AFEI
Australian Federation of Employers & Industries

Standing Committee on Law and Justice: Statutory review of the State Insurance and Care Governance Act 2015

AFEI response to questions on notice: Threshold

Question:

Mr DAVID SHOEBRIDGE: That hard and fast $30,000 threshold seems to be something that produces a whole lot of adverse consequences—either in employers not employing or being far more aggressive in how they deal with the workers compensation claims or the like. Should there be some sort of sliding scale so that you do not have this harsh threshold? Has that been explored with icare? Maybe you can take that on notice. Mr BRACK: It was $10,000 once; now it is $30,000. You might come up with lots of other things that try to ease the move into claims experience cost. The CHAIR: We have to wrap it up. Mr DAVID SHOEBRIDGE: Given we have run out of time, could you take on notice whether a sliding scale might be a way of avoiding that? The Hon. LYNDA VOLTZ: I ask that each of the organisations answer that question.

Answer:

There is no perfect threshold value, however, we would be happy if the threshold was phased in starting at $30,000 and ranging up to an actuarially determined figure which is certified as not being detrimental to employers or the scheme.

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Standing Committee on Law and Justice: Statutory review of the State Insurance and Care Governance Act 2015

AFEI response to questions on notice: Claims

Question:

The Hon. DAVID CLARKE: Will you supply the Committee with detailed information on the extent of these bogus claims as you see them? Mr BRACK: Does that mean the names of employers? Mr DAVID SHOEBRIDGE: One case. Mr BRACK: If they are prepared to, yes, we will. The Hon. DAVID CLARKE: Except one swallow does not a summer make. Will you supply more than one case? Will you give the Committee detailed information to show that there are widespread bogus claims out there? I put the same question to Mr Aitken. Mr BRACK: I will take that question on notice.

Answer:

The following claim summaries were extracted from our members' recent call files:

Claim 1

An employee had been working as a probationary field technician for less than six months and was to be dismissed for unsatisfactory performance for inaccurate work, poor attendance and the loss of his driver's licence, which was required for his work. At this point the employee claimed to have injured his knee while at work. There was no evidence of the injury occurring at work, to the contrary, the worker had earlier referred to having an "old surfing injury'. The worker was certified unfit for two weeks. The claim was accepted without investigation and the worker placed on restricted office duties of two hours per day nine days per fortnight. During this time the worker discussed his cave exploring with colleagues and took two weeks annual leave overseas. On his return he showed colleagues pictures of him climbing a mountain.

Three months after reporting the injury the worker had surgery on his knee, calling the insurer on the day of surgery to inform them it was proceeding. At that point the insurer had not approved the surgery and had not done an independent claim assessment but agreed on that day that the surgery would be approved. The employee was certified as totally unfit for four weeks after the surgery. He was then certified fit for carrying out light office duties for two hours per day for nine days a fortnight. During this time the employee was observed at a local sporting working bee doing physical work specifically excluded by his work capacity certificate – squatting, twisting, bending. A month later the return to work plan was altered to 3.5 hours for nine days per fortnight. The worker was recalcitrant in adhering to his return to work plan, was frequently late to work, left early or did not attend at all. His compliance was not enforced by the insurer. Four months after the surgery the surgeon has declared the employee's knee to be fully recovered and certified him fit for return to pre injury duties. The worker has not yet returned to work with the rehabilitation provider advising the employer that there is to be another claim review date in a month's time.

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Claim 2

The employee alleged she sustained a fall in wet weather during a recess period on a Friday and hurt her arm. She made no mention of this on the day and employees working alongside her on that day provided signed statements in the factual investigation that the employee showed no sign of having slipped on wet ground, or having an injury and performed her duties as usual and without complaint. These duties included lifting objects of various weights.

On Saturday the employee's Facebook profile, shared by co workers, at 8.46 am asked *"What was on today"*. At 11:28 am on the same day a further post showed the employee was at the hospital and that she had *"broken her arm"*. On Tuesday, the employee attended work with a work capacity certificate, stating a *"severe sprain/fracture"* and the date of injury as the previous Friday, for restricted duties for a two week period. The employee subsequently remained on restricted duties capacity for a month and resigned a month later. Following her resignation, the employee, not the insurer, notified the employer that her claim had been accepted. The insurer has advised the employer that as the worker is no longer employed they do not have to provide the employer with information about the claim, despite its cost to the employer.

Claim 3

A clerical worker with a desk job claimed a knee injury whilst at work which required surgery. Following surgery, the worker was reluctant to return to work on suitable duties even though the work was clerical and required no physical activity. Four months later the employer was becoming frustrated by the worker continually being certified unfit for any work by his treating doctor. The employer advised the rehabilitation provider that the claimant's behaviour was causing unease and disruption in the workplace. The rehabilitation provider suggested the employer withdraw their provisions for suitable employment and that the rehabilitation provider would place this worker on a job seeking program.

However, the worker remained on weekly benefits and not at work for another year. At this time the employer was advised that their premium would increase by more than $100,000. Realizing they needed to take action they sought external advice to assess the worker's capacity and to encourage the insurer to return the worker to suitable employment for the worker's capacity. The worker declined the offer and weekly benefits were finally stopped by the insurer. The employer suffered the cost of this claim in their premium for three years.

Claim 4

Employee had been on workers compensation suitable duties for seven months following surgery for a hernia which had been accepted by the insurer as caused by work. Throughout this period his behaviour in the office environment was very disruptive and a distraction for other workers and required close supervision of the worker to avoid problems with fellow employees. It also required considerable management time expended on getting the worker to adhere to his return to work plan, including attendance at work and medical appointments. Shortly before he was scheduled to be certified fit for usual duties the worker alleged that he had slipped at work and injured his shoulder. There were no witnesses or evidence of the event. This claim was also accepted by the insurer. The employer is now faced with an even lengthier period of having to provide suitable duties for a worker who does not comply with return to work obligations and an insurer who does not require employee compliance.

Claim 5

Employee performing gardening duties claimed he sprained his ankle at work. After two months of being certified unfit for any work, the employee accepted a return to work plan which set out a graduated suitable duties plan of restricted work on reduced hours and reduced days. The employee failed to comply with these requirements and required continual employer intervention with the insurer's rehabilitation provider to encourage the employee to accept a plan he could comply with. Despite continual adjustments to the return to work plan and the involvement of other service providers, including extensive physiotherapy and pain management specialists, after two years the employee contends that he is still unable to wear the safety boots needed for him to perform his usual duties and remains unwilling to meet the requirements of a return to work plan on a weekly basis.

Claim 6

The employee was placed on a work performance plan after almost 6 months of service. This followed a formal warning after it was found that she did not properly supervise children in accordance with mandatory procedures. Shortly after this, she was given a second warning for the same misconduct.

At this time the employee claimed she injured her ankle while at work, provided a work capacity certificate and was on restricted duties for two days. She then again breached operating procedures, was given a final warning and was dismissed. She was provided with 4 weeks payment in lieu of notice and commenced employment with another preschool within this period. During this period the employee obtained a work capacity certificate certifying her as only fit for light duties and was paid two week's additional compensation by the insurer. The employee refused to provide a statutory declaration to the insurer regarding her employment status.

The employer, who was premium impacted, complained to the insurer about the additional payment, who after a period of four months acknowledged by email that the above amount was incorrectly paid. The employer was subsequently transferred to another insurer but without final confirmation that the amount was wrongly paid, or that the amount had been recovered and that it would not impact the employer's premium.

Claim 7

The employee was off work for most of the past year with an injured shoulder and limited work capacity according to the treating doctor's work capacity certificates. The employer offered to retrain him in other areas and he refused suitable duties. When given a full clearance and recommencing work, the employee claimed that he injured the other shoulder and this has been accepted by the insurer. This is his sixth workers compensation claim.

Claim 8

An employee was issued with a warning for a serious breach of workplace policies, which were known and understood by the employee. She was issued with a warning. The following day, a Friday, at the employer's instigation, the employee was not required for work but was paid for this day. On the Monday the employee called in sick and provided a Work Capacity Certificate stating no work capacity for a week due to her anxiety caused by workplace bullying, which was attributed to a staff rostering meeting one month earlier. An identical second work capacity certificate followed for a further week. On the same day the employee resigned, giving the required one week notice period. During this time

the employee obtained employment elsewhere ie within the time period certified as having no work capacity. The employer complained to the insurer, requested the claim be reasonably declined and investigated. The employee was referred to an IME for an appointment later the following month and some two months later the employer was notified that the claim had been declined.

Claim 9

Employee was given a final warning for multiple performance issues which included using derogatory language to fellow female workers, threatening and aggressive behaviour at work. The employee then made a claim for a back injury which his doctor certified as a work injury. This was accepted by the insurer. The worker has not worked for twelve months because of his ongoing work capacity certificate restrictions which preclude any work with his pre injury employer. The rehabilitation provider and the insurer have not sought to find alternative employment opportunities elsewhere.

Claim 10

An employee who was being performance managed requested leave to go on a holiday. The employee's leave entitlements had been exhausted and her subsequent request for unpaid leave was refused for operational reasons. The employee then made a claim for psychological injury alleging that she was injured because of a bullying and harassment incident which occurred two years earlier. The work capacity certificate certified her unfit for work for two weeks and was subsequently followed by additional certificates on a fortnightly basis for an additional month, at which point the employee was returned to work on a graduated basis of reduced hours and days.

The insurer accepted the claim despite conducting an investigation which did not substantiate the harassment and bullying claim and that it had never been raised by the employee prior to making the claim. This included during the performance management process in which management was attempting to identify any factors which may have been contributing to her poor work record and to assist her to improve her work. The employer also undertook an investigation into the allegation. This employer had stringent policies and procedures in place to prevent, report and address workplace bullying and provided an EAP readily available and cost free to their employees.

Claim 11—Numerous claims with following characteristics:

- Employee is being performance managed or on final warning.
- Makes a psychological injury claim for bullying and harassment.
- Insurer accepts claim, even where investigation does not objectively find bullying/harassment occurred and in circumstances where the employer should be exempt from the claim being made for having taken reasonable management action in a reasonable manner (1987 Act s 11A). icare and the NTD accept the worker's perception as the primary determinant of claims acceptance.
- Employee is certified as having no work capacity, even in situations where the employer can provide suitable duties in an environment which would not present psychological risks to the worker.
- Employee can be absent from work for many months, typically at least two months with no work capacity. If they return to work at all, this is usually with numerous restrictions as to hours and duties, a situation which can continue indefinitely.

- Frequently the employee resigns after a period of time on compensation, leaving the employer with no opportunity to provide a return to work plan and consequent increased claims costs.
- These claims are extremely expensive for claims impacted employers. The median time lost for mental disorder has risen from 11.2 weeks in 2000-01 to 16 weeks in 2014-15. At the same time, spinal cord injuries dropped by over half, from 26 weeks to 12 weeks. (Safe Work Australia)

Employer costs are exacerbated by the detrimental impact these claims have on co workers and the workplace culture. They demonstrate the ease with which claims with lengthy periods off work can be made, requiring only the worker's perception that they have suffered an injury and this is accepted by their NTD. They engender resentment that workers are able to re engineer their working arrangements with lengthy return to work plans which can be to the detriment of other workers.

What employers say about icare claims acceptance and management – recent comments to AFEI about their current claims experience:

The workers compensation system is broken. The word of the employee, no matter how vague their claim is, is always accepted and can be used to drag out their return to work for months. The number of times we have seen an injury or stress claim dragged out when if the same issue occurred outside work they probably would not even to go to the doctor or physio etc. There is a complete imbalance and readiness of the treating doctor, insurers and icare to accept claims and allow employees to take advantage of workers comp without any thought of the costs borne by employers.

I usually do not get a rationale for accepting claims but in this one it was because the insurer felt the employee's manager should have been more proactive in making pastoral calls to the employee – even tho' the employee had made it clear they wanted no contact and communicated in very clipped text messages.

Icare have told us that if the employee says they are injured at work and the doctor thinks they were, that is all that is needed to accept a claim.

The insurer says they accept claims because if they are disputed, they will not get through the workers compensation commission.

Even when we have presented strong factual evidence to external factors being the primary source of the claim, the insurer says this does not disprove that the injury was connected to work related activities.

The cost and number of specialists used to get an employee back to work is excessive. No one would pay for this if it was a non work injury. The system is there to be taken advantage of. Genuine claims are a different matter but more needs to be done to place more responsibility on the employee. Treating doctors often treat the employer as the enemy when all we are trying to do is get the employee back to work. The amount of time off seems often not a reflection of the condition but the employee. We have had more serious incidents where the employee returns quickly and other claims we question drag on with the employee off work for months and the treating doctor and rehab just support this.

Rehab providers hinder the shorter duration of claims.

The treating practitioner's information was insufficient but icare still decided against providing an IME to assess a workers fitness and to provide a good treatment outcome. Six months later they are still off work.

Staff have a very low burden of proof to satisfy that they can take time off work and we feel powerless to stop them gaming the system.

Employees can simply say they hurt themselves at work and we have to wear the claims, no questions asked.

Workers compensation is costing us thousands. They change the system but the outcome stays the same and there is never real reform. Employees see workers comp as an entitlement with no consequence for the employer. We pay very close attention to safety and spend thousands on that too but the compo system just encourages employees to make claims. They also think we don't pay for it – we do. No wonder wages aren't increasing we can't afford it!

Employers are vulnerable to employees leading the claim and deciding when/if they are going to participate fully in genuinely working toward a return to work and PID. Our experience is that doctors are not supportive or educated in the benefits of staff recovering at work and are unduly influenced by the employee's own preferences.

The investigator informed us there was no basis for the claim but the insurer accepted it anyway. We could not get a clear explanation as to why, other than it was because of the doctor.

In workers comp staff have all the rights it's impossible to prove the employee wrong.

The insurer's investigator told us that there was no evidence showing the claim happened at work but it was accepted anyway.

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