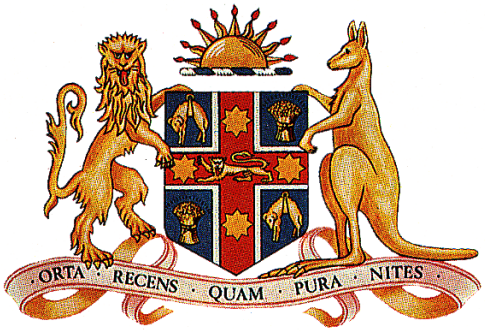

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Waste Levy Guidelines

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Contents

Definitions

The following terms, which are used throughout these Waste Levy Guidelines, have the following meanings. Any other terms, if stated, take the same meaning as in the Protection of the Environment Operations (Waste) Regulation 2014.

EPA means the NSW Environment Protection Authority.

Operational purpose means the purpose for which a waste described in the 'Kind of waste' column of the table in clause 15(1) of the Waste Regulation may be used in order to be eligible for an operational purpose deduction at a scheduled waste facility. The purpose of use for each 'Kind of Waste' is set out in the 'Purpose' column in that table.

OWT means the EPA's online waste tracking system at www.epa.nsw.gov.au/owt/aboutowt.htm

POEO Act means the *Protection of the Environment Operations Act 1997*.

The Waste Regulation means the Protection of the Environment Operations (Waste) Regulation 2014.

Verified weighbridge means a weighbridge that is verified in accordance with the *National Measurement Act 1960 (Cth*).

Introduction

These Waste Levy Guidelines contain specific legal requirements which occupiers of scheduled waste facilities must meet in addition to their obligations under the POEO Act and the Waste Regulation.

The Guidelines include how waste is measured to calculate levy liability, when certain levy deductions can be claimed, and how records, surveys and reports are required to be made, kept and provided to the EPA in order for the occupier to fulfil their obligations under the Waste Regulation.

Each Guideline, and the relevant clause(s) of the Waste Regulation under which the Guideline has been made, is listed below.

1. **Waste Levy Guideline 1:** Operational purpose – materials used for roads or other construction works (*Item 2 of the Table in clause 15(1) of the Waste Regulation*) and bedding layers (*Item 10 of the Table in clause 15(1) of the Waste Regulation)*
2. **Waste Levy Guideline 2:** Records (*clauses 32, 33(a), 34, 36(3)(g) of the Waste Regulation)*
3. **Waste Levy Guideline 3:** Waste streams and waste types *(clauses 22(2)(b), 26(1)-(2), 27(a), 28(a), 30(a) and 31(1)-(2) of the Waste Regulation)*
4. **Waste Levy Guideline 4:** Weight conversion factors (*clauses 5(b), 36(3)(d)(ii), 36(4) and 38 of the Waste Regulation*)
5. **Waste Levy Guideline 5:** Volumetric and Topographical surveys for scheduled waste facilities (*clauses 23(1)-(2) and 24(1)(b) and 33 of the Waste Regulation)*
6. **Waste Levy Guideline 6:** Waste and environment (liquid waste) levy: Technical Guidelines *(clause 17(b) of the Waste Regulation).*

These Waste Levy Guidelines take effect on and from 21 December 2018. Any previous versions of these Guidelines (including any published in the Government Gazette) are revoked on and from that date.

1. Waste Levy Guideline 1: Operational purpose

1.1 Materials used for roads or other construction works

See Item 2 of the Table in clause 15(1) of the Waste Regulation.

An occupier of a scheduled waste facility may apply to the EPA for approval to use at the facility any waste received from off-site for the purpose of roads or other construction works of a kind specified in these Guidelines.

The other kinds of construction works which an operator may apply for approval to use are: application of materials to land as foundational supports (e.g. hardstands, building foundations and infrastructure support).

Materials that are to be used for the purpose of roads or other construction works at the facility must meet the specifications contained in Table 1.1.

The occupier may then claim a deduction from the waste levy for any waste the occupier uses in accordance with the approval granted by the EPA in accordance with clause15(4)-(6) of the Waste Regulation for the Operational Purpose.

Table 1.1: Specifications

Operational purpose	Specifications
Roads	1. Natural materials excavated from a quarry, which do not contain any sulfidic ores or soils; OR 2. Recycled road base (base course and sub-base road making materials) that meet all specifications defined in IPWEA, 2010* for Road Base Class R1 or R2 and which has been supplied consistent with all requirements for the supply of 'recovered aggregate' under the Recovered Aggregate Order** These materials may only be used for roads which have a wearing surface.
Construction Works	1. Natural materials excavated from a quarry, which do not contain any sulfidic ores or soils, or 2. Materials used for construction works that meet all the specifications defined in IPWEA, 2010* for Select Fill Class S or Road Base Class R1 or R2 and which has been supplied consistent with all requirements for the supply of 'recovered aggregate' under the Recovered Aggregate Order**

* Institute of the Public Works Engineering Australia (NSW) (IPWEA) *Specification for Supply of Recycled Material for Pavements, Earthworks and Drainage 2010*, Department of Environment Climate Change and Water NSW, April 2010

** The Recovered Aggregate Order means the *Recovered Aggregate Order 2014* (as in force from time to time) issued by the EPA. The current version of the Recovered Aggregate Order is published on the EPA's website at: http://www.epa.nsw.gov.au/wasteregulation/orders-exemptions.htm

1.2 Materials used for bedding layers

See Item 10 in the Table in clause 15(1) of the Waste Regulation.

An occupier of a scheduled waste facility may apply to the EPA for approval to use at the facility any waste received from off-site for the purpose of bedding layers to protect landfill lining systems if the layers are of a kind specified in these Guidelines.

Materials that are to be used for the purpose of bedding layers at the facility must meet the specifications contained in Table 1.2.

The occupier may then claim a deduction from the waste levy for any waste the occupier uses in accordance with the approval granted by the EPA in accordance with clause 15(4)-(6) of the Waste Regulation for the Operational Purpose.

Table 1.2: Specifications

Operational purpose	Specification
Bedding Layers	The material must, at the time it is received at the facility: 1. Be fine particulate matter (being sand or such other material expressly authorised in the environment protection licence held by the occupier to be used for the operational purpose of a bedding layer) having a thickness not greater than 150mm; 2. Have adequate thickness, particle size distribution, permeability, internal shear strength and interface friction with adjacent layers; 3. Protect the geonet drainage geocomposite by providing an overlying padding or protection layer.

2 Waste Levy Guideline 2: Records

See clauses 32, 33(a), 34 and 36(3)(g) of the Waste Regulation.

This Guideline sets out how an occupier of a facility must record, keep and provide to the EPA (where relevant) information required to be recorded under Part 3 of the Waste Regulation.

2.1 General requirements

Each occupier of a scheduled waste facility must ensure for all information required to be recorded under Part 3 of the Waste Regulation that:

- the original records of the information (such as paper documents) are retained and are accessible by the EPA in their original form
- all record-keeping systems are designed so that details of any adjustments to records are recorded against the adjusted record, including that the record has been amended and the extent of the change
- all electronic records are backed up weekly and the back-up records are stored in a secure location
- quantity of waste is recorded to two decimal places (e.g. 14.22 tonnes)
- all electronic records are able to be downloaded by the EPA in an .xls, .xlsx, .csv or .dbf format at any time.

2.2 Records for transactions

For each vehicle entry (transaction) into a scheduled waste facility, records must be kept in a manner that is exportable, copyable and accessible by the EPA in spreadsheet form. Records must display all information required to be recorded under clauses 27-30 and 32 of the Waste Regulation for each transaction. Each field for a transaction (e.g. date, weight, vehicle registration number) must be displayed as a heading in the first row and the content required for that field set out below that heading.

2.3 Electronic data capture system

For facilities with data capture software connected to a verified weighbridge ('electronic data capture system'), all of the information required to be recorded under clauses 27-30 of the Waste Regulation must be recorded into the electronic data capture system unless:

- the weighbridge is out of operation, or
- the electronic data capture system malfunctions whilst the weighbridge continues to operate.

In these circumstances, the information required to be recorded for a transaction must be manually recorded, and entered into the electronic data capture system as soon as the system resumes operation (with details confirming that the original recording was manual).

2.4 Recording and reporting of trackable liquid waste

Scheduled waste facilities receiving trackable liquid waste must use the EPA's online waste tracking system (or an alternative system approved by the EPA in writing) to record and provide the information required under Part 3 of the Waste Regulation for trackable liquid waste.

Scheduled waste facilities receiving trackable liquid waste must also maintain original records of the information required under Part 3 of the Waste Regulation for:

- trackable liquid waste and other material received at the facility
- trackable liquid waste and other material stored at the facility
- trackable liquid waste transported from the facility
- waste and material other than trackable liquid waste transported from the facility.

2.2 and 2.3 of this Waste Levy Guideline 2 do not apply to scheduled waste facilities which only have levy liability in relation to trackable liquid waste.

3 Waste Levy Guideline 3: Waste streams and waste types

See clauses 22(2)(b), 26(1)-(2), 27(a), 28(a), 30(a) and 31(1)-(2) of the Waste Regulation.

The Waste Regulation requires that occupiers of scheduled waste facilities keep records, and report on waste streams and waste types received at, stockpiled on or sent from their facility in certain circumstances. This guideline sets out what information must be recorded and reported.

3.1 Waste streams

Under clause 27(a) and 28(a) the occupier of a scheduled waste facility must record waste as one of the following three waste streams:

Municipal waste consists of one or more of the following waste types: domestic waste, other domestic waste, council waste, or garden organics (as those terms are defined in 3.1.1 below).

Commercial and industrial waste includes waste generated by businesses (including shopping centres), industries, schools, hospitals, other institutions, or government offices.

Construction and demolition waste is generated from construction or demolition works, and includes asphalt waste or excavated natural material.

Other if it is not possible to identify whether the waste is municipal waste, commercial and industrial waste or construction and demolition waste.

3.1.1 Municipal waste

Where municipal waste is recorded as the waste stream, the occupier must also record the municipal waste sub-stream, whether the waste is:

- domestic waste – household waste (other than garden organics) collected by or on behalf of a council as part of a routine kerbside service carried out at least once per fortnight
- other domestic waste – household waste (other than garden organics or domestic waste) collected by or on behalf of a council or taken directly to the waste facility by or on behalf of the householder
- council waste – waste (other than garden organics) collected by or on behalf of a council from parks or gardens, council street bins, the sweeping of streets by or on behalf of the council, council waste drop-off centres and major public events
- Garden organics – waste consisting of plants or parts of plants, including compost or mulch.

3.2 Waste types

Table 3.1 lists waste types, including the corresponding Code for the purposes of the record-keeping requirements under clauses 27(a), 28(a), 31(1)-(2) and the Waste Contributions Monthly Report (clause 22(2)(b)).

Table 3.1: Waste types

Description of waste	Code
Aggregate, road base or ballast	AGG
Aluminium (non-ferrous)	AL
Asbestos (N220)	ASB
Asbestos contaminated soil	ASBSOIL
Ashes	ASH
Asphalt	ASPH
Batteries	BATT
Bricks or concrete	BC
Biosolids or manures	BIO
Ceramics, tiles, pottery	CER
Commingled recyclables	COMM
Composts or mulches	COMP
Contaminated soil	CONT
Dredging spoil	DSP
E-waste	EWASTE
Ferrous (iron or steel)	FE
Food or kitchen	FOOD
Glass	GLASS
Mattresses	MATT
Mixed waste *	MIX
Mixed waste organic outputs	MWOO
Non-ferrous (metals, not iron steel or aluminium)	NFE
Oil	OIL
Paper or cardboard	PAPER
Plasterboard	PB
Pharmacy or clinical	PHARM
Plastic	PL
Potential Acid Sulphate Soils	PASS
Problem Waste	PROB
Residues or rejects	RES
Shredder floc	FLOC
Soil (not contaminated or VENM)	SOIL
Textiles, rags	TEXT
Tyres	TYRE
Vegetation or garden	VEG
Virgin excavated natural material	VENM
Veterinary waste	VET
Wood, trees or timber	WOOD

* For loads which contain more than one waste type, the ‘description of waste’ and ‘Code’ should be mixed waste and MIX respectively.

The waste types that are required to be recorded under clause 30 for wastes that are used for an operational purpose at a scheduled waste facility are listed in the table in clause 15(1) under the column ‘Kind of waste’.

The EPA will advise when the operational purpose deduction is granted:

- if the waste type is required to be reported in the Waste Contributions Monthly Report (WCMR), and
- the appropriate Code (if any) for recording and reporting in the WCMR.

4 Waste Levy Guideline 4: Weight conversion factors

See clauses 5(b), 36(3)(d)(ii), 36(4) and 38 of the Waste Regulation.

An occupier of a scheduled waste facility is required to measure the quantity of waste that is transported into or out of the facility. This Guideline sets out when conversion factors can be used to measure the quantity of waste.

4.1 Vehicle conversion factors

Vehicle conversion factors may only be used by the occupier of a scheduled waste facility who is required under the Waste Regulation to install a weighbridge if:

- the verified weighbridge at a scheduled waste facility is out of operation; or
- the EPA has specifically exempted or deferred the occupier from the requirement to install a verified weighbridge under the Waste Regulation, and if an alternative measuring system has not been prescribed in the notice of exemption or deferral.

In these circumstances operators must use the conversion factors listed in Table 4.1 to measure the quantity of a load of waste or other material transported into or out of the waste facility, for the specified type of vehicle or bin in which the waste is transported.

Table 4.1: Vehicle and bin weight conversion factors

	Sources		
Open truck	**Municipal, Commercial & Industrial waste** **Deemed tonnage (or t/m^3 if stated) of load**	**Construction & Demolition waste** **Deemed tonnage (or t/m^3 if stated) of load**	**Sand, soil or soil like material including clay rock, stone or similar quarried materials** **Deemed tonnage (or t/m^3 if stated) of load**
Single rear axle with two rear wheels or four small rear wheels	0.62	0.98	2.47
Single rear axle with four normal size wheels	1.16	2.76	5.58
Tandem rear axle (bogie drive)	3.74	7.14	10.97
Twin steer with twin rear axles	5.57	7.61	10.97
Tipping semi-trailer	5.79	15	15
Skip Bins			
Skip Bin	0.8 (t/m^3)*	Mixed waste: 0.7 (t/m^3))	1.5 (t/m^3)*

	Sources		
		Segregated concrete or brick: 1.2 (t/m^3) Crushed concrete & brick base material: 1.5 (t/m^3) Crushed aggregate: 1.3(t/m^3) All other waste: 1.1 (t/m^3) *	
Enclosed Trucks, Compactors, Trucks and Dogs, B-doubles	**All Sources** **Deemed tonnage**		
Single Steer with single rear axle	2.72		
Single steer with tandem rear axle	6.38		
Tandem rear axle (bogie drive) with trailer (truck and dog)	29.1		
Twin Steer with tandem rear axle	7.96		
Waste transfer truck (Walking floor)	19.89		
B-double	39.3		
Small vehicles and Mobile Garbage Bins (all sizes)			
Car / station wagon	0.06		
Van / ute / trailer	0.3		
Mobile Garbage Bin (as used for normal domestic kerbside collections: all sizes)	0.06 per bin**		

*** The total deemed weight of a load in a skip bin is to be determined based on bin size, not amount of waste or material in the bin.**
**** If more than six mobile garbage bins are delivered in a ute or trailer, the maximum deemed weight is 0.3 tonnes: that is the standard conversion factor applying to utes and trailers.**
***NOTE:* The above conversion factors for specified vehicles apply to each load of waste or material in the vehicle, regardless of how full.**

4.2 Liquid waste conversion of volume to weight

For the purposes of clause 5(b) of the Waste Regulation, one kilolitre of liquid waste that is measured by volume is taken to weigh one tonne.

5 Waste Levy Guideline 5: Volumetric and topographical surveys for scheduled waste facilities

See clauses 23(1)-(2), 24(1)(b) and 33 of the Waste Regulation.

An occupier of a scheduled waste facility is required to provide results of a topographical or volumetric survey in an approved form and manner specified by the Waste Levy Guidelines. This Guideline sets out how the results must be provided.

Landfill Facilities

Sections 5.1- 5.4 apply to any scheduled waste disposal facility that is a landfill site.

5.1 Submitting survey results to EPA

Any results from a survey required must be submitted to EPA by completing the:

- Landfill Survey Checklist set out in section 5.2,
- Landfill Facility Information Certificate set out in section 5.3, and
- The Stockpile Information and Schedule of Material Movements Form set out in section 5.4.

The completed documents must be submitted together with the survey plan of the facility in electronic format (e.g. .dwg, .xls, .xlsx, .pdf) to:

wasteauditunit@epa.nsw.gov.au

OR

by mail to the following address:

Waste Audit Unit

Environment Protection Authority

PO Box A290

Sydney South 1232

Note: Guidance as to the meaning of key terms used in sections 5.2 to 5.4 can be found at Volumetric Survey Definitions. These definitions should be referred to when completing these documents.

5.2 Landfill Volumetric Survey Checklist (LVSC)

Facility:	
Licence number:	
Survey period:	
Date of survey:	

Survey item	Yes
Survey to be carried out by a qualified surveyor as defined in Clause 7 of the Protection of the Environment Operations (Waste) Regulation 2014.	
Survey results are presented in the form of a survey plan. The survey plan shows survey results to the licensed boundaries of the facility at the time of the survey.	
Terrain levels are represented on the survey plan by contours at not more than one metre intervals.	
All levels are related to Australian Height Datum and the origin of levels noted on the survey plan.	
Spot levels are taken at sufficient frequency to allow interpolation of levels from the survey plan to ±0.2 metres at the 90% confidence level.	
Boundaries of the site, date of survey, adjoining title information, scale bar, buildings, roads, fences, ponds, landfill cell extraction areas, weighbridges, settlement, subsidence and any other significant details that will likely impact on the volume usage are noted on the survey plan.	
The boundaries of all active cells which received waste during the survey period are noted on the survey plan by use of the Map Grid of Australia 1994 (MGA94).	
The boundaries of all cells which are currently being excavated, mined or quarried for any purpose are noted on the survey plan by use of the Map Grid of Australia 1994 (MGA94).	
All changes in the volume in the active cells and any other area on the facility during the survey period are noted on the survey plan and listed in the Landfill Facility Information Certificate (Form 5.3).	
Stockpile locations are clearly noted on the survey plan and provided with an identification number that correlates with the Landfill Facility Information Certificate (Form 5.3) and Landfill Stockpile Information Form (Form 5.4).	

Signed: _____

Date: _____

Name (surveyor): _____

(organisation): _____

5.3 Landfill Facility Information Certificate (LFIC)

Licence no:			
Survey period:		**Date of survey:**	
Facility name:			
Facility address:			
Occupier's name:			
Site area (in hectares):			
Title details:			
Lot:		**D.P:**	
Lot:		**D.P:**	
Lot:		**D.P:**	
Lot:		**D.P:**	

Note: The MGA94 coordinates of licensed boundaries, all active cells, all excavated areas and all subsidence areas must be shown on the survey plan.

Landfill capacity details:	
Total design capacity:	
Void space remaining at beginning of survey period:	
Change in void space during this survey period*:	
Change in void space in active cell(s) during this survey period:**	
Void space remaining as at end of survey period:	

* If the value is different from active cell/s figure, provide individual volumes (m^3) on survey plan using a text box and also highlight the boundaries of those areas (including active cell/s) that contribute to the total volume change

** If more than one active cell during survey period, provide individual volumes (m^3) on survey plan using a text box.

Stockpile details

Stockpile identification	Volume (m^3)

If space is insufficient, please attach a separate schedule or insert rows in the Microsoft Excel version of this form. The surveyor should sign the Schedule (see next page).

Surveyor's certification

I, **(full name)**

a qualified surveyor, of*

*(provide company name and must include relevant ABN or ACN)

certify that the above information is correct and that the survey and computations represented in the attached survey plans have been conducted in accordance with the approved form and manner requirements of the Protection of the Environment Operations (Waste) Regulation 2014.

Signature **Date**

5.4 Landfill Stockpile Information and Schedule of Material Movements Form

Facility:			
Licence number:			
Survey period:		**Date of survey:**	

	Stockpile Information					
Stockpile ID on volumetric survey[1]	**Material type (using WCMR codes)**	**Volume in m^3**	**Density Value in t/m^3**	**Weight in tonnes**	**Stockpile won on site – Yes/No**	**Applicable financial year for levy rate**

WCMR = Waste Contribution Monthly Report.

[1] **Please ensure that the Stockpile ID order is the same as that given in Form 5.3**

Schedule of Material Movements			
Materials IN			**Tonnes**
(a)	**Reportable material received at site**		
(b)	**Non-reportable material received at site**		
	Please indicate separately any waste received subject to DIN or OP		
		(I) Subtotal (a) + (b)	
Materials OUT			**Tonnes**
(c)	**Reportable material removed from site**		
(d)	**Non-reportable material removed from site**		
		(II) Subtotal (c) + (d)	
		NET (I) – (II)	

DIN = deduction identification number; OP = operational purpose.

Signed: _____ **Date:**

Name: **of**

(position) (licensee)

Resource Recovery Facilities

Sections 5.5 - 5.7 apply to any scheduled waste facility other than a scheduled waste disposal facility that is a landfill site.

5.5 Submitting survey results to EPA

Any results from a survey required must be submitted to EPA by completing the:

- Resource Recovery Survey Checklist set out in section 5.7,
- Resource Recovery Facility Information Certificate set out in section 5.8

The completed documents must be submitted together with the survey plan of the facility in electronic format (e.g. .dwg, .xls, .xlsx, .pdf) to:

wasteauditunit@epa.nsw.gov.au

Or

By mail to the following address:

Waste Audit Unit

Environment Protection Authority

PO Box A290

Sydney South 1232

Note: guidance as to the meaning of key terms used in sections 5.7 to 5.8 can be found at Volumetric Survey Definitions. These definitions should be referred to when completing these documents.

5.6 Resource Recovery Survey Checklist

Facility name:			
Facility address:			
Occupier's name:			
Licence number (if applicable):			
Survey period:		**Date of survey:**	

Survey item	**Yes**
Survey to be carried out by a qualified surveyor as defined in Clause 7 of the Protection of the Environment Operations (Waste) Regulation 2014.	
Survey results must be presented in the form of a topographical plan. The survey plan must show survey results to the licensed boundaries of the Facility. In the case of an unlicensed facility, the survey plan must show survey results to the legal boundaries of the Facility.	
Terrain levels must be represented on the survey plan by contours at not more than one metre intervals.	
All levels must be related to Australian Height Datum and the origin of levels noted on the survey plan.	
Spot levels must be taken at sufficient frequency to allow interpolation of levels from the survey plan to ± 0.2 metres at the 90% confidence level.	
Boundaries of the site, date of survey, adjoining title information, scale bar, buildings, roads, fences, ponds, and weighbridges must be noted on the survey plan.	
Stockpile locations must be clearly noted on the survey plan and provided with an identification number that correlates with the Facility Information Certificate below.	

Signed: **Date:**

Name (surveyor) **of**

(organisation)

5.7 Resource Recovery Facility Information Certificate

Facility name:				
Facility address:				
Occupier's name:				
Licence number (if applicable):				
Survey period:			**Date of survey:**	
Site area (in hectares):				
Title details:				
Lot:		**D.P:**		
Lot:		**D.P:**		
Lot:		**D.P:**		
Lot:		**D.P:**		
Map Grid Australia (MGA) coordinates of licensed or legal boundaries (show on plan)				

Stockpile Volumes and Tonnages (if also being calculated as part of the topographical survey).

Stockpile identification	Volume m^3	Density value (t/m^3)	Derived tonnage(s)

If space is insufficient, attach a separate schedule or insert rows in the Microsoft Excel version of this form. The surveyor should sign the schedule (see next page).

Surveyor's certification

I, **(full name)**

a qualified surveyor, of*

*(provide company name and must include relevant ABN or ACN)

certify that the above information is correct and that the survey and computations represented in the attached survey plans have been conducted in accordance with the approved form and manner requirements of the Protection of the Environment Operations (Waste) Regulation 2014.

Signature: **Date:**

6 Waste Guideline 6: Waste and Environment (Liquid Waste) Levy: Technical Guidelines

See clause 17(b) of the Waste Regulation.

The occupier of a scheduled waste facility who is required to pay the waste levy may deduct from the levy payable an amount in respect of trackable liquid waste received at the facility which is transported from the facility as a substance other than trackable liquid waste to a place for lawful recycling, re-use or processing, but only if any requirements of the Waste Levy Guidelines have been satisfied.

For the purpose of clause 17(b), the requirements in each row of Column 3 of Table 6.1 apply in relation to the type of substance described in Column 1 that is transported to a place for the purpose in Column 2.

Table 6.1: Requirements

Column 1 Substance	Column 2 Purpose	Column 3 Requirements
The liquid component of processed, treated or recycled trackable liquid waste.	Lawful recycling, re-use or processing as industrial water in a commercial or industrial process.	The liquid component must comply with relevant industrial specifications, standards and guidelines for the particular commercial or industrial process. Where a specification is not available or applicable, a risk management plan must be undertaken (and made available to the EPA) consistent with the principles outlined in the National Guidelines for Water Recycling: Managing Health and Environmental Risks (2006)[1]
The aqueous liquid component of processed, treated or recycled trackable liquid waste.	Lawful[2] recycling, re-use or processing in the irrigation of agricultural land or public parks or other recreational facilities.	The aqueous fraction of treated or processed liquid waste must be of a quality appropriate for irrigation on agricultural land or application to land without causing harm to the environment or human health. The water quality of the aqueous fraction must not exceed the trigger values for the specific physical, chemical and biological parameters outlined in: 1. The Australian and New Zealand Guidelines for Fresh and Marine Water Quality (2000), Chapter 4: Primary Industries, Sections 4.2.1–4.2.9 Water Quality for Irrigation (the ANZECC Guidelines).[3]

[1] Environment Protection and Heritage Council, Natural Resource Management Ministerial Council, Australian Health Ministers' Conference 2006, *National Water Quality Management Strategy: Australian Guidelines for Water Recycling: Managing Health and Environmental Risks (Phase 1)*, EPHC, NRMMC, AHMC.

[2] Any application of the substance to land must comply with any applicable resource recovery order and exemption. The current versions of orders and exemptions are published on the EPA's website at http://www.epa.nsw.gov.au/wasteregulation/orders-exemptions.htm. Where no resource recovery order or resource recovery exemption is currently available for the intended use of a waste material, an application can be made to the EPA: see https://www.epa.nsw.gov.au/your-environment/recycling-and-reuse/resource-recovery-framework/apply-for-an-order-and-exemption

[3] Australia and New Zealand Environment and Conservation Council, Agriculture and Resource Management Council of Australia and New Zealand 2000, *Australian and New Zealand Guidelines for Fresh and Marine Water Quality*, ANZECC, ARMCANZ.

Column 1 Substance	Column 2 Purpose	Column 3 Requirements
		2. The 'health' guideline values in the Australian Drinking Water Guidelines (2011), [4] Chapter 10: Monitoring for Specific Characteristics in Drinking Water (Table 10.10).[5]
The solid or liquid component of processed, treated or recycled trackable liquid waste which has been recovered into its original substance (e.g. solvent, chemical, fuel or oil) (Original Form)	Lawful recycling, re-use or processing (other than application to land) in the substance's Original Form	The solid or liquid component must be sent off-site for re-use in its Original Form and must comply with relevant legislation, specifications, standards and guidelines for the proposed re-use.

[4] National Health and Medical Research Council, Natural Resource Management Ministerial Council 2011, National Water Quality Management Strategy: Australian Drinking Water Guidelines 6, Version 3.5 Updated August 2018, NHMRC, NRMC.

[5] Where no appropriate guideline values are available for identified chemicals or where the waste contains greater than trace amounts of substances, such as heavy metals, solvents, chlorinated organic compounds, agricultural chemical residues or petrochemicals, the waste in question is generally not suitable for application to land for irrigation purposes.

[n2018-4306]

Other Government Notices

WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998

Revocation of 'WorkCover Interim Payment Direction Guidelines'

I, Carmel Donnelly, Chief Executive of the State Insurance Regulatory Authority do hereby revoke the *WorkCover Interim Payment Direction Guidelines 2009* made under sections 291 and 376(1) of the *Workplace Injury Management and Workers Compensation Act 1998* and which commenced on 1 May 2009.

Revocation is effective as at the date of publication of this instrument in the NSW Government Gazette.

Name: Carmel Donnelly

Signed:

Date: 18/12/18

[n2018-4307]

Workers compensation medical dispute assessment guidelines

State
Insurance
Regulatory
Authority

Contents

General introduction

Publication and commencement

The State Insurance Regulatory Authority (SIRA) is a statutory body constituted under the *State Insurance and Care Governance Act 2015* which is responsible for regulating workers compensation insurance, motor accidents compulsory third party (CTP) insurance and home building compensation insurance in NSW.

These Guidelines are published by SIRA and replace the WorkCover *Medical Assessment Guidelines* 2006 which were issued on 25 October 2006. These Guidelines apply to all existing disputes in the Commission and to new disputes under Part 7 of Chapter 7 of the 1998 Act from 1 January 2019.

Legislative framework

The following legislation outlines the rights, responsibilities and obligations of workers, employers and insurers, should a person suffer a work-related injury in NSW:

- *Workers Compensation Act 1987* (the 1987 Act)
- *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act)
- Workers Compensation Regulation 2016 (2016 Regulation).

Guideline-making power

These Guidelines are made under sections 328, 331 and 376 of the 1998 Act.

Interpretation of the guidelines

These Guidelines should be read in conjunction with the relevant provisions of the Acts and the Regulation; the chapter on independent medical examinations and reports in the *Workers compensation guidelines;* SIRA Guides made under section 322 of the 1998 Act; the Workers Compensation Commission Rules, Practice Directions and Registrar's Guidelines issued by the Workers Compensation Commission.

Purpose of the Guidelines

These Guidelines set out the procedures for the referral of medical disputes for assessment and appeal, and the procedures for assessment and on appeal under Part 7 of Chapter 7 of the *1998 Act*.

Application of the Guidelines

Relevant parts of the Guidelines apply to key scheme stakeholders and service providers, including:

- insurers
- health practitioners
- lawyers and other representatives
- staff of the Authority

- decision makers
- courts and other dispute resolution bodies.

Scope of the Guidelines

The Guidelines contain the following Parts:

- Part 1: Interpretation
- Part 2: The referral process
- Part 3: The assessment procedure
- Part 4: The medical assessment certificate
- Part 5: Reviewing or appealing the medical assessment certificate.

Definitions

Words defined in the NSW workers compensation legislation have the same meaning in these Guidelines.

Part 1: Interpretation

Abbreviations used in these Guidelines

1.1 In these Guidelines, these abbreviations are used:

Abbreviation	Term
AMS	approved medical specialist
Commission	Workers Compensation Commission
Registrar	Registrar of the Workers Compensation Commission
MAC	medical assessment certificate
MAP	Medical Appeal Panel
SIRA	State Insurance Regulatory Authority
WPI	whole person impairment
1998 Act	*Workplace Injury Management and Workers Compensation Act 1998*
1987 Act	*Workers Compensation Act 1987*
2016 Regulation	Workers Compensation Regulation 2016

Words and phrases defined in these Guidelines

1.2 In these Guidelines these words and phrases have the following meanings:

Word/phrase	Definition
approved medical specialist	A medical practitioner appointed under Part 7 of Chapter 7 of the 1998 Act as an AMS
day or days	Calendar days unless specified as working days
claimant	A person who has made a claim under the 1998 Act
lead assessor	A lead assessor is nominated by the Commission where a worker's injury requires more than one AMS to assess different body systems, structures and/or disorders.
party	Includes the claimant, an insurer or an employer
insurer	An insurer within the meaning of the: • *Workers Compensation Act 1987* • *Workplace Injury Management and Workers Compensation Act 1998.* It includes a: • licensed insurer • former licensed insurer • specialised insurer • self-insurer or former self-insurer, and scheme agent.

Part 2: The referral process

Referral to an approved medical specialist

2.1 A court, the Commission or the Registrar may refer a medical dispute for assessment by an AMS.

2.2 The Registrar is to give the parties notice of the referral.

2.3 A party can request a medical dispute be referred to an AMS.

2.4 The request must be in the form approved by the Registrar for that purpose.

Choosing an approved medical specialist

2.5 The parties to the dispute may advise the Registrar in writing of the name of the AMS they have agreed to appoint at the time of filing the application and/or reply or within seven days after the dispute is referred by the Registrar.

2.6 If the parties do not notify the Registrar of an agreed AMS within seven days as set out above, the Registrar is to choose the AMS who is to assess the dispute and advise the parties in writing of the name of the AMS – section 321(2) of the 1998 Act.

2.7 If the chosen AMS is not available within two months, the parties should select another AMS or the Registrar may appoint one.

2.8 When choosing an AMS, the parties or the Registrar should consider:

- 2.8.1 only AMSs on the Commission's list who are appropriate given the body systems to be assessed
- 2.8.2 which location to attend the examination would be most convenient to the worker
- 2.8.3 the availability of the AMS.

2.9 The full list of AMSs is available on the Commission's website at www.wcc.nsw.gov.au

2.10 The Registrar may choose a different AMS if not satisfied that the AMS chosen by the parties meets the above criteria.

Lead and non-lead assessments

2.11 In the case of a complex injury where different medical assessors are required to assess different body systems, a lead assessor will be appointed to coordinate and calculate the final degree of permanent impairment as a percentage of WPI resulting from the individual assessments.

2.12 If the parties do not notify the Registrar of the agreed lead assessor within seven days, the lead assessor will be selected by the Registrar.

2.13 The AMSs chosen to undertake the multiple assessments will be notified by the Registrar in the referral of the lead assessor and non-lead assessor(s).

2.14 In matters concerning complex injury, the non-lead assessor will carry out an assessment and provide it to the lead assessor. The lead assessor undertakes an

assessment, consolidates it with the non-lead assessor's assessment and provides a consolidated MAC.

2.15 There may be more than one non-lead assessor undertaking an assessment for consolidation by a lead assessor.

Conflict of interest

2.16 It is important that the medical assessment process promotes public confidence through transparency, impartiality and fairness. A conflict of interest arises when an AMS is unable, or appears unable, to perform his or her responsibilities independently and free from any influence external to the assessment. An apparent or potential conflict may involve pecuniary interests or non-pecuniary interests.

2.17 An AMS to whom a matter is allocated must not accept a referral if there is a known conflict of interest.

2.18 The AMS should review the referral documents within seven days of receiving them to identify any potential conflict of interest.

2.19 If the AMS considers that there may be a conflict of interest, the AMS is to immediately notify the Registrar and return the referral documents. The matter will then be reallocated to another AMS by the Registrar.

2.20 A party may apply to the Registrar to have the matter reallocated on the grounds that the AMS, to whom the matter has been allocated, has a conflict of interest. To do that, the party must apply:

2.20.1 within seven days of receiving notification of the name and contact details of the AMS

2.20.2 in writing, detailing the reasons in support of the reallocation.

2.21 The Registrar is to decide on the application for reallocation within seven days of receipt.

2.22 If the Registrar is of the opinion that there are reasonable grounds for believing that the appointed AMS may have a conflict of interest (for example, someone previously treated or examined or where there is a personal relationship), the Registrar must reallocate the matter.

The Registrar arranges the assessment

2.23 The Registrar advises the parties of the date, time and location of the assessment.

2.24 If an interpreter is required, the Registrar is to organise for a National Accreditation Authority for Translators and Interpreters (NAATI) certified interpreter to attend the examination. In circumstances where a NAATI certified interpreter is unavailable the Registrar may approve an interpreter.

2.25 When the Registrar refers the matter to the AMS, the Registrar is to provide the AMS with:

2.25.1 all documentation admitted on behalf of a party to proceedings relevant to the medical dispute referred in compliance with the 2016 Regulation

2.25.2 any applicable provisions of the *Workers Compensation Commission Rules 2011,* and

2.25.3 any orders of a Court or the Commission.

8 Workers compensation medical dispute assessment guidelines

2.26 The Commission file may contain video surveillance material obtained as part of investigators' reports. Video surveillance shall not be disclosed to the AMS unless ordered by the Commission in exceptional circumstances.

2.27 Parties to a medical dispute are not to attach legal submissions in the documents lodged in connection with the dispute. Any legal submissions will be removed from the documents lodged prior to referral to the AMS.

2.28 If it is necessary for a worker to bring x-rays or similar documents to the assessment, the worker will be advised of this in the letter from the Registrar.

2.29 The parties are not to communicate directly with the AMS at any time with the exception of the worker during the examination.

2.30 The parties are not to provide additional information directly to the AMS at any time.

2.31 An AMS may call for the production of medical records necessary or desirable for the purposes of assessing a medical dispute. This request should be made through the Registrar.

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Part 3: The assessment procedure

Examination by approved medical specialist

3.1 The *Medico-Legal Guidelines* of the NSW Medical Board, as in force from time to time, apply to examinations by AMSs.

3.2 The AMS Code of Conduct governs the conduct of AMSs. The Code seeks to guide AMSs in carrying out their duties in a manner that is consistent with the objectives of the Commission.

3.3 The procedures set out in the *NSW workers compensation guidelines for the evaluation of permanent impairment* apply to the conduct of assessments relating to whole person impairment. The applicable guidelines are those in force at the time of the assessment.

3.4 The *Table of Disabilities* applies when assessing permanent loss for injuries before 01 January 2002. The *Table of Maims* applies to injuries received before 4 pm on 30 June 1987.

3.5 The Commission does not allow workers to record examinations undertaken by an AMS.

3.6 When assessing a medical dispute, an AMS is not restricted to the material before him or her. The AMS may do any one or more of the following:

- 3.6.1 consult with any medical practitioner or other health care professional who is treating, or has treated, the worker
- 3.6.2 call for medical records (including x-rays and the results of other tests) and other information that the AMS considers necessary or desirable to assess the dispute
- 3.6.3 require the worker to submit himself or herself for examination by the AMS.

3.7 An AMS may examine the worker by video consultation as an alternative to a face-to-face consultation in limited circumstances. For example, assessment of a psychological injury where a worker is situated in a rural or remote location.

3. 8 The Registrar's approval is required before an assessment is done by video consultation.

Assessing a medical dispute "on the papers"

3.9 In the majority of matters, the AMS will need to medically examine the worker to form an opinion.

3.10 However, the AMS may make an assessment without a medical examination if satisfied that the information provided is sufficient to enable determination of the issues in dispute.

3.11 In exercising the discretion not to conduct a medical examination, the AMS must consider:

- 3.11.1 the nature and complexity of the issues in dispute
- 3.11.2 the likely impact of non-examination on the outcome of the dispute
- 3.11.3 the extent and detail of the information provided

3.11.4 any submission by the parties as to why a medical examination is required

3.11.5 the availability of the worker.

3.12 Assessment without a medical examination occurs only in rare circumstances, for example, where a worker suffered an injury and later died before an examination was able to be undertaken.

3.13 The AMS should confirm in the Medical Assessment Certificate (MAC) the reasons why an examination of the worker was not required.

Accompanying person for the worker at an assessment

3.14 A support person, such as a family member or friend may accompany the worker to a medical assessment if it is reasonable in the circumstances.

3.15 A union representative or legal practitioner instructed to act for the worker in the Commission is not permitted to accompany a worker to a medical assessment.

3.16 The accompanying person is to conduct himself or herself appropriately during the examination.

3.17 Before the examination commences, the AMS should explain that the support person must not take an active role.

3.18 The AMS has the right to ask the support person to withdraw if their behaviour interferes with the conduct of the examination.

Interpreters

3.19 The Registrar will appoint a NAATI certified interpreter if required.

3.20 If appointed, an interpreter should disclose any potential conflict of interest and the Registrar will then determine whether another interpreter is required.

3.21 In limited circumstances, where a certified interpreter is not available, a non-certified interpreter may be appointed.

3.22 Any non-certified interpreter will hold appropriate qualifications and must demonstrate the absence of any conflict of interest with the worker or AMS.

Non-attendance by the worker

3.23 If the worker is unable to attend the scheduled assessment, the worker is to notify the Registrar prior to the date of the examination.

3.24 The AMS must notify the Registrar in writing if the worker did not attend the scheduled appointment. The notification is to be provided within two working days of the scheduled appointment.

3.25 Failure to attend on two occasions without a reasonable excuse may result in the proceedings being dismissed.

Paying the worker's expenses

3.26 The insurer must meet any reasonable costs incurred by the worker, including wages, travel, maintenance and accommodation. This may include pre-payment of travel and accommodation expenses. If the worker is not reasonably able to travel unescorted, this may include expenses for the worker's escort (section 330 of the 1998 Act).

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Part 4: The medical assessment certificate

4.1 The AMS is to provide the Registrar with a completed MAC within 10 working days of the assessment.

4.2 The MAC must be in the form approved by the Registrar and must include the following information:

- 4.2.1 details of the matters referred for assessment
- 4.2.2 the AMS's opinion with respect to those matters
- 4.2.3 total amount of whole person impairment (where applicable)
- 4.2.4 the facts on which that opinion is based
- 4.2.5 the AMS's reasons for that opinion or diagnosis
- 4.2.6 in matters related to permanent impairment, correct reference to the Table of Disabilities (injuries before 1 January 2002) or to the *NSW workers compensation guidelines for the evaluation of permanent impairment* (injuries from 1 January 2002) is required. The *Table of Maims* applies to injuries received before 4 pm on 30 June 1987.

Issuing a medical assessment certificate

4.3 The Registrar issues the MAC to the parties.

4.4 Before issuing a MAC, the Registrar is to ensure the MAC addresses the matters referred for assessment.

4.5 The following matters assessed in a MAC are conclusively presumed to be correct in proceedings before the Commission:

- 4.5.1 the degree of permanent impairment of the worker as a result of an injury
- 4.5.2 whether any proportion of permanent impairment is due to any previous injury or pre-existing condition or abnormality
- 4.5.3 the nature and extent of loss of hearing suffered by a worker
- 4.5.4 whether impairment is permanent
- 4.5.5 whether the degree of impairment is fully ascertainable.

4.6 The MAC may also contain other matters which are not conclusively presumed to be correct in proceedings before the Commission but may be admitted into evidence. These matters are:

- 4.6.1 the worker's condition (including the worker's prognosis), aetiology of the condition and the treatment proposed or provided
- 4.6.2 the worker's fitness for employment.

Errors in the medical assessment certificate

4.7 The Commission's practice direction *No 4 Correction of "obvious error"* sets out what constitutes an obvious error in a MAC and the procedure for parties to follow to correct the obvious error.

4.8 If the Registrar is satisfied that the MAC contains an obvious error, the Registrar may issue an amended MAC to correct the error.

4.9 Once the MAC has been corrected, an amended MAC will be issued.

4.10 The Registrar is to provide the parties and the AMS with a copy of the amended MAC.

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Part 5: Reviewing or appealing the medical assessment certificate

Time for making an appeal

5.1 An appeal application (on the grounds that the assessment was made on the basis of incorrect criteria or the MAC contains a demonstrable error), must be lodged within 28 days after the date the MAC is issued, unless special circumstances apply.

5.2 If the appeal application is lodged after 28 days, the appealing party must lodge submissions setting out the special circumstances to be considered by the Registrar.

5.3 A party cannot appeal against a medical assessment if the Commission has already issued a Certificate of Determination in respect of the dispute concerned.

Application for appeal/opposition

5.4 Parties lodging an appeal, or opposition to an appeal, must use the approved forms and attach relevant submissions. For further information on completing these forms refer to *Guides for completing forms* available on the Commission website at http://www.wcc.nsw.gov.au.

5.5 The appeal will be rejected if the party lodging the appeal does not use the approved form or attach relevant submissions.

5.6 If the appeal application is on the grounds that the assessment was made on the basis of incorrect criteria or the MAC contains a demonstrable error and the application is lodged after 28 days, the appealing party must lodge submissions setting out the special circumstances for the Registrar to consider, including justification for extra time to make the appeal.

Procedure for appeals against a decision of an approved medical specialist

5.7 If an appeal against a decision of an AMS is accepted for filing, the application and copies will be sealed and issued to the appealing party.

5.8 A standard timetable will be issued to ensure that the parties comply with the legislation and guidelines. The timetable will provide for the period to lodge a certificate of service and notice of opposition.

5.9 The filing party should serve an unsealed copy of the opposition on each other party (including the insurer) prior to lodgement with the Commission.

Referral for appeal, further assessment or reconsideration

5.10 The Registrar will review an appeal application and any submissions.

5.11 If the Registrar is not satisfied that a ground of appeal is made out on the face of the application and any submissions that a ground of appeal is made out, the appeal will not proceed to an appeal panel.

5.12 Where the Registrar is satisfied on the face of the application and any submissions made to the Registrar that a ground of appeal has been made out, the Registrar may refer the matter for determination of the appeal by a MAP, or for further assessment as an alternative to an appeal.

5.13 The Registrar may refer a matter to the AMS for reconsideration on one or more occasions (section 329(1A) of the 1998 Act).

Procedure of the medical appeal panel

5.14 A MAP consists of two AMSs and one arbitrator.

5.15 The MAP is to be constituted by the Registrar. Confirmation of the members of the MAP is to be communicated to the parties.

5.16 The MAP will undertake a preliminary review of the matter.

5.17 The MAP may adopt any of the following procedures in accordance with the needs of the individual case:

5.17.1 'on-the-papers' review

5.17.2 further medical examination by an approved medical specialist on the appeal panel

5.17.3 assessment hearing.

5.18 The MAP decides which of the procedures is to be adopted.

5.19 The decision of the appeal panel is to be informed by its assessment of the needs of the particular case.

5.20 Where a further medical examination is required, the Registrar will advise the worker of the time and place of the examination.

5.21 A support person (other than an agent or legal adviser) may accompany a worker to the examination.

5.22 The worker should not bring any additional medical or other reports to the examination, unless specifically asked to do so.

5.23 If it is necessary to bring x-rays or similar documents the worker will be advised of this in the letter from the Registrar.

Hearing

5.24 Where the MAP determines a matter is not capable of determination on the papers, either with or without a further medical examination, a hearing will be arranged.

5.25 The MAP hearing will be informal and non-legalistic, and will afford the parties a full opportunity to present oral submissions in support of their claims. The hearing is non-adversarial and in most cases no evidence will be taken or cross-examination permitted.

5.26 A party is entitled to be represented at the hearing and may choose to be accompanied by a person (including but not limited to a legal adviser or agent) to assist in the presentation of their case.

5.27 The hearing will be sound recorded and a copy of the recording will be available to the parties on request.

Revocation or confirmation of the medical assessment certificate

5.28 The MAP can confirm the MAC issued by the AMS or revoke that MAC and issue a new certificate.

5.29 The decision of a majority of the members of a MAP is the decision of the MAP.

5.30 In all cases where the MAP decides to revoke the MAC and issue a new certificate, the Registrar will send the new certificate to the parties.

Disclaimer

This publication may contain information that relates to the regulation of workers compensation insurance, motor accident third party (CTP) insurance and home building compensation in NSW. It may include details of some of your obligations under the various schemes that the State Insurance Regulatory Authority (SIRA) administers.

However, to ensure you comply with your legal obligations you must refer to the appropriate legislation as currently in force. Up to date legislation can be found at the NSW Legislation website legislation.nsw.gov.au

This publication does not represent a comprehensive statement of the law as it applies to particular problems or to individuals, or as a substitute for legal advice. You should seek independent legal advice if you need assistance on the application of the law to your situation.

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[n2018-4308]

Workers compensation guidelines

Requirements for insurers, workers, employers, and other stakeholders

State Insurance Regulatory Authority

December 2018

Contents

About these Guidelines

The State Insurance Regulatory Authority (SIRA) is the government organisation responsible for regulating and administering workers compensation, motor accidents compulsory third party (CTP) insurance and home building compensation insurance in New South Wales (NSW).

Context

Under section 23 of the *State Insurance and Care Governance Act 2015,* a principal objective of SIRA in exercising its functions is to provide for the effective supervision of claims handling and disputes arising under NSW workers compensation legislation.

SIRA has undertaken a comprehensive review of the current claims handling framework for workers compensation in NSW. From this review, SIRA has revised the Guidelines. The new Guidelines are supported by Standards of practice (Standards) which outline claims administration and conduct expectations for insurers.

SIRA's objective in developing the revised Guidelines and Standards is to improve outcomes in the workers compensation system by ensuring that clear, consistent, easy to access expectations are set for all insurers, to guide insurer conduct and claims management.

It is important that injured workers are protected and that they receive appropriate, timely, respectful services and support. Similarly, it is important that employers are actively engaged in the claims process to support workers with their recovery and return to work.

SIRA intends to use the improved Guidelines and the Standards to hold insurers accountable for delivering high standards of service to workers and their families, carers, employers and other stakeholders.

Legislative framework

The *Workers Compensation Act 1987* (1987 Act) and the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act) establish a workplace injury management and workers compensation system in New South Wales.

The system objectives as described in section 3 of the 1998 Act are:

- to assist in securing the health, safety and welfare of workers and, in particular, preventing work-related injury,
- 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,
- 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,
- to be fair, affordable, and financially viable,

- 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,
- to deliver the above objectives efficiently and effectively.

The *Workers Compensation Regulation* 2016 contains provisions that supplement the implementation and operation of the Acts in a number of key areas.

Purpose

The *Workers Compensation Guidelines* (Guidelines) support delivery of the objects of the Acts and Regulation by informing and guiding insurers, workers, employers, injury management consultants, independent medical examiners and other stakeholders in the process of claiming workers compensation in NSW.

Guideline-making powers

These Guidelines are made under section 376(1)(c) of the 1998 Act, which empowers SIRA to issue guidelines in accordance with specific guideline-making powers throughout the Workers Compensation Acts. Each Part of these Guidelines identifies the section or sections of the Acts that authorise or require Guidelines to be issued by SIRA.

SIRA requires stakeholders to comply with the parts of the Guidelines that apply to them.

Interpretation

These Guidelines are to be read in conjunction with relevant provisions of the Acts and the Regulation and in a manner that supports the system objectives as described in section 3 of the 1998 Act.

Commencement

These Guidelines will take effect and apply to all claims from 1 January 2019 (irrespective of when the claim is made).

The Guidelines will apply until SIRA amends, revokes or replaces them in whole or in part.

Subject to the transitional arrangements below, these Guidelines replace the following:

1. Guidelines for claiming workers compensation dated 1 August 2016
2. Guidelines on injury management consultants dated 27 September 2012
3. Guidelines on independent medical examinations and reports dated 13 March 2012.

Any SIRA document that makes reference to one of the above Guidelines is a reference to these Guidelines.

The Guidelines apply to workers, employers and insurers as defined in the 1987 Act and the 1998 Act.

The Guidelines do not apply to:

- coal miner matters, as defined in the 1998 Act

- dust disease matters, as defined in the *Workers Compensation (Dust Diseases) Act 1942*
- claims made under the *Workers Compensation (Bush Fire, Emergency and Rescue Services) Act 1987*.

Transitional arrangements

Part B, B1.4 of the Guidelines for claiming workers compensation continue to apply until the end of the transitional period provided for in Part 21, clause 3 of Schedule 6 to the 1987 Act (currently 1 July 2019 or as amended by the regulation after these Guidelines have been published).

Exempt categories of workers

Changes made by the *Workers Compensation Legislation Amendment Act 2012* do not apply to police officers, paramedics or firefighters.

These workers were exempt from changes because of clause 25 of Part 19H of Schedule 6 to the 1987 Act. They are known as 'exempt categories of workers'.

Most requirements in these Guidelines apply to exempt categories of workers. Requirements that do not apply are clearly marked.

Scope

The Guidelines contain the following parts:

- Part 1: Initial notification of an injury
- Part 2: Provisional liability
- Part 3: Making a claim
- Part 4: Compensation for medical, hospital, and rehabilitation expenses
- Part 5: Work capacity
- Part 6: Injury management consultants
- Part 7: Independent medical examinations and reports
- Part 8: Lump sum compensation
- Part 9: Commutation of compensation

Words defined in the NSW workers compensation legislation have the same meaning in these Guidelines.

Part 1: Initial notification of an injury

1.1 Initial notification of injury

Section 266 of the 1998 Act provides that initial notification to an insurer of an injury to a worker means the first notification of the injury that is given to the insurer, in the manner and form required by the Workers Compensation Guidelines, by the worker or the employer or by some other person (for example, a medical practitioner) acting for or on behalf of the worker or the employer.

Notifications can be written (including online or by email) or verbal (including by phone).

Table 1.1 Required information for the initial notification of injury

The following information is required to be provided to the insurer in order for there to be an initial notification:

Category	Required information
Worker	Name Contact details (including a phone number and postal address)
Employer	Business name Business contact details
Treating doctor (where known)	Name Name of medical centre or hospital (if known)
Injury	Date of the injury or the period over which the injury emerged Time of the injury Description of how the injury happened Description of the injury Whether any medical treatment is required Whether the injury has cause any partial or total incapacity for work and loss of income
Notifier	Name Relationship to the worker or employer Contact details (including phone number and postal address)

If the insurer receives an incomplete initial notification of injury, it must inform the notifier (and the worker, where possible) within three business days and specify what additional information is needed.

Part 2: Provisional liability

2.1 Delaying provisional weekly payments

Once the insurer has received an initial notification of injury it must:

- start provisional payments within seven calendar days unless there is a reasonable excuse not to or
- delay starting provisional weekly payments by issuing a *reasonable excuse* within seven days or
- determine liability

Section 267(2) of the 1998 Act allows the Guidelines to define what a 'reasonable excuse' may be.

Table 2.1 Reasonable excuses for not starting provisional weekly payments

The insurer has a reasonable excuse for not starting provisional weekly payments if any of the following apply:

Excuse	Reason
There is insufficient medical information	The insurer does not have enough medical information to establish that there is an injury, as a workers compensation certificate of capacity (or other medical information certifying that a work-related injury has occurred) has not been provided. If a certificate of capacity or other medical information is provided and includes a clear diagnosis, the claim cannot be reasonably excused using this reason. Note: Insurers are to use discretion for workers in remote areas if access to medical treatment is not readily available.
The injured person is unlikely to be a worker	The person cannot verify they are a worker. *or* The employer can verify that they are not a worker. If there is any doubt that someone is a worker under NSW workers compensation law, the insurer must verify that person's status. Information that confirms this may include, but is not limited to: • the employer agreeing to the worker's status • the worker's payroll number • a current payslip or a bank statement with regular employer payments • a contract of employment or services.

Excuse	Reason
The insurer is unable to contact the worker	The insurer has not been able to contact the worker after at least: • two attempts by phone (made at least a day apart) **and** • one attempt in writing (which may include an attempt by email).
The worker refuses access to information	The worker will not agree to the release or collection of personal or health information relevant to the injury sufficient to determine provisional liability.
The injury is not work related	The insurer has information that: • the worker did not receive an injury which is compensable under the NSW workers compensation law, or • strongly indicates that compensation for an injury may not be payable under NSW workers compensation law. If the employer believes the injury is not work-related, they are to provide the insurer with any supporting evidence they have, such as: • medical information that the condition already existed and has not been aggravated by work • factual information that the injury did not arise from or during employment **Note:** Suspicion, innuendo, anecdotes or unsupported information from any source, including the employer, is not acceptable.
There is no requirement for weekly payments	Based on the information received as part of the notification of injury or otherwise obtained by the insurer, the insurer is reasonably satisfied there is no requirement for weekly payments, for example because the injury has not resulted in any incapacity or loss of earnings.
The injury is notified after two months	The notice of injury is not given to the employer within two months of the date of injury. **Note**: This reason cannot be used if the acceptance of liability is likely and provisional payments will be an effective way to manage the injury.

A reasonable excuse may apply to provisional weekly payments but not to provisional medical payments.

Where applicable, prior to deciding not to commence provisional weekly payments on the basis of a reasonable excuse, the insurer is to attempt to resolve the reasonable excuse.

2.2 Provisional liability for medical expenses

Section 280 of the 1998 Act allows the Guidelines to specify the amount up to which an insurer can provisionally accept liability for medical expenses relating to a work-related injury.

An insurer can accept liability for medical expenses on a provisional basis and pay up to $10,000 before being required to make a formal determination of liability.

Part 3 Making a claim

In making a claim, workers are asserting a right to receive workers compensation benefits because they believe they meet the necessary legal requirements.

Section 260(2) of the 1998 Act allows the Guidelines to make provision for or with respect to certain matters in connection with the making of a claim, including:

- the form and manner in which a claim is to be made
- the means by which a claim may be made
- the information that a claim is to contain
- requiring specified documents and other material to be included with a claim.

As a minimum, a claim for compensation must provide the insurer with the following information:

- name and contact details of the worker
- name and contact details of the employer (individual or organisation)
- name and contact details of the worker's medical practitioner
- if applicable, the name and contact details of any witnesses or witness statements, including details to identify any witnesses known to the worker if the incident was witnessed.
- description of the injury and how it happened
- information to support the medical expenses and other losses the worker is claiming.

3.1 Requirement for a claim form

Workers are able to complete and submit a claim form to an insurer at any time, subject to the time limits outlined in the 1998 Act. Claim forms are available from the SIRA website or insurers may have their own claim form.

An insurer must require a worker to complete a claim form when:

- a reasonable excuse notice has been issued, the worker is seeking weekly payments of compensation and the reasonable excuse is still relevant, or
- compensation is likely to be claimed beyond the provisional liability limits and the insurer determines that there is insufficient information to determine ongoing liability.

The insurer can waive the requirement for a worker to submit a claim form if they determine they have enough information to make a liability determination.

3.2 Signed authority

Section 260(3) allows the Guidelines to require that a claim be accompanied by a form of authority signed by the worker. This signed authority authorises the sharing of information between service providers and the insurer.

The worker may be required to supply the insurer with a signed authority so providers of medical and hospital treatment or workplace rehabilitation services can give the insurer relevant information relating to the compensable injury.

Information relevant to the worker's injury includes:

- the treatment or service provided, or
- the worker's medical condition, or
- treatment relevant to the claim.

This authority forms part of the claim form available on the SIRA website. Alternatively, the insurer can use its own form.

Part 4: Compensation for medical, hospital, and rehabilitation expenses

4.1 Accessing treatment without pre-approval

Does not apply to exempt workers
There is no requirement for exempt workers to seek pre-approval for treatment; however exempt workers are to be made aware that treatment and services may not be payable without insurer approval. Payment of treatment and services for exempt workers must be assessed based on whether the treatment or service is required as a result of the injury and is considered reasonably necessary and on the provision of properly verified costs.

Workers can claim expenses relating to medical treatments and services, including hospital and rehabilitation.

Medical, hospital and rehabilitation expenses will be paid where the treatment or service:

- meets the definitions described in section 59 of the 1987 Act
- takes place while the worker is entitled to receive compensation (the compensation period) for medical, hospital and rehabilitation expenses
- is reasonably necessary because of the injury
- is pre-approved by the insurer (unless the treatment or service is exempt from pre-approval – see below).

Section 60(2A) of the 1987 Act allows the Guidelines to specify the types or classes of treatment or services that are exempt from the requirement for prior insurer approval.

See Table 3.1.1 for the reasonably necessary treatments and services the worker can receive (including reasonably necessary worker travel), without pre-approval from the insurer.

Table 4.1 Reasonably necessary treatments and services available without pre-approval from the insurer

Treatment	Expense	Timeframe from date of injury
Initial treatment	Initial treatment	Within 48 hours
Nominated treating doctor	Consultation or case-conferencing for the injury, apart from telehealth and home visits	Ongoing
	Treatment during consultation	Within one month
Public hospital	Services provided in the emergency department for the injury	Ongoing
	Further services after receiving treatment at the emergency department for the injury.	Within one month
Medical specialists	If referred by the nominated treating doctor, any consultation and treatment during consultations for the injury (apart from telehealth). Referrals for diagnostic tests must meet the Medicare Benefits Schedule criteria. **Note:** Medical specialist means a medical practitioner recognised as a specialist by the Australian Health Practitioner Regulation Agency and remunerated at specialist rates under Medicare.	Within three months
Diagnostic investigations	If referred by the nominated treating doctor for the injury: • any plain x-rays.	Within two weeks
	If referred by the nominated treating doctor, and the worker has been referred to a medical specialist for further injury management: • ultrasounds and CT scans • MRIs. **Note:** General Practitioners must satisfy the Medicare Benefits Schedule criteria when making a referral for an MRI.	Within three months
	If referred by the treating medical specialist for the injury, any diagnostic investigations.	Within three months

Treatment	Expense	Timeframe from date of injury
Pharmacy	Dispensed prescription drugs and over-the-counter pharmacy items prescribed for the injury by the nominated treating doctor or medical specialist.	Within one month
	Prescription drugs and over-the-counter pharmacy items prescribed for the injury and dispensed through the Pharmaceutical Benefits Scheme (PBS)	Ongoing

Table 4.2 Other treatments and services available without pre-approval from the insurer

Treatment	Expense
SIRA-approved allied health practitioners[1]: 1. Physical practitioners (physiotherapists, osteopaths, chiropractors, accredited exercise physiologists) 2. Psychological practitioners (psychologists and counsellors)	Up to eight consultations if the injury was not previously treated by a provider from the same allied health practitioner group (either 1. Physical or 2. Psychological) and the treatment begins within three months of the injury
	Up to eight consultations per *Allied health recovery request* (AHRR) if the same practitioner is continuing treatment within three months of the injury and: • the practitioner sent an AHRR to the insurer, and • the insurer did not respond within five working days of receiving the AHRR.
	Up to three consultations if the injury was not previously treated by a provider from the same allied health practitioner group (either 1. Physical or 2. Psychological) and the treatment begins more than three months after the injury.
	One consultation with the same practitioner if the practitioner previously treated the injury more than three months ago. This is considered a new episode of care.
	One consultation with a different practitioner if the injury was previously treated by a provider from the same allied health practitioner group (either 1. Physical or 2. Psychological).
	Up to two hours per practitioner for case conferencing that complies with the applicable Fees Order.
	Up to $110 per claim for reasonable incidental expenses for items the worker uses independently at their home or workplace (such as strapping tape, theraband, exercise putty, disposable electrodes and walking sticks).
Interim payment direction	Any treatment or service under an interim payment direction from the Registrar (or delegate) of the Workers

[1] AHPs which meet the requirements of SIRA's Approval Framework under s60(2C)

Treatment	Expense
	Compensation Commission as outlined in section 297 of the 1998 Act.
Commission determination	Any disputed treatment or service the Workers Compensation Commission has determined must be paid.
Permanent impairment medical certificate	Permanent impairment medical certificate or report, and any associated examination, taken to be a medical-related treatment under section 73(1) of the 1987 Act.
Hearing needs assessment	The initial hearing needs assessment where the: • hearing service provider is approved by SIRA, and • nominated treating doctor has referred the worker to an ear, nose and throat medical specialist, to assess if the hearing loss is work-related and, if applicable, the percentage of binaural hearing loss. **Note:** Hearing needs assessment includes: • obtaining a clinical history • hearing assessment as per Australian/New Zealand Standard 1269.4:2014 • determination of communication goals • recommendation of hearing aid, and • clinical rationale for hearing aid.

4.2 Determining reasonably necessary treatment

Before approving or paying for a medical, hospital or rehabilitation treatment or service, an insurer will determine, based on the facts of each case, whether the treatment or service is, as a result of an injury, reasonably necessary.

Section 60(2C)(a) of the 1987 Act allows for the Guidelines to set rules for determining whether medical or related treatment, as defined by section 59 of the 1987 Act, is reasonably necessary.

When considering the facts of the case, the insurer is to understand that:

- what is determined as reasonably necessary for one worker may not be reasonably necessary for another worker with a similar injury
- reasonably necessary does not mean absolutely necessary
- although evidence may show that a similar outcome could be achieved by an alternative treatment, it does not mean that the treatment recommended is not reasonably necessary.

In most cases, the points above should be enough for an insurer to determine what is reasonably necessary treatment.

If the insurer remains unclear on whether a treatment is reasonably necessary, then the following factors may be considered:

- the appropriateness of the particular treatment
- the availability of alternative treatment
- the cost of the treatment

- the actual or potential effectiveness of the treatment
- the acceptance of the treatment by medical experts.

4.3 Qualifications and requirements for treatment or service providers

****Does not apply to exempt workers****

Exempt workers are not required to use SIRA-approved physiotherapists, chiropractors, osteopaths, exercise physiologists, psychologists and counsellors.

Section 60(2C)(e) of the 1987 Act states that the Guidelines may specify the qualifications or experience required in order to be appropriately qualified to provide treatment or service to a worker. This includes mandating SIRA approval or accreditation for providers operating in the NSW workers compensation system.

Services provided by a physiotherapist, chiropractor, osteopath, exercise physiologist, psychologist and counsellor can only be provided by an allied health provider that is approved by SIRA in accordance with the *Guidelines for approval of treating allied health practitioners* and who provides an Allied Health Recovery Request (AHRR) in accordance with those guidelines. Note: an AHRR is optional for practitioners treating workers with a severe injury.

Assessment, diagnosis and treatment of hearing impairment loss injury are to be conducted by an ear nose and throat (ENT) specialist.

Subsequent services in relation to the provision of hearing aids can only be delivered by a SIRA-approved hearing service provider in accordance with the Hearing Services Provider Approval Framework.

4.4 Domestic assistance care plan

Section 60AA(1)(d) of the 1987 Act allows the Guidelines to provide for the making of a domestic assistance care plan.

The insurer must establish a care plan with the worker and medical practitioner, based on what it accepts as reasonably necessary for the worker. The insurer is to do this and pay compensation within 21 days of receiving a claim.

As a minimum, the domestic assistance care plan must clearly state the:

- task(s) it covers
- service provider's name
- number of hours and frequency of assistance
- start and end dates for which the assistance is approved
- cost or rate payable for the assistance
- total cost for the duration of service
- need for the domestic assistance recommended and how this relates to the worker's injury.

4.5 Verifying gratuitous domestic assistance

Gratuitous domestic assistance is domestic assistance provided to a worker for which the worker has not paid and is not liable to pay.

Payment for gratuitous domestic assistance is only to be made if those costs and the provision of the assistance is properly verified.

Section 60AA(5)(b) allows the Guidelines to specify how the performance of domestic assistance services is to be verified.

People providing gratuitous domestic assistance can claim compensation directly from the insurer. To do this, they must provide information to demonstrate that they have lost income or foregone employment because of their assistance.

Information might include:

- pay slips showing fewer hours of overtime or of casual work, with a supporting letter from their employer
- evidence that they have moved from full-time to part-time work
- a certified copy of a letter of resignation or termination, giving reasons.

The amount of lost income or foregone employment is not relevant to the amount of compensation that may be provided to the person.

The provider of gratuitous domestic assistance is to be paid a proper and reasonable amount for the services provided.

4.5.1 Verifying and approving gratuitous domestic assistance

The person providing the assistance may make a claim and the insurer may make a payment for eligible services as they are provided.

Once approved, the insurer must pay the person providing the assistance, not the worker.

Providers of gratuitous domestic assistance must submit a diary of what they have done before the insurer approves and pays compensation. The diary must be signed by both the provider and the worker (if the worker is able to do so).

As a minimum, the diary must include the date, services performed and hours worked.

Part 5: Work capacity assessment

This Part does not apply to exempt workers

Part 5: Work capacity assessments do not apply to exempt workers.

A work capacity assessment is an assessment of an injured worker's current work capacity.

5.1 Work capacity assessment

Section 44(A)(2) of the 1987 Act states that a 'work capacity assessment' is to be conducted in accordance with the Guidelines.

A work capacity assessment can be based on available information (such as a certificate of capacity), or it can require the insurer to gather more information, for example when the worker has some capacity but cannot return to their pre-injury employment.

The insurer must keep a record of any work capacity assessment in the worker's file.

5.2 When to conduct a work capacity assessment

Work capacity assessments are to be conducted throughout the life of the claim whenever new information about the worker's claim, such as a certificate of capacity, is received. This is a part of the normal claims management process.

These assessments may be based on available information or may require the gathering of additional information.

5.3 Requirement to attend appointments

Section 44A(5) of the 1987 Act states that an insurer may require a worker to attend and participate in any appointment in accordance with the Guidelines that is reasonably necessary for the purpose of conducting a work capacity assessment.

An insurer may use available information to assess work capacity, or it may require the worker to attend an appointment to obtain further information.

These Guidelines require the insurer to advise the worker of the date and time of each appointment at least 10 working days before the appointment, unless otherwise agreed by the worker. The advice must include:

- the location of the appointment
- the purpose of the appointment and how it may inform the work capacity assessment
- the information that refusing to attend, or failing to properly participate (so that the assessment cannot take place), may result in the insurer suspending weekly payments until the assessment appointment is completed.

A worker cannot be required by the insurer to attend more than four appointments per work capacity assessment. Of these, there cannot be more than:

- one appointment with the same type of medical specialist (for example, orthopaedic surgeon, psychiatrist)

- one appointment with the same type of healthcare professional (for example, physiotherapist, psychologist).

If the worker is required to attend an appointment with an independent medical examiner, this must be in accordance with these Guidelines.

Part 6: Injury management consultants

Section 45A(4) of the 1998 Act allows the Guidelines to provide for the functions of approved injury management consultants (IMCs).

An IMC is a registered medical practitioner experienced in occupational injury and workplace-based rehabilitation.

An IMC helps the nominated treating doctor, worker, insurer, employer and other service providers to progress a worker's recovery at/return to work and optimise health and work outcomes. An IMC assesses the situation, examines the worker (if necessary) and discusses possible solutions with all parties (particularly the nominated treating doctor). IMCs are not responsible for directing treatment of a worker, though they may comment on treatment in respect to recovery at/return to work.

An IMCs functions do not include:

- an opinion on causation or liability
- undertaking a functional capacity evaluation or work capacity assessment for the insurer.

6.1 IMC functions relating to the nominated treating doctor

The IMC must verbally discuss the worker's fitness for employment with the nominated treating doctor. The IMC may also discuss the following with the worker's nominated treating doctor:

- diagnosis and treatment (if the IMC agrees this is required) to overcome barriers to recovery at/return to work
- suitability of potential work options
- how the NSW workers compensation system operates
- the importance of timely, safe and durable recovery at/return to work
- obtaining agreement on fitness for work, prognosis for recovery and timeframes for the recover at work plan.

6.2 IMC functions relating to the worker

The IMC is to discuss recover at/return to work with the worker, including:

- their recovery from the injury
- their expectations regarding recovery at/return to work
- the importance of timely, safe and durable return to work, and the potential impact resulting from long-term absence from work on the worker's health
- relevant aspects of the workers compensation system
- ways to overcome problems at work which may be delaying the worker's recovery/return to work
- options for their return to work (including a possible teleconference with the nominated treating doctor).

The IMC may examine the worker to aid their evaluation of the worker's ability to undertake specific tasks or functions that may inform decisions about fitness for work.

Where a worker has a union-representative involved in their return to work, the IMC will include that representative in discussions with the worker, at the worker's request.

6.3 IMC functions relating to the employer

The IMC may communicate with the employer to confirm the suitability and availability of identified work. Where appropriate, they may also review the workplace to help facilitate appropriate return to work solutions.

6.4 IMC functions relating to other service providers

The IMC may liaise with other service providers to discuss aspects of the worker's recovery at/return to work.

6.5 IMC functions relating to the Workers Compensation Commission

A worker or employer can request the Workers Compensation Commission (the Commission) to resolve a dispute about a failure to comply with obligations imposed by Chapter 3 of the 1998 Act, such as return to work obligations of insurers, employers and workers.

If there is an application to resolve a dispute, the Commission may request an injury management consultant to conduct a workplace assessment.

The Commission appoints an IMC to assist the Commission to deal with the dispute. For further information please refer to the Commission website at wcc.nsw.gov.au.

6.5 The IMC report

The IMC is required to complete a report following consultation.

A copy of the report must be forwarded to all parties involved in the injury management consultation including the:

- nominated treating doctor
- insurer
- employer (where involved), and
- the worker (unless release of the report would pose a serious threat to the life or health of the worker or any other person).

As a minimum, the report is to include:

- worker details (name, date of birth, claim number)
- referrer and reason for referral
- documents reviewed
- date of consultation/review, including who attended the consultation (for example, interpreter, support person) and whether the consultation was face-to-face or a file review
- consultation with the nominated treating doctor, including:
  - discussion regarding return to work/fitness for work

  - any other discussions to progress the workers recovery at/return to work and optimise health outcomes
- consultation with the employer, including the availability of suitable work and any other relevant issues
- consultation with any other parties (for example, workplace rehabilitation provider or treatment providers)
- the outcome of discussions
- consultation with and examination of the worker (where required)
- an action plan:
  - summarising the action taken and the agreed outcomes with the nominated treating doctor, including timeframes and milestones to reach the outcome
  - if agreement is not reached, suggest alternative actions to the referrer (for example, referral for an independent medical examination or referral to an approved workplace rehabilitation provider).

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Part 7: Independent medical examinations and reports

An independent medical examination (IME) is an assessment conducted by an appropriately qualified and experienced medical practitioner to help resolve an issue in injury or claims management.

An insurer may direct a worker receiving weekly payments of compensation to attend an IME.

Section 119(4) of the 1998 Act allows the Guidelines to specify the requirements for arranging independent medical examinations.

The mandatory obligations for insurers when they require a worker to attend an IME are outlined below.

7.1 Reason for referral

Referral for an IME is appropriate when information from the treating medical practitioner(s) is inadequate, unavailable or inconsistent, and the referrer is unable to resolve the problem directly with the practitioners.

Evidence of contact (or multiple attempts to contact) to try to resolve these issues with the nominated treating practitioner must be documented on the claim file.

An IME is appropriate where the information required relates to:

- diagnosis of an injury reported by the worker
- determining the contribution of work incidents, duties and/or practices to the injury
- whether the need for treatment results from the worker's injury and is reasonably necessary
- recommendations and/or need for treatment
- capacity for pre-injury duties and hours
- the likelihood of and timeframe for recovery
- capacity for other work/duties (descriptions of such duties are to be provided to the independent medical examiner)
- what past and/or ongoing incapacity results from the injury
- physical capabilities and any activities that must be avoided

The reason for the referral must be documented on the claim file.

An insurer may also refer a worker for an independent medical examination for the purpose of obtaining an assessment of permanent injury (injuries before 01/01/2002) or permanent impairment (injuries on and after 01/01/2002) resulting from the injury.

7.2 Qualified and appropriate independent medical examiners

All independent medical examiners must be appropriately qualified medical practitioners with the expertise to adequately respond to the question(s) outlined in

the referral. They must have qualifications relevant to the treatment of the worker's injury.

If the referral includes a question of causation or treatment, the independent medical examiner is to be in current clinical practice or have recently been in clinical practice, or undertake professional activities such that they are well abreast of current clinical practice.

7.2.1 Permanent impairment assessors

If the referral is for an assessment of permanent impairment, the referral must be to a specialist medical practitioner with qualifications, training and experience relevant to the body system being assessed.

The assessor must have successfully completed training and be listed on the SIRA website as a trained assessor of permanent impairment with SIRA workers compensation.

If there is more than one impairment that requires assessment by different medical specialists, one specialist must be nominated as the lead assessor and determine the final amount of whole person impairment.

7.2.2 Conflict of interest

The independent medical examiner must not be in a treating relationship with the worker, nor must there be any conflict of interest between the medical practitioner and worker or medical practitioner and insurer.

The exception to this is an assessment of permanent impairment, where a worker may be assessed by their treating specialist medical practitioner if they are listed for the relevant body system on the SIRA website.

The location of the independent medical examiner's rooms is to be accessible within the worker's travel restrictions as certified by their nominated treating doctor.

In limited circumstances, examination by video consultation may be appropriate and effective and is to be considered by the insurer on a case-by-case basis.

7.4 Special requirements

If the worker has special requirements relating to gender, culture or language, these are to be identified and accommodated.

The rooms must contain appropriate facilities, including access for people with ambulatory difficulties, and accommodate the worker's specific physical needs.

Where it is the assessor's routine practice to record the consultation on audio or video, the worker must be informed of this and agree before the appointment is scheduled. If the worker does not consent and the independent medical examiner will not proceed without recording the consultation, then an alternative independent medical examiner who does not record the examination is to be arranged.

The worker may be accompanied by a person other than their legal representative, however, the accompanying person must not participate in the examination and may be required to withdraw from the examination if requested.

7.5 Notification to the worker

All referrals for IMEs are to be arranged at reasonable times and dates, and with adequate notification given to the worker.

The worker must be advised in writing at least 10 working days before the appointment.

If a shorter time is required because of exceptional and unavoidable circumstances (for example a need to consider an urgent request for treatment), the reduced timeframe must be agreed to by all parties.

The written advice to the worker must include:

- the specific reason for the examination
- an explanation of why information from the treating medical practitioner(s) or author of the assessment report to the insurer's enquiry was inadequate, inconsistent or unavailable
- date, time and location of the appointment
- name, specialty and qualifications of the indendendent medical examiner
- contact details of the indendent medical examiner's offices and appropriate travel directions
- the likely duration of the examination
- what to take (for example, x-rays, reports of investigations/tests, comfortable clothing to enable an appropriate examination to be conducted)
- information that the worker may be accompanied by a person other than their legal representative, however, the accompanying person must not participate in the examination and may be required to withdraw from the examination if requested
- information for the worker when it is the independent medical examiner's routine practice to record the examination on audio or video, that the worker can consent to or decline this before the examination is scheduled. The recording is only to proceed if the worker consents.
- advice that the insurer will meet any reasonable costs incurred by the worker, including wages, travel and accommodation. This may include pre-payment of travel and accommodation expenses. If the worker is not reasonably able to travel unescorted, this may include expenses for the worker's escort.
- advice that a failure to attend the examination or an obstruction of the examination may lead to a suspension of:
  - weekly compensation, and/or
  - the right to recover compensation under the 1987 Act.
- advice that the worker can request a copy of the report as well as documents that were provided to the IME
- advice that their nominated treating doctor will be provided with a copy of the examination report
- advice that the workers compensation legislation gives the worker or a nominee a right to a copy of any report relevant to a decision made by a referrer to dispute liability for or reduce compensation benefits
- what to do if the worker does not believe the examination is reasonable

- what to do if the worker has a complaint about the conduct of the independent medical examiner
- the SIRA brochure about independent medical examinations.

7.6 Further independent medical examinations

Subsequent IMEs must meet the reasons for referral for an indepenent medical examination and can only be conducted in the following situations:

- the employer/insurer has evidence that the worker's injury has significantly changed or resolved, or
- the employer/insurer has a request for, or evidence of, a material change or need for material change in the manner or type of treatment, or
- the worker makes a claim for permanent impairment or work injury damages, or
- the worker requests a review after receiving a notice (issued under section 78 of the Workers Compensation Act 1987) and includes additional medical information that the employer/insurer is asked to consider, or
- the last IME was unable to be completed, or
- it has been at least six months since the last IME required by the employer/insurer, or
- the referrer can provide significant reasoning for the need for a referral in a shorter timeframe. This reasoning must be documented in the claim file and provided in the written advice to the worker regarding the referral.

Subsequent IMEs must be with the same independent medical examiner unless:

- that examiner has ceased to practise (permanently or temporarily)
- the specialty required to assess the injury has changed
- they no longer practise in a location convenient to the worker, or
- both parties agree that a different medical practitioner is required.

7.7 Unreasonable request

If the worker considers the requirement to attend an IME unreasonable, they are to advise the insurer of the reasons for their objection.

The insurer must consider this objection and advise the worker of their decision following this consideration. This advice must include contact information for the Workers Compensation Independent Review Office (WIRO). Benefits are not to be affected prior to adequate written notice being received by the worker.

Any decision to suspend payment of weekly compensation can only be made after the worker has had an opportunity to comply with a reasonable request. This decision must be made on the basis of sound evidence, and the worker must be advised in writing of the reasons for the suspension and what they must do for weekly payments to be reinistated.

Part 8: Lump sum compensation

8.1 Relevant particulars about a claim

Section 282(1) of the 1998 Act states that 'the relevant particulars about a claim' are full details that enable the insurer (as far as practicable) to make a proper assessment of the claimant's entitlement. Section 282(1)(g) allows these Guidelines to specify any further relevant particulars about a claim.

8.1.1 For injuries received on or after 1 January 2002

A claim for lump sum compensation must be accompanied by a report from a permanent impairment assessor listed on the SIRA website, for the body system(s) being assessed.

The assessor's report must include:

- a statement that the condition has reached maximum medical improvement
- an assessment on the part or system of the body being assessed including the percentage of permanent impairment in line with the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment* in effect at the time of the examination
- where the claim relates to hearing loss, a copy of the audiogram used for the medical report.

8.1.2 For injuries received before 1 January 2002

A claim for lump sum compensation must include:

- the percentage of loss or impairment of an injury described in the *Table of disabilities*
- a medical report from a medical practitioner supporting the amount of loss or impairment claimed
- if the claim relates to hearing loss, a copy of the audiogram used for the medical report.

8.2 Complying agreements

Section 66A(4) of the 1987 Act requires complying agreements (regarding the worker's degree of permanent impairment and the lump sum compensation) between the worker and employer, to be recorded by the insurer in accordance with the Guidelines.

If the worker accepts the insurer's offer of settlement, the insurer and worker must enter into a complying agreement.

The complying agreement must include:

- the date of injury or deemed date of injury from which the impairment is agreed to result
- the percentage of permanent impairment or permanent injury, including the injuries described in the *Table of Disabilities* for permanent injuries, for which compensation is being paid
- the percentage allowed for any pre-existing condition or abnormality

- the medical report(s) used to assess/agree this percentage
- the compensation payable (percentage and monetary value)
- the date of agreement
- certification that the insurer is satisfied the worker has obtained independent legal advice or has waived the right to do so.

In addition, for exempt workers, compensation may cover both permanent impairment and pain and suffering. Each type of compensation can be agreed at different times, and may require two complying agreements and separate payments.

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Part 9: Commutation of compensation

9.1 Compensation not to be commuted for catastrophic injuries

The effect of section 87EAA of the 1987 Act is that a liability for medical, hospital and rehabilitation expenses compensation cannot be commuted to a lump sum for workers with a catastrophic injury.

An injury is a catastrophic injury if it meets the criteria for one or more kinds of injury specified below.

9.1.1 Spinal cord injury

A spinal cord injury is an acute traumatic lesion of the neural elements in the spinal canal (spinal cord and cauda equina) resulting in permanent sensory deficit, motor deficit and/or bladder/bowel dysfunction. There must be permanent neurological deficit resulting from the spinal cord injury.

9.1.2 Brain injury

A traumatic brain injury is an injury to the brain, usually with an associated diminished or altered state of consciousness that results in permanent impairments of cognitive, physical and/or psychosocial functions.

Criteria for brain injury

a. The duration of Post Traumatic Amnesia (PTA) is greater than one week. If PTA assessment is not available or applicable, there must be evidence of a very significant impact to the head causing coma for longer than one hour, or a significant brain imaging abnormality, and

b. a score of five or less on any of the items on the FIM™ or WeeFIM® due to the brain injury.

9.1.3 Amputations

There are multiple amputations of the upper and/or lower extremities, meaning that there is more than one of the following types of amputation at or above the level of:

a. a 'short' transtibial or standard transtibial amputation, as defined by the loss of 50 per cent or more of the length of the tibia. This includes all other amputations of the lower extremity (such as knee disarticulation or transfemoral amputation) above this level

b. a thumb and index finger of the same hand, at or above the first metacarpophalangeal joint. This includes all other amputations of the upper extremity (such as below-elbow or above-elbow amputation) above this level.

The worker has had one of the following types of amputation:

c. forequarter amputation (complete amputation of the humerus, scapula and clavicle) or shoulder disarticulation;

d. hindquarter amputation (hemipelvectomy by trans-section at sacroiliac joint, or partial pelvectomy);

e. hip disarticulation (complete amputation of the femur);

f. ‘short’ transfemoral amputation as defined by the loss of 65 per cent or more of the length of the femur;

g. brachial plexus avulsion or rupture resulting in partial or total paralysis; or

h. an equivalent impairment to any of the injuries described in (c) to (g) above.

Equivalent impairment means the functional equivalent to an amputation, resulting from an injury such as (but not limited to) brachial plexus avulsion or rupture, where paralysis exists and movement in the paralysed limb, or relevant part therefore, is minimal or non-existent due to the injury.

Measurement of the percentage loss of length of the amputated tibia or femur is to be calculated using x-ray imaging pre- and post-amputation. Where x-ray imaging is not available, measurement of the contralateral length of the femur is to be compared with the length of the amputated femur to measure percentage loss.

There may be rare circumstances, such as traumatic bilateral transtibial amputation, where contralateral tibial length and tibial length prior to amputation is unknown and therefore percentage measurement is not applicable. In this case, percentage loss is defined as 50 per cent of tibial length calculated from estimated knee height. Estimated knee height is to be calculated from the worker’s documented total height prior to the injury.

9.1.4 Burns

There are full thickness burns greater than 40 per cent of total body surface area, or

a. inhalation burns causing long term respiratory impairment, or

b. full thickness burns to the hand, face or genital area, and

c. one of the following criteria is met:

d. a score of five or less on any of the items on the FIM™ or WeeFIM® due to the burns.

9.1.5 Permanent blindness

The worker is legally blind, when:

a. visual acuity on the Snellen Scale after correction by suitable lenses is less than 6/60 in both eyes, or

b. field of vision is constricted to 10 degrees or less of arc around central fixation in the better eye irrespective of corrected visual acuity (equivalent to 1/100 white test object), or

c. a combination of visual defects resulting in the same degree of visual loss as that occurring in (a) or (b) above.

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