Workers compensation guidelines

Requirements for insurers, workers, employers, and other stakeholders

State Insurance Regulatory Authority

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NSW GOVERNMENT

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About these Guidelines

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

Context

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

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

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

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

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

Legislative framework

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

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

- to assist in securing the health, safety and welfare of workers and, in particular, preventing work-related injury,
- to provide:
    - prompt treatment of injuries, and
    - effective and proactive management of injuries, and
    - necessary medical and vocational rehabilitation following injuries,

  in order to assist injured workers and to promote their return to work as soon as possible,

- to provide injured workers and their dependants with income support during incapacity, payment for permanent impairment or death, and payment for reasonable treatment and other related expenses,
- to be fair, affordable, and financially viable,
- to ensure contributions by employers are commensurate with the risks faced, taking into account strategies and performance in injury prevention, injury management, and return to work,
- to deliver the above objectives efficiently and effectively.

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

Purpose

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

Guideline-making powers

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

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

Interpretation

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

Commencement

These Guidelines will take effect and apply to all claims from 17 April 2020 (irrespective of when the claim is made). Part 10 of these Guidelines, pre-injury average weekly earnings, applies only to workers injured on or after 21 October 2019.

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

These Guidelines replace the *Workers Compensation Guidelines* dated October 2019.

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

The Guidelines do not apply to:

- coal miner matters, as defined in the 1998 Act
- dust disease matters, as defined in the *Workers Compensation (Dust Diseases) Act 1942*
- claims made under the *Workers Compensation (Bush Fire, Emergency and Rescue Services) Act 1987*.

Exempt categories of workers

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

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

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

Scope

The Guidelines contain the following parts:

- Part 1: Initial notification of an injury
- Part 2: Provisional liability
- Part 3: Making a claim
- Part 4: Compensation for medical, hospital, and rehabilitation expenses
- Part 5: Work capacity
- Part 6: Injury management consultants
- Part 7: Independent medical examinations and reports
- Part 8: Lump sum compensation
- Part 9: Commutation of compensation
- Part 10: Pre-injury average weekly earnings

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

Part 1: Initial notification of an injury

1.1 Initial notification of injury

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

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

Table 1.1 Required information for the initial notification of injury

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

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

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

Part 2: Provisional liability

2.1 Delaying provisional weekly payments

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

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

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

Table 2.1 Reasonable excuses for not starting provisional weekly payments

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

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

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

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

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

2.2 Provisional liability for medical expenses

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

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

Part 3 Making a claim

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

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

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

3.1 Minimum requirements for a claim

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

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

3.2 Requirement for a claim form

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

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

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

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

3.3 Signed authority

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

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

Information relevant to the worker's injury includes:

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

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

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

4.1 Accessing treatment without pre-approval

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

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

Payment of treatment and services for exempt workers must be assessed based on whether the treatment or service is required as a result of the injury and is considered reasonably necessary and on the provision of properly verified costs.

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

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

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

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

See Table 4.1 for the reasonably necessary treatments and services the worker can receive (including reasonably necessary worker travel), without pre-approval from the insurer.

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

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

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

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

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

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

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

4.2 Determining reasonably necessary treatment

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

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

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

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

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

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

- the appropriateness of the particular treatment
- the availability of alternative treatment
- the cost of the treatment
- the actual or potential effectiveness of the treatment
- the acceptance of the treatment by medical experts.

4.3 Qualifications and requirements for treatment or service providers

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

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

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

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

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

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

4.4 Domestic assistance care plan

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

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

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

- task(s) it covers
- service provider's name

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

4.5 Verifying gratuitous domestic assistance

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

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

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

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

Information might include:

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

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

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

4.5.1 Verifying and approving gratuitous domestic assistance

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

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

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

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

Part 5: Work capacity Assessment

****This Part does not apply to exempt workers****

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

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

5.1 Work capacity assessment

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

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

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

5.2 When to conduct a work capacity assessment

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

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

5.3 Requirement to attend appointments

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

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

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

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

- Contact information for the Workers Compensation Independent Review Office (WIRO).

The insurer must consider whether the requirement to attend an appointment is reasonable in the circumstances.

This includes the requirement to consider amendments to existing laws and public health orders made in response to COVID-19 (Coronavirus).

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

- one appointment with the same type of medical specialist (for example, orthopaedic surgeon, psychiatrist)
- one appointment with the same type of healthcare professional (for example, physiotherapist, psychologist).

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

Part 6: Injury management consultants

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

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

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

An IMC may conduct a file review where a referrer identifies the need for an injury management consultation but does not consider it necessary for the IMC to examine the worker.

An IMCs functions do not include:

- an opinion on causation or liability
- undertaking a functional capacity evaluation, or work capacity assessment (as defined in section 44A of the 1987 Act) for the insurer.

6.1 IMC functions relating to the nominated treating doctor

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

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

6.2 IMC functions relating to the worker

The IMC may discuss recovery at/return to work with the worker, including:

- their recovery from the injury
- their expectations regarding recovery at/return to work
- the importance of timely, safe and durable return to work, and the potential impact resulting from long-term absence from work on the worker's health

- relevant aspects of the workers compensation system
- ways to overcome problems at work which may be delaying the worker's recovery/return to work
- options for their return to work (including a possible teleconference with the nominated treating doctor).

The IMC may talk to the worker as part of a file review, and/or examine the worker to aid their evaluation of the worker's ability to undertake specific tasks or functions, if this will contribute to achieving recovery and return to work outcomes.

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

6.3 IMC functions relating to the employer

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

6.4 IMC functions relating to other service providers

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

6.5 IMC functions relating to the Workers Compensation Commission

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

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

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

6.6 The IMC report

The IMC is required to complete a report following a consultation or file review. The report should be provided to the referrer within 10 working days of the appointment or file review, or a different timeframe if agreed between the parties.

A copy of the report must be forwarded to the:

- nominated treating doctor
- insurer

- the worker (unless release of the report would pose a serious threat to the life or health of the worker or any other person).

A copy of the report may also be provided to the employer and any other party, if involved in the injury management consultation.

As a minimum, the report is to include:

- worker details (name, date of birth, claim number)
- referrer and reason for referral
- documents reviewed
- date of consultation/review, including who attended the consultation (for example, interpreter, support person) and whether the consultation was face-to-face or a file review
- consultation with the nominated treating doctor, including:
  - discussion regarding return to work/fitness for work
  - any other discussions to progress the workers recovery at/return to work and optimise health outcomes
- consultation with the employer, including the availability of suitable work and any other relevant issues
- consultation with any other parties (for example, workplace rehabilitation provider or treatment providers)
- the outcome of discussions
- consultation with and examination of the worker (where required)
- an action plan:
  - summarising the action taken and the agreed outcomes with the parties involved, including timeframes and milestones to reach the outcome
  - if agreement is not reached, suggest alternative actions to the referrer (for example, referral for an independent medical examination or referral to an approved workplace rehabilitation provider).

Part 7: Independent medical examinations and reports

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

An insurer may direct a worker who has given notice of an injury or is receiving weekly payments of compensation to attend an IME.

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

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

7.1 Reason for referral

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

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

An IME is appropriate where the information required relates to:

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

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

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

7.2 Qualified and appropriate independent medical examiners

All independent medical examiners must be appropriately qualified medical practitioners with the expertise to adequately respond to the question(s) outlined in the referral. They must have qualifications relevant to the treatment of the worker's injury.

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

7.2.1 Permanent impairment assessors

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

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

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

7.3 Conflict of interest

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

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

7.4 Special requirements

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

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

A pandemic, such as the outbreak of COVID-19 (Coronavirus) in Australia is considered a special circumstance for the purposes of this Part.

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

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

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

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

7.5 Notification to the worker

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

The worker must be advised in writing at least 10 working days before the examination takes place. Additional notice should be considered for rural/regional workers.

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

The written advice to the worker must include:

- the specific reason for the examination
- an explanation of why information from the treating medical practitioner(s) or author of the assessment report to the insurer's enquiry was inadequate, inconsistent or unavailable
- date, time and location of the appointment
- name, specialty and qualifications of the independent medical examiner
- contact details of the independent medical examiner's offices and appropriate travel directions
- the likely duration of the examination
- what to take (for example, x-rays, reports of investigations/tests, comfortable clothing to enable an appropriate examination to be conducted)
- information that the worker may be accompanied by a person other than their legal representative, however, the accompanying person must not participate in the examination and may be required to withdraw from the examination if requested
- advice when it is the independent medical examiner's routine practice to record the examination on audio or video; and that the worker must either consent to or decline this before the examination. The recording is only to proceed if the worker consents.
- advice that the insurer will meet any reasonable costs incurred by the worker, including wages, travel and accommodation. This may include pre-payment of travel

and accommodation expenses. If the worker is not reasonably able to travel unescorted, this may include expenses for the worker's escort.

- advice that a failure to attend the examination or an obstruction of the examination may lead to a suspension of:
  - weekly compensation, and/or
  - the right to recover compensation under the 1987 Act.
- advice that the worker can request a copy of the report as well as documents that were provided to the IME
- advice that their nominated treating doctor will be provided with a copy of the examination report
- advice that the workers compensation legislation gives the worker or a nominee a right to a copy of any report relevant to a decision made by a referrer to dispute liability for or reduce compensation benefits
- what to do if the worker does not believe the examination is reasonable
- what to do if the worker has a complaint about the conduct of the independent medical examiner
- the SIRA brochure about independent medical examinations.

7.6 Further independent medical examinations

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

- the employer/insurer has evidence that the worker's injury has significantly changed or resolved, or
- the employer/insurer has a request for, or evidence of, a material change or need for material change in the manner or type of treatment, or
- the worker makes a claim for permanent impairment or work injury damages, or
- the worker requests a review after receiving a notice (issued under section 78 of the *Workplace Injury Management and Workers Compensation Act 1998*) and includes additional medical information that the employer/insurer is asked to consider, or
- the last IME was unable to be completed, or
- it has been at least six months since the last IME required by the employer/insurer, or
- the referrer can provide significant reasoning for the need for a referral in a shorter timeframe. This reasoning must be documented in the claim file and provided in the written advice to the worker regarding the referral.

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

- that examiner has ceased to practise (permanently or temporarily)
- the specialty required to assess the injury has changed
- they no longer practise in a location convenient to the worker, or

- both parties agree that a different medical practitioner is required.

7.7 Unreasonable request

The insurer must consider whether the requirement to attend an IME is reasonable in the circumstances.

This includes the requirement to consider amendments to existing laws and public health orders made in response to COVID-19 (Coronavirus).

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

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

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

Part 8: Lump sum compensation

8.1 Relevant particulars about a claim

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

8.1.1 For injuries received on or after 1 January 2002

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

The assessor's report must include:

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

8.1.2 For injuries received before 1 January 2002

A claim for lump sum compensation must include:

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

8.2 Complying agreements

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

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

The complying agreement must include:

- the date of injury or deemed date of injury from which the impairment is agreed to result

- the percentage of permanent impairment or permanent injury, including the injuries described in the *Table of Disabilities* for permanent injuries, for which compensation is being paid
- the percentage allowed for any pre-existing condition or abnormality
- the medical report(s) used to assess/agree this percentage
- the compensation payable (percentage and monetary value)
- the date of agreement
- certification that the insurer is satisfied the worker has obtained independent legal advice or has waived the right to do so.

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

Part 9: Commutation of compensation

9.1 Compensation not to be commuted for catastrophic injuries

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

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

9.1.1 Spinal cord injury

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

9.1.2 Brain injury

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

Criteria for brain injury

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

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

9.1.3 Amputations

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

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

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

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

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

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

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

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

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

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

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

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

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

9.1.4 Burns

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

a. inhalation burns causing long term respiratory impairment, or

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

c. one of the following criteria is met:

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

9.1.5 Permanent blindness

The worker is legally blind, when:

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

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

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

Part 10: Pre-injury average weekly earnings

****This Part does not apply to exempt workers****

Part 10: Pre-injury average weekly earnings do not apply to exempt workers.

This part applies to workers injured on or after 21 October 2019.

10.1 Pre-injury average weekly earnings of apprentices, trainees and young people

Clause 5(4) of Schedule 3 to the 1987 Act states that the Guidelines may make provision for the matters to be taken into account to determine the weekly earnings a worker is likely to have been entitled to in a week had the injury not occurred and they had continued in the employment.

Apprentices, trainees and young people who are entitled to weekly payments must have their PIAWE adjusted at each age or stage after their injury when such an increment is due.

When adjusting the PIAWE the insurer is to assess against the considerations included in table 10.1.

Table 10.1 Considerations, in order of priority:

Consideration	Detail
The relevant Award or Enterprise Bargaining Agreement (EBA)	If the worker is paid in accordance with an Award or EBA then the hourly base rate of pay and any applicable penalty rates and allowances are to be used.
A comparable relevant Award or EBA	If the worker is not paid in accordance with an Award or EBA, however there is a similar relevant Award or EBA that could apply to the worker, this may be used.
Comparable average earnings (where no Award or EBA applies to the worker)	A rate can be determined by reference to the average weekly amount earned by other persons who have attained the age or stage in employment for the performance of similar work as the worker. The rate determined is to be based on the date the amount is to be applied.

When deciding on the most appropriate rate for an apprentice, trainee or young person, an insurer must give regard to relevant allowances (if any) that would have been payable to the worker had they not been injured.

Overtime hours and shift work performed prior to the injury should be included at the rate applicable at the time any increase in PIAWE is determined. This is to reflect the pattern of overtime and shift work prior to injury, as identified when PIAWE is first determined for the worker.

The new PIAWE is calculated to take effect from:

- with respect to apprentices and trainees, the anniversary from commencement of the workers apprenticeship or training, or
- with respect to young people, each birthday after the workers injury until they reach the age of 21 years (where an increment is applicable).

10.2 Determining whether a benefit has been provided and whether the worker is entitled to use of the benefit

Clause 6(4) of Schedule 3 to the 1987 Act states that the Guidelines may make provision for the matters to be taken into account to determine whether a non-monetary benefit has been provided to a worker and whether the worker is entitled to the use of that benefit.

An insurer is to determine if a benefit has been provided to a worker by requiring the employer to provide the tax reporting records kept by the employer about that worker.

An employer is obliged to record the value of fringe benefits provided to their workers for Australian Tax Office reporting purposes. They may also have to report the notional value of some benefits which are exempt from fringe benefits tax.

A worker is considered to have been provided with a non-monetary benefit if they have use of the benefit at the date of the injury.

Where a non-monetary benefit has been provided to a worker for the performance of work by the worker, which expressly provides a personal benefit to the worker, it should be included in the worker's PIAWE from the date that the benefit has been relinquished by the worker or withdrawn by the employer post-injury.

The insurer is to consider the following to ascertain whether a worker is entitled to the use of a non-monetary benefit:

- if a worker continues to have access to the non-monetary benefit for personal use
- whether the provision of the non-monetary benefit/s are specified in the worker's contract of employment
- other evidence in writing from the worker and/or the employer

If a non-monetary benefit was provided or removed during the relevant earning period, written evidence is to be requested from the employer about the change. This is to include the date of effect of the change.

If a worker has relinquished, or an employer has withdrawn, a non-monetary benefit post injury, the insurer is to request written evidence from the worker and/or the employer including the date which this took effect, to enable the insurer to promptly re-calculate PIAWE.

10.3 Monetary value of non-monetary benefits

Schedule 3, clause 7(1)(b) of the 1987 Act states that the Guidelines may determine an amount which is reasonably payable for a non-monetary benefit that is not a fringe benefit or not otherwise subject to fringe benefits tax.

When fringe benefits tax does not apply to a non-monetary benefit (for example, benefits provided to employees of most not-for-profit organisations) the insurer must determine a reasonable value for that non-monetary benefit. The reasonable value is to be determined as a pre-tax value expressed as a weekly amount.

Insurers are to refer to the following when determining the monetary value of a non-monetary benefit:

- Pay As You Go (PAYG) summaries provided to the worker, or accounting / tax return information for working directors
- the worker's contract of employment
- records kept by the employer as to the value of the non-monetary benefit
- any records kept by the worker

Insurers may consider other available information where appropriate to do so.

10.3.1 Residential accommodation not subject to fringe benefits tax

If a worker is provided with residential accommodation which is not subject to fringe benefits tax, the monetary value is the amount that would reasonably be payable for that accommodation or equivalent accommodation in the same area, if it were let on commercial terms, as a weekly rate.

To establish the value as a weekly rate the insurer is to have regard to relevant and current real estate guide information for rental properties in a similar location and size to that provided to the worker by the employer.

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

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

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

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