Submission No 36

REVIEW OF THE EXERCISE OF THE FUNCTIONS OF THE WORKCOVER AUTHORITY

Organisation: WorkCover Independent Review Office

Date received: 7/02/2014

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WorkCover independent review office

FIRST REVIEW OF THE EXERCISE OF THE FUNCTIONS OF THE WORKCOVER AUTHORITY

SUBMISSION OF THE WORKCOVER INDEPENDENT REVIEW OFFICER TO THE LAW AND JUSTICE COMMITTEE

7 FEBRUARY 2014

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1 Introduction

The WorkCover Independent Review Officer ("WIRO") was created by the NSW Government as part of the 2012 reforms in response to stakeholder feedback for an independent body to deal with individual complaints and provide greater accountability to the NSW Workers Compensation System.

The functions of WIRO are set out in section 27 of the *Workplace Injury Management and Workers Compensation* Act 1998 ("1998 Act") and are as follows:

- to deal with complaints made to WIRO by a worker about any act or omission of an insurer that affects the entitlements rights or obligations of the worker under the Workers Compensation Acts;
- to review work capacity decisions of insurers;
- to inquire into and report to the Minister on such matters arising in connection with the operation of the Workers Compensation Acts as WIRO considers appropriate or as may be referred to WIRO for enquiry and report by the Minister;
- to encourage the establishment by insurers and employers of complaint resolution processes for complaints arising under the Workers Compensation Acts; and
- such other functions as may be conferred on WIRO by or under the Workers Compensation Acts or any other Act.

In addition the Government conferred on WIRO the management of the Independent Legal Assistance and Review Service ("ILARS") which was also operational from 1 October 2012.

The information WIRO receives from its functions enables the office to be at the forefront of any issues with the conduct of the WorkCover Scheme.

Further information about WIRO and its performance can be found at our website www.wiro.nsw.gov.au.

2 Regulator or Insurer?

The WorkCover Authority ("WorkCover") is the regulator responsible for the administration and regulation of the Workers Compensation Acts in New South Wales.

The role of the regulator in a general sense is to achieve the Government's legislation objectives by facilitating compliance with the legislative framework through education, engagement and enforcement in a cost effective way.

The Nominal Insurer is responsible for one of the largest injury compensation funds in Australia. It is the principal insurer of Workers Compensation in New South Wales, along with the the self and specialised insurers. The Nominal Insurer appoints Scheme Agents through contractual arrangements, known as the Scheme Agent Deed, to issue workers compensation policies to employers and undertake the management of claims made by injured workers.

While there are references throughout the legislation to insurance and insurers these are quite misleading to members of the public because in fact there is no insurance and no insurers. There is a fund which collects the monies paid by employers and which distributes those monies in the payment of benefits for those who are eligible for benefits as a result of a workplace injury. It should be noted that about one third of all payments from the fund are for medical treatment and related expenses.

In essence, the role of the regulator is to ensure compliance with the law and to make those who break the law accountable. In contrast, the Nominal Insurer has the commercial imperative to keep the scheme commercially viable. By virtue of section 23A of the 1998 Act, WorkCover acts on behalf of the Nominal Insurer.

WorkCover is primarily organised by its regulatory responsibility, that is, Work Health and Safety and Workers Compensation. The legislative framework and organisational structure does not assist staff to separate their tasks and manage the potential conflicts as and when they may emerge.

The legislation intertwines the responsibilities in such a way as to often confuse the two roles. Decisions on issues such as premium and benefit level, medical and legal costs are controlled by WorkCover in its capacity as regulator. The regulator also issues the claims technical manual which provides detailed instruction on the management of claims and their categorisation. Whereas the Nominal Insurer issues operational directions to Scheme Agents and contract management of the Scheme Agent Deed.

The performance of the Nominal Insurer is reliant in part upon the performance of Scheme Agents and in part by the investment performance of the fund. The effectiveness of the Scheme Agents is controlled primarily through the Scheme Agent Deed and with performance incentive arrangements.

Unfortunately, the incentive arrangements are not available publicly or otherwise, in general or in detail, making it impossible to comment on whether the incentive arrangement is effective or appropriate.

The Workers Compensation Insurance Division's organisational structure provides no distinction or separation between its regulatory and insurance functions. Indeed the delegation manual for WorkCover outlines that senior staff who have delegations for the regulatory functions also have delegation for the functions of the Nominal Insurer. To an outsider, the only way at times to distinguish in which capacity the personnel within WorkCover are acting is the letterhead in which correspondence is written. So whose interests prevail when a conflict between objectives arises and what governance arrangements are in place to address this?

At present there appears to be an inadequate separation of powers and functions between WorkCover's role as a regulator and the Nominal Insurer. It is recommended that the functions and responsibilities between the regulator and the Nominal Insurer be separated to ensure that the Nominal Insurer's commercial objectives do not interfere with the administration and regulation of the scheme.

3 Non Compliance with the Legislation

3.1 General

One of the fundamental functions of WorkCover is to ensure compliance with legislation, namely the Workers Compensation Acts[1]. This is part of its regulatory role. A disconnect exists between the Workers Compensation Acts and Regulations in New South Wales and the way the legislation is implemented by the regulator.

Ironically, WorkCover has not complied with the legislation that it is responsible for in setting policy directives for Insurers in respect to the management of claims by injured workers.

Whilst it is acknowledged that the management of any workers compensation scheme is complex and the task of implementing the June 2012 legislative reforms was a significant project. WorkCover have on occasions failed to comply with the legislation for which it is responsible.

There are a number of examples to demonstrate this lack of compliance.

3.2 Transition of injured workers to the new weekly payments regime.

The Government determined that there should be four categories of injured worker that were impacted on by the reform process. These were:

[1] See section 22(1)(a)of the *Workplace Injury and Workers Compensation Act* 1998

(a) Seriously injured workers;

(b) Those workers injured before 1 October 2012 who had made a claim and who were in receipt of weekly payments compensation immediately before that date;

(c) Those workers who were injured before 1 October 2012 who had made a claim but were not in receipt of weekly payments compensation at that date;[2] and

(d) Workers who first make a claim after 1 October 2012 irrespective of the date of the injury.

The Legislation provided that injured workers who fell into category (a) would be subject to the new regime from 17 September 2012 and those in category (b) would be required to be transitioned to the new weekly payments regime on or before 31 March 2014. Those in categories (c) and (d) would be subject to the new regime with effect from 1 October 2012.

Clause 2 of Schedule 8 to the Workers Compensation Regulation 2010 provided that a seriously injured worker[3] who had made a claim before 17 September 2012 would receive the new weekly payments. This applied irrespective of whether or not the seriously injured worker was an existing weekly recipient.

Clause 3 of Division 1 of Part 19H of Schedule 6 of the *Workers Compensation Act* 1987 ("1987 Act") provided that an amendment made by the Workers Compensation Legislation Amendment Act extended to:

- an injury received before the commencement of the amendment;
- a claim for compensation made before that commencement; and
- proceedings pending in the Commission before the commencement of the amendment (except where provided by Part 19H or the regulations).

Division 2 of Part 19H of Schedule 6 of the 1987 Act relates to weekly payments. Clause 6 outlines how the changes made to weekly payments are to apply to existing claimants i.e. workers who fall into category (b) as described above.

Clause 6 provides

> *An existing recipient of weekly payments remains entitled to compensation under Division 2 of Part 3 of the 1987 Act as if the weekly payments amendments had not been made, but only until the weekly payments amendments apply to the compensation payable to the person as provided by this Division.*

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[2] This group also includes workers who
(a) Had made claim which was declined by the insurer;
(b) Workers in receipt of medical benefits only; and
(c) Workers who have a future medical entitlement

[3] Assessed as having a degree of permanent impairment of more than 30 per cent.

This Clause is the mechanism that governed the transition of injured workers that fall in category (b) to the new weekly payments regime. Consequently, the only group of workers who can be transitioned are those in category (b) as it only applied to workers already in receipt of weekly benefits immediately before 1 October 2012 and not to those workers who were entitled to but not in receipt of weekly benefits immediately before 1 October 2012.

The definition of "existing recipient of weekly payments" is contained in Clause 1 of Division of Part 19H of Schedule 6 of the 1987 Act which is in the following terms:

> "***existing recipient of weekly payments*** means an injured worker who is in receipt of weekly payments of compensation immediately before the commencement of the weekly payments amendments."

As a result of the provision of Clause 6 and Clause 1, it was only possible for an insurer as part of the transition process to conduct a work capacity assessment of workers who fell into category (b) as described above.

Notwithstanding this WorkCover determined and advised insurers that all injured workers who had made a claim before 1 October 2012 which was still considered "open", that is those workers described in categories (b) and (c) had to be transitioned and therefore the subject of a work capacity assessment.

That does not appear to be in compliance with the legislation. It is also contrary to findings of the Workers Compensation Commission.

What impact does this have?

Injured workers whose claims were the subject of a denial of liability were informed that their pre-injury average weekly earnings would be fixed at the transition rate rather than the correct earnings rate.

Insurers have conducted a significant number of work capacity assessments which were not required. The reported statistics for the transition of the required injured workers are therefore distorted. There is no proper measure of the success of the transition phase following the reforms.

3.3 Zero weekly entitlements

Sections 32 - 37 of the 1987 Act govern the calculation and period of entitlement to weekly benefits. WorkCover issued a policy directive to insurers regarding the determination of periods of entitlement for the purposes of calculating the number of weeks in each entitlement period.

Once a claim has been accepted, it is necessary to determine the amount of the weekly payment payable. If the calculation results in the amount of the currently weekly earnings being equal or higher to the amount of pre injury weekly earnings then no weekly benefit payment is payable.

WorkCover suggested that those workers entitled to benefits but who received zero weekly benefits were to be treated as if they were in receipt of weekly benefits for the purposes of determining the period of entitlement.

What impact does this have?

The real impact of this policy determination is that the cap on the number of weeks that an injured worker is entitled to a weekly payment is calculated by including a week in which the worker did not in fact receive a payment. If this view was correct it would be possible to exhaust an injured worker's rights by paying zero per week for 130 weeks.

3.4 Enforcement Activity

Section 23(l) provides the specific function for compliance and enforcement activity in relation to injury management, worker rehabilitation, workers compensation insurance and insurer licensing.

A review of the WorkCover and lawlink websites do not disclose any compliance or enforcement activity in relation to offences created under the Workers Compensation Acts, despite there being many offences.

The only enforcement activity relates to fraudulent claims made by injured workers.

The lack of enforcement activity may be illustrated through examining section 54 of the 1987 Act and reports provided by medical specialists.

3.4.1 Section 54 Notice required before termination or reduction of weekly benefits

Section 54(1) states:

(1) If a worker has received weekly payments of compensation for a continuous period of at least 12 weeks, the person paying the compensation must not discontinue payment, or reduce the amount, of the compensation without first giving the worker not less than the required period of notice of intention to discontinue payment of the compensation or to reduce the amount of the compensation.

Maximum penalty: 50 penalty units.

Despite the widespread failure throughout the Insurers to comply with the proper notice required in sections 54 (2)(a) &(b) there has not been any prosecution of any insurer for any breach.

What impact does this have ?

The need to provide the correct notice to an injured worker of the reduction of his or her weekly payments or the termination of them is important given the restriction on an injured worker obtaining legal advice[4] about his or her entitlements and the lack of alternative specialist advice.

While there appears to be the right to recover weekly payments not correctly made because of incorrect notice there is no simple remedy available to an injured worker to recoup any loss. That assumes the injured worker is aware of the failure by the insurer to provide the proper notice and that there is a concession that an offence has occurred.

3.4.2 Medical Specialists Refusal to comply with legislation

One of the fundamental requirements for an injured worker who considers that he or she has reached the threshold which entitles them to a payment of lump sum compensation in respect of an injury which caused permanent impairment is to obtain evidence of the degree of permanent impairment.

This is usually done by the lawyer for the injured worker providing an independent medical specialist with the details of the circumstances which led to the injury and seeking an opinion in accordance with the standards promulgated in the appropriate WorkCover guidelines of the degree of permanent impairment.

The provision of such reports are regulated by the *Workplace Injury Management and Workers Compensation (Medical Examinations and Reports) Order 2014.* The Order sets out the basis upon which the reports to be provided and the maximum fees to be charged by the independent medical specialist.

There are many instances of the deliberate refusal or failure by medical practitioners to comply with the terms of this Order. I have referred details of some of these breaches to WorkCover but I am not aware of any action taken by WorkCover in that regard.

What impact does this have ?

My office is not entitled to reimburse the lawyer who has paid for the independent medical examination and report in excess of the scheduled fee. That means that either the lawyer meets the additional cost or more usually the injured worker has to fund the excess over the scheduled fee.

[4] Section 44(6) of the *Workers Compensation Act* 1987.

3.5 Status of Guidelines

WorkCover Guidelines carry different statuses - some are delegated legislation and some are simply Guidelines for the guidance of insurers. However it is difficult to appreciate the difference and the response by WorkCover as to the status of each Guideline is not always clear or consistent.

Best Practice Decision-making Guide

The initial version of the Guidelines for Work Capacity Decision Internal Reviews by Insurers and Merit Reviews by the Authority (referred to as the "Review Guidelines") was cited as being delegated legislation in its companion guideline "Work Capacity Guidelines".

The Review Guidelines outlined four "Guiding Principles" for the making of work capacity decisions which required adherence to the "Best Practice Decision-making Guide". That Guide does not exist and has never existed. Any decision of an insurer during that period has been held to be invalid.

Although this failure has to date been appreciated by less than a hundred injured workers the potential remains for further consideration of the procedures of the insurers.

What impact does this have?

According to the information provided by WorkCover, as at 1 October 2013 (being the date closest to the amending Guideline) there are approximately 9,000 affected workers.

3.6 Production of approved forms

There are in sections 38 & 44 of the 1987 Act references made to the "form approved by the Authority" in four separate subsections. WorkCover produced some but not all of these forms. The ones not produced were those required by section 44(3)(a) being the notices of the decisions of the Insurer on an internal review and of the WorkCover Authority on a merits review.

WorkCover provided a revised version of the Work Capacity Guidelines in October 2013. This version included the form for the notice of the decision on an internal review but not the one for the merit review.

What impact does this have ?

Section 44(3)(a) provides that an injured worker has 30 days from the time when she or he receives notice in the approved form to seek a review of the decision of the Insurer on the internal review.

The time for a worker to seek a review of the decisions completed prior to 8 October 2013 remains open and an application for review may be made at any time until such notice is properly given.

There are approximately 1,800 injured workers who could be affected by this failure.

Similarly as there is no form as yet approved by WorkCover, the same group may seek a review of any Merit Review recommendation.

While reference to this aspect may seem pedantic the time for seeking a review remains open into the future with the consequent potential contingent liability for the Scheme.

4 Transparency, Consultation and Communication

Generally, there is a reluctance by WorkCover to engage with the participants in the Workers Compensation Community. The opportunity to contribute, receive feedback and be informed of the work being undertaken is often denied.

During the reform process, consultation with stakeholders was undertaken albeit with different levels of success. However, following the introduction of the legislation those sessions and groups appear to have been disbanded. An example of this was the legal reference stakeholder group.

Obtaining information from WorkCover is also challenging, whether it be informally or formally. The WorkCover website is difficult to navigate and populated with outdated and incorrect information.

4.1 Amendments to the Regulations

4.1.1 Legal costs – amendment made on 21 December 2012[5]

Section 341 of the *Workplace Injury Management and Workers Compensation Act* 1998 was amended to provide that injured workers had to pay their own legal costs in relation to a claim for compensation. This provision took effect from 1 October 2012.

The *Workers Compensation Regulation* 2010 which had been gazetted on 28 September 2012 provided that the previous section 341 costs regime (injured worker's costs generally paid by the insurer) would continue to apply to those injured workers with a claim before 1 October 2012 who lodged an application with the Workers Compensation Commission before 1 January 2013.

As a result lawyers for injured workers expended considerable effort and resources to attempt to lodge claims with the Commission. This also resulted in considerable resources being devoted to the process within the Commission.

[5] SI 665 of 2012

The Government (upon the recommendation of WorkCover) introduced a regulation on 21 December 2012 which was published on the Government website but not otherwise announced extending the time for lodgement to 31 March 2013.

4.1.2 Medical treatment expense entitlement Regulation - 20 December 2013

Almost exactly a year later, the same situation arose. This time in relation to the entitlement to medical expenses. A cohort of injured workers existed who had been approved for treatment which could not be completed within the 12 month timeframe but for which these injured workers would otherwise be entitled to.

The late amendment and the lack of consultation impacted upon the eligibility of workers to organise themselves accordingly. My office was refusing ILARS grants as there was no prospect of getting the required report and then the treatment within the timeframe. Had my office been consulted and had the amendment to the regulation be made earlier a smoother and fairer transition would have occurred.

My office had consulted with and obtained significant cooperation from the Workers Compensation Commission who were excellent in adapting their work flow and timetables to accommodate the prompt resolution of medical disputes to permit the treatment to be performed prior to 31 December 2013.

I should also congratulate the Scheme Agents who also went to great lengths to accommodate the urgent requests from injured workers (some of whom felt desperate) for approval of medical treatment again so that it could be undertaken before the year end.

There was no inkling within this group that there could possibly be an extension of time for the treatment to be undertaken and that all that would be required was an approval before 31 December 2013.

My office which had dealt with hundreds of requests for assistance had commenced informing injured workers from the first week in December that there was no point in seeking approval for further medical treatment unless they were certain that it could be undertaken in time.

The sudden change of policy has left hundreds of workers unable to have their medical treatment covered by the insurers as it was not approved prior to 31 December 2013. When the Regulation was issued there were four business days (including Christmas Eve) for workers to attempt to gain approval for treatment.

A search of the WorkCover website does not reveal any reference to this amendment and how it impacts injured workers rights.

4.2 Consultation and Communication with Workers Compensation Community

In the 15 months that this office has been operation, it has observed a lack of genuine consultation by WorkCover with the Workers Compensation stakeholder Community. Often the only parties that are spoken with on a regular basis are the Scheme Agents.

During the reform period there have been various amendments made to the Guidelines and Regulations, however WIRO has not been invited to discuss or participate in the revision process, despite employing 14 principal lawyers who specialise in Workers Compensation and informing WorkCover on a number of occasion of significant deficiencies to be addressed.

I am not aware of any consultation with lawyers, medical professionals and unions in relation to these changes. However, we are aware of consultation with Scheme Agents in relation to the Guidelines. Further, once the changes are made there is no communication to relevant parties to inform them.

The Guidelines are not clearly published and easily accessible on WorkCover's website so it can be at times difficult to determine which Guidelines are current or obsolete. [6]

The lack of consultation and communication impacts on the level of awareness in the Workers Compensation Community resulting in inefficiencies and unfairness in the management of matters.

Further, there is very little information about the WIRO office and its functions on WorkCover's website and associated fact sheets which were published between December 2012 and April 2013. I have brought these issues formally to WorkCover's attention and have yet to observe any changes to the information available.

4.3 Sharing of Statistical Information and Performance Reporting

Section 23(m) provides for WorkCover to collect, analyse and publish statistical data. Unfortunately, this function has not been maintained. The last statistical bulletin was published in 2010 for the period 2008/2009 and the last Scheme Agent claims performance report was published in December 2012.

[6] The Guidelines are currently found under forms and publications page and searching under guides. It should be noted that this also brings up a suite of other guides unrelated to the administration of workers compensation.

5. High Cost Aspects of the Scheme

There are a number of high cost aspects of the WorkCover Scheme which WorkCover has the function to identify[7]. My office has endeavoured to assist with initiatives in these areas with a view to a reduction in those unnecessary high costs.

(1) The present system is that an injured worker who has sustained a workplace injury has to obtain an independent medical report from a qualified specialist which is then submitted to the Insurer in support of a claim for lump sum compensation.

If the insurer disagrees it proceeds to obtains its own report. Where that differs from that of the worker the dispute is not capable of resolution except if the parties agree to one of the ratings of permanent impairment. WorkCovers position is not to allow a Scheme Agent to enter into a commercial compromise of the claim.

This leads to the silly situation that a dispute may exist over a difference of less than a few thousand dollars but which then costs more than that to resolve which the Scheme has to fund.

It is uneconomic to have a dispute resolution mechanism which costs more than the amount in dispute.

(2) An injured worker who alleges that the employer was negligent has to first endure the dispute resolution process in respect to determining her or his right to lump sum compensation through the Workers Compensation Commission which may involve a contested hearing and then has to start again in a different jurisdiction (District or Supreme Court) and endure the process of evidence gathering and again face a contested hearing.

While there may be incidents surrounding the injury which require careful review and there may be differences in the potential award of damages the cost and delay for many workers is unacceptable.

The dispute in many cases is able to be simply resolved at the very early stage and it should be open to the parties to resolve both claims at a much earlier stage of the process.

KA Garling
WorkCover Independent Review Officer
7 February 2014

[7] Section 23 (1)(c) of the 1998 Act