CAC's submission to the WorkSafe review of complex claims management by Peter Rozen QC

Background – Paul Serong

My company Counselling Appraisal Consultants Pty. Ltd. (CAC) has been an Occupational Rehabilitation Provider in the Victorian Workers Compensation system for 25 years.

Personal Background

Previous Roles:

- CEO – Catholic Church Insurances Ltd
- CEO – Xchanging/Cambridge, workers compensation claims services
- Current – CEO and Owner of Counselling Appraisal Consultants

I have had extensive experience managing a National Insurance company that was both a claims manager in the Victorian system and an insurance underwriter of workers compensation claims in NSW, SA, WA, NT, ACT and Tasmania. I then spent 5 years as CEO of Xchanging and its predecessor Cambridge, in the Victorian Agent claims system.

Since October 2012 I have been the CEO and owner of Counselling Appraisal Consultants an OR Provider in the Victorian WorkCover system.

WorkCover is a no-fault system. An injured worker becomes injured in the workplace and submits a claim with supportive documentation – primarily a WorkSafe certificate of capacity from their treating practitioner. Combined with paperwork supplied by the employer, the claim is submitted, for determination, to the employer's chosen WorkSafe insurance agent – Allianz, CGU, EML, Gallagher Bassett or Xchanging.

Employers pay an annual premium to the WorkSafe agents to manage the risk of workplace injury claims. The cost of claims –mainly treatment and time lost wage payments - will impact the premium amount to be paid over the following tail off 3-year period. Additionally, the WorkSafe agent is keen to maintain the business relationship with the large employer as a high net worth "customer."

Addressing the terms of reference

a) Whether the agent model is effective in delivering and achieving positive health and recovery outcomes, including prompt, effective and proactive treatment and management of injuries.

The outsourced agent model in administering workers compensation claims remains suitable. The alternative model of a large departmental structure (e.g. TAC) would not necessarily improve worker outcomes.

It is our belief that the current claims process - the incentive structures and personnel currently employed within the system – are key contributing factors to the unreasonable management of claims and are a causative factor in making them "complex".

Greater focus- within the current structure– on supporting recovery strategies early with properly qualified staff- (allied health trained and clinically experienced) would mean that injured workers are provided with seamless access to a structured injury management plan. It is protracted recovery and frustrations with the bureaucratic layers which are large contributors to claim complexity.

The ministerial review classifies complex claims as those claims progressing beyond 130 weeks.

It is our view that claim complexity arises- in many cases- well prior to the 130 week mark in the claim and that the underlying cause of the increased complexity can be prevented if identified early and appropriate rehabilitation support is provided.

We believe the **current model is a contributing factor to claims becoming complex** as-

- **Insurance agent case managers are inexperienced at managing injuries.** Case managers are generally young, without an allied health background (some without university degree) yet are expected to be integral to assisting workers with injury management.
- There is reduced capability within the agents - there are fewer allied health professionals employed by the agents.

  Any staff with an allied health background are usually without clinical injury management experience yet they are expected to advise injured workers and make decisions on treatment appropriateness

- Many agencies have replaced Injury Management Advisors (previously only allied health trained) with the Return to Work Specialists or mobile case managers (no allied health background- usually case managers who have been promoted to this role and with a firm return to work – not recovery-focus)

Identifying complex claims or potentially complex claims early will allow them to be properly addressed so delivering an optimal outcome for the injured worker – recovery and return to preinjury lifestyle which includes work.

There are 3 key reasons cases become complex for both physical and psychological injuries-

1. The original injury was significant with extended recovery time – eg requiring urgent medical treatment/hospitalisation
2. The injury has not been managed in a way which has allowed for timely recovery and/or there are additional compensable overlays which have contributed to a **secondary psychological injury** (often referred to WorkSafe and the agents as 2MI)
3. There are age and/or performance management/HR overlays

b) Whether the case management processes and practices for complex claims reflect best practice and provide tailored treatment and support based on biopsychosocial factors, individual circumstances and medical advice

These factors contribute to claim complexity and secondary psychological injury and are exacerbated by the current claims management process-

- **Significant trauma**- eg construction or other major trauma incident – where WorkSafe is called out and hospitalisation has been required.

- **High degree of psychological trauma** associated with the injury event- eg occupational violence where there is a physical and psychological injury possibly concurrent with Human Resource overlays as particular processes have or have not been followed to cause the incident. The extent of the psychological injury is not recognised nor managed by the claims agent particularly well if the main presenting injury was physical. For example – a violent child in a school injures a teacher often the physical is misdiagnosed as the major injury whereas the psychological trauma often becomes the barrier to return to work. This has application also with Victoria Police, Prisons System and Health Care where occupational violence often occurs.

- **Poor treatment planning and coordination.** Workers who initially accessed treatment through the public hospital system and are not assisted to source treatment privately so that consistent care with a chosen practitioner can be provided.

  Workers do not have assumed knowledge of the medical system – simple advice e.g. that the orthopaedic surgeon will require an MRI of the injury prior to making a diagnosis (worker to have this arranged prior to the appointment so they are not sent off from the initial appointment with a further 6 week wait for review and, hence, delay in recovery)

- **Poor treatment efficacy** – treating practitioners continue to administer ineffective treatment without proper oversight

- **Protracted agent approval** of standard investigation and treatment for a given injury.

  For example-a 50yo+ truck driver who suffered an open and comminuted forearm fracture through equipment failure. The fracture was surgically internally fixed but failed to unite. The worker required repeat surgery-possibly with a bone graft to facilitate bony union however this was not facilitated by the agent for over 12 months. During this time, the worker experienced significant pain, dysfunction, disconnection with his preinjury lifestyle including work and a strained personal relationship. No sense of urgency.

Currently the agents use the opinion of Independent Medical Examiners to determine surgery approval. Workers do report being briefly assessed and questioned for that decision to be made which may sit in contrast to repeat visits to a specialist supported by their own treating GP.

There are certainly examples of surgery requested where evidence indicates mixed long-term outcomes – it is not necessarily the rejection of the procedure but the protracted process and time delays for any decision at all. If the approval is not granted, workers are seldom provided with a clear rationale/reason which needs to be evidence based.
Protracted decisions surrounding recommended surgery can have the potential to result in poor surgical outcomes as associated soft tissue structures flexibility diminish over time.

- **Rejection of treatment requests for injured areas not considered part of the original claim** which are associated with the mechanism of injury.
  For example, a teacher in a special education setting experiencing a traction injury to her arm through interaction with an oppositional student who dropped to the ground while holding the staff member's arm. The accepted injury was for the shoulder with evident associated trauma to the neck through the injury mechanism. Shoulder treatment only was accepted as part of the claim with the worker needing to go through a conciliation process to access appropriate treatment for the neck injury.

  This may also include a failure to address associated comorbidities as part of the claim- e.g. pre-existing/underlying psychological/psychiatric conditions which have become exacerbated through the injury experience

- **Repeated explanation of the injury circumstance-** in the case of psychological injury- by the injured worker has the potential to cause symptom exacerbation on each occasion through revisiting the traumatic event – not facilitated by a psychologist.

- **High levels of pain associated with poor pain management and patient education**- this may include inappropriate or long-term use of addictive pain medication.
  Current pain management programmes appear to have low efficacy, are expensive and frequently do not result in an improved outcome for the injured worker in terms of both the pain experience and return to work.

- **Poor employer relationship and communication –** either no contact from the employer or persistent contact/pressure to respond or no contact from immediate supervisor/colleagues as though nothing has happened

- **Financial stress –** employers can be slow to pay wages as they are due. Workers submit certificate of capacity for each period of incapacity for pre-injury employment to the employer, who pays them as advised by the claims agent. There can be delays as part of this process causing ensuing financial insecurity for the worker.

Other biopsychosocial factors

- **Extended period out of the workforce** even without a compensable injury has adverse mental health impacts due to -
    - Lack of routine
    - No sense of achievement
    - Reduced or no meaningful social interaction
    - Reduced control over finances
    - Reduced opportunity for personal growth
    - Increased pressure on home life dynamics

- **Breakdown in personal and social relationships** due to changed family and social dynamics

- **Loss of control** – instructions are provided, and choice rarely given within the current structure

- **Low socio-economic status or English as a second language**- reduced ability to self- advocate to access suitable treatment as well as manage administration tasks associated with the claim

- **Poor social supports – pre-existing but not always acknowledged by agents as potential barrier to accessing treatment and providing documentation**

- **Claims process** –
    - Poor explanation of administrative requirements to the injured worker – using terminology which is confusing and unfamiliar to the injured worker
    - requested treatment intervention requires prior approval which causes unnecessary delay
    - Certificates of capacity required for payment of wage entitlements. This is a reasonable expectation however there are examples where agents have been unreasonable in assessing whether to accept certificates as being valid. For example, a treating health practitioner failing to complete a small section on the certificate would make it invalid when reviewed by the insurance agent so that the injured worker may not be entitled to receive wages in that payment period. An injured worker undergoing surgery needs to be advised to request the treating surgeon completes a certificate of incapacity so that they will continue to receive wages throughout the recovery period- visiting their GP is not possible due to mobility limitations during the post-operative recovery phase.

- **Claims process which focuses solely on return to work to the original employer as the primary goal** in the first 52 weeks of the claim. This occurs even when it is highly unlikely - as advised by treating practitioners- due to the extent and nature of the injury matched against the demands of the preinjury that sustainable return to pre-injury work will not occur.

c) Whether policy, oversight and governance arrangements, including financial and performance incentives support and promote best practice, timely, sustainable and quality decision making by agents

- Within the current agent model of claims management there is a **conflict between approving recommended treatments and minimising medical and like expenditure on the claim**. In the past agents were paid an incentive to minimise medical costs. This has the potential to lead to indecision or rejection of valid treatment requests, so the agent can earn an incentive.

- As mentioned above, **approvals for standard treatment interventions can be protracted** and injured workers can be forced to go to conciliation to have co- located body parts accepted as part of the claim so that treatment can be accessed (eg neck and shoulder, foot and ankle) Delays for these reasons can be lengthy and require the worker to repeatedly engage with an agent unwilling to listen to health information provided- presenting resistance at every turn.

- There is an **erroneous payments** process between the WorkSafe agents and WorkSafe. Agents who pay for services not within the tight guidelines of WorkSafe and this is discovered during an audit will be requested to repay these amounts. This can be a considerable sum. This process hinders decision making in the best interests of the worker and prevents real barriers to injury recovery and return to work from being addressed. Eg this may include standard treatments or simple equipment requests which would address return to work barriers (eg work boots)

- **Occupational Rehabilitation Providers (ORP) are measured by WorkSafe against benchmarks**. One of the benchmarks is known as Outcomes it measures sustainable return to **full time duties** for at least 3 months with the existing employer. If the ORP does not believe this can occur due the extend of the injury, they will not commence assisting the injured worker as it will affect their Benchmark measure and may jeopardise their retention on the WorkSafe OR Panel. This means that some injured workers do not receive Occupational Rehabilitation support when they should have because the WorkSafe target inhibits effective injury management. The seriously injured workers, with lower chance of successful return to work with their original employer, get less assistance as they will adversely impact statistical outcomes.

- Prompt, effective treatment coordination ideally to be provided by a clinically experienced allied health professional having a full understanding of the biopsychosocial impacts of injury and within the scope of occupational rehabilitation – where this level of expertise already lies.

The new Heads of Workers' Compensation Authorities Principles of Practice for Workplace Rehabilitation Providers September 2019 (attached), clearly states under

- **Principle one**
  - *Adopt a biopsychosocial approach to build capacity through work participation occupational rehabilitation consultants should*
  - *11. Provide independent evidence-based advice on the most effective pathway to recovery.*
  - (includes engagement with treating practitioners for improved coordination and implementation of treatment)
- **Principle two**
  - *Empower the worker and employer to achieve the goals of return to work*
  - *To empower the worker and employer to achieve goals, Workplace Rehabilitation Providers:*
  - 1. Support and motivate the worker and employer to be actively involved in the development of the program.
  - 2. Establish that the worker has an awareness and understanding of the treating practitioner's recovery expectations relevant to their injury or condition.
  - 3. Develop SMART goals (specific, measurable, achievable, relevant and timed) in collaboration with the worker.
  - 4. Consider the value of health literacy as a motivating tool for the worker and employer, including the health benefits of good work to aid recovery, reasonable adjustments to work, team support and the critical importance of making suitable work available.

- **Principle three**
  - *Deliver outcome driven workplace-based services*
  - *To identify tailored goals and support cost effective goal achievement, Workplace Rehabilitation Providers ensure that:*
  - 2. Treating providers are engaged early to establish how work could be used as therapy and how work activities can support and reinforce the treatment plan.

- The skills required to deliver this level of service are found within **Allied Health trained Occupational Rehabilitation consultants** (Occupational therapists, Physiotherapists, Psychologists and others) who can provide complete injury management with a biopsychosocial approach
  - Currently there is a sole focus on return to work to the original employer (OES) Within the 52-week employer obligation period despite evidence that return to preinjury work is highly unlikely to occur and to be sustainable
  - Early assessment of likely injury outcome matched against preinjury employment demands so that the injured worker can remain engaged with suitable retraining and sourcing of new employment (NES) as soon as this has been established as the ideal course of action.
  - Understanding of the bio psychosocial impacts of injury so that this is addressed throughout the course of the claim

d) Any other matters that the Reviewer deems necessary, including any potential system wide implications

Large employers who have high premium accounts with an agent have been known to unduly influence the claims process-

- at the determination phase by advising the agent to reject the claim from the outset or make the hurdles for claim acceptance unreasonable
- during return to work efforts when pressure is applied for workers to return to work prematurely or progress faster than recovery allows
- encouraging agents to review and terminate the claim

These influences are made to minimize the premium payable on the insurance coverage.

As a result of the above factors contributing to claim complexity, complicating bio psychosocial risk factors become evident at any point of a claim- frequently well before 130 weeks.

Poor injury recovery linked with complicated claims management processes, creates a situation where symptoms become chronic, unhelpful thoughts and emotions prevail and a breakdown in personal and social relationships eventuates.

The injured worker may present as having difficulty with managing their life daily.

- Poor injury progress
- No return to work in what would be reasonable time frames for the injury to recover
- Poor personal hygiene and physical presentation
- Limited or no socialisation
- Low activity levels
- Poor sleep patterns
- Symptom and/or claim focused

The underlying reasons for poor progress become largely biopsychosocial usually with injustice, fear of exacerbating symptoms, catastrophising linked to established disability beliefs.

WorkSafe and the agents are beginning to identify complex claims where there is noted secondary psychological injury either linked to a primary physical or primary psychological claim.

It is referenced as “2MI” – another acronym.

It may be identified through document scanning which detects key words linked to mental injury or via a request for psychology services or prescriptions for psychotropic medications.

Usually, by the time the “system” has identified the issue, the problems associated with the increased complexity of the claim are well established.

There are only a few agents prepared to use evidence-based programmes to address secondary psychological injury once it has been identified. These may include providing exercise physiology as a means to increase daily life engagement or the **Progressive Goal Attainment Programme.**

Injured Workers are entitled to Occupational Rehabilitation

Section 230 of the Accident Compensation Act 2013 outlines the entitlement of Occupational Rehabilitation for injured workers.

- The accident compensation act 2013 section 230 States that –
- *(1) A worker is entitled to receive occupational rehabilitation services referred to in this Division-*

  (a) from a provider of an occupational rehabilitation service chosen by the worker from a list of at least 3 approved providers given to the worker by the Authority, employer or self-insurer, having regard, as far as possible to—

  (i) *the type of injury the worker has suffered; and*

  (ii) *the type of occupational rehabilitation service required; and*

  (iii) *where the worker resides; and*

  (iv) *where the provider is requested by the Authority, self-insurer or employer to provide the services; or*

Injured Workers are not offered Occupational Rehabilitation services as a normal methodology of managing a claim.

Most if not all injured workers do not know they are entitled to Occupational Rehabilitation services as part of their claim.

It is the agent's decision to appoint an OR provider if they believe Occupational Rehabilitation will assist with a return to work.

The use of OR services increased in 2016/17 when WorkSafe introduced a return to work target at 26 weeks known as Better @ Work for agents to achieve at 26 weeks mark of a claim. In June 2018 the return to work rate at 26 weeks in the WorkSafe scheme was 77.74%.

In October 2018 the Scheme Actuaries advised WorkSafe that provisions needed to be increased for OR costs for future years as OR costs had increased over the previous 18 months.

In October 2018 agents were advised by WorkSafe to reduce the OR referrals to control the spend on Occupational Rehabilitation, even though the return to work rate at 6 months was at an all time high.

Subsequently the return to work rate at the 26-week mark as at 30 June 2020 had reduced to 68.76%. This is a significant reduction of return to work, meaning more people are staying on the Scheme for a longer period and their claims are becoming more complex.

The Actuaries value the Scheme liabilities twice per year, at the 31 December and 30 June, at the 31 December 2019 the Actuaries increased the future weekly payments by $1.149B.

I would expect the 30 June valuation to increase even further.

The reduction of the use of Occupational Rehabilitation has resulted in many injured workers not returning to work and thus increasing the weekly benefits costs into the future.

New Employer Services

Should an injured worker not be able to return to their existing employer because of their injury then the agents can offer them an OR service known as New Employer Services (NES).

This service assists them in job seeking, interview training, CV preparation and identifies suitable roles given any limitations.

I have asked WorkSafe on three occasions to advise me how many workers are terminated in a 12 month period at 130 weeks without being offered NES services, They are not prepared to advise me how many exist, I can only assume that they are in the hundreds .I estimate in excess of 500. OR Providers normally assist at least 25-28% of these worker obtain another job, effective use of NES would result in at least 125 injured workers back to the workforce each year but they are not being offer these services do to the mismanagement of their claim.

Survey of Long-Term Injured Workers

I was part of a committee that reviewed the effects of being on workers compensation for a long term. The committee commissioned a study by the Institute for Safety, Compensation and Recovery Research (ISCRR) part of Monash University a copy of the final research report is attached for your information.

It is estimated that more than 500 workers are terminated each year form the Victorian WorkSafe scheme and have not returned to work most end up on CentreLink benefits.

Complex Claims post 130 Weeks

There are a large cohort of claims that pass the 130-week second entitlement test and stay on the Scheme some for many years, others forever.

A lot of these claims have biopsychosocial barriers that have never been addressed. Some have been on the WorkSafe system for quite some time and they are disconnected from the community and live an abnormal life.

These workers need a specially developed program to reconnect them into the community with the use of a PGAP style program and an assimilation approach, this may take 12-18 months and will be expensive to execute.

The Occupational Rehabilitation industry has had discussions with WorkSafe on this topic but there does not seem any appetite at WorkSafe to invest in these workers, other than for them to remain on the Scheme.

Recommendation

It is CAC's recommendation that skilled, experienced allied health trained, and clinically experienced Occupational Rehabilitation consultants become the **injury management specialists** for claims identified as the potential to become complex.

Occupational Rehabilitation consultants can-

- Assist the worker to receive appropriate, timely and well-coordinated treatment
  Where there are requests for procedures, these can be assessed as reasonable and safe for the claimant to undertake through the sourcing of a second opinion rather than waiting weeks or months for Independent Medical Examination approval.
- Recognise and manage biopsychosocial issues if/when they arise
- Assist with any claims process issues
- Support the worker and employer relationship concurrently
- Plan and implement suitable return to work whether to the original or to a new employer

Plan

The whole system needs review and overhaul-

- tighter oversight of agents by WorkSafe and a reconsideration of Annual Performance Adjustment (APA) and financial incentives linked to outcomes so that agent behaviours linked to positive outcomes for injured workers are driven. Agents should not be rewarded for terminating claims
- a triage tool to identify complex claims or potentially complex claims needs to be developed for universal use across the agents and mandated to be used. OR providers should be used to develop such a tool.
- Complex or potentially complex claims need to be identified within a few weeks of injury-earlier the better – knowing that claims may become complex over time – a continual or repeated application of the triage tool needs to occur to accurately identify these claims.
- Complex claims need early referral to occupational rehabilitation primarily aimed initially at assisting with accessing suitable treatment under the WorkSafe guidelines and other support services to which the workers are eligible- eg home help. Early occupational rehabilitation will also form a strong link between the injured worker and the employer so that future communications and return to work become more streamlined.

Claims agents to manage non- complex and non-contentious claims only.

Significant trauma- eg construction or other major trauma incident – where WorkSafe is called out and/or hospitalisation has been required should be considered as potentially complex from the outset and should be referred immediately (pre claim submission) to an Occupational Rehabilitation consultant for injury management support if this is agreed with the worker.

- Claims identified as complex – where the system has failed to prevent this occurring- need specialised programmes to address the underlying biopsychosocial factors inhibiting progress.
  - PGAP –Progressive Goal Attainment Programme- is an evidence- based intervention specifically targeting the known inhibitors to recovery –
    - A sense of injustice linked to frustration, loss of lifestyle due to the injury and continually managing the claims process
    - Fear of symptom exacerbation due to poor pain education and management
    - Catastrophising thoughts
    - Unhelpful disability beliefs

- CAC has been working with agents and WorkSafe to promote PGAP as an intervention in those cases where biopsychosocial overlays predominate. Some agents have been open to the programme – others are resistant to new ideas – sometimes out of a miscalculation of the cost/benefit.
- PGAP has return to work and return to pre- injury lifestyle as its prime goal and desired outcome.
- An example of its efficacy is a worker who had experienced systematic bullying in an office environment.

JB had been bullied in an unhealthy workplace over many years. She was not expected to return to work at all, given her age, transferable skills and injury impact. JB was unable to manage her own self- care – not washing regularly and taking no heed to her personal appearance. She was socially withdrawn and had no structure to her day- spending hours in front of the television. Through the PGAP programme JB was encouraged to take control of her own life, set small, achievable goals and has moved on to undertake retraining in a new area of work , securing a new role and remaining in that role today – more than a year later.

Currently a positive claim outcome as far as reducing insurer liability is concerned can be achieved in two ways. There are incentives paid to finalise a claim prior to 130 weeks and achieving this in either of these ways receives the same incentive reward.

1. An injured Worker receives appropriate treatment has a full recovery and returns to either preinjury work or suitable work with a new employer which matches their long-term capacity so that they no longer require wage compensation

2. A worker's claim is terminated.

Agents actively work to terminate claims to minimise the liabilities sometimes with the encouragement of employers hoping to control their tail off insurance premium linked to that claim.
Claims are terminated upon Independent Medical Examination and Vocational Assessment that the worker has the capacity to work in relation to their compensable injury.
Workers can challenge this decision through a conciliation process which may lead to their claim being reopened or the termination being upheld. Further challenge of this decision requires the worker to commence legal proceedings.

Workers with low educational level, English as a second language or other complicating bio psychosocial factors are less likely to challenge termination decisions.

Claims agents need to be provided with an incentive for sustainable return to work and not be rewarded for terminations.

Summary

It is CAC's belief that through an outsourced **injury management model**, properly supporting the worker through their recovery journey that many more workers would successfully return to meaningful employment, whether with their pre-injury employer or a new employer- should return to work to pre- injury work not be medically possible.

Having allied health trained and experienced Occupational Rehabilitation consultants manage the injury recovery aspect of the claim will substantially minimise the number of claims classified as complex due to the prevention and management of secondary psychological injury.

In so doing more injured workers would be able to benefit from the well-known health benefits associated with meaningful work. Initially OR costs would rise, but cases would become less complex and more workers would return to work earlier this would reduce the impact on the scheme liabilities. Should a claim extend beyond 6 months the claim estimate increases to at least $350,000 this is the cause of the scheme liabilities increasing by $1.140B at the 31 December 2019.

The injury management model will result in WorkSafe scheme liabilities being reduced over time and the scheme's financial viability being robust.

P.A. Serong

7 September 2020