall seeing his name on a list. It may be there—and I will provide the list—but I do not think that he is there.

Mr DAVID SHOEBRIDGE: Can you provide details of Mr Yap's remuneration over the course of his contract?

Mr BELL: No, I think in answer to a question either you or Mr Mookhey asked earlier, I was to produce a list of executives who received a bonus—

Mr DAVID SHOEBRIDGE: But I am now asking if you will provide on notice details of Mr Yap's employment.

The CHAIR: Mr Shoebridge, same deal. Mr Bell has to be allowed to finish his answer before you ask another question or interrupt with a comment.

Mr DAVID SHOEBRIDGE: I understand. I am simply asking to provide details.

Mr BELL: You are seeking two things. Just so I am clear, you want the list of executives who received a bonus—

Mr DAVID SHOEBRIDGE: I am not revisiting any of that, Mr Bell.

Mr BELL: You are not interested anymore—

Mr DAVID SHOEBRIDGE: I am not revisiting any of that.

Mr BELL: Okay.

The CHAIR: Mr Shoebridge!

Mr DAVID SHOEBRIDGE: I am asking about Mr Yap.

The CHAIR: Order! This is not going to work if you continue to do this. Mr Bell was asking for clarification—

Mr DAVID SHOEBRIDGE: Which I gave him.

The CHAIR: You gave him in a manner which was quite rude and, frankly, it is not productive. The witnesses are allowed to ask for clarification. If not, I will have to continue ruling this way and burning up all your time.

The Hon. DANIEL MOOKHEY: Thank you, Mr Chair. Thank you, Mr Bell, I accept your answer that you will take it on notice.

Answer

Mr Yap was not eligible for a bonus and did not receive a bonus as a contingent worker for icare.

Employee	Period of service in the Treasurer's office: Start date	Period of service in the Treasurer's office: End date	Annual Salary Cost	Salary Amount Paid
Edward Yap	1 August 2017	11 July 2019	$141,749	$271,661
	12 July 2019	26 April 2020	$148,925	$115,797
	27 April 2020	5 August 2020	$168,351	$45,170
				Total = $432,628

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Mr DAVID SHOEBRIDGE: Will you provide to the Committee, on notice, full details of who in the employ of icare or contracted to icare has been paid while performing work in the Treasurer's office, including by name and by the amount that they were paid?

Mr FERGUSON: Yes, presuming there are no privacy issues. It does not sound like there would be, so yes.

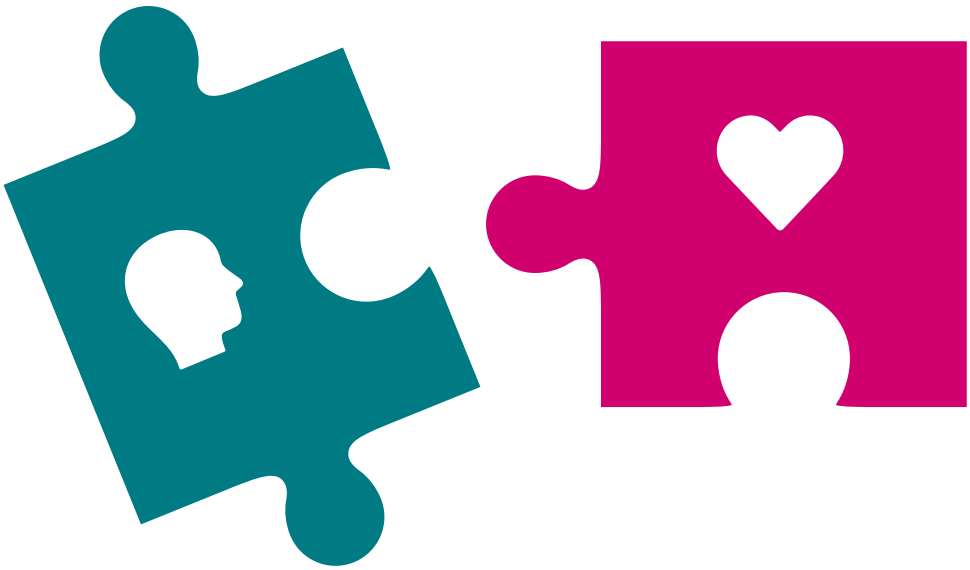
Answer

Please see **Tab B**.

icare™
Insurance and Care NSW

Regulatory requirements for health care arrangements in the NSW workers compensation and CTP schemes

RESPONSE TO CONSULTATION PAPER
NOVEMBER 2019



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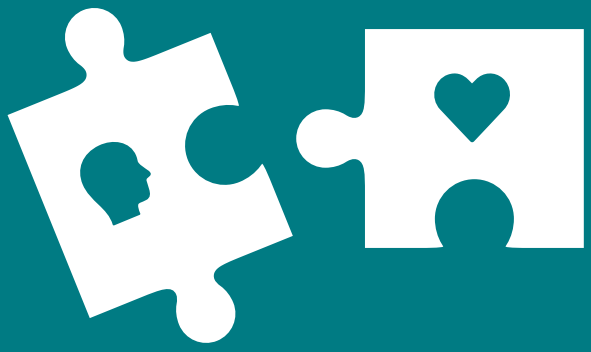

Introduction

icare welcomes the opportunity to contribute to the State Insurance Regulatory Authority's (SIRA) review of the NSW Workers Compensation and the Compulsory Third Party (CTP) schemes.

We acknowledge that SIRA's aim is to manage costs and improve outcomes for injured workers and those injured on NSW roads. We also note that the intent of this review is to ensure the health care arrangements within personal injury schemes in NSW promote safety and quality in services and reflect the principles of value-based care.

In this context, icare primarily manages workers compensation, and is also responsible for the lifetime care and support of those who have been severely injured on NSW's roads.

This document is mostly confined to the challenges we currently face in the workers compensation setting.

We support the 'value-based' care[1] framework advocated by NSW Health that seeks to improve:

- the health outcomes that matter to patients
- the experience of receiving care
- the experience of providing care
- the effectiveness and efficiency of care.

Adopting the value-based care goals of NSW Health means that personal injury scheme patients would receive the same effective, evidence-based treatment, and same quality of care, as they would in the public or private health system.

Further, value-based care is becoming increasingly recognised globally as a more effective approach to limiting unsustainable healthcare costs than traditional approaches[2].

This submission outlines the benefits of value-based care, and how icare believes it should be extended to injured people in NSW, through:

- improved processes and governance
- indexed health care provider fees
- clearer guidelines for healthcare providers and
- more effective use of data and evidence to correctly assess what interventions injured workers will gain the best outcomes from.

1 Elizabeth Koff, Secretary for NSW Health, describes value based care as putting the patient experience and patient outcomes at the centre of delivery of care; 24 January 2019; https://www.health.nsw.gov.au/Value/Pages/default.aspx

2 Soderlund, N., Kent, J., Lawyer, P; Larsson, F; 'Progress Toward Value-Based Health Care – Lessons from 12 Countries'; 6 June 2012; https://www.bcg.com/en-au/publications/2012/health-care-public-sector-progress-toward-value-based-health-care.aspx

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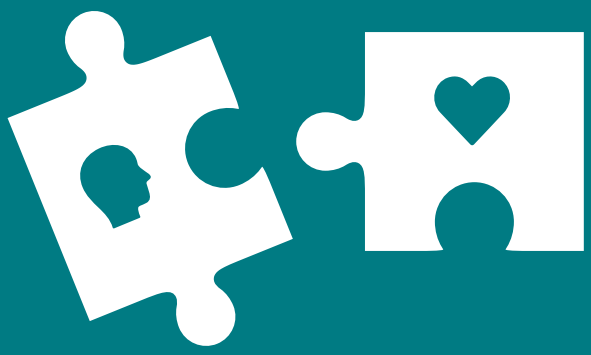

Executive Summary

icare recognises the positive contribution that medical practitioners and allied health professionals make to the well-being of our community in NSW, including helping injured people return to employment.

During the 2018/19 financial year, more than 55,000 medical and allied health service providers delivered treatment and services to injured NSW workers.

These professionals include general practitioners, orthopaedic surgeons, neurosurgeons, pain management specialists, other medical specialists, physiotherapists, chiropractors, counsellors, psychologists, rehabilitation providers, diagnostic imaging specialists and pharmacists.

However, as far back as 2003, the Australian House of Representatives' Standing Committee on Employment and Workplace Relations identified structural weaknesses in the system, that provided opportunity for over-servicing by some service providers, and inappropriate behaviour by a small group of others.

Almost two decades later, many of those same issues remain in the NSW workers' compensation scheme.

We therefore believe the best approach to help injured workers is through delivery of 'value-based' care[1], a framework advocated by NSW Health, coupled with a more robust regulatory regime.

Such a system helps encourage injured workers to recover at work and/or return to work as soon as it is safe to do so, in order to protect their financial, emotional, physical and social well-being. This approach also helps prevent injuries deteriorating into chronic conditions where possible.

The need is clear. The longer an injured worker is off work, the less likely they are to return. For injured workers out of employment for 70 days or more, the chance of returning to paid work is as low as 35%[2].

Therefore, in many cases the best place for injured workers to recover is in a supportive work environment, with modified duties.

As a result, icare believes the healthcare framework within the NSW workers compensation system should be modified, and significant changes implemented in both the short-term and long-term, to achieve the best clinical outcomes for injured workers.

icare has provided six key areas for improvement, together with a range of supplementary proposals, that we believe will improve the system. For ease of review, we have ranked our sub-recommendations as 'vital', 'high' or 'moderate' priority.

Direct answers to the questions posed in the consultation paper can be found in Appendix A.

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1 Elizabeth Koff, Secretary for NSW Health, describes value based care as putting the patient experience and patient outcomes at the centre of delivery of care; 24 January 2019; https://www.health.nsw.gov.au/Value/Pages/default.aspx

2 Return to Work Matters, 2015; https://www.rtwmatters.org/handbook/injury-and-case-management/web/?not_back_at_work_after_3weeks.htm

Recommendation 1 – Address fee schedules and indexation

Currently the gazetted fees paid to surgeons for NSW Workers Compensation claims are up to four times those of the Medicare Benefits Scheme (MBS), making them the most expensive in the country[3].

This is partially a result of the scheme using Australian Medical Association (AMA) rates, where the rate of indexation of recommended fees since the mid-1980s has been consistently above that recommended in the MBS for the same item[4]. With the freeze on indexation of MBS fees from 2013 only recently being lifted, this has resulted in further disparity between AMA and MBS fees. The NSW Workers Compensation scheme further compounds this difference by applying additional loading for surgical item numbers.

This creates an environment that enables providers to charge significantly more for the same surgical services they might provide to the general public. It also creates an opportunity for surgeries to be performed that might not be readily acceptable within the greater medical community.

Therefore, icare believes SIRA has an opportunity to investigate alternate funding models that simultaneously provide a favourable solution for workers (through better health outcomes), providers (through fair and equitable fees), and the NSW workers compensation scheme (through financial sustainability).

This would also be an opportunity for SIRA to be active in improving health literacy among claimants, so they understand the options available to them under different funding models.

We therefore recommend SIRA:

Recommendation		Priority
1.1	Moving all NSW personal injury schemes to MBS item numbers, descriptions and billing rules, with their own fee structure.	**Vital**

1.2	Improving the process of indexation in NSW by:
	• negotiating fees with private hospitals on an annual basis
	• indexing based upon needs and performance of the scheme
	• considering allowing insurers to set fee schedules directly with medical and allied health providers
	• considering alternate funding models, such as
	  ◦ bundling payments
	  ◦ introducing gap payments
	  ◦ incentivised payments scheme
		Vital

1.3	Introducing a 'fee for outcome' system that remunerates service providers on the rehabilitation or return to work outcomes of the injured worker.	**Vital**
1.4	Providing greater transparency around the calculation of rates for allied health service provision.	**High**
1.5	Review of existing national and international health literacy principles and strategies and leverage this information to develop a plan for building health literacy amongst injured people in NSW to further support value based care interventions.	**Moderate**

3 *'Healthcare in Personal Injury Schemes'*, Report for SIRA, Workers Compensation scheme; Ernst & Young; 24 July 2019
4 *'Why is there a gap?'*; AMA Fees Gaps Poster 2019; Australian Medical Association; https://feeslist.ama.com.au/resources-ama-gaps-poster

Recommendation 2 - Replace the "Reasonably necessary" test

In most Australian workers' compensation jurisdictions, the test for determining whether treatment or services are appropriate, is based on the concept of 'reasonable and necessary'.

NSW is different and uses the 'reasonably necessary' test.

This small wording change has profound, and potentially unforeseen, consequences for claimants by creating incentives for medical and allied health service providers around fee-for-service, rather than encouraging the system to take a holistic view of a person's ability to 'function and recover'.

One example is the number of spinal fusions being approved and undertaken within the scheme for back injuries, despite the evidence suggesting this is not best practice[5]. In some cases, spinal fusion may result in permanent reduction of function, which may limit future work ability.

The current system therefore provides a financial incentive for surgeons to recommend surgery, rather than consider conservative treatment options that may lead to better health outcomes in the long-term.

icare believes this financial incentive should be removed in favour of the value-based care framework, which adheres to the following four principles:

I. person centred approach

II. evidence based care

III. outcome focused care

IV. effective and efficient.

icare believes the "reasonably necessary" test is not appropriate for the NSW workers compensation scheme, as it allows all types of treatments to be approved, including those considered as being of low value or potentially harmful. This has contributed to an increased medical spend, and persistent non-improvement in injured worker outcomes.

In order to deliver value-based care in the NSW workers compensation system, we believe consideration should be given to amending "reasonably necessary" to another definition that supports value-based care. An example may be "reasonable and necessary", per the test in the *Motor Accidents Injuries Act 2017*[6].

This test ensures that services requested are well supported, and those that are unnecessary and excessive do not meet the threshold. Additionally, the principles require the treatment to be aligned to a certain outcome or goal, something the existing NSW workers compensation test does not do.

We therefore recommend SIRA:

Recommendation	Priority
2.1 - Implement a new definition that supports value-based care for assessing and approving medical treatment within the NSW workers compensation system from the current 'reasonably necessary'. SIRA to introduce operational guidelines which clearly outline how this test should be applied, similar to the Lifetime Care and Support Guidelines[7] or the NDIS.[8]	**Vital**

5 *Choosing Wisely Australia*; Faculty of Pain Medicine, ANZCA: tests, treatments and procedures clinicians and consumers should question; 13 February 2018; https://www.choosingwisely.org.au/recommendations?q=&organisation=312&medicineBranch=&medicalTest=&medicineTreatment=&conditionSymptom

6 *Motor Accident Injuries Act 2017 No 10* [NSW]

7 https://www.icare.nsw.gov.au/injured-or-ill-people/motor-accident-injuries/guidelines-and-policies/#gref

8 '*Planning Operational Guideline – The statement of participant supports*'; 18 July 2019; https://www.ndis.gov.au/about-us/operational-guidelines/planning-operational-guideline/planning-operational-guideline-statement-participant-supports#9.2

Recommendation 3 - Introduce a robust clinical governance framework

icare acknowledges the overwhelming majority of medical and allied health providers who deliver services within the NSW workers compensation system do so in a professional and timely manner.

We therefore believe a strong Clinical Governance Framework will support those doing the right thing, and drive individual and organisational behaviour towards optimal patient and clinical care.

Such a framework needs to ensure appropriate credentialing and experience, high standards of clinical performance, clinical risk management, clinical audit, ongoing professional development and well-developed processes.

Current SIRA Guidelines issued across the NSW insurance schemes could be strengthened to support meaningful governance of healthcare providers.

Whilst it is acknowledged that the Australian Health Practitioner Regulation Association (AHPRA) is responsible for the registration and accreditation of Medical and Allied Health Providers, there is a need for SIRA to implement a complimentary layer of governance mechanisms within the context of the NSW personal injury schemes to enable a more responsive and timely means of managing performers within the scheme, who are at risk of causing potential harm to injured workers and creating adverse health outcomes. It will also enable icare to direct customers to high quality providers.

icare believes that SIRA should consider implementing a more robust clinical governance framework to protect the safety of individuals within both the NSW workers compensation and CTP schemes, by ensuring all healthcare providers have clearly defined skills, qualifications, experience and performance expectations to perform their roles.

We therefore recommend SIRA:

Recommendation		Priority
3.1	Adopt a clinical framework for the delivery of medical and allied health services, beyond what is currently available, including details about SIRA accreditation, along with initial and ongoing education for all health care providers.	**Vital**
3.2	Introduce more robust performance monitoring, including when a healthcare provider would have their accreditation removed should they fail to meet the accreditation standards, or following a negative outcome resulting from investigation.	**Vital**
3.3	Share existing and up-to-date materials from reputable peak bodies nationally and internationally, enabling injured people to have access to accurate and appropriate health information.	**High**
3.4	Refine the existing training and materials available to medical and allied health providers to help their understanding of the NSW workers compensation and CTP schemes.	**High**
3.5	Develop more robust, simple and accessible information for medical practitioners, allied health providers, and case managers across the NSW personal injury schemes.	**High**
3.6	Introduce public reporting of provider performance to enable transparency around the quality of their services, increase provider accountability, and provide the public with reassurance over quality of care (i.e. the regulator is regulating its healthcare providers). More specifically, identify providers who deliver high quality health and wellbeing outcomes (including recovery at work), so injured people can make informed choices about their healthcare providers.	**High**
3.7	Recommence publication of a 'Provider Watchlist' to ensure injured workers are receiving treatment from providers who do not have significant restrictions or conditions placed on their registration.	**High**
3.8	Establish clear guidelines, role clarity and accountabilities between SIRA, AHPRA and insurers, using information developed by the Insurance Council of Australia and Comcare to ensure a more seamless, consistent way of managing providers who may pose a risk to their patients.	**Moderate**

Recommendation 4 - Introduce additional guidelines, and strengthen those which currently exist

The current NSW workers compensation system allows for provision of low value care services, irrespective of the needs of the injured worker.

For example, most cases of lower back pain resolve within a month or so[9]. In the majority of instances, best practice supports keeping active and using over-the-counter medications only. Imaging during this period may be considered unnecessary and may lead to unintended consequences, such as surgery. This has ongoing impacts on the worker's recovery time.

Best practice clinical care also dictates that surgery should be one of the last resorts for conditions such as back pain. Less invasive conservative treatments consistently provide better long-term health outcomes for injured workers.

Evidence shows that back and knee injuries in the workers compensation system are likely to take longer to recover than in the general community[10].

There is no reason why that should be the case. icare believes that regardless of how someone is injured – whether in the workforce or in their own time – the management of their injury should be the same.

Therefore, tightening guidelines on what treating doctors can prescribe in the workers compensation system may lessen the incentive for invasive and unnecessary procedures that would not normally occur out of the system, and that can lead to poor long-term outcomes for workers.

Also, of importance is the need to define 'best outcomes' within these guidelines – not just from the perspective of cost and return on investment, but also from the perspective of the injured worker. Doing so, will ensure all parties are provided with clear expectations on what the intended outcome or goal should look like.

Furthermore, introducing electronic methods of submitting or sharing information to better track data in a timely manner, would not only enhance scheme efficiency, but also provide greater visibility around any services being delivered outside of the expected standards.

We therefore recommend SIRA:

Recommendation		Priority
4.1	Provide a clear and uniform definition of 'best outcomes' – that extends beyond cost to include best return on investment for the schemes and the injured person – for the NSW personal injury scheme.	**Vital**
4.2	Implement a pharmacy policy that defines and stipulates: • what can and cannot be funded through personal injury schemes • explains the requirement to prescribe and dispense under the Pharmaceutical Benefits Scheme (PBS) • identifies mark-up and dispensing fees for all pharmacy items, and • defines the restrictions around prescribing certain medications.	**Vital**
4.3	Implement operational guidelines which clearly outline how to assess and approve treatment within the NSW workers compensation system.	**High**
4.4	Introduce treatment guidelines in the NSW workers compensation and CTP schemes to specifically enable identification of inappropriate treatment or over-servicing.	**High**
4.5	Amend, and potentially reduce (if based on evidence), the list and frequency of treatments not requiring (pre) approval by the insurer, particularly the number of allied health treatment sessions and MRI referrals by the NTD.	**High**

9 Choosing Wisely Australia; Australasian Faculty of Occupational and Environmental Medicine: tests, treatments and procedures clinicians and consumers should question; 25 September 2017; https://www.choosingwisely.org.au/recommendations?q=&organisation=273&medicineBranch=&medicalTest=&medicineTreatment=&conditionSymptom

10 De Moreas VY, Godin K, Tamaoki MJS, Faloppa F, Bhandari M et al; 'Workers' Compensation Status: Does It Affect Orthopaedic Surgery? A Meta-Analysis. PLoS ONE. 2012; 7(12)

Recommendation		Priority
4.6	Increase controls over concurrent treatments within the allied health category, particularly physical therapies such as physiotherapy, chiropractic and osteopathy.	**High**
4.7	Implementation of secure electronic methods of submitting and sharing information among stakeholders to increase the efficiency of the scheme and enable the effective and timely collection of data, and to assist with identifying cost leakages and maintaining payment integrity. For example: • electronic Certificate of Capacity • Allied Health Recovery Request • Electronic invoicing	**High**
4.8	Review and reconsider the treatment approval decision timelines to allow for greater scrutiny of treatment requests that fall outside the standard treatment protocol, including extra ordinary circumstances where a provider is not recognised by SIRA accreditation protocols but may be the most appropriate provider for delivering 'best outcomes'.	**Moderate**

Recommendation 5 – Improve Healthcare Data and Coding

Workers compensation insurance claims are typically coded in insurance language, while the rest of the health system utilises recognised healthcare clinical coding classification systems.

There is no obvious reason why this should be so. The effect is that there is no visibility over the medical management of workers compensation claims, including hospital stays, discharge times and surgery durations.

Hospital Casemix Protocol is an example of data which provides the granular detail required to understand trends in hospital spending, the largest health-related spend category in NSW workers compensation. A dataset such as this would assist in our understanding about whether the system is operating effectively and efficiently; and enable comparison with non-workers compensation healthcare schemes. Its absence may help explain why health care costs in the NSW workers compensation system have risen by 50% in the last four years alone.

Furthermore, there is little information within the scheme to assist stakeholders in understanding specific pharmaceutical treatments being provided to workers. The system currently spends around $1 million per month on pharmacy costs. Due to all pharmacy costs being coded under the single code of PHS001, it is difficult to determine how the medications are prescribed (eg. prescription vs over the counter, whether prescriptions are on a private script or one covered by the Pharmaceutical Benefits Scheme (PBS)), as well as the type of medications prescribed (for example, drugs of dependence or other).

The opaque nature of the system comes as opioid use is escalating across Australia, including NSW. This lack of visibility impedes icare's ability to ensure the most appropriate and clinically indicated treatments are provided to workers.

Outcomes need to be measured to ensure performance standards are met, and better health care data and coding will assist with this. In addition to the existing outcome measures which focus on RTW measures and cost of treatment, there is value in also introducing Patient Reported Measures (PRMs) for use within the NSW personal injury scheme. Patient reported measures are already being used to report on patient experiences and patient outcomes across the wider healthcare system in Australia. The use of these measures within the workers compensation and CTP schemes can be used to inform and improve the experiences and outcomes of injured workers, and those injured on NSW roads.

We therefore recommend SIRA:

Recommendation		Priority
5.1	Undertakes the collection of Hospital Casemix Protocol data from hospitals as per Section 40B of the Workplace Injury Management and Workers Compensation Act 1998, and share relevant data with insurers who fund these services.	**Vital**
5.2	Update the Workers Compensation Insurer Data Reporting Requirements to include additional pharmacy codes to capture specific information on drug type, dose, frequency, prescription costs and any other goods supplied by pharmacists.	**Vital**
5.3	Transition data coding requirements from TOOCS to ICD-10 to allow for better identification of the nature and magnitude of injuries and to help put in place the procedures and treatments that support best practice, value-based care.	**Vital**
5.4	Introduce specific outcome measures for healthcare services within the NSW workers compensation system and CTP, which also includes Patient Reported Experience Measures, and Patient Reported Outcome Measures.	**Vital**
5.5	Investigate methods which allow for timely data acquisition to assist with performance and risk management, which may mean sourcing data beyond what SIRA would require from insurers.	**Vital**

Recommendation 6 - Shift to American Medical Association (AMA) 6 for whole person impairment

There are various methods to assess Whole Person Impairment (WPI) across personal injury in NSW, with the workers compensation schemes using the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 5th Edition (AMA 5) and the CTP scheme and the Lifetime Care and Support scheme using AMA 4.

The method of assessment in the AMA 5 Guides attribute greater degrees of impairment for subsequent interventions in the management of an injury. This provides a perverse incentive for injured workers to undergo low-value medical treatments, such as surgery, in order to reach impairment benchmarks without any improvement in function[11].

Whilst there are current reasons as to why each scheme uses a different edition of the AMA Guides, AMA 6 seeks to rectify the issues identified in each previous edition, aligning medical treatments with improved patient outcomes rather than increased impairment. However, the prospect of reaching these 'thresholds' for extended entitlements may delay some injured workers' recovery and could result in the development of illness behaviours and a poorer health outcome.

With the proposed reforms to simplify the dispute resolution system across Personal Injury in NSW, it is timely to assess the use of AMA 6 across both the workers compensation and CTP schemes.

We therefore recommend SIRA:

Recommendation	Priority
Adopt and align the American Medical Association's Guides to the Evaluation of Permanent Impairment, 6th Edition (AMA 6) for both NSW workers compensation and CTP, as a means of aligning medical treatments with improved patient outcomes rather than increased impairment. This could be implemented over a three to five year period, to allow appropriate time for transition.	**Vital**

11 *'Comparative benefits of the Sixth Edition of the AMA Guides for evaluating permanent impairment'*. (Appendix C)

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Recommendation 1

Address fee schedules and indexation

1. Healthcare funding models

Personal injury jurisdictions in NSW operate on a fee for service model. However, this is not necessarily the best way of delivering value-based care to those who need it.

If the NSW personal injury schemes are to truly place the injured person at the centre of care, using an evidence-based, best practice, outcomes-focused approach, and the introduction of alternative healthcare funding models needs to be considered.

A number of possible healthcare funding models have been outlined below:

Bundled payments

A bundled payments model may be considered either in isolation for certain treatments, or with regards to overall treatment for the injury. Bundled payments are designed to move toward value-based care by incentivising providers to take accountability for the care as well as the outcomes provided to injured people[1]. In North America and Canada[2], where bundled payments have been trialled, success has been demonstrated particularly for finite episodes of care. This would therefore make it a reasonable model to trial within the workers compensation system, as the majority of physical injuries are not chronic in nature on initial notification.

An extension of the bundled payments model noted above is to integrate different components of care, with a central body or organisation taking responsibility for coordinating care amongst all healthcare providers.

Outcomes-based payments model

Under a fee for service model, the objective of the healthcare provider may be at odds with that of the scheme. A fee for outcomes arrangement with healthcare providers serves to align the objectives of the scheme and the healthcare provider, by ensuring that both are centred on achieving positive outcomes for the injured person.[3] It is anticipated that such a model use a combination of fixed and hourly rates for payments.

If such a model of fee payment were to be adopted, an appropriate method for monitoring performance, outcomes, and benchmarking is required. For this to be meaningful, a change in the codes captured for monitoring and reporting is necessary to align with healthcare coding systems. icare recommends capturing healthcare codes such as International Classification of Disease (ICD), codes included in the Hospital Casemix Protocol (HCP) dataset and Patient Reported Measures. For further detail regarding coding, please refer to Recommendation 5 – Improve healthcare data and coding in this document. An unintended consequence of this model may be to disincentivise the management of more complex or challenging claims.

Incentivised payments scheme

Incentivised payments schemes are already in use in the Australian public healthcare system. The Practice Incentives Program[4] has been instituted in general practice healthcare to encourage continuous improvement, quality care, enhanced capacity and improved access and health outcomes for patients. However, reviews of incentivised payments schemes overseas have not been able to identify how best to stimulate quality improvement.[5] A report published by the Institute of Actuaries of Australia[6] concluded that incentive measures are one way to encourage provider behaviours that are better aligned to the objectives of the scheme.

1 *'What Are Bundled Payments?'*; NEJM Catalyst; 28 February 2018; https://catalyst.nejm.org/what-are-bundled-payments/
2 Farrell M, Scarth F, Custers T et al; *'Impact of bundled care in Ontario'*;. International Journal of Integrated Care. 2018;18(S2):89
3 *Hardy, P., Knight, B., Edwards, B; 'The role of incentive measures in workers' compensation schemes'*; Nov 2011
4 *'PIP QI Incentive guidance'*; The Department of Health; 10 October 2019; https://www1.health.gov.au/internet/main/publishing.nsf/Content/PIP-QI_Incentive_guidance
5 *'Paying For Care: In Depth'*; RAND Health Care; https://www.rand.org/health-care/key-topics/paying-for-care/in-depth.html
6 *Hardy, P., Knight, B., Edwards, B; 'The role of incentive measures in workers' compensation schemes'*; Nov 2011

Patient choice bundled care

This model of care could be considered as similar to that rolled out in the NDIS. For it to work effectively, the injured person needs to have a reasonable level of health literacy. Unfortunately, the current levels of health literacy in Australia are poor, with only approximately 41% of adults having adequate health literacy to meet the demands of everyday life.[7]

icare acknowledge SIRA has already produced guidance material that assists in improving health literacy of workers. icare recommends leveraging this work, as well as work undertaken by other key stakeholders in the area, to continue to build and maintain a health literacy environment. This model can only be effectively implemented once health literacy levels have increased to a level that allows workers to understand their injury management options.

Contracting Providers

Private health insurers in Australia have introduced a two-tiered approach to healthcare provider payments, with those that agree to be contracted receiving a higher amount from the private health insurer, compared with those that remain non-contracted. For consumers using their private health insurance, this impacts their out of pocket expenses for an episode of care.[8]

A similar model of care could be introduced across the NSW personal injury schemes, with contractual arrangements made between SIRA and the healthcare provider. Higher rates could be offered to those who proceed with a contractual arrangement, with service level agreements put in place to ensure appropriate outcomes are measured and monitored. Those providers that choose not to become contracted providers would be offered a different rate.

This two-tiered model would negate the need to pass on any additional costs to the NSW scheme or injured person and would encourage those providing healthcare services to be accountable for delivering the best outcomes for workers. Alternatively, additional costs to meet the gap between non-contracted and contracted providers might be met by the injured person (noting however, that the NSW workers compensation legislation does not permit this).

Gap payments are used in two workers compensation jurisdictions in Australia – Comcare[9] and WorkSafe Victoria.[10] It is worth noting, the use of gap payments does not always result in a lower fee being set across all medical payments, however does put some onus on the injured worker to seek second opinions and ensure the recommended treatment will provide the best possible outcome for them.

A supplementary layer of rigour could be implemented by benchmarking all providers and only contracting those that meet a minimum standard. Much like other models mentioned above, this would rely on the appropriate measure and monitoring of healthcare metrics to ensure that outcomes are focused on return to health as well as work.

Benchmarking

Benchmarking can be used as an indirect measure to incentivise desired behaviours in a personal injury scheme's service providers. Medical and allied health practitioners rely on their reputation to receive ongoing business and future referrals. Public acknowledgment of their success in achieving the desired outcomes of the scheme can enhance this. The regulation of service providers can be an effective tool to ensure that providers meet minimum standards with respect to each scheme's performance objectives.

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7 *'National statement on health literacy. Taking action to improve safety and quality'.* Australian Commission on Safety and Quality in HealthCare. 2014

8 *'Private health insurance'*; Australian Competition and Consumer Commission; https://www.accc.gov.au/consumers/health-home-travel/private-health-insurance

9 Australian Government Comcare; www.comcare.gov.au

10 Work Safe Victoria; www.worksafe.vic.gov.au

2. Better indexation controls

Regardless of the approach to the management of health practitioner costs, better and more consistent indexation controls are needed in the NSW workers compensation system.

Consumer Price Index (CPI) and health costs continue to increase over time, at varying rates. Analysis of ABS data has shown that health costs have more than doubled the rise in CPI nationally since 2013.[11] As such, medical costs must continue to be indexed appropriately to retain and remunerate suitable healthcare providers within the scheme.

The Medicare Benefits Schedule (MBS) fees are indexed annually according to the Government's Wage Price Index. However, there was a freeze on the indexation of MBS fees in 2013. This freeze on indexation is being lifted in stages, commencing in 2017.[12] In contrast, the AMA Fees List is indexed annually at a rate that takes into account the cost of providing medical services,[13] resulting in a higher indexation of fees annually.

icare believes there are several options that could be implemented to improve the process of indexation in NSW, which, in turn, could help deliver value-based care and achieve better health outcomes for injured people:

1. Rather than apply a direct indexation model, SIRA could request that private hospitals apply to them each year to negotiate through discussion and agreement the rates to be set for that year; and
2. Indexation could be based on the needs of the scheme with regard to medical costs in the year prior; or,
3. Consider allowing gap payments by the injured person for medical expenses in each scheme (noting that currently the NSW workers compensation legislation does not permit this).

3. Better management of costs

Medical costs in the NSW workers compensation system have continued to rise, by an average 12% year on year from 2015 to 2018.

A review of medical costs has confirmed that hospital costs, driven by surgical interventions, were the largest single factor of rising medical costs.[14]

A second contributing factor is a historical, structural problem. Fees paid for medical treatments across the NSW workers compensation system are extremely high when compared with other Australian workers compensation jurisdictions, or with costs for NSW patients outside the system[15].

Allied health provider spend has followed the same trend and is now the third largest spend category following surgery and hospital costs. This is often driven by arbitrary and unconsidered referrals for treatment within pre-approved limits.

Several factors support perverse financial incentives for healthcare providers to deliver services without consideration for improving outcomes. These include:

- the current fee structure, with loadings for most surgical procedure items which increase the incidence of medical procedures for increased remuneration
- the legislative stipulation that treatments need only be 'reasonably necessary' for the patient's treatment to be approved.
- the current method of assessment of whole person impairment (WPI) which, combined with the above factors, supports low value care procedures to be performed that increases impairment without necessarily improving function

If NSW is to provide a cost-effective and sustainable workers compensation system for the NSW employers that fund the scheme, the over-pricing currently endemic in the system should be addressed through:

11 *'Health Costs Outpace Inflation'*; The Australian Institute; 2 May 2019; https://www.tai.org.au/content/health-costs-outpace-inflation
12 Biggs, A; '*Medicare*'; Parliament of Australia; 18 May 2017; https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/BudgetReview201718/Medicare
13 '*Setting Medical Fees and Billing Practices 2017*'; Australian Medical Association; 25 July 2017; https://ama.com.au/position-statement/setting-medical-fees-and-billing-practices-2017
14 '*High Medical Costs in the NSW Workers Compensation System*'. Submission to SIRA. May 2019
15 '*Healthcare in Personal Injury Schemes*', Report for SIRA, Workers Compensation scheme; Ernst & Young; 24 July 2019

Revision of the methodology for setting gazetted fee maximums for healthcare treatments in NSW; and,

- introduction of greater checks and balances around the medical treatments prescribed and billed for injured workers in NSW, including Guidelines under the Workplace Injury Management and Workers Compensation Act 1998.
- as an alternative to the current arrangement whereby SIRA set the maximum fees in the scheme, icare suggests that responsibility of the setting of fees for medical treatments could be delegated to the insurers. This would be similar to the manner in which fees are set in Queensland. Doing so will enable market forces to drive the appropriate indexation of fees.
- greater scrutiny of medical billing will also support icare's goal of value-based care[16] by putting the injured workers' experience and health outcomes at the centre of all decision-making regarding medical treatments. An electronic method for submitting invoices would provide greater visibility and opportunity for this scrutiny to occur consistently, and if coupled with more robust coding practices, will limit opportunity for incorrect billing for services.

Table 1: Workers compensation billing rules across jurisdictions

JURISDICTION	ITEM NUMBERS	FEE BASE	BILLING RULES
NSW[17]	AMA	AMA	AMA Fees List with exceptions 1. attendances use AMA rates, except for those specified in the Medical Practitioner fees order 2. some items e.g. MRI are gazetted at lower rates than listed in the AMA Fees List 3. spinal surgical rules and conditions must follow those listed in the MBS 4. additional loading to AMA fees for surgical procedures
Comcare[18]	AMA	AMA	AMA Fees List applies, gap payments are allowable (employer liable) Fees for diagnostic services may be adjusted in accordance with services in other schemes
Victoria[19]	MBS	MBS	MBS items, explanations, definitions, rules and conditions AMA multiple operation rule Rates determined by WorkSafe Gap payments are allowable [20]
SA	MBS	MBS	MBS items, descriptions and payment rules Fees are an uplift of the MBS fees (though less than the AMA Fees List) A number of services are considered not applicable in the scheme
QLD[21]	MBS	AMA	MBS items and descriptions AMA Fees (flat) AMA multiple operation rule applies
WA[22]	MBS	MBS/AMA	Procedure dependent

16 Elizabeth Koff, Secretary for NSW Health, describes value based care as putting the patient experience and patient outcomes at the centre of delivery of care; 24 January 2019; https://www.health.nsw.gov.au/Value/Pages/default.aspx
17 State Insurance and Regulatory Authority; www.sira.nsw.gov.au
18 Australian Government Comcare; www.comcare.gov.au
19 Work Safe Victoria; www.worksafe.vic.gov.au
20 *Treatment expenses*; Work Safe Victoria; 25 June 2018; https://www.worksafe.vic.gov.au/treatment-expenses
21 WorkSafe Queensland; www.worksafe.qld.gov.au
22 Work Cover WA Government of Western Australia; www.workcover.wa.gov.au

The impact of these differences can be clearly demonstrated when calculating the cost of the same procedure across jurisdictions. For example, the 2018/19 rates applicable in each jurisdiction have been applied to a number of procedures in the table below.[23]

In reviewing medical costs, moving from the current model of AMA fees with increased loading, to flat AMA fees or MBS fees would result in an estimated saving of $21m and $144m in the Nominal Insurer, respectively per year.

Hospital Costs – Public Hospitals

In NSW, the National Efficient Price (NEP) and National Weighted Activity Unit (NWAU) are used to determine prices for public hospital services and admissions. Other states, however, use State-specific pricing models.[24]

icare believes SIRA should undertake a full analysis of the NSW-specific fee structure versus the current use of NEP and NWAU to determine which is the most appropriate value-based model.

Hospital Costs – Private Hospitals

Costs for Private Hospital services and admissions vary across Australian jurisdictions. WorkSafe Victoria has arrangements with some private hospitals, including individually agreed fees. Non-arrangement hospitals abide by the fee schedule available on WorkSafe Victoria's website.

Unlike Private Health Insurers, the current NSW workers compensation fee structure enables a per day, per diem charge by private hospitals, for which there is no pre-approval of costs by the insurer, creating the capacity for hospitals to keep the patient longer in order to charge a higher fee.

icare believes that SIRA should explore the possibility of making arrangements with private NSW hospitals to help manage and reduce costs by realising efficiencies of supply.

Allied Health Services

Allied health service costs vary across jurisdiction and type of allied health provider. It is worth noting that not all allied health providers are approved to provide services across the various Australian workers compensation jurisdictions or even within the NSW personal injury schemes.[25]

In addition to the differences in rates for service, there are several cross-jurisdictional differences in the provision of allied health services between the Australian workers compensation schemes, including:

- number of sessions of treatment pre-approved by the regulator in each jurisdiction;
- associated paperwork;
- which providers can/cannot provide services within that scheme;
- treatments that can/cannot be utilised concurrently; and,
- whether or not a referral from a medical practitioner is required to commence treatment.

Table 2: Cost of surgery by jurisdiction:

	NSW	QLD	Victoria	Comcare	MBS	AMA	Codes
Spinal Fusion	$20379.40	$9281.25	$7319.55	$9281.25	$2421.25	$9281.25	MZ741, MZ731, MZ761, MZ751, MZ820
Disc Replacement	$8400	$5600	$4100.30	$5600	$1822.35	$5600	MZ830
Knee Reconstruction/Repair	$4290	$2860	$2474.56	$2860	$956.50	$2860	MW145
Shoulder Reconstruction/Repair	$4290	$2860	$2474.56	$2860	$956.50	$2860	MT800
Knee Arthroscopy + Meniscectomy	$2790	$1860	$1450.20	$1860	$551.60	$1860	MW215

[23] Note that these figures are for the primary procedure only, and do not include fees for associated services such as hospital and anaesthesia.

[24] '*Healthcare in Personal Injury Schemes. Summary of preliminary findings for NSW Workers Compensation and Compulsory Third Party schemes*'; State Insurance Regulatory Authority;11 September 2019.

[25] Eg. In SA, allied health providers are not required to be approved by RTWSA. In QLD, Counsellors are not approved allied health providers, and treatment is considered on a case by case basis; https://www.worksafe.qld.gov.au/service-providers/allied-health-providers

- A comparison of some services provided across all jurisdictions is outlined below. As there is a large variation between service descriptions across jurisdictions, best match codes and descriptions have been used. See table below:

icare submits that injured workers should be encouraged to return to health, function and work faster by applying more stringent controls to:

- the types of providers working within the scheme;
- accreditation, training and ongoing governance of healthcare providers in the scheme;
- the services that attract payment, and in what combinations; and
- the expected outcomes of treatment,

Pre-approval of Treatment – Workers Compensation

The NSW workers compensation scheme offers a number of treatments and services that do not require pre-approval from the insurer. As an example, up to eight allied health consultations delivered by the same practitioner for continuing treatment within three months of the date of injury do not require pre-approval from the insurer.[26]

Standards for pre- approval of treatment varies across jurisdictions. For example, Queensland only allows pre-approval of the initial physiotherapy consultation[27] and Comcare only allows five sessions of physiotherapy, before a Treatment Notification Plan is required for approval.[28]

Conservatively, if each injured worker managed by icare was to use all of their pre-approved physiotherapy sessions, this would translate into 180,000 additional sessions more than what is allowable under Comcare and would contribute an additional $4.88 million to annual medical expenditure (based on 60 000 claims per year)[29].

It is unclear how the number of pre-approved sessions has been determined in each jurisdiction, or in NSW.

By reducing the pre-approved sessions in NSW to five (in line with some of the other jurisdictions), a request for further treatment with justification would be required of the allied health provider. This would provide greater rigour in the approval process and facilitate a move toward value-based care, without unduly delaying treatment for the injured worker.

SIRA should also give consideration to tightening the framework around pre-approvals for investigations. For example, reducing the pre-approved timeframes for MRIs, ultrasounds and CT scans from the current three months to two weeks from date of injury would enable better operational control of imaging requests which are more likely to be related to the injury as well as ensure there is appropriate clinical justification for investigations (noting that those requests submitted after the two week period expires can still be approved by the insurer if they are medically indicated).

Table 3: Physiotherapy and psychology fee comparison across jurisdictions

	NSW	Comcare	Victoria	SA	QLD	WA
Physiotherapy	$81.40/session	Rates align with each state; ACT rate - $80.46/sessions	$58.33/session	$68/session	$77/session	$69.30/session
Psychology	$190.80/hr	$218.00/hr	$170.76/hr	$185.40/hr	$183/hr	$249.25/hr

26 *'Part 4.2 Determining Reasonably Necessary, from Workers compensation guidelines'*; https://www.sira.nsw.gov.au/workers-compensation-claims-guide/legislation-and-regulatory-instruments/guidelines/workers-compensation-guidelines#part

27 Physiotherapy table of costs, effective 1 July 2019, WorkCover Queensland; https://www.worksafe.qld.gov.au/__data/assets/pdf_file/0010/178084/2019-Physiotherapy-table-of-costs.pdf;

28 Physiotherapy policy, Comcare; 4 April 2014; https://www.comcare.gov.au/claims_and_benefits/medical_treatment/medical_practitioners/clinical_policies/pysiotherapy_policy,

29 This has been calculated by using the physiotherapy standard treatment and consultation rate of $81.40 as specified in Schedule A of the Government Gazette No 138 of Friday 14 December 2018: https://www.sira.nsw.gov.au/__data/assets/pdf_file/0008/435905/Workers-Compensation-Physiotherapy,-Chiropractor,-Osteopathy-Fees-Order-2019.pdf

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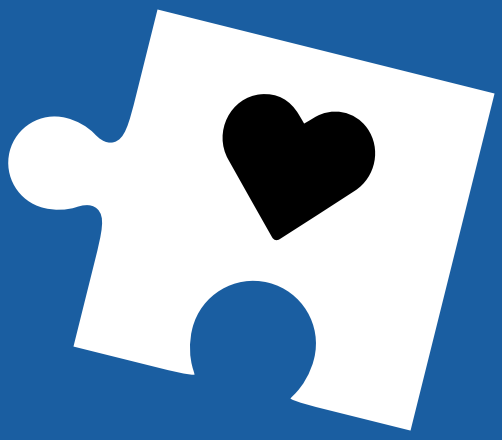

Recommendation 2

Replace the "Reasonably necessary" test

Under Section 60 of the *Workers Compensation Act 1987*[1], medical treatment must be seen to be "reasonably necessary", which is one of the many factors limiting the NSW workers compensation scheme from implementing value-based care.[2].

icare believes:

- the "reasonably necessary" test requires more rigour, as it allows all manner of treatments to be approved (including those considered as being of low value or potentially harmful). This has contributed to the increased medical spend, and persistent non-improvement in patient outcomes. A review of case law relating to 'reasonably necessary' treatment supports this.
- the *Workers Compensation Guidelines' (October 2019)*[3] expanded list of pre-approved medical treatments has relaxed the 'reasonably necessary' test even further, with workers able to access services and incidental expenses with limited scope for denial under the legislation. In fact, icare has seen instances where workers were told they were 'entitled' to pre-approved allied health services.
- These changes have a direct impact on the increase in medical expenditure. As an example, if every claim managed by icare as the Nominal Insurer, used the allowable $110 per claim for reasonable incidental expenses (such as strapping tape, TheraBand, exercise putty, disposable electrodes and walking sticks), this would add an additional $6.6 million to annual medical expenditure (based on 60,000 claims per year). If applied across all NSW workers compensation claims, this figure alone would exceed $10 million.

In "A Best Practice Workers Compensation Scheme'[4] paper published in May 2015, the Insurance Council of Australia submitted that:

"A best practice scheme will provide medical and other treatment that is 'reasonable and necessary', with payments made as costs are incurred. This definition has established jurisprudence. Treatments will include doctor visits, physiotherapy, surgery, other hospital, pharmaceuticals, prostheses, occupational therapy, vocational rehabilitation and associated travel."

It is well-established in case law that the 'reasonable and necessary' test is more demanding than the 'reasonably necessary' test.[5] In *State Super SAS Trustee Corp Ltd v Perrin*[6], the Court of Appeal held that the 'reasonably necessary' standard did not require absolute necessity for surgery proposed. The adverb 'reasonably' modified the strictness of what was 'necessary'.

icare submits that, in order to manage medical treatments and escalating costs, and to be able to deliver value-based care in the NSW workers compensation system, consideration should be given to legislative amendment of the test for approval of medical treatment and expenses, from "reasonably necessary" to another definition that supports value-based care. An example may be "reasonable and necessary", as is applied in the *Motor Accident (Lifetime Care and Support) Act 2006 and adopted in the Motor Accidents Injuries Act 2017*.

This test ensures not only that the services requested are well supported, but also that the criteria for approval weeds out unnecessary and excessive requests. This more demanding test is used by Lifetime Care and Support and the National Disability Insurance Scheme (NDIS). The principles require the treatment to be aligned to meeting a certain outcome or goal, which is something the existing NSW workers compensation test does not have.

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1 Workers Compensation Act 1987 No 70 [NSW]

2 Proposed Customer Service Conduct Principles Submission; icare; 15 August 2019 –page 4

3 '*Workers Compensation Guidelines, Requirements for insurers, workers employers and other stakeholders*'; State Insurance Regulatory Authority, October 2019; Table 4.1; https://www.sira.nsw.gov.au/workers-compensation-claims-guide/legislation-and-regulatory-instruments/guidelines/workers-compensation-guidelines

4 *'A Best Practice Workers Compensation Scheme*'; Insurance Council of Australia published in May 2015 https://www.insurancecouncil.com.au/issue-submissions/reports/best-practice-workers-compensation-scheme

5 *Diab v NRMA Ltd* [2014] NSWWCCPD 72, *Watson's Culcairn Hotel Pty Ltd v Dwyer* [2016]

6 *State Super SAS Trustee Corporation Ltd v Perrin [2016] NSWCA 232*

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Recommendation 3

Introduce a robust clinical governance framework

Governance of Healthcare Providers

According to the Australian Council on Healthcare Standards, clinical governance is defined as "the system by which the governing body, managers, clinicians and staff share the accountability for the quality of care, continuously improving, minimising risks, and fostering an environment of excellence in care for consumers/patients and residents".[1]

The goal of a clinical governance framework is to drive individual and organisational behaviour, that leads to better patient and clinical care. The framework needs to include principles to ensure high standards of clinical performance, clinical risk management, clinical audit, ongoing professional development and well-developed processes.

To date, SIRA has published the Workers compensation guide for medical practitioners[2] in the workers compensation system, and some supporting material for allied health providers titled Clinical framework for the delivery of health services[3].

icare believes that SIRA needs to implement a more robust clinical governance framework to protect the safety of individuals within both the NSW workers compensation and CTP schemes.

At an organisational level, icare believes that healthcare provider practices/organisations should be responsible for:

- credentialing and defining scope of clinical practice
- clinical education and training
- performance monitoring and management
- whole-of-organisation clinical, and safety and quality education and training.

At an individual level, icare believes that any clinician providing services should be required to:

- maintain, where appropriate, unconditional health professional registration;
- maintain personal professional skills, competence and performance;
- comply with professional regulatory requirements and codes of conduct; and,
- monitor personal clinical performance.

Assessing clinical performance should be routinely undertaken to review safety and quality of care. Measures should include:

- compliance with legislative, regulatory and policy requirements;
- process indicators that have supporting evidence to link them to outcomes; and,
- indicators of outcomes of care including patient reported outcome and experience measures.

A core set of measures should be developed that includes qualitative and quantitative data, that provide timely and accurate information regarding organisational safety and performance. Data integrity should be tested, and tools set up and used to recognise both good performance and under-performance.

icare believes the Australian Commission on Safety and Quality and Health Care's *Australian safety and quality framework*[4] should be used by healthcare providers in the NSW personal injury schemes, as it references key components required to achieve optimal outcomes and value-based care of injured people.

Another suggested resource is the *Clinical framework for the delivery of health services,*[5] developed by the Transport Accident Commission (TAC) and the Victorian WorkCover Authority. This framework is an evidence-based guide designed to support healthcare providers delivering services to people with workers compensation injuries. It is endorsed by other States and Territories, and has been supported by WorkCover NSW in the past.

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1 The Australian Council of Healthcare Standards; https://www.achs.org.au/

2 'Workers compensation guides for medical practitioners'; State Insurance Regulatory Authority; https://www.sira.nsw.gov.au/resources-library/workers-compensation-resources/publications/health-professionals-for-workers-compensation/sira-nsw-medical-guide

3 '*Medical and related services*'; State Insurance Regulatory Authority; https://www.sira.nsw.gov.au/workers-compensation-claims-guide/insurer-guidance/medical-and-related-services/allied-health-practitioners

4 'Australian Safety and Quality Framework for Health Care'; Australian Commission on Safety and Quality in Health Care; https://www.safetyandquality.gov.au/sites/default/files/migrated/ASQFHC-Guide-Healthcare-team.pdf

5 'Clinical Framework for the Delivery of Health Services'; WorkSafe Victoria; https://www.workcover.wa.gov.au/wp-content/uploads/2014/Documents/Health%20providers/Publication_Clinical-Framework-for-the-Delivery-of-Health-Services.pdf

Accreditation and Training of Allied Health Providers – Workers Compensation

Some allied health providers must be approved by SIRA before providing services under the NSW workers compensation system, including training and a commitment to the requirements set out in SIRA's *Guideline for approval of treating allied health practitioners*[6].

However, other than the one-off training program, there is no further monitoring or review conducted by SIRA, nor a clinical framework outlining the principles expected of allied health providers dealing with injured workers.

The accreditation and training of healthcare providers mandated in other Australian jurisdictions are almost universally more stringent than the demands in NSW (Appendix D).

By addressing the accreditation and training of allied health providers, icare believes that better operational controls can be realised across the NSW workers compensation system, enabling the delivery of value-based care.

Clinical Governance

A Clinical Governance framework provides a set of domains governing the provision of safe, reliable and effective clinical services. One of those domains is Clinical Performance and Effectiveness, where health service providers are required to have the right qualifications, skills, experience and supervision to provide safe, high-quality clinical services to our customers.

The overall goal of the framework is to improve injury outcomes by:

- establishing measures and data required to monitor the clinical safety and quality of care provided through personal injury schemes;
- providing guidance on escalations that occur from monitoring activities; and
- implementing measures to ensure the reliability, safety and effectiveness of clinical service delivery.

From 1 July 2019, SIRA has also published details of scheme and insurer performance and commenced publication of compliance and enforcement activity. However, from a healthcare perspective, this list does not name healthcare providers and does not go into specific detail on compliance.

Again, whilst this regulatory activity and transparency of activity is useful, the information reported does not provide the level of detail required by scheme agents or other insurers to take the necessary actions to address breaches at an operational level. In order to effect change as a result of publishing this work, there may be benefit in SIRA providing each insurer (as the ones paying for services), detail of any regulatory/ enforcement activity they undertake with respect to healthcare providers.

Clinical Safety

Healthcare providers are required to work within a framework of clinical safety and quality within the health system. However, the same expectations are not extended to practitioners in the NSW personal injury schemes.

icare believes that a framework for governance of clinical safety can be developed by SIRA by examining the Australian Safety and Quality Framework (endorsed in 2010) developed by the Australian Commission on Safety and Quality and Health Care.

The Australian Commission on Safety and Quality and Health Care has also developed guidelines, titled "Credentialing health practitioners and defining their scope of clinical practice", of which the principles and processes identified in the guide can be applied to any healthcare providers where credentialing processes are required by a jurisdiction or health service organisation.[7]

In addition, NSW Health currently has in place the "NSW Patient Safety and Clinical Quality Program" (scheduled for review in December 2019). This initiative is designed to support clinicians and managers with improving quality and safety for patients and will focus on promoting and providing the delivery of the best care in health services.[8]

icare believes that SIRA can leverage the work of NSW Health to develop its own clinical safety program.

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6 'Guidelines for the approval of treating allied health practitioners 2016 No 2'; State Insurance Regulatory Authority; https://www.sira.nsw.gov.au/workers-compensation-claims-guide/legislation-and-regulatory-instruments/guidelines/guidelines-for-the-approval-of-treating-allied-health-practitioners-2016-no-2

7 '*Credentialing health practitioners and defining their scope of clinical practice: a guide for managers and practitioners*'; Australian Commission on Safety and Quality in Health Care; December 2015; https://www.safetyandquality.gov.au/sites/default/files/migrated/Credentialing-health-practitioners-and-defining-their-scope-of-clinical-practice-A-guide-for-managers-and-practitioners-December-2015.docx; accessed 12/10/2019

8 '*Patient Safety and Clinical Quality Program*'; Secretary, NSW Health; 26 July 2005; https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2005_608.pdf, pp1, 2. NSW Health, 2005; accessed 12/10/2019

Transparent performance monitoring and reporting

Provider watchlist

From 2011 to 2015, WorkCover NSW provided a service where practitioners with suspended, cancelled or conditional registrations in NSW were publicly identified for the benefit of insurers and other stakeholders in the NSW workers compensation scheme. After SIRA was established under the *State Insurance and Care Governance Act 2015*, it continued to provide and publish this list until July 2016.

Publication of the list ceased in July 2016. A SIRA Bulletin was issued that indicated insurers should ensure they have good claims management practices in place to identify practitioners not appropriately registered or accredited.

Given the value that knowledge of deregistered or discredited practitioners will have across all NSW personal injury schemes, icare recommends this service be recommenced by SIRA as a centralised benefit for all stakeholders. This dissemination of information, (such as date of and reason for deregistration or suspension and other key details) will contribute to the quality of care that is provided to injured people, and will ensure the focus is on recovery, not administration.

Performance Monitoring

icare has previously submitted the following arguments to SIRA[9] regarding customer service conduct principles:

- While icare can undertake some investigation into healthcare providers who have been reported as delivering inappropriate or inconsistent care, Guidelines issued by SIRA across the NSW insurance schemes do not allow for any meaningful clinical governance of healthcare providers.
- The lack of clinical governance mechanisms to manage those who are considered poor performers may result in potential harm to injured workers and adverse health outcomes.
- Further action is needed from SIRA, as the regulator and accreditor of certain healthcare providers, for the management of health care providers, particularly those that under-perform.

icare provided its view on the appointment and reappointment of authorised practitioners, and the proposed terms of appointment. While the submission is in respect of the proposed Injury Management Consultant approval and regulatory framework, the feedback therein is valid for other healthcare providers working within the system. (Appendix B)

Clearly Defined Roles and Accountability around Provider Management

The role of the Australian Health Practitioner Regulation Agency (AHPRA) [10] is separate to SIRA. Complaints about practitioners are reported to, and investigated by, the Healthcare Complaints Commission (HCCC). The HCCC liaise with AHPRA to publish on their website any restrictions or notations on a practitioner's registration. The HCCC has a Complaints Management Framework, under which they will listen to concerns raised by people, and respond to complaints promptly, empathetically and fairly. The HCCC will deal with concerns raised when:

- a practitioner's behaviour places the public at risk;
- a practitioner is practising their profession in an unsafe way; or
- a practitioner's ability to make safe judgements about their patients might be impaired because of their health.

There is no indication on either SIRA's, the HCCC's or AHPRA's website that they liaise with each other if a complaint is raised with any party. There is also no detail as to what the process is after a complaint has been lodged and who is informed.

In its paper titled *A best practice workers compensation scheme May 2015*[11], the Insurance Council of Australia (ICA) indicated that managing providers, authorising them and monitoring their performance and effectiveness can only be done at a macro level (whole of scheme) and is the responsibility of the Scheme regulator. If concerns are raised about the quality of practice of a service provider (such as over-servicing, or biased reports) the scheme regulator should use this information, along with practice peer reviews, to assess the service provider's practices. The scheme regulator may counsel the provider, initiate a complaint to the relevant professional body, and/or prevent that provider from operating in the scheme.

9 Proposed Customer Service Conduct Principles Submission; icare; 15 August 2019
10 Australian Health Practitioner Regulation Agency; 18 November 2019;https://www.ahpra.gov.au/
11 'A best practice workers compensation scheme'; Insurance Council of Australia, 21 May 2015; Finity Consulting Pty Ltd; https://www.insurancecouncil.com.au/issue-submissions/reports/best-practice-workers-compensation-scheme

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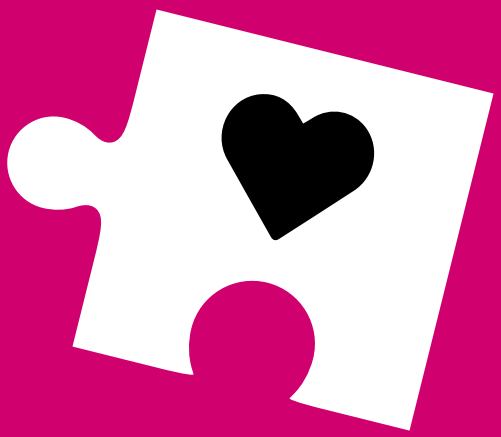

Recommendation 4

Introduce additional guidelines, and strengthen those which currently exist

icare already provides training to case managers in NSW workers compensation, Lifetime Care and Dust Diseases Care. Agreements are in place with scheme agents in the workers compensation scheme to ensure insurance services provided are consistent with achieving best health and return to work outcomes.

However, icare submits that there is a need for more robust treatment guidelines and in some instances, policies, to enable stakeholders to understand treatment pathways. Such guidelines are a good opportunity for SIRA to help regulate and make the NSW personal injury schemes consistent in their approach to managing injuries (many of which are the same across the schemes). Further, having strong guidelines in place will set up clear expectations of care to be provided and will help achieve the strategic goals of value-based care by ensuring only the care that is necessary and cost-effective is approved.[1] An understanding of the different schemes' strengths and weaknesses will also be required.[2] They will also contribute towards the framework required to assist with monitoring the performance of service providers operating within the scheme.

Policies and Guidelines to assist treating providers with determining evidence-based treatment

The current NSW workers compensation system allows for provision of low value care services, irrespective of the needs of the injured worker. Low value care is a clinical intervention where evidence suggests it offers no or very little benefit for patients, where the cost or the risk of harm exceeds the likely benefit.[3] Implementation of more robust guidelines, can help reduce the incidence of delivery of low value care.

Other jurisdictions in Australia, such as WorkSafe Victoria, have a combination of policies and guidelines[4] which are evidence based, easy to read, and easy to follow.

One such example is a pharmacy policy.

At present, the NSW Workers Compensation scheme does not have a general policy on the payment of pharmaceutical items. This is in contrast with WorkSafe Victoria, Comcare and WorkCover WA.

WorkSafe Victoria has six pharmaceutical-related policies which:

- define relevant pharmacy medications
- stipulate what can and cannot be paid for
- explain the requirement to prescribe under the Pharmaceutical Benefits Scheme (PBS) where available
- outline what information the agent needs to make a decision
- identify mark up and dispensing fees for non-PBS items
- define the restrictions around prescribing certain medications
- detail invoicing requirements.

According to the six WorkSafe Victoria policies,[5] medication must be registered in the Australian Register of Therapeutic Goods and provided in accordance with the PBS where clinically appropriate and available. Non-PBS medication will only be approved if it is deemed clinically appropriate and there are no alternatives available on the PBS.

Likewise, Comcare and WorkCover WA will only pay for non-PBS (privately prescribed) medications if there is no readily available alternative on the PBS. Additionally, where a medical practitioner or dentist prescribes a dosage over the PBS limit for prescribed medications, an authority from Medicare Australia is required.

WorkSafe Victoria and Comcare also set caps on non-PBS items (where a PBS equivalent is not readily available). WorkSafe Victoria will

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1 According to Finity, best practice workers compensation insurance schemes need to have guidelines in place, even if just for the most common injuries. Doing so sets clear expectations around which treatments are value based, low value, or potentially harmful, based upon the type of injury, and what the expected recovery timeframe should be: A best practice workers compensation scheme, Insurance Council of Australia, May 2015 Atkins, G and Robinson, F on behalf of Finity. Accessed 10/10/2019

2 George, K., Walls, M; '*Workers Compensation Treatment Guidelines: Obstacles and Opportunities*';. April 2017; https://www.irmi.com/articles/expert-commentary/workers-compensation-treatment-guidelines; accessed 10/10/2019

3 Badgery-Parker, T., Pearson, S., Chalmers K, et al; '*Low-value care in Australian public hospitals: prevalence and trends over time*'; BMJ Quality & Safety 2019;28:205-214.

4 WorkSafe Victoria; Information for Providers; https://www.worksafe.vic.gov.au/information-for-providers

5 These guidelines are: General pharmacy policy, Drugs of Dependence (Schedule 8 and Schedule 4 medications), Erectile Dysfunction, Glucosamine, Sedatives and Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

pay the wholesale cost of the non-PBS medication plus one of three set mark-up fees (depending on the cost of the item) and a set dispensing fee. Comcare will pay "a maximum mark-up of the wholesale price of up to 25 per cent plus the standard dispensing fee".

A specific pharmacy policy would benefit the NSW scheme by:

- Clearly stating the use of PBS prescriptions as the default within the workers compensation scheme (while still requiring pre-approval for certain medications);
- Outlining the circumstances in which private scripts are/are not acceptable, including the need for clinical justification if requested;
- Outlining the circumstances in which over-the-counter and complementary medicines could be paid for; and,
- Applying controls to the prescription and use of drugs of dependence.

Additionally, a clinical guidance policy for allied health providers in NSW would benefit the personal injury scheme by:

- emphasising an evidence-based, goal-oriented and outcomes-focused approach that would provide improved guidance to allied health practitioners, as well as assist case managers with decision making on treatment requests.
- including, for example, the use of standardised outcome measures to monitor and report on progress, as well as emphasising self-management and functional independence for the injured person.
- Consideration could also be given to an initial treatment plan that outlines the entire proposed management program, with justification required if there is requirement to extend the treatment plan.

Finally, there is also a need to provide guidance or policy material specific to new or novel treatments. Novel chronic pain treatments such as medicinal cannabis, ketamine infusions and scrambler therapy are more frequently being requested in NSW workers compensation without guidance as to how to best manage these requests.

Given the pace at which healthcare continues to move forward, and the new technologies available, having a policy that manages such treatments would be beneficial as guidance to those working in the scheme, particularly with regard to whether or not these treatments fall under the definition of *'reasonably necessary'.*

Rather than create their own guides or guidelines, SIRA may have an opportunity to leverage these existing guidelines to help with building healthcare literacy in the NSW personal injury schemes.[6]

SIRA could also utilise the following resources:

- Source a selection of the 42,000 clinical practice guidelines[7], systematic reviews and clinical trials already available.
- Select guidelines from a central source such as the National Institute for Health and Care Excellence (https://www.nice.org.uk/process/pmg20/chapter/introduction-and-overview).
- Use 'Choosing Wisely' information (http://www.choosingwisely.org.au/home#clinicians).

Additionally, part of the challenge currently faced by the NSW workers compensation scheme is how providers, insurers, and, more broadly the compensation scheme, define 'best outcomes'. SIRA could use the Guidelines to define 'best outcomes', from the perspective of the injured worker, as well as from a cost and return on investment perspective, hence enabling a common view of the ultimate goal among all stakeholders.

The challenge, however, will be around how to encourage (or potentially mandate) healthcare providers to apply such guidelines. A more robust provider accreditation and governance framework, including a strong provider management approach, may assist with this.

Guidelines to assist case managers with treatment approval

From a claims management perspective, workers compensation legislation gives insurers 21 days

6 Similarly to the *Clinical Framework for the Delivery of Health Services*, which was originally developed by the Transport Accident Commission and WorkSafe Victoria: *Workers compensation guide for allied health practitioners*, SIRA https://www.sira.nsw.gov.au/resources-library/workers-compensation-resources/publications/health-professionals-for-workers-compensation/workers-compensation-guide-for-allied-health-practitioners, accessed 10/10/2019

7 Zadro, J., O'Keeffe, M., Maher, C; '*Do physical therapists follow evidence-based guidelines when managing musculoskeletal conditions?*' BMJ Open; 2019

after receiving a request to make treatment approval decisions; or five days for requests for further allied health treatments within three months of the injury.[8] In the latter circumstance, failure to respond to the request is considered approval.

SIRA's Standard of Practice[9] (S.4 Liability for medical or related treatment and S.15 Approval and payment of medical, hospital and rehabilitation services) is not specific around the expectations relating to instances where determining treatment approval may require longer than 21 days. icare is concerned that this lack of clarity can lead to insurers having no other option other than to approve (or outright decline, even when not indicated) treatment – or, risk being in breach of the legislation.

Not only do these practices undermine achievement of best outcomes for the injured worker, it may also lead to inconsistent decisions, which is contrary to the concept that injured workers and advocates need to have reasonable expectations of how the scheme will deal with them.[10]

In addition, in some cases, further investigation and research is required to determine if treatment does meet the 'reasonably necessary' criteria for approval. Unfortunately, there will be times when this can take longer than the allocated 21 days. Some examples of this occurring include:

- If a case manager asks a provider for more information on what the treatment is and how it is expected to support the injured worker's recovery and return to work goals, and the provider does not respond, a case manager may be required to approve the request by default to prevent exceeding the 21-day timeframe, or must give notice under section 78 of the *Workplace Injury Management and Workers Compensation Act 1998*[11].
- If an independent medical examination is required, injured workers are entitled to 10 days' notice of the examination, the case manager requires time to articulate the questions they require the examination to answer, and the examiner requires time to formulate a response to the questions.
- Extra ordinary circumstances where a provider that is not covered by SIRA accreditation protocols is identified as offering a service that would deliver 'best outcomes' for the injured person and the scheme in that instance.

SIRA's Standard of Practice S.15 (Approval and payment of medical, hospital and rehabilitation services) recommends using the principles of the Transport Accident Commission and Worksafe Victoria for the active management of providers, to ensure services will benefit the injured worker. However, there are no consequences for provider's recommending treatments that do not meet the principles (which highlights the need for better controls and governance in the provision of health care).

Operationalisation of policies and guidelines

A key to successfully implementing value-based care in NSW workers compensation relies upon the operationalisation of policies and guidelines. Guidelines which clearly indicate the expectations of providers and how they may enact their responsibilities will ensure consistency in service delivery. One good example of operationalisation of guidelines is the Certificate of Capacity (CoC).

Certificate of Capacity – Workers Compensation

Apart from Western Australia and NSW, other jurisdictions all allow health providers other than the medical practitioner to complete the CoC:

- Under the national Comcare program, if treatment for an injury is provided solely by an occupational therapist, chiropractor, dentist, optometrist, physiotherapist or massage therapist, that provider can complete and submit the certificate.[12]
- In South Australia, nurse practitioners can fill out a shortened version of the Certificate, with a reduced number of days the certificate remains valid.[13]

8 SIRA Standards of Practice, Appendix 2; https://www.sira.nsw.gov.au/resources-library/workers-compensation-resources/publications/workers-and-claims/standards-of-practice/appendix-2-practice-guidance-pre-approval-of-treatment
9 SIRA Standards of Practice; 21 October 2019;https://www.sira.nsw.gov.au/workers-compensation-claims-guide/legislation-and-regulatory-instruments/other-instruments/standards-of-practice
10 A Best Practice Workers Compensation Scheme (May 2015) Insurance Council of Australia (page 40)
11 Workplace Injury Management and Workers Compensation Act 1998 – Sec 78 Insurer to give notice of decisions; Austlii; http://www8.austlii.edu.au/cgi-bin/viewdoc/au/legis/nsw/consol_act/wimawca1998540/s78.html
12 Australian Government Comcare; www.comcare.gov.au
13 Return to Work SA; www.rtwsa.com

- In Queensland, doctors, dentists and nurse practitioners can complete the certificate.[14]
- In Victoria, registered chiropractors, osteopaths and physiotherapists can write a subsequent (not initial) certificates for a maximum of 28 days; the initial certificate, however, must be completed by a Medical Practitioner.[15]

In addition to limited providers being able to complete the CoC, the various channels within which to deliver a CoC can cause unnecessary delays in providing the worker with the treatment and services they require. In 2018, icare piloted an electronic transfer of the NSW Certificate of Capacity into the claims teams, to assist with more efficient, consistent and timely transfer of information.

Based upon the key learnings from the pilot and consideration of existing practices within other jurisdictions, icare suggests the following:

- In the interests of efficiency, the initial CoC to be completed by the Nominated Treating Doctor (NTD) however, subsequent certificates could be completed by:
    a. An allied health provider active in the injured worker's care with the proper accreditation by SIRA. This may potentially result in a certificate that outlines more function-related capacity decisions or
    b. A nurse practitioner in the practice, who is accredited by SIRA, following a review by the NTD, and thereby alleviating the administrative burden on the NTD and allowing the NTD to deliver optimal care.
- Introduce an electronic CoC, to be integrated into the medical practitioner's practice management software with the capacity to:
    a. Digitise/pre-fill forms such that predicative search text is enabled for the clinical diagnosis, injury/disease (ICD-10) coding is entered at a granular level, patient consent is digitised, and information is pre-populated from the practice systems of the NTD;
    b. Optimise back-end processing where digital submissions are electronically sent to all recipients at the same time, including the icare system;
    c. Utilise a "Smartform" to optimise the completion of the form with a "branched" question design and suggested options for the NTD to provide better quality information. There will need to be full integration between the NTD and icare systems;
    d. Allow for 'pop-up' hover items to assist healthcare providers in filling out the form, such as reminding them that medications can be prescribed under PBS;
    e. Add additional boxes to capture pertinent information such as the dose and frequency of prescribed medication.

Furthermore, consideration is to be given into electronic methods for submitting other forms such as Allied Health Recovery Requests would also be advantageous in enhancing scheme efficiency and visibility of services being requested and provided to claimants.

We therefore believe that the development of consistent, clear operational Guidelines, which indicate the processes, and key responsibilities of different health care providers around certification and service provision, will assist with the delivery of value-based care for the scheme.

14 '*Work capacity certificates*'; WorkCover Queensland; 7 March 2018; https://www.worksafe.qld.gov.au/service-providers/medical-services/certificates

15 '*Certificate of Capacity for health providers*'; WorkSafe Victoria; https://www.worksafe.vic.gov.au/certificate-capacity-health-providers

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Recommendation 5

Improve Healthcare Data and Coding

icare's ability to understand the nature and magnitude of injuries in the workers compensation system is impacted by the quality of data it receives, which in turn affects its ability to support value-based care.

Data systems

The coding used for reporting within the NSW workers compensation system is insurer-related coding, rather than health-related coding.

NSW Workers Compensation currently uses the Australian Types of Occurrence Classification System (TOOCS) to code workers' injuries, which is a requirement under a national agreement that all Australians jurisdictions use for workers compensation data.

However, the TOOCS system lacks the clarity, granularity and currency needed to support icare's needs into the future. icare's reporting to SIRA is based on TOOCS.

An alternative is the International Classification of Disease (ICD) coding system, developed by the World Health Organisation (WHO), and is used by all health systems in Australia and internationally, except workers compensation schemes.

It is noted that the coding used in the Compulsory Third Party (CTP) scheme uses another separate system, known as the Abbreviated Injury Scale coding. Having such vast differences in coding, and the lack of consistency in reporting across the NSW personal injury schemes, makes it more difficult than necessary to achieve best outcomes for injured people of NSW.

Merits of ICD

ICD-10 has been translated into more than 40 languages and is used by most WHO member countries to report mortality data. The current Australian Modification (ICD-10-AM) is updated on a regular basis to ensure it remains current for Australian clinical practice and to incorporate regular updates of ICD.

ICD-10 contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease. Whilst still capturing the same data as TOOCS, ICD-10 provide more specific clinical data.

Using ICD-10 coding will increase the scheme's ability to substantiate the medical necessity of diagnostic and therapeutic services, and enable comparison of data and injury types across the Australian and international healthcare sectors.

ICD allows for[1]:

- easy storage, retrieval and analysis of health information for evidenced-based decision-making;
- sharing and comparing health information between hospitals, regions, settings and countries; and,
- data comparisons in the same location across different time periods.

icare has adopted the use of ICD-10 coding to assist with triage, approvals and data analysis of claims being managed by icare, as the Nominal insurer. In order to support implementation of this coding, icare was readily able to develop natural language to ICD-10 mapping as well TOOCS to ICD-10 mapping, ensuring case manager and other non-clinical staff could easily implement this coding system with minimal training.

We acknowledge that ICD-11 has recently been released, but is not currently used by the wider Australian healthcare system.

icare believes that SIRA should consider transitioning data coding requirements to ICD-10 to allow for better identification of the nature and magnitude of injuries and to help put in place the procedures and treatments that support best practice.

Pharmacy Coding

icare currently has little information about the medications used by injured workers, as a single code, PHS001, is used for all pharmacy costs incurred by the NSW workers compensation system. Although icare can determine how much is spent on pharmaceuticals per claim, there is no way of knowing what medications or pharmacy items are prescribed on any particular claim, against any specific injury types, or whether the pharmacy items are related to a primary or secondary injury.

This makes it difficult to identify overall trends in prescriptions for injured workers at a scheme level, and identify whether workers are being prescribed inappropriate medications or those with addictive properties.

The scheme is currently:

- unable to use or access data on medication dispensing to help address the issue of opioid (or other drugs of dependence) prescription and use
- unable to confirm the prices we pay for pharmacy items are equivalent to prices paid for the same pharmacy items outside the scheme

1 '*Classifications*'; World Health Organisation; 2019; http://www.who.int/classifications/icd/en/; accessed: 24/10/2019

- unable to monitor the rate of dispensing of particular medications by pharmacists, and indirectly monitor inappropriate prescribing behaviours by doctors.

Further detail on the merits of defining a pharmacy policy are outlined in *Recommendation 1 – Address fee schedules and indexation*.

Hospital Coding

Across all NSW personal injury schemes, there is a lack of specificity in the current payment codes that prevents deeper insight into what is occurring before, during and after an injured person's hospital stay. In order for icare to monitor compliance and understand whether the services provided, and payments made are accurate and necessary, further medical information is required.

Under the Private Health legislation,[2] private and public hospitals are required to provide Hospital Casemix Protocol (HCP) data to private health insurers, and private hospitals are also required to provide data to the Federal Department of Health. The data is to be supplied monthly, within six weeks from the end of each month.

Overall, there are 115 individual data points that can be obtained from the HCP dataset. Of these, only 36 data points can be obtained from either Claims Data Repository (CDR) or invoices. For the remaining 79 data points, 23 may have significant implications for healthcare insights and operational control.

At an individual patient level, HCP data will enable:

- Assessment of injury complexity
- Identification of additional diagnoses not captured in CDR
- Identification of delays between injury occurrence and hospital treatment
- Procedures to be made in accordance with the relevant ICD10 code
- Determination of surgery duration, to check that invoices are accurate
- Identification of a pattern of care – source of admission and mode of discharge (particularly public to private hospital referrals), additional surgery as inpatient and readmission within 28 days of ICU admission (in public hospitals).

At a wider level, HCP data will allow:

- Determination of overall appropriateness of invoicing, and identification of patterns of when/where invoicing may be incorrect
- Determination of whether any additional charges are occurring for pharmacy/aids while injured people are in hospital
- Checking that MBS item numbers are matching up to correct AMA codes
- Breakdown of services by hospital provider number to determine any patterns of treatment.

icare submits that SIRA should mandate the collection of HCP data from hospitals within the NSW workers compensation system; and share relevant data with insurers.

We note that section 40B of the *Workplace Injury Management and Workers Compensation Act 1998* allows SIRA to collect data from hospitals, including HCP data, that relates to claims for workers compensation, and to exchange that data with icare.

The HCP dataset will help ease pain points within the scheme, particularly in relation to the following:

- *Identity of the hospital providing the service* – icare is currently unable to determine what hospital a surgery occurs in, and subsequently is unable to identify spend or service trends. Currently icare receives ABN details from hospitals, which are often related to an overall parent company, such as Healthscope or Ramsay Health, and which provides no detail about the particular hospital in which a service occurred.
- *Length of stay* – There is no data capture point for the hospital discharge date, therefore length of stay can only be ascertained by looking at the invoiced fees. This can be complicated when invoiced charges are based on partial days, there are multiple gazetted fees for one service code, or the gazetted fee changes for an extended stay.
- *Prostheses* – While there is a specific code to capture surgical prostheses in private hospitals (PTH009; from 1 Jan 2019), there is still no further clarity as to what prostheses are being used, whether they are appropriate, and if they are being charged at the correct rate.
- *Anaesthetist fees* – icare currently receives invoices from anaesthetists that are based on surgery duration and comorbidity multipliers, meaning we have no insight into whether invoiced anaesthetist fees are correct.

[2] Private Health Insurance Act 2007; Private Health Insurance Act (Health Insurance Business) Rules 2019; Private Health Insurance (Data Provision) Rules 2019

- *Surgery duration* – There is no data point that captures surgery duration. As such, there is no way of understanding the average surgery time for different procedures, and whether some surgeons are taking substantially longer to do the same procedure as other surgeons.
- *National Weighted Activity Unit (NWAU)* – In order to calculate the cost of public hospital services, the gazetted fees order calls for application of the NWAU. In order to determine whether the NWAU is correct, the Diagnosis Related Group (DRG) is required. There is currently no data capture point in the Claims Technical Manual for DRG.

Patient Reported Measures

Outcomes need to be quantitively and qualitatively measured to ensure performance standards are met. Current measures of outcomes in the NSW workers compensation system are limited to RTW measures and cost of treatment. Within the workers compensation system, icare submits that there is a need to measure outcomes with respect to health (the change in health) and experience (the quality of care).

The Patient Reported Measures (PRMs) Program is part of the NSW Health Integrated Care strategy and can be applied within a State compensation scheme setting. The program aims to "enable patients to provide direct, timely feedback about their health-related outcomes and experiences to drive improvement and integration of healthcare across NSW."[3]

PRMs include:

- Patient-Reported Experience Measures (PREMs) are used to obtain patients' views and observations on aspects of health care services they have received. This includes their views on "the accessibility and physical environment of services…and aspects of the patient-clinician interaction (such as whether the clinician explained procedures clearly or responded to questions in a way that they could understand)".[4]
- Patient-Reported Outcome Measures (PROMs) capture patients' perspectives on how illness or care impacts their health and wellbeing. Standardised and validated tools measure patient outcomes, including quality of life or symptoms related to a specific disease or condition. This information can be used for care planning and decision-making, to provide timely person-centred care and ensure referrals are appropriate and based on identified patient needs.[5]

We know these outcomes are measurable and reportable, with the Australian Bureau of Statistics Patient Experience Survey (PES) using this information to report annually on patient experiences of health care services (in general) in Australia.[6] Further information on the current use of PRMs in Australia, and the information already available for use, is published by the Australian Commission on Safety and Quality in Health Care.[7]

icare submits that using PRMs can help inform and improve the experiences and outcomes of injured workers and motorists in NSW. PRMs will not only help determine and inform the appropriateness and safety of care but can also inform and guide selection of high performing healthcare providers

3 '*Patient reported measures*'; Agency for Clinical Innovation (ACI), 2019; https://www.aci.health.nsw.gov.au/nhn/health-professionals/tools-and-resources/patient-reported-measures;

4 Australia's Health 2018, Chapter 7.17; Australia's health series no. 16. AUS 221. Canberra: by *Australian Institute of Health and Welfare* (AIHW) https://www.aihw.gov.au/getmedia/31d2844d-323e-400a-875e-e9183fafdfad/aihw-aus-221-chapter-7-17.pdf.aspx,

5 '*Patient reported measures*'; Agency for Clinical Innovation (ACI), 2019; https://www.aci.health.nsw.gov.au/nhn/health-professionals/tools-and-resources/patient-reported-measures)

6 Australia's Health 2018, Chapter 7.17; Australia's health series no. 16. AUS 221. Canberra: by *Australian Institute of Health and Welfare* (AIHW) https://www.aihw. gov.au/getmedia/31d2844d-323e-400a-875e-e9183fafdfad/aihw-aus-221-chapter-7-17.pdf.aspx

7 'Patient-reported outcome measures'; Australian Commission on Safety and Quality in Health Care; https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/patient-reported-outcome-measures>

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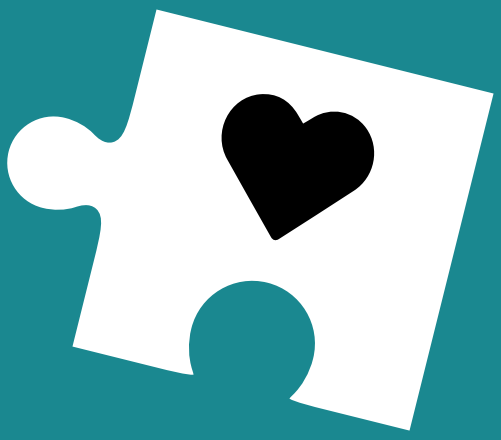

Recommendation 6

Shift to AMA 6 for whole person impairment

Different editions of the American Medical Association's (AMA) *Guides to the Evaluation of Permanent Impairment* are used across personal injury schemes in Australian jurisdictions, with AMA Guides 4th edition (AMA 4) or AMA 5th edition (AMA 5) used in every jurisdiction except the Northern Territory (which uses AMA 6th edition, and AMA 6 in their motor accident compensation scheme[1]). Internationally, variance also exists regarding the edition of the AMA Guides in use. New Zealand, Canada and several countries in Europe currently use AMA 6. States in the US vary in their usage from AMA 3 to AMA 6, with approximately 30% of states currently using AMA 6 to determine permanent impairment.

The levels of whole person impairment in the NSW workers compensation system are currently assessed in accordance with AMA 5.

The AMA 5 Guides attribute greater degrees of impairment for subsequent interventions in the management of an injury, without resulting in functional improvement.

For example, where an injured worker has had surgery to resolve a known injury, AMA 5 requires an assessor to assign a higher impairment rating even though the injured worker has improved post-surgery.[2]

This method of assessment may not result in the best outcome for the injured worker where it is advantageous to present with a higher impairment to access greater entitlements, and may act as a perverse incentive for injured workers to undergo low-value medical treatments in order to reach impairment benchmarks.[3] The ultimate goal should be for all parties to strive for the best health and vocational outcome for the injured worker.

In the CTP and in the Lifetime Care and Support scheme, AMA 4 (with modifications) is used, but they are faced with similar issues when assessing impairment. It is worth noting that while AMA 4 forms the base for WPI assessment, modifications have been drawn from AMA 5.

The more contemporary *American Medical Association's Guides to the Evaluation of Permanent Impairment*, 6th Edition (AMA 6) recognises the issues in AMA 4 and AMA 5, and seeks to align medical treatments with improved patient outcomes rather than increased impairment.

Given the benefits, consideration should now be given to transitioning across to AMA 6 across both NSW personal injury schemes to ensure value-based care principles continue through the life of the claim. Appendix C goes into further detail on why this change is believed to be necessary.

Additionally, in August 2019, the NSW Government endorsed reforms to simplify the dispute resolution system for injured road users and injured workers who make a compensation claim by establishing a single personal injury commission to hear workers compensation and comprehensive third party (CTP) disputes. Given these reforms, it is timely to consider a single methodology for assessing an individual's WPI, aligning the workers compensation and CTP schemes. This will reduce red tape and unnecessary costs as well as align outcomes for the same injury types across both schemes.

1 Ranavaya M, Brigham C, '*International Use of the AMA Guides to the Evaluation of Permanent Impairment; AMA Guides Newsletter*', May/June 2011.

2 Brigham C, Uejo C, McEntire A, Dilbeck L, '*Comparative analysis of AMA Guides ratings by the fourth, fifth, and sixth editions*' AMA Guides Newsletter, January/February 2010.

3 '*Comparative benefits of the Sixth Edition of the AMA Guides for evaluating permanent impairment*'. Submission to State Insurance Regulatory Authority (SIRA) June 2019 icare

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Appendices

Appendix A

Answers to questions raised by SIRA

Matters for Consultation		Response	Reference
	Ensuring best outcomes for injured people		
1.	Do you think that injured people are receiving high quality, evidence-based health care in the personal injury schemes (workers compensation and motor accidents schemes)?	Unfortunately, in the current system, injured people may not be receiving high quality health care.	**Recommendations 1 - 6**
2.	Which issues need to be addressed to ensure injured people receive high quality, evidence-based health care?	The current construct of health care in NSW personal injury schemes financially rewards disability, creating perverse incentives. A holistic review of health care is required to overhaul the way health care is currently delivered, with a shift towards a model of value-based care. High quality, evidence-based health care can be achieved in the workers compensation system by addressing the high fees payable to health providers, adjusting the "reasonably necessary" test along with the method by which whole person impairment is assessed, and improving clinical and regulatory governance in this space. In addition, the collection and collation of data and updating of coding requirements will help improve the quality of care received by injured people in NSW.	**Recommendations 1 - 6**
3.	How can SIRA, insurers and providers help injured workers and motorists access the best outcomes?	Injured workers and those injured on NSW roads can achieve the best outcomes through the delivery of "value-based care" and a robust regulatory regime. In particular, SIRA, insurers and providers can: • align NSW personal injury schemes with the MBS and improve the indexation process; • introduce a "fee for outcome" service; • implement policies to assist in the guidance of medical treatments • enforce stronger governance of health care through legislative reform (eg reasonable and necessary); • adopt a robust clinical framework, including monitoring of provision of health care; • move away from outdated medical guides through the adoption of the AMA 6 for the assessment of permanent impairment; and, • address data and reporting issues by collecting data, improving data reporting requirements, and introducing specific outcome measures for healthcare services in NSW.	**Recommendations 1 - 6**
4.	From your observation, what are some of the reasons for the increase in service utilisation (i.e. the increase in the amount of services each person is receiving)?	Contributing factors may include: • a fee-for-service model in NSW; • the current fee structure, including loadings; • the less onerous "reasonably necessary" test, which allows more treatment to be approved; • limits on entitlements incentivising "bracket creep" and increased treatment and assessments of impairment; • lack of clinical governance and accountability of providers; • limited influence of the insurers over appropriate health care provision; and, • complexity of Fee Orders/billing rules. Healthcare providers make an overwhelmingly positive contribution to the well-being of injured people in NSW. However, and certainly compared to other personal injury schemes in Australia, health care providers in NSW are generously remunerated, and this may contribute to an increase in service utilisation.	**Recommendations 1 - 6**

Matters for Consultation		Response	Reference
	Setting and indexing of health practitioner fees		
5.	Should fee setting and indexation be used in these schemes?	icare recommends that fee setting should be aligned to the Medicare Benefits Schedule (MBS).	**Recommendation 1**
6.	How can rates best be set for doctors? Are there other options available to set rates?	icare recommends NSW personal injury schemes to transition to MBS item numbers, descriptions and billing rules (including their fee structure). Failing this, consideration be given into other methods of billing, as indicated in Section 1.	**Recommendation 1**
7.	Should NSW use MBS item numbers and billing rules to classify and report services instead of the AMA's? Are there other options available?	NSW should adopt the item numbers and billing rules listed in the MBS. Given the sizeable difference in rates that currently exist between the gazetted fees (AMA rates with loading) and the MBS fees, there may be a step-down approach, in which first the AMA loading is removed, and subsequently the MBS structure is implemented.	**Recommendations 1.3**
8.	How could SIRA appropriately set and index private and public hospital fees with the aim of better outcomes?	Rather than the 'fee for service' model that currently exists, better outcomes could be achieved by implementing an outcomes-based payment model, where there is more emphasis placed on the governance and accountability of service delivery and outcomes on health professionals. Additionally, indexation could be determined between SIRA and hospitals on an annual basis.	**Recommendations 1.2 and 1.3**
9.	How could SIRA appropriately set and index allied health fees with the aim of better outcomes?	SIRA could amend the current requirements for accreditation of allied health providers to ensure services are provided by the best qualified practitioners. Fees could be better controlled with reference to and assessment against the expected outcomes of treatment. Furthermore, gazetted fees should be calculated based on the annual costs from the prior year, with the aim of ensuring only necessary services are provided.	**Recommendations 1.3**
10.	Should consideration be given to the schemes having fee setting mechanisms for additional health practitioners? If so, which ones, and why?	It is recommended that fee setting mechanisms should be implemented for all providers within the AHPRA framework (e.g. pharmacy, podiatry etc).	**Recommendation 1**
	Improving processes and compliance		
11.	What could help improve administrative processes – including reducing paperwork and leakage – for providers, insurers, and other scheme participants?	In order to improve administrative processes, SIRA can: • introduce electronic data forms; • simplify fee orders and billing rules; • adopt appropriate health care coding i.e. ICD-10; • access HCP data for greater visibility of hospital services, for both operational and regulatory management; • clearly define roles and accountabilities of providers, insurers, and participants; and, • re-introduce a provider watchlist.	**Recommendations 3 and 5**

Matters for Consultation		Response	Reference
12.	What enhancements to claims administration requirements would help ensure scheme sustainability and improve understanding of the outcomes being achieved?	Some enhancements to claims administration requirements to improve scheme sustainability and outcomes include: • introducing robust and nationally-consistent treatment guidelines to enable stakeholders to understand treatment pathways; • review of pre-approved services to be aligned to injury type and best practice recommendations; • definition of reasonably necessary be amended to reasonable and necessary to enable health care interventions that best support recovery; • increased clinical accountability and obligations for healthcare providers; and, • ensuring consistent coding and reporting mechanisms across NSW.	**Recommendations 4 and 5**
13.	What improvements to monitoring, data collection, and reporting would help ensure scheme sustainability and improved understanding of the outcomes that are being achieved?	Some suggested enhancements to monitoring, data collection and reporting requirements to improve scheme sustainability and outcomes include: • Simplification of fee orders and billing rules; • adoption of appropriate health care coding i.e. ICD-10; • access to HCP data for greater visibility for operational and regulatory management; • pharmacy coding; and, • the introduction of patient reported measures with respect to health and experience.	**Recommendation 5**
	Implementing value-based care		
14.	What opportunities does a value-based care approach present for the personal injury scheme? How could these be implemented?	The 'value-based' care' framework is advocated for by NSW Health, and helps encourage injured workers to recover at work and/or return to work as soon as it is safe to do so, in order to protect their financial, emotional, physical and social well-being. This approach also helps prevent injuries deteriorating into chronic conditions where possible and helps ensure that injured workers can recover at work in a supportive work environment, with modified duties. There is an opportunity to reform health care in the personal injury schemes in NSW, including shifting from schemes focused on the degree of an individual's "disability" to one that focuses on a person's functional capacity and "ability". Engaging with the injured person and assessing their experience through data collection and self-report measures will help drive this change.	**Recommendations 1 - 6**
15.	What options are there to better understand and influence the health outcomes and patient experiences within the personal injury schemes?	In order to better understand and influence health outcomes and patient experiences, an objective review of the current state is required, removing personal bias or gain, to implement change that supports the objectives of the personal injury schemes in NSW. There are a multitude of resources available that can help assist in the development of policies and guidelines to help build healthcare literacy in NSW.	**Recommendations 4 and 5**

Appendix B

ICARE SUBMISSIONS TO SIRA – 2015 TO 2019

Work-related hearing loss

- In October 2019, icare made a commercial-in-confidence submission to SIRA on work-related hearing loss in the NSW workers compensation system. icare strongly supported a systematic review of the work-related hearing loss claims process and agreed that a simplification of the claims experience would deliver best outcomes for injured workers and other stakeholders in the system.
- icare recommended that SIRA consider:
  - Simplifying the process for lodging a hearing loss claim, including requiring a Hearing Service Provider report only (with additional supporting information and evidence) to enable an injured worker to lodge a claim. This would allow an insurer to assess the claim in a timely fashion and minimises delays, ensuring the injured worker has access to hearing aids as needed.
  - Simplifying the process for seeking replacement hearing aids or servicing existing hearing aids, requiring general practitioner sign-off only. In addition, or in the alternative, consideration may be given to amending the workers compensation legislation to permit commutation of a worker's lifelong entitlement to this type of compensation.
  - Reviewing the availability of remote and regional IMEs to enable fair, consistent and equitable assessments to be carried out.
  - Focusing on education initiatives for injured workers, employers and service providers, to help each party manage the claims process and their expectations from the system.

Proposed customer service conduct principles

- In August 2019, icare made a submission to SIRA on SIRA's proposed customer service conduct principles.
- In that submission, icare made clear that it has endeavoured to construct and deliver a value-based healthcare delivery model, focusing on customer outcomes, rather than on quantitative measures. icare submitted that the value-based healthcare model is congruent with the way health care is increasingly being provided, both in NSW and Australia and worldwide, and acknowledges that customers have greater expectations and understanding of the benefits and services they are entitled to receive.
- In line with this health care construct, icare confirmed implementation of a Value based care Strategy, which enabled customers to:
  - receive safe, effective, reliable, evidence-based, cost-effective care;
  - achieve the best functional improvement; and,
  - return to health and return to work (where applicable),

  while maintaining financially viable insurance schemes.
- icare also submitted that, in order to properly apply the Customer Service Conduct Principles, and for them to work effectively, further direction was needed from SIRA, as the regulator and accreditor of certain healthcare providers, for the management of health care providers, particularly those that under-perform.

A review of gazetted fees

- icare made a submission to SIRA in May 2019 about the review of gazetted fees for medical providers involved with the treatment/assessment of injured workers. icare suggested that, if NSW is to provide a truly cost effective and sustainable system for the NSW employers that fund the Scheme, the over-pricing currently endemic in the system should be addressed through:
  - revision of the methodology for setting gazetted fee maximums for medical treatments in NSW, noting that the NSW workers compensation system has the highest surgical costs across all Australian jurisdictions; and
  - introduction of greater checks and balances around the medical treatment prescribed and billed for injured workers in NSW, including gazetted billing guidelines that reference evidence-based, best practice treatment.

- On 29 July 2019, icare received further background from SIRA regarding the rationale for why the Fees Schedule in NSW is significantly higher than any other scheme/jurisdiction. It appears that in 2004, the Australian Society of Orthopaedic Surgeons (ASOS) made a submission to the then WorkCover NSW, arguing that fees be increased given the movement of a range of cost indicators over the previous five years; and that WorkCover then increased fees based on the Australian Medical Association (AMA) rates, with loadings of up to 50 per cent. Loadings have now been applied to surgical procedure item numbers (excluding paediatric item codes).

SIRA framework for non-treating healthcare practitioners

- icare provided feedback to SIRA in a letter dated 1 April 2019, titled S*IRA framework for non-treating healthcare practitioners*, which included suggestions on added rigour and process to the terms for appointment and re-appointment of healthcare practitioners.
- icare also suggested clarification in relation to how SIRA will monitor practitioners' registration, conditions, undertakings, reprimands, limitations or restrictions on a practitioner's registration, to improve compliance and ensure quality care is provided to injured workers.

Coding of data and invoicing

- icare has made a proposal to SIRA that modifications and greater scrutiny are needed in relation to the coding of medical data, shifting from insurance-based coding, such as TOOCS to healthcare-based coding, such as ICD to code for disease/condition. Other additional coding to be considered includes measuring patient outcomes using, for example, PREMS and PROMS as well as understanding surgical and hospital complication rates.
- The availability of data and quality of coding impacts the Scheme's ability to understand the nature and magnitude of injuries coming through the system, and increases the costs attributed to managing these injuries. It is necessary to put in place the policies, procedures and treatments that support best practice, such as governance, healthcare provider guidelines, whole person impairment rating guidelines.
- A preliminary coding audit conducted by icare identified several issues in how surgical interventions and hospital stays are invoiced within NSW Workers compensation, including:
  - over-servicing or up coding on a select number of claims reviewed; and
  - longer than necessary hospital stays without supporting documentation, such as a six day stay for Anterior Cruciate Ligament reconstruction when an average stay is three days or less.
- icare has suggested to SIRA that a change in the rules for surgical and hospital coding as well as the requirement for implementation of standard healthcare data coding systems would provide greater granularity, consistency, clarity and overall quality of the data available.
- In the absence of granular healthcare data, icare is developing and implementing machine-based learning to read invoices, for the purpose of identifying cost leakages and maintaining payment integrity.

Provider qualifications and scrutiny

- icare has previously requested that SIRA review metrics to ensure appropriate credentialing of providers under the Scheme. Currently, SIRA only accredits injury Management Consultants and those assessing whole person impairment; while other healthcare providers, such as General Practitioners (an integral component) and independent medical examiners (IMEs), do not require accreditation.
- Poor governance of Healthcare Providers working in the Scheme promotes inconsistency of treatment and can undermine optimum outcomes for injured workers. icare has suggested that SIRA introduce accreditation and minimum training requirements for all IMEs to ensure assessments are independent, objective and based on medical evidence.

- icare has also suggested that SIRA should continue monitoring and disseminating an exception reporting to ensure all Healthcare Providers operating within the NSW Workers Compensation Scheme are appropriately qualified and maintain unconditional registration with the Australian Health Practitioner Regulation Agency (AHPRA), and the minimum currency of practice requirements set out by AHPRA to promote best practice and evidence-based assessments. For those Healthcare Providers who do not require registration with AHPRA, a similar arrangement is required with the relevant society. This would ensure minimal delay in applying restrictions from all insurers in the NSW Workers Compensation scheme.
- In addition, icare has suggested to SIRA that oversight is needed to prevent 'doctor shopping', noting that there are currently no governance mechanisms to ensure all injured workers are being managed in accordance to best practice guidelines.
- SIRA has advised icare that responsibility for ensuring appropriate conduct and quality of service by IMEs sits with insurers; however, icare disagrees that this view is in accordance with SIRA's Workers Compensation Guidelines, which give SIRA authority to specify the qualifications or experience a person requires to provide to treatment or services to injured workers under the Scheme.
- icare is also developing a strategy for identifying healthcare provider 'outliers' based on normative historical data. However, this will form only part of the picture given the current limitations in data collection to date.

Whole person impairment assessments

- icare has discussed with SIRA the need to address the current Guidelines used to assess whole person impairment (WPI) within workers compensation. Currently, AMA5 (American Medical Association *Guides to the Evaluation of Permanent Impairment*, 5th edition), with NSW specific guidelines overlaid, is used in the NSW Workers Compensation system to evaluate WPI and American Medical Association *Guides to the Evaluation of Permanent Impairment*, 4th edition, with NSW specific guidelines overlaid, used in CTP. The current impairment guidelines in use are outdated, and can drive behaviours that increase medical costs under the Scheme. These include seeking to avoid caps on benefits by undergoing surgery before all conservative treatments have been exhausted, undergoing low value medical treatments in order to reach WPI benchmarks (and increase impairment ratings), or seeking to include additional body parts or injuries in their WPI.
- icare has discussed with SIRA the benefits of transitioning to the most recent (sixth) edition of the American Medical Association (AMA) *Guides to the Evaluation of Permanent Impairment*. The evolution of this edition mirrors the wider evolution of concepts and approaches in clinical medicine and science. It provides a more unified methodology, supporting consistency in impairment ratings and more precise documentation of the functional outcomes used to modify impairment ratings. It also recognises that medical treatments for injured injured workers should typically result in improved patient outcomes rather than increased impairment.

Reasonably necessary treatment

- icare has held discussions with SIRA regarding options for a number of possible Scheme reforms, including reasonably necessary treatment. It noted that the words 'reasonably necessary' in relation to the medical treatments funded under the Scheme are leading to the approval of some treatments that may jeopardise workers' recovery and wellbeing.
- icare's view is that the wording of the legislation, and associated case law, puts pressure on the Workers Compensation Scheme, and the Workers Compensation Commission Approved Medical Specialists, to accede to requests for certain treatment when the interventions are not evidence based, best practice, and may result in worsening functional outcomes and other harm.

Independent Medical Examiners (IMEs)

- icare made a submission to SIRA in September 2017 around the conduct of IMEs, including pushing for the protection of workers from unacceptable or abusive behaviour, as well as reviewing minimum eligibility requirements for IMEs.
- icare recommended a Scheme-wide Provider Watchlist be reinstituted to alert insurers if the AHPRA registration of an IME (or other healthcare practitioner) is cancelled or restricted.

Appendix C

Comparative benefits of the Sixth Edition of the AMA Guides for evaluating permanent impairment

Introduction

The American Medical Association (AMA) *Guides to the Evaluation of Permanent Impairment (Guides)* is the recognised standard for quantifying the degree of bodily impairment resulting from an injury.

The most recent edition of the *Guides* is the Sixth Edition (AMA 6), which departs substantially from the methodologies used in AMA 4 and 5. The innovations in AMA 6 were developed in response to substantial problems associated with use of previous editions, including variability in assessment results[1].

Australian workers compensation jurisdictions across Australia continue to use AMA 5 or 4 as their mandated standard, despite the availability of AMA 6. This submission explores the differences between AMA 6 and previous editions, outlines the benefits and impacts of AMA 6, and argues for the adoption of AMA 6 as the new standard for the workers compensation system in NSW.

The evolution to AMA 6 mirrors the wider evolution of concepts and approaches in clinical medicine and science. AMA 6 has also succeeded in providing a more unified methodology, supporting consistency in impairment ratings and more precise documentation of the functional outcomes used to modify impairment ratings.

Also critical is the recognition by AMA 6 that medical treatments for injured workers should typically result in improved functional outcomes rather than increased impairment. Earlier editions of the *Guides* reverse this proposition by providing higher scores in case of surgical and certain other medical procedures, which may act as a perverse incentive for injured workers to undergo low-value medical treatments in order to reach impairment benchmarks.

icare supports the goal of value-based health care,[2] which puts the injured worker's experience and health outcomes at the centre of all decision-making on medical treatments. We therefore urge SIRA to consider this submission on the benefits of transitioning to AMA 6 as the mandated standard for the workers compensation system in NSW.

AMA Guides

The *Guides* is used in workers compensation systems, federal systems, automobile accidents and personal injury cases to express the degree of permanent impairment as a percentage value, with zero per cent representing a typically healthy person. The value assigned to permanent impairment may be used as a benchmark to determine eligibility for income and medical compensation for injury over time, or as the basis for assessing the injured person's non-economic loss.

AMA 6 was published in 2007[3] and while many territories use this most recent edition as their standard, both AMA 5 (published in 2000) and AMA 4 (1993) are used in other jurisdictions:

- The majority of workers compensation jurisdictions in the United States and Canada have mandated the use of AMA 6, while a smaller number use earlier editions or do not specify a particular edition.[4]
- Workers compensation and motor accident compensation systems across Australia use AMA 5 and 4.[5]
- Many European countries use AMA 6 as a reference for determining impairment. The Dutch Association of Medical Officers has adopted AMA 6 as part of its core curriculum for insurance medicine trainees.[6]
- The impairment rating guidelines of many Asian territories are highly influenced by the Guides. Singapore uses AMA 6 as the standard for assessing work injury compensation.[7]

Depending on the territory and the legislated scheme, use of the *Guides* is supplemented by reference to locally determined standards. For example, most Australian jurisdictions use the *Guide to the Evaluation of Psychiatric Impairment*

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1 Results showed relatively high levels of both inter and intraoperator variability: the same clinician (intra) could assess the same person/condition on a different day and get a different result. Also, two different clinicians (inter) could assess the same person/disease on the same day and get a different result.

2 Elizabeth Koff, Secretary for NSW Health, describes value based care as putting the patient experience and patient outcomes at the centre of delivery of care: https://www.health.nsw.gov.au/Value/Pages/default.aspx

3 With corrections in 2009

4 Busse, J. W., M. M. de Vaal, S. J. Ham, B. Sadeghirad, L. van Beers, R. J. Couban, S. M. Kallyth and R. W. Poolman (2018). "Comparative Analysis of Impairment Ratings From the 5th to 6th Editions of the AMA Guides." *Journal Occupational and Environmental Medicine* 60 (12): 1108-1111.

5 Except the Northern Territory, which has adopted the use of AMA 6 with a lower threshold of 5% WPI for permanent impairment compensation caused by a motor vehicle accident

6 Note, this does not include the United Kingdom, which does not provide fault compensation through its national injury disablement scheme. Guidelines for the level of disablement associated with 55 injuries are provided under UK legislation.

7 Singapore, W.I.C.M.B.M.o.M., *A Guide to the Assessment of Traumatic Injuries and Occupational Diseases for Work Injury Compensation*. 2011.

for Physicians[8] as the standard for assessing mental and behavioural disorders, rather than the *Guides*. In NSW, it is noted that there are NSW specific modifications to the AMA guides for use in both the workers compensation and CTP schemes

Evolution of the Guides

According to a comparative analysis of the three editions[9], the evolution of the *Guides* is consistent with changes in other areas of medicine: "Concepts and approaches are improved with time; for example, in medicine, some treatments are found to be ineffective and are dropped from practice and new approaches are adopted. This also occurs with the medical assessment of impairment. With the change in impairment methodology, there will also be changes in impairment values associated with specific conditions. As clinical medicine evolves and there is increased efficacy of treatment, it is hoped that improved outcomes will reduce impairment previously associated with injury and illness."[10]

There were substantial issues to be addressed when developing AMA 6, with criticism of previous editions summarised as follows[11]:

- their method failed to provide a comprehensive, valid, reliable, unbiased, and evidence-based rating system
- impairment ratings did not adequately or accurately reflect loss of function
- numerical ratings were more the representation of "legal fiction than medical reality".

Research showed erroneous ratings in impairment using both AMA 4 and AMA 5. Of the 80 per cent erroneous AMA 5 ratings found in one study[12], 90 per cent had higher ratings than appropriate based on the information provided. Further, upon expert re-rating, 37 per cent were found to have no impairment at all. These errors were often due to bias, confusion or misapplication of the *Guides*.

The following recommendations[13] were made for the development of AMA 6:

- standardise assessment of activities of daily living limitations associated with physical impairments
- apply functional assessment tools to validate impairment rating scales
- include measures of functional loss in the impairment rating
- Improve overall intrarater[14] and interrater reliability and internal consistency.

AMA 6

The new approach used for AMA 6 is based on an adaptation of the World Health Organisation's *International Classification of Functioning, Disability and Health* (ICF), although many of the fundamental principles underlying the *Guides* remain unchanged. Adoption of the ICF framework[15] places AMA 6 methodology more appropriately within a biopsychosocial model – recognising that personal, social and environmental modifiers may alter the disabling effects of impairment in any given case.

The preface of AMA 6 lists the following as features of the new edition:

- a standardised approach across organ systems and chapters
- the most contemporary evidence-based concepts and terminology of disablement from the ICF
- the latest scientific research and evolving medical opinions provided by nationally and internationally recognised experts
- unified methodology that helps physicians calculate impairment ratings through a grid construct and promotes consistent scoring of impairment ratings
- a more comprehensive and expanded diagnostic approach
- precise documentation of functional outcomes, physical findings, and clinical test results, as modifiers of impairment severity.

The most important shifts in AMA 6 when compared with previous editions are outlined.

8 Written by Australian psychiatrists.
9 Comparative Analysis of AMA Guides Ratings by the 4th, 5th and 6th editions, by Christopher R. Brigham, MD et al, *AMA Guides Newsletter,* January/February 2010, p.1
10 ibid
11 ibid
12 Brigham, C.R., AMA Guides Newsletter, 2006.
13 Brigham et al, 2010
14 Intrarater refers to a single evaluator doing multiple evaluations of a patient; interrater refers to multiple evaluators doing an evaluation of the same patient.
15 ICF replaces the WHO's earlier ICIDH framework; it emphasises the interplay between the body, the person, and broader social and environmental factors in determining the content of disability.

Diagnosis-based grid

AMA 6 uses a diagnosis-based grid[16] to classify most diagnoses relevant to a particular organ or body part into five classes of impairment severity: from Class 0 (normal) to Class 5 (very severe). The final impairment rating is then determined by adjusting the initial rating based on factors such as history, physical findings, the results of clinical tests, and functional reports by the patient.

The basic template of the grid (see Table 1) is common to each organ system and chapter of AMA 6, so although there is variation in the ancillary factors used for the impairment rating (depending on the body part), there is greater internal consistency between chapters than in previous editions.[17] See table below

Appropriate class assignment is the critical factor in this methodology: class assignment is made solely by the diagnosis and associated clinical information; non-key factors may only be used to modify the grade within a class and will not result in impairment ratings lower or higher than the values associated with the particular diagnosis and class.

Emphasis on functional assessment

AMA 6 gives greater weight to functional assessment. The highest level of independence with which a given activity (e.g. bathing, dressing, cooking) is consistently and safely performed is considered the functional level for that individual.

AMA 6 acknowledges that "no well-accepted, cross-validated outcomes scales exist for the musculoskeletal organ system", and recommends functional assessment tools for the spine, upper extremities and lower extremities: the Pain Disability Questionnaire (PDQ), the Disability to the Arm, Shoulder and Hand (DASH), and the Lower Limb Outcomes Questionnaire, respectively. Importantly, AMA 6 methodology allows the use of reliable results from these tools to adjust the impairment percentage to reflect different functional outcomes.

Table 1. Diagnosis-Based Grid Template Introduced in AMA 6[18]

Diagnostic Criteria	Class 0	Class 1	Class 2	Class 3	Class 4
RANGES	0%	Minimal %	Moderate %	Severe %	Very Severe %
GRADE		A B C D E	A B C D E	A B C D E	A B C D E
History	No problem	Mild problem	Moderate problem	Severe problem	Very severe problem
Physical Findings	No problem	Mild problem	Moderate problem	Severe problem	Very severe problem
Test Results	No problem	Mild problem	Moderate problem	Severe problem	Very severe problem

16 While previous editions use diagnosis-based rating, AMA 6 brings greater uniformity to diagnosis-based evaluation and greater consistency in the methodology across body systems.

17 Brigham, C. R. (2011). *"AMA Guides - Sixth Edition: Evolving Concepts, Challenges and Opportunities."*

18 Christopher R. Brigham; Robert D. Rondinelli;, E.G.C.U.M.E.-A., "Sixth Edition: the New Standard". American Medical *The Guides Newsletter*, 2008.

Effects of treatment

AMA 6 also differs from previous additions in that it allows for the effect of treatment on impairment ratings. For example, improvement in neck function following cervical fusion would have the effect of reducing the impairment rating under AMA 6. This approach recognises that surgery and all therapeutic endeavours should improve function and therefore should not routinely be used to increase impairment ratings,[19] which is the practice using previous editions.

Impact of AMA 6 on impairment ratings

The impairment values for the most frequently used impairments and diagnoses in AMA 6 are similar to AMA 5. However, AMA 6 ratings are based more on the end-result and impact on the patient rather than what types of treatments or surgeries have been performed.[20] The result is lower ratings in some cases.[21]

Comparative research findings

Research shows that AMA 6 provides systematically lower impairment ratings for injured workers than AMA 5.

I. A 2010 comparative study[22] assessed 200 cases and used the clinical data to determine the whole person impairment (WPI) ratings resulting from use of AMA 6, AMA 5 and AMA 4. It showed that:
   - The average WPI per case was 4.82% per AMA 6, 6.33% per AMA 5, and 5.5% per AMA 4.
   - The overall average WPI impairment for each diagnosis was 3.53% per AMA 6, 4.59% per AMA 5, and 4.00% per AMA 4.
   - Analysis revealed a statistically significant difference between average WPI ratings when comparing AMA 6 with AMA 5, but not when comparing AMA 6 with AMA 4.
   - There were meaningful changes in impairment ratings with AMA 6 as a result of not providing additional impairment for surgical (therapeutic) spine procedures, improved outcomes with surgical release for carpal tunnel syndrome, and improved outcomes with total knee and hip replacement.

   The authors of the study concluded that average values had increased from AMA 4 to AMA 5, yet without clear scientific rationale.

II. A 2018 study[23] of the difference in impairment ratings using AMA 6 and AMA 5 analysed real time data from a sample of 249 injured workers and showed that:
   - The median whole person impairment rating (WPI) was 4.0% for 118 claimants assessed with AMA 6 and 7.0% for 131 claimants assessed with AMA 5.
   - Multivariable analysis showed a 36.4% relative reduction in impairment rating with AMA 6 versus AMA 5.
   - AMA 6 demonstrated excellent interrater reliability.

NSW standards

Evolution of the standards

AMA 5 was introduced as the standard for evaluating impairment in the NSW workers compensation system as part of legislative reform in 2001 (*The Workers Compensation Legislation Further Amendment Act 2001*). AMA 5 required modification to suit local conditions and accommodate new procedures (e.g. disc replacement surgery), which prompted WorkCover to bring together a group of medical specialists to advise on supplementary regulation to ensure that use of the *Guides* aligned with Australian Clinical Practice.

The First Edition of the WorkCover (now SIRA) Guides for the Evaluation of Permanent Impairment was issued in December 2001 as a supplement to AMA 5. The new basis for evaluating permanent impairment applied for any injury occurring on or after 1 January 2002.

Current usage

- AMA 5 is still used in the NSW system for evaluating impairment in most body systems. Any deviations from AMA 5 are defined in the SIRA Guides, which takes precedence over AMA 5.

The fourth, and current, edition of the (SIRA) Guides was issued in 2016. It is based on a template developed through a national process facilitated by Safe Work Australia in an attempt at national harmonisation. South Australia and Western Australia are

19 Brigham, MD et al, *AMA Guides Newsletter*, January/February 2010, p.
20 Dilbeck, C.R.B.C.U.A.M.a.L., "Comparative Analysis of AMA Guides Ratings by the Fourth, Fifth, and Sixth Editions". *AMA Guides Newsletter* 2010.
21 Brigham, *AMA Guides Newsletter* 2006.
22 Brigham, MD et al, *AMA Guides Newsletter*, January/February 2010, p.3

23 Busse, J. W., M. M. de Vaal, S. J. Ham, B. Sadeghirad, L. van Beers, R. J. Couban, S. M. Kallyth and R. W. Poolman (2018). "Comparative Analysis of Impairment Ratings From the 5th to 6th Editions of the AMA Guides." Journal Occupational and Environmental Medicine 60 (12): 1108-1111.

the two states which have adopted similar Guides to NSW.

The current deviations from AMA 5 are for psychiatric and psychological disorders, chronic pain, and visual and hearing injuries.

Future use of the Guides in NSW

icare believes that the best future course for assessment of WPI in the NSW workers compensation system would be to move to AMA 6 as the mandated standard for workers compensation and CTP. With the proposed reforms to establish a single personal injury commission, it is timely to align the assessment of permanent impairment across both schemes.

When compared with previous editions of the *Guides*, AMA 6 features the most contemporary, evidence-based concepts and terminology of disablement through its link to the ICF framework, and draws on more recent scientific research and medical opinion from recognised experts. To put it simply, the evolution to AMA 6 mirrors the wider evolution of concepts and approaches in clinical medicine and science.

AMA 6 has also succeeded in providing a more unified methodology, which helps promote consistency in impairment ratings and more precise documentation of the functional outcomes and other factors used as modifiers of impairment ratings. These outcomes are confirmed by research showing high interrater reliability when using AMA 6.

Also critical is the recognition by AMA 6 that medical treatments for injured workers should typically result in improved patient outcomes rather than increased impairment. Earlier editions of the *Guides* reverse this proposition by providing higher scores in case of surgical and certain other medical procedures, which may act as a perverse incentive for injured workers to undergo low-value medical treatments in order to reach WPI benchmarks.

Different editions of the AMA Guides are used across personal injury schemes in Australian jurisdictions, with AMA 4 or 5 used in every jurisdiction except the Northern Territory, which uses AMA 6 in their motor accident compensation scheme. Internationally, variance also exists regarding the edition of the AMA Guides in use. New Zealand, Canada and several countries in Europe currently use AMA 6. States in the US vary in their usage from AMA 3 to AMA 6, with approximately 30% of states currently using AMA 6 to determine permanent impairment.

icare is keen to discuss the use of AMA 6 further and we look forward to meeting with you on this issue in the near future.

icare
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Appendix D

In Australian jurisdictions, the following accreditation and training of healthcare providers is required:

WorkSafe Victoria

- The mandatory requirements for registered practitioners are governed by the Australian Health Practitioners Regulation Agency (AHPRA) under the National Registration and Accreditation Scheme.
- To provide services to injured workers under the Victorian workers compensation legislation, WorkSafe Victoria requires that providers must satisfy the eligibility requirements for the specified service type or specialisation.
- WorkSafe Victoria requires that healthcare providers at all times maintain board registration in order to be a WorkSafe registered provider.
- For non-board registered allied health providers, the qualifications of the service provider, business registration and insurance coverage must be acceptable to WorkSafe Victoria. To support the application, the provider may be required to provide evidence such as relevant tertiary qualifications, professional experience or membership of a professional association (or evidence of eligibility for membership).

Comcare

- Medical practitioners, including dentists, must be registered with AHPRA.
- Allied healthcare providers must be qualified by their registration or training to provide the specified treatment; and a registered provider may supervise the treatment being provided.
- Investigations must be ordered by a qualified medical practitioner or dentist.

ReturntoWorkSA (RTWSA)

- General Practitioners are provided with extensive education, including onsite delivery (30 mins per module, 2 areas of education – RTW scheme literacy and work injury management), education workshops (free for GPs) and online modules (including the health benefits of good work, how GPs can help their patients return to work, how to navigate a return to work).
- Guidance is available on the RTWSA website to assist with filling out certificates of capacity appropriately.
- All allied healthcare providers must be registered to provide services with RTWSA, have the appropriate training, and have registered with the appropriate organisation.
- Materials to assist allied healthcare providers are available online, including psychosocial screening tools, outcome measurement and practice resources.

WorkCover Queensland

- Webcasts, podcasts and short films are available on a range of process and clinical issues.
- Allied healthcare providers must be registered with the appropriate board.

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