MANAGEMENT OF MEDICAL COSTS FOR INJURED WORKERS

Executive summary

1. This submission is intended to respond to your request for:

   "*a submission from icare in relation to the management of medical care and costs for injured workers and icare's proposed changes, which summarises the matters raised and*

   1. *identifies matters*

      a. *which are within icare's control,*

      b. *which are within icare's control in part, and*

      c. *which are wholly outside icare's control but could be improved with other changes*

   2. *particularly where the matter is in whole or part outside icare's control, identifies the recommendations for change."*

2. icare acknowledges that rising medical costs is one of the largest expense drivers in the NSW workers compensation system. icare is grateful for the opportunity to provide a further submission in this regard.

3. According to work undertaken by icare and the State Insurance Regulatory Authority (**SIRA**) to understand the reasons for increased medical costs:

   a. utilisation (being the number of services accessed by a claimant) is the principal driver of increasing medical costs; and

   b. regulated costs for medical treatments in the NSW workers compensation system, which are set by SIRA,[1] are higher than the costs in all other Australian workers

[1] See section 61 of the *Workers Compensation Act 1987* (the **1987 Act**). See also sections 62, 63, 63A, and 64 in relation to other fees which are set by SIRA.

compensation jurisdictions and higher than the costs for NSW patients outside the workers compensation system.[2]

4. Broadly speaking, increased utilisation has led to an increased growth in medical costs, whereas higher regulated costs ensure absolute medical costs are high.

5. In relation to utilisation, icare considers a significant contributor to the over-utilisation of medical services in the NSW workers compensation system is the ease with which workers can access low value care, which has little to no benefit for injured workers, as opposed to driving value-based care, which is focused on effective, patient-centred interventions that improve health outcomes.[3] Although NSW Health's goal is to achieve a value-based healthcare system by directing patients away from low value options, the workers compensation system is not similarly focused.

6. While icare has the ability to control some matters relating to the provision of low value care and medical spend through improvements within its claims management framework, icare submits that all other matters are outside its control.[4] The following areas must be addressed if health outcomes are to be improved for workers and to better manage medical spend within the NSW workers compensation system:

    a. legislative and regulatory amendments, including:

        i. replacing the legislative "*reasonably necessary*" test with one which better drives the provision of value-based care;

        ii. reviewing medical and related treatment Fee Orders, which may include investigation into alternate funding models that simultaneously provide a favourable solution for workers (through better health outcomes), providers (through fair and equitable fees), and the NSW workers compensation

[2] See Ernst & Young, *Healthcare in Personal Injury Schemes Report for SIRA Workers Compensation Scheme* dated 24 July 2019 [Annexure 4B to Item 4: Mismanagement of Medical Services and Costs of icare's response to media issues dated 25 September 2020 (**icare's Media Issues Response: Item 4**)] (**EY Report dated 24 July 2019**); paragraphs [5]-[10] of icare's Media Issues Response: Item 4; paragraphs [28]-[31] of icare's ToR 2(b) submissions

[3] In its Healthcare Review Final Report, SIRA has similarly concluded that the high growth rate in service utilisation can be attributed to broader scheme-wide healthcare challenges, including unintended consequences associated with the workers compensation system incentivising claimants to maximise benefits.

[4] Consistent with the findings of *Quantium Health: Analysis into icare medical cost increases in Nominal Insurer and Treasury Managed Fund 28 April 2020* [Annexure 4E to icare's media issues response dated 25 September 2020]

scheme (through financial sustainability). It is noted that SIRA has committed to further reviewing fees in January 2021;

iii. transitioning from the American Medical Association's Guides to the Evaluation of a Permanent Impairment, 5th Edition (**AMA 5**) to 6th edition (**AMA 6**)[5], which aligns medical treatments with improved patient outcomes rather than increased impairment; and

iv. increasing the number of services that require pre-approval from the insurer,[6] rather than being automatically available;

b. implementing a robust and enforceable clinical governance framework where all healthcare providers are required to meet clearly defined skills, qualifications, experience and performance expectations to support them to perform their roles;

c. developing enforceable best practice treatment and provider management Guidelines;

d. meaningful and timely data capture in order to share insights and improve systems and processes, including transitioning from the Australian Types of Occurrence Classification System (**TOOCS**) to the International Classification of Diseases system (**ICD**) to code workers' injuries, which will provide the clarity, granularity and currency required to analyse and substantiate the medical necessity of diagnostic and therapeutic services and enable comparison of data and injury types both within NSW personal injury schemes, and across other healthcare settings; and

e. the system-wide implementation of a Health Outcomes Framework.

7. A complete list of icare's recommendations is set out below. For the avoidance of doubt, these relate to matters that are either wholly or partly outside icare's control. We have also identified those which align with SIRA's recommendations following its review of healthcare across the NSW workers compensation and Compulsory Third Party schemes, published in its final report in December 2020 (**SIRA's Healthcare Review Final Report**).

[5] As currently outlined in the NSW workers compensation guidelines for the evaluation of permanent impairment, April 2016.
[6] As currently outlined in Part 4.1 of SIRA's Workers compensation guidelines, April 2020.

Recommendations

No.	Recommendation	Timeframe
1.	SIRA to align scheduled fees with other Australian workers compensation jurisdictions.	Short term
2.	SIRA to investigate alternate fee structures and funding models for the provision of medical and related care that provide a favourable solution for workers (through better health outcomes), providers (through fair and equitable fees), and the NSW workers compensation system (through financial sustainability). *In SIRA's Healthcare Review Final Report, SIRA has identified the need to review both the level and the structure of the NSW workers compensation healthcare fee schedules.*	Medium to long term
3.	SIRA to increase the number of services that require pre-approval from the insurer, rather than being automatically available.	Short to medium term
4.	The introduction of a new definition that supports value-based care for assessing, approving and funding medical treatment within the NSW workers compensation system, away from the current "*reasonably necessary*" test. As an interim measure, SIRA should also consider the introduction of operational guidelines which clearly outline how the "*reasonably necessary*" test should be applied, similar to the Lifetime Care and Support Guidelines (see Part 6, section 2) or the Planning Operational Guidelines from the NDIS.	Medium to long term
5.	SIRA to adopt and align the American Medical Association's Guides to the Evaluation of Permanent Impairment, 6th Edition in the NSW workers compensation system as a means of aligning medical treatments with improved patient outcomes, rather than increased impairment.	Medium to long term
6.	SIRA to implement robust and enforceable treatment Guidelines to set clear expectations regarding value-based treatment and care to be provided through the NSW workers compensation system.	Short to medium term

No.	Recommendation	Timeframe
	SIRA has identified the need to improve clinical quality through evidence-based clinical frameworks and standards. SIRA has commenced a clinical quality improvement project to help deliver evidence-based care. SIRA has undertaken to enhance monitoring of utilisation, expenditure, outcomes and efficiency across the scheme.	
7.	A transition from TOOCS to ICD coding across the workers compensation system, as well as the introduction of additional coding metrics and health-related outcome measures. *SIRA will be developing a 12-month plan for filling data gaps alongside the finalisation of data metrics and standardisation to increase the reliability of reporting. SIRA will also be developing a data governance framework to capture components such as data quality, access, security and standards, and roles and responsibilities.*	Short to medium term
8.	SIRA to consider simplification of the billing and invoicing methodology applied within the NSW workers compensation system to minimise risk and probable causes of leakage. *SIRA has undertaken to review and benchmark gazetted fee schedules and indexation methodologies and given consideration to the adoption of alternative billing rules and practices.*	Short to medium term
9.	SIRA continue its important and ongoing work on the implementation of a clinical governance framework, including credentialing, clinical education and training in the workers compensation system, and performance monitoring and management.	Medium term
10.	SIRA to continue with its work on the system-wide implementation of a Health Outcomes Framework.	Medium term

Matters raised to date

8. The following information regarding the management of medical care and costs in the Workers Compensation Nominal Insurer (the **Nominal Insurer**) and Treasury Managed Fund (**TMF**) workers compensation schemes has previously been provided to the Review:

    a. Item 4: Mismanagement of Medical Services and Costs of icare's response to media issues dated 25 September 2020 (**icare's Media Issues Response: Item 4**); and

    b. paragraphs [28]-[42], [67]-[105] and [153]-[166] of icare's submissions in response to Term of Reference 2(b) dated 18 November 2020 (**icare's ToR 2(b) submission**).

9. For completeness, icare confirms that actuarial analysis makes clear that there have been increases to medical costs above general inflation over the 2016/17 to 2019/20 financial years, particularly in the earlier two years.[7]

10. Both icare and SIRA have undertaken work to understand the causal reasons or drivers for the increase. To that end, several internal and external reviews have been conducted, including in the lead up to SIRA's Healthcare Review Final Report.[8]

11. According to this work:

    a. utilisation (being the number of services accessed by a claimant) is the principal driver of increasing medical costs; and

    b. regulated costs for medical treatments in the NSW workers compensation system, which are set by SIRA,[9] are higher than the costs in all other Australian workers compensation jurisdictions and higher than the costs for NSW patients outside the workers compensation system.[10]

[7] See paragraphs [11]-[16] of icare's Media Issues Response: Item 4; paragraphs [71]-[78] and [153]-[155] of icare's ToR 2(b) submission
[8] See EY Report dated 24 July 2019; Ernst & Young, *Healthcare in Personal Injury Schemes Summary of preliminary findings for NSW Workers Compensation and Compulsory Third Party schemes* dated 11 September 2019 [Annexure 4C to icare's Media Issues Response: Item 4]; Quantium Health, *Analysis into icare medical cost increases in Nominal Insurer and Treasury Managed Fund* dated 28 April 2020 [Annexure 4E to icare's Media Issues Response: Item 4]; Synapse, *SIRA Industry Presentation* dated 10, 11 and 12 June 2020 [Annexure 4F to icare's Media Issues Response: Item 4]; paragraphs [17]-[18] of icare's Media Issues Response: Item 4; paragraphs [79]-[80] of icare's ToR 2(b) submission
[9] See section 61 of the 1987 Act. See also sections 62, 63, 63A, and 64 in relation to other fees which are set SIRA.
[10] See EY Report dated 24 July 2019; paragraphs [5]-[10] of icare's Media Issues Response: Item 4; paragraphs [28]-[31] of icare's ToR 2(b) submissions

12. In order to address these matters, icare has taken steps to address service over-utilisation and has committed to increased, targeted oversight of healthcare providers with particularly high spend or utilisation.[11] icare has also made a number of submissions to SIRA, as the relevant Authority, regarding the importance of regulatory measures outside of icare's functions to align the NSW approach with other jurisdictions.[12]

Low value care versus value-based care

13. Following a public consultation conducted in late 2019, on 22 December 2020 (after the submission of icare's Media Issues Response: Item 4 and icare's ToR 2(b) submission), SIRA published SIRA's Healthcare Review Final Report.

14. In its report, SIRA acknowledges the importance of implementing a value-based care approach to healthcare arrangements within SIRA's schemes.[13] SIRA has begun important work on developing a health outcomes framework as a critical component of the shift towards value-based care, with a focus on strengthening reporting and transparency, monitoring, evaluation, governance and continuous improvement. The measurement of outcomes will be assisted by baseline and ongoing analysis of customer experience, focusing on trust and health and social outcomes. SIRA will also examine areas where there is a risk of low value care being provided to claimants.[14]

15. Low value care is a clinical intervention where evidence suggests it offers no or very little benefit for patients, or where the cost or the risk of harm exceeds the likely benefit.[15] One example of such low value care is the number of spinal fusions being approved and undertaken within the workers compensation system for back injuries, despite the evidence

[11] See paragraphs [19]-[30] of icare's Media Issues Response: Item 4; paragraphs [83]-[102] and [157] of icare's ToR 2(b) submission
[12] See icare's Submission on Regulatory Requirements for Health Care Arrangements in the NSW workers compensation and CTP Schemes dated November 2019 [Annexure 4D to icare's Media Issues Response: Item 4] (**icare's Healthcare Submission dated November 2019**)
[13] Being the NSW workers compensation and Compulsory Third Party schemes
[14] In addition, SIRA is addressing some shorter-term gaps, including:
1. data availability and quality through SIRA's Data System Modernisation Project;
2. a review of Fee Schedules to align with a value-based approach to treatment; and
3. the release of Practice Requirements for Allied Health Providers for 2021 on fees, billing and approval processes, with the aim of reducing billing and coding errors.

[15] Badgery-Parker, T., Pearson, S., Chalmers K, et al*; 'Low-value care in Australian public hospitals: prevalence and trends over time';* BMJ Quality & Safety 2019;28**:**205-214.

suggesting this is not best practice.[16] In some cases, spinal fusion may even result in permanent reduction of function, which may limit future work ability.[17]

16. On the other hand, according to the NSW Ministry of Health, value-based care in NSW means delivering services that improve:

    a. the health outcomes that matter to injured workers;

    b. the experience of receiving care;

    c. the experience of providing care; and

    d. the effectiveness and efficiency of care.

17. Value-based care strives to treat every patient the same regardless of where or when the injury occurred. It is well accepted that the provision of health services in an insurance framework often adversely impacts the injured person.[18] Navigating an injury within a compensation scheme affects the management of an injury,[19] as does the inherently adversarial system that encourages parties to take up fixed opposing positions in pursuit of a successful judgment, rather than the rehabilitation and recovery of the injured person.[20] Against this background, aspects of the NSW workers compensation system continue to allow access to low value care, in contrast with the priorities of the broader NSW healthcare system.[21]

18. icare supports SIRA's move to a system of value-based care and has advocated strongly for this.[22] A value-based care system will require the endorsement and advocacy of all

[16] Choosing Wisely Australia; Faculty of Pain Medicine, ANZCA: tests, treatments and procedures clinicians and consumers should question; 13 February 2018; http://www.choosingwisely.org.au/recommendations/fpm
[17] See Recommendation 2 of icare's Healthcare Submission dated November 2019
[18] Disability Care and Support Inquiry Report, 10 August 2011 *https://www.pc.gov.au/inquiries/completed/disability-support/report/34-disability-support-appendixj.pdf* pg. 10
[19] This has also been identified by SIRA in its Healthcare Review Final Report dated 22 December 2020 [page 13]: *"[The] structure of the WC scheme may lead to unintended consequences in certain scenarios, such as decisions to take actions (or delay actions) to maximise the assessment of the injury (the Whole Person Impairment) in order to access additional benefits (lump sum and/or common law), and to extend access to income replacement and medical benefits. These consequences are not present in Medicare and private health insurance."*
[20] '*Compensable Injuries and Health Outcomes';* The Australasian Faculty of Occupational Medicine; The Royal Australasian College of Physicians, Health Unit 2001 Pg. 6
[21] The Secretary for NSW Health has stated NSW Health's goal of achieving a value-based healthcare system by putting the patient's experience and health outcomes at the centre of its delivery of care, and achievement of this goal influences all aspects of work in NSW Health including clinical care, procurement, capital and service planning, health technology assessment, workforce training and education;[21] see Elizabeth Koff, Secretary for NSW Health, describes value based care as putting the patient experience and patient outcomes at the centre of delivery of care; 24 January 2019; https://www.health.nsw.gov.au/Value/Pages/default.aspx.
[22] See pages 4 and 5 of icare's Healthcare Submission dated November 2019

stakeholders in the system and should sit within a well-articulated regulatory and compliance framework to ensure desired outcomes are met.

19. For the purposes of the following sections, we have outlined those matters that are within, partially within and outside icare's control when it comes to reducing the incidence of low value care and moving to a system of value-based care. Where matters are wholly or partially outside icare's control, recommendations for reform are set out.

Matters within icare's control

20. Relevant matters within icare's control largely derive from its claims management framework. Actions icare has taken or is taking to address rising medical costs include:

    a. uplifting staff capability;

    b. providing decision-making support for case managers; and

    c. improving systems and data capture to support legislative compliance.

Uplifting staff capability

21. Appropriately trained claims management staff play a significant role in controlling medical spend. Through suitable training and upskilling, claims management staff develop the capabilities required for robust medical decision-making and the effective monitoring of medical and allied health treatment referrals and spend, whilst also building health literacy amongst workers by encouraging them to make informed decisions to access value-based care.

22. icare retains accountability for staff capability within the Nominal Insurer and TMF schemes. In partnership with our claims management providers, icare provides support to drive an uplift in staff capability, through training and the development of a capability framework for claims management, including the management of medical and other healthcare services.

23. icare has implemented tools and resources to help support claims management providers to make decisions regarding medical and related treatment and continues to work closely with its claims management providers to improve workers compensation claims management performance across NSW.[23]

[23] See paragraphs [79]-[144] of icare's submissions in response to Term of Reference 1(a) dated 18 November 2020 for an outline of icare's ongoing management of its claims management providers.

Providing decision-making support for case managers

Guidance materials and other claims support tools

24. icare provides guidance materials in relation to claims practices via Knowledge Articles, training (online and in person) and Direction Notices (for the Nominal Insurer scheme) to help support case managers in their medical decision-making and to bolster existing guides, Guidelines and Standards of Practice from SIRA. This includes guidance on how to assess whether medical treatment requests are "*reasonably necessary*" and how to utilise other applicable claims decision support tools to help curtail the approval of low value treatments and reduce unnecessary spend.[24]

25. In 2017, icare introduced a claims decision support tool across the Nominal Insurer scheme based on the Official Disability Guidelines (**ODG**) that set out expectations of recovery, return to work and recommended treatment options for workers compensation injuries, with a focus on empowering claims staff when making decisions regarding requests for medical investigations and treatments.[25] The tool draws on evidence-based medical literature and claims data analytics to provide recommendations and is used extensively in workers compensation in the United States of America.

26. icare has customised the ODG as part of its claims practices to reflect the NSW and Australian context. Ongoing customisation occurs on an annual basis, increasing the size of the data set and improving the specificity of the tool for use in the NSW workers compensation scheme.[26] This customised tool gives case managers evidence-based guidance on best medical practice for different injuries, in line with SIRA Guidelines, and assists with setting realistic expectations for all relevant parties. The tool also helps highlight cases where case managers may be required to seek additional information from healthcare providers, helping ensure compliance with legislative requirements and timeframes.

[24] See further paragraphs [20]-[27] of icare's Media Issues Response: Item 4 and [87]-[91] of icare's ToR 2(b) submission
[25] See paragraphs [20]-[27] of icare's Media Issues Response: Item 4 for additional information.
[26] The closed claims data for the current dataset covers claims from 1987 to 2019, with a total of 832,216 closed claims from the Nominal Insurer included in the Australian customisation.

Medical Support Panel

27. icare provides support to claims management providers and case managers through its Medical Support Panel (**MSP**), which was established in May 2017 for the Nominal Insurer scheme. The MSP has since been partially rolled out for aspects of the TMF scheme.[27]

28. The MSP is comprised of medical specialists with the expertise to review case files and make recommendations as to whether medical investigations and health interventions are evidence-based, best practice or reasonably necessary. The MSP empowers case managers to better understand the medical aspects of a claim and enhances their discussions with injured workers regarding appropriate treatment. It also conducts peer to peer discussions with relevant treating providers and employers as required.

29. The MSP helps reduce medical spend in complex cases and helps encourage value-based treatment and care.[28] In the 2018/19 financial year, the combined cost to the Nominal Insurer of the MSP and related Independent Medical Examinations (**IMEs**) was $17.7 million, compared to the $27 million cost of IMEs alone in the 2017/18 financial year.

Improving systems and data capture to support legislative compliance

30. icare has been focused on understanding the extent of medical spend it can reduce through its own systems.[29] To enable this, icare has quantified the medical spend that it can address and has identified key areas for change. This has led to improvements in icare's claims management procedures and payment processes in the Nominal Insurer scheme, including through the introduction of inbuilt mechanisms and controls to address payment integrity and minimise medical cost leakage.[30]

31. These mechanisms and controls were introduced in early 2019 across the Nominal Insurer scheme following implementation of the single claims system and include:

[27] See further paragraphs [88]-[92] of icare's submissions in response to Term of Reference 3 dated 18 November 2020
[28] See paragraphs [43] to [48] of Item 1: Treatment of Injured Workers of icare's response to media issues dated 25 September 2020 for additional information.
[29] Including undertaking a comprehensive review of the Synapse Presentation findings delivered on behalf of SIRA in June 2020. For additional information, see paragraphs [18(e)(viii)] to [18(e)(x)] of icare's Media Issues Response: Item 4. icare provided a detailed analysis to SIRA on its findings in November 2020.
[30] See paragraph [19] of icare's Media Issues Response: Item 4 and paragraphs [83]-[102] of icare's ToR 2(b) submission.

a. introducing claims system alerts that raise red flags when treatment is inconsistent with SIRA gazettes and fee schedules, including when treatment fees are billed above the scheduled Fee Orders;[31] and

b. enabling the capture of additional healthcare information to help facilitate better decision-making by case managers.[32]

32. In particular, icare has adopted the use of the ICD coding system (version 10).[33] The ICD is a coding system used currently by all health systems in Australia except workers compensation schemes. The ICD coding system provides significant clarity, granularity and currency to analyse and substantiate the medical necessity of diagnostic and therapeutic services.

33. Using ICD coding within its claims model assists icare and its claims management providers with claim segmentation, approvals and data analysis within the Nominal Insurer scheme.

34. In order to achieve maximum benefits from its system validations and enhanced data capture, icare is developing additional guidance material and has provided ongoing education for case managers to drive better compliance with SIRA's revised Standards of Practice and adherence to SIRA Fees and Rates Orders.

35. icare is focusing on ensuring billing and invoicing rules (beyond those explicitly outlined by the Fee Orders) are incorporated into the system, where possible, given the relatively high risk of human error in respect of payments due to the complexity of billing and invoicing methodologies within the NSW workers compensation system.[34]

36. In order to mitigate this risk and address these challenges, icare is focusing on:

a. upskilling icare's capability to understand the various billing, invoicing and approval rules and requirements that must be considered, including by introducing an in-house claims manager with specialist medical coding skills;

b. implementing appropriate system controls and enhancements to improve data and payment accuracy, such as heightened invoice scrutiny and outlier reporting;

[31] See paragraph [94] of icare's ToR 2(b) submission.
[32] Annexure 2B-3 to icare's ToR 2(b) submission contains a complete list of enhancement actions taken by icare to address payment integrity
[33] The current ICD Australian Modification (ICD-10-AM) is updated on a regular basis to ensure it remains current for Australian clinical practice and to incorporate regular updates of ICD.
[34] The Synapse review by SIRA concluded that 33% of a sample set of payments were incorrect. icare has reviewed these findings and provided a detailed analysis to SIRA in November 2020.

c. reviewing and engaging with providers to improve billing practices; and

d. ongoing regulatory engagement with SIRA to improve injury coding and data acquisition and capture.

37. To help achieve these goals, icare recommends the use of ICD coding across the whole NSW workers compensation system, and further simplification of the coding process. For further submissions on this point, see paragraph [70] below.

Matters partly within icare's control

38. The following aspects of the NSW workers compensation system may appear to be levers available to icare to control medical spend:

    a. negotiating fees payable for medical and allied health services;

    b. approving treatment; and

    c. managing the performance of medical and allied health providers.

39. However, in practice, there are considerable limitations on the extent to which icare can influence these matters.

Negotiating fees payable for medical and allied health services

40. From its inception to June 2020, icare has realised approximately $27 million in medical-related expenses savings through:[35]

    a. renegotiating provider contracts for hearing aids, which has resulted in a significant reduction in the average unit price from a baseline of $2,400 to a maximum of $1,750 and an overall saving of $21 million since the 2016/17 financial year; and

    b. introducing a reduced provider fee regime for medical imaging service providers, resulting in a $6 million saving since the 2018/19 financial year.

41. However, icare's ability to influence or negotiate fees any further is heavily constrained. Pursuant to the *Workers Compensation Act 1987* (the **1987 Act**), SIRA is responsible for setting the maximum fees applicable for medical or related treatment.[36] Fees paid to medical

[35] For further details, see paragraphs [14]-[17] of icare's submissions in response to Term of Reference 1(c) Realisation of Benefits dated 18 November 2020.
[36] See section 61 of the *Workers Compensation Act 1987*. See also sections 62, 63, 63A, and 64 in relation to other fees which are set by SIRA.

and allied health providers by insurers (including the Nominal Insurer and the NSW Self Insurance Corporation for the TMF scheme) are limited by the scheduled Fee Orders issued by SIRA on an annual or bi-annual basis.

42. Scheduled fees for medical treatments in the NSW workers compensation system are higher than the scheduled fees for other Australian workers compensation jurisdictions or for NSW patients outside the workers compensation system.[37] In a majority of instances, medical and healthcare providers charge at the maximum allowable rate under the workers compensation scheduled fees and insurers are bound by legislation to pay any rates that do not exceed those scheduled fees.

43. Theoretically, insurers could negotiate lower rates with medical and healthcare providers. As noted in paragraph [40] above, icare has had some success in this regard. However, icare's results with each of the two examples described above have been mixed:

    a. *Hearing devices*: Based on the results of a market review in May 2016, icare (acting for the Nominal Insurer) was able to successfully negotiate for the provision of hearing devices at a rate approximately 30% lower than the gazetted fee for such devices.

    b. *Imaging services:* In June 2018, icare trialled a similar approach by introducing a diagnostic imaging fee schedule which set fees at a lower rate than the SIRA scheduled fee (which is approximately 180% of the Medicare Benefits Schedule rate). Despite significant engagement and negotiation in the lead up, uptake of the diagnostic imaging fee schedule remains at low levels (approximately 35% across all imaging categories) due to poor provider incentives, a lack of endorsement by peak industry bodies and the non-enforceable nature of the initiative.

44. For most medical and related treatment providers, icare's market share is too low to offer any significant bargaining power to make negotiations effective, noting:[38]

    a. anecdotally, workers compensation claims account for approximately 3% of a general practitioner's workload;

[37] See EY Report dated 24 July 2019; paragraphs [5]-[10] of icare's Media Issues Response: Item 4; paragraphs [28]-[31] of icare's ToR 2(b) submissions
[38] Also see paragraphs 28 to 31 in of icare's ToR 2(b) submissions

b. workers compensation claims accounted for 1.5% of the aggregate NSW Government and non-Government recurrent healthcare expenditure in the 2018/19 financial year,[39] which is minimal in comparison to private health insurers; and

c. there is strong Australian Medical Association (NSW) support for the current fee model (with loadings).[40]

45. Regulatory amendment to fee schedules will have the greatest impact in addressing the high costs of medical and related treatment in the NSW workers compensation system.[41] In its Healthcare Review Final Report, SIRA has committed to reviewing and potentially revising the fee schedules in 2021.

RECOMMENDATION 1: In the short term, SIRA to align scheduled fees with other Australian workers compensation jurisdictions.

RECOMMENDATION 2: SIRA to investigate alternate funding models that provide a favourable solution for workers (through better health outcomes), providers (through fair and equitable fees), and the NSW workers compensation system (through financial sustainability).

Approving treatment

46. Claims management providers and case managers are responsible for approving treatment and related costs. In paragraphs [24] to [37] above, we have outlined several actions taken by icare to ensure better decision-making by case managers in this regard.

47. However, case managers are limited by pre-approved treatment and services within the SIRA Guidelines. This enables all workers, regardless of the type or severity of injury, to access treatment without the pre-approval of the insurer or claims management service provider. In these instances, both utilisation and expenditure are outside icare's control.

[39] This is based on $6.3 billion in total health expenditure in NSW for the 2018-19 financial year (Australian Institute of Health and Welfare, *Health expenditure* Australia, 2018-19 https://www.aihw.gov.au/getmedia/a5cfb53c-a22f-407b-8c6f-3820544cb900/aihw-hwe-80.pdf.aspx?inline=true) versus $935,635,998 in total health spend in the NSW workers compensation system in the same financial year (SIRA Payment statistics dashboard, https://www.sira.nsw.gov.au/open-data/system-overview/paymentsdata#!)

[40] As outlined in the AMA response to SIRA's 2019 consultation paper on "Regulatory requirements for health care arrangements in the NSW WC and CTP schemes"; AMA NSW Submission on Regulatory requirements for health care arrangements consultation, Australian Medical Association, NSW, 29 November 2019. https://www.sira.nsw.gov.au/__data/assets/pdf_file/0007/598642/Submission-037-Australian-Medical-Association-NSW.pdf

[41] See Recommendation 1 of icare's Healthcare Submission dated November 2019

48. Case managers are also limited by treatment approval timeframes. Under section 279 of the *Workplace Injury Management and Workers Compensation Act 1998,* an insurer has 21 days to approve or decline a request for treatment, or five days to approve or decline requests for further allied health treatments within three months of injury.[42] A failure to comply with these legislated timeframes deems liability for treatment accepted, even in situations where additional (often independent) information is sought and/or medical or allied health providers fail to respond to requests for further information that would enable a case manager to make an informed decision. Automatic acceptance of treatment under these circumstances disempowers case managers, impeding the delivery of value-based care and paramount health outcomes.

49. Of particular concern is the pre-approval of allied health provider services, which allows workers to access eights sessions of treatment by any type of allied health provider from both physical and psychological practitioners irrespective of their injury. Additionally, workers can access $110 per claim for reasonable incidental expenses and equipment provision (such as strapping tape, TheraBand, exercise putty, disposable electrodes and walking sticks). This alone could add an additional $6.6 million to annual medical expenditure (based on 60,000 claims per year). If applied across all NSW workers compensation claims, this figure alone could exceed $10 million annually.[43]

50. The Workers Compensation Independent Review Officer is currently seeking stakeholder feedback on these legislative timeframes, in recognition of ongoing delays and non-compliance to legislative timeframes by insurers across the NSW workers compensation system, which icare supports.

RECOMMENDATION 3: SIRA to increase the number of services that require pre-approval from the insurer,[44] rather than being automatically available.

Managing the performance of medical and allied health providers

51. icare has conducted a preliminary analysis of compliance rates of allied health providers and has identified a number of instances of over-servicing. Feedback from providers has suggested that confirmation of the insurer's remit in managing provider performance is

[42] Per clause 4 of the Guidelines for the approval of treating allied health practitioners 2016 No 2.

[43] See Recommendation 2 of icare's Healthcare Submission dated November 2019

[44] As currently outlined in Part 4.1 of SIRA's Workers compensation guidelines, April 2020.

necessary. Providers have also suggested the manual verification of data-driven findings of 'over-utilisation' may be needed to account for particularly complex cases.

52. There are no legal barriers to icare negotiating and contracting directly with hospitals, surgeons or other medical and healthcare providers for services. Doing so could lead to lower rates and require compliance with key performance indicators.[45] However, there are no incentives for these providers to contract directly with icare,[46] and the choice of provider (driven by the injured worker or preference of their nominated treating doctor or surgeon)[47] takes precedence, negating the value of such contracts unless icare were able to contract with all healthcare providers in the NSW workers compensation system.

53. Beyond this, icare submits that additional legislative and regulatory controls are necessary to ensure effective oversight of providers, particularly as SIRA does not pre-approve or accredit all healthcare providers in the NSW workers compensation system. A State-wide governance framework to manage providers and service standards in a way that drives value-based care would give icare levers to address non-compliance and non-performance. Such levers are currently are not available, rendering icare a 'toothless tiger'. This framework is discussed further in paragraphs [85] to [100] below.

Outside icare's control

54. There are a number of matters in the NSW workers compensation system beyond icare's control, but within the remit of the regulator.

55. icare submits that system-wide healthcare reform could curb the provision of low value care which contributes to increasing medical costs in the system, through:[48]

    a. regulatory and legislative amendments to the workers compensation legislation, regulations and subordinate legislation framework (including Guidelines) to drive

[45] As provided in icare's submissions in response to Term of Reference 1(c) dated 18 November 2020, from its inception to June 2020, icare has successfully realised $214 million in claims-related expenses savings through improved claims operations and contract negotiations with certain suppliers, including legal and medico-legal services and investigators.
[46] As noted in paragraph [44] above, icare has limited bargaining power to enter into such arrangements with healthcare providers.
[47] Per section 47(3) of the *Workplace Injury Management and Workers Compensation Act 1998*.
[48] icare notes that many of these matters are also outside the control of self and specialised insurers, however these insurers have some additional influence when it comes to guiding injured workers to "company doctors" or other healthcare providers that support the provision of value-based care.

value-based care, including amendments to the "*reasonably necessary*" test and a revision of permanent impairment assessment methods;

b. development of enforceable treatment Guidelines;

c. improving healthcare coding and data capture;

d. implementation of a system-wide clinical governance framework, including revising and simplifying billing and invoicing rules; and

e. implementation of a Health Outcomes Framework.

Regulatory and legislative amendments

56. Current regulatory and legislative arrangements in the NSW workers compensation system create incentives for medical and allied health service providers in respect of fee-for-service, rather than enabling a value-based care approach which encourages a holistic view of a person's ability to function and recover.

57. For example, the current system provides a financial incentive towards a recommendation for surgery, rather than the consideration of conservative treatment options that may lead to better health outcomes in the long-term.[49] In addition, the method of assessment in the AMA 5 Guides attributes greater degrees of impairment for subsequent interventions in the management of an injury, providing a perverse incentive for injured workers to undergo multiple low-value medical treatments, such as surgery, in order to reach impairment benchmarks.[50]

58. icare advocates for a complete review of existing regulatory and legislative arrangements to ensure they support value-based care to avoid low value care and interventions in the NSW workers compensation system. In particular, icare recommends the following areas be addressed immediately.

[49] See Recommendation 2 of icare's Healthcare Submission dated November 2019 for more details.
[50] 'Comparative benefits of the Sixth Edition of the AMA Guides for evaluating permanent impairment', as referred in Recommendation 6 of icare's Healthcare Submission dated November 2019

The "reasonably necessary" test

59. The 1987 Act uses the "*reasonably necessary*" test.[51] The test in the 1987 Act differs from similar personal injury schemes in NSW,[52] as well as Commonwealth schemes like the NDIS, which apply a "*reasonable and necessary*" test.

60. The "*reasonably necessary"* test allows all manner of treatment to be approved, including those considered as being of low value or potentially harmful.[53] This has contributed to the steadily increasing medical spend, and persistent non-improvement in patient outcomes, over the years.

61. The Workers Compensation Guidelines (October 2019),[54] which expanded the list of pre-approved medical treatments, has relaxed the "*reasonably necessary*" test even further, as workers are able to access services and incidental expenses with limited scope for denial under the legislation. These changes have a direct impact on the increase in medical expenditure.

62. While it is outside of icare's control, icare recommends the introduction of a new definition that supports value-based care for assessing and approving medical treatment within the NSW workers compensation system, rather than the current "*reasonably necessary*" test.[55] Consideration should also be given to providing regulatory guidance on how to apply the definition in practice.

63. As an interim measure, SIRA should also consider the introduction of operational guidelines which clearly outline how the "*reasonably necessary*" test should be applied, similar to the Lifetime Care and Support Guidelines (see Part 6, section 2) or the Planning Operational Guidelines from the NDIS.[56]

[51] See Section 60(1) of the 1987 Act. See also sections 59, 60A, 60AA, 61, 62 and 63 of the 1987 Act.
[52] See e.g. the *Motor Accidents Injuries Act 2017*; *Motor Accident (Lifetime Care and Support) Act 2006*
[53] See paragraphs [32] to [42] of icare's ToR 2(b) submission and Recommendation 2 of icare's submission to the Regulatory requirements for health care arrangements in the NSW workers compensation and CTP schemes dated November 2019.
[54] '*Workers Compensation Guidelines, Requirements for insurers, workers employers and other stakeholders'*; State Insurance Regulatory Authority, October 2019; Table 4.1; https://www.sira.nsw.gov.au/workers-compensation-claims-guide/legislation-and-regulatory-instruments/guidelines/workers-compensation-guidelines
[55] See Recommendation 2 of icare's submission to the Regulatory requirements for health care arrangements in the NSW workers compensation and CTP schemes dated November 2019.
[56] See Recommendation 2 of icare's Healthcare Submission dated November 2019

RECOMMENDATION 4: The introduction of a new definition or test that supports value-based care for assessing and approving medical treatment within the NSW workers compensation system, away from the current "*reasonably necessary*" test.

As an interim measure, SIRA should also consider the introduction of operational guidelines which clearly outline how the "*reasonably necessary*" test should be applied, similar to the Lifetime Care and Support Guidelines (see Part 6, section 2) or the Planning Operational Guidelines from the NDIS.

Revision of permanent impairment assessment methods

64. Medical costs are also impacted by the assessment methods used in personal injury schemes. As outlined in the NSW workers compensation guidelines for the evaluation of permanent impairment,[57] the workers compensation system in NSW uses the AMA 5 assessment guidelines. The method of assessment in the AMA 5 Guide attributes greater degrees of impairment for subsequent interventions in the management of an injury. This provides a potential perverse incentive for injured workers to undergo low value medical treatments, such as surgery, in order to reach impairment benchmarks.[58]

65. icare has previously recommended that the NSW workers compensation guidelines for the evaluation of permanent impairment be amended to require the use of the AMA 6 Guide for assessment of permanent impairment, as it better aligns medical treatments with improved function and patient outcomes, as opposed to increased impairment.[59]

RECOMMENDATION 5: SIRA to adopt and align the American Medical Association's Guides to the Evaluation of Permanent Impairment, 6th Edition in the NSW workers compensation system as a means of aligning medical treatments with improved patient outcomes, rather than increased impairment.

Development of enforceable treatment Guidelines

66. icare provides training to claims management providers to ensure medical and related treatment management and services provided are up to standard, but its influence across the

[57] https://www.sira.nsw.gov.au/resources-library/workers-compensation-resources/publications/health-professionals-for-workers-compensation/workers-compensation-guidelines-for-the-evaluation-of-permanent-impairment
[58] Busse et al, *Comparative Analysis of Impairment Ratings From the 5th to 6th Editions of the AMA Guides*, JOEM 60 No 12 December 2018
[59] See Recommendation 6 and Appendix 6 icare's submission to the Regulatory requirements for health care arrangements in the NSW workers compensation and CTP schemes dated November 2019.

system is limited. icare encourages SIRA to implement robust and enforceable treatment Guidelines across the NSW workers compensation system to enable healthcare providers to understand treatment pathways and management, and to limit low-value, unnecessary or invasive procedures.

67. Having robust and enforceable Guidelines in place will set up clear expectations of treatment and care to be provided and will help achieve the strategic goal of value-based care by ensuring only treatment and care that is necessary and cost-effective is approved.[60] A number of Guidelines and resources have been created by other jurisdictions, which can be leveraged to provide better clarity, consistency and treatment for injured workers in NSW.[61]

RECOMMENDATION 6: SIRA implements robust and enforceable treatment Guidelines to set clear expectations regarding treatment and care to be provided through the NSW workers compensation system.

Improved healthcare coding and data capture across the NSW workers compensation system

68. SIRA defines and sets data capture and reporting requirements.[62] icare considers there are four relevant areas where improved data and analytics can reduce medical spend:

    a. transition from the TOOCS to ICD system of healthcare coding;

    b. simplification of billing and invoicing requirements;

    c. capturing additional data fields, with system-wide provider benchmarking; and

    d. system-wide real-time data exchange.

69. Importantly, for any amendments to healthcare coding and data capture to be effective, any changes must be implemented across the whole NSW workers compensation system. SIRA is best placed to introduce and enforce such changes.

[60] According to Finity, best practice workers compensation insurance schemes need to have guidelines in place, even if just for the most common injuries. Doing so sets clear expectations around which treatments are value based, low value, or potentially harmful, based upon the type of injury, and what the expected recovery timeframe should be: *A best practice workers compensation scheme,* Insurance Council of Australia, May 2015 Atkins, G and Robinson, F on behalf of Finity (accessed 10/10/2019)
[61] See icare's submission on Regulatory requirements for health care arrangements in the NSW workers compensation and CTP schemes Recommendation 4 (pages 24 to 28) dated November 2019
[62] See the Workers Compensation Insurer Data Reporting Requirements, made by SIRA under section 40C of the 1998 Act

Transition from the TOOCS to ICD system of healthcare coding

70. The quality of healthcare coding impacts icare's ability to:

    a. compare and benchmark injuries, treatments, costs and outcomes against all other Australian and international healthcare sectors;

    b. understand the nature and magnitude of injuries coming through the workers compensation system; and

    c. implement policies, procedures, systems and treatments that support value-based care.

71. The NSW workers compensation currently uses the TOOCS system. icare's reporting to SIRA is based on TOOCS.

72. The TOOCS system lacks both the granularity and consistency needed to support the production of quality data sets, which is integral for the proper implementation of value-based care. icare has therefore adopted the use of ICD coding to assist with approvals and data analysis within the Nominal Insurer scheme.

73. Adopting ICD across the NSW workers compensation system would permit more specific clinical data to be captured and greatly increase data effectiveness by enabling the comparison of data and injury types across both Australian and international healthcare sectors.

RECOMMENDATION 7: Transition from TOOCS to ICD coding across the workers compensation system, as well as the introduction of additional coding metrics and outcome measures.

Simplification of billing and invoicing requirements

74. The NSW workers compensation fee schedules reference rules outlined in the Australian Medical Association (**AMA**) Fees List. While there are some codes contained within the AMA Fees List that translate to Medicare Benefits Schedule (**MBS**) item numbers, the two lists have become increasingly divergent over time in both content and pricing. The relationship

between the AMA, MBS and NSW workers compensation Fees Orders are "*opaque, at best*".[63]

75. To add to this complexity, the NSW workers compensation fee schedules identify certain AMA payment codes that:

    a. are not relevant for workers, and therefore do not attract payment within the NSW workers compensation system;

    b. attract a different maximum amount for services rendered under the NSW workers compensation system compared with other healthcare services; or

    c. attract different loadings compared to that stated within the AMA Fees List.

76. In addition, there are payment codes[64] for SIRA-specific medical and allied healthcare services provided within the NSW workers compensation system that do not appear in the fee schedules.

77. This lack of clarity in fees arguably results in medical costs leakage, including:

    a. poor visibility on how providers calculate their invoices;

    b. poor controls to identify erroneous item combinations; and

    c. confusion about the rules outlined in each fee schedule.

78. We note that in its Healthcare Review Final Report, SIRA has undertaken to review and benchmark gazetted fee schedules and indexation methodologies and considered the adoption of alternative billing rules and practices to better align with the AMA and MBS.[65]

RECOMMENDATION 8: SIRA to consider simplification of the billing and invoicing methodology applied within the NSW workers compensation system to minimise risk and probable causes of leakage.

[63] From SIRA's Synapse presentation dated June 2020: *'There is no national curriculum on medical billing and never has been. The MBS and AMA are becoming increasingly divergent, though both are likely to stick. AMA codes will become increasingly more difficult to cross match against hospital claims. The system has become byzantine over 40 years. Aligning fee schedules and systems will benefit payers, patients and providers nationally*.'

[64] A full list of which is contained in the Workers Compensation Insurer Data Reporting Requirements – Payment classification reference.

[65] See page 22 of SIRA's Healthcare Review Final Report

Capturing additional data fields

79. The capture of additional health care related data fields, including provider details, pharmacy and hospital costs[66] and experience and outcome measures[67], would also help identify cost levers, trends and compliance rates at a system-wide level.

80. SIRA has acknowledged the poor availability and quality of data in the NSW workers compensation system and the challenges this presents for the monitoring of health outcomes and experience measures. SIRA has undertaken to further develop these data points to ensure consistency and robustness in outcomes measures to help support the effective implementation of a health outcomes framework.[68]

81. As provided below from paragraph [89], provider benchmarking also plays a key role in a clinical governance framework.

System-wide real-time data exchange

82. As the regulator, SIRA collects and collates all data captures within the NSW workers compensation system on a monthly basis. It can take up to three months or longer for this data to be shared with insurers. This significant lag time means any undesired behaviour can continue for months before insurers are made aware of issues, delaying remediation action or consequences as a result.

83. As regulator, SIRA has requested and has been granted access to Commonwealth medical and health care data. System-wide access to this data could enable continuous improvement of systems and processes. To date, SIRA's findings and insights following its preliminary analysis of this data have not been shared with insurers. icare is concerned that continued delays in releasing these insights may render the data out of date and possibly redundant (as it is not static).

[66] icare acknowledges the steps SIRA has recently taken to address these matters through its acquisition of retrospective Hospital Casemix Protocol data and the introduction of an additional 13 pharmacy codes. icare looks forward to SIRA publishing an accompanying policy to assist with the operationalisation of these codes.
[67] Outcomes should be measured with respect to health (the change in health) and experience (the quality of care) through Patient-Reported Experience Measures and Patient-Reported Outcome Measures. Using these outcome measures will align the NSW workers compensation system with health care services in Australia and inform the appropriateness of care and quality of healthcare provider, reducing the incidence of low-value care. This data could be used to develop case manager and workers' health literacy and assist them with making informed decisions towards providers who deliver value-based care.
[68] See section 3.4 (page 18) of SIRA's Healthcare Review Final Report.

84. Improved timeliness and availability of data will enhance icare's ability to understand the nature and magnitude of injuries being sustained, and in turn, improve the management of medical costs in the NSW workers compensation system.

Implementation of a system-wide clinical governance framework

85. The key areas to be considered in the development of a clinical governance framework are:[69]
    a. provider selection, accreditation and training;
    b. ongoing monitoring of provider performance; and
    c. revival of SIRA's provider watchlist.
86. According to the Australian Council on Healthcare Standards, clinical governance is "*the system by which the governing body, managers, clinicians and staff share the accountability for the quality of care, continuously improving, minimising risks, and fostering an environment of excellence in care for consumers/patients and residents*".[70]
87. The goal of a clinical governance framework is to drive behaviours, both individual and organisational, that lead to better patient and clinical care. While icare and other insurers can undertake some investigation into healthcare providers who have been reported as delivering inappropriate or inconsistent care, the Workers Compensation Guidelines do not allow for any meaningful governance of healthcare providers.
88. The lack of governance mechanisms to manage those who are considered poor performers may result in over-servicing, potential harm to injured workers and adverse health outcomes as it limits the worker's – and icare's – ability to make an informed choice towards high quality providers. Poor performance and low-value care contribute to increasing medical costs in the system.

Provider selection, accreditation and training

89. Currently, provider selection, accreditation and training are inconsistent. For example:

[69] See also icare's submission on Regulatory requirements for health care arrangements in the NSW workers compensation and CTP schemes Recommendation 3 (pages 21 to 23) dated November 2019
[70] https://www.achs.org.au/; The Australian Council of Healthcare Standards

a. SIRA accredits some but not all healthcare providers;[71]

b. SIRA-approved allied healthcare providers must complete a training program and meet and adhere to the requirements set out in SIRA's *Guideline for approval of treating allied health providers*,[72] before they can deliver services under the system. However, other than the one-off training program, and reference to a clinical framework, there is no further monitoring or review conducted to determine whether services delivered by allied health care providers is consistent with these principles and expectations.

90. icare recommends regular, proactive engagement between SIRA and health care providers to provide training and updates on the NSW workers compensation system.

Ongoing monitoring of provider performance

91. icare recommends the ongoing monitoring of provider performance against endorsed Guidelines and best practice pathways, including the modification of invoice validation and provider identification processes.

92. At an organisational level, SIRA should require healthcare providers to ensure that organisational systems are in place, and subject to periodic review of system performance, performance monitoring and management. As per other healthcare sectors, individual clinicians should be required to comply with a set of professional regulatory requirements and codes of conduct, with individual clinical performance also monitored.

93. Assessing clinical performance should be routinely undertaken to review safety and quality of care. Measures should include:

a. compliance with legislative, regulatory and policy requirements;

b. process indicators that have supporting evidence to link them to outcomes; and

c. indicators of outcomes of care including patient reported outcome and experience measures.

[71] SIRA accredits certain allied health providers including physiotherapists, chiropractors, osteopaths, exercise physiologists, psychologists and counsellors, as well as medical practitioners who undertake Whole Person Impairment assessments

[72] Note: these are currently being updated to introduce more stringent and recurring requirements to be met. '*Guidelines for the approval of treating allied health practitioners 2016 No 2*'; State Insurance Regulatory Authority; https://www.sira.nsw.gov.au/workers-compensation-claims-guide/legislation-and-regulatory-instruments/guidelines/guidelines-for-the-approval-of-treating-allied-health-practitioners-2016-no-2

94. icare recommends that a core set of measures be developed, including qualitative and quantitative data. Data integrity should be tested, and tools set up and used to recognise both good performance and under-performance.

95. Ongoing provider monitoring, and the publication of the results, is also recommended. Clarity in respect of the roles, responsibilities and accountabilities of each stakeholder in the provision of healthcare through a clinical governance framework will assist in delivering value-based care to all injured workers and help manage costs to the system.

Timely access to provider watchlist

96. As a corollary, timely access to a provider watchlist tracking all medical and allied health providers would assist to promote the delivery of safe, effective and reliable treatments, and avoid the delivery of low-value care. It is not within icare's statutory powers to access this data from the Australian Health Practitioner Regulation Agency (**AHPRA**).[73] SIRA has recently requested access to AHPRA's "live feed" of providers who may have conditions and restrictions placed on their registration.

97. Timely and regular distribution by SIRA of this list to workers compensation insurers will not only minimise risk of harm to workers but will also reduce the number of invoices unknowingly paid by case managers to providers who should not be operating within the NSW workers compensation system.

RECOMMENDATION 9: SIRA continue its important and ongoing work on the implementation of a clinical governance framework, including credentialing, clinical education and training in the workers compensation system, and performance monitoring and management.

SIRA's Health Outcomes Framework

98. SIRA has begun important work on developing a health outcomes framework as a critical component of the shift towards value-based care, with a focus on strengthening reporting and transparency, monitoring, evaluation, governance and continuous improvement.

[73] The national organisation responsible for implementing the National Registration and Accreditation Scheme across Australia and maintaining a register of the registration status of practitioners: https://www.ahpra.gov.au/About-AHPRA.aspx#:~:text=The%20Australian%20Health%20Practitioner%20Regulation,the%20National%20Scheme)%20across%20Australia.&text=Anyone%20can%20make%20a%20complaint,Committee%20or%20a%20National%20Board

99. The measurement of outcomes will be assisted by baseline and ongoing analysis of customer experience, focusing on trust and health and social outcomes. SIRA will also examine areas where there is a risk of low value care provided to claimants.[74] Importantly, the framework accounts for the role of the injured person in the compensatory system, including their physical and mental health and wellbeing.

100. An implementation roadmap is currently being developed by SIRA. icare submits that seeking the endorsement and advocacy of all stakeholders in the NSW workers compensation system, enabled by a robust regulatory and compliance framework managed by SIRA, will ensure the success of the health outcomes framework and the delivery of value-based care to the injured workers of NSW.

RECOMMEDATION 10: SIRA to continue with its work on the system-wide implementation of a Health Outcomes Framework.

[74] In addition, SIRA is addressing some shorter-term gaps, including:
1. data availability and quality through SIRA's Data System Modernisation Project;
2. a review of Fee Schedules to align with a value-based approach to treatment; and
3. the release of Practice Requirements for Allied Health Providers for 2021 on fees, billing and approval processes, with the aim of reducing billing and coding errors.