Schonstein et al: WorkCover's physiotherapy forms: Purpose beyond paperwork?

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We retrospectively analysed 219 consecutive treatment plans submitted to a large New South Wales workers' compensation insurer for workers coded by the insurer as suffering from back pain. The purpose was to (i) describe the quality of goals of treatment provided to insurers by physiotherapists for workers with back pain using guidelines provided by the WorkCover Authority of New South Wales (WorkCover); (ii) compare the physiotherapists' prognoses against prognoses indicated in clinical practice guidelines; and (iii) make recommendations about the communication system between physiotherapists and insurers. The back pain of most treated workers was classified as acute and the majority of physiotherapists estimated that treatment would be of short duration, which is concordant with current treatment guidelines. However, most physiotherapists did not provide precise, measurable or time-specific treatment goals, despite this being emphasised by WorkCover. We propose ways of improving communication practices between physiotherapists and insurers. [Schonstein E, Kenny DT and Maher CG (2002): WorkCover's physiotherapy forms: Purpose beyond paperwork? Australian Journal of Physiotherapy 48: 221-225]

Key words: Communication; Low Back Pain; Patient Care Planning; Workers' Compensation

Introduction

Physiotherapists play a key role in the management and treatment of compensable back pain. A recent Australian study (Schonstein and Kenny 2000) that examined the treatment practices of nominated treating doctors with respect to compensable low back pain indicated that physiotherapy is the most frequently recommended treatment for back pain.

Randomised controlled trials have provided good evidence for the efficacy of some physiotherapy practices and demonstrated the ineffectiveness of others (Herbert et al 2001, Maher 2000). There is strong evidence that simple interventions such as “reassurance” and “advice to return to normal activity as soon as possible” can prevent the development of chronic low back pain (Herbert et al 2001) and that “functional restoration programs” (Schonstein et al 2001) can produce a clinically worthwhile reduction in disability and handicap associated with chronic low back pain. Additionally, clinical practice guidelines (National Health and Medical Research Council 1998, Waddell and Burton 2000) suggest that encouraging workers to remain at or return to work following a back pain episode at work, is more likely to reduce disability than passive treatments.

Back pain continues to be a frequent and costly occurrence. Statistics from WorkCover (WorkCover Authority NSW 2000) indicate that there has been a stable trend in the last eight years, of back injuries accounting for 30% of the cost of all workplace injuries, with a gross incurred cost of $203 million for 1998/99. While the combined cost of physiotherapy and chiropractic for all conditions accounted for only 2.4% ($60,466,000) of all payments in 1998/1999, there has been an 7.5 fold increase in these costs in the last decade, a rate of increase much greater than that of medical treatment (2.9 fold; WorkCover Authority NSW 2000). Following an assessment of selected claimants' physiotherapy costs from January 1997 to June 1999, WorkCover concluded that “the communication between physiotherapists and insurers was generally inadequate for insurers to have a good understanding of the reason for continuing treatment, or expected period of continuation” (WorkCover Authority NSW 1999b, p. 15). Accordingly, the cost and quality of physiotherapy services has become an area of interest for WorkCover.

In January 1997, WorkCover introduced the Notification of Commencement Form (NOC). This form was designed in consultation with the Australian Physiotherapy Association NSW Branch (APA) and was introduced to provide insurers with additional information regarding physiotherapy treatments (WorkCover Authority NSW 1999a). The WorkCover publication entitled A Physiotherapist's Guide to WorkCover NSW specifically states that physiotherapists “must be able to demonstrate to the insurer that [physiotherapy] intervention is in part assisting the worker to return to work” and that the insurers require the information included in the NOC forms “in order to determine whether the proposed treatment is reasonably necessary” (WorkCover 1999a, p. 19). This same publication includes detailed information on how to fill in the “Goals of treatment” section of the form and gives specific examples on treatment goals relating to symptoms
Physiotherapists were required to submit the NOC form to insurers with their first monthly account. In June 2001, WorkCover replaced the Notification of Commencement form with the Physiotherapy Plan (http://www.workcover.nsw.gov.au/pdf/physio.pdf). Physiotherapists are required to submit this new form to insurers if they anticipate that more than 10 treatments will be provided. The old NOC form and the new Physiotherapy Plan are similar in that they both require physiotherapists to state goals of treatment and to estimate the number of treatments to be provided, and therefore this study is relevant to both the old and the new systems of physiotherapy reporting to WorkCover.

The purposes of this study were to:

i describe the quality of goals of treatment provided to insurers by physiotherapists for workers with back pain using guidelines provided by WorkCover;

ii compare the physiotherapists’ prognoses with prognoses indicated by clinical practice guidelines; and

iii make recommendations about the communication system between physiotherapists and insurers.

**Method**

We examined retrospectively all 219 NOC forms submitted to a large NSW workers’ compensation insurer in the period July 2000 to January 2001, for workers coded by the insurer as suffering from back pain. All NOC forms were de-identified by the insurer prior to the analysis.

Two authors independently categorised goals of treatment listed on the NOC forms as: physical; symptoms; return to work (RTW); or not a goal. By “physical” we mean goals that relate to physical impairment and functional tasks such as range of motion, strength or walking tolerance, by “symptoms” we mean patients’ reported problems such as pain or inability to sleep; and by “RTW” we mean any goal that specifically indicates return to work duties.

<table>
<thead>
<tr>
<th>Goal Category</th>
<th>Goal 1</th>
<th>Goal 2</th>
<th>Goal 3</th>
<th>Total frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms</td>
<td>163(75)</td>
<td>33(17)</td>
<td>9(7)</td>
<td>205(37)</td>
</tr>
<tr>
<td>Physical</td>
<td>42(19)</td>
<td>128(64)</td>
<td>58(41)</td>
<td>228(41)</td>
</tr>
<tr>
<td>Not a goal</td>
<td>12(5)</td>
<td>22(11)</td>
<td>38(27)</td>
<td>72(13)</td>
</tr>
<tr>
<td>Return to work</td>
<td>1(1)</td>
<td>16(8)</td>
<td>35(25)</td>
<td>52(9)</td>
</tr>
<tr>
<td>Total</td>
<td>218(100)</td>
<td>199(100)</td>
<td>140(100)</td>
<td>557(100)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal Category</th>
<th>Precise</th>
<th>Measurable</th>
<th>Time-specific</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>74(32)</td>
<td>19(8)</td>
<td>4(2)</td>
</tr>
<tr>
<td>Symptoms</td>
<td>73(36)</td>
<td>34(17)</td>
<td>24(12)</td>
</tr>
<tr>
<td>RTW</td>
<td>24(46)</td>
<td>21(40)</td>
<td>19(37)</td>
</tr>
<tr>
<td>Not a goal</td>
<td>3(4)</td>
<td>2(3)</td>
<td>2(3)</td>
</tr>
<tr>
<td>Total</td>
<td>173(31)</td>
<td>75(13)</td>
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</tbody>
</table>

Each goal was then scored on a dichotomous scale (yes/no) according to whether it was precise, measurable and time-specific. A goal was considered “precise” if the body area or part treated was specified. For example, goals such as “relieve pain” and “increase muscle strength” were categorised as imprecise, whereas “relieve leg pain” or “increase trunk muscle strength” were coded as precise. A goal was coded as measurable when it contained information on current and predicted patient status that would allow a decision as to whether there had been a change in patient status at follow-up and to what extent the goal had been reached. Examples of such goals are “decrease leg pain from 6/10 to 1/10” or “increase lifting tolerance from 5 kilograms to 10 kilograms”, or “increase sitting tolerance from 5 minutes to 30 minutes”. Time-specificity was coded “yes” when an indication was given about the time frame within which the goal was to be achieved. These definitions were derived from information provided to all physiotherapists by WorkCover to assist them in completion of the NOC forms. These three elements - precision, measurability and time-specificity - are considered essential elements for high quality treatment goals. The two raters agreed on 81.6% of all goal decisions. Disagreements were resolved by consensus between the two authors. Areas of disagreements related mostly to the interpretation of definitions of categories of treatment goals.

Additional information collected from the NOC forms studied included: worker’s year of birth, gender, occupation, area(s) treated, date of injury, date of commencement of physiotherapy, prior physiotherapy, period between date of injury and commencement of physiotherapy, anticipated RTW status, and estimated duration of treatment.
Data relating to the number of weeks of paid incapacity, defined as the number of weeks the insurer made partial or total disability payments to the worker, and cost of physiotherapy treatment, defined as the total amount paid by the insurer to the treating physiotherapist, for each worker was supplied by the participating insurer. This data represents the amounts paid by the insurer up to the date of data collection.

Approval for the study was obtained from the Human Ethics Committee, The University of Sydney.

Results

Demographic characteristics In the sample of workers studied, mean (SD) age was 38.2 (11.4), the mean number of days from date of injury to first physiotherapy treatment was 22.8 (55.1), mean cost of physiotherapy treatment was $601 ($522), and the mean duration of paid incapacity was 6.0 weeks (8.1 weeks). Fifty-eight per cent of workers studied were males.

Pain category The back pain of 165 (75%) treated workers was classified as acute (defined as less than of symptomatic days), 32 (15%) were classified as sub-acute (between of symptoms) and 13 (6%) were chronic (more than of symptoms). Nine (4%) workers could not be classified because the information provided by physiotherapists on the NOC forms was inadequate.

Goals of treatment The 219 NOC forms provided a total of 557 goals (Table 1), with 218 (99.5%) forms specifying at least one goal of treatment, 199 (91%) at least two goals, and 140 (64%) at least three goals.

The majority (75%) of first goals of treatment were classified as symptoms (Table 1), whereas the majority (64%) of second and third (41%) goals of treatment were classified as physical with the largest percentage (25%) of RTW goals being included in the third goal.

Table 1 presents frequencies and percentages of the three goal categories and indicates that most goals (41%) referred to physical impairments (alone or in combination with other goals) such as “increase range of movement”. Only 9% of goals incorporated RTW. Examples of these are “return to suitable duties by 6/52”, or simply “return to work”. Thirteen per cent of nominated “goals” could not be classified as goals, as these statements described treatments to be provided, for example “advice on home program”, “support neck and relative rest”, or “stabilise for ligament strain using SIJ belt”.

The qualitative scoring of goals provided on the NOC forms studied indicated that the majority of forms were not precise, measurable or time-specific. Table 2 indicates that while 31% of physiotherapists provided precise goals of treatment, only 9% provided a time-specific framework in which to achieve these goals.

Prognostic information The NOC forms require physiotherapists to estimate the time frame and the number of treatments to be provided. The majority of NOC forms [133 (61%)] estimated that treatment would be of short duration, completed in less than six weeks. Within this short period, 27 NOCs (20%) indicated that patients would require between one and eight treatments; 79 (59%) nominated nine to 16 treatments; 25 (19%) nominated 17 to 24 treatments; and only two (2%) nominated more than 25 treatments.

Seventy-seven NOC forms (35%) had been completed by physiotherapists who estimated the duration of treatment to fall in the medium term (seven to 12 weeks). Fifty eight (75%) of these were for workers in the acute phase of their condition. In this medium term category, the 16 to 30 treatments box was the most frequently endorsed (47%), followed by 31 to 45 treatments (28%) and 1 to 15 treatments (21%). Only 4% ticked the more than 46 treatments box.

Discussion

WorkCover has provided some information to assist physiotherapists in the completion of the NOC forms, mostly by way of examples (WorkCover Authority NSW 1999a). This information is more extensive for the new Physiotherapy Plan (WorkCover Authority NSW 2001).

This study provides some indirect evidence that physiotherapists are aware of the publication A Physiotherapist’s Guide to WorkCover NSW (WorkCover Authority NSW 1999a). This is reflected in the fact that the majority of first goals of treatment were symptoms, followed by physical findings and then RTW, in accordance with examples given in this publication. However, most physiotherapists in this study did not provide precise, measurable or time-specific treatment goals despite these features being emphasised in this same publication. This finding supports WorkCover’s assertion that the quality of information provided by physiotherapists to insurers is inadequate. Insurers need information on measurability and time-specificity for all treatment goals. More importantly, information on the RTW goal is essential as this provides insurers with guidelines regarding salary replacement and treatment costs. Physiotherapists provided better quality information relating to physical and symptom findings than on RTW goals. The discrepancy in priorities of treatment between physiotherapists’ more clinical perspective and insurers’ more pragmatic goals underlies the identified problem in communication between the two groups. Kenny (1995 and 1999) highlighted the need for the development of shared goals and clear communication channels between stakeholders in the injury management process.

Although WorkCover provides clear instructions and examples for physiotherapists to follow in their publication (WorkCover Authority NSW 1999a), WorkCover places the RTW goal last in both the examples section and in the title
of the goals of treatment box on the NOC form, perhaps giving the impression to physiotherapists that goals of treatment relating to reported symptoms and physical findings are more important than RTW goals. This approach has been improved on the new Physiotherapy Plan that has replaced the NOC form, in which specific instruction is given to the physiotherapist on the form, to “detail progress of treatment and RTW goals (symptoms, physical findings and function).” However, “function” is placed third after “symptoms and physical findings”. The new Guide (WorkCover Authority NSW 2001) gives notes to physiotherapists on how to complete the Physiotherapy Plan to justify past and future treatments. However, the example given (p. 31) is unfortunate, because it includes a prognostic factor (disc lesion on MRI) that is not evidence-based, treatment that is not evidence-based (massage and laser), and there is not a clear link between the physical impairments cited and the RTW goal. WorkCover examples given in the Guide could be modified to better reflect evidence-based practice.

Some physiotherapists may be reluctant to indicate RTW goals on their treatment plans because they do not believe that achieving RTW is an integral part of their physiotherapy role. These physiotherapists may assume that, by focusing their treatments on decreasing symptoms such as pain and reversing physical impairments such as reduced range of movement, a return to work would automatically follow. There is currently considerable evidence that this is not the case, as pain, impairment and disability are only weakly linked (Waddell and Burton 2000). Additionally, clinical practice guidelines (National Health and Medical Research Council 1998, Waddell and Burton 2000) suggest that encouraging workers to remain at or return to work, even if they have residual or recurrent symptoms, is more likely to lead to recovery than some traditional physiotherapy treatments (eg heat) that focus on symptomatic relief.

The WorkCover guide explicitly states: “The proposed treatment must have an outcome focus. It must clearly explain how treatment will assist the injured worker to return to work or to stay at work” (WorkCover Authority NSW 2001, p. 6). Such information would be helpful to doctors (should this information be passed on to them) who may be more confident, on the advice of the treating physiotherapist, to upgrade workers’ fitness for work on medical certificates.

Another potential explanation for the poor quality of treatment goals is that currently, WorkCover does not reimburse physiotherapists for completing these forms. We do not find this explanation compelling because we noted similar problems with the old WorkCover Review Forms, for which reimbursement was provided. While we have not formally studied Review Forms, as we have here studied NOC forms, our experience is that in many cases the information provided is not of high quality and there is an emphasis on pain and physical impairments rather than on function and RTW. We therefore conclude that remuneration alone will not improve the quality of reporting and that an education package must form part of the remedial action. In this regard we are pleased to note that WorkCover has commenced educational courses on outcomes in 2002.

This study also showed that for the majority (61%) of NOC forms studied, physiotherapists predicted that the duration of treatment needed would be less than six weeks. Physiotherapists predicted that amongst the workers with an acute condition, 145 (88%) would require between one and 30 treatments. This pattern of treatments is supported by evidence that suggests that most workers with low back pain can continue or return to work within a few days or weeks of onset of symptoms (Waddell and Burton 2000). The fact that 12% of all workers studied, who were in the acute phase of their condition, were estimated by their physiotherapist to need more than 30 treatments over a period of seven to 12 weeks is of potential concern. Further research is required to fully understand why physiotherapists would plan to treat for extended periods contrary to best practice guidelines.

Conclusions and recommendations

The majority of physiotherapists included in this study predicted patterns of treatment that are concordant with practice guidelines. The treatment plans we reviewed were typically of low quality and would not achieve their intended purpose of allowing improved communication between treating physiotherapists and insurers. Future research needs to establish the cause of this problem so that appropriate interventions or practice requirements can be developed to effectively change reporting practices. One way of achieving this would be to interview both physiotherapists and insurance companies regarding the reasons for some poor practices. Improvement of physiotherapy communication practices should be based upon strategies that combine appropriate undergraduate education and multifaceted strategies that include an assessment of barriers to change for graduate physiotherapists. The Physiotherapy Plan currently used by physiotherapists should be changed to better reflect communication priorities with insurers.

Acknowledgment

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References


