SIRA

Self-audit guide

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State Insurance
Regulatory Authority

NSW GOVERNMENT

Introduction

The SIRA Insurer claims management audit guide is an information resource to be used alongside the SIRA audit tool to guide the audit. It incorporates the reference materials and guidance materials listed below, however this list is not exhaustive, and the lead auditor should determine which reference materials are appropriate for the audit being undertaken.

Legislation

- Workers Compensation Act 1987
- Workplace Injury Management and Workers Compensation Act 1998
- Workers Compensation Regulation 2016
- Workers Compensation Amendment Regulation 2018
- Interpretation Act 1987
- Health Records and Information Privacy Act 2002
- Privacy and Personal Information Protection Act 1998
- Privacy Act 1988 (Commonwealth Act)

SIRA guidelines

- Workers Compensation Guidelines
- Standards of Practice
- Workers compensation benefits guide
- Workers Compensation Insurer Data Reporting Requirements
- NSW workers compensation guidelines for the evaluation of permanent impairment

Guidance material

- Injury management program – a guide and checklist for insurers
- Clinical framework for the delivery of health services
- NSW supplement to the guide: Nationally consistent approval framework for workplace rehabilitation providers
- Workers compensation guide for allied health practitioners
- Guidelines for the approval of treating allied health practitioners 2016
- SIRA funded programs to support recovery at work
- A recovery at work guide for workers
- A worker's compensation guide for employers
- Workers compensation guide for medical practitioners
- Procedural Direction WC4 – Work injury damages

These materials can be also found on the SIRA website.

For further assistance or clarification on the application of this audit guide, please contact the SIRA Portfolio Manager or email SelfSpecialisedInsurers@sira.nsw.gov.au.

1. Injury management and recovery at work – assessment

Criterion Number	Component	Auditing principles and considerations	Benchmark
1.1	Compliance	<u>Contact on notification of significant injury</u> Within 3 working days after being notified of a significant injury to a worker, the insurer initiates action under their injury management program and in accordance with that program, makes contact with the worker, the employer and (if appropriate and reasonably practicable) the worker's treating doctor. Reference: s42(1), s43(4) of the 1998 Act	Evidence of contact and/ or action taken is clearly documented on the claim file.
1.2	Case Mgt Practice	<u>Employer initial communication</u> The employer is educated on the importance of recovery at work and advised of their injury management plan obligations which are to: • participate and co-operate in the establishment of an injury management plan • comply with the injury management plan • provide suitable employment so far as reasonably practicable. The employer is also advised that the worker is protected from being terminated as a result of their injury. Reference: Standard of Practice 33, 34 s46, s49 of the 1998 Act s32A of the 1987 Act	Evidence of contact and/ or action taken is clearly documented on the claim file.
1.3	Case Mgt Practice	<u>Worker initial communication</u> The worker is educated on the importance of recovery at work and advised of their injury management plan obligations which are to: • participate and co-operate in the establishment of an injury management plan • comply with obligations detailed in the injury management plan • nominate a treating doctor to assist in developing an injury management plan	Evidence of contact and/ or action taken is clearly documented on the claim file.

		• make reasonable efforts to return to work in suitable employment or pre-injury employment and • be advised of the procedure to change their nominated treating doctor. The worker is advised of reasonably necessary treatments and services they can access without pre-approval. Reference: Standard of Practice 33, 34 Customer Service Conduct Principles s43, s45, s47, s48 of 1998 Act	
1.4	Compliance	<u>Workers consent</u> The confidentiality of the worker's personal and health information is respected at all times and is dealt with only in accordance with their consent. The worker's informed consent is obtained prior to releasing or requesting personal and health information from a third party. When requesting a worker's consent, they are advised of: • their rights and obligations, including the right to withdraw or modify consent • 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. Reference: s243 of the 1998 Act PPIP Act HRIP Act Privacy Act 1988 Standard of Practice 1	Evidence of consent is clearly documented on the claim file prior to requesting information from a third party.

2. Injury management and recovery at work – planning

Criterion Number	Component	Auditing principles and considerations	Benchmark
2.1	Compliance	<u>Initial injury management planning</u> Initial injury management planning commences when the injury is a significant injury and is consistent with the insurer's injury management program. Initial injury management planning is undertaken within three working days of being notified of a significant injury. Reference: s43, s45 of the 1998 Act	Evidence on the claim file that the injury management plan is issued In line with the insurer's injury management program.
2.2	Case Mgt Practice	<u>Injury management planning</u> As part of the injury management process, the injury management plan is developed in consultation with the worker, employer and nominated treating doctor to coordinate and manage treatment and rehabilitation. Risk factor identification is implemented, with appropriate actions to address the identified risks across four domains (personal, workplace, insurance and healthcare). The injury management plan also meets the requirements of s45 of the 1998 Act and: • is specific to the worker • is consistent with available medical and treatment information • includes the goal of the plan and actions tailored to the delivery of the goal • includes a statement about how and when the plan is reviewed, with appropriate due dates • includes the rights and obligations of all stakeholders Where new information is received regarding the injury or treatment, the injury management plan is reviewed in consultation with relevant stakeholders and updated accordingly. Due consideration is given to engaging an Injury Management Consultant where assistance may be required to progress a worker's recovery at/return to work. Reference: s43, s45 of the 1998 Act Standard of Practice 12, 33, 34	Decisions and rationale supporting decisions are clearly noted on the claim file. Evidence on the claim file that the injury management plan is issued In line with the insurer's injury management program.

3. Injury management and recovery at work – implementation (additional component RE: workers obligation to comply with injury management

Criterion Number	Component	Auditing principles and considerations	Benchmark
3.1	Case Mgt Practice	<u>Promoting recovery at work</u> Where the employer (or self-insurer) is unable to provide suitable duties, then the insurer gives due consideration to other programs to support recovery at work and/or vocational programs where appropriate. Due consideration is given to engaging a workplace rehabilitation provider where it is apparent that the worker may require additional support returning to work. Reference: Standard of Practice 34 s49, s53, s56 of the 1998 Act s248 s32A of the 1987 Act	Decisions and rationale supporting decisions are clearly documented on the claim file.
3.2	Case Mgt Practice	<u>Case conferencing</u> Case conferences are conducted in line with the insurer's injury management program, and in a manner that promotes return to work and respects the worker's right to confidential medical consultations. Where a case conference has been arranged, the insurer has advised the worker of their intention to seek a case conference and the reasons for doing so. A statement of purpose and agenda for the case conference has been provided to all parties involved. Reference: Standard of Practice 16	Decisions and rationale supporting decisions to have a case conference are clearly documented on the claim file.
3.3	Case Mgt Practice	<u>Claim handovers</u> Where a case handover is required a review of the whole claim and the specific case strategy occurs at the time of the case handover (as per Injury Management Program). The case manager receiving the claim makes timely contact with the employer, worker and affected parties to establish working relationships.	Evidence on the claim file of a case handover and contact with relevant parties.

4. Injury management and recovery at work – finalisation

Criterion Number	Component	Auditing principles and considerations	Benchmark
4.1	Case Mgt Practice	Notification of claim closure Before claim closure, contact has been made with the worker, the employer (not required for self-insurers), and any relevant service providers to advise of the intention to close the claim and reasons for doing so. Within 2 working days of claim closure, the insurer confirms 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 (s59A notification) and • what to do if the worker or employer believes the claim needs to be re-opened. Reference: Standard of Practice 19, 30	Evidence on the claim file that relevant stakeholders have been advised of claim closure.
4.2	Case Mgt Practice	Payment of invoices prior to claim closure Service providers understand the implications of claim closure and are provided with an opportunity for any outstanding invoices or reimbursements to be paid. Reference: Standard of Practice 30	Evidence on the claim file that outstanding invoices are paid prior to claim closure.

5. Liability determination

Criterion Number	Component	Auditing principles and considerations	Benchmark
5.1	Compliance	<u>Initial liability determination is made within timeframes</u> A liability determination is made following the initial notification of injury and within legislative timeframes. Liability decisions are informed by careful consideration of all available information and proactive consultation with the worker and employer. All relevant information is considered, and consultation occurs with the worker and the employer, and a decision is made at the earliest possible opportunity. Within 7 days after receiving an initial notification of injury the insurer has: • started provisional payments • delayed starting provisional weekly payments by issuing a reasonable excuse, or • determined liability. * day of notification = day 0 Reference: s266, s267, s280 of the 1998 Act Standard of Practice 3 Workers Compensation Guidelines Part 2	Evidence on the claim file that a liability determination is made within 7 calendar days.
5.2	Compliance	<u>Initial liability decision notice</u> Where weekly payments commence the following information is provided to stakeholders: Worker: • notice of commencement of payments as per s269 of the 1998 Act (if applicable) • the worker's pre-injury average weekly earnings (PIAWE) or average weekly earnings (AWE) and how that amount was calculated or by way of agreement • 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 they disagree with the amount or don't receive payment	Decisions and rationale supporting decisions are clearly documented on the claim file. Written notices are provided to the worker and employer within two working days of the decision being made.

		• what information they must provide (including when and to whom) to continue to be entitled to weekly payments. Employer: • confirmation that weekly payments are to commence • the period for which provisional payments will continue • an injury management plan will be developed for the worker if required by Chapter 3 of the 1998 Act, and • the worker is entitled to make a claim for compensation and how that claim can be made. Reference: s267, s269, s274, s275 of the 1998 Act Standard of Practice 3 Where a reasonable excuse is applied, the following information has been provided to the worker and the employer (employer contact not required for self-insurers): • notice of reasonable excuse as per s268 of the 1998 Act • information on 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 IRO • the worker has a right to seek an expedited assessment by the Personal Injury Commission (PIC). Note: A reasonable excuse may not be applied to provisional medical payments. Where an insurer is accepting liability for medical payments only (fully or provisionally) there is still a requirement on notification of injury to commence weekly payments within 7 days unless a reasonable excuse is applied (in this instance 'no requirement for weekly payments'). As such, an initial liability decision notice would be required to meet reasonable excuse requirements (for the weekly benefits) and acceptance for the medical expenses. Reference: s267, s268 of the 1998 Act Standard of Practice 3 Workers Compensation Guideline Part 2	Where an adverse liability decision has been made, the decision was reviewed by someone other than the original decision maker.

		Where liability is disputed, a decision notice is given under section 78 of the 1998 Act. A decision notice summary in the approved form has been included and positioned on the front page of the insurer decision notice. Reference: s78, s79 of the 1998 Act clause 38, 41 of the Workers Compensation Amendment Regulation 2018	
5.3	Compliance	<u>Ongoing liability</u> Where a claim is accepted under provisional liability, the insurer actively investigates the claim and keeps the employer and worker informed throughout the process (employer contact not required for self-insurers). Claims accepted under provisional liability are accepted for a maximum period of 12 weeks for weekly payments and/or $10,000 for medical expenses, however a formal liability decision is made as soon as the insurer has sufficient information to make a decision. Where a reasonable excuse has been applied, and is subsequently resolved, the insurer makes a liability decision as soon as possible (i.e. accepts provisional liability, accepts liability or disputes liability). If the worker chooses to make a claim for compensation after the reasonable excuse has been made, the insurer makes a liability decision within 21 days from the date the claim is made (i.e. accepts provisional liability, accepts liability or disputes liability). Reference s267, s274, s278 of the 1998 Act Standard of Practice 3	Decisions and rationale supporting decisions are clearly documented on the claim file. Where an adverse liability decision has been made, the decision was reviewed by someone other than the original decision maker.
5.4	Compliance	<u>Liability for medical and related treatment</u> All relevant information is considered, and consultation has occurred with the worker and all relevant parties prior to each decision for medical and related expenses being made. Consideration is given as to whether the treatment or service is reasonably necessary, as a result of an injury. A decision is made within the timeframes for assessing liability for each request for medical and related expenses. All relevant parties are advised of the outcome and reasons for the decision. If liability for a medical or related expense is disputed, a decision notice is given under section 78 of the 1998 Act. A decision notice summary in the approved form is included and positioned on the front page of the insurer decision notice.	Decisions and rationale supporting decisions are clearly documented on the claim file. Where an adverse liability decision has been made, the decision was reviewed by

		Reference: s60 of the 1987 Act s78, s79 of the 1998 Act Clause 38 of the Workers Compensation Amendment Regulation 2018 Standards of Practice 4 Workers Compensation Guidelines Part 4	someone other than the original decision maker
5.5	Compliance	<u>Liability for additional or consequential medical conditions</u> Where an additional or consequential medical condition not previously diagnosed or reported is added to a certificate of capacity, the insurer takes prompt action and seeks advice from the treating doctor to establish the reason for inclusion. Where the treating doctor considers that the additional or consequential medical condition may result from the compensable injury, contact is made with the worker to establish whether they intend to make a claim for the additional or consequential condition. If the worker is not making a claim for treatment or weekly payments for the additional or consequential medical condition, this is documented on the claim file. Where the worker advises of their intention to make a claim for treatment or weekly payments for the additional or consequential medical condition, a liability decision is made with 21 days. If liability for the additional or consequential condition is disputed, a decision notice is given under section 78 of the 1998 Act. A decision notice summary in the approved form is included and positioned on the front page of the insurer decision notice. Reference: s78, s274 of the 1998 Act Standard of Practice 13	Decisions and rationale supporting decisions are clearly documented on the claim file. Liability decisions are made within timeframes. Where an adverse liability decision has been made, the decision was reviewed by someone other than the original decision maker.
5.6	Data Quality	<u>Data: Liability</u> The liability status code and the date the liability status was made reflect the liability decisions made on the claim at the time of the latest data submission. Reference: Workers Compensation Insurer Data Reporting Requirements. Section C:2.2.4 and C:2.2.9	Data reported is consistent with the data on the claim record.

6. Weekly Payments

Criterion Number	Component	Auditing principles and considerations	Benchmark
6.1	Compliance	<u>Initial PIAWE calculation</u> Pay information is requested from the employer for the purposes of calculating the worker's PIAWE. *On or after 21 October 2019:* Where an agreement between the worker and employer has been made (within 5 working days of notification), the insurer has provided a determination on the application within 7 days (of receiving the notification). If the insurer 'refuses to approve' the agreement, the insurer makes a work capacity decision to notify all parties of the calculated PIAWE. (Note: *Employer consultation is not required for self-insurers*) Weekly payments to workers commence as soon as possible, and workers are not disadvantaged because the insurer has not been able to obtain all information required to calculate PIAWE. Reference: Clause 8N of the Workers Compensation Regulation 2016 Division 2 Sub-Division 2 of the 1987 Act. Schedule 3 to the 1987 Act Standards of Practice 7, 23 Workers Compensation Guidelines part 10	Actions and decisions taken are clearly documented on the claim file.
6.2	Compliance	<u>Interim PIAWE calculation</u> Where there is insufficient information to make a complete PIAWE calculation, the worker and the employer are consulted and PIAWE is calculated based on the best available information available. The calculation is communicated in a work capacity decision (interim PIAWE) within two working days after the decision being made. Where an interim PIAWE calculation has been made, the employer has again been requested to provide the information required to undertake a complete PIAWE calculation within five working days.	Actions and decisions taken are clearly documented on the claim file.

		The workers PIAWE has been recalculated following receipt of the information from the employer within five working days from receipt of the required information. Where the interim PIAWE amount was incorrect, the worker is advised in a work capacity decision of the new PIAWE amount and: • where the new PIAWE calculation is more than the interim PIAWE calculation, the insurer must make payment within 14 days after making calculation • where the new PIAWE calculation is lower than the interim PIAWE calculation, the overpayment to the worker is dealt with in accordance with Standard 23. Reference: Clause 8N of the Workers Compensation Regulation 2016 Division 2 Sub-Division 2 of the 1987 Act. Schedule 3 to the 1987 Act Standards of Practice 7, 23 Workers Compensation Guidelines part 10	
6.3	Compliance	<u>Weekly payments</u> Where a worker is entitled to receive weekly payments, these payments are calculated by the insurer using the determined PIAWE. A weekly payment of compensation is paid: a) at the employer's usual times of payment of wages to the worker, b) at fortnightly or other shorter intervals, or c) at such other intervals as are agreed on between the employer and the worker. The correct amount of weekly payments are paid in accordance with the PIAWE, correct entitlement period and legislative requirements. Where weekly payments are paid to the employer, there is supporting documentation to verify the reimbursement amount and worker's capacity for work. Reference: s44C of the 1987 Act Division 2 Sub-Division 2, Sub Division 4 of the 1987 Act. Schedule 3, clause 7(1)(b) of the 1987 Act Workers Compensation Benefits Guide (relevant edition)	Evidence on the claim file that the worker is receiving the correct weekly payments and is being paid on time. Details and reasoning of calculations is clearly documented on the claim file.

		Workers Compensation Regulation 2016 S83 and s84 of 1987 Act Workers Compensation Guidelines Part 10	
6.4	Compliance	<u>Certificate of Capacity</u> The worker must have a valid certificate of capacity to claim weekly payments. When making weekly payments to the worker or as reimbursement to the employer, the insurer has a valid certificate of capacity for all periods paid. For periods where a certificate was not provided, evidence on file that the insurer has contacted the worker and employer, notifying of requirement to provide certificate within 7 days of request and failing so weekly payments may be discontinued. Reference: s44B 1987 Act s270 1998 Act	Evidence on the claim file
6.5	Data Quality	<u>Data: Payment of weekly entitlements</u> The date of the payment transaction is the date that has been reported to SIRA, and the weekly payments classification codes are consistent with the entitlement periods paid and reported to SIRA. Reference: Workers Compensation Insurer Data Reporting Requirements C.2.5.5, C2.5.17	Data reported is consistent with the data on the claim record.
6.6	Case Mgt Practice	<u>Statutory reduction in payments</u> The worker is advised no less than 15 working days prior to a statutory step-down in their weekly payments. Where the employer is making weekly payments directly to the worker, they are advised prior to the statutory step-down of the correct weekly payment to be paid to the worker after the step-down (does not apply to self-insurers). Reference: Standards of Practice 9	Evidence of written notification is on the claim file.

6.7	Case Mgt Practice	<u>Cessation of entitlement</u> Workers affected by the 260-week limit to weekly payments are provided with at least 13 weeks' notice prior to cessation of weekly payments, and receive written notification advising of the following: • 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 their entitlement to vocational and return to work assistance programs • information on how to contact Centrelink, and • who to contact for further information. Retiring age notification Workers affected by the 12-month limit to weekly payments after a worker reaches retirement age are provided with at least 13 weeks' notice prior to the cessation of entitlements. Written notification includes: • 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. Reference: Standards of Practice 17, 18	Evidence of written notification on the claim file.

7. Work capacity

Criterion Number	Component	Auditing principles and considerations	Benchmark
7.1	Compliance	<u>Assessing work capacity</u> Work capacity assessments are conducted throughout the life of the claim as part of the normal claim's management process, and where new information indicating a change in work capacity is received. Where a certificate of capacity is received indicating a change in fitness, the following occurs: • the reasons for the change in capacity are investigated and noted • where necessary, consultation with relevant stakeholders has occurred • the workers capacity has been re-assessed and a work capacity decision made • the worker has been advised of the assessment and decision made within 2 working days of the decision being made. Reference: s38, s43, s44 of the 1987 Act Standard of Practice 11 Workers Compensation Guidelines Part 5	Work capacity assessments are conducted in accordance with the Guidelines. Decisions and rationale supporting all work capacity decisions are clearly documented and recorded on the claim file.
7.2	Compliance	<u>Work capacity appointments</u> An insurer may use available information to assess work capacity, or it may request the worker to attend an appointment to obtain further information. Where the worker is required to attend an appointment, they are advised of the date and time of each appointment at least 10 working days before the appointment, unless otherwise agreed to by the worker. The advice includes: • 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 may result in the suspension of weekly payments until the assessment appointment is completed.	Work capacity appointments are conducted in accordance with the Guidelines. Decisions and rationale supporting decisions are clearly documented on the claim file.

		Reference s44A (5) of the 1987 Act Workers Compensation Guideline Part 5	
7.3	Compliance	<u>Adverse work capacity decisions</u> The insurer gives notice of a work capacity decision to discontinue or reduce the amount of weekly payments of compensation. A relevant summary in the approved form is included and positioned on the front page of the insurer decision notice. Contact is made or attempted by telephone or in person with the worker at the time of the decision to inform of the decision. The insurer does not discontinue weekly payments to a worker or reduce the amount of the compensation being paid, unless the required period of notice has expired. Reference s43 1987 Act s78(1)(b), s79 s80 of the 1998 Act Workers Compensation Regulation 2016	Evidence on the claim file that the insurer has given notice of the decision and that the appropriate notice period has been paid
7.4	Compliance	<u>Optional reviews and work capacity disputes</u> The insurer conducts an optional review where the worker has applied for a review of a work capacity decision. The insurer completes the review and notifies of the decision and reason in writing within 14 days after the request is made. All relevant material submitted by the worker in connection with the request is considered, and the review is conducted by someone other than the person that made the original decision The worker may elect to dispute a work capacity decision and refer this to the PIC for determination. Where a worker has lodged a dispute with the PIC before the date the decision takes effect, the insurer has operated to stay the decision, and the workers weekly payments continue until a decision is made by the PIC. Reference: s81, s82 1998 Act s287A, s289B of the 1998 Act cl42A, cl42B Workers Compensation Regulation 2016	Decisions and rationale supporting decisions are clearly documented on the claim file. Review is conducted within timeframes.

7.5	Data Quality	Data: Work Capacity Decisions Where an adverse work capacity decision has been made the data reflects the lifecycle of that decision as follows: • the date the insurer issued the original decision notice to the worker • the work capacity type • the stage of the work capacity decision • the date the work capacity activity occurs • the result of the work capacity assessment or work capacity assessment review. Reference: Workers Compensation Insurer Data Reporting Requirements: Section C:2.8.1 - C:2.8.9	Data reported is consistent with the data on the claim record.

8. Service provider management and related expenses

Criterion Number	Component	Auditing principles and considerations	Benchmark
8.1	Case Mgt Practice	Payment of worker claim reimbursements The worker receives prompt payment of reimbursements for medical, hospital and rehabilitation services and related travel expenses. Payments are processed in line with the insurer's injury management program and are made no later than ten working days after receipt of relevant documentation for expenses that do not require pre-approval or where pre-approval has been obtained. Where there is likely to be a delay in payment of a reimbursement, the worker is advised within 10 working days of the insurer receiving the claim for reimbursements, the reasons for delay and the anticipated time to resolution. Reference: Standard of Practice 10 s59, s60 of the 1987 Act.	Evidence on the claim file that payments have been made in line with the insurer's injury management program and within timeframes.
8.2	Case Mgt Practice	Section 59A notification For workers who are reaching the end of their medical entitlements, insurers provide written notification to the worker, the nominated treating doctor and practitioners providing treatment or rehabilitation services at least 13 weeks prior to the cessation of medical benefits. Written notification 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 IRO). Reference: Standard of Practice 19 S59A of the 1987 Act	There is evidence on the claim file that notification has been provided to stakeholders.

8.3	Compliance	Service and treatment provider approvals Only allied health providers (physiotherapist, chiropractor, osteopath, exercise physiologist, psychologist and counsellors) who have a SIRA provider number and who submit an Allied Health Recovery Request (AHRR) provide treatment or services to a worker. Note this does not apply to interstate practitioners. All AHRR are reviewed by the insurer and assessed to ensure clear treatment and return to work goals are established, and that the intervention contributes to recovery at work or optimum outcome for the worker and the claim. If not subject to pre-approval, insurers required to determine request for medical, hospital and rehabilitation services within 21 days. Reference: s279 Worker's Compensation Act 1998 Workers Compensation Guidelines Part 4 Standards of Practice 15 Guidelines for approval of treating allied health practitioners	Decisions and rationale supporting decisions are clearly documented on the claim file.
8.4	Case Mgt Practice	Payment of service provider invoices Providers receive prompt payment of invoices and reimbursements for medical, hospital and rehabilitation services. Service provider invoices are reviewed prior to payment to ensure: • rates and items billed align with approvals • rates do not exceed the maximum amount prescribed by any relevant Workers Compensation Fees Orders, • invoices contain all relevant information, including application of GST or input tax credits where appropriate. Payments are made no later than ten working days from receipt of a valid invoice for approved treatment, or within a provider's terms, whichever is the later. Where there is likely to be a delay in payment of an invoice, the provider is advised within 10 working days from receipt of the invoice of the reasons for delay and the anticipated time to resolution. Reference: Standard of Practice 10, 15 s59, s60 of the 1987 Act	Evidence on the claim file that provider invoices are paid promptly.

8.5	Case Mgt Practice	Vocational programs A completed vocational program – claim for payment form and relevant invoices or receipt are submitted to facilitate the payment of vocational programs. Payments are made in line with the amount(s) approved and are only made where there is evidence of cost/expenditure (e.g. purchase order, tax invoice, receipts or record of travel such as a travel log or fares). The insurer has evidence of controls in place to prevent duplicate payments being made and claimed. Reference: S53 1998 Act	Evidence on the claim file that correct documentation has been completed and correct payments made/claimed.
8.6	Case Mgt Practice	Workplace rehabilitation Workplace rehabilitation providers are appointed in line with the insurer's injury management program and are engaged to implement goals focused on optimising function, participation and return to work, and are not used for general claims management activities. Where a workplace rehabilitation provider has been appointed, all parties are made aware of the role of the workplace rehabilitation provider and what they can expect from their involvement. When approving services from workplace rehabilitation providers, insurers ensure that services are consistent with the SIRA's Workers compensation workplace rehabilitation provider approval framework. Reference: Standard of Practice 15 SIRA's Workers compensation workplace rehabilitation provider approval framework	Evidence on the claim file that workplace rehabilitation is engaged in line with the insurer's injury management program. Evidence insurer ensures all parties understand role of provider and what to expect from involvement.
8.7	Compliance	Injury management consultations Injury management consultants are engaged where the insurer has identified a risk of delayed recovery or where a specific return to work or injury management issue has been identified. Written communications to stakeholders confirming the referral occurs as follows: • nominated treating doctor is advised within 5 days of the referral being made • worker is advised of the referral at least 10 working days prior to the appointment • IMC is provided with relevant claim information at least 10 working days prior to the appointment • meets the requirements of the Standard of Practice 14.	Decisions and rationale supporting decisions to engage (or not to engage) an IMC are clearly documented on the claim file.

		Reference: Workers Compensation Guidelines Part 6 Standard of Practice 14	
8.8	Compliance	<u>Independent medical examinations</u> The insurer refers to an independent medical examination (IME) for the appropriate reasons and when information from the treating medical practitioner(s) is inadequate, unavailable or inconsistent, and the insurer is unable to resolve the problem directly with the practitioner/s. An IME referral is appropriate if it 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/suitable duties • what past and/or ongoing incapacity results from the injury • physical capabilities and any activities that must be avoided. The worker is advised in writing at least 10 working days before the appointment. If a shorter time is required because of exceptional and unavoidable circumstances, the reduced timeframe has been agreed to by all parties. The location of the independent medical examiner's rooms is within the worker's travel restrictions as certified by their nominated treating doctor. Reference: Workers Compensation Guidelines: Part 7	Evidence of contact, or attempts to contact the treating doctor are documented on the claim file prior to an IME referral being actioned. Decision and decision rationale for the IME referral is clearly documented on the claim file. The written advice to the worker includes all information as prescribed by 7.4 of the Workers Compensation Guidelines.
8.9	Case Mgt Practice	<u>Factual investigations and surveillance</u> Factual investigations are used when necessary and are undertaken in a fair and ethical manner and only when the required information cannot be obtained by other less intrusive means. The purpose for undertaking factual investigations is clearly documented. Where the worker is requested to participate in a factual investigation, the insurer has advised them in writing at least five working days prior to the proposed factual interview.	Decision to refer for factual investigation or surveillance and the rationale supporting the decision is clearly

	Decisions to engage surveillance services are based on firm evidence. Surveillance of a worker is only conducted 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. Surveillance is conducted in an ethical manner, and any information obtained through surveillance is used and stored appropriately. Reference: Standards of Practice 24, 25	documented on the claim file. Surveillance referral meets the requirements of Standards of Practice 25.

9. Claims estimates

Criterion Number	Component	Auditing principles and considerations	Benchmark
9.1	Case Mgt Practice	Updating claim estimates Claim estimates are reviewed at scheduled and event driven review points in accordance with the insurer's business plan or in-house policy. *(Not applicable for self-insurers)* Claim estimates that impact on premium are communicated to the employer in a timely manner. The employer is encouraged to actively participate in providing suitable work and support a worker's recovery at work to reduce the impact of claims costs.	Evidence on the claim file
9.2	Data Quality	Data: Estimates An estimate is recorded where the liability status indicates an estimate is required. The estimate reported on the date of data submission (i.e. submission end date of the previous data month) is consistent with the estimate on the claim at that time). Note: This criterion is N/A where liability status code is 01, 06, 09, or 12 Reference: Workers Compensation Insurer Data Reporting Requirements C:2.6.4 and C:2:6.5	Data reported is consistent with the data on the claim record

10. Data management

Criterion Number	Component	Auditing principles and considerations	Benchmark
10.1	Data Quality	Data: Work status code The work status code and date on the insurer's system matches the current work status of the worker. Work status code at the time of data submission matches the work status of the worker at that time. Reference: Workers Compensation Insurer Data Reporting Requirements. Section C:2.2.13	Data reported is consistent with the data on the claim record.
10.2	Data Quality	Data: Injury codes The following codes are consistent with SIRA data reporting requirements and are reflective of the current status of the claim: • TOOCS Bodily location • TOOCS Mechanism of injury • TOOCS Breakdown Agency. Reference: TOOCS 3.1	Data reported is consistent with the data on the claim record.

11. Permanent impairment

Criterion Number	Component	Auditing principles and considerations	Benchmark
11.1	Compliance	Referring for a permanent impairment assessment The insurer refers for a permanent impairment assessment where there is evidence that the worker has reached maximum medical improvement and where it is likely that the worker will have their entitlements extended due to their degree of permanent impairment. Where an insurer refers a worker for an independent medical examination for the purpose of obtaining an assessment of permanent impairment, the insurer must ensure that the assessor is a specialist medical practitioner with qualifications, training and experience relevant to the body system being assessed. The assessor must also be a listed on the SIRA website as a SIRA workers compensation trained assessor of permanent impairment. Reference: Section 39, S59A, s65 1987 act S119 of 1998 Act Workers Compensation Guidelines Part 7 Guidelines for the evaluation of permanent impairment.	Evidence on the claim file that a referral has been actioned well within the relevant entitlement period to ensure that a worker is assessed prior to the entitlement limit being reached. Evidence on the claim file that the referral is made in line with the Guidelines.
11.2	Compliance	Assessing the relevant particulars Where a permanent impairment claim has been received, the insurer has made a proper assessment of the relevant particulars of the claim. Where it is determined that the relevant particulars are insufficient to determine the claim, the worker or their representative are advised within two weeks that additional information is being sought by the insurer. Reference: s282 of the 1998 Act S66 of the 1987 Act Guidelines for the evaluation of permanent impairment. Workers Compensation Guidelines Part 8	There is evidence on the claim file that the insurer has assessed the relevant particulars of the claim in line with the Guidelines.

11.3	Case Mgt Practice	<u>Permanent impairment assessment</u> Permanent impairment entitlements are assessed in line with the insurer's injury management program. Permanent impairment reports are reviewed within 10 working days and objectively evaluated to ensure correct and consistent assessment for the determination of entitlements. Where it has been determined that the assessment is consistent with the information in the claim file and with the NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment, an offer of settlement is made. Where more information is required, or the report is not consistent with the Guidelines, the insurer has requested clarification or amendment from the assessor. Reference: Standard of Practice 20 NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment	There is evidence on the claim file that permanent impairment assessment reports are objectively evaluated, and permanent impairment entitlements assessed in line with the insurer's injury management program.
11.4	Compliance	<u>Determining the claim for lump sum compensation</u> The insurer has determined the claim for lump sum compensation within the relevant timeframes. The claim has been determined and a settlement offer made: a) 1 month after the degree of permanent impairment first became fully ascertainable, as agreed by the parties or as determined by an approved medical specialist, or b) within 2 months after the claimant provided the insurer all relevant about the claim. Where the insurer disputes liability in respect of a claim for permanent impairment, a s78 decision notice is issued in line with legislative requirements. Reference: s78, s281 & 282 of the 1998 Act clause 38 of the Workers Compensation Regulation 2018	Evidence on the claim file that the claim for lump sum is determined within the relevant timeframes
11.5	Case Mgt Practice	<u>Negotiation on the degree of permanent impairment</u> Where appropriate the degree of permanent impairment is negotiated, and agreement reached between the parties. The worker is provided with all relevant reports and other evidence at least five working days prior to negotiating the degree of permanent impairment.	There is evidence on the claim file that the insurer attempts to negotiate and achieve a timely permanent impairment

		Before entering into an agreement regarding the worker's degree of permanent impairment, there is evidence that the insurer is satisfied that the worker has made an informed decision and has obtained (or waived the right to obtain) independent legal advice regarding the consequences of entering into the agreement. Where an agreement can't be reached and the matter proceeds within the PIC, all parties participate in PIC teleconferences, conciliations/arbitrations and mediations in good faith and with a view to achieving the timely and effective resolution of disputes. Reference: Standard of Practice 21, 22 s66A of the 1987 act Workers Compensation Guidelines Part 8	settlement where appropriate.
11.6	Case Mgt Practice	<u>Proactive engagement with Centrelink and Medicare</u> The implications of lump sum payments for Centrelink benefits, including possible repayments to Centrelink or temporary preclusion from Centrelink benefits, are proactively managed to minimise impacts on workers. Due care is given in the management of claims to mitigate risks arising from the interaction between Medicare and the workers compensation scheme. Reference: Standard of Practice 26, 27	There is evidence on the claim file that appropriate documentation has been provided to Centrelink and Medicare within five working days of settlement.
11.7	Compliance	<u>Complying agreements and payment of settlement money</u> Where the insurer and the worker agree the degree of permanent impairment, the complying agreement that is entered into satisfies the requirements of section 66A of the 1987 Act and the Workers Compensation Guidelines. The worker is paid the correct permanent impairment compensation in line with the degree of impairment recorded in the complying agreement. Reference: Workers Compensation Guidelines Part 8 s66A (4) of the 1987 Act SIRA Workers compensation benefits guide (relevant edition)	A complying agreement between the worker and employer are recorded by the insurer in accordance with the Guidelines.

11.8	Data Quality	<u>Data: Permanent impairment estimates and payments</u> The code for the PI estimate on the claim record is consistent with data submitted at date of data submission. Where a permanent impairment payment has been made, these are coded as WPI001, and the amount and date paid are consistent with the data submitted to SIRA. Reference: Workers Compensation Insurer Data Reporting Requirements. Section C.2.2.44, C:2.5.5, C:2.5.7, C:2.5.17	Data reported is consistent with the data on the claim record.

12. Commutations

Criterion Number	Component	Auditing principles and considerations	Benchmark
12.1	Compliance	Commutation agreements A liability may be commuted to a lump sum where the relevant pre-conditions are met and with the agreement of the worker. Informal lump sum agreements are not entered, and compensation for catastrophic injuries are not commuted. Before the commutation agreement is entered into, the insurer is satisfied the worker received advice from a legal practitioner independent of the insurer and employer. On reaching an agreement of the commutation amount, an application is made to SIRA for a commutation certificate confirming that the worker has met the pre-conditions, and then an application is made to the PIC to register the agreement. Reference: Part 3 Division 9 of the 1987 Act Workers Compensation Guidelines Part 9	Evidence on the claim file that the preconditions for commutation are met and the appropriate documentation is submitted to SIRA for review.
12.2	Case Mgt Practice	Proactive engagement with Centrelink and Medicare The implications of lump sum payments for Centrelink benefits, including possible repayments to Centrelink or temporary preclusion from Centrelink benefits, are proactively managed to minimise impacts on workers. Due care is given in the management of claims to mitigate risks arising from the interaction between Medicare and the worker's compensation scheme. Reference: Standard of Practice 26, 27	There is evidence on the claim file that appropriate documentation has been provided to Centrelink and Medicare within five working days of settlement.

12.3	Compliance	Payment of settlement The agreed commutation amount is paid within seven days after the agreement is registered or within a longer period as agreed. Interest is paid for any overdue amounts. Reference: Part 3 Division 9 of the 1987 Act (s87F (7))	Evidence on the claim file that settlement has been paid correctly
12.4	Data Quality	Data: Commutation settlement payments The total amount and the date paid on the claim record are consistent with the data submitted to SIRA. All payments for commutations are coded as COM001 in the data submission. Reference: Workers Compensation Insurer Data Reporting Requirements. Sections C:2.5.5 and C:2.5.7	Data reported is consistent with the data on the claim record.

13. Work Injury damages

Criterion Number	Component	Auditing principles and considerations	Benchmark
13.1	Compliance	Eligibility to claim The claim for WID has been reviewed in line with the following criteria: • the injury resulted in the death of the worker or a degree of permanent impairment of the worker that is at least 15% • the injury was caused by the negligence or other tort of the worker's employer • a claim for lump sum compensation is made before or at the same time as the claim for WID • proceedings have commenced within 3 years of the date of injury (or with leave of the court). The claim is determined no later than two months after receipt of all relevant particulars about the claim. The insurer takes action by: • making an offer of settlement or • disputing liability. Where the insurer has disputed liability a decision notice under section 78 of the 1998 Act has been issued. Reference: s150, s151of the 1987 Act Part 5 of 1987 Act s78 of the 1998 Act. Chapter 7 Part 3, Division 4 of the 1998 Act c 38A Workers Compensation Regulation 2016	Evidence on the claim file that the claim has been reviewed and meets eligibility criteria, and that a reasonable offer of settlement is made, or the claim is disputed.
13.2	Compliance	Responding to the pre-filing statement Response to the pre-filing statement is made within 28 days (or no longer than 42 days to allow a defence to be filed). Within 28 - 42 days after the pre-filing statement is served the insurer responds by: a) accepting or denying liability (wholly or in part), and/or b) served a defence to the claim setting out such particulars of the defence and evidence that the defendant will rely on to defend the claim.	Evidence on the claim file that the insurer has responded to the pre-filing statement

		Reference: s316, s318 of the 1998 Act	
13.3	Compliance	<u>Participation in mediation</u> All parties will participate in PIC mediations in good faith and with a view to achieving the timely and effective resolution of disputes. When served with an application for mediation to resolve a WID claim, the insurer has lodged a response within 21 days of registration. The insurer only declines to participate in mediation if they wholly dispute liability for the claim. Reference: s318A of the 1998 Act Procedural Direction WC4 – Work injury damages	Evidence on the claim file that the insurer participates in mediation with the aim of timely and effective resolution of the dispute.
13.4	Case Mgt Practice	<u>Deed of release</u> The insurer is in receipt of settlement documents and complies with the terms of settlement. Where the worker has an entitlement to weekly benefits, the worker continues to receive payments up to the date damages monies are released to their solicitor. Entitlement to medicals cease on the date the Deed is signed (unless otherwise agreed).	Evidence on the claim file that the insurer has complied with the terms of settlement.
13.5	Case Mgt Practice	<u>Proactive engagement with Centrelink and Medicare</u> The implications of lump sum payments for Centrelink benefits, including possible repayments to Centrelink or temporary preclusion from Centrelink benefits, are proactively managed to minimise impacts on workers. Due care is given in the management of the claims to mitigate risks arising from the interaction between Medicare and the workers compensation scheme. Reference: Standard of Practice 26, 27	There is evidence on the claim file that appropriate documentation has been provided to Centrelink and Medicare within five working days of settlement.

Disclaimer

This publication may contain information that relates to the regulation of workers compensation insurance, motor accident compulsory third party (CTP) insurance and home building compensation in NSW. 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.

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