Consultation Draft Guidelines for the Provision of Relevant Services (Health and Related Services)

Background

I have been an IMC since its inception since the late 1990's and have been involved in treating workplace and motor vehicle accident injuries for almost 30 years.

I wholeheartedly welcome these changes and have been calling for these for sometime. Once the guidelines have been finalised , I trust they will be implemented and acted upon accordingly as there are a number of practitioners in my experience and day to day work (both medical and allied health practitioners) who are adversely impacting injured workers outcomes and needlessly costing the workers compensation and CTP systems vast sums of money and employers premium increases which have caused some to go bankrupt.

Overall I think the guidelines are excellent, I will confine my comments to the relevant sections

Part 3: Requirements for the provision of relevant services
Registration/accreditation requirements

21. Relevant services cannot be provided by a RSP who has:
(a) had their registration or licence under any relevant law, their accreditation or registration by, or membership of, a self-regulating professional organisation, limited or subject to any condition as a result of a disciplinary process or been suspended or disqualified from practice [1]

(b) had a complaint upheld about them or action taken by insurance, compensation or health authorities, government agencies or statutory bodies regarding their conduct

- (i) in any role in any insurance or compensation system in any Australian jurisdiction or
- (ii) in the provision of health services.

(c) been convicted of any criminal offence or have any pending criminal charges, or any civil proceedings lodged against them or their practice.

I absolutely support this change. I often look up a doctors AHPRA status, especially if they are being obstructive or difficult. The number of times that they have had adverse findings against them and /or restrictions on their practice is very high. I agree that they should not be allowed to treat injured workers.

Part 4: Requirements for the delivery of relevant services
26. Relevant services must be delivered in accordance with:
(a) the current version of the nationally endorsed *Clinical Framework for the Delivery of Health Services* [2]. In particular, note its five principles:

- (i) measure and demonstrate the effectiveness of treatment
- (ii) adopt a biopsychosocial approach
- (iii) empower the injured person to manage their injury

- (iv) implement goals focused on optimising function, participation and return to work
- (v) base treatment on best available research evidence.

(b) the current version of the Australasian Faculty of Occupational and Environmental Medicine's Australian and New Zealand Consensus Statement on the *Health Benefits of Work* as current from time to time, including:

- (i) discussing the health benefits of good work, if the injured person is employed
- (ii) encouraging and supporting an injured person to stay at work in some capacity, or recover at work
- (iii) discussing recovery through work options with the injured person, employer, and support team
- (iv) encouraging an injured person to stay active in their usual activities, as appropriate.

(c) value-based healthcare and the quadruple aim, which strives to deliver care that improves:

- (i) health outcomes that matter to people
- (ii) experiences of receiving care
- (iii) experiences of providing care
- (iv) effectiveness and efficiency of care.

This is an area that I come across on a daily basis at least as an IMC. I have made submissions to SIRA that nominated treating doctor's are accredited as allied health professionals, rehabilitation consultants etc are but this is has not occurred as yet. When these are implemented, this part of the guidelines should be made well known to nominated treating doctors and others. I believe a 1-2 page document that comes from SIRA outlining "what constitutes capacity" would be very helpful as it is a constant sticking point. The nominated treating doctor also needs to understand that it is their responsibility to accurately advise insurers , employers etc of an injured workers capacity and not be swayed by the worker, legal representative or other party. If nominated treating doctor's were accredited and didnt meet the requirements when reaccrditation was due, their authority to treat injured workers could be revoked.

I strongly recommend SIRA implements training and accreditation for doctors and practices so they fully understand their role and requirements. In my view, this is the biggest roadblock in the system for return to work and treatment.

27. RSPs must complete any additional training at the request of SIRA, to the standard required by SIRA, within the required timeframe and at the practitioner's own expense.

28. RSPs must fully cooperate with reviews by injury management consultants, or any other independent review of relevant services arranged by insurers, in the form, timeframes and manner required by SIRA from time to time.

This is another welcome development. I think "fully co-operate" needs to be further defined. I get asked to submit a list of questions for the nominated treating doctor or nominated treating specialist etc to complete. It needs to be clear that this is a discussion not a written list of questions. On this topic,

another couple of areas need clarifying;

Consent - my assistant is constantly being told "Dr X doesn't have consent to speak to Dr Cameron" and she has to explain by the injured worker signing the fromt page of the certificate of capacity , that gives consent. Many times they still don't believe it. If this can be communicated to RSP's it would streamline the process.

"The worker has to be present for the discussion" - this is another area that is poorly understood. Both I and my assistant explain this is a practitioner to practitioner frank discussion about their claim, NOT as case conference. If a Stage 3 has been performed, the injured worker has had an hour to tell the IMC whatever they feel is relevant. If it is a Stage 2 and the injured worker wants to be involved in the process, this occurs after the Stage 2 is complete.

Requirements for communication with the support team

29. Relevant services must be delivered in communication with the support team, including:

(a) the treating doctor to discuss diagnosis, current and proposed treatment and how treatment will aid recovery and build capacity/fitness for work/activity

(b) the referrer (if the referrer is not the treating doctor)

(c) the injured person's employer and/or return to work coordinator and workplace rehabilitation provider (if involved) to ensure an understanding of the injured person's pre-injury duties and the availability of suitable work

(d) discussing expectations of the injured person's recovery and formulating common recovery at/return to work/activity and treatment goals with other members of the support team, with the consent of the injured person.

This is another problem area ie not responding to questions from the insurer, employer , vocational options etc. I think nominated treating doctor's need to be educated that "I don't do case conferences" or "I don't talk to employers, insurers , rehabilitation consultants etc" is not an option if they take on the role as nominated treating doctor.

Requirements to ensure continuity of care

30. In the provision of relevant services, relevant service providers must ensure:

(a) coordination of care, and provide continuity of care, including consistent service provision by the same RSP

(b) an injured person is referred to an appropriate RSP when the services the injured person requires are outside the scope of practice of the current RSP

(c) services are not delivered to an injured person concurrently with another similar relevant service (e.g. an injured person should not be receiving concurrent physiotherapy and exercise physiology services) unless the RSPs have provided a clinical justification to the insurer.

There are a number of practices who only refer "in house" to physiotherapy , psychology, psychiatrist , specialist etc. There seems to be what I have observed as overservicing. There is also evidence of excessive radiological investigations by some nominated treating doctors and their relationship with certain radiology providers should be examined. There are a few well known

doctors who will cancel all previous providers so they can refer in house.

I have also witnessed referrals from legal firms to certain practitioners and vice versa so that a nominated treating doctor will give them a "better legal outcome". I have had injured workers tell me they were pressured to either change doctor or lawyer which is unacceptable. If something addressing this could be added to the guidelines to prevent this.

Requirements regarding telehealth services

31. Relevant services can only be provided via telehealth if:

(a) there has been a face-to-face consultation by the RSP with the injured person within the last 12 months (except where the injured person is in a remote or very remote area [3])

(b) service provision via telehealth is determined to be suitable for the injured person following consideration of the following factors [4]:

- (i) whether a physical assessment is required
- (ii) availability of support at the injured person's location
- (iii) availability and access to a suitable device e.g. videoconferencing units/systems or a personal device capable of videoconferencing
- (iv) ability of the injured person to participate, considering any physical, mental, social, and cognitive barriers
- (v) the injured person has requested or consents to participate in a telehealth consultation
- (vi) ability to schedule telehealth session within the timeframes for a service
- (vii) the injured person's access to fast internet connection and internet or mobile data quota/allowance
- (viii) the injured person's capability/capacity to access care this way.

There has been a well known practice that was closed for 3 years from the start of the pandemic and I understand has only recently reopened. They only did telehealth consults for the whole time, whether video or over the phone. Whilst Telehealth has its place, especially when we were locked down, face to face is a far better option for assessing patients, be they physical or psychological injuries. In my view, not seeing patients face to face in the current environment is substandard care.

I think (V) the injured person has requested or consents to participate in a telehealth consultation allows both practitioner and patient to avoid face to face assessments. I spoke to a psychologist recently and asked why she wasnt seeing the injured worker in person and she responded "I work from home and dont see people face to face".

In a number of psychological cases, part of the treatment is "making" the patient leave the house and attend treatment. The way (V) is currently worded , this would allow them to not have to attend treatment

Part 5: Requirements for prescription of medication

32. Medications must be prescribed through the Pharmaceutical Benefits Scheme (PBS) unless there are extenuating circumstances, such as [5]:

(a) a medication is not available on the PBS, and after the first month from the date of injury pre-approval has been obtained from the insurer to prescribe it privately

(b) a medication is available on the PBS, but the patient does not meet the criteria for PBS prescribing

(c) the quantity of medication or number of repeats being prescribed for a medication available through the PBS falls outside the PBS prescribing criteria, can be clinically justified by the prescribing practitioner, and after the first month from the date of injury pre-approval has been obtained from the insurer.

33. Private prescription of any high-risk medication (i.e. opioids, medication-assisted treatment of opioid dependency, injectable narcotics, benzodiazepines, Z-drugs, or medicinal cannabis) and drugs of addiction (Schedule 8 [6]) that is not available through the PBS, or that is available through the PBS through a private prescription, must be accompanied by a written clinical rationale provided to the insurer.

This has been an area I have strongly disagreed with for many many years. The PBS is a very generous scheme funded by the tax payers of Australia. Whilst I have no problem as a tax payer contributing to this system for non work/motor vehicle accident related medications, I do have a problem subsidising medication for people who are injured at work or in a motor vehicle accident. What I mean by this, if they hadn't had this injury/accident they would not be taking this medication. Surely this should be covered by the insurance company for these injuries/accidents, just as we don't ask the taxpayer ie Medicare to fund surgery, physiotherapy , psychological or other services to injured workers etc.

I acknowledge there has been some price gouging by certain pharmacists and this is clearly unacceptable. Safeguards need to be put in place so this does not occur

Part 6: Requirements for provision of relevant medico-legal services[7]

34. In the provision of relevant services that are medico-legal services, RSPs who are medico-legal providers must:

(a) act without bias and in a way that does not give rise to an apprehension of bias in the performance of their responsibilities

(b) comply with the *Procedural Direction PIC4 – Expert Witness Evidence* and any subsequent procedural directions issued by the President of the Personal Injury Commission relating to expert witness evidence, and promptly notify SIRA of any compliance breaches

(c) have access to the necessary resources and infrastructure to do all administrative activities necessary for the role

(d) comply with all legal requirements for practice, including relevant policies and codes of conduct

(e) comply with the standards and conduct for medico-legal consultations, examinations and reports, as set out in the Medical Council of NSW's *Guideline for Medico-Legal Consultations and Examinations* in effect at the time of the relevant service. This applies to all RSPs undertaking medico-legal work in the CTP and WC schemes. Where the *Guideline for Medico-Legal Consultations and Examinations* refers to the Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia*, this only applies to RSPs who are medical practitioners under the *Health Practitioner Regulation National Law (NSW)*.

(f) not provide treatment advice and/or services to injured persons referred to the RSP for examination or assessment in their capacity as a medico-legal practitioner

(g) not accept a referral or examine an injured person if the RSP has a conflict of interest (personal, work-related, or financial)

(h) not engage in activities or publicly express opinions that might be perceived to compromise the practitioner's ability to undertake the medico-legal role in an impartial and unbiased manner

(i) not undertake medico-legal assessments outside of their area(s) of expertise.

Being the Chief Medical Officer of a company involved in the provision of Medicolegal reports as well as my 30 years experience in the area, gives me a unique perspective to comment on this. Whilst I agree with the proposed guidelines I will make a few comments.

Bias - there are a number of well known IME's who basically write the same report every time ie "there is nothing wrong with this worker and if there is, its not work related". The case manager then usually declines a claim based on this report, which if they take it to the PIC, is overturned in the vast majority of cases, adding unnecseasry cost, hardship and suffering for the injured worker. There are also specialists who do reports predominately for lawyers who inflate their WPI's. I saw a new patient a few years ago who had a motor vehicle accident and had two reports, one from each type of specialist described above. One had a WPI of 0% and the other was 50%!

I take my role as an independent consultant very seriously and give my honest opinion on each case, regardless of who is requesting the report. I think SIRA needs to look at those IME's who fall into one of these categories and if necessary , withdraw their accrediaition if their practices don't change.

Standards and conduct - further to my point above, many of these type of specialists have someone in for an assessment for a very short period of time. The number of times I have heard, "I was only in with Dr X for 5 or 10 minutes … how was that long enough to assess me properly?". Its hard to argue with this.

Area of expertise - I spend a lot of time trying to educate case managers to try wherever possible, to refer to an IME in the same speciality. I think it is a responsibility of the IME to say it is outside their area. I had a case recently where it was a complex hand problem and an IME was done by a General orthopaedic surgeon (not a Hand surgeon) and in my opinion, gave the wrong opinion and now requires another IME with a Hand surgeon. I encourage case managers to send hip problems to someone who specialises in this area and the same for knees, shoulders , hands etc.

Age of IME's - I realise this is a delicate topic and I am over 60 so am not a young man criticising "old doctors". I do question the ability of doctors who graduated decades ago to be able to make informed comments on new procedures, treatments and investigations. I had a patient a few years ago who took his MRI scans to an IME and was told "I can't read those, they came in after I retired". How can this IME then provide a relevant report ? I have had retired neurosurgeons commenting on disc replacement requests with no experience in this area. I understand we all age differently and some people at 80 are sharper than some 50 year old but I believe there needs to be some review of reports

done by these IME's. I had a case recently with 2 IME reports, one graduated in 1959 and the other 1961. If you have an average age at graduation of 23, that meant these IME's were 85-87 years of age. We assess people over 80 to make sure they can drive properly and safely. There should be similar review of IME's , especially ensuring they have the knowledge to comment on recent treatments , procedures etc.

Security - IMEs and IMC's must be required to meet Australian Privacy and Heath records Act requirements, which would eliminate the exchange of confidential information via post, email and fax? This is a requirement in the clinical arena and should also be a requirement in medicolegal.

To address the issue of quality reports, I also think there should be a Case Study test that accredited IMEs sit every five years to maintain their accreditation. Potentially it should consist of a video mock consultation, and the IME should be required to write a report that includes the calculation of WPI based on the video case study. Too often IMEs forget deductions or don't know how they should be interpreting the tables. They would obviously need to provide a report that was sound in order to maintain their accreditation. If they don't , they will receive feedback and have the opportunity to re-sit. If they fail three times, they should be off the list.

Part 7: Requirements for RSPs providing allied health services

35. In the provision of allied health services RSPs must:

(a) inform the nominated treating doctor (WC)/treating doctor (CTP) (if the referral was not received from that doctor) that they are treating the injured person

(b) when an injured person is being transitioned from one allied health practitioner to another for management of the same injury area:

- (i) provide concurrently no more than two sessions per practitioner to facilitate transition of management (except in cases of severe injury)
- (ii) collaborate to ensure effective continuation of the injured person's rehabilitation.

(c) not exceed a maximum class size of six participants in group classes provided by physiotherapists, exercise physiologists, chiropractors, osteopaths, psychologists, and counsellors (workers compensation scheme only).

Requirements for use of Allied Health Treatment Request forms[8]

36. In the provision of relevant services, RSPs who are allied health practitioners must:

(a) submit an Allied Health Treatment Request (AHTR) form (using the form approved by SIRA – available on SIRA's website) for approval of treatment proposed, except where treatment is:

- (i) pre-approved in the workers compensation scheme – see Part 4 of the *Workers Compensation Guidelines*
- (ii) for injured persons with severe injury (where use of the AHTR is optional).

(b) not seek approval for more than 8 treatment sessions per AHTR

(c) must tailor all requests for treatment via an AHTR to the injured person's individual clinical presentation with respect to both the number and type of treatment consultations

(d) make evidence-based treatment requests and specify how outcomes that empower injured persons to manage their injury and maximise their independence will be measured and demonstrated in the AHTR.

Part 9: Requirements for billing for relevant services

38. Except where specified, the requirements below apply to billing in both the WC and CTP schemes.

39. In billing for the provision of relevant services, the RSP must:

(a) bill a fee similar to the amount customarily paid within the community for the type of service provided, where maximum fees for the service provided by the RSP is not established in a SIRA fees order made under ss61 – 63A of the *Workers Compensation Act 1987* [9] (workers compensation scheme only)

(b) not charge a fee for cancellation or non-attendance by an injured person for treatment services

(c) not charge a fee for a relevant service unless it is directly payable to the RSP that has provided the treatment or related service or diagnostic procedure to an injured person, i.e. payment for services will not be provided to a third party or a referral service

(d) not bill a fee to provide a report to the referring general practitioner and a copy to the insurer when charging a subsequent consultation fee (surgical services)

(e) not bill a fee for surgical services consultation during routine aftercare following a surgical procedure, unless clinical justification is provided to the insurer

(f) not bill a fee for consultations conducted on the same day as planned surgery (the cost of these consultations is already included in the fee for the surgical procedure)

(g) not bill for a hearing-related aid and/or accessory unless the insurer is provided with a clinical justification as to how the hearing-related aid and/or accessory recommended is required to meet a hearing goal

(h) where provision of medical records has been requested, and the records have been stored electronically, they must be provided electronically and billed according to the maximum fee for provision of electronic records provided in the relevant SIRA fees order made under ss61 – 63A of the *Workers Compensation Act 1987* [10] (workers compensation scheme only)

(i) for a report regarding the management of a person's injury that is additional to any report routinely provided as part of consultation by a RSP, the RSP must:

- (i) have pre-approval from the insurer to provide and bill for the report; and
- (ii) bill for it according to the payment code for report writing from the relevant SIRA fees order made under ss61 – 63A of the *Workers Compensation Act 1987* [11], prorated to accurately reflect the time taken to prepare the report. The RSP must not bill for it using a fee item from the *Workplace Injury Management and Workers Compensation (Medical Examinations and Reports Fees) Order 2022* or the version of that fees order in effect at the time
- (iii) the above apply to the workers compensation scheme only.

j) bill for a case conference only where (workers compensation scheme only):

- (i) the purpose of the case conference is to clarify the person's capacity for work, barriers to return to work, and strategies to overcome these barriers (ie. not to discuss treatment) to ensure parties share the same expectations about the person's recovery at work or return to suitable employment
- (ii) the case conference is attended by the treating health service provider and any or all of the following:
    - the employer
    - the workplace rehabilitation provider
    - an injury management consultant

        - the insurer
        - other treatment practitioner/s delivering services to the person (including the nominated treating doctor)
        - the injured person if there is at least one other attendee from this list
- (iii) the health service provider organising the case conference
    - retains file notes of the case conference, including date, duration, participants, topics and outcomes. This information may be required for invoicing or auditing purposes
    - permits the injured person to bring a support person to a case conference if they wish to do so.

(k) not bill for use of a Consultation C item [12] (physiotherapy, chiropractic, osteopathy and exercise physiology services only, and workers compensation scheme only) unless:

- (i) two or more evidence-based risk screening/standardised outcome measures relevant to the clinical presentation are documented to demonstrate the complexities of the case and the clinical rationale for delivery of a Consultation C, and they are used to measure outcomes and demonstrate effectiveness of Consultation C treatment
- (ii) the provider reduces Consultation C duration time over time and transitions to a subsequent consultation as the workers progresses towards self-management and independence.

(l) not bill for travel costs:

- (i) unless it has been pre-approved by the insurer
- (ii) unless the reasonable travel charge has been divided evenly between claims where multiple workers are being treated in the same visit to a facility or in the same geographical area on the same day
- (iii) if the relevant services are provided on a regular or contracted basis to facilities such as a private hospital
- (iv) if the relevant services are provided by a provider who does not have a commercial place of business for the delivery of treatment services (for example, the provider has a mobile practice).

(m) not bill to amend a report provided by an RSP to correct an obvious error when the correction has been requested in writing by the referrer.

Invoicing requirements for relevant services, excluding pharmacy services (workers compensation scheme only)

40. Invoices for relevant services rendered must:

(a) be submitted within 30 calendar days of the service provided and must be itemised in accordance with relevant SIRA fees order/s (if fees order/s apply to the services delivered) and comply with the SIRA's itemised invoicing requirements.

(b) include:

- (i) the injured person's first and last name, and claim number
- (ii) payee details
- (iii) ABN
- (iv) name of the relevant health provider who delivered the relevant service
- (v) in the case of medical services, the providers:
    - Australian Health Practitioner Regulation Agency (AHPRA) number, and

    - Medicare provider number (unless not registered with Medicare)
- (vi) in the case of allied health services, the providers:
    - (SIRA approval number (where applicable), and
    - AHPRA number/professional association accreditation/membership number
- (vii) date of service
- (viii) relevant SIRA payment classification code or Australian Medical Association (AMA) Fees List item number where applicable
- (ix) service cost for each SIRA payment classification code or AMA item number and service duration (if applicable)
- (x) date of invoice (must be on the day of or after last date of service listed on the invoice)
- (xi) in the case of allied health services provided interstate, the service provider number INT0000 must be included on the invoice in addition to either the AHPRA number, or where the profession doesn't have AHPRA registration, the professional association accreditation number, or peak association membership number
- (xii) in the case of allied health services provided to exempt workers, the service provider number EXT0000 must be included on the invoice in addition to either the AHPRA number, or where the profession doesn't have AHPRA registration, the professional association accreditation number, or peak association membership number.

Again , I support and agree with the above. I will make the following comments;

There is a well known practice that I have heard from multiple sources bills an AA040 for almost every consultation. To put that into context , I think I have billed AA040 twice in 30 years.

With current technology, it should be possible to audit practitioners and if they are found to be overservicing , take appropriate action and recover money. In the Medicare system if you are found to have billed inappropriately, they demand you pay it back. I did a case last year of a Chiropracter who billed 250 visits in 18 months! Even one visit a week would have taken 5 years! I understand he has now had his SIRA accreditation withdrawn but am unsure if he was asked to pay back any money.

Summary

Thank you for the opportunity to comment on the draft guidelines. I hope these have been helpful. If you would like to discuss them in further detail, I'd be happy to. My number is [redacted] or email is [redacted]

Kind regards

Dr Greg Cameron