Workers Compensation
independent review office

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ANNUAL REPORT 2016 - 2017

The Workers Compensation Independent Review Office 2016 –17 Annual Report has been prepared in accordance with the relevant legislation for the Hon. Victor Dominello MP.

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18 December 2017

The Hon. Victor Dominello MP
Minister for Innovation and Better Regulation
Parliament House
Macquarie Street
Sydney NSW 2000

Dear Minister,

In accordance with section 27C of the *Workplace Injury Management and Workers Compensation Act 1998*, I have pleasure in submitting, for your information and presentation to Parliament, the Annual Report of the Workers Compensation Independent Review Officer for the period from 1 July 2016 to 30 June 2017.

Yours sincerely,

Kim Garling
Workers Compensation Independent Review Officer

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INDEPENDENT REVIEW OFFICER'S MESSAGE

This year has been busy and productive with particular challenges to be met and important and ambitious new projects either implemented or commenced.

WIRO is the only Government entity dedicated solely to oversight and scrutiny of the workers compensation scheme. The information WIRO receives from its functions enables the office to be at the forefront of any emerging issues.

WIRO has handled 22,000 complaints and inquiries since its inception 5-years ago with the WIRO Solutions Group solving innumerable worker problems by communicating directly with insurers and preventing the issues from escalating.

WIRO's Solutions Group success has been possible through the support from insurers to find solutions. Achieving quick results for workers before the complaints become legal disputes is a unique service provided by no other organisation. It often involves a patient unravelling of facts and requires a sound knowledge of the complicated legislation and Guidelines.

The scheme is increasingly complex as the result of the 2012 changes, due to the amendments and the interaction of the legislation with the Regulation and Guidelines. The well-documented and various difficulties arising from having different types of insurer decisions and the resulting dispute resolution pathways is but one example.

Further complications arise because not everyone injured at work is subject to the 2012 reforms, including coal miners, police officers, paramedics, firefighters and volunteers.The legislation's complexity makes it essential that those providing advice and assistance, legal and otherwise, have the necessary knowledge and experience.

A significant development this year has been the publication in March 2017 of the report of the Legislative Council's Standing Committee on Law and Justice ("SCLJ") entitled "First Review of the Workers Compensation Scheme". The report followed the SCLJ's review of the scheme which commenced in August 2016 with two public hearings in November. The SCLJ has played an important role in oversighting the workers compensation schemes in NSW.

Its recommendations following its review of the functions of the WorkCover Authority in 2014 played some part in the 2015 legislative reforms by which WorkCover was abolished and three new agencies assumed its roles - the State Insurance Regulatory Authority ("SIRA"), Insurance and Care NSW ("icare") and SafeWork NSW. I was pleased and encouraged that several recommendations made by WIRO and other stakeholders were taken up by the SCLJ in its recent report.

These included a recommendation relating to possible amendment of section 322A of the *Workplace Injury Management and Workers Compensation Act 1998* ("WIM Act") to allow up to two assessments of permanent impairment for certain injuries prone to deterioration.

A useful recommendation was made with respect to the metrics currently used to measure return to work rates and the need for clearer data. The SCLJ accepted that these rates should not be capturing workers who, for example, have returned to work for just an hour or who simply no longer receive workers compensation payments.

Most significant were the SCLJ's recommendations with respect to the need for an overhaul of the current bifurcated dispute resolution system which has been the subject of widespread and well documented stakeholder complaints since the 2012 legislative reforms. The SCLJ recommended the establishment of a "one stop shop" forum for the resolution of all workers compensation disputes and further recommended that the Government consider the benefits of developing a more comprehensive specialised personal injury jurisdiction in NSW.

I am pleased that the Government has already acted on this recommendation with the commencement of a consultation process, led by the Central Policy Office in the Department of Finance, Services and Innovation, to develop options to deliver this one stop forum.

Major challenges have arisen in the last year due to the impending commencement of operation of section 39 of the *Workers Compensation Act 1987*("1987 Act") from September 2017. This section, introduced as part of the 2012 reforms, provides for the termination of weekly benefits after 260 weeks unless an injured worker has a degree of permanent impairment of greater than 20%. The operation of this section will affect thousands of workers, some of whom have been in receipt of compensation for many years preceding the 2012 changes. The WIRO has devoted much time and effort into minimizing, as much as is possible, the effects of the provision by trying to ensure that affected workers know what is happening and are aware of their rights. WIRO's initiatives in this regard are discussed later in this report.

The situation is complicated by the interaction of various sections of the workers compensation legislation, in particular section 322A of the WIM Act which provides that a worker is entitled to only one medical assessment, necessary to determine a worker's level of permanent impairment. In practice this means that some workers may not be entitled to a further assessment or some may lose the opportunity to claim other benefits if they elect to see whether they are eligible for the continuation of weekly benefits after 260 weeks.

The Government published the *Workers Compensation Amendment (Transitional Arrangements for Weekly Payments) Regulation 2016* in December 2016, which is retrospective but only applies to workers in receipt of weekly payments immediately prior to 1 October 2012. The Regulation is helpful for this category of injured worker only, who are able to have one further assessment of their permanent impairment for the purposes of section 39.
It also means an insurer is able to accept that a worker has a permanent impairment of more than 20% without the need to obtain a binding Medical Assessment Certificate to that effect.

I am proud of the progress this office has made in the last year in terms of the transformation of our service delivery, improved data analysis and its contribution to better policy and our engagement with new startups and scale ups across the innovation and entrepreneurship ecosystem.

Finally, I would like to thank all members of the WIRO team who work diligently and enthusiastically every day to assist injured workers in NSW. This office would be unable to function as successfully as it does without such commendable individual effort.

K A Garling
Workers Compensation Independent Review Officer

ABOUT THIS REPORT

Welcome to our Annual Report for the period from 1 July 2016 to 30 June 2017.

This Report provides a comprehensive account of how this office has carried out its statutory functions set out in section 27 of *the Workplace Injury Management and Workers Compensation Act 1998* ("WIM Act") and detailed below.

Section 27C obliges the Independent Review Officer to provide an Annual Report which is to include the following information:

(a) the number and type of complaints made and dealt with under this Division during the year,

(b) the sources of those complaints,

(c) the number and type of complaints that were made during the year but not dealt with,

(d) information on the operation of the process for review of work capacity decisions of insurers during the year and any recommendations for legislative or other improvements to that process,

(e) such other information as the Independent Review Officer considers appropriate to be included or as the Minister directs to be included.

As well as reporting on the activities of this office's Solutions Group, which deals with the complaints mentioned above and the WIRO procedural review of work capacity decisions, the Report also provides information on the work of the ILARS team, the Operations Group and the Employer Complaints team. Recommendations are made with respect to problems and issues identified by the various WIRO teams.

The Report includes an update on various WIRO initiatives including its very popular educational seminars and advancements with respect to its data collection and analysis.

Finally, the Report contains comments on continuing friction points in the scheme not covered earlier in the Report, which is important information falling within the parameters of section 27C(4)(e).

ABOUT WIRO

Our functions

The NSW Government established the WorkCover Independent Review Office ("WIRO") in 2012 as part of its reform of the state's workers compensation scheme. As the result of legislative changes effective on 1 September 2015 our name changed to the Workers Compensation Independent Review Office.

We are still known as WIRO.

The statutory functions of the office, set out in section 27 of the WIM Act are:

(a) to deal with complaints made to the Independent Review Officer under this Division,

(b) to review work capacity decisions of insurers under Division 2 (Weekly compensation by way of income support) of Part 3 of the 1987 Act,

(c) to inquire into and report to the Minister on such matters arising in connection with the operation of the Workers Compensation Acts as the Independent Review Officer considers appropriate or as may be referred to the Independent Review Officer for inquiry and report by the Minister,

(d) to encourage the establishment by insurers and employers of complaint resolution processes for complaints arising under the Workers Compensation Acts,

(e) such other functions as may be conferred on the Independent Review Officer by or under the Workers Compensation Acts or any other Act.

In addition WIRO manages the Independent Legal Advice and Review Service ("ILARS") which funds the legal and associated costs for workers to determine their entitlements to compensation and where necessary to challenge decisions of insurers (other than work capacity decisions).

WIRO also runs an extensive education program for various scheme stakeholders.

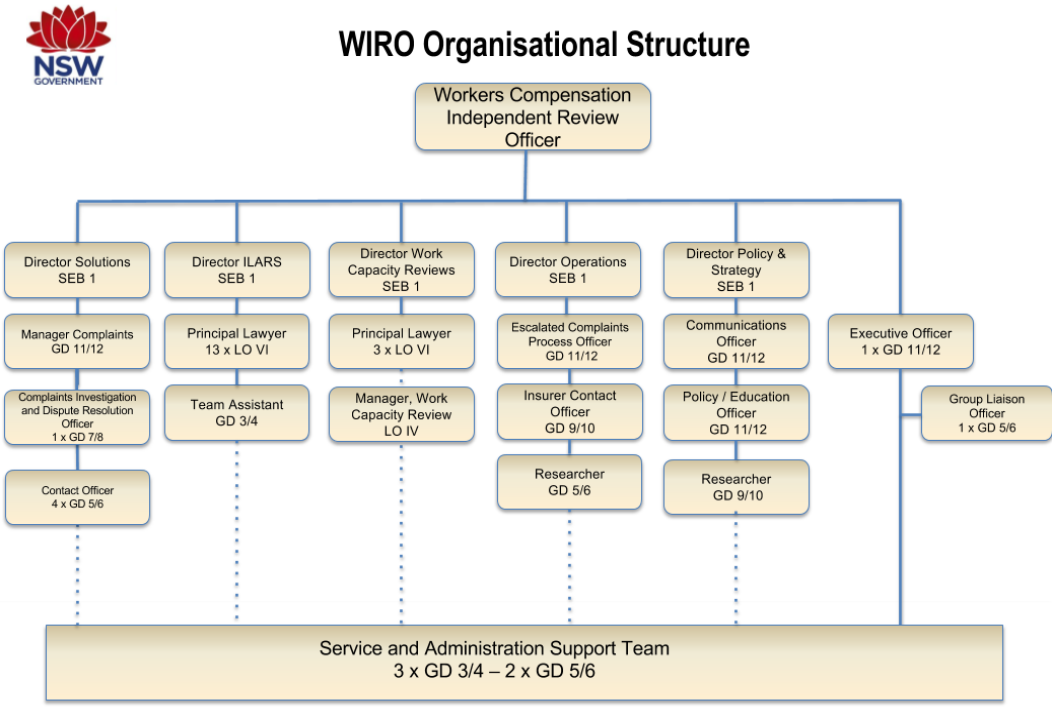
Our structure

WIRO is a small office with 37 staff as at 30 June 2017 headed by the Independent Review Officer ("IRO"). WIRO's functions are performed in the following way:

- The Solutions Group consisting of a team of 8 considers and seeks a solution to complaints made by workers about insurers.
- WIRO has a Director whose dedicated role is to carry out procedural reviews of work capacity decisions.
- The Employer Complaints Group deals with complaints from employers about insurers and attempts to resolve them and encourage complaint resolution processes.
- The Independent Legal Assistance and Review Service ("ILARS") consists of 15 specialised workers compensation lawyers who consider applications from ILARS approved lawyers for legal assistance for injured workers.
- The Policy and Strategy team which is responsible for the development of all policy recommendations, engagement, education and communication with WIRO stakeholders.

The structure of WIRO at 30 June 2017 is shown in Figure 1.

Figure 1



Our leadership – Executive Management

Kim Garling – Independent Review Officer

Kim Garling is a long serving member of the legal profession who has throughout his distinguished career made significant contribution to law reform in New South Wales. Kim is a past president of the Law Society of NSW. He was an instrumental driving force in the reform of NSW Young Lawyers as a separate entity of the Law Society and in the establishment of Law Week, which celebrated its 30th year in 2013. Kim is currently the Chair a Legal Aid Review Committee of the Legal Aid Commission of NSW and has been a member of this committee since 1981.He was a member of the Judicial Committee of the Australian Rugby Union for 15 years.

Wayne Cooper – Director Work Capacity

Wayne Cooper commenced in the Workers Compensation field at the former Government Insurance Office in May 1987. In the intervening period he worked mainly in private practice as both a barrister and a solicitor, before going to the former WorkCover Authority. In 2013 he started at WIRO and more than 680 procedural reviews of work capacity decisions have taken place in that time.

Jeffrey Gabriel – Director Solutions

Jeffrey Gabriel is an accredited specialist in personal injury law. He has been employed by WIRO since January 2013. Prior to that, Jeffrey was a solicitor in private practice where he acted for both claimants and insurers in a range of personal injury jurisdictions in New South Wales.

Paul Gregory – Director ILARS

Paul Gregory joined the WIRO office on 2 October 2012. He was given the task of developing and implementing the ILARS scheme. Paul holds a Master's degree in Law from the University of Sydney. During his career he has been the Managing Partner of 2 city based mid-tier law firms and for a time was Senior Vice President of international sports management company IMG.(Paul retired in July 2017)

Phil Jedlin – Director Operations

Phil Jedlin is responsible for looking after employer/insurer complaints, WIRO's IT and finance functions, data analysis and reporting and process improvement projects. Prior to starting at WIRO in November 2012, Phil spent 22 years at the CBA in a wide range of roles covering money market and equity dealing, product development, process improvement, project and change management. He was fortunate to have senior roles in both CommSec in its early days and in the implementation of CBA's CRM system – CommSee. After he left CBA Phil completed the requirements to be admitted as a practising lawyer.

Maria MacNamara – Acting Director Policy & Strategy

Maria is responsible for the Policy and Strategy functions at WIRO which incorporates education, communication and engagement with WIRO's stakeholder groups. Prior to joining WIRO, Maria was the Head of Strategy and Engagement for the Australian Government's Digital Transformation Agency. She has spent over 25 years advising legal and accounting firms in the transformation of underperforming practices. Maria co-founded the Awesome Women's Project and the Ecosystem Leaders' Lunch, and sat on the advisory board delivering the Women in Fintech initiative at Stone & Chalk. She is a non-executive director of The Spark Festival and the Australia-Israel Chamber of Commerce.

Our values and goals

WIRO is able to carry out its statutory functions, which include advising on ways to ensure the best system for a fair and just compensation scheme for injured workers, with a strategy which includes:

- continuous review of the compensation processes
- driving the adoption of advanced technology
- recommending reforms
- managing disputes cost effectively
- funding claims for legal assistance for injured workers

At the heart of our values are the values of the NSW public sector. These values are integrity, trust, service and accountability. Further information is available here.

In addition to adopting these public sector values WIRO has developed its own values which we feel represent our staff and what the WIRO office stands for. WIRO's values are:

- independence – we are impartial, fair and just
- innovation - we find new and better ways of solving problems
- respect – we are generous, polite and honest
- collaboration – we work together harmoniously and focus on building unity
- accessibility – we encourage direct contact by stakeholders

We are successful when:

- we have an innovative, fair and efficient compensation scheme
- we have a well - respected process for the early resolution of disputes
- we have achieved a reduction in the funding of future legal claims
- we drive an earlier return to health program
- there is a high awareness and satisfaction among the WIRO stakeholders

THE SOLUTIONS GROUP

Background

Section 27(a) of the WIM Act provides as follows:

> The Independent Review Officer has the following functions:
>
> (a) to deal with complaints made to the Independent Review Officer under this Division

Section 27A of the WIM Act provides:

> 27A Complaints about insurers
>
> (1) A worker may complain to the Independent Review Officer about any act or omission (including any decision or failure to decide) of an insurer that affects the entitlements, rights or obligations of the worker under the Workers Compensation Acts.
>
> (2) The Independent Review Officer deals with a complaint by investigating the complaint and reporting to the worker and the insurer on the findings of the investigation, including the reasons for those findings. The Independent Review Officer's findings can include non-binding recommendations for specified action to be taken by the insurer or the worker.
>
> (3) The Independent Review Officer is to deal with a complaint within a period of 30 days after the complaint is made unless the Independent Review Officer notifies the worker and the insurer within that period that a specified longer period will be required to deal with the complaint.
>
> (4) The Independent Review Officer may decline to deal with a complaint on the basis that it is frivolous or vexatious or should not be dealt with for such other reason as the Independent Review Officer considers relevant.

It became apparent shortly after the office commenced operations on 1 October 2012 that the real demand was not for the office to conduct the traditional investigations of an "ombudsman" with a report produced about each matter, but rather to achieve a fast and satisfactory outcome for the worker who was often in a vulnerable position.

A protocol was established with insurers in which they agreed to respond to a "preliminary enquiry" about a particular claim within two business days of WIRO making contact, following a telephone or email request for assistance from the worker or the worker's representative. All such communications from workers are dealt with promptly and personally by members of the Solutions Group.

It is the experience of the Group that this protocol response time is met in almost all cases due to the cooperation that WIRO receives from each insurer in endeavouring to find a solution rather than strenuously defending their decision. The WIRO Solutions Group and the IRO meet regularly with insurers to ensure ongoing cooperation and open communication between WIRO and insurers.

WIRO also assists with enquiries from workers which involve a request for information or guidance with respect to a claim.

The Solutions Group also works directly with the ILARS Group to ensure that, where appropriate, disputes are resolved expeditiously without the need for the workers compensation scheme to incur unnecessary legal costs.

While each of icare, its claims managers (Scheme Agents) and SIRA all have provision for “complaints” to be made about the conduct of claims, they do not have the statutory function of this office. Each of these “complaints services” operates under different principles which do not allow for a transparent reporting of the reasons for the complaints and the systemic issues which may arise.

Another effect of having multiple complaint agencies is that the data collected cannot be aggregated to obtain a clear picture of the performance by insurers.

Some of the documents issued by insurers inform injured workers that they must first contact the insurer before contacting WIRO. These statements are untrue and misleading as every worker has the right and entitlement to contact WIRO at any time and raise concerns about the conduct of their claim.

In November 2016 WIRO commenced the publication of the monthly on line *Solutions Brief* which delivers to subscribers relevant statistics, updates, information and case studies. All editions are also available on the WIRO website.

Number and type of complaints

Between 1 July 2016 and 30 June 2017 WIRO received 2,750 complaints and 3,157 enquiries.

Some of the complaints made to WIRO raised multiple issues which explains why the total in Figure 2 below exceeds the number of complaints above. During the year WIRO updated the issues used to categorise complaints and enquiries so that they better reflected the nature of injured workers' grievances. This explains the expanded list below. Some issues were only used for complaints during calendar year 2016.Other issues were used for complaints during calendar year 2017.

Figure 2

ISSUE OF CASE	RECEIVED		
	2016	**2017**	**GRAND TOTAL**
Communication	104	1	105
Delay	159		159
Denial of Liability (S.74 Notice)	79		79
IME	21	1	22
Incorrect Calculations	7		7
Medical costs	80	1	81
Medical treatment	214	1	215
Rehabilitation	73		73
Weekly Benefits	472	5	477
Work Capacity (general)	50		50
WPI	33	1	34
Insurer management of claim	56		56
Issues Relating to Liability	127	3	130
Non-Compliant Worker	1		1
S39 Matter	1	50	51

ISSUE OF CASE	RECEIVED		
Stay	1		1
Denial of Liability - s74 Notice	1	149	150
Weeklies - incorrect payment amount/PIAWE		131	131
Communication (Can't contact insurer/insurer not returning calls)		148	148
Rehabilitation/RTW		175	175
ILARS enquiry/worker complaint re lawyer		2	2
Medico Legal Examination/WPI		67	67
Delay in determination of Liability		287	287
Payment, reimbursement of Medicals/Travel expenses	1	300	301
Work Capacity/Stay	1	32	33
Weeklies		296	296
Delay in Payment under COD or Settlement		108	108
Suspension of benefits/Non-compliant worker		12	12
PIAWE - Incorrect calculation of wages	1		1
Grand Total	1482	1770	3252

Source of complaints

In the vast majority of cases the injured worker contacts WIRO direct by telephone rather than through the website or email to make a complaint or make an enquiry. WIRO records details of how injured workers were referred to WIRO.

Figure 3

SOURCE	NUMBER	%
Lawyer	1949	71%
Web search	331	12%
Insurer	115	4%
Word of Mouth	86	3%
icare/SIRA	69	3%
Union	58	2%
Other source	42	1%
Doctor	38	1%
Rehabilitation Provider	31	1%
WIRO Campaign	12	0%
Government Department	9	0%
Workers Compensation Commission	8	0%
Employer	2	0%
Total	**2750**	

Number and type of complaint not dealt with

At the beginning of the reporting year WIRO had 45 complaints which had been received but not finalised. At the conclusion of the reporting period WIRO had 87 outstanding complaints. The types of complaints which WIRO had not dealt with at the conclusion of the year are set out in Figure 4. Complaints outstanding at the end of the year were finalised within 30 days.

Figure 4

ISSUE OF CASE	NUMBER OF CASES
Communication (secondary issue only)	1
Delay in determining liability	24
Delay in payment	5
Denial of liability	10
Medico Legal Examination/WPI	2
Payment, reimbursement of Medicals/Travel expenses	11
PIAWE	1
Rehabilitation	2
RTW	7
S39 Matter Fast Track	1
Weeklies	12
Weeklies - incorrect payment amount/PIAWE	9
Weekly Benefits	1
Work Capacity Decision	1
Grand Total	**87**

Complaints finalised

The Solutions Group finalised 2,708 complaints in the period to 30 June 2017. More information including the types of issues dealt with is found in Appendix 1.

WIRO aims to resolve complaints within two business days. The majority of complaints received are finalised within seven days. There were 27 complex complaints which took longer than 30 days to finalise.

The Data Advantage

The Solutions Group collates information from each complaint and enquiry received. Each complaint and enquiry is logged on a central database. From this database we can sort complaints by issue, time and insurer. WIRO is able to identify if particular insurers have a propensity to receive complaints about certain issues over others. We have used this data when meeting with insurers as an educative tool. Feedback from insurers has been positive in this regard. WIRO's data has had a tangible effect on training programmes at insurers.

As the first point of contact, WIRO is also able to identify issues before they are litigated. For example, we have received hundreds of enquiries concerning the termination of weekly payments under Section 39 of the 1987 Act. This information has been published and has been used to inform icare and insurers about best practice when notifying workers of the effect of the section.

No Responses to Claim

The ILARS team at WIRO will refer complaints and enquiries where insurers fail to determine claims within legislative timeframes. These matters are classified as No Response to Claim (NRTC). Before ILARS commits to funding proceedings to commence in the Workers Compensation Commission, WIRO tries to ascertain the insurer's position in relation to a claim or dispute. This informs ILARS as to the merits of a claim. In some cases, our enquiries obviate the need for proceedings to commence because it is discovered that a counter offer was made or a claim was accepted. This means a speedier resolution for the parties to a claim or dispute as well as costs saving to the scheme. Broadly speaking, there are three types of failures to determine:

1. Failure to determine a claim for lump sum compensation within two months.
2. Failure to determine a claim for weekly payments and/or medical expenses within 21 days.
3. Failure to respond to a request for a review of a dispute notice within 14 days.

The figure below sets out the number of NRTC matters WIRO opened during 2016-17 and the type of resolution to these matters.

Figure 5

PRIMARY OUTCOME							
SECONDARY AND TERTIARY OUTCOMES	NO RESPONSE TO CLAIM	NO RESPONSE TO REVIEW REQUEST	NO RESPONSE	SPECIAL INQUIRY	NOT RECORDED	NRTRR SETTLED	GRAND TOTAL
Claim accepted or counter offer accepted - no funding required	144						144
Counter offer issued	92						92
Claim accepted or counter offer accepted - no funding required		15					15
Claim already determined, response already issued	156	44					200
Claim accepted or counter offer accepted - no funding required	27	0					27
Claim disputed	97	44					141
Counter offer issued	32						32
Claim disputed	1	1					2
Decision Issued after our inquiry	229	77					306
Claim disputed	220	77					297

PRIMARY OUTCOME							
Counter offer issued	9						9
Insurer within timeframes to make a decision	158	2					160
No claim received	52	7					59
No Response - Insurer not in a position to issue a response, delay	85	1					86
No Secondary and Tertiary Outcomes	4		3	4	43	15	69
Delay	1						1
Not MMI	3						3
Not on Risk	7						7
Grand Total	**932**	**147**	**3**	**4**	**43**	**15**	**1144**

Systemic Issues

The table in Figure 2 above identifies the number and type of complaints WIRO received from injured workers about insurers. From this data, we have identified a number of matters which highlight systemic issues within the workers compensation scheme concerning insurer behaviour and flaws in legislation. WIRO has achieved numerous successes in these areas as the examples show. However, the case studies also demonstrate an opportunity for legislative reform and/or increased cooperation by the regulator.

(a) Responses to Initial Notifications of Injury

WIRO receives a significant number of claims from injured workers where insurers have failed to commence weekly payments within seven days of initial notification of injury.

Section 267 of the WIM Act obliges an insurer to commence provisional weekly payments of compensation within seven days of an initial notification of injury. The penalty for failing to commence weekly payments within seven days is a fine of up to 50 penalty units, pursuant to section 267(5).

Notwithstanding the above, an insurer is released from their obligation to commence provisional payments of weekly compensation if they have a reasonable excuse for not commencing those weekly payments. There are published Guidelines about what constitutes a "reasonable excuse" not to commence payments. Reasonable excuses include insufficient medical information or questions about whether the injured person is a "worker" for the purpose of the Acts.

Section 268 of the WIM Act obliges an insurer within seven days of an initial notification of injury to notify a claimant in writing that the insurer has a reasonable excuse for not commencing weekly payments. The penalty for failing to notify a worker in writing that weekly payments have been reasonably excused is a fine of up to 50 penalty units.

The justification for these statutory obligations is self-evident. It is important for workers to receive a prompt response to their claims at a time when they are injured and suffering a loss of income. Injured workers are often vulnerable at this time. Prompt responses allow injured workers to make arrangements to manage their affairs in the event of an adverse decision. For example, workers are better informed to obtain legal advice. In the case of provisional payments, a response within seven days provides workers with financial and medical support at a time of need which helps facilitate a prompt return to work.

An insurer's notification of reasonable excuse or their decision to commence provisional payments is usually the first correspondence an injured worker receives from an insurer. These responses are extremely important as they set the tone for all the engagements that follow. In the context of a claim that is likely to be open for several months or over a year, it is important to cultivate a relationship of trust between insurers and injured workers.

Despite the obligations to respond and the important role first impressions play in the ongoing management of a claim, WIRO is not satisfied with the volume of complaints we receive concerning an insurer's failure to respond to claims within seven days of initial notification as required by the legislation. WIRO understands that the financial penalties are not enforced by SIRA for breaches of these provisions, despite numerous complaints and reports from injured workers and their representatives.

The following case study is an example of an insurer not responding to a claim within seven days.

> *"A car detailer suffered an injury at the workplace. It appears that standing in puddles of soapy water aggravated blisters in his foot which became infected. The worker was hospitalised from 10-13 January 2017. While in hospital, part of the worker's foot had to be amputated. The worker reported the injury to his employer on 18 January 2017 and that day the employer notified the insurer.*
>
> *The worker received no response from the insurer within seven days of 18 January 2017. On 1 February 2017, the worker submitted a Certificate of Capacity to his employer, which the employer forwarded to the insurer on 14 February 2017. On 22 February 2017 the insurer notified the worker it was reasonably excusing the claim due to a lack of medical information. This was the first response the worker had received from the insurer, some 35 days after the insurer was initially notified about the injury.*
>
> *WIRO raised a preliminary inquiry asking why the insurer had failed to respond within seven days of initial notification. The insurer responded saying that since the claim had been made as "notification only," on 18 January 2017 benefits were not paid.*
>
> *WIRO advised the insurer that there does not appear to be any provision in the Guidelines for "notification only" and that when the insurer is notified of a claim they shall commence paying provisional weekly benefits, issue a reasonable excuse notice or determine liability within seven days. The insurer had not done any of these.*
>
> *WIRO reiterated that the Guidelines state that if a reasonable excuse notice is not provided within seven days of notification, the worker is entitled to provisional payments. The insurer maintained a Certificate was required. WIRO responded that legislation does not state that a certificate of capacity is a requirement.*
>
> *Upon receipt of this response, the insurer agreed to make the provisional payments on 14 March 2017, nearly two months after the insurer was first notified of the injury.*

The above conduct runs contrary to the wording and intention of sections 267 and 268 of the WIM Act. The injured worker, already dealing with partial amputation of his foot, was not informed about the insurer's response to the claim in a timely manner. This deprived him of the opportunity to obtain support and advice at an early stage to manage his affairs. Further, the insurer's early conduct is likely to lead to a breakdown in trust which may make the worker less willing to engage with the insurer in helping to return to work.

The case study below is also from the same insurer. This complaint was raised several months after the first complaint.

> *"The worker's lawyer contacted WIRO. Her client was allegedly indecently assaulted in the workplace. A claim was made for psychological injury on 14 June 2017 but no response had been provided as at 25 June 2017. WIRO contacted the insurer who confirmed the claim was reported by the employer via telephone on 14 June 2017 and marked by the insurer as notification only. The insurer also stated the claim form itself was not*

received until 22 June 2017. The insurer maintained they had until 29 June 2017 to make a decision regarding provisional liability.

WIRO suggested that the legislative obligation to respond to a claim within seven days relates to the date of notification, not the date a claim form was submitted. Neither the legislation or Guidelines refer to an initial notification as relieving the insurer of their duty pursuant to s267 of the 1998 Act with respect to provisional payments.

The Guidelines also state that if a notification is not considered complete, the insurer is to request the specific information required from the employer and the worker within three business days. In response the insurer provided several definitions from the claims technical manual marking the claim as code 12, meaning no action was required.

The insurer admitted they changed from code 12 to code 1 resulting in the need for a provisional liability decision by 29 June 2017. WIRO responded that regardless of how the claims technical manual requires an insurer to report their data, there remains a legal obligation to respond within seven days of notification. It had been two weeks since notification of an indecent assault and no action had been taken.

WIRO queried why code 12 was entered. That is, how the insurer determined that a report of indecent assault on 14 June 2017 caused them to conclude at the time that no further action be taken. The insurer replied on 29 June 2017 stating that provisional payment of medical expenses would be made and that the worker needed to submit a Certificate of Capacity, after which the insurer had 21 days to determine a claim for weekly payments.

WIRO responded that a certificate of capacity did not need to be provided and referred to the insurer's obligations under s267 of the 1998 Act. The insurer at this stage was nine days outside the timeframes. Upon receipt of this, the insurer agreed to commence provisional weekly payment, backdated to 21 June 2017."

WIRO is of the view that the insurer's handling of this notification of injury was below standard. The responses in these two case studies were almost identical. In each case, injured workers who suffered traumatic experiences were not provided with swift responses and support at a time of high vulnerability. This is contrary to the purpose of s267 and s268 of the 1998 Act.

(b) Production of Medical reports

WIRO receives several complaints each week from injured workers or their lawyers about insurers failing to provide them with medical reports in connection with their claim.

There are very limited circumstances where the legislation mandates that insurers provide copies of medical reports to injured workers. Section 126 of the WIM Act provides for access in certain circumstances as follows:

126 Copies of certain medical reports to be supplied to worker (cf former s 134)

(1) In this section:

insurer means a licensed insurer or a former licensed insurer.

medical report, in relation to an injured worker, means a written report by:

(a) a medical practitioner by whom the worker has been referred to another medical practitioner for treatment or tests related to the injury, or

(b) a medical practitioner who has treated the injury, or

(c) a medical practitioner who has been consulted by a medical practitioner referred to in paragraph (a) or (b) in connection with treatment of, or tests related to, the injury.

(2) The regulations may make provision for or with respect to requiring an employer or insurer in possession of a medical report relating to an injured worker to provide a copy of the report to the worker, the worker's legal representative or any other person, if the worker's claim is disputed.

(3) If an employer or insurer fails to provide a copy of a report as required by the regulations under subsection (2):

(a) the employer or insurer cannot use the opinion or report to dispute liability to pay or continue to pay compensation or to reduce the amount of compensation to be paid and cannot use the report for any other purpose prescribed by the regulations for the purposes of this section, and

(b) the report is not admissible in proceedings on such a dispute before the Commission, and

(c) the report may not be disclosed to an approved medical specialist or an Appeal Panel in connection with the assessment of a medical dispute under Part 7 of Chapter 7.

There are several reasons why a worker may need to request copies of medical reports from the insurer. Many injured workers have misplaced reports provided to them from time to time over the life of their claim. Requesting these reports from individual doctors and medical treatment providers can be time consuming and expensive. The insurer is the only source of a worker's collated medical records relating to their claim.

If a claim is denied, access to medical reports will assist workers and their representatives to assess whether to dispute the insurer's decision. Even where liability is not disputed, access to medical reports allows solicitors to advise workers about any future entitlements they have available to them under the legislation.

Section 126 above is the provision most commonly cited by injured workers and their representatives when requesting medical reports from insurers. However, the requirement to provide that information exists only "if the worker's claim is disputed."

In many cases, information is requested when liability is not disputed and insurers are correct at law when they refuse to supply reports. However, this attitude may not facilitate the efficient management of a claim. Without access to all medical reports workers or their representative will often make flawed claims. These flawed claims lead to disputes, which then trigger the operation of Section 126 and compel the insurer to release the reports requested in the first place.

The following case study provides a good example:

> *An injured worker's solicitor wrote to the insurer requesting medical reports in accordance with section 126 of the WIM Act. The insurer declined the request on the basis that there was not a current dispute. The solicitor then wrote to WIRO, noting that the worker was involved in a serious motor vehicle accident in 2013 which resulted in a serious brain injury. As a result his memory was extremely poor and he was unable to recount any information about his prior claims.*
>
> *WIRO wrote to the insurer who acknowledged the requirement for a claim to be disputed under section 126. WIRO made further submissions noting that although the insurer's position was correct at law, the injured worker's traumatic injury and loss of function meant he did not retain sufficient details about his claim to instruct his lawyers. The reports were required in order to assist his representatives in advising him of his entitlements. In light of these special circumstances, WIRO requested the insurer to reconsider its decision. In response the insurer agreed to provide the requested documents.*

This case study demonstrates the success of WIRO's non-confrontational approach. It also highlights a flaw in the legislation. While the insurer's refusal to provide medical reports requested was correct at law this response would have had several undesirable consequences. A vulnerable worker would have been made to go through the time and expense of contacting individual service providers, if he could remember who they were. Further, there could have been a delay in his receipt of accurate legal advice about his entitlements, since the content of medical reports can inform such advice. Finally, it is possible that without access to certain medical reports, any advice given could have been inadequate.

To their credit, many insurers are cooperative and elect to supply reports even when liability is not disputed. However, this generosity is not universal or absolute and insurers often make exceptions. For example, an insurer may be less inclined to provide reports relating to a claim that is twenty years old and where a large volume of records are not digitised.

Some injured workers have the option of making an application under the *Government Information (Public Access) Act* 2009 (GIPA). This avenue can be more expensive and time consuming than requesting documents from the insurer by way of a simple letter or email. Further, the option of a GIPA request is not always available. For example, claims managed by private sector self-insurers are outside the scope of GIPA.

WIRO understand this issue was raised in submissions to the SCLJ review of the workers compensation scheme. In the interests of facilitating better advice for injured workers and a swifter resolution of claims, consideration should be given to legislative reform which encourages the exchange of information and medical reports. Such reform would minimise disputes and improve the experience of injured workers and other stakeholders in the scheme. Claims data is increasingly being stored on digital platforms which will make it cheaper and easier to store and disseminate records and minimise the cost of such a reform.

(c) Calculation of Pre Injury Average Weekly Earnings

The 2012 amendments introduced the concept of pre injury average weekly earnings ("PIAWE") as the basis upon which weekly payments are calculated. PIAWE is defined in Sections 44C-44I of the 1987 Act. Further, Section 44C makes reference to Schedule 3 of the 1987 Act, for further expansion of the definition of PIAWE. It is uncontroversial to say that the definition of PIAWE and the resulting calculations required are much more complex than the pre 2012 concept and requirements with respect to current weekly wage rate.

Insurers are required to determine a worker's PIAWE within seven days of being notified of an injury. To assist insurer case managers, icare issued a 88 page PIAWE handbook, which demonstrates the difficulties of the calculations involved.

WIRO receives many complaints from injured workers questioning the insurer's calculation of PIAWE. Since weekly benefits, a significant component of many claims, are a function of PIAWE, there is considerable reported anxiety surrounding these complaints. The number of complaints WIRO receives about PIAWE is a reflection of many factors:

1. The complexity of the definition means insurers must take many steps to determine PIAWE. This increases the opportunities for a mistake to arise.

2. Insurers are required to obtain wage material from employers and determine PIAWE within seven days. This short turnaround means insurers often report great difficulty obtaining wage information within the timeframes which compromises the quality of the PIAWE decisions made.

3. The material requested of an employer is not always readily available. Consider the definition of relevant period contained in Section 44D(1)(a) of the 1987 Act. It states:

> **44D Definitions applying to pre-injury average weekly earnings—relevant period**
>
> (1) Subject to this section, a reference to the relevant period in relation to pre-injury average weekly earnings of a worker is a reference to:
>
> (a) in the case of a worker who has been continuously employed by the same employer for the period of **52 weeks immediately before the injury**, that period of 52 weeks (Emphasis added)

The definition is not as straightforward as requiring an employer to provide the payslips for the 52 most recent pay periods. Unless a worker is injured on the same day as their pay period ceases, insurers cannot just rely on those payslips.

For example, if a worker is injured on a Friday but their pay period ceases on a Wednesday, the relevant period could require assessment of 53 weekly payslips.

Furthermore, the insurer would need to obtain siphon income from the 1st and 53rd weeks to exclude any income received for work outside the relevant period of "52 weeks immediately before the injury." This information is often not readily provided by employers within seven days.

4. Section 43(1)(d) of the 1987 Act classifies a decision concerning the amount of PIAWE as a work capacity decision. Section 44BF of the 1987 Act contains a general prohibition against workers obtaining paid legal advice in relation to disputing work capacity decisions. The effect of Section 44BF has been partially curbed by a regulation allowing for payment of legal costs for merit review. However workers must still navigate the initial internal review process unassisted by lawyers and WIRO undoubtedly will continue to receive complaints about PIAWE calculations.

The difficulties surrounding the concept of PIAWE are well known across the workers compensation industry. As part of the 2015 amendments, a provision was created allowing the *Workers Compensation Regulation 2016* to vary the method by which pre-injury average weekly earnings (PIAWE) are calculated. The provision has not yet commenced operation.

Unfortunately, there has been no progress concerning amendments to PIAWE calculations. Submissions closed in April 2016 and a PIAWE forum attended by key stakeholders was held in December 2016. In our opinion, this is an area of the legislation that requires urgent attention.

The WIRO Solutions Group have received training from icare and the CFMEU's internal expert concerning the calculation of PIAWE and are able to play a positive role in settling disputes about PIAWE as demonstrated in the case study below:

> *The worker contacted WIRO stating that she works two jobs for a total of 21.7 hours per week. However, her PIAWE had been calculated with respect to time lost for work with only one employer, even though she is unfit to work for both employers. WIRO suggested to the insurer that the worker's PIAWE and weekly benefits ought to be calculated pursuant to Item 8 of Schedule 3 of the 1987 Act, as the worker was employed for 21.70 hours per week in total and the ordinary hours as specified in her EBA is listed as 38 hours per week.*
>
> *The insurer agreed that they had mistakenly classified the worker under Item 4, when her PIAWE ought to be calculated pursuant to Item 8, which states that:*
>
> > *"the worker's pre-injury average weekly earnings are the worker's average ordinary earnings expressed as an amount per hour for all work carried out by the worker for all employers multiplied by: (a) the prescribed number of hours per week, or (b) the total of the worker's ordinary hours per week, whichever is the lesser."*
>
> *The insurer recalculated the worker's PIAWE and determined that the worker was owed weekly benefits of an additional $961.45 per week.*

WIRO's involvement delivered a significant weekly benefit for the worker at no cost and demonstrated the expertise of the Solutions Group team in this complex area.
It could have taken several months for a worker, without the assistance of a lawyer, to achieve this outcome, if at all. Many injured workers do not have the ability to understand several sections of complex legislation and apply them to their circumstances.

The next example demonstrates the complexity surrounding PIAWE calculations and other fundamental problems with the work capacity decision review process:

> *The worker was told by her insurer that she had been overpaid and that they (the insurer) would be required to make deductions from her future weekly benefits to recover the overpayments. The worker was told her PIAWE was overstated and her benefits overpaid as she had been working a second job while receiving weekly benefits.*
>
> *The worker disputed the insurer's narrative. She stated she had two pre-injury employers, but that she was only incapacitated for one of these jobs. The worker stated her PIAWE had been calculated with reference to her first employer, and she was very concerned about having to pay back the insurer when her second job had not even been included in the original PIAWE calculation. WIRO sought clarification about the PIAWE calculation from the insurer.*
>
> *Having established that the worker indeed was only incapacitated for one job and not two, WIRO asked the insurer why the PIAWE was not calculated in accordance with Item 7 of the Schedule, and her second employer earnings should be deducted from the combined PIAWE from both roles. The insurer responded agreeing that PIAWE ought to be calculated in accordance with Item 7. The worker's PIAWE was thus increased from $1,144.51 per week to $1,678.50 per week.*

As a result of WIRO's intervention, the worker received an increase in weekly benefits of over $500 per week. This result was delivered swiftly and without cost to the worker. We note that there is some uncertainty about whether this resolution was legally accurate, although it maximised the worker's recovery, due to unclear directions in the icare PIAWE handbook. Unfortunately WIRO cannot determine whether SIRA has dealt with this issue at Merit Review because the Merit Review Service does not publish their decisions. This issue is discussed later in this Report.

(d) Independent Medical Examination Locations

From time to time, an insurer will request the worker attend an independent medical examination for the purpose of reviewing a worker's entitlement to compensation or managing their return to work. WIRO receives many complaints from injured workers located in regional NSW concerning the venues for these appointments. Workers in regional areas often need to travel several hours to attend these examinations. This impacts a worker's ability to carry out domestic duties, such as child minding. The travel itself may also exceed what their doctor says is reasonable in relation to the injury suffered. The case study below raised both of these issues:

> *An injured worker living in northern NSW contacted WIRO concerning a medical appointment arranged by her insurer. The venue for the appointment was a 90 minute drive away from her place of residence. The worker protested she was unable to attend the IME for 3 reasons. First, the time of the appointment did not allow for her to arrive home in time to pick up her first child from school. Secondly, the travel to the appointment was along a winding road the worker had previously been cautioned against driving on due to the aggravation it may cause her shoulder injury. Finally, the worker's second child had special needs and she would need to take him with her as she could not arrange a carer nearby.*
> *WIRO discussed alternate travel locations with the worker. She confirmed that a medical appointment in the Gold Coast region of Queensland would be a better option if available. It was a shorter drive along better roads and the worker would be able to arrange care for her second child at this location. WIRO liaised with the insurer who agreed to change the IME appointment. They wrote to the worker with a list of three*

alternative doctors, each located in the Gold Coast-Tweed Heads region. The worker was then able to choose a day on which both of her children had alternate care arrangements.

This example demonstrates WIRO's significant role as an intermediary in many disagreements between workers and insurers. Lawyers are unable to provide assistance with these problems and complaints as they do not relate to a specific denial of benefit. It would also be uneconomical to pay lawyers to get involved in such matters.

WIRO encourages insurers to take a more innovative approach to organising medical examinations in order to minimise travel. For example, insurers could try using video conferencing technology by which a worker attends their GP who contacts a specialist via video link. The specialist will question the worker via video. If physical tests are required, the specialist instructs the GP to conduct physical examinations and report results. This method of examination, where appropriate, will reduce travel expenditure considerably and cause less inconvenience to injured workers.

(e)Travel to and From Medical Examinations

Section 125 of the WIM Act relates to a worker's entitlement to recover expenses and lost earnings incurred as a result of attending medical examinations at the request of insurers or the Workers Compensation Commission ("Commission"). It states:

> **125 Reimbursement of worker for loss of wages and expenses associated with medical examination (cf former s 133)**
>
> (1) If a worker is required to submit himself or herself for examination pursuant to this Division, the worker is entitled to recover from the worker's employer, in addition to any compensation otherwise provided:
>
> (a) the amount of any wages lost by the worker by reason of so submitting himself or herself for examination, and
>
> (b) the cost to the worker of any fares, travelling expenses and maintenance necessarily and reasonably incurred in so submitting himself or herself.

Many injured workers complain to WIRO that insurers refuse to pay for travel expenses in advance, instead preferring to reimburse workers after the medical examination has taken place.

The legislation refers to "reimbursement" suggesting there is no obligation on the insurer to prepay travel expenses. This is problematic because workers being referred for medical examinations at the request of the insurer or the Commission are often suffering financial hardship. Their claim may have been disputed or they are in receipt of benefits that are less than their pre-injury average weekly earnings. They have less disposable income than they would have had but for the injury.

The following case study is typical of the complaints WIRO receives surrounding this issue:

An injured worker's lawyer contacted WIRO. They advised the insurer was in the process of assessing a claim for permanent impairment. The worker had been referred to the Approved Medical Specialist after proceedings had been commenced in the Workers Compensation Commission. The insurer advised the worker they were unwilling to pay for travel costs upfront. The worker lived in regional New South Wales and had to travel some distance to the appointment. The worker was very distressed, citing financial hardship for his inability to pay for travel and await reimbursement. After WIRO made a preliminary inquiry raising the issue of the worker's financial hardship, the insurer revisited the worker's request and arranged the worker's travel to the appointment with the Approved Medical Specialist.

The insurer's understanding in this matter was most welcome. They could have held their ground in accordance with the legislation but this would have caused delay in the determination of the dispute. To their credit, most insurers are prepared to prepay travel expenses when the need arises but this is not consistent across all insurers. Many insurers cite the risk that they may expend funds in advance and then a worker will refuse to attend the appointment.

In order to minimise disputes and facilitate a swifter resolution of claims, WIRO recommends clarification of this provision to encourage prepayment of travel expenses to medical examinations arranged at the request of the employer, insurer or the Commission.

(f) Travel to Medical Appointments

Section 60 (2) of the 1987 Act relates to an insurer's liability to pay for travel associated with medical and related treatment. It states:

> **60 Compensation for cost of medical or hospital treatment and rehabilitation etc**
>
> (2) If it is necessary for a worker to travel in order to receive any such treatment or service (except any treatment or service excluded from this subsection by the regulations), the related travel expenses the employer is liable to pay are:
>
> (a) the cost to the worker of any fares, travelling expenses and maintenance necessarily and reasonably incurred by the worker in obtaining the treatment or being provided with the service, and
>
> (b) if the worker is not reasonably able to travel unescorted—the amount of the fares, travelling expenses and maintenance necessarily and reasonably incurred by an escort provided to enable the worker to be given the treatment or provided with the service.

WIRO receives numerous complaints in relation to this provision, particularly concerning travel for persons to escort injured workers to and from medical treatment. Often the need for escorted travel arises where workers are in regional areas and need to travel to Sydney for medical treatment. Similarly, requests for travel escorts are more common shortly after the injurious event, where workers receive significant trauma.

WIRO has achieved much success in relation to this type of complaint, as the following case study demonstrates:

> *A woman contacted WIRO to advise her brother suffered a severe injury to his eye in the course of his employment. The accident occurred in Dubbo. He was transferred to Sydney via emergency air ambulance the evening of the accident and then operated on the next morning. Despite the operation, the worker was at risk of losing his eye and was still in hospital. The insurer advised the worker over the telephone that the cost of his transport back to Dubbo via aeroplane was not reasonably necessary. Further, the insurer was declining to pay for travel for the worker's mother to escort the worker back to Dubbo, even though the worker was in a fragile emotional state as a result of the trauma suffered to his eye.*
>
> *WIRO made urgent contact with the insurer. WIRO contacted the insurer pointing out section 60(2) of the 1987 Act and the severity of the worker's injuries. WIRO queried the insurer's position on travel arrangements back to Dubbo and why travel for an escort was disputed. The insurer responded advising the worker's air travel and the expenses incurred by his mother to escort him would be paid. The insurer advised WIRO the decision would be made on compassionate grounds.*

The insurer's conduct before and after the complaint was not helpful. The insurer ought to have communicated its decision to dispute liability for travel in writing, in accordance with Section 74 of the WIM Act. This would have informed the worker of the insurer's reasoning and the worker's legal rights. Non-compliance with this section is an offence under Section 283 of the WIM Act.

WIRO did not accept that the insurer made their decision to fund travel on "compassionate" grounds, as on the facts before WIRO there appeared to be a strong legal argument pursuant to Section 60(2) for these expenses to be paid.

(g) Complaints concerning the cost of medical treatment for hearing aids

Section 602C(b) – (c) of the 1987 Act allows SIRA to produce guidelines with respect to employers' liability to pay for medical treatment and services. During the reporting year, WIRO received several complaints about insurers seeking to impose their own restrictions outside the guidelines. The following case study is one example:

> *An injured worker complained to WIRO that the full cost of hearing aids he claimed were not being funded by his insurer. WIRO made an inquiry with the insurer noting that the wholesale price of the hearing aids was $2350 per aid. This was less than the $2500 maximum fee published by SIRA in the Workers Compensation (Hearing Aids Fees) Order 2017. In response the insurer said that icare undertook a tendering process in April 2016 and as a result of that tender the brand of hearing aids referred to in the claim would be at a maximum $1,750 per aid.*

While it may be appropriate for icare to use its bargaining power to lower the price of hearing aids and achieve value for the scheme, the power to set maximum fees lies with SIRA. The worker and his treatment provider were complying with the limits set by SIRA but the insurer was still disputing the costs, causing delay and anxiety for the worker. An insurer is not entitled to create its own maximum fee order.

Conclusions

The experience of WIRO's Solutions Group members and their relationship with insurers has resulted in excellent outcomes this year. Each month, hundreds of complaints and enquiries are resolved, improving the experience of claimants and educating insurers.

From this experience the Solutions Group has identified a number of areas where there can be improvement. These are summarised as follows:

1. WIRO recommends that SIRA takes a more active approach toward enforcement of penalties under Sections 267 and 268 of the WIM Act. The present "no fines" approach is not translating into improved performance for many insurers. Insurers have strict obligations to respond to claims within seven days but in a large minority of cases insurers are not complying.

2. The legislature should consider statutory reform to encourage greater dissemination of medical reports held by insurers to injured workers. A more liberal exchange of information will speed up the resolution of disputes and save the scheme money otherwise spent contacting different medical treatment providers.

3. Section 125 of the 1998 Act should be reviewed to allow for a worker's travel to be paid in advance of a medical appointment. Often injured workers do not have the means to outlay the cost of travel and await reimbursement.

EMPLOYER /INSURER RELATIONS

Section 27(d) of the WIM Act provides:

> **27 Functions of Independent Review Officer**
>
> The Independent Review Officer has the following functions:
>
> (d) to encourage the establishment by insurers and employers of complaint resolution processes for complaints arising under the Workers Compensation Acts

There is no mechanism for an employer to challenge a decision of a scheme agent about a claim from an injured worker even though the insurer's decision to accept liability or its general claim management performance can have a significant deleterious impact on the employer's business, including the level of premium paid by the employer.

WIRO made a submission (21 November 2016) to SIRA's Workers Compensation Financial and Premium Supervision Discussion Paper, which is available through the WIRO website.The submission considers the impact of claims on small 'experience rated' employers under icare's new premium model. Currently employers have an ability to appeal the calculation of the premium only. Some of the adverse impacts could be reduced if employers had a forum to resolve disputes and a common feature of employer complaints is the lack of a general dispute resolution process to address their issues.

During the year WIRO received 48 complaints and enquiries. Almost all the employers were experience rated which means that the impact of any claims will increase their premium for the next three years. The two major issues related either to the scheme agent's management of the claim (42%) or to the acceptance of liability of the claim by the insurer (25%). In both cases action or inaction by the scheme agent had a large impact on the cost of the employer's premium.

The scheme agents are not accountable to employers for their performance in managing a claim. If a claim is not managed to optimal time lines, icare's premium calculation formula for experience rated employers punishes the employer for any delays in managing the claim as the 'cost of the claim' is primarily based on weekly payments.

Common employer complaints received by WIRO include:

- The employer does not believe the injury was work related. This is more common when the injury is for a psychological claim;
- The employer is complaining that the insurer is not looking after the injured worker appropriately by either not accepting the claim or delaying payment of weekly benefits;

- The scheme agent issuing a policy for an employer then denying liability for the claim on the basis that the person was not a worker or not issuing a policy for an employer as they didn't have employees then deeming an injured person an employee when a claim is made;

- A small employer should be able to get a definitive answer from icare or its agents as to whether they need workers compensation insurance. It is not appropriate for small businesses to have to apply for private rulings from SIRA. Calls from employers asking whether they need insurance should be dealt with by a specialised unit and confirmed in writing.

- Complaints about the management of a claim include lack of communication with the employer from the scheme agent in relation to the claim, medical expenses, liability, PIAWE and return to work. Employers complain that scheme agents do not respond to emails of phone messages at all or within acceptable time frames.This leads to frustration and anger for employers who often have little experience in managing workers compensation claims.

- Late fees or penalties have been applied by scheme agents for unpaid premiums. WIRO has worked with employers and scheme agents to lodge appeals to icare seeking a refund of the fee or penalty;

- Changes in work industry classification("WIC") following a change in scheme agent resulting in a large increase in premium.

INDEPENDENT LEGAL ASSISTANCE AND REVIEW SERVICE (ILARS)

The Government announced the establishment of this Service in September 2012 and delegated its operation to the WIRO. The Service's function is to provide funding to enable injured workers to access free, independent legal advice and assistance with respect to a dispute with insurers regarding entitlements. WIRO's procedures for administering these grants are set out in the ILARS Policy found on the WIRO website.

Injured workers have a choice of their own lawyer providing that lawyer is experienced in workers compensation and has sought approval from WIRO to provide legal services to injured workers.

As at 30 June 2017 there were 822 lawyers who are WIRO approved legal service providers ("ALSPs") actively involved in workers compensation. There were also 132 barristers approved by WIRO to undertake advocacy for injured workers.

When an injured worker seeks assistance with the conduct of a claim the lawyer will take basic instructions from the worker and complete a WIRO application for a grant of funding which sets out essential facts and indicates what grant type is sought.

That application, which is lodged by email, is then considered by one of the 15 ILARS lawyers, who are all highly experienced in workers compensation practice and procedure. The ILARS lawyer will consider whether, on the basis of the information provided, it is reasonable to fund preliminary enquiries and evidence gathering to support the claim.

ILARS undertakes to assess applications and advise lawyers of the outcome within five working days. Often the response time is much quicker. Urgent applications for funding are dealt with on the same day. Applications for funding of a specific type will be prescribed a specific timeframe for response.

The grant of assistance will cover the cost of medical reports and clinical notes, as well as providing funding, in appropriate cases, for the lawyer to obtain further reports consistent with the proper conduct and preparation of the claim.

Every application requires careful attention by the responsible ILARS lawyer given the extreme complexity of the legislation and associated regulation, rules, guidelines and fee orders.

Some matters may be referred to the Solutions Group if it appears the dispute is capable of early or simple resolution. WIRO is focused on resolving disputes quickly, fairly and cheaply and we encourage lawyers to adopt the same practical approach.

To this end ILARS also adopts flexible practices including the introduction of fast track applications if required, for example, as the result of changes to legislation or judicial determinations. In November 2016 ILARS introduced a fast track application for funding with respect to advice about cessation of a worker's weekly benefits at the expiration of 260 weeks pursuant to section 39 of the 1987 Act.

For the year ended 30 June 2017 ILARS received 11,398 applications for grants of funding for legal assistance. 10,825 applications (95%) were approved.

ILARS paid out over ($35.8m) in professional fees and approximately ($16.8m) in disbursements in the year ended 30 June 2017.A full breakdown of the types of payments made and other statistical information with respect to grants appears in Appendix 2.

The Director of ILARS regularly visited law firms to discuss the firm performance in workers compensation and the performance of individual Approved Legal Service Providers within the firms.

The information obtained in the course of the funding of these claims has enabled WIRO to develop a unique and comprehensive program which utilises the data to assist lawyers to better understand their practice and their efficiency compared with other lawyers in their area or across the whole system. ALSPs are able to identify opportunities to improve performance which results in a speedier resolution of their client's claims.

The data also allows for useful analysis with respect to medical practitioners and insurers. This is discussed in more detail later in this Report.

PROCEDURAL REVIEWS OF WORK CAPACITY DECISIONS

One of the functions of the WIRO conferred by section 27 of the WIM Act is:

> (b) to review work capacity decisions of insurers under Division 2 (Weekly compensation by way of income support) of Part 3 of the 1987 Act.

Relevantly, Part 3 of the 1987 Act contains section 44BB which sets out the process by which work capacity decisions can be reviewed. WIRO may conduct a procedural review only after both internal review by the insurer and merit review by WorkCover, now SIRA.

This means that WIRO is to conduct a procedural review of a work capacity decision and may not inquire into the merits of the original decision or the merit review recommendation. An aggrieved worker may approach the Supreme Court for judicial review at any stage of the process.

Section 27C(d) of the WIM Act provides the that WIRO Annual Report must include "information on the operation of the process for review of work capacity decisions of insurers during the year and any recommendations for legislative or other improvements to that process." These recommendations appear below.

The Year in Numbers

In the reporting year from 1 July 2016 to 30 June 2017 WIRO conducted 122 procedural reviews of work capacity decisions. As at 30 June 2017 there were 2 applications outstanding or in-progress. More detailed statistics are found in Appendix 4.

Trends

The overall trend is now showing that insurers comply with the legislation, the Regulation and the Guidelines, making it less likely for workers to succeed with overturning work capacity decisions on procedural grounds.

TOTAL RECOMMENDATIONS	WORKER SUCCESSFUL	WORKER UNSUCCESSFUL
122 (100%)	22 (18%)	100 (82%)

3 applications did not result in a recommendation.

In the previous year [2015-2016] workers had a success rate of 39%.

New Guidelines and 'substantial compliance'

New *Guidelines for claiming workers compensation* ("new Guidelines") came into force on 1 August 2016. The new *Guidelines* introduced the concept of "substantial compliance." On page 6 the new Guidelines say:

> *If a worker or insurer provides information or takes action that is substantially compliant with these guidelines, but is a technical breach of these guidelines, then the information or action remains valid unless a party has, as a result of that breach:*
>
> - *been misled*
> - *been disadvantaged, or*
> - *suffered procedural unfairness.*

This has had the predictable effect of making it harder for workers to succeed in challenging work capacity decisions on procedural grounds.

Judicial Review by the Supreme Court of New South Wales

The Supreme Court has inherent jurisdiction to oversee the administration of justice and this includes the scrutiny of decisions made by insurers and public servants which impact on the rights of injured workers. In the reporting year there were two cases brought by workers seeking to challenge work capacity decisions (and consequential section 44BB reviews). Both plaintiffs failed.

In *Hallmann v The National Mutual Life Association of Australia Ltd* [2017] NSWSC 151 the court had to consider the right of an insurer to make a work capacity decision in the absence of evidence that a worker either did or did not have what would now be called high or highest needs (at the time of the original work capacity decision, the relevant term was "seriously injured worker," which reflected a whole person impairment (WPI) of greater than 30%). Wilson, J determined that an insurer could make a work capacity decision, and in certain circumstances was required by the legislation to make a work capacity decision, *unless* it was satisfied that a worker suffered WPI of greater than 30%. The onus of proof falls on the worker, not the insurer. Relevantly, her Honour said:

> 40. The plaintiff asserts that, to make a determination that a worker is not a seriously injured worker[1] the insurer must be positively satisfied that the worker's whole person impairment is not more than 30%. This, however, inverts the language of the provision. What is required is a state of satisfaction that the degree of permanent impairment is likely to be more than 30%.
>
> 41. The insurer is entitled, and in specific instances required, to conduct a work capacity assessment unless "satisfied" that the level of impairment "is likely to be more than 30%."
>
> ……..
>
> 43. It is not necessary for the decision-maker to reach a state of satisfaction about the worker's level of impairment as a prerequisite to the conduct of a work capacity assessment.

[1] Now described as "a worker with highest needs."

In *Bhusal* v *Catholic Health Care* [2017] NSWSC 838 (23 June 2017) the Supreme Court (per Button, J.) determined that:

(i) the word "must" in section 44BB(3)(a) of the *Workers Compensation Act* 1987 is to be construed as mandatory;

(ii) section 44BB(3)(a) is a prohibition or qualification on the exercise of power, not a pre-condition to the exercise of power; and

(iii) the date of receipt by a worker of a work capacity decision (or any subsequent decision in the review process) is not a "jurisdictional fact" determinable by the Court *de novo* in the course of a judicial review.

Section 44BB(3)(a) of the 1987 Act is in the following terms, relevantly highlighted:

> (4) The following provisions apply to the review of a work capacity decision when the reviewer is the Authority or the Independent Review Officer:
>
> (a) an application for review **must be made within 30 days after the worker receives notice** in the form approved by the Authority of the insurer's decision on internal review of the decision (when the application is for review by the Authority) or the Authority's decision on a review (when the application is for review by the Independent Review Officer),

The worker had signed an application for merit review in which she stated that she had received the insurer's internal review decision on 2 May 2016. The application for merit review was dated 7 June 2016, being more than 30 days after the stated date of receipt of the internal review, and therefore out of time. SIRA had declined to conduct a merit review for this reason. WIRO also declined to conduct a procedural review, since no merit review had occurred.

In the course of the judicial review proceedings the worker sought to introduce evidence that the date of 2 May 2016 was a mistake, and that she had in fact received the internal review decision on 2 June 2016, only five days prior to the application for merit review. The worker argued that SIRA, bound by the rules of procedural fairness, had an obligation to check with her that the date was correct before dismissing her application.

In the course of the Court's decision his Honour made the following observations:

> 44..... as a matter of statutory interpretation, I consider that the use of the word "*must"* is indeed mandatory in the true sense. I think one should take that word at face value. I also think it important that Parliament could have created some sort of ameliorative ancillary regime if it had wished to; it did not.

The issue of "*jurisidictional fact*" arose for consideration for the first time in this case and was dealt with as follows:

> 39. … I was assured by senior counsel for the plaintiff (whose experience in this particular field is well-established) that the question of statutory interpretation raised in his submissions had not been the subject of judicial consideration in the past, either directly or analogously; counsel for the defendant did not gainsay that proposition.
> ……..
> 52. I consider that it follows that, unless I characterise the question of when it was the plaintiff actually received personal notice of the adverse decision as a jurisdictional fact, the disentitling decision of SIRA cannot be impugned.
>
> 53. Whether or not the effluxion of the time limit is such a fact is a matter of interpreting the statute that creates that restriction upon the exercise of jurisdiction: see *Woolworths Ltd v Pallas Newco Pty Ltd* (2004) 61 NSWLR 707; [2004] NSWCA 422 and the other cases referred to by Leeming JA, writing extra-judicially, in *Authority to Decide: The Law of Jurisdiction in Australia* (Federation Press, 2012) 65 (*Authority to Decide*). Characterisation of the precondition of compliance with the time limit as such a fact would mean, as a matter of practicality, that any adverse finding about that question by SIRA would be reviewable *de novo* by this Court in proceedings for judicial review: see the judgment of the plurality in *City of Enfield v Development Assessment Commission* (2000) 199 CLR 135; [2000] HCA 5 at [22], [38] and [50].
>
> 54. In that regard, I cannot accept that it has been the intention of Parliament, as this regime of non-curial determination of rights of injured workers to compensation has evolved, that the question raised by s 44BB(3)(a) of the Act is able to be determined curially in that way, whenever it is answered adversely by SIRA. To my mind, the whole thrust of the regime under consideration is in the opposite direction.
>
> 55. Indeed, to adopt respectfully the language used by Ward JA at [116] in a different but perhaps analogous context, I consider that to find that this Court is to determine *de novo* every dispute about compliance with s 44BB(3)(a) of the Act would have an *"extraordinarily impractical result"*: see *Insurance Australia Ltd t/as NRMA Insurance v Scott* [2016] NSWCA 138.
>
> 56. And speaking more generally, I accept that whether or not a fact is jurisdictional or not is contestable, and (as counsel for the defendant conceded) the applicable legal principles are not able to be stated with the utmost precision. Nevertheless, I approach this task of characterisation on the basis that it is a large step judicially to determine that a fact is a jurisdictional fact, and that that is a determination that one would make only very cautiously. I am not affirmatively satisfied that I should do so.
>
> 57. In short, I do not accept that Parliament intended that the question of precisely when an applicant for review of an adverse decision personally received notice of it should be a jurisdictional fact that would permit of *de novo* determination by a judge of this Court in judicial review proceedings. To adopt respectfully the contrast adopted by Leeming JA at p 64 of *Authority to Decide*, I construe s 44BB(3)(a) of the Act as constituting a *"prohibition or qualification upon the exercise of power"*, and not as a *"precondition to the exercise of power"*.

58. It follows that I reject the third basis for intervention of senior counsel for the plaintiff. It also follows that I retrospectively determine that the evidence about the topic that was placed before me, and that had not been placed before SIRA, is inadmissible.

This case is clear authority for two propositions:

(i) the time limitation in section 44BB(3)(a) will be construed strictly, since "must" admits of no discretion; and

(ii) the question of when a worker receives a document is not a "jurisdictional fact" determinable by the Supreme Court in the course of judicial review.

Salary Sacrificed Superannuation Contributions

During the reporting year it became obvious that SIRA (through its Merit Review Service) takes a different view to that taken by icare on the treatment of salary sacrificed superannuation contributions when calculating a worker's pre-injury average weekly earnings (PIAWE). SIRA seems to believe that section 44E(2) requires an insurer to exclude *all* superannuation payments from PIAWE, despite the section being in the following clear terms:

> 44E(2) A reference to ordinary earnings does not include a reference to any ***employer*** superannuation contribution. (emphasis added)

The ***PIAWE handbook*** produced by icare clearly explains at pp 30-31 that salary sacrificed superannuation contributions (that is, payments made at the election of the worker) should be distinguished from compulsory payments made by employers as a result of Commonwealth legislation. The former should be regarded as part of the worker's base rate of pay, whereas the latter is caught by section 44E(2) and should be excluded on that basis.

Payment for legal assistance

Since 16 December 2016 it has been permissible for lawyers to charge a fee for assisting workers in the course of seeking a section 44BB review. A lawyer may advise that no such review is wise and still recover a fee from the insurer. In the event of a successful merit review the lawyer might recover a higher fee ($1,800) than in the case of an unsuccessful merit review ($1,200). As at 30 June 2017 this Office is unaware of a single case in which a worker so assisted by a lawyer has sought procedural review.

Several Work Capacity Decisions as opposed to One Work Capacity Decision

The common law indicates that the merit review process should produce the "best or preferable decision." This is universally acknowledged and has been the subject of much learned scholarship over the years. Put shortly, the reviewer is to consider the totality of the case and come to the most just solution possible in the circumstances.

Despite this, SIRA continues to issue findings and recommendations from its merit review service which deliberately and expressly ignore certain elements of a worker's claim on the basis that work capacity decisions are divisible into individual elements set out in section 43(1)(a)-(f). If a worker does not refer specifically to an issue when requesting a merit review, the Authority finds its hands tied and will not consider reviewing the relevant part of the claim. This ostensibly arises from a reading of the legislation which holds that only such "decisions" as are referred for merit review can be the subject of review, and therefore a decision under section 43(1)(a) might be reviewed in complete isolation from section 43(1)(c) or 43 (1)(d), despite the pretence that a review is being done "on the merits."

The difficulty to which this approach may lead can be easily illustrated. If SIRA chooses to identify the constituent parts of decisions as "decisions" which exist independently of one another and which therefore require separate referral for review, then if a worker, possibly struggling with English and not represented by a lawyer, only complains specifically about one of those constituent parts (or "decisions") – for instance, the calculation of PIAWE – the merit reviewer might well uphold an absurd decision simply because the worker had not complained specifically about the most absurd part of the original decision – for instance the "suitable duties" identified might be completely unsuitable for a worker with the medical conditions described in the reports of the various doctors. Illustrative examples might be found in WIRO recommendations 2117 and 2217.

An anomalous consequence

Taking the approach of the Merit Review Service in relation to the supposed divisibility of decisions into account, it is intriguing to ponder what would happen were a lawyer acting for an injured worker to take the same approach. It is possible to contemplate such a lawyer giving advice about referring for merit review the decision under section 43(1)(a) on Monday, giving advice about referring for merit review the decision under section 43(1)(b) on the Tuesday, giving advice about referring for merit review the decision under section 43(1)(c) on the Wednesday, giving advice about referring for merit review the decision under section 43(1)(d) on the Thursday, giving advice about referring for merit review the decision under section 43(1)(e) on the Friday and giving advice about referring for merit review any other decision under section 43(1)(f) the following Monday. That same lawyer would be within his/her rights to send a tax invoice for $1,200 on Monday, another on Tuesday and so on for a total of $7,200 ($1,200 x 6). Of course should the merit reviewer uphold the worker's objection to the original decision, the lawyer might become entitled to $10,800 ($1,800 x 6).

Clearly the above scenario is absurd. The reason for the absurdity is that a decision to vary (or confirm) a worker's weekly payments has to be made ***as a consequence of*** the steps in section 43(1). Therefore it is a separate step in the process.

If it were contemplated that all an insurer had to do was make a decision about PIAWE and a separate decision about (say) work capacity to constitute a "work capacity decision" (perhaps two work capacity decisions in that example), it would leave a gaping hole where the consequences of those decisions should be. It is the ***consequential decision*** to vary weekly benefits (or to not vary weekly benefits, as the case may be) based on the elements set out in section 43(1)(a)-(f) which forms the subject of section 44BB review. The approach of SIRA is erroneous and should cease immediately.

Recommendation for Legislative Improvement – Work Capacity Decisions

1. WIRO recommends that consideration be given to clarifying the calculation of PIAWE when a worker had made salary sacrificed superannuation payments prior to their injury.

2. WIRO recommends that consideration be given to clarifying by legislation that a worker is entitled to have the totality of the insurer's work capacity decision reviewed by the merit review service, irrespective of the grounds of review set out in the application.

OTHER INITIATIVES

Education

A major and increasingly important function of WIRO is as an educator to various scheme stakeholders.

There has been huge support for the biannual Sydney conference, with the last event in June 2017 attracting over 650 delegate registrations including lawyers, insurers, brokers, rehabilitation providers and representatives from the regulator and icare.WIRO was delighted that the Minister for Finance, Services and Property, the Honourable Victor Dominello MP, was able to provide an opening address at the conference.

The theme of the conference, which received very favourable feedback, was the future of workers compensation in NSW. Topics included the difficult issues arising from the impending operation of section 39 of the 1987 Act and the continuing problems arising under the bifurcated dispute resolution system.

The conference also provided a useful venue for various WIRO representatives to present analyses of interesting trends and statistics revealed by WIRO's data collection and an update of WIRO policy and procedure.

In addition to the Sydney seminars a number of very well attended regional seminars for ILARS lawyers have been held. Locations, most of which have been visited twice in the last year, have included Ballina, Wollongong, Orange, Newcastle, Albury and Bathurst.

A new initiative this year has been the introduction of half day seminars for paralegals. Six such courses have been held in Sydney this year and most have been over- subscribed. These seminars have also been conducted in regional areas such as Bathurst.

The first full day seminar for insurer representatives was held in Sydney and the positive feedback suggests that further seminars will be organised.

Benefits of this educational program include increasing the standard of competency and efficiency in the scheme and providing forums for the identification of friction points in the claims and dispute resolution processes and possible solutions.

Attendees who are lawyers earn continuing legal education points and insurer stakeholders earn points from the National Insurance Brokers Association.

WIRO is able to deliver immediate updates to subscribers on important developments such as significant legal decisions or changes in legislation via its email WIRE publication, which provides a valuable educational tool.

Other online publications include the monthly Bulletin and Solutions Brief directed to lawyers and insurers. The Bulletin includes summaries of recent legal decisions in the Workers Compensation Commission or Supreme Court together with other news updates, information and trends.

The Solutions Brief includes snapshots of the types of problems resolved by the Solutions Team, for the particular benefit of insurers, in addition to updated statistics and the trends revealed.

All these publications are accessible on the WIRO website.

WIRO Website

This year WIRO has embarked on a significant update and redesign of its website to deliver a more accurate and user friendly source of information for all scheme stakeholders.

WIRO uses the Swift Digital Suite of products to send out its various announcements (for example WIRES to ALSPs), its various publications (Solutions Brief and the Bulletin), manage events and conduct surveys.

All past issues of WIRO's various publications are also available on the website, as are all work capacity procedural review decisions and annual reports.

WIRO analyses and publishes a number of metrics on performance of ALSPs and insurers.

The redevelopment work will include the introduction of a performance dashboard which will enable the public live reporting of available data and outcomes.

Technology is also being introduced to better track the popularity of particular pages on the website and to facilitate the improved delivery of information to users.

New technology will convert documents currently in PDF and word format to improve their appearance and functionality.

Data

WIRO collects extensive data on all complaints, enquiries, ILARS grants, employer complaints and work capacity procedural reviews it receives. The data captured includes complainant details, type and body location of injury, the lawyer (for ILARS matters) representing the injured worker, the name of the insurer, the issues of the dispute, the outcome of the matter and for ILARS the amounts paid to the lawyers.

WIRO believes that by making the dispute process more transparent all stakeholders can better understand blockages, friction points and issues in the dispute process.

WIRO uses the data for 3 main purposes.

Firstly, WIRO publishes quarterly reports on its website and presents data analysis (which is also published) at our seminars.

Most of the data published by WIRO is not available from any other participants. The published data helps improve transparency within the workers compensation dispute process.

Secondly, WIRO uses the data to look at trends and patterns in behaviour for similar cases. This helps WIRO identify issues in the workers compensation scheme that may need to be improved.

Thirdly, WIRO produces data analysis for law firms to help them understand how their application quality, issues, outcomes and invoices compare to the industry average. This assists law firms better understand their practice and improve their productivity. Similar reports are produced for insurers.

Direct payment of medical disbursements

During the year WIRO entered into arrangements with a number of medical report companies for WIRO to pay directly for medical reports and clinical notes. Approved Lawyers who wish to avail themselves of these arrangements contact the medical report provider companies seeking a medical report or clinical notes. The invoice for the report or clinical notes is then sent to WIRO on a monthly basis for payment. This arrangement is in a trial phase and will be evaluated to determine if it has a positive impact on the early resolution of matters.

Section 39 of the 1987 Act

A major change included in the 2012 legislative reforms to the workers compensation scheme was the introduction of a limit of 260 weeks (aggregate not consecutive) for workers eligibility to receive weekly payments of compensation. This provision is found in section 39 of the 1987 Act.It is estimated that the operation of this section will affect approximately 6,000 workers by 30 June 2018, whose eligibility for weekly payments will cease unless it can be established that the worker's injury results in a degree of permanent impairment more than 20%. Some of these workers have been in receipt of compensation by way of weekly payments for over 20 years.

Each of these affected workers is entitled to be assessed as to their degree of permanent impairment (either informally or formally) to determine their eligibility to continue to receive payments.

This year insurers have been forwarding letters to affected workers advising them of the number of weeks of weekly payments already paid, current evidence, if available, as to the degree of whole person impairment and whether the weekly payments are expected to cease at 260 weeks. Arrangements have been made for workers to be medically assessed to determine their current level of whole person impairment.

WIRO has engaged in multiple meetings with icare and SIRA to manage problems likely to arise from the operation of section 39 and icare have been responsive to various suggestions made by WIRO. These have included recommendations about redrafting the letters sent out by insurers. Early letters did not clearly advise workers with respect to their rights to seek their own report from a medical specialist to challenge the insurers' assessment or how to seek assistance from WIRO to obtain legal advice.

If the insurer does not accept the worker's medical assessment then the worker is entitled to seek a final determination from an approved medical specialist through the Workers Compensation Commission. One problem is that there remains a large number of affected workers who have not taken steps to seek such a determination or obtained legal advice about their options. To assist this process WIRO introduced a fast track ILARS application form for section 39 matters. As at 30 June 2017 ILARS had made 650 grants to ALSPs to advise with respect to proposed cessation of benefits and to seek an Independent Medical Report if appropriate.

WIRO also produced three separate videos which were developed for injured workers, insurers and ALSPs to provide essential and accessible information and advice about options, which are available on social media. As at 30 June 2017 the workers' video had attracted 867 views, the lawyers' had 603 and the insurers' 505 views.

This topic has also been the subject of several presentations at WIRO's various 2017 seminars.

Inquiries

The WIM Act provides in section 27(c) that the Independent Review Officer has a function to inquire into and report to the Minister on such matters arising in connection with the Workers Compensation Acts as the Independent Review Officer considers appropriate.

WIRO reported in 2014 – 2015 that funding was not available for WIRO to complete the Parkes and Hearing Loss Inquiries. WIRO did not undertake any formal inquiries in 2016 -2017 in circumstances where there was no assurance that funding would be available to pursue inquiries in accordance with its legislative mandate.

It is noted that the SCLJ in its March 2017 report recommended (Recommendation 4) that the NSW Government consider the need for the Workers Compensation Independent Review Office to complete the Parkes Review.

OTHER INFORMATION PURSUANT TO SECTION 27C(4)(e) OF THE WIM ACT

Section 27C(4)(e) provides that the Independent Review Officer can include in the Annual Report such other information as the Independent Review Officer considers appropriate to be included**.** The matters discussed are issues relevant as at 30 June 2017 although it is appreciated that some of them may be addressed as part of the proposed redesign of the dispute resolution system. Pursuant to section 27C (4) (e) the following issues are raised:

Independence of WIRO

It is a significant impediment to WIRO'S effective and efficient functioning that it is not a separate government agency. The Better Regulation Division of the Department of Finance, Services and Innovation, which is a body that contains SIRA, provides services such as staff, finance and premises to WIRO. WIRO has oversight of SIRA.

It was a recommendation of the 2014 report of the SCLJ following its "Review of the exercise of the functions of the WorkCover Authority" that the NSW Government amend Part 3 of Schedule 1 of the *Government Sector Employment Act 2013* to designate the WIRO as a separate public sector agency. This recommendation has not been implemented and there has been no discussion about it.

The 2016 report of the SCLJ noted that the absence of financial independence has hampered the work of WIRO. The report found that "For many stakeholders and injured workers WIRO is seen as a genuinely helpful, independent part of the scheme. Ensuring that the office is able to continue to exercise its functions is clearly in the interests of all scheme participants".

WIRO's ability to assist injured workers is also impeded by the historical reluctance of icare and SIRA to direct injured workers to contact WIRO. This is evidenced by the initial brochures and letters sent to injured workers to be affected from September 2017 by the operation of section 39 of the 1987 Act.

It is also very frustrating to note that various statutory forms remain out of date since the legislative changes in 2015. The claims form which the worker completes to commence the claims process still refers to "WorkCover" as does the certificate of capacity completed by the medical profession.

Insurer practices

It is the experience of the WIRO office that despite the legislation and guidelines governing the scheme being extremely complex, confusing and difficult to manage the conduct of claims by insurers is generally of a high standard. However, there have been problematic systemic issues which include the practice of referring workers for permanent impairment assessments to medical specialists whose conservative approach is well known. This inevitably leads to contested disputes.

A related issue is the referral of a request by the worker's doctor for surgery to a doctor who is not a specialist in the relevant field and therefore unfamiliar with current practice and theory.

The WIRO raised in its submission to the SCLJ Review the issue of whether scheme agents should be subject to the NSW Government's Model Litigant Policy for Civil Litigation. This office endorses the recommendation of the SCLJ (Recommendation 24) that as scheme agents are performing a service on behalf of icare they should be subject to the policy and that the requirement be included in the scheme agent deed.

Finally, we mention the shortcomings with the ability or proclivity of the regulator to enforce compliance by insurers with the legislation. There is certainly a marked reluctance to impose pecuniary sanctions for breaches of statutory provisions as evidenced by the absence of any fines issued to insurers for contravention of the notice provisions in section 54 of the 1987 Act.

In terms of inadequate enforcement provisions we mention section 27B(1) of the WIM Act which provides that WIRO "may require an insurer or a worker" to provide specified information for the purposes of "the exercise of any function" of the WIRO.

While section 27B(2) says that "it is a condition of an insurer's licence" that the insurer comply with a request for information from WIRO, there is no specific provision setting out a penalty for non-compliance. It is extremely unlikely that any regulator will revoke the licence of an insurer for failure to provide documents and in the absence of a more realistic penalty it is hard to see how WIRO or the regulator can force a reluctant insurer to comply.

Another example is Section 44BF of the 1987 Act which commenced on 16 December 2016 and which provides for payment of a regulated fee to lawyers for advising with respect to a merit review of a work capacity decision. There is no provision for non-compliance.

Work capacity decisions

(a) <u>Section 44BC Stay</u>

WIRO raised in its submission to the SCLJ Review issues which have arisen with respect to the interpretation of section 44BC of the 1987 Act which was introduced as part of the 2015 reforms of the scheme. When a worker applies for a review of a work capacity decision, section 44BC provides for a stay or suspension of that decision to apply for the duration of the review process. Unfortunately some insurers have unfairly interpreted that section to the detriment of the worker and take the view that if, for example payments have been stopped after merit review but before commencement of the procedural review then they cannot be resumed because no "action" may be taken by an insurer while the decision is stayed. The WIRO was pleased that the SCLJ has recommended (Recommendation 11) that SIRA issue a guidance note explaining the appropriate operation of section 44BC of the 1987 Act.

(b) Section 38(3)(c)

By virtue of section 38(3)(c) an insurer has within its discretion the power to assess that a worker "is and is likely indefinitely to be, incapable of undertaking further work that would increase the worker's current weekly earnings." It is only the insurer which has this power. The wording of the section does not refer to objective criteria or to the possibility that any other body, including a body conducting a review under section 44BB, might come to the same or a different conclusion with consequences for the worker.

Despite this clear provision, the Merit Review Service of SIRA has made recommendations in several matters which clearly contradict the assessment of the insurer, sometimes to the detriment of workers.

WIRO Procedural Review recommendation No: 2516 is an illustrative case, which involves a worker who was assessed by her treating doctors as being capable of working for 20 hours per week. This was accepted by the insurer, which had, in accordance with section 38(3)(c), assessed that the worker would be incapable of working further hours.

Her weekly payments were reduced by the insurer from about $1,000 to $300 in the process of transitioning the claim onto the 2012 reforms regime.

The worker was perhaps understandably surprised to find that the Merit Reviewer did not accept the assessment of the insurer and instead found that the worker was capable of working for forty (40) hours per week. Consequently the Merit Reviewer presumed to issue a recommendation that reduced the worker's benefits to $0.00 per week. This was contrary to the submissions of both parties to the dispute and purported to be based on a finding which was not open to the Merit Reviewer, given the strict terms of section 38(3)(c).

Given that WIRO has no power to "review" the Merit Review recommendation, the only recourse open to this worker would be to make application to the Supreme Court for Judicial Review under section 69 of the *Supreme Court Act 1970*. The cost of any such challenge and the risk of an adverse costs order would prohibit this action in almost all cases.

c) No fair notice

A further disturbing element of the Merit Reviewer's actions in this case is that no opportunity was given to the worker to withdraw her application so as to avoid the adverse outcome. If an insurer is in the process of preparing to make a decision which may have an adverse outcome for a worker, the Work Capacity Guidelines clearly require the insurer to give the worker at least two weeks' notice.

It is an alarming prospect for workers that a review process set up for their benefit can have devastating outcomes with no warning and no opportunity to withdraw the application for review.

(d) Publication of decisions

WIRO recommends that SIRA ensure that all recommendations by the Merit Review Service be published on the SIRA website immediately after issue. To date SIRA has published only a very small number of what it considers "notable decisions".

There is no known benefit in secrecy of decision making and it is suggested that publication of all merit review recommendations might lead to greater consistency of decision making. It has been a common complaint to WIRO from insurers that there are widely differing and unpredictable outcomes in the course of merit review. It would also be advantageous if injured workers could obtain a better idea of what to expect from the merit review process. WIRO has taken the step of publishing a number of merit review decisions on its website.

It is noted that WIRO has published on its website redacted versions of every procedural review recommendation it has made, taking out the names of all witnesses, including doctors. Insurers and injured workers have been able to read the decisions and know what to expect in the course of procedural review.

(e) Questions of law

Section 105(1) of the 1998 Act purports to give the Workers Compensation Commission "exclusive jurisdiction to examine, hear and determine all matters arising under this Act and the 1987 Act." Immediately following this, a note appears in the following terms:

> **Note**. The Commission does not have jurisdiction to determine any dispute about a work capacity decision of an insurer and is not to make a decision in respect of a dispute before the Commission that is inconsistent with a work capacity decision of an insurer. See section 43 of the 1987 Act.

There is a lacuna with respect to a party who wishes to have a question of law resolved when that question of law arises in the course of a work capacity dispute. It is imperative that workers and insurers have a forum which can definitively rule on questions of law which arise in disputes over which the Commission itself has no (or no primary) jurisdiction.

A convenient example is where an insurer in the course of a work capacity decision finds that "suitable employment" for a worker might be as a "business owner." Such a decision by an insurer is only reviewable under section 44BB of the 1987 Act.

The Merit Review Service and the WIRO might well take the view that "business owner" is neither suitable nor employment, leaving aside "suitable employment". However, while such questions must be referred from or by Arbitrators if they arise in the course of "proceedings" before the Commission pursuant to section 351 of the WIM Act, there is currently no similar provision allowing for the referral of such questions which might arise in the course of a section 44BB review.

It would be undesirable for competing lines of authority to arise out of differing interpretations of the law. Ideally the Commission, constituted by a Presidential Member, should be able to consider questions of law which arise in the course of a section 44BB review. A simple stated case might be made in accordance with the current section 351(7) of the WIM Act.

Currently the prohibition on the Commission determining "any dispute" about a work capacity decision is too broadly expressed to allow for the exception of referral of questions of law. An appropriate amendment might profitably be made to both section 105 and 351 of the WIM Act and to section 43 of the 1987 Act.

One assessment of degree of permanent impairment

One of the significant changes made in the 2015 legislative reforms was the introduction of various thresholds determining workers' entitlements to payment of medical expenses. There are now a plethora of threshold limitations based on impairment levels which govern many facets of workers' entitlements, including time limits for weekly payments and medical expenses.

In summary, the respective impairment thresholds and their implications are as follows:

1. 0% to 10% (or is it 1% to 10%?) medical expenses limited to payment within a period of two years after the date of claim or the date on which weekly compensation ceases (section 59A(2)(a) of the 1987 Act).

2. Greater than 10% - entitlement to receive lump sum compensation for permanent impairment (section 66(1) of the 1987 Act).

3. More than 10% but not more than 20% - entitled to medical expenses for five years from the date of claim or the date weekly compensation ceased (section 59A(2)(b) of the 1987 Act).

4. At least 15% - possible entitlement to the payment of work injury damages (section 151H(1) of the 1987 Act) and one pre-condition to commutation satisfied (section 87EA(1)(a) of the 1987 Act).

5. More than 20% - worker with high needs (section 32A of the 1987 Act), entitled to weekly compensation after five years (section 39(2) of the 1987 Act) and period of entitlement to medical and treatment expenses not restricted (section 59A(5) of the 1987 Act).

6. More than 30% - worker with highest needs (section 32A of the 1987 Act) and "special" entitlements to weekly compensation.

The regime is complicated by the fact that in most cases the worker will be entitled to one claim only for lump sum compensation for permanent impairment pursuant to section 66 of the 1987 Act, even where there has been a significant deterioration in the worker's condition.

More problematic, in this environment where an assessment of permanent impairment is required to access different classes of benefits, is the operation of section 322A of the WIM Act which provides that only one medical assessment may be made of the degree of permanent impairment of an injured worker.

For example, if the worker has to obtain that assessment to determine whether he or she is able to receive medical treatment then the opportunity for a further assessment due to deterioration or the result of surgery is lost. The one assessment provision is also causing complications with respect to section 39 of the 1987 Act and interesting arguments such as whether the Commission has any jurisdiction to refer a claimant for assessment of impairment by an Approved Medical Specialist in circumstances where there is no "dispute".

It is the WIRO's view that this section should be amended to permit workers to have their permanent impairment assessed at various stages of their injury in order to access benefits of different kinds, in particular following a demonstrable change in their condition.

Pre -approval of medical treatment

There remain significant issues with the pre-approval requirements in section 60 (2A)(a) of the 1987 Act. Section 60(2A)(a) provides:

(2A) The worker's employer is not liable under this section to pay the cost of any treatment or service (or related travel expenses) if:

(a) the treatment or service is given or provided without the prior approval of the insurer (not including treatment provided within 48 hours of the injury happening and not including treatment or service that is exempt under the Workers Compensation Guidelines from the requirement for prior insurer approval)

It is significant to note that section 60(2A)(a) foreshadowed, given its own terms, that the section may operate unfairly or in unforeseen circumstances and that it may be necessary to effectively amend it by the inclusion in the relevant Workers Compensation Guidelines of exemptions to its operation.

In accordance with this section SIRA's Guidelines for Claiming Workers Compensation provide for some exemptions to this provision. New Guidelines were introduced on 1 August 2016 which expand on the list of medical interventions for which pre- approval is not required. In addition there has been amendment of the Guideline exemption dealing with a Workers Compensation Commission Determination which now reads:

Any treatment or service that has been disputed and the Workers Compensation Commission has made a determination to pay for treatment or services.

It is noted that the pre-approval requirement was considered during the SCLJ 2014 Inquiry and Recommendation (Number 7) provided that "The NSW government consider amendments to the WorkCover scheme to allow for payment of medical expenses where through no fault of the injured worker it was not reasonable or practical for the worker to obtain the pre-approval of medical expenses before undertaking the treatment".

This recommendation has not been implemented nor been the subject of any discussions with WIRO.

This section was considered again by the SCLJ during the most recent Inquiry. Recommendation 5 in the 2017 Report states that "SIRA issue a guidance note explaining how the new Guidelines for claiming workers compensation operate with respect to s 60(2A) of the *Workers Compensation Act 1987."* The SCLJ received various submissions from stakeholders, including the WIRO, about the problems caused by the pre-approval requirement and exemptions and recent Workers Compensation Commission decisions relevant to this issue.

The decision in *Deans v Roderic Neil Mitchell t/as R N Mitchell and Workers Compensation Nominal Insurer [2016]* NSWWCC 279 is significant. In that matter the insurer invoked section 60(2A) where treatment conceded to be reasonably necessary was not approved prior to it being provided. The insurer had issued a section 74 notice post treatment which disputed liability on the basis that the services were provided without prior approval.

The Guidelines in question were the version in force pre- August 2016 (WorkCover Guidelines for Claiming Workers Compensation Benefits) Government Gazette No 125, Oct 2013) which were amended with effect from 11 October 2013.

The Arbitrator found (at 43) that there were "no liability issues and therefore the Commission cannot make a determination of liability in the applicant's favour". The case fell into the anomalous scenario described by Arbitrator Wardell in *Peter Muscat v Chris Waller Racing Pty Ltd* [2016] NSWWCC 168 when an insurer could invoke section 60(2A)(a) where treatment otherwise reasonably necessary has been provided but not pre- approved, by accepting liability for that treatment but simply stating it is not liable for it by virtue of section 60(2A)(a).

The exemption wording in the new Guidelines does not appear to remedy this situation and WIRO suggests SIRA give this issue further attention.

Workers Compensation (Psychology and Counselling Fees) Order 2016 No 2

On 29 July 2016 SIRA published the *Workers Compensation (Psychology and Counselling Fees) Order 2016 No 2* ("Order") and the State Insurance Regulatory Authority Workers Compensation Regulation Guideline for Approval of treating Allied Health Practitioners.

The Explanatory Note to the Order states:

> "Treatment by a Psychologist or Counsellor is medical or related treatment covered under the *Workers Compensation Act 1987*."

Section 60(1) of the 1987 Act provides:

> If, as a result of an injury received by a worker, it is reasonably necessary that:
>
> (a) any medical or related treatment (other than domestic assistance) be given, or
>
> the worker's employer is liable to pay, in addition to any other compensation under this Act, the cost of that treatment or service and the related travel expenses specified in subsection (2).

Section 59 contains the definition of "medical or related treatment" which so far as is relevant is as follows:

> medical or related treatment includes:
>
> (a) treatment by a medical practitioner, a registered dentist, a dental prosthetist, a registered physiotherapist, a chiropractor, an osteopath, a masseur, a remedial medical gymnast or a speech therapist,
>
> ……
>
> (h) treatment or other thing prescribed by the regulations as medical or related treatment,

That section does not provide for Psychology or Counselling treatment to be "medical or related treatment". It is of course open for that treatment to be authorised by Regulation.

An explanation was sought from SIRA as to the power to make this Order and SIRA responded as follows:

> "Please note that s 61 (2) of the *Workers Compensation Act 1987* provides for the authority to set a maximum amount for any particular medical or related treatment by order published in the Gazette. The definition of 'medical or related treatment' is contained within s59 of the Workers Compensation Act 1987.
>
> *Sankey v New South Wales Fire Brigade* (1998) found that the definition of "medical or related treatment" in s59 is not exhaustive (see [6] to [10]).

> This means that "medical or related treatment" can be interpreted to include other treatment not currently listed in paras (a) to (h) in the definition of "medical or related treatment" in s59, for example treatment by a psychologist."

The difficulty with that explanation is that the consideration of the meaning of the definition of "medical or related treatment" in the quoted case has not been adopted by the Court of Appeal in subsequent cases and therefore cannot be considered as authority.

In the judgment of the Court of Appeal in *Our Lady of Loreto Nursing Home v Patricia Olsen* [2000] NSWCA 12 it was stated:

> "17 It was not submitted on behalf of the worker that the definition of medical or related treatment in s 59 was an inclusive one so as to permit claims for such treatment falling outside the terms of the various paragraphs of the definition. It was established "includes" in the corresponding definition in s 10(2) of the former Act meant "means and includes" so that the definition was exclusive and exhaustive. See *Lamont v Commissioner for Railways* (1963) 80 WN (NSW) 1242 and *Thomas v Ferguson Transformers Pty Ltd* [1979] 1 NSWLR 6. The current definition retains the basic structure of the former one and its settled interpretation has generally been accepted as applicable to the new definition. Compare *Bresmac Pty Ltd v Starr* (1992) 29 NSWLR 318."

And again in the judgment of the Court of Appeal in *Western Suburbs Leagues Club v Everill* [2001] NSWCA 56:

> "5 HANDLEY JA: This appeal from a decision of Truss CCJ involves the interpretation of s 59(f) of the *Workers Compensation Act 1987* (the Act) which is part of a comprehensive definition of medical or related treatment. The paragraph covers "care (other than nursing care) of a worker in the worker's home …". The definition operates for the purposes of s 60 which obliges the employer to pay for the cost of such treatment given to the worker which is reasonably necessary as a result of his or her injury.
>
> 6 Section 59 contains in terms an inclusive definition of medical or related treatment, but its settled interpretation and that of its predecessor in s 10(2) of the 1926 Act is that the definition is exhaustive. See *Our Lady of Loretto Nursing Home v Olsen* (2000) 19 NSWCCR 465 CA, and the cases there cited. Moreover authority in the Compensation Court establishes that the various paragraphs, including para (f), are themselves to be understood in the context of the phrase "medical or related treatment" which is being defined."

The clear statements by the Court of Appeal in two cases appear to cast significant doubt upon the power of SIRA to determine that "Psychology and Counselling Services" fall within the definition in section 59 of the 1987 Act.

The Explanatory Note to the Order also provides that no fees are payable for Psychology or Counselling treatment provided by a Psychologist or Counsellor who is not approved by the State Insurance Regulatory Authority (the Authority).

Section 60(2C)(e) of the 1987 Act provides:

> (2C) The Workers Compensation Guidelines may make provision for or with respect to the following:
> (e) specifying the qualifications or experience that a person requires to be appropriately qualified for the purposes of this section to give or provide a treatment or service to an injured worker (including by providing that a person is not appropriately qualified unless approved or accredited by the Authority).

However this may only apply with respect to providers of "medical or related treatment" as defined in section 59 of the 1987 Act.

The Explanatory Note also states that the incorrect use of any item referred to in this Order can result in penalties, including the Psychologist or Counsellor being required to repay monies to the Authority that the Psychologist or Counsellor has incorrectly received.

WIRO has been unable to find any authority for this statement.

APPENDIX 1 – SOLUTIONS GROUP STATISTICS

Complaint and Enquiry Issues

ISSUE (OF CASE) ISSUE	COMPLAINT NUMBER	%	ENQUIRY NUMBER	%
Communication	252	8%	239	7%
Delay	434	14%	108	3%
Denial of Liability (S.74 Notice)	223	7%	567	17%
IME	22	1%	47	1%
Medical costs	81	3%	64	2%
Medical treatment	215	7%	197	6%
Rehabilitation	73	2%	104	3%
Weekly Benefits	760	24%	576	17%
Work Capacity (general)	50	2%	165	5%
WPI	34	1%	168	5%
Insurer management of claim	56	2%	46	1%
Issues Relating to Liability	130	4%	136	4%
Non-Compliant Worker	1	0%	2	0%
S39 Matter	50	2%	270	8%
Weeklies - incorrect payment amount/PIAWE	134	4%	67	2%
Rehabilitation/RTW	167	5%	185	5%
ILARS enquiry/worker complaint re lawyer	2	0%	95	3%
Medico Legal Examination/WPI	65	2%	149	4%
Payment, reimbursement of Medicals/Travel expenses	288	9%	131	4%
Work Capacity/Stay	33	1%	107	3%
Delay in Payment under COD or Settlement	104	3%	15	0%
Suspension of benefits/Non-compliant worker	11	0%	2	0%
Grand Total	**3185**	**100%**	**3441**	**100%**

Note: A case may have more than 1 issue

Complaint Outcomes

For cases closed between 1 July 2016 and 31 December 2016

CASE WITHDRAWN		
Case Withdrawn	1	0%
Complaint Declined	16	1%
Further Inquiry No Further Action	7	1%
Further Inquiry Resolved	6	1%
Preliminary Inquiry No Further Action	293	26%
Preliminary Inquiry Resolved	816	71%
Not Recorded	10	1%
New category	10	1%
Grand Total	**1142**	**100%**

For cases closed between 1 January 2017 and 30 June 2017

New Complaint outcomes

OUTCOMES	SCHEME AGENT	SELF-INSURED	SPECIALISED INSURER	TMF	GRAND TOTAL
Resolved after Preliminary Enquiry	**1106**	**173**	**64**	**302**	**1645**
Communication	**53**	**11**	**9**	**20**	**93**
Insurer already attempted to contact worker	8	1		4	13
Insurer not providing information/documents	2	2			4
Insurer to provide information/documents	23	3	8	12	46
Insurer to respond to Worker	20	5	1	4	30
Delay in determining liability	**159**	**31**	**16**	**67**	**273**
Claim Reasonably excused worker to lodge Claim Form	7	3	1	8	19
Insurer accepts claim	44	10	5	15	74
Insurer outside timeframes	24	4	2	12	42
Insurer within timeframes	32	7		17	56
S74 Notice issued	52	7	8	15	82
Delay in Payment under COD or Settlement	**49**	**18**	**6**	**26**	**99**
Insurer outside timeframes agree payment to be made by certain date	27	15	3	18	63
Insurer waiting on Settlement documents	12	2		4	18
Insurer within timeframes	10	1	3	4	18
Denial of Liability - s74 notice	**100**	**17**	**3**	**26**	**146**
Claim accepted after inquiry (decision overturned)	6			1	7
Insurer agree to pay closed period/requested treatment	2			1	3
Insurer maintain denial	53	7	3	16	79
Insurer outside timeframes (review still not completed)	2	1		2	5
Insurer overturn denial	13	1			14
Insurer to pay correct notice period	2				2
Insurer within timeframes	3	2			5
Request for review not received	5	1		1	7
S74 already issued before inquiry	10	5		4	19
S74 issued after inquiry	4			1	5
ILARS Enquiry/Worker Complaint re Lawyer	**1**				**1**
Medico Legal Examination Issue/WPI	**44**	**7**	**3**	**9**	**63**
Claim accepted/resolved after inquiry	7			2	9
Claim already determined - claim settled before inquiry	1	1			2
Claim already determined - s74 issued before inquiry	1				1
Counter offer issued after inquiry	3		1		4

OUTCOMES	SCHEME AGENT	SELF-INSURED	SPECIALISED INSURER	TMF	GRAND TOTAL
Counter offer issued before inquiry	1				1
Incorrect notice period of IME given - Insurer to rearrange IME	7				7
Insurer agree to give worker choice of 3 IME's	3				3
Insurer agree to pay travel to IME	1				1
Insurer still unable to determine claim and outside timeframes	2			1	3
Insurer within timeframes	4	1			5
Insurer within timeframes or organised IME	1			3	4
Not MMI	1				1
Notice correct - Worker to attend IME	4	1		3	8
S74 notice issued after inquiries	5	1	1		7
Second IME with different doctor of same speciality	3	3	1		7
Payment or reimbursement of Medicals/Travel expenses	**196**	**33**	**9**	**53**	**291**
Claim accepted after inquiry	44	3		10	57
Insurer not on risk	2	3			5
Insurer outside timeframes	13	7		4	24
Insurer within timeframes	26	1	2	7	36
No Pre-Approval of Medicals	10	1	1	2	14
Request not received	21	6		5	32
Request/payment approved	55	8	2	19	84
S74 already issued before inquiry	3	2	1	1	7
S74 issued after inquiry	12	2	1	3	18
S74 Notice issued	5		1		6
Section 59A application	5		1	2	8
Rehabilitation/RTW	**107**	**16**	**5**	**29**	**157**
Employer provides suitable duties	16	2		3	21
Employer states suitable duties not available	11	2		1	14
Insurer adjusts stance on job seeking diary	2			1	3
Insurer maintains need for job seeking diary	1				1
Insurer to provide RTW Plan/Amend Plan	26	6	3	12	47
Rehabilitation services approved	35	4		11	50
Rehabilitation services not approved	16	2	2	1	21
Section 39	**36**	**6**	**1**	**4**	**47**
Worker referred to WIRO approved Lawyer	35	6	1	4	46
Insurer accept worker >20%	1				1
Suspension of benefits/Non-compliant worker	**12**			**1**	**13**
Insurer maintain suspension - Worker to comply before benefits recommence	5				5
Insurer recommenced benefits	3				3
Insurer withdraws suspension notice	4			1	5
Weeklies	**217**	**27**	**8**	**42**	**294**
Insurer has already processed payment	59	6	4	16	85
Insurer mistake - payment to now be made	106	10	3	19	138

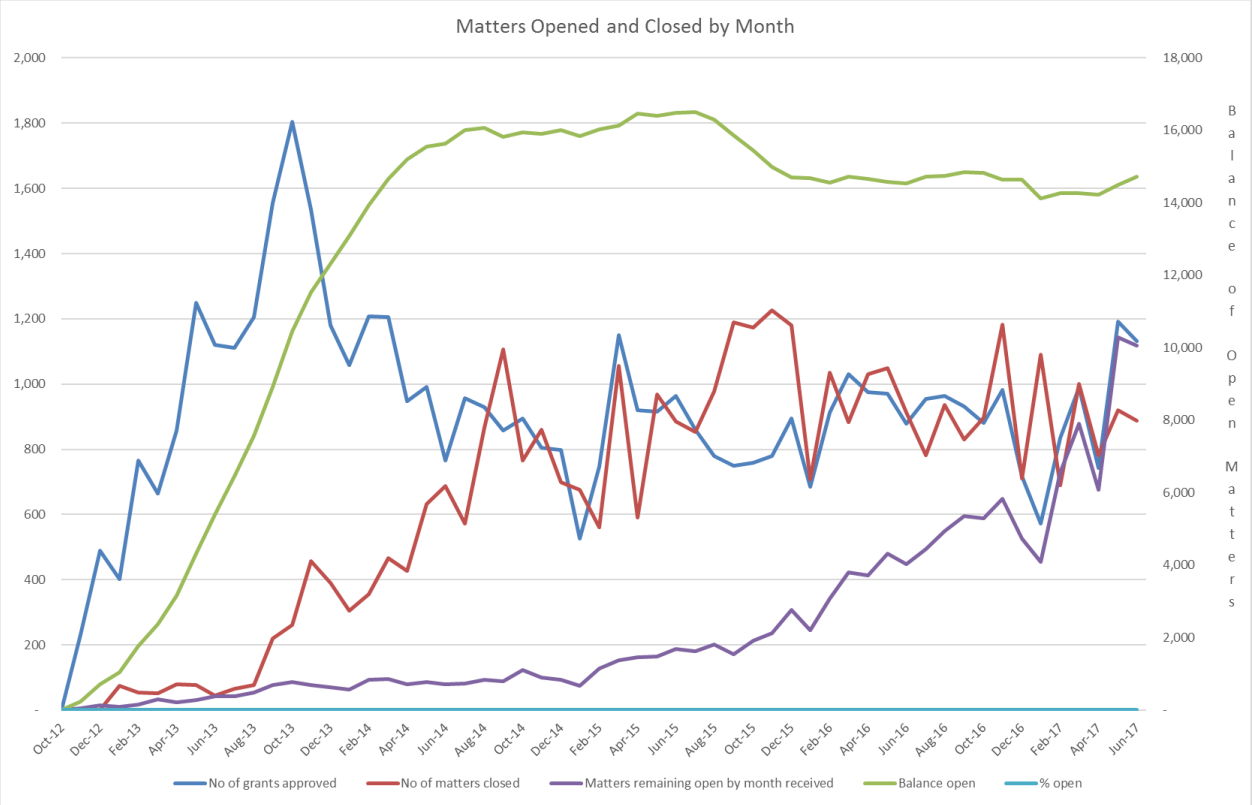
OUTCOMES	SCHEME AGENT	SELF-INSURED	SPECIALISED INSURER	TMF	GRAND TOTAL
Insurer unable to process payment - awaiting documents	40	11	1	5	57
No longer eligible for payments	12			2	14
Weeklies - incorrect payment amount/PIAWE	**106**	**6**	**4**	**22**	**138**
Correct amount has been processed	46	3		7	56
Insurer alter PIAWE calculation	17	1	1	4	23
Insurer maintain PIAWE calculation	11	1	2	9	23
Insurer mistake - Correct amount to be processed	15	1		1	17
Insurer waiting on further information from worker	17		1	1	19
Work Capacity/Stay	**26**	**1**		**3**	**30**
Insurer agree to pay the stay period	2				2
Insurer maintain WCD	14	1		1	16
Insurer withdraw WCD	4				4
Stay period not applicable	5			2	7
Insurer already paid the stay period	1				1
Resolved following further enquiry	**7**	**2**	**2**	**4**	**15**
Communication	**1**			**1**	**2**
Insurer to provide information/documents	1				1
Insurer to respond to Worker				1	1
Delay in determining liability	**1**	**1**			**2**
Insurer accepts claim	1	1			2
Delay in Payment under COD or Settlement			**1**		**1**
Insurer within timeframes			1		1
Denial of Liability - s74 notice	**1**	**1**	**1**		**3**
Insurer maintain denial			1		1
Insurer overturn denial		1			1
S74 already issued before inquiry	1				1
Payment or reimbursement of Medicals/Travel expenses	**2**				**2**
Insurer not on risk	1				1
S74 issued after inquiry	1				1
Weeklies	**1**			**3**	**4**
Insurer has already processed payment	1				1
Insurer unable to process payment - awaiting documents				2	2
No longer eligible for payments				1	1
Work Capacity/Stay	**1**				**1**
Insurer agree to pay the stay period	1				1
Grand Total	**1113**	**175**	**66**	**306**	**1660**

Complaint timeliness

ISSUE OF COMPLAINT	SAME DAY	NEXT DAY	2 TO 7 DAYS	8 TO 15 DAYS	16 TO 30 DAYS	MORE THAN 30 DAYS	GRAND TOTAL
Weekly Benefits	14	17	198	146	68	7	**450**
Weeklies	9	21	129	71	31	1	**262**
Payment, reimbursement of Medicals/Travel expenses	7	16	131	73	29	1	**257**
Delay in determining liability	7	13	128	51	44	6	**249**
Medical treatment	4	6	96	47	18	1	**172**
RTW	7	6	75	42	16	1	**147**
Denial of liability	6	8	60	36	22	3	**135**
Communication (secondary issue only)	4	9	76	18	10		**117**
Weeklies - incorrect payment amount/PIAWE		8	49	32	26	1	**116**
Issues Relating to Liability		5	62	26	18		**111**
Delay in payment	3	7	53	17	21	1	**102**
Delay		10	46	14	2		**72**
Denial of Liability (S.74 Notice)	4	3	33	15	5	2	**62**
Communication	2	6	35	13	5		**61**
Rehabilitation	1	5	28	15	11		**60**
Medical costs	3	2	34	16	4		**59**
Medico Legal Examination/WPI	1	4	23	17	7		**52**
Insurer management of claim	3	4	23	14	5	1	**50**
S39 Matter	3	1	21	14	5		**44**
Work Capacity (general)	3	3	17	11	4	1	**39**
Work Capacity Decision	3	5	10	7	5		**30**
WPI		5	17	7	1		**30**
IME/IMC		3	6	6			**15**
Suspension of benefits/Non-compliant worker	1		2	4	3	1	**11**
Incorrect Calculations			3	1			**4**
Non-Compliant Worker			1				**1**
ILARS Lawyer Complaint			1				**1**
PIAWE					1		**1**
Grand Total	**85**	**167**	**1357**	**713**	**361**	**27**	**2710**

APPENDIX 2 – ILARS STATISTICS

ILARS Matters Opened and Closed by Month



Amounts Paid

PAYMENT TYPE	TOTAL AMOUNT	NUMBER OF PAYMENTS	% OF DISBURSEMENTS	AVERAGE AMOUNT
Professional fees	$35,805,996	9,868		$3,628
Medico-legal	$11,707,349	10,202	70%	$1,148
Barrister Fees	$2,595,559	1,883	15%	$1,378
Clinical Notes	$948,733	8,225	6%	$115
Travel	$242,795	1,224	1%	$198
Barrister Country Loading	$168,584	264	1%	$639
NTD Report	$401,150	1,099	2%	$365
Treating Specialist Report	$569,675	1,134	3%	$502
Interpreter	$82,888	451	0%	$184
Other	$37,944	185	0%	$205
Meal Allowance	$3,205	75	0%	$43
Solicitor Loading	$64,817	100	0%	$648
Non-attendance fee	$17,351	47	0%	$369
Grand Total	**$52,563,877**	**34,610**		
Total disbursements	**$16,840,049**		**32%**	
Note: Professional fees includes GST				

Types of Injury for ILARS Grants

INJURY TYPE	TOTAL	PERCENTAGE
Ear	2609	24%
Back	2199	20%
Psychological system	1209	11%
Shoulder	742	7%
Knee	668	6%
Multiple -Trunk and limbs	522	5%
Other body location	344	3%
Multiple -Neck and shoulder	341	3%
Hand, fingers and thumb	290	3%
Neck	205	2%
Ankle	197	2%
Other head	194	2%
Wrist	180	2%
Other leg	166	2%
Upper limb - multiple locations	151	1%
Death	130	1%
Other arm	122	1%
Foot and toes	105	1%
Trunk - multiple locations	96	1%
Internal Body System	96	1%
Elbow	81	1%
Hip	70	1%
Abdomen and pelvic region	63	1%
Eye	45	0%
Grand total	**10825**	**100%**

Nature of Injury

NATURE OF INJURY	TOTAL
A. Intracranial injuries	**50**
B. Fractures	**373**
C. Wounds, lacerations, internal organ damage	**328**
D. Burn	**31**
E. Injury to nerves and spinal cord	**2266**
F1. Trauma to joints and ligaments	**1989**
F2. Trauma to muscles and tendons	**1070**
G. Other injuries Poisoning, Electrocution, etc	**19**
H1. Joint diseases	**16**
H2. Spinal disc diseases	**244**
H3. Diseases involving the synovium	**3**
H4. Diseases of muscle & tendons	**17**
H5. Other soft tissue diseases	**19**
I. Mental disorders	**1205**
J. Digestive system diseases	**39**
K. Skin and subcutaneous tissue diseases	**23**
L. Nervous system and sense organ diseases	**2673**
M. Respiratory system diseases	**43**
N. Circulatory system diseases	**9**
O. Infectious and parasitic diseases	**5**
P. Neoplasms (cancer)	**55**
Q. Other diseases	**3**
R. Other claims	**6**
S. Death	**130**
Not Recorded	**209**
Grand Total	**10825**

ILARS outcomes

OUTCOME	DESIRED OUTCOME NOT ACHIEVED	GRANT ACHIEVED DESIRED OUTCOME	GRAND TOTAL
Instructions withdrawn	1431		1431
ILARS Funding Withdrawn	437		437
Cram Fluid Applies	17		17
Not Recorded	15		15
Not eligible for funding - (e.g worker determined to be exempt worker)	27		27
No Response to ILARS Follow Up	372		372
Old Costs provisions apply	6		6
Not proceeding after preliminary grant	1177		1177
Medical evidence not supportive	428		428
Not Recorded	59		59
Worker does not reach WPI threshold	678		678
S39 - Below Threshold	10		10
S39 - Not MMI	2		2
Other not specified reason - see summary box	119	22	141
Resolved after ILARS referral to complaints	5	40	45
Commutations		32	32
Discontinued from WCC - No result	99		99
Resolved prior to WCC		3191	3191
Not Recorded		5	5
Resolved - Insurer Accepts Claim		1250	1250
Resolved after application for review/insurer accepts Claim		344	344
Resolved by complying agreement after claim made		1551	1551
S39 - Advice given		31	31
S39 - Over threshold by agreement		10	10
Resolved in WCC	384	3201	3585
Resolved at Arbitration by Arbitrator - Employer	46		46
Resolved at Arbitration by Arbitrator - Worker		365	365
Medicals		126	126
Not Recorded		3	3

OUTCOME	DESIRED OUTCOME NOT ACHIEVED	GRANT ACHIEVED DESIRED OUTCOME	GRAND TOTAL
Weeklies		21	21
Weeklies & Medicals		111	111
WPI		58	58
WPI & Medicals		20	20
WPI & Weeklies		3	3
WPI, Weeklies & Medicals		23	23
Resolved at Conciliation - settled by consent		911	911
Closed Period		15	15
Medicals		114	114
Not Recorded		3	3
Weeklies		49	49
Weeklies & Medicals		451	451
WPI		97	97
WPI & Medicals		29	29
WPI & Weeklies		11	11
WPI, Weeklies & Medicals		73	73
Wrap up		69	69
Resolved at settlement during Arbitration		148	148
Medicals		28	28
Not Recorded		2	2
Weeklies		7	7
Weeklies & Medicals		68	68
WPI		25	25
WPI & Medicals		7	7
WPI & Weeklies		2	2
WPI, Weeklies & Medicals		9	9
Resolved following MAC	339	971	1310
COD for WPI		934	934
Not reached threshold	328		328
Not Recorded	1	2	3
Surgery not reasonably necessary	10		10
Surgery reasonably necessary		35	35
Resolved TC - settled by consent		778	778
Closed Period		14	14
Medicals		193	193

OUTCOME	DESIRED OUTCOME NOT ACHIEVED	GRANT ACHIEVED DESIRED OUTCOME	GRAND TOTAL
Not Recorded		5	5
Weeklies		55	55
Weeklies & Medicals		276	276
WPI		117	117
WPI & Medicals		43	43
WPI & Weeklies		7	7
WPI, Weeklies & Medicals		31	31
Wrap up		37	37
Resolved WIM Dispute	1	26	27
In favour of worker		26	26
In favour of employer	1		1
Appeals	99	181	280
Resolved after appeal from decision of Arbitrator to President	12	16	28
By the employer in favour of Employer	2		2
By the employer in favour of Worker		6	6
By the worker in favour of Employer	10		10
By the worker in favour of Worker		10	10
Resolved after appeal to Supreme Court	1	1	2
By the worker in favour of Employer	1		1
By the worker in favour of Worker		1	1
Resolved after Medical Appeal Panel	86	161	247
By the employer in favour of Employer	25		25
By the employer in favour of Worker		84	84
By the worker in favour of Employer	61		61
By the worker in favour of Worker		77	77
Resolved after appeal to Court of Appeal		3	3
By the employer in favour of Worker		1	1
By the worker in favour of Worker		2	2
Resolved after Intervention by ILARS Director		22	22
Death Benefits		88	88
Grand Total	**3745**	**6773**	**10518**

APPENDIX 3 – MATTERS RECEIVED BY INSURER

INSURER	COMPLAINT	ENQUIRY	ILARS	WCDR	NO RESPONSE	GRAND TOTAL
Scheme agent	**1839**	**2031**	**7476**	**98**	**838**	**12282**
Allianz Australia Workers Compensation (NSW) Ltd	490	579	2067	24	254	3414
CGU Workers Compensation (NSW) Ltd	357	312	1100	22	119	1910
Employers Mutual NSW Limited	293	338	1219	24	150	2024
Gallagher Bassett Services Pty Ltd	1	5	27		0	33
GIO General Limited	337	315	1247	9	131	2039
QBE Workers Compensation	361	482	1798	19	184	2844
Xchanging			18		0	18
Self-insured	**290**	**208**	**1045**	**5**	**139**	**1687**
ANZ Banking Group Limited	1	2	9		2	14
Arrium Limited	4	1	30		7	42
Ausgrid	9	9	34		2	54
Blacktown City Council		1	15		1	17
Bluescope Steel Ltd	6	3	86		10	105
BOC Workers' Compensation Ltd.	3	2	5		1	11
Brambles Industries Limited	1		5		2	8
Brickworks Ltd			6		0	6
Broadspectrum (Australia) Pty Ltd	18	3	23		8	52
Campbelltown City Council		1	3		2	6
Canterbury Bankstown Council	1		7		3	11
Central Coast Council		2	4		0	6
City of Sydney Council	3	3	11		1	18
Coles Group Ltd	63	47	151	3	23	287
Colin Joss & Co Pty Limited	1		6		0	7
CSR Limited		3	8		0	11
Echo Entertainment Group Ltd	5	2	2		1	10
Electrolux Home Products Pty Ltd	1		6		0	7
Endeavour Energy	2	1	11		0	14
Fairfield City Council			5		1	6
Fletcher International Exports Pty Ltd.			2		0	2
Gosford City Council			5		0	5
Holcim (Aust) Holdings Pty Limited	5		10		1	16
Inghams Enterprises Pty Ltd		3	6		1	10
ISS Facility Services	2	2	4		1	9

INSURER	COMPLAINT	ENQUIRY	ILARS	WCDR	NO RESPONSE	GRAND TOTAL
ISS Property Services Pty Ltd	2	2	3		4	11
JELD-WEN Australia Pty Ltd	1		6		1	8
Lake Macquarie City Council			20		1	21
Liverpool City Council	1	1	5		0	7
MARS Australia Pty Ltd	1		1		0	2
McDonald's Australia Holdings Limited	2	1	6		1	10
Myer Holdings Ltd			8		2	10
Newcastle City Council			9		1	10
Northern Beaches Council	1	2	5		5	13
Northern Co-Operative Meat Company Limited	9		3		0	12
NSW Trains	1		3		0	4
Pacific National (NSW) Pty Ltd	1		12		3	16
Primary Health Care Limited	1		9		0	10
Programmed	9	10	13		1	33
Qantas Airways Limited	11	9	91		9	120
Rail Corporation NSW	2	5	13		0	20
Rocla Pty Limited	1		3		0	4
Shoalhaven City Council	2		7		1	10
Southern Meats Pty Ltd.		1			0	1
Sutherland Shire Council			7		0	7
Sydney Trains	5	6	8		1	20
Toll Pty Ltd	12	10	44		2	68
Transport for NSW Workers Compensation Services	12	12	96		5	125
Transport Service of NSW (State Transit Group)	2	6	27		2	37
UGL Rail Services Pty Limited	1	3	10		0	14
Unilever Australia (Holdings) Pty Limited		4		0	4	
University of New South Wales	1	4	3		0	8
University of Wollongong			3		0	3
Veolia Environmental Services (Australia) Pty Ltd	2		6		5	13
Westpac Banking Corporation Ltd	8	18	25		3	54
Wollongong City Council	1	1	16	2	1	21
Woolworths Limited	75	32	117		24	248
Wyong Shire Council	1		8		0	9

INSURER	COMPLAINT	ENQUIRY	ILARS	WCDR	NO RESPONSE	GRAND TOTAL
Specialised insurer	**110**	**105**	**367**	**6**	**50**	**638**
Catholic Church Insurance Limited	25	28	83	2	14	152
Club Employers Mutual (part of Hospitality Employers Mutual)	11	8	28		9	56
Coal Mines Insurance Pty Limited		3	2		0	5
Guild Insurance Ltd	6	7	10		2	25
Hospitality Employers Mutual Limited	3	3	17		0	23
Hotel Employers Mutual (part of Hospitality Employers Mutual)	15	28	49	3	6	101
Icare- Lifetime Care	1	1	1		0	3
Racing NSW Insurance Fund	12	6	29		3	50
StateCover Mutual Ltd	37	21	148	1	16	223
TMF	**494**	**422**	**1234**	**10**	**200**	**2360**
Allianz TMF	160	145	452	5	38	800
Employers Mutual NSW Ltd - TMF	89	87	266	3	30	475
QBE TMF	245	190	516	2	132	1085
***Other Insurer including Not Provided**	**18**	**392**	**1320**	**0**	**4**	**1734**
Grand Total	**2751**	**3158**	**11442**	**119**	**1237**	**18707**

*Workers who make enquiries often do not identify the insurer

APPENDIX 4 – WORK CAPACITY PROCEDURAL REVIEW DECISIONS

OUTCOME	2016						2017						GRAND TOTAL
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	
Could not proceed			1				1						2
Dismissed	6	17	5	8	14	10	8	8	9	7	4	1	97
No decision		1											1
Review rejected	1	1											2
Upheld	3	7	1	1	2	1	3		2	1	1	1	23
Grand Total	**10**	**26**	**7**	**9**	**16**	**11**	**12**	**8**	**11**	**8**	**5**	**2**	**125**

APPENDIX 5 - SCHEDULE OF WIRO MEETINGS AND PRESENTATIONS 2016-2017

DATE	DESCRIPTION
6/07/16	City of Sydney Law Society - Address by Attorney General
8/07/16	Meeting with SIRA
12/07/16	CGU visit to WIRO
13/07/16	Meeting with ICNSW & SIRA
25/07/16	Meeting with SIRA - Legal costs in Work Capacity Decisions Reviews
1/08/16	ICNSW - CASE Awards - Judging meeting
4/08/16	Attend Shine Lawyers 40th Anniversary Function
5/08/16	Meeting with Shine Lawyers - Performance discussion
12/08/16	Meeting with McNally Jones Staff - Performance discussion
23/08/16	Meeting with PSA
25/08/16	Presentation to TWU Conference
29/08/16	Meeting with Unions NSW
30/08/16	Meeting with Acacia Products CEO
31/08/16	Paralegal Seminar
7/09/16	Meeting with CFMEU
8/09/16	SIRA Consultation meeting
12/09/16	Meeting with ICNSW - s.39 issues
13/09/16	Presentation to TWU Delegates meeting
19/09/16	Meeting with GIO
22/09/16	ICNSW regular meeting
22/09/16	Meeting with EML
30/09/16	WIRO Sydney Seminar - Westin

DATE	DESCRIPTION
7/10/16	WIRO Newcastle Seminar
14/10/16	WIRO Ballina Seminar
19/10/16	WIRO Paralegal Course
21/10/16	WIRO Albury Seminar
24/10/16	Meeting with Victorian Ombudsman
25/10/16	ICNSW regular meeting
28/10/16	WIRO Bathurst Seminar
3/11/16	Attend Self & Specialised Insurers AGM
4/11/16	Attend SCLJ hearing
7/11/16	Appear at SCLJ hearing
11/11/16	WIRO Wollongong Seminar
14/11/16	Meeting with GIO
15/11/16	Meeting with SIRA - s.39 issues
17/11/16	Address ARPA meeting
17/11/16	Attend City of Sydney Law Society Annual Dinner
25/11/16	Presentation - Workers Compensation Conference
28/11/16	ICNSW regular meeting
14/12/16	Meeting with MLCOA
16/12/16	Attend SIRA PIAWE forum
21/12/16	Meeting with Public Service Commissioner
22/12/16	ICNSW regular meeting
5/01/17	Meeting with M Dawson - Chief of Staff for Minister Dominello
17/01/17	Meeting with ICNSW - s.39

DATE	DESCRIPTION
18/01/17	Meeting with Allianz
24/01/17	ICNSW regular meeting
1/02/17	Meeting with G Larkin (icare) - s.39 issues
8/02/17	Meeting with CEO, Law Society
10/02/17	Meeting at SIRA - s.39
14/02/17	Meeting with Allianz
14/02/17	Meeting with Data Transformation Agency
15/02/17	Meeting with QBE TMF
17/02/17	Meeting with G Larkin (icare) - s.39 issues
22/02/17	Bathurst paralegal course
22/02/17	IAIABC International Committee telephone meeting
23/02/17	ICNSW regular meeting
27/02/17	Workers Compensation Summit - Melbourne
10/03/17	Meeting with G Larkin (icare) - s.39 issues
13/03/17	Meeting at SIRA - s.39
14/03/17	Meeting with Allianz
15/03/17	NCAT - disciplinary hearing - WIRO complaint against lawyer
21/03/17	Workers Compensation Conference - Bonville
23/03/17	ICNSW regular meeting
24/03/17	Meeting with G Larkin (icare) - s.39 issues
30/03/17	Meeting with Guidewire
3/04/17	Meeting with Workers Compensation Commission - s.39
5/04/17	SIRA Consultation meeting

DATE	DESCRIPTION
6/04/17	WIRO Insurer training workshop
10/04/17	Meeting with IMO
11/04/17	Visit to WIRO by Minister Dominello
13/04/17	ICNSW regular meeting
24/04/17	IAIABC Forum - Kansas City - International Committee Meeting
25/04/17	IAIABC Forum - Kansas City - Commissioners Forum
26/04/17	IAIABC Forum - Kansas City - Dispute Resolution Committee
9/05/17	Meeting with Allianz
11/05/17	Presentation to AAMLP meeting
12/05/17	ICNSW presentation about agents model
12/05/17	Meeting with G Larkin (icare) - s.39 issues
17/05/17	Dispute Resolution Reference Group - Meeting with Minister Dominello
19/05/17	WIRO Ballina Seminar
25/05/17	ICNSW regular meeting
26/05/17	WIRO Wollongong Seminar
30/05/17	Meeting with QBE TMF
30/05/17	Meeting with icare about fatalities
5/06/17	WIRO Sydney Seminar - ICC
22/06/17	ICNSW regular meeting
22/06/17	Meeting with G Larkin (icare) - s.39 issues
23/06/17	WIRO Newcastle Seminar