Government Gazette
OF THE STATE OF
NEW SOUTH WALES
Number 30
Friday, 23 March 2012
Published under authority by Government Advertising

SPECIAL SUPPLEMENT

WORKCOVER GUIDELINES ON INDEPENDENT MEDICAL EXAMINATIONS AND REPORTS

I, Julie Newman, Acting Chief Executive Officer of the WorkCover Authority of New South Wales, under section 119 (4) and section 376 of the Workplace Injury Management and Workers Compensation Act 1998, issue the following guidelines.

Dated this 13th day of March 2012.

JULIE NEWMAN,
A/ Chief Executive Officer,
WorkCover Authority of NSW

WORKCOVER GUIDELINES ON INDEPENDENT MEDICAL EXAMINATIONS AND REPORTS

Workplace Injury Management and Workers Compensation Act 1998

These guidelines are issued under section 119 (4) and section 376 of the Workplace Injury Management and Workers Compensation Act 1998. 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 replace guidelines dated 14 April 2009 and published in the NSW Government Gazette No. 63.

These guidelines commence on 23 March 2012.

In this guideline, 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

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 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 made when answers to one or more of the questions outlined on page 5, 'Reasons for referral' are sought.

All referrals for independent medical examinations 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 medical practitioner 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, e.g. a hand or plastic surgeon for hand injuries, a spinal surgeon for complex back injuries, a neurosurgeon or rehabilitation specialist for head injuries.

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 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 with qualifications relevant to the treatment of the injured worker's injury; 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, 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, clause 9.3, Part 2). 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. The insurer is to respond to these requests.

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
- When an injured worker submits a report from an assessor of permanent impairment who is the worker's treating medical practitioner and the assessment of permanent impairment is less than 10% whole person impairment, if questions regarding that assessment arise they are to be posed to the author in the first instance. If the response from the assessor is inadequate, unavailable, inconsistent or not received in 10 working days, a referral for an independent medical examination may be made.
- The worker can be referred for an independent medical assessment if the worker submits an assessment of permanent impairment that is equal to or more than 10% whole person impairment.
- The worker can be required to submit themselves for an independent medical assessment if the claim is for additional permanent impairment or permanent loss, when one or more previous claims for permanent impairment or permanent loss have already been determined and paid.
- In any case, if the worker submits an assessment of permanent impairment by an assessor who is not the worker's treating medical practitioner, and the employer/insurer determines to refer the worker for an independent medical examination, the worker should be referred to the treating medical practitioner for assessment of permanent impairment if that practitioner is trained in whole person impairment.

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 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 the specific reason for the 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 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.

It is not acceptable to list standard questions that are not relevant to the specific aspect of the claim leading to this referral.

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 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 is to be obtained.

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 on audio or video, the worker must be informed of this and be in agreement prior to the examination being scheduled. The recording of the examination is only to proceed if the worker consents.

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 supplied in a manner that facilitates review/perusal by the independent medical examiner. This includes the provision of an index of all documents provided with the documentation organised accordingly. The index is to be attached to the referral.

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 for the independent medical examination must include:

- the specific reason for the examination
- if applicable, an explanation of why the response from the treating medical practitioner or author of the assessment report to the insurer's enquiry was inadequate, inconsistent or unavailable
- 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 requested
- that no one may be present during the actual physical/psychological examination of the injured worker, unless agreed by the worker and 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 examination report is to list the material reviewed, provided by the referrer and/or any material provided by the worker at the time of consultation, 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. Such requests are to be made in writing.

Where the referrer requests that the examiner review additional information and seeks a supplementary report, that report will attract an additional cost.

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 maximum fees to be charged and 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 is to either:

a. agree the category of report being requested with the independent medical examiner and confirm the request in writing indicating that payment will be made within 10 days of receipt of a properly completed report and invoice; or

b. pay in accordance with a contractual arrangement between the medical practice and the referring body on receipt of a properly completed tax invoice.

Either arrangement cannot agree to a fee above the maximum fee prescribed in the Workers Compensation (Medical Examinations and Reports) Order.

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 conducted by a WorkCover approved assessor of permanent impairment 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.

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 classifies the problems to be addressed into standard, moderately complex and complex. Definitions of these are:

A. **Standard Reports** are reports relating solely to a single event or injury in relation to:
   - causation; or
   - fitness for work; or
   - treatment; or
   - simple permanent impairment assessment of one body system.

B. **Moderately Complex Reports** are:
   - reports relating to issues involving a combination of two of the following:
     - o causation
     - o fitness for work
     - o treatment
     - o simple permanent impairment assessment of one body system

     or
   - reports of simple permanent impairment assessment of two body systems or more than one injury to a single body system.

C. **Complex Reports** are:
   - reports relating to issues involving a combination of 3 or more of the following:
     - o causation
     - o fitness for work
     - o treatment
     - o simple permanent impairment assessment of one body system.

     or
   - A complex method of permanent impairment assessment on single body system or multiple injuries involving more than one body system.

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 at the time of receiving the referral.

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 provider.services@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 to the specific questions asked in the letter of referral (refer to page 5).
- If the referral is about 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 there is any deduction for a pre-existing condition must be addressed. A summary table (see Table 1) and a copy of all calculations must be included.

Table 1 – Whole Person Impairment (WPI)

Body part or system	*Date of injury*	*Chapter, page and paragraph number in WorkCover Guides*	*Chapter, page, paragraph, figure and table numbers in AMA5 Guides*	*% WPI*	*% WPI deductions pursuant to section 323 for pre-existing injury, condition and abnormality*	*Sub-total/s % WPI in whole numbers (after any deduction/s in column 5)*
1.						
2.						
3.						
Total % WPI (the Combined Table values of all sub-totals in whole numbers)						

WORKCOVER GUIDELINES FOR CLAIMING COMPENSATION BENEFITS

Workers Compensation Act 1987

Workplace Injury Management and Workers Compensation Act 1998

Explanatory Note

These guidelines are made under section 376 (1) of the Workplace Injury Management and Workers Compensation Act 1998. 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 dated 17 April 2009 and published in the *NSW Government Gazette* No. 63.

These guidelines commence on 23 March 2012.

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.

Dated: 13 March 2012.

JULIE NEWMAN,
A/ Chief Executive Officer,
WorkCover NSW

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 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 timely, safe and durable return to work as early as possible having regard to the nature of the injury
- 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.

TABLE OF CONTENTS

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

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 and employer:

- 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, *Information for injured workers*, is to be given to the worker. *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 may need to be made and a claim form should be enclosed (see clause 2, Part 2).

6.8 include in the notice to the employer details about how the weekly payments of compensation are to be made and for small employers a copy of the WorkCover brochure, *Employers guide: what to do if an injury occurs*.

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 Not Commence 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 is 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

7.8 **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.

7.9 **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
- How the issue will be resolved by the insurer or how the worker may resolve the issue
- 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

7.10 **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. *(Refer to clause 2, Part 2 re Need for a Claim Form)*.

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*.

The requirement to commence provisional payments is waived if liability for the claim is determined, and notice of this decision given to the worker within 7 days of receipt of the claim.

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

In most circumstances, the need for a claim form can be waived and the claim taken to have been made.

A claim form is only required if:

- a reasonable excuse notice has been issued and the reason continues to exist
- compensation is claimed or payable beyond the provisional liability period for weekly payments of compensation or where medical expenses under provisional liability may exceed $7,500 and there is insufficient information to determine ongoing liability
- an injury notification is made but there is insufficient information to determine liability. (See clause 7.9, Part 1 for requirements for a notice).

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 reasons 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 –
  - o worker has failed or refuses to sign the declaration form
  - o 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 and employer 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.

Include in the notice to the worker and employer:

- that benefits have commenced on the basis of acceptance of liability
- 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
- a copy of the WorkCover brochure for injured workers, *Information for injured workers*. *Reference section 269 of the 1998 Act*.
- a copy of the WorkCover brochure, Employers guide: what to do if an injury occurs, to small employers (if not previously provided).

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 Employer Expectations

Decisions on liability, reduction or termination of weekly benefits or declinature of other entitlements, are to be advised to the employer of the injured worker. This is of particular importance whilst the cost of claim impacts on the employer's premium.

Small employers are unlikely to have knowledge or experience of the workers compensation system and should be provided with additional information e.g WorkCover Brochure, *Employers guide: what to do if an injury occurs*.

10. Requests from Employers and Union representatives

Insurers are to respond to requests from union and employer representatives on behalf of their members with appropriate consent from the member.

11. Managing Worker Obligations

11.1 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 clause 6, Part 4, of these guidelines). The worker should be advised to contact their union or WorkCover's Claims Assistance Service for further information.

11.2 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 reasonably 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.

11.3 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 and 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.

12. 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.

13. 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.

14. 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.

15. 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 medical practitioner with qualifications relevant to the treatment of the injured worker's injury (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 decision to dispute liability should not be made lightly.

The section 74 notice must give the worker notice, in clear and unambiguous language, of the issue(s) that are genuinely in dispute and the reason(s) for the dispute. It is not acceptable to list all potential issues that may arise under the legislation, regardless of their relevance to the claim under consideration. Nor is it acceptable to say, for example that "notice of injury" is disputed. The insurer must state precisely which aspect of that "notice of injury" is disputed, why it is disputed and upon which section or sub-section of the legislation it relies.

A section 74 notice will identify the issues that may be referred to the Workers Compensation Commission (WCC) for determination and must therefore be prepared by a responsible officer who has a detailed knowledge of the worker's claim and the legislation. The notice should only be prepared after a comprehensive and detailed consideration of the factual and legal issues in the claim.

A section 74 notice must:

- precisely identify, in plain language in the body of the document, the issue(s) in dispute AND, in respect of each issue, the insurer's reasoning for disputing the issue
- identify the sections and, if necessary, the sub-sections of the legislation on which the insurer relies and that are relevant to the issues in dispute
- have attached to it any relevant document to which clause 37 of the Workers Compensation Regulation 2003 applies. The obligation 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
- state that the worker has the right to request a review of the claim by the insurer
- state that the worker can seek advice or assistance from the Claims Assistance Service or from their trade union or from a lawyer
- state that the worker can refer the dispute for determination by the WCC
- if the insurer has referred or proposes to refer the dispute to the WCC, include a statement to that effect specifying the date of referral or proposed referral
- state that the matters that may be referred to the WCC are limited to matters notified in the notice or in any notice issued after a further review or in correspondence prior to a referral concerning an offer of settlement or in a request for further review.

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 general, plain language nature of the workers compensation benefit(s) that is/are in dispute. It should also include who made the decision and the date it was made and who confirmed the decision and the date it was confirmed.

4.2 reasons the insurer disputes liability

A section 74 notice must show the legislative basis for the insurer to dispute liability by referring to the sections or clauses of the workers compensation legislation, regulations or guidelines that are relevant and relied upon by the insurer for its decision.

It is not acceptable to list standard grounds of objection that are not relevant to the actual issues in dispute.

4.3 a statement of the insurer and claimant issues relevant to the matter in dispute, The section 74 dispute notice must include a plain language description of all that the insurer has considered in coming to the decision to dispute liability for all or part of a worker's entitlement to workers compensation benefits.

The information provided must be comprehensive as it informs all parties of the line of reasoning that the insurer has relied on in disputing liability and will rely on if the claimant files an Application to Resolve a Dispute in the WCC.

It must be written on a case-by-case basis, as it must reflect the facts of the case. Precedents cannot be relied on.

All of the information that has been considered by the insurer (either provided by or on behalf of the worker or obtained by the insurer) in making the decision and the conclusions the insurer has drawn from this must be included.

The level of detail must be sufficient to substantiate the legislative basis (i.e. each section and sub-section of the Act cited) to dispute liability as shown in 4.2. This will assist the worker to accept the decision or decide if an optional review should be requested.

4.4 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.

4.5 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 4.7 below).

4.6 a statement identifying that all reports and documents relevant to the decision to dispute the claim, as referred to in 4.4 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 4.4 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 4.7 below) with the exception of those workers who are not represented by a solicitor.

4.7 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).

4.8 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.

4.9 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.

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 comply with the requirements of section 74. 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, unless already provided.

The worker may request more than one review.

6. Section 74 template

Headings

1. A statement of the matter(s) in dispute.
2. Reasons the insurer disputes liability.
3. A statement of the insurer and claimant issues, relevant to the matter in dispute.
4. A statement identifying all reports and documents which were relevant to the claim or aspect of the claim to which the decision relates.
5. A statement identifying the reports and documents submitted by the worker in making the claim.
6. A statement identifying that all reports and documents relevant to the decision to dispute the claim referred to in 4 above (and which are in the possession of the insurer) are attached to the dispute notice.
7. A statement indicating that the worker can request a review of the claim by the insurer (optional review).
8. Other matters (see 4.8 above).
9. 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.

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 medical practitioner with qualifications relevant to the treatment of the injured worker's injury (refer to WorkCover *Guidelines on independent medical examinations and reports*)
- injury management 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 decision to dispute liability should not be made lightly.

The section 54 notice must give the worker notice, in clear and unambiguous language, of the issue(s) that are genuinely in dispute and the reason(s) for the dispute. It is not acceptable to list all potential issues that may arise under the legislation, regardless of their relevance to the claim under consideration. Nor is it acceptable to say, for example that "notice of injury" is disputed. The insurer must state precisely which aspect of that "notice of injury" is disputed, why it is disputed and upon which section or sub-section of the legislation it relies.

A section 54 notice will identify the issues that may be referred to the Workers Compensation Commission (WCC) for determination and must therefore be prepared by a responsible officer who has a detailed knowledge of the worker's claim and the legislation. The notice should only be prepared after a comprehensive and detailed consideration of the factual and legal issues in the claim.

A section 54 notice must:

- precisely identify, in plain language in the body of the document, the issue(s) in dispute AND, in respect of each issue, the insurer's reasoning for disputing the issue
- identify the sections and, if necessary, the sub-sections of the legislation on which the insurer relies and that are relevant to the issues in dispute
- have attached to it any relevant document to which clause 37 of the Workers Compensation Regulation 2003 applies. The obligation 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
- state that the worker has the right to request a review of the claim by the insurer
- state that the worker can seek advice or assistance from the Claims Assistance Service or from their trade union or from a lawyer
- state that the worker can refer the dispute for determination by the WCC
- if the insurer has referred or proposes to refer the dispute to the WCC, include a statement to that effect specifying the date of referral or proposed referral
- state that the matters that may be referred to the WCC are limited to matters notified in the notice or in any notice issued after a further review or in correspondence prior to a referral concerning an offer of settlement or in a request for further review.

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 general, plain language nature of the weekly compensation benefits claim that is/are in dispute. It should also include who made the decision and the date it was made and who confirmed the decision and the date it was confirmed.

4.2 reasons the insurer is terminating or reducing weekly payments of compensation

A section 54 notice must show the legislative basis for the insurer to terminate or reduce weekly compensation. The reasons must refer to those parts of the workers compensation legislation, regulations or guidelines that are relevant and relied upon by the insurer for its decision.

It is not acceptable to list standard grounds of objection that are not relevant to the actual issues in dispute.

4.3 a statement of the insurer and claimant issues relevant to the matter in dispute

The section 54 notice must include a plain language description of all that the insurer has considered in coming to the decision to dispute liability for all or part of a worker's entitlement to weekly compensation benefits.

The information provided must be comprehensive as it informs all parties of the line of reasoning that the insurer has relied on in disputing liability and will rely on if the claimant files an Application to Resolve a Dispute in the WCC.

It must be written on a case-by-case basis, as it must reflect the facts of the case. Precedents cannot be relied on.

All of the information that has been considered by the insurer (either provided by or on behalf of the worker or obtained by the insurer) in making the decision and the conclusions the insurer has drawn from this must be included.

The level of detail must be sufficient to substantiate the legislative basis (i.e. each section and sub-section of the Act cited) to dispute liability as shown in 4.2. This will also assist the worker to accept the discussion or determine if an optional review should be requested.

4.4 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.

4.5 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 4.7 below).

4.6 a statement identifying that all reports and documents relevant to the decision to terminate or reduce weekly payment as referred to in 4.4 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 4.4 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 4.7 below) with the exception of those workers who are not represented by a solicitor.

4.7 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).

4.8 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

4.9 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

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 unless already provided.

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. Reasons the insurer is terminating or reducing weekly compensation.
3. Statement of the insurer and claimant issues relevant to the matter in dispute.
4. A statement identifying all reports and documents relevant to the claim or aspect of the claim to which the decision relates.
5. A statement identifying the documents submitted by the worker in making the claim which are relevant to the decision.
6. A statement identifying that all reports and documents relevant to the decision to terminate or reduce weekly payments of compensation referred to in 4. above (and which are in the possession of the insurer) are attached to the dispute notice.
7. A statement indicating that the worker can request a review of the claim.
8. Other matters – see 4.8 above.
9. 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.

Part 5 MAKING AND HANDLING A CLAIM FOR LUMP SUM COMPENSATION (PERMANENT IMPAIRMENT AND PAIN AND SUFFERING)

To be eligible for lump sum compensation under section 66 of the 1987 Act a worker must have sustained an injury, as defined in section 4 of the 1998 Act that resulted in permanent impairment.

1. Minimum Information Required for a Worker to Initiate a Claim

If a claim is already in progress for the injury and the insurer has sufficient information regarding the injury sustained and is satisfied that the injury has resulted in permanent impairment and that it has reached maximum medical improvement, then the permanent impairment claim form is not required. If this claim proceeds as a dispute to the Workers Compensation Commission, a claim form is not to be required.

A permanent impairment claim form is required if a worker is initiating a claim for permanent impairment and pain and suffering (if applicable) related to an injury and has not previously made a claim in respect of the injury or if the insurer does not have sufficient information about the injury for which the claim is being made.

2. Relevant Particulars about a Claim. *(Refer to section 282 of the 1998 Act)*.

The claim must include relevant particulars about the claim.

2.1 ***For injuries pre 1 January 2002:***

- 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)
- all impairments arising from the injury
- the amount of loss as measured by the Table of Disabilities
- 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)
- details of all previous employment to the nature of which the injury is or may be due
- information as to whether or not the degree of impairment resulting from the injury is permanent
- a medical report supporting the amount of loss claimed.

2.2 ***For injuries from 1 January 2002:***

- 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
- all impairments arising from the injury
- whether the condition has reached maximum medical improvement
- the amount of whole person impairment assessed in accordance with the WorkCover *Guides for the evaluation of permanent impairment*
- a medical report 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 lead assessor and determine the final amount of whole person impairment
- 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 receives a claim for permanent impairment the insurer must determine the claim by the latest date of either:

(a) 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

(b) within 2 months after the claimant has provided to the insurer all relevant particulars about the claim

For (a) above, 'fully ascertainable as agreed by the parties' means that

- the claimant has reached maximum medical improvement
- the medical report has been prepared by a WorkCover trained assessor of permanent impairment in accordance with the WorkCover *Guides for the evaluation of permanent impairment*
- the medical report has been provided to the insurer
- the level of permanent impairment (as per the medical report) is agreed by the insurer.

Claim to be determined within 1 month from the receipt of the report. For (b) above the following applies:

- If the insurer considers the report is not in accordance with the WorkCover Guides the insurer advises the injured worker within 2 weeks of receipt of the claim that further information is required and seeks clarification from the author, with a copy of the request sent to the injured worker's legal representative. If the required information is not forthcoming within 10 working days the insurer arranges an independent medical examination.
- The insurer will determine the worker's entitlements and advise the worker within 2 months from the date of the examination of the worker or within 1 month of receiving that report, whichever is the earlier.

Referrals for an independent medical examination are only to be made when one or more of the questions outlined in "reasons for referral" on page 5 of the *Guidelines on Independent Medical Examinations and Reports* are sought.

The offer of payment to the injured worker must be in accordance with a properly completed report by a trained assessor of permanent impairment. If there is more than one way to assess the level of impairment the more beneficial result is to be chosen. (See paragraph 3.5 in the WorkCover *Guides for the evaluation of permanent impairment*).

When an offer is made it should be accompanied by the medical report on which this offer is based, see also Clause 8 in relation to a "complying agreement".

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.

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.

Any payment for permanent impairment is to be in accordance with the level of permanent impairment assessed by a trained assessor of permanent impairment 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:
  - o contact WorkCover's Claims Assistance Service on 13 10 50
  - o seek assistance from the worker's union or lawyer
  - o apply 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 the outcome of the assessment of permanent impairment is nil whole person impairment and there are no other issues in dispute the insurer is to issue a letter to the worker that incorporates the following requirements:

- the date of injury
- the injury to which the claim relates
- the advice that a decision has been made that no offer will be made in respect of the worker's claim for lump sum compensation as the injury has not resulted in any degree of permanent impairment
- description of the reports and documents relied upon by the insurer in reaching the decision not to make an offer. NOTE: The reports and document must also be attached unless supply would pose a serious threat to the life or health of the worker or any other person, in which case they may be supplied to a medical practitioner nominated by the worker
- description of the reports and documents served and relied upon by the worker in support of the claim
- a statement that advises if the worker wishes to pursue their claim, the worker can:
  - o contact WorkCover's Claims Assistance Service on 13 10 50
  - o seek assistance from the worker's union or lawyer
  - o apply to the Registrar for determination by the WCC one month after receipt of advice from the Insurer (including the postal and email address of the Registrar).
- that the matters that can be referred to the WCC are limited to matters notified in writing between the parties concerning the claim.

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: .....

ISSN 0155-6320

Authorised to be printed
TONY DUCKMANTON, Government Printer.