

APA Submission on 2019 review of Regulatory requirements for health care arrangements in the NSW Workers Compensation and CTP Schemes

November 2019

Authorised by:

Thy Cao
NSW Branch President
Australian Physiotherapy Association
Level 1, 1175 Toorak Rd
Camberwell VIC 3124
Phone: (03) 9092 0888
Fax: (03) 9092 0899
www.physiotherapy.asn.au

Contents

Introduction	2
Terms of reference.....	3
Responses to Matter identified for consideration.....	4
Ensuring best outcomes for injured people	4
Setting and indexing of health practitioner fees.....	4
Improving processes and compliance	5
Implementing value-based care	6
Recommendations	7
Physiotherapists Issuing Certificate of Fitness.....	7
Recommendation 1	7
Improve access for telehealth as an alternative mode of patient management.	7
Recommendation 2.....	8
Development of next level of Allied Health training and linking to incentives.....	8
Recommendation 3.....	8
Development of a positive strategy of using Independent Clinicians to help with guidance and compliance.	9
Recommendation 4.....	9
Provide a training platform to front line claims staff which includes risk stratification and strategies to help recovery and return to work	9
Recommendation 5.....	9
Conclusion	9
About the APA	9

Introduction

The Australian Physiotherapy Association (APA) is pleased to provide this submission to the review of regulatory requirements for healthcare arrangements in the NSW Workers Compensation and CTP Schemes.

The APA has taken an approach to respond to the review with a forward looking response, but also we also note that, for valuable input on managing increasing, data specific to physiotherapy, inclusive of regions, frequency of servicing from onset of injury and including headline scheme measures would be highly valuable in the future.

APA recognises that sensible reform is required to deliver favourable return to work and recovery outcomes.

Physiotherapy has further potential, as yet unused within NSW CTP insurance and Workers Compensation schemes, to achieve this. Physiotherapists are key personnel in managing the physical needs of compensable clients and are well positioned to certify and facilitate return to work¹.

Research shows that physiotherapists:

- Are well placed to facilitate return to work because they have a good understanding of worker's functional status and requirements of work roles and set goals to increase functional capabilities;
- Influence recovery and self-management strategies;
- Have a high level of evidence-based medicine; and
- Have an improved ability to implement a biopsychosocial approach.

The following is the data provided by SIRA on medical spend:

- Health care costs are rising. Medical spend represents more than 30% of the cost of NSW CTP and WC schemes, and continued growth could pose a risk to workers compensation scheme sustainability
- Current data collections do not contain sufficient information to analyse health outcomes within the schemes
- The WC scheme is undergoing faster medical spend growth, particularly in recent years, than either Private Health Insurers in NSW, or Medicare.
Percentage change in costs year on year

To complement the above analysis costs was the information on utilisation:

- There has been consistent year-on-year increases in spend on surgery across both schemes. The growth includes increases in items billed and earlier approvals of surgery
- Increased service utilisation has been observed in both schemes
- There are variations in billing practices including how codes are used
- There is increased utilisation of some technologies, such as imaging, that the evidence suggests may be contra-indicated
- Clinical pathways are not always available to guide leading practice and evidence-based medical care.

The APA is supportive of models of care which incentivise optimal, patient centred and outcome focused care and support. Currently, the incentives to provide a high level of service and hence, provide high quality do not exist.

Terms of reference

The APA has noted the discussion paper of September 2019 and compliments SIRA for taking a broad collaborative approach to some of the current challenges. The data that has been provided on rising healthcare costs, inclusive of a 30% increase between 2016-17 and 2018-19 for physiotherapy,

¹ Gosling C, Keating J, Iles R, Morgan P, Hopmans R. Strategies to enable physiotherapists to promote timely return to work following injury. Melbourne: ISCRR and Monash University; 2015. p.1-170.

chiropractic and osteopathy highlights the need to be open and transparent with specific data sets to help relevant engagement with peak bodies.

The APA has structured the response around the guidance material provided and the questions under each heading. At the completion of the responses to the questions, the APA has also provided some clear recommendations for improved health care arrangements in the NSW Workers Compensation and CTP Schemes.

Responses to Matter identified for consideration

Ensuring best outcomes for injured people

One of the challenges with providing the highest of quality of services with the ever expanding evidence base, is that the training required to ensure that the quality of servicing must keep up to date and continue to challenge health care providers.

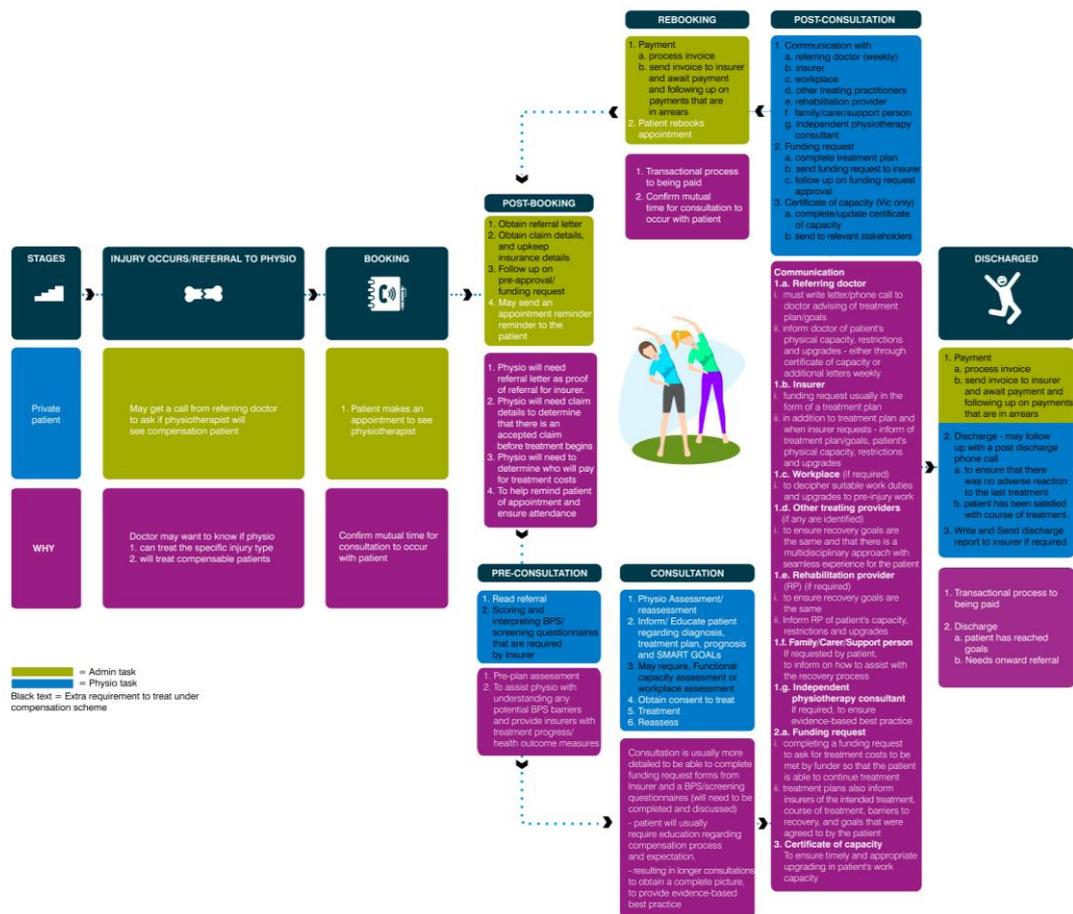
The APA is completely supportive of the provision of education resources and materials to help provide insights, awareness and knowledge of the schemes and how to best help injured people with their recoveries. It is well known that the complexities of compensable systems and helping patients navigate through this to have a successful return to work requires all stakeholders to work together. The inequitable health outcomes that are currently seen in rural and remote communities is also another consideration. The APA has been advocating for improved access for Physiotherapists to provide telehealth services. As the technology has progressed and the knowledge of how to translate this into practice has improved, the ability for this service to provide a highly useful service delivery option for clients in rural and remote communities is a highly important solution.

Setting and indexing of health practitioner fees

The APA believes that currently, the fee schedules in the schemes do not offer incentives and opportunities for health care providers to deliver high quality care. The current schedule for service delivery is a flat rate for allied health providers. The current schedule also does not allow for the broad scope of physiotherapy practice. The APA has undertaken work previously to help provide an understanding of the breadth of practice and highlighted this is a useful [document](#) to understand the breadth of service delivery and clear descriptors of the provision of the service expectation. The model of providing a minimal level of training into managing patients in compensable schemes and focus on outcome based treatment is a strong aspect of the current schemes.

In the context of fee structure, it may be useful to draw a comparison with the Victorian Workcover system of service provision for physiotherapy. The development of a set of quality standards and deliverables for providers who were interested and willing to engage enabled the development of a network of health care providers that has increased training and commitment and in return access to an improved fee schedule with a wider range of availability of service codes in the Early Intervention Physiotherapy.

The APA strongly believes that a fee structure that attracts the most experienced and skilled physiotherapists to work within the Compensable systems is the ideal setting. The following infographic has been developed to provide insight into the range of extra activities that are required in providing a high level of servicing to compensable patients:



It has been shown in numerous previous submissions that the standard fee schedules for physiotherapists is well below market rates. This creates a simple equation for physiotherapists and patients alike. If the physiotherapists charge their standard (market) rates, they are required to either charge the patient a gap fee, or to adjust their treatment times. This in turn creates a decision pathway for patients, but also has an implication in regards to equity of access.

The APA has seen some positive examples of price setting and fee schedules which have had a positive impact on involvement and uptake by physiotherapists and also relayed into patient satisfaction and outcomes. Regular bilateral price setting activities are required for long term sustainable engagement. The APA is currently undertaking some activities to help determine the economic value and health impacts of high value care. The activities will also review operating costs, including business operating costs and non-billing administration time. The ability to be able to be open and transparent with relevant commissioned reports would create a pathway to have fee structures which attract the most highly skilled physiotherapists to work with SIRA clients.

Improving processes and compliance

The APA feels that aligning both schemes to have clear guidelines in regards to the administration would be in client and providers best interests. These guidelines could look as simple as:

- 8-10 treatments to be automatically approved with the completion of relevant treatment plans and notifications.

- Any further treatment would require another treatment plan with outcome measures.
- An agreed approval timeframe (eg. 5 days) is provided and if no response in this period, then the plan is taken as approved.

The APA is supportive of moves to align fee structures with outcome focused treatment and compliance with quality and standards that are required of the scheme. As a profession, Physiotherapists have pioneered and championed the use of outcome measures and stratification.

The evidence strongly supports the use of stratification measures and questionnaires to ensure that those that need increased layers of support and services are offered these. An example of this can be seen in Workcover Queensland and their project with Monash University.(1) The APA strongly recommends the use of risk stratification and outcome measures at all levels of claims processing. What can be seen when this does not occur, is clients with complex needs, missing out on extra layers of support, guidance and treatment. These clients are where the important interventions that can really assist in return to work and health improvements.

By having all stakeholders having the same agreed outcomes which are measurable and comparable will assist in outcome focused service delivery. The net effect will also result in a more collaborative patient centered management plan.

Fee structures which reward the above behaviors and the important role of collaboration between a variety of service providers will help to create a sustainable and viable scheme for generations to come.

Implementing value-based care

As has previously been mentioned, incentives for providers to deliver best practice activities is a key to facilitating improved scheme outcomes. One such example is the value of non face-to-face communication. The important role of communicating with stakeholders regards progress of clients and capacity for work and functional activities is well known. The model of empowering clients to be able to self-manage and self-advocate is also an important consideration, but in some settings, extra levels of communication is required to help clients feel secure and supported through their rehabilitation. Currently, the fee schedule does not support this level of activity.

The NDIS fee schedule as an example of guidance for non face to face communication is a good example. The increasing use of email as a form of written communication between Health providers and Insurers should be also be considered in regards to remuneration.

This further leads onto the important role of defining what agreed goals and outcomes are. The two schemes overseen by SIRA have broadly different high level client objectives. The commonalities involve improved health outcome and also functional outcomes of which return to work is one. By being open and clear what the headline outcomes the scheme is aiming to achieve and reporting on this will allow all stakeholders to have knowledge and buy in on these outcomes. The importance of patients working with their health care providers on goal setting and what outcome measures will help them track their progress is often understated. When clients expected outcomes match the broader headline KPIs, then the commonality of delivering outcomes will have all stakeholders working toward the same cause.

Continuity of care has been shown to provide highly positive client experiences. The role of physiotherapists as a first point of contact is an important consideration in providing positive experiences. That is why some of the previously mentioned issues of minimizing administration burden and improved awareness of knowledge of the scheme are important to get right. If the

providers who are providing the continuity of care for clients are not engaged maximally in the scheme then this has a ripple effect on client experiences.

Another best practice development which has been highlighted to great effect is the ability to broaden the ability for Physiotherapists to be able to provide certificates in some situations for patients. One of the key considerations for consumers in health care provision is choice. If a patient has a positive relationship with one particular provider, e.g. Their Physiotherapist, then the ability for the certificate of capacity to be completed by that provider enables the key concept of choice to be maximized. The important role Physiotherapists can play in the return to work and certification process will be outlined further in the recommendations section.

Recommendations

Physiotherapists Issuing Certificate of Fitness.

Physiotherapists in Victoria and Queensland have been able to write certificates of capacity for injured workers since 2014. Victorian data shows that the percentage of subsequent certificates written by physiotherapists has nearly doubled, increasing from 4.7% in April 2014 to 7.5% in August 2016 and this has continued to trend upwards. Fifty five per cent of all certificates issued by a physiotherapist¹ recommended a return to alternate or modified duties compared with just 23% of general practitioners². The APA and its members have a strong commitment to promoting the health benefits of work and facilitating safe and durable return to work (RTW) plans for injured workers.

Australian physiotherapists are recognised diagnosticians with ‘first contact’ rights (i.e. patients do not require a doctor’s referral to see a physiotherapist). The current arrangement has the injured person going back to see their doctor for certification, even if the injury is purely a musculoskeletal with no further complication (minor injury) and the only treatment they were receiving was physiotherapy. This would then facilitate the doctor to contact the physiotherapist for an update on the injured person’s capacity to then accurately fill out a certificate of capacity. This results in delays in returning to work/usual activities and unnecessary costs to the scheme. Allowing NSW physiotherapists to issue a certificate of fitness will overcome this hurdle. The APA believe this will result in improved return to work outcomes and efficiencies for the healthcare and compensation systems.³

Recommendation 1

We recommend that the Committee support the introduction of physiotherapists issuing certificate of capacity within the NSW CTP scheme for low risk, high volume claims, as this will:

- improve return to work and recovery outcomes
- improve patient experience and consumer value by not having to attend unnecessary appointments to duplicate administrative information for minor injuries
- improve the administrative efficiency within the CTP Scheme

Improve access for telehealth as an alternative mode of patient management.

Developing telehealth as an alternative mode of patient management to reduce the burden on acute services and to improve the patient experience for those who are unable to attend physiotherapy because of location.

NSW covers a large land mass and as such physiotherapy services needs to be able to reach all parts of the state to service rural and remote patients. The efficacy of health delivery via telehealth has been demonstrated in osteoarthritis management.⁴

A systematic review by Australian researchers that assessed the economic value synchronous or real-time video communication (video consultations) found that:

- 61% of the studies found telehealth to be less costly than the non-telehealth alternative
- 9% gave the same or mixed results.⁵

In terms of health outcomes, this review reported that:

- 33% of studies found improved health outcomes
- 58% of studies found outcomes were not significantly different
- 6% found that telehealth was less effective
- 3% found outcomes differed according to patient group.

A recent systematic review reported that telerehabilitation in addition to usual care is more favourable than usual care alone, whilst treatment delivered solely via telerehabilitation is equivalent to face-to-face intervention for the improvement of physical function and pain.⁶

Telehealth has the opportunity to reduce the burden on patients and transport facilities by offering alternative options for health delivery as well as delivering a potential saving to the CTP scheme.

Recommendation 2

We recommend that the Committee consider in the next tranche of reform exploring the opportunities for physiotherapy led telehealth initiatives (particularly the use of video-consultation) to alleviate the burden for patients where by travelling to healthcare facilities.

Development of next level of Allied Health training and linking to incentives.

Developing the next level of educational training, offers some excellent opportunities to work collaboratively with healthcare providers. It also helps to provide some much needed education and awareness on the scheme for stakeholders. There currently exists a number of training modules which have been designed to help provide an understanding of what best practice service delivery looks like. The APA recommends the following aspects of training modules be considered:

- A refresh on the clinical framework as a model of treatment planning.
- The use of risk stratification and outcome measures and how to put these into practice.
- Return to work conversations and communications around this.
- Complex patient management
- Case Studies

The ability to engage with Peak bodies will maximize the impact of these training modules. The ability to be able to associate training modules with a variety of incentives, such as CPD points and access to a wider range of fee schedules could also be considered in the behavioral economic considerations.

Recommendation 3

The APA recommend that SIRA commence a broader education strategy and engage with the Health Care providers to deliver a range of training and educational materials that help provide awareness and knowledge of the scheme and working to best assist clients. This would be best to be highly inclusive of Allied Health Providers. The APA would be happy to be involved in the development and

delivery of any training. Linking the training also to CPD points is also an additional strength of this model for improved engagement.

Development of a positive strategy of using Independent Clinicians to help with guidance and compliance.

The APA has been made aware of a number of situations where treating Physiotherapists have found the involvement of the Independent Physiotherapists has not resulted in a positive outcome. This in turn has created a negative relationship with the provider and one can only assume the same with the injured client. It is also the APA's understanding that the engagement of the Independent Physiotherapists is driven by individual claims staff. In turn, this creates an adversarial relationship and has difficulty in helping with any awareness raising or educational opportunities.

The APA believes a positive relationship with peak bodies and the profession, as a whole would lead to significantly better buy in and also more positive communication with patients.

Recommendation 4

The APA recommend that SIRA consider the use and role of the Independent Advisors and develop a positive strategy of engagement and awareness raising, to help with ensuring compliance with best practice, clinical framework and awareness raising. Cohorts of claims to review should also be linked into a broader educational and awareness training which can be used strategically to engage with different providers.

Provide a training platform to front line claims staff which includes risk stratification and strategies to help recovery and return to work

The recent activities that have occurred through Workcover Queensland and Monash University around the value of improved awareness and collaboration of front line claims staff and clients and their providers on outcome measurement and risk stratification has shown some positive signs. This model would have a number of benefits to SIRA and also help to utilize services and claims related activities in an optimal fashion.

Recommendation 5

The APA would be supportive and happy to be involved in the development and engagement of training modules for claims staff on risk stratification and outcome measurement.

Conclusion

The APA is committed to improving the value of the health system. Physiotherapists constitute a valuable resource which is being utilised in many countries to streamline services and make them more efficient and cost-effective.

We would welcome the opportunity to provide evidence to the Committee and to work with the Committee and other stakeholders on the reforms that emerge.

About the APA

The APA vision is that all Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing.

The APA is the peak body representing the interests of Australian physiotherapists and their patients. It is a national organisation with state and territory branches and specialty subgroups. The APA represents more than 23,000 members who conduct more than 23 million consultations each year.

The APA corporate structure is one of a company limited by guarantee. The APA is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association.

References

- ¹ Gosling C, Keating J, Iles R, Morgan P, Hopmans R. Strategies to enable physiotherapists to promote timely return to work following injury. Melbourne: ISCRR and Monash University; 2015. p.1-170.
- ² Collie A, Ruseckaite R, Brijnath B, Kosny AA, Mazza D. Sickness certification of workers compensation claimants by general practitioners in Victoria, 2003-2010. *Med J Aust* 2013; 199:480-3.
- ³ Papagoras et al (2017). Supporting return to work through appropriate certification: a systematic approach for Australian primary care. *Australian Health Review*. 2017 Mar 7. doi: 10.1071/AH16247. [Epub ahead of print]
- ⁴ Bennell KL, Nelligan R, Dobson F et al. Effectiveness of an internet-delivered exercise and pain-coping skills training intervention for persons with chronic knee pain – a randomized trial. *Annals of Internal Medicine*. Apr 4 2017;166(7):453-62.
- ⁵ Wade VA, Karnon J, Elshaug AG et al. A systematic review of economic analyses of telehealth services using real time video communication. *BMC Health Services Research* 2010;10:233.
- ⁶ Cottrell MA, Galea OA, O'Leary SP et al. Real-time telerehabilitation for the treatment of musculoskeletal conditions is effective and comparable to standard practice: a systematic review and meta-analysis. *Clinical Rehabilitation*. May 2017;31(5):625-38.

2018 Edition

NATIONAL PHYSIOTHERAPY SERVICE DESCRIPTORS



physiotherapy.asn.au

Contents

Introduction	3
The National Physiotherapy Service Descriptors	3
‘Foundation activities’	3
Relativities	4
Clumping and splitting	4
Consumables and incidentals	5
An overview of some important changes in the 2017 National Physiotherapy Service Descriptors	6
A consultation is defined as ‘synchronous audio-visual communication’	6
Travel is a separate service	6
We distinguish the task of ‘assessing’	7
We include descriptors that allow for physiotherapists to seek an independent opinion / plan	8
Our schedule for services seeks to systematically accommodate the impact of pre-existing disability that predictably increases consultation complexity and/or time	8
The elements of our service descriptors	9
Indicative schedule of service descriptors	10
Assessments	11
Summary	11
Assessment 1	12
Assessment 2	13
Assessment 3	13
Assessments (specialised)	14
Lymphoedema Assessment	14
Neurological Assessment	14
Pelvic Floor Conditions Assessment	15
Assessment of persistent or recurrent pain	15
Wheelchair Assessment	16
Independent Clinical Review	17
Consultations	18
Summary	18
Consultation 1	19
Consultation 2	19
Consultation 3	19
Group Consultation (land)	20
Group Consultation (water)	20
Class Consultation (land)	20
Class Consultation (water)	21
Primary Prevention Activity	21
Consultations (specialised)	21
Lymphoedema care	21
Neurological Rehabilitation	21
Pelvic Floor Condition Care	22
Consultation with client who has persistent or recurrent pain	22

Return to work	23
Environment / Workplace Assessment	23
Functional Capacity Assessment	23
Suitable Duties Program	23
Communication	24
Summary	24
Professional communication	25
Case conference	25
Provision of a written report	26
Discharge plan	26
Custom-made orthosis	27
Summary	27
Custom-made orthosis (lower limb) Consultation	28
Custom-made orthosis (upper limb) Consultation	28
Review of custom-made orthosis	28
Travel	29
Travel	29
Other costs and incidentals	30
Non-Attendance	31
Fee for client non-attendance	31
Relativity	32
Relativity Table	33
Definitions	35
Activity	35
Circumstances of the consultation	35
Clump and split	35
Complex	35
Consultation	36
Episode of care	36
Falls outside the expected course of care	36
In person	36
Management continuity	36
New episode of care	36
Normal opening hours	36
Normal practice	36
Occasion of service	37
Primary prevention	37
Screened for risks	37
Severe injury	37
Trigger for (re)assessment	37
Parameters of travel costs	38

Introduction

The Australian Physiotherapy Association's (APA's) National Physiotherapy Service Descriptors (the Descriptors or NPSDs) are our description of services provided by physiotherapists and physiotherapy services in their day-to-day practice.

The central focus of our approach is on using physiotherapy to achieve the best value for clients in contact with our services (ie, optimise the health outcomes achieved per dollar spent)¹.

The NPSDs are endorsed by our Board, and thus represent the profession's view on the scope of each service type and the differentiation between service types.

The purpose of the NPSDs is to provide the physiotherapy profession, consumers and third party insurers with a description of the services provided by physiotherapists and physiotherapy services. As a result of changes in the ways that physiotherapy services are provided, the NPSDs need to change over time so that they reflect contemporary modes of physiotherapy practice.

The National Physiotherapy Service Descriptors apply to the whole health system

Australia's health system is characterised by being supported by a range of insurance schemes.

Historically, the focus of the NPSDs has been on their role in describing services subsidised by private health insurance schemes. However, the overt intersection of insurance schemes and the increasingly fluid definition of what is 'private' and 'public', and the blurring of what is 'in-hospital' and 'out-of-hospital (through hospital in the home models, for example), require a different thinking.

As a result, this 2017 edition of our NPSDs is an overarching set of NPSDs which distil the core of the ways that physiotherapy is practised in a wide range of contexts. It contains a small number of service descriptors which will be used by only some insurance schemes (eg, those services which are specific to the provision of return-to-work care, which are likely to be used only by workers' compensation insurers).

Foundation activities

The practice of physiotherapy involves a set of professional and ethical obligations, carried out as a part of practice. These activities include gaining informed consent, clinical note-making, garnering professional support and expertise when needed, and collaborating with members of the broader 'care team' as appropriate. In short, we call this diverse range of activities foundation activities.

It would be possible to explicitly reference these activities in each service descriptor.

We have chosen, instead NPSDs to provide a set of accompanying guidance on these activities. This allows the focus of the service descriptors to be on the factors that differentiate the services described.

Our decision to omit foundation activities from the descriptors aims to ensure that the NPSDs are clearly differentiated and suitably brief. Our decision to omit foundation activities DOES NOT reduce the nature of the obligation. It merely removes it from the text of the descriptor and positions it more clearly as an obligation the nature of which is principally self-regulated.

Relativities

Embedded in our NPSDs are a set of 'relativities'.

These relativities reflect the relative resource demand to provide a high quality service in a sustainable basis. The resources include human resources (both capacity/volume and capability/expertise), equipment and capital, systems such as clinical governance and safeguarding, and a range of incremental costs (eg, the incremental costs of consumables and professional indemnity insurance).

Relativities are an important consideration for consumers, physiotherapists and funding schemes, as they reflect the real costs of safe, sustainable and high quality care.

We do not have contemporary evidence of the relativities (ie, the relative resource consumption across our services). It is not possible to gather robust evidence within the timeline needed to make changes for the coming year. As a result, we have based our relativities on relativities documented in previous versions of our NPSDs and on contemporary expert opinion.

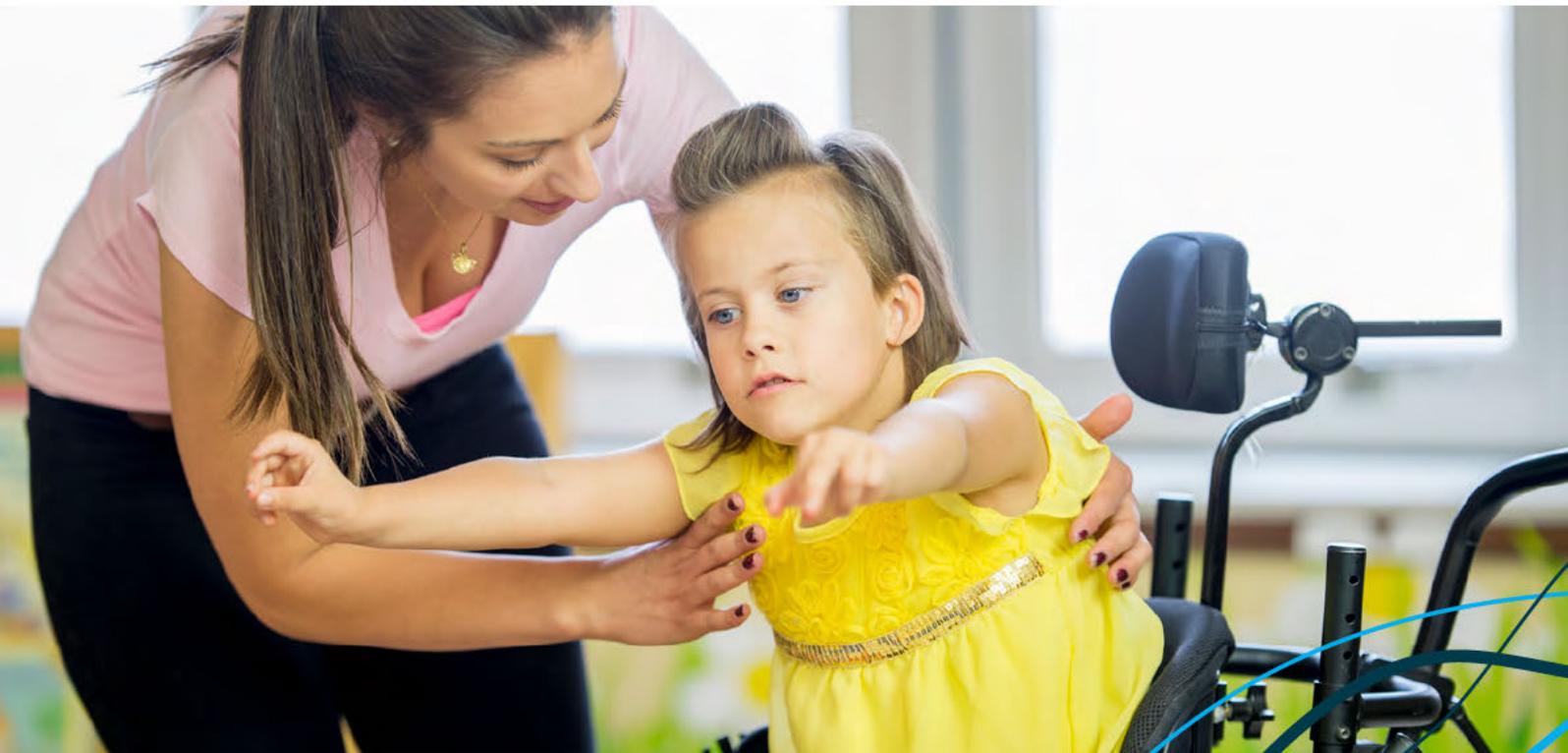
Clumping and splitting

It is inevitable that our NPSDs require us to 'clump' and 'split'.

One consideration in our approach to clumping and splitting has been the way in which insurance schemes bundle cost elements of physiotherapy services (eg, travel costs and professional services costs when a home visit occurs) and create structures that mitigate against sustainable service provision.

Our approach has been to separate the cost elements so that they are transparent and can be bundled at point of payment, rather than 'disguised' in ways that compromise the quality and sustainability of services for consumers.

Another consideration has been the utility of differentiating services. We can see three potential benefits from differentiation.



Firstly, differentiation of some services can assist to gain a better understanding of both the prevalence of these issues within physiotherapy and the trajectory of client care. In the case of pelvic floor conditions, for example, our profession thinks that these may be under-detected and that the resulting needs of people with pelvic floor conditions only partly met. Introducing a specialised assessment item provides a mechanism that would allow the profession, its consumers and their funders to look at the service use and outcomes for individuals and the cohort of people with these conditions and thus to improve the model(s) of care and funding.

It has been suggested that it is important to differentiate services for people with persistent or recurrent pain, as an assessment coded as such sends an important message to the insurer about the constellation of problems being seen. This has the potential to allow for proactive approaches to care.

It has been suggested that differentiation of a small number of services would assist with the 'authorising environment' and allow funders to trigger access to aids, garments, equipment and other inputs for care. It may also send a signal about the potential for the costs for care to diverge from the norm. This is the case in conditions such as lymphoedema.

Differentiation can also send a signal in the profession, to consumers and to the funders about the level of expertise necessary and being used for this care. In some cases, especially for isolated consumers, this could trigger the use of other services (eg, [Professional communication](#) and [Independent clinical review](#) which are an integral part of hospital-based model and need to be a part of the funded model across physiotherapy.

In particular, the way we deal with travel and the way we separate assessment and consultations/treatment, is reflective of key choices in 'clumping' and 'splitting'.

The ways that we clump and split interact with the systems that facilitate payment. Thus, our method can increase transaction costs at the physiotherapy practice (eg, by requiring two transactions to facilitate payment); and at the insurer level (eg, by requiring new information architecture).

Consumables and incidentals

Consumables and incidentals usually occur in two contexts.

The first context is that of high volume and routine physiotherapy services. We take the view that there is a reasonable expectation amongst clients and third-party funders that the costs of consumables and incidentals will be encompassed within the fees charged for these high volume and routine services.

The second arena relates to differentiated services, often of lower volume and often at the more progressed edge of physiotherapy (eg, lymphoedema and pain management). Increasingly, costs which are not marginal are integral to the provision of these services (eg, garments in the case of lymphoedema). We anticipate that these costs will be additional to the costs of the consultation and that the client's informed consent will be gained when the cost is to be incurred.

We think it will be beneficial to all parties to develop an efficient authorising environment that facilitates the funding of aids, equipment, tools, orthoses and garments; and engage in discussions about their adequate coverage outside the NPSDs.

This is the approach we have taken to [travel costs](#).

An overview of some important changes in the 2017 National Physiotherapy Service Descriptors

A consultation is defined as 'synchronous audio-visual communication'

There is consistent evidence about the positive value of digitally-mediated services.^{2,3,4}

Our clients are increasingly seeking digitally-mediated services as a part of their service mix. Increasingly, physiotherapists are providing services through digitally-mediated channels; and there is a view that the substantive impediment to widespread adoption is the way this mode of physiotherapy is dealt with my insurance schemes.

In line with the professional services being provided by physiotherapists in 2017, the NPSDs define a consultation as being synchronous audio-visual communication.

These services can meet some unmet needs in some populations (eg, regional and rural populations). They need to be provided by physiotherapists and thus displace other services when undertaken.

As with all other physiotherapy services we anticipate that physiotherapists will consider the appropriateness of this mode of service delivery on a case-by-case basis; and that the services will be delivered in accordance with the principles of professional conduct and the relevant professional and practice guidelines.

Travel is a separate service

On each occasion that travel to a client has occurs, the core of the interaction is the provision of a professional service. This service is not travel. The same principle applies to face-to-face meetings with insurers and other professionals – the service is what occurs at the end of the travel (and before the return to the clinic or travel to the next occasion of service).

The direct and indirect costs of travel are separate to the professional service (eg, the home-based treatment). These costs include an opportunity cost – of being prevented from providing other services. In addition, they include overhead/transit costs (eg, 'wear and tear' on a vehicle; public transport costs where this is a suitable alternative to private transport; and additional insurance costs where work-related travel is outside the existing workers' compensation model).

Thus, one might conceive a consultation which occurs away from the usual setting to involve three cost elements – the 'professional service', the 'opportunity cost' and the 'transit cost'.

As a result, the NPSDs reflect two services:

- The professional service (which is assessed as though it occurred at the [normal practice](#) and billed on that basis)
- The travel (allowing for recovery of the cost of the lost opportunity and transit cost).

Indicative rules surrounding travel (for incorporation in explanatory notes) are being considered. This sort of model might change the arrangements for mobile services, as there would be no 'normal practice' as a base.

The transit cost is considered to be captured as a component of the opportunity cost (ie, the overheads incorporated into the hourly rate for professional services are cover these transit costs).

We distinguish the task of 'assessing'

Our NPSDs need to provide clarity and minimise ambiguity.

In clinical practice, despite the underlying principles of what is occurring being the same, there are three distinct uses of the notion of 'assess'/'(re)assess'. 'Assessment' can be:

- A substantive activity, undertaken at the start of each phase of care – a form of summative assessment
- An incremental activity undertaken within a (treatment) session, based on the observation of something that requires marginal adjustment of the approach – a form of formative assessment
- A (usually) brief activity that is summative (ie, 'I'm confident about your achievement, and you can cease seeing me.'). This is less frequently discussed and explicitly documented. In the context of models of assertive outreach, it may be – 'and I'll follow up in 3 months to see how you are doing.'

To reflect contemporary practice, we have differentiated 'substantive' assessment from the 'incremental' or brief appraisal and created specific service descriptors for the 'substantive task'.

When we use the term 'assessment' we mean this substantive task.

In line with our broader approach, we are silent about the foundation activity of incremental, within-consultation 'assessment'. Our decision to omit this foundation activity from the descriptors DOES NOT reduce the nature of the obligation. It merely removes it from the text of the descriptor and positions it more clearly as an obligation the nature of which is principally self-regulated.



We include descriptors that allow for physiotherapists to seek an independent opinion / plan

The reality for our clients is that progress of treatment and/or rehabilitation may fall outside the plan or expected course of injury management.

Where this occurs, it is important for client care to be reviewed and for physiotherapists to have access to professional support. It is also important for the advanced expertise of specialised physiotherapists who provide this support to be recognised.

We have developed a service descriptor that reflects this need.

Our schedule for services seeks to systematically accommodate the impact of pre-existing disability that predictably increases consultation complexity and/or time

A material proportion of clients come to physiotherapy with existing disability that predictably and routinely increases consultation time. The disability may exist prior to, and be unrelated to the presenting problem. The disability may, for example, be one associated with communication, be an intellectual disability, or impair the ease or speed of movement.

The prevalence of these circumstances is likely to increase as the life expectancy of people with disability and their participation in society increases.

Constructing a payment model focused solely on the nature and complexity of the presenting problem and the requirements for its remediation creates a systemic disadvantage to people with some pre-existing disabilities. Provided care on an equal footing, especially where the rebates/fees/subsidies are comparatively low, people with existing disabilities that slow the flow of care are likely to receive less care, or, in the alternate, physiotherapists will need to bear the marginal cost of providing equivalent care.

The physiotherapy profession considers the provision of equitable services to be a matter of social justice.

Our definition of 'complexity' has incorporated the ability to accommodate the presence of disability which increases the time needed in a consultation. In doing this we provide a means for affected clients to ensure that their subsidy/rebate is appropriate to the context, as providing services of sufficient length runs a risk of resulting in systematically higher out-of-pocket costs for people who have a pre-existing disability.

The elements of our service descriptors

Each NPSD has a long title, a short title, an activity descriptor which describes the service/activity and a relative value. For example,

Long title	Assessment – uncomplicated
Short title	Ass 1
Activity descriptor	<p>A <u>consultation</u> that usually incorporates:</p> <ul style="list-style-type: none"> • collection of, or confirmation of, demographic data (eg, date of birth Aboriginal status, gender), contact details of the patient and their doctor/practice and (health-related) insurance status • assessment of : <ul style="list-style-type: none"> – the client’s understanding and description of their condition and its symptoms, its context and its trajectory (subjective assessment) – the objective signs related to the client’s presentation (objective assessment) • application of professional acumen to interpret and draw inferences from the subjective and objective assessment • use of the assessment and its interpretation to plan care.
Relativity	1.5

We provide an explanation of our approach to relative values later in this document.

Indicative schedule of service descriptors

Overall, the documentation of our NPSDs in this form it follows a clinical path from assessment through to discharge.

The categories we have used to date are:

- Assessments
- Plans
- Requests for authorisation
- (Subsequent) consultations
- Other specialised consultations
- Return to work service descriptors
- Reviews
- (Verbal) Communication
- Report writing
- Travel
- Incidentals and other costs
- Non-attendance.

Assessments

Summary

Assessment consultations may occur more than once. They may occur when:

- there is a new episode of care and/or
- the progress of treatment and/or rehabilitation falls outside the expected course of care anticipated in the client's management plan
- there is a specific trigger for (re)assessment (eg, the client requests to be assessed prior to undertaking a particular activity such as diving).

The following assessment services are proposed:

- [Assessment 1](#)
- [Assessment 2](#)
- [Assessment 3](#)
- [Lymphoedema Assessment](#)
- [Neurological Assessment](#)
- [Pelvic Floor Condition\(s\) Assessment](#)
- [Assessment of persistent or recurrent pain](#)
- [Wheelchair Assessment](#)
- [Independent Clinical Review](#)



Notes

In an environment where physiotherapists increasingly adopt a bio-psycho-social model of care⁵, the notion of 'two areas' is restricting. It is difficult to accommodate the impact of some mental health co-morbidities in the model (for example), unless the approach defaults to the view that all mental health issues make an assessment 'complex' (which is a limited view of the continuum of mental health conditions). As a result, we have endeavoured to provide for an assessment service (Assessment 2) that moves beyond the notion of 'two areas'.

Additionally, we have endeavoured to provide a clear but encompassing definition of 'complex' based on the diversity of factors our members address. The definition can be considered as a sort of algorithm, allowing members to document the complexity in the client's clinical notes by referring to the factors that give rise to the complexity.

The proposed Wheelchair Assessment service descriptor is unusual, in that it includes a specific checklist. For a very small number of items, where comprehensiveness of the assessment is very critical, we believe that a checklist will enhance safety and quality.

Long title	Assessment 1
Short title	ASS 1
Activity descriptor	<p>A consultation that usually incorporates:</p> <ul style="list-style-type: none"> • collection of, or confirmation of, demographic data (eg, date of birth Aboriginal status, gender), contact details of the patient and their doctor/practice and (health-related) insurance status • assessment of : <ul style="list-style-type: none"> – the client's understanding and description of their condition and its symptoms, its context and its trajectory (subjective assessment) – the objective signs related to the client's presentation (objective assessment) • application of professional acumen to interpret and draw inferences from the subjective and objective assessment • use of the assessment and its interpretation to plan care.
Relativity	1.5

Long title	Assessment 2
Short title	ASS 2
Activity descriptor	<p>A consultation that usually incorporates:</p> <ul style="list-style-type: none"> • collection of, or confirmation of, demographic data (eg, date of birth Aboriginal status, gender), contact details of the patient and their doctor/practice and (health-related) insurance status • assessment of : <ul style="list-style-type: none"> – the client’s understanding and description of their condition and its symptoms, its context and its trajectory (subjective assessment) – the objective signs related to the client’s presentation (objective assessment) • application of professional acumen to interpret and draw inferences from the subjective and objective assessment • use of the assessment and its interpretation to plan care • where: <ul style="list-style-type: none"> – two separate injuries or conditions are present, AND – the physiotherapy intervention applied to one injury or condition does not affect the symptoms of the others, AND – neither of the injuries/conditions results in referred pain to another area; OR – the client’s presenting circumstances are of equivalent complexity.
Relativity	2.25

Long title	Assessment 3
Short title	ASS 3
Activity descriptor	<p>A consultation that usually incorporates:</p> <ul style="list-style-type: none"> • collection of, or confirmation of, demographic data (eg, date of birth Aboriginal status, gender), contact details of the patient and their doctor/practice and (health-related) insurance status • assessment of : <ul style="list-style-type: none"> – the client’s understanding and description of their condition and its symptoms, its context and its trajectory (subjective assessment) – the objective signs related to the client’s presentation (objective assessment) • application of professional acumen to interpret and draw inferences from the subjective and objective assessment • use of the assessment and its interpretation to plan care • where the client’s presentation is complex.
Relativity	3

Assessments (specialised)

Long title	Lymphoedema Assessment
Short title	ASS LYMPH
Activity descriptor	<p>A consultation that usually incorporates:</p> <ul style="list-style-type: none"> • collection of, or confirmation of, demographic data (eg, date of birth Aboriginal status, gender), contact details of the patient and their doctor/practice and (health-related) insurance status • assessment of : <ul style="list-style-type: none"> – the client's understanding and description of their condition and its symptoms, its context and its trajectory (subjective assessment) – the objective signs related to the client's presentation (objective assessment) • application of professional acumen to interpret and draw inferences from the subjective and objective assessment • use of the assessment and its interpretation to plan care • where the client has lymphoedema or is at risk of developing lymphoedema. <p>Lymphoedema assessment is conducted by a physiotherapist who has undertaken post-entry education specific to this area of care and developed competencies specific to this area of care.</p>
Relativity	3

Long title	Neurological Assessment
Short title	ASS NEURO
Activity descriptor	<p>A consultation that usually incorporates:</p> <ul style="list-style-type: none"> • collection of, or confirmation of, demographic data (eg, date of birth Aboriginal status, gender), contact details of the patient and their doctor/practice and (health-related) insurance status • assessment of : <ul style="list-style-type: none"> – the client's understanding and description of their condition and its symptoms, its context and its trajectory (subjective assessment) – the objective signs related to the client's presentation (objective assessment) • application of professional acumen to interpret and draw inferences from the subjective and objective assessment • use of the assessment and its interpretation to plan care • where the client has a neurological disorder. <p>The neurological assessment is conducted by a physiotherapist who has undertaken post-entry education specific to this area of care and developed competencies specific to this area of care.</p>
Relativity	3

Long title		Pelvic Floor Conditions Assessment
Short title	ASS PEL FLR	
Activity descriptor	<p>A consultation that usually incorporates:</p> <ul style="list-style-type: none"> • collection of, or confirmation of, demographic data (eg, date of birth Aboriginal status, gender), contact details of the patient and their doctor/practice and (health-related) insurance status • assessment of : <ul style="list-style-type: none"> – the client’s understanding and description of their condition and its symptoms, its context and its trajectory (subjective assessment) – the objective signs related to the client’s presentation (objective assessment) • application of professional acumen to interpret and draw inferences from the subjective and objective assessment • use of the assessment and its interpretation to plan care • where the client presents with signs or symptoms of a pelvic floor condition. <p>Pelvic floor assessment is conducted by a physiotherapist who has undertaken post-entry education specific to this area of care and developed competencies specific to this area of care.</p>	
Relativity	3	

Long title		Assessment of persistent or recurrent pain
Short title	ASS PAIN	
Activity descriptor	<p>A consultation that usually incorporates:</p> <ul style="list-style-type: none"> • Confirmation of demographic data (eg, date of birth, Aboriginal status, gender), contact details of the client and their doctor/practice and (health-related) insurance status • An interview based assessment of : <ul style="list-style-type: none"> – the client’s understanding of their condition and its symptoms, its context including health status, prior exposure to risk factors including psychosocial factors, and their expectations of your intervention • Development of hypotheses to be tested in physical assessment. • Physical examination <ul style="list-style-type: none"> – To exclude signs of sinister pathology (ie, ‘red flags’) – For signs of pathology related to the client’s pain reports – For evidence of the impact on function and movement related to the client’s presentation • Application of clinical reasoning to interpret findings from the clinical assessment (particularly identification of underlying mechanisms/pathologies relating to the client’s pain presentation) • Development of a plan of action • Choice of appropriate measures to gauge change over time (including psychosocial measures). <p>The assessment of persistent or recurrent pain is conducted by a physiotherapist who can demonstrate competence in a psychologically informed manner of assessment and management of clients with pain.</p>	
Relativity	3	

Long title	Wheelchair Assessment
Short title	ASS WHEEL
Activity descriptor	<p>A consultation that usually incorporates:</p> <ul style="list-style-type: none"> • collection of, or confirmation of, demographic data (eg, date of birth Aboriginal status, gender), contact details of the patient and their doctor/practice and (health-related) insurance status • assessment of : <ul style="list-style-type: none"> – Physical capacity – Decision-making capacity – Psycho-social and behavioural considerations – Cognition and perception – Sensory impairments – Upper limb capacity and risk of injury – Cardiovascular fitness – Co-morbid conditions – Use of alcohol, prescribed medicines and illicit drugs – Long term need of the wheelchair – Health and safety concerns – The required features of the wheelchair – The propulsion of the wheelchair – The needs for education and training of the client, their family and friends, and – The maintenance requirements of the wheelchair and the client's ability to meet these. • application of professional acumen to interpret and draw inferences from the subjective and objective assessment • use of the assessment and its interpretation to plan care. <p>The assessment for prescription of a wheelchair (or scooter) is provided by a physiotherapist, in person and to an individual client.</p> <p>The assessment for prescription of a wheelchair is conducted by a physiotherapist who has undertaken post-entry education specific to this area of care and developed competencies specific to this area of care</p>
Relativity	To be paid in 6 minute increments of an agreed hourly rate.

Long title	Independent Clinical Review
Short title	<i>IND REV</i>
Activity descriptor	<p>An <u>episode of care</u> provided by an independent specialised physiotherapist that aims to:</p> <ul style="list-style-type: none"> • identify the causes of treatment / care / rehabilitation that has fallen outside the planned course of injury management • provide • a critical appraisal of the assessment undertaken by the treating physiotherapist • re-assessment (where appropriate) of • the client's understanding and description of their condition and its symptoms, its context and its trajectory (subjective assessment) • the objective signs related to the client's presentation (objective assessment) • an interpretation and clinical impression based on the subjective and objective assessment • a revised / alternative plan for care • a revised selection of: • the way(s) that the impact of the actions are to be monitored, and • the timing and indicators for evaluation of the planned and provided care • a written post-review report from the independent consultant • a post-review discussion between the treating physiotherapist and the independent specialised physiotherapist that aims to inform and upskill the treating physiotherapist.
Relativity	To be paid in 6 minute increments of an agreed hourly rate.

Consultations

Summary

Overall, we have worked on an approach that separates an assessment from treatment.

There are two reasons for this:

- A substantive 'assessment' can occupy the entire 'space' of a clinical encounter and our members have wanted us to establish a framework that makes this clear
- Physiotherapists increasingly report that the level of patient subsidy for encounters means that they need to focus on completion of one activity at a time, resisting the pressure to compromise both assessment and treatment because of the level of subsidy
- A complaint from some insurance schemes is the absence of re-assessments in the course of clinical care; and distinguishing the assessment activity assists to make clear when this occurs.

In this context, patients would claim two items for one episode of care – where they were both assessed and treated. We appreciate that this may add to transaction costs and confusion. An alternative would be to create codes which are combined – an A+C model – A = Assessment, C = Consultation; A+C=B (B is a single claim for both services).

The following assessment services are proposed:

- [Consultation 1](#)
- [Consultation 2](#)
- [Consultation 3](#)
- [Group Consultation \(land\)](#)
- [Group Consultation \(water\)](#)
- [Class Consultation \(land\)](#)
- [Class Consultation \(water\)](#)
- [Primary Prevention Activity](#)
- [Lymphoedema Care](#)
- [Neurological Rehabilitation](#)
- [Pelvic Floor Condition Care](#)
- [Consultation with client who has persistent or recurrent pain](#)

Notes

We have not created group and class service descriptors for different conditions (eg, antenatal care, or osteoarthritis).

The *Class Consultation* service descriptors use the term 'activity' rather than 'consultation' as the definition of an activity is not restricted to the provision of direct clinical care.

Long title	Consultation 1
Short title	CONS 1
Activity descriptor	<p>A consultation that is subsequent to, and informed by, an assessment.</p> <p>The intervention undertaken is anticipated within the client's management plan and aims to achieve outcomes anticipated in the management plan.</p> <p>The circumstances of the consultation are comparatively uncomplicated.</p>
Relativity	1

Long title	Consultation 2
Short title	CONS 2
Activity descriptor	<p>A consultation that is subsequent to, and informed by, an assessment.</p> <p>The client has:</p> <ul style="list-style-type: none"> • two separate injuries or conditions are present, AND • the physiotherapy intervention applied to one injury or condition does not affect the symptoms of the others, AND • neither of the injuries/conditions results in referred pain to another area; OR • the client's presenting circumstances are of equivalent complexity. <p>The intervention undertaken is anticipated within the client's management plan and aims to achieve outcomes anticipated in the management plan.</p> <p>The circumstances of the consultation are relatively uncomplicated.</p>
Relativity	1.5

Long title	Consultation 3
Short title	CONS 3
Activity descriptor	<p>A consultation that is subsequent to, and informed by, an assessment.</p> <p>The client's presentation is complex and/or the circumstances of the consultation are complex.</p> <p>The intervention undertaken is anticipated within the client's management plan and aims to achieve outcomes anticipated in the management plan.</p>
Relativity	3

Long title	Group Consultation (land)
Short title	CONS GRP L
Activity descriptor	<p>A land-based consultation led by a physiotherapist in which a group of clients are provided with differentiated interventions.</p> <p>Each person participating in a land-based Group Consultation will have had an individual pre-intervention assessment that informs this consultation.</p> <p>Each participant will undertake an intervention designed specifically for them. The physiotherapist will provide each participant with tailored feedback and adjust the intervention where clinically indicated during the session.</p> <p>The session will be of sufficient length to allow this feedback and adjustment for each participant to occur.</p>
Relativity	0.75

Long title	Group Consultation (water)
Short title	CONS GRP W
Activity descriptor	<p>A water-based consultation led by a physiotherapist in which a group of clients are provided with differentiated interventions.</p> <p>Each person participating in a water-based Group Consultation will have had an individual pre-intervention assessment that informs this consultation.</p> <p>Each participant will undertake an intervention designed specifically for them. The physiotherapist will provide each participant with tailored feedback and adjust the intervention where clinically indicated during the session.</p> <p>The session will be of sufficient length to allow this feedback and adjustment for each participant to occur.</p>
Relativity	0.80

Long title	Class Consultation (land)
Short title	CONS CLASS L
Activity descriptor	<p>A land-based activity led by a physiotherapist in which a number of clients are provided with the same intervention simultaneously.</p> <p>Each person participating in a land-based Class Consultation will have been screened for risks to their safe participation in the Class.</p>
Relativity	0.60

Class Consultation (water)	
Long title	Class Consultation (water)
Short title	CONS CLASS W
Activity descriptor	A water-based activity led by a physiotherapist in which a number of clients are provided with the same intervention simultaneously. Each person participating in a water-based Class Consultation will have been screened for risks to their safe participation in the Class.
Relativity	0.65

Primary Prevention Activity	
Long title	Primary Prevention Activity
Short title	PRIM PREV
Activity descriptor	An activity , led by a physiotherapist, the aim of which is primary prevention . The provision of the activity does not require screening or assessment of an individual prior to the activity.
Relativity	To be paid in 6 minute increments of an agreed hourly rate.

Lymphoedema care	
Long title	Lymphoedema care
Short title	CONS LYMPHO
Activity descriptor	A consultation that is subsequent to, and informed by, a Lymphoedema assessment . Lymphoedema care is provided by a physiotherapist who has undertaken post-entry education specific to this area of care and developed competencies specific to this area of care.
Relativity	3

Neurological Rehabilitation	
Long title	Neurological Rehabilitation
Short title	CONS NEURO
Activity descriptor	A consultation that is subsequent to, and informed by, a Neurological assessment . Neurological rehabilitation is provided by a physiotherapist who has undertaken post-entry education specific to this area of care and developed competencies specific to this area of care.
Relativity	3

Long title		Pelvic Floor Condition Care
Short title	CONS PEL FLR	
Activity descriptor	<p>A consultation that is subsequent to, and informed by, a Pelvic Floor Conditions assessment.</p> <p>The intervention undertaken is anticipated within the client's management plan.</p> <p>Care for a person with a pelvic floor condition is provided by a physiotherapist who has undertaken post-entry education specific to this area of care and developed competencies specific to this area of care.</p>	
Relativity	3	

Long title		Consultation with client who has persistent or recurrent pain
Short title	CONS PAIN	
Activity descriptor	<p>A consultation that usually incorporates:</p> <ul style="list-style-type: none"> • a re-assessment of clinically important parameters established during initial or subsequent assessment • identification of any change in status with regard to client's presentation or related health and well-being status • education might consist of: <ul style="list-style-type: none"> – explaining pain mechanisms – sharing common impacts of persistent pain – comparing the efficacy of active versus passive treatment – teaching cognitive and behavioural strategies including pacing – presenting the benefits of movement and exercise – providing resources (written/visual or internet-based) for education and training • devising or revising home- or work-based exercise program • manual therapy for increasing confidence with movement, facilitating improvement in range of movement and general body awareness and control <p>The consultation with a pain client is conducted by a physiotherapist who can demonstrate advanced competence in the assessment and management of clients with pain.</p>	
Relativity	3	

Return to work

Long title	Environment / Workplace Assessment
Short title	WORKPLACE ASS
Activity descriptor	<p>An activity that is an assessment by a physiotherapist of the environment in which the client is required to function, where that environment has an impact on the management plan for the patient.</p> <p>An environment / workplace assessment progresses the rehabilitation program and / or reports rehabilitation progress via assessment of the working, home and / or external environment.</p> <p>A patient environment / workplace assessment is utilised to assist the patient, medical practitioner, employer, vocational rehabilitation provider and/or third party payer in primary and secondary prevention.</p> <p>Environment / workplace assessments can occur between the physiotherapist and the patient, employer, vocational rehabilitation provider, solicitor, private health insurer and / or the third party payer.</p>
Relativity	To be paid in 6 minute increments of an agreed hourly rate.

Long title	Functional Capacity Assessment
Short title	FUN CAP ASS
Activity descriptor	<p>A consultation that is a systematic assessment, by a physiotherapist, using a series of standardised tests and work specific simulation activities to assess a worker's functional capacity for work or potential to return to suitable work.</p> <p>The objectives of the FCE are to:</p> <ul style="list-style-type: none"> determine a worker's abilities over a range of physical demands to assist their functional recovery assess the worker's functional capacity determine a worker's ability to work; determine a worker's job-specific rehabilitation needs document a worker's progress before, during or after rehabilitation. <p>See Guidelines for Functional Capacity Assessment.</p>
Relativity	To be paid in 6 minute increments of an agreed hourly rate.

Long title	Suitable Duties Program
Short title	SUIT DUT PROG
Activity descriptor	An activity that involves documentation of suitable duties for a worker, detailing specific information necessary for a safe and effective return to the workplace.
Relativity	To be paid in 6 minute increments of an agreed hourly rate.

Communication

We take the position that communication with clients generally occurs within consultations. The position that we have taken about synchronous audio-visual communication leaves telephone contact as a mode of care outstanding as an issue.

Summary

The following assessment communication services are proposed:

- [Professional communication](#)
- [Case Conference](#)
- [Provision of a written report](#)
- [Discharge plan](#)

Notes

The idea of including a Professional communication service descriptor arises from the need to reflect bilateral communication in addition to case conferencing which is multilateral.

We want to ensure that 'professional courtesies' continue. It is common for 'transactional' contacts to be less than three (3) minutes in areas like call-centres. However some members have reported problems with external stakeholders calling repeatedly for short periods resulting in a situation which, as a whole, is Professional communication beyond professional courtesies.

Professional communication	
Long title	
Short title	COMM PROF
Activity descriptor	<p>An <u>activity</u>, the purpose of which is to facilitate progress towards a client's outcomes as agreed in an <u>assessment</u>.</p> <p>The activity involves:</p> <ul style="list-style-type: none"> • bilateral verbal communication between a treating physiotherapist and • an individual client's family member or friend or • another professional in the care team or • another professional acting on behalf of the client. <p>Although an occasion of communication lasting less than 3 (three) minutes, between the treating physiotherapist and the people listed in this descriptor, is not covered by this descriptor, a series of short occasions may be considered to be an activity covered by this descriptor.</p>
Relativity	To be paid in 6 minute increments of an agreed hourly rate.

Case conference	
Long title	
Short title	CASE CONF
Activity descriptor	<p>An <u>activity</u>, the purpose of which is to facilitate <u>management continuity</u>.</p> <p>The activity involves synchronous audio-visual contact between the physiotherapist and at least two of the following people:</p> <ul style="list-style-type: none"> • an individual client • an individual client's family member or friend • another professional in the care team • another professional acting on behalf of the client.
Relativity	To be paid in 6 minute increments of an agreed hourly rate.

Long title	Provision of a written report
Short title	<i>REPORT</i>
Activity descriptor	<p>An activity, the purpose of which is to communicate to a third party (ie, not to the client).</p> <p>A report, generally, is made at the request of a referral source, compensable scheme, employer or solicitor.</p> <p>A scope of the communication may involve documentation of:</p> <ul style="list-style-type: none"> • a client's <ul style="list-style-type: none"> – eligibility for service, and/or – assessment, and/or – management plan, and/or – progress in the context of their management plan, and/or – Capacity for work, and/or – Recommendations regarding future treatment, – prognosis • the impact that a client's home environment may have on their return to work and recommendations for improving the likelihood of prompt and sustained return to work • the impact that a client's work environment may have on their return to work and recommendations for improving the likelihood of prompt and sustained return to work • documented task analysis in a setting (including the home or workplace) • occupational risk identification in a setting (including a workplace) and recommendations for their remediation. <p>The scope of the report would usually be outlined by the party commissioning it.</p>
Relativity	To be paid in 6 minute increments of an agreed hourly rate.

Long title	Discharge plan
Short title	<i>DIS PLAN</i>
Activity descriptor	<p>An <u>activity</u> which has its focus on referring the patient to another service provider.</p> <p>The activity includes:</p> <ul style="list-style-type: none"> • preparation of a written summary of the management undertaken, outcomes achieved, and recommendations for future management or • providing a written plan to the patient for ongoing self-management.
Relativity	To be paid in 6 minute increments of an agreed hourly rate.

Custom-made orthosis

This area of the NPSDs reflects an ongoing concern about how to manage the role of providing orthoses.

Summary

It is proposed that we include the following service descriptors:

- [Custom-made orthosis \(lower limb\) Consultation](#)
- [Custom-made orthosis \(upper limb\) Consultation](#)
- [Review of custom-made orthosis](#)

Notes

We are in discussion about the provision of garments in the care of lymphoedema.

The profession is keen to achieve an approach to garments for the care of lymphoedema which is equitable across insurers.

Long title		Custom-made orthosis (lower limb) Consultation
Short title		CM ORTH LL
Activity descriptor		<p>This is an activity undertaken by a physiotherapist involving:</p> <ul style="list-style-type: none"> • assessment of the injury or condition • measurement of the affected lower limb • moulding, fitting and modification of the materials to create an orthosis • provision of education about self-care during the use of the orthosis. <p>This activity is undertaken by a physiotherapist who has undertaken post-entry education specific to this area of care and developed competencies specific to this area of care.</p> <p><i>NB: This item does not include the cost of any orthosis.</i></p>
Relativity		1.5

Long title		Custom-made orthosis (upper limb) Consultation
Short title		CM ORTH UL
Activity descriptor		<p>This is an activity undertaken by a physiotherapist involving:</p> <ul style="list-style-type: none"> • assessment of the injury or condition • measurement of the affected upper limb • moulding, fitting and modification of the materials to create an orthosis • provision of education about self-care during the use of the orthosis. <p>This activity is undertaken by a physiotherapist who has undertaken post-entry education specific to this area of care and developed competencies specific to this area of care.</p> <p><i>NB: This item does not include the cost of any orthosis.</i></p>
Relativity		1.5

Long title		Review of custom-made orthosis
Short title		ORTH REV
Activity descriptor		<p>This is an activity undertaken by a physiotherapist involving:</p> <ul style="list-style-type: none"> • re-assessment of the injury or condition • measurement of the affected limb where required • moulding, fitting and modification of the materials to adjust an orthosis • provision of education about self-care during the use of the orthosis. <p>This activity is undertaken by a physiotherapist who has undertaken post-entry education specific to this area of care and developed competencies specific to this area of care.</p> <p><i>NB: This item does not include the cost of any orthosis.</i></p>
Relativity		1.5

Travel

Long title	Travel
Short title	<i>TRAVEL</i>
Activity descriptor	This service descriptor is applicable where the most appropriate clinical management of the client or attendance at professional meetings pertaining to a client or service provision that requires a physiotherapist to travel off site. Examples include but are not limited to: home, hospital, pool, worksite, gymnasium, school, sports venue, residential care facility and community centre.
Relativity	Hourly professional services fee plus a mileage rate at least at ATO rate.

Other costs and incidentals

Long title	Other costs
Short title	<i>OTHER COSTS</i>
Activity descriptor	Provision of equipment, garments, products, technologies and other adjuncts to physiotherapy that is: <ul style="list-style-type: none"> • clinically indicated and appropriate as a part of the management plan • not marginal in cost.*
Relativity	Cost plus appropriate margin.

* Where there is a reasonable expectation amongst clients and third-party funders that the costs of consumables and incidentals are marginal and would be encompassed within the fees, it is preferable to ensure that the fee charged for the service incorporates the relevant costs, rather than use this item.

Non-Attendance

Long title	Fee for client non-attendance
Short title	<i>NON-ATTEND</i>
Activity descriptor	A non-attendance fee occurs when a client does not present for a booked appointment without sufficient prior notification. The client or third party payer is liable for the full cost of the cancelled or missed service where this is not prohibited by legislation.
Relativity	Discretionary.

Relativity

In the ideal, remuneration for services would take account of the degree to which the service achieved health outcomes – the notion that the goal is to optimise the health outcomes achieved per dollar spent.¹

A number of factors, including the challenges of competing desired outcomes, achieving outcomes and measuring outcomes mean that a more pragmatic approach is needed.

Historically, we have taken a 'relative value' approach. This is better characterized as a 'relativity' approach as work on 'value' is complex.

In this approach, the relativity reflects the *cost* of delivering the service *relative* to one 'base unit.' Our base unit has been the cost of what we are indicatively calling a *Consultation – uncomplicated*, undertaken at the [normal practice](#) during [normal opening hours](#).

Historically, our service descriptors have been service-based and not time-based. We have retained this method.

One reason for this is that time does not equate to risk. A circumstance with more risk, even if the time taken for the service is equal, needs to attract a higher relativity. This higher relativity is designed to take account of the incentives needed to work in the environment and the potential costs (eg, marginal additional profession indemnity insurance costs, capital and equipment costs) in ensuring reliable quality.

Additionally, time taken does not necessarily equal safety and quality provided. For example, a more competent/advanced practitioner may be able to treat a client with multiple problems in less time than an entry-level physiotherapist. The advantage of a relativity model is that the relativity works on the basis of the 'good physiotherapist' and should a more advanced physiotherapist be able to provide the service in a shorter period, then they are advantaged.

Time, as a surrogate for cost also fails to account for the need to have particular infrastructure, including equipment, for some physiotherapy services.

However, there are exceptions where it is useful to characterize some services as having a value based on the time taken (eg, preparation of reports, and professional communication including case conferences).

As a result, we end up with a marker for an hourly rate.

Following is our current model of relativities.

Relativity Table

Activity Descriptor	Current (2011) relativity	Proposed relativity
Assessments		
Assessment 1	1.5	1.5
Assessment 2	2.25	2.25
Assessment 3	3	3
Lymphoedema Assessment	n.a.	3
Neurological Assessment	n.a.	3
Pelvic Floor Conditions Assessment	n.a.	3
Assessment of persistent or recurrent pain	n.a.	3
Wheelchair Assessment	n.a.	Increment of hourly rate
Independent Clinical Review	n.a.	Increment of hourly rate
Consultations		
Consultation 1 ⁶	1 [base rate]	1 [base rate]
Consultation 2	1.5	1.5
Consultation 3	2	2
Group Consultation (land)	0.75	0.75
Group Consultation (water)	0.8	0.8
Class Consultation (land)	0.6	0.6
Class Consultation (water)	0.65	0.65
Primary Prevention Activity	n.a.	Increment of hourly rate
Lymphoedema care	n.a.	3
Neurological Rehabilitation	n.a.	3
Pelvic Floor Condition Care	n.a.	3
Consultation with client who has persistent or recurrent pain	n.a.	3
Return to work		
Environment / Workplace Assessment	n.a.	Increment of hourly rate
Functional Capacity Assessment	n.a.	Increment of hourly rate
Suitable Duties Program	n.a.	Increment of hourly rate

Activity Descriptor	Current (2011) relativity	Proposed relativity
Communication		
Professional communication	Hourly	Increment of hourly rate
Case conference	Hourly	Increment of hourly rate
Provision of a written report	Hourly	Increment of hourly rate
Discharge Plan	Hourly	Increment of hourly rate
Custom-made orthosis		
Custom-made orthosis (lower limb) consultation	None	1.5
Custom-made orthosis (upper limb) consultation	None	1.5
Review of custom-made orthosis	None	1.5
Travel		
Travel	Hourly	Increment of hourly rate
Non-attendance		
Fee for client non-attendance	Discretionary	Discretionary

Definitions

Activity

Activity means any action, whether remunerated or not, in which the individual uses their skills and knowledge as a physiotherapist. The definition of an activity is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with patients or clients, working in management, administration, education, research, advisory, regulatory or policy development roles and any other roles that have an impact on safe, effective delivery of health services in the health profession.⁷

Circumstances of the consultation

Historically, the focus on the NPSDs has been on the complexity of the patient's presentation. Since 2000, there has been a growing movement to complement a person-based approach to safety with a systems-based approach to safety.⁸

In this context, the factors that make a consultation complex may reside in factors mediated by:

- the clinical condition (eg, the extent or severity of burns)
- the patient (eg, having a pre-existing disability that materially impedes the routine flow of the consultation)
- the setting (eg, that it has very low infrastructure).

'Clump' and 'split'

Differentiation / splitting of services into discrete NPSDs can have a number of advantages, including the ability to differentiate fees and the ability to track (differential) utilisation patterns.

Despite the potential benefits, we have been mindful of the problems that have arisen in the Medicare Benefits Schedule – that the schedule for payments has become complex and long. This complexity adds to transaction costs for the provider and funder, and can create opportunities for 'roting'.

As a result, we have endeavoured to arrive at a functional group of service descriptors.

We have considered which services are 'the same/similar' and which are 'different'. In creating categories, we have been conscious of two orientations:

- Clumping – that two things are in the same category unless there is some convincing reason to divide them; or
- Splitting – that two things are in different categories unless there is some convincing reason to unite them.

We have taken a 'clumping' orientation. This means, that, as a general rule, we have classed all 'assessments' as an 'assessment' and distinguished them only when we thought that there was a convincing reason (eg, the required expertise of the physiotherapist and the likely relativities).

However, we have split 'assessment' from 'treatment'. This 'splitting' reflects a view in the profession that the activities need to be able to be distinguished and combined in a variety of ways (eg, Assessment 2 and Consultation 2; or Assessment 2 and Consultation 1). We envisage there being administrative tools (eg, online claiming tools) which would allow the efficient claiming of multiple services through one transaction.

Complex

Complex means:

- consisting of many different and connected parts
 - which need to be perceived as a whole⁹ and
 - which need to be appraised for their relative significance and impact.¹²

Complex means, but is not limited to:

- Condition-mediated factors such as:
 - Extensive or severe burns
 - Complicated hand injuries involving multiple joints and tissues
 - Some paediatric conditions
 - Some neurological and gerontological conditions (eg, acquired brain injuries, head injuries, spinal cord and severe spinal injuries and major trauma)
 - Chronic pain conditions and
 - Some women's health conditions
- Patient-mediated factors such as:
 - Having a language spoken at home which is different to that spoken routinely by the physiotherapist in their professional practice

- Having a pre-existing disability that materially impedes the routine flow of the consultation (eg, a disability that impairs the ease of communication, the ease of movement in the setting, or learning and education – such as an intellectual disability)
- Setting-mediated factors such as:
 - Infrastructure at a lower level than usually used (other than at the normal practice)
 - High time pressure on decision-making due to circumstances beyond the physiotherapist's control.

Consultation

A consultation is an activity that requires synchronous audio-visual contact between the patient and the physiotherapist (or the person delegated by the physiotherapist to undertake a task within the consultation).

It is not necessary for the physiotherapist and the client to be physically collocated for the activity to be a consultation.

Where the activity is occurring for more than one client simultaneously, the activity is a Group Consultation or Class Consultation.

A consultation ceases when the audio-visual contact between the patient and the physiotherapist ceases, unless the physiotherapist provides a structured hand-off to a physiotherapy assistant or student in an accredited physiotherapy course who is delegated to undertake a defined task (or tasks) which is integral to achieving the planned outcomes of the consultation; and the consultation is concluded with contact with the treating physiotherapist.

A consultation may occur on land or in water, or a combination of these.

Episode of care

An episode of care refers to all clinically-related health services used to treat one patient who has been diagnosed with distinct conditions arising from injury or health-related issues. An episode of care lasts from the physiotherapist's assessment and diagnosis of the symptoms, and the delivery of treatment until the patient has reached their goals as indicated by the treatment plan and is discharged.

Falls outside the expected course of care

The health outcome may fall outside the expected course of care for a variety of reasons. These include:

- The client presents with an additional condition or injury
- The client's response to the care is other than anticipated

In person

In person means that the physiotherapist and client are physically collocated.

Management continuity

Management continuity is a consistent and approach by members of the care team to the management of a health condition that responds to a client's changing needs.¹⁰

New episode of care

A new episode of care occurs when a worker has ceased treatment more than three (3) months previously and returns for additional treatment for the same injury with the same or a different physiotherapist. The determination of whether three (3) months has passed is to exclude brief occasions of contact between the physiotherapist and the worker that involve outreach by the physiotherapist to monitor whether the worker's wellbeing is maintained after treatment has ceased.

Normal opening hours

Ordinary hours of work for physiotherapists and their staff in private practice are set out in the Health Professionals and Support Services Award (2010). The public sector is governed by individual and different Awards in each state and territory. The ordinary hours set out in each Award are a guide only and employers and employees have discretion to negotiate their own ordinary hours of work.

We do not need to refer directly to 'ordinary hours of work'.

Normal practice

Normal practice means the premises in, or from which, a physiotherapist operates and treats patients. It also includes facilities where services for a variety of patients may be delivered on a regular or contracted basis such as a private hospital, hydrotherapy pool, workplace or gymnasium. Although services for an individual patient might require regular attendance at a site such as a private hospital or workplace, where this is within a single patient's episode of care, such a setting is not the physiotherapist's normal practice.

Occasion of service

An [activity](#) and a [consultation](#) are occasions of service.

An occasion of service is defined in the National Health Data Dictionary (NHDD). Thus we may want to align our terminology within the NPSDs, in order to facilitate health services research.

Broadly, the NHDD defines an occasion of service as any examination, consultation, treatment or other service provided to a patient.

A diagnostic test or a simultaneous set of related diagnostic tests for one patient referred to a hospital's pathology department should be reported as one occasion of service ie, multiple pathology tests performed on one sample are counted as a single occasion of service. Likewise multiple X-rays taken at a single referral represent one occasion of service. However, if a patient attends two different outpatient areas of the hospital on the same day, two different occasions of service would be recorded. Similarly, if a patient visits a cardiology clinic at which blood is taken for pathology testing and has a single script made up in the pharmacy department, the visit to the cardiology clinic is recorded under the medical/diagnostic clinic heading and the services provided by the pathology and pharmacy departments are also each counted separately. Occasions of service may comprise individual consultation and/or treatment or may be provided to groups of patients.

Primary prevention

Primary prevention is concerned with preventing the onset of disease; it aims to reduce the incidence of disease. It involves interventions that are applied before there is any evidence of disease or injury.

Screened for risks

Physiotherapists are familiar with tools that screen for risk (eg, 'Timed Up and Go', 'Sit to Stand Test', '6-metre Walk' and the Geriatric Depression Scale).

In screening for risks the physiotherapist / physiotherapy service would need to screen for risks that are:

- Patient mediated (eg, ability to understand risk in the context, or pregnancy), and
- Condition mediated (eg, poor balance).

The setting mediated risks (eg, slip hazards, the use of hydrotherapy or the use of exercise equipment) would need to inform the screening tool / checklist, allowing for foreseeable risks to be managed.

Screening would occur at the beginning of attendance for the mode of care and be monitored, rather than repeated, at the beginning of any occasion of service.

Severe injury

Severe injury includes, but is not limited to:

- spinal cord injury — acute traumatic lesion of the neural elements in the spinal canal (spinal cord and cauda equina) resulting in permanent sensory deficit, motor deficit or bladder/bowel dysfunction as a result of the workplace injury
- traumatic brain injury — based on evidence of a significant brain injury which results in permanent impairments of cognitive, physical and/or psychosocial functions. A defined period of post traumatic amnesia plus a Functional Independence Measure (FIM) at five or less, or two points less than the age appropriate norm (or equivalent where other assessment tools are used) is required
- multiple amputations (or equivalent loss of function) of the upper and/or lower extremities or single amputations (or equivalent loss of function) involving forequarter amputation or shoulder disarticulation, hindquarter amputation, hip disarticulation or "short" trans femoral amputation involving the loss of 65% or more of the length of the femur
- burns — full thickness burns greater than 40 per cent of the total body surface area or full thickness burns to the hands, face or genital area, or inhalation burns causing long term respiratory impairment, plus a FIM score at five or less, or two points less than the age norm (or equivalent where other assessment tools are used)
- permanent traumatic blindness, based on the legal definition of blindness.

Trigger for (re)assessment

A trigger for reassessment is the cause of reassessment. This may be the value recorded on measure in a Patient Reported Outcome Measure (PROM) in the context of an individual plan for care or in comparison to a relevant cohort. The trigger may be time-related (eg, a date on which follow-up after provisional discharge from care has occurred).

In the context of neurological assessment, reassessment might follow the person having a recent fall, a relapse of multiple sclerosis, an orthopaedic injury or vestibular condition in addition to an existing chronic neurological condition.

Parameters of travel costs

Travel costs can be claimed when the most appropriate clinical management of the client or attendance at professional meetings pertaining to a client or service provision that requires a physiotherapist to travel away from their [normal practice](#).

Such professional activities can include:

- Participating in a case conference
- Providing an independent clinical assessment or activities of daily living assessment or re-assessment or other service for the patient
- Meeting with an employer or insurance scheme officer to discuss return to work.

Examples of sites, travel to which may be appropriate, include but are not limited to:

- The patient's home
- A hospital in which the patient is an inpatient or visiting outpatient
- The patient's workplace
- A pool
- A gymnasium
- A school
- A sports venue
- A residential care facility, and
- A community centre.

The fee should be calculated per 6 minute block.

If services are provided to more than one worker at a single site, the travel costs for the journey are to be apportioned equally between workers.

Where multiple workers are being treated at different sites, but on the same episode of travel away from the physiotherapists normal practice, the travel charge must be divided proportionately, based on the time spent travelling between stops in the journey from, and back to, the normal practice (or, from and back to, the physiotherapist's home should this be the starting/finishing point).

Service Delivery Time

Service delivery time refers to the time of day that the service is delivered.

Service Delivery Time	Relativity
Normal hours	1
After hours	1.5

References

1. Porter ME. A Strategy for Health Care Reform — Toward a Value-Based System. *N Engl J Med* 2009; 361(2): 109-12.
2. Bennell KL Nelligan R Dobson F et al. Effectiveness of an Internet-Delivered Exercise and Pain-Coping Skills Training Intervention for Persons With Chronic Knee Pain: A Randomized Trial. *Ann Intern Med*. [Epub ahead of print 21 February 2017] doi: 10.7326/M16-171.
3. Nancarrow S Banbury A Buckley J. Evaluation of a National Broadband Network-enabled Telehealth trial for older people with chronic illness. *Australian Health Review* 2016; 40: 641-48.
4. Hwang R Bruning J Morris NR et al. Home-based telerehabilitation is not inferior to a centre-based program in patients with chronic heart failure: a randomised trial. *Journal of Physiotherapy* 2017, [http://www.journalofphysiotherapy.com/article/S1836-9553\(17\)30031-0/fulltext](http://www.journalofphysiotherapy.com/article/S1836-9553(17)30031-0/fulltext)
5. Kamper SJ Apeldoorn AT Chiarotto A et al. Multidisciplinary biopsychosocial rehabilitation for chronic low back pain: Cochrane systematic review and meta-analysis. *BMJ* 2015;350:h444 doi: 10.1136/bmj.h444 (Published 18 February 2015) (for example)
6. In the existing (2012) NPSDs this is called a Subsequent Consultation 1 area.
7. Based on the definition of 'practice' in the Physiotherapy Board of Australia Code of conduct for registered health practitioners <http://www.physiotherapyboard.gov.au/Codes-Guidelines.aspx>
8. Reason J. Human error – models and management. *BMJ* 2000; 320: 768–70.
9. Benner P. From novice to expert. *American Journal of Nursing* 1982; 82(3): 402-7.
10. Haggerty JL Reid RJ Freeman GK et al. Continuity of care – a multidisciplinary review. *BMJ* 2003; 327:1219–21.



physiotherapy.asn.au

