Workers compensation inquiry
Submission No. 65

INQUIRY INTO ASPECTS OF AUSTRALIAN WORKERS COMPENSATION SCHEMES

VACC SUBMISSION TO THE HOUSE OF REPRESENTATIVES

EMPLOYMENT WORKPLACE RELATIONS COMMITTEE

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SUMMARY

VACC is an employer organisation that represents some 4500 members in Victoria and Tasmania for the automotive repair, services and retail industry. As an employer organisation, VACC has particular interest in the current workers compensation schemes, especially the ease in which some employees can participate in fraudulent conduct.

VACC believe that there are several standard incidents of fraudulent conduct, which are supported with case studies. In addition, there are contributing structural factors that may encourage fraudulent behaviour, such as those provided by medical and legal practitioners, rehabilitation providers and insurers. The "too easy" claims process is also a significant factor that may generate fraudulent behaviour with some employees. Case studies have been provided to support our arguments in the body of the submission. These case studies have been obtained from colleagues who have dealt with these particular situations.

The current workers compensation system in Victoria needs to address some serious issues that should result in a fairer system for employers. Currently employers in Victoria lack control and input, which is exacerbated by the mismanagement of claims by Insurers. Employers are often disadvantaged by either employee fraudulent claims or by increased premiums as a result of the industry classification they come under. By addressing some of the inadequate structural factors in the workers compensation scheme, a more adequate system of workers compensation should result.

The automotive industry is classified in Victoria under the Transport and Storage Industry. This classification is high in occupational injuries, therefore high premiums are applied and many employers in the automotive industry are disadvantaged just by simply having to fall into this classification program. The limited classification programs therefore create a number of problems for employers across many industries.

TERMS OF REFERENCE 1.

THE INCIDENCE AND COSTS OF FRAUDULENT CLAIMS AND FRAUDULENT CONDUCT BY EMPLOYEES AND EMPLOYERS AND ANY STRUCTURAL FACTORS THAT MAY ENCOURAGE SUCH BEHAVIOUR

Incidents of employee fraudulent conduct

The current workers compensation system in Victoria reflects the policy that an employee has a right to make a worker's compensation claim for any workplace injury or illness. The process involves obtaining medical certification and lodgement of documentation including the certificate with the employer. Once a claim is submitted, employers through their insurers are obliged to disprove the relationship or accept the claim. In challenging a claim, the cost and any other action required to disprove the claim rests with the employer. The direct and indirect costs associated with mounting a challenge are generally prohibitive for minor claims. In addition, the employer bears a cost through increased premiums.

There are a number of ways in which employees may take advantage of the system.

- Employee makes a claim where there is no injury or illness that exists.
- Workers compensation claims are made and accepted too easily.
- Employee makes a claim for an injury that is not work related.
- An injury or illness is exaggerated or embellished in order to continue to receive compensation payments.
- Employee does not inform the insurer of a second job while receiving compensation.

Structural factors that may encourage such conduct

In addition to these factors, there are many links in the chain that may contribute towards employee's fraudulent claims behaviour. There are so many steps involved in the process of returning the employee to their pre- injury duties, that without strict monitoring, employees' fraudulent behaviour may be overlooked.

Medical Practitioners

Medical Practitioners (MPs) do not necessarily have an understanding of an employee's workplace, nor the capacity in which the injury occurred. (MPs) can and often do make a medical assessment of the injury without the (MPs) being required to investigate for further information, speak to the employer or other workers who may offer a significant contribution to the factors that caused the injury.

In many cases (MPs) are reluctant to attend the workplace, even though an employer may invite the (MP) to attend, quite often simply due to doctor patient confidentiality. Therefore the (MP) relies solely on the word of the injured worker. The objective of (MPs) is to meet patient's needs therefore they accept the untested version of events as told to them by the patient. (MPs) appear reluctant to verify the accuracy of claims made by an employee.

Case one

The worker underwent a stapling of the stomach to reduce her weight sometime in 2001. The company where she was employed operated from a small regional site at which this employee worked with her husband. By mid 2001 the company evaluated the ongoing cost of operation of this site. Due to significant falls in LPG sales, it was decided that the site was not economically feasible. The Managing Director at that stage did not want to close the site, but wanted to see whether sales would improve in the second half of the year.

In early December, both employees were told that the company had no choice but to close the business due to falling sales, but would remain open until Christmas. The two employees were informed of the severance payment they would receive, at which both were quite pleased. At this meeting the employee said she had injured her knee. A WorkCover claim was filed the week before the business closed, alleging that the injury occurred in 1993, whilst she was employed by the previous owner of the company.

The company disputed liability. Initially the insurer did not accept liability on the basis that notice of injury was not given to the employer. In response the worker filed an appeal. In January 2002, a conciliation conference was held, but the employer was advised that they were not required to attend. The solicitor for the worker filed information of which the employer was never given any detail.

The claim was subsequently accepted. Through persisting with the insurer and conducting a further investigation of the incident, VACC found out that the worker alleged that she was required to lift 30 cylinders per day weighing 200kg each in the course of her work. She also alleged that she had advised her employer of the injury and that she thought it would be detrimental to her employment if she filed a WorkCover claim at the time of injury or whilst undertaking treatment.

The employer denies any knowledge of alleged treatment and previous owner denies any knowledge of injury. Evidence of sales disprove the allegation of 30 cylinders, in fact it was the job of the husband or delivery driver to unload the few deliveries- her job was primarily in the office. The employer was not given any opportunity to view the allegations or provide a response.

The company believes she may have arthritis, but it was more likely due to the weight she carried for many years (3-4 times her current weight), however, this information was never considered by the doctor who issued the certificate.

Recommendations

1) Medical Practitioners should be more proactive prior to making their initial medical assessment of an injured worker. Medical practitioners should be required to visit the workplace to observe work processes, converse with the employer and any other workers who may have witnessed the incident.

2) The Medical Practitioner should be required to complete a thorough investigation of the incident prior to a medical assessment being made. The Medical Practitioner should be required to complete a specially designed checklist that asks appropriate questions of the injured person. This checklist could then be attached to the medical certificate before the claim will be acknowledged and or accepted. This would require the MP to undertake a thorough assessment of the events surrounding the injury and assist with diagnosis.

3) Injured workers should be required to attend only Occupational Physicians who are specially trained in dealing with work related injuries.

Insurers & the Claims Process

The ease at which employees can make a workers compensation claim is also a contributing factor for employee fraudulent claims. There is a high degree of difficulty in disputing a claim as the onus to challenge a claim, rests entirely with the employer. The process is also too easy for employees to submit a claim. In addition to this, if a claim is denied, that was proven to be fraudulent, there are no ramifications or penalties for the employee. This does not discourage potentially fraudulent claims.

Quite often it is the simple inaction of the insurer that contributes to fraudulent claims. This may be due to the volume of claims that claims managers are required to handle. A lack of monitoring and continuity of the claims managers handling each case, may result in a claim being accepted by an Insurer. Also with the insurers, a degree of apathy exists. The simple act of not following up a claim, has resulted in claims that have been accepted because the employers request to dispute liability was not followed up.

Case 1

Before starting work the employee had a coffee with all staff within the small business. This was part of the daily routine. On one particular day, the employee does not have a coffee, but commences work on his own. He alleges he suffered a strain at about 9.30am, when there were 3 other employees on duty. No one witnessed the alleged incident, but he says that one person did.

Rather than going to the doctor the employee went to a chiropractor and insisted that his employer pay the chiropractic bills. The employer paid the bills at first. After some months when the worker submitted a WorkCover claim form, the employer explained that he required a medical certificate from the worker

The worker is issued a medical certificate without the doctor making the initial assessment. The doctor then recommends physio and some modified duties. The worker however continued with the chiropractor.

Case 2

A worker was employed as a short - term motor mechanic for two (2) periods of three (3) months, and ceased final employment in March 2001. The worker was not required to lift heavy weights in this position. The worker openly conducts his own business as a "mechanical backyarder" as well as working in a band. The worker revealed to a witness that his band work required him to lift heavy amplifiers and speakers for setting up.

In May 2001, the worker submitted a claim to his employer for a neck and back injury although he had not made an entry in the Register of Injuries book or reported an incident to his employer. The claim was forwarded to the insurer and an investigation process commenced. Subsequently the employer was advised by the insurer that the claim had been rejected.

There were a number of claims officers handling this particular case. The rejection of the claim had not been recorded properly and the matter sat dormant until twelve (12) months later when the employer received a request for conciliation because the employee had not received any money. Without consulting the employer, the claims officer accepted the claim of the employee seeking ongoing medical expenses and weekly payments.

Case 3

An employee was injured at work and unable to undertake pre injury duties. Liability was accepted by the insurer and the employee received ongoing treatment by the chiropractor for the injury. The injured employee left the company and the previous employer identified the fact that the employee was working at another workplace undertaking his pre- injury duties. The initial employer was required to pay for ongoing treatment. After contact with the claims officer, the employer was told that they were " behind with files". There was no assistance by the insurer with regards to further investigation into the conduct of the injured worker.

Recommendations

1) The claims process for employees needs to be thoroughly regulated to prevent claims being accepted too easily.

2) The disputation process should not involve an employer bearing the onus to disprove a claim. This would make it an easier process for employers to challenge fraudulent claims.

3) Penalties, such as demerit points to reduce future compensation claims and subsequent payments, could be given to employees who lodge a claim of a fraudulent nature, that was successfully disputed by the employer.

4) Insurers need to provide a consistent, reliable and accountable service when handling claims. This will facilitate with early return to work, therefore a reduction in costs for employers.

Rehabilitation Providers
The services of Rehabilitation Providers are an essential component in the "return to work" process. However, the present system allows for over-servicing by means of inadequate monitoring and review periods, where currently rehabilitation providers are not required to be accountable for the services they provide in assisting the injured worker in returning to work. In addition, an injured worker may be reluctant to be rehabilitated to a point where they can reduce or cease treatment because they are not financially disadvantaged to motivate an active return to work.

Recommendations

1) Billing hours for rehabilitation services should be actively monitored.
2) Current financial incentives that impede the return to work process should be reviewed.
3) Regular file reviews should occur where there are unsatisfactory delays in an early return to work
4) Rehabilitation Providers should be changed after 13 weeks if a return to work is not achieved.

Legal Practitioners
Another contributing factor towards fraudulent claims by employees is the powerful role legal practitioners play, particularly that of advocate of an injured worker. A strong medium that legal practitioners use is advertising their services to entice injured employees to obtain compensation lump sums, which seems to be increasing of late. This activity promotes a "what is in it for me" attitude as opposed to the active co-operation by the employee to return to work. The advertising services of the legal practitioner require regulating.

Case 1
A person is employed as a panel beater over a number of years for different employers. During this time no hearing protection was worn or wearing of hearing protection enforced. The person requires a hearing aid due to hearing loss and notices an advertisement in the paper stating that the company running the advertisement will be able to assist with making a claim for compensation for work related hearing loss. Person visits the company and has a hearing examination where it is identified that his hearing loss may be due to the work environment, however the question remained which employer would he sue? With legal assistance the person sued the employer that he was last employed with and received not only a hearing aid but also $8,000 in workers compensation.

Recommendations

1) The role and services provided by legal practitioners in Workers Compensation claims should be regulated with the scope of their involvement.

TERMS OF REFERENCE 2.

THE METHODS USED AND COSTS INCURRED BY WORKERS COMPENSATION SCHEMES TO DETECT AND ELIMINATE:

A) FRAUDULENT CLAIMS AND

B) THE FAILURE OF EMPLOYERS TO PAY THE REQUIRED WORKERS COMPENSATION PREMIUMS OR OTHERWISE FAIL TO COMPLY WITH THEIR OBLIGATIONS

VACC is concerned that nationally there are fraudulent claims but consider these claims to be symptomatic of a scheme whose structural arrangements have contributed to the incidence of fraud and level of non compliance, rather than a failure on the behalf of employers to pay the required workers compensation premiums or otherwise to fail to comply with their legal obligations.

In an attempt to address these structural difficulties, the Victorian State Government commenced in 2002 to implement an improved claims management system and a simpler and fairer premium system. Major reforms include a new panel of Agents, a performance based system for Agents, better treatment and return to work and hence anticipated lower costs for Victorian businesses. However Rehabilitation and Return to Work obligations remain complex and diverse.

Employer conduct

As an employer association, a focus of VACC resides with reducing questionable employee conduct. VACC argue that Insurer inaction contributes to fraudulent claims. In addition to this inaction, the complex nature of the legislative framework, is a major contributing factor to the failure of employers to meet their legislative obligations under the Accident Compensation Act 1985. Failure to comply with obligations on the part of employers is a result of the complexities of an ineffective workers compensation scheme.

Recommendations

1) Simpler Rehabilitation and Return to Work obligations be implemented.

2) The complex legislation and insurer inaction are re-examined with a view to simplifying the obligations employers have to meet.

TERMS OF REFERENCE 3.

FACTORS THAT LEAD TO DIFFERENT SAFETY RECORDS AND CLAIMS PROFILES FROM INDUSTRY TO INDUSTRY AND THE ADEQUACY, APPROPRIATENESS AND PRACTIBILITY OF REHABILITATION PROGRAMS AND THEIR BENEFITS.

Safety records and claims profiles

The Victorian WorkCover Authority reported that there were 70 claims per annum in the tyre fitting industry and 175 claims per annum in automotive workshops. Poor performing industries such as Automotive are increasingly coming under the spotlight of the Victorian WorkCover Authority, under its Transport and Storage Industry Program. The aim of this program is to reduce the number of claims by consulting with industry stakeholders and developing appropriate guidance materials. In addition the National Occupational Health and Safety Strategy requires the commitment of each State jurisdiction and peak employer and employee bodies to meet national targets to reduce fatalities, injury and disease in the workplace.

However it is difficult to demonstrate the cost benefits associated with the implementation of safety management systems to small employers, who not only find health and safety difficult to resource because of the cost burden, but also difficult to identify alternative duties, due to the nature of automotive work. Prevention activities are therefore not a major priority for small business or the automotive group as an industry. Employers who operate in different states are also required to comply with the requirements of the different jurisdictions with regard to both Workers Compensation and Occupational Health and Safety. These employers struggle in their efforts to comply with the complex legislation.

Rehabilitation

More often than not an early return to work is influenced by the ability of the employer to provide suitable and meaningful employment, however in many instances it is difficult to identify alternative duties in the automotive industry that are meaningful and suitable. For example a mechanic sweeping the floor, or administration duties where there may be literacy and numeracy problems.

In addition employers do not have any legislative power to consult and participate in medical interventions, although the current system requires the active participation of the employer, many medical practitioners operate at an arms length from the employer and hamper an employer's participation.

Return to work may also be influenced by the willingness or unwillingness of the employee, due in large to current benefit structures that discourage an early return to work. Difficulties may also be experienced where the injured worker has English as a second language.

CONCLUSION

In concluding, there are a number of structural issues that need to be addressed in order for a fairer workers compensation system to exist, particularly the involvement of treating medical practitioners, legal practitioners, rehabilitation providers, Insurers and the claims management process. Tighter regulations for service providers and a thorough and systematic approach needs to be adhered to, with a goal to eliminating fraudulent employee conduct.

VACC recommend that there be simpler rehabilitation and return to work obligations implemented along with closer re-examination of the complex legislation with a view to simplify the obligations employers must meet.

As the case studies provided in the VACC submission identify there are several incidents of employee fraudulent conduct due mainly to a system that supports this behaviour. By addressing the inadequacies in the structural factors of the current workers compensation system, a more adequate and fairer system may result.

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