Have self-insurers adopted any of the 1 January 2018 changes implemented by iCare and if not do you think the Committee should formally recommend that they be required to?

We endeavoured to obtain information about this from key self-insurers however they have not provided this information prior to the deadline for response. If we are able to get further information about this we would be happy to share that with the Committee.

We note that we frequently see delay in notification of the injury. Whilst the onus is on the employer to report or notify the insurer of an injury, not on the insurer to chase up potential injuries one would expect that being self-insured, the process would be quicker. However, there seem to be issues with employers not notifying the insurer of injuries until a WorkCover certificate is handed in. Even in these circumstances, occasionally the WorkCover certificates are not passed on within 48 hours to the insurer either. Therefore we say self-insurers should be encouraged to implement the 1 January changes and effectively communicate this.

In respect to the self-insurers and their dispute resolution procedure, given that your association has slightly disproportionate levels of exposure to the self-insurers, are you able to tell us a little more about how they are going?

We encounter a variety of issues in the workers compensation claims process and dispute resolution process. Given that the SDA almost exclusively deals with self-insurers it is not known whether these are system wide problems or specific to self-insurers so we intend to highlight the key problems we experience with both.

A key issue we encounter with self-insurers is a high frequency of reasonably excusing claims (not paying medical expenses straight up or accepting provisional liability). This often occurs at the latest possible date so that an injured worker is left waiting only to discover that they have to continue to wait for a decision without payment. Insurers should advise injured workers as soon as possible about whether provisional liability is accepted or reasonably excused. This is not always done promptly and if they decide not to accept provisional liability, they sometimes take more than 21 days to make a decision on liability.

There are constant problems with weekly payments of compensation – the employer gives details of what hours were worked to the insurer and the insurer then pays the employer who then pays the injured worker. Despite being a self-insurer and the level of consistency that should exist in this situation we frequently see mistakes in payments made or payments may not being made at all.

In addition to this, case managers do not communicate effectively with injured workers. They often do not return phone calls or emails and the correspondence are not always clear and too technical for the injured workers to understand. Case managers are not always prompt in approving treatment and the injured worker is left waiting for approval of treatment. The combination of these factors frequently results in a secondary psychological injury for the injured worker as they are without pay, in limbo waiting for information and cannot contact anyone for information. This also makes the dispute process difficult when a point of contact cannot be easily found.

In terms of efficiency on ILARS, it is all online and it is all done within five days. Can you think of a more efficient way of doing ILARS?

We have consulted with our solicitors in relation to this question and whilst they have indicated their views about the pros and cons of the ILARS process no suggestions have been offered about improving the efficiency of the process. The concerns predominantly arise out of the current funding levels. One issue raised is that there can be difficulty and delays when a solicitor requires further funding as they must repeatedly reach out to WIRO to discuss and justify the funding request.

We also note on the point of WIRO/ILARS funding, as a representative of low paid workers, that they encounter issues with the system as one of the requirements for provision of funding is that they need to have suffered a financial loss of at least $3000. For those injured workers who are on a low income and may have only taken off a couple of weeks off work, or have only had 1 MRI and not too many medical expenses, they wouldn't qualify for funding of their disputes. We understand that this may not be economically viable for ILARS to fund a $700 claim to invest thousands of dollars to fund the claim however $700 is a significant cost to a low paid employee. We suggest the $3000 qualification be removed or reduced and the necessary funding be provided to ILARs to enable this.