IRO Inquiry report: Delay in determining liability - June 2021

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Executive summary

Analysis of data

Complaints by injured workers about delays by insurers in determining liability are consistently the most common complaint type received by the Workers Compensation Independent Review Office (WIRO).[1] In 2019/20, WIRO received 2,176 complaints from injured workers alleging delays by insurers in determining liability for claims of workers compensation, accounting for more than a quarter of all complaints (28 per cent).

We analysed 100 complaints about delays in determining liability received in 2019/20 and relating to weekly payments and/or medical expenses where WIRO recorded the statutory timeframes were not met by the insurer. The analysis included complaints about delayed decisions from all insurer types.

In almost half the complaints analysed (47 per cent) the insurer ultimately accepted liability for the claim. And in almost half the complaints analysed (48 per cent) the insurer's decision was more than one month outside statutory timeframes.

Where the insurer provided a reason for delay it was most commonly that the insurer was awaiting further information (39 per cent) such as medical reports, Medical Support Panel (MSP) considerations or pay information. Another common cause of delay was administrative error (22 per cent) including incorrect contact details and miscommunications. In over one third of matters (39 per cent) the insurer provided no reason for the delay.

In matters where the insurer was awaiting further information, a common resolution to the complaint was for the insurer to deny liability for medical or related treatment and to commit to undertaking a further review once the information was available. However, where a commitment to undertake a review does not take place in a timely manner, further complaints occur.

The impact of the delays in determining liability demonstrated by the complaints analysed included a negative effect on injured workers' physical, financial and psychological wellbeing. It can also disadvantage injured workers in medical claims that have a limited entitlement period.

Key findings

- common causes of complaints about delays in determining liability include deficient case management and poor communication
- insurers have identified both existing good practice and opportunities for improvement that would reduce these causes of complaint
- there are also opportunities to consider enhancements to the regulatory framework to reduce the causes of complaints about delays in determining liability
- there is no system-wide data to reliably quantify the scale of the issue of delay in determining liability
- complex claims such as surgery requests and novel treatments, where more information may be required, are more likely to take longer than the statutory timeframe to determine
- there are opportunities to improve how decisions in these matters are made
- the Independent Review Office (IRO) can increase information it provides about delay in determining liability complaints.

[1] From 1 March 2021, WIRO became the Office of the Independent Review Officer (IRO) – see Schedule 5 to the *Personal Injury Commission Act 2020*. This report is issued by the IRO as the successor to the WIRO.

Recommendations

Recommendation 1

This report be used as a resource to inform actions of the Nominal Insurer and its agents to respond to the recommendations of recent reviews, to illustrate the importance of good case management in reducing complaints by injured workers and the consequent adverse impact and cost they cause.

This report be used as a resource by other insurers to inform them of the causes of complaints about delays in determining liability and the opportunities to improve case management activities to reduce unnecessary complaints.

Recommendation 2

Insurers review their claims management systems and business processes:

- to establish whether they accurately record and can report on information about compliance with statutory timeframes when determining claims
- to rectify any deficiencies identified in the review as part of their programmed system and business process improvements.

Recommendation 3

The State Insurance Regulatory Authority (SIRA) consider the findings of this report and other relevant evidence, and explore opportunities to improve standards and guidance notes, including:

- opportunities to improve Standard of Practice 4 to provide for a timelier acknowledgement of requests, regular updates to injured workers where requests cannot be quickly determined and notification of decisions within the 21-day time frame provided for in section 279 of the *Workplace Injury Management and Workers Compensation Act 1998* (WIM Act)
- opportunities to improve GN 6.2 Surgery to outline additional information that surgeons should provide when recommending surgery, and to explore the development of a standard template for surgery requests which encompasses all relevant information requirements
- the opportunity to develop a standard or guidance note setting out the expectations of and benchmarks for insurers where they dispute liability for medical and other treatment claims in circumstances where further information is required.

Overview of report

An insurer's delay in determining whether to accept or dispute liability for an injured worker's compensation claim, or any aspect of that claim, can negatively impact the worker's physical, psychological and financial wellbeing. It also potentially defers access to dispute resolution and impacts on the efficient operation of the workers compensation scheme.

This report:

a. analyses the potential systemic causes of complaints about delays in determining liability made by injured workers to WIRO/IRO relating to medical expenses and weekly payments under sections 274 and 279 of the WIM Act.
b. provides recommendations to reduce the number of complaints relating to delay in determining liability and improve the overall efficiency of the workers compensation system.

Background

Under paragraph 27(c) of the WIM Act, WIRO had a statutory function to inquire into and report to the Minister on matters arising in connection with the operation of the Workers Compensation Acts. This function has transferred to the IRO[2] and is found in subclause 6(b) of Schedule 5 to the *Personal Injury Commission Act 2020* (Commission Act).

A complaint[3] about a delay in determining liability is one where an injured worker expresses dissatisfaction in the time taken by an insurer to either accept or deny liability for a claim for compensation.

Complaints about delays in determining liability are consistently the most common complaint type received by WIRO/IRO, accounting for over a quarter of all complaints. Table 1 shows that delay in determining liability has been the most frequent complaint type over the past three (3) financial years.[4]

Table 1: Top 3 number and type of complaints received by WIRO 2017/18 – 2019/20

	2019/20		**2018/19**		**2017/18**	
Complaint type	**No.**	**%**	**No.**	**%**	**No.**	**%**
Delay in determining liability	2,176	27.9	1427	30.4	852	27.6
Delay in payment for medical treatment expenses	1,660	21.3	517	11	410	13.3
Weekly Benefits	1,168	15.0	1290	27.5	681	22.1

[2] Clause 14I of Schedule 1 to the Personal Injury Commission Regulation 2020.
[3] A complaint is an expression of dissatisfaction or grievance made to WIRO/IRO about an insurer where a response or resolution is explicitly or implicitly expected. Sections 27 and 27A of the WIM Act provided that one of the functions of the Independent Review Officer is to deal with complaints about the acts or omissions of insurers that affect a worker's rights, entitlements or obligations under workers compensation legislation (this function is now provided for in clauses 6 and 8 of Schedule 5 to the Commission Act). Where an injured worker contacts WIRO/IRO to make a complaint about a new issue, a new complaint record is opened.
[4] Since 1 January 2019 WIRO/IRO has dealt with all complaints made by injured workers about the acts or omissions of insurers. Prior to 1 January 2019 this function was shared with SIRA. This is one reason for the increase in absolute numbers of all complaints, and the increase in complaints about delays in determining liability.

WIRO received 2,176 complaints about delays in determining liability during 2019/20.

The most common types of delays complained about are delays in determining claims for weekly payments or medical expenses in circumstances where liability to pay compensation as a result of an injury is not in issue. Instead, the complaint will be in respect of a claim for a specific medical expense or weekly payment where initial liability for injury has been accepted.

Under sections 274 and 279 of the WIM Act liability is required to be determined for weekly payments and medical treatment expenses within 21 days of the claim being made. There were 1404 complaints in 2019/20 (or 65 per cent of all complaints about delays in determining liability) about alleged failure by the insurer to determine claims for weekly payments or medical expenses within the required timeframe.

In 774 of the complaints (36 per cent of all complaints about delays in determining liability) the complaint of delay was considered as outside timeframes or substantiated. In other matters, WIRO was either unable to make an assessment (for example, because there was insufficient information available) or satisfied after dealing with the complaint that there was no delay in determining liability.

Methodology

We analysed 'delay in determining liability' complaints relating to weekly payments and/or medical expenses where WIRO recorded the statutory timeframes were not met by the insurer from 2019/20.

As noted above, there were 774 complaints where WIRO recorded that insurers were outside of the legislative timeframes for determining weekly payments or medical expenses claims. A consistent number of complaints that fell into this category were received across each quarter, as shown in Table 2.

Table 2: Number of complaints where insurer outside timeframes provided for in sections 274 and 279 WIM Act by quarter, 2019/20

Quarter 2019/20	**No. complaints**
Quarter 1 – (Jul -Sept)	184
Quarter 2 – (Oct – Dec)	185
Quarter 3 – (Jan – Mar)	202
Quarter 4 - (April – Jun)	203
Total	**774**

Complaints about delays in determining liability where WIRO did not determine whether the insurer was outside required timeframes were out of scope of the analysis.

Methodology for qualitative data analysis

100 complaints were analysed, representing 13 per cent of the total complaints within scope (774). A random sample of 25 complaints from each quarter of the year was analysed to identify commonalities or themes in the complaints.

Each complaint was qualitatively analysed using the following criteria:

- what is the insurer type (scheme agent, TMF, specialised insurer, self-insured)?
- what is the factual scenario?

- does the complaint relate to weekly payments (section 274) or medical expenses (section 279)?
- what were the reasons/explanation given for delay by insurer?
- how long outside 21 days was liability determined? The delay beyond the prescribed 21 days, was broken down into three (3) categories; delay of less than a month, delay of one (1) and two (2) months, and a delay of three months or more.
- what was the final outcome (liability accepted, denied or no decision made)?
- what was the impact of the delay on the injured worker (financial, psychological, physical)?

The data was then quality assured to ensure that all complaints in the sample were correctly categorised as delay in determining liability relating to medical expenses or weekly payments, where the insurer was found to be outside of required timeframes.

Consultation with insurers and system participants

We consulted insurers and system participants, including icare and SIRA, in January 2021. We provided the draft report and findings, with 5 targeted discussion questions for comment (see Appendix 1).

We received submissions from SIRA, EML, Hospitality Employers Mutual (HEM), Catholic Church Insurance (CCI), Coles and icare during February 2021.

Additional information was then requested from EML and icare in March 2021 to assist with understanding the scope of the issue and to understand the volume of claims with medical treatments that may require additional time to determine. This information was provided in April and May 2021.

We met with SIRA in June 2021 to discuss our findings and to canvass recommendations that may reduce unnecessary complaints about delays in determining liability.

Data limitations and the role of IRO information

We requested additional data from icare and EML to assess the proportion of medical treatment claims determined within time.

In its response to our draft report and findings, EML provided a response with regard to all New South Wales workers compensation claims managed on its proprietary claims systems.[5] EML stated that '*when we have reviewed the overall volumes of approvals completed, we do not believe there is a systemic issue in this area , albeit we agree there are opportunities to improve and enhance our approach*'. The data relied upon to support this includes that less than one (1) per cent of treatment and service requests result in a complaint (including WIRO enquiries) and that 99.96% of claims were identified in 21 days or less.[6]

icare provided data from the Guidewire platform[7] that indicated over 99 per cent compliance with medical treatment timeframes (that is, that a decision was made within legislated timeframes). icare advised that Guidewire does not disaggregate data such that compliance with legislated timeframes can be specifically assessed. Instead, what can be assessed is completion of the activity generated within the system within timeframes. Further, all data is subject to accurate recording/data input by case managers.

[5] which includes the claims operations for Hospitality Employers Mutual, Workers Insurance NSW, Insurance for NSW, and National Self Insurance (Woolworths).

[6] EML advised (letter of 9 February 2021) that between 1 July and 31 December 2020 56,577 documents about treatment and service requests were processed. 192 treatment related complaints/escalations were registered in the same period. EML state this '*indicates that 99.66% of treatment requests did not result in escalation for resolution*'.

[7] the Nominal Insurer Single Platform for claims primarily used by icare and EML for claims lodged on or after 4 February 2019

icare acknowledged that the system generated activities are reliant on case managers acting upon the alerts. As a proxy report, completion of the medical treatment approval activity does not guarantee that the necessary approval/decision has been sent to the requestor/worker.

Our review of the data provided by insurers for the purpose of this inquiry aligns with the findings in the McDougall review that there is a lack of appropriate data that would enable tracking of the time taken to approve medical treatment.[8] Only insurers have data on treatment approvals timeframes, and this data is not tracked or verified.

In a circumstance where there is lack of appropriate data available from insurers, the IRO's complaints data, case studies and other information provide a valuable and unique insight into the timeliness of decision making.

Given delay in determining liability is, year after year, the most common issue in complaints made to the IRO, and the information provided by the worker and the insurer in many matters validates the complaint, it is a serious issue that warrants close examination and ongoing attention to address the causes of any delays.

Results

Complaints by nature of claim

Eighty-five (85) of the 100 complaints analysed related to medical expenses (section 279 WIM Act). There were 12 complaints about weekly payments (section 274) and three (3) complaints that dealt with both medical expenses and weekly payments.

Complaints by insurer type

All insurer types were represented in the sample analysed and received complaints about delay in determining liability for medical expenses or weekly payments. The distribution of complaints aligns broadly with the number of employees covered by the each of the four insurer types in the NSW workers compensation system.[9]

Table 3: Number of 'delay in determining liability' complaints where insurers were outside of the legislative timeframes for sections 274 or 279 of the WIM Act by insurer type

	Scheme agent	Treasury Managed Fund (TMF)	Specialised insurer	Self-insurer	Total complaints (number/%)
Total (number/%)	63	17	11	9	100

Type of treatment being requested

The most common type of medical treatment claimed in the sample was surgery (identified in 24 complaints) followed by requests for psychological treatment which were in issue for 11 complaints.

[8] icare and State Insurance and Care Governance Act 2015 Independent Review, Hon Robert McDougall QC, Independent Reviewer, 30 April 2021,(McDougall review) Pg.49

[9] According to SIRA, the Nominal insurer accounted for 74 per cent of reported wages in 2018/19, Government self-insurer (TMF) 13 per cent, specialised insurers 6 per cent and self-insurers 7 per cent: https://www.sira.nsw.gov.au/__data/assets/pdf_file/0011/897779/workers-compensation-monthly-data-report-april-2020.pdf

There were also requests for other treatments including physiotherapy, scans, pain relief and special support equipment.

Outcome of complaint

Forty-seven (47) per cent of the complaints analysed resulted in the insurer accepting liability as an outcome of the complaint. A further 40 per cent resulted in a denial of liability by the insurer. There were 13 complaints where there was no decision recorded at the time the complaint was closed by WIRO.

Complaint outcomes were largely consistent across insurer types. The proportion of complaints accepted was lower (30 per cent) for complaints delayed three (3) months or more compared to complaints with a lesser delay, where over 50 per cent of claims were accepted.

Table 4: Outcome of claim and length of delay beyond 21 days

	Outcome			
Length of Delay beyond 21 days	**Accepted**	**Denied**	**No decision**	**Total length(number/%)**
Less than a month	27 (52%)	22 (42%)	3 (6%)	**52**
1 – 2 months	13 (54%)	9 (38%)	2 (8%)	**24**
3 months or more	7 (30%)	9 (37%)	8 (33%)	**24**
Total outcome (number/%)	47	40	13	**100**

Length of delay

The length of delay, beyond the statutory timeframe of 21 days, ranged from a few days to over three (3) months.

As set out in Table 4, the length of delay was categorised as less than a month for just over half (52) of all complaints analysed. There were 24 complaints each for both delays of one (1) and two (2) months, and delays of three (3) months and over.

Most complaints for all insurer types, except TMF, related to a delay of less than a month. There was also at least one outstanding claim of three (3) months or more beyond the required 21 days recorded for each insurer type. Almost half of all specialised insurer complaints related to complaints of three (3) months or more.

Table 5: Length of delay to determine complaints by insurer type

	Insurer Type				
Length of Delay beyond 21 days	**Scheme agent**	**TMF**	**Specialised insurer**	**Self-insurer**	**Total length (number/%)**
Less than a month	34 (54%)	6 (35%)	6 (55%)	6 (67%)	52
1 – 2 months	14 (22%)	8 (47%)	-	2 (22%)	24
3 months or more	15 (24%)	3 (18%)	5 (45%)	1 (11%)	24
Total insurer (number/%)	63	17	11	9	100

There were examples of injured workers waiting up to a month beyond the statutory timeframe for a decision about liability for medical treatment including hand surgery, knee imagery and pain management treatments. The injured workers only became aware of the issue and status of their claims once they contacted WIRO.

Case study 1

The injured worker sought approval for imaging for a knee injury in early March. After WIRO's enquiry the insurer advised that the treating doctor was running behind on reports. A decision to deny liability was provided a week late at the start of April.

Case study 2

The insurer received a claim for a spinal cord stimulator in late April and promptly sought clinical information from the treating doctor. The insurer received only part of requested information in early May and made a further request. The injured worker, through their solicitor, contacted WIRO in late May when a decision still had not been made. The insurer subsequently approved the claim in early June following WIRO enquiries. The insurer stated that they did not want to issue a decision notice earlier for the purpose of timeframes as they had received inadequate information.

There were 24 complaints where there was a delay of three (3) months or over. This means that in almost a quarter (24 per cent) of complaints analysed the injured worker waited at least four (4) times longer than the statutory time period of 21 days.

In following case study, the injured worker waited over three months for approval of pain management treatment.

Case study 3

The injured worker claimed medical treatment (a 3-month trial of CBD oil) for pain management related to an arm injury. The treating doctor (pain management specialist) sent a report and the claim to the insurer in November. The insurer requested a report from a Pharmacy specialist which was provided in mid-February. The injured worker contacted WIRO in mid-March, approximately one month after the insurer had received the specialist report. Two days after WIRO's inquiry to the insurer, the decision to accept liability was provided to the injured worker.

Also see case studies 7, 9 & 10 for examples of delays over three (3) months.

Reason for delay provided by insurer

Based on the complaints data collected, all liability decisions were categorised as delayed for one of three (3) reasons:

- **Information required** – the decision is not made due to the insurer awaiting outstanding information or medical reports
- **No reason provided** – no explanation for the delay provided by the insurer
- **Administrative error** – the insurer attributed the delay to an administrative oversight or error.

Table 6: Length of delay and reason for delay to determine complaints

	Reason for delay			
Length of Delay beyond 21 days	**Information required**	**No reason provided**	**Administrative error**	**Total length (number/%)**
Less than a month	18 (46%)	23 (59%)	11 (50%)	52
1 – 2 months	11 (28%)	7 (18%)	6 (27%)	24
3 months or more	10 (26%)	9 (23%)	5 (23%)	24
Total reason (number/%)	39	39	22	100

Information required

Insurers did not determine claims due to waiting on outstanding information or reports (‘**information required**’) in 39 per cent of cases. The documentation types required included medical reports from Independent Medical Examinations (IME) or Nominated Treating Doctors (NTD), or information from employers such as payslips to determine weekly payments. Outstanding information is not a valid reason for an insurer not to decide a request for medical treatment or weekly payments under sections 274 or 279 of WIMA.

An IME is a medical examination by a medical practitioner arranged for a worker by an employer or insurer to help resolve an issue in injury or claims management. All referrals for IMEs must be conducted in accordance with the Workers Compensation Guidelines issued by SIRA.[10]

SIRA also publishes a ‘Workers compensation guide for medical practitioners’[11] which outlines that a NTD should provide responses to requests within 10 working days.

Case study 4

The injured worker claimed a range of treatments for pain management, including radio frequency and acid injections, in August. The insurer requested an updated report from an IME the injured worker had previously attended almost immediately after receiving the claim. The insurer did not receive the IME report within 10 days and did not follow up with the doctor. The decision to deny liability was made in late September.

[10] https://www.sira.nsw.gov.au/__data/assets/pdf_file/0006/966120/Workers-Compensation-Guidelines-April-2020.pdf (pg. 27)

[11] A workers compensation guide for medical practitioners (nsw.gov.au)

No reason provided

Where there was no explanation for the delay provided by the insurer as part of the WIRO complaint, the matters were classified as '**no reason provided**'. In most cases a decision on liability was provided after the complaint was made and WIRO prompted the insurer to review the claim.

There was no explanation for the delay provided by the insurer as part of the WIRO complaint in 39 per cent of cases. This included delays in determining claims for pain management treatment, shoulder scans, back surgery and spinal fusion.

Case study 5

The injured worker contacted WIRO complaining that the insurer had not responded to a claim for spinal fusion surgery made in December. The insurer acknowledged that it was outside timeframes and that decision was due in early January. The insurer reviewed the claim as a result of the WIRO inquiry and approved the spinal fusion in mid-February.

In the following case studies, there was no evidence of communication initiated by insurer with injured worker or approved lawyer about delays in determining claim. This is despite reported attempts by the injured worker or approved lawyer to follow-up the insurer for a determination.

Case study 6

A claim for back surgery was made in late March. The injured worker attended an IME examination in May. No decision on liability was forthcoming despite numerous attempts to follow up by the injured worker's legal representative. A decision notice denying liability was issued in mid-August, over 3 months after it was due and four days after WIRO's inquiry.

Case study 7

The injured worker claimed for an MRI and CT scan of the shoulder in mid-February. The insurer did not determine the claim for two months, but promptly accepted liability in late April within two days of WIRO opening the complaint.

An examination of these matters suggests that, in addition to any unexplained delay, other common reasons such as the insurer waiting for additional information provide some explanation (see case study 6). However, this information and explanation was not provided to the injured worker.

In the case study below while the insurer did not provide a reason, the facts suggest that the delay was a result of the MSP recommending an IME before a liability decision was made. There was also no evidence of communication initiated by the insurer with the injured worker, despite multiple attempts by the injured worker and their treating doctor. This was also delay of over three (3) months or four (4) times the required timeframe.

Case study 8

The injured worker made the claim for neck surgery in August. Two weeks later the insurer referred the claim to its MSP, which recommended an IME. The injured worker attended the IME in late September. The IME report was provided to the insurer a month later, in late October. The insurer then provided the report to the MSP in early November, and the MSP provided a recommendation a month later in early December. The decision to deny liability was provided to the injured worker in late December, and only after the worker lodged a complaint with WIRO.

The insurer admitted that they were outside timeframes but did not offer an explanation or apology.

Administrative error

The remaining 22 per cent of complaints the insurer attributed the delay to an **administrative oversight or error**. Examples include having the wrong contact details, miscommunications or unreadable/corrupted documents.

Case study 9

An injured worker waited over 6 months for a decision about ankle surgery. The claim was lodged in August. The insurer cited confusion as to which of two concurrently open claims the claim belonged. The insurer declined the request after an inquiry from WIRO in late January. This case then proceeded for an ILARS funding grant.

In this case study there is no evidence of communication with the injured worker after receipt of claim and an assumption made the request belonged to another claim.

After prompting from WIRO, insurers sometimes progressed the claim by issuing a decision notice to decline liability as they did not yet have enough information to determine the claim. This is known as a 'soft decline'.

Case study 10

The injured worker sought cannabis oil for pain relief. The NTD requested approval in late July for an assessment to determine suitability for the use of medical cannabis. This request was overlooked by the insurer. After contact by WIRO in November the insurer agreed to expedite an urgent request to their MSP for review and consideration of the request for cannabis oil. The advice of the MSP was that the worker should attend an IME. Given the insurer was already delayed in making a decision, it issued a 'soft decline' for the treatment. The insurer undertook to further review the request once the IME report was received.

In case study 9, the insurer also used a soft decline as they were out of time but had not yet considered the claim.

Impact on injured workers

The analysis assumed that there was an administrative burden on all injured workers who complained to WIRO. Based on the information provided as part of the complaint an assessment was made whether there was likely to have been a physical, psychological or financial impact on the injured worker as a result of the delay.

Many of the complaints were made after the injured worker had already been waiting over a month for a decision. Delays without adequate explanation may reduce the trust between insurer and injured worker, which can be detrimental to future engagement around the claim, including for return to work, treatment and general claims management.

Delays in determining liability can also result in disputes escalating and the worker seeking resolution by the Workers Compensation Commission (or WCC, now the Personal Injury Commission (Commission)) in circumstances where, had a timely decision been made, no further action may have been required on the part of the worker.

Case study 11

An injured worker claimed reimbursement for the cost of an ergonomic bed (around $4000) in May. More than two months passed without a decision. The insurer then denied the claim after prompting from WIRO with no reason provided for the delay. The injured worker was referred to an Approved Lawyer who sought and ILARS grant of funding. The claim proceeded to WCC where it was accepted over 6 months after the claim was originally made

There was a physical impact on the injured worker identified in 76 per cent of complaints analysed due to the delay in obtaining medical treatment. As exemplified in the case studies above, delays in obtaining medical interventions such as surgery or pain treatment can cause or unnecessarily extend physical discomfort. The delay in psychological treatment was categorised as resulting in deleterious psychological impacts on injured workers in 16 per cent of cases.

Case study 12

*The injured worker was awaiting approval for surgery. They alleged that six different case managers had been allocated to their case. The injured worker was in considerable pain, on stress leave and seeing a psychologist. They were finding it difficult to cope at home and at work. After WIRO's inquiry, the surgery was approved. The insurer acknowledged that they were out of time but indicated that they were waiting on a supplementary report from the IME '*to ensure we had all of the required information before completing the approval.'

In 23 per cent of complaints analysed, the injured workers were identified as suffering financial impacts caused by waiting on a decision for weekly payments or reimbursements for medical treatment.

Discussion

Impact on efficiency and effectiveness of workers compensation system

'Providing prompt treatment of injuries … to assist injured workers and promote their return to work as soon as possible' is a key objective of the workplace injury management and workers compensation system.[12]

Delays in determining liability can undermine this legislative intention. In almost a quarter (24 per cent) of complaints analysed the injured worker waited approximately four (4) times longer than the statutory time period of 21 days for a decision.

Delays impact on an injured worker's physical, financial and/or psychological wellbeing.

Delayed treatment may also result in greater costs for the workers compensation system by both delaying return to work and contributing to a requirement for additional treatment that might not have otherwise been required. A decline in return to work rates has been identified as key issue with the scheme[13]. Reducing the delay in determining liability may help contribute to improvements in return to work rates across the system.

In addition, delays can contribute to a breakdown of the claimant/insurer relationship leading to potentially poor claims management outcomes and adversarial positions. Delays in determining

[12] paragraph 3(b), WIM Act

[13] SIRA, for example, has identified a trend of deteriorating RTW rates in NSW workers compensation in 2019 when compared with the same reporting periods in 2018, 2017 and 2016: https://www.sira.nsw.gov.au/consultations/measuring-return-to-work

liability can also result in disputes escalating unnecessarily, with workers requiring legal assistance and potentially seeking resolution by the Commission in circumstances where, had a timely decision been made, no further action may have been required on the part of the worker.

Impact on fairness of workers compensation system

Ensuing that liability decisions are determined within timeframes is important so that injured workers are not disadvantaged in medical claims where their entitlement period is limited. For example, section 59A of the *Workers Compensation Act 1987* provides for strict time limits on entitlements to medical treatment based on a worker's degree of whole person impairment and last receipt of weekly payments.

Where an injured worker claims but does not receive treatment during an entitlement period, they are not entitled to be compensated for that treatment. Where the insurer delays approval, an injured worker may miss out on treatment.[14]

Insurer case management

Good administrative practice

Effective case management is the bedrock of ensuring timely and effective decision making on claims. However, cases examined in the inquiry provide multiple examples of deficient case management. These included matters where:

- the insurer failed to act on the request at all
- the insurer failed to promptly request information, or failed to follow up requests relevant to deciding a claim
- the insurer failed to promptly act on information received or requested
- administrative errors (such as multiple claims) resulted in no action being taken
- claims were managed by multiple managers resulting in no decisions being made.

Feedback from insurers highlighted a range of systems and processes to promote good case management, including:

- daily reports, tasks and reminders, including effective use of these reports by leaders and managers
- the use of case conferences including workers and treatment providers
- regular follow-up with providers to obtain information requested.

Insurers also identified a range of potential improvements including:

- upskilling case managers on legislative obligations
- early discussions with injured workers where they may assist in obtaining any required information
- consistent operational processes across different claims management systems
- early escalation to team leaders or specialists where there are potential delays
- regular audits of claims to enhance feedback and identify systemic improvement opportunities.

Continuous improvement in case management practices will help to reduce unnecessary complaint and frustration.

The issue of inadequate case management and its impact on outcomes has been identified in relation to the Nominal Insurer in a number of reviews and reports, including:

[14] The operation of statutory entitlement periods for medical and related treatment and impact on injured workers is the focus on IRO's next inquiry.

- the December 2019 report of Janet Dore, *Independent reviewer report on the Nominal Insurer of the NSW workers compensation scheme* (Dore Report)
- the *Operational review of Insurance and Care and delivery of recommendations of the Dore Report*' published in March 2021 as an input to the McDougall review
- *Nominal Insurer claims file reviews* conduct by EY on behalf of SIRA[15]
- the McDougall review.

Good communication practice

Effective communication and customer engagement between injured workers and insurers are a central element of effective case management, and both promotes better outcomes for injured workers and prevents complaints and disputes, reducing costs to the system and impacts on injured workers and insurers alike.

Delays (actual or apparent) without adequate explanation may reduce the trust between insurer and injured worker, which can be detrimental to future engagement around the claim, including for return to work, treatment and general claims management.

Communication failures evidenced in this inquiry include circumstances where insurers:

- did not contact the worker at all after the request for treatment was made
- failed to respond to workers and their lawyers who were following up requests for treatment
- did not explain or apologise for delays in dealing with or determining requests for treatment.

Many of the cases analysed demonstrated the impact on injured workers when there was inadequate communication about claims they had made.

The Dore Report (at section 4.8) noted that the single most common issue raised in that review was communication. This issue was also reflected in observations from the McDougall review (for example, at section 8.3). Our inquiry suggests it is an issue for many insurers.

Insurers who responded to our preliminary report provided examples of good practice in communicating with workers, including:

- making contact with workers to update them when decisions are pending
- providing weekly updates where requests cannot be quickly determined
- engaging workers to assist with outstanding information requests.

Implementing these steps consistently would substantially address the communication concerns identified in our inquiry.

Complaints and learnings to inform good practice

The various recommendations made in these and other reviews of the Nominal Insurer and its agents – about matters such as investing in case manager skills and professional development – should have an impact on reducing complaints about delays in determining liability resulting from inadequate case management. Our recommendation focuses on use of information from this inquiry to inform these actions.

The review also demonstrates that opportunities for better case management is relevant to all insurers. Given this, there is value in sharing widely the learnings from these complaints and good case management practice recommended by and for insurers.

[15] https://www.sira.nsw.gov.au/__data/assets/pdf_file/0004/876568/EY-Report-Nominal-Insurer-2020-Quarter-1-claims-file-review.pdf

Recommendation 1

This report be used as a resource to inform actions of the Nominal Insurer and its agents to respond to the recommendations of recent reviews, to illustrate the importance of good case management in reducing complaints by injured workers, and the consequent adverse impact and cost they cause.

This report be used as a resource by other insurers to inform them of the causes of complaints about delays in determining liability and the opportunities to improve case management activities to reduce unnecessary complaints.

Communication standard

An important element informing good communication practice is the regulatory framework setting out expectations for insurers to communicate with injured workers. SIRA publishes Standards to hold insurers accountable for the delivery of a high standard of service to workers and their families, carers, employers and other system stakeholders.[16]

The SIRA Standard of Practice 4[17] deals with *Liability for medical or related treatment* and provides for expectations including:

- a request for medical or related treatment is to be acknowledged within 10 working days.

  However, 10 working days is more than half the 21-day decision-making time provided to insurers to determine a claim. It may not meet contemporary expectations for responsive service. It may cause unnecessary enquiries from and concerns on the part of an injured person. If a shorter time frame is required, and the worker is aware that their request will be promptly acknowledged, administrative failings (such as a request being overlooked) will likely be more quickly identified.

- advice about the outcomes and reasons for a decision is to be provided within 2 working days after the decision.

  However, where a decision is made on the 21st day, advice about the outcome may not be provided until up to 4 calendar days after the decision and outside the statutory timeframe for determining the claim. Such an outcome will inevitably lead to unnecessary enquiries from workers awaiting a decision on their claim

The findings in this report indicate that the expectations in Standard of Practice 4 may not be sufficient and point to possible improvements to acknowledge worker request more quickly, to provide regular updates where requests cannot be promptly decided, and to ensure decisions are notified within 21 days.

Data quality

One reason it has been hard to quantify the scale of the issue of delay in determining liability other than that it is the most common cause of complaint to the IRO, is that the data available from some insurers to assess this at best a proxy measure (see page 6, Data Limitations).

[16] A principal objective of SIRA in exercising its functions is to provide for the effective supervision of claims handling and disputes arising under NSW workers compensation legislation, in accordance with section 23 of the State Insurance and Care Governance Act 2015. The Standards of Practice: Expectations for insurer claims administration and conduct (Standards) together with the Workers Compensation Guidelines (Guidelines) set clear, consistent, accessible and enforceable expectations that will guide insurer conduct and claims management.
[17] https://www.sira.nsw.gov.au/workers-compensation-claims-guide/legislation-and-regulatory-instruments/other-instruments/standards-of-practice/s4.-liability-for-medical-or-related-treatment

Recommendations from a number of the reviews noted above reflect the essential priority of high-quality data. In our view, insurers should be able to provide information, with a high degree of certainty, that demonstrates their compliance with the timeliness requirements set in legislation for determining liability about medical and related treatment claims made by workers. Our recommendation addresses this expectation.

Recommendation 2

Insurers review their claims management systems and business processes:

- **to establish whether they accurately record and can report on information about compliance with statutory timeframes when determining claims**
- **to rectify any deficiencies identified in the review as part of their programmed system and business process improvements.**

Complex claims

As identified in the case studies there are situations where medical information is still pending when the 21-day timeframe to determine a claim has expired. This situation may occur even with proactive and client centric case management. There may be some claims which are complex and therefore difficult to decide within the 21-day timeframe.

Typically, these are claims for the cost of medical treatment or services that are not exempt under the Workers Compensation Guidelines from the requirement for insurer pre-approval (subsection 60(2A) *Workers Compensation Act 1987*).

For example, decisions to accept liability for surgeries may be complex. Surgery was the most common type of medical treatment claimed in the sample of delayed matters, identified in 24 complaints. Many of the most delayed matters are complaints related to claims for surgery. EML, icare, HEM, Coles and CCI all identified surgery requests as the type of medical treatments that may not be determined within timeframes.

Standardised surgery requests

SIRA has published guidance (GN 6.2 Surgery[18]) that outlines what insurers should consider when a request for surgery is received. It includes guidance on the information that the surgeon recommending the surgery should provide as follows:

- the reason surgery is required
- an outline of the conservative (non-surgical) management undertaken to date
- the expected outcome from surgery
- the name, item codes and costs for the surgery requested (including name and cost of any prosthesis required)
- whether a surgical assistant is required.

GN 6.2 also requires the insurer to clarify the:

- anticipated period of stay in hospital
- time of total incapacity expected
- treatment required after surgery
- anticipated progress after surgery.

[18] https://www.sira.nsw.gov.au/workers-compensation-claims-guide/insurer-guidance/medical-and-related-services/surgery

Further, GN 6.2 specifies that the insurer should liaise with the surgeon or NTD if they have question about the proposed surgery and approval of surgery is not to be delayed while obtaining this information.

Based on our finding, approvals for surgeries are being delayed where insurers require outstanding medical information.

CCI's submission suggested the development of a standardised template for surgery requests. They noted that this would '*significantly speed up timeframes for making a liability decision if insurers received all required information at the time of the initial request*'.

Consideration of a form or template that formalises the information required by insurers to make an informed decision may reduce the time taken to assess surgery requests, and the work required to collate and consider all the necessary information. It may also reduce matters where liability is disputed on the basis that the insurer does not have sufficient information to properly determine the claim.

In this respect, other information that insurers may require to determine a surgery request and that may be appropriate to specify (either in GN 6.2 or in a template request) includes:

- confirmation of diagnosis and whether this is related to the workplace injury or pre-existing condition
- provision of clinic letters completed after consultations and copies of diagnostic reports received
- a post-surgery protocol.

The Parkes Project, conducted by WIRO under its inquiry function, was not completed, but substantial progress was made towards formulating improvements to the workers compensation system. Various Discussion Papers were produced. The Medical and Treatment Expenses Discussion Paper recommended a standardised Request for Medical Treatment form '*would assist in reducing the time spent in obtaining necessary information from treating doctors and the confusion and anxiety around the approval process*'[19]. This CCI submission aligns with this recommendation.

Other complex treatments

Feedback from insurers identified the types of medical treatments other than surgery requests that may not be determined within timeframes. Alternative, experimental medical treatments or high-risk treatments are often complex and may be time consuming to determine.

Examples of the types of medical treatments that may not be determined within timeframes identified by insurers include:

- medicinal cannabis
- spinal cord stimulators
- pain management treatment
- new and emergent treatments e.g. stem cell therapies
- multiple procedures and equipment included in a single treatment request.

In these matters some insurers seek the advice of their MSP and/or an IME before determining the claims. For example, icare advised that new and novel treatments account for approximately 10 per cent of all referrals made to their MSP.

In any matter where an IME is requested, it must be conducted in accordance with the Workers Compensation Guidelines. Under the Guidelines a worker must be advised in writing at least 10 working days before the IME is scheduled to take place. Compliance with this important procedural

[19] Parkes Project, *Discussion Paper – Medical and Treatment Expenses*; page 8

safeguard in a matter where an IME is deemed necessary by the insurer, will almost inevitably result in the request not being fully considered within 21 days.

Disputing liability where further information is required

In a number of cases reviewed in this inquiry, insurers resolve a complaint by an injured worker about a delay in determining a claim by disputing liability, with the reasons evidencing that not all the required information was available to inform the insurer's decision. This was most common in respect of complex claims. These decisions:

- are in the form of a notice under section 78 of the WIM Act
- state that the insurer is disputing liability for the medical or related treatment
- set out, in the reasons for decision, why the information available is insufficient to demonstrate the requested treatment is reasonably necessary
- provide information about the additional information that will be obtained
- advise that a further review of liability will be undertaken once the additional information is obtained and assessed
- provide information about how to seek a review of the insurer's decision.

Referred to as a 'soft decline', this approach may achieve compliance (or reduce the period of non-compliance) with legislated timeframes.

Making a decision to meet timeframes (or reduce any period of non-compliance) in circumstances where the insurer is awaiting or needing to seek further information ensures an injured worker has a decision and can promptly exercise their review rights. By receiving a dispute notice, the worker can also assess the insurer's reasoning.

In our experience, workers often will not dispute these decisions and instead actively work with the insurer to obtain the required information. Their expectation is that the insurer will act promptly to gather and assess the additional information and review the liability decision.

There is a real question, however, about whether disputing liability for medical and related treatment claims because further information is required, only to ensure legislated timeframes are met, promotes the objectives of the scheme or represents value for money. Instead of ensuring effort directed at treatment and rehabilitation, the worker (including through a scheme-funded lawyer) and insurer may become engaged in a formal dispute resolution process. Where this occurs, the dispute resolution process can become an expensive and time-consuming proxy for effective case management.

In addition, with such decisions, there is no obligation on the insurer to initiate a timely (or any) review of the decision to dispute liability of the claim after additional information is received. Consequently, there may be additional complaints, disputes or concerns where insurers do not act promptly to collect and consider additional information or simply do not review their decision unless requested to do so, including through the worker requesting an internal review by the insurer or referring the dispute for determination by the Commission.

Feedback from insurers to this inquiry about circumstances where liability is disputed because further information is required includes:

- the use of this approach is generally not preferred or is actively discouraged
- it does, however, allow time for further investigation or the gathering of required information to determine a claim
- it can be an effective tool, if communicated clearly to the worker, as a short-term decision pending further investigations.

Good insurer practice when disputing liability where further information is required

Given:

- the current legislated requirement for insurers to determine a claim within 21 days after it is made, and
- that it is inevitable for some complex, novel or high cost treatments, that more than 21 days will be required for the insurer to make a fully informed decision about whether the treatment is reasonably necessary

we expect insurers will continue to make decisions to dispute liability in some circumstances where additional information is required.

Our view is that, in circumstances where the required information genuinely cannot be marshalled and assessed within 21 days, an approach where the insurer makes a decision to dispute liability and also commits to undertaking a further review once the information is available ensures compliance with the law and strikes a reasonable balance between the rights and interests of the worker and insurer. This is subject to the insurer acting promptly and diligently to collect outstanding information and to make a fresh decision.

There is currently no specific acknowledgment of or guidance for these types of decisions in the regulatory framework. Our view is that there is value in setting out what is expected of insurers when they dispute liability for medical and related treatment claims because further information is required. Having a standard approach helps injured workers as well as insurers. As noted by Coles in their response to our inquiry:

> *'when communications appropriately explain the reason for delay, next steps and timeframes, there are generally better outcomes for the team member*'.

The development of guidance may promote good practice in case management, provide increased accountability and transparency and reduce complaints and legal actions. If developed, important considerations will include that the guidance

- would align with SIRA Standard of Practice 4, and the expectation that, when determining liability for medical or related treatment, insurers are to obtain and consider all relevant information, consult with the worker and relevant parties as required, and make a decision at the earliest possible opportunity
- in addition to other notice requirements, would address matters relevant to circumstances where the insurer is seeking more information and committing to a further review of the request such as:
  - specifying the additional information being requested
  - outlining the steps and providing a timeframe for the further review
  - regularly communicating with the injured worker about the further review
  - providing a fresh notice of decision about the request at the completion of the review.

Opportunities to enhance insurer guidance

We have discussed the findings of this report with SIRA. That discussion reinforced both the importance of evidence-led policy development, and the value of IRO data in contributing to the evidence base.

As a consequence, we will recommend SIRA consider the findings of this report and other relevant evidence, to explore opportunities to improve standards and guidance notes relevant to timely decision-making about requests. These include:

- opportunities to improve how requests are acknowledged and workers kept informed
- opportunities to improve the information provided at the time a surgery request is made

- opportunities to provide a clear framework for handling requests where insurers dispute liability in circumstances where further information is required.

In making this recommendation, we note the importance of consultation with insurers, injured workers and their representatives and others (including the IRO) to develop the most effective and appropriate solutions; hence we have not sought to be prescriptive. In addition, there may be additional relevant evidence that informs the best regulatory interventions; keeping an open mind about this will facilitate the most appropriate response.

Recommendation 3

SIRA consider the findings of this report and other relevant evidence, and explore opportunities to improve standards and guidance notes, including:

- **opportunities to improve Standard of Practice 4 to provide for a timelier acknowledgement of requests, regular updates to injured workers where requests cannot be quickly determined and notification of decisions within the 21-day time frame provided for in section 279 of the WIM Act**
- **opportunities to improve *GN 6.2 Surgery* to outline additional information that surgeons should provide when recommending surgery, and to explore the development of a standard template for surgery requests which encompasses all relevant information requirements**
- **the opportunity to develop a standard or guidance note setting out the expectations of and benchmarks for insurers where they dispute liability for medical and other treatment claims in circumstances where further information is required.**

Possible alternative approach to extend decision-making timeframes

It is not uncommon for some legislative schemes to provide for extensions of time to consider complex matters. For example, section 57 of the *Government Information (Public Access) Act 2009* provides for an extended period (up to 15 days) for an agency to decide and access application where records are required to be retrieved from archives or consultation is required.

Allowing for an extension of time in certain limited matters where it may not be realistic to expect a properly informed decision to be made within 21 days (such as some complex treatments noted above) may provide both increased certainty and fairness to both workers and insurers.

HEM noted that the potential benefits of 'an alternative approach when additional information is needed, has the potential to improve the customer experience and reduce premature complaints and litigation'.

A possible regime could include:

- clear specification (in regulations) of the types of matters where an extension of time may be appropriate
- clear specification of the permissible reasons to extend time (for example, to obtain a medical report or other specified information)
- a cap on the maximum time permitted to make a decision
- a requirement for the insurer to communicate to the injured worker about matters such as the information required and the expected additional time
- a right for the injured worker to dispute the extension of time or seek a decision on the request
- regular reporting to the regulator on use of the extension of time provision.

While this may support a more flexible approach to dealing with complex treatment claims, there are risks with any legislated timeframe extension. Extending timeframes may just delay the problem,

rather than resolve it and not result in more efficient decision making. Further, determining the medical treatments to allow extra time for and keeping the list contemporary would likely be a complex and resource intensive exercise.

At this time, our view is that incremental improvements – to case management, communication and the handling of matters where additional information is required before a decision is made – may substantially address the most common causes of complaints about delays in determining liability. In addition, better data would provide a more informed assessment of the size of any remaining systemic problem.

However, if these actions do not have the effect of reducing unnecessary complaints, further consideration could be given to legislative reform which would permit types of treatment to be specified where an extension of time for an insurer to determine a request is permissible. Any such reform would require careful consideration so as not to disadvantage workers, address any flow-on consequences (for example, to entitlement periods) and promote the objectives of the legislation.

Monitoring compliance with legislated timeframes and data sharing

The IRO complaint data set is essential in identifying areas for continuous improvement in the scheme. As noted in the McDougall review there is a lack of appropriate data that would enable tracking of the time taken to approve medical treatment. Only insurers have data on treatment approvals timeframes which is not tracked or verified. SIRA does not collect any direct data on delays in treatment approvals.

We have made a recommendation that insurers consider how improvements can be made to data quality relevant to assessing the issue of delay in determining liability.

As part of previous regular engagement between SIRA and WIRO, particular cases where there has been a significant or high impact delay in determining liability by an insurer have been raised and discussed. However, the WIRO did not routinely exchange information with SIRA about complaints where the assessment is that a decision in respect of liability is delayed.

With the establishment of the IRO, SIRA and the IRO are currently finalising an information-sharing agreement enabled by Schedule 5 to the Commission Act. This will allow a more structured and regular exchange of information between the IRO and SIRA. This includes information regarding regulatory non-compliance, which may assist SIRA to target future compliance activities.

There is also an opportunity for the IRO to share data more regularly with insurers to promote continuous improvement. Coles suggested in their submission that quarterly reporting of complaints data would be beneficial. icare suggested monthly reporting of IRO complaints trends to better understand root cause and analysis.

The IRO is currently working on a Data and Insights Strategy to improve how we collect, analyse and disseminate IRO data to increase our impact in improving statutory compensation schemes. This includes finding better ways to share data with system participants about our work.

While these are not matters where it is necessary for recommendations to be made, the IRO will monitor these actions consistent with the intent of this inquiry to reduce complaints about delays in determining liability.

Appendix 1 – Discussion questions

WIRO consulted with the following organisations:

SIRA	Self-Insurers Association
EML	StateCover
icare	Hospitality Employers Mutual
Coles	Catholic Churches Insurance Limited
Transport New South Wales	Unions NSW
Shoalhaven City Council	CFMEU NSW
Woolworths	NSW Law Society

WIRO posed the following discussion questions to further understand opportunities to reduce the number of complaints relating to delay in determining liability and to improve the efficiency of the workers compensation scheme.

Question 1: What systems and processes do insurers have for making timely liability decisions on claims for weekly payments and treatment expenses? For example:

What business processes are in place to guide and monitor decision-making in respect of claims after their receipt by the insurer, to ensure legislated timeframes are met?

What business processes to escalate matters to more senior team members where there is a risk that a decision will not be made in legislated timeframes?

How does the insurer regularly review business processes to identify and address any systemic causes of delay to decision-making?

What improvements could be made to these processes?

Question 2: How do insurers currently keep workers informed about the progress of claims? What are the additional steps insurers could take to communicate with workers where a delay to decision-making is encountered?

Question 3: What approach (systems and processes) do insurers take for handling claims they may need to decline due to insufficient information? What opportunities are there to improve these processes to both promote timely decision-making and reduce dissatisfaction or complaints from workers?

Question 4: What are the types of medical treatments that may not be determined within timeframes? Does the current legislation provide enough flexibility for determining these claims? What would be the benefits and risks of providing for an extension of time for insurers to decide whether to pay for specified treatments?

Question 5: What are the opportunities for WIRO and SIRA to improve data exchange about complaints of delays in determining liability?