IRO Issues Paper: Practical Issues Arising from the Operation of Section 59A *Workers Compensation Act 1987* - October 2021

Contents

Background

The IRO commenced an Inquiry into the practical issues arising from the operation of section 59A of the *Workers Compensation Act 1987* (1987 Act) during the first half of 2021. The focus of the Inquiry is current issues impacting the fairness of thresholds for treatment compensation.

As part of the Inquiry, the IRO has developed this Issues Paper outlining the matters of concern and seeking views about possible solutions.

Prior to the release of the Issues Paper, the NSW Government announced in August 2021 that a consultation in response to recommendations of the Hon Robert McDougall QC in the *icare and State Insurance and Care Governance Act 2015 Independent Review* (McDougall Review) and the NSW Parliament Standing Committee on Law and Justice in the *2020 Review of the Workers Compensation Scheme* (SCLJ Review) would be conducted by State Insurance and Regulatory Authority (SIRA).

Given the timing and overlap between the IRO's Inquiry and matters the subject of SIRA's proposed consultation, the IRO requested that the Inquiry issues be referred to SIRA to consider in its consultation, rather than conducting a separate consultation, planned to occur during September and October 2021.

The Inquiry issues have now been incorporated into SIRA's *Public consultation: McDougall Review recommendations, COVID-19 and future opportunities for personal injury schemes consultation* (SIRA McDougall consultation) at section 8.2. This Issues Paper, modified to most effectively compliment the SIRA McDougall Consultation, provides a full context to assist in understanding the scope of the issues, evidence to demonstrate our concerns, and possible solutions that might be considered.

The IRO has offered to continue to work with SIRA to consider any feedback on the issues raised.

Feedback

Feedback on this Issues Paper can be provided to SIRA as part of the SIRA McDougall consultation. The consultation will be open from 5 October 2021 to 1 November 2021. You can provide your views by:

- visiting the SIRA website www.sira.nsw.gov.au
- visiting the NSW Government Have Your Say website www.nsw.gov.au/have-your-say
- emailing Policy&Design@sira.nsw.gov.au

SIRA may publish submissions on its website unless accompanied by a request for confidentiality.

You may also send feedback directly to the IRO, either in addition to SIRA (as a copy of your submission) or directly to us, at feedback@iro.nsw.gov.au. We will consider any feedback we receive and provide SIRA our additional views to inform its advice to Government.

Purpose of Issues Paper

Under clause 6(b) of Schedule 5 to the *Personal Injury Commission Act 2020* (PIC Act) the Independent Review Officer (the Officer) has a statutory function to inquire into and report tothe Minister on matters arising in connection with the operation of enabling legislation (including the Workers Compensation Acts) as the Officer considers appropriate.

The Officer has determined that a suitable subject of inquiry is the application of section 59A of the 1987 Act, which provides for limits on the payment ofcompensation for medical, hospital and rehabilitation expenses.

The focus of the inquiry is the fairness of the following matters:

- circumstances where a worker claims treatment, a service or assistance (hereinafter calledtreatment) during the compensation period[1] that is not given or provided during the compensation period (hereinafter called 'treatment claimed but not received')

- circumstances where, prior to proposed treatment the compensation period for the workerhas expired, but as a result of the treatment the worker will be unable to work entitling them to weekly payments of compensation, and therefore reviving a limited entitlement totreatment compensation (hereinafter called 'revival of treatment compensation').

This Issues Paper outlines these issues for consideration by scheme participants on possible solutions and any other issues arising.

Scope

The scope of this Issues Paper is limited to two issues: treatment claimed but not received; and revival of treatment compensation.

There are a range of other important concerns that have been raised about limits of payment of compensation to injured workers, focused on matters such as the use of permanent impairment thresholds as a gateway to access treatment compensation, and more generally about the use of expiry periods.

A summary of these concerns is included at **Appendix A**. That they are not examined is not to diminish their significance.

Methodology

In preparing this Issues Paper the following have been considered:

[1] Compensation period is defined in section 59A(2), 1987 Act

- complaints made to the IRO
- grants made under the IRO's Independent Legal Assistance and Review Service (ILARS)
- the history of section 59A of the 1987 Act, relevant legislative reviews and case law
- IRO data and data provided by icare.

Section 59A 1987 Act

Legislative provisions dealing with the entitlement to treatment compensation have been the subject of substantial change since 2012. **Appendix B** provides a summary of relevant changes.

Part 3, Division 3 of the 1987 Act currently provides for compensation for medical, hospital and rehabilitation expenses, and section 59A provides for time limits for this compensation:

> ***59A Limit on payment of compensation***
>
> *(1) Compensation is not payable to an injured worker under this Division in respect of any treatment, service or assistance given or provided after the expiry of the compensation period in respect of the injured worker.*
>
> *(2) The compensation period in respect of an injured worker is—*
>
> *(a) if the injury has resulted in a degree of permanent impairment assessed … to be 10% or less, or the degree of permanent impairment has not been assessed …, the period of two-years commencing on—*
>
> *(i) the day on which the claim for compensation in respect of the injury was first made (if weekly payments of compensation are not or have not been paid or payable to the worker), or*
>
> *(ii) the day on which weekly payments of compensation cease to be payable to the worker (if weekly payments of compensation are or have been paid or payable to the worker), or*
>
> *(b) if the injury has resulted in a degree of permanent impairment assessed … to be more than 10% but not more than 20%, the period of five-years commencing on—*
>
> *(i) the day on which the claim for compensation in respect of the injury was first made (if weekly payments of compensation are not or have not been paid or*
>
> *(ii) the day on which weekly payments of compensation cease to be payable to the worker (if weekly payments of compensation are or have been paid or payable to the worker).*

(3) If weekly payments of compensation become payable to a worker after compensation under this Division ceases to be payable to the worker, compensation under this Division is once again payable to the worker but only in respect of any treatment, service or assistance given or provided during a period in respect of which weekly payments are payable to the worker.

(4) For the avoidance of doubt, weekly payments of compensation are payable to a worker for the purposes of this section only while the worker satisfies the requirement of incapacity for work and all other requirements of Division 2 that the worker must satisfy in order to be entitled to weekly payments of compensation.

(5) This section does not apply to a worker with high needs (as defined in Division 2).

(6) This section does not apply to compensation in respect of any of the following kinds of medical or related treatment—

(a) the provision of crutches, artificial members, eyes or teeth and other artificial aids or spectacles (including hearing aids and hearing aid batteries),

(b) the modification of a worker's home or vehicle,

(c) secondary surgery.

Other than in respect of some limited circumstances (such a treatment provided within the first 48 hours of the injury happening), the insurer is not liable to pay the cost of treatment given or provided without prior approval – see section 60 of the 1987 Act.

The compensation periods provided for in section 59A run from one of two dates:

- either 2 or 5 years (depending on an assessment of the worker's permanent impairment,if any) commencing on the day on which the claim for compensation was first made if weekly payments have not been paid to the injured worker

OR

- either 2 or 5 years (depending on an assessment of the worker's permanent impairment, if any) commencing on the day on which weekly payments of compensation cease to be payable to the worker, in circumstances where weekly payments have been made.

Because time limits for treatment in section 59A are tied to the last date of weekly payments (if weekly payments were made), much turns on whether and when an injured worker has taken time off work due to incapacity caused by the injury. The IRO receives many complaints and enquiries from workers concerned by the forthcoming cessation of payment for treatment expenses. The IRO is often able to assist workers by discovering after enquiries with insurers that a period of relevant weekly payments has been made. The compensation period for treatment expenses is thereby extended.

Case study 1

The injured worker contacted WIRO[2] in December 2020 and reported that the insurer had advised their compensation period would end in November 2020. A treatment request had also been provided by the worker's treating practitioner to the insurer and no response had been received before the expiry of the compensation period. The worker was concerned the insurer may not pay for the required treatment.

WIRO established that the worker had been certified unfit for work as a result of the injury in early November, shortly before their compensation period for treatment was to expire. WIRO sought information from the insurer to establish whether it had made a decision about weekly benefits as a result of the worker's incapacity. The insurer responded that a decision had been made to accept liability for weekly payments and as a consequence the compensation period for treatment would not expire. WIRO explained the effect of the insurer's response, and the additional period of entitlement to treatment compensation, to the worker.

Similarly, decisions of the Workers Compensation Commission, now the Personal Injury Commission (Commission), such as that of *Kolovos - Rutledge v Eureka Operations Pty Ltd t/as Coles* [2020] NSWWCC 358, demonstrate the importance of a worker's capacity and entitlement to weekly compensation; a brief summary is set out below:

The worker sustained an ankle injury in January 2018 but was able to continue working normal hours of work with restrictions.

In April 2019 the insurer issued a dispute notice asserting the effect of the injury had ceased. In January 2020, the insurer issued a further dispute notice declining liability to pay ongoing medical and related treatment expenses claiming the treatment compensation period had expired under section 59A.

Shortly before the expiry of the treatment compensation period, the worker underwent a full-day procedure to treat the ankle.

In March 2020 the worker's orthopaedic surgeon requested approval for surgery to the ankle. The insurer disputed liability for the surgery.

After examining the medical and other evidence the Commission determined that the full-day procedure to treat the ankle in January 2020 was reasonably necessary as a result of the work injury. This resulted in the worker being entitled to weekly payments of compensation for the period of incapacity (the day of the procedure). As a consequence, the worker was not disentitled by section 59A. The Commission also determined that the additional surgery requested by the worker's orthopaedic surgeon was reasonably

[2] From 1 March 2021 the Workers Compensation Independent Review Office (WIRO) became the IRO – see Schedule 5, PIC Act

necessary, and that the insurer should pay the costs of the surgery.

Issue 1 – Treatment Claimed But Not Received

Section 59A provides that treatment must be "*given or provided*" within the compensation period; it is not enough that the treatment has been claimed, that the insurer has pre- approved the treatment or even that the Commission has decided that the treatment is reasonably necessary.

The requirement that the treatment must actually be given or provided within the compensation period, rather than only that the treatment must be claimed and/or approved can result in arbitrary and potentially unfair outcomes.

The reason for this is that there are a range of reasons why receiving treatment may be delayed, all beyond the control of the worker, including:

- there may be a delay by the insurer in approving the treatment claimed
- other events may intervene that impact on access to treatment.

Delays in Determining Liability

Under section 279 of the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act) liability is required to be determined for medical treatment expenses within 21 days of the claim being made.

Complaints by injured workers about delays by insurers in determining liability are consistently the most common complaint type received by the IRO, with more than 2271 complaints (28 per cent of all workers compensation complaints) raising this issue in 2020-21. Given this, the IRO has recently inquired into the causes of these complaints; the Executive Summary of the inquiry report is attached at **Appendix C**.

The report notes that delays in insurer decisions occur for a range of reasons, including where the information necessary to make a decision is not available to the insurer or there are administrative failings in dealing with requests for treatment. Sometimes, no reasons are provided.

In these types of matters, through events most often beyond the control of the injured worker,an entitlement to treatment compensation may be lost or compromised, even though the claim is made in a timely manner; see case study 2.

Case study 2

In October 2020 (6 months prior to the end of the compensation period) the worker claimed 6 sessions of chiropractic treatment over 6 months. In March 2021 the worker contacted the IRO to complain that they had not received a response. The worker was aware that their compensation period would end in April 2021, and they were concerned the delay unfairly affected their ability to

access treatment. After IRO inquiries, the insurer acknowledged they took an extended period to approve the treatment and approved six sessions of chiropractic treatment. As the worker's compensation period ended in April 2021, the insurer asked that the request be amended to 1-2 sessions a week over 4 weeks.

Following further IRO inquiries, the insurer advised they may, as a gesture of good will, pay for treatment for, at most, a further 4 weeks beyond the expiry of the compensation period.

Decisions can also be delayed where an insurer disputes liability for a treatment request, for example on the basis the treatment is not reasonably necessary. Internal review and dispute resolution before the Commission takes time – see for example *Hedges v Executive Director of Catholic Schools* [2017] NSWWCC 78 summarised below.

Even where the eventual decision is in favour of the injured worker, if the treatment is not given or provided within the compensation period, there is no legal recourse under the 1987 Act for the worker to be compensated for the cost of the treatment; see *Air Electrical Pty Ltd t/as DJ Staniforth and Co v Mortimer* [2015] NSWWCCPD 18 at paragraph 21 and *Peter Johnstone v Tammy Schmetzer* [2020] NSWWCC 78 at 99.

Intervening Events

Events that impact substantial parts of the community can affect a worker's ability to be given or provided with treatment within the prescribed timeframes.

Most recently, an impact of the COVID-19 pandemic has been that some non-urgent medical treatments were unavailable for weeks and months.

The operation of section 59A meant that, in circumstances beyond the control of the worker,their treatment was compromised as their entitlement to treatment compensation expired, and the treatment was not given or provided in the compensation period.

Case study 3 – worker's surgery delayed

An injured worker contacted WIRO in July 2020 and advised that payment of their medical expenses would expire in early September 2020. The worker required ankle surgery which had been delayed as a result of elective surgery cancellations caused by COVID-19. The worker enquired whether an extension was possible if the surgery could not be provided before the expiry of the compensation period.

WIRO advised that the legislation did not provide for such an extension. WIRO recommended the worker endeavour to have surgery performed before the expiry of the compensation period.

Case study 4 – worker unable to attend treatment

An injured worker was unable to access exercise physiology treatment at the gym for four months due to COVID-19 business closures. The worker had been advised that their entitlements to medical expenses would cease in November 2020 pursuant to section 59A, and they had unsuccessfully sought a 4-month extension of this period. The insurer had advised the worker to obtain assistance via telehealth services.

WIRO explained the worker's entitlements to medical treatment based on the assessment of their level of permanent impairment and the option of seeking legal advice from an Approved Lawyer. WIRO recommended the worker contact the exercise physiologist urgently to discuss alternative treatments and exercising at home.

Case study 5

An injured worker complained to the IRO that their entitlement to payment of medical expenses was due to expire soon and they requested a 3-month extension of the time limit to allow further physiotherapy and gym sessions to assist rehabilitation of their knee. The worker explained that COVID-19 had severely impacted their rehabilitation in 2020 due to the extended closure of gyms and their inability to attend in-person exercise physiology sessions.

WIRO explained that the legislation does not allow for an extension and insurers are under no obligation to consider one. WIRO recommended that the worker apply for a specific number of physiotherapy sessions before expiry of the compensation period to be utilised after the expiry date and explain to the insurer the adverse effects of the COVID restrictions.

Insurers' Acts to Reduce Adverse Impact of Compensation Periods

Insurers sometimes take steps to mitigate the impact of the compensation period imposed by section 59A, including by fast-tracking decisions about liability (see case study 6 below) or allowing additional time beyond the compensation period where liability will be accepted for treatment to be given or provided (see case study 2 above). The IRO view is that insurers should consider taking these steps where their own actions have contributed to the worker's concern – such as where decision making is delayed or information about expiry dates wrongly communicated.

Case study 6

The worker was originally advised by the insurer that their compensation period would end in November 2020. In October 2019 the insurer advised that the correct date was November 2019. The worker's doctor requested an injection

treatment in late October 2019, and the worker was concerned the compensation period would expire before a decision was made and the treatment given. WIRO contacted the insurer who fast-tracked the decision and approved the treatment on the same day the request was received.

Issue 2 – Revival of Treatment Compensation; Subsection 59A (3)

Subsection 59A (3) of the 1987 Act deals with the circumstance where a worker whose compensation period has expired under subsections 59A (1) and (2), becomes eligible for weekly payments, resulting in a revival of a limited entitlement to treatment compensation:

> *(3) If weekly payments of compensation become payable to a worker after compensation under this Division ceases to be payable to the worker, compensation under this Division is once again payable to the worker but only in respect of any treatment, service or assistance given or provided during a period in respect of which weekly payments are payable to the worker.*

How is Treatment Compensation Revived?

In the case of *Flying Solo Properties Pty Ltd t/as Artee Signs v Collet* [2015] NSWWCCPD 14 (*Flying Solo*) Roche DP provided a useful explanation of how subsection 59A (3) operates. The legislation has been amended since this decision, but the reasoning remains relevant. A summary of the case and key principles is set out below:

> A worker injured his cervical spine in the course of his employment and as a result needed to have surgery. The worker had not received weekly payments for a substantial time since the injury. The insurer applied section 59A and decided it had no liability for the cost of the surgery.
>
> The Commission observed that a worker will cease to be entitled to weekly compensation if, having previously been entitled to such compensation, their right to receive actual weekly compensation comes to an end. That can occur because of the application of the legislation or because the worker has recovered from the effects of the injury. Section 59A is concerned with an actual entitlement to receive weekly compensation, not with whether the "entitlement periods" as defined in the 1987 Act have expired. That is so, even though the right to receive actual weekly compensationmay revive at a later time, which is dealt with in subsection 59A (3).
>
> If by operation of subsection 59A (1) and (2), a worker has ceased to be entitled to treatment compensation, their right to such compensation is revived during a period when weekly compensation is again payable by operation of subsection 59A (3). The compensation period is limited to any treatment, service or assistance given or provided during the period when weekly compensation is payable to the worker.
>
> Section 59A (4) clarifies that weekly payments of compensation are payable to a worker for the purposes of the section only while the worker satisfies the requirement of

> incapacity for work, and all other requirements of Division 2 of the 1987 Act (which deals with weekly compensation by way of income support) the worker must satisfy in order to be entitled to weekly compensation.
>
> For these reasons, given that at the time the surgery was claimed the worker was not entitled to weekly compensation, the Commission did not have the power to order the insurer to pay the cost of the proposed surgery. However, the worker was not left without a remedy because the time off work for the surgery would result in the worker being entitled to weekly compensation, and therefore also entitle him to treatment compensation for the cost of the surgery. Though the Commission could not order the payment of the cost of the surgery, the insurer will have an obligation to meet that cost.

However, on occasion the issue may not be clear-cut, as demonstrated by the matter of *Hedges v Executive Director of Catholic Schools* [2017] NSWWCC 78:

> A worker who suffered a hearing injury in October 2014 requested neuromonics treatment be approved in November 2015, which was disputed by the insurer. An application to review the insurer's decision was lodged in November 2016 and heard by the Commission in 2017. The worker had not received any weekly payments as a result of the injury.
>
> In addition to disputing whether the treatment was reasonably necessary, the insurer claimed the treatment compensation period had expired.
>
> The Commission found that the proposed neuromonics treatment was reasonably necessary but determined that the worker could not recover the costs of the treatment due to the expiry of the compensation period.
>
> The Commission found that it was not clear that if the worker underwent the treatment proposed that there would be an entitlement to weekly payments of compensation. It was not a case where the applicant was undergoing surgery that would require her to be hospitalised and to take a period of time off work. The worker was seeking to undergo neuromonics treatment at an audiology clinic.
>
> The Commission also noted that if the worker proceeded to have the proposed treatment at her own expense and required time off work for the treatment, and then submitted medical certificates and a claim for weekly compensation, that once such compensation was paid the insurer would have an obligation to meet the cost of the treatment.

Varied Outcomes Where Treatment Will Result in Incapacity and Revive Compensation

The IRO has been able to solve many complaints by workers where the treatment compensation period has or will shortly expire by bringing the case of *Flying Solo* to the insurer's attention, and the insurer agreeing to take a pragmatic approach: see Case studies 7and 8.

Case study 7

The worker's claim for left shoulder surgery was disputed under section 59A. The insurer advised that as Whole Person Impairment had not been assessed and the worker had not received weekly benefits, they had reached the end of the compensation period. Additionally, as the worker did not currently have an incapacity which resulted in wage loss, treatment compensation was not revived under subsection 59A (3).

WIRO contacted the insurer and suggested the intention of subsection 59A (3) is to provide for circumstances where surgery is requested and the worker is unable to work as a result. WIRO referred to Flying Solo, where the Commission expressed the view that the insurer should pay for the surgery because as soon as the worker undergoes the surgery they would have no capacity and would be entitled to weekly payments. The insurer advised they were not aware of the case law and on review agreed the surgery would be approved.

Case study 8

A worker's surgeon requested approval for proposed rotator cuff repair surgery in October 2019. The surgery was not approved by the insurer as the worker's treatment compensation period was to expire. The insurer advised that the worker had been provided with notice in July 2019 that their medical entitlements would cease in October due to section 59A.

Upon review WIRO suggested to the insurer that the worker's entitlement to treatment could be revived pursuant to subsection 59A (3) if the surgery resulted in incapacity for work. WIRO requested that the insurer determine whether the surgery was reasonably necessary. The insurer subsequently approved the surgery.

However, there are instances where insurers refuse to approve proposed treatment, in circumstances where there is no issue that the treatment is reasonably necessary, by relying on the expiry of the compensation period.

Case study 9

An Approved Lawyer complained that an insurer was refusing to approve their client's claim for surgery despite a determination of the Commission that the treatment was reasonably necessary arising from the nature and conditions of employment. The arbitrator had noted that the respondent was not directed to pay for the proposed surgery because section 59A applied.

A subsequent request for this surgery approval was met with a formal denial by the insurer based on the expiry of the treatment compensation period under

section 59A, and the fact the worker had not provided a certificate of capacity indicating any incapacity. WIRO suggested that the Approved Lawyer put the decision and reasoning in Flying Solo to the insurer.

There are a range of other matters relevant to the operation of revival of treatment compensation:

- compensation is payable but only in respect of any treatment given or provided during a period in respect of which weekly payments are payable to the worker; this raises a similarissue to that outlined in section 1, that is whether the requirement that the treatment must actually be given or provided within the revived compensation period, rather than only that the treatment must be claimed and/or approved, can result in arbitrary and potentially unfair outcomes

- section 59A (3) can be of no assistance where there is no longer an entitlement to weeklypayments, for instance when retirement age is reached: *Air Electrical Pty Ltd t/as DJ Staniforth and Co v Mortimer [*2015] NSWWCCPD 18.

Areas for Feedback

Issue 1 - Treatment Claimed but Not Received

The first issue is that compensation is not payable for treatment given or provided after the expiry of the compensation period, where that compensation is claimed prior to the expiry. Case studies demonstrate the potential for unfairness of this framing of the expiry of a compensation period. Events entirely outside the control of the injured worker, including insurer delays and unforeseen external situations, may mean that treatment that would otherwise be approved and paid for by the insurer will not be compensable. The case studies demonstrate that the current framing of section 59A may disadvantage one worker as against another where:

- the first worker's insurer is not efficient in administering a claim, or the insurer disputes arequest that is ultimately determined in the worker's favour

- the first worker's injury requires specialist treatment that is not readily available

- the first worker is impacted by unforeseen events outside of their control.

In our view, such arbitrary outcomes cannot be the intention of the provision. It is worth considering other options to remove this impact.

What is the preferable framing of section 59A of the 1987 Act to ensure workers have fair and equitable access to treatment before the expiry of the relevant compensation period?

a) Would a framing to the effect that 'compensation is not payable in respect of any treatment <u>requested</u> after the expiry of the compensation period' strike a better balance?[3]

[3] This proposal aligns with a recommendation made by the Parkes Project Inquiry Advisory Committee in its *Statement*

b) What would be the risks (if any) of such a framing? How could these risks be mitigated?

c) What are the other options available, and what are the benefits and risks of these options?

Issue 2 - Revival of Treatment Compensation

The second issue is that there is real uncertainty for workers, in circumstances where a compensation period has expired, and where further treatment results in weekly compensation payments being made which may result in a revival of treatment compensation. Issues can include:

- there may be a dispute about whether the treatment is reasonably necessary, but thisissue may not be considered or addressed by the insurer because the request is determined only on the basis that the compensation period has expired there may be a dispute as to whether, for treatment that is reasonably necessary, the treatment will result in the worker having an incapacity for work such that weekly payments will be payable to the worker

- even where these matters are not in dispute, a decision may, in some circumstance, not be able to be made about a future entitlement to treatment compensation until after the worker is again entitled to weekly payments. This may mean the worker is required to pay for the treatment in the first instance.

While these matters may sometimes be resolved through the best efforts of the parties, the uncertainty may result in unnecessary disputes and litigation. Providing for a clear path to enable pre-approval of treatment compensation for reasonably necessary treatment in this circumstance aligns with the workers compensation system objectives.[4]

What is the preferable approach, in circumstances where reasonably necessary treatment may result in a revival of treatment compensation, for such a request to be decided?

a) Is the existing framework provided for in section 59A for revival of treatment compensation adequate and appropriate? Please explain your view.

b) What are the opportunities to improve the framework?

c) A specific example may be to enable a worker whose compensation period for treatment compensation has expired, to make a request to an insurer:

- to determine whether the requested treatment is reasonably necessary, and

- if so, to determine whether the treatment will revive the worker's entitlementto treatment compensation,

of Principles and Recommendations of July 2015 – Medical Expenses Recommendations 4 and 5.

and to permit these decisions to be reviewable by the Commission.

What would be the risks (if any) of such a framing? How could these risks be mitigated?

d) What are the other options available, and what are the benefits and risks of these options?

Appendix A - Concerns about the Operation of Section 59A

The IRO acknowledges that there are other wider and more complex concerns raised by section 59A, including its linking of medical treatment entitlement to an impairment assessment.

The scope of this Issues Paper is narrow, and it does not seek to address all the problems related to section 59A of the 1987 Act.

The Parkes Project Inquiry, conduct by WIRO in 2014-15, examined a range of matters related to ambiguities, conflicts, complexity and opportunities for improvement to the Workers Compensation Acts. The Advisory Committee, in its final Statement of Principles and Recommendations of July 2015, adopted a number of principles and made a number of recommendations about medical expenses.

Some of these have since been acted upon in the 2015 workers compensation reforms outlined in Appendix B below.

Another area for recommended action was reform to address treatment claimed but not received, outlined under Issue 1 above.

A number of other concerns still remain unaddressed. These include the following principles and recommendations:

- Principle 2, that access to medical treatment and services should not depend on impairment evaluation
- Principle 3, that medical expenses claims processes including pre-approval processes must be prescribed and be simple; and Recommendations 9 and 10 to provide an easier path for pre-approval of specific treatments (including post-operative treatment plans) and add to the exemptions to pre-approval those services provided on emergency admissions to hospital outside the first 48 hours
- Principle 7 and Recommendation 7, that there should be a general exception to the cap on duration of medical treatment to cover:
    - reasonably necessary surgery
    - treatment required to ensure the worker remains at work or is capable of returning to work
    - essential services to ensure a worker's health or ability to undertake the necessary activities of daily living does not significantly deteriorate

The question of whether how access to medical services is rationed for persons injured at work (the matters noted in Parkes Project Principle 2) was considered both by the McDougall Review and the SCLJ Review.

Both reviews provide substantial information about the challenges that arise from use of an assessed level of permanent impairment as the determinant for the period in which a worker is entitled to treatment compensation.

Both reviews made recommendations that further consideration be given to the use of permanent impairment as a threshold to access treatment:

- *That consideration be given to a replacement threshold test for entitlement to ongoing weekly and medical benefits that more accurately reflects the need for compensation* (McDougall Review recommendation 37).
- *That SIRA investigate whether the use of the whole person impairment test in the workers compensation scheme is appropriate* (SCLJ Review recommendation 9).

The SIRA McDougall consultation, which commences in October 2021, is considering these matters.

The question of the timeliness of pre-approval processes was raised in the 2021 IRO Inquiry Report Delay in Determining Liability - June 2021, and recommendation 3 focused on regulatory steps that could streamline aspects of the pre-approval process for medical treatment; this is aligned to Parkes Project Principal 3 and Recommendation 9.

Appendix B - Brief Outline of Changes in Treatment Compensation Since 2012

Major changes were made to the NSW workers compensation scheme in 2012 by way of the *Workers Compensation Legislation Amendment Act 2012* (Amending Act). The amendments were far reaching and included reduced benefits and entitlements with respect to weekly payments, lump sum compensation for permanent impairment and medical and related expenses and exclusion of various claim types.

The Amending Act introduced substantial amendments to the medical expenses arrangements in the 1987 Act by Schedule 4:

- Introducing section 59A - limit on payment of compensation (cap on *duration)*
- Amending section 60 requiring pre-approval of certain treatments or services andproviding for conditions for pre-approval and service provision and exemptions therefrom.
- Amending section 61 - rates applicable for medical or related treatment
- Amending section 63A - rates applicable for workplace rehabilitation services

The explanatory note relating to section 59A in the *Workers Compensation Legislation Amendment Bill* 2012 read as follows:

> *"payment of an injured worker's expenses for medical, hospital and rehabilitation treatment and services will be limited to treatment and services provided within 12 months after a claim for compensation is first made or within 12 months after weekly payments cease (whichever provides a longer period), with an exception for injured workers with more than 30% whole person impairment)*".

The 2012 reforms had been preceded by the NSW Government's Workers Compensation Scheme Issues Paper (Issues Paper) produced in April 2012 in response to the deteriorating performance of the scheme which was considered financially unsustainable without significant reform. The Issues Paper set out 16 "options for change', one of which was to cap medical cover duration. With respect to medical treatment the Issues Paper found that *"WorkCover has limited power to strongly discourage payments treatments and services that do not contribute to recovery and return to work"*.[5]

As at December 2011 the second biggest contributor to the outstanding claims liability was medical expenses. The Government identified as a potential cause of high medical expenses the fact that in NSW "*workers compensation insurers must meet the cost of all medical and related treatment provided to injured workers, with no cap on cost or duration, provided the treatment relates to a work injury. Treatment costs are met after retirement age*".

[5] NSW Workers Compensation Issues Paper, April 2012, Page 5

It was noted that *'most other schemes cap medical treatment and related treatment expenses by duration orcost'*.[6]

The Joint Select Committee on the NSW Workers Compensation Scheme was established in May 2012 and was required to inquire into and report on the NSW Workers compensation scheme. The Committee's June 2012 report recommended that the NSW Government seek to amend the 1987 Act to cap reasonably necessary medical and related treatment expenses to those incurred whilst weekly benefits are paid and for one year after the cessation of those payments[7]. The Committee recommended that "seriously injured workers" (those with a whole person impairment of greater than 30%) should be excluded from the operation of any duration cap on medical expenses.

It became evident relatively quickly that there was an emerging problem as the legislation required treatment to have been undertaken within the time limit. Remedial subordinate legislation, the *Workers Compensation Amendment (Existing Claims) Regulation 2014,* was gazetted in September 2014. The changes were of limited application as they affected only 'existing claims' (claims for compensation in respect of an injury made before 1 October 2012). The amendments extended medical benefits to eligible workers with whole person impairment of between 21% and 30% until statutory retirement age. Payment for crutches, artificial aids, hearing aids, prostheses and home and vehicle modifications until statutory retirement age was also introduced.

More substantial reforms to the section were made in 2015 as part of the beneficial reforms in the *Workers Compensation Amendment Act 2015*. The reforms to medical and related expenses were as follows:

- Duration cap on medical expenses increased from 12 months to two years for workers whose degree of permanent impairment is assessed at 10% or less or is not assessed
- Duration cap on medical expenses increased from 12 months to five years for workers whose degree of permanent impairment is assessed between 11% and 20%
- Various treatments and services to be generally exempted from time limits including artificial aids, members, hearing aids, home and vehicle modifications and secondary surgery in certain circumstances.

This reflects the current position. The duration of an injured worker's entitlement to medical treatment expenses is now tied to the level of the worker's assessed whole person impairment.

[6] Issues Paper, Pages 18 - 19

[7] NSW Workers Compensation Scheme Report, Joint Select Committee on the Workers Compensation Scheme,June 2012, Page 10

Appendix C: Executive Summary: IRO Inquiry Report on Delay in Determining Liability - June 2021

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).[8] 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

[8] 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.

- 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.

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

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 frameprovided 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.