SIRA - Regulatory requirements for health care arrangements – consultation paper

Ensuring best outcomes for injured people

It is not clear whether injured people in the schemes are all receiving evidence-based care, or that clinical guidance and evidence-based practice is always followed.

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)?

   We have seen a rise in medical spend recently, with an increasing amount of experimental treatment being requested, as well as conservative and traditional modalities of reasonably necessary treatment slipping through the gaps at times in preference for more invasive treatment modalities or for treatment that has little to inconclusive evidence to support their effectiveness. We often see that these treatments bypass the more conservative approach in favor for a quick fix. We have also seen there are several service providers that continue to treat outside the limits of evidence-based treatment leading to delayed recovery and return to work within the scheme.

2. Which issues need to be addressed to ensure injured people receive high quality, evidence-based health care?

   More education needs to be provided on multiple fronts to try and engage with the medical community, starting as early as university through to current communities of practice that could be coordinated between SIRA, ARPHA, the AMA, RACGP and other relevant organizations.
   There needs to be tighter and clearer guidelines on definition of item codes and services. There also needs to be a way of distributing information to ensure practitioners have read and understood it.

   Treating practitioners understanding of the healthy benefits of work need to be revised, perhaps as a part of the application process to be SIRA accredited. As for allied health providers perhaps, more can be done via educational workshops.

3. From your observation what are some of the reasons for the increase in service utilisation (ie the increase in the amount of services each injured person is receiving)?

Lack of influence as an insurer to control utilization of higher gazette fees such as level C and D consultation, often the NTD will place the insurer in a difficult position as they will refuse to continue to treat unwell workers if we don't pay unreasonable fees or charge workers directly.
Little to no communication from inpatient or outpatient programs leading to a need for multiple, lengthy and costly stays.
Medical practitioners and allied health professionals lack of communication between themselves is leading to less individualized care plans to the worker's needs – multi disciplinary program requests for example and duplication of treatment.
We are also seeing emergence of secondary psychological diagnosis being made by GP's following a primary physical injury leading to utilization of pain management physicians and programs, lengthy pharmacological use and over utilization of passive care under allied health practitioners such as physio's and EP's.

Setting and indexing of health practitioner fees
How can fee-setting and indexation be better used to improve outcomes in the schemes?

1. Currently some jurisdictions use MBS rates while others use AMA rates to set fees for doctors and for coding and billing purposes.
   How can rates best be set for doctors? Are there other options available to set rates?

   Whether its MBS or AMA, one system would be beneficial.

2. Should NSW use MBS item numbers and billing rules to classify and report services instead of the AMA's? Are there other options available?

   There needs to one consistent approach that we can govern with.

3. How could SIRA appropriately set and index private and public hospital fees with the aim of better outcomes?

   We are unaware of any data that is indicative of patient outcome vs cost of hospital stay or type of hospital. Perhaps NPS can be bought in on this. Stronger focus needs to be placed on medical practitioners performing procedures. There is no accountability for surgery/procedure outcomes in the workers compensation scheme. Workers compensation patients are also often lead to believe unrealistic recovery from procedure, often leading to secondary surgery/s, secondary psychological issues and/or chronic pain.
   Post-operative in patient stays could use revision as there is no consistency between hospitals, reporting expectations or communication standards.

4. How could SIRA appropriately set and index allied health fees with the aim of better outcomes?

   Just as rehabilitation providers are reviewed and audited against their outcomes, this would be a highly beneficial process to undertake with allied health practitioners. Setting stronger guidelines around the definition of all fees but especially complex fees, case conferences and aids/equipment would be of assistance to allow insurers to be able to hold provider more accountable.

5. Should consideration be given to the schemes having fee setting mechanisms for additional health practitioners? If so, which ones, and why?

   Acupuncture is coming more prominent. Podiatrist utilized for orthotics is also commonly referred to by specialists to assist with management of lower limb conditions. Whilst not an allied health practitioners Dentistry fees should be reviewed. The increased cost in this area from secondary complications due to medication use and preexisting conditions often presents with fee's upwards of $20,000.00 and workers who often require urgent treatment.

Improving processes and compliance

1. What could help improve administrative processes – including reducing paperwork and leakage – for providers, insurers and other scheme participants?

   Assistant surgeons need to indicate on invoicing if they are in fact a registrar on rotation to an approved private hospital training rotation, when assisting in a public hospital.

2. What enhancements to claims administration requirements would help ensure scheme sustainability and improve understanding of the outcomes being achieved?

   Timeframes to surgery would be reduced if practitioners were obliged to provide information on their initial requests around; clinical indication as to why the surgery has been requested, timeframes for recovery, which hospital they will be attending, treatment recommendations post op etc. This would save on the agent chasing this and potentially IME costs to determine these facts.
   There may be more compliance with appropriately completed and more tailored AHRR and a lot less backwards and forwards if the providers where allowed to charge for every AHRR on file.

3. What improvements to monitoring, data collection and reporting would help ensure scheme sustainability and improve understanding of the outcomes that are being achieved?

   We would need to receive data to be able to determine this. Transparency on what is collected would go a long way to assist us in identify leakage or difficulty providers earlier. The release of rehab data after audits would greatly assist in our management and understanding of this category too.
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Implementing value-based care

The concept of 'value-based care' was developed to help health purchasers move from paying for the volume of individual services, towards payment based on value – ie performance and patient outcome.

1. What opportunities does a value-based care approach present for the personal injury schemes? How could these be implemented?

   Whilst a good idea, no two patients or practitioners are the same, nor their beliefs on best practice. There are more fundamental issues with consistency of patient care that would need to be addressed first.

   This is something that could be also considered with rehab providers and we would welcome the opportunity to further explore this.

2. What options are there to better understand and influence the health outcomes and patient experiences within the personal injury schemes?

   Support for recovery at work

   Clinical reasoning and justification why the medical or allied health practitioner does not support recovery at work

   Clinical reasoning and justification regarding best evidence to support requests and treatment plans.

   NPS and transparency with these outcomes.

Any other issues

Are there any other issues you want to raise or comments you would like to make?

Codes and guidelines for mediation and redeployment services. Great rigor around guidelines for ADLS would be helpful as services as cost are growing in this space