Comcare AUSTRALIA

Deterring Reconsiderations

An analysis of disputed claims in COMCARE

A report prepared for

COMCARE

by

Transformation Management Services
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Terms of Reference

Comcare contracted Transformation Management Services to undertake an analysis of a representative sample of reviewed files for the year 1995/96. The project was to deliver:

- An analysis of case management processes that will identify opportunities to reduce costs and delays and/or redirect resources.
- A cumulative cost curve giving costs at each stage, and identifying the components of the system where contributing to cost.
- A chart showing anomalies in contributions from different agencies.
- Statistical requirements for future dispute monitoring.
- Recommendations based on best practice to identify a range of possible actions that would deliver both immediate and longer term impacts on the number of cases in progress.
- A series of example disputed claim profiles contrasted against a best practice model.

Background

In 1995, Transformation Management Services completed a comprehensive international and Australian review of best practice dispute resolution practices in workers compensation. Among other findings, this review established that early intervention on the part of workers compensation agencies could substantially reduce or could deter disputation and the higher scheme costs that are associated with disputes.

Comcare has one of the lowest disputation rates in Australia with only 1 in every 10 claim decisions being challenged and being subject to review. Later management of cases is not as successful, with 1 in every 4 cases reviewed ending in an expensive Administrative Appeals Tribunal dispute.

This analysis seeks to identify the factors in claims officer file handling and in review operations that can achieve lower rates at both levels. It identifies unit costs and makes recommendations for savings based on comparative analysis of some 60 file action variables. These variables have been drawn from best practice information on case flow management, file practices in other jurisdictions and from observations of consistent characteristics in the behaviour of parties to a dispute.

Data Collection and Analysis

The analysis of files sought firstly to independently identify and quantify factors influencing disputation, to meet the terms of reference requirements and then to test assumptions underpinning Comcare officer s views about the factors exacerbating or causing disputation.

A selection of 260 files were randomly drawn from reviews completed during the 1995/96 financial year. Each file was examined and measures on 60 variables were recorded. Data From each file was matched with another 16 variables taken from APSTAT and from PRAXYS.

Data was collected in chronological sequence, proceeding from the originating claim or decision to terminate benefits up until final decision at the Administrative Appeals Tribunal. (See Attachment A.)

Information recorded included:

- the value of the dispute
- the extent of contact with the parties
- evidence of pre-existing disputation and pre-disposition to disputation of both worker and department
- the use and effectiveness of outside specialist information
- the impact of legal involvement
- actual delays as experienced by workers and departments
- the extent of control over information collection by the Comcare office including file tracking practices
- the amount of activity in the Comcare office at each level of the process.

Information on the timing of events and costs associated with each step in the process was drawn from APSTAT and PRAXYS and matched to the data collected on each file.

Interviews were conducted with officers from Comcare Corporate Centre, ACT, Victoria, NSW and Qld. Views were recorded on: file handling techniques, work priorities, resource allocation issues, departmental activities, current causes of dispute, past strategies to reduce disputes and interactions with the AAT process. Local views were also sought on the application of best practice, in particular the introduction of information collection control techniques, medical panels and the use of conciliation and mediation. The effectiveness of review as a quality mechanism for claims officer decision-making was also canvassed.

The objective of the interviews was to identify local assumptions that underpinned thinking about file handling and resource allocation. In other studies these assumptions (or myths) have proven to be accurate or unfounded but in either case, profoundly influential in shaping file management practices and resource decisions. The aim of the analysis was to obtain some hard information about the validity of local assumptions.

Acknowledgments

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1 Factors Contributing to the Exacerbation of Disputes

This report documents the findings of an analysis of a random sample of 1995/96 files conducted during August and September of this year. It is divided into four parts. The first part details the factors contributing to the escalation of disputation in Comcare and the related claims profiles. The second part outlines the cost. The third makes proposals for additional statistical measures to identify these factors and the last part maps recommendations for Comcare's move to best practice in workers compensation dispute resolution.

1.1 Overall Findings

State and Territory Offices show different practices at claims, review and AAT levels which directly affect the local incidence and persistence of disputes. These differences are internally rather than externally driven.

The patterns of claims office and review activity show consistent results and produce significantly[1] higher or lower incidences of AAT matters. Practices that are successful in deterring disputation are:

- taking early control of the claim and inviting and managing information lodgment
- ensuring that sufficient information is available to decide the claim
- enforcing time lines.

Practices that appear to foster disputation are:

- reliance on specialist medical opinion to the exclusion of other sources of information
- limiting investigatory and contact activity by Review Officers

Research has pointed to personal contact with the worker as a factor that can reduce disputation. Review of Comcare files showed data that was consistent with that view. However, tests of specific contacts did not identify any one contact as significant in reducing AAT disputes. Case analysis did indicate that low initial worker contact on each claim may be more efficient for claims assessment, but probably carries a cost for those cases that proceed to review. The analysis would need to be extended to cases successfully finalised at claims level and to AAT outcomes, to determine the extent to which managing worker contact can reduce disputation costs.

Overall, 1 in every 4 cases subject to the review process end in an expensive Administrative Appeals Tribunal Case. Victorian staff reported these AAT matters (about 780 completed pa) when taken to the door of

1 *****In this report significant is taken to mean that the results met criteria for significance in non-parametric statistical tests.($P<0.05$)

the Tribunal cost the fund on average $30,000. All AAT matters attracted additional legal costs of between $3,000 and $7,000 each.

By adopting changed practices to reduce disputation Comcare could:
- reduce legal expenditure in s37 costs by just under one third.
- reduce reviews from an estimated 10% of the annual claims population to between 5% and 7%
- reduce AAT annual caseloads from just under 1000 to well under 700.

This will mean that significant reductions will be possible in resources required to manage reviews. However, before this can be achieved Comcare needs to redirect resources to deterrent practices. Typically, this involves a shift from a concentration on volume processing to a concentration on quality.

1.2 Deterrent Patterns

This project examined cases from registration of a claim until finalisation at the AAT. A range of file-handling patterns were observed.

Distinct differences were apparent between the jurisdictions and importantly, within jurisdictions, between claims teams. Methods of dealing with cases were observed which yielded fewer AAT proceedings regardless of the validity or nature of the claims. Other methods which were thought by Comcare officers to have an effect showed no real impact. These two groups are detailed below.

1.2.1 Specialist Medical Reports

Specialist medical reports were defined as instances where claims or review officers made appointments on behalf on Comcare for the worker to attend a medico-legal provider. Typically, the reports were requested immediately work on the claim was initiated. The request and the subsequently received report were the only file actions before determination or decision. The decision or determination then quoted the report as reference. In some cases more reasons were given but in others the quotation was the only reason.

Cases where claims officers appeared to rely exclusively on a specialist medical opinion were 45% (118) of the total sample files.

Overall, 32% of reviewed cases that rely on specialist medical opinion obtained at claims level end in AAT action.

Initial decisions were affirmed in 28% (73) of files by Review Officers and reversed or varied in 17% (45).

When a decision was reversed and the specialist medical opinion ignored, only 2% (5) cases proceeded to the AAT; the rest, 15% (40) did not .

When the claims decision was affirmed with no further reasons, 5.4% (14) went to the AAT. Where more detailed reasons were given, 7.3% (19) went to the AAT.

Of the cases that were not affirmed, half were reversed due to new medical information. One third were resolved because of claims officer error (ie, selective use of the medical opinion). Over a third were legally represented, (either pointing out selective use of the information or providing new information).

Where specialist medical opinion was not relied on, only 19% (27) of cases ended in AAT action.

A pattern emerges of inappropriate use of medical opinion or of use of inappropriate medical specialists, leading to the need for later correction. This also shows that one-sided decision making based on one piece of medical information may well be changed later with the addition of new information provided by the worker. If received earlier, this pattern could be avoided.

1.2.2 Contact

Where Comcare contacts the worker before the reconsideration determination, the likelihood of AAT action appears to be reduced. While the sample figures did not reach statistical significance, all combinations of worker contact examined against AAT action showed the same trend. With more contact there was less likelihood of AAT action, whether the contact was intitiated by Comcare or the worker.

Contact occurred:	**21% go to the AAT**
No contact:	**39% go to the AAT**

The sample size did not allow us to examine the different sorts of contact in detail or to assess whether contact was more important in deterring claims from reaching review level. This aspect of claims management may merit further examination. (See *Contact on Rejection,* below)

1.2.3 Investigation

The three larger states are reducing investigation activity at the review level and to some extent at the claims level. This was reported to be driven by resource constraints as fewer file actions require fewer resources. File analysis showed that investigation did make a significant* difference to the likelihood of AAT action.

Investigation:	**17% go to the AAT**
No investigation	**29% go to the AAT**

Investigation can occur at either or both claims and review level and investigation at either level was equally likely to reduce subsequent AAT action. Reasons for this result may be as simple as: more work produces better decisions that are less likely to be appealed.

This result was consistent across all states with the exception of the ACT office. In that state a reverse effect was observed; 58% of cases investigated went to the AAT, while only 21% went without investigation. Unlike other

jurisdictions, the ACT tend to undertake investigations in response to legal firms, workers themselves and other representatives initiating work. The finding in ACT may simply reflect a level of self selection of difficult cases or may indicate claimant s prior decision to take the case further in any event.

1.2.4 Time lines

Effective caseflow management relies upon tight control of the submission of information. One tool to achieve this is setting deadlines for submission of relevant information and then enforcing those deadlines. Parties' expectations of what is to happen and when are clear, and confidence in the process is reinforced. Assured time lines reduces frustrations, the tendency to seek alternative redress and to constantly be in contact about progress. (The last causes unnecessary work). The legislature has assumed that this is how Comcare will manage the cases with provision in the legislation for extensions.

The effectiveness of the approach is borne out in the data. In Comcare the presence of time lines is significant* in preventing AAT action.

Clear Time lines:	**18% go to the AAT**
No Time lines:	**27% go to the AAT**

Again the exception was in ACT where 1 in 2 cases with Time lines went to the AAT as against the 1 in 4 that did not. This result may reflect a high level of client initiated file actions for complex cases, or a failure to enforce time lines, decreasing their value and decreasing confidence in the review process.

1.2.5 Worker Information

Workers Compensation schemes where legal activity is high are beset by withheld information at review level. This makes resolution much more difficult. Information is necessary to resolve the claim and typically it may not be lodged until the door of the court or tribunal. Obviously if lodged earlier, cheaper resolutions could be concluded.

There is no difference in the lodgment patterns across Comcare. However, in Victoria and ACT 1 in 3 cases involving withheld information are likely to go to the AAT as against a national rate of 1 in 4. This difference is significant*. It may indicate over-active lawyers, or less faith in the review process on the part of workers.

In Victoria, lawyers were present in 90% of these cases and in the ACT in 50%.

1.2.6 Lawyer Involvement

Over all jurisdictions, greater lawyer involvement was associated with higher levels of AAT disputation.

35% (38) cases involving lawyers ended with AAT action and only 18%(27) cases not involving lawyers resulted in AAT action.

States showed differences with regard to the effects of lawyer involvement. Only ACT and Victoria showed a high incidence of lawyer involvement and both jurisdictions reported that they believed lawyers increased likelihood of AAT action.

In ACT, lawyer involvement did significantly increase AAT action. 48% of cases involving lawyers ended with AAT action and only 22% not involving lawyers ended this way. In Victoria, lawyer involvement was associated with a 36% AAT level which was **not** significantly greater than the 20% of cases not involving lawyers, that ended at the AAT.

The analysis of file actions in both Victoria and ACT showed marked differences in the way the legal firms managed their internal processing of Comcare claims.

In Victoria, legal firms were more likely to offer summaries of their case, presenting arguments to assist or persuade review officers in their decision making. These submissions were lodged at the same time as the request.

In ACT the more likely lawyer action was confined to letters requesting updates on the progress of the case or to letters expressing indignation or reactions to Comcare decisions. Little systematic analysis of the arguments was undertaken and the relationship between Comcare and lawyers appeared confrontational.

In other workers compensation jurisdictions, there are instances of lawyers co-operating poorly with the administrative review processes with the intention of forcing the case through to a more lucrative jurisdiction. The Comcare file analysis detected only minimal and sporadic evidence of this type of practice.

1.2.7 Comcare Involvement

A third party who intervenes in a dispute may become a separating or obscuring force rather than an assistance to resolving the dispute. In some cases, a meddling third party can escalate a dispute.

If departments were managing potential disputes well, intervention by Comcare may be counter productive. Similarly, properly organised departments may be more able to resolve potential claim issues, if allowed the time to get on with the task. To examine this possibility, the effect of Comcare involvement immediately following lodgement of the claim was compared to later Comcare involvement.

Where Comcare become involved early in the case, fewer reviews ended in AAT disputes. Where Comcare was not immediately involved the level of AAT cases was significantly* greater.

Comcare involvement: **1 in 5 go to the AAT**

No Comcare involvement: 1 in 3 go to the AAT

This suggests a level of expertise in claims management in Comcare that does not exist in the departments. It also may reflect the impact of taking control of cases early on and thus reducing disputation levels.

1.3 File-handling Patterns Showing No Impact on AAT Numbers

It was equally important to identify factors that had little bearing on AAT activity, but were presumed by staff to have an effect. Delay, for example, was perceived to be a matter of concern, but apart from stimulating a large amount of work in responding to complaints, was not of itself a cause of disputation.

1.3.1 Delay

General delays in processing claims are possible causes of matters proceeding to the AAT. While the median delay for the sample was 71 days from request to decision, in the group proceeding to the AAT, the median delay was 77 days. There was also little difference in the number of matters older than one month in both groups indicating that delay of itself is not a cause of AAT activity. The figure below shows median times between file actions as taken from the files.

The median delay from request for review to completion is 71 days across Australia.

Fig 1 Median Delay Times - Injury to Review Decision

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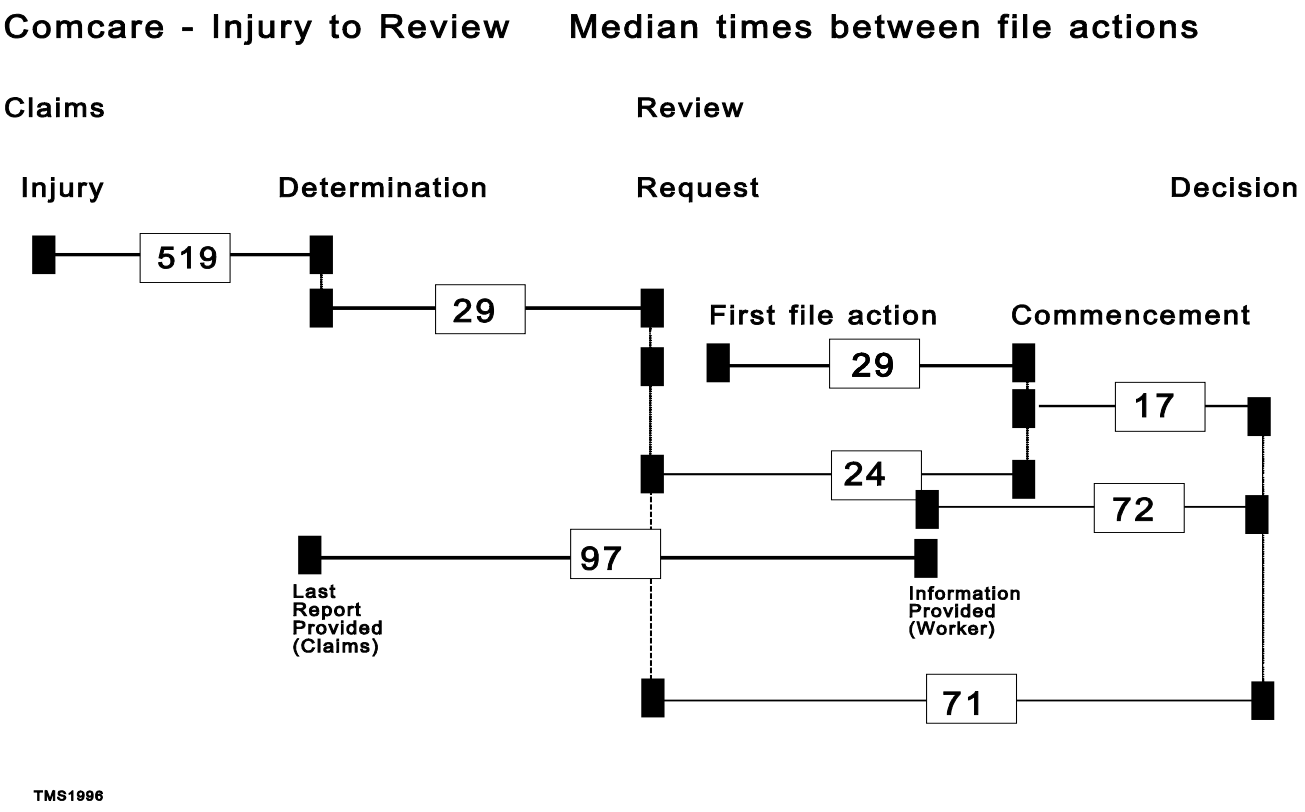


The figure also shows the timing of the lodgement of information. Claims information was lodged some 97 days before further information provided by the worker. Worker information was provided in half of the sample. In three quarters of these cases specialist medical information had been obtained by

the claims officer. A small number of these cases were reversed by review officers and one in three proceeded to the AAT. Ideally information should be obtained from the worker much earlier in the process and at the same time or shortly after claims information.

Note: APSTAT and PRAXYS dates provided to the project show shorter delays and a variation of up to 10% on all figures indicating that data input is less than accurate.

1.4 Departmental and Claimant Roles in Disputation

Several assumptions were made about departments in initial interviews for this project. They included:

- Early contact between the department and the worker, especially where a rehabilitation plan was in place would deflect further disputation
- Early contact or interference by the department would lead to further disputation
- Pre-existing management issues or the existence of adjacent disputes caused through poor management practices would lead to further workers compensation disputation
- Multiple staff involved in departmental activity would lead to further disputation. (There was not enough data to substantiate any finding on this issue.)

Claimants were thought to be more likely to dispute if they were not professionally or physically involved with their workplace.

1.4.1 Management Issues

Where management issues (ie, documented complaints over poor management) existed, the sample showed that there was slightly higher likelihood of the matter proceeding to the AAT, although this is not a significant difference. [Note: Most of these cases were stress matters.]

1.4.2 Rehabilitation plans

Similarly the presence or non-presence of a rehabilitation plan on the file had no effect. The issue here may be the different quality of plans by rehabilitation providers and in-house department providers, a distinction difficult to draw from the hard copy files. A more detailed review of rehabilitation plans would need to be made.

1.4.3 Departmental Support for the Claim

Departmental intransigence was cited as one reason cases proceeded to the AAT. This seems to be borne out, but the data sample was not big enough to confirm. Some claims were supported by the departments but still went to the AAT indicating differences in Comcare s perception of the claim.

1.4.4 Specific Department Findings

All of the data for 1995/96 cases was collated to establish the review frequency ranking of departments. Data about each of the most common was then drawn from the sample to establish if there were any patterns. These departments contributed 10% or more of the review work of a jurisdiction, and were present in each jurisdiction with the exception of ACT Health & Community Care.

Differences were found and these are represented on the next page.
Fig 2

*Note to fig 2: The sample results were compared on the basis that each department should show a similar share on each indicator to its share of cases in the sample. Most showed variations well above or below. These results should be treated as indicative only.

Figure 2 suggests that based on the above findings, changes to practices may reduce the number of reviews.

- In the departments with high worker contact, the quality of the contact may be an issue.

- More immediate involvement by Comcare in the Department of Defence and in DEET and DSS is indicated.

- The Department of Defence should increase its level of worker contact. This may be explained by a large number of hearing loss claims from past employment. Department advice on the claims in these cases denied any knowledge of the claimant and an inability to trace files.

(While the CBA is no longer in Comcare, it has been included for comparative purposes).

1.4.5 Contribution by Claimants

While claimant treatment by a department or by Comcare might alienate claimants to the point that they may appeal, there was also a view that some claimants were more likely to appeal regardless. These claimants were said to be likely to have histories of sick leave and evidence of poor alignment with work-place requirements. The files were examined for this type of precursor information. The data showed that only 25% of the review cases where this information existed went on to AAT processes. This was in line with the percentage for the overall sample and with the 1995/96 ratios.

Special treatment of this group is not merited.

2 Costs

Accurate costing is particularly crucial at the current time when options are being sought to pare resources in different parts of the organisation. Obviously decisions must be made based on accurate assessments of unit costs.

2.1 What is the Unit Cost of Disputation?

The cost of disputation in Comcare is the administrative cost of managing the all disputes divided by the number of disputes. Arriving at acceptable measures of both costs and numbers is not simple.

Administrative costs are made up of staff costs and overheads for review officer, out-sourced assistance, and legal costs. Awards from the fund are injury driven and result from a decision or settlement. They are not included in disputation costs.

Measures of case volumes from PRAXYS and APSTAT provide an initial assessment of numbers of disputes. These include:

1. The number of applications for reconsideration
2. Reconsiderations completed
3. AAT applications
4. AAT matters completed
5. s67 costs

However, these totals grouped either as applications or completed matters do not give an accurate picture of the work undertaken. This is because the allocation of staff and other resources is on the basis of ongoing files.

A claims officer takes a file from registration through to determination. They may also be involved later when the case moves through review. Review officers take individual cases from request through to the door of the Tribunal, not only making the decision but instructing the lawyer acting on Comcare's behalf.

The unit of dispute is actually the total action on a file from the date of request to the date of finalisation.

There are additional complexities in trying to establish a unit cost using the available data. It is clear that in completing files, varying degrees of work are undertaken in different jurisdictions and different mixes of resources are used. In some states the level of AAT involvement is higher than in others. Some states also out-source this work. Resources applied can be within the assigned staffing and legal budgets or outside of them. Other jurisdictions have changed file management practices to avoid or reduce costs and time.

The table below shows the possible sources of disputation cost and the pool of available resources.

Resources/Costs	Tasks
Review Officers	Review investigation
Out sourced non-legal review assistance	Obtain Specialist medico-legal reports
Out sourced legal advice on reviews	Contact worker - interview or telephone
Out sourced Panel legal advice on AAT matters	Review decision preparation X file summary X decision writing
Medico-legal opinion at review and at AAT level	AAT documents
	AAT case summary
	AAT instructions to panel solicitors
	AAT settlement discussions
	Decision implementation

Despite these variations it is possible to obtain an estimate of the unit cost for comparative purposes between the states.

The average number of file actions at both review and AAT levels was taken from the sample files and used as the basis for calculating the proportion of staffing costs used on each file.

Disputes that went on to the AAT were counted as one case. The sources of data were:

X Reconsiderations completed during 1995/96

X AAT applications made during 1995/96 (but not necessarily completed).

[Note: It was not possible to obtain an accurate estimate of non-budget out sourcing to include in these statistics. ACT and NSW, where this activity exists may therefore show underestimated unit costs.]

Fig 3. Unit Cost of Disputation in Comcare

Comparisons of unit costs are more meaningful for those jurisdictions where the sample of files was larger (NSW, ACT, QLD and VIC).

Unit costs of AAT cases in ACT are about $2,000 higher than the other major states. Comcare officers in ACT indicated that this may arise from a higher proportion of complex and precedent setting cases in the ACT. This could be investigated further.

Smaller states show higher unit costs for both reviews and AAT cases. This indicates that economies of scale may operate against those states.

The data shows some possibilities for the re-direction of resources and rationalisation of others. It also shows that further investigation should be made into the settlement payouts in each jurisdiction. For instance while Victoria has a greater review staff involvement in AAT preparation, this may achieve lower pay-outs. Similarly SA has higher unit costs in both review and in AAT matters but a lower incidence of AAT matters and therefore less opportunity for door of the tribunal settlements.

Analysis of files showed that work practices are also important. In NSW for example, some teams showed little investigatory work at claims or at review level. The onus appeared to be on the claimant to provide all information to support the claim. In other states some work is done at both levels to clarify issues and to obtain the information to needed to assess entitlement.

The NSW team approach may mean higher rejection levels and higher affirmations levels, both resulting in higher review request ratios and higher AAT application ratios. (It was not possible to establish this from the available data. Alternatively over-generous decision making could stave off appeals. In order to reach a sound conclusion the total population of potential appeals would need to be identified. (See *Statistics* below.)

Disputation rates by state - 1995/96

State	NSW	ACT	VIC	QLD	SA	WA
Rejection rate (all claims)*	15.10	15.47	11.56 (Tas 12.9)	18.06	5.06 (NT 7.3)	7.28
Review to AAT	23.8	26.32	29.2	24.9	11.8	15.6

*Note: Cease effects not included. In other jurisdictions, appeal rates are universally almost total. Benefits decisions are also not included.

In summary, while unit costs are attractive pointers they must be considered in light of downstream cost impacts. This means the overall cost of AAT matters.

2.2 State Comparisons

The following table gives details by state of the results of the analysis showing variations in file actions which may indicate where resources might be redirected in more effective ways. The circled numbers (highs) indicate favoured actions in comparison to similarly sized states. The L marks indicate lows. The shaded group is the high caseload group and the non-shaded group is that representing the jurisdictions with small caseloads.

3 Statistics

3.1 New Statistical Requirements

Statistics currently collected include the Monthly State Reports from APSTAT and the National Performance Standards for Review. This analysis has shown that this information could be usefully supplemented. New measures are described below. These relate to:

- information lodgement and management
- reasons for affirmations, variations
- base population information - adverse decisions on claims that could result in review.

3.1.1 Information

Information management is an important element in preventing further disputation. Statistical measures that reflect the current state of information collection are useful in determining whether **delays** and **backlogs** are caused by too few resources or by claimant delay in lodging information. Measuring the lodgment times of both parties indicates in what order information is being collected.

Serial collection of information, although necessary in some cases to test previous medical or factual findings, can more often be avoided. Concurrent collection requires more careful management including time lines and accordingly should result in a lower level of disputation.

Suggested measures are listed below. A higher incidence of **both** will indicate that information management is practised carefully and should reflect a lower incidence of disputation. The measures can also indicate where additional resources should be placed to overcome delays. The extent of the **real delay** will be reflected in the number of cases awaiting decisions where all the necessary information is already on the file.

Add

- ***Number of matters awaiting information from the claimant***

- ***Number of matters awaiting information from Comcare initiated investigations***

- ***Number of matters awaiting both***

- ***Number of matters awaiting decision with complete sets of information***

3.1.2 Reason for Affirmation and Rejections

Decisions by claims officers and by insurance officers generally may be reversed for a range of reasons that do not automatically include or imply error. These may include the lodgement of later information that illuminated an aspect of the claim not clear previously. The claim may be part of a multiple groups of claims and may be resolved for reasons other than the facts of the original claim. Alternatively, legal precedent or interpretation may change meaning that previous decisions are not correct.

The files also showed cases where the review officer affirmed the case but for reasons other than those given by the claims officer. In some of these cases the claims officer was actually incorrect but the case was affirmed in any event. Accordingly theses clauses should not relate to whether the case was affirmed or rejected. If collected carefully they should give a true indication of where training resources should be directed.

Add

- X ***Claims officer in error***
  - ***legal interpretation***
  - ***interpretation of medical evidence***
- X ***New medical information***
- X ***Associated with other file***

Claims error rates indicate a lack of training or knowledge. Review decisions appear to play an important role in reducing this type of error. An observation drawn from the analysis is that where cases are affirmed by review officers with more reasons, then claims officer error is lower. This would appear to indicate that the feedback provided by the decisions to claims officers may have an educating effect and prevent future error of a similar kind. Where affirmations were **rubber stamps** of the claims decisions, the error rate was higher.

This information is not an argument for longer decisions by review officers, however it does show that education back to claims officers may be lacking. That education may take a number of forms. Better briefing on legal matters, better briefing on the interpretation of medical reports and better training on the implications of the legislation may be areas requiring attention. Alternatively, promulgation of descriptions of review decisions to all claims officers may have a similar effect to that of the individual offices.

Ensure claims officers are exposed to the detail and reasoning behind both affirmations and rejections of claims.

3.1.3 Claim Rejection Rates and Measures of Potential Disputes

Comcare at present collects information on the rejection rates of what appear to be new liability claims. Rejection rates for **cease effects**, medical treatment claims, permanent impairment cases and other types of claims were reported by Comcare Corporate Office and by various state offices as being difficult to identify. The total sum of all of these groups would give a base adverse decision rate.

The base adverse determination rate is important to give Comcare a reference point to measure success or failure in reducing disputation.

Include adverse determination counts in current statistical reports.

4 Moving to Best Practice

Comcare is one of the signatories to the Heads of Workers Compensation Authorities Report, *Best Practice in Workers Compensation*. The headings below are drawn from that document. This section gives a description of steps that Comcare needs to undertake to move towards the objectives identified. (Readers are also referred to *Resolving Disputes* - TMS 1996 which contains a much more comprehensive description of the elements of best practice schemes).

Recommendations arising from the conclusions drawn in the analysis are given first.

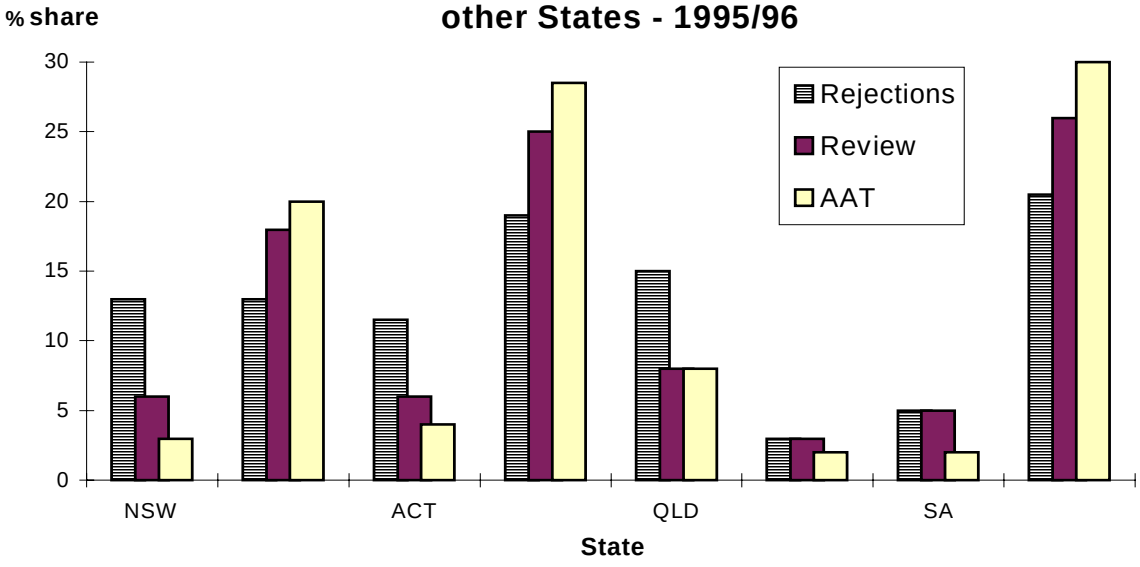
4.1 Recommendations arising from this Analysis

4.1.1 Contact on Rejection

The Stress Claims Management Claims Centre was reported to have a policy of contacting all claimants to explain the rejection of a claim. There is some evidence to show that this policy has a direct effect on the number of reviews and flow-on AAT matters. The chart below shows the relationship between the expected share of population of NSW and the ACT between stress cases and non-stress cases of reviews and AAT cases.

Fig 4

Comparison of Stress Centre Rejection, Review and AAT Market Shares with Non-stress Shares in NSW and ACT and other States - 1995/96



The results may also reflect the quality of the counselling and other communication skills applied in the Stress Claims Management Centre. It may also support the major finding on contact in this analysis. Given the additional workload, a better approach may be to undertake testing in non-stress environment before generally introducing this policy.

State Offices should assess the effect of adopting a contact on rejection policy in their own environments by establishing a pilot project comparing two groups over time*. *One group should initiate contact and the other proceed as usual.

4.1.2 Specialist Medical Opinion

Comcare needs to revise the manner in which claims officers use this source of information. Reasons for the larger groups of escalated disputes may be as simple as claims officers find it easier to abnegate responsibility for the decision to an expert. Alternatively, they may not understand the medical condition and require an expert explanation. Alternatively they may find it difficult to explain to the worker that the claim is not valid and need a third party to blame.

In best practice schemes, these problems are avoided by seeking treating doctor advice initially and relying on it in a majority of cases. For this to work, doctors have to be trained. In the better schemes they are accredited and there are many of them.

Comcare should develop checking procedures to ensure that claims officer recourse to expert medical opinion is merited and required for investigatory reasons only.

Comcare should increase the use of treating doctor reports and increase the number of doctors able to provide reports of the required standard through training and accreditation processes.

4.1.3 Claims Teams

The file analysis showed distinct approaches to claims and review case management which, while initially thought to be based in state practices, showed up as more files were read, to be based on differences between teams. Some teams generated more work for the AAT than other teams. In seeking to change practices which may have become entrenched over time, a set of team based performance indicators and supporting incentives may be a useful means of changing behaviours.

Teams should be monitored on the number of adverse decisions reaching review, and with greater weighting, the number of these cases reaching the AAT.

Teams should be assigned unit cost based budgets with incentives to reduce unit costs over time.

Teams should be given access to training in effective communication with workers and treating doctors and should be actively monitored on the number and quality of contacts made.

Teams should be monitored on the number of specialist reports requested and relied upon in decision making.

Specific training in decision-making, effective investigation and reasoning skills should be provided at both claims and review levels.

Teams should be encouraged to steer away from rote responses to files. Paper and document production should be mechanised using technology as much as possible to give scope for intelligent file appraisal.

Teams should be rewarded for increasing their internal levels of decision-making accountability while maintaining quality.

4.1.4 Unnecessary Work and Pro-active File Management

The files showed some practices which could be streamlined and rationalised. Requests for files under s 59, for example, could be automatically processed without the need for applications to be considered and formally replied to.

Work on files that remains largely unaccounted for in case-work systems is time spent reacting to claimants' queries and concerns over delay and process. Much of this reactive work could be obliterated if the cases were taken under control of the office from the beginning. This implies that a clearly identified file-track is identified and documented with appropriate advice to claimants and other doctors. Queensland files showed the best examples of this style of pro-active file management. As detailed above the simple use of time-lines in letters can have a positive effect.

There is also a lot of work involved in referring cases to outside sources of advice, arranging appointments, and transferring files. Use of in-house legal and medical expertise at strategic points will avoid a lot of this, however, care should be taken that the availability of ready advice does not translate to an abnegation of decision responsibility.

Comcare should examine file practices to eliminate unnecessary work and introduce consistent file-tracking procedures and caseflow management processes as a priority in all jurisdictions.

Comcare should introduce in-house sources of legal and medical advice.

4.1.5 Education and Navigation Information

Good information and navigation assistance is credited with removing 60% of all potential disputes in best practice schemes. Information provided to the worker before and at all stages of claims and review must be easily understood and comprehensive. It provides a function in deterring claimants

from lodging claims that they know to fail. Some of the files examined showed that the quality of information could be improved. A string of reviews from claimants seeking physical treatment for stress claims were rejected at claims and review level on the basis of what appeared to be Comcare policy. These could have been deterred if the information was provided at the start of the claim.

An indicator of the size of this problem is the number of cases that were reviewed following legal interpretation by the claims officer - 59 of the 260. The letter giving details of the application of the Act may not have been clear enough. Some attention to letters in general with accompanying phone-calls may reduce this number, together with better literature explaining the application of the Act before a claim is made.

Comcare should consider reviewing all standard letters and explanatory literature for clarity.

Trend tracking should be undertaken which enables quick identification of repeated claimant misunderstandings or lack of specific information with a view to producing appropriate literature.

4.2 Best Practice Recommendations

4.2.1 Information Exchange

Early exchange of information or a *cards on the table* approach prompts parties to abandon claims or to resolve them. Better schemes insist on exchange before court action is started and refuse late lodgments thus reducing delay and cost. The optimum time for exchange is at claim level. This means that claims officers have to manage the investigatory function and have a good understanding of the requirements of the case at the start. Successful schemes combine this with a screening and streaming function to ensure that this understanding is achieved.

Comcare should introduce initial file assessment procedures and ensure that as much information is exchanged with the claimant as possible at claims level. This may include automatic provision of medical reports to the worker as soon as they are available.

4.2.2 Screening and Streaming

Some states are already doing this in a rough form. Claims are divided into Type 1 and Type 2 for claims purposes. At the next stage a report for reconsideration is prepared in some states detailing the action already taken and pointing out the level of difficulty of the claim.

Screening and streaming would mean the placement of senior claims staff at the door with instructions to:

- Set a timetable for the claim
- Map out the investigatory material required including the need for legal advice on interpretation and medical advice.

- Advise the worker of the steps that are to be taken and requiring their information by a certain time.
- Immediately initiating the collection of any Comcare information
- Regularly reviewing the files to enforce deadlines
- Initiate a referral to a medical arbiter or medical panel in the case of medical conflict.

These officers should also be able to develop a set of streaming options for cases that meet specific criteria that are more comprehensive than those currently used. Options may include the use of interviews and case conferences. Criteria might include medical complexity. A similar **gate-keeper** at review level might be able to direct cases to conciliation conferences or to quickly identify potential legal involvement and manage the collection of information accordingly.

Comcare should establish screening and streaming processes at review and claims levels.

4.2.3 Facilitation

Facilitation for Comcare includes mediation and conciliation systems operating at review level and also includes the negotiations and **mediations** conducted by solicitors in the AAT to settle a case. Conciliation will resolve up to 70% of workers compensation disputes and will have follow-on benefits in reduced disputation from departments and in better claims decision-making. However, Comcare's review rate compares favourably with a 75% disposal rate and the unit cost of single reviews compares favourably with an Australian average of around $600 per conciliation (excluding department and claimant costs).

Comcare may consider out-sourcing specific types of cases to conciliation. The best use of conciliation would be for cases involving a need for the expression of hidden objectives hindering resolution of the claim. These could be cases arising from management issues or from perceived persecution.

One in five cases in the sample showed that the worker considered that they had been persecuted either by Comcare or by the department. These cases are amenable to conciliation because it gives the worker a chance to resolve an often unrelated issue to a person **in authority**. They can otherwise drag on and result in excessive unnecessary work in letters to other authority figures.

Comcare should introduce a pilot out-sourcing conciliation process for specific cases.

4.2.4 Medical Panels

While the sample showed few real issues with duelling experts[2], there were some files that required resolution of conflicting medical opinion. Typically this

2 Some jurisdictions report routine cases with up to 4 specialists on either side - extraordinary cases can have as many as 50 opinions. See Resolving Disputes.

was provided at AAT level in the form of a Comcare lawyer-recommended specialist. The case was then resolved often overturning the earlier specialist used by the claims officer. The question this raised was why such a **better** specialist could not be used earlier. Comcare requires easier access to more reliable medical advice. The options should be considered of commissioning medical specialists with impeccable credentials and independent stature to resolve conflicting opinion at an earlier stage.

Comcare should investigate the feasibility of establishing a national Medical Panel and national medical arbiter network to resolve medical conflict at an earlier stage and to set precedent for repetitive types of claims.

Transformation Management Services

October 1996

Attachment A

Data Collection Points - Explanatory Note

Up to 54 pieces of data were collected from each file. Questions were designed to test anecdotal evidence about the factors exacerbating or causing disputation as well as to reflect Comcares's adherence to causes more extensively documented and proven elsewhere. Data was collected in rough chronological order proceeding from the originating claim or decision to terminate benefits up until final decision at the Administrative Appeals Tribunal.

1. Value of Reconsideration

The cost effectiveness of any dispute resolution system relies to some extent on the value of the claim. Disputes over small amounts may be dealt with in alternative ways to full blown disputation paths involving costly legal services as well as the substantial administrative cost. Unit cost estimates of dispute processes, ie for each dispute for Comcare show averages of between $300 and $700 . Obviously disputes over lower amounts, unless placed within the context of broader claim issues or a pattern of repeat minor claims could be alternatively paid or made **ex-gratia** or without admission of liability.

1.1
1.2
1.3
Various states reported the impact of local cultures on the size of claims. ACT reported more **benefit** disputes as Comcare claims officers sought to stem the extent of palliative care and the perceived industry rehabilitative **rorts**.
1.4
Percentage disputes where disputing doctors vary by more than 10% indicate scope for management of impairment assessments. Medico legal advisors may tend to be perceived as pro-insure or pro-worker and may advise accordingly. The presence of extreme groups of this kind in any jurisdiction will exacerbate dispute levels.
1.5
The presence of compromise agreements in a system indicate capacity for conciliation, settlement and mediation techniques. These dispute resolution mechanisms work well in other workers compensation jurisdictions but empirical evidence of some level of acceptance within Comcare shows that factors mitigating against these devices may be overcome.

The other point of interest is where the compromise occurred. Authority to settle might be less expensively conferred than at the **tribunal door**.

2. Key Dates

Delay is a major contributing factor to the exacerbation of disputes. Managed delays or certain timetables communicated to all participants will mitigate the effects. However, delay that is uncertain will encourage recourse at more

expensive levels. The lack of consistency in these times also shows an absence or presence of a file throughput mechanism according to managed time lines and caseload levels.
2.3
First file action relates to acknowledgement letters.
2.2
Commencement relates to the first action by the Review Officer on the file indicated by letter date, telephone file note or other written file note. In some cases the first action was the decision itself.

3. Department Actions

3.1
3.5
3.7
Various interviewees posited the nature of departmental involvement as a causative factor for later disputes. Theories suggested included:

- more than one departmental representative involved alienated the worker inhibiting back to work efforts and rational compensation decisions. This was particularly so if the interaction was bureaucratic and careless showing weak lines of accountability.
- early intervention by the department was beneficial -workers felt valued and still part of the working environment
- early intervention by the department was not beneficial - it alienated workers
- immediate Comcare involvement interacted either beneficially or detrimentally to the above

The presence of a Rehabilitation Plan was seen as indicative of a department that was well organised in terms of workers compensation and less likely to have disputes.
3.2
Early personal contact with workers deters further disputation (or exacerbates)
3.3
Early contact with the treating doctor and more particularly reliance on the view of the treating doctor deters disputes.
3.4
Evidence of a management issue indicates working places where supervisors management styles are the subject of criticism either by claimants, their doctors or co-workers. Evidence included statements from supervisors over counselling sessions or reporting incidents.
3.8
Workers more likely to dispute matters or to make claims are described as those with extensive sick records; or reported as complaining about work tasks in the absence of a management issue. Precursor information is indicated by regular sick records.

4. Claims Officer Activity

Best Practice schemes are characterised by intensive efforts at claims assessment level to interact personally with the worker, the employer and preferably the rehabilitation team (including the treating doctor).

4.1.

4.2

Contact with the worker personally or indicated in a letter as following discussions. Most files showed that this type of contact was initiated by the worker. Where clear that it was the claims officer, this was recorded.

4.3

Many schemes rely on specialist medical reports as a port of first call. (These statistics should be read in line with the termination decisions usually preceded by a specialist report.) Where these reports are relied upon to the exclusion of other information the classic **duelling experts** scene is set.

4.4

Indicated by paraphrasing or straight quotation of worker medical phrases within the reports.

4.5

Indicated by similar action in respect of department written or oral advice.

4.6

Indicates interpretation of the Act or reference to the boundaries of entitlement. Most of these cases did not show the facts or fulfill the criteria to support a claim. Others involved the calculation of entitlement.

4.7

Investigations outside any of the above were included here. They indicated that the claims officer had put extra effort into the claim. Praxys print-outs

5. Claims Officer Medical Reports

Critics of delays in compensation claims often place the responsibility on the collection of medical information. Previous studies have found this to be a myth. Doctors reports are not delayed by doctors but generally by claims officers (or review level investigation officers) delaying requests. This section also gives an indication of the information collection activity of claims officers, giving some idea of the work involved in a claim and the amount of investigation undertaken.

5.1

Delays may also be caused by departments in lodging existing medical, rehabilitation or assessment reports.

5.2

Fresh investigation of the claim by the claims officer and the seeking of specialist medical information is recorded here. Some schemes failed to collect any information at all and placed the onus of providing information on the worker. Other schemes are haunted by long delays in collecting information or a lack of cooperation by workers and employers in providing relevant material.

5.3

5.4

These give the latest date for provision of medical reports and any other type of documentation as shown by received stamps or in their absence the date of the covering letter. It can be assumed that once all of the information is in, then delay attributable to the claims section starts to run until decision date.
5.5
Short supply of doctors in this field or overuse of one particular group of doctors may be shown in these fields, with the exception of inevitable delays over the Christmas period.

(Preparation of reports is another delay area for doctors although rare. Most doctors dictate reports shortly after seeing a patient. If indicted they are noted below at Question 12.2.)
5.6
Poor decision making is often indicated by procrastination and a predilection to seeking further and unnecessary information. This can be seen in repeat medical reports from the same doctor over a short period. They also show poor questioning practices or poor reporting practices. Reports older than 6 months however, may be justifiable. (This aspect of the analysis may need to be re-checked with a smaller period between reports ie 2 months. It should also be read with PRAXYS records showing repeat bills for the same specialist.)
5.7
This item flags the existence of existing departmental reports attached to the claim.

6. Reconsideration Information

The different jurisdictions reported different policy approaches to the level of investigation undertaken by Review Officers. The suggestion was made that investigatory work at review level had stemmed the number of AAT appeals, usually predicting obvious factual deficiencies at claims level and correcting them there rather than at the more expensive later level.
6.1
The use of specialist medicals is one tool. These statistics reflect the use of Comcare appointed specialists. Some states used the treating specialist. This is noted.
6.2
Legal involvement is seen a s a major factor in causing later tribunal or court activity in most systems, mainly due to the cost rewards associated with further activity. The date of legal involvement, not necessarily accurate in all cases, gives a rough guide as to the satisfaction level of workers with their treatment at claims level. The information is taken from telephone file notes, and letters.
6.3
This is the same as Claims Officer above.
6.4
6.5
6.6
6.7

An invitation to submit information is sent out by most jurisdictions, although some ignore this step. The inclusion of a time line in the letter shows an information management approach that if enforced will reduce further disputation.

6.8

6.9

In assessing changes in outcome and the overall fairness of the procedure, representation is important.

7

Contact with the worker is important as already stated. Bias in favouring department representations will show here as will a pre-disposition to rubber-stamp claims officer decisions/ and to provide feedback on error.

8

The importance of treating doctor contact shows in all the literature as very important in dispute reduction. In some jurisdictions lawyers are blatantly subversive of non-court processes. Letters exhibiting this signal a high cost reward at court level.

Delay causes

8.5

Section 5.9 is usually matched with legal representation. The scope of its use in non legal representation is important in determining preparation work done at review level by workers. The process could be made automatic. Note: It should go direct to the worker as well as to the lawyer.

9

9.1.1

Multiple files? Is the system claim based or person based and is there room for rationalisation. Avoidance of AAT matched with compromise indicate high level of disputation still existing and likely to leave parties dissatisfied with the outcome.

9.1.3

Claims officer error to be actually measured rather than assumed on the basis of reversed decisions at review level. This also shows up a low level of feedback in quality control terms from review to claims if high.

9.1.4

Legal precedent may indicate a need for legal advice inserted at a lower level.

9.1.5

Changes in medical evidence point to lags in collection of key information.

9.1.6

Reason same as CO show **rubber stamping** and **free pass filter** processes.

9.1.7

Is review a value added process? This question also highlights states where investigation processes are now limited. However, if further reasoning was used, it distinguishes this group from 9.1.6.

9.2

Complex or **prolix** decisions encourage disputation and give courts and tribunals more to quibble about. In some instances brief **user-friendly** decisions are more effective in reducing decisions to proceed further.

10
Reasons for reversal are important if new information that could have been lodged earlier is the determining factor. If careful review predominates then feedback evidence to claims officers should show as a reduced level of claims error.
11
Preliminary interviews showed that review officers although assessed on caseload at review have a hidden workload in the amount of time spent in preparation of AAT cases. These questions measure the different aspects of this additional work. It also seeks to find out why matters settle at the door of the Tribunal and when. PC means preliminary conference and DH means directions hearing. Capitulations on Comcare's behalf should preferably occur earlier.
12
General delay explanations as indicated in >other comments.
13 & 14
are seeking rough guides to 11. Actions include letters, file-notes and memos of telephone/e-mail exchanges.
15
Amount of work done and information collected - a rough measure.
16
This relates to work place persecution ie sexual harassment, violence, whistleblower retaliation. (ADR mechanisms may be more appropriate than review mechanisms in these cases.) See comments.
17
The research indicates that workers returned to work quickly are less likely to seek legal redress for workers compensation problems due to peer group pressure and general loyalty to the employer.