

Guidelines for claiming workers compensation

Requirements,
information and
guidance for
workers, employers,
insurers and other
stakeholders.



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About these guidelines

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

SIRA has developed these *Guidelines for claiming workers compensation* (guidelines) in accordance with the legislation to support, inform and guide workers, employers, insurers and other stakeholders in the process of claiming workers compensation in NSW.

These guidelines explain what workers, employers and insurers must do in relation to claims under the NSW workers compensation legislation:

- *Workers Compensation Act 1987* (the 1987 Act)
- *Workplace Injury Management and Workers Compensation Act 1998* (the 1998 Act)
- *Workers Compensation Regulation 2010* (the 2010 Regulation).

SIRA issues these guidelines under section 376(1)(c) of the 1998 Act and they operate by force of law as delegated legislation. Specific sections of the workers compensation legislation that place obligations on stakeholders and provide guideline making powers are referenced throughout the document. Where these obligations and powers are referenced, the term 'must' has been adopted.

These guidelines also outline SIRA's expectation of best practice claims processes. Where these guidelines express SIRA's expectations but there is no specific legislative obligation, the term 'should' has been adopted.

Transitional provisions

Chapters B4.1 and B4.2 (Return to work assistance) of these guidelines commence from the date of gazettal.

All other chapters of these guidelines commence on 1 August 2016.

Accordingly, from 1 August 2016, these guidelines apply to all claims activities and replace the following:

- *WorkCover Guidelines for claiming compensation benefits* published in the NSW Government Gazette No. 125 on 8 October 2013 (page 4,340)
- *WorkCover Guidelines for work capacity* dated 4 October 2013
- *Guidelines for work capacity decision internal reviews by insurers and merit reviews by the authority* dated 4 October 2013
- *WorkCover Guidelines for the provision of domestic assistance 2004*.

Any SIRA document that makes reference to one of the above Guidelines is a reference to these guidelines.

What is their scope?

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

Insurers include:

1. Workers Compensation Nominal Insurer and its five agents: Allianz Australia Workers' Compensation (NSW) Limited, CGU Workers Compensation (NSW) Limited, Employers Mutual NSW Limited, GIO General Limited and QBE Workers Compensation (NSW) Limited.
2. SICorp through the Treasury Managed Fund and its three workers compensation claims management service providers: Allianz Australia Insurance Ltd, Employer's Mutual Limited and QBE Insurance Australia Limited.
3. Self insurers - those employers SIRA has licenced to manage their own workers compensation liabilities and claims.
4. Specialised insurers, who hold a licence to provide workers compensation insurance for a specific industry or class of business or employers.

The guidelines do not apply to:

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

Exempt categories of workers

The Workers Compensation Legislation Amendment Act 2012 changed the workers compensation laws. The 2012 amendments do not apply to police officers, paramedics or fire fighters.

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

Most requirements in these guidelines apply to exempt categories of workers. Please see Part C for information specific to exempt workers.

What do they cover?

The guidelines have three main sections:

Part A: How the claims process works	The main steps in the claims process, from initial notification of a work related injury to making and responding to a claim. This Part applies to all workers.
Part B: What compensation may cover	Types of compensation workers can claim, from weekly payments to payments such as medical expenses, domestic assistance and property damage.
Part C: Exempt categories of workers	Requirements for exempt categories of workers, where they vary from the requirements outlined in Part B.

Information for the reader

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

References to applicable legislative provisions are made throughout the document where further information can be obtained.

Substantial compliance

If a worker, employer or insurer provides information or takes action that is substantially compliant with these guidelines, but is a technical breach of these guidelines, then the information or action remains valid unless a party has, as a result of that breach:

- been misled
- been disadvantaged, or
- suffered procedural unfairness.

This does not affect the obligations on workers, employers or insurers to fully comply with all applicable workers compensation legislation.

How can you learn more?

Workers or employers with queries about these guidelines or a claim should first contact the **insurer**.

SIRA's Customer Service Centre can help those who have raised a query or dispute with their insurer and are not satisfied with the outcome. It can also answer queries about these guidelines.

Please phone 13 10 50 or email contact@sira.nsw.gov.au.

Workers Compensation Independent Review Officer can help workers or employers with:

- complaints about their insurer
- disputes about an entitlement for compensation
- funding for legal assistance.

Please phone 13 94 76 or email complaints@wiro.nsw.gov.au.

Part A – How the claims process works

A1 Initial notification of an injury

About this section

The first step in claiming compensation for a work related injury is to notify the employer and insurer of that injury.

This section explains:

- when an initial notification must be made and who can do this
- what to include
- how the insurer must respond.

Notifying the employer and insurer

If a worker is injured at work, they must tell their employer as soon as possible after the injury happens, unless special circumstances apply. A worker can notify their employer verbally or in writing.



Sections [254](#) and [255](#) of the 1998 Act

The employer must keep a readily accessible register of injuries in the workplace.



[Section 256](#) of the 1998 Act

When employers become aware of a work related injury, they must ensure their insurer is notified within 48 hours. This notification can also be made by:

- the worker
- a representative of either the worker or the employer (such as a doctor or union representative).

Notifications can be written (including by email) or verbal (including by phone). This notification to the insurer is called the 'initial notification'.



Sections [44](#) and [266](#) of the 1998 Act

In any case, the worker or representative should ask the employer for the insurer's name. The employer must provide the insurer's name to the worker. If the employer does not or cannot give a name, the worker can phone the SIRA Customer Service Centre on 13 10 50 or email contact@sira.nsw.gov.au.

How to notify an insurer of a work related injury

As the notifier, the following information is required to be provided to the insurer:

Worker	<ul style="list-style-type: none">■ Name■ Contact details (including a phone number and postal address)
Employer	<ul style="list-style-type: none">■ Business name■ Business contact details
Treating doctor (where relevant)	<ul style="list-style-type: none">■ Name■ Name of medical centre or hospital
Injury	<ul style="list-style-type: none">■ Date of the injury or the period over which the injury emerged■ Time of the injury■ Description of how the injury happened■ Description of the injury
Notifier	<ul style="list-style-type: none">■ Name■ Relationship to the worker or employer■ Contact details (including phone number and postal address)

Confirming the employer's policy

If the insurer cannot find a policy that covers the employer within three business days of receiving a notification, the notified insurer should contact the employer and the notifier to learn more and take the below actions.

If it cannot identify the policy, the notified insurer should:

- tell the worker, employer and notifier that it is not the current insurer
- refer the notification to the SIRA Customer Service Centre.

If the current insurer can be identified, the notified insurer should:

- pass the notification on to the current insurer immediately
- advise the worker, employer and notifier in writing.

Acting on the initial notification

If the insurer receives an incomplete notification, it should tell the notifier (and the worker, where possible) within three business days and specify the information needed.

The date the notification is completed becomes the 'initial notification date', which affects provisional payments (see [A2](#)).



[Section 266 of the 1998 Act](#)

Once the notification is complete, the insurer must review the information and take one of these actions:

5. Start provisional payments (see [A2](#)).
6. Delay starting provisional weekly payments due to a reasonable excuse (see [A2](#)).
7. Determine liability (see [Part B](#) or [Part C](#)).

A2 Provisional payments

About this section

The insurer may make provisional payments before it determines liability (see [Part B](#) or [Part C](#)) to cover:

- up to 12 weeks of payments for loss of income
- up to \$7,500 for reasonably necessary medical treatment.



[Sections 267, 275 and 280](#) of the 1998 Act

This section sets out the steps the insurer must take to:

- start provisional payments
- delay starting provisional weekly payments due to a reasonable excuse.

Starting provisional payments

Once the insurer has received an initial notification of an injury, it must start provisional weekly payments within seven calendar days unless it has a reasonable excuse not to. For more information on how the insurer will gather information to calculate weekly payments, see [B1.1](#) and [C1.1](#).

The insurer may also commence payments for medical expenses on a provisional basis.

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



[Section 279](#) of the 1998 Act

Where provisional medical payments are to be made, these should be commenced as soon as possible. Where a worker claims medical expenses but these are not paid under provisional payments, the insurer must determine liability within 21 calendar days (see [B2](#)).

Starting provisional payments does not mean the insurer or employer admits liability for the injury. It simply allows the insurer to provide the worker with financial assistance and early intervention whilst they perform any necessary investigations and determine liability on the claim.

Where the insurer does not commence provisional payments and/or issue a reasonable excuse, the worker may seek assistance from:

- the insurer
- SIRA's Customer Service Centre on 13 10 50
- Workers Compensation Independent Review Officer (WIRO) on 13 94 76

The worker also has a right to seek an expedited assessment by application to the Registrar of the Workers Compensation Commission. The Registrar (or delegate) of the Workers Compensation Commission may direct that provisional payments commence under an interim payment direction.



[Sections 297](#) of the 1998 Act

How to start provisional weekly payments

As an insurer, when starting provisional payments you must notify the worker in writing. You should also inform the employer.

The notice must explain:

- that the payments have started but are on a provisional basis
- how long they are expected to last for
- that an injury management plan will be developed if the worker is unable to return to their pre-injury employment for seven continuous days
- that the worker can make a claim and how to do so.

It should also include:

- the worker's pre-injury average weekly earnings
- 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.

You should also supply a claim form and the [Information for injured workers](#) brochure.





[Section 269 of the 1998 Act](#)

If you include information in this notice which is a work capacity decision, you should ensure that it is communicated to the worker as prescribed in the 'Work capacity decision' chapter (see [B1.3](#)).

Delaying provisional weekly payments

Where applicable, prior to delaying provisional weekly payments, the insurer should attempt to resolve the reasonable excuse.

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

<p>There is insufficient medical information</p>	<p>The insurer does not have enough medical information to establish that there is an injury, as a <i>Workers compensation certificate of capacity</i> or other medical information certifying that an injury has occurred, has not been provided.</p> <p>Note: Use discretion for workers in remote areas if access to medical treatment is not readily available.</p>
<p>The injured person is unlikely to be a worker</p>	<p>The person cannot verify they are a worker or the employer can verify that they are not a worker.</p> <p>If there is any doubt that someone is a worker under the workers compensation law, the insurer must verify that person's status.</p> <p>Information that confirms this may include but is not limited to:</p> <ul style="list-style-type: none"> ■ the employer agreeing to the worker's status ■ the worker's payroll number ■ a current payslip or a bank statement with regular employer payments ■ a contract of employment or services. <p> Sections <u>4</u> and <u>5</u>, and <u>Schedule 1</u>, of the 1998 Act</p>
<p>The insurer is unable to contact the worker</p>	<p>The insurer has not been able to contact the worker after at least:</p> <ul style="list-style-type: none"> ■ two attempts by phone (made at least a day apart) ■ one attempt in writing (which may include an attempt by email).
<p>The worker refuses access to information</p>	<p>The worker will not agree to the release or collection of personal or health information relevant to the injury to help determine their entitlement to compensation.</p>
<p>The injury is not work related</p>	<p>The insurer has information that:</p> <ul style="list-style-type: none"> ■ the worker did not receive an injury which is compensable under the NSW workers compensation law, or ■ strongly indicates that compensation for an injury may not be payable under the workers compensation law. <p>If the employer believes the injury is not work related, it should provide to the insurer supporting information, such as:</p> <ul style="list-style-type: none"> ■ medical information that the condition already existed and has not been aggravated by work ■ factual information that the injury did not arise from or during employment. <p>Note: Suspicion, innuendo, anecdotes or unsupported information from any source, including the employer, is not acceptable.</p> <p> <u>Section 4</u> of the 1998 Act and sections <u>9A</u>, <u>9B</u> and <u>10</u> of the 1987 Act</p>
<p>There is no requirement for weekly payments</p>	<p>A notification of injury has been received; however the insurer has verbal or written confirmation from the worker and employer that they do not anticipate that weekly payments will be claimed.</p>
<p>The injury is notified after two months</p>	<p>The notice of injury is not given to the employer within two months of the date of injury.</p> <p>Note: The insurer should disregard this excuse if liability is likely to exist and it believes provisional payments will be an effective way to manage the injury.</p>

 Section 267 of the 1998 Act

How to communicate a reasonable excuse for delaying payments

As an insurer, if you have a reasonable excuse for not starting provisional weekly payments, you:

- must give the worker written notice within seven days of receiving the initial notification
- should also tell the employer in writing as soon as possible.

The notice to the worker must set out:

- the excuse(s), and should include copies of all relevant information you considered in the decision
- that the worker can still make a claim for compensation, which the insurer will determine within 21 days of receipt
- how the worker can make that claim.

You should supply a claim form and explain:

- 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, SIRA's Customer Service Centre on 13 10 50 or Workers Compensation Independent Review Officer on 13 94 76.
- that the worker has a right to seek an expedited assessment by application to the Registrar of the Workers Compensation Commission.



Section 268 of the 1998 Act

Stopping provisional payments

The insurer can stop provisional weekly payments if the worker does not supply, within seven days of receiving a request for:

- a certificate of capacity, or
- a signed form of authority to allow the insurer to obtain information about the injury.



Section 270 of the 1998 Act

Provisional weekly payments can also be stopped if:

- the worker returns to work before the provisional payments end and faces no ongoing loss of earnings, or
- liability for the claim for weekly payments is accepted or disputed.

The insurer can stop provisional medical payments if:

- the worker is not seeking any further medical treatment for the injury, or
- liability for the medical expenses claim is accepted or disputed.

If liability for compensation benefits is disputed while provisional payments are being made, the insurer must issue a notice of dispute (see B10 or C4).



Section 74 of the 1998 Act

A3 Claims for compensation

About this section

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

This section sets out:

- how a worker can make a claim
- what must happen after the claim has been submitted.

For more on claiming a specific entitlement, please see [Part B](#) or [Part C](#).

Requirement for a claim form

A worker is able to complete and submit a claim form to the insurer at any time. A claim form is available at www.sira.nsw.gov.au.

A claim form is required if:

- a reasonable excuse notice has been issued and the excuse continues to exist, or
- compensation is likely to be claimed beyond provisional payments and the insurer determines that there is insufficient information to determine ongoing liability.

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

The claim must be made within six months of a worker's injury or accident (or within six months of a worker becoming aware of an injury). This time limit may be extended in certain circumstances.



[Section 261 of the 1998 Act](#)

Information required to support a claim

As a worker, if you are claiming compensation, you must supply information that shows you:

- were employed



[Sections 4 and 5, and Schedule 1, of the 1998 Act](#)

- received an injury from or during the employment
- have lost income, need medical treatment or may incur other expenses because of that injury.

You can also provide other information that supports your claim.

Responding to a claim

The employer must:

- forward any workers compensation claim or information about a claim to the insurer within seven days of receiving it
- respond to the insurer's requests for information about a claim within seven days.



[Section 264 of the 1998 Act](#)

If the insurer cannot find a policy that covers the employer within three business days of the claim being made, the insurer must follow the steps in [A1](#).

In all other circumstances, the insurer must assess the information and decide on its liability within the timeframes the law specifies. It will either:

- accept liability (see [B1.1-B9](#) or [C1.1-C3](#))
- dispute liability (see [B10](#) or [C4](#)).

Part B – What compensation may cover

B1.1 Weekly payments

This chapter does not apply to exempt categories of workers (police officers, fire fighters, paramedics). These workers should refer to chapter [C1.1](#) and [C1.2](#) for information on weekly payments.

About this section

Weekly payments may be made to a worker to compensate for loss of earnings as a result of a work related injury.

This section explains how the insurer can:

- assess the worker's entitlement
- calculate pre-injury average weekly earnings
- calculate the weekly payments.

Understanding eligibility

To be entitled to weekly payments, the worker must be:

- totally or partially incapacitated for work due to an injury
- losing earnings due to the incapacity.

How to demonstrate capacity

As a worker, you must provide a completed *Workers compensation certificate of capacity* (your medical practitioner will have this).

Part A of the certificate should be completed by you.

Part B of the certificate must be completed by the medical practitioner and:

- specify a period of no more than 28 days (if the medical practitioner gives special reasons for a longer period that satisfy the insurer, the certificate may be accepted)
- certify your capacity for work during this period, which must be no more than 90 days before the date the certificate is provided
- state the expected length of your incapacity.

Part C of the certificate must be completed by you.



Section 44B of the 1987 Act

You can give the certificate to the insurer, or to your employer who must forward it to the insurer within seven days.



Section 264 of the 1998 Act

Determining liability

The insurer must within 21 days of receiving a claim for weekly payments:

- accept liability and start weekly payments, or
- dispute liability (see B10).

However, if the insurer has started provisional payments and notified the worker (see A2), it only needs to determine liability before these provisional payments end (no more than 12 weeks).



Section 275 of the 1998 Act

Calculating pre-injury average weekly earnings (PIAWE)

The insurer should ask the employer and worker for information to calculate the worker's PIAWE.



Sections 44C, 44D, 44E, 44F, 44G and 44H of the 1987 Act

Workers and employers can either:

- complete the *Calculating pre-injury average weekly earnings* form (see www.sira.nsw.gov.au), or
- give the insurer the minimum information necessary, which the form outlines.

Workers with more than one current employer or who are self-employed should provide any other information the insurer needs to correctly calculate their PIAWE.



Schedule 3 of the 1987 Act

The insurer should calculate the PIAWE promptly to work out the worker's weekly payment entitlement and meet the legislative timeframes for commencing weekly payments (seven days for provisional payments or 21 days for accepting liability).

The insurer should then try to agree on the amount with the worker and employer.


This calculation is a work capacity decision and should be communicated as outlined in [B1.3](#). If the worker disagrees with the calculated PIAWE, they can ask the insurer to review it (see [B1.4](#)).

 Sections [43](#) and [44BB](#) of the 1987 Act

If the insurer is required to start weekly payments but does not have enough information to determine PIAWE, it should identify a suitable work classification in an award or industrial instrument and use the ordinary earnings rate for setting PIAWE at an interim rate. The insurer should try to get the missing information as soon as possible and review the PIAWE so the worker receives the correct amount. Where the PIAWE amount is incorrect, the insurer should advise the worker in a work capacity decision of the new PIAWE amount and how any discrepancies will be remedied.

Calculating weekly payments

The insurer must use a formula from the 1987 Act to calculate the worker's weekly payments. The formulas are referenced in the table at the end of this chapter.

 Sections [36](#), [37](#), [38](#) and [38A](#) of the 1987 Act

The amount the insurer must pay depends on, but is not limited to:

- whether the worker has current work capacity or no current work capacity (as defined at [s32A of the 1987 Act](#))
- the worker's PIAWE and any current weekly earnings
- how long the worker has received weekly payments
- whether the worker has returned to work
- the worker's ability to earn in suitable employment
- whether the worker's income includes non-pecuniary benefits from the employer (for example, residential accommodation, use of a car, health insurance or education fees).

 [Division 2 of Part 3 of the 1987 Act](#)

If the worker is earning in any paid employment, the worker must provide enough information for the insurer to calculate the correct weekly amount.

The weekly payment entitlement period starts on the day of the worker's first incapacity (total or partial) from a work related injury. This means that what constitutes a week is different for each worker and there is no set period (as in Sunday to Saturday).

For example, for a worker first incapacitated on a Wednesday, their weekly entitlement period is Wednesday to Tuesday.

A worker's entitlement week may not correspond with the worker's payroll week; however workers should continue to be paid in line with their payroll period. The insurer should calculate the worker's weekly payment and adjust it to their payroll week and where necessary, inform the employer of the payments to be made.

 [Section 84 of the 1987 Act](#)

When calculating weekly payments, the earnings factor of the calculation must be in accordance with the entitlement period, not the payroll week.

Where weekly payments change because of entitlement periods, the insurer should advise the worker, by phone (keeping a record of the conversation) and in writing.

If 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 must arrange for tax to be paid in line with income tax law.

How to start weekly payments

As the insurer, you should inform the worker and employer in writing when starting weekly payments. This information should explain:

- that the payments have started as the insurer has accepted liability for them
- 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 calculated and explain the review process
- what to do if the worker does not receive payment
- that an injury management plan will be developed, if the worker is unable to return to their pre-injury employment for seven continuous days
- 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*



Section 44B of the 1987 Act

- that the worker must tell the insurer of any change in employment that affects their earnings, such as starting work for another employer.



Sections 57 of the 1987 Act

If you include information which is a work capacity decision, you should ensure that it is communicated to the worker as outlined in the 'Work capacity decision' chapter (see B1.3).

You should also include the Information for injured workers brochure.

Weekly payments

Entitlement period	Section of the 1987 Act	No current work capacity (inability to return to work in suitable or pre-injury employment)	Has current work capacity (able to return to suitable employment but not pre-injury employment)	
0-13 weeks - 1st entitlement period	36	The lesser of: (AWE x 95%) - D OR MAX - D	The lesser of: (AWE x 95%) - (E+D) OR MAX - (E+D)	
14-130 weeks - 2nd entitlement period	37	The lesser of: (AWE x 80%) - D OR MAX - D	Working less than 15 hours per week	Working 15 hours or more per week
			The lesser of: (AWE x 80%) - (E+D) OR MAX - (E+D)	The lesser of: (AWE x 95%) - (E+D) OR MAX - (E+D)
53 weeks onwards	44C	Exclude overtime and shift allowance from AWE		
131-260 weeks - special requirements after second entitlement period	38	Cessation of weekly benefits after 130 weeks of weekly payments unless:		
		Worker is assessed as having no current work capacity which is likely to continue indefinitely. The lesser of: (AWE x 80%) - D OR MAX - D	Worker has applied to the insurer after 78 weeks for continuation of weekly payments beyond 130 weeks, and is working 15 hours or more and has current weekly earnings of at least the amount specified in s38 (3) (b) (as indexed) per week, and the insurer has assessed the worker is, and is likely to continue indefinitely to be, incapable of undertaking additional employment that would increase the worker's current weekly earnings OR worker has applied to the insurer after 78 weeks for continuation of weekly payments beyond 130 weeks, and worker is a worker with high needs (as defined in s32A of the 1987 Act). The lesser of: (AWE x 80%) - (E+D) OR MAX - (E+D)	
Certain circumstances don't affect payments after second entitlement period	40		Worker continues to have an entitlement under s38 even if the worker, for up to four weeks in the first 12 consecutive week period (or any subsequent consecutive period of 12 weeks of s38 payments), has: worked more or less hours (even if less than 15hrs) than the hours worked at the time of making the s38 application, or received higher or lower current weekly earnings (even if less than the amount specified in s38 (3) (b) (as indexed) per week).	
Special provision for workers with highest needs	38A	If the determination of weekly payments for a worker with highest needs is less than a minimum amount, the amount payable is to be treated as the minimum amount.		
Special compensation because of surgery after the second entitlement period	41	Special compensation for incapacity resulting from injury related surgery is payable at s37 rate: incapacity must not occur during the first 13 consecutive weeks after the end of the second entitlement period; payable for a maximum period of 13 weeks following surgery; and only if the worker is not otherwise entitled to payment under s38 after 130 weeks. To be eligible the worker must have received weekly payments and had current work capacity prior to incapacity from injury related surgery; and must have returned to work after the initial injury for 15 hours or more and have current weekly earnings of at least the amount specified in s38 (3) (b) (as indexed) per week.		
After five years (260 weeks) of weekly payments	39	Weekly payments of compensation cease to be payable unless the worker's injury results in a permanent impairment greater than 20%. Worker with high needs may continue after 260 weeks but require a work capacity assessment to be done at least once every two years. Workers with highest needs continue to be entitled to weekly payments without the requirement for a work capacity assessment. A worker's entitlement after 260 weeks is still subject to the requirements of s38.		

Factors	Definition
MAX (Section 34 of the 1987 Act)	The maximum weekly compensation amount applicable as prescribed in section 34 and indexed. Refer to www.sira.nsw.gov.au for maximum amount.
D (Section 35 of the 1987 Act)	Deductible amount, sum of the value of each non-pecuniary benefit (for example residential accommodation, use of a motor vehicle, health insurance, education fees) provided by the employer to a worker (for the benefit of the worker or their family) in respect of that week.
E (Section 35 of the 1987 Act)	Worker's earnings after the injury and is the greater of the amount the worker is able to earn in suitable employment or the worker's current weekly earnings.
AWE (Section 44C of the 1987 Act)	Also known as pre-injury average weekly earnings (PIAWE). Average of worker's ordinary earnings during the relevant period plus overtime and shift allowance. <i>Overtime and shift allowance only to be included in the PIAWE calculation in the first 52 weeks.</i>
Workers with high needs (Section 32A of the 1987 Act)	A worker whose injury has resulted in permanent impairment and: <ul style="list-style-type: none"> a. the degree of permanent impairment has been assessed for the purposes of Division 4 to be more than 20%, or b. an assessment of the degree of permanent impairment is pending and has not been made because an approved medical specialist has declined to make the assessment on the basis that maximum medical improvement has not been reached and the degree of permanent impairment is not fully ascertainable, or Note. Paragraph b. no longer applies once the degree of permanent impairment has been assessed. c. the insurer is satisfied that the degree of permanent impairment is likely to be more than 20% d. includes a worker with highest needs.
Workers with highest needs (Section 32A of the 1987 Act)	A worker whose injury has resulted in permanent impairment and: <ul style="list-style-type: none"> a. the degree of permanent impairment has been assessed for the purposes of Division 4 to be more than 30%, or b. an assessment of the degree of permanent impairment is pending and has not been made because an approved medical specialist has declined to make the assessment on the basis that maximum medical improvement has not been reached and the degree of permanent impairment is not fully ascertainable, or Note. Paragraph b. no longer applies once the degree of permanent impairment has been assessed. c. the insurer is satisfied that the degree of permanent impairment is likely to be more than 30%.

This information is general and does not replace the 1987 Act or 2010 Regulation.

B1.2 Work capacity assessments

This chapter does not apply to exempt categories of workers (police officers, fire fighters, paramedics).

About this section

Where a worker is entitled to receive weekly payments, an insurer may review their capacity to work. This is called a work capacity assessment. The insurer may consider this necessary for the purpose of informing a work capacity decision (see [B1.3](#)).

This section sets out:

- what an insurer must do when conducting a work capacity assessment
- when a work capacity assessment can be conducted.

Understanding work capacity assessments

An insurer performs a work capacity assessment to determine whether a worker has:

- current work capacity – a present inability arising from an injury such that the worker is not able to return to his or her pre-injury employment but is able to return to work in suitable employment, or
- no current work capacity – a present inability arising from an injury such that the worker is not able to return to work, either in the worker's pre-injury employment or in suitable employment.



Sections [32A](#) and [44A](#) of the 1987 Act

Assessing work capacity

A work capacity assessment should consider two questions:

1. Does the worker have a present ability to return to their pre-injury employment?
2. Does the worker have a present ability to return to suitable employment?

A work capacity assessment can be simple and based on limited information, or it can be more complex, such as where the worker has some capacity but cannot return to their pre-injury employment.

Insurers should consider the principles of procedural fairness, including fair notice, when making any assessment that may affect a worker's rights or interests. Insurers will need to determine what the principles of procedural fairness require, on a case by case basis, having regard to the nature and potential consequences of the outcome of the assessment.

A worker is able to provide any information to the insurer that they wish to be considered in a work capacity assessment (for example certificate of capacity, treating specialist reports, job description).

The insurer must keep a record of a work capacity assessment in the worker's file, including the:

- work capacity assessment date
- where applicable, dates of contact with the worker and case notes of discussion points
- details and dates of any other assessment the worker had to attend
- assessor's identity
- outcome of the assessment (for example, whether a work capacity decision is required).

If the insurer assesses that the worker cannot return to their pre-injury employment, then it must assess if the worker can instead work in other employment that is suitable.

If this is the case, the insurer must also identify the type(s) of employment the worker is currently suited to.



Section 44A of the 1987 Act

Assessing suitable employment

The insurer should assess suitable employment using all the available information and applying the definition within the legislation.

suitable employment means employment in work for which the worker is currently suited:

(a) *having regard to:*

- (i) *the nature of the worker's incapacity and the details provided in medical information including, but not limited to, any certificate of capacity supplied by the worker (under section 44B), and*
- (ii) *the worker's age, education, skills and work experience, and*
- (iii) *any plan or document prepared as part of the return to work planning process, including an injury management plan under Chapter 3 of the 1998 Act, and*
- (iv) *any occupational rehabilitation services that are being, or have been, provided to or for the worker, and*
- (v) *such other matters as the Workers Compensation Guidelines may specify, and*

(b) *regardless of:*

- (i) *whether the work or the employment is available, and*
- (ii) *whether the work or the employment is of a type or nature that is generally available in the employment market, and*
- (iii) *the nature of the worker's pre-injury employment, and*
- (iv) *the worker's place of residence.*



Section 32A of the 1987 Act

Timing the assessments

Insurers can perform a work capacity assessment whenever they need to assess a worker's work capacity.

An insurer must perform a work capacity assessment after a worker has received a total of 78 weeks of weekly payment, where it is likely that the worker will have an entitlement to weekly payments after receiving 130 weeks of weekly payments. This assessment must be completed prior to the worker accumulating 130 weeks of weekly payments. Before the insurer does this assessment it must notify the worker in writing including:

- the purpose of the assessment
- what information the worker can provide to the insurer for consideration
- the expected completion date
- the matters it may decide on.

Where the insurer assesses the worker as having a current work capacity, it must provide them with the *Application for continued weekly payments after 130 weeks* form and inform them they need to use this form to apply in writing for weekly payments to continue. See www.sira.nsw.gov.au for this form.

Section 38 of the 1987 Act

The insurer must assess the worker's current work capacity at least every two years from the date of this assessment.

Insurers must not perform a work capacity assessment for a worker with highest needs, unless the worker requests one and the insurer thinks it appropriate.

Sections 32A and 38 of the 1987 Act

Attending assessment appointments

An insurer may use available information to assess work capacity, or they may require the worker to attend an assessment appointment if further information is required. Any assessment appointments required by the insurer must be reasonably necessary. A worker cannot be required by the insurer to attend more than four appointments per work capacity assessment. Of these there cannot be more than:

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

Section 44A (5) of the 1987 Act

If the worker is required to attend an appointment with an independent medical examiner, this must be in accordance with the *Guidelines on independent medical examinations and reports*.

The insurer must advise the worker of the date and time of each appointment at least 10 working days before the appointment occurs. The advice must include:

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

Section 44A (6) of the 1987 Act

If the worker agrees, the insurer can set the date of an assessment appointment in less than 10 working days. The insurer should keep a record of this discussion.

Suspending benefits due to refusal or non-participation

Where the insurer requires the worker to attend an assessment appointment and the worker has refused to attend or the assessment did not take place due to the failure of the worker to properly participate in the assessment, the insurer may suspend a worker's weekly payments. Before suspending the payments, the insurer should be satisfied that it possesses sufficient information to confirm that the worker has refused to attend the appointment or the assessment did not take place due to the failure of the worker to participate in the assessment.

The insurer should advise the worker that weekly payments will remain suspended until the assessment appointment has taken place. Where suspension has occurred, the insurer should expedite the new assessment appointment and advise the worker of the details.

Section 44A (6) of the 1987 Act

B1.3 Work capacity decisions

This chapter does not apply to exempt categories of workers (police officers, fire fighters, paramedics).

About this section

A work capacity decision is made by an insurer and may affect a worker's entitlement to weekly payments.

This section sets out:

- what is a work capacity decision
- what the insurer should do when making a work capacity decision
- how the insurer should communicate a work capacity decision to the worker.

Understanding work capacity decisions

An insurer may make a work capacity decision about:

- the worker's current work capacity
- what is suitable employment for the worker
- how much the worker can earn in suitable employment
- the worker's pre-injury average weekly earnings (PIAWE) or current weekly earnings
- whether a worker is, as a result of injury, unable without substantial risk of further injury to engage in employment of a certain kind because of the nature of that employment
- any other decision of an insurer that affects a worker's entitlement to weekly payments of compensation, including a decision to suspend, discontinue or reduce the amount of the weekly payments of compensation payable to a worker on the basis of any decision referred to in the above bullet points.



Section 43 of the 1987 Act

Insurers make work capacity decisions regularly throughout the life of a claim.

Insurers should consider the principles of procedural fairness, including fair notice, when making any decision that may affect a worker's rights or interests. Insurers will need to determine what the principles of procedural fairness require, on a case by case basis, having regard to the nature and potential consequences of each decision that may be made.

It is important that work capacity decisions are not confused with other claim decisions. For instance, these are not work capacity decisions:

- a decision to dispute liability for weekly payments (see [B10](#))
- a decision to dispute liability for a medical, hospital or rehabilitation expense (see [B10](#)).

Work capacity decisions that do not change the amount of weekly payments that a worker receives can be simple and based on limited information. These decisions do not require any process that could potentially interrupt or delay weekly payments, however the worker should be informed of the decision and the right to request an internal review if they do not agree with the decision.

Work capacity decisions can be more complex, such as where an insurer is making a decision that establishes or changes the amount of weekly payments that a worker will receive. In these cases, the insurer should provide to the worker, all the information and reasons used to make a work capacity decision that establishes or changes a worker's amount of weekly payments for example:

- PIAWE
- ability to earn in suitable employment.

Where a worker has received weekly payments for a continuous period of at least 12 weeks, the insurer must provide a three month period of notice before the work capacity decision that reduces or terminates the worker's weekly payments takes effect. This provides an opportunity for workers to seek a review of the decision and to submit additional information to be considered in the review (See [B1.4](#)).



[Section 54 of the 1987 Act](#)

Where an insurer identifies that they have made an error in a work capacity decision, they should make a new work capacity decision and inform the worker accordingly.

How to advise the worker of the work capacity decision

As an insurer, you can advise the worker of a work capacity decision in different ways.

Where the decision does not change the amount of weekly payments that a worker receives, you should contact the worker to inform them of the decision and the right to request an internal review if they do not agree with the decision. You should also keep a record of the communication.

Where the decision establishes or changes the amount of weekly payments that a worker receives, this should be communicated in writing and by phone providing the following information:

- the work capacity decision
- its consequences, including any effects on the worker's entitlement to weekly payments and future medical, hospital and rehabilitation services under [Division 3 of Part 3 of the 1987 Act](#)
- reasons for the decision
- the information considered
- the date that the work capacity decision takes effect including when the required period of notice will cease
- the process for requesting an internal review of the decision
- the date by which the worker needs to apply for a stay of the decision to operate (see [B1.4](#))
- that if the worker requests a review:
 - they may provide any additional information relevant to the request for the internal review
 - they need to specify the decision or decisions for review and the grounds on which the review is sought
 - the operation of any stay on the original decision during the review.
- the review process after an internal review
- the [Work capacity - application for internal review by insurer](#) form
- that the worker can seek help from their insurer, SIRA's Customer Service Centre on 13 10 50, the Workers Compensation Independent Review Officer (WIRO) on 13 94 76, or their trade union.

You can include the work capacity decision in other correspondence, but it should always be clearly identified. For example, a letter accepting liability for a claim for weekly payments might include the work capacity decision with the amount of the worker's PIAWE.

The work capacity decision can be delivered personally to a worker. Where provided to the worker by post, the work capacity decision is taken to have been delivered to the worker on the fourth working day after it was posted. Any required period of notice needs to include this additional time period.



[Section 76 of the Interpretation Act 1987](#)

B1.4 Reviews of work capacity decisions

This chapter does not apply to exempt categories of workers (police officers, fire fighters, paramedics).

About this section

A worker can ask for a work capacity decision to be reviewed.

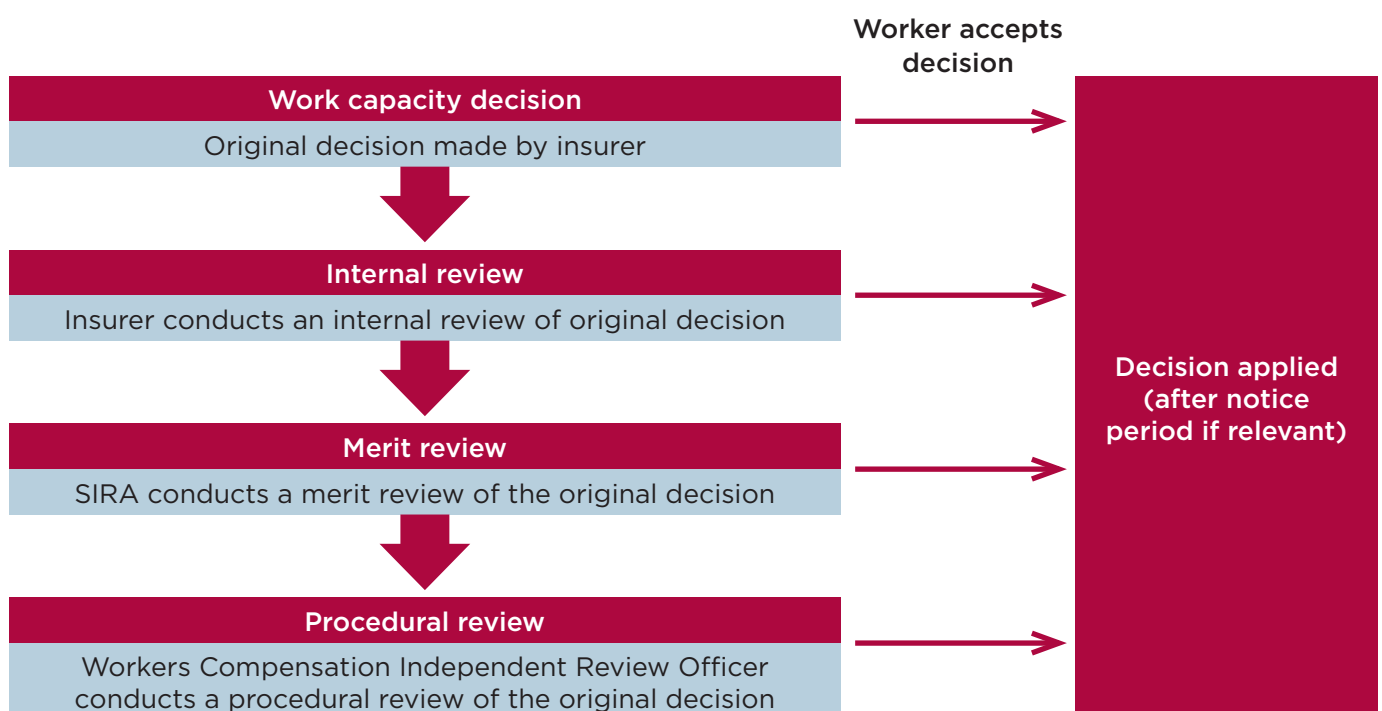
This section explains:


- the different types of reviews
- the stay of a work capacity decision
- how a worker can apply for a review
- what an insurer must do for an internal review.

Understanding the available review options

A work capacity decision can only be reviewed if the worker makes an application for the decision to be reviewed. There are three types of administrative review:

1. an internal review, where the insurer undertakes the review and informs the worker of the review decision
2. a merit review, where SIRA undertakes the review and informs the worker and insurer of its findings and recommendations
3. a procedural review, where the Workers Compensation Independent Review Officer (WIRO) undertakes the review and informs the worker, insurer and SIRA of its findings.



 Section 44BB of the 1987 Act

Additionally, workers may seek a judicial review of work capacity decisions by the Supreme Court of NSW.

The stay of a work capacity decision

Where a work capacity decision is made by an insurer, the worker is able to request the work capacity decision be reviewed. Where the work capacity decision involves discontinuation or reduction of a worker's weekly payments, an application for review may act to stay the operation of the work capacity decision.

Where a stay operates, it temporarily prevents the insurer taking action on the decision for the period between the application for the review and the notification of the decision or findings of the review.

The purpose of the stay is to provide protection to the worker by maintaining their weekly payments while the review is being undertaken.

A stay can only prevent a decision taking effect. It cannot reinstate what has already occurred.

A stay does not extend the required period of notice contained in the work capacity decision. If the required period of notice expires at a time when a review is not being undertaken, the worker's weekly payment of compensation will be reduced or discontinued in accordance with the work capacity decision. If the worker then subsequently applies for a review, for example, a merit review by SIRA, the workers weekly compensation rate during the review will continue at the rate shown in the work capacity decision.

An application for review can stay the effect of the decision if it is made in these timeframes:

Review type	A stay applies where the worker:
Internal review	Applies to the insurer within 30 days of receiving the work capacity decision.
Merit review	Applies to SIRA: <ul style="list-style-type: none">■ within 30 days of receiving the insurer's internal review decision (or after 30 days from making an application to the insurer for an internal review, where the insurer has failed to conduct the internal review and notify the worker within 30 days), and■ before the work capacity decision has taken effect after the required notice period.
Procedural review	Applies to WIRO: <ul style="list-style-type: none">■ within 30 days of receiving the merit review findings, and■ before the work capacity decision has taken effect after the required notice period.

A stay will no longer apply if a worker withdraws a review application.

Applying for an internal review

A worker can apply to the insurer to perform an internal review of the work capacity decision at any time. The worker must apply for an internal review within 30 days of receiving the work capacity decision advice for a stay of the decision to apply during the internal review process. The application must be made by supplying a completed *Work capacity - application for internal review by insurer* form to their insurer. The form is available from www.sira.nsw.gov.au or the insurer.

The application form must identify the decision that the worker is requesting be reviewed and include the worker's reasons for seeking the review of the decision. It can also include additional relevant information for the insurer to consider (for example medical or employment information).

The insurer cannot refuse to perform an internal review after receiving a review application.

How to acknowledge and respond to a request for internal review

As an insurer, your response will vary depending on the timing of a worker's application for an internal review.

If a worker applies **within 30 days** of being notified of the work capacity decision, your response must explain that the work capacity decision is stayed and the decision will not take effect until you notify them of your internal review decision, or at the end of the notice period, whichever is later.

If a worker applies **after 30 days** of being notified of the work capacity decision, your response must explain that the work capacity decision is not stayed and the decision will take effect at the end of the required notice period.

In both cases, your response must be in writing and posted to the worker within five business days of receipt of the application. The communication must include:

- that the review will be completed within 30 days of the application being made by the worker
- the date by which the worker will be notified (with consideration to the postal rule)
- how to apply for a merit review, and that this option is available if the worker does not receive the decision within 30 days of making the application for internal review
- the *Work capacity - application for merit review by the authority* form
- confirmation that you have received any new information the worker has supplied.



Section 44BB of the 1987 Act

How to complete an internal review

As an insurer, you must comply with the following when completing an internal review of a work capacity decision:

- the review must be completed within 30 days of the worker's application
- no one involved in the original decision may conduct the review
- the reviewer must be identified by name
- the reviewer can ask the worker for more information
- the reviewer must consider any new information obtained or provided.

The purpose of the internal review is to make the most correct decision based on all the available information that may or may not have been available when the original work capacity decision was made.



Section 44BB of the 1987 Act

How to notify the worker of the internal review decision

As an insurer, you must notify the worker of the review decision when the internal review is complete. The review decision will either affirm the original decision or give a different decision.

You must notify the worker of the review decision as soon as practicable. This must be in writing and you should use the *Work capacity – notice of decision of the insurer following an internal review of a work capacity decision* form. It should include:

- the review decision
- its consequences, including any effects on the worker's entitlement to weekly payments and future medical, hospital and rehabilitation services under Division 3 of Part 3 of the 1987 Act
- reasons for the decision
- the information considered
- the process and timeframe for requesting a merit review of the decision
- whether a stay of the operation of the decision applies and, if so, the required timeframe for applying for a merit review
- a copy of the *Work capacity – application for merit review by the authority* form
- the review process after a merit review
- that the worker can seek help from their insurer, SIRA's Customer Service Centre on 13 10 50, the Workers Compensation Independent Review Officer (WIRO) on 13 94 76, or their trade union.



Section 44BB of the 1987 Act

Applying for a merit review

After the insurer has completed the internal review (or has not completed the review within 30 days of the application), the worker has the option to seek a merit review of the insurer's work capacity decision by SIRA.

The worker must apply for a merit review within 30 days of:

- receiving the internal review decision, or
- the due date of the internal review decision if the insurer has not notified the worker of its decision.

The worker must apply using the *Work capacity – application for merit review by the authority* form. The worker must also notify the insurer of the merit review application by providing them with a copy of the application form.

The reviewer may decline to review a decision if:

- it determines that the application is frivolous or vexatious
- the worker does not provide information that it has requested
- the application is made outside the 30 day timeframe outlined above.

The insurer is bound by the reviewer's findings and recommendations and must give effect to them. This should happen immediately.

Further information in relation to merit reviews can be found within the *Merit review user guide*.

Applying for a procedural review

After the worker is informed of the findings from the SIRA reviewer, the worker can seek a procedural review of the work capacity decision by applying to the Workers Compensation Independent Review Officer (WIRO).

The worker must apply using the *WIRO Application for a procedural review* form within 30 days of receiving the SIRA reviewer's merit review decision. The form is available from www.wiro.nsw.gov.au. The worker must also notify the insurer of the procedural review application by providing them with a copy of the application form.

A procedural review examines the insurer's procedures in making the work capacity decision. It does not assess the merits of the decision.

The reviewer may decline to review a decision if:

- it determines that the application is frivolous or vexatious
- the worker does not provide information that it has requested
- the application is made outside the 30 day timeframe outlined above.

The insurer is bound by the reviewer's findings and recommendations and must give effect to them. This should happen immediately.

Further information in relation to procedural reviews can be found at www.wiro.nsw.gov.au.

B2 Medical, hospital and rehabilitation expenses

This chapter does not apply to exempt categories of workers (police officers, fire fighters, paramedics). These workers should refer to chapter [C2](#) for information on medical, hospital and rehabilitation expenses.

About this section

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



[Section 60 of the 1987 Act](#)

This section explains:

- what treatments the worker can claim, either with or without the insurer's pre-approval
- when the insurer will determine liability
- how much to pay for a treatment or service.

Understanding eligibility

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

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

A worker (and escort if necessary) who needs to travel for an approved treatment or service is also entitled to be reimbursed for fares, travel costs and maintenance, necessarily and reasonably incurred. The worker must gain prior approval by the insurer for the incurred travel costs (unless the travel is for treatment exempt from prior approval).

The worker is not entitled to travel expenses for a treatment or service where it is provided at a location that necessitates more travel than is reasonably necessary.



[Sections 59, 59A and 60 of the 1987 Act](#)

Compensation period

Workers may claim medical, hospital and rehabilitation expenses during a specific compensation entitlement period.

Criteria	Compensation period
Workers with no permanent impairment or a permanent impairment assessed as 1%-10%	Two years from: <ul style="list-style-type: none">■ when weekly payments stop, or■ from the date of claim if no weekly payments made.
Workers with a permanent impairment assessed as 11%-20%	Five years from: <ul style="list-style-type: none">■ when weekly payments stop, or■ from the date of claim if no weekly payments made.
Workers with high needs. This refers to workers: <ul style="list-style-type: none">■ with a permanent impairment assessed as greater than 20%■ where an approved medical specialist who has declined to make an assessment as the worker has not reached maximum medical improvement■ whose insurer is satisfied that the worker is likely to have a permanent impairment of greater than 20%.	For life



Section 59A of the 1987 Act

Determining what is reasonably necessary

Before approving or paying for a medical, hospital or rehabilitation treatment or service, an insurer will determine, based on the facts of each case, whether the treatment or service is:

- reasonably necessary, and
- required as a result of the injury.

When considering the facts of the case, the insurer should understand that:

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

The above points should be sufficient in most cases for an insurer to determine reasonably necessary. Where the insurer remains unclear on whether a treatment is reasonably necessary, then the following factors may be considered:

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

 Section 60 of the 1987 Act



Accessing treatment without pre-approval

Workers can receive the following reasonably necessary treatments and services as a result of the work related injury (including reasonably necessary travel) without pre-approval from the insurer.

 Section 60 of the 1987 Act

Treatment	Expense
Initial treatment	Any treatment within 48 hours of the injury happening.
Nominated treating doctor	Any consultation or case conferencing for the injury, apart from telehealth and home visits. Any treatment during consultation for the injury, within one month of the date of injury.
Public hospital	Any services provided in the emergency department, for the injury. Any services after receiving treatment at the emergency department for the injury, within one month of the date of injury.
Medical specialists	If referred by the nominated treating doctor, any consultation and treatment during consultations for the injury (apart from telehealth), within three months of the date of injury. Note: Medical specialist means a medical practitioner recognised as a specialist in accordance with the <u>Schedule 4 of Part 1 of the Health Insurance Regulations 1975</u> who is remunerated at specialist rates under Medicare.
Diagnostic investigations	If referred by the nominated treating doctor for the injury: <ul style="list-style-type: none"> ■ any plain x-rays, within two weeks of the date of injury ■ ultrasounds, CT scans or MRIs within three months of the date of injury, where the worker has been referred to a medical specialist for further injury management. On referral by the medical specialist for the injury, any diagnostic investigations within three months of the date of injury. Note: A General Practitioner’s MRI referral must meet the Medicare Benefits Schedule criteria.
Pharmacy	Prescription and over-the-counter pharmacy items prescribed by the nominated treating doctor or medical specialist for the injury and dispensed: <ul style="list-style-type: none"> ■ within one month of the date of injury, or ■ after one month of the date of injury if prescribed through the Pharmaceutical Benefits Scheme.

Treatment	Expense
<p>SIRA-approved physical treatment practitioners (physiotherapist, osteopath, chiropractor, accredited exercise physiologist)</p>	<p>Up to eight consultations if the injury was not previously treated and treatment starts within three months of the date of injury.</p> <p>Up to three consultations if the injury was not previously treated and treatment starts over three months after the date of injury.</p> <p>Up to eight consultations per <i>Allied health recovery request</i> (AHRR) if the same practitioner is continuing treatment within three months of the date of injury and:</p> <ul style="list-style-type: none"> ■ the practitioner sent an AHRR to the insurer, and ■ the insurer did not respond within five working days of receiving the AHRR. <p>One consultation with the same practitioner if the practitioner previously treated the injury over three months ago. This is a new episode of care.</p> <p>One consultation with a different practitioner if the injury was previously treated.</p> <p>Up to two hours per practitioner for case conferencing that complies with the applicable Fees Order.</p> <p>Up to \$100 per claim for reasonable incidental expenses for items the worker uses independently (such as strapping tape, theraband, exercise putty, disposable electrodes and walking sticks).</p> <p>Notes:</p> <ul style="list-style-type: none"> ■ Consultations with an accredited exercise physiologist require a referral from a medical practitioner. ■ All treatments exclude home visits, telehealth and practitioner travel. ■ A list of SIRA approved practitioners can be found at www.sira.nsw.gov.au. <p>See the <i>SIRA workers compensation guideline for the approval of treating health practitioners</i> for more on practitioner approval.</p>
<p>SIRA-approved psychologist or counsellor</p>	<p>Up to eight consultations if a psychologist or counsellor has not previously treated the injury and treatment starts within three months of the date of injury.</p> <p>Up to three consultations if a psychologist or counsellor has not previously treated the injury and treatment starts over three months after the date of injury.</p> <p>Up to eight consultations per <i>Allied health recovery request</i> (AHRR) if the same practitioner is continuing treatment within three months of the date of injury and:</p> <ul style="list-style-type: none"> ■ the practitioner sent an AHRR to the insurer, and ■ the insurer did not respond within five working days of receiving the AHRR. <p>One consultation with the same psychologist or counsellor if the practitioner previously treated the injury over three months ago. This is a new episode of care.</p> <p>One consultation with a different psychologist or counsellor if the injury was previously treated.</p> <p>Up to two hours per practitioner for case conferencing that complies with the applicable Fees Order.</p> <p>Up to \$100 per claim for reasonable incidental expenses for items the worker uses independently (such as relaxation CDs and self-help books).</p> <p>Notes:</p> <ul style="list-style-type: none"> ■ These consultations require a referral from a medical practitioner. ■ All treatments exclude home visits, telehealth and practitioner travel. ■ A list of SIRA approved practitioners can be found at www.sira.nsw.gov.au. <p>See the <i>SIRA workers compensation guideline for the approval of treating health practitioners</i> for more on practitioner approval.</p>

Treatment	Expense
Interim Payment Direction	Any treatment or service under an Interim Payment Direction from the Registrar (or delegate) of the Workers Compensation Commission directing that medical expenses be paid.  Section 297 of the 1998 Act
Commission determination	Any treatment or service that has been disputed and the Workers Compensation Commission has made a determination to pay for treatment or services.
Permanent impairment medical certificate	Obtaining a permanent impairment medical certificate or report, and any associated examination, taken to be a medical-related treatment under section 73(1) of the 1987 Act.  Section 73 of the 1987 Act
Hearing needs assessment	The initial hearing needs assessment where the: <ul style="list-style-type: none"> ■ hearing service provider is approved by SIRA, and ■ nominated treating doctor has referred the worker to a medical specialist who is an ear, nose and throat doctor, to assess if the hearing loss is work-related and the percentage of binaural hearing loss. <p>Note: Hearing needs assessment includes obtaining a clinical history, hearing assessment as per Australian/New Zealand Standard 1269.4:2005, determination of communication goals, recommendation of hearing aid and clinical rationale for hearing aid.</p>

How to claim treatment and services

As a worker, you or your provider must give the insurer enough information to determine whether the treatment or service you have asked for is or was reasonably necessary.

This information might include:

- a *Workers compensation certificate of capacity* recommending treatment
- allied health recovery requests
- specialist referrals or reports.

If the insurer needs to know more, it should first contact the treatment provider. If the provider does not supply more information, or the information is inadequate or inconsistent, the insurer may then ask for an independent opinion. This may require you to attend a medical appointment.

 [WorkCover guidelines on independent medical examinations and reports](#)

Determining liability

The insurer must within 21 days of receiving a claim for medical expenses:

- accept liability, or
- dispute liability (see [B10](#)).



Sections [279](#) and [280](#) of the 1998 Act

However, if the insurer has started provisional payments and notified the worker (see [A2](#)), it only needs to determine liability before these provisional payments end (maximum \$7,500).

If an insurer has approved specific services, it is liable for the related costs unless:

- the entitlement stops due to [section 59A of the 1987 Act](#)
- the insurer tells the worker that it disputes liability for the services before the services are provided (see [B10](#)).

If the insurer knows an entitlement will end on a future date, it should inform the worker. It should also inform the provider about this date when it approves expenses.

If the insurer disputes liability for services after previously approving, it should also tell the provider that it has withdrawn its approval.

Determining rates for treatment and services

To work out how much to pay for a treatment or service, the insurer should use the relevant SIRA Workers Compensation Fees Order, available from www.sira.nsw.gov.au. A schedule in each Order sets out the maximum gazetted amount that can be reimbursed for a medical treatment or service.

For treatments or services not covered by a Fees Order, the insurer should agree a fee with the provider beforehand, based on what the community would normally pay. The insurer should specify these costs when notifying the worker and provider of its approval.

A worker is not to pay any amount above maximum amounts set by SIRA.

B3 Domestic assistance

About this section

Workers can claim the cost of domestic assistance for tasks such as:

- household cleaning and laundry
- lawn or garden care
- transport not otherwise covered as a medical, hospital and rehabilitation expense.



Section 60AA of the 1987 Act

This section sets out:

- what assistance the worker can receive
- when a worker may be eligible for domestic assistance
- when the insurer will determine liability and how it should design a care plan
- how providers of gratuitous domestic assistance can claim reimbursement.

Understanding eligibility

A worker can receive domestic assistance where:

- a medical practitioner has certified, based on a functional assessment, that the assistance is reasonably necessary and that the necessity arises directly from the worker's injury, and
- the worker did the domestic tasks before the injury happened, and
- the injury to the worker has resulted in a permanent impairment of at least 15 per cent or if the assistance is temporary, up to six hours a week for up to a total period of three months (whether or not consecutive), and it follows a care plan the insurer has set up in line with this section.



Section 60AA of the 1987 Act

Determining liability

The insurer must within 21 days of receiving a claim:

- accept liability, or
- dispute liability (see B10).



Sections 279 and 280 of the 1998 Act

The insurer must establish a care plan with the worker and medical practitioner, based on what it accepts is reasonably necessary for the worker. It should do this before paying compensation.

How to design a domestic assistance care plan

As an insurer, you must establish a care plan that sets out the domestic assistance you have approved. As a minimum, it must state the:

- task(s) it covers and the provider's name
- number of hours and their frequency
- dates the tasks are approved from and to
- cost or rate due and total cost.

You can add this care plan template to the worker's injury management plan:

Task	Provider	Hours	Frequency	Approved from	Approved to	Cost or rate	Total cost
Lawn mowing	ABC Mow	2	Fortnightly	12/2/2015	26/2/2015	\$35/hour	\$70
Cleaning	XYZ Care	3	Weekly	12/2/2015	19/2/2015	\$20/hour	\$60

Gratuitous domestic assistance

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

Reimbursing gratuitous domestic assistance

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

Information might include:

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

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

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

There is however, a maximum amount that an insurer can pay for gratuitous domestic assistance. The maximum hours that can be paid is capped at 35 hours a week. The hourly rate will be calculated by:

- taking the Australian Bureau of Statistics' full-time adult average weekly (ordinary time) earnings of all NSW employees
- dividing this number by 35.



Sections [60AA](#) and [61](#) of the 1987 Act

Verifying and approving gratuitous domestic assistance

The person providing the assistance must claim and the insurer must pay for eligible services as they are provided. Once approved, the compensation goes to the person providing the assistance, not the worker.

Providers of gratuitous domestic assistance must submit a diary of what they have done before the insurer approves and pays compensation. Both the provider and the worker (if able) must sign the diary.

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

This template shows the information needed.

Date	Domestic assistance services	Number of hours

Worker: I confirm that I received the services set out above.

Name	Signature	Date
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Provider: I confirm that I provided the services set out above.

Name	Signature	Date
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 Section 60AA of the 1987 Act

B4.1 Return to work assistance (new employment assistance)

This chapter does not apply to exempt categories of workers (police officers, fire fighters, paramedics). These workers should refer to www.sira.nsw.gov.au for information on vocational rehabilitation programs.

About this section

Workers may be able to claim new employment assistance that will enable them to return to work with a new employer.

This section sets out:

- what new employment assistance the worker can receive
- when a worker may be eligible for the assistance
- what information the worker needs to supply to make a claim for new employment assistance
- when the insurer will determine liability.

New employment assistance the worker can receive

New employment assistance expenses may include:

- transport
- child care
- clothing
- education or training
- equipment, or
- any similar service or assistance.

The maximum amount that a worker can claim for new employment assistance is a cumulative total of \$1,000 in respect of the injury received.



[Section 64B of the 1987 Act](#)

Understanding eligibility

Workers are able to access new employment assistance where:

- they are unable to return to work with their pre-injury employer because of the injury
- they accept an offer of employment with a new employer
- the offer of employment has been made in writing
- the offer of employment is for a period of three months or more, and
- the new employment assistance is provided to assist the worker to return to work.



[Section 64B of the 1987 Act and clause 14 of the 2010 Regulation](#)

How to make a claim for new employment assistance

As a worker, you must supply the following information to the insurer to make a claim:

- a copy of the written offer of employment
- information on the new employment assistance that is being claimed
- how the new employment assistance will assist you to return to work
- the amount claimed including supporting invoices or quotes.



Section 260 of the 1998 Act

Determining liability

The insurer must within 14 days of receiving a claim for new employment assistance:

- accept liability, or
- dispute liability (see B10).



Clause 14 of the 2010 Regulation

Further vocational assistance

SIRA administers vocational rehabilitation programs that can assist workers to return to work.

The worker may be eligible for alternative funding from a vocational rehabilitation program where:

- they have exhausted their entitlement to new employment assistance
- they are not eligible for the new employment assistance, or
- the insurer disputes liability for the new employment assistance.

More information on these programs can be found at www.sira.nsw.gov.au.



Section 53 of the 1998 Act

B4.2 Return to work assistance (education or training assistance)

This chapter does not apply to exempt categories of workers (police officers, fire fighters, paramedics). These workers should refer to www.sira.nsw.gov.au for information on vocational programs.

About this section

Workers may be able to claim the cost of education or training that will assist them to return to work.

This section sets out:

- what education or training expenses the worker can receive
- when a worker may be eligible for the education or training
- what information the worker needs to supply to make a claim for education or training
- when the insurer will determine liability.

Education or training assistance the worker can receive

The cost of education or training may include:

- education or training course fees
- other related expenses (for example, text books, travel).

The maximum amount that a worker can claim for education or training expenses is a cumulative total of \$8,000 in respect of the injury received.

Understanding eligibility

Workers are able to access education or training assistance where:

- the worker has been assessed as having a permanent impairment of more than 20 per cent (see [B6](#))
- weekly payments have been paid or payable to the worker for more than 78 weeks
- the education or training is provided to assist the worker to return to work
- the education or training is consistent with the workers injury management plan, and
- the training is provided by either:
 - a NVR registered training organisation within the meaning of the *National Vocational Education and Training Regulator Act 2011* of the Commonwealth, or
 - a registered higher education provider within the meaning of the *Tertiary Education Quality Standards Agency Act 2011* of the Commonwealth.



[Section 64C of the 1987 Act](#) and [clause 14A of the 2010 Regulation](#)

The injury management plan

A worker's injury management plan must be established by the insurer in consultation with the worker, employer and treating doctor to the extent that their cooperation and participation allow. The insurer must as far as possible ensure that any education or training provided for a worker under an injury management plan is reasonably likely to lead to a real prospect of employment or an appropriate increase in earnings for the worker.



[Section 45 of the 1998 Act](#)

How to make a claim for education or training assistance

As a worker, to make a claim for education or training assistance you must complete the *Training application* form and provide this to the insurer. This form is available at www.sira.nsw.gov.au.



[Section 260 of the 1998 Act](#)

Determining liability

The insurer must within 21 days of receiving a claim for education or training assistance:

- accept liability, or
- dispute liability (see [B10](#)).



[Clause 14A of the 2010 Regulation](#)

Further vocational assistance

SIRA administers vocational rehabilitation programs that can assist workers to return to work. The worker may be eligible for alternative funding from a vocational rehabilitation program where:

- they have exhausted their entitlement to education or training assistance
- they are not eligible for education or training assistance, or
- the insurer disputes liability for education or training assistance.

More information on these programs can be found at www.sira.nsw.gov.au.



[Section 53 of the 1998 Act](#)

B5 Property damage

About this section

Workers can also claim compensation for damage to some items of property.

This section describes:

- what property damage the worker can claim
- when the insurer will determine liability
- how the compensation is worked out.

Understanding eligibility

If property is damaged because of a work-related accident, a worker can make a claim for the repair or replacement of:

- crutches
- artificial members, eyes, or teeth
- other artificial aids
- spectacles
- clothes
- the amount of any fees paid or wages lost by the worker due to attending a consultation, examination or prescription to replace the property.

The worker does not have to be injured to claim for property damage.



Division 5 of Part 3 of the 1987 Act

How to claim for property damage

As a worker, you must claim the reasonable costs of repairing or replacing damaged item(s) from the insurer in writing.

You must include enough information so the insurer can determine:

- that an accident happened because of or during your employment
- what types of items were damaged and their value, and
- how they were damaged.

Determining liability

The insurer must within 28 days of receiving a claim for property damage:

- accept liability, or
- dispute liability (see B10).



Section 289 of the 1998 Act

Deciding what compensation is payable

Once approved, the compensation should equal the reasonable cost of repairing or, if necessary, replacing the damaged property, up to:

- \$2,000 for crutches, artificial members, eyes or teeth, other artificial aids or spectacles
- \$600 for clothing.

This amount can be increased on a case by case basis by application to SIRA or a direction from the Workers Compensation Commission.



Sections 76 and 77 of the 1987 Act

Compensation is **not** payable if the damage:

- was caused by the worker's serious and wilful misconduct
- was caused intentionally by the worker, or
- was not caused by an accident arising from or during the worker's employment.



Section 78 of the 1987 Act

B6 Lump sum compensation for permanent impairment

This chapter does not apply to exempt categories of workers (police officers, fire fighters, paramedics). These workers should refer to chapter [C3](#) for information on lump sum compensation for permanent impairment.

About this section

Workers can claim lump sum compensation, such as permanent impairment or permanent injuries.

This section sets out:

- what compensation the worker can claim
- when the insurer will determine liability
- what happens after the insurer accepts liability.

Understanding eligibility

A claim for lump sum compensation is for:

Type of loss	Date of injury	Eligibility
Permanent impairment	For an injury received on or after 1 January 2002	<ul style="list-style-type: none">■ The permanent impairment for a physical injury is greater than 10%■ The permanent impairment for a primary psychological injury is at least 15%.
Permanent injuries	For an injury received before 1 January 2002	See the Table of Disabilities.

Where a claim for lump sum compensation has been made and that claim has been resolved, a worker has no further entitlement to lump sum compensation.



[Section 66 \(1A\) of the 1987 Act](#)

However, a worker who made a claim for lump sum compensation before 19 June 2012 may be entitled to make one further lump sum compensation claim.



[Clause 11A of Part 1 of Schedule 8 of the 2010 Regulation](#)

How to claim lump sum compensation for an injury received on or after 1 January 2002

As a worker, your claim must be in writing and describe:

- what the injury is and any impairments arising from it
- when it happened
- any previous injury, condition or abnormality, which caused or might have caused part of an impairment, including any related compensation
- any previous employment, which caused or might have caused the injury.

It must include a report from a permanent impairment assessor listed on the SIRA website, as trained in the assessment of the part or body system being assessed. The report must include:

- a statement that the condition has reached maximum medical improvement
- an assessment on the part or system of the body being assessed including the percentage of permanent impairment in line with the *NSW workers compensation guidelines for the evaluation of permanent impairment* in effect at the time of the examination
- if the claim relates to hearing loss, a copy of the audiogram used for the medical report.

If the claim is the first notification of the injury, you must then supply information to show that:

- you were a worker, as defined by sections 4 or 5 and Schedule 1 of the 1998 Act, at the date of the injury
- the injury meets the definition in section 4 of the 1998 Act.

Please see www.sira.nsw.gov.au for a *Permanent impairment claim* form.



Section 282 of the 1998 Act

How to claim lump sum compensation for an injury received before 1 January 2002

As a worker, your claim must be in writing and describe:

- what the injury is
- when it happened
- any previous injury, condition or abnormality, which caused or might have caused part of the loss or impairment, including any related compensation
- any previous employment, which caused or might have caused the injury.

The claim must also include:

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

If the claim is the first notification of the injury, you must also supply information to show that:

- you were a worker as defined by section 4 of the 1998 Act at the date of the injury
- the injury meets the definition in section 4 of the 1998 Act.

Please see www.sira.nsw.gov.au for a *Permanent impairment claim* form.



Section 282 of the 1998 Act

Determining liability

Regardless of the date of injury, the requirements for determining liability for lump sum compensation claims are the same where the lump sum compensation claim has been made on or after 1 January 2002.



Section 259 of the 1998 Act

If the degree of permanent impairment or injuries is fully ascertainable, the insurer must within one month of receiving a claim:

- accept liability and make a reasonable offer of settlement, or
- dispute liability (see B10).

‘Fully ascertainable’ means the degree of impairment or injury has been:

- agreed by the parties, or
- determined by an approved medical specialist (and not appealed).

Otherwise, the insurer has two months after a worker has provided all relevant information to dispute liability or make an offer of settlement.

If the insurer determines that all relevant particulars have not been provided about the claim, within two weeks of receiving the claim it must:

- ask the worker to supply this information, and/or
- arrange for a permanent impairment assessor listed on the SIRA website to examine the worker, and give the worker details of the appointment.

In these cases, the two-month timeframe for determining the claim begins on the date the worker supplies the requested information or attends the examination.



Sections 281 and 282 of the 1998 Act

The lump sum amount payable

For an injury received on or after 1 January 2002	For an injury received before 1 January 2002
Compensation must be based on an assessment of the impairment contained in a medical report from a permanent impairment assessor listed on the SIRA website, as trained in the assessment of the part or body system being assessed.	Compensation may be agreed based upon medical reports or negotiated between the parties.

Please see the *SIRA Workers compensation benefits guide* at www.sira.nsw.gov.au for the amount payable for lump sum compensation.

How to make a settlement offer

As an insurer, the settlement offer should include:

- the details of the compensation
- information about the injury
- the agreed percentage of permanent impairment or permanent injury
- details of how the offer was calculated
- the extent of any existing condition or abnormality
- the documents the worker submitted for the claim
- the documents the insurer relied on in making the offer
- information on how the worker can accept or not accept the offer
- a statement that, if the offer is not accepted, the worker can lodge an application to resolve a dispute with the Workers Compensation Commission. This must be at least one month after the offer is made
- the postal and email address of the Registrar of the Workers Compensation Commission
- information about the worker getting independent legal advice or waiving the right to such advice.

Issuing a complying agreement

If the worker accepts the offer of settlement, the insurer and worker must complete a complying agreement.



Section 66A of the 1987 Act

It must include:

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



Sections 281 and 314 of the 1998 Act

B7 Payments in the event of death

About this section

If a worker dies as a result of an injury, the worker's dependants or legal personal representative can be paid compensation for the death.

This section sets out how the insurer will:

- determine liability for the death
- assess who is entitled to compensation
- pay weekly payments
- pay a lump sum, apportioned between dependants
- pay other expenses, such as funeral costs.

Legal representation

Each dependant may be able to seek funding for legal representation by contacting the Workers Compensation Independent Review Officer on 13 94 76.

Dependants of exempt workers (police officers, fire fighters, paramedics) may be entitled to costs for legal representation and may seek to recover these costs through the Workers Compensation Commission.

Determining liability

When the insurer is notified about a work related death, it should act promptly and not delay liability decisions.

The insurer should write to the worker's family or the family's legal representative to tell them that compensation may be payable for the death. It should also tell them of the liability decision as soon as it has determined liability.

To assist in determining liability, the following sources of information may need to be referred to if required:

- information from the employer and witnesses
- any factual investigation
- the death certificate
- treating medical records
- the coroner's or autopsy report
- the police report.

Assessing dependency

Before paying compensation, the insurer must determine whether there are any:

- dependants who are eligible for the lump sum benefit, and how this benefit should be apportioned
- dependent children who are eligible for weekly payments.

Anyone who believes they are a dependant must supply enough information for the insurer to determine if they meet the legal definition of dependants of a worker.



Section 4 of the 1998 Act

To determine who is wholly or partly dependent on the worker, the insurer should consider all the available facts and investigate further if it needs to. For example, it might consider:

- any factual investigation
- birth or death certificates
- any marriage certificates
- statutory declarations from possible dependants, family and those close to the worker
- financial records.

Determining dependency for lump sum and weekly payments

As the question of dependency for the lump sum death benefit is one of fact and degree, the insurer should carefully consider all the circumstances of a relationship. Dependency extends beyond financial support to include any services the worker provided that cannot be measured financially.

Weekly payments apply to each dependent child of the worker who is under 16 (or under 21 if receiving full-time education at a school, college or university) at the date of the death.



Section 25 of the 1987 Act

The insurer should gather necessary information to determine dependency. Where dependency is unclear, the insurer should apply to the Workers Compensation Commission for a determination. It should do so promptly so benefits are not delayed unnecessarily.

For an application form, please see www.wcc.nsw.gov.au.

Apportioning payments

Where there is only one dependant (whether wholly or partly dependent), the full lump sum benefit goes to that dependant. For more than one dependant, the full lump sum benefit must be apportioned between all dependants.

Apportionment is a question of fact, where the law is applied to the facts of each case. This does not mean that it calls for a purely mathematical calculation. Each case requires the application of correct legal principles to determine apportionment that takes into account all the relevant circumstances. Factors to consider may include:

- the extent of past dependence and likely future dependence
- the ages of the dependants
- their health, special needs and lifestyles.

The insurer should identify and notify those who might be entitled to compensation. Each potential dependant must have the chance to present information or make a submission on the apportionment.

Where there is more than one dependant identified, an application must be made to the Workers Compensation Commission for a determination of the apportionment. This may be done at the same time there is an application for a determination on dependency (see above).



Section 29 of the 1987 Act

For an application form, please see www.wcc.nsw.gov.au.

Paying lump sum and weekly benefits

When a lump sum death benefit is payable, the insurer must promptly pay either:

- the dependants or the NSW Trustee, in line with the apportionment ordered by the Workers Compensation Commission, or
- the worker's legal personal representative, if there are no dependants.

Insurers should start weekly payments for dependent children as soon as possible after liability is accepted. Unless the Workers Compensation Commission orders otherwise, payments should go to the surviving parent. If there is no surviving parent, payments go to either:

- the NSW Trustee for the child's benefit, or
- the person with guardianship, care or custody of the child (as approved by the NSW Trustee).



Section 31 of the 1987 Act

Please see the *SIRA Workers compensation benefits guide* at www.sira.nsw.gov.au for the amounts payable.

Paying other expenses

The insurer will also compensate expenses for:

- the worker's funeral
- transporting the body of the worker.

The claimant must give the insurer enough information to determine its liability and the amount it should pay.

Compensation for funeral expenses can be up to \$15,000. Costs for transporting the worker's body are considered separately.



Sections 26 and 28 of the 1987 Act

B8 Commutation of compensation

About this section

A commutation is where the worker and insurer agree to a lump sum, and the insurer is no longer liable to pay future weekly payments and/or medical, hospital and rehabilitation expenses for the injury.

This section sets out how to apply for a commutation.

Starting the process

For a claim to be commuted:

- the worker and the insurer must agree to both the commutation and the amount
- one of the parties must then apply to SIRA, with supporting information to show that all pre-conditions for a commutation have been met
- SIRA must certify that the pre-conditions have been met
- the Workers Compensation Commission must register the commutation agreement.

Where a worker is legally incapacitated because of their age or mental incapacity, the Workers Compensation Commission can determine the commutation.



Division 9 of Part 3 of the 1987 Act

Meeting the pre-conditions

To proceed, SIRA must certify it is satisfied that:

- the injury has led to at least 15 per cent permanent impairment (see [B6](#))
- the worker's entitlement to permanent impairment compensation has been paid
- more than two years have passed since the worker first claimed weekly payments for the injury
- all opportunities for injury management and return to work have been fully exhausted
- the worker has received weekly payments regularly for the past six months
- the worker has an existing and continuing entitlement to weekly payments
- the worker has not had weekly compensation payments terminated through failing to meet return to work obligations.



Section 87EA of the 1987 Act

Agreeing to a commutation

Before entering into a commutation agreement, the worker must receive independent legal advice. The legal adviser must certify in writing that the worker has been advised:

- on the full legal implications of the agreement
- that it is in their best interest to get independent advice about any financial consequences before entering into the agreement.

The worker must then confirm in writing that they have received and understood this advice.

The worker can withdraw from the agreement within 14 days of entering into it by telling the insurer in writing. In effect, there is a 14 day 'cooling off' period.



Section 87F of the 1987 Act

Applying for a commutation of compensation

A worker (or their legal representative) or the insurer can make the application for the commutation of compensation. The person completing the application should:

- reach an agreement on the commutation amount with both parties
- fill in a commutation application form, available from www.sira.nsw.gov.au
- attach all the necessary documents to show that the pre-conditions have been met
- write the worker's name and claim number on these attachments
- send the application to SIRA and inform the other party that this has occurred.

Certifying and registering an agreement

The following steps must occur before a commutation agreement is certified and registered:

1. SIRA issues a certificate to the lodging party once satisfied on the pre-conditions. A commutation agreement has no effect unless SIRA certifies it.



[Section 87EA of the 1987 Act](#)

2. One of the parties lodges an application with the Workers Compensation Commission to register the agreement by forwarding SIRA's certificate with the relevant forms, available from www.wcc.nsw.gov.au.
3. The Commission's Registrar registers the commutation agreement, which has no effect until then.



[Section 87F \(6\) of the 1987 Act](#)

Making payment

Once the agreement is registered, the insurer must pay the money:

- within seven days of the registration, or
- within a longer period if the agreement specifies one.



[Section 87F \(7\) of the 1987 Act](#)

B9 Work injury damages

About this section

A claim for work injury damages relates to settlement for a worker's past economic loss and future lost earnings because of a work injury resulting from the employer's negligence.

This section explains:

- what the worker can claim
- when the insurer will determine liability
- what happens after the insurer accepts liability
- when the worker can start mediation or court proceedings over a claim.

Understanding eligibility

For a claim of work injury damages, the injury must have:

- resulted from the employer's negligence or other tort, and
- led to permanent impairment of at least 15 per cent.

The worker must also claim lump sum compensation for the injury under [section 66 of the 1987 Act](#) (see [B6](#)), either before or at the same time as claiming these damages.



Sections [150B](#) and [151H](#) of the 1987 Act and [section 280A of the 1998 Act](#)

Some work injury damages claims may result in court proceedings. If starting court proceedings for work injury damages, the worker must do so within three years of the injury date, unless they have the court's leave.



Sections [151D](#) and [151DA](#) of the 1987 Act

Where this time limit is reached but the permanent impairment is not fully ascertainable, the worker should claim work injury damages, detailing the claim and the evidence to be relied on (apart from the degree of permanent impairment, which will be assessed when fully ascertainable).

How to claim work injury damages

As a worker, your claim must be in writing and describe:

- what the injury is and any impairments arising from it
- when it happened
- any previous injury, condition or abnormality, which caused or might have caused part of an impairment, including any related compensation
- any previous employment, which caused or might have caused the injury
- the employer's alleged negligent act(s), and any available supporting documentation
- the economic loss being claimed as damages and any available supporting documentation.

It must include a report from a permanent impairment assessor listed on the SIRA website, as trained in the assessment of the part or body system being assessed. The report must include:

- a statement that the condition has reached maximum medical improvement
- an assessment on the part or system of the body being assessed including the percentage of permanent impairment in line with the *NSW workers compensation guidelines for the evaluation of permanent impairment* in effect at the time of the examination
- if the claim relates to hearing loss, a copy of the audiogram used for the medical report.



Section 282 of the 1998 Act

Determining liability

Once the degree of the worker's permanent impairment is fully ascertainable, the insurer must within one month:

- accept liability, or
- dispute liability (see B10).

'Fully ascertainable' means the degree of impairment or injury has been:

- agreed by the parties, or
- determined by an approved medical specialist (and not appealed).

If the insurer needs more information, within two weeks of receiving the claim it must:

- ask the worker to supply this information, and/or
- arrange for an independent medical practitioner to examine the worker, and give the worker details of the appointment.

In these cases, the two-month timeframe for determining the claim begins on the date the worker supplies the missing information or attends the examination.

When it has determined liability, the insurer must notify the worker whether it accepts that the degree of permanent impairment is enough to award damages (that is, at least 15 per cent).



Section 281 of the 1998 Act

Making an offer of settlement

If the insurer accepts liability, it must make an offer of settlement that sets out the amount of damages or a way to determine this amount.

Where it only accepts partial liability, the offer must include enough details to show how much is accepted.



Section 281 of the 1998 Act

How to make a settlement offer

As an insurer, your settlement offer should include:

- details of the damages
- information about the injury, such as the date
- the extent of any existing condition or abnormality
- the documents the worker submitted for the claim
- the documents the insurer relied on in making the offer
- information on how the worker can accept or not accept the offer
- a statement that, if the offer is not accepted, the worker must serve on the insurer and employer a pre-filing statement setting out the particulars of the claim that will be relied on to support the claim.

Issuing a pre-filing statement

Before a worker can start mediation or court proceedings to recover work injury damages, the worker must serve a pre-filing statement on the employer and the insurer.

The worker can only do this if the insurer:

- wholly disputes liability for the claim, or
- has made an offer of settlement and one month has passed, or
- has not determined the claim on time.



Section 281 of the 1998 Act

The pre-filing statement must include:

- details of the claim and the evidence the worker will rely on
- a copy of the Statement of Claim the worker intends to file in the court
- attachments with information and documents required by the Workers Compensation Acts and *Workers Compensation Commission Rules 2011*.

The attachments must contain a certificate from an approved medical specialist or notification of the insurer's acceptance that the injury has led to permanent impairment of at least 15 per cent.



Section 315 of the 1998 Act and Part 17 of the Workers Compensation Commission Rules 2011

Responding to a pre-filing statement

The insurer must respond to the pre-filing statement within 28 days of receiving it, by accepting or denying liability (wholly or partly).

If the insurer does not accept liability, it must issue a pre-filing defence to the worker, detailing its defence and the evidence it will rely on.



Section 316 of the 1998 Act

If the pre-filing statement is defective, the insurer must advise the worker within seven days. It must state the alleged defects and outline how the worker can correct these. If the worker disputes the defects, the dispute can be referred to the Registrar of the Workers Compensation Commission.



Section 317 of the 1998 Act

Starting mediation

Before starting court proceedings, the worker must refer a claim to the Workers Compensation Commission for mediation. The worker must wait at least 28 days after issuing the pre-filing statement before doing so.

However, if the insurer fails to respond within 42 days of receiving this statement, the worker can start court proceedings to recover damages without mediation. Where this occurs, the insurer is prevented from filing a defence and cannot deny liability for the claim.



Sections 316 and 318A of the 1998 Act

The insurer may only decline to take part in the mediation if it wholly disputes liability.

The mediator will try to help the parties agree, so there is no need to go to court. If they cannot agree:

- the mediator will issue a certificate certifying the final offers of settlement the parties have made
- the offers made at the mediation must not be disclosed to the court in any later proceedings.



Sections 318A, 318B and 318E of the 1998 Act

For more information, please see the *Registrar's Practice Guide for Work Injury Damages in the Workers Compensation Commission* at www.wcc.nsw.gov.au.

Starting court proceedings

If starting court proceedings for work injury damages, the worker must do so within three years of the injury date, unless they have the court's leave.



Sections 151D and 151DA of the 1987 Act

Court proceedings may start when a worker has issued a pre-filing statement and:

- the insurer has failed to respond within 42 days
- the insurer has wholly disputed liability and declined to take part in mediation, and the mediator has issued a certificate to this effect, or
- mediation has been unsuccessful, and the Registrar has issued a certificate to this effect.

In court, the parties can only refer to:

- the matters from the pre-filing statement and pre-filing defence
- the reports and evidence in those statements, except with the court's leave.

B10 Disputes and failure to determine a claim

This chapter does not apply to exempt categories of workers (police officers, fire fighters, paramedics). These workers should refer to chapter [C4](#) for information on disputes and failure to determine a claim.

About this section

Sometimes when a worker makes a claim for compensation, the insurer will dispute its liability for that compensation.

This section describes:

- why an insurer can dispute liability
- how it must notify the worker of its decision
- how the worker can ask for a review
- what happens if the insurer fails to determine liability within the legislated timeframes.

Disputing liability

A dispute happens when the insurer decides, based on available information, that a person does not meet the legal requirements to be entitled to workers compensation benefits.

This might mean, for example, that the insurer does not:

- pay weekly payments or stops weekly payments after they have started
- pay for a service or treatment
- agree that a worker is entitled to lump sum compensation.

An insurer may dispute liability for many reasons, including, but not limited to:

Reason to dispute liability	Reference
The worker has not sustained an injury.	Section 4 of the 1998 Act
The person is not a worker.	Section 4 and 5, and Schedule 1, of the 1998 Act
Employment was not a substantial contributing factor to the injury.	Section 9A of the 1987 Act
The psychological injury was wholly or predominantly caused by the employer's reasonable actions.	Section 11A of the 1987 Act
Claimed medical, hospital and rehabilitation expenses are not reasonably necessary because of the injury.	Section 60 of the 1987 Act
The claim for property damage covers items the Act does not.	Section 74 and 75 of the 1987 Act
There is no total or partial incapacity for work.	Section 33 of the 1987 Act
The degree of permanent impairment does not reach the required thresholds for a lump sum payment.	Section 65A and 66 of the 1987 Act
The worker was injured on a journey with no real and substantial connection between their employment and the accident that caused the injury.	Section 10 of the 1987 Act


Notifying the worker


Before notifying the worker of the dispute, the insurer should make sure an appropriately qualified person reviews all the information it has considered in the decision and the reasons for the decision. This should be someone other than the original decision maker.

If satisfied by its decision, the insurer must then issue a notice of dispute to the worker. Timeframes vary depending on the type of compensation claimed (see chapter [B1.1–B9](#) to learn more).

The notice of dispute

As an insurer, the notice of dispute must include:

Reasons for and issues in disputing liability	<p>A concise, easy-to-understand statement of:</p> <ul style="list-style-type: none">■ why the insurer disputes liability■ the issues relevant to the decision■ any legislative provision the insurer is relying on■ any required period of notice before the dispute takes effect.
Documents the worker has submitted	<p>A list of reports and documents the worker has submitted and relied on in making the claim.</p>
Documents the insurer has considered	<ul style="list-style-type: none">■ A statement identifying the reports of the type referred to in Clause 46 of the 2010 Regulation that are relevant to the decision, whether or not they support the reasons for the decision■ A statement that a copy of the reports accompany the notice■ A copy of all these reports. <p>Note: If reports are not provided to the worker they cannot be used to dispute liability.</p> <p>Note: If the insurer believes that giving the worker a report would pose a serious threat to anyone's life or health, the insurer can instead:</p> <ul style="list-style-type: none">■ give a medical report to the medical practitioner the worker has nominated for that purpose■ give any other report to the worker's legal practitioner■ seek SIRA's direction on another approach when these options are not appropriate. <p> Clause 46 of the 2010 Regulation</p>
How to request a review	<p>The procedure the worker should follow to request a review of the decision.</p>
Where to seek assistance	<p>Statements that the worker:</p> <ul style="list-style-type: none">■ can seek further information from the insurer■ can seek help from a trade union, a lawyer, SIRA's Customer Service Centre on 13 10 50 or Workers Compensation Independent Review Officer on 13 94 76.
Where to refer an application for determination of a dispute	<p>The street and email addresses of the Registrar of the Workers Compensation Commission or the Registrar of the District Court, as appropriate.</p> <p>If the notice is about a claim for work injury damages, it must also include statements that the claimant:</p> <ul style="list-style-type: none">■ must serve a pre-filing statement before starting court proceedings■ cannot raise matters in court that are materially different from the pre-filing statement, except with the court's leave.

 [Section 74 of the 1998 Act](#) and clauses [43](#) and [46](#) of the 2010 Regulation

Understanding dispute timeframes

The insurer must give the worker notice by post or in person.

 [Section 236 of the 1998 Act](#)

Where the dispute includes a decision on weekly payments, the insurer must also follow the required period of notice in section 54 of the 1987 Act.

If a defect is identified in the notice of dispute, the insurer should correct the defect and reissue the notice. The notice period for the dispute restarts on the date the corrected notice is issued.

When issued by post, the notice cannot take effect until four working days after it was posted (or four working days after any relevant period the notice specifies).

 [Section 76 of the *Interpretation Act 1987*](#)

Requesting a review of the insurer's decision

A worker can ask the insurer to review the decision to dispute a claim at any time before an application for dispute resolution is lodged with the Workers Compensation Commission.

However, the request for a review does not delay the timeframe for the dispute to take effect.

When the insurer receives a request, it must review the claim and respond to the person within 14 days. The review might lead the insurer to:

- accept liability
- dispute liability

The insurer should ensure that the person undertaking the review is appropriately qualified and was not involved in making the original decision.

Where the insurer continues to dispute the claim, it must issue a further notice of dispute.

 [Section 287A of the 1998 Act](#)

The worker can request more than one review.

Failing to determine a claim

Where an insurer does not determine a claim in the timeframe applicable to the compensation benefit claimed, the worker should seek help from:

- SIRA's Customer Service Centre on 13 10 50 or contact@sira.nsw.gov.au
- the Workers Compensation Independent Review Officer on 13 94 76 or complaints@wiro.nsw.gov.au
- The Workers Compensation Commission on 1300 368 040 or registry@wcc.nsw.gov.au

Changes to compensation that are not a liability dispute

There is no liability dispute and no need to issue a dispute notice when a worker's entitlements change due to:

- weekly payments being reduced because entitlement periods change. However, the insurer should advise the worker of the change by phone (keeping a record of the conversation) and in writing
- shift and overtime allowances being removed from the calculation of PIAWE (after 52 weeks)
- a work capacity decision (see [B1.3](#)).

B11 Worker representation

This chapter does not apply to exempt categories of workers (police officers, fire fighters, paramedics). These workers should refer to chapter [C5](#) for information on worker representation.

About this section

This section identifies how a worker may be represented for workers compensation matters.

Legal representation

A worker may be able to seek funding for legal representation by contacting the Workers Compensation Independent Review Officer on **13 94 76** or contact@wiro.nsw.gov.au.

Union representation

Insurers should respond to requests from union representatives on behalf of their members with appropriate consent from the member.

Part C – Exempt categories of workers

This part applies to exempt categories of workers (police officers, fire fighters, paramedics) where the requirements vary from information covered in [Part B](#).

These workers should see [Part A](#) for:

- initial notification of an injury
- provisional payments
- claims for compensation

These workers should see [Part B](#) for the following specific compensation:

- domestic assistance
- property damage
- payments in the event of death
- commutation of compensation
- work injury damages.

C1.1 Weekly payments

All references to the 1987 Act in this chapter are to the historical version of the Act, effective as at [30 September 2012](#).

All references to the 2010 Regulation in this chapter are to the historical version of the Regulation, effective as at [30 September 2012](#).

About this section

Weekly payments may be made to a worker to compensate for loss of earnings as a result of a work related injury.

This section explains how the insurer can:

- assess the worker's entitlement
- calculate the pre-injury earnings
- calculate the weekly payments.

Understanding eligibility

To be entitled to weekly payments, the worker must be:

- totally or partially incapacitated for work due to an injury, and
- losing earnings due to the incapacity.

The worker must give the insurer information for it to establish entitlement, then calculate and start weekly payments. The worker must supply a medical certificate to the insurer. The current *Workers compensation certificate of capacity* would fulfil this requirement.

Determining liability

The insurer must within 21 days of receiving a claim for weekly payments:

- accept liability and start weekly payments, or
- dispute liability (see [C4](#)).

However, if the insurer has started provisional payments and notified the worker (see [A2](#)), it only needs to determine liability before these provisional payments expire (no more than 12 weeks).

Calculating pre-injury earnings

The insurer should identify the current weekly wage rate (CWWR) and average weekly earnings (AWE) applicable at the date of the injury.

The CWWR applies where the worker is employed under an agreement that fixes a rate for a weekly or longer period. If the worker has no agreement like this, the CWWR is 80 per cent of the worker's average weekly earnings.

AWE shows the actual amount the worker was receiving as an average weekly amount over a period. The calculation would reflect the worker's weekly pay rate and would usually cover:

- the previous period of the worker's employment up to 12 months
- amounts such as overtime and shift allowance.

Where possible, the insurer should seek agreement between the worker and the employer on the worker's AWE to avoid disputes.

If the worker has more than one employer, including self-employment, and tells the insurer, the insurer will ask for extra information to correctly calculate the AWE. The worker needs to supply this information so the correct calculation can be made.

If the insurer needs to start weekly payments but does not have enough information to work out the AWE, it should use the award ordinary earnings rate in the first instance. As the insurer gets more information, it should review the AWE to ensure that the worker's weekly payment is correctly calculated.



Sections [42](#) and [43](#) of the 1987 Act

Calculating weekly payments

The insurer must base its calculation of weekly payments on the worker's CWWR and AWE using the relevant method from the 1987 Act. More information can be referenced in the table at the end of this chapter.



Sections [35](#), [36](#), [37](#), [38](#) and [40](#) of the 1987 Act

How to start weekly payments

As an insurer, you should inform the worker and employer in writing when starting weekly payments.

The information should explain:

- that the payments have started as the insurer has accepted liability for them
- what the weekly payment is and 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 explain the dispute process
- what to do if the worker does not receive payment
- that an injury management plan will be developed, if the worker is unable to return to their pre-injury employment for seven continuous days
- that the worker must give the employer ongoing evidence of incapacity (for example certificate of capacity)
- that the worker must tell the insurer of any change in employment that affects their earnings, such as starting work for another employer (see [section 57 of the 1987 Act](#)).

You should also include the [Information for injured workers](#) brochure.

If making payments directly, the insurer must ask the worker to fill in an Australian Taxation Office [tax file number declaration form](#) and must arrange for tax to be paid in line with income tax law.

Weekly payments

	Section of the 1987 Act	Weekly payment calculation	
Total incapacity – first 26 weeks	36	The worker's current weekly wage rate which is: The worker's award weekly wage rate OR 80% of the worker's average weekly earnings if not employed under an award.	
Total incapacity – from 27 weeks	37	The lesser of: the statutory indexed rate OR 90% of the worker's average weekly earnings.	
Partially incapacitated – first 26 weeks. Where worker is seeking suitable employment but not employed	38	Note: Section 38 payments may only be paid for a period not exceeding 52 weeks.	Note: This period of 26 weeks at the CWWR will be reduced by the number of weeks that the worker has received weekly payments under <u>section 36</u> .
Partially incapacitated – from 27 weeks. Where worker is seeking suitable employment but not employed	38		Note: This period of 26 weeks will be increased greater than 26 weeks where the worker has received weekly payments under <u>section 36</u> so as to reach the <u>52 week</u> total period.
Partial incapacity – first 26 weeks. Where worker is working or not seeking suitable employment	40	The lesser of: A – B = weekly payment OR The weekly amount that the worker would be paid if totally incapacitated (in accordance with <u>section 36</u> that is the current weekly wage rate). A = Average weekly earnings B = Actual earnings or capable of earning	
Partial incapacity – from 27 weeks. Where worker is working or not seeking suitable employment	40	The lesser of: A – B = weekly payment OR The weekly amount that the worker would be paid if totally incapacitated (in accordance with <u>section 37</u> that is the statutory indexed rate). A = Average weekly earnings B = Actual earnings or capable of earning	
Dependants	37	Additional payments may be payable for dependant spouse and children.	

Factors	Definition
Maximum weekly payment (<u>Section 35 of the 1987 Act</u>)	The weekly compensation amount payable to a worker cannot exceed the maximum weekly payment of compensation. Refer to www.sira.nsw.gov.au for maximum amount.
Current Weekly Wage Rate (CWWR) (<u>Section 42 of the 1987 Act</u>)	The CWWR applies where the worker is employed under an agreement that fixes a rate for a weekly or longer period. If the worker has no agreement like this, the CWWR is 80% of the worker's average weekly earnings.
Average Weekly Earnings (AWE) (<u>Section 43 of the 1987 Act</u>)	AWE shows the actual amount the worker was receiving as an average weekly amount over a period. The calculation would reflect the worker's weekly pay rate and would usually cover: <ul style="list-style-type: none"> ■ the previous period of the worker's employment up to 12 months ■ amounts such as overtime and shift allowance.
Statutory Indexed Rate	As determined in <u>section 37</u> and indexed in accordance with section 82 on 1 April and 1 October each year.

This information is general and does not replace the 1987 Act or 2010 Regulation

C1.2 Reducing or discontinuing weekly payments

All references to the 1987 Act in this chapter are to the historical version of the Act, effective as at 30 September 2012.

All references to the 2010 Regulation in this chapter are to the historical version of the Regulation, effective as at 30 September 2012.

About this section

Where a worker receives weekly compensation payments, the insurer may decide to reduce or end these payments under certain circumstances.

This section explains:

- how to notify the worker
- reduction and discontinuation timeframes
- when entitlements change.

Reducing or discontinuing a worker's weekly payments

Where a worker receives weekly compensation payments, the insurer may decide to reduce or discontinue these payments after gathering information obtained on the worker's:

- ability to earn, or
- unfulfilled capacity for work.




Sections 40, 40A and 52A of the 1987 Act


Notifying the worker

Before notifying the worker of the change, the insurer must make sure an appropriately qualified person reviews all the information it has considered in its decision. This should be someone other than the original decision-maker.

The notice of reduction or discontinuation of weekly payments

As an insurer, your notice must include:

Reasons and issues in reducing or discontinuing payments	<p>Statements explaining:</p> <ul style="list-style-type: none">■ why the insurer has decided to reduce or discontinue weekly payments and the issues relevant to its decision■ that the decision can be referred to the Workers Compensation Commission, if disputed■ whether the insurer plans to refer the dispute to the Commission, or has already done so, including the related date of referral■ that issues can only be referred to the Commission if they have been raised in the notice or in a request for or notice after a further review.
Calculation of reduced compensation	<p>A statement of how the reduced compensation has been calculated if:</p> <ul style="list-style-type: none">■ the notice relates to reducing weekly payments because of <u>section 40 of the 1987 Act</u>, and■ the worker is not earning money (or the compensation is calculated on the worker's ability to earn, rather than actual earnings, after the injury).
Documents the worker has submitted	<p>A statement identifying all reports and documents the worker submitted in the claim for weekly payments.</p>
Documents the insurer has considered	<ul style="list-style-type: none">■ A statement identifying the reports that are relevant to the decision, whether or not they support the reasons for the decision■ A statement that a copy of the reports accompany the notice■ A copy of all these reports. <p>Note: If the insurer believes that giving the worker a report would pose a serious threat to anyone's life or health, the insurer can instead:</p> <ul style="list-style-type: none">■ give a medical report to the medical practitioner the worker has nominated for that purpose■ give any other report to the worker's legal practitioner■ seek SIRA's approval on another approach when these options are not appropriate. <p> <u>Clause 46 of the 2010 Regulation</u></p>
How to request a review	<p>A statement that the worker can ask the insurer to review the decision, and the procedure for doing so.</p>
Where to seek assistance	<p>A statement that the worker can seek help from a trade union, a lawyer, SIRA's Customer Service Centre on 13 10 50 or Workers Compensation Independent Review Officer on 13 94 76.</p>
Where to refer an application for determination	<p>The street and email addresses of the Registrar of the Workers Compensation Commission.</p>

 Section 54 of the 1987 Act and Clauses 14 and 46 of the 2010 Regulation

Understanding reduction or discontinuation timeframes

The insurer must give the worker notice by post or in person.



Section 236 of the 1998 Act

The insurer must also apply the required period of notice in section 54 of the 1987 Act (in effect at 30 September 2012).

If a defect is identified in the notice, the insurer should correct the defect and reissue the notice. The notice period restarts on the date the corrected notice is issued.

When issued by post, the notice cannot take effect until four working days after it was posted (or four working days after any relevant period the notice specifies).



Section 76 of the *Interpretation Act 1987*

Changing entitlements

There is no need to issue a reduction or discontinuation notice when a worker's amount of weekly payments is reduced because of the application of lower rates of compensation after previous periods have expired, where higher rates were payable.

However, the insurer should advise the worker by phone (keeping a record of the conversation) or in writing of the change.

C2 Medical, hospital and rehabilitation expenses

All references to the 1987 Act in this chapter are to the historical version of the Act, effective as at 26 June 2012.

About this section

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



Section 60 of the 1987 Act

This section explains:

- what treatments the worker can claim
- when the insurer will determine liability
- how much to pay for a treatment or service.

Understanding eligibility

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

- meets the definitions described in section 59 of the 1987 Act
- is reasonably necessary because of the injury.

A worker (and escort if necessary) who needs to travel for an approved treatment or service is also entitled to be reimbursed for fares, travel costs and maintenance, necessarily and reasonably incurred.



Sections 59 and 60 of the 1987 Act

The worker must claim and the insurer must pay eligible expenses as they are incurred.

Determining what is reasonably necessary

Before approving or paying for a medical, hospital or rehabilitation treatment or service, an insurer will determine, based on the facts of each case, whether the treatment or service is:

- reasonably necessary, and
- required as a result of the injury.

When considering the facts of the case, the insurer should understand that:

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

The above points should be sufficient in most cases for an insurer to determine reasonably necessary. Where the insurer remains unclear on whether a treatment is reasonably necessary, then the following factors may be considered:

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



[Section 60 of the 1987 Act](#)

How to claim treatment and services

As a worker, you or your provider must give the insurer enough information to determine that the treatment or service is or was reasonably necessary.

This information might include:

- a *Workers compensation certificate of capacity* recommending treatment
- allied health recovery requests
- medical specialist referrals or reports.

If the insurer needs to know more, it should contact the treatment provider. If the provider does not supply more information, the insurer may then ask for an independent opinion.



[WorkCover guidelines on independent medical examinations and reports](#)

Determining liability

The insurer must within 21 days of receiving a claim:

- accept liability, or
- dispute liability (see [C4](#)).



[Sections 279 and 280 of the 1998 Act](#)

If the insurer disputes liability for services after previously approving, it should also tell the provider that it has withdrawn its approval.

Determining rates for treatment and services

To work out how much to pay for a treatment or service, the insurer should use the relevant SIRA Workers Compensation Fees Order, available from www.sira.nsw.gov.au. A schedule in each Order sets out the maximum gazetted amount that can be reimbursed for a medical treatment or service.

For treatments or services not covered by a Fees Order, the insurer should agree a fee with the provider beforehand, based on what the community would normally pay. The insurer should specify these costs when notifying the worker and provider of its approval.

A worker is not to pay any amount above maximum amounts set by SIRA.

C3 Lump sum compensation for permanent impairment

All references to the 1987 Act in this chapter are to the historical version of the Act, effective 26 June 2012.

About this section

Workers can claim lump sum compensation, such as permanent impairment or permanent injuries.

This section sets out:

- what compensation the worker can claim
- when the insurer will determine liability
- what happens after the insurer accepts liability.

Understanding eligibility

A claim for lump sum compensation can include compensation for:

Type of loss	Date of injury	Eligibility
Permanent impairment	For an injury received on and after 1 January 2002	<ul style="list-style-type: none">■ There is permanent impairment from a physical injury■ The permanent impairment for a primary psychological injury is at least 15%
Permanent injuries	For an injury received before 1 January 2002	See the Table of Disabilities
Pain and suffering		<ul style="list-style-type: none">■ The agreed permanent impairment is 10% or greater, or■ The agreed permanent injury is 10% of the maximum compensation payable in the Table of Disabilities.



Sections 66 and 67 of the 1987 Act

How to claim lump sum compensation for an injury received on or after 1 January 2002

As a worker, your permanent impairment claim must be in writing and describe:

- what the injury is and any impairments arising from it
- when it happened
- any previous injury, condition or abnormality, which caused or might have caused part of an impairment, including any related compensation
- any previous employment, which caused or might have caused the injury.

It must include a report from a permanent impairment assessor listed on the SIRA website, as trained in the assessment of the part or body system being assessed. The report must include:

- a statement that the condition has reached maximum medical improvement
- an assessment on the part or system of the body being assessed including the percentage of permanent impairment in line with the *NSW workers compensation guidelines for the evaluation of permanent impairment* in effect at the time of the examination
- if the claim relates to hearing loss, a copy of the audiogram used for the medical report.

If your claim is the first notification of the injury, you must then supply information to show that:

- you were a worker, as defined by sections 4 or 5 and Schedule 1 of the 1998 Act, at the date of injury
- the injury meets the definition in section 4 of the 1998 Act.

Please see www.sira.nsw.gov.au for a *Permanent impairment claim form*.



Section 282 of the 1998 Act

How to claim lump sum compensation for an injury received before 1 January 2002

As a worker, your claim must be in writing and describe:

- what the injury is
- when it happened
- any previous injury, condition or abnormality, which caused or might have caused part of the loss or impairment, including any related compensation
- any previous employment, which caused or might have caused the injury.

It must also include:

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

If your claim is the first notification of the injury, you must also include information to show that:

- you were a worker as defined by section 4 of the 1998 Act at the date of injury
- the injury meets the definition in section 4 of the 1998 Act.

Please see www.sira.nsw.gov.au for a *Permanent impairment claim form*.



Section 282 of the 1998 Act

Determining liability

Regardless of the date of injury, the requirements for determining liability for lump sum compensation claims are the same where the lump sum compensation claim has been made on or after 1 January 2002.



Section 259 of the 1998 Act

If the degree of permanent impairment or injuries is fully ascertainable, the insurer must within one month of receiving a claim:

- accept liability, or
- dispute liability (see C4).



Section 281 of the 1998 Act

‘Fully ascertainable’ means the degree of impairment or injury has been:

- agreed by the parties, or
- determined by an approved medical specialist (and not appealed).

Otherwise, the insurer has two months after a worker has provided all relevant information to dispute liability or make an offer of settlement.

If the insurer determines that all relevant particulars have not been provided about the claim, within two weeks of receiving the claim it must:

- ask the worker to supply this information, and/or
- arrange for an independent medical practitioner to examine the worker, and give the worker details of the appointment.

In these cases, the two-month timeframe for determining the claim begins on the date the worker supplies the missing information or attends the examination.

Liability determination for pain and suffering compensation is secondary to meeting the thresholds for permanent impairment or permanent injuries.

The lump sum amount payable

For an injury received on or after 1 January 2002	For an injury received before 1 January 2002
Compensation must be based on an assessment of the impairment contained in a medical report from a permanent impairment assessor listed on the SIRA Workers Compensation website, as trained in the assessment of the part or body system being assessed.	Compensation may be agreed based upon medical reports or negotiated between the parties.

Please see the *SIRA workers compensation benefits guide* at www.sira.nsw.gov.au for the amount payable for permanent impairment and permanent injuries.

How to make a settlement offer

As an insurer, the settlement offer should include:

- the details of the compensation
- information about the injury
- the agreed percentage of permanent impairment or permanent injury
- details of how the offer was calculated
- the extent of any existing condition or abnormality
- the documents the worker submitted for the claim
- the documents the insurer relied on in making the offer
- information on how the worker can accept or not accept the offer
- a statement that, if the offer is not accepted, the worker can lodge an application to resolve a dispute with the Workers Compensation Commission. This must be at least one month after the offer is made
- the postal and email address of the Registrar of the Workers Compensation Commission
- information about the worker getting independent legal advice or waiving the right to such advice.

Issuing a complying agreement

If the worker accepts the offer of settlement, the insurer and worker must complete a complying agreement.



Section 66A of the 1987 Act

It must include:

- the percentage of permanent impairment or permanent injury, including the injuries described in the table of compensation for permanent injuries, for which compensation is being paid
- the percentage allowed for any pre-existing condition or abnormality
- the medical report(s) relied on to assess this percentage
- the compensation payable, including an amount for pain and suffering (percentage and monetary value) where applicable
- the date of agreement
- certification that the insurer is satisfied the worker has obtained independent legal advice or has waived the right to do so.

Where compensation will cover both permanent impairment or permanent injuries and pain and suffering, each type of compensation can be agreed at different times. This might require two complying agreements and separate payments.

C4 Disputes and failure to determine a claim

All references to the 1987 Act in this chapter are to the historical version of the Act, effective as at 26 June 2012.

All references to the 2010 Regulation in this chapter are to the historical version of the Regulation, effective as at 30 September 2012.

About this section

Sometimes when a worker asserts a right to receive compensation, the insurer will dispute its liability for that compensation.

This section describes:

- why an insurer might decide to dispute liability
- how it must notify the worker of its decision
- how the worker can ask for a review
- what happens if the insurer fails to determine liability within the legislated timeframes.

Disputing liability

A dispute happens when the insurer decides, based on available information, that a person does not meet the legal requirements to be entitled to workers compensation benefits.

This might mean, for example, that the insurer does not:

- pay weekly payments or stops weekly payments after they have started
- pay for a service or treatment
- agree that a worker is entitled to lump sum compensation.

An insurer may dispute liability for many reasons, including, but not limited to:

Reason to dispute liability	Reference
The worker has not sustained an injury.	<u>Section 4 of the 1998 Act</u>
The person is not a worker.	<u>Sections 4 and 5, and Schedule 1, of the 1998 Act</u>
Employment was not a substantial contributing factor to the injury.	<u>Section 9A of the 1987 Act</u>
The psychological injury was wholly or predominantly caused by the employer's reasonable actions.	<u>Section 11A of the 1987 Act</u>
Claimed medical, hospital and rehabilitation expenses are not reasonably necessary because of the injury.	<u>Section 60 of the 1987 Act</u>
The claim for property damage covers items the Act does not.	<u>Sections 74 and 75 of the 1987 Act</u>
There is no total or partial incapacity for work.	<u>Section 33 of the 1987 Act</u>
The degree of permanent impairment does not reach the required thresholds for a lump sum payment.	<u>Sections 65A and 67 of the 1987 Act</u>


Notifying the worker

Before notifying the worker of the dispute, the insurer must make sure an appropriately qualified person reviews all the information it has considered in the decision and the reasons for the decision. This should be someone other than the original decision maker.

If satisfied by its decision, the insurer must then issue a notice of dispute to the worker within the legislated timeframes.

The notice of dispute

As an insurer, your notice of dispute must include:

Reasons for and issues in disputing liability	<p>Concise, easy-to-understand statements explaining:</p> <ul style="list-style-type: none">■ why the insurer disputes liability and the issues relevant to its decision■ that the dispute can be referred to the Workers Compensation Commission for determination or the District Court for judgement■ whether the insurer plans to refer the dispute to the Commission, or has already done so, including the related date of referral■ that issues can only be referred to the Commission if they have been raised in the dispute notice, in correspondence relating to an offer of settlement, or in a request for or notice after a further review.
Documents the worker has submitted	<p>A list of reports and documents the worker has submitted and relied on in making the claim.</p>
Documents the insurer has considered	<ul style="list-style-type: none">■ A statement identifying the reports of the type referred to in Clause 46 of the Regulation that are relevant to the decision, whether or not they support the reasons for the decision.■ A statement that a copy of these reports accompany the notice■ A copy of all these reports. <p>Note: If reports are not provided to the worker they cannot be used to dispute liability.</p> <p>Note: If the insurer believes that giving the worker a report would pose a serious threat to anyone's life or health, the insurer can instead:</p> <ul style="list-style-type: none">■ give a medical report to the medical practitioner the worker has nominated for that purpose■ give any other report to the worker's legal practitioner■ seek SIRA's direction on another approach when these options are not appropriate. <p> Clause 46 of the 2010 Regulation</p>
How to request a review	<p>A statement that the worker can ask the insurer to review the decision, and the procedure for doing so.</p>
Where to seek assistance	<p>Statements that the worker can seek:</p> <ul style="list-style-type: none">■ further information from the insurer■ help from a trade union, a lawyer, SIRA's Customer Service Centre on 13 10 50 or Workers Compensation Independent Review Officer on 13 94 76.
Where to refer an application for determination of a dispute	<p>The street and email addresses of the Registrar of the Workers Compensation Commission or the Registrar of the District Court, as appropriate.</p> <p>If the notice is about a claim for work injury damages, it must also include statements that the claimant:</p> <ul style="list-style-type: none">■ must serve a pre-filing statement before starting court proceedings■ cannot raise matters in court that are materially different from the pre-filing statement, except with the court's leave.



[Section 74 of the 1998 Act](#) and clauses [43](#) and [46](#) of the 2010 Regulation

Understanding dispute timeframes

The insurer must give the worker notice by post or in person.



Section 236 of the 1998 Act

Where the dispute includes a decision on weekly payments, the insurer must also follow the required period of notice in section 54 of the 1987 Act (in effect at 30 September 2012).

If a defect is identified in the notice of dispute, the insurer should correct the defect and reissue the notice. The notice period for the dispute restarts on the date the corrected notice is issued.

When issued by post, the notice cannot take effect until four working days after it was posted (or four working days after any relevant period the notice specifies).



Section 76 of the Interpretation Act 1987

Requesting a review of the insurer's decision

A person can ask the insurer to review the decision to dispute the claim at any time before an application for dispute resolution is lodged with the Workers Compensation Commission.

However, the request for a review does not delay the timeframe for the dispute to take effect.

When the insurer receives a request, it must review the claim and respond to the person within 14 days. The review might lead the insurer to:

- accept liability
- dispute liability.

Where the insurer continues to dispute the claim, it must issue a further notice of dispute.



Section 287A of the 1998 Act

The person may request more than one review.

Failing to determine a claim

Where an insurer does not determine a claim in the timeframe applicable to the compensation benefit claimed, the worker should seek help from:

- SIRA's Customer Service Centre on 13 10 50 or contact@sira.nsw.gov.au
- Workers Compensation Independent Review Officer on 13 94 76 or complaints@wiro.nsw.gov.au.

C5 Worker representation

About this section

This section identifies how a worker may be represented for workers compensation matters.

Legal representation

Workers may be entitled to costs for legal representation and may seek to recover these costs through the Workers Compensation Commission.



Section 341 of the 1998 Act (as at 26 June 2012)

Union representation

Insurers should respond to requests from union representatives on behalf of their members with appropriate consent from the member.



SIRA
State Insurance
Regulatory Authority

Disclaimer

This publication may contain information about the regulation of workers compensation in NSW. It may include some of your obligations under some of the legislation that the State Insurance Regulatory Authority administers. To ensure you comply with your legal obligations you must refer to the appropriate legislation.

Information on the latest laws can be checked by visiting the NSW legislation website www.legislation.com.au

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

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