

Submission to the Legislative Council Legal and Social Issues Committee Inquiry into claims made through the Transport Accident Commission (TAC)

Submitted by: Optometry Australia

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1. Introduction

Optometry Australia (OA) welcomes the opportunity to make a submission to the Inquiry into claims made through the Transport Accident Commission (TAC).

This submission primarily addresses **term of reference (1), processes around legitimate claims, including disputed claims**, and secondarily **term of reference (3), private provider discretion to set fees exceeding the Medicare Benefits Schedule rate**. OA does not seek to comment on the full operation of the TAC scheme, nor on the merits of individual claims. Rather, this submission is directed to process issues affecting access to timely, appropriate optometric care for TAC clients.

OA is the national peak professional body for optometrists representing over 8 in 10 Victorian optometrists. OA supports members in understanding funding, regulatory and professional obligations, and regularly receives enquiries about third-party payer arrangements, including TAC-funded care for Victorian optometrists.

2. Why optometry is relevant to this inquiry

Optometry is plainly part of the TAC treatment pathway. TAC's published optometrist guidance states that TAC can help pay for optometric consultations, computerised perimetry, spectacle glasses and contact lenses, replacement glasses damaged in a transport accident, and some equipment. TAC's public policy on optical, orthoptic and optometry services also confirms that these services sit within the TAC treatment framework.

TAC's published guidance further indicates that, within the first 90 days after a transport accident, optometric treatment and services may be funded without prior approval where the treatment is recommended by a health professional, related to the accident injury and delivered in line with the Clinical Framework. Beyond 90 days, TAC approval is required, and where a client has not received treatment for 6 months, approval is again required before further treatment will be paid.

Given this published framework, the way TAC processes optometry-related claims is directly relevant to an inquiry examining legitimate and disputed claims.

3. Issues raised with OA by Victorian members

OA has recently received several enquiries from Victorian optometrists describing uncertainty and inconsistency in TAC decision-making for optometry services and prescription eyewear following transport accidents.

The issues reported to OA include:

- inconsistent outcomes for similar requests
- uncertainty about whether particular optical items and treatments are being assessed as standard prescription eyewear or as non-established, new or emerging treatments and services (NeNETS)
- limited visibility of the criteria being applied to those requests
- delayed or unclear payment for consultations or investigations that members believed had been approved or indicated as covered
- uncertainty about what documentation, evidence threshold, or approval pathway applies when a request extends beyond an initial period of funding.

OA acknowledges that these accounts are member-reported and that TAC may have information not available to OA in relation to individual matters. For that reason, this submission does not invite the Committee to reach conclusions on any single case. Instead, OA submits that the reported pattern points to a broader process issue: where policy boundaries and decision criteria are not sufficiently visible to providers, there is increased risk of inconsistency, confusion, delay, and dispute.

4. Need for clearer boundaries between standard optometric care and NeNETS

A key issue emerging from member enquiries is the apparent uncertainty around when TAC treats an optometry-related request as part of ordinary prescription eyewear or clinically indicated optometric care, and when it treats a request as a non-established, new or emerging treatment or service.

TAC's published NeNETS policy states that TAC will consider funding non-established, new or emerging treatments and services only in exceptional circumstances, and that requests must be supported by strong clinical evidence of safety and efficacy. The policy further states that, where decisions from bodies such as MSAC, MBS, PBAC or similar do not exist, consideration will only be given where a medical practitioner provides strong clinical evidence, identified as NHMRC Level 1 or 2 evidence, and where the treatment is required following a reasonable trial of available established treatments and services.

OA does not take a position in this submission on the merits of any individual product, lens design, tint or therapy. However, OA submits that there is a substantial practical difference between:

- a framework in which providers can readily identify in advance which requests are treated as standard optometric care and which are treated as NeNETS, and
- a framework in which that boundary is unclear, communicated inconsistently, or only becomes apparent after a request is refused.

Where that boundary is unclear, providers may struggle to advise patients accurately, prepare requests efficiently, or understand whether the issue relates to eligibility, evidence, approval timing, or classification under a separate policy. That uncertainty is itself a process issue relevant to legitimate and disputed claims.

OA also submits that the Committee should consider whether TAC's published optometry framework provides sufficient clarity when compared with other Australian compensating schemes, including the Department of Veterans' Affairs (DVA). DVA's public materials demonstrate that a compensating scheme can publish a more detailed and transparent framework for optical appliances, lens options, prior approval items and certain eye-related investigations. DVA's Pricing Schedule for Visual Aids expressly itemises a range of optical appliances and lens features, including photosensitive lenses, progressive and high-index progressive lenses, grind prisms, tint, UV coating, sunglasses items, and non-schedule lens, frame and prism items subject to prior financial authorisation.

By contrast, TAC's public optometry materials clearly cover consultations, computerised perimetry, spectacles, contact lenses and replacement glasses, and TAC's published optometry fee schedule includes consultation items, contact lens items, computerised perimetry, low vision assessment and children's vision assessment. However, TAC's public optometry-facing materials do not appear to set out an equivalent itemised framework for common optical features or appliances such as prism, tint, photosensitive lenses, UV-type coatings, or non-standard prism or lens requests.

This comparison is relevant not because OA suggests TAC should mirror DVA funding settings, but because it illustrates that a comparable Australian scheme may recognise some clinically indicated optical appliances, lens features and related investigations within an ordinary published funding framework or prior approval pathway. In those circumstances, it is important that TAC clearly explain when and why a similar request is instead treated as non-established, new or emerging.

Where a scheme publishes only broad categories, without clearly identifying the practical boundaries of cover, providers and patients may be left uncertain as to whether a request is being considered as standard prescription eyewear, a clinically justified optical appliance, or a request requiring a higher evidence or approval threshold. OA's recent member enquiries suggest that this lack of clarity may be contributing to inconsistent outcomes and avoidable disputes.

5. Timeliness, written reasons and provider-facing clarity

OA submits that a well-functioning TAC claims process for optometry should enable providers and clients to identify, at the outset:

- what services and items are ordinarily within scope
- when prior approval is required
- what information must accompany a request
- what policy basis applies where a request is declined in full or in part
- what review or escalation pathway is available.

At present, TAC's published materials confirm the broad funding framework for optometry, including the 90-day approval trigger, the 6-month gap rule, fee schedule arrangements and the existence of the NeNETS policy. However, OA's recent member enquiries suggest that providers may still lack a single practical source of truth explaining how those rules apply in common optometry scenarios.

OA also notes that TAC's client-facing information states that treatment is paid at the TAC rate and that, where a provider charges more than the TAC rate, the client may need to pay the difference as a gap payment. In most cases, TAC states it is unable to reimburse that gap payment. OA submits that where approval processes are unclear or delayed, and where fee gaps may arise, the result can be additional uncertainty and potential barriers to timely care for injured Victorians.

6. Recommendations

OA respectfully recommends that the Committee consider recommending that TAC:

1. Publish a consolidated provider-facing optometry guidance document

This should bring together, in one place, current funding rules, approval triggers, exclusions, documentation requirements, and links to the relevant policies and fee schedules.

2. Provide clearer written reasons for decisions

Where a request is declined or only partly approved, TAC should clearly identify the policy basis for the decision, including whether the request was assessed as ordinary optometric care, equipment, or a NeNETS request.

3. Clarify the application of the NeNETS framework to optometry-related requests

Providers should be able to understand when an optical item, treatment, or investigation will be assessed under NeNETS, what evidence threshold is expected, and whether any change in TAC's interpretation or practice has occurred and from when.

4. Improve timeliness and transparency around payment of approved services

Where consultations or investigations have been approved, or providers have been advised they are covered, payment pathways should be timely and transparent, with a clear escalation point where payment is delayed.

5. Review whether fee settings and gap exposure create access barriers

TAC's published arrangements contemplate gap payments where provider fees exceed TAC rates. The Committee should consider whether this creates affordability barriers for some TAC clients in accessing necessary optometric care.

7. Conclusion

OA's submission is modest in scope. It does not ask the Committee to resolve the clinical merits of individual treatments or products. Rather, OA asks the Committee to consider whether TAC's current processes for optometry-related claims are sufficiently clear, consistent, transparent and timely.

Where a statutory compensation scheme includes optometry within its treatment framework, providers and injured clients should be able to understand what is covered, when approval is required, what evidence is needed, why a request has been refused, and how to resolve disputes efficiently. OA submits that improvements in these areas would better support legitimate claims and reduce avoidable uncertainty for both clinicians and TAC clients.

OA would welcome the opportunity to provide further information, including de-identified case examples, should that assist the Committee. We would also be happy to assist with development of any guidance documents if helpful.

Yours sincerely,

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