Standards of Practice

Expectations for insurer claims administration and conduct

State Insurance Regulatory Authority

26 June 2020

NSW GOVERNMENT

Contents

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
ILARS	Independent Legal Assistance and Review Service
NTD	Nominated treating doctor
PIAWE	Pre-injury average weekly earnings
GST	Goods and services tax
Permanent Impairment Guidelines	NSW workers compensation guidelines for the evaluation of permanent impairment, fourth edition, April 2016

About the Standards

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.

Context

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, in accordance with section 23 of the *State Insurance and Care Governance Act 2015.*

SIRA has developed the *Standards of practice: Expectations for insurer claims administration and conduct* (Standards) after undertaking a comprehensive review of the workers compensation claims handling framework in NSW.

These Standards are supported by streamlined and consolidated Workers compensation guidelines (Guidelines). Together, the Standards and revised Guidelines set clear, consistent, accessible and enforceable expectations that will guide insurer conduct and claims management.

The Standards and Guidelines are part of SIRA's regulatory framework, which also includes the:

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

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 insurer processes or procedures have impacted on the worker's claims experience. They may also seek to provide clarity where confusion or inconsistency among insurers have led 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 guide all claims management activity 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
- timeliness and efficiency.

Application

The Standards within this document form the claims administration manual, for the purposes of section 192A of the 1987 Act.

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, SIRA encourages all insurers operating in the NSW workers compensation system to adopt the overarching claims management principles and any relevant Standard.

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, firefighters, rescue workers, and bushfire, emergency and rescue service volunteers.

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

Scope

The Standards contain overarching claims management principles that apply generally to all claims handling and administration activities. They 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 and explain the rationale for each Standard is included in the online claims management guide.

Words used in the Standards of Practice have the same meaning as the words contained in the NSW workers compensation legislation.

Commencement

The overarching claims management principles and standard principles 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.

Directions to comply with these Standards, including the expectations and benchmarks, 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.

SIRA may issue a Direction to insurer(s) to comply with individual Standards and/or all of the Standards.

New COVID-19 related Standard of practice

A new Standard of practice has been developed on the management of claims during the COVID-19 pandemic. It aims to set expectations for insurers about the handling of COVID-19 workers compensation claims and claims handling practices more generally throughout the period of the pandemic. Specifically, it is designed to:

- clarify expectations regarding insurer decision making and determination of weekly payment entitlements to promote transparency and consistency, and provide certainty for impacted workers
- reduce barriers and ensure workers are fully informed of supports and options available to them
- support workers through their recovery and return to work.

Standard of practice 32 will apply to insurers during the COVID-19 pandemic period. It will commence from **26 June 2020**, and will be in effect for 12 months unless SIRA amends, revokes or replaces the Standards earlier.

Given the unprecedented nature of COVID-19 and the uncertainty about how the pandemic may unfold, SIRA will closely monitor the management of COVID-19 related claims and will consult on the need to further refine this Standard if appropriate.

Overarching claims management principles

These overarching claims management principles apply generally across all aspects of claims management and 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	Weekly payments to workers will commence as soon as possible. Workers will not be disadvantaged if the insurer has not been able to obtain all information required to calculate PIAWE, or if an insurer has not yet approved a PIAWE agreement.
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	Principle
Standard 9: Reduction in payments of compensation	Workers will be provided with notice in advance before a statutory step-down in their weekly payments.
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 (IMCs) are facilitators who should be used to mediate between relevant parties to progress a worker's recovery at or return to work and optimise health and work outcomes.
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 beforethe 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 before the cessation of weekly payments.

Standard	Principle
Standard 19: Section 59A notification	Workers whose medical benefits are due to cease will be provided with appropriate notice before 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 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	Principle
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 before 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 32: Managing claims during the COVID-19 pandemic	Insurers will be flexible and adaptable during the COVID-19 pandemic and ensure that claims are managed with empathy and transparency, making liability decisions and paying entitlements without delay.

Standard 1: Worker consent

Protecting a worker's personal and health information and ensuring a worker's consent is obtained before 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 are required to obtain the worker's consent before 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 are to provide advice to the worker about: • 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 are to consider whether existing worker consent is sufficient to enable release of 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 are to advise workers of their right to access their personal and health information.	Evidence on claim file
S2.2	Insurers are to ensure third-party providers are aware that any report provided in relation to a worker may be released to the worker.	Evidence on claim file
S2.3	Insurers are to promptly respond to any request by the worker or their representative for information contained in the insurer's claim file.	Written response provided within 10 working days from receipt of the request

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 are to 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)	If accepting provisional liability, the insurer is to provide the following information to the worker (in addition to the notice requirements in section 269 of the 1998 Act): • 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)	If accepting provisional liability, the insurer is to provide the following information to the employer: • 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	Written notice provided to the employer within two working days after decision

	• that the worker is entitled to make a claim for compensation and how that claim can be made.	
Expectations		**Benchmarks**
S3.4 (Reasonable excuse)	If the insurer has a reasonable excuse not to commence provisional weekly payments, the insurer is to provide the following information to the worker (in addition to the notice requirements set out in section 268 of the 1998 Act) and to the employer: • 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.	Written notice provided to the worker within two working days after decision
S3.5 (Full liability)	If accepting liability for a claim for weekly payments, the insurer is to provide the following information to the worker and the employer: • 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 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 • 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.	Written notice provided to the worker and employer within two working days after decision
S3.6 (Full liability)	If an insurer requires a completed claim form to determine liability, they are to proactively request this from the worker and allow sufficient time for the worker to complete and submit the form.	Request at least four weeks before expiration of provisional period or upon exhaustion of provisional

		medical expenses
S3.7 (Full liability)	Upon request, the insurer is to provide the employer with information relevant to the liability decision, including the evidence considered and legislative provisions relied upon. In the event the information requested by the employer cannot be lawfully provided, the reasoning should be clearly documented on the claim file.	Written response provided within 10 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 are to 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 is to acknowledge the request and keep the worker informed of the status of their claim.	Request acknowledged within 10 working days
S4.3	The insurer is to 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 is to 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 are to 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

Providing for interim pre-injury average weekly earnings (PIAWE) enables workers to be supported by the commencement of weekly payments when the insurer has insufficient information to make a complete calculation, or an application for agreement between the worker and employer as to PIAWE has not yet been approved.

Interim pre-injury average weekly earnings		
Principle		
Weekly payments to workers will commence as soon as possible. Workers will not be disadvantaged if the insurer has not been able to obtain all information required to calculate PIAWE, or if an insurer has not yet approved a PIAWE agreement.		
Expectations		**Benchmarks**

S7.1	For claims where weekly payments may be payable, as soon as possible after notification, insurers are to advise the worker and the employer:
	• that a worker's pre-injury average weekly earnings (PIAWE), to be used for the calculation of weekly payments, may be determined:
	  ○ by agreement between the worker and employer, or
	  ○ by the insurer using the prescribed methodology to make a work capacity decision.
	• what information and evidence is to be supplied and applicable timeframes for each approach.
		Communication with the employer and worker within three working days from receipt of an initial notification

S7.2	For claims where the employer and worker do not make an application for approval of a PIAWE agreement to the insurer, and the insurer does not have sufficient information to make a complete PIAWE calculation, the insurer is to: • commence weekly payments using an interim PIAWE, calculated based on the best available information, and communicated via a work capacity decision • inform the employer and the worker that all of the information required to undertake a complete PIAWE calculation should be provided to the insurer, as soon as possible, following which PIAWE will be determined.	Evidence on the claim file of communication with the worker and employer before commencing weekly payments

S7.3	For claims where an interim PIAWE work capacity decision has been made, insurers are to recalculate a worker's PIAWE as soon as possible following receipt of the complete information required. If the amount determined differs to the interim PIAWE amount, a new work capacity decision is to be made.	PIAWE to be recalculated within five working days from receipt of required information
S7.4	If the insurer makes a work capacity decision, and the PIAWE is more than: • the rate in the application for approval of the PIAWE agreement which was refused to be approved by the insurer after weekly payments commenced, or • the interim PIAWE, the insurer is to pay any adjustment payment due to the worker as soon as possible. If the insurer makes a work capacity decision, and the PIAWE is less than: • the rate in the application for approval of the PIAWE agreement which was refused to be approved by the insurer after weekly payments commenced, or • the interim PIAWE, any overpayment made to the worker is to be dealt with in accordance with Standard 23.	Adjustment payment to the worker paid no later than 14 days from the work capacity decision
Application	This standard **does not** apply to exempt workers. Note: any reference in this Standard to an 'agreement' only relates to injuries on or after **21 October 2019**.	

Standard 8: Insurer making weekly payments

All stakeholders should be kept informed where weekly payments need to be processed directly by the insurer to the worker. This will 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 is to 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 weekly payments directly to the worker, the insurer is to: • request the worker to complete an Australian Taxation Office tax file number declaration form • arrange for tax to be paid on behalf of the worker.	Request made within five working days after the insurer's decision to commence payments
S8.3	The insurer is to advise the worker and employer as soon as practicable after commencing weekly payments directly to the worker.	Written advice to the 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 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 before **a statutory step-down in their weekly payments.**		
Expectations		Benchmarks
S9.1	Insurers are to advise a worker before a statutory step-down in their weekly payments.	Advice provided no less than 15 working days before a reduction in payments
S9.2	Where the employer is making weekly payments directly to the worker, the insurer is to: • advise the employer before a statutory step-down in the worker's weekly payments • advise the employer of the correct weekly payment to be paid after the step-down.	Advice provided no less than 15 working days before 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 are to pay invoices that meet SIRA's standard invoicing requirements for treatment that has been pre-approved or does not require pre-approval.	Payment no later than 10 working days from receipt of a valid invoice for approved treatment, or within a provider's terms, whichever is later
S10.2	Insurers are to review service provider invoices before payment and ensure: • 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 where appropriate.	Demonstrated in payment approval procedure (in Injury Management Program)
S10.3	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 are to advise the relevant party of the reasons for delay and the anticipated resolution time.	Advice to relevant party within 10 working days of receipt of invoice
S10.4	Insurers are to reimburse workers for expenses that do not require pre-approval or for which pre-approval has been obtained as soon as practicable after receipt of relevant documentation.	Payment no later than 10 working days from receipt of

		relevant documentation
S10.5	Insurers are to advise the worker of the reasons for any delayed reimbursement and the anticipated timeframe to resolution. For example, in the case of receipts submitted more than 12 months after the expense was incurred or where insufficient evidence was provided.	Advice to the worker within 10 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, so workers continue to receive appropriate compensation and support.

Changes in capacity		
Principle		
A worker's work capacity will be reassessed 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 are to 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 is to 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 are to 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 section 45 of the 1998 Act, the injury management plan is expected to: • 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: – 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	When new information about an injury or treatment is received, insurers are expected to review injury management plans in accordance with the statement in the plan or as soon as practicable.	Evidence on claim file

Standard 13: Additional or consequential medical conditions

It is important that prompt and proactive consideration is given to 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 is to 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 is to 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 is to 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) are facilitators who should be used to mediate between relevant parties to progress a worker's recovery at or return to work and optimise health and work outcomes.

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**
S14.1	Insurers are only to refer to an IMC when • 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 (or their representative), employer, nominated treating doctor (NTD) or other treating practitioner and attempts have been made to resolve the issue.	Evidence on claim file
S14.2	Before making a referral to an IMC an insurer is to contact the worker to discuss the intended referral, explain the role of the IMC and the reasons for referral. If the insurer is considering a file review, the insurer is to ask the worker if they would like to be involved in discussions with the IMC, via a telephone call as part of a case conference with the NTD or relevant treatment provider. Alternatively, if the worker wishes to be more actively involved, the insurer is to offer a face-to-face appointment with the IMC instead of a file review.	Evidence on claim file
S14.3	If an insurer refers to an IMC, the insurer is to advise the NTD 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.	Advice provided to the doctor within five days after the referral is made

S14.4	When referring a worker: • to attend an appointment with an IMC, the insurer is to: – ensure the IMC is located within the worker's travel restrictions – 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 can 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 worker's consent for the consultation to be recorded, and – avoid conflicts of interest between the IMC and the NTD or employer. • for an IMC file review: – ensure any special requirements of the worker are accommodated, such as those arising from gender, culture and language – consult the worker and take into consideration the injury type when deciding which IMC to engage – let the worker know they will be provided with a copy of the report from the IMC file review, and that a copy will also be provided to their NTD and any other parties involved in the injury management consultation – avoid conflicts of interest between the IMC and NTD or employer.	Evidence on claim file

Expectations		Benchmarks
S14.5	Insurers are to provide the worker with the following information before attending any appointment with an IMC: • 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 (for example, 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 WIRO or their union for assistance.	Written notification provided to the worker at least 10 working days before an IMC appointment
S14.6	When making a referral to an IMC, the insurer is to provide the IMC with sufficient information to support the referral, including: • 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. Note: Referrals must not include questions concerning liability.	Referral information to be provided to IMC at least 10 working days before an IMC appointment
S14.7	Insurers are to make subsequent IMC referrals to the same IMC unless that IMC: • 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.	Evidence on claim file

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**
S15.1	Before making a decision about approval for services, insurers are to determine: • 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
S15.2	When approving services from workplace rehabilitation providers, insurers are to ensure that services are consistent with the *Guide: Nationally consistent approval framework for workplace rehabilitation providers* and the *NSW Supplement to the Guide*.	Evidence on claim file or other operational documents/ agreements
S15.3	Insurers are to review service provider invoices before payment and ensure: • 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	When seeking to arrange a case conference, the insurer is to: • advise the worker of the insurer's 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 before cessation of weekly payments helps to ensure that workers have sufficient time to prepare for cessation and make any necessary arrangements.

Section 39 notification		
Principle		
Workers affected by the 260-week limit to weekly payments will be provided with appropriate notice before **the cessation of weekly payments.**		
Expectations		**Benchmarks**
S17.1	Insurers are to provide written notification to a worker before ceasing weekly entitlements in accordance with section 39 of the 1987 Act and must include: • 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 (including WIRO).	Notification provided at least 13 weeks before cessation of weekly payments
Application	This standard **does not** apply to exempt workers.	

Standard 18: Retiring age notification

Providing early notification before 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 before **the cessation of weekly payments.**	
Expectations	**Benchmarks**
S18.1 Insurers are to provide written notification to a worker before ceasing weekly entitlements 12 months after a worker reaches retirement age and must include: • 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, and • who to contact for further information (including WIRO).	Notification provided at least 13 weeks before cessation of weekly payments

Standard 19: Section 59A notification

Providing early notification before 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 before **the cessation of those benefits.**		
Expectations		**Benchmarks**
S19.1	Insurers are to provide written notification to a worker and the nominated treating doctor before the cessation of medical benefits and must include: • the date on which compensation for reasonably necessary medical treatment and services is due to cease, and • in the case of the worker, who to contact for further information (including WIRO).	Notification provided at least 13 weeks before cessation of benefits
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 should 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 are to 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 *NSW workers compensation guidelines for the evaluation of permanent impairment* (Permanent Impairment Guidelines).	Within 10 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 Permanent impairment guidelines, the insurer is to request clarification or amendment from the assessor.	Request made within 10 working days after determining that further information is required or that the report is not consistent with the 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 are to provide workers with copies of all relevant reports and other evidence before negotiating the degree of permanent impairment, to allow for informed negotiation.	Reports and evidence are provided to the worker at least five working days before negotiations commence
S21.2	Before entering into an agreement regarding the worker's degree of permanent impairment, the insurer is to be satisfied that the worker has obtained, or has 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 regarding the degree of permanent impairment, insurers are to ensure that any agreement entered into satisfies the requirements of section 66A of the 1987 Act and the *Workers compensation guidelines*.	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 are to 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 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 is to 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 is to demonstrate they have considered the individual circumstances of the worker and potential financial hardship.	Evidence on claim file
S23.3	The insurer is to obtain informed consent from the worker before commencement of any repayment arrangement.	Evidence on claim file

Standard 24: Factual investigations

Factual investigations can play an important role in the workers compensation scheme, however, they can erode worker trust and should 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 are only to undertake factual investigations when the required information cannot be obtained by another less intrusive means. Insurers must also clearly document the purpose for undertaking any factual investigation.	Evidence on claim file
S24.2	If the worker is requested to participate in a factual investigation, the insurer is to advise the worker in writing and provide the following information: • the purpose of the factual investigation and the contact details of the investigator • the anticipated duration of each interview, which is expected not to 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 10 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 may be used to help determine liability for their claim.	Complete advice provided to the worker at least five working days before the proposed factual interview. If a shorter time is required because of exceptional and unavoidable circumstances, a reduced timeframe is to be agreed by all parties.

Standard 25: Surveillance

Surveillance can play an important role in the workers compensation scheme, but can significantly erode worker trust, so insurers are expected to use it 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	The insurer is to only conduct surveillance of a worker when: • 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, and • 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, and • the surveillance is likely to gather the information required.	Evidence on claim file

Expectations		Benchmarks
S25.2	Insurers are to ensure that any surveillance meets the following requirements: • 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.	Evidence on claim file, or other operational documents/ agreements
25.3	Insurers are not to 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.	Evidence on claim file
25.4	If the insurer provides material gathered through surveillance to a third party, the insurer is to inform the third party about relevant confidentiality and privacy obligations.	Evidence on claim file

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	Insurers are to consider whether to request a notice of past benefits from Medicare 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 (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.	Where appropriate, Medicare notice of past benefits to be initiated within five working days of the 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	Insurers are to provide appropriate documentation to Centrelink when: • 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 the 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 are to 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 understood.	Evidence on claim file
S28.2	When engaging the services of an interpreter, insurers are to: • 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 are to apply the cascading 'State of connection' tests in the *Cross border arrangements for workers compensation* 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 before 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 before **the closure of a claim.**		
Expectations		Benchmarks
S30.1	Before closing a claim, the insurer is to 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 is to finalise all outstanding invoices before closing the claim.	Evidence on claim file
S30.3	The insurer is to confirm in writing the closure of a claim to the worker and the employer, including: • 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 reopened.	Notification within two 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 is to 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 is to 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 are to determine liability for death claims as soon as practicable, and where a liability decision is likely to be delayed, insurers are to document the steps taken to obtain information relevant to determining liability.	Liability determined within 21 days after becoming aware of the death (unless not reasonably practicable to do so, with reasons clearly recorded on the claim file)

S31.4	In circumstance where more than one dependant or potential dependant is identified, insurers are to: • make an application to the Commission to apportion the lump sum death benefit • seek the details of all persons who may 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 • write to all persons who may have an entitlement to advise that they may be able to claim in relation to the lump sum death benefit, of the need to lodge an application to the Commission for apportionment of the lump sum, the nature of proceedings in the Commission and the availability of independent legal advice through ILARS.	Evidence that the insurer has written to all potential dependants no later than 10 working days after accepting liability, to advise of their potential entitlement
S31.5	Insurers are to 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 are to commence weekly payments for dependent children as soon as possible after liability is accepted.	Commencement of weekly payments within 10 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 are to advise the surviving parent or guardian (or legal representative) to seek advice regarding the tax implications of such payments.	Evidence on claim file

Standard 32: Managing claims during the COVID-19 pandemic

Insurers are to adopt a flexible and adaptable approach to claims management during the COVID-19 (Coronavirus) pandemic. This will deliver a tailored approach that meets the needs of workers, employers and other system participants.

Managing claims during the COVID-19 pandemic		
Principle		
Insurers will be flexible and adaptable during the COVID-19 pandemic and ensure that claims are managed with empathy and transparency, making liability decisions and paying entitlements without delay.		
Expectations		**Benchmarks**
S32.1 (Initial contact)	Following notification of an injury where the worker has a diagnosis of COVID-19, the insurer is to proactively contact all parties as soon as possible to discuss: • the individual circumstances of the worker • the health needs of the worker • any potential barriers to recovery and return to work, and what options are available to the worker • commence injury management planning, where appropriate (the injury is likely to be a significant injury).	Evidence on claim file
S32.2 (Applying the presumption)	For each claim notified for COVID-19, the insurer is to: • ascertain whether the worker is in 'prescribed employment' and whether the presumption applies • confirm with the worker what is required to establish they have contracted COVID-19 for the purposes of the legislation. If further information is required to determine liability (including whether the presumption applies, or where the presumption doesn't apply but where there is a high risk of exposure), the insurer is to: • explain to the worker and employer what further information is required to determine liability, and • provisionally accept liability and commence provisional payments without delay. Note: If the insurer has a reasonable excuse for not starting provisional weekly payments in accordance with Part 2.1 of the Workers Compensation Guidelines, this is to be clearly documented on the claim file.	Evidence on claim file

S32.3 (Full liability decision)	Insurers are to: • take proactive steps to obtain further information if required • make a decision on full liability for a claim made by a worker with a confirmed diagnosis of COVID-19 at the earliest possible opportunity and as soon as relevant information is available • notify the worker and the employer of the decision and the evidence relied upon to support that decision. Note: An insurer is not prevented from accepting liability before the end of the provisional liability period (section 278 of the 1998 Act).	Evidence on claim file Liability determined within 21 days of a claim being made, or before the end of the provisional period (whichever is the later)
S32.4 (JobKeeper Payment scheme)	Insurers are to determine the impact, if any, to weekly payments as a result of the JobKeeper Payment scheme. The insurer is required to: • contact the employer to determine whether they have applied for the JobKeeper payment for the worker • maintain contact with the worker and the employer to stay informed about whether a worker commences, is no longer entitled, or ceases to receive the JobKeeper payment • provide information to the worker about the impact of JobKeeper payments on their weekly payments. This information may be via written notification or fact sheets, and is to include where to obtain more information about the JobKeeper Payment scheme, changes to the worker's weekly payments, the effect of the cessation of the JobKeeper payment on their weekly payments and who to contact for further information (including WIRO). Note: The employer's eligibility to claim the JobKeeper payment on behalf of their workers is determined by the Australian Tax Office. Changes in work capacity may affect a worker's eligibility for the JobKeeper payment. Insurers will need to prepare workers for changes in earnings once JobKeeper payments cease.	Evidence on claim file Information provided to the worker and employer within 5 working days of changes to weekly payments due to JobKeeper; or as soon as reasonably practicable

S32.5 (Weekly payments)	Insurers are to ensure that workers impacted by the COVID-19 pandemic continue to receive weekly payment entitlements without delay or interruption. The insurer is to inform the worker that certificates of capacity: • may be obtained for periods of longer than 28 days where 'special reasons' exist, and • may be obtained from their treating physiotherapist or psychologist (applies to second and subsequent certificates only from 17 April 2020). Note: SIRA would consider the COVID-19 pandemic to be a 'special reason' for the purposes of section 44B(4) of the 1987 Act.	Evidence on claim file, and/or information publicly available that an injured worker can easily access
S32.6 (Weekly payments in advance)	The insurer can, if appropriate, use discretion to agree to payment of weekly payment entitlements in advance (up to six weeks), as long as: • the worker has a current certificate of capacity for the period in advance, and • the worker's capacity is not likely to change within that period, and • the worker agrees to receive payment in advance. The insurer is to consider the impact of JobKeeper payments and whether this would impact the amount of weekly payments.	Evidence on claim file
S32.7 (Treatment)	The insurer is to ensure that the worker is informed of additional options available to them to access treatment during the COVID-19 pandemic, where appropriate. This includes advice to the worker about options for accessing treatment, including use of telehealth or videoconferencing.	Evidence on claim file
S32.8 (Recovery at work support)	When an insurer becomes aware a worker's ability to maintain suitable work is affected by the COVID-19 pandemic, the insurer is to, where appropriate, proactively contact the worker and employer to: • identify and address barriers to return to work, including options for flexible work • facilitate engagement with appropriate community, rehabilitation and education services to encourage recovery • explain what SIRA funded programs may be available to support return to work.	Evidence on claim file

S32.9 (Independent consultations, work capacity assessments)	When scheduling an independent assessment (including an injury management consultant service, independent consultant service, or work capacity assessment appointment), the insurer is to: • consider whether the issue can be resolved through further contact with the nominated treating doctor, treating specialist or allied health practitioner/s, and/or whether the appointment/service can be postponed until a later date • consider the most suitable option for the appointment/service, including scheduling the appointment/service via video conferencing (where appropriate) or alternatively telephone (only where permissible) • where a face-to-face examination is required, the insurer is to ensure appropriate travel arrangements have been made and agreed with the worker, including informing the worker that reasonable travel costs will be met by the insurer • keep the employer informed regarding any upcoming examination or assessment and outcomes.	Evidence on claim file or claims procedure process

32.10 (Independent Medical Examinations and assessments of permanent impairment)	When scheduling an Independent Medical Examination (IME) for a worker, the insurer is to: • consider the need for the examination including whether further information can be obtained from the nominated treating doctor or specialist in the first instance, and/or whether the examination can be postponed until a later date • consider the urgency of the matter, ensuring those workers whose entitlements may be impacted, such as matters where an assessment of permanent impairment is required for threshold purposes, are expedited • consider the appropriate method of assessment, and whether a video-consultation is appropriate, or whether a face-to-face examination is required • where a face-to-face examination is required, ensure appropriate travel arrangements have been made and agreed with the worker, including informing the worker that reasonable travel costs will be met by the insurer • keep the employer informed regarding any upcoming Independent Medical Examinations and outcomes. In circumstances where an IME has been delayed or postponed due to the COVID-19 pandemic, and a worker's entitlements will be impacted, the insurer is to: • contact the worker to explain the delay and the impact to the worker's entitlements • inform the worker about what options they may have and who they can contact for assistance (including WIRO). Note: In some circumstances, the insurer will need to give notice in accordance with section 78 of the 1998 Act.	Evidence on claim file and/or evidence of arrangements with IME providers
Application	This standard applies to **all claims** during the COVID-19 pandemic from **26 June 2020**. Note: S32.1, 32.2, and 32.3 apply only to claims made for COVID-19 (i.e. the worker has been diagnosed with COVID-19).	

Disclaimer

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

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

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

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