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SPECIAL SUPPLEMENT

NSW GOVERNMENT | WorkCover

WorkCover Guidelines for Claiming Compensation Benefits

Workers Compensation Act 1987

Workplace Injury Management and Workers Compensation Act 1998

I, Julie Newman, the Acting Chief Executive Officer of the WorkCover Authority of New South Wales, under sections section 376 (1) and 260 of the *Workplace Injury Management and Workers Compensation Act* 1998 and section 60 (2A) of the *Workers Compensation Act* 1987, issue the following guidelines.

Dated this 27th day of September 2012

JULIE NEWMAN

A/Chief Executive Officer

WorkCover Authority

NSW GOVERNMENT | WorkCover

Guidelines for Claiming Compensation Benefits

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
- exemptions from prior approval for medical and hospital treatments
- disputing all or part of the claim
- reducing or terminating weekly payments
- making and handling claims for lump sum compensation
- making and handling claims for work injury damages.

Effective: 1 October 2012

Contents

Introduction

Explanatory Note

These guidelines are made under section 376 (1) and section 260 of the *Workplace Injury Management* and *Workers Compensation Act* 1998 and section 60 (2A) of the *Workers Compensation Act* 1987. 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').

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- making and handling claims for work injury damages.

These guidelines replace guidelines dated 13 March 2012 and published in the *NSW Government Gazette* on 30 March 2012 (page 802).

These guidelines commence on 1 October 2012. However, Part 3 of these Guidelines (*Exemption from the requirement that workers obtain prior approval for medical and allied health provider or hospital treatments)* commences on the date of publication of these Guidelines in the Gazette.

A step taken in claims making or handling in accordance with the replaced guidelines is as valid as it would have been if done under these guidelines.

Questions about these guidelines should be directed to the WorkCover NSW Information Centre on 13 10 50.

Application of These Guidelines

The Workers Compensation Legislation Amendment Act 2012 introduced changes to a number of provisions of the workers compensation legislation. The following dates may be relevant to a worker's claim for weekly payments:

- 19 June 2012: New provisions apply for claims for permanent impairment lump sum compensation and damages for nervous shock
- 17 September 2012: New weekly payments provisions commenced for seriously injured workers.
- 1 October 2012: New weekly payments provisions commence for claims made on or after 1 October 2012.
- 1 January 2013: New weekly payments provisions commence for claims made by workers (other than seriously injured workers) who had made a claim prior to 1 October 2012.

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 1987 Act:

(a) means personal injury arising out of or in the course of employment;

*(b) includes a **disease injury**, which means:*

(i) a disease that is contracted by a worker in the course of employment but only if the employment was the main contributing factor to contracting the disease, and

(ii) the aggravation, acceleration, exacerbation or deterioration in the course of employment of any disease, but only if the employment was the main contributing factor to the aggravation, acceleration, exacerbation or deterioration of the disease, 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".

The definition of disease injury does not apply to police officers, fire fighters and paramedics. For these classes of workers refer to the definition of injury in the historical version of the 1987 Act as at 26 June 2012.

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 Exemptions from prior approval for medical hospital treatment

Part 4 Disputing all or Part of the Claim

Part 5 Terminating or Reducing Weekly Payments of Compensation

Part 6 Making and Handling a Claim for Lump Sum Compensation

Part 7 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, WorkCover Certificate of Capacity
7. ***privacy*** The relevant privacy legislation and principles and non disclosure requirements are to apply.

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 their capacity for work is effected by work injuries and they are returning to employment
- 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.

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.

1.1. 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 1.7, Part 1 below) 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 payments may be made under section 36 of the 1987 Act except for police officers, fire fighters and paramedics. For these classes of workers weekly payments may be made under section 36, 38 or 40 of the 1987 Act in the historical version of the 1987 Act as at 26 June 2012.

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.

The insurer will need to promptly identify the injured worker's pre injury average weekly earnings so that weekly payments can be commenced within the legislated timeframe. The insurer should ask the employer and the worker what were the worker's pre injury average weekly earnings. To avoid the worker being disadvantaged, the information obtained at the initial notification should be used to calculate the weekly entitlements. The employer should within 7 days of commencement of the provisional weekly payment, provide to the insurer a completed pre injury average weekly earnings form. The insurer is to arrange any adjustment to the past and future weekly benefit payments to correct the amount in line with the information provided in the form.

Provisional liability also applies to provision of compensation benefits under section 60 (eg ambulance services, medical or related treatment, hospital treatment and workplace rehabilitation services, etc). *Reference section 280 of the 1998 Act*.

1.2. 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.

1.2.1 Worker's information:

- name
- contact details
- residential address
- date of birth.

1.2.2 Employer's information:

- business name
- business address.

1.2.3 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.

1.2.4 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.

1.2. 5 Notifier information:

- name of person making the initial notification
- relationship to worker or employer
- contact details, telephone and address.

1.2.6 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 work and expected return to work date
- details of any time off work
- person to whom the payment is to be paid
- the worker's pre injury average weekly earnings (PIAWE).

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.

1.3. 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.

1.4. 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 or disease injury and to determine the worker's expected capacity for work. 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 Certificate of Capacity. 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 capacity for work, 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.

1.5. 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, i.e. 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 on Page 3 these guidelines when making a decision.

1.6. Action Following Initial Notification

When an insurer receives an initial notification, it is to:

1.6.1 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

1.6.2 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

1.6.3 start injury management if the worker is likely to have incapacity for work for more than 7 continuous days, even if any of the days are not work days. Reference section 45 of the 1998 Act

1.6.4 approve provisional liability for weekly compensation benefits and commence weekly payments of compensation within 7 days unless a reasonable excuse applies (see Clause 1.7, Part 1 below) or unless liability is disputed. This will include calculating the PIAWE. Actions should include:

- obtaining the earnings information contained in the PIAWE form completed by the employer. If possible, agreement should be reached between the worker and the employer regarding the PIAWE to avoid disputes.
- advising the employer and the worker that the worker’s weekly payments will be based on the information provided on the PIAWE form in line with the legislated equations
- advising the worker that if they disagree with the calculation of the PIAWE, they can request a review of the calculation in writing, and provide supporting evidence to the insurer to review the calculation. The insurer has 28 days to respond.

Note: Where insurers need to commence weekly payments but do not have a completed PIAWE form the insurer should determine what the base rate of pay or actual earnings are and commence the payment using that rate for the purpose of the calculation of the weekly payment as an interim rate. As other information is obtained on the PIAWE from the completed PIAWE form or through other means e.g. documentary evidence provided by the worker, the past and future weekly payments should be adjusted to ensure the correct weekly payment has been or is paid.

1.6.5 decide the period of time for which benefits will be paid on the basis of the nature of the injury, and the information available on the worker's current work capacity.

1.6.6 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 1.7, Part 1 below).
Note: All medical expenses must meet the test of 'reasonably necessary' in order to be approved by the insurer (see Clause 1.10, 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*.
Note: Refer also to Part 3 regarding exemptions from the requirement that workers obtain prior approval for medical and allied health provider or hospital treatments.

1.6.7 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
- the amount to be paid each week and how that amount is calculated - if this is an interim rate this will need to be confirmed to the worker and the employer once the PIAWE form has been completed and the insurer has finalised the calculation
- 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 form may need to be completed and a claim form needs to be enclosed (see clause 2.2, Part 2).

1.6.8 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 within 7 days of becoming aware that the worker is to be off work.

1.7. Reasonable Excuse to Not Commence Provisional Payments

The insurer has a reasonable excuse for not commencing provisional liability payments if:

1.7.1 **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 1.4, Part 1 above). 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 WorkCover Certificate of Capacity or other requested information to the insurer.

1.7.2 **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

1.7.3 **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

1.7.4 **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

1.7.5 **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, as defined. The insurer should consider sections 4, 9A, 9B, 10 and 11A of the 1987 Act when considering their evidence.

1.7.6 **the injury is not a significant injury –**

if the injury is not significant, (i.e. the worker is not incapacitated for work for more 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.

1.7.7 **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

1.7.8 **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.

1.7.9 **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

1.7.10 **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.

1.8. The insurer has satisfied its obligations to start paying:

1.8.1 **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

1.8.2 **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

1.8.3 **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, e.g. the requirement for the worker to provide ongoing WorkCover Certificates of Capacity and Worker Declaration 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
- how the employer can withdraw from the agreement

1.8.4 **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.

1.8.5 **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.*

1.9. 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 worker's current work capacity.

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 section 36 of the 1987 Act. If payment is not paid during the 12 week period, the period of non-payment is not included in the 12 week period.

1.10. 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. **Note:** Refer to Part 3 regarding exemptions from the requirement that workers obtain prior approval for medical and allied health provider or hospital treatments.

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?

The $7,500 limit is not to be 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. **Note:** Refer also to Part 3 regarding exemptions from the requirement that workers obtain prior approval for medical and allied health provider or hospital treatments.

1.11. Need for a WorkCover Certificate of Capacity and Worker Declaration

Reference section 270 of the 1998 Act and section 44B of the 1987 Act.

If the insurer has commenced making weekly payments of compensation, the worker must provide to the insurer a WorkCover Certificate of Capacity and Worker Declaration covering any period for which weekly payments have been or are to be made. A completed WorkCover Certificate of Capacity under s 44B of the 1987 Act satisfies the requirements of section 270 of the 1998 Act. The WorkCover Certificate of Capacity must:

- Be completed by a medical practitioner in the approved form
- Certify the worker's capacity for work during the period stated in the certificate but not exceeding 28 days (unless special reasons are given by the person completing the certificate and the insurer is satisfied the certificate should be accepted due to those special reasons)
- Specify the duration of the worker's incapacity
- Has no effect if it relates to a period that is more than 90 days before the certificate is provided.

The worker must also provide to the insurer with:

- a form authorising a provider of medical or related treatment to give the insurer information regarding the -worker's medical treatment or condition relevant to the injury (s 270 (1)(b));
- a Worker Declaration as to whether the worker is engaged in any form of employment or self-employment for remuneration since last providing a WorkCover Certificate of Capacity (s 44B(1)(b)).
- The insurer may discontinue weekly payment if a worker fails to comply with these requirements within 7 days after the requirement is communicated to the worker by the insurer.
  The requirements 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 to be covered by the WorkCover Certificate of Capacity
- that the worker must give the WorkCover Certificate of Capacity, and Worker Declaration 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 documentation is not received by the insurer.

1.12. Circumstances Affecting Payment under Provisional Liability

1.12.1 **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 for the periods the injured worker is incurring economic loss due to the injury 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.

1.12.2 **If payments are made for at least 8 weeks**
Once an insurer has paid weekly payments to a worker under provisional liability for at least 8 weeks, the insurer is to notify the worker that they will need to provide a claim form if they will require weekly payments to be paid beyond 12 weeks because of ongoing certification of no current work capacity or current work capacity. *(Refer to clause 2.2, Part 2 re Need for a Claim Form)*.

1.12.3 **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).

1.12.4 **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 form 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.

1.13. Ceasing Provisional Liability for Weekly Payments

Provisional liability for weekly payments ceases for one of the following reasons:

1.13.1 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

1.13.2 if liability for the worker's claim is accepted.

In either of the above cases, the insurer need not notify the worker that the provisional liability for weekly payments is to cease.

1.14. Circumstances in which Provisional Liability may be Discontinued

Provisional liability may be discontinued if the following circumstances occur:

1.14.1 if the worker unreasonably fails to comply with a requirement of Chapter 3 of the 1998 Act in respect of injury management. *Reference section 48A of the 1998 Act*

1.14.2 if the worker does not provide a WorkCover Certificate of Capacity and Worker Declaration as outlined in clause 1.11 above.

1.14.3 if the insurer receives new credible evidence (e.g. the worker is not a worker as defined, employment is not a substantial contributing factor to the injury, employment is not the main contributing factor to a disease injury) that was not available at the time the provisional payments began.

Note: In the 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.

1.15. Re-opening a Provisional Liability Claim

The insurer may recommence provisional liability on a notification of injury in the following circumstances:

1.15.1 for administration purposes to make further payments

1.15.2 if provisional liability for payment of compensation benefits has ceased or been discontinued for reasons described above at clauses 1.13.1 and clauses 1.14.1 to 1.14.3 and the worker becomes eligible again for compensation benefits, the payments can start again provided 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 are not included in the 12 weeks.

1.15.3 recurrence of original injury, i.e. 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.

1.15.4 claim is litigated.

Note: The insurer must notify the employer within 7 days that provisional liability has recommenced, unless the has only been re-opened for administrative purposes.

2. Making and Handling a Claim for Weekly Payments and Medical Expenses Compensation

2.1. 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 (e.g. 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.

2.2. Need for a Claim Form

The need for a claim form can be waived and the claim is taken to have been made if the injury was notified through the insurer's injury notification system and provisional liability payments have commenced. The date at which the claim is taken to have been made is the notification date. *Reference section 260 of the 1998 Act.*

A claim form is 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 1.7.9, Part 1 for requirements for a notice).

2.3. 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 to the insurer a WorkCover Certificate of Capacity (if one has not already been given to the insurer). A WorkCover Certificate of Capacity satisfies the requirement for a 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 or section 60 expenses that is related to the same injury.

Where an injury has been sustained by a worker while on a journey, an Other Work Related Injuries claim form is to be completed.

2.4. 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, particularly information necessary to determine the worker's pre injury average weekly earnings. *Reference section 264 (1) and (2) of the 1998 Act and section 44C of the 1987 Act*. The employer should complete the PIAWE form and send it to the insurer. The information contained in this form will be utilised to calculate the workers weekly payments. The worker may apply to the insurer to alter the weekly payment amount. *Reference section 42 of the 1987 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.

2.5. 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, i.e. 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, i.e. 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, i.e. 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, i.e. 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, i.e. not obvious or typographical and how to correct that deficiency. This could include –
  - worker has failed or refuses to sign the declaration form
  - no WorkCover Certificate of Capacity or Worker Declaration 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.

2.6. 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 Certificate of Capacity completed by the nominated treating doctor (and signed by the worker), the Worker Declaration form completed 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 4, Clause4.4.

2.7. Accepting Liability

When liability is accepted, the insurer must notify the worker and employer that workers compensation benefits will commence.

Include in the notice to the worker and employer:

- what benefits have commenced on the basis of acceptance of liability
- the amount to be paid each week as weekly payments 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).

2.7.1 Weekly payments of compensation are to be determined, and continue to be made based on:

- pre injury average weekly earnings of the worker supplied by the employer
- the current WorkCover Certificate of Capacity and Worker Declaration supplied by the worker
- a work capacity decision by the insurer
- the application of Sections 36 to 39 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.

The worker may apply to the insurer to alter the weekly payments amount. *Reference section 42 of the 1987 Act*

Note: Where insurers need to commence weekly payments but do not have a completed PIAWE form the insurer should determine what the base rate of pay or actual earnings are and commence the payment using that rate for the purpose of the calculation of the weekly payment as an interim rate. As other information is obtained on the PIAWE from the completed PIAWE form or through other means e.g. documentary evidence provided by the worker, the past and future weekly payments should be adjusted to ensure the correct weekly payment has been or is paid.

2.7.2 Reasonably necessary services for the compensable injury 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.

The worker's employer is not liable to pay for the cost of any treatment or service provided after the first 48 hours of injury, or related travel expenses without the prior approval of the insurer unless the treatment or service is exempt from the prior approval requirement. Part 3 of these Guidelines describe exemptions from the requirement that workers obtain prior approval for medical and allied health provider or hospital treatments. 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. 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 providing pre approval has been given for the service or the service is within the exemption limit – Refer Part 3.

2.8. 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.

The worker or their representative may also need to refer to the WorkCover Work Capacity Guidelines regarding payment of weekly payments.

2.9. Obligations of Employers and Workers

2.9.1 Obligations of an Injured Worker

An injured worker is obliged to:

- Make reasonable efforts to return to work in pre injury employment or suitable employment.
- Participate and cooperate in the establishment of an injury management plan
- Comply with the obligations imposed on the worker under an injury management plan
- Actively participate and cooperate in workplace / vocational rehabilitation
- Actively seek future employment prospects
- Actively participate and cooperate in assessment for the determination of their capacity for employment.

If a worker has a capacity for work and it is established that the employer cannot provide suitable employment, the worker must then seek suitable employment and/or participate and cooperate with a workplace rehabilitation service if required to obtain suitable employment.

Where a worker cannot return to work either in suitable employment or pre injury employment because of non work injury related factors, their weekly payments will be calculated as if they were performing employment that they have been assessed as having a capacity to perform.

Section 48A of the 1998 Act provides that if a worker who has current work capacity does not make reasonable efforts to return to work in line with the obligations specified in section 48 of the 1998 Act then the insurer may suspend weekly payments and this may lead to termination of weekly payments.

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 48A of the 1998 Act will contain:

- the reason for giving the notice; and
- the date weekly payments to the worker will be suspended unless the worker complies with the obligations; and
- the consequences of failing to comply with the notice.

Where an employer fails to provide suitable employment despite being requested to do so by the worker the worker should report the failure to WorkCover on 13 10 50.

2.9.2 Work Capacity Assessment

A work capacity assessment is an assessment of an injured worker's current work capacity. A work capacity assessment can be conducted by an insurer at any time. Refer to WorkCover Work Capacity Guidelines for more information.

2.9.3 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, the worker 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.

2.9.4 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.

2.9.5 Obligations of Employers

An employer must provide a worker who has been totally or partially incapacitated for work as a result of injury and is able to return to work whether on a full-time or part-time basis and whether or not to his or her previous employment with suitable employment if requested to do so by the worker – *section 49, 1998 Act*. Failure of an employer to comply with this requirement can result in prosecution or the employer may be issued with an improvement notice by a WorkCover inspector.

The obligation of an employer to provide suitable employment does not apply if:

(a) it is not reasonably practicable to provide suitable employment, or

(b) the worker voluntarily left the employment of that employer after the injury happened (whether before or after the commencement of the incapacity for work), or

(c) the employer terminated the worker's employment after the injury happened, other than for the reason that the worker was not fit for employment as a result of the injury.

If a worker has a capacity for work and the employer has provided suitable duties and subsequently withdraws the suitable duties because the employer cannot provide suitable duties the factor 'E' in the calculation of weekly payments is deemed to have a value of $0 until such time that a work capacity decision is made for the purpose of determining 'E'.

2.9.6 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 where 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*.

2.10. 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.

2.11. 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.

2.12. Closing a Claim

A claim may be closed when a decision can be made that the worker has no ongoing entitlement to benefits and this decision is not being disputed. Factors to be considered include:

- worker has achieved optimal return to work and health outcomes
- all payments have been made
- no recovery action is current.

Prior to closing a claim, the worker is to be notified in writing giving the reason for the decision and that the claim may be reopened on receipt of sufficient reasons.

2.13. Re-opening a Claim

A claim can be re-opened after it has been closed for the following reasons:

- recurrence of original injury
- further payments or recoveries
- claim is litigated
- claims administration.

If a claim is re-opened again other than for administration purposes, a decision on the additional compensation benefits must be determined again within 21 days.

The insurer must also notify the employer within 7 days that a claim made by their worker has been re-opened, unless it is re-opened for administrative purposes.

3. Exemptions from Prior Approval for Medical and Hospital Treatment

3.1 Definitions

This part is the Guideline for exempt medical or hospital treatment and rehabilitation etc under section 60(2A) that describes treatment or service that is exempt from the requirement for prior insurer approval.

In this part the following definitions apply:

- registered practitioner is a health care practitioner registered with the Australian Health Practitioner Regulation Agency and who has no limitations or conditions on their registration.
- insurer has the same meaning as provided in section 42 of the *Workplace Injury Management and Workers Compensation Act* 1998.
- nominated treating doctor means the medical practitioner nominated by the injured worker under section 42 of the Workplace Injury Management and Workers Compensation Act 1998.
- specialist medical practitioner is a medical practitioner recognised as a specialist by the Australian Medical Council and remunerated in accordance with Health Insurance Commission Health Insurance Regulations 1975, Schedule 4, Part 1 at specialist rates under Medicare.
- WorkCover approved practitioner means a registered practitioner or other allied health provider with a WorkCover approval number.
- public hospital service means a service provided in a public hospital as defined in section 59 of the Workers Compensation Act 1987.
- pharmacy items means any medication or article prescribed in accordance with the current Pharmaceutical Benefits Schedule at http://www.pbs.gov.au/pbs/home made pursuant to the Commonwealth Pharmaceutical Benefits Scheme.

3.2 Exemptions

The following treatments are exempt from the requirement for prior insurer approval.

Note: These exemptions only apply where provisional liability for medical expenses or liability for a claim has been accepted.

3.2.1 Nominated treating doctor

Any consultation with the nominated treating doctor in relation to the injury claimed except for consultations for mental health treatment items AA905 and AA910 in current Australian Medical Association List of Medical Services and Fees.

3.2.2 Specialist medical practitioner

The first consultation for the injury with a specialist medical practitioner, on referral by the worker's nominated treating doctor.

3.2.3 Pharmacy

3.2.3.1 Pharmacy items prescribed by the nominated treating doctor or specialist medical practitioner for the injury in the first 3 weeks post injury, to a maximum of $500.

3.2.3.2 Pharmacy items excluded from the Pharmaceutical Benefits Schedule to a maximum amount of $100.

3.2.4 X-Ray

All plain x-rays performed on referral from the nominated treating doctor or specialist medical practitioner in relation to the injury claimed and provided within one week of injury.

3.2.5 Public hospital

Any services provided in public hospitals that are provided by or consequent upon presentation at the hospital's emergency department for the injury claimed that are within one month of the date of injury.

3.2.6 Physiotherapy, Osteopathy or Chiropractic treatment

3.2.6.1 The initial consultation and up to a further seven treatment sessions provided by a registered practitioner where:

a) The injured worker has not previously received treatment for the injury claimed, or
b) The treatment resumes with the same practitioner within a three month period from the last treatment and less than eight treatment sessions were provided originally.
c) The treatment resumes with the same practitioner within a three month period under a previously approved plan and deemed as the same episode of care.

3.2.6.2 The initial assessment for a new episode of care where a worker ceased treatment more than three months previously and returns for additional treatment for the same injury. The registered practitioner cannot utilise any remaining treatment sessions that may have been approved under the previous episode of care.

3.2.7 Psychology treatment or counselling

3.2.7.1 The initial consultation and up to a further five treatment or counselling sessions provided by a WorkCover approved practitioner where:

a) The injured worker has not previously received treatment/counselling for the injury claimed, or
b) The treatment/counselling resumes with the same practitioner within a three month period from the last treatment and less than six treatment sessions were provided originally.
c) The treatment/counselling resumes with the same practitioner within a three month period under a previously approved plan and deemed as the same episode of care.

3.2.7.2 The initial assessment for a new episode of care where a worker ceased treatment/counselling more than three months previously and returns for additional treatment/counselling for the same injury. The registered practitioner cannot utilise any remaining treatment/counselling sessions that may have been approved under the previous episode of care.

3.2.7.3 The preconditions to be met before the exemption will apply are:

a) The psychologist must be WorkCover approved and
b) The injured worker's nominated treating doctor or treating specialist medical practitioner who is a psychiatrist must make the referral for treatment.

3.2.8 Remedial Massage

3.2.8.1 No more than 5 sessions of remedial massage, where there has been no previous remedial massage therapy for the injury claimed.

3.2.8.2 The precondition to be met before the exemption applies is:

a) The remedial massage therapist must be WorkCover approved.

3.2.9 Hearing needs assessment

3.2.9.1 The initial hearing needs assessment only.

3.2.9.2 The preconditions to be met before the exemption will apply are:

a) The hearing service provider must be WorkCover approved and
b) The injured worker's nominated treating doctor is to have referred the worker to a treating specialist medical practitioner who is an ear, nose and throat physician to determine that the hearing loss is work-related and that there is binaural hearing loss of 6% or more. The ENT makes the referral for treatment.

4. Disputing All or Part of a Claim

4.1. 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 weekly payments after they have started (see also under Part 5); 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.

Note: A section 74 notice is not required to advise a worker of an insurer's work capacity decision.

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 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, Division 3 of the 1987 Act that is not reasonably necessary or property damage under Division 5 of the 1987 Act that is not compensable
- the incapacity or need for treatment or permanent impairment does not result from the injury.

4.2. 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
- WorkCover Certificates of Capacity
- 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 review reports (eg independent physiotherapist consultant).

4.3. Internal Review Before Issuing a Dispute Notice

Before giving notice of a 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 proposed decision to dispute relates.

At a minimum, the review is to be conducted by someone other than the person recommending the proposed 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.

4.4. 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 43 of the *Workers Compensation Regulation 2010* (the Regulation) provides additional information to be included in a section 74 notice.

An insurer must comply with the requirements in section 74 and clause 43. Any defect in a notice should be corrected as soon as it comes to the insurer's attention.

Where a decision to dispute liability includes a decision on liability for weekly payments the insurer must ensure they provide to the worker the required period of notice. *Refer section 54 (2) (b)*.

A decision to dispute liability should not be made lightly.

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:

- contain a concise and readily understandable statement of the reason the insurer disputes liability and of the issues relevant to the decision (indicating, in the case of a claim for compensation, any provision of the workers compensation legislation on which the insurer relies to dispute liability);
- contain a statement identifying all the reports and documents submitted by the worker in making the claim for compensation
  - 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)
- contain a statement identifying all the medical reports and other reports obtained by the insurer referred in clause 46 of the Regulation with attached copies of all reports relevant to the claim or any aspect of the claim to which

the decision relates, whether or not the reports support the reasons for the decision

- state that the worker has the right to request a review of the claim by the insurer
  - 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. **Note:** A request for review under section 287A cannot be made for a work capacity decision of 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 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, e.g. 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 dispute liability. 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)
- state that the worker can seek advice or assistance from the Claims Assistance Service on 13 10 50 or from their trade union or from a lawyer
- state that the worker can refer the dispute for determination by the WCC.
  - 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.
- Provide the street and email address of the Registrar of the Commission (compensation claims) or the Registrar of the District Court (work injury damages disputes).

Note: The current arrangements continue to apply for a transitional period for claims made before 1 October 2012 that are disputed before 1 January 2013 (*refer Schedule 8, Clause 6 of the Workers Compensation Regulation 2010*).

4.5. Dispute Review Notice

If the insurer continues to dispute the claim following a request for internal 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.

4.6. Section 74 template Headings

1. Reasons and Issues in Disputing Liability.
2. Reports and Documents submitted by the Worker.
3. Reports and Documents considered in the Decision.
4. Request for Review of the Decision.
5. Where to seek assistance.
6. Where to refer for Determination of the Dispute

5. Terminating or Reducing Weekly Payments of Compensation

5.1. 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

The insurer shall not discontinue payment or reduce the amount, of the compensation during the required period of notice specified in section 54 (2) (a) or (b).

Failure to give the required 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:

- on the basis of any reassessment by the insurer of the entitlement to weekly payments resulting from a work capacity assessment
- if the insurer disputes liability for the claim.

Note: A section 54 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.

5.2. Evidence Relevant to the Decision

Evidence relevant to the decision about terminating or reducing payments on the basis of a reassessment by the insurer of the entitlement to weekly payments resulting from a work capacity assessment will be as specified in the WorkCover Work Capacity Guideline.

Evidence relevant to the decision where the decision is about terminating or reducing payments on the basis of disputing liability for the claim will be as specified in Part 4, clause 4.2 of these Guidelines.

5.3. 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 proposed decision. This includes reviewing all documents which are relevant to the claim or any aspect of the claim to which the proposed or recommended 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 recommendation and by someone with requisite expertise, e.g. Technical Advisor or Senior Claims Supervisor. The reviewer(s) must have comprehensive knowledge of the legislation as it applies to the decision 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.

5.4. Requirements for a Notice to Terminate or Reduce Weekly Payments of Compensation

Section 54 of the 1987 Act provides that if an insurer intends to terminate or reduce weekly compensation, they must first give notice of intention to reduce or terminate payments to the worker.

Where the insurer's decision is about terminating or reducing payments on the basis of a reassessment by the insurer of the entitlement to weekly payments resulting from a work capacity assessment an insurer must comply with the required period of notice specified in section 54 (2) (a) of the 1987 Act and inclusions in the notice specified in the WorkCover Work Capacity Guideline. Any defect in a notice should be corrected as soon as it comes to the insurer's attention.

Where the insurer is disputing liability for the payment of weekly payments the insurer should complete a section 74 notice as specified in Part 4 of these Guidelines and ensure that they have given the required period of notice in line with section 54 (2) (b) of the 1987 Act.

6. Making and Handling a Claim for Lump Sum Compensation

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 greater than 10% - *refer section 66 (1) of the 1987 Act*. From 19 June 2012, only one claim can be made under the 1987 Act for permanent impairment compensation that results from an injury – r*efer section 66 (1A) of the 1987 Act* - and there can be only one medical assessment of degree of permanent impairment in the Workers Compensation Commission for the purposes of a claim for permanent impairment compensation, commutation or work injury damages claim – *refer section 322A of the 1998 Act*.

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

A permanent impairment claim form is required if a worker is initiating a claim for permanent impairment related to an injury under section 66 in respect of the injury. A claim for compensation (weeklies and medical etc expenses) does not equate to a claim for lump sum compensation.

6.2. Relevant Particulars about a Claim.

*(Refer to section 282 of the 1998 Act)***.**

The claim must include relevant particulars about the claim.

6.2.1 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.

6.2.2 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.

6.3. 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.

6.4. 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 or applies to the Workers Compensation Commission for an assessment of the degree of permanent impairment.
- 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. When an offer is made it should be accompanied by the medical report on which this offer is based, see also clause 6.7 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.

6.5. 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.

6.6. 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 the evaluation of permanent impairment (for injuries from 1 January 2002), there may be no need to obtain further assessments and an offer of payment may 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 the evaluation of permanent impairment (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:
  - contact WorkCover's Claims Assistance Service on 13 10 50
  - seek assistance from the worker's union or lawyer
  - 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 less than 11% permanent impairment the insurer is to issue a notice under section 74 of the 1998 Act – refer to Part 4 of these Guidelines.

6.7. 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 the insurer must be satisfied that a worker has obtained independent legal advice, or has waived the right to obtain independent legal advice, before entering into the complying agreement. 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
- date of agreement
- certification by insurer that it is satisfied that the worker has obtained independent legal advice or has waived the right to obtain independent legal advice.
- If the worker has waived the right to obtain legal advice the agreement must also include acknowledgement by the worker that the worker is aware:
  - they can only make one claim for permanent impairment compensation in respect of the permanent impairment that results from an injury. Refer section 66 (1A) of the 1987 Act
  - the permanent impairment that is assessed and agreed constitutes a claim being made and determined for the purposes of section 66 (1A).
  - compensation paid for permanent impairment less than 15% will mean the worker cannot claim for work injury damages. Refer section 314 (3) of the 1998 Act

The complying agreement may be contained in one or more documents which must be kept on the insurer's file.

6.8. 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 4 of these guidelines.

7. Making and Handling a Claim for Work Injury Damages

7.1. 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 permanent impairment.

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 permanent impairment must have been assessed to be at least 15 percent and the permanent impairment benefit must have been paid. The assessment of permanent impairment must have been made in accordance with the WorkCover *Guides for the Evaluation of Permanent Impairment*. *Reference sections 313, 314, 322 and 280B of the 1998 Act and section 151H of the 1987 Act*.

7.2. 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 permanent impairment
- evidence of the negligent act/s of the employer
- economic loss that is being claimed as damages. Reference section 282 of the 1998 Act.

7.3. 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 permanent impairment 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 7.2 above, with the exception of the degree of assessed permanent impairment.

7.4. 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*.

7.5. Insurer Action on Receipt of a Claim for Work Injury Damages

The insurer is to determine the claim:

- within 1 month of the permanent impairment 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 permanent impairment 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*.

7.6. Resolution of Dispute about Degree of Whole Person Impairment

If an insurer does not agree that the worker has at least 15 percent permanent impairment 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 permanent impairment and this assessment will be conclusively presumed to be correct. *Reference sections 313 and 314 of the 1998 Act*.

7.7. 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 permanent impairment of at least 15 percent. *Reference section 315 of the 1998 Act*.

7.8. 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*.

7.9. Mediation

Before a worker can commence court proceedings the claim must be referred for mediation except as stated above in clause 7.8. 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*.

7.10. 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 (please specify date of notice)

……

Please identify the decision that you are requesting the insurer review:

- o liability for the injury
- o medical expenses
- o amount of weekly payments
- o property damage
- o 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: .....

Guidelines for work capacity decision Internal Reviews by Insurers and Merit Reviews by the Authority

Workers Compensation Act 1987

Workplace Injury Management and Workers Compensation Act 1998

I, Julie Newman, the Acting Chief Executive Officer of the WorkCover Authority of New South Wales, under sections section 376 (1) of the *Workplace Injury Management and Workers Compensation Act* 1998 and section 40(1)(a) of the *Workers Compensation Act* 1987, issue the following guidelines.

Dated this 27th day of September 2012

JULIE NEWMAN

A/Chief Executive Officer

WorkCover Authority

Guidelines for work capacity decision Internal Reviews by Insurers and Merit Reviews by the Authority

These Guidelines are issued pursuant to section 376(1)(c) of the *Workplace Injury Management and Workers Compensation Act* 1998 (NSW) and section 44(1)(a) the *Workers Compensation Act* 1987 (NSW). The Guidelines set out the procedures to be followed by insurers, workers and the WorkCover Authority when carrying out a review of Work Capacity Decisions.

These Guidelines come into effect on 1 October 2012.

Contents

Explanatory note

These Review Guidelines;

- are made with respect to the procedures to be followed by insurers, workers and the WorkCover Authority in Reviews by insurers and by the Authority under section 44 of the Workers Compensation Act 1987 (NSW) ('the 1987 Act') of work capacity decisions made by insurers.
- are made under section 376(1)(c) of the *Workplace Injury Management and Workers Compensation Act 1998* (NSW) ('the 1998 Act') and section 44(1)(a) the 1987 Act and operate by force of law as if they were delegated legislation.
- apply in respect of a claim made by a Worker on or after 1 October 2012. They do not apply in respect of a claim made by a worker before 1 October 2012.
- explain the operation of those sections of the 1987 Act relating to the Review by insurers and by the Authority of work capacity decisions made by insurers, and instruct insurers, workers, the Authority and its Officers, and legal and other representatives of those parties how to make and deal with such applications for Review.

This is the first version of these Review Guidelines issued and there are no transitional provisions required relating to existing versions.

It is anticipated that these Guidelines may need to be revised and replaced prior to 1 January 2013 to enable these Guidelines to have a wider application to all existing claims on foot on or after 1 January 2013.

Questions about these Guidelines should be directed to the Director, Assessment Services.

Julie Newman
A/Chief Executive Officer
Safety Return to Work and Support Division

Geniere Aplin
General Manager, Workers Compensation Insurance
WorkCover Authority of NSW
Safety Return to Work and Support Division

Cameron Player
A/Director, Assessment Services
Motor Accidents Authority of NSW and WorkCover Authority of NSW
Safety Return to Work and Support Division

Division 1. Introduction

1. Commencement, Definitions

Commencement date

1.1 These Guidelines may be referred to as the **'Review Guidelines'** and are made pursuant to section 44(1)(a) of the 1987 Act and section 376(1)(c) of the 1998 Act. They apply in respect of a claim made by a worker on or after 1 October 2012. These Guidelines are delegated legislation.

Definitions

1.2 The terms used in these Review Guidelines have the following meanings:

1.2.1	**1987 Act**	Workers Compensation Act 1987
1.2.2	**1998 Act**	Workplace Injury Management and Workers Compensation Act 1998
1.2.3	**Application**	The means by which a worker requests the referral of a work capacity decision by an insurer for a Review
1.2.4	**Authority**	WorkCover Authority of NSW, an agency in the Safety, Return to Work and Support Division
1.2.5	**Days**	A reference in these Guidelines to a number of days is a reference to a number of calendar days, unless otherwise stated
1.2.6	**DX box**	Exchange box in the Australian Document Exchange Pty Ltd
1.2.7	**ECM system**	An electronic case management system established by the Authority
1.2.8	**Electronic Transactions Act**	Electronic Transactions Act 2000
1.2.9	**Form**	A form approved by the Authority that may be an application and/or a reply to an application
1.2.10	**WIRO**	The WorkCover Independent Review Officer
1.2.11	**WorkCover Independent Review Officer**	The person who may conduct a Review of the insurer's procedures in making a work capacity decision that may occur after an Internal Review by the insurer and a Review by the Authority (See also Chapter 2, Part 3 of the 1998 Act)
1.2.12	**Insurer**	Any party against whom a claim is made under the Workers Compensation Acts
1.2.13	**Internal Reviewer**	The person conducting an Internal Review by the insurer of a work capacity decision made by the insurer
1.2.14	**Matter**	The application, reply and all supporting documents and correspondence held by the Authority in relation to one

discrete application for Review by the Authority. Each matter lodged with the Authority is given a discrete matter number.

1.2.15 **Merit Reviewer**

The person conducting a Review by the Authority of a work capacity decision made by an insurer

1.2.16 **Officer** An officer of the Authority undertaking work in relation to Reviews of work capacity decisions as directed by, or as delegated by the Director, Assessment Services

1.2.17 **Regulation** Workers Compensation Regulation 2010

1.2.18 **Reply** The means by which an insurer answers an application lodged by a worker seeking a Review by the Authority

1.2.19 **Workers Compensation Acts**

The Workers Compensation Act 1987 (NSW) and the Workplace Injury Management and Workers Compensation Act 1998 (NSW)

1.3 To the extent that they are not defined in clause 1.2, the definitions in section 3, section 4 and section 32A of the 1987 Act, and section 4 and section 70 of the 1998 Act, apply to these Review Guidelines.

2. Time, Delivery of documents, ECM system

Reckoning of time

2.1 Any period of time fixed by these Guidelines for doing something shall be considered in accordance with clauses 2.1, 2.2 and 2.3.

2.2 Where a time of 1-day or longer is to be calculated by reference to a given day or event, the given day or the day of the given event shall not be counted.

2.3 Where, apart from this sub-clause, the period in question, being a period of 5-days or less, would include a weekend or public holiday, those days shall be excluded.

Delivery of documents

2.4 For documents lodged other than via an ECM system, for the purpose of these Guidelines, where a worker or insurer has given an address for delivery or receipt of documents, then leaving a document at that address, or sending a document to that address, shall be taken, in the absence of any contrary information, to be received by the person at the following times:

2.4.1 in the case of a physical address, on the day the document is left at that address;

2.4.2 in the case of a postal address, on a day 5-days after the document is sent;

2.4.3 in the case of a DX box, leaving a document addressed to the recipient in that DX box or at another DX box for transmission to that DX box, 2-days after the document is so left;

2.4.4 in the case of an email address, on the day the email or email attachment is sent if sent before 5:00pm, or on the day after the email or email attachment is sent if sent at or after 5:00pm; or

2.4.5 in the case of a facsimile number, on the day the facsimile is sent if sent before 5:00pm, or on the day after the facsimile is sent if sent at or after 5:00pm.

2.5 For matters lodged via the ECM system, for the purpose of these Guidelines the provisions of section 13 of the Electronic Transactions Act apply.

Electronic case management system

2.6 The Authority may establish an ECM system to do one or more of the following:

2.6.1 enable documents with respect to applications for review to be created, exchanged, filed, issued and used in electronic form;

2.6.2 enable parties to applications for review to communicate in electronic form with the Authority and with other parties to those disputes;

2.6.3 enable information concerning the progress of applications to the Authority for review to be provided in electronic form to parties to those disputes; and/or

2.6.4 enable the Authority to communicate in electronic form with parties to applications for review.

2.7 The Authority may establish a protocol for the use of the ECM system, and for persons to become registered users of the ECM system.

2.8 Such a protocol under clause 2.7 may provide, amongst other things, for the specification of the level of access to the system to which persons or specified classes

of persons are entitled, the conditions of use of the system applicable to persons generally or persons of any such class, the security methods by which persons using the system are identified and verified, and how users gain access to the system.

2.9 Subject to any protocol established under clause 2.7, a person may not use the ECM system for particular applications unless the person is a registered user of the ECM system and is:

2.9.1 a party to the application for Review; or

2.9.2 a person representing a party to the application for Review.

2.10 In relation to any application for Review, the level of access to the ECM system to which a user is entitled, and the conditions of use applicable to a user, are subject to any decision of the Authority.

2.11 Documents and information lodged via the ECM system may be dealt with in accordance with the provisions of the Electronic Transactions Act.

2.12 When the Authority sends documents, or forwards correspondence to a party who is a registered user of the ECM system, the Authority will generally only do so via electronic communication to that party.

3. Workers Compensation System Objectives

3.1 The 1998 Act sets out its purpose in section 3 as follows:

> ***"3 System objectives***
>
> *The purpose of this Act is to establish a workplace injury management and workers compensation system with the following objectives:*
>
> *(a) to assist in securing the health, safety and welfare of workers and in particular preventing work-related injury,*
>
> *(a) to provide:*
>
> - *prompt treatment of injuries, and*
> - *effective and proactive management of injuries, and*
> - *necessary medical and vocational rehabilitation following injuries,*
>
> *in order to assist injured workers and to promote their return to work as soon as possible,*
>
> *(b) to provide injured workers and their dependants with income support during incapacity, payment for permanent impairment or death, and payment for reasonable treatment and other related expenses,*
>
> *(c) to be fair, affordable, and financially viable,*
>
> *(d) to ensure contributions by employers are commensurate with the risks faced, taking into account strategies and performance in injury prevention, injury management, and return to work,*
>
> *(e) to deliver the above objectives efficiently and effectively."*

3.2 In exercising their functions and interpreting the provisions of these Guidelines Insurers, the Authority and its Officers must have regard to these system objectives.

4. Work capacity decisions and Reviews

4.1 An application may be made by a worker for a Review of a work capacity decision by an insurer in accordance with section 44 of the 1987 Act, to an insurer for an Internal Review of a work capacity decision, and then by a worker to the Authority for a Merit Review, and then by a worker to the WIRO for a Procedural Review.

4.2 Work capacity decisions by insurers are defined in subdivision 3, section 43 of the 1987 Act, extracted in its entirety below:

> ***"43 Work capacity decisions by insurers***
>
> *(1) The following decisions of an insurer (referred to in this Division as work capacity decisions) are final and binding on the parties and not subject to appeal or review except review under section 44 or judicial review by the Supreme Court:*
>
> *(a) a decision about a worker's current work capacity,*
>
> *(b) a decision about what constitutes suitable employment for a worker,*
>
> *(c) a decision about the amount an injured worker is able to earn in suitable employment,*
>
> *(d) a decision about the amount of an injured worker's pre-injury average weekly earnings or current weekly earnings,*
>
> *(e) a decision about whether a worker is, as a result of injury, unable without substantial risk of further injury to engage in employment of a certain kind because of the nature of that employment,*
>
> *(f) any other decision of an insurer that affects a worker's entitlement to weekly payments of compensation, including a decision to suspend, discontinue or reduce the amount of the weekly payments of compensation payable to a worker on the basis of any decision referred to in paragraphs (a)–(e).*
>
> *(2) The following decisions are not work capacity decisions:*
>
> *(a) a decision to dispute liability for weekly payments of compensation,*
>
> *(b) a decision that can be the subject of a medical dispute under Part 7 of Chapter 7 of the 1998 Act.*
>
> *(3) The Commission does not have jurisdiction to determine any dispute about a work capacity decision of an insurer and is not to make a decision in respect of a dispute before the Commission that is inconsistent with a work capacity decision of an insurer."*

4.3 The jurisdiction for Internal Review by insurers, and Merit Review by the Authority, are established in section 44 of the 1987 Act, and those provisions as relevant are extracted in later sections of this Guideline relating to each specific jurisdiction.

Legal practitioners may not recover costs from a worker or insurer

4.4 Workers' legal costs in relation to the review of work capacity decisions are referred to specifically in section 44(6) of the 1987 Act, which provides that:

> *"A legal practitioner acting for a worker is not entitled to be paid or recover any amount for costs incurred in connection with a review under this section of a work capacity decision of an insurer."*

4.5 insurers' legal costs in relation to the review of work capacity decisions are referred to specifically in Schedule 8, clause 9 of the Regulation, which provides that:

> *"A legal practitioner is not entitled to be paid or recover any amount for a legal service provided to an insurer in connection with an internal or other review under section 44 of the 1987 Act of a work capacity decision of the insurer."*

Advisory Services to assist workers

4.6 The Authority will provide and maintain an advisory service to assist workers in connection with the procedures for Reviews of work capacity decisions.

Division 2. Internal Review by insurers

5. Internal Review by insurers

5.1 A worker who has received a work capacity decision from an insurer may make an application to the insurer for an Internal Review of the work capacity decision, in accordance with the relevant provisions of the 1987 Act.

5.2 The jurisdiction for Internal Review by insurers is established in section 44 of the 1987 Act, and the relevant parts of that section are extracted below:

> ***"44 Review of work capacity decisions***
>
> *(1) An injured worker may refer a work capacity decision of an insurer for review:*
>
> *(a) by the insurer (an internal review) in accordance with the WorkCover Guidelines within 30-days after an application for Internal Review is made by the worker, or*
>
> *(b) …*
>
> *(c) …*
>
> *(2) An application for review of a work capacity decision must be made in the form approved by the Authority and specify the grounds on which the review is sought. …*
>
> *(3) …*
>
> *(4) A review of a work capacity decision does not operate to stay the decision or otherwise prevent the taking of action based on the decision.*
>
> *(5) The Commission is not to make a decision in proceedings concerning a dispute about weekly payments of compensation payable to a worker while a work capacity decision by an insurer about those weekly payments is the subject of a review under this section.*
>
> *(6) A legal practitioner acting for a worker is not entitled to be paid or recover any amount for costs incurred in connection with a review under this section of a work capacity decision of an insurer."*

6. Applications to insurers for Internal Review

Form of application

6.1 An application for Internal Review must be made to the insurer by the worker in the form approved by the Authority, available on the Authority's website at http://www.workcover.nsw.gov.au.

6.2 The application form must set out the grounds on which the Review is being sought and may attach any new or additional information relevant to the work capacity decision.

6.3 An insurer may decline to Review a decision if an application for Review is not lodged in the form approved by the Authority.

6.4 A worker may be assisted in completing the application form by another person such as the insurer, a support person, agent, union representative, employer, legal representative, or interpreter.

(**Note**: Legal practitioners may not recover costs from a worker or insurer, see Clause 4.4 and 4.5.)

Time limit for lodgement

6.5 An application for Internal Review must be lodged by the worker with the insurer within 30-days of receiving the work capacity decision from the insurer.

6.6 An insurer shall decline to review a decision if an application for Review is not lodged by the worker within 30-days of the worker receiving the work capacity decision, unless the insurer is satisfied that exceptional circumstances exist sufficient to justify any delay.

Frivolous or vexatious applications

6.7 An insurer may decline to Review a decision at any stage of the Internal Review process if an application for Review is, or becomes, frivolous or vexatious.

Declining to Review a decision

6.8 The insurer must notify the worker in writing if the insurer declines to Review a decision under clause 6.3 (approved form), clause 6.6 (time limit) or clause 6.7 (frivolous or vexatious).

6.9 If an insurer does decline to Review a decision under clause 6.3 (approved form), clause 6.6 (time limit) or clause 6.7 (frivolous or vexatious), the dispute has not 'been the subject of Internal Review by the insurer' as is required under section 44(1)(b) and (c) of the 1987 Act before an application may be made for Merit Review by the Authority or for a Review by WIRO.

Multiple work capacity decisions or claims

6.10 An application may refer for Internal Review more than one work capacity decision, about one or more of the worker's related claims that are managed by the same insurer, however the time limit requirements must be met for each work capacity decision.

6.11 The insurer may determine whether or not such Internal Reviews of multiple work capacity decisions are most appropriately conducted together or separately as is appropriate in the circumstances of each particular case.

7. Internal Review process and decisions

Acknowledgement of application

7.1 The insurer must write to the worker within 7-days of receiving the application for Review to acknowledge receipt of the application and to:

7.1.1 explain the Review process that will be undertaken;

7.1.2 confirm that a Review of a work capacity decision does not operate to stay the decision or otherwise prevent the taking of action based on the decision;

7.1.3 confirm that the worker may provide any new or additional information relevant to the work capacity decision and advising when that information is due to be received; and

7.1.4 indicate when and how the decision will be conveyed to the worker.

Internal Reviewer and decision

7.2 The Internal Review is to be undertaken by a person who was not involved in the making of the original work capacity decision.

7.3 The Internal Review is to be conducted by a person with the appropriate level of knowledge, expertise and skill relevant to the particular work capacity decision referred.

7.4 The Internal Reviewer may request additional information from the worker, and if doing so should allow the worker no less than 7-days to supply any such information.

7.5 The Internal Reviewer is to consider all of the material substantively and on its merits as if the original work capacity decision had not been made, and is obliged to make the decision that they think is more likely than not to be correct.

Notification of the Internal Review decision

7.6 The insurer must write to the worker within 30-days of receiving the application advising of the outcome of the Internal Review and if the insurer fails to do so the worker may then make an application for Merit Review by the Authority.

7.7 The notification of the decision must be in writing and must include:

7.7.1 details of the decision and its impacts:

7.7.2 a statement of reasons which includes the following:

7.7.2.1 findings on material questions of fact, referring to the documents or other material on which those findings were based;

7.7.2.2 the Internal Reviewer's understanding of the applicable law and rules, including the legislation, regulations or guidelines;

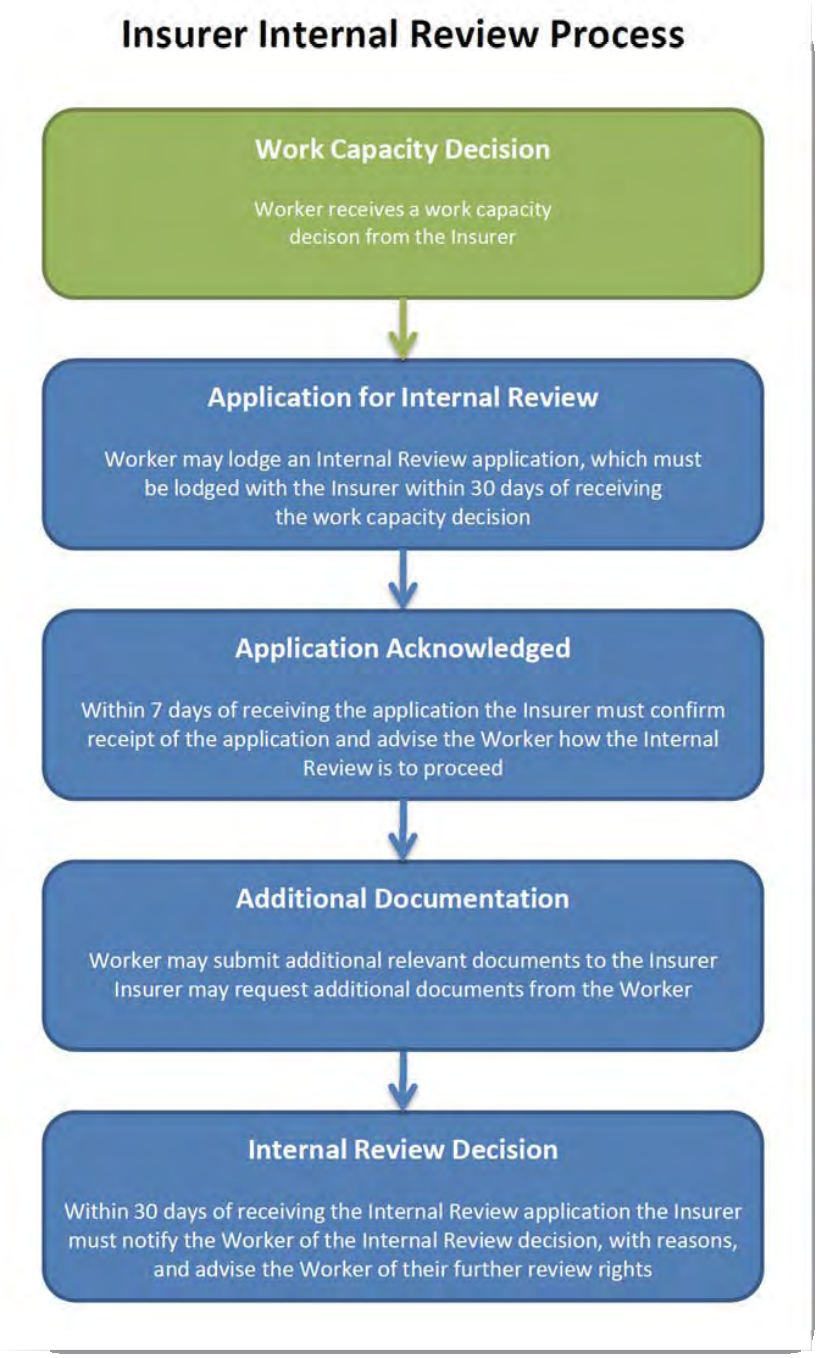
7.7.2.3 the reasoning process that led the Internal Reviewer to their decision;

7.7.3 advice to the worker about the availability of further Review options including:

7.7.3.1 that the worker may make an application to the Authority for a Merit Review within 30-days after receipt of the Internal Review decision;

7.7.3.2 a copy of, or a website link to, the application form approved by the Authority; and

7.7.3.3 advice on where and how such an application is to be made.


Insurer Internal Review Process
Work Capacity Decision
Worker receives a work capacity decison from the Insurer
Application for Internal Review
Worker may lodge an Internal Review application, which must be lodged with the Insurer within 30 days of receiving the work capacity decision
Application Acknowledged
Within 7 days of receiving the application the Insurer must confirm receipt of the application and advise the Worker how the Internal Review is to proceed
Additional Documentation
Worker may submit additional relevant documents to the Insurer
Insurer may request additional documents from the Worker
Internal Review Decision
Within 30 days of receiving the Internal Review application the Insurer must notify the Worker of the Internal Review decision, with reasons, and advise the Worker of their further review rights

Division 3. Merit Review by the Authority

8. Merit Review by the Authority

8.1 A worker may refer a work capacity decision to the Authority for Merit Review, but only after the dispute has been the subject of an Internal Review by the insurer.

8.2 The jurisdiction for Merit Review by the Authority is established in section 44 of the 1987 Act, and the relevant parts of that section are extracted below:

> ***"44 Review of work capacity decisions***
>
> *(1) An injured worker may refer a work capacity decision of an insurer for review:*
>
> *(a) …*
>
> *(b) by the Authority (as a Merit Review of the decision), but not until the dispute has been the subject of Internal Review by the insurer, or*
>
> *(c) …*
>
> *(2) An application for review of a work capacity decision must be made in the form approved by the Authority and specify the grounds on which the review is sought. The worker must notify the insurer in a form approved by the Authority of an application made by the worker for review by the Authority or the Independent Review Officer.*
>
> *(3) The following provisions apply to the review of a work capacity decision when the reviewer is the Authority or the Independent Review Officer:*
>
> *(a) an application for review must be made within 30 days after the worker receives notice in the form approved by the Authority of the insurers decision on Internal Review of the decision (when the application is for review by the Authority) or the Authority's decision on a review (when the application is for review by the Independent Review Officer),*
>
> *(b) an application for review by the Authority may be made without an Internal Review by the insurer if the insurer has failed to conduct an Internal Review and notify the worker of the decision on the Internal Review within 30-days after the application for Internal Review is made,*
>
> *(c) the reviewer may decline to review a decision because the application for review is frivolous or vexatious or because the worker has failed to provide information requested by the reviewer,*
>
> *(d) the worker and the insurer must provide such information as the reviewer may reasonably require and request for the purposes of the review,*
>
> *(e) the reviewer is to notify the insurer and the worker of the findings of the review and may make recommendations to the insurer based on those findings (giving reasons for any such recommendation),*
>
> *(f) …*
>
> *(g) recommendations made by the Authority are binding on the insurer and must be given effect to by the insurer,*
>
> *(h) …*
>
> *(4) A review of a work capacity decision does not operate to stay the decision or otherwise prevent the taking of action based on the decision.*
>
> *(5) The Commission is not to make a decision in proceedings concerning a dispute about weekly payments of compensation payable to a worker while a work capacity decision by an insurer about those weekly payments is the subject of a review under this section.*
>
> *(6) A legal practitioner acting for a worker is not entitled to be paid or recover any amount for costs incurred in connection with a review under this section of a work capacity decision of an insurer."*

9. Applications to the Authority for Merit Review

Form of application

9.1 An application for Merit Review to the Authority must be made by the worker in the form approved by the Authority, available on the Authority's website at http://www.workcover.nsw.gov.au.

9.2 The application form must set out the grounds on which the Review is being sought and may attach any new or additional information relevant to the work capacity decision.

9.3 The Authority may decline to Review a decision if the worker has not complied with clause 9.1.

9.4 The worker does not need to attach to their application all of the existing documents and information relating to the claim or the work capacity decision, as the insurer will be required to provide all relevant information to the Authority as part of their reply to the application.

9.5 A worker may be assisted in completing the application form by another person such as the insurer, a support person, agent, union representative, employer, legal representative, or interpreter.

(**Note**: Legal practitioners' may not recover costs from a worker or insurer, see Clause 4.4 and 4.5.)

Multiple work capacity decisions or claims

9.6 An application may refer for Review by the Authority more than one work capacity decision, about one or more of the worker's claims, whether or not they are managed by the same insurer, however the time limit requirements must be met for each decision.

9.7 The Authority may determine whether or not such Merit Reviews of multiple work capacity decisions are most appropriately conducted together or separately as is appropriate in the circumstances of each particular case.

Exchange and lodgement of application by worker

9.8 Section 44(2) of the 1987 Act requires the worker to notify the insurer of an application for Review by the Authority, in a form approved by the Authority. The form approved by the Authority for that purpose is the *'Application to the Authority for Review'* form.

9.9 The worker must send the insurer a copy of the *'Application to the Authority for Review'* form before, or at the same time as, lodging the application with the Authority.

9.10 The Authority may decline to Review a decision if the worker has not complied with clause 9.9.

Time limit for lodging an application with the Authority

9.11 An application for Merit Review must be lodged by the worker with the Authority within:

9.11.1 30-days of receiving the Internal Review decision from the insurer; or

9.11.2 if the insurer failed to issue an Internal Review decision on time under clause 7.7, within 30-days of the date that the insurers' Internal Review decision was due.

9.12 The Authority shall decline to Review a decision if the workers application does not satisfy clause 9.11, unless it is satisfied that exceptional circumstances exist sufficient to justify any delay.

Frivolous or vexatious applications

9.13 The Authority may decline to Review a decision at any stage of the Merit Review process if an application for Review is, or becomes, frivolous or vexatious.

Declining to Review a decision

9.14 The Authority must notify the worker and insurer in writing if the Authority declines to Review a decision under clause 9.3 (approved form), clause 9.10 (exchange), clause 9.12 (time limit) or clause 10.1 (frivolous or vexatious).

9.15 If the Authority does decline to Review a decision under 9.3 (approved form), clause 9.10 (exchange), clause 9.12 (time limit) or clause 10.1 (frivolous or vexatious), the dispute has not 'been the subject of Merit Review by the Authority as is required under section 44(1)(c) of the 1987 Act before an application may be made for a Review by the WIRO.

Lodging an application with the Authority

9.16 The Authority shall establish and maintain a registry for the referral of applications for Review by the Authority. For the purposes of delivery or sending of documents for lodgement the address is:

Merit Review Service
WorkCover Authority of NSW
Level 4, 1 Oxford Street, Darlinghurst, NSW, 2010
Email: wcdmeritreviewservice@workcover.nsw.gov.au

9.17 For the purposes of delivery or sending of documents for lodgement using the ECM system, access may be made available to registered ECM users via password login to the Authority's website address at http://www.workcover.nsw.gov.au.

9.18 Except on Saturdays, Sundays and public holidays, the registry shall be open to the public for lodgement of documents in person between 8.30am and 5:00pm.

9.19 The registry may make provision for lodgement of documents electronically and also outside the registry's usual opening hours. Any documents lodged electronically after 5:00pm are deemed to be received on the next registry business day.

9.20 The registry shall, notwithstanding clause 9.14, be kept open to the public for business or closed for business, at such times and on such days as the Authority shall determine.

9.21 It is sufficient notification, or service, for any document or correspondence directed to the Authority relating to these Guidelines to be left in the DX box of the Authority at DX xxxxxx Sydney, or at another DX box for transmission to that exchange box.

9.22 The Authority shall arrange for all applications made under these Guidelines to be allocated a matter number and registered. All subsequent correspondence concerning the application is to quote that matter number.

Exchange and lodgement of reply by insurer

9.23 A reply to an application for Merit Review must be lodged by the insurer with the Authority in the form approved by the Authority, as quickly as possible and within 7-days of receiving the worker's application.

9.24 The reply lodged with the Authority must be submitted electronically via email or via the ECM system and must:

9.24.1 include a detailed list of all documents relevant to the work capacity decision and the Review of that decision, including documents supplied by the worker;

9.24.2 attach electronic copies of all of the documents included in the list of relevant documents, including documents supplied by the worker.

9.25 The insurer must first notify the worker of its reply to the application, by sending the worker a copy of the reply before, or at the same time as, lodging the reply with the Authority.

9.26 The reply provided to the worker shall include the list of all relevant documents but does not need to attach copies of all the relevant documents being lodged with the reply. The insurer is required to provide the worker with copies of any of those documents which have not already been provided to the worker previously.

Surveillance images

9.27 Any surveillance images to be lodged with the Authority are to be provided in DVD format and must first be provided to the worker. Any investigator's or loss adjuster's report concerning those surveillance images must also be provided with the images when they are provided to the worker and when lodged with the Authority.

9.28 If surveillance images have been provided by an insurer to a worker for the first time in support of a reply lodged with the Authority, the worker will be offered an opportunity to respond to the surveillance images.

9.29 Surveillance images held by the Authority are, where they contain personal information, subject to the Privacy and Personal Information Protection Act 1998 (NSW).

Privacy

9.30 Merit Reviews by the Authority are to be conducted in private and are not open to the public. Any decision, recommendations or statement of reasons are not available to the public.

(**Note**: An individual's privacy should be respected. Failure to respect the privacy of an individual may result in a breach of the Privacy and Personal Information Protection Act 1998 (NSW) and/or the Health Records and Information Privacy Act 2002 (NSW).

The Authority recommends that no application, reply, decision, recommendation, or statement of reasons should be published, distributed or used in any way unless the privacy of all individuals referred to in the documents is respected, including workers, their relatives, support persons, Employers and their staff, insurers' staff, officers of the Authority, legal representatives, medical practitioners, witnesses, interpreters, Internal Reviewers, Merit Reviewers, and any other individual person.

The Authority recommends that no such documents should be published, distributed or used in any way unless the express consent of any such identified individuals has first been obtained, or unless the documents have been thoroughly and sufficiently de-identified to ensure that the privacy of those individuals is respected.)

10. Merit Review process and decisions

Acknowledgement of worker's application

10.1 The Authority shall write to the worker and insurer within 7-days of receiving the application for Review to acknowledge receipt of the application and to:

10.1.1 explain the Review process that will be undertaken;

10.1.2 confirm that a Review of a work capacity decision does not operate to stay the decision or otherwise prevent the taking of action based on the decision;

10.1.3 confirm that the worker or insurer may provide any new or additional information relevant to the work capacity decision, after first exchanging that with the other party, and advising when that information is due to be received;

10.1.4 indicate when and how the decision will be conveyed to the worker and insurer.

Acknowledgement of insurer's reply

10.2 The Authority shall write to the worker and insurer within 7-days of receiving the reply from the insurer to acknowledge receipt of the application and to:

10.2.1 advise whether any further information is required from either of the parties for the purposes of the Review; and

10.2.2 confirm that a Review of a work capacity decision does not operate to stay the decision or otherwise prevent the taking of action based on the decision.

Exchange of Information by workers and insurers

10.3 Any information that the worker sends to the Authority, whether as part of an Application, in response to a request by the Authority, or otherwise, must be sent to the insurer before, or at the same time as, sending the information to the Authority.

10.4 Any information that the insurer sends to the Authority, whether as part of a Reply, in response to a request by the Authority, or otherwise, must be sent to the worker before, or at the same time as, sending the information to the Authority.

Merit Reviewer and decision

10.5 The Merit Review by the Authority is to be undertaken by a person:

10.5.1 who was not involved in the making of the original work capacity decision or the internal review by the insurer; and

10.5.2 with the appropriate level of knowledge, expertise and skill relevant to the particular work capacity decision referred.

10.6 The Merit Reviewer may determine their own procedure and is not bound by the rules of evidence and may inquire into any matter relating to the Review of the work capacity decision in such manner as they think fit.

10.7 The Merit Reviewer is to take such measures as are reasonably practicable to ensure that the parties understand the nature of the application, the issues to be considered and the role of the Reviewer as an independent decision-maker, and that they have had an opportunity to have their submissions and any relevant documents or information considered.

10.8 The Merit Reviewer is to act with as little formality as the circumstances of the matter permit and according to equity, good conscience and the substantial merits of the matter without regard to technicalities and legal forms.

10.9 The Merit Reviewer is to take into account the workers compensation system objectives at all times.

10.10 The Merit Reviewer may reasonably require additional information from the worker or the insurer for the purposes of the Review, which the worker and insurer must provide.

10.11 If requiring additional information from the worker the Merit Reviewer should allow the worker no less than 7-days to supply any such information. The Merit Reviewer may decline to Review a decision if the worker fails to provide information requested by the reviewer within the time allowed.

10.12 The Merit Reviewer is to consider all of the material substantively and on its merits as if the original work capacity decision had not been made, and is obliged to make the decision that they think is more likely than not to be correct.

10.13 The Merit Reviewer may also make recommendations to the insurer based on their findings, which are binding on the insurer and must be given effect to by the insurer.

Notification of the Merit Review decision

10.14 The Authority shall write to the worker and insurer within 30-days of receiving the application advising of the outcome of the Merit Review.

10.15 The notification of the decision must be in writing and shall include:

10.15.1 details of the decision and its impacts;

10.15.2 details of any recommendations to the insurer;

10.15.3 a statement of reasons which includes the following:

10.15.3.1 findings on material questions of fact, referring to the documents or other material on which those findings were based;

10.15.3.2 the Merit Reviewer's understanding of the applicable law and rules, including the legislation, regulations or guidelines;

10.15.3.3 the reasoning process that led the Merit Reviewer to their decision and to any recommendations they have made;

10.15.4 advice to the worker about the availability of further Review options including:

10.15.4.1 that the worker may make an application to the WorkCover Independent Review Officer (WIRO) for a Review of the insurer’s procedures in making the work capacity decision, within 30-days after receipt of the Merit Review decision from the Authority;

10.15.4.2 advice on where the worker can obtain the application form approved by the Authority; and

10.15.4.3 advice on where and how such an application is to be made.


Authority Merit Review Process
Internal Review Decision
Worker receives an Internal Review decison from the Insurer
Application for Merit Review
Worker may lodge a Merit Review application, which must be sent to the Insurer and lodged with the Authority within 30 days of receiving the Internal Review decision
Application Acknowledged
Within 7 days of receiving the application the Authority must confirm receipt of the application and advise the Worker and Insurer how the Merit Review is to proceed
Reply to Application
Within 7 days of receiving the application, the Insurer must lodge a reply with the Authority, and send a copy to the Worker
Reply Acknowledged
Within 7 days of receiving the reply the Authority must confirm receipt of the reply, and advise the Worker and Insurer whether any further information is required and when by
Merit Review Decision
Within 30 days of receiving the application the Authority must notify the parties of the decision, any reccomendations, with reasons, and advise the Worker of their further review rights

Workcover Guidelines on Injury Management Consultants

Workplace Injury Management and Workers Compensation Act 1998

I, Julie Newman, the Acting Chief Executive Officer of the WorkCover Authority of New South Wales, under sections 45A, 119(4) and 376 of the *Workplace Injury Management and Workers Compensation Act* 1998*,* issue the following guidelines.

Dated this 27th day of September 2012

JULIE NEWMAN

A/Chief Executive Officer

WorkCover Authority

Guidelines on Injury Management Consultants

Workplace Injury Management and Workers Compensation Act 1998

These guidelines are issued pursuant to sections 45A, 119 and 376 of the *Workplace Injury Management and Workers Compensation Act* 1998. The guidelines set out WorkCover's policy in respect to the approval and functions of injury management consultants as well as providing guidance on the referral process to an injury management consultant.

These guidelines will come into effect on 1 October 2012 and apply to approvals of injury management consultants and referrals made from that date. The previous *WorkCover Guidelines on Injury Management Consultants*, published in the *NSW Government Gazette* on 18 February 2011, are revoked.

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.

In these guidelines, an insurer is an insurer within the meaning of the 1987 Act and the 1998 Act and includes scheme agents of the Workers Compensation Nominal Insurer, and self and specialised insurers.

Contents

1. Introduction

1.1 Purpose and scope of the Guidelines

When differences arise between the nominated treating doctor, the employer, insurer and/or injured worker about return to work it may be appropriate for an injury management consultant to review the worker.

The purpose of these guidelines is to provide the basis for a shared understanding of the role and approval of injury management consultants in the NSW workers compensation system.

The guidelines also outline the process of referral to an injury management consultant and recommended reporting by injury management consultants.

This document is intended for use by:

- those who refer injured workers to injury management consultants
- injury management consultants
- injured workers, employers and their representatives.

2. Definition of an injury management consultant

An injury management consultant (IMC) is a registered medical practitioner experienced in occupational injury and workplace-based rehabilitation, approved under section 45A of the 1998 Act. Injury management consultants are facilitators who will assist insurers, employers, workers and treating doctors find solutions to problems in complex return to work plans and injury management.

3. The role of the injury management consultant

An injury management consultant is expected to assess the situation, examine the worker (if necessary), and discuss possible solutions with all parties (particularly the nominated treating doctor). Injury management consultants are not involved in the treatment of an injured worker, nor do they provide any opinion on the current treatment regime to the referrer. They assess the nature of the problem and attempt to mediate a solution. The role of the injury management consultant is distinctly different from that of the independent medical examiner. For further information on the role of the independent medical examiner please refer to the *WorkCover Guidelines on independent medical examinations and reports*.

An injury management consultant does not become involved in commenting to the referrer on:

- the appropriateness of treatment or diagnostic procedures
- liability for a workers compensation claim.

An injury management consultant's role with each of the parties is outlined below.

1. Nominated treating doctor

   The injury management consultant MUST verbally discuss the injured worker's capacity for work with the nominated treating doctor. A minimum of three attempts at discussion must be made by the injury management consultant within the report submission time frames. The injury management consultant may discuss the following:

   - issues in relation to treatment and diagnosis (if required) and options to overcome barriers to return to work
   - current work capacity
   - availability of suitable duties
   - how the NSW workers compensation system operates
   - the importance of timely, safe and durable return to work
   - obtaining agreement on work capacity, prognosis for recovery and time frames for the return to work plan.

2. Injured worker

   The injury management consultant will discuss return to work with the injured worker including:

   - their recovery from injury
   - the importance of timely, safe and durable return to work and potential impact on the workers health of absence from work
   - relevant aspects of the workers compensation system
   - issues and problems at work
   - options for their return to work (including a possible tele-conference with the nominated treating doctor)
   - their expectations regarding recovery and return to work.

   The injury management consultant will often examine the worker to assist in their appraisal of the worker's capacity to return to work.

   Where an injured worker has a union representative involved in their return to work, the injury management consultant will include that representative in discussions with the worker.

   The union representative's role is to advise and support their member in achieving a timely, safe and durable return to work.

3. Employer

   The injury management consultant may liaise with the employer to confirm the availability and appropriateness of identified duties and where appropriate conduct a workplace assessment, if required.

4. Other Service Providers

   The injury management consultant may liaise with other service providers to assist in determining fitness for work or identifying suitable duties.

4. Referrals to an injury management consultant

1. Reasons for referral

Prior to any referral to an injury management consultant there must be a specific return to work or injury management problem. Efforts should have been previously made to rectify the area(s) of concern without success. Following this, an insurer or employer can refer to an injury management consultant when there are:

- confused goals,
- complexity of injury or workplace environment
- poor communication between insurer, employer or nominated treating doctor
- perceived conflict between the nominated treating doctor's recommendations and the workplace requirements
- unexplained changes in work capacity
- disagreement about the suitability of duties offered to an injured worker
- worker not upgrading duties at work.

Where a nominated treating doctor identifies the need for an injury management consultant for any of the reasons stated above, they may contact the insurer to organise the referral on their behalf.

Where a referrer identifies the need for an injury management consultation but does not believe it is necessary for the injury management consultant to talk to the injured worker, then a file review may take place. The referral must still meet the criteria for referral (as listed above) and the injury management consultant must verbally discuss the case with the nominated treating doctor.

2. Responsibility of referrer

The referrer has a responsibility to ensure that:

- all parties are informed of the appointment details
- the worker is provided with an explanation of the reasons for the appointment, and details of the appointment including the nature of the appointment
- the worker's special needs are catered for eg interpreter, disabled access
- the injury management consultant is provided with details of the worker and reason for referral
- the nominated treating doctor is provided with a copy of the referral to the injury management consultant with a covering letter and the brochure *Doctors and WorkCover injury management consultants*.

3. Selection of an appropriate injury management consultant

Where a worker is required to attend an injury management consultant's rooms the location should be geographically close to the worker's home address 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.

The injury management consultant should be able to provide an appointment within a reasonable time.

The decision on which particular injury management consultant to engage should be made in consultation with the injured worker (and their union, if involved).

Where an employer is making the referral to an injury management consultant there should be no conflict of interest between the injury management consultant and the employer.

4. Communication with the injury management consultant

The format for the referral letter is attached at Attachment A.

The letter of referral to the injury management consultant must include:

- details of the worker
- specific reason for the referral
- details of the nominated treating doctor
- details of the employer and contact person
- all relevant reports and certificates of capacity.

Referrers are not to ask the injury management consultant to answer questions about the appropriateness of treatment or diagnostic procedures or liability for a workers compensation claim.

Where an injury management consultant is requested by a referrer to comment on issues outside the role, the injury management consultant will notify the referrer that they are unable to complete all aspects of the referral.

Complaints about inappropriate referrals to an injury management consultant may be referred to the WorkCover doctors' hotline on 1800 661 111 or by email to provider.services@workcover.nsw.gov.au.

5. Notification and explanation to the worker

The worker must be advised in writing at least 10 working days before the appointment, unless a shorter timeframe is agreed by all parties.

Advice about the appointment with an injury management consultant must include:

- the specific reason for the referral
- that the injury management consultation is an opportunity for them to actively participate in their return to work
- the name of the injury management consultant
- date, time and place of the appointment and contact details of the injury management consultant
- the expected duration of the appointment
- the need to be punctual
- to wear suitable clothing to allow examination
- a copy of the brochure *Doctors and WorkCover injury management consultants*
- the worker may be accompanied by a support person, with the agreement of the injury management consultant
- what to take, e.g. x-rays, rehab provider reports etc.
- how costs are to be paid and any charges that may be incurred for cancellation of the appointment without sufficient notice
- how complaints are to be managed
- that no one may be present during the actual physical/psychological examination of the injured worker, unless agreed by the worker and by the injury management consultant
- 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)
- that the injured worker will receive a copy of the report from the appointment
- where the injury management consultant's routine practice is to record the consultation on audio or video, the worker must be informed of this in writing and given the opportunity to decline should they not consent. Therefore the insurer will need to ascertain whether the injury management consultant records consultations at the time the appointment is scheduled.

Where the injury management consultant is conducting a file review the referrer should inform the injured worker that the injury management consultant will be reviewing the file and discussing their case with their nominated treating doctor to facilitate their return to work.

If a worker has any problem about the referral they can contact the WorkCover Claims Assistance Service on 13 10 50 or their union for assistance.

5. Injury management consultant reports

The format for the report is at Attachment B.

An injury management consultant's report will outline the action taken and outcome(s) agreed between the parties, or suggest alternative actions such as the need for a specialist opinion or referral to an approved workplace rehabilitation provider. The injury management consultant will ensure a copy of the report is provided on a confidential basis, to all parties involved in the consultation process including the nominated treating doctor, injured worker, employer (where involved) and insurer.

Any key benchmarks identified within the report should be followed up at the time they fall due by the insurer to ensure the integrity of the process and successful resolution of any issues. If benchmarks are not met or other problems emerge, the insurer is to refer back or discuss alternatives with the same injury management consultant.

The report should be provided to the referrer within 10 working days of the appointment, or within a different timeframe if agreed between the parties.

6. Injury management consultants and the Workers Compensation Commission

A worker or an employer can request the Workers Compensation Commission to resolve a dispute about the suitability of employment.

If there is an application to resolve a dispute regarding suitable duties, the Workers Compensation Commission may request an injury management consultant to conduct a workplace assessment and provide an opinion regarding the availability of suitable duties. These assessments are conducted within five days of receiving the request and the report is provided to the Registrar of the Workers Compensation Commission within seven days of conducting the assessment. The report is available on a confidential basis to the involved parties.

The role of the injury management consultant for the Workers Compensation Commission is to assist the Commission in resolving a dispute about return to work. For further information please refer to the Workers Compensation Commission website at http://www.wcc.nsw.gov.au.

7. Selection criteria

An injury management consultant must have:

- registration as a medical practitioner with the Medical Board of Australia (through the Australian Health Practitioner Regulation Agency), with no restrictions placed on that registration
- at least 12 months experience in workplace based rehabilitation
- knowledge of the NSW workers compensation system
- demonstrated adherence to all legislation, guidelines and fees schedules in the workers compensation system
- good communication and negotiation skills
- references supporting their approval from employers, insurers and/or unions.

8. Approval process

Section 45A of the 1998 Act provides for approval of injury management consultants by WorkCover.

The approval process for an injury management consultant is outlined below:

- medical practitioner completes application form demonstrating ability to meet all of the selection criteria
- WorkCover's Provider Services Branch reviews the application to ensure applicant meets all selection criteria and seeks further information as necessary
- WorkCover contacts referees to obtain reports on applicants who meet all selection criteria
- the Director, Claims considers all information and as the delegate under the Act, approves or rejects the approval
- the applicant is advised of the outcome of the application
- applicants who are not successful are advised of the reason for rejection and the appeal process
- following approval, an injury management consultant must undertake training in mediation/negotiation skills as arranged by WorkCover.

9. Term of approval

The initial term of approval is 12 months with a review after that time.

Subsequent terms of approval are for a maximum period of 3 years.

10. Re-approval

An injury management consultant is required to seek re-approval by providing information to WorkCover regarding their activities as an injury management consultant, together with referees who can support their re-approval.

Re-approval of an injury management consultant is based on the following criteria:

- must meet all selection criteria for approval as an Injury Management Consultant
- works within boundaries of the injury management consultant role
- negotiates with nominated treating doctor to establish clear agreed outcomes from injury management consultation
- adheres to all WorkCover legislation, guidelines and fees orders
- completes mediation/negotiation skills training
- no complaints warranting revocation of approval,with regard to any role they fulfil within the workers compensation system
- no evidence of fraudulent conduct
- the medical practitioner has completed at least one injury management consultation in the previous 12 months.

The re-approval process for an injury management consultant is outlined below:

- WorkCover's Provider Services Branch will contact the injury management consultant informing them of the need for re-approval and ask them to complete an "Application for re-approval as an injury management consultant", providing the following information:
  - their intent to continue work as an injury management consultant
  - confirmation that they are a registered medical practitioner with the Medical Board of Australia, with no restrictions placed on that registration
  - a summary of the last 3 injury management consultations they have undertaken
  - provision of contact details of 3 referees who can discuss the medical practitioner's work in the role of an injury management consultant
  - provision of a copy of their latest referral and associated report
- WorkCover's Provider Services Branch reviews the application to ensure the applicant meets all selection criteria and seeks further information as necessary and contacts referees to obtain reports on applicants who meet all criteria
- the Delegate considers all information and approves or rejects the re-approval.

11. Appeal Process for Non-Selection or Non Re-approval

A person who is not approved as an injury management consultant or not re-approved as an injury management consultant can appeal against the decision by submitting additional information in support of their application to the General

Manager, Workers Compensation Insurance Division, WorkCover who will consider the original application/re-approval application and all additional information.

The 1998 Act provides for the Administrative Decisions Tribunal to review decisions in relation to revocation of approval under ss45A (6).

12. Complaints about an injury management consultant

If the worker has concerns about the conduct of the injury management consultant during the appointment, they should raise those issues with the doctor at the time of the appointment. The doctor 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 consultation. 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 in writing to WorkCover and/or the Medical Council of NSW and/or the Health Care Complaints Commission.

Complaints about an injury management consultant are investigated by WorkCover's Provider Services Branch as follows:

- details of the complaint are discussed with the complainant and other parties as appropriate
- the injury management consultant is invited to offer a response to the complaint
- WorkCover assesses the information from all parties
- WorkCover advises the complainant and injury management consultant of the outcome of the investigation and takes further action as necessary.

Following the investigation WorkCover may:

- take no further action
- refer the matter to the Medical Council of NSW and/or the Health Care Complaints Commission to consider, if the complaint is about clinical practice
- revoke the injury management consultant's approval.

The worker may at any time make a complaint to WorkCover, the insurer, the Health Care Complaints Commission, and/or the Medical Council of NSW.

13. Revocation of approval

WorkCover may revoke the approval of an injury management consultant on the following grounds:

- no longer meets all selection criteria for approval as an injury management consultant
- complaints about performance found to be justified with regard to any role they perform within the workers compensation system
- does not adhere to WorkCover legislation, guidelines and fees orders
- non-performance as an injury management consultant for a consecutive period of 12 months
- fraudulent conduct
- failure to perform the role of the injury management consultant
- failure to attend mediation-negotiation training
- failure to adhere to these guidelines
- such other reason as the Authority thinks appropriate.

An injury management consultant may apply to the Administrative Decisions Tribunal for a review of WorkCover's decision to revoke the Consultant's approval.

14. Fees and payments

The maximum fees to be charged and paid are those set out in the *Workplace Injury Management and Workers Compensation (injury management consultants) Order* in force 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

Injury management consultant- Referral format

An insurer or employer refers an injured worker to an injury management consultant. All relevant reports and work capacity certificates are to be attached to the referral to assist the injury management consultant to determine the nature of the problem, the worker's medical status and rehabilitation progress.

Injury management consultant details

Name _____

Phone _____

We have referred (Worker's name and claim number)_____

_____

to you because

Reason for referral (tick appropriate box(es)

- ❑ confused goals
- ❑ complexity of injury or workplace environment
- ❑ poor communication between insurer, employer or nominated treating doctor
- ❑ perceived conflict between the nominated treating doctor's recommendations and the workplace requirements
- ❑ unexplained changes in capacity certification
- ❑ disagreement about the suitability of duties offered to an injured worker
- ❑ worker not upgrading duties at work
- ❑ other (please specify)

Insurer is to expand on above and describe the specific problem / reason for referral

_____

_____

_____

and request that you: (tick appropriate box(es)

- ❑ assess the attached documentation
- ❑ contact the nominated treating doctor to discuss facilitating capacity for employment
- ❑ consult the worker's employer to identify the availability / suitability of duties, if necessary
- ❑ examine the worker
- ❑ develop a strategy to improve capacity for employment in agreement with these parties

Worker details

Name _____ Claim number _____

Date of Birth:_____ Date of Injury:_____ Date Last Worked:_____

Injury _____

Occupation _____

Nominated treating doctor details

Name _____

Address _____

Phone _____ Fax _____

Employer details

Name of Employer _____

Contact Person _____

Address _____

Phone _____ Fax _____

Union details (if involved)

Name of Union _____

Contact Person _____

Address _____

Phone _____ Fax _____

Please forward a copy of the report that explains the agreed outcomes to the nominated treating doctor and all parties involved in the consultation process including the worker, insurer and employer (where still involved).

Documentation enclosed

- ❑ history of injury, any surgical interventions, current ongoing treatment and relevant reports from the nominated treating doctor, the treating medical specialist and any other treating personnel.
- ❑ rehabilitation progress, including capacity restrictions, medical status of the injured worker, the involvement of a rehabilitation provider

Insurer/referrer details

Name _____

Contact person _____

Phone _____ Fax _____

Attachment B

Injury management consultant - Report format

Dear _____

Referrer's name

Re: _____

Worker's name and claim number

Thank you for referring the abovementioned worker to me.

The reason for referral was _____

_____

_____

The documents reviewed included _____

_____

_____

_____

Consultation with the nominated treating doctor involved _____

_____

_____

_____

_____

_____

Comment on:

- outcome of treatment to date
- issues identified as impacting on return to work/capacity for work
- outcome of discussion

Consultation with the employer _____

_____

_____

_____

Comment on:

- availability of suitable duties
- other relevant issues

Examination and consultation with worker _____

_____

_____

_____

_____

As a result of the review, it is concluded that _____

_____

_____

_____

_____

Action Plan

Summarise the action taken and the outcomes agreed with the nominated treating doctor, including timeframes and milestones to reach the agreed outcome.

Agreed Action	Outcome to Be Achieved	By Whom	By When

If agreement is not reached, suggest alternative actions to the referrer eg. Referral for independent medical examination, referral to an approved workplace rehabilitation provider.

Yours sincerely

Injury management consultant

cc. nominated treating doctor and all parties involved in the consultation process including the worker, insurer and employer (where still involved)

WorkCover Work Capacity Guidelines

Workers Compensation Act 1987

Workplace Injury Management and Workers Compensation Act 1998

I, Julie Newman, the Acting Chief Executive Officer of the WorkCover Authority of New South Wales, under sections section 376 (1) of the *Workplace Injury Management and Workers Compensation Act* 1998 and section 44A of the *Workers Compensation Act* 1987, issue the following guidelines.

Dated this 27th day of September 2012

JULIE NEWMAN

A/Chief Executive Officer

WorkCover Authority

NSW GOVERNMENT WorkCover

Work Capacity Guidelines

Instructions and guidance to insurers regarding the appropriate and consistent application of work capacity assessments, decisions and reviews.

Contents

1. Introduction

In June 2012 the Government introduced changes to the NSW worker's compensation system. The changes are focussed on encouraging and assisting injured workers to stay at work as part of their rehabilitation wherever possible, or to support their safe return to employment. The changes will also reduce the impact of injury on workers and their families. The changes will provide better financial support for seriously injured workers and assist employers to meet their return to work commitments. The concept of a work capacity assessment was introduced as an important part of return to work planning and determination of entitlement to weekly payments.

These changes were introduced in the *Workers Compensation Legislation Amendment Act 2012* (referred to as '*the 2012 Amendment Act'*) passed by Parliament on 22 June 2012 and assented on 27 June 2012. *The 2012 Amendment Act* amended 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'*).

1.1. Purpose

This document provides instructions and guidance to insurers regarding the appropriate and consistent application of work capacity assessments and decisions in the NSW workers compensation system. It also explains the process for insurers' internal review of work capacity decisions when this is requested by a worker, including matters concerning the following specific sections of *the 1987 Act*:

- Section 38 Special requirements for continuation of weekly payments after second entitlement period (after 130 weeks)
- Section 43 Work capacity decisions by insurers
- Section 44 Review of work capacity decisions
- Section 44A Work capacity assessment
- Section 44B Evidence as to work capacity

The work capacity assessments provisions do not apply to those workers whose claims are excluded, including police officers, paramedics and fire-fighters, people injured working in or around coal mines, volunteer bush fire fighters, emergency and rescue service volunteers, people with a dust disease claim under the *Workers Compensation (Dust Diseases) Act 1942*, or workers who currently receive weekly payments as a result of an injury under the *1926 Act*. Seriously injured workers, as defined by section 32A of the *1987 Act* are not required to undergo a work capacity assessment unless the worker requests it and the insurer considers such an assessment appropriate.

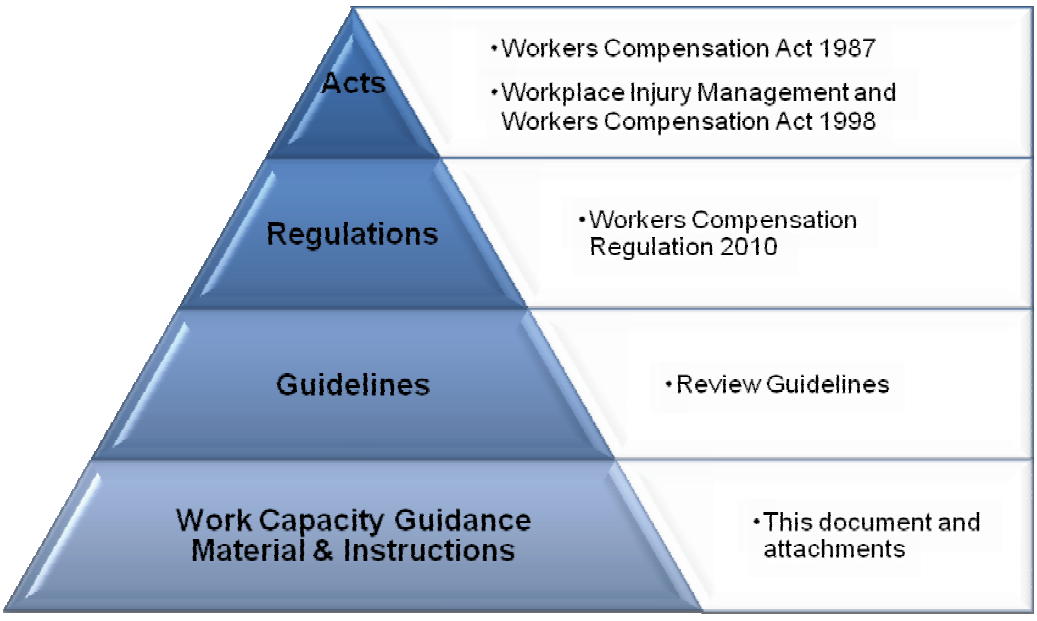
These guidance materials and instructions apply to all claims made on or after 1 October 2012.

From 1 January 2013, these guidance materials and instructions will apply to all claims.

1.2. Legislative framework

These guidance materials and instructions are to be read in conjunction with, and in light of, the legislative framework governing work capacity certificates, assessments, decisions and reviews as contained in the relevant legislation and delegated legislation including

- *the 1987 Act*
- *the 1998 Act*
- the *Workers Compensation Regulation 2010* (referred to as *'the Regulation'*)
- *Guidelines for the Internal Review and WorkCover Review of Work Capacity Decisions (*referred to as *'the Review Guidelines')* as gazetted.



2. Guiding principles

2.1. A focus on facilitating the worker's capacity for work

Work promotes recovery, reduces the risk of long-term disability and loss of employment, and improves quality of life and wellbeing. An integrated and multi-disciplinary approach to injury management supports the worker to stay at work as part of their rehabilitation wherever possible, and participate in opportunities to improve their capacity for employment.

It is essential that all relevant parties work together. Early development of clear return to work goals, the injury management plan, and regular reviews of the plan are important elements to support the worker's rehabilitation.

2.2. Effective communication throughout the life of the claim

Transparent and effective communication from notification of an injury onwards can help to set clear expectations regarding the roles and responsibilities of the worker, insurer, employer and medical and other service providers.

The implementation of this claims management approach, and any associated decisions must include plain language communication and be considerate of the worker's and employer's primary language, cultural background and literacy skills.

Communication issues and difficulties should be promptly addressed to ensure expectations are aligned and to minimise the risk of disputes.

2.3. Soundly based decisions

All decisions made in relation to the worker's recovery and work capacity should be timely, informed and evidence based. Decisions should be made and communicated in a transparent and robust manner free from preference and prejudice ensuring that effective outcomes are achieved and due process is followed. Decisions should be made in line with the *Best Practice Decision-Making Guide.*

The insurer must use a sound decision-making model that includes appropriate controls and review processes aligned with the *General Insurance Code of Practice* incorporating a quality assurance and continuous improvement framework.

2.4. A tailored approach

Work capacity assessments should be tailored to the worker. An understanding of the worker's circumstances and their injury ensures the right approach at the right time.

3. WorkCover Certificate of Capacity

(1987 Act: S.44B)

From 1 October 2012, the *WorkCover Certificate of Capacity* replaces the WorkCover medical certificate as the primary tool for the nominated treating doctor or treating specialist to communicate with all parties involved in the return to work process.

The *WorkCover Certificate of Capacity* is attached at section 7.1.

The nominated treating doctor or treating specialist is responsible for completing the *WorkCover Certificate of Capacity*. The *Information for medical practitioners completing the WorkCover Certificate of Capacity* provides further detail regarding the certificate.

The *WorkCover Certificate of Capacity* is one of the many sources of information used to help inform a tailored approach to injury management and return to work planning for each worker.

The worker is responsible for providing a completed *WorkCover Certificate of Capacity* to the employer and the insurer to be eligible for weekly payments.

4. Work capacity assessment

(1987 Act: S.32A, S.44A)

A work capacity assessment is an assessment conducted by the insurer of a worker's current work capacity in accordance with section 44A of *the 1987 Act*.

current work capacity, in relation to a worker, is defined in section 32A of *the 1987 Act* as:

"a present inability arising from an injury such that the worker is not able to return to his or her pre-injury employment but is able to return to work in suitable employment."

A work capacity assessment undertaken by the insurer is a review of the worker's functional, vocational and medical status and helps to inform decisions by the insurer about the worker's ability to return to work in his or her pre-injury employment or suitable employment with the pre-injury employer, or at another place of employment.

The insurer may conduct a work capacity assessment at any stage throughout the life of a claim. It is an ongoing process of assessment and reassessment that commences on notification of a workplace injury and continues as needed during the life of the claim.

suitable employment, in relation to a worker, is defined in Section 32A of *the 1987 Act* as:

"employment in work for which the worker is currently suited:

(a) having regard to:
- *(i) the nature of the worker's incapacity and the details provided in medical information including, but not limited to, any certificate of capacity supplied by the worker (under section 44B), and*
- *(ii) the worker's age, education, skills and work experience, and*
- *(iii) any plan or document prepared as part of the return to work planning process, including an injury management plan under Chapter 3 of the 1998 Act, and*
- *(iv) any occupational rehabilitation services that are being, or have been, provided to or for the worker, and*
- *(v) such other matters as the WorkCover Guidelines may specify, and*

(b) regardless of
- *(i) whether the work or employment is available, and*
- *(ii) whether the work or the employment is of a type or nature that is generally available in the employment market, and*
- *(iii) the nature of the worker's pre-injury employment, and*
- *(iv) the worker's place of residence"*

A work capacity assessment considers all available information which may include, but is not limited to:

- reports from the treating doctor, treating specialist or other allied health professionals;

- *WorkCover Certificates of Capacity;*
- independent medical reports;
- injury management consultant reports;
- the worker's self report of their abilities and any other information from the worker;
- the injury management plan;
- reports from a workplace rehabilitation provider such as workplace assessment reports, return to work plans, functional capacity evaluation reports, vocational assessment report, work trial documents, job seeking logs, activities of daily living assessments, etc;
- information from the employer such as documents relating to return to work planning; and
- information obtained and documented on the insurer's claim file.

Referrals to a medical practitioner, workplace rehabilitation provider or other relevant party may be needed as part of the assessment if the information on the claim file is incomplete. This information from third party service providers will then form part of the body of evidence considered in the insurer's work capacity assessment.

As provided by section 44A of *the 1987 Act*, the worker must attend and participate in any evaluation required as part of the work capacity assessment. If the worker does not attend or participate their weekly payments may be suspended until the assessment has taken place.

4.1. Timing of a work capacity assessment

A work capacity assessment may be conducted at any stage throughout the life of a claim.

At a minimum, the insurer must commence a review of the worker's capacity for work once the worker has received a cumulative total of 78 weeks of weekly payments.

If a worker has an ongoing entitlement to weekly payments beyond 130 weeks, the insurer must conduct a work capacity assessment at least once every two years after this point, until such time as the worker's entitlement ceases.

4.2. Work capacity assessments and seriously injured workers

Work capacity assessments must not be conducted for a seriously injured worker unless the worker requests it. If a seriously injured worker requests an assessment for example, to assist with return to work planning, the insurer must decide whether or not it is appropriate considering the worker's circumstances.

Section 32A of *the 1987 Act* defines a ***seriously injured worker*** as

"a worker whose injury has resulted in permanent impairment and:

(a) the degree of permanent impairment has been assessed for the purposes of Division 4 to be more than 30%, or

(b) the degree of permanent impairment has not been assessed because an approved medical specialist has declined to make an assessment until satisfied that the impairment is permanent and the degree of permanent impairment is fully ascertainable, or

(c) the insurer is satisfied that the degree of permanent impairment is likely to be more than 30%."

5. Work capacity decision

(1987 Act: S.43)

A work capacity decision is a specific type of decision by the insurer which is defined in section 43 of *the 1987 Act.*

Work capacity decisions by insurers are decisions defined in section 43 of *the 1987 Act* as:

"(a) a decision about a worker's current work capacity,

(b) a decision about what constitutes suitable employment for a worker,

(c) a decision about the amount an injured worker is able to earn in suitable employment,

(d) a decision about the amount of an injured worker's pre-injury average weekly earnings or current weekly earnings,

(e) a decision about whether a worker is, as a result of injury, unable without substantial risk of further injury to engage in employment of a certain kind because of the nature of that employment,

(f) any other decision of an insurer that affects a worker's entitlement to weekly payments of compensation, including a decision to suspend, discontinue or reduce the amount of the weekly payments of compensation payable to a worker on the basis of any decision referred to in paragraphs (a)–(e).

The following are not work capacity decisions:

(a) a decision to dispute liability for weekly payments of compensation,

(b) a decision that can be the subject of a medical dispute under Part 7 of Chapter 7 of the 1998 Act"

A work capacity decision is a discrete decision that may be made at any point in time and can be about any one of the factors described in section 43(1), such as the worker's capacity to earn in suitable employment. This is different to a work capacity assessment which is a review process that may or may not lead to the making of a work capacity decision or another type of decision regarding a claim.

Work capacity decisions should be made in line with the *Best Practice Decision-Making Guide*.

5.1. Making a work capacity decision

Work capacity decisions will be made at many points throughout the life of a claim.

The insurer may make a work capacity decision on receipt of new information that relates to the worker's capacity for employment which may affect the calculation of weekly payments. Such information may include, but is not limited to:

- evidence of the worker's pre-injury wages or current wages
- *WorkCover Certificates of Capacity*
- a change in the worker's personal circumstances
- confirmation that the worker has returned to work
- confirmation that the worker has become unable to work at all, or as much as they had been
- a report from a medical practitioner or allied health practitioner
- a workplace rehabilitation report
- an investigation report.

When making a work capacity decision the insurer should follow the *Best Practice Decision-Making Guide* including:

- ensuring that all reasonable opportunities to establish capacity for work have been provided to the worker
- ensuring that the insurer meets their responsibility of establishing and supporting an injury management plan tailored to the worker's injury as set out in Chapter 3 of the 1998 Act
- evaluating all available and relevant evidence
- following a robust and transparent decision-making process with clear, concise and understandable information provided to the worker giving reasons for decisions
- seeking any additional information that is required to ensure the worker's current capacity for work is fully understood

- providing opportunity for the worker to contribute additional information, especially if the decision may result in reduction or discontinuation of the worker's weekly payments
- ensuring decision makers have the appropriate expertise, ability, and support to make the decision they are making.

Any work capacity decision should be logical, rational and reasonable. It should be a decision that is more likely than not to be correct. In many cases the insurer will already have all the information they need to make a work capacity decision without the need to refer the worker for additional evaluations by third party service providers.

Example: The worker is recovering from recent surgery. The *WorkCover Certificate of Capacity* and report from the treating specialist indicates the worker has no current work capacity. A work capacity decision can be made based on this information probably without the need for any further evidence.

***Example*:** The worker has returned to work in their full pre-injury role. It is confirmed that the worker is in receipt of their pre-injury average weekly earnings. A work capacity decision can be made based on this information probably without the need for any further evidence.

***Example*:** The worker has returned to suitable employment, working reduced hours. Information has been received from the worker's physiotherapist and nominated treating doctor indicating that the worker has capacity for full pre-injury hours. The insurer can make a work capacity decision about the amount the worker is able to earn in this suitable employment, working full hours, probably without the need for any further evidence.

5.2. Fair notice provisions

Before making a work capacity decision that may result in a reduction or discontinuation of the worker's weekly payments the insurer must, at least two weeks prior to the work capacity decision, communicate this to the worker in a way that is appropriate in the circumstances of the case, and preferably by telephone or in person. This must be done to:

- inform the worker that a review of their current work capacity is being undertaken and that a work capacity decision is going to be made
- explain that this review may include further discussions with other parties such as their employer, nominated treating doctor or other treatment providers
- advise the potential outcome of this review and detail the information that has led the insurer to their current position

- provide an opportunity for the worker to supply any further information to the insurer for further consideration and the date that this information is to be provided by
- tell the worker when this decision is expected to be made.

This information should also then be confirmed in writing to the worker.

This requirement does not apply to a reduction or discontinuation in weekly payments that is due to the application of different rates as defined in the legislation (section 36, section 37, and section 38 of *the 1987 Act*) or changes as a result of the indexation of benefits.

5.3. A worker's capacity to earn in suitable employment

(1987 Act: S.32A, S.35)

Determining the worker's current work capacity and the amount they are able to earn in suitable employment are work capacity decisions. These decisions must be made considering the definition of suitable employment in section 32A of *the 1987 Act* (also see section 4 of this document).

Suitable duties in the workplace may be identified that are able to accommodate the worker's work restrictions due to their injury and to facilitate their return to work. These are not necessarily in an existing role and may be a role created by the employer to assist the worker in their efforts to rehabilitate and return to work.

Suitable duties may not necessarily constitute suitable employment. Suitable employment has a broader definition and requires the employment to be transferrable to other workplaces.

Section 35 of the 1987 Act defines:

*"**E** means the amount to be taken into account as the worker's earnings after the injury, calculated as whichever of the following is the greater amount:*

(a) the amount the worker is able to earn in suitable employment,
(b) the worker's current weekly earnings"

***Example of suitable duties*:** A truck driver is provided with administrative duties to accommodate his physical restrictions. The employer has created this role especially for the worker as they do not have another position available and/or the worker does not have any other transferrable skills to undertake any other existing or available position the employer may have. The duties do not constitute a role that is transferrable to another workplace. The employer advises they can no longer provide these suitable duties. The worker has capacity to work. The worker has been compliant with all of his injury management requirements under Section 48 of *the 1987 Act*.

- A decision to reduce weekly payments should not be made at this stage, as reasonable return to work support has not yet been provided to the worker. Factor '***E***', used in the calculation of weekly payments should be taken to be a value of 'zero' until a soundly based decision of the worker's capacity to earn in suitable employment can be made.

- A revised injury management plan that identifies and documents realistic return to work strategies should be developed in consultation with all relevant parties. This may include a vocational or other assessment and assistance with job seeking. When the worker has been provided with reasonable return to work opportunities, and when suitable employment options have been

identified for the worker, the insurer should then determine the appropriate timing for a subsequent work capacity decision.

***Example of suitable employment*:** A truck driver is provided with administrative duties to accommodate his physical restrictions. The worker has the transferrable skills to undertake these duties, as his previous employment and education history included managing his own business, which involved administrative tasks, and completing a MYOB and Certificate IV in Office Management. The employer advises they can no longer provide suitable duties. The worker has been compliant with all his injury management requirements under Section 48 of *the 1987 Act*. The worker has capacity to work, and has demonstrated this capacity for 6 months.

- There should be sufficient evidence in this situation for the insurer to deem an administrative role as suitable employment for the worker. '***E***' can be determined and a decision made to reduce or discontinue the worker's weekly payments accordingly. The insurer must provide notification of the decision in line with these guidelines. At least 3 months notice must be provided before applying the appropriate reduction in the worker's weekly payments.

5.4. Notification of a work capacity decision

Upon making a work capacity decision that will result in a reduction or discontinuation of the worker's weekly payments the insurer shall:

- telephone and speak to the worker at the time of the decision to:
    - inform the worker that a work capacity decision has been made
    - explain the outcome and consequences of this decision and the information that has led the insurer to their current position
    - explain the internal review process and that a review application will be sent with the notice
    - confirm that the decision will be conveyed in writing.

The insurer must then notify the worker in writing of the work capacity decision.

The insurer must provide 3 months notice before reducing or discontinuing the worker's weekly payments.

***Example*:** The worker returns to work full time and is receiving their pre-injury average weekly earnings. The insurer confirms this with the worker and the employer. The insurer makes a work capacity decision that the worker's weekly payments are to be discontinued.

- The insurer should notify the worker their weekly payments will cease as there is no loss of income however a **Work Capacity Decision Notice** is not required. No notice period applies.

***Example*:** The worker is currently receiving weekly benefits and the *WorkCover Certificate of Capacity* deems they have no current work capacity. The insurer undertakes a work capacity assessment and the insurer then makes a work capacity decision that the worker has current work capacity. This decision will result in a reduction or discontinuation of the worker's weekly payments.

- Formal notification of this work capacity decision is required. The insurer must provide 3 months notice before reducing or discontinuing benefits
- This notification must be made in accordance with **5.4.2 Requirements of a Work Capacity Decision Notice** of this guideline.

***Example*:** The worker has now received a cumulative total of 13 weeks of weekly payments. The worker has no capacity for work. The insurer decides that the amount of weekly payments the worker is entitled to receive is to be reduced due to the application of a different rate of payment (that is, the weekly payments are now calculated under section 37 of *the 1987 Act*, rather than section 36).

- The insurer should notify the worker of the change in their rate of payment and how it was calculated however a **Work Capacity Decision Notice** is not required. No notice period applies.

A reduction or discontinuation in weekly payments due to information supplied by the worker does not require formal notification by the insurer.

5.4.1. Standards for notifying of a work capacity decision

The insurer must provide the worker and other relevant parties with plain language communication regarding the work capacity decision.

Plain language communication requires:

- being considerate of the nature of the worker's circumstances
- communicating respectfully
- communicating a clear message
- presenting concise information
- adapting communication style to meet the worker's needs.

Insurers must make reasonable efforts to communicate work capacity decisions that affect the amount of weekly payments a worker is entitled to receive, in an appropriate way, preferably by telephone or in person as well as in writing. If needed, an accredited interpreter should be engaged to assist in giving effective communication.

Other forms of communication such as face-to-face meetings, facsimile and emails may also form part of the communication of the work capacity decision as appropriate.

In some cases, it may be appropriate to communicate a work capacity decision in the presence of the nominated treating doctor or other relevant health care professional. For example, when communicating a decision to reduce or discontinue weekly payments for a worker with a psychological injury.

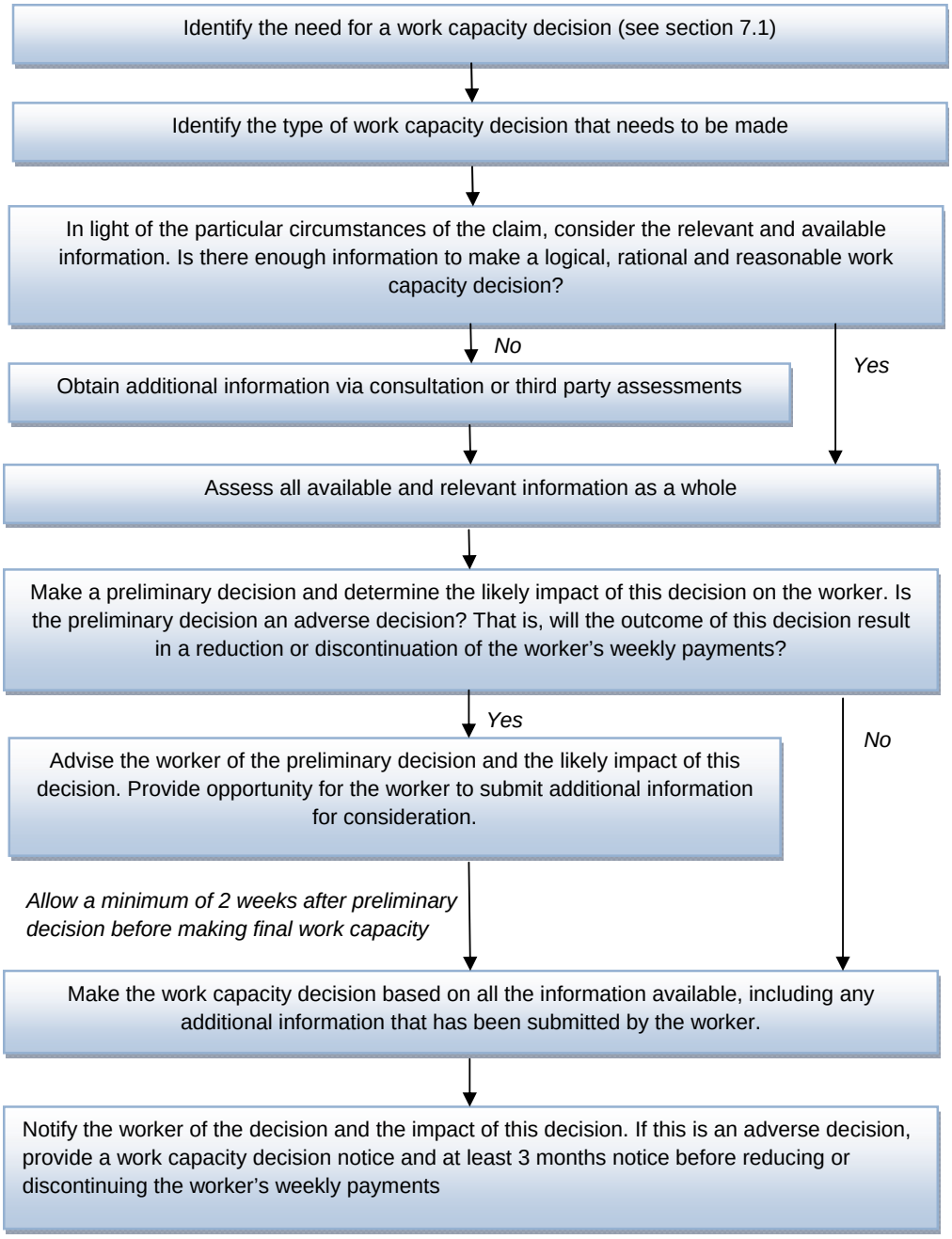
Effective communication will help to minimise the risk of disputes.

5.4.2. Requirements of a Work Capacity Decision Notice

The **Work Capacity Decision Notice** must:

- reference the relevant legislation
- explain the relevant entitlement periods
- state the decision and give brief reasons for making the decision
- outline the evidence considered in making the decision, noting the author, the date and any key information. All evidence considered should be referred to, regardless of whether or not it supports the decision.
- clearly explain the line of reasoning for the decision
- state the impact of the decision on the worker in terms of their entitlement to weekly payments, entitlement to medical and related treatment expenses and return to work obligations
- advise when the decision will take effect
- detail any support, such as job seeking support, which will continue to be provided during the notice period
- advise that any documents or information that have not already been provided to the worker can be provided to the worker on request to the insurer
- advise of the process available for requesting review of the decision and how to access the required form, *Application for review of a work capacity decision by insurer*.

5.5. Flow chart - making a soundly based work capacity decision

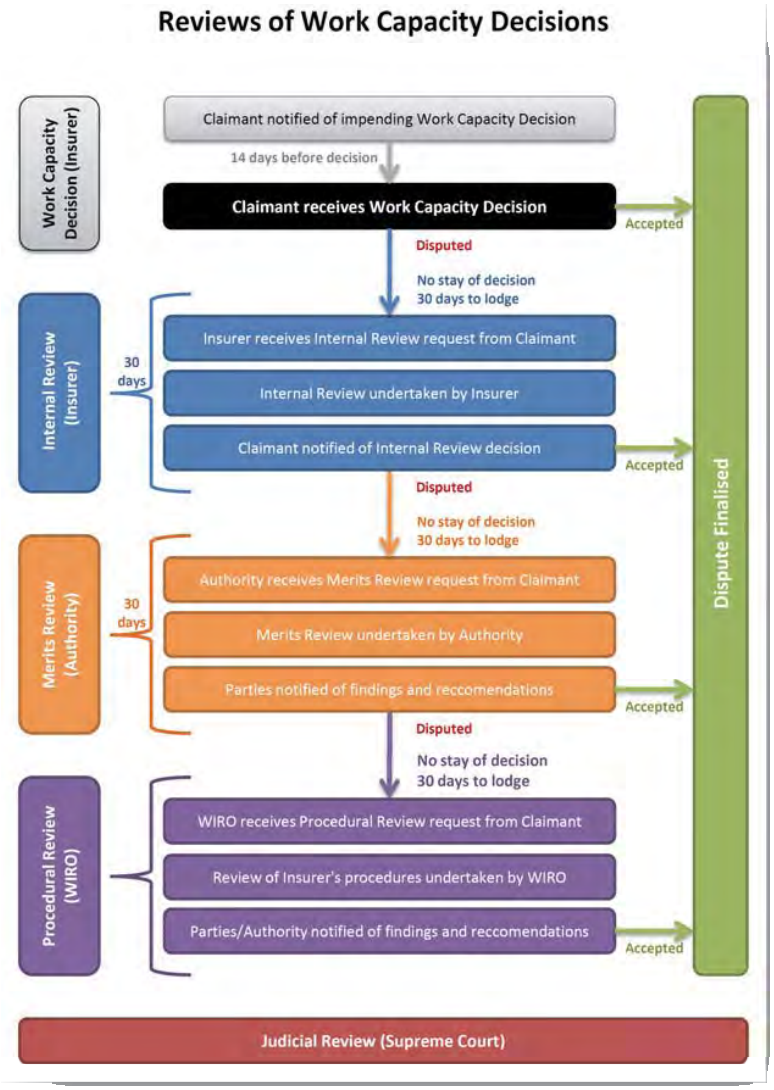


6. Reviews of work capacity decisions

(1987 Act: S.44)

A worker may refer a work capacity decision by an insurer for an internal review by the insurer, and afterwards for a merits review of the decision by the WorkCover Authority and afterwards for a review of the insurer's procedures to the WorkCover Independent Review Officer.

6.1. Flow chart – reviews of work capacity decisions



6.2. Internal review by insurers of work capacity decisions

(1987 Act: S.44)

(Review Guidelines: Division 2, Chapters 5, 6 & 7)

The ability for a worker to seek an internal review of a work capacity decision by an insurer is provided for in section 44 of *the 1987 Act*, and the rules and requirements applying to such reviews are further detailed in the *Review Guidelines*, which are delegated legislation.

6.2.1. Application by a worker to an insurer for an internal review of a work capacity decision

(1987 Act: S.44(2))

(Review Guidelines: 6.1 to 6.4)

A worker may refer a work capacity decision for an internal review by the insurer. The insurer should have given the worker the application form with the work capacity decision notice.

The worker may be assisted in completing the application form by another person such as the insurer, a support person, agent, union representative, employer, legal representative or interpreter. In accordance with section 44(6) of *the 1987 Act,* a legal practitioner is not entitled to be paid for costs incurred in connection with a review of a work capacity decision.

WorkCover will provide and maintain a service to assist workers in connection with the procedures for reviews of work capacity decisions.

6.2.2. Time limit for lodgement

(1987 Act: S.44(1)(a))

(Review Guidelines: 6.5, 6.6)

If a worker wishes to refer a work capacity decision for an internal review, they should lodge a completed *Application for Review of a Work Capacity Decision* form with the insurer within 30 days of receiving the work capacity decision from the insurer.

The *Application for Review of a Work Capacity Decision* form is attached to this document at section 7.2. The application must be in the approved form, specify the grounds on which the review is being sought and any additional information to be considered. (For example, the worker is able to supply further medical information or the worker believes that the suitable employment identified places them at substantial risk of further injury.)

An insurer shall decline to review a decision if an application for review is not lodged by the worker within 30 days of the worker receiving the work capacity decision unless the insurer is satisfied that exceptional circumstances exist sufficient to justify any delay.

6.2.3. Multiple work capacity decisions or claims

(Review Guidelines: 6.10, 6.11)

In one *Application*, a worker may refer for internal review more than one work capacity decision about one or more of the worker's related claims managed by the same insurer, as long as the 30 day lodgement time limit is met for each decision.

The insurer will determine whether or not those internal reviews are most appropriately conducted together or separately as is appropriate in the circumstances of each particular case.

6.2.4. Acknowledgement of application

(Review Guidelines: 7.1)

The insurer must acknowledge the referral in writing to the worker within 7 days of receiving the application and:

- explain the review process;
- advise that a review of a work capacity decision does not operate to stay the decision or otherwise prevent the taking of action based on the decision;
- clarify with the worker any new information supplied or any other information that the worker is in the process of obtaining; and
- indicate when and how the decision will be conveyed to the worker.

6.2.5. Frivolous or vexatious applications

(Review Guidelines:6.7, 6.8, 6.9)

An insurer may decline to review a decision at any stage of the internal review process if an application for review is, or becomes, frivolous or vexatious. If an insurer does decline to review a decision, the decision that has been declined has not been the subject of internal review by the insurer and cannot therefore be referred by the worker for a merit review by the Authority.

The insurer must notify the worker in writing of the decision.

6.2.6. Internal reviewer and decision

(Review Guidelines: 7.2 to 7.5)

The internal reviewer is to undertake the review of the work capacity decision in accordance with the insurer's complaints and disputes handling model including at a minimum:

- the review of the work capacity decision is to be undertaken by a party independent to the original work capacity decision;
- the review of the work capacity decision is to be conducted by someone with a comprehensive knowledge of the legislation as it applies to the work capacity decision referred and the issues arising from it, and has the appropriate expertise and authority for the decision they are making;
- the reviewer is to undertake a full consideration of the subject of the work capacity decision considering all available information and making a fresh work capacity decision; and
- the reviewer has an obligation to make a decision they think is more likely than not to be correct.

6.2.7. Notification of the internal review decision

(1987 Act: S.44(1)(a))

(Review Guidelines: 7.6, 7.7,)

The insurer must write to the worker within 30 days of receiving the application advising of the outcome of the internal review and if the insurer fails to do so the worker may then make an application for Merit Review by the Authority.

The notification must be in writing and must include the decision, its impacts and reasons. The notification must also advise the worker about the availability of further review options.

6.2.8. Outcomes of internal review

An internal review of a work capacity decision will result in a new decision being made. The new decision may be the same as the original decision or it may be different.

If the review decision is the same, it could be based on the same reasons applied to the same information as the original decision maker's decision, or it may be the same despite being made based on different reasons or new information.

If the review decision is different, it could be based on different reasons applied to the same information as the original decision maker had, or it may be based on different reasons or based on new information the original decision maker did not have.

6.3. Merit Review by the Authority

(1987 Act: S.44)

(Review Guidelines: Division 3, Chapters 8, 9 & 10)

If the worker is not satisfied with the outcome of the insurer's internal review of a work capacity decision, or if an internal review by the insurer is not completed within 30 days, the worker may lodge an application for a further review by the WorkCover Authority.

6.3.1. Applications by a worker to the Authority for merit review

(1987 Act: S.44(1)(b), S.44(2), S.44(3)(a) and (b))

(Review Guidelines: 9.1 to 9.22)

A worker may be assisted in completing the application form by another person such as the insurer, a support person, agent, union representative, employer, legal representative or interpreter.

WorkCover will provide and maintain a service to assist workers in connection with the procedures for reviews of work capacity decisions.

The application by the worker must be made within 30 days of either receiving the insurer's internal review decision or the date when the insurer's internal review decision was due.

In one *Application*, a worker may refer for internal review more than one work capacity decision about one or more of the worker's related claims managed by the same insurer, as long as the 30 day lodgement time limit is met for each decision.

The worker must send the insurer a copy of the application before, or at the same time, as lodging the application with the Authority.

The worker does not need to attach to their application all of the existing documents and information relating to the claim or the work capacity decision, as the insurer will be required to provide all relevant information to the Authority as part of their Reply to the application.

The Authority will write to the worker and insurer within 7 days of receiving the application from the worker to acknowledge receipt of the application.

6.3.2. Reply by insurer to a merit review application

(Review Guidelines: 9.23 to 9.26)

On receiving the worker's application, the insurer is to exchange and lodge a Reply to the Application in the approved form (attached at section 7.3) as quickly as possible and within 7 days of receiving the application.

The Insurer must send the Reply to the worker before, or at the same time, as lodging the reply with the Authority.

The reply **lodged with the Authority** must be submitted electronically via email and must include;

- a list of all documents relevant to the work capacity decision and the Review of that decision, including documents supplied by the worker;
- attach electronic copies of all of the documents included in the list of relevant documents, including documents supplied by the worker.

The reply **sent to the worker** must include;

- the list of all relevant documents, but;
- does not need to attach copies of **all** the relevant documents being lodged with the reply, as the insurer should only attach any documents which have **not already been provided** to the worker previously.

Any surveillance images lodged with the Authority are to be provided in DVD format and must first be provided to the worker with any investigator's or loss adjuster's report. If surveillance images are provided to a worker for the first time in support of a Reply, the worker will be offered an opportunity to respond to the surveillance images.

The Authority will write to the worker and insurer within 7 days of receiving the Reply from the insurer.

6.3.3. Merit review decision by the Authority

(1987 Act: S.44(3)(c), (d), (e) and (g))

(Review Guidelines: Chapter 10)

The Authority's merit reviewer may require additional information from the worker or the insurer for the purposes of the review, which the worker and insurer must provide.

The Merit Reviewer will consider all of the material substantively and on its merits as if the original work capacity decision had not been made, and is obliged to make the decision that they think is more likely than not to be correct.

The Merit Reviewer may also make recommendations to the insurer based on their findings, which are binding on the insurer and must be given effect to by the insurer.

The Authority must write to the worker and insurer within 30 days of receiving the application advising of the outcome of the Merit Review and must include the decision, its impacts, any recommendations and reasons. The notification must also advise the worker about the availability of further review options.

6.4. Procedural review by WIRO

(1987 Act: s.44(1)(c), s.44(2), s.44(3)(a), (c), (d), (f) and (h))

If the WorkCover review does not resolve the issue, the worker may lodge an application for review with the WorkCover Independent Review Officer (WIRO) within 30 days of receiving the WorkCover review decision.

The WIRO review is a review only of the insurer's procedures in making the work capacity decision, not of any judgment or discretion exercised by the insurer in making the decision. Recommendations made by the WIRO are binding on the insurer and the Authority.

7. Approved forms

Attached to this document are the following notices and forms approved by the Authority;

7.1. WorkCover Certificate of Capacity

This is the 'form approved by the Authority' referred to in section 44B(3)(a) of *the 1987 Act* for the certificate of capacity to be given by a medical practitioner.

This certificate includes within it the declaration by a worker which is the 'form approved by the Authority' referred to in section 44B(1)(b) of *the 1987 Act.*

7.2. Application for review of a work capacity decision by insurer

This is the 'form approved by the Authority' referred to in section 44(2) of *the 1987 Act* for applications by a worker under section 44(1)(a) to an insurer for internal review of a work capacity decision by the insurer.

7.3. Application for review of a work capacity decision by the Authority

This is the 'form approved by the Authority' referred to in section 44(2) of *the 1987 Act* for applications by a worker under section 44(1)(b) to the Authority for a merit review of a work capacity decision by an insurer.

This is also the 'form approved by the Authority' referred to in section 44(2) of *the 1987* Act for the worker to notify the insurer of an application by a worker under section 44(1)(b) to the Authority for a merit review of a work capacity decision by an insurer..

7.4. Reply to an Application for review of a work capacity decision by the Authority

This is a form approved by the Authority for an Insurer to lodge a reply to an application by a worker under section 44(1)(b) to the Authority for a merit review of a work capacity decision by the insurer.

8. Glossary

current work capacity**,** in relation to a worker, is defined in section 32A of *the 1987 Act*:

"means a present inability arising from an injury such that the worker is not able to return to his or her pre-injury employment but is able to return to work in suitable employment"

days

a reference to a number of days means the number of calendar days unless otherwise stated

injury management is defined in section 42 of *the 1998 Act*:

"means the process that comprises activities and procedures that are undertaken or established for the purpose of achieving a timely, safe and durable return to work for workers following workplace injuries."

injury management plan is defined in section 42 of *the 1998 Act*:

"means a plan for co-ordinating and managing those aspects of injury management that concern the treatment, rehabilitation and retraining of an injured worker, for the purpose of achieving a timely, safe and durable return to work for the worker. An injury management plan can provide for the treatment, rehabilitation and retraining to be given or provided to the injured worker."

injury management program is defined in section 42 of *the 1998 Act*:

"means a co-ordinated and managed program that integrates all aspects of injury management (including treatment, rehabilitation, retraining, claims management and employment management practices) for the purpose of achieving optimum results in terms of a timely, safe and durable return to work for injured workers."

insurer is defined in section 42 of *the 1998 Act*:

"means a licensed insurer, specialised insurer or self-insurer."

medical practitioner

means a person registered under the Health Practitioner Regulation National Law (NSW) No. 86a in the medical profession who is not a Specialist Surgeon.

month

"means a period commencing at the beginning of a day of one of the 12 named months and ending:

(a) immediately before the beginning of the corresponding day of the next named month, or

(b) if there is no such corresponding day, at the end of the next named month."

no current work capacity, in relation to a worker, is defined in section 32A of *the 1987 Act*:

"means a present inability arising from an injury such that the worker is not able to return to work, either in the worker's pre-injury employment or in suitable employment."

nominated treating doctor is defined in section 42 of *the 1998 Act*:

"means the treating doctor nominated from time to time by a worker for the purposes of an injury management plan for the worker."

seriously injured worker is defined in section 32A of *the 1987 Act*:

" means a worker whose injury has resulted in permanent impairment:

(a) the degree of permanent impairment has been assessed for the purpose of Division 4 to be more than 30%, or
(b) the degree of permanent impairment has not been assessed because an approved medical specialist has declined to make an assessment until satisfied that the impairment is permanent and the degree of permanent impairment is fully ascertainable, or
(c) the insurer is satisfied that the degree of permanent impairment is likely to be more than 30%."

suitable employment, in relation to a worker, is defined in section 32A of *the 1987 Act*:

"means employment in work for which the worker is currently suited:

(a) having regard to:
- *(i) the nature of the worker's incapacity and the details provided in the medical information including, but not limited to, any certificate of capacity supplied by the worker (under section 44B), and*
- *(ii) the worker's age, education, skills and work experience, and*
- *(iii) any plan or document prepared as part of the return to work planning process, including an injury management plan under Chapter 3 of the 1998 Act, and*
- *(iv) any occupational rehabilitation services that are being, or have been, provided to or for the worker, and*
- *(v) such other matters as the WorkCover Guidelines may specific, and*

(b) regardless of
- *(vi) whether the work or employment is available, and*
- *(vii) whether the work or the employment is of a type or nature that is generally available in the employment market, and*
- *(viii) the nature of the worker's pre-injury employment, and*
- *(ix) the worker's place of residence."*

treating specialist

is defined in Schedule 4 of the *Health Insurance Regulations 1975:*

"specialist medical practitioner is a medical practitioner recognised as a specialist by the Australian Medical Council and remunerated in accordance with Health Insurance Commission Health Insurance Regulations 1975, Schedule 4, Part 1 at specialist rates under Medicare. "

work capacity assessment

is an insurer's assessment of an injured worker's current work capacity, conducted in accordance with section 44A of *the 1987 Act*

work capacity decision

is a specific type of decision that is made by the insurer defined in section 43 of *the 1987 Act.*

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