

WORKCOVER PROVISIONAL LIABILITY AND CLAIMS GUIDELINES

**WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION
ACT 1998**

EXPLANATORY NOTE

These guidelines are pursuant to sections 376(1) of the Workplace Injury Management and Workers Compensation Act 1998 (“the Act”). They explain the operation of those sections of the Act relating to provisional liability and claims.

The Guidelines set out the procedures for the initial notification of an injury, making provisional liability payments and the making and handling of claims under Part 3 of the Act.

These Guidelines are primarily intended to assist WorkCover NSW Licensed Insurers. Questions about provisional liability and claims making and these Guidelines should be directed to the General Manager of WorkCover NSW.

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WorkCover NSW Guidelines

These Guidelines are in 2 Parts:

- **Part 1** **Initial notifications and provisional liability**
-for a detailed table of contents, see page 4.
- **Part 2** **Making and handling claims**
-for a detailed table of contents, see page 21.

The governing principles and aims of the Guidelines are set out on the next page.

The guidelines are made pursuant to sections 376(1) of the Workplace Injury Management and Worker's Compensation Act 1998 ("the Act"). The guidelines apply to injuries notified after 1 January 2002, and claims made after that date.

Further the guidelines apply to an insurer responsible for managing injuries under the Worker's Compensation Act 1987 and Workplace Injury Management and Worker's Compensation Act 1998. An Insurer means any of the following:

- **Licensed insurer**
- **Self-Insurer**
- **Specialised and Group Insurer's**

These guidelines do not apply to Coal Mines Insurance and Uninsured Liability Scheme.

Governing principles

1. **The WorkCover Guidelines are founded on the following principles:**
 - 1.1 **Timely** To satisfy legislative requirements, insurer's, employers, worker's, and advisers will obtain and provide information about the injury in a timely manner.
 - 1.2 **Active insurer's** Insurer's are required to obtain certain information to make certain assessments.
 - 1.3 **Sound up to date decisions** Insurer's will make sound decisions on the information available within the timeframes the law allows and they will keep those decisions up to date as they receive new information.
 - 1.4 **Documented reasons** Insurer's will record the reasons for their decisions and show that they have considered all relevant decisions.
 - 1.5 **Peer review** Insurer's will arrange for all decisions not to pay provisional liability weekly payments to be reviewed by a suitably experienced person.
 - 1.6 **Consent** Worker's consent to the collection, use and disclosure of personal and health information when they sign the medical certificate.
 - 1.7 **Privacy** The Commonwealth privacy law and the National Privacy Principles apply to the information collected and used for the purposes of handling the worker's claim.

Aims

2. The aims of these guidelines are:

- 2.1 to ensure the prompt management of a worker's injuries
- 2.2 to ensure a worker's return to work as early as possible
- 2.3 to give a worker's certainty and proper income support while they are incapacitated by work injuries
- 2.4 to facilitate timely and sound decision-making
- 2.5 to reduce disputes
- 2.6 to maintain the employment relationship between the worker and the employer
- 2.7 to promptly resolve disputes if they happen
- 2.8 to set the requirements for making a claim under the *Workplace Injury Management Act* and the *Worker's Compensation Act 1998*

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Part 1 Initial notifications and provisional liability

The insurer's obligations to commence injury management as described in Chapter 3 Workplace Injury Management and Worker's Compensation Act 1998 are required by, and work in parallel with the provisional liability provisions in, Part 3 Division 1 of that Act.

What is provisional liability?

1. Provisional liability allows an insurer to make weekly and medical expenses payments without admitting liability. This enables an insurer to make early payments to the worker without delay.
Reference sections 267 (3), (4)

What is an initial notification of injury?

2. An initial notification means the first notification of a workplace injury that is given to the insurer who is responsible to cover the worker. *Reference section 266.*

Who can make an initial notification?

3. A worker, employer or their representative can make an initial notification of workplace injury to the insurer who is responsible to cover the worker.
Reference section 266

How may a worker, employer or their representative give the insurer initial notification?

4. The worker, employer or their representative may give an insurer initial notification electronically, in writing, or verbally (including over the phone). If an initial notification is made in writing, it must indicate that an initial notification is being made.

What information is the worker, the employer or their representative to give at the initial notification?

5. At the initial notification, the worker, the employer or their representative is to give the insurer the information set out in Part 1, rule 5.1.

The insurer is to implement systems to make sure that the person giving the information is guided through the process to make sure they give all the information needed for the notification to be handled swiftly and efficiently.

Criteria 1 - Minimum identifying information

5.1 At the initial notification, the insurer is to gather the following information:

5.1.1 Worker's information:

- name
- residential address
- date of birth

5.1.2 Employer's information:

- name and
- current business address

5.1.3 Treating doctor information:

- name (The insurer may need to be flexible in relation to workers in remote rural areas where access to medical treatment is not readily available.); or
- if the worker is hospitalized, the name of the hospital is enough.

5.1.4 Injury or illness and accident details:

- Date of workplace injury
- Describe how the workplace injury happened
- Description of the workplace injury

5.1.5 Notifier information

- Name of person making the initial notification
- Relationship to worker or employer
- their contact details, telephone or address etc.

Supporting information

5.2 It is good practice to gather supporting information at the initial notification (but this information is not formally required and is not part of the Criteria 1 information), this may include:

- Worker's telephone number
- Employer's policy number
- Employer contact name
- Employer's telephone number
- Telephone number of treating doctor
- Date of consultation with treating doctor
- Diagnosis of workplace injury
- Worker's capacity to return to work and expected return to work date
- Details of any time off work
- Person to who the wage payment is to be paid
- Current weekly wage details

When is initial notification complete?

6. The initial notification is complete when the worker, employer or their representative has given all the information required by Part 1, rule 5.1 to the insurer who is responsible to cover the worker.

What happens if Criteria 1 information is not provided?

7. If the Criteria 1 information is not provided at the initial notification, then the initial notification is not complete. However, if the missing information:
 - 7.1 *is not materially necessary* for the insurer to decide about a worker's entitlement to provisional liability, then the insurer may start payments.
 - 7.2 *is materially necessary*, then the initial notification is incomplete and the insurer must, within the next 3 working days, inform the person (verbally, or in writing) who made the notification that the notification has not been made. The person may then make another initial notification.

What if the insurer can't find the policy?

8. If the insurer can not find a current policy that covers an initial notification within 7 days after the notification, then the insurer is to either:
 - 8.1 contact the employer, and the person who made the notification, and request more information in order to identify the policy. If the policy still cannot be identified, then the insurer is to inform the employer and the person who made the notification that the insurer is not the current insurer. The insurer must then refer the initial notification to the Claims Assistance Service (CAS); or
 - 8.2 pass the initial notification to the current insurer if known. The insurer who received the initial notification may be able to find out who is the current insurer (by looking for a request for past claims experience from the new insurer or from the cancellation request made by the employer).

What information is the insurer to gather after the initial notification?

9. Within 7 days after the initial notification is made, the insurer is to gather enough information to satisfy:
 - 9.1 Criteria 2, see Part 1, rule 10;
 - 9.2 Criteria 3, see Part 1, rule 11; and
 - 9.3 Criteria 4, see Part 1, rule 12.

What medical information is the insurer to gather? Criteria 2

10. After the initial notification, the insurer is to gather the following medical information to verify the worker has suffered a workplace injury and to determine the expected period of incapacity.

The insurer may gather this information from any one or more of the following places. (the insurer does not have to see a WorkCover medical certificate):

Information from the Doctor or hospital

- 10.1 Confirmation from the treating doctor or hospital that the worker has been treated for a workplace injury and the expected period of incapacity. This may be in any form including a WorkCover medical certificate.

Information about the worker's hospitalisation

- 10.2 Confirmation obtained by any means that the worker has been hospitalised (excluding treatment as an outpatient) as a result of a workplace injury.

Information from the employer

- 10.3 Information from the employer (including the employer's nominated return to work coordinator, the employer's designated worker's compensation officer, or another person the employer has nominated to the insurer):
- 10.3.1 as to the date of consultation
 - 10.3.2 about the diagnosis of a workplace injury and expected period of incapacity taken from a WorkCover medical certificate for that injury
 - 10.3.3 obtained by any means confirming that the worker received a workplace injury.

Information from the worker

- 10.4 Information from the worker (or if the worker is unable to participate in the verification, someone acting for the worker):
- 10.4.1 as to the date of consultation
 - 10.4.2 about the diagnosis of a workplace injury and expected period of incapacity taken from a WorkCover medical certificate for that injury

What evidence that the injury is work related is the insurer to gather? Criteria 3

- 11 After the initial notification, the insurer is to gather evidence from the employer, the worker, and the treating doctor to corroborate that the worker's injury is work related.

What if the employer doubts that the worker's injury is work related?

- 11.1 If an employer doubts that the worker's employment is a substantial contributing factor to the workplace injury, then the insurer is to ask the employer to provide evidence to support that opinion.

The following are examples of acceptable proof of the employer's doubt:

- 11.1.1 a signed statement from a third party that includes information specific to the circumstances of the worker's injury that conflicts with the workplace injury as notified
- 11.1.2 available public information specific to the circumstances of the worker's injury that conflicts with the workplace injury as notified
- 11.1.3 medical information that confirms the existence of the injury before the date of the workplace injury reported by the worker. This excludes initial notifications for aggravation, acceleration, exacerbation or deterioration of a pre-existing condition.

However, anecdotal or unsupported information received from any source, including the employer alone, is not acceptable evidence.

What if there's doubt that the worker is really a "worker"? Criteria 4

- 12 If after the initial notification, there is any doubt that the worker is a "worker", then the insurer is to verify the worker's status. However, if there is no doubt, then the insurer does not have to verify the status.

The relevant definition of worker is in the Workplace Injury Management & Worker's Compensation Act 1998 section 4 and section 5 and Schedule 1 Deemed employment of worker's.

Acceptable evidence of the worker's status are the employer agreeing to that status, or the insurer seeing copies, or having verbal confirmation of, any of the following of the worker's:

- Current pay slip
- Payroll number
- Bank statement that includes regular employer payment entries
- Contract of employment.

If the worker and employer disagree as to the worker's status, then the insurer is required to consider the governing principles of these

guidelines when making a decision.

What is an insurer to do when it receives an initial notification?

- 13 When an insurer receives an initial notification, it is to:
 - 13.1 *issue a notification number* to the notifier at the time of initial notification (if made by telephone) and to the worker and employer within 7 days after the notification is made;
 - 13.2 *gather information for Criteria 2, Criteria 3 and Criteria 4*, see Part 1, rules 10, 11 and 12;
 - 13.3 *start injury management* if the worker is likely to be off work for more than 7 continuous days even if any of the days are for partial incapacity. *Reference section 45*
 - 13.4 ***Within 7 days*** *decide whether to start provisional weekly payments of compensation* (and if so for how long) on the basis of the nature of the injury, the period of the worker's incapacity and the expected future period of their incapacity. If payments are to be paid, see Part 1, rule 14. If the insurer decides that it has a reasonable excuse (as set out in Part 1, rule 16) for not making payments, see Part 1, rule 15. *Reference section 267*
 - 13.5 ***Within 7 days*** *decide whether to approve provisional medical expenses up to \$5000 or approve medical expenses as part of an injury management plan*. *Reference section 50 and section 280.*

What does the insurer do if it decides to commence weekly payments?

- 14 If the insurer decides that it will commence provisional weekly payments, then the payments are to start within 7 days after the initial notification. Also, the insurer must give a written notice about its decision to commence payment to the worker and employer soon after payments start. *Reference section 269*

What information is to be in the notice to the worker and employer?

- 14.1 The insurer's notice to the worker must include the following:
Reference 269.
 - 14.1.1 that payments have commenced on the basis of provisional acceptance of liability
 - 14.1.2 the period of expected provisional weekly payments
 - 14.1.3 the amount to be paid each week
 - 14.1.4 whether the insurer or the employer will pay the worker
 - 14.1.5 what the worker should do if they do not receive payment.
 - 14.1.6 that an injury management plan will be developed if required

14.1.7 details of how to make a claim

Regardless of whether or not the worker has returned to work the insurer is required to tell the worker that they are entitled to make a claim. However:

14.1.7.1 *if the worker has returned to work*, the insurer's letter might emphasise that the worker does not have to make a claim; unless the worker expects any further problems from the workplace injury; or

14.1.7.2 *if the worker has not returned to work*, the insurer's letter might enclose a claim form. The letter should include advice to the worker that if the worker expects to be off for more than the period agreed to by the insurer then a claim will need to be made

14.2 The insurer's notice to the employer must include details about how the weekly payments are to be made; see Part 1, rule 18

What does the insurer do if it has a reasonable excuse?

15. If the insurer has a reasonable excuse for not making provisional weekly payments, it is:

15.1 to give written notice to the worker within 7 days after the initial notification; and

15.2 to inform the employer as soon as practicable

What information is to be in the notice to the worker and employer?

15.3 The Insurer's notice to the worker is to include the following:

Reference section 268

15.3.1 details of the reasonable excuse

15.3.2 that the worker may contact Claims Assistance Service on 131050 for assistance

15.3.3 that the worker can make a claim and that claim will be determined within 21 days

15.3.4 details of how to make a claim

15.3.5 a claim form.

15.4 The insurer's notice to the employer is to include the following:

15.4.1 details of the reasonable excuse given to the worker; and

15.4.2 that the employer may contact Claims Assistance Service on 131050 for assistance

What is a reasonable excuse for not commencing provisional payments?

- 16 The insurer has a reasonable excuse for not commencing provisional liability payments if any of Part 1, rule 16.1 to 16.7 apply. *Reference section 267(2)*. The governing principles on page 2 particularly apply to determining if a reasonable excuse exists.

Insufficient medical information

- 16.1 The insurer has a reasonable excuse if it does not have enough medical information (Criteria 2) from any source listed in Part 1, rule 10. However, the insurer may have to allow special consideration for worker's in remote rural areas where access to medical treatment is not readily available.

Worker unlikely to be a "worker"

- 16.2 The insurer has a reasonable excuse if:
- 16.2.1 the worker has been unable to verify their status as a worker as described in; Criteria 4, Part 1, rule 12; or
 - 16.2.2 the employer is able to verify that the worker is not a worker

Insurer unable to contact "worker"

- 16.3 The insurer has a reasonable excuse if it needs to contact the worker to determine whether to pay or not and it is unable to do so after trying repeatedly, by phone, electronic means or in writing.

Worker refuses access to information (privacy)

- 16.4 The insurer has a reasonable excuse if the worker will not consent to the release or collection of personal and health information in relation to the workplace injury to determine the worker's entitlement to provisional payments.

Injury is not work related

- 16.5 The insurer has a reasonable excuse if the employer has provided evidence that the worker's employment is not a substantial contributing factor to the injury.

Acceptable forms of evidence could include:

- 16.5.1 a signed statement from a third party specific to the circumstances of the worker's injury that conflicts with the workplace injury as notified
- 16.5.2 available public information specific to the circumstances of the worker's injury that conflicts with the workplace injury as notified

16.5.3 medical information that confirms the existence of the workplace injury before the date of the workplace injury reported by the worker. This excludes initial notifications for aggravation, acceleration, exacerbation or deterioration of a pre-existing condition.

However, anecdotal or unsupported information received from any source, including the employer alone; is not acceptable.

Injury is not significant

16.6 If the injury is not significant, (that is the worker is likely to be off work for less than 7 continuous days even if any of the days are for partial incapacity), then the insurer may extend the time to assess provisional liability entitlements to 21 days after the initial notification is made. *Reference section 45*

If the insurer does that, then within 7 days after the initial notification, the insurer is to notify the worker in writing that a decision will be made within 21 days of the initial notification.

Injury notified after 2 months

16.7 The insurer has a reasonable excuse if the notice of injury is not given to the employer within 2 months after the date of the injury. However, the insurer may ignore this excuse if a liability is likely to exist and if it believes paying provisional payments to the worker will be an effective injury management intervention.

How a notice of injury can be given to an employer

Reference Part 2 Division 1 – Giving notice of injury and making a claim.

A notice of injury may be given orally or in writing and must be given to the worker's supervisor or any person designated by the employer as soon as possible after the injury happened.

A notice of injury must state:

- The name and address of the person injured, and
- The cause of the injury (in ordinary language), and
- The date on which the injury happened.

If particulars of an injury are entered in a register of injuries as soon as possible after an injury happened, the entry is sufficient notice of the injury.

When are payments to start?

17. Payments are to start within 7 days of the initial notification.

However, if when an initial notification is made the worker has not had time off work but they later require time off, then the insurer is to start paying weekly benefits within 7 days after the insurer becomes aware that the worker is off work.

When has an insurer satisfied the obligation to start weekly payments?

18. The insurer has satisfied its obligations to start paying if:

- the employer agrees to pay (before the insurer pays the employer), see Part 1, rule 18.1
- the insurer has to pay the employer before the employer pays the worker, see Part 1, rule 18.2
- the insurer or self-insurer is to pay the worker directly, see Part 1, rule 18.3 and 18.4.

The employer agrees to pay (before the insurer pays the employer)

18.1 The insurer has satisfied its obligations if any one or more of the following apply:

18.1.1 *if the insurer and the employer have agreed in writing that the employer is to pay a worker for any time off work, and the insurer has confirmed to the employer:*

- the amount of weekly payments
- the period for which the employer is authorised to pay, and
- any special conditions the insurer requires.

18.1.2 *if the period to be paid is for a closed period and is to be paid in one amount, and the insurer has confirmed in writing to the employer the:*

- period to be paid
- the amount to be reimbursed to the employer
- that the amount will be paid to the employer within a further 7 days
- that the employer must pay the worker as soon as practicable. *Reference section 264(3)*

18.1.3 *if ongoing payments are to be made and the insurer and employer agree that for this worker and this injury the employer will pay, and the insurer has given the employer written confirmation of this agreement including at least:*

- employer's agreement to make payments to the worker on their usual pay day

- the amount of weekly payments to be paid to the worker
- the approved period of payment
- any special conditions the insurer requires, for example the requirement for the worker to provide ongoing WorkCover Medical certificates to the employer for continuing payments.
- the time when the insurer will pay the first payment to the employer
- the schedule for ongoing weekly payments if applicable
- that the employer must pay the worker as soon as practicable. *Reference section 264(3)*
- how the employer can withdraw from the agreement

The insurer has to pay the employer before the employer pays the worker

18.2 The insurer has satisfied its obligations if the insurer had paid the employer and given the employer written confirmation of at least:

18.2.1 the period paid and amount

18.2.2 that the employer must pay the worker as soon as practicable. *Reference section 264(3)*

The insurer or self-insurer is to pay the worker directly,

18.3 The insurer has satisfied its obligations if it has made the weekly payment direct to the worker. In that case, the insurer is to arrange with the worker about the payment of taxation in accordance with the Income Tax Assessment Act 1936 and the Income Tax Assessment Act 1997.

18.4 Provisional weekly payments cannot be deducted from a worker's leave entitlements. *Reference section 233*

For how long are provisional weekly payments to be paid?

19 The insurer is to continue to make weekly payments for the expected period (up to 12 weeks) of provisional liability determined by the nature of the worker's injury and the expected period of incapacity notified to the worker for no more than 12 weeks.

When does the 12 week period start?

19.1 When calculating the 12 week period for provisional weekly payments, the period starts on the first day the worker becomes entitled to weekly benefits compensation. The 12 week period can be paid under sections 36, 38 or 40 or any combination of these entitlements. *Reference section 36, 38 and 40.*

Does the insurer have to receive a WorkCover medical certificate?

19.2 The insurer may continue payments even if it has not received a WorkCover medical certificate-unless the insurer has asked the worker for one, see Part 1, rule 19.4 and 21.3.

What period can the first provisional weekly payment cover?

19.3 The insurer must start paying weekly payments within 7 days after an initial notification. *Reference section 267(1)*. The insurer is to assess each initial notification and the first weekly payment period on the basis of:

- The expected period of incapacity
- Information available to the insurer
- Whether the worker is already back at work
- The date of the workplace injury and the date of initial notification
- If the insurer has requested a WorkCover medical certificate, see rule 19.4 or an authority to obtain information regarding treatment or the worker's medical condition, see Part 1, rule 21.3

Reference section 270.

When can an insurer request a WorkCover Medical Certificate?

19.4 If weekly payments have started, the insurer is entitled to request the worker to provide a WorkCover medical certificate that certifies any period of incapacity. The request can be made in writing or verbally. When the insurer makes the request, it is to notify the worker:

19.4.1 Of the period of incapacity the WorkCover medical certificate is to cover

19.4.2 That the worker must give the WorkCover medical certificate to the insurer within 7 days after the request

19.4.3 That weekly payments may stop if the WorkCover medical certificate is not received by the insurer

What if a worker returns to work and is then off work again?

19.5 If the worker returns to work and is then off work again, the insurer may pay provisional weekly payments again as long as the period paid does not exceed a total of 12 weeks. This would be considered an injury management intervention, is not mandatory and is to be determined on a case by case basis

What if payments are stopped during the 12 weeks?

19.6 The insurer may stop payments during the first 12 weeks for

reasons described in rule 21. However, any periods for which payments are not made because they have been stopped are not included in the 12 weeks payment period. The insurer may start payments again at any time as long as the total period for which payments are paid does not exceed 12 weeks. See Part 1, rule 19.1

What happens if payments are made for 8 weeks?

19.7 If a worker has received provisional weekly payments for at least 8 weeks, then the insurer is to notify the worker that they must make a claim if weekly benefits compensation is likely to be paid for more than 12 weeks after the date of the injury

Can provisional weekly payments start after a reasonable excuse is given?

19.8 If the reasonable excuse the insurer relied on no longer exists, then the insurer may start paying provisional payments again.

What provisional medical expenses can be paid?

20 The insurer may pay provisional medical expenses compensation up to \$5000. There are no time limits over what period the medical treatment can be given as long as the \$5000 limit is not exceeded. *Reference 280.*

What if the worker has already paid for medical treatment?

20.1 If the worker has paid for medical treatment, the insurer is to reimburse the worker within 7 days after the worker requests payment.

What if the worker has paid for traveling expenses?

20.2 If the worker has paid for traveling expenses to receive medical treatment or to attend a medical appointment that the insurer has arranged, the insurer is to reimburse the worker within 7 days after the worker requests payment.

May the insurer stop provisional weekly payments?

21 The insurer may stop provisional weekly payments after they have commenced for one of the following reasons:

21.1 If the insurer stops payments for these reasons then the worker does not have to receive a notice

21.1.1 If the worker returns to work before the end of the agreed period of provisional payments; or

21.1.2 If the worker makes a claim and this claim is accepted

21.2 If the insurer stops payment because the worker has not complied with injury management, then the insurer must send the worker: *Reference section 57(2)*

a dispute notice and must send a copy to the employer. The notice must include the following:

- that weekly payments have stopped
- the reason the weekly payments have stopped
- the action the worker must do for the payments to start again
- that the worker and employer may contact Claims Assistance Service on 131050 for assistance

21.3 The insurer must send the worker a section 74 dispute notice if it stops paying:

21.3.1 because the worker does not provide a WorkCover medical certificate that certifies the worker's incapacity within 7 days after the insurer requesting the certificate, see Part 1, rule 19.5; or

21.3.2 because the worker does not authorise a provider of medical or hospital treatment or occupational rehabilitation services to give an insurer the following information within 7 days after the insurer making the request; *Reference section 270 (1)(b)*

21.3.2.1 information regarding the treatment or service given to the worker in connection with the injury; or

21.3.2.2 information regarding the worker's medical condition; or

21.3.2.3 information regarding treatment relevant to the injury:or

21.3.3 because the insurer receives new evidence that was not available at the time the provisional payments began.

21.4 What must a section 74 dispute notice include?

A section 74 dispute notice must be in plain language, in writing and given to the worker and the employer. It must include a statement:

- 21.4.1 of the reason the insurer disputes liability
- 21.4.2 of what part of the legislation the insurer relies on to dispute liability
- 21.4.3 of the particulars that support the reason for the decision, including the required details for each report (if any) on which the insurer relies to support that reason, and
- 21.4.4 advising that the claimant may request a copy of a report specified in the statement of particulars from the insurer, and
- 21.4.5 advising that the claimant may request the insurer to review the decision, and advising of the procedure for making such a request, and
- 21.4.6 to the effect that:
 - i. in the case of a dispute about a claim that is an existing claim within the meaning of Chapter 7 of the 1998 Act, the claimant may apply to the Compensation Court for determination of the dispute, or
 - ii. in the case of a dispute about a claim within the meaning of Chapter 7 of the 1998 Act, the claimant may refer the dispute to the Registrar for determination by the Commission, and
- 21.4.7 of the address and fax number for the Registrar of the Court or the Registrar of the Commission, as appropriate.
- 21.4.8 that the worker can seek assistance from a trade union or from a lawyer
- 21.4.9 that the worker or the employer may contact the Claims Assistance Service on 131050 for assistance

When may a provisional claim be reopened?

22 The insurer may reopen a provisional claim as a provisional claim in the following circumstances

- 22.1 for administration purposes to make further payments; or
- 22.2 if the worker returns to work and is then off work again, the insurer may pay provisional weekly payments again as long as the total period for which payments are paid does not exceed 12 weeks. This would be considered an injury management intervention, is not mandatory and is to be determined on a case by case basis

22.3 If provisional payments are stopped for reasons described in Part 1, rule 21 and the worker becomes eligible again for provisional weekly payments, then the payments can start again as long as the total period for which payments are paid does not exceed 12 weeks. Any periods for which payments are not made because they have been stopped is not included in the 12 weeks.

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Part 2 Making and handling claims

If a claim the insurer receives is the first initial notification of injury then an insurer must commence provisional weekly payments within 7 days after the claim is received. However, the insurer does not have to do that if the insurer has a reasonable excuse. See Part 1 of these guidelines. *Reference section 267 and 275.*

Does the worker have to make a claim?

1. A worker can make a claim for compensation at any time as long as it is made within the time limits allowed, see Part 2, rule 2.

What if the claim is for weekly benefits or medical expenses?

- 1.1 A worker does not have to make a claim for weekly benefits or medical expenses if an initial notification of their workplace injury was made and the worker was paid provisional liability payments. However, the worker must make a claim if:
 - 1.1.1 the worker requires benefits that exceed their entitlements under provisional liability; that is weekly payments more than 12 weeks, see Part 1, rule 19 or compensation for medical expenses more than \$5000, see Part 1, rule 20.
 - 1.1.2 the insurer has stopped making provisional liability payments and the worker thinks they are still entitled to more benefits
 - 1.1.3 the insurer requests a claim to be made

What if the claim is for permanent impairment or work injury damages?

- 1.2 A worker must make a claim for permanent impairment or work injury damages, see Part 2, rule 6.

What are the time limits on making a claim?

- 2 Before a worker can make a claim the worker must serve a notice of injury on the employer, see Part 2, rule 3. Also, the first claim must be made within 3 years after the injury happened, see Part 2, rule 2. *Reference section 256(4) or 257.*

However:

- 2.1 the Authority may approve to extend this period; and
- 2.2 if the worker first became aware of the injury after they received the injury, then the 3 year period doesn't start until the date on which the worker became aware of the injury; and
- 2.3 if the claim is for compensation for death, or serious and permanent impairment, the claim may be made at any time.

How does a worker serve a notice of injury on the employer?

Reference Part 2 Division 1 – Giving notice of injury and making a claim

3. A notice of injury may be given orally or in writing and must be given to the worker's supervisor or any person designated by the employer as soon as possible after the injury happened.

What must a notice of injury state?

3.1 A notice of injury must state:

- 3.1.1 The name and address of the person injured, and
- 3.1.2 The cause of the injury (in ordinary language),
and
- 3.1.3 The date on which the injury happened.

If particulars of an injury are entered in a register of injuries as soon as possible after an injury happened, the entry is sufficient notice of the injury

What if the injury involves loss of hearing?

3.2 A notice of injury must be given by providing the information in Form 1 to the employer. *Reference regulations clause 38.*

For an injury that involves loss of hearing, what employer does the notice of injury- Form 1 have to be served on?

3.3 The notice of injury –Form 1 must be served;

- 3.3.1 if the worker is employed by an employer in an employment to the nature of which that injury is due to that employer; or
- 3.3.2 if the worker is not so employed then Form 1 is served on the last employer by whom the worker was employed in an employment to the nature of which the injury is due.

What information must be included in Form 1 – loss of hearing notice?

3.4 *Workers Compensation (General) Regulation 1995 Form 1 is a prescribed form and located in;*

Industrial deafness Notice of injury

- 1 Name and address of worker:
- 2 Age and occupation of worker:
- 3 Name and address of employer to whom notice of injury is given:
- 4 If not employed by the above employer at the date that this notice of injury is given, date of last day of employment with the employer:
- 5 Has the worker been paid any compensation for loss of hearing in Australia or elsewhere? YES/NO If YES give details:
- 6 Using the following list, give the worker's complete work history in any noisy work in Australia or elsewhere, including work as an employee, in any business carried on by the worker (either alone or with anyone else), in military service or otherwise. Include work in the list even if unsure about

how noisy the work was.

Type of occupation . State whether employee/own business/ other (specify)
Name and address of employer, business or other period of work.

Signature of Worker
Date signed by worker.

How does a worker make a claim?

- 4 To make a claim, a worker must serve the information listed in Part 2, rule 6 on the relevant person which is either:
 - 4.1 the employer from whom the worker claims compensation; or
 - 4.2 the insurer responsible for covering the worker for compensation.

The information must be in writing on a form designed for making a claim for workers compensation benefits pursuant to the Workers Compensation Act 1987 and Workplace Injury Management and Workers Compensation Act 1998.

How may a worker serve a claim?

5. A worker may serve a claim in any of the following ways:
 - 5.1 by giving it in writing personally to the relevant person, see Part 2 rule 4.
 - 5.2 by having it delivered or sent by post to the current residence of the relevant person or to any current place of business of that person
 - 5.3 by sending it by email or facsimile to the relevant person
 - 5.4 by leaving it at, or posting it to, the relevant company's registered office
 - 5.5 by having it delivered to a director of the company who resides in Australia
 - 5.6 if a liquidator or administrator of the company has been appointed, by leaving it at, or posting it to, the address of the liquidator's or administrator's office
 - 5.7 if the claim is for only medical expenses up to \$5,000, the worker may make the claim verbally to the employer or the insurer, or the employer may make the claim verbally to the insurer. Supporting documentation of the amount claimed must be provided for payment to be made.

What is the minimum information required to make a claim?

6. To make a claim, the worker must provide certain information depending on what the worker is making a claim for. An employer can provide any information about the claim to the insurer but a suggested minimum amount of information is listed in Part 2, rule 6.8.

If a worker has provided information in relation to one claim for an injury, that information is relevant for any other claim the worker makes for the same injury.

What information from the worker is needed to make a claim?

6.1 Information about the worker:

- Given and family names
- Residential address
- Date of birth
- Occupation
- Interpreter required, if yes language.
- Country of birth

6.2 Information about the employer

- Name
- Current business address
- ABN if known
- Policy number if known

6.3 Information about the treating doctor

- Name

6.4 Information about the worker's employment

- Full time or part time
- Permanent or casual
- Gross pay per week
- Total hours worked per week
- Normal working hours
- Details of enterprise or workplace agreement or an award if known
- Date the worker started employment with the employer
- 2nd employers name and contact details if applicable
- gross pay per week from 2nd employer
- hours worked per week for 2nd employer

6.5 Information about the workplace injury

- Date and time of the workplace injury
- How the injury happened
- What part of the body is injured?
- Was this part of the body normal before the workplace injury?
- The address where the workplace injury happened
- Name of any witness to the workplace injury

- Name of person at workplace the injury was reported to
- Date the workplace injury was reported to the employer

6.6 Additional information

- Details of any previous similar injuries or conditions
- That may assist when determining the claim
- Worker's declaration, see Part 2, rule 6.7.

What must the "worker's declaration" include?

6.7 A declaration must be signed by the worker and must say words that mean the same as:

I certify that the information I have provided is correct. I consent to my insurer and its appointed service providers collecting personal information about me and using it for the purpose of assessing and managing my worker's compensation claim, including determining liability and whether my claim is true. I consent to my insurer disclosing my personal information to medical practitioners, rehabilitation providers, investigators, legal practitioners and other experts or consultants for the purposes of assessing and managing my claim. I also consent to my insurer disclosing my personal details to the WorkCover Authority which is authorized to use this information to fulfil it's functions under the NSW workers compensation legislation. I understand that if any information I have given is untrue, that my claim may be denied and that I may be prosecuted

What information is required from the employer?

6.8 The information the insurer may obtain from the employer is:

- Name
- Current business address
- Policy number
- ABN
- Number of people at the workplace
- Details of enterprise or workplace agreement or an award
- Confirmation that the information the worker provided about their employment in Part 2, rule 6.4 and their workplace injury in Part 2, rule 6.5 is accurate.
- Additional information that may assist in determining the claim
- Employer's signature, name and position.

What if the claim is for weekly benefits?

6.9 To make a claim for weekly benefits the worker must:

- provide the minimum information listed in Part 2 rule 6.1 to 6.7; and
- provide a WorkCover medical certificate . (if one has not already been given to the insurer or employer, or a medical report that includes the same information)

What if the claim is for medical expenses?

- 6.10 To make a claim for medical expenses compensation the worker must:
- provide the minimum information listed in rule 6.1 to rule 6.7

What if the claim is for permanent impairment or lump sum damages?

- 6.11 To make a claim for permanent impairment or lump sum damages the worker must provide relevant particulars about a claim. Relevant particulars about a claim are full details of the following, sufficient to enable the insurer, as far as practicable, to make a proper assessment of the claimant's full entitlements on the claim. The relevant particulars to be provided to the insurer are:

- 6.11.1 The minimum information listed in Part 2, rule 6.1 to 6.7; and
- 6.11.2 all impairments arising from the injury; and
- 6.11.3 any previous injury, or any pre-existing condition or abnormality, to which any proportion of an impairment is or may be due (whether or not it is an injury for which compensation has been paid or is payable under Division 4 of Part 3 of the 1987 Act); and
- 6.11.4 in the case of a claim for work injury damages, any economic losses and other losses that are being claimed as damages; and
- 6.11.5 information relevant to a determination as to whether or not the degree of permanent impairment resulting from the injury will change; and
- 6.11.6 in the case of a claim for lump sum compensation, details of all previous employment to the nature of which the injury is or may be due.
Reference section 282.
- 6.11.7 A medical report completed as described in WorkCover Guidelines on Assessment of Permanent Impairment.
Reference section 282, regulation clause 39

What if the claim is for permanent impairment hearing loss?

- 6.12 To make a claim for permanent impairment hearing loss the worker must provide relevant particulars about a claim. Relevant particulars about a claim are full details of the following, sufficient to enable the insurer, as far as practicable, to make a proper assessment of the claimant's full entitlements on the claim. The relevant particulars to be provided to the insurer are:

- 6.12.1 Information in Form 1– Notice of hearing loss, see Part 2 rule 3.4
- 6.12.2 Workers declaration, see Part 2, rule 6.7.

6.12.3 A copy of the audiogram used by the medical practitioner in preparing the medical certificate or report that accompanies the claim

6.12.4 A medical report completed as described in WorkCover Guidelines on Assessment of Permanent Impairment.
Reference section 282, regulation clause 39

What if the claim is for property damage?

6.13 To work make a claim for property damage compensation the worker must:

6.13.1 provide the minimum information in Part 2, rule 6.1 to 6.7

6.13.2 provide documentation to support the amount claimed.

What if the claim is for pain and suffering?

6.14 To make a claim for pain and suffering the worker must provide relevant particulars about a claim. Relevant particulars about a claim are full details of the following, sufficient to enable the insurer, as far as practicable, to make a proper assessment of the claimant's full entitlements on the claim.

The relevant particulars to be provided to the insurer are:

6.14.1 The minimum information listed in Part 2, rule 6.1 to 6.7;
and

6.14.2 the loss or permanent impairment and (if applicable) treatment from which the pain and suffering resulted;

6.14.3 the degree and duration of the pain and suffering and to what extent it is attributable to the past, present or future;

6.14.4 to what extent the pain and suffering consists of actual pain and to what extent it consists of distress or anxiety;

6.14.5 the proportion (expressed either as a percentage or an amount of money) of the maximum amount of compensation under section 67 claimed for the pain and suffering.

What must an employer do when it is served with a claim?

7. Within 7 days after an employer receives a claim, the employer must send the claim to the insurer responsible to cover the worker for compensation. From then on, if the insurer requests more information, the employer must respond within 7 days of receiving the request with all information that is reasonably attainable. *Reference 264 (1), 264(2).*

Note: When a worker is expected to be away from their normal duties for 7 or more calendar days the employer must notify the insurer of the injury within 48 hours.

What must an insurer do when it is served with a claim?

8. When an insurer is served with a claim it must:
 - 8.1 **If the claim is for weekly or medical expenses compensation?**
 - 8.1.1 Determine the claim within 21 days, see Part 2, rule 10.1 and
 - 8.1.2 notify the employer within 7 days that a claim has been made by their worker.
 - 8.2 **If the claim is for permanent impairment or lump sum damages?**

When an insurer is served with a claim for permanent impairment the insurer must determine the claim by the latest date of either:

- 8.2.1 *Within 1 month after* the degree of permanent impairment first becomes fully ascertainable, as agreed by the parties or as determined by an approved medical specialist, or
- 8.2.2 *Within 2 months after* the claimant has provided to the insurer all relevant particulars about the claim
Reference section 281.

An insurer can only delay determining a claim under 8.2.1 if, within two months of receiving all relevant particulars about a claim, they have notified the worker the degree of permanent impairment is not fully ascertainable.

If the claim is served on the insurer the insurer must notify the employer a claim has been made.

What if the insurer can't find the policy?

9. If the insurer can not find a current policy that covers a claim within 7 days after the claim is made, then the insurer is to either:
 - 9.1 contact the employer, and person who made the claim, and request more information in order to identify the policy. If the policy still cannot be identified, then the insurer is to inform the employer and the person who made the claim that the insurer is not the current insurer. The insurer must then refer the claim to the Claims Assistance Service (CAS); or
 - 9.2 pass the claim to the current insurer if known. (maybe known by a request for past claims experience from the new insurer or from the cancellation request made by the employer).

When must the insurer determine the claim?

10. The time allowed for an insurer to determine a claim is different for each type of claim

What if the claim is for weekly or medical expenses compensation?

- 10.1 An insurer must determine a claim for weekly benefits or medical expenses compensation within 21 days after the claim was made see Part 2, rule 4 unless one of the reasonable excuses in Part 2, rule 10.1.1 to 10.1.5 for not determining the claim applies *Reference section 274 and 283.*
- 10.1.1 *Expiry date greater than due date* The expiry date of the expected provisional liability period is greater than the claim determination due date. In that case, the insurer must determine the claim when the provisional liability weekly payments end if a determination is still required.
- 10.1.2 *Returned to work* The worker has returned to work on pre-injury duties, and received provisional liability payments for the amounts claimed, and is not expected to suffer any future loss from the injury.
- 10.1.3 *Medical expenses only* The claim is for only medical expenses compensation and has been provisionally accepted. *Reference section 280.*
- 10.1.4 *Medical expenses for permanent impairment.* The claim is for artificial aids, spectacles, home care or vehicle or home modifications and is made at the same time as a lump sum or work injury damages claim. *Reference section 59 (d), (f), (g) .* The insurer must determine this claim at the same time as the claim for permanent impairment.
- 10.1.5 *Deficient claim* Within 7 days after the insurer received the claim, the insurer has notified the worker in writing that the claim contains an error that is not obvious or typographical; and how to correct that deficiency. This could include
- Worker refuses to sign the declaration
 - No medical certificate received

The worker may correct the error at any time. When the error is corrected the claim is then made and the insurer must determine it within 21 days of the correction being notified to the insurer.

What if the claim is for permanent impairment?

- 10.2 An insurer must, within the time specified in Part 2, rule 8.2 determine the claim by:

- 10.2.1 accepting liability and making a reasonable offer of settlement to the worker, or
- 10.2.2 disputing liability

If the claim for work injury damages is for a death of a person this rule does not apply.

What must the insurer do if it accepts liability for a permanent impairment or work injury damages claim?

Reference section 281

- 10.3 When an insurer accepts liability for a permanent impairment or work injury damages claim it must make a reasonable offer of settlement to the claimant within the time allowed, see Part 2, rule 8.2

An offer of settlement is to specify an amount of compensation or damages or a manner of determining an amount of compensation or damages.

If an offer of settlement is made on the basis that the insurer accepts only partial liability for the claim, the offer is to include details sufficient to ascertain the extent to which liability is accepted.

What if the claim is for property damages?

- 10.4 An insurer must determine a claim for property damages within 21 days after the claim was made.

What must an insurer do if it disputes any claim?

- 10.5 When an insurer disputes liability for any claim the insurer must issue a dispute notice under section 74, see Part 1, rule 21.4.
A section 74 dispute notice is not required if a section 54 notice that includes the requirements of a section 74 notice is issued to the worker.

What if the claim was closed and the worker needs to claim more?

- 10.6 A claim can be re-opened after it has been closed for the following reasons:
- Recurrence of original injury
 - Further payments or recoveries
 - Claim is litigated
 - Claims administration

If a claim is re-opened again other than for administration purposes, a decision on the additional weekly benefits or medical expenses must be determined again within 21 days, see Part 2, rule 10.

The insurer must also notify the employer within 7 days that a claim made by their worker has been re-opened.