

Standards of practice

Expectations for insurer claims
administration and conduct

State Insurance
Regulatory
Authority

December 2018

Contents

Glossary	3
About the Standards.....	4
Overarching claims management principles	7
Standard of practice principles	8
Standard 1 - Worker consent	11
Standard 2 - Worker access to personal information	12
Standard 3 - Initial liability decisions - general, provisional, reasonable excuse or full liability	13
Standard 4 - Liability for medical or related treatment	15
Standard 5 - Recurrence or aggravation of a previous workplace injury.....	16
Standard 6 - Recoveries	17
Standard 7 - Interim pre-injury average weekly earnings calculation.....	18
Standard 8 - Insurer making weekly payments.....	19
Standard 9 - Reduction in payments of compensation	20
Standard 10 - Payment of invoices and reimbursements.....	21
Standard 11 - Changes in capacity	22
Standard 12 - Injury management plans	23
Standard 13 - Additional or consequential medical conditions	24
Standard 14 - Referral to an injury management consultant.....	25
Standard 15 - Approval and payment of medical, hospital and rehabilitation services...	27
Standard 16 - Case conferencing	28
Standard 17 - Section 39 notification.....	29
Standard 18 - Retiring age notification	30
Standard 19 - Section 59A notification	31
Standard 20 - Permanent impairment assessment reports.....	32
Standard 21 - Negotiation on degree of permanent impairment.....	33
Standard 22 - Insurer participation in disputes and mediations	34
Standard 23 - Recovery of overpayments due to insurer error	35
Standard 24 - Factual investigations.....	36
Standard 25 - Surveillance	37
Standard 26 - Arrangement for payments to Medicare Australia	39
Standard 27 - Notification and recovery of Centrelink benefits from lump sum payments.....	40
Standard 28 - Interpreter services.....	41
Standard 29 - Cross-border provisions.....	42
Standard 30 - Closing a claim	43
Standard 31 - Death claims.....	44
Appendix 1 - Context and relevant provisions	46
Appendix 2 - Practice guidance	70

Glossary

Term	Definition
NSW	New South Wales
1987 Act	Workers Compensation Act 1987
1998 Act	Workplace Injury Management and Workers Compensation Act 1998
The Workers Compensation Acts	Workers Compensation Act 1987 and Workplace Injury Management and Workers Compensation Act 1998
The Regulation	Workers Compensation Regulation 2016
MAC	Medical assessment certificate
Standards	Standards of practice
SIRA	State Insurance Regulatory Authority
WIRO	Workers Compensation Independent Review Office
The Commission	Workers Compensation Commission of New South Wales
NAATI	National Accreditation Authority for Translators and Interpreters
Exempt worker	Specific classes of workers for which most of the amendments made to the Workers Compensation Acts in 2012 and 2015 do not apply
RTW	Return to work
IME	Independent medical examiner
IMC	Injury management consultant
NTD	Nominated treating doctor
PIAWE	Pre-injury average weekly earnings
GST	Good and services tax
Permanent Impairment Guides	NSW workers compensation guidelines for the evaluation of permanent impairment, fourth edition, April 2016

About the Standards

The State Insurance Regulatory Authority (SIRA) is the government agency responsible for regulating and administering the workers compensation system 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

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. Through this review, SIRA has developed the Standards of practice: Expectations for insurer claims administration and conduct (Standards). These Standards are supported by streamlined and consolidated Workers compensation guidelines (Guidelines).

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

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

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

Purpose

SIRA has developed these Standards to support and encourage insurers to have effective claims management practices that will help deliver positive experiences and outcomes for workers, employers and the people of NSW.

The Standards require insurers to apply principles across a range of processes and procedures in claims handling and administration. The principles and expectations target activities where it is known that insurer processes or procedures are impacting the worker claims experience. They may also seek to provide clarity where there is confusion or inconsistency among insurers, leading to inequitable compensation outcomes for workers and employers. They are not a comprehensive suite of claims practices.

The Standards contain overarching claims management principles. These principles apply generally, and operate to guide all claims management activity in order to meet

the system objectives outlined in section 3 of the 1998 Act. The principles articulate a strategy built on:

- fairness and empathy;
- transparency and participation; and
- timeliness and efficiency.

Application

For the purposes of section 192A of the 1987 Act, the Standards set out within this document form the claims administration manual (CAM).

The Standards form part of SIRA's regulatory framework. All insurers are expected to comply with these Standards, except for Coal Mines Insurance Pty Ltd and the Workers Compensation (Dust Diseases) Authority (Dust Diseases Care).

However, adoption of the overarching claims management principles and any relevant Standard is encouraged by all insurers operating in the NSW workers compensation system.

Exempt categories of workers ('exempt worker')

The term 'exempt worker' refers to specific classes of workers for which most of the amendments made to the Workers Compensation Acts in 2012 and 2015 do not apply. These classes of workers include police officers; paramedics; fire fighters; rescue workers; and bushfire, emergency and rescue service volunteers.

Standards apply to exempt categories of workers unless otherwise indicated in the standard.

Scope

The Standards contain overarching claims management principles that are intended to apply generally to all claims handling and administration activities. They clearly state the outcomes insurers are to achieve in the administration of claims.

Individual Standards apply to particular claims management topics, and are presented in a way to make clear the following elements:

- **Principle:** the broad principle to be adopted by insurers when dealing with a particular aspect of a claim.
- **Expectations:** SIRA expectations for processes, procedures or methods to be applied in the handling and administration of claims relevant to that Standard topic.
- **Benchmarks:** an indication of what claims activities or actions SIRA may use to measure insurer performance against expectations.

The Standards should be read in conjunction with the requirements of the workers compensation legislation, regulation and guidelines.

Additional information to provide context for each Standard is provided in **Appendix 1**.

Further practice guidance information is provided in **Appendix 2**. The information provided in Appendix 2 is intended to support and guide insurers.

Specific references to relevant legislative provisions or relevant links are made throughout. Words defined in the NSW workers compensation legislation have the same meaning in these Standards of practice.

Commencement

The overarching claims management principles and standard principles will take effect and apply to all claims from **1 January 2019**. The principles will continue to apply until SIRA amends, revokes or replaces them in whole or in part.

A transitional period will apply for expectations, to ensure insurer systems, claims processes and procedures are updated to support implementation. Further consultation on and refinement of these expectations will be undertaken during this period.

After the transition period, directions to comply with these Standards may be issued to insurers under Division 4 of Part 7 of the 1987 Act, which will make contravention (breach) of a requirement of the Standards an offence under section 209 of the 1987 Act. Section 194(2) makes compliance with a direction to insurers a condition of an insurer's license issued under the Act.

Overarching claims management principles

These overarching claims management principles apply generally across all aspects of claims management, to provide direction for the handling and administration of claims under the workers compensation system. These principles support the workers compensation system objectives outlined in [section 3](#) of the 1998 Act.

Principle 1 Fairness and Empathy

The management of claims will be undertaken in an empathetic manner intended to maximise fairness for workers by:

- ensuring that workers understand their rights, entitlements and responsibilities, and making clear what workers and employers can expect from insurers and other scheme participants; and
- ensuring workers are afforded procedural fairness and decisions are made on the best available evidence, focused on advancing the worker's recovery and return to work.

Principle 2 Transparency and Participation

Workers, employers and other scheme participants will be empowered and encouraged to participate in the management of claims by:

- ensuring transparent and timely communication of the reasons and information relied upon for decisions and facilitating right-of-reply and prompt, independent review of decisions; and
- ensuring opportunities are provided to workers, employers and other scheme participants to contribute information that can support and inform claims management.

Principle 3 Timeliness and Efficiency

Claims management decisions will be made promptly and proactively, and claims will be managed in a manner intended to reduce delays and costs and maximise efficiency by:

- promptly and efficiently processing claims, responding to inquiries, determining entitlements and making payments;
- progressing claims without unnecessary investigation, dispute or litigation.

Standard of practice principles

Standard of practice principles articulate the core outcomes that should drive insurer claims administration and conduct at various points in the life of a claim. It is expected that insurers will adhere to these standard of practice principles from 1 January 2019.

Standard	Principle
Standard 1: Worker consent	The confidentiality of workers' personal and health information will be respected at all times and workers' personal and health information will be dealt with only in accordance with their consent.
Standard 2: Worker access to personal information	Workers will be provided with convenient and timely access to their personal and health information in accordance with relevant privacy and workers compensation laws.
Standard 3: Initial liability decisions – general, provisional, reasonable excuse or full liability	Liability decisions will be informed by careful consideration of all available information and proactive consultation with the worker and employer.
Standard 4: Liability for medical or related treatment	Liability decisions will be informed by careful consideration of all available information and proactive consultation with relevant stakeholders.
Standard 5: Recurrence or aggravation of a previous workplace injury	All available evidence will be considered to determine whether an injury is the recurrence of a previous injury or a new injury, and all reasonable support will be provided to the worker in either case.
Standard 6: Recoveries	Claims will be screened early to determine whether any third-party recoveries are to be pursued.
Standard 7: Interim pre-injury average weekly earnings calculation	Weekly payments to workers will commence as soon as possible, and workers will not be disadvantaged because the insurer has not been able to obtain all information required to calculate PIAWE.
Standard 8: Insurer making weekly payments	The rights and responsibilities of all parties will be respected in circumstances where weekly payments will be made by the insurer.
Standard 9: Reduction in payments of compensation	Workers will be provided with notice in advance prior to a statutory step-down in their weekly payments.

Standard	Principle
Standard 10: Payment of invoices and reimbursements	Workers and providers will receive prompt payment of invoices and reimbursements for medical, hospital and rehabilitation services.
Standard 11: Changes in capacity	A worker's work capacity will be re-assessed promptly upon receipt of new information indicating a change in work capacity.
Standard 12: Injury management plans	Injury management planning will be undertaken in a timely and proactive manner to support workers' treatment, rehabilitation and return to work.
Standard 13: Additional or consequential medical conditions	Prompt action will be taken to assess and address any additional or consequential medical condition identified on a certificate of capacity.
Standard 14: Referral to an injury management consultant	Injury management consultants will be engaged to assist workers identified as at risk of delayed recovery and in circumstances where a specific issue has been identified.
Standard 15: Approval and payment of medical, hospital and rehabilitation services	Prompt consideration will be given to approving medical, hospital and rehabilitation services and payment will be made as soon as practicable after services are invoiced.
Standard 16: Case conferencing	Case conferences will be conducted in a manner that promotes return to work and respects the worker's right to confidential medical consultations.
Standard 17: Section 39 notification	Workers affected by the 260-week limit to weekly payments will be provided with appropriate notice prior to the cessation of weekly payments.
Standard 18: Retiring age notification	Workers affected by the 12-month limit to weekly payments after a worker reaches retirement age will be provided with appropriate notice prior to the cessation of weekly payments.
Standard 19: Section 59A notification	Workers whose medical benefits are due to cease will be provided with appropriate notice prior to the cessation of those benefits.
Standard 20: Permanent impairment assessment reports	Permanent impairment assessment reports will be objectively evaluated to ensure correct and consistent assessment for the determination of entitlements.

Standard	Principle
Standard 21: Negotiation on degree of permanent impairment	Where appropriate, parties will be encouraged to consider negotiating and agreeing the degree of permanent impairment.
Standard 22: Insurer participation in disputes and mediations	All parties will participate in Commission teleconferences, conciliations/arbitrations and mediations in good faith and with a view to achieving the timely and effective resolution of disputes.
Standard 23: Recovery of overpayments due to insurer error	Risks relating to overpayment or duplication of payments to workers will be mitigated to the greatest extent practicable while ensuring efficient management of claims, and overpayments will be managed in a fair and transparent manner.
Standard 24: Factual investigations	Factual investigations will only be used when necessary and will always be undertaken in a fair and ethical manner.
Standard 25: Surveillance	Decisions to engage surveillance services will be based on firm evidence; surveillance will be conducted in an ethical manner; and information obtained through surveillance will be used and stored appropriately.
Standard 26: Arrangement for payments to Medicare Australia	Due care will be given in the management of claims to mitigate risks arising from the interaction between Medicare and the workers compensation scheme.
Standard 27: Notification and recovery of Centrelink benefits from lump sum payments	The implications of lump sum payments for Centrelink benefits, including possible repayments to Centrelink or temporary preclusion from Centrelink benefits, will be proactively managed to minimise impacts on workers.
Standard 28: Interpreter services	Workers will have access to qualified and culturally-appropriate interpreter services in the worker's nominated language.
Standard 29: Cross-border provisions	Workers who work in more than one State or Territory will be promptly assessed under cross-border arrangements for their correct entitlements.
Standard 30: Closing a claim	All relevant stakeholders will be notified prior to the closure of a claim.
Standard 31: Death claims	Death claims will be managed with empathy and respect, and liability decisions and payment of entitlements in relation to death claims will be prioritised and not unnecessarily delayed.

Standard 1 - Worker consent

Protecting a worker's personal and health information and ensuring a worker's consent is obtained prior to providing, obtaining or using information about a worker's injury and recovery promotes trust and ensures the integrity of the scheme.

Worker consent

Principle

The confidentiality of workers' personal and health information will be respected at all times and workers' personal and health information will be dealt with only in accordance with their consent.

Expectations		Benchmarks
S1.1	Insurers must obtain the worker's consent prior to releasing to or requesting from a third party a worker's personal or health information.	Evidence on claim file.
S1.2	When requesting a worker's consent, insurers must provide advice to the worker about: <ul style="list-style-type: none">the worker's rights and obligations, including the right to withdraw or modify consent and the potential impacts of not providing or withdrawing consent.the types of information that may be released, obtained or used and who is authorised to release, obtain or use the information.	Evidence on claim file.
S1.3	When a request is made to an insurer from a third party seeking release of information relating to a worker's injury or claim, insurers must consider whether existing worker consent is sufficient to enable release the information.	Evidence on claim file.

Standard 2 - Worker access to personal information

Facilitating workers’ access to their personal and health information empowers workers to contribute to decisions about their recovery and return to work.

Worker access to personal information

Principle

Workers will be provided with convenient and timely access to their personal and health information in accordance with relevant privacy and workers compensation laws.

Expectations		Benchmarks
S2.1	Insurers must advise workers of their right to access their personal and health information.	Evidence on claim file.
S2.2	Insurers must ensure third-party providers are aware that any report provide in relation to a worker may be released to the worker.	Evidence on claim file.
S2.3	Insurers must promptly respond to any request by the worker or their representative for information contained in the insurer’s claim file.	Written response provided within ten working days.

Standard 3 – Initial liability decisions – general, provisional, reasonable excuse or full liability

Making initial liability decisions promptly, in consultation with key stakeholders and based on all available evidence will ensure that workers and employers can focus on recovery and return to work.

Initial liability decisions

Principle

Liability decisions will be informed by careful consideration of all available information and proactive consultation with the worker and employer.

Expectations		Benchmarks
S3.1 (General)	When determining liability, insurers must obtain and consider all relevant information, consult with the worker and the employer, and make a decision at the earliest possible opportunity.	Evidence on claim file.
S3.2 (Provisional liability)	<p>If accepting provisional liability, the insurer must provide the following information to the worker (in addition to notice set out in section 269 of the 1998 Act):</p> <ul style="list-style-type: none">• the worker's pre-injury average weekly earnings (PIAWE) or average weekly earnings (AWE) and how that amount has been calculated;• the amount of the weekly payment and how that amount has been calculated;• who will pay the worker and when;• what the worker can do if the worker disagrees with the amount or does not receive payment; and• what information the worker must provide (including when and to whom) to continue to be entitled to weekly payments.	Written notice provided to the worker within two working days after decision.
S3.3 (Provisional liability)	<p>If accepting provisional liability, the insurer must provide the following information to the employer:</p> <ul style="list-style-type: none">• confirmation that weekly payments are to commence;• the period for which provisional payments will continue;• that the insurer will develop an injury management plan for the worker if required to do so by Chapter 3 of the 1998 Act; and• that the worker is entitled to make a claim for compensation and how that claim can be made.	Written notice provided to the employer within two working days after decision.

Expectations	Benchmarks
<p>S3.4 (Reasonable excuse)</p> <p>If the insurer has a reasonable excuse not to commence provisional weekly payments, the insurer must provide the following information to the worker (in addition to notice set out in section 268 of the 1998 Act) and to the employer:</p> <ul style="list-style-type: none"> • how the excuse can be resolved; • details about how further information can be sought from the insurer; • that the worker can seek assistance from their union, a legal representative or the WIRO; and • that the worker has a right to seek an expedited assessment by the Workers Compensation Commission. 	<p>Written notice provided to the worker within two working days after decision.</p>
<p>S3.6 (Full liability)</p> <p>If accepting liability for a claim for weekly payments, the insurer must provide the following information to the worker and the employer:</p> <ul style="list-style-type: none"> • confirmation of the decision to accept liability; • the worker's pre-injury average weekly earnings (PIAWE) or average weekly earnings (AWE) and how that amount has been calculated; • the amount of the weekly payments and how that amount has been calculated; • who will pay the worker and when; • what the worker can do if the worker disagrees with the amount or does not receive payment; and • that the insurer will develop an injury management plan for the worker if required to do so by Chapter 3 of the 1998 Act; and • what information the worker must provide (including when and to whom) to continue to be entitled to weekly payments. 	<p>Written notice provided to the worker and employer within two working days after decision.</p>
<p>S3.7 (Full liability)</p> <p>If an insurer requires a completed claim form to determine liability, they must proactively request this from the worker and allow sufficient time for the worker to complete and submit the form.</p>	<p>Request at least four weeks before expiration of provisional period or upon exhaustion of provisional medical expenses.</p>
<p>S3.8 (Full liability)</p> <p>Upon request, the insurer must provide the employer with information relevant to the liability decision, including the evidence considered and legislative provisions relied upon.</p>	<p>Written response provided within ten</p>

Expectations	Benchmarks
	working days.

Standard 4 – Liability for medical or related treatment

Making medical or treatment liability decisions promptly, in consultation with key stakeholders and based on all available evidence will reduce the likelihood of disputes and ensure workers can focus on recovery and return to work.

Liability for medical or related treatment

Principle

Liability decisions will be informed by careful consideration of all available information and proactive consultation with relevant stakeholders.

Expectations	Benchmarks
S4.1 When determining liability for medical or related treatment, insurers must obtain and consider all relevant information, consult with the worker and relevant parties as required, and make a decision at the earliest possible opportunity.	Evidence on claim file.
S4.2 When a claim for medical or related treatment is received, the insurer must acknowledge the request and keep the worker informed of the status of their claim.	Request acknowledged within ten working days.
S4.3 The insurer must advise the relevant parties of the outcome and reasons for a decision regarding liability for medical or related treatment.	Advice provided within two working days after decision.

Standard 5 – Recurrence or aggravation of a previous workplace injury

Clarity and certainty regarding the distinction between the recurrence of an injury and a new injury is important for workers and employers because of the potential impact on a worker’s benefits and an employer’s premium.

Recurrence or aggravation of a previous workplace injury

Principle

All available evidence will be considered to determine whether an injury is the recurrence of a previous injury or a new injury, and all reasonable support will be provided to the worker in either case.

Expectations	Benchmarks
S5.1 If the insurer determines that an injury is a recurrence of a previous injury or a new injury to a previously injured body part, the insurer must contact the worker and employer to advise of the reasons for that decision and its implications.	Advice provided to the worker and employer within two working days after decision.

Standard 6 – Recoveries

Enabling insurers to recover funds from third parties who share a proportion of the liability for an injury helps to ensure the sustainability of the workers compensation system.

Recoveries		
Principle		
Claims will be screened early to determine whether any third-party recoveries are to be pursued.		
Expectations		Benchmarks
S6.1	Insurers must screen all new claims for potential recoveries and make a record of the investigation undertaken to determine whether recoveries are relevant and the outcome of the investigation.	Initial screening to occur within 15 working days of receipt of a new claim.

Standard 7 – Interim pre-injury average weekly earnings calculation

Providing for an *interim* pre-injury average weekly earnings (PIAWE) calculation enables workers to be supported by commencement of weekly payments, even when the insurer has insufficient information to make a complete calculation.

Interim pre-injury average weekly earnings calculation

Principle

Weekly payments to workers will commence as soon as possible, and workers will not be disadvantaged because the insurer has not been able to obtain all information required to calculate PIAWE.

Expectations	Benchmarks
<p>S7.1 For claims where weekly payments may be payable, insurers must request from the employer as soon as possible any pay information required for the purposes of calculating the worker's PIAWE.</p>	<p>Request made within three working days from receipt of an initial notification.</p>
<p>S7.2 If the insurer is required to start weekly payments but does not have sufficient information to make a complete PIAWE calculation, the insurer must consult the worker and the employer, calculate PIAWE based on the best available information and communicate the calculation in a work capacity decision (interim PIAWE).</p>	<p>Worker and employer informed within two working days after decision.</p>
<p>S7.3 Where the insurer makes an interim PIAWE calculation, the insurer must again request from the employer as soon as possible the information required to undertake a complete PIAWE calculation.</p>	<p>Further information sought within five working days after interim PIAWE calculation.</p>
<p>S7.4 Insurers must recalculate a worker's PIAWE as soon as possible following receipt of the information required to undertake a complete PIAWE calculation.</p> <p>If the interim PIAWE amount was incorrect, the insurer must advise the worker in a work capacity decision of the new PIAWE amount and:</p> <ul style="list-style-type: none"> • if the new PIAWE calculation is more than the interim PIAWE calculation, the insurer must pay the backpay due to the worker; or • if the new PIAWE calculation is lower than the interim PIAWE calculation, the overpayment to the worker must be dealt with in accordance with Standard 23. 	<p>PIAWE to be recalculated within five working days from receipt of required information.</p>

Standard 8 – Insurer making weekly payments

All stakeholders should be kept informed in cases where it is necessary for weekly payments to be processed directly by the insurer to the worker, to ensure the worker receives ongoing and timely support and the employer is informed of their ongoing obligations and responsibilities

Insurer making weekly payments

Principle

The rights and responsibilities of all parties will be respected in circumstances where weekly payments will be made by the insurer.

Expectations		Benchmarks
S8.1	Before commencing weekly payments directly to a worker, the insurer must consult with the employer and advise that claims costs will continue to accrue.	Evidence on claim file.
S8.2	As soon as possible after deciding to commence making payment directly to the worker, the insurer must request that the worker complete an <u>Australian Taxation Office</u> tax file number declaration form and arrange for tax to be paid on behalf of the worker.	Request made within five working days after insurer decision to commence payments.
S8.3	The insurer must advise the worker and employer as soon as practicable after commencing weekly payments directly to the worker.	Written advice to worker and employer within five working days after commencing payments.

Standard 9 – Reduction in payments of compensation

Workers need to be kept informed about their claim, particularly in circumstances where their entitlements are to be stepped down due to the application of the legislation.

Reduction in payments of compensation

Principle

Workers will be provided with notice in advance prior to a statutory step-down in their weekly payments.

Expectations		Benchmarks
S9.1	Insurers must advise a worker prior to a statutory step-down in their weekly payments.	Advice provided no less than 15 working days prior to reduction in payments.
S9.2	Where the employer is making weekly payments directly to the worker, the insurer must advise the employer prior to a statutory step-down in the worker's weekly payments and advise the employer of the correct weekly payment to be paid after the step-down.	Advice provided no less than 15 working days prior to reduction in payments.

Standard 10 – Payment of invoices and reimbursements

Prompt payment of invoices and reimbursements for medical, hospital and rehabilitation services ensures workers can remain focused on their recovery and helps to maintain the integrity of the system.

Payment of invoices and reimbursements

Principle

Workers and providers will receive prompt payment of invoices and reimbursements for medical, hospital and rehabilitation services.

Expectations		Benchmarks
S10.1	As soon as practicable after receipt of relevant documentation, insurers must pay invoices that meet SIRA's standard invoicing requirements and are for treatment that does not require pre-approval or for which pre-approval has been obtained.	Payment no later than ten working days from receipt of a valid invoice for approved treatment.
S10.2	Where there is likely to be a delay in payment of an invoice, for example in the case of illegible invoices or invoices submitted more than 12 months after treatment, insurers must advise the party to whom payment is due of the reasons for delay and the anticipated time to resolution.	Advice to relevant party within ten working days of receipt of invoice.
S10.3	As soon as practicable after receipt of relevant documentation, insurers must pay reimbursements to workers for expenses that do not require pre-approval or for which pre-approval has been obtained.	Payment no later than ten working days from receipt of relevant documentation.
S10.4	Where there is likely to be a delay in payment of a reimbursement, for example in the case of receipts submitted more than 12 months after the expense was incurred or where insufficient evidence is provided, insurers must advise the worker of the reasons for delay and the anticipated time to resolution.	Advice to the worker within ten working days of receipt of relevant documentation.

Standard 11 – Changes in capacity

It is important for work capacity assessments to be undertaken promptly following receipt of a certificate indicating a change in a worker's capacity, to ensure workers continue to receive appropriate compensation and support.

Changes in capacity

Principle

A worker's work capacity will be re-assessed promptly upon receipt of new information indicating a change in work capacity.

Expectations

Benchmarks

S11.1	Upon receipt of a certificate of capacity indicating a change in a worker's capacity, insurers must investigate the reasons for a change in a worker's capacity, which may require consultation with the worker, the nominated treating doctor and any treating specialists or workplace rehabilitation providers.	Evidence on claim file.
S11.2	As soon as practicable upon receipt of a certificate of capacity indicating a change in a worker's capacity, the insurer must conduct a work capacity assessment, make a work capacity decision and advise the worker of the outcomes of the assessment and decision.	Advice provided to the worker within two working days after decision.

Application This standard **does not** apply to exempt workers.

Standard 12 – Injury management plans

Development of an injury management plan to coordinate and manage treatment, rehabilitation and, if necessary, retraining of a worker supports timely, safe and durable return to work.

Injury management plans

Principle

Injury management planning will be undertaken in a timely and proactive manner to support workers' treatment, rehabilitation and return to work.

Expectations	Benchmarks
S12.1 Insurers must commence injury management planning with the worker immediately upon receipt of an initial notification of injury and must develop an injury management plan if a workplace injury is identified as likely to be a significant injury.	Injury management plan developed within 20 working days from identification of a workplace injury as likely to be a significant injury.
S12.2 In addition to the requirements in <u>section 45 of the 1998 Act</u> , the injury management plan must: <ul style="list-style-type: none">• be specific to the worker;• be developed in consultation with the worker, the nominated treating doctor and the employer;• be consistent with available medical and treatment information; and• include:<ul style="list-style-type: none">– the goal of the plan and actions tailored to delivery of the goal– a statement about how and when the plan will be reviewed– the rights and obligations of all stakeholders.	Evidence on claim file.
S12.3 Insurers must review injury management plans in accordance with the statement in the plan or as soon as practicable when new information about an injury or treatment is received.	Evidence on claim file.

Standard 13 – Additional or consequential medical conditions

It is important that prompt and proactive consideration is given to the development of additional or consequential medical conditions to ensure workers continue to receive appropriate compensation and support.

Additional or consequential medical conditions

Principle

Prompt action will be taken to assess and address any additional or consequential medical condition identified on a certificate of capacity.

Expectations		Benchmarks
S13.1	When an insurer receives a certificate of capacity that identifies an additional or consequential medical condition not previously diagnosed or reported, the insurer must seek advice from the treating doctor to establish the reason for inclusion on the certificate of the additional or consequential condition.	Advice sought within five working days after receipt of certificate.
S13.2	If the treating doctor considers that the additional or consequential medical condition may result from the compensable injury, the insurer must contact the worker to establish whether they intend to make a claim for reasonably necessary treatment for the condition.	Contact with the worker attempted within five working days after receipt of certificate.
S13.3	If the worker makes a claim for treatment or weekly benefits for the additional or consequential medical condition, the insurer must make a liability decision.	Liability decision made within 21 days of lodgement of the claim.
S13.4	If the worker is not making a claim for treatment or weekly benefits for the additional or consequential medical condition, this is to be documented on the claim file.	Evidence on claim file.

Standard 14 – Referral to an injury management consultant

Injury management consultants (IMCs) should be used to provide expert advice and assistance regarding a worker's recovery at or return to work.

Referral to an injury management consultant

Principle

Injury management consultants will be engaged to assist workers identified as at risk of delayed recovery and in circumstances where a specific issue has been identified.

Expectations	Benchmarks
<p>S14.1 Insurers must only refer to an IMC when:</p> <ul style="list-style-type: none"> • a worker has been identified at risk of delayed recovery; • a specific return to work or injury management issue has been identified; or • referral has been requested by the worker, employer, nominated treating doctor or other treating practitioner. 	<p>Evidence on claim file.</p>
<p>S14.2 Insurers must only refer to an IMC in circumstances where a specific return to work or injury management issue has been identified if attempts have been made to resolve the issue.</p>	<p>Evidence on claim file.</p>
<p>S14.3 If an insurer refers to an IMC, the insurer must advise the nominated treating doctor that the referral has been made, provide the reasons for referral, and advise that the nominated treating doctor can be paid for time taken to communicate with the IMC.</p>	<p>Advice provided to the doctor within five days after referral in made.</p>
<p>S14.4 When making a referral to an IMC, the insurer must:</p> <ul style="list-style-type: none"> • ensure the IMC is located within the worker's travel restrictions if the worker is required to attend the IMC; • ensure any special requirements of the worker are accommodated, such as those arising from gender, culture, language and accessibility; • consult the worker and take into consideration the injury type when deciding which IMC to engage; • only engage an IMC who is able to provide an appointment within a reasonable timeframe; • enquire whether the IMC records consultations (audio or video) and if so inform the worker and seek the workers consent for the consultation to be recorded; and • avoid conflicts of interest between the IMC and the nominated treating doctor or employer. 	<p>Evidence on claim file.</p>

Expectations	Benchmarks
<p>S14.5 Insurers must provide the worker with the following information prior any appointment with an IMC:</p> <ul style="list-style-type: none"> the name, speciality and qualification of the IMC and the date, time, location and likely duration of the appointment; the reasons for the referral; what information or documentation the worker must take to the consultation (eg. imaging or reports of investigations/tests); how costs (including for travel) will be paid; that the worker may be accompanied by a support person; that the worker and the nominated treating doctor will both receive a copy of the report; what the worker is to do if they do not believe the assessment is reasonable or if they have a complaint about the conduct of the IMC; the SIRA brochure about injury management consultations; and that the worker can contact <u>WIRO</u> or their union for assistance. 	<p>Written notification provided to the worker at least ten working days prior to an IMC appointment.</p>
<p>S14.6 When referring a worker to an IMC, the insurer must provide the IMC with sufficient information to support the referral, including:</p> <ul style="list-style-type: none"> a detailed description of the reason for referral; contact details for the worker, nominated treating doctor and employer; and relevant documentation from the file to enable the IMC to understand the claim. <p>Note: Referrals must not include questions concerning liability.</p>	<p>Referral information to be provided to IMC at least ten working days prior to an IMC appointment.</p>
<p>S14.7 Insurers must make subsequent IMC referrals to the same IMC unless that IMC:</p> <ul style="list-style-type: none"> has ceased to practise (temporarily or permanently); no longer practises in a location convenient to the worker; or the parties agree that a different IMC is required. 	<p>Evidence on claim file.</p>

Standard 15 – Approval and payment of medical, hospital and rehabilitation services

Prompt approval and payment for medical, hospital and rehabilitation services ensures workers can remain focused on their recovery and helps to maintain the integrity of the scheme.

Approval and payment of medical, hospital and rehabilitation services

Principle

Prompt consideration will be given to approving medical, hospital and rehabilitation services and payment will be made as soon as practicable after services are invoiced.

Expectations	Benchmarks
<p>S15.1 Before making a decision about approval for services, insurers must determine:</p> <ul style="list-style-type: none"> • whether the service provider is appropriately qualified to provide the service; • whether the proposed fees are appropriate and/or consistent with Workers Compensation Fees Orders; and • whether the services requested align to appropriate billing/payment codes. 	Evidence on claim file.
<p>S15.2 When approving services from workplace rehabilitation providers, insurers must ensure that services are consistent with the <i>Nationally Consistent Approval Framework for workplace rehabilitation providers</i> and the <i>NSW Supplement</i>.</p>	Evidence on claim file.
<p>S15.3 Insurers must review service provider invoices prior to payment and ensure:</p> <ul style="list-style-type: none"> • rates and items billed align with approvals; • rates do not exceed the maximum amount prescribed by any relevant Workers Compensation Fees Orders; and • invoices contain all relevant information, including application of GST or input tax credits where appropriate. 	Evidence on claim file.

Standard 16 – Case conferencing

Case conferences bring together the worker, the nominated treating doctor and other parties such as the insurer, the employer and workplace rehabilitation providers to discuss how to deliver the best possible return to work outcomes for the worker.

Case conferencing		
Principle		
Case conferences will be conducted in a manner that promotes return to work and respects the worker's right to confidential medical consultations.		
Expectations		Benchmarks
S16.1	<p>When seeking to arrange a case conference, the insurer must:</p> <ul style="list-style-type: none">• advise the worker of the insurers intention to seek a case conference and the reasons for doing so;• provide a statement of the purpose and agenda for the case conference to all parties involved; and• schedule the case conference at a time separate to the worker's medical consultation, unless otherwise agreed by the worker and the nominated treating doctor.	Evidence on claim file.

Standard 17 – Section 39 notification

Providing early notification prior to cessation of weekly payments helps to ensure that workers have sufficient time to prepare for cessation and make any necessary arrangements.

Standard 39 notification

Principle

Workers affected by the 260-week limit to weekly payments will be provided with appropriate notice prior to the cessation of weekly payments.

Expectations

Benchmarks

S17.1	<p>Insurers must provide written notification to a worker prior to ceasing weekly entitlements in accordance with section 39 of the 1987 Act and must include:</p> <ul style="list-style-type: none">• the date on which payments will cease and the date the last payment will be processed;• supporting documentation for the assessment of permanent impairment;• the date on which entitlement to medical benefits will cease;• information regarding the worker's entitlement to vocational and return to work assistance programs;• information on how to contact Centrelink; and• who to contact for further information.	Notification provided at least 13 weeks prior to cessation of weekly payments.
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Application This standard **does not** apply to exempt workers.

Standard 18 – Retiring age notification

Providing early notification prior to cessation of weekly payments helps to ensure that workers have sufficient time to prepare for cessation and make any necessary arrangements.

Retiring age notification

Principle

Workers affected by the 12-month limit to weekly payments after a worker reaches retirement age will be provided with appropriate notice prior to the cessation of weekly payments.

Expectations	Benchmarks
<p>S18.1 Insurers must provide written notification to a worker prior to ceasing weekly entitlements 12 months after a worker reaches retirement age and must include:</p> <ul style="list-style-type: none">the date on which payments will cease and the date the last payment will be processed;the date on which entitlement to medical benefits will cease; andwho to contact for further information.	<p>Notification provided at least 13 weeks prior to cessation of weekly payments.</p>

Standard 19 – Section 59A notification

Providing early notification prior to cessation of medical benefits helps to ensure that workers have sufficient time to prepare for cessation and make any necessary arrangements.

Section 59A notification

Principle

Workers whose medical benefits are due to cease will be provided with appropriate notice prior to the cessation of those benefits.

Expectations

Benchmarks

S19.1	Insurers must provide written notification to a worker and the nominated treating doctor before the cessation of medical benefits and must include: <ul style="list-style-type: none">the date on which compensation for reasonably necessary medical treatment and services is due to cease; andin the case of the worker, who to contact for further information.	Notification provided at least 13 weeks prior to cessation of benefits.
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Application This standard **does not** apply to exempt workers.

Standard 20 – Permanent impairment assessment reports

Permanent impairment can be an integral and important component of a worker's entitlements. Accordingly, permanent impairment assessment reports must be objectively reviewed for accuracy and consistency with claim records.

Permanent impairment assessment reports

Principle

Permanent impairment assessment reports will be objectively evaluated to ensure correct and consistent assessment for the determination of entitlements.

Expectations		Benchmarks
S20.1	Insurers must objectively consider any report on the assessment of permanent impairment to determine whether the assessment is consistent with the information in the claim file and consistent with the <i>NSW workers compensation guidelines for the evaluation of permanent impairment</i> .	Within ten working days from receipt of the report.
S20.2	If an insurer determines that further information is required in the report or that a report is not consistent with the <i>NSW workers compensation guidelines for the evaluation of permanent impairment</i> , the insurer must request clarification or amendment from the assessor.	Request made within ten working days after determining that further information is required or that the report is not consistent with Guidelines.

Standard 21 – Negotiation on degree of permanent impairment

Seeking to reach agreement on the degree of permanent impairment can reduce time, costs and the likelihood of disputes.

Negotiation on degree of permanent impairment

Principle

Where appropriate, parties will be encouraged to consider negotiating and agreeing the degree of permanent impairment.

Expectations		Benchmarks
S21.1	Insurers must provide workers with copies of all relevant reports and other evidence prior to negotiating the degree of permanent impairment, to allow for informed negotiation.	Reports and evidence provided to the worker at least five working days prior to commencement of negotiations.
S21.2	Before entering into an agreement regarding the worker's degree of permanent impairment, the insurer must be satisfied that the worker has obtained (or waived the right to obtain) independent legal advice regarding the consequences of entering into the agreement.	Evidence on claim file.
S21.3	Where the insurer and the worker agree the degree of permanent impairment, insurers must ensure that an agreement is entered into that satisfies the requirements of <u>section 66A</u> of the 1987 Act and the <i>Workers compensation guidelines</i> .	Evidence on claim file.

Standard 22 – Insurer participation in disputes and mediations

Fully informed and good-faith participation in Commission dispute resolution processes can assist the timely and effective resolution of disputes.

Insurer participation in disputes and mediations

Principle

All parties will participate in Commission teleconferences, conciliations/arbitrations and mediations in good faith and with a view to achieving the timely and effective resolution of disputes.

Expectations		Benchmarks
S22.1	As far as possible, insurers must ensure that a person with knowledge of the relevant claim and who holds appropriate delegation to make decisions and provide instructions to legal providers is either in attendance in person or available by phone during Commission dispute resolution processes.	Evidence on claim file.

Standard 23 – Recovery of overpayments due to insurer error

Managing overpayments to workers in a fair and transparent manner contributes to the viability of the system and helps to preserve the relationship between the insurer and the worker.

Recovery of overpayments due to insurer error

Principle

Risks relating to overpayment or duplication of payments to workers will be mitigated where practicable while ensuring efficient management of claims, and overpayments will be managed in a fair and transparent manner.

Expectations		Benchmarks
S23.1	Where an insurer identifies an overpayment to a worker due to an error and wishes to seek recovery, the insurer must advise the worker of the details of the payment(s) and clearly describe the error and the potential impact to the worker.	Evidence on claim file.
S23.2	Where the insurer negotiates a repayment arrangement with the worker, the insurer must demonstrate they have considered the individual circumstances of the worker and potential financial hardship.	Evidence on claim file.
S23.3	The insurer must obtain informed consent from the worker prior to commencement of any repayment arrangement.	Evidence on claim file.

Standard 24 – Factual investigations

Factual investigations play an important role in the workers compensation scheme; however, they can erode worker trust and must therefore be used judiciously.

Factual investigations

Principle

Factual investigations will only be used when necessary and will always be undertaken in a fair and ethical manner.

Expectations		Benchmarks
S24.1	Insurers must only undertake factual investigations when required information cannot be obtained by another less intrusive means and insurers must clearly document the purpose for undertaking any factual investigation.	Evidence on claim file.
S24.2	<p>If the worker is requested to participate in a factual investigation, the insurer must advise the worker in writing and provide the following information:</p> <ul style="list-style-type: none">• the purpose of the factual investigation and the contact details of the investigator;• the anticipated duration of the factual interview, which must not exceed two hours;• that the worker can nominate the place of the interview and may have a support person (including union representative) present;• that the worker may request an interpreter if required, who does not count as a support person• that the worker will receive a copy of their statement or transcript within ten working days of the interview;• that the worker can identify witnesses to be considered to assist the investigation; and• advice to the worker that they are not obligated to participate in the factual investigation, however the factual investigation will be used to help determine liability for their claim.	Complete advice provided to the worker at least five working days prior to the proposed factual interview.

Standard 25 – Surveillance

Surveillance plays a small but important role in the workers compensation scheme; however, it can significantly erode worker trust and must therefore be used judiciously.

Surveillance

Principle

Decisions to engage surveillance services will be based on firm evidence; surveillance will be conducted in an ethical manner; and information obtained through surveillance will be used and stored appropriately.

Expectations

Benchmarks

S25.1	<p>The insurer must only conduct surveillance of a worker when:</p> <ul style="list-style-type: none">• there is evidence that the worker is exaggerating an aspect of the claim or providing misleading information in relation to a claim; the insurer reasonably believes that the claim is inconsistent with information in the insurer's possession; or the insurer reasonably believes that fraud is being committed; <p>AND</p> <ul style="list-style-type: none">• the insurer is satisfied that it cannot gather the information required through less intrusive means and that the benefit of obtaining the information outweighs the intrusion into the worker's privacy; <p>AND</p> <ul style="list-style-type: none">• the surveillance is likely to gather the information required.	Evidence on claim file.
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Expectations	Benchmarks
<p>S25.2 Insurers must ensure that any surveillance meets the following requirements:</p> <ul style="list-style-type: none"> • the scope and duration of the surveillance is clearly articulated; • surveillance is only conducted in or from places regarded as public; • the surveillance does not interfere with the worker's activities while under observation; • the surveillance does not include any acts of inducement, entrapment or trespass, including the use of social media with the intention to induce, entrap or deceive; • the surveillance is undertaken in a way that demonstrates sensitivity to the privacy rights of children, takes reasonable action to avoid video surveillance of children, and where possible does not show images of children in reports and recordings; • where possible, reports and recordings are redacted or censored to minimise the likelihood of other individuals being identifiable; • communication is not undertaken with other individuals in a way that may reveal (directly or indirectly) that surveillance is in place; and • recordings and any other materials collected are securely stored. 	<p>Evidence on claim file.</p>
<p>25.3 Insurers must not provide misleading information in response to a question from a worker about whether surveillance is in place; however, insurers are to take into consideration an investigator's safety and the worker's wellbeing when responding to a worker's question.</p>	<p>Evidence on claim file.</p>
<p>25.4 If the insurer provides material gathered through surveillance to a third party, the insurer must inform the third party about relevant confidentiality and privacy obligations.</p>	<p>Evidence on claim file.</p>

Standard 26 – Arrangement for payments to Medicare Australia

Proactive engagement with Medicare Australia and correct attribution of medical costs helps to ensure prompt payment of entitlements and reduces the risk that a worker will be inadvertently subject to recovery action from Medicare.

Arrangement for payments to Medicare Australia

Principle

Due care will be given in the management of claims to mitigate risks arising from the interaction between Medicare and the workers compensation scheme.

Expectations		Benchmarks
S26.1	<p>Insurers must request a notice of past benefits from Medicare when:</p> <ul style="list-style-type: none">• an application for dispute resolution has been lodged with the <u>Workers Compensation Commission</u> (excluding disputes that only relate to work capacity decisions)• accepting liability for a condition that is contracted or caused by gradual process or that may be an aggravation of a disease;• there is a retrospective entitlement to compensation (ie. when liability for medical expenses had been disputed but subsequently accepted six months or more after the liability dispute date); or• a settlement of a claim for compensation is initiated that will exceed \$5,000.	Medicare notice of past benefits to be initiated within five working days of relevant event.

Standard 27 – Notification and recovery of Centrelink benefits from lump sum payments

Prompt advice to [Centrelink](#) and correct attribution of lump sum payments helps to ensure prompt payment of entitlements and reduces the risk of a worker becoming inadvertently subject to recovery action from Centrelink.

Notification and recovery of Centrelink benefits from lump sum payments

Principle

The implications of lump sum payments for Centrelink benefits, including possible repayments to Centrelink or temporary preclusion from Centrelink benefits, will be proactively managed to minimise impacts on workers.

Expectations		Benchmarks
S27.1	<div>Insurers must provide appropriate documentation to Centrelink when:</div> <ul style="list-style-type: none">• settlement occurs for commutation or damages matters or other matters settled in the Workers Compensation Commission; and• in the case of workers whose entitlements have been affected by delays or reconsideration of entitlements, outstanding amounts owed to the worker are calculated by the insurer.	Information provided to Centrelink within five working days after relevant event.

Standard 28 – Interpreter services

Appropriate use of interpreters ensures equitable services for workers whose first language is not English or who are hearing-impaired.

Interpreter services

Principle

Workers will have access to qualified and culturally-appropriate interpreter services in the worker's nominated language.

Expectations		Benchmarks
S28.1	Insurers must engage the services of a qualified interpreter if the worker asks for an interpreter, indicates a preference for communicating in their own language, does not appear to understand questions or is not easily able to be understood.	Evidence on claim file.
S28.2	<p>When engaging the services of an interpreter, insurers must:</p> <ul style="list-style-type: none">• engage a NAATI-certified interpreter (for languages where this certification is available);• consider whether the communication should be face-to-face or whether using a telephone interpreter is sufficient;• ensure there is no conflict of interest;• ensure consideration of the workers cultural background; and,• explain the purpose of the communication to the interpreter.	Evidence on claim file.

Standard 29 – Cross-border provisions

Correct application of cross-border provisions helps to ensure prompt payment of entitlements, to enable workers to focus on recovery and return to work.

Cross-border provisions		
Principle		
Workers who work in more than one State or Territory will be provided with assistance to understand their entitlement to compensation.		
Expectations		Benchmarks
S29.1	If a worker works in more than one State or Territory, insurers must apply the cascading ‘State of connection’ tests in the <i>Cross border arrangements for workers compensation</i> when determining liability for a claim, to determine whether the worker’s employment is connected with NSW.	Evidence on claim file.

Standard 30 – Closing a claim

Appropriate consultation should occur with relevant stakeholders prior to the closure of a claim, to ensure that the reasons for and implications of the closure are clearly understood.

Closing a claim		
Principle		
All relevant stakeholders will be notified prior to the closure of a claim.		
Expectations		Benchmarks
S30.1	Before closing a claim, the insurer must contact the worker, the employer and any relevant service providers to advise of the intention to close the claim, including the reasons for doing so, and provide an opportunity for any outstanding invoices or reimbursements to be paid.	Evidence on claim file.
S30.2	The insurer must finalise all outstanding invoices prior to closing the claim.	Evidence on claim file.
S30.3	The insurer must confirm in writing the closure of a claim to the worker and the employer, including: <ul style="list-style-type: none">• the date the claim was closed;• the date on which medical benefits will cease (not applicable to exempt workers); and• what to do if the worker or employer believes the claim needs to be re-opened.	Notification within 2 working days after the claim is closed.

Standard 31 – Death claims

Death claims require proactive and sensitive management to ensure families and others are provided with appropriate support.

Death claims

Principle

Death claims will be managed with empathy and respect, and liability decisions and payment of entitlements in relation to death claims will be prioritised and not unnecessarily delayed.

Expectations	Benchmarks
S31.1 If an insurer becomes aware of a death that may be work-related, the insurer must proactively investigate the circumstances of the death, including in cases where the death occurred some time after a work-related injury.	Proactive investigation to commence within five working days after becoming aware of the death.
S31.2 When an insurer is notified of a death that may be work-related, the insurer must contact the worker's family, the family's legal representative or another appropriate party without delay to advise them of the insurer's role.	Contact within five working days after being notified of a death.
S31.3 Insurers must determine liability for death claims as soon as practicable; and where a liability decision is likely to be delayed, insurers must document the steps taken to obtain information relevant to determining liability.	Liability determined within 21 days after becoming aware of the death.
S31.4 In circumstance where more than one dependant or potential dependant is identified, insurers must: <ul style="list-style-type: none">• make an application to the Commission to apportion the lump sum death benefit;• seek the details of all persons who conceivably have an entitlement, including potential dependants who may be eligible for the lump sum death benefit and potential dependent children who may be eligible for weekly payments; and• advise all persons who conceivably have an entitlement of their potential entitlement.	Application to the Commission for apportionment made within ten working days after accepting liability.

Expectations	Benchmarks
S31.5 Insurers must advise the family or legal representatives of the deceased as soon as possible after a liability decision is made.	Written confirmation of the liability decision within two working days after the decision is made.
S31.6 Insurers must commence weekly payments for dependent children as soon as possible after liability is accepted.	Commencement of weekly payments within ten working days after accepting liability.
S31.7 If weekly payments are payable to an adult dependent child (18-21 years in full-time education), insurers must advise the surviving parent or guardian (or legal representative) to seek advice regarding the tax implications of such payments.	Evidence on claim file.







Appendix 1 – Context and relevant provisions

Standard	Context	Relevant provisions
Overarching claims management principles	<p>The overarching claims management principles apply generally across all aspects of claims management, to provide direction for the handling and administration of claims under the workers compensation system. These principles support the workers compensation system objectives outlined in <u>section 3</u> of the 1998 Act.</p> <p>Claims management that is supportive, non-adversarial and accessible can provide a positive experience for workers and employers, and focus the efforts of system participants to achieve the best possible return to work and health outcomes.</p> <p>The management of claims should be undertaken in an empathetic manner, intended to maximise fairness for workers. A worker should not have to face significant challenges or barriers to access benefits to which they are entitled, and employers should be kept informed throughout the claims management process.</p> <p>Honest and transparent communication underpins a fair and equitable workers compensation system. When workers, employers and other scheme participants are empowered and encouraged to participate in the management of a claim, they can fully contribute toward achieving the best possible return to work and health outcomes for the worker.</p> <p>Model litigant principles apply to civil claims and civil litigation involving the NSW Government and/or its agencies. Where relevant, these principles have been incorporated. This means all insurers are required to maintain proper litigation standards within the workers compensation system, and ensure system objectives are prioritised.</p> <p>The system objectives recognise that prompt, proactive and efficient action is needed to deliver optimal outcomes. Timely and efficient claims handling can reduce conflict, and allow more time to focus on worker and employer needs and outcomes.</p>	<p>Directions to insurers with respect to claims procedures:</p> <ul style="list-style-type: none"> 🚩 Section 194, 1987 Act <p>Claims administration manual:</p> <ul style="list-style-type: none"> 🚩 Section 192A, 1987 Act <p>Relevant links:</p> <ul style="list-style-type: none"> 🚩 SIRA strategic plan 2018 🚩 NSW workers compensation system objectives 🚩 NSW model litigant policy 🚩 Insurer claims management audit manual

Standard	Context	Relevant provisions
Standard 1 – Worker consent.	<p>Protecting a worker’s personal and health information and ensuring a worker’s consent is obtained prior to providing, obtaining or using information about a worker’s injury and recovery promotes trust and ensures the integrity of the system.</p> <p>Insurers must gain consent from a worker in order to exchange and receive information about their health, injury and recovery. This promotes good communication and transparent decision-making between the worker, employer and the return to work team.</p> <p>Informed consent is where a worker is properly and clearly informed about how their personal information will be handled before consenting to the release and exchange of information. It ensures the worker understands the benefits of providing consent and implications of not doing so.</p> <p>For claims where the SIRA <u>Worker’s injury claim form</u> has not been completed, it is likely worker consent would only be provided through the SIRA <u>certificate of capacity</u> (medical certificate for exempt workers). Consent provided on the claim form explains to the worker that it is current for the duration of the claim and not just for the period of the certificate of capacity (or medical certificate).</p> <p>Requests from third parties outside the claims management process (for example life insurance or superannuation providers) are not covered by the consent provided to manage the worker’s compensation claim.</p> <p>The insurer must ensure that the worker’s personal and health information is not obtained or disclosed without current and express consent.</p>	<p>Disclosure requirements:</p> <ul style="list-style-type: none"> 🚩 Section 243, 1998 Act <p>Obligation to provide authorisations:</p> <ul style="list-style-type: none"> 🚩 Section 270, 1998 Act <p>Relevant links:</p> <ul style="list-style-type: none"> 🚩 Improving worker access to information in the NSW workers compensation system 🚩 Privacy and Personal Information Protection Act 1998 🚩 Health Records and Information Privacy Act 2002 🚩 Government Information (Public Access) Act 2009 🚩 Australian Privacy Principles (for government agencies) 🚩 National Privacy Principles (for non-government business and entities)
Standard 2 – Worker access to personal information.	<p>Facilitating workers’ access their personal and health information empowers workers to contribute to decisions about their recovery and return to work.</p>	<p>Access to medical and other insurer reports:</p> <ul style="list-style-type: none"> 🚩 Section 126, 1998 Act

Standard	Context	Relevant provisions
	<p>NSW workers compensation legislation does not limit or prevent workers from exercising their rights under the relevant privacy laws to access their personal and health information.</p> <p>Consistent with relevant privacy principles and privacy laws in NSW and Australia, a worker's personal and health information held by insurers should be available to the worker at their request. While there are some exemptions to the general presumption of access, these exist in limited circumstances.</p> <p>Allowing workers access to information empowers them to manage their own injuries, as well as promote and participate fully in their return to health and work. Access to their personal and health information also ensures workers are informed throughout the claims process.</p> <p>Any grounds for caution regarding the release of information to a worker should be based on concerns regarding the safety and well-being of the worker or others.</p> <p>A worker's personal and health information should not be withheld because release of the information may be contrary to employer or insurer interests in the event of litigation (subject to legal professional privilege).</p>	<p>🚩 Clause 41, Part 9 of the Workers Compensation Regulation 2016</p> <p>Relevant links:</p> <p>🚩 Improving worker access to information in the NSW workers compensation system</p> <p>🚩 Privacy and Personal Information Protection Act 1998</p> <p>🚩 Health Records and Information Privacy Act 2002</p> <p>🚩 Government Information (Public Access) Act 2009</p> <p>🚩 NSW Information and Privacy Commission</p> <p>🚩 Office of the Australian Information Commissioner</p> <p>🚩 Australian Privacy Principles (for government agencies)</p> <p>🚩 National Privacy Principles (for non-government business and entities)</p>









Standard	Context	Relevant provisions
<p>Standard 3 - Initial liability decisions – general, provisional, reasonable excuse or full liability.</p>	<p>Making initial liability decisions promptly, in consultation with key stakeholders and based on all available evidence will ensure that workers and employers can focus on recovery and return to work.</p> <p>Liability decisions must be made in accordance with the legislation and informed by the careful consideration of all evidence. Key to the principles of fairness and transparency is the observation of procedural fairness and proactive consultation with the worker and employer.</p> <p>When determining initial liability for an injury, insurers are to gather the relevant evidence, consult with key stakeholders (including the employer and worker) and ensure that the decision is made in a timely manner and communicated appropriately.</p> <p>Insurers can accept liability for weekly benefits outright or they may accept liability on a provisional basis for a period of up to 12 weeks, having regard to the nature of injury and period of incapacity.</p> <p>Alternatively, the insurer can delay making a liability decision on the claim by applying a reasonable excuse to the claim if they have sufficient reason for doing so. Reasons for when a “reasonable excuse” are detailed in the <i>Workers compensation guidelines</i>.</p> <p>Once the reasonable excuse has been resolved, the insurer can either provisionally accept within seven days or, fully accept, or deny liability for the claim within 21 days.</p> <p>If a claim for weekly payments has been accepted provisionally, the insurer is required to determine the claim, by either accepting or disputing liability, before the end of the provisional period. This does not apply to claims finalised before the expiration of the provisional period.</p> <p>Proactive communication with the worker and the employer is an integral part of sound decision-making. Decisions need to be made in a fair and transparent manner – this requires full and open communication between stakeholders.</p>	<p>Requirement to contact stakeholders for significant injury to a worker:</p> <p>🚩 Section 43(4), 1998 Act</p> <p>Duty to commence weekly payments following initial notification of injury:</p> <p>🚩 Section 267, 1998 Act</p> <p>Insurer must notify worker of reasonable excuse for not commencing weekly payments:</p> <p>🚩 Section 268, 1998 Act</p> <p>Liability to be accepted and weekly payments commenced within 21 days:</p> <p>🚩 Section 274, 1998 Act</p> <p>Claims for medical expenses:</p> <p>🚩 Section 279(1), 1998 Act</p> <p>🚩 Section 280, 1998 Act</p> <p>Dispute notice requirements:</p> <p>🚩 Section 78, 1998 Act</p> <p>🚩 Clause 38, Workers Compensation Regulation 2016</p> <p>Commencing provisional weekly payments notice requirements:</p>

Standard	Context	Relevant provisions
		 Section 269, 1998 Act
Standard 4 - Liability for medical or related treatment.	<p>Making medical or treatment liability decisions promptly, in consultation with key stakeholders and based on all available evidence will reduce the likelihood of disputes and ensure workers can focus on recovery and return to work.</p> <p>Insurers are required to make liability decisions at various points during a claim. Each time a worker makes a claim for medical or related treatment, the insurer is required to determine liability in accordance with the legislation. Insurers are to gather the relevant evidence, consult with key stakeholders and ensure that the decision is soundly based, made in a timely manner and communicated appropriately.</p> <p>Liability decisions must be made in accordance with the legislation and informed through careful consideration of all evidence. Key to the principles of fairness and transparency is the observation of procedural fairness and proactive consultation with the worker and employer.</p> <p>NSW workers compensation legislation requires liability to be determined within 21 calendar days after a claim for medical expenses has been made. If the treatment requested is already covered under the pre-approval provisions of the Workers compensation guidelines, the worker and provider are to be informed to avoid unnecessary delay.</p> <p>Decisions should be made in a fair and transparent manner and include communication with the worker, nominated treating doctor and other relevant parties.</p>	<p>Timeframe for making a liability decision for medical expenses</p> <p> Section 279(1), 1998 Act</p> <p>Dispute notice requirements</p> <p> Section 78, 1998 Act</p> <p> Clause 38, Workers Compensation Regulation 2016</p>
Standard 5 - Recurrence or aggravation of a previous workplace injury.	<p>Insurers must have regard to the facts and medical evidence to properly determine whether an injury is a recurrence of a previously accepted workplace injury, or a new injury to a body part previously injured at work.</p> <p>The distinction between a recurrence of an injury and a new injury can be significant for workers and employers. The insurer's decision will impact the calculation of a worker's benefits and may be significant for an employer's premium. Determining whether the claim should be treated as</p>	<p>Definition of 'injury':</p> <p> Section 4, 1987 Act</p> <p>No compensation payable unless employment substantial contributing factor to injury:</p> <p> Section 9A, 1987 Act</p>

Standard	Context	Relevant provisions
	<p>a recurrence or a new injury requires a common-sense evaluation of the evidence.</p> <p>A recurrence occurs where, after a worker suffers a work-related injury, there is a later increase in symptoms or a re-emergence of symptoms needing treatment or causing incapacity. An example is a worker who is symptom-free for a period of time and then symptoms start again, whether or not this occurs at work. Provided the work-related injury caused or materially contributed to the further incapacity or need for treatment, liability should be accepted for a recurrence of the injury and the insurer should reactivate the original claim made by the worker.</p> <p>If a worker suffers a new work-related injury to a body part that has previously been injured at work, the insurer should decide which of the two injuries caused or materially contributed to the incapacity or need for treatment. For example, a worker may have had a work-related knee injury that has resolved. If the worker suffers a further injury to the knee at work and the medical evidence supports that the further injury was the cause of the incapacity or need for treatment, this should be accepted as a new claim.</p> <p>If both injuries contribute, it is preferable that the injury that was the most material of the contributors should be accepted. However, if acceptance of an injury as the main contributor would result in the worker not being entitled to compensation (for example, because of the expiry of a compensation period such as provided by section 39 or section 59A), careful consideration should be given to accepting the other injury if it also materially contributed to the incapacity or need for treatment.</p>	<p>Aggravation etc of diseases – employer liable, date of injury, etc:</p> <p>🚩 Section 16, 1987 Act</p> <p>Compensation to be apportioned where there is more than one injury:</p> <p>🚩 Section 22, 1987 Act</p>
Standard 6 – Recoveries.	<p>In certain circumstances, workers compensation insurers will be able to recover from other insurers or persons (third-parties) who share a proportion of liability for an injury.</p> <p>Enabling insurers to recover funds from third parties who share a proportion of the liability for an injury helps to ensure the sustainability of the workers compensation system.</p> <p>Early identification and effective management of third-party recoveries helps ensure the sustainability of the NSW workers compensation system.</p>	<p>Recovery against both employer and stranger:</p> <p>🚩 Section 151Z, 1987 Act</p>

Standard	Context	Relevant provisions
	<p>Insurers may also consider informing the worker or worker's representatives of the potential right to claim damages from a third-party.</p>	
<p>Standard 7 - Interim pre-injury average weekly earnings calculation.</p>	<p>Providing for an <i>interim</i> pre-injury average weekly earnings (PIAWE) calculation enables workers to be supported by commencement of weekly payments, even when the insurer has insufficient information to make a complete calculation. This ensures workers are not disadvantaged or experience delays in receiving weekly payments where the employer has not provided the required information to the insurer for the purposes of calculating pre-injury average weekly earnings (PIAWE).</p> <p>One of the key system objectives is to provide workers with income support during incapacity.</p> <p>Sometimes insurers are unable to calculate PIAWE within the required timeframe for the first weekly payment as they have insufficient information to correctly calculate it. In such instances insurers are to calculate an interim PIAWE to commence payments without delay.</p> <p>Where there is an interim PIAWE, and the employer does not respond to insurer requests for information, the insurer can contact SIRA on 13 10 50.</p>	<p>Insurer obligation to commence provisional weekly payments:</p> <ul style="list-style-type: none"> 🚩 Section 275, 1998 Act 🚩 Section 267, 1998 Act <p>Employer obligation to provide insurers with information:</p> <ul style="list-style-type: none"> 🚩 Section 264(2), 1998 Act <p>How a worker's PIAWE is calculated:</p> <ul style="list-style-type: none"> 🚩 Section 44C, 1987 Act 🚩 Section 44D, 1987 Act 🚩 Section 44E, 1987 Act 🚩 Section 44F, 1987 Act 🚩 Section 44G, 1987 Act 🚩 Section 44H, 1987 Act 🚩 Section 44I, 1987 Act 🚩 Schedule 3, 1987 Act
<p>Standard 8 - Insurer making weekly payments.</p>	<p>Weekly payment of compensation to workers may be made by the employer or the insurer.</p> <p>All stakeholders should be kept informed in cases where it is necessary for weekly payments to be processed directly by the insurer to the worker, to ensure the worker receives ongoing and timely support.</p>	<p>How workers are to be paid:</p> <ul style="list-style-type: none"> 🚩 Section 83, 1987 Act <p>Timing of payments to workers:</p>

Standard	Context	Relevant provisions
	<p>Insurers are responsible for ensuring workers receive correct weekly payments in a timely manner. In most cases the worker is paid by the employer. In some instances, it is appropriate for the insurer to make payments directly to the worker.</p> <p>In instances where it is appropriate that weekly payments be processed directly by the insurer to the worker, it is important to ensure that key stakeholders are kept informed of claim progress and remain aware of their obligations and responsibilities.</p>	<p>🚩 Section 84, 1987 Act</p>
Standard 9 - Reduction in payments of compensation.	<p>Workers need to be kept informed about their claim, particularly in circumstances where their entitlements are to be stepped down due to the application of the legislation.</p> <p>Where the workers compensation legislation provides for a reduction in weekly payments of compensation, insurers are required to provide affected workers with sufficient notification to prepare for the change in their weekly payments of compensation.</p>	<p>Weekly payments in second entitlement period (weeks 14-130):</p> <p>🚩 Section 37, 1987 Act</p> <p>Required period of notice does not apply to a reduction in weekly compensation due to the application of different rates of compensation after the expiration of earlier periods of incapacity for which higher rates were payable:</p> <p>🚩 Section 80(6), 1987 Act</p> <p>Definition – pre-injury average weekly earnings:</p> <p>🚩 Section 44C, 1987 Act</p> <p>For exempt workers – legislation as in-force prior to 19 June 2012</p> <p>Weekly payment during total incapacity – after first 26 weeks:</p>

Standard	Context	Relevant provisions
		<p>  Section 37, 1987 Act Partially incapacitated workers not suitably employed—special initial payments while seeking employment: </p> <p>  Section 38, 1987 Act Weekly payments during partial incapacity—general: </p> <p>  Section 40, 1987 Act </p>
Standard 10 - Payment of invoices and reimbursements.	<p>Prompt payment of invoices and reimbursements for medical, hospital and rehabilitation services ensures workers can remain focused on their recovery and helps to maintain the integrity of the system.</p> <p>In accordance with workers compensation legalisation, insurers are to pay invoices and reimbursements for medical, hospital and rehabilitation services promptly.</p> <p>NSW workers compensation legislation requires the prompt payment of compensation following the acceptance of liability for the service.</p> <p>The timely payment of invoices and reimbursements on all claims supports worker recovery through the development of trust and respect among treatment providers and other stakeholders.</p> <p>Non-payment of an invoice can be detrimental to the insurer-health practitioner relationship, negatively impacting worker recovery.</p>	<p>Definition of services:</p> <p>  Section 59, 1987 Act Compensation for cost of medical or hospital treatment and rehabilitation etc: </p> <p>  Section 60, 1987 Act Duty of insurer to pay promptly: </p> <p>  Section 74A, 1998 Act </p>
Standard 11 - Changes in capacity.	<p>There will be times when new information advising of a change in capacity comes to the attention of the insurer.</p> <p>It is important for work capacity assessments to be undertaken promptly following receipt of a certificate indicating a change in a worker's capacity, to ensure workers continue to receive appropriate compensation and support.</p>	<p>Work capacity assessment</p> <p>  Section 44A, 1987 Act </p> <p>Evidence as to work capacity:</p> <p>  Section 44B, 1987 Act </p>

Standard	Context	Relevant provisions
	<p>If a worker submits a certificate of capacity reflecting a change in capacity, an insurer must promptly conduct a work capacity assessment to investigate the reason for the change. The change in capacity may change the amount of the weekly payment of compensation payable to the worker.</p> <p>The insurer is required to consider this new information and review the worker's capacity for work (perform a work capacity assessment) and determine the worker's current work capacity. This work capacity assessment should involve talking to the nominated treating doctor about the change in capacity.</p> <p>A work capacity decision can be simple and based on available information (e.g. the certificate of capacity), or it can be more complex (e.g. to determine what is suitable employment where the worker has some capacity but cannot return to their pre-injury employment). A more complex work capacity assessment may require the sourcing of additional information through assessments such as a functional or vocational assessment.</p> <p>The outcome of the work capacity assessment may or may not change the amount of weekly payments the worker receives, however, when an insurer makes a decision about a worker's current work capacity they are making a work capacity decision.</p> <p>The insurer is required to inform the worker of the outcome of the work capacity assessment and decision, and clearly communicate changes (if any) to the amount of weekly payments. The information must also advise the worker of the review options available if they do not agree with the decision.</p> <p>An insurer can advise the worker of the work capacity decision in different ways. Where the decision doesn't change the amount of weekly payments the worker receives, the worker should be contacted to inform them of the decision, and their right to request an internal review if they do not agree with the decision. This conversation should be noted in the worker's file.</p> <p>Where the decision reduces or discontinues payment of weekly payments to a worker, then communication to the worker must be in person or by post and should be communicated by telephone as well.</p>	<p>Work capacity decisions by insurers:</p> <p>🚩 <u>Section 43(1), 1987 Act</u></p>

Standard	Context	Relevant provisions
Standard 12 - Injury management plans.	<p>The development of an injury management plan to coordinate and manage the treatment, rehabilitation, and if necessary, retraining of a worker, supports the achievement of a timely, safe and durable return to work.</p> <p>NSW workers compensation legislation requires the development of an injury management plan when it appears that a workplace injury is a 'significant injury' as defined in section 42(1) of the 1998 Act.</p> <p>An injury management plan is a comprehensive plan for managing a worker's injury or condition. It provides details on treatment and rehabilitation as well as strategies to support the worker's recovery at/return to work.</p> <p>An injury management plan should provide the stakeholders (specifically the worker) with the information they need to understand the direction of injury management and the activities required to help the worker recover at work.</p>	<p>Workplace injury management:</p> <ul style="list-style-type: none"> 🚩 Chapter 3, 1998 Act <p>Requirement to develop an injury management plan:</p> <ul style="list-style-type: none"> 🚩 Section 45, 1998 Act <p>Definition of 'significant injury':</p> <ul style="list-style-type: none"> 🚩 Section 42, 1998 Act <p>Relevant links:</p> <ul style="list-style-type: none"> 🚩 Health benefits of good work, Royal Australian College of Physicians
Standard 13 - Additional or consequential medical conditions.	<p>It is important that prompt and proactive consideration is given to the development of additional or consequential medical conditions to ensure workers continue to receive appropriate compensation and support.</p> <p>As claims progress, it is not uncommon for additional medical conditions or consequential conditions to be added to a certificate of capacity. This may have an impact on the management of a claim including the need for treatment, and the worker's degree of permanent impairment. Insurers should be proactive in their review of certificates of capacity.</p> <p>If the additional medical condition or consequential condition is accompanied by a request for treatment, the insurer must make a liability decision within 21 calendar days to determine if the employer is liable for costs and expenses related to the condition.</p> <p>Insurers need to be aware of any medical condition which may impact a worker's recovery at/return to work, whether work-related or not.</p> <p>Properly responding to additional information on the certificate of capacity confirms to the worker and nominated treating doctor that</p>	<p>Compensation the employer is liable to pay:</p> <ul style="list-style-type: none"> 🚩 Section 60, 1987 Act <p>Determine within 21 days:</p> <ul style="list-style-type: none"> 🚩 Section 279, 1998 Act

Standard	Context	Relevant provisions
	<p>requests for reasonably necessary treatment will be considered without delay.</p> <p>If the additional or consequential medical condition is not work-related, prompt action by the insurer enables the treating doctor to appropriately manage the non-work-related medical condition.</p>	
<p>Standard 14 - Referral to an injury management consultant.</p>	<p><u>Injury management consultants</u> (IMCs) should be used to provide expert advice and assistance regarding a worker's recovery at/ or return to work.</p> <p>An IMC is a registered medical practitioner experienced in occupational injury and workplace-based rehabilitation. An IMC can help progress a worker's recovery at/return to work through communication with the Nominated Treating Doctor and other stakeholders as required.</p> <p>Referral to an IMC is appropriate when a worker is identified as at risk of delayed recovery or there is a specific return to work or injury management issue.</p> <p>An IMC helps the nominated treating doctor, worker, insurer and employer progress a worker's recovery at/return to work and optimise health and work outcomes. An IMC is to assess the situation, examine the worker (if necessary), and discuss possible solutions with all parties (specifically the nominated treating doctor). IMCs are not involved in the treatment of a worker, though they may comment on treatment in respect to recovery at/return to work. The IMC may also visit the workplace.</p> <p>An IMC does not provide an opinion on causation or liability; or undertake a functional capacity evaluation or work capacity assessment for the insurer.</p> <p>The worker and the nominated treating doctor are to be provided with information about the role of the IMC and the consultation process.</p> <p>Consultation with an IMC is not an examination under <u>section 119</u> of the 1998 Act and there is no impact on benefits or entitlements if the worker elects not to participate.</p>	<p>Injury management consultants:</p> <p>🚩 <u>Section 45A, 1998 Act</u></p>

Standard	Context	Relevant provisions
Standard 15 - Approval and payment of medical, hospital and rehabilitation services.	<p>Prompt approval and payment for medical, hospital and rehabilitation services ensures workers can remain focused on their recovery and helps to maintain the integrity of the system.</p> <p>Insurers are responsible for the approval and payment for treatment and services during the worker's claim.</p> <p>Key to managing provider services is ensuring that the services under consideration are:</p> <ul style="list-style-type: none"> • provided by an appropriately qualified provider • reasonably necessary because of the injury • cost-effective, and • progress or promote the worker's recovery. <p>SIRA recommends considering the five principles outlined in the Transport Accident Commission (TAC) and Worksafe Victoria's <u>Clinical framework for the delivery of health services</u> as an effective method to ensure active management of a provider. These principles require the provider to:</p> <ul style="list-style-type: none"> • measure and demonstrate the effectiveness of the intervention • adopt a biopsychosocial approach • empower the person to manage their recovery • implement goals focused on optimising function, participation and return to work • base intervention on the best available research evidence. <p>Where the insurer is uncertain of the value of requested treatment or services they may seek guidance from a SIRA-approved independent consultant.</p> <p>In approving services provided by a third-party, the insurer must ensure the injury management plan is updated where necessary. They must also actively engage all stakeholders to achieve the expected outcome from the approved service.</p>	<p>Definitions:</p> <ul style="list-style-type: none"> ▀ <u>Section 59, 1987 Act</u> <p>Compensation for cost of medical, hospital and rehabilitation etc:</p> <ul style="list-style-type: none"> ▀ <u>Section 60, 1987 Act</u> <p>Relevant links:</p> <ul style="list-style-type: none"> ▀ <u>Workers Compensation Fees Orders</u> ▀ <u>Guidelines for claiming workers compensation</u> ▀ <u>Clinical framework for the delivery of health services, TAC and Worksafe Victoria</u> ▀ <u>Health benefits of good work, Royal Australian College of Physicians</u> ▀ <u>Nationally consistent approval framework for workplace rehabilitation providers</u> ▀ <u>NSW supplement to the Guide: Nationally consistent approval framework for workplace rehabilitation providers</u>

Standard	Context	Relevant provisions
	To ensure cost-effective service provision and payment in-line with legislative requirements, insurers should actively review billing and rates when paying for services.	
Standard 16 - Case conferencing.	<p>Effective injury management is a coordinated effort involving the worker, employer, nominated treating doctor and others, such as a workplace rehabilitation provider. Communication between these stakeholders should be transparent and collaborative.</p> <p>A worker's scheduled medical review with their nominated treating doctor is confidential and does not involve other stakeholders. However, the involvement of other parties in the recovery process can assist and promote the worker's recovery to good health and to work.</p> <p>A case conference is a meeting (either in-person or over the phone) with the worker, the nominated treating doctor and either some, or all, of the other members of the support team such as the insurer, employer and a workplace rehabilitation provider.</p> <p>A case conference can be used to set goals, ensure roles and responsibilities are understood, and to agree on timeframes for recovery at/return to work.</p> <p>A case conference is separate to the worker's scheduled medical review. If a stakeholder requests the insurer arrange a case conference, a separate appointment should be made for it. This is usually adjacent to the worker's scheduled medical review but also may be at another time and/or date.</p> <p>There may be limited circumstances where this is not possible, for instance, rural or remote locations with limited availability. The insurer should liaise with the worker to identify an appropriate alternative, which may include conducting the case conference via video or conference call, or obtaining the worker's agreement to attend their scheduled consultation.</p>	Nil.
Standard 17 - Section 39 notification.	Workers affected by the 260-week (five year) limit to weekly payments under <u>section 39</u> of the 1987 Act should be provided with appropriate notification before the cessation of weekly payments.	Cessation of weekly payments after 260 weeks (5 years):

Standard	Context	Relevant provisions
	<p>Throughout the life of the claim, the insurer is required to communicate regularly with the worker, employer and stakeholders regarding the number of weeks paid.</p> <p>Insurers should start planning well in advance for cases where a worker is approaching 260 weeks of weekly payments. Communications should clearly inform how the insurer has counted the entitlement weeks so that it can be easily understood.</p> <p>Providing early notification prior to cessation of weekly payments helps to ensure that workers have sufficient time to prepare for cessation and make any necessary arrangements.</p>	<p>🚩 Section 39, 1987 Act</p>
Standard 18 - Retiring age notification.	<p>Workers can receive weekly payments up until the one-year anniversary of reaching retiring age.</p> <p>Workers injured after retiring age are limited to weekly payments for up until 12 months after the date of first incapacity.</p> <p>The insurer is required to communicate regularly with the worker, employer and other relevant stakeholders throughout the life of the claim. Workers should be provided with appropriate notification prior to the cessation of weekly payments.</p> <p>Providing early notification prior to cessation of weekly payments helps to ensure that workers have sufficient time to prepare for cessation and make any necessary arrangements.</p>	<p>Termination of weekly payments on retiring age:</p> <p>🚩 Section 52, 1987 Act</p> <p>Relevant links:</p> <p>🚩 Age pension eligibility, Department of Human Services</p>
Standard 19 - Section 59A notification.	<p>Most workers are entitled to either two or five years of reasonably necessary medical treatment and services after their claim was first made, or from the date the worker's weekly payments stopped being payable, whichever is the later.</p> <p>Medical and related treatment may be necessary to:</p> <ul style="list-style-type: none"> • maintain wellbeing, as opposed to rehabilitation and/or return to work, or 	<p>Limit on payment of compensation:</p> <p>🚩 Section 59A, 1987 Act</p>



Standard	Context	Relevant provisions
	<ul style="list-style-type: none"> develop appropriate strategies and pathways for a worker's recognised injury and/or degree of permanent impairment, to ensure any specific or specialised dependency need is supported. <p>Workers may still require access to medical and related treatment after they cease to be entitled to medical and related expenses under the workers compensation legislation.</p> <p>In these circumstances, it is our expectation that insurers provide necessary support to help determine where a worker can access services through the public/private system, and help them transition either during or on conclusion of the entitlement period.</p>	
Standard 20 - Permanent impairment assessment reports.	<p>Permanent impairment assessment reports must be objectively reviewed for accuracy and consistency with claim records.</p> <p>. This report is referred to in the legislation (section 73 of the 1987 Act) as a permanent impairment medical certificate.</p> <p>A report of the assessment of permanent impairment may be obtained by the worker or insurer to certify that the worker has received a work-related injury resulting in permanent impairment, and the degree of permanent impairment resulting from the work-related injury.</p> <p>The medical assessor must have successfully completed requisite training in using the NSW workers compensation guidelines for the evaluation of permanent impairment (that is in effect at the time of the assessment) for each body system they assess. These trained assessors are listed on the SIRA website.</p> <p>A report of the assessment of permanent impairment may be used to:</p> <ul style="list-style-type: none"> claim non-economic loss compensation provide evidence of reaching or surpassing a threshold to be entitled to certain ongoing or extended compensation claim damages, or seek to commute liability for a claim. <p>The permanent impairment assessment should contain factual information based on medical information and investigations, as well as the assessor's</p>	<p>Permanent impairment medical certificate:</p> <p>🚩 Section 73, 1987 Act</p> <p>Relevant particulars about a claim:</p> <p>🚩 Section 282, 1998 Act</p> <p>Assessment of impairment:</p> <p>🚩 Section 322, 1998 Act</p> <p>Relevant links:</p> <p>🚩 NSW workers compensation guidelines for the evaluation of permanent impairment 4th edition</p>

Standard	Context	Relevant provisions
	<p>history-taking and clinical examination. Other medical information, reports or investigations that are reviewed by the assessor must be referenced in the report. These facts should be thoroughly checked by the insurer.</p> <p>Note: There are three permanent impairment methods of assessment:</p> <ul style="list-style-type: none"> • assessment under the 1926 Act, using the Table of Maims • assessment under the 1987 Act, using the Table of Disabilities, which applies to injuries received from 4:00 pm on 30 June 1987 to 31 December 2001, and • assessment under the 1998 Act, using AMA 5 as modified by the NSW workers compensation guidelines for the evaluation of permanent impairment, which applies to injuries received on or after 1 January 2002. <p>The assessment under each method differs and there are different entitlements attached to each assessment. This Standard primarily addresses assessments of injuries received on or after 1 January 2002.</p>	
<p>Standard 21 - Negotiation on degree of permanent impairment.</p>	<p>Insurers and workers are not precluded from reaching an agreement on a worker's degree of permanent impairment.</p> <p>Seeking to reach agreement on the degree of permanent impairment can reduce time, costs and the likelihood of disputes.</p> <p>An agreed degree of permanent impairment must be confirmed through a complying agreement. Where a worker enters into a complying agreement, <u>section 66A(3)</u> of the 1987 Act gives power to the <u>Workers Compensation Commission</u> (the Commission) to award additional compensation subject to the provisions of <u>section 66(1A)</u> of the 1987 Act.</p>	<p>Determination of degree of permanent impairment:</p> <p>🚩 <u>Section 65, 1987 Act</u></p> <p>Agreements for compensation:</p> <p>🚩 <u>Section 66A, 1987 Act</u></p> <p>No proceedings to enter up award on agreement for compensation:</p> <p>🚩 <u>Section 66B, 1987 Act</u></p> <p>Reimbursement for costs of medical certificate and examination:</p> <p>🚩 <u>Section 73, 1987 Act</u></p>

Standard	Context	Relevant provisions
		<p>Claims for lump sum compensation and work injury damages:</p> <p>🚩 Division 4, Part 3, Chapter 7, 1998 Act</p> <p>Medical assessment:</p> <p>🚩 Part 7, Chapter 7, 1998 Act</p>
Standard 22 - Insurer participation in disputes and mediations.	<p>The Workers Compensation Commission (the Commission) is required to use its best endeavours to bring the parties to a dispute to a settlement/agreement.</p> <p>Fully informed and good-faith participation in Commission dispute resolution processes can assist the timely and effective resolution of disputes.</p> <p>In representing the employer in a dispute, the insurer is required to genuinely participate in the Commission disputes and mediations.</p>	<p>Offence of referring non-genuine disputes:</p> <p>🚩 Section 285, 1998 Act</p> <p>Duties of insurer when dispute referred to Commission:</p> <p>🚩 Section 291, 1998 Act</p> <p>Arbitrator to attempt conciliation:</p> <p>🚩 Section 355, 1998 Act</p> <p>Representation before Commission:</p> <p>🚩 Section 356, 1998 Act</p> <p>Objectives of the Commission:</p> <p>🚩 Section 367, 1998 Act</p> <p>Subrogation:</p> <p>🚩 Clause 12, Schedule 3, Workers Compensation Regulation 2016</p>

Standard	Context	Relevant provisions
Standard 23 - Recovery of overpayments due to insurer error.	<p>Insurers should have processes in place to minimise any risk of overpayment or duplication of payments to workers. In instances where there may be an overpayment, this is to be managed in a fair and transparent manner.</p> <p>Managing overpayments to workers in a fair and transparent manner, and in accordance with the law contributes to the viability of the system and minimises the likelihood of the relationship between the insurer and the worker being placed at risk.</p> <p>If the overpayment is due to a return to work impacting the worker's earnings, the insurer can seek an order for recovery from the <u>Workers Compensation Commission</u> (the Commission).</p> <p>The Commission may also make such orders as it thinks fit for the adjustment of weekly payments to a worker to take account of any overpayments in respect of any previous period. When the overpayment has arisen from fraud, SIRA may issue the order for recovery.</p> <p>Overpayments to a worker resulting from insurer error are only to be recovered with informed and written consent of the worker.</p>	<p>Order for refund of overpayments of compensation:</p> <p>🚩 Section 235D, 1998 Act</p> <p>Refund of weekly payments paid after return to work etc:</p> <p>🚩 Section 58, 1987 Act</p>
Standard 24 - Factual investigations.	<p>Factual investigations play an important role in the workers compensation scheme; however, they can erode worker trust and must therefore be used judiciously.</p> <p>Factual investigations involve the use of a third-party service provider to conduct an investigation to determine the available facts of a claim.</p> <p>Factual investigations may be used to gather information to inform decision-making with respect to liability and other entitlements. Circumstances under which a factual investigation may be warranted include but are not limited to:</p> <ul style="list-style-type: none"> • determining if a worker meets the legislative definition of a worker • where the issues surrounding the injury are unclear or disputed, or • when there may be potential for recovery from a third-party. <p>A factual investigation may involve an interview with the worker, employer and/or witnesses, as well as a physical inspection or other external</p>	<p>Relevant links:</p> <p>🚩 Commercial Agents and Private Inquiry Agents Act 2004</p> <p>🚩 Commercial Agents and Private Inquiry Agents Regulation 2017</p> <p>🚩 Surveillance Devices Act 2007</p> <p>🚩 Workplace Surveillance Act 2005</p>

Standard	Context	Relevant provisions
	<p>enquiries required to determine relevant details. Factual investigators are not to provide an opinion on medical aspects of the claim.</p> <p>Factual services should only be used when necessary and should be conducted in an ethical manner. Any information obtained must be used and stored appropriately.</p>	
Standard 25 - Surveillance.	<p>Surveillance may be used to gather information to inform decision-making with respect to liability and other entitlements.</p> <p>Surveillance plays a small but important role in the workers compensation scheme; however, it can significantly erode worker trust and must therefore be used judiciously.</p> <p>Surveillance refers to the covert monitoring and recording of behaviour using photography, video recording, direct observations and social media monitoring. Surveillance is used to observe and record a worker's activities and capabilities.</p> <p>Surveillance services should only be used when information is required that cannot be obtained from other, less intrusive, means. The insurer is to rely on sound information when identifying the need for surveillance and is not to rely on hearsay, innuendo or rumour.</p> <p>Surveillance is to be conducted in an ethical manner and any information obtained is to be used and stored appropriately.</p>	<p>Relevant links:</p> <ul style="list-style-type: none"> 🚩 Commercial Agents and Private Inquiry Agents Act 2004 🚩 Commercial Agents and Private Inquiry Agents Regulation 2017 🚩 Surveillance Devices Act 2007 🚩 Workplace Surveillance Act 2005
Standard 26 - Arrangement for payments to Medicare Australia.	<p>Proactive advice to Medicare and correct attribution of the payment of medical costs, allows insurers to make prompt payment of entitlements and reduces the risk that a worker is inadvertently subject to recovery action from Medicare Australia.</p> <p>The Health and Other Services (Compensation) Act 1995, applies when a person receives eligible benefits provided through Australian Government programs, including Medicare benefits</p> <p>A Medicare request for notice of past benefits is required when a payment greater than \$5,000 is likely and medical services for a work-related injury may have been paid by Medicare Australia.</p>	<p>Relevant links</p> <ul style="list-style-type: none"> 🚩 Medicare compensation recovery 🚩 Health and Other Services (Compensation) Act 1995

Standard	Context	Relevant provisions
	<p>The Health and Other Services (Compensation) Act 1995, applies when a person receives eligible benefits provided through Australian Government programs, including Medicare benefits.</p> <p>In accordance with this Act, the compensation payer (usually the insurer) must tell the Department of Human Services:</p> <ul style="list-style-type: none"> • within 28 days from the date of a judgment or settlement • when settlement fixes the value of compensation awarded at more than \$5,000 including all costs, or • when a reimbursement arrangement is made more than six months from the date the claim was made. 	
<p>Standard 27 - Notification and recovery of Centrelink benefits from lump sum payments.</p>	<p>Prompt advice to Centrelink and correct attribution of lump sum payments helps insurers make prompt payment of entitlements. This reduces the risk of a worker becoming inadvertently subject to recovery action from Centrelink.</p> <p>An insurer is required to notify Centrelink where lump sum workers compensation payments of weekly benefits made to workers may include amounts repayable to Centrelink, or result in a preclusion period for access to Centrelink benefits. Under Commonwealth law insurers are required to notify Centrelink before paying lump sum compensation payments of weekly benefits, and pay any amounts payable to the Commonwealth.</p> <p>Insurers are also required to notify Centrelink immediately where a preclusion period from Centrelink entitlements may apply.</p> <p>Note: There is no requirement to advise Centrelink of lump sum payments for permanent impairment.</p>	<p>Relevant links:</p> <p> Centrelink compensation recovery</p>
<p>Standard 28 - Interpreter services.</p>	<p>Appropriate use of interpreters ensures equitable services for workers whose first language is not English or who are hearing-impaired.</p> <p>To ensure equal access to services for which workers are eligible, an insurer is required to engage appropriately qualified interpreter services in the worker's nominated language, dialect (and gender, where requested).</p>	<p>Compensation for cost of interpreter services:</p> <p> Section 64A, 1987 Act</p> <p>Provision of interpreter services:</p>

Standard	Context	Relevant provisions
	<p>Workers from culturally and linguistically diverse backgrounds may face additional difficulties in navigating the workers compensation system. Being injured at work and making a claim for workers compensation may involve new and unfamiliar concepts that are compounded if English is not the worker's first language.</p> <p>The appropriate use of interpreters enables an equitable service and experience for workers where English is not their first language. The use of an independent qualified interpreter also allows for impartial and confidential communications to a worker.</p> <p>Workers who require <u>Auslan</u> interpretation are also covered by this Standard of practice.</p>	<p>🚩 Section 23, 1998 Act</p> <p>Relevant links:</p> <p>🚩 National Accreditation Authority for Translators and Interpreters</p>
<p>Standard 29 - Cross-border provisions.</p>	<p>Correct application of cross-border provisions helps to ensure prompt payment of entitlements, to enable workers to focus on recovery and return to work.</p> <p>Where a worker works across more than one State or Territory, insurers are required to apply the 'State of connection' provisions to determine whether the worker's employment is connected with the state of New South Wales (NSW). If not, they must be referred to the relevant State or Territory Authority.</p> <p>If a worker works in more than one State or Territory, a series of tests are to be applied to determine a worker's 'State of connection'.</p> <p>These tests apply to a particular contract or term of employment for a worker. The tests are cascading and should be considered and applied when an insurer becomes aware that a worker may work in employment other than exclusively in NSW.</p> <p>The cascading test means that if the first test is satisfied there is no need to consider the second test, and so on.</p>	<p>Liability for compensation</p> <p>🚩 Section 9AA, Workers Compensation Act 1987</p> <p>🚩 Section 9AB, Workers Compensation Act 1987</p> <p>Relevant links</p> <p>🚩 SIRA's Cross border arrangements for workers compensation</p>
<p>Standard 30 - Closing a claim.</p>	<p>Before closing a claim, insurers should ensure that all activities have been completed and relevant stakeholders (including service providers) have been notified that the claim is to be closed.</p>	<p>Nil.</p>

Standard	Context	Relevant provisions
	<p>Appropriate consultation should occur with relevant stakeholders prior to the closure of a claim.</p> <p>The reasons and implications of the closure are to be clearly communicated to all relevant stakeholders. Clear communication is required to ensure fairness and transparency and that stakeholders are not disadvantaged during the process.</p>	
Standard 31 - Death claims.	<p>If a worker dies because of a work-related injury or disease, compensation is payable.</p> <p>Death claims require proactive and sensitive management to ensure families and others are provided with appropriate support.</p> <p>If a work injury results in the worker's death, his/her dependant(s) or estate is entitled to be paid the compensation. Entitlements can include:</p> <ul style="list-style-type: none"> • a lump sum death benefit apportioned among dependants (or if no dependants, to the deceased's estate) • weekly compensation for dependent children • reasonable funeral expenses, and • compensation for the expense of transporting the body to the deceased's usual place of residence or an appropriate place for its burial or cremation. <p>Some death claims are clearly work-related while for others, the nexus between death and work may not be clear. Insurers are to review all deaths that may be work-related that they become aware of (whether or not a claim has been made).</p> <p>Death claims require proactive and sensitive management to ensure dependants are provided with appropriate support, and delays are minimised. Insurers can help the <u>Workers Compensation Commission</u> (the Commission) and families to reduce delay and legal costs.</p>	<p>Relevant provisions:</p> <p>Death of a worker leaving dependents:</p> <p>🚩 Section 25, 1987 Act</p> <p>Funeral expenses:</p> <p>🚩 Section 26, 1987 Act</p> <p>Expenses of transporting body:</p> <p>🚩 Section 28, 1987 Act</p> <p>Apportionment of payments between dependents:</p> <p>🚩 Section 29, 1987 Act</p> <p>🚩 Section 30, 1987 Act</p> <p>Payment in respect of dependent children:</p> <p>🚩 Section 31, 1987 Act</p> <p>Payment where no dependants:</p> <p>🚩 Section 32, 1987 Act</p> <p>Payments to NSW Trustee for benefit of beneficiary:</p>

Standard	Context	Relevant provisions
		<p> Section 85, 1987 Act</p> <p>Payment of benefits to beneficiaries:</p> <p> Section 85A, 1987 Act</p> <p>Relevant links:</p> <p> Workers Compensation Commission Registrar's Practice guide for death claims</p>

Appendix 2 – Practice guidance

Contents

Worker access to personal and health information	72
Overview.....	72
Rights of the worker	72
Specific requirements for medical reports	73
Access and release.....	73
Proactive release of information	74
Exemptions.....	74
Security of personal information.....	74
Complaints	75
Pre-approval of treatment.....	76
Overview.....	76
Informing workers and service providers of approval.....	79
Disputed matters.....	80
Medical treatment and services requiring prior approval	80
Timeframe for treatment approval.....	80
Disputing treatment.....	81
Rehabilitation services during case management.....	82
Overview.....	82
Making a referral to a workplace rehabilitation provider	82
Approving a rehabilitation plan	83
Fees and invoices.....	83
Complaints about a provider	84
Provider attendance at worker medical consultations.....	84
Making weekly payments.....	85
Overview.....	85
When an insurer may make payments directly to the worker	85
Insurer actions when making weekly payments to the worker	85
Written advice to the employer and worker.....	86
Weekly payments after the second entitlement period.....	87
Overview.....	87
Work capacity assessment	87
No current work capacity.....	87
Current work capacity	87
Applying to the insurer.....	88
Working 15 hours per week and earning at least \$190 (as indexed).....	88

Current available evidence	88
Capacity for employment.....	89
Where a worker provides more information to show they satisfy the requirements	89
Review of an insurer's work capacity decision	90
Payments to workers with highest needs.....	91
Overview.....	91
June 2012 workers compensation reforms	91
2015 benefit reforms.....	91
Special provision for workers with highest needs	92
When the special provision does not apply	92
Entitlement to weekly payments	92
Example.....	93
Payments to Medicare Australia	94
Overview.....	94
Claim for a lump sum greater than \$5,000 initiated	94
Medical services for a work-related injury paid by Medicare	94
Recovery of Centrelink benefits from lump sum payments	96
Overview.....	96
Lump sums for arrears or future weekly payments	96
Arrears and Workers Compensation Commission matters	97
Lump sum payments, lost earnings and lost capacity to earn.....	97
Death claims	98
Overview.....	98
Entitlements	98
Determining whether death results from an injury	99
Worker	99
Injury	99
Causation.....	99
Intentional self-inflicted injury	99
Information to determine liability	100
Role of the Coroner	101
Dependency	101
Information to determine dependency	102
Apportionment.....	102
Payment of compensation.....	104
Interest.....	104

Worker access to personal and health information

References

- ❏ [Section 126, Workplace Injury Management and Workers Compensation Act 1998](#)
- ❏ [Clause 41, Workers Compensation Regulation 2016](#)
- ❏ [Privacy and Personal Information Protection Act 1998](#)
- ❏ [Health Records and Information Privacy Act 2002](#)
- ❏ [Government Information \(Public Access\) Act 2009](#)
- ❏ [Health privacy principles](#)
- ❏ [Australian privacy principles](#) (for government agencies)
- ❏ [National privacy principles](#) (for non-government business and entities)
- ❏ [Privacy Act 1988](#) (Commonwealth)

Overview

Allowing workers access to their own personal and health information ensures they are informed throughout the claims process. It also promotes their full participation during injury management.

NSW workers compensation legislation provides for worker access to certain types of information. However, the workers compensation legislation does not limit or prevent a worker from exercising their rights under relevant privacy laws to access their personal and/or health information. Under these laws, a worker can request access to information at any time.

Consistent with relevant privacy principles and privacy laws in NSW and Australia, a worker's personal and health information held by insurers should be available to the worker at their request. While there are some exemptions to the general presumption of access, these exist in limited circumstances.

Insurers are to comply with relevant privacy laws and should have processes in place to facilitate worker access.

Rights of the worker

Insurers and employers all have obligations to comply with NSW and Federal privacy laws, that deal with the collection, use, storage and disclosure of personal and health information and, how they will obtain consent from the individual.

The privacy law(s) that may apply will vary depending on the insurer type and the type of information being dealt with. For example, the [Privacy and Personal Information Protection Act 1998](#) (PPIP Act) and [Government Information \(Public Access\) Act 2009](#) (GIPA Act) apply to the Nominal Insurer. However, many employers and other insurers may be bound by the Commonwealth [Privacy Act 1988](#). The [Health Records and Information Privacy Act 2002](#) (HRIP Act) applies more broadly to any organisation in NSW, however is limited to health information.

Generally, the principles outlined in these laws provides that the worker has the right to:

- know why personal and health information is being collected, how it will be used and who it will be disclosed to
- ask for access to personal information (including health information)
- ask for incorrect personal and health information to be corrected
- make a complaint about an entity if there is a belief that personal or health information may have been mishandled.

Information collected about a worker falls into two broad categories - **personal information** and **health information**. It is the insurer's responsibility to be aware of and comply with relevant privacy laws. Insurers should have processes in place to meet their obligations and to facilitate worker access. Further information regarding privacy laws is available from the [NSW Information Privacy Commission](#) and the [Office of the Australian Information Commissioner](#).

Specific requirements for medical reports

In addition to the general provisions under privacy legislation, [section 126 of the 1998 Act](#) requires the employer or insurer to release medical reports to a worker if those reports are to be relied upon in a dispute.

[Clause 41 of the 2016 Regulation](#) requires the inclusion of other documents that the insurer has relied upon in a dispute. This includes certificates of capacity, clinical notes, investigator reports, workplace rehabilitation provider reports, and other reports obtained or provided to the insurer.

Access and release

'Standard of practice 2: Worker consent' outlines expectations for insurers regarding worker access to information. It states insurers are expected to:

- advise workers of their right to access their personal and health information
- promptly respond to any request by the worker or their representative for information contained in the insurer's claim file
- ensure third-party providers are aware that any report they provide in relation to a worker, may be released to that worker.

Insurers should have appropriate claims handling processes and procedures in place to ensure the above requirements are met, and to deal with a worker request to access their personal and health information.

These processes and procedures should be developed to:

- provide workers with access (where appropriate) without unnecessary delay or cost
- inform third-party providers that information may be released to the worker at the time of referral, and prior to the preparation of the report
- ensure appropriate record-keeping on a claim, including:
 - evidence of the request made by the worker
 - what personal and health information has been requested
 - the insurer response to the worker, including what information has been released and the date of release
- ensure that any personal information collected, used or disclosed is accurate, complete, and current.

In some circumstances, it may be reasonable for the insurer to require the worker to forward a written request supported by identity verification before releasing the worker's personal or health information.

Proactive release of information

In demonstrating commitment to claims management transparency and participation, insurers should support the proactive release of information where this will help return to work and injury management.

Workers have a right to be informed and educated about their injury, and therefore be empowered to participate in injury management.

Access only in the event of a dispute may disadvantage a worker in the claims process and has the potential to cause reactive rather than co-operative behaviour in injury management and hinder return to work objectives.

Exemptions

If the insurer determines that releasing information to the worker would pose a serious threat to the life or health of the worker or any other person, the insurer can release the information in accordance with clause 41(5) of the 2016 Regulation.

In this situation the insurer may instead supply medical reports to a medical practitioner nominated by the worker for that purpose or in any other case, to the worker's legal representative.

Insurers are encouraged to contact the medical practitioner and/or legal representative to discuss the release of the information, including any particular concerns with respect to the safety and well-being of the worker or others. All actions taken by the insurer should be clearly and accurately documented on the claim file.

Insurers may also assess whether exemptions apply in accordance with the other relevant privacy legislation.

Any grounds for caution regarding the release of information to a worker should be based on concerns regarding the safety and well-being of the worker or others. A worker's personal and health information should not be withheld arbitrarily however legal professional privilege may apply in certain circumstances.

If the insurer decides not to provide access to personal information, there should be written reasons for the denial of access or refusal provided to the worker. The rationale for the decision should be clearly noted on the claims file. A worker may have a right to have that decision reviewed through the NSW Civil and Administrative Tribunal.

Security of personal information

Personal and health information is collected and stored to enable the insurer to process, assess and manage a worker's compensation claim and to verify any evidence that may be submitted in support of a claim.

Internal procedures should ensure the safe handling and storage of all personal information including procedures for safe custody and transit. Insurers are to take reasonable steps to protect personal information from misuse and loss and from unauthorised access, interference, modification and disclosure.

All information entrusted to the insurer must be securely stored in physical and electronic form. Where the personal information is no longer required, reasonable steps

are to be taken to secure, destroy or permanently de-identify that information in accordance with the law.

Complaints

Insurers should provide workers with information on the complaints process (including how to lodge a complaint) in case the worker is not satisfied with the insurer's response to a request for access to personal or health information.

Insurers should recommend a worker contact the insurer, in the first instance, to discuss a complaint and provide an opportunity for the matter to be resolved.

Note: new pathways are available for enquiries and complaints from 1 January 2019.

Workers with an unresolved enquiry, or complaint about the insurer, can contact Workers Compensation Independent Review Office (WIRO) on 13 94 76 or contact@wiro.nsw.gov.au.

Employers or other stakeholders with an unresolved enquiry or complaint, or workers with a complaint about their employer or provider can contact SIRA on 13 10 50 or contact@sira.nsw.gov.au.

Workers can also make a complaint to the Office of the Australian Information Commissioner (OAIC) about the handling of their personal information by private sector organisations covered by the Commonwealth *Privacy Act 1988*.

The NSW Information Privacy Commissioner receives complaints from members of the public regarding alleged breaches of privacy (the violation of, or interference with, an individual's privacy), which may be dealt with under the *Privacy and Personal Information Protection Act 1998* or, in certain circumstances, the *Health Records and Information Privacy Act 2002*.

Pre-approval of treatment

References

- Part 4.1, *Workers compensation guidelines*
 - Section 60(2A), *Workers Compensation Act 1987*
-

Application to exempt workers

There is no requirement for exempt workers to seek pre-approval for treatment, however exempt workers should be made aware that treatment and services may not be payable without insurer approval.

The payment of treatment and services for exempt workers should be assessed with consideration to whether:

- the treatment or service is required as a result of the injury
 - the treatment or service is considered reasonably necessary, and
 - the provision of costs has been properly verified.
-

Overview

Section 60(2A) of the 1987 Act states that an employer is not liable for any medical treatment or service, or related travel expenses, if:

- a) the insurer has not granted prior approval for the treatment or service. This does not include:
 - treatment provided within 48 hours of the injury happening
 - treatment which is exempt from the requirements of prior insurer approval as outlined in the *Workers compensation guidelines* (the Guidelines).
- b) the person is not appropriately qualified to provide the treatment or service
- c) the treatment or service is not in accordance with the conditions outlined in the Guidelines, or
- d) the treatment is given or provided by a health practitioner whose registration is limited or subject to any condition imposed as a result of disciplinary process, or who is suspended or disqualified from practice.

The Guidelines detail exemptions from insurer pre-approval (refer to Part 4, Tables 4.1 and 4.2). These tables are reproduced below.

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	<p>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.</p> <p>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.</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</p>	Within three months

Treatment	Expense	Timeframe from date of injury
	when making a referral for an MRI.	
	If referred by the treating medical specialist for the injury, any diagnostic investigations.	Within three months
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

Other reasonably necessary treatments and services available without pre-approval from the insurer

Treatment	Expense
<p>SIRA-approved allied health practitioners¹:</p> <p>1. Physical practitioners (physiotherapists, osteopaths, chiropractors, accredited exercise physiologists)</p> <p>1. Psychological practitioners (psychologists and counsellors)</p>	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 <i>Allied health recovery request</i> (AHRR) if the same practitioner is continuing treatment within three months of the injury 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) 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).

¹ Allied health practitioners that meet the requirements of SIRA's approval framework under section 60(2C), 1987 Act.

Treatment	Expense
	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 of the 1998 Act</u> .
Commission determination	Any disputed treatment or service the <u>Workers Compensation Commission</u> 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 <u>section 73(1) of the 1987 Act</u> .
Hearing needs assessment	<p>The initial hearing needs assessment where the:</p> <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: Hearing needs assessment includes:</p> <ul style="list-style-type: none"> obtaining a clinical history hearing assessment as per <u>Australian/New Zealand Standard 1269.4:2014</u> determination of communication goals recommendation of hearing aid, and clinical rationale for hearing aid.

The exemptions outlined in the Guidelines only apply where provisional liability for medical expenses or liability for a claim has been accepted.

Informing workers and service providers of approval

Workers should receive prompt treatment and medical services without unnecessary delay.

Where treatment may be necessary for the worker, the insurer should inform the worker (and service provider, where appropriate) of treatments or services that do not require pre-approval. This can form part of the injury management process and the initial conversations between the insurer and the worker/provider about how to achieve the best outcome.

The insurer should also make sure other relevant parties, including the employer and nominated treating doctor, are appropriately informed.

Workers should not be made to pay for treatment and medical services directly. Where the worker has received treatment or services and has paid the invoice directly, the insurer is expected to promptly reimburse the worker as required by 'Standard of practice 10: Payment of invoices and reimbursements'.

Disputed matters

The Workers Compensation Commission (the Commission) can make an interim payment direction under [section 297 of the 1998 Act](#). Where a medical dispute is referred for an interim payment direction, then the insurer must pay for the treatment or services if directed by the Commission to do so.

The maximum amount payable under an interim payment direction is indexed, with the amounts updated bi-annually in SIRA's [Workers compensation benefits guide](#).

Under the Guidelines, an insurer is required to pay for a treatment or service determined by the Commission to be reasonably necessary, regardless of whether or not the worker sought pre-approval of the treatment or service.

Medical treatment and services requiring prior approval

Medical treatment and services not listed in the Guidelines require approval from the insurer *before* they are provided. When considering a request for treatment, the insurer should consider the following questions:

- Is the treatment or service captured by one of the definitions described in [section 59 of the 1987 Act](#)?
- Will the treatment or service take place while the worker is entitled to receive compensation (the compensation period) for medical, hospital and rehabilitation expenses?
- Is the treatment or service reasonably necessary as a result of the injury? (see Part 4.2 of the Guidelines)

If the insurer has any concerns or queries regarding the treatment proposed, they should contact the medical provider to discuss and resolve the issue(s) directly.

There may be instances where a referral to an independent medical examiner (IME) is appropriate. The Guidelines provide that referral is appropriate when information from the treating medical practitioner(s) is inadequate, unavailable, or inconsistent, and the insurer is unable to resolve the problem directly with the practitioner. Reasons for referral are detailed in Part 7.1 of the Guidelines.

Timeframe for treatment approval

Insurers are to determine treatment approval as soon as possible after receiving a request. All treatment requests must be determined within 21 days of receipt. See 'Standard of practice 4: Liability for medical or related treatment' and [section 279 of the 1998 Act](#) for further information.

If a treating practitioner requests further treatment using an [allied health recovery request](#) (AHRR), and it is within three months of the injury, insurers are required to respond within five days of receiving it. If the insurer does not respond within five days, the request is automatically approved. The allied health practitioner must be able to demonstrate the AHRR was lodged with the insurer in these instances.

Treatment approval should be provided to the worker in writing (for example, a signed AHRR or email). The insurer should also call the worker and employer (where appropriate) so treatment can commence as soon as possible. Informing the treatment practitioner and other relevant stakeholders will also help the management of treatment.

Disputing treatment

Any decision to dispute liability for treatment should be made in accordance with the legislation and in the context of the claim in its entirety. It should also follow appropriate and sound decision-making process and procedural fairness.

When a treatment or service is not approved, a dispute notice is to be issued to the worker, as required by section 78 of the 1998 Act. Informing the treatment practitioner and other relevant stakeholders will assist with the management of the worker's claim.

It is at the insurer's discretion to approve payment of reasonably necessary treatment that is provided without prior approval.

Rehabilitation services during case management

References

 Sections 60 and 63A, *Workers Compensation Act 1987*

Overview

Workplace rehabilitation providers can be engaged to help workers return to work following a work-related injury or illness. The workplace rehabilitation provider works with the worker, employer, doctor and insurer to achieve a recovery at work outcome.

Depending on the needs of the worker and employer, a workplace rehabilitation provider can be engaged to provide a single service (such as a workplace assessment), or provide ongoing support until the worker has achieved a safe, timely and durable return to work.

Making a referral to a workplace rehabilitation provider

Referral to a workplace rehabilitation provider can be made to help:

- a worker return to their pre-injury role or find suitable alternative work
- identify and design duties for the worker to help an employer meet their obligation to provide their worker with suitable work
- identify and coordinate rehabilitation strategies that ensure workers are able to safely perform their duties
- with equipment, retraining and workplace modification needs
- strengthen engagement between the insurer, employer and treatment providers to ensure a focus on a safe and durable return to/recovery at work
- deal with complex injury or communication barriers that are preventing the worker's return to work.

An insurer may engage a workplace rehabilitation provider of their own choosing, or one nominated by the employer or worker. Insurers can search for approved workplace rehabilitation providers on [SIRA's website](#). Insurers should select a workplace rehabilitation provider with expertise related to the worker's injury and industry types.

While it is usually the employer or insurer who decides which workplace rehabilitation provider to use, the worker should be consulted and given the opportunity to nominate or request a change in provider.

The insurer should make sure all parties understand the role of the workplace rehabilitation provider and what they can expect from their involvement. The insurer should provide the employer and worker with:

- the name and contact details of the provider
- an explanation as to why the referral has been made

- an indication as to when the workplace rehabilitation provider will make contact
- information that the worker has the right to request a change of provider.

Insurers should not refer to workplace rehabilitation providers for general claims management activities.

‘Standard of practice 15: Approval and payment of medical, hospital and rehabilitation services’ states that when approving services from workplace rehabilitation providers, the insurer is to ensure that the services are consistent with the *Nationally Consistent Approval Framework for workplace rehabilitation providers* and the *NSW Supplement*.

Approving a rehabilitation plan

A workplace rehabilitation provider can be engaged to achieve an agreed recovery at work goal through the development, implementation and monitoring of a rehabilitation plan. The rehabilitation plan should be submitted for the insurer’s approval and should include the:

- the goal
- activities required to achieve the goal, and
- proposed costs.

Insurers are encouraged to review and either approve or reject the plan within five days to assist with timely provision of services.

The engagement of a workplace rehabilitation provider does not take away from the insurer’s responsibility to manage, monitor and update the injury management plan (section 45 of the 1998 Act). Insurers should maintain regular communication and engagement with all stakeholders to ensure that the rehabilitation plan remains relevant.

Fees and invoices

There are no gazetted fees for workplace rehabilitation providers in the NSW workers compensation system. Providers are required to obtain insurer approval for services and fees before commencing any services.

The insurer should review any invoices submitted by the workplace rehabilitation provider and check they include:

- the worker’s first and last name
- claim number
- payee details
- ABN
- name of the service provider who provided the service
- SIRA workers compensation approval number
- SIRA workers compensation payment classification code
- service cost for each SIRA workers compensation payment classification code
- the date of service
- the date of invoice (must be on the day of or after the last date of service i.e. not before the treatment has taken place).

Insurers should call the workplace rehabilitation provider if they have questions regarding an invoice. Errors or queries can often be resolved quickly over the phone. If telephone contact is unsuccessful, then an email or letter should be sent seeking clarification.

Insurers are expected to pay provider invoices promptly, in line with 'Standard of practice 10: Payment of invoices and reimbursements'.

Complaints about a provider

If the employer or worker raises concerns about the workplace rehabilitation provider, these should be addressed according to the insurer's complaints handling process. Insurers should consider whether a change to a different provider is required, with serious concerns to be referred for SIRA's attention.

Provider attendance at worker medical consultations

It is not appropriate for a workplace rehabilitation provider to attend a worker's confidential medical consultation with their nominated treating doctor. Where a case conference is required to discuss the worker's recovery process, insurers should ensure a case conference is scheduled separate to the worker's medical consultation.

As stated in 'Standard of practice 16: Case conferencing', the insurer should also inform the worker of the intention to arrange a case conference and the reasons for it.

Where a referral is received for a workplace rehabilitation provider to attend a case conference and they have not yet met the worker, the provider should first arrange a meeting with the worker to assess and understand their requirements prior to scheduling a case conference.

Making weekly payments

References

- Sections 83 and 84, *Workers Compensation Act 1987*
- 'Standard of practice 8: Insurer making weekly payments'

Overview

It is the insurer's responsibility to ensure the worker receives their correct weekly entitlement.

Weekly payments to workers are usually made by the employer at the time wages are paid to all workers. An insurer may pay the worker directly in some circumstances, so it is important to ensure that key stakeholders are kept informed of the claim's progress.

If an insurer makes weekly payments directly to the worker, the employer's obligations under [Chapter 3 of the 1998 Act](#) continue to apply.

Insurers should also consider the expectations outlined in 'Standard of practice 8: Insurer making weekly payments'.

When an insurer may make payments directly to the worker

An insurer may commence making weekly payments directly to the worker for the following reasons:

- when a worker ceases employment with their pre-injury employer
- when an insurer elects to take over the responsibility due to delays or disputes regarding payment.

Insurer actions when making weekly payments to the worker

Where reasonably practicable, the insurer should obtain the employer's agreement to take over payments. As stated in 'Standard of practice 8: Insurer making weekly payments', before the insurer begins paying the worker directly, it is to:

- consult with the employer and advise that claims costs continue to accrue
- ask the worker to complete an [Australian Taxation Office](#) tax file number declaration form and arrange for tax to be paid in-line with income tax law.

As part of the consultation with the employer the insurer may also remind the employer that their obligations under the workers compensation legislation continue even though the weekly payments are being made by the insurer.

Insurers are expected to observe the requirements for the protection of tax file number information in accordance with [Privacy \(Tax File Number\) Rule 2015](#) issued under section 17 of the [Privacy Act 1988](#) (Cth).

The frequency of weekly payments should align with the worker's pay cycle or as otherwise agreed between the worker and insurer (and if reasonably practicable, the employer).

Written advice to the employer and worker

The standard of practice requires insurers to advise the employer and worker as soon as practicable after commencing weekly payments directly to the worker.

The written advice to the employer should inform them of:

- the date payments of weekly compensation to the worker will commence
- the amount of the weekly payment the insurer will make to the worker
- the employer's continuing obligations under Chapter 3 of the 1998 Act, regardless of who makes weekly payments to the worker.

The written advice to the worker should include:

- the date payments of weekly compensation by the insurer will commence
- the amount of the weekly payment the insurer will make to the worker
- a request for the Australian Taxation Office tax file number declaration form to be completed (with a copy of the blank form provided to the worker).

The worker should also be provided with information about the collection, storage and use of their tax file number in accordance with the Privacy (Tax File Number) Rule 2015.

Insurers can refer to Privacy agency resource 5: The Privacy (Tax File Number) Rule 2015 and the protection of tax file number information by the Office of the Australian Information Commissioner for more information on this.

Weekly payments after the second entitlement period

References

- 🚩 [Section 38, Workers Compensation Act 1987](#)
 - 🚩 [Section 32A, Workers Compensation Act 1987](#) (definition of worker with high and highest needs)
 - 🚩 [Continuation of weekly payments after 130 weeks – application](#)
-

Application to exempt workers

This information does not apply to exempt workers.

Overview

[Section 38 of the 1987 Act](#) details special requirements for the continuation of weekly payments to workers after the second entitlement period (after 130 weeks).

Work capacity assessment

To assess a worker's entitlement to weekly payments after 130 weeks, an insurer must conduct a work capacity assessment during the last 52 weeks of the second entitlement period (from 78 weeks), and thereafter at least once every 2 years.

An insurer is not to conduct a work capacity assessment of a worker with highest needs unless the insurer thinks it appropriate to do so and the worker requests it. However an insurer can make a work capacity decision about a worker with highest needs without conducting a work capacity assessment.

No current work capacity

A worker who is assessed by the insurer as having no current work capacity, and this is likely to continue indefinitely, is entitled to compensation after the second entitlement period.

Current work capacity

A worker (other than a worker with high needs) who is assessed by the insurer as having current work capacity is entitled to weekly payments of compensation after the second entitlement period only if:

- the worker has applied to the insurer after receiving 78 weeks of weekly payments, and
- the worker has returned to work 15 hours or more per week and is in receipt of current weekly earnings of at least \$155 per week (indexed annually on 01 July; currently \$190), and
- the worker is assessed by the insurer as being, and as likely to continue indefinitely to be, incapable of undertaking further additional employment or work that would increase the worker's current weekly earnings.

A worker will need to satisfy each of these requirements to continue to be eligible to receive weekly payments of compensation.

Applying to the insurer

An insurer will need to provide the worker with the Continuation of weekly payments after 130 weeks application form.

An insurer should write to the worker to inform them of the requirement to submit the application form after they have received 78 weeks of weekly payments.

The insurer should include an explanation of the eligibility criteria under section 38(3)(b) of the 1987 Act that the worker must satisfy to be eligible for continuing weekly payments after 130 weeks.

A reminder to submit the application form should be provided to the worker prior to reaching 130 weeks.

Working 15 hours per week and earning at least \$190 (as indexed)

Section 38(3)(b) of the 1987 Act requires that the worker has returned to work for not less than 15 hours per week and be in receipt of current weekly earnings of at least \$190 (as at 01 July 2018 indexed annually).

An insurer will need to determine that both requirements have been met. The insurer may need to request payslips or other evidence from the worker to determine whether they are working.

A worker will need to be receiving some remuneration in exchange for providing a service. This can either be in self-employment or other employment.

Unpaid voluntary work or unpaid work experience is not included in hours of work for the purposes of section 38(3)(b) of the 1987 Act.

Example

Anita has received 132 weeks of weekly payments of compensation. She submits information to the insurer to confirm she is working 15 hours per week at an hourly rate of \$12 per hour. The insurer assesses her current weekly earnings to be \$180.00. While Anita is working 15 hours per week, she does not meet the requirements of section 38(3)(b) of the 1987 Act as she is not in receipt of at least \$190 per week.

Current available evidence

SIRA's overarching claims management principles provides that claims management decisions should be:

- made promptly and proactively, and
- in a manner to reduce delays and costs, and maximise efficiency by progressing claims without unnecessary investigation, disputes or litigation.

An insurer will need to make a work capacity decision about the worker's capacity for work. The insurer may consider evidence such as:

- certificates of capacity
- medical reports from the worker's nominated treating doctor and specialists
- Independent Medical Examiner reports
- Injury Management Consultant reports

- functional assessment reports
- current payslips
- evidence provided by the worker.

Capacity for employment

Section 38(3)(c) of the 1987 Act requires the worker to secure employment up to their capacity for employment to continue to receive weekly payments of compensation after 130 weeks. This means their current work capacity, rather than the amount they are able to earn in the employment.

Note: the requirements in section 38(3)(c) of the 1987 Act do not require the worker to maximise his or her earning capacity by locating the highest paid suitable employment available.

An insurer should request copies of the most recent payslips from the worker to determine how many hours they are working each week.

An insurer should also consider whether the worker is capable of undertaking further hours of work.

To determine whether a worker is likely to continue indefinitely to be incapable of undertaking additional work that would increase their earnings, an insurer should consider:

- stability of recent work history
- medical opinion – in particular, from the worker’s treating practitioner/s
- other treating practitioner reports
- Injury Management Consultant opinion
- workplace assessment reports.

The current labour market conditions will have no impact on the workers individual circumstances.

A work capacity assessment at a point in time does not prevent the making of another assessment at a time in the future.

Example

The insurer finds that Martin has the capacity to work 20 hours per week based on his most recent certificate of capacity. This is confirmed by a recent medical report provided by Martin’s nominated treating doctor. Martin submits payslips to the insurer that show he is only working 16 hours per week. Martin does not meet the requirements under section 38(3)(c) of the 1987 Act. Martin would need to work 20 hours per week to satisfy the requirements.

Where a worker provides more information to show they satisfy the requirements

The work capacity assessment and decision process is ongoing.

A worker who does not satisfy the requirements under section 38(3) of the 1987 Act of the 1987 Act may later provide further evidence to show that they now meet the requirements. If the worker does so, the insurer should consider this information as part of a new work capacity assessment.

Review of an insurer's work capacity decision

The Workers Compensation Legislation Amendment Bill 2018 was passed by the NSW Parliament on 17 October 2018. The changes seek to improve current dispute resolution processes. An improved dispute resolution system will benefit injured workers, employers and insurers from 1 January 2019.

Workers can go to the Workers Compensation Commission (Commission) for all disputes, including those involving work capacity.

Workers who disagree with all or part of an insurer's work capacity decision have the right to request a review. A worker can either ask for a review by the insurer, or lodge a dispute directly with the Commission as there is no mandatory requirement for an insurer review under the improved dispute resolution system.

Note: disputes relating to work capacity decisions will be dealt with by the Commission from 1 January 2019. Insurers will need to consider the approach taken by the Commission with respect to the application of section 38 of the 1987 Act.

Payments to workers with highest needs

References

- Section 38A, *Workers Compensation Act 1987*
- Section 32A, *Workers Compensation Act 1987* (definition of worker with highest needs)

Application to exempt workers

This information does not apply to exempt workers.

Overview

June 2012 workers compensation reforms

The Workers Compensation Legislation Amendment Act 2012 introduced a number of changes to workers compensation benefits.

This included new weekly payment arrangements in which a worker's entitlements to weekly payments were made by reference to their pre-injury average weekly earnings (PIAWE). The changes to weekly benefits came into effect on 1 October 2012 for new claims, and 1 January 2013 for existing claims.

Workers with a permanent impairment of more than 30 per cent ('seriously injured workers') were entitled to additional benefits, which came into effect on 17 September 2012.

2015 benefit reforms

In 2015, the Workers Compensation Amendment Act 2015 (the 2015 Amending Act) introduced amendments providing additional benefits to properly meet the needs of the most seriously injured workers.

The 2015 amendments also replaced the definition of 'seriously injured worker' with that of 'worker with highest needs'. As outlined in section 32A of the 1987 Act, a worker is a '**highest needs**' worker if they have an injury which has resulted in permanent impairment, and:

- the degree of permanent impairment has been assessed by a trained assessor of permanent impairment as being more than 30 per cent, or
- an assessment is pending - an examination has been made by an approved medical specialist and the specialist has declined to make the assessment because maximum medical improvement has not been reached and the degree of permanent impairment is not fully ascertainable, or
- the insurer is satisfied that the degree of permanent impairment is likely to be more than 30 per cent.

Special provision was made for workers with 'highest needs' as they were now able to access a minimum weekly payment amount.

Special provision for workers with highest needs

Section 38A of the 1987 Act commenced on 4 December 2015 and provides that the minimum amount of weekly compensation that a worker with highest needs will be eligible to receive will be the amount of \$788.32, as adjusted bi-annually.

Note: the minimum weekly payment amount is indexed in April and October each year, with the applicable rate found in the *Workers Compensation Benefits Guide* (the rate as at 1 October 2018 is \$831.00).

The minimum weekly payment acts as a safety net for workers with highest needs, particularly those who had a lower PIAWE.

The minimum amount will be payable by the insurer, regardless of earnings.

Note: This is consistent with the current interpretation of section 38A of the 1987 Act: refer to the decision in *Vostek Industries Pty Limited v White* [2018] NSWCCPD 47.

When the special provision does not apply

Transitional provisions (clause 35 of Schedule 8 to the Regulation) provide that in certain circumstances, section 38A of the 1987 Act does not apply.

This includes the determination of the compensation payable in respect of any period of incapacity occurring before 17 September 2012 (when seriously injured workers were first transitioned).

This also includes where a worker whose PIAWE have been deemed to be equal to the transitional amount for the purposes of the application under clause 9 or 10 of Part 19H of Schedule 6 to the 1987 Act of the weekly payments amendments. These workers are entitled to 80 per cent of the transitional amount (indexed) as prescribed in clause 2(1) of Part 19H of Schedule 6 to the 1987 Act.

The table below outlines the differences between the minimum safety net amount provided by Section 38A of the 1987 Act, and the amount available to existing recipients being 80 per cent of the transitional rate as indexed twice per year.

From	To	Transitional rate	80% of Transitional Rate	Section 38A minimum
1/10/2015	31/03/2016	\$993.70	\$794.96	\$788.32
1/04/2016	30/09/2016	\$1,006.90	\$805.52	\$793.00
1/10/2016	31/03/2017	\$1,014.40	\$811.52	\$796.00
1/04/2017	30/09/2017	\$1,027.60	\$822.08	\$808.00
1/10/2017	31/03/2018	\$1,035.90	\$828.72	\$814.00
1/04/2018	30/9/2018	\$1,049.10	\$839.28	\$826.00
1/10/2018	31/3/2019	\$1,057.40	\$845.92	\$831.00

Entitlement to weekly payments

A worker becomes eligible for the minimum weekly payment amount from the date they are a 'highest needs' worker as outlined in section 32A of the 1987 Act.

For instance, this may be the date they were assessed by a trained assessor of permanent impairment to have greater than 30 per cent permanent impairment or the

date the insurer is satisfied that the degree of permanent impairment is likely to be more than 30 per cent, provided they meet the preconditions which are outlined below.

To be entitled to the special compensation for workers with highest needs, certain preconditions² need to be satisfied:

- there must be a determination made of the amount of weekly payments of compensation payable,
- there must be an amount of weekly payments of compensation payable, and
- the amount of compensation must be less than \$788.32 (indexed).

Note: Insurers should note that the matter of *Hee v State Transit Authority of NSW* [2018] NSWCPD 6, which considers the application of section 38A of the 1987 Act, is under consideration by the NSW Court of Appeal, decision reserved. Insurers will be required to apply section 38A of 1987 Act in a matter consistent with the Courts interpretation.

Insurers should also note:

- a work capacity assessment of a worker with highest needs is not to be conducted unless the insurer thinks it appropriate to do so and the worker requests it (section 44A(4) of the 1987 Act).
- a work capacity decision can be made for a worker with highest needs, however only workers with a 'current work capacity' or 'no current work capacity' (as defined under section 32A of the 1987 Act) have an entitlement to weekly payments.

All workers who meet the above definition of a worker with highest needs are entitled to the special provision for workers with highest needs, but only for periods of incapacity on and from 17 September 2012.

Example

A worker with highest needs is currently working 30 hours per week, and their current weekly earnings are \$1,260.00 per week.

Their PIAWE was calculated at \$1,596.00 per week. They are in the second entitlement period.

To calculate their weekly payment:

$$(\$1,596.00 \times 95\%) - \$1,260.00 = \$256.20$$

The worker is entitled to the special compensation as they are a worker with highest needs; weekly payments of compensation are payable, and the amount of compensation is less than \$788.32 (indexed).

In this scenario, the worker would receive the minimum amount, in addition to their earnings.

² Relevant matter *Hee v State Transit Authority of NSW* [2018] NSWCPD 6 under consideration by the NSW Court of Appeal, decision reserved.

Payments to Medicare Australia

References

- 'Standard of practice 26: Arrangement for payments to Medicare Australia'
- *Medicare form mo023: Medicare compensation recovery section 23A statement*
- *Medicare form mo022: Medicare compensation recovery notice of judgment or settlement*
- *Medicare form mo026: Medicare compensation recovery Medicare history statement request*
- *Medicare form mo021: Medicare compensation recovery third party authority*

Overview

To ensure workers receive their full statutory entitlement for lump sum compensation without delay, a *Medicare notice of past benefits* should be initiated at the point in a claim when it is indicated that medical services for a work-related injury might have been paid by Medicare Australia.

Insurers are to actively identify claims where medical services for a work-related injury may have been paid by Medicare. For example, when:

- an application for dispute resolution has been lodged with the Workers Compensation Commission (excluding disputes that only relate to work capacity decisions)
- accepting liability for a condition that is contracted or caused by gradual process or that may be an aggravation of a disease
- there is a retrospective entitlement to compensation (i.e. when liability for medical expenses had been disputed but later accepted six months or more after the liability dispute), or
- a settlement of a claim for compensation is initiated that will exceed \$5,000.

Claim for a lump sum greater than \$5,000 initiated

If the worker indicates that no Medicare benefits have been paid in relation to their compensable work-related injury, or none have been paid since their last *Medicare notice of past benefits* was issued, it is prudent for the insurer to determine whether this is consistent with the history of the claim.

The insurer should ask the worker to complete a *Section 23A statement* (Form mo023). This is forwarded to Medicare Australia with a *Notice of judgment or settlement* (Form mo022) at the time the claim is determined. Full payment can then be made to the worker.

Medical services for a work-related injury paid by Medicare

If the insurer has determined that reasonably necessary medical treatment and services for a work-related injury have been paid by Medicare, and the lump sum (all costs) exceeds \$5,000, then the following steps apply:

1. The insurer, with the worker, completes a *Medicare history statement request* (Form mo026).

If the form is not completed with the worker, the information on the *Medicare history statement* can only be released to the insurer where a *Medicare*

compensation recovery third party authority (Form mo021) has been signed by the worker.

2. The insurer forwards the form/s to:

Department of Human Services
Medicare Compensation Recovery
GPO Box 4104
Sydney NSW 2001

3. Medicare will send the worker a *Medicare history statement* which the worker returns to Medicare having identified the services relating to the compensable injury. If no response is received from the worker, Medicare will deem that all the Medicare services relate to the injury.
4. The insurer will check the *Medicare history statement* and reimburse Medicare costs incurred for reasonably necessary medical treatment relating to the compensable injury.
5. Medicare then sends a *Medicare notice of past benefits* to the insurer for payment once settlement on the claim is reached. This is valid for six months. If it expires before settlement, another *Medicare history statement* should be requested from Medicare prior to finalisation of settlement.
6. The *Medicare notice of past benefits* becomes a *Medicare notice of charge* once settlement is reached.
7. The *Notice of judgment or settlement* is sent to Medicare within 28 calendar days of the judgment or settlement date.

Further information (including how to make payments to Medicare) can be found on the Medicare website.

Recovery of Centrelink benefits from lump sum payments

References

- 'Standard of practice 27: Notification and recovery of Centrelink benefits from lump sum payments'
- *Centrelink form si039: Authority to release personal information*
- *Centrelink form ss445: Compensation advice for periodic payments*
- *Centrelink form Mod C: Compensation and damages*
- *Centrelink form ss446: Compensation advice of lump sum payments*

Overview

Under Commonwealth legislation, insurers are required to notify [Centrelink](#) before lump sum payments are made, and pay any amounts owing to the Commonwealth. Prompt action by insurers is required to ensure a worker's entitlements are paid without delay.

Insurers are also required to notify Centrelink as soon as they become aware that a preclusion period from access to Centrelink payments may apply.

Lump sums for arrears of weekly payments

Lump sums for arrears (debts) of weekly payments may be made in the following circumstances:

1. When a decision made to issue a reasonable excuse or dispute a claim is reconsidered, and liability (including provisional) is accepted.
2. When determining a claim for an injury that has been contracted by gradual process.
3. A retrospective entitlement to weekly compensation (or economic loss) is likely.

To ensure there is no reimbursement owing from a worker's weekly compensation payments, insurers are expected to provide appropriate documentation to Centrelink.

If the worker has identified that they are or have been in receipt of Centrelink payments, the insurer should provide appropriate documentation to Centrelink before payment of weekly compensation to the worker.

Insurers are to:

1. Obtain a signed [Authority to release personal information](#) (Form si039) from the worker.
2. Send the signed form to Centrelink along with [Compensation advice for periodic payments](#) (Form ss445), including the gross amount per week the worker will receive and the period for which it will be paid.
3. Obtain in writing from Centrelink which payments (if any) are repayable.
4. Use the information supplied by Centrelink to calculate the amount to be paid to Centrelink and the worker, and make the respective payments.

If the worker is unwilling to provide the signed [Authority to release personal information](#) form, the insurer should advise the worker to discuss the matter with

Centrelink. Centrelink and the worker will then resolve that requirement via Centrelink procedures.

An insurer proposing to disclose a worker's personal information to Centrelink (or any other agency) should ensure compliance with Commonwealth and State privacy requirements.

The insurer should make a note in the claims file, and send a letter to the worker acknowledging the outcome and requesting that they complete the Centrelink Compensation and damages form (Form Mod C).

Arrears and Workers Compensation Commission matters

Where a dispute about liability is determined by the Workers Compensation Commission (the Commission), and a determination is made that an amount for weekly compensation is payable to the worker, the insurer is to:

5. Complete the Compensation advice of lump sum payments form (Form ss446) and forward it to Centrelink along with the Commission's *Certificate of Determination*. Once received, Centrelink will calculate the amount (if any) that is repayable and advise the insurer.
6. Pay the repayable amount to Centrelink, and the remaining amount for weekly compensation payments to the worker.

Insurers should maintain appropriate records on the claim file.

Lump sum payments and preclusion periods

Lump sum payments (including payments to cover the lost capacity to earn) will preclude a worker from access to most Centrelink payments for a period of time. An insurer is required to advise Centrelink of any lump sum payment of this type.

This is relevant to lump sums paid for work injury damages and commutations.

Once the lump sum has been paid, the insurer should notify Centrelink by completing the Compensation advice of lump sum payments form (Form ss446) and forwarding to Centrelink along with the signed settlement documents.

Centrelink will determine the preclusion period and advise the worker and their legal representative of the worker's date of eligibility for Commonwealth social security benefits. If the lump sum also includes an amount for arrears of weekly payments, then the insurer should ensure Centrelink are paid any amounts owing before the worker is paid the lump sum.

Further information can be found on the Centrelink website.

Death claims

References

- Part 3, [Division 1](#) and [Division 7](#) of the *Workers Compensation Act 1987*
- 'Standard of practice 31: Death claims'

Overview

Death claims can be some of the most challenging claims a case manager is required to determine and manage. These claims require *proactive and sensitive* management.

Case managers determining death claims are required to make fair, evidence-based, timely decisions while interacting empathetically with family members, employers and other persons impacted by the death. Matters can be factually, legally and medically complex.

Case managers involved in determining and managing death claims require training and support. Insurers should consider how best to achieve this within their internal and external resources.

Entitlements

If a work injury results in the worker's death, his or her dependants or estate are entitled to compensation. Entitlements can include:

- *A lump sum death benefit* apportioned among dependants. If there are no dependants the lump sum death benefit is paid to the legal personal representative of the deceased worker's estate. The lump sum amount payable is the amount in force at the date of the worker's death (not the date of injury or the date the claim is brought).
- *Weekly compensation* for dependent children continue until the child reaches the age of 16 years and in the case of a child who is a student, until the age of 21 years.
- *Reasonable funeral expenses*. When considering what is reasonable, insurers should consider the diverse religious and cultural beliefs and practices that exist in Australian society in the 21st century. Reasonable funeral expenses can include (but are not limited to):
 - the cost of the funeral service (including cremation or burial)
 - cemetery site
 - death certificate
 - flowers
 - coffin
 - funeral director's professional fees
 - catering for mourners
 - any other reasonable costs associated with the legitimate disposal of a human body.
- *Expense of transporting the body* to the deceased's usual place of residence or what would be an appropriate place for its burial or cremation (whichever is the lesser cost).

The monetary values of the various benefits are indexed periodically and are listed in the Workers Compensation Benefits Guide available on the SIRA [website](#).

Entitlements may also exist at common law in respect of a workplace death, for example under the *Compensation to Relatives Act 1897*. Families should be encouraged to get independent legal advice on any common law entitlements.

Note: Prior to the *Workers Compensation Legislation Amendment (Benefits) Act 2008*, the benefits provided in Division 1 Part 3 of the 1987 Act (sections 25 to 32) were for the benefit of dependants only, apart from funeral and associated expenses.

Determining whether death results from an injury

Insurers should not wait for a formal claim from the family or estate of a deceased worker before commencing their investigation. Families may be unaware of their rights and delay may make it difficult for the insurer to gather contemporaneous evidence.

Worker

When determining if the deceased worker is a ‘worker’ under the legislation, the same rules apply.

Injury

Section 25 of the 1987 Act requires that “death results from an injury”. Death itself is not an injury. Compensable “injury” to the deceased worker needs to be proven in the usual way.

Causation

Death can occur immediately or soon after an incident or some considerable time later.

The test commonly applied on causation is that in *Kooragang Cement v Bates*. A common-sense evaluation of the causal chain is required and there is no requirement that the injury be the immediate or proximate cause of death. Incapacity, impairment or death can have multiple causes - causation can be established if an event makes a material contribution to death.

Kooragang Cement v Bates [1994]

The worker suffered a back injury. He became depressed and inactive as a consequence of his back injury. He suffered cardiac disease and ultimately died from a myocardial infarction some years after the accident. The Court held that:

“... each case where causation is in issue in a worker’s compensation claim, must be determined on its own facts. Whether death or incapacity results from a relevant work injury is a question of fact. The importation of notions of proximate cause by the use of the phrase ‘results from’, is not now accepted. By the same token, the mere proof that certain events occurred which predisposed a worker to subsequent injury or death, will not, of itself, be sufficient to establish that such incapacity or death ‘results from’ a work injury. What is required is a common-sense evaluation of the causal chain’.

Intentional self-inflicted injury

Compensation is not payable in respect of any injury to or death of a worker caused by an intentional self-inflicted injury (section 14(3) of the 1987 Act).

Where it is not clear the worker's death was as a result of an accident or self-inflicted, the burden of proof falls on the employer to establish that the worker's death was self-inflicted.

Bluescope Steel Limited v Pitaroska [2014] NSWCCPD 21

Mr Pitaroska died when his body was immersed in a large vat of molten metal known as a "Treadwell". The employer asserted that the deceased had jumped into the Treadwell with the intention of ending his life, and sought to rely upon section 14(3) of the 1987 Act as a bar to compensation. The deceased's widow argued her husband had accidentally fallen to his death. The Arbitrator determined that the employer had not discharged the burden of proof that, on the balance of probabilities, the proper inference to be drawn from all of the evidence was that the deceased worker had committed suicide. Accordingly, the worker's death could not be proved to be self-inflicted and s14(3) of the 1987 Act did not apply.

On appeal, the Deputy President found that the Arbitrator had not erred in her approach in respect of the onus of proof.

In matters that require a consideration of accidental or intentional self-harm, insurers should be mindful of the significant decision of the NSW Court of Appeal in *Holdlen Pty Ltd v Walsh* [2000] NSWCA 87.

The Holdlen decision was a case of death by suicide. The employer appealed the awards of lump sum and weekly payments to a dependent child. The worker committed suicide and the trial judge found the worker's death resulted from a work injury and the worker was insane at the time of his death. The Court of Appeal formulated the 'proper enquiry' and it is this approach that continues to be applied in self-harm matters – that is, that the deceased's volition was overthrown such that the suicide could not be characterised as an intentional act.

Holdlen Pty Ltd v Walsh [2000] NSWCA 87

The worker had suffered a severe work-related knee injury that the trial judge found led to chronic depression, alcohol abuse and the breakdown of his marriage. The Court of Appeal considered a long line of cases founded on the principle that suicide would break the chain of causation unless the worker was insane at the time of suicide so that the suicide would not be an intentional act. The Court held that death by suicide could be found to have resulted from a work-related injury without a finding that the worker was insane at the time of the suicide and *the proper enquiry is into the worker's mental state to determine whether the worker's will was overborne so that the suicide was not an intentional act*.

Information to determine liability

In determining a claim, evidence is required to establish:

- the cause of death
- the relationship between death and employment.

The type and amount of information required will vary based on the cause and circumstances of death. A case manager should gather and carefully consider the available relevant information in order to make a sound, evidence-based decision.

Documents may include (but is not limited to):

- Death Certificate

- post mortem (or autopsy) results
- accident reports (for example, Police reports)
- information from the employer and witnesses
- any factual investigation or expert reports
- treating medical records
- ambulance reports and hospital admission notes.

In the case of a worker who had an existing workers compensation claim prior to death, the entire claim file may need to be reviewed. Insurers should not, in the general course of events, defer making a decision solely because a matter is referred to the Coroner.

Role of the Coroner

The role of the Coroner is to investigate certain kinds of deaths in order to determine the identity of the deceased and the date, place, circumstances and medical cause of death. The State Coroner oversees and co-ordinates coronial services in NSW, and is assisted by the Deputy State Coroners. The State Coroner and Deputy State Coroners are all Magistrates, with Coroners situated in Local Courts around New South Wales.

Doctors, healthcare professionals, emergency service workers and police are under a statutory obligation to report deaths to the Coroner in a wide range of circumstances.

A large proportion of reported deaths *do not* result in an inquest. An inquest is a court hearing where the Coroner considers evidence to determine the identity of the deceased and the date, place, manner and cause of death of the deceased. The Coroner can decide a formal inquest is not necessary, if they are satisfied that there are no outstanding issues from the available evidence. It can take several months for the Coroner to obtain the information necessary to make this decision which is why it is important insurers should not, in the general course of events, defer making a liability decision solely because a matter is referred to the Coroner.

More information about the Coroners Court is available at www.coroners.justice.nsw.gov.au.

Dependency

“Dependants” is defined in section 4 of the 1998 Act. The definition is broad and inclusive. For example, children of the deceased born posthumously have been held to be a dependant.

Dependency is a question of fact and can require a careful consideration of complex situations. Dependency extends beyond financial support and can include services rendered by the deceased which are capable of quantification in monetary terms.

Abraham Seda Ghati v Sayan & Ors [2010] NSWCCPD 74

The deceased died as a result of a fall from a scaffold while carrying out welding work. At the time of his death the deceased was 54 years old. He had four children, the youngest of whom was in his final year of High School. In considering the question of dependency, the Deputy President was of the view that consideration of “*past events and future probabilities*” are relevant both to the question of the existence or otherwise of the dependency and to the question of the extent of the dependency, that is, whether it be whole or partial.

In the context of death claims, dependency is relevant for two separate entitlements:

- lump sum death benefit
- weekly compensation payable to dependent children.

There is no limitation on age of dependants for the purposes of the lump sum death benefit; the adult children of a deceased worker can be considered a dependant. A dependant can include a person who had a reasonable expectation of support, financial or in kind, from the deceased either at that time or in the future.

However, there are age limits for dependent children to be eligible to receive weekly compensation (refer [section 25 of the 1998 Act](#)).

Information to determine dependency

The identification of potential dependants should not delay the making of a liability decision. Optimal case management in death claims is not a linear process and insurers should progress multiple lines of enquiry simultaneously. Where there is no issue that the death benefit is payable, insurers should make the liability decision while continuing to communicate with all potential dependants.

It is often the case that insurers will need to commence proceedings in the Commission seeking orders for dependency, payment and/or apportionment. This assists the Commission and families to speed up the process and reduce legal costs.

The following sources of information may inform dependency decisions:

- statutory declarations including declarations as to any other known dependants
- employment records (naming next of kin and superannuation nominations)
- Marriage Certificate
- Birth Certificate(s)
- Death Certificate
- Last Will and Testament
- Probate or Letters of Administration
- financial records (tax returns, Centrelink details, bank account details).

Apportionment

If the insurer is fully satisfied there is only one dependant of the deceased (whether wholly or partially dependent), then the entire lump sum death benefit should be paid to that dependant.

If there are no dependants, the lump sum should be paid to the deceased's legal personal representative in accordance with [section 32 of the 1987 Act](#). A decision to pay in accordance with [section 32 of the 1987 Act](#) should be based on unequivocal evidence that the deceased left no dependants.

However, if there is more than one dependant or there is any reason to believe there may be more than one dependant, insurers must refer the matter to the Commission or the NSW Trustee & Guardian ([section 29\(1\) of the 1987 Act](#)).

Note: for all practical purposes, this power is not exercised by the NSW Trustee & Guardian and they will refer matters back to the Commission as the body with exclusive jurisdiction in matters arising under the Acts.

In proceedings arising out of the death of a worker it is essential that all potential dependants are identified and joined to the proceedings (even though the person

initiating the proceedings may not be acting in the interests of the other parties). Insurers should be mindful of the Commission Rules in this regard.

Each potential dependant may be able to seek funding for separate legal representation by contacting the WIRO on 13 94 76. This applies equally to the children of deceased workers where there is a surviving parent.

Dependent children have their own entitlement to their share of the lump sum benefit – their right does not derive through their surviving parent. It is not uncommon for a surviving parent to seek orders in the Commission that all, or the majority of, the lump sum death benefit be paid to the parent in order to purchase a family home or pay off a mortgage. The Commission will generally not make such orders. The reason for this is the risk of the dependent children's entitlements being eroded as a result of the surviving parent re-partnering, step-children, children from a later marriage, etc.

The facts relevant to the apportionment of compensation amongst dependants are set out in the decision in *Wratten v Kirkpatrick & Others* [1996]:

“The exercise of power to determine the correct amount to be apportioned to each dependant requires an examination of all relevant facts including the extent of past dependence, the anticipated future dependence, the ages of the dependants, their health, special needs, lifestyle, etc”.

It is important that the fact-finding exercise be carried out with due notice to those who may be entitled to a share of the compensation and they should be entitled to present submissions to the Commission in relation to the apportionment.

People can have complex personal histories. The need for proper enquiry and independent legal representation is highlighted in the matter of *Kaur v Thales Underwater Systems Pty Ltd* [2011] NSWCCPD 6

Kaur v Thales Underwater Systems Pty Ltd [2011] NSWCCPD 6

The deceased worker, Mr Dhillon, had been married three times. He died on 20 December 2005. He was first married to Narinda Kaur. There were three children to that marriage – none claimed dependency or workers compensation benefits. After divorcing his first wife, Mr Dhillon married Gurmeet Kaur in 1997. At the time of their marriage Gurmeet had two daughters – one from a previous marriage born in 1984 and a daughter born in 1991 who was the deceased's daughter. The marriage to Gurmeet Kaur was dissolved in February 2004. On 10 December 2005, Mr Dhillon married Harbendar Kaur. At the time of the marriage, she had two daughters. The children were age 14 and 15 at the time of the worker's death (just 10 days after the marriage).

Proceedings were brought in the Commission by both Gurmeet Kaur and her children and Harbendar Kaur and her children each claiming dependency. In his decision, His Honour Judge Keating held:

“While the respective length of the marriage of the deceased to Gurmeet and Harbendar may be a relevant matter, it is not determinative of the existence or extent of dependency at the date of death. The extent of dependency depends on many things...the question whether there is in fact dependence or reliance at the date of death is not to be answered by looking only to the circumstances as they existed at that date, “past events and future probabilities” have to be considered”.

Payment of compensation

It is usual for the Commission, when ordering and apportioning lump sum compensation, to order that the insurer pay the apportioned amount directly to the widow, widower or de facto and any other dependants who have reached 18 years of age. It is also usual for the Commission to order payments of apportioned amounts in respect of children to the NSW Trustee & Guardian.

Note: Insurers can sometimes be asked to pay the entire lump sum death benefit to the surviving spouse of a worker. For example, the widow of the deceased (and mother of the dependent children) asks for the entire amount to be paid to her in order to discharge a mortgage on the family home. An insurer cannot apportion the lump sum death benefit where more than one dependant or potential dependant is identified. Where more than one dependant is identified, an application must be made to the Workers Compensation Commission to apportion the lump sum death benefit. Any payments must then be in accordance with the Commission's orders.

Weekly payments of compensation in respect of dependent children shall be paid to the surviving parent, if there is one. However, the Commission has discretion to make alternative payment orders. For example, where the child is in the care of a grandparent.

Parents and guardians of dependent children in receipt of weekly payments should be encouraged to get independent advice regarding the tax implications of such payments.

Interest

Section 109 of the 1998 Act provides for order by the Commission of interest on compensation *prior to the date of order for payment*. It is a discretionary power and may be made on the whole or part of a sum payable. It cannot be ordered in respect of periods before a claim is made, is not compound and its function is compensatory and not punitive.

Interest is usually calculated using the rate prescribed by the Uniform Civil Procedure Rules. Because of the substantial nature of the lump sum death benefit, substantial interest can accrue quickly and insurers should be aware of the potential consequences.

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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Catalogue no. SIRA08984 | ISBN 978-0-7347-4598-9 © State Insurance Regulatory Authority NSW 1218