

## **Second Submission to Review of Physiotherapy Enquiry – August 2007**

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### **1. Draft Review**

Mr Goddard, thank you for your Draft Report which comprehensively looked at all issues. It was particularly gratifying to read your recommendation on increases to sustainable levels for fees and your acknowledgement of the importance of recognising post-grad qualifications and clinical expertise within the profession. However in response to some of your findings and events subsequent to the first hearing I would like to offer my second submission.

### **2. Ethics and Treatment Profiles**

The Draft Report states (point 1.32) that signing an EPN contract does not breach the ethics of the Physiotherapy profession. I completely agree. However it is not the EPN contract that is causing Physiotherapists to act in a manner inconsistent with our ethical responsibilities – it is the way we are forced to treat within the restrictions of the treatment profiles that compromises the ethics of both EPN and regulation providers.

Our professional ethics – from the NZSP website state that –

- The Physiotherapist must act in the best interests of their patients.
- The Physiotherapist has the ultimate responsibility for all aspects of Physiotherapy clinical care.
- The Physiotherapist ceases intervention when the Physiotherapy clinical practice has achieved and sustained agreed defined functional goals.

Alongside this is ACC's own legislation that encourages Physiotherapists to use 'the provision of entitlements that restores to the maximum practicable extent a claimant's health'.

By treating my patients only within the bounds of the treatment profile, and accepting the decline of a 32 without question, I believe that I am in breach of these professional ethics and standards.

As a provider I use my medical knowledge and clinical expertise to judge what treatment is required, and how many treatments are required, for my patients to be fully rehabilitated to the 'maximum practicable extent'.

If I require more treatment than the profile I must complete an ACC32 and wait for ACC's Medical Fees team to process it. If they then decline this or approve less than I know I need - I believe I am breaching my ethics if I just accept this and stop treating my patient.

- I am not acting in the best interests of my patient.
- I am not holding ultimate responsibility for all aspects of their clinical care.
- I am not restoring my patient's health to the maximum practicable extent.
- And I am acting against my own professional judgment that my patient requires more treatment.

ACC stated in their submission that it is the treating medical provider who dictates the ACC32 process and the number of treatments allowed. This is clearly not so. Only ACC has the power to dictate the number of treatments a patient receives. Firstly through the treatment profile attached to the injury description and then through their power to accept, restrict or decline ACC32s.

I agree with your suggestion that advanced practitioners should be authorised to approve additional treatments above the standard profile. And also I want to stress the point very vigorously that the treatment profiles MUST be reviewed – the Draft Report clearly shows that the current profiles are based on faulty and very limited data and they must be immediately reviewed and extended.

ACC also use these treatment profiles to provide a measure of provider quality (ie a 'good' provider treats a patient within the profile and a 'bad' provider doesn't) despite the evidence in the Draft Report that the initial ways these profile numbers were decided upon were completely flawed. ACC should not use such profiles to monitor provider quality and identify outliers when it is clear that quality is determined by many more factors than adherence to treatment profiles.

Physiotherapists know that ACC judges them on the basis of their treatment numbers thus indirectly ACC is forcing providers (through the threat of audit, investigations or other action) to stay within the treatment profiles - and try to limit the number of ACC32s used so as not to draw unnecessary attention to themselves.

We as Physiotherapists are put into a very difficult ethical dilemma. Stick to what we know is right and what our patients need by keeping on applying for more treatments and continuing to treat patients while ACC32s are being considered – and thus risk being

accused of fraud and investigated as an outlier because our treatment numbers are too high - OR just shut up, accept what we get given and convince our patients that it is all they need and that they are rehabilitated to the maximum practicable extent.

I ask you Mr Goddard is this acceptable?

### **3. ACC 32s process**

ACC have submitted that their processing times for ACC32s are 90% within one week. I keep a record of the date my clinic sends the 32 application and then the date we receive a response. As of the 17<sup>th</sup> of August I can tell you that we have submitted 20 ACC32s – by Wednesday 22<sup>nd</sup> we have received 7 responses. My maths is poor but it isn't that bad – that is a long way from 90%.

And of the 7 responses received only 3 patients got the treatments requested (all received 10 of 10) and 4 received less - being 8 of 12, 12 of 16, 5 of 10 and 16 of 20. This is not surprising and I am happy to submit my clinic's records for 2007 which clearly show a pattern of usually over 2 weeks to receive a response and frequently less treatments given than requested.

I understand that postage adds a couple of days – I do not understand why the acceptances cannot be emailed?

The last patient mentioned – who was allowed 16 of 20 treatments applied for brings up another interesting point. ACC submitted that they have no formal limit in place for a maximum numbers of treatments given under a 32 – I believe this is untrue. This patient was referred to my clinic by his specialist after a complete knee replacement. Clearly this patient will need a substantial amount of treatment and even ACC's processing staff (who often lack clinical knowledge) should have understand this.

His actual ACC claim from his initial injury – which eventually led to the knee replacement – is coded as Meniscus Tear thus we can only see him for 14 treatments under the profile. With his specialist urging us to see him several times a week we used these quite quickly and in our first 32 we asked for 20 more. We received 16. What possible justification can there be for only approving 16 treatments for this patient? I believe the maximum allowed is in fact 16 and I have never received more despite having many extremely complex patients.

I have also NEVER received a response within 5 days – as ACC's own guidelines set out. Interesting how there is a firm punishment if a provider doesn't act within ACC guidelines but nothing when ACC doesn't comply with their own rules.

**ACC32 spreadsheet submitted to the Enquiry.**

The answers that ACC are giving this review are inaccurate and untrue.

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ACC's clinical advisors and processing staff have advised me that ACC will not in any circumstances pay for treatment given before an ACC32 is approved. I refuse to tell my patients to stop treatment, live in pain and risk their condition deteriorating because of administrative incompetence on the part of ACC.

In fact, my professional ethics do not allow me to stop treatment for these reasons. However other Physiotherapists may do this because of fear of reprisals from ACC or fear of the being unable to recover the cost from their patient if further treatments are declined. I know I am not the only Physiotherapist put in this position by ACC and having the worry of continuing to treat patients when I know that ACC may decline to pay for these treatments.

#### 4. ABP Referrals

ACC submitted to the Review that they have advised Case Managers that they should not refer a patient to an activity based program without consulting (or at least advising) the treating Physiotherapist. Last week I instructed my receptionist to check on the status of a patient's 32 (sent August 3<sup>rd</sup>) – she was told this patient had been seen by an ACC specialist and referred elsewhere for an ABP by the Medical Fees department. There had been NO communication or correspondence with me whatsoever about this. I then discussed this with ACC further and was eventually approved 8 treatments (out of 12) and told that this patient was now not going to an ABP. I was extremely unimpressed with the way this matter was handled and again would like to state the difference between the cooperative answers ACC is giving the Review and the reality for a practicing regulation funded Physiotherapist.

#### 5. Audit (Quest III) and Internal Report into Investigation Units

ACC describes the decision to investigate only regulation funded providers under Quest III as **an administrative decision, the rationale for which cannot now be ascertained.**

I do not understand this answer to the enquiry!

In ACC's own words and the answers given to the Ombudsman, ACC have been very clear about the intent of Quest III. Once I realised my entire practice was being investigated - through patients telling me rather than ACC - I contacted numerous people at ACC to try and find out why etc. I was continually denied any information and eventually I went to the Ombudsman for help. They too did not receive much information but they were told (and advised me in a letter of 25<sup>th</sup> May 2006) that

'Quest III is the investigative tool that has been developed by ACC for the detection of errors and possible fraud by its service providers...as such ACC claims justification for withholding this document pursuant to section 6C of the Official Information Act [which]

provides for the withholding of information where disclosure would be likely to prejudice the maintenance of law including the prevention, investigation and detection of offences”

You will realise that this is nearly 2 years after the audit and yet ACC is still not providing information regarding it?

Clearly Quest III was a well-thought out and comprehensively developed investigative tool. ACC continued to protect this tool - in 2006 - on the basis that withholding the information was necessary for the prevention, investigation and detection of offences. If Quest III was some strange ill-conceived administrative error that had been over-turned in the new 2005 audit guidelines and was best forgotten and consigned to the mistake bin of history why on earth would it still be essential to withhold information regarding it? Why are they protecting it?

It indicates that ACC either intended to keep using it or knew that it contained information that would reflect badly on them and their investigative practices. I strongly doubt that ACC cannot ascertain the reason that Quest III only targeted regulation-funded providers – I suggest they do not wish to explain the reason. Perhaps their internal review of their fraud units may provide this information?

This is another example of ACC deliberately withholding information from the Review. From the information we do have, it is clear that ACC had identified their targets and went after them.

In his Evaluation of Clinic Practice Presentation in April 2000, Dr Rankin looks at provider monitoring and how to **change provider behaviour**. He focused on using outlier analysis and looking for criminal intent in fraud investigations.

He outlines these steps in the “Profile Process.”

- Collect data.
- Format information.
- Distribute information.
- Investigate outliers.
- Report back to providers.
- Reward effective providers.
- **Hound fraudulent providers.**

He then produces the results of this Profiling and concludes that 57% of providers are Neutral, Poor or Very Poor. This very simplistic profiling was obviously flawed but still I am astounded that ACC could consider the majority of its providers to be less than good.

And to highlight only effective versus fraudulent providers as if no other types exist or there is a clear black and white boundary between the two!! A completely fraudulent provider could be considered very effective by ACC as long as their fake claims all fell within the treatment profiles.

Dr Rankin then identifies these next steps –

- Encouraging peer comparison.
- Preferential engagements of providers.
- **Be ruthless with bad providers**

Do the words **Bad, Hound** and **Ruthless** belong in any kind of professional presentation by ACC? They strongly indicate ACC intention towards providers and the results speak for themselves.

In this same time period under Dr Rankin's leadership we see the development of the following -

- **EPN network (with a much higher payment than regulation providers)**
- **Treatment Profiles**
- **Quest III audits and investigations.**

Could there be any clearer examples of preferential engagement and rewarding effective providers versus hounding and being ruthless with so called bad providers?

ACC had very clear intentions and they acted upon them through the development of these processes. To now deny the reasons why Quest III was developed or the implications of the EPN is simply dishonest. I understand this is all considered just historical stuff and quite irrelevant by many people at this review – let me assure you that as a victim of Quest III it is certainly not in the past or irrelevant to me. I have submitted my confidential Victim Impact Report about the effects of this audit alongside this submission.

ACC's own internal investigation into its Fraud units - which has just been released - supports much of the evidence of inappropriate behaviour that my patients and I reported in our first submission. The evidence of a distinct sub-culture in the units, of detached, secretive behaviour, of being rigid, over-bearing and aggressive, of the majority of staff being ex-police and private investigators with no clinical expertise who consistently act from the behalf that fraud is their starting point and prosecution their ideal result and the investigative processes themselves and their many problems.

All of this is very gratifying for me and I feel vindicated in these areas. I am well aware that many (both within ACC and the Physiotherapy profession) consider me to be obsessed with my audit and paranoid about being targeted and it is very pleasing to have these matters finally being investigated seriously.

I am very satisfied to see this matters being formally reviewed and I expect it is now time for ACC to consider reparation and compensation for the providers who were victims of these units.

I understand such compensation is outside the scope of this Review; however I would like to take the chance to mention it now and ensure it is on public record.

## 6. ACC New Culture – Partnership and Communication

In common with many of the findings of the Draft Report I was pleased to see the announcement of a new direction and culture at ACC with a focus on a partnership and treating patients as individuals etc. However I have grave concerns that its a lot of nice sounding words and very little action.

- ACC are still declining or restricting treatment under ACC32s and providing no explanation or making no attempt to discuss this with the provider.
- ACC are still declining patients access to treatment if degenerative changes are shown in X-rays due to age even when the patient has had no previous problems prior to the accident and the mechanism of injury is clear.

I would like to submit an affidavit from my patient Jenni Farmer who has been declined further treatment on a shoulder claim. She has my support and that of a specialist that her symptoms are caused by her accident and thus was considering whether to go to Review when ACC phoned her last week and told her that they would agree to pay for the 10 treatments previously declined on the proviso that she would agree that they would never pay any treatment in the future for this shoulder injury or any future injury that they felt could be related in any way to this one.

She phoned my Practice Manager who told her that she must have misunderstood; she re-confirmed with ACC that she was correct. This amounts to threatening behaviour probably to ensure she wouldn't go to Review. ACC cannot issue such ultimatums to patients. Jenni's affidavit is attached and I will be supporting her in her Review process.

It is imperative that the culture of ACC is looked at more closely and that changes are forced upon them rather than just suggested. This Review must be compelling in its recommendations to ensure ACC doesn't just continue its historical habits of saying the right words and then continuing to act in the same autocratic manner.

ACC have stated in this review that they are keen to have transparent communication and a true partnership with the Physiotherapy profession to work in the future. However we do not see this as yet.

The Physiotherapy Trust – of which I am a member – requested copies of the internal fraud investigation report before the public release date and were given this series of untruths and lies as follows. These requests were made by different people.

- The Trust cannot view the report until after the Board meets on the 17<sup>th</sup>.
- A reporter we know rung – was told they could view the report on the 16<sup>th</sup>.
- Another media person was told they could view it on the 15<sup>th</sup>.

- A Trustee rung and was told the person who dealt with such requests was away with a sick child. A request was made for the Trust to be called back – no call was received.
- A different Trustee rung with the same request but asked to speak with a different person. This Trustee was told this person was also away with a sick child.

Unfortunately Sir we happen to know that one of these people does not have any children. Clearly this was more lies and attempts to stop the Trust (which has been highly critical of ACC) from seeing the report. How can we possibly believe in a more transparent partnership relationship when this kind of thing occurs? The media are treated better than ACC's own providers.

There is no honesty or communication.

## **7. Conclusions.**

The only consistency I see is inconsistency. Between what ACC says and what it does, between what it tells the Review and how it continues to behave with providers and in all likelihood between what it says it plans to do in the future and what it will actually do.

They have demonstrated within this enquiry that they think they can still do as they please, by delaying their answers, leaving out important information, being unable to answer difficult questions and misrepresenting other facts. In a court of law I believe we would be considering the question of perjury. At the very least they are guilty of half-truths, deceit and misleading answers.

I want to say again that ACC was guilty of inappropriate and possibly illegal fraud allegations and investigations. There needs to be some accountability for this and justice for the victims.

Sir your Draft Report was excellent and has highlighted many important points. However in light of this evidence of ongoing problems and the information provided by ACC's own internal Fraud Units investigation report I ask that you be much more forceful in the changes you recommend for ACC's future.

History shows ACC has had these matters brought to its attention in 1994 and in 2002 and not changed its ways or culture. In fact it has got worse. Now 15 years later we are still discussing the same things. This time ACC must be punished, they must be made accountable for their actions and the effects it has on their victims. Compensation may be outside the scope of this Enquiry but I know you can recommend for process to start and I ask you to do exactly that.

Thank you.