REVIEW OF THE WAY IN WHICH PHYSIOTHERAPY SERVICES ARE FUNDED AND ACCREDITED BY ACC

ACC's response to questions arising from the Hearing held 14-18 May 2007 from David Goddard, QC, Chairman

25 May 2007

Questions arising from Physiotherapy Review Hearing 14-18 May 2007

1. **Detail where the Provider Monitoring process map can be found (p41 of transcript)**

This was supplied to the Reviewer on Thursday 17.5.07.

2. **Provide Mr Goddard with the information obtained from South Australia about the approach that they are adopting to determining prices for provision of treatment, which looks at the high level as to how they approach that (p42 of transcript)**

This was supplied to the Reviewer on Monday 21.5.07.

3. **Provide short note on what the key elements of a sustainable pricing régime are, from ACC's perspective, and indicate briefly whether you agree with paragraph 78 or not, and if there are any differences, provide a short statement of what you see as the key elements of sustainability (p47 of transcript)**

ACC recognises the value that physiotherapy plays in helping claimants to recover their quality of life and return to work or independence following an injury. ACC purchases physiotherapy services on behalf of claimants who have an assessed need, either through contracts and / or by making a contribution prescribed in regulation.

ACC is the largest purchaser of physiotherapy in New Zealand and many physiotherapy practices derive much of their income from treating ACC claimants.

The role of ACC is to help injured people, not support physiotherapy as an industry. However, ACC acknowledges the interdependency between; on the one hand, ACC ensuring claimants receive physiotherapy services they are entitled to either through the public or private sector and, on the other hand, there being a stable market with sufficient physiotherapists available to provide these services.

The number of people providing physiotherapy services to ACC claimants (and ACC expenditure on physiotherapy services) is growing; ACC has not seen any evidence to suggest that claimants are missing out on their physiotherapy entitlements.

ACC considers that the following factors would contribute towards a sustainable market:

- the ability to maintain the skill level of staff;
- a level that encourages continuous improvement and adopting technologies or other techniques to achieve efficiencies;
- a price that represents the risk and intellectual property;
- a prices that is comparable/consistent with other sectors of the market the ability to maintain and develop the business; and

- affordability.

ACC has also been asked whether it agrees with the definition at paragraph 78 of the initial NZSP submission.

ACC does not believe that there is 'one right price', nor that there is a 'right' definition. Having said that, ACC agrees that these points are largely valid, but does not agree that ACC should be expected to necessarily fund 'best practice' (if this implies a gold standard). ACC would also like to be clear that it does not consider that it is responsible for the sustainability of the physiotherapy profession in New Zealand.

4. **Has the approach referred to in section 324, the Regulations provision subsection (4) paragraph (a), that it is possible to prescribe different payments for work-related and non-work injuries in regulations, ever been considered in the history of the ACC scheme, or in recent years? (p48 of transcript)**

ACC is not aware of any work that has been conducted specifically in relation to the approach referred to in section 324, subsection (4) paragraph (a) around the possibility of prescribing different payments for work-related and non-work injuries in Regulations. However, there has been work undertaken by the Department of Labour in relation to achieving compliance with ILO Convention 17, which requires signatory countries to ensure that the costs of work injuries are not borne by workers.

5. **Again, looking at the question of what section 324 permits, is there any reason you are aware of why one couldn't under section 324 make Regulations which provided for indexation of payments made by ACC for treatments? I know the Regulations don't do that at present, but is there any legal reason -- none leaps out at me -- why there couldn't be a figure and an indexation provision in the Regulations? (p49 of transcript)**

   Cf paragraph 3.2.3 of the ACC submissions, and the description of the process for amending the Cost of Treatment Regulations; if there is a significant change in the basis of payment then this whole mechanism of consultation makes good sense and is prescribed by the Act, but the legal question is whether it's necessary and also the practical question of whether if all that's happening is maintenance of the real value of payments, practically, is it sensible to go through a process of this length and complexity? (p50) To provide an answer on whether it's legally possible to provide for indexation in Regulations, and on the competing practicalities perhaps of doing an annual review to take account of those factors (p50 of transcript)

   <u>From letter dated 11 May 2007</u>

   Question 9: This question may have been misunderstood. We would welcome ACC's comments on whether there is any barrier in the IPRC Act to amending the Regulation to provide for indexation.

Original question: Is there any legal barrier to providing indexation of payments under the COT Regulations? What is the rationale for not providing indexation of such sums?

The following response is a combined answer to the three questions posed above.

Legal advice is that section 324 does not permit regulations to be made which provide for indexation of ACC's regulated contributions towards treatment. Section 324 would need to be amended to allow for an indexation system to be included in the Regulations.

In the past, Governments have not been in favour of annual indexation of the regulated contributions under the Cost of Treatment Regulations. The reason for this is that indexation is believed to reduce flexibility and has the possibility of over-inflating rates in the long run.

ACC is aware that the Department of Labour is preparing advice for the Minister for ACC on options for reviewing and adjusting the regulated amounts that ACC contributes toward treatment. This advice will be provided in time to be included alongside a suite of other changes to be included in the Injury Prevention, Rehabilitation, and Compensation Bill that is scheduled to be introduced in September 2007.

The ACC Board's view on a mechanism for adjusting ACC's regulated contribution towards treatment is that a two-tiered system is required. The first is a simple mechanism for making across-the-board inflationary-type adjustments as soon as possible once funding is available, and the second is a more extensive and consultative process where specific provider groups are targeted for increases.

6. **What's ACC's view on whether if there were to be indexation of regulation payments the LCI would be the appropriate index factor, or whether some other index or some other mechanism would be appropriate? So it's a hypothetical – question that were there to be indexation of regulation payments, what would the most appropriate index be? (p50 of transcript)**

A response to this question will be provided by 1 June 2007.

7. **To provide a copy of the Cabinet policy committee minute in relation to the review of the Cost of Treatment Regulations for 2000 (mentioned on page 15 of ACC's submission in table 5) (p50 of transcript)**

The Minister for ACC has authorised the release of the Cabinet Minute you have sought access to. This is included in these documents, but must be returned to ACC at the completion of your Review. This document is provided in hard copy only.

8. **In terms of patient satisfaction have any data been collected or studies carried out to ascertain whether there is a higher rate of patient satisfaction from treatment by EPN practices than regulation practices? (p57 of transcript)**

Research in relation to patient satisfaction with services provided by particular groups of providers does not exist. ACC has not carried out any further studies on patient satisfaction other than the general claimant satisfaction surveys.

9. **What work, if any, has been done to assess whether clinical outcomes are better following treatment by EPN practices compared with Regulation practices? (p57 of transcript)**

Apart from the EPN Service Evaluation Report, March 2007, ACC has not performed any work to assess whether clinical outcomes are better following treatment by EPN practices than Regulation practices. The data for EPN treatment has not been mature enough to determine such information. However, this may be a consideration when ACC reviews the Physiotherapy Treatment Profiles later in the year.

10. **Para 3.3.6 references a survey ACC commissioned in relation to co-payments to help set the initial EPN payment rates. Is that one of the surveys under tab 3 or a different one?**

The survey, Physiotherapist Co-payment Survey: Mystery Shopping – Top-line Results September 2003 was supplied to the Reviewer on Wednesday 16.5.07.

11. **Has ACC considered whether the methodology adopted by Deloitte is an appropriate approach to identifying the sustainable price required to operate a physiotherapy practice? Also what, if any, you perceive as the limits of the approach, what reservations you might have about it. Is that best dealt with as a package when you come back? (p63 of transcript)**

ACC believes that the methodology is one way of pricing services. ACC understands that there are other ways of approaching this, but are satisfied that the methodology is robust and is as good a basis on which to work as any other approach may be.

ACC is happy to use the model as one part of the information that will inform ACC going forward in determining a suitable price.

12. **Deloitte's methodology for developing a sustainable price. To provide ACC's perspective on how far it is useful and what its limits are and that there's no other quantitative methodology that you are working with or thinking about at the moment. (p65 of transcript)**

ACC considers the model is useful as one component of a range of information or considerations that will be used in determining a price. As stated at the Review, ACC

has been provided with a pricing model from South Australia. This has since been provided to NZSP and the Reviewer.

13. cf ACC's first submission, in paragraph 4.3; why is it a matter for concern when these are just supposed to be for the plain vanilla cases and when things are variable and when they are just guidelines? Why is it a matter for concern? Why is it even surprising that 16 percent fall outside those guidelines? (p68 of transcript)

The Treatment Profile provides two numbers for each diagnosis. The number of treatments agreed in the development of the profiles and a “trigger” number. The trigger number is typically 20 – 30% higher than the treatment number.

It is correct that if the treatment number was set at one standard deviation from the mean, then the percentage of cases that would exceed this would be expected to be approximately 16% and therefore the finding that there are 16% is not surprising.

However, the details on the exact basis of the setting of the treatment number are not known, but given that if it was based upon one standard deviation and then the trigger margin was added, the numbers of ACC32 being received would be expected to be less than the 16% that are being received.

The Treatment Profiles will be updated and a closer examination of these issues will be undertaken.

14. To provide prosecution policy and process map that spells out the process of investigating fraud. Also to provide details of Private Investigators with providers. (p72/73 of transcript)

These documents were supplied to the Reviewer on Wednesday 16.5.07.

15. Is ACC not doing the interviews with the claimants to establish the number of visits that they might have had with individual providers? To provide work breakdown and percentages. (p75 of transcript)

Yes, ACC does perform interviews with claimants to establish the number of visits they may have had with individual providers. The majority of these are conducted by our internal staff.

The total cost of Private Investigators in relation to provider fraud investigations for the current financial year (i.e. 1 July 2006 until the end of April 2007) is $55,440.30.

Private Investigators are predominantly used in Provider Fraud Investigations to obtain witness statements and conduct telephone or face-to-face surveys in relation to individual investigations.

In addition, Private Investigators are used in isolated instances to accompany ACC's internal Fraud Provider Investigators at an evidential interview or in accompanying Police executing search warrants.

In all cases private investigators are acting under the instruction and direction of ACC fraud investigators.

ACC does not collect the data required to provide a breakdown or percentage of instances where private investigators are used as opposed to ACC internal staff.

16. **Re request for prior approval of treatment process, theACC32 process; whether an approval obtained in this way is always limited to a specific number of treatments or whether it's possible for an approval to be given that, for example, is indefinite, one treatment per week but subject to review or for a time period rather than a number of payments. How does that work? (p76 of transcript)**

Prior approval for further treatment is always limited to a number of treatments. The approvals apply for 12 months from the date that the ACC32 was signed.

ACC32 forms are intended to be used as prior approval forms, once initial treatment according to the relevant Treatment Profiles has been exceeded. However, a significant number of forms are received after the additional treatment being requested has already been provided to the claimant.

17. **Is ACC32 approval always tied to a specific number of treatments or can it be indefinite or can it be until some other sort of trigger is reached? To provide data on timeframes for approval decisions in respect of ACC32s. Looking at the provider handbook that is identified on page73, a maximum time for responding of five days was stated. Is this still the target or whether that's changed since the 2004/5 provider handbook was issued? (p77 of transcript)**

Letter dated 11 May 2007

Question 12*:* We have a follow up question relating to the ACC32 decision making process. Please provide data on time frames for ACC decisions on the ACC32 forms relating to physiotherapy, preferably going back to 2002. We would appreciate receiving it in the following form if possible:

- **A% approved in less than one working day from receipt**
- **B% approved within 1 week**
- **C% approved within 1-2 weeks**
- **D% approved within 2-3 weeks**
- **E% approved within 3-4 weeks**
- **F% approved within 1-2 months**
- **G% approved after more than two months**

Please provide the information broken down by EPN and non-EPN practices.

The following response is a combined answer to the two questions posed above.

Approval is given in terms of numbers of treatments, i.e. it is a quantitative approval. It is not possible to receive indefinite approval. Ongoing treatment needs periodic review to ensure the treatment is still related to the covered injury. Long-term physiotherapy treatment is not generally needed outside a hospital or contracted/separately purchased care (for serious injury) setting.

ACC expects to be able to apply the (industry agreed) Treatment Profiles to requests for additional treatment. However, most ACC32 requests are well in excess of the Treatment Profiles and many treatment plans do not explain why treatment in excess of the Treatment Profiles is needed.

There is also a time trigger (generally 12 months from approval). Time is not a suitable trigger for shorter duration claims. Post-surgery treatment is considered to start from scratch – i.e. pre-surgery treatment is not counted against Treatment Profiles.

Data for approval decision timeframes

Time for approval of all physiotherapist ACC32s	1 week	1-2 weeks	2-3 weeks	3-4 weeks	4-8 weeks	8 weeks or more	Total	Volume	Volume increase
March year change	%	%	%	%	%	%	%		%
4.1.2005 - 31.3.2006	90.2	5.7	1.3	0.6	1.2	1.1	100	70,646	
1.4.2006 - 31.3.2007	87.9	7.0	1.7	1.0	1.5	0.9	100	83,761	19
1.4.2007 - 12.5.2007	95.4	2.9	1.0	0.5	0.2	0.0	100	9,793	

Data for periods before this is not available as there was no formal structure for recording ACC32 requests.

Volume of all ACC32s (including physiotherapists)	Volume	Volume Increase
June year change		%
2002-03	56,534	-
2003-04	59,987	6
2004-05	71,945	20
2005-06	85,477	19

- The target turnaround for approval decisions is five working days. This has been the target since about 2001. During lower-volume periods (July to December), the turnaround is often two to three days. If it is going to take longer, ACC notifies both the claimant and provider that a decision will be delayed.

  ACC32 forms are frequently held back in practices and submitted to ACC in “batches”. All forms are date-stamped on receipt by ACC. It is common for there to be gaps of one to four weeks between the date the form was signed and the date of receipt by ACC.

- Decisions on ACC32s can be delayed for a number of reasons. Sometimes, ACC32s are returned to the provider as insufficient information has been provided on the form to enable ACC to make a decision. In other cases, notes or other information are requested to try and identify the reasons for ongoing treatment (particularly for injuries that are more than two years old, and injuries where there have already been a large number of treatments provided - generally more than 36). We are not able to differentiate in our statistics between ACC32s held up awaiting further information and those held up by a processing delay. In both cases, providers and claimants are notified, as per the second bullet point above.

18. Are there any differences in the way in which ACC32 requests are handled for EPN and regulation providers? To provide the breakdown by EPN and regulation. (p78 of transcript)

ACC does not distinguish between EPN and non-EPN practices for turnaround. ACC32s are processed on a first-in, first-out basis (unless further information is requested from the provider).

19. How any difference in cost of providing EPN services or in quality or value is perceived by ACC would translate into a difference in payment rates as between EPN and regulation services? Explain whether the main driver of the difference is affordability and budget constraints rather than any perceived difference in cost or value of service? What level of difference is justified by the reasons identified? (p78 of transcript) Relates to Reviewer question 5 from first set of questions

<u>Letter dated 11 May 2007</u>

You were asked (question 5 in secondary submission): What reasons can be identified for setting different rates for payments as between the EPN contract regime and the Regulations? What level of difference is justified by the reasons identified?

Your answer does not appear to have addressed the second part of the question. We were hoping for a response that provided a reasonably detailed analysis of how any differences in cost/quality/value constituted a justification for the considerable difference in ACC payments under EPN and under regulations. Could you please address this in more detail?

The following response is a combined answer to the two questions posed above.

ACC acknowledges that there is a significant difference in the rates paid under Regulations to the rates paid under the EPN agreement. Rates paid under Regulations are designed to be a contribution toward the cost of treatment and are set by Government. The level of rates paid under Regulations is subject to

Government funding decisions. Rates paid under the EPN, however, are negotiated between ACC and physiotherapists.

The rationale for setting a much higher rate for physiotherapy provided under the EPN when compared with physiotherapy provided under Regulations is to achieve the Government agreed policy objectives of the EPN. These policy objectives of the EPN are:

a) to encourage quality treatment;
b) to eliminate co-payments for treatment provided during hours to encourage access to treatment for claimants in line with International Labour Organisation Convention 17 (ILO 17) requirements; and
c) to remove co-payments during working hours to improve access to treatment for claimants in order to reduce weekly compensation duration.

While ACC believes that the EPN encourages quality treatment, in terms of treatment outcomes, however, it has no empirical data that shows that claimants receiving treatment from a physiotherapist paid under the EPN are any better or worse off than claimants receiving treatment from a physiotherapist paid under Regulations.

Under the EPN co-payments are removed for treatment provided during working hours. ACC acknowledges that in this area New Zealand is achieving compliance with ILO 17.

Of the three per cent of claimants receiving physiotherapy treatment who were also receiving weekly compensation, claimants receiving treatment from an EPN physiotherapist experienced on average 1.9 days less weekly compensation when compared with claimants receiving treatment from a physiotherapist paid under regulations. ACC's view is that this is a marginal reduction in the time it takes claimants to be rehabilitated back to work.

20. **Explain the rationale for not distinguishing between different types of treatments under the Regulations in, for example, the same way as the EPN contract (p79). Is there any good reason not to differentiate in that way in the Regulations? Why wouldn't it make sense to pay different contributions depending on the cost of provision of what are recognised in the EPN contract as different services? In terms of what makes sense, what's appropriate, it's an issue we've got to tackle. Is there any principled reason not to differentiate in that way? (p80) Given those precedents which suggest it is doable, and the EPN contract, which also suggests that the administrative issues are not insuperable, although everything comes at a cost, Mr Goddard would be very interested to understand whether there is any barrier to that sort of approach as a matter of principle or practicality going forward. (p81 of transcript)**

ACC is not aware of any rationale for not distinguishing between different types of physiotherapy treatments under the Regulations. Although administratively this would be possible, Government would need to change Regulations to enable this to occur.

21. **To check whereabouts the ACC32 team or teams are located? (p81 of transcript)**

This information was supplied to the Reviewer on Thursday 17.5.07.

22. **How big are the teams? We know they have 80,000 claims to process, approximately, a year. Do you have any sense of how big those teams are? (p82 of transcript)**

There are four full-time equivalent Clinical Advisors in Auckland, and two in Dunedin. Over the two centres there are nine claims officer and two team managers supporting this process.

23. **What are the skills and experience of the admin team?**

The administration team consists of claims officers who deal with entitlement requests for additional treatment (ACC32), pharmaceuticals, and medical fee invoices.

The claims officers undergo a full training programme that includes:

- Specific training on the legislation that supports the ACC32 entitlement decisions;
- The ACC32 process;
- ACC – cover;
- Work-related gradual process criteria;
- Making entitlement decisions;
- The disentitlement process;
- Managing information and privacy requests;
- Training on treatment; and
- An overview of the review process.

They also have access to:

- The ACC helpdesk;
- Clinical Advisors;
- Programme Managers;
- Procurement Advisors; and
- Provider Relationship Managers.

In addition to this training they also undergo ACC's other basic training that covers areas such as Health and Safety, and the Code of claimant rights.

It’s important to note that claims officers will only decline requests for treatment on clinical grounds (as opposed to not being a covered injury etc) after receiving advice from a Clinical Advisor.

24. **What kind of key performance indicators do they operate under? How many clinical advisers would they have access to? To provide info re the experience and background of the team members who are not clinical advisers. If admin team declines an ACC32 request, does it go to Clinical Advisor for checking? (p82/83 of transcript)**

The claims officers have one main key performance indicator: turnaround of ACC32 decisions within five days (unless there is insufficient information on the ACC32 or additional information needs to be requested from the claimant's GP or other treatment provider).

If the administration team declines an ACC32 request, the Clinical Advisor will then check the ACC32. However, claims officers can decline requests without reference to a clinical adviser where there is no cover for the injury.

25. **How the current EPN rates first set - outlined in the first submission in paragraph 3.3.6 on page 19. How were the co-payments identified from the surveys used to produce the EPN rates, the four specific EPN rates, and if that process involved estimating notional consult times and a notional hourly rate? (p83 of transcript)**

Identification of co-payments for the EPN Pilot

The pricing mechanism for the pilot was developed in consultation with treatment providers (building on the already established programmes) and was consistent with the findings of the Department of Labour Blue Lotus report.

ACC's suggestion was that the method for setting the fees for the Pilot should address legitimate concerns that fees were either too low (a potential criticism from treatment providers) or too high (government agencies with budget responsibilities). The pilot method was a combination of contestable processes, survey work and discussion. The details of the method in general terms were the following:

- Geographic regions selected (ensuring the particular needs of rural/urban and Maori/non-Maori groups are dealt with);
- Expression of Interests (with fees) called for to provide these services (applying the endorsement criteria); and
- Survey results used to assess 'reasonableness' of fees.

Details of Survey

ACC developed a project (the 'survey') that interpreted the 'full cost' of treatment based on what was reasonable cost, specifically through a survey of practices and analysis of physiotherapy, radiology and GP practice financial statements. It was noted at the time that both the New Zealand Medical Association and the New Zealand Society of Physiotherapists were unwilling to act as arbiter of a reasonable fee.

The approach of the survey was to assess the following and to make a considered judgement as to the cost of the treatment:

- Year to date accounts (usually including income);
- Staff rosters to determine the skill levels and 'manning' throughout the day and week;
- Numbers of patients treated, time of day and week; and
- Factors affecting profitability that could be used to set an appropriate return on investment given the risks involved relative to a wider financial market.

This information was discussed with accounting and medical personnel to verify understanding and consistency of interpretation.

Past Experience

It should be noted that prior to the EPN Pilot there was considerable pricing experience gained already and this was applied in the setting of the fees from Accident and Medical (A & M) clinics, specialist consultations, elective surgery, dental specialists, post-acute residential care, and community nursing services.

General Practitioners (GPs)

A contract was developed for A & M Clinics. There were 75 clinics that accounted for around 18 per cent of ACC's new claims each year. The contract was based on four consultations (short, standard, long, and prolonged) coupled with payment for the treatment of fractures and lacerations. It was recommended a similar approach be implemented as a means of paying endorsed GPs for the purposes of the pilot.

Radiologists

For general radiology services ACC propose to apply the process used for high-tech radiology. The high-tech contract was negotiated with the College of Radiologists based on a relative value scale for procedures. Once the terms and conditions of the contract were agreed, requests for proposal were called nationally asking for tenders on price for service. Although prices ranged from $25 to $90, there was a clear cluster of prices around the $47 - $52 mark. ACC offered $50 and all parties have now accepted this offer.

Physiotherapists

It was recommended ACC investigate paying physiotherapists for first visits on the basis of two consultation units and any subsequent visits or referrals as a single consultation unit.

Identification for co-payments for the national roll-out

The co-payments for the national roll-out were calculated from the surveys in the BRC Marketing and Social Research Physiotherapy Co-payment Survey: Mystery Shopping survey in 2003. The physiotherapy practices were called and asked the co-payment charge for both an initial and follow-up consultation for an ankle injury. This determined Level A.

Level B was initially based on the rate paid and the usage of complex care level from the pilot (complex care being the same as the ACC32 process for the pilot group). ACC used this as a guide.

The consultation was based on a fee for service without a timeframe being set. This allowed the practice to run their business as they saw fit, and as long as their treatment notes and treatment plans met the accreditation (now certification) level, ACC was happy for that to be the external control.

Practices argued that there would be different consultation times across the country – shorter appointment times in the Auckland central business district than with Gore, and some practitioners when signing the contract voiced their concerns that they would need to reduce their appointment time to have sufficient revenue to cover the no co-payment.

Internally, ACC calculated that a level A would be 20 minutes and a level B would be 30-40 minutes. This would enable a practice to do three Level A treatments an hour or 1 Level B and a Level A an hour. ACC compared this to the Regulation payment of $29 plus the co-payment and in the majority of cases it was higher on the EPN rate for the number of consultations per hour.

26. **There's mention of deriving the price from the main co-payment plus one standard deviation and the price as a result meeting or exceeding the current cost for providing the service for 84 percent of physiotherapy practices. Was the reason for setting rates one standard deviation out rather than two, or you know, further out to capture a higher proportion of then prevailing rates a desire to derive efficiency improvements or some other goal? What was/is the rationale for selecting that cut-off point? (p84 of transcript)**

    I would really like some help with why people say that the right answer is one standard deviation out or two standard deviations out, and what the factors are that influence that choice. We need to put that back to ACC and say well, why did you pick that particular benchmark? (p163)

A response to this question will be provided by 1 June 2007.

27. **There seems to have been an affordability issue or it might have been an explicit desire to bring the highest cost, highest charging practices more into line with others and drive efficiency improvements in those; what were the goals and what was the basis/rationale for those? Following on from that, whether any of the studies of co-payments, either that original one or the subsequent ones which have been provided with ACC's materials, looked at whether there were geographical differences in levels of co-payment charged by regulation providers? Is there any geographical analysis? (p84 of transcript)**

A response to this question will be provided by 1 June 2007.

28. If costs are higher in some centres than others, if it costs more to provide the same service, what's the rationale for having the same level of payment under the EPN contract regardless of location? (p85 of transcript)

There are conflicting arguments for higher costs in both urban and rural areas. It should also be noted that there are differences in the cost of running a business within regions, which can be influenced by a range of factors.

It is apparent that there are different levels of capability to run an efficient business within this (as in any other profession) and this can be just as influential as geography.

ACC considers that implementation of such a regime would be problematic especially around deciding and defining criteria for cost-banded areas. The cost of administering and monitoring such a system would be significant.

ACC has not made any decision on whether to pay more for the same services in different areas.

29. About the process of becoming an EPN provider: there's a requirement to obtain certification against the relevant standard from one of a number of providers. If that's achieved, are there any circumstances in which ACC would decline to enter into an EPN contract with a practice? What's the timeframe for processing a request to move from Regulation provision to EPN provision once certification against the relevant standard has been achieved? (p87 of transcript)

ACC has not declined an application to date. ACC has deferred a small number of applicants and the reasons for these have been:

- Currently undergoing prosecution by ACC's Fraud unit and deferred pending the prosecution outcome.
- Providers identified as an outlier who are not providing ACC with appropriate information to clarify why they are an 'outlier'. As these are providers who would potentially breach the contract; information is required to understand why they are an outlier.

ACC currently has two providers that are deferred.

On receipt of a registration of interest that a provider would like to apply for an EPN contract, ACC undertakes a pre-application screening process. If we are provided with the correct screening information, we send a pack to the applicant within 15 working days.

During the pre-screening process ACC monitors existing provider compliance while treating under Regulations. The areas monitored are:

- Schedule 1 Clause 2 - Injury Prevention Rehabilitation, and Compensation Act 2001;
- Knowledge and expertise in providing the service gained through professional evidence-based best practice;
- Physiotherapy Treatment Profiles 2000;
- Physiotherapy Claims Lodgement Framework;
- ACC32 prior approval process;
- Evidence of or anticipated compliance with key aspects of the Endorsed Provider Network Contract; and
- Evidence of or anticipated compliance with key aspects of the Operational Guidelines of the Endorsed Provider Network contract.

Timeframes for receipt of contract by ACC and returning a signed contract to a provider are generally 10 working days.

30. Re contract provider network/on-line provider network (EPN); why "endorsed" is the term that's been used when other labels are available e.g. contracted, online etc? Also whether you have any concerns about the possible inference that that's a quality endorsement or an implicit criticism of the providers that don't interact in that way? (p88 of transcript)

'Endorsed' was used, as it was the NZPAS accreditation scheme that was 'endorsed' by ACC as a measure of a quality management system within the business. It was never an endorsement of quality treatment over other physiotherapy clinics.

31. Re group sessions such as hydrotherapy: can you outline briefly how those are remunerated at present? (p89 of transcript)

If decided by the provider to be necessary and appropriate based on the rehabilitation claim, and having met the particular criteria, then a provider may be paid for group hydrotherapy sessions if deemed necessary as part of the Multidisciplinary persistent pain programme (MDPP). There are currently four providers nationally with a contract for this programme. The programme is specific to claimants with significant chronic pain conditions, which have persisted for 12 weeks or more.

It is also possible that if a case manager felt it appropriate for a claimant to receive such therapy the claimant might be sent on a 'pool programme' and would be claimed under the payment code 'Social Rehabilitation Other'. ACC does not currently have a specified contract for hydrotherapy.

32. To outline briefly how community-based visits (including travel costs) are remunerated at present. Is travel time paid at half the normal hourly rate? If so, is that appropriate? To outline how the cost of doing that is recovered from ACC by the treatment provider in those circumstances,

the basis on which travel time and costs are remunerated? (p89 of transcript)

The costs for community-based visits are recovered by invoicing ACC with reference to that particular service item code. This is applicable only to contracts, and in this case, the EPN. Providers claiming under the current Regulations do not have the ability to claim travel costs from ACC.

Please refer to the travel schedule table (below) from the EPN contract. The first hour is half of the subsequent hours a provider can claim for.

Within the EPN contract there is travel codes included. These are as follows:

Service Item Code	Service Item Description	Service Item Definition	Price (excl GST)	Price (incl GST)
TRAVT5	Travel Time – first hour	ACC will pay for the Service Provider's travel time to deliver Services to a Claimant, if: • the travel is necessary; and • the Service Provider travels via the most direct, practical route available between their base/facility and the Claimant's address; and • the distance the Service Provider travels exceeds 20km and/or the time the Service Provider travels exceeds 30 minutes TRAVT5 is payable for: • the first hour or less of travel time on any one day	46.66	52.49
TRAVT1	Travel Time – subsequent hours	TRAVT1 is payable for: • the additional hours required after payment for the first hour through TRAVT5 • for the total travel time after the first hour of travel on any one day	93.32	104.98
TRAVD10	Travel Distance	Where return travel via the most direct, practicable route from the facility base or worker residence to claimant contact point (whichever is the closest) exceeds 20 km. Payment is for the total distance travelled including the 20km. If travel includes more than one claimant payment is on a pro-rata basis.	0.62	0.70

33. Are there any internal guidelines for case managers to refer someone to an activity-based programme without first discussing that with an existing treatment provider, that make that clear that you'd be able to point me to or provide? (p89 of transcript)

These were supplied to the Reviewer on Wednesday 16.5.07 am.

34. Re complaints process for providers where they do have a concern: Is there any guidance for providers on the complaint process that will be followed if the provider has a concern? (p90 of transcript) Is the same process used for both claimants and providers? Please clarify.

General Concerns

Concerns regarding the services provided by ACC can be raised with ACC directly through either ringing ACC on the Provider Helpline on 0800 222 070, or by contacting one of the Provider Relationship Managers. Contact details for individual geographical areas can be found on page 21 of the ACC Treatment Provider Handbook.

Accredited Employers

Should a provider have concerns regarding an Accredited Employer, these should be discussed directly with the Accredited Employer in the first instance. As the contract holder with ACC, an Accredited Employer is obliged to comply with our legislation, and to ensure that any Third Party Providers involved in the provision of these services are also compliant.

If they are unhappy with the response or actions of the Accredited Employer, they can bring their concerns to the attention of a Senior Account Manager within ACC, by calling the ACC Business Service Centre on 0800 222 776.

The Office of the Complaints Investigator also receives and investigates complaints relating to claims managed by Accredited Employers.

Independent internal Investigations

Should a provider have ongoing concerns regarding the services provided by ACC or service provided by one of its staff, a provider can bring these concerns to the Office of the Complaints Investigator. The Chief Complaints Investigator can look into any service or unresolved issue a provider may have with ACC.

The current Treatment Provider Handbook 2004/05 does not give clear instructions with regards to accessing the complaints process, however, the new version of the Treatment Provider Handbook, due for release shortly, has clearer instructions regarding complaints that providers may have.

Independent External Investigations

The Office of the Ombudsman is empowered to investigate any complaints or concerns raised by the general public about ACC, the way it applies its empowering legislation, the services it provides to the Public, and any decision making process it undertakes.

Concerns of providers are an area that the Ombudsman can investigate should they consider it appropriate.

ACC's complaints processes are split into two distinct areas, complaints that fall under the Code of ACC Claimants' Rights, and complaints that either predate the Code, or are not about, or concerning a claimant.

Provider complaints fall under the non-Code complaints process.

In the first instance a provider can access the ACC complaints line (0800 650 222), where they will be allocated to a Customer Support Officer. That staff member will record the concerns that are raised by the complainant, and refer the issue back to the business unit responsible for the relationship management. The business unit has four working days to resolve the concerns to the complainant's satisfaction; otherwise the matter is escalated to the Office of the Complaints Investigator (OCI).

From there, a Complaints investigator will seek information from the complainant and ACC regarding the issues that have been raised. An impartial investigation will be undertaken, which will take into account the information provided by both parties. Should further information be required, the investigator is able to seek that information from either party.

Depending on the complexity of the issues considered, the Investigator may issue a provisional decision regarding the complaint, and give both parties an opportunity to provide any further information that they may consider relevant. Once that information is received, the investigator will move to a final decision. Where the issues and the investigation required are less complex, there is no provisional decision letter.

Should a provider be unhappy with the decision issued by the Investigator, they are able to raise their concerns with the Chief Complaints Investigator. The Chiefs Complaints Investigator can then review the investigation and issue a further finding as required.

35. Has ACC ever considered whether it's desirable to have an external or independent complaints process for providers? Is there any intention to develop a customised process for providers? If one already, then provide. (p91 of transcript)

No, ACC has not considered introducing an external complaint process for providers, outside of those processes already available with the Office of the Ombudsman, the Health and Disability Commissioner, the Privacy Commissioner and the professional bodies which a provider may belong to.

ACC's complaints process begins initially within the Corporation. This remains an important consideration, as ACC has recently embarked on a process of service and issues resolution, known as "Service Recovery". This approach places the recovery of any relationship with the business unit that primarily manages the most direct contact with a complainant. The approach is to identify the issue quickly, refer it to

the relevant business unit, and obtain a resolution, where possible, within four working days.

Removing the complaint resolution process away from the area most directly responsible for managing any ongoing relationship will limit opportunities for relationship recovery, and for learning from any mistakes or poor service.

Where Service Recovery either does not produce a resolution acceptable to the complainant, or they choose to forego Service Recovery, the matter is referred to ACC's Office of the Complaints Investigator (OCI) for a more formal investigation. ACC is confident that the OCI can undertake an objective and impartial investigation of any concerns a provider may have. Where the complaint falls outside of the scope of ACC's responsibilities (e.g. relates to the actual conduct of a provider during a consult), the matter is then referred to an appropriate external organisation.

There are no plans to develop a customised process for providers.

36. **To provide an ACC45 form. Is it ACC's view that the consent that's included in the ACC45 form is sufficient justification for providers to release all clinical information, if requested, for an audit or investigation? Clarify why those are sought in some cases but not others. Also, provide any legal advice that ACC has received on a confidential basis and without waiver of privilege. Also provide, if there have been any exchanges with the relevant regulatory bodies, i.e. Privacy Commissioner or the Health and Disability Commissioner. (p91 of transcript)**

The ACC45 form was supplied to the Reviewer on Thursday 17.5.07.

ACC is satisfied that the ACC45 provides sufficient authority for ACC to access medical records to confirm cover, entitlements and payment for treatment.

Where a case is expected to be managed by ACC for longer than seven weeks or is escalated to management in an ACC branch, ACC obtains consent from a claimant using an ACC167 form. ACC considers that the ACC45 is sufficient authority for ACC's purposes regarding treatment. However, ACC recognises that during the longer term management of a case it is appropriate for a more specific authorisation to be obtained, one which is focused on the rehabilitation needs of the claimant. ACC also notes that the ACC18 certificate for incapacity includes an authorisation for ACC to utilise in the management of a person's rehabilitation and is provided every 13 weeks. Copies of the ACC18 and ACC167 are included with this document.

ACC is collating any legal advice received about this matter and will provide any advice as soon as possible.

ACC has contacted the Privacy Commissioner and the Health and Disability Commissioner regarding any exchanges it has had with those agencies about this

issue. We haven't had a response from either agency to date and will provide any information once we have a response.

37. Re supporting document from the first submission Document 10B (graph under paragraph 9.18): to clarify that every six months some 12 percent or so of providers go out of business. On page 26, there are six-monthly figures which are around 12 percent, if cumulatively that means something like 24 percent of providers go out of business each year. First of all, that seemed a surprising figure - could that really be right; secondly, if it were the case, what is ACC's view of the cause of that? (p92 of transcript)

ACC does not consider the figure of 12 per cent can be accumulated over each business year. The 12 per cent is a consistent figure over the periods shown in the graph, as it is a snapshot in time.

As a proxy for the number of providers not billing ACC, for whatever reason, the analysis in the table used the number of providers (as identified by their provider number) lodging claims in one six-monthly period but not the next six-monthly period. This number is given as a rate of those in business during the previous period. As the figure is a ratio at a given point in time, it is not appropriate to add the figures together. It is also important to note that using provider figures is different from those of practices.

The reasons for providers not billing ACC at the 12 per cent from one 6 month period to another could be due to:

- Physiotherapists leaving New Zealand e.g. overseas experience (OE);
- Maternity leave;
- Retirement;
- Entering the public hospital system and therefore billing under one vendor number; and
- Natural business attrition.

38. NZSP 2nd submission pg 23 para 93-96 Discrepancy in NZSP survey and ACC data. Explain the discrepancy. (p93 of transcript)

Para 93-96 of NZSP submission, I have already asked ACC about the differences between the ACC data and the survey data reported in para 93. I'd be grateful if you (NZSP) could liaise with ACC, perhaps, to try to come back to me with an agreed position on what some reasonable assumptions would be. (p404 of transcript)

The following response is a combined answer to the two questions posed above.

ACC's data only includes registered claimants and does not include private patients. ACC's data is based on payments made for services provided. ACC also based this information on actual treatments on average per day and ACC notes that NZSPs

data was based on a survey. NZSP's Barrister, Mr Taylor, is drawing up the response to this and will send it through to the Reviewer when completed.

39. Re review in 2004 of audit and investigation procedures: the answer provided was that ACC weren't aware of such an audit. Cf paragraph 323 of the first submission of the Society stating that there was a review of audit and investigation procedures in 2004. It may be that there wasn't a formal review, or a report – but clarify if that's a mistake, or whether there was an informal review which may have paper documentation. (p94 of transcript)

ACC can clarify that it is not aware of any such audit, formal or otherwise. ACC has no supporting documentation that an audit took place.

40. Re EPN pilot cost/benefit assessment from July 2002 which is under tab 7 of the ACC documents: Was the cost/benefit assessment the basis for ACC's recommendation to go ahead with implementation of the EPN programme? Is it appropriate for ACC to make decisions of that significance on the basis of material that hasn't been the subject of robust statistical analysis, including tests for statistical levels of confidence levels. What's ACC's view on its reliability as a basis for decision-making in 2002 and what ACC's approach today is to minimum standards for quantitative analysis that feed into significant policy decisions – more significantly, how will things be done in the future. (p95/96 of transcript)

The Endorsed Provider Network Extension Pilot Cost Benefit Assessment report dated 9th July 2002 was one of a number of assessments ACC took into consideration when it recommended to the Minster that a national roll-out of the EPN was viable.

The key outcomes of the second phase report of the EPN pilot in April 2002 were noted to be:

- Treatment by an endorsed provider was associated with a significantly shorter time on weekly compensation (-13 per cent);
- There is a high level of public support for the scheme; and
- There was improved access for Maori and claimants from lower socio-economic backgrounds.

Reported Outcomes

Public response

The Colmar Brunton general public and claimant surveys 2002 in Christchurch and Wellington indicated that:

- About 90 per cent of claimants believe that the physiotherapy treatment that they received was significant in assisting them to get back to work and to return to their normal lifestyle.

- The general public believes that the EPN scheme will encourage physiotherapists to improve the quality of their treatment.

- Only 15 per cent of the general public were aware of the pilot.

- Qualitative data indicates that for 56 per cent of claimants cost is not a factor in determining whether or not to seek treatment. Eighty per cent of the surveyed claimants would still have gone to the same physiotherapist if they had to pay a co-payment. Quality, location and referral information are the primary determinants for selecting a physiotherapist.

- Significantly more claimants travelled further or waited longer for an appointment with an endorsed physiotherapist.

Provider Response
The participating providers observed the following:

- There were reduced transaction costs and improved cash flow due to the contract requirement of electronic claiming every 48 hours;

- Most providers reported that the EPN was positive in that it allowed more time per treatment session when treating complex injuries (care plan approval required for hourly rate payment) and when treating claimants with more than one injury site. Some providers stated that the hourly rate did not adequately compensate considering the time required for completing and administering the care plans;

- There was a significant increase in the volume of claimants attending the clinics. At times the clinics were unable to provide an appointment when most convenient for the claimant;

- There was up to a 46 per cent increase in the number of claimants not attending for their appointments. This equated to about one appointment per week for most clinics;

- Forty-three per cent of claimants were referred by GPs. Many of these claimants were unaware of the pilot;

- A Rotorua clinic (that has been participating in the EPN since October 2000) reported a significant increase in the volume of Maori claimants and claimants from low socio-economic backgrounds. Many claimants attended and completed rehabilitation who had symptoms from long-term injuries but had never before attended physiotherapy;

- Providers reported increased administrative difficulties when providing services for claimants working for companies involved in the Partnership Programme (Accredited employers). Some accredited employers do not pay the contract rates; and

- Both providers and most ACC case managers were positive about the payment of treatment for gradual process injuries while the claims are on hold.

Volume Changes

Claim Rate Changes

- There was no increase in the number of claims treated in the pilot sites that could not be explained by previously existing trends.

- There was no evidence to indicate a change in the severity or complexity of claims, possibly reflecting the absence of growth that could be attributed to the EPN.

Claim Duration and Treatment Frequency

Treatment by an endorsed provider was associated with a significantly shorter time (-13%) on weekly compensation, suggesting higher quality or more effective treatment (see table 3). This finding was based on claims that have recently been treated and returned to work.

Table 3: Accident year ending 31 July, first physiotherapy. Treatment from 1 August 01.

	WC duration (days) [1]		Total cost to ACC ($ ex GST)[2]	
Year of claim	Endorsed	Non-endorsed	Endorsed	Non-endorsed
2001	58.4	72.5	459	585
2002	30.6	35.1	253	255

Endorsed physiotherapists have lower visits per claim per month than non-endorsed providers (6%).

Table 4 outlining the changes in treatment frequency

Visits per claim per month										
	Pilot Sites		Christchurch		Invercargill		Rotorua		Wanganui	
	End	Non-end	End	Non-End	End	Non-End	End	Non-end	End	Non-End
12 months to Dec 01	3.10	3.29	2.97	3.21	3.42	3.58	3.19	3.29	3.88	3.96

There was no observable difference between the total number of treatments per claim between endorsed and non-endorsed physiotherapists for recently treated and closed claims. However, EPN providers did require fewer treatments per claim for many specific injuries, except gradual process claims. (See table 5)

[1] For closed claims that have received weekly compensation.

[2] Average cost of weekly compensation, rehabilitation, and physiotherapy, osteopath, acupuncturist and chiropractor treatment for all closed claims.

Table 5: Summary of total visits for claims (including specific injury sites of high volume) that have been closed and inactive since the end of December 2001

	First Physio since Aug 01, claim lodged since Aug 01		First Physio since Aug 01, Accident during year Aug.00 - end July 01		First physio July 95 or earlier, accident in any year.	
Injury	Endorsed	Non-endorsed	Endorsed	Non-Endorsed	Endorsed	Non-endorsed
Gradual process injury	7.1	5.4	7.2	6.2	9.4	8.5
Cruciate ligament sprain	4.2	5.9	5.8	9.3	6.3	6.6
Meniscal tear	5.6	5.3	6.4	6.4	6.2	6.9
Rotator Cuff Sprain	6.1	5.7	6.0	6.9	7.2	7.4
All	**5.1**	**5.1**	**6.0**	**6.0**	**6.7**	**7.4**

Provider Switching

- Consumers did switch providers to take advantage of zero co-payments. About 10 per cent of the growth in endorsed provider volumes was attributed to switching.
- There was no evidence of claimants switching either from hospital-based physiotherapists or from osteopaths, chiropractors or acupuncturists.
- There was no evidence to indicate that there was a change in the severity or complexity of claims treated. This may in part be due to the low public awareness of the pilot (15%).
- As reported earlier, one clinic reported that significantly more claimants who had never received any rehabilitation were attending with old injuries. In this respect, the injuries were more complex because symptoms had become chronic.

Financial Impact

Impact by Account

The following table outlines the impact cost by account of the EPN in year 1.

Table 6: Summary of impacts of implementing the EPN Scheme (Fully funded cost, $thousand)

Year of claim ending March 03	Physiotherapy claim costs	Weekly Compensation (savings)	**Net cost**
Medical Misadventure	3.4	-3.5	-0.1
Self employed	267	-230	37
Employers	627	-610	17
Non earners	1,976	-5	1,971
Motor Vehicle	156	-91	65
Earners	2,850	1,225	1,625
ACC Total	**5,879**	**-2,164**	**3,715**

Note: numbers may not add due to rounding.

The following participant feedback was also considered.

- EPN participants are pleased with the manner in which the trial has been conducted by ACC, and the ongoing support received from the project manager and team. The operational issues discussed are areas EPN trial participants agree would improve the implementation of a national rollout.

- Participants endorse the findings for the report by ACC, stating that there was improved access for Maori claimants and claimants from lower socio-economic backgrounds. A number of claimants reported that they would not have attended physiotherapy because they could not have afforded to pay the surcharge.

- Participants acknowledge that the trial has had a positive effect for both claimants and providers. Feedback from provider surveys showed that claimants approved of the trial framework and a substantial proportion of survey respondents were prepared to pay a surcharge for the quality services.

- EPN participants recognise that the process of rehabilitation and returning people to work in a timely and appropriate manner requires skills, quality systems and processes and experience deserving appropriate recognition from ACC. They also recognise that continuous quality improvement does incur additional costs.

- Participants believe that the process of accreditation has improved the quality of physiotherapy services provided to claimants. It provides an incentive to continually assess and review patient-focused systems, review clinical practice and implement best practice procedures to ensure optimal and effective patient outcomes.

- The continued viability of the New Zealand Physiotherapy Accreditation Scheme (NZPAS) is dependent on the outcome of the EPN trial. Many physiotherapists have decided to pursue accreditation because of the ability to

utilise an expanded schedule of EPN fees and the need to compete with their accredited peers. Should the EPN trial not roll out nationally the NZPAS would be unlikely to continue to operate. The NZPAS is a well-established and credible system that is the envy of other professions.

- EPN trial participants support the ability to raise a patient co-payment for physiotherapy treatment. A significant proportion of patients also believe an affordable co-payment should be paid.

- Participants have expressed the view that if a reasonable fee were established by way of a national tender and indexed to price inflation of 2.2 per cent as described on page 12 of the ACC report, current EPN trial participants would support a fully funded EPN.

The payment systems used in 2002 were adequate for data analysis at the time. Since then, the payment system has evolved and analysis is now able to be better substantiated by the number of additional data fields that are collected. The 2002 systems required a number of assumptions to be made, but there is no reason to believe that any of these assumptions were incorrect.

41. Re the cost/benefit analysis in the pilot and, for example, the fact that payments of compensation turn up in table 12 and in the corresponding summary table: under ACC there's an expected saving and compensation, but no corresponding entry under consumers. To provide comment on whether you still consider that the cost/benefit framework that was applied here is appropriate. Also comment on whether that is something that Mr de Raad can help or whether you would prefer to address it from ACC's perspective. (p97 of transcript)

Mr de Raad has addressed this question. His response was supplied to the Reviewer Wednesday 23 May 2007.

42. The process of completing an ACC32 form, there is no separate payment to the physiotherapist for the time required to do that, is there? MS SALTER: It would be helpful to clarify whether what is paid is the standard payment by the regulation or EPN and if it is a separate fee and if so what is it. (p467)

CHAIRMAN: That was my question, is it intended to be covered by the standard fee payable for the resulting consultations or is there a separate payment in and of itself for completing the form. (p467)

ACC pays for the completion of the ACC32R (treatment within 12 months from the date of the accident) and for the ACC32A (treatment over 12 months from the date of the accident). For regulated providers, ACC pays $24.48 (GST inclusive) for the completion of ACC32R forms and $38.35 for the ACC32A. For EPN providers, ACC pays as per the contract terms and conditions of $38.35 for both the ACC32R &

ACC32A. In addition to this, ACC pays for a treatment if the treating provider provides a hands-on treatment at the time.

43. ACC to provide me with the complete file from your audit (Mr Murray Hing - physiotherapist, Flexa Clinic physiotherapy, Northcote, Auckland) and also its provider records in respect of the knee treatment outlier exchange so that I can review those on a confidential basis. (p315)

Mr Hing's recollection of the outlier records that the Reviewer requires: Some years ago I was sent my injury profile for knees. I was an outlier, again. ... I got a phone call from someone at ACC that wanted to talk to me about this. (p309/310)

ACC understands that the information provided to you in the course of your review can be considered to be confidential and protected. In order to support a full and open process of review, ACC has provided the information regarding Mr Hing's fraud investigation, inclusive of the personal information about Mr Hing and other parties held on the file. ACC would ask that you treat this information confidentially, and return it to ACC at the conclusion of your Review.

Provided in a separate folder with this document is a complete file of the audit undertaken in relation to Mr Murray Hing and Flexa Clinic. Please note that there has been no individual investigation or audit in relation to Mr Hing or Flexa Clinic. The attached documentation forms part of the Quest III study

The attached folder contains the following information:

- Mr Hing's request for information dated June 2005 and the response provided by ACC's Customer Relations team;
- All documentation relating to a complaint made by Mr Hing surrounding the manner adopted by an agent used by ACC to undertake interviews. This complaint was managed by the Provider Investigations Manager;
- Quest III documentation relating to transactions claimed by Flexa Clinic; and
- Copies of all documentation previously disclosed to Mr Hing via the ACC Customer Relations team.

ACC records show that Mr Hing has been formally contacted on eight occasions between 12 June 2002 and 1 February 2006 concerning incomplete ACC32 applications for further treatment. This is a standard procedure where the incomplete information is indicated in the letter sent and requests this missing information be provided in order to consider the request.

Mr Hing has been contacted once by telephone on 8 March 2006 concerning clarification of an invoice received in connection with his time taken editing treatment notes. On that occasion ACC has recorded a notation that Mr Hing remarked that he believed ACC scrutinised non-EPN providers unfairly.

ACC contacted Mr Murray Hing in 2005 seeking his participation in regard to an Individual Feedback Report (IFR) for the Rotator Cuff disorders mail out in 2005 as

were a number of other physiotherapists. These reports are treated as confidential and not reported on individually. It is not apparent if Mr Hing returned the IFR as there are always a percentage of providers who do not return these.

ACC has not been able to find any record of Mr Hing having been contacted in regard to his 'outlier' status regarding knee injuries or management of knee injuries. This is not to say that Mr Hing was not contacted by ACC, merely that ACC has not been able to find a record of this. We would be happy to receive a copy of any written information or an accurate date of any contact to investigate this further.

ACC has undergone a number of staff changes and the person who may have contacted Mr Hing may no longer be with ACC as an employee.

ACC contacted a physiotherapist other than Mr Hing at Flexa Clinic on 25 January 2006 for a matter that fell into the category of 'Level 1' of the Monitoring Team Process (requiring education or information) and this has since been resolved without issue.

44. So perhaps one of the things I will ask you to comment on is whether you anticipate any initiatives emerging in the near future and how we are going to ensure that that compliments what we are doing here. (p452)

ACC made the decision at the beginning of the Review process to continue with projects and initiatives. This 'business as usual' approach was relayed to the physiotherapy sector late last year.

Initiatives ACC will be working on this year are as follows:

- The role of the Advanced Practitioner: ACC anticipates working closely with the physiotherapy sector on recognition of the advanced practitioner and its role within this profession;
- Exemption of Advanced Physiotherapy Practitioners from the ACC32 process. This project is in the initial scoping stage and is likely to include up to 80 advanced practitioners, exempting them from prior approval when they reach the treatment limit;
- Treatment Profiles/ACC32 Process: ACC will be undertaking a review of the current Physiotherapy Treatment Profiles. As a workstream of this project, ACC will also be reviewing the whole ACC32 prior approval process;
- There are also a number of minor projects ACC will be undertaking during the Review process. We will be reviewing the current service specifications and requirements about physiotherapists and site visits, treating off site; and
- ACC is also undergoing a review of Pain Management Services and redesign of Activity-based Programmes.

We are currently working, and will continue to do so, closely and collaboratively with the physiotherapy sector on all of these projects.

45. It arises out of your second submission on page 46 where you set out the categories in respect of which outliers are measured for monitoring

purposes for each of the regulation providers and EPN providers. There's a list of categories on which outliers are measured, and they are different. It's an answer to my question 13, and you explained that it is necessary to compare like with like, EPN with EPN, regulation with regulation. I understand that.

David Goddard: What I am not sure I understand is why you'd also compare them on different dimensions, and the lists are quite different on page 46. (p463)

Diane Salter: to add to that, the reason it was puzzling was the feeling in each case you have physiotherapists providing claimants with a similar range of services and similar range of injuries, the EPN people are getting twice as much money probably on average for consultation so the risk to ACC seems to me similar if not potentially higher so it is puzzling as to why some aspects being monitored for regulation providers aren't on the list for EPN. I'd be interested to know why. (p463)

By way of background, neither the Regulation nor EPN physiotherapist services had a Service Monitoring Plan (SMP) in place at the time those services were reviewed. The SMPs for both EPN and Regulation physiotherapy services were completed in December 2005.

The purpose of the first EPN service review was to understand how the EPN services were being employed by the providers in regard to the specific contract itemised services. This was the prime reason for using different criteria when reviewing EPN and Regulation physiotherapy providers. It was not a review in the context of 'outliers' as has been discussed for other services or in regard to legislation or Treatment Profiles.

The service review for EPN occurred in March 2005, analysing data from the period April 2004 – October 2004.

Part of the agreement between ACC and the NZSP was that ACC would undertake this review and examine the first six months of the contract operation. This had been agreed with the NZSP prior to the contract going 'live'. The purpose was that ACC and the contract holders would gain insight into how the new services (PT01, PT02, PT03 and PT04) were being utilised in line with the Operational Guidelines.

In order to establish an understanding of how the contract and Operational Guidelines were to be utilised comparisons within the peer group were made in regard to the new services invoiced. For example where providers showed significantly higher or lower utilisation of PT03 and PT04 (Level B initial assessment and Level B follow-up appointment) information was obtained from providers.

From this peer comparison some assumptions could begin to be made. This did not infer that any disparities between peers in these instances equated to aberrant behaviour, but simply that some providers were either using high or uncommonly low numbers of the service items.

The providers' understanding of the Operation Guideline criteria and contractual requirements for these services were collected to determine why their data was so markedly different. The criteria used in measuring Regulation remunerated providers would not have been able to identify individual service items special to the EPN contract.

The service performance review of Regulation providers was more 'business as usual' in that the base data for the 25th and 75th percentiles was better established as there were several years of invoicing data to refer to. Regulation provider data was analysed in the latter half of 2005, reviewing data from the period July 2004 – June 2005.

The performance of Regulation providers was reviewed in the more correct context of 'service performance' and 'outliers' than the EPN as the patterns/trends in regard to legislation and treatment profiles were better established.

There have been no data analysis or 'outlier' service reviews of either Regulation or EPN providers since the SMPs were put into place. As ACC has gained greater numbers of EPN contract holders it is likely that the criteria for future service reviews would require reviewing first to determine if the criteria initially used is still relevant to the service.

46. Why is the EPN contract terminable on 3 month's notice and the answer I think was all your contracts are terminable on 3 month's notice, with service providers; is that right? Check to see whether any EPN contract has, in fact, been terminated on notice. That would be helpful. (p464/465)

A response to this question will be provided to the Reviewer by 1 June 2007.

47. ACC45 forms. An issue was raised about the signature of those forms in circumstances where the form is lodged electronically. Could you just explain briefly what the process is in terms of signature and the electronic lodgement context? (p466) Am I right to understand, though, that it's the responsibility of a provider, before submitting an electronic ACC45, to ensure that a hard-copy has been signed by the claimant at their practice? Is that right? MS SALTER: As a follow up on that, does that imply, though, that at the point where someone at your end may --at ACC's end --may be requesting clinical notes, they don't know for certain whether or not someone has signed it because if they had that signed copy is at the practitioner end it is no longer at the ACC end? (p467)

MR MORRIS: There is a problem there, and I think you have seen this reflected in some of the answers where in some situations, indeed my understanding is that in many situations, ACC when requesting clinical records gets a second consent in writing and provides that to the treatment provider. Reviewer: It would be sensible to deal with the electronic lodgement as part of the answer to the earlier process question.(p467)

A response to this question will be provided to the Reviewer by 1 June 2007.

48. **Activity-based programme, ABP contracts. If you were able to summarise for me ACC's policy on when it will or will not enter into an ABP contract, what the reasons would be for declining, that would be very helpful. I was particularly interested in the circumstance of the physiotherapist from Cambridge suggesting that even though there was no provider there, ACC wasn't willing to contract with him for that, which meant that people had to travel to Hamilton. So if you could explain that, that would be helpful. (p468)**

When applying to hold a contract to provide a service for ACC, an applicant may or may not already be an ACC Master Agreement holder. If they are not, they will be applying to hold a Master Agreement and also applying to hold a contract to provide specific services.

ACC will enter into an Activity Based Programme (ABP) services contract if the applicant either already holds an ACC Master Agreement *or* is applying for and meets all requirements of the ACC Master Agreement *and* the Service Specifications of the ABP.

Reasons for declining can be varied depending on whether or not the applicant has a Master Agreement or not, and if not, whether they meet the rigorous requirements of the Master Agreement. The applicant must also meet all requirements of the ABP service specifications.

With reference to the query from the provider in Cambridge;

ABP has an open market. All Expressions of Interest (EOI) are sent to the Programme Manager of the service and then to the Health Procurement team for processing. An application pack is then sent to potential Vendors who express an interest in providing the service.

EOI's are received directly from the Vendor or via the Service Performance Managers and/or the Provider Relationship Managers.

If an applicant meets the requirements of the Master Agreement and the Service Schedule, then the Vendor will be awarded a contract. There are occasions when ACC requests the Vendor to provide more information e.g. evidence of policies and processes that are required as per the Master Agreement, or to demonstrate evidence that they have skill, interest and experience in providing the service.

49. **An issue raised in particular I think by the Acclaim submission was what happens where a decision to decline further treatments by ACC is reversed on review or on appeal, and the patient meanwhile has proceeded to obtain the treatment which they considered desirable and which with the benefit of the review or appeal decision it's now been**

held ACC should have funded. Will those treatments that have taken place in the interim be reimbursed to the claimant? (p471)

Where an ACC decision has been overturned from 'declined' to 'accept treatment', ACC must reimburse the treatments in question. Note that ACC can only contribute against the regulated amounts and where costs are above the regulated amounts co-payments maybe incurred by the claimant.

50. **Independent review of ACC's fraud practices that's been commissioned by the Chief Executive. ...I need to be kept informed about what the Terms of Reference are, what its timeline is, and the purpose for which it is being conducted so that I understand how it fits with what I am doing. (p482)**

The Terms of Reference for the review of ACC's fraud unit is included with this document.

51. **ACC32s - what I would like to understand in more detail is how decisions are made on ACC32 requests?....any explanation of the substantive framework that's applied for making decisions for saying yes, you have requested 12 treatments and that's appropriate or no, you have requested 12 but 8 is more appropriate. So if it's possible to provide an explanation of the substantive decision making criteria in a way that a mere lawyer can understand, that would be helpful....helpful to understand how those substantive criteria interface with the process map, in other words, of the different decision makers contemplated as making decisions at different points, whether it is case co-ordinators or clinical advisers, what criteria are each of them applying?...Where there is a case manager, whether it is a requirement of the process that there be a discussion with that case manager when making a decision about whether to accept or decline a request for further treatment....Mr Forster raised the point whether the delegation manual had changed in 2006 no longer requiring that....so in the process of providing that explanation of the process and the substantive criteria, can touch on the relevance of the delegation manual, so we understand that, and the relevance of that change to it. (pp472-474)**

<u>How decisions are made on ACC32s</u>

The ACC32 form is required when additional treatment is needed beyond the number of treatments expected for a particular injury (as per the Physiotherapy Treatment Profiles).

The ACC32 form provides ACC with information about the injury, details of the current diagnosis and condition, reasons why the current condition has not resolved itself within expected timeframes and the results of treatment to date. It also provides information on the likely outcome of the condition without further treatment (please refer to the ACC32 completion guide that is sent to providers when they order ACC32 forms – included with this document).

The ACC32 form is both a request and a source of supporting information that plays an important role in helping with the decision about further treatment. In all cases, ACC issues a decision to the claimant (with a copy to the provider) that states the number of treatments being approved and gives the claimant review rights if they disagree with the decision.

The ACC32 is not the only source of information used. Other sources of information include:

- The previous claims history held on ACC's claimant database (multiple claims for the same injury are common as a way of getting around Treatment Profile limits);
- Previous or new clinical notes held on ACC's files or requested direct from the provider/s;
- Clinical Advisor discussion with the treating provider (by phone); and
- Operational guidelines i.e. EPN, and must be supported by legislation criteria. (schedule 1, Part 1 ss2,1 IPRC Act 2001, also Part 1, (4), section 25 sc 3).

Key criteria used to determine the amount of additional treatment approved

Information contained on the ACC32 should:

- Demonstrate that the patient is presenting with an injury-related condition and not a medical condition that does not meet ACC's cover criteria (particularly degenerative changes);
- Show that there is a significant clinical casual link to the original covered injury and that the other non-injury related conditions contributing to the ongoing need have been taken into consideration when validating the further need to treatment; and
- Show that the treatment requested is necessary and appropriate for the injury type and the clinical information shows there is improvement in the clinical objective measures.

Volumes

The Clinical Advisors review approximately 20 per cent of ACC32 forms - mainly treatment requests that are well in excess of any Treatment Profile recommendation. The other 80 per cent are managed by the claims officer role. Of the total treatment requested, ACC approves 96 per cent of all treatment, which includes treatment requests that have been modified (i.e. requested 12 treatments but approve 8 treatments), and of that 92 per cent is approved in full (see attached table for the year to October 2006).

Screening Criteria (for ACC32s referred to Clinical Advisors)

Claims officers use screening criteria, as follows, to determine which ACC32s are referred to a Clinical Advisor:

- Ensuring there is an accepted registered claim;
- Confirming the treatment appears to relate to the covered injury;

and either:

- Approve the treatment if the treatment totals less than 36 treatments, or less than two years from the date of injury, is the third ACC32 submitted; or
- Gather additional information about the injury; and
- Refer the ACC32 to the Clinical Advisors where applications for treatments exceed these thresholds.

Note that the thresholds for these referrals are significantly in excess of the recommended Treatment Profiles. However, referrals are limited by the physical capacity of the limited number of Clinical advisors available to adequately review the volume of ACC32s referred to them.

Case Managed Claims

If the claim is being case managed (relatively rare in the case of ACC32s), both the Clinical Advisor and the claims officer will seek advice and input with the case owner to determine appropriateness of treatment.

Where the decision is made to decline treatment this is generally done by the case manager as they are managing the claimant relationship.

Table of Treatments Requested vs Treatments Approved: Year to October 2006

		Number of Treatments Approved >>>>>>>																											
		0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	30
Number of Treatments Requested (on an ACC32)	0	73	30	34	32	77	33	556	13	100	4	74	2	80	1	2	0	32	0	0	0	0	0	0	0	0	0	0	0
	1	213	3805	4	0	2	2	1	0	1	1	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	2	70	44	2797	5	13	7	14	3	4	0	3	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	3	35	25	36	1259	16	13	8	3	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	4	79	46	139	99	3993	19	68	14	43	2	4	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	5	34	30	34	64	69	1889	51	25	23	3	2	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
	6	131	101	76	117	339	57	9416	22	100	22	16	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	7	26	5	7	15	14	14	17	932	19	8	4	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	8	102	119	48	47	333	95	445	37	11404	20	26	9	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	9	30	8	1	4	2	21	13	15	10	714	9	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	10	136	178	19	27	125	132	606	58	586	42	11931	4	14	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	11	44	4	0	2	8	10	10	21	10	12	10	689	9	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
	12	173	198	18	33	98	52	505	52	1095	47	457	20	11834	2	1	0	1	0	0	0	0	0	0	0	0	0	0	0
	13	5	2	1	0	1	0	5	1	7	5	2	4	12	102	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	14	20	10	1	0	2	6	18	4	56	1	89	3	386	0	497	0	0	0	0	0	0	0	0	0	0	0	0	0
	15	6	3	0	0	0	2	5	3	15	2	22	19	72	2	0	271	0	0	0	0	0	0	0	0	0	0	0	0
	16	21	22	1	5	12	6	21	2	75	4	102	8	550	2	4	1	917	0	0	0	0	0	0	0	0	0	0	1
	17	0	1	0	0	0	1	0	0	0	0	2	1	1	0	0	0	0	5	0	0	0	0	0	0	0	0	0	0
	18	2	1	0	0	0	0	2	0	2	1	1	0	29	0	1	2	8	0	29	0	0	0	0	0	0	0	0	0
	19	0	0	0	0	0	0	0	0	0	0	1	1	1	0	0	2	1	0	0	8	0	0	0	0	0	0	0	0
	20	2	2	0	1	1	1	5	1	10	0	15	0	49	0	3	2	40	0	1	0	48	0	0	0	0	0	0	0
	21	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0
	22	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	5	0	0	0	0	0
	23	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0
	24	0	3	0	0	1	0	2	0	1	0	4	0	34	0	0	0	30	0	0	0	0	0	0	0	26	0	0	0
	25	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
	26	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0
	29	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
	30	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	2	0	0	0	0	2	0	0	0	0	0	0	4
	32	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	36	0	0	0	1	0	0	1	0	2	0	0	0	3	0	0	0	2	0	0	0	0	0	0	0	4	0	0	0
	40	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	42	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	50	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
	60	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
	86	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	121	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	140	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
		1202	4637	3216	1711	5106	2360	11770	1206	13568	888	12775	765	13090	109	509	284	1032	5	30	8	51	2	5	1	31	1	3	6

52. **Reference was made in the final comments of the NZSP this morning to an ABP consultation document that's been recently released. I would be grateful for a copy of that….I'd really like to get straight what the current practice is before someone who is undergoing a course of treatment with a physiotherapist is referred to an activity-based programme, and what is proposed for the future with this consultation document.**

The Activity-based Programme consultation document is included with this response.

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Questions from letter dated 11 May 2007

1. **Does ACC accept the evidence of Strategic Pay on fair remuneration rates or does it stand by the benchmarking in the Deloitte Final Report, or does it have some other view?**

ACC intends to further analyse this information before forming a view.

2. **Does ACC seek a determination of fair notional remuneration from this Review?**

3. **If not, what process does ACC intend to follow to determine fair notional remuneration, and does it intend to make that decision contestable through arbitration or similar?**

No, ACC does not seek a price determination from the Review.

ACC intends to continue to consider the Deloitte model, information provided by other parties including the Physiotherapy groups, and other factors before making a decision on pricing.

This is not a contestable process.

4. **For ACC and Deloitte – Physiotherapist Consultation Times**

   In the initial determination of payment levels for PT01 – PT04 EPN visits, did ACC adopt notional consult times for pricing of those visits based on an hourly rate?

   If so, what were the notional consult times used, and how were they calculated? If not, how were initial EPN payment levels set?

This question has been answered above.

5. **The Deloitte Final Report identifies a number of issues raised by NZSP in its Response to Deloitte Second Draft Physiotherapy Pricing Report as 'areas for further discussion' with ACC. These are:**

- *use of median revenue split rather than average revenue split (KPMG Brief 1, para 73 / Deloitte Final Report p 11);*

- *pricing at the 87th percentile (or some point higher than the average) of adjusted costs in the Deloitte model to replicate the initial setting of EPN*

prices, and to account for the prohibition on co-payments (KPMG Brief 1 para 56 / Deloitte Final Report p 13);

- *whether there is a direct relationship between levels of ACC funding and the remuneration received by business owners and employed physiotherapists, and the ongoing viability of the profession generally (KPMG brief 1, para 23 / Deloitte Final Report p 14);*

- *whether the Deloitte surveyed practices and profession have poor investment in their equipment and facilities which needs adjustment in the Deloitte model, and how fixed assets should be incorporated in the Deloitte Model generally (including use of ORC methodology (KPMG Brief 1 para 87 – 97 / Deloitte Final Report p 14); salaries (KPMG Brief 1, para 122 - 124 / Deloitte Draft Report p 14);*

- *whether consistent consult times should be used in the Deloitte model for both EPN and regulation consults, by weighting the average regulation consult times according to the likely proportion of simple and complex visits and the EPN times used for each type of visit (KPMG Brief 1 para 62 – 69 / Deloitte Final Report p 18);*

- *whether the cost of Holidays Act compliance (extra holiday week) should be incorporated into the Deloitte model, and what level of adjustment should occur for benefits paid in the public but not private sectors (NZSP Submission 1 para 286 & para 246 - 272 / Deloitte Final Report p 21); 17.8. The salary rates paid in the model (Strategic Pay Report / Deloitte Final Report p 21); and*

- *whether Unavoidable Cost principles should be adopted to acknowledge the status of ACC revenue as foundation revenue for physiotherapy businesses, with an appropriate weighting added to the EPN cost split accordingly (KPMG brief 1 para 76 – 86 / Deloitte Final Report – not addressed).*

These questions were answered in detail by Deloitte by way of a presentation to the Reviewer on 17 May.

6. **ACC states that Deloitte disagreed with NZSP and KPMG on these areas, rather than them being for further discussion. Which is correct?**

   If Deloitte disagrees with those points, what are its detailed reasons in regard to each issue? Can those be reduced to writing for consideration by the Reviewer (and NZSP)?

Deloitte states that there were some points of disagreement. Mr Goddard has directed Deloitte and KPMG to address these.

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As both Deloitte and ACC have consistently stated, the Deloitte model provides a basis for discussion - it is just one way of looking at the issue and intends to consider the model, along with other relevant factors in the course of arriving at a price.

7. **What is ACC's view on each of those points, and why?**

ACC is satisfied with the rationale provided by Deloitte in each of these areas.

ACC intends to use the model as one of the factors in determining a fair price.

ACC and Deloitte – Implementation and Cross Checks

8. **How does ACC intend to convert the hourly rates outcome of the Deloitte Project into EPN consult fees, and what time estimates does it intend to use?**

ACC does intend to compare the rates arrived at by Deloitte against current rates. This is part of the process that ACC intended to continue, however, the Review has occurred during this 'work in progress'.

9. **Has ACC or Deloitte undertaken any cross checks to ensure that the percentage increase in the revenue base resulting from cost input and ROI adjustments is actually reflected in increases to the EPN consult fees? If so, what checks have been performed, and what were their outcomes? If not, why not?**

This is something that ACC and Deloitte were intending to, and continue to address as part of the ongoing work around pricing.

ACC has asked Deloitte to undertake some sensibility checks on the rates that the model produces. Deloitte will seek to ensure that when actual practice/data is fed into the model, the net profit looks sensible based on the rate per hour.

Follow-up sought on responses to questions previously posed by Reviewer

10. **Page 13: You refer to an NZIER literature review on co-payments in May 2005 entitled, 'Co-payments, utilisation, and health outcomes'. Could you please provide us with a copy of this.**

This was supplied to the Reviewer on Monday 14.5.07 pm.

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11. **Question 5: You were asked: What reasons can be identified for setting different rates for payments as between the EPN contract regime and the Regulations? What level of difference is justified by the reasons identified?**

    Your answer does not appear to have addressed the second part of the question. We were hoping for a response that provided a reasonably detailed analysis of how any differences in cost/quality/value constituted a justification for the considerable difference in ACC payments under EPN and under regulations. Could you please address this in more detail.

This question was answered at question 19 in the answers to the oral questions from the Hearing (above).

12. **Experience with co-payments by different provider groups**

    On page you note that detailed reports are available for a number of different provider type as well as comparative reports that provide an overview of year on year changes in the levels of co-payments. Could you please provide us with a copy of each of the 'Overview' reports and we will then consider if we need any further data analysis.

The following reports are included with this document:

- BRC Marketing and Social Research Physiotherapy Services Co-payment Charges Survey: 2003/04 and 2004/05 Comparative Analysis Final Report – October 2004
- BRC Marketing and Social Research Physiotherapy Services Co-payment Charges Survey: 2004/05 and 2005/06 Comparative Analysis Final Report – September 2005
- Research New Zealand Comparative Report: 2 August 2006: Physiotherapists Co-payment Survey

13. **Question 9: This question may have been misunderstood. We would welcome ACC's comments on whether there is any barrier in the IPRC Act to amending the regulation to provide for indexation.**

    Original question: Is there any legal barrier to providing indexation of payments under the COT Regulations? What is the rationale for not providing indexation of such sums?

This has been answered at question 5 in the answers to the oral questions from the Hearing (above).

14. **Question 12*:* We have a follow up question relating to the ACC32 decision making process. Please provide data on time frames for ACC decisions on**

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the ACC32 forms relating to physiotherapy, preferably going back to 2002. We would appreciate receiving it in the following form if possible:

- **A% approved in less than one working day from receipt**
- **B% approved within 1 week**
- **C% approved within 1-2 weeks**
- **D% approved within 2-3 weeks**
- **E% approved within 3-4 weeks**
- **F% approved within 1-2 months**
- **G% approved after more than two months**

Please provide the information broken down by EPN and non-EPN practices.

This question has been answered at question 17 in the answers to the oral questions from the Hearing (above).

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List of attached documents

Question 7

- Cabinet policy committee minute [POL Min (01) 9/10] (hard copy)

Question 36

- ACC167 Claimant authority for collection of information form; (hard copy)
- ACC18 Medical Certificate (hard copy)

Question 43

- File on Mr Murray Hing (confidential) (hard copy)

Question 50

- Terms of Reference - Review of ACC's Fraud Unit (soft & hard copy)

Question 51

- Request for pre-Approval of Treatment Form (ACC32) Completion Guide (soft copy)

Question 52

- Activity-based Programme consultation document (soft & hard copy)

From Questions in Letter dated 11 May 2007

Question 12

- Physiotherapy Services Co-payment Charges Survey 2003/4 and 2004/5 Comparative Analysis - Final Report – October 2004 (soft & hard copy)
- Physiotherapy Services Co-payment Charges Survey 2004/05 and 2005/06 Comparative Analysis - Final Report – September 2005 (soft & hard copy)
- Comparative Report: Physiotherapists Co-payment Survey (#3351) (soft & hard copy)

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