

Investigation into the management of complex
workers compensation claims and WorkSafe oversight

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Letter to the Legislative Council and the Legislative Assembly

To

The Honourable the President of the Legislative Council

and

The Honourable the Speaker of the Legislative Assembly

Pursuant to sections 25 and 25AA of the *Ombudsman Act 1973*, I present to Parliament my *Investigation into the management of complex workers compensation claims and WorkSafe oversight*.

A handwritten signature in black ink, appearing to read 'Deborah Glass', with a stylized flourish extending to the right.

Deborah Glass OBE

Ombudsman

12 September 2016

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Foreword

'I commend you on attending to the number of people suffering twice – once from their injury and then again via the system.'

Email from health care professional following announcement of investigation

Workers compensation has a fraught history in most jurisdictions and Victoria is no exception. It is socially responsible to provide for a universal system of insurance covering work related injury to recognise the value of workers and the risks of work, and economically responsible both to support a return to work and to ensure that premiums neither stifle business nor bankrupt the state.

Successive governments have wrestled with the complexity of creating a scheme that is both fair and financially viable; that delicate balancing act has resulted in our present system in which claims are managed by private insurers, regulated by WorkSafe.

The vast majority of claims are neither complex nor contentious: these are rarely the subject of complaint and WorkSafe's own surveys show a high level of customer satisfaction. But in the area of complex claims the current system has failed some particularly vulnerable people.

The announcement of an Ombudsman investigation does not usually trigger an impassioned public response. Although I had not asked for submissions – we already had over 500 complaints from the previous year – my investigation into whether WorkSafe agents were making unreasonable decisions to reject or terminate claims prompted over 50 people to contact my office with offers of help. These included not only injured workers eager to share their painful experience, but health care professionals horrified by what was happening to their patients.

We looked at cases from all five WorkSafe agents, involving both public and private sector workers – police and prison officers, nurses, teachers, truck drivers, farmers and many others, male and female, young and old – and claims of both physical and psychological injury. What this wide variety of cases had in common was the complexity of the case and in the overwhelming majority, the fundamental unfairness of the process they experienced. In one particularly tragic case, the injured worker was denied psychiatric treatment and medical expenses for months. The worker's entitlements were finally reinstated, but the worker committed suicide not long after.

'These insurers rely on people being too sick and exhausted to fight back... Words will never describe how angry, how hurt and how sad I am that my [parent] is gone... I know that they are a business and some people cheat the system, but my [parent] was not one of them. [They were] truly and completely mentally ill and they cut off [their] treatment.'

Family member of injured worker with an accepted claim for a psychological condition
– see case study 4

We found agents cherry-picking evidence to support a decision to reject or terminate a claim – as little as one line in a medical report – while disregarding overwhelming evidence to the contrary. We found Independent Medical Examiners (IMEs) – whose opinions agents use to support their decision-making on compensation – receiving selective, incomplete or inaccurate information. We also saw evidence that some IMEs were used selectively to advantage the insurers – including those described by agent staff as 'good for terminations'.

'[Independent Medical Examiner X] strikes again. We need to use this guy more often.'

Internal email from agent manager advising staff member to issue a termination

We found examples of agents maintaining unreasonable decisions at conciliation, in some cases despite acknowledging that the decision was unreasonable and would be overturned. In effect, we found cases in which agents were working the system to delay and deny seriously injured workers the financial compensation to which they were entitled – and which they eventually received if they had the support, stamina and means to pursue their cases through the dispute process.

The impact of this on vulnerable people cannot be overstated. The cessation of payments – for up to two years before a case is concluded – will inevitably lead to financial hardship and as the cases illustrate, can equally lead to depression and despair. In such cases the system itself compounds the injury – not only to the detriment of the worker, but ultimately to all of us who bear the social and financial cost.

How much is this behaviour driven by financial incentives? It is of course reasonable for WorkSafe agents to expect to make a commercial profit, and the contract between WorkSafe and the agents is carefully calibrated across a range of areas. Plainly, the cases we examined were those in which concerns had been raised, and cannot be said to be indicative of the tens of thousands of cases dealt with by agents each year without controversy. But the evidence of unreasonable decision-making, including the 75 per cent of 130 week termination decisions overturned by the courts, strongly suggests that at the disputed end of the spectrum, the balance is tilting away from fairness.

The overall system is not broken, but the problems we identified in complex cases – some 20 per cent of overall claims – go beyond a few isolated examples of bad behaviour. They cannot simply be explained away as a few bad apples spoiling the barrel.

'Knock your socks off and terminate away!'

Internal email from agent staff member to manager in relation to a 130 week termination

The system needs a better safety net for the vulnerable. Action must be taken to address the complex end of the system where terminations are rewarded. WorkSafe needs to examine its incentives – and the use of IMEs – to ensure that the system rewards sustainable decisions and to target its oversight accordingly. The process for resolving disputes also demands careful reconsideration – it is in the interests of workers, employers and the public at large that the resolution of claims should be both timely and fair.

WorkSafe has begun addressing many of these issues, and we have already seen improvements since my investigation began in 2015. This work must go on: the cases we investigated are not merely files, numbers or claims; they involved people's lives, and the human cost should never be forgotten.

Deborah Glass

Ombudsman

Executive summary

1. WorkSafe, through its five agents, manages some 90,000 claims every year. The vast majority of these are not contentious but a number of complaints to my office and evidence from people working in the system suggested a pattern of discontent in complex cases which warranted close examination.
2. Public concern about insurers' treatment of claimants in both the private and public sectors has continued since my investigation began, with a number of scandals brought to light in recent months suggesting undue focus on profits by insurers, at the expense of the rights and well-being of individuals.
3. My officers looked at cases from all five agents and across different types of workers and injuries to assess whether:
 - agents unreasonably denied liability or terminated entitlements for workers compensation claims
 - agents did this in order to obtain financial rewards available under the remuneration arrangements with WorkSafe
 - WorkSafe provided effective oversight of agents' claims management, particularly regarding agents' use of IMEs.
4. The evidence for my investigation included:
 - a detailed review of 65 complex claims across all five agents
 - a random sample of the email records of agent staff
 - interviews with injured workers and their families, executives from the five agents and former agent staff
 - engagement with stakeholders, including the Accident Compensation Conciliation Service (ACCS), the Australian Medical Association, the Police Association of Victoria, the Community and Public Sector Union, WorkCover Assist and WorkSafe.

Background

5. The Victorian workers compensation scheme seeks to reduce workplace injuries; to provide for rehabilitation and compensation of workers suffering work-related injuries and illnesses; and to help injured workers back into the workforce. It is funded by a compulsory system of insurance that covers employers for the cost of providing compensation to injured workers.
6. The current scheme is underwritten by WorkSafe, with claims management functions outsourced to five private insurance agents. At the time of my investigation, the agents were Allianz, CGU, Gallagher Bassett, QBE and Xchanging.
7. WorkSafe oversees the agents' management of claims and remunerates them in line with their contract. One component of this remuneration is a set of financial rewards and penalties tied to agents' performance against benchmark measures, which include the termination of claims before they exceed certain milestones (13 weeks, 52 weeks and 134 weeks).
8. While complex claims make up just 20 per cent of claims received each year, they are 90 per cent of the scheme's liabilities.

Unreasonable decision-making by agents

9. While private insurers are driven by commercial interests, in their capacity as WorkSafe agents, they must act in accordance with WorkSafe's statutory functions and in the public interest. The agents are also bound by a range of policies and guidelines on making sound, evidence-based decisions on claims, which also govern their conduct during the dispute process.
10. We saw instances of good administrative decision-making and practices by some agent staff. However, my investigation found cases of unreasonable decision-making across all five of the agents. In these cases, agents:
 - unreasonably used evidence in decision-making
 - maintained unreasonable decisions at conciliation
 - made decisions contrary to binding Medical Panel opinions
 - allowed employers to improperly influence their decision-making
 - provided inadequate internal review processes.
11. In its key principles in its Claims Manual, WorkSafe requires agents to make decisions on claims that are based on and supported by the best available evidence. Agents use the opinions of IMEs to support their decision-making.
12. Contrary to the key principles, my investigation found numerous examples of agents selectively using evidence to reject or terminate a claim, while disregarding other available evidence. This occurred even where the weight of evidence in support of the worker's claim was considerable. One former agent employee said that for claims staff, 'it was a matter of just finding something to terminate on'.¹
13. There were also cases in which agents:
 - failed to provide crucial background information about injured workers to IMEs when they were forming their opinion, which agents then relied on to reject or terminate workers' entitlements²
 - requested multiple supplementary reports from IMEs in an attempt to influence or change their opinion, which some witnesses described as a 'fishing exercise'
 - engaged in 'doctor shopping' for an IME opinion that would support a rejection or termination of entitlements. One former agent executive said agents 'tend to send the worker to a whole host of Independent Medical Examiners until they find a doctor who is prepared to say, "yes this person has work capacity"'
 - posed leading questions to IMEs in an attempt to receive an opinion that would support a rejection or termination.

Agents' use of evidence in decision-making

11. In its key principles in its Claims Manual, WorkSafe requires agents to make decisions on claims that are based on and supported by the best available evidence. Agents use the opinions of IMEs to support their decision-making.

¹ See for example case study 1.

² See for example case study 5.

Maintaining unreasonable decisions at conciliation

14. Injured workers are able to dispute an agent's decision on their claim through the ACCS. If the dispute remains unresolved, the worker can take the matter to court for determination. Agents are required to only defend decisions that are 'sustainable' and have a reasonable prospect of success if they proceed to court. Where this is not the case, agents should withdraw their decision and reinstate the worker's entitlements.
15. In some cases we found agents maintained decisions to reject or terminate claims at conciliation, despite knowing that their decision was not sustainable or 'barely arguable'. Examples of this practice included instances where agents proceeded to conciliation, despite acknowledging that:
 - their decision was 'difficult to maintain'³
 - if they let the matter go to court 'it would get chucked out immediately'⁴
 - their grounds for rejecting and terminating were 'not strong', and that the case should not 'proceed to conciliation as [the] decision [could not] be sustained'.⁵
16. Statistics on disputed cases show a high rate of overturn:
 - 58.5 per cent of decisions disputed at conciliation were changed
 - between 64 and 75 per cent of decisions disputed at court were overturned or changed
 - 71 per cent of decisions referred to a Medical Panel were overturned.
17. This failure to withdraw unsustainable decisions prior to or at conciliation wastes scheme money. The cost of escalating disputes is significant, with the average cost of a conciliation being close to \$1,500, and the average court proceeding amounting to over \$27,000.
18. While there is no financial cost to a worker disputing a decision at conciliation, there can be a profound impact on injured workers and their recovery. The process can be lengthy and stressful, with the average time from agent decision to conciliation outcome being over five months. Proceeding to court can be costly and it can take nearly two years.

Decisions contrary to binding Medical Panel opinions

19. During the dispute process, the ACCS or a court may refer a matter to a Medical Panel if there is a medical dispute, including about the worker's medical condition and/or capacity for work. The opinion provided by a Medical Panel must be accepted as 'final and conclusive' by all parties.

³ Case study 11 in this report.

⁴ Case study 22 in this report.

⁵ Case study 25 in this report.

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20. Contrary to this requirement, my investigation found cases in which agents terminated workers' entitlements in conflict with binding Medical Panel opinions.⁶

Agents improperly allowing employers to influence claims management

21. An injured worker's employer is a key stakeholder in their recovery and return to work. However, the decision-making power regarding a worker's entitlements resides with the agent and there are very limited circumstances in which an employer can object to the acceptance of a claim.
22. Despite this, my investigation identified cases in which agent staff had accommodated requests or sought direction from employers on their management of a claim.⁷

Inadequate agent internal review process

23. In addition to disputing matters at conciliation, workers can request that an agent conduct an internal review of any decision. The evidence obtained during my investigation suggested that, in practice, these reviews can be little more than a 'box ticking exercise'. As such, they are not always an effective mechanism to safeguard the quality of decision-making.

The effect of the financial rewards and penalties on agent decision-making

24. As commercial entities, it is reasonable for WorkSafe agents to expect to make a profit, and the financial reward and penalty measures in agent contracts are intended to act as a disincentive for poor agent performance. But evidence of unreasonable decision-making strongly suggests that in disputed and complex matters the financial measures are encouraging a focus on terminating and rejecting claims to achieve the financial rewards.
25. This is evidenced by the strong emphasis on terminations we observed in the files and emails, including where agent staff, and in particular, managers:
- documented 'termination strategies' in internal file notes on claims
 - referred to terminated claims that fell within the financial reward measures as 'winners' or 'wins'
 - referred to the importance of achieving the financial rewards and the monetary amount that could be made for terminating claims.

⁶ See for example case studies 16 and 17.

⁷ See for example case study 22.

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26. Email evidence showed:
- management advising staff to do 'everything they could' to stop claims exceeding the termination timeframes associated with the financial rewards and penalties, emphasising that 'any one of these claims could be worth \$100K to the business'
 - agent management providing monetary prizes to staff who terminated the highest number of claims.
27. In some cases agents made unreasonable decisions in order to achieve the financial rewards available under the contract.⁸ There is also evidence that four of the five agents manipulated, or that staff contemplated manipulating, claims in order to achieve the financial rewards or avoid penalties.
28. There is evidence of agents maintaining unsustainable decisions at conciliation and making offers of limited payments to workers in order to achieve the financial rewards or to avoid penalties. One example was an email, described as 'completely unacceptable' by the agent's General Manager, which showed staff seeking advice on the financial reward measure:
- Do we make more money off 13 week [financial measure] ... or 52? If we make more off the 13 weeks I'll go with the offer of 4 weeks, if we make more money on the 52 weeks then I'll try to put forward an offer greater than 30 June.⁹
29. Witnesses also raised concerns about agents' practice of making offers of limited payments, with one former agent employee stating that agent management placed pressure on staff to maintain decisions at conciliation and to not pay compensation past a certain date to ensure the agent did not 'breach' its 'targets'. The former employee said that this occurred even in cases where concerns were raised about the evidence base of the decision.
30. In addition to those cases where I found direct evidence of the financial rewards influencing decision-making, I consider it reasonable to infer that some other examples of unreasonable decisions to terminate claims at 130 weeks were motivated by the 134 week financial reward given the agents' disregard for evidence, the timing of their decisions aligning with the financial reward measures and multiple references to the financial rewards in file notes.

⁸ See for example case study 25.

⁹ See paragraph 378 in this report.

WorkSafe oversight

31. WorkSafe delegates its claims management functions and powers to the agents, but remains responsible for overseeing the agents' performance against scheme objectives, and ensuring that appropriate compensation is paid to injured workers as expeditiously as possible.
32. WorkSafe has a range of mechanisms for oversight and review including setting the financial rewards and penalties, auditing the quality of agent decision-making, responding to complaints and feedback from stakeholders, and overseeing the IME system.
33. While these have been evolving over time, my investigation found that WorkSafe's oversight has been deficient in some areas.

The financial rewards and penalties offered by WorkSafe to the agents

34. The financial reward and penalty measures are intended to drive agent performance against the scheme's strategic objectives. My investigation found that the measures provide greater rewards to agents for terminating claims, without sufficient incentive for agents to make good quality decisions.
35. This concern was identified by the Victorian Auditor-General (VAGO) in 2009. VAGO recommended that WorkSafe introduce quality measures linking outcomes, including in relation to return to work and terminating claims, to good practice case management.

36. In response, WorkSafe introduced a new financial reward and penalty measure in relation to the quality of agent decision-making, which was, and remains, 'the only [measure] where a review of the Agent decision-making is undertaken'. However, until 2014, the measure only examined agents' initial decision to accept or reject a new claim; the measure has only recently been expanded to provide some incentive to the agents to make good-quality decisions after a claim has been accepted.

Financial reward for return to work

37. A primary focus of the workers compensation scheme is to support workers to return to work. In line with this, the return to work financial measure set by WorkSafe has provided agents considerable incentive to assist workers to return to work within six months. However, WorkSafe provided no incentive to the agents to focus on return to work past six months. This is particularly noteworthy given a considerable number of claims my officers examined involved long periods of incapacity.
38. An additional limitation of the return to work financial reward measure has been its narrow focus on whether a worker returned to work within six months, without adequate attention given to whether they remained at work.

WorkSafe's audits of agent decision-making

39. Prior to 2014-15, WorkSafe audited around 300 claims each year. In 2014-15, this was increased to 662 claims. However, given agents manage approximately 90,000 claims every year, and make over two million entitlement decisions, this is a very small percentage.
40. Follow up on these audits has also been inadequate. WorkSafe did not examine whether decisions that failed the audits had been overturned or should have been overturned. As they were only undertaken twice yearly, there was often a long delay between the agent decision and the feedback provided by WorkSafe to the agent.
41. WorkSafe also requires agents to maintain internal quality controls, including to ensure appropriate and timely action is taken to withdraw decisions at conciliation where it is identified that the decision is not technically sound and/or based on reasonable evidence. However, multiple case studies discussed in my report¹⁰ show that agents are maintaining unsustainable decisions through the dispute process even when the agent acknowledges the decision is not sound.

WorkSafe's response to issues with the financial rewards and penalties

42. WorkSafe intends to take, or has taken, a number of steps in 2016-17 to address these issues, which include:
 - increasing the monetary value of the reward and penalty available to agents under the quality decision measure
 - extending the scope of the quality decision measure to all entitlement decisions by agents, including all termination decisions

- trialling a new long-term return to work financial reward measure, to ensure that return to work is embedded as a focus for claims involving periods of incapacity longer than six months
- increasing the number of claims audited to 1,500
- changing the timing of the audits, which will now occur on a monthly basis
- examining whether a decision that failed the audits should be overturned.

Using intelligence from complaints, feedback and overturned decisions

43. Complaints and feedback from stakeholders, and decisions that have been overturned through the dispute process, can provide WorkSafe with valuable insights into the management of claims by agents and potential areas for improvement. WorkSafe does not optimally use this information to monitor complaints and identify potential systemic issues, and the perception of some stakeholders is that WorkSafe has not taken adequate action on their concerns.
44. In some cases, where WorkSafe did identify concerns¹¹ that an agent had made a poor decision which may have unfairly deprived a worker of their entitlements, WorkSafe was reluctant to step in and use its legislative power to direct an agent to reinstate entitlements. Instead, the injured worker was required to dispute the decision through conciliation or court.¹²

¹⁰ See for example case studies 3, 5, 7, 9, 10, 11, 13, 14, 15, 16, 22, 24, 25 and 27 in this report.

¹¹ Such concerns may be identified through a complaint, stakeholder feedback, or a WorkSafe audit.

¹² See case studies 11 and 29 in this report.

45. WorkSafe does not record, track, collate or review data from ACCS directions, complaints and feedback to identify and address systemic issues with agent practices. WorkSafe has acknowledged that there are opportunities to optimise the data available to it to more effectively investigate systemic issues.

Oversight of the IME system

46. Another core component of WorkSafe's oversight is its management of the IME system. The issues in this report arising from agents' use of IMEs highlight the need for reform in this area. Providing workers with a choice of IME and requiring the sharing of IME reports with treating health practitioners could have made a significant difference to many of the complaints to my office. It is encouraging that WorkSafe is considering these options.

47. WorkSafe has gradually improved and strengthened its management of the IME system, but there is scope for further improvement, including:

- targeting its quality assurance process to those IMEs subject to a high number of complaints
- systematically reviewing agent claims decisions where a deficient IME report is identified, to examine whether the agent incorrectly disentitled a worker.

Conclusions

48. The evidence to this investigation showed genuine hardship and distress to complainants and others whose cases we examined, and some compelling evidence of agents gaming the system. We also examined statistics evidencing the high percentage of cases overturned following independent review.

49. However my investigation did not extend to the entire WorkSafe claims management system and the evidence of this investigation does not indicate that it is broken. On the contrary, as WorkSafe points out, 80 per cent of claims are finalised within 13 weeks of injury, and its last annual survey of injured workers recorded satisfaction of over 85 per cent.

50. While we also saw instances of good decision-making and practices by some agent staff, the fact that the case studies revealed poor behaviour by all five agents indicates forcefully that the system does not work well at the complex end of the spectrum. Agents are responsible for their decision-making – they should be adhering to the agreed standards and held to account when they do not – but they are also motivated by incentives in the scheme which must be recalibrated to address the issues my investigation raises.

51. WorkSafe's oversight needs to directly target the management of complex, disputed claims to ensure that there is a safety net for the most vulnerable.

52. The processes for the resolution of disputes after conciliation also need further consideration. The conciliation process is quick and inexpensive, and successfully resolves some 65 per cent of disputed claims. However, where conciliation does not succeed workers often have no choice but to pursue matters through the courts, where a lengthy wait is inevitable. It is in the interests of workers, employers and the public at large that the resolution of claims be both timely and fair.

Background

53. Victoria's workers compensation scheme seeks to reduce workplace injuries; to provide for rehabilitation and compensation of workers suffering work-related injuries and illnesses; and to help injured workers back into the workforce.
54. The scheme is administered by WorkSafe, with claims management functions delegated to five appointed agents. At the time of commencing my investigation, those agents were Allianz Workers' Compensation (Allianz); CGU Workers Compensation (CGU); Gallagher Bassett Workers Compensation (Gallagher Bassett); QBE Workers Compensation Insurance (QBE); and Xchanging Workers Compensation (Xchanging). In April 2016, WorkSafe announced that from 1 July 2016, QBE would be replaced by EML VIC Pty Ltd.¹³
55. In 2014-15, my office received 503 complaints about the workers compensation scheme, including 394 about WorkSafe agents and 102 about WorkSafe itself.¹⁴ The most common complaint (55 per cent) related to claims decisions and processes, including a failure to consider evidence in reaching claims decisions. The second most common complaint was about payments, including delayed payments and poor decision-making.
56. Data from the ACCS showed a 37.2 per cent increase in the number of requests for conciliation from 2009 and 2015, prior to my investigation commencing.¹⁵
57. Historically, many complainants who have contacted my office about an agent's decision on their workers compensation claim have been advised to dispute the matter at conciliation. The ACCS was established specifically to deal with these matters; it has the expertise to conciliate disputed claims, and the process is free.
58. However, given the increasing number of complaints to my office and the increasing number of claims decisions disputed at conciliation, in June 2014 I decided to conduct enquiries on complaints where the complainant was able to identify a potential administrative error on the part of the agent.
59. My staff made detailed enquiries into a series of complaints about agent decision-making. My enquiries identified that the agents had unfairly terminated the workers' entitlements in many of these cases. Consultation with stakeholders indicated that the issues I had identified may have been more widespread, and that the agents may have been motivated in their decision-making by the financial incentives offered by WorkSafe.
60. Two previous reports on Victoria's workers compensation scheme (discussed in the next chapter) had also raised concerns about a focus on liability management at the expense of quality case management and problems with record keeping.

¹³ WorkSafe's new Agent Panel <https://www.worksafe.vic.gov.au/__data/assets/pdf_file/0019/192160/WorkSafe_Agent-Panel-2016-FAQs-Healthcare-Providers_final.pdf> April 2016.

¹⁴ We also received complaints about WorkCover Assist and self-insurers, which comprise the remainder of the total complaints.

¹⁵ ACCS, *Annual Reports 2014/2015, 2013/2014, 2012/2013, 2011/2012, 2010/2011 and 2009/2010*.

My investigation

61. I therefore decided to conduct an 'own motion' investigation into WorkSafe and its agents' claims management practices.
62. On 24 September 2015, I notified The Hon Robin Scott MP, the Minister for Finance; Ms Clare Amies, Chief Executive, WorkSafe; Mr Paul Barker, Chair, WorkSafe; and the general managers of each of the then five agents of my intention to conduct this investigation.

Authority to investigate

My jurisdiction to conduct own motion investigations is derived from section 16A of the *Ombudsman Act 1973*.

As a public statutory body under item 13 of Schedule 1 to the Ombudsman Act, WorkSafe is an authority within my jurisdiction.

As specified entities under items 16 and 17 of Schedule 1, the agents are also authorities subject to my jurisdiction.

Terms of reference

63. The specific terms of reference were to examine whether:
 - agents have unreasonably denied liability or terminated entitlements for workers compensation claims
 - agents have unreasonably denied liability or terminated entitlements for workers compensation claims to obtain financial rewards available under the remuneration arrangements with WorkSafe
 - WorkSafe provides effective oversight of agents' claims management, particularly regarding agents' use of IMEs.
64. My investigation examined the management of a sample of claims where a worker had an entitlement to weekly payments and/or payment of medical expenses for their workplace injury. My investigation did not examine:
 - common law (fault) claims, which are determined by the Magistrates' Court
 - permanent impairment benefit claims.
65. While my office has jurisdiction in relation to WorkSafe self-insurers¹⁶ under item 18 of Schedule 1 to the Ombudsman Act, the investigation did not include self-insurers because there is no remuneration arrangement between self-insurers and WorkSafe.

¹⁶ A self-insurer is an employer approved by WorkSafe to manage its own workers compensation claims and has full responsibility for meeting its claims liabilities.

Methodology

66. My investigation involved:

- reviewing 65 claims where the five agents had rejected or terminated entitlements in 2014-15 and 2015-16;¹⁷ these included claims for injuries sustained from the 1980s to 2015
- examining material from WorkSafe, including the WorkSafe Claims Manual;¹⁸ WorkSafe's contract with the agents,¹⁹ including the remuneration agreement; and documents related to WorkSafe's oversight (including agent performance against the financial reward and penalty measures, IME registration and complaints, claims audits, health checks and WorkSafe complaint-handling)
- examining material provided by the agents, including internal policies and procedures
- making enquiries on new complaints received during my investigation
- obtaining email records of 15 technical managers²⁰ from each of the agents, for the period April to June 2015
- receiving information from, and speaking with, more than 20 injured workers and their families

- meeting with stakeholders, including the Police Association of Victoria, the ACCS, the Australian Medical Association, the Community and Public Sector Union, medical practitioners, Medical Panel panellists, an IME and experts on workers compensation from other jurisdictions²¹
- conducting interviews with staff from the ACCS, WorkCover Assist and WorkSafe; executives from each of the agents; and former staff from the agents. Of the 21 people interviewed, 12 were interviewed voluntarily and nine compulsorily.²² Five witnesses were accompanied at interview by a legal representative and one was accompanied by a support person
- providing a copy of my draft report, in August 2016, to affected parties; considering their responses; and fairly reflecting these in my report, where relevant.

Review of claims files

67. The 65 examined claims related to physical and psychological injuries and were from a variety of different workplaces.

17 In one case, case study 5, the agent's decision was made in 2012; however, the decision was the subject of a Medical Panel opinion in 2014-15. In two other cases, the decisions were made in early 2014.

18 WorkSafe Victoria, *Claims Manual*, last updated 18 September 2015.

19 WIRC Act 2013, s. 500 and 501; WorkSafe Victoria, *Agency Agreement*, 2011.

20 Agent staff employed as experts in the claims management legislation and the financial rewards and penalties.

21 In response to my draft report, WorkSafe noted that the report did not include comments or views from employers. While I understand the important role employers play in the workers compensation system, no employers contacted me to participate in my investigation. I also note that employers should have no role in agent claims management decisions, which was the focus of my investigation.

22 A compulsory appearance under s. 2 of the Ombudsman Act is one where a witness appears in accordance with a witness summons, or is examined under oath or affirmation. A voluntary appearance is anything other than a compulsory appearance.

68. Most were selected for review on the basis of my concerns around the agents' handling of the claim. Those concerns were identified through:

- complaints to my office
- directions and recommendations issued by the ACCS
- concerns raised by the ACCS to my office or WorkSafe
- complaints about IMEs to WorkSafe
- claims audited by WorkSafe.

69. Most of the cases we looked at involved what WorkSafe identifies as complex claims; that is, a claim that involves a long term period of incapacity (which may or may not be continuous) and/or long term requirement for medical treatment. WorkSafe stated that such complex claims often involve associated mental health issues, further complicating claims management. WorkSafe advised my investigation that such complex claims comprise about 20 per cent of new claims, but about 90 per cent of the liabilities.²³

70. All of the examined claims also involved a dispute and/or a complaint by the injured worker. The files examined related to disputes at all phases of the life of a claim, from initial eligibility through to termination of weekly payments at or beyond 130 weeks,²⁴ as well as those that had been resolved at all points in the dispute process: at conciliation, after a Medical Panel decision, or at court (or just before court proceedings).

71. I have included detailed case studies to highlight the patterns of repeated unreasonable decision-making by the agents in some cases. While the case studies are included in particular sections to identify a particular deficiency in agent decision-making, they often detail other issues that are discussed elsewhere in my report.

Protection of privacy

72. To respect the privacy of injured workers and their families, I have de-identified the case studies in my report. While some individuals may be able to identify themselves in this report, I consider it is in the public interest to include these stories.

Standard of proof and adverse comment

73. In reaching my opinion in this report, the standard of proof I have applied is the balance of probabilities.

74. This report includes adverse comments about an IME in case study 30. In accordance with section 25A(2) of the Ombudsman Act, I provided the IME with a reasonable opportunity to respond to the material in the report. Their response, where relevant, is fairly set out in my report.

75. This report also includes adverse comments about WorkSafe and the five agents subject to my investigation: Allianz, CGU, Gallagher Bassett, QBE and Xchanging. In accordance with section 17(4) of the Ombudsman Act, I provided the principal officers of these authorities with a reasonable opportunity to respond to the material in the report. Their responses, where relevant, are fairly set out in my report.

²³ Email from WorkSafe General Counsel dated 1 August 2016.

²⁴ An agent must terminate a worker's entitlement to weekly payments after they have received 130 weeks of payments if they have a work capacity, or alternatively, they are incapacitated but this is unlikely to continue indefinitely.

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76. During the investigation, the general managers of Xchanging and Allianz changed and QBE ceased to be an agent. As my conclusions relate to the period in which the former general managers were responsible for workers compensation divisions at the agents, I provided a copy of my draft report to these individuals. They declined to comment.
77. In accordance with section 25A(3) of the Ombudsman Act, I advise that any other persons who are or may be identifiable from the information in this report are not the subject of any adverse comment or opinion and:
- I am satisfied that it is necessary or desirable in the public interest that the information that identifies or may identify those persons be included in this report, and
 - I am satisfied that this will not cause unreasonable damage to those persons' reputation, safety or wellbeing.

About the workers compensation scheme

What is the workers compensation scheme?

78. Victoria's workers compensation scheme is funded by a compulsory system of insurance that covers employers for the cost of providing compensation to injured workers. Entitlements to compensation include weekly payments to replace earnings, as well as reasonable costs associated with treatment, rehabilitation and hospitalisation.
79. The scheme also allows injured workers to pursue common law damages if the injury is serious, and where the employer was at fault.
80. The scheme's evolution over the last century plays an important part in understanding some of the tensions apparent in this report between the obligation of a public body to act in the public interest and the commercial imperatives of private insurer agents.
82. Through the 1970s, workers compensation schemes in most Australian jurisdictions were administered by private insurers and were seen as 'problematic' because of 'soaring premiums' which 'jeopardised the financial viability of the system', 'inadequate' compensation payments and a lack of 'incentive for employers to implement preventive measures or safer work practices'.²⁶
83. The Victorian scheme was reformed in the mid-1980s when the *Accident Compensation Act 1985* was passed and public underwriting of the scheme was introduced. The reforms focused on prevention, rehabilitation and compensation as a way of reducing the social costs of workplace accidents.²⁷
84. In his second reading of the 1985 Bill, the then Treasurer The Hon Rob Jolly MLA said:

The internal contradictions in the present workers compensation system have brought it to the brink of collapse.

The iniquitous system of compensation payments, coupled with the disturbingly long delays and the explosion of premium costs has led to universal recognition that the system is in need of a fundamental overhaul.

The days of tinkering with the system have long passed. The challenge for the Government was to resist the forces of vested interest groups and to create a solution which will bring lasting social and economic benefits to the State.

...

The Bill forms a major part of the workcare package. The other legislative measures required for this reform—the Occupational Health and Safety Bill and the Dangerous Goods Bill—are now before this House.²⁸

A complicated history

81. Prior to the introduction of the *Workers' Compensation Act 1914*, workers could only seek compensation for injuries where employers were at fault, or found to be negligent. The 1914 Act rendered employers liable for accidental injuries sustained by their workers in the course of their employment. Employers were required to obtain insurance from either a state or approved private insurer to cover such injuries.²⁵

25 Marianna Stylianou, "'To strike a balance' A History of Victoria's Workers' Compensation Scheme, 1985–2010' (Research Report R1-011-018, June 2011) page 6. Available online at <http://www.iscrr.com.au/__data/assets/pdf_file/0009/297180/To-strike-a-balance-WorkSafe-History.pdf>.

26 Ibid.

27 Parliament of Victoria, *Parliamentary Debates*, Legislative Assembly, 2 July 1985, 1005 (Treasurer, The Hon Rob Jolly MLA).

28 Ibid.

85. Following concerns around agent performance,²⁹ the Accident Compensation Act was amended to provide for a performance based system of payment for agents. Under the new system, agents received payment on the closure of a case, rather than on opening, and a weekly fee was paid to them, the amount of which decreased over time. This was designed to encourage better claims management.
86. Despite these changes, the scheme remained troubled throughout the late 1980s and early 1990s with increasing medical, legal and common law costs and a high number of disputes about claims decisions.³⁰
87. Another overhaul, including a name change, saw the scheme achieve greater financial stability by the late 1990s.
88. The *Workplace Injury Rehabilitation and Compensation Act 2013* (WIRC Act) came into operation on 1 July 2014. It consolidated the *Accident Compensation Act 1985*³¹ and the *Accident Compensation Act (WorkCover Insurance) 1993* into a single Act, which WorkSafe stated would 'make it easier for employers and workers to use the legislation and understand their rights, obligations and responsibilities'.³² The WIRC Act did not change the benefits available to injured workers.³³

Previous reports on claims management

Victorian Auditor-General's report into claims management

89. In 2009, VAGO tabled a report on *Claims Management by the Victorian WorkCover Authority*.³⁴ The audit assessed the effectiveness and efficiency of claims management by WorkSafe and its agents. It found WorkSafe had improved the scheme's financial position since the introduction of a new claims model in 2002 and that reductions in long-term claim costs – in particular, weekly payments and medical and like expenses – had directly contributed to the financial sustainability of the scheme.
90. VAGO stated, however, that WorkSafe's remuneration model (including the financial incentives offered to agents) was driving the agents to focus on liability management rather than the quality of case management practices.³⁵ VAGO made a number of recommendations to WorkSafe to address this.

29 The Department of Treasury and Finance Victoria 'National Competition Policy Review of Victorian Workplace Accident Compensation Legislation' (20 December 2000) page 41. Available online at <<http://ncp.ncc.gov.au/docs/Victorian%20review%20of%20workplace%20accident%20compensation%20legislation,%20December%202000.pdf>>.

30 Marianna Stylianou, "'To strike a balance' A History of Victoria's Workers' Compensation Scheme, 1985-2010' (Research Report R1-011-018, June 2011) page 6. Available online at <http://www.iscrr.com.au/___data/assets/pdf_file/0009/297180/To-strike-a-balance-WorkSafe-History.pdf>.

31 Claims that were made under the Accident Compensation Act continue to be dealt with under this Act.

32 WorkSafe Victoria, *Information about Workplace Injury Rehabilitation and Compensation Act 2013*, viewed 3 June 2016, <www.worksafe.vic.gov.au>.

33 Ibid.

34 Victorian Auditor-General, *Claims Management by the Victorian WorkCover Authority*, June 2009.

35 Victorian Auditor-General, *Claims Management by the Victorian WorkCover Authority*, June 2009, page 41.

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91. The VAGO audit and WorkSafe's response are discussed further in the chapter of my report titled 'WorkSafe's oversight'.

Victorian Ombudsman's report into WorkSafe agents' record keeping

92. In 2011, my predecessor tabled his report of an *Investigation into record keeping failures by WorkSafe agents*. The investigation identified that WorkSafe's processes and systems did not support good record keeping practice. This had resulted in:

- improper conduct by agent staff in relation to the manipulation of unpaid accounts to maximise the financial rewards offered by WorkSafe
- delays in payments to injured workers and service providers
- medical practitioners and other providers refusing to provide services to injured people on workers compensation
- privacy breaches.

93. The report noted that poor record keeping at the agents hindered the effective oversight and auditing of their management of claims.

94. The investigation found that poor record keeping was a result of inadequate file maintenance, inadequate understanding of statutory obligations and outdated information technology systems.

Roles and responsibilities

WorkSafe

95. The Victorian WorkCover Authority, operating as WorkSafe, regulates Victoria's workplace occupational health and safety and return to work requirements and also underwrites the workers compensation scheme. WorkSafe was established under the Accident Compensation Act and is governed by a board of management. It is accountable to the Minister for Finance.³⁶

96. WorkSafe's obligations are set out in several Acts of Parliament³⁷ and its five objectives under the WIRC Act are:
- managing the workers compensation scheme as effectively, efficiently and economically as possible
 - managing the workers compensation scheme in a financially viable manner
 - ensuring that appropriate compensation is paid to injured workers in the most socially and economically appropriate manner and as expeditiously as possible
 - developing such internal management structures and procedures as will enable it to perform its functions effectively, efficiently and economically
 - administering the WIRC Act and other relevant Acts.³⁸

³⁶ WIRC Act 2013, s. 495(1).

³⁷ These include the *Occupational Health & Safety Act 2004*, the *Accident Compensation Act 1985*, the *WIRC Act*, the *Dangerous Goods Act 1995* and the *Equipment (Public Safety) Act 1994*.

³⁸ WIRC Act 2013, s. 492.

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97. With respect to the management of workers compensation claims, WorkSafe's functions include:
- receiving, assessing and accepting or rejecting claims for compensation
 - paying compensation to persons entitled to compensation under the WIRC Act or Accident Compensation Act
 - promoting the effective occupational rehabilitation of injured workers and their early return to work
 - encouraging the provision of suitable employment opportunities to workers who have been injured.³⁹

WorkSafe's contract with insurance agents

98. WorkSafe administers the workers compensation scheme by delegating most of its claims management and premium collection functions to insurance agents in the private sector. These agents are appointed through a common contract with WorkSafe⁴⁰ (the contract).
99. Section 500(4) of the WIRC Act provides that a function or power performed or exercised by an agent is taken to have been performed or exercised by WorkSafe. Further, section 70 provides that WorkSafe is directly liable to a worker to pay compensation and damages in accordance with the Act.
100. While the contract outlines that WorkSafe delegates its powers and functions to the agents under section 500 of the WIRC Act, it also outlines that a major component of the claims management model is WorkSafe's oversight of the agents' performance of its functions. It states:
- The agents agree to be bound by, observe and carry out their obligations under the contract, the Acts, and all written directions of WorkSafe and Ministerial Directions (clause 2.5).
 - The agents are required to submit reports and provide access to data to WorkSafe (Schedule A).
 - WorkSafe has the power to audit an agent in relation to its quality controls or in relation to any other matters (Schedule B).
 - WorkSafe has the power to evaluate the agents' performance against its functions for the purpose of assisting WorkSafe in identifying performance improvement opportunities (Schedule G).
101. WorkSafe uses various mechanisms to oversee the agents' claims management processes and decisions. These include performance reporting, complaint handling, claims audits and health checks. WorkSafe also produces the *WorkSafe Claims Manual*⁴¹ (the Claims Manual). Agents are obliged to use the Claims Manual when managing claims.⁴²

³⁹ WIRC Act 2013, s. 493.

⁴⁰ WIRC Act 2013, s. 500 and s. 501; WorkSafe Victoria, *Agency Agreement, 2011*.

⁴¹ I have relied on the most recent version of the Claims Manual, dated 18 September 2015.

⁴² WorkSafe Victoria, Response to the Ombudsman's request for information – schedule of request reference 10 provided on 22 July 2016.

102. The contract also outlines WorkSafe's ability to financially penalise an agent for failing to comply with its obligations, which includes where an agent:

- fails to maintain effective internal quality controls
- manipulates data
- consistently makes decisions on claims that are inconsistent with the objectives of the contract, the Act, written directions, Ministerial directions and any other applicable regulations.⁴³

103. In accordance with the contract, WorkSafe pays agents an annual service fee with inbuilt incentives, a lump sum fee (tied to long-term improvements in claims cost management) and an annual performance adjustment. These are discussed in more detail in the chapter titled 'The effect of the financial rewards and penalties on agent decision-making'.

104. WorkSafe states that 'the strategic intent of the remuneration framework is to provide good value for money by ensuring that agents who deliver scheme outcomes can earn suitable commercial profits'⁴⁴.

105. WorkSafe and its agents entered into a new contract that commenced on 1 July 2016, which WorkSafe said 'aims to further improve how services are delivered to Victorian employers and workers and ensure the sustainability of the workers compensation scheme'.⁴⁵

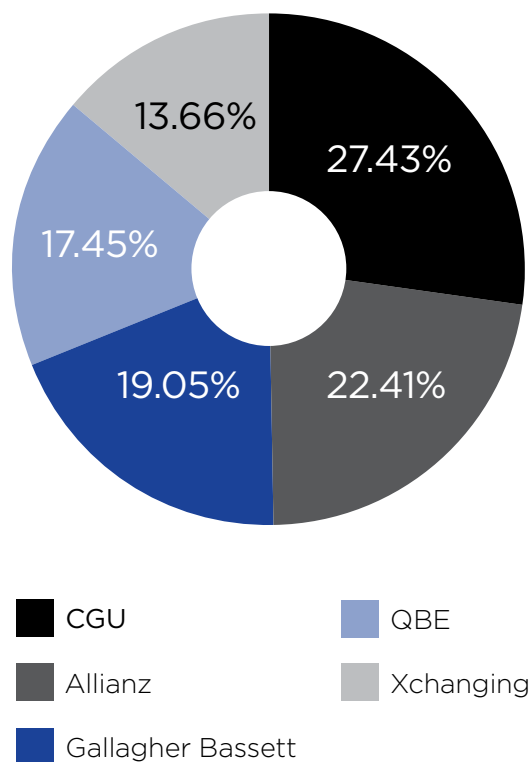
106. Under the contract between WorkSafe and its agents, an agent is required to act on behalf of WorkSafe in relation to compensation claims for work-related injuries and illnesses. The agent is required to determine liability and entitlement for all claims in accordance with the relevant Acts and within legislative timeframes.

107. Collectively, the agents manage around 90,000 claims every year, and make over two million entitlement decisions, which occur at various stages throughout the life of each claim.⁴⁶

The five agents subject to the investigation

108. As employers choose the agent by which they are insured, agents' share of the workers compensation market varies. The agents subject to my investigation held the following percentage share of the market:⁴⁷

Figure 1: Market share of the agents



43 WorkSafe Victoria, *Agency Agreement*, Schedule C, 2011.

44 WorkSafe Victoria, *Overview of Performance Management Framework*, provided to my office on 8 October 2015 in response to a request for information, page 5.

45 Letter from Chief Executive, WorkSafe to Victorian Ombudsman, 28 July 2016.

46 Letter from Chief Executive, WorkSafe to Victorian Ombudsman, 28 July 2016.

47 As at 30 June 2015.

Injured workers

109. If an individual sustains a work-related injury, and wishes to make a claim for loss of income (weekly payments) or medical and like expenses, they must notify their employer of their injury and submit a written claim.⁴⁸ They may be required to attend a medical examination⁴⁹ and provide a statement. The agent will inform the worker of its decision to accept or reject the claim within 28 days.⁵⁰
110. Under the WIRC Act, if the worker's claim is accepted by the agent, the injured worker must:
- make 'reasonable efforts' to return to work in suitable or pre-injury employment⁵¹
 - make 'reasonable efforts' to actively participate and cooperate in return to work planning and assessments of their capacity for work and use occupational rehabilitation services⁵²
 - attend further IMEs at 'reasonable intervals', as required by the agent.⁵³
111. If the worker fails to comply with any of the above, the agent can suspend or terminate their entitlements.⁵⁴ Diagram 1 in this chapter illustrates the claim process, including the obligations of injured workers.

Employers

112. Under the WIRC Act, employers must:
- keep a register of injuries
 - acknowledge receipt of claims and notify WorkSafe and/or the agent within 10 calendar days
 - maintain an offer of suitable employment for 52 weeks after an injured worker starts weekly payments⁵⁵
 - develop return to work plans and appoint a return to work coordinator in certain circumstances
 - pay the injured worker weekly payments for loss of income if the worker is unable to do their normal work.⁵⁶

48 WIRC Act 2013, s. 18.

49 WIRC Act 2013, s. 27.

50 WIRC Act 2013, s. 75.

51 WIRC Act 2013, s. 114.

52 WIRC Act 2013, s. 111, s. 112, s. 113 and s. 115.

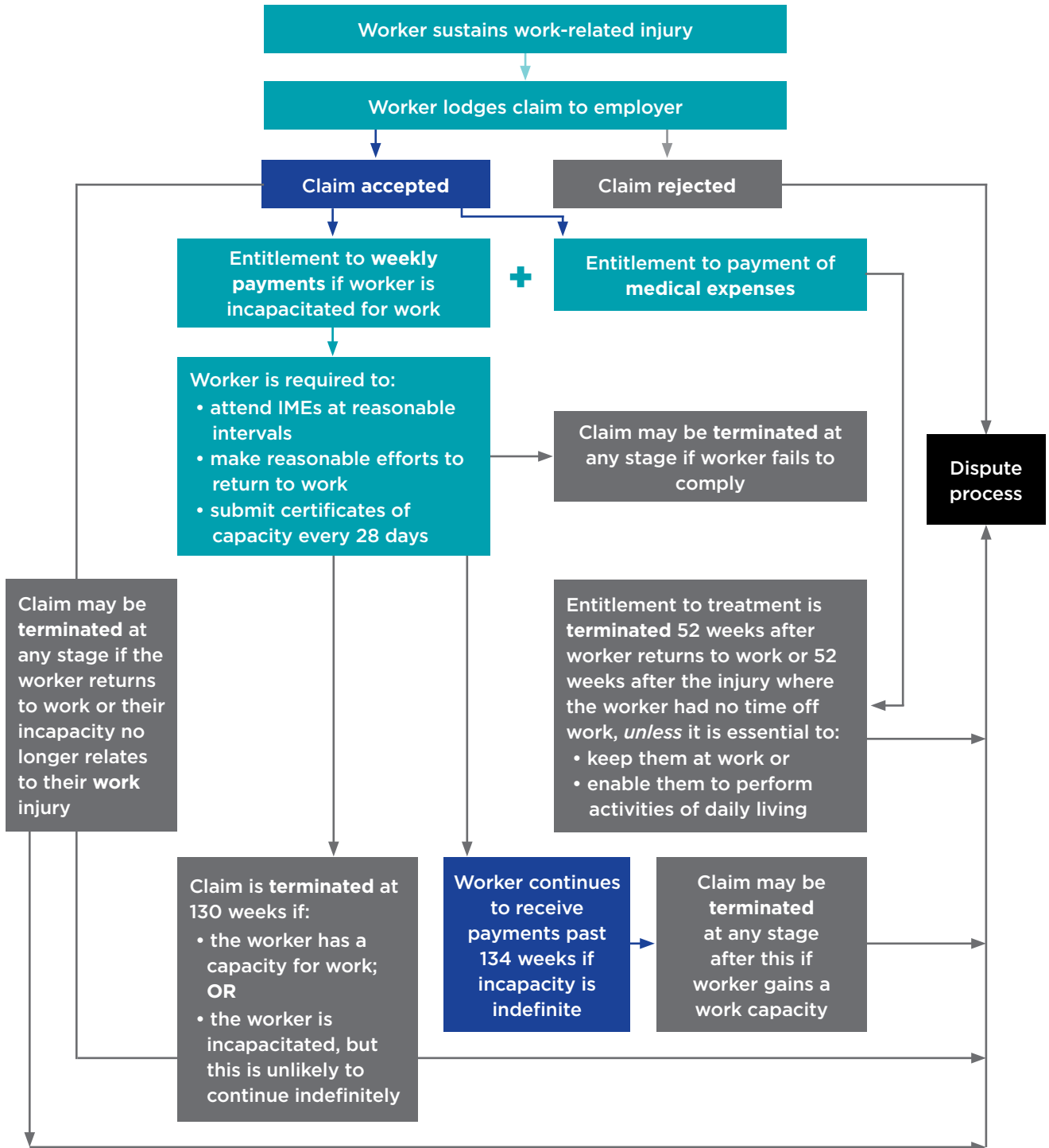
53 WIRC Act 2013, s. 27.

54 WIRC Act 2013, s. 116 and s. 27.

55 WIRC Act 2013, s. 103.

56 WorkSafe Victoria, Claims process overview, viewed 17 June 2016 <<http://www.worksafe.vic.gov.au/injury-and-claims/claims-process-overview>>.

Figure 2: The claim process



Accident Compensation Conciliation Service

113. The ACCS is established under the Accident Compensation Act⁵⁷ and ‘provides an independent service that uses the principles of alternative dispute resolution to resolve workers’ compensation disputes in Victoria’.⁵⁸ The ACCS resolves disputes by involving all parties – injured workers, employers and agents or self-insurers – in the conciliation process.⁵⁹
114. If an injured worker’s claim is rejected, or their entitlements are terminated, they may dispute the matter through the ACCS. This is the first formal stage of the dispute process if an injured worker disagrees with a decision made by an agent.
115. The ACCS’ role is largely facilitative rather than determinative – it facilitates conciliation, provides information about the WIRC Act and assists the agent and worker to reach an agreement.⁶⁰
116. The Claims Manual states that the aim of conciliation is to ‘resolve disputes and avoid litigation’⁶¹ and that ‘it is in everyone’s interest to resolve [disputes] quickly and fairly to avoid litigation’.⁶²
117. According to the ACCS, about 65 per cent of disputes are resolved as a result of conciliation.⁶³
118. The conciliation process may lead to the dispute being resolved if:
 - the worker chooses to accept the original decision or withdraws their request for conciliation
 - the agent withdraws or alters their original decision, leading to an agreement being reached
 - the conciliation officer or one of the parties proposes a recommendation for resolving the dispute, which the parties choose to accept.⁶⁴
119. If the parties involved are unable to reach an agreement, the conciliation officer may:
 - exercise their discretion to refer the matter to the Medical Panel for a final opinion (where the dispute relates to medical questions and there are no facts in dispute)⁶⁵
 - issue a Direction that weekly payments and/or medical expenses be paid with which the agents must comply (where the ACCS is satisfied that there is ‘no arguable case’ for denying payment)⁶⁶
 - issue a Genuine Dispute or Unresolved Certificate allowing the worker to take action in the Magistrates’ Court or County Court to determine the matter (where they are satisfied there is an ‘arguable case’ and that all reasonable steps have been taken by the injured worker to settle the dispute).⁶⁷

57 *Accident Compensation Act 1985*, s. 52A, as in force immediately before 1 July 2014.

58 ACCS, *About us*, viewed 3 June 2016 <<http://www.conciliation.vic.gov.au/about-us/what-we-do>>

59 *Ibid.*

60 ACCS, *Annual Report 2014/15*, retrieved online on 28 June 2016 via <http://www.conciliation.vic.gov.au/__data/assets/pdf_file/0003/176736/Annual-report-2014-15.pdf>.

61 *WorkSafe Victoria, Claims Manual*, Section 7.2.1 Dispute referred to conciliation, updated 18 September 2015.

62 *WorkSafe Victoria, Claims Manual*, Section 7 Dispute Resolution, updated 18 September 2015.

63 ACCS, *Conciliation process outcomes*, viewed 3 June 2016, <<http://www.conciliation.vic.gov.au/conciliation-process/outcomes/potential-outcomes>>.

64 *WorkSafe Victoria, Claims Manual*, Section 7.3.3 Conciliation outcome, updated 18 September 2015; WIRC Act 2013, s. 294.

65 WIRC Act 2013, s. 308.

66 WIRC Act 2013, s. 297. ‘Arguable case’ is defined later in the report. *Claims Manual*, section 7.3.3 Conciliation outcome, updated 18 September 2015.

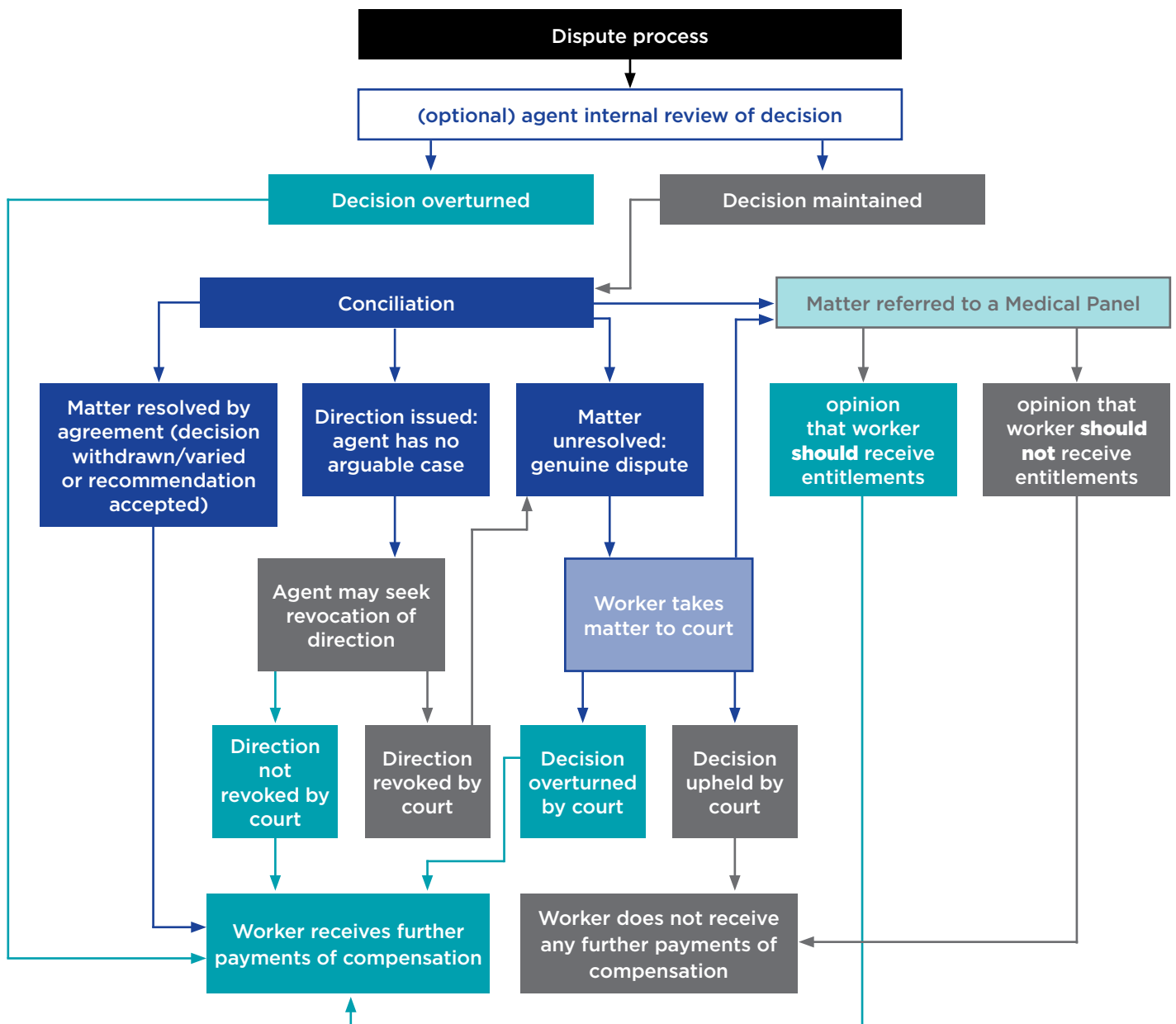
67 WIRC Act 2013, s. 298.

120. In 2014-15, the ACCS issued 46 directions.⁶⁸ However, the then Senior Conciliation Officer of the ACCS stated that for each direction issued there are numerous directions that are proposed by the ACCS to achieve fair offers and realistic outcomes.⁶⁹ In some cases examined by my office, agents withdrew a decision if the ACCS proposed to issue a direction.

121. Depending on when a termination notice takes effect, the injured worker may not receive the weekly payments or medical expense reimbursements that are the subject of the dispute until the matter is resolved.⁷⁰

122. Figure 3 depicts the dispute process, and illustrates each of the steps involved, as well as potential outcomes.⁷¹

Figure 3: The dispute process



68 Note that WorkSafe states that 46 directions have been issued, *Claims Liability Report*, 31 July 2015. However, ACCS data states that 45 directions were issued.

69 Email from the former Senior Conciliation Officer of the ACCS dated 26 July 2016.

70 Termination notices do not take effect immediately, rather a notice will stipulate the date from which the worker will no longer receive payments.

71 See also Chart 7 of the WIRC Act for a more detailed flowchart.

WorkCover Assist and Union Assist

123. WorkCover Assist is a free service provided by WorkSafe to assist injured workers with the conciliation process.
124. WorkCover Assist states that it can explain the conciliation process; provide technical assistance about the dispute; help identify information to assist in the resolution of the dispute; help the worker identify any other benefits they may be eligible for; and attend the conciliation conference as the 'worker's assistant'.⁷²
125. Union Assist is another free service funded by WorkSafe to assist injured workers with a dispute at conciliation. Union Assist can assist a worker to challenge a decision on a claim when a referral is made by a union.

Independent Medical Examiners

126. Before a claim is accepted, and at reasonable intervals during the life of a claim, an IME approved by WorkSafe may be asked by an agent to examine an injured worker and provide an opinion about the worker's injury or illness, work capacity and treatment.⁷³ The IME's report may be used to help the agent make decisions about the injured worker's entitlement to weekly payments and medical and like services.⁷⁴
127. IMEs are not employees or representatives of WorkSafe or the agents. However, they are paid by the agents for their opinion.⁷⁵

128. The WIRC Act requires IMEs to be registered and that they meet mandatory selection criteria. They must also sign the *Independent Medical Examiners Declaration*, which applies terms, conditions and standards, including the requirement to participate in peer reviews for quality assurance purposes.⁷⁶

Medical practitioners

129. WorkSafe regards the injured workers' medical practitioners (including general practitioners, surgeons and specialists), as responsible for the overall management of an injured worker's recovery, rehabilitation and return to work.⁷⁷ WorkSafe can pay the reasonable costs of medical services provided by a medical practitioner to an injured worker.⁷⁸

Medical Panels

130. Medical Panels are established under section 537 of the WIRC Act. A Medical Panel may be convened to provide a legally conclusive and binding opinion on the medical issue(s) in dispute if there is a disagreement about aspects of an injury or medical condition.⁷⁹ Figure 3 in this chapter illustrates that one outcome of conciliation is referral to a Medical Panel. Further details about Medical Panels are included in the chapter 'Unreasonable decision-making by agents'.

72 WorkCover Assist, *About us*, viewed 3 June 2016, <<http://www.workcoverassist.vic.gov.au>>.

73 WIRC Act 2013, s. 27.

74 WorkSafe Victoria, *Workers: The people involved in the claims process*, viewed 17 June 2016, <<http://www.worksafe.vic.gov.au/injury-and-claims/claims-process-overview/workers-the-people-involved-in-the-claims-process>>.

75 Ibid.

76 WorkSafe Victoria, *Independent Medical Examiner Declaration*, [undated].

77 WorkSafe Victoria, *Medical practitioners*, viewed 3 June 2016, <<http://www.worksafe.vic.gov.au/health-professionals/medical-practitioners>>.

78 Ibid.

79 Medical Panels Victoria, *About us*, viewed 3 June 2016, <<http://www.medicalpanels.vic.gov.au/about-us>>.

131. Each Medical Panel is independent and functions as a tribunal that provides answers to questions referred to it by the ACCS or court.⁸⁰ The WIRC Act states that courts, organisations and individuals must 'adopt and apply' the opinion of a Medical Panel. As well, that opinion 'must be accepted as final and conclusive by any court, body or person – irrespective of who referred the medical question to the Medical Panel or when the medical question was referred'.⁸¹

132. In forming its opinion, a Medical Panel may ask a worker to:

- meet with the Medical Panel and answer questions
- supply copies of documents related to the medical question(s)
- undergo a medical examination.⁸²

'The request for [spinal] surgery was rejected. The patient is now living on anti-depressants and pain killers ... He is, of course, not able to return to work.'

Letter to VO from orthopaedic surgeon

⁸⁰ WIRC Act 2013, s. 313(1) and s. 313(2); Medical Panels Victoria, *Information about Medical Panels*, retrieved from <<http://www.medicalpanels.vic.gov.au/about-us>> on 8 June 2016.

⁸¹ WIRC Act 2013, s. 313(4).

⁸² WorkSafe Victoria, *Claims Manual*, Section 7.4.1 Medical Panel referrals, updated 18 September 2015.

Legislative and policy framework

Workplace Injury Rehabilitation and Compensation Act 2013

133. Victoria's workers compensation scheme is primarily governed by the *Workplace Injury Rehabilitation and Compensation Act 2013* (WIRC Act). The WIRC Act came into operation on 1 July 2014. Throughout this report, I refer to the WIRC Act.
134. The nine objectives of the WIRC Act include to:
- 'reduce the incidence of accidents and diseases in the workplace'
 - provide 'for the effective occupational rehabilitation of injured workers and their early return to work'
 - 'ensure appropriate compensation ... is paid to injured workers in the most socially and economically appropriate manner, as expeditiously as possible'
 - 'ensure workers compensation costs are contained so as to minimise the burden on Victorian businesses'
 - 'establish incentives that are conducive to efficiency and discourage abuse'
 - 'maintain a fully-funded scheme'
 - 'improve the health and safety of persons at work and reduce the social and economic costs to the Victorian community of workers compensation'.⁸³

Claims Manual

135. The purpose of the Claims Manual is to assist agents to make decisions in line with the relevant legislation.⁸⁴ Accordingly, the Claims Manual outlines detailed requirements in relation to decision-making and claims management. WorkSafe advised my investigation that the Claims Manual is a Written Direction issued pursuant to the contract with the agents. As such, agents are obliged to use the entirety of it when managing claims.⁸⁵

Sound decision-making

136. The Claims Manual provides agents with a 'sound and proper decision making checklist'. This includes a declaration that agent staff must sign upon issuing a rejection or termination notice. The declaration confirms they have made a 'fair and proper decision taking into consideration all available information'.⁸⁶
137. The Claims Manual also outlines principles of good administrative decision-making to which agents are required to adhere.⁸⁷ These align with the commonly accepted tenets of sound decision-making by public sector agencies.

⁸⁴ WorkSafe Victoria, *Claims Manual*, Purpose of the manual, updated 18 September 2015.

⁸⁵ WorkSafe Victoria, Response to the Ombudsman's request for information - schedule of request reference 10 provided on 22 July 2016.

⁸⁶ WorkSafe Victoria, *Claims Manual*, Appendix - Sound & Proper Decision Making Checklist, updated 18 September 2015.

⁸⁷ Summary of key principles from WorkSafe Victoria, *Claims Manual*, section 1.4.1.4, Principles of good administrative decision-making, updated 18 September 2015.

⁸³ WIRC Act 2013, s. 10.

WorkSafe's principles of good administrative decision-making

- Agents can only make decisions authorised by the legislation.
- An agent can only exercise a statutory power for the purpose for which it was conferred under the legislation (i.e. not for an improper purpose).
- Agents must consider all matters relevant to the decision to be made.
- Agents must not rely on irrelevant considerations in reaching a decision. This includes incorrect or unsubstantiated facts.
- Agents should always consider the limits of their discretion, ensuring they act in accordance with the legislative framework.
- Decisions made by agents should be based on, and supported by, the best available evidence.
- Agents must give proper, genuine and realistic consideration to the merits of a decision, and this should be documented in case the decision is challenged.
- Agents should list all matters considered in reaching a decision.⁸⁸

138. While the Claims Manual is regularly updated, these principles are reflected consistently in previous versions.

WorkSafe's five values

139. The Claims Manual also notes the importance of ensuring that WorkSafe's five values guide the management of the scheme by ensuring that WorkSafe and the agents are:

Constructive in the way we provide information, advice and service.

Accountable for what we do and what we say. We live up to our promises. Working in a **transparent** way in an environment which is open and honest. **Effective** by working collaboratively to deliver high quality services. **Demonstrate care** by showing empathy in our dealings with everyone we work with⁸⁹ [my emphasis].

140. Adherence to these values is particularly important for private insurers who must act in accordance with WorkSafe's statutory functions and in the public interest while being driven by commercial interests.

141. WorkSafe's five values are consistent with the broader Victorian Public Sector values which, among other things, oblige public officials to:

- demonstrate integrity by 'being honest, open and transparent in their dealings' and 'striving to earn and sustain public trust of a high level'
- demonstrate impartiality by 'making decisions and providing advice on merit without bias, caprice, favouritism or self-interest' and 'acting fairly by objectively considering all relevant facts and fair criteria'.⁹⁰

88 Ibid.

89 WorkSafe Victoria, *Claims Manual*, section 1.1.2 Vision, mission & values of WorkSafe, updated 18 September 2015.

90 Victorian Public Sector Commission, *Code of Conduct for Victorian Public Sector Employees*, 1 June 2015.

Ministerial Guidelines

142. The *Ministerial Guidelines as to Authorised Agent, Self-insurer, Employer and Workers' Assistant Conduct at Conciliation Conference* (the Ministerial Guidelines) relate to the conduct of agents, employers and workers during the conciliation process. They were issued by the then Assistant Treasurer to the ACCS in 2011.
143. The Ministerial Guidelines require agents participating in the conciliation process to take all reasonable steps to settle disputes by, among other things:
- 'meaningfully and genuinely discussing all relevant issues raised at conference'
 - 'ensuring that it [the agent] maintains only the decisions which have a reasonable prospect of success were they to proceed to Court'.⁹¹
144. WorkSafe reinforces the requirement to take all reasonable steps to settle disputes in its contract with the agents.⁹²

Model Litigant Guidelines

145. Under the contract, agents are also required to comply with the *Victorian Government Model Litigant Guidelines* when defending decisions through the dispute process.⁹³ These guidelines set standards for how State Government agencies, including WorkSafe and the agents, should behave as a party to legal proceedings, which includes during alternative dispute resolution processes such as conciliation.
146. The guidelines state that being a model litigant requires agencies to act 'fairly', 'with complete propriety' and 'in accordance with the highest professional standards'. The guidelines further state that the obligation to act as a model litigant 'may require more than merely acting honestly and in accordance with the law and court rules'.⁹⁴

⁹¹ *Ministerial Guidelines as to Authorised Agent, Self-insurer, Employer and Workers' Assistant Conduct at Conciliation Conference*, Section 5, issued by The Hon Gordon Rich-Phillips MLC, Assistant Treasurer on 13 April 2011.

⁹² WorkSafe Victoria, *Agency Agreement*, Schedule A, 2011.

⁹³ Ibid.

⁹⁴ Ibid.

147. The requirements covered in the guidelines include that an agency must:

- (a) act fairly in handling claims and litigation brought by or against the State or an agency;
- (b) act consistently in the handling of claims and litigation;
- (c) deal with claims promptly and not cause unnecessary delay;
- (d) make an early assessment of:
 - (i) the State's prospects of success in legal proceedings; and
 - (ii) the State's potential liability in claims against the State;
- (e) pay legitimate claims without litigation, including making partial settlements of claims or interim payments, where it is clear that liability is at least as much as the amount paid;
...
- (h) when participating in ADR [alternative dispute resolution such as conciliation] or settlement negotiations, ensure that as far as practicable the representatives of the State or the agency:
 - (i) have authority to settle the matter so as to facilitate appropriate and timely resolution; and
 - (ii) participate fully and effectively.
...
- (j) do not take advantage of a claimant who lacks the resources to litigate a legitimate claim;
- (k) do not undertake and pursue appeals unless the State or the agency believes that it has reasonable prospects of success or the appeal is otherwise justified in the public interest; and
- (l) consider apologising where the State or the agency is aware that it or its representatives have acted wrongfully or improperly.⁹⁵

148. In addition to litigation, WorkSafe requires agents to apply the guidelines when reviewing a decision prior to conciliation and when participating in a conciliation conference.⁹⁶

95 Ibid.

96 WorkSafe Victoria, *Participant Workbook - Dispute Resolution Officer Training*, 2011, page 12.

Unreasonable decision-making by agents

A key focus of my investigation was to establish whether agents had unreasonably denied liability or terminated entitlements for workers compensation claims.

We saw instances of good administrative decision-making and practices by some agent staff. However, my investigation found examples of unreasonable decision-making by all five agents. Specifically, I found that agents had, in some cases:

- unreasonably used evidence in decision-making
- maintained unreasonable decisions at conciliation
- made decisions contrary to binding Medical Panel opinions
- allowed employers to improperly influence their decision-making
- provided inadequate internal review processes.

Agents' use of evidence in decision-making

149. As discussed in the previous chapter, the WIRC Act provides the framework within which agents manage workers compensation claims. It outlines when a worker is and is not entitled to compensation, and the decisions that agents may make to manage claims.
150. In addition, the Claims Manual provides agents with detailed guidance on decision-making and claims management. Under the contract, agents are 'obliged to use the entirety of the Claims Manual when managing claims'.⁹⁷

151. I identified a range of ways that agents used evidence to make decisions that were inconsistent with the requirements of the Claims Manual and did not demonstrate good administrative decision-making.
152. In some cases, the evidence shows agents:
- selectively using evidence to reject or terminate entitlements
 - providing incomplete or inaccurate information to IMEs, whose opinion they then relied on to reject or terminate entitlements
 - requesting supplementary reports from IMEs to attempt to influence or change their opinion
 - selectively using IMEs whom they believed would likely provide an opinion that was adverse to the worker
 - engaging in 'doctor shopping' for IME opinions
 - posing leading questions to IMEs.
153. Each of these issues is set out separately below.

Selective use of evidence

154. Agents are required to make decisions on claims based on and supported by the best available evidence, taking into account all relevant considerations to the decision.⁹⁸
155. Sometimes there will be differing medical opinions about a worker's condition and capacity to return to work, particularly in complex cases where a worker has multiple injuries or conditions. However, agents must consider all relevant evidence in reaching decisions, and document their rationale for any evidence they choose to disregard.⁹⁹

⁹⁷ WorkSafe Victoria, Response to the Ombudsman's request for information, reference 10, 22 July 2016.

⁹⁸ WorkSafe Victoria, *Claims Manual*, section 1.4.1.4 Principles of good administrative decision-making, updated 18 September 2015.

⁹⁹ WorkSafe Victoria, *Agent Remuneration, Quality Decisions Measure Business Rules, Annual Performance Adjustment Fee 2014/2015*, March 2015.

156. A QBE email showed these requirements being reinforced to staff. The email advised staff not to ignore the opinions of a worker's doctor(s) 'in favour of the IME [Independent Medical Examiner] outcome'¹⁰⁰ and stated:

[I]n being transparent in our determinations, and having a need to consider all relevant evidence – both the good and the bad – we should refer to all reports obtained as a matter of course. Whenever addressing evidence in our adverse notice that doesn't support our decision we should indicate in our summary as to why other evidence is preferred.¹⁰¹

157. Despite the Claims Manual's clear requirements, there are numerous examples of agents selectively using evidence to support a decision to reject or terminate a claim, while disregarding other available evidence. This occurred even in cases where the weight of evidence in support of the worker's claim was considerable, including from several different sources.

158. Examples identified by my investigation included cases where agents relied on one piece of evidence over other available evidence, as well as cases where agents used isolated extracts within a single medical report, without considering the practitioner's whole opinion.

159. At interview, a worker representative said that they had seen decisions disputed at conciliation where the agents had selectively relied on one line of a medical report to issue a termination. The representative stated:

[I've seen cases where] they've [the agent] asked the [IME] doctor a question and he's answered that question in two or three different ways and one of those ways is to their [the agent's] favour, then they'll grab hold of that line and use that line to terminate the worker's entitlement.¹⁰²

160. A psychiatrist who treats injured workers also stated:

During my time [as a psychiatrist] ... I have experienced numbers of examples where my patients, who have long-standing disabilities associated with work injuries, have been abruptly terminated on the basis of one examination by a so-called independent medical examiner. My contrary opinion, based on seeing the patient on a regular basis often over a period of years was ignored as was that of their general practitioners.¹⁰³

161. In case study 1, Xchanging rejected a worker's claim based on one piece of evidence, despite significant medical evidence indicating it should have been accepted. This matter was brought to my attention by an Xchanging staff member who provided my office with several emails demonstrating they had raised concerns about this claim with senior management, who had pressured them to make a decision that conflicted with all of the available evidence.¹⁰⁴

162. When my officers examined Xchanging's files for this claim, these emails were not stored on either the electronic or hard copy file. This is inconsistent with the agents' obligations under the contract.¹⁰⁵ Agents' failure to store documents relating to decision-making on the relevant file was an issue identified in several other claims that we examined.

100 Email dated 18 February 2015 between QBE staff.

101 Email dated 20 May 2015 between QBE staff.

102 Interview of worker representative.

103 Letter dated 13 December 2015 from Psychiatrist.

104 Email between Xchanging staff in August 2014.

105 Clause 21 of the WorkSafe Agency Agreement required the agent to maintain full and accurate hard copy and/or electronic records in accordance with standards issued under the *Public Records Act 1973*. Section 13 of the *Public Records Act* states that agencies have an obligation to ensure that 'full and accurate records of the business of the office' are made and kept. Non-compliance with the *Public Records Act* may amount to a breach of the Act.

Case study 1: Rejection of claim despite the ‘weight of evidence’ in support

In early 2014, a worker made a claim to Xchanging for injuries they sustained as a result of two falls at work, both of which were witnessed by other employees. After lodging the claim, the worker’s employer wrote to Xchanging stating that it wanted the agent to hold off on making a decision, pending examination of the worker by one of two specific IMEs. The agent then arranged an examination with one of the specified IMEs (IME 1). The Claims Manual states employers must not exert influence on the choice of the IME and the process.¹⁰⁶

IME 1 expressed an indefinite opinion on cause of injury

IME 1 was unable to provide a specific diagnosis regarding the worker’s injury but, on the balance of probabilities, concluded that employment had not contributed. He specifically stated that further evaluation was **‘urgently required’** [his emphasis], including a neurological opinion.

IME revised his view and Xchanging requested a second report

After providing his report, IME 1 contacted Xchanging to advise that he had been premature in his opinion and that, on the balance of probabilities, the falls at work could have caused the injury.

Xchanging provided IME 1 with a copy of the circumstance investigation report and requested a supplementary report. IME 1 again advised he could not provide a precise diagnosis as Xchanging had not provided him with a neurological opinion or MRI scan, as suggested in his first report. He stated that:

The relationship between employment and the worker’s condition could ... be work-related but I stress this depends upon a precise diagnosis ... [T]he fall [at work] ... could be a significant contributing factor ...

Xchanging rejected the claim despite IME 1’s conditional statement

Xchanging rejected the worker’s claim on the basis that the circumstance report stated the worker’s injuries were not caused by work. This was despite IME 1 having reviewed the circumstance report and still concluding in his supplementary report that the fall at work could have been a significant contributing factor to the worker’s injury, and despite his urgent recommendation for further evaluation.

IME 2 concluded three times that the work incidents were the cause of the worker’s injury

After rejecting the claim, Xchanging sent the worker to be examined by a neurologist (IME 2). It is unclear why Xchanging did not seek this opinion before issuing the rejection notice.

¹⁰⁶ WorkSafe Victoria, *Claims Manual*, Section 2.7.2 IME examination and report, updated 18 September 2015.

IME 2 concluded that the work incidents were the cause of the worker's injury, that it was a new injury, and that the worker had no work capacity. IME 2 confirmed in two subsequent supplementary reports that the injury was caused by work.

Following this, a manager advised a Senior Officer in an email that '[This claim is] clearly an accept.'

IME 2 restated his previous position a fourth time

Internal file notes show that the employer asked Xchanging to review the claim further. As a result, Xchanging requested a third supplementary report from IME 2, outlining Xchanging's 'observations', including that a witness to the fall could not recall any obvious injuries to the worker and there was a delay in the worker seeking treatment.

IME 2 provided a further report noting Xchanging's comments, but stating he remained of the view that the injury was caused by the incidents at work. This was the fourth report in which IME 2 had provided their opinion that the injury was caused by work.

On this basis, an Xchanging manager drafted an email to the worker's employer advising that Xchanging needed to reverse its decision as all of the available evidence indicated the worker had sustained a work-related injury, and the worker's claim should therefore have been accepted.

Xchanging senior management subsequently redrafted the email to the employer, providing them with two options as to how Xchanging would proceed:

1. Maintain current rejection of liability. We believe this would be a short term situation as the worker has indicated [they] will appeal to Conciliation, should the original rejection decision not be changed. With the weight of the evidence we believe the Conciliation Service would most likely issue a Direction to make payments in this matter.
2. Reverse the original decision and accept liability on the basis of evidence supporting a work related injury.

I note that a direction can only be issued at conciliation if the ACCS considers the agent's decision to be unarguable. Xchanging stated in the email to the employer that they 'looked forward to [the employer's] decision in this matter'.

Xchanging maintained its rejection, despite the weight of evidence supporting acceptance

Xchanging maintained its rejection. The worker lodged a request for conciliation and it was not until late 2014, seven months after the claim was lodged, that Xchanging withdrew its decision and accepted the claim prior to conciliation.

It is evident that this delay in Xchanging's acceptance of the claim resulted in financial stress for the injured worker, as evidenced in this email from the worker to Xchanging:

I feel that Xchanging is not doing the right thing to me ... I am using my own long service [leave] to pay my house and other bill[s]. I have only 3 week of pay left so I do[n't] know what to do after this. So please help me.

163. The following was another example identified through a sample of email data. In this case, Gallagher Bassett rejected a worker's request for treatment, relying on isolated parts of a referral from the worker's General Practitioner (GP). This was despite the referral, when read in full, supporting approval of the treatment.

Case study 2: Agent admits 'nothing to rely on in rejecting his claim'

A police officer lodged a claim for post-traumatic stress disorder (PTSD) that developed following involvement in a shooting. Gallagher Bassett accepted the claim.

The worker experienced a range of symptoms as a result of their PTSD, including daily nightmares, and subsequently fell out of bed during a nightmare, injuring their arm. The worker sent Gallagher Bassett a referral from their GP for physiotherapy treatment and requested it confirm approval of payment.

Gallagher Bassett omitted evidence from the worker's GP in its decision-making

Gallagher Bassett rejected the worker's request for treatment on the basis that the worker's GP's referral did not support a link between the requested treatment and their accepted workplace condition of PTSD. Its notice included extracts from the GP's referral detailing the diagnosis and recommended treatment, but omitted the extracts that demonstrated the link between the injury and the worker's PTSD.

Decision to reject was reviewed and found to have no basis

The worker asked Gallagher Bassett to review its decision, raising concerns about its selective use of evidence, stating:

An avid reader could conclude based on the information you have placed into this letter that there is no nexus between the ... [arm] injury and the PTSD I am on workcover for however my issue is that you have only included half of the information on the referral provided by [my GP].

...
By reading this FULL referral and not selectively removing elements that are detrimental to your justification, it can clearly be seen that the injured ... [arm] is directly related to my approved workcover claim for PTSD. I find it quite disturbing that you feel that you can use poetic licence on a medical document to add weight to your decision.

Gallagher Bassett's initial review concluded that the decision to reject 'seemed to have no basis' and to have been made 'purely on the basis that the work injury is for PTSD and the new injury is a physical injury'.

The senior officer reviewing the matter stated that 'no analysis of the connection [had] been made and it wouldn't even get past the arguable test case'.¹⁰⁷ The senior officer went on to say, 'if I was a conciliation officer, I'd issue a direction on this one'.

Two weeks after its original decision, Gallagher Bassett reversed its decision, acknowledging it had 'nothing to rely on in rejecting [the] claim'.

¹⁰⁷ At conciliation, the ACCS may issue a direction that an agent pay compensation to a worker where it is satisfied that there is 'no arguable case'. This is further explained in the next chapter of my report.

164. The sample of email data examined during my investigation provided another example of agents' selective use of evidence, as shown in case study 3.

Case study 3: 'Last ditch effort' to change IME's opinion

A personal carer made a claim for a wrist injury sustained at work, which Allianz accepted. The worker subsequently returned to work, but later stopped work and underwent surgery twice.

IME 1 recommended the worker be re-examined post-surgery

A few months before the worker's second surgery, Allianz arranged for the worker to be examined by IME 1 who concluded the worker had no work capacity for the foreseeable future. IME 1 recommended the worker be re-examined after their surgery.

Surgeon's first report indicated return to work to modified duties in 9-12 weeks

Following the surgery, Allianz obtained a report from the worker's surgeon that stated he expected the worker to be able to return to modified duties in nine to twelve weeks' time.

IME 2's first report confirmed worker was incapacitated indefinitely

Allianz then sent the worker to be examined by IME 2 (as IME 1 was unavailable), who concluded that the worker was incapacitated and this may continue indefinitely. The IME said the worker was unlikely to have a capacity for suitable employment in the next six to 12 months and their capacity was dependent upon their post-operative outcome, which would not be clear for some time.

Allianz sought a second report from IME 2 as a 'last ditch attempt'

Allianz sought a supplementary report from IME 2, and provided him with a copy of the worker's surgeon's report. An internal Allianz email said this was done 'as a last ditch effort' to see if it changed IME 2's opinion.

IME 2 reinforced that the incapacity was indefinite

In IME 2's report to Allianz, he reiterated that if the worker was to develop a work capacity, it would only be to perform modified duties. IME 2 suggested a trial return to work period could commence once the worker's wrist had stabilised.

A second report from the worker's surgeon did not specify a timeframe for gaining work capacity

Around the same time, Allianz obtained a further report from the worker's surgeon, in which he said the worker's recovery was continuing and that their ability to return to work would be discussed with them at their next upcoming review.

Neither IME 2 nor the worker's surgeon specified a timeframe within which the worker would gain a capacity.

Emails show Allianz relying on one piece of evidence to support termination

Internal emails showed that Allianz considered issuing a 130 week termination notice¹⁰⁸ to the worker, but had concerns around the supporting evidence. One email from a manager said:

I'm not sure it's strong enough to withstand conciliation but happy to write it up [as a 130 week termination notice] upon your direction to do so.

¹⁰⁸ An agent must terminate a worker's entitlement to weekly payments after they have received 130 weeks of payments if they have a work capacity, or alternatively, they are incapacitated but this is unlikely to continue indefinitely.

The email noted that IME 2 had concluded in two separate reports that the worker's incapacity was indefinite, meaning the worker was entitled to weekly payments under the WIRC Act. However, the email proposed that Allianz issue a termination notice on the basis of the first report from the worker's surgeon, which stated that the worker would have a capacity within nine to 12 weeks. It also noted that IME 2 had maintained his opinion even after being provided with the report from the worker's surgeon.

Another manager responded to the email advising they would need to seek a further report from the worker's surgeon while noting that they would 'clearly be fishing for a termi[nation] here'.

Worker's surgeon reiterated that the worker was unfit for work

In a subsequent third report, the worker's surgeon again said the worker was unfit for work and their capacity would be reviewed at their next consultation.

Allianz terminated on selective evidence

Allianz consequently terminated the worker's entitlements at 130 weeks on the basis of the worker's surgeon's first report. This was despite both IME 1 and IME 2's opinions that the worker's incapacity was indefinite, and the worker's surgeon's two subsequent reports, which indicated that the timeframe within which they would gain a capacity was unclear.

The worker disputed the termination at conciliation and the ACCS concluded there was a genuine dispute. As such, the termination remained in effect at the time of my investigation and the worker remained without payments.

In response to my draft report, Allianz stated:

The medical opinions suggest that although the worker remained incapacitated at the time of assessment, it was not evident that this incapacity would persist indefinitely. The claims team, in this instance, chose to afford greater weight to the evidence of the worker's treating surgeon. It was considered that the treating surgeon in this instance, having an intimate knowledge of the worker and their postsurgical recovery, was best placed to determine capacity. We submit that this should not be regarded as a 'selective use of evidence' but rather the use of the 'best evidence' ...

We note that the worker was concurrently employed throughout the life of the claim, absent from work only for the purpose of undergoing surgery and subsequent convalescence. This is a clearly demonstrated work capacity, and we advise that our decision to terminate the worker's entitlement at the 130 week mark has been maintained on this basis.

165. In a submission to my office, a psychologist who treats injured workers provided a further example of agents' selective use of evidence. In this case, he said the agent had terminated a worker's entitlements on the basis that the worker had 'unreasonably refused medical treatment'. He said the agent's notice to the worker selectively quoted extracts from IME reports as well as reports from the psychologist, which referred to the worker 'refusing' to take anti-depressants to treat his psychological condition.

166. The psychologist provided a letter for conciliation highlighting the extracts of the reports that the agent had omitted. They included that the IME had noted that taking any medication was voluntary, and the worker had expressed concerns on numerous occasions that they would become addicted to or overdose on such medication. The psychologist said the worker's payments were later reinstated.

Provision of incomplete or inaccurate information to IMEs

167. In many cases, IMEs have not had any contact or previous involvement with an injured worker before an IME examination. This means the background material that agents provide to IMEs to inform their assessment is important. This is especially so for historical claims where the worker's original injury may date back many years, or where the worker's condition is particularly complex.

'It is essential we send appropriate material to IME's to assist them in the medical review of your injured worker. I am aware of past circumstances where we may have sent too little - or too much ... in preparing the IME's letter, carefully consider what information would assist the IME in providing an informed medical opinion ... your diligence will go a long way towards ensuring informed and sustainable decision-making.'

Email from agent manager to claim staff

The Claims Manual outlines what agents should send to IMEs

This includes:

- details about if and when the IME has previously examined the worker
- the worker's claim form and certificate(s) of capacity
- any previous IME reports from different IMEs
- any treating health practitioner reports, including radiology or surgical reports
- the worker's position description (pre-injury and/or current).¹⁰⁹

It states that other relevant information may include:

- the worker's previous claims history
- requests for acceptance of liability for proposed surgery
- report(s) by an occupational rehabilitation provider.¹¹⁰

¹⁰⁹ WorkSafe Victoria, *Claims Manual*, Section 2.7.3.4 Information for the IME, updated 18 September 2015.

¹¹⁰ *Ibid.*

168. A QBE email showed these requirements being reinforced to staff. The email stated:

It is essential we send appropriate material to IME's [*sic*] to assist them in the medical review of your injured worker. I am aware of past circumstances where we may have sent too little - or *too much* [QBE emphasis] ... in preparing the IME's letter, carefully consider what information would assist the IME in providing an informed medical opinion ... your diligence will go a long way towards ensuring informed and sustainable decision-making.¹¹¹

169. However, claims files showed that in some cases agents failed to provide key information and reports to IMEs.

'I feel that [the agent] is not doing the right thing to me ... I am using my own long service [leave] to pay my house and other bill[s]. I have only 3 week of pay left so I do[n't] know what to do after this. So please help me.'

Email from the injured worker in case study 1

170. Case study 4 is an example. This case came to my attention after the worker's family member contacted my office. In this case CGU sought an IME's opinion on a worker's long-standing psychological condition without providing historical information about the work incidents that had caused the condition. CGU later terminated the worker's entitlements based on the IME's report. This case had a tragic outcome with the worker committing suicide shortly after the decision to terminate payments was overturned.

Case study 4: Injured worker suicides after entitlements are finally reinstated

A business manager lodged a claim with CGU for a psychological condition that developed after having been sexually harassed and assaulted by their boss. CGU initially rejected the claim. After disputing the matter at conciliation, the case proceeded to the Magistrates' Court – over a year after the initial rejection. The Magistrate found that 'serious sexual misconduct and harassment' had occurred and that the worker had sustained a work-related injury as a result, which had rendered them incapacitated and needing medical treatment.

CGU accepted the worker's claim on the basis of this finding

Over the coming years, CGU received several medical reports from both IMEs and the worker's doctors. These reports provided relatively consistent opinions on the worker's condition and incapacity for work. CGU funded a range of treatments for the worker including sessions with a psychiatrist, medication, psychiatric inpatient stays and day programs.

CGU did not provide relevant historical records to an IME

Following a request in mid-2015 from the worker's treating psychiatrist for the worker to participate in further programs, CGU sent the worker to be examined by an IME. CGU stated the purpose of the examination was to obtain an opinion on the reasonableness of the requested programs, whether the worker's condition continued to be work-related and whether the treatment they were receiving was reasonable.

¹¹¹ Email dated 29 May 2015 from QBE Manager to claims staff.

In its request to the IME, CGU failed to provide any historical medical reports from the time of the worker's initial diagnosis and claim acceptance. Nor did it provide any details regarding the court finding.

In her report to CGU, the IME provided a different diagnosis to the worker's treating psychiatrist and previous IMEs. The IME concluded that as a result of the work incident, the worker had suffered a work-related aggravation of a pre-existing condition, but that the work-related aggravation had now ceased. She stated the worker would continue to require treatment indefinitely but this was no longer for a work-related injury.

On numerous occasions in her report, the IME noted the lack of documentation and information provided to her by CGU. She made comments such as 'I was not provided any documentation to assist', 'based on my clinical examination but no further evidence provided ...' and 'I would have been assisted in providing this report by additional documentation in order to answer the specific questions posed for the examination in more depth'.

On the basis of the IME report, CGU rejected the request for program support and terminated all entitlements

Based solely on the IME report, CGU issued notices to the worker rejecting the request for the further programs and terminating all of their entitlements.

The notices made no reference to other medical evidence such as reports from the worker's treating psychiatrist, which did not support the decisions. Nor did CGU document any rationale as to why they chose to rely solely on the IME's opinion over all other available evidence.

The worker subsequently lodged a request for conciliation.

CGU failed to provide relevant history a second time

In a supplementary report, the IME again confirmed the worker required treatment but stated she considered the worker's work injury had ceased, instead referring to a pre-existing condition. Again, the IME made comments about the lack of information provided by CGU, including that she had 'not been provided with sufficient information to make connection between this deterioration in mental state and work related injury which occurred in [the mid-2000s]'

CGU provided partial history when requesting a second supplementary report

Following concerns raised by the worker's treating psychiatrist and the provision of further medical evidence to CGU supporting an ongoing nexus between the worker's condition and work-related incidents, CGU sought a second supplementary report from the IME. In this request, CGU provided the IME with copies of two previous IME reports as well as recent reports from the worker's doctors.

However, CGU again failed to provide any information about the Magistrates' Court finding on which CGU's acceptance of the claim was based. In response, the IME again noted that 'the circumstances of [the] events/sexual assaults are not clear'.

Following Medical Panel opinion, CGU's decision was overturned

Further medical reports provided to the ACCS for the purpose of conciliation supported the treating psychiatrist's view on the continuing relationship between the worker's condition and workplace incidents. The ACCS referred the matter to a Medical Panel, which concluded that the claimed work-related injury still materially contributed to the worker's condition.

The Medical Panel noted the IME's opinion; however, it stated 'on the basis of its own history taking and examination and clinical judgement and experience, the Panel formed a different diagnostic opinion'. The panel also noted that its opinion regarding the worker's diagnosis was consistent with all other medical evidence, with the exception of one IME - the IME used by CGU to terminate the claim.

CGU reinstated the worker's entitlements and approved the requested programs on the basis of the Medical Panel opinion. Sadly, however, the worker committed suicide shortly after this decision.

In response to the draft report, CGU stated:

Mental health and suicide is complicated and there are a multitude of factors that can play a part in suicide. The indications are that there are matters outside of just the work related component that may have contributed.

...

We note that the IME has noted that she was not provided with information relating to the workplace incident that caused the initial injury. The matters surrounding the incident were not in dispute. The claim was subject of a Magistrates Court hearing where the Magistrate found in favour of the injured worker and CGU has not disputed the injured worker's allegations surrounding the workplace incident. CGU would note that the IME was provided with previous IME reports ... which themselves reference earlier material. CGU acknowledges that improvements can be made to the decision making around information that is provided to IMEs ...

'My issue is that you have only included half of the information on the referral provided by [my GP] ... By reading this FULL referral and not selectively removing elements that are detrimental to your justification, it can clearly be seen that the injured ... [arm] is directly related to my approved workcover claim for PTSD. I find it quite disturbing that you feel that you can use poetic licence on a medical document to add weight to your decision.'

Email from the injured worker in case study 2

171. In the following case study, Gallagher Bassett failed to provide relevant background information to an IME about a work-related condition that was diagnosed over 20 years prior to the claim. Gallagher Bassett later relied on this IME's opinion to terminate the worker's claim. This case came to my attention as a result of a complaint to my office.

Case study 5: Termination of 20 year claim despite knowing the decision was ‘not strong’

A police officer was diagnosed with Type 1 diabetes in the late 1980s, found to have been caused by workplace stress.

The worker’s claim was initially rejected but later accepted. The worker returned to work after having a short period of time off; however, the worker continued to receive payments for medical expenses relating to their ongoing treatment.

In 2012, more than 20 years after the acceptance of the claim, Gallagher Bassett sent the worker to an IME ‘to determine if the worker’s employment with Victoria Police remains a significant contributing factor, and if there is a direct relationship between the worker’s psychological condition and [the worker’s] diabetes’. In doing so, Gallagher Bassett sought to re-examine liability for the previously accepted claim.

According to WorkSafe, an agent is only able to re-examine liability if there is ‘significant new information’.¹¹² However, in this case, there was no new information, and no change in the worker’s condition to warrant such a review.

Gallagher Bassett failed to provide the IME with historical medical reports

In its request to the IME, Gallagher Bassett did not provide any historical documentation about the worker’s condition, such as medical reports from the 1980s, which provided the basis for the acceptance of the claim.

In a report to Gallagher Bassett, the IME stated:

You have already indicated that [the worker has] an accepted claim for [their] diabetes being due to work-related stress. I am not sure whether this question is here to challenge that claim ... it is difficult 24 years later to be able to fully assess [their] state at the time. However on the basis of what information is available to me, I would find it difficult to attribute the onset of Type 1 diabetes to [their] work.

Gallagher Bassett terminated the worker’s entitlements based on the IME’s report, despite the IME noting the difficulties he had assessing the worker’s state at the time of diagnosis, and that he was only able to provide an opinion based on the material available to him.

The worker lodged a request for conciliation.

Gallagher Bassett maintained their decision at conciliation, despite knowing it was ‘not strong’

An internal file note documenting Gallagher Bassett’s review of the matter prior to conciliation acknowledged that the decision was ‘not strong’ and that the worker’s condition had ‘progressively got worse (as would be expected) not better’. Despite this, Gallagher Bassett maintained the decision at conciliation.

The decision to terminate was overturned following Medical Panel opinion

It took until 2014, more than 18 months after the worker’s entitlements were terminated, for the matter to be referred to the Medical Panel. This was due to the extensive enquiries the worker needed to make to obtain historical medical reports as evidence of the cause of their condition.

The Panel provided their opinion in mid-2014, concluding that the worker’s employment materially contributed to their diabetes. As a result, Gallagher Bassett reinstated the worker’s entitlements.

¹¹² WorkSafe Victoria, Response to Victorian Ombudsman, reference 1, 21 July 2016.

Requests for supplementary IME reports

172. Once an IME has examined a worker and provided an opinion to an agent, the agent may request additional information through a supplementary report from that IME. In providing a supplementary report, the IME is not required to re-examine or recontact the worker.¹¹³
173. WorkSafe expects that supplementary reports will only be sought in limited circumstances, for example, where new information needs to be considered. A WorkSafe Executive elaborated at interview:
- [If] you receive another [piece of] information that you think might change things that the IME didn't have the time [to consider], you can actually say 'would you now consider this piece'. But really, that should be the only reason why you would say 'we're now seeking a supplementary report for you to review your opinion because we now have this piece of information'. That would be our expectations.
- ...
- a supp[lementary] report's not around seeking someone to change their opinion, it's around would that change because now there's different information ...¹¹⁴
174. There is no time limit within which a supplementary report may be sought; however, where six months have passed since the original examination, the agent is required to consider the nature of the extra information and the time passed. Where necessary, agents should seek advice from the IME as to whether they would need to re-examine the worker to provide the further report.¹¹⁵

Evidence from witnesses

175. Witnesses raised concerns about agents' use of supplementary reports, suggesting that they were often requested to attempt to change an IME's original opinion or gain further evidence to support a termination or rejection.
176. Officers of the ACCS advised that they had observed:
- common reliance on and/or need for the Authorised Agents to obtain supplementary reports from IME's [*sic*] – it's not uncommon for there to be multiple sup[plementary] reports. The requests for supplementary reports are often based on leading questions and often there is a lack of transparency when these 'fishing' exercises are undertaken.¹¹⁶
177. At interview, the then Senior Conciliation Officer of the ACCS further advised:
- The [agent] will get a report and it doesn't quite say what they want it to say. So they will frame another question and go back to the [same IME] and they will keep asking questions framed just differently enough to finally get the one answer they want. They will ignore everything previous to that and hang their hat on that last statement ... [The agent] is essentially opinion shopping ... [this practice is] very unjust.¹¹⁷
178. The Police Association of Victoria raised similar concerns about 'selective request[s] for supplementary reports by the agent', which they stated often contained 'targeted questions solely intended to elicit an opinion to deprive our members of their entitlements'.¹¹⁸
179. In response to the draft report, Gallagher Bassett stated:
- The lack of evidentiary support and use of incendiary language about assumed intentions is unjustified.

113 WorkSafe Victoria, *Claims Manual*, Section 2.7.4.4 Supplementary reports, updated 18 September 2015.

114 Interview of a WorkSafe Executive on 23 May 2016.

115 WorkSafe Victoria, *Claims Manual*, Section 2.7.4.4 Supplementary reports, updated 18 September 2015.

116 Information provided by the ACCS to the Victorian Ombudsman on 10 November 2015.

117 Interview of the former Senior Conciliation Officer of the ACCS on 7 September 2015.

118 Letter dated 18 November 2015 from the Secretary of the Police Association Victoria to the Victorian Ombudsman.

180. A former agent employee said that they witnessed this practice during their employment:

I do know other staff would request supp[lementary] reports to try and manipulate a decision of the IME ... by outlining a situation and asking them for clarification if that fit into the client's situation.¹¹⁹

181. A worker representative also commented that they had seen requests for supplementary reports by agents which appeared to be an attempt to change the IME's opinion. They said:

I've seen agents seek supplementary reports from doctors [IMEs] ... [where] they've asked the doctor the same question two or three times ... that's a frustration, clearly they're asking a doctor a question who's answered it, then they've asked the doctor the same question, then he's answered it again, then they may ask again, and it may alter his opinion.¹²⁰

'The [agent] will get a report and it doesn't quite say what they want it to say. So they will frame another question and go back to the [same IME] and they will keep asking questions framed just differently enough to finally get the one answer they want. They will ignore everything previous to that and hang their hat on that last statement ... [The agent] is essentially opinion shopping ... [this practice is] very unjust.'

Comment by the Senior Conciliation Officer of the ACCS

Agent views

182. Interviewed agent executives said they were not aware of this occurring, noting that it would be inconsistent with the Claims Manual.

183. The then Allianz General Manager commented:

My understanding of supplementary ... [reports] is to seek further clarification of the original examination, and it is a normal part of our business.

...

It's clearly not ... my expectations or the expectations of anyone in my organisation to direct a doctor to change their opinion.¹²¹

184. The National Manager Fee States at CGU similarly said:

... they shouldn't be doing it to change their opinion but should be doing it to seek clarification or when they've got other information that they need the IME to take into account. There's WorkSafe guidelines around when to request a supplementary report and when not to. So they should be doing that in accordance with WorkSafe's manual.¹²²

185. The following case provides an example of an agent seeking a supplementary report in an attempt to change the IME's opinion.

¹¹⁹ Interview of former agent employee on 20 April 2016.

¹²⁰ Interview of worker representative.

¹²¹ Interview of the former General Manager Workers Compensation, Allianz on 5 May 2016.

¹²² Interview of the National Manager Fee States, CGU on 24 May 2016.

Case study 6:¹²³ A supplementary report sought despite Allianz acknowledging it was difficult to ‘salvage an arguable case’

Allianz terminated a worker’s claim on the basis that they had a work capacity. The worker disputed the termination and Allianz acknowledged in its internal records that it was ‘difficult to see how we would be able to salvage an arguable case out of this’.

Two weeks later, Allianz requested a supplementary report from an IME who had already provided an opinion on two occasions that did not support the termination.

Allianz included leading information in its request to the IME, emphasising that it was ‘keen to assist in any way to facilitate a return to work’, and asking whether the worker would have a work capacity after completing a nominated training course.

The IME provided a further report to Allianz in which he said that the training course would have a ‘real prospect of leading to a return to work’; however, he did not state the worker had a capacity at that time.

In response to my draft report, Allianz stated:

We strongly refute that there is anything untoward in suggesting to an IME that retraining options were being considered.

This demonstrates Allianz’s commitment to exploring ways in which injured workers might transition into fulfilling and sustainable roles given return to work is a primary objective of the Victorian workers compensation scheme.

However, the timing of this request, coupled with Allianz’s file note which acknowledged the difficulty maintaining the decision, suggests that Allianz’s intention was to seek information to support a termination.

¹²³ Other issues were identified on this claim, which are detailed in case study 15 in this report.

186. Case study 1 in this report highlights similar issues. In this case, Xchanging sought three supplementary reports from the one IME.¹²⁴ The IME’s opinion remained unchanged. Information contained on the worker’s claim file suggested that Xchanging wanted to reject the worker’s claim and was trying to obtain evidence to support this.

Selective use of IMEs

187. The role of IMEs is established in the WIRC Act¹²⁵ and a number of WorkSafe documents:

As an IME you are being engaged by the requesting agent not as their agent (even though they are paying you), nor to act as the claimant’s personal doctor, but to provide a fully independent professional medical assessment of the case.¹²⁶

188. So, too, are requirements around agents’ interactions with IMEs, which state that agents should not attempt to influence IMEs and should not select IMEs based on any ulterior motive.

‘... the whole experience has been nothing short of horrendous ... I would not want my worst enemy to experience the process that I have endured.’

Email to VO from police officer

¹²⁴ These were in addition to the initial report provided by the IME following their examination of the injured worker. The IME provided a total of four reports to Xchanging.

¹²⁵ WIRC Act 2013, s. 27.

¹²⁶ WorkSafe Victoria, *Guide for Independent Medical Examination Reports*, Section 6, September 2013, retrieved online on 29 March 2016 from <https://www.worksafe.vic.gov.au/__data/assets/pdf_file/0011/102071/WSV1588-Handbook-for-independent-medical-examination-reports_web.pdf>.

Obligations of agents in selecting and engaging with IMEs

The Claims Manual states:

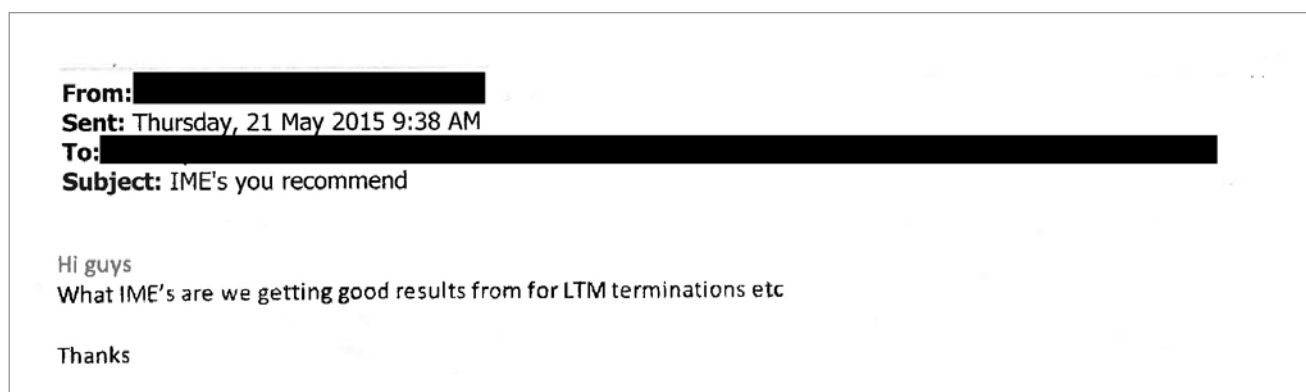
- The primary consideration about choice of IME should be to match the specialty of the IME to the worker's injury, the medical treatment, RTW [return to work] or claims issue to be resolved.
- The choice of the IME should not be motivated by the opportunity to obtain an opinion from an IME who is considered to hold particular views (adverse to workers or employers) on specific medical conditions or treatment issues.
- The Agent must not exert influence on the IME about the outcome of the examination report.
- Employers must not exert influence on the choice of the independent medical examiner and the process.¹²⁷

189. In some cases, the evidence suggested that agents' choice of IMEs may have been motivated by the opportunity to obtain an opinion from an IME who was considered to hold particular views.

190. Agent email data shows examples where agents sent injured workers to certain IMEs based on a belief that those IMEs were 'good for terminations'. This evidence included:

- a Gallagher Bassett 'approved IME list' that listed the details of several individual IMEs and their 'best use'. This included an IME who was described as 'good for terminations' and another who 'regularly endorsed a CWC [current work capacity]'¹²⁸
- an 'IME outcomes' spreadsheet maintained by Gallagher Bassett detailing the percentage of reports from each IME in which they had endorsed a work capacity, and the percentage of reports upon which a termination had been issued.¹²⁹ I note that, in response to the draft report, Gallagher Bassett stated that the use of this spreadsheet 'is mandated by GB's internal quality controls, endorsed by WorkSafe'
- another email from a Gallagher Bassett manager to several staff seeking their advice on the IMEs they recommend for long term terminations, see Figure 4 below:

Figure 4: Email seeking advice on IMEs that are recommended for terminations



¹²⁷ WorkSafe Victoria, *Claims Manual*, Section 2.7.2 IME examination and report, updated 18 September 2015.

¹²⁸ Gallagher Bassett, *Approved IME List*, undated.

¹²⁹ Gallagher Bassett, *IME outcomes*, undated.

- an email from an Xchanging Manager advising a staff member to issue a termination notice based on an IME opinion, stating '[IME X] strikes again. We need to use this guy more often'. Another staff member responded saying 'We are trying to use [IME X] as much as possible but it depends on the worker's location as well. I'm a fan of his'¹³⁰
- emails between CGU staff around 'preferred IMEs'. In one case, an officer responded they had not used one of the suggested IMEs much; however, they 'remember recently looking at a few ... terminations and they'd all come from him'.¹³¹ In response to the draft report, CGU stated:

[I]t is usual for Claims Managers to discuss claims and claims process and ... the performance and outcomes from IMEs should not be considered as inappropriate in every respect ... CGU does not condone the use of IMEs outside of the requirements set out in the Claims Manual.

WorkSafe and agent executives' evidence

191. WorkSafe and agent executives refuted this evidence at interview. They suggested that agents who select IMEs because they are 'good for terminations' may be referring to how well the IMEs' reports 'stand up' in the dispute process when an agent has relied on their opinion to terminate or reject a claim. For example, the General Manager of Gallagher Bassett said:

What it refers to is the ability of these guys to give evidence, [to] stand up and give evidence ... the wording they could have used is 'reliable in court' ... whilst the wording [in the emails] isn't great, ... that's intentionally what it means.¹³²

192. In response to the CGU email outlined above, the CGU National Manager Fee States similarly stated:

It may not actually just be a termination it may be also the sustainability and good quality decisions. So, it could be that they're just not articulating themselves clearly ... it's not about finding somebody [an IME] whose going to give you the opinion you want, you want to find someone who's going to give you an opinion that is accurate and sustainable ... I don't condone the language or how it's been framed ... I just don't know whether or not ... there was good intent or evil intent in it.¹³³

193. When shown some of the agent email evidence at interview, a WorkSafe Executive similarly questioned the meaning of agent staff's comments around IMEs being 'good for terminations', but said she had some concerns about the behaviour. She stated:

I do encourage them [the agents] ... to use across the list as much as possible ... So it's not something that we would encourage around an approved list, it should be around who is the most appropriate specialist for the issue that you're dealing with.

...

[I would question] what do they mean 'good for terminations'. So it could be that it's a very thorough report that they provide with all the reasons and everything very clearly articulated. So it may be a report that stands up well. It may not necessarily mean that ... they will always terminate.

...

Am I comfortable with the discussion? Probably not, I'd have concerns if there were particular IMEs that were known to terminate and I would be absolutely hoping that we're picking [them] up through our quality assurance program. And that [program] ... does assess bias as well, or ... if anyone was influenced around a decision.¹³⁴

¹³⁰ Emails between Xchanging staff on 20 May 2015.

¹³¹ Emails between CGU staff on 10 and 11 June 2015.

¹³² Interview of the General Manager Workers Compensation, Gallagher Bassett on 9 May 2016.

¹³³ Interview of the National Manager Fee States, CGU on 24 May 2016.

¹³⁴ Interview of Executive, WorkSafe on 23 May 2016.

194. The Executive reinforced that WorkSafe expects agents to use a variety of IMEs and noted that WorkSafe ensures IME reports are of a high quality through its quality assurance processes. She stated:

... we make sure that they're good quality reports because we have a quality assurance program to ensure that they are good quality reports, so again, it's not what I would be seeing as the way that you select an IME.

...

The message from us is that we want them [the agents] to use a spread of IMEs. We really do want them to try and use the list fairly extensively rather than just always using the same IMEs.¹³⁵

Witness evidence

195. Witness evidence shows that agents sometimes selectively use IMEs, with the ACCS stating that many matters that go to conciliation rely 'on a small pool of heavily used IMEs, many of whom are largely removed from current clinical practice'.¹³⁶

196. At interview, a former agent executive said that agents have preferred lists of IMEs from whom they are more likely to get a report that would support a termination or rejection¹³⁷.

197. At interview, a psychologist who treats injured workers said that agents often send workers to the same IMEs, noting that 'there's a great incentive for them [IMEs] not to have an independent opinion, so they get repeat business'.¹³⁸

198. A worker representative also said they had observed agents overusing certain IMEs and suggested that agents should have less control over which IME a worker is sent to.¹³⁹

Perceptions that IMEs may be aligned to agents

199. An analysis of the costs paid by each agent to individual IMEs in 2014-15 confirmed that some IMEs are favoured and frequently used by particular agents. The table below outlines each agent's spend on its most frequently used IME.

Agent	IME	Total spend by agent on the IME	Total costs paid to the IME across scheme
CGU	IME A	Over \$600,000*	\$1.25 million
QBE	IME B	Over \$500,000^	\$1.1 million
Allianz	IME C	Over \$375,000^^	\$695,873
Xchanging	IME D	Over \$360,000#	\$446,874
Gallagher Bassett	IME E	Over \$245,000**	\$403,557

* This was 9% of CGU's total spend on IMEs for that year.

^ This was 9.6% of QBE's total spend on IMEs for that year.

^^ This was 6% of Allianz's total spend on IMEs for that year.

This was 8% of Xchanging's total spend on IMEs for that year.

** This was 4.3% of Gallagher Bassett's total spend on IMEs for that year.

135 Ibid.

136 The ACCS, *Information provided by the ACCS to the Victorian Ombudsman*, 10 November 2015.

137 Interview of former agent executive on 18 November 2015.

138 Interview of psychologist on 6 January 2016.

139 Interview of worker representative.

200. Evidence indicates that availability is a key consideration in agents' choice of IMEs. As such, some agents have 'block bookings' with specific IMEs. Comments were made at interview by both WorkSafe and agent executives that agents may 'favour' or frequently use certain IMEs based on the reliability and quality of their reports.

201. However, agents' frequent use of certain IMEs may create a perception that the agent and the IME are aligned.

202. Evidence provided by a WorkSafe Executive supported this:

... by you using that doctor all the time, [it] can be [seen as] 'well you use them all the time because of the opinion that they give you'.

...

If you're constantly working for just the one agent ... there is a perception that you're actually quite aligned with that agent.¹⁴⁰

'Doctor shopping'

203. There is evidence that, in some cases, agents are 'shopping' for an IME opinion; that is, agents are seeking an opinion from a second IME when the first IME's opinion does not enable it to terminate or reject a claim. Such behaviour is inconsistent with the requirements of the Claims Manual in relation to agents' use of IMEs.¹⁴¹

'The [agents'] main objective of an IME is to form an independent medical opinion which is adverse. That's why they [the agents] do it, so they can create a dispute.'

Comment made by an officer of the ACCS

204. At interview, a former agent executive said that this particularly occurred in agent teams responsible for 130 week terminations.¹⁴² The executive stated:

Their sole job is to terminate the benefits. They are the ones who tend to send the worker to a whole host of Independent Medical Examinations until they find a doctor who is prepared to say, 'yes this person has work capacity'.¹⁴³

205. The same former agent executive said it was 'well known' among agent staff that 'doctor shopping' had been occurring in the scheme for at least the last 10 years.¹⁴⁴ The former Senior Conciliation Officer of the ACCS also stated that IME doctor shopping was 'systemic in the WorkCover scheme'.¹⁴⁵

206. In correspondence to my office, a psychologist who treats injured workers also raised concerns about 'IME shopping', stating that 'if the insurers are getting the same answer [from an IME] that the client is not able to work, they often send them to someone else'.¹⁴⁶

207. An officer of the ACCS stated:

The [agents'] main objective of an IME is to form an independent medical opinion which is adverse. That's why they [the agents] do it, so they can create a dispute.¹⁴⁷

208. An email between CGU staff evidenced this, stating:

... I have booked this worker in with [an IME] ... so hopefully I will be able to issue a CWC [current work capacity] termo [termination] on him in June.¹⁴⁸

¹⁴² An agent must terminate a worker's entitlement to weekly payments after they have received 130 weeks of payments if they have a work capacity, or alternatively, they are incapacitated but this is unlikely to continue indefinitely.

¹⁴³ Interview of former agent executive on 18 November 2015.

¹⁴⁴ Interview of former agent executive on 18 November 2015.

¹⁴⁵ Interview of the former Senior Conciliation Officer of the ACCS on 7 September 2015.

¹⁴⁶ Letter dated 28 March 2016 from Psychologist.

¹⁴⁷ Meeting between the Victorian Ombudsman and an officer of the ACCS on 4 December 2015.

¹⁴⁸ Email dated 23 April 2015 from CGU Manager to other staff.

¹⁴⁰ Interview of Executive, WorkSafe on 6 May 2016.

¹⁴¹ WorkSafe Victoria, *Claims Manual*, Section 2.7.2 IME examination and report, updated 18 September 2015.

209. In response to my draft report, CGU stated:

CGU notes that this case is a long running claim with significant evidence suggesting that the injured worker grossly exaggerates his symptoms.

210. A separate CGU email in relation to another injured worker similarly stated:

He has an ime on Friday so hopefully we'll get a termo [termination] out of it.¹⁴⁹

211. In response to my draft report, CGU stated:

... CGU does not condone the language shown in these examples. Notwithstanding the language used, CGU considers discussions between claims staff on the sustainability of decisions reasonable, noting that we are required to make tens of thousands of decisions on thousands of claims a year.

212. At interview, a WorkSafe Executive elaborated on the purpose of examinations by IMEs, stating:

The purpose really is around obtaining medical information that the agent may not have available or may need. It sometimes can be a second opinion. So, really it is about purchasing the medical opinion of the medical practitioner.

...

As far as purchasing for a termination, that's not the purpose of it, it's for information and you shouldn't only be basing your decision on only one piece of information. It really should be that's the whole picture and there's a whole story in there. And the IME is really part of that story as well.

...

it isn't about terminating the injured worker from benefits, it's around getting medical opinion that's more information to help you make a decision and ... in [being] truly independent you shouldn't know what that information is until you actually get it back.¹⁵⁰

213. The Executive further said that this was 'not the approach we [WorkSafe] would like to see' but rather the approach should be around what agents can do to get workers recovered and back to work.¹⁵¹

'[I]n being transparent in our determinations, and having a need to consider all relevant evidence - both the good and the bad - we should refer to all reports obtained as a matter of course.'

Email between agent staff

'He has an ime on Friday so hopefully we'll get a termo out of it.'

Email between agent staff

214. In case study 7, Gallagher Bassett rejected a claim based on select extracts of an IME report and maintained its decision despite being aware that it had 'little prospect of success'. The ACCS subsequently raised concerns that Gallagher Bassett had 'shopped around' for an IME opinion to enable it to terminate the worker's claim.

149 Email dated 22 June 2015 from CGU Manager to CGU Manager.

150 Interview of Executive, WorkSafe on 23 May 2016.

151 Interview of Executive, WorkSafe on 23 May 2016.

Case study 7: ‘Doctor shopping’ for opinions to reject and later terminate claim

A supermarket employee made a claim to Gallagher Bassett for a back injury they sustained in mid-2014 as a result of repetitive heavy lifting, twisting and reaching to lift items at work.

IME 1 concluded the worker’s employment contributed to the injury

To determine whether it would accept the claim, Gallagher Bassett had the worker examined by IME 1. In his report to Gallagher Bassett, IME 1 stated four times that the worker’s employment had contributed to his injury:

[The worker’s] actual disc protrusion did not occur at the time of [their] working. However, it is reasonable to accept that [they were] predisposed to this event through the nature of [their] duties, including [their] last shift at work ... This is a new injury in a susceptible individual ... [the worker’s] employment, in my opinion, has contributed ... [the] contribution through [their] employment has been a major factor.

Gallagher Bassett rejected the claim based on selective extracts of the report

Gallagher Bassett subsequently rejected the worker’s claim on the basis that they had not sustained a work-related injury, noting that the IME had stated that the injury did not occur while the worker was working. In doing so, Gallagher Bassett failed to include IME 1’s comments that it was reasonable to accept that the injury had nevertheless been caused by work. Gallagher Bassett’s decision was also inconsistent with all other medical evidence available to it, including information it had received from the worker’s treating practitioners.

IME 1’s supplementary report concluded there was no connection between injury and work duties

After rejecting the worker’s claim, Gallagher Bassett sought a supplementary report from IME 1. Gallagher Bassett provided IME 1 with information about the worker’s duties, which was inconsistent with the duties the worker had described to IME 1. IME 1 provided a supplementary report in which he changed his opinion, stating there was no connection between the injury and the worker’s duties.

The IME did not explain any reasons for this conclusion. Nor did they provide a rationale for the change in opinion. The matter remained unresolved at conciliation, and proceeded to court.

IME 2 expressed opinion that the worker’s injury was work-related

In mid-2015, WorkSafe’s panel solicitor arranged for a report to be obtained from IME 2, who provided their opinion that employment had been a materially contributing factor to the injured worker’s condition.

Concerns around sustainability of decision

Information on the claim file indicated that Gallagher Bassett was aware that, apart from the supplementary report from IME 1, there was ‘overwhelming’ medical evidence that the injury was caused by work. Additionally, advice provided to Gallagher Bassett by a WorkSafe lawyer was that the decision had ‘little prospects of success’ and that it had become evident that a finding would be made against Gallagher Bassett.

Gallagher Bassett withdrew its rejection

Prior to court, Gallagher Bassett withdrew its decision to reject the claim and agreed to a settlement providing the worker with weekly payments.

This occurred almost a year after the worker was injured and 10 months after Gallagher Bassett rejected the claim.

Gallagher Bassett requested a further opinion from IME 3

Less than two months after the settlement, Gallagher Bassett sent the worker to another IME (IME 3), without providing the IME any previous IME or medical reports.

IME 3 provided a report in which he stated that the worker's work-related injury had now ceased and that they remained incapacitated because they were 'overweight and unfit'. Importantly, the injured worker was the same weight as when examined by IME 2 in April 2015, prior to the court settlement.

The agent provided IME 3 with a copy of IME 2's report from three months earlier and asked if there had been a material change since IME 2 examined the worker. In response, IME 3 stated in a supplementary report that while the injured worker's condition was 'deteriorating', this was not related to his work injury.

Gallagher Bassett's subsequent decision to terminate was inconsistent with most evidence

Gallagher Bassett subsequently terminated the injured worker's entitlements on the basis that the work-related injury had ceased. This decision was inconsistent with the majority of the evidence available to Gallagher Bassett.

The worker disputed the termination at conciliation.

The ACCS expressed concerns around 'doctor shopping' and outlined its intention to issue a direction

An email from Gallagher Bassett to the ACCS indicated that Gallagher Bassett was aware that its decision was not sustainable. The ACCS raised concerns in emails to Gallagher Bassett that it had 'shopped around for an IME' and had sought an opinion from IME 3 only weeks after IME 2's report. This practice is inconsistent with the Claims Manual. After the ACCS outlined its intention to issue a direction, Gallagher Bassett withdrew its decision.

Impact of Gallagher Bassett's decision-making on the injured worker: 'how would you feel?'

Following Gallagher Bassett's withdrawal of their initial rejection of the worker's claim, the injured worker wrote an email¹⁵² describing the impact of the delay in accepting the claim:

You must understand my concern, a family can't live without finances. I have children to feed if the shoe was on the other foot how would you feel if you were in my shoes.

'You must understand my concern, a family can't live without finances. I have children to feed if the shoe was on the other foot how would you feel if you were in my shoes.'

Email from the injured worker in case study 7

¹⁵² Email from the injured worker dated 1 July 2015 and held on the worker's claim file.

Leading questions posed to IMEs

215. The Claims Manual requires agents to ensure the questions asked of IMEs are appropriate and relevant to the IME's specialty and the worker's circumstances and claim.¹⁵³
216. WorkSafe has developed a range of standard questions agents use in their requests to IMEs. These are based on relevant provisions of the WIRC Act. Agents also have the ability to draft a small subset of questions to address specific issues that may relate to an injured worker's individual circumstances.¹⁵⁴
217. It is reasonable for agents to tailor their questions to individual claims. However, in some cases, agents are posing what could be interpreted as leading questions to IMEs.
218. At interview, one IME stated that 'some of the IME questions seemed designed to get a specific answer'.¹⁵⁵ A surgeon who treats injured workers raised similar concerns in correspondence to my office, stating that agents often attempt to 'bias' IME assessments 'with suggestive and leading questions'.¹⁵⁶
219. In case study 8, Gallagher Bassett sought an IME's opinion on whether a worker's injury remained work-related, while emphasising the worker had not worked for more than seven years. Gallagher Bassett later relied on the IME's opinion to terminate the worker's claim. This case is also an example of agents selectively using evidence.

Case study 8: Suggestion that a back injury was no longer work-related because worker had not worked for several years

A police officer made a claim in the late 1990s for a back injury they suffered after lifting heavy stolen goods. The claim was accepted and the management of it was taken over by Gallagher Bassett some years later.

15 years after the claim was accepted, Gallagher Bassett asked an IME a leading question

Over 15 years later, Gallagher Bassett sent the worker to an IME to assess the worker's condition and ongoing entitlements. Gallagher Bassett included a leading question in its request by asking if the worker's incapacity was still related to the claimed injury 'bearing in mind there has been no work aggravation/exposure for in excess of 7 years'. Gallagher Bassett further said 'Please note worker has not attempted to return to suitable employment since ... 2008'.

The IME confirmed a continuing relationship between the original injury and current presentation

In his report to Gallagher Bassett, the IME noted that at the time of the examination the worker was experiencing a 'flare of [their] recurring chronic back pain' related to their work injury and that further treatment was appropriate.

¹⁵³ WorkSafe Victoria, *Claims Manual*, Section 2.7.3.4 Information for the IME, updated 18 September 2015.

¹⁵⁴ Interview of Executive, WorkSafe on 23 May 2016.

¹⁵⁵ Interview of an IME.

¹⁵⁶ Letter from surgeon to Victorian Ombudsman dated 13 November 2015.

The IME noted that there was evidence of ‘degenerative disc disease’;¹⁵⁷ however, he confirmed there was a continuing relationship between the original workplace injury and the worker’s current presentation. The IME stated that it was ‘impossible for [the worker] to do any form of remunerative work as verified by multiple doctors’ reports’, that they were unfit to participate in occupational rehabilitation and that the worker should be next reviewed in 10 years’ time.

The agent’s request for a subsequent report included further leading questions

Gallagher Bassett sought a supplementary report from the IME to clarify a number of comments in his original report, including ‘how the present condition was degenerative but still work related’ and ‘why the worker was unfit to participate in occupational rehabilitation given [they were] 42 years old’.

The reference to the worker’s age is leading and could be seen as an attempt by Gallagher Bassett to influence the IME’s opinion by suggesting that the worker’s relative youth could enable them to participate in occupational rehabilitation. This is despite the IME’s opinion provided in his original report that the worker was not fit to participate in occupational rehabilitation, at which time the IME would have been aware of the worker’s age.

The IME provided a further report to Gallagher Bassett in which he clarified that the worker’s injury remained work-related, stating it was ‘very reasonable to diagnose the current condition as degenerative but it started with the work-related event’.

Termination was based on selective quotes from the two IME reports

Gallagher Bassett subsequently terminated the worker’s entitlements on the basis that the condition was no longer work-related. In doing so, Gallagher Bassett selectively quoted extracts of the IME’s original and supplementary reports and relied on select isolated comments within the IME’s supplementary report, despite the IME confirming several times in his two reports that there was a continuing link between the original workplace injury and the worker’s presentation at the time of examination.

The worker lodged a request for conciliation in relation to the termination.

Gallagher Bassett expressed doubt about the decision being maintained at conciliation

In a review of the matter, Gallagher Bassett stated they were ‘unsure how this decision can be maintained when the IME has stated that the current condition and the WR [work-related] event are linked’.

On this basis, Gallagher Bassett withdrew its notice and reinstated the worker’s entitlements prior to conciliation.

¹⁵⁷ Degenerative conditions are those that relate to ‘normal bodily deterioration’ (i.e. with age). Therefore, conditions that are solely degenerative are not covered by WorkCover.

220. A further example of a leading question can be seen in case study 13 where QBE asked an IME if a worker's shoulder dislocation at work was 'the first or one of many prior'. There was no evidence the worker had experienced prior dislocations.

221. In case study 14, Gallagher Bassett sent a worker to an IME about six months after accepting the worker's claim, and asked:

Given that [the] worker has been ceased work since [the injury date] and has not been exposed to the workplace ... do you believe that employment with Victoria Police remains a material contributing factor to [the worker's] ongoing psychiatric condition?

The phrasing of this question is leading, given the IME would have been aware that the worker had ceased work and not returned (based on information already provided by Gallagher Bassett).

Inappropriate leading questions that remove reference to age

222. The WIRC Act requires that agents consider age as a factor in regard to suitable employment when examining work capacity and posing questions to IMEs.

223. However, there is evidence that agents asked IMEs 'not to factor in a worker's age' when responding to questions about an injured worker's capacity to return to work. This was particularly so in cases involving older workers.

224. Officers from the ACCS advised my investigation that they had observed agents asking IMEs 'not to factor in a worker's age'. They stated that agents have 'no genuine consideration of worker age limits' in regard to 130 week terminations, and that the ACCS will often see agents ceasing a worker's weekly payments when they are only three to six months off retirement age.¹⁵⁸

225. A worker representative similarly commented:

They [the agent] take the age out of it ... [they ask the IME] does the worker have a current work capacity ... taking away the age, nationality, the other barriers that they may have, do they have a current work capacity? So we're seeing a lot more workers at the age of 64 and a half being terminated.¹⁵⁹

226. An example of this was identified through my office's review of claims files. Allianz sent a 59-year old injured worker to an IME. The worker had worked in the same job their entire life and was unable to return to that job due to his injury. Case study 23 has further detail. Allianz asked the IME:

Without factoring the worker's age and non-work related issues, is the worker likely to have a capacity for suitable employment within the next 6 to 12 months? When should a review of their capacity take place?

227. If the IME provided an opinion that the worker had a work capacity, Allianz would be able to terminate the worker's claim.

228. This question was also posed in case studies 3 and 26. In case 26, for example, Allianz sent the worker to an IME for a return to work assessment. At this time the worker was aged 64 and was to reach retirement age in less than a year. Under the WIRC Act, the worker's weekly payments would cease at retirement age, irrespective of their capacity.¹⁶⁰ In its request to the IME, Allianz asked the IME to respond to questions about the worker's work capacity 'without factoring in their age'.

¹⁵⁹ Interview of worker representative.

¹⁶⁰ Section 171 of the WIRC Act 2013 states that unless certain circumstances apply, a worker's weekly payments will cease when they attain retirement age.

¹⁵⁸ Information provided by the ACCS to the Victorian Ombudsman, 10 November 2015.

Maintaining unreasonable decisions at conciliation

229. In some cases, agents maintained claim rejection and termination decisions at conciliation despite knowing they were unreasonable.

Requirement to maintain 'sustainable' decisions during conciliation

Under the Ministerial Guidelines, agents must take all reasonable steps to settle disputes during the conciliation process, and ensure they only maintain decisions that have a reasonable prospect of success if they were to proceed to court.¹⁶¹ This means decisions that are sustainable. The contract between WorkSafe and the agents stipulates that they are required to comply with the Ministerial Guidelines.¹⁶²

WorkSafe's contract with the agents also requires them to comply with the *Victorian Government Model Litigant Guidelines*, including when reviewing a decision for sustainability and when participating in a conciliation conference.¹⁶³

In the Claims Manual, WorkSafe reinforces the requirement that agents only maintain 'sustainable' decisions.

The Claims Manual states that agents must review disputed decisions before conciliation to ensure that they are technically sound, based on reasonable evidence and are appropriate in light of any new evidence received.¹⁶⁴

The Claims Manual also states that a decision should be withdrawn before conciliation if, upon review, the agent considers there would be no reasonable prospect of successfully maintaining it if it were to proceed to court (i.e. it is not sustainable).¹⁶⁵

The manual further states that on the day of the conciliation conference, agents must ensure that participation in the conciliation process is 'quick, fair and economical for all parties involved'. Should the agent form a view that the decision is not 'sustainable' it should be withdrawn or the matter resolved.¹⁶⁶

¹⁶¹ *Ministerial Guidelines as to Authorised Agent, Self-insurer, Employer and Workers' Assistant Conduct at Conciliation Conference, Section 5*, issued by The Hon Gordon Rich-Phillips MLC, Assistant Treasurer on 13 April 2011.

¹⁶² WorkSafe Victoria, Agency Agreement, Schedule A, 2011.

¹⁶³ WorkSafe Victoria, *Participant Workbook - Dispute Resolution Officer Training*, 2011, page 12.

¹⁶⁴ WorkSafe Victoria, *Claims Manual*, Section 7.2.4 Notification of conciliation and Section 7.2.6 Prepare for conciliation, updated 18 September 2015.

¹⁶⁵ *Ibid.*

¹⁶⁶ WorkSafe Victoria *Claims Manual*, Section 7.3.1 At conciliation, updated 18 September 2015.

230. Agents are required to maintain decisions that are ‘sustainable’, but the ACCS’s ability to overturn an agent decision is based on a lower threshold. Under the WIRC Act, an ACCS Conciliation Officer may direct an agent to pay compensation if they are ‘satisfied that there is no genuine dispute with respect to the liability to make, or continue to make, weekly payments’.¹⁶⁷ The WIRC Act states that there is no genuine dispute if there is no ‘arguable case’ in support of the agent’s decision to deny liability.¹⁶⁸

231. The term ‘arguable case’ is not defined in the WIRC Act; however, WorkSafe advised that it considers an arguable case to mean:

[T]hat there is either a legitimate legal dispute between the parties and/or evidence supporting the decision in dispute. The courts have held that there is an “arguable case” as long as the denial of liability is not frivolous or without adequate enquiry and consideration.¹⁶⁹

232. While these provisions only apply to the power of the ACCS, the effect of them is that an agent only needs to have an ‘arguable case’ to successfully maintain its decision to reject or terminate a claim at conciliation, and avoid a direction by the ACCS.

233. Witnesses provided evidence demonstrating that the threshold for agents to have an ‘arguable case’ is low. The ACCS said:

Since one IME report (or part thereof) may be enough to provide an ‘arguable case’ (which is a very low threshold to reach at law), the agent officer often ignores the bulk of material and/or worker presentation. Thus consideration is not given to a more holistic picture, and the sustainability of an adverse decision.¹⁷⁰

234. At interview, one worker representative similarly described an ‘arguable case’ as ‘medical evidence to support said decision’, but noted that this may just be one report, or even one line in a report that supports the decision.¹⁷¹

Evidence of agents maintaining decisions they knew were unsustainable

235. Documentary and oral evidence indicates that agents sometimes maintain unsustainable decisions at conciliation.

236. In some cases, agents maintained decisions despite knowing they were ‘barely arguable’ or would likely be overturned. The evidence suggests that agents are primarily focused on having an ‘arguable case’, and are failing to consider the sustainability of decisions in line with the requirements under the Ministerial Guidelines, Model Litigant Guidelines and the Claims Manual.

¹⁶⁷ WIRC Act 2013, s. 297.

¹⁶⁸ WIRC Act 2013, s. 297.

¹⁶⁹ WorkSafe Victoria, Response to Victorian Ombudsman, reference 9, 21 July 2016.

¹⁷⁰ The ACCS, Information provided by the ACCS to the Victorian Ombudsman, 10 November 2015.

¹⁷¹ Interview of worker representative.

237. At interview:

- a worker representative said that, in many cases, agents will have an ‘arguable case’ at conciliation, however, their consideration of the sustainability of that decision is not apparent. The representative said:

There’s always evidence to support it [the decision], but as to whether it’s sustainable or is it really going to be sustainable as the matter goes forward, I have question marks in relation to that.¹⁷²

- a former agent employee involved in dispute resolution said that for claims staff:

[I]t was a matter of just finding something to terminate on. [Then leaving] it to the dispute resolution team because they’ve done their job. We’ve terminated it ... It wasn’t the fact, well hold on, it has to actually be a maintainable decision ... So yeah that was my major concern across the board.¹⁷³

- a former agent executive said that agents will often terminate or reject claims based on little evidence, hoping that the worker will not dispute it at conciliation¹⁷⁴
- an injured worker also said of one agent:

[The agent] seem[s] to have a culture or policy of objecting, ignoring and contesting everything, no matter how reasonable the request is or how it is supported by genuine professional evidence ... they have rejected, declined & on occasions halted already accepted claims, causing me to apply for conciliation. [The agent] on every occasion has withdrawn, just before the actual conciliation hearing & one can only be left with the impression that they object to everything in the hope that fragile claimants cannot stand the stress of fighting [the agent] & going through the conciliation process.¹⁷⁵

238. It was apparent, in some cases, that the primary objective of agents at conciliation was to maintain and defend their decisions through whatever means possible, even in cases where they knew the evidence did not support their decision to reject or terminate the claim.

‘... one can only be left with the impression that they [the agent] object to everything in the hope that fragile claimants cannot stand the stress of fighting’

Email to VO from police officer

239. The agent email data obtained by my office provided examples of this behaviour, one of which is detailed in case study 9. Before Allianz withdrew its decision on this matter it made several attempts to maintain the unsustainable decision.

172 Interview of worker representative.

173 Interview of former agent employee on 20 April 2016.

174 Interview of former agent executive on 18 November 2015.

175 Email dated 10 March 2016 from injured worker.

Case study 9: 'It is obvious we will need to reinstate weekly payments ... Unless [another Manager] can think of anything??'

In an email chain between Allianz managers relating to the agent's decision to terminate an injured worker's claim, a manager stated:

... based on the IME report it is obvious we will need to reinstate weekly payments
... Unless [another manager] can think of anything??

Another manager responded that 'on a really quick glance agree we are pretty screwed' and suggested that Allianz seek a supplementary report from an IME who previously saw the worker, despite noting that the particular IME 'very rarely changes his opinion when pushed but I'd have a last minute crack at it if it hasn't been scheduled for [conciliation] Conference in the next 2 weeks'.

A third manager responded, advising that the matter was scheduled for conciliation in five days:

In my opinion, your only shot at maintaining this is a report from the [worker's] surgeon giving us something. I would say it's a little too late for that though. Happy for you to prove me wrong ...

A later email from one of the managers advised that Allianz had withdrawn its decision at conciliation, to which a senior manager responded:

In the future, if the claims [*sic*] already at concil[iation], let's see if they [the injured worker] want to accept a limited period [of payments] before taking away the term[ination]. There's a 1% chance that we should be taking, just in case it's agreed upon.

In response to my draft report, Allianz stated:

It is evident from the email that neither [of the managers] were particularly hopeful of maintaining the termination. Consistent with their concerns, the notice was withdrawn.

240. In case study 10, QBE rejected a worker's claim and maintained its decision at conciliation, despite acknowledging that the matter would likely be overturned if it were to proceed to court.

Case study 10: Dispute goes to conciliation despite the agent knowing the worker would likely ‘succeed’ at court

In early 2014, a nurse sustained a back injury when lifting and moving a patient. The worker consulted a physiotherapist the same day and their treating GP a few days later. To determine liability, QBE sent the worker to an IME, who provided a report stating that the cause of the injury was the lifting incident at work and employment was the sole factor for the worker’s symptoms.

Despite the IME’s opinion, QBE rejected the worker’s claim, stating that it did not accept that the injury was caused by work on the basis that the worker:

- continued to work for two days following the injury
- did not immediately report the injury
- did not immediately seek medical treatment or have time off work until four days after the injury.

The injured worker lodged a request for conciliation.

QBE acknowledged the decision was not sustainable but proceeded to conciliation

A QBE file note prior to conciliation acknowledged that the decision was not sustainable and stated:

request a gd [genuine dispute] – though I am confident worker would take matter to court and likely that on the facts [they] would succeed.

At conciliation, the worker provided further evidence including medical reports and clinical notes that showed consultations with the treating practitioner and physiotherapist, stating the cause of the injury.

At this point QBE acknowledged it had little evidence to support that the injury was not work related and accepted a recommendation at conciliation that the claim be accepted with no admission of liability.

241. Case study 11 also shows an agent maintaining a decision it knew was unsustainable. In this case, Allianz terminated a catastrophically injured farmer’s claim on the basis that the farmer had a work capacity. Allianz later maintained this decision at conciliation despite concerns raised by the ACCS and WorkSafe, and its own acknowledgement that the termination would be ‘difficult to maintain’.

Case study 11: Catastrophically injured farmer's claim terminated based on 'token' work capacity

In early 2012, a farmer suffered what has been described variously by Allianz, WorkSafe and IMEs as 'extremely serious', 'extensive' and 'severe life threatening injuries' after being injured while working on their farm. The injured worker was in and out of hospital for months as a result of the various injuries, including a brain injury. In 2012 the claim was accepted by Allianz and the worker began receiving weekly payments and payment of medical expenses.

The worker was deemed to have no 'functional capacity'

Allianz file notes in mid-2012 stated that 'there are limited to no suitable duties on the farm' to which the worker could return.

The worker's incapacity was also confirmed by WorkSafe on two occasions in 2013 and by various doctors and IMEs. WorkSafe noted that while the farmer was able to travel around their property supervised at all times by their spouse, they had 'not returned to work' and did not have a 'functional capacity'. Medical opinions on the file also indicated that the injured worker's capacity to work was limited and that the worker would be reliant on contractors to perform work.¹⁷⁶

Allianz terminated entitlement at 130 weeks

Allianz terminated the worker's entitlement to weekly payments at 130 weeks.¹⁷⁷ Allianz stated that the worker had a current work capacity on the basis that the worker had been certified as fit by their doctor. However, a number of Allianz file notes in the following months noted that the work they were performing was 'nothing that would be considered a realistic job' and that there were 'currently no realistic employment options' for the worker. Allianz's file notes also indicated that the duties the worker was performing on the farm were 'supervision only'.

Following this, the farmer's doctor declared the worker unfit for work and the worker disputed the termination at conciliation.

ACCS raised concerns with WorkSafe about Allianz's termination

The ACCS subsequently raised concerns with WorkSafe about Allianz's decision and stated that the worker's spouse had become 'very distressed as [they] relayed the reality of that "capacity", which requires [the spouse] to shadow [the worker] to ensure that [the worker does not] come to harm'. The ACCS stated:

I seriously question whether this amounts to a capacity for suitable employment, within the meaning of the Act ... [They] have put their farm on the market due to costly outsourcing to cover [the injured worker's] pre-injury work.

¹⁷⁶ IME 1 and 2 both in early 2013 and two treating practitioners.

¹⁷⁷ An agent must terminate a worker's entitlement to weekly payments after they have received 130 weeks of payments if they have a work capacity, or alternatively, they are incapacitated but this is unlikely to continue indefinitely.

The ACCS stated that the worker was certified for 'what seems to be a token capacity for work' and highlighted that there 'were no realistic employment options' for the worker. The ACCS also raised concerns that the worker had not been psychiatrically assessed and asked for WorkSafe to intervene.

WorkSafe raised concerns about whether the farmer was undertaking 'suitable work'

WorkSafe reviewed Allianz's decision with a focus on the duties the worker was performing and whether they could be considered 'suitable'.

WorkSafe raised concerns with Allianz that there were questions about the 'suitability' of the work the worker was undertaking (based on a legal precedent). Allianz agreed.

Psychiatric assessment concluded the worker had no work capacity

A subsequent assessment by a psychiatrist IME concluded that the farmer had no current work capacity for suitable and achievable employment options. The IME stated the worker 'should have a capacity for some suitable employment within the next 12 months'. However, the IME stated this should be reviewed in 12 months' time. A further assessment by a neurologist IME concluded that the worker had tried to get back to work; however, this was not successful and that the worker was only 'working' one and a half hours per day, supervised by their spouse. The IME stated the worker's neurological condition would be permanent and that the worker's capacity was unlikely to improve.

Allianz maintained the decision to terminate at conciliation despite the agent's own view that it was 'difficult to maintain'

An Allianz file note stated that there was:

Much discussion around the type of work [the worker] is performing, nothing that would be considered a realistic job, is constantly supervised by [their spouse] ...

14/10/14, Feed back [sic] from WorkSafe & subsequent discussions with [a Senior WorkSafe Manager], decision is difficult to maintain ...

Despite this, Allianz maintained its decision at conciliation on the basis that the worker was working on the farm in a 'very limited capacity' and thus was deemed to have a work capacity.

The ACCS issued a genuine dispute at conciliation and the worker was required to dispute this decision at court. Allianz received legal advice during litigation and, as a result, withdrew its termination decision.

Due to the lengthy dispute process, it took more than a year from the termination for the worker's weekly payments to be reinstated.

Percentage of decisions overturned through the dispute process

242. Information provided by WorkSafe shows that a significant portion of disputed decisions are overturned or changed at conciliation and court.¹⁷⁸ This suggests that agents are not adhering to the requirement that they only maintain sustainable decisions that have a reasonable prospect of success.

243. In 2014-15, over half (58.5 per cent) of the decisions disputed at conciliation were changed.¹⁷⁹ This included:

- 46 decisions where a direction was issued (0.3 per cent)
- 2,514 decisions where a recommendation was issued (16 per cent)
- 5,628 decisions where the agent decision was varied (36 per cent)
- 901 decisions where the agent withdrew its decision (6 per cent).¹⁸⁰

244. In response to my draft report, WorkSafe noted that an agent decision may be varied for a number of reasons, including that new information was produced at conciliation. WorkSafe stated further:

The whole purpose of conciliation is to get an outcome and we expect there to be a change in the decision as a result of the conciliation.

245. While I note that decisions may be changed in these circumstances, my investigation identified that in several cases agents maintained decisions they knew were unsustainable at conciliation. This behaviour is likely to contribute to the high number of decisions overturned at conciliation.

246. The figures are comparatively high for matters that proceed to court.¹⁸¹ In 2014-15:

- 69 per cent of claim rejections were overturned or changed
- 75 per cent of terminations up to 130 weeks were overturned or changed
- 64 per cent of terminations post 130 weeks were overturned or changed.¹⁸²

247. Of the total matters disputed at conciliation and court combined that were referred to a Medical Panel,¹⁸³ about 71 per cent of decisions¹⁸⁴ in 2014-15 were overturned.¹⁸⁵

‘My claim was unfairly and unreasonably denied (as found by order of the ACCS). It was subsequently unreasonably terminated (as found by the Magistrates Court). This not only costs the scheme a considerable amount of money unnecessarily, but it cost me my opportunity for a supported return to work. It cost me my health and I continue to suffer a significant loss of enjoyment of life as a result. The agent acted unconscionably.’

Email from an injured worker

178 This includes matters referred to a Medical Panel by the ACCS or court.

179 Note: this figure includes impairment benefits (common law) claims and maims claims, which were not examined during my investigation.

180 WorkSafe Victoria, Claims Liability Report, 31 July 2015.

181 WorkSafe was unable to provide data on the number of medical and like entitlement decisions overturned or changed at court, and so these figures are limited to weekly payments disputes.

182 WorkSafe Victoria, *Claims Liability Report*, 30 September 2015.

183 This includes matters referred to a Medical Panel by the ACCS and a court.

184 This figure relates to the rejection and termination of entitlements to i) weekly payments and ii) medical and like expenses. WorkSafe was unable to provide specific data on the number of medical and like entitlement decisions overturned at court and so these figures were based on the number of matters ‘resolved’ at court.

185 WorkSafe Victoria, Response to Victorian Ombudsman request, reference 2, attachment 2-1, 21 July 2016.

Costs of conciliation

248. Apart from breaching the Ministerial Guidelines, Model Litigant Guidelines and Claims Manual, agents maintaining unsustainable decisions at conciliation is costly to the scheme.¹⁸⁶
249. In some cases, the costs associated with defending the decision far outweigh the often small monetary amount in dispute. In evidence, representatives from the Australian Medical Association said that agents will say:
- ‘Oh we’re not going to pay for that’ so the person then has got to go through all the stress and often it’s a disputation about a small amount of money anyway. And I can imagine that they’re sort of paying thousands of dollars to go to medical panels having gone through a conciliation process et cetera and they end up having to pay what’s a thousand dollars or something for a service that really they could’ve reasonably worked out that it’s something the person needed.¹⁸⁷
250. The ACCS similarly stated that agents spend time and money on ‘saying no’ and defending disputed decisions, instead of paying the worker their entitlements, which would often be less costly.¹⁸⁸ An ACCS conciliation officer said such behaviour ‘flies in the face of trying to be conciliatory, to prevent litigation, to prevent delay, and additional costs to the scheme’.¹⁸⁹

Cost of disputes

In 2014-15, 14,313 disputes regarding weekly payments and/or payment of medical expenses proceeded to conciliation.

The average cost to WorkSafe of resolving a matter at conciliation was \$1,440.¹⁹⁰

In cases where the ACCS found there was a genuine dispute and the worker disputed the matter further at court, the average cost to WorkSafe in 2014-15 was \$27,200.¹⁹¹

Financial, health and psychological impacts of lengthy conciliation

251. Maintaining unsustainable decisions at conciliation also has an impact on injured workers and their recovery, particularly those suffering psychological conditions. There is no financial cost for a worker involved in disputing a matter at conciliation, but the process can be lengthy and stressful.
252. In 2014-15, the average time from an agent’s decision to the outcome of the conciliation process was over five months (161 days).¹⁹² The average time from an agent’s decision to a court outcome was nearly two years (680 days).¹⁹³

¹⁸⁶ As noted earlier in this report, the workers compensation scheme is funded by employers through the payment of annual insurance premiums.

¹⁸⁷ Meeting between Victorian Ombudsman and representatives of the Australian Medical Association on 26 February 2016.

¹⁸⁸ Meeting between the Victorian Ombudsman and representatives of the ACCS on 30 October 2015.

¹⁸⁹ Interview of an ACCS Conciliation Officer on 4 December 2015.

¹⁹⁰ WorkSafe Victoria, Response to Victorian Ombudsman request, reference 4.1, 15 June 2016.

¹⁹¹ WorkSafe Victoria, Response to Victorian Ombudsman request, reference 4.1, 15 June 2016.

¹⁹² WorkSafe Victoria, Response to Victorian Ombudsman request, reference 4.1, 15 June 2016.

¹⁹³ Ibid.

Injured workers and their families

253. Many injured workers provided evidence highlighting the impact agent decision-making and involvement in the dispute process has had on their recovery. One injured worker wrote:

My claim was unfairly and unreasonably denied (as found by order of the ACCS). It was subsequently unreasonably terminated (as found by the Magistrates Court). This not only costs the scheme a considerable amount of money unnecessarily, but it cost me my opportunity for a supported return to work. It cost me my health and I continue to suffer a significant loss of enjoyment of life as a result. The agent acted unconscionably.¹⁹⁴

254. The concerns of another injured worker were reflected in a CGU file note (described further in case study 16). As a result of CGU terminating the worker's claim three times, the injured worker did not receive weekly payments for a year and eight months. Notes on the worker's claim file indicated the worker was under significant stress as a result of CGU's decision-making, with the injured worker stating they were having suicidal thoughts and that CGU's decision-making was affecting their mental health:

I believe my consultation with your doctor was more of an interrogation and threat to me. By the end of the consultation I felt worse and fearful and as a result I am having suicidal thoughts now ... He is definitely not an independent doctor as you say but rather paid by CGU to write this report ... The report seems one sided ...

255. Case study 4 outlines how a worker committed suicide shortly after the agent decided to reinstate their entitlements to medical treatment. The worker's family member provided information to my investigation in relation to the impact CGU's handling of the case had on their family:

While my [parent] was cut off from [their] medical expenses, such as [their] medication which was ridiculously expensive, we struggle[d] to keep up with them, all of [their] treatment was denied and the sheer stress and anxiety caused [them to] get worse and I watched [them] lose all hope ... my [parent] proceeded to commit suicide ... and passed away ... [A few days later] I received letters from CGU stating that **every** program had been approved and [their] medical expenses reinstated; I burst into tears and couldn't look at them anymore [family member's emphasis].

The help that the treatments could have given my [parent] are unimaginable ... [they] may still be alive. My [parent's] payments should never have been cut off and I knew that they wanted [them] off the books as soon as they sent [them] to an IME. Without my help, my [parent] would have never made it to the Medical Panel ... these insurers rely on people being too sick and too exhausted to fight back, this means that though 5/10 may object to the IME and be reinstated, the other 5 will not know how or have the energy. Words will never describe how angry, how hurt and how sad I am that my [parent] is gone and [that] there are no repercussions for them kills me. I know that they are a business and some people cheat the system, but my [parent] was not one of them. [My parent] was truly and completely mentally ill and they cut off [their] treatment. I want companies like these to be held accountable for their actions, that although business and bottom line minded [their decisions] have real life and traumatic consequences on people and their families..

¹⁹⁴ Email dated 26 February 2016 from injured worker.

256. The impact on injured workers is evidenced through other case studies in this report.

Case study 12: Rejection overturned following enquiries by my office

In early 2015, a police officer made a claim to Gallagher Bassett after they developed PTSD.

Gallagher Bassett initially rejected the claim on the basis that the worker's condition was not caused by work. This decision was later withdrawn at conciliation and Gallagher Bassett accepted the worker's claim.

After a brief period of incapacity, the police officer returned to work, only to again be certified unfit by their treating health practitioner. Gallagher Bassett rejected the worker's entitlement to weekly payments during this period of incapacity and terminated the worker's entitlement to medical expenses.

Gallagher Bassett stated it made that decision on the basis of information provided by the worker's doctor that indicated the worker's condition at that time related to a separate medical condition.

Rejection of weekly payments was maintained at conciliation

The worker lodged a request for conciliation in relation to these decisions.

Gallagher Bassett agreed to reinstate the worker's entitlement to medical expenses. However, the ACCS issued a genuine dispute certificate in relation to the rejection of weekly payments. The worker was therefore required to take the matter to court if they wanted to dispute it further.

A further internal review identified decision was not sustainable

My office made enquiries with Gallagher Bassett upon receiving the worker's complaint. Gallagher Bassett advised that it had undertaken a legal review of its decision and that it would withdraw the decision. It stated the review indicated that the worker's employment remained a significant contributing factor to their PTSD condition.

Gallagher Bassett acknowledged that the worker was suffering from a non-work-related condition, but that all of the available evidence indicated that the worker's PTSD had not resolved. On this basis, Gallagher Bassett concluded that its rejection would not hold up in court.

The worker's subsequent stress affected recovery

In a complaint to my office, the worker outlined the impact of Gallagher Bassett's decisions on their recovery, stating:

My PTSD has been further exacerbated by my treatment by Gallagher Bassett. The impersonal phone call ... and subsequent letter ... from Gallagher Bassett informing me that they have rejected my claim caused me further stress. As a result of this I had to seek a consultation with my attending psychologist. This has interrupted my recovery and the plan I had to soon return to my workplace. At this time my doctor and psychologist have recommended that I suspend my plans to return to work as planned.

Professionals and industry groups

257. In correspondence, the Australian Medical Association highlighted the impact of unnecessary rejections and terminations:

Suffering an injury is difficult for anyone. This hurt is often exacerbated by rejection and suspension of claims for medical and like expenses. These decisions by agents are often overturned at Medical Panels or during conciliation. Both processes lead to a delay in return to work and health.

...

These rejections, even if subsequently rectified can seriously damage injured workers' recovery.¹⁹⁵

258. A psychiatrist wrote that many of his clients' entitlements had been 'abruptly terminated' and they were:

... held to be fit to return to work despite continuing severe disability which in fact made work quite impossible. This has caused terrible disruption to their lives, they have had to appeal against the decision and their appeals have, I think, always been upheld. They have sometimes had the expense and stress of having to go to court to have their payments reinstated. As a result they have experienced great hardship struggling on inadequate incomes, unable to meet payments for their mortgages and other debts and have become profoundly depressed to the point of experiencing suicidal ideation and requiring hospitalisation.¹⁹⁶

'... many of my clients perceive insurer action as another form of "bullying behaviours"... These exacerbate their original injury and injures them again on another, more toxic and permanent level.'

Email to VO from treating psychologist

259. The Police Association Victoria similarly raised concerns about the impact agent behaviour has had on its members who have suffered workplace injuries, stating:

The Association has long been concerned about the activities of the regulator, WorkSafe Victoria, and its agents with regard to the adoption of processes and procedures that are not in the best interests of our members who apply for weekly payments and/or payment for medical treatment. We believe, that in many circumstances, these processes and procedures have, firstly, actively prevented our members returning to good health, secondly, have prevented our members from returning to work and thirdly, when our members have returned to work, Gallagher Bassett Services have attempted to take away the treatment which in turn has made it difficult for our members to remain at work.¹⁹⁷

260. In response to my draft report, Gallagher Bassett noted:

... the collaborative relationship between it, Victoria Police, WorkSafe and Gallagher Bassett that has been focussed on improving outcomes for injured police officers, especially those with PTSD and other mental injuries. The quality and impetus of this collaboration have resulted in increased claims acceptances and improved return to work outcomes. The importance of this relationship is sharpened by all parties' response to the findings of the Victorian Police Mental Health Review recently conducted by Dr Peter Cotton.

261. Gallagher Bassett also stated:

The lack of evidentiary support [about the impact of Gallagher Bassett's claims management practices on members of the Victoria Police Association] means that the inference of wide-ranging damage to member's wellbeing cannot be challenged and is therefore unjust.

¹⁹⁵ Letter to the Victorian Ombudsman dated 27 January 2016 from a representative of the Australian Medical Association Victoria.

¹⁹⁶ Letter dated 13 December 2015 from psychiatrist.

¹⁹⁷ Letter dated 18 November 2015 from the Secretary of the Police Association Victoria.

WorkSafe and the agents' responses

262. At interview, a WorkSafe Director confirmed that WorkSafe's expectation is that agents should not put workers through unnecessary disputes and that agents should only make and maintain decisions that are sustainable. She said:

If someone is making a decision that they know is unsustainable, then they shouldn't be making it. And that – we've been very clear about that, that what we are looking for is decisions that are sustainable, because from a service perspective and from a sustainability perspective, nothing else makes sense for us. So we're absolutely wanting decisions to be sustained ... It's in nobody's best interest to be putting people through disputes for no good reason ... we expect decisions to be made that are sustainable and people not be put through unnecessary disputes.¹⁹⁸

263. Agent executives also conveyed their expectations in regard to the sustainability of decisions. The National Manager Fee States at CGU said:

The decision has to be sustainable for us long term. If it can't be sustained then we're wasting our time. And that time also comes with a cost ... it should be a view held across by all the CGU employees and they should be looking at what they need to be making sure the decision is sustainable, making sure it's the right decision, the right evidence at the right point in time.¹⁹⁹

264. In regard to agent staff making unsustainable decisions, the then Allianz General Manager said:

... that's not behaviour that I would condone and it's not a behaviour that I would expect and if I was made aware of that circumstance, there would be, as I said, that remedial action would be taken to address the, the gap in competency that they're showing there by making those sorts of decisions.²⁰⁰

Attempted revocation of ACCS directions

265. In addition to maintaining unsustainable decisions at conciliation, in some cases agents took further action to defend unsustainable decisions by seeking revocation of directions issued by the ACCS.

266. Agents are required to comply with any direction issued by the ACCS and can be penalised for non-compliance.²⁰¹ However, if an agent disagrees with such a direction, it may apply to have it revoked.²⁰² To do this, agents must submit a request to WorkSafe. WorkSafe reviews the matter and determines whether to pursue revocation through application to the Magistrates' Court or County Court.²⁰³ If the relevant court revokes the direction, the agent's obligation to pay the injured worker compensation under the direction ceases.²⁰⁴

'Suffering an injury is difficult for anyone. This hurt is often exacerbated by rejection and suspension of claims for medical and like expenses. These decisions by agents are often overturned at Medical Panels or during conciliation. Both processes lead to a delay in return to work and health.'

Letter from the Australian Medical Association

198 Interview of the Director, WorkSafe on 25 May 2016.

199 Interview of the National Manager Fee States, CGU on 24 May 2016.

200 Interview of the former General Manager Workers Compensation, Allianz on 5 May 2016.

201 WIRC Act 2013, s. 295.

202 WIRC Act 2013, s. 299; WorkSafe Victoria, *Claims Manual*, section 7.3.3 Conciliation outcome, updated 18 September 2015.

203 WorkSafe Victoria, *Claims Manual*, Section 7.3.3 Conciliation outcome, updated 18 September 2015.

204 WIRC Act 2013, s. 299(3).

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267. In 2014-15, WorkSafe received 25 revocation requests from the agents collectively, 16 of which (64 per cent) were not pursued by WorkSafe. The remaining nine requests (36 per cent) were pursued and successfully revoked.
268. In 2015-16, WorkSafe received 22 revocation requests from agents, five of which (23 per cent) were pursued and successfully revoked.²⁰⁵
269. These figures are consistent with the claims files I examined, which show that in some cases agents sought revocation of directions despite evidence that their decisions were not sustainable. In most cases WorkSafe did not pursue revocation as it did not view the decision as sustainable and considered that the decision would not hold up in court.
270. These cases demonstrate the inconsistency between the standards applied by WorkSafe and the agents, in that agents have maintained decisions because they believe them to be arguable, whereas WorkSafe expects them to only maintain sustainable decisions in line with the Model Litigant Guidelines, Ministerial Guidelines and the Claims Manual.
271. The following case study shows QBE denying a worker payments and maintaining its decision at conciliation, despite having concerns that the decision was not sustainable and that it should be withdrawn prior to conciliation. Upon receiving a direction at conciliation, QBE sought revocation. This request was not approved by WorkSafe on the basis that the decision was not sustainable.

Case study 13: Agent seeks revocation of unreasonable decision

In late 2014, a worker lodged a claim for a dislocated shoulder after tripping over at work. The claim was accepted by QBE. After a brief period of recovery, the worker returned to work on modified duties.

IME 1 confirmed injury was caused by work and was a new injury

About a month after accepting the worker's claim, and after the worker had returned to work, QBE sent the worker to an IME to assess their condition and capacity.

The IME confirmed the worker's injury was work-related and they had a capacity for modified duties. The IME later confirmed in two supplementary reports that the worker's injury was a new injury (as opposed to a recurrence of a pre-existing or prior injury); that the worker was not fit to return to pre-injury duties; and that the worker did not require any further treatment unless they continued to have pain, in which case they may require surgery.

QBE regarded further dislocations as unrelated injuries

In early 2015, the worker ceased work again after sustaining two further dislocations while at home carrying out routine activities. QBE advised the worker that they were not entitled to weekly payments for this period because these were new injuries sustained outside the workplace, and unrelated to the worker's accepted workplace injury.²⁰⁶

This decision was made despite clinical notes evidencing that the worker was carrying out their daily activities and not doing anything particularly strenuous when they sustained the further injuries.

²⁰⁵ WorkSafe Victoria, Response to Victorian Ombudsman request, reference 7, 21 July 2016.

²⁰⁶ QBE issued a notice to the worker under section 185 of the WIRC Act which provides that an agent may determine not to pay weekly compensation payments where a worker's weekly earnings are reduced due to reasons unrelated to their incapacity and claimed injury.

The worker lodged a request for conciliation in relation to this decision. The worker also requested conciliation in relation to a failure by QBE to respond to a request for the worker to undergo shoulder surgery.

IME 2 concluded further dislocations were related to original work injury despite misleading information from QBE

In mid-2015, QBE sent the worker to IME 2 to assist it in determining liability for the requested surgery. QBE advised the IME that the worker ‘allegedly has had previous dislocations of the shoulder’ and asked the IME to confirm whether the dislocation at work ‘was the first or one of many prior’.

No evidence on the worker’s claim file suggested they had experienced previous dislocations. In fact, information on the worker’s claim file indicated the contrary.

IME 2’s report to QBE stated that the worker had recurrent dislocations of their shoulder and recommended they undergo shoulder surgery. The IME also stated that the workplace injury was the cause of the worker’s ‘current situation’ (being recurrent dislocations) and confirmed a relationship between the original and further injuries.

QBE maintained its decision despite internal concerns

Based on this report, QBE approved the worker’s surgery. In relation to the weekly payments dispute, internal emails show that QBE held concerns about the sustainability of the decision. A QBE Manager stated in an email:

... my view is to withdraw [the decision] based on the [IME 2] opinion of the ongoing instability of the work related injury contributing to the further incapacity.

However, QBE maintained the decision at conciliation following advice from a QBE senior legal manager.

ACCS overturned on the basis that QBE had no arguable case

QBE’s decision was overturned at conciliation after the ACCS issued a direction on the basis that QBE had not provided any information to support its argument that an ‘aggravating incident’ occurred to account for the two further dislocations.

QBE nevertheless applied for revocation

Following the conciliation outcome, QBE submitted an application to WorkSafe to pursue revocation of the direction, on the basis that QBE believed it had an arguable case.

WorkSafe responded to QBE advising it would not pursue revocation because:

- WorkSafe was not satisfied that the worker’s reason for their incapacity arose from a non-work related injury
- the worker dislocated their shoulder at work and the evidence on the file indicated that the worker had not recovered from their injury prior to their two further dislocations, which resulted in the worker requiring further treatment
- the worker was scheduled to undergo surgery that month, which had been approved by QBE.

WorkSafe also criticised QBE for the ‘unreasonable’ four-month delay in approving the worker’s surgery and questioned the adverse impact this may have had on any return to work opportunities.

272. Case study 14 also illustrates this issue. In this case, Gallagher Bassett terminated a worker's claim on the basis that their condition was no longer work related, and maintained the termination at conciliation. This was despite their own acknowledgement that the decision would likely be overturned if it was referred to the Medical Panel. Gallagher Bassett later sought revocation of a direction issued at conciliation. This was not pursued by WorkSafe.

Case study 14: WorkSafe 'harping on' about requiring decisions to terminate to be sustainable

In 2013, an unsworn member of Victoria Police made a claim to Gallagher Bassett for a psychological condition developed as a result of a number of workplace stressors. The worker's claim was accepted following an examination with an IME (IME 1) and the worker remained off work.

IME reports over the next 18 months drew conflicting conclusions:

- In a further report, IME 1 concluded the worker's condition was no longer work-related. In requesting this report, Gallagher Bassett posed a leading question, discussed earlier in this chapter.
- IME 2 concluded the worker's condition was still work-related.
- IME 1 conducted a third examination and concluded the condition was no longer work-related.

Gallagher Bassett terminated the worker's entitlements on the basis of IME 1's third report. This report was not supported by any material and was contrary to other available medical evidence, including IME 2's report and treating health practitioner reports.

The worker lodged a request for conciliation.

Gallagher Bassett maintained its decision, despite knowing it would likely be overturned

A file note documenting Gallagher Bassett's review of the matter prior to conciliation noted that the decision was based solely on IME 1's report and stated a preference for a 'genuine dispute outcome', but there was a 'real threat of medical panel referral of which the outcome [was] likely to be reinstatement [of payments]'.

Despite this, Gallagher Bassett maintained its decision at conciliation and offered the worker a limited period of payments to resolve the dispute.

In reviewing the matter, the ACCS expressed concerns that Gallagher Bassett did not have an arguable case, and noted that IME 1's report appeared to be a 'cut and paste' of an earlier report. The matter was adjourned to allow the worker to consider Gallagher Bassett's offer.

Gallagher Bassett intended to have the ACCS direction revoked before the direction had been issued

Gallagher Bassett anticipated that the ACCS was going to issue a direction and began liaising with WorkSafe to seek their view on pursuing revocation. No direction had been issued at this stage.

An internal email between Gallagher Bassett staff regarding their communication with WorkSafe stated:

I felt that as per my discussion with [WorkSafe] yesterday, that we may have a negative outcome [in regard to any revocation application]. I get the impression that [WorkSafe] may respond with their 'arguable but not sustainable' view.

A further email referred to WorkSafe 'harping on [about] the sustainability of the decision'.

The ACCS proceeded to issue a direction to Gallagher Bassett to reinstate the worker's payments, noting that the conclusion reached by IME 1 was not supported by 'any material whatsoever'. The ACCS stated they were 'at a loss to understand his [IME 1's] opinion given that treatment and medication for the accepted injury ha[d] been consistent all through the claim'.

WorkSafe chose not to pursue revocation

Gallagher Bassett formally lodged a request to pursue revocation with WorkSafe. WorkSafe subsequently declined on the basis that the merits of the decision would not hold up in court.

'I believe my consultation with your doctor was more of an interrogation and threat to me. By the end of the consultation I felt worse and fearful and as a result I am having suicidal thoughts now ... He is definitely not an independent doctor as you say but rather paid by [the agent] to write this report ... The report seems one sided ...'

Email from the injured worker in case study 16

273. Case study 15 is a further example of an agent maintaining unsustainable decisions at conciliation. In this case, Allianz terminated a prison officer's claim on the basis that the worker 'may' have a work capacity in the future. Allianz maintained its decision at conciliation despite acknowledging that it was going to be 'difficult to salvage an arguable case'. Allianz then sought revocation of the direction issued at conciliation. This was not pursued by WorkSafe.

Case study 15: Termination maintained despite it being ‘difficult to salvage an arguable case’²⁰⁷

A prison officer was involved in a hostage situation, described by witnesses as a serious and dangerous situation. After the incident, the worker continued to work for a number of months before ceasing employment after being diagnosed with PTSD. Following this, the worker made a claim to Allianz.

IME 1 diagnosed the worker with PTSD as a result of the work-related incident, stating that the prison officer had no work capacity and should be reviewed following treatment.

Allianz accepted the claim.

Further IME views confirmed IME 1’s findings, with IME 3 noting worker ‘may’ have a capacity at a later date

Following this, Allianz arranged for the worker to be examined by IME 2 and IME 3. Both IMEs confirmed the diagnosis of work-related PTSD, and stated that the worker was traumatised to a major degree, the injury was significant, the prognosis was poor and the worker had no work capacity. IME 3 stated the worker ‘may’ have a capacity in six to nine months, however, this should be reviewed again in nine months.

IME 3 provided a similar opinion when he re-examined the worker a few months later and stated that the injury had not resolved and the worker was not fit to work. He stated that the worker ‘should’ have a work capacity in six to 12 months and should be reviewed again in six months.

Allianz terminated claim based on IME’s use of ‘may’ and ‘should’

Allianz issued a 130 week termination notice to the worker on the basis that their incapacity was not likely to continue indefinitely. Allianz referred to various IME reports that stated the worker had no current work capacity but ‘may’ or ‘should’ be fit for duties in the future.

The worker disputed the termination at conciliation, which was later adjourned while Allianz sought another examination of the worker by IME 3.

IME 3 then provided a further report that stated the worker remained incapacitated, that the psychiatric symptoms were still severe and that while the worker ‘may’ be able to return to work in 12 months, it was reasonable to review capacity at that time.

Allianz maintained its decision despite knowing it was unarguable

Following this, in February 2015, an Allianz file note reviewing the matter further for the purposes of conciliation stated:

We have really been walking a fine line with capacity through the whole claim it seems. More recently with [IME 3’s] reports where he considers the worker ‘may’ or ‘should’ have a capacity for employment within 12 months or so – but has always written that this needs to be reviewed again within that time. His recent report of January 2015 really undoes any slight argument we might have had from his previous report.

...

At the end of the day, we are really hanging our hat on the treating psych opinion ... that the worker ‘should’ have a capacity for alternative employment within 4-6 months. We then of course though, now have [IME 3’s] report which is a significant issue, especially considering he has seen the treating psych report ... It is difficult to see how we would be able to salvage an arguable case out of this.²⁰⁸

²⁰⁷ This case is also discussed at case study 6.

²⁰⁸ Allianz file note dated 24 February 2015.

The file note also indicated that the notice would likely be subject to a direction at conciliation. It is clear from the file note that Allianz knew its decision was unarguable as the ACCS may only issue a direction if it is satisfied there is no arguable case. Despite this, Allianz maintained its decision.

In early 2015, four months after the worker's claim was terminated, the ACCS issued a direction to Allianz on the basis that there was no genuine dispute with regard to the liability to provide weekly payments.

WorkSafe did not pursue revocation

Despite Allianz knowing that its case was unarguable, Allianz made a request to WorkSafe to pursue revocation of the direction. WorkSafe did not approve the request as it did not consider a court would uphold the decision, particularly considering Allianz's reliance on opinions that were not definitive and stated 'may' and 'should'.

Decisions contrary to binding Medical Panel opinions

274. Medical Panels are a key part of the dispute process. They can be used by the ACCS or the courts to resolve a dispute where there is disagreement or uncertainty about a worker's injury or medical condition.²⁰⁹
275. The Claims Manual reiterates the provisions of the WIRC Act, including that an opinion by the Medical Panel is final, conclusive and binding.²¹⁰
276. Contrary to the WIRC Act and Claims Manual, some agents have made decisions on claims in conflict with a binding Medical Panel opinion.

Cost of referral to Medical Panels

In 2014-15, the Medical Panel received 2,084 referrals in relation to weekly compensation and medical and like decisions by agents. Weekly payment disputes made up the majority of these at 71 per cent (or 1,481 decisions).²¹¹

The average cost to WorkSafe of a referral to a Medical Panel in 2014-15 was \$4,100.

²⁰⁹ WIRC Act 2013, s. 308; Medical Panels Victoria, *Information about Medical Panels*, retrieved online on 8 June 2016 via <<http://www.medicalpanels.vic.gov.au/about-us>>.

²¹⁰ WorkSafe Victoria, *Claims Manual*, Section 7.4 Medical Panel, updated 18 September 2015.

²¹¹ Medical Panels Victoria, The Officer of the Convenor of Medical Panels end of year results 2014/15, November 2015. Retrieved from <http://www.medicalpanels.vic.gov.au/__data/assets/pdf_file/0004/187222/Medical-Panels-Annual-Report-2014-15.pdf> on 8 June 2016.

Payments reinstated based on Medical Panel opinion, only to be later terminated

277. There are cases where agents reinstated a worker's entitlements after receiving a binding Medical Panel opinion, only to terminate payments shortly after on the basis of a conflicting IME opinion.
278. The following case study is an example. CGU reversed its first termination of the worker's claim based on the binding Medical Panel opinion. They later terminated the worker's claim twice by relying on an IME opinion which expressly disagreed with the Medical Panel opinion. Documents on the worker's claim file indicated that CGU knew it could not ignore the Medical Panel opinion, yet chose to maintain its terminations through the dispute process.

Case study 16: Claim terminated twice despite knowing Medical Panel opinion could not be ignored

Termination 1 based on one report despite subsequent reports confirming incapacity

CGU accepted a worker's claim for a psychological condition that developed as a result of the worker's treatment at work. CGU terminated entitlements after four weeks on the basis of a report by IME 1 that concluded the worker had a capacity for alternative duties.

The worker disputed the termination at conciliation.

Subsequent reports from IME 2 and IME 3, as well as a further report from IME 1, all concluded the worker was unfit to work as a result of the injury.

Nevertheless, CGU continued to maintain its decision and the worker challenged this decision at court.

CGU maintained its decision to terminate despite knowing it was unarguable

CGU's advice a year after the termination stated that it was likely a court would determine that the worker remained incapacitated and entitled to weekly payments. The advice stated:

Given we consider the prospects of defending the worker's claim before a Magistrate are poor ... we consider CGU may have a better prospect of defending the claim via a referral to a Medical Panel.

CGU maintained its decision and the matter was referred to a Medical Panel. In late 2013, the Medical Panel provided its opinion that the worker had a psychiatric condition caused by work and remained incapacitated for work. CGU was ordered by the Magistrates' Court to set aside its decision and to pay the injured worker compensation. At this stage, the worker had been without weekly payments for almost a year and a half.

Termination 2 was in conflict with the Medical Panel opinion

Three months after the court order, CGU requested a report from a further IME (IME 4). CGU did not provide IME 4 with a copy of the Medical Panel opinion nor the reports of IME 1 and 3 (although IME 4's report indicated he had received information about IME 1's opinion from the worker).

IME 4 agreed with IME 1's initial opinion that the worker had a work capacity. (This was despite IME 1's original opinion having been superseded by his later opinion and the Medical Panel opinion.)

An internal file note indicated that CGU was aware that IME 4 had not viewed the Medical Panel opinion. In its request for a supplementary report, CGU summarised the Medical Panel opinion, but still did not provide a full copy.

On the same day as making this request, CGU issued the worker with a termination notice on the basis of IME 4's opinion – despite the pending supplementary report from IME 4. The notice did not make any reference to the Medical Panel opinion.

The worker challenged the decision at conciliation and their lawyers wrote to CGU stating:

I would like to direct your attention to the Medical Panel Opinion ... the Medical Panel found that the worker had no capacity, and that [their] incapacity was materially contributed to by a work related injury ... I note that the report on which the termination is based [by IME 4], does not address or reference the Medical Panel at all ... [T]he termination is unjustified, and an abuse of process as this matter was decision [*sic*] by the Medical Panel very recently.

IME 4 subsequently provided a supplementary report to CGU, agreeing with IME 1's original opinion that the worker was fit for work. In regard to the Medical Panel opinion, IME 4 stated:

While the Medical Panel might be "binding" legally in certain respects, it is not "binding" on me and as I have indicated I do not agree with that opinion.

Termination 3 was in conflict with the Medical Panel opinion

CGU continued to rely on IME 4's opinion, and issued a second notice to the worker terminating entitlements at 130 weeks. This was issued in the event that termination 2 was overturned. The worker also challenged this decision at conciliation.

CGU's defence of its actions was at odds with good administrative decision-making

CGU wrote to the ACCS in mid-2014 justifying its disregard of the Medical Panel opinion. CGU said it had relied on a previous court ruling²¹² that the opinion of the Medical Panel was only binding on the matter that was before it, and not on any other matter.

Despite this ruling, the principles of good administrative decision-making outlined in the Claims Manual required the agent to consider all relevant matters. An internal file note showed that CGU was aware of this:

[IME 4] was forwarded the Medical Panel Opinion for consideration. In a supplementary report [in May 2014], he disagreed with the opinion, and would not accept their diagnosis. However this Medical Panel Opinion has been accepted by CGU, and cannot be ignored.

The file did not contain any analysis as to how CGU had considered the Medical Panel opinion and whether its decision was consistent with it.

The ACCS subsequently raised concerns with WorkSafe and CGU that there was no arguable case and stated:

[T]he decision to terminate [the worker's] claim is based on an IME's opinion who disagrees with the medical panel. While the IME is entitled to form his opinion, I consider that a recent medical panel decision has provided a different diagnosis. No additional information has been provided justifying the change in diagnosis/capacity since September 2013 apart from the IME saying his opinion is the same as [IME 1's].

212 *Wingfoot v Kocak* [2013] HCA 43.

As a result, CGU withdrew termination 2; however, it maintained termination 3 (the 130 week termination) despite knowing it was also unsustainable, evidenced by a file note which stated:

Decision is based on [IME 4] who concludes that the wkr [worker] does have a very significant capacity for work. In his sup report dated 12.05.2014 IME feels that the Medical Panel's approach (24.09.2013) was incorrect and he gives a good basis for how this conclusion was reached. I would argue that this effectively means our Notice is unsustainable ... Agreed Outcome: Maintain.

While IME 4 further explained his position, the file note highlighted that the agent was aware that its decision to rely on IME 4's report was not sustainable because IME 4 disagreed with a binding Medical Panel opinion.

Termination 3 was also overturned following further referral to a Medical Panel

Instead of withdrawing termination notice 3, CGU sent the worker to be examined by another IME (IME 5), asking if there had been a material change and improvement since the Medical Panel. IME 5 advised CGU that the injured worker's condition had improved and that the worker had a work capacity.

At conciliation the matter was again referred to a Medical Panel. In late 2014, the panel provided the opinion that the worker still had a psychiatric condition relevant to the claimed work injury and that the worker's incapacity was likely to continue indefinitely. As a result, CGU's third termination decision was also overturned.

While CGU's three terminations were either overturned or withdrawn, the worker was left without payments they were entitled to for one year and eight months.

In response to my draft report, CGU stated:

CGU acknowledges that this claim could have been managed differently and that the decisions that have been made on this claim have had an impact on the injured worker. CGU has made changes to how liability is determined and improved the Senior Review process to ensure that quality decisions are made on claims and the entirety of the information is reviewed in this process.

279. In case study 17, discussed below, QBE issued a termination notice to a worker, which was later referred to a Medical Panel at conciliation. While awaiting that opinion, QBE issued a second notice to the worker terminating their entitlements on different grounds, in the event that the first notice was overturned. QBE later withdrew its first termination notice upon receiving the Medical Panel opinion, but maintained its second notice based on an IME's opinion with which the Medical Panel had specifically disagreed.

Case study 17: ‘Unsustainable, unsafe and unfair’ decision to terminate despite a binding Medical Panel opinion

While working in 2012, a sales manager was involved in a motor vehicle accident and sustained multiple injuries to their back and neck. QBE accepted the claim for both physical and psychological injuries.

In 2013, the worker was examined by IME 1 and IME 2 who both confirmed the physical and psychological injuries were caused by the accident.

Termination 1 was based on reports that worker had a work capacity

File notes on the worker’s claim file in early 2014 indicated that the worker’s condition had deteriorated. However, IME 3 (an occupational physician), and IME 4 (a psychiatrist) both stated that the worker had a work capacity.

QBE terminated the worker’s weekly payments in mid-2014 on this basis.

Termination 2 occurred despite pending Medical Panel opinion

The worker challenged the termination at conciliation and the matter was referred to a Medical Panel. A QBE file note in mid-2014 stated:

‘Case Goals: 130 week termination if current no longer contributing term [termination 1] gets overturned ...’

While the Medical Panel decision was pending, QBE issued another notice to the worker terminating the worker’s claim at 130 weeks. This decision was based on the opinions of IME 3 and IME 4, and a vocational assessment. QBE advised the worker that even if weekly payments were reinstated as a result of the Medical Panel opinion, the worker would no longer be entitled to those payments on the 130 week grounds.

The worker also challenged termination 2 at conciliation.

Medical Panel concluded the worker was incapacitated and condition was severe

Ten days after QBE’s second termination letter, the Medical Panel provided its opinion that while the worker’s physical injury had resolved, the worker was suffering a psychological condition and the worker was incapacitated for work as a result. In its reasons, the Medical Panel specifically stated that it ‘disagreed with the opinion of IME 4’ and stated that the injured worker’s condition was more severe and extensive than diagnosed by IME 4.

QBE’s reliance on an IME opinion was in conflict with the Medical Panel

On the basis of the Medical Panel opinion, QBE withdrew its first termination notice but maintained its second termination on the basis of IME 4’s report.

The ACCS raised its concerns with QBE and questioned its reliance on IME 4’s report:

The Medical Panel specifically disagrees with the opinion of [IME 4] which is relied upon in the 130 week Notice. In my view this makes the 130 week decision at the very least unsafe if not unsustainable.

Following this, in early 2015, QBE provided a copy of the Medical Panel report to IME 4 and asked him to provide a supplementary report commenting on the worker’s capacity. The last time IME 4 had examined the worker was nine months earlier in 2014, prior to the Medical Panel.

IME 4 provided a report to QBE in which he stated that when he had examined the worker in mid-2014, he felt they were fit for pre-injury duties. IME 4 stated that to 'be consistent with my previous opinion I would have to say that ... [the worker] is fit for the job options identified in [a] Vocational Assessment'. However, IME 4 acknowledged that the Medical Panel disagreed with his opinion and considered the worker's condition more severe. He stated 'I realise that the [Medical] panel's opinion is final and binding and therefore it overrides my opinion'.

QBE maintained its decision that the worker was fit for alternative duties on the basis of IME 4's opinion.

WorkSafe and the ACCS concluded that QBE's decision was unsustainable, unsafe and unfair

WorkSafe raised concerns with QBE about the sustainability of its decision and, subsequently, the ACCS issued a direction to QBE to reinstate the worker's payments. The ACCS noted that IME 4 did not accept the Medical Panel opinion and that the comments IME 4 made were consistent with comments that pre-dated the Medical Panel opinion.

The ACCS stated that it was 'not safe, fair or appropriate for the agent to rely upon the opinion of [IME 4]' in these circumstances. The ACCS stated that QBE's decision was not only in conflict with the Medical Panel opinion, but was not evidence-based.

WorkSafe did not pursue revocation

Despite the clear evidence available to QBE that its decision was unarguable, QBE applied to WorkSafe to have the direction revoked. WorkSafe later advised QBE that it would not pursue the revocation of the direction as it was not satisfied that QBE's decision was sustainable.

Impact of QBE's decision-making on the worker

It was evident from a report by the worker's doctor that QBE's attempts to terminate the worker's entitlements negatively impacted the worker. The worker's doctor said that the worker had been 'subject to relentless pressure from the claims agent that [had] exacerbated [their] stress' and that this had had an 'impact on [the worker's] recovery'.

'I have experienced numbers of examples where my patients, who have longstanding disabilities associated with work injuries, have been abruptly terminated on the basis of one examination by a so-called independent medical examiner. My contrary opinion ... was ignored ... They were held to be fit to return to work despite continuing severe disability which in fact made work quite impossible. This has caused terrible disruption to their lives. They have had to appeal against the decision and their appeals have, I think, always been upheld. They have sometimes had the expense and stress of having to go to court to have their payments reinstated ... they have experienced great hardship struggling on inadequate incomes, unable to meet payments for their mortgages and other debts ...'

Email to VO from treating psychiatrist

Terminations based on 'material change' without evidence of change

280. A Medical Panel opinion must be considered 'final and conclusive'²¹³ and is binding on the agent. An agent may, however, reasonably terminate a worker's claim if there has been a 'material change'²¹⁴ in the worker's condition and capacity. This may include where a worker's condition has improved or resolved, or where they have returned to work.
281. Despite these requirements, there are examples where agents terminated a worker's claim after a Medical Panel opinion but failed to identify evidence of a material change in the worker's condition or circumstances. Such decisions are therefore in conflict with the binding Medical Panel opinion, rendering them in breach of the WIRC Act.
282. The following case study is an example. CGU approved a worker's continuing payments following an opinion by a Medical Panel, then terminated them three times, despite IMEs confirming there had been no material change since the panel's opinion.

²¹³ WIRC Act 2013, s. 313(4).

²¹⁴ WorkSafe Victoria, Response to Victorian Ombudsman request, reference 8, 21 July 2016.

Case study 18: Payments terminated three times despite no change since Medical Panel opinion

In the early 2000s, a sales representative made a claim to CGU for a shoulder injury sustained after falling over at work. This claim – and a subsequent claim for a secondary psychological condition – were accepted by CGU. About a year after the claims were accepted, the worker returned to work with their pre-injury employer; however, the worker was retrenched in late 2009 because they were unable to return to their full pre-injury duties.

Rejection of application for ‘top up’ payments was based on worker’s ability to earn more

The worker successfully obtained a new job in 2010 with a different employer. Because the worker’s hours remained reduced due to the work injury, they made an application²¹⁵ to CGU for weekly payments to supplement their salary to the level of their pre-injury job. Injured workers are able to make such an application if they have returned to work but, because of their work-related injury, are indefinitely incapable of undertaking further additional employment that would increase their earnings. CGU rejected the worker’s application on the basis that the worker had the capacity to increase their earnings by acquiring a job that paid more.

Medical Panel overturned CGU’s decision

The worker lodged a request for conciliation and the matter was referred to a Medical Panel in late 2011. CGU’s decision was overturned following the Medical Panel opinion, which concluded that the worker was ‘indefinitely incapable of undertaking further or additional employment or work’. The Panel noted that the worker had told them of the struggle:

... to cope with [their current] hours and has only been able to keep working because of the undemanding nature of the work and the autonomy of [their] position ... which allows [the worker] to take frequent rest breaks. The Panel also noted the worker’s history that [the worker] needs to take painkillers to get through the work day.

Three subsequent terminations of payments were in conflict with Medical Panel opinion

Following the Medical Panel opinion, CGU accepted the worker’s request for ‘salary top up’ payments. However, CGU later terminated the worker’s payments three times, the first of which was only four months after the Medical Panel opinion. The second termination was approximately one and a half years later, and the third, a further six months later.

²¹⁵ This was an application under s. 165 of the WIRC Act 2013 (formerly section 93CD of the Accident Compensation Act), which provides that a worker may apply for a continuation of weekly payments post the second-entitlement period (130 weeks) if they meet the criteria set out in the Act.

The terminations were issued on the same grounds as the initial rejection – that the worker could seek alternative employment where they would be paid more. This was despite the Medical Panel opinion that the worker was indefinitely incapable of undertaking additional work or increasing their earnings, and IME opinions confirming there had been no material change in the worker’s circumstances or condition since the opinion.

In issuing the third termination, CGU selectively used extracts of IME reports in relation to the suitability of employment options identified in vocational assessments, and disregarded the IMEs’ comments that there had been no material change since the Medical Panel.

Medical report highlighted the negative impact of CGU’s pressure on worker

A medical report prepared by the worker’s doctor noted the impact of CGU’s decision-making on the worker, criticising CGU’s ‘pressure’ on the worker to increase their hours or change jobs. The doctor stated that:

It is our considered opinion that if these perceived unreasonable requests continue it is likely for [the worker’s] condition overall to worsen. We believe strongly that [the worker] should be allowed to continue with [the] current level of work for as long as [the worker] is able without pressure from workcover to increase [the] hours or change jobs and employer for no really good reason.

Decision was overturned by the ACCS at conciliation and WorkSafe did not pursue revocation

At the conciliation for the third termination, the ACCS issued a direction that CGU reinstate the worker’s payments on the basis that there had been no material change since the Medical Panel opinion, and therefore CGU’s decision was in conflict with the opinion.

CGU subsequently sought revocation of the direction through a request to WorkSafe. WorkSafe later advised it would not be pursuing revocation. WorkSafe said that while CGU may have had an arguable case, it referred to the ‘sustainability test’, and noted that the worker had clear restrictions based on their injuries. WorkSafe stated there was no indication that the worker’s circumstances or condition had changed since the Medical Panel opinion.

Narrow interpretation of Medical Panel opinion

283. There are cases where agents took a narrow interpretation of Medical Panel opinions to maintain a termination or issue a new one at a later stage. In the following case, Xchanging argued that the Medical Panel opinion only applied to certain elements of the worker's circumstances. Xchanging's decision was overturned at conciliation.

Case study 19: Termination of weekly payments maintained contrary to Medical Panel opinion

A production operator lodged a claim for a back injury sustained from lifting a heavy tub at work. Xchanging accepted the claim. The worker returned to work on modified duties two weeks later and Xchanging continued to pay the medical expenses relating to the worker's injury.

Three months later the worker attended their doctor, reporting a flare up of back pain while lifting their child. As a result, the doctor certified the worker as unfit for work and the worker made a request to Xchanging for weekly payments to be reinstated.

Xchanging rejected request for payments to be reinstated

Xchanging advised the worker they were not entitled to weekly payments as it considered the 'flare up' of the injury to be unrelated to employment. Xchanging sent the worker to be examined by an IME. In a report, the IME stated the worker was still experiencing symptoms from the original workplace injury when the worker aggravated their back lifting their child. However, the IME also stated they were not certain whether the aggravation resulted from the work injury or whether the worker's incapacity still related to the work injury.

Xchanging terminated entitlement to medical expenses

Xchanging sought a supplementary report from the IME, in which the IME stated that the work injury would have now ceased and that the aggravation was no longer work-related. The IME did not explain what caused this change in opinion.

On the basis of the IME's reports, Xchanging also terminated the worker's entitlement to medical expenses. The worker challenged Xchanging's decisions at conciliation and the matter was referred to a Medical Panel.

Medical Panel opinion concluded that the condition and incapacity were work-related

The Medical Panel concluded that the worker's injury and incapacity were caused by work and that medical treatment was appropriate. The Medical Panel specifically disagreed with the IME's opinion that the worker's condition was no longer work-related. The Medical Panel also noted that the worker's back pain had persisted from the date of injury to the date of the Medical Panel opinion and the worker was incapacitated for pre-injury employment.

Medical expenses were reinstated, but not weekly payments

As a result of the Medical Panel opinion, Xchanging reinstated the worker's entitlement to medical expenses, but refused to reinstate weekly payments. An internal Xchanging email showed that it was relying on an argument that the worker had ceased work for reasons unrelated to the work injury, and the panel's opinion only related to incapacity for pre-injury duties, not the modified duties the worker had been undertaking.

However, the Medical Panel was aware of the modified duties the worker had been undertaking, the incident with their child and that the worker was subsequently certified unfit for all work and had ceased work. Having reviewed this information, the Medical Panel still concluded that the worker's incapacity for work was related to the work injury. An email from the worker's lawyer to Xchanging stated:

It seems like the agent is choosing certain parts of the MP [Medical Panel] opinion to rely on. ...

[The Panel] clearly states that they "disagree with [the IME's opinion] that the worker's condition is no longer work related" ... If [Xchanging's] view is to be accepted, this totally contradict[s] what the panel says here.

Xchanging's decision was overturned at conciliation

The ACCS later issued a direction to Xchanging to reinstate the worker's entitlement to weekly payments on the basis that the Medical Panel affirmed an ongoing incapacity for work relevant to the work injury.

Following this, Xchanging made a request to WorkSafe to pursue revocation of the direction. In late 2015, WorkSafe wrote to Xchanging advising that while the decision was 'technically arguable', it was not sustainable. WorkSafe stated that Xchanging had to accept the Medical Panel opinion, and as a result it could not be argued that the reason the worker ceased work was unrelated to the work injury.

Xchanging subsequently reinstated weekly payments for the injured worker. This occurred one year after the worker made the request for reinstatement.

Negative attitude of agents towards Medical Panel referrals

284. Some claims staff hold a negative attitude toward referrals to Medical Panels, given the high percentage of decisions overturned by them.

285. Emails between CGU staff included comments that they were 'hesitant on referring to the medical panel given the outcomes are generally in favour of the worker',²¹⁶ and that 'in relation to the medical panel, this generally doesn't have a good result'.²¹⁷ In response to my draft report, CGU stated:

CGU acknowledges that the language in this email could be improved. CGU considers that the earlier statistics that 71 per cent of decisions referred to a Medical Panel are overturned is in the context for this personal opinion being held by claims staff in the industry ...

286. At interview, a former agent employee made similar comments, stating there was a view among staff that the Medical Panel:

... would see in the worker's favour and then they've got their [the worker's] claim for another two years.²¹⁸

287. There is also some evidence of agents disregarding the 'final and conclusive'²¹⁹ nature of a Medical Panel opinion. This was demonstrated in case studies 16, 17 and 18. In the following case study, Allianz stated that they reserved their right to maintain their decision, irrespective of the Medical Panel's opinion.

²¹⁶ Email from CGU Manager to an external party dated 29 April 2015.

²¹⁷ Email from CGU Manager to an external party dated 9 April 2015.

²¹⁸ Interview of former agent employee on 20 April 2016.

²¹⁹ WIRC Act 2013, s. 313(4).

Case study 20: Refusal to approve treatment irrespective of opinion of Medical Panel

A nurse made a claim that was accepted by Allianz for a shoulder injury sustained after falling over at work. Shoulder surgery did not substantially improve the worker's pain and the worker's doctor made a request to Allianz for payment of specialised pain injections. Allianz rejected the request on the basis that it was a 'non-established, new or emerging treatment', not sufficiently supported by a high-level evidence base.

The worker lodged a request for conciliation and the ACCS referred the matter to a Medical Panel. The ACCS provided a copy of the draft Medical Panel referral to Allianz for comment before finalisation, to ensure it was satisfied with the agreed facts and there was no missing or incorrect information.

In response, Allianz requested that the ACCS attach its submission to the Medical Panel referral, which stated as follows:

- There was no evidence to support the effectiveness of the injections in shoulders.
- A Medical Panel in another matter had recently stated that the injections were, to date, largely an unproven treatment, and the relevant scientific papers had confirmed the Medical Panel's opinion that the treatment was still considered experimental.
- The WIRC Act requires an agent to pay the 'reasonable costs' of medical services. The cost of a treatment should not be considered 'reasonable' if it is experimental and unproven.
- The Medical Panel should find that the proposed treatment was not appropriate.

Allianz also stated in its email to the ACCS:

We reserve the right to maintain the rejection of the treatment even if the Medical Panel is of the opinion the treatment is 'appropriate' on the basis that such a finding would not compel us to conclude that an experimental treatment is a 'reasonable' medical service.

Allianz subsequently approved the treatment under recommendation at conciliation, on the basis of a 'relaxation of WorkSafe policy' in relation to 'non-established, new or emerging treatment' for a limited period of time. The matter therefore did not proceed to a Medical Panel.

While Allianz may have had legitimate concerns around whether the treatment in question was reasonable for the worker's injury, Allianz's submission to the ACCS demonstrates a disregard for the legislative requirement that all parties, including the agent, accept a Medical Panel opinion as final and conclusive.

In response to my draft report, Allianz stated:

Even if deemed appropriate or adequate, there is additionally the question of 'reasonableness' to consider. Whether the treatment is reasonable might hinge on the cost of the treatment or service, the availability of alternatives or, as it was in this case, the reported novel and experimental nature of the treatment. Allianz, on this basis, determined that the treatment was not a reasonable medical expense ... Following an expansion of WorkSafe's guidelines, we were able to exercise discretion in favour of the worker and the worker was afforded the treatment.

However, Allianz had already noted in its submission to the Medical Panel its concerns about the reasonableness of the treatment. If the Medical Panel's opinion was that the treatment was appropriate in spite of Allianz's submission, Allianz has to accept the Medical Panel finding as binding.

Agents improperly allowing employers to influence claims management

288. An injured worker's employer is a key stakeholder in the worker's recovery and return to work. Aside from assisting the worker's return to work, the role of the employer in the claims management process is largely to provide information to inform agent decision-making, particularly at the initial stage of claim lodgement.²²⁰

289. Employers are only able to lodge an objection to an agent's acceptance of a claim and request that it be reviewed by WorkSafe if:

- the alleged worker is not a 'worker' within the meaning of the WIRC Act²²¹
- the claimed employer was not the correct employer of the worker at the time of the injury.²²²

290. Outside of these circumstances, there are no provisions in the legislation or the Claims Manual allowing an employer to dispute or influence decision-making on claims, including claim acceptance.

291. Based on these provisions, it is apparent that the decision-making power on claims resides with the agents, who are required to make objective decisions based on all available evidence, without undue influence by external parties such as employers. This was confirmed by the former Xchanging General Manager. When asked whether there were any circumstances in which an employer would be able to influence a claim, the General Manager stated:

The employer can input information to us. I wouldn't use the word influence because the decision making rests solely with us.²²³

Evidence of employers attempting to influence

292. Despite having no role in the decision-making process, some employers attempt to influence agents in their management of claims.

293. At interview, the then General Manager of QBE said that some employers were 'more vocal than others'. He said:

I know there's tension. I certainly hear noise around there being tension ... that's one of the hardest things that our people have to do every day ... some of the employers are quite abusive towards our people ... it's a tough job. You're making a decision based on evidence and based on legislation and you've got the emotional business owner, employer having an opinion about things ... and our people sit very much in the middle of that and that's a really difficult thing.²²⁴

'My PTSD has been further exacerbated by my treatment ... The impersonal phone call ... and subsequent letter ... informing me that they have rejected my claim caused me further stress. As a result of this I had to seek a consultation with my attending psychologist.'

Email from the injured worker in case study 12

²²⁰ WorkSafe Victoria, *Claims Manual*, Section 2.6.1 Determine liability, updated 18 September 2015.

²²¹ The definition of a 'worker' is outlined in section 3 of the WIRC Act 2013.

²²² WIRC Act 2013, s. 79; WorkSafe Victoria, *Claims Manual*, Section 2.6.5 Object to acceptance of liability, updated 18 September 2015.

²²³ Interview of the former Xchanging General Manager on 4 May 2016.

²²⁴ Interview of the former General Manager, QBE Workers Compensation on 13 May 2016.

294. At interview, the General Manager of Gallagher Bassett similarly commented on attempts by employers to influence agent decision-making, stating:

[The employer will] say to the agent 'There's a new claim, we want to investigate it'. And we look at it and go, 'Well there's no grounds to investigate it. It's straight forward'. Well we're going to move our business [i.e. go to another agent for workers compensation insurance] ... we took a decision ... five or six years ago where we said that if we had an employer that really dug in on those grounds, we don't want that employer. Because those employers actually cost you money and time, effort.²²⁵

295. At interview, a former agent employee described the pressure staff were under, particularly when managing claims of workers from 'big income clients' of the agent. They said:

... bigger clients that had large premiums, that were also very demanding obviously, from a business to business point of view if they weren't happy then we were trying to make them happy as a business in regards to reducing premium, those sorts of things ... And obviously maintaining decisions and keeping costs low on all claims.²²⁶

'The worker has been 'subject to relentless pressure from the claims agent that [had] exacerbated [their] stress' and that this had had an 'impact on [the worker's] recovery'

Letter from a doctor in case study 17

Evidence of agents accommodating employers

296. Employers may attempt to exert pressure on agent staff to make certain decision on claims, but agents are required to reach decisions objectively. Those decisions need to be evidence-based and in line with the WIRC Act and the Claims Manual.

297. In some cases, agent staff accommodated requests or sought direction from employers on their management of a claim.

298. An example is case study 1 in this report. In that case study, Xchanging not only accommodated an employer's request that the worker be sent to a specific IME, but also sought the 'decision' of the employer as to whether to reject or accept the worker's claim. This was despite conclusive evidence that the claim should be accepted. The claim was rejected by Xchanging. The Xchanging employee who brought this matter to my attention stated that the employer was one of Xchanging's main clients and this was the main driver for the decision not to accept liability.²²⁷

299. Agent email data also provided examples of this behaviour. For example, in relation to a dispute at conciliation, emails show QBE's decision-making was not objective and in line with the WIRC Act. In this case, QBE held a view that the worker was not entitled to compensation, but intended to reinstate the worker's payments in order to satisfy the employer.

²²⁵ Interview of the General Manager Workers Compensation, Gallagher Bassett on 9 May 2016.

²²⁶ Interview of former agent employee on 20 April 2016.

²²⁷ Telephone call 2 with Xchanging staff member on 4 December 2014.

Case study 21: Agent influenced by the employer as ‘customer service prevails’

This case related to an injured worker whose medical entitlements had been terminated by QBE. The injured worker lodged a request for conciliation to dispute the decision.

The employer told the agent it wanted the worker’s entitlements to be reinstated to avoid the matter being referred to a Medical Panel, noting that two previous decisions on separate claims with the employer had been overturned by Medical Panels. As such, the employer suggested that QBE instead reinstate the worker’s entitlements, but that QBE have the worker re-examined by an IME (nominated by the employer) in a few months’ time with a view to re-issuing the termination. It appears the employer was aware that if the worker’s entitlements were reinstated following an opinion by a Medical Panel, QBE would be unable to revisit the decision in the near future.

A later email between QBE staff acknowledged that QBE believed the decision to terminate entitlements should be maintained. However, the email stated that there would be ‘a customer service issue’ if QBE did not reinstate as per the employer’s request. A QBE officer subsequently stated that they would ‘make one final attempt’ to convince the conciliation officer not to refer the matter to a Medical Panel, and said ‘if that fails, I’ll reinstate as customer service prevails’.

300. The following case study is another example of employer influence, in which Gallagher Bassett maintained a termination notice based on requests from the worker’s employer. This was despite an acknowledgement that if the case proceeded to court ‘it would get chucked out immediately’.

Case study 22: Unsustainable decision maintained to 'keep employer happy'

In mid-2014, a truck driver lodged a claim with Gallagher Bassett after they developed pain in both elbows at work. Gallagher Bassett sent the worker to an IME to assist in determining liability for the claim. The IME concluded that the worker's condition was directly attributable to employment. Gallagher Bassett accepted the claim.

Gallagher Bassett sought a supplementary report from the IME after receiving an ultrasound request from the worker's GP. In that request, the GP stated the worker had been experiencing elbow pain since the start of 2014 (some five months prior to the date of the injury). Gallagher Bassett sought the IME's opinion on whether, based on this information, the worker's condition was still work-related. The IME concluded, on the balance of probabilities, the most likely reason for the worker's ongoing incapacity was a pre-existing condition.

On the basis of this report, Gallagher Bassett terminated the worker's entitlements and the worker lodged a request for conciliation. However, an internal Gallagher Bassett file note questioned whether the GP had made a 'typo' in regard to the date the worker first experienced elbow pain as the GP had only provided clinical notes from mid-2014 when the injury occurred.

Medical evidence indicated Gallagher Bassett's decision should be withdrawn

Conciliation was later adjourned following a suggestion by the ACCS that Gallagher Bassett seek a further report from the worker's GP to clarify when the worker first experienced symptoms. The GP confirmed that his earlier statement was incorrect.

Internal Gallagher Bassett emails noted that this report 'essentially wipes our entire argument as, the only reason the IME backtracked ... is because we highlighted that the doctor indicated symptoms backdating to [early] 2014'. The email further stated that if Gallagher Bassett let the matter go to court 'it would get chucked out immediately'. Even so, the email questioned whether requesting a further supplementary report from the IME 'would be worth [their] time'.

Further emails stated that Gallagher Bassett staff thought the worker was a 'crook', but that it was 'just the proof [they were] missing', and suggested that Gallagher Bassett speak with the employer about how to proceed. Gallagher Bassett then sought assistance from the employer as to what further evidence might be available to dispute the worker's entitlements. Later emails show that the employer wanted Gallagher Bassett to seek a further report from the worker's GP, despite the GP already having provided a second report clarifying that his initial report was incorrect.

Agent made offer of limited payments at conciliation, despite knowing decision was unsustainable

Gallagher Bassett proceeded to make an offer of limited payments to the worker to resolve the dispute, despite earlier acknowledgment that if it went to court ‘it would get chucked out immediately’.

This offer was rejected by the injured worker’s lawyer, who noted there was no foundation for Gallagher Bassett’s decision, and requested that it be withdrawn.

The ACCS held similar concerns, advising Gallagher Bassett that it believed sufficient information had been provided by the GP, and stating that ‘Given the worker is not in receipt of weekly payments as a result of the GBS decision I assume you will now review as a priority and withdraw the notice’.

Further enquiries were made at employer’s request

At the employer’s request, Gallagher Bassett then sought further information from the worker’s GP, noting that:

Conciliator is requesting withdrawal of our notice (rightly so)

We are pretty much only making further queries with the doctor to keep the employer happy. Otherwise we have an unhappy employer ...

After several unsuccessful attempts to obtain further information from the worker’s GP, Gallagher Bassett finally withdrew its decision in early 2015.

301. An Allianz email provides a further example of this issue. The email shows that staff intended to make a ‘commercial decision’ to reject a claim based on the potential risk of losing an employer as a client, despite evidence that the decision would be unsustainable.

302. However, the email showed the then Allianz General Manager did not endorse this decision:

We are unable to make a ‘commercial decision’ you refer to below. We are bound by the legislation, guidelines and the experience of our staff to assess a decision that will stand up under a conciliation review. [Various senior managers at Allianz] all agreed this will not stand up at Concil[iation]. Therefore I am not prepared to run the risk of rejecting the claim in the hope that it does not go to concil[iation] in the full knowledge that if it does the decision will be asked to be withdrawn ...

...

there is an implied issue that the [employer] account is at risk over this decision ...

... I would not support changing our decision at this time on the basis that failure to do so will result in the loss of this account. The profitability issue is incidental in this case.²²⁸

‘I would not support changing our decision at this time on the basis that failure to do so will result in the loss of this account. The profitability issue is incidental in this case.’

Email from the agent General Manager

²²⁸ Email from the former Allianz General Manager dated 15 May 2015.

Inadequate agent internal review process

303. The internal review process by agents, while not mandatory or legislated, is another component of the dispute process.

304. The Claims Manual requires agents to inform injured workers of their right to have a decision reviewed by a senior manager (also known as a 'senior review') and requires that these reviews be undertaken by someone who was not originally involved in the disputed decision.²²⁹ It states that senior reviews should involve:

- reviewing the decision
- reviewing the material relied on for the decision and any new material received
- considering the claim file documentation
- seeking any further relevant material from the worker and/or employer
- informing the worker in writing of the decision to either maintain, withdraw or vary the original decision.²³⁰

305. While this option is available to injured workers, they may elect to skip the senior review process and go straight to conciliation.

306. At interview, agent executives advised my investigation that the senior review process is one of the key internal controls to ensure agent staff make decisions in accordance with the WIRC Act and the Claims Manual. However, sometimes, senior reviews can be little more than a 'box ticking exercise'.

307. Some of the senior reviews contained little detail around how the decision was reviewed and the rationale for the outcome. Additionally, the letters agents sent to injured workers outlining the outcome of the senior review process did not detail how the agent considered their concerns nor did they provide any explanation as to how the outcome was reached.

308. In one case, Xchanging maintained a 130 week termination decision upon senior review, despite staff raising concerns in internal emails that the decision was unarguable (see case study 24 in this report). The letter to the worker outlining the outcome of the senior review did not provide reasons for maintaining the decision nor discuss the specific circumstances of the injured worker's claim. The letter stated:

The Senior Review was based on the additional information provided, the information used to make the original decision, and the information you provided on the Senior Review Request Form.

After careful consideration I am satisfied that the original decision is appropriate and has been determined in accordance with the *Workplace Injury Rehabilitation and Compensation Act 2013*. Accordingly there will be no variation to the decision.

²²⁹ WorkSafe Victoria, *Claims Manual*, Section 7.2 Senior Review, updated 18 September 2015.

²³⁰ Ibid.

309. A further example of a deficient senior review is highlighted in case study 29, which relates to a decision by CGU to terminate a worker's claim, in conflict with the available evidence. The worker sought a senior review of the decision, raising a number of specific concerns about CGU's decision being inconsistent with the WIRC Act and the Claims Manual. The decision was upheld through the senior review process and the outcome letter to the worker merely stated that the review had been conducted by a suitably qualified senior staff member not involved in the original decision and that there would be no variation to CGU's decision at that time. The letter did not address any of the specific concerns raised by the worker, nor was there any evidence on the worker's file indicating proper analysis by CGU of the concerns raised.

310. In response to my draft report, CGU stated:

CGU acknowledges that the management of the decision making in this matter could have been better. As the [Ombudsman] is aware, CGU has made a number of changes to how Senior Reviews are undertaken to ensure that the entirety of the available information is reviewed as part of this process.

311. Witnesses also raised concerns about the effectiveness of the senior review process. One worker representative described it as a 'rubber stamp' process:²³¹

I don't think the senior review has a real process ... [I see matters where] there has been further material provided, why haven't they [the agent] overturned the decision, but they'll focus on the original decision ... I think the senior review is just a process that takes place that doesn't really alter [the decision].

312. The representative said that when workers seek their advice during the dispute process, they tell them 'don't waste your time' with the senior review process, and to go straight to conciliation.²³² Another worker representative similarly told my investigation that they advise workers to bypass the senior review process.²³³

²³¹ Interview of worker representative.

²³² Interview of worker representative.

²³³ Interview of worker representative.

The effect of the financial rewards and penalties on agent decision-making

In addition to examining whether agents made unreasonable claims decisions, my investigation sought to establish whether the way in which WorkSafe financially rewards and penalises agents influences decision-making.

It is of course reasonable for Worksafe agents to expect to make a commercial profit, and the financial reward and penalty measures in agency contracts are intended to act as a disincentive for poor agent performance. But the evidence suggests that at the disputed and complex end of the spectrum, these measures are driving a focus on terminating and rejecting claims.

In some cases, agents:

- manipulated claims to achieve the financial rewards and avoid penalties
- unreasonably terminated or rejected claims to achieve the financial rewards or to avoid penalties
- maintained unsustainable decisions at conciliation and made offers of limited payments to workers to achieve the financial rewards or to avoid penalties.

The financial rewards and penalties

313. WorkSafe pays agents in line with the remuneration framework outlined in the contract.²³⁴ Agents are entitled to:

- an *Annual Service Fee* provided for core agent functions. This includes an Annual Premium Based Fee related to the employer premiums collected by the agent.²³⁵ The service fee has in-built incentives, 'effectively rewarding agents for reducing injury rates and claim durations'²³⁶
- a *Lump Sum Fee*, which is a long term incentive over the life of the contract, tied to long term improvement in claim management costs
- the *Annual Performance Adjustment (APA)*, which are financial rewards and penalties offered by WorkSafe to the agent²³⁷ for performance against a set of key measures tied to WorkSafe's strategic objectives of Service, Sustainability (financial sustainability of the scheme) and Return to Work.²³⁸ The financial rewards and penalties are a percentage of the Annual Premium Based Fee. Each performance measure has a 'base performance'. The agent receives a financial reward if its performance is better than the base performance and is penalised if its performance is worse than the base performance.

²³⁴ Schedule D of the WorkSafe Victoria, *Agency Agreement*, 2011.

²³⁵ WorkSafe Victoria, *APA Background Paper 2014-15: Agent Remuneration and the Annual Performance Adjustment*, undated, provided to my office on 8 October 2015 in response to a request for information.

²³⁶ WorkSafe Victoria, *Overview of Performance Management Framework*, provided to my office on 8 October 2015 in response to a request for information, page 5.

²³⁷ The financial rewards and penalties are known by WorkSafe and the agents as the 'Annual Performance Adjustment measures'. These are referred to as 'financial rewards' and 'penalties' in this report.

²³⁸ WorkSafe Victoria, *Agency Agreement*, 2011, Clause 6, Schedule D.

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314. There is no publicly available information that provides the details of the financial reward and penalty measures.
315. WorkSafe states that the strategic intent of the remuneration framework is 'to provide good value for money by ensuring that agents who deliver scheme outcomes can earn suitable commercial profits'.²³⁹

2014-15 performance measures

316. Most of the claims examined during my investigation relate to agent decisions made in 2014-15, and my report focused on the financial reward and penalty measures for that year.²⁴⁰
317. The following table details these measures and the maximum possible rewards and penalties for the agents collectively in 2014-15, expressed as a percentage of an agent's Annual Premium Fee. My investigation largely focused on the measures that directly related to agent decision-making on claims, as highlighted in this table. Other measures for which the agents may be financially rewarded or penalised, which are not directly relevant to the scope of my investigation, are not discussed.

²³⁹ WorkSafe Victoria, *Overview of Performance Management Framework*, provided to my office on 8 October 2015 in response to a request for information, page 5.

²⁴⁰ There have been changes to the financial rewards and penalties since 2015. Analysis of changes to the financial incentives in the 2015-16 and 2016-17 financial years is set out in the next chapter.

Table 2: The 2014-15 financial reward and penalty measures*

Measure	Description	Reward	Penalty
Return to Work Index	A measure that assesses an agent's performance on the percentage of workers not working six months (26 weeks) after the claim was received.	6.5%	-3%
Continuance Rates 13, 52 and 134 weeks	Relate to the number of weeks injured workers continue to receive weekly payments. Reward agents for reducing the number of weekly payment claims that continue past 13, 52 and 134 weeks. Only relate to injured workers who have had at least 20 days off work.	7%	-5%
Active Claims Measure	Rewards agents for reducing the number of active weekly payment claims for workers who were injured from 1985 to 2009.	2%	-1%
Quality Decision Measure	Rewards agents for the quality of agent decision-making, including: <ul style="list-style-type: none"> initial eligibility decisions[^] decisions to cease medical treatment and services 52 weeks after the entitlement for weekly payments cease, or 52 weeks after the injury for medical claims only. 	2.5%	-1.5%
52 Week Medical and Like Entitlement Review continuance rate	Rewards agents for reducing the number of claims where payments of medical treatment and services are made 52 weeks after the entitlement for weekly payments ceases, or 52 weeks after the injury for medical claims only.	1.5%	-1.5%
Medical Measure	Rewards agents for reducing the growth in paramedical and other medical expenditure costs for injured workers. The measure only takes into account medical costs paid more than one year after the date of the injury.	2%	-2%
Survey Measures	This includes an Injured Worker Survey which measures the worker's perception of agent service delivery. It also includes an Event Based Survey which measures the injured worker's perception of agent service delivery following a specific event (e.g. Return to Work, Adverse Decisions, Eligibility, IME and Treatment).	10%	-5.5%

* WorkSafe Victoria, *APA Background Paper 2014-15: Agent Remuneration and the Annual Performance Adjustment*, 2014-15, provided to my office on 8 October 2015 in response to a request for information, pages 9-10.

[^] Note that in 2014-15 this measure only related to initial claim rejections by agents.

Financial rewards received by the five agents

318. The total actual financial rewards received collectively by the five agents in 2014-15 was more than \$52 million. The breakdown of the financial rewards received by each agent in 2014-15 was as follows:

Agent	Total
Allianz	\$11,948,292
CGU	\$15,444,494
Gallagher Bassett	\$10,703,893
QBE	\$7,696,335
Xchanging	\$7,006,716
Total	\$52,799,730

* WorkSafe Victoria, *APA results for 2014-15: Scheme Performance Annual Performance Adjustment 2014-15*, October 2015.

Manipulation of claims to maximise financial rewards

319. Agents have manipulated claims data to maximise the financial rewards and avoid penalties. Manipulation of data has included agent staff recording false and inaccurate information on claims; falsifying documents or records; paying more or less compensation on claims so the claim would be eligible for the financial rewards; and delaying the payment of compensation.
320. Between 2002 and 2016, WorkSafe financially penalised CGU four times and Gallagher Bassett twice for manipulating data to maximise financial rewards.²⁴¹ Most of the manipulations involved mid-level management.
321. Most of the manipulations were identified by WorkSafe via audits or through its monitoring of performance against the financial reward measures. In some cases, the agent self-reported.
322. The following table details WorkSafe's findings in relation to manipulations and the associated penalties.²⁴²

'The below listed claims may impact the 52wk ... [financial reward and penalty measure]. Before you process any payment for these claims between now and 01.07.2015, can you please speak to me first. If we can hold off until this date we can positively effect [sic] this measure.'

Internal email from an agent manager

²⁴¹ CGU and Gallagher Bassett are the only current agents to have been penalised for manipulations of the financial rewards. However, all five agents have been subject to penalties for non-compliance with the contract.

²⁴² WorkSafe's response to request for information on agent penalties from 2002 on provided to my office on 6 June 2016.

Table 4: Manipulation of claims by agents including penalty amounts and findings					
Agent	Year	Penalty amount	How identified	Staff involved*	Findings
CGU	2015	\$456,000	CGU's internal audit of claims	Two managers	CGU overpaid weekly payments on more than 40 claims to the cost of \$97,000, so that the claims would exceed 20 days off work and would therefore be subject to some of the financial reward and penalty measures.^ The staff involved also manipulated the return to work date of workers. WorkSafe estimated that in the worst case scenario, CGU could potentially have achieved a financial reward of \$388,000 as a result of the manipulation.*^
CGU	2010	\$2.8 million	CGU self-reported to WorkSafe	A senior executive, senior manager and three other staff	CGU staff were struggling to keep up with payment of invoices in a timely manner. This created a risk that CGU would not receive the financial reward from WorkSafe for the timely processing of invoices. As a result, CGU staff intentionally delayed the processing of about 10,000 invoices, which were found hidden in a locked cupboard.**
GBS	2010	\$50,000	WorkSafe audit	A manager	GBS manipulated and falsified documents, by changing dates to indicate actions were taken within a required timeframe, in order to achieve a financial reward.
CGU	2009	\$1 million	WorkSafe's internal actuaries and investigation	Three senior managers	CGU staff manipulated data relating to impairment benefit claims to maximise the financial reward.
GBS	2008	\$320,000	WorkSafe audits	A manager	GBS manipulated approximately 46 claims to improve its performance regarding the number of weeks injured workers had received weekly payments.
CGU	2003	\$363,675	WorkSafe audits	Two senior executives, a senior manager and a number of other staff under the instructions of senior management	CGU backdated and altered documents, and created file notes containing false information.

* Based on the findings of WorkSafe.

^ Claims where the injured worker has received less than 20 days of weekly payments are not included in the cohort of claims subject to some of the financial reward/penalty measures.

*^ WorkSafe Victoria, *CGU: Data Manipulation and failure to maintain effective internal controls*, Schedule C Process, September 2015.

** Victorian Ombudsman, *Investigation into record keeping failures by WorkSafe agents*, May 2011.

323. There is other evidence of agents manipulating, or trying to manipulate, claims data to achieve financial rewards. These examples outlined below, combined with the instances identified by WorkSafe above, show that at least four of the five agents have engaged in this behaviour.

324. Evidence included agent staff being advised by managers to delay payments or delay matters at conciliation or court until the commencement of the new financial year (1 July). This was to improve the agent's performance against the financial reward and penalty measures in 2014-15.

325. WorkSafe does not require agents to repay financial rewards if decisions for which they were rewarded are overturned after October in the following financial year.²⁴³ WorkSafe states:

[The financial reward and penalty] measures are based on individual financial year performance by Agents. Therefore where a claim within an [particular measure] has a decision made that is overturned within that financial year the Agent will not be remunerated for the original decision. Where a claim within [a measure] has a decision made that is overturned within the following financial year, there will be a negative impact for the Agent (that will vary depending on the nature of the individual [financial reward]). However, the negative outcome would not result in the 'repayment' of [a financial reward] ...²⁴⁴

326. The 'negative impact' referred to by WorkSafe is that agents may have greater difficulty achieving the relevant financial reward and penalty measure in the following financial year. A WorkSafe director provided the following information:

... so we measure it at 30 June for the prior year, but we also set the target for the next year off scheme performance. So if for example they made a decision that is subsequently then overturned then the target is potentially harder than it otherwise would have been, which means that they are disadvantaged if you like in the next year because they are not going to be able to perform to that level because it was an artificial level. So it is designed to sort of try and make sure that there are ...balances that everything you do is incentivised to try and do the right thing at all times.²⁴⁵

Allianz emails

327. In one email, an Allianz team leader asked staff not to process payments for claims that would potentially have an impact on the 52 week financial reward and penalty measure until the new financial year. The email stated:

The below listed claims may impact the 52wk ... [financial reward and penalty measure]. Before you process any payment for these claims between now and 01.07.2015, can you please speak to me first. If we can hold off until this date we can positively effect [sic] this measure.²⁴⁶

²⁴³ There is a financial reward review and validation cycle undertaken by WorkSafe following the end of financial year where any financial reward or penalty is not finalised until October after the end of financial year.

²⁴⁴ WorkSafe's response to VO request for information - Impact of overturned decisions on APA remuneration - 23 December 2015.

²⁴⁵ Information provided by the Director, WorkSafe via a telephone call on 18 July 2016.

²⁴⁶ Email from an Allianz Manager dated 10 June 2015.

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328. At interview, a WorkSafe Director described this behaviour as 'completely inappropriate'.²⁴⁷
329. In another email, an Allianz manager asked staff to delay matters at court or conciliation until the next financial year to improve Allianz's performance against the 134 week financial reward and penalty measure. The email stated:

Hoping your [sic] all able to remember to let me know should there be a claim at court or conciliation that may effect [sic] the 134 measure should we have to make payments. If we can influence the result, even by delaying it a few weeks/ days, we may be able to put ourselves in a much better position for the 30/6 [end of financial year].

Around this time of year, each claim is worth approx. \$110K.²⁴⁸

330. At interview, the then Allianz General Manager said he did not condone such behaviour:

... it's not the sort of behaviour that I think is appropriate. We stress the fact that good claims management should be undertaken at all times.

...

it's not consistent with the practice that we would expect our staff to undertake in terms of managing claims in a consistent manner.²⁴⁹

331. He also stated in relation to the first email:

I am not aware of any practice within Allianz of delaying payments. In my opinion, no such practice or culture exists within Allianz. Following the interview, my team and I reviewed the list of payments made around the time that this particular email was sent and we found no evidence that any payments were delayed.²⁵⁰

Gallagher Bassett emails

332. One email showed that a Gallagher Bassett manager had been advised by another staff member not to enter the date a worker ceased work into the claims management system until the next financial year, due to the negative impact this would have on Gallagher Bassett's performance against the return to work financial reward and penalty measure.

333. The worker in question had returned to work after their injury, meaning that Gallagher Bassett would have received a financial reward for this claim under the return to work measure. However, the worker later ceased work again, which meant Gallagher Bassett would no longer receive the financial reward.

334. The emails suggest that staff tried to ensure that Gallagher Bassett received the reward by not updating the system to reflect the worker had ceased work, despite this meaning that the worker would not receive the payments they were entitled to due to their incapacity.

335. In the emails, the first manager stated:

The reason no cease date is included is because [another manager] advised us not to due to the RTW index. It's getting a bit ridiculous now ...

...

But we do need to pay it because [the worker] does have an entitlement.

336. A second manager then stated:

Yeah, and I'm sure Worksafe will ask why we waited until 1 July to update it.

337. The first manager then responded:

So I'm going to try pay it this week because it looks really dodgy ...

247 Interview of WorkSafe Director on 25 May 2016.

248 Email from an Allianz Manager dated 12 June 2015.

249 Interview of the former Allianz General Manager on 5 May 2016.

250 Letter from the former Allianz General Manager to Victorian Ombudsman dated 22 June 2016.

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338. Based on these emails it appears that Gallagher Bassett did not go ahead with the attempted manipulation.
339. At interview, the Gallagher Bassett General Manager said that he was 'not happy' with this behaviour, stating that it looked 'pretty condemning' and was not appropriate. He further stated that 'one claim is not going [to] make any difference' to Gallagher Bassett's performance against the associated financial reward measure and questioned why this behaviour had even occurred.²⁵¹
340. In response to the draft report, Gallagher Bassett stated:
- Unethical behaviour is not tolerated by GB staff. Staff are subject to annual ethics training. GB has an ethics reporting and investigation system overseen by a National Ethics Manager the rejection of the proposal by senior managers is more illustrative of GB's culture than the contents of one email.

QBE email

341. For a claim to be eligible for the financial reward, the injured worker must have at least 20 days off work. A QBE email shows that staff manipulated data by paying a worker more weekly payments than they were entitled to for 'CR [continuance rate] purposes'; that is, so that the QBE claim would be eligible for the financial reward.²⁵²
342. The QBE State Manager said at interview that such behaviour 'on face value ... doesn't look good' and that he would be 'very concerned' if staff were providing workers compensation that was 'not payable'.²⁵³

Focus on terminations

343. The evidence suggests that, in some cases, some of the financial reward and penalty measures are driving a focus on terminating and rejecting claims to achieve the financial rewards.
344. There are examples of agent staff:
- documenting 'termination strategies' in internal file notes on claims
 - being rewarded for terminating or rejecting the highest number of claims
 - referring to terminated claims that fell within the financial reward measure as 'winners' or 'wins'.
345. Many of these examples related to the termination of injured workers' weekly payments under section 163 of the WIRC Act. Section 163 provides that a worker's entitlement to weekly payments ceases at 130 weeks unless the agent determines that the worker has no current work capacity and this is likely to continue indefinitely. WorkSafe rewards agents for reducing the number of weekly payment claims that continue past 134 weeks.

Documentary evidence of a focus on financial rewards

346. In one Allianz email, management highlighted to staff the monetary value of an individual claim to Allianz's overall performance against one of the financial reward measures. One of the emails referred to claims within the 134 week measure that were at risk of 'tipping' (meaning Allianz would not receive a financial reward for these). It stated that staff needed to do 'all [they] could to stop' the claims 'tipping' and that 'any one of these claims could be worth \$100K to the business'.²⁵⁴

²⁵¹ Interview of General Manager of Workers Compensation, Gallagher Bassett on 9 May 2016.

²⁵² Email from a QBE Manager dated 29 April 2015.

²⁵³ Interview of QBE State Manager on 13 May 2016.

²⁵⁴ Email from a Manager at Allianz to various Allianz staff dated 23 April 2015.

347. Gallagher Bassett emails showed a similar practice, with a manager conveying to staff that each claim terminated at 130 weeks was 'worth \$60k to GB [Gallagher Bassett]'; presumably referring to the 134 week measure.

348. At interview, the then Allianz General Manager said he did not believe quoting such monetary figures puts pressure on staff and said:

... these are the measures that WorkSafe have of us and the way in which we go about achieving the targets that we have. And this is the way in which we cascade those measures to our staff, and this is a consequence of those targets that are set for the staff.

...

I don't believe it's inappropriate in the sense that there are a range of finite ways in which a claim can be assessed, and those are as per the legislation, and that we only act within the realms of the legislation, and that those decisions are made in that context.

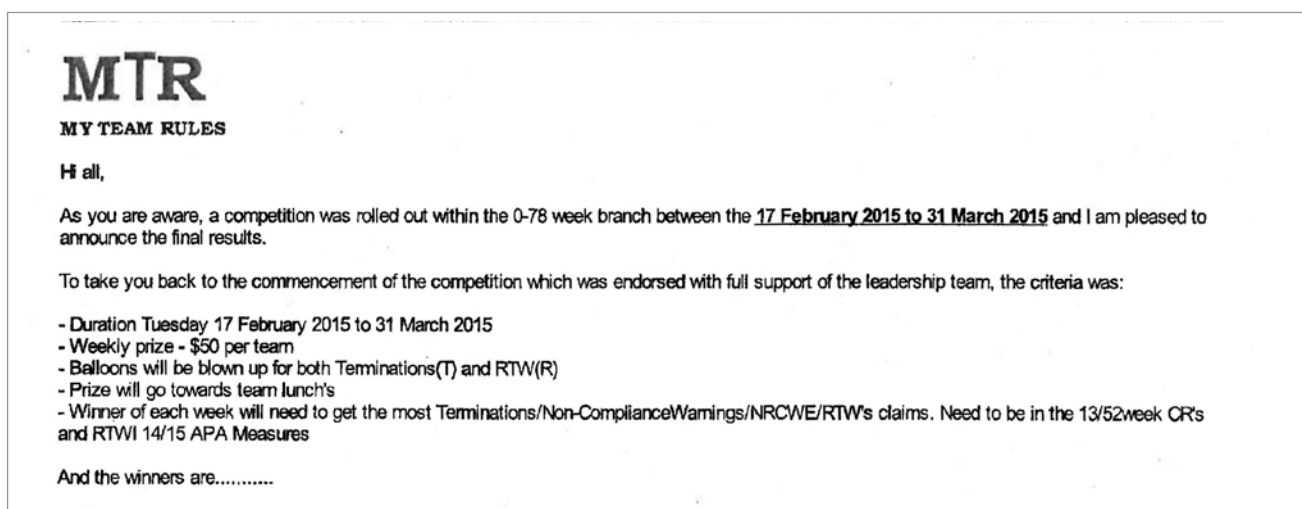
...

I think the way in which the financial measure is put on the claims is something that happens ... towards the end of the year as a way in which we are able to accurately measure our performance over the financial year. It is simply a way of quantifying our performance, but in no way should influence whether or not they are making the right decision.²⁵⁵

349. The then Allianz General Manager stated that staff have 'no financial interest in the outcome'; with only senior staff rewarded with bonuses. The other four agents confirmed that some staff received performance-based bonuses, a component of which related to performance against the financial reward and penalty measures.

350. A QBE email showed that management held competitions to reward staff for terminations of claims or return to work that would result in QBE receiving a financial reward. The email (pictured below) shows that there were monetary prizes, with balloons blown up for each termination and return to work outcome.

Figure 5: Email showing prizes offered to staff for terminations or return to work



255 Interview of the former Allianz General Manager on 5 May 2016.

351. At interview, the QBE State Manager acknowledged the perception such competitions could create, and said:

... on its own, I can see one might have concerns about this email but without understanding the full context of ... the checks and balances and the cases that sit behind it and the decision-making controls that sit behind it, it's hard to take on its own without seeing what, I guess, all of the information [that] sits behind this document. But ... in its own right, I can see that it would – it could be seen as a concern.

...

you could say that ... they're driving a particular behaviour around terminations and around getting particular outcomes in terms of claims ... I would like to think that there's been no decisions made unless there was absolutely evidence and absolutely the right controls and checks and balances in places to make any of the decisions that give light to these outcomes. That's what I would like to think.²⁵⁶

352. Allianz emails also showed management identifying staff who had 'achieved their termination target', and congratulating the 'Top Terminator' and 'Top Deny/Rejector'.²⁵⁷

353. The then Allianz General Manager denied there was too much focus on terminating claims and said:

... we do measure terminations, but ... it is one part of a number of activities that we measure in terms of our overall performance and our claims management approach.

...

this is part of our need to make sure we are compliant with our legislation, and that we ensure ... injured workers receive their appropriate entitlements.²⁵⁸

354. An Xchanging email highlighted the emphasis on terminating claims within the 134 week financial reward and penalty measure. It was titled '134 [week measure] – 1 month to go' and congratulated staff on their performance, stating:

We are smashing them. Number 1 agent by a mile. Keep pushing the troops guys.²⁵⁹

355. Another Xchanging email highlighted a focus on terminating claims. The staff member wrote:

The Act is a wonderful thing. There are many avenues to get rid of claims that people are generally not aware of because they have never been shown ... or looked for an alternative way to do things that fit within the legislation.²⁶⁰

356. In one Gallagher Bassett email, a staff member questioned why a particular injured worker had been classified as having a 'catastrophic' injury, stating they did not believe the worker qualified for this categorisation because they just had 'a crook back and low education'. The staff member said that they were 'planning on (though not necessarily hopeful) of a 130 week termi[nation]', to which another staff member responded: 'Knock your socks off and terminate away!!'

357. On the language in the above emails, a WorkSafe Director said at interview:

... it's certainly not what we would be wanting them to focus [on], we'd be wanting them to focus on making the right decision at the right time.²⁶¹

256 Interview of QBE State Manager on 13 May 2016.

257 Emails between Allianz Managers dated 1 April 2015.

258 Interview of the former Allianz General Manager on 5 May 2016.

259 Email from a Manager dated 1 June 2015.

260 Email from Xchanging officer to other staff dated 3 June 2015.

261 Interview of WorkSafe Director on 25 May 2016.

Witness statements about agents' profits focus

358. Witnesses also raised concerns about agents' attitudes. A former agent executive said:

[The agents] are driven by the [financial rewards] that WorkCover pays ... There is no regard for the injured worker ... [they are] just a number.

...

The injured worker is almost the forgotten person. It should be about them, it shouldn't be about ... how the executives get paid their bonuses, how the agents get paid their bonuses. That shouldn't be the driver of the behaviour but that is what has been happening for a number of years.²⁶²

359. A former agent employee said that injured workers were 'treated like a number' and the key focus of agent staff was:

meeting the figures, the benchmarks so we could get remunerated ... we need to hit those targets to get that remuneration because otherwise the company's actually running the Workers Comp division at a deficit for what it costs it ... Your overheads actually cost us more than what you actually bring in from [WorkSafe]. And so messages [from management] about the need to meet the benchmarks or the financial [rewards] - [were] constant.²⁶³

360. The former agent staff member stated they had worked at three of the five agents and this focus was common across all of them.

361. A doctor who was formerly employed by an agent and WorkSafe said that the agents exist to make money and that the financial rewards influenced the way the agents dealt with claims.²⁶⁴

362. The following case study illustrates an agent's focus on terminating claims to achieve a financial reward. In this matter, Allianz terminated a worker's claim at 130 weeks, despite consistent IME opinions about the worker's incapacity. Several internal file notes on the worker's claim file referred to Allianz's 'goal' being to terminate the claim at 130 weeks.

'The injured worker is almost the forgotten person.'

Comment of a former agent senior executive

²⁶² Interview of a former senior executive of an agent on 18 November 2015.

²⁶³ Interview of a former agent staff member on 20 April 2016.

²⁶⁴ Telephone call with former agent and WorkSafe doctor.

Case study 23: Termination was the 'goal' despite no evidence of the worker's capacity

A butcher made a claim to Allianz for a shoulder injury sustained from lifting a heavy carcass of meat and then later falling over at work. The claim for the shoulder injury, as well as a secondary psychological condition, was accepted by Allianz. The worker ceased work following their injury and did not return.

Consistent opinions from IME 1 and IME 2 confirmed no work capacity

Between late 2012 and mid-2014, Allianz arranged for the worker to be examined by an occupational physician IME (IME 1) for their shoulder injury on four occasions and a psychiatrist IME (IME 2) for their secondary psychological condition on three occasions. The opinions of IME 1 and IME 2 remained relatively unchanged over this period.

IME 1 indicated that the worker's shoulder injury was initially contributing to their incapacity for work, but that he believed from October 2013 the worker had a capacity for work purely from a physical perspective. However, IME 1 noted the worker's psychological condition seemed to be preventing them from returning to work.

IME 2 concluded in his three reports that:

- the worker's psychological condition was rendering them incapacitated for work
- the worker had not improved over the time since IME 2 first saw them and their condition was probably permanent
- the worker was unlikely ever to return to work.

Allianz file made explicit references to financial reward and penalty measures

Despite these opinions, internal Allianz file notes indicated that Allianz's 'goal' was to terminate the worker's claim. For example:

- A file note from mid-2013 noted that the 52 week continuance rate was 'estimated to tip' in September 2013 and so the claim was 'more likely to be a 134 week termi[nation]'
- A file note from late 2013 noted that the worker remained incapacitated from a psychiatric perspective but stated 'we are currently aiming for the 134 week CR [continuance rate]', noting that it was unknown whether Allianz would meet this target.
- A file note from early 2014 similarly noted that Allianz was 'aiming for the 134 week CR', and that this target was 'potentially achievable' although might be difficult from a psychiatric perspective.
- A file note from mid-2014 stated that Allianz's 'goals' were for 'the worker to obtain a capacity from a psychiatric perspective' and to 'issue [a] 130 week termination'.

At the time of these file notes, Allianz had no evidence to suggest that the worker had a work capacity based on his psychological condition nor that he would gain one in the foreseeable future.

Worker sent to different psychiatrist IME (IME 3)

In late 2014, Allianz sent the worker to be examined by a different psychiatrist IME (IME 3), only four months after their examination by IME 2, who was also a psychiatrist. This was despite the consistent conclusions reached by IME 1 and IME 2, and comments by both IMEs earlier in 2014 that the worker would not have a work capacity in the next 12 months. It is unclear why Allianz arranged for the worker to be examined by a different IME when:

- IME 2 had examined the worker on three prior occasions and thus held a greater understanding of the worker's history
- there had been a clear pattern of Allianz sending the worker to the same IME over a period of time for opinions on their condition and capacity.

In its request to IME 3, Allianz asked the IME to respond to questions around the worker's capacity for work without factoring their age. As noted in the previous chapter of this report, such questions are inconsistent with the WIRC Act, which requires that a range of factors be considered in regard to a worker's capacity for suitable employment, including their age and work experience. At this time, the worker was 59 years of age and had no experience outside of being a butcher.

Intention to terminate despite no evidence

A few days before receiving IME 3's report, Allianz staff completed file notes stating that a 130 week termination was to be issued, but noting that Allianz was awaiting IME 3's report to determine whether they could go ahead and issue the notice. At this stage Allianz had no evidence to support a termination based on the worker's psychological condition.

IME 3's report - worker will have capacity in 6-12 months

Allianz received IME 3's report a few days later, in which he concluded that the worker did not have a work capacity and so 'the question of restrictions [could not] be considered yet'. IME 3, however, stated that he believed the worker would have a capacity for suitable employment within six to 12 months. IME 3 qualified this statement by saying that his 'opinion would be better informed by reports from the treating psychiatrist and psychologist', none of which were provided by Allianz.

On three further occasions in his report, IME 3 noted the lack of treating practitioner reports provided by Allianz, and the impact that this had on his opinion.

Termination based on selective use of evidence

Allianz subsequently terminated the worker's payments on the basis of IME 3's opinion that the worker would have a work capacity within six to 12 months.²⁶⁵

Decision overturned at conciliation

The worker lodged a request for conciliation and the ACCS subsequently requested a report from the worker's treating psychiatrist as Allianz had not obtained one. The report later provided concluded that the worker's incapacity for work was indefinite, stating that their 'future capacity for work is poor and it is doubtful if [they] will ever be able to go back to the workforce'.

Allianz maintained its decision at conciliation and the ACCS subsequently issued a direction to Allianz to reinstate the worker's payments on the basis that it did not have an arguable case. The ACCS noted that while IME 3 had concluded that the worker would have capacity in six to 12 months, he made several statements in his report undermining this conclusion, including:

- The worker had no work capacity for any duties and so the question of restrictions when he returned could not yet be considered.
- When the worker was 'well', they could possibly retrain and seek suitable employment at a future date.
- His opinion was less informed due to the absence of treating health practitioner reports.

Allianz subsequently reinstated the worker's payments in line with the direction.

²⁶⁵ Under the WIRC Act, a worker's entitlement to weekly payments ceases at 130 weeks if they have a work capacity, or alternatively, they are incapacitated but this is unlikely to continue indefinitely.

Unsustainable decisions and financial rewards

363. At interview, agent executives emphasised that claims decisions need to be evidence-based and in line with the WIRC Act, and that the financial rewards should not influence decision-making on claims. The National Manager Fee States at CGU said:

I don't think the continuance rate [one of the financial reward and penalty measures] should influence the decision. The decision has to come back to whether or not the person has an entitlement or not. It's based on the Act. It's as simple as that I think... The profitability and all that comes out afterwards. We've got to manage the claims by the Act and not any other factor.²⁶⁶

364. The General Manager of Workers Compensation at Gallagher Bassett also said that the financial reward and penalty measures should not influence decision-making, and that many staff would not even be aware whether a claim fell within a measure. He said:

You make your decisions based on the evidence you have, not on, 'oh that might impact that or that'. You really don't. And the average case manager wouldn't know anyway, to be honest with you. That a decision to accept liability or reject liability or whatever it may be is going to have - impact X, Y and Z. They wouldn't know. Certainly managers would know but not the average case manager.²⁶⁷

365. The then Xchanging General Manager similarly advised my officers that claims staff do not actively consider the financial reward and penalty measures when making decisions:

Claims staff actually ... they don't get fully involved with the [financial reward measures] ... things that at a higher level you look at to see how the operation is performing. Our staff, their role, their responsibilities are quite clear. You've got a book of [claim] files, your role is to ensure that you make the calls, you do the triage ... you work with the parties to get a return to work outcome ... so for staff ... I can't see whether they look at a file and say 'that's going to make Xchanging money', they're going to say 'I've got to do these things now because it's my job, to try and get a return to work'.²⁶⁸

366. However, there are examples where the financial reward and penalty measures influenced decision-making by staff, and where agents unreasonably terminated or rejected claims to achieve financial rewards. Moreover, the agents went on to maintain such decisions at conciliation.

²⁶⁶ Interview of National Manager Fee States, CGU on 24 May 2016.

²⁶⁷ Interview of General Manager of Workers Compensation, Gallagher Bassett on 9 May 2016.

²⁶⁸ Interview of the former Xchanging General Manager on 4 May 2016.

367. An Allianz email provided an example of this behaviour. Allianz staff suggested a claim be terminated so that Allianz could 'save a tip',²⁶⁹ suggesting it could receive a financial reward, despite having no evidence that the worker had a work capacity:

In the interest of saving a tip, let's issue this [termination] and review [our] position after receipt of [an IME report].

[H]owever I note we do not have anything that evidences [work] capacity at this stage

Our notice will look quite strange.²⁷⁰

368. Allianz did not end up terminating the claim.

'In the interest of saving a tip, let's issue this [termination] and review [our] position after receipt of [an IME report].

[H]owever I note we do not have anything that evidences [work] capacity at this stage

Our notice will look quite strange.'

Internal email from an agent manager

369. The following case study shows that Xchanging terminated a worker's claim at 130 weeks despite not knowing what their work capacity would be following scheduled neck surgery.

²⁶⁹ Agent staff sometimes refer to a claim that has or will exceed the relevant timeframe of weekly payments associated with the relevant financial reward and penalty measures as a 'tip'. Reference to 'saving a tip' means ensuring that a claim does not exceed the measure's timeframe, thereby meaning the agent would achieve a financial reward.

²⁷⁰ Email from an Allianz Manager dated 2 June 2015.

Case study 24: Agent staff member concerned - nothing in the IME's opinion supports our decision to terminate

In late 2012, a personal care attendant made a claim to Xchanging for a neck injury sustained while assisting a patient. The worker ceased work as a result of their injury and their claim was accepted by Xchanging. In early 2013, the worker underwent neck surgery funded by Xchanging.

IME 1 concluded that work capacity may be hampered by further surgery

In late 2014, Xchanging sent the worker to be examined by IME 1 to assist it in determining the worker's ongoing entitlement to payments. IME 1 concluded that the worker could return to alternative duties of a sedentary nature, depending on whether there was a need for further surgery. He stated the worker would not have a work capacity while recovering from any further surgery. The worker's surgeon subsequently made a request to Xchanging to perform a second surgery on the worker. This was approved by Xchanging.

IME 1's supplementary report did not include a definitive opinion

Xchanging then sought a supplementary report from IME 1 to clarify timeframes for the worker's recovery and return to work after surgery. IME 1 provided a further report to Xchanging in which he stated that recovery might take up to six months. His view was that the worker should have a work capacity three to six months after surgery depending on the speed of recovery.

The use of the word 'should' in IME 1's report demonstrates that his opinion was not definitive. WorkSafe guidelines to agents on 130 week terminations state that a medical opinion that is not definitive (i.e. an opinion that states should or may have a capacity) is not sufficient for agents to terminate a claim at 130 weeks.²⁷¹

In early 2015, Xchanging terminated the worker's entitlements at 130 weeks - one week prior to the worker's scheduled surgery. The worker lodged a request for conciliation in relation to the termination.

File notes made explicit reference to expected financial rewards

Internal file notes in the months leading up to the termination consistently referenced the 130 and 134 week dates, noting that the 134 week measure was the next relevant financial reward and penalty measure.

The termination issued by Xchanging aligned with this date and Xchanging would have received a financial reward for terminating the worker's claim.

Xchanging ignored evidence to support a withdrawal of the termination

After the surgery, the worker's surgeon anticipated the worker would be able to return to sedentary employment once full recovery had taken place, and said that 'this may occur towards the end of 2015'.

A file note documenting Xchanging's further review of this matter stated:

worker has now had surgery and is currently suffering a post [operation] wound infection and is currently an inpatient

a post [operation] report has been provided by the surgeon who is indicating that the worker will have a capacity by the end of this year

maintain decision.

²⁷¹ WorkSafe Victoria, Quality Decision Making APA 2014-15, presentation on 4 May 2015.

Xchanging appears to have interpreted the worker's surgeon's comments in this way to enable it to maintain the termination.

Subsequently:

- The worker's surgeon and GP indicated that the timeframe in which the worker would be able to return to work was dependent on the extensive period of recovery the worker needed, thereby suggesting Xchanging's termination should be withdrawn.
- Two Xchanging managers expressed concerns that there was no 'arguable case' for the termination; however, Xchanging maintained the decision at conciliation.
- IME 2 concluded that the worker would 'take at least 12 to 18 months to recover from surgery, that is, it is unlikely there will be much change in that period of time'. The IME said the worker was 'totally and temporarily incapacitated for work' but that they would eventually be able to return to some form of work, meaning that their incapacity was not indefinite. He suggested that the worker be reviewed again in six months' time.

Further emails suggested decision-making was based on expected financial rewards

Internal emails show that Xchanging acknowledged that, based on IME 2's report, its decision was no longer sustainable. However, the emails stated that given IME 2's use of the phrase 'not indefinite' Xchanging should try to resolve the matter with an offer to the worker of limited payments.

The emails noted that the claim had another 12 weeks before it reached the 130 week date and so recommended an offer of 12 weeks of payments. If accepted by the worker, Xchanging would still receive the financial reward under the 134 week measure.²⁷²

A manager subsequently raised concerns with the staff involved about their overreliance on IME 2's use of the word 'indefinite', without considering the totality of his opinion. The manager said 'when reading [IME 2's report] it becomes abundantly clear, in my view, that when [IME 2] states that [the worker's] incapacity is "not indefinite" that he is simply stating [they] will return to some form of employment someday'. The manager said that he could not point to any part of IME 2's opinion that supported Xchanging's decision to terminate at 130 weeks.

Xchanging made an offer of limited payment, despite concerns about sustainability of decision

Despite these concerns, Xchanging proceeded to make the offer of 12 weeks of payments. This was rejected by the worker's lawyer, who requested the notice be withdrawn based on the evidence supporting the worker's indefinite incapacity.

Upon receipt of the worker's lawyer's correspondence, Xchanging withdrew its decision and reinstated the worker's payments.

370. The following case study shows that QBE denied a worker weekly payments without any evidence. The decision appears to have been based on QBE's desire to achieve a financial reward for this claim.

²⁷² At conciliation, an agent may maintain their decision but make an offer of limited payments to an injured worker to resolve the dispute, without admitting liability for the claim. This is discussed further below, in the section titled 'Limited offers at conciliation to achieve a financial reward'.

Case study 25: 'This claim is scheme (and QBE) sensitive'

In the 1990s, an electrician made a claim to QBE for a back injury sustained after falling off a ladder at work. The worker's claim was accepted and, after a short period of recovery, they returned to their role as an electrician with their pre-injury employer before changing to a new company a few years later.²⁷³

While the worker was able to remain in full-time work, they continued to suffer chronic back pain and experience significant 'flare ups'. As a result, the worker continued to receive regular treatment funded by QBE.

An IME opinion in early 2014 confirmed that the worker's original workplace injury had not resolved and they continued to experience occasional 'flare ups'. The IME also confirmed that the worker did not have any pre-existing medical conditions and had no back symptoms prior to their workplace injury in 1996.

QBE rejected request for weekly payment and terminated entitlements without evidence

In late 2014, the worker experienced a major 'flare up' that rendered them incapacitated for work for eight days. As a result, the worker made a request to QBE to reinstate their weekly payments. Their request was accompanied by certification from their doctor that they were unfit to work for this period.

QBE rejected the worker's request for weekly payments (the rejection) and also terminated their entitlement to medical and like expenses (the termination) on the basis that the worker had recovered from their original injury, and had experienced 'further incidents' while working for a different employer. QBE claimed it was these further incidents that had aggravated the worker's back injury. As a result, QBE suggested the worker lodge a new claim for the 'new injury'.

Dispute resolution staff expressed concerns about the strength of the decisions

The worker lodged a request for conciliation in relation to both the rejection and termination. An internal QBE file note identified concerns held by dispute resolution staff about the strength of QBE's decisions:

[The last IME] acknowledges that the workers [*sic*] condition had not resolved and [they] would continue to get bouts of pain and stiffness. I do not believe our grounds are strong for rejecting and terminating medical and like expenses as we did not obtain an up to date physical IME to confirm if workers [*sic*] condition was still work related after temporary flare up.

A later file note, shortly before the scheduled conciliation conference, noted similar concerns:

I note that [another Officer] raised concerns during the initial review, and I share those concerns.

I don't believe we should proceed to conciliation as our decision cannot be sustained.

The report from [the IME] ... does not support the ground that medical and like treatment is no longer related to the claimed injury.

²⁷³ As the worker returned to work, they stopped receiving weekly payments, however, continued to receive medical and like entitlements for their claim.

Manager referred to the negative impact a reversal of decisions would have on agent financial reward

A QBE manager later reviewed the matter stating they believed that 'strategically' the decisions were correct and the worker should submit a new claim form for the 'new injury'. The manager noted that '**being a 1996 DOI [date of injury] this claim is scheme (and QBE sensitive)**' [QBE's emphasis]. This appears to be a reference to the Active Claims financial reward and penalty measure, and the impact that reversal of these decisions would have on QBE's performance against this measure.

As outlined in Table 2 earlier in this chapter, claims with a date of injury from 1985 to 2009 were subject to the Active Claims measure in 2014-15, meaning that termination or cessation of weekly payments on any of these claims would help the agent receive a financial reward under this measure. Conversely, an agent's performance against this measure would be adversely affected (i.e. no financial reward received and potential for penalty) if weekly payments were reinstated.

QBE's suggestion that the worker lodge a new claim would, however, not adversely impact the Active Claims measure, as the timeframes associated with the financial rewards would start again with a new claim.

Decision overturned at conciliation as agent had no arguable case

As a result of the manager's advice, the officer decided to proceed to conference and 'run the argument', stating that they would 'give it [their] best shot' and would 'push for a GD [genuine dispute]'.

At conciliation QBE continued to maintain its decisions despite requests from the ACCS that they be withdrawn because there was no arguable case. This resulted in the ACCS issuing a direction.

Subsequently, QBE reinstated the worker's medical entitlements and agreed to pay the worker weekly payments for the requested period.

371. Case studies 23 and 26 from this chapter both demonstrate agents making unreasonable decisions to terminate claims at 130 weeks which appeared to have been driven by the agents' desire to achieve the financial reward for reducing the number of claims that exceed 134 weeks.
372. Case studies 3, 11, 15, 16, and 17 in the previous chapter also relate to flawed decisions to terminate claims at 130 weeks. In these case studies, I did not find direct evidence that the agents' decisions were motivated by the 134 week financial reward, but I consider it is reasonable to infer that this may have been the case given the agents' disregard for evidence, the timing of their decisions aligning with the financial reward measures and multiple references to the financial rewards in file notes.
373. In response to my draft report, CGU stated that it considers that 'if no direct evidence has been found, then it is not reasonable to make inferences.'

Limited offers at conciliation to achieve financial rewards

374. In some cases, agents made offers of limited payments to workers at conciliation to achieve financial rewards. This included cases where the agent acknowledged their decision was not sustainable. This practice is not problematic in itself if the offer is consistent with what the worker is entitled to; however, this was not the case in some matters.
375. At conciliation, an agent may maintain their decision but make an offer of limited payments to an injured worker to resolve the dispute, without admitting liability for the claim. For example, an agent may have terminated a worker's entitlements but offer to pay them a further four weeks of payments.
376. As outlined earlier, agents receive financial rewards for terminating claims before they reach 13, 52 and 134 weeks of payments. Where an agent terminates a claim but that decision is overturned at conciliation, the agent does not receive the financial reward for that claim.²⁷⁴ However, if the agent makes an offer of payments to the worker at conciliation that are within the timeframes of the associated measure, and the worker accepts the offer, the agent is able to receive a financial reward.
377. At interview, agent executives said that the financial rewards should not influence the offers made by agents at conciliation; rather, offers should be made based on what the agent believes is appropriate compensation in line with the Act.²⁷⁵
378. However, a Gallagher Bassett email showed a manager seeking advice on the financial reward measure that would make Gallagher Bassett 'more money', stating that they would make an offer to the worker on this basis:
- Do we make more money off 13 week ... [financial measure] or 52? If we make more off the 13 weeks I'll go with the offer of 4 weeks, if we make more money on the 52 weeks then I'll try to put forward an offer greater than 30 June.²⁷⁶
379. The General Manager of Gallagher Bassett said that this behaviour was 'completely unacceptable' and that he would 'never sit [t]here and tick off an approval of someone making offers based on that'.²⁷⁷ He further said:
- ... that [email] clearly indicates he's asking what he wants us to do in terms of an offer, in terms of a better outcome. Which is not a better outcome for the worker and employer, it's a better outcome for us ... that's wrong on so many fronts.²⁷⁸
380. Emails from the ACCS to WorkSafe also highlight a case in which CGU told the ACCS that they could not agree to an offer put forward by an injured worker at conciliation because they needed to check the impact that any further payments would have on 'the statistics'.²⁷⁹

²⁷⁴ This only applies where the decision is overturned within the same financial year that it was made; this was explained in further detail in the previous section on manipulation of the financial reward/penalty measures.

²⁷⁵ Interview of the General Manager Gallagher Bassett Services on 9 May 2016 and the General Manager of CGU on 24 May 2016.

²⁷⁶ Emails between a Gallagher Bassett Officer and Manager on 10 June 2015.

²⁷⁷ Interview of General Manager of Workers Compensation, Gallagher Bassett on 9 May 2016.

²⁷⁸ Interview of General Manager of Workers Compensation, Gallagher Bassett on 9 May 2016.

²⁷⁹ Emails between a Conciliation Officer from the ACCS and WorkSafe dated 30 April 2013.

381. In another email example, CGU staff acknowledged their argument would be 'difficult to maintain' at court stating:

This claim is affecting our 13 week continuance rate [financial reward and penalty measure], therefore do you think it's possible to start negotiations under 13 weeks?²⁸⁰

382. When shown similar emails, the National Manager Fee States at CGU said that offers should not be influenced by the financial reward and penalty measures and instead should be based on 'what they think is the person's entitlement'.²⁸¹ She said:

... there's no reason to mention the [financial rewards]. It shouldn't be factoring in their decision-making ... it should be settling at the right amount and ... the [financial rewards] shouldn't factor into any of the conversations or discussions.²⁸²

383. Xchanging emails also provide an example of this practice. In one matter, Xchanging was concerned that it was 'not in a position to maintain' a disputed decision at conciliation. A later email, however, referred to the date the claim would exceed the relevant financial reward and penalty measure, and stated that Xchanging could therefore not make any offers to the worker. The email showed that, despite the acknowledgement of its weak case, Xchanging intended to let the matter go to conciliation:

The conciliator will need to determine if an arguable case exists or not. If they are satisfied that an arguable case exists then the file will either be referred to Medical Panel or a GD [genuine dispute] will be issued.²⁸³

384. Another Xchanging email²⁸⁴ highlighted a case where Xchanging was concerned that the available medical information did not support its termination of the worker's claim. The email stated that Xchanging could offer the worker up to 18 weeks of payments at conciliation. This number of payments would not breach the relevant financial reward date, and Xchanging would still achieve the financial reward for its termination of that claim.

385. Witnesses raised concerns about this practice. At interview, one former agent employee said that management placed pressure on staff to maintain decisions at conciliation and to not pay compensation past a certain date. This was to ensure the agent did not 'breach' their 'targets'. The former employee said this occurred in cases even where concerns were raised about the evidence-base of the decision.²⁸⁵

'Do we make more money off 13 week ... [financial measure] or 52? If we make more off the 13 weeks I'll go with the offer of 4 weeks, if we make more money on the 52 weeks then I'll try to put forward an offer greater than 30 June.'

Internal email between an agent officer and an agent manager

280 Email from a CGU Manager dated 23 April 2015.

281 Interview of National Manager Fee States, CGU on 24 May 2016.

282 Ibid.

283 Internal email from an Xchanging Manager dated 1 May 2015.

284 Email from Xchanging Manager to another Manager dated 23 April 2015.

285 Interview of a former agent employee on 20 April 2016.

Professional and industry views

386. Information provided by a worker representative, an ACCS officer and the Police Association of Victoria is consistent with some of the documentary evidence of limited offers at conciliation.

387. At interview, a worker representative said they had heard the agents talk about the financial rewards when making offers at conciliation. The representative said:

I have heard them [the agents] talk about they have made an offer and they can't make any more because of financial benefits, well not financial, but because of their benchmarks...[and] KPIs.

Every so often you will get [an Agent staff member] say 'Well I can't offer any more because of our KPI measures'²⁸⁶.

388. The then Senior Conciliation Officer of the ACCS raised concerns about the practice of making limited offers of compensation at conciliation up to an 'arbitrary date', which the ACCS believed was directly linked to the financial reward measure dates.²⁸⁷ As mentioned earlier, details about the financial rewards and penalty measures are not made public and the ACCS does not know whether a claim falls within a particular financial reward and penalty measure.

389. The Secretary of the Police Association of Victoria similarly commented that it had 'over time noticed a pattern of limited offers of weekly payments at conciliation of less than 13 weeks' which he presumed were linked to the 'performance indicators'.²⁸⁸ The Association's observations are noteworthy given WorkSafe financially rewards agents for reducing the number of claims where weekly payments exceed 13 weeks.

390. The following case study is an example of an agent making a limited offer. In this case, Allianz terminated a worker's claim and made a limited offer of payments to the worker at conciliation in line with the relevant financial measure date. Allianz refused to provide a further six weeks of payments on the basis that it would prevent Allianz achieving the financial reward for the termination of this claim.

Case study 26: Agent 'can offer up to 13 weeks [of payments] only', otherwise claim will 'tip'

A 62-year-old delivery driver lodged a claim for a shoulder injury sustained after falling off the step of their truck. Allianz accepted the worker's claim and the worker subsequently underwent shoulder surgery.

One month after their surgery, Allianz sent the worker to an IME to assess their condition and capacity to return to work. Despite being asked not to factor in the worker's age, the IME concluded that the worker had no work capacity and their incapacity was indefinite.

Allianz terminated payments based on selective use of evidence and an outdated report

Allianz nevertheless terminated the worker's entitlements at 130 weeks on the basis that the worker had a work capacity, or their incapacity was not indefinite. Allianz's decision was based on a report from the worker's GP which stated the worker could return to sedentary duties part time. However, the GP also stated that their return to work could be hampered by any future shoulder surgery and that 'full recovery was uncertain'.

²⁸⁶ Interview of a worker representative.

²⁸⁷ Interview of the former Senior Conciliation Officer, the ACCS on 7 September 2015.

²⁸⁸ Letter from the Secretary of the Police Association of Victoria dated 18 November 2015.

The GP's report had been completed prior to the worker's surgery.

Allianz also relied on a certificate of capacity completed by the worker's GP post-surgery, based on the worker's intention to return to work pending the success of their surgery.

In its termination notice, Allianz noted the IME's opinion that the worker's incapacity was indefinite but did not explain why it chose to ignore that opinion and instead rely on the worker's GP's opinion.

Allianz provided IME with outdated reports

A week after issuing the termination, Allianz sought a supplementary report from the IME, providing copies of the GP report and certificate of capacity, as well as a report by an occupational rehabilitation provider. Both reports (excluding the certificate of capacity) pre-dated the worker's surgery. As a result, their reliability in regards to the worker's condition and work capacity post-surgery was questionable. It is also unclear why, if Allianz deemed these documents to be relevant to the IME's assessment of the worker, they were not provided with the original request.

Allianz's provision of outdated reports to the IME, combined with internal file notes on the worker's file, suggests that Allianz was seeking for the IME to change his opinion.

Allianz made a limited offer at conciliation to achieve financial reward

The worker lodged a request for conciliation in relation to the termination.

Further information provided during the conciliation process indicated that the worker had deteriorated following surgery, continued to be certified unfit for work, and was awaiting surgery on their other shoulder.

An internal Allianz file note by an officer stated:

In my view we should consider making an offer to pay under [recommendation from the ACCS] up to age 65 years otherwise face taking a Direction which will not be able to be revoked.

However, further internal Allianz emails and file notes stated that Allianz could only offer the worker 13 weeks of payments because 'the additional 19 weeks to retirement age' would breach the date associated with the financial reward and penalty measure. Allianz noted that it was 'not sure whether the worker would accept this'. If the worker accepted Allianz's offer of 13 weeks, the claim would not exceed the 134 week financial measure and the agent would achieve the financial reward for terminating this claim.

Allianz's offer was rejected by the worker and the ACCS issued a direction to Allianz that it reinstate the worker's payments to retirement age, on the basis that it had failed to establish on its own material that the worker had a work capacity, or that their incapacity was not indefinite. Allianz reinstated the worker's entitlements.

In response to my draft report, Allianz stated:

This case study provides an example where Allianz attempted to settle a claim at conciliation. It is not an unreasonable case management action to make an offer to settle a claim, and in some cases, this is the worker's preferred outcome. In this case, the settlement offer was rejected and the worker continued to receive benefits until retirement.

However, I do not consider it was appropriate to make such an offer to achieve a financial reward where it is evident that Allianz knew that the worker was entitled to payments until retirement.

391. In the following case study, Xchanging made an offer of limited payments to a worker at conciliation to achieve a financial reward measure, despite acknowledgement that its decision was unarguable.

Case study 27: Agent says the conciliation officer was ‘not persuaded [by Xchanging’s argument] (not surprisingly!)’

A nurse made a claim for a psychological injury, which was accepted by Xchanging after receiving an opinion from IME 1 that the condition had been caused by the nurse’s work.

Four months later, Xchanging asked IME 2 to provide an opinion on what had caused the worker’s condition. In his report, IME 2 stated that the condition was a ‘constitutional disorder’²⁸⁹ and that employment was not a cause. Xchanging terminated the worker’s claim on this basis and the worker lodged a request for conciliation.

Xchanging made an offer of limited payments, despite concerns around sustainability of the decision

File notes on the worker’s file show that Xchanging had concerns about the sustainability of its decision. The agent noted that the report from IME 1, upon which it accepted the claim, was a ‘significant complication’. Xchanging noted a ‘danger’ that the ACCS may issue a direction given conflicting IME reports and recorded in a file note that the decision was likely to be overturned given IME 2’s report was ‘not compelling’.

Internal emails similarly noted that the decision would likely be overturned. The emails noted that Xchanging could only offer up to a certain date, which internal file notes indicated was the date relevant to the 52 week financial reward measure. The offer was suggested ‘given real risks of direction and/or potential poor Medical Panel outcome’.

Xchanging was not surprised by a ‘threatened direction’

At conciliation, the ACCS raised concerns about Xchanging’s decision, noting that Xchanging seemed to be under ‘the incorrect impression that liability can be re-visited without any evidence of any factual/circumstantial change in the evidence that gave rise to the liability in the first place’.

Xchanging subsequently agreed to withdraw its notice because of a ‘threatened direction’ by the ACCS. An internal email noted:

In short, we initially accepted liability based on the opinion of [IME 1] and then terminated it based on [IME 2] some 8 months later (in effect, we were trying to revisit liability again but under the guise of something else, namely stating that her incapacity was unrelated to work which didn’t wash!) See my emails to the conciliator below and her response. She was not persuaded (not surprisingly!).²⁹⁰

²⁸⁹ Relating to the essential nature of the person and originating from their constitution rather than their experience.

²⁹⁰ Email from Xchanging manager to the employer dated 6 July 2014.

WorkSafe's oversight

WorkSafe's oversight of agents' management of claims includes:

- setting the financial reward and penalty measures for agents
- auditing the quality of agent decision-making
- responding to feedback from stakeholders and complaints
- having the power to issue directions to agents where it identifies concerns around decision-making
- overseeing the IME system
- providing performance reports to agents and 'health checks'
- ensuring agents have adequate internal control frameworks in place.

My investigation found that WorkSafe's oversight has been deficient in some of these areas. In particular, the financial reward and penalty measures have provided greater rewards to agents for terminating claims, without sufficient incentive for agents to make good quality decisions and to support long-term injured workers back to work.

WorkSafe's oversight mechanisms have been evolving over time and it is undertaking to improve agents' claims management and the experience of injured workers.

WorkSafe's oversight role

392. Under the WIRC Act, WorkSafe's five objectives are:

- managing the accident compensation scheme as effectively, efficiently and economically as possible
- managing the accident compensation scheme in a financially viable manner
- ensuring that appropriate compensation is paid to injured workers in the most socially and economically appropriate manner and as expeditiously as possible
- developing such internal management structures and procedures as will enable it to perform its functions effectively, efficiently and economically
- administering the WIRC Act and other relevant Acts.²⁹¹

393. The contract outlines that a major component of the claims management model is WorkSafe's oversight of the agents' performance of its functions.

394. The contract states:

- The agent agrees to be bound by, observe and carry out its obligations under the contract, the relevant legislation, and all Written Directions of WorkSafe and Ministerial Directions.²⁹²
- The agents are required to submit reports and provide access to data to WorkSafe. WorkSafe has the power to audit the agent in relation to its quality controls or in relation to any other matters.²⁹³
- WorkSafe has the power to evaluate the agents' performance against its functions for the purpose of assisting WorkSafe in identifying performance improvement opportunities.²⁹⁴

²⁹¹ WIRC Act 2013, s. 492.

²⁹² WorkSafe Victoria, *Agency Agreement*, clause 2.5, 2011.

²⁹³ WorkSafe Victoria, *Agency Agreement*, Schedule A, 2011.

²⁹⁴ WorkSafe Victoria, *Agency Agreement*, Schedule G, 2011.

395. The contract also outlines WorkSafe's ability to financially penalise an agent for failing to comply with its obligations. This includes where an agent:

- fails to maintain effective internal quality controls
- manipulates data
- consistently makes decisions on claims which are inconsistent with the objectives of the contract, the relevant legislation, written directions, Ministerial directions and any other applicable regulations.²⁹⁵

396. Under the WIRC Act, delegated functions performed by the agents are taken to have been performed by WorkSafe²⁹⁶ and WorkSafe remains directly liable to a worker to pay compensation in respect of work-related injuries.²⁹⁷

'We spend all this time and do things for every case ... despite ... that ... most clients will come in, get better, and out, really quickly ... [we need to] let them go, get out of the way, make it easy, make it really streamlined, help them, support them, give them the right information, but not have that intensive claims management approach to it.'

WorkSafe Executive

Financial rewards and penalties

397. As noted in the last chapter, WorkSafe has a range of performance measures under which agents may be financially rewarded or penalised. Each of these carry different weightings and dollar amounts. WorkSafe states that the strategic intent of the remuneration framework is 'to provide good value for money by ensuring that agents who deliver scheme outcomes can earn suitable commercial profits'.²⁹⁸

VAGO's concerns that measures foster a focus on liability

398. VAGO's 2009 audit sought to assess the effectiveness and efficiency of claims management by WorkSafe and the agents. The audit found that WorkSafe had improved the scheme's financial position since the introduction of a new claims model in 2002 and that reductions in long-term claim costs – in particular, weekly payments and medical and like expenses – had directly contributed to the financial sustainability of the scheme.²⁹⁹

399. However, VAGO stated that WorkSafe's remuneration model (financial rewards and penalties) was driving 'a stronger focus by agents on liability management, rather than the quality of case management practices'³⁰⁰.

400. VAGO highlighted the importance of good quality agent decision-making, noting the impact that poor decision-making and delays in resolving disputes could have on an injured worker's return to work and rehabilitation.³⁰¹

²⁹⁸ WorkSafe Victoria, *Overview of Performance Management Framework*, October 2015, page 5.

²⁹⁹ Victorian Auditor General's Office, *Claims Management by the Victorian WorkCover Authority*, June 2009, page 6 and 7.

³⁰⁰ Victorian Auditor General's Office, *Claims Management by the Victorian WorkCover Authority*, June 2009, page 41.

³⁰¹ Victorian Auditor General's Office, *Claims Management by the Victorian WorkCover Authority*, June 2009, pages 32-33.

²⁹⁵ WorkSafe Victoria, *Agency Agreement*, Schedule C, 2011.

²⁹⁶ WIRC Act 2013, s. 500(4).

²⁹⁷ WIRC Act 2013, s. 70.

401. VAGO concluded:

- WorkSafe needed to develop a stronger focus on monitoring and improving the effectiveness of agents' case management practices.
- Additional quality measures were needed to clearly link outcomes in relation to return to work and termination decisions to agents' performance against good practice case management.³⁰²

Rewards and penalties for quality decision-making

402. VAGO made a number of recommendations to WorkSafe including introducing new measures that directly rewarded and/or penalised agents on the basis of the quality of their decision-making. WorkSafe accepted this recommendation in part, stating:

While there exists scope to attach financial measures to Agents' performance against quality measures for claims management, these need to be carefully balanced against other elements that also impact on a worker's experience.³⁰³

403. Following the VAGO Audit, WorkSafe introduced a new financial reward and penalty measure called the 'Quality Decision Measure'. WorkSafe stated to my office that this has been 'the only [measure] where a review of agent decision-making is undertaken'.³⁰⁴

404. The measure initially only applied to an agent's decision to accept or reject a new claim. Despite VAGO's comments that a quality measure was needed to link outcomes in relation to termination decisions with good practice case management, WorkSafe did not introduce such a reward for five years. In 2014-15, WorkSafe expanded the measure to examine decisions to terminate medical expenses after 52 weeks; and in 2015-16, it was expanded further to review the quality of 130 week terminations.

405. The audits through which WorkSafe examines agent performance against this measure are discussed in further detail later in this chapter.

Table 5: Expansion of the Quality Decision Measure

Year	Types of decisions audited
2009 to 2014	<ul style="list-style-type: none"> • Initial eligibility decisions: audits the quality of initial acceptance or rejection of claims*
2014-15	<ul style="list-style-type: none"> • Initial eligibility decisions • Medical and like entitlement review:^ audits the quality of decisions to terminate medical expenses after 52 weeks of entitlements
2015-16	<ul style="list-style-type: none"> • Initial eligibility decisions • Medical and like entitlement review • 130 week decisions:*^ audits the quality of 130 week termination decisions

* While WorkSafe initially audited accepted and rejected initial eligibility decisions, WorkSafe now only audits rejected claims.

^ WorkSafe Victoria, *Agent Remuneration: Quality Decisions Measure Business Rules: Annual Performance Adjustment Fee 2014/15*, March 2015.

** WorkSafe Victoria, *Agent Remuneration: Quality Decisions Measure Business Rules: Annual Performance Adjustment Fee 2015/16*, August 2015.

302 Victorian Auditor-General, *Claims Management by the Victorian WorkCover Authority*, June 2009, page 61.

303 Victorian Auditor-General, *Claims Management by the Victorian WorkCover Authority*, June 2009, page 13.

304 Information provided by WorkSafe on 24 December 2015 in response to a request for documents by my office.

406. In response to my draft report, WorkSafe stated:

The Quality Decision Measure is not the only means of incentivising good quality decision making by agents. WorkSafe has a number of measures it uses and has used over the years to review decision making by agents.

Initial measures had a process focus ...

In recent years, WorkSafe has focused on outcome measures rather than process measures to drive quality ...

407. None of the measures referred to by WorkSafe in its response involved a review of the quality of agent termination decisions.

Unbalanced weightings given to financial reward and penalty measures

408. There is more of a financial reward for the agents to terminate and reject claims than there is for agents to make decisions that are evidence-based and sustainable. The following table shows that, in 2014-15, agents could have achieved a reward of 19 per cent of the premium fee and a penalty of 12.5 per cent for claim outcomes, including terminating claims.

409. In contrast, the below table shows the maximum reward for the quality decision measure in the 2014-15 financial year was 2.5 per cent of the premium fee, with a maximum penalty of -1.5 per cent.

Table 6: 2014-15 financial rewards and penalties for outcome measures*

Outcome Measure	Reward	Penalty
Terminating claims before they reach 13, 52 and 134 weeks	7%	-5%
Workers returning to work within six months	6.5%	-3%
Terminating long-term claims [^]	2%	-1%
Terminating medical and like entitlements at 52 weeks	1.5%	-1.5%
Reducing medical expenditure ^{**}	2%	-2%
Total	19%	-12.5%

* WorkSafe Victoria, *APA Background Paper 2014-15: Agent Remuneration and the Annual Performance Adjustment*, undated, pages 9-10.

[^] The APA Active Claims measure.

^{**} The APA Medical measure.

Table 7: 2014-15 financial rewards and penalties for quality decision-making*

Outcome Measure	Reward	Penalty
Quality Decision Measure	2.5%	-1.5%
Survey Measures	10%	-5.5%
Total	12.5%	-7%

* WorkSafe Victoria, *APA Background Paper 2014-15: Agent Remuneration and the Annual Performance Adjustment*, undated, pages 9-10.

410. Even when including the Survey Measure (discussed further below), agents can achieve more of a financial reward and penalty for measures linked to outcomes, including terminating claims, than good quality decision-making. There are no financial rewards or penalties associated with the sustainability of decisions through the dispute process.

The Survey Measure

411. At interview, some WorkSafe and agent executives referred to the survey measure as a key mechanism to ensure the quality of agent decision-making. This measure relates to the financial reward or penalty that an agent can receive for surveys conducted with injured workers. WorkSafe and agent executives highlighted the substantial reward available to agents under this measure.

412. The survey measure focuses on workers' satisfaction with the service provided by an agent at key points in the claim cycle, including initial eligibility; return to work; examination by an IME; requests for treatment; termination of benefits; and communication. The surveys comprise 5000 phone interviews with injured workers (selected at random), to capture the workers' experience.³⁰⁵ The surveys include questions as to whether the agent:

- provided the injured worker an opportunity to submit information relevant to a decision
- listened to the injured worker
- clearly explained the reasons for a decision
- answered questions in a timely manner
- provided adequate information about what to expect next
- provided information about the worker and employer obligations and support that is available in relation to return to work.³⁰⁶

413. Workers can also provide verbatim feedback to open ended questions around their reasons for any dissatisfaction with the agent; whether the information they received from the agent was sufficient and accurate; and whether further support could have been provided. WorkSafe stated that survey data, including the verbatim comments, are used 'to continually improve on service provided to workers'.³⁰⁷

414. WorkSafe stated that in 2014-15 WorkSafe and the agents 'received a record high score on the services provided to injured workers, with 86.2 [per cent] of workers being satisfied with the service they received'.³⁰⁸ WorkSafe noted that this was an improvement on the score in 2013-14 of 83.9 per cent.³⁰⁹

³⁰⁵ WorkSafe Victoria, Letter from Chief Executive, WorkSafe to the Ombudsman, dated 28 July 2016.

³⁰⁶ WorkSafe Victoria, *Agent Remuneration: Injured Worker Survey Business Rules, Annual Performance Adjustment, 2014-15*.

³⁰⁷ WorkSafe Victoria, Letter from Chief Executive, WorkSafe to the Ombudsman, dated 28 July 2016.

³⁰⁸ Ibid.

³⁰⁹ Ibid.

415. A WorkSafe Director explained that they believed the survey measure was an indicator of the quality of agent decision-making because:

... if a worker believes a decision is wrong, they'll exercise their appeal rights. We know that if someone [is] at concil[iation] that the service levels would go down.

...

If it is a good decision and the communication is good, the probability of an appeal or all those other frictional costs flowing reduce.³¹⁰

Financial rewards and penalties to be increased for quality and timely decision-making

416. WorkSafe advised that it has reviewed the financial rewards and penalties as a result of challenges faced in the 2015-16 financial year, which included '[g]rowing stakeholder feedback on the need to focus more on quality and timely decision making'.³¹¹ In 2016-17 WorkSafe intends to focus a greater proportion of the incentive model 'explicitly on the assessment of quality and accurate decision making'.³¹²

417. Specifically, WorkSafe intends to increase the weighting assigned to the quality measure.³¹³ WorkSafe has decided to do this 'to reinforce the consequence for Agents of not delivering a quality service'.³¹⁴

418. WorkSafe advised that it also intends to expand the scope of the measure to all entitlement decisions and will increase the number of claims audited, stating:

For 2016/17, the aim is to expand the [quality] measure to include all [adverse] decisions over the life of the claim. This will be accompanied by a refreshed audit and review program. More than 1000 claims across the Scheme will be audited across the year moving to a monthly audit cycle.³¹⁵

419. A WorkSafe Director stated that further expansion and focus on quality decision-making by the agents may be required in future. Specifically, they said WorkSafe may need to establish 'quality' as a stand-alone strategic objective (in addition to return to work, sustainability and service) and further increase the percentage of the reward offered to agents for the quality of decision-making.

420. The WorkSafe Director also stated that WorkSafe could do more to communicate its expectations to the agents in relation to the purpose of the financial incentives:

I think one of the things we need to make sure that we're doing is communicating right down the line about what the expectation is, and what the measures are there to do and what we are trying to achieve, what's acceptable behaviour. We do that with the state managers and the operations managers, and I think ... we have a role in making sure that we are absolutely looking at ways that we communicate that in a more direct line as to what's acceptable behaviour, and then what the consequences are.³¹⁶

310 Interview with WorkSafe Executive Director on 23 May 2016.

311 WorkSafe Victoria, *Background Paper: Annual Performance Adjustment - 2016/17*, undated, page 2.

312 Ibid.

313 WorkSafe Victoria, Response to Victorian Ombudsman request, schedule of request reference 13, provided to my office on 22 July 2016.

314 WorkSafe Victoria, *Background Paper: Annual Performance Adjustment - 2016/17*, undated, page 5.

315 WorkSafe Victoria, *Background Paper: Annual Performance Adjustment - 2016/17*, undated, page 3.

316 Interview of WorkSafe Director on 25 May 2016.

Limitations of the Return to Work Index

421. The objectives of the WIRC Act include making provision for the effective occupational rehabilitation of injured workers and their early return to work.³¹⁷ The Return to Work Index is a financial reward measure linked to this objective, which assesses an agent's performance on the percentage of workers who have not returned to work six months (26 weeks) after the claim was received. The Return to Work index was introduced in 2009-10 after VAGO raised concerns that the return to work rate in Victoria had not improved.³¹⁸

422. Since introducing the Return to Work Index, WorkSafe advised that it has seen an improvement in return to work outcomes for injured workers, with more workers returning to work sooner.³¹⁹ However, VAGO's audit stated that while the Return to Work index should give more timely insights into agents' performance, the Return to Work index is only an outcome measure and:

This means that in the absence of additional measures clearly linked to agents' claims management practice it can only give limited insight into how agents can improve.³²⁰

423. One former agent executive stated that the Return to Work Index has resulted in agents 'pushing people to go back to work who aren't ready to go back to work'.³²¹ The executive added that agents are not interested in whether the worker stayed at work after the Return to Work Index date:

There is a lot of money [in relation to the Return to Work index] ... The sort of behaviour that that is driving is the agents are putting their high performing case managers onto those cases... Those case managers, all they are interested in is getting the worker back to work. If the worker goes back to work for one hour in the last week before the six months it is a tick. The fact that the injured worker may not have the capacity to go to work, may not be able to stay at work because they got to work too soon - they [the agent] are not concerned about that at all ... [I often saw that a lot that the] person hasn't come back to work, it is not durable return to work ... the agent is just not interested in that, they don't care. What is happening is the money that is on the table is driving this behaviour.³²²

424. An agent's performance against the Return to Work Index is based on data recorded in the claims management system. In this regard, agents still receive a financial reward for the Return to Work index for claims where a worker has returned to work but later ceased work as a result of the work injury.

³¹⁷ WIRC Act 2013, section 10.

³¹⁸ VAGO, *Claims Management by the Victorian WorkCover Authority*, Victorian Auditor General's Office, June 2009, page 59.

³¹⁹ WorkSafe Victoria, Letter from Chief Executive, WorkSafe to the Ombudsman, dated 28 July 2016.

³²⁰ *Claims Management by the Victorian WorkCover Authority*, Victorian Auditor General's Office, June 2009, page 59.

³²¹ Interview of a former senior executive of an agent on 18 November 2015.

³²² Interview of a former senior executive of an agent on 18 November 2015.

425. While WorkSafe conducts audits on this data to assess the financial reward an agent is entitled to, the key focus is on whether the worker returned to work before the Return to Work Index date, and not on whether the worker stayed at work after the Return to Work Index date, or the period of time in which the worker continued to work.³²³

426. In 2014-15 WorkSafe audited a sample of claims where the worker returned to work and ceased work again within seven days of the Return to Work Index date to identify whether the agent had 'falsified' a return to work to artificially improve the agent's results. WorkSafe did not find any falsification of data. In each of the audited claims, WorkSafe found 'genuine reasons' for the worker having ceased work.³²⁴

427. While the Return to Work index has encouraged agents to focus on assisting a worker to get back to work within six months, until 2016-17 there was no incentive for agents to return workers to work after six months.³²⁵ WorkSafe stated there were indirect incentives before 2016-17, such as the 52 week and 134 week weekly payment measures;³²⁶ however, my office identified that, in some cases (including case study 11), the agents' focus was on terminating the claim (particularly at 130 weeks). A WorkSafe Director also stated that the injured worker survey was an indirect incentive as people who are back at work tend to provide better survey scores.

A new measure

428. WorkSafe has recognised that there needs to be a greater focus on return to work after six months. As a result, it is trialling a new longer term return to work measure in 2016-17. This will reward agents where workers return to work before 104 weeks. A WorkSafe Director stated that this measure has been introduced to:

- embed return to work as a focus of agent claim management practice, and
- ensure WorkSafe makes it explicit to agents that there needs to be a focus on return to work beyond six months.³²⁷

429. WorkSafe is expecting this measure will be expanded and become a key feature of the financial reward and penalty measures in coming years.³²⁸

430. WorkSafe states that it has also partnered with Monash University to run a study of injured workers, with a focus on comparing differences in the return to work process between older and younger workers and between different types of claimed injuries. This will comprise interviews with 576 workers at three time points: soon after claim acceptance, six months after claim acceptance and then at 12 months. WorkSafe states it will also use this study to inform claims management practices and processes.³²⁹

³²³ Telephone call with a WorkSafe Director on 26 July 2016.

³²⁴ WorkSafe Victoria, *WorkSafe Data Verification Process 2014-15 APA Measures*, September 2015.

³²⁵ Telephone call with a WorkSafe Director on 26 July 2016.

³²⁶ Ibid.

³²⁷ Ibid.

³²⁸ WorkSafe Victoria, *Annual Performance Adjustment - 2016-17 Background Paper*, undated, provided to my office on 25 May 2016.

³²⁹ WorkSafe Victoria, Letter from Chief Executive, WorkSafe to the Ombudsman, dated 28 July 2016.

Quality decision-making audits

431. WorkSafe audits a randomly-selected sample of claims to assess agents' performance against the quality decision-making financial reward and penalty measure.

432. In 2014-15, WorkSafe audited two types of decisions:

- initial eligibility
- medical and like entitlement.

433. WorkSafe found that the agents made quality decisions in over 90 per cent of the decisions audited.

434. In 2015-16, WorkSafe audited three types of decisions by agents:

- initial claim rejections
- terminations of medical and like entitlements at 52 weeks
- terminations of claims at 130 weeks.

435. Eighty per cent of the claims audited by WorkSafe must 'pass' the audit for the agent to receive a financial reward. If the agent fails to meet this benchmark they are penalised.³³⁰

436. The audits assessed whether decisions were:

- made based on the facts and merits of the claim

- supported by the best available evidence
- in accordance with the legislation
- made taking into account all relevant matters
- made with reasons provided if any relevant evidence was disregarded when making the decision
- supported by evidence on file at the time of the decision
- documented on file
- made in a timely manner.³³¹

Audit sample size

437. The percentage of total claims decisions that WorkSafe audits varies from year to year. Between 2012-14, WorkSafe audited approximately 300 claims per year. In 2014-15 WorkSafe increased the number of total claims audited to 662. As an example of the percentage of claims audited table 8 shows, in 2014-15, WorkSafe audited eight per cent of the claims rejected by all agents.

438. During my investigation, WorkSafe informed my office that it had worked with Price Waterhouse Coopers to identify a 'statistically valid sample number' for audits and that, from 2016-17, it will annually audit around 1,500 claims³³² in relation to quality decisions.

Table 8: Percentage of rejected claims audited in 2014-15

Number of claims received by agents	24,201*
Number of claims rejected	3,940 (16%)
Number of rejected claims audited by WorkSafe	328 (8%)

* This refers to only 'time loss' claims; namely, those where the worker was incapacitated for work and as such, sought weekly payments.

³³⁰ WorkSafe Victoria, *Agent Remuneration: Quality Decisions Measure Business Rules: Annual Performance Adjustment Fee 2014/15*, March 2015.

³³¹ WorkSafe Victoria, *Agent Remuneration: Quality Decisions Measure Business Rules: Annual Performance Adjustment Fee 2014/15*, March 2015.

³³² Telephone interview of WorkSafe Director on 18 July 2016.

Consideration of the use of ‘pass’ and ‘fail’

439. Where a claim is deemed to have ‘failed’ the quality audit, WorkSafe conducts a preliminary assessment of whether the fail should be overturned. WorkSafe then provides the agent with a draft results report and the agent can either accept the draft results or request a review by a WorkSafe Review Panel.³³³
440. If the WorkSafe Review Panel³³⁴ maintains the fail, the agent can lodge a request for review by an Appeal Panel.³³⁵ If either the review or appeal panel is not unanimous as to whether the agent made the correct decision, the decision is reclassified as a pass ‘in favour of the agent for [financial reward] purposes’.³³⁶
441. A sample of WorkSafe’s audits and the associated claims files, showed that WorkSafe considered the quality and evidence-base of agents’ decisions. In the cases reviewed, WorkSafe appropriately criticised the agents for decision-making that was not evidence-based or was of poor quality.

442. However, WorkSafe did not consider the outcomes of conciliation, Medical Panel or court as part of the audits.³³⁷ This was despite the audits sometimes occurring months after the decision by the agent and, in some cases, where the agent decision had been subsequently challenged and overturned.

443. Case study 28 illustrates this. Xchanging received a financial reward for the decision under the quality measure, despite the decision being overturned at conciliation as it was found to have no arguable case.

³³³ WorkSafe Victoria, *Agent Remuneration: Quality Decisions Measure Business Rules: Annual Performance Adjustment Fee 2014/15*, March 2015.

³³⁴ An internal WorkSafe panel established to review the quality decision-making audits.

³³⁵ WorkSafe Victoria, *Agent Remuneration: Quality Decisions Measure Business Rules: Annual Performance Adjustment Fee 2014/15*, March 2015. The Appeal Panel is also an internal WorkSafe panel established as an avenue of appeal where an agent disagrees with an audit outcome.

³³⁶ An example of this is in the Xchanging Audit Results for Audit 1 2014-15.

³³⁷ Interview of WorkSafe Director on 25 May 2016.

Case study 28: Xchanging eligible for reward, despite unarguable case

A worker made a claim to Xchanging for compensation for a back injury. Xchanging arranged for the worker to be examined by an IME, who indicated that the diagnosis was 'most likely a lumbosacral disc derangement and the cause of the condition is the incident at work'. A circumstance investigation report also confirmed that on the day of the injury, the worker advised their employer of the injury and pain in their legs, and the employer arranged another employee to replace them in their work duties. Despite the IME and circumstance report indicating that the worker's condition was caused by the incident at work, Xchanging rejected the claim on the basis that:

- the worker continued to work for 45 minutes following the incident
- the worker did not report their injury immediately
- the IME did not provide a precise diagnosis.

The ACCS issued a direction as there was no arguable case

The worker appealed the decision at conciliation and the ACCS issued a direction to Xchanging on the basis that there was no arguable case to support its denial of liability. As a result, Xchanging accepted the worker's claim.

WorkSafe's audit reassessed Xchanging's decision as a 'pass' for the purposes of the financial rewards

The decision was subsequently audited by WorkSafe and initially assessed as a fail due to lack of evidence supporting Xchanging's decision to reject liability. Xchanging requested a review of the fail decision.

WorkSafe's Review Panel considered the claim and Xchanging's response and was unable to reach a unanimous view on whether Xchanging made the correct decision to reject the claim. Despite the direction issued by the ACCS and the initial audit fail, the Review Panel reassessed Xchanging's decision as a pass for the purposes of the financial reward measure.

444.A WorkSafe Director explained WorkSafe's rationale for this practice at interview, stating:

... the rationale behind that is, if we can't agree for the purposes of [the financial reward], it's – the view is it's difficult to hold someone to say you should have made that decision if we can't agree internally, that that was right or wrong ... [If there is a] split then it's very hard to say well you should have made that decision, because we can't even agree. And a lot of the decisions there are various perspectives. So from [a financial reward] perspective ... if we can't agree, it's hard to go well [the agent] definitively made the wrong decision.³³⁸

Action taken by WorkSafe to remedy decisions that failed

445. Information provided by WorkSafe shows that from 2012-13 to 2014-15 there were 58 claims that failed the quality decision-making audits.

446. Most of these claims decisions had been overturned or changed, including 21 at conciliation; 12 via an agent review; and two as a result of the WorkSafe audit. There were also six claims where the worker received payments on another claim or where WorkSafe stated that the decision did not affect the worker's treatment.

447. Thirteen claims failed the audits and were not disputed by the worker. As a result, these decisions were not overturned. A further four claims were disputed but remained unresolved.

448. WorkSafe advised it takes the following action to resolve claims decisions that fail an audit:

At the conclusion of the audit a meeting is held with all agents where general findings and improvement opportunities are discussed. Those files where WorkSafe has identified a failure are also discussed in detail.³³⁹

449. Outside of these meetings, WorkSafe does not take any further action because:

WorkSafe audits are usually done months after the initial agent decision and the review options available to the worker have normally commenced.

...

[I]t needs to be highlighted that the audit process was originally designed to improve scheme performance through continuous improvement. The nature of the majority of these decisions is that they are subjective and based on interpretation of facts and legislation, where only a Court or Medical Panel is able to fully investigate all of the facts and make a conclusive decision on appropriateness of a decision. Also, WorkSafe's involvement occurs a significant period after the initial decision and may not be appropriate for the parties involved. WorkSafe will review the timing and approach of the audit program to ensure the audit program meets the original continuous improvement intent as well as considering if individual claims require further intervention.³⁴⁰

³³⁸ Interview with WorkSafe Director on 25 May 2016.

³³⁹ Information provided by WorkSafe on 24 December 2014 in response to a request for documents by my office.

³⁴⁰ Information provided by WorkSafe on 24 December 2014 in response to a request for documents by my office.

WorkSafe's commitment to monthly audits and stronger directions

450. Historically, WorkSafe's audits have been undertaken twice yearly;³⁴¹ once at the end of the calendar year and once at the end of the financial year. As WorkSafe noted, this poses a number of problems:

As a result of the delay between the date of an adverse decision and audit feedback being up to 6 months old, the information provided to the Agent may have been lost on other similar adverse decisions made within that time.

In addition, due to the time delay there is no action taken by the agent to revise a decision and/or the worker may have already lodged an appeal to ACCS for review of the decision.³⁴²

451. From July 2016, WorkSafe's audits will be undertaken on a monthly basis.³⁴³ This will enable WorkSafe to focus audit activity on recent decisions so that agents have an opportunity to take immediate action on claims where a decision is found to be incorrect. WorkSafe states that monthly audits will also enable it to recommend remedial action or enable the agent to reverse its decision where it is found to be incorrect.³⁴⁴

452. To complement this process, WorkSafe advises it has introduced a new policy for issuing a direction to an agent where the agent refuses to change its decision (discussed later in this chapter).³⁴⁵

453. WorkSafe advises that in line with its new policy, it will review claims from 2014-15 and 2015-16 where agent decisions that failed the audits had not been disputed and it appeared the worker had been 'incorrectly disentitled'.³⁴⁶ In its review so far, WorkSafe has identified four cases where a worker may have been incorrectly disentitled and has undertaken to further review these cases.³⁴⁷

'During the Ombudsman's investigation process we have identified opportunities to optimise complaint data to more effectively investigate systemic issues giving rise to complaints. WorkSafe is currently developing processes to better capture this data to input into current improvement initiatives.'

Letter from the Chief Executive of WorkSafe

341 WorkSafe Victoria, *Agent Remuneration: Quality Decisions Measure Business Rules: Annual Performance Adjustment Fee 2014-15*, March 2015 and WorkSafe Victoria, *Agent Remuneration: Quality Decisions Measure Business Rules: Annual Performance Adjustment Fee 2015-16*, August 2015.

342 WorkSafe Victoria, *STL Meeting: Quality decision Making APA Measure Audit Program*, April 2016.

343 Ibid.

344 Ibid.

345 WorkSafe Victoria, *STL Meeting: Quality decision Making APA Measure Audit Program*, April 2016, page 3.

346 WorkSafe Victoria, *WorkSafe/Agent Operations Manager's Forum: WorkSafe process following identification of an Agent decision that has incorrectly disentitled a worker*, 14 April 2016.

347 WorkSafe Victoria, WorkSafe's response to the Ombudsman, Attachment 11.4 Claim Summary of audit fails, 27 April 2016.

Feedback, complaints and dispute outcomes

WorkSafe's response to feedback from stakeholders

454. Some witnesses provided evidence that they had raised concerns with WorkSafe but WorkSafe had failed to take remedial action.

Evidence from the Senior Conciliation Officer at the ACCS

455. The Senior Conciliation Officer of the ACCS submitted by email that WorkSafe appears to be 'out of touch' with some agent practices and issues and that it does not always give the impression of awareness when issues are raised.³⁴⁸ At interview,³⁴⁹ he stated that WorkSafe has not been accountable for agent practices. He said he had raised the following concerns with WorkSafe about agent practices via quarterly meetings and telephone calls from early 2013:

- The ACCS' perception that financial rewards and penalties were 'skewed' to rejecting or terminating claims and this was resulting in agents failing to resolve disputes at conciliation and was not generating 'useful outcomes' for workers. He said WorkSafe's response was 'we are not telling the agents to do that' (reject or terminate claims to achieve the financial rewards).
- An increase in adverse decisions at certain timeframes, which the ACCS considered was related to the financial rewards and penalties.

- Issues with IMEs, including agent use of IMEs and decision-making in relation to IME reports. He stated that 'IME shopping' and incorrectly interpreting IME reports are 'systemic' issues.
- Concerns that agent staff were making limited offers of compensation at conciliation to achieve the financial rewards. He said he is not aware of WorkSafe taking action because WorkSafe said it needed more evidence of the relevant claims that were affected to confirm this was happening.

456. The Senior Conciliation Officer said WorkSafe either did not respond to his feedback or would say, 'No, we don't have a written policy ... on that'. He recognised that WorkSafe is not obliged to listen to the ACCS and he did not believe the ACCS's feedback would influence WorkSafe. He also noted that the ACCS did not have the full picture regarding the financial reward targets and other considerations and pressures influencing agent decisions. This made it difficult for the ACCS to give specific feedback to WorkSafe regarding these issues.

457. He stated he had a 'hard time accepting' that WorkSafe was unaware of various issues, including those mirrored in the investigation. He noted that WorkSafe is on the frontline, interacting with the agents and completing various reports and audits. He also said that he was new to the system and identified the above issues within his three years as the Senior Conciliation Officer. He stated that, in his view, there was 'definitely' a level of knowledge about the issues at WorkSafe, including systemic issues such as limited offers at conciliation, IME shopping and agents incorrectly interpreting IME reports.

³⁴⁸Email from the former Senior Conciliation Officer of the ACCS dated 26 July 2016.

³⁴⁹All further comments here are from interviews with the former Senior Conciliation Officer of the ACCS on 13 July 2016, 7 September 2015 and 3 September 2014.

Evidence of professional and industry representatives raising concerns

458. A worker representative advised that they had also raised concerns with WorkSafe on a number of occasions about agents making decisions based on the financial rewards. The representative had suggested to WorkSafe that agents should have more power to make larger offers at conciliation to resolve more matters at that point, without the need for Medical Panel referrals or having matters proceed to court.

459. The representative advised that in response to concerns that agents were making decisions based on the financial rewards WorkSafe said:

Nothing really. Well the answer of WorkSafe is that 'No they [agents] don't make financial[ly based] decisions'.³⁵⁰

460. The worker representative said they had raised concerns with WorkSafe about matters at conciliation that they anticipated would be overturned at court or by a Medical Panel; however, WorkSafe advised him:

'There is little we can do about it' ... [WorkSafe] say they will just wait and see and that it [the claim] will track its normal path through court and Medical Panel.³⁵¹

461. The worker representative also said they raised concerns with WorkSafe about the percentage of decisions overturned by Medical Panels following referral at conciliation, and about the impact of the dispute process on injured workers, stating they had seen workers deteriorate psychologically and want to give up.

462. Another worker representative reportedly raised concerns with WorkSafe about the increased number of disputes at conciliation and that agents were failing to make genuine efforts to resolve disputes.³⁵² The representative stated that they had raised various concerns with WorkSafe about agent decision-making and practices at conciliation and made recommendations a number of times to WorkSafe; however, WorkSafe had not implemented any changes.³⁵³

463. The Australian Medical Association stated that they had regularly raised concerns with WorkSafe about agents' practices and attitudes and WorkSafe had responded, 'No, we haven't got a problem'³⁵⁴ or that, alternatively, the problem would be addressed. They stated that when concerns were raised, WorkSafe's response was 'relative ambivalence'.³⁵⁵

Evidence that the ACCS had raised concerns with WorkSafe

464. Some emails showed that the ACCS raised concerns with WorkSafe that agents were making limited offers of compensation at conciliation to achieve the financial rewards. In one of these emails the ACCS informed WorkSafe that while it would attempt to provide information on a case by case basis, this would be 'time consuming and cumbersome' and would 'not address the systemic problem'.³⁵⁶

350 Interview of a worker representative.

351 Interview of a worker representative.

352 WorkSafe Victoria, *Rehabilitation and Compensation Working Group meeting*, 28 November 2014.

353 Interview of a worker representative.

354 Interview with three members of the Australian Medical Association on 26 February 2016.

355 Ibid.

356 Email from the ACCS to WorkSafe in May 2013.

465. Further emails also showed ACCS staff, including the Senior Conciliation Officer, raised concerns with WorkSafe about agent practices including:

- agents making unsustainable decisions
- agents making decisions to achieve the financial rewards
- agents seeking supplementary reports to obtain a desired outcome
- agents asking IMEs leading questions or 'fishing' for an opinion
- agents disregarding Medical Panel opinions and using reports that conflict with Medical Panel opinions
- delays in resolving disputes.³⁵⁷

466. An example is demonstrated in case study 11, that was discussed previously in the chapter 'Maintaining unreasonable decisions at conciliation'. In that instance, Allianz had terminated a catastrophically injured farmer's claim based on a 'token' work capacity. Upon the worker lodging a request for conciliation, the ACCS raised concerns with WorkSafe that the worker did not appear to have a realistic capacity for work and that Allianz's termination decision was inconsistent with the WIRC Act. WorkSafe failed to take adequate action to address the ACCS' concerns and the worker had little choice but to dispute this decision at court.

**Case study 11 (see also page 64):
WorkSafe fails to ensure reinstatement
of worker's entitlements despite
concerns about the sustainability of
Allianz's decision**

In this case a farmer suffered what was described variously by Allianz, WorkSafe and IMEs as 'extremely serious', 'extensive' and 'severe life threatening injuries' after being injured while working on their farm. The injured worker was in and out of hospital for months as a result of their injuries.

Allianz terminated the worker's claim at 130 weeks despite concerns raised by both WorkSafe and the ACCS that the worker did not have a genuine capacity for work. The ACCS asked WorkSafe to intervene due to the 'very real hardship' the decision imposed on the farmer. The ACCS stated:

I have great difficulty accepting that the policy underlying the provisions supports an outcome where a worker as seriously injured as [the farmer], who is effectively doing no real farm work at all, is no longer in receipt of weekly payments.

WorkSafe raised concerns with Allianz that the decision was difficult to sustain

WorkSafe reviewed this matter as a result of the concerns raised by the ACCS. WorkSafe's review highlighted questions around whether the duties the worker was undertaking fulfilled the criteria of 'suitable employment'. Under the WIRC Act, agents may terminate a claim at 130 weeks if it can demonstrate that the worker has a work capacity for suitable employment.³⁵⁸ In considering suitable employment the agent must have regard to factors including the nature of the worker's incapacity and the nature of the worker's pre-injury employment. WorkSafe had concerns following its review that Allianz's decision was difficult to sustain.

³⁵⁷ Many of these emails were provided to my office by WorkSafe in response to my office's request for information dated 24 September 2015. Others were provided by officers from the ACCS.

³⁵⁸ WIRC Act 2013, s. 3.

Case involving similar circumstances where the duties were found by the court not to be suitable

In late 2014, WorkSafe emailed Allianz highlighting that the evidence in the worker's file supports that the worker sustained severe injuries and required extensive ongoing treatment and support. WorkSafe highlighted the ACCS' concerns about Allianz' decision-making and asked Allianz to review the claim decision with a focus on the duties the worker was performing and whether Allianz had demonstrated a capacity for suitable employment. WorkSafe attached a copy of a previous court case involving 'similar circumstances' where the worker was working, however, the duties were found by the court not to be suitable. The case highlighted that: '[I]f one looks at the evidence, [the worker] is plainly unsuited to that job, or any other, and regrettably, this will last indefinitely'.

Allianz acknowledged difficulty maintaining the decision but termination maintained

An Allianz file note shows that WorkSafe also had a discussion with Allianz about the difficulty maintaining the decision. A WorkSafe email shows that Allianz agreed that there were questions about the suitability of the 'work' performed. WorkSafe requested Allianz review its decision but did not use its power to issue Allianz with a direction. Allianz maintained its decision and the worker was required to dispute this decision at court. As noted previously, during litigation Allianz received legal advice and as a result of this withdrew its termination decision. However, due to the lengthy dispute process, it took more than a year from the termination for the worker's weekly payments to be reinstated.

467. Another example of WorkSafe failing to take adequate action in response to stakeholder feedback is illustrated in case study 20, in which Allianz said it would maintain its decision irrespective of any finding by the Medical Panel. The ACCS raised concerns with WorkSafe that Allianz had indicated that it was 'of the view that they can ignore the [binding] opinion of the Medical Panel'. Based on the documents provided in relation to this matter, WorkSafe took no action in response to these concerns.

WorkSafe's response to injured worker complaints

468. WorkSafe receives complaints from injured workers and other affected parties about poor decision-making by the agents. *WorkSafe's Complaints Handling Policy*³⁵⁹ guides its investigation of complaints and states that WorkSafe can receive complaints about claims issues such as poor decision-making, poor explanations, lack of or incorrect information, and poor or inappropriate communication.³⁶⁰
469. The policy requires WorkSafe to investigate complaints fairly, and in a quick and courteous manner. Remedies WorkSafe may use to resolve complaints under the policy include:
- an apology
 - changes to decisions where appropriate
 - providing access to services/benefits to which the complainant has an entitlement.

³⁵⁹ WorkSafe Victoria, *Complaints Handling Policy*, 12 September 2013, retrieved online on 7 July 2016 via <https://www.worksafe.vic.gov.au/__data/assets/pdf_file/0009/103113/Complaints-Handling-Policy.pdf>.

³⁶⁰ WorkSafe can also handle complaints about IMEs; this process is discussed later in this chapter.

470. In 2014-15, WorkSafe received 763 complaints related to agent claims management. WorkSafe advised my office that it investigates all individual complaints received by stakeholders. In doing so, 'WorkSafe provides agents with a copy of each complaint it receives and works closely with the agents to achieve a resolution outcome'.³⁶¹ WorkSafe stated that this may or may not lead to a decision being changed.

471. In the following case study, a worker complained to WorkSafe about a poor decision by CGU. Despite its documented concerns about CGU's decision-making, WorkSafe failed to take adequate action, even though the worker made multiple requests. Instead, WorkSafe advised the worker to raise their concerns at conciliation if they wished to pursue the matter further. It was not until my office contacted WorkSafe about its handling of the complaint and asked it to respond to the worker, that WorkSafe provided a further response – 10 months after the worker first complained.

Case study 29: Worker told by WorkSafe to dispute decision at conciliation, despite its knowledge of 'damning' evidence

In the early 2000s, a teacher made a claim for a psychological injury sustained while employed at a school. Numerous medical reports by seven different medical practitioners between 2000 and 2014 found the injury had been caused by work. The claim was accepted by CGU.

In 2006, a Medical Panel concluded that the worker was suffering a severe psychological injury as a result of work, which had resulted in a permanent impairment of 50 per cent.

A few years later, there was a significant bushfire in the town in which the worker lived, during which the worker had to be rescued by emergency workers. Two IMEs (IME 1 and IME 2) examined the worker a few years later and found that the worker's condition was still materially contributed to by the work-related injury despite some deterioration following the bushfire.

CGU terminated entitlements on the basis of one IME opinion

In 2014, CGU arranged for the worker to be examined by IME 3. IME 3 provided a report to CGU in which they stated that the worker 'has not been exposed to the workplace for 13 years'.³⁶² The IME stated their circumstances had changed since the Medical Panel opinion in 2006 and that 'common sense would indicate that any current emotional distress would be caused' by the 'life threatening circumstances in the ... bushfires' rather than the experience in the workplace. IME 3 also stated:

³⁶¹ WorkSafe Victoria, Response to the Ombudsman Victoria own motion investigation into workers compensation claims management – schedule of request reference 15, undated, provided to my office on 22 July 2016.

³⁶² The IME's report also stated that the worker 'admitted to me that [they] never think ... about the workplace now'. However, the worker disputed that they said this.

A reliance on common sense is often not the case in Medical Panel determinations or in the legislation which insists that the Medical Panel's Opinion is final and conclusive. [The] overall condition regardless of cause remains one of a person who presents as severely debilitated by emotional distress.

IME 3 stated that the worker's condition was attributable to non-work factors of a 'constitutional nature'. IME 3's conclusions were inconsistent with all other evidence available, including the Medical Panel opinion and the opinions of IME 1 and IME 2. Despite this, CGU terminated the worker's entitlements.

An inadequate senior review did not show proper analysis

The decision was upheld through the senior review process and the outcome letter to the worker merely stated that the review had been conducted by a suitably qualified senior staff member not involved in the original decision and that there would be no variation to CGU's decision at that time.

The letter did not address any of the specific concerns raised by the worker, nor was there any evidence on the worker's file indicating any proper analysis by CGU of the concerns raised.

WorkSafe held concerns about the sustainability of the decision but did not convey this in response to the worker's further eight requests for help

The worker also complained to WorkSafe about CGU's decision-making. A subsequent internal email between WorkSafe staff highlighted concerns with CGU's termination of the worker's claim and the quality of CGU's letter to the worker.

WorkSafe's email stated there was a 'sustainability risk should the decision proceed to [conciliation] conference':

At the heart of the workers [sic] complaint are the inconsistencies within the report. It would be my view that in some respects the IME had not been clear in his opinion and the Agent has then chosen or interpreted the items best suited to the construction of a decision. However ... even this has been poorly undertaken ... In summary I would not consider that the IME report has sufficient information or provides sufficient clarity [sic] to enable [CGU] to terminate the workers [sic] entitlements ... Of particular note is [the IME's] reference to the worker having an injury 'regardless of cause'. Particularly damning, the THP [treating health practitioner] has provided a report ... detailing ongoing contribution of employment to the injury ... It is clear that [CGU] did not seek clarification and should have done so especially prior to terminating the claim and in the context of the THP indicating a continuing employment contribution ...

On at least eight subsequent occasions, the worker asked WorkSafe to address their concerns about CGU's decision-making and to provide any information WorkSafe had to assist the worker at conciliation. Despite this, WorkSafe did not provide the worker with any information in relation to its concerns about CGU's decision.

WorkSafe said it was not its role to intervene

WorkSafe advised my office that after identifying concerns with CGU's decision, it 'had a discussion' with CGU and advised that it thought 'CGU should consider withdrawing its decision'. However, WorkSafe stated that it was up to CGU to determine whether there was enough information on which to base its decision and CGU had advised WorkSafe that it considered the decision to be sound. WorkSafe advised that agents have delegation to make claims decisions without needing to seek WorkSafe's approval.

My office requested file notes of its discussion with CGU, however, WorkSafe did not document the discussion.

CGU withdrew its decision as a result of a threatened direction by the ACCS

The worker disputed CGU's decision at conciliation, at which time the ACCS advised CGU it would issue a direction if CGU did not withdraw its decision. The ACCS raised concerns that CGU had not sought information from the worker's doctor, which may have been relevant to the decision; failed to consider the opinions of the two IMEs who examined the worker following the bushfires; and that CGU had improperly relied on IME 3's report. CGU subsequently withdrew its decision.

WorkSafe's response to the worker was five months after the initial complaint – and did not address the initial concern with CGU

WorkSafe provided a response to the worker more than five months after their initial complaint and provided a copy of IME 3's response to the issues raised, stating that IME 3 did not change his opinion.

WorkSafe's response did not address the concerns raised by the worker in relation to CGU's decision-making. WorkSafe advised the worker that the appropriate course of action was to take the matter to the ACCS, which it noted the worker had already done.

WorkSafe's response at the instigation of my office was 10 months after the original complaint

It was not until my office raised concerns with WorkSafe about its handling of the complaint about CGU's decision-making and requested that it respond to the worker, that WorkSafe provided a further response in 2016, 10 months after the complaint. In the further response, WorkSafe acknowledged there were deficiencies in CGU's decision-making and stated that:

... clearly there were shortcomings, both in terms of the quality of the information and evidence gathered by CGU. It is disappointing that this was not identified by CGU processes prior to the notice being issued.

WorkSafe advised it would write to CGU senior management reiterating its expectations in relation to decision-making.

In response to my draft report, CGU stated:

CGU would note that this is a long running claim and that CGU as an Agent is required to conduct reviews of an injured worker's entitlement to compensation. CGU acknowledges that the management of long standing mental injuries is complex and is an area where improvements in understanding the complexity and management of injuries is ongoing.

CGU has implemented changes to our Senior Review process as a result of the issues raised by the injured worker and the Ombudsman and is working with independent experts in mental health to advise on best practice on dealing with injured workers with mental health issues.

IME's response to my draft report

The IME raised concerns about WorkSafe and the ACCS's findings about the quality of his report. While WorkSafe and the ACCS identified concerns about the IME's report, I make no adverse finding on this issue as my investigation focused on the behaviour of the agents and WorkSafe, not the IME's.

472. Case study 27, that was also discussed in the chapter 'Limited offers at conciliation to achieve financial rewards', provides a further illustration. In this case, Xchanging had terminated the worker's claim based on one IME report that was in conflict with all other available evidence. The injured worker complained to WorkSafe about Xchanging's flawed decision-making; however, WorkSafe took no action and referred the worker to the ACCS.

**Case study 27 (see also page 120):
Worker told to dispute decision at
conciliation despite 'flawed arguments'**

The injured worker made a claim for a psychological injury, which was accepted by Xchanging after receiving an IME opinion (IME 1) that the condition had been caused by the worker's workplace. Despite IME 1's opinion and Xchanging's acceptance of the claim, Xchanging arranged for the worker to be examined by a different IME (IME 2) four months later. Xchanging asked the IME to provide an opinion on the cause of the worker's condition. Xchanging then terminated the injured worker's claim on the basis of IME 2's opinion that employment was not the cause.

In this case, Xchanging's file notes and internal emails noted that Xchanging's decision would likely be overturned. Despite concerns about the sustainability of its decision, Xchanging maintained its decision and made a limited offer of 52 weeks payments to the injured worker at conciliation.

At conciliation, the ACCS also raised concerns about Xchanging's decision, noting that Xchanging seemed to be under 'the incorrect impression that liability can be revisited without any evidence of any factual/circumstantial change in the evidence that gave rise to the liability in the first place'. Xchanging withdrew its decision at conciliation because of a 'threatened direction' by the ACCS.

The injured worker complained to WorkSafe about IME 2 and Xchanging's decision-making and 'flawed arguments', including Xchanging's reassessment of the cause of their injury. The injured worker raised concerns about Xchanging's reliance on the report by IME 2 and failure to consider the report by IME 1. The worker stated:

I no longer have much faith in a fair and honest system of Work Cover, and feel that [IME 2's] reports have been a substantial barrier to my rehabilitation and return to work. It appears to me the report was sought by Xchanging as a means to cease my claim. If I am able to understand the basics of how my claim should be managed it is a poor reflection on the process and those that administer it if clear breaches such as this can be allowed to occur ... My entire Work Cover journey has led to a drop in self-esteem, feelings of powerlessness, distrust of others, diminished concentration, clouded judgement, despondency, mood swings, emotional injury, physical illness and further psychological injury.

In response, WorkSafe requested a response from the IME. Once it received this response, WorkSafe responded to the injured worker that the appropriate course of action was to take the matter to the ACCS, as they had already done.

Subsequent to their complaint to WorkSafe, the injured worker raised the same complaint with this office, which resulted in our writing to Xchanging highlighting issues with its decision-making on this claim.

'[I]t is a poor reflection on the process and those that administer it if clear breaches such as this can be allowed to occur.'

Email from the injured worker in case study 27

473. In case studies 27 and 29, WorkSafe 'resolved' the worker's complaint by advising the worker to lodge a request for conciliation if they wished to dispute the matter further. WorkSafe stated to my office that it refers workers to the ACCS as the ACCS is the appropriate legislative body to hear matters where workers are dissatisfied with an agent decision.³⁶³

474. However, it is not the ACCS' role to investigate complaints about agent behaviour, poor agent decision-making or breaches of WorkSafe policy. Further, the ACCS does not:

- have access to the agent claim files and internal file notes outlining the basis of agent decision-making
- have the power to recommend changes to agents' practices or procedures. It may only make recommendations for an agent to pay a worker compensation on the case before it.

'I no longer have much faith in a fair and honest system of Work Cover ... My entire Work Cover journey has led to a drop in self-esteem, feelings of powerlessness, distrust of others, diminished concentration, clouded judgement, despondency, mood swings, emotional injury, physical illness and further psychological injury.'

Injured worker in case study 27

Identifying patterns or systemic complaints

475. In failing to properly address the complaints in case studies 27 and 29, WorkSafe missed opportunities to identify and resolve issues with agent decision-making and practices.

476. WorkSafe only tracks the number and nature of the complaints it receives.³⁶⁴ It does not track:

- the number of complaints that result in WorkSafe raising concerns with the agent about its decision nor their outcomes
- the number of agent decisions changed as a result of a complaint.

477. WorkSafe said it regularly reviews the nature of the complaints received to identify any systemic scheme issues that require addressing and that this has led to improvement in agent practices. WorkSafe also stated that it identified some years ago that 'too many decisions were being disputed' and that an 'increased effort in the quality and communication of decisions was required'.³⁶⁵

³⁶³ WorkSafe Victoria, Response to the Ombudsman Victoria own motion investigation into workers compensation claims management – schedule of request reference 17, undated, provided to my office on 22 July 2016.

³⁶⁴ Ibid.

³⁶⁵ WorkSafe Victoria, Letter from Chief Executive, WorkSafe, to the Ombudsman, dated 28 July 2016.

478. WorkSafe advised that it is implementing a strategy to reduce disputes linked to poor decision-making. This includes expanding the WorkSafe audits of claim decisions and increasing the financial reward for quality decision-making.

479. At interview, WorkSafe management stated they were unaware of the extent of the issues identified by my office in relation to agents making unreasonable decisions.³⁶⁶ WorkSafe submitted:

During the Ombudsman's investigation process we have identified opportunities to optimise complaint data to more effectively investigate systemic issues giving rise to complaints. WorkSafe is currently developing processes to better capture this data to input into current improvement initiatives.³⁶⁷

WorkSafe's response to agent decisions overturned after conciliation, Medical Panel or court

480. Before commencing this investigation, my office identified that agent decisions that had been disputed and overturned may be reflective of agents' poor decision-making. As a result, my investigation and review of claim files focused on agent decisions that had been overturned via disputes at conciliation, Medical Panel and court.

481. My investigation confirmed that some overturned decisions involved unreasonable decision-making by the agents, some of which were influenced by a desire to achieve the financial rewards.

482. Reports to WorkSafe had highlighted concerns about the low rate of sustainability of decisions.

Overtuned decisions 2014-15

At conciliation

- 58.5 per cent of the decisions disputed at conciliation were changed³⁶⁸

At court

- 69 per cent of claim rejections were overturned or changed
- 75 per cent of pre long-tail claim (pre 130 weeks) terminations were overturned or changed
- 64 per cent of post long-tail terminations (post 130 weeks) were overturned or changed.

At Medical Panel (including referrals from the ACCS and a court)

- 71 per cent³⁶⁹ of the total matters disputed at conciliation and court combined were overturned.³⁷⁰

Unless otherwise noted, the data is from Claims Liability Report, 31 July 2015 and 30 September 2015

³⁶⁶ Interview with a WorkSafe Executive and a WorkSafe Director.

³⁶⁷ WorkSafe Victoria, Letter from Chief Executive, WorkSafe to the Ombudsman, dated 28 July 2016.

³⁶⁸ WorkSafe Victoria, Claims Liability Report, 30 September 2015.

³⁶⁹ This figure relates to the rejection and termination of entitlements to i) weekly payments and ii) medical and like expenses. WorkSafe was unable to provide specific data on the number of medical and like entitlement decisions overturned at court and so these figures were based on the number of matters 'resolved' at court.

³⁷⁰ WorkSafe Victoria, Response to Victorian Ombudsman request, reference 2, attachment 2-1, dated 21 July 2016.

483. WorkSafe internal reports specifically highlighted concerns about the sustainability of decisions at Medical Panels and that agents had the opportunity to resolve a greater number of matters without a referral to a Medical Panel.³⁷¹

484. Despite the high percentage of claims that were overturned or changed at conciliation and court – and despite being aware of issues with sustainability of agent decisions at Medical Panels – WorkSafe does not systematically review or audit claims that have been overturned at conciliation, Medical Panel or court.

WorkSafe directions to agents

485. Case studies 11 and 29 warranted action from WorkSafe to ensure the workers received their legislative entitlements under the Act. However, WorkSafe did not use its power to issue a direction that the agent pay compensation.³⁷² WorkSafe has not issued a direction to an agent to take action in relation to a claim ‘in years’,³⁷³ despite identifying concerns in relation to agent decision-making.

486. WorkSafe advised that where it identifies issues with an agent decision, it normally engages with the agent and requests that it review its decision. WorkSafe said that it would expect an agent to change its decision where WorkSafe had expressed concerns.³⁷⁴

487. WorkSafe does not record these conversations. Nor does it have any data on the number of decisions for which it expressed a concern to an agent, nor the number of decisions that were changed.³⁷⁵ As a result, WorkSafe cannot be sure that this process of engaging with the agent is achieving an appropriate outcome. WorkSafe acknowledged to my office that it needs to better record and track this information.³⁷⁶

488. A worker representative stated that WorkSafe’s view is that it is up to the agents to make decisions on claims. He stated that even where it was likely a decision would be overturned, WorkSafe did not direct the agent to change the decision. This included cases where WorkSafe was aware that the decision was not sustainable. He said:

... I would like to see [WorkSafe] intervene [on some matters] more and instruct the [agent] to overturn their decision. But they don’t. They say that it is the [agent] that is the one that makes the decision [and it can be] managed through the appeal process.³⁷⁷

489. A WorkSafe Director explained WorkSafe’s reluctance to regularly ‘step in and direct’ agents, stating:

... we’re paying agents to make decisions, we want them to take responsibility for the decisions they make. It’s a balancing act.³⁷⁸

371 WorkSafe Victoria, *Review of Workers Compensation referrals to the Medical Panels*, 11 June 2015.

372 WorkSafe stated that written directions to agents can include formal written directions issued relying on the power in section 501 of the WIRC Act, informal written directions given during claim management discussions and any other written directions, policies and procedures or guidelines, for example, the Claims Manual. WorkSafe stated that all written directions must be complied with or a breach of the WIRC Act occurs.

373 WorkSafe Victoria, Response to Victorian Ombudsman request, reference 11, provided to my office on 22 July 2016.

374 Interview of WorkSafe Executive on 25 May 2016; Interview of WorkSafe Director on 23 May 2016.

375 WorkSafe Victoria, Response to Victorian Ombudsman request, reference 16-1, provided to my office on 22 July 2016.

376 Ibid.

377 Interview of a worker representative.

378 Interview of WorkSafe Director on 23 May 2016.

WorkSafe policy on issuing directions to agents

490. Prior to the commencement of my investigation, WorkSafe did not have a policy or procedure regarding the issuing of directions where WorkSafe raises concerns with an agent and the agent refuses to change its decision.³⁷⁹ However, during my investigation WorkSafe noted that:

There is mounting pressure on the Scheme to ensure quality decision making and for WorkSafe, the Scheme regulator, to ensure the Agent alters [decisions] where WorkSafe identifies a decision that has incorrectly disentitled a worker.³⁸⁰

491. WorkSafe has since introduced a procedure for it to issue a direction as a result of a complaint, an audit or another review of an individual claim.³⁸¹

492. As noted earlier, a failure to comply with a WorkSafe direction may result in a penalty for an agent under the contract. While WorkSafe stated to my office that complaints in themselves would not ordinarily give rise to a penalty, it will now consider issuing a penalty to an agent where a complaint identifies a breach of an agent's obligations or a control failure.³⁸²

Oversight of the IME system

493. Another component of WorkSafe's oversight is its management of the IME system. This can be divided into three categories:

- IME appointment and registration
- complaint handling
- quality assurance.

494. While WorkSafe has gradually improved and strengthened its management of the IME system, my investigation identified scope for improvement.

IME appointment and registration

495. All medical practitioners seeking to become an IME must undergo an application process managed by WorkSafe. This involves assessment against selection criteria.

496. WorkSafe advised that the current selection criteria were introduced around 2003 'with a view to improving the quality of IME service, by ensuring they had current knowledge of accepted clinical practice and evidence based research'.³⁸³ Prior to this, a WorkSafe Executive said the requirements to become an IME were much lower and less stringent.³⁸⁴

³⁷⁹ WorkSafe Victoria, *WorkSafe/Agent Operations Manager's Forum: WorkSafe process following identification of an Agent decision that has incorrectly disentitled a worker*, 14 April 2016.

³⁸⁰ WorkSafe Victoria, *WorkSafe/Agent Operations Manager's Forum: WorkSafe process following identification of an Agent decision that has incorrectly disentitled a worker*, 14 April 2016 page 1.

³⁸¹ WorkSafe Victoria, *WorkSafe/Agent Operations Manager's Forum: WorkSafe process following identification of an Agent decision that has incorrectly disentitled a worker*, 14 April 2016.

³⁸² WorkSafe Victoria, Letter from Chief Executive, WorkSafe to the Ombudsman, dated 28 July 2016.

³⁸³ WorkSafe response dated 29 April 2016 to Victorian Ombudsman request dated 8 April 2016, item 1.

³⁸⁴ Interview of WorkSafe Executive on 6 May 2016.

Current WorkSafe criteria to become an IME³⁸⁵

- current registration as a medical practitioner without conditions, limitations or restrictions
- compliance with all relevant Australian Health Practitioner Regulation Agency (AHPRA)³⁸⁶ standards, which cover areas such as English language skills, criminal history and continuing professional development
- minimum of five-years full time experience in their chosen specialty
- holder of the necessary professional indemnity insurance and public liability insurance
- strong verbal and written skills.³⁸⁷

Prospective IMEs must submit an application to WorkSafe addressing these criteria and providing a professional reference. The form also requires them to make a number of declarations, including whether they:

- have previously had approval as an IME revoked
- have ever been found guilty of an offence, disciplinary action or adverse finding, including by an interstate or overseas body
- are currently under investigation or party to proceedings regarding their conduct
- have ever been found guilty of an indictable offence.³⁸⁸

IMEs who are approved are required to sign a further declaration upon their appointment confirming they agree to the terms of being an IME, which include that they must:

- be, and appear to be, independent of WorkSafe and the agents
- adhere to the Service Standards set out by WorkSafe
- act without bias or prejudice.³⁸⁹

497. IMEs are appointed for a period of three years and are required to submit a new IME declaration and renewal application to WorkSafe if they wish to have their appointment continued.

498. WorkSafe provides individual induction sessions for new IMEs. These ensure IMEs are 'well-versed in the expectations set out in the declaration and service standards'.³⁹⁰

499. WorkSafe now has strict selection criteria and registration processes in place for the appointment and renewal of IMEs. However, my investigation identified an appointment some time ago of concern. WorkSafe renewed the IME's appointment despite subsequently becoming aware that the practitioner had been found guilty of professional misconduct. The following case study outlines WorkSafe's consideration of the matter.

³⁸⁵Note: this is a summary of the criteria and is not exhaustive.

³⁸⁶AHPRA is the Australian Health Practitioner Regulation Agency and is responsible for setting national standards, registering health practitioners and auditing compliance.

³⁸⁷WorkSafe Victoria and the Transport Accident Commission, Selection Criteria for Independent Medical Examiners (Effective from 1 April 2015).

³⁸⁸WorkSafe Victoria and the Transport Accident Commission, *Application Forms for Allied Health Practitioners, Dentists, Medical Practitioners and Medical Practitioners – Specialists seeking approval as independent medical examiners* [undated].

³⁸⁹WorkSafe Victoria, *Independent Medical Examiner Declaration template* [undated].

³⁹⁰WorkSafe Victoria, *Response to Victorian Ombudsman request, item 1*, dated 29 April 2016.

Case study 30: IME approved by WorkSafe despite professional misconduct finding regarding patient deaths

Practitioner X has been working as an IME for around 15 years. Following the introduction of more strict selection criteria for IMEs around 2003, Practitioner X applied to WorkSafe to have their IME registration renewed. The new criteria required IMEs, both upon appointment and renewal, to disclose any offences for which they had been found guilty or disciplinary action they had faced. This included any proceedings against them where there was yet to be an outcome. Prior to this, there was no such requirement to make these declarations.

On their renewal form, Practitioner X declared to WorkSafe that they had been found guilty of professional misconduct by a tribunal. Following receipt of Practitioner X's declaration, WorkSafe states that it undertook a 'comprehensive, thorough and immediate assessment' of the application. It states that this involved obtaining legal advice; and consulting with the tribunal, the relevant medical associations and colleges, and Practitioner X.

WorkSafe initially recommended that Practitioner X not be approved to continue as an IME. However, it later changed its decision on the basis of legal advice it received in relation to:

- Practitioner X's ability to initiate legal proceedings challenging the rejection of their renewal application
- Practitioner X's reasonable expectation that they be renewed based on their previously held status as an IME

- the time that had passed since the misconduct incidents, during which there had been no further adverse findings made against Practitioner X.

On the basis of the advice, WorkSafe concluded that injured workers would not be at risk were they to be examined by Practitioner X and approved Practitioner X to continue as an IME.

Practitioner X continues to perform IME work in the scheme today. I am not aware of any other misconduct findings against Practitioner X during his time as an IME over the past 13 years.

By WorkSafe's own acknowledgement, the findings against Practitioner X were 'serious' and Practitioner X's registration would likely not have been approved if their initial application had been processed under the new criteria.

Injured workers, the ACCS and a medical practitioner who treats injured workers raised concerns with my office about Practitioner X's history, information about which is publicly available.

Approval of a medical practitioner with this history to undertake work funded by the government has real potential to diminish injured workers' trust in the IME system.

WorkSafe's decision to renew Practitioner X's appointment as an IME despite their history is inconsistent with its rationale for its decision to lift the standards required of IMEs, recognising the heightened expectations of medical practitioners performing work for a government agency.

I note that in 2017, the registration of all IMEs will be reviewed by WorkSafe.

In response to my draft report, the IME stated:

WorkSafe's decision to reverse its initial decision not to renew my registration was made by reference, not simply to 'legal advice it received', but also by reference to: (a) the findings of the [tribunal] ...[and] (b) detailed written responses that I provided to address WorkSafe's concerns ...

A reasonable person, who was informed of the facts of the finding of professional misconduct against me, would not consider my appointment as an IME likely to affect the integrity of the IME system. This is clear from the fact that the sanction I received for the finding of professional misconduct was the mildest sanction available to the [tribunal] ...

To the extent that the finding of professional misconduct against me is relevant to my appointment as an IME, the concern is suitably addressed in the way that WorkSafe has addressed it. In renewing my IME, WorkSafe made me the subject to selective peer review ...

... I have not only 'not been the subject of any other misconduct findings' but have been appointed to a range of professional appointments that evidence my respected standing within Victoria's psychiatric profession.

Complaint handling

500. In addition to registering IMEs, WorkSafe handles complaints from injured workers about IME conduct. This is limited to investigating administrative complaints, as other complaints about the professional and ethical conduct of IMEs are referred to a more appropriate body, such as the Australian Health Practitioner Regulation Agency (AHPRA), the Health Services Commissioner³⁹¹ or the relevant medical/allied health board.³⁹²
501. WorkSafe does not request information about the outcome of complaints referred to AHPRA. However, WorkSafe advised that 'it is standard practice for AHPRA to notify the referrer of the outcome of their investigation'. It also advised that IMEs are required to notify WorkSafe of any formal complaint made about them in a professional capacity, including complaints made by workers direct to AHPRA.³⁹³
502. In 2014-15, WorkSafe received 238 complaints about IMEs, relating to a range of issues including IME conduct, length and thoroughness of examinations, inaccuracies in IME reports, inappropriate comments and questions, and disagreement with IMEs' opinions.
503. Of these, 101 were finalised on the basis of the IME's response; and WorkSafe notified its Quality Assurance division³⁹⁴ of 52 (this is further discussed later in this chapter).
504. In nearly a third of the complaints (66), the worker did not provide consent for WorkSafe to provide their complaint to the IME,³⁹⁵ so WorkSafe did not investigate the complaints or refer them to its Quality Assurance division.

391 The Health Services Commissioner assists with the resolution of complaints about health service providers.

392 WorkSafe Victoria, *Claims Manual*, section 2.7.7 Complaints against IMEs, updated 18 September 2015.

393 WorkSafe Victoria, Response to Victorian Ombudsman request, reference 14, 21 July 2016.

394 This division is responsible for coordinating the IME quality assurance process outlined in the next section of this chapter.

395 WorkSafe Victoria, Response to Victorian Ombudsman request, reference 15 - Summary of WorkSafe IME complaints 2014-15, 8 October 2015.

Complaint handling process in relation to IMEs

WorkSafe advised that its current complaint handling process is based on 'recognition that WorkSafe does not necessarily have the experience to deal with complaints about professional standards or conduct of IMEs', and thus matters are referred to more appropriate bodies where applicable.³⁹⁶

Is this a matter for WorkSafe?

Where it believes AHPRA to be the more appropriate body to handle a complaint, WorkSafe encourages the worker to contact AHPRA direct.

WorkSafe only refer complaints to AHPRA in limited circumstances – for example, where the complaint pertains to the IME's registration as a medical practitioner.³⁹⁷

Consent required from worker

Where WorkSafe can take action, it reviews a complaint then obtains the consent of the worker to provide a copy of the complaint to the IME for a response. Once consent has been provided, WorkSafe writes to the IME seeking clarification or further information.

If the worker is not willing to provide consent, WorkSafe states that it is unable to take any further action.³⁹⁸

Response received from IME and worker informed of outcome

Once the IME's response is received, WorkSafe reviews all of the information available and provides the outcome to the injured worker.

WorkSafe's response may include an explanation or clarification, additional information, a review of a report where factual or health information was incorrect, or referral to a more appropriate body to handle the complaint.³⁹⁹

Quality assurance

505. Supplementary to the complaint process, WorkSafe manages an IME quality assurance process. This was introduced to 'ensure that IME reports were of a high quality and contained the highest quality medical opinion to guide claims management and decision-making'.⁴⁰⁰
506. The quality assurance process involves anonymous peer review of IME reports by other IMEs who provide feedback to WorkSafe against the standards required of an IME. The feedback is focused on the clarity of the IME's report structure and the consistency and evidence-base of their medical opinion.⁴⁰¹
507. A 2011 WorkSafe review⁴⁰² showed that the quality assurance process has contributed to improvements in the quality of IME reports; however, my investigation identified concerns about the way in which IMEs are selected for peer review, delays in the process, and the practical outcomes achieved by it.

³⁹⁶ WorkSafe Victoria, Response to Victorian Ombudsman request, item 1, 29 April 2016.

³⁹⁷ WorkSafe Victoria, Response to Victorian Ombudsman request, reference 14, 21 July 2016.

³⁹⁸ WorkSafe Victoria, Independent Medical Examiners Complaints Process.

³⁹⁹ WorkSafe Victoria, Independent Medical Examiners Complaints Process.

⁴⁰⁰ WorkSafe Victoria, Response to Victorian Ombudsman request, item 1, 27 April 2016.

⁴⁰¹ WorkSafe Victoria, Response to Victorian Ombudsman request, reference 7, 8 October 2015; WorkSafe Victoria, *IME peer reviewer services agreement template* [undated].

⁴⁰² WorkSafe Victoria, Response to Victorian Ombudsman request, item 1, dated 29 April 2016.

Selection of IMEs for peer review

508. WorkSafe selects IMEs for peer review based on criteria including the number of reports they have provided to agents; the number of complaints about the IME; performance history; and internal feedback.⁴⁰³
509. Peer reviewers assess reports and give them a score that may fall into one of the three categories in Table 9.
510. While there have been IMEs subject to the category 3 quality assurance processes, WorkSafe advised that no IMEs have had their approval revoked from July 2010 to July 2015.⁴⁰⁴ However, some IMEs have 'self-selected' out of their IME agreement when concerns were raised with them in relation to their reports and performance.⁴⁰⁵

Quality assurance of IMEs subject to complaint

511. Complaints against an IME are one of the reasons that WorkSafe may select an IME to undergo peer review quality assurance. My investigation found that in 2014-15 WorkSafe did not select the IMEs subject to the highest number of complaints for peer review.
512. WorkSafe received 238 complaints about IMEs in 2014-15. WorkSafe's Quality Assurance division was notified of 52 of them.

Table 9: Potential outcomes of IME peer reviews

	Assessment	Action taken
Category 1	Report meets the requirements to a high standard	WorkSafe takes no further action.
Category 2	Report overall meets requirements but could be improved and/or displays some minor deficiencies	WorkSafe provides feedback to the IME and they may be subject to further review in 12 months. <i>If there is no improvement following further review, they progress to category 3.</i>
Category 3	Report does not meet criteria	WorkSafe meets with the IME to discuss their performance and reviews further reports from the IME within three months.* <i>If the IME fails to demonstrate improvements upon further review, WorkSafe considers withdrawal of their approval as an IME.^</i>

* WorkSafe states that this will occur 'subject to availability'.

^ WorkSafe Victoria, *IME peer reviewer services agreement template* [undated]; WorkSafe Victoria, *Guide for Independent Medical Examination Reports*, July 2015.

403 WorkSafe Victoria, *Guide for Independent Medical Examination Reports*, July 2015.

404 WorkSafe Victoria, Response to Victorian Ombudsman, attachment 16-0, 8 October 2015.

405 WorkSafe Victoria, Response to Victorian Ombudsman, item 1 29 April 2016.

513. Most IMEs were subject to fewer than 10 complaints each. The following four IMEs received the highest number of complaints:

- Psychiatrist W, subject to 20 complaints
- General surgeon X, subject to 18 complaints
- Psychiatrist Y, subject to 12 complaints
- Occupational physician Z, subject to 11 complaints.⁴⁰⁶

None was selected for peer review through the quality assurance process.⁴⁰⁷

514. IMEs undertaking a greater number of examinations have a greater likelihood of being the subject of complaints; and the four IMEs subject to the highest number of complaints in 2014-15 were also in the top 10 most used IMEs by the agents. However, there were many other IMEs used just as frequently by the agents. Our examination of WorkSafe records revealed these IMEs were subject to significantly fewer or no complaints.

Delays in addressing deficiencies

515. Where deficiencies in IMEs' reports and opinions are identified, it is important that WorkSafe address them in a timely manner so that injured workers do not continue to be examined by an IME who is failing to meet the required standards.

516. WorkSafe has not always followed up on such concerns in a timely manner; and case study 31 is an example. The case study shows a significant delay in peer review of reports by an IME. The delay was particularly concerning given the multiple and continuing deficiencies identified in the IME's reports.

Case study 31: Three-year delay in addressing deficiencies in IME's reports

The IME was selected for the quality assurance process around 2010. Following peer review of his reports, WorkSafe advised the IME that he had received a category 2 rating, and that further review was required to ensure he improved.

In mid-2011, WorkSafe met with the IME on the basis that he had not improved and the deficiencies in his reports had not been addressed following further peer review. In mid-2012, the IME was subject to further peer review; and deficiencies were again identified with the quality of his reports. As a result, WorkSafe advised the IME that he had now received a category 3 rating.

Despite this, it was not until almost three years later, in early 2015, that the IME was subject to further peer review. WorkSafe wrote to the IME, apologising for the three-year delay.

Following further peer review, the IME again received a category 2 rating.

⁴⁰⁶WorkSafe Victoria, Response to Victorian Ombudsman request, reference 15 - Summary of WorkSafe IME complaints 2014-15, 8 October 2015.

⁴⁰⁷WorkSafe Victoria, Response to Victorian Ombudsman request, reference 71 - IME Quality Assurance Tracking Sheet (2013-15), 8 October 2015.

Practical outcomes

517. Where negative feedback is provided through the quality assurance process, WorkSafe stated that it monitors the quality of the IMEs' reports to ensure they improve or the practitioner does not continue as an IME. Additionally, a WorkSafe Executive advised that:

[where] significant issues are raised that cause concern about the report and its potential to impact the injured worker, we review the claim to determine whether a decision had been made relying on the IME report. In consultation with our Medical Consultant, IBU [insurance business unit] and the Agent we determine whether any action is required.⁴⁰⁸

518. The results from the 2014-15 peer reviews show that while some IMEs received positive feedback and scorings, others were criticised and deficiencies were identified.

519. Examples of this feedback and comments included:⁴⁰⁹

[Report no. 1]

... I do not understand how the IME can arrive at [their] conclusion so adamantly ... based on my reading of this report, and based on my experience and expertise, the report as it stands is poor and lazy, and possibly arrogant and biased.

[Report no. 2]

This is a very sketchy report which lacks detail.

[Report no. 3]

My overall impression is that this IME conducted the assessment in a rather superficial manner and provided very limited information as to the actual clinical findings on physical examination.

[Report no. 4]

THE OPINION IN THIS CASE WAS CONFUSED ... THE CLAIMS AGENT WOULD NOT BE ABLE TO MAKE A DECISION ON THE BASIS OF THIS REPORT WHICH FAILED TO PROVIDE THE REQUIRED INFORMATION.

[Report no. 5]

[there is a] possibility that the IME's conclusions are biased, in terms of raising issues of personality dysfunction, or simply concluding that the condition ... is not work-related.

520. The WorkSafe Executive stated that WorkSafe reviews an individual claim file where significant issues are identified with an IME report. In doing so, reviewers would be wanting to determine if the agent had based a decision on the report. In an email to my office, they advised:

- This process is not documented but rather occurs through 'routine IME relationship and claim management activities'.
- This process occurs 'from time to time'; however, WorkSafe does not have readily available data on the number of times it has taken such action.⁴¹⁰

Future changes: 'make it easy, make it really streamlined'

521. WorkSafe is considering a number of changes to improve its management and oversight of the IME system.

522. A WorkSafe Executive said that WorkSafe was 'shifting its way of thinking' in regard to the current IME model, and was looking at what it could do to ensure injured workers were able to recover and return to work in a supportive way⁴¹¹.

523. The WorkSafe Executive advised that WorkSafe's approach will be to reduce unnecessary interventions (such as the need for visits to an IME) and assist workers to return to work and recover in a more supportive environment, noting that the majority of workers will naturally recover and return to work without difficulty.

408 Email from WorkSafe Executive, 28 July 2016.

409 WorkSafe Victoria, Response to Victorian Ombudsman request, attachment 7-4, Quality Assurance Process Reviews.

410 Email from WorkSafe Executive, 28 July 2016.

411 Interview of WorkSafe Executive on 6 May 2016. All subsequent remarks from the Executive in this section are from this interview.

524. The WorkSafe Executive outlined that, in future, WorkSafe intends to limit intensive case management to the small portion of claims that most need it, noting:

We spend all this time and do things for every case ... despite ... that ... most clients will come in, get better, and out, really quickly. So why are we spending all this effort on causing grief in some respects for some of the things that we actually ask them to do, we send them off to appointments, when actually they're in and out of the scheme, their recovery is in their control, they manage it well and back to work, or back to life pretty quickly.

... [we need to] let them go, get out of the way, make it easy, make it really streamlined, help them, support them, give them the right information, but not have that intensive claims management approach to it. And then for the around 25 per cent ... who have not gone back to work within three months ... that's when you start thinking hey there's some complexity in here, this person should have recovered by now, but they're not, so that's when we do the intensive case management, support, information ... that's when you actually focus there. And that's where I think moving to ... [a more] collaborative approach with using specialists to actually work with treaters ... it's more possible because you're not doing it for 30,000 claims, you're doing it for more like 7,000 claims ... And it's a tailored approach for each case ... what does this person need to actually help them get back to work, what can we do around the barriers of getting back to work.

525. The WorkSafe Executive advised that this approach would allow it to reduce the overall pool of IMEs, as fewer examinations of workers would be required. This means WorkSafe could tighten and increase the requirements practitioners must meet to become an IME.

526. In addition, the WorkSafe Executive advised that WorkSafe was looking at alternatives to IMEs, including more collaboration with workers' treating health practitioners; use of case conferences; and examinations by a panel of IMEs where a worker has multiple injuries and requires examination by more than one specialist.

527. In regard to its approval of IME applications, the WorkSafe Executive outlined that WorkSafe will be looking to increase its decision-making discretion on these. The WorkSafe Executive advised that:

we would like to be able to bring in more of that discretion around – okay you need to meet the qualifications, standards, experience, those things, but we'd also [like to] be able to have a bit more discretion around 'but you're actually not the right person for the job', because I don't know what philosophy you might be bringing to it, your approach, your interpersonal skills may not be right.

528. WorkSafe further said that:

With current IME approvals due to expire in 2017, WorkSafe is in the process of developing an enhanced performance management framework for IMEs with the aim of improving the expertise and quality of IMEs and their reporting as well as improving worker experience of the IME process. This process involves a review of the IME selection criteria and development of clear revocation pathways for IMEs who fail to meet the performance framework standards.⁴¹²

⁴¹² Letter from Chief Executive, WorkSafe to Victorian Ombudsman, dated 28 July 2016.

529. The WorkSafe Executive advised that WorkSafe is also considering ways to address agents' selective use of IMEs to reduce the perception that agents and certain IMEs are aligned. This includes limiting individual IME caseloads to a certain number of examinations for each agent and the introduction of a new IME booking system, through which IME selection would be less driven by agent staff and more automated.

530. WorkSafe is also considering providing injured workers with the choice of three IMEs, as currently, agents select the IME. The WorkSafe Executive advised that these changes are designed to give workers more control over what happens to them and make the process less 'adversarial':

[It will be less] 'you have an appointment with so and so at this time' and here's all the legislation that says what will happen to you if you don't go. This is around ... we need this information, would like you to attend a specialist, here's three that are in your area ... and you ring up and make the appointment and go from there.

531. A further change being considered by WorkSafe is for IME reports to automatically be shared with workers' treating health practitioners to increase transparency. At present, reports are only shared when requested by the worker or practitioner.

Performance reports to agents and 'health checks'

532. WorkSafe produces a range of reports comparing and contrasting agent performance against targets, the scheme and other agents. The reports include monthly performance scorecards that summarise and rank each agent's performance against the financial reward measures.⁴¹³

533. WorkSafe reportedly uses the reports to identify opportunities for improvement, and agent performance is discussed at internal WorkSafe forums and at monthly meetings with the agents.⁴¹⁴

534. WorkSafe also reportedly uses the reports to identify any discrepancies in agent claim management practices, including whether agents have manipulated the financial rewards or have made claims decisions to achieve the financial rewards. For example, WorkSafe conducts validation activities to 'test' the validity of the agents' performance against the financial reward and penalty measures. (An increase in the number of terminations towards the end of the financial year may indicate that agents are trying to maximise the financial reward.)

535. In the 2014-15 financial year, WorkSafe examined whether agents had delayed payments of medical expenses so they could benefit from the financial reward. WorkSafe's documents indicated that it was possible that all agents could have gained financially in 2014-15 by delaying payments until the new financial year. As such, WorkSafe concluded that it needed to monitor this issue.⁴¹⁵

413 WorkSafe Victoria, *Workers Compensation (Vic) Limited Monthly Agent Performance Report – Report on APA & Key Measures to 30 June 2015*, July 2015.

414 WorkSafe Victoria, *Overview of Agent Performance Model*, October 2015.

415 WorkSafe Victoria, *Annual Performance Adjustment Results for 2014-15*, October 2015.

536. WorkSafe also examined whether there was any agent manipulation of claims falling within the financial rewards for terminations at 13, 52 and 134 weeks and for active claims. WorkSafe did not identify any examples of manipulations.

537. WorkSafe also completes other risk-based audits called 'health checks'. Health checks are conducted to provide insight into opportunities for improvement and are reportedly conducted on an 'as needs' basis depending on emerging issues and opportunities.⁴¹⁶

538. The WorkSafe Director, Agent Performance and Relationships stated at interview that there were limitations to the systems WorkSafe uses for performance reporting.⁴¹⁷ The Director said that a more sophisticated system (one that could collate information from WorkSafe's reporting, the complaints database and the audit program) would help WorkSafe to identify systemic issues and where it should focus to drive improvement.⁴¹⁸

Agent internal controls

539. WorkSafe's contract with the agents requires the agents to maintain internal quality controls so they can perform their obligations, duties, powers and functions under the contract and the relevant legislation.

540. To comply with the contract, the director of the agent must certify the agent's compliance with the legislation and various other requirements, and that the internal controls are effective. Agents are also required to engage an external auditor to audit the agent records to confirm that the quality controls are in place, enforced by the agent and are sufficient.

541. The WorkSafe Internal Control Framework⁴¹⁹ outlines that the agent must put controls in place to effectively manage the financial rewards and internal processes to ensure that accurate and sustainable entitlement decisions are made within specified timeframes. Further, the agents are required to have internal controls so that appropriate and timely action is taken to withdraw decisions at conciliation where it is identified that the decision is not technically sound and/or based on reasonable evidence. However, multiple case examples⁴²⁰ reviewed during my investigation show that agents are maintaining unsustainable decisions through the dispute process, even when the agent acknowledges the decision is not sound.

542. At interview, a WorkSafe Director referred to the importance of agent internal controls to ensure appropriate decision-making. The Director stated that WorkSafe relies on the agents' internal controls to ensure that the agents are 'comfortable that [their employees] are doing the right thing'.⁴²¹ At interview, agent executives also referred to the internal controls as a key mechanism to ensure agent staff are making appropriate decisions.

⁴¹⁶ WorkSafe Victoria, Audit and Compliance Framework: Risk-based approach to audit and compliance 2014-15, undated and WorkSafe Victoria, WorkSafe Audit Protocol, August 2015.

⁴¹⁷ Specifically, WorkSafe uses Excel spreadsheets to analyse data, including audit data. Further, WorkSafe only has a small audit team.

⁴¹⁸ Interview with a WorkSafe Director on 25 May 2016.

⁴¹⁹ WorkSafe Victoria, WorkSafe Internal Control Framework, July 2015.

⁴²⁰ Including case studies 3, 5, 7, 9, 10, 11, 13, 14, 15, 16, 22, 24, 25 and 27.

⁴²¹ Interview of WorkSafe Director on 25 May 2016.

Conclusions

543. Any workers compensation scheme involving private insurers inevitably presents challenges. While private insurers are driven by commercial interests, in their capacity as WorkSafe agents, they must act in accordance with WorkSafe's statutory functions, an ethical decision-making framework and in the public interest. Public trust in the scheme's fairness as well as its financial viability is essential to its success.
544. The evidence to this investigation showed genuine hardship and distress to complainants and others whose cases we examined, and some compelling evidence of agents gaming the system. We also examined statistics evidencing the high percentage of cases overturned following independent review.
545. However, my investigation did not extend to the entire WorkSafe claims management system and the evidence of this investigation does not indicate that it is broken. On the contrary, as WorkSafe points out, 80 per cent of claims are finalised within 13 weeks of injury, and its last annual survey of injured workers recorded satisfaction of over 85 per cent.
546. We saw instances of good administrative decision-making and practices by some agent staff, including:
- advising their colleagues not to ignore the opinions of a worker's doctor in favour of an IME
 - indicating that a claim be accepted despite inappropriate attempts by management to reject liability
 - reinforcing that it is essential to send appropriate information to IMEs
 - advising staff that they should not be influenced by an employer to make a 'commercial decision' to reject a claim even if there was a potential risk of losing the employer as a client.
547. Be this as it may, the evidence of unreasonable decision-making is too strong to be explained away as a few 'bad apples'. This investigation found that complex claims involving long periods of incapacity or a long term requirement for medical treatment are those where there is more likely to be a concentration of unreasonable decision-making.
548. The fact that the case studies revealed poor behaviour by all five agents indicates forcefully that the system does not work well at this end of the spectrum. Agents are responsible for their decision-making – they should be adhering to the agreed standards and held to account when they do not – but they are also responding to incentives in the scheme which must be recalibrated to address the issues my investigation raises.
549. While complex claims make up just 20 per cent of claims received each year, they are 90 per cent of the scheme's liabilities. It is not surprising then, that there are significant financial rewards under the scheme for managing such claims. These financial incentives, however, can lead to unfair outcomes for many Victorians. WorkSafe's oversight needs to directly target the management of complex, disputed claims to ensure that there is a safety net for the most vulnerable.

Unreasonable decision-making by agents

550. The requirements of the legislation are clear, and WorkSafe clearly articulates its expectations in regard to decision-making by agents through its contract, the Claims Manual and training. This includes a range of policies and binding guidelines on making sound, evidence-based decisions on claims, and agent conduct during the dispute process.

551. We found numerous examples of agents unreasonably rejecting and terminating workers' entitlements and cherry-picking slim evidence to support a decision to reject or terminate a claim while disregarding overwhelming evidence to the contrary. The cases also demonstrated provision of selective, incomplete or inaccurate information to IMEs; leading questions to IMEs; and selective use of IMEs – including those described by agent staff as 'good for terminations'.

552. In many of these cases, agents unreasonably rejected or terminated claims where the agents knew the worker was entitled to compensation. Examples included agents maintaining unreasonable decisions at conciliation, in some cases despite acknowledging that the decision was unreasonable and would be overturned.

Independent Medical Examiners

553. The opinions of IMEs in workers compensation claims assist agents' decision-making on claims. WorkSafe requires that agents should not attempt to influence IMEs and that they should not be selected based on any ulterior motive. However, contrary to this my officers found that in some cases agents' choice was plainly motivated by the opportunity to obtain an opinion from an IME who was considered to hold particular views adverse to an injured worker. There was also evidence in some cases of agents 'shopping' for an IME opinion by going to multiple doctors until they received an opinion that would allow them to terminate.

554. The case studies, agents' emails and costs paid to particular IMEs show that agents are in some instances selectively using IMEs, 'fishing' for certain outcomes by requesting supplementary reports or asking leading questions in order to get a report that would support a termination or rejection.

Maintaining unreasonable decisions at conciliation

555. The Claims Manual, Ministerial Guidelines and the Model Litigant Guidelines all require that agents should only maintain decisions that have a reasonable prospect of success if they were to proceed to court.

556. My investigation identified cases in which agents maintained claim rejection and termination decisions at conciliation despite knowing that they were 'not strong' or 'barely arguable' and were likely to be overturned. It was apparent in some of the cases that the primary objective of agents at conciliation was to maintain and defend their decisions through whatever means possible, even where they knew the evidence did not support their decision to reject or terminate the claim, apparently in the hope that workers would not dispute the matter further at court.

557. An agent maintaining unsustainable decisions at conciliation is not only inconsistent with a key objective of the WIRC Act:

ensuring that appropriate compensation is paid to injured workers in the most socially and economically appropriate manner and as expeditiously as possible

but also means injured workers are exposed to a protracted dispute process, often to the detriment of their health and recovery, and that scheme money is spent arguing indefensible decisions.

558. The significant number of agents' decisions overturned at conciliation and court suggests that agents' internal controls to ensure that appropriate and timely action is taken to withdraw unsustainable decisions at conciliation are not adequate.

559. While WorkSafe articulates that the agents must make and maintain decisions that are sustainable, we observed that the ACCS only has power to overturn a decision if it is not 'arguable'. An 'arguable' case – described by one witness as requiring just one piece of evidence – is clearly a lower threshold than a 'sustainable' decision, which agents are required to make in keeping with the Model Litigant Guidelines, Ministerial Guidelines and Claims Manual.

Decisions contrary to binding Medical Panel opinions

560. My investigation identified cases in which, contrary to the WIRC Act and Claims Manual, agents made decisions on claims in conflict with a binding Medical Panel opinion, including examples where agents:

- reinstated a worker's entitlements after receiving a binding Medical Panel opinion, only to terminate payments shortly after on the basis of a conflicting IME opinion
- terminated a worker's claim after a Medical Panel opinion, but had failed to identify evidence supporting that there had in fact been a material change in the worker's condition or circumstances
- took a narrow interpretation of Medical Panel opinions in order to maintain a termination or issue a new one at a later stage.

561. Such cases, and internal emails showing a negative attitude by some claims staff towards referrals to Medical Panels on the basis of the high percentage of decisions overturned by them, evidence a disregard by agents for the 'final and conclusive' nature of a Medical Panel opinion.

Inadequate agent internal review process

562. The evidence also suggested both a lack of confidence by injured workers in the internal review process, and that, in practice, senior reviews can be little more than a 'box ticking exercise', rather than an effective mechanism to safeguard the quality of decision-making.

563. This is highlighted by cases we examined where a senior review had been undertaken, in which neither the file nor the letter to the injured worker contained sufficient detail as to how the decision was reviewed or the rationale for the outcome reached. At best, this creates the perception that the agent did not give genuine consideration to the concerns raised by the injured worker.

Poor record-keeping

564. Claims files revealed that emails between agent staff in relation to decision-making on the relevant file were often not stored on either the electronic or hard copy file. This is inconsistent with the agents' obligations under the contract (clause 21) and the *Public Records Act 1973* (section 13).

The effect of the financial rewards and penalties on agent decision-making

565. It is, of course, reasonable for WorkSafe agents to expect to make a commercial profit. However, the evidence of unreasonable decision-making strongly suggests that at the disputed and complex end of the spectrum, the financial reward and penalty measures are driving a focus on terminating and rejecting claims to achieve financial rewards.

566. This is evidenced by the strong emphasis on terminations we observed in the files, including where agent staff, and in particular, managers referred to ‘termination strategies’; described terminated claims that fell within the financial reward measure as ‘winners’ or ‘wins’; rewarded staff for terminating or rejecting the highest number of claims; and referred to the monetary amount that could be made for terminating claims.

567. Some cases provided direct evidence of agents making unreasonable decisions in order to achieve the financial rewards available under the contract. In some other cases it is reasonable to infer that the decision was influenced by the financial rewards, given the agents’ disregard for evidence not supporting the decision, the timing of decisions aligning with the financial reward measures, and multiple references to the financial rewards in agent file notes and emails.

568. There is also evidence that four of the five agents manipulated or attempted to manipulate claims to achieve the financial rewards and avoid penalties.

WorkSafe’s oversight of the scheme

Insufficient incentive to drive good quality decision-making by agents

569. Financial reward and penalty measures are a key driver of agent performance and it is imperative that there are sufficient checks and balances to safeguard against unfair decisions and an abuse of process.

570. It is evident from this investigation that while WorkSafe has reviewed and adjusted the financial reward and penalty measures on an annual basis, including responding to a VAGO audit in 2009, there is still insufficient incentive to the agents to make sustainable decisions of sound quality on claims. This is particularly so when compared to the incentive WorkSafe provides to agents to terminate claims within certain timeframes.

571. In response to the VAGO report, WorkSafe did not introduce a financial reward relating to the quality of agent termination decisions until 2014-15, five years after VAGO’s report; and only extended this to all adverse decisions in 2016-17.

572. Although WorkSafe assesses agents’ performance through audits, in my view the sample has been insufficient relative to the number of decisions made by agents. The frequency of the audits, twice per year, was also problematic as issues with agent decisions would often be identified months after the original agent decisions were made.

573. WorkSafe previously did not examine claims that failed the audit to consider whether injured workers were incorrectly disentitled. It is also a concern that agents could receive a financial reward from a claim that an independent review did not unanimously agree was sustainable.

574. I note that WorkSafe has taken a number of steps in recent times to address these issues, including:

- an intention to extend the scope of the quality decision measure to all entitlement decisions by agents
- an intention to increase the monetary value of the reward and penalty available to agents under the quality decision measure
- an increase in the number of claims audited
- changes to the timing of the audits, which will now occur on a monthly basis.

Inadequate focus on sustainable and long-term return to work

575. The return to work financial measure set by WorkSafe has provided agents considerable incentive to assist workers to return to work within six months; however, there has been no direct financial incentive to agents to continue this focus past six months. This is particularly noteworthy given a considerable number of claims examined during my investigation involved long-term incapacity. An additional limitation of the return to work measure has been its narrow focus on whether a worker returned to work within six months, without adequate attention given to whether they remained at work.

576. I welcome WorkSafe's trial introduction of a new longer term return to work measure in 2016-17. WorkSafe should also consider ways to ensure that the return to work outcomes for which agents are rewarded under these measures are genuine and sustainable.

Using intelligence from complaints, feedback and overturned decisions

577. Complaints and feedback from stakeholders and decisions that have been overturned through the dispute process can provide WorkSafe with valuable insights into the management of claims by agents and potential areas for improvement. WorkSafe does not optimally use this information to monitor complaints and identify potential systemic issues, and the perception of some stakeholders is that WorkSafe has not taken adequate action on their concerns.

578. WorkSafe was aware of the high percentage of claims that were overturned or changed at conciliation and court, and of issues with sustainability of agent decisions at Medical Panels. However, WorkSafe has not systematically reviewed such claims.

579. While recognising WorkSafe's preferred cooperative approach to managing issues with agents, its reluctance to step in and direct agents has meant that, in some cases, poor agent decisions were maintained and injured workers were forced go through a dispute process, and did not receive their entitlements in a timely manner.

580. On a systemic level, WorkSafe does not yet adequately record, track, collate and review the information available to it to identify and address issues with agent practices.

Oversight of the IME system

581. The issues in this report arising from agents' use of IMEs highlight the need for reform in this area. Providing workers with a choice of IME and requiring the sharing of IME reports with treating health practitioners could have made a significant difference to many of the complaints. It is encouraging that WorkSafe is considering these options.

582. There is scope for WorkSafe to better target its quality assurance process to those IMEs receiving a higher number of complaints to ensure optimum value and outcomes from the process, and that any potential conduct issues raised in complaints are appropriately examined. WorkSafe should also systematically consider whether an agent's decision should be withdrawn following a quality review of an IME's report where deficiencies in the report are identified.

Dispute resolution

583. The processes for the resolution of disputes after conciliation also need further consideration. The conciliation process is quick and inexpensive, and successfully resolves some 65 per cent of disputed claims. However, where conciliation does not succeed workers often have no choice but to pursue matters through the courts, where a lengthy wait is inevitable. The WIRC Act rightly places emphasis on efficient and expeditious settlement of claims. It is in the interests of workers, employers and the public at large that the resolution of claims be timely and fair.

'I am more than convinced that this system kills people. It isolates them, makes them feel worthless, fearful for their futures, takes away their dignity and their livelihood.'

Email to VO from parent of injured apprentice worker

Opinion under section 23 of the Ombudsman Act

584. On the basis of the evidence obtained in my investigation and in relation to the particular claims considered, in my opinion, there were instances where:

- Agents appear to have acted unreasonably and unjustly⁴²² by:
 - rejecting and terminating claims without adequate supporting evidence
 - maintaining unsustainable decisions through the dispute process, as they failed to act consistently with an objective of the WIRC Act to ensure appropriate compensation is paid to injured workers 'in the most socially and economically appropriate manner, as expeditiously as possible'.⁴²³
- Agents appear to have acted in a way that is wrong⁴²⁴ by:
 - acting inconsistently with a binding Medical Panel opinion⁴²⁵
 - failing to maintain accurate records.
- WorkSafe appears to have acted in a way that is wrong⁴²⁶ by:
 - having inadequate systems in place in its oversight of complex claims to ensure compensation was paid 'in the most socially and economically appropriate manner and as expeditiously as possible'
 - failing to issue directions to the agents in case studies 11 and 29.

422 Ombudsman Act 1973, s. 23(b).

423 WIRC Act 2013, s. 10(d).

424 Ombudsman Act 1973, s. 23(g).

425 WIRC Act 2013, s. 313.

426 Ombudsman Act 1973, s. 23(g).

Recommendations

To the Government:

Recommendation 1

Review the current dispute resolution model for workers compensation, in particular the process following unsuccessful conciliation, to ensure the model is fair and timely.

Recommendation 2

Amend the WIRC Act to empower the ACCS to issue a direction to an agent where a decision has no reasonable prospect of success were it to proceed to court, i.e. it is not 'sustainable'.

To WorkSafe:

Recommendation 3

Consider how the overall operation of the scheme can better target its resources and oversight to ensure quality decision-making in the cohort of complex cases where disputes frequently arise.

Recommendation 4

Implement a system to record, collate and track complaints, feedback, discussions with agents and outcomes, and use this data to:

- a. identify and remedy complaint patterns and systemic issues
- b. assist identifying trends in agent decision-making practices and potential systemic issues in the scheme
- c. conduct ongoing audits of samples of claims disputed at conciliation, Medical Panels and court where the decision was changed.

Recommendation 5

Provide conciliation officers access on request to the relevant agent claim files to enable better informed conciliation outcomes.

Recommendation 6

Review all claims subject to a direction at conciliation to identify opportunities to improve agent practices.

Recommendation 7

Use its power to issue a written direction to an agent where it identifies that an agent's decision is unreasonable and/or unsustainable, and the agent refuses to withdraw it.

Recommendation 8

Update the Claims Manual to outline WorkSafe's expectations in relation to the 130 week test and use of the 'indefinite ground',⁴²⁷ including:

- a. that a medical opinion that is not definitive (i.e. states 'possibly', 'may' or 'should have a capacity' and/or provides no clear reason or justification) is not sufficient to meet the test
- b. WorkSafe's expectations around timeframes.

Recommendation 9

Review the weightings given to the financial reward and penalty measures for 2017-18 to ensure that there is sufficient focus on good quality and sustainable decision-making.

⁴²⁷ As detailed in the WorkSafe Victoria, *Quality Decision Making APA 2014-15* presentation dated 4 May 2015.

Recommendation 10

Amend its quality decision-making audit procedure so that agents cannot be rewarded for a decision upon which a review or appeal panel cannot reach a unanimous view.

Recommendation 11

Amend the scope of the Return to Work Index audits to ensure that it rewards agents for genuine and sustainable return to work outcomes.

Recommendation 12

In consultation with the agents, provide training to agent staff on the financial reward and penalty measures, including their purpose and their relationship to good administrative decision-making (referred to in the Claims Manual) on claims and offers at conciliation.

Recommendation 13

Publish information on each of the financial reward and penalty measures at the start of each financial year.

Recommendation 14

Implement changes to the current IME system to:

- a. prevent agents from selectively using 'preferred IMEs' or
- b. provide injured workers a choice of the IME with the appropriate speciality, by whom they are examined.

Recommendation 15

Amend its IME complaint handling policy to provide scope for examination of complaints where a worker does not provide consent for the complaint to be provided to the IME, which may include the referral of the matters raised to the IME quality assurance division for intelligence gathering purposes.

Recommendation 16

Amend the IME quality assurance process to:

- a. ensure IMEs subject to a high number of complaints are peer reviewed
- b. document the process by which WorkSafe will review an individual claim file where significant deficiencies are identified in relation to an IME's report, to ensure a worker's entitlements have not been unreasonably rejected or terminated based on the report.

Recommendation 17

Review the injured worker's case detailed in case study 3 to ensure the worker has not been incorrectly disentitled to compensation.

WorkSafe's response:

WorkSafe accepts your recommendations to us. We will implement those which we have not already undertaken of our own volition.

Appendix 1: WorkSafe's response



25 August 2016

Ms D Glass
Victorian Ombudsman
Level 1, North Tower
439 Collins Street
Melbourne VIC 3000

Dear Ms Glass

Own motion investigation into management of workers compensation claims in Victoria

Thank you for your letter dated 24 August 2016 and for the opportunity to respond to your recommendations arising out of your investigation into the management of workers compensation claims in Victoria.

Victorian workers compensation scheme

Let me say upfront that Victoria is fortunate to have a workers compensation scheme which provides significant benefits to injured workers and at the same time generally functions efficiently and cost effectively. We believe that our scheme compares favourably with the schemes in other states and territories of Australia and international best practice standards.

WorkSafe's role in relation to the scheme is defined by the *Workplace Injury Rehabilitation and Compensation Act 2013 (Vic) (WIRC Act)*. Our statutory objectives as an organisation include managing the scheme in a 'financially viable manner' and 'as effectively, efficiently and economically as is possible'.

The objectives of the WIRC Act include to make provision for effective occupational rehabilitation of, and suitable employment for, injured workers to enable their early return to work; to ensure workers compensation costs are contained so as to minimise the burden on Victorian businesses; to establish incentives that are conducive to efficiency and discourage abuse; and to maintain a fully funded scheme.

WorkSafe must have regard to all of these objectives in addition to the objective which is the focus of your report; that of ensuring that appropriate compensation is paid to injured workers in the most socially and economically appropriate manner, as expeditiously as possible.

Continuous improvement

WorkSafe, led by its board of directors and senior management team, seeks to continuously improve scheme processes, operations and outcomes. We believe that we have made considerable progress in many areas in recent years and we intend to continue to improve into the future.

In this context, we welcome external reviews such as yours, and approach with an open mind all suggestions as to areas for improvement. We believe that we have responded proactively to all external reviews in the past, including the audit of our claims management model by the Victorian Auditor General's Office in 2009 and your office's investigations into the Transport Accident Commission's and WorkSafe's administrative processes for medical practitioner billing in 2009 and record keeping by WorkSafe agents in 2011.

Dispute Resolution

WorkSafe is currently engaging with an independent expert to conduct a full end-to-end review of the dispute resolution model, with the aim of reducing disputation.

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WorkSafe Victoria is a trading name of the Victorian WorkCover Authority



One important component of our dispute resolution model is conciliation, which WorkSafe considers to be an expedient way to resolve disputes. The aim of conciliation is for the parties to negotiate an agreed outcome. The role of the conciliator is to facilitate frank and open discussion, not to evaluate the strengths and weaknesses of each parties' position and make a decision on the merits. The only qualification under the current system is that a conciliator may issue a direction if the conciliator forms the view that the arguments advanced by the agent are essentially hopeless. It would fundamentally and detrimentally affect the conciliator's capacity to mediate negotiated outcomes if the conciliator's role included assessing whether a position was 'sustainable' as opposed to 'arguable'.

Conciliation is a non-adversarial process, in respect of which the parties are not legally represented. It would become considerably more adversarial if, at the end of a conciliation which did not reach a compromise, the conciliator then abruptly changed roles and became the judge of which party's arguments were to be preferred.

Disputes which are not resolved at conciliation proceed to an adversarial process in the courts. WorkSafe does not support the introduction of an arbitral process as an addition to the current dispute system. We believe that would add another layer of complexity and cost to the system and would be contrary to the general objective of reducing the level of dispute.

Your recommendations to the Government

The Act strikes a balance between the level of weekly compensation available to injured workers and the financial viability of the scheme. This is a balance which, in WorkSafe's view, should not be upset, either by legislative drafting changes or otherwise, without careful consideration of all relevant aspects and consultation with all stakeholders.

Whilst your recommendations are a matter for the Victorian Government, for the reasons set out above, WorkSafe does not support them.

Your recommendations to WorkSafe

WorkSafe accepts your recommendations to us. We will implement those which we have not already undertaken of our own volition.

Your conclusions

You have not invited us to comment on your proposed conclusions, but I would like to put on record that we consider that they substantially overreach the limited evidence considered in the course of your investigation.

Your investigation focused on 60 claims which were selected because they were the subject of complaints to you. The sample was drawn from claims for injuries sustained from as long ago as the 1980s, in respect of which entitlements were rejected or terminated between 2011 and 2016. During that five year period, agents made approximately 10 million entitlement decisions on approximately 90,000 claims on the scheme each year, so your sample cannot be said to be representative or statistically significant.

As your report acknowledges, our data indicates that 80% of injured workers return to their pre-injury employment within 13 weeks of injury. The claims reviewed by your office were not in the 80%; they were all complex claims which necessarily involve matters of judgment in relation to which there is scope for differences of view

For the five year period to which your sample of 60 complex claims relates, there were approximately 90,000 claims involving periods off work exceeding 13 weeks, and approximately 16,000 claims involving periods off work approaching or exceeding 130 weeks.

The WIRC Act defines injured workers' entitlements to weekly compensation payments by reference to entitlement periods. The first period is 13 weeks and the second period is an additional 117 weeks. At the conclusion of these two periods, a total of 130 weeks during which weekly payments of compensation have been paid to a worker, the Act requires that the worker's entitlement to weekly payments ceases, unless the worker is assessed as having 'no current work capacity' and is 'likely to continue indefinitely to have no current work capacity'¹.

¹ s163 of the WIRC Act

The cessation of weekly payment entitlements after 130 weeks if the worker has some work capacity, or if the worker is not likely to continue indefinitely to have no work capacity, is a fundamental design feature of the scheme. It requires important entitlement decisions to be made at the 130 week point. In this way, the Act strikes a balance between the level of weekly compensation available to injured workers and the financial viability of the scheme.

Entitlement decisions made at the 130 week point can be difficult and complex, particularly where the probability of an injured worker developing some work capacity in the future needs to be assessed. Evidence may conflict and medical opinions may vary. Inevitably, there will be disputes. The Act establishes a mechanism for such disputes to be resolved or determined.

There will always be claims which could and should have been handled differently than they were. Your investigation identified 27 such claims (the examples referred to in your report), out of tens of thousands of comparable claims. We do not accept that those claims can be taken to be representative, or that they can justify broad conclusions regarding the management of complex claims.

We particularly object to your conclusion that agents may have acted contrary to law or that WorkSafe appears to have acted in a way that was 'wrong'. We do not accept that the evidence justifies these conclusions and we believe that insufficient weight has been accorded to the matters referred to in this letter. We point in particular to the general level of satisfaction with claims handling as indicated by survey results.

Claims and agency management model

Competition between authorised agents in the delivery of claims handling services is an inherent feature of our scheme under the WIRC Act. In accordance with broader competition policy principles (as most recently advocated at the Commonwealth level in the 'Harper Committee' report²), competitive pressures drive innovation and efficiencies, consistent with the objective of managing the scheme as effectively, efficiently and economically as possible.

Facilitating and encouraging competition through financial incentives and penalties is, in consequence, an essential aspect of the claims and agency management model. Recognising this, WorkSafe has initiated several external reviews of the model, including by McKinseys in 2001, the Boston Consulting Group in 2009 and PricewaterhouseCoopers in 2014. Their recommendations were taken into account in our continuous improvements of the model.

One of the measures of agents' performance is the outcome of a monthly survey of injured workers, which involves telephone interviews of 5,000 injured workers per annum selected at random. The 15 minute survey covers service perceptions of 6 key aspects of claims handling – eligibility, return to work, independent medical examinations, requests for treatment, termination of benefits and recent communications.

In FY14, the survey yielded an overall satisfaction level of 83.9%. In FY15, this figure climbed to 86.2%. The figure for FY16 will be published in our annual report. We believe that this is an important measure of the performance of agents, including in relation to quality decision making, and is appropriate to be brought into account in the agent remuneration model.

Review and scrutiny

The correctness of decisions made by agents' staff concerning workers' entitlements is subject to review and scrutiny through several mechanisms. Each agent has an internal review process for reconsideration of entitlement decisions by senior, experienced agency staff. The agents decision-making processes and claims handling is subject to regular internal audit by leading accounting firms. WorkSafe also regularly audits agents' processes and claims handling and reviews in details claims which are the subject of complaints to it.

These quality assurance measures have themselves been subject to regular review and improvement.

There are also effective complaints channels, including through the Accident Compensation Conciliation Service (ACCS). The ACCS process is funded by WorkSafe and is free of charge to workers, as is

² Competition Policy Review – Final Report, March 2015 by Professor Ian Harper, Peter Anderson, Su McCluskey and Michael O'Bryan QC

assistance with conciliation through WorkCover Assist and Union Assist. Complaints can also be made to WorkSafe and to your office.

IMEs

WorkSafe is currently reviewing the system for medical assessment of workers' injuries by independent medical examiners (**IMEs**). WorkSafe will consider making changes to the IME system to better enable agents to select appropriate, available IMEs with the level of skills and expertise required for the assessment of a worker's injuries, well located geographically for the worker to visit. WorkSafe will also consider providing injured workers with a choice of IMEs with the appropriate speciality, subject to availability and location.

WorkSafe strategy 2030

WorkSafe's 2017 strategy is coming to an end. We are currently developing a new strategy through to 2030. This will guide our future operations and continued improvement of scheme processes and outcomes.

WorkSafe is keen to explore ways to reduce disputation in the scheme generally and to make dispute processes less adversarial. This will be a focus for WorkSafe in developing our 2030 strategy. The current dispute resolution model is quick and inexpensive; attributes which are not common in more adversarial models. The conciliation process in particular facilitates negotiated outcomes, which WorkSafe believes are generally regarded as more efficient, timely and better accepted by the parties than externally determined outcomes.

WorkSafe also remains committed to reducing the frequency and severity of workplace injuries. Our strategy will continue to focus on the health benefits of safe work and supporting injured workers to safely return to work. More broadly, we will redouble our efforts to improve service delivery to injured workers and reduce red tape, whilst at the same time administering a financially sustainable, cost effective scheme which delivers fair compensation in a timely and efficient manner.

Yours sincerely



Clare Amies
Chief Executive
WorkSafe Victoria

Appendix 2: Agents' responses

585. In response to my draft report, each of the agents accepted that my investigation identified concerns with their handling of workers compensation claims and that there are opportunities for improvement. They noted, however, that the cases represent a small sample of the significant number of claims they manage each year – 90,000 collectively in 2015-16 – and do not represent typical behaviour by the agents.

586. I have fairly set out the agents' responses throughout the report, where relevant. Their responses to the investigation more broadly, and details of the work being undertaken by the agents to improve their management of workers compensation claims, are detailed below.

Allianz

Thank you for providing us with the opportunity to respond to your draft report. Not only does it give us an opportunity to provide clarification on the points you raise on the specific cases managed by Allianz Australia Workers' Compensation (Victoria) Limited (Allianz), but also assists us to understand the broader concerns you raise about the workers compensation system. We have seriously considered the issues raised and the case studies detailed in your report.

Allianz does not support communications undertaken by employees which is [*sic*] in any way suggestive of a culture where injured workers and their entitlements are not managed with empathy and respect. We are cognisant of the emails quoted in your report which bring to light this concern and wish to assure you that Allianz has undertaken immediate action to reinforce our Code of Conduct. We remain dedicated to ensuring a professional and compassionate culture exists within our organisation.

In response to your draft report containing details of concerning language in emails, Allianz has escalated the matter to the highest levels by including the matter in its company risk register, which will ensure that relevant audit processes are undertaken and appropriate controls are enforced.

We are acutely aware that decisions that we, as agents, make every day have a monumental bearing on injured workers and their families during a time when they are often most vulnerable. It is precisely because of this that we take steps to ensure that the responsibility that attaches to each of our decisions to reduce entitlements never solely resides with a single member of our claims team. We note that the case studies relied upon illustrate that Allianz's internal process of evidence gathering and peer review, in addition to the use of external services such as the Accident Compensation Conciliation Service and Medical Panels, have operated to ensure the system delivers benefits and services to injured workers in Victoria who are duly entitled.

Workers compensation is a highly complex environment and we are always seeking to improve our claims management processes. There will undoubtedly be instances where claims might have been managed differently and perhaps even more effectively, but by and large our processes and decisions have been effective and appropriate.

Ensuring workers have access to the correct entitlements under the Act is a key focus for Allianz. We have sound structures and processes embedded in our claims management model, for example:

- Independent review and sign off to any decision which may have an adverse impact on an injured worker's entitlements to benefits
- Highly experienced specialist employees, including over 50 FTE who provide expert advice and oversight independent of the case manager role
- Comprehensive learning and development programs with a focus on quality decision making
- Extensive reporting to ensure timely decision making
- Independent oversight by a highly experienced internal compliance team.

WorkSafe and its agents have worked collaboratively to increase the focus on quality decision making. In 2015, WorkSafe introduced a new 130 week quality decision making measure. A sample of Allianz claims were reviewed by WorkSafe against qualitative criteria and we were very pleased with our result of over 96%, which was better than the WorkSafe benchmark. Additionally, in the 12 months to June 2016, we have seen improvements in our dispute management practices, with a 4% reduction in matters lodged for conciliation and internal pre-conciliation reviews resulting in 15% of matters listed for conciliation resolved prior to conference.

Another example of the quality of our adverse decision process is the excellent feedback given by workers in an independent survey conducted for WorkSafe, where a sample of workers were asked a series of questions about their experience in the adverse decision process. Allianz's average score on these questions was 95%, which is above the scheme result.

The report, insofar as it refers to Allianz, references complex claims resulting in adverse decisions and highly likely to be subject to complaints by workers so affected. The select seven claims managed by our employees over a five-year period should be seen in context of the 50,406 active claims, 6,727 terminations of weekly payments issued and most importantly, the successfully facilitated rehabilitation and return to work of 33,821 Victorian workers managed by Allianz.

CGU

... CGU Workers Compensation (Vic) Limited ("CGU") appreciates the opportunity to provide a response to the preliminary conclusions set out in the Draft Report.

As an agent of the workers' compensation scheme in Victoria, we work closely with WorkSafe to administer the scheme in accordance with legislation and standards and procedures set by WorkSafe ...

In the 2015/2016 financial year CGU registered 10,255 claims and manages around 15,000 active claims at any point in time. Further, CGU documented approximately 117,000 contacts with our stakeholders, including injured workers, employers and service providers. In the same period, CGU undertook 23,000 case reviews for the same period and received 8,000 independent medical reports ...

CGU acknowledges that there are always improvements to be made and we have continuously worked to address any concerns made by the Ombudsman, particularly around quality decision making.

In 2015, CGU introduced the role of the Eligibility Technical Specialist to support ongoing quality and sustainable decision making. This role reviews all adverse decisions before they are issued to the injured worker and they must then take on the accountability for that decision. This process is then used as a review point to identify capability gaps and customer service improvement opportunities. In addition to this, the Senior Legal Manager selectively reviews notices to injured workers and facilitates training on making sustainable and quality adverse decisions. This is also supplemented with education sessions for employers, where we use an external legal provider to assist in improving the understanding of employers around decision making on workers compensation claims.

The decisions that are made at the 130 week review point are also now subject to Adverse Decision Compliance Checks which check quality of decision making, the adverse decision process and service delivery. From July 2015, CGU implemented a further review point to include further review of the evidence and reasons supporting each ground relied upon when making an adverse decision.

CGU works to continually improve our management of claims as an Agent for WorkSafe. Our WorkSafe external audit for quality decision making shows an average of 95% accuracy, complying with applicable legislation and guidelines. Initial Eligibility Quality Decision Making was audited in November 2015 and again in May 2016, and the 130 week Quality Decisions was audited in February and again in March 2016.

Gallagher Bassett

I accept the majority of the case study findings and believe they warrant review of my operation.

...

I accept that the report has identified, in a small number of claims, claims management practices that need to be improved. The findings of those claims are helpful insofar as they confirm that the targets of our constant improvement initiatives are appropriate. These initiatives commenced last year, have been amended and augmented since then and additional fine tuning is planned in the immediate future:

- In July 2015, an independent review process was implemented on decisions impacting entitlement to weekly compensation after the expiration of the second entitlement period, initial eligibility and 52 week medical entitlement.
- In December 2015, a root and branch review was conducted into conciliation disputes (type and outcome), the process around medical and surgery requests, payment processes, staff training and capability, and the nature and number of complaints.
- The December review led to the launch of the “Service First” initiative in April 2016, resulting in a system of fast-tracking assessment and authorisation of requests for medical services; senior review and sign-off of material contribution, long-tail, initial eligibility and medical termination decisions; refinement of the processes around feedback from dispute resolution officers to claim teams; increased profile and activity in the ACCS/ WorkSafe working group; increased authorities to streamline payment of medical and allied accounts; implementation of “human element” training; and initiation of an employer service working group to better manage employer expectations and communications. This has resulted in significantly reduced ACCS disputes (down 19.79%) and complaints (reduced by 23.05%) and improvement in stakeholder satisfaction results.

- GB is creating a new senior role – Manager of Sound and Proper Decision Reviews, whose team will be responsible for reviewing all termination and rejection decisions. The team will be independent of the claims operation, [and] will report to the Senior Legal Manager. The team Manager will undertake all senior review requests made by workers.

QBE

... QBE appreciates the opportunity to review and provide feedback on the relevant parts of your initial report that relate to QBE. We are always very open to receiving feedback and improving our claims experience for our customers and claimants and are happy to consider the Ombudsman’s comments and observations in this context ...

QBE’s dedicated team worked hard to look after injured workers and provide care and support to those who were, in many cases, going through a challenging time. Our team were specially-trained and coached to put people first and be empathetic when handling claims. QBE had measures in place to ensure quality decision making, particularly in relation to complex claims. Qualified teams and specialists with allied health qualifications were available to assist the case managers in making decisions and managing complex claims ...

QBE took seriously its obligation as a scheme agent and had processes in place to ensure our people adhered not just to the guidelines as read, but the spirit in which they were intended. Case managers and assistant case managers were regularly and routinely reminded and trained in these protocols and processes. We are pleased that this was in fact highlighted by the Ombudsman in the report, with reference made to several internal QBE emails to our people as examples.

Xchanging

... We look forward to any recommendations which help us achieve socially and economically responsible outcomes.

In November 2014 and July 2015 your office referred two complaints to us [case studies 1 and 27] ...

At the time of the complaints you outlined the issues you would like to see addressed and the remedies you would like to see implemented. We provided a detailed response to you regarding the first complaint, and to WorkSafe regarding the second complaint for submission to you. In our responses we outlined the circumstances of each case and the improvements we had put in place since to ensure no recurrence. We believe the complaints and subsequent investigations have positively influenced our decision making processes since then and resulted in a more balanced and fairer approach to the application of the legislation.

We believe that both internal and external reviews add value to our learnings and help us refine practices. Improvement initiatives are often the result.

Injured workers and employers in Victoria rate Xchanging as the best service provider in the Scheme - a result driven in large part by our response to external feedback.

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