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SPECIAL SUPPLEMENT

New South Wales

Proclamation

under the

Workers Compensation Legislation Amendment (Miscellaneous Provisions) Act 2005 No 113

MARIE BASHIR, Governor

I, Professor Marie Bashir AC, CVO, Governor of the State of New South Wales, with the advice of the Executive Council, and in pursuance of section 2 (1) of the *Workers Compensation Legislation Amendment (Miscellaneous Provisions) Act 2005*, do, by this my Proclamation, appoint 1 November 2006 as the day on which the uncommenced provisions of that Act (except Schedule 3.1 [11] and 3.2 [5]) commence.

Signed and sealed at Sydney, this 25th day of October 2006.

By Her Excellency's Command,

L.S.

JOHN DELLA BOSCA, M.L.C.,
Minister for Commerce

GOD SAVE THE QUEEN!

Explanatory note

The object of this Proclamation is to commence certain amendments made by the *Workers Compensation Legislation Amendment (Miscellaneous Provisions) Act 2005*. The amendments made by that Act that will remain uncommenced are amendments to the *Workplace Injury Management and Workers Compensation Act 1998* and the *Workers Compensation Act 1987* that apply a provision of the *Legal Profession Act 2004* (relating to reasonable prospects of success) to the referral of disputes, and appeals, to the Workers Compensation Commission.

New South Wales

Workers Compensation Amendment (Miscellaneous Provisions) Regulation 2006

under the

Workers Compensation Act 1987 and Workplace Injury Management and Workers Compensation Act 1998

Her Excellency the Governor, with the advice of the Executive Council, has made the following Regulation under the *Workers Compensation Act 1987* and the *Workplace Injury Management and Workers Compensation Act 1998*.

JOHN DELLA BOSCA, M.L.C.,
Minister for Commerce

Explanatory note

The objects of this Regulation are as follows:

(a) to prescribe the period within which wage details must be provided to an injured worker for the purposes of the worker calculating his or her average weekly earnings (see Schedule 1 [1]),

(b) to deal with the following matters that arise as a result of the amendments made to the *Workplace Injury Management and Workers Compensation Act 1998* (***the 1998 Act***) by Schedule 1.1 to the *Workers Compensation Legislation Amendment (Miscellaneous Provisions) Act 2005*:

(i) modifying the details required to be included by insurers in a notice of intention to discontinue or reduce weekly payments, so that they are the same as those now required by the 1998 Act to be included in a notice that liability is disputed (see Schedule 1 [2] and [3]),

(ii) adding to the details required to be included by insurers in a notice that liability is disputed and omitting from the details that the regulations require to be included in such a notice those details that are now required by the 1998 Act (see Schedule 1 [4] and [5]),

(iii) restating the obligations on employers and insurers in possession of reports relating to an injured worker to provide the reports to the worker if liability is disputed, so as to ensure all relevant documents are served on a worker at the same time as serving a notice disputing a workers compensation claim and so as to prevent reports being used in proceedings unless they are disclosed prior

to the proceedings (see Schedule 1 [6], which inserts a provision in place of those omitted by Schedule 1 [6] and [8]),

(iv) omitting a redundant provision relating to requirements in relation to examinations of workers at the direction of employers (as this matter is now to be dealt with by the WorkCover Guidelines) (see Schedule 1 [7]),

(v) removing the right of appeal against all orders, determinations, rulings and directions of an interlocutory nature of the Commission constituted by an Arbitrator, to a Presidential Member of the Workers Compensation Commission (see Schedule 1 [16]),

(c) to make the following amendments in relation to restrictions on obtaining medical reports:

(i) extending the operation of provisions imposing restrictions on obtaining medical reports to work injury damages threshold disputes as well as claims (see Schedule 1 [9], [10] and [12]),

(ii) limiting the medical reports that are admissible in proceedings to one report from the specialty treating the injured worker or, if no specialist has treated the worker, to one report from a specialist of a specialty relevant to the treatment of the worker's injury (see Schedule 1 [10]) and clarifying the application of that limitation to all medical reports of a medico-legal nature (see Schedule 1 [10], to the extent that it inserts proposed clause 43 (4)),

(iii) replacing the concept of permissible updates to medical reports with supplementary reports, which are admissible in prescribed circumstances (see Schedule 1 [11] and [13]),

(iv) clarifying the operation of a provision that imposes restrictions on the disclosure of medical reports to approved medical specialists, to make it clear that medical reports must be disclosed in the listed circumstances and must not be otherwise disclosed and extending it to work injury damages threshold disputes (see Schedule 1 [12]),

(v) clarifying the application of those restrictions to all medical reports of a medico-legal nature (see Schedule 1 [12], to the extent that it inserts proposed clause 43A (4)),

(vi) providing that a party to a claim or to proceedings on a claim is not entitled to be paid for or recover the cost of obtaining a medical report in connection with the claim unless the report has been admitted into those proceedings on behalf of the party or has been disclosed to an approved medical specialist (see Schedule 1 [14]),

(vii) making a transitional provision relating to the application of restrictions on obtaining medical reports and on the recovery of costs associated with medical reports (see Schedule 1 [15]).

This Regulation is made under the *Workers Compensation Act 1987*, including section 280 (the general regulation-making power) and the *Workplace Injury Management and Workers Compensation Act 1998* (as amended by the *Workers Compensation Legislation Amendment (Miscellaneous Provisions) Act 2005*), including section 248 (the general regulation-making power).

Workers Compensation Amendment (Miscellaneous Provisions) Regulation 2006

under the

Workers Compensation Act 1987 and Workplace Injury Management and Workers Compensation Act 1998

1 Name of Regulation

This Regulation is the *Workers Compensation Amendment (Miscellaneous Provisions) Regulation 2006*.

2 Commencement

This Regulation commences on 1 November 2006.

3 Amendment of Workers Compensation Regulation 2003

The *Workers Compensation Regulation 2003* is amended as set out in Schedule 1.

Schedule 1 Amendments

(Clause 3)

[1] Clause 14A

Insert after clause 14:

14A Computation of average weekly earnings

For the purposes of section 43 (2) of the 1987 Act, the period of 14 days is prescribed in relation to any request made on or after 1 November 2006.

[2] Clause 15 Notice of intention to discontinue or reduce weekly payments

Omit clause 15 (1). Insert instead:

(1) The notice referred to in section 54 of the 1987 Act must include the following:

(a) a statement of the reason for the decision to discontinue payment, or reduce the amount, of weekly payments of compensation and of the issues relevant to the decision,

(b) a statement identifying all the reports and documents submitted by the worker in making the claim for weekly payment of compensation,

(c) a statement identifying all the reports of the type to which clause 37 applies that are relevant to the decision, whether or not the reports support the reasons for the decision,

(d) a statement advising that a copy of a report required to be provided by the insurer under clause 37 (3) (except as provided by clause 37 (5) or (6)) accompanies the notice,

(e) a statement to the effect that the worker can request a review of the decision by the insurer,

(f) a statement to the effect that the matters that may be referred to the Commission or District Court are limited to matters specified as disputed in the notice, in a request for a further review of the decision or in a notice after a further review of the decision,

(g) advice as to the procedure for requesting a review of the decision,

(h) unless paragraph (i) applies, a statement to the effect that the worker can refer the dispute about the decision for determination by the Commission (in the case of a dispute about a matter other than a coal miner matter) or the District Court (in the case of a dispute about a coal miner matter),

(i) if the insurer has referred or proposes to refer the disputed discontinuation or reduction for determination by the Commission or District Court, a statement to that effect specifying the date of referral or proposed referral,

(j) a statement to the effect that the worker can seek advice or assistance from the worker's trade union organisation, from a lawyer or from the WorkCover Claims Assistance Service,

(k) the street address and email address of the Registrar of the Commission or Registrar of the District Court, as appropriate.

[3] Clause 15 (3)

Omit the subclause.

[4] Clause 34 Notice of dispute about liability

Omit clause 34 (1). Insert instead:

(1) The notice given to a claimant under section 74 of the 1998 Act must contain the following:

(a) in relation to a coal miner matter:

(i) a statement to the effect that the worker can refer the dispute for determination by the District Court, and

(ii) if the insurer has referred or proposes to refer the dispute for determination by the District Court, a statement to that effect specifying the date of referral or proposed referral, and

(iii) a statement to the effect that the matters that may be referred to the District Court are limited to matters notified in the notice, in a notice after a further review in correspondence prior to any such referral concerning an offer of settlement or in a request for a further review, except with the leave of the District Court,

(b) in relation to a work injury damages dispute:

(i) a statement to the effect that, before a claimant can commence court proceedings, the claimant must firstly serve a pre-filing statement (in accordance with section 315 of the 1998 Act) on the defendant and secondly refer the claim to the Commission for mediation (in accordance with section 318A of the 1998 Act), and

(ii) a statement to the effect that the claimant is not entitled to raise matters in court proceedings that are materially different from those contained in the pre-filing statement, except with the leave of the court,

(c) a statement identifying all the reports and documents submitted by the worker in making the claim for compensation,

(d) a statement identifying all the reports of the type to which clause 37 applies that are relevant to the decision, whether or not the reports support the reasons for the decision,

(e) a statement advising that a copy of a report required to be provided by the insurer under clause 37 (3) (except as provided by clause 37 (5) or (6)) accompanies the notice,

(f) advice as to the procedure for requesting a review of the decision,

(g) a statement to the effect that the worker can seek advice or assistance from the worker's trade union organisation, from a lawyer or from the WorkCover Claims Assistance Service,

(h) the street address and the email address of the Registrar of the Commission or the Registrar of the District Court, as appropriate.

Note. Section 74 of the 1998 Act requires the notice to also include the following:

(a) a statement of the reason the insurer disputes liability and of the issues relevant to the decision,

(b) a statement to the effect that the worker can request a review of the claim by the insurer,

(c) a statement to the effect that the worker can refer the dispute for determination by the Commission,

(d) if the insurer has referred or proposes to refer the dispute for determination by the Commission, a statement to that effect specifying the date of referral or proposed referral,

(e) a statement to the effect that the matters that may be referred to the Commission are limited to matters notified in the notice, or in a notice after a further review or in correspondence prior to any such referral concerning an offer of settlement or in a request for a further review,

(f) a statement to the effect that the worker can also seek advice or assistance from the worker's trade union organisation or from a lawyer.

[5] Clause 34 (4)

Omit the subclause.

[6] Clause 37

Omit the clause. Insert instead:

37 Access to certain medical reports and other reports obtained by insurer: sections 73 and 126 of 1998 Act

(1) This clause applies to the following types of reports that an employer or insurer has in the employer's or insurer's possession:

(a) medical reports, including medical reports provided pursuant to section 119 of the 1998 Act (Medical examination of workers at direction of employer),

(b) medical certificates,

(c) clinical notes,

(d) investigators' reports,

(e) occupational rehabilitation providers' reports,

(f) health service providers' reports,

(g) reports of assessments under section 40A (Assessment of incapacitated worker's ability to earn) of the 1987 Act,

(h) reports obtained by or provided to an employer or insurer that contain information relevant to the claim on which a decision to dispute liability is made,

(i) wage details required to be supplied under section 43 (2) of the 1987 Act where a decision has been made to decline payment of, or reduce the amount of, weekly benefits, but only if such details have not already been supplied to the worker.

(2) This clause applies to the following decisions of an employer or insurer relating to an injured worker:

(a) a decision to dispute liability in respect of a claim, or any aspect of a claim (in circumstances requiring the insurer to give the worker a notice and reasons under section 74 of the 1998 Act),

(b) a decision to discontinue payment, or to reduce the amount of weekly benefits (in circumstances requiring the insurer to give the worker a notice of intention under section 54 of the 1987 Act),

(c) a decision on the review under section 287A of the 1998 Act of a decision described in paragraph (a) or (b) that confirms the original decision.

(3) If an employer or insurer makes a decision to which this clause applies, the employer or insurer must provide a copy of any relevant report to which this clause applies to the worker, as an attachment to a notice under section 74 of the 1998 Act, section 54 of the 1987 Act or section 287A of the 1998 Act, as the case may be, except where the report has already been supplied to the worker and that report is identified in a statement under clause 15 (1) (c) or 34 (1) (d).

(4) The obligation in this clause to provide a copy of a report applies to any report that is relevant to the claim or any aspect of the claim to which the decision relates, whether or not the report supports the reasons for the decision.

(5) If the employer or insurer is of the opinion that supplying a worker with a copy of a report would pose a serious threat to the life or health of the worker or any other person, the employer or insurer may instead supply the report:

(a) in the case of a medical report, medical certificate or clinical notes—to a medical practitioner nominated by the worker for that purpose, or

(b) in any other case—to a legal practitioner representing the worker.

(6) If, on the application of an employer or insurer, the Authority is satisfied that supplying the worker with a copy of the report would pose a serious threat to the life or health of the worker or any other person and that supplying the report as provided by this clause would not be appropriate, the Authority may:

(a) direct that the report be supplied to such other persons as the Authority considers appropriate, or

(b) make such other directions as the Authority thinks fit.

[7] Clause 39 Medical examination of worker at direction of employer

Omit the clause.

[8] Clause 40 Access to medical opinion or report obtained by employer: sec 119 of 1998 Act

Omit the clause.

[9] Clause 42 Definitions

Insert in alphabetical order:

work injury damages threshold dispute means a dispute within the meaning of section 314 of the 1998 Act.

[10] Clause 43

Omit the clause. Insert instead:

43 Restrictions on number of medical reports that can be admitted

(1) In any proceedings on a claim or a work injury damages threshold dispute in relation to an injured worker, only one forensic medical report may be admitted on behalf of a party to proceedings.

(2) A report referred to in subclause (1) must be from a specialist medical practitioner with qualifications relevant to the treatment of the injured worker's injury.

(3) Where the injury has involved treatment by more than one specialist medical practitioner, with different qualifications, then an additional forensic medical report may be admitted from a medical practitioner with qualifications in that specialty.

(4) In this clause:

forensic medical report:

(a) means a report from a specialist medical practitioner who has not treated the worker and has been obtained for the purpose of proving or disproving an entitlement, or the extent of an entitlement, in respect of a claim or dispute, and

(b) includes a medical report provided by a specialist medical practitioner in respect of an examination of the injured worker pursuant to section 119 of the 1998 Act.

[11] Clause 43AA

Insert after clause 43:

43AA Supplementary reports admissible

(1) Despite clauses 43 and 43A, a medical report other than the original report (***a supplementary report***) may be admitted if:

(a) it has the purpose of clarifying the original report, for example, where it can be shown that there has been some omission in relation to the material originally provided that could lead to an opinion in the original report being expressed on the basis of inaccurate or incomplete information, and

(b) it does not go outside the parameters of the original report, but merely confirms, modifies or retracts an opinion expressed in the original report.

(2) A supplementary report can be provided as an addendum to the original report and in such a case the original report together with that addendum constitute the report referred to in clauses 43 and 43A.

(3) A supplementary report must have been provided by the medical practitioner who provided the original report except when the medical practitioner has ceased (permanently or temporarily) to practise in the specialty concerned, in which case the supplementary report must be provided by another medical practitioner of the same specialty.

[12] Clause 43A

Omit the clause. Insert instead:

43A Restriction on disclosure of forensic medical reports to approved medical specialists

(1) A forensic medical report must be disclosed to an approved medical specialist in connection with a claim or a work injury damages threshold dispute if any of the following occurs:

(a) the report was admitted in proceedings on the claim or dispute,

(b) no decision has been made as to whether or not the report is to be admitted, and:

(i) the report was the report nominated by the claimant or respondent as the report that the claimant or respondent concerned would introduce into evidence in proceedings on the claim, or

(ii) the report was the sole report in the particular specialty concerned that was lodged in relation to the claim by the claimant or respondent, as the case may be,

(c) the approved medical specialist calls for the production of the report under section 324 (1) (b) of the 1998 Act.

(2) A forensic medical report is not to be disclosed to an approved medical specialist in connection with a claim or a work injury damages threshold dispute otherwise than in accordance with this clause.

(3) Nothing in this clause permits more than one forensic medical report of the type referred to in clause 43 to be disclosed to an approved medical specialist on behalf of a party to proceedings.

(4) In this clause:

approved medical specialist has the same meaning as in section 319 of the 1998 Act.

forensic medical report:

(a) means a report from a specialist who has not treated the worker and has been obtained for the purpose of proving or disproving an entitlement, or the extent of an entitlement, in respect of a claim or dispute, and

(b) includes a medical report provided by a medical practitioner in respect of an examination of the injured worker pursuant to section 119 of the 1998 Act.

[13] Clause 44 Permissible updates of medical reports

Omit the clause.

[14] Clause 45

Omit the clause. Insert instead:

45 Restrictions on recovery of cost of medical reports

(1) A party to proceedings on a claim is not entitled to be paid for or recover the cost of a medical report in connection with the claim unless:

(a) the report has been admitted into those proceedings on behalf of the party, or

(b) the report has been disclosed to an approved medical specialist.

(2) A party to a claim where no proceedings have been taken is not entitled to be paid for or recover the cost of a medical report in connection with the claim unless the report has been served on another party, and:

(a) the report would be admissible in proceedings on behalf of the party, or

(b) the report could be disclosed to an approved medical specialist.

(3) In this clause:

(a) a reference to a claim includes a reference to an initial notification of injury (as defined in Part 3 of Chapter 7 of the 1998 Act), and

(b) a reference to proceedings on a claim includes a reference to proceedings in respect of the payment of provisional weekly payments of compensation under the 1998 Act.

(4) In this clause:

approved medical specialist has the same meaning as in section 319 of the 1998 Act.

[15] Clause 48A

Insert after clause 48:

48A Further transitional provision

(1) In this clause:

the amending Regulation means the *Workers Compensation Amendment (Miscellaneous Provisions) Regulation 2006*.

(2) The amendments made to this Part by the amending Regulation do not affect the use of a medical report in evidence in proceedings or as part of disclosure to an approved medical specialist where the report relates to an application lodged with the Registrar prior to 1 November 2006.

(3) The amendments made to this Part by the amending Regulation apply to all claims or work injury damages threshold disputes lodged with the Registrar on and from 1 November 2006.

(4) Despite subclause (3), where the medical examination to which the relevant medical report relates occurred before 1 November 2006, this Part, as in force immediately before 1 November 2006, continues to apply in respect of the report if the report:

(a) formed part of an application lodged with the Registrar prior to 1 December 2006, or

(b) formed part of a reply filed in respect of such an application within 21 days of the application being lodged.

(5) Despite subclause (3), clause 45, as in force immediately before 1 November 2006, applies in respect of a medical report where the medical examination to which the report relates occurred before 1 November 2006 and either:

(a) the claim to which the report relates was resolved on or after 1 November 2006 without referral to the Registrar for determination by the Commission, or

(b) the application to which the report relates, or referral of the dispute for determination by the Commission to which the report relates, was lodged with the Registrar before 1 December 2006, except where there was a discontinuance of proceedings (without the consent of both parties) on or after 1 November 2006.

[16] Clause 200B

Insert after clause 200A:

200B New claims procedures—appeal against decision of Commission constituted by Arbitrator

For the purposes of section 352 (8) of the 1998 Act, all preliminary or interim orders, determinations, rulings and directions of an interlocutory nature are prescribed.

Workers Compensation Amendment (Costs) Regulation 2006

under the

Workers Compensation Act 1987 and the Workplace Injury Management and Workers Compensation Act 1998

Her Excellency the Governor, with the advice of the Executive Council, has made the following Regulation under the *Workers Compensation Act 1987* and the *Workplace Injury Management and Workers Compensation Act 1998*.

JOHN DELLA BOSCA, M.L.C.,
Minister for Commerce

Explanatory note

The objects of this Regulation are as follows:

(a) to establish a new scheme fixing maximum costs for legal or agent services provided to claimants, employers and insurers in or in connection with workers compensation matters,

(b) to provide that, in workers compensation matters, no amount is recoverable for costs that are not referred to in the regulations,

(c) to provide that, in workers compensation matters, no amount is recoverable for costs unless the matters have been resolved as set out in substituted Schedule 6,

(d) to prescribe the provision of clinical notes, records and reports by a health service provider as being within the definition of ***costs*** in section 332 of the 1998 Act,

(e) to provide that bills of costs in workers compensation matters are to be given in or to the effect of an approved form,

(f) to authorise the Registrar to make costs orders in connection with interim payment directions, disputes concerning past weekly payments and disputes about non-compliance with Chapter 3 of the 1998 Act, where these are dealt with by the Registrar,

(g) to provide that no appeal lies against a decision of the Registrar of the Workers Compensation Commission arising in proceedings in respect of the assessment of costs under Schedule 6 (but this does not affect appeals already instituted),

(h) to make other amendments of a minor, consequential, ancillary or transitional nature.

The new scheme (the details of which are set out in substituted Schedule 6) is based on a "lump sum" costs model, rather than an "activity based" costs model. The costs, and the maximum amount of those costs, that are recoverable when a claim or dispute is resolved cover the overall costs in reaching that resolution rather than the individual services that may have been provided.

This Regulation is made under the *Workers Compensation Act 1987*, including section 280 (the general regulation-making power), and under the *Workplace Injury Management and Workers Compensation Act 1998*, including sections 59 (g), 248 (the general regulation-making power), 337, 338, 347 and 376 (6).

Workers Compensation Amendment (Costs) Regulation 2006

under the

Workers Compensation Act 1987 and the Workplace Injury Management and Workers Compensation Act 1998

1 Name of Regulation

This Regulation is the *Workers Compensation Amendment (Costs) Regulation 2006*.

2 Commencement

This Regulation commences on 1 November 2006.

3 Amendment of Workers Compensation Regulation 2003

The *Workers Compensation Regulation 2003* is amended as set out in Schedule 1.

Schedule 1 Amendments

(Clause 3)

[1] Clause 81 Definitions

Insert in alphabetical order:

health service provider has the same meaning as in the *Health Care Complaints Act 1993*.

number of an item in a Table in Part B of Schedule 6 includes a letter.

[2] Section 81, note

Omit the note. Insert instead:

Note. Section 332 (2) of the 1998 Act provides that expressions used in Division 1 of Part 8 of Chapter 7 of that Act (and consequently expressions used in this Part) have the same meanings as they have in Part 3.2 of the *Legal Profession Act 2004*, except as provided by section 332 (Definitions) of the 1998 Act. Under section 302 of the *Legal Profession Act 2004*, costs includes fees, charges, disbursements and remuneration.

[3] Clause 81A

Insert after clause 81:

81A Sec 332 of 1998 Act: definition of "costs"

For the purposes of paragraph (f) of the definition of ***costs*** in section 332 (1) of the 1998 Act, the costs of providing clinical notes, records and reports by a health service provider are prescribed as costs within that definition.

[4] Clause 82 Costs not regulated by this Part

Insert "Costs referred to in clause 82 are recoverable under, and may be regulated by, other legislation (including regulations under the *Legal Profession Act 2004*) or common law principles." before "Under" in the note.

[5] Clause 82 (e)

Insert "(except as provided in item 4 of Part C of Schedule 6)" after "providers".

[6] Clause 84 Maximum costs recoverable

Omit "Commission" from clause 84 (3). Insert instead "Registrar".

[7] Clause 84A

Insert after clause 84:

84A Maximum costs involving medical or related treatment or certain fees for health service providers

In workers compensation matters, the costs that are recoverable, and the maximum costs that are recoverable, in respect of costs of a kind referred to in clause 82 or Part C of Schedule 6 are, if section 61 of the 1987 Act or section 339 of the 1998 Act applies in respect of costs of that kind, costs equal to the amount fixed by or by order under the section concerned.

[8] Clause 85 Special provisions for costs where claim transferred to Commission

Omit "an election by the worker under clause 225".

Insert instead "the transfer of the claim to the Commission under clause 225 or 226".

[9] Clause 85 (a)

Omit "when the claimant makes the election".

Insert instead "of the transfer".

[10] Clause 85 (b)

Omit "election". Insert instead "transfer".

[11] Clause 85A

Insert after clause 85:

85A Costs not recoverable in certain circumstances (workers compensation matters)

(1) This clause applies to workers compensation matters.

(2) No amount is recoverable for costs (including disbursements) that are referred to in neither clause 82 nor Schedule 6.

(3) No amount is recoverable for costs for any service or matter unless the claim or dispute (or the relevant aspect of the claim or dispute) to which the service or matter relates is resolved or otherwise dealt with in accordance with Schedule 6.

(4) Despite subclause (3), if an appeal is lodged in respect of a claim or dispute, no amount is recoverable for costs for any service or matter (or the relevant aspect of the claim or dispute) unless the appeal is determined, is withdrawn or lapses.

[12] Clause 96 Application by client for assessment of practitioner/client or agent/client costs

Omit "those costs" from clause 96 (1).

Insert instead "so much of those costs as are payable on a practitioner and client basis or an agent and client basis".

[13] Clause 97 Application by instructing practitioner or agent for assessment of practitioner/client or agent/client costs

Omit clause 97 (1). Insert instead:

(1) A legal practitioner or agent who:

(a) retains another legal practitioner or agent to act on behalf of the client, and

(b) is given a bill of costs in accordance with this Part by the other legal practitioner or agent,

may apply to the Registrar for an assessment of the whole, or any part of, so much of those costs as are payable on a practitioner and client basis or an agent and client basis.

[14] Clause 98 Application by billing practitioner or agent for assessment of practitioner/client or agent/client costs

Omit "those costs" from clause 98 (1).

Insert instead "so much of those costs as are payable on a practitioner and client basis or an agent and client basis".

[15] Clause 98 (2) (a) (ii)–(viii)

Omit clause 98 (2) (a) (ii) and (iii). Insert instead:

(ii) if relevant, an identification of each general resolution type referred to in Table 2 in Part B of Schedule 6 by reference to the item number and column number in Table 2 of the general resolution type that was attained,

(iii) if relevant, an identification of each special resolution type referred to in Table 3 in Part B of Schedule 6 by reference to the item number and column number in Table 3 of the special resolution type that was attained,

(iv) if relevant, an identification of the phase of each general resolution type referred to in Table 1 in Part B of Schedule 6 by reference to the item number and column number in Table 1 of the general resolution type that was attained,

(v) if relevant, an identification of each additional legal service or other factor referred to in Table 4 in Part B of Schedule 6 by reference to the item number and (where relevant) column number in Table 4 of the legal service or factor,

(vi) an identification of each disbursement incurred by reference to a paragraph number in clause 82 or an item number in Part C of Schedule 6,

(vii) an identification of each activity, event or stage specified in Schedule 7, by reference to the item number of the activity, event or stage, that was carried out,

(viii) the amount sought, and

[16] Clause 98A

Insert after clause 98:

98A Application for assessment of party/party costs—compensation matters

(1) A person who is entitled to receive or who has received costs, in or in connection with a workers compensation matter, as a result of:

(a) an order for the payment of an unspecified amount of costs made by a court or the Commission, or

(b) an agreement, evidenced in writing by the party liable to pay the costs, for the payment of an unspecified amount of costs,

may apply to the Registrar for an assessment of the whole of, or any part of, those costs.

(2) A person who has paid or is liable to pay costs, in or in connection with a workers compensation matter, as a result of an order or agreement referred to in subclause (1) may apply to the Registrar for an assessment of the whole of, or any part of, those costs after the period of 60 days after the making of the order or agreement.

(3) A court or the Commission may direct the Registrar to assess costs payable as a result of an order made by the court or the Commission. Any such direction is taken to be an application for assessment duly made under this Division.

[17] Clause 99 Application for assessment of party/party costs—work injury damages matters

Insert ", in or in connection with a work injury damages matter," after "costs" where firstly occurring in clause 99 (1).

[18] Clause 101

Omit the clause. Insert instead:

101 Persons to be notified of application

The applicant for assessment is to cause a copy of the application for assessment to be given to:

(a) each other party and each legal practitioner, agent and other client involved, and

(b) any other persons to whom the Registrar requires the applicant to give notice of the application,

within 7 days after the application is accepted by the Registrar for registration.

[19] Clause 110 Assessment of costs—costs ordered by court or Commission or subject of agreement

Insert "or as a result of an agreement referred to in clause 98A (1) (b)" after "Commission" in clause 110 (1).

[20] Clause 110 (2)

Insert "or agreement" after "order".

[21] Clause 119 Appeal against decision of Registrar as to matter of law

Insert after clause 119 (4):

(5) Subclause (1) does not apply to any decision of the Registrar arising in proceedings on an application in respect of the assessment of costs under Schedule 6 as in force at any time before, on or after 1 November 2006, unless:

(a) an appeal against the decision has been instituted in accordance with this clause before that date, or

(b) the decision is made in or in connection with the reference of a dispute to the Registrar under clause 84 (3).

[22] Clause 125 Transitional provisions

Insert "or 226" after "225" in clause 125 (1) (c).

[23] Clause 125 (3)

Insert "taking effect before 1 November 2006" after "Schedule 6".

[24] Clause 125A

Insert after clause 125:

125A Transitional provisions—amendments made by Workers Compensation Amendment (Costs) Regulation 2006

(1) **Costs (other than disbursements)—proceedings commenced in Commission before commencement date**
This Part and Schedule 6 as in force before 1 November 2006 continue to apply to and in respect of costs (other than disbursements) where proceedings in the matter were commenced in the Commission before that date.

(2) **Costs (other than disbursements)—proceedings commenced in Commission on or after commencement date**
This Part and Schedule 6 as in force on 1 November 2006 apply to and in respect of costs (other than disbursements) where proceedings in the matter are commenced in the Commission on or after that date (subject to any relevant amendments made after that date).

(3) **Costs (other than disbursements)—matters resolved before commencement date without recourse to Commission**
This Part and Schedule 6 as in force before 1 November 2006 continue to apply to and in respect of costs (other than disbursements) in matters resolved before that date without recourse to the Commission.

(4) **Costs (other than disbursements)—matters resolved on or after commencement date without recourse to Commission**
This Part and Schedule 6 as in force on 1 November 2006 apply to and in respect of costs (other than disbursements) in matters resolved on or after that date (subject to any relevant amendments made after that date) without recourse to the Commission.

(5) **Disbursements incurred before commencement date**
Subject to clauses 45 and 48A, a disbursement incurred before 1 November 2006 is to be reimbursed subject to and in accordance with this Part and Schedule 6 as in force before that date.

(6) **Disbursements incurred on or after commencement date**
A disbursement incurred on or after 1 November 2006 is to be reimbursed subject to and in accordance with:

(a) this Part and Schedule 6 as in force before that date, where proceedings in the matter were commenced in the Commission before that date, or

(b) this Part and Schedule 6 as in force on or after that date (subject to any relevant amendments made after that date), where:

(i) proceedings in the matter are commenced in the Commission on or after that date, or

(ii) the matter is resolved on or after that date without recourse to the Commission.

(7) **Costs orders applicable to directions or recommendations given or made before commencement date**
The Registrar may, subject to Schedule 6 as in force before 1 November 2006, make a costs order in connection with:

(a) the giving of an interim payment direction under Division 2 of Part 5 of Chapter 7 of the 1998 Act, or

(b) the making of a recommendation under Division 3 of Part 5 of Chapter 7 of the 1998 Act,

where the application was made, the direction was given or the recommendation was made before that date, and may do so by making a global order of a general nature.

(8) **Interpretation**
For the purposes of this clause, proceedings were or are commenced in the Commission when the initiating application has been accepted by the Registrar for registration.

(9) For the purposes of this clause, a matter was or is resolved without recourse to the Commission when:

(a) the insurer notifies the claimant, or the legal practitioner or agent representing the claimant, in writing that the claim or an aspect of the claim has been accepted, or

(b) payment has been made to the claimant by the insurer in respect of the claim,

whichever is the sooner.

(10) For the purposes of this clause, a matter relating to the insurer's legal representative's or agent's costs was or is resolved without recourse to the Commission when:

(a) the insurer notifies the claimant, or the legal practitioner or agent representing the claimant, in writing that the insurer disputes liability in respect of the claim or an aspect of the claim, and

(b) the decision of the insurer to do so is not disputed by the claimant.

Nothing in this subclause affects the application of subclause (9) to the insurer's legal representative's or agent's costs.

[25] Clauses 126A and 126B

Insert after clause 126:

126A Bill of costs to be in approved form

In workers compensation matters, a bill of costs (as defined by clause 95):

(a) must, if there is a form approved by the Authority for the purposes of this clause, be given in or to the effect of the approved form, and

(b) must include relevant particulars of the kind referred to in clause 98 (2) (a) even if the bill is not one to which clause 98 applies.

126B Costs orders in respect of certain matters

The Registrar may, subject to Schedule 6, make a costs order in connection with any of the following:

(a) an application for or the giving of an interim payment direction under Division 2 (Disputes concerning weekly payments or medical expenses) of Part 5 of Chapter 7 of the 1998 Act,

(b) the determination of a dispute under Division 2A (Disputes concerning past weekly payments) of that Part,

(c) the making of recommendation under Division 3 (Disputes about non-compliance with Chapter 3) of that Part.

[26] Schedule 6

Omit the Schedule. Insert instead:

Schedule 6 Maximum costs—compensation matters

(Clause 84)

Part A Application and operation of Schedule

1 Introduction

(1) This Schedule applies to:

(a) workers compensation claims and disputes that are resolved before proceedings are commenced in the Workers Compensation Commission (the ***Commission***) (in certain circumstances), and

(b) disputes that are resolved after proceedings have been commenced in the Commission.

Note. Clause 125A of the *Workers Compensation Regulation 2003* contains transitional provisions regarding the operation of Schedule 6 as in force before 1 November 2006 and as substituted with effect from that date.

(2) When a claim or dispute is resolved, legal practitioners or agents representing the parties will need to determine what type of resolution has been reached and when it was resolved. By applying these factors to this Schedule, the legal practitioners or agents will be able to ascertain the costs recoverable.

(3) If a claim or dispute involves a number of resolution types that are resolved concurrently, or within a specified time frame, the costs recoverable are restricted to the resolution for which the highest amount of costs is payable.

(4) The recoverable costs will be either:

(a) a maximum flat, predetermined figure, or

(b) in the case of certain "special resolutions", a maximum amount establishing a range within which the parties may negotiate their costs entitlement.

(5) If a claim or dispute (other than a claim or dispute resolved by special resolution) includes "additional legal services" or involves "factors" as referred to in Table 4, there may be an additional allowance that can be added to the entitlement to costs.

(6) Part C determines regulated disbursements. Unregulated disbursements as identified by clause 82 of the *Workers Compensation Regulation 2003*, may be determined by the *Legal Profession Regulation 2005*, or if that Regulation does not apply, then principles of fairness and reasonableness apply. Disbursements that are neither regulated under Part C nor specified in clause 82 of the *Workers Compensation Regulation 2003* are not recoverable, subject to clause 17 of this Part (Recovery of certain charges for certain documents from public authorities).

(7) This Schedule contains three Parts:

Part A contains definitions, describes how the Tables operate and in some cases modifies the operation of the Tables.

Part B contains four tables:

Table 1 sets out the phases at which claims and disputes may be resolved and the costs that apply for the resolution at each phase.

Table 2 sets out the types of resolutions that apply to Table 1, and indicates the level of costs (ie 75% or 100%) that will apply to that resolution type.

Table 3 sets out alternate or "special" resolution types and the applicable costs for each party. Tables 1 and 2 do not apply to these "special" resolution types.

Table 4 sets out additional legal services and other factors that may result in an increase to the costs claimable under Table 1.

Part C lists regulated disbursements.

2 Definitions

(1) In this Schedule:

application means an application for resolution of a claim or dispute in the approved form accepted by the Registrar for registration.

complying agreement has the same meaning as in section 66A of the 1987 Act.

dispute notice means:

(a) a notice issued under section 54 of the 1987 Act, or

(b) a notice issued under section 74 of the 1998 Act, or

(c) a notice issued under section 287A of the 1998 Act.

fee order means an order made by the Authority in relation to fees.

insurer includes the Nominal Insurer, a self-insurer and a specialised insurer.

lead scheme agent means the agent who is representing the Nominal Insurer on behalf of a number of scheme agents in the conduct of a claim or dispute.

legal practitioner means an Australian legal practitioner.

Nominal Insurer has the same meaning as in the 1987 Act.

resolved—see subclauses (2) and (3).

respondent means a person who is a party to a dispute other than the applicant.

scheme agent has the same meaning as in the 1987 Act.

self-insurer has the same meaning as in the 1987 Act.

specialised insurer has the same meaning as in the 1987 Act.

Table means a Table in Part B.

teleconference means a telephone conference conducted by the Registrar or the Commission.

the 1926 Act means the *Workers' Compensation Act 1926*.

(2) **Meaning of "resolved"—claimant**

For the purposes of this Schedule, a claim or dispute is resolved, in relation to a claimant, if:

(a) the claim or dispute is wholly or partly resolved in the claimant's favour, or

(b) an application brought by an insurer in relation to the claim or dispute is successfully defended in whole or in part,

but does not include a matter discontinued, withdrawn, dismissed or struck out without any resolution referred to in paragraph (a) or (b) unless otherwise ordered or certified for the purposes of cost recovery by the Commission or the Registrar.

(3) **Meaning of "resolved"—insurer**

For the purposes of this Schedule, a claim or dispute involving a claimant is resolved, in relation to an insurer, if:

(a) the claim or dispute is concluded, or

(b) an application brought by the insurer in respect of the claim or dispute is concluded,

unless otherwise ordered or certified for the purposes of cost recovery by the Commission or the Registrar.

(4) **Meaning of other compensation claim or dispute in Table 1**

A reference in Table 1 to an ***other compensation claim or dispute*** (or ***other compensation dispute***) is a reference to a claim or dispute (or a dispute) concerning compensation to which the resolutions in items 5–16 of Table 2 relate.

Note. The purpose of this subclause is to make it clear that the successive use of the word "other" in Table 1 does not result in successive narrowing of the terms used.

(5) **Notes**

Despite clause 3 (2) of the *Workers Compensation Regulation 2003*, notes included in this Schedule form part of this Regulation.

3 Overall application of Schedule

(1) This Schedule is to be read and applied in its entirety, and accordingly this Schedule applies in relation to costs in accordance with:

(a) the descriptions contained in Tables 1 to 4, and

(b) the notes in Part B, and

(c) Parts A and C.

(2) This Schedule prescribes the maximum costs recoverable in respect of work carried out to achieve the resolution types described in Tables 2 and 3 for:

(a) resolving claims and disputes before an application is accepted by the Registrar for registration, or

(b) resolving disputes after an application is accepted by the Registrar for registration.

4 General application of Tables

(1) **General resolution types**

The maximum amount of costs for the resolution of a claim or dispute as described in Table 2 are the amounts set out in:

- column 1 or 2 of Table 1 for the claimant, and
- column 3 or 4 of Table 1 for the insurer,

for the applicable phase.

However:

(a) that maximum amount may be decreased by an amount already received under an entitlement from Table 3 in circumstances specified in that Table, and

(b) that maximum amount may be increased by an entitlement under Table 4 in circumstances specified in that Table.

(2) **Special resolution types**

The maximum amount of costs for the resolution of a claim or dispute as described in Table 3 are the amounts set out in that Table.

(3) **Additional legal services or other factors—general**

The maximum amount of costs for an additional legal service or other factor in respect of a resolution as described in items 1–5 of Table 4 is up to the amount or percentage of costs set out in:

- columns 1 and 3 of items 1–4 of Table 4 for the claimant, and
- columns 2 and 4 of items 1–4 of Table 4 for the insurer, and

- column 5 of item 5 of Table 4 for the claimant, and
- column 6 of item 5 of Table 4 for the insurer.

Accordingly and for the avoidance of doubt:

(a) an entitlement to costs under item 1, 2 or 3 of Table 4 as certified by the Commission or the Registrar may be added to the costs recoverable under item B, D, E or F of Table 1, and

(b) an entitlement to a percentage increase in costs ascertained under item 4 or 5 of Table 4 and as certified by the Commission or the Registrar applies to increase the costs claimable under item D, E or F of Table 1, and

(c) an entitlement to costs under item 1, 2 or 3 of Table 4 as certified by the Commission or the Registrar is recoverable by an insurer in respect of a resolution referred to in item B of Table 1 even though no costs may be recoverable by the insurer under that item.

(4) **Additional legal services or other factors—multiple respondents or lead scheme agent**

The maximum costs for an additional legal service or other factor as described in items 6 and 7 of Table 4 are up to the percentage applicable for the claimant and insurer as specified.

Accordingly and for the avoidance of doubt, an entitlement to a percentage increase in costs ascertained under items 6 and 7 of Table 4 applies to increase the costs claimable under items A to F of Table 1.

(5) **Table 4 costs not separately claimable**

Except as referred to in subclause (3) (c), costs specified in Table 4 are recoverable only if costs as described in Table 1 are also recoverable.

5 When Table 1 costs recoverable

Costs specified in clause 4 of this Part are recoverable only on resolution of the claim or dispute concerned.

6 Special provisions for Table 1 costs—dispute about permanent impairment and pain and suffering

(1) An exception to the standard method of determining the appropriate Table 1 costs for a claimant and an insurer based upon the meaning of "resolved" under clause 2 of this Part and the types of resolutions set out in Table 2 applies, where:

(a) a claimant has made an application to the Commission to resolve a dispute about permanent impairment and pain and suffering pursuant to sections 66 and 67 of the 1987 Act, and

(b) the section 67 claim has been substantiated by:

(i) a report, from a medical specialist with qualifications and training relevant to the body system being assessed who has been trained in the WorkCover Guidelines, to the effect that the claimant has sustained 10% or more whole person impairment where:

- the injury was sustained on or after 1 January 2002, and
- that report has been served on the insurer, or

(ii) a medical report to the effect that the claimant has sustained a loss or losses of 10% or more of the maximum amount referred to in section 66 (1) of the 1987 Act where:

- the injury was sustained before 1 January 2002, and
- that report has been served on the insurer, and

(c) the medical assessment certificate issued by an approved medical specialist or a Medical Appeal Panel is to the effect that the degree of whole person impairment of the claimant is below 10% or the loss or losses are not 10% or more of the maximum amount referred to in section 66 (1) of the 1987 Act.

(2) In a case to which subclause (1) applies:

(a) the claimant is entitled to maximum costs in the amount of $4,000, and

(b) the insurer is entitled to maximum costs in the amount of $1,875.

Note. The deduction in respect of an advice to an insurer under item F of Table 3 applies to this costs provision.

7 When Table 3 costs recoverable, and reduction of subsequent Table 1 costs

(1) **When Table 3 costs recoverable**

Costs specified in Table 3 as "Special Resolution Types" are recoverable only:

(a) on resolution of the dispute in respect of items A, B and C of that Table, or

(b) on registration of the agreement with the Commission in respect of item D of that Table, or

(c) when an existing decision of the insurer has been varied as a consequence of a legal service, where it was reasonable to carry out that service in respect of item E of that Table, or

(d) when written advice has been provided to the insurer in respect of item F of that Table, or

(e) when independent legal advice has been given to a claimant in respect of a complying agreement proposed by an insurer in respect of item G of that Table.

(2) **Reduction of subsequent Table 1 costs**

The costs referred to in subclause (1) are not payable or recoverable in conjunction with any other items in this Schedule (with the exception of disbursements under Part C or disbursements specified in clause 82 of the *Workers Compensation Regulation 2003*) with the result that:

(a) if costs have been recovered in respect of item A, B or C of Table 3 and costs subsequently become recoverable under Table 1 in respect of a resolution that relates to the same issue, the entitlement to costs under Table 1 is to be reduced by any payment already made in respect of item A, B or C of Table 3, and

(b) if costs have been recovered in respect of item E of Table 3 and costs subsequently become payable under Table 1 in respect of a resolution that relates to the same issue, the entitlement to costs under Table 1 is to be reduced by any payment made in respect of item E of Table 3, and

(c) if costs have been recovered in respect of item F of Table 3 and costs subsequently become payable under Table 1 in respect of a claim or dispute relating to the issue addressed in the written advice, the entitlement to costs under Table 1 is to be reduced by any payment made in respect of item F of Table 3 (but the maximum reduction is the amount paid for the first such advice), and

(d) if costs have been recovered in respect of item G of Table 3 and costs subsequently become payable under Table 1 in respect of a claim or dispute relating to the issue addressed in the complying agreement, the entitlement to costs under Table 1 is to be reduced by a payment made in respect of item G of Table 3.

(3) Subclause (2) (c) does not apply where:

(a) payment was for advice given on issues that are not in dispute and thus are not part of the Table 1 resolution, in which case there is to be no deduction, or

(b) a period of more than 12 months has elapsed between the giving of the advice and the Table 1 resolution, or

(c) the Registrar, on application, determines that the need for the costs to be incurred for the Table 1 resolution could not have been foreseen at the time that costs for the advice were first incurred.

No costs are payable or recoverable in respect of an application for the purposes of paragraph (c).

(4) Subclause (2) (d) does not apply where a period of more than 12 months has elapsed between the giving of the advice in respect of the complying agreement and the Table 1 resolution.

8 Maximum payable where more than one resolution type

(1) Subject to clause 7 of this Part, where the resolution includes more than one resolution type in Table 2, or includes resolution types in Tables 2 and 3, the following provisions apply:

(a) in relation to a claimant:

(i) if all resolutions fall within column 1 of Table 1, the single highest amount claimable for a resolution is payable, once only, or

(ii) if all resolutions fall within column 2 of Table 1, the single highest amount claimable for a resolution is payable, once only, or

(iii) if resolutions fall within both columns 1 and 2 of Table 1, the single highest amount claimable for a resolution is payable, once only, or

(iv) if resolutions fall within both Tables 1 and 3, the single highest amount claimable for a resolution is payable, once only,

(b) in relation to an insurer:

(i) if all resolutions fall within column 3 of Table 1, the single highest amount claimable for a resolution is payable, once only, or

(ii) if all resolutions fall within column 4 of Table 1, the single highest amount claimable for a resolution is payable, once only, or

(iii) if resolutions fall within both columns 3 and 4 of Table 1, the single highest amount claimable for a resolution is payable, once only, or

(iv) if resolutions fall within both Tables 1 and 3, the single highest amount claimable for a resolution is payable, once only.

(2) Where subclause (1) applies and additional legal services or other factors set out in Table 4 are also claimable, the Table 4 items are payable up to the highest rate claimable, once only.

9 Maximum payable where more than one claim or dispute

(1) If more than one claim or dispute is resolved in respect of a particular injury, the maximum costs recoverable, regardless of how many resolution types there are, is the maximum as set out in clause 8 of this Part.

(2) Subclause (1) does not apply if:

(a) a period of more than 12 months has elapsed between each successive resolution in respect of the injury, or

(b) the Commission or the Registrar, on application, orders that the resolutions are to be treated as separate resolutions for the purposes of the calculation or assessment of costs.

No costs are payable or recoverable in respect of an application for the purposes of paragraph (b).

10 Maximum payable covers all work

The costs allowed under:

(a) Table 1 in column 1, 2, 3 or 4 for each type of general resolution, and

(b) Table 3 for each type of special resolution, and

(c) Table 4 for additional legal services or other factors,

cover all work performed in the course of the claim, dispute, legal service or factor. This includes but is not limited to conferences, seeking a review of the claim, completing all necessary preparation and documentation, appearances and advocacy, executing and lodging settlement documents, reviewing the determination of the Commission and concluding attendances.

11 Determination of maximum payable where an upper limit is set

If Table 3 or 4 or Part C sets an upper limit for the maximum payable by way of any costs, the maximum payable is to be an amount determined, within the range from and including nil to and including the upper limit, by reference to:

(a) any applicable practice direction or Registrar's guideline, and

(b) subject to paragraph (a), the nature and extent of the service performed.

12 Table 2—resolution after teleconference and before further attendance

Where the Commission or the Registrar issues a determination in respect of a resolution type in Table 2, following the initial teleconference and before any further attendances, the costs in relation to that resolution fall within item D of Table 1.

13 Table 3—orders

For the purposes of Table 3, the Commission or the Registrar may order declaring that a particular proceeding is in respect of the resolution of "other proceedings" as referred to in item C of that Table.

14 Special provisions for Table 1 and Table 3 costs—legal advice to claimant on complying agreement

(1) Costs are not recoverable under item A of Table 1 in respect of independent legal advice given to a claimant in respect of a complying agreement proposed by an insurer, if the only service provided to the claimant relates to the giving of that advice.

(2) Costs are not recoverable under item G of Table 3 in respect of independent legal advice given to a claimant in respect of a complying agreement proposed by an insurer, unless the only service provided to the claimant relates to the giving of that advice.

Note. Section 66A (6) of the 1987 Act provides that nothing in section 66A prevents a complying agreement from containing provision as to the payment of costs. Accordingly, a complying agreement may provide for the payment of costs, but the maximum recoverable is subject to Part B.

15 Country/interstate loadings—Part C

Country or interstate loadings (including travel and accommodation expenses) are payable in accordance with clause 3 or 4 (as relevant) of Schedule 1 to the *Motor Accidents Compensation Regulation 2005*, and the provisions of those clauses apply, with any necessary modifications and with any modifications contained in a practice direction or Registrar's guideline, for that purpose.

16 Certain agents not entitled to costs

(1) No amount is recoverable for costs by an agent who is not an agent as defined in section 356 (6) of the 1998 Act, with the result that the agent is not entitled to be paid or recover any amount for the service or matter concerned.

(2) Nothing in this clause prevents an agent who is a legal practitioner from being entitled to be paid or recover any costs.

17 Recovery of certain charges for certain documents from public authorities

Nothing in the *Workers Compensation Regulation 2003* (including this Schedule) prevents the recovery, as a disbursement, of the fee or charge set for any of the following reports, certificates, searches or services by the agency concerned in a claim in respect of a particular injury:

(a) a report from a coroner, the NSW Police or the Roads and Traffic Authority relevant to the claim,

(b) a land title search from Land and Property Information NSW relevant to the claim,

(c) a certificate from the Registry of Births, Deaths and Marriages relevant to the claim,

(d) an application under the *Freedom of Information Act 1989* relevant to the claim,

(e) a company or business name search from the Australian Securities and Investments Commission relevant to the claim.

18 Costs unreasonably incurred

Where the Commission is satisfied that a party's costs have been unreasonably incurred in accordance with section 342 of the 1998 Act, the maximum amount of recoverable costs, if any, is restricted to the costs recoverable in the phase where the circumstances referred to in section 342 (2) of that Act arose and is not to include any further costs.

Part B Costs

Table 1 General resolution types—costs payable

Item	General resolution (for general resolution types refer to Table 2)	Claimant		Insurer	
		Column 1 75%	Column 2 100%	Column 3 75%	Column 4 100%
A	Lump sum compensation claim or dispute resolved • before application accepted by the Registrar (Table 2—items 1–4—Claimant; item 2 only—Insurer)	$2,475	$3,275	$1,575	N/A
B	Lump sum compensation claim or dispute resolved • after application accepted by the Registrar and up to and including the issue of a Certificate of Determination (Table 2—items 1–4—Claimant; item 2 only—Insurer)	$3,525	$4,675 (or $4,000 where clause 6 of Part A applies)	$2,550 (or $1,875 where clause 6 of Part A applies)	N/A
C	Other compensation claim or dispute resolved • after dispute notice issued and before application accepted by the Registrar, or • before application accepted by the Registrar in relation to a claim for compensation in respect of the death of a worker (Table 2—items 5–16)	$2,860	$3,785	$2,345	$3,100

Item	General resolution (for general resolution types refer to Table 2)	Claimant		Insurer	
		Column 1 75%	Column 2 100%	Column 3 75%	Column 4 100%
D	Other compensation dispute resolved • after application accepted by the Registrar, and up to and including the initial teleconference including consequential settlement attendances (Table 2—items 5–16)	$3,870	$5,135	$3,355	$4,450
E	Other compensation dispute resolved • after initial teleconference and up to and including conciliation conference including consequential settlement attendances (Table 2—items 5–16)	$4,250	$5,645	$3,665	$4,860
F	Other compensation dispute resolved • following conciliation conference and up to and including arbitration hearing (Table 2—items 5–16)	$4,615	$6,125	$3,935	$5,225

Table 2 General resolution types—applicable rate

Item	General resolution types	Column 1 75%	Column 2 100%
	Lump sum compensation resolutions		
1	Lump sum compensation for permanent impairment under section 66 of the 1987 Act (excluding any claim for pain and suffering under section 67 of that Act) where: • the extent of impairment is the only issue, or • a dispute notice has not been issued (Claimant only—item A or B of Table 1)	75%	—
2	Lump sum compensation for pain and suffering under section 67 of the 1987 Act (item A or B of Table 1)	75%	—
3	Lump sum compensation under section 16 of the 1926 Act where: • the extent of impairment (or loss) is the only issue, or • a dispute notice has not been issued (Claimant only—item A or B of Table 1)	75%	—
4	Lump sum compensation for permanent impairment under section 66 of the 1987 Act and for pain and suffering under section 67 of that Act where: • the extent of impairment and pain and suffering are the only issues, or • a dispute notice has not been issued (Claimant only—item A or B of Table 1)	—	100%
	Other compensation resolutions		
5	Lump sum compensation for permanent impairment where: • a dispute notice has been issued, or • the matter is referred by the Registrar for determination by an arbitrator (Item C, D, E or F of Table 1)	—	100%

Item	General resolution types	Column 1 75%	Column 2 100%
6	Weekly payments compensation for a period not exceeding 12 weeks in total, excluding interim payment directions under Chapter 7, Part 5, of the 1998 Act (Item C, D, E or F of Table 1)	75%	—
7	Weekly payments compensation for a period exceeding 12 weeks in total, being a period in respect of which an interim payment direction under Chapter 7, Part 5, of the 1998 Act has not been made (Item C, D, E or F of Table 1)	—	100%
8	Termination or reduction of weekly payments compensation (on a review under section 55 of the 1987 Act) (Insurer only—item C, D, E or F of Table 1)	—	100%
9	Successfully defending an application to terminate or reduce weekly payments compensation (Claimant only—item C, D, E or F of Table 1)	—	100%
10	Increase in weekly payments compensation (on a review under section 55 of the 1987 Act) (Claimant only—item C, D, E or F of Table 1)	—	100%
11	Defending an application to increase weekly payments compensation (on a review under section 55 of the 1987 Act) (Insurer only—item C, D, E or F of Table 1)	—	100%
12	Medical expenses compensation not exceeding $7,500, excluding interim payment directions under Chapter 7, Part 5, of the 1998 Act (Item C, D, E or F of Table 1)	75%	—
13	Medical expenses compensation exceeding $7,500 (Item C, D, E or F of Table 1)	—	100%

Item	General resolution types	Column 1 75%	Column 2 100%
14	Compensation in respect of the death of a worker under Part 3, Division 1, of the 1987 Act where: • the respondent admits liability, and • there is no dispute regarding dependency (Item C of Table 1)	75%	—
15	Compensation in respect of the death of a worker under Part 3, Division 1, of the 1987 Act where: • the respondent disputes liability, and/or • the respondent disputes dependency (Item C, D, E or F of Table 1)	—	100%
16	Reduction in liability of employer to reimburse the WorkCover Authority Fund under section 145 of the 1987 Act by determination of the Commission or agreement after referral (Item D, E or F of Table 1)	75%	—

Table 3 Special resolution types—costs payable

Item	Special resolution types	Application of behalf of claimant		Application of behalf of insurer	
		Column 1 Claimant	Column 2 Insurer	Column 3 Claimant	Column 4 Insurer
A	**Interim payment dispute resolved**				
	1 Dispute resolved by direction or agreement, after application accepted by the Registrar	$1,650	$1,400	N/A	N/A

Item	Special resolution types	Application of behalf of claimant		Application of behalf of insurer	
		Column 1 Claimant	Column 2 Insurer	Column 3 Claimant	Column 4 Insurer
	2 If further dispute about the same claim is resolved by direction or agreement, after application accepted by the Registrar	$550	$550	N/A	N/A
B	**Workplace injury management dispute resolved**				
	1 Dispute resolved by direction, recommendation, determination or agreement, after application accepted by the Registrar	$1,925	$1,675	$1,925	$1,675
	2 If further dispute about the same claim is resolved by direction, recommendation, determination or agreement, after application accepted by the Registrar	$550	$550	$550	$550
C	**Resolution of other proceedings**				
	1 As ordered or certified by the Commission or the Registrar	Upper limit of $1,100	Upper limit of $1,100	Upper limit of $1,100	Upper limit of $1,100

Item	Special resolution types	Application of behalf of claimant		Application of behalf of insurer	
		Column 1 Claimant	Column 2 Insurer	Column 3 Claimant	Column 4 Insurer
D	**Registration of commutation agreement**				
	1 Where agreement approved by WorkCover Authority and registered with the Registrar (including all preparation and documentation in approved form in accordance with Rules	$1,500	$1,500	$1,500	$1,500
Item	**Special resolution types**	**Claimant**			
E	**Legal service to claimant before dispute notice**				
	1 Where an insurer's decision on the existing entitlement to weekly payments is varied to the worker's benefit by an increase of 5% or more in weekly payments as a consequence of a legal service, where it was reasonable to carry out that service	Upper limit of $1,100			

Item	Special resolution types	Insurer
F	**Written advice provided at the request of the insurer**	
	1 Where: • the legal advice to an insurer is the provision of written advice at the request of the insurer before the issue of a dispute notice, and • costs are not recoverable under Table 1 in respect of the claim or dispute the subject of that advice (subject to clause 7 of Part A)	Upper limit of $825
Item	**Special resolution types**	**Claimant**
G	**Advice in respect of complying agreement**	
	1 Where independent legal advice given to a claimant in respect of a complying agreement proposed by an insurer under section 66A of the 1987 Act (subject to clause 7 of Part A)	$825

Table 4 Additional legal services or other factors

Item	Additional legal services or other factors	Application on behalf of claimant		Application on behalf of insurer	
		Column 1 Claimant	Column 2 Insurer	Column 3 Claimant	Column 4 Insurer
1	**Appeal against an arbitral decision to Presidential member**				
	Appeal resolved by decision of Presidential member Costs to be as ordered or certified by the Presidential member and may encompass all parties' costs	(a) Nil if unsuccessful (b) Upper limit of $2,200 if successful	Upper limit of $2,200	Upper limit of $2,200	(a) Nil if unsuccessful (b) Upper limit of $2,200 if successful
2	**Question of law determined by the President**				
	Matter resolved by the decision of the President Costs to be as ordered or certified by the President and may encompass all parties' costs	Upper limit of $2,200	Upper limit of $2,200	Upper limit of $2,200	Upper limit of $2,200

Item	Additional legal services or other factors	Application on behalf of claimant		Application on behalf of insurer	
		Column 1 Claimant	Column 2 Insurer	Column 3 Claimant	Column 4 Insurer
3	**Appeal against a medical assessment under Chapter 7, Part 7, of the 1998 Act**				
	Appeal resolved by the decision of Appeal Panel Costs to be as ordered or certified by the Commission or the Registrar and may encompass all parties' costs	(a) Nil if result is not more favourable (b) Upper limit of $1,100 if result is more favourable	Upper limit of $1,100	Upper limit of $1,100	(a) Nil if result is not more favourable (b) Upper limit of $1,100 if result is more favourable
4	**Dispute determined or otherwise resolved after proceedings have been commenced in the Commission**				
	If: • the Commission or the Registrar certifies the matter as complex, and • neither item 6 nor 7 of this Table also applies	Percentage increase—upper limit of 30% of costs at item D, E or F of Table 1	Percentage increase—upper limit of 30% of costs at item D, E or F of Table 1	Percentage increase—upper limit of 30% of costs at item D, E or F of Table 1	Percentage increase—upper limit of 30% of costs at item D, E or F of Table 1

Item	Additional legal services or other factors	Column 5 Claimant	Column 6 Insurer
5	**Dispute determined or otherwise resolved after proceedings have been commenced in the Commission**		
	If: • the Commission or the Registrar certifies the matter as complex, and • item 6 or 7 of this Table would otherwise have application	Percentage increase—upper limit of 45% of costs at item D, E or F of Table 1	Percentage increase—upper limit of 45% of costs at item D, E or F of Table 1
Item	**Additional legal services or other factors**	**Claimant**	
6	**Costs associated with multiple respondents**		
	If the claim or dispute is resolved by an award or settlement apportioned between more than one respondent **Note.** This allowance does not apply to any resolution that has an increase in fees under item 4 or 5 of this Table.	Percentage increase—upper limit of 30% of costs payable under Table 1 and items 1, 2 and 3 of this Table **Note.** The increase does not apply for each additional respondent, and accordingly 30% is the maximum allowable increase notwithstanding the number of respondents.	

Item	Additional legal services or other factors	Insurer
7	**Costs associated with acting for lead scheme agent**	
	If the claim or dispute is resolved by a scheme agent on behalf of multiple scheme agents **Note.** This allowance does not apply to any resolution that has an increase in fees under item 4 or 5 of this Table.	(a) Lead scheme agent: percentage increase—upper limit of 30% of costs payable under Table 1 and items 1, 2 and 3 of this Table (b) Other agents: no costs recoverable **Note.** The increase referred to in paragraph (a) does not apply for each additional scheme agent, and accordingly 30% is the maximum allowable increase notwithstanding the number of scheme agents who are parties to the resolution.

Part C Regulated disbursements

Item	Disbursement	Applicable provisions
1	Country/interstate loadings (including travel and accommodation expenses)	Payable in accordance with the *Motor Accidents Compensation Regulation 2005*, Schedule 1, clause 3 or 4 (as relevant). **Note.** Clause 15 of Part A applies for this purpose.
2	Conduct money to comply with notice for the production of documents	Where the producer is a party other than the worker—nil payable Where the producer is the worker—an amount sufficient to meet the reasonable expenses of complying with the notice is payable

Item	Disbursement	Applicable provisions
3	Conduct money to comply with direction for the production of documents	An amount sufficient to meet the reasonable expenses of complying with the direction is payable In the case of medical practitioners, the term "sufficient to meet the reasonable expenses" is an amount calculated in accordance with the AMA Revised Recommended Scale as in force from time to time In the case of production by a government agency—the standard rate applied by that agency is payable
4	Treating health service provider's report	If a claim or dispute is resolved whether before or after proceedings commenced: Claimant: (a) nil fee payable, unless paragraph (b) applies, or (b) fee allowed in accordance with any applicable fee order where: (i) request for report made to insurer, and (ii) either: • insurer does not provide report within 14 days, or • report supplied by insurer does not address the report requirements of the claimant, and (iii) report is served on insurer Insurer: (a) fee allowed in accordance with any applicable fee order

Item	Disbursement	Applicable provisions
5	Report of independent medical examination by an appropriately qualified and experienced medical practitioner in accordance with WorkCover Guidelines Fee allowed in accordance with any applicable fee order where paragraph (a) or (b) opposite applies **Note.** A supplementary report that complies with clause 43AA of the *Workers Compensation Regulation 2003* gives rise to a further entitlement to costs under this item, if the supplementary report otherwise satisfies the provisions of this item.	(a) If a claim or dispute is resolved before proceedings are commenced—a report of the kind referred to in clause 43 has been served on the other party (b) If a dispute is resolved after proceedings are commenced—a report of the kind referred to in clause 43 has been admitted in the proceedings or disclosed to an approved medical specialist

Item	Disbursement	Applicable provisions
6	Treating health service provider's clinical notes and records	If a claim or dispute is resolved whether before or after proceedings commenced: Claimant: (a) nil fee payable, unless paragraph (b) applies, or (b) payment in accordance with AMA Revised Recommended Scale as in force from time to time or any applicable fee order (the latter to prevail over the former) where: (i) request made to insurer, and (ii) insurer does not provide within 7 days, and (iii) clinical notes and records are served on insurer Insurer: (a) nil fee payable if clinical notes and records are served by claimant under paragraph (b) above, or (b) otherwise, payment in accordance with AMA Revised Recommended Scale as in force from time to time or any applicable fee order (the latter to prevail over the former)
7	Fee for the provision of independent financial advice by a qualified financial adviser for a commutation by agreement that is approved by the Authority and registered with the Commission	Upper limit of $1,000, on the production of account or receipt

Workers Compensation Commission Rules 2006

Under the

Workplace Injury Management and Workers Compensation Act 1998

I, John Della Bosca, Minister for Commerce, do by this my Order make the following Rules of the Workers Compensation Commission in pursuance of the *Workplace Injury Management and Workers Compensation Act 1998*.

John Della Bosca MLC
Minister for Commerce

Explanatory note

The object of these rules is to provide rules for the Workers Compensation Commission.

The rules make provision for the following matters in connection with the jurisdiction of the Commission under the *Workers Compensation Act 1987* and the *Workplace Injury Management and Workers Compensation Act 1998*:

(a) administrative matters (including the establishment and location of the Commission's Registry and its hours of business),
(b) the commencement of proceedings before the Commission,
(c) the parties to proceedings before the Commission,
(d) dispute resolution procedures,
(e) proceedings before the Commission,
(f) medical assessments and evidence,
(g) appeals,
(h) work injury damages.

These rules are made under the *Workplace Injury Management and Workers Compensation Act 1998*, including section 364 (the general rule-making power).

CONTENT

5

WORKERS COMPENSATION COMMISSION RULES 2006

PART 1 - PRELIMINARY

1.1 Name of Rules

These rules are the *Workers Compensation Commission Rules 2006.*

1.2 Commencement

These rules commence on 1 November 2006.

1.3 Repeal and transitional

(1) The *Workers Compensation Commission Rules 2003* are repealed.

(2) Subject to these rules, these rules apply to proceedings commenced before or after the commencement of these rules.

(3) Subject to these rules, a step taken in any proceedings in accordance with the Workers Compensation Commission Rules 2003 before the commencement of these rules is as valid as it would be if taken in accordance with these rules.

(4) A matter that was, in accordance with the Workers Compensation Commission Rules 2003, or with any relevant Practice Direction or WorkCover Guideline, referred or listed to be determined by an Arbitrator, and had not been so determined, before the commencement of these rules is to be determined by an Arbitrator whether or not these rules require matters of that class to be determined by the Registrar.

(5) A matter that was, in accordance with the Workers Compensation Commission Rules 2003, or with any relevant Practice Direction or WorkCover Guideline, referred or listed to be determined by the Registrar, and had not been so determined, before the commencement of these rules is to be determined by the Registrar whether or not these rules require matters of that class to be determined by an Arbitrator

(6) Where, immediately before the commencement of these rules, a timetable was in effect in respect of any proceedings by virtue of any direction given or by the operation of the Workers Compensation Commission Rules 2003, that timetable remains in effect until its completion unless the Commission or the Registrar otherwise directs.

1.4 Interpretation

In these rules:

applicant means a person referring a matter to the Commission for determination;

day means calendar day unless otherwise stated;

electronic communication has the meaning that it has for the purposes of the *Electronic Transactions Act 2000;*

lodge means lodge with the Commission, and, for the purposes of the *Electronic Transactions Act 2000*, or any other Act the operation of which requires a document to be filed with the Commission, includes "file";

notice in writing includes notice given by electronic communication in accordance with these rules, and ***written notice*** has a similar meaning;

party means a party to proceedings;

proceedings means proceedings in the Commission, and includes matters commenced by application to the Registrar;

respondent means a person who is a party to a dispute other than the applicant;

sealed means affixed with the seal of the Commission;

Workers Compensation Acts means the 1987 Act and the 1998 Act;

1987 Act means the *Workers Compensation Act 1987*;

1998 Act means the *Workplace Injury Management and Workers Compensation Act 1998*.

(2) A document is registered for the purposes of these rules when it has been lodged and accepted by the Registrar.

(3) Words and expressions used in these rules have the same meanings as they have in the Workers Compensation Acts unless the context or subject-matter otherwise indicates or requires.

(4) A reference in these rules to the Commission includes a reference to the Registrar or any other member of the Commission.

1.5 Procedure wanting or in doubt

(1) If a person desires to commence proceedings or take any step in any proceedings, and the manner or form of procedure is not prescribed by the Workers Compensation Acts or these rules, or by or under any other Act, or the person is in doubt as to the manner or form of procedure, the Commission may, on application by the person or of its own motion, give directions.

(2) Proceedings commenced in accordance with the directions of the Commission are taken to be properly commenced.

(3) A step taken in accordance with the directions of the Commission is taken to be regular and sufficient.

(4) An application for directions under this rule may be made whether or not proceedings have been commenced.

1.6 Adherence to and relief from rules

(1) Subject to subrule (2) and to rule 1.5, the practice in the Commission is to be the practice provided by the Workers Compensation Acts or these rules.

(2) The Commission may if it thinks fit on terms dispense with compliance with any of the requirements of these rules, either before or after the occasion for the compliance arises.

(3) The general practice of the Commission prescribed by these rules applies to all proceedings authorised by any existing or future Act to be commenced, taken or continued in the Commission, except in so far as that practice is inconsistent with any provision of or under any such Act.

(4) If a provision of these rules is not complied with in relation to the commencement (or purported commencement) of proceedings or conduct of proceedings, the Commission may determine that the proceedings are, or any step taken in the proceedings is, a nullity, in which case the Commission may strike out the proceedings or any such step.

(5) If the Commission does not make a determination as referred to in subrule (4) in respect of a failure to comply with a provision of these rules, the failure is to be treated as an irregularity only.

(6) For the avoidance of doubt, it is declared that the Registrar may exercise the Commission's functions referred to in subrule (4).

(7) The striking out of proceedings under this rule does not prevent the proceedings from being recommenced.

PART 2 - ADMINISTRATION

2.1 Registry

(1) The Commission is to maintain a registry.

(2) The registry is to be under the control and direction of the Registrar, subject to the general control and direction of the President.

2.2 Location of registry

(1) The address of the registry is:

(a) for the purpose of delivery of documents:

Workers Compensation Commission
Level 19, 1 Oxford Street
Darlinghurst NSW

(b) for the purpose of sending documents or correspondence:

(i) by post:
The Registrar
Workers Compensation Commission
PO Box 594, Darlinghurst NSW 1300

(ii) by document exchange (DX):
The Registrar
Workers Compensation Commission
DX 11524 Sydney Downtown

(iii) by facsimile transmission (fax):
The Registrar
Workers Compensation Commission
1300 368 018

(iv) by electronic communication (email):
registry@wcc.nsw.gov.au

(2) The Registrar may vary the address, for any of the purposes mentioned in subrule (1), of the registry by advertising the varied address at appropriate times and in an appropriate manner.

2.3 Hours of business

Except on Saturdays, Sundays and public holidays or other days on which public offices are closed, the registry is to be open to the public for business at such times and on such days as the Registrar directs from time to time.

2.4 Registers

(1) The registry is to maintain the following:

(a) a register of approved medical specialists appointed by the President pursuant to section 320 of the 1998 Act,

(b) a register of all current proceedings,

(c) a register of Arbitrators and mediators appointed by the President pursuant to sections 368 and 318F respectively of the 1998 Act.

(2) The registers referred to in subrule (1) are to be available for inspection by the general public on the Commission's website at http://www.wcc.nsw.gov.au or in such other manner and at such times as are determined by the Registrar from time to time.

2.5 Seal

(1) The Commission is to have a seal.

(2) The seal is to be in such form (including electronic form) as the President may determine from time to time.

(3) The seal is to be kept under the control of the Registrar at all times.

(4) The seal is to be affixed to all documents registered by the Commission and to all certificates of decisions and determinations by the Commission and to such other documents as may be prescribed in these rules or as the President may determine from time to time.

PART 3 - TIME

3.1 Fixing of time

Where no time is fixed by the Workers Compensation Acts, or these rules, or by a Practice Direction, or by any decision or order of the Commission in any proceedings, for the doing of any thing in or in connection with the proceedings, the Commission may, by order, fix the time within which the thing is to be done.

3.2 Extension and abridgment of time

(1) The Commission may by order extend or abridge any time fixed by these rules or under Part 9 of Chapter 7 of the 1998 Act.

(2) For the avoidance of doubt, it is declared that the functions of the Commission under subrule (1) may be exercised by the Registrar.

(3) The Commission constituted as it was when it made a decision or order that fixed a period of time may, on the application of a party or of its own motion, extend or abridge that period.

3.3 Running of time

Time does not run in respect of any proceedings during such period as may be fixed by order of the Commission in the proceedings or by a Practice Direction.

3.4 Time of commencement of proceedings

The time of commencement of proceedings is the time when the Registrar registers the document lodged for the commencement of the proceedings by affixing the seal of the Commission.

PART 4 - DOCUMENTS GENERALLY

4.1 Form of documents

(1) The President may approve forms for use in the Commission, and a reference in these rules to an approved form is a reference to a form approved by the President.

(2) The Registrar may cause the approved forms to be published on the Commission's website at http://www.wcc.nsw.gov.au

(3) Every document lodged at or served on the registry must:

(a) be headed so as to identify clearly the proceedings to which the document relates and the nature and purpose of the document, and

(b) be in the approved form and otherwise in substantial compliance with these rules, any Practice Direction, and any direction issued by the Registrar, and

(c) be clearly written, typed or reproduced.

(4) For the purpose of determining whether a document is in the approved form, it is sufficient compliance with any requirement as to the form of a document if the document is substantially in accordance with the requirement or has only such variations as the case requires.

(5) Where no form has been approved under this rule in respect of a document to be lodged, the document is to be drafted to the satisfaction of the Registrar.

(6) The Registrar may refuse to accept, seal, or issue any document that, in the opinion of the Registrar, contravenes this rule.

(7) Without limiting subrule (6), the Registrar may refuse to register an incomplete or otherwise defective document lodged for the commencement of proceedings.

(8) Where the Registrar has refused to register a document as referred to in subrule (7), a new document may be lodged to replace that document.

4.2 Amendment of documents

(1) Subject to subrule (2), the Commission may, on the application of a party to any proceedings before the Commission, give the party leave to amend any document lodged by the party in the proceedings if the Commission considers the amendment to be necessary for the avoidance of injustice.

(2) Where a party seeks leave to amend a document, and the amendment would have the effect of substantially altering the parties to the proceedings or the nature of the proceedings, the Commission must not give the leave unless the Commission considers the amendment to be necessary in the interests of justice.

(3) An amendment referred to in subrule (1) may be made at any stage of the proceedings (including the commencement or purported commencement of the proceedings), and on such terms as the Commission thinks fit, but any application for an amendment must be made at least 7 days before any teleconference fixed in the proceedings.

(4) Where the Commission gives leave to amend a document the Commission may give directions as to the conduct of the proceedings consequent on the amendment, and any such direction must be complied with as though it were a provision of these rules.

(5) Subrule (1) does not extend to allow amendment of any information or document required by rule 10.3 to be lodged.

(6) Subject to subrule (2), where the amendment for which leave is sought:

(a) is of a minor nature and will not have any substantive effect on the case to be put by any party, or
(b) is consented to by all parties to the proceedings,

the Registrar (or, if the proceedings have been referred to an Arbitrator and remain so referred, the Arbitrator) may give the party applying leave to make the amendment without complying with the provisions of subrule (7) or (8) (as the case may require).

(7) Subject to subrule (6), where a party to any proceedings applies for leave to amend as referred to in subrule (1) before the proceedings are referred to an Arbitrator, the following provisions apply:

(a) the application must be in writing and must fully set out the grounds for the application,

(b) the party applying must serve the application on all other parties to the proceedings and must lodge the application with the Registrar

(c) a party to the proceedings who wishes to object to the amendment must serve on the party applying, and lodge with the Registrar, written notice of the reasons for the objection within 2 working days of being served with the application,

(d) subject to paragraph (f)(iii), the Registrar must determine an application lodged under paragraph (b),

(e) the Registrar may determine an application lodged under paragraph (b) solely on the basis of the written application and the written notice of objection (if any),

(f) without limiting paragraph (e), when considering an application lodged under paragraph (b) the Registrar may do any of the following:

(i) seek further oral or written information from the parties, or any of them,

(ii) list the application for hearing before the Registrar,

(iii) refer the application to an Arbitrator for determination.

(8) Subject to subrule (6), where a party to any proceedings applies for leave to amend as referred to in subrule (1) after the proceedings are referred to an Arbitrator, the following provisions apply:

(a) the application must be in writing and must fully set out the grounds for the application,

(b) the party applying must serve the application on all other parties to the proceedings and must lodge the application with the Registrar

(c) a party to the proceedings who wishes to object to the amendment must serve on the party applying, and lodge with the Registrar, written notice of the reasons for the objection within 2 working days of being served with the application,

(d) the Arbitrator must determine an application lodged under paragraph (b),

(e) the Arbitrator may determine an application lodged under paragraph (b) solely on the basis of the written application and the written notice of objection (if any),

(f) without limiting paragraph (e), when considering an application lodged under paragraph (b) the Arbitrator may do any of the following:

(i) seek further oral or written information from the parties or any of them,

(ii) list the application for hearing before the Arbitrator.

PART 5 ELECTRONIC CASE MANAGEMENT

5.1 Definition

In this Part:

ECM system means an electronic case management system established for the Commission and the Registrar under section 14B of the *Electronic Transactions Act 2000*.

5.2 Users of the system

(1) Subject to any protocol established under subrule (2), and to any order of the Registrar, a person may not use the ECM system for particular proceedings unless the person is:

(a) a party to the proceedings, or

(b) a legal practitioner representing a party to the proceedings, or

(c) a person authorised to use the ECM system in relation to the proceedings by a legal practitioner representing a party to the proceedings.

(2) The President may establish a protocol for the use of the ECM system, either generally or for particular proceedings.

(3) Such a protocol may provide for public access to information held by the Commission in respect of any proceedings or proceedings generally, but not to the contents of any document held by the Commission in respect of any proceedings.

(4) Subject to subrule (3), such a protocol may provide for the specification of the level of access to the system to which persons generally or persons of specified classes are entitled and the conditions of use of the system applicable to persons generally or persons of any such class.

(5) In relation to any proceedings, the level of access to the ECM system to which a user is entitled, and the conditions of use applicable to a user, are subject to any order of the Registrar.

5.3 Electronic lodging of documents

(1) In any proceedings, a document may be lodged on behalf of a party, by means of the ECM system, by:

(a) the party, or

(b) a person who is authorised to sign documents on the party's behalf, or

(c) a person who has been directed to lodge the document by a person who is so authorised.

(2) When lodged by means of the ECM system, a document that is required to be signed by a person is taken:

(a) to have been duly signed, and

(b) to have been duly authenticated for the purposes of section 14E of the *Electronic Transactions Act 2000*,

if the person's name is printed where his or her signature would otherwise appear.

(3) A document that is lodged by means of the ECM system is so lodged as soon as it is received by the Commission, and is registered as soon as it is accepted by the Registrar.

(4) The Registrar must register a document that is lodged by means of the ECM system unless the Registrar refuses to accept the document under rule 4.1(7).

(5) Notice, and the date, of the lodging and registering of a document is to be given, by means of the ECM system, to the person by whom the document was lodged.

5.4 Lodging of statutory declarations

(1) This rule applies to a statutory declaration that is lodged by means of the ECM system.

(2) In the case of a statutory declaration lodged by a legal practitioner or agent of a party, the legal practitioner or agent is taken:

(a) to have affirmed to the Commission that he or she has possession of the original statutory declaration, and

(b) to have undertaken to the Commission that, if the Commission so directs, he or she will lodge the original statutory declaration in accordance with the direction.

(3) In the case of a statutory declaration lodged otherwise than by a legal practitioner or agent, the original statutory declaration must be lodged if the Commission so directs.

(4) Any document referred to in a statutory declaration that cannot be lodged by means of the ECM system is taken to be an exhibit, and not an annexure, regardless of the terms of the statutory declaration.

5.5 Electronic issuing of a document

The Commission or Registrar may issue a document to any party by means of the ECM system.

PART 6 - PERSONS UNDER LEGAL INCAPACITY

6.1 Definition

In this Part, ***person under legal incapacity*** means:

(a) a child under the age of 18 years, and

(b) a temporary patient, continued treatment patient or forensic patient within the meaning of the *Mental Health Act 1990*, and

(c) a person under guardianship within the meaning of the *Guardianship Act 1987*, and

(d) a protected person within the meaning of the *Protected Estates Act 1983*, and

(e) an incommunicate person, being a person who has such a physical or mental disability that he or she is unable to receive communications, or express his or her will, with respect to his or her property or affairs.

6.2 Proceedings generally

(1) In proceedings other than proceedings for work injury damages, the Commission may, subject to subrule (2), appoint any person it thinks fit to represent a party who appears to the Commission to be a person under legal incapacity.

(2) Where the person under legal incapacity is:

(a) a person under guardianship within the meaning of the *Guardianship Act 1987*, or

(b) a protected person within the meaning of the *Protected Estates Act 1983*,

the Commission may not appoint a person under subrule (1) who is not a person having, under the relevant Act, control of the affairs of the person under legal incapacity.

(3) Where the Commission appoints a person under subrule (1) the Commission may give directions as to the participation of the person in the further conduct of the proceedings.

6.3 Proceedings for work injury damages

Where a party to proceedings for work injury damages is a person under legal incapacity, the provisions of the *Uniform Civil Procedure Rules 2005* relating to such persons apply to the proceedings as though the proceedings were proceedings in the District Court.

PART 7 - REPRESENTATION

7.1 Notice of representation

(1) A party to proceedings must notify the Registrar and the other parties of the appointment at any stage of the proceedings of a legal practitioner or agent to represent the party, within 7 days of the appointment.

(2) If at any stage in proceedings a party changes the legal practitioner or agent by whom the party is represented, the party must notify the Registrar and the other parties of that change within 7 days.

(3) If at any stage in proceedings a legal practitioner or agent representing a party ceases to represent the party, the legal practitioner or agent must so notify the Registrar and the other parties within 7 days.

(4) If the legal practitioner or agent is to represent the party from the commencement of proceedings, the notice required under subrule (1) is deemed to be given if the legal practitioner or agent signs the first document lodged on behalf of the party in the proceedings and gives in that document the address of the legal practitioner or agent as the party's address for service.

(5) A notice under this rule must indicate whether the authority of the legal practitioner or agent to act on behalf of the party in the proceedings is limited or restricted in any way and, if so, in what manner and to what extent, and unless the notice contains such an indication the Registrar is entitled to assume that the authority is not limited or restricted.

(6) A notice required under this rule to be given by a party may be given by the party's legal representative or agent.

PART 8 - SERVICE AND LODGING OF DOCUMENTS

8.1 Service of documents by or on Commission and lodging of documents

(1) All documents required or permitted to be lodged in or with, or issued by, the Commission must be lodged at, or issued from, the registry.

(2) Subject to subrule (3), lodging of documents with, or issuing or service of documents by, the Commission may be by means of hand delivery, post, document exchange (DX), facsimile transmission (fax) or electronic communication, in accordance with these rules and the Workers Compensation Acts.

(3) The Registrar may direct that a document, or documents of a class, is or are not to be lodged with or served on the Commission by fax.

(4) Subject to subrule (3), a document may be lodged with or served on the Commission, and correspondence directed to the Commission may be forwarded to the Commission:

(a) by hand, by delivering it to the Commission at the registry, or

(b) by post, by sending it by prepaid post to the postal address set out in, or varied under rule 2.2, or

(c) by DX, by leaving it in the DX box set out in, or varied under, rule 2.2 or in another DX box for transmission to that DX box, or

(d) by fax, by faxing it to the fax number set out in, or varied under, rule 2.2 and receiving notification on the sending facsimile machine of a successful transmission, or

(e) by electronic communication, by sending an electronic communication of the document or correspondence to the email address set out in, or varied under, rule 2.2.

(5) For the purposes of these rules, a document is lodged with or served on the Commission, and correspondence directed to the Commission is received by the Commission by 4:30pm as set out in subclauses (a)-(d), but if that time is after 4.30pm on any day, or is on a Saturday, Sunday or public holiday, on the next day that is not a Saturday, Sunday or public holiday:

(a) if by hand, on the day of delivery, or

(b) if by post, or DX on the day of receipt at the registry, or

(c) if by fax, on the day of transmission (subject to receipt on the sending facsimile machine of notification of a successful transmission), or

(d) if by electronic communication, at the time of entering the information system addressed to the email address set out in, or varied under, rule 2.2.

(6) For the purposes of these rules, a document is served by the Commission, and correspondence forwarded by the Commission is received by 4:30pm as set out in subclauses (a)-(e) but if that time is after 4.30pm on any day, or is on a Saturday, Sunday or public holiday, on the next day that is not a Saturday, Sunday or public holiday:

(a) if by hand, on the day of delivery, or

(b) if by post, on the fourth day after the day of sending by prepaid post, or

(c) if by DX, on the day following the day of leaving in the DX box of the person to whom it was addressed or in another DX box for transmission to that DX box, or

(d) if by fax, on the day of transmission (subject to receipt on the sending facsimile machine of notification of a successful transmission) or,

(e) if by electronic communication, at the time of entering the information system addressed to the person's email address.

(7) Service by the Commission on, or forwarding of correspondence by the Commission to, a party by electronic communication may be effected only if the party gives as part of its address for service an email address.

(8) This rule applies subject to the *Service and Execution of Process Act 1992* of the Commonwealth.

8.2 Service on Authority

(1) Where these rules require service on the Authority, that service is to be effected at the office of the Authority at:

Legal Group WorkCover NSW Level 1, 60-70 Elizabeth Street Sydney 2000. (Non ULIS matters)	OR	Claims Branch WorkCover NSW Level 4, 92-100 Donnison Street Gosford 2250 (ULIS matters)

(2) Service of a document may be effected at the office of the Authority:

(a) by hand, by delivering it to the address set out in subrule (1), or

(b) by post, by sending it by prepaid post to:

Legal Group WorkCover NSW GPO Box 2677 Sydney NSW 2001,	OR	Claims Branch WorkCover NSW Locked Bag 2906 Lisarow NSW 2252, or

(c) by DX, by leaving it in the DX box at DX 731, Phillip Street Sydney or in another DX box for transmission to that DX box.

8.3 Address for service

(1) The address for service of a party to any proceedings is, in the case of the applicant, the address set out as the applicant's address in the first document lodged on behalf of the applicant in the proceedings, and in the case of a respondent, the address set out as the respondent's address in that document unless the respondent indicates in writing a different address.

(2) A respondent's address set out on behalf of the applicant as referred to in subrule (1) must be the address of the respondent's principal place of business or residence last known to the applicant, or, in the case where the respondent is a corporation, the address of the respondent's registered office.

(3) Subject to subrule (2), a party's address for service may be or include a postal address, document exchange (DX) box, fax number, email address (for electronic communications) or a physical address.

(4) A party may give its address for service as care of its legal representative or agent.

(5) A party to proceedings, or the party's legal representative or agent, may change the party's address for service at any stage of the proceedings, but must notify the Registrar and the other parties to the proceedings within 2 working days of the change.

8.4 Service at address for service

(1) A document is taken to have been served on or provided to a party if the document is delivered, or forwarded by one of the methods referred to in subrule (2), to the address for service of the party.

(2) Service of a document by a party on another party is taken to be effected if received by 5pm as follows. If that time is after 5pm on any day, or is on a Saturday, Sunday or public holiday, on the next day that is not a Saturday, Sunday or public holiday:

(a) if by hand, on the day of delivery, or

(b) if by post, on the fourth day after the day of sending by prepaid post, or

(c) if by DX, on the day following the day of leaving in the DX box of the party to whom it was addressed or in another DX box for transmission to that DX box, or

(d) if by fax, on the day of transmission (subject to receipt on the sending facsimile machine of a notification of a successful transmission), or

(e) if by electronic communication, at the time of entering the information system addressed to the email address set out in the address for service.

(3) This rule applies subject to the *Service and Execution of Process Act 1992* of the Commonwealth.

8.5 Sealed copies of documents

Where a party is required to serve a sealed copy of a document:

(a) if the document is lodged in the form of a hard copy, the party must tender to the registry with the document one additional copy of the document and as many other additional copies of the document as there are parties to be served, and

(b) on registering the document, the Registrar must seal any copies of the document tendered as required by paragraph (a) and return those copies to the party, and

(c) the party must, within 7 days after service of the document, lodge a certificate certifying the date of service, the method of service, the party or other person served, and the address at which service was effected.

8.6 Substituted service

(1) Where for any reason it is impracticable to effect service of a document on a party by any method provided for in this Part, the Registrar may, on application supported

by a statutory declaration showing grounds, by order direct that instead of service such steps be taken as are specified in the order for the purpose of bringing the document to the notice of the party.

(2) The Registrar may order that service be taken to have been effected on the happening of any specified event or on the expiry of any specified time.

8.7 Service in a foreign country

Where a document is to be served in a foreign country, the document is to be served in accordance with these rules:

(a) subject to any applicable convention relating to the service of documents made between Australia and the country of service, and

(b) with a translation in the official language of the country of service, with a certificate setting out the name and relevant qualifications of the translator.

PART 9 PROCEEDINGS COMMENCED OTHER THAN BY APPLICATION TO RESOLVE A DISPUTE

9.1 Application of Part

(1) This Part applies to proceedings that are commenced other than by way of an application to resolve a dispute.

(2) This Part is to be read in accordance with any relevant WorkCover Guidelines.

9.2 Proceedings commenced by application for interim payment direction

(1) Proceedings under section 297 of the 1998 Act in relation to:

(a) the failure to determine a claim for weekly benefits as and when required by the 1998 Act, or

(b) the issue of a dispute notice in respect of a claim for weekly benefits, or

(c) the failure to determine a claim for medical expenses compensation as and when required by the 1998 Act, or

(d) the issue of a dispute notice in respect of a claim for medical expenses compensation, or

(e) the failure to commence provisional payments of compensation as required by Division 1 of Part 3 of Chapter 7 of the 1998 Act following initial notification of an injury,

are to be commenced by way of application for an interim payment direction.

(2) An application for an interim payment direction is to be lodged with the Commission and include as attachments the information and other documents required by the approved form of application.

(3) The applicant is to serve the application on the respondent on the same day as the application is lodged with the Commission, and is not required to serve a sealed copy of the application.

(4) If the respondent is an employer (but not a self-insurer) the applicant must also, and on the same day, serve a copy of the application on the employer's insurer.

(5) The Registrar may provide a copy of the application to the respondent, and may obtain the respondent's views as to the application in such manner as the Registrar considers appropriate.

9.3 Interim payment directions

An interim payment direction is to include:

(a) the name of the party to whom it is addressed, and

(b) the name and address of the person to whom payment is to be made, and

(c) whether the direction is in respect of weekly payments or is for medical expenses, and

(d) in the case of weekly payments, the amount and the number of weeks for which the payments are to be made and when payments are to commence and conclude, and

(e) in the case of medical expenses, the amount to be paid and the time by which payment is to be made, and

(f) advice that a person who fails to comply with an interim payment direction is guilty of an offence in accordance with section 300 of the 1998 Act, and

(g) the conditions (if any) subject to which the direction is given.

9.4 Notice of revocation by Registrar of interim payment direction

(1) The Registrar can, acting under section 299(1) of the 1998 Act, revoke an interim payment direction on application by a party or on the Registrar's own motion.

(2) An application for revocation by the Registrar of an interim payment direction is to be lodged with the Commission and is to include as attachments the information and other documents required by the approved form of application.

(3) The applicant for revocation is to serve the application on the respondent to the application on the same day as the application is lodged with the Commission, and is not required to serve a sealed copy of the application.

(4) The Registrar may provide a copy of the application to the respondent to the application, and may obtain that respondent's views as to the application in such manner as the Registrar thinks appropriate.

(5) Notice of any revocation by the Registrar of an interim payment direction is to be given by the Registrar to each of the parties to the proceedings.

9.5 Refund of interim payment direction payments

An order for the purpose of section 304 of the 1998 Act is to include:

(a) the name of the person to whom it is addressed, and

(b) the name and address of the person to whom payment is to be made, and

(c) the amount of payments to be refunded or reimbursed and the time by which payment is to be made, and

(d) the reasons for which the Commission has determined to issue the order.

9.6 Review of order to refund payments

(1) A person against whom an order is made under section 235D(2) of the 1998 Act may apply for a review of the order by lodging:

(a) a copy of the order, and

(b) an application for review of the order, which must include the arguments to be put in favour of the application.

(2) The applicant for a review must serve the application on the Authority on the same day as the application is lodged with the Commission, and is not required to serve a sealed copy of the application.

9.7 Workplace injury management plans

(1) Where a party to a dispute to which Division 3 of Part 5 of Chapter 7 of the 1998 Act applies seeks to have the Registrar deal with the dispute under section 306 of that Act, the party must lodge with the Registrar, and serve on all other parties to the dispute, an application to resolve the workplace injury management dispute.

(2) Before exercising a power under section 306 of the 1998 Act in respect of a dispute, the Registrar is to contact the parties to the dispute and advise them of the course of action the Registrar proposes to take, and that contact is to be made with a view to resolving the dispute expeditiously.

(3) A direction by the Registrar that a workplace assessment is to be conducted is to include:

(a) the names and addresses of the parties to the dispute, and

(b) a statement of the nature of the obligation with which one of the parties is alleged to have failed to comply, and

(c) the name of the injury management consultant or other suitably qualified person who is to conduct the workplace assessment, and

(d) the amount of, and a note that the employer is liable for, the fee payable for the conduct of the workplace assessment.

(4) A copy of the direction that a workplace assessment be conducted is to be sent to each of the parties, the insurer (if not a party) and the person who is to conduct the assessment.

(5) The injury management consultant or other suitably qualified person who is to conduct the assessment must contact the parties and arrange to carry out the assessment as soon as practicable, but not more than 7 days after receiving the direction.

(6) The injury management consultant or other suitably qualified person who is to conduct the assessment must provide the Registrar with a brief written report of the outcome of the assessment, setting out the reasons for any finding, as soon as practicable, but in any case not later than 7 days, after the assessment has been conducted, and the Registrar must make the report available to the parties.

(7) A recommendation by the Registrar that a party to a dispute take specified action is to be in writing and must include:

(a) the name of the party to whom the recommendation is made, and

(b) the nature of the obligation with which one of the parties is alleged to have failed to comply, and

(c) the action that the Registrar considers necessary or desirable for the party to take to remedy the failure with which the dispute is concerned, and

(d) a note referring the party to whom the recommendation is made to the period for compliance or for requesting referral to the Commission as provided by section 308 of the 1998 Act.

(8) A copy of the recommendation issued by the Registrar is to be sent to each of the parties and the insurer (if not a party).

9.8 Referral to Arbitrator of workplace injury management dispute

(1) The Registrar may, on the Registrar's own motion or if the Registrar thinks fit on application by a party (or a party's insurer if not a party), refer a dispute about non-compliance with Chapter 3 of the 1998 Act to an Arbitrator for determination.

(2) In the event that the employer's insurer is not a party to the proceedings but the insurer's identity is known to the Registrar or readily ascertainable on the face of the documents, the Registrar is to notify the insurer of any such reference.

9.9 Partial dependants of deceased worker

(1) A party to an agreement referred to in section 26(b) of the 1987 Act may apply for approval by the Commission of the agreement by lodging:

(a) a copy of the agreement, and

(b) a request for approval of the agreement, specifying the arguments to be put in favour of the request and having attached to it any supporting documentation to be relied upon.

(2) The Registrar is to make arrangements for the Commission to consider the agreement and for notifying the Commission's decision to the party who applied for the approval.

9.10 Registration of commutation agreements

(1) In this rule, commutation agreement means an agreement referred to in section 87F of the 1987 Act.

(2) A party to a commutation agreement may apply for registration of the agreement by lodging:

(a) a copy of the agreement, and

(b) an application for registration of the agreement, including evidence that the requirements of section 87F(2) of the 1987 Act have been complied with, and having attached to it the relevant certificate issued by the Authority as referred to in section 87EA(1) of that Act.

(3) If a commutation agreement for which an application is made for registration is incomplete or otherwise defective, the Registrar may reject the application, and in such case the application may be lodged again after the defect is rectified.

PART 10 PROCEEDINGS COMMENCED BY APPLICATION TO RESOLVE A DISPUTE

10.1 Application of Part

This Part applies to proceedings that are commenced by way of an application to resolve a dispute.

10.2 Commencement by application to resolve a dispute

(1) Subject to these rules, proceedings in relation to a matter under the Workers Compensation Acts are to be commenced by way of an application to resolve a dispute.

(2) Where an application to resolve a dispute concerns a matter to which Part 9 applies, the Registrar may deal with the matter or dispute in accordance with Part 9, and in such a case the requirement for the respondent to lodge a reply to the application is deferred until such time as the Commission determines.

(3) Where an application to resolve a dispute concerns:

(a) a dispute to which Division 2A of Part 5 of Chapter 7 of the 1998 Act applies, or

(b) a dispute requiring assessment of the degree of permanent impairment of a worker,

the Registrar may direct that the application be dealt with in accordance with procedures set out in any Practice Direction or WorkCover Guideline issued for that purpose, and if such a direction is given these rules apply to the application as modified to meet the requirements of those procedures.

(4) The Registrar is not to accept a dispute for referral for determination by the Commission unless:

(a) the application to resolve the dispute is accompanied by a certificate by the applicant, or the applicant's legal practitioner or agent, that the

dispute is not prevented from being referred for determination by the Commission by the operation of any provision of Part 4 of Chapter 7 of the 1998 Act, and

(b) the Registrar is satisfied that the dispute is not so prevented from being referred.

(5) Within 7 days after the Registrar registers an application to resolve a dispute, the applicant must serve a sealed copy of the application on the respondent and any other party to the proceedings.

(6) If the respondent is an employer (but not a self-insurer), the applicant must also serve a sealed copy of the application on the employer's insurer.

(7) Subject to subrule (2), where in respect of an application to resolve a dispute:

(a) a respondent has not lodged a reply in accordance with these rules, and

(b) the applicant has not lodged a certificate of service certifying service of the application on that respondent in accordance with these rules,

the proceedings as against that respondent are deemed to have been struck out, and no further step may be taken in the proceedings unless the proceedings are restored.

(8) The Commission or Registrar may, on application by a party and on terms, restore any proceedings deemed to have been struck out under subrule (7).

10.3 Material to be lodged with application or reply

(1) For the purposes of section 290 of the 1998 Act, a party to proceedings must lodge and serve with:

(a) the application to resolve the dispute, if the party is the applicant, or

(b) the reply required by rule 10.4(1), if the party is a respondent, or

(c) the reply required by rule 11.1(7), if the party is a party joined under rule 11.1(4),

all information and documents on which the party proposes to rely and that are in the possession or control of the party, and that have not been lodged by a party in the current proceedings.

(2) Subject to subrules (3) - (5), a party may not in proceedings introduce evidence that has not been lodged and served as required by subrule (1) or has not been provided to any other party as required by the 1998 Act or any Regulation or Guideline made under that Act.

(3) The Commission may, if it is satisfied that it is necessary to do so in the interests of justice, allow a party to introduce evidence that the party would otherwise be prevented from introducing because of the operation of subrule (2).

(4) Where a party wishes to rely on a document produced as required by a direction issued under rule 13.4 or a notice for production served under rule 12.2, or inspected in response to a notice of objection served under rule 12.4(1)(b)(i), and claims that the party was:

(a) unaware of the relevant information in the document, or

(b) unable to obtain possession of the document,

at the time the party lodged the application to resolve the dispute or reply by the party in the proceedings, the party must, as soon as practicable after becoming aware of the information, lodge and serve on all other parties to the proceedings:

(c) a copy of the document, or

(d) if the document was inspected in response to a notice of objection served under rule 12.4(1)(b)(i), a description of the document.

(5) Without limiting subrule (3), where a party complies with subrule (4) in respect of any information, the Commission may allow the party to introduce evidence of that information.

10.4 Reply by respondent

(1) The respondent in any proceedings must, within 21 days from the date of registration of the application to resolve a dispute in the proceedings, lodge a reply to the application and serve a sealed copy of the reply on the applicant and any other party to the proceedings.

(2) If the applicant is an employer (but not a self-insurer), the respondent must also serve the reply on the employer's insurer.

(3) Without leave of the Commission, the failure of a worker to notify of an injury as required by the Workers Compensation Acts may not be raised as an issue in the reply by the respondent if that issue has not been included in the notice given in accordance with section 74 of the 1998 Act.

PART 11 JOINDER OF ADDITIONAL PARTIES AND DISPUTES

11.1 Joining other parties and disputes

(1) Proceedings may relate to one or more disputes arising out of a claim or in relation to the same injury (or series of injuries).

(2) If there is more than one dispute arising out of the same injury (or series of injuries), the Registrar may direct that those disputes be dealt with in the same proceedings.

(3) Two or more persons can be joined as the applicant or the respondent in any proceedings where:

(a) if separate proceedings are brought by or against each of them, some common question of law or fact would arise in all of those proceedings and all rights claimed in those proceedings (whether they are joint, several or alternative) would be in respect of or arise out of the same injury (or series of injuries), or

(b) the Commission gives leave to do so.

(4) If a person who is not a party to any proceedings:

(a) should have been joined as a party to the proceedings, or

(b) is a person the joining of whom as a party to the proceedings is necessary to ensure that all matters in dispute may be effectually and completely determined,

the Registrar, on application by the person or by a party, or on the Registrar's own motion, may order that the person be joined as a party to the proceedings and make such other relevant orders, including orders for amendment, in relation to the proceedings as the Registrar considers appropriate.

(5) If a person is joined by order under subrule (4) on application by a party, the party must serve on the person:

(a) a notice that advises the person of the joinder and of the time within which the person must lodge and serve a reply (14 days after the date of service of the notice), and

(b) a copy of any document lodged to commence the proceedings, any document lodged in answer to that document or to any other document lodged in the proceedings, and any information or document required to be lodged and served with any such document, and

(c) a copy of a notice to any other person joining that other person as a party to the proceedings.

(6) If a person is joined by order under subrule (4) on the person's own application or on the motion of the Registrar, the Registrar is to serve notice of the joinder on the person.

(7) Where the proceedings were commenced by way of application to resolve a dispute, the person joined as a party must lodge with the Commission and serve on the applicant and any other party to the proceedings a reply to the application to resolve a dispute within 14 days of being served with notice under subrule (5) or (6).

(8) If the person joined is an employer (but not a self-insurer), the notice required by subrule (5) or (6) to be served must also be served on the employer's insurer.

(9) Without leave of the Commission, the failure of a worker to notify of an injury as required by the Workers Compensation Acts may not be raised as an issue in the reply by the party joined if that issue has not been included in the notice given in accordance with section 74 of the 1998 Act by the party joined.

(10) A party joined who wishes to object to the joinder must include in the party's reply the reasons why the party should not properly be included as a party to the proceedings.

(11) No proceedings are rendered invalid by reason only of the joinder of a person in error or by the failure to join a person as a party to those proceedings.

PART 12 - NOTICES FOR PRODUCTION

12.1 Definitions

(1) In this Part:

document does not include a document that must be provided to a requesting party by a worker, employer or insurer in respect of a claim for compensation, whether upon request or otherwise, under the *Workers Compensation Acts,* the *Workers Compensation Regulation 2003* or any related WorkCover Guidelines, except where the worker, employer or insurer has failed to provide the document as and when required under any such provision,

party to proceedings includes the insurer of an employer,

parties means the requesting party and the producer,

producer means a party to proceedings named or proposed to be named in a notice for production,

requesting party means a party to proceedings who intends serving or has served a notice for production on a producer.

(2) For the purposes of this Part, a document is taken to be relevant to a fact in issue if it could, or contains material that could, rationally affect the assessment of the probability of the existence of that fact (otherwise than by relating solely to the credibility of a witness), regardless of whether the document would be admissible in evidence.

12.2 Notice for production

A requesting party may serve a notice for production on a producer at the producer's address for service requiring the producer to produce for inspection any document that is:

(a) clearly identified in the notice, and

(b) relevant to a fact in issue in the proceedings.

12.3 Time for service and production

(1) A notice for production must be served within 21 days from the date of registration of the application to resolve the dispute in the proceedings.

(2) A notice for production must be complied with within 7 days of service of the notice for production.

12.4 Compliance with notice for production

(1) A producer complies with a notice for production by:

(a) delivering to the requesting party, at the requesting party's address for service and within the time required by rule 12.3(2), copies of such of the documents referred to in the notice as are in the possession or control of the producer and are not the subject of a notice of objection referred to in paragraph (b), and

(b) serving on the requesting party, at the requesting party's address for service and within the time required by rule 12.3(2), a notice of objection concerning any document not so delivered stating:

(i) that the document is not suitable for copying but may be inspected at a place and time stated in the notice of objection and on a date within 7 days of service of the notice of objection, or such other date as the parties may agree, or

(ii) that the document is a privileged document and the reasons for the claim of privilege, or

(iii) that the document is not relevant to a fact in issue in the proceedings and the reasons why it is not so relevant, or

(iv) any other objection to production and the reasons for the objection, or

(v) if the producer is an applicant worker, that sufficient money has not been paid or tendered to meet the reasonable expenses of complying with the notice for production, and the reasons for making this assertion, or

(vi) that the document has already been produced to the requesting party, or

(vii) that the document is to the best of the producer's knowledge, information or belief in the possession or control of such other person as may be specified in the notice of objection, or

(viii) that the producer has no knowledge, information or belief as to the existence or whereabouts of the document.

(2) Where a producer has failed to comply with a notice for production:

(a) the requesting party may, by notice in writing to the Registrar not later than 2 working days after the time for compliance has expired, request that the Registrar refer the matter to the Authority for consideration as to prosecution of the producer for an offence under section 290(2) of the 1998 Act, and

(b) the Commission may, on application by the requesting party or of its own motion, make such determination as to costs under Division 3 of Part 8 of Chapter 7 of the 1998 Act as the Commission thinks fit.

(3) For the avoidance of doubt, it is declared that the Registrar may exercise the Commission's functions referred to in subrule (2)(b) in addition, or in the alternative, to the Registrar's power to make an order under section 290(6)(c) of the 1998 Act.

12.5 Opposition to objection

(1) A requesting party who wishes to oppose a notice of objection referred to in rule 12.4(1)(b) must lodge and serve written notice of opposition within 2 working days of being served with the notice of objection.

(2) The written notice referred to in subrule (1) must:

(a) set out the reasons for the opposition, and

(b) attach a copy of the notice for production and the notice of objection.

(3) The Arbitrator or Registrar may determine an objection to a notice for production.

(4) The Arbitrator or Registrar may, following determination of an objection to a notice for production:

(a) set aside the notice for production in whole or in part, or

(b) direct that the documents the subject of the objection be produced to the requesting party or to the Commission, or

(c) make such other order as the Arbitrator or Registrar thinks fit.

12.6 Conduct money

(1) Where the producer is an applicant worker, the producer is not required to comply with the notice for production, other than as required by rule 12.4(1)(b)(v), unless an amount sufficient to meet the reasonable expenses of complying with the notice is paid or tendered to the producer at the time of service of the notice or not later than a reasonable time before the date for production under rule 12.3(2).

(2) The amount sufficient to meet the reasonable expenses of compliance referred to in subrule (1) is to be calculated in accordance with any relevant provision of the *Workers Compensation Regulation 2003*.

PART 13 DIRECTIONS FOR PRODUCTION AND SUMMONSES

13.1 Production of Commission records

(1) A party to any proceedings (the first proceedings) may request the Registrar, in writing, to produce the Commission's record of any other proceedings:

(a) for inspection by the party, or

(b) for use as evidence in the first proceedings, or

(c) for both such inspection and use.

(2) The Registrar must comply with a request made in accordance with subrule (1) unless the Registrar is of the opinion that the request is unreasonable.

(3) This Part, other than this rule, does not apply to the production of records of the Commission.

13.2 Definitions

In this Part:

the producer means the person named or proposed to be named in a direction for production;

first access order means an order specifying:

(a) which party to proceedings is to have first access to documents produced to the Commission in accordance with a direction for production, and

(b) the period of first access for that party.

13.3 Request for direction for production

(1) A party to proceedings may request the Arbitrator to whom the proceedings are referred to order the issue of a direction under section 357 of the 1998 Act for production of documents by a person who is not a party to the proceedings.

(2) A proposed direction for production must include a proposed first access order.

13.4 Direction for production

(1) Subject to subrule (2), the Arbitrator to whom proceedings are referred may, at any teleconference fixed in the proceedings, or, in a special case and for the avoidance of injustice, subsequently, order or refuse to order the issue of a direction for production requested under rule 13.3(1).

(2) A direction for production of documents must not issue where the party requesting the direction is entitled to be provided with the documents, or copies of the documents:

(a) pursuant to an obligation imposed upon a worker, employer or insurer in respect of a claim for compensation, whether upon request or otherwise, under the Workers Compensation Acts, the *Workers Compensation Regulation 2003*, or any related WorkCover Guidelines, or

(b) pursuant to an obligation arising under Part 7 of the 1987 Act, including under any regulation, guideline, contractual term or procedural arrangement made or arising thereunder, in circumstances where the documents are in the possession or control of the Workers Compensation Nominal Insurer established under section 154A of the 1987 Act, or any agent of that Nominal Insurer.

(3) In deciding whether to order the issue of the direction for production, the Arbitrator may do any of the following:

(a) determine any objection by a party,

(b) direct the time for service of the direction and the time for production by the producer,

(c) direct the making of access orders, including a first access order,

(d) make such other provision as the Arbitrator thinks fit.

(4) Where the Arbitrator orders the issue of a direction for production, the party who requested the order must engross the direction in accordance with the terms of the order and deliver it to the Registrar, and the Registrar must issue the direction.

13.5 Service of direction

(1) The party who requested an order for a direction for production made by an Arbitrator must serve the direction on the producer and all other parties to the proceedings not later than 7 days before the date for production specified in the direction.

(2) The mode of service of a direction on a producer is the mode of service required by these rules for service of a document by a party to the proceedings on another party.

13.6 Conduct money and expenses

(1) Subject to subrule (2), a producer is not required to comply with a direction for production unless an amount sufficient to meet the reasonable expenses of compliance is paid or tendered to the producer at the time of service of the direction or not later than a reasonable time before the date for production.

(2) A producer is not excused under subrule (1) from compliance with a direction for production unless the producer objects to production under rule 13.8 and provides in the objection the reasons why the producer asserts that an amount sufficient to meet the reasonable expenses of compliance has not been paid or tendered.

(3) Where a producer, in consequence of service of the direction, reasonably incurs expense or loss substantially exceeding any amount paid or tendered as referred to in subrule (1), the Registrar may order that the party who requested the issue of the direction pay to the producer an additional amount in respect of the expense or loss.

(4) The amount sufficient to meet the reasonable expenses of compliance referred to in subrule (1) is to be calculated in accordance with any relevant provision of the *Workers Compensation Regulation 2003.*

13.7 Compliance

(1) The producer may produce documents by hand, post, DX, or electronic communication to the address of the Commission stated in the direction for production.

(2) Unless the direction for production otherwise provides, the producer may comply with the direction for production by producing clear, sharp photocopies of the documents to be produced.

(3) The Registrar must advise the parties to the proceedings when documents have been produced to the Commission in compliance with a direction for production.

(4) Subject to rule 13.6, where a producer fails to comply with a direction for production, the party who requested the order for the direction may:

(a) by oral or written notice to the producer excuse the producer from complying with the direction, or

(b) by written notice to the Registrar not later than 7 days after the date for production:

(i) request that the terms of the direction be altered
(ii) request an extension of time for compliance with the direction
(iii) request that the matter be referred to the Authority for consideration as to prosecution for an offence under section 357(3) of the 1998 Act.

13.8 Objection by producer

(1) A producer may object to a direction for production by objecting to any of the following:

(a) the production of documents under the direction,

(b) the terms of access to the documents produced under the direction.

(2) A producer who objects to a direction for production under subrule (1) must notify the Arbitrator or Registrar in writing prior to the date for production.

(3) An objection to a direction for production made in accordance with subrule (2) must clearly identify the documents that are the subject of the objection and provide reasons for the objection.

(4) A producer who objects to a direction for production in accordance with subrule (2) is excused from complying with the direction until the objection is determined.

(5) The Arbitrator or Registrar must notify the parties to the proceedings of an objection notified in accordance with subrule (2).

(6) A party to the proceedings who wishes to oppose an objection to a direction for production must lodge written notice, including the reasons for the opposition, within 2 working days of being notified of the objection in accordance with subrule (5).

(7) The Arbitrator or Registrar may determine an objection to a direction for production solely on the basis of the written objection notified in accordance with subrule (2) and the written opposition lodged in accordance with subrule (6).

(8) Without limiting subrule (7), when considering an objection to a direction for production the Arbitrator or Registrar may do any of the following:

(a) determine the objection,

(b) seek further oral or written information from the parties to the proceedings or the producer,

(9) The Arbitrator or Registrar may set aside or vary the terms of a direction for production following determination of an objection to the direction.

(10) The Registrar may, on the Registrar's own motion or on the request of any person having sufficient interest, but only if the request is made in accordance with these rules, set aside or vary a direction for production wholly or in part.

13.9 Objection after production by a party entitled to first access

(1) A party to proceedings who is entitled to first access to documents produced to the Commission in accordance with a direction for production may object to another party accessing those documents.

(2) A party who objects under subrule (1) to another party having access must, prior to the expiry of the period contained in the first access order:

(a) if any documents in respect of which the objection is made are produced to the Commission by electronic communication, obtain a hard copy of those documents, and

(b) separately package and identify the documents in respect of which the objection is made from any other documents that have been produced, and

(c) notify the Arbitrator or Registrar and the other parties to the proceedings of the objection in writing clearly identifying the documents in respect of which the objection is made and providing reasons for the objection.

(3) Where a party has notified an objection in accordance with subrule (2), the other parties to the proceedings may access documents only in accordance with the terms of the objection until the objection is determined.

(4) A party who wishes to oppose an objection notified in accordance with subrule (2) must, prior to the expiry of the access period for that party, notify the Arbitrator or

Registrar and the other parties in writing of the opposition and the reasons for the opposition.

(5) The Arbitrator or Registrar may determine an objection to access solely on the basis of the written objection notified in accordance with subrule (2) and the written opposition notified in accordance with subrule (4).

(6) Without limiting subrule (5), when considering an objection to access the Arbitrator or Registrar may do any of the following:

(a) determine the objection,

(b) seek further oral or written information from the parties to the proceedings or the producer,

(c) list the objection for hearing before the Arbitrator or Registrar,

(7) The Arbitrator or Registrar may vary the terms of a direction for production following determination of an objection to the direction.

13.10 Inspection of produced material

(1) A party or a party's legal representative or agent may, subject to these rules and the terms of the access order made or varied by the Arbitrator or Registrar:

(a) inspect documents produced in compliance with a direction for production, and

(b) make copies of any documents so inspected.

(2) For the purposes of subrule (1), the Registrar may give directions concerning the removal from and return to the Commission of documents produced in compliance with a direction for production.

13.11 Return of documents

(1) Unless the Commission otherwise orders:

(a) original documents produced to the Commission may be returned to the producer, and

(b) copy documents produced to the Commission may be returned to the producer, if so requested, or destroyed,

60 days after expiry of the access period or, where more than one access period has been ordered, access periods in respect of the documents.

(2) For the avoidance of doubt, it is declared that the Registrar may exercise the Commission's functions under subrule (1).

13.12 Exercise of function or power under this Part

When proceedings are before any other member of the Commission, any function or power of the Registrar under this Part may be exercised by that member.

13.13 Summons - issue and service

(1) A request by a party for the issue of a summons under section 359 of the 1998 Act in any proceedings is to be made by lodging the summons.

(2) The Registrar must ensure that the correct date, time and place for the attendance of the person required to attend (the attendee) are specified in the summons, and must then seal and issue the summons.

(3) The party who requested the issue of the summons must serve the summons on the attendee, and on each other party to the proceedings, not less than 7 days before the date on which the attendee is required to attend.

(4) Where the party who requested the issue of the summons applies in writing to the Registrar for the abridgment of the time specified in subrule (3), and provides written reasons for the application, the Registrar may abridge that time if the Registrar is satisfied that:

(a) the attendee has consented to the abridgment, or

(b) the circumstances of the case warrant the abridgment.

(5) The attendee is not required to comply with a summons unless:

(a) the summons is served on the attendee in accordance with these rules, and
(b) an amount sufficient to meet the reasonable expenses of compliance is paid or tendered to the attendee at the time of service of the summons or not later than a reasonable time before the time at which the attendee is required to attend.

(6) The amount sufficient to meet the reasonable expenses of compliance referred to in subrule (5)(b) is to be calculated in accordance with any relevant provision of the *Workers Compensation Regulation 2003.*

(7) Where the attendee is not a party to the proceedings and in consequence of the service of the summons incurs expense or loss substantially exceeding any amount paid or tendered as referred to in subrule (5)(b), the Registrar may order that the party who requested the issue of the summons pay to the attendee an additional amount in respect of the expense or loss.

13.14 Summons – variation

(1) The Registrar may, on the Registrar's own motion or on the application of any person having sufficient interest, set aside or vary a summons wholly or in part.

(2) The Registrar may, on written application (including reasons) made, by the party who requested the issue of the summons, on or before the date on which the attendee is required to attend, order that:

(a) the attendee be excused from complying with the summons, or

(b) the terms of the summons be altered.

13.15 Summons - non-compliance

Where the attendee has not complied with a summons, the Registrar:

(a) may, and

(b) on the application of the party who requested the issue of the summons made not later than 7 days after the date on which the attendee was required to attend, must

refer the matter to the Authority for consideration as to prosecution for an offence under section 359(2) of the 1998 Act.

PART 14 - EVIDENCE

14.1 Tapes, films, photographs, etc.

(1) This rule applies to:

(a) videotapes, and

(b) audiotapes, and

(c) films or photographs, and

(d) x-ray film, and

(e) the results of specialised medical investigations, including computerised tomography, medical ultrasound and magnetic resonance imaging scans, and

(f) any documents produced or received by electronic means,

on which a party proposes to rely in any proceedings.

(2) Where a document to which this rule applies constitutes surveillance material, any investigator's report concerning the material:

(a) must clearly and unambiguously identify the material, and

(b) is, for the purposes of subrule (3), deemed to be part of the document.

(3) A document to which this rule applies is, subject to this rule, a document for the purposes of rule 10.3.

(4) In the case of documents referred to in subrule (1)(e):

(a) original films or scans are not to be lodged with the Commission, and

(b) the lodging and service of a list describing and clearly identifying the films or scans satisfies the lodging and service requirements of rule 10.3, and

(c) original films or scans may be taken or delivered to an approved medical specialist undertaking an assessment for the purposes of the relevant proceedings.

(5) A party who intends to take or deliver original films or scans as referred to in subrule (4)(c) in the course of proceedings must notify the Commission and the other parties to the proceedings by notice in writing, not less than 7 days prior to the taking or delivery, of the party's intention.

14.2 Calling of witnesses

(1) Where a party proposes to rely on the oral evidence of a witness, the party must lodge and serve a document containing:

(a) the name of the witness, and

(b) a written statement of the evidence to be given by the witness, signed by the witness,

with the information and documents required under rule 10.3 to be lodged and served by the party.

(2) Subject to subrules (3) and (4), a party may not in proceedings call a witness to give oral evidence that has not been included in a document lodged and served as required by subrule (1) unless:

(a) the party has lodged and served with the information and documents required under rule 10.3 a statement revealing:

(i) the specific nature of the evidence, and

(ii) the reliance the party intends to place on the evidence, and

(iii) the reasons why the evidence has not been included in a statement as required by subrule (1), and

(iv) the time the evidence is expected to be so included, and

(b) the evidence is included in a written statement lodged and served on all other parties as soon as practicable after that statement can be obtained.

(3) Where:

(a) a person refuses to sign a statement of the oral evidence to be given in proceedings by the person, and

(b) the party wishing to adduce the evidence has served a summons issued under rule 13.13 in respect of the person,

this rule does not prevent the party from calling the person to give the evidence.

(4) The Commission may, for the avoidance of injustice, allow a party to introduce oral evidence that the party would otherwise be prevented from introducing because of the operation of subrule (2).

(5) Where a party proposes to give oral evidence, this rule applies to the party as though the party were the party's witness as well as being the party.

14.3 Expert witness

(1) Rule 14.2 applies in respect of an expert witness as it applies in respect of any other witness.

(2) A party proposing to call a witness to give evidence as an expert witness has a duty to ensure that the witness is aware of and adheres to any Practice Direction in force with respect to expert witnesses.

(3) Expert evidence that does not comply with any Practice Direction referred to in subrule (2) is not admissible in any proceedings unless the Commission otherwise orders

PART 15 - FURTHER PROVISIONS REGARDING PROCEEDINGS

15.1 Procedural orders by Arbitrators

(1) Where proceedings are referred to an Arbitrator, the Arbitrator may, while the referral continues, make any order relating to the procedure to be followed in the proceedings (including an order striking out the proceedings or any step in the proceedings) that could be made by the Registrar.

(2) Subrule (1) does not limit any other powers of an Arbitrator.

15.2 Principles of procedure

When informing itself on any matter, the Commission is to bear in mind the following principles:

(a) evidence should be logical and probative,

(b) evidence should be relevant to the facts in issue and the issues in dispute**,**

(c) evidence based on speculation or unsubstantiated assumptions is unacceptable,

(d) unqualified opinions are unacceptable.

15.3 Measures to assist parties

The Commission is to take such measures as are reasonably practicable to:

(a) assist the parties to any proceedings to understand the nature of the proceedings and the legal implications of any assertion made in any documents or otherwise in the proceedings, and

(b) explain to the parties any aspect of the procedure or any decision or ruling made by the Commission in relation to the proceedings, and

(c) ensure that the parties have the fullest opportunity practicable to have their case in the proceedings considered without compromising the objectives of the Commission, and

(d) ensure that the parties have the opportunity to explore settlement in the proceedings.

15.4 Statement as to agreed facts and issues

(1) The Commission may direct the parties to lodge a joint signed statement setting out the facts and issues on which the parties agree, and the facts and issues that continue to be in dispute.

(2) The parties are bound by the statement and may not assert the contrary except with the leave of the Commission.

(3) A direction issued under subrule (1) must, unless the Commission otherwise orders, direct that the joint signed statement be lodged not later than 7 days prior to the next subsequent conference, teleconference or hearing in the proceedings.

15.5 Schedule of earnings

In proceedings in which the quantum of weekly compensation is or may be an issue and there is or may be a dispute in respect of the actual or probable earnings of a worker during any relevant period, the following provisions have effect unless the Commission otherwise orders:

(a) the applicant must include in the application to resolve the dispute a schedule containing full particulars of those earnings, including where applicable details of the current weekly wage rate as defined in section 42 of the 1987 Act.

(b) if a party wishes to dispute the accuracy of any matter in the schedule, the party must lodge and serve with the first document lodged and served by the party in the proceedings, in addition to any documents required under rule 10.3(1) to be lodged and served by the party, a schedule of the party's allegations of the earnings,

(c) a matter not disputed by a party as provided in paragraph (b) is deemed to be admitted by the party.

15.6 Certificates of determination

(1) A statement of the Commission's reasons referred to in section 294(2) of the 1998 Act is to include:

(a) the Commission's findings on material questions of fact, referring to the evidence or other material on which those findings were based, and

(b) the Commission's understanding of the applicable law, and

(c) the reasoning processes that lead the Commission to the conclusions it made.

(2) Without limiting subrule (1), the reasons set out in a statement referred to in subrule (1) are to be stated sufficiently (in the opinion of the Commission) to make the parties aware of the Commission's view of the case made by each of them.

15.7 Discontinuance

(1) An applicant may discontinue any proceedings, or any part of any proceedings, as against any or all of the other parties to the proceedings, at any time.

(2) The applicant and any other party to any proceedings may agree to the discontinuance of the proceedings (or any part of the proceedings) as against that other party at any time.

(3) A discontinuance referred to in subrule (1) or (2) takes effect when a notice of the discontinuance, stating the limits (if any) of the discontinuance, is lodged and served on all parties to the proceedings who are not parties to the discontinuance.

(4) A party against whom proceedings are discontinued and who has not agreed to the discontinuance may, within 7 days after the discontinuance takes effect, lodge and serve an application to the Commission for an order for payment of the party's costs of the proceedings incurred before the discontinuance.

15.8 Dismissal for want of due despatch

Failure by an applicant to prosecute the proceedings with due despatch is a ground of dismissal for the purposes of section 354(7A)(c) of the 1998 Act.

15.9 Determination by consent order

(1) Where the parties, or some of the parties, to proceedings in respect of a dispute agree as to the terms of an order to be made determining the dispute as between those parties, and that order is an order that the Commission otherwise has power to make, the Commission may determine the dispute as between those parties by making that order.

(2) An order referred to in subrule (1) may be drawn up, with the consent of each party who has agreed to the order endorsed on it and signed by the party or the party's legal representative or agent in the proceedings, and lodged.

(3) The Commission may make an order referred to in subrule (1) by signing the order as lodged under subrule (2).

PART 16 REFERRAL OF QUESTIONS OF LAW AND APPEALS

16.1 Referral of question of law

(1) A question of law arising in proceedings before the Commission constituted by an Arbitrator may be referred under section 351 of the 1998 Act for the opinion of the Commission constituted by the President only if a certificate of determination has not been issued in respect of the proceedings.

(2) A party to any proceedings applying for the reference by an Arbitrator of a question of law in the proceedings under section 351 of the 1998 Act must lodge the application and serve it on the Arbitrator, the Authority, and the other parties to the proceedings as soon as practicable.

(3) An application referred to in subrule (2) must include, or have attached, full details of the question of law and the reasons for seeking its referral, including the reasons why it is alleged that the question involves a novel or complex question of law as referred to in section 351(3) of the 1998 Act.

(4) When a party seeks to oppose an application referred to in subrule (2) the party must, within 14 days of being served with the application, lodge and serve on the Arbitrator, the Authority, and the other parties notice of that opposition.

(5) A notice of opposition must include, or have attached, full details of the reasons for opposing the application.

(6) Where an application is lodged under subrule (2), and a party wishes to object to the matter of leave to refer the question of law being decided solely on the basis of the written application and any written notice of opposition lodged, the party must state that objection, including the reasons for the objection in full, in the application or notice of opposition lodged by the party.

(7) Where an Arbitrator, on the application of a party, seeks leave to refer a question of law under section 351 of the 1998 Act, the Arbitrator must give to the Registrar, as soon as practicable and in any case before any certificate of determination is issued in respect of the proceedings:

(a) the application served on the Arbitrator under subrule (2), and

(b) any notice of opposition served on the Arbitrator under subrule (4), and

(c) any statement of the question of law that the Arbitrator wishes to be considered by the President.

(8) Where an Arbitrator, of the Arbitrator's own motion, decides to seek leave to refer a question of law under section 351 of the 1998 Act, the Arbitrator must, as soon as practicable, give to the Registrar a notice of that decision including, or having attached, full details of the question of law and the reasons for seeking leave to refer it, including the reasons why it is alleged that the question involves a novel or complex question of law as referred to in subsection (3) of that section.

(9) Where an Arbitrator seeks leave to refer a question of law under section 351 of the 1998 Act and decides not to make an award in the matter in which the question arose (as authorised by subsection (5) of that section), the Arbitrator must give to the Registrar a notice of that decision including, or having attached, the reasons for the decision.

(10) The Registrar must, as soon as practicable, give to the parties copies of any notice under subrule (8) or (9) received by the Registrar.

16.2 Appeal against Arbitrator's decision

(1) A party to any proceedings applying for leave to appeal under section 352 of the 1998 Act against a decision of an Arbitrator must lodge the application within 28 days after the making of the decision, or within such extended time for making the appeal as may be ordered under subrule (11).

(2) For the purposes of subrule (1), a decision is made, in respect of a dispute, when the Commission issues a certificate as to the determination of the dispute as required by section 294(1) of the 1998 Act.

(3) If the Registrar determines that he or she is not satisfied that the requirements of section 352 of the 1998 Act, or any applicable Rules and regulations, as to the making of the appeal have been complied with, the Registrar is to return the application to the party who lodged it, with a statement particularising the non-compliance.

(4) An application referred to in subrule (1) must have attached to it a copy of the certificate as to the determination of the dispute referred to in subrule (2), and must include, or have attached, full details of:

(a) the arguments to be put in favour of review of the decision sought to be appealed against, and

(b) for the purposes of section 352(2) of the 1998 Act, the amount of compensation alleged to be at issue on the appeal, and

(c) any new evidence in respect of which leave is to be sought, by the party lodging the application, in accordance with section 352(6) of the 1998 Act, and

(d) if the party lodging the application wishes to object to the matter of leave to make the appeal, or the appeal, being decided solely on the basis of the written application and any written notice of opposition lodged, the reasons for the objection.

(5) The party lodging an application referred to in subrule (1) must serve a sealed copy of the application, including any attachments, on;

(a) all other parties to the proceedings, and

(b) where any of those parties is an employer (but not a self-insurer), the employer's insurer.

during the period of 14 days commencing on the day on which the Registrar registers the application.

(6) The appealing party must lodge a certificate of service within 7 days of the date of service, certifying service of the application on the other parties.

(7) Where a party seeks to oppose an application referred to in subrule (1), or the appeal in respect of which the application is made, the party must, within 28 days of being served with the application, lodge and serve on the other parties notice of that opposition.

(8) A notice of opposition referred to in subrule (7) must include, or have attached, full details of:

(a) the arguments to be put against review of the decision sought to be appealed against, and

(b) for the purposes of section 352(2) of the 1998 Act, the amount of compensation alleged to be at issue in the appeal, and

(c) any new evidence in respect of which leave is to be sought, by the party lodging the notice, in accordance with section 352(6) of the 1998 Act, and

(d) if the party lodging the notice wishes to object to the matter of leave to make the appeal, or the appeal, being decided solely on the basis of the written application and any notice of opposition lodged, the reasons for the objection.

(9) The party opposing the application must lodge a certificate of service within 7 days of the date of service, certifying service of the notice of opposition on the other parties.

(10) For the purposes of section 352(4) of the 1998 Act, an appeal is made when the application for leave to make the appeal is lodged as required by subrule (1).

(11) The Commission constituted by a Presidential member may, if a party satisfies the Presidential member, in exceptional circumstances, that to lose the right to seek leave to appeal would work demonstrable and substantial injustice, by order extend the time for making an appeal.

(12) A party who seeks an extension of time as referred to in subrule (11) must:

(a) as soon as practicable give notice to the other parties of the intention to seek the extension, and

(b) lodge and serve with the application for leave to appeal an application for the extension of time, including full details of the arguments to be put in favour of granting the extension.

PART 17 WORK INJURY DAMAGES

17.1 Definitions

In this Part, ***claimant*** and ***defendant*** have the meaning given to them by section 311 of the 1998 Act.

17.2 Threshold disputes

(1) A claimant who seeks assessment of the degree of permanent impairment disputed as referred to in section 313 of the 1998 Act must lodge an application for that assessment.

(2) An application referred to in subrule (1) must include, or have attached:

(a) evidence that a claim has been made on the defendant or insurer in accordance with the relevant WorkCover Guidelines, and that a threshold dispute exists as referred to in section 314 of the 1998 Act, and
(b) all documents that the claimant wishes to be considered by the approved medical specialist who is to assess the degree of permanent impairment.

(3) The claimant must serve an application referred to in subrule (1), including any attachments, on the defendant involved in the threshold dispute within 7 days after the Registrar registers the application.

(4) The claimant must lodge a certificate of service within 7 days of the date of service, certifying service of the application on the other parties.

(5) A defendant served with an application referred to in subrule (1) must, within 21 days from the date of registration of the application, lodge and serve on the claimant all documents that the defendant wishes to be considered by the approved medical specialist who is to assess the degree of permanent impairment.

17.3 Pre-filing statement

(1) For the purposes of section 315 of the 1998 Act, a pre-filing statement is to consist of a copy of the statement of claim intended to be filed in the court of relevant jurisdiction and is to include as attachments the information and other documents required by the Workers Compensation Acts and these rules.

(2) If the defendant is an employer (but not a self-insurer), the claimant must serve the pre-filing statement on both the employer and the employer's insurer.

17.4 Material to be served with pre-filing statement

For the purposes of sections 315 and 318 of the 1998 Act, a claimant for work injury damages must serve with the pre-filing statement all information and documents upon which the claimant proposes to rely including:

(a) any notification provided to the claimant as required by section 281(2B) of the 1998 Act that the degree of permanent impairment of the injured worker resulting from the injury is accepted as being sufficient for an award of work injury damages, or
(b) if the dispute has been referred to an approved medical specialist for assessment of permanent impairment, the medical assessment certificate issued by the approved medical specialist in accordance with section 325 of the 1998 Act.

17.5 Pre-filing defence

(1) In accordance with section 316 of the 1998 Act, a pre-filing defence is to consist of a copy of the defence intended to be filed in the court of relevant jurisdiction and is to include as attachments the information and documents required by the Workers Compensation Acts and these rules.

(2) Without leave of the Commission, the failure of a worker to notify of an injury as and when required by the Workers Compensation Acts may not be raised as an issue in the pre-filing defence served by the defendant if that issue has not been included in the notice given in accordance with section 74 of the 1998 Act.

17.6 Material to be served with pre-filing defence

For the purposes of sections 316 and 318 of the 1998 Act, the defendant must serve with the pre-filing defence all information and documents upon which the defendant proposes to rely.

17.7 Defective pre-filing statement

(1) A claimant who has been notified in accordance with section 317(1) of the 1998 Act in respect of the claimant's pre-filing statement must, within 7 days of being so notified, serve on the defendant advice as to whether the claimant accepts or denies that the pre-filing statement is defective, and in what detail and to what extent.

(2) Where a claimant has served advice in accordance with subrule (1) and has not, within 7 days of that service, been notified by the defendant that the defendant no longer alleges that the pre-filing statement is defective, the claimant must lodge:

(a) a copy of the pre-filing statement, and

(b) a copy of the defendant's notification and the claimant's advice referred to in subrule (1), and

(c) a request that the dispute be referred to the Registrar for determination under section 317(2) of the 1998 Act,

and on the same day serve the request on the defendant.

(3) Where a claimant does not comply with subrule (1), or, where subrule (2) applies, the pre-filing statement is taken not to have been served.

(4) Where a claimant requests in accordance with this rule that a dispute be referred to the Registrar for determination under section 317(2) of the 1998 Act, and lodges a certificate certifying service of the request on the defendant within 2 working days of that service, the dispute is so referred.

(5) Where a dispute is referred for determination in accordance with subrule (4) and the Registrar determines that the pre-filing statement is defective, the pre-filing statement is, in accordance with section 317(4) of the 1998 Act, considered to have been served on the date of service on the defendant of the last document or information required to cure the defect.

(6) Where a dispute is referred for determination in accordance with subrule (4) and the Registrar determines that the pre-filing statement is not defective, the Registrar may direct that the pre-filing statement be considered to have been served on the date when it was in fact served or a subsequent date.

(7) Where a defendant has given notification in accordance with section 317(1) of the 1998 Act and subsequently in respect of the same claim serves a pre-filing defence as referred to in rule 17.5:

(a) despite any application of subrule (3), the pre-filing statement is taken to have been served, and

(b) the defendant is taken to have waived any objection to the defects alleged in the notification.

17.8 Directions for access to information and premises

(1) A claimant may apply for a direction under section 318I(1) of the 1998 Act by lodging the proposed direction, and the Registrar may give or refuse to give the direction as proposed.

(2) Where a direction is given by the Registrar the claimant must serve the direction:

(a) on the defendant, and

(b) where the direction is a direction to provide or allow access to specified premises and the premises are in the direct control of an agent or representative of the defendant, on the agent or representative,

at least 28 days before the expiry of the period specified in the direction for compliance with the direction.

(3) The claimant must lodge a certificate of service within 7 days of the date of service, certifying service of the direction on the other parties.

(4) A defendant may object to a direction by notifying the Registrar and the claimant of the objection in writing, giving the reasons for the objection, before the expiry of the period specified in the direction for compliance with the direction.

(5) A defendant who objects to a direction is excused from complying with the direction until the objection is determined.

(6) If the claimant wishes to oppose an objection referred to in subrule (4), the claimant must notify the Registrar and the defendant of the opposition in writing, giving the reasons for the opposition, within 2 working days of being notified of the objection.

(7) The Registrar must determine an objection notified in accordance with subrule (4), and may do so solely on the basis of the written objection and any written opposition notified in accordance with subrule (6).

(8) Without limiting subrule (7), when considering the objection the Registrar may do any of the following:

(a) seek further oral or written information from the parties to the proceedings,

(b) list the objection for hearing before the Registrar.

(9) The Registrar may set aside or vary the terms of a direction following the determination of an objection to the direction.

17.9 Referral for mediation

(1) A claimant may apply for the referral of a claim for mediation as mentioned in section 318A of the 1998 Act by lodging:

(a) an application for mediation, and

(b) a copy of the pre-filing statement served by the claimant as required by section 315 of the 1998 Act, and

(c) copies of all information and documents served with the pre-filing statement as required by rule 17.4.

(2) A claimant who applies to refer a claim for mediation must serve the application on the defendant within 7 days of registration of the application.

(3) The claimant must lodge a certificate of service within 7 days of the date of service, certifying service of the application on the other parties.

(4) If the defendant does not lodge a response in accordance with rule 17.10, the claim may not be referred to mediation until the claimant lodges a certificate certifying service of the application for the referral.

17.10 Response to application for mediation

(1) A defendant served with an application for mediation of a claim as referred to in rule 17.9 must, within 21 days of registration, lodge:

(a) a response to the application, and

(b) a copy of the pre-filing defence served by the defendant in accordance with section 316(1)(b) of the 1998 Act, and

(c) copies of all information and documents served with the pre-filing defence as required by rule 17.6.

(2) A response referred to in subrule (1) must indicate whether or not the defendant will decline, under section 318A(3) of the 1998 Act, to participate in mediation of the claim.

(3) A defendant who lodges a response as required by subrule (1)(a) must serve the response on the claimant within 7 days of lodging the response.

17.11 Mediator unable to mediate

If the mediator to whom a claim is referred by the Registrar is unwilling or unable to act as a mediator in respect of the claim:

(a) the mediator must notify the Registrar of the unwillingness or inability, in writing, as soon as practicable, and

(b) the Registrar must then so notify the parties, and

(c) the Registrar may revoke the direction referring the claim to the mediator and make a direction referring the claim to another mediator.

17.12 Certificate of mediation outcome

(1) Where a defendant has lodged, under rule 17.10, a response that indicates that the defendant declines to participate in mediation on the grounds that the defendant wholly disputes liability in respect of the claim, the Registrar may issue a certificate to that effect.

(2) A certificate of mediation outcome issued in accordance with section 318B of the 1998 Act is to include:

(a) the names and addresses of the parties to the dispute, and

(b) the names of persons in attendance at the mediation, and

(c) a statement that the parties failed to resolve the dispute and reach settlement, and

(d) the final offers of settlement made by the parties to the mediation.

PART 18 - MISCELLANEOUS

18.1 Practice Directions

The President, in consultation with the Deputy Presidents, may issue Practice Directions in relation to the operation of these rules, and may from time to time rescind or amend any such Practice Direction.

18.2 Certificate as to amount ordered to be paid

(1) A party entitled to recover any amount ordered by the Commission to be paid may apply for a certificate under section 362 of the 1998 Act by lodging a statutory declaration containing and verifying a statement of:

(a) the date of the order, and

(b) the amount of money originally payable under the order, and

(c) the amount of costs originally payable under the order, if that amount has been fixed, and

(d) the total amount, if any, paid by the debtor under the order in reduction of the amount payable, and

(e) the total amount of any credits accrued in reduction of the amount payable otherwise than by payment, and

(f) the amount or amounts on which, and the date or dates from which, the party claims to be entitled to interest in respect of the amount payable, and

(g) such other particulars, if any, as are necessary to calculate the balance payable under the order, and

(h) the amount payable under the order on the date of making the statutory declaration, and

(i) the full name, and the address of the place of residence or business, of the debtor under the order.

(2) A statutory declaration mentioned in subrule (1) may not be lodged if it is made more than 14 days before the day on which it is submitted for lodging.

(3) The amount certified by the Registrar must not exceed the amount verified in accordance with subrule (1)(h).

18.3 Interpreters

(1) Subject to subrule (2), only interpreters accredited by the National Accreditation Authority for Translators and Interpreters (NAATI) may be used in proceedings before the Commission.

(2) In any proceedings before the Commission requiring interpreters in languages for which interpreters are yet to be accredited by NAATI, or in circumstances where the Registrar determines it is otherwise necessary in view of the unavailability of NAATI-accredited interpreters, the Registrar may approve an interpreter or interpreters for use in the proceedings.

18.4 Continuation of proceedings in the case of death or bankruptcy and substitution of parties

(1) If a party dies or becomes bankrupt but a claim in the proceedings survives, the proceedings do not abate by reason of the death or bankruptcy.

(2) If the interest or liability of a party in respect of any proceedings passes by assignment, transmission, devolution or otherwise to another person, the Commission may make orders for the addition, removal or re-arrangement of parties, and may make orders for the further conduct of the proceedings.

(3) The Commission may act under subrule (2) on application by a party or by a person to whom the interest or liability passes, or of its own motion.

(4) If the Commission orders that a party be substituted for another party or a former party, all things done in the proceedings before the making of the order have effect in relation to the new party as if that party were the old party, unless the Commission otherwise orders.

(5) An administrator or executor may continue or defend proceedings in like manner as if he or she were a party claiming or defending in his or her own right. If it appears to the Commission that a deceased person was interested, or that the estate of the deceased person is interested, in any matter in question in the proceedings and there is no personal representative, the Commission may appoint a person, with the person's consent, to represent the estate for the purposes of the proceedings.

(6) In the case of the death of a party, the Commission may order that the proceedings be dismissed if no application has been made for an order under subrule (2).

WORKCOVER GUIDELINES FOR CLAIMING COMPENSATION BENEFITS

I, Jon Blackwell, the Chief Executive Officer of the WorkCover Authority of New South Wales, under sections 260, 266 and 376 of the *Workplace Injury Management and Workers Compensation Act 1998*, and section 192A of the *Workers Compensation Act 1987,* issue the following guidelines.

Dated, this twenty-fifth day of October 2006.

Jon Blackwell
Chief Executive Officer
WorkCover Authority

Explanatory Note

The guidelines refer to sections in both the *Workers Compensation Act 1987* (referred to as 'the 1987 Act') and the *Workplace Injury Management and Workers Compensation Act 1998* (referred to as 'the 1998 Act').

The guidelines set out the procedures for:

- the initial notification of an injury and making provisional liability payments
- the making and handling of claims for weekly payments and medical expenses compensation
- disputing all or part of the claim for weekly payments or medical expenses
- reducing or terminating weekly payments
- making and handling claims for lump sum compensation (permanent impairment and pain and suffering)
- making and handling claims for work injury damages.

These guidelines replace guidelines issued December 2001.

These guidelines commence on 1 November 2006.

A step taken in claims making or handling in accordance with the replaced guidelines is as valid as it would have been if done under these guidelines.

Questions about these guidelines should be directed to the WorkCover NSW Information Centre on 13 10 50.

APPLICATION OF THESE GUIDELINES

These guidelines apply to:

- injuries notified from 1 January 2002
- claims made from 1 January 2002, even if the injury was received before 1 January 2002.

These guidelines apply to workers, employers and insurers within the meaning of the *Workers Compensation Act 1987* and the *Workplace Injury Management and Workers Compensation Act 1998*. Insurers include Scheme Agents for the Nominal Insurer and self and specialised insurers who hold a licence under Division 3 of Part 7 of the 1987 Act.

These guidelines do not apply to:

- the workers compensation company within the meaning of the *Coal Industry Act 2001*; or
- claims made or determined under the Uninsured Liability and Indemnity Scheme established under Part 4 the 1987 Act (section 141 of the 1987 Act; or
- claims arising from the dust diseases which are referable to the NSW Dust Disease Board or the NSW Dust Disease Tribunal.

DEFINITION

Injury is defined in Section 4, Part 1 of the *Workers Compensation Act 1987*:

(a) "means personal injury arising out of or in the course of employment;
(b) includes-
i. a disease which is contracted by a worker in the course of employment and to which the employment was a contributing factor; and
ii. the aggravation, acceleration, exacerbation or deterioration of any disease, where the employment was a contributing factor to the aggravation, acceleration, exacerbation or deterioration; and
(c) does not include (except in the case of a worker employed in or about a mine to which the Coal Mines Regulation Act 1982 applies) a dust disease, as defined by the Workers Compensation (Dust Diseases) Act 1942, or the aggravation, acceleration, exacerbation or deterioration of a dust disease, as so defined".

STRUCTURE OF THESE GUIDELINES

These guidelines contain six parts:

Part 1 Initial Notifications and Provisional Liability
Part 2 Making and Handling a Claim for Weekly Payments and Medical Expenses Compensation
Part 3 Disputing all or Part of the Claim for Weekly Payments and Medical Expenses
Part 4 Terminating or Reducing Weekly Payments of Compensation
Part 5 Making and Handling a Claim for Lump Sum Compensation (Permanent Impairment and Pain and Suffering)
Part 6 Making and Handling a Claim for Work Injury Damages
Appendix 1 Application for Review by Insurer

GOVERNING PRINCIPLES

The WorkCover guidelines are founded on the following principles:

1. ***timeliness*** To satisfy legislative requirements, workers, employers, insurers and other persons acting on behalf of the worker or employer will obtain and provide information about the injury in a timely manner.

2. ***active decision making*** Insurers are required to obtain certain information to make certain assessments.

3. ***sound up-to-date decisions*** Insurers will make sound decisions on the information available within the timeframes the law allows and they will review and update decisions as they receive new information.

4. ***documented reasons*** Insurers will record the reasons for their decisions and show that they have considered all relevant information.

5. ***peer review*** Insurers will arrange for all decisions to dispute all or part of a claim, to terminate or reduce weekly payments, or to decline provisional payments on the basis of a reasonable excuse, to be reviewed by a suitably experienced person

6. ***consent*** Worker's consent to the collection, use and disclosure of personal and health information when they sign the claim form or medical certificate

7. ***privacy*** Section 243 of the 1998 Act, the Commonwealth privacy law, the National Privacy Principles and the NSW *Health Records and Information Privacy Act 2002* apply to the information collected and used for the purposes of handling the worker's claim. In relation to workers compensation claims, medical advice will be kept confidential and information released to other parties only on a "need to know" basis eg medical information would only be released to an employer if it was relevant to an injured worker's return to work.

AIMS

The aims of these guidelines are to:

- ensure the prompt management of a worker's injuries
- ensure a worker's return to work as early as possible
- give workers certainty and proper income support while they are incapacitated by work injuries
- facilitate timely and sound decision-making
- reduce disputes
- maintain the employment relationship between the worker and the employer
- clarify all issues in dispute and promptly resolve disputes if they do occur
- set the requirements for making a claim under the1998 Act for compensation benefits pursuant to the 1987 Act.

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Part 1 Initial Notifications and Provisional Liability

Part 2 Making and Handling a Claim for Weekly Payments and Medical Expenses Compensation

PART 1 INITIAL NOTIFICATIONS AND PROVISIONAL LIABILITY

Chapter 3 of the 1998 Act sets out workers', employers' and insurers' obligations to participate and co-operate in injury management for injured workers.

Part 3 of Chapter 7 of the 1998 Act sets out an insurer's duty to accept provisional liability and commence weekly payments to an injured worker.

Part 3 of the 1987 Act sets out compensation benefits payable to injured workers.

1. Provisional Liability

Provisional liability enables an insurer to make available compensation benefits to provide income support and effect injury management strategies for an injured worker without admitting liability. An insurer that fails to commence weekly payments as required by section 267 of the 1998 Act is guilty of an offence. *Reference section 267(5) of the 1998 Act.*

Provisional liability requires an insurer to commence making weekly payments by way of income support on a provisional basis within 7 days of receiving initial notification, unless the insurer is able to properly rely on one of the 7 formal reasonable excuses (see Clause 7, Part 1) and this is communicated to the worker within the 7 days. This enables payments to be made to an injured worker without delay. *Reference section 267 of the 1998 Act.* These weekly compensation payments may be made under section 36, 38 or 40 of the 1987 Act.

An important feature of provisional liability is that, after initial notification, the insurer is to collect information that is sufficient to enable them to make a soundly based decision to commence weekly payments of compensation.

Provisional liability also applies to provision of compensation benefits under section 60 (eg ambulance services, medical or related treatment, hospital treatment and occupational rehabilitation services, etc). *Reference section 280 of the 1998 Act.*

2. Initial Notification of Injury

An initial notification means the first notification of a workplace injury that is given to the relevant insurer. *Reference section 266 of the 1998 Act.* A worker, employer or their representative (for instance, a medical practitioner) can make the initial notification of workplace injury to the relevant insurer.

All incidents involving an injury, where workers compensation is payable or may be payable, are to be notified to the insurer within 48 hours. *Reference section 44 of the 1998 Act.*

The notification may be in writing (including by electronic means) or verbally (including over the phone).

The insurer must have implemented systems and allocated sufficient resources to make sure that the person giving the information is guided through the process to assist them to give all the information needed for the notification to be handled swiftly, efficiently and fairly.

Minimum Identifying Information for Initial Notification

At the initial notification, the insurer is to gather the following information.

2.1 Worker's information:

- name
- contact details
- residential address
- date of birth.

2.2 Employer's information:

- business name
- business address.

2.3 Treating doctor information:

- name (the insurer may need to be flexible in relation to workers in remote rural areas where access to medical treatment is not readily available); or
- if the worker is hospitalised, name of hospital.

2.4 Injury or illness and accident details:

- date and time of workplace injury or period of time over which the illness/injury emerged from date of first symptoms
- description of how the workplace injury happened
- description of the workplace injury.

2.5 Notifier information:

- name of person making the initial notification
- relationship to worker or employer
- contact details, telephone and address.

Supporting Information

It is good practice to gather supporting information at the initial notification. This may include:

- employer's policy number
- employer contact name and position/title
- employer's telephone number and/or email address
- telephone number of treating doctor
- date of consultation with treating doctor
- diagnosis of workplace injury
- worker's capacity to return to work and expected return to work date
- details of any time off work
- person to whom the payment is to be paid
- current weekly wage details.

The initial notification is complete when the worker, employer or representative has provided the minimum identifying information to the insurer. If information is missing which is essential for the insurer to make a decision about the worker's entitlement to provisional liability, the insurer must, within the next 3 working days, inform the person (verbally or in writing) who made the notification that the notification is incomplete. The person may then make another initial notification. If the missing information does not prevent a decision being made, the insurer may start payments.

3. No Identifiable Workers Compensation Policy

If the insurer cannot identify a current policy that covers the worker who is the subject of an initial notification within 7 days after the notification is made, then the insurer is to either:

- contact the employer, and the person who made the notification and request more information in order to identify the policy. If the policy still cannot be identified, then the insurer is to inform the employer and the person who made the notification that the insurer is not the current insurer. The insurer must then refer the notification to WorkCover's Claims Assistance Service (CAS) and notify the worker; or
- pass the notification to the current insurer, if the identity of the current insurer can be determined, and notify the worker.

4. Consideration that the Injury is Work Related

After the initial notification, the insurer is to obtain medical information to verify that the worker has sustained a work related injury and to determine the worker's expected period of incapacity. This information may be obtained from:

- the treating doctor or hospital, subject to authority completed by the worker,
- the employer, or the employer's representative; or
- the worker or the worker's representative.

The information may be in any form, including a WorkCover medical certificate (although the insurer does not have to see a WorkCover medical certificate). Information from the employer or a representative of the employer may:

- confirm or refute the claim that the worker has sustained a work related injury
- confirm or refute the details of the injury and the worker's expected period of incapacity, if the employer has those details.

If the employer believes the injury is not work related, the employer must provide evidence to support the assertion, eg medical evidence that the medical condition already existed and has not been aggravated by work, or factual evidence that the injury occurred in circumstances not arising out of or in the course of employment.

However, suspicion, innuendo, anecdotal or unsupported information received from any source, including the employer alone, is not acceptable evidence and cannot be the basis for not commencing provisional payments.

5. Confirm Worker Status

If there is any doubt that the injured person is a worker within the meaning of the workers compensation legislation, the insurer is to verify the worker's status.

The relevant definition of worker is in section 4 of the 1998 Act, and provisions in regard to deemed workers are in section 5 and Schedule 1 of the 1998 Act which concerns the special categories of "Deemed employment" of workers, ie various factual situations outlined in the schedule where the legislation deems or makes a person a worker under the Act, although they may not satisfy the common law test of an employment relationship.

Acceptable evidence of the worker's status is the employer agreeing to that status, or the insurer seeing copies, or having verbal confirmation, of any of the following of the worker's:

- current payslip
- payroll number
- bank statement that includes regular employer payment entries
- contract of employment.

If the worker and employer disagree as to the worker's status, then the insurer is required to consider the governing principles of these guidelines when making a decision.

6. Action Following Initial Notification

When an insurer receives an initial notification, it is to:

6.1 issue a claim notification number to the notifier at the time of initial notification (if made by telephone) and to the worker and employer in writing within 7 days after the notification is made

6.2 make early contact with the worker, employer and nominated treating doctor (if appropriate) to gather information to use in considering if provisional liability is appropriate and to assist in making decisions about reasonably necessary services and the claims estimate

6.3 start injury management if the worker is likely to be incapacitated (total or partial) for more than 7 continuous days, even if any of the days are not work days. *Reference section 45 of the 1998 Act*

6.4 approve provisional liability for weekly compensation benefits and commence weekly payments of compensation within 7 days unless the reasonable excuses apply (see Clause 7, Part 1)

6.5 decide the period of time for which benefits will be paid on the basis of the nature of the injury, the period of the worker's incapacity and the expected future period of incapacity

6.6 decide whether to approve provisional liability for medical expenses up to $7,500 or approve medical expenses as part of an injury management plan within 7 days. *Reference sections 50 and 280 of the 1998 Act.*

Note: The only reason for not approving provisional liability for compensation benefits is if an insurer has a reasonable excuse (see Clause 7, Part 1).

Note: All medical expenses must meet the test of 'reasonably necessary' in order to be approved by the insurer (see Clause 10, Part 1).

If the insurer decides to approve provisional liability for compensation benefits, the insurer must give written notice about the decision to commence payment to the worker and employer as soon as practicable after payments start. *Reference sections 267 and 269 of the 1998 Act.*

6.7 include in the notice to the worker:

- that benefits have commenced on the basis of provisional acceptance of liability

- the period of expected weekly payments of compensation
- the amount to be paid each week and how that amount is calculated
- whether the insurer or the employer will pay the worker
- what the worker should do if they do not receive payment
- that an injury management plan will be developed, if required
- the worker's entitlement to make a claim, including details of how to make a claim
- a copy of the WorkCover brochure for injured workers, detailing workers' rights and responsibilities. *Reference section 269 of the 1998 Act.*

If the worker has returned to work, the insurer's letter is to advise that the worker does not have to make a claim unless the worker expects further problems from the workplace injury.

If the worker has not returned to work, the letter should include advice to the worker that if the worker expects to be off work for more than the period approved by the insurer, a claim will need to be made and a claim form should be enclosed.

6.8 include in the notice to the employer details about how the weekly payments of compensation are to be made.

If a worker does not immediately have time off work following initial notification but later requires time off, the insurer is to commence weekly payments of compensation within 7 days of becoming aware that the worker is to be off work.

7. Reasonable Excuse to Decline Provisional Payments

The insurer has a reasonable excuse for not commencing provisional liability payments if:

7.1 there is insufficient medical information –

the insurer has a reasonable excuse if it does not have enough medical information to establish there is an injury or that the injury cannot be related to the worker's employment (refer to Clause 4, Part 1). However, the insurer may have to allow special consideration for workers in remote rural areas if access to medical treatment is not readily available. This reasonable excuse can only be utilised in circumstances where there has been a failure to provide a medical certificate or information to the insurer despite requests from the insurer

7.2 the injured person unlikely to be a worker –

- the worker has been unable to verify their status as a worker as described above; or
- the employer is able to verify that the worker is not a worker

7.3 the insurer is unable to contact worker –

and is unable to do so after trying repeatedly by phone or electronic means, and at least once in writing

7.4 the worker refuses access to information –

the insurer has a reasonable excuse if the worker will not consent to the release or collection of personal or health information in relation to the workplace injury to determine the worker's entitlement to compensation benefits under provisional liability

7.5 the injury is not work related –

the insurer has a reasonable excuse if the employer has provided acceptable evidence that the worker did not sustain an injury or the worker's employment is not a substantial contributing factor to the injury. Evidence that may lead to this conclusion is set out in Clause 4, Part 1. Employment is required to be a substantial contributing factor (not **the** substantially contributing factor) under section 9A of the 1987 Act. It may be a substantial contributing factor, even if it is one of a number of factors

7.6 the injury is not a significant injury –

if the injury is not significant, (ie the worker is likely to be incapacitated for work, whether partial or total or a combination of both, for less than 7 continuous days), the insurer may extend the time to assess provisional liability entitlements to 21 days after the initial notification is made.

If the insurer does that, then within 7 days of the initial notification, the insurer is to notify the worker in writing that a decision will be made within 21 days of the initial notification.

7.7 the injury is notified after 2 months –

the insurer has a reasonable excuse if the notice of injury is not given to the employer within 2 months after the date of the injury. However, the insurer may ignore this excuse if a liability is likely to exist and if it believes paying compensation benefits to the worker under provisional liability will be an effective injury management intervention

if the insurer has a reasonable excuse for not accepting provisional liability and commencing payments, it is to –

- give written notice to the worker within 7 days after the initial notification
- inform the employer as soon as practicable.

Reference sections 267 and 268 of the 1998 Act.

7.8 the insurer's notice to the worker is to include the following –

- details of the reasonable excuse, including copies of all information, documents, and medical reports that are relevant and were considered in making the decision
- that the worker may contact WorkCover's Claims Assistance Service on 13 10 50 or their union for assistance
- that the worker can make a claim for compensation and that claim will be determined within 21 days of receipt by the insurer
- details of how to make a claim
- a claim form

Reference section 268 of the 1998 Act

7.9 the insurer's notice to the employer is to include the following –

- details of the reasonable excuse given to the worker
- that the employer may contact WorkCover's Claims Assistance Service on 13 10 50 for assistance.

8. The insurer has satisfied its obligations to start paying:

8.1 if the insurer and the employer have agreed in writing that the employer is to pay a worker for any time off work, and the insurer has confirmed with the employer –

- the amount of weekly payments and how that amount was calculated
- the period for which the employer is authorised to pay
- any special conditions the insurer requires

8.2 if the period to be paid is for a closed period and is to be paid in one amount, and the insurer has confirmed in writing to the employer –

- the period to be paid
- the amount to be reimbursed to the employer
- that the amount will be paid to the employer within a further 7 days
- that the employer must pay the worker as soon as practicable

Reference section 264 (3) of the 1998 Act

8.3 if ongoing payments are to be made and the insurer and employer agree that for this worker and this injury the employer will pay, and the insurer has given the employer written confirmation of this agreement including at least –

- employer's agreement to make payments to the worker on their usual pay day
- the amount of weekly payments to be paid to the worker and how that amount was calculated
- the approved period of payment
- any special conditions the insurer requires, eg the requirement for the worker to provide ongoing WorkCover medical certificates to the employer for continuing payments
- the time when the insurer will pay the first payment to the employer
- the schedule for ongoing weekly payments, if applicable
- that the employer must pay the worker as soon as practicable *Reference section 264 (3) of the 1998 Act*
- how the employer can withdraw from the agreement

8.4 if the insurer pays the employer before the employer pays the worker and the insurer has given the employer written confirmation of at least –

- the period paid and amount

- that the employer must pay the worker as soon as practicable.

Reference section 264 (3)of the 1998 Act

8.5 if the insurer pays the worker directly, the insurer has satisfied its obligations if it has made the weekly payment direct to the worker. In that case, the insurer is to arrange with the worker about the payment of taxation in accordance with the *Income Tax Assessment Act 1936* of the Commonwealth and *the Income Tax Assessment Act 1997* of the Commonwealth.

Provisional weekly payments cannot be deducted from or held against a worker's entitlements. Any such deductions can be recovered as a debt by the worker. *Reference section 233 of the 1998 Act.*

9. Period of Payment of Provisional Liability

The insurer is to continue to make weekly payments of compensation for the expected period of provisional liability. This period (up to a maximum of 12 weeks) will be determined by the nature and seriousness of the worker's injury and the expected period of incapacity.

The 12 week period for weekly payments of compensation starts on the first day the worker becomes entitled to this payment. The 12 week period can be paid under sections 36, 38 or 40 of the 1987 Act. If payment is stopped during the 12 week period, the period of non-payment is not included in the 12 week period.

10. Provisional Liability for Medical Expenses

The insurer can pay section 60 benefits up to $7,500 provided they are reasonably necessary for the management of the injury, as would be required by the insurer if liability had been admitted.

Relevant factors in determining reasonably necessary treatment

The treatment or service must have the purpose and potential effect to:

- alleviate the consequences of the injury
- maintain the worker's state of health; or
- slow or prevent its deterioration given the injury.

A decision about reasonably necessary treatment must include consideration of all of the following: appropriateness, effectiveness, the alternatives available, cost benefit and its acceptance among the medical profession:

appropriateness – the capacity to relieve the effects of the injury

effectiveness – the degree to which the treatment will potentially alleviate the consequences of the injury

alternatives – consideration must be given to all other viable forms of treatment for the injury

cost benefit – there must be an expected positive benefit, given the cost involved, that should deliver the expected health outcomes for the worker

acceptance – the acceptance of the treatment among the medical profession must be considered, ie is it a conventional method of treatment and would medical practitioners generally prescribe it?

There are no time limits over what period the medical treatment can be given as long as the $7,500 limit is not exceeded. *Reference section 280 of the 1998 Act.* The insurer can pre-approve above $7,500 in exceptional circumstances.

WorkCover fees orders are gazetted and set out the maximum fee amount for which an employer is liable under the Act for treatment of an injured worker. The insurer must not pay above these amounts.

If the worker has paid for reasonably necessary medical treatment, the insurer is to reimburse the worker within 7 days after the worker requests payment.

If the worker has paid for travelling expenses to receive medical treatment or to attend a medical appointment that the insurer has arranged, the insurer is to reimburse the worker within 7 days after the worker requests payment.

11. Need for a WorkCover Medical Certificate

Reference section 270 of the 1998 Act.

If the insurer has commenced making weekly payments of compensation, the insurer is entitled to request the worker to provide a WorkCover medical certificate covering any period of incapacity for which payments have been or are to be made.

The request can be made to the worker or the worker's representative in writing or verbally. If the request is made verbally then it must be confirmed in writing. When the insurer makes the request, it is to notify the worker:

- of the period of incapacity the WorkCover medical certificate is required to cover
- that the worker must give the WorkCover medical certificate to the insurer within 7 days after the request or within a period agreed by the insurer and worker
- that weekly payments may be discontinued if the WorkCover medical certificate is not received by the insurer.

12. Circumstances Affecting Payment under Provisional Liability:

12.1 If a worker returns to pre-injury duties and is then off work again

Provisional liability can be paid for a cumulative total of 12 weeks, even if the worker returns to work for intermittent periods and workers compensation is not paid during those periods.

If the worker returns to work and is then off work again, the insurer may pay weekly payments of compensation for the periods the injured worker is 'off work' under provisional liability. These periods must not exceed a cumulative total of 12 weeks, and apply where the worker has had a recurrence and this additional period will progress injury management and return to work for the worker. However, if the worker had resumed pre-injury work and sustained a further injury or aggravated the original injury, this is a new injury and a further potential 12 weeks of provisional liability may be payable

12.2 If payments are made for at least 8 weeks

Once an insurer has paid weekly payments of compensation to a worker under provisional liability for at least 8 weeks, the insurer is to notify the worker that they will need to make a claim if they will require payments of compensation to be paid beyond 12 weeks because of ongoing partial or total incapacity

12.3 After a reasonable excuse no longer exists

If the reasonable excuse the insurer relied on for not commencing provisional weekly payments ceases to exist, the insurer must commence payment within 7 days (unless information identifying a further reasonable excuse exists and is relied on by the insurer)

12.4 If the initial notification of injury is a claim

An insurer must commence payments of compensation benefits under provisional liability within 7 days of the claim being received, unless the insurer has a reasonable excuse. *Reference sections 267 and 275 of the 1998 Act.*

13. Ceasing Provisional Liability for Weekly Payments of Compensation

Provisional liability for weekly payments of compensation ceases for one of the following reasons:

13.1 if the worker returns to work before the end of the approved period for provisional liability for weekly payments and is not incurring any economic loss; or

13.2 if the worker makes a claim and this claim is accepted.

In either of the above cases, the insurer need not notify the worker that the provisional liability for weekly payments of compensation is to cease.

14. Circumstances in which Provisional Liability may be Discontinued

Provisional liability may be discontinued if the following circumstances occur:

14.1 if the worker unreasonably fails to comply with a requirement of Chapter 3 of the 1998 Act in respect of injury management. *Reference section 57 (1) and (2) of the 1998 Act*

14.2 if the worker does not provide a WorkCover medical certificate that certifies the worker's incapacity within 7 days after the insurer requested the certificate. *Reference section 270 (1) (a) and (2) of the 1998 Act*; or

14.3 if the worker does not authorise a provider of medical or hospital treatment or occupational rehabilitation services to give an insurer the information specified in section 270 (1) (b) of the 1998 Act within 7 days after the insurer making the request. *Reference section 270 (1) (b) and (2) of the 1998 Act*

14.4 if the insurer receives new credible evidence (eg the worker is not a worker as defined, employment is not a substantial contributing factor to the injury) that was not available at the time the provisional payments began.

In the four circumstances described above, the insurer must send the worker written notice that provisional liability and payments have been discontinued and must send a copy to the employer and service providers, if appropriate. The notice must inform the worker that provisional payments have been discontinued, the reason that they have been discontinued, attach all documents and medical reports

relevant to the decision. In the case of non-compliance, the notice must detail any action that the worker can take to comply and enable the insurer to re-commence provisional liability and make payments . The notice must also inform the worker and employer that they may contact WorkCover's Claims Assistance Service on 13 10 50, their union or employer association for further information (see section 74 notices, Part 3 of these guidelines).

15. Re-opening a Provisional Liability Claim

The insurer may recommence provisional liability on a notification of injury in the following circumstances:

15.1 for administration purposes to make further payments

15.2 if provisional liability for payment of compensation benefits has ceased or been discontinued for reasons described above at Clauses 13.1 and Clauses 14.1 to 14.4 and the worker becomes eligible again for compensation benefits, the payments can start again if the cumulative totals are not exceeded (12 weeks of weekly payments of compensation and $7,500 of expenses under section 60 of the 1987 Act). Any periods for which weekly payments of compensation are not made because they have been stopped is not included in the 12 weeks

15.3 recurrence of original injury, ie spontaneous re-emergence of symptoms needing treatment or causing incapacity as opposed to a new injury which is an aggravation or further incident, impacting on the same area of the body as the original claim

15.4 claim is litigated.

The insurer must notify the employer within 7 days that provisional liability has been re-opened, unless it has only been re-opened for administrative purposes.

PART 2 MAKING AND HANDLING A CLAIM FOR WEEKLY PAYMENTS AND MEDICAL EXPENSES COMPENSATION

1. Time Limits for Making a Claim

Claims are generally to be made within 6 months of the injury. *Reference section 261(1) of the 1998 Act.*

Before a worker can make a claim the worker must give notice of injury to the employer except in special circumstances. *Reference section 254 of the 1998 Act.*

A notice of injury may be given orally or in writing and must be given to any person designated by the employer for that purpose (eg as specified in an employer's return to work program) or to any person under whose supervision the worker is employed (which may include a person other than a direct supervisor).

A notice of injury must state:

- the name and address of the person injured
- the cause of the injury (in plain language)
- the date on which the injury happened.

2. Need for a Claim Form

A claim form is required if compensation is to be paid beyond the provisional liability period for weekly payments of compensation or where medical expenses under provisional liability may exceed $7,500.

In some circumstances the need for a claim form may be waived and the claim taken to have been made, eg. where the worker is unable to complete the form and there is sufficient evidence to make a decision on liability.

3. Minimum Information Required to Make a Claim

If a claim is to be made it is to be completed on the claim form available from the employer's insurer for workers compensation purposes. The claim form must be completed to the full extent that the relevant information is available and must include the worker's particulars, injury details, injured worker's declaration, work details and employer's particulars. Further information in support of the claim should be provided as soon as possible after it is received. In making a claim, the worker must provide all reports and documents that they rely upon in making the claim as soon as possible after that information is received to either:

- the employer from whom they are claiming workers compensation benefits
- the insurer responsible for providing the employer's workers compensation insurance.

If the claim is for weekly payments of compensation, the worker must provide a WorkCover medical certificate (if one has not already been given to the insurer or employer) or a medical report that includes the information normally provided on a WorkCover medical certificate.

If a worker has completed a claim form in relation to one claim for an injury, that information is relevant for any subsequent claim for weekly payments, section 60 expenses or permanent impairment that is related to the same injury.

Where an injury has been sustained by a worker while on a journey, a journey claim form is to be completed.

4. Employer Actions when Served with a Claim

Within 7 days after an employer receives a claim, the employer must complete their relevant sections on the form and send the claim to the insurer responsible for covering the worker for compensation. From then on, if the insurer requests more information, the employer must respond within 7 days of receiving the request with all information that is reasonably attainable. *Reference section 264 (1) and (2) of the 1998 Act.* The employer must also forward to the insurer, within 7 days of receipt, any documentation the employer receives in respect of the claim.

Failure by the employer to forward the information to the insurer within 7 days, where the information is in the employer's possession or reasonably obtainable, renders the employer liable for prosecution under section 264(1) of the 1998 Act. *Reference Clause 14A of the Workers Compensation Regulation 2003.*

An employer must, within 14 days of a request from the worker, supply to the worker the wage and earning details set out in section 43(2) of the 1987 Act.

Failure by the employer to forward the information to the worker within 14 days, without reasonable excuse, renders the employer liable for prosecution under section 43(2A) of the 1987 Act.

5. Insurer Actions when Served with a Claim

Once the insurer receives the claim for weekly compensation or medical compensation benefits, they are responsible for gathering further information from all relevant sources to enable the claim to be determined within 21 days, unless one of the following reasonable excuses for not determining the claim applies:

- expiry date beyond the due date, ie. The expiry date of the expected provisional liability period for weekly payments is greater than the claim determination due date. If a determination is still required, the insurer must determine the claim prior to the conclusion of the approved period of provisional liability
- returned to work, ie the worker has returned to work on pre-injury duties and received payments for the amounts claimed, and is not expected to be entitled to receive any further compensation benefits resulting from the injury
- medical expenses only, ie the claim is for only medical compensation benefits and liability has been provisionally accepted for the claimed expenses *Reference section 280 of the 1998 Act*
- deficient claim, ie within 7 days after the insurer received the claim, the insurer has notified the worker in writing that the claim contains an error that is material, ie not obvious or typographical and how to correct that deficiency. This could include –
    - worker has failed or refuses to sign the declaration form
    - no medical certificate received (where weekly compensation payments are claimed).

The worker may correct the error at any time. When the error is corrected, the claim is then made and the insurer must determine it within 21 days of the correction being notified to them.

The insurer is also to notify the employer within 7 days that a claim has been made by their worker.

If the insurer cannot find a current policy that covers a claim within 7 days after the claim is made, then the insurer is to either:

- contact the employer and person who made the claim, and request more information in order to identify the policy. If the policy still cannot be identified, then the insurer is to inform the employer and the person who made the claim that the insurer is not the current insurer. The insurer must then refer the claim to WorkCover's Claims Assistance Service (CAS) on 13 10 50; or
- pass the claim to the current insurer if known. (May be identified by a request for an employer's past claims experience from the new insurer or from the cancellation request made by the employer)
- pass the information in writing on to the worker or the worker's representative.

Upon request from a worker or a worker's representative, a copy of medical information or a report from a treating medical practitioner should be supplied. If the insurer is of the opinion that supplying the worker with a copy of a medical report would pose a serious threat to the life or health of the worker or any other person, the insurer may instead supply the medical report to a medical practitioner nominated by the worker for that purpose.

6. Evidence to Support a Decision on Liability

Information which the insurer can use to inform their decision on liability includes the initial report of injury, the claim form, the WorkCover medical certificate completed by the nominated treating doctor (and signed by the worker), further information received from the worker and the responses made by the worker, employer and doctor during any contact made with them by the insurer.

It is the role and responsibility of the insurer to gather sufficient information to enable them to make a soundly based decision on liability and on any other aspect of the claim within the prescribed time-frame.

When seeking a report, especially from medical practitioners, an insurer must state clearly that the worker will have an entitlement under the legislation to a copy of the report.

Gaining objective, evidence based medical information from the nominated treating doctor, which explains and clarifies issues regarding the injury, treatment and any period of incapacity, is particularly important.

When a decision is made to deny liability, all documents relevant to that decision must be made available to the worker, as set out in Part 3, Clause 4.7.

7. Accepting Liability

When liability is accepted, the insurer must notify the worker that workers compensation benefits will commence and that they will include the provision of reasonably necessary services as set out in Division 3 of Part 3 of the 1998 Act.

7.1 Weekly payments of compensation are to be determined, and continue to be made based on:

- wage records supplied by the employer

- the current medical certificate supplied by the worker
- current work status
- the application of Sections 36 to 40 of the 1987 Act.

Section 84 of the 1987 Act provides that weekly payment of compensation is payable at the employer's usual time of payment – at fortnightly or shorter intervals, or at intervals agreed between the employer/insurer and the worker.

7.2 Reasonably necessary services must be approved by the insurer once the need for treatment has been justified in a report or a treatment plan which specifies:

- the services proposed
- the anticipated outcome
- duration
- frequency
- cost of the service.

If there is insufficient or inadequate information upon which to make a soundly based decision, further information should be requested from the treatment provider. Failing this, it may be necessary to obtain an independent opinion.

When notifying the treatment provider of approval, the insurer should specify the costs approved, consistent with WorkCover fee schedules where these have been gazetted, or with rates that are customarily charged in the community. Once a plan is approved, the insurer is liable for costs, unless they advise the provider that liability for the services has been declined before the services are provided.

Insurers should make payments to service providers in a timely manner to guarantee continuity of service provision.

8. No Response from the Insurer

If the insurer does not respond to a new claim or a request for a specific benefit under Part 3, Divisions 2, 3 and 5 of the 1987 Act within 21 days, the worker can seek assistance from WorkCover's Claims Assistance Service (CAS) on 13 10 50 or their union. CAS will issue the worker with a CAS reference number upon initial contact and then contact the insurer to facilitate a response.

CAS will send a letter to the worker within 7 days of the request advising either:

- the insurer's response (ie the action the insurer has taken or will take); or
- that there is still no response.

Once the 7 days has elapsed, the worker may lodge a dispute with the Workers Compensation Commission (WCC) quoting the CAS reference number and attaching the CAS letter. For the purpose of relying on the CAS reference number or letter to commence proceedings in the WCC, the CAS inquiry must be made no earlier than 7 days before the time limit for determining the claim has expired.

9. Managing Worker Obligations

9.1 Failure to comply with injury management

Section 57 of the 1998 Act states that if a worker fails unreasonably to comply with a requirement of Chapter 3 of the 1998 Act after being requested to do so by the insurer, the worker has no entitlement to weekly payments of compensation during the period that the failure continues.

To ensure a fair process and before proceeding to suspend weekly payments of compensation, the insurer is to explore the reasons for non-compliance and assist the worker to comply with the requirement. The insurer is to take steps to give the worker the opportunity to comply with the requirement and explain to the worker that weekly payments of compensation may be suspended if they do not comply and they will not be entitled to be paid for the period of suspension. In the event of suspension, they will be notified in writing. The notice under section 57 of the 1998 Act should contain similar information to that contained in a notice under section 54 of the 1987 Act. (Refer to Part 4, clause 6 of these guidelines). The worker should be advised to contact their union or WorkCover's Claims Assistance Service for further information.

9.2 Non-participation by the nominated treating doctor

Section 47 of the 1998 Act states that the worker must, when requested to do so by the insurer, nominate as the worker's treating doctor for the purpose of an injury management plan for the worker, a medical practitioner who is prepared to participate in the development of, and in arrangements under, the plan.

If the nominated treating doctor does not participate in injury management, the insurer is to write to the worker (with a copy to the nominated treating doctor and employer) advising them that if the doctor does not participate, they may need to change their nominated treating doctor using the procedure for changing the nominated treating doctor that is stated on the injury management plan. *Reference section 47(6) of the 1998 Act*. The insurer is to ask the worker to show the letter to the doctor and request the doctor to participate. The insurer is to follow this procedure and consider any reasons the worker may have for remaining with the doctor despite the non-participation of the doctor.

9.3 Failure by worker to attend medical examination at the direction of the employer

Section 119 of the 1998 Act requires a worker who has given notice of injury to submit to an examination by a medical practitioner, provided and paid by the insurer/employer, if so required. The insurer is to ensure that the worker understands why they are being asked to comply with the requirement, that weekly payments of compensation may be suspended if they do not comply, and that in the event of suspension they will be notified in writing. Such notice must be given in accordance with the *WorkCover Guidelines on Independent Medical Examinations & Reports.*

To ensure due process and before proceeding to suspend weekly

payments of compensation, the insurer is to explore the reasons for the non-compliance and assist the worker to comply with the requirement.

10. Reviewing the Claim

The claim should be reviewed at scheduled review points and when new information is received which may impact on the status and direction of the claim. The injury management plan and claims estimate need to be revised and updated in accordance with any information received.

11. Approval to Exceed the Statutory Maximum for Medical and Hospital Expenses

Insurers must apply to WorkCover when it is likely that medical and related expenses or hospital costs will exceed $50,000 or a previously approved maximum amount.

12. Closing a Claim

A claim may be closed when a decision can be made that the worker has no ongoing entitlement to benefits and this decision is not being disputed. Factors to be considered include:

- worker has achieved optimal return to work and health outcomes
- all payments have been made
- no recovery action is current.

Prior to closing a claim, the worker is to be notified in writing giving the reason for the decision and that the claim may be reopened on receipt of sufficient reasons.

13. Re-opening a Claim

A claim can be re-opened after it has been closed for the following reasons:

- recurrence of original injury
- further payments or recoveries
- claim is litigated
- claims administration.

If a claim is re-opened again other than for administration purposes, a decision on the additional compensation benefits must be determined again within 21 days.

The insurer must also notify the employer within 7 days that a claim made by their worker has been re-opened, unless it is re-opened for administrative purposes.

PART 3 DISPUTING ALL OR PART OF A CLAIM FOR WEEKLY PAYMENTS AND MEDICAL EXPENSES

1. Relevant Legislation and Reasons for Disputing Liability

Section 74 of the 1998 Act applies when the insurer has credible evidence to indicate that they are not liable for all or part of a claim, meaning that they:

- do not commence weekly payments
- cease or reduce weekly payments after they have started (see also under Part 4); or
- decline to pay for a service that has been requested.

Note: A section 74 notice is not required when payments are to be reduced as a result of the application of a different rate of compensation after the expiration of an earlier period or incapacity for which a higher rate is payable. In this case, the insurer is to send a letter to the worker advising of the reduction, the new rate, how it is calculated, and the legislative basis for the change.

The reasons for disputing liability may include the evidence the insurer has regarding the liability for the provision of compensation benefits, for example:

- that the worker has not sustained an injury as defined in section 4 of the 1998 Act
- that the worker has no incapacity for work
- that the worker is not a worker, as defined in section 4 of the 1998 Act
- that employment is not a substantial contributing factor to the injury as set out in section 9A of the 1987 Act
- that psychological injury was wholly or predominantly caused by reasonable actions of the employer, as set out in section 11A of the 1987 Act
- that a service that has been requested under Part 3, Divisions 2, 3 and 5 of the 1987 Act is not reasonably necessary
- the incapacity or need for treatment or permanent impairment does not result from the injury.

2. Evidence Relevant to the Decision

The insurer must consider all evidence relevant to the claim to which the decision relates, including reports and plans submitted on behalf of the worker and independent reports obtained by the insurer. This evidence may include but is not limited to:

- the claim form
- medical certificates
- medical reports prepared by treating practitioners and specialists
- treatment plans
- return to work plans
- rehabilitation reports
- factual/investigative reports
- independent medical reports prepared by a specialist of the type who has treated the worker (refer to *WorkCover Guidelines on Independent Medical Examinations & Reports)*
- injury management consultant reports
- independent treatment review reports (eg independent physiotherapist consultant).

3. Internal Review Before Issuing a Dispute Notice

Before giving notice of the decision to dispute liability on all or part of the claim, the insurer must carry out an internal review of all of the evidence considered in arriving at the decision. This includes reviewing all documents which are relevant to the claim or any aspect of the claim to which the decision to dispute relates. At a minimum, the review is to be conducted by someone other than the person who has made the original decision and, by someone with requisite expertise, eg Technical Advisor or Senior Claims Supervisor. The reviewer(s) must have comprehensive knowledge of the legislation as it applies to the matter in dispute and the issues arising from it. Where a self insurer or specialised insurer does not have a person within their organisation who can review the decision, this review may be undertaken by a person external to the organisation with the requisite knowledge and expertise.

4. Requirements for a Notice Disputing Liability

Section 74 of the 1998 Act requires an insurer who disputes liability in respect of a claim, or any aspect of a claim, to give notice of the dispute to the worker and adhere to the requirements for the notice of dispute. All matters in dispute at that time must be given in this notice.

Clause 34 of the *Workers Compensation Regulation 2003* provides additional information to be included in a section 74 notice.

An insurer must comply with the requirements in section 74 and clause 34. Any defect in a notice should be corrected as soon as it comes to the insurer's attention.

A section 74 notice may not need to be given to a worker by an insurer if a correct section 54 notice, as per the 1987 Act, has been given. Section 54 of the 1987 Act deals with requirements for insurers to give notice to workers before discontinuing or reducing benefits. If a notice given by an insurer under section 54 contains all the information required by section 74, a separate section 74 notice is not required and the section 54 notice becomes the dispute notice.

A section 74 notice must be written in plain language, as specified in section 74(2B) and must include:

4.1 a statement of the matter(s) in dispute

This identifies the specific nature of the workers compensation claim or aspect of the claim that is in dispute, the decision made and the basis for that decision. Examples of the basis of a decision are:

- *the worker is no longer incapacitated*
- *the worker did not sustain an injury as defined in section 4 of the 1998 Act*
- *treatment is not/no longer reasonably necessary*
- *employment was not a substantial contributing factor to the injury.*

4.2 a statement indicating that the matters that may be referred to the WCC are limited to matters notified in the dispute notice or in a dispute review notice.

4.3 reasons the insurer disputes liability

A section 74 notice must indicate why the insurer is disputing liability. The reasons should refer to those parts of the workers compensation legislation and regulations relied upon by the insurer for its decision,

for example –

- *the injury which occurred on x date is no longer interfering with your capacity to work. Consequently, you are no longer entitled to weekly compensation payments as defined in Division 2 of Part 3 of the Workers Compensation Act 1987*
- *you did not sustain an injury arising out of or in the course of employment as defined in section 4 of the Workplace Injury Management and Workers Compensation Act 1998. Consequently, you are not entitled to weekly compensation payments as defined in Division 2 Part 3 of the Workers Compensation Act 1987*
- *a second MRI is not considered reasonably necessary as there is no evidence of any reason to believe that a subsequent MRI will show anything different to the first MRI.*

4.4 a statement of the insurer and claimant issues relevant to the matter in dispute, for example –

- *your most recent medical certificate advises that you are partially incapacitated for work. We have evidence that indicates that the injury no longer interferes with your capacity to work and that you have the same capacity to work as you would have if the injury had not occurred*
- *you claim that your work was a substantial contributing factor to the injury to your right arm. We have evidence that you played sport on the weekend of (date) and that you suffered a right arm injury. According to our investigations your ongoing incapacity results from the sporting injury rather than your work*
- *an MRI was conducted 3 months ago. Your most recent medical certificate recommends a second MRI, however, there is no evidence of any intervening event and no change in your functional capacity, your overall health status or any other signs or symptoms.*

4.5 a statement identifying all reports and documents relevant to the claim or aspect of the claim to which the decision relates

The notice must refer to all reports in the possession of the insurer that were considered in making the decision to dispute the claim, or any aspect of the claim. This extends to reports and documents that do not support the decision reached but are still relevant and must include, but are not limited to:

- medical reports, certificates and clinical notes (including reports under sections 119 and 126 of the 1998 Act)
- treatment plans
- factual/investigation reports
- rehabilitation reports
- assessment reports under section 40A of the 1987 Act
- any other relevant reports
- wage details required to be supplied under section 43(2) of the 1987 Act.

Reference to reports must include the name and relevant qualifications of the person who wrote the report, and the date of the report.

4.6 a statement identifying the reports and documents submitted by the worker in making the claim

This refers to relevant information received by the insurer from the worker or on the worker's behalf in support of the worker's claim. It also includes information obtained from the worker pursuant to an obligation under section 71 of the 1998 Act to comply with any reasonable request by the insurer to furnish specified information (in addition to information furnished in the claim form).

The worker is limited to this information in any application for dispute resolution lodged with the WCC, except where the worker was not legally represented at the relevant time or where additional information is provided in a request for review (refer clause 4.8 below).

4.7 a statement identifying that all reports and documents relevant to the decision to dispute the claim, as referred to in 4.5 above (and which are in the possession of the insurer), are attached to the dispute notice.

A relevant report does not have to be attached where it has already been supplied to the worker provided it is identified in the statement referred to in clause 4.5 above.

If the insurer is of the opinion that supplying the worker with a copy of a report would pose a serious threat to the life or health of the worker or any other person, the insurer may instead :

- in the case of a medical report, supply the report to a medical practitioner nominated by the worker for that purpose; or
- in any other case, supply the report to a legal practitioner representing the worker; or
- when neither of the above options are appropriate, seek a direction or authority from WorkCover to redirect, eg this could be appropriate when a union is representing a worker.

Should a matter proceed to the WCC, both parties are limited to relying on reports and documents identified in the dispute notice or dispute review notice (refer clause 4.8 below) with the exception of those workers who are not represented by a solicitor.

4.8 a statement indicating that the worker can request a review of the claim by the insurer (optional review)

Section 287A of the 1998 Act provides the worker with an opportunity to request the insurer to review the decision to dispute the claim or any aspect of the claim at any time before an application for dispute resolution is lodged with the WCC. When a request for review is made, the claim must be reviewed by the insurer and a response made within 14 days after the request is made. A request is taken to have been made when it is first received by an insurer.

The statement in the notice must describe the procedure for requesting a review and indicate that the worker may raise further issues and introduce further supporting evidence when seeking the review. The

notice must also include a statement advising the worker that this extra information must be provided if the worker is to include it in any application for dispute resolution referred to the WCC.

The optional review must be carried out in accordance with the insurer's complaints and disputes management model. At a minimum, the review is to be conducted by someone other than the person who has made the original decision and by someone with requisite expertise, eg technical advisor or senior claims supervisor. The reviewer(s) must have comprehensive knowledge of the legislation as it applies to the matter in dispute and the issues arising from it. Where a self insurer or specialised insurer does not have a person within their organisation who can review the decision, this review may be undertaken by a person external to the organisation with the requisite knowledge and expertise.

The response will either be to accept the worker's claim or issue a new dispute review notice (see Clause 5 below).

The request for an optional review of a dispute notice does not constitute a stay of the decision to terminate or reduce payments.

The worker may separately contact the insurer to seek clarification of the notice or correction of a defect.

A standard form for requesting the review is to be attached to the dispute notice. (See Appendix 1).

4.9 the notice must also include a statement advising that the worker may –

- contact WorkCover's Claims Assistance Service on 13 10 50
- seek assistance from the worker's union or a lawyer
- refer the dispute to the registrar for determination by the WCC (including the postal and email address of the registrar).

Where the insurer has referred or proposes to refer the dispute for determination by the WCC, the notice must also include a statement to that effect, specifying the date of referral or proposed referral.

5. Dispute Review Notice

If the insurer continues to dispute the claim following the optional review, they must issue a further dispute notice. The content of this dispute notice must contain the same type of information as the original dispute notice. Any further reports that have come into the possession of the insurer and that are relevant to the review decision are to be attached. The notice can refer to and rely on the content of the original section 74 notice and attachments, provided they remain applicable. Information and documents relevant to the dispute review decision are also to be attached.

The worker may request more than one review.

6. Section 74 template

Headings

1. A statement of the matter(s) in dispute.

2. A statement indicating that the matters that may be referred to the WCC are limited to matters notified in the dispute notice or in a dispute review notice.
3. Reasons the insurer disputes liability.
4. A statement of the insurer and claimant issues, relevant to the matter in dispute.
5. A statement identifying all reports and documents which were relevant to the claim or aspect of the claim to which the decision relates.
6. A statement identifying the reports and documents submitted by the worker in making the claim.
7. A statement identifying that all reports and documents relevant to the decision to dispute the claim referred to in 5 above (and which are in the possession of the insurer) are attached to the dispute notice.
8. A statement indicating that the worker can request a review of the claim by the insurer (optional review).
9. Other matters (see 4.9 above).

PART 4 TERMINATING OR REDUCING WEEKLY PAYMENTS OF COMPENSATION

1. Relevant Legislation and Reasons for Terminating or Reducing Payments of Weekly Compensation

Section 54 of the *1987 Act* applies if a worker:

- has received weekly payments of compensation for a continuous period of at least 12 weeks
- has provided the worker's employer or the employer's insurer with a certificate by a medical practitioner specifying the expected duration of the worker's incapacity
- and the insurer has evidence to support the termination or reduction of payment of weekly compensation.

The insurer shall not discontinue payment, or reduce the amount, of the compensation during the period of incapacity so specified without giving the worker the prescribed period of notice of intention to discontinue payment of the compensation or to reduce the amount of the compensation.

Failure to give the prescribed period of notice under section 54 of the 1987 Act by the insurer or employer is an offence rendering the insurer liable for prosecution under section 54(1) and also liable to the worker to pay the amount of compensation that would have been payable had the prescribed period been properly observed.

The reasons for terminating or reducing payments may include:

- if the insurer receives evidence impacting on the claim with respect to entitlement to weekly compensation under section 40 or section 52A of the 1987 Act.

Note: A section 54 notice is not required for a reduction in weekly benefits when payments are reduced as a result of application of legislative requirements, eg. under section 37 or section 38 of the 1987 Act. In this case, the insurer is to send a letter to the worker advising of the reduction, the new rate, how it is calculated and the legislative basis for the change.

2. Evidence Relevant to the Decision

The insurer must consider all evidence relevant to the decision, including reports and plans submitted on behalf of the worker and independent reports obtained by the insurer. This evidence may include but is not limited to:

- the claim form
- medical certificates
- medical reports prepared by treating practitioners and specialists
- treatment plans
- return to work plans
- rehabilitation reports
- factual/investigative reports
- independent medical reports prepared by a specialist of the type who has treated the worker (refer to Guidelines on Independent Medical Examinations & Reports)
- injury management consultant consultant reports
- independent treatment reports (eg independent physiotherapist consultant).

All issues and information relevant to the decision are to be provided to the claimant when a decision to reduce or terminate payments is communicated to the claimant.

When seeking a report, especially from medical practitioners, an insurer must give clear advice that the worker will have an entitlement under the legislation to a copy of the report.

3. Internal Review Before Issuing a Notice to Terminate or Reduce Weekly Payments of Compensation

Before giving notice of the decision to terminate or reduce weekly payments of compensation, the insurer must carry out a review of all the evidence considered in arriving at the decision. This includes reviewing all documents which are relevant to the claim, or any aspect of the claim to which the decision to terminate or reduce relates. At a minimum, the review is to be conducted by someone other than the person who has made the original decision and by someone with requisite expertise, eg technical advisor, or senior claims supervisor. The reviewer(s) must have comprehensive knowledge of the legislation as it applies to the matter in dispute and the issues arising from it. Where a self insurer or specialised insurer does not have a person within their organisation who can review the decision, this review may be undertaken by a person external to the organisation with the requisite knowledge and expertise.

4. Requirements for a Notice to Terminate or Reduce Weekly Payments of Compensation

Section 54 of the 1987 Act provides that if an insurer terminates or reduces weekly compensation, they must give notice of the decision to reduce or terminate payments to the worker. It also sets out the requirements for the notice of dispute.

Clause 15 of the *Workers Compensation Regulation 2003* provides additional information to be included in a section 54 notice. An insurer must comply with the requirements in section 54 and clause 15. Any defect in a notice should be corrected as soon as it comes to the insurer's attention.

If a notice given by an insurer under section 54 contains all the information required by section 74 of the 1998 Act, a separate section 74 notice is not required in the event of a dispute and the section 54 notice becomes the dispute notice.

A section 54 notice must be written in plain language, and must include the following in order to operate as a dispute notice as well as a section 54 notice:

4.1 a statement of the matter(s) in dispute

This identifies the specific nature of the workers compensation claim or aspect of the claim that is in dispute, the decision made and the basis for that decision. Examples of the basis of a decision are:

- *the worker's entitlement to weekly payment of compensation under section 40 of the Workers Compensation Act 1987 , eg reduction of weekly payment as the worker has increased capacity for work*
- *the worker's entitlement to weekly payment of compensation under the applicable provision of section 52A of the Workers Compensation Act 1987, eg worker not suitably employed and not seeking suitable employment.*

4.2 a statement indicating that any matters that may be referred to the WCC are limited to matters notified in the dispute notice or in a dispute review notice

4.3 reasons the insurer is terminating or reducing weekly payments of compensation

A section 54 notice must indicate why the insurer has terminated or reduced weekly compensation. The reasons should refer to those parts of the workers compensation legislation and regulations relied upon by the insurer for its decision, for example:

- *your weekly payments of compensation under section 40 of the Workers Compensation Act 1987 will be reduced to $100.00 on (date). The payment has been reduced as we have evidence that you have the physical and vocational ability to be employed as (jobs). While employed at (pre-injury employer) your probable weekly earnings as a worker had you not been injured would be $500.00 / week. Your current ability to earn in (assessed jobs) is $400.00 / week. Your entitlement to weekly payments of compensation is now $100.00 / week*
- *your weekly payments of compensation will be terminated on (date) by the application of section 52A(1)(a) of the Workers Compensation Act 1987 because we have evidence that you have repeatedly failed to seek suitable employment.*

4.4 a statement of the insurer and claimant issues relevant to the matter in dispute

A section 54 notice must provide a statement of the insurer and claimant issues relevant to the matter in dispute. The statement should be in plain English, for example:

- *your probable weekly earnings as a worker, but for the injury, in the same or some comparable employment have been determined as $500.00 / week as it is probable that, but for the injury, you would have remained with the same employer, with wage increases in keeping with the wages of comparable employees. Your current ability to earn in some suitable employment is determined to be $400.00 / week as you have the ability to perform suitable employment in the following job categories…*
- *98 weeks compensation has been paid whilst you were partially incapacitated and prior to the section 54 notice being issued. We have evidence that you have repeatedly failed to seek suitable employment on…*

4.5 A statement identifying all reports and documents relevant to the claim or aspect of the claim to which the decision relates

The notice must refer to all reports and documents in the possession of the insurer which are relevant to the decision. This extends to reports that do not support the decision reached but are still relevant, and may include but are not limited to:

- medical reports, certificates and clinical notes (including reports under sections 119 and 126 of the 1998 Act)
- treatment plans

- factual/investigation reports
- rehabilitation reports
- assessment reports under section 40A of the 1987 Act
- any other relevant reports or documents
- wage details required to be supplied under section 43(2) of the 1987 Act.

Reference to reports must include the name and relevant qualifications of the person who wrote the report and the date of the report.

4.6 a statement identifying the reports and documents submitted by the worker in making the claim

This refers to relevant information received by the insurer from the worker in support of the worker's claim. It also includes information obtained from the worker pursuant to an obligation under section 71 of the 1998 Act to comply with any reasonable request by the insurer to furnish specified information (in addition to information furnished in the claim form).

The worker is limited to this information in any application for dispute resolution lodged with the WCC, except where the worker was not legally represented at the relevant time or where additional information is provided in a request for review (refer clause 4.8 below).

4.7 a statement identifying that all reports and documents relevant to the decision to terminate or reduce weekly payment as referred to in 4.5 above (and which are in the possession of the insurer) are attached to the dispute notice

A relevant report does not have to be attached where it has already been supplied to the worker provided it is identified in the statement referred to in clause 4.5 above.

If the insurer is of the opinion that supplying the worker with a copy of a report would pose a serious threat to the life or health of the worker or any other person, the insurer may instead:

- in the case of a medical report, supply the report to a medical practitioner nominated by the worker for that purpose; or
- in any other case supply the report to a legal practitioner representing the worker
- when neither of the above options are appropriate seek a direction or authority from WorkCover to redirect, eg this would be appropriate when a union is representing a worker.

Should a matter proceed to the WCC, both parties are limited to relying on reports and documents identified in the dispute notice or dispute review notice (refer clause 4.8 below) with the exception of those workers who are not represented by a solicitor.

4.8 a statement indicating that the worker can request a review of the claim (optional review)

Section 287A of the 1998 Act provides the worker with an opportunity to request the insurer to review the decision to dispute the claim, or any aspect of the claim, at any time before the dispute is referred to the WCC.

When a request for review is made, the claim must be reviewed by the insurer and a decision made within 14 days of the request. A request is taken to have been made when it is first received by the insurer.

The statement in the notice must describe the procedure for requesting a review and indicate that the worker may raise further issues and introduce further supporting evidence when seeking the review. The notice must also include a statement advising the worker that this extra information must be provided if the worker is to include it for any application to dispute referred to the WCC.

The optional review is to be carried out in accordance with the insurer's complaints and disputes handling model. At a minimum, the review is to be conducted by someone other than the person who has made the original decision and by someone with requisite expertise. The reviewer(s) must have comprehensive knowledge of the legislation as it applies to the matters in dispute and the issues arising from it. Where a self insurer or specialised insurer does not have a person within their organisation who can review the decision, this review may be undertaken by a person external to the organisation with the requisite knowledge and expertise.

The response will be to either accept the workers response to the dispute notice or to issue a new dispute review notice (see clause 5 below).

The request for an optional review of a dispute notice does not constitute a stay of the decision to terminate or reduce payments.

The worker may separately contact the insurer to seek clarification of the notice or correction of a defect.

A standard form for requesting the review is to be attached to the dispute notice. (see Appendix 1).

4.9 the notice must also include a statement advising that the worker may –

- contact WorkCover's Claims Assistance Service on 13 10 50
- seek assistance from the worker's union or lawyer
- refer the dispute to the registrar for determination by the WCC (including the postal and email address of the registrar).

The notice referred to in this section is also to include information about the possible entitlements of the injured worker under section 38 of the 1987 Act and the requirements for the worker to obtain those benefits if –

- the notice relates to a reduction in the amount of the worker's weekly compensation as a result of the application of section 40
- the injured worker is not in receipt of earnings
- the information has been supplied to the worker under section 40A
- a statement as to how the reduced compensation has been calculated
- the worker has not previously received section 38 benefits

5. Dispute Review Notice

If the insurer maintains the original decision following the optional review, they must issue a further notice. This must contain the same type of information as the original section 54 notice. Any further reports that have come into the possession of the insurer and that are relevant to the review decision are to be attached. The notice can refer to and rely on the content of the original notice and attachments provided they remain applicable. Information and documents relevant to the dispute review decision are also to be attached.

The worker may request more than one review.

6. Section 54 template

Note: The format for this template may also be used for a section 57 suspension notice.

Headings

1. A statement of the matter(s) in dispute.
2. A statement indicating that any matters that may be referred to the WCC are limited to matters notified in the dispute notice or in a dispute review notice.
3. Reasons the insurer is terminating or reducing weekly compensation.
4. Statement of the insurer and claimant issues relevant to the matter in dispute.
5. A statement identifying all reports and documents relevant to the claim or aspect of the claim to which the decision relates.
6. A statement identifying the documents submitted by the worker in making the claim which are relevant to the decision.
7. A statement identifying that all reports and documents relevant to the decision to dispute the claim referred to in 5. above (and which are in the possession of the insurer) are attached to the dispute notice.
8. A statement indicating that the worker can request a review of the claim.
9. Other matters – see 4.9 above.

PART 5 MAKING AND HANDLING A CLAIM FOR LUMP SUM COMPENSATION (PERMANENT IMPAIRMENT AND PAIN AND SUFFERING)

To claim lump sum compensation, a worker must have sustained an injury, as defined in section 4 of the 1998 Act, that resulted in permanent impairment, as referred to in section 66 of the 1987 Act, and made a claim related to that injury. If the insurer is satisfied that an injury that has resulted in permanent impairment has reached maximum medical improvement, the insurer may initiate an assessment of permanent impairment which may lead to a subsequent payment pursuant to a complying agreement.

1. Minimum Information Required to Make a Claim

To make a claim a worker must complete a permanent impairment claim form which is available from the employers' insurer for workers compensation purposes. The claim form must be completed fully. In making a claim, the worker must provide all reports and documents that they rely upon, as soon as possible after that information is received, in making the claim to either:

- the employer from whom they are claiming workers compensation benefits,
- the insurer responsible for providing the employer's workers compensation insurance.

2. Relevant Particulars about a Claim

The claim must include relevant particulars about the claim.

For injuries pre 1 January 2002:

2.1 the injury received (as identified in claim for workers compensation. If no claim for compensation has been made, it will be necessary to separately make such a claim)

2.2 all impairments arising from the injury

2.3 the amount of loss as measured by the Table of Disabilities

2.4 any previous injury, or any pre-existing condition or abnormality, to which any proportion of an impairment is or may be due (whether or not it is an injury for which compensation has been paid or is payable under Division 4 of Part 3 of the 1987 Act)

2.5 details of all previous employment to the nature of which the injury is or may be due

2.6 information as to whether or not the degree of impairment resulting from the injury is permanent

2.7 a medical report supporting the amount of loss claimed.

For injuries from 1 January 2002:

2.8 the injury received, as identified in claim for workers compensation. If no claim for compensation has been made, it will be necessary to separately make such a claim

2.9 all impairments arising from the injury

2.10 whether the condition has reached maximum medical improvement

2.11 the amount of whole person impairment assessed in accordance with the *WorkCover Guides for the Evaluation of Whole Person Impairment*

2.12 a medical report completed in accordance with the *WorkCover Guides for the Evaluation of Whole Person Impairment* by a medical specialist with qualifications and training relevant to the body system being assessed who has been trained in the WorkCover Guides.
If there is more than one impairment that requires assessment by different medical specialists, one specialist must be nominated as lead assessor and determine the final amount of whole person impairment

2.13 if the claim is for permanent impairment of hearing, a copy of the audiogram used by the medical specialist in preparing the report that accompanies the claim.

3. Claim for Pain and Suffering

Reference section 67 of the 1987 Act.

To make a claim for pain and suffering the worker must provide relevant particulars about a claim:

- a claim for permanent loss or whole person impairment completed on the permanent impairment claim form
- evidence that the loss according to the Table of Disabilities is at least 10% of the maximum that can be awarded, or the level of whole person impairment is 10% or above
- a description of the effect the impairment has on their work, domestic and leisure activities
- the proportion of the maximum amount of compensation under section 67 claimed for the pain and suffering.

4. Employer Action on Receipt of a Claim for Permanent Impairment

Within 7 days after an employer receives a claim, the employer must send the claim to the insurer responsible for covering the worker for compensation. From then on, if the insurer requests more information, the employer must respond within 7 days of receiving the request with all information that is reasonably obtainable. The employer must also forward to the insurer within 7 days of receipt any documentation the employer receives in respect of the claim. *Reference section 264 (1) and (2) of the 1998 Act.*

Failure by the employer to forward the information to the insurer within 7 days, where the information is in the employer's possession or reasonably obtainable, renders the employer liable for prosecution under section 264(1) of the 1998 Act.

5. Insurer Action on Receipt of a Claim for Permanent Impairment

Reference section 281 of the 1998 Act.

When an insurer is served with a claim for permanent impairment the insurer must determine the claim by the latest date of either:

- within 1 month after the degree of permanent impairment first becomes fully ascertainable, as agreed by the parties or as determined by an approved medical specialist; or
- within 2 months after the claimant has provided to the insurer all relevant particulars about the claim. An insurer is not entitled to delay the determination of a claim on the ground that the particulars are insufficient unless the insurer has requested additional particulars and/or referred a worker for a medical examination within 2 weeks of receiving the claim.

If the claim is served on the insurer, the insurer must notify the employer that a claim has been made within 2 working days.

If the insurer cannot find a current policy that covers a claim within 7 days after the claim is made, then the insurer is to either:

- contact the employer, and the person who made the claim, and request more information in order to identify the policy. If the policy still cannot be identified, then the insurer is to inform the employer and the person who made the claim that the insurer is not the current insurer. The insurer must then refer the claim to WorkCover's Claims Assistance Service; or
- pass the claim to the current insurer, if the identity of the current insurer can be determined and notify the worker in writing.

An insurer must, within the time specified above determine the claim by:

- accepting liability and making a reasonable offer of settlement to the worker, in accordance with the properly assessed level of impairment
- determining that the claim does not contain the relevant particulars, in which case the insurer is to advise the worker how to correct the deficiency. Once the deficiency is rectified, the insurer has 2 months to determine the claim
- disputing liability in which case the insurer must issue a dispute notice under section 74 of the 1998 Act. (See Part 3 of these guidelines.)

6. No Response from the Insurer

If the insurer does not respond to a claim for permanent impairment within 2 months, the worker can seek assistance from WorkCover's Claims Assistance Service (CAS) on 13 10 50. CAS will issue the worker with a CAS reference number upon initial contact, and then contact the insurer to facilitate a response.

CAS will send a letter to the worker within 7 days of the request advising either:

- the insurer's response; or
- that there is still no response.

Once the 7 days has elapsed, the worker may lodge a dispute with the Workers Compensation Commission (WCC) quoting the CAS reference number and attaching the CAS letter. For the purpose of relying on the CAS reference number or letter to commence proceedings in the WCC, the CAS inquiry must be made no earlier than 7 days before the time limit for determining the claim has expired.

7. Insurer Accepts a Claim for Permanent Impairment

If the insurer is satisfied with the claim made, and the level of impairment properly assessed in accordance with the WorkCover Guides (for injuries from 1 January

2002), there is no need to obtain further assessments and an offer of payment will be made to the worker in accordance with section 66 of the 1987 Act.

Where a further assessment is obtained and a counter offer made, this offer or any further offers made must be in writing and are to be based on an assessment conducted in accordance with the WorkCover Guides for injuries from 1 January 2002. The offer needs to set out:

- the date of the injury
- the injury to which the offer relates
- the amount of the offer or extent of pre-existing condition or abnormality, if any
- the reports and documents relied upon in making the offer
- the reports and documents served and relied upon by the worker in support of the claim (the worker is limited to this information in any application for dispute resolution lodged with the WCC, except where the worker was not legally represented at the relevant time or where additional information is provided in further correspondence prior to referral to the WCC)
- a statement that if the offer is not accepted, the worker can refer the dispute to the registrar for determination by the WCC one month after the offer is made (including the postal and email address of the registrar)
- a statement that the matters that may be referred to the WCC are limited to matters notified in writing between the parties concerning the offer of settlement.

Copies of the reports and documents relied upon by the insurer in the making of the offer must be attached to the written advice of the offer to the worker. If the insurer is of the opinion that supplying the worker with a copy of a medical report would pose a serious threat to the life or health of the worker or any other person, the insurer may instead supply the medical report to a medical practitioner nominated by the worker for that purpose.

Where an insurer forms the view, based upon available evidence, that the percentage impairment is nil the insurer should issue a notice as referred to in clause 9 below, except where the decision is made on the basis that there is no permanent impairment in respect of the injury. In this latter case, a letter may issue to this effect.

8. Complying Agreements

Reference section 66A of the 1987 Act.

Prior to making a payment to the worker for permanent impairment under section 66 of the 1987 Act and for pain and suffering under section 67 of the 1987 Act, the insurer must be satisfied that a worker has obtained independent legal advice in order to record the payment details as a complying agreement. Evidence of independent legal advice can be in either:

- a letter from the worker's solicitor; or
- details of the agreement regarding payment signed and returned to the insurer by the worker.

The following details must be included in a complying agreement:

- degree of permanent impairment
- medical report(s) relied on to assess the degree of permanent impairment
- amount of compensation payable in respect of degree of permanent impairment
- amount of pain and suffering compensation (if applicable)

- date of agreement
- certification by insurer that it is satisfied that the worker has obtained independent legal advice.

The complying agreement may be contained in one or more documents which must be kept on the insurer's file.

9. Insurer Disputes Liability for the Claim

If an insurer disputes liability in respect of a claim for permanent impairment, the insurer must issue a section 74 Notice in accordance with Part 3 of these guidelines.

PART 6 MAKING AND HANDLING A CLAIM FOR WORK INJURY DAMAGES

1. General

A claim for work injury damages (WID) must meet two criteria:

- the work injury is a result of the negligence of the employer
- the work injury resulted in at least 15 percent whole person impairment (WPI).

A claim for WID can only be made where a claim for lump sum compensation for the work injury has been made pursuant to section 66 of the 1987 Act. The claim under section 66 must be made before or at the same time as the claim for WID. *Reference section 280A of the 1998 Act.*

Before a worker is entitled to claim for work injury damages the degree of WPI must have been assessed to be at least 15 percent. The assessment of WPI must have been made in accordance with the *WorkCover Guides for the Evaluation of Permanent Impairment*. *Reference sections 313, 314 and 322 of the 1998 Act and section 151H of the 1987 Act.*

2. Particulars of the Claim and Evidence Relied Upon

To make a claim for WID the worker must provide particulars about the claim and the evidence to be relied upon. This must include:

- details of the injury to the worker caused by the negligence or other tort of the employer
- degree of assessed WPI
- evidence of the negligent act/s of the employer
- economic loss that is being claimed as damages.

Reference section 282 of the 1998 Act.

3. Where Whole Person Impairment not Fully Ascertainable

Court proceedings for WID must be commenced within 3 years after the date on which the injury was received. *Reference section 151D of the 1987 Act.*

Where this time limit is reached but the WPI for the injured worker is not fully ascertainable, the worker should make a claim for WID setting out the particulars of the claim and the evidence to be relied upon as per clause 2 above, with the exception of the degree of assessed WPI.

4. Employer Action on Receipt of a Claim for Work Injury Damages

The employer must send the claim to the responsible insurer within 7 days of receipt.

If the insurer requests more information the employer must also respond within 7 days of receiving the request with all information that is reasonably obtainable. The employer must also forward any documents received in respect of the claim to the insurer within 7 days of receipt. *Reference section 264 (1) and (2) of the 1998 Act.*

5. Insurer Action on Receipt of a Claim for Work Injury Damages

The insurer is to determine the claim:

- within 1 month of the WPI being fully ascertainable; or
- within 2 months after all relevant particulars have been supplied, whichever is the later.

The insurer is to determine the claim by:

- accepting liability and making a reasonable offer of settlement; or
- disputing liability.

The insurer is to notify the worker of the determination.

This notification is to include whether or not the insurer accepts that the degree of WPI of the injured worker resulting from the work injury is sufficient for an award of damages.

Where liability is disputed the insurer is to issue a notice pursuant to section 74 of the 1998 Act in accordance with the requirements of Part 3 of these Guidelines.

Where liability is accepted and an offer of settlement is made it is to specify an amount of damages or a manner of determining an amount of damages.

Where only partial liability for the claim is accepted the offer is to include details sufficient to ascertain the extent to which liability is accepted. *Reference section 281 of the 1998 Act.*

6. Resolution of Dispute about Degree of Whole Person Impairment

If an insurer does not agree that the worker has at least 15 percent WPI the matter is to be resolved by an application to resolve the dispute at the WCC. This will be referred directly to an approved medical specialist (AMS). The AMS will make an assessment of the degree of WPI and this assessment will be binding on all parties. *Reference sections 313 and 314 of the 1998 Act.*

7. Requirement for Pre-Filing Statement before Commencing Court Proceedings

Before a worker can commence court proceedings for the recovery of work injury damages, the worker must serve on the employer or the insurer a pre-filing statement (PFS) setting out the particulars of the claim and the evidence that the worker will rely on to establish or support the claim.

The PFS cannot be served unless:

- the person on whom the claim is made wholly disputes liability for the claim; or
- the person on whom the claim is made has made an offer of settlement to the claimant, pursuant to the determination of the claim and when required by section 281 of the 1998 Act and one month has elapsed since the offer was made; or
- the person on whom the claim is made has failed to determine the claim as and when required by section 281 of the 1998 Act.

The PFS is to consist of a copy of the statement of claim intended to be filed in the court and is to include as attachments the information and other documents required by the Workers Compensation Acts and Workers Compensation Commission Rules including the certificate issued by an AMS or notification of acceptance that the work injury has resulted in a degree of WPI of at least 15 percent. *Reference section 315 of the 1998 Act.*

8 Insurer Action on Receipt of a Pre-Filing Statement

The insurer must respond to the PFS within 28 days after the PFS is received by:

- accepting or denying liability (wholly or in part)
- if the insurer does not accept liability, serving on the worker a pre-filing defence (PFD), setting out all particulars of the defence and evidence that the insurer will rely on in order to defend the claim (as the Workers Compensation Commission Rules may require).

If the insurer fails to respond to the PFS within 42 days the worker can commence court proceedings for the recovery of work injury damages and does not have to refer the dispute for mediation. *Reference Section 316 of the 1998 Act.*

If the PFS is defective the insurer must advise the worker within 7 days of receipt and include in the advice to the worker how the worker can fix the defect. If there is a dispute as to whether the PFS is defective this may be referred to the Registrar of the WCC for determination. *Reference Section 317 of the 1998 Act.*

9 Mediation

Before a worker can commence court proceedings the claim must be referred for mediation except as stated above in clause 8. This cannot happen until 28 days after the PFS has been served on the insurer. The worker must apply to the WCC for mediation.

The insurer may only decline to participate in the mediation if liability for the claim is wholly disputed. *Reference Section 318A of the 1998 Act.*

The mediator will attempt to bring the parties to agreement for the matter, so that court proceedings will not be necessary. If the mediator cannot bring the parties to agreement the mediator will issue a certificate certifying the final offers of settlement made by the parties in the mediation. *Reference Section 318B of the 1998 Act.*

If mediation is not successful the offers made at the mediation are not to be disclosed to the court in any subsequent court proceedings. *Reference Section 318E of the 1998 Act.*

10 Commencing Court Proceedings

Court proceedings may commence when:

- a worker has served a PFS on the insurer; and -
    - the insurer has failed to respond to the PFS within 42 days; or
    - the insurer has wholly disputed liability and declined to participate in mediation and the mediator has issued a certificate to this effect; or
    - mediation has taken place but has not been successful and the mediator has issued a certificate to this effect.

If court proceedings commence all parties are limited to the matters raised in the PFS and the PFD and to the reports and other evidence disclosed in those statements except by leave of the court. Additionally, where an insurer fails to respond to the PFS within 42 days the insurer cannot dispute liability for the claim. *Reference Section 318 of the 1998 Act.*

APPENDIX 1

APPLICATION FOR REVIEW BY INSURER

This is an application form to request the review of a decision made to dispute a workers compensation claim (or any aspect of a claim). This application is made under section 287A of the *Workplace Injury Management and Workers Compensation Act 1998.*

Worker's name	
Insurer/Scheme Agent	
Claim number	

Requested by:

worker worker's representative dependant dependant's representative

Name	
Address	
Phone number	
Mobile number	
Fax number	

Decision to be Reviewed

Decision referred to in the notice under sections 74 or 287A of the *Workplace Injury Management and Workers Compensation Act 1998* or section 54 of the *Workers Compensation Act 1987* (please specify date of notice)
……..

Please identify the decision that you are requesting the insurer review:

- ❑ liability for the injury
- ❑ medical expenses
- ❑ amount of weekly payments
- ❑ property damage
- ❑ other (please specify)……..

……
……..

Reasons for Seeking the Review

Please provide:

- reasons in support of your application
- any further information which supports your reasons for requesting the review.

…..……
……..……

……
……
……
……

Additional Reports or Documents

Please list and provide copies of all further information, reports and documents in support of this application for review.

……
……
……
……
……

Important

If you have any new or additional matters that you want the insurer to consider, these must be raised with, and copies of relevant documents provided to the insurer, as part of this application. Should you later wish to dispute the decision at the Workers Compensation Commission, you must have supplied all information for consideration. The Workers Compensation Commission will not allow introduction of any information not previously considered by the insurer. The Workers Compensation Commission is limited to consideration of matters notified in the final dispute notice or in this application (reference section 289 of the *Workplace Injury Management and Workers Compensation Act 1998*).

Signed:……
(worker or representative)

Dated:… ……..

WORKCOVER GUIDELINES ON INDEPENDENT MEDICAL EXAMINATIONS AND REPORTS

I, Jon Blackwell, the Chief Executive Officer of the WorkCover Authority of New South Wales, under section 119 and section 376 of the *Workplace Injury Management and Workers Compensation Act 1998,* issue the following guidelines.

Dated this twenty-fifth day of October 2006.

Jon Blackwell
Chief Executive Officer
WorkCover Authority

WORKCOVER GUIDELINES ON INDEPENDENT MEDICAL EXAMINATIONS AND REPORTS

The guidelines set out WorkCover's policy in respect of independent medical examinations as well as the mandatory obligations for employers/insurers when referring a worker for a medical. They also provide guidance for all parties, including referrers, examining medical practitioners, and injured workers.

These guidelines commence on 1 November 2006. The previous *Guidelines on Independent Medical Examinations and Reports*, published in the *NSW Government Gazette* on 16 March 2005, are revoked.

In these guidelines, the *Workers Compensation Act 1987 is referred to as the 1987 Act,* and the *Workplace Injury Management and Workers Compensation Act 1998*, is referred to as the 1998 Act.

Definition of Insurer

Insurer is an insurer within the meaning of the *Workers Compensation Act 1987* and the *Workplace Injury Management and Workers Compensation Act 1998* and includes Scheme Agents, and self and specialised insurers.

TABLE OF CONTENTS

INTRODUCTION

Purpose and Scope of the Guidelines

Medical questions that arise in the context of managing a workers compensation claim should be directed to the treating medical practitioner(s) in the first instance. The nature of the relationship between the injured worker and the practitioner(s), and their knowledge of the worker's medical history, before and after the injury, make their input invaluable to the management of the worker's injury.

Referral for an independent medical examination is only appropriate when information from the treating medical practitioner(s) is inadequate, unavailable or inconsistent and where the referrer has been unable to resolve the problem directly with these practitioner(s).

Against this background, the purpose of these guidelines is to provide the basis for a shared understanding of the role of independent medical examinations in the management of compensable injuries in the NSW workers compensation system.

The guidelines outline mandatory [as per section 119(4) of the 1998 Act] and other obligations for the referral, conduct and reporting of independent medical examinations, and complaints management.

Mandatory obligations are set out in Part 1 of these guidelines. These are made in accordance with section 119(4) of the 1998 Act which states that an examination of a worker who has given notice of an injury must be in accordance with the WorkCover guidelines.

The other obligations set out in the Introduction and Part 2 of the guidelines apply to all independent medical examinations.

This document is intended for use by those who:

- refer injured workers for independent medical examinations
- undertake independent medical examinations and provide reports
- use independent medical examination reports in managing injuries, claims and disputes.

This document is also intended for use by injured workers and their representatives. A brochure is available from WorkCover for injured workers who are referred for independent medical examinations. The NSW Medical Board policy 'Medico-Legal Guidelines' provides useful information for workers and referrers (available from their website www.nswmb.org.au).

This document covers referrals by employers/insurers and lawyers involved in the workers compensation system, but not referrals to approved medical specialists by the Workers Compensation Commission of New South Wales.

Definition of Independent Medical Examination

Independent medical examination means an impartial assessment based on the best available evidence that is requested by a worker, a worker's solicitor or employer/insurer and undertaken by an appropriately qualified and experienced medical practitioner (who is not in a treating relationship with the worker) for the purposes of providing information to assist with workers compensation injury and claims management.

PART 1 MANDATORY OBLIGATIONS FOR EMPLOYERS/INSURERS

Part 1 sets out the mandatory obligations (pursuant to section 119(4) of the 1998 Act for employers/insurers when they require a worker to attend an independent medical examination.

Referral for an independent medical examination is only appropriate when information from the treating medical practitioner(s) is inadequate, unavailable or inconsistent and where the referrer has been unable to resolve the issues related to the problem directly with the practitioners.

All referrals for independent medical examinations are to be arranged at reasonable times and dates and with adequate notice provided to the worker, as outlined on page 7, 'Notification and explanation to the worker'.

Referrals for an independent medical examination are only to be made when one or more of the questions outlined on page 5, 'Reasons for referral', cannot be obtained from the treating medical practitioner(s).

All referrals to independent medical examiners are to be to appropriately qualified medical practitioners who have the expertise to adequately respond to the question(s) outlined in the referral. The independent medical examiner is to be a specialist with qualifications relevant to the treatment of the injured worker's injury. Care is to be taken when referring a worker with complex injuries. Referrers are to ensure that medical specialists with specific expertise are selected, eg. a hand or plastic surgeon for hand injuries, a spinal surgeon for complex back injuries, a neurosurgeon or rehabilitation specialist for head injuries.

If the worker has not been treated by a medical specialist, the referral is to be arranged with a medical practitioner with qualifications and expertise in the treatment of the worker's injury.

The employer/insurer must meet any reasonable costs incurred by the worker, including wages, travel and accommodation. This may include pre-payment of travel and accommodation expenses. If the worker is not reasonably able to travel unescorted, this may include expenses for the worker's escort. *Reference section 125 of the 1998 Act*.

A worker receiving weekly compensation payments can be required to submit themselves for subsequent independent medical examinations only when information from the treating medical practitioners remains inadequate, unavailable or inconsistent and where the referrer cannot resolve the issues related to the problem directly with the treating practitioner(s) and:

- the subsequent independent medical examination is with a specialist medical practitioner of the same specialty as has treated the worker for the injury or resulting conditions; and
- the employer/insurer has evidence that the worker's medical condition as a result of the injury has changed; or
- the employer/insurer has evidence of a change in the worker's health not resulting from the injury which will affect the worker's participation in the labour market; or
- the employer/insurer has evidence of a material change, or need for material change, in the manner or type of treatment; or

- the worker makes a claim for section 66 lump sum compensation or work injury damages; or
- the worker requests a review pursuant to a notice issued under section 54 *of the 1987 Act* or section 74 of the 1998 Act and includes additional medical information that the employer/insurer is asked to consider; or
- there has been at least 6 months since the last independent medical examination required by the employer/insurer; or
- the last independent medical examination was unable to be completed.

Subsequent independent medical examinations must be with the same medical practitioner unless they have ceased to practise (permanently or temporarily) in the specialty concerned, or they no longer practise in a location convenient to the worker, or both parties agree that a different medical practitioner is required.

If the worker considers the requirement to attend an independent medical examination is unreasonable, the worker is to advise the referrer of the reasons for their objection. The referrer must take account of this objection and advise the worker of their decision following this consideration. Benefits are not to be affected prior to adequate written notice being received by the worker following this consideration (see *WorkCover Guidelines for Claiming Compensation Benefits, Part 2 Clause 9.3*). Any decision to suspend payment of weekly compensation can only be made after the worker has had an opportunity to comply with a reasonable request and must be made on the basis of sound evidence and the worker advised in writing of the reasons for the suspension. The worker may contact WorkCover's Claims Assistance Service on 13 10 50 or their union for assistance in relation to such requests and decisions.

PART 2 OBLIGATIONS FOR ALL INDEPENDENT MEDICAL EXAMINATIONS

Part 2 sets out the obligations for all independent medical examinations (in addition to the mandatory obligations set out in Part 1).

1. Referral for Independent Medical Examination

Reasons for referral

An independent medical examination is appropriate where the information required relates to:

- diagnosis of an injury reported by the worker and determining the contribution of work incidents, duties and/or practices to that injury
- diagnosis of the worker's ongoing condition and whether it still results from the injury
- recommendations and/or need for treatment
- fitness for pre-injury duties and hours, and the likelihood of, and timeframe for recovery
- fitness for other jobs/duties, including those in the worker's recent employment history (descriptions of such duties are to be provided to the independent medical examiner)
- what past and/or ongoing incapacity results from the injury
- physical capabilities and any activities that must be avoided
- an assessment of permanent loss (injuries pre 1 January 2002) or whole person impairment (injuries on and after 1 January 2002) resulting from the injury, including any proportion to be deducted that is due to a pre-existing injury, abnormality or condition.

Barriers in relation to return to work and difficulties in communicating with a treating doctor might best be resolved through use of an Injury Management Consultant (refer to WorkCover's *Guidelines on the Appointment and Functions of Injury Management Consultants*).

Responsibility of referrer

The referrer has a responsibility to ensure that:

- the referral is made to an appropriate medical practitioner
- an appointment can be made within a reasonable period of time (usually 4 weeks)
- all parties are informed of the appointment details of the examination
- the worker is provided with an explanation of the nature of the examination and the details of the appointment
- the worker's special needs are catered for, eg interpreter, disabled access
- the independent medical examiner is provided with details of the worker and clear reasons for referral
- all the information relevant to the referral question(s) is provided to the independent medical examiner
- the independent medical examiner is paid promptly for providing the service at the rate set out in the Workplace Injury Management and Workers Compensation (Medical Examinations and Reports) Order 2005 in force at the time of the examination (www.workcover.nsw.gov.au).
- there is no conflict of interest in relation to the worker and referrer.

Selection of an appropriate medical practitioner for the examination

It is important that the independent medical examiner who is selected to provide the examination is appropriately qualified and has the expertise to competently provide an opinion on the question(s) in the referral. The independent medical examiner is to be a medical specialist with qualifications relevant to the treatment of the injured worker's injury. If the worker has not been treated by a medical specialist, an appointment is to be arranged with a medical practitioner in a specialty relevant to the treatment of the worker's injury. If the referral includes a question of causation or treatment, the independent medical examiner is to be in current clinical practice.

If the medical report relates to a claim for permanent impairment, it must be completed in accordance with the *WorkCover Guides for the Evaluation of Permanent Impairment* by a medical specialist with qualifications and training relevant to the body system being assessed who has been trained in the WorkCover Guides.

If there is more than one impairment that requires assessment by different medical specialists, one specialist must be nominated as the lead assessor and determine the final amount of whole person impairment.

A subsequent examination is to be with the same independent medical examiner who conducted the original examination, whenever practical.

The location of the independent medical examiner's rooms should be as geographically close to the worker's home address as possible or accessible by direct transport routes. The rooms should contain appropriate facilities, including access for people with ambulatory difficulties, and accommodate the worker's specific physical needs.

Special requirements of the worker relating to gender, culture or language are to be accommodated.

If the worker wishes to have an accompanying person with them at the examination, the independent medical examiner's agreement to the presence of a companion should be obtained prior to the appointment.

The independent medical examiner should be able to provide an appointment within a reasonable time, usually 4 weeks, and a report of the examination within 10 working days, unless different arrangements are agreed by the parties.

Where it is the independent medical examiner's routine practice to record the examination, the worker must be informed of this and be in agreement prior to the examination being scheduled. The worker must provide consent to the recording of the examination at the time of the examination.

Communication with the selected medical practitioner

The letter of referral to the independent medical examiner must provide clear direction about the question(s) to be addressed and the medical opinions sought.

Documents to be included

The independent medical examiner must be provided with all the information that is relevant to the questions to be addressed. Documents could include a claim form, medical certificates, witness reports, employer reports of injury, clinical notes/reports of treating doctors, medical reports, medical investigation reports, rehabilitation and functional assessment reports, job descriptions and duty statements, details of work with other employers and details of other settlements or awards.

Independent medical examiners are not able to order additional radiological or similar investigations so the results of all existing investigations are to be made available to the independent medical examiner.

Reports and/or electronic records of lay investigators are not to be provided with referrals for assessment of permanent impairment.

Documents are to be provided to the independent medical examiner at least 10 days prior to the arranged appointment. They should be provided in a manner that facilitates review/perusal by the independent medical examiner.

Notification and explanation to the worker

The worker is to be first advised in writing at least 10 working days before the appointment, unless a shorter time is required because of exceptional and unavoidable circumstances and agreed to by the parties, eg a need to consider an urgent request for treatment.

Advice about the appointment with the independent medical examiner must include:

- the reason for the examination
- the likely duration of the examination
- name, specialty and qualifications of the examiner
- date, time and location of the appointment and contact details of the examiner’s offices and appropriate travel directions
- the need to be punctual

- what to take, eg x-rays, reports of investigations/tests, comfortable clothing to enable an appropriate examination to be conducted
- how costs are to be paid
- that a failure to attend the examination or an obstruction of the examination may lead to –
  - a suspension of weekly compensation and/or
  - the right to recover compensation under the1987 Act
- that the worker may be accompanied by a person other than their legal representative with the agreement of the independent medical examiner, however, the accompanying person must not participate in the examination and may be required to withdraw from the examination if the examiner requests it
- that no one may be present during the actual physical/psychological examination of the injured worker, unless invited by the worker and agreed to by the medical examiner
- whether the travel costs for an accompanying person will be met (this usually only applies if the worker requires an attendant as a result of the injury)
- how complaints are to be managed
- that the workers compensation legislation gives the worker or a nominee a right to a copy of any report relevant to a decision made by a referrer to dispute liability for, or reduce, compensation benefits.

A WorkCover brochure about independent medical examinations is to be provided to the worker with the written notice of the appointment.

2. Conduct of an Independent Medical Examination

The NSW Medical Board's policy 'Medico-Legal Guidelines' provides principles for the independent medical examiner's conduct during the examination.

If the worker provides the independent medical examiner with any additional information at the time of the examination, this information is to be noted in the examiner's report.

If the injured worker fails to attend the examination, the independent medical examiner must notify the referrer as soon as possible.

3. Reporting an Independent Medical Examination

The suggested format for the report is attached as Attachment A.

The report is to be written in plain English and use accepted medical terminology as the intended audience is insurer staff, workers and workers' representatives, eg unions, legal representatives.

The report is to answer the referrer's question(s) and include other information elicited during the examination that is relevant to those questions. The independent medical examiner's report will list the material reviewed, any facts relied upon, the relevant medical history, examination findings, and the medical reasons for their conclusions.

The report should be provided to the referrer within 10 working days of the examination, or within a different timeframe if agreed between the parties.

4. Corrections and Updating of Reports

Where a report contains an obvious error, the referrer may request the independent medical examiner to clarify and correct the report at no extra cost.

Where the referrer requests that the examiner review additional information and seeks a supplementary report, that report will attract an additional cost.

The Workplace Injury Management and Workers Compensation (Medical Examinations and Reports) Order 2005 (Amendment No 1 2006) allows for updating reports where there has been no intervening incident or re-examination, or where there has been an intervening incident.

5. Complaints about Independent Medical Examinations

If the worker has concerns about the conduct of the independent medical examiner during the examination, they should raise those issues with the examiner at the time of the examination. The examiner should record the complaint and forward this to the referrer with their report and advise the worker to do likewise.

If the worker does not feel confident enough to do this, the worker should raise their concerns with the referring party as soon as possible after the examination. All insurers have in place a complaints management process. Making such a complaint can be facilitated by a union.

If the complaint is unable to be satisfactorily resolved, the worker may forward their complaint to WorkCover. WorkCover will advise the independent medical examiner of the complaint and provide an opportunity for the examiner to respond to the complaint.

WorkCover may refer the matter to the Health Care Complaints Commission, if it meets the criteria for such referral, eg more than 5 complaints about one independent medical examiner are received within a 12 month period and found to be justified, or if professional misconduct or fraudulent action are alleged.
The worker may at any time make a complaint to WorkCover, the insurer, the Health Care Complaints Commission, or the NSW Medical Board.

6. Complaints about Workers

Independent medical examiners should report any unreasonably late or non-attendance by the worker to the referring party. Similarly, any inappropriate behaviour or behaviour which impeded the examination should likewise be brought to the notice of the referrer within 2 days.

7. Fees and Payments for Properly Completed Reports

The referrer will be responsible for payment to the independent medical examiner within 10 working days of receipt of a properly completed report that addresses the referrer's questions and a tax invoice containing all necessary details.

Fees for such reports are not to be pre-paid in whole or in part.

The fees to be paid are those set out in the Workplace Injury Management and Workers Compensation (Medical Examinations and Reports) Order in force at the time of the examination.

The referrer's liability to pay for a report will be contingent on the report containing the information listed in the standard format, or as agreed between the parties.

If it involves an assessment of permanent impairment for an injury on or after 1 January 2002, the assessment must be in accordance with the *WorkCover Guides for the Evaluation of Permanent Impairment.*

In some instances, the referrer will require an assessment in accordance with the *WorkCover Guides for the Evaluation of Permanent Impairment*, even though the injury is before 1 January 2002. The independent medical examiner must be advised if this is the case.

Use of an interpreter, multiple system injuries and more complex matters will attract a surcharge in addition to the basic fees. These are listed in the Workplace Injury Management and Workers Compensation (Medical Examinations and Reports) Order current at the time of the examination.

The Workplace Injury Management and Workers Compensation (Medical Examinations and Reports) Order 2005 classifies the problems to be addressed into standard, moderately complex and complex.
Definitions of these are:

standard Single question posed or simple permanent impairment assessment involving single body system/single injury, eg single digit uncomplicated amputation, back injury

moderately complex More than one question posed, eg attribution of current work and prior injury to worker's condition, or a permanent impairment assessment involving two or more body systems, or complex method of assessment, eg amputation of limb with associated sensory deficit, impairment of joints

complex Several questions posed, eg causation, apportionment in accordance with employment history, fitness for work, or a permanent impairment assessment involving several body systems or complex injuries in one body region, eg burns, spinal cord or head injury.

The referrer is to indicate the expected level of complexity on referral and the independent medical examiner should advise the reason for any difference from this level.

Fees for cancellations, non-attendance or late cancellation by the worker or another party, such as an interpreter, are included in the Workplace Injury Management and Workers Compensation (Medical Examinations and Reports) Order current at the time of the examination.

Complaints about patterns of late or non-payment by insurers should be referred for investigation to the WorkCover doctors' hotline on 1800 661 111 or by email to WIMB@workcover.nsw.gov.au

ATTACHMENT A

Report format

- **Worker's details including:**
  - date of examination
  - worker's name
  - date of birth/age
  - details of who attended the examination (ie interpreter, family member or friend).

- **General history including:**
  - date of injuries
  - brief history of the circumstances of the injuries
  - job description/work tasks (when relevant).

- **Clinical history including:**
  - summary of injuries received and diagnoses made of the worker's condition.
  - summary of all treatment provided
  - details and dates of clinical investigations carried out
  - details of any previous or subsequent injuries, condition or abnormality.

- **Examination findings including:**
  - list of injuries assessed
  - your findings on comprehensive clinical examination, including negative findings
  - your comments on consistency of presentation and, where appropriate, how this compares to the medical reports and other material sighted.

- **Conclusions**
  - Your opinion in relation the worker's injuries and diagnosis of current condition and the rationale for the opinion.

- Responses to **specific questions** asked in the letter of referral (refer to page 5).

- Responses to questions indicated by referrer for **permanent loss of use** as a result of injuries received before 1 January 2002 or for **whole person impairment** for injuries received on or after 1 January 2002, questions regarding maximum medical improvement, whether the condition has resulted in a permanent impairment, and whether any deduction for a pre-existing condition must be addressed. A summary table (see Table 1) and a copy of all calculations must be enclosed.

Table 1– Whole Person Impairment (WPI)

Body Part or system	Chapter, page and paragraph number in WorkCover Guides	Chapter, page, paragraph, figure and table numbers in AMA5 Guides	% WPI	% WPI deductions pursuant to S323 for pre-existing injury, condition and abnormality	Sub-total/s % WPI in whole numbers (after any deductions in column 5)
1.					
2.					
3.					
Total % WPI (the Combined Table values of all sub-totals in whole numbers)					

WORKCOVER GUIDELINES FOR THE EVALUATION OF PERMANENT IMPAIRMENT

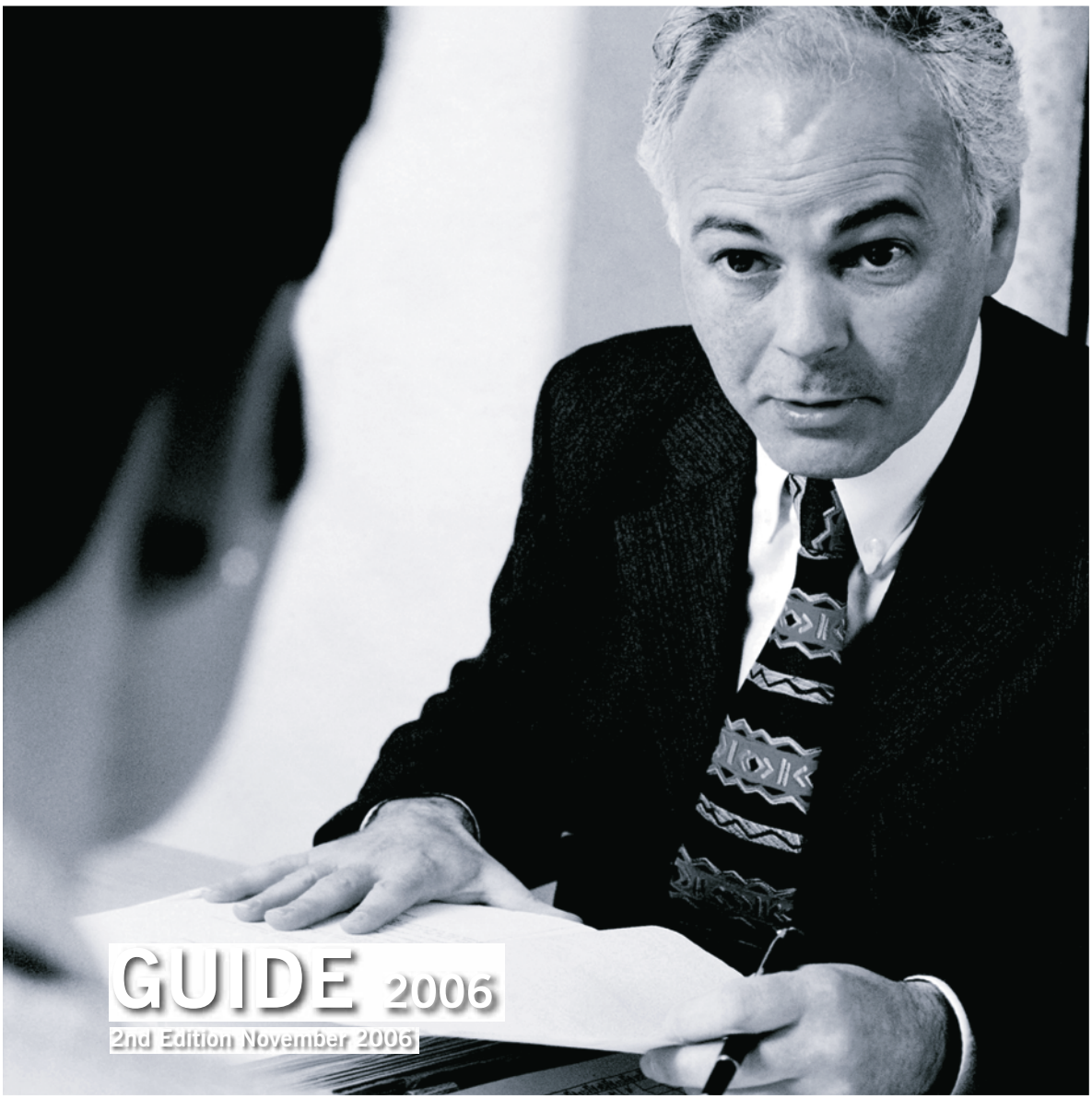
I, Jon Blackwell, the Chief Executive Officer of the WorkCover Authority of New South Wales, under sections 322, 376 and 377 of the *Workplace Injury Management and Workers Compensation Act 1998,* issue the following guidelines.

Dated, this 24 day of October 2006.

Jon Blackwell
Chief Executive Officer
WorkCover Authority

WorkCover
NEW SOUTH WALES

WORKCOVER GUIDES
FOR THE EVALUATION OF
PERMANENT IMPAIRMENT



WorkCover. **Watching out for you.**

New South Wales Governme

2nd Edition – 1st November 2006

Disclaimer

This publication contains information regarding occupational health, safety, injury management or workers compensation. It includes some of your obligations under the various workers compensation and occupational health and safety legislation that WorkCover NSW administers. To ensure you comply with your legal obligations you must refer to the appropriate Acts.

This publication may refer to WorkCover NSW administered legislation that has been amended or repealed. When reading this publication you should always refer to the latest laws. Information on the latest laws can be checked at www.legislation.nsw.gov.au or contact 1300 656 986.

CONTENTS

Questions regarding these guides should be directed to:

Provider Services Group
Workers Compensation Division
WorkCover NSW

Tel: 1800 661 111

Foreword

These Guidelines, known as the *WorkCover Guides*, are issued under section 376 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act) for the purpose of assessing the degree of permanent impairment that arises from a work related injury or condition in accordance with section 322(1) of the 1998 Act. The focus of the workers compensation legislation is injury management which aims to assist the injured worker to recover and return to work. When a worker sustains a permanent impairment, however, these Guides are intended to ensure an objective, fair and consistent method for evaluating the level of permanent impairment. This second edition of the *WorkCover Guides* replaces the first edition which was issued in December 2001.

The Act requires that assessments of permanent impairment be made in accordance with these Guides. Medical specialists trained in the use of the *WorkCover Guides* are to assess the degree of permanent impairment arising from a work related injury or condition.

The *WorkCover Guides* are based on the American Medical Association's (AMA) *Guides to the Evaluation of Permanent Impairment,* fifth edition. The AMA guides are the most authoritative and widely used source for the purpose of evaluating permanent impairment. However, extensive work by eminent medical specialists, representing all Medical Colleges, has gone into reviewing the AMA guides to ensure that they are aligned with Australian clinical practice.

These Guides apply to all assessments of the degree of permanent impairment that occur after 1 November 2006.

Jon Blackwell

Chief Executive Officer
WorkCover NSW

1 Introduction

1.1 WorkCover NSW has introduced guides for the evaluation of permanent impairment based on the American Medical Association's *Guides to the Evaluation of Permanent Impairment,* fifth edition (AMA5).

1.2 These Guides, to be known as the *WorkCover Guides*, are issued under section 376 of the *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act). The *WorkCover Guides* were introduced in December 2001 and the current edition is the second edition.

1.3 The *WorkCover Guides* adopt AMA5 in most cases. Where there is any deviation, the difference is defined in the *WorkCover Guides*. Where differences exist, the *WorkCover Guides* are to be used as the modifying document. The procedures contained in the *WorkCover Guides* are to prevail if there is any inconsistency with AMA5.

1.4 The *WorkCover Guides* are to be used wherever there is a need to establish the level of permanent impairment that results from a work-related injury or disease. The assessment of permanent impairment is conducted for the purposes of awarding a lump sum payment under the statutory benefits of the NSW Workers Compensation Scheme and also for determining access to Common Law, domestic assistance and commutation of claims.

1.5 Assessing permanent impairment involves determining:

- whether the claimant's condition has resulted in impairment
- whether the condition has reached Maximum Medical Improvement (MMI)
- whether the resultant impairment is permanent
- the degree of permanent impairment that results from the injury
- the proportion of permanent impairment due to any previous injury, pre existing condition or abnormality, if any.

1.6 By the time an assessment of permanent impairment is required, the question of liability for the primary condition would normally have been determined. The exceptions to this could be those conditions which are of slow onset.

1.7 Medical assessors are expected to be familiar with Chapters 1 and 2 of AMA5 in addition to the information contained in this Introduction.

1.8 In the case of a complex injury, where different medical assessors are required to assess different body systems, a 'lead assessor' should be nominated to coordinate and calculate the final %WPI resulting from the individual assessments. In the case of a dispute, the 'lead assessor' should be agreed between the parties or nominated by the Worker's Compensation Commission.

Development of the *WorkCover Guides*

1.9 The *WorkCover Guides* were developed by groups of medical specialists brought together by WorkCover to review the *AMA Guides to the Evaluation of Permanent Impairment*. The groups included specialists who were nominated by the Labor Council of NSW (now Unions NSW). Initially, the fourth edition of the *AMA Guides to the Evaluation of Permanent Impairment* (AMA4) was considered but, on the advice of the medical specialists involved, focus was changed to the fifth edition of the Guides. AMA5 is used for most body systems, with the exception of Vision where, on the medical specialists' advice, assessments are conducted according to the AMA4. The Chapters on Pain (Chapter 18 in AMA 5) and on Mental and Behavioural Disorders (Chapter 14 in AMA 5) are likewise omitted. WorkCover has substituted its own Chapter on Psychiatric and Psychological Disorders (see Chapter 11 in this Guide) but chronic pain is excluded entirely at the present time (see Note: Evaluation of permanent impairment arising from chronic pain p 81, for a fuller explanation). No assessment should be made of impairments associated with chronic pain.

1.10 The members of each original working group and the members who advised on the 2005 revision are listed in Appendix 1 (pp 77–78).

1.11 The *WorkCover Guides* are to be reviewed and updated as subsequent editions of the *AMA Guides to the Evaluation of Permanent Impairment* become available. The *WorkCover Guides* will also be reviewed if anomalies or insurmountable difficulties in their use become apparent.

1.12 The *WorkCover Guides* are meant to assist suitably qualified and experienced medical specialists to assess levels of permanent impairment. They are not meant to provide a 'recipe approach' to the assessment of permanent impairment. Medical specialists are required to exercise their clinical judgement in determining diagnosis, whether the original condition has resulted in an impairment and whether the impairment is permanent. The degree of permanent impairment that results from the injury must be determined using the tables, graphs and methodology given in the *WorkCover Guides* and AMA5. Section 1.5 of Chapter 1 of AMA5 (p 10) applies to the conduct of assessments and expands on this concept.

Body systems covered by the *WorkCover Guides*

1.13 Most body systems, structures and disorders included in AMA5 are included in the *WorkCover Guides*. Pain (Chapter 18 of AMA5) is excluded. Psychiatric and Psychological Disorders are evaluated using the specific *WorkCover Guides* Chapter (Chapter 11). The Visual System adopts AMA4, *not* AMA5. Evaluation of Permanent Impairment due to Hearing Loss adopts the methodology indicated in these guides (Chapter 9) with some reference to AMA5, Chapter 11 (pp 245–251), but uses National Acoustic Laboratory (NAL) Tables from the NAL Report No 118, *Improved Procedure for Determining Percentage Loss of Hearing* January 1988.

Psychiatric and psychological impairments

1.14 Psychiatric and psychological disorders are defined as primary psychological and psychiatric injuries in which work was found to be a substantial contributing factor. Permanent impairment due to psychiatric and psychological disorder is determined in accordance with Chapter 11 of the *WorkCover Guides*.

1.15 A *primary* psychiatric or psychological impairment is one which arises from a condition to which the person's employment was a substantial contributing factor. The condition will result from specific incidents at the workplace.

1.16 A primary psychiatric condition is distinguished from a *secondary* psychiatric or psychological condition, which arises as a consequence of, *or secondary to*, another work-related condition (eg depression associated with a back injury). No permanent impairment assessment is to be made of secondary psychiatric and psychological impairments. The payments for 'Pain and Suffering' available under section 67 are intended to compensate people who come into this category (for further information refer to paragraph 1.52).

Multiple impairments

1.17 Impairments arising from the same injury are to be assessed together (section 322(2) of the 1998 Act). Impairments that result from more than one injury arising out of the same incident are to be assessed together to assess the degree of permanent impairment of the injured worker (section 322(3) of the 1998 Act), with the exception of impairments arising from psychological and psychiatric injuries.

1.18 Impairments arising from primary psychological and psychiatric injuries are to be assessed separately from the degree of impairment that results from physical injuries arising out of the same incident (section 65A(4)(a) of the 1987 Act). A worker is entitled to receive compensation for impairment resulting from only one of these injuries, whichever results in the greater amount of compensation being payable, and is not entitled to receive compensation for an impairment resulting from the other injury.

1.19 The Combined Values Chart (pp 604-606, AMA5) is used to derive a %WPI that arises from multiple impairments. An explanation of its use is found on pp 9-10 of AMA5.

Permanent impairment — maximum medical improvement

1.20 Assessments are only to be conducted when the medical assessor considers that the degree of permanent impairment of the injured worker is fully ascertainable. The permanent impairment will be fully ascertainable where the medical assessor considers that the person has attained maximum medical improvement. This is considered to occur when the worker's condition has been medically stable for the previous three months and is unlikely to change by more than 3%WPI in the ensuing 12 months with or without further medical treatment (ie further recovery or deterioration is not anticipated).

1.21 If the medical assessor considers that treatment has been inadequate and maximum medical improvement has not been achieved, the assessment should be deferred and comment should be made on the value of additional/different treatment and/or rehabilitation.

Refusal of treatment

1.22 If the claimant has been offered, but refused, additional or alternative medical treatment that the assessor considers is likely to improve the claimant's condition, the medical assessor should evaluate the current condition, without consideration of potential changes associated with the proposed treatment. The assessor may note the potential for improvement in the claimant's condition in the evaluation report, and the reasons for refusal by the claimant, but should not adjust the level of impairment on the basis of the worker's decision.

Future deterioration of a condition

1.23 Similarly, if a medical assessor forms the opinion that the claimant's condition is stable for the foreseeable future, but that it is expected to deteriorate in the long term, the assessor should make no allowance for this deterioration, but note its likelihood in the evaluation report. If the claimant's condition deteriorates at a later time, the claimant may re-apply for further evaluation of the condition.

Information required for assessments

1.24 On referral, the medical assessor should be provided with all relevant medical and allied health information, including results of all clinical investigations related to the injury in question.

1.25 AMA5 and these *WorkCover Guides* indicate the information and investigations that are required to arrive at a diagnosis and to measure permanent impairment. Assessors must apply the approach outlined in the Guides. Referrers must consult these documents to gain an understanding of the information that should be provided to the assessor in order to conduct a comprehensive evaluation.

Medical assessors

1.26 An assessor will be a medical specialist with qualifications, training and experience in a medical specialty relevant to the body system being assessed who has undertaken the requisite training in use of the *WorkCover Guides*. A list of trained medical assessors may be obtained from the WorkCover website **www.workcover.nsw.gov.au**.

1.27 Assessors may be one of the claimant's treating specialists or an assessor engaged on behalf of the employer/insurer/Scheme Agent/claimant to conduct an assessment for the purposes of assessing the level of permanent impairment.

1.28 Assessors of levels of permanent impairment are required to use the *WorkCover Guides for the Evaluation of Permanent Impairment* current at the time of the assessment.

Code of conduct

1.29 Assessors are referred to the NSW Medical Board's *Guidelines for Medico-Legal Consultations and Examinations* which are reproduced in Appendix 2 (p 79).

1.30 Assessors are reminded that they have an obligation to act in an ethical, professional and considerate manner when examining claimants for the determination of permanent impairment.

1.31 Effective communication is vital to ensure that the claimant is well-informed and able to maximally cooperate in the process. Assessors should:

- ensure that the claimant understands who the assessor is and the assessor's role in the evaluation
- ensure that the claimant understands how the evaluation will proceed
- take reasonable steps to preserve the privacy and modesty of the claimant during the evaluation
- not provide any opinion to the claimant about their claim.

1.32 Useful information is also provided in the pamphlet developed by the Australian Medical Association and the Law Society that informs applicants what to expect during an examination by an independent medical assessor. This pamphlet is reproduced in Appendix 3 (p 82) and additional copies are available from the AMA.

1.33 WorkCover has also produced information for workers regarding independent medical examinations and assessments of permanent impairment, which the insurer should have supplied to the worker when advising the appointment details.

1.34 Complaints received by WorkCover in relation to the behaviour of an assessor during an evaluation will be initially reviewed by WorkCover. If complaints recur or the initial review reveals a problem potentially exists, the complaint will be referred to the Health Care Complaints Commission and the NSW Medical Board for investigation and appropriate action.

Adjustment for the effects of orthoses and prostheses

1.35 Assessments of permanent impairment are to be conducted without assistive devices, except where these cannot be removed. The assessor will need to make an estimate as to what is the level of impairment, without such a device, if it cannot be removed for examination purposes. Further details may be obtained in the relevant Chapters in the *WorkCover Guides*.

1.36 Impairment of vision should be measured with the injured worker wearing their prescribed corrective spectacles and/or contact lenses, if this was usual for the injured worker before the workplace injury. If, as a result of the workplace injury, the injured worker has been prescribed corrective spectacles and/or contact lenses for the first time, or different spectacles and/or contact lenses than those prescribed pre-injury, the difference should be accounted for in the assessment of permanent impairment.

Adjustment for the effects of treatment

1.37 In circumstances where the treatment of a condition leads to a further, secondary impairment, other than a secondary psychological impairment, the assessor should use the appropriate parts of the *WorkCover Guides* to evaluate the effects of treatment, and use the Combined Values Chart (pp 604-606 AMA5) to arrive at a final Whole Person Impairment.

1.38 Where the effective long term treatment of an illness or injury results in apparent substantial or total elimination of the claimant's permanent impairment, but the claimant is likely to revert to the original level of impairment if treatment is withdrawn, the assessor may increase the percentage of whole person impairment by 1, 2 or 3%WPI. This percentage should be combined with any other impairment percentage, using the Combined Values Chart. This paragraph does not apply to the use of analgesics or anti-inflammatory medication for pain relief.

1.39 As previously indicated, where a claimant has declined treatment which the assessor believes would be beneficial, the impairment rating should be neither increased or decreased.

Reports

1.40 A report of the evaluation of permanent impairment should be accurate, comprehensive and fair. It should clearly address the question being asked of the assessing medical specialist. In general, the assessor will be requested to address issues of:

- current clinical status, including the basis for determining maximum medical improvement
- the degree of permanent impairment that results from the injury
- the proportion of permanent impairment due to previous injury, pre-existing condition or abnormality, if any.

1.41 The report should contain factual information based on the assessor's own history taking and clinical examination. If other reports or investigations are relied upon in arriving at an opinion, these should be appropriately referenced in the assessor's report.

1.42 The *WorkCover Guides*, as modified from time to time, are to be used in assessing permanent impairment in the NSW Workers Compensation scheme. The report of the evaluation should provide a rationale consistent with the methodology and content of these Guides. It should include a comparison of the key findings of the evaluation with the impairment criteria in the Guides. If the evaluation was conducted in the absence of any pertinent data or information, the assessor should indicate how the impairment rating was determined with limited data.

1.43 The assessed level of impairment is to be expressed as a percentage of whole person impairment (%WPI). Regional body impairments, where used (for example, percentage upper extremity impairment) are to be indicated in the report and then converted to %WPI.

1.44 The report should include a conclusion of the assessor, including the final %WPI. This is to be included as the final paragraph in the body of the report, and not as a separate report.

1.45 Reports are to be provided within ten working days of the assessment being completed, or as agreed between the referrer and the assessor.

Ordering of additional investigations

1.46 As a general principle, the assessing medical specialist should not order additional radiographic or other investigations purely for the purpose of conducting an assessment of permanent impairment.

1.47 If, however, the investigations previously undertaken are not as required by the *WorkCover Guides* or are inadequate for a proper assessment to be made, the medical assessor should consider the value of proceeding with the evaluation of permanent impairment without adequate investigations.

1.48 In circumstances where the assessor considers that further investigation is essential for a comprehensive evaluation to be undertaken and deferral of the evaluation would considerably inconvenience the claimant (eg when the claimant has travelled from a country region specifically for the assessment), the assessing medical specialist may proceed to order the appropriate investigations, provided that there is no undue risk to the claimant. The approval of the referring body for the additional investigation will be required to ensure that the costs of the test are met promptly.

Deductions for pre-existing condition or injury

(AMA5 Section 1.6, p11)

1.49 In assessing the degree of permanent impairment resulting from the injury, the assessor is to indicate the proportion of WPI due to any previous injury, pre-existing condition or abnormality. This proportion is known as 'the deductible proportion'.

1.50 If this amount is difficult or costly to determine, the assessor should indicate this in the report. In this case, for the injury now being assessed, the deduction is 10% of the impairment, unless this is at odds with the available evidence.

1.51 Impairment assessors may be requested to specify parts of the deductible proportion in accordance with legislative requirements concerning type of work, when the work was performed, and the dates injuries were received.

Compensation for pain and suffering

1.52 A claimant may receive a separate payment for compensation for pain and suffering, under section 67 of the *Workers Compensation Act 1987*, where the level of whole person impairment is assessed at or above the threshold percentage. 'Pain and Suffering' means actual pain, or distress, or anxiety suffered, or likely to be suffered by the injured worker resulting from the permanent impairment or any necessary treatment.

1.53 Once agreement is reached on the level of permanent impairment, an amount can also be agreed for pain and suffering. The determination of the amount to be paid for pain and suffering is independent of the percentage of whole person impairment. Medical assessors of permanent impairment are not required to indicate the level of pain and suffering to be awarded.

Disputes over assessed levels of permanent impairment

1.54 A dispute about the level of permanent impairment compensation can be referred to the Workers Compensation Commission. The parties can agree on the selection of an Approved Medical Specialist (AMS) to determine the dispute. If the two parties are unable to agree on the selection of an AMS within 7 days of being notified of a dispute by the Registrar of the Commission, the Registrar will appoint an AMS to assess the dispute.

1.55 A certificate will be provided by the appointed AMS after completing the evaluation.

1.56 The certification of the level of permanent impairment by the AMS appointed to resolve the dispute is conclusively presumed to be correct (section 326 of the 1998 Act).

1.57 The certificate provided by the appointed AMS will form the basis of the Arbitrator's decision on the amount of money to be awarded for permanent impairment and pain and suffering.

Conditions which are not covered by the WorkCover/AMA5 Guides – Equivalent or analogous conditions

1.58 AMA5 (p 11) states: 'Given the range, evolution and discovery of new medical conditions, the *Guides* cannot provide an impairment rating for all impairments . . . In situations where impairment ratings are not provided, the *Guides* suggest that medical specialists use clinical judgment, comparing measurable impairment resulting from the unlisted condition to measurable impairment resulting from similar conditions with similar impairment of function in performing activities of daily living . . .

The physician's judgment, based upon experience, training, skill, thoroughness in clinical evaluation, and ability to apply the *Guides* criteria as intended, will enable an appropriate and reproducible assessment to be made of clinical impairment.'

Inconsistent presentation

1.59 AMA5, p 19, states: 'Consistency tests are designed to ensure reproducibility and greater accuracy. These measurements, such as one that checks the individual's range of motion are good but imperfect indicators of people's efforts. The physician must use the entire range of clinical skill and judgment when assessing whether or not the measurements or test results are plausible and consistent with the impairment being evaluated. If, in spite of an observation or test result, the medical evidence appears insufficient to verify that an impairment of a certain magnitude exists, the physician may modify the impairment rating accordingly and then describe and explain the reason for the modification in writing.' This paragraph applies to inconsistent presentation only. The requirements stated in paragraph 1.12 apply to all assessments.

Activities of daily living

1.60 Many tables in AMA5 give class values for particular impairments, with a range of possible impairment values within each class. Commonly, the tables require the medical specialist to consider the impact of the injury/illness on activities of daily living in determining the precise impairment value. The activities of daily living which should be considered, if relevant, are listed in Table 1-2, p 4, AMA5. The impact of the injury on activities of daily living is not considered in assessments of the upper or lower extremities.

1.61 The assessment of the impact of the injury on activities of daily living should be verified wherever possible by reference to objective assessments, for example, physiotherapist or occupational therapist functional assessments.

Rounding

1.62 Occasionally the methods of the Guides will result in an impairment value which is not a whole number (eg an assessment of a peripheral nerve impairment in the upper extremity). All such values must be rounded to the nearest whole number before moving from one level of impairment to the next (eg from finger impairment to hand impairment, or from hand impairment to upper extremity impairment) or from a regional impairment to a whole person impairment. Figures should also be rounded before using the combination tables. This will ensure that the final whole person impairment will always be a whole number. The usual mathematical convention is followed where rounding occurs – values of 0.4 or less are rounded down to the nearest whole number and values of 0.5 and above are rounded up to the next whole number. The method of calculating a further hearing loss is shown in Chapter 9, paragraph 9.15, p 42.

2 Upper extremity

AMA5 Chapter 16 applies to the assessment of permanent impairment of the upper extremities, subject to the modifications set out below.

Introduction

2.1 The upper extremities are discussed in AMA 5 Chapter 16 (pp 433-521). This chapter provides guidelines on methods of assessing permanent impairment involving these structures. It is a complex chapter that requires an organised approach with careful documentation of findings.

2.2 Evaluation of anatomical impairment forms the basis for upper extremity impairment assessment. The ratings reflect the degree of impairment and its impact on the ability of the person to perform activities of daily living. There can be clinical conditions where evaluation of impairment may be difficult, for example, lateral epicondylitis of the elbow. Such conditions are evaluated by their effect on function of the upper extremity, or, if all else fails, by analogy with other impairments that have similar effects on upper limb function.

The approach to assessment of the upper extremity and hand

2.3 Assessment of the upper extremity mainly involves clinical evaluation. Cosmetic and functional evaluations are performed in some situations. The impairment must be permanent and stable. The injured person will have a defined diagnosis that can be confirmed by examination.

2.4 The assessed impairment of a part or region can never exceed the impairment due to amputation of that part or region. For an upper limb, therefore, the maximum evaluation is 60% whole person impairment, the value for amputation through the shoulder.

2.5 Active range of motion should be measured with several repetitions to establish reliable results. Only active motion is measured, not passive motion.

2.6 To achieve an accurate and comprehensive assessment of the upper extremity, findings should be documented on a standard form. AMA 5 Figures 16-1a and 16-1b (pp 436-437) are extremely useful, both to document findings and to guide the assessment process.

2.7 The hand and upper extremity are divided into regions: thumb, fingers, wrist, elbow, and shoulder. Close attention needs to be paid to the instructions in Figures 16-1a and 16-1b (pp 436-437, AMA5) regarding adding or combining impairments.

2.8 Table 16-3 (pp 439, AMA5) is used to convert upper extremity impairment to whole person impairment.

Specific interpretation of the AMA 5 Guides – the hand and upper extremity

Impairment of the upper extremity due to peripheral nerve disorders

2.9 If an upper extremity impairment results solely from a peripheral nerve injury the assessor should not also evaluate impairment(s) from Section 16.4, abnormal motion (pp 450-479, AMA5) for that upper extremity. Section 16.5 should be used for evaluation of such impairments. For peripheral nerve lesions use Table 16-15 (p 492, AMA5) together with Tables 16-10 and 16-11 (pp 482 and 484, AMA5) for evaluation.

2.10 When applying Tables 16-10 (pp 482, AMA5) and Table 16-11 (p 484, AMA5) the examiner must use clinical judgement to estimate the appropriate percentage within the range of values shown for each severity grade. The maximum value is NOT applied automatically.

Impairment due to other disorders of the upper extremity

2.11 The section 'Impairment of the upper extremity due to other disorders' (AMA5 Section 16.7 pp 498-507) should be used only when other criteria (as presented in Sections 16.2 – 16.6 [pp 441-498 of AMA 5]) have not adequately encompassed the extent of the impairments. Impairments from the disorders considered in Section 16.7 are usually estimated using other criteria. The assessor must take care to avoid duplication of impairments.

2.12 Relevant imaging studies for carpal instability (AMA5 Table 16-25, p 503) should only be considered, if available, along with the clinical signs. X-ray examination should not be performed solely for this evaluation.

2.13 If strength evaluation is chosen as a method of upper extremity impairment assessment, the caveats detailed on AMA5 p 508, under the heading '16.8a Principles' need to be observed, ie, decreased strength cannot be rated in the presence of decreased motion, painful conditions, deformities and absence of parts (eg thumb amputation).

Conditions affecting the shoulder region

2.14 All shoulder assessments must have the following 'inclusion criteria' :

1. A clear history of a shoulder injury.
2. Symptoms consistent with a shoulder disorder (to be distinguished from symptoms due to referred pain from the neck).
   (i) Most shoulder disorders with an abnormal range of movement are assessed according to AMA5 Section 16.4 – evaluating abnormal motion.
   (ii) Rare cases of rotator cuff injury, where the loss of shoulder motion does not reflect the severity of the tear, and there is *no associated pain*, may be assessed according to AMA5 Section 16.8c – strength evaluation.
   (iii) Other specific shoulder disorders, where the loss of shoulder motion does not reflect the severity of the disorder, *associated with pain*, should be assessed by comparison with other impairments that have similar effect(s) on upper limb function.

2.15 **Ruptured long head of biceps** shall be assessed as an upper extremity impairment (UEI) of 3%UEI or 2%WPI where it exists in isolation from other rotator cuff pathology. Impairment for ruptured long head of biceps cannot be combined with any other rotator cuff impairment.

2.16 **Impingement**. Diagnosis of impingement is made on the basis of positive findings on appropriate provocative testing and is only to apply where there is no loss of range of motion. Symptoms must have been present for at least 12 months. An impairment rating of 3%UEI or 2%WPI shall apply.

Fractures involving joints

2.17 Displaced fractures involving joint surfaces are generally to be rated by range of motion. If, however, this loss of range is not sufficient to give an impairment rating and movement is accompanied by pain and there is 2 mm or more of displacement, allow 2%UEI (1%WPI).

3 Lower extremity

AMA5 Chapter 17 applies to the assessment of permanent impairment of the lower extremities, subject to the modifications set out below.

Introduction

3.1 The lower extremities are discussed in AMA5 Chapter 17 (pp 523–564). This section is complex and provides a number of alternative methods of assessing permanent impairment involving the lower extremity. An organised approach is essential and findings should be carefully documented on a worksheet.

The approach to assessment of the lower extremity

3.2 Assessment of the lower extremity involves physical evaluation, which can use a variety of methods. In general, the method should be used that most specifically addresses the impairment present. For example, impairment due to a peripheral nerve injury in the lower extremity should be assessed with reference to that nerve rather than by its effect on gait.

3.3 There are several different forms of evaluation that can be used, as indicated in Sections 17.2b to 17.2n (pp 528–554, AMA5). Table 17–2 (p 526, AMA5) indicates which evaluation methods can be *combined* and which cannot. It may be possible to perform several different evaluations as long as they are reproducible and meet the conditions specified below and in AMA5. The most specific method of impairment assessment should be used.

3.4 It is possible to use an algorithm to aid in the assessment of lower extremity impairment. Use of a worksheet is essential. Table 3.2 of these *WorkCover Guides* (p 19) is such a worksheet and may be used in assessment of permanent impairment of the lower extremity.

3.5 In the assessment process, the evaluation giving the highest impairment rating is selected. That may be a combined impairment in some cases, in accordance with the Guide to the Appropriate Combination of Evaluation Methods Table (Table 17–2, p 526, AMA5), using the Combined Values Chart (pp 604–606, AMA5).

3.6 When the Combined Values Chart is used, the assessor must ensure that all values combined are in the same category of impairment rating (ie, %WPI, Lower extremity impairment percentage, Foot impairment percentage, and so on). Regional impairments of the same limb (eg several lower extremity impairments) should be combined **before** converting to %WPI.

3.7 Table 17–2 (p 526, AMA5) needs to be referred to frequently to determine which impairments can be combined and which cannot.

Specific interpretation of AMA5 — the lower extremity

Leg length discrepancy

3.8 When true leg length discrepancy is determined clinically (AMA5 Section 17.2b, p 528), the method used must be indicated (for example, tape measure from anterior superior iliac spine to the medial malleolus). Clinical assessment of leg length discrepancy is an acceptable method but if computerised tomography films are available they should be used in preference. Such an examination should not be ordered solely for determining leg lengths.

3.9 When applying Table 17–4 (p 528, AMA5), the element of choice should be removed and impairments for leg length discrepancy should be read as the higher figure of the range quoted (ie, 0, 3, 5, 7, or 8 for whole person impairment, or 0, 9, 14, 19, or 20 for lower limb impairment).

Gait derangement

3.10 If gait derangement (AMA5 Section 17.2c, p 529) is used as the method of impairment assessment for the lower extremity it cannot be combined with any other evaluation in the lower extremity section of AMA5. It should rarely be used (see 3.13).

3.11 Any walking aid used by the subject must be permanent and not temporary.

3.12 In the application of Table 17–5 (p 529, AMA5), delete item b, as the Trendelenburg sign is not sufficiently reliable.

3.13 Assessment of gait derangement should be used as the method of last resort. Methods of impairment assessment most fitting the nature of the disorder should always be used in preference.

Muscle atrophy (unilateral)

3.14 This section (AMA5 Section 17.2d, p 530) should be used infrequently. It is not applicable if the limb other than that being assessed is abnormal (for example, if varicose veins cause swelling, or if there is other injury).

3.15 In the use of Table 17–6 (p 530, AMA5) the element of choice should be removed in the impairment rating and only the higher figure used. Therefore, for the thigh, the whole person impairment should be assessed as 0, 2, 4, or 5%, or lower limb impairment as 0, 8, 13, or 13% respectively. For the calf the equivalent figures have the same numerical values.

Manual muscle strength testing

3.16 The Medical Research Council (MRC) gradings for muscle strength are universally accepted. They are not linear in their application, but ordinal. Only the six grades (0–5) should be used, as they are reproducible among experienced assessors. The descriptions in Table 17–7 (p 531, AMA5) are correct. The results of electrodiagnostic methods and tests are not to be considered in the evaluation of muscle testing which can be performed manually. Table 17–8 (p 532, AMA5) is to be used for this method of evaluation.

Range of motion

3.17 Although range of motion (ROM) (AMA5 Section 17.2f, pp 533–538) appears to be a suitable method for evaluating impairment, it is subject to variation because of pain during motion at different times of examination, possible lack of cooperation by the person being assessed and inconsistency. If there is such inconsistency then ROM cannot be used as a valid parameter of impairment evaluation.

3.18 If range of motion is used as an assessment measure, then Tables 17–9 to 17–14 (p 537, AMA5) are selected for the joint or joints being tested. If a joint has more than one plane of motion, the impairment assessments for the different planes should be *added*. For example, any impairments of the six principal directions of motion of the hip joint are *added* (p 533, AMA5).

Ankylosis

3.19 For the assessment of impairment when a joint is ankylosed (AMA5 Section 17.2g, pp 538–543) the calculation to be applied is to select the impairment if the joint is ankylosed in optimum position (See Table 3.1 below), and then if not ankylosed in the optimum position by *adding* (not combining) the values of %WPI using Tables 17–15 to 17–30 (pp 538–543, AMA5).

Table 3.1 Impairment for ankylosis in the optimum position

Joint	Whole person	Lower extremity	Ankle or foot
Hip	20%	50%	–
Knee	27%	67%	–
Ankle	4%	10%	14%
Foot	4%	10%	14%

Note that the whole person impairment from ankylosis of a joint, or joints, in a lower limb cannot exceed 40% whole person impairment or 100% lower limb impairment. If this figure is exceeded when the combination of a lower limb impairment is made then only 40% can be accepted as the maximum whole person impairment for a lower limb.

Arthritis

3.20 Impairment due to arthritis (AMA5 section 17.2n, pp 544–545) following a work-related injury is uncommon, but may occur in isolated cases. The presence of arthritis may indicate a pre-existing condition and this should be assessed and an appropriate deduction made (see Chapter 1, p 9, *WorkCover Guides*).

3.21 The presence of osteoarthritis is defined as cartilage loss. Cartilage loss can be assessed by plain radiography, computed tomography (CT), magnetic resonance imaging (MRI) or by direct vision (arthroscopy). MRI using cartilage sensitive sequences is superior to plain radiology in demonstrating cartilage deficiency, but is not required if the diagnosis of osteoarthritis is obvious on plain radiography.

3.22 Detecting the subtle changes of cartilage loss on plain radiography requires comparison with the normal side. All joints should be imaged directly through the joint space, with no overlapping of bones. If the optimal views are not available, they should be obtained. If comparison views are not available, AMA5 Table 17–31 (p 544) is used as a guide to assess joint space narrowing.

3.23 One should be cautious in making a diagnosis of cartilage loss on plain radiography if secondary features of osteoarthritis, such as osteophytes, subarticular cysts or subchondral sclerosis are lacking, unless the other side is available for comparison. The presence of an intra-articular fracture with a step in the articular margin in the weight bearing area implies cartilage loss.

3.24 The accurate radiographic assessment of joints always requires at least two views. In some cases, further supplementary views will optimise the detection of joint space narrowing or the secondary signs of osteoarthritis.

Sacro-iliac joints: Being a complex joint, modest alterations are not detected on radiographs, and cross-sectional imaging may be required. Radiographic manifestations accompany pathological alterations. The joint space measures between 2 mm and 5 mm. Osteophyte formation is a prominent characteristic of osteoarthritis of the sacro-iliac joint.

Hip: An anteroposterior view of the pelvis and a lateral view of the affected hip are ideal. If the affected hip joint space is narrower than the asymptomatic side, cartilage loss is regarded as being present. If the anteroposterior view of pelvis has been obtained with the patient supine, it is important to compare the medial joint space of each hip as well as superior joint space, as this may be the only site of apparent change. If both sides are symmetrical, then other features, such as osteophytes, subarticular cyst formation, and calcar thickening should be taken into account to make a diagnosis of osteoarthritis.

Knee:

- **Tibio-femoral joint:** The best view for assessment of cartilage loss in the knee is usually the erect intercondylar projection, as this profiles and stresses the major weight bearing area of the joint which lies posterior to the centre of the long axis. The ideal x-ray is a posteroanterior view with the patient standing, knees slightly flexed, and the x-ray beam angled parallel to the tibial plateau. Both knees can readily be assessed with the one exposure. In the knee it should be recognised that joint space narrowing does not necessarily equate with articular cartilage loss, as deficiency or displacement of the menisci can also have this effect. Secondary features, such as subchondral bone change and the past surgical history, must also be taken into account.
- **Patello-femoral joint:** Should be assessed in the 'skyline' view, again preferably with the other side for comparison. The x-ray should be taken with 30 degrees of knee flexion to ensure that the patella is load-bearing and has engaged the articular surface femoral groove.

Ankle: The ankle should be assessed in the mortice view, (preferably weight-bearing) with comparison views of the other side, although this is not as necessary as with the hip and knee.

Subtalar: This joint is better assessed by CT (in the coronal plane) than by plain radiography. The complex nature of the joint does not lend itself to accurate and easy plain x-ray assessment of osteoarthritis.

Talonavicular and calcaneocuboid: Anteroposterior and lateral views are necessary. Osteophytes may assist in making the diagnosis.

Intercuneiform and other intertarsal joints: Joint space narrowing may be difficult to assess on plain radiography. CT (in the axial plane) may be required. Associated osteophytes and subarticular cysts are useful adjuncts to making the diagnosis of osteoarthritis in these small joints.

Great toe metatarsophalangeal: Anteroposterior and lateral views are required. Comparison with the other side may be necessary. Secondary signs may be useful.

Interphalangeal: It is difficult to assess small joints without taking secondary signs into account. The plantar–dorsal view may be required to get through the joints, in a foot with flexed toes.

3.25 If arthritis is used as the basis for assessing impairment assessment, then the rating *cannot be combined* with gait disturbance, muscle atrophy, muscle strength or range of movement assessments. It can be combined with a diagnosis-based estimate. (Table 17–2, AMA5, p 526.)

Amputation

3.26 Where there has been amputation of part of a lower extremity Table 17–32 (p 545, AMA5) applies. In that table the references to 3 inches for below-the-knee amputation should be converted to 7.5 cm.

Diagnosis-based estimates (lower extremity)

3.27 Section 17.2j (pp 545–549, AMA5) lists a number of conditions that fit a category of Diagnosis-Based Estimates. They are listed in Tables 17–33, 17–34 and 17–35 (pp 546–549, AMA5). When using this table it is essential to read the footnotes carefully.

3.28 It is possible to *combine* impairments from Tables 17–33, 17–34 and 17–35 for diagnosis-related estimates with other components (eg nerve injury) using the Combined Values Chart (pp 604–606, AMA5) after first referring to the Guide to the Appropriate Combination of Evaluation Methods (see 3.5 above).

3.29 In the interpretation of Table 17–33 (p 547, AMA5), reference to the hindfoot, intra-articular fractures, the words *subtalar bone, talonavicular bone*, and *calcaneocuboid bone* imply that the bone is displaced on one or both sides of the joint mentioned. To avoid the risk of double assessment, if avascular necrosis with collapse is used as the basis of impairment assessment, it cannot be combined with the relevant intra-articular fracture in Table 17–33 column 2. In Table 17–33 column 2, metatarsal fracture with loss of weight transfer means dorsal displacement of the metatarsal head.

3.30 Table 17–34 and Table 17–35 (pp 548–549, AMA5) use a different concept of evaluation. A point score system is applied, and then the total of points calculated for the hip (or knee) joint is converted to an impairment rating from Table 17–33. Tables 17–34 and 17–35 refer to the hip and knee joint replacement respectively. Note that, while all the points are *added* in Table 17–34, some points are *deducted* when Table 17–35 is used.

3.31 In respect of 'distance walked' under 'b. Function' in Table 17–34 (p 548, AMA5), the distance of six blocks should be construed as 600 m, and three blocks as 300 m.

Skin loss (lower extremity)

3.32 Skin loss (p 550, AMA5) can only be included in the calculation of impairment if it is in certain sites and meets the criteria listed in Table 17–36 (p 550, AMA5).

Peripheral nerve injuries (lower extremity)

3.33 When assessing the impairment due to peripheral nerve injury (pp 550–552, AMA5) assessors should read the text in this section. Note that the separate impairments for the motor, sensory and dysaesthetic components of nerve dysfunction in Table 17–37 (p 552, AMA5) are to be *combined.*

3.34 Note that the (posterior) tibial nerve is not included in Table 17–37, but its contribution can be calculated by subtracting ratings of common peroneal nerves from sciatic nerve ratings.

3.35 Peripheral nerve injury impairments can be *combined* with other impairments, but not those for gait derangement, muscle atrophy, muscle strength or complex regional pain syndrome, as shown in Table 17–2 (p 526, AMA5).

Complex regional pain syndrome (lower extremity)

3.36 The Section 17.2m, 'Causalgia and Complex Regional Pain Syndrome (Reflex Sympathetic Dystrophy)' (p 553, AMA5) should not be used. Complex Regional Pain Syndrome involving the lower extremity should be evaluated in the same way as the upper limb using the method described in Section 16.5e (pp 495–497, AMA5). This section provides a detailed method that is in keeping with current terminology and understanding of the condition. Use of the same methods of impairment assessment for Complex Regional Pain Syndrome involving either the upper or lower extremity also will improve the consistency of these *WorkCover Guidelines*.

Peripheral vascular disease (lower extremity)

3.37 Lower extremity impairment due to vascular disorders (pp 553–554, AMA5) is evaluated using Table 17–38 (p 554, AMA5). Note that Table 17–38 gives values for lower extremity not whole person impairment. In that table there is a range of lower extremity impairments within each of the classes 1 to 5. As there is a clinical description of which conditions place a person's lower extremity in a particular class, the assessor has a choice of impairment rating within a class, the value of which is left to the clinical judgement of the assessor.

Table 3.2: Lower extremity worksheet

Item	Impairment	AMA5 Table	AMA5 page	Potential impairment	Selected impairment
1	Limb length discrepancy	17–4	528		
2	Gait derangement	17–5	529		
3	Unilateral muscle atrophy	17–6	530		
4	Muscle weakness	17–8	532		
5	Range of motion	17–9 to 17–14	537		
6	Joint ankylosis	17–15 to 17–30	538–543		
7	Arthritis	17–31	544		
8	Amputation	17–32	545		
9	Diagnosis-based estimates	17–33 to 17–35	546–549		
10	Skin loss	17–36	550		
11	Peripheral nerve deficit	17–37	552		
12	Complex regional pain syndrome	Section 16.5e	495–497		
13	Vascular disorders	17–38	554		
	Combined impairment rating (refer to Table 17–2, p 526, AMA5 for permissible combinations)				

Potential impairment is the impairment percentage for that method of assessment. Selected impairment is the impairment, or impairments selected that can be legitimately combined with other lower extremity impairments to give a final lower extremity impairment rating.

4 The spine (excluding spinal cord injury)

AMA5 Chapter 15 applies to the assessment of permanent impairment of the spine, subject to the modifications set out below.

Introduction

4.1 The spine is discussed in AMA5 Chapter 15 (pp 373–431). That chapter presents two methods of assessment, the diagnosis-related estimates method and the range of motion method. Evaluation of impairment of the spine under WorkCover is to be done using diagnosis-related estimates (DREs).

4.2 The method relies especially on evidence of neurological deficits and less common, adverse structural changes, such as fractures and dislocations. Using this method, DREs are differentiated according to clinical findings that can be verified by standard medical procedures.

4.3 The assessment of spinal impairment is made when the person's condition has stabilised and has reached maximal medical improvement (MMI), as defined in AMA5. If surgery has been performed, the outcome of the surgery as well as structural inclusions must be taken into consideration when making the assessment.

Assessment of the spine

4.4 The assessment should include a comprehensive, accurate history; a review of all pertinent records available at the assessment; a comprehensive description of the individual's current symptoms and their relationship to daily activities; a careful and thorough physical examination; and all findings of relevant laboratory, imaging, diagnostic and ancillary tests available at the assessment. Imaging findings that are used to support the impairment rating should be concordant with symptoms and findings on examination. The assessor should record whether diagnostic tests and radiographs were seen or whether they relied solely on reports.

4.5 The DRE model for assessment of spinal impairment should be used. The Range of Motion model (Sections 15.*8-15*.13 inclusive, AMA5, pp 398-427) should *not* be used.

4.6 If a person has spinal cord damage, he or she is assessed according to the method described in Chapter 5 (the Nervous System) of the *WorkCover Guides* and Chapter 13 (AMA5). This material is repeated in the Spine Chapter of AMA5 (Section 15.7, pp 395-398 – see example 15-17, pp 396-397).

4.7 If an assessor is unable to distinguish between two DRE categories, then the higher of those two categories should apply. The reasons for the inability to differentiate should be noted in the assessor's report.

4.8 Possible influence of future treatment should not form part of the impairment assessment. The assessment should be made on the basis of the person's status at the time of interview and examination, if the assessor is convinced that the condition is stable and permanent. Likewise, the possibility of subsequent deterioration, as a consequence of the underlying condition, should not be factored into the impairment evaluation. Commentary can be made regarding the possible influence, potential or requirements for further treatment, but this does not affect the assessment of the individual at the time of impairment evaluation.

4.9 All spinal impairments are to be expressed as a percentage whole person impairment (%WPI).

4.10 Section 15.1a (AMA5, pp 374–377) is a valuable summary of history and physical examination, and should be thoroughly familiar to all assessors.

4.11 The assessor should include in the report a description of how the impairment rating was calculated, with reference to the relevant tables and/or figures used.

4.12 Assessors should state the method they have used to measure the percentage compression of a vertebral body from relevant X-rays. The loss of vertebral height should be measured at the most compressed part and must be documented in the impairment evaluation report. The estimated normal height of the compressed vertebra should be determined where possible by averaging the heights of the two adjacent (unaffected and normal) vertebra.

Specific interpretation of AMA5

4.13 The range-of-motion (ROM) method is *not* used, hence any reference to this is omitted (including Table 15-7, p 404, AMA5).

4.14 Motion segment integrity alteration can be either *increased* translational or angular motion, or *decreased* motion resulting from developmental changes, fusion, fracture healing, healed infection or surgical arthrodesis. Motion of the individual spine segments cannot be determined by a physical examination, but is evaluated with flexion and extension radiography.

4.15 The assessment of altered motion segment integrity is to be based upon a report of trauma resulting in an injury, and not on developmental or degenerative changes.

4.16 When routine imaging is normal and severe trauma is absent, motion segment disturbance is rare. Thus, flexion and extension imaging is indicated *only* when a history of trauma or other imaging leads the physician to suspect alteration of motion segment integrity. Generally, studies are not to be ordered by the assessor.

DRE definitions of clinical findings

4.17 The clinical findings used to place an individual in a DRE category are described in Box 15–1 (AMA5, pp 382–383).

4.18 In 'Clinical Findings' in Box 15–1 (AMA5, pp 382–383), reference to 'Electrodiagnostic Verification of Radiculopathy' should be disregarded.

(The use of electrodiagnostic procedures such as electromyography is proscribed as an assessment aid for decisions about the category of impairment into which a person should be placed. It is considered that competent assessors can make decisions about which DRE category a person should be placed in from the clinical features alone. The use of electrodiagnostic differentiators is both unnecessary and subject to artefact).

4.19 Cauda equina syndrome and neurogenic bladder disorder are to be assessed by the method prescribed in the nervous system chapter of AMA5 (pp 305–356).

Applying the DRE method

4.20 The specific procedures and directions section of AMA5 (Section 15.2a, pp 380–381) indicates the steps that should be followed to evaluate impairment of the spine (excluding references to the ROM method). Table 4.1 is a simplified version of that section, incorporating the amendments listed above.

Table 4.1: Procedures in evaluating impairment of the spine

History

Physical examination

⇓

Diagnosis

⇓

Use clinical findings to place an individual's condition in a DRE category according to Box 15.1, AMA5 pp 382–383

⇓

Choose the category that determines the percentage impairment:

Lumbar region	**AMA5 Table 15–3, p 384**
Thoracic region	**AMA5 Table 15–4, p 389**
Cervical region	**AMA5 Table 15–5, p 392**

4.21 Common developmental findings, spondylolysis, spondylolisthesis and disc protrusions without radiculopathy occur in 7%, 3%, and up to 30% respectively in individuals up to the age of 40 (AMA5, p383). Their presence does not of itself mean that the individual has an impairment due to injury.

4.22 **Loss of sexual function** should only be assessed as an impairment related to spinal injury where there is other objective evidence of spinal cord, cauda equina or bilateral nerve root dysfunction. The ratings described in Table 13–21 on p 342 of AMA5 are used in this instance. There is no additional impairment rating system for loss of sexual function in the absence of objective clinical findings.

4.23 **Radiculopathy** is the impairment caused by malfunction of a spinal nerve root or nerve roots. Assigning of a DRE for spinal injury includes the presence or absence of radiculopathy (Category III in the lumbo-sacral region). In general, in order to conclude that a radiculopathy is present two or more of the following signs should be found:

- positive root tension sign (some examples are given at p 375, AMA5)
- loss or asymmetry of reflexes
- muscle wasting/atrophy (Box 15-1, p 382, AMA5)
- muscle weakness that is anatomically localised to an appropriate spinal nerve root distribution
- reproducible impairment of sensation that is anatomically localised to an appropriate spinal nerve root distribution
- findings on an imaging study consistent with the clinical signs (AMA5, p 382).

4.24 Note that radicular complaints of pain or sensory features that follow anatomical pathways but cannot be verified by neurological findings (somatic pain, non-verifiable radicular pain) do *not* alone constitute radiculopathy.

4.25 Global weakness of a limb related to pain or inhibition or other factors does not constitute weakness due to spinal nerve malfunction.

4.26 **Multilevel structural compromise** implies spinal fractures and/or dislocations at more than one spinal level, without spinal cord compromise. If there is no radiculopathy, the individual is assigned to DRE category IV; if radiculopathy is present, then the person is assigned to category DRE category V.

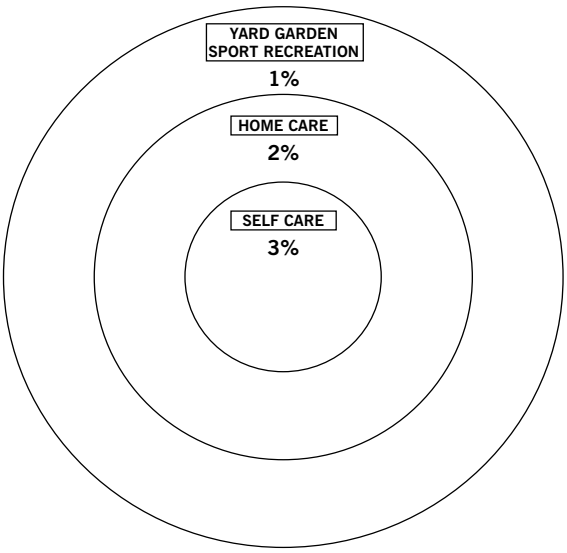
(Multilevel structural compromise is to be interpreted as fractures of more than one vertebra. Such fractures are defined as *any* fracture of the vertebral body, or of the posterior elements forming the ring of the spinal canal. It *does not* include fractures of transverse processes or spinous processes, even at multiple levels).

4.27 Displaced fractures of transverse or spinous processes are assessed as DRE Category II because the fracture does not disrupt the spinal canal (AMA5, p 385) and they do not cause multilevel structural compromise.

4.28 Within a spinal region separate spinal impairments are not combined. The highest value impairment within the region is chosen. Impairments in different spinal regions are combined using the combination tables.

4.29 Impact of ADLs. Tables 15-3, 15-4 and 15-5 of AMA5 give an impairment range for DREs II-V. The bottom of the range is chosen initially, and a percentage of from 0-3% may be added for the impact of the injury on the worker's ADLs. Hence, for example, for an injury which is rated DRE Category II, the impairment is 5%, to which may be added an amount of up to 3% for the impact of the injury on the worker's ADLs.

4.30 The following diagram should be used as a guide to determine whether 0, 1, 2, or 3%WPI should be added to the bottom of the appropriate impairment range.



4.31 The diagram is to be interpreted as follows: if the worker's capacity to undertake activities of daily living has not been impaired, or only minimally impaired, 0% should be added to the base impairment level. If the worker's capacity to undertake tasks related to sport, recreation, gardening, etc, has been impaired, the base impairment should be increased by 1%WPI. If the worker's capacity to undertake household tasks (eg cooking, climbing stairs) has been affected, increase the base impairment by 2%WPI. If the worker's capacity to undertake personal care activities (eg dressing, washing) has been affected, increase the base impairment by 3%WPI.

4.32 The maximum amount that the base impairment due to a spinal injury can be increased due to impact on ADLs is 3% WPI .

4.33 The ADLs reported as being affected by the injury need to be consistent with the clinical evidence and with other reports such as functional assessments, physiotherapy reports, etc.

4.34 **Effect of surgery**: Tables 15–3, 15–4 and 15–5 (AMA5, pp 384, 389 and 392), do not adequately account for the effect of surgery upon the impairment rating for certain disorders of the spine:

- operations where the radiculopathy has resolved are considered under the DRE category III (AMA5, Tables 15–3, 15–4, 15–5)
- operations with surgical ankylosis (fusion) are considered under DRE category IV (AMA5, Tables 15–3, 15–4, 15–5)
- radiculopathy persisting after surgery is not accounted for by AMA5 Table 15-3, and incompletely by Tables 15-4 and 15-5, which only refer to radiculopathy which has improved after surgery.

Therefore, Table 4.2 was developed to rectify this anomaly. Table 4.2 indicates the additional ratings which should be combined with the rating determined using the DRE method where an operation for an intervertebral disc prolapse or spinal canal stenosis has been performed and where there is a residual radiculopathy following surgery.

Example 15-4 (AMA5, p 386) should therefore be ignored.

Table 4.2: Modifiers for DRE categories where radiculopathy persists after surgery

Procedures	Cervical	Thoracic	Lumbar
Discectomy, or single-level decompression with residual signs and symptoms	3%	2%	3%
2nd and further levels, operated on, with medically documented pain and rigidity	*1% each additional level*	*1% each additional level*	*1% each additional level*
Second operation	2%	2%	2%
Third and subsequent operations	1% each	1% each	1% each

In summary, to calculate whole person impairment (WPI) for persisting radiculopathy (as per definition) following surgery:

1. Select the appropriate DRE category from Table 15-3, 15-4, or 15-5.
2. Determine a WPI value within the allowed range in Table 15-3, 15-4 or 15-5 according to the impact on the worker's activities of daily living.
3. Combine this value with the appropriate additional amount from Table 4.2 to determine the final WPI.

4.35 **Disc Replacement Surgery**. The impairment resulting from this procedure is to be equated to that from a spinal fusion.

4.36 Impairment due to **pelvic fractures** should be evaluated with reference to AMA5 Section 15.14 (pp 427–428). Specific ratings for pelvic fractures are provided in Table 15–19 (AMA5, p 428). Impairment due to disorders of the pelvis, other than those due to specific pelvic fractures, should be estimated using the criteria and categories indicated in Table 17–33 (AMA5, p 546).

4.37 **Arthritis:** See sections 3.20–3.23 of Chapter 3 of these WorkCover Guides (p 15).

5 Nervous system

AMA5 Chapter 13 applies to the assessment of permanent impairment of the nervous system, subject to the modifications set out below.

Introduction

5.1 AMA5 Chapter 13, The Central and Peripheral Nervous System (pp 305–356), provides guidelines on methods of assessing permanent impairment involving the central nervous system. It is logically structured and consistent with the usual sequence of examination of the nervous system. Cerebral functions are discussed first, followed by the cranial nerves, station, gait and movement disorders, the upper extremities related to central impairment, the brain stem, the spinal cord and the peripheral nervous system, including neuromuscular junction and muscular system. A summary concludes the chapter.

5.2 Spinal cord injuries are to be assessed using AMA5 Chapter 13.

5.3 The relevant parts of the upper extremity, lower extremity and spine sections of AMA5 Chapter 13 should be used to evaluate impairments of the peripheral nervous system.

The approach to assessment of permanent neurological impairment

5.4 AMA5 Chapter 13 disallows combination of cerebral impairments. However, for the purpose of the *WorkCover Guides,* cerebral impairments should be evaluated and *combined* as follows:

- consciousness and awareness
- mental status, cognition and highest integrative function
- aphasia and communication disorders
- emotional and behavioural impairments.

The Assessor should take care to be as specific as possible and not to double-rate the same impairment, particularly in the mental status and behavioural categories.

These impairments are to be combined using the Combined Values Chart (AMA5, pp 604–606). These impairments should then be combined with other neurological impairments indicated in AMA5 Table 13–1 (p 308).

5.5 Impairments due to spinal cord pathology (AMA5, pp 340–342) are to be combined using the Combined Values Chart (AMA5, pp 604–606). It should be noted that AMA5 Sections 13.5 and 13.6 (pp 336–340) should be used for *all* motor or sensory impairments caused by a central nervous system lesion**.** Thus this section covers hemiplegia due to cortical injury as well as spinal cord injury.

5.6 Complex regional pain syndrome is to be assessed using the method indicated in AMA5 Chapter 16, The Upper Extremities (pp 495–497).

5.7 The nervous system Chapter of AMA5 (Chapter 13) lists many impairments where the range for the associated whole person impairment is 0–9% or 0–14%. Where there is a range of impairment percentages listed, the assessor should nominate an impairment percentage based on the complete clinical circumstances revealed during the consultation and in relation to all other available information.

Specific interpretation of AMA5

5.8 In assessing **disturbances of mental status and integrative functioning, and emotional or behavioural disturbances** (Sections 13.3d and 13.3f, AMA5 pp 319–322, 325– 327), the assessor should make ratings of mental status impairments and emotional and behavioural impairments based on clinical assessment and the results of neuropsychometric testing. Clinical assessment should indicate at least one of the following:

- significant medically verified abnormalities in initial post injury Glasgow Coma Scale score, or
- significant duration of post traumatic amnesia, or
- significant intracranial pathology on CT scan or MRI.

Neuropsychological testing should be conducted by a registered clinical neuropsychologist who is a member, or is eligible for membership, of the Australian Psychological Society's College of Neuropsychology.

5.9 Assessment of **arousal and sleep disorders** (AMA5 Section 13.3c, pp 317–319): refers to assessment of primary sleep disorders following neurological injury. The assessor should make ratings of arousal and sleep disorders based on the clinical assessment that would normally have been done for clinically significant disorders of this type (ie, sleep studies or similar tests).

5.10 **Olfaction and taste**: the assessor should use AMA5 Chapter 11, Section 11.4c (p 262) and Table 11–10 (pp 272–275) to assess olfaction and taste, for which a maximum of 5% whole person impairment is allowable for total loss of either sense.

5.11 **Visual impairment** assessment (AMA4 Chapter 8, pp 209–222): An ophthalmologist should assess all impairments of visual acuity, visual fields, extra-ocular movements or diplopia.

5.12 **Trigeminal nerve** assessment (AMA5, p 331): Sensory impairments of the trigeminal nerve should be assessed with reference to AMA5 Table 13–11 (p 331)**.** The words 'sensory loss or dysaesthesia' should be added to the table after the words 'neuralgic pain' in each instance. Impairment percentages for the three divisions of the trigeminal nerve should be apportioned with extra weighting for the first division. If present, motor loss for the trigeminal nerve should be assessed in terms of its impact on mastication and deglutition (AMA5, p 262).

5.13 **Spinal accessory nerve**: AMA5 provides insufficient reference to the spinal accessory nerve (cranial nerve XI). This nerve supplies the trapezius and sternomastoid muscles. For loss of use of the nerve to trapezius, the assessor should refer to AMA5 Chapter 16 on upper limb assessment, and a maximum of 10% impairment of the upper limb may be assigned. For additional loss of use of sternomastoid, a maximum of 3% upper limb impairment may be added.

5.14 Assessment of **sexual functioning** (AMA5, Chapter 7, pp 143–171): Impotence should only be assessed as an impairment where there is objective evidence of spinal cord, cauda equina, or bilateral nerve root dysfunction, or lumbo-sacal plexopathy. There is no additional impairment rating for impotence in the absence of ojective clinical findings.

6 Ear, nose, throat and related structures

AMA5 Chapter 11 applies to the assessment of permanent impairment of the ear (with the exception of hearing impairment), nose, throat and related structures, subject to the modifications set out below.

Introduction

6.1 AMA5 Chapter 11 (pp 245–275) details the assessment of the ear, nose, throat and related structures. **With the exception of hearing impairment, which is dealt with in Chapter 9 of the *WorkCover Guides***, AMA5 Chapter 11 should be followed in assessing permanent impairment, with the variations included below.

6.2 The level of impairment arising from conditions that are not work related needs to be assessed by the medical assessor and taken into consideration in determining the level of permanent impairment. The level at which pre-existing conditions and lifestyle activities such as smoking contribute to the level of permanent impairment requires judgement on the part of the clinician undertaking the impairment assessment. The manner in which any deduction for these is applied needs to be recorded in the assessing specialist's report.

The ear

6.3 **Equilibrium** is assessed according to AMA 5 Section 11.2b (pp 252–255), but add these words to AMA5 Table 11–4 (p 253), Class 2:

'. . . without limiting the generality of the above, a positive Hallpikes test is a sign and an objective finding.'

The face (AMA5, pp255–259)

6.4 AMA5 Table 11–5 (p 256) should be replaced with Table 6.1, below, when assessing permanent impairment due to facial disorders and/or disfigurement.

Table 6.1: Criteria for rating permanent impairment due to facial disorders and/or disfigurement

Class 1 0%–5% impairment of the whole person	Class 2 6%–10% impairment of the whole person	Class 3 11%–15% impairment of the whole person	Class 4 16%–50% impairment of the whole person
Facial abnormality limited to disorder of cutaneous structures, such as visible simple scars (not hypertrophic or atrophic) or abnormal pigmentation (refer to AMA5 Chapter 8 for skin disorders) or mild, unilateral, facial paralysis affecting most branches or nasal distortion that affects physical appearance or partial loss or deformity of the outer ear.	Facial abnormality involves loss of supporting structure of part of face, without cutaneous disorder (eg depressed cheek, nasal, or frontal bones) or near complete loss of definition of the outer ear.	Facial abnormality involves absence of normal anatomic part or area of face, such as loss of eye or loss of part of nose, with resulting cosmetic deformity, combine with any functional loss, eg vision (AMA5 Chapter 12) or severe unilateral facial paralysis affecting most branches or mild, bilateral, facial paralysis affecting most branches.	Massive or total distortion of normal facial anatomy with disfigurement so severe that it precludes social acceptance, or severe, bilateral, facial paralysis affecting most branches or loss of a major portion of/or entire nose.

Note: Tables used to classify the examples in AMA5 Section 11.3 (pp 256–259) should also be ignored and assessors should refer to the modified table above for classification.

6.5 AMA5 Example 11–11 (p 257): Add 'Visual impairment related to **enophthalmos** must be assessed by an Ophthalmologist'.

The nose, throat and related structures

Respiration (AMA5 Section 11.4a, pp259–261)

6.6 In regard to sleep apnoea (3rd paragraph, AMA5 Section 11.4a, p 259): a sleep study and an examination by an ear, nose and throat specialist is mandatory before assessment by an approved assessor.

6.7 The assessment of sleep apnoea is addressed in AMA5 Section 5.6 (p 105) and assessors should refer to this Chapter, as well as sections 8.8–8.10 (pp 38-39) in these *WorkCover Guides*.

6.8 **AMA5 Table 11–6 criteria for rating impairment due to air passage defects** (AMA5, p 260): this table should be replaced with Table 6.2, below, when assessing permanent impairment due to air passage defects.

Table 6.2: criteria for rating permanent impairment due to air passage defects

Percentage impairment of the whole person					
Class 1a 0%–5%	**Class 1 0%–10%**	**Class 2 11%–29%**	**Class 3 30%–49%**	**Class 4 50%–89%**	**Class 5 90%+**
There are symptoms of significant difficulty in breathing through the nose. Examination reveals significant partial obstruction of the right and/or left nasal cavity or nasopharynx or significant septal perforation.	Dyspnea does not occur at rest and dyspnea is not produced by walking freely on a level surface, climbing stairs freely, or performance of other usual activities of daily living and dyspnea is not produced by stress, prolonged exertion, hurrying, hill-climbing, or recreational or similar activities requiring intensive effort* and examination reveals partial obstruction of the oropharynx, laryngopharynx, larynx, upper trachea (to the fourth cartilaginous ring), lower trachea, bronchi, or complete (bilateral) obstruction of the nose or nasopharynx.	Dyspnea does not occur at rest and dyspnea is not produced by walking freely on a level surface, climbing one flight of stairs, or performance of other usual activities of daily living but dyspnea is produced by stress, prolonged exertion, hurrying, hill-climbing, or recreational or similar activities (except sedentary forms) and examination reveals partial obstruction of the oropharynx, laryngopharynx, larynx, upper trachea (to the fourth cartilaginous ring), lower trachea, bronchi, or complete (bilateral) obstruction of the nose or nasopharynx.	Dyspnea does not occur at rest and dyspnea is produced by walking freely more than one or two level blocks, climbing one flight of stairs even with periods of rest, or performance of other usual activities of daily living and dyspnea is produced by stress, prolonged exertion, hurrying, hill-climbing, or recreational or similar activities and examination reveals partial obstruction of the oropharynx, laryngopharynx, larynx, upper trachea (to the fourth cartilaginous ring), lower trachea or bronchi.	Dyspnea occurs at rest, although individual is not necessarily bedridden and dyspnea is aggravated by the performance of any of the usual activities of daily living (beyond personal cleansing, dressing or grooming) and examination reveals partial obstruction of the oropharynx, laryngopharynx, larynx, upper trachea (to the fourth cartilaginous ring), lower trachea, and/or bronchi.	Severe dyspnea occurs at rest and spontaneous respiration is inadequate and respiratory ventilation is required and examination reveals partial obstruction of the oropharynx, laryngopharynx, larynx, upper trachea (to the fourth cartilaginous ring), lower trachea or bronchi.

*Prophylactic restriction of activity, such as strenuous competitive sport, does not exclude subject from class 1.

Note: Individuals with successful permanent tracheostomy or stoma should be rated at 25% impairment of the whole person. AMA5 Example 11–16 (p 261): Partial obstruction of the larynx affecting only one vocal cord is better linked to voice (AMA5 Section 11.4e).

6.9 When using AMA5 Table 11–7, Relationship of Dietary Restrictions to Permanent Impairment (p 262), consider % impairment of the whole person — first category to be 0–19%, not 5%–19%.

Speech (AMA5, pp262–264)

6.10 Regarding the first sentence of the 'Examining procedure' subsection (pp 263–264): the examiner should have sufficient hearing for the purpose — disregard 'normal hearing as defined in the earlier section of this Chapter on hearing.'

6.11 Examining procedure (pp 263–264), second paragraph: 'The examiner should base judgements of impairment on two kinds of evidence: (1) attention to and observation of the individual's speech in the office — for example, during conversation, during the interview, and while reading and counting aloud — and (2) reports pertaining to the individual's performance in everyday living situations.' Disregard the next sentence: 'The reports or the evidence should be supplied by reliable observers who know the person well.'

6.12 Examining procedure (pp 263–264): where the word 'American' appears as a reference, substitute 'Australian', and change measurements to the metric system (eg 8.5 inch = 22 cm).

The voice (AMA5 Section 11.4e, pp264–267)

6.13 Substitute the word 'laryngopharyngeal' for 'gastroesophageal' in all examples where it appears.

6.14 Example 11.25 (Impairment Rating, p 269), second sentence: add the underlined phrase 'Combine with appropriate ratings due to other impairments *including respiratory impairment* to determine whole person impairment.'

Ear, nose, throat and related structures impairment evaluation summary

6.15 AMA5 Table 11–10 (pp 272–275): Disregard this table, except for impairment of olfaction and/or taste, and hearing impairment as determined in the *WorkCover Guides*.

7 Urinary and reproductive systems

AMA5 Chapter 7 applies to the assessment of permanent impairment of the urinary and reproductive systems, subject to the modifications set out below.

Introduction

7.1 AMA5 Chapter 7 (pp 143–171) provides clear details for assessment of the urinary and reproductive systems. Overall, the chapter should be followed in assessing permanent impairment, with the variations included below.

7.2 For both male and female sexual dysfunction, identifiable pathology should be present for an impairment percentage to be given.

Urinary diversion

7.3 AMA5 Table 7–2 (p 150) should be replaced with Table 7.1, below, when assessing permanent impairment due to urinary diversion disorders. This table includes ratings for neobladder and continent urinary diversion.

7.4 **Continent urinary diversion** is defined as a continent urinary reservoir constructed of small or large bowel with a narrow catheterisable cutaneous stoma through which it must be emptied several times a day.

Table 7.1: Criteria for rating permanent impairment due to urinary diversion disorders

Diversion type	% Impairment of the whole person
Ureterointestinal	10%
Cutaneous ureterostomy	10%
Nephrostomy	15%
Neobladder/replacement cystoplasty	15%
Continent urinary diversion	20%

Bladder

7.5 AMA5 Table 7–3 (p 151) should be replaced with Table 7.2, below, when assessing permanent impairment due to bladder disease. This table includes ratings involving urge and total incontinence (defined in paragraph 7.80).

Table 7.2: Criteria for rating permanent impairment due to bladder disease

Class 1 0%–15% impairment of the whole person	Class 2 16%–40% impairment of the whole person	Class 3 41%–70% impairment of the whole person
Symptoms and signs of bladder disorder and requires intermittent treatment and normal functioning between malfunctioning episodes.	Symptoms and signs of bladder disorder eg urinary frequency (urinating more than every two hours); severe nocturia (urinating more than three times a night); urge incontinence more than once a week and requires continuous treatment.	Abnormal (ie under- or over-) reflex activity (eg intermittent urine dribbling, loss of control, urinary urgency and urge incontinence once or more each day) and/or no voluntary control of micturition; reflex or areflexic bladder on urodynamics and/or total incontinence eg fistula.

7.6 AMA 5 Example 7–16 (p151) should be reclassified as an example of Class 2, as the urinary frequency is more than every two hours and continuous treatment would be expected.

Urethra

7.7 AMA5 Table 7–4 (p 153) should be replaced with Table 7.3, below, when assessing permanent impairment due to urethral disease. This table includes ratings involving stress incontinence

Table 7.3: Criteria for rating permanent impairment due to urethral disease

Class 1 0%–10% impairment of the whole person	Class 2 11%–20% impairment of the whole person	Class 3 21%–40% impairment of the whole person
Symptoms and signs of urethral disorder and requires intermittent therapy for control.	Symptoms and signs of urethral disorder; stress urinary incontinence more than three times a week and cannot effectively be controlled by treatment.	Urethral dysfunction resulting in intermittent urine dribbling, or stress urinary incontinence at least daily.

Urinary incontinence

7.8 **Urge urinary incontinence** is the involuntary loss of urine associated with a strong desire to void. **Stress urinary incontinence** is the involuntary loss of urine occurring with clinically demonstrable raised intra-abdominal pressure. It is expected that urinary incontinence of a regular or severe nature (necessitating the use of protective pads or appliances) will be assessed as follows:

Stress urinary incontinence (demonstrable clinically):	11–25% according to severity
Urge urinary incontinence:	16–40% according to severity
Mixed (urge and stress) incontinence:	16–40% according to severity
Nocturnal enuresis or wet in bed:	16–40% according to severity
Total incontinence (continuously wet, eg from fistula):	50–70%

The highest scoring condition is to be used to assess impairment — combinations are not allowed.

Male reproductive organs

Penis

7.9 AMA5, p 157: the box labelled 'Class 3, 21–35%' should read 'Class 3, 20% Impairment of the Whole Person' as the descriptor 'No sexual function possible' does not allow a range. (The correct value is shown in Table 7–5). Note, however, that there is a loading for age, so a rate higher than 20% is possible.

Testicles, epididymides and spermatic cords

7.10 AMA5 Table 7–7 (p 159) should be replaced with Table 7.4, when assessing permanent impairment due to testicular, epididymal and spermatic cord disease. This table includes rating for infertility and equates impairment with female infertility (see Table 7.5, in this Chapter of the *WorkCover Guides*). Infertility in either sex must be considered to be of equal impact, age for age.

7.11 **Male infertility** is defined as azoospermia or other cause of inability to cause impregnation even with assisted contraception techniques.

7.12 Loss of sexual function **related to spinal injury** should only be assessed as an impairment where there is other objective evidence of spinal cord, cauda equina or bilateral nerve root dysfunction. The ratings described in Table 13–21 on p 342 of AMA5 are used in this instance. There is no additional impairment rating system for loss of sexual function in the absence of objective clinical findings.

Table 7.4: Criteria for rating permanent impairment due to testicular, epididymal and spermatic cord disease

Class 1 0%–10% impairment of the whole person	Class 2 11%–15% impairment of the whole person	Class 3 16%–35% impairment of the whole person
Testicular, epididymal or spermatic cord disease symptoms and signs and anatomic alteration and no continuous treatment required and no seminal or hormonal function or abnormalities or solitary testicle.	Testicular, epididymal or spermatic cord disease symptoms and signs and anatomic alteration and cannot effectively be controlled by treatment and detectable seminal or hormonal abnormalities.	Trauma or disease produces bilateral anatomic loss of the primary sex organs or no detectable seminal or hormonal function or infertility.

Female reproductive organs

Fallopian tubes and ovaries

7.13 AMA5 Table 7–11 (p 167) should be replaced with Table 7.5, below, when assessing permanent impairment due to fallopian tube and ovarian disease. This table includes rating for infertility and equates impairment with male infertility (see Table 7.4, above). Infertility in either sex must be considered to be of equal impact, age for age.

7.14 **Female infertility**: a woman in the childbearing age is infertile when she is unable to conceive naturally. This may be due to anovulation, tubal blockage, cervical or vaginal blocking or an impairment of the uterus.

Table 7.5: Criteria for rating permanent impairment due to fallopian tube and ovarian disease

Class 1 0%–15% impairment of the whole person	Class 2 16%–25% impairment of the whole person	Class 3 26%–35% impairment of the whole person
Fallopian tube or ovarian disease or deformity symptoms and signs do not require continuous treatment or only one functioning fallopian tube or ovary in the premenopausal period or bilateral fallopian tube or ovarian functional loss in the postmenopausal period.	Fallopian tube or ovarian disease or deformity symptoms and signs require continuous treatment, but tubal patency persists and ovulation is possible.	Fallopian tube or ovarian disease or deformity symptoms and signs and total tubal patency loss or failure to produce ova in the premenopausal period or bilateral fallopian tube or bilateral ovarian loss in the premenopausal period; infertility.

8 Respiratory system

AMA5 Chapter 5 applies to the assessment of permanent impairment of the respiratory system, subject to the modifications set out below.

Introduction

8.1 AMA5 Chapter 5 provides a useful summary of the methods for assessing permanent impairment arising from respiratory disorders.

8.2 The level of impairment arising from conditions that are not work related needs to be assessed by the medical assessor and taken into consideration in determining the level of permanent impairment. The level at which pre-existing conditions and lifestyle activities such as smoking contribute to the level of permanent impairment requires judgement on the part of the clinician undertaking the impairment assessment. The manner in which any deduction for these is applied needs to be recorded in the assessing specialist's report.

Examinations, clinical studies and other tests for evaluating respiratory disease (AMA5 Section 5.4)

8.3 AMA5 Tables 5–2b, 5–3b, 5–4b, 5–5b, 5–6b and 5–7b give the lower limits of normal values for pulmonary function tests. These are used in Table 5–12 to determine the impairment classification for respiratory disorders.

8.4 Classes 2, 3 and 4 in Table 5–12 list ranges of whole person impairment. The assessor should nominate the nearest whole percentage based on the complete clinical circumstances when selecting within the range.

Asthma (AMA5 Section 5.5)

8.5 In assessing permanent impairment arising from occupational asthma, the assessor will require evidence from the treating physician that:

- at least three lung function tests have been performed over a six month period and that the results were consistent and repeatable over that period
- the worker has received maximal treatment and is compliant with his/her medication regimen.

8.6 Bronchial challenge testing should not be performed as part of the impairment assessment, therefore in AMA5 Table 5–9 (p 104) ignore column four (PC_{20} mg/mL or equivalent, etc).

8.7 Permanent impairment due to asthma is rated by the score for the best post-bronchodilator forced expiratory volume in one second (FEV_1) (score in column two, AMA5 Table 5–9) plus percent of FEV_1 (score in column 3) plus minimum medication required (score in column 5). The total score derived is then used to assess the percent impairment in AMA5 Table 5–10 (p 104).

Obstructive sleep apnoea (AMA5 Section 5.6)

8.8 This section needs to be read in conjunction with AMA5 Section 11.4 (p 259) and Section 13.3c (p 317).

8.9 Before permanent impairment can be assessed, the person must have appropriate assessment and treatment by an ear, nose and throat surgeon and a respiratory physician who specialises in sleep disorders.

8.10 Degree of permanent impairment due to sleep apnoea should be calculated with reference to AMA5 Table 13–4 (p 317).

Hypersensitivity pneumonitis (AMA5 Section 5.7)

8.11 Permanent impairment arising from disorders included in this section are assessed according to the impairment classification in AMA5 Table 5–12.

Pneumoconiosis (AMA5 Section 5.8)

8.12 This section is excluded from the *WorkCover Guides,* as these impairments are the subject of the Dust Diseases Legislation.

Lung cancer (AMA5 Section 5.9)

8.13 Permanent impairment due to lung cancer should be assessed at least six months after surgery. Table 5–12 (not Table 5–11) should be used for assessment of permanent impairment.

8.14 Persons with residual lung cancer after treatment are classified in Respiratory Impairment Class 4 (Table 5–12).

Permanent impairment due to respiratory disorders (AMA5 Section 5.10)

8.15 Table 5–12 (AMA5, p 107) should be used to assess permanent impairment for respiratory disorders. The pulmonary function tests listed in Table 5–12 must be performed under standard conditions. Exercise testing is not required on a routine basis.

8.16 An isolated abnormal diffusing capacity for carbon monoxide (D_{CO}) in the presence of otherwise normal results of lung function testing should be interpreted with caution and its aetiology should be clarified.

9 Hearing

AMA5 Chapter 11 applies to the assessment of permanent impairment of hearing, subject to the modifications set out below.

Assessment of hearing impairment (hearing loss)

9.1 A worker may present for assessment of hearing loss for compensation purposes before having undergone all or any of the health investigations that generally occur before assessment of permanent impairment. For this reason and to ensure that conditions other than 'occupational hearing impairment' are precluded, the medical assessment should be undertaken by an ear, nose and throat specialist or other appropriately qualified medical specialist. The medical assessment needs to be undertaken in accordance with the hearing impairment section of AMA5 Table 11–10 (pp 272–275). The medical specialist performing the assessment must examine the worker. The medical specialist's assessment must be based on medical history and ear, nose and throat examination, evaluation of relevant audiological tests and evaluation of other relevant investigations available to the medical assessor. Only medical specialists can sign medical reports.

9.2 Disregard AMA5 Sections 11.1b and 11.2 (pp 246-255), but retain Section 11.1a (Interpretation of Symptoms and Signs, p 246).

9.3 Some of the relevant tests are discussed in the AMA5 Hearing Impairment Evaluation Summary Table 11–10 (pp 272–275). The relevant row for these guides is the one headed 'Hearing impairment' with the exception of the last column headed 'Degree of impairment'. The degree of impairment is determined according to this *WorkCover Guide*.

9.4 The level of hearing impairment caused by non-work-related conditions is assessed by the medical specialist and considered when determining the level of work-related hearing impairment. While this requires medical judgement on the part of the examining medical specialist, any non-work-related deductions should be recorded in the report.

9.5 Disregard AMA5 Tables 11–1, 11–2, 11–3 (pp 247–250). For the purposes of the *WorkCover Guides*, National Acoustic Laboratory (NAL) Tables from the NAL Report No. 118, 'Improved Procedure for Determining Percentage Loss of Hearing' (January 1988) are adopted as follows:

- Tables RB 500–4000 (pp 11–16)
- Tables RM 500–4000 (pp 18–23)
- Appendix 1 and 2 (pp 8–9)
- Appendix 5 and 6 (pp 24–26)
- Tables EB 4000–8000 (pp 28–30)
- Table EM 4000–8000 (pp 32–34).

In the presence of significant conduction hearing loss, the extension tables do not apply.

AMA5 Table 11–3 is replaced by Table 9.1 at the end of this chapter.

Hearing impairment

9.6 Impairment of a worker's hearing is determined according to evaluation of the individual's binaural hearing impairment.

9.7 *Permanent hearing impairment* should be evaluated when the condition is stable. Prosthetic devices (that is, hearing aids) must not be worn during the evaluation of hearing sensitivity.

9.8 *Hearing threshold level for pure tones* is defined as the number of decibels above standard audiometric zero for a given frequency at which the listener's threshold of hearing lies when tested in a suitable sound attenuated environment. It is the reading on the hearing level dial of an audiometer that is calibrated according to Australian Standard AS 2586–1983.

9.9 *Evaluation of binaural hearing impairment*: Binaural hearing impairment is determined by using the tables in the 1988 NAL publication with allowance for presbycusis according to the presbycusis correction table, if applicable, in the same publication.

The Binaural Tables RB 500–4000 (NAL publication, pp 11–16) are to be used, except when it is not possible or would be unreasonable to do so. For the purposes of calculating binaural hearing impairment, the better and worse ear may vary as between frequencies.

Where it is necessary to use the monaural tables, the binaural hearing impairment (BHI) is determined by the formula:

$$\text{BHI} = \frac{[4 \times (\text{better ear hearing loss})] + \text{worse ear hearing loss}}{5}$$

9.10 *Presbycusis correction* (NAL publication, p 24) only applies to occupational hearing loss contracted by gradual process — for example, occupational noise induced hearing loss and/or occupational solvent induced hearing loss.

9.11 *Binaural hearing impairment and severe tinnitus:* Up to 5% may be added to the work-related binaural hearing impairment for severe tinnitus caused by a work-related injury:

- after presbycusis correction, if applicable, and
- before determining whole person impairment.

Assessment of severe tinnitus is based on a medical specialist's assessment.

9.12 *Only hearing ear*: A worker has an 'only hearing ear' if he or she has suffered a non-work-related severe or profound sensorineural hearing loss in the other ear. If a worker suffers a work-related injury causing a hearing loss in the only hearing ear of *x* dBHL at a relevant frequency, the worker's work-related binaural hearing impairment at that frequency is calculated from the binaural tables using *x* dB as the hearing threshold level in both ears. Deduction for presbycusis if applicable and addition for severe tinnitus is undertaken according to this guide.

9.13 When necessary, binaural hearing impairment figures should be rounded to the nearest 0.1%. Rounding up should occur if equal to or greater than .05%, and rounding down should occur if equal to or less than .04%.

9.14 Table 9.1 is used to convert binaural hearing impairment, after deduction for presbycusis if applicable and after addition for severe tinnitus, to whole person impairment.

9.15 The method of subtracting a previous impairment for noise induced hearing loss is as shown in the following example:

- The current level of binaural hearing impairment is established by the relevant specialist.
- Convert this to Whole Person Impairment from Table 9.1 in the WorkCover Guides.
- Calculate the proportion of the current binaural hearing impairment that was accounted for by the earlier assessment and express it as a percentage of the current hearing impairment.
- The percentage of current hearing impairment that remains is the amount to be compensated.
- This needs to be expressed in terms of Whole Person Impairment for calculation of compensation entitlement.

Example:

- The current binaural hearing loss is 8%.
- % Whole Person Impairment is 4%.
- The binaural hearing impairment for which compensation was paid previously is 6% which is 75% of the current hearing impairment of 8%.
- The remaining percentage, 25%, is the percentage of Whole Person Impairment to be compensated.
- 25% of the Whole Person Impairment of 4% is 1%.

The worker is compensated an additional 1% Whole Person Impairment.

Table 9.1: Relationship of binaural hearing impairment to whole person impairment

% Binaural hearing impairment	% Whole person impairment	% Binaural hearing impairment	% Whole person impairment
0.0 – 5.9	0	51.1 – 53.0	26
		53.1 – 55.0	27
6.0 – 6.7	3	55.1 – 57.0	28
6.8 – 8.7	4	57.1 – 59.0	29
8.8 – 10.6	5	59.1 – 61.0	30
10.7 – 12.5	6	61.1 – 63.0	31
12.6 – 14.4	7	63.1 – 65.0	32
14.5 – 16.3	8	65.1 – 67.0	33
16.4 – 18.3	9	67.1 – 69.0	34
18.4 – 20.4	10	69.1 – 71.0	35
20.5 – 22.7	11	71.1 – 73.0	36
22.8 – 25.0	12	73.1 – 75.0	37
25.1 – 27.0	13	75.1 – 77.0	38
27.1 – 29.0	14	77.1 – 79.0	39
29.1 – 31.0	15	79.1 – 81.0	40
31.1 – 33.0	16	81.1 – 83.0	41
33.1 – 35.0	17	83.1 – 85.0	42
35.1 – 37.0	18	85.1 – 87.0	43
37.1 – 39.0	19	87.1 – 89.0	44
39.1 – 41.0	20	89.1 – 91.0	45
41.1 – 43.0	21	91.1 – 93.0	46
43.1 – 45.0	22	93.1 – 95.0	47
45.1 – 47.0	23	95.1 – 97.0	48
47.1 – 49.0	24	97.1 – 99.0	49
49.1 – 51.0	25	99.1 – 100	50

9.16 AMA5 Examples 11.1,11.2, 11.3 (pp 250–251) are replaced by *WorkCover* Examples 9.1-9.7, below, which were developed by the Working Party.

Table 9.2: Medical assessment elements in examples

Element	Example No.
General use of binaural table — NAL 1988	1,2
'Better ear'–'worse ear' crossover	1,2
Assessable audiometric frequencies	7 — also 1,2,4,5,6
Tinnitus	1,2,3,4
Presbycusis	All examples
Binaural hearing impairment	All examples
Conversion to whole person impairment	All examples
Gradual process injury	3
Noise-induced hearing loss	1,2,3,5,6,7
Solvent-induced hearing loss	3
Acute occupational hearing loss	4,5
Acute acoustic trauma	5
Pre-existing non-occupational hearing loss	6
Only hearing ear	6
NAL 1988 Extension Table Use	7
Multiple Causes of Hearing Loss	3,5,6
Head injury	4

Example 9.1: Occupational noise-induced hearing loss and severe tinnitus

A 60 year old man, a boilermaker for 30 years, gave a history of progressive hearing loss and tinnitus. The assessing medical specialist has assessed the tinnitus as severe. The external auditory canals and tympanic membranes were normal. Rinne test was positive bilaterally and the Weber test result was central. Clinical assessment of hearing was consistent with results of pure tone audiometry, which showed a bilateral sensorineural hearing loss. The medical specialist diagnosed noise induced hearing loss.

Pure tone audiometry

Frequency (Hz)	Left (dB HL)	Right (dB HL)	Binaural hearing impairment (%BHI)
500	15	10	0
1000	15	15	0
1500	15	20	0.4
2000	25	30	1.5
3000	50	45	4.2
4000	65	70	6.8
6000	30	30	–
8000	20	20	–
Total %BHI			12.9
Less Presbycusis correction of 0.8			12.1
Add 3.0% for severe tinnitus			15.1
Adjusted total %BHI			15.1
Resultant total BHI of 15.1% = 8% whole person impairment (Table 9.1)			

Example 9.2: Occupational noise-induced hearing loss and mild tinnitus

A 55 year old man, a steelworker for 30 years, gave a history of increasing difficulties with hearing and tinnitus. The assessing medical specialist diagnosed occupational noise-induced hearing loss with mild tinnitus.

Pure tone audiometry

Frequency (Hz)	Left (dB HL)	Right (dB HL)	Binaural hearing impairment (%BHI)
500	15	15	0.0
1000	15	15	0.0
1500	20	25	1.0
2000	30	35	2.5
3000	50	45	4.2
4000	55	55	5.2
6000	30	30	–
8000	20	20	–
Total %BHI			12.9
No presbycusis correction			12.9
Adjusted total %BHI			12.9
Resultant total BHI of 12.9% = 7% whole person impairment (Table 9.1)			

Comment

The assessing medical specialist's opinion is that the tinnitus suffered by the worker is not severe and thus no addition to the binaural hearing impairment was made for tinnitus.

Example 9.3: Multiple gradual process occupational hearing loss

A 63 year old male boat builder and printer gave a history of hearing difficulty and tinnitus. There had been marked chronic exposure to noise and solvents in both occupations for 35 years altogether. The assessing medical specialist diagnosed bilateral noise-induced hearing loss and bilateral solvent-induced hearing loss with severe tinnitus.

The assessing medical specialist's opinion is that the solvent exposure contributed to the hearing impairment as a gradual process injury. The total noise-induced and solvent-induced BHI was 17.5%.

The appropriate presbycusis deduction was applied. Then, the assessing medical specialist added 2% to the after-presbycusis binaural hearing impairment for severe tinnitus.

Pure tone audiometry

Frequency (Hz)	Left (dB HL)	Right (dB HL)	Binaural hearing impairment (%BHI)
500	15	15	0.0
1000	15	15	0.0
1500	25	25	1.4
2000	35	40	3.8
3000	60	60	6.3
4000	60	60	6.0
6000	45	50	–
8000	40	40	–
Total noise-induced and solvent-induced BHI (%)			17.5
Presbycusis correction of 1.7%			15.8
2% addition for medically assessed severe tinnitus			17.8
Adjusted Total BHI			17.8
Resultant total BHI of 17.8% = 9% whole person impairment (Table 9.1)			

Example 9.4: Occupational hearing loss from head injury

A 62 year old male worker sustained a head injury after falling from a ladder. He suffered left hearing loss and tinnitus unaccompanied by vertigo. The assessing medical specialist assesses his tinnitus as severe. External auditory canals and tympanic membranes are normal. Rinne test is positive bilaterally and Weber test lateralises to the right. CT scan of the temporal bones shows a fracture on the left. Clinical assessment of hearing is consistent with pure tone audiometry, which shows a flat left sensorineural hearing loss and mild right sensorineural hearing loss.

Pure tone audiometry

Frequency (Hz)	Left (dB HL)	Right (dB HL)	Binaural hearing impairment (%BHI)
500	45	15	2.0
1000	50	15	2.8
1500	55	10	2.5
2000	50	15	1.7
3000	60	20	1.7
4000	60	25	1.5
6000	60	15	–
8000	60	20	–
Total %BHI			12.2
No correction for presbycusis applies			–
Add 4.0% for severe tinnitus			16.2
Adjusted total BHI			16.2
Resultant total BHI of 16.2% = 8% whole person impairment (Table 9.1)			

Example 9.5: Occupational noise-induced hearing loss with acute occupational hearing loss

A 65 year old production worker for 10 years was injured in an explosion at work. He reported immediate post-injury otalgia and acute hearing loss in the left ear. The assessing medical specialist diagnosed occupational noise-induced hearing loss and left acute acoustic trauma. The assessing medical specialist had no medical evidence that, immediately before the explosion, the hearing in the left ear was significantly different from that in the right ear.

Pure tone audiometry

Frequency (Hz)	Left (dB HL)	Right (dB HL)	Binaural hearing impairment (%BHI)	BHI due to noise-induced hearing loss
500	30	15	1.0	0.0
1000	45	15	2.5	0.0
1500	55	15	2.5	0.0
2000	70	15	2.2	0.0
3000	80	25	2.4	0.7
4000	80	30	2.3	0.8
6000	>80	30	–	–
8000	>80	25	–	–
Total BHI (%)			12.9	
Occupational noise-induced BHI(%) before presbycusis correction				1.5
Occupational noise-induced BHI(%) after presbycusis correction of 2.4%				0
Acute acoustic trauma BHI (%)			11.4	
Presbycusis does not apply to acute acoustic trauma			–	
Resultant total BHI due to acute acoustic trauma of 11.4% = 6% whole person impairment (Table 9.1)				

Example 9.6: Occupational noise-induced hearing loss in an only hearing ear

A 66 year old woman has been a textile worker for 30 years. Childhood mumps had left her with profound hearing loss in the left ear. She gave a history of progressive hearing loss in her only hearing ear unaccompanied by tinnitus or vertigo. External auditory canals and tympanic membranes appeared normal. Rinne test was positive on the right and was false negative on the left. Weber test lateralised to the right. Clinical assessment of hearing is consistent with pure tone audiogram showing a profound left sensorineural hearing loss and a partial right sensorineural hearing loss. The medical assessor diagnosed noise induced hearing loss in the right ear.

Pure tone audiometry

Frequency (Hz)	Left (dB HL)	Right (dB HL)	Binaural hearing impairment (%BHI)	Occupational %BHI
500	>95	10	3.4	0
1000	>95	15	4.3	0
1500	>95	20	4.2	0.6
2000	>95	25	3.8	1.1
3000	>95	50	5.4	4.8
4000	>95	70	8.0	7.5
6000	>95	50	–	–
8000	>95	40	–	–
Total %BHI			29.1	
Total occupational %BHI				14.0
Presbycusis correction does not apply to a 66 year old woman				–
No addition for tinnitus				–
Adjusted total occupational %BHI				14.0
Total occupational BHI of 14% = 7% whole person impairment (Table 9.1)				

Example 9.7: Occupational noise-induced hearing loss where there is a special requirement for ability to hear at frequencies above 4000 Hz

A 56 year old female electronics technician who worked in a noisy factory for 20 years had increasing hearing difficulty. The diagnosis made was bilateral occupational noise-induced hearing loss extending to 6000 Hz or 8000 Hz. The assessing medical specialist was of the opinion that there was a special requirement for hearing above 4000 Hz. There was no conductive hearing loss.

Pure tone audiometry

			Binaural hearing impairment (%BHI)	
Frequency (Hz)	**Left (dB HL)**	**Right (dB HL)**	**Using extension table – 4000, 6000 and 8000 Hz**	**Not using extension table**
500	10	10	0.0	0.0
1000	15	15	0.0	0.0
1500	20	25	1.0	1.0
2000	30	35	2.5	2.5
3000	45	45	4.1	4.1
4000	45	50	2.2	3.6
6000	60	55	1.6	–
	8000		0.2	–
	50			
	20			
Total BHI (%) using extension table			11.6	
Total BHI (%) not using extension table				11.2
Presbycusis correction			0	
The assessing medical specialist is of the opinion that the binaural hearing impairment in this matter is 11.6% rather than 11.2%				
Adjusted total %BHI			0	
Resultant Total BHI of 11.6% = 6% whole person impairment (Table 9.1)				

10 The visual system

AMA4 Chapter 8 applies to the assessment of permanent impairment of the visual system, subject to the modifications set out below.

Introduction and approach to assessment

10.1 The visual system must be assessed by an ophthalmologist.

10.2 Chapter 8 (pp 209–222) of the American Medical Association Guides to the Assessment of Permanent Impairment ***Fourth Edition*** (AMA4) are adopted for the *WorkCover Guides* without significant change.

10.3 AMA4 is used rather than AMA5 for the assessment of permanent impairment of the visual system because:

- the equipment recommended for use in AMA5 is expensive and not owned by most privately practising ophthalmologists (eg the Goldman apparatus for measuring visual fields)
- the assessments recommended in AMA5 are considered too complex, raising a risk that resulting assessments may be of a lower standard than if the AMA4 method was used
- there is little emphasis on diplopia in AMA5, yet this is a relatively frequent problem
- many ophthalmologists are familiar with the Royal Australian College of Ophthalmologists' impairment guide, which is similar to AMA4.

10.4 Impairment of vision should be measured with the injured worker wearing their prescribed corrective spectacles and/or contact lenses, if that was normal for the injured worker before the workplace injury. If, as a result of the workplace injury, the injured worker has been prescribed corrective spectacles and/or contact lenses for the first time, or different spectacles and/or contact lenses than those prescribed before the injury, the difference should be accounted for in the assessment of permanent impairment.

10.5 The ophthalmologist should perform, or review, all tests necessary for the assessment of permanent impairment rather than relying on tests, or interpretations of tests, done by the orthoptist or optometrist.

10.6 An ophthalmologist should assess visual field impairment in all cases.

10.7 In AMA4 Section 8.5, 'Other Conditions' (p 222), the 'additional 10% impairment' referred to means 10% *whole person* impairment, not 10% impairment of the visual system.

11 Psychiatric and psychological disorders

AMA5 Chapter 14 is excluded and replaced by this chapter.

Introduction

11.1 This chapter lays out the method for assessing psychiatric impairment. The evaluation of impairment requires a medical examination.

11.2 Evaluation of psychiatric impairment is conducted by a psychiatrist who has undergone appropriate training in this assessment method.

11.3 Permanent impairment assessments for psychiatric and psychological disorders are only required where the primary injury is a psychological one. The psychiatrist needs to confirm that the psychiatric diagnosis is the injured worker's primary diagnosis. This assessment is not done for the purposes of determining 'pain and suffering' as defined for the purposes of section 67 of the *Workers Compensation Act 1987*. 'Pain and suffering' means actual pain, distress or anxiety, suffered or likely to be suffered by the injured worker, whether resulting from the permanent impairment concerned or from any necessary treatment of that impairment.

Background to the development of the scale

11.4 The psychiatric impairment rating scale (PIRS) used here was originally developed, using AMA4, for the New South Wales Motor Accidents Authority. It was then further modified for Comcare. At this time the conversion table was added. Finally, to ensure relevance in the NSW Workers Compensation context, the PIRS was extensively reviewed with reference to AMA5. Changes have been made to the method for assessing pre-injury impairment, and to some of the descriptors within each of the functional areas.

Diagnosis

11.5 The impairment rating must be based upon a psychiatric diagnosis (according to a recognised diagnostic system) and the report must specify the diagnostic criteria upon which the diagnosis is based. Impairment arising from any of the somatoform disorders (DSM IV TR, pp 485–511) are excluded from this chapter.

11.6 If pain is present as the result of an organic impairment, it should be assessed as part of the organic condition under the relevant table. This does not constitute part of the assessment of impairment relating to the psychiatric condition. The impairment ratings in the body organ system chapters in AMA5 make allowance for any accompanying pain.

11.7 It is expected that the psychiatrist will provide a rationale for the rating based on the injured worker's psychiatric symptoms. The diagnosis is among the factors to be considered in assessing the severity and possible duration of the impairment, but is not the sole criterion to be used. Clinical assessment of the person may include information from the injured worker's own description of his or her functioning and limitations; from family members and others who may have knowledge of the person. Medical reports, feedback from treating professionals, results of standardised tests, including appropriate psychometric testing performed by a qualified clinical psychologist, and work evaluations may provide useful information to assist with the assessment. Evaluation of impairment will need to take into account variations in the level of functioning over time. Percentage impairment refers to 'whole person impairment'.

Permanent impairment

11.8 A psychiatric disorder is permanent if in your clinical opinion, it is likely to continue indefinitely. Regard should be given to:

- the duration of impairment;
- the likelihood of improvement in the injured workers' condition;
- whether the injured worker has undertaken reasonable rehabilitative treatment;
- any other relevant matters.

Effects of treatment

11.9 Consider the effects of medication, treatment and rehabilitation to date. Is the condition stable? Is treatment likely to change? Are symptoms likely to improve? If the injured worker declines treatment, this should not affect the estimate of permanent impairment. The psychiatrist may make a comment in the report about the likely effect of treatment or the reasons for refusal of treatment.

Co-morbidity

11.10 Consider co-morbid features (eg Alzheimer's disease, personality disorder, substance abuse) and determine whether they are directly linked to the work-related injury or whether they were pre-existing or unrelated conditions.

Pre-existing impairment

11.11 To measure the impairment caused by a work-related injury or incident, the psychiatrist must measure the proportion of WPI due to a pre-existing condition. Pre-existing impairment is calculated using the same method for calculating current impairment level. The assessing psychiatrist uses all available information to rate the injured workers pre-injury level of functioning in each of the areas of function. The percentage impairment is calculated using the aggregate score and median class score using the conversion table on p 54 of these Guides. The injured worker's current level of impairment is then assessed, and the pre-existing impairment level (%) is then subtracted from their current level to obtain the percentage of permanent impairment directly attributable to the work-related injury. If the percentage pre-existing impairment cannot be assessed, 10% of the estimated level of the condition now being assessed is to be deducted.

Psychiatric impairment rating scale (PIRS)

11.12 Behavioural consequences of psychiatric disorder are assessed on six scales, each of which evaluates an area of functional impairment:

1. Self care and personal hygiene (Table 11.1)
2. Social and recreational activities (Table 11.2)
3. Travel (Table 11.3)

} Activities of daily living

4. Social functioning (relationships) (Table 11.4)
5. Concentration (Table 11.5)
6. Employability (Table 11.6).

11.14 Impairment in each area is rated using class descriptors. Classes range from 1 to 5, in accordance with severity. The standard form must be used when scoring the PIRS. The examples of activities are examples only. The assessing psychiatrist should take account of the person's cultural background. Consider activities that are usual for the person's age, sex and cultural norms.

Table 11.1: Psychiatric impairment rating scale — Self care and personal hygiene

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population.
Class 2	Mild impairment: able to live independently; looks after self adequately, although may look unkempt occasionally; sometimes misses a meal or relies on take-away food.
Class 3	Moderate impairment: can't live independently without regular support. Needs prompting to shower daily and wear clean clothes. Does not prepare own meals, frequently misses meals. Family member or community nurse visits (or should visit) 2–3 times per week to ensure minimum level of hygiene and nutrition.
Class 4	Severe impairment: needs supervised residential care. If unsupervised, may accidentally or purposefully hurt self.
Class 5	Totally impaired: needs assistance with basic functions, such as feeding and toileting.

Table 11.2: Psychiatric impairment rating scale — Social and recreational activities

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population: regularly participates in social activities that are age, sex and culturally appropriate. May belong to clubs or associations and is actively involved with these.
Class 2	Mild impairment: occasionally goes out to such events without needing a support person, but does not become actively involved (eg dancing, cheering favourite team).
Class 3	Moderate impairment: rarely goes out to such events, and mostly when prompted by family or close friend. Will not go out without a support person. Not actively involved, remains quiet and withdrawn.
Class 4	Severe impairment: never leaves place of residence. Tolerates the company of family member or close friend, but will go to a different room or garden when others come to visit family or flat mate.
Class 5	Totally impaired: cannot tolerate living with anybody, extremely uncomfortable when visited by close family member.

Table 11.3: Psychiatric impairment rating scale — Travel

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population: can travel to new environments without supervision.
Class 2	Mild impairment: can travel without support person, but only in a familiar area such as local shops, visiting a neighbour.
Class 3	Moderate impairment: cannot travel away from own residence without support person. Problems may be due to excessive anxiety or cognitive impairment.
Class 4	Severe impairment: finds it extremely uncomfortable to leave own residence even with trusted person.
Class 5	Totally impaired: may require two or more persons to supervise when travelling.

Table 11.4: Psychiatric impairment rating scale — Social functioning

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population: no difficulty in forming and sustaining relationships (eg partner, close friendships lasting years).
Class 2	Mild impairment: existing relationships strained. Tension and arguments with partner or close family member, loss of some friendships.
Class 3	Moderate impairment: previously established relationships severely strained, evidenced by periods of separation or domestic violence. Spouse, relatives or community services looking after children.
Class 4	Severe impairment: unable to form or sustain long term relationships. Pre-existing relationships ended (eg lost partner, close friends). Unable to care for dependants (eg own children, elderly parent).
Class 5	Totally impaired: unable to function within society. Living away from populated areas, actively avoiding social contact.

Table 11.5: Psychiatric impairment rating scale — Concentration, persistence and pace

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population. Able to pass a TAFE or university course within normal time frame.
Class 2	Mild impairment: can undertake a basic retraining course, or a standard course at a slower pace. Can focus on intellectually demanding tasks for periods of up to 30 minutes, then feels fatigued or develops headache.
Class 3	Moderate impairment: unable to read more than newspaper articles. Finds it difficult to follow complex instructions (eg operating manuals, building plans), make significant repairs to motor vehicle, type long documents, follow a pattern for making clothes, tapestry or knitting.
Class 4	Severe impairment: can only read a few lines before losing concentration. Difficulties following simple instructions. Concentration deficits obvious even during brief conversation. Unable to live alone, or needs regular assistance from relatives or community services.
Class 5	Totally impaired: needs constant supervision and assistance within institutional setting.

Table 11.6: Psychiatric impairment rating scale — Employability

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population. Able to work full time. Duties and performance are consistent with the injured worker's education and training. The person is able to cope with the normal demands of the job.
Class 2	Mild impairment. able to work full time but in a different environment from that of the pre-injury job. The duties require comparable skill and intellect as those of the pre-injury job. Can work in the same position, but no more than 20 hours per week (eg no longer happy to work with specific persons, or work in a specific location due to travel required).
Class 3	Moderate impairment: cannot work at all in same position. Can perform less than 20 hours per week in a different position, which requires less skill or is qualitatively different (eg less stressful).
Class 4	Severe impairment: cannot work more than one or two days at a time, less than 20 hours per fortnight. Pace is reduced, attendance is erratic.
Class 5	Totally impaired: cannot work at all.

Using the PIRS to measure impairment

11.15 Rating psychiatric impairment using the PIRS is a two-step procedure:

1. Determine the median class score.
2. Calculate the aggregate score.

Determining the median class score

11.16 Each area of function described in the PIRS is given an impairment rating which ranges from Class 1 to 5. The six scores are arranged in ascending order, using the standard form. The median is then calculated by averaging the two middle scores. Eg:

Example A:	1, 2, **3, 3**, 4, 5	Median Class = 3
Example B:	1, 2, **2, 3**, 3, 4	Median Class = 2.5 = 3*
Example C:	1, 2, **3, 5**, 5, 5	Median Class = 4

*If a score falls between two classes, it is rounded up to the next class. A median class score of 2.5 thus becomes 3.

11.17 The median class score method was chosen, as it is not influenced by extremes. Each area of function is assessed separately. While impairment in one area is neither equivalent nor interchangeable with impairment in other areas, the median seems the fairest way to translate different impairments onto a linear scale.

Median class score and percentage impairment

11.18 Each median class score represents a range of impairment, as shown below.

Class 1 = 0–3%

Class 2 = 4–10%

Class 3 = 11–30%

Class 4 = 31–60%

Class 5 = 61–100%

Calculation of the aggregate score

11.19 The aggregate score is used to determine an exact percentage of impairment within a particular Median Class range. The six class scores are added to give the aggregate score.

Use of the conversion table to arrive at percentage impairment

11.20 The aggregate score is converted to a percentage score using the conversion table.

11.21 The conversion table was developed to calculate the percentage impairment based on the aggregate and median scores.

11.22 The scores within the conversion table are spread in such a way to ensure that the final percentage rating is consistent with the measurement of permanent impairment percentages for other body systems.

Table 11.7: Conversion table

% Impairment	Aggregate score																								
	6	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**
Class 1	0	0	1	1	2	2	2	3	3																
Class 2				4	5	5	6	7	7	8	9	9	10												
Class 3								11	13	15	17	19	22	24	26	28	30								
Class 4												31	34	37	41	44	47	50	54	57	60				
Class 5																61	65	70	74	78	83	87	91	96	100

Conversion table — explanatory notes

A. Distribution of aggregate scores

- The lowest aggregate score that can be obtained is: 1+1+1+1+1+1=6.
- The highest aggregate score is 5+5+5+5+5+5= 30.
- The table therefore has aggregate scores ranging from 6 to 30.
- Each Median Class score has an impairment range, and a range of possible aggregate scores (eg Class 3 = 11–30%).
- The lowest aggregate score for Class 3 is 13 (1+1+2+3+3+3= 13).
- The highest aggregate score for Class 3 is 22. (3+3+3+3+5+5=22).
- The conversion table distributes the impairment percentages across aggregate scores.

B. Same aggregate score in different classes

- The conversion table shows that the same aggregate score leads to different percentages of impairment in different median classes.
- For example, an aggregate score of 18 is equivalent to an impairment rating of:
  - 10% in Class 2
  - 22% in Class 3
  - 34% in Class 4.
- This is due to the fact that an injured worker whose impairment is in Median Class 2 is likely to have a lower score across most areas of function. They may be significantly impaired in one aspect of their life, such as travel, yet have low impairment in Social Function, Self-care or Concentration.
- Someone whose impairment reaches Median Class 4 will experience significant impairment across most aspects of his or her life.

Examples: (Using the previous cases)

Example A

PIRS scores						Median class
1	2	**3**	**3**	4	5	= 3

Aggregate score						Total	% Impairment
1 +	2 +	3 +	3 +	4 +	5 =	18	22%

Example B

PIRS scores						Median class
1	2	**2**	**3**	3	4	= 3

Aggregate score						Total	% Impairment
1 +	2 +	2 +	3 +	3 +	4 =	15	15%

Example C

PIRS scores						Median class
1	2	**3**	**5**	5	5	= 4

Aggregate score						Total	% Impairment
1 +	2 +	3 +	5 +	5 +	5 =	21	44%

Table 11.8: PIRS rating form

Name		Claim reference number	
D.O.B.		Age at time of injury	
Date of injury		Occupation before injury	
Date of assessment		Marital status before injury	

Psychiatric diagnoses	1.	2.
	3.	4.
Psychiatric treatment		
Is impairment permanent?	Yes No (Circle one)	

PIRS category	Class	Reason for decision
Self care and personal hygiene		
Social and recreational activities		
Travel		
Social functioning		
Concentration, persistence and pace		
Employability		

Score

Class **Median**

						=

Aggregate score **Total** **%**

+	+	+	+	+	=	
Impairment (%WPI) from table 11.7						
Less pre existing impairment (if any)						
Final Impairment (%WPI)						

12 Haematopoietic system

AMA5 Chapter 9 applies to the assessment of permanent impairment of the haematopoietic system, subject to the modifications set out below.

Introduction

12.1 AMA5 Chapter 9 (pp 191–210) provides guidelines on the method of assessing permanent impairment of the haematopoietic system. Overall, that chapter should be followed when conducting the assessment, with variations indicated below.

12.2 Impairment of end organ function due to haematopoietic disorder should be assessed separately, using the relevant chapter of the *WorkCover Guides*. The percentage whole person impairment due to end organ impairment should be combined with any percentage whole person impairment due to haematopoietic disorder, using the Combined Values Table (AMA5, pp 604–606).

Anaemia

12.3 Table 12.1 (below) replaces AMA5 Table 9–2 (p 193).

Table 12.1: Classes of anaemia and percentage whole person impairment

Class 1: 0–10% WPI	Class 2: 11–30% WPI	Class 3: 31–70% WPI	Class 4: 71–100% WPI
No symptoms and haemoglobin 100–120g/L and no transfusion required.	Minimal symptoms and haemoglobin 80–100g/L and no transfusion required.	Moderate to marked symptoms and haemoglobin 50–80g/L before transfusion and transfusion of 2 to 3 units required, every 4 to 6 weeks.	Moderate to marked symptoms and haemoglobin 50–80g/L before transfusion and transfusion of 2 to 3 units required, every 2 weeks.

12.4 The assessor should exercise clinical judgement in determining whole person impairment, using the criteria in Table 12.1. For example, if comorbidities exist which preclude transfusion, the assessor may assign Class 3 or Class 4, on the understanding that transfusion would, under other circumstances, be indicated. Similarly, there may be some claimants with Class 2 impairment who, because of comorbidity, may undergo transfusion.

12.5 Pre-transfusion haemoglobin levels in Table 12.1 are to be used as indications only. It is acknowledged that for some claimants, it would not be medically advisable to permit the claimant's haemoglobin levels to be as low as indicated in the criteria of Table 12.1.

12.6 The assessor should indicate a percentage whole person impairment, as well as the Class.

Polycythaemia and myelofibrosis

12.7 The level of symptoms (as in Table 12.1) should be used as a guide for the assessor in cases where non-anaemic tissue iron deficiency results from venesection.

White blood cell diseases

12.8 In cases of functional asplenia, the assessor should assign 3% whole person impairment. This should be combined with any other impairment rating, using the Combined Values Table (AMA5, pp 604–606).

12.9 AMA5 Table 9–3 (p 200) should not be used for rating impairment due to HIV infection or auto immune deficiency disease. Section 67A (1) of the *Workers Compensation Act 1987* indicates that HIV infection and AIDS are each considered to result in a degree of permanent impairment of 100%.

Haemorrhagic and platelet disorders

12.10 AMA5 Table 9–4 (p 203) is to be used as the basis for assessing haemorrhagic and platelet disorders.

12.11 For the purposes of these *WorkCover Guides*, the criteria for inclusion in Class 3 of AMA5 Table 9–4 (p 203) is:

- Symptoms and signs of haemorrhagic and platelet abnormality

and/or

- Requires continuous treatment

and

- Interference with daily activities; requires occasional assistance.

12.12 For the purposes of these *WorkCover Guides*, the criteria for inclusion in Class 4 of Table 9–4 (p 203, AMA5) is:

- Symptoms and signs of haemorrhagic and platelet abnormality

and/or

- Requires continuous treatment

and

- Difficulty performing daily activities; requires continuous care.

Thrombotic disorders

12.13 AMA5 Table 9–4 (p 203) is used as the basis for determining impairment due to thrombotic disorder.

13 The endocrine system

AMA5 Chapter 10 applies to the assessment of permanent impairment of the endocrine system, subject to the modifications set out below.

Introduction

13.1 AMA5 Chapter 10 provides a useful summary of the methods for assessing permanent impairment arising from disorders of the endocrine system.

13.2 Refer to other chapters in AMA5 for related structural changes — the visual system (Chapter 12), the skin (eg pigmentation — Chapter 8), the central and peripheral nervous system (memory, Chapter 13), the urinary and reproductive system (infertility, renal impairment, Chapter 7), the digestive system (dyspepsia, Chapter 6), the cardiovascular system (Chapters 3 and 4).

13.3 The clinical findings to support the impairment assessment are to be reported in the units recommended by the Royal College of Pathologists of Australia. (See Appendix 1 of this Chapter, pp 60–63).

13.4 Westergren erythrocyte sedimentation rate (WSR) is equivalent to ESR.

Adrenal cortex

13.5 AMA5, p 222, first paragraph: disregard the last sentence, 'They also affect inflammatory response, cell membrane permeability, and immunologic responses, and they play a role in the development and maintenance of secondary sexual characteristics.' Replace with: 'Immunological and inflammatory responses are reduced by these hormones and they play a role in the development and maintenance of secondary sexual characteristics.'

13.6 AMA5 Example 10–18 (pp 224–225): see reference to ESR (13.4, above).

13.7 AMA5 Example 10–20 (p 225): History: For 'hypnotic bladder' read 'hypotonic bladder'.

Diabetes mellitus

13.8 AMA5, p 231: refer to the Australian Diabetes Association Guidelines with regard to levels of fasting glucose. (Position statement from the Australian Diabetes Society, reprinted in Appendix 2 of this Chapter, pp 64–68).

13.9 AMA5, p 231: insert at the end of the second paragraph: 'The goal of treatment is to maintain haemoglobin A Ic within 1% of the normal range (4%–6.3%)'.

Mammary glands

13.10 AMA5 Example 10–45 (p 239), Current Symptoms: Disregard the last sentence, 'Both bromocriptine and cabergoline cause nausea, precluding use of either drug' and replace with: 'Routine use of bromocriptine and cabergoline is normal in Australia. It is rare that nausea precludes their use.'

Criteria for rating permanent impairment due to metabolic bone disease

13.11 AMA5, p 240: Impairment due to a metabolic bone disease itself is unlikely to be associated with a work injury and would usually represent a pre-existing condition.

13.12 Impairment from fracture, spinal collapse or other complications may arise as a result of a work injury associated with these underlying conditions (as noted in AMA5, Section 10.10c) and would be assessed using the other Chapters indicated, with the exception of Chapter 18 (Pain) which is excluded from the *WorkCover Guides*.

Appendix 13.1: Interpretation of pathology tests

From *Manual of Use and Interpretation of Pathology Tests*, 3rd edition. Reprinted with kind permission of the Royal College of Pathologists of Australasia.

Reference ranges, plasma or serum, unless otherwise indicated

Alanine aminotransferase (ALT)	(adult)	< 35 U/L
Albumin	(adult)	32–45 g/L
Alkaline phosphatase (ALP)	(adult, non-pregnant)	25–100 U/L
Alpha fetoprotein	(adult, non-pregnant)	< 10 µg/L
Alpha-1-antitrypsin		1.7–3.4 g/L
Anion gap		8–16 mmol/L
Aspartate aminotransferase (AST)		< 40 U/L
Bicarbonate (total CO_2)		22–32 mmol/L
Bilirubin (total)	(adult)	< 20 µmol/L
Calcium	(total)	2.10–2.60 mmol/L
	(ionised)	1.17–1.30 mmol/L
Chloride		95–110 mmol/L
Cholesterol (HDL)	(male)	0.9–2.0 mmol/L
	(female)	1.0–2.2 mmol/L
Cholesterol (total) *(National Heart Foundation [Australia] recommendation)*		< 5.5 mmol/L
Copper		13–22 µmol/L
Creatine kinase (CK)	(male)	60–220 U/L
	(female)	30–180 U/L
Creatinine	(adult male)	0.06–0.12 mmol/L
	(adult female)	0.05–0.11 mmol/L
Gamma glutamyl transferase (GGT)	(male)	< 50 U/L
	(female)	< 30 U/L
Globulin	adult	25–35g/L
Glucose	(venous plasma) – (fasting)	3.0–5.4 mmol/L
	(venous plasma) – (random)	3.0–7.7 mmol/L
Lactate dehydrogenase (LD)	(adult)	110–230 U/L
Magnesium	(adult)	0.8–1.0 mmol/L
Osmolality	(adult)	280–300 m.osmoll/kg water
pCO2	(arterial blood)	4.6–6.0 kPa (35–45 mmHg)
PH	(arterial blood)	7.36–7.44 (36–44 nmol/L)
Phosphate		0.8–1.5 mmol/L
pO2	(arterial blood)	11.0–13.5 kPa (80–100 mmHg)
Potassium	(plasma)	3.4–4.5 mmol/L
	(serum)	3.8–4.9 mmol/L
Prolactin	(male)	150–500 mU/L
	(female)	0–750 mU/L
Protein, total	(adult)	62–80 g/L
Sodium		135–145 mmol/L
Testosterone and related androgens	*See* Table A (below)	

Therapeutic intervals

Amitriptyline	150–900 nmol/L	60–250 μg/L
Carbamazepine	20–40 μmol/L	6–12 mg/L
Digoxin	0.6–2.3 nmol/L	0.5–1.8 μg/L
Lithium	0.6–1.2 mmol/L	
Nortriptyline	200–650 nmol/L	50–170 μg/L
Phenobarbitone	65–170 μmol/L	15–40 mg/L
Phenytoin	40–80 μmol/L	10–20 mg/L
Primidone	22–50 μmol/L	4.8–11.0 mg/L
Procainamide	17–42 μmol/L	4–10 mg/L
Quinidine	7–15 μmol/L	2.3–4.8 mg/L
Salicylate	1.0–2.5 mmol/L	140–350 mg/L
Theophylline	55–110 μmol/L	10–20 mg/L
Valproate	350–700 μmol/L	50–100 mg/L
Thyroid stimulating hormone (TSH)		0.4–5.0 mIU/L
Thyroxine (free)		10–25 pmol/L
Triglycerides (fasting)		< 2.0 mmol/L
Triiodothyronine (free)		4.0–8.0 pmol/L
Urate	(male)	0.20–0.45 mmol/L
	(female)	0.15–0.40 mmol/L
Urea	(adult)	3.0–8.0 mmol/L
Zinc		12–20 μmol/L

Table A: Reference intervals for testosterone and related androgens (serum)

	Male		Female	
	Pre-pubertal	Adult (age related)	Pre-pubertal	Adult (age related)
Free testosterone (pmol/L)		170–510		< 4.0
Total testosterone (nmol/L)	< 0.5	8–35	< 0.5	< 4.0
SHBG (nmol/L)	55–100	10–50	55–100	30–90 (250–500 in the 3rd trimester)
Dihydrotestosterone (nmol/L)		1–2.5		

Reference ranges, urine

Calcium		2.5–7.5 mmol/24 hours
Chloride (depends on intake, plasma levels)		100–250 mmol/24 hours
Cortisol (free)		100–300 nmol/24 hours
Creatinine	(child)	0.07–0.19 mmol/24 hours/kg
	(male)	9–18 mmol/24 hours
	(female)	5–16 mmol/24 hours
HMMA	(infant)	< 10 mmol/mol creatinine
	(adult)	< 35 μmol/24 hours
Magnesium		2.5–8.0 mmol/24 hours
Osmolality (depends on hydration)		50–1200 m.osmol/kg water
Phosphate (depends on intake, plasma levels)		10–40 mmol/24 hours
Potassium (depends on intake, plasma levels)		40–100 mmol/24 hours
Protein, total		< 150 mg/24 hours
	(pregnancy)	< 250 mg/24 hours
Sodium (depends on intake, plasma levels)		75–300 mmol/24 hours
Urate	(male)	2.2–6.6 mmol/24 hours
	(female)	1.6–5.6 mmol/24 hours
Urea (depends on protein intake)		420–720 mmol/24 hours

Reference ranges, whole blood

Haemoglobin (Hb)	(adult male)	130–180 g/L
	(adult female)	115–165 g/L
Red cell count (RCC)	(adult male)	4.5–6.5 x 10^{12}/L
	(adult female)	3.8–5.8 x 10^{12}/L
Packed cell volume (PCV)	(adult male)	0.40–0.54
	(adult female)	0.37–0.47
Mean cell volume (MCV)		80–100 fL
Mean cell haemoglobin (MCH)		27–32 pg
Mean cell haemoglobin concentration (MCHC)		300–350 g/L
Leucocyte (White Cell) Count (WCC)		4.0–11.0 x 10^9/L
Leucocyte differential count		
– Neutrophils		2.0–7.5 x 10^9/L
– Eosinophils		0.04–0.4 x 10^9/L
– Basophils		< 0.1 x 10^9/L
– Monocytes		0.2–0.8 x 10^9/L
– Lymphocytes		1.5–4.0 x 10^9/L
Platelet count		150–400 x 10^9/L
Erythrocyte sedimentation rate (ESR)	male 17–50 yrs	1–10 mm/hour
	male >50 yrs	2–14 mm/hour
	female 17–50 yrs	3–12 mm/hour
	female >50 yrs	5–20 mm/hour
Reticulocyte count		10–100 x 10^9/L (0.2–2.0%)

Reference ranges, plasma or serum, unless otherwise indicated

Iron	(adult)	10–30 μmol/L
Iron (total) binding capacity (TIBC)		45–80 μmol/L
Transferrin		1.7–3.0 g/L
Transferrin saturation		0.15–0.45 (15–45%)
Ferritin	(male)	30–300 μg/L
	(female)	15–200 μg/L
Vitamin B12		120–680 pmol/L
Folate	(red cell)	360–1400 nmol/L
	(serum)	7–45 nmol/L

Reference ranges, citrated plasma

Activated partial thromboplastin time (APTT)	25–35 seconds
– Therapeutic range for continuous infusion heparin	1.5–2.5 x baseline
Prothrombin time (PT)	11–15 seconds
International normalised ratio (INR)	
– Therapeutic range for oral anticoagulant therapy	2.0–4.5
Fibrinogen	1.5–4.0 g/L

Reference ranges, serum

Rheumatoid factor (nephelometry)	< 30 IU/L
C3	0.9–1.8 g/L
C4	0.16–0.50 g/L
C-reactive protein	< 5.0 mg/L
Immunoglobulins:	
IgG	6.5–16.0g/L
IgA	0.6–4.0g/L
IgM	0.5–3.0g/L

Reference intervals for lymphocyte subsets

	Adult
Total lymphocytes	1.5–4.0
CD3	0.6–2.4
CD4 (T4)	0.5–1.4
CD8 (T8)	0.2–0.7
CD19	0.04–0.5
CD16	0.2–0.4
CD4/CD8 ratio	1.0–3.2

Appendix 13.2: New classification and criteria for diagnosis of diabetes mellitus

Position Statement from the Australian Diabetes Society,* New Zealand Society for the Study of Diabetes,† Royal College of Pathologists of Australasia‡ and Australasian Association of Clinical Biochemists§

Peter G Colman,* David W Thomas,‡ Paul Z Zimmet,* Timothy A Welborn,* Peter Garcia-Webb§ and M Peter Moore†

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Key messages

Diagnosis of diabetes is not in doubt when there are classical symptoms of thirst and polyuria and a random venous plasma glucose level ≥ 11.1 mmol/L.

The Australasian Working Party on Diagnostic Criteria for Diabetes Mellitus recommends:

- Immediate adoption of the new criterion for diagnosis of diabetes as proposed by the American Diabetes Association (ADA) and the World Health Organization (WHO) — fasting venous plasma glucose level ≥ 7.0 mmol/L;
- Immediate adoption of the new classification for diabetes mellitus proposed by the ADA and WHO, which comprises four aetiological types — type 1, type 2, other specific types, and gestational diabetes — with impaired glucose tolerance and impaired fasting glycaemia as stages in the natural history of disordered carbohydrate metabolism.
- Awareness that some cases of diabetes will be missed unless an oral glucose tolerance test (OGTT) is performed. If there is any suspicion or other risk factor suggesting glucose intolerance, the OGTT should continue to be used pending the final WHO recommendation.

Introduction

Recently, there has been major growth in knowledge about the aetiology and pathogenesis of different types of diabetes and about the predictive value of different blood glucose levels for development of complications. In response, both the American Diabetes Association (ADA) and the World Health Organization (WHO) have re-examined, redefined and updated the classification of and criteria for diabetes, which have been unchanged since 1985. While the two working parties had cross-representation, they met separately, and differences have emerged between their recommendations.

The ADA published its final recommendations in 1997,[1] while the WHO group published its provisional conclusions for consultation and comment in June 1998.[2]

The WHO process called for comments on the proposal by the end of September 1998, with the intention of finalising definitive classification and criteria by the end of December 1998 and of publishing these soon thereafter. However, WHO publications need to go through an internal approval process and it may be up to 12 months before the final WHO document appears.

A combined working party of the Australian Diabetes Society, New Zealand Society for the Study of Diabetes, Royal College of Pathologists of Australasia and Australasian Association of Clinical Biochemists was formed to formulate an Australasian position on the two sets of recommendations and, in particular, on the differences between them. This is an interim statement pending the final WHO report, which will include recommendations on diabetes classification as well as criteria for diagnosis. We see it as very important to inform Australasian health professionals treating patients with diabetes about these changes.

What are the new diagnostic criteria?

The new WHO criteria for diagnosis of diabetes mellitus and hyperglycaemia are shown in Box 1. The major change from the previous WHO recommendation[3] is the lowering of the diagnostic level of fasting plasma glucose to ≥7.0 mmol/L, from the former level of ≥7.8 mmol/L. For whole blood, the proposed new level is ≥6.1 mmol/L, from the former ≥6.7 mmol/L.

1: Values for diagnosis of diabetes mellitus and other categories of hyperglycaemia[2]

	Glucose concentration (mmol/L [mg/dL])			
	Whole blood		Plasma	
	Venous	Capillary	Venous	Capillary
Diabetes mellitus				
Fasting	≥6.1 (≥110)	≥6.1 (≥110)	≥7.0 (≥126)	≥7.0 (≥126)
or 2 h post-glucose load	≥10.0 (≥180)	≥11.1 (≥200)	≥11.1 (≥200)	≥12.2 (≥220)
or both				
Impaired glucose tolerance (IGT)				
Fasting (if measured)	< 6.1 (< 110)	< 6.1 (< 110)	< 7.0 (< 126)	< 7.0 (< 126)
and 2 h post-glucose load	≥6.7 (≥120) and < 10.0 (< 180)	≥7.8 (≥140) and < 11.1 (< 200)	≥7.8 (≥140) and < 11.1 (< 200)	≥8.9 (≥160) and < 12.2 (< 220)
Impaired fasting glycaemia (IFG)				
Fasting	≥5.6 (≥100) and < 6.1 (< 110)	≥5.6 (≥100) and < 6.1 (< 110)	≥6.1 (≥110) and < 7.0 (< 126)	≥6.1 (≥110) and < 7.0 (< 126)
2 h post-glucose load (if measured)	< 6.7 (< 120)	< 7.8 (< 140)	< 7.8 (< 140)	< 8.9 (< 160)

For epidemiological or population screening purposes, the fasting or 2 h value after 75 g oral glucose may be used alone. For clinical purposes, the diagnosis of diabetes should always be confirmed by repeating the test on another day, unless there is unequivocal hyperglycaemia with acute metabolic decompensation or obvious symptoms. Glucose concentrations should not be determined on serum unless red cells are immediately removed, otherwise glycolysis will result in an unpredictable underestimation of the true concentrations. It should be stressed that glucose preservatives do not totally prevent glycolysis. If whole blood is used, the sample should be kept at 0–4°C or centrifuged immediately, or assayed immediately. Table reproduced with permission from Alberti KGMM, Zimmet PZ. Definition, diagnosis and classification of diabetes mellitus and its complications. Part 1: diagnosis and classification of diabetes mellitus. Provisional Report of a WHO Consultation. *Diabet Med* 1998; 15: 539–553. Copyright John Wiley & Sons Limited.

This change is based primarily on cross-sectional studies demonstrating the presence of microvascular[4] and macrovascular complications[5] at these lower glucose concentrations. In addition, the 1985 WHO diagnostic criterion for diabetes based on fasting plasma glucose level (≥7.8 mmol/L) represents a greater degree of hyperglycaemia than the criterion based on plasma glucose level two hours after a 75 g glucose load (≥11.1 mmol/L).[6] A fasting plasma glucose level of ≥7 mmol/L accords more closely with this 2 h post-glucose level.

Recommendation: *The ADA and the WHO committee are unanimous in adopting the changed diagnostic level, and the Australasian Working Party on Diagnostic Criteria recommends that healthcare providers in Australia and New Zealand should adopt it immediately.*

Clinicians should note that the diagnostic criteria differ between clinical and epidemiological settings. In clinical practice, when symptoms are typical of diabetes, a single fasting plasma glucose level of ≥7.0 mmol/L or 2 h post-glucose or casual postprandial plasma glucose level of ≥11.1 mmol/L suffices for diagnosis. If there are no symptoms, or symptoms are equivocal, at least one additional glucose measurement (preferably fasting) on a different day with a value in the diabetic range is necessary to confirm the diagnosis. Furthermore, severe hyperglycaemia detected under conditions of acute infective, traumatic, circulatory or other stress may be transitory and should not be regarded as diagnostic of diabetes. The situation should be reviewed when the primary condition has stabilised.

In epidemiological settings, for study of high-prevalence populations or selective screening of high-risk individuals, a single measure — the glucose-level 2 h post-glucose load — will suffice to describe prevalence of impaired glucose tolerance (IGT).

What about the oral glucose tolerance test?

Previously, the oral glucose tolerance test (OGTT) was recommended in people with a fasting plasma glucose level of 5.5–7.7 mmol/L or random plasma glucose level of 7.8–11.0 mmol/L. After a 75 g glucose load, those with a 2 h plasma glucose level of < 7.8 mmol/L were classified as normoglycaemic, of 7.8–11.0 mmol/L as having IGT and of ≥11.1 mmol/L as having diabetes.

The new diagnostic criteria proposed by the ADA and WHO differ in their recommendations on use of the OGTT. The ADA makes a strong recommendation that fasting plasma glucose level can be used on its own and that, in general, the OGTT need not be used.[1] The WHO group[2] argues strongly for the retention of the OGTT and suggests using fasting plasma glucose level alone only when circumstances prevent the performance of the OGTT.

There are concerns that many people with a fasting plasma glucose level < 7.0 mmol/L will have manifestly abnormal results on the OGTT and are at risk of microvascular and macrovascular complications. This has major ramifications for the approach to diabetes screening, particularly when the Australian National Diabetes Strategy proposal,[7] launched in June 1998 by Dr Michael Wooldridge, then Federal Minister for Health and Aged Care, has early detection of type 2 diabetes as a key priority.

2: Aetiological classification of disorders of glycaemia*

Type 1 (β-cell destruction, usually leading to absolute insulin deficiency)

Autoimmune
Idiopathic

Type 2 (may range from predominantly insulin resistance with relative insulin deficiency to a predominantly secretory defect with or without insulin resistance)

Other specific types

Genetic defects of β-cell function
Genetic defects in insulin action
Diseases of the exocrine pancreas
Endocrinopathies
Drug or chemical induced
Infections
Uncommon forms of immune-mediated diabetes
Other genetic syndromes sometimes associated with diabetes

Gestational diabetes

* As additional subtypes are discovered, it is anticipated they will be reclassified within their own specific category. Includes the former categories of gestational impaired glucose tolerance and gestational diabetes. Table reproduced with permission from Alberti KGMM, Zimmet PZ. Definition, diagnosis and classification of diabetes mellitus and its complications. Part 1: diagnosis and classification of diabetes mellitus. Provisional Report of a WHO Consultation. Diabet Med 1998; 15: 539-553. Copyright John Wiley & Sons Limited.

Recommendation: The Australasian Working Party on Diagnostic Criteria has major concerns about discontinuing use of the OGTT and recommends that a formal recommendation on its use in diabetes screening be withheld until the final WHO recommendation is made. However, in the interim, the OGTT should continue to be used.

Diabetes in pregnancy

The ADA has retained its old criteria for diagnosis of gestational diabetes.[1] These differ from those recommended by both WHO[2] and the Australian Working Party on Diabetes in Pregnancy[8] and are generally not recognised outside the United States. The new WHO statement retains the 1985 WHO recommendation that both IGT and diabetes should be classified as gestational diabetes. This is consistent with the recommendations of the Australasian Diabetes in Pregnancy Society, which recommended a diagnostic 2 h venous plasma glucose level on the OGTT of ≥8.0 mmol/L. In New Zealand, a cut-off level of ≥ 9.0 mmol/L has been applied.[8]

How has the classification of diabetes changed?

The proposed new classification encompasses both clinical stages and aetiological types of hyperglycaemia and is supported by numerous epidemiological studies. The classification by aetiological type (Box 2) results from new knowledge of the causes of hyperglycaemia, including diabetes. The terms insulin-dependent and non-insulin-dependent diabetes (IDDM and NIDDM) are eliminated and the terms type 1 and type 2 diabetes retained. Other aetiological types, such as diabetes arising from genetic defects of β-cell function or insulin action, are grouped as 'other specific types', with gestational diabetes as a fourth category.

The proposed staging (Box 3) reflects the fact that any aetiological type of diabetes can pass or progress through several clinical phases (both asymptomatic and symptomatic) during its natural history. Moreover, individuals may move in either direction between stages.

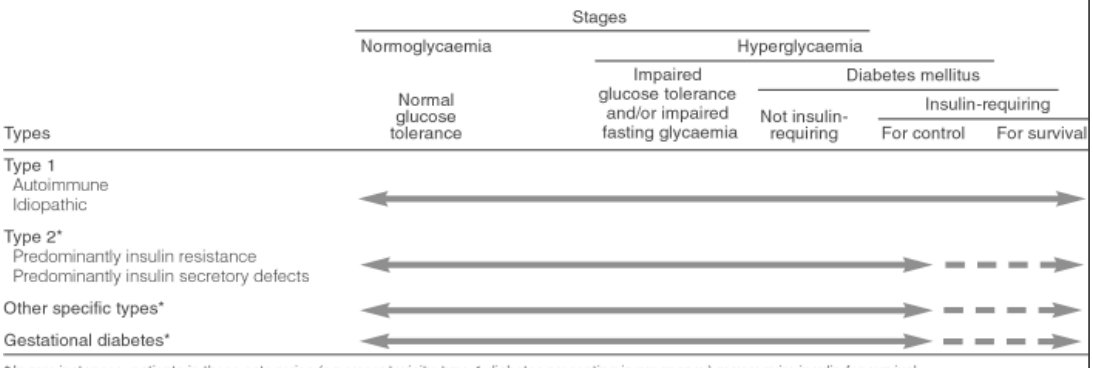
Impaired glucose tolerance and impaired fasting glycaemia

Impaired glucose tolerance (IGT), a discrete class in the previous classification, is now categorised as a stage in the natural history of disordered carbohydrate metabolism. Individuals with IGT are at increased risk of cardiovascular disease, and not all will be identified by fasting glucose level.

In reducing the use of the OGTT, the ADA recommended a new category — impaired fasting glycaemia (IFG) — when fasting plasma glucose level is lower than that required to diagnose diabetes but higher than the reference range (< 7.0 mmol/L but ≥ 6.1 mmol/L). Limited data on this category show that it increases both risk of progressing to diabetes[9] and cardiovascular risk.[5] However, data are as yet insufficient to determine whether IFG has the same status as IGT as a risk factor for developing diabetes and cardiovascular disease and as strong an association with the metabolic syndrome (insulin resistance syndrome).

IFG can be diagnosed by fasting glucose level alone, but if 2 h glucose level is also measured some individuals with IFG will have IGT and some may have diabetes. In addition, the number of people with OGTT results indicating diabetes but fasting plasma glucose level < 7.0 mmol/L is unknown, but early data suggest there may be major variation across different populations.[10] A number of studies, including the DECODE initiative of the European Diabetes Epidemiology Group, have reported that individuals classified with IFG are not the same as the IGT group.[11-15] The European Group believes that, on available European evidence, the ADA decision to rely solely on fasting glucose level would be unwise.

3: Disorders of glycaemia: aetiological types and clinical stages



*In rare instances, patients in these categories (eg, vacor toxicity, type 1 diabetes presenting in pregnancy) may require insulin for survival.
Table reproduced with permission from Alberti KGMM, Zimmet PZ. Definition, diagnosis and classification of diabetes mellitus and its complications. Part 1: diagnosis and classification of diabetes mellitus. Provisional Report of a WHO Consultation. *Diabet Med* 1998; 15: 539-553. Copyright John Wiley & Sons Limited.

Recommendation: *The Australasian Working Party on Diagnostic Criteria recommends immediate adoption of the new classification. However, clinicians should be aware that some cases of diabetes will be missed unless an OGTT is performed. Thus, if there is any suspicion or other risk factor suggesting glucose intolerance, the working party continues to recommend use of an OGTT pending the final WHO recommendation.*

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14 The skin

AMA5 Chapter 8 applies to the assessment of permanent impairment of the skin, subject to the modifications set out below.

14.1 AMA5 Chapter 8 (pp 173–190) refers to skin diseases generally rather than work-related skin diseases alone. This Chapter has been adopted for measuring impairment of the skin system, with the following variations.

14.2 Disfigurement, scars and skin grafts may be assessed as causing significant permanent impairment when the skin condition causes limitation in the performance of activities of daily living (ADL).

14.3 For cases of facial disfigurement, refer to Table 6.1 in the *WorkCover Guides* (p 29).

14.4 AMA5 Table 8–2 (p 178) provides the method of classification of impairment due to skin disorders. Three components — signs and symptoms of skin disorder, limitations in activities of daily living and requirements for treatment — define five classes of permanent impairment. The assessing specialist should derive a specific percentage impairment within the range for the class that best describes the clinical status of the claimant.

14.5 The case examples provided in AMA5 Chapter 8 do not, in most cases, relate to permanent impairment that results from a work-related injury. The following New South Wales examples are provided for information.

14.6 Work-related case study examples 14.1, 14.2, 14.3, 14.4, 14.5, 14.6 are included below, in addition to AMA5 Examples 8.1–8.22 (pp 178–187).

Example 14.1: Cumulative irritant dermatitis

Subject: 42 year old man.

History: Spray painter working on ships in dry dock. Not required to prepare surface but required to mix paints (including epoxy and polyurethane) with 'thinners' (solvents) and spray metal ships' surface. At end of each session, required to clean equipment with solvent. Not supplied with gloves or other personal protective equipment until after onset of symptoms. Gradual increase in severity in spite of commencing to wear gloves. Off work two months leading to clearance, but frequent recurrence, especially if the subject attempted prolonged work wearing latex or PVC gloves or wet work without gloves.

Current: Returned to dry duties only at work. Mostly clear of dermatitis, but flares.

Physical examination: Varies between no abnormality detected to mild dermatitis of the dorsum of hands.

Investigations: Patch test standard + epoxy + isocyanates (polyurethanes). No reactions.

Impairment: 0%.

Comment: No interference with activities of daily living (ADL).

Example 14.2: **Allergic contact dermatitis to hair dye**

Subject: 30 year old woman.

History: Hairdresser 15 years, with six month history of hand dermatitis, increasing despite beginning to wear latex gloves after onset. Dermatitis settled to very mild after four weeks off work, but not clear. As the condition flared whenever the subject returned to hairdressing, she ceased and is now a computer operator.

Current: Mild continuing dermatitis of the hands which flares when doing wet work (without gloves) or when wears latex or PVC gloves. Has three young children and impossible to avoid wet work.

Investigation: Patch test standard + hairdressing series. Possible reaction to paraphenylene diamine.

Impairment: 5%.

Comment: Able to carry out ADL with difficulty, therefore limited performance of *some* ADL.

Example 14.3: **'Cement dermatitis' due to chromate in cement**

Subject: 43 year old man.

History: Concreter since age 16. Eighteen month history of increasing hand dermatitis eventually on dorsal and palmar surface of hands and fingers. Off work and treatment led to limited improvement only.

Physical examination: Fissured skin, hyperkeratotic chronic dermatitis.

Investigation: Patch test. Positive reaction to dichromate.

Current: Intractable, chronic, fissured dermatitis.

Impairment: 12%.

Comment: Unable to obtain any employment because has chronic dermatitis and on disability support pension. Difficulty gripping items including steering wheel, hammer and other tools. Unable to do any wet work, (eg painting). Former home handyman, now calls in tradesman to do any repairs and maintenance. Limited performance in *some* ADL.

Example 14.4: Latex contact urticaria/angioedema with cross reactions

Subject: Female nurse, age 40.

History: Six month history of itchy hands minutes after applying latex gloves at work. Later swelling and redness associated with itchy hands and wrists and subsequently widespread urticaria. One week off led to immediate clearance. On return to work wearing PVC gloves, developed anaphylaxis on first day back.

Physical examination: No abnormality detected or generalised urticaria/angioedema.

Investigation: Latex radioallergosorbent test, strong positive response.

Current: The subject experiences urticaria and mild anaphylaxis if she enters a hospital, some supermarkets or other stores (especially if latex items are stocked), at children's parties or in other situations where balloons are present, or on inadvertent contact with latex items including sport goods handles, some clothing, and many shoes (latex based glues). Also has restricted diet (must avoid bananas, avocados and kiwi fruit).

Impairment: 17%

Comment: Severe limitation in *some* ADL in spite of intermittent activity.

Example 14.5: Non-melanoma skin cancer

Subject: 53 year old married man.

History: 'Road worker' since 17 years of age. Has had a basal cell carcinoma on the left forehead, squamous cell carcinoma on the right forehead (graft), basal cell carcinoma on the left ear (wedge resection) and squamous cell carcinoma on the lower lip (wedge resection) excised since 45 years of age. No history of loco-regional recurrences. Multiple actinic keratoses treated with cryotherapy or Efudix over 20 years (forearms, dorsum of hands, head and neck).

Current: New lesion right preauricular area. Concerned over appearance 'I look a mess.'

Physical examination: Multiple actinic keratoses forearms, dorsum of hands, head and neck. Five millimetre diameter nodular basal cell carcinoma right preauricular area, hypertrophic red scar 3 cm length left forehead, 2 cm diameter graft site (hypopigmented with 2 mm contour deformity) right temple, non-hypertrophic scar left lower lip (vermilion) with slight step deformity and non-hypertrophic pale wedge resection scar left pinna leading to 30% reduction in size of the pinna. Graft sites taken from right post auricular area. No regional lymphadenopathy.

Impairment: 6%

Comment: Refer to Table 6.1 (facial disfigurement), p 29.

Example 14.6: **Non-melanoma skin cancer**

Subject: 35 year old single female professional surf life-saver.

History: Occupational outdoor exposure since 19 years of age. Basal cell carcinoma on tip of nose excised three years ago with full thickness graft following failed intralesional interferon treatment.

Current: Poor self esteem because of cosmetic result of surgery.

Physical examination: One centimetre diameter graft site on the tip of nose (hypopigmented with 2 mm depth contour deformity, cartilage not involved). Graft site taken from right post-auricular area.

Impairment: 10%

Comment: Refer to Table 6.1 (facial disfigurement), p 29.

15 Cardiovascular system

AMA5 Chapters 3 and 4 apply to the assessment of permanent impairment of the cardiovascular system, subject to the modifications set out below.

Introduction

15.1 The cardiovascular system is discussed in AMA5 Chapters 3 (Heart and Aorta) and 4 (Systemic and Pulmonary Arteries) (pp 25–85). These Chapters can be used to assess permanent impairment of the cardiovascular system with the following minor modifications.

15.2 It is noted that in this chapter there are wide ranges for the impairment values in each category. When conducting a WorkCover assessment, assessors should use their clinical judgement to express a specific percentage within the range suggested.

Exercise stress testing

15.3 As with other investigations, it is not the role of a WorkCover medical assessor to order exercise stress tests purely for the purpose of evaluating the extent of permanent impairment.

15.4 If exercise stress testing is available, then it is a useful piece of information in arriving at the overall percentage impairment.

15.5 If previous investigations are inadequate for a proper assessment to be made, the Medical Assessor should consider the value of proceeding with the evaluation of permanent impairment without adequate investigations and data (see Chapter 1, p 8 — Ordering of additional investigations).

Permanent impairment — maximum medical improvement

15.6 As for all assessments, maximal medical improvement is considered to have occurred when the worker's condition has been medically stable for the previous three months, and is unlikely to change substantially in the next 12 months without further medical treatment.

Vascular diseases affecting the extremities

15.7 Note that in this section, AMA5 Table 4–4 and Table 4–5 (p 76) refer to percentage impairment of the upper or lower extremity. Therefore, an assessment of impairment concerning vascular impairment of the arm or leg requires that the percentages identified in Tables 4–4 and 4–5 be converted to whole person impairment. The table for conversion of the upper extremity is AMA5 Table 16–3 (p 439) and the table for conversion of the lower extremity is AMA5 Table 17–3 (p 527).

Thoracic outlet syndrome

15.8 Impairment due to thoracic outlet syndrome is assessed according to AMA5 Chapter 16, The Upper Extremities and *WorkCover Guides*, Chapter 2 (p 11).

Effect of medical treatment

15.9 If the claimant has been offered, but refused, additional or alternative medical treatment which the medical assessor considers is likely to improve the claimant's condition, the assessor should evaluate the current condition, without consideration for potential changes associated with the proposed treatment. The assessor may note the potential for improvement in the claimant's condition in the evaluation report, and the reason for refusal by the claimant, but should not adjust the level of impairment on the basis of the worker's decision (Chapter 1, Permanent impairment — maximum medical improvement, p 5).

Future deterioration

15.10 If a medical assessor forms the opinion that the claimant's condition is stable in the foreseeable future, but expected to deteriorate in the longer term, the assessor should make no allowance for deterioration, but note its likelihood in the evaluation report. Where the claimant's condition suffers long term deterioration, the claimant may reapply for further evaluation of the condition at a later time.

16 Digestive system

AMA5 Chapter 6 applies to the management of permanent impairment of the digestive system.

16.1 The digestive system is discussed in AMA5 Chapter 6 (pp 117-142).This Chapter can be used to assess permanent impairment of the digestive system.

16.2 **AMA5, p 136: Section 6.6 Hernias**. Occasionally in regard to inguinal hernias there is damage to the ilio inguinal nerve following surgical repair. Where there is loss of sensation in the distribution of the ilio inguinal nerve involving the upper anterior medial aspect of the thigh, a 1%WPI should be assessed.

16.3 Where, following repair, there is severe dysaesthesia in the distribution of the ilio inguinal nerve, a 2%WPI should be assessed.

16.4 Where, following repair of a hernia of the abdominal wall, there is residual persistent excessive induration at the site, which is associated with significant discomfort, this should be assessed as a Class 1 herniation (AMA5, Table 6-9, p 136).

16.5 Impairments due to nerve injury and induration can not be combined.

The higher impairment should be chosen.

16.6 A person who has suffered more than one work related hernia recurrence and who now has limitation in ADLs (eg lifting) should be assessed as herniation Class 1 (AMA5, Table 6-9, p 136).

Note: Evaluation of permanent impairment arising from chronic pain (exclusion of AMA5, Chapter 18)

Following consultation with Professor Michael Cousins and Doctor Mike Nicholas of the University of Sydney Pain Management and Research Centre, the AMA5 Chapter devoted to assessment of chronic pain is to be disregarded for the purposes of the *WorkCover Guides*.

The reasons for this are:

- The Chapter does not contain validated instruments that convert the rating given by an examiner into a whole body impairment rating.
- No work has been done at this time to enable such conversion to occur.
- Measuring impairment for this condition is complex and requires a high degree of specialised knowledge and experience. This level of knowledge and experience is not widespread and it would be difficult to ensure consistency and equity in the assessment process.

Impairment ratings in the *WorkCover Guides* attempt to account for the pain commonly associated with many disorders and others, such as complex regional pain syndrome, are specifically included in the Guides. It is recognised in AMA5 that chronic pain is not adequately accounted for in the other Chapters. However, work on a better method is still in progress and it would be premature to specify an alternative at present.

Work is being undertaken by the University of Sydney Pain Management and Research Centre that will enable such a chapter to be written in the future.

As with all largely subjective complaints in compensation systems, there is a concern that monetary compensation for non-specific conditions such as chronic pain can in some cases complicate the restorative and rehabilitative efforts of the worker and his or her health advisers. Hence the need for further investigation to determine a better and fairer system that recognises the difficulties associated with these conditions while, at the same time, promoting effective rehabilitation.

When the work is completed, it will be possible to review this policy decision and introduce assessment of permanent impairment arising from chronic pain, at which time it may be possible to use this assessment as the means of quantifying 'pain and suffering' compensation under section 67 of the *Workers Compensation Act 1987*.

Appendix 1: Working groups on permanent impairment

Permanent Impairment Co-ordinating Group

Name	Position
Dr Jim STEWART	Chair
Ms Kate McKENZIE	WorkCover
Mr John ROBERTSON	Labor Council of NSW
Ms Mary YAAGER	Labor Council of NSW
Dr Ian GARDNER	Medical Representative to Workers Compensation and Workplace Occupational Health and Safety Council of NSW
Dr Stephen BUCKLEY	Rehabilitation Physician
Prof Michael FEARNSIDE	Professor of Neurosurgery
Dr John HARRISON	Orthopaedic Surgeon
Dr Jonathan PHILLIPS	Psychiatrist
Prof Bill MARSDEN	Professor of Orthopaedic Surgery
Dr Dwight DOWDA	Occupational Physician
Assoc Prof Ian CAMERON	Professor of Rehabilitation Medicine
Dr Robin CHASE	Australian Medical Association
2005 Revisions	
Dr Robin Pillemer	Orthopaedic Surgeon
Dr John Dixon Hughes	General Surgeon
Dr Yvonne Skinner	Psychiatrist

Working Groups

Psychiatric and Psychological	Spine	Upper Limb
Dr Julian PARMEGIANI Dr Derek LOVELL Dr Rod MILTON Dr Yvonne SKINNER Dr Jonathan PHILLIPS Dr Chris BLACKWELL Dr Bruce WESTMORE Dr Susan BALLINGER Ms Lyn SHUMACK Dr Jack WHITE Ms Sandra DUNN Dr Tim HANNON	Prof Michael FEARNSIDE Dr John CUMMINE Prof Michael RYAN Dr Dwight DOWDA Assoc Prof Ian CAMERON Dr Hugh DICKSON Dr Conrad WINER Dr Mario BENANZIO Dr Jim ELLIS Dr Jim BODEL Dr William WOLFENDEN Dr Kevin BLEASEL Dr John HARRISON Prof Sydney NADE **2005 Revisions** Dr Roger Pillemer	Dr Dwight DOWDA Assoc Prof Ian CAMERON Prof Bill MARSDEN Assoc Prof Bruce CONELLY Dr David CROCKER Dr Richard HONNER Dr Jim ELLIS Dr Conrad WINER Dr David DUCKWORTH **2005 Revisions** Dr Roger Pillemer Dr Graham McDougall Dr Brian Noll Dr Bruce Connelly
Hearing	**Urinary and Reproductive**	**Respiratory, Ear, Nose and Throat**
Dr Brian WILLIAMS Dr Joseph SCOPPA Dr Stanley STYLIS Dr Paul NIALL Assoc Prof Ian CAMERON	Prof Richard MILLARD Dr Kim Boo KUAH Assoc Prof Ian CAMERON	Dr Julian LEE Prof David BRYANT Dr Joseph SCOPPA Dr Michael BURNS Dr Frank MACCIONI Dr Peter CORTE Dr Brian WILLIAMS Assoc Prof Ian CAMERON

Skin	Vision	Lower Limb
Dr Victor ZIELINSKI Dr Scott MENZIES Dr Edmund LOBEL Assoc Prof Ian CAMERON	Dr Michael DELANEY Dr Peter DUKE Dr Peter ANDERSON Dr John KENNEDY Dr Neville BANKS Assoc Prof Ian CAMERON	Dr Dwight DOWDA Assoc Prof Ian CAMERON Prof Bill MARSDEN Dr Peter HOLMAN Dr Jay GOVIND Dr Jim BODEL Dr Mario BENANZIO Dr Jim ELLIS Dr Conrad WINER Dr Cecil CASS Dr John HARRISON Dr John KORBER
Cardiovascular	**Digestive**	**Haematopoietic**
Dr Thomas NASH Dr John GUNNING Dr George MICHELL Dr Stephen BUCKLEY Dr Melissa DOOHAN Dr Charles FISHER	Prof Philip BARNES Dr David De CARLE Dr Dwight DOWDA	Prof John GIBSON Dr Stephen FLECKNOE-BROWN Dr Peter SLEZAK Assoc Prof Ian CAMERON Prof John DWYER
Endocrine	**Nervous System**	
Dr Alfred STEINBECK Prof Peter HALL Dr Stephen BUCKLEY	Dr Stephen BUCKLEY Assoc Prof Ian CAMERON Dr Dwight DOWDA Dr Ivan LORENTZ Dr Keith LETHLEAN Dr Peter BLUM Prof Michael FEARNSIDE Dr Tim HANNON	

Appendix 2: Guidelines for medico-legal consultations and examinations

(issued by the New South Wales Medical Board, December 2005)

The Medical Board receives many complaints about medico-legal consultations. In these circumstances, the practitioner is not in a therapeutic relationship with the examinee, and the interview and examination may need to be more extensive than the examinee might have been expecting. While some procedures may be simple or routine for the practitioner, they may not be seen as such by the examinee. Effective communication is crucial, especially when the examinee may be nervous and anxious about the possibility of receiving an adverse medical report from the practitioner.

Practitioners are reminded that they have a duty to act in an ethical, professional and considerate manner when examining people, whether or not they are responsible for their care. The same level of professional skill is required of a practitioner acting in a medico-legal capacity as in a therapeutic setting.

Practitioners practising as medico-legal consultants are practising medicine, and accordingly are subject to the provisions of the *Medical Practice Act 1992* regarding conduct, health and performance and must abide by the Board's Code of Professional Conduct: *Good Medicine Practice.*

Practitioners should only undertake medico-legal assessments in their areas of expertise and should decline a request if,

- they are not adequately qualified or experienced
- there may be a conflict of interest (personal, work-related or financial)
- for any other reason they are unable to complete the task within the terms stipulated by the third party.

At all times, practitioners should treat the examinee with dignity and respect. In order to avoid appearing insensitive, rude, or abrupt in their manner or rough in their examination, practitioners are advised to give particular attention to identifying the examinee's concerns, and to adequately explain the reasons for the examination. Adequate time should be allowed for the consultation to enable a complete assessment to be carried out.

In order to prevent misunderstandings between doctors and examinees, the Board has proposed the following guidelines:

The consultation

1. At all times the practitioner should communicate with the examinee in language they can understand.
2. The examinee has the option of having an accompanying person present during the history and/or the examination. This should be explained to the examinee when the interview is being scheduled. The role of the accompanying person is to support the examinee, but not to answer questions or contribute to the assessment. However, should the examinee have an intellectual or speech difficulty, it is appropriate for the accompanying person to assist in the communication between practitioner and examinee.
3. A professional interpreter should be used where the examinee has a difficulty with spoken English. Interpretation should not be provided by a support person or member of the examinee's family.
4. The practitioner should not make unnecessary personal remarks, especially when the consultation involves an intimate examination.

5. The practitioner should be aware of differing cultural sensitivities, especially when conducting an intimate examination.
6. Some practitioners choose to video or audio record the examination. The reason for this should be clearly explained to the examinee and consent should be obtained in advance.
7. The practitioner should not offer any opinion to the examinee on their claim or medic-legal circumstances.
8. The practitioner should not offer any opinion on the examinee's medical or surgical management by other practitioners.
9. In the majority of cases it is appropriate to advise the examinee of an incidental clinical finding which has been identified by the examining practitioner. There may be some situations where it is preferable to notify the examinee's treating practitioner.
10. It is not appropriate for the practitioner to undertake any form of treatment in relation to the examinee.

The introduction

1. The practitioner should properly introduce himself or herself and explain his or her specialty field of medicine in language which the examinee can understand.
2. The practitioner should explain the purpose and nature of the consultation and examination and that it is not the practitioner's role to treat the examinee.
3. The practitioner should explain that his or her role is that of an independent reviewer who is providing an impartial opinion for use in a court or before another decision-making body and that there are limitations on the confidentiality of the assessment. The practitioner should be aware that the patient may believe that they are not independent, but are working for the third party.

The interview

1. The practitioner should limit their questions to matters that are relevant to the purpose of the assessment, prefacing personal questions with an explanation as to why they are necessary.
2. The examinee should be given an opportunity to provide information that they believe may be relevant to the assessment.

The physical examination

1. It is essential that prior to commencing an examination, the practitioner explains which part of the body is to be examined, why it is to be examined, and what the examination entails, including the extent to which undressing is required. The position of the practitioner during the examination should also be explained, particularly when the practitioner will be standing behind the examinee.
2. The examinee's modesty should be preserved by:
    - the provision of a screen behind which the examinee can undress and dress
    - the practitioner excusing himself or herself from the consulting room whilst the examinee is undressing
    - the provision of a gown or sheet.

3. The practitioner should examine the examinee in privacy, unless the examinee has brought a support person to be with them at the time, although the practitioner may choose to have a chaperone present during the examination.
4. Examination should be limited to the area relevant to the examinee's problem. It is inappropriate for the practitioner to examine any part of the body without the examinee's consent. This may limit the scope of the practitioner's examination and subsequent report.
5. If an intimate examination is warranted, the reasons and nature of the examination must be carefully explained to the examinee, and the examinee's permission obtained. This should be noted in the report.

The report

1. The practitioner should ensure that their report contains both the examinee's history and examination findings and that it notes all diagnostic possibilities. Any limitations to a full assessment should be noted.
2. The report should be impartial and unbiased, and reflect the practitioner's consideration of the available opinions of other practitioners and health professionals who have assessed, treated or provided reports on the examinee in the past.
3. The report should be completed within the timeframe requested by the third party unless there are forseeable delays or the deadline is unreasonable, in which case the practitioner should negotiate a new timeframe.
4. The report should set out the material relied upon and any assumptions made.
5. The report should be comprehensible, easy to read and explain medical terminology.
6. The practitioner should be aware of the risks inherent in utilising his or her previous reports as the basis of a subsequent report without further review of the examinee.

Appendix 3: Understanding medico-legal examinations

[Text of a pamphlet prepared by the New South Wales Branch of the Australian Medical Association and the Law Society of New South Wales for the information of members of the public.]

You have been asked to go to a medical examination as part of the legal action you are taking. This brochure will help you understand the examination and your part in it.

This examination aims:

- To find out what injury or medical condition you have;
- To find out its cause;
- To find out if your condition is caused by an accident or by your work conditions;
- To find out if an accident or your work has aggravated some underlying condition.

The examination is intended to be an independent and honest effort to assess your problem so that an impartial report can be prepared.

Who arranges the examination?

The examination has been arranged by your solicitor or by one of the other parties to the legal action, such as the employer, the insurance company or a solicitor acting for one of the other parties.

You have the right to know who has arranged the examination, and you may ask your solicitor or the doctor who carries out the examination.

A report will be sent from the doctor to the person who has arranged the examination. That person pays the doctor for the report. The report will be confidential and the doctor will not be able to give you an opinion about your condition or about any treatment you have had.

About the doctor

The doctor is a specialist who is generally an expert in diagnosing and advising about conditions such as yours. The doctor is usually not an employee of an insurance company or legal firm but a privately or self-employed doctor who often runs a busy medical or surgical practice. The doctor will write a report based on what he learns from you, and your cooperation will be most important. The report will be independent; that is, it will be saying exactly what the doctor thinks about your condition and not aiming to be for or against any side in the legal case.

As you are not seeing the examining doctor as his/her patient, the doctor is not able to give you advice about your problem. The doctor cannot give you treatment. Please do not embarrass the doctor by asking. You will need to ask your own doctor about such matters.

Before the appointment

Please check that you have the correct appointment time and address. You should tell your solicitor or the person arranging the appointment if you are likely to need an interpreter. You should bring all x-rays and tests relevant to your condition so that the doctor can make a thorough assessment.

The report

This will be sent to the person who has arranged the examination and who has paid for it. The report could be used in determining the outcome of your claim. It becomes a legal document and could be used as evidence in court.

The examination

The examination has several parts.

The doctor's secretary will ask you to give some routine particulars. The doctor will introduce himself/herself and try to put you at ease.

The examining doctor will not know whether you need the help of an interpreter. If such help is needed, your solicitor should arrange the interpreter. By mutual agreement with the doctor, you may wish to have a friend or relative with you,

but that person should not interrupt or interfere with the examination.

The doctor will ask you about your work history and will ask you about the accident or circumstances that caused your injury or condition. He/she will ask you about the treatment you have had and about how the injury or condition affects you now. He/she will ask you about your medical history. The questions may be wide-ranging and not just about the body part that has been injured.

Your x-rays and any other investigations will be examined.

The doctor will carry out a physical examination and will explain or demonstrate what he/she wants you to do. The doctor will examine the injured parts of your body and possibly other parts of your body as well. The examination may involve measuring height and weight and the movement of various joints and reflexes.

Every consideration will be given

The doctor will carry out an examination of you in a respectful manner. In the physical examination he/she will not hurt you. The doctor will not expect you to do anything that would cause pain.

A complex medical history may take an hour or more, but many examinations are completed in less than that time. The doctor will be aiming to let you go as soon as possible.

How can you help?

Be punctual. The doctor will try and be punctual too, but remember that doctors sometimes have to deal will urgent matters.

It is best to turn off your mobile phone.

Be pleasant to the doctor, particularly if the examination has been arranged by the other side. Remember that the doctor will be giving an independent report. No one benefits from an unpleasant atmosphere. A hostile attitude might mean deferral or termination of the examination.

Be prepared if possible with important dates and names. Don't be worried if you cannot remember — the doctor simply wants your best recollection.

Be honest and straightforward with your answers, even if you think that the questions are not closely related to the main problem.

Wear clothes that are suitable. For example, if your back is to be examined, it is usual for outer clothing to be removed. Women should wear a bra and pants so that the back can be examined thoroughly while preserving the modesty of the patient and out of respect for the practitioner. It is never necessary to fully disrobe a patient. Modesty will be considered at all times, but an adequate examination requires adequate exposure. The doctor's report may mention the fact if a patient is unwilling to undress sufficiently for adequate examination.

What if there are problems during an examination?

Reading this brochure should help you know what to expect.

If the doctor asks you a question that you do not wish to answer, then you may say so. However, this may be mentioned in the medical report.

If the doctor asks you to do something that would cause pain, then mention this to the doctor. But don't forget that the doctor is expecting your best cooperation during the examination.

If you believe that there is a complete breakdown in your relationship with the doctor, then you may choose to say so and to leave the examination. However, if you do, you may be liable for the cost of the examination and report.

If you are in doubt about something during the examination, a quick phone call to your solicitor may help.

Repeat examinations

Sometimes legal cases go on for a long time. Repeat examinations are arranged so that the doctor can report on your progress. The doctor has no say about whether the case is resolved or whether you get compensation and simply reports on your condition.

Feedback

Please let the AMA or the Law Society know if you think this brochure can be improved; everyone is keen to make this necessary examination as easy as possible for you.

Comments in writing on suggested brochure improvements will be received by:

The Australian Medical Association (NSW)
33 Atchison Street
St Leonards, NSW 2065

and

The Law Society of New South Wales
170 Phillip Street
Sydney NSW 2000

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WORKCOVER INTERIM PAYMENT DIRECTION GUIDELINES

I, Jon Blackwell, the Chief Executive Officer of the WorkCover Authority of New South Wales, under sections 291 and 376(1) of the *Workplace Injury Management and Workers Compensation Act 1998,* issue the following guidelines.

Dated, this twenty-fifth day of October 2006.

Jon Blackwell
Chief Executive Officer
WorkCover Authority

EXPLANATORY NOTE

These guidelines are made pursuant to sections 291 and 376 (1) of the *Workplace Injury Management and Workers Compensation Act 1998* (referred to in these guidelines as the 1998 Act) and refer in particular to the following provisions of the 1998 Act:

- section 267 (duty to commence weekly payments following initial notification of injury)
- section 274 (claims for weekly benefits – liability to be determined within 21 days)
- section 279 (claims for medical expenses – liability to be accepted within 21 days)
- section 292 (expedited assessment)
- section 295 (disputes to which Part 5 of Chapter 7 of the 1998 Act applies)
- section 297 (directions for interim payment of weekly payments or medical expenses compensation)
- section 298 (period for which interim payment of weekly payments can be directed)
- section 299 (revocation of Interim Payment Direction)
- section 300 (failure to comply with Interim Payment Direction)
- section 301 (effect of payment under Interim Payment Direction)
- section 378 (reconsideration of decisions).

The guidelines set out the procedures for making and determining an application for an Interim Payment Direction under Part 5 of Chapter 7 of the 1998 Act.

These guidelines replace guidelines dated December 2001.

These guidelines commence on 1 November 2006.

These guidelines are intended to assist workers, employers and insurers. Questions about Interim Payment Directions and these guidelines should be directed to the registrar of the Workers Compensation Commission (referred to in these guidelines as the registrar) or the WorkCover NSW Information Centre on 13 10 50.

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INTERIM PAYMENT DIRECTIONS

1. Legislative Framework

These guidelines set out the procedures for referring and managing disputes dealt with by an Interim Payment Direction under Part 5 of Chapter 7 of the 1998 Act. These guidelines should be read in conjunction with the sections of the 1998 Act referred to in these guidelines, Clause 38 of the *Workers Compensation Regulation 2003*, Workers Compensation Commission Rules 2006, the Workers Compensation Commission Practice Directions, and approved forms and guides for completing the forms.

2. Intention of Interim Payment Directions

An Interim Payment Direction is intended to ensure that a worker is able to receive their correct entitlements, primarily where an insurer fails to commence payments or determine liability within the legislated timeframe, ie within 7 days after initial notification of an injury when provisional weekly benefits may be payable (and there is no reasonable excuse for non payment) or within 21 days of lodging a claim for weekly benefits or medical expenses.

Even where a dispute notice has been issued, some medical expenses disputes can best be resolved by expedited assessment, provided the cumulative amount is under $7,500. This may also be the case in respect of a weekly payments dispute, eg where it is the first application to come before the registrar and a question arises as to the validity or correctness of the dispute notice.

The registrar will determine if it is appropriate for a matter to be dealt with by an expedited assessment and Interim Payment Direction. Where this is not appropriate, the registrar will refer the matter to an arbitrator for final resolution of the dispute.

Where a matter is being dealt with as an interim payment direction application, and a dispute notice has not been issued, the insurer will review the claim and advise the outcome of the review to the registrar and the worker. If a dispute notice has been issued as a result of the review and before a teleconference is conducted, it may then be appropriate, for the same reasons as set out above, for the dispute to be referred to an arbitrator for final resolution of the dispute.

Where a dispute notice has been issued in respect of a weekly payments dispute, the separate ‘small claims’ expedited assessment process is available for past weekly benefits of up to 12 weeks. This process will result in a Certificate of Determination being issued which will finalise the dispute.

Reference sections 304A, 304B of the 1998 Act.

For further clarification of the application of the Interim Payment Direction process to particular applications refer to Part 8 of this guideline and to the Workers Compensation Commission Rules 2006.

Reference sections 288, 292 of the 1998 Act.

3. Interim Payment Directions

An Interim Payment Direction is a direction by the registrar to pay:

- weekly payments of compensation for a period that does not exceed 12 weeks and can be for a period that is before the direction, but that period must not exceed 10 weeks
- medical expenses compensation for an amount up to $7,500 (where the cumulative total of medical and related expenses under consideration in connection with the claim is likely to exceed $7,500, the registrar will refer the matter to an arbitrator for final resolution of the dispute).

Any payments authorised in an Interim Payments Direction must be in accordance with WorkCover gazetted fees orders.

Payments made by a respondent, pursuant to an Interim Payment Direction are made without an admission of liability.

Reference sections 297, 298 & 301 of the 1998 Act.

4. Types of Interim Payment Direction Applications

An application may be dealt with as an Interim Payment Direction application when any dispute concerns:

- weekly payments of compensation where:
  - provisional payments have not commenced within 7 days of initial notification of injury and there has been no reasonable excuse by the insurer for non payment
  - there has been a failure to determine liability within 21 days of a claim being made
  - a dispute notice has been issued and the matter is appropriate to be dealt with as an interim payment direction application (refer Clause 2)
- medical expenses compensation where:
  - there has been a failure to pay medical expenses within 21 days of a claim being made
  - a dispute notice has been issued and the matter is appropriate to be dealt with as an interim payment direction application (refer Clause 2).

Reference sections 267, 274, & 279 of the 1998 Act.

5. Requirement for Claiming Compensation

An application may be dealt with as an Interim Payment Direction application without a claim being made where:

- initial notification has been given to the insurer containing the minimum information required
- payment of weekly compensation has not commenced within 7 days without a reasonable excuse being issued by the insurer as specified in the *WorkCover Guidelines for Claiming Compensation Benefits*.

In all other cases a claim must be made in accordance with *WorkCover Guidelines for Claiming Compensation Benefits.*

Reference section 295 of the 1998 Act.

6. Interim Payment Direction for Weekly Payments Compensation

Presumption in favour of worker

The 1998 Act provides that the registrar is to presume that an Interim Payment Direction for weekly payments of compensation is to be made unless any one or more of the following is the case:

- the worker has returned to work
- the worker did not report the injury to the employer as soon as possible after the injury happened
- the claim has minimal prospects of success
- there is not enough medical evidence available concerning the worker's period of incapacity
- a section 74 notice disputing liability has been served.

Where the presumption does not apply, the registrar will determine how best to deal with the matter and may refer it to an arbitrator for final resolution of the dispute (refer Clause 2 above).

Reference section 297 of the 1998 Act.

Evidence based decision making

In deciding whether to make an Interim Payment Direction for weekly payments compensation the registrar will consider:

- promotion of injury management and return to work
- available medical evidence that supports the claim and period of incapacity
- views of all parties.

Generally, an Interim Payment Direction should not be made when:

- a reasonable excuse for not commencing provisional payments has been notified to the worker by the insurer
- the provisional liability entitlements have been exhausted and the worker has not provided further evidence of their incapacity; or
- the worker has not provided information that the insurer has requested; or
- the worker has unreasonably failed to comply with an injury management plan and the insurer has notified the worker what the worker must do to comply with the injury management plan.

Reference section 297 of the 1998 Act.

7. Interim Payment Direction for Medical Expenses Compensation.

Presumption in favor of the worker

The registrar is to presume an Interim Payment Direction for medical expenses is warranted where an injury management plan is in place or the insurer has accepted that the worker has received an injury, provided the registrar is satisfied that the relevant treatment or service for medical expenses compensation is reasonably necessary:

- to prevent the worker's condition deteriorating; or
- to promote the worker's early return to work; or
- to relieve the worker's significant pain or discomfort.

Where the presumption does not apply, eg where a dispute notice has been served or where the cumulative total of medical and related expenses is likely to exceed $7,500, the registrar will determine how best to deal with the matter and may refer it to an arbitrator for final resolution of the dispute (refer Clause 2 above).

Evidence based decision-making

In deciding whether to make an Interim Payment Direction for medical expenses compensation the registrar will consider:

- whether the treatment is reasonably necessary (for further information on 'reasonably necessary treatment' refer to *WorkCover Guidelines for Claiming Compensation Benefits*, Part 1, clause 10)
- the views of an approved medical specialist to whom the dispute is referred, if any
- WorkCover gazetted fees orders and treatment provider guidelines.

Reference section 297 of the 1998 Act.

8. Procedures at the Workers Compensation Commission (WCC)

Before the registrar decides to make an Interim Payment Direction, the registrar may

- consider the information contained in the application and the reply
- consider the views of all parties
- if necessary, request additional relevant information and documents be lodged and served
- schedule a teleconference within 14 days of referral of the dispute.

Following advice from the parties, if the registrar is satisfied that sufficient information has been supplied in connection with an application for an Interim Payment Direction, the registrar may determine the application without holding a teleconference.

Prescribed procedures for the production of documents under the Workers Compensation Commission Rules 2006 do not have application to Interim Payment Direction applications.

9. Imposing Conditions on Interim Payment Directions.

The registrar may impose conditions on any interim payment order as the registrar thinks fit. In doing so, the registrar should consider the objectives of the WCC and the overall objectives of the workers compensation system.

The conditions may include a requirement that the worker submit medical certificates certifying the period of their incapacity.

Reference section 297 of the 1998 Act.

10. Notification to Parties

When the registrar makes an Interim Payment Direction, a notice will be issued to the worker, employer and the insurer.

11. Compliance with an Interim Payment Direction

Unless otherwise directed within the notice:

- if the Interim Payment Direction is for weekly payments or for medical expenses the worker has already paid, the insurer must pay within 7 days of the notice being issued by the registrar
- if the Interim Payment Direction is for other medical expenses compensation, the insurer must approve any treatment within 7 days of the notice being issued by the registrar.

Reference section 297 of the 1998 Act.

12. Non-compliance with an Interim Payment Direction.

A person who fails to comply with an Interim Payment Direction is guilty of an offence and will be reported to WorkCover.

Reference section 300 of the 1998 Act.

13. Changing an Interim Payment Direction.

When the registrar makes an Interim Payment Direction, payments must be made as directed except as follows:

- if new evidence that was not available when the Interim Payment Direction was made becomes available, a written application to revoke the Interim Payment Direction can be made as specified in Parts 14 below
- the registrar will use these guidelines to review the application.

14. Revocation of an Interim Payment Direction

The registrar, on the application of a party or on the registrar's own motion, can revoke an Interim Payment Direction.

If the registrar revokes an Interim Payment Direction, a notice will be provided to the parties and any obligation to make a payment under the direction ceases.

The revocation of an Interim Payment Direction does not affect the requirement to make payments directed to be paid before the revocation.

Reference section 299 of the 1998 Act.

15. The Effect of an Interim Payment Direction

Interim Payment Directions are not an admission of liability.

Reference section 301 of the 1998 Act.

WORKCOVER MEDICAL ASSESSMENT GUIDELINES

I, Jon Blackwell, the Chief Executive Officer of the WorkCover Authority of New South Wales, under sections 328, 331 and 376 of the *Workplace Injury Management and Workers Compensation Act 1998* issue the following guidelines.

Dated, this twenty-fifth day of October 2006.

Jon Blackwell
Chief Executive Officer
WorkCover Authority

Explanatory note

These guidelines set out the procedures for the referral of medical disputes for assessment and appeal, and the procedures for assessment and on appeal under Part 7 of Chapter 7 of the 1998 Act and, in particular, refer to the following provisions of the 1998 Act :

- section 321 (referral of medical dispute for assessment)
- section 322 (assessment of impairment)
- section 323 (deduction for previous injury or pre-existing condition or abnormality)
- section 324 (powers of approved medical specialist on assessment)
- section 325 (medical assessment certificate)
- section 326 (status of medical assessment)
- section 327 (appeal against medical assessment)
- section 328 (procedure on appeal)
- section 329 (referral of matter for further medical assessment).

The guidelines commence on 1 November 2006. The guidelines replace guidelines dated 19 December 2003 and published in Government Gazette No 197 at page 11564.

Questions about these guidelines or medical assessments should be directed to the Registrar of the Workers Compensation Commission.

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MEDICAL ASSESSMENT GUIDELINES

These guidelines set out the procedures for referring medical disputes for assessment and appeal and the procedures for assessment and on appeal under Part 7 of Chapter 7 of the 1998 Act.

These guidelines should be read in conjunction with the *WorkCover Guidelines on Independent Medical Examinations and Reports Guidelines.*

CHAPTER A: INTERPRETATION

Abbreviations used in these Guidelines

1. In these Guidelines, these abbreviations are used:

NAATI	National Accreditation Authority for Translators and Interpreters
MAC	Medical Assessment Certificate
WCC	Workers Compensation Commission
WPI	Whole Person Impairment

Words and Phrases Defined in these Guidelines

2. In this part, these words and phrases have the following meanings:

- *approved medical specialist* means a medical practitioner appointed under Part 7 of Chapter 7 of the 1998 Act as an approved medical specialist
- *day* or *days* means calendar days unless specified as working days
- *registrar* means the registrar of the Workers Compensation Commission
- *claimant* means a person who has made a claim under the 1998 Act
- *lead assessor* means an approved medical specialist nominated to co-ordinate the degree of whole person impairment resulting from complex injuries requiring assessment of multiple body systems
- *party* includes the claimant, an insurer or an employer
- *insurer* is an insurer within the meaning of the *Workers Compensation Act 1987* and the *Workplace Injury Management and Workers Compensation Act 1998* and includes Scheme Agents, self and specialised insurers.
- *the 1998 Act* means the *Workplace Injury Management and Workers Compensation Act 1998*
- *WorkCover Guides* means the *WorkCover Guides for the Evaluation of Permanent Impairment.*

Chapter B: THE REFERRAL PROCESS

Referral to an Approved Medical Specialist

3. A party to a dispute can request a matter be referred to an approved medical specialist.

   A court or the WCC is to notify the registrar when a matter is to be referred to an approved medical specialist, either on their own motion or on the request of a party.

   The notification must be in the form approved by the registrar for that purpose.

4. Only the registrar has the power to refer disputes regarding the level of permanent impairment. These disputes are commenced by the filing of an application to resolve a dispute which is limited to or includes lump sum compensation.

   All disputes about the level of permanent impairment are referred to an approved medical specialist.

Choice of Approved Medical Specialist

5. The parties to the dispute must advise the registrar in writing of the name of the approved medical specialist they have agreed to appoint at the time of filing the application and/or reply or within 7 days after the dispute is referred.

6. If the parties do not advise the registrar as set out above, the registrar is to choose the approved medical specialist who is to assess the dispute and advise the parties in writing of the name of the approved medical specialist.

7. If the chosen approved medical specialist is not available within a period of 2 months, parties should select another approved medical specialist or the registrar will appoint one.

8. In the rare case of a complex injury where different assessors are required to assess different body systems, a lead assessor should be agreed between the parties and advised to the registrar at the time of filing the application and/or reply or within 7 days after the dispute is referred.

9. If the parties do not advise the registrar the name of the lead assessor within this time the registrar is to appoint the lead assessor and advise the parties in writing of the name of the approved medical specialist.

Basis for Registrar Appointment of an Approved Medical Specialist

10. When choosing an approved medical specialist, the parties or the registrar should consider:
    - the approved medical specialists on the WCC's list who are appropriate given the body systems to be assessed
    - which location would be most convenient to the worker and the approved medical specialist
    - the availability of the approved medical specialist within 2 months.

Grounds for Objection to an Approved Medical Specialist the Registrar has Appointed

11. A party may apply to the registrar to have the matter reallocated on the grounds that the approved medical specialist to whom the matter has been allocated has a conflict of interest. To do that, the party must apply:
    - within 7 days of receiving notification of the name and contact details of the approved medical specialist
    - in writing, detailing the reasons.

12. The registrar is to decide on the application for reallocation within 7 days of receipt. If the registrar is of the opinion that there are reasonable grounds for believing that the appointed approved medical specialist may have a conflict of interest (eg someone previously treated or examined or where there is a personal relationship) the registrar must reallocate the matter.

The Registrar Arranges the Assessment

13. The registrar is to contact the agreed or appointed approved medical specialist to obtain an appointment for assessment. An appointment for assessment is usually provided within 21 days of the request.

14. The registrar advises the parties of the date and location of the assessment.

15. If an interpreter is required, the registrar is to organise for a NAATI accredited interpreter to assist with the assessment.

16. When the registrar refers the matter to the approved medical specialist, the registrar is to provide the approved medical specialist with:
    - all information and documentation on which the parties are relying in connection with the particular medical dispute referred and which have been lodged with the Commission and which comply with the *Workers Compensation Regulation 2003,* any applicable provisions of the *Workers Compensation Commission Rules 2006* and any orders of a Court or the WCC
    - where the referral is in connection with the assessment of permanent impairment, videos and other electronic records obtained as part of lay investigators' reports shall not be disclosed to the approved medical specialist.

17. The registrar may communicate with the parties, or any of the worker's treatment or service providers to clarify the matter or matters in dispute.

18. The parties are not to communicate directly with the approved medical specialist at any time with the exception of the worker during the examination. The parties are not to provide additional information to the approved medical specialist at any time, unless requested by the approved medical specialist.

19. An approved medical specialist may decline to accept a referral for valid reasons conveyed to the registrar within 7 days of receiving the referral documents.

CHAPTER C: THE ASSESSMENT PROCEDURE

Conflict of Interest

20. An approved medical specialist to whom a matter is allocated must not accept a referral if there is a known conflict of interest (eg someone previously treated or examined or where there is a personal relationship). For the purpose of identifying any potential conflict of interest, the approved medical specialist is to review the referral documents within 7 days of receiving them.

21. If the approved medical specialist considers that there may be a conflict of interest the approved medical specialist is to immediately notify the registrar and return the referral documents. The matter will then be reallocated to another approved medical specialist by the registrar.

Examination by Approved Medical Specialist

22. The *Medico-Legal Guidelines* of the NSW Medical Board, as in force from time, to time apply to examinations by approved medical specialists.

23. The procedures set out in the WorkCover Guides apply to the conduct of assessments relating to whole person impairment. The applicable Guides are those in force at the time of the assessment. The Table of Disabilities applies when assessing permanent loss for injuries pre 1 January 2002.

24. The approved medical specialist may do any one or more of the following:

- consult with any medical practitioner or other health care professional who is treating, or has treated, the worker
- call for medical records (including x-rays and the results of other tests) and other information that the approved medical specialist considers necessary or desirable to assess the dispute
- require the worker to submit himself or herself for examination by the approved medical specialist.

25. For the majority of matters, a medical examination of the worker will be necessary for the approved medical specialist to be able to form an opinion.

26. However, the approved medical specialist may make an assessment without a medical examination if satisfied that the information provided is sufficient to enable determination of the issues. In exercising the discretion not to conduct a medical examination, the approved medical specialist must consider:

- the nature and complexity of the issues in dispute
- the likely impact of non-examination on the outcome of the dispute
- the extent and detail of the information provided
- any submission by the parties as to why a medical examination is required.

If no examination is to be conducted, the worker will not attend an appointment with the approved medical specialist.

27. The approved medical specialist will confirm in the Medical Assessment Certificate (MAC) that a clinical examination was conducted or the reasons that it was not required.

Accompanying Person for the Worker at an Assessment

28. A support person nominated by the worker may accompany the worker to a medical assessment if it is reasonable in the circumstances and the approved medical specialist agrees. A union representative or legal practitioner instructed to act for the worker in the WCC must not accompany a worker to a medical assessment.

29. The accompanying person is to conduct himself or herself appropriately during the examination. The approved medical specialist has the right to ask the person to withdraw if their behaviour interferes with the conduct of the examination.

Interpreters

30. Interpreters accredited by NAATI should be used for assessments when an interpreter is required. If appointed, an interpreter should disclose any potential conflict of interest and the registrar will then determine whether another interpreter is required.

31. In the absence of a NAATI accredited interpreter, a non-NAATI interpreter may be used at the discretion of the registrar as long as that person holds appropriate qualifications as an interpreter and can demonstrate that there is no conflict of interest eg personal or financial relationship with the worker or assessor.

Non-attendance by the Worker

32. The approved medical specialist must notify the registrar in writing if the worker did not attend the scheduled appointment. The notification is to be provided within 2 working days of the scheduled appointment.

33. Failure to attend on two occasions without a reasonable excuse will be evidence of a failure to proceed with the application and will result in the proceedings being dismissed.

Paying the Worker's Expenses

34. The insurer must meet any reasonable costs incurred by the worker, including wages, travel and accommodation. This may include pre-payment of travel and accommodation expenses. If the worker is not reasonably able to travel unescorted, this may include expenses for the worker's escort. *Refer Section 330 of the 1998 Act*.

CHAPTER D: THE MEDICAL ASSESSMENT CERTIFICATE

35. The approved medical specialist is to provide the registrar with a completed MAC within 10 working days of the assessment.

36. The MAC must be in the form approved by the registrar and must include the following information:

- details of the matters referred for assessment
- the approved medical specialist's opinion with respect to those matters
- total amount of whole person impairment (where applicable)
- the facts on which that opinion is based
- the approved medical specialist's reasons for that opinion

- in matters related to permanent impairment, correct reference to the Table of Disabilities (injuries pre 1 January 2002) or to the WorkCover Guides (injuries from 1 January 2002).

Registrar's Action on Medical Assessment Certificate

37. Prior to issuing a MAC to the parties, the registrar is to ensure that the matters referred for assessment by the registrar are addressed in the MAC.

    The registrar will then issue the MAC and if the MAC addresses the level of the worker's permanent impairment and other matters that are conclusively presumed to be correct, each of the parties must also be provided with a notice advising of the appeal provisions.

    Matters conclusively presumed to be correct in proceedings before the WCC are:

    - the degree of permanent impairment of the worker as a result of an injury
    - whether any proportion of permanent impairment is due to any previous injury or pre-existing condition or abnormality
    - the nature and extent of loss of hearing suffered by a worker
    - whether impairment is permanent
    - whether the degree of impairment is fully ascertainable.

    The MAC may also contain other matters which are evidence but not conclusive evidence in proceedings. These matters are:
    - the worker's condition (including the worker's prognosis), aetiology of the condition and the treatment proposed or provided
    - the worker's fitness for employment.

Errors in the Medical Assessment Certificate

38. If the registrar identifies that a MAC contains an obvious error the registrar must consult the approved medical specialist. Typographical and calculation errors may be corrected by the registrar and confirmed in writing by the approved medical specialist or the MAC will be returned to the approved medical specialist for correction.

39. If the MAC is corrected, the replacement MAC is taken to be the decision of the approved medical specialist.

40. The registrar is to provide the parties and the approved medical specialist with a copy of the replacement MAC.

CHAPTER E: REVIEWING OR APPEALING THE MEDICAL ASSESSMENT CERTIFICATE

Time for Making an Appeal

41. An appeal application (on the grounds that the assessment was made on the basis of incorrect criteria or the MAC contains a demonstrable error), must be lodged within 28 days after the date the MAC is issued, unless special circumstances apply.

    If the appeal application is lodged after 28 days, the appealing party may lodge a submission setting out the special circumstances to be considered by the registrar.

    A party cannot appeal against a medical assessment if the WCC has already issued a Certificate of Determination.

Application for Appeal/Opposition

42. Parties lodging an appeal, or opposition to an appeal, must use the approved forms and attach relevant submissions. For further information on completing WCC forms refer to *Guides for Completing Forms* available on WCC website at http://www.wcc.nsw.gov.au/.

    If the party lodging the appeal does not use the approved form and attach relevant submissions, the appeal will be rejected. If the appeal is subsequently lodged out of time, submissions addressing the special circumstances that apply will also be required.

Procedure for Appeals Against a Decision of Approved Medical Specialist

43. If an appeal against a decision of an approved medical specialist is accepted for filing, the application and copies will be sealed and issued to the appealing party. A standard timetable will be issued to ensure that the parties comply with the legislation and guidelines.

    The appealing party must lodge a Certificate of Service (Form 4) within 14 days of the date of acceptance of the application by the registrar or by the date referred to in the standard timetable, certifying service of the application and timetable on the other parties.

    The other parties to the appeal may lodge an opposition within 21 days of acceptance of the application by the registrar. The filing party should serve an unsealed copy of the opposition on each other party (including the insurer) prior to lodgement with the WCC.

Referral for Appeal, Further Assessment or Reconsideration

44. Where the registrar is satisfied on the face of the application and any submissions made to the registrar that a ground of appeal has been made out, the registrar may refer the matter for determination of the appeal by a medical appeal panel or for further assessment or reconsideration by the approved medical specialist who issued the MAC, as an alternative to an appeal.

    The power of an AMS to reconsider a decision, which is provided for under section 378 of the 1998 Act, can only be exercised where a matter is referred back to the AMS by the Registrar as an alternative to an appeal.

    The registrar will reject an appeal if not satisfied that a ground of appeal has been made out.

Procedure of the Appeal Panel

45. An appeal panel consists of two approved medical specialists and one arbitrator. The appeal panel may adopt any of the following procedures in accordance with the needs of the individual case:

    - preliminary review (in all matters),
    - 'on the papers' review,
    - further medical examination by an approved medical specialist on the appeal panel,
    - assessment hearing.

Where a further medical examination is required, the registrar will advise the worker of the time and place of the examination. A support person (other than an agent or legal adviser) may accompany a worker to the examination. The worker should not bring any additional medical or other reports to the examination, unless specifically asked to do so. If it is necessary to bring x-rays or similar documents the worker will be advised of this in the letter from the registrar.

The registrar must be advised in advance if an interpreter is required for the examination.

Assessment Hearing

46. Where the appeal panel determines a matter is not capable of determination on the papers, either with or without a further medical examination, an assessment hearing will be arranged.

The appeal panel assessment hearing will be informal and non-legalistic, and will afford the parties a full opportunity to present oral submissions in support of their claims. The assessment hearing is non-adversarial and in most cases no evidence will be taken or cross-examination permitted. A party is entitled to be represented at the assessment and may choose to be accompanied by a person (including but not limited to a legal adviser or agent) to assist in the presentation of their case. The assessment will be sound recorded and a copy of the recording will be available to the parties on request. The parties may seek clarification of matters raised with the assistance of the panel members.

Revocation or Confirmation of the Medical Assessment Certificate

47. The appeal panel can:
    - confirm the MAC issued by the approved medical specialist; or
    - revoke that MAC and issue a new certificate.

The decision of a majority of the members of an appeal panel is the decision of the appeal panel.

In all cases where the appeal panel decides to revoke the medical assessment certificate and issue a new certificate, the new certificate will be sent to the parties by the registrar.

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