

Draft workers compensation guidelines

Requirements for workers, employers,
insurers and other stakeholders

Consultation draft

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About these Guidelines

The State Insurance Regulatory Authority (SIRA) is the government organisation responsible for regulating and administering workers compensation in New South Wales (NSW).

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).

Context

SIRA has undertaken a comprehensive review of the current claims handling framework for workers compensation in NSW. Arising from this review, SIRA is developing Claims Administration Manual Standards of Practice (CAM Standards) that will outline mandatory claims administration and conduct requirements for insurers. The CAM Standards will be supported by streamlined and consolidated Workers Compensation Guidelines.

SIRA's objective in developing the CAM Standards and revised Guidelines is to improve outcomes in the workers compensation system by ensuring that clear, consistent, easy to access and enforceable 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. SIRA intends to use the CAM Standards and improved Guidelines to hold insurers accountable for delivering high standards of service to workers and their families, carers, employers and other stakeholders.

Guideline-making powers

SIRA issues these Guidelines under section 376(1)(c) of the 1998 Act and they operate by force of law as delegated legislation.

Specific sections of the workers compensation legislation that provide guideline-making powers are referenced throughout the document.

Purpose

SIRA has developed these *Workers Compensation Guidelines* (Guidelines) in accordance with the legislation to support, inform and guide workers, employers, insurers and other stakeholders in the process of claiming workers compensation in NSW.

These Guidelines explain what workers, employers and insurers must do in relation to claims under the NSW workers compensation legislation.

Commencement

These Guidelines will take effect and apply to all claims from DD MM YYYY.

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

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.

Application

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.

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

The first step in claiming compensation for a work-related injury is to notify the employer and insurer of that injury.

Section 266 of the 1998 Act allows the Guidelines to specify the manner and form of an 'initial notification' of injury.

The 'initial notification' of an injury is the first time the insurer is informed that the worker has suffered a work-related injury, and that compensation is or may be payable. Sometimes an insurer can be both notified of an injury under s266 and notified of a claim for compensation (weekly payments and/or medical expenses) at the same time. Where this happens, insurers are to both note the notification and manage the claim accordingly.

When employers become aware of a work-related injury, they must ensure their insurer is notified within 48 hours. This notification can also be made by:

- the worker
- a representative of either the worker or the employer (such as a doctor or union representative).

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

Table 1.1 Required information for the initial notification of injury

The following information should be provided to the insurer during the initial notification of injury:

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

Category	Required information
Notifier	Name Relationship to the worker or employer Contact details (including phone number and postal address)

If the insurer receives an incomplete 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, and compensation for weekly payments is (or may be) payable, it must

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

Section 267(2) of the 1998 Act allows the Guidelines to define what a 'reasonable excuse' may be when an insurer believes it should not or cannot pay provisional weekly payments.

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	<p>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.</p> <p>If a certificate of capacity or other medical information is provided and includes a valid diagnosis, the claim cannot be reasonably excused using this reason.</p> <p>Note: Insurers should use discretion for workers in remote areas if access to medical treatment is not readily available.</p>
The injured person is unlikely to be a worker	<p>The person cannot verify they are a worker.</p> <p><i>or</i></p> <p>The employer can verify that they are not a worker.</p> <p>If there is any doubt that someone is a worker under NSW workers compensation law, the insurer must verify that person's status.</p> <p>Information that confirms this may include, but is not limited to:</p> <ul style="list-style-type: none">• 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: <ul style="list-style-type: none"> two attempts by phone (made at least a day apart) and <ul style="list-style-type: none"> 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 to help determine their entitlement to compensation.
The injury is not work related	The insurer has information that: <ul style="list-style-type: none"> 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 should provide the insurer with any supporting evidence they have, such as: <ul style="list-style-type: none"> 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.
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. <p>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.</p>

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

Where applicable, prior to delaying provisional weekly payments, the insurer should 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 because they believe they meet the legal requirements for receiving compensation.

Section 260(2) of the 1998 Act allows the Guidelines to make provision for 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
- the requirement of 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
- name and contact details of any witnesses or witness statements (if applicable)
- description of the injury and how it happened.

3.1 Requirement for a claim form

Workers are able to complete and submit a claim form to an insurer at any time. Claim forms are available from the [SIRA website](#).

A claim form is required if:

- a reasonable excuse notice has been issued, the worker wishes to continue to seek weekly payment compensation and the reasonable excuse is still relevant, or
- compensation is likely to be claimed beyond the provisional payment period 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 must 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.

Relevant information 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 to seek pre-approval for treatment however exempt workers should be aware that payment for treatment and services is not guaranteed without insurer pre-approval.

Payment of treatment and services 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 4.1 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	Any treatment	Within 48 hours
Nominated treating doctor	Any consultation or case-conferencing for the injury, apart from telehealth and home visits	Ongoing
	Any treatment during consultation	Within one month
Public hospital	Any 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	<p>If referred by the nominated treating doctor, any consultation and treatment during consultations for the injury (apart from telehealth).</p> <p>Note: Medical specialist means a medical practitioner recognised as a specialist in accordance with Schedule 4 of Part 1 of the Health Insurance Regulations 1975 who is remunerated at specialist rates under Medicare.</p>	Within three months
Diagnostic investigations	<p>If referred by the nominated treating doctor for the injury:</p> <ul style="list-style-type: none"> any plain x-rays. 	Within two weeks
	<p>If referred by the nominated treating doctor, and the worker has been referred to a medical specialist for further injury management:</p> <ul style="list-style-type: none"> ultrasounds and CT scans MRIs. <p>Note: General Practitioners must satisfy the Medicare Benefits Schedule criteria when making a referral for an MRI.</p>	Within three months
	<p>If referred by the treating medical specialist for the injury, any diagnostic investigations.</p>	Within three months

Treatment	Expense	Timeframe from date of injury
Pharmacy	All 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. 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).
	Up to eight consultations per <i>Allied health recovery request</i> (AHRR) if the same practitioner is continuing treatment and: <ul style="list-style-type: none"> 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).
	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 <u>Workers Compensation Commission</u> as outlined in <u>section 297</u> of the 1998 Act.
Commission determination	Any disputed treatment or service the <u>Workers Compensation Commission</u> has determined should be paid.

Permanent impairment medical certificate	Permanent impairment medical certificate or report, and any associated examination, taken to be a medical-related treatment under <u>section 73(1)</u> of the 1987 Act.
Hearing needs assessment	The initial hearing needs assessment where the: <ul style="list-style-type: none"> • 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.
	<p>Note:</p> <p>Hearing needs assessment includes:</p> <ul style="list-style-type: none"> • 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:

- reasonably necessary, and
- required as a result of the injury.

Section 60(2C)(a) of the 1987 Act allows for the Guidelines to set rules for determining what is a reasonably necessary treatment or service.

When considering the facts of the case, the insurer should 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 in accordance with those guidelines.

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.

Assessments of hearing impairment are to be conducted by an ear nose and throat (ENT) specialist.

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 should do this before paying compensation.

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
- that they have moved from full-time to part-time work
- a certified copy of the 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 should 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 should include the date, services performed and hours worked.

Part 5: Work capacity

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

Part 5: Work capacity does not apply to exempt workers.

5.1 When to conduct a work capacity assessment

Where a worker is entitled to receive weekly payments, an insurer may review their capacity to work. This is called a work capacity assessment.

The insurer may consider this necessary to inform a work capacity decision.

Section 44A(1) of the 1987 Act allows the Guidelines to specify when an insurer must conduct a work capacity assessment.

5.1.1 Work capacity assessment schedule

Insurers must perform work capacity assessments at the following schedule as a minimum:

1. After 10 entitlement weeks, where it is likely that the worker's entitlement to weekly payments will continue beyond the first entitlement period.
2. After 78 entitlement weeks, where it is likely that the worker's entitlement to weekly payments will continue beyond 130 weeks. The assessment must be completed prior to the worker accumulating 130 weeks of weekly payments.
3. At least every two years from the date of the assessment in 5.1.1(2) above.

In addition, insurers should conduct a work capacity assessment where the insurer becomes aware of claims management flags or indicators that suggest a review of work capacity is required, including receipt of a certificate of capacity which indicates a downgrade in capacity.

Before the insurer does these assessments, it must notify the worker in writing. The notification must include:

- the purpose of the assessment
- an outline of any information the worker may provide for insurer consideration
- the expected completion date
- the matters the assessment may decide on.

5.2 Conduct of a 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 should consider two questions:

1. Does the worker have a present ability to return to their pre-injury employment?
2. Does the worker have a present ability to return to suitable employment?

A work capacity assessment can be simple and based on limited information (such as using a certificate of capacity), or it can be more complex, (where the worker has some capacity but cannot return to their pre-injury employment).

Insurers are required to consider the principles of procedural fairness (including fair notice) when making any assessment that may affect a worker's rights or interests. Insurers need to determine what the principles of procedural fairness require, on a case-by-case basis, having regard to the nature and potential consequences of the outcome of the assessment.

A worker can provide any information to the insurer that they wish to be considered in a work capacity assessment (for example, a certificate of capacity, treating specialist reports, job description).

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

- the assessment date
- where applicable, dates of contact with the worker and case notes of discussion points
- details and dates of any other assessment the worker had to attend
- details of the assessor(s)
- outcome of the assessment (for example, whether a work capacity decision is required).

If the insurer assesses that the worker cannot return to their pre-injury employment, then it must assess if the worker can instead work in other employment that is suitable.

If this is the case, the insurer must also identify the type(s) of employment that currently suits the worker.

5.3 Requirement to attend work capacity assessments

An insurer may use available information to assess work capacity, or they may require the worker to attend an appointment if further information is required.

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

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).

6.1 IMC functions relating to the nominated treating doctor

The IMC can be asked to discuss the following with the worker's nominated treating doctor:

- the worker's capacity for work
- issues in relation to diagnosis and treatment (if 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 work capacity, prognosis for recovery and timeframes for the recover at work plan.

6.2 IMC functions relating to the worker

The IMC should discuss recover at/return to work issues 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
- issues and problems at work which may be delaying the worker's return
- 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 capacity 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 work or return to work.

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)
- 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:
 - comment on issues identified as impacting on return to work/capacity for work
 - comment on the outcome of treatment to date (if required).
- 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, treatment providers)
- the outcome of discussions
- consultation with and examination of (where required) the worker
- 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).

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 workers to attend 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
- an assessment of permanent injury (injuries before 01/01/2002) or permanent impairment (injuries on and after 01/01/2002) resulting from the injury.

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

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.

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 should not be in a treating relationship with the worker, nor should 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.

7.3 Geographical location

The location of the independent medical examiner's rooms should be as geographically close to the worker's home address as possible or accessible within the worker's travel restrictions.

In limited circumstances, examination by video consultation may be appropriate and effective and should 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 should 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 should 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 Notice to the worker

All referrals for IMEs are to be arranged at reasonable times and dates, and with adequate notice 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 independent medical examiner
- contact details of the independent 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.
- notice 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.

- a copy or list of the documents that are being provided to the independent medical examiner
- notice 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.
- notice that the worker can request a copy of the report
- notice that their nominated treating doctor will be provided with a copy of the examination report
- notice 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 independent 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 evidence of a change in the worker's health not resulting from the injury which will affect their participation in the labour market, 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 should 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 advised in writing of the reasons for the suspension and what they must do for weekly payments to be reinstated.

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
- whether 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 complete a complying agreement.

The complying agreement must include:

- 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.

Part 9: Commutation of compensation

9.1 Compensation not to be commuted for catastrophic injuries

Section 87EAA of the 1987 Act states that medical expenses compensation cannot be commuted for workers with a catastrophic injury, and that an injury satisfies the criteria for 'catastrophic' if it meets the definition specified in the Guidelines.

Catastrophic injuries must be certified by a medical specialist and meet the injury criteria for a spinal cord injury, brain injury, amputations, burns, or permanent blindness as specified below. SIRA will review the information supplied and determine if an injury is catastrophic.

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), or
- f. 'short' transfemoral amputation as defined by the loss of 65 per cent or more of the length of the femur.

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 should 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.

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

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