Welcome to The Intelligent Rebellion

The Intelligent Rebellion, founded by Rhea Mercado is a think tank and community of people who are contributing their vision towards a better future.

Topic is: EPA009 Consultation C in SIRA NSW

The Intelligent Rebellion hosted a Think Tank Session on 17 February 2023 attended by industry professionals. We would like to thank the participants of the think tank session for their time, candour, and for contributing their vision towards a better future.

The topic of the Think Tank session was EPA009 Consultation C in the context of SIRA NSW Accredited Exercise Physiology Fees and Practice Requirements 2023.[1] And, so as expected, it was attending by majority Accredited Exercise Physiologists working in the SIRA NSW workers compensation scheme. A group of professionals who are simply trying their best to support the injured worker community with their recovery and rehabilitation, and to navigate through a scheme which at times can be challenging and frustrating.

I will acknowledge there was obviously a bias during the discussion. As with any group, we were limited by our knowledge, and our own experiences. A more diverse group would lead to an increase in perspectives. Say, if we had a medical doctor, an injured worker, a physiotherapist, or a claims management professional in the session, or any other combination of people, the discussion would have been different. The Intelligent Rebellion encourages diversity by design because we are acutely aware of these limitations. This is the reason for our Think Tank Sessions only requiring two criteria to attend, which are, 1) be human; and 2) be curious.

The main purpose of the session was to discuss ideas, share experiences, and to imagine and explore the possibilities. The group were asked to enter the think tank with a curious, open and amateur mindset. We encouraged diverse, creative, and emergent thinking in a safe and inclusive environment. The discussion points for the session were:

- What is a complex case in relation to Consultation C?
- Share your experience with requesting Consultation C
- What feedback have you been receiving about Consultation C?
- Is it possible to have a general consensus about defining Consultation C?

It is important to place the discussion into context of The Five Principles Of The Clinical Framework as per the *Clinical Framework For the Delivery of Health Services*.[2] As a participant wrote to me after the session, this framework reflects the most contemporary approach in the delivery of treatment, and outlines expectations when treating a person with a compensable injury.

The five principles are:

1. Measure and demonstrate the effectiveness of treatment
2. Adopt a biopsychosocial approach
3. Empower the injured person to manage their injury
4. Implement goals focused on optimising function, participation and return to work
5. Base treatment on the best available research evidence.

[1] https://www.sira.nsw.gov.au/__data/assets/pdf_file/0017/1122623/Accredited-exercise-physiology-fees-and-practice-requirements-effective-1-February-2023.pdf
[2] https://www.sira.nsw.gov.au/resources-library/motor-accident-resources/publications/for-professionals/clinical-framework-single.pdf

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What was evident during the discussion is that all the allied health professionals in attendance, and the teams which they manage had every intention to meet the five principles of the framework. They had designed their services, workflows, and governance to empower their workforce to meet the principles, and to provide their patients with the best care.

Where barriers existed was when there was push back and resistance from claims services providers upon requests for Consultant C sessions. Specifically, when the justification and rationale for the request was predominantly to address the first two principles. The scheme expects professionals to address the biopsychosocial factors to recovery, though fails to fully acknowledge the breadth of biopsychosocial factors which influence the recovery process. As a result, there a many instances of claims services providers not approving interventions, treatments, nor gives allied health professionals (AHP) sufficient time needed to implement an evidence-based treatment regime. A shared frustration not only amongst the group, but also by the wider allied health professional community.

In the case of exercise physiology, specifically, it is commonplace for referral to be last in the chain of treatment providers. Patients referred to exercise physiology often present well past the acute stages of injury, at times, more than 12 months after the date of injury, have undergone, and multiple treatment modalities and interventions. And, as is often seen in cases with protracted recovery, these patients also present with significant psychosocial risk factors.

Exercise Physiology services are traditionally not considered as part of the acute or even sub-acute treatment option, physiotherapy being the default option. There is certainly a need to discuss the scope of practice, best-practice guidelines and which allied health professional is appropriate during stages of recovery. Though, this is not the place.

Though, on the topic of comparing allied health professionals, the SIRA *Healthcare costs and outcomes in the workers compensation and CTP schemes* report[3], reported, during Q3 2021 there were over 250,000 physiotherapy services provided, compared to under 100,000 exercise physiology services provided, and approximately 50,000 psychological services.[4] Again, this discussion paper will not address the reasons for why this might be, I will park that for now.

More often than not, when an injured worker is referred to an exercise physiologist, to put it bluntly, it's the last resort because nothing else has worked.

During the think tank session, the group focused on four discussion points:

1. What is a complex case in relation to Consultation C?
2. Share your experience with requesting Consultation C
3. What feedback have you been receiving about Consultation C?
4. Is it possible to have a general consensus about defining Consultation C?

The following pages are a combination of commentary, reflection and opinion. The intention of this piece is to spark a conversation, to share experiences, and to explore the possibilities.

Ready? Let's go…

[3]https://www.sira.nsw.gov.au/__data/assets/pdf_file/0017/1035161/Healthcare-costs-and-outcomes-in-the-wc-and-cpt-schemes-dashboard-Mar-2021.pdf
[4]https://www.sira.nsw.gov.au/__data/assets/pdf_file/0017/1035161/Healthcare-costs-and-outcomes-in-the-wc-and-cpt-schemes-dashboard-Mar-2021.pdf

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What is a complex case in relation to Consultation C (EPA009)?

According to SIRA's *Accredited-Exercise Physiology Fees and Practice Requirements 2023*[5] which was relevant at the time of the session, Consultation C (EPA009) is defined as:

> *"Consultation C – is for the management of workers with complex pathology and clinical presentations who require a matched intensity and relevance of treatment. Only a small number of workers will require treatment within this category. As workers progress in their recovery towards self-management and independence, it is expected there will be a reduction in Consultation C duration time, or transition to a subsequent consultation (EPA002). It is expected that two (2) or more evidence-based risk screening/standardised outcome measures relevant to the clinical presentation are documented to demonstrate the complexities of the case and form the basis for the clinical rationale for delivery of Consultation C. Practitioners are expected to measure and demonstrate effectiveness of Consultation C treatment outcomes. Consultation C means a treatment session related to complex pathology and clinical presentations including, but not limited to:*
>
> - *three (3) or more entirely separate compensable injuries or conditions*
> - *extensive burns*
> - *complex neurological/orthopaedic/pain/cardio-respiratory conditions"*

So, let's get into the nitty gritty, shall we? The group's discussions centred around two of the three named criteria, that being:

- *three (3) or more entirely separate compensable injuries or conditions*
- *complex neurological/orthopaedic/pain/cardio-respiratory conditions*

"three (3) or more entirely separate compensable injuries or conditions"
Pretty obvious, right? Nope.

The argument of what defines a compensable versus non-compensable injury is fraught. There was consensus amongst the group that, at face value, if the certificate of capacity stated three or more diagnosis, then this would satisfy the criteria. Despite this seemingly clear-cut criteria, a member of the group shared an example in which, in spite of three entirely separate compensable injuries and conditions noted on the certificate of capacity, the AHRR which was still challenged and not approved by the claims service provider's injury management specialist (IMS). It took a review by SIRA to overturn the claims service provider's decision, and the AHRR was ultimately approved.

"complex neurological/orthopaedic/pain/cardio-respiratory conditions"
There is a lot to unpack here. My interpretation of the forward slashes separating the conditions indicate all are possible and acceptable alternatives to one another. The group discussed the immense difficulty in defining and identifying each and every possible diagnosis and/or condition. (note: my intentional use of the forward slash).

I had at one stage suggested we attempt to create a list to assist with classifying and defining what is a complex case. This was very quickly tested by the group musing that it would only serve to narrow the scope and limit options. Agreed. Though well-intentioned, trying to create a specific list, of diagnoses, pathologies and/or

[5] https://www.sira.nsw.gov.au/__data/assets/pdf_file/0017/1122623/Accredited-exercise-physiology-fees-and-practice-requirements-effective-1-February-2023.pdf

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conditions, to define what could be considered "*complex neurological/orthopaedic/pain/cardio-respiratory conditions",* would only limit the scope, and introduce yet another "check list" into an already process-driven scheme.

More importantly, creating such list would fail to acknowledge the diversity of injured worker community.

As it currently stands, the ambiguity of the criteria actually does allow room for context, reasoning, and flexibility. The group discussed multiple examples of cases which they had defined as complex. Some of the factors included:

- The diagnosis
- Surgical intervention
- Pain experience / reported pain
- Chronic pain (diagnosed or experience)
- Kinesophobia (side note: what a great word!)
- Outcome of psychosocial screening / questionnaires. Captivatingly, during the around long-form OMPQ, even within the group, there was discussion as to what was the cut-off to meet the criteria for complex.
- Mental health issues
- Non-English-speaking background
- Cultural differences
- Literacy / numeracy skills
- Time between date of injury and the date of referral for treatment
- Previous failed treatments
- The number of treatment sessions to date (with previous or current professional)
- The type of work
- Physical access to treatments
- Socio-economic status
- Family commitments

In reality, and when placed in context, any item or combination of items listed in the FACTORWEB[6], within the standard outcome measures[7], in a flags assessment, and in every psychosocial questionnaire and risk assessment tool in existence, could be used to identify and rationalise a case as being complex.

In a letter from Matt Pearson, Executive General Manager – Statutory Schemes of Suncorp Group to the Independent Review into the Agent Model and the Management of Complex Claims dated 21 September 2023, Matt Pearson wrote:

> *"Identifying and assessing complex claims*
> *ii. What are the features of a claim for worker's compensation that make it complex, or at risk of being complex?*
>
> *While it can be tempting to define a 'complex' claim solely on the duration of the claim (i.e. over 130 weeks), duration should be only one factor that makes a claim complex. Complexity managing recovery of a case can present as early as three weeks into a claim. A case can take*

[6] https://www.sira.nsw.gov.au/resources-library/workers-compensation-resources/publications/help-with-getting-people-back-to-work/factorweb-identifying-personal-and-environmental-risk-factors
[7] https://www.sira.nsw.gov.au/for-service-providers/treatment-advice-centre/outcome-measures

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more than 130 weeks and not be 'complex' if the person is recovering as expected. Assessing whether a claim is complex should have regard to:
- extent of injury,
- extent of anticipated required surgeries and treatment,
- individual patient mindset,
- whether the recovery pathway was interrupted, and,
- non-compliance by injured worker and/or scheme agent claims manager during the claim."

What all this demonstrates is, defining a complex case is, well - complex.

One deliciously obvious point raised during the session was that a complex case tends to remain complex. Particularly in the cases of significant injury, psychological conditions, and numerous psychosocial factors. What does change is one's outlook, acknowledgement and acceptance of the situation.

To sum up the question, "What is a complex case in relation to Consultation C?"
It is difficult and situational.

Share your experience with requesting Consultation C?

The main recurring theme was time, more specifically the amount needed. It generally took a lot of time to process through the allied health recovery request (AHRR) document, submit it, and then to respond to any queries from the claims service provider.

The group gave examples of receiving feedback and queries from claims management professional where it was evident that the AHRR had not been carefully read through. As a response to the various queries, these professionals, have highlighted sections, reiterated their justification, and in one instance took a screenshot of a particular section of the AHRR which answered the query.

In other examples, professionals would attach to the AHRR, fact sheets, explanatory notes, and/or links to SIRA guidance material to further justify their meeting the criteria for Consultation C sessions. Another provider felt the need to place text in bold font, highlight, or to capitalise specific sections to draw the claims management professional's attention to those sections, almost anticipating where queries might arise.

All this takes time. Valuable, valuable time, and in the majority of cases - unbillable time.

In the SIRA NSW *Accredited Exercise Physiologist Fees and Practice Requirements 2023*[8] the fee for an initial consultation (EPA001) is $129.30, for a subsequent consultation (EPA002) is $87.87, and EPA009 Consultation C is $17 per 5-minutes to a maximum of one hour.

The AHRR is five pages in length and it takes more time than the scheme currently allows to complete it, especially when requesting Consultation C sessions. Professionals are able to charge a fee of $40 to complete the first AHRR, and cannot charge a fee for subsequent ones. Some businesses have implemented a peer review and quality assurance process to ensure AHRR meet both best-practice and scheme standards. And, because only that first AHRR attracts a fee, businesses must absorb the expense of the additional hours spent to complete the process.

[8] https://www.sira.nsw.gov.au/__data/assets/pdf_file/0017/1122623/Accredited-exercise-physiology-fees-and-practice-requirements-effective-1-February-2023.pdf

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This additional time spent is placing pressure not only on businesses, but also individual professionals. The group discusssed scenarios in which the process of completing, justifying, peer reviewing, submitting, and then answering queries about an AHRR had become so onerous, that they had entertained the idea of simply giving up. Though, talk to any allied health professional, and they will tell you, they exist to help their patients, and so they persist and endure the process.

This is unsustainable.

To sum up the topic, "Share your experience with requesting Consultation C"
It's time consuming.

What feedback have you been receiving about Consultation C?

The general feedback being received from claims service providers, is simply the worker's case does not satisfy the criteria for a complex claim requiring Consultation C sessions. As discussed previously in this paper, defining Consultation C is both difficult, and situational. The onus is on the professional to justify why a case is complex using the broad criteria provided in the fees and practice requirements.

In the SIRA NSW *Accredited Exercise Physiologist Fees and Practice Requirements 2023*[9], the four words which precede the dot point criteria are *"including, but not limited to:"* The group mused that this phrasing allowed for context, flexibility, and for the AHP to use a vast array of assessments to determine and then justify what is a complex pathology and clinical presentation. Though, even with submitting a AHRR with appropriate justification, evidence-based treatment modalities, outcome measures, a clear pathway to self-management, and supporting documents – an initial AHRR being submitted by a professional requesting the Consultation C sessions, would probably be scrutinised.

Fascinatingly, a shared experience by the group was once the initial AHRR had been approved, then subsequent AHRR were also likely to be approved, though without scrutiny. One group member, who mostly treated workers post-operatively, expressed that their AHRRs were generally approved for the Consultation C sessions. After scrutiny of the initial AHRR, about 90% of all AHRR are approved…eventually. I was pleasantly surprised by this rate of approval; I had thought it would've been fewer than 90%.

Unsurprisingly, it turns out that if the claims management professional is familiar with the AHP and the work which they do, the AHRR is also more likely to be approved, again, without scrutiny. Both within individual experiences and amongst the group, the overall feedback from claims services providers was a mixed bag.

This begs the question then, about consistency in decision making of the claims management professional employed by the claims service providers, and who are entrusted by the scheme to make decisions about treatment approval. Is there a need to educate and train claims management professionals with the aim of improving consistency in decision making, understanding fees and practice requirements, understanding allied health disciplines, understanding injuries and medical conditions, and identifying and acknowledging bias. And, if so would that training look like?

From the anecdotes shared during the session, and those shared amongst the wider allied health professional community, the general feeling is that claims management professionals, as a cohort, tend to lack the basic knowledge of the different allied health disciplines, the scope of practice, and treatment modalities. I am not

[9] https://www.sira.nsw.gov.au/__data/assets/pdf_file/0017/1122623/Accredited-exercise-physiology-fees-and-practice-requirements-effective-1-February-2023.pdf

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suggesting that they need to be experts, but simply to have a fundamental understanding, or at least be open to exploring each AHRR in the context of the overall circumstance, recovery and rehabilitation of the injured worker.

The tendency to recruit claims management professionals in the same vein as recruiting customer service representatives is myopic and foolish. Supporting a person after they have sustained a workplace injury is immensely different to asking Vodafone for my PUK code (yes, I am almost 40 years old).

To sum up the question, "What feedback have you been receiving about Consultation C?"
It's irrational and inconsistent.

The Timing of Service Delivery

The timing of service delivery is decidedly pertinent. Exercise physiology services are not traditionally regarded as an early intervention. The question which jumped into my brain during the session was this one:

"If a previous allied health professional had been approved to provide Consultation C / complex treatment sessions, would the likelihood of approval for an AHRR requesting Consultation C submitted by the next AHP increase or decrease?"

Two factors which seem to inform the decisions of claims management professionals are; 1) the number of treatment sessions, and 2) the duration since the date of injury. Rightly so, there must be an expectation for allied health professionals, to "*empower the injured person to manage their injury*," which is the third of the five principles as per the *Clinical Framework For the Delivery of Health Services.*[10]

Where the frustration lies is in knowing that by the time an exercise physiologist has received a referral to treat an injured worker, the recovery timeframes are already protracted. As such, a referral to exercise physiologist is often regarded as the last resort, when nothing else has worked, and after a patient has attended treatments sessions over a number of months (or even years) with a different allied health professional.

Irrespective of the allied health discipline, it is both perverse, and prejudicial to expect that the newly referred professional would be able to achieve the rehabilitation goals in a quicker timeframe, with increased scrutiny, fewer resources, and more risk factors and barriers than the previous AHP. This is where the majority of the group and many of their peers had usually found themselves. In being expected to effectively treat a diagnosis, identify and address multiple psychosocial barriers and significant risk factors, and educate the worker, in fewer sessions, and in fewer total treatment hours than the previous professional.

Much like a sullen six-year-old child who's been told he can only have one Cadbury Crème Egg, the scheme needs to change its expectations and attitudes. There has been much discussion about parity between the allied health disciplines. My belief is, this is the wrong direction. Comparing different allied health disciplines, and attempting to bring them on par is like comparing apples to oranges. It is illogical and impractical.

Allied health disciplines do not need parity, they need equity and to be allocated the exact resources and opportunities needed to effectively support injured workers, to meet the principles of the framework, and to achieve the outcomes which the scheme so desperately desires. This inequity, in my view is a major factor for

[10] https://www.sira.nsw.gov.au/resources-library/motor-accident-resources/publications/for-professionals/clinical-framework-single.pdf

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one fundamental flaw of the scheme. That it does not allow for a multidisciplinary treatment approach. Why? Because, currently, the scheme views every single allied health discipline as being exactly the same.

Is it possible to have a general consensus about defining Consultation C?

This was the final discussion point of the session. It was quick fire and pragmatic.
The short answer: No.

So, What now?

If you have skipped to this section. Go back and read from the start. Like an AHRR, the context is critical. We acknowledged that any systemic change takes time, resources, and most crucially the willingness of those in power to make the change. In summary, the following is proposed.

Time
Allocate sufficient time for allied health professionals to do a good job. A start is to give additional time, particularly in the initial consultation phase to enable a professional to complete a thorough assessment, identify barriers, discuss goals and expectations with the worker, educate the worker, reflect and think, and complete the relevant documentation. In reviewing future fees structures, the scheme must consider equity and not parity, which brings us to the next recommendation.

Equity
Even with some similarities, every allied health discipline is different. Allied health disciplines do not need parity, they need equity and to be allocated the exact resources and opportunities needed to effectively support injured workers, to meet the principles of the framework, and to achieve the outcomes which the scheme so desperately desires.

The scheme must consider the role of each discipline, and at which stage of the recovery process the disciplines is referred. AHP providing services in the acute stage of recovery has vastly different needs to the one providing services in the sub-acute, and chronic stages. Additionally, AHP employ various techniques and modalities in the delivery of services, again which require different resources.

Acceptance of a multidisciplinary team approach
The recovery and rehabilitation of an injured worker is multifaceted and requires a coordinated approach. icare and SIRA NSW need to acknowledge that best-practice rehabilitation involves a multidisciplinary team approach across primary health providers, allied health disciplines, and the wider rehabilitation support team.

Workplace QLD issued a bulletin in April 2022[11] which explicitly says the best practice approach for chronic pain is to *"take a collaborative, multidisciplinary approach to support your workers living and working with chronic pain."*

[11] https://www.worksafe.qld.gov.au/news-and-events/newsletters/rehabilitation-and-return-to-work/2022-bulletins/april-2022/supporting-workers-with-chronic-pain

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The *Clinical Framework For the Delivery of Health Services*[12] suggests one of the questions which an AHP should ask themselves during an assessment of risk factors and flags is:

> *"would other healthcare professionals, health services (such as multidisciplinary services) or evidence-based treatments improve the injured person's rate of recovery?"*

Furthermore, the framework stated:

> *"Developing a treatment plan to address these biological, psychological and social risk factors, and shape behaviour, is an important aspect of effectively preventing or managing persistent pain, activity limitation and participation restriction. It is also important to monitor flags or risk factors and adjust the treatment plan as an injured person's experiences change. Some psychosocial factors cannot be changed, but a person's perceptions and responses may be amenable to positive change. An effective biopsychosocial approach is usually based on good communication among stakeholders and often includes the involvement of multiple healthcare professionals."*

Allied health professionals should not have to compete for sessions and resources. The current standard of not permitting two allied health disciplines within the same group (for example, exercise physiology and physiotherapy) to simultaneously provide services to an injured worker is antithetical to the purpose of scheme.

This standard actively promotes a siloed approach to recovery, cultivates unnecessary competition between disciplines, discourages appropriate referrals to other AHP, and prevents the injured worker from accessing reasonable and necessary treatments at the right time. This guidance also leads to professionals gaming the system and finding work arounds, whilst limiting the opportunity for incidental peer review which naturally occurs when there are multiple allied health disciplines involved in a patient's care.

Training & Education

The roll out of the icare Professional Standards Framework[13] for claims professionals is welcomed and only time will tell if the framework and associated training is successful in improves the experience of injured workers and of providers in the scheme. Claims management professionals need adequate education and training to improve:

- the consistency of decision-making across the scheme
- understanding of allied health disciplines, fees and practice requirements
- knowledge of medical conditions and injuries, or at least where to find resources
- acknowledging heuristics and bias, and ethics training

On the flip side, allied health professionals also need adequate training in the similar areas:

- the consistency and evidence-based approach to their decision-making
- understanding of their responsibilities within the scheme, their fees and practice requirements
- knowledge where to find resources to support their practice and their patients
- acknowledging heuristics and bias, and ethics training

[12] https://www.sira.nsw.gov.au/resources-library/motor-accident-resources/publications/for-professionals/clinical-framework-single.pdf
[13] https://www.icare.nsw.gov.au/-/media/icare/unique-media/global-header/news-and-stories/news/icare-announces-professional-standards-framework-partnership/professional-standards-framework-nsw-nominal-insurer--treasury-managed-fund-workers-compensation.pdf

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Approval Timeframes

There is some clarity relating to approval timeframes during the first three months of claim. Though, there is ambiguity with regards to approval timeframes for AHRR. More specifically, what are the pre-approval requirements after submission of an AHRR after the first three months.

The delays in processing and responding to AHRR is yet another frustration expressed by the group, and the wide allied health community. Claims Service Providers must understand that any delay accessing treatments, or at least in a response to a request negatively affects the trajectory of recovery.

The SIRA NSW *Reversing the trend - improving return to work outcomes in NSW* document, published in October 2020[14] reads:

> *"There is strong evidence to confirm timely liability decisions and decisions relating to approval for treatment and services improves RTW outcomes. Excessive delays in claim decision-making has been reported as stressful by claimants, and is associated with greater disability, higher incidence of anxiety and depression, and lower quality of life[52]. More than 34% of claims take longer than 30 days between incident and insurer liability decision[53]. This provides a clear opportunity for improving RTW outcomes across the workers compensation scheme.*

Always end with optimism

As is always, let's end with optimism. The Think Tank Session brought together a group of people who actually give a shit. Yes, because their livelihood depends on it, though so do the hundreds, and thousands of injured workers, and patients they treat, educate and support on the pathway to recovery.

The system must change. If it genuinely intends to meet the purpose of helping an injured worker with their recovery and rehabilitation, it must enable and encourage allied health professionals to responsibly and ethically provide the right services, at the right time.

As I wrapped up the Think Tank Session, I did shed a few tears. It was in that moment, as I looked at all the faces in little tiny boxes on a screen, that I came to realise that all this was real. This is a movement, and together, our community are going to speak up and contribute our vision towards a better future.

The question is: Are *you* ready to listen?

Cheers for now,
-Rhea
23 February 2023

[14] https://www.sira.nsw.gov.au/fraud-and-regulation/research/reversing-the-trend-improving-return-to-work-outcomes-in-nsw
[52] Cullen K.L., Irvin E., Collie A., et al. Feb 2017. Effectiveness of workplace interventions in RTW for musculoskeletal, pain-related and mental health conditions: an update of the evidence and messages for practitioners. Journal of Occupational Rehabilitation
[53] Collie, A., Lane, T., Di Donato, M. and Iles, R. August 2018. Barriers and enablers to RTW: literature review. Insurance Work and Health Group, Monash University: Melbourne, Australia.

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