15/03/2016

Liane Steele
Manager Provider Strategy and Policy
RTW Operations

Re: SIRA gazetted provider fees – 2016 (travel reimbursements)

Dear Liane,

Exercise & Sports Science Australia (ESSA) is a professional association representing over 6,000 members (including accredited exercise physiologists), the Australian Physiotherapy Association (APA) represents over 20,000 members, Osteopathy Australia (OA) represents over 2,080 members and Chiropractors Association of Australia NSW (CAANSW) represents over 760 members. ESSA, APA, OA and CAANSW would like to jointly submit feedback to the NSW State Insurance Regulatory Authority (SIRA) regarding the 2016 gazetted fees for Exercise Physiologists, Physiotherapists, Osteopaths and Chiropractors.

As raised in our previous correspondence (including ESSA's letter dated 15/01/16), we are very concerned about the implications of the significant reduction in travel fee allowances allocated to providers working within the SIRA. We request immediate review of this decision and reinstatement of 2016 gazetted travel fees to >$1.65/km (indexed from 2015 fees). This is supported by the following reasons:

1. **Often, rehabilitation activities cannot exclusively be undertaken in the worker's usual workplace setting or a practitioner's usual place of practice.**

Integration of injured workers back into the workforce and community is optimised in a healthy, community based environment, rather than the worker simply attending an AHP practice. For example, a gym or pool enviornment creates a formal, more structured environment for intervention which promotes worker integration with the community, and promotes worker self-management to continue post-treatment (and is particularly advantageous for workers not yet ready to return to work). These environments create a sense of belonging within the community, something they have not received being out of work.

Furthermore, for some injured workers, particularly with significant head injuries or other complex conditions, it is not possible for the injured worker to travel to a clinic on their own and perhaps without a carer or other assistance. There are some very experienced and highly skilled therapists that provide these special services who have been seriously affected by the new fees and who can no longer afford to treat these injured workers.

The new gazette renders it financially unsustainable for an AHP to travel to these facilities, penalising those injured workers most in need. We acknowledge not all workers will need AHP services requiring a travel component, however, we do not support disincentivising AHP travel for those injured workers where rationale for travel is clinically and practically justified.

2. Case Conferencing in person is much more effective than by teleconference.
Many employers, injured workers, rehabilitation consultants, and doctors request the treating practitioner to attend in person to hold meaningful discussions during case conferencing. These discussions are more powerful and effective, particularly for matters that are sensitive or complex, which frequently occur in workers rehabilitation cases.

AHPs will not travel for case conferences if they are reimbursed at the new rate. Additionally, we question why SIRA is increasing complexity and costs through bringing in a workplace rehabilitation provider to undertake travel related services (because the AHP will not travel to see the doctor), when the issue could be resolved by simply having the AHP travel to see the doctor and progress RTW/work capacity (removing the need for workplace rehabilitation provider involvement).

We would like to table our comments further to SIRA's letter of response to ESSA (22/02/16):

3. Quote: *"Allied health practitioners, including accredited exercise physiologists (AEPs) are expected to deliver their services to workers from their normal place of practice. This means workers should be encouraged to attend their treatment sessions at the allied health practitioner's premises. This is to reinforce to the worker that they are expected to be an active participant in their rehabilitation, to encourage their participation in accessing the community, and to promote their independence in managing their recovery. The process of attending an allied health practitioner, receiving treatment and advice, and then returning to their own home, workplace or community setting to complete a self-managed treatment plan is a cornerstone of how SIRA expects treatment services to be delivered within the NSW workers compensation system. The role of the AEP, as an allied health practitioner, is to provide the worker with tools and strategies to enable the worker to effectively recover at/return to work and the community without the practitioner."*

We agree that this can be applied where possible for simple, recoverable injured workers. But there are many injured workers, noting chronic conditions and biopsychosocial factors, where integration into the community without the practitioner, is not possible. It requires the practitioner to assist them to integrate in the community, with the practitioner reducing their assistance as the worker becomes more independent, resilient, and confident. This requires the AHP to travel.

Additionally, the legislative changes within the NSW workers compensation system were to ensure a well-balanced scheme that supports injured workers in most need. Home based appointments for the most significantly injured workers, particularly those that require a more specialised or experienced allied health practitioner (AHP) to travel, will simply not occur at the new travel rate.

SIRA are penalising those injured workers who are most at need, such as individuals with complex and chronic injury (e.g. spinal injuries), who are at greatest risk to the scheme.

4. Quote: *"In the NSW workers compensation system, allied health practitioners do not have approval to enter a workplace to provide treatment services for a worker. In contrast, workplace rehabilitation providers' intervention and scope of practice is principally carried out at the workplace of the worker to address and assist injury management. It is expected workplace rehabilitation providers will undertake significant travel as part of their work. Travel is therefore charged by time not per kilometre for these providers."*

We would like to highlight that AHPs and workplace rehabilitation providers attend case conferencing in person, at the workplace (this is not treatment), or doctor clinic (this is not treatment). This is unfair on the AHP to be paid a small reimbursement in comparison to time based rehabilitation providers.

5. Quote: "*Consultation was not undertaken for this one element of the Fees Order that was not indexed, as it was anticipated to have minimal impact on the majority of practitioners who are complying with the requirements of a SIRA approved practitioner, the relevant Fees Order and the definition of 'normal place of practice' therein. Travel should not represent a standard aspect of treatment, and is considered the exception rather than the rule when it comes to allied health practitioners providing a treatment service. This concept is also shared in WorkCover Queensland, a scheme which you specifically made reference to in your correspondence, where travel, although paid at an hourly rate, is 'only paid where the provider is required to leave their normal place of practice to provide a service to a worker at their place of residence, rehabilitation facility, hospital or the workplace'. If the Queensland definition were to be applied in the NSW workers compensation system, the AEP would rarely be reimbursed for travel. Treating AEPs do not perform workplace assessments in NSW; rehabilitation facilities and hospitals generally have their own employed or contracted staff; and where treatment is indicated at the worker's home, Queensland requires the worker to have been certified unfit to travel by their treating doctor. It should be noted that teleconferencing is a viable option for case conferences.*"

Again, ESSA, APA, OA and CAANSW strongly advocate against SIRA penalising the injured workers most in need. We propose a compromise that rather than reducing the 'travel rate', by way of being a disincentive for the AHP to travel, SIRA should maintain the travel rate indexed at $1.65/km+GST so that travel can be provided when required. Travel will not be provided when not required, (i.e. it is at the discretion of medical practitioners and SIRA as to whether AHPs travel, both under the old system and current system). SIRA's decision to reduce travel rates will disincentivise AHPs from providing mobile travel based services, and this decision is only harming the most needy services, who require mobile based services (as aforementioned).

6. Quote: *"It is also noted Medicare does not pay for travel and its fees are considerably less than SIRA's. Similarly, private health funds pay a rebate based on the delivery of service, and do not make specific allowances for the reimbursement of travel."*

We do not believe this is a fair comparison. The expectations placed on AHPs in the workers compensation system are far greater than Medicare and Private Health. This is evident in referring to the guidelines and AHP provider number approval process, and answering to a

WorkCover insurer/scheme agent who wants RTW results. This contrasts with Medicare and Private Health Insurance which require less complex clinical guidelines and decision making to be followed. Also, as a result of Medicare and Private Health funds not paying for travel, it is rare that home visits and other travel for services are provided by AHPs. This often results in poorer outcomes and lack of access to services for those in most need. It is not a good model for SIRA to aim to implement and does not result in the best outcomes in many cases, particularly in complex cases.

7. Quote: *"If AEPs choose to deliver services to workers in the NSW workers compensation system, SIRA expects them to comply and adhere to SIRA's principles and procedures, including the criteria to which they have agreed in their application for SIRA approval eg. that their practice location meets several criteria, including a dedicated consulting room."*

AHPs adhere to good practice in regards to privacy.

8. Quote: *"Consultation was not undertaken for this one element of the Fees Order that was not indexed, as it was anticipated to have minimal impact on the majority of practitioners".*

We recognise this may have minimal impact on the majority but major impact on the minority physiotherapists/EPs for whom home visits represent a significant proportion of their practice. In the interest of ensuring the best possible outcomes, all stakeholders should be consulted to ensure a robust review of the any benefits and possible negative outcomes can be made before any change is made.

9. **We maintain that these inadequate and unfair travel reimbursements will reduce AHP involvement within the scheme, disadvantaging SIRA and the injured workers it aims to protect.**

A key goal of AHP interventions within SIRA is to foster a patient's independent management of their health and support effective integration into the community. Without adequate funding for travel, it is not financially viable for AHPs (particularly small businesses and sole-traders) to travel to a client to break down barriers to participation and achieve effective rehabilitation and independence. This is further exacerbated in rural and remote regions (and high traffic density areas), where an AHP's travel time is increased.

In correspondence with SIRA on 06/01/2015, ESSA was advised that the significant changes to travel fees were a result of creating 'fairness in the scheme by bringing down AEP travel reimbursements in line with the reimbursement awarded to injured workers and government employees for travel'. ESSA, APA, OA and CAANSW strongly disagree with this rationale because **inadequate travel reimbursement will make it financially unviable for many providers to work within the scheme.**

We would like to highlight that government employees also receive a salary in addition to the awarded travel allowance (i.e. they are paid a salary in addition to ~$0.75/km for travel). The rationale for the newly introduced provider fee in the 2016 gazette does not account for this, whereby providers are only paid $0.75/km for travel with no additional remuneration for time spent commuting, unlike the additional salary provided to government employees. Additionally, the Australian Tax Office (ATO) provides a travel allowance of $0.65/km to simply cover fuel and vehicle wear related to provider travel. Therefore, ensuring appropriate reimbursement for providers (related to business overheads and provider time associated with travel), SIRA can optimise workforce sustainability through retention of experienced providers. Consequently, ESSA, APA, OA and CAANSW advocate for the reversal of SIRA's decision to drastically reduce provider travel fees.

We welcome the opportunity to discuss any of the aforementioned points further, and appreciate your consideration of our concerns and recommendations. Please do not hesitate to contact katie.lyndon@essa.org.au and nada.martinovic@physiotherapy.asn.au if you require further information.

Kind Regards,

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Appendix:
Please see attached.

ESSA EXERCISE & SPORTS SCIENCE AUSTRALIA | AUSTRALIAN PHYSIOTHERAPY ASSOCIATION | CAANSW Chiropractors' Association of Australia (NSW) | osteopathy AUSTRALIA

Appendices to Joint letter from ESSA, APA, OA and CAANSW

Please refer to the case studies below for specific 'real-life' examples supporting our concerns on how reduced travel rates will directly impact providers, injured workers and SIRA.

De-identified member response 1:

The rate we can charge the agent for travel \$.66/ km is actually less than the award rate \$.78/km that I have to reimburse staff at.

We are a company whose core business relates to the management (and prevention) of work-related injuries. Integral to this (and from what I can see strongly endorsed through SIRA) is for the need of the treating physiotherapist to be intimately involved in the 'recovery at work' philosophy. We regularly integrate our treatment consultations with ensuring the appropriate application of all developed strategies within the workplace. This involves travel to the workplace and with our current client base, this can involve travel to locations throughout the Hunter region.

For our staff to travel off-site, we have to pay for their time and travel expenditure to do this. With the downgrade of the travel fee, we can now only charge the same travel costs to the agent as what I am directly paying to our staff member for their travel entitlements and then in turn there is no opportunity to change the time/wage cost taken for our staff member to make the travel. Additionally, we are seeing a significant increase in requests for our staff members to attend case conferences with the NTD and/or rehab provider at the NTD rooms.

The opposing view at present is that Rehabilitation Providers can continue to charge the agent at their standard rates for all travel they undertake.

De-identified member response 2:

I am a neurological physiotherapist and I have been affected. I travel from Ryde NSW to Frenches Forest NSW to see someone in a gym to set-up a community based program for someone with a chronic SCI. It was ~\$11.80 (one way) and then \$23.60 (return) for what I would realistically have to allocate 1.5 hours (45 minutes each way). It is not as if I am going for 6 hours of work and/or do this nature of work on a regular basis. I will go and see him 2-3 times over 6 months. It is not feasible for me to continue this work and have put these people on hold until we have some resolution.

SIRA runs the risk of people with specific skills only accepting people who are around the corner, or you will either get local and not specialised, or people that cannot get other work doing it. The patient will not get the most appropriate therapist.

De-identified member response 3:

Neil sustained multiple orthopaedic fractures and significant mental health conditions during the course of his work. He was working as a courier driver, when he was at fault causing a four vehicle motor accident.

Neil had progressed from in-patient rehabilitation. He was now at home, reliant on two crutches. With his wife working, and busy with three young children, it was difficult for Neil to receive support from his family and travel to numerous health care providers – general practitioner, two orthopaedic surgeons, psychiatrist, psychologist, physiotherapist.

Neil lives in an apartment complex where a pool and gymnasium community exercise facility is nearby for the residents. Neil had previously tried to do home based exercises, but lacked motivation due to his low mood. He was inside for most of the day, sleeping and watching television.

Neil needed to organise travelling 14 km each way to access the nearest pool, other than the residential complex exercise facility nearby. Neil was not confident using the residential exercise facility on his own. There were no suitably qualified health care providers who normally work at this residential facility. All medical practitioners involved in Neil's care strongly recommended Neil to access the pool and gymnasium complex to improve his physical and mental health. This consisted of pool/hydrotherapy to assist with pain management for the therapeutic and buoyancy effects of water for graded weight bearing activity, gymnasium for a formal graded exercise program which he would complete out of the home and the benefits of his mental health.

A suitably experienced allied health provider was sourced, who was willing to travel to undertake Neil's rehabilitation at the exercise facility convenient to his residence. This was to establish, monitor, and progress his rehabilitation, in a healthy, community based setting. Neil would use this facility for supervised sessions, and be comfortable using this facility for independent sessions.

The allied health service provider was required to travel 22 km each way to assist Neil. A lot of this travel takes place in high density traffic. Beyond the time travelling in the car, there is additional time for the service provider to get to and from their car from their previous location, and Neil's local exercise facility. It takes 2 ½ hours of the service provider's time to undertake this service (travel each way + treatment session).

This service commenced in 2015, and continued into 2016. The 2016 change in travel rates resulted with the following:

2015	Rate, excluding GST	2016	Rate, excluding GST
Supervised treatment session	$141.30	Supervised treatment session	$144.50
Travel 44km	$1.65/km x 44 = $72.60	Travel 44km	$0.75/km x 44 = $33
TOTAL	$213.90	TOTAL	$177.50
Equivalent hourly rate across 2.5 hours	$85.56, less running expenses	Equivalent hourly rate across 2.5 hours	$59.16, less running expenses

Leading into 2016, with the increased costs of running a small business, the service provider budget forecasted an increase to their fee scheduled of 2.2%, equivalent to inflation. The service provider expected their total rate for the 2.5 hours taken to undertake each treatment session to increase from $213.90 +GST (2015), to $218.60 +GST (2016).

Rather, the remuneration reduced by 17%, from $213.90 +GST (2015), to $177.50 +GST (2016), equating to a 19% reduction to the CPI forecasted rate ($218.60 +GST). Extrapolating this change in rate across the overall treatment to be provided for Neil by this service provider, who required a further 12 sessions and two face-to-face case conference meetings with Neil's treating doctor to facilitate return to work progression, this resulted with the service provider losing $575.40 +GST of forecasted revenue.

Neil's treating doctor was only willing to discuss Neil's rehabilitation and work capacity face-to-face, due to the sensitive nature of Neil's condition and situation. This required the allied health service provider to travel (and willing) to Neil's treating doctor. The small business health provider has numerous operational costs to provide this mobile service prior to making a viable profit. It is these passionate small businesses, who are willing, and appropriately experienced and skilled to provide the service required for Neil.

As a result of these changes, the allied health service provider who was undertaking this mobile service, which is imperative for Neil's health recovery and return to work, determined that it is not financially viable to continue with this service. The services were discontinued in early 2016. Neil was referred to attend an alternative allied health clinic his home. He had challenges attending this clinic, needing to organize transport. He did not apply the independent rehabilitation strategies as these were home based and he was stale in this environment. His mental health worsened. His physical function worsened. His condition and work capacity regressed.

De-identified member response 4:
As a physio working with long-term patients with acquired brain injury in their homes, I tend to travel out of my local area to treat them. I am based at Pennant Hills.

The majority of my patients are now covered through the Lifetime Care and Support System which recognises travel time and hourly treatment times. With a lifetime care patient, if I see them/carers/family for 1 ½ - 2 hours, I am paid for that time. I am also paid for preparing home programmes and liaising with other team members outside the treatment session. With Workcover patients, there is a flat rate of reimbursement for a treatment, regardless of the time spent with the patient and their carers etc and there is no allowance for home programme preparation, liaison with other team members etc. I currently have 3 Workcover patients on my active treating list:

1) Patient at Orchard Hills
- 92km return trip.
- Trip takes 1.5 – 2 hours return.
- M2 and M7 tolls are paid and not reimbursed.
- Each session with the patient takes at least 1.25 hours, often longer.
- Charging travel @ $1.65 per km, I was reimbursed $151.80 per treatment session for travel, plus the complex treatment fee.
- With the new schedule of .66c per km, I will be reimbursed $60.72 for approx. 2 hours travel with the added expense of tolls.

- This is a long-term patient of a number of years, who has carers taking her to a gym programme.
- She continues to need to be reviewed every 6 – 8 weeks. When reviewed, her home programme often needs updating and liaison with the care agency is also required.
- Due to the long-term relationship already established, I am attempting to continue treating this patient as I feel morally and ethically that I should.

2) Patient at Doonside

- 56 km travel.
- Travel takes 1 ¼ - 1 ½ hrs return, without tolls.
- I saw this patient for a review late last year at the insurer's request. I had been his treating physiotherapist a few years ago.
- That review visit took 2.25 hours due to the issues that were occurring for him. It was planned that I would review him mid-February.
- Due to the changes in the travel reimbursement, combined with the overall times that treatment takes with the patient when he is not seen regularly, I do not intend to continue treating him. The tipping point for my decision is the change in travel reimbursement by SIRA.
- Previously: 56 x $1.65 = $92.40, plus complex treatment fee.
- New rate: 56 x .66c = $36.96, plus complex treatment fee.

3) Patient at Glenwood

- 30km travel.
- Travel time 1 hour return (no tolls).
- Previous travel fee: $49.50.
- New rate: $19.80.
- I am finishing the current approval with this patient and then intend to advise the insurance company that a new physiotherapist will need to be found.
- With the current travel arrangements I will decline any new referrals covered by Workcover unless they are within 5km of my practice address.

De-identified member response 5:

This is a good representative of the type of client that requires community based services. A key aspect of all of these programs is the training of attendant care workers, in following through with the program. It is so much more effective to provide this training and reviews in a community context. The other thing to note is that as a community therapist working with complex clients with TBI or SCI, we are focused on improving community participation, not just treating impairments. Because of the cognitive impairments that our clients have providing training and a context specific environment, it is important to ensure carry over into their normal life. I cannot just give them a bunch of exercises in a clinic setting and expect them to make improvements.

Additionally, I am not seeing most of these clients frequently but to review and upgrade their program. The nature of a neurological impairment such as TBI is that clients will need to have intermittent therapy in order to maintain their mobility, fitness etc.

1) Patient at Revesby (I charge travel from Burwood where I have an office)

Mr M sustained a TBI as the result of a car accident in the mid 90's. Has ongoing neurological impairments, including a hemiparesis and uses a BIOness foot splint to assist him to walk. Has a home and gym based physio program which he does with the support of an attendant care worker (ACW).

I review Mr M, once every 3 months to update his home and gym program, check changes to muscle length as he is prone to contractors because of spasticity and provide training to the ACW to follow through with the program. This service helps prevent deterioration of Mr M's gait and contributes to him being able to mobilise independently in the community. The focus of the intervention is updating the gym program, which obviously has to be done at a gym and training the carer in the home program and it is much more effective to do this in the home than in a clinic setting. I have had to indicate to the insurer that I can no longer see this man.

2) Patient at Nowra (I charge travel from Wollongong, where I am based).
He had a TBI as the result of a truck accident about 10 years ago. Although 10 years post injury he continues to make physical improvements in his walking ability. He has very severe motor impairments with widespread spasticity, weakness and contractures. He currently walks with a rollator frame.

He lives with his parents but has carers during the day to provide support for his program. As part of a gait rehabilitation program and physical maintenance program he has a gym program, a pool based program and a home program. He generally spends 1-2 hours a day exercising and although this may sound excessive, it is what he needs to do in order to maintain his ability to walk which has numerous health benefits. I have been seeing him fortnightly but would have reduced this to monthly in the next month or so given his slow progress. Essentially the physiotherapy intervention involves training the attendant care workers to follow through with his program and to update and upgrade the program as appropriate. A normal private practice physiotherapist does not have the experience or skills dealing with this type of client and this type of therapy cannot be effectively provided in a physiotherapy clinic setting. This man continues to have Botox injections to manage his spasticity and physiotherapy follow-up, following this intervention is essential in order to maximise outcomes.

3) Patient in a group home in North Strathfield (travel is charged from Burwood).
The home has carers 24 hours a day who support the clients to access community based activities. Mr D also had a TBI a number of years ago and has mild neurological deficits with impaired balance, decreased ability to manage stairs, occasional falls but walks without a walking aid. I have previously set Mr D up with a gym program that is done with the support of his carers. I was previously asked by a private case manager (not from the insurance company) to conduct a review and upgrade this man's program. Unfortunately I had to inform the CM that I could not provide this review under the new WC travel rates. The only alternative is for this man to go to a generalist physio who doesn't understand the cognitive and physical impairments of TBI and would not be able to review how this man is going at the gym.

4) Patient lives with his wife and family in Glenwood (I charge travel from Burwood).
He had a hypoxic brain injury following a cardiac arrest whilst doing a work activity 2 years

ago (injury was deemed to be work related). Has severe ataxia and a mild left hemiparesis. Has care during the day when his wife is at work. Has a gym program to improve strength and a home program targeting gait retraining. He follows the program with his carers which I have established. I generally review and upgrade his program on a monthly basis. He continues to make improvements in his walking speed, endurance and quality. I have had to indicate to this client that I cannot continue to provide this service.

6) Mr M - Lives in a community retirement centre past Camden.

Has severe ataxia and very limited mobility - walks with a FASF- also has a number of secondary health problems most likely as the result of limited mobility and exercise. I was requested by the insurer initially to set up a gym program to improve his fitness and gait, which I have done. I only need to review this program once every 2-3 months but am now unable to do this.