NSW Business Chamber Limited
140 Arthur Street
North Sydney NSW 2060
Postal address
Locked Bag 938
North Sydney NSW 2059
DX 10541 North Sydney
t 13 26 96
f 1300 655 277
e businesshotline@nswbc.com.au

23 November 2018

Mr Darren Parker
A/Executive Director
Workers and Home Building Compensation Regulation
State Insurance Regulatory Authority (NSW)

By email: PolicyDesignWHBCR_SIRA@sira.nsw.gov.au

Dear Mr Parker

CONSULTATION DRAFT: *CLAIMS ADMINISTRATION MANUAL - STANDARDS OF PRACTICE FOR INSURERS*

The NSW Business Chamber (the Chamber) welcomes the opportunity to provide comments to the draft *Claims Administration Manual: Standards of practice for insurers*.

The Chamber is one of Australia's largest business support groups, with a direct membership of 20,000 businesses and providing services to over 30,000 businesses each year. The Chamber works with businesses spanning all industry sectors including small, medium and large enterprises.

Employers are key stakeholders in the NSW workers compensation system. Employers both fund the system and are under a statutory obligation to meet any deficit of the Insurance Fund. The Chamber takes an active interest in issues that have the potential to both positively and negatively impact the system.

The Chamber welcomes the opportunity to provide recommendations on the proposed standards of practice designed to strengthen SIRA's oversight of insurers in accordance with section 192A of the *Workers Compensation Act 1987*. The Chamber believes the imposition of a comprehensive set of standards will overcome many of the shortcomings that currently exist in the NSW workers compensation system.

Feedback from our members suggests the current claims management system designed by icare and administered by insurers (on behalf of icare) falls well short of meeting the objectives stated in the standards for an effective claims system.

Specifically, the standards emphasise the claims management system should be one that operates:

- fairly and equitably;
- transparently and honestly; and
- proactively, timely, efficiently and effectively.

The Chamber's submission, which represent a culmination of two year's work of collecting and collating member feedback on how the claims management system needs to improve, calls for amendments of the draft standards so they can adequately address the following issues currently being experienced by employers:

Information access and advice

For the system to be effective, employers need to be treated as partners in the claims management process. Information and advice around medical treatment should be appropriately shared with employers to ensure that they understand how treatment is progressing and how they might support an injured worker. Employers have cited multiple instances where they have not been updated on an injured workers medical status (including no communication on an injured worker undergoing a surgical operation, or any advice provided about an injured worker who was having suicidal thoughts).

An effective system needs employers to be properly informed around the status of injured workers and this can only be achieved where appropriate and accurate information is shared.

Exclusion from claims management

Feedback from employers suggests that despite wanting to engage and support injured workers recovery and ensure that claims are being managed effectively, employers are being excluded from important stages of the process. This interferes not only with the employer's ability to discharge its statutory obligations but with its business operations as well.

The Chamber believes measures need to be put into place to ensure employers are not only kept informed of a claim's (and worker's) progress, but are afforded the right to be involved in a number of key processes and procedures.

Decision making (liability)

Employers hold very strong concerns that liability is being accepted by icare and EML for injuries where employment is neither (for injuries other than a disease injury) a *'substantial contributing factor'* or (for disease injuries, including psychological injuries) the *'main contributing factor'*.

It appears that icare and EML, when making a liability decision, are refusing to accept evidence from employers and relying solely on the nominated treating doctor's description of how the injury occurred (which is unreliable hearsay).

For the system to be effective, it is critical objective decision-making not only takes place but is seen to have taken place.

This can only happen if it is clear to all stakeholders that, in reaching the decision, the decision-maker has considered all the relevant statutory requirements, taken all of the evidence provided to it into consideration and has made a decision based on those requirements and evidence.

Privacy

It is not unusual for employers to complain to the Chamber about how they are denied access to information clearly covered by the form of consent signed by an injured worker on their current certificate of capacity.

Employers support the current form of consent used in the Certificate of Capacity, but are becoming increasingly frustrated by the apparent lack of understanding on the part of insurers and claims managers in relation to both the effect of that consent clause and privacy laws in general.

Use of Experts

Employers are becoming increasingly concerned with both:

- the inexperience and lack of medical training of claims managers engaged by icare and EML; and
- icare and EML's over-reliance on the combined expertise of their claims managers and the nominated treating doctor in circumstances where a more appropriate course of action would be to either refer the matter for a second opinion or to refer the matter on to a more suitably qualified subject matter expert, such as a rehabilitation provider, psychologist, or physiotherapist.

NSW Business Chamber Limited
140 Arthur Street
North Sydney NSW 2060
Postal address
Locked Bag 938
North Sydney NSW 2059
DX 10541 North Sydney
t 13 26 96
f 1300 655 277
e businesshotline@nswbc.com.au

One example is the current trend to close off rehabilitation services being provided to the worker as soon as he or she is back on full hours (as opposed to being back at full working capacity).

Monitoring of injured workers

An additional standard is required to ensure employers have comfort in knowing the insurer:

- is monitoring the injured worker's behaviour to ensure the worker is complying with his or her statutory obligations (for example, to notify of a return to work with other employers; to comply with his or her injury management plan obligations; or to comply with his or her return to work obligations);
- will act upon the employer's concerns that the worker is not complying with these obligations;
- will cease payments of weekly benefits should it find the injured worker to be in breach of his or her return to work obligations; and
- will appropriately notify and include the employer in its decision-making powers and processes.

Specific amendments to the text of the current version of the draft standards are attached as Appendix A to this document.

For more information regarding the Chamber's submissions, please contact Elizabeth Greenwood, Policy Manager, Workers Compensation, WHS and regulation on (02) 9458 7078 or elizabeth.greenwood@nswbc.com.au .

Yours sincerely

Chris Lamont
Director, Policy and Advocacy

Standard of practice 1: Claims management principles

The Chamber would like to see Standard of Practice 1 strengthened by including a new S1.4.

#	Standard

S1.4	Insurers are required to publish materials:
	• Explaining their requirements for:
	  o 'Best available evidence' (S1.1);
	  o 'Relevant information' (S4.1 and S5.1)
	  o Surveillance (S26.1), including:
	    ▫ The type of evidence required (for example, eye-witness statements) and, if relevant, the hierarchy to be assigned to different types of evidence.
	    ▫ The reasons why certain types of evidence (for example, social media posts and photographs that are in the public domain) cannot be taken into account.
	• Explaining (preferably in the form of case notes) what they consider to be 'unnecessary disputes, investigation and litigation' (S1.1, 4th dot point); and
	• Outlining their customer service standards (for example, a 5 business day turnaround time to approve an employer's or nominated treating doctor's request for provider intervention) to explain how they intend to comply with S1.3.

Standard of practice 2: Worker consent

The 'context' to this draft standard implies the form of consent currently contained in the standard certificate of capacity will be replaced with a document-specific consent which can only be given after each document has been created and then examined by the injured worker.
The Chamber strongly:

- opposes the introduction of the proposed standard as it will exacerbate inefficiencies in the claims management system but also has the potential to unreasonably interfere with an employer's statutory obligations to identify suitable duties for an injured worker's return to work; and
- urges inclusion of a principle to ensure the current wording of the consent contained in the certificate of capacity is not only retained (providing a single consent for the sharing of information between key parties, including the employer, over a stipulated period) but is supplemented by an acknowledgement that the release of personal and health information relevant to assess a worker's capacity for work and identify suitable duties is necessary to enable an employer to comply with its statutory obligations under the Act.

NSW Business Chamber

Standard of practice 3: Worker access to personal information

#	Standard
S3.2	Insurers must ensure workers are aware of their right to access their own personal and health information, **including but not limited to**: • Independent Medical Examiner reports • Injury Management Consultant reports • Independent Consultant reports • workplace rehabilitation reports • reports gathered for work capacity assessments • any insurer-requested reports from the nominated treating doctor, nominated treating specialists, allied health providers, and workplace rehabilitation providers. *The Chamber has concerns about the width of this principle due to the presence of the words 'including but not limited to' in S3.2 and submits that this standard needs to be reworded to:* • *confine 'personal information' to particular types of reports;* • *exclude information that has been developed for the primary purpose of obtaining evidence of how an injury was caused (for example, witness statements); and* • *ensure that only appropriately qualified professionals (especially where psychological injuries are concerned) can determine whether an individual's 'safety and wellbeing' is likely to be 'affected'.*

NSW Business Chamber

Standard of practice 4: Initial liability decisions

<table>
<tr><th>#</th><th>Standard</th></tr>
<tr><td>S4.3</td><td>If accepting provisional liability, the insurer is to provide notice to the employer at the same time a notice is provided to the worker under section 269 of the 1998 Act ~~as soon as practicable, and no later than two business days after the decision has been made~~.
The notice is to include:
• The statutory requirements:
  o In all notices and in all circumstances – the requirements of sections 4, 9, 9A, 14 and 23 of the 1987 Act.
  o If relevant to the circumstances - the requirements of sections 9AA, 9AB, 9AC, 9B, 10, 11, 11A, 12, 15, 16, 17, 18, 19, 20, 21, 22A, 22C and 24.
• The evidence (relevant to the issue of liability) received from both the worker and the employer.
• Both the decision reached and the reasons for reaching that decision (to be cross-referenced back to the relevant statutory requirements and the relevant evidence). If any evidence is rejected as not being relevant, that fact, together with the reasons why the evidence is not relevant should also be included.
• confirmation that provisional weekly payments are to commence
• the period for which provisional payments are to continue (up to a maximum of 12 weeks)
• that the insurer will develop an injury management plan for the worker (if required to do so by Chapter 3 of the 1998 Act), and
• that the worker is entitled to make a claim for compensation, including details of how that claim can be made.
• a copy of the notice provided to the worker under section 269 of the 1998 Act</td></tr>
</table>

NSW Business Chamber

#	Standard

S4.4	If the insurer has a reasonable excuse not to commence provisional weekly payments, the insurer is to provide written notice to the worker as required under section 268 of the 1998 Act, and also include in this notice:
	• The statutory requirements:
	  ○ In all notices and in all circumstances – the requirements of sections 4, 9, 9A, 14 and 23 of the 1987 Act.
	  ○ If relevant to the circumstances - the requirements of sections 9AA, 9AB, 9AC, 9B, 10, 11, 11A, 12, 15, 16, 17, 18, 19, 20, 21, 22A, 22C and 24.
	• The evidence (relevant to the issue of liability) received from both the worker and the employer.
	• Both the decision reached and the reasons for reaching that decision (to be cross-referenced back to the relevant statutory requirements and the relevant evidence). If any evidence is rejected as not being relevant, that fact, together with the reasons why the evidence is not relevant should also be included.
	• how the excuse can be resolved
	• that the worker can talk to the insurer for further information
	• that the worker can seek help from their union or WIRO, and
	• that the worker has a right to seek an expedited assessment by application to the Registrar of the Workers Compensation Commission
	The insurer must also advise the employer of the reasonable excuse ~~as soon as practicable and no later than two business days after the decision has been made~~ on the same day it provides written notice to the worker, by sending the employer a written notice advising of the decision and enclosing a copy of the worker's written notice'.

NSW Business Chamber

#	Standard

S4.5	If accepting liability for a claim for weekly payments, the insurer is to provide written notice to the worker and employer of the decision and reasons as soon as practicable, and no later than two business days after an initial liability decision has been made.
	The written notice must include:
	• The statutory requirements:
	  ○ In all notices and in all circumstances – the requirements of sections 4, 9, 9A, 14 and 23 of the 1987 Act.
	  ○ If relevant to the circumstances - the requirements of sections 9AA, 9AB, 9AC, 9B, 10, 11, 11A, 12, 15, 16, 17, 18, 19, 20, 21, 22A, 22C and 24.
	• The evidence (relevant to the issue of liability) received from both the worker and the employer.
	• Both the decision reached and the reasons for reaching that decision (to be cross-referenced back to the relevant statutory requirements and the relevant evidence). If any evidence is rejected as not being relevant, that fact, together with the reasons why the evidence is not relevant should also be included.
	• confirmation of the decision to accept liability
	• the workers pre-injury average weekly earnings (PIAWE) and entitlement to weekly payments, including how that amount has been calculated
	• who will pay the worker (either the employer or the insurer)
	• what to do if the worker disagrees with the amount calculated and the review process
	• that an injury management plan will be developed (if required to do so by Chapter 3 of the 1998 Act)
	• that to continue to be entitled to weekly payments the worker must give the employer or insurer a properly completed workers compensation certificate of capacity.

NSW Business Chamber

#	Standard
S4.6	If an insurer requires a duly completed claim form to determine liability, they are required to proactively request this from the worker and enable sufficient time for the worker to complete and submit the claim form. Immediately after having either requested a duly completed claim form or, after having requested it, having received the completed claim form, the insurer must advise the employer each of those events Note: requesting this at least four calendar weeks before the expiration of the provisional period, or before the anticipated expiration of medical costs, would provide sufficient time. The insurer may deviate from this timeframe if demonstrated this is reasonable having regard to the individual facts and circumstances of the claim.

Standard of practice 5: Liability for medical or related treatment

#	Standard
S5.1	Insurers must proactively request and obtain relevant information from the employer and the injured worker to determine liability for claims made for medical or related treatment.

S5.2	Insurers are expected to promptly determine liability and not unreasonably delay a decision until the end of the time limit (21 calendar days) and must include the following: .
	• The statutory requirements:
	  ○ In all notices and in all circumstances – the requirements of sections 4, 9, 9A, 14 and 23 of the 1987 Act.
	  ○ If relevant to the circumstances - the requirements of sections 9AA, 9AB, 9AC, 9B, 10, 11, 11A, 12, 15, 16, 17, 18, 19, 20, 21, 22A, 22C and 24.
	• The evidence (relevant to the issue of liability) received from both the worker and the employer.
	• Both the decision reached and the reasons for reaching that decision (to be cross-referenced back to the relevant statutory requirements and the relevant evidence). If any evidence is rejected as not being relevant, that fact, together with the reasons why the evidence is not relevant should also be included.

#	Standard
S5.3	When a request for medical or related treatment is received the insurer is to acknowledge the request as early as possible and keep the worker and employer informed of the status of ~~their~~ the claim and the timeframe within which liability is required to be made. Note: Insurers are to acknowledge the request by the 14th calendar day. This applies unless the insurer has made a decision and communicated this to the worker, or is able to demonstrate that deviation from this timeframe is reasonable having regard to the individual facts and circumstances of the claim.

Standard of practice 6: Recurrence or aggravation

#	Standard
S6.1	Insurers must consider the facts and medical evidence provided by or on behalf of the injured worker and the employer to determine whether an injury is an: • aggravation of a previous injury, which is to be managed as a new injury (within normal legislative requirements), or • a recurrence of a previous injury, which is to be managed on the existing claim.

Standard of practice 10: Inform worker of legislated reduction of weekly compensation

#	Standard
S10.2	The insurer is required to contact the employer ~~verbally or~~ in writing at least two weeks prior to the legislated reduction to advise of the change and ensure that the employer pays the correct entitlement.

Standard of practice 12: Determining work capacity following a downgrade in capacity

#	Standard
S12.2	The insurer is to conduct a work capacity assessment to consider the new information and make a new work capacity decision as soon as practicable, and within 21 calendar days of the notification of downgrade. The insurer must consider whether the matter should be referred to another general practitioner for a second opinion or to a more appropriately qualified professional, such as a rehabilitation provider, psychologist or physiotherapist

NSW Business Chamber

Standard of practice 13: Injury management plans

#	Standard

S13.2	The injury management plan is:
	• to be specific to the worker
	• to be developed in consultation with the worker and their employer and other relevant stakeholders
	• to consistent with available medical and treatment information
	• is to include:
	  ○ the goal of the plan
	  ○ actions tailored to the worker and their goal (including involved parties and timeframes)
	  ○ when the plan will be reviewed, and
	  ○ rights and obligations of all stakeholders, which may be included in the plan or referenced and attached as an appendix or a separate document.

Standard of practice 14: Addition of a new medical condition or consequential injury to a certificate of capacity

#	Standard
S14.3	If the worker is making a claim, the insurer is to promptly advise the worker and employer of their liability decision (made within the required 21 calendar days period).

Standard of Practice 15: Referral to an injury management consultant

#	Standard
S15.1	An employer may request the worker to be referred to an IMC and, is the insurer refuses the employer's request, it must provide written notice to the employer of it decision and its reasons for the decision. The insurer may only refuse the employer's request if the grounds for that refusal are reasonable.
S15.12	The insurer is to advise the worker, the employer and nominated treating doctor of the referral and the reason(s) for the referral being made, irrespective of whether the referral is for a file review or an appointment with the worker. The insurer is to advise the nominated treating doctor that they can be paid for the time taken to communicate with the IMC.

NSW Business Chamber

#	Standard
S15.~~2~~3	When making a referral to an IMC, the following obligations apply to the insurer: • where a worker is required to attend an IMC's rooms the location should be ~~geographically convenient~~ practicable, given ~~for~~ the worker's circumstances~~, for example, close to the worker's home or work address~~ • any special requirements of the worker are to be accommodated, such as gender, culture, language and accessibility (including travel requirements) • the decision on which IMC to engage should take into consideration the injury type • the IMC should be able to provide the appointment within a reasonable timeframe, and • the insurer is to determine whether the IMC records consultations at the time of making the appointment to inform the worker and obtain their consent (written or verbal) beforehand.
S15.~~3~~4	If the worker is to be assessed by an IMC, the worker is to be given at least 10 working days' written notice of the appointment unless a shorter timeframe is agreed by all parties. The written notice is to include: • all relevant appointment details, including the name, speciality and qualification of the IMC, the date, time, location, and likely duration • the specific reason for the referral to the IMC • that the injury management consultation is an opportunity for them to actively participate in their return to work • preparation, including what to take (e.g. x-rays, reports of investigations/tests) and advice regarding suitable clothing to allow for an appropriate assessment to be conducted • how costs (including for travel) are to be paid • that the worker may be accompanied by a support person • that the worker and the nominated treating doctor will both receive a copy of the report • what the worker is to do if they do not believe the assessment is reasonable or if they have a complaint about the conduct of the IMC • where the IMC's routine practice is to record the consultation on audio or video, the worker must be informed of this in writing and given an opportunity to decline should they not consent, and • the SIRA brochure about injury management consultations is to be provided to the worker with the written notice of the appointment.

NSW Business Chamber

#	Standard
S15.45	The insurer must provide the IMC with adequate and relevant information to support the referral including: • a detailed description of the reason for referral • contact details of the worker and nominated treating doctor, and • relevant documentation from the file to assist the IMC's understanding of the claim.
S15.56	Subsequent IMC referrals must be with the same IMC unless that IMC: • has ceased to practise (temporarily or permanently) in the role • ~~they no longer practice in a location convenient to the worker~~ is unable to see the worker or, for other reasons, it is no longer practicable for the worker to be seen by the same IMC., or • after having consulted with the employer, both parties agree that a different IMC is required.
S15.7	The insurer must notify the employer of any change in IMC

Standard of practice 16: Approval and payment of medical, hospital and rehabilitation services

#	Standard
S16.1	Prior to making a decision about approval for services, insurers must determine: • actively engage with key stakeholders, including the employer. • whether the services requested are reasonably necessary • whether the service provider is appropriately qualified to provide services to workers e.g. SIRA approval as an allied health provider • whether the proposed fees are appropriate, that is, not in excess of the maximum rates in SIRA Workers Compensation Fees Orders or at an appropriate community rate (where no Fees Order applies) • whether the services requested align to appropriate billing /payment codes.

NSW Business Chamber

Standard of practice 17: Case conferencing

#	Standard
S17.1	When seeking to arrange a case conference, the insurer must: • inform the worker and employer beforehand of the intention to arrange a case conference and the reasons for it • provide the purpose or agenda of the case conference to all parties (including the employer) to be involved • schedule the case conference in a timely manner to be held (also in a timely manner) separately to the worker's medical consultation.
S17.2	The insurer must consider an employer's request to arrange a case conference and, if the insurer decides to refuse that request, provide the employer with written notice of its decision and the reasons for the refusal. An insurer may not refuse an employer's request unless the request is based on reasonable grounds.
S17.3	If the insurer decides to arrange a case conference in accordance with the employer's request, the employer has the right to: • Have additional items included in the agenda of a case conference. • Require the presence of the nominated treating doctor. • Nominate a suitably qualified practitioner (such as a rehabilitation provider) to attend the case conference as the employer's representative.
S17.4	No-one has the right to exclude an employer from a case conference.
	Note: if the insurer is not able to schedule the case conference separate to the worker's medical consultation, the insurer is to record this on the file and is to consider an appropriate alternative in consultation with the worker.

Standard of practice 23: Insurer participation in disputes and mediation

#	Standard
S23.2	The insurer must keep the employer informed of the progress of a dispute involving the injured worker

NSW Business Chamber

Standard of practice 25: Factual investigations

#	Standard
S25.2	If the worker is required to participate in the factual investigation they must be advised in writing. This advice is to include: • the purpose of the factual investigation • the worker may choose not to participate in the investigation, however it will help determine their claim if they do so • the contact details of the investigator • the anticipated duration of the factual interview and that the worker may request a break or postpone investigation interviews if the interview is to be prolonged (interviews are not to exceed two hours) • the worker can nominate the place of the interview • the worker may have a support person (including union representative) present • the worker may request an interpreter if required (does not count as a support person) • the worker will receive a copy of their statement or transcript within 10 working days of the interview • the worker can nominate witnesses to assist the investigation • Insurers are to advise the worker that they are not obligated to participate in the factual investigation. They are to explain however that the factual investigation will be used to help determine liability for their claim. *s25 needs to be re-worked to:* • *Make it clear that the evidence to be obtained by a factual investigation is not confined to the evidence of a worker.* • *Ensure that a factual investigation proceeds even though a worker has chosen not to participate in the investigation.* • *Allow a worker's evidence to be provided later (but still in a timely manner), should the worker be incapacitated (for example, due to being in a coma) at the time the factual investigation is being conducted.* • *Ensure the factual investigation is conducted in a timely manner.*

NSW Business Chamber

Standard of practice 26: Surveillance

#	Standard
S26.1	The insurer is only to conduct surveillance of the worker when: • there is evidence to indicate that the worker is exaggerating an aspect of the claim, providing misleading information or documents in relation to a claim, where the insurer reasonably believes that the claim is inconsistent with information or documents in the insurer's possession or that fraud is being committed; and • the insurer is satisfied that they cannot gather the information through less intrusive means ~~and that the benefit from obtaining the information outweighs the intrusion of the worker's privacy~~; and • the surveillance is likely to gather the information required. The insurer must document on the file the reason for the referral including what the purpose of the surveillance is and why surveillance is required to obtain the information.
	S26.1 needs to be re-worked to include: • *delete the words shown above.* • *The requirement of an insurer to not only document the reason for the referral (or the refusal of an employer's request for surveillance), but to provide the employer with a written notice of the decision and the reasons relied upon by the insurer to reach that decision.*

NSW Business Chamber

Standard of practice 32: Death claims

The phrase 'investigate the circumstances of death' without words of qualification is too wide, as it implies an insurer has the power to conduct workplace fatality investigations for which the that are currently (and properly) undertaken by the Police and SafeWork NSW who are resourced to undertake this type of investigation.

So S32.1 should be amended to be consistent with the text in the 'context' section of the standards.

#	Standard
S32.1	Once an insurer becomes aware of the death of a worker, ~~they~~ it must proactively investigate the circumstances of the death to determine whether or not the death is a work-related injury'. This includes deaths that occur months or years after the work-related injury.
S32.3	Insurers are to commence investigation and make appropriate contact with the worker's family or representatives and the employer immediately prior to the injury within 21 calendar days of becoming aware of the death. Insurers are to determine liability for death claims as soon as practicable. If an insurer is unable to make a decision within 21 days, they must document the reasons why, clearly identifying the additional information required and what steps have been taken to obtain the information.

S32.5	An insurer is required to advise the family or legal representative and the employer immediately prior to the injury as soon as a liability decision is made. This should be confirmed in writing within 2 days, such notice in writing must include the following information:
	• The statutory requirements:
	  ○ In all notices and in all circumstances – the requirements of sections 4, 9, 9A, 14 and 23 of the 1987 Act.
	  ○ If relevant to the circumstances - the requirements of sections 9AA, 9AB, 9AC, 9B, 10, 11, 11A, 12, 15, 16, 17, 18, 19, 20, 21, 22A, 22C and 24.
	• The evidence (relevant to the issue of liability) received from both the worker and the employer.
	• Both the decision reached and the reasons for reaching that decision (to be cross-referenced back to the relevant statutory requirements and the relevant evidence). If any evidence is rejected as not being relevant, that fact, together with the reasons why the evidence is not relevant should also be included.