Claims administration manual

Standards of practice for insurers

Consultation draft

October 2018

NSW GOVERNMENT

Contents

Introduction

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

In stewarding the NSW workers compensation system, it is our mission to ensure that the system is:

- equitable and fair
- efficiently delivered
- affordable for the community
- sustainable and viable for generations to come
- delivering scheme outcomes effectively
- providing positive experiences.

A principle objective under section 23 of the *State Insurance and Care Governance Act 2015* states that SIRA is responsible for the effective supervision of claims handling and disputes arising under NSW workers compensation legislation.

We have developed these Standards of practice (Standards) for claims handling and administration to set expectations for insurers, and to support the effective and efficient management of claims under the workers compensation system.

For the purposes of section 192A of the *Workers Compensation Act 1987* (the 1987 Act), the Standards proposed within this document form the claims administration manual (CAM).

Purpose

The Standards will form one part of a broader digital platform (platform) that will make available online comprehensive workers compensation information, resources and better practice guidance for insurers and other system stakeholders.

The digital platform will collate relevant information in a readily accessible format and help all stakeholders easily navigate the NSW workers compensation system.

The interrelated elements of the platform are outlined in the table below.

Element	Purpose
Workers compensation guidelines	Classification of certain matters as prescribed by the workers compensation legislation.
Standards of practice	Mandatory **standards of practice** to standardise operational activity across all insurers and ensure system -wide equity and fairness in the administrative processing elements of claims management.
Practice notes	Guidance and support to communicate to insurers what SIRA would consider as acceptable practice.
Educate and assist	Innovative on-line educate and assist platform designed to assist all stakeholders to navigate the legislative

Element	Purpose
	landscape, creating a centralised and connected framework.
Better Practice Repository	To promote better practice in case management and injury management with links to external sites and/or research.

The Standards will 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.

Standards of practice

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

SIRA is committed to stewarding an affordable and sustainable workers compensation system in NSW. Our regulatory principles are described below:

- **outcomes-based,** prescribe activities aimed to facilitate work and health outcomes for workers and a viable and sustainable workers compensation scheme for employers
- **risk-based,** prescribe practice where there is a significant risk of harm and/or affect to system outcomes that is not otherwise mitigated
- **evidence-based,** address known harms that are not adequately addressed through other mechanisms.

The Standards are also informed by claims management principles. These principles guide claims management activity in order to meet the system objectives outlined in section 3 of the *Workplace Injury Management and Workers Compensation Act 1998 (*1998 Act). The principles articulate a strategy built on:

- fair and equitable claims management
- transparent and honest communication
- proactive, prompt, efficient and effective claims management.

Further details on the claims management principles can be found in S1 – Claims management principles.

Scope

The CAM will form part of SIRA's regulatory framework and will apply to all insurers, except for Coal Mines Insurance Pty Ltd and The Workers Compensation (Dust Diseases) Authority (Dust Diseases Care). However, adoption of the claims management principles and any relevant standard of practice is encouraged by all insurers operating in the NSW workers compensation system.

Exempt categories of workers ('exempt worker')

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

Each standard of practice specifies whether it applies to 'exempt workers'.

How to use these standards

The Standards are mandatory requirements for insurers.

Practice notes will be developed on a range of topics to provide guidance and support to insurers, and to outline what may be considered acceptable practice. They are not intended as mandatory requirements. However, SIRA may issue a direction to insurers to comply with a specific process, procedure, strategy, policy or method contained in a practice note where the evidence and risk warrant it. For the purposes of this document, practice note content has not been included.

It is not intended that this document provide comprehensive guidance on all claims management matters. It should be read in conjunction with the requirements of the workers compensation legislation, regulation and guidelines.

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

Measurement and enforcement

These Standards form part of the workers compensation regulatory framework and work alongside other SIRA regulatory tools and supports. This includes the *Insurer claims management audit manual*, the *Workers compensation licensed insurer business plan guidelines*, and the *Injury management program guide*.

Managing compliance with, and enforcement of, the Standards will be undertaken in line with the SIRA Compliance and Enforcement Policy.

The Standards form directions to insurers with respect to claims procedures issued under Division 4 of Part 7 of the 1987 Act and therefore contravention of a requirement pursuant to the Standards may constitute an offence under section 209 of the 1987 Act. Section 194(2) makes compliance with a direction to insurers a condition of an insurers license issued under the Act.

For the purposes of section 192A of the 1987 Act, the Standards proposed within this document form the CAM with which licensed insurers must comply.

Sections 192A and 194 of the 1987 Act are provided at Appendix A.

Reference numbers have been allocated to the Standards of practice as per below:

- **S1** – Standard of practice topic heading
- **S1.1** – Standard of practice element.

Standards of practice

S1. Claims management principles

The claims management principles provide direction for the handling and administration of claims under the workers compensation system.

Context

These principles are deemed necessary to support the workers compensation system objectives outlined in section 3 of the *1998 Act.*

Claims management that is supportive, non-adversarial and accessible can provide a positive experience for workers and employers, and focus the efforts of system participants to achieve the best possible return to work and health outcomes.

The workers compensation system should be administered in a way that is fair and equitable. A worker should not have to face significant challenges or barriers to access benefits to which they are entitled and employers should be kept informed throughout the claims management process.

Honest and transparent communication underpins a fair and equitable workers compensation system. When all system participants can understand the claims process, and the decisions made within it, they can fully contribute toward achieving the best possible return to work and health outcomes for the worker.

Model litigant principles apply to civil claims and civil litigation involving the NSW Government and/or its agencies. Where relevant, these principles have been incorporated. This means all insurers are required to maintain proper litigation standards within the workers compensation system, and ensure system objectives are prioritised.

The system objectives recognise that prompt, proactive and efficient action is needed to deliver optimal outcomes. Timely and responsive claims handling can reduce conflict, and allow more time to focus on worker and employer needs and outcomes. To be effective, the workers compensation system should support and facilitate return to work and recovery outcomes for workers.

Standard of practice 1: Claims management principles	
S1.1	Insurers are required to manage claims *fairly and equitably* by: • acting in good faith in the investigation and consideration of claims • implementing decision-making procedures that allow for right of reply and prompt, independent review • making objective decisions on the best available evidence as soon as it is received • promptly paying legitimate claims without unnecessary disputes, investigation and litigation.
S1.2	Insurers are required to communicate *transparently and honestly* with workers, employers and providers by: • providing appropriate, relevant and accessible information on entitlements, decisions, processes, procedures, rights and responsibilities • providing opportunities for workers, employers and providers to contribute information that can support and inform claims management • communicating, in plain English, the reasons and information relied upon for all decisions made regarding the claim • supporting workers who do not fully understand claims management or dispute processes, and ensuring they are informed of their rights and obligations
S1.3	Insurers are required to manage claims *proactively, timely, efficiently and effectively* by: • proactively making decisions to determine entitlements • promptly and efficiently processing claims and payments in accordance with the law • promptly responding to and actioning incoming communication • trying to avoid disputes and litigation wherever possible • ensuring claims activities are focused on advancing the worker's recovery and return to work.
Application	These standards apply equally to exempt workers.

Further information to help you

Relevant provisions

Directions to insurers with respect to claims procedures:

- *Section 194, Workers Compensation Act 1987*

Claims administration manual:

- *Section 192A, Workers Compensation Act 1987*

Relevant links

- SIRA Strategic plan 2018
- NSW workers compensation system objectives
- NSW model litigant policy
- SIRA Insurer claims management audit manual

S2. Worker consent

Insurers must gain consent from a worker to exchange and receive information about their health, injury and recovery. This promotes good communication and transparent decision-making between the worker, the employer and the RTW team.

Context

Informed consent is where a worker is given all the relevant information before consenting to the release and exchange of information. It ensures the worker understands the benefits of providing consent and risks of not doing so.

A worker's consent is only genuine and valid if they have been given this information and can understand, provide and communicate their consent. This includes accommodating the needs of workers with a disability and those who do not speak English.

The insurer must ensure that the worker's personal and health information is not obtained or disclosed without consent.

Where the insurer relies on the consent provided by the worker, the consent must be express and current. This promotes transparency in the claims process and protects the worker's privacy.

Standard of practice 2: Worker consent	
S2.1	Insurers must deal with a worker's personal and health information in accordance with the worker's current and express consent.
S2.2	When requesting a worker's written consent, insurers are required to ensure the worker knows and understands: • their rights and obligations • what type of information will be exchanged • who will be authorised to exchange and release information.
S2.3	Where a request to release personal information is received from a third-party in relation to a worker's injury and/or workers compensation claim, the insurer must determine whether existing worker consent is sufficient or if new consent is required prior to release.
Application	These standards apply equally to exempt workers.

Further information to help you

Relevant claims handling principles

- Fair and equitable claims processes
- Transparent and honest communication

Relevant provisions

Disclosure requirements:

- *Section 243, Workplace Injury Management and Workers Compensation Act 1998*

Relevant links

- Improving worker access to information in the NSW workers compensation system
- *Privacy and Personal Information Protection Act 1998*
- *Health Records and Information Privacy Act 2002*
- *Government Information (Public Access) Act 2009*
- Australian Privacy Principles (for government agencies)
- National Privacy Principles (for non-government business and entities)

S3. Worker access to personal information

NSW workers compensation legislation does not limit or prevent workers from exercising their rights under the relevant privacy laws to access their personal and health information.

Context

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

Allowing workers access to information empowers them to manage their own injuries, as well as promote and participate fully in their return to health and work. Access to their personal and health information also ensures workers are informed throughout the claims process.

Any grounds for caution regarding the release of information to a worker should be based on concerns regarding the safety and well-being of the worker or others.

A worker's personal and health information should not be withheld because release of the information may be contrary to employer or insurer interests in the event of litigation (subject to legal professional privilege).

Standard of practice 3: Worker access to personal information	
S3.1	Insurers are required to demonstrate compliance with the relevant privacy laws and produce any information required under those laws upon request of the worker.
S3.2	Insurers must ensure workers are aware of their right to access their own personal and health information, including but not limited to: • Independent Medical Examiner reports • Injury Management Consultant reports • Independent Consultant reports • workplace rehabilitation reports • reports gathered for work capacity assessments • any insurer-requested reports from the nominated treating doctor, nominated treating specialists, allied health providers, and workplace rehabilitation providers.
S3.3	Insurers must ensure third party providers are aware that any report they provide in relation to a worker, may be released to that worker.
S3.4	Insurers must either: a. proactively release relevant reports and documents referred to in S3.2, or b. promptly process any request by the worker (or their representative) for information contained within the insurer's claim file, and not withhold that information unless the insurer has concerns regarding the safety and well-being of the worker or others, if the information is released to the worker.

Standard of practice 3: Worker access to personal information	
S3.5	If the insurer determines that releasing information to the worker may affect the safety and well-being of the worker or others, the insurer is to release the information in accordance with clause 41 (5) of the Workers Compensation Regulation 2016.
Application	These standards apply equally to exempt workers.

Further information to help you

Associated claims handling principles

- Fair and equitable claims processes
- Transparent and honest communication

Relevant provisions

Providing notice and reasons:

- *Section 54, Workers Compensation Act 1987*
- *Section 74, Workplace Injury Management and Workers Compensation Act 1998*
- Clause 38, Part 8 of the Workers Compensation Regulation 2016

Access to medical and other insurer reports:

- *Section 126, Workplace Injury Management and Workers Compensation Act 1998*
- Clause 41, Part 9 of the Workers Compensation Regulation 2016

Relevant links

- Improving worker access to information in the NSW workers compensation system
- *Privacy and Personal Information Protection Act 1998*
- *Health Records and Information Privacy Act 2002*
- *Government Information (Public Access) Act 2009*
- NSW Information and Privacy Commission
- Australian Privacy Principles (for government agencies)
- National Privacy Principles (for non-government business and entities)

S4. Initial liability decisions – provisional, reasonable excuse or full liability

Liability decisions must be made in accordance with the legislation and informed by the careful consideration of all evidence. Key to the principles of fairness and transparency is the observation of procedural fairness and proactive consultation with the worker and employer.

Context

When determining initial liability for an injury, insurers are to gather the relevant evidence, consult with key stakeholders (including the employer and worker) and ensure that the decision is made in a timely manner and communicated appropriately.

The workers compensation legislation provides that an insurer is to commence provisional weekly payments within seven days after initial notification of an injury, unless they have a reasonable excuse not to commence weekly payments. The insurer can accept provisional liability for up to 12 weeks, having regard to the nature of injury and period of incapacity.

Within 21 days of a claim being made, the insurer is required to determine the claim by either accepting or disputing liability. However, if a claim for weekly payments has been accepted provisionally, the insurer is required to determine the claim, by either accepting or disputing liability, before the end of the provisional period. This does not apply to claims finalised before the expiration of the provisional period.

Proactive communication with the worker and the employer is an integral part of sound decision-making. Decisions need to be made in a fair and transparent manner – this requires full and open communication between stakeholders.

Standard of practice 4: Initial liability decisions	
S4.1	When determining liability, insurers must: • proactively request and obtain relevant information to determine liability on a claim • promptly determine liability and not delay a decision until the end of the relevant time limit • make the decision based on available evidence, in accordance with legislation, and in consultation with the employer and worker.
S4.2	If accepting provisional liability, the insurer is to provide written notice to the worker as required under section 269 of the 1998 Act, and also include in this notice: • the workers pre-injury average weekly earnings (PIAWE) • the amount of weekly payment and how that amount has been calculated (including a copy of the completed PIAWE form where one has been provided) • who will pay the worker (either the employer or the insurer) • what to do if the worker disagrees with the amount or does not receive payment • what information the worker needs to provide the insurer for weekly payments to continue.

Standard of practice 4: Initial liability decisions	
S4.3	If accepting provisional liability, the insurer is to provide notice to the employer as soon as practicable, and no later than two business days after the decision has been made. The notice is to include: • confirmation that provisional weekly payments are to commence • the period for which provisional payments are to continue (up to a maximum of 12 weeks) • that the insurer will develop an injury management plan for the worker (if required to do so by Chapter 3 of the 1998 Act), and • that the worker is entitled to make a claim for compensation, including details of how that claim can be made.
S4.4	If the insurer has a reasonable excuse not to commence provisional weekly payments, the insurer is to provide written notice to the worker as required under section 268 of the 1998 Act, and also include in this notice: • how the excuse can be resolved • that the worker can talk to the insurer for further information • that the worker can seek help from their union or WIRO, and • that the worker has a right to seek an expedited assessment by application to the Registrar of the Workers Compensation Commission The insurer must also advise the employer of the reasonable excuse as soon as practicable and no later than two business days after the decision has been made.
S4.5	If accepting liability for a claim for weekly payments, the insurer is to provide written notice to the worker and employer of the decision and reasons as soon as practicable, and no later than two business days after an initial liability decision has been made. The written notice must include: • confirmation of the decision to accept liability • the workers pre-injury average weekly earnings (PIAWE) and entitlement to weekly payments, including how that amount has been calculated • who will pay the worker (either the employer or the insurer) • what to do if the worker disagrees with the amount calculated and the review process • that an injury management plan will be developed (if required to do so by Chapter 3 of the 1998 Act) • that to continue to be entitled to weekly payments the worker must give the employer or insurer a properly completed workers compensation certificate of capacity.
S4.6	If an insurer requires a duly completed claim form to determine liability, they are required to proactively request this from the worker and enable sufficient time for the worker to complete and submit the claim form.

Standard of practice 4: Initial liability decisions	
	Note: requesting this at least four calendar weeks before the expiration of the provisional period, or before the anticipated expiration of medical costs, would provide sufficient time. The insurer may deviate from this timeframe if demonstrated this is reasonable having regard to the individual facts and circumstances of the claim.
Application	These standards apply equally to exempt workers.

Further information to help you

Associated claims handling principles

- Fair and equitable claims processes
- Transparent and honest communication
- Proactive, prompt and efficient claims management

Relevant provisions

Requirement to contact stakeholders for significant injury to a worker:

- *Section 43(4), Workplace Injury Management and Workers Compensation Act 1998*

Duty to commence weekly payments following initial notification of injury:

- *Section 267, Workplace Injury Management and Workers Compensation Act 1998*

Liability to be accepted and weekly payments commenced within 21 days:

- *Section 274, Workplace Injury Management and Workers Compensation Act 1998*

Timeframe for making a liability decision for medical expenses:

- *Section 279(1), Workplace Injury Management and Workers Compensation Act 1998*

Dispute notice requirements:

- *Section 74, Workplace Injury Management and Workers Compensation Act 1998*
- Clause 38, Workers Compensation Regulation 2016

Commencing provisional weekly payments notice requirements:

- *Section 269, Workplace Injury Management and Workers Compensation Act 1998*

S5. Liability for medical or related treatment

Insurers are required to make liability decisions at various points during a claim. Each time a worker makes a claim for medical or related treatment, the insurer is required to determine liability in accordance with the legislation.

Insurers are to gather the relevant evidence, consult with key stakeholders and ensure that the decision is soundly based, made in a timely manner and communicated appropriately.

Context

Liability decisions must be made in accordance with the legislation and informed through careful consideration of all evidence. Key to the principles of fairness and transparency is the observation of procedural fairness and proactive consultation with the worker and employer.

NSW workers compensation legislation requires liability to be determined within 21 calendar days after a claim for medical expenses has been made.

Communication with the worker and employer is an important part of decision-making. Decisions should be made in a fair and transparent manner. This requires full and open communication between stakeholders.

Standard of practice 5: Liability for medical or related treatment	
S5.1	Insurers must proactively request and obtain relevant information to determine liability for claims made for medical or related treatment.
S5.2	Insurers are expected to promptly determine liability and not unreasonably delay a decision until the end of the time limit (21 calendar days).
S5.3	When a request for medical or related treatment is received the insurer is to acknowledge the request as early as possible and keep the worker informed of the status of their claim and the timeframe within which liability is required to be made. Note: Insurers are to acknowledge the request by the 14th calendar day. This applies unless the insurer has made a decision and communicated this to the worker, or is able to demonstrate that deviation from this timeframe is reasonable having regard to the individual facts and circumstances of the claim.
S5.4	As soon as practicable, and no later than two business days after a liability decision has been made, the insurer must contact the worker and employer to advise of the outcome and reasons for that decision.
Application	These standards apply equally to exempt workers.

Further information to help you

Associated claims handling principles

- Fair and equitable claims processes
- Transparent and honest communication
- Proactive, prompt and efficient claims management

Relevant provisions

Timeframe for making a liability decision for medical expenses:

- Section 279(1), Workplace Injury Management and Workers Compensation Act 1998

Dispute notice requirements:

- Section 74, Workplace Injury Management and Workers Compensation Act 1998
- Clause 38, Workers Compensation Regulation 2016

S6. Recurrence or aggravation

Insurers must have regard to the facts and medical evidence relied on to properly determine whether an injury is a recurrence of an existing injury, or an aggravation of a pre-existing condition.

Context

The distinction between the recurrence of a compensable injury/disease and a new claim made due to the aggravation at work of a pre-existing injury can be significant for workers and employers. The insurer's decision will impact the calculation of a worker's benefits and may be significant for an employer's premium. Each case needs to be determined on its own facts and the medical evidence.

A recurrence occurs where a worker suffers a work-related injury, and there is a later, spontaneous re-emergence of symptoms needing treatment or causing incapacity.

An aggravation occurs where the worker's employment was a substantial contributing factor in exacerbating a pre-existing injury.

For a disease injury (including aggravation to a disease), employment must be the main contributing factor to the aggravation of the disease (not to the underlying condition). The disease itself may have had many other factors contributing to its pathology. Each case should be considered on its own facts and the medical evidence.

Standard of practice 6: Recurrence or aggravation	
S6.1	Insurers must consider the facts and medical evidence to determine whether an injury is an: • aggravation of a previous injury, which is to be managed as a new injury (within normal legislative requirements), or • a recurrence of a previous injury, which is to be managed on the existing claim.
S6.2	As soon as practicable, and no later than two business days after the insurer determines whether the injury is a recurrence or aggravation, they must contact the worker and employer to advise of the outcome and reasons for that decision.
Application	These standards apply equally to exempt workers (please note for exempt workers work need to be a substantial contributing factor not the main contributing factor).

Further information to help you

Associated claims handling principle

- Fair and equitable claims processes

Relevant provisions

Definition of 'injury':

Section 4, Workers Compensation Act 1987

No compensation payable unless employment substantial contributing factor to injury:

Section 9A, Workers Compensation Act 1987

Aggravation etc of diseases – employer liable, date of injury, etc:

- *Section 16, Workers Compensation Act 1987*

Compensation to be apportioned where more than one injury:

- *Section 22, Workers Compensation Act 1987*

S7. Recoveries

In certain circumstances, workers compensation insurers will be able to recover from other insurers or persons (third parties) who share a proportion of liability for an injury.

Context

Early identification and effective management of third-party recoveries helps ensure the sustainability of the workers compensation system.

Standard of practice 7: Recoveries	
S7.1	Screening for potential recovery should occur within 21 calendar days of receipt of the claim so that claims with potential recovery can be identified for further investigation.
S7.2	The insurer claim file is to clearly record: • investigation activities undertaken regarding recoveries, and • decisions made regarding pursuing recoveries, including the evidence considered to support that decision.
Application	This standard applies equally to exempt workers

Further information to help you

Associated claims handling principle

- Proactively, timely, efficiently and effectively.

Relevant provisions

Recovery against both employer and stranger:

- *Section 151Z, Workers Compensation Act 1987*

S8. Interim Pre-Injury Average Weekly Earnings calculation

Workers are not to be disadvantaged by delays in receiving weekly payment where the employer has not provided the required information to the insurer for the purposes of calculating pre-injury average weekly earnings (PIAWE).

Context

One of the key system objectives is to provide workers with income support during incapacity.

Sometimes insurers are unable to calculate PIAWE within the required timeframe for the first weekly payment as they have insufficient information to correctly calculate it. In such instances insurers are to calculate an interim PIAWE to commence payments without delay.

Where there is an interim PIAWE, and the employer does not respond to insurer requests for information, the insurer can contact SIRA so that we can contact the employer directly.

Standard of practice 8: Interim PIAWE calculation	
S8.1	For claims where weekly payments may be payable, an insurer is required to proactively request pay information from the employer for the purposes of calculating the worker's PIAWE. The request is to specify the pay information is to be provided within 7 calendar days.
S8.2	If the insurer is required to start weekly payments but does not have sufficient information to determine PIAWE accurately, they are to calculate PIAWE based on the best available information (having consulted the employer and worker) and communicate the calculation in a work capacity decision (interim PIAWE).
S8.3	Where there is an interim PIAWE, the insurer must follow-up with the employer regarding the information required to calculate the worker's PIAWE accurately within 14 calendar days of initial notification of injury.
S8.4	Once the employer has forwarded the required information, the insurer must recalculate the worker's PIAWE. If the interim PIAWE amount was incorrect, the insurer should advise the worker in a work capacity decision of the new PIAWE amount and pay any backpay due the worker.
Application	These standards **do not** apply to exempt workers.

Further information to help you

Associated claims handling principle

- Proactive, prompt and efficient claims management

Relevant provisions

Insurer obligation to commence provisional weekly payments:

- *Section 275, Workplace Injury Management and Workers Compensation Act 1998*

Employer obligation to provide insurers with information:

- *Section 264(2), Workplace Injury Management and Workers Compensation Act 1998*

How a worker's PIAWE is calculated:

- *Section 44C, Workers Compensation Act 1987*
- *Section 44D, Workers Compensation Act 1987*
- *Section 44E, Workers Compensation Act 1987*
- *Section 44F, Workers Compensation Act 1987*
- *Section 44G, Workers Compensation Act 1987*
- *Section 44H, Workers Compensation Act 1987*
- *Section 44I, Workers Compensation Act 1987*
- *Schedule 3, Workers Compensation Act 1987*

S9. Insurer making weekly payments

The payments of weekly payment of compensation to workers may be made by the employer or the insurer.

Context

Insurers are responsible for ensuring workers receive correct weekly payments in a reasonable manner. In most cases the worker is paid by the employer. In some instances, it is appropriate for the insurer to make payments directly to the worker.

In instances where it is appropriate that weekly payments be processed directly by the insurer to the worker, it is important to ensure that key stakeholders are kept informed of claim progress and remain aware of the obligations and responsibilities.

Standard of practice 9: Insurer making weekly payments	
S9.1	Before commencing weekly payments of compensation directly to a worker, the insurer is required to advise the employer and where reasonably practicable, obtain their agreement.
S9.2	The insurer must advise the employer that claims costs continue to accrue, and their obligations under workers compensation legislation continue, even if the insurer makes weekly payments directly to the worker.
S9.3	The insurer must advise the worker and employer in writing as soon as practicable after taking over payments made directly to the worker.
S9.4	When making payments directly to the worker, the insurer must ask the worker to fill in an Australian Taxation Office tax file number declaration form and arrange for tax to be paid in-line with income tax law.
Application	These standards apply equally to exempt workers.

Further information to help you

Associated claims handling principles

- Fair and equitable claims processes
- Transparent and honest communication

Relevant provisions

How workers are to be paid:

- *Section 83, Workers Compensation Act 1987*

Timing of payments to workers:

- *Section 84, Workers Compensation Act 1987*

S10. Inform worker of reduction of weekly payments of compensation

Where the workers compensation legislation provides for a reduction in weekly payments of compensation, insurers are required to provide affected workers with sufficient notice to prepare for the change in their weekly payments of compensation.

Context

Workers need to be kept informed about their claim, including when entitlements are to be reduced due to the application of the legislation. Advising workers in a timely fashion allows them to prepare for any reduction in payments.

Standard of practice 10: Inform worker of legislated reduction of weekly compensation	
S10.1	Insurers are required to inform a worker in writing prior at least two to four weeks prior to a legislated reduction in their weekly payments. Note: if the insurer deviates from this timeframe they must be able to demonstrate this is reasonable having regard to the individual facts and circumstances of the claim. For non-exempt workers, this includes the following situations: • before the end of the first entitlement period • before the removal of shift and/or overtime amounts from a worker's PIAWE (where shift and/or overtime amounts are included in the calculation of their PIAWE). For exempt workers, this includes the following situations: • before a reduction in weekly payments after the first 26 weeks of incapacity • before a reduction in weekly payments after the maximum entitlement payable under section 38 (52 weeks).
S10.2	The insurer is required to contact the employer verbally or in writing at least two weeks prior to the legislated reduction to advise of the change and ensure that the employer pays the correct entitlement.
Application	These standards apply equally to exempt workers.

Further information to help you

Associated claims handling principles

- Fair and equitable claims processes
- Transparent and honest communication

Relevant provisions

Weekly payments in second entitlement period (weeks 14-130):

Section 37, Workers Compensation Act 1987

Required period of notice does not apply to a reduction in weekly compensation due to the application of different rates of compensation after the expiration of earlier periods of incapacity for which higher rates were payable:

Section 54(6), Workers Compensation Act 1987

Definition – pre-injury average weekly earnings:

- *Section 44C, Workers Compensation Act 1987*

S11. Payment of invoices and reimbursements

In accordance with workers compensation legalisation, insurers are to pay invoices and reimbursements for medical, hospital and rehabilitation services promptly.

Context

NSW workers compensation legislation requires the prompt payment of compensation following the acceptance of liability for the service. The timely payment of invoices and reimbursements on all claims supports worker recovery through the development of trust and respect among treatment providers and other stakeholders. Non-payment of an invoice can be detrimental to the insurer-health practitioner relationship, negatively impacting worker recovery.

Ensuring prompt payment of invoices and reimbursements allows workers to fully participate in efforts to recover at work and return to health; and providers to focus on treatment and outcomes.

Standard of practice 11: Payment of invoices and reimbursements	
S11.1	Insurers are to promptly pay approved, valid invoices in accordance with SIRAs standard invoicing requirements, as soon as possible and no later than 30 calendar days from date of receipt. Invoices submitted to the insurer greater than 12 months of date of service or are ineligible may take longer to process. In these instances, the insurer should keep a record of the delay on file and keep the party informed as to the delay. 'Approved' refers to invoices for treatment that does not require pre-approval or for treatment for which pre-approval has been obtained.
S11.2	Insurers are to promptly pay approved reimbursements to workers as soon as practicable, and within 15 calendar days from receipt. If a payment cannot be processed within this timeframe, the insurer is to advise the worker of the timeframe in which they can expect to receive payment and the reason for the delay. Reimbursements lodged outside 12 months of date or service or without appropriate evidence may take longer to process. The insurer is to advise the worker within 15 days of receipt, of the anticipated timeframe. "Approved" refers to reimbursements for expenses that do not require pre-approval or for treatment for which pre-approval has been obtained.
Application	These standards apply equally to exempt workers.

Further information to help you

Associated claims handling principle

- Proactive, prompt and efficient claims management

Relevant provisions

Definition of services:

- *Section 59, Workers Compensation Act 1987*

Compensation for cost of medical or hospital treatment and rehabilitation etc:

- *Section 60, Workers Compensation Act 1987*

Duty of insurer to pay promptly:

- *Section 74A, Workplace Injury Management and Workers Compensation Act 1998*

S12. Determining current work capacity following a downgrade in capacity

If a worker's capacity for work is downgraded insurers are required to determine the reasons for the change as soon as possible and clearly communicate the outcome to the worker.

Context

There may be times when new information advising of a downgrade in capacity comes to the attention of the insurer.

The insurer is required to consider this new information and review the worker's capacity to work by performing a work capacity assessment and making a new work capacity decision.

A work capacity decision may be simple and based on limited information, and not change the amount of weekly payments that a worker receives.

A work capacity decision can be more complex, and require a decision that changes the amount of weekly payments that a worker will receive.

The insurer is required to inform the worker of the outcome of the work capacity assessment and decision, and clearly communicate changes (if any) to the amount of weekly payments, or how to request a review if they do not agree with the decision.

Standard of practice 12: Determining work capacity following a downgrade in capacity	
S12.1	If a worker provides a certificate of capacity that reflects a downgrade in their capacity, the insurer is required to promptly investigate the reasons for the downgrade. This may require contact with the worker, the nominated treating doctor, as well as any treating specialist.
S12.2	The insurer is to conduct a work capacity assessment to consider the new information and make a new work capacity decision as soon as practicable, and within 21 calendar days of the notification of downgrade.
S12.3	All work capacity assessments, decisions and reasons are to be clearly documented on file.
Application	These standards **do not** apply to exempt workers.

Further information to help you

Relevant claims handling principles

- Fair and equitable claims processes
- Transparent and honest communication

Relevant provisions

Work capacity assessment:

- *Section 44A, Workers Compensation Act 1987*

Evidence as to work capacity:

- *Section 44B, Workers Compensation Act 1987*

S13. Injury management plans

The development of injury management plans to coordinate and manage the treatment, rehabilitation, and, if necessary, retraining of a worker supports the achievement of a timely, safe and durable return to work.

Context

NSW workers compensation legislation requires the development of an injury management plan when it appears that a workplace injury is a 'significant injury' as defined in section 42(1) of the 1998 Act.

An injury management plan is a comprehensive plan for managing a worker's injury or condition. It provides details on treatment and rehabilitation as well as strategies to support the worker's recovery at/return to work.

An injury management plan that meets these requirements below will provide the stakeholders (specifically the worker) with the information they need to understand the direction of the injury management and the activities required to help the worker recover at work.

Standard of practice 13: Injury management plans	
S13.1	Insurers are required to commence injury management planning with the worker from initial contact, and develop an injury management plan as soon as practicable but no later than 20 business days from the date the injury is determined to be a significant injury.
S13.2	The injury management plan is: • to be specific to the worker • to be developed in consultation with the worker and their employer • to consistent with available medical and treatment information • is to include: – the goal of the plan – actions tailored to the worker and their goal (including involved parties and timeframes) – when the plan will be reviewed, and – rights and obligations of all stakeholders, which may be included in the plan or referenced and attached as an appendix or a separate document.
S13.3	Insurers are to review the injury management plan as per the review points specified in the plan or as new information is received. Evidence of the review is to be documented on the claims record.
Application	These standards apply equally to exempt workers.

Further information to help you

Associated claims handling principles

- Fair and equitable claims processes
- Transparent and honest communication

Relevant provisions

Workplace Injury Management:

Chapter 3, Workplace Injury Management and Workers Compensation Act 1998

Requirement to develop an Injury Management Plan:

- *Section 45, Workplace Injury Management and Workers Compensation Act 1998*

Definition of significant injury:

- *Section 42, Workplace Injury Management and Workers Compensation Act 1998*

Relevant links

- Health Benefits of Good Work Initiative

S14. Addition of a new medical condition or consequential injury to a certificate of capacity

Insurers are to take prompt action and respond to any new medical condition or consequential injury included on the certificate of capacity.

Context

As claims progress, it is not uncommon for new medical conditions or consequential injuries to be added to a certificate of capacity. This may have a significant impact on the management of a claim including the worker's degree of permanent impairment. Insurers should be vigilant and proactive in their review of certificates of capacity.

If the inclusion of a new medical condition or consequential injury is accompanied by a request for treatment, the insurer must make a liability decision within 21 calendar days to determine if the employer is liable for costs and expenses related to the new condition or consequential injury.

Insurers need to be aware of any medical condition which may impact a worker's recovery at/return to work, whether work-related or not.

Properly responding to additional information on the certificate of capacity confirms to the worker and nominated treating doctor that requests for reasonably necessary treatment will be considered without delay. If the new condition is not work-related, prompt action by the insurer enables the treating doctor to appropriately manage the non-work related medical condition.

Standard of practice 14: Addition of a new medical condition or consequential injury to a certificate of capacity	
S14.1	When an insurer receives a certificate of capacity which contains a new medical condition or consequential injury not previously diagnosed or reported, they are to contact the doctor to establish the basis for the inclusion.
S14.2	If the doctor considers that the medical condition or consequential injury could be as a result of the compensable injury, the insurer is required to contact the worker to establish whether they intend to make a claim for costs and expenses for the condition.
S14.3	If the worker is making a claim, the insurer is to promptly advise the worker and employer of their liability decision (within 21 calendar days).
S14.4	If the worker is not making a claim, this is to be documented on the claim file.
Application	These standards apply equally to exempt workers.

Further information to help you

Associated claims handling principle

- Proactive, prompt and efficient claims management

Relevant provisions

Compensation the employer is liable to pay:

- *Section 60, Workers Compensation Act 1987*

Determine within 21 days:

- *Section 279, Workplace Injury Management and Workers Compensation Act 1998*

S15. Referral to an Injury Management Consultant

An Injury Management Consultant (IMC) is a registered medical practitioner experienced in occupational injury and workplace-based rehabilitation. They are approved by SIRA under section 45A of the 1998 Act.

Context

Referral to an IMC is appropriate when a worker is identified at risk of delayed recovery or there is a specific return to work or injury management issue.

An IMC helps the nominated treating doctor, worker, insurer and employer progress a worker's recovery at/return to work and optimise health and work outcomes. The worker and the nominated treating doctor are to be provided with full information about the process and the desired outcome of engaging an IMC.

Assessment by an IMC is not an examination under section 119 of the 1998 Act and there is no impact on benefits or entitlements if the worker elects not to attend.

Standard of Practice 15: Referral to an injury management consultant	
S15.1	The insurer is to advise the worker and nominated treating doctor of the referral and the reason(s) for the referral being made, irrespective of whether the referral is for a file review or an appointment with the worker. The insurer is to advise the nominated treating doctor that they can be paid for the time taken to communicate with the IMC.
S15.2	When making a referral to an IMC, the following obligations apply to the insurer: • where a worker is required to attend an IMC's rooms the location should be geographically convenient for the worker, for example, close to the worker's home or work address • any special requirements of the worker are to be accommodated, such as gender, culture, language and accessibility • the decision on which IMC to engage should take into consideration the injury type • the IMC should be able to provide the appointment within a reasonable timeframe, and • the insurer is to determine whether the IMC records consultations at the time of making the appointment to inform the worker and obtain their consent (written or verbal) beforehand.
S15.3	If the worker is to be assessed by an IMC, the worker is to be given at least 10 working days' written notice of the appointment unless a shorter timeframe is agreed by all parties. The written notice is to include: • all relevant appointment details, including the name, speciality and qualification of the IMC, the date, time, location, and likely duration • the specific reason for the referral to the IMC • that the injury management consultation is an opportunity for them to actively participate in their return to work • preparation, including what to take (e.g. x-rays, reports of investigations/tests) and advice regarding suitable clothing to allow for an appropriate assessment to be conducted

Standard of Practice 15: Referral to an injury management consultant	
	• how costs (including for travel) are to 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 • where the IMC's routine practice is to record the consultation on audio or video, the worker must be informed of this in writing and given an opportunity to decline should they not consent, and • the SIRA brochure about injury management consultations is to be provided to the worker with the written notice of the appointment.
S15.4	The insurer must provide the IMC with adequate and relevant information to support the referral including: • a detailed description of the reason for referral • contact details of the worker and nominated treating doctor, and • relevant documentation from the file to assist the IMC's understanding of the claim.
S15.5	Subsequent IMC referrals must be with the same IMC unless that IMC: • has ceased to practise (temporarily or permanently) in the role • they no longer practice in a location convenient to the worker, or • both parties agree that a different IMC is required.
Application	These standards apply equally to exempt workers.

Further information to help you

Associated claims handling principles

- Fair and equitable claims processes
- Transparent and honest communication

Relevant provisions

Injury Management Consultants:

- *Section 45A, Workplace Injury Management and Workers Compensation Act 1998*

S16. Approval and payment of medical, hospital and rehabilitation

Insurers are responsible for approval and payment for treatment and services during the worker's claim. Key to managing provider services is ensuring that the services under consideration are:

- provided by an appropriately qualified provider
- reasonably necessary because of the injury
- cost-effective, and
- progress or promote the worker's recovery.

Context

SIRA recommends consideration of the five principles outlined in the Transport Accident Commission (TAC) and Worksafe Victoria's *Clinical Framework for the Delivery of Health Services* as an effective method to ensure active management of a provider. They are:

1. Measure and demonstrate the effectiveness of the intervention.
2. Adopt a biopsychosocial approach.
3. Empower the person to manage their recovery.
4. Implement goals focused on optimising function, participation and return to work.
5. Base intervention on the best available research evidence.

Where the insurer is uncertain of the value of requested treatment or services they may seek guidance from a SIRA approved independent consultant.

In approving services provided by a third-party, the insurer must ensure the injury management plan is updated where necessary. They must also actively engage all stakeholders to achieve the expected outcome from the approved service.

To ensure cost-effective service provision and payment in-line with legislative requirements, insurers should actively review billing and rates when paying for services.

Standard of practice 16: Approval and payment of medical, hospital and rehabilitation services	
S16.1	Prior to making a decision about approval for services, insurers must determine: • whether the services requested are reasonably necessary • whether the service provider is appropriately qualified to provide services to workers e.g. SIRA approval as an allied health provider • whether the proposed fees are appropriate, that is, not in excess of the maximum rates in SIRA Workers Compensation Fees Orders or at an appropriate community rate (where no Fees Order applies) • whether the services requested align to appropriate billing /payment codes.
S16.2	When approving services from workplace rehabilitation providers insurers are to ensure that services are in line with *Nationally Consistent Approval Framework for workplace rehabilitation providers* and *NSW Supplement*.

Standard of practice 16: Approval and payment of medical, hospital and rehabilitation services	
S16.3	Insurers must review service provider invoices prior to payment and ensure: • rates and items billed align with approvals provided • rates do not exceed the maximum amount prescribed by the respective SIRA Workers Compensation Fees Orders (where relevant), and • invoices are accurate and contain all relevant information, including consideration of whether GST or input tax credits apply.
S16.4	Insurers are to ensure active oversight of payment systems to identify, report and manage any duplication, overpayment and/or fraudulent payments to service providers.
Application	These standards apply equally to exempt workers.

Further information to help you

Associated claims handling principles

- Fair and equitable claims processes
- Proactive, prompt and efficient claims management

Relevant provisions

Definitions:

- *Section 59, Workers Compensation Act 1987*

Compensation for cost of medical, hospital and rehabilitation etc:

- *Section 60, Workers Compensation Act 1987*

Relevant links

- Workers Compensation Fees Orders
- Guidelines for claiming workers compensation
- Clinical Framework for the Delivery of Health Services, TAC and Worksafe Victoria
- Realising the Health Benefits of Good Work, Royal Australian College of Physicians
- Guide: Nationally Consistent Approval Framework for Workplace Rehabilitation providers
- NSW Supplement: Supplement to the Guide: Nationally consistent approval framework for workplace rehabilitation providers

S17. Case conferencing

Effective injury management is a coordinated effort involving the worker, the employer, the nominated treating doctor and others, such as a workplace rehabilitation provider. Communication between these stakeholders should be transparent and collaborative.

Context

A case conference is a meeting that can include the worker, nominated treating doctor, employer, insurer, and workplace rehabilitation provider (where applicable). A case conference can be used to set goals, ensure roles and responsibilities are understood, and agree on timeframes to recover at / return to work.

While the communication between a nominated treating doctor and worker is confidential, involvement of other parties in the recovery process can assist and promote the worker's recovery to good health and to work.

A case conference is separate to the worker's scheduled medical review and can occur any time throughout a claim. If an employer, insurer or workplace rehabilitation provider wishes to meet with the doctor and the worker, a separate appointment should be made for a case conference. There may be limited circumstances where this may not be possible, for instance rural or remote locations with limited availability. The insurer should liaise with the worker to identify an appropriate alternative, which may include conducting the case conference via video or conference call, or agreement to attend their scheduled consultation.

Standard of practice 17: Case conferencing	
S17.1	When seeking to arrange a case conference, the insurer must: • inform the worker beforehand of the intention to arrange a case conference and the reasons for it • provide the purpose or agenda of the case conference to all parties to be involved • schedule the case conference separate to the worker's medical consultation. Note: if the insurer is not able to schedule the case conference separate to the worker's medical consultation, the insurer is to record this on the file and is to consider an appropriate alternative in consultation with the worker.
Application	This standard applies equally to exempt workers.

Further information to help you

Associated claims handling principle

- Transparent and honest communication
- Fair and equitable claims processes

Regulatory references

Nil.

S18. Section 39 notice

Workers affected by the 260-week limit to weekly payments under section 39 of the 1987 Act should be provided with appropriate notice prior to the cessation of weekly payments.

Context

The insurer is required to communicate regularly with the worker, employer and stakeholders throughout the life of the claim, regarding the number of weeks paid. Insurers should commence planning well in advance for cases where a worker is approaching 260 weeks of weekly payments. Communications should clearly inform how the insurer has counted the entitlement weeks so that it can be easily understood.

Providing workers with at least 13 weeks' written notice ensures that workers who have been in receipt of workers compensation payments for an extended period are provided with sufficient time to prepare for the cessation of payments.

Standard of practice 18: Section 39 notice	
S18.1	Insurers are required to provide written notice to a worker at least 13 weeks prior to the cessation of weekly entitlements at 260 weeks due to section 39.
S18.2	Notice to the worker is to include: • the date payments are due to cease • the date the last payment will be processed • supporting documentation for how the entitlement limit was reached (i.e. list of payments) • supporting documentation for the assessment of permanent impairment • ongoing entitlement to medical benefits under section 59 • Information on how to contact Centrelink • who to contact for further information (i.e. WIRO).
Application	This standard **does not** apply to exempt workers.

Further information to help you

Associated claims handling principles

- Fair and equitable claims processes
- Transparent and honest communication

Relevant provisions

Cessation of weekly payments after 5 years:

- *Section 39, Workers Compensation Act 1987*

S19. Retiring age notice

Workers can receive weekly payments up until the one-year anniversary of reaching retiring age. Workers injured after retiring age are limited to weekly payments for up until 12 months after the date of first incapacity. Workers should be provided with appropriate notice prior to the cessation of weekly payments.

Context

The insurer is required to communicate regularly with the worker, employer and other relevant stakeholders throughout the life of the claim.

Providing workers with at least 13 weeks' written notice ensures that workers who have been in receipt of workers compensation payments will be provided with sufficient time to prepare for the cessation of payments.

Standard of practice 19: Retiring age notice	
S19.1	Insurers are required to provide written notice to a worker at least 13 weeks prior to the cessation of weekly entitlements due to reaching their retiring age plus 12 months.
S19.2	Notice to the worker should include: • the date payments are due to cease • the date the last payment will be processed • ongoing entitlement to medical benefits under section 59 • who to contact for further information (i.e. WIRO).
Application	This standard applies to exempt workers.

Further information to help you

Associated claims handling principles

- Fair and equitable claims processes
- Transparent and honest communication

Relevant provisions

Termination of weekly payments on retiring age:

- *Section 52, Workers Compensation Act 1987*

Relevant links

- Age pension eligibility – Department of Human Services

S20. Section 59A notice

Workers are entitled to at least two years of reasonably necessary medical treatment and services after their claim was first made, or from the date the worker's weekly payments stopped being payable, whichever is the latter.

Context

Medical and related treatment may be necessary to:

- maintain wellbeing, as opposed to rehabilitation and/or return to work, or
- develop appropriate strategies and pathways for a worker's recognised injury and/or degree of permanent impairment, to ensure any specific or specialised dependency need is supported.

Workers may still require access to medical and related treatment after they cease to be entitled to medical and related expenses under the workers compensation legislation. In these circumstances, it is our expectation that insurers provide necessary support to help determine where a worker can access services through the public/private system, and help them transition either during or on conclusion of the entitlement period.

Standard of practice 20: Section 59A notice	
S20.1	Insurers are required to provide written notice to a worker at least 13 weeks prior to the cessation of the compensation period for reasonably necessary medical treatment and services.
S20.2	Notice to the worker should include: • the date compensation for reasonably necessary medical treatment and services payments are due to cease • who to contact for further information (ie. WIRO)
S20.3	Contact is to be made with the nominated treated doctor and other treatment providers to ensure that they are aware that the compensation period for entitlements will cease.
Application	These standards **do not** apply to exempt workers.

Further information to help you

Associated claims handling principles

- Transparent and honest communication
- Proactive, prompt and efficient claims management

Relevant provisions

Limit on payment of compensation:

- *Section 59A, Workers Compensation Act 1987*

S21. Objective review of report of assessment of permanent impairment

Insurers should objectively review reports of the assessment of permanent impairment. This report is referred to in the legislation (s73 of the 1987 Act) as a permanent impairment medical certificate.

Context

A report of the assessment of permanent impairment may be obtained by the worker or insurer to certify that the worker has received a work-related injury resulting in permanent impairment and the degree of permanent impairment resulting from the work-related injury.

The medical assessor must have successfully completed requisite training in using the *NSW workers compensation guidelines for the evaluation of permanent impairment* (that is in effect at the time of the assessment) for each body system they assess. These trained assessors are listed on the SIRA website.

A report of the assessment of permanent impairment may be used for claiming non-economic loss compensation, to provide evidence of reaching or surpassing a threshold to be entitled to certain ongoing or extended compensation, to claim damages or seek to commute liability for a claim.

The permanent impairment assessment should contain factual information based on medical information and investigations, as well as the assessor's history-taking and clinical examination. Other medical information/reports or investigations that are reviewed by the assessor must be referenced in the report. These facts should be thoroughly checked by the insurer.

Standard of practice 22: Objective review of report of assessment of permanent impairment	
S21.1	When an insurer receives an assessment of permanent impairment report (initiated by either the insurer or worker), the insurer must objectively review the report to determine: • Whether the assessment of permanent impairment is in accordance with the *SIRA NSW workers compensation guidelines for the evaluation of permanent impairment* (in effect at the time of assessment), and • whether the information documented in the assessment report is consistent with information and facts available in the claims file to determine the relevant particulars about a claim.
S21.2	When an insurer identifies that a report may not be in accordance with the *SIRA NSW workers compensation guidelines for the evaluation of permanent impairment* or further relevant particulars need to be obtained (or clarified), the insurer is to request written clarification or correction from the assessor.
Application	These standards apply equally to exempt workers.

Further information to help you

Associated claims handling principles

- Fair and equitable claims processes
- Proactive, prompt and efficient claims management

Relevant provisions

Permanent impairment medical certificate:

- *Section 73, Workers Compensation Act 1987*

Relevant particulars about a claim:

- *Section 282, Workplace Injury Management and Workers Compensation Act 1998 No 86*

Assessment of impairment:

- *Section 322, Workplace Injury Management and Workers Compensation Act 1998 No 86*

Relevant links

- *NSW workers compensation guidelines for the evaluation of permanent impairment 4th edition*

S22. Negotiation on degree of permanent impairment

Insurers and workers are not precluded from reaching a compromise on a worker's degree of permanent impairment.

Context

The NSW workers compensation legislation does not prohibit a negotiated outcome for the degree of permanent impairment.

A negotiated degree of permanent impairment must be confirmed through a Complying Agreement. Where a worker enters into a Complying Agreement, significant protections are provided in section 66A(3) of the 1987 Act by way of the power of the Workers Compensation Commission (WCC) to award additional compensation.

Standard of practice 21: Negotiation on degree of permanent impairment	
S22.1	Where insurers and workers reach a compromise as to the degree of permanent impairment, the negotiated position must: • be supported by an assessment of permanent impairment in accordance with *Part 7 of Chapter 7, of the 1998 Act* and • insurers must provide all copies of reports and other evidence to the worker prior to agreement to allow for informed negotiation.
S22.2	Before entering into a negotiated agreement as to the worker's degree of permanent impairment, the insurer is to be satisfied that the worker has obtained independent legal advice or has waived the right to obtain independent legal advice before entering into the agreement as to the consequences of entering into the agreement (including the impact on Part 3 of the 1987 Act; Part 7 of Chapter 7 of the 1998 Act and on any entitlement to damages).
S22.3	Where insurers and workers reach a compromise as to the degree of permanent impairment, a Complying Agreement that satisfies the requirements of section 66A of the 1987 Act must be entered into. A copy of the signed Complying Agreement must be recorded in the insurer's claim file.
Application	These standards apply equally to exempt workers.

Further information to help you

Associated claims handling principles

- Fair and equitable claims processes
- Proactive, prompt and efficient claims management

Relevant provisions

Determination of degree of permanent impairment:

- *Section 65, Workers Compensation Act 1987*

Agreements for compensation:

- *Section 66A, Workers Compensation Act 1987*

No proceedings to enter up award on agreement for compensation:

- *Section 66B, Workers Compensation Act 1987*

Reimbursement for costs of medical certificate and examination:

- *Section 73, Workers Compensation Act 1987*

Claims for lump sum compensation and work injury damages:

- *Division 4, Part 3 of Chapter 7, Workplace Injury Management and Workers Compensation Act 1998*

Medical assessment:

- *Part 7, Chapter 7, Workplace Injury Management and Workers Compensation Act 1998*

S23. Insurer participation in disputes and mediations

The Workers Compensation Commission (the Commission) is required to use its best endeavours to bring the parties to a dispute to a settlement/agreement.

Context

In representing the employer in a dispute in the WCC, the insurer is required to genuinely participate in WCC disputes and mediations.

Standard of practice 23: Insurer participation in disputes and mediation	
S23.1	Insurers are required to make all reasonable efforts to genuinely participate in teleconferences, conciliation/arbitrations and mediations in the WCC. Genuine participation by insurers is assisted by either: a. the attendance in person of the Case Manager (or other person on behalf of the insurer) with knowledge of the matter and appropriate delegation to provide instructions, or b. where attendance in person is not practicable, insurers must make available a person with knowledge of the matter and who holds appropriate delegation to provide instructions to the legal provider without delay.
Application	This standard applies equally to exempt workers.

Further information to help you

Associated claims handling principles

- Fair and equitable claims processes
- Transparent and honest communication

Relevant provisions

Offence of referring non-genuine disputes:

- *Section 285, Workplace Injury management and Workers Compensation Act 1998*

Duties of insurer when dispute referred to Commission:

- *Section 291, Workplace Injury Management and Workers Compensation Act 1998*

Arbitrator to attempt conciliation:

- *Section 355, Workplace Injury Management and Workers Compensation Act 1998*

Representation before Commission:

- *Section 356, Workplace Injury Management and Workers Compensation Act 1998*

Objectives of the Commission:

- *Section 367, Workplace Injury Management and Workers Compensation Act 1998*

Subrogation:

- Clause 12, Schedule 3, Workers Compensation Regulation 2016

S24. Recovery of overpayments to workers due to insurer error

Insurers should have processes in place to minimise any risk of overpayment or duplication of payments to workers. In instances where there may be an overpayment, this is to be managed in a fair and transparent manner.

Context

Managing overpayments to workers in a fair and transparent manner, and in accordance with the law contributes to the viability of the system and minimises the likelihood of the relationship between the insurer and the worker being placed at risk.

If the overpayment is due to a return to work impacting the worker's earnings, the insurer can seek an order for recovery from the Workers Compensation Commission (WCC). When the overpayment has arisen from fraud, SIRA may issue the order for recovery.

Overpayments to a worker resulting from insurer error are only to be recovered with informed and written consent of the worker.

Standard of practice 24: Recovery of overpayments due to insurer error	
S24.1	Where an insurer identifies an overpayment to a worker on a claim due to an error, and wishes to seek recovery, they are required to write to the worker with details of the payment(s) to the worker that clearly and explicitly describes the error and correct entitlement.
S24.2	Where the insurer negotiates a repayment arrangement with the worker, the insurer must demonstrate they have considered the individual circumstances of the worker and potential financial hardship.
S24.3	The insurer must obtain signed and informed consent from the worker before any agreed repayment arrangement can commence, and this must be evident on the claim file.
Application	These standards apply equally to exempt workers.

Further information to help you

Associated claims handling principle

- Fair and equitable claims processes

Relevant provisions

Order for refund of overpayments of compensation:

- *Section 235D, Workplace Injury Management and Workers Compensation Act 1998*

Refund of weekly payments paid after return to work etc:

- *Section 58, Workers Compensation Act 1987*

S25. Factual investigations

Factual investigations may be used to gather information to inform decision-making with respect to liability and other entitlements.

Context

Factual investigations involve the use of a third-party service provider to conduct an investigation to determine the available facts of a claim. The investigation may involve an interview with the worker, employer and/or witnesses, as well as a physical inspection or other external enquiries required to determine relevant details.

Factual services should only be used when necessary and conducted in an ethical manner. Any information obtained to be used and stored appropriately.

Standard of practice 25: Factual investigations	
S25.1	The insurer must document on the file the reason for the referral including the purpose of the investigation and why a factual investigation is required to obtain the information.
S25.2	If the worker is required to participate in the factual investigation they must be advised in writing. This advice is to include: • the purpose of the factual investigation • the worker may choose not to participate in the investigation, however it will help determine their claim if they do so • the contact details of the investigator • the anticipated duration of the factual interview and that the worker may request a break or postpone investigation interviews if the interview is to be prolonged (interviews are not to exceed two hours) • the worker can nominate the place of the interview • the worker may have a support person (including union representative) present • the worker may request an interpreter if required (does not count as a support person) • the worker will receive a copy of their statement or transcript within 10 working days of the interview • the worker can nominate witnesses to assist the investigation • Insurers are to advise the worker that they are not obligated to participate in the factual investigation. They are to explain however that the factual investigation will be used to help determine liability for their claim.
Application	These standards apply equally to exempt workers.

Further information to help you

Associated claims handling principles

- Fair and equitable claims processes
- Transparent and honest communication

Relevant links

- *Commercial Agents and Private Inquiry Agents Act 2004*
- Commercial Agents and Private Inquiry Agents Regulation 2017
- *Surveillance Devices Act 2007*
- *Workplace Surveillance Act 2005*

S26. Surveillance

Surveillance may be used to gather information to inform decision-making with respect to liability and other entitlements.

Context

Surveillance refers to the covert monitoring and recording of behaviour using photography, video recording, direct observations and social media monitoring.

Surveillance services should only be used when necessary and conducted in an ethical manner. Any information obtained is to be used and stored appropriately.

Standard of practice 26: Surveillance	
S26.1	The insurer is only to conduct surveillance of the worker when: • there is evidence to indicate that the worker is exaggerating an aspect of the claim, providing misleading information or documents in relation to a claim, where the insurer reasonably believes that the claim is inconsistent with information or documents in the insurer's possession or that fraud is being committed and • the insurer is satisfied that they cannot gather the information through less intrusive means and that the benefit from obtaining the information outweighs the intrusion of the worker's privacy and • the surveillance is likely to gather the information required. The insurer must document on the file the reason for the referral including what the purpose of the surveillance is and why surveillance is required to obtain the information.
S26.2	Insurers, or investigators acting on behalf of the insurer, are to ensure that any surveillance they undertake or engage abides by the following: • establishing clear limits to the scope and duration of surveillance • only conducting surveillance in places regarded as public or where the worker, while on private property, is observable by members of the public going about their ordinary daily activities • not actively interfering with the worker's activities while under observation or interact with the worker so as to have an impact on their activities • not engaging in any acts of inducement, entrapment or trespass when carrying out surveillance activities. Inducement or entrapment can include social media activities such as sending friend requests with the intention to induce, entrap or deceive • demonstrate sensitivity to the privacy rights of children, take reasonable action to avoid unnecessary video surveillance of children and where possible, hide images of children in reports and recordings. • where possible, censoring of other individuals and any information which may identify other individuals in reports and recordings

Standard of practice 26: Surveillance	
	• not undertaking communication with other individuals that would reveal (directly or indirectly) that surveillance is in place • securely storing recordings and any other materials collected during the course of the investigation.
S26.3	Insurers are to have a protocol in place for when a worker queries whether surveillance is being undertaken. Insurers are not to provide misleading information but are to take into consideration the investigator's safety and the worker's wellbeing at the time the query is made.
S26.4	Where the insurer sends surveillance material to a third party, the insurer is to inform that party about confidentiality and relevant privacy obligations
Application	These standards apply equally to exempt workers.

Further information to help you

Associated claims handling principles

- Fair and equitable claims processes
- Transparent and honest communication

Relevant links

- *Commercial Agents and Private Inquiry Agents Act 2004*
- Commercial Agents and Private Inquiry Agents Regulation 2017
- *Surveillance Devices Act 2007*
- *Workplace Surveillance Act 2005*

S27. Arrangement for payments to Medicare Australia

A Medicare Request for Notice of Past Benefits is required when a payment greater than $5,000 is likely and medical services for a work-related injury may have been paid by Medicare Australia.

Context

The *Health and Other Services (Compensation) Act 1995* (1995 Act), applies when a person receives eligible benefits provided through Australian Government programs, including Medicare benefits.

In accordance with the 1995 Act, the compensation payer (usually the insurer) must tell the Department of Human Services:

- within 28 days from the date of a judgment or settlement
- when settlement fixes the value of compensation awarded at more than $5,000 including all costs, or
- when a reimbursement arrangement is made more than six months from the date the claim was made.

Prompt advice to Medicare and correct attribution of the payment of medical costs, allows insurers to make prompt payment of entitlements and reduces the risk that a worker is inadvertently subject to recovery action from Medicare Australia.

Note: Recovery action is only appropriate from lump sums which include amounts for weekly payments and medical expenses. There is no recovery action by Medicare from lump sum payments for permanent impairment therefore no Notice of Past Benefits is required.

Standard of practice 27: Arrangements for payments to Medicare Australia	
S27.1	Medicare Notice of Past Benefits is to be initiated within seven calendar days from: • liability being accepted following the issuing of a reasonable excuse or dispute, such that it is likely that or Medicare benefits have been paid in the interim • when an application for dispute resolution has been lodged with the Workers Compensation Commission • determining claims for a condition that is contracted or caused by gradual process or may be an aggravation etc. of a disease • when there is a retrospective entitlement to compensation • when a claim for compensation that is likely to exceed $5,000 is initiated.
Application	This standard applies equally to exempt workers.

Further information to help you

Associated claims handling principles

- Proactive, prompt and efficient claims management

Relevant links

Medicare compensation recovery

S28. Notification and recovery of Centrelink benefits from lump sum payments

An insurer is required to notify Centrelink where lump sum workers compensation payments of weekly benefits made to workers may include amounts repayable to Centrelink, or result in a preclusion period for access to Centrelink benefits.

Context

Before paying lump sum compensation payments of weekly benefits, under Commonwealth law insurers are required to notify Centrelink and pay any amounts payable to the Commonwealth. Insurers are also required to notify Centrelink immediately where a preclusion period from Centrelink entitlements may apply.

Prompt advice to Centrelink and correct attribution of lump sum payments assists insurers to make prompt payment of entitlements. This reduces the risk of a worker becoming inadvertently subject to recovery action from Centrelink.

Note: Recovery action is only appropriate from lump sums which include amounts for weekly payments. There is no recovery action by Centrelink from lump sum payments for permanent impairment and therefore no need to advise Centrelink.

Standard of practice 28: Notification and recovery of Centrelink benefits from lump sum payments	
S28.1	Insurers are to provide appropriate documentation to Centrelink within seven calendar days of: • the date of settlement for commutation or damages matters or other matters settled in the Workers Compensation Commission • the date outstanding amounts owed to the worker are calculated by the insurer, in the case of workers whose entitlements have been affected by delays or reconsideration of entitlements.
Application	This standard applies equally to exempt workers.

Further information to help you

Associated claims handling principles

- Fair and equitable claims processes
- Proactive, prompt and efficient claims management

Relevant links

- Centrelink compensation recovery

S29. Interpreter services

To ensure equal access to services for which workers are eligible, an insurer is required to engage appropriately qualified interpreter services in the worker's nominated language, dialect (and gender, where requested).

Context

Workers from culturally and linguistically diverse backgrounds may face additional difficulties in navigating the workers compensation system. Being injured at work and making a claim for workers compensation may involve new and unfamiliar concepts that are compounded if English is not the worker's first language.

The appropriate use of interpreters enables an equitable service and experience for workers where English is not their first language. The use of an independent qualified interpreter also allows for impartial and confidential communications to a worker.

Workers who require Auslan interpretation are also covered by this standard of Practice.

Standard of practice 29: Interpreter services	
S29.1	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 or answer questions so they can be understood, or • is not able to be understood more generally.
S29.2	When engaging the services of a qualified interpreter, insurers are to: • engage a NAATI accredited interpreter (for languages where this accreditation is available) • carefully consider whether the communication should be face-to-face or whether using a telephone interpreter is sufficient • explain the purpose of the communication to the interpreter • ensure there is no conflict of interest, and • ensure consideration of cultural background.
Application	These standards apply equally to exempt workers.

Further information to help you

Associated claims handling principles

- Fair and equitable claims processes
- Transparent and honest communication

Relevant provisions

Compensation for cost of interpreter services:

- *Section 64A, Workers Compensation Act 1987*

Provision of interpreter services:

- *Section 23, Workplace Injury Management and Workers Compensation Act 1998*

Relevant links

- National Accreditation Authority for Translators and Interpreters

S30. Cross-border provisions

Where a worker works across more than one State or Territory, insurers are required to apply the 'State of connection' provisions to determine whether the worker's employment is connected with the state of New South Wales (NSW). If not, they must be referred to the relevant State or Territory Authority.

Context

If a worker works in more than one State or Territory, a series of tests are to be applied to determine a worker's 'State of connection'.

These tests apply to a particular contract or term of employment for a worker. The tests are cascading and should be considered and applied when an insurer becomes aware that a worker may work in employment other than exclusively in NSW.

The cascading test means that if the first test is satisfied there is no need to consider the second test, etc.

Standard of practice 30: Cross border provisions	
S30.1	Insurers are required to apply the hierarchical 'State of Connection' tests to determine whether a worker's employment is connected with NSW when determining liability for a claim. Insurers are required to refer to SIRA's *Cross border arrangements for workers compensation* for more detailed information on how to apply the tests.
Application	This standard applies equally to exempt workers.

Further information to help you

Associated claims handling principles

- Fair and equitable claims processes
- Proactive, prompt and efficient claims management

Relevant provisions

Liability for compensation

- *Section 9AA, Workers Compensation Act 1987*
- *Section 9AB, Workers Compensation Act 1987*

Relevant links

- SIRA's *Cross border arrangements for workers compensation*

S31. Closing a claim

Before closing a claim, insurers should ensure that all activities have been completed and relevant stakeholders (including service providers) have been notified that the claim is to be closed.

Context

Appropriate consultation should occur with relevant stakeholders prior to the closure of a claim. The reasons and implications of the closure are to be clearly communicated to all relevant stakeholders. Clear communication is required to ensure fairness and transparency and that stakeholders are not disadvantaged during the process.

Standard of practice 31: Finalising a claim	
S31.1	Before closing a claim, the insurer must advise the worker and the employer of the intention to close the claim, including the reasons for doing so, and provide an opportunity for further accounts or reimbursements to be paid.
S31.2	The insurer must confirm in writing the details of the closure to the worker and the employer and include: • the date the claim was / is to be closed • expiration period of medical benefits under section 59A of the 1987 Act (not applicable to exempt workers), and • what to do if the worker or employer believes the claim needs to be re-opened.
S31.3	The insurer must advise current service providers on the claim that the claim is being closed. This notification is to confirm the relevant date beyond which services will not be paid for by the insurer. The insurer is to actively attempt to obtain and finalise all outstanding invoices before closing the claim.
Application	These standards apply equally to exempt workers.

Further information to help you

Associated claims handling principles

- Transparent and honest communication

S32. Death claims

If a worker dies because of a work-related injury or disease, compensation is payable.

Context

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

- a lump sum death benefit apportioned among dependants (or if no dependants, to the deceased's estate)
- weekly compensation for dependent children
- reasonable funeral expenses, and
- compensation for the expense of transporting the body to the deceased's usual place of residence or an appropriate place for its burial or cremation.

Some death claims are clearly work related whilst for others the nexus between death and work may not be clear. Insurers are to review all deaths they become aware of (whether or not a claim has been made).

Death claims require proactive and sensitive management to ensure dependants are provided with appropriate support, and delays are minimised. Insurers can assist the Workers Compensation Commission (the Commission) and families to reduce delay and legal costs.

Standard of practice 32: Death claims	
S32.1	Once an insurer becomes aware of the death of a worker, they must proactively investigate the circumstances of the death. This includes deaths that occur months or years after the work-related injury.
S32.2	When notified of a death that could be compensable, an insurer must contact the worker's family, the family's legal representative or other appropriate party without delay to advise compensation may be payable and keep them informed of insurer investigations.
S32.3	Insurers are to commence investigation and make appropriate contact with the worker's family or representatives within 21 calendar days of becoming aware of the death. Insurers are to determine liability for death claims as soon as practicable. If an insurer is unable to make a decision within 21 days, they must document the reasons why, clearly identifying the additional information required and what steps have been taken to obtain the information.
S32.4	To assist the Commission's objective of timely resolution of matters, insurers are required to actively seek details of all persons who conceivably have an entitlement under the 1987 Act and advise them of the matter so they can pursue a claim if they wish. This includes: • identifying all potential dependants who may be eligible for the lump sum death benefit, and • identifying all potential dependent children who may be eligible for weekly payments. An insurer cannot apportion the lump sum where more than one dependant or potential dependant is identified. Where more than one

Standard of practice 32: Death claims	
	dependant is identified, an application must be made to the Commission to apportion the lump sum death benefit.
S32.5	An insurer is required to advise the family or legal representative as soon as a liability decision is made. This should be confirmed in writing within 2 days.
S32.6	Insurers are required to start weekly payments for dependent children as soon as possible after liability is accepted.
S32.7	Insurers are to liaise with the surviving parent or guardian (or legal representative) to request Tax File Numbers for each dependent child, but this should not delay the commencement of weekly payments in respect of dependent children.
Application	These standards apply equally to exempt workers.

Further information to help you

Associated claims handling principles

- Fair and equitable claims processes
- Transparent and honest communication

Relevant provisions

Death of a worker leaving dependents:

- *Section 25, Workers Compensation Act 1987*

Funeral expenses:

- *Section 26, Workers Compensation Act 1987*

Expenses of transporting body:

- *Section 28, Workers Compensation Act 1987*

Apportionment of payments between dependents:

- *Sections 29, Workers Compensation Act 1987*
- *Section 30, Workers Compensation Act 1987*

Payment in respect of dependent children:

- *Section 31, Workers Compensation Act 1987*

Payment where no dependents:

- *Section 32, Workers Compensation Act 1987*

Payments to NSW Trustee for benefit of beneficiary:

- *Section 85, Workers Compensation Act 1987*

Payment of benefits to beneficiaries:

- *Section 85A, Workers Compensation Act 1987*

Relevant links

- Workers Compensation Commission Registrar's Practice Guide for Death Claims

Appendix A

Section 192A, Workers Compensation Act 1987

192A Claims administration manual (cf former s 93B)

1. The Authority may prepare and publish a claims manual for use by licensed insurers under this Division.
2. In preparing the claims manual, the Authority is required to promote, as far as practicable:
   a. the prompt processing of claims and payment of amounts duly claimed, and
   b. the giving of information about workers' entitlements and about procedures for the making of claims and the resolution of disputes, and
   c. the minimisation of the effect of injuries to workers by the making of prompt arrangements for rehabilitation, and
   d. the proper investigation of liability for claims, and
   e. the recovery of proper contributions in connection with claims from other insurers or persons.
3. The claims manual may make provision (not inconsistent with this Act, the 1998 Act or the regulations under those Acts) in connection with all matters relating to the administration of claims, including:
   a. liaison between insurers and employers concerning rehabilitation assessment of injured workers, and
   b. the provision or arrangement of suitable employment or rehabilitation training for partially incapacitated workers, and
   c. the monitoring of employment-seeking activities or rehabilitation training by partially incapacitated workers, and
   d. arrangements for the settlement of claims for damages, and
   e. procedures to be followed before a claim is made, such as procedures in connection with early notification of injury and provisional acceptance of liability.

3a. The Workers Compensation Guidelines under the 1998 Act can make provision in connection with any matter in connection with which the claims manual can make provision.

4. The Authority may give an insurer directions as to the procedure to be followed in the administration of any claim or class of claims in order to comply with the claims manual, the Workers Compensation Guidelines, the 1998 Act and this Act.

4a. An insurer who fails to comply with a direction under subsection (4) is guilty of an offence.

Maximum penalty: 50 penalty units.

5. It is a condition of the licence of an insurer under this Division that the insurer comply with any direction given to the insurer under this section.
6. Any claims manual in force under section 93B, immediately before its repeal, is taken to have been prepared and published under this section.

Section 194, Workers Compensation Act 1987

194 Directions to insurers with respect to claims procedures

1. The Authority may give insurers (or any particular insurer or class of insurers) directions for or with respect to requiring the adoption and use by them of specified processes, procedures, strategies, policies and methods in the handling and administration of claims for compensation or work injury damages, either generally or in respect of a specified class or classes of cases.
2. It is a condition of an insurer's licence under this Act that the insurer must comply with a direction under this section.

Disclaimer

This publication may contain information that relates to the regulation of workers compensation 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.

Workers Compensation Regulation, Level 6, McKell Building, 2-24 Rawson Place, Sydney NSW 2000

Phone: 13 10 50 | Website www.sira.nsw.gov.au

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