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ANNUAL REPORT

2017 - 2018

The Workers Compensation Independent Review Office 2017 –18 Annual Report has been prepared in accordance with the relevant legislation for the Hon. Victor Dominello MP.

Workers Compensation Independent Review Officer

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

13 November 2018

Dear Minister,

In accordance with section 27C of the *Workplace Injury Management and Workers Compensation Act 1998*, I have pleasure in submitting, for your information and presentation to Parliament, the Annual Report of the Workers Compensation Independent Review Officer for the period from 1 July 2017 to 30 June 2018.

Yours sincerely,

Kim Garling

Workers Compensation Independent Review Officer

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MESSAGE FROM THE INDEPENDENT REVIEW OFFICER

This year has been both busy and productive and has seen challenges met and important and ambitious new projects implemented or commenced.

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

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

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

The scheme is complex. This reflects the multiple changes over decades. The Parkes Enquiry initiated by this office brought together representatives from all entities involved in the workers compensation scheme. After careful and thorough review there was unanimous agreement between everyone as to the aspects of the scheme which required change. Despite this agreement which had not occurred before there appears to be a reluctance to implement these changes.

The result is that injured workers and insurers have to deal with cases where there is ambiguity as to the entitlements of the workers and this results in increased disputes and the delays in finalising the cases. There is the additional cost involved across the scheme.

The Minister for Finance, Services and Property announced a review of one of the recommendations of the Parkes Enquiry which was subsequently endorsed by the Standing Committee on Law & Justice. That is the removal of the bifurcated dispute pathway. It is anticipated that this change will be effective by the end of 2018.

That is a significant step forward in easing the dispute pathway for injured workers and restoring their right to seek independent legal advice. It is unlikely to reduce the number of disputes which arise because the legislation which is confusing and ambiguous remains unchanged.

The team that manage the Independent Legal Assistance and Review Service have continued to monitor the funding and the management of the disputes which are funded by this office. Since the inception of this Service WIRO has funded over 80,000 cases for injured workers. About four out of every ten cases are resolved without the need to proceed to a formal dispute pathway.

In the course of the funding service it became apparent that major challenges would arise in the last year due to the impending commencement of operation of section 39 of the *Workers Compensation Act 1987* ("1987 Act") from September 2017. This section, introduced as part of the 2012 reforms, provides for the termination of weekly benefits after 260 weeks unless an injured worker has a degree of permanent impairment of greater than 20%.

The operation of this section will affect thousands of workers, some of whom have been in receipt of compensation for many years preceding the 2012 changes. The WIRO has devoted much time and effort into minimizing, as much as is possible, the effects of the provision by trying to ensure that affected workers know what is happening and are aware of their rights. WIRO's initiatives in this regard are discussed later in this report.

The situation is complicated by the interaction of various sections of the workers compensation legislation, in particular s 322A *Workplace Injury Management and Workers Compensation Act 1998* which provides that a worker is entitled to only one medical assessment, necessary to determine a worker's level of permanent impairment. In practice, this means that some workers may not be entitled to a further assessment or some may lose the opportunity to claim other benefits if they elect to see whether they are eligible for the continuation of weekly benefits after 260 weeks.

The Government published the *Workers Compensation Amendment (Transitional Arrangements for Weekly Payments) Regulation 2016* in December 2016, which is retrospective but only applies to workers in receipt of weekly payments immediately prior to 1 October 2012. The Regulation is helpful for this category of injured worker only, as they are able to have one further assessment of their permanent impairment for the purposes of section 39.

I was pleased to participate in the Spark Festival which took place in October and involved a gathering of the tech start-ups in this State. The response was amazing and there was a large number of events showcasing the potential developments.

I am proud of the progress this office has made in the last year in terms of the transformation of our service delivery, improved data analysis and our contribution to better policy.

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

Kim Garling

ABOUT THIS REPORT

Welcome to our Annual Report for the period from 1 July 2017 to 30 June 2018.

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

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

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

(b) the sources of those complaints,

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

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

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

As well as reporting on the activities of this office's Solutions Group, which deals with the complaints mentioned above and the WIRO procedural review of work capacity decisions, the Report also provides information on the work of the ILARS team, the Operations Group and the Employer Complaints team.

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

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

ABOUT WIRO

Our functions

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

The statutory functions of the office, set out in *s 27 WIMA* are:

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

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

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

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

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

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

WIRO also runs an extensive education program for the benefit of the scheme's stakeholders.

Our structure

WIRO is a small office with 45 staff headed by the Independent Review Officer ("IRO"). WIRO's functions are performed in the following way:

- The Director of the Solutions Group manages a team which includes a Manager and consisting of a team of 7 dispute resolution officers who operate the WIRO Call Centre and respond to the Enquiries and Complaints from injured workers.
- An Office of the General Counsel whose role includes undertaking the procedural reviews of work capacity decisions and to whom the Manager of Legal Education reports.
- The Employer Complaints Group deals with complaints from employers about insurers and attempts to resolve them and encourage complaint resolution processes.
- The Independent Legal Assistance and Review Service ("ILARS") consists of specialised workers compensation lawyers who consider applications from ILARS approved lawyers for legal assistance for injured workers.

- The Policy and Strategy team which is responsible for the development of all policy recommendations, engagement, education and communication with WIRO stakeholders.
- The Operations Group which is responsible for the management of the data collection, storage and analysis of the data together with ensuring that all the accounts are paid promptly and efficiently.

Our leadership – Executive Management

Kim Garling – Independent Review Officer

Kim Garling is a long serving member of the legal profession who has throughout his distinguished career made significant contribution to law reform in New South Wales. Kim is a past president of the Law Society of NSW. He was an instrumental driving force in the reform of NSW Young Lawyers as a separate entity of the Law Society and in the establishment of Law Week, which celebrated its 35th year in 2017. Kim is currently the Chair of a Legal Aid Review Committee of the Legal Aid Commission of NSW and has been a member of this committee since 1981

Wayne Cooper – Director Work Capacity & General Counsel

Wayne Cooper commenced in the Workers Compensation field at the former Government Insurance Office in May 1987. In the intervening period, he worked mainly in private practice as both a barrister and a solicitor, before going to the former WorkCover Authority. In 2013, he joined WIRO and more than 700 procedural reviews of work capacity decisions have taken place in that time.

Jeffrey Gabriel – Director Solutions

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

Roshana May – Director ILARS

Roshana has over 30 years of experience as a lawyer and spokesperson in personal injury law, particularly in relation to statutory compensation schemes. She is a subject matter expert in workers compensation law and practice. She has been involved in workers compensation policy formulation and representation for the legal profession for many years. Before she took up her current role she was the ALA spokesperson in the NSW CTP reform process and ALA representative on the Ministerial Implementation Committee formed for the 'new CTP scheme'. In her current role, Roshana oversees funding of private lawyers for injured workers in the workers compensation scheme.

Phil Jedlin –Director Operations

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

Maria MacNamara – Acting Director Policy & Strategy

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

Our values and goals

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

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

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

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

- independence – we are impartial, fair and just
- innovation - we find new and better ways of solving problems
- respect – we are generous, polite and honest
- collaboration – we work together harmoniously and focus on building unity
- accessibility – we encourage direct contact by stakeholders We are successful when:
- we have an innovative, fair and efficient compensation scheme
- we have a well - respected process for the early resolution of disputes
- we have achieved a reduction in the funding of future legal claims
- we drive an earlier return to health program
- there is a high awareness and satisfaction among the WIRO stakeholders.

THE SOLUTIONS GROUP

Overview

Section 27 (a) *WIMA* provides that the Independent Review Officer has the function, *"to deal with complaints made to the Independent Review Officer under this Division".*

Section 27A *WIMA* 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.*

Shortly after WIRO's establishment in 2012, a protocol was established with insurers in which they agreed to respond to a "preliminary enquiry" about a particular claim within two business days of WIRO making contact, after we received a telephone or emailed request for assistance from either the worker or the worker's representative. All such communications from workers are dealt with promptly and personally by members of the Solutions Group.

In our experience, this protocol response time is met in almost all cases due to the cooperation received from the insurers, which endeavour to find a solution to the issue rather than strenuously defending their decision. WIRO also assists with enquiries from workers that involve a request for information or guidance with respect to a claim.

Outreach

The WIRO Solutions Group and the IRO meet regularly with insurers to ensure ongoing cooperation and open communication between WIRO and insurers.

During the reporting period, the Solutions Group met GIO, Allianz, QBE TMF, Employers Mutual Limited (TMF), State Insurance Regulatory Authority (SIRA), Allianz TMF, iCare, Craig's Table, United Services Union, Catholic Church Insurance, StateCover Mutual Limited, Independent Education Union, Safework NSW, NSW Nurses and Midwives' Association, the Transport Workers Union, Unions NSW and the Australian Meat Industries Employees Union (Newcastle & Northern).

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

iCare, its Scheme Agents and SIRA each have a complaints procedure, which operate under different principles, but they lack WIRO's statutory function. Their procedures do not facilitate the transparent reporting of issues raised and any systemic issues that are identified. The data that these agencies collect during the investigation of these complaints cannot be aggregated to produce a clear picture of insurers' overall performances within the scheme.

Some of the notices issued by insurers advised workers that they must contact the insurer regarding any issue or complaint before they contacted WIRO. That advice was both misleading and untrue. Every worker has the right and entitlement to contact WIRO at any time during the life of their claim to raise concerns regarding the insurer's conduct and claim management.

In November 2016, WIRO began publishing the monthly on-line *Solutions Brief,* which delivers relevant statistics, updates, information and case studies to subscribers. All editions of the *Solutions Brief* are published on WIRO's website.

Number and type of complaints

Between 1 July 2017 and 30 June 2018 WIRO received 3084 complaints and 3501 enquiries. Some complaints raised multiple issues, which explains why the total in Figure 2 below exceeds the number of complaints above. Figure 2 also indicates the specific issues raised, which includes complaints that Solutions Group could not accept because they were outside our jurisdiction (e.g. complaints about the conduct of lawyers):

Figure 2

Issue	Complaint		Enquiry	
	Number	%	Number	%
Communication (secondary issue only)	71	2%	70	2%
Delay in determining liability	880	26%	342	9%
Delay in payment, Denial of liability, Further Inquiry (secondary issue only), ILARS lawyer complaint, IME/IMC, Medico Legal Examination/WPI	924	27%	1221	34%
NRTC	22	1%	9	0%
Payment, reimbursement of Medicals/Travel expenses	4	0%	2	0%
PIAWE	161	5%	96	3%
Rehabilitation	192	6%	302	8%
RTW	83	2%	167	5%
S126	132	4%	112	3%
S39	129	4%	669	19%
Weeklies	740	22%	461	13%
Work Capacity Decision	50	1%	155	4%
Total	**3388**	**100%**	**3606**	**100%**

Source of complaints

In most cases, complaints are raised with WIRO directly by the injured worker or their representative by telephone. However, WIRO also receives complaints and enquiries via our website and by email. The manner of contact is recorded in Figure 3 below.

Figure 3

Source	%	Number
Lawyer	65%	4294
Web search	11%	743
Insurer	6%	372
icare/SIRA	5%	330
Word of Mouth	6%	410
Other source	3%	192
Union	3%	172
Doctor	1%	72
Rehabilitation Provider	1%	62
WIRO Campaign	1%	45
Workers Compensation Commission	1%	34
Government Department	0%	30
Referral source not provided - Enquiries	0%	23
Employer	0%	5
Total	**65%**	**4294**

Number & type of 2017 complaints finalised this reporting year

At the commencement of the current reporting year, Solutions Group undertook a review of how complaints were categorised and we changed how we record issues. Therefore, the issues reported this year differ from those that were reported in the 2017-18 year. The issues relating to cases received in 2016/17 and closed in 2017/18 are shown in Figure 4 below:

Figure 4

Issue	Number of cases
Delay in determining liability	17
Delay in payment	6
Denial of liability	6
IME/IMC	1
NRTC	1
PIAWE	1
Rehabilitation	5
RTW	1
S126	3
S39	1
Weekly Benefits	16
Work Capacity Decision	4
Grand Total	**62**

Complaints finalised

The Solutions Group resolved 2,988 complaints during the current reporting year. More information including the types of issues dealt with is found in Appendix 1.

WIRO aims to resolve complaints within two clear business days and the majority are resolved within seven days. However, WIRO received many complex complaints that took more than 30 days to resolve.

Figure 5 below sets out the number of complaints received by WIRO regarding an insurer's failure to respond to a claim during the current reporting year and the outcomes achieved. This includes complaints where more than one type of issue was raised.

Figure 5

Outcomes	Scheme agent	Self- insured	Specialised insurer	TMF	Total
Delay in determining liability	**560**	**110**	**52**	**135**	**857**
Medical treatment	**296**	**65**	**24**	**76**	**461**
Insurer inside timeframes ND	51	7	4	15	77
Insurer outside timeframes ND	34	8	2	8	52
IW referred to an IME	15	3	2	4	24
Liability determined inside timeframes	75	16	3	21	115
Liability determined outside timeframes	121	31	13	28	193
s66	**29**	**6**	**1**	**5**	**41**
Counter offer made	5	1		2	8
Insurer inside timeframes ND	5	2			7
Insurer outside timeframes ND	4	1			5
IW referred to an IME	2	2		1	5
Liability determined inside timeframes	5			1	6
Liability determined outside timeframes	8		1	1	10
Weekly benefits	**75**	**9**	**4**	**21**	**109**
Insurer inside timeframes ND	12	1		3	16
Insurer outside timeframes ND	4	1		3	8
Liability determined inside timeframes	30	1	2	7	40
Liability determined outside timeframes	29	6	2	8	45
Whole claim	**160**	**30**	**23**	**33**	**246**
Insurer inside timeframes ND	24	10	2	10	46
Insurer outside timeframes ND	11	9	5		25
Liability determined inside timeframes	43	3	8	8	62
Liability determined outside timeframes	82	8	8	15	113
Delay in payment	**262**	**62**	**17**	**75**	**416**
COD	**151**	**31**	**9**	**41**	**232**
Centrelink/Medicare delay	33	7	4	11	55
Insurer Admin error	85	14	3	18	120
Interest Obtained	3			1	4
Interpretation Dispute/Insurer within timeframes	16	6	1	8	31
Lawyer hasn't provided all documents required	14	4	1	3	22
Medical/Travel	**111**	**31**	**8**	**34**	**184**
Already paid	23	8	1	3	35
Claim disputed	12			2	14
Claim not received	15	5	2	5	27
Correct amount paid after PI	54	14	3	20	91
Providers invoices not paid	7	4	2	4	17
Denial of liability	**207**	**36**	**19**	**51**	**313**
Incorrect notice given	15	2	1	7	25
Insurer maintain denial on review	125	27	13	26	191
Insurer overturns decision	51	4	5	14	74
IW required to attend an IME	16	3		4	23

Outcomes	Scheme agent	Self- insured	Specialised insurer	TMF	Total
Refer worker to the OLSC	**8**			**4**	**12**
IME/IMC	**40**	**10**	**3**	**12**	**65**
Choice of 3 IMEs not provided	4			1	5
Complaint about the IME doctor	12	4		5	21
Inconvenient location	12	5	2	2	21
Insufficient notice provided	7		1	3	11
No contact made with treating doctors before referral	5	1		1	7
PIAWE	**126**	**14**	**4**	**19**	**163**
Insurer changes PIAWE	45	5	2	7	59
Insurer maintains decision	27	5	1	4	37
Review process explained	54	4	1	8	67
Rehabilitation	**100**	**16**	**7**	**26**	**149**
ADL assessment approved	37	7		10	54
ADL not approved	8	1		2	11
Case conference cancelled	4		1	3	8
IMP	**7**		**3**	**4**	**14**
IW not complied with obligations			2	2	4
No current IMP	5			2	7
Insurer not complied with obligations	2		1		3
Rehab provided s41A	14	3	1	3	21
Rehab provider changed	25	5	1	3	34
Work Trial not suitable	5		1	1	7
RTW	**46**	**10**	**2**	**18**	**76**
Job Seeking Diaries	**3**	**1**			**4**
Too many jobs required	2				2
Not provided to insurer		1			1
Suspension s48A	1				1
Suitable Employment	**43**	**9**	**2**	**18**	**72**
Duties not suitable	13	2		3	18
RTW plan updated	7	2		1	10
S/duties not provided by employer	9	1	2	5	17
S/duties provided	10	2		7	19
Workplace assessment required	4	2		2	8
S126	**67**	**26**	**10**	**22**	**125**
Documents not provided	11	9		3	23
Documents provided	56	17	10	19	102
S39	**89**	**6**	**1**	**14**	**110**
Choice of 3 IMEs not provided				2	2
Insurer accepts worker is over 20%	14	2		3	19
Worker referred to an ALSP	75	4	1	9	89

Outcomes	Scheme agent	Self- insured	Specialised insurer	TMF	Total
Weekly Benefits	**507**	**49**	**26**	**86**	**668**
Correct amount paid after PI	259	28	12	38	337
Delayed payment	124	13	3	27	167
Employer not passing on weekly payments	63	4	6	10	83
Insurer taking over payments (Payments paid to employer in error)	12			1	13
Overpayment deducted without agreement	10	1		5	16
Suspension maintained	9		3	1	13
Suspension overturned	22	1	2	1	26
Weekly payments suspended	8	2		3	13
Work Capacity Decision	**25**	**3**	**2**	**4**	**34**
Application not received by insurer/MRS	4		1	1	6
Incorrect notice provided	3			1	4
Stay not applied	7		1	1	9
WCD not received/delayed	9	2		1	12
WCD withdrawn	2	1			3
Grand Total	**2037**	**342**	**143**	**466**	**2988**

The Data Advantage

The data that the Solutions Group collects in relation to each complaint and enquiry is entered into a central database, which enables WIRO to sort complaints and enquiries by issue, time and insurer. WIRO can then analyse the types of complaints or enquiries made with respect to each insurer and the frequency that specific issues are raised regarding each insurer. This enables WIRO to identify the issues that require redress by the insurers and we have met with them to discuss these issues. To date, the insurers' feedback has been positive and the data that WIRO has provided to the insurers has had a tangible effect upon their in-house training programmes.

As the first point of contact, WIRO is uniquely placed to identify emerging issues before they are litigated. This means that WIRO can notify SIRA, insurers and other stakeholders about matters that require attention.

For example, WIRO identified misleading information on SIRA's website in relation to hearing loss claims that had resulted in scheme agents denying liability. WIRO raised the issue with SIRA after receiving a complaint from an injured worker. If WIRO had not been the initial point of contact for the injured worker, the dispute would likely have been litigated and significant legal costs would have been incurred. That would also have resulted in a significant delay in the injured worker receiving medical and related treatment and it is likely that the misleading information posted on SIRA's website may not have been brought to its attention until a much later time.

Towards the end of the 2017 calendar year, WIRO received an increasing number of enquiries and complaints regarding the termination of weekly payments under s 39 of the 1987 Act. WIRO published data regarding these enquiries and complaints, which has been used to inform iCare and insurers regarding best practice when notifying affected workers of the impact of s 39.

Systemic issues

The Table in Figure 3 above identifies the number and types of complaints that WIRO received from injured workers about insurers. Based upon this data, WIRO identified multiple systemic issues within the scheme, including regarding insurer behaviour and inconsistencies/conflict in legislation.

WIRO has successfully resolved many of the issues that have been identified, as evidenced by the case studies. The case studies also provide a basis for potential legislative reform and/or increased regulation by SIRA.

Section 39 WCA

Section 39 of the Workers Compensation Act 1987 was inserted into the legislation as part of the 2012 amendments. It reads as follows:

39 Cessation of weekly payments after 5 years

(1) Despite any other provision of this Division, a worker has no entitlement to weekly payments of compensation under this Division in respect of an injury after an aggregate period of 260 weeks (whether or not consecutive) in respect of which a weekly payment has been paid or is payable to the worker in respect of the injury.

(2) This section does not apply to an injured worker whose injury results in permanent impairment if the degree of permanent impairment resulting from the injury is more than 20%.

Note. For workers with more than 20% permanent impairment, entitlement to compensation may continue after 260 weeks but entitlement after 260 weeks is still subject to section 38.

(3) For the purposes of this section, the degree of permanent impairment that results from an injury is to be assessed as provided by section 65 (for an assessment for the purposes of Division 4).

The transitional provisions provided that no regard was to be had to weekly payments made prior to the date of commencement of s 39, which was either on or before 1 January 2013, depending upon whether the worker was an existing recipient of weekly payments.

The savings and transitional provisions of the Workers Compensation Regulation 2016, found in Schedule 8, Part 2A, provide some scope for workers who were existing recipients of weekly payments before 1 October 2012 to avoid the restrictions set out in s 39.

Clause 28B provides:

28B - Application and operation of Part

(1) This Part takes effect on and from 1 October 2012.

(2) This Part applies to an injured worker who is an existing recipient of weekly payments.

Clause 28C provides:

28C - 5-year limit on weekly payments

Section 39 of the 1987 Act (as substituted by the 2012 amending Act) does not apply to an injured worker if the worker's injury has resulted in permanent impairment and:

(a) an assessment of the degree of permanent impairment for the purposes of the Workers Compensation Acts is pending and has not been made because an approved medical specialist has declined to make the assessment on the basis that maximum medical improvement has not been reached and the degree of permanent impairment is not fully ascertainable, or

(b) the insurer is satisfied that the degree of permanent impairment is likely to be more than 20% (whether or not the degree of permanent impairment has previously been assessed).

Clause 28D provides:

28D Further permanent impairment assessments

(1) This clause applies to an injured worker if the degree of permanent impairment resulting from the worker's injury is or has been assessed for the purposes of the Workers Compensation Acts.

(2) Section 322A of the 1998 Act does not operate to prevent a further assessment being made of the degree of permanent impairment resulting from the worker's injury for the purposes of Part 3 of the 1987 Act.

(3) However, only one further assessment may be made of the degree of permanent impairment resulting from the worker's injury.

Towards the end of 2017, the first group of injured workers had their weekly payments cease because of the operation of s 39 and WIRO received many complaints about this.

Solutions Group referred most of these workers to lawyers to obtain ILARS-funded independent legal advice regarding their rights and entitlements and their prospects of establishing a degree of permanent impairment of greater than 20% (which would exempt them from the operation of s 39).

WIRO also received many complaints in which the insurers failed to apply Schedule 8 Part 2A of the Regulation. The following case studies are examples of these complaints:

Case Study 1

The insurer gave the worker notice under s 39 to the effect that his weekly payments would cease in December 2017. The worker's lawyer wrote to the insurer in September 2017, and enclosed a medical report that contained an assessment of 34% WPI, and asked the insurer to concede that the worker was likely to have a degree of permanent impairment of greater than 20% WPI so that the worker's weekly payments would not cease in December 2017. However, the insurer failed to respond for a period exceeding 10 weeks. Following WIRO's enquiries, the insurer advised that it was satisfied that the injury had resulted in a degree of permanent impairment that was likely to be more than 20%. As a result, weekly payments did not cease in December 2017.

Case Study 2

The worker's lawyer contacted WIRO, advising that the worker underwent surgery in August 2017 and had not yet reached maximum medical improvement. The worker's lawyer had contacted the insurer and requested that it concede that the injury had resulted in a degree of permanent impairment that was likely to be more than 20% WPI. The insurer had not responded. Following contact from WIRO, the insurer stated that it was awaiting a supplementary report from its medical expert and that it had referred the matter to iCare. Subsequently, iCare allowed the insurer to confirm that the worker's weekly payments would continue beyond 260 weeks.

WIRO commends iCare, the scheme agents and selected other insurers who have pre-emptively written to injured workers advising them of the effects of s 39. Many workers received several months' notice regarding the impact of s 39, which allowed them to prepare for this.

However, as the case studies demonstrate, some insurers failed to respond in a timely manner to injured workers who sought to challenge their decision that the relevant threshold was not satisfied and that weekly payments would cease.

It is likely that the insurers were overwhelmed by the sheer volume of s 39 enquiries in late 2017, noting that several thousand workers' weekly benefits ceased in December 2017. However, the number of s 39 complaints received by WIRO has declined markedly in 2018.

Transition of claims from QBE and CGU

In early 2017, iCare announced that QBE and CGU would no longer be scheme agents for the nominal insurer. As a result, during the latter half of 2017, workers compensation claims were transitioned from QBE and CGU to GIO for ongoing management.

Solutions Group received dozens of complaints from injured workers regarding deterioration in service from QBE and CGU before their claims were transitioned to GIO. In many instances, QBE and CGU failed to determine the claims within statutory timeframes that expired prior to transition of the claims.

A large volume of complaints also related to a lack of response from GIO following the transition and in many cases, GIO failed to respond to claims within a period of weeks to several months following transition.

In many cases, injured workers experienced a lack of response both prior to and following transition of their claims between scheme agents.

WIRO raised these issues with iCare during several meetings, during which we brought to iCare's attention that GIO was having significant difficulties in recruiting staff to manage these claims and that GIO was also experiencing data conversion issues, which meant that claims documentation was not readily accessible in its claims database.

No Response to Claim

WIRO receives a significant number of complaints from injured workers where insurers have failed to commence weekly payments of compensation within seven days of the initial notification of the claim.

Section 267 *WIMA* requires an insurer to commence weekly payments under provisional liability within seven days of receiving initial notification of a claim.

Notwithstanding this obligation, an insurer is not required to commence weekly payments where it has a reasonable excuse and the Guidelines specify the permitted ‘reasonable excuses’. These include an assertion that insufficient medical information has been submitted and a dispute that the claimant is not a ‘worker’ for the purposes of the Acts.

Section 268 *WIMA* requires an insurer to notify the claimant in writing that it has a reasonable excuse for not commencing weekly payments within seven days of initial notification of the claim.

The insurer’s notification to the worker of either the commencement of weekly payments, or the existence of a reasonable excuse for not commencing weekly payments, is often the first correspondence that the injured worker receives from the insurer in response to their claim.

Despite the statutory obligation to respond within seven days and the important role that first impressions play in the management of a claim, WIRO is concerned that there is still a high volume of complaints in relation to breaches of ss 267 and 268 *WIMA*. In our view, this is an issue that requires ongoing attention and redress by insurers.

The following case studies are example of an Insurer failing to properly respond to notification of an injury.

> *Case study 3*
>
> *The worker sustained a wrist injury with the deemed date of injury in May 2017.*
>
> *The following day, the worker saw their GP and received a Certificate of Capacity, which stated that the worker had current work capacity. The worker gave this certificate to the Insurer.*
>
> *On 22 June 2017, a representative from the Insurer met with the worker and advised that no suitable duties were available.*
>
> *On 29 June 2017, a consultant then retained by the Insurer to manage its claims, received the Certificate of Capacity from the employer.*
>
> *On 3 July 2017, a consultant provided the worker with a letter advising that it had a reasonable excuse for not commencing weekly payments.*
>
> *In its response to WIRO’s contact, the Insurer maintained that the decision to ‘reasonably excuse’ the claim was made within time (i.e. within 7 days of notification to the insurer) because the reasonable excuse letter was sent out 4 days after the consultant received the Certificate of Capacity.*

The Act provides that a reasonable excuse notice must be issued within 7 days of the insurer being notified and the consultant is not the insurer, but rather a third-party provider of claims management services.

The injured worker was not informed about the insurer’s response to the claim in a timely manner, which deprived them of the opportunity to obtain support and legal advice at an early stage.

Case study 4

A worker injured her knee at work in May 2018 and notified the employer of the injury that day.

Later in May 2018, The Insurer through its claims consultant issued a notice to the worker on behalf of the Insurer that it had a reasonable excuse for not commencing weekly payments, namely:

1. *The injury is not work-related – there is no medical information supporting that employment is a substantial contributing factor to the injury;*
2. *There is insufficient medical information.*

In relation to reasonable excuse 1, WIRO referred to page 11 of the Guidelines, which provides that the insurer must supply either medical information or factual information as to why the injury is not work-related. However, the notice did not discuss or provide any information to that effect.

In relation to reasonable excuse 2. WIRO also referred to page 11 of the Guidelines, which provides that this excuse is usually used only where no Certificate of Capacity has been provided. However, a supporting Certificate of Capacity had been submitted to the Insurer.

WIRO raised these issues with the Insurer and suggested that the reasonable excuse notice should be withdrawn because it did not cite valid excuses. However, the Insurer refused to withdraw the notice.

Case study 5

The worker notified the Insurer of her injury in May 2018 and presented the Insurer with a Certificate of Capacity.

In early June 2018, a reasonable excuse notice was issued to the worker, asserting that the injury may not be work-related and that there was insufficient medical information.

WIRO raised several concerns with the Insurer (through its claims consultant), including:

1. *the reasonable excuse notice was issued 9 days after notification of the injury;*
2. *the reasonable excuse of 'insufficient medical information' should not have been used because a Certificate of Capacity was submitted in support of the claim; and*
3. *the reasonable excuse of 'the injury was not work-related" was not used as required by the Guidelines as there was no medical or factual information that supported it.*

In WIRO's view, this Insurer's approach to complying with its obligations to respond to claims is unacceptable considering the repeated breaches of ss 267 and 268 *WIMA*.

If this Insurer continues this practice in the next period I will name them.

However, this issue is not confined to a single insurer. WIRO has observed conduct of a similar nature from most insurers and we consider this a significant problem within the scheme. The following case study involves a different Insurer.

Case Study 6

The worker fell from a chair at work in January 2018, and suffered a significant spinal injury that ultimately required surgery. The worker was treated by paramedics in the workplace and was taken to hospital by ambulance.

Later in January 2018, the Insurer received a signed claim form from the worker. The next day, it received a Certificate of Capacity issued by a Hospital doctor. The worker was discharged from hospital and the Insurer issued a reasonable excuse notice that alleged that there was insufficient medical information and that the injury may not be work-related.

WIRO asked the Insurer when it received notification of the injury and it responded that this occurred on 11 January 2018, when it received the signed claim form.

WIRO put to the self-insurer that: (1) it was clearly notified of the injury on 8 January 2018 and that the reasonable excuse notice was issued out of time; (2) the excuse of "insufficient medical information" did not apply because the worker had submitted a Certificate of Capacity; and (3) the excuse of "the injury may not be work related" was not supported by any medical or factual evidence as required by the Guidelines.

The nature of the Insurer's response demonstrates an apparent lack of knowledge and understanding concerning the operation of ss 260, 267 and 268 *WIMA* and the Guidelines, as follows:

- Its assertion that it did not receive notification of the injury until the worker submitted a signed claim form is contradicted by its subsequent admission that it received an incident report while the worker was receiving treatment on the date of the injury; and
- Its explanation that it asserted that the injury may not be work-related because the worker did not wear a neck brace when returning a work car after a 5-day hospital admission is not credible in view of the supporting medical evidence that it received.

As a result, the worker was left without financial support for a period of several weeks and it was only after WIRO presented this case study at its Seminar in March 2018 that the Insurer decided to commence weekly payments.

It is WIRO's view that a lack of understanding of the legislation and Guidelines, combined with a lack of education, continue to cause prejudice to injured workers.

Insurers' reluctance to issue dispute notices

WIRO received many complaints regarding insurers' failure to issue dispute notices. The relevant legislative provisions are as follows:

Section 274 (1) *WIMA* provides:

(1) Within 21 days after a claim for weekly payments is made the person on whom the claim is made must determine the claim by:

(a) accepting liability and commencing weekly payments, or

(b) disputing liability.

Note. Section 283 makes failure to comply with this section an offence. Section 74 requires notice of a dispute to be given.

Section 279 (1) *WIMA* provides:

> *(1) Within 21 days after a claim for medical expenses compensation is made the person on whom the claim is made must determine the claim by accepting or disputing liability.*
>
> *Note. Section 283 makes failure to comply with this section an offence. Section 74 requires notice of a dispute to be given.*

Although these provisions impose a clear obligation upon an insurer to determine claims within the specified timeframes and to issue written dispute notices where the claim is not accepted, WIRO frequently receives complaints regarding insurers' refusal to issue dispute notices.

During August and September 2017, WIRO received multiple complaints about the conduct of one Insurer, namely that it refused to issue dispute notices in cases where its own qualified medical expert had recommended alternative medical and related treatment.

Case study 7

> *In November 2016, the worker sought approval for surgery from the insurer. Further requests for approval were sent to the insurer in December 2016 and February 2017, but no response was received.*
>
> *In response to contact from WIRO, the Insurer advised that its file was closed following prior WCC and that its own medical expert had recommended surgery of a different type.*
>
> *Several months later, the worker's lawyer complained to WIRO that the Insurer had not issued a dispute notice to the worker.*
>
> *WIRO contacted the Insurer and expressed the view that it was significantly out of time to determine the claim for medical treatment expenses and requested that it issue a dispute notice. However, in September 2017, the Insurer replied (inter alia):*
>
> > *"We are not interested in disputing this claim for treatment if it is not necessary and not the appropriate course of action to take. Particularly given Dr…agrees that surgery is needed- and there is just a difference of opinion as to what surgery to proceed with."*

The Insurer's response was clearly unsatisfactory. WIRO noted that the worker had not sought approval of any other type of medical or related treatment, but rather sought approval to undergo a specific surgical procedure and that if the insurer was asserting that an alternative treatment was appropriate and that the requested surgery was not reasonably necessary, it was clearly disputing the claim under s 60 *WCA. S 279 WIMA* clearly requires the insurer to issue a written dispute notice under s 74 *WIMA* and to serve it upon the worker.

Case study 8

A worker's claim was managed by a scheme agent. In August 2017, the worker made a claim for weekly payments and sought approval for surgery.

The Insurer did not respond to the claim and the matter transitioned to another scheme agent in late 2017.

Following receipt of the transitioned claim, the new scheme agent failed to determine the claim and it was not until February 2018 that the new scheme agent issued a dispute notice with respect to the proposed surgery. However, it did not determine the weekly payments claim.

WIRO asked the scheme agent why it did not determine the weekly payments claim in the February 2018 dispute notice. They responded that the worker, "would not have an entitlement to weekly benefits from this date as there is no deemed ongoing partial or total incapacity."

WIRO considered that response as being illogical. If it formed the view that the worker has no entitlement to weekly compensation then that claim is disputed and a dispute notice, which complies with s 74 *WIMA*, should be issued to the worker.

WIRO considers this to be a significant operational issue within the scheme, as ss *74, 274 and 279 WIMA* are designed to compel insurers to provide injured workers with a timely and easy to understand response to their claims. An Insurer's failure to comply with its obligations causes distress to the worker, which can compound the effects of their injury by delaying medical treatment and inhibit subsequent rehabilitation and return to work initiatives.

Overpayment of weekly compensation

There are limited circumstances in which an insurer is entitled to recover overpayments of weekly compensation from an injured worker.

Section *235D WIMA* allows SIRA to order a refund of any amounts that are overpaid if it is satisfied that the person has received the overpayment either as a result of, or partly as a result of, a contravention of s *235A WIMA* (fraud on the workers compensation scheme) or s *235C WIMA* (false claims).

WIRO has encountered other circumstances in which workers receive overpayments of weekly compensation.

For example, where the insurer omits to deduct shift penalties and overtime allowances from its calculation of pre-injury average weekly earnings after the first 52 weeks in the life of a claim. As a result, the worker continues to receive weekly payments calculated at a higher rate.

This type of overpayment is not occasioned by any action by the worker and it is far more difficult for an insurer to recover it from the worker. The Courts have taken the view that orders for repayment by the worker are not warranted where the worker has received the overpayment innocently or without blame.

WIRO frequently received complaints from workers that insurers were attempting to recover overpayments that were made because of the insurer's error. Please see the following case study:

Case study 9

The worker received a letter from the insurer requesting re-payment of an overpayment totalling $900 and stating that the overpayment was made because it failed to apply s 37 WCA after 13 weeks.

WIRO issued a preliminary inquiry to the insurer. In response, the insurer agreed that the overpayment resulted from its error and it withdrew the request for recovery.

Case study 10, is an example of an overpayment that resulted from change in the amount of pre-injury average weekly earnings.

Case study 10

The worker noted a deduction of $50 in their pay slips for the last 4 pay periods and asked the employer and insurer for an explanation. However, neither responded.

WIRO issued an inquiry to the insurer. In response, the insurer stated that weekly payments had temporarily been topped up to 100% of PIAWE and that the employer was deducting the overpayment.

WIRO advised the worker that they were not obliged to repay the overpayment. The injured worker was anxious as they continued to work for the employer and "did not want to make things difficult with them". The worker decided to approach the employer, which did not obtain an authority to deduct the overpayment from his wages, and to consider further action based upon the employer's response.

The worker's response in case study 10 demonstrates why recoveries of overpayments that are not ordered by the WCC cause problems for the worker. While they were not to blame for the insurer's mistake, and were unlikely to be ordered to make the repayment, many workers prefer to endure financial hardship rather than jeopardise their relationship with the employer and insurer.

In many cases of this nature workers are not advised that they are entitled to obtain independent legal advice and that there may not be any statutory power for an insurer to recover the overpayments from them. There is a clear power imbalance that favours the insurer.

In our experience, the majority of complaints regarding overpayments have been received from public sector workers in which NSW Self Insurance Corporation (TMF) is the insurer. This is because most workers who receive weekly payments from TMF receive these via their employer's pay run.

Case study 11

An injured worker underwent surgery and as a result, she was certified as having no capacity for work for a period of 3 weeks. She submitted a Certificate of Capacity to the employer and insurer.

While the worker was off work, she was paid 100% of her salary and her pay slips described this as salary, rather than workers compensation. However, some weeks later, the employer discovered the worker had been paid 100% of her PIAWE, rather than 95% and it contacted the worker and asked her to repay the overpayment.

WIRO issued an inquiry to the Insurer, which advised that it had failed to advise the employer of the correct rate of weekly benefits that were to be paid to the worker. The insurer stated that it could not assist WIRO with this matter as it was the employer that was seeking recovery of the overpayment. It also argued that as the payslips described the payments as salary, this was an overpayment of wages and not weekly payments.

WIRO argued that if the insurer asserted that the injured worker had been overpaid wages, it was a tacit admission that it had underpaid weekly payments as it submitted that weekly payments had not been paid. It was apparent that the overpayment occurred because of the insurer's failure to communicate with the employer regarding the correct rate of payments. The Insurer then agreed to meet payment of the recovery sought by the employer.

Case study 11 is one of many instances in which that employer has made an error of that nature and it raises an issue concerning jurisdiction.

Most public-sector agencies have policies and procedures in place to recover overpayments of wages, including possible legal action if the worker does not agree to repay the overpayment. It is important to note that those policies do not apply to weekly payments of compensation as these are not in the nature of wages.

However, by mislabelling weekly payments of compensation as "salary/wages" or "sick leave", public-sector agencies may seek to enliven the recovery provisions under the relevant award, noting that it is easier to recover overpayments of wages or salary than weekly payments. It is arguable that there is a clear incentive to mislabel these payments as a type of insurance against accidental overpayments.

In WIRO's view, the insurer's response was unacceptable as the insurer cannot avoid responsibility for weekly payments made as a result of an error by the employer. As the insurer in respect of a claim in which the employer is paying compensation to the worker and seeking reimbursement from it, it is the insurer's responsibility to educate and instruct the employer to ensure that weekly payments are properly calculated and paid to the worker. The insurer should also be conducting routine audits to ensure that the employer is complying with its instructions.

Unfortunately, WIRO's experience has been that relationships between the TMF agents and the public-sector agencies lack sufficient oversight. Mistakes of this nature cause unnecessary distress to workers, undermines their confidence in the scheme and adversely impacts upon rehabilitation and return to work measures.

Employer not paying weekly payments at the correct rate

The above case studies in relation to overpayments are not the only examples of where employers made weekly payments at an incorrect rate. WIRO has received many complaints that incorrect payments have been made without the insurer's knowledge.

In some of these cases, employers retained all weekly payments made by the insurer and did not account to the worker. In other cases, the employer made its own calculations and paid weekly payments accordingly without reference to the rate determined by the insurer.

Case study 12 is an example of such a complaint that was raised against a scheme agent.

Case study 12

> *The worker received a letter from the insurer that advised him that his rate of weekly payments would reduce to $1,330 per week after the first 52-weeks, as shift penalties and overtime allowances would no longer be included in the calculation of PIAWE. However, this confused the worker because he had only received payments of $1,000 per week from the employer.*
>
> *WIRO issued an inquiry to the insurer. In response, the insurer said that it would provide the worker with a list of payments made to the employer to enable the worker to compare this with his payslips. It stated that if there was any discrepancy, the worker should contact the employer.*
>
> *However, WIRO queried the insurer's response, as it is the insurer's duty to investigate whether the employer was paying weekly compensation at the correct rate. We asked the insurer to submit a list of payments made by the employer and to review this against its own determination to determine whether there had been an underpayment. Following investigation, the insurer determined that the worker had been underpaid an amount of approximately $40,000.*

In case study 12, the employer had underpaid the worker for a period of approximately one year and had retained weekly payments it received from the insurer, and in doing so, it arguably defrauded the insurer. It was apparent that the insurer had not conducted an audit during that period and that even when WIRO issued its enquiry, the insurer did not seek to conduct an audit. The discrepancy and underpayment was only ascertained because of WIRO's intervention.

Case study 13 is a further example, although it was a case involving another scheme agent.

> ### *Case Study 13*
>
> *The worker was injured in February 2018 and complained he had been underpaid weekly benefits since the date of injury.*
>
> *The insurer determined that PIAWE was $1,602 per week, but the employer did not agree with that determination and determined that PIAWE was $1,122.97 per week.*
>
> *The insurer reviewed its PIAWE determination and determined that its original rate was correct. It instructed the employer to pay compensation as per its determination. However, the employer refused to do so.*
>
> *The insurer then contacted the employer and the employer then agreed that the insurer's determination was correct and that payments would be made at that rate. It also acknowledged that its previous payments were at an incorrect rate. However, five days later the worker met with the employer, during which he was verbally abused and threatened.*
>
> *The worker complained that he had not received any back-payment of weekly payments. WIRO requested that the insurer take over making weekly payments and the insurer agreed. It subsequently advised WIRO that the employer had agreed to make a back-payment to the worker from the date of injury by close of business the following day.*

As case study 13 clearly demonstrates, it is the insurer's obligation to ensure that weekly payments are correctly paid and its role does not cease when it pays monies to the employer.

While the majority of employers correctly pass on weekly compensation to injured workers, insurers should remain diligent in ensuring that the employer does so, as where employers fail to so act the result is often one of financial hardship for the worker.

Claims for domestic assistance

In WIRO's experience, domestic assistance is a type of compensation that is not commonly claimed (except in relation to a claim for work injury damages) and is an entitlement that is poorly understood. The entitlement arises under s 60AA (1) *WCA*, which provides, emphasis added:

> *(1) If, **as a result of an injury** received by a worker, it is reasonably necessary that any domestic assistance is provided for an injured worker, the worker's employer is liable to pay, in addition to any other compensation under this Act, the cost of that assistance if:*
>
> *(a) a medical practitioner has certified, on the basis of a functional assessment of the worker, that it is reasonably necessary that the assistance be provided and that the necessity for the assistance to be provided arises as a direct result of the injury, and*
>
> *(b) the assistance would not be provided for the worker but for the injury (because the worker provided the domestic assistance before the injury), and*
>
> *(c) the injury to the worker has resulted in a degree of permanent impairment of the worker of at least 15% or the assistance is to be provided on a temporary basis as provided by subsection (2), and*
>
> *(d) the assistance is provided in accordance with a care plan established by the insurer in accordance with the Workers Compensation Guidelines.*

The first requirement is that the worker needs domestic assistance because of the injury.

WIRO has received complaints from injured workers where the insurer had declined claims for domestic assistance on the basis that there were persons who could provide this assistance gratuitously. Case study 14 is an example.

Case study 14

The worker with highest needs requested approval of domestic assistance (personal grooming) from the insurer. The Insurer replied:

> *"You have stated that your father and two daughters have provided you with assistance in self-care and grooming. Specifically, you stated that your father attends your home and uses nail clippers to cut your toenails when required. Your daughters provide assistance in hair washing."*

The worker sought approval for paid domestic assistance because it was no longer feasible for her family members to provide this. The self-insurer's response did not address the test set out in s 60AA (1) *WCA*, as there was no dispute that the worker required the domestic assistance because of the injury.

In another case, the worker claimed the cost of engaging removalists, as he was due to move to a different house when he was to undergo ankle fusion surgery. The insurer declined the claim on the basis that the worker's decision to move to a different house was not undertaken to assist in his recovery or to enable him to undertake alternative employment. However, this response also did not address the test in s 60AA *WCA*.

Calculation of PIAWE

The 2012 amendments introduced the concept of PIAWE as the basis for calculation of the entitlement to weekly payments. This is defined in ss 44C to 44I *WCA* (inclusive) and s 44C refers to Sch 3 *WCA* for a further expanded definition.

It is not controversial to say that the calculation of PIAWE is a far more complex task than calculation of the current weekly wage rate (which applies to claims by exempt workers).

Insurers are required to determine a worker's PIAWE within 7 days of being notified of an injury. To assist its scheme agents, iCare issued a "PIAWE Handbook", which comprises 88 pages. While this is meant to make the calculation of PIAWE easier, its length and cross-referencing only highlights the complexities involved. Self-insurers and specialised insurers do not have access to the Handbook, as it is an iCare resource available to scheme agents only.

Solutions Group continues to receive a large number of complaints from workers regarding the insurer's calculation of PIAWE. The complaints reflect many factors, including:

1. The complex definitions mean that insurers are required to take multiple steps to determine PIAWE. As a result, there is an increased opportunity for mistakes to occur.

2. The short timeframe for obtaining wage records from employers and determining PIAWE, namely 7 days, compromises the quality of the determination. This is particularly so where the insurer has difficulty obtaining appropriate wage records from the employer.

3. The records that the insurer requests from the employer are not always readily available. For example, s 44D (1) (a) *WCA* defines the "relevant period" for calculation of PIAWE as follows (emphasis added):

   44D Definitions applying to pre-injury average weekly earnings—relevant period

   (1) Subject to this section, a reference to the relevant period in relation to pre-injury average weekly earnings of a worker is a reference to:

   (a) in the case of a worker who has been continuously employed by the same employer for the period of ***<u>52 weeks immediately before the injury</u>****, that period of 52 weeks.*

   The definition requires the employer to provide payslips for the 52 most-recent pay periods. However, unless the worker is injured on the same day as the pay period ends, the insurer cannot merely rely upon the payslips. If a worker is injured part-way through a pay period, the calculation of PIAWE may require the production of payslips for the 53 most-recent pay periods and the insurer would need to adjust income from the 1st week to exclude income received before the period of 52 weeks immediately before the injury. All of this information may not be available from the employer within the 7-day statutory timeframe for determining PIAWE.

4. Section 43 (1) (d) *WCA* defines a decision concerning the amount of PIAWE as a work capacity decision by the insurer.

Section 44BF *WCA* contains a general prohibition against workers obtaining paid legal advice in relation to disputes concerning work capacity decisions.

As a result, WIRO is one of the few available avenues from whom injured workers may seek advice about disputing a work capacity decision.

While the impact of s 44BF has been partially alleviated by the Regulation that permits a worker to obtain paid legal advice in relation to a merits review of a work capacity decision, workers are still required to navigate the mandatory internal review process without the benefit of paid legal assistance.

Solutions Group's staff are highly trained in relation to the calculation of PIAWE. This means that WIRO can adopt a positive role in resolving disputes about PIAWE. Case study 15 is an example of such a case involving a scheme agent:

Case study 15

The worker was injured before the commencement of the 2012 amendments.

Until April 2014, the worker received weekly payments of approximately $1,700 per week. The insurer then informed him that his weekly payments would calculated against the transitional rate, which applied to workers who were in receipt of weekly payments immediately before 1 October 2012. However, the worker provided WIRO with a list of payments proving that he was not in receipt of weekly payments between 20 August 2012 and 3 October 2012.

WIRO issued an inquiry to the Insurer and the insurer responded that the worker's weekly payments had been suspended during that period because he failed to submit Certificates of Capacity and job logs. It agreed that the worker was not an existing recipient of weekly payments and that the worker was entitled to back-payments from April 2014 of approximately $115,000.

Case study 15 is an example of where WIRO achieved a significant outcome for the worker without legal costs being incurred. It also demonstrates the benefit resulting from expertise within the Solutions Group, as if the worker was required to navigate the administrative review process without assistance, it could have taken several months to resolve and very few workers have the expertise to traverse the relevant legislative provisions and apply them to their circumstances.

Case studies 16 and 17 are example of the complex issues involved in the determination of the amount of PIAWE.

Case study 16

The worker complained to WIRO that the insurer had incorrectly calculated the amount of PIAWE. Prior to the injury she worked for two employers and earned approximately $1,900 per week, but the insurer calculated the amount of PIAWE to be around $1,200 per week and she did not understand the basis for this.

WIRO issued an inquiry to the Insurer and requested that it produce its calculations and relevant payslips, which the insurer produced. This indicated that in calculating the amount of PIAWE, the insurer had added the worker's gross earnings from both employers over a period of 52 weeks and then divided the total by 52. However, the worker had only been employed by the second employer for about 5 weeks and the earnings from that work should not have been divided by 52.

WIRO referred the insurer to iCare's PIAWE handbook, which indicates that several relevant periods may need to be considered depending upon the worker's length of service. The insurer then recalculated PIAWE and determined that it exceeded $1,800 per week.

Because of WIRO's intervention, the worker received an increase in the rate of weekly payments and the result was achieved expeditiously and without legal costs being incurred.

Case study 17

The worker was employed as a sales representative, a job that required a lot of driving and most of the worker's salary comprised commission. However, the worker complained to WIRO that the insurer did not include commission and the car allowance in its calculation of the amount of PIAWE.

WIRO issued an inquiry to the insurer supported by payslips that were received from the worker. The insurer agreed to increase the PIAWE from $1,300 per week to $2,100 per week and to make back-payments to the worker for a period of 7 weeks.

Under the current legislation, a decision by the insurer regarding the amount of PIAWE is a work capacity decision and the decision is subject to the administrative review process, requiring internal review by the insurer, followed by a merits review by SIRA and a procedural review by WIRO.

WIRO publishes all procedural review decisions as well as some Merit Review Service decisions.

WIRO has amassed a library of published decisions, which in addition to training provided to the Solutions Group, provides the Solutions Group with the expertise to properly query insurers' decisions.

Suspension of weekly payments under s 48A WIMA

Section 57 *WIMA* gave the insurer power to suspend payments of weekly compensation to a worker if the worker unreasonably failed to comply with their workplace injury management obligations under Chapter 3 of that Act. However, s 57 was repealed in 2012.

Case study 18

Towards the end of 2017, WIRO received a complaint from a worker that the insurer had suspended his weekly payments and purported to rely upon s 57 WIMA in doing so.

By the time that WIRO received this complaint, the management of the claim had transitioned to another scheme agent.

In response to WIRO's inquiry, the scheme agent immediately revoked the suspension

Section 48A *WIMA* was proclaimed in 2012 and it empowers the insurer to suspend, terminate or cease payments of weekly compensation to a worker if a worker fails to comply with the obligations to return to work that are imposed under s 48 *WIMA*. It also prescribes a procedure that the insurer must follow, which includes the issue of a warning letters notifying the worker of their breach and providing them with an opportunity to comply.

The terms of s 48A *WIMA* are significantly narrower than those of s 57 *WIMA* and the procedure to be followed by the insurer is more onerous. However, during the preceding period WIRO received numerous complaints from workers where insurers sought to rely upon s 48A. The following case studies are examples.

Case study 19

WIRO received a complaint from the worker's solicitor that the insurer had suspended weekly payments to the worker after he failed to attend a medical examination.

WIRO issued an inquiry to the insurer and requested copies of documents relating to the suspension. The insurer provided these documents, which included a warning letter dated on 20 October 2017, which requested the worker to contact his treating doctor within 14 days. However, the worker was overseas at the time and he did not receive the insurer's letter. His weekly payments were suspended on 9 November 2017.

WIRO expressed the view that the insurer could not validly suspend weekly payments to the worker under s 48A WIMA in these circumstances as there was no breach of the return to work obligations. It asked the insurer to revoke the suspension.

The insurer revoked the suspension and made back-payments to the worker.

Case study 20

The worker complained that the insurer terminated weekly payments on the basis that he had ceased employment the day after he made a claim for a recurrence of injury, citing ss 48, 48A, and 49 WIMA. The worker said that his employer told him that if he did not resign, his employment would be terminated and he chose to resign. He provided WIRO with a copy of an email from his employer setting out that threat.

WIRO issued an inquiry to the insurer and provided it with a copy of the employer's email to the worker. We sought a chronology and documents evidencing the insurer's compliance with s 48A, but the insurer was unable to provide these.

WIRO expressed the view that the worker had been constructively dismissed and that he was deprived of the opportunity to return to work in suitable employment with the employer. Therefore, he could not have breached his obligations to return to work and that the suspension under s 48A WIMA was invalid.

In response, the insurer revoked the suspension and paid weekly compensation.

In WIRO's view, iCare and SIRA should consider further education for the insurers regarding s 48A *WIMA*, to avoid scenarios of the type described in these case studies arising in the future.

Delays in determining claims for hearing loss

In the final quarter of the current reporting year Solutions Group received a growing number of complaints against Employers Mutual Limited (EML), in its capacity as the scheme agent for the nominal insurer for all claims made on or after 1 January 2018, regarding the insurer's failure to determine claims for hearing loss within statutory timeframes.

WIRO brought this trend to the attention of both EML and iCare and we were advised that EML were experiencing difficulties in recruiting sufficient staff to enable it to manage the number of new claims.

Misleading information on SIRA's website regarding hearing loss claims

In February 2018, WIRO received a complaint from Allianz regarding an injured worker who had made a claim for hearing aids based upon a medical report from a specialist who was not a SIRA-approved assessor of permanent impairment. Allianz expressed the view that this was required by the *SIRA Guidelines for Hearing Impairment Claims* and it cited the following extract from SIRA's website:

> *If you are concerned about your hearing, you should consult your general practitioner to obtain referral to an ear, nose and throat (ENT) specialist.*
>
> *The ENT specialise must be selected from the SIRA list of approved assessors of permanent impairment for hearing.*

However, the requirement for an ENT specialist to be a SIRA trained assessor of permanent impairment applies only to claims for lump sum compensation for permanent hearing loss.

Where a worker makes a claim for hearing aids only, the worker is only required to comply with s *60 WCA* and the *SIRA Guidelines for Claiming Workers Compensation.* This issue was determined by the Workers Compensation Commission in *Delaqueze v Drum Reconditioners Pty Limited* [2014] NSWWCC 364.

In February 2018, WIRO wrote to SIRA's Director of Claimant Outcomes advising of the misleading information on its website. However, no response has been received and the misleading information remains on SIRA's website as at the date of writing this report.

Conclusions and recommendations

The Solutions Group's expertise and WIRO's rapport with insurers continues to facilitate the achievement of excellent outcomes for injured workers. Based upon information that WIRO has gathered during the investigation of complaints, we have identified the following issues within the scheme where improvement is required. We make the following recommendations:

1. SIRA should adopt a more active role in its management of insurers and issue enforcement notices under ss 267 and 268 *WIMA*, where required, with a view to ensuring behavioural change and compliance with their statutory obligations.

   WIRO notes that SIRA does not hesitate to publicise penalties issued and charges made against claimants in relation to CTP claims. This approach is odds with SIRA's approach to management of insurers within the workers compensation scheme.

   WIRO made a similar recommendation in last year's Annual Report. However, the continuing significant level of complaints regarding the insurers' failure to properly respond to claims within statutory timeframes and absence of evidence of enforcement action against the insurers causes us to repeat it.

2. SIRA should provide insurers with more education regarding the operation of the Guidelines, particularly with respect to the issue of 'reasonable excuse' notices to workers. The case studies set out in this report clearly evidence the insurers' lack of understanding of the Guidelines, which causes unnecessary hardship for workers and undermines the relationship of trust that is essential to achieving optimal outcomes.

3. In every case in which an insurer seeks to recover an overpayment of weekly compensation from the worker, the insurer must be required to advise the worker that they do not have to consent to a recovery plan and that they are entitled to obtain independent legal advice or contact WIRO before giving consent.
4. Greater communication should be encouraged between TMF Agents and public-sector employer with a view to ensuring that weekly payments are correctly paid to workers.
5. Insurers should be required to undertake an increased number of audits to ensure that weekly payments are being properly paid by employers to workers, particularly at times when the rate of weekly payments is likely to change by operation of the law (i.e. at weeks 13, 52 and 130).
6. SIRA should facilitate education for insurers regarding s *48A WIMA* and particularly, when it is appropriate to rely upon that provision and the procedures that must be complied with when it is used. SIRA may wish to develop either a specific Guideline or Operational Instruction in relation to this issue.
7. SIRA should facilitate education for insurers to ensure their compliance with obligations to determine claims within statutory timeframes and issue proper dispute notices whenever a claim is not accepted.
8. iCare should take such action as is appropriate to ensure that the transition of claim files between its scheme agents does not result in a deterioration in the level of service provided to stakeholders. This includes ensuring that scheme agents have sufficient staff available to manage the claims before they are transitioned and that data relating to those claims is readily transferrable between scheme agents.
9. The manner of calculation of PIAWE requires legislative reform. WIRO understands that this is currently under consideration.
10. SIRA should publish decisions made by its Merit Review Service, to facilitate greater transparency within the scheme and to provide stakeholders with a knowledge base that will assist them to make properly considered work capacity decisions.

EMPLOYER / INSURER RELATIONS

Section 27(d) *WIMA* 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*

The introduction of the new scheme model on 1 January 2018, has led to an increase in complaints to WIRO from NSW Employers.

Since 1 January 2018, all premium underwriting has been undertaken by iCare, and EML is the Scheme Agent for all new policies. Serious concerns were raised by NSW Employers while the new model was being fine-tuned.

The following serious issues of concern have been raised by NSW Employers.

NSW Employers have generally reported significant delays as a result of new premiums being underwritten by iCare. Delays have been noted in relation to:

a. Premium calculations;

b. Issue of correspondence after attempts were made to contact the Nominal Insurer regarding policy renewals or cancellations’

c. Receipt of premium relief outcomes for Experience Rated Employers, whose policy has been impacted for the next 3 years because EML accepted liability for claims made this year.

NSW Employers have complained that during the early life of a claim it is essential that they have prompt and reliable access to the Scheme Agent’s Claims Managers, particularly when they request that a claim be placed under reasonable excuse within 7 days of notification of an injury under s 261 *WIMA*.

NSW Employers have also raised concerns regarding decisions made by EML to approve medical and related treatment for injured workers during the provisional liability period. WIRO notes that on many occasions, Employers have found it necessary to schedule medical treatment for injured workers to assist them to return to work in a timely manner, as EML has not decided whether that treatment is reasonably necessary for the purposes of s 60 *WCA*.

A significant number of NSW Employers have complained to WIRO about difficulties in communicating with EML by telephone. They have expressed dissatisfaction about inadequate staffing of EML’s contact line; an unacceptable time that they are required to spent ‘on hold’; and difficulties arising from improperly trained and/or overworked staff members answering their phone calls.

NSW Employers have complained that during the current reporting year, EML has developed a general reluctance to reasonably excuse claims unless it is specifically requested to do so by the policy holder. Further, EML does not seem to be complying with the 7-day timeframe for determining provisional liability and, as a result, a default decision is made to commence provisional payments without adequate investigations being conducted.

In the current reporting year, WIRO notes with concern that many of these complaints have been raised by large employers who operate within the NSW Scheme and in other States and that they have reported a universally unfavourable comparison between the level of claims management in NSW as compared with other States. One employer (located in the Hunter Region) reported a significant drop in service levels by EML since the introduction of the 2018 Model.

Several Employers have complained that they have not been assigned a dedicated Account Manager for their policies after 1 January 2018. This is contrary to both their previous experience both with EML and other pre-2018 Scheme Agents the practice in other State workers compensation jurisdictions. They have complained that a different person appears to answer their calls each time an enquiry is made about individual claims and that the staff member who takes the call is then scrambling to get up to speed and clearly therefore lacks the level of knowledge that is required to enable them to provide assistance.

Although Employers have generally conceded that online claims lodgement has simplified and streamlined the initial notification of claims, Employers contend that the level of customer service then drops significantly as EML appears to be overwhelmed by its workload.

Many NSW Employers have reported a trend during 2018 by which psychological claims have been accepted without due diligence being undertaken, which may be due to its overwhelming workload.

One insurance broker contacted WIRO and made 4 separate complaints relating to psychological injury claims where EML had accepted liability contrary to the express wishes of the employers that the claims be further investigated before acceptance. The broker subsequently lodged Premium Relief Requests to iCare through WIRO, due to the substantial adverse financial impact of those claims upon their employer clients.

Employers have also expressed a significant degree of frustration regarding EML's reluctance to organise Independent Medical Examinations in 2018. WIRO notes that based upon its own criteria, the newly-appointed iCare Medical Support Panel appears reluctant to authorise independent medical examinations - even when they are specifically requested by the policy holder to assist EML in determining liability.

WIRO notes that in response to several recent inquiries, EML has responded to the effect that it feels "hamstrung" by this process. As a result, EML often lacks the medical evidence required to enable a proper determination of liability.

WIRO continues to enjoy a productive and professional working relationship with representatives of iCare, SIRA, EML, the TMF Agents and the numerous Self and Specialised Insurers. Their response times to many complex enquiries raised by WIRO during the current reporting year has been exceptional and the Enquiry and Claims Handling Protocol that has been in place since WIRO's inception remains unmatched within the NSW Scheme.

While WIRO is not always able to facilitate a positive outcome for Employers, the information obtained by the insurers under the Protocol is invaluable and enables WIRO to assist NSW Employers with the management of complex claims.

WIRO remains committed to assisting all stakeholders as the current Model evolves and matures.

In WIRO's view, further education is required to ensure that all small business owners in NSW are made aware of their obligation to hold a current workers compensation insurance policy where they employ any workers within NSW as the financial repercussions of operating uninsured can be devastating.

An uninsured employer may be liable to reimburse the Nominal Insurer for an amount not exceeding the compensation paid to an injured worker under s 145 *WCA* and they may also be liable to a fine by SIRA for their failure to hold a current insurance policy at the date of the injury.

INDEPENDENT LEGAL ASSISTANCE AND REVIEW SERVICE (ILARS)

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

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

As at 30 June 2018 there were 1,063 lawyers who are WIRO-approved legal service providers ("ALSPs") actively involved in workers compensation. There were also 143 barristers approved by WIRO to undertake advocacy for injured workers.

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

That application, which is lodged by email, is then considered by one of the 19 ILARS Principal Lawyers, who are all highly experienced in workers compensation practice and procedure. The ILARS Principal Lawyer then considers whether, based on the information provided, funding is approved to conduct preliminary enquiries and evidence gathering to support the claim or the giving of advice.

ILARS undertakes to assess applications and advise lawyers of the outcome within five working days. Often the response time is much quicker. Urgent applications for funding are determined within 24 hours. Applications for funding of a specific type will be prescribed a specific timeframe for response.

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

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

Where it appears that the funded matter is capable of early or simple resolution it may be referred to WIRO's Solutions Group. WIRO is focused on resolving disputes quickly, fairly and cheaply and we encourage the ALSP's to adopt the same practical approach.

To this end, ILARS also adopts flexible practices including the introduction of fast track applications, if required, for example, as the result of changes to legislation or judicial decisions.

For the year ended 30 June 2018, ILARS received 13,154 applications for grants of funding for legal assistance. 12,691 applications (96 %) were approved or were pending.

ILARS paid out over $34.1m in professional fees and approximately $20.5m in disbursements in the year ended 30 June 2018. A full breakdown of the types of payments made and other statistical information with respect to grants appears in **Appendix 2**.

The information obtained during the funding of these claims has enabled WIRO to develop a unique and comprehensive program available for the benefit of ALSPs and their clients. The data collected is utilised to assist lawyers to better understand their practice and their efficiency compared with other lawyers in their area or across the whole scheme. ALSPs can identify opportunities to improve their performance, which results in the more efficient resolution of disputes.

The data also allows for useful analysis with respect to medical practitioners and insurers. The major single issue for ILARS during the 2018 reporting year has been managing the impact of the operation of s 39 *WCA*, as the maximum 260-week entitlement period for weekly compensation for workers who were injured before 1 January 2013, and who had not suffered permanent impairment of more than 20% WPI, expired. Many of those injured workers were impacted in December 2017, but while s 39 *WCA* remains in force it will continue to result in the termination of weekly compensation (and, consequently in time, medical benefits) entitlements. The lessons learned and the experience gained by WIRO will therefore be of continuing benefit.

WIRO established early, regular and effective communication with iCare to ensure that the operation of s 39 *WCA* was managed in a practical and sensible way. Effort and care were taken to ensure that all affected workers were provided with information and support and an opportunity to obtain paid legal advice and assistance regarding their rights, entitlements and obligations under the legislation and to pursue any necessary applications in the Workers Compensation Commission.

With iCare's cooperation, the transition for many workers was made as smooth as possible in the circumstances and, in many instances, successful challenges were made to the insurer's initial stance regarding the application of s 39 *WCA*. Many injured workers whose degree of permanent impairment was initially assessed as being 20% WPI or less have remained in receipt of weekly compensation after obtaining an assessment from an Approved Medical Specialist through the Workers Compensation Commission that satisfied the threshold. In many other cases, a sensible approach was adopted by insurers that avoided the need for such an assessment.

In addition, many practical ancillary matters, including issues of whether statutory interpretation such as whether back-pay was payable to an injured worker and from when, have been identified as an issue requiring clarification by a Presidential Member of the Workers Compensation Commission. WIRO notes that Arbitrators have, to date, expressed differing views as to whether the Commission has jurisdiction to order an insurer to back-pay weekly compensation where payments ceased by operation of s 39 *WCA*.

PROCEDURAL REVIEWS OF WORK CAPACITY DECISIONS

One of the functions of the WIRO conferred by s 27 *WIMA* is:

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

Relevantly, Part 3 *WCA* contains s 44BB, which sets out the process by which work capacity decisions can be reviewed. WIRO may conduct a procedural review only after completion of an internal review by the insurer and merit review by the Authority.

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

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

The Year in Numbers

In the current reporting year, WIRO conducted 38 procedural reviews of work capacity decisions. As at 30 June 2018, no applications were outstanding or in-progress. More detailed statistics are found in Appendix 4.

Trends

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

Total Recommendations	Worker Successful	Worker Unsuccessful
38 (100%)	8 (21%)	30 (79%)

In the previous year 2016-2017 workers had a success rate of 18%.

Of the 38 workers seeking procedural review, 11 used the services of a legal practitioner and 5 of those workers successfully challenged the insurer's decision. Despite the small sample size, it appears that workers are more likely to succeed with the assistance of a lawyer.

Judicial Review by the Supreme Court of New South Wales

The Supreme Court has inherent jurisdiction to oversee the administration of justice, including the scrutiny of decisions made by insurers and public servants that impact on the rights of injured workers. In the current year there was a significant case brought by a worker challenging a work capacity decision (and consequential s 44BB reviews).

In *Bhusal v Catholic Health Care Ltd* [2018] NSWCA 56 the Court of Appeal considered a matter where the worker applied for merit review by the Authority within 30 days of receiving the internal review decision, but erroneously entered a date on the application form that suggested that the application was out of time. Instead of writing "2/6/2016," the worker wrote "2/5/2016" on her application dated 9 June 2016. SIRA made no further enquiries and declined to conduct a merit review on the basis that the application was, on its face, out of time, and it had no jurisdiction to extend the period for lodgement.

WIRO declined to conduct a procedural review as a pre-condition of the procedural review is completion of a merit review.

The worker applied to the Supreme Court of New South Wales for Judicial Review of SIRA's decision. Button J, held that SIRA correctly rejected the application and that the word "must" in s 44BB (3) (a) *WCA* was "mandatory in the true sense". As a result, SIRA had no discretion to determine applications made outside the 30-day timeframe and he dismissed the summons.

The worker appealed to the Court of Appeal, alleging that a denial of procedural fairness by SIRA as it failed to call for submissions on the issue of non-compliance with the 30-day period. The worker also argued that the construction and operation of s 44BB (3) (a) *WCA* permitted an application to be filed after the 30-day period had expired and that compliance with that period was a "jurisdictional fact" and the primary judge erred by failing to determine compliance.

The appeal succeeded on the following grounds:

(1) Procedural fairness is concerned with a fair hearing, not a fair outcome. In determining whether a person has been denied procedural fairness the key issue is whether the procedures adopted by the decision-maker have caused "practical injustice" to that person.

    SZBEL v Minister for Immigration and Multicultural and Indigenous Affairs (2006) 228 CLR 152; [2006] HCA 63, cited; *Minister for Immigration and Border Protection v WZARH* (2015) 256 CLR 326; [2015] HCA 40, cited; *Kioa v West* (1985) 159 CLR 550; [1985] HCA 81, followed.

(2) The procedure adopted by SIRA caused the applicant to suffer practical injustice. This is not because SIRA's decision on the jurisdictional question was wrong but because the applicant was denied the opportunity to make submissions to SIRA on the issue that proved critical to the outcome of her merit review application.

(3) This conclusion does not imply that SIRA, when conducting a merit review, is obliged to check the accuracy of information provided by an applicant that appears adverse to his or her case. There was a denial of procedural fairness here because neither SIRA nor the insurer directed the applicant's attention to the critical issue on which SIRA's decision turned. The applicant was thus denied the opportunity to be heard on that issue.

(4) It was unnecessary to determine the remaining grounds of appeal.

The Court of Appeal did not feel it necessary to decide questions of law that were referred to it, particularly since, if answered in a particular way the worker's case may possibly have failed due to futility. In other words, if Button, J was correct to hold that a date on a form is not a "jurisdictional fact" that is capable of examination by the Court and that SIRA has no discretion to allow an application to proceed out of time, then it is hard to see the benefit of calling for "submissions" on a question that allows of no discretion.

Recommendation for reform

WIRO notes that a very high percentage of 'work capacity disputes' arise from the calculation of PIAWE. S 43 (1) (d) *WCA* provides that calculation of PIAWE is a work capacity decision.

There is currently a proposal to simplify the calculation of PIAWE.

It is possible to separate the calculation of PIAWE from the work capacity decision-making process, as has happened in other jurisdictions. The rationale for this is that PIAWE is a figure arrived at by considering the worker's pre-injury earnings and it is clearly severable from considerations that arise after an injury, such as return to work prospects and suitable employment. PIAWE can also be determined without evidence of a worker's medical condition.

It is recommended that s 43 (1) (d) *WCA* be amended to delete any reference to "an injured worker's pre-injury average weekly earnings." If this is done a significant number of PIAWE disputes could be resolved by way of a simple internal review and/or expedited determination by the WCC.

OTHER INITIATIVES

Education

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

There has been huge support for the Sydney conference, with the last event in March 2018 attracting over 900 delegate registrations and professionals, which was a growth of 30% on 2017 registrations. Professionals from nine different industries attended, with lawyers making up over 54% of attendees.

WIRO was delighted that the Minister for Finance, Services and Property, the Honourable Victor Dominello MP, was able to provide a video, which was projected as an opening address at the conference.

The theme of the conference, which received very favourable feedback, was the future of workers compensation in NSW. Topics included: the difficult issues arising from the operation of section 39 of the 1987 Act; future options for dispute resolution; claims management – 2018 and the future; the cross-over between workers compensation claims and CTP claims; rehabilitation and return to work initiatives; a review of the ILARS Scheme after 5 years of operation; and the continuing problems arising under the bifurcated dispute resolution system.

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

In addition to the Sydney seminars, WIRO also conducted regional seminars for ILARS lawyers in Ballina (36 delegate registrations), Wollongong (55 delegate registrations), Newcastle (117 delegate registrations) and Bathurst (22 delegate registrations). A seminar will also be held for ILARS lawyers in Wagga Wagga in August 2018.

WIRO has continued to conduct half day seminars for paralegals, in Sydney on 7 December 2017 (48 delegate registrations), Newcastle on 14 February 2018 (24 delegate registrations), Wollongong on 19 February 2018 (17 registrants) and Ballina on 3 May 2018 (6 registrants).

WIRO's educational program is aimed at improving the standard of knowledge, competency and efficiency amongst the stakeholders in the workers compensation scheme, with obvious benefits for injured workers. It also aims to provide forums in which emerging issues and difficulties within the scheme and the dispute resolution model can be identified, discussed and hopefully resolved.

Legal practitioners who attend WIRO's seminars are entitled to claim MCLE points and insurer delegates can also earn points from the National Insurance Brokers Association.

WIRO's ongoing commitment to education is evidenced by the creation of a specialist position of Manager of Legal Education within the Office of the General Counsel.

The Manager of Legal Education is responsible for the WIRO Bulletin, which is published monthly and provides an analysis of recent decisions from all relevant Courts and Tribunals and information regarding amendments to legislation, regulations, Fees Orders and emerging trends. All issues of the Bulletin are available for viewing and download from WIRO's website.

In addition, WIRO also delivers immediate updates to subscribers about emerging issues and developments via its email WIRE publication – the WIRO Wire. This is a valuable educational resource for all stakeholders within the scheme. All WIRO Wires are available for viewing and download from WIRO's Website.

WIRO also publishes a Solutions Brief, which is directed at lawyers and insurers, which includes snapshots of the types of problems that are raised with and resolved by the Solutions Team. It also contains statistical information regarding complaints and enquiries that have been received and resolved and an analysis of trends that have been identified from those statistics, which is particularly relevant for insurers. All Solutions Briefs are available for viewing and download from WIRO's website.

Based upon an analysis of data collected under the ILARS scheme WIRO can provide a report to stakeholders regarding their performance within the workers compensation scheme. This service is available upon request and it has been utilised by stakeholders including Law Firms, Insurers and Self and Specialised insurers and it has proven to be an effective tool for identifying, addressing and overcoming particular issues that inhibit performance and assist in achieving better outcomes.

In addition, WIRO also publishes all work capacity procedural reviews and annual reports, which are available for viewing and download from the WIRO website.

WIRO Website

The re-design and update of WIRO's website is continuing with the aim of delivering an accurate and user-friendly resource for the distribution of information to all stakeholders.

WIRO uses the Swift Digital Suite of products to publish its information, including the WIRO Wires, WIRO Bulletin and the Solutions Brief, and to manage events and conduct surveys.

It is intended that the website will ultimately include a performance dashboard, which will enable the public live reporting of available data and outcomes. Technology is also being introduced that will enable accurate tracking of the popularity of particular pages that are featured on the website and facilitate the improved delivery of information to all users – i.e. the conversion of documents that are currently posted in PDF and word format in order to improve appearance and functionality.

Technology and Process Improvement

During the year WIRO was involved in many technology projects.

Firstly, WIRO was part of Wave 5 of the DFSI SAP implementation and worked closely with the SAP Connect team to ensure WIRO's requirements were incorporated in the project.

The implementation of SAP supported by GovConnect would have a major impact on WIRO's operations particularly in relation to the payments of grants to ALSP's. Under the current system WIRO manages the approval of a grant and subsequent invoices in our Resolve case management system.

Approved invoices including a pdf copy are forwarded to BRD Accounts Payable in Gosford for manual input into Oracle financials. Law firm financial information including bank account details are managed by the Accounts Payable team. This team input over 10,500 non-PO invoices into Oracle during the year.

DFSI's implementation of SAP was focused on Purchase Orders (POs) as the prime method for paying invoices. Non-PO payments took more time and the GovConnect charging model penalised business units for using this payment process.

As ILARS grants did not fit into the PO process, WIRO worked extensively with the SAPConnect project team to find a more efficient and cost-effective method to process ILARS invoices. The SAP Connect team designed a simple batch file approach where approved payments from Resolve would be passed directly to SAP at the end of each day.

This would work as Resolve managed the grant (purchase order), goods receipting (the ILARS lawyer checking the invoice was in terms of the grant) and the invoice and vendor validation. The implementation of the batch file rather than a manual non-PO payment is estimated to save WIRO over $500,000 per annum.

In addition to the passing of a payments file to SAP, WIRO needed to make changes to Resolve to manage Law Firm financial information. WIRO took this opportunity to make other process improvement changes to Resolve to improve ILARS's productivity in managing over 16,000 open grants.

The next year will see the implementation of the above changes and further process and technological change with Resolve to ensure that WIRO's paperless office stays at the cutting edge of complaints handling and case management.

Data

WIRO collects extensive data on all Complaints, Enquiries, ILARS grants, Employer Complaints and Work Capacity Procedural reviews it receives. The data captured includes complainant details, type and body location of injury, the lawyer (for ILARS matters) representing the injured worker, the name of the insurer, the issues of the dispute, the outcome of the matter and for ILARS the amounts paid to the lawyers.

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

WIRO uses the data for 3 main purposes.

1. Firstly, WIRO publishes quarterly reports on its website and presents data analysis (which is also published) at our seminars. Most of the data published by WIRO is not available from any other participants. The published data helps improve transparency within the workers compensation dispute process.
2. Secondly, WIRO uses the data to look at trends and patterns in behaviour for similar cases. This helps WIRO identify issues in the workers compensation scheme that may need to be improved. During the year WIRO commenced work with an Artificial Intelligence company using IBM Watson technology to analyse ILARS data with a view to identifying sub-optimal practice behaviour in managing ILARS matters. This analysis is being conducted from an applicant law firm, respondent law firm and insurer perspective.
3. Thirdly, WIRO produces data analysis for law firms to help them understand how their application quality, issues, outcomes and invoices compare to the industry average. This helps law firms better understand their practice and improve their productivity. Similar reports are produced for insurers.

Direct payment of medical disbursements

WIRO's arrangements with many Medical Report Providers (MRP's) to pay directly for medical reports and clinical notes continued to expand during the year. ALSP's who wish to avail themselves of these arrangements may contact the MRP of their choice directly. The invoice for the requested service or documents is then included in a monthly bulk invoice to WIRO for payment. WIRO then matches the fees and charges to each ILARS case which has become a major administrative task.

During the coming financial year these reports will be entered directly into Resolve and will require validation only.

Inquiries

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

In the 2015 reporting year, WIRO reported that funding was not available to enable it to complete the Parkes and Hearing Loss Inquiries. WIRO did not undertake any formal inquiries in the 2017 and 2018 reporting years in circumstances where there was no assurance that funding would be available to pursue inquiries in accordance with its legislative mandate.

It is noted that the SCLJ in its March 2017 report recommended (Recommendation 4) that the NSW Government consider the need for the Workers Compensation Independent Review Office to complete the Parkes Review. However, that recommendation has not been implemented.

OTHER INFORMATION PURSUANT TO S 27C (4) (e) WIMA

Section 27C(4)(e) provides that the Independent Review Officer can include in the Annual Report such other information as the Independent Review Officer considers appropriate to be included**.** The matters discussed are issues relevant as at 30 June 2018 although it is appreciated that some of them may be addressed as part of the proposed redesign of the dispute resolution system.

Pursuant to s 27C(4)(e) *WIMA* the following issues are raised:

Independence of WIRO

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

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

One-Stop Shop

Another recommendation of the SCLJ had been the establishment of what some are pleased to describe as a "one-stop shop" for the resolution of disputes between workers and employers/insurers. To this end DFSI established a working party and conducted research of a very preliminary nature in order to reach a position to be able to make a submission. The process was incomplete as at 30 June 2018, although it appeared likely that the work capacity decision review pathway in section 44BB would be repealed and that all disputes would ultimately be referred to the Commission. That would result in the abolition of both merit reviews and procedural reviews.

One 'Notice'

As an adjunct to the "one-stop shop," DFSI and SIRA also proposed that there should be "one notice" for the notification of disputes between workers and employers/insurers.

It is difficult to identify the utility of this proposal as an insurer terminating weekly payments or declining liability for medical expenses will be in a different position to a worker, who will be reacting to an adverse work capacity decision.

One example might be that a worker is advised by a notice from an insurer that his/her weekly benefits will increase by (say) $50 per week. The worker might respond with their own notice disputing the amount of the proposed increase and allege that a greater increase is appropriate. It is unlikely that the first “notice” (sent by the insurer to the worker) will be in the same form as the “notice” sent by the worker to the insurer.

This scenario will become more complicated in the Commission, where it will be necessary to triage at least some (if not all work capacity disputes) into a separate resolution stream. There may also be room for the view that having a different notice and WCC Form for those disputes would be advantageous. This issue remained unresolved as at 30 June 2018.

Section 39 *WCA*

Approximately 3,000 injured workers (injured prior to 1 January 2013) were potentially impacted by the expiration of their 260-week entitlement to weekly benefits ceasing on 26 December 2017. The unfortunate timing was caused by the wording of the section which specified 260 weeks, whereas the effluxion of 5 years takes 260 weeks and 6 days (that is, 6 days when there is only one leap year in the period and 7 days [totalling 261 weeks] when there are two leap years in the period).

WIRO established a fast-track ILARS funding procedure to assist affected workers.

Acting in cooperation with iCare, which identified workers to whom notices of termination of payments were likely to have been sent, WIRO was able to provide ILARS funding for approximately 2,200 workers to enable them to obtain legal advice and representation regarding the s 39 notice before the end of December 2017. Data that we have collected suggests that approximately 30% of affected workers have been entitled to receive ongoing weekly payments as a result of findings that they had suffered more than 20% WPI or that they had not yet reached maximum medical improvement, or because the insurer agreed that they had suffered more than 20% WPI.

WIRO does not know the total number of injured workers affected by s 39 WCA as at 30 June 2018, but we estimate that approximately 80 to 100 workers may be affected each month.

Calculation of PIAWE

This issue was raised in the Annual Report for 2016-17. At that time, Professor Tania Sourdin, from the University of Newcastle Faculty of Law had been commissioned by SIRA to conduct a review of the calculation of PIAWE with a view to simplifying the process. While we believe Professor Sourdin completed her report in the first half of 2017, the report had not been either published or implemented as at 30 June 2018.

APPENDIX 1 – SOLUTIONS GROUP STATISTICS

Complaint and Enquiry Issues

Issue	Complaint		Enquiry	
	Number	%	Number	%
Communication (secondary issue only)	71	2%	70	2%
Delay in determining liability	880	26%	342	9%
Delay in payment	447	13%	145	4%
Denial of liability	322	10%	545	15%
Further Inquiry (secondary issue only)	59	2%	8	0%
ILARS Lawyer Complaint	19	1%	350	10%
IME/IMC	74	2%	167	5%
Medico Legal Examination/WPI	3	0%	6	0%
NRTC	22	1%	9	0%
Payment, reimbursement of Medicals/Travel expenses	4	0%	2	0%
PIAWE	161	5%	96	3%
Rehabilitation	192	6%	302	8%
RTW	83	2%	167	5%
S126	132	4%	112	3%
S39	114	3%	576	16%
S39 Matter Fast Track	15	0%	93	3%
Weeklies	13	0%	8	0%
Weeklies - incorrect payment amount/PIAWE	3	0%	2	0%
Weekly Benefits	724	21%	451	13%
Work Capacity Decision	50	1%	155	4%
Grand Total	**3388**	**100%**	**3606**	**100%**

Note: A case may have more than 1 issue

Complaint Outcomes

For cases closed between 1 July 2017 and 30 June 2018

Outcomes	Scheme agent	Self-insured	Specialised insurer	TMF	Grand Total
Delay in determining liability	**560**	**110**	**52**	**135**	**857**
Medical treatment	**296**	**65**	**24**	**76**	**461**
Insurer inside timeframes ND	51	7	4	15	77
Insurer outside timeframes ND	34	8	2	8	52
IW referred to an IME	15	3	2	4	24
Liability determined inside timeframes	75	16	3	21	115
Liability determined outside timeframes	121	31	13	28	193
s66	**29**	**6**	**1**	**5**	**41**
Counter offer made	5	1		2	8
Insurer inside timeframes ND	5	2			7
Insurer outside timeframes ND	4	1			5
IW referred to an IME	2	2		1	5
Liability determined inside timeframes	5			1	6
Liability determined outside timeframes	8		1	1	10
Weekly benefits	**75**	**9**	**4**	**21**	**109**
Insurer inside timeframes ND	12	1		3	16
Insurer outside timeframes ND	4	1		3	8
Liability determined inside timeframes	30	1	2	7	40
Liability determined outside timeframes	29	6	2	8	45
Whole claim	**160**	**30**	**23**	**33**	**246**
Insurer inside timeframes ND	24	10	2	10	46
Insurer outside timeframes ND	11	9	5		25
Liability determined inside timeframes	43	3	8	8	62
Liability determined outside timeframes	82	8	8	15	113
Delay in payment	**262**	**62**	**17**	**75**	**416**
COD	**151**	**31**	**9**	**41**	**232**
Centrelink/Medicare delay	33	7	4	11	55
Insurer Admin error	85	14	3	18	120
Interest Obtained	3			1	4
Interpretation Dispute/Insurer within timeframes	16	6	1	8	31
Lawyer hasn't provided all documents required	14	4	1	3	22
Medical/Travel	**111**	**31**	**8**	**34**	**184**
Already paid	23	8	1	3	35
Claim disputed	12			2	14

Outcomes	**Scheme agent**	**Self-insured**	**Specialised insurer**	**TMF**	**Grand Total**
Claim not received	15	5	2	5	27
Correct amount paid after PI	54	14	3	20	91
Providers invoices not paid	7	4	2	4	17
Denial of liability	**207**	**36**	**19**	**51**	**313**
Incorrect notice given	15	2	1	7	25
Insurer maintain denial on review	125	27	13	26	191
Insurer overturns decision	51	4	5	14	74
IW required to attend an IME	16	3		4	23
ILARS Lawyer Complaint	**8**			**4**	**12**
Refer worker to the OLSC	**8**			**4**	**12**
IME/IMC	**40**	**10**	**3**	**12**	**65**
Choice of 3 IMEs not provided	4			1	5
Complaint about the IME doctor	12	4		5	21
Inconvenient location	12	5	2	2	21
Insufficient notice provided	7		1	3	11
No contact made with treating doctors before referral	5	1		1	7
PIAWE	**126**	**14**	**4**	**19**	**163**
Insurer changes PIAWE	45	5	2	7	59
Insurer maintains decision	27	5	1	4	37
Review process explained	54	4	1	8	67
Rehabilitation	**100**	**16**	**7**	**26**	**149**
ADL assessment approved	37	7		10	54
ADL not approved	8	1		2	11
Case conference cancelled	4		1	3	8
IMP	**7**		**3**	**4**	**14**
IW not complied with obligations			2	2	4
No current IMP	5			2	7
Insurer not complied with obligations	2		1		3
Rehab provided s41A	**14**	**3**	**1**	**3**	**21**
Rehab provider changed	**25**	**5**	**1**	**3**	**34**
Work Trial not suitable	**5**		**1**	**1**	**7**
RTW	**46**	**10**	**2**	**18**	**76**
Job Seeking Diaries	**3**	**1**			**4**
Too many jobs required	2				2
Not provided to insurer		1			1
Suspension s48A	1				1
Suitable Employment	**43**	**9**	**2**	**18**	**72**
Duties not suitable	13	2		3	18
RTW plan updated	7	2		1	10
S/duties not provided by employer	9	1	2	5	17

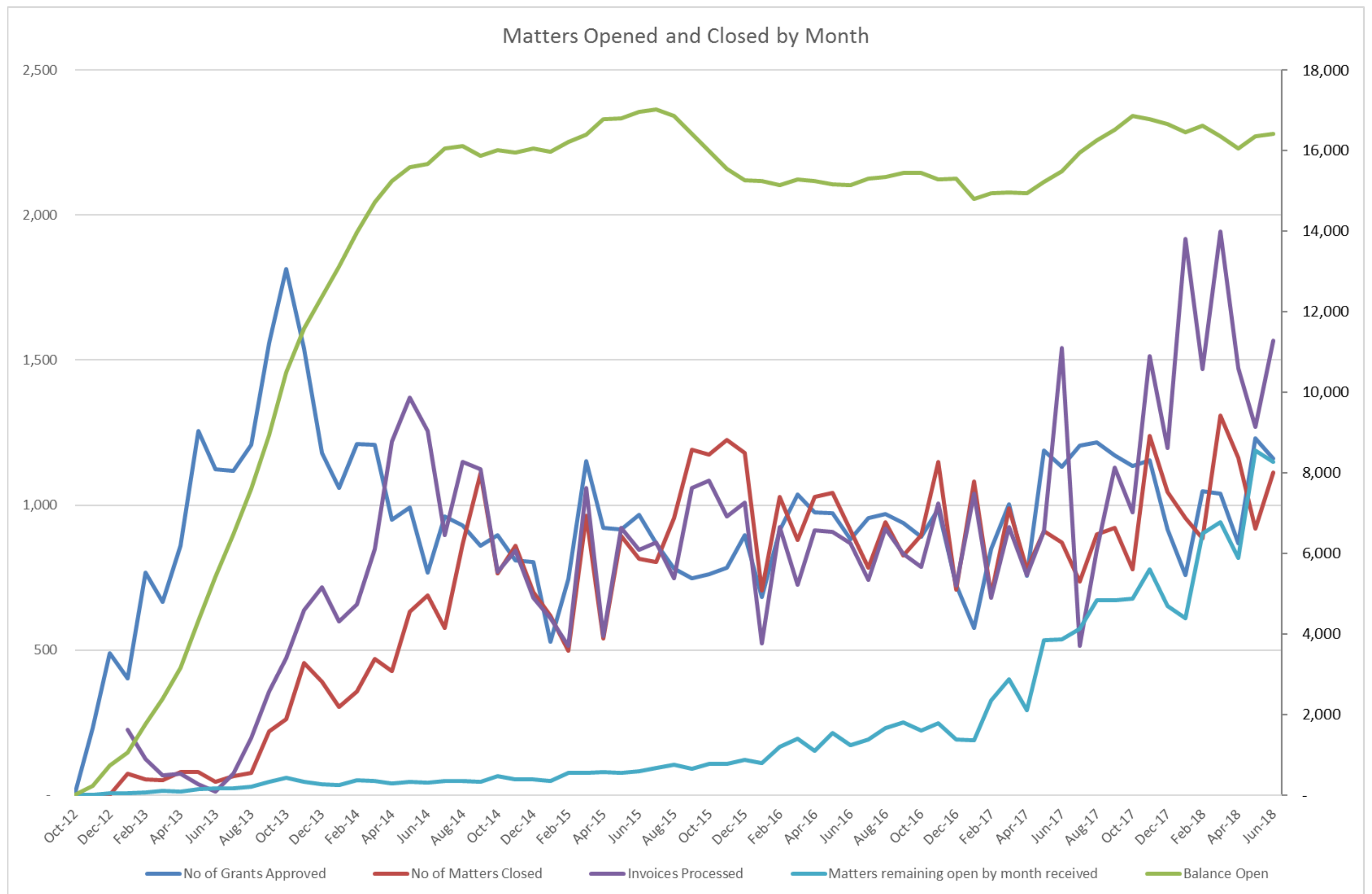
Outcomes	Scheme agent	Self-insured	Specialised insurer	TMF	Grand Total
S/duties provided	10	2		7	19
Workplace assessment required	4	2		2	8
S126	**67**	**26**	**10**	**22**	**125**
Documents not provided	11	9		3	23
Documents provided	56	17	10	19	102
S39	**89**	**6**	**1**	**14**	**110**
Choice of 3 IMEs not provided				2	2
Insurer accepts worker is over 20%	14	2		3	19
Worker referred to an ALSP	75	4	1	9	89
Weekly Benefits	**507**	**49**	**26**	**86**	**668**
Correct amount paid after PI	259	28	12	38	337
Delayed payment	124	13	3	27	167
Employer not passing on weekly payments	63	4	6	10	83
Insurer taking over payments (Payments paid to employer in error)	12			1	13
Overpayment deducted without agreement	10	1		5	16
Suspension maintained	9		3	1	13
Suspension overturned	22	1	2	1	26
Weekly payments suspended	8	2		3	13
Work Capacity Decision	**25**	**3**	**2**	**4**	**34**
Application not received by insurer/MRS	4		1	1	6
Incorrect notice provided	3			1	4
Stay not applied	7		1	1	9
WCD not received/delayed	9	2		1	12
WCD withdrawn	2	1			3
Grand Total	**2037**	**342**	**143**	**466**	**2988**

Complaint timeliness

Issue (of Case) Issue	A - Same day	B - Next day	C - 2 to 7 days	D - 8 to 15 days	E - 16 to 30 days	F - more than 30 days	Grand Total
Delay in determining liability	39	59	460	209	97	19	883
Weekly Benefits	28	49	317	219	76	18	707
Delay in payment	15	34	236	124	29	1	439
Denial of liability	26	22	142	91	39	6	326
Rehabilitation	13	15	103	43	11	1	186
PIAWE	3	5	75	48	26	3	160
S126	12	15	68	29	4	1	129
S39	17	8	48	22	15	2	112
RTW	9	3	44	23	8	4	91
IME/IMC	5	6	36	19	6		72
Communication (secondary issue only)	4	4	41	16	6		71
Further Inquiry (secondary issue only)	1		2	18	21	13	55
Work Capacity Decision	4	2	21	17	2	1	47
Weeklies	2	2	14	6	3	2	29
NRTC	1	1	15	2	1	1	21
ILARS Lawyer Complaint	11	2	2	2	1	1	19
Payment, reimbursement of Medicals/Travel expenses			3	11	2	1	17
S39 Matter Fast Track	5	2	7	2			16
Weeklies - incorrect payment amount/PIAWE			4	3	4	1	12
Medico Legal Examination/WPI			4	1		1	6
Suspension of benefits/Non-compliant worker			1				1
Grand Total	**195**	**229**	**1643**	**905**	**351**	**76**	**3399**

APPENDIX 2 – ILARS STATISTICS

ILARS Matters Opened and Closed by Month



Amounts Paid

Payment Type	Total amount	Number of payments	% of disbursements	Average amount
Professional fees	$34,144,425	10,452		$3,267
Medico-legal	$14,321,234	10,985	70%	$1,304
Barrister Fees	$2,500,349	1,612	12%	$1,551
Clinical Notes	$1,522,242	11,471	7%	$133
Travel	$331,163	1,457	2%	$227
Barrister Country Loading	$174,784	262	1%	$667
NTD Report	$397,083	984	2%	$404
Treating Specialist Report	$550,447	982	3%	$561
Interpreter	$109,922	558	1%	$197
Other	$46,250	211	0%	$219
Meal Allowance	$5,919	103	0%	$57
Solicitor Loading	$60,712	98	0%	$620
Non-attendance fee	$63,350	193	0%	$328
Grand Total	**$54,503,544**	**43,534**		
Total Disbursements	**$20,471,999**		**38%**	
Total Professional Fees	**$34,144,425**		**62%**	

Types of Injury for ILARS Grants

Injury location	Percentage
Ear	26%
Back	17%
Psychological system	11%
Multiple -Trunk and limbs	10%
Shoulder	5%
Knee	5%
Multiple -Neck and shoulder	4%
Hand, fingers and thumb	2%
Other head	2%
Upper limb - multiple locations	2%
Other leg	2%
Wrist	1%
Ankle	1%
Neck	1%
Other body location	1%
Other arm	1%
Death	1%
Foot and toes	1%
Trunk - multiple locations	1%
Internal Body System	1%
Elbow	1%
Abdomen and pelvic region	1%
Not Recorded	1%
Hip	1%
Total	**100%**

Nature of Injury

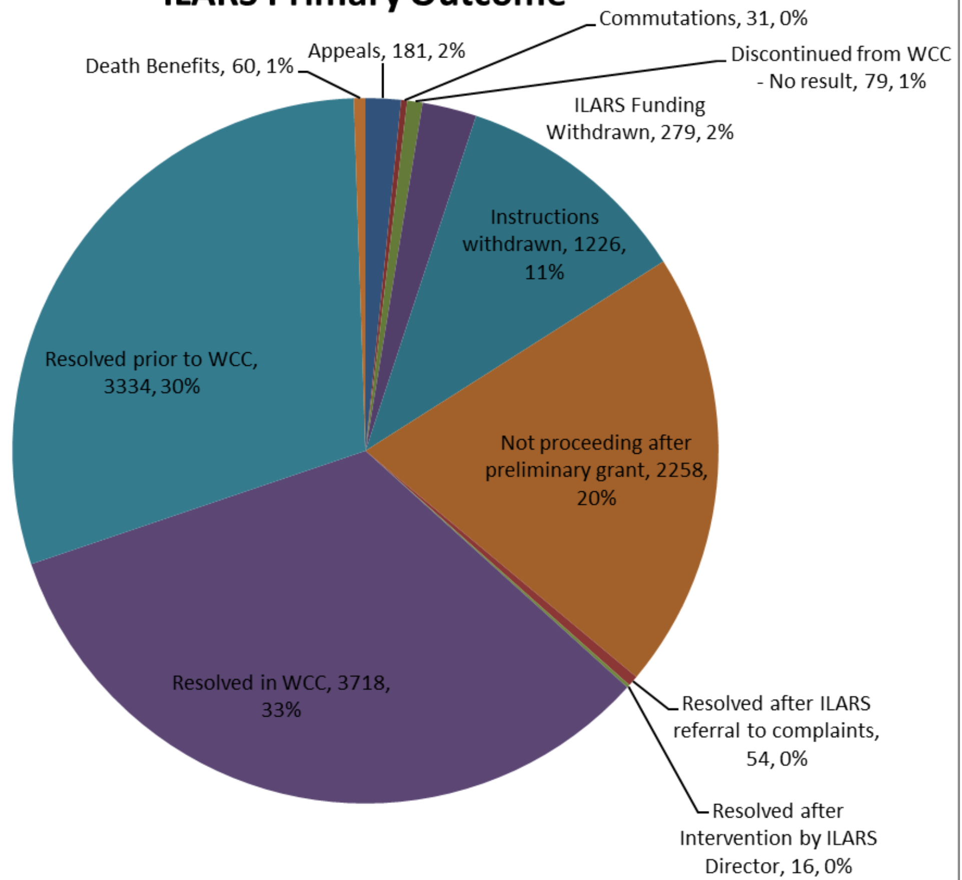
Nature of Injury	Percentage
A. Intracranial injuries	1%
B. Fractures	3%
C. Wounds, lacerations, amputations and internal organ damage	3%
D. Burn	0%
E. Injury to nerves and spinal cord	16%
F1. Trauma to joints and ligaments	17%
F2. Trauma to muscles and tendons	12%
G. Other injuries, ?Poisoning, Electrocution, heat stress etc	0%
H1. Joint diseases (arthropathies) and other articular cartilage diseases	1%
H2. Spinal vertebrae and intervertebral disc diseases	6%
H3. Diseases involving the synovium and related tissue	0%
H4. Diseases of muscle, tendon and related tissue	1%
H5. Other soft tissue diseases	0%
I. Mental disorders	11%
J. Digestive system diseases	0%
K. Skin and subcutaneous tissue diseases	0%
L. Nervous system and sense organ diseases	26%
M. Respiratory system diseases	0%
N. Circulatory system diseases	0%
O. Infectious and parasitic diseases	0%
P. Neoplasms (cancer)	0%
Q. Other diseases	0%
R. Other claims	0%
S. Death	1%
Not Recorded	1%
Grand Total	**100%**

ILARS Outcomes

Outcome	Desired Outcome not achieved	Grant achieved desired outcome	Grand Total
Instructions withdrawn	**1213**		**1213**
ILARS Funding Withdrawn	**270**		**270**
Cram Fluid Applies	4		4
Not Recorded	15		15
Not eligible for funding - (e.g worker determined to be exempt worker)	16		16
No Response to ILARS Follow Up	233		233
Old Costs provisions apply	2		2
Not proceeding after preliminary grant	**2251**		**2251**
Medical evidence not supportive	496		496
Not Recorded	89		89
Worker does not reach WPI threshold	1023		1023
S39 - Below Threshold	640		640
S39 - Not MMI	3		3
Other not specified reason - see summary box	**170**	**35**	**205**
Resolved after ILARS referral to complaints		**54**	**54**
Commutations		**31**	**31**
Discontinued from WCC - No result	**79**		**79**
Resolved prior to WCC		**3333**	**3333**
Not Recorded		6	6
Resolved - Insurer Accepts Claim		1131	1131
Resolved after application for review/insurer accepts Claim		287	287
Resolved by complying agreement after claim made		1732	1732
S39 - Advice given		31	31
S39 - Over threshold by agreement		146	146
Resolved in WCC	**581**	**3132**	**3713**
Resolved at Arbitration by Arbitrator - Employer	**45**		**45**
Resolved at Arbitration by Arbitrator - Worker		**318**	**318**
Medicals		102	102
Not Recorded		7	7
Weeklies		19	19
Weeklies & Medicals		104	104
WPI		52	52
WPI & Medicals		13	13
WPI & Weeklies		4	4
WPI, Weeklies & Medicals		17	17

Outcome	Desired Outcome not achieved	Grant achieved desired outcome	Grand Total
Resolved at Conciliation - settled by consent		**752**	**752**
Closed Period		15	15
Medicals		85	85
Not Recorded		9	9
Weeklies		38	38
Weeklies & Medicals		377	377
WPI		87	87
WPI & Medicals		33	33
WPI & Weeklies		4	4
WPI, Weeklies & Medicals		69	69
Wrap Up		35	35
Resolved at settlement during Arbitration		**106**	**106**
Medicals		19	19
Not Recorded		1	1
Weeklies		7	7
Weeklies & Medicals		50	50
WPI		17	17
WPI & Medicals		4	4
WPI & Weeklies		1	1
WPI, Weeklies & Medicals		7	7
Resolved following MAC	**534**	**1109**	**1643**
COD for WPI		1025	1025
Not reached threshold	326		326
Not Recorded	4	7	11
Surgery not reasonably necessary	3		3
Surgery reasonably necessary		17	17
S39 - Above threshold		60	60
S39 - Not reached threshold	39		39
Discontinued post MAC no COD	10		10
S39 - Not MMI	131		131
S39 - Not MMI MAC refused	21		21
Resolved TC - settled by consent		**832**	**832**
Closed Period		18	18
Medicals		188	188
Not Recorded		12	12
Weeklies		42	42
Weeklies & Medicals		320	320
WPI		125	125
WPI & Medicals		55	55
WPI & Weeklies		6	6
WPI, Weeklies & Medicals		49	49
Wrap Up		17	17

Outcome	Desired Outcome not achieved	Grant achieved desired outcome	Grand Total
Resolved WIM Dispute	**2**	**15**	**17**
In favour of worker		15	15
In favour of employer	2		2
Appeals	**74**	**107**	**181**
Resolved after appeal from decision of Arbitrator to President	**10**	**10**	**20**
By the employer in favour of Employer	4		4
By the employer in favour of Worker		6	6
By the worker in favour of Employer	6		6
By the worker in favour of Worker		4	4
Resolved after Medical Appeal Panel	**64**	**95**	**159**
By the employer in favour of Employer	10		10
By the employer in favour of Worker		44	44
By the worker in favour of Employer	54		54
By the worker in favour of Worker		51	51
Resolved after appeal to Court of Appeal		**2**	**2**
By the worker in favour of Worker		2	2
Resolved after Intervention by ILARS Director		**16**	**16**
Death Benefits		**60**	**60**
Grand Total	**4638**	**6768**	**11406**


ILARS Primary Outcome
Commutations, 31, 0%
Appeals, 181, 2%
Death Benefits, 60, 1%
Discontinued from WCC - No result, 79, 1%
ILARS Funding Withdrawn, 279, 2%
Instructions withdrawn, 1226, 11%
Resolved prior to WCC, 3334, 30%
Not proceeding after preliminary grant, 2258, 20%
Resolved in WCC, 3718, 33%
Resolved after ILARS referral to complaints, 54, 0%
Resolved after Intervention by ILARS Director, 16, 0%

Appendix 3 – Matters received by Insurer

Insurer	Complaint	Employer Complaint	Enquiry	ILARS	WCDR	No Response	Grand Total
Scheme agent	**2316**	**48**	**2398**	**8870**	**24**	**850**	**14506**
Allianz Australia Workers Compensation	534	9	671	2452	4	156	**3826**
CGU Workers Compensation (NSW)	114		146	473	3	45	**781**
Employers Mutual NSW Limited	523	21	488	2261	10	302	**3605**
GIO General Limited	972	11	850	2736	4	285	**4858**
QBE Workers Compensation	173	7	243	948	3	62	**1436**
Self-insured	**380**	**1**	**267**	**1309**	**2**	**144**	**2103**
3M Australia Pty Ltd				1			**1**
ANZ Banking Group	1		1	12			**14**
Ausgrid	2		7	39		2	**50**
Blacktown City Council			2	14		1	**17**
Bluescope Steel Ltd	12		2	89		11	**114**
BOC Workers' Comp			2	2		1	**5**
Boral Limited	1			3			**4**
Brambles Industries				7			**7**
Brickworks Ltd	2			3			**5**
Broadspectrum	21		8	35		6	**70**
Campbelltown City Council	3		1	4		1	**9**
Canterbury Council	1			7			**8**
Central Coast Council	1		1	15			**17**
City of Sydney Council	5		3	31		5	**44**
Coles Group Ltd	85		63	189		17	**354**
Colin Joss & Co Pty Limited	1			4			**5**
CSR Limited	1		1	7			**9**
Echo Entertainment Group	6		2	6		2	**16**
Electrolux Home Products				3			**3**
Endeavour Energy	3		6	3	1	1	**14**
Fairfield City Council	4			9			**13**
GFG Alliance (form. Arrium)	11		3	33		4	**51**
Gosford City Council	1			4		1	**6**
Hawkesbury City Council				1		1	**2**
Holcim (Aust) Holdings	7		7	4			**18**

Hurstville City Council			1			1	**2**
Inghams Enterprises	4		3	13		3	**23**
ISS Facility Services	4		7	15		2	**28**
ISS Property Services	4		3	10			**17**
JELD-WEN Australia	1		2	9			**12**
Lake Macquarie City Council			1	9			**10**
Liverpool City Council	5		1	6			**12**
MARS Australia Pty Ltd				1			**1**
McDonald's Australia	7		4	8			**19**
Myer Holdings Ltd	3			7			**10**
Newcastle City Council	2		1	12			**15**
Northern Beaches Council	2			2			**4**
Northern Co-Operative Meat Company Limited	19		5	12			**36**
NSW Trains	1			3			**4**
OneSteel Trading Pty Ltd (Moly-Cop)			2				**2**
Pacific National (NSW)	3			23		1	**27**
Port Stephens Council				1			**1**
Primary Health Care	1		3	11		2	**17**
Programmed Skilled Workforce Limited	10		9	16		2	**37**
Qantas Airways Limited	19		13	136	1	12	**181**
Rail Corporation NSW	1		6	12		1	**20**
Rocla Pty Limited				1			**1**
Shoalhaven City Council				11			**11**
Southern Meats Pty Ltd.	1		1	3			**5**
Sutherland Shire Council	1			9		1	**11**
Sydney Trains	6		2	13			**21**
Toll Holdings Ltd	15		19	46		7	**87**
Transport for NSW Workers Compensation Services	14		11	94		8	**127**
Transport Service of NSW (State Transit Group)	4		4	32		2	**42**
UGL Rail Services Pty			3	14		2	**19**
Unilever Australia (Holdings) Pty Limited	2			7			**9**
University of NSW	4		1	3		1	**9**
Veolia Environmental Services (Australia) Pty Ltd	2			2		4	**8**
Westpac	7		7	33		4	**51**

Wollongong City Council			1	20		4	**25**
Woolworths Limited	70		50	187		34	**341**
Wyong Shire Council				1			**1**
Specialised insurer	**174**		**136**	**516**		**47**	**873**
Catholic Church Insurance	65		43	122		16	**246**
Club Employers Mutual	20		13	25		3	**61**
Coal Mines Insurance	3		4	8			**15**
Guild Insurance Ltd	12		5	21		3	**41**
Hospitality Employers Mutual Limited	1		3	39		1	**44**
Hotel Employers Mutual	18		10	36		2	**66**
Icare- Lifetime Care	5		4	28		3	**40**
Racing NSW Insurance Fund	14		12	51		4	**81**
StateCover Mutual Ltd	36		42	186		15	**279**
TMF	**520**		**468**	**1538**	**2**	**155**	**2683**
Allianz TMF	186		156	431		44	**817**
Employers Mutual - TMF	95		96	368	2	42	**603**
QBE TMF	239		216	739		69	**1263**
Other - including Not Provided	**20**	**12**	**595**	**1920**		**9**	**2556**
Grand Total	**3410**	**62**	**3864**	**14153**	**28**	**1061**	**22578**

APPENDIX 4 – Work Capacity Procedural Reviews

Outcome	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Total
Could not proceed				1			1	1	1			**4**
Dismissed	2	3	5	2	4	2	2	2	3	3	2	**30**
Upheld	1		1	2	1		1	1				**7**
Referred to insurer	1											**1**
Grand Total	**4**	**3**	**6**	**5**	**5**	**2**	**4**	**4**	**4**	**3**	**2**	**42**

APPENDIX 5 - SCHEDULE OF WIRO MEETINGS AND PRESENTATIONS 2017 – 2018

Date	Details
4/07/17	Meeting with Allianz
6/07/17	Meeting of DFSI Dispute Resolution Reference Group
21/07/17	WIRO Albury Seminar
25/07/17	Meeting with Allianz TMF
26/07/17	Meeting with AMA
31/07/17	Meeting with Shadow Minister
8/08/17	Meeting with ICNSW about complaints
10/08/17	Presentation by Hyper Anna
10/08/17	Meeting with Unions NSW
23/08/17	Meeting of DFSI Dispute Resolution Reference Group
24/08/17	TWU Annual Conference
25/08/17	TWU Annual Conference
28/08/17	Meeting with ICNSW - s.39
29/08/17	Meeting with Taylor Fry
13/09/17	Meeting with CEO UHG
14/09/17	Meeting of the International Committee of IAIABC
18/09/17	Meeting of DFSI Dispute Resolution Reference Group
19/09/17	Meeting with Carroll & O'Dea
21/09/17	Meeting with ICNSW - s.39
25/09/17	Data Presentation by Taylor Fry - DFSI Dispute Resolution
26/09/17	Demonstration of HyperAnna
2/10/17	IAIABC Annual Conference - Portland Oregon
5/10/17	Meeting of DFSI Dispute Resolution Reference Group
13/10/17	Opening Session - Spark Festival
16/10/17	Meeting with Parliamentary Secretary - Finance, Property & Services
23/10/17	Meeting with eReports
24/10/17	Meeting with ICNSW - s.39
24/10/17	Presentation to Carroll & O'Dea
24/10/17	Meeting with Allianz TMF
26/10/17	Attend Safework NSW Awards Dinner
27/10/17	Meeting with GIO
1/11/17	Meeting with DFSI Policy Group - Dispute Resolution
2/11/17	Briefing Meeting with Chair SCLJ
6/11/17	Meeting of DFSI Dispute Resolution Reference Group
7/11/17	Attend Standing Committee on Law & Justice Hearing

Date	Details
8/11/17	Address Greens Parliamentary Forum
8/11/17	Operational meeting with Carroll & O'Dea
9/11/17	Attend Self and Specialised Insurers AGM
10/11/17	Meeting with Chief of Staff to NSW Attorney General
16/11/17	Attend Annual Dinner - City of Sydney Law Society
20/11/17	Meeting with ICNSW - s.39
21/11/17	SIRA/WCC/WIRO/iCare meeting - s.39 updates
23/11/17	Presentation at Legalwise Seminar
29/11/17	Attend ICNSW CASE Awards Dinner
5/12/17	SIRA/WCC/WIRO/iCare meeting - s.39 updates
6/12/17	WIRO Paralegal Course
7/12/17	WIRO Paralegal Course
14/12/17	Meeting with Allianz
19/12/17	SIRA/WCC/WIRO/iCare meeting - s.39 updates
16/01/18	Meeting with DFSI - Branding Guidelines
23/01/18	SIRA/WCC/WIRO/iCare meeting - s.39 updates
30/01/18	Meeting with CFMEU
30/01/18	Meeting with Catholic Church Insurances
30/01/18	Meeting with Law Society about Dispute Resolution
1/02/18	Meeting with MSBC
9/02/18	Attending presentation by CEO WorkCover Victoria CEO
12/02/18	Meeting of DFSI Dispute Resolution Reference Group
15/02/18	Meeting with Allianz TMF
19/02/18	Attend NCAT Hearing - Peter Livers
20/02/18	Attend National Workers Compensation Summit
21/02/18	Attend National Workers Compensation Summit
1/03/18	Presentation to Unions NSW
8/03/18	WIRO Sydney Seminar
12/03/18	DFSI Briefing – SAP Connect
15/03/18	Meeting with ICNSW - s.39
17/03/18	Meeting of the International Committee of IAIABC
19/03/18	Attend Bonville Conference
20/03/18	Presentation - Bonville Conference
23/03/18	Presentation - UNSW Seminar
5/04/18	Meeting with ICNSW - s.39
10/04/18	SIRA/WCC/WIRO/iCare meeting - s.39 updates
16/04/18	Presentation to IAIABC Dispute Resolution Committee - Atlanta Georgia
27/04/18	Meeting with Professor McCluskey - Sydney Eye Hospital
3/05/18	WIRO Ballina Paralegal Course

Date	Details
4/05/18	WIRO Ballina Seminar
10/05/18	Meeting with ICNSW - s.39
11/05/18	WIRO Wollongong Seminar
16/05/18	WIRO Bathurst Seminar
17/05/18	Meeting with ICNSW - s.39
18/05/18	Presentation to College of Law Specialisation Conference
25/05/18	WIRO Newcastle Seminar
5/06/18	Meeting with CFMEU
7/06/18	Presentation to Legalwise Psychiatric Injuries Seminar
13/06/18	Meeting with President & Registrar Workers Compensation Commission
15/06/18	DFSI Dispute Resolution Steering Committee
20/06/18	Meeting with UHG
21/06/18	Meeting with iCare - Complaints management workshop
28/06/18	SIRA/WCC/WIRO/iCare meeting - s.39 updates
29/06/18	DFSI Dispute Resolution Steering Committee