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FIRST REVIEW OF THE WORKERS COMPENSATION SCHEME

Organisation: Workers Compensation Independent Review Office (WIRO)

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SUBMISSION TO THE STANDING COMMITTEE ON LAW & JUSTICE

REVIEW OF THE WORKERS COMPENSATION SCHEME

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WHAT IS THE WORKERS COMPENSATION INDEPENDENT REVIEW OFFICE AND WHAT DOES IT DO ?

The Workers Compensation Independent Review Office ("WIRO") was created in the 2012 Reforms and on 1 October 2016 will complete four years of operations. The Office undertakes the following functions:

[1] Complaints from injured workers about the conduct of their claims by insurers;

[2] Disputes between employers and their scheme agents;

[3] Conducting procedural reviews of work capacity decisions by insurers of workers;

[4] Conducting reviews of the workers compensation scheme and reporting to the Minister;

[5] Funding injured workers legal costs in relation to disputes with insurers.

The office is funded from the Workers Compensation Operational Fund which is maintained by the State Insurance Regulatory Authority ("SIRA") which is part of the Department of Finance Services and Innovation ("DFSI"). There are limited financial and recruitment delegations from DFSI for the WIRO. In practice this limits the independence of WIRO.

The various functions of WIRO have enabled the office to accumulate very significant data about the operation of the workers compensation scheme across all insurers not just the Nominal Insurer which is managed by Insurance & Care NSW ("icare").

WIRO FUNCTIONS

COMPLAINTS BY INJURED WORKERS

Section 27(a) of the *Workplace Injury Management and Workers Compensation Act* 1998 (1998 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 1998 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".*

While each of icare and its claims managers (Scheme Agents) as well as SIRA all have provision for "complaints" to be made about the conduct of claims, none of them have the statutory function that this office has. Each of these "complaints services" operate under different principles which does not allow for a transparent reporting of the reasons for the complaints and the systemic issues which may arise.

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

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

In addition section 27C of the 1998 Act provides:

27C Annual report

(1) As soon as practicable after 30 June (but before 31 December) in each year, the Independent Review Officer is to prepare and forward to the Minister a report on his or her activities for the 12 months ending on 30 June in that year….

(4) The report 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,

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

I established a "Protocol" with Insurers in which they agreed to respond to a "Preliminary Enquiry" about a particular claim within 2 business days. The worker or her or his representative may telephone the WIRO Call Centre (13 94 76) or email a request.

The Call Centre deals with every call promptly and personally.

The experience of this group now known as the "Solutions Group" is that within the 2 day timeframe WIRO receives a response for the worker in almost all enquiries. This occurs because of the cooperation that WIRO receives from every insurer in endeavouring to find a solution rather than strenuously defending their decision.

WIRO publishes quarterly the data about the complaints received and the reasons for those complaints and the insurer involved.

In Appendix "A", I set out the statistics published for the year to 30 June 2016 which is published on the WIRO website.

In Appendix "B" I set out just a few examples of the outcomes achieved by the Solutions Group.

DISPUTES BETWEEN EMPLOYERS AND SCHEME AGENTS

Section 27(d) of the 1998 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,*

I have interpreted this function as not being relevant for self insurers.

There is presently no mechanism for an employer to challenge a decision of a Scheme Agent about a claim from an injured worker. While an injured worker has the right to institute proceedings in the Workers Compensation Commission ("WCC") to overturn a decision of an Insurer there is no such right for an employer.

This is a restriction on the ability of an employer (whose annual premium may be seriously increased as a result of the decision of the insurer) to challenge the insurer's decisions.

In Appendix "C", I look at the impact of claims on small 'experience rated' employers under icare's new premium model. These financial impacts can result from employer, injured worker, scheme agent or other service provider action or inaction. 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.

In order to suggest to employer groups and the insurers a mechanism to enable these disputes to be managed as effectively as possible WIRO has been in consultation with various employer groups as well as directly with individual employers.

WIRO recommends that icare consult with WIRO as to the establishment of a formal process to resolve matters of concern between employers and the Nominal Insurer.

PROCEDURAL REVIEWS OF INSURER WORK CAPACITY DECISIONS

Section 27(b) provides:

> *"The Independent Review Officer has the following functions:*
>
> *(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"*

The 2012 Reforms created a method of dealing with managing claims for compensation by way of weekly payments. A four step process was introduced:

1. A work capacity decision by the Insurer

   The Insurer to consider the following matters arising from a claim for weekly payments by an injured worker:

   (a) a decision about a worker's current work capacity,

   (b) a decision about what constitutes suitable employment for a worker,

   (c) a decision about the amount an injured worker is able to earn in suitable employment,

   (d) a decision about the amount of an injured worker's pre-injury average weekly earnings or current weekly earnings,

   (e) a decision about whether a worker is, as a result of injury, unable without substantial risk of further injury to engage in employment of a certain kind because of the nature of that employment,

   These factors are all considered by an Insurer when making a work capacity decision which cannot be challenged except through the administrative review pathway. As a general principle these are all required to be determined before an Insurer can decide on whether to make payments following the initial notification of an injury to a worker.

   Each time (usually every twenty eight days) when an insurer receives further information about the matters in (a) to (c) and (e) the Insurer makes a new work capacity decision. Often that may not impact either favourably or unfavourably on the worker and may not result in any notification of a change to the weekly payment.

2 An internal review by the Insurer.

The worker may request the Insurer to formally review the decision known as an "Internal review". Ironically the original decision will already have been reviewed by the Insurer before it is issued.

The Insurer has 30 days from the request to either affirm the original decision or issue a new work capacity decision.

3. The Merit Review of the Work Capacity Decision

If the worker is still unhappy she or he may seek a review by the Merit Review Service of SIRA providing that request is made within 30 days of the receipt of the reviewed decision or after expiry of 30 days from the date of the request for internal review.

4. The Procedural Review of the Work Capacity Decision

The final step in the review pathway is to WIRO for a consideration as to whether the insurer complied with the correct process. This too must be made within 30 days of receipt of the recommendation by the Merit Review Service.

Where the Merit Review Service recommends that the insurer undertake a new capacity decision to comply with the recommendation that new decision is subject to the review pathway from the start and such a decision is not reviewable directly by WIRO.

However, even if the new work capacity decision is not reviewable directly by WIRO, the original work capacity decision continues to be reviewable which may lead to some very confusing outcomes.

Each of these reviews must be undertaken by the injured worker without the ability to hire and pay for a lawyer to assist. However, there are a small number of reviews performed by lawyers on a pro bono basis.

Given that there have been hundreds of thousands of work capacity decisions made in the four years the number of challenges through the administrative process is miniscule.

WIRO publishes on its website every procedural review recommendation immediately it is made with the relevant particulars redacted.

WIRO also publishes on its website quarterly data about the procedural review recommendations.

This administrative review process has not been welcomed by any of the stakeholders and has resulted in a miniscule number of reviews compared to the number of weekly payment disputes conducted by the WCC.

WIRO recommends that the administrative dispute resolution process be amended and that the work capacity decisions be reviewable in the Workers Compensation Commission or in a new Personal Injury Division of NCAT.

UNDERTAKING INQUIRIES

Section 27(c) of the 1998 Act provides:

> The Independent Review Officer has the following functions:
>
> *"(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"*

WIRO has also attempted, pursuant to that statutory function to initiate Inquiries:

The two Inquiries were:

[1] The Parkes Project; and

[2] The Effeney Review of Hearing Loss

Neither of these very important Inquiries were finalised because funding was withdrawn by the Department of Finance, Services and Innovation.

[1] PARKES

When the Minister announced that there would be a review of the workers compensation legislation I instituted an Inquiry pursuant to section 27 of the 1998 Act into those parts of the legislation which could be improved in any amending legislation.

There were a number of provisions of the legislation that were internally contradictory and there were other sections which caused difficulties for those dealing with claims management on a daily basis.

I was fortunate in securing the services of Roshana May an expert lawyer to be the Project Manager.

I was also assisted by having The Honourable Conrad Staff, recently retired as a Justice of the NSW Industrial Commission agree to Chair the Parkes Project.

I was able to gather 36 leaders of the workers compensation industry together as an Advisory Group for regular meetings to consider a range of topics around the workers compensation scheme and the need for change.

As a result of the meetings of this powerful advisory group the Project Manager identified those issues which appeared to cause the greatest practical concerns. Research papers were prepared and circulated. These were then the subject of frank discussion by the Group.

Over the course of the work of the Advisory Group a schedule of principles was developed and had support from all parties. The twelve agreed matters are set out in Appendix "D".

It remains a puzzle that with agreement from all participants across the industry that those advising the Minister appeared to not take any of these recommendations into account when recommending some amendments in the 2015 changes which have caused further confusion.

The opportunity to ensure that there was a consistent interpretation of the legislation which reflected the Government policy was lost.

WIRO recommends that funding be restored to complete the Project and that the Advisory Committee continue to be funded to regularly provide advice to the Minister on the progress of any reforms

[2] HEARING LOSS

I was fortunate to acquire the services of Mr David Effeney, a retired surgeon to assist me review the areas in which the workcover scheme interacted with the medical profession.

After some preliminary enquiry I decided upon his recommendation to review the hearing loss legislation and practice.

Mr Effeney identified that there needed to be some changes to the rules which set out the calculation of the degree of hearing loss which the experts agreed.

The project then considered whether it would be possible to develop an innovative method of determining which workers met the threshold for the provision of hearing aids or the award of damages for permanent impairment.

At present the worker has to undergo testing by an audiologist to determine the degree of hearing loss. The worker then instructs a lawyer to obtain a report from a qualified medical specialist as to the degree of hearing loss and whether it is consistent that the hearing loss was as a result of noisy employment.

The lawyer obtains instructions about the employment history.

A software program was developed which would enable audiologists to measure the extent of hearing loss and therefore determine the worker's entitlement to hearing aids or to lump sum compensation for the permanent impairment.

This process would avoid the need for every injured worker suffering hearing loss to have to obtain a report from an ENT medical specialist.

This would have three significant improvements for the worker and his family.

Firstly there would be no delay in being provided with hearing aids. A process that could take up to two years through the Insurer and then the Workers Compensation Commission.

Secondly, there would be a significant annual cost saving for all insurers in removing the need for the worker to see an ENT specialist to provide a report.

Thirdly there would be a saving in legal costs for both the lawyer for the worker and the lawyer for the insurer.

It is estimated that the savings for the Scheme would be in excess of $15m per annum.

Unfortunately DFSI declined to continue to fund the completion of the project and it has not been consummated. This innovation would have had benefit for the other schemes around the country.

Given the removal of funding that significant work has ceased and been archived.

THE INDEPENDENT LEGAL ASSISTANCE AND REVIEW SERVICE ("ILARS")

The Government announced in September 2012 the establishment of this Service and delegated the operation of it to this office.

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

There are presently over 1,000 lawyers who have requested to be approved by WIRO and whom currently provide legal services to injured workers.

When an injured worker seeks assistance with the conduct of her or his claim then the lawyer will take basic instructions and complete a form which sets out essential facts and indicates what assistance is sought.

That application is then considered by WIRO Lawyers (15 full time lawyers) who are experienced in workers compensation practice and procedure as to whether on that information it appears to be reasonable to fund preliminary enquiries and evidence gathering to support the claim.

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

Given the extreme complexity of the legislation and associated regulation and rules the consideration of every application is carefully considered by the WIRO lawyers.

About 7% of applications are declined although they may subsequently be approved if further information is obtained.

In the four years since it has been operating there have been over 45,000 applications processed.

The information obtained in the course of the funding of these claims has enabled WIRO to develop a program which utilises the data to assist lawyers with understanding their practice and their efficiency compared with other lawyers in their area or across the whole system.

This is very comprehensive and is not available elsewhere. Individual data is provided to lawyers and firms which informs them as to the processing of claims. The lawyer or firm is able to be provided a ranking across the Scheme.

In Appendix "E" is a sample of a firm sourced from different data.

This will also allow WIRO to compare performance by individual insurers.

It also allows WIRO to compare the performance of medical specialists. It has been utilised in a pilot project covering one speciality in which it was apparent that the same individual medical specialist was biased in assessing the degree of whole person impairment depending upon whether a report was being prepared for an employer or a worker.

Having drawn this alarming disparity to the group concerned there has been a significant improvement.

When there is a significant Commission or Court decision; a change in legislation or other significant event WIRO issues an email communication known as a WIRO WIRE within a very short time (often within an hour) informing the subscribers of the news.

There are over 2,000 subscribers to this service which has a very successful open and read rating by industry standards.

The whole of ILARS is electronic so that communication is quick and the lawyers are able to make decisions with no delay. The delivery standard adopted is that every email is responded to within five business days. Every application is processed within 5 business days. Usually the response rate is much quicker.

Payment of invoices is also electronic by way of direct deposit.

EDUCATION

One of the very important roles of the WIRO office is to ensure that those who work within the industry from insurance staff through to lawyers and associated professionals are able to be kept informed of current developments.

Each of the WIRO major Seminars have attracted over 500 attendees and are acknowledged as being of significant value throughout the industry.

Seminars are also held every six months in regional areas with these being in demand.

A recent development was the introduction of a full day course in conjunction with the NSW College of Law in the presentation of a certificate for paralegals and secretaries in law firms.

These will be held regularly and if required will be conducted in regional areas.

WIRO also attends at a variety of other conferences where information is provided to attendees. This has recently included the Transport Workers Union Annual Delegates Conference attended by over 800 members.

A WIRO Bulletin is also issued every month with case reports and other information.

THE SCLJ 2014 RECOMMENDATIONS

On 17 September 2014 The Upper House's Standing Committee on Law and Justice tabled its first review of the WorkCover Authority of NSW entitled Review of the exercise of the functions of the WorkCover Authority

There were a number of recommendations in that Review that involved this office:

Recommendation 1:

"That the Minister for Finance and Services, in consultation with the WorkCover Independent Review Office and other stakeholders, consider establishing a separate agency or other administrative arrangements to clearly separate the roles of a regulator and nominal insurer in the workers compensation scheme, and implement that model as soon as practicable."

The new structure was implemented through legislation and took effect from 1 September 2015. There was no consultation with this Office.

Recommendation 2

"That the WorkCover Authority of NSW consult with stakeholders, including worker and employer representatives, during its review of the segregation of functions and delegations around its role in work capacity decisions, and that it publish the review's findings."

The reasoning for this Recommendation appears in paragraphs 3.36 and 3.37 of the Report:

> Paragraph 3.36 stated:
>
> *"Mr Gary Jeffrey, Acting General Manager, Workers Compensation Insurance Division, WorkCover, acknowledged the concerns raised by review participants in this regard. With specific reference to the Transfield case, Mr Jefffrey advised that WorkCover was currently determining how to better structure internal operations to minimise potential conflicts, including examining models used in other jurisdictions such as Victoria, Western Australia and Queensland"*

There has been no consultation with this Office.

I am not aware of the publication of the findings of the review.

Recommendation 4

"That the NSW Government amend Part 3 of Schedule 1 of the Government Sector Employment Act 2013 to designate the WorkCover Independent Review Office as a separate public sector agency"

During November 2014 the provision of shared services previously undertaken by Safety Return to Work was transferred to then then Office of Finance and Services which was subsequently subsumed by DFSI. This was done without this office being notified.

There has been no discussion at all about the recommendation.

Recommendation 5

"That the NSW Government expand the operational parameters of the WorkCover Independent Review Office to include worker health and safety and review the resources of the office to ensure that it has the extra capacity to undertake this additional responsibility."

This has not been the subject of any consultation.

Recommendation 6

"That the NSW government restore lifetime medical benefits for hearing aids prostheses home and vehicle modifications for all injured workers noting the actuarial evidence as to the relatively minimal cost of restoring such benefits to the workers compensation scheme in that it promptly review the viability of restoring all lost medical benefits for injured workers under the scheme"

The Government introduced the "*Workers Compensation Amendment (Existing Claims" Regulation 2014"*. This Regulation only applied to those injured workers who had first made a claim before 1 October 2012.

It exempted these workers from the compensation period restriction in section 59A of the 1987 Act in respect to compensation payable in respect of the provision of crutches, artificial members, eyes or teeth and other artificial aids or spectacles (including hearing aids and hearing aid batteries), as well as compensation payable in respect of the modification of a worker's home or vehicle.

Workers injured after 1 October 2012 are able to obtain similar benefits through the application of the savings and transitional provisions of the 1987 Act.

Recommendation 7

"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 preapproval of medical expenses before undertaking the treatment"

This recommendation has not been the subject of any discussion nor has it been implemented.

There have been further cases in which the Insurer has refused to meet medical expenses for this reason. In one alarming case the worker had pre approval from an Insurer and proceeded with the surgery only to discover later that it was the wrong insurer and the correct insurer refused to meet the cost of the surgery as it had not been the subject of a request for pre-approval.

There is an even more alarming case where an Insurer approved the surgery and later decided that the surgery did not arise from the work injury and cancelled the approval and sought to recover the expense.

Recommendation 8

"that the WorkCover authority of NSW and WorkCover Independent Review Office collaborate to develop a process whereby disagreements over assessments of permanent impairment can be resolved through negotiation between an insurer and an injured worker'

Despite regular requests for this to occur it has not been implemented much to the concern of injured workers affected who have to undergo further medical examinations to determine the correct degree of impairment. That emotional distress is exacerbated by the delay involved.

Recommendation 9

"that the WorkCover authority of New South Wales develop through consultation with all stakeholders and their representatives finding operational directives the workers compensation nominal insurer's scheme agents or licensed insurers that ensure all parties are aware of their rights and responsibilities"

This recommendation has not been the subject of any discussion nor has it been implemented by SIRA.

Recommendation 10

"That the NSW government consider amending section 44 (6) of the *Workers Compensation Act* 1987 to allow legal practitioners acting for a worker to be paid or recover fair and reasonable fees for the work undertaken in connection with a review of a work capacity decision of an insurer, subject to analysis of its financial impact"

While SIRA Issued a discussion paper and sought comments from interested parties there has not been any final recommendation.

Recommendation 13

"that the WorkCover Authority of NSW develop an engagement plan in consultation with all stakeholders and their representatives and publish it as soon as practicable"

There was consultation with advisors some time ago. I am not aware of any progress.

Recommendation 19

"That the WorkCover Authority of NSW immediately update its "Contact us" webpage as well as any automated phone messages used by the customer service centre, to include information about the WorkCover Independent Review Office"

This was implemented on the website of icare and SIRA. The Customer Service Centre makes no reference to this office.

Recommendation 20

"That the WorkCover Authority of NSW undertaken a review of all guidelines that apply to the workers compensation scheme, in consultation with stakeholders, to simplify and consolidate the guidelines"

The review of the Claiming Compensation Guidelines which had been under way for twelve months before the publication of the report was concluded recently.

THERE ARE VARIOUS PRACTICAL OBSTACLES TO THE SYSTEM BEING CONSIDERED A FAIR AND JUST SCHEME

SPECIFIC ISSUES

1. THE 44BC STAY

The September 2014 Report noted at paragraphs 5.24-5.25 that the Committee was "deeply concerned" about the consequences to workers of the "significant delays" in completion of Merit Reviews by the then WorkCover Authority. One of the main problems was that there was no "stay" of any work capacity decision during the course of review under section 44BB of the *Workers Compensation Act 1987* ('1987 Act"). It followed that when the three months' notice given under section 54 of the 1987 Act expired, workers would lose their weekly payments, even if the decision continued to be disputed at Merit Review and was subsequently successful.

The introduction of section 44BC has provided for a stay to apply for the duration of the review process.

Section 44BD says that if the Review Decision affirms the original decision, then no further notice period applies. Despite the obvious intention of the legislature and the well-known nature of the mischief the section was intended to overcome, some Insurers dispute the meaning of section 44BC.

Some scheme agents take the view that if payments have been stopped after (for instance) Merit Review but before the commencement of the Procedural Review then they cannot be resumed, because no "action " may be taken by an Insurer while the decision is stayed.

This is with respect a complete misreading of section 44BC(1), which only prohibits the taking of any action "based on the decision." The resumption of weekly payments is hardly going to be action based on a decision to cease the same payments.

Section 44BC(1) has two provisions within it: first, it imposes a stay on the implementation of the decision during the course of section 44BB review; and secondly, it prohibits the taking

of "any action by an insurer based on the decision" during the stay. While the first does not include the second, the second may well include the first.

However the section is read, it is clear that the cessation or reduction of weekly payments based on a work capacity decision of an insurer cannot proceed during the course of a section 44BB review. To that extent, section 44BC creates a new head of entitlement. Even if the notice given under section 54 expires between finalisation of merit review and the commencement of procedural review, the work capacity decision is "stayed" in the course of procedural review and the worker is therefore entitled to receive for the duration of theprocedural review the same payments as they received immediately prior to the work capacity decision of the insurer.

WIRO recommends that the Government clarify with amending legislation (if necessary) the clear policy as stated by the Minister that the weekly payments continue until a final decision is made through the review process.

2. MERIT REVIEW SERVICE OF SIRA

The September 2014 Report spent considerable time examining the time delays being then experienced at merit review, but very little was said about two important aspects of the section 44BB review process:

2.1. Quality and consistency of merit review decisions

WIRO is aware of anecdotal evidence from scheme agents that in similar cases where identical decisions have been made by insurers, but they have received widely differing outcomes in the course of merit review. Some insurers have said that they prefer the certainty of the Commission to the uncertainty of Merit Review. While insurers might understandably have a negative view of their decisions being overturned, it is a consistent

complaint to WIRO that merit review is capable of producing almost totally unpredictable outcomes.

2.2 The "High Needs" Problem

While a want of consistency might be of itself undesirable, there is some consistency which might be best avoided. In particular the merit reviewers regularly recommend to Insurers that they undertake an assessment of whether or not the worker is a "high needs" worker, for the purposes of determining the applicability of section 39. Such an assessment is said to be "a work capacity decision under section 43(1)(f)."

The precise wording of section 43(1)(f) is as follows:

> *(f) any other decision of an insurer that affects a worker's entitlement to weekly payments of compensation, including a decision to suspend, discontinue or reduce the amount of the weekly payments of compensation payable to a worker on the basis of any decision referred to in paragraphs (a)–(e).*

The difficulty with the position adopted by the Merit Review Service is that "high needs" is a categorization based on an assessment of Whole Person Impairment (WPI). Such an assessment cannot be done unilaterally by an insurer and must be done in compliance with section 65 of the 1987 Act and Part 7 of the 1998 Act. In part 7 of the 1998 Act a "medical dispute" is defined in section 319 to include a dispute about WPI.

This is relevant because section 43(2) of the 1987 Act exempts certain decisions from the category of "work capacity decisions":

> *(2) The following decisions are not work capacity decisions:*
> *(a) a decision to dispute liability for weekly payments of compensation,*
> *(b) a decision that can be the subject of a medical dispute under Part 7 of Chapter 7 of the 1998 Act.*

It is clear that in light of section 319 of the 1998 Act, section 43(2)(b) specifically exempts disputes concerning WPI (which must include the determination of "high or highest needs") from the category of "work capacity decisions," in contradistinction to the view put forward by merit review.

The Court of Appeal in *Sabanayagam v St George Bank* [2016] NSWCA 145 made very clear that section 43(1)(f) does not confer on insurers powers they do not otherwise have.

2.3. Overstepping Jurisdiction re 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 emphasized that 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 any consequences to the worker.

Despite this clear provision, the Merit Review Service of SIRA has in the recent past made recommendations which clearly contradict the assessment of the Insurer, sometimes to the detrimennt 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.

The cost of any such challenge and the risk of an adverse costs order would prohibit this action in almost all cases.

2.4. 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.

No such scruples appear to have afflicted the conscience of the merit reviewer in this case.

It is an alarming prospect for workers to contemplate that a review process set up for their benefit can have devastating outcomes with no warning and not opportunity to withdraw the application for review.

2.5 Prohibition on Publication

The Guidelines for the making of work capacity decisions and conducting merit reviews, issued by the former WorkCover Authority in 2012 and 2013, contained a prohibition on the publication of recommendations by the Merit Review Service and by WIRO.

The Guidelines are not binding upon either the Merit Review Service or WIRO or injured workers or insurers.

WIRO has published on the web-site redacted versions of every recommendation, taking out the names of all parties as well as the names of all witnesses, including doctors. Insurers and injured workers have been able to read the recommendations and know what to expect in the course of procedural review.

There is no known benefit in secrecy of decision-making and it is submitted that publication of all merit review recommendations (whether in total or in redacted format) might lead to greater consistency of decision-making. It would certainly give injured workers a better idea of what to expect.

WIRO recommends that SIRA ensure that all recommendations by the Merit Review Service be published on the SIRA website forthwith after issue.

3 RESOLUTION OF QUESTIONS OF LAW

Section 105(1) of the 1998 Act purports to give the Workers Compensation Commission (the 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.*

The remainder of section 105 is concerned with allocating work injury damages claims to the District Court and has various elements emphasizing that the former Compensation Court had become secondary to the Commission.

This "purports" to give the Commission exclusive jurisdiction for three reasons:

First, what the section actually confers is the residue of what is left after the Compensation Court and District Court have been allocated functions;

Secondly, no reference appears in the section to the power of approved medical specialists to determine the extent of whole person impairment, which is something the Commission may not do (see section 65(3) of the 1987 Act); and

Thirdly, and most importantly, nothing appears to solve the dilemma of 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.

For present purposes, the first two points above may be set to one side. But 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 "business owner." Such a decision by an Insurer is only reviewable under section 44BB. While the Merit Review Service and the WIRO might well take the view that "business owner" is neither suitable nor employment,

leaving aside "suitable employment," any such finding cannot be thought conclusive because it appears from a reading of section 351 of the 1998 Act that only the Commission, constituted by a Presidential Member, may determine questions of law.

It is certainly the case that such questions must be referred from or by Arbitrators if they arise in the course of "proceedings" before the Commission. There is currently no similar provision allowing for the referral of such questions which might arise in the course of 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 section 44BB review. A simple stated case might be made in accordance with the current section 351(7) of the 1998 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 1998 Act and to section 43 of the 1987 Act.

4 STATUTORY FORMS STILL NOT UPDATED

1. The Claim form which the worker completes to effectively commence the claims process still refers to "WorkCover" and is seen by workers to reflect the current legal position.

   It should be updated immediately.

2. The Certificate of Capacity completed by the medical profession and submitted by workers to insurers needs to be updated.

3. Upon the dissolution of the former WorkCover Authority of NSW the name of the WIRO changed from "WorkCover Independent Review Office" to "Workers Compensation Independent Review Office."

In 2015 the 1987 Act was amended, changing the former section 44 to section 44BB. There is currently no "section 44" in the 1987 Act.

WIRO has repeatedly asked SIRA to amend the application forms used in our office to reflect these changes, to date to no avail. A proposed form has been drafted and provided to SIRA.

Because of this failure by SIRA to act, WIRO still has on its web-site a document headed "WIRO WorkCover Independent Review Office." It goes on to say:

"This form is issued pursuant to section 44(2) of the Workers Compensation Act 1987."

This is despite the repeal of section 44(2) in 2015.

The form has not been updated since June 2013.

It is the form which must be used by all workers seeking procedural review of a work capacity decision. There is a cruel irony in the situation where a worker must use an out-dated, incorrectly worded form to seek procedural review of an insurer's decision.

Since the form is a statutory form, it cannot be amended by the office of WIRO, but must be amended by SIRA, which has the responsibility for administering the legislation, including the official forms.

WIRO recommends that SIRA arrange for these forms to be amended and approved forthwith

5 WORKERS DETERMINED BY THE INSURER TO BE HIGH OR HIGHEST NEEDS

Since September 2015 workers suffering a degree of permanent impairment (WPI) of "more than 20%" of their whole person have been styled "high needs" workers. Those with "more than 30%" WPI are said to have "highest needs." Since 4 December 2015 this distinction has applied to all eligible injured workers.

Relevantly, two sections of the 1987 Act exempt "high" or "highest" needs workers from certain provisions which apply to all others.

S 38(5) says that an insurer "is not to conduct a work capacity assessment of a worker with highest needs unless the insurer thinks it appropriate to do so" (and pausing there, the words following "unless" seem to take away with the left hand what was given by the right) "and the worker requests it. An insurer can make a work capacity decision about a worker with highest needs without conducting a work capacity assessment."

S 39(2) exempts workers with high needs (and, a fortiori, those with highest needs) from the automatic cessation of benefits after 260 weeks (5 years). Such workers remain subject to section 38.

This means that every worker in NSW may have to be assessed for the possibility that they are a high needs or highest needs worker prior to the expiration of 260 weeks from 1 October 2012 (i.e., on or before 30 September 2017).

Given that the Regulator does not allow parties to agree on the degree of WPI in the absence of a Medical Assessment Certificate produced by an approved medical specialist in accordance with section 65 of the 1987 Act and Part 7 of the 1998 Act, the Scheme will have to undertake the processing of these workers through the Workers Compensation Commission system with added expense.

WIRO recommends that the Government amend the 1987 Act to provide the s.32A definition apply to workers subject to s.39.

6 PRIOR APPROVAL BY INSURERS OF MEDICAL TREATMENT

S60 (2A) of the 1987 Act dictates:

> *(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),*

The Guidelines for Claiming Compensation Benefits makes provision for the exemptions allowed in s60(2A)(a) of the 1987 Act:

Any treatment or service provided to an injured worker where liability has been initially declined but where the Workers Compensation Commission or subsequently finds for the worker on liability and it is agreed or determined that the treatment or service provided was reasonably necessary.

Any treatment or service provided to an injured worker where there is a dispute about reasonably necessary treatment or service and the Workers Compensation Commission has found that the treatment or service provided was reasonably necessary.

Where no prior approval is sought and treatment is provided to the injured worker following which there is a denial that the surgery is reasonably necessary or a denial of liability for injury generally, then an exemption may apply. See *Peter Muscutt v Chris Waller Racing Pty Ltd* [2016] NSWWCC122 and *Gittoes v Qantas Airlines Ltd* [2016] NSWWCC 168. It should be noted that these decisions are presently on appeal.

There appears to be no exemption in situations where liability has not been declined, prior approval was not sought and treatment is subsequently found by the insurer to be reasonably necessary.

At paragraph 61of the Muscutt case

> *"There does remain an anomaly arising from of the Exemptions, namely that an insurer could invoke section 60(2A)(a) where treatment otherwise reasonably necessary as a result of injury has been provided but not approved by the insurer prior to it being provided by accepting liability for that treatment but simply saying it is nevertheless not liable for it by operation of section 60(2A)(a).*
>
> *Ultimately, this is the intention of the parliament. However there is a class of workers that fall within the crack, that is, the injured worker who has lodged a claim but the insurer is yet to determine liability. It is inequitable, that they must await the decision of the insurer which may take over 21 days prior to receiving necessary treatment.*

This situation presents itself in the following matter:

In this case the Respondent was uninsured. A number of days following the incident, the IW underwent required surgery in a private hospital. The insurer subsequently accepted liability for the claim and accepts that the treatment was reasonably necessary. It then denied the claim solely on the basis that prior approval was not obtained. The question remains as to whom the injured worker could have sought approval from in a situation where the employer was uninsured and little information had been provided to the injured worker.

Of note is that icare has issued this decision to decline liability.

7. ABILITY OF AN INJURED WORKER TO EXIT THE SCHEME

There is a necessity for a worker to be able at any stage to exit the pension arrangements in the scheme and to receive a lump sum to finalise their entitlements. One of the major causes of complaint that WIRO receives is the emotional distress in having to regularly attend medical appointments for the insurer and submit monthly capacity certificates.

The need for pre-approval which causes further emotional distress.

The majority of workers would accept a lump sum payment cheerfully to exit the control of the case manager and move on with their lives.

8. ONE ASSESSMENT OF THE DEGREE OF PERMANENT IMPAIRMENT

S322A of the 1998 Actwas enacted prior to the introduction of many of the thresholds now imposed upon workers such as those contained within s59A and to s32A definitions. These threshold limitations now govern many facets of worker's entitlement at differing stages of their injury.

The application of s322A shows little enlightenment in its application as it applies to all medical disputes (as defined by s319) including an assessment of permanent impairment. It fails to recognise that a condition may deteriorate causing a permanent impairment assessment to vary. It acts on the presumption that at the time of the assessment, no further change to the assessment may occur unless reliance can be placed on the appeal process. Whilst according with the intent of s66(1A), it fails the other threshold provisions.

This provision, in its application, will in all likely cause litigation, as injured workers will be faced with bringing a s66 lump sum claim at a time when really all that was required was a threshold determination. (such as at the time s59A will preclude the injured worker from claiming etc).

The dilemma then will fall on the lawyer instructed by the injured worker to make an assessment of which entitlement is more valuable, the worker's future entitlements to s66 where a deterioration may occur, (such as following a knee replacement or back surgery), orthe injured worker's ongoing entitlements to s60 expenses or even weekly benefits. In my submission, this was never the intention of Parliament.

We are yet to fully realise the implications of the s322A issue noting that many of the thresholds now imposed did not apply when it was first introduced. It is now a critical section.

Currently the Commission is trying to overcome the effect of s322A via the appeal process in threshold disputes.

In the case of *Lizdenis v Centrel Pty Limited* [2016] NSWWCC 21 it was held that threshold disputes will not be restricted by s322A limitation through the utilisation of s322A(4) and the appeal process under s327(3)(a). This however is limited to deteriorations in relation to the same body parts previously assessed and referred to in the MAC.

However in the decision of *O'Callaghan v Energy World Corporation Ltd* [2015] NSWSS 261 it was held that the deterioration referred to in s327(3)(a) was restricted to the particular body parts that were referred to the Approved Medical Specialist.

This will result in situations where an injured worker suffers a consequential injury, such as a back condition caused by an altered gait, with no remedy.

Another example

In this case, both a claim for lump sum compensation and a MAC was issued post 2012 amendments. The assessment provided utilised the method of assessment under the table of disabilities as the injury sustained occurred prior to 1 January 2002. The injured worker then sought an assessment that the injured worker was a worker of the highest needs. Funding was provided as a test case to s322A ie to argue an assessment under the table of disabilities may not be a "permanent impairment" assessment as defined and therefore the injured worker had not had their one MAC. This would obviate the need to go through the appeal process.

This however leaves injured workers with post 2002 permanent impairment MACs exposed to the implications of s322A.

It is my view that s322A should be completely abolished or its current form amended to restrict its application to claims for lump sum compensation only, thereby giving effect to the intentions of parliament with respect to the one claim policy (s66(1A)). As a result of the threshold impairments, injured workers should be entitled to have their permanent impairment assessed at any stage of their injury and in particular following a demonstrable change in their condition.

WIRO recommends that an injured worker be permitted to have more than on assessment of impairment for different purposes.

9. THE VALIDITY OF FEES ORDERS

Background:

On 29 July 2016 SIRA published the following Orders:

Workers Compensation (Psychology and Counselling Fees) Order 2016 No 2
Workers Compensation (Massage Therapy Fees) Order 2016 No 2
Workers Compensation (Accredited Exercise Physiology Fees) Order 2016 No 2
Workers Compensation (Physiotherapy, Chiropractic, OsteopathyFees) Order 2016 No 2

On the same day SIRA published:

State Insurance Regulatory Authority Workers Compensation Regulation Guideline for Approval of treating Allied Health Practitioners

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

1. The Explanatory Note to the *Workers Compensation (Psychology and Counselling Fees) Order* 2016 No 2states:

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

   Sec. 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).

Sec.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 to that treatment being authorised by Regulation.

I sought an explanation from SIRA as to the power to make such an Order.

SIRA provided the following explanation of its authority:

"Please note that s61 (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 a subsequent case 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:

> *"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 sect 59.

2. 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).

While sect. 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).*

This may only apply with respect to providers of "medical or related treatment" as defined in sect. 59.

3. 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.

I have been unable to find any authority for this statement.

10 SCHEME AGENT A "MODEL LITIGANT" OR SHARP TACTICS ?

A worker was badly injured in a farm accident. The insurer accepted that it was a work injury. The worker's lawyer was provided with funding to pursue a claim for lump sum compensation as a result of the permanent impairment arising from the injury. .

The worker's lawyer obtained an "independent medical report" which concluded that the worker had a degree of permanent impairment of 18%. The lawyer for the worker made a claim on the insurer for the lump sum based on that report.

The insurer instructed external lawyers who did not accept the validity of that report and commissioned a report from another medical specialist. That specialist concluded that the worker had in fact suffered a permanent impairment which was assessed as 32%.

Following the receipt of this report the lawyer for the insurer (presumably acting upon the instructions of the insurer) accepted the claim for lump sum compensation based on the report submitted by the lawyer for the worker at the time the claim was made offered to resolve the claim for a degree of permanent impairment of 18%.

There was no disclosure that the lawyer for the insurer had obtained an expert report which concluded that the degree of permanent impairment was significantly greater to their knowledge.

The additional degree was significant not just because the worker was entitled to additional lump sum compensation but also would be entitled to the ongoing benefits as a worker with highest needs.

The Insurer has refused to acknowledge that the behaviour of their lawyer was acceptable.

However the fundamental issue is one of honesty and fairness.

Given that the workers compensation scheme is an adversarial one is it appropriate to accept this conduct as proper.

KA Garling

WiRO
Workers Compensation
independent review office

27.9.16

WIRO SUBMISSION

APPENDIX "A"

WIRO STATISTICS FOR THE YEAR TO 30 JUNE 2016 as published on the Website.

WiRO

Workers Compensation independent review office

PERIODIC PERFORMANCE REVIEW
1 JULY 2015 TO 30 June 2016

KA Garling

WORKERS COMPENSATION INDEPENDENT REVIEW OFFICER

Complaints and Enquiries: Matters Received

	2015						2016						Grand Total
	July	August	September	October	November	December	January	February	March	April	May	June	
Complaint	207	220	219	232	217	199	135	212	256	205	239	192	2533
Enquiry	206	207	210	175	175	148	138	165	171	217	197	227	2236
Grand Total	**413**	**427**	**429**	**407**	**392**	**347**	**273**	**377**	**427**	**422**	**436**	**419**	**4769**

Complaints and Enquiries: Referral Source

Report	2015						2016						
	July	August	September	October	November	December	January	February	March	April	May	June	Grand Total
Lawyer	230	250	240	234	246	178	169	227	254	248	252	232	**2760**
Web search	41	52	46	48	41	55	38	52	66	61	68	80	**648**
icare/SIRA	45	47	65	32	29	21	17	28	29	27	28	32	**400**
Insurer	35	25	25	25	21	20	21	32	22	27	33	28	**314**
Other source	14	13	12	16	13	10	9	4	13	11	7	12	**134**
Word of Mouth	19	7	9	18	12	11	8	7	14	7	11	7	**130**
Union	9	10	10	8	8	18	4	9	7	12	11	10	**116**
Doctor	5	3	5	4	12	17	0	7	5	7	14	5	**84**
Referral source not provided - Enquiries	3	3	6	4	4	5	1	4	1	3	2	1	**37**
Workers Compensation Commission	3	8	3	6	1	4	0	2	3	3	4	3	**40**
Rehabilitation Provider	0	7	2	5	3	3	2	0	6	8	3	3	**42**
WIRO Campaign	5	2	5	2	1	2	1	3	5	1	0	5	**32**
Employer	3	0	1	3	0	3	1	2	2	3	0	1	**19**
Government Department	1	0	0	2	1	0	2	0	0	4	3	0	**13**
Total	**413**	**427**	**429**	**407**	**392**	**347**	**273**	**377**	**427**	**422**	**436**	**419**	**4769**

Complaints: How long do they take to close

Resolution Period	2015 July	August	September	October	November	December	2016 January	February	March	April	May	June	Grand Total
A - Same day	6	9	11	9	5	8	7	9	10	9	9	2	94
B - Next day	13	10	16	17	10	21	5	6	18	13	7	13	149
C - 2 to 7 days	103	108	114	115	128	118	68	108	125	101	129	108	1325
D - 8 to 15 days	59	69	69	57	52	55	24	48	54	58	58	65	668
E - 16 to 30 days	26	15	22	22	22	20	15	24	33	34	36	18	287
F - more than 30 days	2	1	1	1	1	3		1		1	2	1	14
Grand Total	**209**	**212**	**233**	**221**	**218**	**225**	**119**	**196**	**240**	**216**	**241**	**207**	**2537**

Note: The time to close a complaint is measured in calendar and not business days.

Complaints and Enquiries: Issues by Insurer

Insurer	Communication	Delay	Denial of Liability	IME	Incorrect Calculations	Medical costs	Medical treatment	Rehabilitation	Weekly Benefits	Work Capacity (general)	WPI	Insurer management of Liability	Issues Relating to Worker	Non-Compliant Reg	2015 Lump Sum	Grand Total
Scheme agent	**200**	**228**	**455**	**35**	**16**	**246**	**606**	**200**	**1053**	**258**	**145**	**125**	**178**	**1**	**2**	**3748**
Allianz Australia Workers Compensation (NSW) Ltd	51	62	131	9	3	74	183	56	297	35	35	27	41		2	1006
CGU Workers Compensation (NSW)	24	34	62	7	3	34	91	28	170	36	20	15	34			558
Employers Mutual NSW Limited	46	44	70	2	5	45	131	34	176	75	18	23	28			697
Gallagher Bassett Services Pty Ltd		2	1	1		1			1	1			1			8
GIO General Limited	24	27	90	8	3	32	67	31	175	27	24	23	31			562
Not provided (hearing loss)	1												1			2
QBE Workers Compensation	54	59	100	8	2	60	134	51	234	83	47	36	42	1		911
Xchanging			1							1	1	1				4
Self-insured	**36**	**38**	**48**	**8**	**3**	**23**	**70**	**19**	**129**	**12**	**15**	**14**	**24**			**439**
ANZ Banking Group Limited			1				1		1							3
Arrium Limited		2	1	1		2	2						2			10
Ausgrid	1		4				2		2	1						10
Bankstown City Council										1						1
Blacktown City Council								1	3							4
Bluescope Steel Ltd			2				1		1							4
BOC Workers' Compensation Ltd.									2							2
Brambles Industries Limited							1									1
Broadspectrum (Australia) Pty Ltd	1	1	3	1		1	5		6			2	1			21
Campbelltown City Council							2									2
City of Sydney Council								2	4							6
Coles Group Ltd	6	6	9	2		2	12	2	20		3	4	3			69
CSR Limited							1									1

Insurer	Communication	Delay	Denial of Liability	IME	Incorrect Calculations	Medical costs	Medical treatment	Rehabilitation	Weekly Benefits	Work Capacity (general)	WPI	Insurer management of Liability	Issues Relating to Worker	Non-Compliant Reg	2015 Lump Sum	Grand Total
Echo Entertainment Group Ltd			2			1	3		2							8
Endeavour Energy		1	1				1			2						5
Fairfield City Council	1	1									1					3
Forestry Corporation of NSW			1						1							2
Gosford City Council	1	1				1	1		3	2	1		1			11
Holcim (Aust) Holdings Pty Limited						1										1
Hurstville City Council					1				1							2
Inghams Enterprises Pty Ltd			1						2							3
ISS Property Services Pty Ltd		4	4	1			2	1	3			1	1			17
JELD-WEN Australia Pty Ltd													1			1
Lake Macquarie City Council	1								1				1			3
McDonald's Australia Holdings Limited							1		1		2					4
Myer Holdings Ltd								1	2							3
Northern Co-Operative Meat Company Limited	1		1					1								3
NSW Trains		2					1		1							4
Pacific National (NSW) Pty Ltd	1			1												2
Primary Health Care Limited						1			1	2						4
Qantas Airways Limited	2		1	1		2	1		3				1			11
Rail Corporation NSW	3	1	2				3	1	4		1	1	1			17
Skilled Group Limited	1								1			2				4
Sutherland Shire Council									2	2						4
Sydney Trains		1	1				2		2				2			8
Toll Pty Ltd	1	2	3			2	6	3	3				2			22
Transport for NSW Workers Compensation Services	2					2	3	1	6		2		2			18
Transport Service of NSW (State Transit Group)	1		6				2		6							15
UGL Rail Services Pty Limited		3	2		2		1		6							14

Insurer	Communication	Delay	Denial of Liability	IME	Incorrect Calculations	Medical costs	Medical treatment	Rehabilitation	Weekly Benefits	Work Capacity (general)	WPI	Insurer management of	Issues Relating to Liability	Non-Compliant Worker	2015 Lump Sum Reg	Grand Total
Unilever Australia (Holdings) Pty Ltd	1															1
Veolia Environmental Services (Australia) Pty Ltd	1							1								2
Westpac Banking Corporation Ltd			1				1		4							6
Wollongong City Council		1											1			2
Woolworths Limited	11	12	2	1		7	15	5	35	2	5	4	5			104
Wyong Shire Council						1										1
Specialised insurer	11	17	23	2	1	14	25	9	57	10	3	5	16			193
Catholic Church Insurance Limited	5	6	6	2		4	8	2	20	5	2	1	7			68
Club Employers Mutual (part of Hospitality Employers Mutual)	0	3	2		1	2	4	1	4	1		2	2			22
Coal Mines Insurance Pty Limited	1	3	1				1	1	4				1			12
Guild Insurance Ltd			1						2							3
Hospitality Employers Mutual Limited			1													1
Hotel Employers Mutual (part of Hospitality Employers Mutual)	2		6			1	2		11			2	3			27
Racing NSW Insurance Fund	1	1	1			4	6	2	9	1						25
StateCover Mutual Ltd	2	4	5			3	4	3	7	3	1		3			35
TMF	57	58	79	10		43	111	51	204	41	27	25	39			745
Allianz TMF	16	16	17	2		11	34	22	60	12	9	6	6			211
Employers Mutual NSW Ltd - TMF	21	14	21	3		14	30	17	56	17	9	10	7			219
QBE TMF	20	28	41	5		18	47	12	88	12	9	9	26			315
Other Insurer including Not Provided	69	8	64	3		18	30	35	106	17	46	5	21			422
Grand Total	373	349	669	58	20	344	842	314	1549	338	236	174	278	1	2	5547

Note: A matter may have more than one issue.

ILARS: Grant Applications Received

Grant Application Status	2015						2016						Grand Total
	July	August	September	October	November	December	January	February	March	April	May	June	
Accepted	824	739	727	727	762	876	653	889	992	949	919	821	9878
Declined	48	61	64	43	38	34	28	38	37	40	61	39	531
Pending	31	30	21	24	17	20	22	25	34	26	62	64	376
Grand Total	**903**	**830**	**812**	**794**	**817**	**930**	**703**	**952**	**1063**	**1015**	**1042**	**924**	**10785**

Note:

- The data reflects iLARS matters received up to 30 June2016 and grants which have an accepted or pending status as at 4.43 pm on 5 August 2016.
- Differences from previous publications reflect grant applications which have been declined by WIRO since the date of the report or pending application which have been accepted.

ILARS – Injury Location for Grants

Injury Location	2015						2016						
	July	August	September	October	November	December	January	February	March	April	May	June	Grand Total
Back	191	182	169	173	178	143	126	165	272	318	240	249	**2406**
Ear	214	166	193	163	156	232	170	270	240	159	181	135	**2279**
Psychological system	100	82	92	102	78	75	83	97	96	81	103	84	**1073**
Shoulder	67	66	62	74	49	68	55	82	107	62	65	50	**807**
Knee	54	49	55	56	46	83	59	79	62	61	64	64	**732**
Multiple -Trunk and limbs	18	18	7	9	37	35	16	16	14	57	75	100	**402**
Neck	31	31	27	33	24	22	30	35	22	17	9	4	**285**
Hand, fingers and thumb	17	23	20	17	24	26	16	18	24	29	27	22	**263**
Other head	21	21	7	11	24	22	10	16	19	22	28	25	**226**
Wrist	15	10	22	21	17	14	17	25	19	16	22	14	**212**
Other body location	8	17	13	13	26	15	9	15	28	15	21	25	**205**
Multiple -Neck & shoulder	24	15	22	18	8	18	9	10	18	21	25	10	**198**
Ankle	8	10	0	1	27	10	9	17	36	24	22	26	**190**
Upper limb - multiple	6	5	0	3	30	46	10	4	2	5	13	23	**147**
Death	20	9	6	18	8	8	12	6	10	15	10	5	**127**
Other leg	4	8	7	1	2	30	3	7	5	15	9	1	**92**
Lower leg	10	6	9	9	8	9	11	8	7	6	8	2	**93**
Elbow	8	5	6	5	7	5	8	9	9	11	13	5	**91**
Foot and toes	8	7	7	5	6	12	6	9	13	4	4	9	**90**
Hip	12	11	6	7	5	8	3	3	4	5	6	10	**80**
Abdomen & pelvic region	7	6	8	3	7	5	7	7	8	10	7	4	**79**
Eye	4	12	8	6	3	3	3	5	8	5	11	6	**74**
Other arm	0	2	0	1	7	4	1	4	0	13	15	11	**58**
Trunk - multiple locations	8	8	2	2	2	3	2	7	3	4	3	1	**45**
Total	**855**	**769**	**748**	**751**	**779**	**896**	**675**	**914**	**1026**	**975**	**981**	**885**	**10254**

Note: The data reflects iLARS matters received up to 30 June2016 and grants which have an accepted or pending status as at 4.43 pm on 5 August 2016.

-Differences from previous publications reflect grant applications which have been declined by WIRO since the date of the report.

Any Difference between the total on this page and the total of matters received represents matters where the injury location has not yet been recorded.

ILARS – Nature of Injury

Nature of the Injury	2015						2016						Grand Total
	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	
A. Intracranial injuries	10	10	3	5	8	10	10	10	8	2	3	4	83
B. Fractures	30	26	34	25	26	30	21	36	30	20	16	30	324
C. Wounds, lacerations, amputations	20	20	32	18	20	12	3	6	11	20	24	25	211
D. Burn	2	4	4	2	1	3	3	3	1	2	1	4	30
E. Injury to nerves and spinal cord	251	208	215	190	201	208	119	197	199	175	176	132	2271
F1. Trauma to joints and ligaments	165	154	160	164	162	276	145	214	305	287	328	271	2631
F2. Trauma to muscles and tendons	36	34	23	31	52	69	73	65	22	12	18	23	458
G. Other injuries Poisoning, Electrocution, etc	2	5	4	1	4	1			1			1	19
H1. Joint & other articular cartilage diseases	4				2	2	4	16	6	3	2	1	40
H2. Spinal vertebrae & intervertebral disc diseases	3	4		5	2	35	53	73	24	16	27	26	268
H3. Diseases involving the synovium	0	1			7			1					9
H4. Diseases of muscle, tendon and related tissue	3	2			1	2	2	1	2	1	1	5	20
H5. Other soft tissue diseases	3	2		1	2	5	2	3	5	4	4	4	35
I. Mental disorders	100	81	91	102	77	75	83	97	96	82	103	84	1071
J. Digestive system diseases	1		1	1	1	1	2	4	11	6	5	5	38
K. Skin and subcutaneous tissue diseases	1	2	1		3		3	3	4	1	4	7	29
L. Nervous system and sense organ diseases	192	187	173	180	181	149	133	172	283	322	246	253	2471
M. Respiratory system diseases	0		1	3	1	2	1	3	5	2	4		23
N. Circulatory system diseases	0					2		2		1		1	6
O. Infectious and parasitic diseases	5	1			3	1	1	1		1	2	2	17
P. Neoplasms (cancer)	3	5		2		1	3	1	1	3	5	2	26
Q. Other diseases	1	2				1	1				1		6
R. Other claims	1	1			1				1				4
S. Death	21	9	6	18	8	9	12	6	10	15	10	5	129
Grand Total	**855**	**758**	**748**	**748**	**763**	**894**	**674**	**914**	**1025**	**975**	**980**	**885**	**10219**

Note: The data reflects iLARS matters received up to 30 June2016 and grants which have an accepted or pending status as at 4.43 pm on 5 August 2016.

-Differences from previous publications reflect grant applications which have been declined by WIRO since the date of the report.

Any Difference between the total on this page and the total of matters received represents matters where the nature of the injury has not yet been recorded.

ILARS – Issues per Insurer

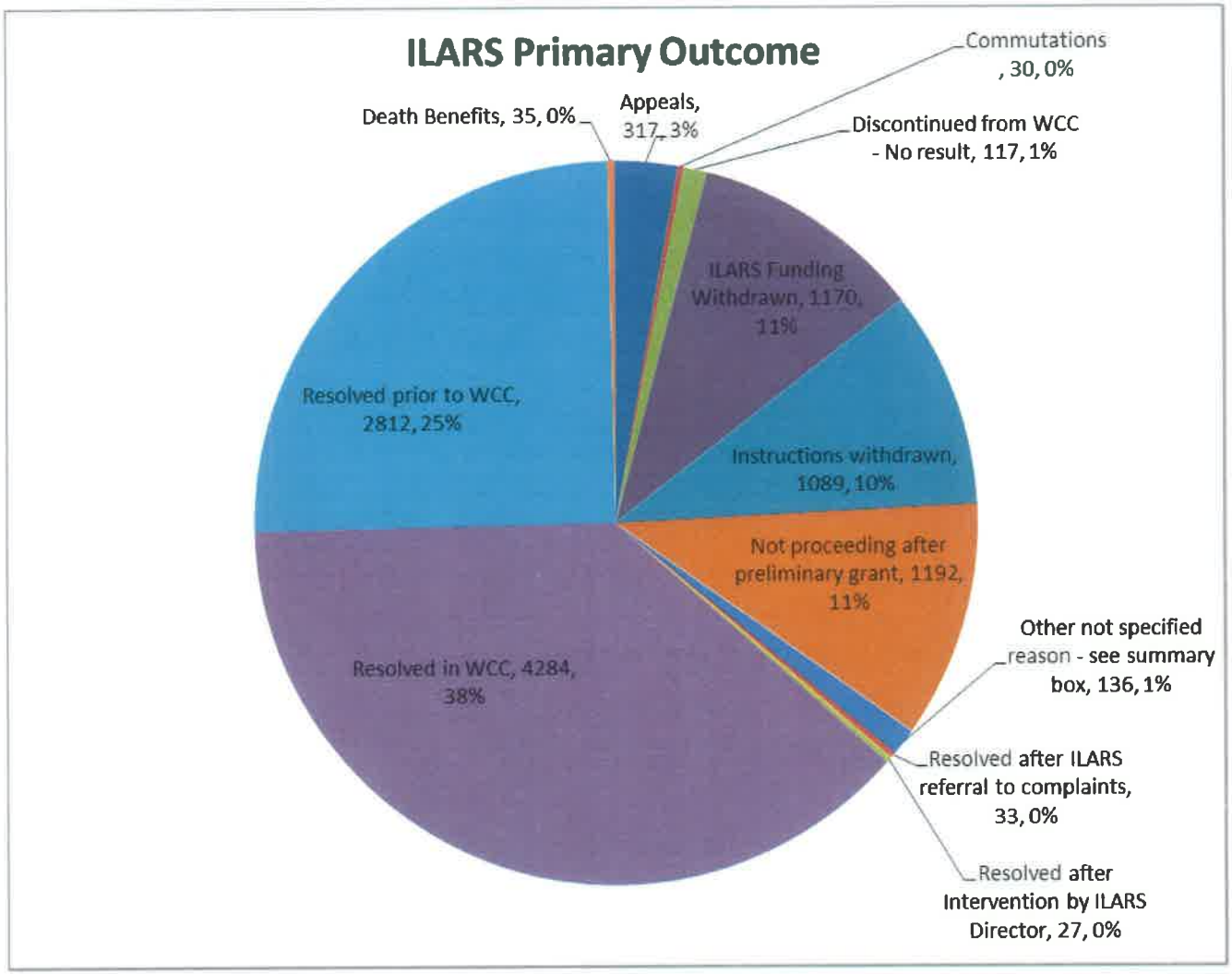
Insurer	Death Claim	Denial of Liability	Medical treatment	Weekly Payments	WPI	Other	Commutation	2015 Lump Sum Reg	Grand Total
Scheme agent	**116**	**1805**	**3974**	**1820**	**4780**	**37**	**36**	**814**	**13382**
Allianz Australia Workers Compensation (NSW) Ltd	36	471	769	441	1106	10	12	250	**3095**
CGU Workers Compensation (NSW) Ltd	12	281	424	296	589	4	2	97	**1705**
Employers Mutual NSW Limited	16	275	408	299	705	3	7	130	**1843**
Gallagher Bassett Services Pty Ltd		21	25	18	47		2	15	**128**
GIO General Limited	22	335	513	341	596	2	6	94	**1909**
Not provided (hearing loss)		2	1166	1	732	8		2	**1911**
Xchanging		10	11	5	29			9	**64**
QBE Workers Compensation	30	410	658	419	976	10	7	217	**2727**
Self-insured	**2**	**211**	**453**	**236**	**420**	**6**	**2**	**58**	**1388**
ANZ Banking Group Limited					2			1	**3**
Arrium Limited		4	21	5	20			1	**51**
Ausgrid		1	12	4	10	1		1	**29**
Bankstown City Council		1	3	2	1				**7**
Blacktown City Council		4	5	4	9				**22**
Bluescope Steel Ltd		3	54	4	34			13	**108**
BOC Workers' Compensation Ltd.					3			1	**4**
Brambles Industries Limited			2	1	4				**7**
Brickworks Ltd		3	2	1	3				**9**
Broadspectrum (Australia) Pty Ltd		7	20	11	22			4	**64**
Campbelltown City Council		1	2		3				**6**
City of Sydney Council		3	5	3	4			1	**16**
Coles Group Ltd		70	78	74	56	2	1	5	**286**
Colin Joss & Co Pty Limited		1	3	3					**7**
CSR Limited		4	7	3	1				**15**

Insurer	Death Claim	Denial of Liability	Medical treatment	Weekly Payments	WPI	Other	Commutation	2015 Lump Sum Reg	Grand Total
Delta Electricity			1		1				**2**
Echo Entertainment Group Ltd		2	3	1	3				**9**
Electrolux Home Products Pty Ltd			6	1	1				**8**
Endeavour Energy		1	4	2	6				**13**
Fairfield City Council	1	4	7	6	3			1	**22**
Fletcher International Exports Pty Ltd.					1				**1**
Gosford City Council		3	4	3	5				**15**
Holcim (Aust) Holdings Pty Limited		2	4	3	4				**13**
Inghams Enterprises Pty Ltd		6	7	5	10				**28**
ISS Property Services Pty Ltd		8	9	10	6				**33**
Lake Macquarie City Council		1	1	1	1				**4**
Liverpool City Council		2	2	2				1	**7**
McDonald's Australia Holdings Limited		2	2	2	2				**8**
Myer Holdings Ltd		3	4	3	3				**13**
Newcastle City Council			1		6				**7**
Northern Co-Operative Meat Company Limited		3	6	5					**14**
NSW Trains		3	5	5	5	1			**19**
Pacific National (NSW) Pty Ltd			4		4				**8**
Pasminco Ltd			2		1				**3**
Primary Health Care Limited		4	3	4	4				**15**
Qantas Airways Limited		11	43	11	30			3	**98**
Rail Corporation NSW		6	20	11	27			8	**72**
Rocla Pty Limited					1				**1**
Shoalhaven City Council		1	1	1	1				**4**
Skilled Group Limited			8		6				**14**
Sutherland Shire Council		1	5	1	4			1	**12**
Sydney Trains		4	8	6	8				**26**
Toll Pty Ltd		9	14	6	17			2	**48**
Transport for NSW Workers Compensation Services		5	22	7	18			1	**53**

Insurer	Death Claim	Denial of Liability	Medical treatment	Weekly Payments	WPI	Other	Commutation	2015 Lump Sum Reg	Grand Total
Transport Service of NSW (State Transit Group)		3	7	3	12				25
UGL Rail Services Pty Limited		3	6	2	7				18
Unilever Australia (Holdings) Pty Limited		1	3	1	1				6
University of New South Wales		2	1	1	1				5
University of Wollongong			1		2			1	4
Veolia Environmental Services (Australia) Pty Ltd		2	3	2	2				9
Warringah Council			1		1				2
Westpac Banking Corporation Ltd		6	6	6	13	1	1	3	36
Wollongong City Council		4	5	3	3			1	16
Woolworths Limited	1	6	9	6	26	1		9	58
Wyong Shire Council		1	1	1	2				5
Specialised insurer	**1**	**128**	**171**	**128**	**184**	**3**		**17**	**632**
Catholic Church Insurance Limited	1	45	45	41	45	1		7	185
Club Employers Mutual (part of Hospitality Employers Mutual)		19	28	22	19				88
Coal Mines Insurance Pty Limited		2	3	1	1			1	8
Guild Insurance Ltd		3	4	5	6				18
Hotel Employers Mutual (part of Hospitality Employers Mutual)		13	17	14	21				65
Racing NSW Insurance Fund		8	8	5	24			1	46
StateCover Mutual Ltd		37	65	39	66	2		8	217
Hospitality Employers Mutual Limited		1	1	1	2				5
TMF	**7**	**212**	**289**	**211**	**353**	**1**	**2**	**46**	**1121**
Allianz TMF	2	62	88	59	97	1	1	5	315
Employers Mutual NSW Ltd - TMF		62	70	59	111		1	19	322
QBE TMF	5	88	131	93	145			22	484
Other Insurer including Not Provided	**7**	**16**	**88**	**62**	**128**	**2**	**1**	**20**	**324**
Grand Total	**133**	**2372**	**4975**	**2457**	**5865**	**49**	**41**	**955**	**16847**

Note: A matter may have more than one issue.

ILARS – Primary Outcomes



Note: Outcome data is for cases closed from 1 July 2015 to 30 June 2016.

ILARS – Outcomes

Outcome	Desired Outcome not achieved			Grant achieved desired outcome		
	Number of Cases	Total Amount Paid	Average Amount Paid	Number of Cases	Total Amount Paid	Average Amount Paid
Instructions withdrawn	**1263**	**$2,159,325**	**$2,327**			
ILARS Funding Withdrawn	**1784**	**$2,677,013**	**$3,363**			
Cram Fluid Applies	699	$2,377,151	$3,559			
Not Recorded	46	$33,974	$2,265			
Not eligible for funding	48	$21,947	$2,439			
No Response to ILARS Follow Up	922	$238,130	$2,358			
Old Costs provisions apply	69	$5,811	$1,937			
Not proceeding after preliminary grant	**1234**	**$3,275,723**	**$2,788**			
Medical evidence not supportive	352	$856,658	$2,580			
Not Recorded	86	$150,144	$2,383			
Worker does not reach WPI threshold	796	$2,268,922	$2,909			
Other not specified reason - see summary box	**77**	**$85,182**	**$2,937**	**53**	**$182,786**	**$4,687**
Resolved after ILARS referral to complaints	**1**			**30**	**$34,320**	**$1,320**
Commutations				**30**	**$74,814**	**$2,494**
Discontinued from WCC - No result	**118**	**$823,949**	**$7,165**			
Resolved prior to WCC				**2808**	**$9,880,355**	**$3,535**
Not Recorded				4	$4,872	$1,218
Resolved - Insurer Accepts Claim				994	$1,986,400	$2,013
Resolved after application for review/insurer accepts Claim				175	$652,867	$3,731
Resolved by complying agreement after claim made				1635	$7,236,215	$4,442
Resolved in WCC	**458**	**$2,984,047**	**$6,530**	**3816**	**$31,669,162**	**$8,316**
Resolved at Arbitration by Arbitrator - Employer	**72**	**$674,524**	**$9,368**	**1**	**$9,741**	**$9,741**
Resolved at Arbitration by Arbitrator - Worker				**463**	**$4,827,551**	**$10,449**
Medicals				134	$1,345,826	$10,043
Not Recorded				12	$116,007	$9,667

Outcome	Desired Outcome not achieved			Grant achieved desired outcome		
	Number of Cases	Total Amount Paid	Average Amount Paid	Number of Cases	Total Amount Paid	Average Amount Paid
Weeklies				40	$425,049	$10,626
Weeklies & Medicals				131	$1,402,795	$10,791
WPI				85	$873,015	$10,271
WPI & Medicals				16	$168,158	$10,510
WPI & Weeklies				11	$109,534	$9,958
WPI, Weeklies & Medicals				34	$387,165	$11,387
Resolved at Conciliation - settled by consent				**1077**	**$10,491,352**	**$9,778**
Closed Period				47	$473,867	$10,082
Medicals				120	$1,069,969	$8,916
Not Recorded				11	$109,874	$9,989
Weeklies				67	$638,411	$9,529
Weeklies & Medicals				475	$4,759,533	$10,105
WPI				102	$924,032	$9,059
WPI & Medicals				33	$331,250	$10,038
WPI & Weeklies				10	$100,945	$10,095
WPI, Weeklies & Medicals				76	$794,749	$10,457
Wrap up				136	$1,288,724	$9,476
Resolved at settlement during Arbitration				**144**	**$1,415,231**	**$9,828**
Medicals				30	$294,287	$9,810
Not Recorded				4	$27,632	$6,908
Weeklies				9	$73,951	$8,217
Weeklies & Medicals				53	$558,631	$10,540
WPI				23	$209,381	$9,104
WPI & Medicals				6	$67,527	$11,254
WPI & Weeklies				4	$43,719	$10,930
WPI, Weeklies & Medicals				15	$140,102	$9,340
Resolved following MAC	**385**	**$2,303,402**	**$5,998**	**1174**	**$7,903,945**	**$6,738**
COD for WPI				1079	$7,208,593	$6,687
Not reached threshold	365	$2,185,671	$6,005	3	$16,648	$5,549

Outcome	Desired Outcome not achieved			Grant achieved desired outcome		
	Number of Cases	Total Amount Paid	Average Amount Paid	Number of Cases	Total Amount Paid	Average Amount Paid
Not Recorded	3	$15,952	$5,317	20	$152,808	$7,640
Surgery not reasonably necessary	17	$101,779	$5,987			
Surgery reasonably necessary				72	$525,896	$7,304
Resolved following PD on question of Law				**2**	**$24,418**	**$12,209**
Resolved TC - settled by consent				**925**	**$6,898,611**	**$7,474**
Closed Period				35	$276,222	$8,124
Medicals				263	$1,911,490	$7,268
Not Recorded				17	$102,512	$6,030
Weeklies				60	$396,800	$6,725
Weeklies & Medicals				272	$2,104,049	$7,735
WPI				143	$1,009,573	$7,060
WPI & Medicals				32	$267,903	$8,372
WPI & Weeklies				5	$41,065	$8,213
WPI, Weeklies & Medicals				36	$303,038	$8,418
Wrap up				62	$485,958	$7,838
Resolved WIM Dispute	**1**	**$6,121**	**$6,121**	**30**	**$98,312**	**$3,277**
Not Recorded				1	$5,193	$5,193
In favour of worker				29	$93,120	$3,211
In favour of employer	1	$6,121	$6,121			
Appeals	**131**	**$1,084,767**	**$8,281**	**185**	**$1,795,911**	**$9,708**
Resolved after appeal from decision of Arbitrator to President	**11**	**$127,298**	**$11,573**	**21**	**$289,178**	**$13,770**
By the employer in favour of Employer	1	$7,211	$7,211			
By the employer in favour of Worker				10	$142,413	$14,241
By the worker in favour of Employer	10	$120,088	$12,009			
By the worker in favour of Worker				11	$146,765	$13,342
Resolved after appeal to Supreme Court	**2**	**$21,773**	**$10,887**	**1**	**$57,475**	**$57,475**
By the employer in favour of Employer	2	$21,773	$10,887			
By the worker in favour of Worker				1	$57,475	$57,475
Resolved after Medical Appeal Panel	**118**	**$935,696**	**$7,930**	**162**	**$1,408,570**	**$8,695**

Outcome	Desired Outcome not achieved			Grant achieved desired outcome		
	Number of Cases	Total Amount Paid	Average Amount Paid	Number of Cases	Total Amount Paid	Average Amount Paid
By the employer in favour of Employer	27	$230,688	$8,544			
By the employer in favour of Worker				79	$704,459	$8,917
By the worker in favour of Employer	91	$705,007	$7,747			
By the worker in favour of Worker				83	$704,111	$8,483
Resolved after appeal to Court of Appeal				**1**	**$40,687**	**$40,687**
By the employer in favour of Employer				1	$40,687	$40,687
Resolved after Intervention by ILARS Director				**27**	**$77,860**	$2,995
Death Benefits				**35**	**$245,160**	**$7,005**
Grand Total	**5066**	**$13,090,006**	**$3,605**	**6984**	**$43,960,367**	**$6,331**

Note: Outcome data is for cases closed from 1 July 2015 to 30 June 2016.

The total amount paid in this report (sum of both columns) represents the total amounts paid on the matters over the life of the matter and not just during the reporting period.

ILARS Payments (excluding GST)

Cost item	Total amount paid	% of disbursements
Professional fees	$36,565,782	
Medico-legal	$10,543,141	73%
Barrister Fees	$2,343,943	16%
Clinical Notes	$462,214	3%
NTD Report	$431,446	3%
Treating Specialist Report	$238,268	2%
Barrister Country Loading	$219,757	2%
Travel	$205,731	1%
Interpreter	$61,808	0%
Other	$29,429	0%
Meal Allowance	$3,420	0%
Grand Total	**$51,104,939**	
Total disbursements	$14,539,157	27%

Note: Payment data from 1 July 2015 to 30 June 2016.

This represents all amounts approved for payment by WIRO.

Work Capacity Procedural Reviews: Matters Completed

Case Outcome	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Grand Total
Case Withdrawn	0	0	0	0	0	0	0	1	0	0	2	0	3
WCDR Upheld	8	2	5	6	11	4	0	4	4	8	7	4	63
Dismissed	12	8	11	5	5	11	10	5	8	10	6	5	96
Grand Total	20	10	16	11	16	15	10	10	12	18	15	9	162

Note:

- Case Withdrawn relates to matters received then withdrawn by the Injured Workers or the insurer has withdrawn the WCD.
- WCDR Upheld refers to matters where the application for review was in favour of the injured worker.
- This table shows the number of matters with a case type of 'Work Capacity' which are Procedural Reviews of a Work Capacity Decision and will differ from the tables on previous pages which show 'Work Capacity' as an issue in a matter.

WIRO SUBMISSION

APPENDIX "B"

OUTCOMES FROM THE WIRO SOLUTIONS GROUP

1. In March 2016, an injured worker sought approval for the Insurer for an MRI scan as recommended by her treating doctor. The initial response from the Insurer was that they were seeking further information from the worker's treating specialist. The Insurer then acknowledged that that was not correct and that they had only just located the request. The treatment was approved within two business days.

2. The injured worker had undergone surgery two weeks before contacting WIRO. He was concerned as the surgeon had directed him to recover for six weeks after the surgery but his GP had certified him as fit to return to work. He was also concerned that the Insurer had determined his PIAWE at one third of what he considered it was.

   The same day as a request was sent to the Insurer they responded and agreed that he had no capacity for six weeks and that his PIAWE was incorrect. The Insurer paid him an amount over $5,000 immediately.

3. The employer of an injured worker had been placed in liquidation and its wage records and information had been poorly recorded. The worker went through the "Internal Review" and then the "Merit Review" process with an outcome which he considered to be incorrect as to the calculation of his PIAWE.

   He was considering seeking a Procedural Review and contacted the Solutions Group. WIRO contacted the Insurer who agreed that the decisions were not correct and agreed to retrospectively adjust his PIAWE. Payment was made promptly in the sum of $40,000.

4. The Insurer made a work capacity decision which reduced the entitlement to compensation by way of weekly payments from $1,800 per week to $300 per week based upon the earning capacity of the worker. The worker within the requisite period lodged an application for an internal review and was entitled to the stay of the original work capacity decision while the review was undertaken.

   The worker sought a Merit Review and the stay continued. However, the original notice period expired immediately following the issue of the Merit Review recommendation and the weekly payments ceased. The worker sought a Procedural Review within the required period and was successful in having the original work capacity decision set aside and her entitlement to weekly payments restored.

   The Insurer was initially reluctant to accept that the stay continued after merit review and insisted that the original decision was now immediately effective. After contact from WIRO they agreed to make the back payment of $6,000. The Insurer then

declined liability and so that issue will be disputed in the Workers Compensation Commission.

Appendix C

Employers' premium calculation and claim's impact submission

Icare is committed to build a "NSW Workers Insurance Scheme that rewards employers who focus on the safety and return-to-work of their employees"

These are admirable aspirations for the scheme, however, from an employer's perspective this may not actually be the case.

Workers compensation is a no fault scheme from an employee's perspective, even if he is completely at fault in causing the injury. The reverse is true for experienced rated employers. (These are employers who pay more than $30,000 in premium). An experienced rated employer is at fault even if they have the safest of work places.

Experienced rated employers have their premium impacted by a claims made in the preceding 3 years. The amount of the impact is called the Claims Performance Measure and is the amount of weekly payments paid to injured workers divided by the base premium (total wages multiplied by the WIC Rate called the "Average Performance Premium" - APP) over the last 3 years. The Claims Performance Measure is then divided by the Scheme performance measure (currently 4.55%) to give the "Claims Performance Rate" -CPR. Icare then use a table (called the "Claims performance Table") based on the BTP and the CPR to produce the Claims Performance Adjustment.

Where the CPR is under 100% then the employer receives a discount to their premium. Where it is over 100% the CPR will range from 1 to 3.5. The CPR is then multiplied BTP to produce an adjustment amount which is added to the BTP. See below for examples.

A medium sized employer with a premium of $30,000 can range from 3 people in concrete constructions to 154 in a bank. The number of employees is often a better indication of the resources a company has to manage non-core functions such as workers compensation claims.

Icare say that under this system approximately 80% of employers will receive a discount for having below average claims.

WIRO is concerned that the purpose for 'experience rating employers' is not being reflected in the impact for some employers.

In this submission WIRO wishes to raise a number of employer related issues including

- The calculation of the 'Claims Performance Adjustment amount'
- The impact of past claims for employers who move from small to experienced rated
- The impact of delays in 'return to work' which are outside the employer's control

<u>The calculation of the 'Claims Performance Adjustment amount'</u>

Icare has made a number of changes to the calculation of premium for experienced rated employers over the last few years. One of the main changes is that the calculation of claim costs has been

simplified to include only weekly benefits. Previously it included medical, weeklies and the estimated cost of the claim.

The impact of this is that the Claims Performance Adjustment amount is far more sensitive to changes in weekly payments. Icare would like you to believe that an employer has the biggest influence on injured workers return to work. Our experience at WIRO would suggest that this is not always the case, for example

- Claims are often submitted after an injured worker leaves the employer where the injury occurred. The employer then has no influence on minimising the time off work and will pay for any increase in weekly benefits through an increase in the Claims Performance Adjustment amount. Over 3 years this can be up to 5 times the amount of the increased weekly payments.
- For claims where the injured worker has a psychological claim where they have alleged that the employer (or staff at the employers) have bullied or harassed them, then generally the injured worker does not return to the work place and the employer can continue to pay weeklies until they find other employment. There is no urgency on the injured worker or the scheme agent to get back to work
- There is no accountability from the scheme agent to the employer to minimise the time an injured worker receives weekly benefits.
- An injured worker my miss medical appointments (either intentionally or unintentionally) without losing their weekly benefits. It regularly takes more than a month to make another appointment.

<u>The unexpected consequences of a growing business</u>

The premium calculation model also adversely affect growing business or business whose premium become greater than $30,000 as a result of a change in industry classification.

Where the BTP is below $30,000 the claims history over the last 3 years has no impact on the employer's premium. Once the BTR is greater than $30,000 then the claims history becomes part of the calculation as it is part of icare's risk assessment of the employer. The impact of including the claims history could double the cost of the premium.

Retrospectively including the claims history does not satisfy icare's goals of building a scheme that" rewards employers who focus on the safety and return-to-work of their employees".

<u>The impact of delays in 'return to work' which are outside the employer's control</u>

An injured worker my delay their return to work for a number of reasons which are outside the employer's control and will increase the cost of the claim. These include:

- An injured worker missing a medical appointment or other treatment.
- A work capacity procedural review in favour of the worker as a result of an errors or omissions made by the scheme agent.
- A change in case manager resulting in slow or no action by the scheme agent.
- Delays by scheme agents responding to employer's emails and phone calls.
- Scheme agents not managing cases to minimum time frames.

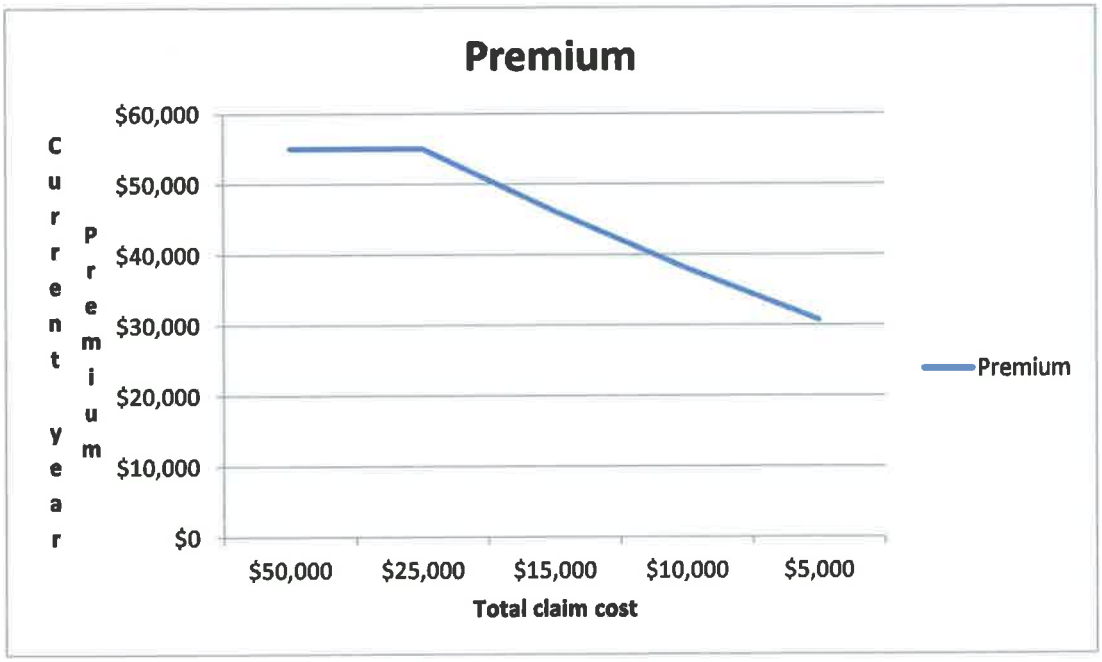
Impact of Claims on small Experienced Rated employer

Premium Summary

Wages(ave per annum)	$1,300,000	$1,300,000	$1,300,000	$1,300,000	$1,300,000
Total Claims for past 3 years	$50,000	$25,000	$15,000	$10,000	$5,000
Total Average Performance Premium - BTP for past 3 years	$110,032	$110,032	$110,032	$110,032	$110,032
Claims performance measure	45.44%	22.72%	13.63%	9.09%	4.54%
Scheme Performance Measure	4.55%	4.55%	4.55%	4.55%	4.55%
Claims Performance Rate (CPR)	9.987	4.994	2.996	1.997	0.999
Claims Performance Adjustment Rate (CPA)	1.750	1.750	1.475	1.225	1.000
Average Performance Premium for current year	$32,409	$32,409	$32,409	$32,409	$32,409
ESI @ 10%	-$3,241	-$3,241	-$3,241	-$3,241	-$3,241
Claims Perf Adj CPA	$24,307	$24,307	$15,394	$7,292	$0
Dust Levy	$1,573	$1,573	$1,573	$1,573	$1,573
Total Premium	$55,048	$55,048	$46,135	$38,033	$30,741

Graph

Total Premium	$55,048	$55,048	$46,135	$38,033	$30,741
Total Claims	$50,000	$25,000	$15,000	$10,000	$5,000
Impact for each dollar of additional weekly payments		$0.00	$0.89	$1.62	$1.46
Over 3 years		$0.00	$2.67	$4.86	$4.38



WIRO SUBMISSION

APPENDIX "D"

Parkes Inquiry Principles

PARKES PROJECT ADVISORY COMMITTEE

STATEMENT OF PRINCIPLES

These principles have unanimous endorsement from the Parkes Project Advisory Committee.

They will form part of the Final Report to the Minister.

Where unanimous agreement is not reached a minority view has been included.

SETTLEMENT AND FINALISATION OF CLAIMS

Principles adopted

1. Workers should be entitled to exit the Scheme on a fair and reasonable basis with minimal constraints.

2. Negotiation between degrees of impairment should be permitted.

WEEKLY PAYMENTS

Principles adopted

1. The calculation of Pre Injury Average Weekly earnings should be a **simple and fair process**

2. The calculation method of PIAWE should provide a fair outcome regardless of the class of worker (for example, to ensure workers are not penalised for working more than one job, part time hours, or are aged)

3. 'PIAWE' should reflect the **current value** of 'pre-injury average weekly earnings' (Indexation) as should the Maximum cap on weekly payments.

4. Where there has been an inadequate payment of weekly payments, adjustments should be easily arrived at and paid from the date of the claim/notification

5. An injured worker should not be penalised because of their continued lack of any capacity (total incapacity) for work.

6. The suitable employment test has resulted in unfairness in the measure of benefits/earnings for certain categories of injured workers.

MEDICAL EXPENSES

Principles adopted

1. Prompt and early medical treatment underscores and supports early and successful return to health and work.

2. Access to medical treatment and services should not depend on impairment evaluation.

3. A medical expenses claims process including pre-approval processes must be prescribed and be simple.

4. Delays in treatment can lead to undesirable outcomes.

5. The 12 month cap on medical expenses should run from when weekly payments are last made and should capture all claims for medical treatment expenses **made** within that 12 months (currently, must have *received the treatment within the 12 months*).

6. For medical treatments or services, recognition should be given to the best practice scheduling of such treatments and standard treatment plans. (*Effect should be given to section 60(2C)(d) of the 1987 Act).*

7. There should be a general exception to the cap on duration of medical treatment to cover:

   a. Reasonably necessary surgery

   b. Treatment required to ensure the worker *remains at work* or is capable of returning to work

   c. Essential services to ensure that the worker's health or ability to undertake the necessary activities of daily living does not significantly deteriorate

- **Minority Position:** the 12 month cap should be removed for all injured workers.

PERMANENT IMPAIRMENT

Principles adopted

1. Workers should receive fair compensation for the permanent impairment which arises as a consequence of a work related injury.

2. Workers whose impairment significantly increases as an unintended consequence of reasonably necessary surgery or deterioration of the underlying injury/condition should be compensated for the consequent 'permanent impairment'.

3. There should be an exception to the one claim policy if it is established that an agreed degree of impairment is manifestly too low or there has been a significant increase in the degree of impairment.

4. The impairment assessment methodology and quantification of compensation should be the same regardless of when the injury occurred.

5. In a scheme where impairment thresholds determine access to various levels and types of benefit there must be exceptions to the 'one assessment' principle.

6. **Minority Position:**

   a. Workers should be able to access compensation for pain and suffering in addition to permanent impairment;

   b. There should be no threshold for permanent impairment compensation;

   c. there should be no restriction on claims for permanent impairment compensation (repeal section 66(1A) of the 1987 Act).

7. **Further Minority Position:**

   a. Reduce threshold in section 66(1) of the 1987 Act to 5%

   b. As an alternative to 6 a. above, incorporate the former pain and suffering compensation (section 67) into the compensation available for permanent impairment,

SERIOUSLY INJURED WORKERS

Principles adopted

1. There should be a separate assessment for determining whether a worker is seriously injured which is for the purpose of determining entitlement to weekly payments and medical treatment.

2. All of a worker's injuries and impairments should be considered for the purpose of satisfying a seriously injured worker threshold test, so long as there are compensable rights attached to each injury and impairment evaluation.

3. Determination of the apportionment of liability between insurers to the benefits payable to a seriously injured worker should be prescribed in the legislation.

4. A seriously injured worker who has no prospect of returning to work should be exempt from monthly medical assessments and regular certification of capacity where appropriate clinically.

DISPUTE RESOLUTION SYSTEMS

Principles Adopted

1. There should be one Dispute Resolution System which works within the legislation.

2. There should be one form of dispute notification.

3. Minor disputes or issues should be capable of resolution in a timely manner without the formality required for more complex issues.

COSTS AND LEGAL REPRESENTATION

Principles adopted

1. Workers and insurers should be able to obtain legal **advice** and representation with respect to all disputes (including WCDs)

2. Costs should reflect proper remuneration for all lawyers for both workers and insurers.

3. Part 16 "Marketing of Work Injury Legal Services and Agent Services" of the *Workers Compensation Regulation 2010* and Division 8 of Part 2 of Chapter 4 "Prohibited Conduct Related to Touting for Claims" of the *Workplace Injury Management and Workers Compensation Act 1998* should be deleted as this will be the subject of the *Legal Profession Uniform Law Application Legislation Amendment Bill 2015* introduced into NSW Parliament on 27 May 2015.

RETURN TO WORK OBLIGATIONS AND SUITABLE EMPLOYMENT

Principles adopted

1. Supported early return to work after injury is fundamental to the system and the scheme.

2. The test for suitable employment should be an actual test not a theoretical test

3. Disputes about provision of suitable employment or return to work should be simply and quickly managed.

4. Incentives should be provided to employers to provide suitable employment to injured workers and to workers to return to work after injury.

5. Rehabilitation following work injury should be meaningful and provided in a timely manner.

JOINT TORTFEASORS AND SECTION 151Z

Principles adopted

1. Workers should not be penalised in a joint third party tortfeasor action where they are unable to recover work injury damages from the employer

2. The insurer should be able to recover additional compensation paid to or on behalf of a worker as a consequence of a subsequent negligent act of a third party (not the employer)

3. Third Party tortfeasors should be able to be compelled to attend Mediation in Work Injury Damages claims.

ACCESS TO INFORMATION BY A WORKER

Principles adopted

1. There should be transparency about information collected by an employer or insurer about an individual injured worker.

2. A worker should be provided by the employer or insurer with information of the kind referred to in clause 46 of the WCR 2010 with the general exception that if the supply of that information would pose a serious threat to the life or health of the worker or any other person, the information, in the case of medical information, must be provided to a medical practitioner, or in other case, to a legal practitioner.

DEFINITIONS

Principles adopted

1. There should be consistency of language, terminology and drafting throughout the legislation.

2. The legislation should be clear on its face as to its meaning and intention.

3. The structure of the Act(s) should reflect the practical operation of the Scheme.

4. Where possible there should be national consistency or harmony of definitions used in workers compensation legislation.

INDEPENDENT MEDICAL EXAMINERS / EXAMINATIONS (IME'S)

Principles adopted

1. Where possible only one IME should be requested by a worker and an employer/insurer in relation to a medical issue with respect to a worker unless there are comorbid conditions.

2. Independent Medical Examiners (IMEs) should have qualifications, training and clinical experience commensurate with the body part/injury they are required to assess.

3. There should be better regulation of the use of IMEs in all circumstances (see section 119 WIM Act)

4. The Guideline on Independent Medical Examination requires updating through stakeholder consultation to achieve relevance in the current scheme design.

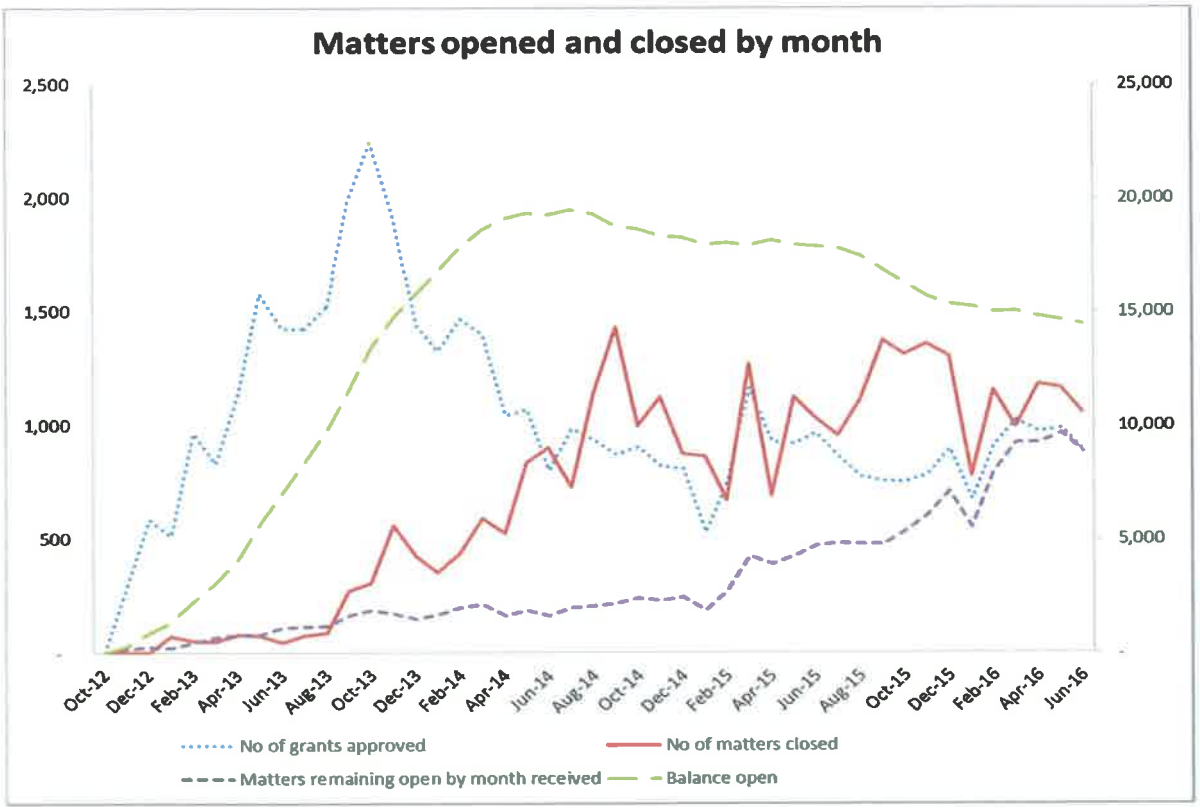
WIRO SUBMISSION

APPENDIX "E"

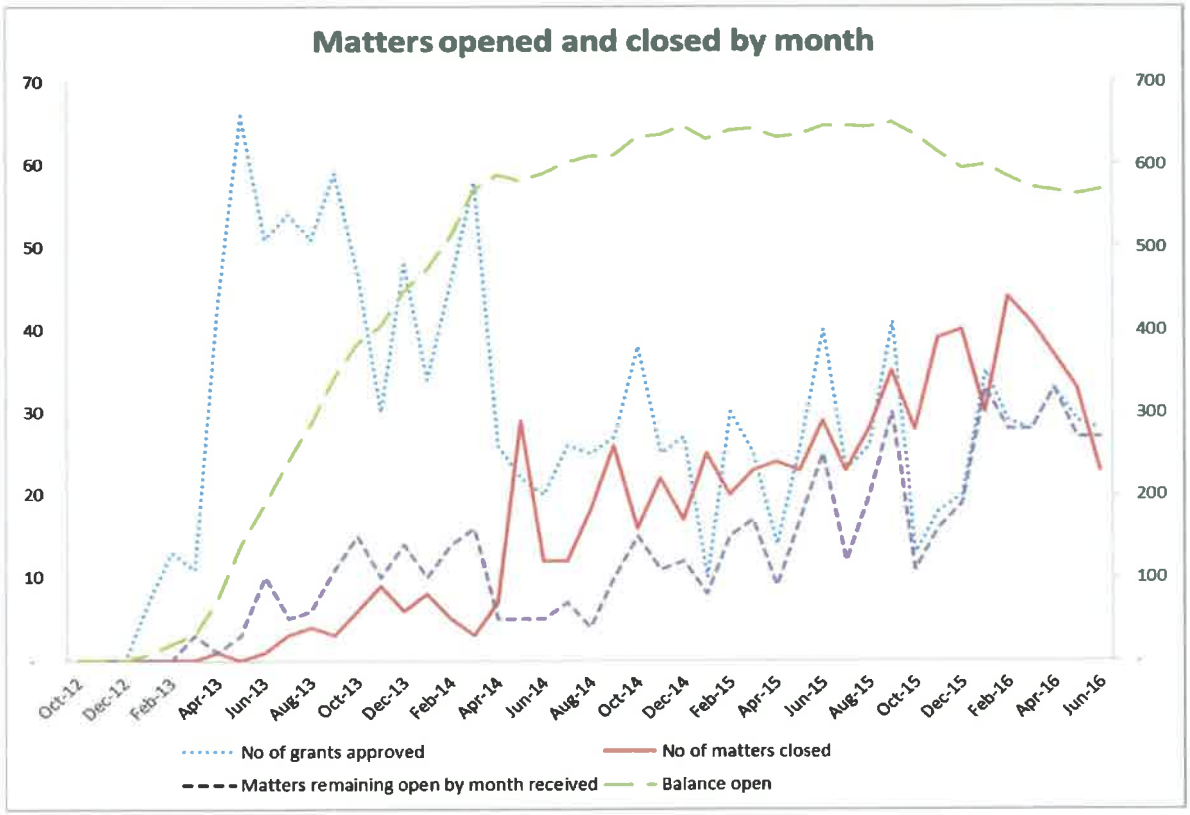
A Sample of the statistics maintained for a Law Firm

Graph showing ILARS matters opened and closed each month

Graph showing all ILARS matters



Graph showing **Lawyers Pty Ltd** **matters only**



Management of ILARS Matters

These reports help measure the efficiency of the ALSP against all other lawyers.

1 Emails sent and received per matter

Lawyer name	Number of cases	Total emails	Maximum	Average number per matter
All lawyers			**148**	**9.9**
Individual lawyer	473	4748	43	10
Individual lawyer	421	5637	49	13
Individual lawyer	284	3290	89	12
Individual lawyer	93	733	38	8
Individual lawyer	45	412	37	9
Individual lawyer	21	222	26	11
Individual lawyer	15	183	22	12
Individual lawyer	7	92	32	13
Individual lawyer	5	29	10	6
Individual lawyer	5	43	15	9
Individual lawyer	5	5	1	1
Individual lawyer	2	23	20	12
Individual lawyer	2	10	7	5
Individual lawyer	1	10	10	10

Note:

1: These numbers come directly from our system and subject to the ILARS Lawyer may include 'one email' for a whole conversation or one email for each part of the conversation

2: The number of emails includes system generated emails.

2 Number of matters where requisition raised

A requisition is a request by an ILARS lawyer for further informaton on a matter

ALSP Name	Matters Accepted or Pending	Matters Declined	Total Matters	% Accepted or Pending	% Declined	Number of matters where requisition raised	% of matters with requisitions
All ALSPs	**41,894**	**2,925**	**44,819**	**93%**	**7%**	**7,966**	**18%**
Lawyers Pty Ltd	**1,310**	**113**	**1,423**	**92%**	**8%**	**296**	**21%**
Individual lawyer	448	30	478	94%	6%	86	18%
Individual lawyer	86	10	96	90%	10%	18	19%
Individual lawyer	1	-	1	100%	0%	-	0%
Individual lawyer	3	2	5	60%	40%	2	40%
Individual lawyer	272	18	290	94%	6%	67	23%
Individual lawyer	2	-	2	100%	0%	1	50%
Individual lawyer	3	2	5	60%	40%	-	0%
Individual lawyer	21	2	23	91%	9%	8	35%
Individual lawyer	14	1	15	93%	7%	1	7%
Individual lawyer	48	3	51	94%	6%	8	16%
Individual lawyer	7	-	7	100%	0%	-	0%
Individual lawyer	398	45	443	90%	10%	104	23%
Individual lawyer	2	-	2	100%	0%	1	50%
Individual lawyer	5	-	5	100%	0%	-	0%

3 Number of invoices with errors or defects returned by WIRO

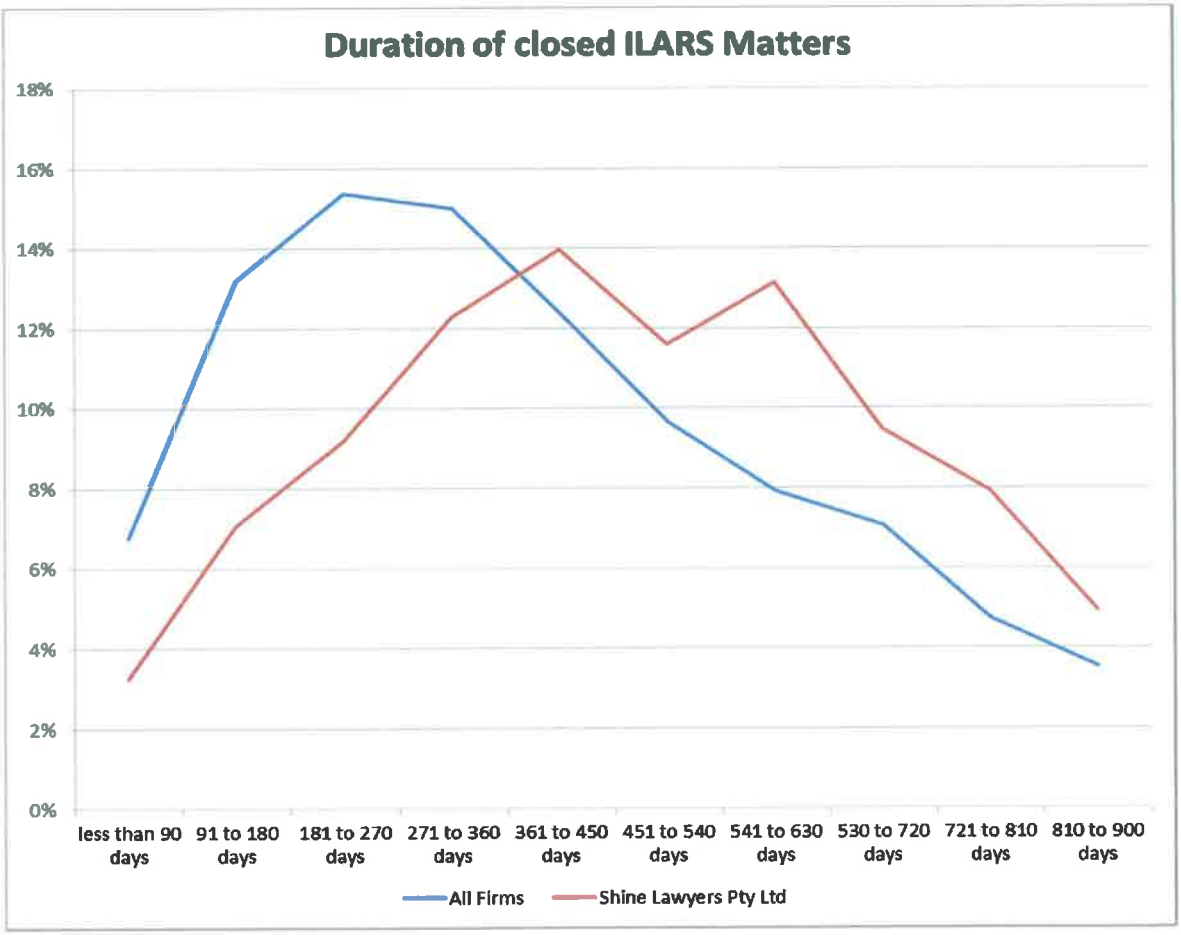
This table shows the percentage of invoices that are returned to the ALSP because they conatain an error or defect.

Period: 1/08/15 to 30/06/16

	Number of invoices where invoice is returned to law firm for correction							
	Number of invoices with no errors	Once	Twice	3 times	4 times	5 times	Total Invoices	Error percentage
All firms	**8,360**	**1,679**	**204**	**47**	**16**	**4**	**10,310**	**19%**
Average errors across lawyers >10 invoices		*19%*		*Median*	*18%*			
Lawyers Pty Ltd	248	60	9	2	-	-	319	22%
Individual lawyer	106	25	1	1			133	20%
Individual lawyer	80	21	3	1			105	24%
Individual lawyer	35	8	3				46	24%
Individual lawyer	11	5					46	76%
Individual lawyer	5		1				46	89%
Individual lawyer	3	1	1				46	93%
Individual lawyer	3						46	93%
Individual lawyer	3						46	93%
Indivldual lawyer	2						46	96%

4 Elapsed Days

This shows the number of days taken to close matters



What are the matters about?

This records the issues involved in each matter. There may be more than one issue in a matter.

Workers Compensation independent review office

	Denial of Liability	Medical costs	Weekly Payments	WPI	Other Issue	Death Claim	Total	Number of issues
Total all Firms	**16%**	**24%**	**11%**	**46%**	**2%**	**0%**	**100%**	**68,631**
Lawyers Pty Ltd	**19%**	**17%**	**15%**	**47%**	**2%**	**0%**	**100%**	**2,074**
Individual lawyer	21%	16%	18%	42%	3%	0%	100%	724
Individual lawyer	15%	16%	12%	54%	2%	1%	100%	124
Individual lawyer	*100%*	0%	0%	0%	0%	0%	100%	1
Individual lawyer	0%	0%	0%	100%	0%	0%	100%	3
Individual lawyer	19%	18%	10%	50%	2%	0%	100%	412
Individual lawyer	50%	0%	0%	50%	0%	0%	100%	4
Individual lawyer	0%	67%	0%	33%	0%	0%	100%	3
Individual lawyer	*16%*	0%	11%	74%	0%	0%	100%	19
Individual lawyer	*13%*	0%	0%	80%	7%	0%	100%	15
Individual lawyer	18%	18%	14%	38%	12%	0%	100%	154
Individual lawyer	13%	19%	25%	44%	0%	0%	100%	16
Individual lawyer	18%	16%	14%	50%	1%	0%	100%	590
Individual lawyer	*0%*	100%	0%	0%	0%	0%	100%	1
Individual lawyer	13%	13%	25%	38%	13%	0%	100%	8

Who are the respondents?

This records the number of matters each lawyer has as a percentage against each type of Insurer.

	Scheme agent	Self-insured	Specialised insurer	TMF	Grand Total
All Law Firms	**77%**	**10%**	**4%**	**8%**	**100%**
Lawyers Pty Ltd	**84%**	**7%**	**3%**	**5%**	**100%**
Individual lawyer	88%	6%	3%	4%	100%
Individual lawyer	82%	9%	3%	6%	100%
Individual lawyer	0%	100%	0%	0%	100%
Individual lawyer	100%	0%	0%	0%	100%
Individual lawyer	82%	7%	4%	7%	100%
Individual lawyer	0%	50%	0%	50%	100%
Individual lawyer	100%	0%	0%	0%	100%
Individual lawyer	*63%*	30%	4%	4%	100%
Individual lawyer	*73%*	27%	0%	0%	100%
Individual lawyer	92%	8%	0%	0%	100%
Individual lawyer	50%	0%	0%	50%	100%
Individual lawyer	84%	6%	4%	7%	100%
Individual lawyer	*50%*	0%	0%	50%	100%

Analysis of closed case outcomes

from 01-Jul-15 to 30-Jun-16

3 - the number, total cost and average cost for each outcome

	Desired Outcome not achieved			Grant achieved desired outcome			Totals		
Outcomes of Matters	Number of Matters	Total of Invoices	Average Invoice Cost	Number of Matters	Total of Invoices	Average Invoice Cost	Number of Matters	Total of Invoices	Average Invoice Cost
Instructions withdrawn	**43**	**$89,449**	**$2,485**				**43**	**$89,449**	**$2,485**
ILARS Funding Withdrawn	**60**	**$68,692**	**$4,041**				**60**	**$68,692**	**$4,041**
Cram Fluid Applies	**17**	**$67,584**	**$4,224**				**17**	**$67,584**	**$4,224**
Not eligible for funding - (e.g worker determined to be	**1**						**1**		
No Response to ILARS Follow Up	**38**	**$1,107**	**$1,107**				**38**	**$1,107**	**$1,107**
Old Costs provisions apply	**4**						**4**		
Not proceeding after preliminary grant	**44**	**$142,734**	**$3,398**				**44**	**$142,734**	**$3,398**
Medical evidence not supportive	**10**	**$30,287**	**$3,365**				**10**	**$30,287**	**$3,365**
Not Recorded	**2**	**$5,301**	**$2,651**				**2**	**$5,301**	**$2,651**
Worker does not reach WPI threshold	**32**	**$107,146**	**$3,456**				**32**	**$107,146**	**$3,456**
Other not specified reason - see summary box	**2**			**2**	**$440**	**$440**	**4**	**$440**	**$440**
Discontinued from WCC - No result	**2**	**$9,074**	**$9,074**				**2**	**$9,074**	**$9,074**
Resolved prior to WCC				**48**	**$232,771**	**$4,849**	**48**	**$232,771**	**$4,849**
Resolved - Insurer Accepts Claim				**9**	**$37,158**	**$4,129**	**9**	**$37,158**	**$4,129**
Resolved after application for review/Insurer accepts Claim				**2**	**$11,313**	**$5,656**	**2**	**$11,313**	**$5,656**
Resolved by complying agreement after claim made				**37**	**$184,300**	**$4,981**	**37**	**$184,300**	**$4,981**
Resolved In WCC	**10**	**$70,540**	**$7,054**	**146**	**$1,295,052**	**$8,931**	**156**	**$1,365,592**	**$8,810**
Resolved at Arbitration by Arbitrator - Employer	**3**	**$30,773**	**$10,258**				**3**	**$30,773**	**$10,258**
Resolved at Arbitration by Arbitrator - Worker				**15**	**$156,782**	**$11,199**	**15**	**$156,782**	**$11,199**
Medicals				3	$30,476	$10,159	3	$30,476	$10,159
Weeklies				1	$13,354	$13,354	1	$13,354	$13,354
Weeklies & Medicals				4	$38,343	$12,781	4	$38,343	$12,781
WPI				4	$40,467	$10,117	4	$40,467	$10,117
WPI & Medicals				1	$13,229	$13,229	1	$13,229	$13,229
WPI & Weeklies				1	$11,030	$11,030	1	$11,030	$11,030
WPI, Weeklies & Medicals				1	$9,883	$9,883	1	$9,883	$9,883
Resolved at Conciliation - settled by consent				**57**	**$564,057**	**$9,896**	**57**	**$564,057**	**$9,896**
Medicals				6	$54,352	$9,059	6	$54,352	$9,059
Weeklies & Medicals				24	$249,802	$10,408	24	$249,802	$10,408
WPI				11	$99,863	$9,078	11	$99,863	$9,078
WPI & Weeklies				1	$10,521	$10,521	1	$10,521	$10,521
WPI, Weeklies & Medicals				6	$61,930	$10,322	6	$61,930	$10,322
Wrap up				9	$87,589	$9,732	9	$87,589	$9,732
Resolved at settlement during Arbitration				**7**	**$68,539**	**$9,791**	**7**	**$68,539**	**$9,791**
Medicals				2	$25,260	$12,630	2	$25,260	$12,630
Weeklies & Medicals				3	$27,665	$9,222	3	$27,665	$9,222
WPI, Weeklies & Medicals				2	$15,613	$7,806	2	$15,613	$7,806
Resolved following MAC	**7**	**$39,767**	**$5,681**	**50**	**$370,076**	**$7,402**	**57**	**$409,843**	**$7,190**
COD for WPI				45	$319,844	$7,108	45	$319,844	$7,108
Not reached threshold	6	$35,184	$5,864				6	$35,184	$5,864
Not Recorded	1	$4,583	$4,583	2	$20,049	$10,024	3	$24,632	$8,211
Surgery reasonably necessary				3	$30,183	$10,061	3	$30,183	$10,061
Resolved TC - settled by consent				**17**	**$135,598**	**$7,976**	**17**	**$135,598**	**$7,976**
Medicals				2	$14,777	$7,388	2	$14,777	$7,388
Weeklies				2	$12,561	$6,281	2	$12,561	$6,281
Weeklies & Medicals				7	$56,511	$8,073	7	$56,511	$8,073
WPI				3	$24,646	$8,215	3	$24,646	$8,215
WPI, Weeklies & Medicals				3	$27,104	$9,035	3	$27,104	$9,035
Appeals	**2**	**$19,516**	**$9,758**	**13**	**$123,627**	**$9,510**	**15**	**$143,143**	**$9,543**
Resolved after appeal from decision of Arbitrator to President				**3**	**$32,290**	**$10,763**	**3**	**$32,290**	**$10,763**
By the employer in favour of Worker				2	$18,129	$9,064	2	$18,129	$9,064
By the worker in favour of Worker				1	$14,161	$14,161	1	$14,161	$14,161
Resolved after Medical Appeal Panel	**2**	**$19,516**	**$9,758**	**10**	**$91,337**	**$9,134**	**12**	**$110,853**	**$9,238**
By the employer in favour of Worker				2	$17,072	$8,536	2	$17,072	$8,536
By the worker in favour of Employer	2	$19,516	$9,758				2	$19,516	$9,758
By the worker in favour of Worker				8	$74,265	$9,283	8	$74,265	$9,283
(blank)	**1**	**$825**	**$825**	**7**	**$28,616**	**$4,769**	**8**	**$29,441**	**$4,206**
Grant application declined	**1**						**1**		
Resolved after Intervention by ILARS Director				**1**	**$5,849**	**$5,849**	**1**	**$5,849**	**$5,849**
Grand Total	**165**	**$400,829**	**$3,677**	**217**	**$1,686,356**	**$7,880**	**382**	**$2,087,184**	**$6,462**

Analysis of closed case outcomes

from 01-Jul-15 to 30-Jun-16

4 - Comparison of law firm Outcomes versus market

Overall	**38%**		**62%**				**37%**	**63%**
	Lawyers Pty Limited						**All Law firms**	
Outcomes	**Desired Outcome not achieved**		**Grant achieved desired outcome**		**Total cases**		**Desired Outcome not achieved**	**Grant achieved desired outcome**
	Percentage	**Number of cases**	**Percentage**	**Number of cases**	**Percentage**	**Number of cases**	**Percentage**	**Percentage**
Appeals	**2%**	**2**	**6%**	**13**	**4%**	**15**	**3%**	**3%**
Resolved after appeal from decision of Arbitrator to Presiden	0%		1%	3	1%	3	0%	0%
Resolved after Medical Appeal Panel	2%	2	5%	10	3%	12	3%	2%
Discontinued from WCC - No result	**2%**	**2**	**0%**		**1%**	**2**	**3%**	**0%**
ILARS Funding Withdrawn	**26%**	**34**	**0%**		**10%**	**34**	**27%**	**0%**
Cram Fluid Applies	12%	16	0%		5%	16	16%	0%
No Response to ILARS Follow Up	11%	14	0%		4%	14	9%	0%
Old Costs provisions apply	3%	4	0%		1%	4	1%	0%
Instructions withdrawn	**29%**	**39**	**0%**		**11%**	**39**	**26%**	**0%**
Not proceeding after preliminary grant	**32%**	**43**	**0%**		**12%**	**43**	**28%**	**0%**
Medical evidence not supportive	7%	9	0%		3%	9	8%	0%
Not Recorded	2%	2	0%		1%	2	1%	0%
Worker does not reach WPI threshold	24%	32	0%		9%	32	18%	0%
Other not specified reason - see summary box	**2%**	**2**	**1%**	**2**	**1%**	**4**	**2%**	**1%**
Resolved after Intervention by ILARS Director	**0%**		**0%**	**1**	**0%**	**1**	**0%**	**0%**
Resolved in WCC	**8%**	**10**	**67%**	**146**	**45%**	**156**	**11%**	**54%**
Resolved at Arbitration by Arbitrator - Employer	2%	3	0%		1%	3	2%	0%
Resolved at Arbitration by Arbitrator - Worker	0%		7%	15	4%	15	0%	7%
Resolved at Conciliation - settled by consent	0%		26%	57	16%	57	0%	15%
Resolved at settlement during Arbitration	0%		3%	7	2%	7	0%	2%
Resolved following MAC	5%	7	23%	50	16%	57	9%	16%
Resolved TC - settled by consent	0%		8%	17	5%	17	0%	13%
Resolved prior to WCC	**0%**		**22%**	**48**	**14%**	**48**	**0%**	**39%**
Resolved - Insurer Accepts Claim	0%		4%	9	3%	9	0%	14%
Resolved after application for review/insurer accepts Claim	0%		1%	2	1%	2	0%	2%
Resolved by complying agreement after claim made	0%		17%	37	11%	37	0%	23%
(blank)	**1%**	**1**	**3%**	**7**	**2%**	**8**	**0%**	**0%**
Grand Total	**100%**	**133**	**100%**	**217**	**100%**	**350**	**100%**	**100%**