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CONTENTS

Proclamations

Workers Compensation Legislation Amendment Act 2001 No 61—Proclamation

MARIE BASHIR, Governor

I, Professor Marie Bashir AC, Governor of the State of New South Wales, with the advice of the Executive Council, and in pursuance of section 2 of the *Workers Compensation Legislation Amendment Act 2001*, do, by this my Proclamation, appoint 1 January 2002 as the day on which the uncommenced provisions of that Act commence.

Signed and sealed at Sydney, this 19th day of December 2001.

L.S.

By Her Excellency's Command,

JOHN DELLA BOSCA, M.L.C.,
Special Minister of State

GOD SAVE THE QUEEN!

Explanatory note

The object of this proclamation is to commence uncommenced amendments to the *Workers Compensation Act 1987*, the *Workplace Injury Management and Workers Compensation Act 1998* and various other Acts. These amendments relate to the following matters:

(a) commutation procedures,

(b) assistance for injured workers,

(c) claims assistance for injured workers,

(d) lump sum compensation,

(e) new claims procedures,

(f) transitional, miscellaneous and consequential matters.

Workers Compensation Legislation Further Amendment Act 2001 No 94 —Proclamation

MARIE BASHIR, Governor

I, Professor Marie Bashir AC, Governor of the State of New South Wales, with the advice of the Executive Council, and in pursuance of section 2 of the *Workers Compensation Legislation Further Amendment Act 2001*, do, by this my Proclamation, appoint 1 January 2002 as the day on which the uncommenced provisions of that Act (except Schedule 1.2 [8]) commence.

Signed and sealed at Sydney, this 19th day of December 2001.

L.S.

By Her Excellency's Command,

JOHN DELLA BOSCA, M.L.C.,
Special Minister of State

GOD SAVE THE QUEEN!

Explanatory note

The object of this proclamation is to commence uncommenced amendments to the *Workers Compensation Act 1987*, the *Workplace Injury Management and Workers Compensation Act 1998* and various other Acts.

Certain amendments to the *Workers Compensation Act 1987* relating to common law damages are taken to have commenced at 9 am on 27 November 2001 (the day that the Bill for the *Workers Compensation Legislation Further Amendment Act 2001* was introduced into Parliament—see section 2 (2) of that Act).

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The amendments commenced by this proclamation relate to the following matters:

(a) common law damages,

(b) lump sum compensation,

(c) compensation for domestic assistance,

(d) savings and transitional matters,

(e) the jurisdiction of the Workers Compensation Commission,

(f) the repeal of private insurance arrangements,

(g) Industrial Magistrates,

(h) the Uninsured Liability and Indemnity Scheme,

(i) miscellaneous matters.

An amendment relating to the WorkCover Guidelines remains uncommenced.

Regulations

Workers' Compensation (Dust Diseases) Amendment (Reimbursement) Regulation 2001

under the

Workers' Compensation (Dust Diseases) Act 1942

Her Excellency the Governor, with the advice of the Executive Council, has made the following Regulation under the *Workers' Compensation (Dust Diseases) Act 1942*.

JOHN DELLA BOSCA, M.L.C.,
Special Minister of State

Explanatory note

Section 8E of the *Workers' Compensation (Dust Diseases) Act 1942* (***the Act***) provides the Dust Diseases Board (***the Board***) with a right to be reimbursed for compensation paid or payable by it where damages are recovered or recoverable by or in respect of a disabled or deceased worker from a negligent person (other than the worker's employer).

The object of this Regulation is to amend the *Workers' Compensation (Dust Diseases) Regulation 1998* to facilitate the exercise by the Board of its rights under section 8E of the Act. More specifically the Regulation provides for the following:

(a) a requirement for parties to certain proceedings to notify the Board of any award, judgment, settlement or agreement resulting in the final determination of the proceedings and to provide information about those proceedings to the Board,

(b) the method of determination of amounts of reimbursement to be paid to the Board under section 8E of the Act,

(c) the interest payable on such amounts owing to the Board under section 8E of the Act,

(d) the period within which such amounts must be paid.

This Regulation is made under the *Workers' Compensation (Dust Diseases) Act 1942*, including sections 8E and 10 (the general regulation-making power).

Workers' Compensation (Dust Diseases) Amendment (Reimbursement) Regulation 2001

1 Name of Regulation

This Regulation is the *Workers' Compensation (Dust Diseases) Amendment (Reimbursement) Regulation 2001*.

2 Commencement

This Regulation commences on 1 January 2002.

3 Amendment of Workers' Compensation (Dust Diseases) Regulation 1998

The *Workers' Compensation (Dust Diseases) Regulation 1998* is amended as set out in Schedule 1.

4 Notes

The explanatory note does not form part of this Regulation.

Schedule 1 Amendments

(Clause 3)

[1] Part 1, heading

Insert before clause 1:

Part 1 Preliminary

[2] Clause 4 Notes

Omit "and table of contents".
Insert instead ", table of contents and notes in the text of this Regulation".

[3] Part 2, heading

Insert after clause 4:

Part 2 General

[4] Part 3

Insert after clause 11:

Part 3 Reimbursement of compensation from negligent third parties

12 Application of Part

This Part applies to proceedings referred to in section 8E of the Act for damages in respect of disablement or death that:

(a) were commenced on or after the commencement of this Part, or

(b) were commenced before the commencement of this Part but were not finally determined before that commencement.

Note. This Part commenced on 1 January 2002.

13 Definitions

In this Part:

first person and ***second person*** have the same meanings as in section 8E (3) of the Act.

final determination, in relation to proceedings, includes a final determination by judgment, verdict, award, settlement, agreement, dismissal, discontinuance or otherwise.

14 Notification of final determination of proceedings

(1) A person (***the defendant***) against whom proceedings to which this Part applies have been taken must notify the Board in writing of any award, judgment, settlement or agreement resulting in the final determination of the proceedings.

(2) The notification must be given to the Board within 28 days after the final determination.

(3) The notification must be accompanied by the following documents:

(a) a document or documents that set out the following particulars:

(i) the name, address and date of birth of the person who commenced the proceedings (and if more than one, those particulars for each person),

(ii) a statement as to whether or not the defendant was sued in the capacity of employer,

(iii) a statement as to whether or not the defendant has made, or is required to make, any contribution or other payment in connection with the final determination of the proceedings,

(iv) the amount and extent of any such contribution or other payment,

(v) if a contribution or other payment (as referred to in subparagraphs (iii) and (iv)) has been or is to be made—a statement as to whether or not an

amount has been deducted from the contribution or payment as referred to in section 8E (3) (b) of the Act,

(vi) the amount and extent of any such deduction,

(vii) the names and addresses of all parties to the award, judgment, settlement or agreement,

(viii) a statement as to whether or not any person against whom the proceedings were brought (other than the defendant) has made, or is required to make, any contribution or other payment in connection with the final determination of the proceedings,

(ix) the amount and extent of any such contribution or other payment,

(x) if a contribution or other payment (as referred to in subparagraphs (viii) and (ix)) has been or is to be made—a statement as to whether or not an amount has been deducted from the contribution or other payment as referred to in section 8E (3) (b) of the Act,

(xi) the amount and extent of any such deduction,

(b) a copy (whether in electronic or hard copy form) of the following documents:

(i) the final statement of claim in the proceedings,

(ii) the final particulars of damage filed by the person or persons who commenced the proceedings,

(iii) any award, judgment, terms of settlement, agreement, or other document (such as a deed of release) evidencing the terms of the final determination of the proceedings.

(4) It is sufficient compliance with subclause (3) (a) to the extent that documents provided under subclause (3) (b) contain the particulars required by subclause (3) (a).

(5) Where there is more than one defendant in proceedings to which this Part applies, each defendant is required to comply with this clause. In such a case, the Board may consent to a defendant complying with this clause on behalf of other defendants in the proceedings.

(6) The Board may at any time by notice in writing require a defendant in proceedings to which this Part applies to provide to the Board, within 21 days or such longer period as the Board may allow, specified information or documents concerning the determination of the proceedings.

(7) A person who fails to comply with a requirement imposed by or under this clause is guilty of an offence.

Maximum penalty: 1 penalty unit.

(8) The Board may exempt any particular proceedings or class of proceedings from the requirements as to notification under this clause. Any exemption given for a class of proceedings is to be publicised in a manner determined by the Board and any revocation or variation of such an exemption must be similarly publicised.

15 Determination of amount of compensation

For the purposes of section 8E (8) of the Act, in cases where damages were paid otherwise than under an award or judgment, the amount of compensation referred to in section 8E (3) of the Act is to be determined in accordance with, and subject to, the following principles:

(a) Subject to the following paragraphs, the amount of compensation (the ***deducted compensation***) taken to have been deducted from the damages payable by the second person to the first person is the total of the following amounts as assessed by the Board:

(i) the amount of compensation paid by the Board to, or on behalf of, the first person up to the date of final determination, and

(ii) the present value of future benefits payable by the Board to, or on behalf of, the first person after that date (where the assessment of those future benefits is based on the assumption that the medical condition of the worker as to disablement and life expectancy will remain unchanged),

less any reduction required by section 8E (6) of the Act.

(b) The Board may by notice in writing served on the second person give the second person notice (an ***assessment notice***) of the amount of the deducted compensation assessed by the Board under paragraph (a). An assessment notice must include the Board's method of calculation and reasons for the assessment.

Note. When assessing the amount of the deducted compensation under paragraph (a), the Board does not include any damages for non-economic loss.

(c) If a second person disputes the assessment of an amount of deducted compensation set out in an assessment notice, the second person may request that the Board reconsider the assessment (a ***reconsideration request***).

(d) A reconsideration request must:

(i) be in writing in the form approved by the Board, and

(ii) be lodged with the Board within 28 days after the service on the person of the assessment notice.

(e) In reconsidering an assessment, the Board may consider the advice of accountants, actuaries, legal practitioners and other persons.

(f) Following the reconsideration of the assessment, the Board may:

(i) confirm the original assessment of the amount of the deducted compensation made under paragraph (a), or

(ii) if the Board considers that a lesser amount of deducted compensation is appropriate—issue an amended assessment notice setting out that lesser amount.

(g) As soon as practicable (and in any event within 28 days) after the lodgement of a reconsideration request, the Board must notify the second person in writing of the outcome of the reconsideration. The notification must include the Board's reasons for its decision following the reconsideration.

(h) The second person is not entitled to make more than one reconsideration request in relation to an amount of deducted compensation.

16 Interest

(1) Interest is payable on an amount that the second person is liable to pay under section 8E (3) (e) of the Act at the rate prescribed for the time being under section 95 (1) of the *Supreme Court Act 1970* for payment of interest on judgment debts.

(2) That interest begins to run from:

(a) in a case where the damages have been paid under an award or judgment— the date of expiry of the 42 day period referred to section 8E (3) (d) of the Act, or

(b) in a case where the damages have been paid otherwise than under an award or judgment:

(i) if the second person has not lodged a reconsideration request before the expiry of the 28 day period referred to in clause 15 (d) (ii)—the date of expiry of the 42 day period referred to in clause 17 (a) (being 42 days after the service of an assessment notice referred to in clause 15 (b)), or

(ii) if the second person has lodged a reconsideration request before the expiry of the 28 day period referred to in clause 15 (d) (ii)—the date of expiry of the 28 day period referred to in clause 17 (b) (being 28 days after the second person is notified by the Board of the outcome of the reconsideration).

(3) However, if the Board has issued an amended assessment notice in accordance with clause 15 (f) (ii), the amount of interest is to be calculated on the amount of deducted compensation set out in that amended notice.

17 Reimbursement period

For the purposes of section 8E (3) (d) of the Act, in a case in which damages have been or are to be paid by the second person to the first person otherwise than under an award or judgment and the amount of compensation referred to in section 8E (3) of the Act is to be determined in accordance with clause 15, an amount that the second person is liable to pay to the Board under section 8E (3) of the Act must be paid:

(a) if the second person does not lodge a reconsideration request before the expiry of the 28 day period referred to in clause 15 (d) (ii)—within 42 days after the service of the assessment notice determining the amount of compensation, or

(b) if the second person lodges a reconsideration request before the expiry of the 28 day period referred to in clause 15 (d) (ii)—within 28 days after the second person is notified by the Board of the outcome of the reconsideration.

Workers Compensation (General) Amendment (Costs) Regulation 2001

under the

Workplace Injury Management and Workers Compensation Act 1998

Her Excellency the Governor, with the advice of the Executive Council, has made the following Regulation under the *Workplace Injury Management and Workers Compensation Act 1998*.

JOHN DELLA BOSCA, M.L.C.,
Special Minister of State

Explanatory note

The objects of this Regulation are:

(a) to fix maximum costs and disbursements recoverable by a legal practitioner or agent for all legal services or agent services and other matters provided in connection with a claim for statutory compensation or a claim for work injury damages (other than costs that are specifically excluded by the Regulation), and

(b) to place restrictions on the awarding of costs by a court on a party and party basis in court proceedings for work injury damages, and

(c) to provide for the assessment of costs by the Registrar of the Workers Compensation Commission.

This Regulation is made under the *Workplace Injury Management and Workers Compensation Act 1998*, including Part 8 of Chapter 7, and section 248 (the general regulation-making power).

Workers Compensation (General) Amendment (Costs) Regulation 2001

1 Name of Regulation

This Regulation is the *Workers Compensation (General) Amendment (Costs) Regulation 2001*.

2 Commencement

This Regulation commences on 1 January 2002.

3 Amendment of Workers Compensation (General) Regulation 1995

The *Workers Compensation (General) Regulation 1995* is amended as set out in Schedule 1.

Schedule 1 Amendments

(Clause 3)

[1] Part 23

Insert after Part 22 (as inserted by the *Workers Compensation (General) Amendment (Savings, Transitional and Other Matters) Regulation 2001*):

Part 23 Costs

Division 1 Preliminary

105 Definition

In this Part, and in Schedules 6 and 7:

insurer includes an employer.

Note. Section 332 (2) of the 1998 Act provides that expressions in Division 1 (Costs) of Part 8 of Chapter 7 of that Act (and consequently expressions used in this Part) have the same meaning as in Part 11 (Legal fees and other costs) of the *Legal Profession Act 1987*, except where otherwise provided. Under the *Legal Profession Act 1987*, ***costs*** includes barristers' and solicitors' fees as well as other items that may be charged by barristers and solicitors (such as expenses and disbursements).

106 Costs not regulated by this Part

Costs referred to in this Part do not include any of the following:

(a) costs for legal services provided for an appeal under section 353 (Appeal against decision of Commission constituted by Presidential Member) of the 1998 Act,

(b) fees for investigators' reports or for other material produced or obtained by investigators (such as witness statements or other evidence),

(c) fees for accident reconstruction reports,

(d) fees for accountants' reports,

(e) fees for reports from health service providers,

(f) fees for other professional reports relating to treatment or rehabilitation (for example, architects' reports concerning house modifications),

(g) fees for interpreter or translation services,

(h) fees imposed by a court or the Commission,

(i) travel costs and expenses of the claimant in the matter for attendance at medical examinations, a court or the Commission,

(j) witness expenses at a court or the Commission.

Note. Under section 339 of the 1998 Act, the WorkCover Authority may fix maximum fees for the provision of reports, or appearance before the Commission, by health service providers.

Division 2 Costs recoverable in compensation matters

Subdivision 1 Preliminary

107 Application of Division

This Division is made under section 337 of the 1998 Act and applies to the following costs payable on a party and party basis, on a practitioner or agent and client basis or on any other basis:

(a) costs for legal services or agent services provided in or in relation to a claim for compensation, and

(b) costs for matters that are not legal or agent services but are related to a claim for compensation.

Note. Section 337 (3) and (4) of the 1998 Act provide that a legal practitioner or an agent is not entitled to be paid or recover for a legal service or agent service or other matter an amount that exceeds any maximum costs fixed for the service or matter by regulations under section 337.

Subdivision 2 Maximum costs recoverable by legal practitioners and agents in compensation matters

108 Fixing of maximum costs recoverable by legal practitioners and agents

(1) The costs that are recoverable, and the maximum costs that are recoverable, for:

(a) legal services or agent services provided in or in relation to a claim for compensation, and

(b) matters that are not legal or agent services but are related to a claim for compensation,

are the costs set out in Schedule 6, except as otherwise provided by this Part.

Note. The effect of this clause is that a legal practitioner or agent cannot recover any costs in relation to a claim for compensation unless those costs are set out in Schedule 6, except as otherwise provided in this Part.

(2) If there is a change in the legal practitioner or agent retained by a party in or in relation to a claim made or to be made for compensation, the relevant costs are to be apportioned between the legal practitioners or agents concerned.

(3) If there is a dispute as to such an apportionment, either legal practitioner or agent concerned (or the client) may refer the dispute to the Commission for determination.

(4) A legal practitioner or agent has the same right of appeal against a determination made under subclause (3) as the legal practitioner or agent would have under clause 142 if the determination were a determination made by the Registrar in relation to a bill of costs.

Note. Division 2 of Part 11 of the *Legal Profession Act 1987* requires barristers and solicitors, before providing any legal services to a client, to provide the client with a written disclosure of the basis of the costs (or an estimate of the likely costs) of legal services concerned.

Division 3 Costs recoverable in work injury damages matters

Subdivision 1 Maximum costs recoverable by legal practitioners in work injury damages matters

109 Application of Division

This Division is made under section 337 of the 1998 Act and applies to the following costs payable on a party and party basis, on a solicitor and client basis or on any other basis:

(a) costs for legal services or agent services provided in or in relation to a claim for work injury damages, and

(b) costs for matters that are not legal or agent services but are related to a claim for work injury damages.

Note. Section 337 (3) of the 1998 Act provides that a legal practitioner is not entitled to be paid or recover for a legal service or other matter an amount that exceeds any maximum costs fixed for the service or matter by regulations under section 337.

110 Fixing of maximum costs recoverable by legal practitioners

(1) The maximum costs for:

(a) legal services provided in or in relation to a claim for work injury damages, and

(b) matters that are not legal services but are related to a claim for work injury damages,

are the costs set out in Schedule 7, except as otherwise provided by this Part.

Note. The effect of this clause is that a legal practitioner or agent cannot recover any costs in relation to a claim for work injury damages unless those costs are set out in Schedule 7, except as otherwise provided in this Part.

(2) If there is a change in the legal practitioner retained by a party in or in relation to a claim for work injury damages, the relevant costs are to be apportioned between the legal practitioners concerned.

(3) If there is a dispute as to such an apportionment, either legal practitioner concerned (or the client concerned) may refer the dispute to the Commission for determination.

(4) A legal practitioner has the same right of appeal against a determination made under subclause (3) as the practitioner would have under clause 142 if the determination were a determination made by the Registrar in relation to a bill of costs.

Note. Division 2 of Part 11 of the *Legal Profession Act 1987* requires barristers and solicitors, before providing any legal services to a client, to provide the client with a written disclosure of the basis of the costs (or an estimate of the likely costs) of legal services concerned.

111 Contracting out—practitioner/client costs

(1) This clause applies in respect of costs in or in relation to a claim for work injury damages if a legal practitioner:

(a) makes a disclosure under Division 2 of Part 11 of the *Legal Profession Act 1987* (sections 180 and 181 excepted) to a party to the matter with respect to the costs, and

(b) enters into a costs agreement (other than a conditional costs agreement, within the meaning of that Part, that provides for the payment of a premium of more than 10% of the costs otherwise payable under the agreement on the successful outcome of the matter concerned) with that party as to those costs in accordance with Division 3 of that Part, and

(c) before entering into the costs agreement, advises the party (in a separate written document) that, even if costs are awarded in favour of the party, the party will be liable to pay such amount of the costs provided for in the costs agreement as exceeds the amount that would be payable under the 1998 Act in the absence of a costs agreement.

(2) Schedule 7 does not apply to the costs concerned to the extent that they are payable on a practitioner and client basis.

Subdivision 2 Restriction on awarding of costs

Note. This Subdivision is made under section 346 of the 1998 Act, which provides that a party is not entitled to an award of costs to which that section applies (being costs payable by a party in or in relation to a claim for work injury damages, including court proceedings for work injury damages) except as prescribed by the regulations or by the rules of the court concerned.

In the event of any inconsistency between the provisions of this Regulation and rules of court, the provisions of this Regulation prevail to the extent of the inconsistency: section 346 (4).

112 Costs where claimant no less successful than claimant's final offer

If a claimant obtains an order or judgment on a claim that is no less favourable to the claimant than the terms of the claimant's final offer of settlement in mediation under this Act as certified by the mediator under section 318B of the 1998 Act, the court is to order the insurer to pay the claimant's costs on the claim assessed on a party and party basis.

113 Costs where claimant less successful than insurer's final offer or insurer found not liable

(1) If a claimant obtains an order or judgment on a claim that is less favourable to the claimant than the terms of the insurer's final offer of settlement in mediation under this Act as certified by the mediator under section 318B of the 1998 Act, the court is to order the claimant to pay the insurer's costs on the claim assessed on a party and party basis.

(2) If a claimant does not obtain an order or judgment on a claim (that is, if the court finds the insurer has no liability for the claim), the court is to order the claimant to pay the insurer's costs on the claim assessed on a party and party basis.

114 Costs in other cases

Except as provided by this Subdivision, the parties to court proceedings for work injury damages are to bear their own costs.

115 Deemed offer where insurer denies liability and no mediation

If:

(a) the insurer wholly denies liability, and

(b) the matter is not referred to mediation, and

(c) the claimant obtains an order or judgment on the claim,

costs are to be awarded in accordance with this Subdivision as if:

(d) the insurer had made a final offer of settlement at mediation of $0, and

(e) the claimant had made a final offer of settlement at mediation of the amount of damages specified in the pre-filing statement served under section 315 of the 1998 Act.

116 Subdivision does not apply to ancillary proceedings

This Subdivision does not apply to costs payable in or in relation to proceedings that are ancillary to proceedings on a claim for work injury damages, and a court is to award costs in such ancillary proceedings in accordance with the rules of the court.

117 Multiple parties

Where 2 or more defendants are alleged to be jointly or jointly and severally liable to the claimant and rights of contribution or indemnity appear to exist between the defendants, this Subdivision does not apply to an offer of settlement unless:

(a) in the case of an offer made by the claimant—the offer is made to all the defendants and is an offer to settle the claim against all of them, and

(b) in the case of an offer made to the claimant:

(i) the offer is to settle the claim against all the defendants concerned, and

(ii) where the offer is made by 2 or more defendants—by the terms of the offer the defendants who made the offer are jointly or jointly and severally liable to the claimant for the whole amount of the offer.

Division 4 Assessment of costs

Subdivision 1 Preliminary

118 Definitions

In this Division:

agent bill of costs means a bill of costs for providing agent services within the meaning of section 250 of the 1998 Act.

bill of costs means a legal bill of costs or an agent bill of costs

client of a legal practitioner or agent means a person to whom the practitioner or agent has provided legal services or agent services in respect of any workers compensation matter or work injury damages matter.

legal bill of costs means a bill of costs for providing legal services within the meaning of Part 11 of the *Legal Profession Act 1987*.

119 Applications by clients

(1) A client who is given a bill of costs may apply to the Registrar for an assessment of the whole of, or any part of, those costs.

(2) An application relating to a bill of costs may be made even if the costs have been wholly or partly paid.

(3) If any costs have been paid without a bill of costs, the client may nevertheless apply for an assessment. For that purpose the request for payment by the legal practitioner or agent is taken to be the bill of costs.

Note. Section 343 (1) of the 1998 Act provides that the legal representative or agent of a person in respect of a claim for compensation made or to be made by the person is not entitled to recover from the person any costs in respect of the claim unless those costs are awarded by the Commission.

120 Applications by instructing practitioners or agents for assessment of costs in bills

(1) A legal practitioner or agent who retains another legal practitioner or agent to act on behalf of a client may apply to the Registrar for an assessment of the whole of, or any part of,

a bill of costs given in accordance with this Part by the other legal practitioner or agent in relation to the matter.

(2) An application may not be made if there is a costs agreement between the client and the other legal practitioner or agent.

(3) An application is to be made within 30 days after the bill of costs is given and may be made even if the costs have been wholly or partly paid.

121 Application for assessment of costs by legal practitioner or agent giving bill

(1) A legal practitioner or agent who has given a bill of costs may apply to the Registrar for an assessment of the whole of, or any part of, those costs.

(2) An application may not be made unless:

(a) the bill of costs includes the following particulars:

(i) a description of the legal services or agent services provided,

(ii) an identification of each activity, event or stage specified in Schedule 6 or 7, by reference to the item number of the activity, event or stage, that was carried out,

(iii) the amount sought, and

(b) at least 30 days have passed since the bill of costs was given or an application has been made under this Division by another person in respect of the bill of costs.

122 Application for assessment of party/party costs

(1) A person who has paid or is liable to pay, or who is entitled to receive or who has received, costs as a result of an order for the payment of an unspecified amount of costs made by a court or the Commission may apply to the Registrar for an assessment of the whole of, or any part of, those costs.

(2) A court or the Commission may direct the Registrar to assess costs payable as a result of an order made by the court or the Commission. Any such direction is taken to be an application for assessment duly made under this Division.

123 How is an application to be made?

(1) An application for assessment is to be made in the form approved by the Commission and is, subject to subclause (4), to be accompanied by the fee determined by the Commission from time to time.

(2) The application must authorise the Registrar to have access to, and to inspect, all documents of the applicant that are held by the applicant, or by any legal practitioner or agent concerned, in respect of the matter to which the application relates.

(3) The Registrar may waive or postpone payment of the fee either wholly or in part if satisfied that the applicant is in such circumstances that payment of the fee would result in serious hardship to the applicant or his or her dependants.

(4) The Registrar may refund the fee paid under this clause either wholly or in part if satisfied that it is appropriate because the application is not proceeded with.

124 Persons to be notified of application

The Registrar is to cause a copy of an application for assessment to be given to any legal practitioner, agent or client concerned or any other person whom the Registrar thinks it appropriate to notify.

125 Registrar may require documents or further particulars

(1) The Registrar may, by notice in writing, require a person (including the applicant, the legal practitioner or agent concerned, or any other legal practitioner, agent or client) to produce any relevant documents of or held by the person in respect of the matter.

(2) The Registrar may, by any such notice, require further particulars to be furnished by the applicant, legal practitioner, agent, client or other person as to instructions given to, or work done by, the legal practitioner or agent or any other legal practitioner or agent in respect of the matter and as to the basis on which costs were ascertained.

(3) The Registrar may require any such particulars to be verified by statutory declaration.

(4) A notice under this clause is to specify the period within which the notice is to be complied with.

(5) If a person fails, without reasonable excuse, to comply with a notice under this clause, the Registrar may decline to deal with the application or may continue to deal with the application on the basis of the information provided.

(6) A legal practitioner who fails, without reasonable excuse, to comply with a notice under this clause is guilty of professional misconduct.

126 Consideration of applications

(1) The Registrar must not determine an application for assessment unless the Registrar:

(a) has given both the applicant and any legal practitioner, agent, client or other person concerned a reasonable opportunity to make written submissions to the Registrar in relation to the application, and

(b) has given due consideration to any submissions so made.

(2) In considering an application, the Registrar is not bound by rules of evidence and may inform himself or herself on any matter in such manner as he or she thinks fit.

(3) In the case of a legal practitioner, for the purposes of determining whether an application for assessment may be or is required to be made, or for the purpose of exercising any other function, the Registrar may determine any of the following:

(a) whether or not disclosure has been made in accordance with Division 2 of Part 11 of the *Legal Profession Act 1987* and whether or not it was reasonably practicable to disclose any matter required to be disclosed under that Division,

(b) whether a costs agreement exists, and its terms.

127 Assessment to give effect to maximum costs, 1998 Act and orders and rules of the Commission or court

An assessment of costs is to be made in accordance with, and so as to give effect to, orders of the Commission or a court, the Rules of the Commission or rules of court, Part 8 of Chapter 8 of the 1998 Act, this Part, and Schedules 6 and 7.

Subdivision 2 Assessment of bills of costs between practitioner or agent and client

128 Assessment of bills generally

(1) When considering an application relating to a bill of costs, the Registrar must consider:

(a) whether or not it was reasonable to carry out the work to which the costs relate, and

(b) whether or not the work was carried out in a reasonable manner, and

(c) the fairness and reasonableness of the amount of the costs in relation to that work.

(2) The Registrar is to determine the application by confirming the bill of costs or, if the Registrar is satisfied that the disputed costs are unfair or unreasonable, by substituting for the amount of the costs an amount that, in his or her opinion, is a fair and reasonable amount.

(3) Any amount substituted for the amount of the costs may include an allowance for any fee paid or payable for the application by the applicant.

(4) If a legal practitioner is liable under section 182 (3) of the *Legal Profession Act 1987* to pay the costs of the costs assessment (including the costs of the Registrar), the Registrar is to determine the amount of those costs. The costs incurred by the client are to be deducted from the amount payable under the bill of costs and the costs of the Registrar are to be paid to the Commission.

(5) The Registrar may not determine that any part of a bill of costs that is not the subject of an application is unfair or unreasonable.

Note. Clause 127 requires an assessment of costs to give effect to the maximum costs set out in Schedules 6 and 7, as well as to other matters.

Section 337 (3) and (4) of the 1998 Act provide that a legal practitioner or an agent is not entitled to be paid or recover for a legal service or agent service or other matter an amount that exceeds any maximum costs fixed for the service or matter by regulations under section 337.

Section 343 (1) of the 1998 Act provides that the legal representative or agent of a person in respect of a claim for compensation made or to be made by the person is not entitled to recover from the person any costs in respect of the claim unless those costs are awarded by the Commission.

129 Additional matters to be considered in assessing bills of costs

In assessing what is a fair and reasonable amount of costs, the Registrar may have regard to any or all of the following matters:

(a) whether the legal practitioner or agent complied with any relevant regulation, barristers rule, solicitors rule or joint rule,

(b) in the case of a legal practitioner—whether the legal practitioner disclosed the basis of the costs or an estimate of the costs under Division 2 of Part 11 of the *Legal Profession Act 1987* and any disclosures made,

(c) any relevant costs agreement (subject to clause 130),

(d) the skill, labour and responsibility displayed on the part of the legal practitioner or agent responsible for the matter,

(e) the instructions and whether the work done was within the scope of the instructions,

(f) the complexity, novelty or difficulty of the matter,

(g) the quality of the work done,

(h) the place where and circumstances in which the legal services were provided,

(i) the time within which the work was required to be done.

130 Costs agreements not subject to assessment

(1) The Registrar is to decline to assess a bill of costs if:

(a) the disputed costs are subject to a costs agreement that complies with Division 3 of Part 11 of the *Legal Profession Act 1987*, and

(b) the costs agreement specifies the amount of the costs or the dispute relates only to the rate specified in the agreement for calculating the costs.

(2) If the dispute relates to any other matter, costs are to be assessed on the basis of that specified rate despite clause 128. The Registrar is bound by a provision for the payment of a premium that is not determined to be unjust under clause 131.

(3) This clause does not apply to any provision of a costs agreement that the Registrar determines to be unjust under clause 133.

(4) This clause does not apply to a costs agreement applicable to the costs of legal services if a legal practitioner failed to make a disclosure in accordance with Division 2 of Part 11 of the *Legal Profession Act 198* of the matters required to be disclosed by section 175 or 176 of that Act in relation to those costs.

131 Unjust costs agreements

(1) The Registrar may determine whether a term of a particular costs agreement entered into by a legal practitioner and a client is unjust in the circumstances relating to it at the time it was made.

(2) For that purpose, the Registrar is to have regard to the public interest and to all the circumstances of the case and may have regard to the matters specified in section 208D (2) (a)–(j) of the *Legal Profession Act 1987*.

(3) For the purposes of this clause, a person is taken to have represented another person if the person represented the other person, or assisted the other person to a significant degree, in the negotiations process up to, or at, the time the agreement was made.

(4) In determining whether a provision of the agreement is unjust, the Registrar is not to have regard to any injustice arising from circumstances that were not reasonably foreseeable when the agreement was made.

132 Interest on amount outstanding

(1) The Registrar may, in an assessment, determine that interest is not payable on the amount of costs assessed or on any part of that amount and determine the rate of interest (not exceeding the rate referred to in section 190 (4) of the *Legal Profession Act 1987*).

(2) This clause applies despite any costs agreement or section 190 of the *Legal Profession Act 1987*.

(3) This clause does not authorise the giving of interest on interest.

(4) This clause does not apply to or in respect of the assessment of costs referred to in Subdivision 3 (party/party costs).

Subdivision 3 Assessment of party/party costs

133 Assessment of costs—costs ordered by court or Commission

(1) When dealing with an application relating to costs payable as a result of an order made by a court or the Commission, the Registrar must consider:

(a) whether or not it was reasonable to carry out the work to which the costs relate, and

(b) what is a fair and reasonable amount of costs for the work concerned.

(2) The Registrar is to determine the costs payable as a result of the order by assessing the amount of the costs that, in his or her opinion, is a fair and reasonable amount.

(3) If a court or the Commission has ordered that costs are to be assessed on an indemnity basis, the Registrar must assess the costs on that basis, having regard to any relevant rules of the court or Commission.

(4) The costs assessed are to include the costs of the assessment (including the costs of the parties to the assessment, and the Registrar). The Registrar may determine by whom and to what extent the costs of the assessment are to be paid.

(5) The costs of the Registrar are to be paid to the Commission.

Note. Subdivision 2 of Division 3 of this Part limits the circumstances in which costs may be awarded on a party/party basis in relation to a claim for work injury damages.

Clause 127 requires an assessment of costs to give effect to the maximum costs set out in Schedules 6 and 7, as well as to other matters.

134 Additional matters to be considered by Registrars in assessing costs ordered by court or Commission

In assessing what is a fair and reasonable amount of costs, the Registrar may have regard to any or all of the following matters:

(a) the skill, labour and responsibility displayed on the part of the legal practitioner or agent responsible for the matter,

(b) the complexity, novelty or difficulty of the matter,

(c) the quality of the work done and whether the level of expertise was appropriate to the nature of the work done,

(d) the place where and circumstances in which the legal services were provided,

(e) the time within which the work was required to be done,

(f) the outcome of the matter.

135 Effect of costs agreements in assessments of party/party costs

(1) The Registrar may obtain a copy of, and may have regard to, a costs agreement.

(2) However, the Registrar must not apply the terms of a costs agreement for the purposes of determining appropriate fair and reasonable costs when assessing costs payable as a result of an order by a court or the Commission.

136 Court or Commission may specify amount etc

This Division does not limit any power of a court or the Commission to determine in any particular case the amount of costs payable or that the amount of the costs is to be determined on an indemnity basis.

Subdivision 4 Enforcement of assessment

137 Certificate as to determination

(1) On making a determination, the Registrar is to issue to each party a certificate that sets out the determination.

(2) The Registrar may issue more than one certificate in relation to an application for costs assessment. Such certificates may be issued at the same time or at different stages of the assessment process.

(3) In the case of an amount of costs that has been paid, the amount (if any) by which the amount paid exceeds the amount specified in any such certificate may be recovered as a debt in a court of competent jurisdiction.

(4) In the case of an amount of costs that has not been paid, the certificate is, on the filing of the certificate in the office or registry of a court having jurisdiction to order the payment of that amount of money, and with no further action, taken to be a judgment of that court for the amount of unpaid costs, and the rate of any interest payable in respect of that amount of costs is the rate of interest in the court in which the certificate is filed.

(5) For this purpose, the amount of unpaid costs does not include the costs incurred by the Registrar in the course of a costs assessment.

(6) To avoid any doubt, this clause applies to or in respect of both the assessment of costs referred to in Subdivision 2 of this Division (practitioner/client costs) and the assessment of costs referred to in Subdivision 3 of this Division (party/party costs).

(7) If the costs of the Registrar are payable by a party to the assessment (as referred to in clause 139), the Registrar may refuse to issue a certificate relating to his or her determination under this clause until the costs of the Registrar have been paid.

(8) Subclause (7) does not apply in respect of a certificate issued before the completion of the assessment process under subclause (2).

138 Reasons for determination

The Registrar must ensure that a certificate issued under clause 137 that sets out his or her determination is accompanied by:

(a) a statement of the reasons for the Registrar's determination, and

(b) the amount of costs the Registrar determines is fair and reasonable, and

(c) if the Registrar declines to assess a bill of costs under clause 130—the basis for doing so, and

(d) if the Registrar determines that a term of a costs agreement is unjust—the basis for doing so, and

(e) a statement of any determination under clause 132 that interest is not payable on the amount of costs assessed or, if payable, of the rate of interest payable.

139 Recovery of costs of costs assessment

(1) This clause applies when the costs of the Registrar are payable by a party to the assessment (under section 182 (3) of the *Legal Profession Act 1987* or clause 128 or 133 (5)).

(2) On making a determination, the Registrar may issue to each party a certificate that sets out the costs incurred by the Registrar in the course of the costs assessment.

(3) The certificate is, on the filing of the certificate in the office or registry of a court having jurisdiction to order the payment of that amount of money, and with no further action, taken to be a judgment of that court for the amount of unpaid costs.

(4) The Registrar may take action to recover the costs of the Registrar.

140 Correction of error in determination

(1) At any time after making a determination, the Registrar may, for the purpose of correcting an inadvertent error in the determination:

(a) make a new determination in substitution for the previous determination, and

(b) issue a certificate under clause 137 that sets out the new determination.

(2) Such a certificate replaces any certificate setting out the previous determination of the Registrar that has already been issued by the Registrar, and any judgment that is taken to have been effected by the filing of that previously issued certificate is varied accordingly.

141 Determination to be final

The Registrar's determination of an application is binding on all parties to the application and no appeal or other review lies in respect of the determination, except as provided by this Division.

Subdivision 5 Appeals

142 Appeal against decision of Registrar as to matter of law

(1) A party to an application who is dissatisfied with a decision of the Registrar as to a matter of law arising in the proceedings to determine the application may, in accordance with the Rules of the Commission, appeal to the Commission constituted by a Presidential member against the decision.

(2) The appeal is to be in the form approved by the Commission and be accompanied by the fee approved by the Commission from time to time.

(3) After deciding the question the subject of the appeal, the Commission constituted by a Presidential member may, unless it affirms the Registrar's decision:

(a) make such determination in relation to the application as, in its opinion, should have been made by the Registrar, or

(b) remit its decision on the question to the Registrar and order the Registrar to re-determine the application.

(4) On a re-determination of an application, fresh evidence, or evidence in addition to or in substitution for the evidence received at the original proceedings, may be given.

143 Effect of appeal on application

(1) If a party to an application has appealed against a determination or decision of the Registrar, either the Registrar or the Commission constituted by a Presidential Member may suspend, until the appeal is determined, the operation of the determination or decision.

(2) The Registrar or the Commission may end a suspension made by the Registrar. The court or the Commission may end a suspension made by the court or Commission.

Subdivision 6 Miscellaneous

144 Liability of legal practitioner or agent for costs in certain cases

(1) The Registrar may act as set out in subclause (2) if it appears to the Registrar that costs have been incurred improperly or without reasonable cause, or have been wasted by undue delay or by any other misconduct or default.

(2) The Registrar may in the determination:

(a) disallow the costs as between the legal practitioner or agent and the practitioner's or agent's client, and

(b) direct the legal practitioner or agent to repay to the client costs that the client has been ordered by a court or the Commission to pay to any other party, and

(c) direct the legal practitioner or agent to indemnify any party other than the client against costs payable by the party indemnified.

(3) Before taking action under this clause, the Registrar must give notice of the proposed action to the legal practitioner or agent and the client and give them a reasonable opportunity to make written submissions in relation to the proposed action.

(4) The Registrar must give due consideration to any submissions so made.

145 Referral of misconduct to Legal Services Commissioner

(1) If the Registrar considers that any conduct of a legal practitioner or agent involves the deliberate charging of grossly excessive amounts of costs or deliberate misrepresentations as to costs, the Registrar must refer the matter to the Legal Services Commissioner appointed under the *Legal Profession Act 1987*.

(2) For the purposes of the *Legal Profession Act 1987*, the deliberate charging of grossly excessive amounts of costs and deliberate misrepresentations as to costs are each declared to be professional misconduct.

(3) The Registrar may refer any failure by a legal practitioner to comply with a notice issued under clause 125, or with any other provision of this Division, to the Legal Services Commissioner

Division 5 Goods and services tax

146 GST may be added to costs

(1) Despite the other provisions of this Part, a cost fixed by Division 3 (Costs recoverable in work injury damages matters) may be increased by the amount of any GST payable in respect of the service to which the cost relates, and the cost as so increased is taken to be the cost fixed by this Part.

(2) This clause does not permit a legal practitioner or agent to charge or recover, in respect of GST payable in respect of a service, an amount that is greater than:

(a) 10% of the maximum amount payable under this Part to the legal practitioner or agent in respect of the service apart from this clause, or

(b) the amount permitted under the New Tax System Price Exploitation law,

whichever is the lesser.

(3) In this clause:

GST has the same meaning as in the *A New Tax System (Goods and Services Tax) Act 1999* of the Commonwealth.

New Tax System Price Exploitation law means:

(a) the New Tax System Price Exploitation Code, as applied as a law of New South Wales by the *Price Exploitation Code (New South Wales) Act 1999*, or

(b) Part VB of the *Trade Practices Act 1974* of the Commonwealth.

Division 6 Miscellaneous

147 Modifications to Legal Profession Act 1987 relating to assessment of costs

A reference in section 175 (Obligation to disclose to clients basis of costs) or 182 (Effect of non-disclosure of matters related to basis of costs) to assessment of costs under Division 6 of Part 11 of the *Legal Profession Act 1987* is to be read as including, as an alternative to assessment under that Division, assessment of costs under Division 4 of Part 8 of Chapter 7 of the 1998 Act.

148 Transitional provisions

(1) In relation to claims for compensation, this Part:

(a) applies to new claims, and

(b) extends to proceedings with respect to existing claims that are treated as new claims under clause 93 but only if those proceedings had not commenced before clause 93 commenced.

(2) In relation to claims for work injury damages, this Part applies to claims made after 1 January 2002.

(3) In this clause, ***existing claim*** and ***new claim*** have the same meaning as in Chapter 7 of the 1998 Act.

149 Special provision for matters involving coal miners

This Part does not apply to legal services or agent services provided in any workers compensation matter involving a claim for compensation or work injury damages by a coal miner, and regulations made under Division 5 (Costs fixed by regulation) of Part 11 of the *Legal Profession Act 1987* continue to apply to legal services provided in such a matter.

[2] Schedules 6 and 7

Insert after Schedule 5:

Schedule 6 Maximum costs—compensation matters

(Clause 108)

1 Costs determined by reference to activities or events in connection with the matter

(1) In this Schedule:

the table means the Compensation Costs Table at the end of this Schedule.

(2) The maximum costs for an activity or event described in a Part of the table and carried out in or in relation to a claim made or to be made in respect of a particular injury are as follows:

(a) **Making claim for permanent impairment compensation or pain and suffering compensation**
For an activity or event carried out on behalf of a claimant in making a claim for compensation under section 66 or 67 of the 1987 Act—the cost set out in Column 3 of Part 1 of the table opposite that activity or event up to the maximum total costs for that type of activity or event set out in Column 4 of the table.

(b) **Certain events or activities on behalf of claimant until dispute referred or order sought**
For an activity or event carried out on behalf of a claimant in any of the following circumstances (other than for an activity or event covered by paragraph (d) of this clause and Part 3 of the table):

(i) the insurer fails to determine a claim as and when required by the 1998 Act,

(ii) the insurer fails to commence weekly payments of compensation or discontinues or reduces weekly payments,

(iii) the insurer makes a reasonable offer of settlement (in the case of a claim for compensation under section 66 or 67 of the 1987 Act),

(iv) the insurer denies liability in respect of the claim by serving a notice under section 74 of the 1998 Act,

—the cost set out in Column 3 of Part 2A of the table opposite that activity or event up to the maximum total costs for that type of activity or event set out in Column 4 of the table.

(c) **Certain activities or events on behalf of insurer until dispute referred or order sought**

For an activity or event carried out on behalf of an insurer in any of the following circumstances (other than for an activity or event covered by paragraph (d) of this clause and Part 3 of the table):

(i) the insurer fails to determine a claim as and when required by the 1987 Act,

(ii) the insurer fails to commence weekly payments of compensation or discontinues or reduces weekly payments of compensation,

(iii) in the case of a claim for compensation under section 66 or 67 of the 1987 Act, the insurer makes a reasonable offer of settlement on the claim,

(iv) the insurer denies liability in respect of the claim by serving a notice under section 74 of the 1998 Act,

—the cost set out in Column 3 of Part 2B of the table opposite that activity or event up to the maximum total costs for that type of activity or event set out in Column 4 of the table.

(d) **Certain applications for expedited assessment**

For an activity or event carried out on behalf of a claimant or insurer in any of the following circumstances:

(i) the insurer fails to determine a claim for medical expenses involving less than $5000,

(ii) the insurer fails to commence weekly payments of compensation where less than 12 weeks' compensation is sought by the claimant and an interim payment order is made by the Registrar (whether or not the interim payment order was sought by a party to the claim),

—the cost set out in Column 3 of Part 3 of the table opposite that activity or event up to the maximum total costs for that type of activity or event set out in Column 4 of the table.

(e) **Referral of dispute to determination of the dispute**

For an activity or event carried out on behalf of a claimant or insurer from the time of referral of a dispute to the Commission to determination of the dispute by the Commission constituted by an Arbitrator—the cost set out in Column 3 of Part 4 of the table opposite that activity or event up to the maximum total costs for that type of activity or event set out in Column 4 of the table.

(f) **Appeal to a Medical Appeal Panel for dispute about degree of permanent impairment**

For an activity or event carried out on behalf of a claimant or insurer in respect of an appeal to a Medical Appeal Panel involving a medical dispute as to the degree of permanent impairment of the injured worker—the cost set out in Column 3 of Part 5 of the table opposite that activity or event up to the maximum total costs for that type of activity or event set out in Column 4 of the table.

(g) **Referral of a question of law to President**

For an activity or event carried out on behalf of a claimant or insurer in respect of the referral of a question of law to the Commission constituted by the President—the cost set out in Column 3 of Part 6 of the table opposite that activity or event up to the maximum

total costs for that type of activity or event set out in Column 4 of the table.

(h) **Registration of agreement under sec 66A of 1987 Act or a commutation agreement**
For an activity or event carried out on behalf of a claimant or insurer in respect of the registration of an agreement under section 66A of the 1987 Act or a commutation agreement—the cost set out in Column 3 of Part 7 of the table opposite that activity or event up to the maximum total costs for that type of activity or event set out in Column 4 of the table.

(i) **Appeals to Presidential member**
For an activity or event carried out on behalf of a claimant or insurer in respect of an appeal to the Commission constituted by a Presidential Member—the cost set out in Column 3 of Part 8 of the table opposite that activity or event up to the maximum total costs for that activity or event set out in Column 4 of the table.

(j) **Any other substantive proceedings before the Commission**
For an activity or event carried out in respect of any other proceedings before the Commission involving the determination of substantive legal issues (including applications for review of existing orders, disputes relating to suitable duties, and disputes relating to apportionment)—the costs set out in Column 3 of Part 9 of the table opposite that activity or event up to the maximum total costs for that type of activity or event set out in Column 4 of the table.

(3) This clause is subject to this Schedule.

2 Multiple claims or disputes in respect of an injury to be treated as a single claim or dispute

(1) In the event that more than one claim is made in respect of a particular injury, or more than one dispute arises in respect of a claim, the maximum total costs for a type of activity or event in respect of the injury, regardless of how many times the activity or event is carried out, is the maximum set out in Column 4 of the table in relation to that type of activity or event.

(2) Subclause (1) does not apply if:

(a) a period of more than 12 months has elapsed between the making of the first claim in respect of the injury and the making of a subsequent claim (and the same applies to each claim subsequent to that claim), or

(b) a period of more than 12 months has elapsed between the notification of the first dispute in respect of the claim and the notification of a subsequent dispute (and the same applies to each dispute subsequent to that dispute), or

(c) the Commission or the Registrar orders that the claims or disputes are to be treated as separate claims or disputes for the purposes of the calculation or assessment of costs.

3 Restrictions on costs

(1) Costs specified in a Part of the table (other than Part 2A or 2B) are payable only for an activity or event that is carried out in the period commencing when the first activity or event specified in that Part is commenced and concluding on either the completion of the last activity or event specified in that Part or finalisation of the matter (whichever occurs first).

(2) Costs specified in Part 2A or 2B of the table are payable only for an activity or event that is carried out in the period commencing when the first activity or event specified in that Part is commenced and concluding on:

(a) the referral of a dispute in respect of the claim to the Commission, or the seeking of an order from the Commission, or

(b) the completion of the last activity or event specified in that Part, or

(c) finalisation of the matter,

whichever occurs first.

(3) If costs specified in Part 3 of the table are payable in relation to a matter, costs specified in Parts 2A, 2B and 4 of the table are payable only in respect of the matter if the matter is subsequently referred for determination after the conduct of an expedited assessment by the Registrar.

4 Costs where multiple insurers party to claim

If more than one insurer (or any combination of insurers) is a party to a claim or a dispute or other matter in relation to a claim, the maximum costs in respect of the matter are the total of the following:

(a) the costs for the matter calculated in accordance with the table,

(b) 50% of that amount per party (other than the party who made the claim),

and payment of the costs is to be shared equally among the insurers who are parties to the matter.

Note. Clause 105 provides that in Part 23 (Costs) and Schedules 6 and 7, the term ***insurer*** includes an employer.

5 Calculation of hourly rates

If an hourly rate is specified for an activity or event in the table, the maximum amount of costs set out for that activity or event is to be calculated to the nearest quarter hour.

6 Substantive legal issues

The Commission or the Registrar may determine, for the purposes of clause 1 (2) (j), whether a particular activity or event is in respect of a substantive legal issue.

7 Special provision for medical disputes and disputes about weekly payments of compensation

Despite any other provision of this Schedule, if a medical dispute or a dispute about weekly payments of compensation is finalised by an agreement for payment of an amount less than $1,000, or an award for payment of an amount less than $1,000, the maximum amount of costs for the dispute is $200.

8 Certain agents not entitled to costs

An agent who is not an agent within the definition of ***agent*** in section 356 (6) of the 1998 Act is not entitled to be paid or recover any costs.

Compensation Costs Table

Column 1 Item No	Column 2 Activity or event	Column 3 Maximum amount for individual activity/event	Column 4 Maximum total for type of activity/ event
Part 1	**Making claim for permanent impairment compensation or pain and suffering compensation**		
1.01	Obtaining and reviewing medical reports (not including medical practitioners' fees for the reports)	If the matter is finalised by the payment of compensation to the claimant—$150 per report If the matter is not finalised by the payment of compensation—nil	$300
1.02	Lodging claim with insurer if the insurer has not already made an offer of settlement	If the matter is finalised by the payment of compensation to the claimant—$100 If the matter is not finalised by the payment of compensation—nil	$100
Part 2A	**Certain events or activities on behalf of claimant until dispute referred or order sought**		
2.01	Obtaining instructions from client	$250 per hour	$250
2.02	Obtaining medical or other reports from insurer or requesting further information	$20 per request	$40 (for any party)
2.03	Referring insurer's reports to a medical specialist or the claimant's nominated treating doctor for review	$20 per referral	$40

Column 1 Item No	Column 2 Activity or event	Column 3 Maximum amount for individual activity/event	Column 4 Maximum total for type of activity/ event
2.04	Referring claimant to medical practitioner for examination, including review (other than where a report has already been obtained under Item 1.01)	$150 per referral	$300
2.05	Briefing a factual investigator or other investigator to obtain witness statements or other evidence (not including the investigator's fee)	$100	$100
2.06	Requesting a review of the claim from the insurer, prior to referral of the matter to the Commission	$250 per hour	$500
2.07	Agreeing terms of settlement with the insurer following a review of the claim by the insurer for a dispute (not being a claim for compensation under section 66 or 67 of the 1987 Act)	$300	$300
2.08	Agreeing terms of settlement with the insurer in the case of a claim for compensation under section 66 or 67 of the 1987 Act following a review of the claim by the insurer	$750	$750

Column 1 Item No	Column 2 Activity or event	Column 3 Maximum amount for individual activity/event	Column 4 Maximum total for type of activity/ event
Part 2B	**Certain activities or events on behalf of insurer until dispute referred or order sought**		
2.09	Obtaining instructions from client where the claimant seeks a review of the insurer's determination of the claim	$250 per hour	$250
2.10	Referring a further report provided by claimant for review	$20 per referral	$40
2.11	Referring claimant to a medical practitioner for further examination	$150 per referral	$300
2.12	Briefing a factual investigator or other investigator to obtain witness statements, surveillance information or other evidence (not including the investigator's fee)	$100	$100
2.13	Providing advice to the insurer in relation to the review of the insurer's determination of the claim sought by the claimant	$250 per hour	$500
2.14	Agreeing terms of settlement with the claimant following a review of the insurer's determination of the claim for a dispute (not being a claim for compensation under section 66 or 67 of the 1987 Act)	$300	$300

Column 1 Item No	Column 2 Activity or event	Column 3 Maximum amount for individual activity/event	Column 4 Maximum total for type of activity/ event
2.15	Agreeing terms of settlement with the claimant in the case of a claim for compensation under section 66 or 67 of the 1987 Act following a review of the insurer's determination of the claim	$750	$750
Part 3	**Certain applications for expedited assessment**		
3.01	Applying for expedited assessment to the Commission	If the application results in the making of an interim payment order—$200 (claimant's legal practitioner or agent only) If the application does not result in the making of an interim payment order—nil	$200 (claimant's legal practitioner or agent only)
Part 4	**Referral of dispute to determination of the dispute**		
4.01	Lodging any of the following with the Commission: (a) an application for resolution of a dispute, (b) a response to an application, (c) an application for expedited assessment, (d) an application for joinder of another party	$300	$300
4.02	Service of material in relation to Item 4.01 on the other parties to the dispute	$40 for the first party, then $20 for each additional party	$100

Column 1 Item No	Column 2 Activity or event	Column 3 Maximum amount for individual activity/event	Column 4 Maximum total for type of activity/ event
4.03	Requesting the Commission to make orders for the production of documents	$60 for the initial order, then $40 for each additional order	$220
4.04	Lodging an objection to a request for an order for the production of documents	$60 per objection	$120
4.05	Reviewing documentation produced under an order of the Commission, exchanging information with the other parties and obtaining further instructions from client	$250 per hour	$500
4.06	Applying for an order for the attendance of witnesses at proceedings before the Commission	$60 for the initial order, then $40 for each additional order	$140
4.07	Applying to refer a matter to an approved medical specialist, or responding to such an application (including costs associated with agreeing on the approved medical specialist and review of the report by the approved medical specialist).	$100	$100
4.08	Preparing for a conference (including providing advice to client)	$250 per hour	$500
4.09	Attending and participating in a conference with an Arbitrator (other than an arbitration hearing or where Item 4.10 applies)	$250 per hour	$1000

Column 1 Item No	Column 2 Activity or event	Column 3 Maximum amount for individual activity/event	Column 4 Maximum total for type of activity/ event
4.10	Attending and participating in a conference with an Arbitrator where the Arbitrator determines that the matter is complex and the matter proceeds directly to arbitration	$250 per hour	$1500
4.11	Attending and participating in an arbitration hearing (other than where Item 4.10 applies, and subject in the case of a claim for compensation under section 66 or 67 of the 1987 Act to any Rules of the Commission relating to offers of compromise or settlement)	$250	$250
4.12	Reporting to the client on the outcome of a conference or arbitration (including finalising the applicant's matter with the Health Insurance Commission or Centrelink (or both))	$150	$150
Part 5	**Appeal to a Medical Appeal Panel for dispute about degree of permanent impairment**		
5.01	Lodgment of appeal and preparation for appeal, or preparation of a response to such an appeal	If the result of the appeal is more favourable to the applicant for appeal—$100 (applicant's legal practitioner or agent only)	$100

Column 1 Item No	Column 2 Activity or event	Column 3 Maximum amount for individual activity/event	Column 4 Maximum total for type of activity/ event
		If the result of the appeal is not more favourable to the applicant for appeal—nil (applicant's legal practitioner or agent only)	
		For the respondent's legal practitioner or agent—$100	$100
5.02	Attendance at a Medical Appeal Panel hearing	If the result of the appeal is more favourable to the applicant for appeal—$200 per hour (applicant's legal practitioner or agent only)	$400
		If the result of the appeal is not more favourable to the applicant for appeal—nil (applicant's legal practitioner or agent only)	
		For the respondent's legal practitioner or agent—$200 per hour	$400

Column 1 Item No	Column 2 Activity or event	Column 3 Maximum amount for individual activity/event	Column 4 Maximum total for type of activity/ event
Part 6	**Referral of a question of law to President**		
6.01	Obtaining advice from counsel and making an application including written submissions, or preparing a response to such an application including written submissions and obtaining advice from counsel (including counsel's fee for advice)	If the President grants leave to appeal—$600 (applicant's legal practitioner or agent only)	$600
		If the President does not grant leave to appeal—nil (applicant's legal practitioner or agent only)	
		For the respondent's legal practitioner or agent—$600	$600
6.02	Attending at proceedings before the Commission constituted by the President without counsel present	$250 per hour	$500
6.03	Attending at proceedings before the Commission constituted by the President with counsel present (including counsel's fee for attendance)	$125 per hour for legal practitioner (other than counsel) or agent	$250
		$300 per hour for counsel	$600
Part 7	**Registration of agreement under sec 66A of 1987 Act or a commutation agreement**		
7.01	All work associated with registration of the agreement	$120	$120

Column 1 Item No	Column 2 Activity or event	Column 3 Maximum amount for individual activity/event	Column 4 Maximum total for type of activity/ event
Part 8	**Appeals to Presidential member**		
8.01	Lodging application or response to such an application including written submissions	$320	$320
8.02	Obtaining the advice of counsel (including counsel's fee for advice)	$500	$500
8.03	Attending at proceedings before the Commission constituted by the President or Deputy President without counsel present	$250 per hour	$500
8.04	Attending at proceedings before the Commission constituted by the President or Deputy President with counsel present (including counsel's fee for attendance)	$125 per hour for legal practitioner (other than counsel) or agent	$250
		$300 per hour for counsel	$600
Part 9	**Any other substantive proceedings before the Commission**		
9.01	Conduct of any other proceedings before the Commission involving the determination of substantive legal issues, including preparatory work	$250 per hour	$625

Schedule 7 Maximum costs for legal services—work injury damages matters

(Clause 110)

1 Costs determined by reference to certain stages in the matter

(1) The maximum costs for legal services provided for a stage of a claim for work injury damages set out in Column 1 of the Work Injury Costs Table A to this clause are the costs set out in Column 2 opposite that stage.

(2) However, if a legal practitioner was first retained in the matter after a certificate as to mediation was issued under section 318B of the 1998 Act (or, if the matter is not referred to mediation because the insurer wholly denies liability, or the insurer has failed to respond to the pre-filing statement, after the service of the pre-filing statement of claim), the maximum costs are those set out in the Work Injury Costs Table B to this clause.

(3) Costs may be charged for more than one stage described in this Schedule.

(4) Other than stage 1 in the Work Injury Costs Table B to this clause, each stage specifies the maximum costs payable for all legal services provided in the period commencing on the occurrence of one specified event and concluding on either the occurrence of another specified event or settlement of the matter (whichever occurs first).

Work Injury Costs Table A

Column 1 Stage		Column 2 Costs
1	From the acceptance of the retainer to the preparation and service of a claim under section 260 of the 1998 Act (including the provision of all relevant particulars under 281 of that Act)	(a) in the case of a legal practitioner acting for a claimant—$200 (b) in the case of a legal practitioner acting for an insurer—nil

Column 1 Stage	Column 2 Costs
2 From service of the claim under section 260 of the 1998 Act to the preparation and service of the pre-filing statement of claim under section 315 of that Act	(a) in the case of a legal practitioner acting for a claimant—$300 (b) in the case of a legal practitioner acting for an insurer—nil
3 If: (a) the matter is referred to mediation and settlement occurs after the service of the pre-filing statement of claim without the issue of a certificate as to mediation under section 318B of the 1998 Act, or (b) the matter is not referred to mediation (because the insurer denies liability) and settlement occurs without the commencement of court proceedings, or (c) the insurer does not respond to the pre-filing statement of claim and settlement occurs without the commencement of court proceedings —from service of the pre-filing statement to finalisation of the matter	In addition to the $500 specified for stages 1 and 2 (if chargeable): (a) if the settlement amount is $20,000 or less and the insurer wholly admitted liability for the claim—$500 (b) if the settlement amount is $20,000 or less and the insurer wholly or partly denied liability for the claim—10% of the settlement amount (c) if the settlement amount is more than $20,000 but less than $50,001 and the insurer wholly admitted liability for the claim—$500 plus 12% of the settlement amount over $20,000 (d) if the settlement amount is more than $20,000 but less than $50,001 and the insurer wholly or partly denied liability for the claim—$2,000 plus 12% of the settlement amount over $20,000 (e) if the settlement amount is $50,001 or more but less than $100,001 and the insurer wholly admitted liability for the claim—$4,100 plus 10% of the settlement amount over $50,000 (f) if the settlement amount is $50,001 or more but less than $100,001 and the insurer wholly or partly denied liability for the claim—$5,600

Column 1 Stage		Column 2 Costs
		(g) if the settlement amount is $100,001 or more and the insurer wholly admitted liability for the claim—$9,100 plus 2% of the settlement amount over $100,000 (h) if the settlement amount is $100,001 or more and the insurer wholly or partly denied liability for the claim—$10,600 plus 2% of the settlement amount over $100,000
4	If the matter is referred to mediation and settlement occurs after the issue of a certificate as to the mediation under section 318B of the 1998 Act but without the commencement of court proceedings—from service of the pre-filing statement to finalisation of the matter	The total of the following: (a) an amount determined, in accordance with stage 3, by reference to the amount of the settlement, (b) 2% of the amount of the settlement
5	If the matter is referred to mediation and is finalised after the commencement of court proceedings (whether by way of settlement or an award of damages)—from service of the pre-filing statement to finalisation of the matter	The total of the following: (a) an amount determined in accordance with stage 4, by reference to the amount of the settlement or award as if that amount were the amount of the settlement referred to in stage 4, (b) 2% of the amount of the settlement or award

Column 1 Stage	Column 2 Costs
6 If the matter is not referred to mediation and the matter is finalised after the commencement of court proceedings (whether by way of settlement or an award of damages)—from service of the pre-filing statement to finalisation of the matter	The total of the following: (a) an amount determined in accordance with stage 3, by reference to the amount of the settlement or award as if that amount were the amount of the settlement referred to in stage 3, (b) 2% of the amount of the settlement or award

Work Injury Costs Table B

Column 1 Stage	Column 2 Costs
1 Advice on the certificate as to mediation (if the matter is referred to mediation)	$250
2 From the giving of advice on the certificate of mediation (or, if the matter is not referred to mediation, from acceptance of the retainer) to finalisation of the matter by settlement or award of damages.	In addition to the $250 specified for stage 1 (if chargeable): (a) if the settlement amount or award is $20,000 or less—nil (b) if the settlement amount or award is more than $20,000 but less than $50,001—10% of the settlement amount or award over $20,000 (c) if the settlement amount or award is $50,001 or more but less than $100,001—$3,000 plus 8% of the settlement amount or award over $50,000 (d) if the settlement amount or award is $100,001 or more—$7,000 plus 2% of the settlement amount or award over $100,000

2 Other costs for legal services

(1) Maximum costs for legal services provided in a claim for work injury damages may include (in addition to the costs for legal services referred to in clause 1) the costs set out in the Other Work Injury Costs Table to this clause.

(2) However, an amount for the fees for senior counsel, or for more than one advocate, are not to be included unless the court so orders.

Other Work Injury Costs Table

	Nature of costs	Maximum costs
1	Costs associated with a dispute under Part 6 of Chapter 7 of the 1998 Act as to whether the degree of permanent impairment of an injured worker is sufficient for an award of damages (including costs associated with referring the dispute for assessment by an approved medical specialist under Part 7 of that Chapter)	$500
2	Costs associated with a dispute under section 317 of the 1998 Act as to whether a pre-filing statement is defective	$200
3	Cost of representation at a mediation under section 318A of the 1998 Act:	
	(a) flat fee	$400
	(b) additional amount, at the mediator's discretion, if the conference exceeds 2 hours	up to $125 per hour (or part of an hour) in excess of 2 hours

	Nature of costs		Maximum costs
4	If the matter was referred to mediation and counsel advised before mediation about settlement:		
	(a)	counsel's fee for advice about settlement	$500 (separate to the daily rate below)
	(b)	cost of representation in court, per day, for advocate other than senior counsel	$1,500
	(c)	cost of representation in court, per day, for senior counsel	$2,200
	If the matter was not referred to mediation:		
	(a)	cost of representation in court, per day, for advocate other than senior counsel	$1,500
	(b)	cost of representation in court, per day, for senior counsel	$2,200

Workers Compensation (General) Amendment (Savings, Transitional and Other Matters) Regulation 2001

under the

Workers Compensation Act 1987 and Workplace Injury Management and Workers Compensation Act 1998

Her Excellency the Governor, with the advice of the Executive Council, has made the following Regulation under the *Workers Compensation Act 1987* and *Workplace Injury Management and Workers Compensation Act 1998*.

JOHN DELLA BOSCA, M.L.C.,
Special Minister of State

Explanatory note

The *Workers Compensation Legislation Amendment Act 2001* and the *Workers Compensation Legislation Further Amendment Act 2001* make a number of changes to workers compensation legislation.

The object of this Regulation is to amend the *Workers Compensation (General) Regulation 1995* so as to provide for savings and transitional matters, to make amendments consequential to the proposed changes and to implement some of the proposed changes. In particular, this Regulation:

(a) revises the information required to be given to a worker when payments of weekly compensation are proposed to be discontinued or reduced, or when liability to make payments is disputed, and

(b) requires employers and insurers to give copies of certain reports to workers on the request of the worker, and

(c) provides for conciliation of disputes to cease on 1 January 2002, and

(d) limits the application of provisions restricting the number of medical reports that can be admitted in proceedings to existing claims (for new claims this matter will be dealt with by Rules of the new Workers Compensation Commission), and

(e) extends restrictions on recovery of the cost of medical reports to medical reports provided in connection with provisional weekly payments of compensation, and

(f) exempts employers or insurers from paying any costs of a medical assessment or an appeal against a medical assessment if the worker failed without reasonable excuse to attend a medical examination for the assessment or a hearing on the appeal, and

(g) provides for the arrangement of business before the new Workers Compensation Commission, and

(h) provides for requirements as to evidence relating to a restriction on the new Workers Compensation Commission entering an award to give effect to an agreement for lump sum compensation to be dealt with by Rules of the Commission, and

(i) makes consequential modifications to deal with the cessation of conciliation, and

(j) modifies the new provisions of the *Workplace Injury Management and Workers Compensation Act 1998* that provide for medical assessments for permanent impairment compensation in their application to claims in respect of injuries received before the commencement of the provisions dealing with new claims procedures, and

(k) provides for all existing claims to be treated as new claims on and from 1 April 2002, or, if an application in respect of the claim is pending in the Compensation Court on that date, on the day on which the Compensation Court determines the dispute or the parties register an agreement under section 66A of the 1987 Act, whichever occurs first, and

(l) provides for binding medical certificates issued in respect of existing claims before the commencement of the new claims procedures to have continuing effect, so that a further medical assessment under the new procedures is not required, and

(m) preserves the effect of a clause providing for the funding of the WorkCover Authority, and

(n) continues and modifies provisions for conciliation of disputes for coal miners, and

(o) provides for transitional arrangements with respect to:

(i) the extension of the Uninsured Liability and Indemnity Scheme to common law damages for a work injury,

(ii) the appointment of mediators for claims for work injury damages,

(p) provides for certain offences under the workers compensation legislation to be penalty notice offences (that is, offences for which "on the spot" fines may be issued).

This Regulation is made under the *Workers Compensation Act 1987* and *Workplace Injury Management and Workers Compensation Act 1998*, including sections 54, 63A, 66B and 280 of the 1987 Act, and Parts 18 and 18C of Schedule 6 and clause 2 of Part 20 of Schedule 6 to that Act, and sections 73, 74, 119, 246, 248, 297, 330, 349 and 357 of the 1998 Act.

Workers Compensation (General) Amendment (Savings, Transitional and Other Matters) Regulation 2001

1 Name of Regulation

This Regulation is the *Workers Compensation (General) Amendment (Savings, Transitional and Other Matters) Regulation 2001*.

2 Commencement

This Regulation commences on 1 January 2002.

3 Amendment of Workers Compensation (General) Regulation 1995

The *Workers Compensation (General) Regulation 1995* is amended as set out in Schedule 1.

Schedule 1 Amendments

(Clause 3)

[1] Clause 15

Omit the clause. Insert instead:

15 Notice of intention to discontinue or reduce weekly payments

(1) The notice referred to in section 54 of the 1987 Act must:

(a) include a statement of the reason for the decision to discontinue payment, or reduce the amount, of weekly payments of compensation, and

(b) include a statement of the particulars that support the reason for the decision, including the required details for each report (if any) that is relied on to support that reason, and

(c) include a statement advising that the worker may request a copy of a report specified in the statement of particulars from the person paying compensation, and

(d) include a statement advising that the worker may request the person paying the compensation to review the decision and advising of the procedure for making such a request, and

(e) include a statement advising that if the worker disputes the discontinuation or reduction of weekly payments:

(i) in the case of a dispute about a claim that is an existing claim within the meaning of Chapter 7 of the 1998 Act, the worker may apply to the Compensation Court for determination of the dispute, or

(ii) in the case of a dispute about a claim that is a new claim within the meaning of Chapter 7 of the 1998 Act, the worker may refer the dispute to the Registrar for determination by the Commission, and

(f) include the address and fax number for the registrar of the Compensation Court or the Registrar of the Commission, as appropriate.

(2) If:

(a) the notice referred to in section 54 relates to a reduction in the amount of weekly payments of compensation as a result of the application of section 40 of the 1987 Act, and

(b) the worker is not in receipt of earnings (or the compensation is otherwise calculated on the basis of the worker's ability to earn after the injury, rather than on the worker's actual earnings after the injury),

the notice must also include a statement of how the compensation (to be so reduced) has been calculated.

(3) In this clause:

required details, in relation to a report, means the subject matter of the report, the name and relevant professional qualifications of the person who wrote the report and the date of the report.

[2] Clause 30 Revocation by Authority of direction under sec 63A (4)

Insert "or the Commission" after "order of the Compensation Court" in clause 30 (4).

[3] Clause 35 Application of Part to proceedings pending in Compensation Court

Insert "or the Commission" after "pending in the Compensation Court".

[4] Clause 35 (a)

Insert "or the Commission" after "the Court".

[5] Clause 36 Disputes—conciliation procedures etc

Omit the clause.

[6] Clauses 39 and 40

Omit the clauses.

[7] Clause 40A Notice of dispute about liability

Omit clause 40A (1). Insert instead:

(1) The notice given to a claimant under section 74 of the 1998 Act must:

(a) include a statement of the particulars that support the reason for the decision, including the required details for each report (if any) on which the insurer relies to support that reason, and

(b) include a statement advising that the claimant may request a copy of a report specified in the statement of particulars from the insurer, and

(c) include a statement advising that the claimant may request the insurer to review the decision, and advising of the procedure for making such a request, and

(d) include a statement to the effect that:

(i) in the case of a dispute about a claim that is an existing claim within the meaning of Chapter 7 of the 1998 Act, the claimant may apply to the Compensation Court for determination of the dispute, or

(ii) in the case of a dispute about a claim that is a new claim within the meaning of Chapter 7 of the 1998 Act, the claimant may refer the dispute to the Registrar for determination by the Commission, and

(e) include the address and fax number for the registrar of the Court or the Registrar of the Commission, as appropriate.

Note. Section 74 of the 1998 Act also requires the notice to include a statement of the reason the insurer disputes liability.

[8] Clause 40A (4)

Insert after clause 40A (3):

(4) In this clause:

required details, in relation to a report, means the subject matter of the report, the name and relevant professional qualifications of the person who wrote the report and the date of the report.

[9] Clause 41 Form of notice to be posted up at workplace

Omit clause 41 (2)–(6). Insert instead:

(2) Any form approved for the time being by the Authority is an ***approved form*** for the purposes of this clause.

(3) An approved form that ceases to be an approved form (as a result of the amendment or substitution of a form approved by the Authority) continues to be an approved form for the purposes of a notice posted up under section 231 of the 1998 Act that was in that form immediately before it ceased to be an approved form, but only until the earlier of:

(a) the renewal or replacement of the notice, or

(b) 12 months after the form ceases to be an approved form.

(4) A notice posted up under section 231 of the 1998 Act that, immediately before the commencement of this subclause (as inserted by the *Workers Compensation (General) Amendment (Savings, Transitional and Other Matters) Regulation 2001*), was in the form of Form 2 of Schedule 1 (as in force immediately before its repeal by that Regulation) continues to be in the form of an approved form for the purposes of section 231 until 30 June 2002.

[10] Clauses 42A and 42B

Insert after clause 42:

42A Access to certain reports obtained by insurer: sec 73 of 1998 Act

(1) A worker may request an insurer to supply the worker with a copy of a report obtained by the insurer and specified in a notice to the worker under section 54 ((Notice required before termination or reduction of payment of weekly compensation) of the 1987 Act or a notice under section 74 (Insurers to give notice and reasons when liability disputed) of the 1998 Act.

(2) An insurer who receives a request for a copy of such a report must, within 10 days after receiving the request, supply the worker (or a legal practitioner or agent acting on behalf of the worker) with a copy of the report.

Note. A worker may also request from the employer or insurer under clause 43A a copy of a medical opinion or report obtained by the employer, or a medical report relating to treatment of the worker on a disputed claim under section 126 of the 1998 Act.

(3) If the insurer is of the opinion that supplying the worker with a copy of a medical report would pose a serious threat to the life or health of the worker or any other person, the insurer may instead supply the medical report to a medical practitioner nominated by the worker for that purpose.

42B Interim payment direction not presumed to be warranted: sec 297 of 1998 Act

For the purposes of section 297 (3) (e) of the 1998 Act, it is not to be presumed that an interim payment direction for weekly payments of compensation is warranted in circumstances where the insurer has given the worker notice under section 74 of the 1998 Act (Insurers to give notice and reasons when liability disputed).

[11] Clause 43A

Insert after clause 43:

43A Access to medical opinion or report obtained by employer: sec 119 of 1998 Act

(1) A worker may request the employer or insurer to supply the worker with a copy of a medical opinion or report furnished to the employer or insurer under section 119 (Medical examination of workers at direction of employer) of the 1998 Act and specified in a notice to the worker under section 54 (Notice required before termination or reduction of payment of weekly compensation) of the 1987 Act or a notice under section 74 (Insurers to give notice and reasons when liability disputed) of the 1998 Act.

(2) An employer or insurer who receives a request for a copy of such a report must, within 10 days after receiving the request, supply the worker (or a legal practitioner or agent acting on behalf of the worker) with a copy of the report.

Note. A worker may also request from the insurer under clause 42A a copy of other reports obtained by the insurer, or a medical report relating to treatment of the worker on a disputed claim under section 126 of the 1998 Act.

(3) If the employer or insurer is of the opinion that supplying the worker with a copy of a medical opinion or report would pose a serious threat to the life or health of the worker or any other person, the employer or insurer may instead supply the medical report to a medical practitioner nominated by the worker for that purpose.

[12] Clause 44 Application to refer matter to medical referee or panel etc

Insert at the end of the clause:

(2) This clause applies only in respect of existing claims and existing claim matters within the meaning of Chapter 7 of the 1998 Act.

[13] Part 13 Conciliation of disputes

Omit the Part.

[14] Clause 51E Definitions

Omit "a conciliator" from the definition of ***proceedings***.
Insert instead "the Commission".

[15] Clause 51F Restrictions on number of medical reports that can be admitted

Insert before clause 51F (1):

(1A) This clause applies only in respect of existing claims and existing claim matters within the meaning of Chapter 7 of the 1998 Act.

[16] Clause 51G Permissible updates of medical reports

Insert before clause 51G (1):

(1A) This clause applies only in respect of existing claims and existing claim matters within the meaning of Chapter 7 of the 1998 Act.

[17] Clause 51H Restrictions on recovery of cost of medical reports

Insert after clause 51H (2) (a):

(a1) a medical certificate that accompanies an initial notification of injury,

[18] Clause 51H (3)

Insert at the end of clause 51H:

(3) In this clause:

(a) a reference to a claim includes an initial notification of injury (as defined in Part 3 of Chapter 7 of the 1998 Act), and

(b) a reference to proceedings on a claim includes proceedings in respect of the payment of provisional weekly payments of compensation under that Part.

[19] Clause 51J Reports of medical panels and referees not affected

Insert "in connection with an existing claim" after "medical referee" in clause 51J (a).

[20] Clause 51J (b)

Insert "in connection with an existing claim" after "the 1998 Act".

[21] Clause 51J (c)

Insert at the end of clause 51J (b):

, or

(c) a medical report provided by an approved medical specialist under Part 7 of Chapter 7 (Medical assessment) of the 1998 Act in respect of the assessment of a new claim.

[22] Clause 51J (2)

Insert at the end of clause 51J:

(2) In this clause:

existing claim and ***new claim*** have the same meaning as in Chapter 7 of the 1998 Act.

[23] Clauses 82–104

Insert after clause 81:

82 Costs of medical assessment: sec 330 of 1998 Act

(1) An employer or insurer is not required to pay any costs of medical assessment in connection with:

(a) a medical assessment under Part 7 of Chapter 7 of the 1998 Act, if the worker failed without reasonable excuse to submit himself or herself to a medical examination conducted for the assessment, or

(b) any further examination conducted for a medical assessment referred to in paragraph (a), or

(c) an appeal against such a medical assessment, if the worker failed without reasonable excuse to attend a hearing on the appeal, or

(d) any further hearing held on an appeal referred to in paragraph (c).

(2) The worker is required to pay any costs of assessment referred to in subclause (1) (a)–(d).

83 Arrangement of business before Commission: sec 349 of 1998 Act

(1) The President determines which Presidential member will hear an appeal against a decision of an Arbitrator or an application for leave to appeal.

(2) The Registrar determines which Arbitrator will hear any other matter before the Commission.

84 Proceedings to enter up award on agreement for compensation: sec 66B of 1987 Act

An application for determination of a claim for compensation by way of an award to give effect to an agreement between the parties may be lodged only if the application is accompanied by such evidence that the proceedings are not prevented by section 66B of the 1987 Act from being entertained by the Commission as is specified by the Rules of the Commission for that purpose.

Part 21 Provisions consequent on enactment of 2001 amending Acts

Division 1 Preliminary

85 Definitions

In this Part:

existing claim, ***existing claim matter***, ***new claim*** and ***new claim matter*** have the same meaning as in Chapter 7 of the 1998 Act.

amending Acts means the *Workers Compensation Legislation Amendment Act 2001* and the *Workers Compensation Legislation Further Amendment Act 2001*.

Division 2 Cessation of conciliation

86 Cessation of conciliation

(1) On and from 1 January 2002:

(a) Divisions 3 and 4 of Part 2 of Chapter 4 of the 1998 Act cease to apply to all existing claims and there is to be no further conciliation of disputes in respect of existing claims on and from that date, and

(b) a provision of the 1987 Act or the 1998 Act is of no further force or effect to the extent that it confers or imposes a power, authority, duty or function on a conciliator or the Principal Conciliator or provides for conciliation of a dispute.

(2) If a dispute has been referred to conciliation before the commencement of this clause and a conciliation certificate has not been issued before that commencement, court proceedings may be commenced with respect to the dispute in accordance with sections 101–103 of the 1998 Act (as modified by clauses 87–90).

87 Modification of section 101 of 1998 Act (Restrictions on commencing court proceedings about weekly payments)

(1) Section 101 of the 1998 Act is modified by replacing subsections (1)–(3) with the following subsection:

(1) On and from 1 January 2002, a worker cannot commence court proceedings in respect of weekly payments of compensation within 21 days after the worker made the claim for that compensation.

(2) This clause applies whether the claim for compensation was made before or after the commencement of this clause.

88 Modification of section 102 of 1998 Act (Restrictions on commencing court proceedings for lump sum compensation)

(1) Section 102 of the 1998 Act is modified by replacing subsections (1)–(3) with the following subsection:

(1) On and from 1 January 2002, a worker cannot commence court proceedings in respect of compensation under section 66 of the 1987 Act (as in force immediately before its amendment by the amending Acts) within 2 months after the worker made the claim for that compensation.

(2) This clause applies whether the claim for compensation was made before or after the commencement of this clause.

89 Modification of section 103 of 1998 Act (Restrictions on commencing court proceedings about medical, hospital and other expenses)

(1) Section 103 of the 1998 Act is modified by replacing subsections (1)–(3) with the following subsection:

(1) On and from 1 January 2002, a worker cannot commence court proceedings in respect of compensation under Division 3 (Compensation for medical, hospital and rehabilitation expenses etc) or Division 5 (Compensation for property damage) of Part 3 of the 1987 Act within 28 days after the worker made the claim for that compensation.

(2) This clause applies whether the claim for compensation was made before or after the commencement of this clause.

90 Modification of sec 74 of 1998 Act (Insurers to give notice and reasons when liability disputed)

On and from 1 January 2002, section 74 of the 1998 Act as it applies to existing claims (that is, as in force immediately before its amendment by the *Workers Compensation Legislation Amendment Act 2001*) is modified by omitting section 74 (2) (b) and (c).

91 Modification of sec 121 of 1998 Act (Assessment of medical disputes by approved medical specialists)

On and from 1 January 2002, section 121 is modified by reading the reference to the Principal Conciliator in section 121 (2) (b) as a reference to the Registrar of the Commission.

Division 3 Medical assessment of new claims in respect of pre-commencement injuries

92 Assessment of impairment dispute

The following modifications are prescribed to Part 7 of Chapter 7 of the 1998 Act as that Part applies to a new claim in respect of an injury received before the day on which that Part commences:

(a) omit section 322 (Assessment of impairment),

(b) omit section 323 (Deduction for previous injury or pre-existing condition or abnormality).

Division 4 Transfer of existing claims

93 Transfer of existing claims

(1) On and from 1 April 2002, each existing claim in respect of which there is no pending application for determination by the Compensation Court is to be treated as a new claim for the purposes of the Workers Compensations Acts (under clause 5 of Part 18C of Schedule 6 to the 1987 Act).

(2) An existing claim in respect of which an application for determination by the Compensation Court is pending on 1 April 2002 is to be treated as a new claim for the purposes of the Workers Compensation Acts (under clause 5 of Part 18C of Schedule 6 to the 1987 Act):

(a) on the day on which the Compensation Court makes a final award or order determining the claim (including a consent award or order), or

(b) on the day on which the claim is resolved by an agreement between the parties being registered under section 66A of the 1987 Act,

whichever occurs first.

(3) Despite section 105 of the 1998 Act, the Compensation Court has jurisdiction to examine, hear and determine the following matters with respect to existing claims that are treated as new claims under this clause:

(a) reconsideration of a matter to amend a judgment, award or order within 28 days after the judgment, award or order was made or given,

(b) reconsideration of a matter that has been remitted to the Compensation Court for reconsideration by the Court of Appeal,

(c) matters arising under section 112 (Costs) of the 1998 Act, if an application for an order with respect to costs is made within 28 after the day on which the final award or order determining the claim was made,

(d) the making of orders as to matters ancillary to proceedings before the court (for example, matters such as the return of exhibits or enforcement of awards).

94 Transitional provision—medical certificates

(1) If a binding medical certificate has been given for a dispute with respect to an existing claim before the day on which the existing claim is to be treated as a new claim under this Division, then after that day:

(a) the binding medical certificate is conclusively presumed to be correct as to a matter on which the certificate was conclusive evidence when it was issued, and

(b) the dispute is not required to be assessed under Part 7 of Chapter 7 of the 1998 Act (despite section 293 of that Act and clause 4 of Part 18C of Schedule 6 to the 1987 Act).

(2) In this clause:

binding medical certificate means a certificate given under one of the following provisions of the 1998 Act:

(a) section 121 (Assessment of medical disputes by approved medical specialists),

(b) section 122 (Referral of medical disputes to referee or panel on application of worker or employer).

Division 5 Miscellaneous

95 Uninsured Liability and Indemnity Scheme

An amendment made by Schedule 9 to the *Workers Compensation Legislation Further Amendment Act 2001* does not apply in respect of an injury received before the commencement of the amendment.

96 Repeal of private insurance arrangements

The commencement of an amendment made by Schedule 6 to the *Workers Compensation Legislation Further Amendment Act 2001* does not affect clause 73M (Contributions to WorkCover Authority Fund) or anything done under that clause.

97 Appointment of mediators

(1) The President may select one or more Arbitrators to act as mediators until such time as the President appoints one or more persons to be mediators under section 318F of the 1998 Act.

(2) An Arbitrator selected by the President under this clause:

(a) has and may exercise all the functions of a mediator under the 1998 Act, and

(b) ceases to have those functions when one or more mediators are appointed.

Part 22 Provisions for coal miners consequent on enactment of 2001 amending Acts

98 Definitions

In this Part:

amending Acts means the *Workers Compensation Legislation Amendment Act 2001* and the *Workers Compensation Legislation Further Amendment Act 2001*.

Compensation Court conciliator means an officer or employee of the Compensation Court nominated by the registrar of the Compensation Court to carry out conciliation in connection with a claim for compensation in respect of an injury received by a coal miner.

coal miners has the same meaning as in clause 3 of Part 18 of Schedule 6 to the 1987 Act.

99 Compensation Court conciliators

(1) A Compensation Court conciliator has and may exercise all the powers, authorities, duties and functions conferred on a Compensation Court conciliator as a result of the operation of this Part.

(2) The Chief Judge of the Compensation Court may issue guidelines for or with respect to the referral of disputes for conciliation and the conduct of conciliations.

100 Conciliation

On and from 1 January 2002, Divisions 3 and 4 of Part 2 of Chapter 4 of the 1998 Act apply to coal miners subject to the following modifications:

(a) read a reference in those provisions to a conciliator as a reference to a Compensation Court conciliator,

(b) read a reference in those provisions to the Principal Conciliator as a reference to the Chief Judge of the Compensation Court,

(c) omit sections 77 and 78 (1),

(d) read section 78 (2) as requiring the Compensation Court to refer a dispute in respect of which proceedings have been commenced in the Court to a Compensation Court conciliator for conciliation,

(e) omit sections 79A and 81A,

(f) read section 84 (2) as requiring a Compensation Court conciliator to issue a conciliation certificate at the conclusion of the conciliation (including conclusion by way of cessation pursuant to section 90 (as modified by paragraph (j))),

(g) read section 84 (5) as if the words "A conciliation certificate is a certificate as to such of the following matters as the Principal Conciliator directs" were omitted and the following words were inserted instead: "A conciliation certificate is a certificate as to the following matters",

(h) omit section 87 (1) and (5) and read section 87 (4) as providing that Compensation Court conciliators are subject to Rules of the Compensation Court as well as to guidelines issued by the Chief Judge,

(i) omit section 88,

(j) read section 90 as providing (in addition to the matters provided for in that section) that:

(i) conciliation must cease 35 days after the Compensation Court conciliator notifies the parties that the dispute has been referred to conciliation if, before the expiry of that period, the conciliator has not issued a certificate certifying that the conciliation was successful, unless the parties to the conciliation agree to continue the conciliation for a specified period of time (which period may be extended by further agreement), and

(ii) the Compensation Court may not proceed to hear or determine a dispute that has been referred to conciliation until conciliation of the dispute has concluded (whether or not by way of cessation pursuant to section 90 (as modified by this paragraph)).

101 Modification of section 101 of 1998 Act (Restrictions on commencing court proceedings about weekly payments)

(1) Section 101 of the 1998 Act is modified in its application to coal miners by replacing subsections (1)–(3) with the following subsection:

(1) On and from 1 January 2002, a worker cannot commence court proceedings in respect of weekly payments of compensation within 28 days after the worker made the claim for that compensation.

(2) This clause applies whether the claim was made before or after the commencement of this clause.

102 Modification of section 102 of 1998 Act (Restrictions on commencing court proceedings for lump sum compensation)

(1) Section 102 of the 1998 Act is modified in its application to coal miners by replacing subsections (1)–(3) with the following subsection:

(1) On and from 1 January 2002, a worker cannot commence court proceedings in respect of compensation under section 66 of the 1987 Act (as in force immediately before its amendment by the amending Acts) within 2 months after the worker made the claim for that compensation.

(2) This clause applies whether the claim was made before or after the commencement of this clause.

103 Modification of section 103 of 1998 Act (Restrictions on commencing court proceedings about medical, hospital and other expenses)

(1) Section 103 of the 1998 Act is modified in its application to coal miners by replacing subsections (1)–(3) with the following subsection:

(1) On and from 1 January 2002, a worker cannot commence court proceedings in respect of compensation under Division 3 (Compensation for medical, hospital and rehabilitation expenses

etc) or Division 5 (Compensation for property damage) of Part 3 of the 1987 Act within 28 days after the worker made the claim for that compensation.

(2) This clause applies whether the claim was made before or after the commencement of this clause.

104 Application of amendments made by Workers Compensation (General) Amendment (Savings, Transitional and Other Matters) Regulation 2001

(1) Subject to subclause (2), the amendments made by the *Workers Compensation (General) Amendment (Savings, Transitional and Other Matters) Regulation 2001* do not apply to or in respect of coal miners.

(2) The following amendments made by that Regulation apply to and in respect of coal miners:

(a) the amendment that inserts this Part, and

(b) the amendment that repeals Part 13 (Conciliation of disputes).

[24] Schedule 1 Forms

Omit Form 2.

[25] Schedule 5 Penalty notice offences

Insert in appropriate order by section number in Part 1 (Provisions of 1987 Act) of Schedule 5:

Section 192A (4A)	Not comply sec 192A (4) direction (administration of claims)	500

[26] Schedule 5 Part 1

Omit the matter relating to sections 63 (5), 69 (1) (a), 69 (1) (b), 69 (1) (c), 126 (2), 231 (3), 232 (2) (a) and 232 (2) (b).

[27] Schedule 5 Part 2

Insert in appropriate order by section number in Part 2 (Provisions of 1998 Act):

Section 63 (5)	Manager mine/quarry contravene sec 63 (1) (register of injuries)	500
Section 63 (5)	Occupier factory/workshop/office/shop contravene sec 63 (1) (register of injuries)	500
Section 69 (1) (a)	Not forward claim/documents to insurer within 7 days	500
Section 69 (1) (b)	Not provide further information to insurer within 7 days	500
Section 69 (1) (c)	Not pay compensation money as soon as practicable	500
Section 74A (3)	Fail to comply with direction under sec 74A (insurer to pay compensation promptly)	500
Section 126 (2)	Employer/insurer not supply medical report within 10 days	200
Section 231 (3)	Manager mine/quarry contravene sec 231 (post summary of Act)	200
Section 231 (3)	Occupier factory/workshop/office/shop contravene sec 231 (post summary of Act)	200
Section 232 (2) (a)	Employer/employer's agent fail to supply information to worker	200
Section 232 (2) (b)	Employer/employer's agent supply false/misleading information to worker	200
Section 256 (5)	Manager mine/ quarry contravene sec 256 (1) (register of injuries)	500

Section 256 (5)	Occupier site/factory/ workshop/office/shop contravene sec 256 (1) (register of injuries)	500
Section 264 (1)	Not forward claim/documents to insurer within 7 days	500
Section 264 (2)	Not furnish insurer with information/documentation in possession/reasonably obtainable within 7 days after request	500
Section 264 (3)	Not pay compensation money as soon as practicable	500
Section 267 (5)	Fail to commence weekly payments	500
Section 268	Fail to give notice of reasonable excuse within 7 days	500
Section 268	Fail to include in notice details of reasonable excuse/statement of entitlement/details of making claim	500
Section 283 (1)	Fail to determine a claim as and when required	500
Section 285	Referring non-genuine dispute	500
Section 290 (2)	Not comply sec 290 (information exchange between parties)	500
Section 343 (4) (a)	Claim lien without entitlement	500
Section 343 (4) (b)	Deducts costs from sum awarded/ordered/agreed without entitlement	500
Section 357 (3)	Fail to comply with direction under sec 357 (power to require information)	500
Section 358 (3)	Contravene direction under sec 358 (power to provide documents and information)	500
Section 359 (2)	Fail to comply with summons	500

Workers Compensation (Insurance Premiums) Amendment (Cost of Claims) Regulation 2001

under the

Workers Compensation Act 1987

Her Excellency the Governor, with the advice of the Executive Council, has made the following Regulation under the *Workers Compensation Act 1987*.

JOHN DELLA BOSCA, M.L.C.,
Special Minister of State

Explanatory note

The *Workers Compensation Legislation Amendment Act 2001* amends the *Workplace Injury Management and Workers Compensation Act 1998* to require insurers to commence weekly payments of compensation on a provisional basis within 7 days of receiving notification of an injury. As a result, insurers will be making provisional weekly payments of compensation before any formal claim for compensation is received. Insurers may also make provisional payments of medical expenses compensation on the basis of provisional acceptance of liability.

The object of this Regulation is to provide for such provisional payments of weekly compensation or medical expenses compensation to be taken into account in determining the costs for an insurer of claims for compensation with respect to particular employers. This information is used in determining premiums for workers compensation insurance policies.

The Regulation also makes an amendment by way of law revision.

This Regulation is made under the *Workers Compensation Act 1987*, including section 173 and section 280 (the general regulation-making power).

Workers Compensation (Insurance Premiums) Amendment (Cost of Claims) Regulation 2001

1 Name of Regulation

This Regulation is the *Workers Compensation (Insurance Premiums) Amendment (Cost of Claims) Regulation 2001*.

2 Commencement

This Regulation commences on 1 January 2002.

3 Amendment of Workers Compensation (Insurance Premiums) Regulation 1995

The *Workers Compensation (Insurance Premiums) Regulation 1995* is amended as set out in Schedule 1.

Schedule 1 Amendments

(Clause 3)

[1] Clause 10 Definition

Omit the definition of ***cost of claims***. Insert instead:

cost of claims, in relation to an injury year or a period of insurance, means the total of the following costs:

(a) the total of the costs of each individual claim of which the insurer has notice at the time of expiry or renewal (as appropriate) of the policy concerned, being a claim made against a particular employer with respect to an injury received (or that is deemed by the Act or the former Act to have been received) during the injury year or the period of insurance, whichever is relevant, but not including:

(i) in relation to a policy issued or renewed so as to take effect at or after 4 pm on 30 June 1998 (other than a policy to which subparagraph (ii) applies), any claim under section 10 (Journey claims) of the Act, or

(ii) in relation to a policy issued or renewed so as to take effect at or after 4 pm on 30 June 1995, any claim under section 10 (Journey claims) or section 11 (Recess claims) of the Act,

(b) the total of the costs of payment of provisional weekly payments of compensation and provisional payment of medical expenses compensation, if any, under Part 3 of Chapter 7 of the 1998 Act by the insurer, being payments of compensation on the basis of provisional acceptance of liability to a worker employed by a particular employer with respect to an injury received (or that is deemed by the Act to have been received) during the injury year or the period of insurance.

[2] Clause 11A

Insert after clause 11:

11A Cost of provisional payments of compensation

(1) For the purposes of this Regulation, the cost of payment of provisional weekly payments of compensation and provisional payment of medical expenses compensation, if any, with respect to a particular injury is (except as provided by subclause (2)) the sum of the following:

(a) the sum of the payments of provisional weekly payments of compensation and provisional medical expenses compensation, if any, made by the insurer in respect of the injury pursuant to the 1998 Act,

(b) fees and expenses, if any, paid by the insurer to medical practitioners, investigators or assessors in respect of the investigation of the injury,

(c) legal costs, if any, paid by the insurer in relation to the investigation of the injury, the determination of liability to make provisional weekly payments of compensation or provisional payment of medical expenses compensation and otherwise in complying with Divisions 1 and 3 of Part 3 of Chapter 7 of the 1998 Act,

(d) the most accurate estimation for the time being of the insurer's outstanding liability to make provisional weekly payments of compensation and provisional payment of medical expenses compensation, if any, with respect to the injury,

whether the payments were made or the fees, expenses or costs were paid (or the estimation relates to liability that will arise) during or after the injury year or period of insurance in which the injury was received (or is deemed by the Act to have been received).

(2) However, the cost of provisional weekly payments of compensation and provisional payment of medical expenses compensation with respect to a particular injury:

(a) does not include any amount calculated by reference to the insurer's costs of administration or profit, and

(b) is to be reduced by the amounts, if any, that have been recovered or are recoverable by the insurer with respect to the provisional payments under the 1998 Act, and

(c) does not include any amount paid or payable under section 64A (Compensation for cost of interpreter services) of the 1987 Act, and

(d) is to be reduced by an amount that is the most accurate estimation for the time being by the insurer of the amount of any input tax credit or decreasing adjustment that may be claimed or has been claimed by the insurer in respect of the payments, fees, expenses or costs included in the cost of provisional weekly payments of compensation or provisional payment of medical expenses compensation under subclause (1), pursuant to the *A New Tax System (Goods and Services Tax) Act 1999* of the Commonwealth.

(3) In this clause, references to the insurer's outstanding liability to make provisional weekly payments of compensation or provisional payment of medical expenses compensation with respect to an injury are references to the amount calculated to be sufficient to meet all reasonably likely future provisional payments of weekly compensation or medical expenses compensation in respect of the injury.

[3] Clause 28 Interpretation

Omit "clause 11" from the definition of ***cost of claims*** in clause 28 (1). Insert instead "Part 3".

Rules

Interim Workers Compensation Commission Rules 2001

under the

Workplace Injury Management and Workers Compensation Act 1998

I John Della Bosca, Special Minister of State, do by this my Order make the following Rules of the Workers Compensation Commission in pursuance of the *Workplace Injury Management and Workers Compensation Act 1998*.

JOHN DELLA BOSCA, M.L.C.,
Special Minister of State

Explanatory note

The object of these rules is to provide interim rules for the Workers Compensation Commission.

The rules make provision for the following matters in connection with the jurisdiction of the Commission under the *Workers Compensation Act 1987* and the *Workplace Injury Management and Workers Compensation Act 1998*:

(a) administrative matters (including the establishment and location of the Commission's Registry and its hours of business),

(b) the commencement of proceedings before the Commission,

(c) the parties to proceedings before the Commission,

(d) dispute resolution procedures,

(e) proceedings before the Commission,

(f) medical assessments and evidence,

(g) appeals,

(h) work injury damages.

These rules are made under the *Workplace Injury Management and Workers Compensation Act 1998*, including section 364 (the general rule-making power).

Contents

Interim Workers Compensation Commission Rules 2001

Contents

Interim Workers Compensation Commission Rules 2001

Contents

Interim Workers Compensation Commission Rules 2001

Part 1 Preliminary

1 Name of Rules

These rules are the *Interim Workers Compensation Commission Rules 2001*.

2 Commencement

These rules commence on 1 January 2002.

3 Interpretation

(1) In these rules:

approved medical specialist means a medical practitioner appointed under Part 7 of Chapter 7 of the 1998 Act as an approved medical specialist.

applicant means a person referring a matter to the Commission for determination.

electronic communication means:

(a) a communication of information in the form of data, text or images by means of guided or unguided electromagnetic energy, or both, or

(b) a communication of information in the form of sound by means of guided or unguided electromagnetic energy, or both, where the sound is processed at its destination by an automated voice recognition system.

party means a party to proceedings before a mediator or the Commission.

proceedings means proceedings before a mediator or the Commission.

respondent means a person who is a party to a dispute other than the applicant.

sealed means affixed with the seal of the Commission.

Workers Compensation Acts means the 1987 Act and the 1998 Act.

1987 Act means the *Workers Compensation Act 1987*.

1998 Act means the *Workplace Injury Management and Workers Compensation Act 1998*.

(2) Words and expressions used in these rules have the same meanings as they have in the Workers Compensation Acts unless the context or subject-matter otherwise indicates or requires.

(3) When these rules provide for notice to be given, that notice is to be given in writing unless otherwise specified. Notice in writing includes notice given by electronic communication in accordance with the Rules.

(4) A reference in these rules to the Commission includes a reference to the Registrar or any other member of the Commission, as the context requires.

(5) A reference in these rules to a section of a particular number is, unless otherwise indicated, to be read as a reference to the section of that number of the 1998 Act.

4 Procedure wanting or in doubt

(1) If a person desires to commence proceedings or take any step in any proceedings, and the manner or form of procedure is not prescribed by the Workers Compensation Acts or these rules, or by or under any other Act, or the person is in doubt as to the manner or form of procedure, the Commission may, on application by the person in the approved form, or of its own motion, give directions.

(2) Proceedings commenced in accordance with the directions of the Commission are taken to be properly commenced.

(3) A step taken in accordance with the directions of the Commission is taken to be regular and sufficient.

(4) An application for directions under this rule may be made, whether or not proceedings have been commenced.

5 Adherence to and relief from rules

(1) Subject to subrule (2) and to rule 4, the practice in the Commission is to be the practice provided by the Workers Compensation Acts or these rules.

(2) The Commission may if it thinks fit on terms dispense with compliance with any of the requirements of these rules, either before or after the occasion for the compliance arises.

(3) The general practice of the Commission prescribed by these rules applies to all proceedings authorised by any existing or future Acts to be commenced, taken or continued in the Commission, except in so far as that practice is inconsistent with any provision of or under any such Act.

Part 2 Administration

6 Establishment of Registry

The Commission is to establish and maintain a Registry.

7 Location of Registry

(1) For the purpose of delivery of documents the address of the Registry is:

Workers Compensation Commission Registry

Level 21, 1 Oxford Street

Darlinghurst NSW 2010

(2) For the purpose of sending documents or correspondence the address of the Registry is:

By Post:

The Registrar

Workers Compensation Commission Registry

PO Box 594, Darlinghurst NSW 2010

By Document Exchange (DX):

The Registrar

Workers Compensation Commission Registry

DX 11524 Sydney Downtown

By facsimile transmission:

The Registrar

Workers Compensation Commission Registry

(02) 92438801

By email (electronic communication):

Via the website http://www.wcc.nsw.gov.au

8 Hours of business

Except on Saturdays, Sundays and other public holidays or days on which public offices are closed, the Registry is to be open to the public

for business between 8:30 am and 4:00 pm or at such times and on such days as the Registrar directs from time to time.

9 Service of documents

(1) All documents required or permitted to be filed or lodged in or with or issued by, the Commission, must be filed or lodged at the Registry or issued from the Registry of the Commission.

(2) Filing or lodging of documents with, or issuing of documents by, the Commission may be by means of hand delivery, post, document exchange, facsimile transmission or electronic communication in accordance with these rules and the Workers Compensation Acts.

(3) It is sufficient notification or service of any document or correspondence directed to the Commission:

(a) by hand, by delivering it to the Commission at the address of the Commission set out in rule 7,

(b) by post, by sending by prepaid post to the postal address set out in rule 7,

(c) by DX, by leaving in the DX box set out in rule 7 or in another DX box for transmission to that exchange box,

(d) by fax, by faxing to the fax number set out in rule 7 and receiving notification on the sending facsimile machine of a successful transmission,

(e) by electronic communication, by sending an electronic communication to the email address set out in rule 7.

(4) Notification or service of any document or correspondence directed to the Registry or the Commission is taken to have been effected:

(a) if by hand, on the day of delivery, or

(b) if by post, on the fourth day after the day of sending by prepaid post, or

(c) if by DX, on the day following the day of leaving in the DX box of the party to whom it was addressed or in another DX box for transmission to that DX box, or

(d) if by fax, on the day of transmission (subject to receipt at the sending fax of notification of a successful transmission), or

(e) if by electronic communication, at the time of entering the information system addressed to the party's email address as provided by the *Electronic Transactions Act 2000*.

(5) Notification or service of any document or correspondence issued by the Registry or the Commission is taken to have been effected:

(a) if by hand, on the day of delivery, or

(b) if by post, on the fourth day after the day of sending by prepaid post, or

(c) if by DX, on the day following the day of leaving in the DX box of the party to whom it was addressed or in another DX box for transmission to that DX box, or

(d) if by fax, on the day of transmission (subject to receipt at the sending fax of notification of a successful transmission), or

(e) if by electronic communication, at the time of entering the information system addressed to the party's email address as provided by the *Electronic Transactions Act 2000*.

(6) Notification or service of any document or correspondence to a party by electronic communication may be made only where the party gives as part of its address for service an email address.

10 Form of documents

(1) The President may approve forms for use in the Commission and a reference in these rules to an approved form is a reference to a form approved by the President.

(2) Every document lodged at or served on the Registry must:

(a) be in the approved form and otherwise in substantial compliance with these rules and any directions issued by the Registrar, and

(b) be clearly written, typed or reproduced.

(3) The Registrar may refuse to accept, file, seal, or issue any document that, in the opinion of the Registrar, contravenes this rule.

11 Registration of agreements

(1) In this rule:

commutation agreement means an agreement to commute a liability to a lump sum, as provided by section 87F of the 1987 Act.

lump sum agreement means an agreement under section 66A of the 1987 Act.

(2) A commutation agreement or lump sum agreement lodged for registration is to be in the approved form.

(3) Within 7 days after lodgment of a commutation agreement or lump sum agreement for registration, the Registrar is to give notice to the parties identified in the agreement that:

(a) the agreement is registered, in which case the notice must indicate the date of registration, or

(b) registration of the agreement is refused, or

(c) in the case of a commutation agreement, the agreement has been referred for review by the Commission.

(4) If an agreement lodged for registration is incomplete or otherwise defective, the Registrar may give notice requiring the parties to remedy the defect within 7 days during which time the Registrar may hold the application as pending. In the event that the parties fail to rectify the defect in the time specified, the application for registration is taken not to have been made.

(5) In the case of a commutation agreement referred by the Registrar for review by the Commission, within 2 days of the Commission making a recommendation with respect to the agreement, the Registrar is to notify the parties that:

(a) the agreement is registered, in which case the notice must indicate the date of registration, or

(b) registration of the agreement is refused.

12 Registers

(1) The Registry is to maintain the following:

(a) a register of approved medical specialists appointed by the President pursuant to section 320,

(b) a register of all current proceedings,

(c) a register of arbitrators and mediators,

(d) a register of all agreements registered in accordance with rule 11.

(2) Public access to the registers referred to in this rule is as follows:

(a) the registers of approved medical specialists, arbitrators and mediators and register of current proceedings before the Commission referred to in subrule 1 (a), (b) and (c) are to be

available for inspection by the general public on the Internet site of the Commission at http://www.wcc.nsw.gov.au or in such other manner and at such other times as determined by the Registrar from time to time,

(b) the register of agreements registered referred to in subrule 1 (d) is to be available for inspection by the persons and at the times determined by the Registrar from time to time.

13 Seal

(1) The Commission is to have a seal.

(2) The seal is to be in such form (including electronic form) as the President may determine from time to time.

(3) The seal of the Commission is to be kept under the control of the Registrar at all times.

(4) The seal of the Commission is to be affixed to all documents registered by the Commission and to all notices of decisions and determinations by the Commission and to such other documents as the President may determine from time to time.

Part 3 Commencement of proceedings

14 Commencement by application for interim payment direction

(1) Proceedings in relation to:

(a) the failure to determine a claim for weekly benefits as and when required by the 1998 Act, or

(b) the failure to determine a claim for medical expenses compensation as and when required by the 1998 Act, or

(c) the failure to commence provisional payments of compensation as required by Division 1 of Part 3 of Chapter 8 of the 1998 Act following initial notification of an injury,

are to be commenced by way of application for an interim payment direction.

(2) An application for an interim payment direction is to be in the approved form and include as attachments the information and other documents required by the form.

(3) The applicant is to serve the application on the respondent at the same time as making the application for an interim payment direction to the Commission.

(4) The Registrar may provide a copy of the application to the respondent, and may obtain the respondent's views as to the application in such manner as the Registrar considers appropriate.

15 Commencement by application for dispute resolution

(1) Proceedings in relation to a matter under the Workers Compensation Acts are to be commenced by way of an application for dispute resolution.

(2) Where an application for dispute resolution concerns a matter referred to in rule 14 (1), the Registrar may deal with the matter in accordance with that rule, and in such a case the requirement for the respondent to lodge a reply to the application is deferred until such time as the Commission determines.

(3) An application for dispute resolution is to be in the approved form and include as attachments the information and other documents required by the form, the Workers Compensation Acts and these rules.

(4) Within 7 days after the applicant lodges an application for dispute resolution with the Registrar, the applicant must serve a sealed copy of the application on the respondent and any other party to the proceedings.

(5) Within 7 days after serving a copy of the application under subrule (4), the applicant must lodge with the Commission a certificate in the approved form certifying service of a copy of the application in accordance with subrule (4).

(6) If the respondent is an employer (but not a self-insurer), the applicant must serve a copy of the application on both the employer and the employer's insurer.

16 Material to be lodged with application

(1) For the purposes of section 290, the applicant must lodge with the application for dispute resolution all information and documents on which the party proposes to rely that are in the possession of the applicant at that time.

Note. Section 290(3) prevents a party from introducing additional material if it was not provided as and when required by the rules.

(2) Subject to subrule (3), an applicant may not in proceedings introduce evidence that has not been included in a statement, report or other document lodged with the application for dispute resolution in the proceedings unless:

(a) the applicant has served and lodged with the application for dispute resolution a statement revealing:

(i) the specific nature of the evidence, and

(ii) the reliance the party intends to place on the evidence, and

(iii) the reasons why the evidence is not available at the time of service, and

(iv) the time it is expected to be available, and

(b) the evidence is included in a statement, report or other document served on all other parties and lodged as soon as practicable after that evidence becomes available.

(3) The Commission may, for the avoidance of injustice in special circumstances, allow an applicant to introduce evidence that the applicant would otherwise be prevented from introducing because of the operation of subrule (2).

17 Time of commencement of proceedings

The time of commencement of proceedings is the time when the Registrar registers the application for dispute resolution or interim payment direction by affixing the seal of the Commission.

18 Defective application

(1) The Registrar may refuse to register an incomplete or otherwise defective application for dispute resolution or interim payment direction.

(2) A new application for dispute resolution or interim payment direction may be lodged at any time if the Registrar has previously refused to register an incomplete or defective prior application.

19 Effect of irregularity

(1) If a provision of these rules is not complied with in relation to the commencement (or purported commencement) of proceedings or conduct of proceedings before the Commission, the failure to comply is to be treated as an irregularity and does not nullify the proceedings, any step taken in the proceedings or any decision in the proceedings unless the Commission so determines.

(2) The Commission in dealing with any such irregularity may wholly or partly set aside the proceedings, a step taken in the proceedings or a decision in the proceedings.

20 Amendment of documents

(1) The Commission may, in any proceedings before it, amend any document filed in connection with the proceedings if the Commission considers the amendment to be necessary in the interests of justice.

(2) Such an amendment may be made at any stage of the proceedings (including the commencement or purported commencement of proceedings), and on such terms as the Commission thinks fit.

Part 4 Parties

21 Notice of representation

(1) A party to a dispute must notify the Registrar and other parties in writing of the appointment at any stage in the proceedings of a legal practitioner or agent to represent the party, within 5 days of the appointment.

(2) If at any stage in proceedings a party changes the legal practitioner or agent by whom the party is represented, or ceases to be represented by a legal practitioner or agent, the party must notify the Registrar and other parties of that change in writing within 5 days.

(3) If the legal practitioner or agent is to represent the party from the commencement of proceedings, the notice required under subrule (1) may be given, in the case of the applicant, in the application for dispute resolution or interim payment direction and, in the case of the respondent, in the reply to the application for dispute resolution.

(4) A notice under this rule must indicate whether the authority of the legal practitioner or agent to act on behalf of the party in the proceedings is limited or restricted in any way and, if so, in what manner and to what extent, otherwise the Registrar is entitled to assume that the authority is not limited or restricted.

22 Address for service

(1) The address for service of any document on a party to any proceedings is, in the case of the applicant, the address set out by the applicant as the applicant's address in the application for dispute resolution, and in the case of the respondent, the respondent's address set out in the application for dispute resolution, unless the respondent indicates in writing a different address.

(2) A party may give its address for service as care of its legal representative or agent.

(3) A party to a dispute must notify the Registrar in writing within 2 days if at any stage in the proceedings the party's address for service changes.

23 Method of service

(1) A document is taken to have been served on or provided to a party by delivery to the address for service for that party as notified to the Registrar in accordance with this Part.

(2) A party's address for service may be a postal address, document exchange (DX) box, fax number, email address (for electronic communications) or a physical address.

(3) Service of a document on a party is taken to be effected:

(a) if by hand, on the day of delivery, or

(b) if by post, on the fourth day after the day of sending by prepaid post, or

(c) if by DX, on the day following the day of leaving in the DX box of the party to whom it is addressed or in another DX box for transmission to that DX box, or

(d) if by fax, on the day of transmission (subject to receipt at the sending fax of notification of a successful transmission), or

(e) if by electronic communication, at the time of entering the information system addressed to the party's email address included in the party's address for service as provided by the *Electronic Transactions Act 2000*.

24 Alternative method of service

(1) Where for any reason it is impracticable to effect service of any document on a party by any method provided for by this Part, the Registrar may, on application supported by a statutory declaration showing grounds, by order direct that instead of service such steps be taken as are specified in the order for the purpose of bringing the document to the notice of the party.

(2) The Registrar may order that service be taken to have been effected on the happening of any specified event or on the expiry of any specified time.

25 Service in a foreign country

Where a document is to be served in a foreign country, the document is to be served in accordance with these rules:

(a) subject to any applicable convention relating to the service of documents made between Australia and the country of service, and

(b) with a translation in the official language of the country of service, with a certificate setting out the name of the translator and their relevant qualifications.

Part 5 Dispute resolution procedure

26 Reply by respondent

(1) The respondent must lodge with the Commission and serve on the applicant and any other party to the proceedings a sealed reply to an application for dispute resolution within 14 days of being served with a sealed copy of the application by the applicant.

(2) The respondent is to lodge with the Commission a certificate in the approved form certifying service of the reply within 7 days of causing the reply to be served.

(3) If the applicant is an employer (but not a self-insurer), the respondent must serve the reply on both the employer and the employer's insurer.

(4) Without leave of the Commission, the failure of a worker to notify of an injury as required by the Workers Compensation Acts may not be raised as an issue in the reply by the respondent if that issue has not been included in the notice in accordance with section 74.

27 Material to be lodged by respondent

(1) For the purposes of section 290, the respondent must lodge with the reply to an application for dispute resolution all information and documents on which the respondent proposes to rely that are in the possession of the respondent at that time.

Note. Section 290(3) prevents a party from introducing additional material if it was not provided as and when required by the Rules.

(2) Subject to subrule (3), a respondent may not in proceedings introduce evidence that has not been included in a statement, report or other document lodged with the reply to an application for dispute resolution in the proceedings unless:

(a) the respondent has served and lodged with the reply to the application for dispute resolution a statement revealing:

(i) the specific nature of the evidence, and

(ii) the reliance the party intends to place on the evidence, and

(iii) the reasons why the evidence is not available at the time of service, and

(iv) the time it is expected to be available, and

(b) the evidence is included in a statement, report or other document served on all other parties and lodged with the Commission as soon as practicable after that evidence becomes available.

(3) The Commission may for the avoidance of injustice in special circumstances, allow a respondent to introduce evidence that the respondent would otherwise be prevented from introducing because of the operation of subrule (2).

28 Registrar's powers

(1) The Registrar may:

(a) allocate a dispute to an Arbitrator, or

(b) deal with a dispute in accordance with Part 7 (Expedited assessment), or

(c) refer a matter for medical assessment in accordance with Part 8 (Medical assessment), or

(d) take any other action that the Registrar considers appropriate in the circumstances in accordance with the Registrar's powers.

(2) The Registrar is to notify the parties of the reference of the dispute to an Arbitrator or of a matter for medical assessment and of the identity of the Arbitrator or approved medical specialist, as appropriate.

(3) In the event that the employer's insurer is not a party to the proceedings but their identity is known to the Registrar or readily ascertainable on the face of the documents, the Registrar is to notify the insurer of any such reference.

29 Joining other parties and disputes

(1) An application for dispute resolution may relate to one or more disputes arising out of a claim or in relation to the same injury (or series of injuries).

(2) If there is more than one dispute arising out of the same injury (or series of injuries), the Registrar may direct that those disputes be dealt with in the same proceedings of the Commission.

(3) Two or more persons can be joined as the applicant or the respondent in any proceedings before the Commission where:

(a) if separate proceedings are brought by or against each of them, some common question of law or fact would arise in all those

proceedings and all rights claimed in those proceedings (whether they are joint, several or alternative) would be in respect of or arise out of the same injury (or series of injuries), or

(b) the Commission gives leave to do so.

(4) If a person who is not a party to any proceedings:

(a) should have been joined as a party to the proceedings, or

(b) is a person the joining of whom as a party to the proceedings is necessary to ensure that all matters in dispute may be effectually and completely determined,

the Registrar, on application by the person, by a party, or of the Registrar's own motion, may order that the person be added as a party to the proceedings and make such other relevant orders in relation to the matter as the Registrar considers appropriate.

(5) For the purposes of subrule (4), if the person is joined on application by a party, the party must serve on the person a sealed notice in the approved form that:

(a) includes a copy of the application for dispute resolution and documents and other information required to be attached to the application, and

(b) includes a copy of the respondent's reply to the application for dispute resolution including all required documents and information, and

(c) includes a copy of a notice to any other person joining that person to the proceedings, and

(d) advises the party joined of the time within which the party must reply to the Registrar (14 days after the date of receipt of the notice).

(6) For the purposes of subrule (4), if the person is joined on their own application or on the motion of the Registrar, the Registrar is to serve notice on the person in the approved form.

(7) The party joined in the proceedings must lodge with the Commission and serve on the applicant and any other party to the proceedings a sealed reply to an application for dispute resolution within 14 days of being served with the copy of the notice joining the party.

(8) The party joined is to lodge with the Commission a certificate in the approved form certifying service of the reply within 7 days of causing the reply to be served.

(9) If the party joined is an employer (but not a self-insurer), the notice required by this rule to be served on the party must be served on both the employer and the employer's insurer.

(10) Without leave of the Commission, the failure of a worker to notify of an injury as required by the Workers Compensation Acts may not be raised as an issue in the reply by the joined party if that issue has not been included in the notice issued in accordance with section 74 by that joined party.

(11) A party joined may respond giving reasons why the party should not properly be included as a party to the proceedings.

(12) No proceedings of the Commission are rendered invalid by reason only of the joining of a person in error or by the failing to join a person as a party to those proceedings.

30 Material to be lodged by party joined

(1) For the purposes of section 290, a party joined in proceedings must lodge with the reply to an application for dispute resolution all information and documents on which the joined party proposes to rely that are in the possession of the joined party at that time.

Note. Section 290(3) prevents a party from introducing additional material if it was not provided as and when required by the Rules.

(2) Subject to subrule (3), a joined party may not in proceedings introduce evidence that has not been included in a statement, report or other document lodged with the reply to an application for dispute resolution in the proceedings unless:

(a) the joined party has served and lodged with the reply to the application for dispute resolution a statement revealing:

(i) the specific nature of the evidence, and

(ii) the reliance the party intends to places on the evidence, and

(iii) the reasons why the evidence is not available at the time of service, and

(iv) the time it is expected to be available, and

(b) the evidence is included in a statement, report or other document served on all other parties and lodged as soon as practicable after that evidence becomes available.

(3) The Commission may for the avoidance of injustice in special circumstances, allow a joined party to introduce evidence that the joined party would otherwise be prevented from introducing because of the operation of subrule (2).

31 Application for direction requiring production of documents

(1) An application to the Commission by a party to proceedings before the Commission for a direction under section 357 requiring the production of documents or the provision of information may only be made:

(a) if the party is the applicant—within 7 days after being served with the respondent's reply in accordance with rule 26, or

(b) if the party is the respondent— with the reply by the respondent to the Registrar's notice of registration of the application for dispute resolution in accordance with rule 26, or

(c) if the party has been joined—with the reply by the party to the Registrar in accordance with rule 29,

unless the Commission is satisfied that:

(d) the party was not aware, and could not reasonably have become aware through the exercise of due diligence, of the existence of the requested material, at the time that the application was required to be made under paragraph (a), (b) or (c), and

(e) failure to make the direction would result in a substantial injustice to the applicant for the direction, and that the making of the order will not prejudice the other party or parties to the proceedings.

(2) When a party to proceedings makes an application for an order under section 357, the Commission is to give the parties to the proceedings at least 2 days notice of its intention to give the direction. A party may object to the proposed order.

(3) A direction under section 357 must not require production of documents or the furnishing of information unless an amount sufficient to meet the reasonable expenses of complying with the direction is paid or tendered to that person at the time of service of the direction or not later than a reasonable time before the time by which the person must comply with the direction.

32 Form of direction to produce documents or furnish information

(1) A direction by the Commission to a person requiring the production of documents or the furnishing of information in accordance with section 357 is to be in the approved form.

(2) The direction is to specify the time and manner in which the person must comply with it.

33 Commission providing documents or information to another party

(1) When documents or information relevant to proceedings before the Commission are produced or furnished to the Commission by a person pursuant to a direction by the Commission and the Commission intends to produce or furnish the documents or information to another party to the proceedings, that party's legal representative or a medical practitioner, the Commission is to give to the parties and to the person who produced the documents or furnished the information to the Commission not less than 2 days' notice of its intention to do so.

(2) A person required by a direction of the Commission to produce documents or furnish information may at the time of complying with the direction notify the Commission that it objects to the production of those documents or the furnishing of that information to another party to the proceedings, that party's legal representative or a medical practitioner and the grounds on which the objection is raised.

(3) The Commission must take any such objection into account and the views of the parties in determining whether to produce the documents or furnish the information to another party to the proceedings, that party's legal representative or a medical practitioner.

34 Summons

(1) A summons issued by the Registrar requiring attendance of a person at any conference or hearing before the Commission in connection with proceedings before the Commission is to be in the approved form and must be served on the person not less than 7 days prior to the day on which the person is required to attend.

(2) The person serving the summons must complete the section of the approved form concerning service and lodge it with the Registrar within 5 days of service.

(3) A summons does not require attendance of a person unless an amount sufficient to meet the reasonable expenses of complying with the

summons is paid or tendered to that person at the time of service of the summons or not later than a reasonable time before the time at which the person is required to attend.

35 Tapes, films and photographs

(1) When information is produced or furnished to the Commission (whether or not at the direction of the Commission) in the form of surveillance or other videotapes or audiotapes, film or photographs, any investigator's report concerning the surveillance material must be lodged with the material.

(2) In the case of x-rays, computerised tomography, medical ultrasound or magnetic resonance imaging:

(a) original films or scans are not to be lodged with the Commission, and

(b) original films or scans may be taken or delivered to an approved medical specialist undertaking an assessment for the purpose of proceedings concerning a medical dispute.

(3) A party who takes or delivers original x-rays or scans referred to in subrule (3) to an approved medical specialist in the course of proceedings must notify the Commission and other parties by notice in writing not less than 7 days prior to the taking or delivery of the films or scans to the approved medical specialist.

36 Calling of witnesses

(1) A party that proposes to call a witness to provide oral evidence must include the name of that witness and a signed written statement by that witness:

(a) if the party is the applicant—with the application for dispute resolution, or

(b) if the party is the respondent—with the reply by the respondent to the Registrar's notice of registration of the application for dispute resolution in accordance with rule 26, or

(c) if the party is a joined party—with the reply by the party to the Registrar in accordance with rule 29 (7).

(2) A party may call a witness to give evidence where a statement has not been filed in accordance with subrule (1) only with the leave of the Commission.

(3) The Commission cannot grant that leave unless satisfied that admission of the evidence would prevent a substantial injustice to the party.

(4) An application for leave under this rule can only be made if the party lodges a written and signed statement setting out the evidence of the witness.

(5) This rule does not prevent a witness being summonsed in circumstances where the person refused to provide a written and signed statement.

37 Expert witness

(1) If a witness is an expert witness, the person cannot be called to give evidence unless a copy of a report by the witness has been lodged with the application for dispute resolution, respondent's reply (made in accordance with rule 26) or joined party's reply (made in accordance with rule 29 (7)), as appropriate.

(2) A party proposing to call a witness to give evidence as an expert witness must ensure that the witness is aware of and adheres to any Practice Directions dealing with guidelines for expert witnesses in proceedings before the Commission.

Part 6 Commission proceedings

38 Principles of procedure

When informing itself on any matter, the Commission is to bear in mind the following principles:

(a) evidence should be logical and probative,

(b) evidence should be relevant to the facts in issue and the issues in dispute,

(c) evidence based on speculation or unsubstantiated assumptions is unacceptable,

(d) unqualified opinions are unacceptable.

39 Measures to assist parties

The Commission is to take such measures as are reasonably practicable to:

(a) ensure that the parties to the dispute understand the nature of the application for dispute resolution and the legal implications of any assertion made in any documents or proceedings, and

(b) explain to the parties any aspect of the procedure or any decision or ruling made by the Commission in relation to the dispute, and

(c) ensure that the parties have the fullest opportunity practicable to have their side of the dispute considered without compromising the objectives of the Commission, and

(d) ensure that the parties have the opportunity to explore settlement of the dispute.

40 Statement as to agreed facts and issues

(1) The Commission may direct the parties to file a joint signed statement setting out the facts and issues on which the parties agree, and the facts and issues that continue to be in dispute.

(2) The parties are bound by the statement and may not assert the contrary except with the leave of the Commission.

41 Certificates of determination

(1) If a dispute is determined by the Commission, the Commission is to issue a certificate as to the determination in compliance with section 294 in the approved form.

(2) A statement of the Commission's reasons attached to the certificate is to include:

(a) the findings on material questions of fact, referring to the evidence or other material on which those findings were based, and

(b) the Commission's understanding of the applicable law, and

(c) the reasoning processes that lead the Commission to the conclusions it made.

42 Discontinuances

(1) The parties to a dispute before the Commission may agree to discontinue the proceedings at any time.

(2) In the event of agreement to discontinue, the parties are to give notice of the discontinuance to the Registrar as soon as practicable in the approved form.

(3) If the parties so request, the terms on which the parties agree to discontinue the proceedings may form the basis for a determination by the Commission.

(4) In the event that the applicant elects not to proceed with a matter, notice of discontinuance in the approved form is to be given by the applicant to the Registrar and served on all other parties as soon as practicable. The notice to the Registrar is to be accompanied by a certificate in the approved form certifying that a copy of the notice has been served on all other parties.

Part 7 Expedited assessment

43 Interim payment directions

An Interim Payment Direction is to be in the approved form and is to include:

(a) the name of the party to whom it is addressed, and

(b) the name and address of the person to whom payment is to be made, and

(c) whether the direction is in respect of weekly payments or is for medical expenses, and

(d) in the case of weekly payments, the amount and the number of weeks for which the payments are to be made and when payments are to commence and conclude, and

(e) in the case of medical expenses, the amount to be paid and the time by which payment is to be made, and

(f) advice that a person who fails to comply with an interim payment direction is guilty of an offence in accordance with section 300.

44 Refund of interim payment direction payments

An order for the purpose of section 304 is to be in the approved form and is to include:

(a) the name of the person to whom it is addressed, and

(b) the name and address of the person to whom payment is to be made, and

(c) the amount of payments to be refunded or reimbursed and the time by which payment is to be made, and

(d) the reasons for which the Commission has determined to issue the order.

45 Notice of revocation of interim payment direction

(1) An application for revocation of an interim payment direction is to be in the approved form and be lodged with the Commission.

(2) Notice of revocation by the Registrar of an interim payment direction is to be in the approved form and given to each of the parties to the proceedings.

46 Workplace injury management plans

(1) Before exercising a power under section 306, the Registrar is to contact the parties to the dispute and advise them of the course of action the Registrar proposes to take. Contact should be made with a view to resolving the dispute expeditiously.

(2) A direction by the Registrar that a workplace assessment be conducted is to include:

(a) the names and addresses of the parties to the dispute, and

(b) a statement as to the nature of the obligation with which one of the parties is alleged to have failed to comply, and

(c) the name of the injury management consultant or other suitably qualified person who is to conduct the workplace assessment, and

(d) the amount of, and a note that the employer is liable for, the fee payable for the conduct of the workplace assessment.

(3) A copy of the direction that a workplace assessment be conducted is to be sent to each of the parties, the insurer (if not a party) and to the person who is to conduct the assessment.

(4) The injury management consultant or other suitably qualified person who is to conduct the assessment must contact the parties and arrange to carry out the assessment as soon as practicable, but not more than 5 days after receiving the direction.

(5) The injury management consultant or other suitably qualified person who is to conduct the assessment must provide the Registrar with a brief written report in the approved form of the outcome of the assessment, setting out the reasons for any finding, as soon as practicable after it has been conducted but in any case not later than 7 days after the assessment is conducted. The Registrar must make the report available to the parties.

(6) A recommendation by the Registrar that a party to a dispute take specified action is to be in writing and must include:

(a) the name of the party to whom the recommendation is made, and

(b) the nature of the obligation with which one of the parties is alleged to have failed to comply, and

(c) the action that the Registrar considers necessary or desirable for the party to take to remedy the failure with which the dispute is concerned, and

(d) a note referring the party to whom the recommendation is made to the period for compliance or for requesting referral to the Commission as provided by section 308.

(7) A copy of the recommendation issued by the Registrar is to be sent to each of the parties and the insurer if not a party.

Part 8 Medical assessments and medical evidence

47 Appointment of approved medical specialists

(1) On the appointment by the President of a medical practitioner as an approved medical specialist, the Registrar is to issue to the appointee a sealed certificate in the form approved by the President and is to enter the appointee's name on the register of approved medical specialists maintained by the Registrar.

(2) A certificate issued under subrule (1) is to set out the terms on which the appointment is made including the period of the appointment and any restrictions as to the medical disputes that may be referred to the appointee.

48 Submission of medical evidence

(1) In any proceedings on a claim:

(a) only one medical report in any particular specialty may be admitted on behalf of a party to the proceedings, and

(b) a medical report in a specialty may not be admitted on behalf of a party to the proceedings if another medical report in that specialty has already been admitted on behalf of the party in any other proceedings on the claim or in proceedings on a related claim.

(2) Despite subrule (1) (b), a medical report in a specialty may be admitted in proceedings even if another medical report in that specialty has already been admitted in other proceedings on the claim or a related claim if:

(a) the medical report to be admitted is a permissible update (under this rule) of the medical report already admitted in the other proceedings, or

(b) the proceedings are lump sum compensation proceedings and the other proceedings were not lump sum compensation proceedings, or

(c) the medical report to be admitted is prepared pursuant to a direction by the Registrar or the Commission constituted by an arbitrator to the medical practitioner who prepared the report already admitted in the other proceedings to revise that report

in light of the medical reports submitted by the other parties to the proceedings.

(3) Subrule (2) operates only as an exception to subrule (1) (b) and does not affect the requirement under subrule (1) (a) that only one medical report in a particular specialty may be admitted in proceedings on behalf of a party.

(4) For the purposes of this rule, a medical report in more than one specialty is to be regarded as a medical report in each of those specialties.

(5) A medical report (the update report) is a permissible update of another medical report (the original report) if the update report is provided for the purpose of updating the original report and is provided:

(a) more than 6 months after the original report was provided, or

(b) because there has been a further material change in the worker's condition.

(6) The update report must have been provided by the medical practitioner who provided the original report except when that medical practitioner has ceased (permanently or temporarily) to practise in the specialty concerned, in which case the update report can be provided by another medical practitioner.

(7) The update report can be provided as an addendum to the original report and in such a case the original report together with that addendum constitute the permissible update.

(8) This rule does not apply in respect of a medical report provided in respect of the examination of an injured worker by an approved medical specialist under section 322.

Part 9 Appeals

49 Referral of question of law

(1) An application by a party to a dispute for leave to refer a question of law to the Commission constituted by the President is to be in the approved form and is to be lodged with the Arbitrator in the proceedings for referral to the President. The application is to include full details of and documentation supporting the referral.

(2) An application made by an Arbitrator is to be in the same form and a copy of the application is to be provided by the Commission to each of the parties.

(3) A party lodging an application for leave to refer the question of law is to serve a copy of the application (including any attachments) on each of the other parties. The application must be accompanied by a certificate in the approved form certifying that a copy of the application (including any attachments) has been served on all the other parties to the dispute.

50 Appeal against decision of Commission constituted by Arbitrator

(1) An application by a party to a dispute for leave to appeal against a decision of the Commission constituted by an Arbitrator is to be in the approved form. The application is to set out all grounds of appeal and include full supporting documentation.

(2) The application must be lodged with the Registrar within 28 days after the making of the decision against which the appeal is being made.

(3) The party lodging the application for leave to appeal is to serve a copy of the application (including any attachments) on each of the other parties. The application lodged with the Registrar must be accompanied by a certificate in the approved form certifying that a copy of the application (including any attachments) has been served on all the other parties to the dispute.

51 Appeal against medical assessment

An appeal by a party to a medical dispute against a medical assessment is to be lodged in the approved form.

Part 10 Work Injury Damages

52 Pre-filing statement

(1) For the purposes of section 315, a pre-filing statement is to be in the form of the statement of claim to be subsequently filed in the court of relevant jurisdiction and is to include as attachments the information and other documents required by the Workers Compensation Acts and these rules.

(2) If the defendant is an employer (but not a self-insurer), the claimant must serve the pre-filing statement on both the employer and the employer's insurer.

(3) The claimant must lodge with the Commission a certificate in the approved form certifying service of the pre-filing statement within 2 days of causing the pre-filing statement to be served.

Note. Section 313 prevents a pre-filing statement being served if there is a dispute as to whether the degree of permanent impairment is sufficient for an award of damages.

53 Material to be served with pre-filing statement

(1) In accordance with section 315, a claimant for work injury damages must serve with the pre-filing statement all information and documents upon which the claimant proposes to rely including:

(a) notification provided to the claimant in accordance with section 281(2B) that the degree of permanent impairment of the injured worker resulting from the injury is accepted as being sufficient for an award of work injury damages, or

(b) if the dispute has been referred to an approved medical specialist for assessment of permanent impairment, the medical assessment certificate issued by the approved medical specialist in accordance with section 325.

54 Pre-filing defence

(1) For the purposes of section 316, a pre-filing defence is to be in the form of a grounds of defence to be subsequently filed in the court of relevant jurisdiction and is to include as attachments the information and other documents required by the Workers Compensation Acts and the rules.

(2) Without leave of the Commission, the failure of a worker to notify of an injury as and when required by the Workers Compensation Acts may not be raised as an issue in the pre-filing defence served by the defendant if that issue has not been included in the notice issued in accordance with section 74.

(3) The defendant is to lodge with the Commission a certificate in the approved form certifying service of the pre-filing defence within 2 days of causing the pre-filing defence to be served.

55 Material to be served with pre-filing defence

In accordance with section 316, the defendant must serve with the pre-filing defence all information and documents upon which the defendant proposes to rely.

56 Defective pre-filing statement

(1) In accordance with section 317, referral of a dispute as to whether a pre-filing statement served by a claimant is defective, must be in the approved from and lodged with the Registrar within 21 days of the pre-filing statement being served by the claimant.

(2) An application under subrule (1) cannot be made unless the requirements set out in section 317(1) have been complied with.

(3) The party referring the dispute must within 7 days of lodging the approved form with the Registrar serve a sealed copy of the approved form on the other parties to the dispute for work injury damages.

(4) The party referring the dispute as to the pre-filing statement is to lodge with the Commission a certificate in the approved form certifying service of the form referring the dispute within 2 days of causing the approved form to be served.

(5) A direction given by the Registrar in relation to the action necessary to cure a defect in a pre-filing statement served by a claimant is to be served on both the claimant and any other party to the dispute by the Registrar as soon as reasonably practicable.

57 Referral for mediation

(1) An application for mediation is to be in the approved form and include such information as the form requires and is to be accompanied by the pre-filing statement and information required to be served on the defendant and any other party in accordance with rules 53 and 55.

(2) Within 7 days of lodging the application for mediation with the Registrar the claimant must serve a sealed copy of the application on the defendant and any other party to the proceedings.

(3) The claimant must lodge with the Commission a certificate in the approved form certifying service of the application for mediation within 2 days of causing an application to be served.

58 Response to a referral for mediation

(1) The defendant is to lodge with the Commission a reply to an application for mediation within 7 days of being served with a sealed copy of the application by the claimant.

(2) A reply to an application for mediation is to be in the approved form and include such information as the form requires and is to be accompanied by the pre-filing defence and information required to be served on the claimant and any other party in accordance with rules 53 and 55.

(3) If a defendant declines to participate in mediation of the claim on the basis that liability in respect of the claim is wholly denied, the defendant is to notify the claimant and the Registrar in writing within 7 days of being served with the sealed copy of the application for mediation.

(4) The defendant must lodge with the Commission a certificate in the approved form certifying service of the reply to an application for mediation within 2 days of causing a reply to be served

59 Direction as to mediation

(1) A direction given by the Registrar in accordance with section 318A(5) is to include:

(a) the name of the mediator appointed, and

(b) the location at which, and the date and time when, the mediation is to take place.

(2) The Registrar is to cause a copy of the direction to be served on the parties and the mediator within 2 days of the direction being given, and in any case not less that 21 days prior to the date for mediation.

60 Mediator unable to mediate

(1) If a mediator to whom a claim is referred by the Registrar is not prepared, or is unable, to act as a mediator in the matter, the mediator

must notify the Registrar and the parties to the dispute in writing as soon as practicable.

(2) If a mediator appointed by the Registrar declines or fails to act as a mediator with respect to the claim, the Registrar may revoke the direction referring the claim to the mediator and make a direction referring the claim to another mediator.

61 Certificate of Mediation Outcome

(1) A certificate of mediation outcome issued in accordance with section 318B is to be in the approved form and is to include:

(a) the names and addresses of the parties to the dispute, and

(b) the names of persons in attendance at the mediation, and

(c) a statement that the parties failed to resolve the dispute and reach settlement, and

(d) the final offers of settlement made by the parties in the mediation.

(2) If a defendant declines to participate in mediation of the claim on the basis that liability in respect of the claim is wholly denied and the defendant has notified the claimant and the Registrar in accordance with rule 58, the Registrar may issue a certificate specifying that:

(a) the defendant declined to participate in mediation on the basis that liability with respect to the claim is wholly denied, and

(b) for the purposes of section 318A(4) the mediation process is considered to be complete, and

(c) the claimant is now permitted to commence proceedings in a court of competent jurisdiction.

Part 11 General

62 Practice directions

(1) The President, in consultation with the Deputy Presidents, may issue Practice Directions in relation to the operation of these rules.

(2) The Registrar is to publish and make copies generally available of any Practice Direction.

(3) Without limiting the range of matters that may be the subject or a Practice Direction, the matters that may be the subject of a Practice Direction include:

(a) the procedures to be observed in the course of a conference or hearing to be conducted by an Arbitrator (including any preliminary conference or hearing),

(b) what constitutes an "obvious error" in relation to a certificate of determination issued by the Commission for the purposes of section 294 (3) or in relation to a medical assessment certificate for the purposes of section 325 (3),

(c) the procedure to be followed by Arbitrators in the conduct of proceedings.

63 Reckoning of time

Any period of time fixed for the doing of any act in or in connection with a dispute under the jurisdiction of these rules is to be reckoned as follows:

(a) if the period is reckoned by reference to a given day or event, the given day or day of that event is not counted, and

(b) if the period is for 7 days or less and includes a day on which the Registry is closed, that day is excluded, and

(c) if the last day of the period is a day on which the Registry is closed, the period extends to the next day on which the Registry is open.

64 Extension and abridgement of time

Subject to the Workers Compensation Acts, any regulations under those Acts and any current Practice Direction, in relation to any proceedings before the Commission the President may order the

extension or abridgement of time fixed by an any order or determination of the Commission, whether or not requested by a party.

65 Running of time

(1) Time does not run in proceedings before the Commission during such period as may be fixed by a Practice Direction.

(2) In any calculation of time for the purposes of proceedings before the Commission, month means calendar month.

66 Interpreters

(1) Subject to subrule (2), only interpreters accredited by the National Accreditation Authority for Translators and Interpreters (NAATI) may be used in proceedings before the Commission.

(2) In any proceedings before the Commission requiring interpreters in languages for which interpreters are yet to be accredited by NAATI or in circumstances where the President determines it is otherwise necessary in view of the unavailability of NAATI accredited interpreters, the President may approve an interpreter or interpreters for use in those proceedings.

67 Continuation of proceedings in the case of death or bankruptcy

(1) If a party dies or becomes bankrupt but a claim in the proceedings survives, the proceedings do not abate by reason of the death or bankruptcy.

(2) If the interests or liability of a party passes by assignment, transmission, devolution or otherwise to another person, the Commission may make orders for the addition, removal or re-arrangement of parties and may make orders for the further conduct of the proceedings.

(3) The Commission may act under subrule (2) on application by a party, or by a person to whom the interest or liability passes, or of its own motion.

(4) If the Commission orders that a party be substituted for another party or a former party, all things done in the proceedings before the making of the new order have effect in relation to the new party as if that party were the old party, unless the Commission otherwise orders.

(5) An administrator or executor may continue or defend proceedings in like manner as if he or she were a party claiming or defending in his

or her own right. If it appears to the Commission that a deceased person was interested, or that the estate of the deceased person is interested, in any matter in question in the proceedings and there is no personal representative, the Court may appoint a person, with the person's consent to represent the estate for the purposes of the proceedings.

(6) In the case of the death of a party, the Court may order that the proceedings be dismissed if no application has been made under subrule (1).

68 Proceedings involving minors and incapacitated persons

(1) The Commission may appoint any person it thinks fit to represent a party who appears to the Commission to be an incapacitated person.

(2) In this rule:

incapacitated person means:

(a) a minor, or

(b) a person who is totally or partially incapable of representing himself or herself in proceedings before the Commission because the person is intellectually, physically, psychologically or sensorily disabled, of advanced age, a mentally incapacitated person or otherwise disabled.

WORKCOVER MEDICAL ASSESSMENT GUIDELINES

WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998

EXPLANATORY NOTE

These guidelines are made pursuant to sections 376(1) and 331 of the Workplace Injury Management and Workers Compensation Act 2001 ("the Act"). They explain the operation of those sections of the Act relating to referrals for medical assessment.

The Guidelines set out the procedures for the referral and conduct of medical disputes for assessment or review of assessments under Part 7 of the Act.

These Guidelines are primarily intended to assist the legal profession and the Commission. Questions about medical assessments and these Guidelines should be directed to the Registrar at the Commission.

The Hon John Della Bosca MLC
Special Minister of State

December 2001

Medical Assessments Guidelines

The Guidelines in this Part set out the procedures for referring medical disputes for assessment or review of assessments under Part 7 of the Act.

Chapter A: Interpretation

What abbreviations are used in this Part?

1. In this part, these abbreviations are used:

AMS	Approved Medical Specialist
DX Box	Box in the Australian Document Exchange Pty Limited
NAATI	National Accreditation Authority for Translators and Interpreters
WCA	WorkCover Authority of NSW

What words and phrases are defined in this Part?

2. In this Part, these words and phrases have the following meanings:

- *approved medical specialist* means a medical practitioner appointed under Part 7 of the Act as an approved medical specialist.
- *day* or *days* means calendar days.
- *Registrar* means the Registrar of the Commission
- *claimant* means a person who has made a claim under the 1998 Act.
- *Party* includes the claimant, an insurer or an employer
- *WorkCover Guides* means the WorkCover Guidelines for the Evaluation of Permanent Impairment

Chapter B The referral process

How is a matter referred to an AMS?

3. A party, the Court or the Commission is to notify the Registrar when a matter is to be referred to an AMS.

Whom must the Registrar notify of the referral?

4. The Registrar is to notify the parties that a dispute is to be referred to an AMS.

Who chooses the AMS?

5. The parties have 7 days after receiving notice of the referral to jointly tell the Registrar in writing the name of the AMS they have agreed to appoint.

   If the parties cannot agree on an AMS, they are to tell the Registrar in writing the names of the AMSs they have considered but rejected and the reasons why they were rejected. Then, the Registrar is to choose the AMS who is to assess the dispute and advise the parties in writing of the name of the AMS.

On what basis is the Registrar to appoint an AMS?

5.1 When choosing an AMS, the Registrar is to consider:

- which location would be most convenient to the parties and the AMS; and
- the AMSs on the Authority's list who are most appropriate given the nature of the injury, any continuing disabilities, the nature of the dispute, and the specialty and or expertise of the assessor.
- the availability of the AMS.

May the parties object to an AMS the Registrar has appointed?

5.2 A party may apply to the Registrar to have the matter reallocated on the grounds that the AMS to whom the matter has been allocated has a conflict of interest or may not be impartial. To do that, the party must apply:

- within 7 days after receiving notification of the name and contact details of the AMS; and
- in writing with detailed reasons.

The Registrar is to decide on the application within 7 days after receiving it and must re-allocate the matter if the Registrar is of the opinion that there are reasonable grounds for believing that the assessor may have a conflict of interest or may not be impartial.

What details is the Registrar to provide for the AMS?

6. When the Registrar refers the matter to the AMS, the Registrar is to provide the AMS with such details as the Registrar determines including:

- A copy of any minute of order or statement of reasons indicating the nature of the medical dispute, as determined in consultation with the parties;
- A list of the documents attached to the referral with an indication of whether or not each document has been provided to both parties.
- A copy of all reports from the claimants' health care, rehabilitation and care providers.
- A copy of all medico-legal, investigation and expert reports.
- An indication of whether or not there are, or are likely to be other medical disputes in the matter.

May the Registrar communicate with the worker's medical etc. providers?

7. The Registrar may communicate with the parties, or any of the worker's treatment or service providers to clarify the matter or matters in dispute.

May the Registrar make arrangements to deal with a matter?

8. The Registrar is to make such arrangements to deal with the matter as are appropriate.

Chapter C: The assessment procedure

May the AMS return a matter to the Registrar?

9. If the AMS believes that there may be a conflict of interest they are to immediately return the matter to the Registrar for reallocation. An AMS to whom a matter has been allocated must not consider the matter if there is a conflict of interest.

How is the process for the AMS's review determined?

10. Within 7 days of receiving the file, the AMS is to review the material provided by the Registrar and determine the way in which an assessment is to proceed. The review should specifically consider the issue of conflict of interest and return the matter to the AMS.

    The Guidelines for Medico-Legal Consultations of the NSW Medical Board as in force from time to time apply to the making of an assessment by an AMS (See Attachment 1).

    The procedures set out in the WorkCover Guides apply to the conduct of assessments relating to permanent impairment.

    The AMS may do any one or more of the following:

    - consult with any medical practitioner or other health care professional who is treating, or has treated, the worker;
    - call for medical records (including X-rays and the results of other tests) and other information that the AMS considers necessary or desirable to assess the dispute
    - require the worker to submit himself or herself for examination by the AMS.

Who arranges any examination required?

11. As soon as practicable (but within 14 days) after the review, the AMS is to arrange a medical or other examination if they believe one is required. They are to notify the parties of the time, date and location of the examination at least 7 days before the appointment.

12. However, the AMS may make an assessment without a medical examination if they are satisfied that the information they have is sufficient to enable them to determine the issues. In exercising the discretion not to conduct a medical examination, the assessor must consider:

    - The nature and complexity of the issues
    - The likely impact of non-examination on the outcome of the dispute
    - The extent and detail of the information provided
    - The urgency of the matter
    - Any submission by the parties as to why a medical examination is required.

May an interpreter be used as part of the assessment?

13. Only NAATI accredited interpreters may be used during the course of a medical assessment or review, unless the Registrar approves a non-accredited interpreter.

May someone accompany the worker to an assessment?

14. A parent, carer or other support person (other than an agent or legal practitioner) may accompany a worker to a medical assessment if it is reasonable and necessary in the circumstances and the AMS agrees.

15. The accompanying person is to conduct him or herself appropriately during the examination. The AMS has the right to ask the person to withdraw if his/her behaviour interferes with conduct of the examination

Chapter D: The medical assessment certificate

What is required in the AMS's medical certificate? [4.1]

16. The AMS must give the Registrar a medical assessment certificate within ten days after the assessment. The certificate must be in the form approved by the Registrar and must.

- set out details of the matters referred for assessment, and
- certify as to the AMS's opinion with respect to those matters,
- and properly reference the WorkCover Guides
- set out the AMS's reasons for that opinion, and
- set out the facts on which that opinion is based.

What does the Registrar do with the certificate?

17. The Registrar reviews the certificate for any obvious error and if it is correct, sends copies of the medical certificate to:

- the court or relevant member of the Commission who referred the matter for assessment; and
- if the AMS reports that the worker has suffered permanent impairment, each of the parties with notice that they may appeal.

What if the Certificate contains an error?

17.1 If the Registrar is satisfied that a medical assessment certificate contains

- an obvious error, such as a typographical error, provided this does not compromise the meaning of the certificate the Registrar may correct the error; or
- any other error, the Registrar is to refer the matter to the AMS for correction.

If the Registrar corrects an error on the certificate, then the altered certificate is to be the decision of the AMS. The Registrar is to provide the parties and the AMS with a copy of the altered certificate or report within five days of making the alteration.

Chapter E: Reviewing or appealing the assessment

May the Registrar require a further assessment?

18. Where the Registrar or the Commission, refers a matter for reassessment under Part 7 of the 1998 Act (on one or more occasions) the Registrar is to notify both parties of the further medical assessment within five days of it being arranged.

These guidelines apply as if it was an original assessment.

A certificate provided after a matter has been referred for further assessment replaces any earlier certificate to the extent of any inconsistency.

How does a party apply to appeal?

16. To appeal against the decision of an approved medical specialist, a party is to use a Form the Registrar approves, send a copy of the Form and attachments to the registrar and each party and set out:

- A copy of the medical assessment being appealed.
- A list of the documents attached to the assessment.
- A copy of all reports and documents provided to the AMS who made the assessment.
- Submissions in support of the appeal.

Extension of the time limit for an appeal to be made?

17. Where an appeal is made on the grounds:

- The assessment was made on the basis of incorrect criteria;
- The medical assessment certificate contains a demonstrable error;

and the appeal is made more than 28 days after the medical assessment certificate has been issued to the parties, the party must set out the special circumstances that justify the extension of the 28 day period.

Who is to hear an appeal?

20. An appeal is to be heard by an Appeal Panel constituted by 2 AMSs and one Arbitrator, chosen by the Registrar.

What happens at an appeal?

21. The Panel conducts a preliminary review in the absence of the parties, and sets a review date. The appeal is to be by way of review of the original medical assessment. The Appeal Panel may conduct a further medical examination of the injured worker.

The Appeal Panel may seek submissions from the worker's advocate, or the insurer at any appeal.

May a worker be accompanied as part of an appeal?

22. Where a worker is entitled to be accompanied by a person (whether or not a legal adviser or agent) at an Appeal Panel, the party is to give notice to the Registrar.

What powers does an AMS have at an appeal or further assessment?

23. An AMS who is a member of the Appeal Panel, or making a further assessment, has all the powers of an AMS under these rules.

What orders may the Appeal Panel make?

24. The Appeal Panel may:

- Confirm the certificate of assessment given in connection with the medical assessment; or
- revoke that certificate and issue a new certificate as to the matters concerned.

The decision of a majority of the members of an Appeal Panel is the decision of the Appeal Panel.

What is the effect of a new Certificate?

25. In any proceedings before the Commission with which a new certificate is concerned, that new certificate is conclusively presumed to be correct, the same as an original certificate, as to the following matters:

- the degree of permanent impairment of the worker as a result of an injury,
- whether any proportion of permanent impairment is due to any previous injury or pre-existing condition or abnormality,
- the nature and extent of loss of hearing suffered by a worker,
- whether impairment is permanent.

How are notices to be served?

26. The Rules relating to service in the Commission apply to the service of documents under these Rules.

WORKCOVER GUIDES

FOR THE EVALUATION OF

PERMANENT IMPAIRMENT

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WorkCover. **Watching out for you.**

Contents

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WorkCover

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Foreword

These Guidelines, to be known as the "*WorkCover Guides*", are issued under section 376 of the *Workplace Injury Management and Workers Compensation Act* 1998 (the 1998 Act) for the purpose of assessing the degree of permanent impairment that arises from a work related injury or condition in accordance with section 322(1) of the 1998 Act. The focus of the workers compensation legislation is injury management which aims to assist the injured worker to recover and return to work. When a worker sustains a permanent impairment, however, these Guides are intended to ensure an objective, fair and consistent method for evaluating the level of permanent impairment.

The Act requires that assessments of permanent impairment be made in accordance with these Guides. Medical specialists trained in the use of the *WorkCover Guides* are to assess the degree of permanent impairment arising from a work related injury or condition.

The *WorkCover Guides* are based on the American Medical Association's (AMA) *Guides to the Evaluation of Permanent Impairment,* fifth edition. The AMA guides are the most authoritative and widely used source for the purpose of evaluating permanent impairment. However, extensive work by eminent medical specialists, representing all Medical Colleges, has gone into reviewing the AMA guides to ensure that they are aligned with Australian clinical practice.

Their work has been invaluable in allowing WorkCover to produce guides that reflect current clinical practice and knowledge in NSW, in a time frame that will enable the new legislation to be operational in early 2002. The hours of hard work by these specialists is very much appreciated by the management of WorkCover and by the Minister, the Hon John Della Bosca, MLC.

Kate McKenzie
General Manager
WorkCover

1 Introduction

WorkCover NSW has introduced guides to the evaluation of permanent impairment based on the American Medical Association's *Guides to the Evaluation of Permanent Impairment,* fifth edition (AMA5).

These Guidelines, to be known as the *WorkCover Guides*, are issued under section 376 of the Workplace Injury Management and Workers Compensation Act 1998 (the 1998 Act). The *WorkCover Guides* were introduced in December 2001 and the current edition is the first edition.

The *WorkCover Guides* adopt AMA5 in most cases. Where there is any deviation, the difference is defined in the *WorkCover Guides*. Where differences exist, the *WorkCover Guides* are to be used as the modifying document. The procedures contained in the *WorkCover Guides* are to prevail if there is any inconsistency with AMA5.

The *WorkCover Guides* are to be used wherever there is a need to establish the level of permanent impairment that results from a work-related injury or disease. The assessment of permanent impairment is conducted for the purposes of awarding a lump sum payment under the statutory benefits of the NSW Workers Compensation Scheme and also for determining access to Common Law.

Assessing permanent impairment involves determining

- whether the claimant's condition has resulted in impairment,
- whether the condition has reached Maximum Medical Improvement (MMI),
- whether the resultant impairment is permanent,
- the degree of permanent impairment that results from the injury, and
- the proportion of permanent impairment due to any previous injury, pre-existing condition or abnormality, if any.

By the time an assessment of permanent impairment is required, the question of liability for the primary condition would normally have been determined. The exceptions to this could be those conditions which are of slow onset.

Medical assessors are expected to be familiar with Chapters 1 and 2 of AMA5 in addition to the information contained in this Introduction.

Development of the *WorkCover Guides*

The *WorkCover Guides* were developed by groups of medical specialists brought together by WorkCover to review the *AMA Guides to the Evaluation of Permanent Impairment*. The groups included specialists who were nominated by the Labor Council of NSW. Initially, the fourth edition of the *AMA Guides to the Evaluation of Permanent Impairment* (AMA4) was considered but, on the advice of the medical practitioners involved, focus was changed to the fifth edition of the Guides. AMA5 is used for most body systems, with the exception of Vision where, on the medical practitioners' advice, assessments are conducted according to the AMA4. The Chapters on Pain (Chapter 18 in AMA 5) and on Mental and Behavioural Disorders (Chapter 14 in AMA 5) are likewise omitted. WorkCover has substituted its own

Chapter on Psychiatric and Psychological Disorders (see Chapter 11 in this Guide) but chronic pain is excluded entirely at the present time (see Note: Evaluation of permanent impairment arising from chronic pain, page 81, for a fuller explanation). No assessment should be made of impairments associated with chronic pain.

The members of each working group are listed in Appendix 1 (p82).

The *WorkCover Guides* are to be reviewed and updated as subsequent editions of the *AMA Guides to the Evaluation of Permanent Impairment* become available. The *WorkCover Guides* will also be reviewed if anomalies or insurmountable difficulties in their use become apparent.

The *WorkCover Guides* are meant to assist suitably qualified and experienced medical practitioners to assess levels of permanent impairment. They are not meant to provide a "recipe approach" to the assessment of permanent impairment and medical practitioners are required to exercise their clinical judgement in determining diagnosis, whether the original condition has resulted in an impairment, whether the impairment is permanent and, if so, the degree of permanent impairment that results. Section 1.5 of Chapter 1 of AMA5 (p10) applies to the conduct of assessments and expands on this concept.

Body systems covered by the *WorkCover Guides*

Most body systems, structures and disorders included in AMA5 are included in the *WorkCover Guides*. Pain (Chapter 18 of AMA5) is excluded. Psychiatric and Psychological Disorders are evaluated using the specific *WorkCover Guides* Chapter (Chapter 11). The Visual System adopts AMA4, *not* AMA5. Evaluation of Permanent Impairment due to Hearing Loss adopts the methodology indicated in these guides (Chapter 9) with some reference to AMA5, Chapter 11 (pp245–251), but uses National Acoustic Laboratory (NAL) Tables from the NAL Report No 118, *Improved Procedure for Determining Percentage Loss of Hearing*, January 1988.

Psychiatric and psychological impairments

Psychiatric and psychological disorders are defined as primary psychological and psychiatric injuries in which work was found to be a substantial contributing factor. Permanent impairment due to psychiatric and psychological disorder is determined in accordance with Chapter 11 of the *WorkCover Guides*.

A *primary* psychiatric or psychological impairment is one which arises from a condition to which the person's employment was a substantial contributing factor. The condition will result from specific incidents at the workplace.

A primary condition is distinguished from a *secondary* psychiatric or psychological condition, which arises as a consequence of, *or secondary to*, another work-related condition (eg, depression associated with a back injury). No permanent impairment assessment is to be made of secondary psychiatric and psychological impairments. The payments for "Pain and Suffering" available under section 67 are intended to compensate people who come into this category.

Multiple impairments

Impairments arising from the same injury are to be assessed together (section 322(2) of the 1998 Act). Impairments that result from more than one injury arising out of the same incident are to be assessed together to assess the degree of permanent impairment of the injured worker (section 322(3) of the 1998 Act), with the exception of impairments arising from psychological and psychiatric injuries.

Impairments arising from primary psychological and psychiatric injuries are to be assessed separately from the degree of impairment that results from physical injuries arising out of the same incident (section 65A(4)(a) of the 1987 Act). A worker is entitled to receive compensation for impairment resulting from only one of these injuries, whichever results in the greater amount of compensation being payable, and is not entitled to receive compensation for an impairment resulting from the other injury.

The Combined Values Chart (pp604-606, AMA5) is used to derive a %WPI that arises from multiple impairments. An explanation of its use is found on pp9-10 of AMA5.

Permanent impairment — maximum medical improvement

Assessments are only to be conducted when the medical assessor considers that the degree of permanent impairment of the injured worker is fully ascertainable. The permanent impairment will be fully ascertainable where the medical assessor considers that the person has attained maximum medical improvement. This is considered to occur when the worker's condition has been medically stable for the previous three months and is unlikely to change substantially and by greater than 3% in the ensuing 12 months with or without further medical treatment (ie, further recovery or deterioration is not anticipated).

If the medical assessor considers that treatment has been inadequate and maximum medical improvement has not been achieved, the assessment should be deferred and comment should be made on the value of additional/different treatment and/or rehabilitation.

If the claimant has been offered, but refused, additional or alternative medical treatment that the assessor considers is likely to improve the claimant's condition, the medical assessor should evaluate the current condition, without consideration for potential changes associated with the proposed treatment. The assessor may note the potential for improvement in the claimant's condition in the evaluation report, and the reasons for refusal by the claimant, but should not adjust the level of impairment on the basis of the worker's decision.

Similarly, if a medical assessor forms the opinion that although the claimant's condition is stable in the foreseeable future, it is expected to deteriorate in the long term, the assessor should make no allowance for deterioration but note its likelihood in the evaluation report. If the claimant's condition deteriorates at a later time, the claimant may re-apply for further evaluation of the condition.

Relevant information

On referral, the medical assessor should be provided with all relevant medical and allied health information, including results of all investigations related to the injury in question.

AMA5 and these *WorkCover Guides* indicate the information and investigations that are required to arrive at a diagnosis and to measure permanent impairment. Assessors must apply the approach outlined in the Guides. Referrers must consult these documents to gain an

understanding of the information that should be provided to the assessor in order to conduct a comprehensive evaluation.

Medical assessors

An assessor will be a registered medical practitioner with qualifications in the relevant medical specialty who has undertaken the requisite training in use of the *WorkCover Guides*. A list of trained medical assessors may be obtained from the WorkCover website (www.workcover.nsw.gov.au).

Assessors may be one of the claimant's treating practitioners or an assessor engaged on behalf of the employer/insurer to conduct an assessment for the purposes of assessing the level of permanent impairment.

Assessors of levels of permanent impairment will be required to use the current *WorkCover Guides for the Evaluation of Permanent Impairment*.

Code of conduct

Assessors are referred to the NSW Medical Board's *Guidelines for Medico-Legal Consultations and Examinations* which are reproduced in Appendix 2 (p84).

Assessors are reminded that they have an obligation to act in an ethical, professional and considerate manner when examining claimants for the determination of permanent impairment.

Effective communication is vital to ensure that the claimant is well-informed and able to maximally cooperate in the process. Assessors should:

- ensure that the claimant understands who the assessor is and the assessor's role in the evaluation;
- ensure that the claimant understands how the evaluation will proceed;
- take reasonable steps to preserve the privacy and modesty of the claimant during the evaluation;
- not provide any opinion to the claimant about their claim.

Useful information is also provided in the pamphlet developed by the Australian Medical Association and the Law Society that informs applicants what to expect during an examination by an independent medical assessor. This pamphlet is reproduced in Appendix 3 (p86) and additional copies are available from the AMA.

WorkCover has also produced information for workers regarding independent medical examinations and assessments of permanent impairment, which the insurer should have supplied to the worker when advising the appointment details.

Complaints received by WorkCover in relation to the behaviour of an assessor during an evaluation will be initially reviewed by WorkCover. If complaints recur or the initial review reveals a problem potentially exists, the complaint will be referred to the Health Care Complaints Commission and the NSW Medical Board for investigation and appropriate action.

Adjustment for the effects of orthoses and prostheses

Assessments of permanent impairment are to be conducted without assistive devices, except where these cannot be removed. The assessor will need to make an estimate as to what is the level of impairment, without such a device, if it cannot be removed for examination purposes. Further details may be obtained in the relevant Chapters in the *WorkCover Guides*.

Impairment of vision should be measured with the injured worker wearing their prescribed corrective spectacles and/or contact lenses, if this was usual for the injured worker before the workplace injury. If, as a result of the workplace injury, the injured worker has been prescribed corrective spectacles and/or contact lenses for the first time, or different spectacles and/or contact lenses than those prescribed pre-injury, the difference should be accounted for in the assessment of permanent impairment.

Adjustment for the effects of treatment

In circumstances where the treatment of a condition leads to a secondary impairment, other than a secondary psychological impairment, the assessor should use the appropriate parts of the *WorkCover Guides* to evaluate the effects of treatment, and use the Combined Values Chart (pp 604-606 AMA5) to arrive at a final Whole Person Impairment.

Where the effective treatment of an illness or condition results in apparent total remission of the claimant's signs and symptoms, but the claimant is likely to revert to the impaired state if treatment is withdrawn, the assessor may increase the percentage of whole person impairment by 1%–3%. This percentage should be combined with any other impairment percentage, using the Combined Values Chart.

As previously indicated, where a claimant has declined treatment which the assessor believes would be beneficial, the impairment rating should be neither increased or decreased.

Reports

A report of the evaluation of permanent impairment should be accurate, comprehensive and fair. It should clearly address the question being asked of the assessing medical practitioner. In general, the assessor will be requested to address issues of:

- current clinical status, including the basis for determining maximum medical improvement;
- the degree of permanent impairment that results from the injury;
- the proportion of permanent impairment due to any previous injury, pre-existing condition or abnormality, if any.

The report should contain factual information based on the assessor's own history taking and clinical examination. If other reports or investigations are relied upon in arriving at an opinion, these should be appropriately referenced in the assessor's report.

The *WorkCover Guides* to the Evaluation of Permanent Impairment 2001 are to be used in assessing permanent impairment in the NSW Workers Compensation scheme. The report of the evaluation should provide a rationale consistent with the methodology and content of these Guides. It should include a comparison of the key findings of the evaluation with the impairment criteria in the Guides. If the evaluation was conducted in the absence of any

pertinent data or information, the assessor should indicate how the impairment rating was determined with limited data.

The assessed level of impairment is to be expressed as a percentage of whole person impairment (%WPI). Regional body impairments, where used (for example, percentage upper limb impairment) are to be indicated in the report and then converted to %WPI.

The report should include a conclusion of the assessor, including the final %WPI. This is to be included as the final paragraph in the body of the report, and not as a separate report.

Reports are to be provided within seven days of the assessment being completed, or as agreed between the referee and the assessor.

Ordering of additional investigations

As a general principle, the assessing medical practitioner should not order additional radiographic or other investigations purely for the purpose of conducting an assessment of permanent impairment.

If, however, the investigations previously undertaken are not as required by the *WorkCover Guides* or are inadequate for a proper assessment to be made, the medical assessor should consider the value of proceeding with the evaluation of permanent impairment without adequate investigations.

In circumstances where the assessor considers that further investigation is essential for a comprehensive evaluation to be undertaken and deferral of the evaluation would considerably inconvenience the claimant (eg, when the claimant has travelled from a country region specifically for the assessment), the assessing medical practitioner may proceed to order the appropriate investigations, provided that there is no undue risk to the claimant. The approval of the referring body for the additional investigation will be required to ensure that the costs of the test are met promptly.

Deductions for pre-existing condition or injury

(AMA5 Section 1–6, p11) In assessing the degree of permanent impairment resulting from the injury, the assessor is to indicate the proportion of WPI due to any previous injury, pre-existing condition or abnormality. This proportion is known as “the deductible proportion”.

If this amount is difficult or costly to determine, the assessor should indicate this in the report. In this case, for the injury now being assessed, the deduction is 10% of the impairment, unless this is at odds with the available evidence.

Impairment assessors may be requested to specify parts of the deductible proportion in accordance with legislative requirements concerning type of work, when the work was performed, and the dates injuries were received.

Compensation for permanent impairment

The employer, or insurer, and worker can agree on the amount of compensation to be paid following an assessment of permanent impairment. The amount of monetary compensation will be awarded according to the formulae prescribed by the Workers Compensation Act 1987.

Compensation for pain and suffering

A claimant may receive a separate payment for compensation for pain and suffering, under section 67 of the Workers Compensation Act 1987, where the level of whole person impairment is assessed at or above the threshold percentage. "Pain and Suffering" means actual pain, or distress, or anxiety suffered, or likely to be suffered by the injured worker resulting from the permanent impairment or any necessary treatment.

Once agreement is reached on the level of permanent impairment, an amount can also be agreed for pain and suffering. The determination of the amount to be paid for pain and suffering is independent of the percentage of whole person impairment. Medical assessors of permanent impairment are not required to indicate the level of pain and suffering to be awarded.

Disputes over assessed levels of permanent impairment

A dispute about the level of permanent impairment compensation can be referred to the Workers Compensation Commission. The parties can agree on the selection of an Approved Medical Specialist (AMS) to determine the dispute. If the two parties are unable to agree on the selection of an AMS within 7 days of being notified of a dispute by the Registrar of the Commission, the Registrar will appoint an AMS to assess the dispute.

Assessments are to be undertaken within the claimant's geographical region as far as is reasonably practicable. The AMS may consult with any medical practitioner or other health professional who is treating or has treated the worker. The AMS may request access to all or any medical records and investigations and any other information that is necessary for the purpose of assessing the dispute. The AMS may also examine the worker.

A certificate will be provided by the appointed AMS after completing the evaluation.

The certification of the level of permanent impairment by the AMS appointed to resolve the dispute is conclusively presumed to be correct (section 326 of the 1998 Act).

The certificate provided by the appointed AMS will form the basis of the Arbitrator's decision on the amount of money to be awarded for permanent impairment and pain and suffering.

2 Upper extremity

AMA5 Chapter 16 applies to the assessment of permanent impairment of the upper extremities, subject to the modifications set out below.

Introduction

2.1 The upper extremities are discussed in AMA5 Chapter 16 (pp433–521). This long Chapter provides guidelines on methods of assessing permanent impairment involving these structures. It is a complex Chapter that requires an organised approach with careful documentation of findings. Diagnosis-related estimates (DREs) are not used to the same extent as in the lower extremity section of AMA5.

2.2 Evaluation of anatomical impairment forms the basis for upper extremity impairment assessment. The ratings reflect the degree of impairment and its impact on the ability of the person to perform activities of daily living. The most practical and useful approach to evaluating impairment of part of the upper extremity is to compare the current loss of function with the loss resulting from amputation. There can be clinical conditions where evaluation of impairment may be difficult, for example lateral epicondylitis of the elbow. Such conditions are evaluated by their effect on function of the upper extremity, or, if all else fails, by analogy with other impairments that have similar effect(s) on upper limb function.

The approach to assessment of the upper extremity and hand

2.3 Assessment of the upper extremity mainly involves clinical evaluation. Cosmetic and functional evaluations are performed in some situations. The impairment must be permanent and stable. The injured person will have a defined diagnosis that can be confirmed by examination.

2.4 The assessed impairment of a part or region can never exceed the impairment due to amputation of that part or region. For an upper limb, therefore, the maximum evaluation is 60% whole person impairment.

2.5 Active range of motion should be measured with several repetitions to establish reliable results. Only active motion is measured, not passive motion.

2.6 To achieve an accurate and comprehensive assessment of the upper extremity findings should be documented on a standard form. AMA5 Figures 16–1a and 16–1b (pp436–437) are extremely useful, both to document findings and to guide the assessment process. Note, however, that the final summary parts of Figures 16–1a and 16–1b do not make it clear that identifiable impairments which are the result of a peripheral nerve injury (eg, digital nerve sensory loss, decreased range of motion of joints, etc) are not to be separately assessed, evaluated and combined with the impairment evaluation for the peripheral nerve injury. (See also 2.9 below).

2.7 The hand and upper extremity are divided into regions: thumb, fingers, wrist, elbow, and shoulder. Close attention needs to be paid to the instructions in Figures 16–1a and 16–1b (pp436–437, AMA5) regarding adding or combining impairments.

2.8 Table 16–3 (p439, AMA5) is used to convert upper extremity impairment to whole person impairment. **Note that 100% upper extremity impairment is equivalent to 60% whole person impairment.**

Specific interpretation of AMA5 — the hand and upper extremity

Impairment of the upper extremity due to peripheral nerve disorders

2.9 If an upper extremity impairment results solely from a peripheral nerve injury, the assessor should not also evaluate impairment(s) from Sections 16.2 to 16.4 (pp441–479, AMA5) for that upper extremity. Section 16.5 should be used for evaluation of such impairment. For peripheral nerve lesions use Table 16–15 (p492, AMA5) together with Tables 16–10a and 16–11a (pp482 and 484, AMA5) for evaluation.

2.10 When applying Tables 16–10a (p482, AMA5) and Table 16–11a (p484, AMA5) the maximum value for each grade should be used.

Impairment due to other disorders of the upper extremity

2.11 The section "Impairment of the Upper Extremity Due to Other Disorders" (AMA5 Section 16.7 pp498-507) should be used only when other criteria (as presented in Sections 16.2–16.6 [pp 441-498 of AMA5]) have not adequately encompassed the extent of the impairments. Impairments from the disorders considered in Section 16.7 are usually estimated using other criteria. The assessor must take care to avoid duplication of impairments.

2.12 Radiographs for carpal instability (AMA5 Table 16–25, p503) should only be considered, if available, along with the clinical signs. X-ray examination should not be performed solely for this evaluation.

2.13 If strength evaluation is chosen as a method of assessing upper extremity impairment, the caveats detailed on AMA5 page 508, under the heading "16.8a Principles", need to be observed.

3 Lower extremity

AMA5 Chapter 17 applies to the assessment of permanent impairment of the lower extremities, subject to the modifications set out below.

Introduction

3.1 The lower extremities are discussed in AMA5 Chapter 17 (pp523–564). This section is complex and provides a number of alternative methods of assessing permanent impairment involving the lower extremity. An organised approach is essential and findings should be carefully documented on a worksheet.

The approach to assessment of the lower extremity

3.2 Assessment of the lower extremity involves physical evaluation, which can use a variety of methods. In general, the method should be used that most specifically addresses the impairment present. For example, impairment due to a peripheral nerve injury in the lower extremity should be assessed with reference to that nerve rather than by its effect on gait.

3.3 There are several different forms of evaluation that can be used, as indicated in Sections 17.2b to 17.2n (pp528–554 AMA5). Table 17–2 (p526 AMA5) indicates which evaluation methods can be *combined* and which cannot. It may be possible to perform several different evaluations as long as they are reproducible and meet the conditions specified below and in AMA5. The most specific method of impairment assessment should be used.

3.4 It is possible to use an algorithm to aid in the assessment of lower extremity impairment. Use of worksheets is essential. Tables 3.2 and 3.3 of these *WorkCover Guides* (pp20–21) are such worksheets and may be used in assessment of permanent impairment of the lower extremity.

3.5 In the assessment process, the evaluation giving the highest impairment rating is selected. That may be a combined impairment in some cases, in accordance with the Guide to the Appropriate Combination of Evaluation Methods Table (Table 17–2, p 526 AMA5), using the Combined Values Chart (pp604–606, AMA5).

3.6 When the Combined Values Chart is used, the assessor must ensure that all values combined are in the same category of impairment rating (ie, %WPI, Lower extremity impairment %, Foot impairment %, and so on). The final lower extremity impairment percentage has to be converted to %WPI and then it may be combined with the %WPI assessed for other impairments.

3.7 Table 17–2 (p526, AMA5) needs to be referred to frequently to determine which impairments can be combined and which cannot.

Specific interpretation of AMA5 — the lower extremity

Leg length discrepancy

3.8 When true leg length discrepancy is determined clinically (AMA5 Section 17.2b, p528), the method used must be indicated (for example, tape measure from anterior superior iliac spine to the medial malleolus). Clinical assessment of leg length discrepancy is an acceptable method but if computerised tomography films are available they should be used in preference. Such an examination should not be ordered solely for determining leg lengths.

3.9 When applying Table 17–4 (p528, AMA5), the element of choice should be removed and impairments for leg length discrepancy should be read as the higher figure of the range quoted (ie, 0, 3, 5, 7, or 8 for whole person impairment, or 0, 9, 14, 19, or 20 for lower limb impairment).

Gait derangement

3.10 If gait derangement (AMA5 Section 17.2c, p529) is used as the method of impairment assessment for the lower extremity it cannot be combined with any other evaluation in the lower extremity section of AMA5. It should rarely be used (see 3.13).

3.11 Any walking aid used by the subject must be permanent and not temporary.

3.12 In the application of Table 17–5 (p529, AMA5), delete item b, as the Trendelenburg sign is not sufficiently reliable.

3.13 Assessment of gait derangement should be used as the method of last resort. Methods of impairment assessment most fitting the nature of the disorder should always be used in preference.

Muscle atrophy (unilateral)

3.14 This section (AMA5 Section 17.2d, p530) should be used infrequently. It is not applicable if the limb other than that being assessed is abnormal (for example, if varicose veins cause swelling, or if there is other injury).

3.15 In the use of Table 17–6 (p530, AMA5) the element of choice should be removed in the impairment rating and only the higher figure used. Therefore, for the thigh, the whole person impairment should be assessed as 0, 2, 4, or 5 %, or lower limb impairment as 0, 8, 13, or 13 % respectively. For the calf the equivalent figures have the same numerical values.

Manual muscle strength testing

3.16 The Medical Research Council (MRC) gradings for muscle strength are universally accepted. They are not linear in their application, but ordinal. Only the six grades (0–5) should be used, as they are reproducible among experienced assessors. The descriptions in Table 17–7 (p531, AMA5) are correct. The results of electrodiagnostic methods and tests are not to be considered in the evaluation of muscle testing which can be performed manually. Table 17–8 (p532, AMA5) is to be used for this method of evaluation.

Range of motion

3.17 Although range of motion (ROM) (AMA5 Section 17.2f, pp533–538) appears to be a suitable method for evaluating impairment, it is subject to variation because of pain during motion at different times of examination, possible lack of cooperation by the person being assessed and inconsistency. If there is such inconsistency then ROM cannot be used as a valid parameter of impairment evaluation.

3.18 If range of motion is used as an assessment measure, then Tables 17–9 to 17–14 (p537, AMA5) are selected for the joint or joints being tested. If a joint has more than one plane of motion, the impairment assessments for the different planes should be *added*. For example, any impairments of the six principal directions of motion of the hip joint are *added* (p533, AMA5).

Ankylosis

3.19 For the assessment of impairment when a joint is ankylosed (AMA5 Section 17.2g, pp538–543) the calculation to be applied is to select the impairment if the joint is ankylosed in optimum position (See Table 3.1 below), and then if not ankylosed in the optimum position by *adding* (not combining) the values of %WPI using Tables 17–15 to 17–30 (pp538–543, AMA5).

Table 3.1 Impairment for ankylosis in the optimum position

Joint	Whole person	Lower extremity	Ankle or foot
Hip	20%	50%	–
Knee	27%	67%	–
Ankle	4%	10%	14%
Foot	4%	10%	14%

Note that the whole person impairment from ankylosis of a joint, or joints, in a lower limb cannot exceed 40% whole person impairment or 100% lower limb impairment. If this figure is exceeded when the combination of a lower limb impairment is made then only 40% can be accepted as the maximum whole person impairment for a lower limb.

Arthritis

3.20 Impairment due to arthritis (AMA5 section 17.2n, pp544–545) following a work-related injury is uncommon, but may occur in isolated cases. The presence of arthritis may indicate a pre-existing condition and this should be assessed and an appropriate deduction made (see Chapter 1, p11, *WorkCover Guides*).

3.21 The presence of osteoarthritis is defined as cartilage loss. Cartilage loss can be assessed by plain radiography, computed tomography (CT), magnetic resonance imaging (MRI) or by direct vision (arthroscopy). MRI using cartilage sensitive sequences is superior to plain radiology in demonstrating cartilage deficiency, but is not required if the diagnosis of osteoarthritis is obvious on plain radiography.

3.22 Detecting the subtle changes of cartilage loss on plain radiography requires comparison with the normal side. All joints should be imaged directly through the joint space, with no overlapping of bones. If the optimal views are not available, they should be obtained. If comparison views are not available, AMA5 Table 17–31 (page 544) is used as a guide to assess joint space narrowing.

3.23 One should be cautious in making a diagnosis of cartilage loss on plain radiography if secondary features of osteoarthritis, such as osteophytes, subarticular cysts or subchondral sclerosis are lacking, unless the other side is available for comparison. The presence of an intra-articular fracture with a step in the articular margin in the weight bearing area implies cartilage loss.

3.24 The accurate radiographic assessment of joints always requires at least two views. In some cases, further supplementary views will optimise the detection of joint space narrowing or the secondary signs of osteoarthritis.

Sacro-iliac joints: Being a complex joint, modest alterations are not detected on radiographs, and cross-sectional imaging may be required. Radiographic manifestations accompany pathological alterations. The joint space measures between 2 mm and 5 mm. Osteophyte formation is a prominent characteristic of osteoarthritis of the sacro-iliac joint.

Hip: An anteroposterior view of the pelvis and a lateral view of the affected hip are ideal. If the affected hip joint space is narrower than the asymptomatic side, cartilage loss is regarded as being present. If the anteroposterior view of pelvis has been obtained with the patient supine, it is important to compare the medial joint space of each hip as well as superior joint space, as this may be the only site of apparent change. If both sides are symmetrical, then other features, such as osteophytes, subarticular cyst formation, and calcar thickening should be taken into account to make a diagnosis of osteoarthritis.

Knee:

- **Tibio-femoral joint:** The best view for assessment of cartilage loss in the knee is usually the erect intercondylar projection, as this profiles and stresses the major weight bearing area of the joint which lies posterior to the centre of the long axis. The ideal x-ray is a posteroanterior view with the patient standing, knees slightly flexed, and the x-ray beam angled parallel to the tibial plateau. Both knees can readily be assessed with the one exposure. In the knee it should be recognised that joint space narrowing does not necessarily equate with articular cartilage loss, as deficiency or displacement of the menisci can also have this effect. Secondary features, such as subchondral bone change and the past surgical history, must also be taken into account.
- **Patello-femoral joint:** Should be assessed in the "skyline" view, again preferably with the other side for comparison. The x-ray should be taken with 30 degrees of knee flexion to ensure that the patella is load-bearing and has engaged the articular surface femoral groove.

Ankle: The ankle should be assessed in the mortice view, (preferably weight-bearing) with comparison views of the other side, although this is not as necessary as with the hip and knee.

Subtalar: This joint is better assessed by CT (in the coronal plane) than by plain radiography. The complex nature of the joint does not lend itself to accurate and easy plain x-ray assessment of osteoarthritis.

Talonavicular and calcaneocuboid: Anteroposterior and lateral views are necessary. Osteophytes may assist in making the diagnosis.

Intercuneiform and other intertarsal joints: Joint space narrowing may be difficult to assess on plain radiography. CT (in the axial plane) may be required. Associated osteophytes and subarticular cysts are useful adjuncts to making the diagnosis of osteoarthritis in these small joints.

Great toe metatarsophalangeal: Anteroposterior and lateral views are required. Comparison with the other side may be necessary. Secondary signs may be useful.

Interphalangeal: It is difficult to assess small joints without taking secondary signs into account. The plantar–dorsal view may be required to get through the joints, in a foot with flexed toes.

3.25 If arthritis is used as the basis for assessing impairment assessment, then the rating *cannot be combined* with gait disturbance, muscle atrophy, muscle strength or range of movement assessments. It can be combined with a diagnosis-based estimate. (Table 17–2, AMA5, p526.)

Amputation

3.26 Where there has been amputation of part of a lower extremity Table 17–32 (p545, AMA5) applies. In that table the references to 3 inches for below-the-knee amputation should be converted to 7.5 cm.

Diagnosis-based estimates (lower extremity)

3.27 Section 17.2j (pp545–549, AMA5) lists a number of conditions that fit a category of Diagnosis-Based Estimates. They are listed in Tables 17–33, 17–34 and 17–35 (pp546–549, AMA5). When using this table it is essential to read the footnotes carefully.

3.28 It is possible to *combine* impairments from Tables 17–33, 17–34 and 17–35 for diagnosis-related estimates with other components (eg, nerve injury) using the Combined Values Chart (pp604–606, AMA5) after first referring to the Guide to the Appropriate Combination of Evaluation Methods (see 3.5 above).

3.29 In the interpretation of Table 17–33 (p547, AMA5), reference to the hindfoot, intra-articular fractures, the words *subtalar bone, talonavicular bone*, and *calcaneocuboid bone* imply that the bone is displaced on one or both sides of the joint mentioned. To avoid the risk of double assessment, if avascular necrosis with collapse is used as the basis of impairment assessment, it cannot be combined with the relevant intra-articular fracture in Table 17–33 column 2. In Table 17–33 column 2, metatarsal fracture with loss of weight transfer means dorsal displacement of the metatarsal head.

3.30 Table 17–34 and Table 17–35 (pp548–549, AMA5) use a different concept of evaluation. A point score system is applied, and then the total of points calculated for the hip (or knee) joint is converted to an impairment rating from Table 17–33. Tables 17–34 and 17–35 refer to the hip and knee joint replacement respectively. Note that, while all the points are *added* in Table 17–34, some points are *deducted* when Table 17–35 is used.

3.31 In respect of "distance walked" under "b. Function" in Table 17–34 (p548, AMA5), the distance of six blocks should be construed as 600 m, and three blocks as 300 m.

Skin loss (lower extremity)

3.32 Skin loss (p550, AMA5) can only be included in the calculation of impairment if it is in certain sites and meets the criteria listed in Table 17–36 (p550, AMA5).

Peripheral nerve injuries (lower extremity)

3.33 When assessing the impairment due to peripheral nerve injury (pp550–552, AMA5) assessors should read the text in this section. Note that the separate impairments for the motor, sensory and dysaesthetic components of nerve dysfunction in Table 17–37 (p552, AMA5) are to be *combined.*

3.34 Note that the (posterior) tibial nerve is not included in Table 17–37, but its contribution can be calculated by subtracting ratings of common peroneal nerves from sciatic nerve ratings.

3.35 Peripheral nerve injury impairments can be *combined* with other impairments, but not those for gait derangement, muscle atrophy, muscle strength or complex regional pain syndrome, as shown in Table 17–2 (p526, AMA5).

Complex regional pain syndrome (lower extremity)

3.36 The Section 17.2m, "Causalgia and Complex Regional Pain Syndrome (Reflex Sympathetic Dystrophy)" (p553, AMA5) should not be used. Complex Regional Pain Syndrome involving the lower extremity should be evaluated in the same way as the upper limb using the method described in Section 16.5e (pp495–497, AMA5). This section provides a detailed method that is in keeping with current terminology and understanding of the condition. Use of the same methods of impairment assessment for Complex Regional Pain Syndrome involving either the upper or lower extremity also will improve the consistency of these WorkCover Guidelines.

Peripheral vascular disease (lower extremity)

3.37 Lower extremity impairment due to vascular disorders (pp553–554, AMA5) is evaluated using Table 17–38 (p554, AMA5). Note that Table 17–38 gives values for lower extremity not whole person impairment. In that table there is a range of lower extremity impairments within each of the classes 1 to 5. As there is a clinical description of which conditions place a person's lower extremity in a particular class, the assessor has a choice of impairment rating within a class, the value of which is left to the clinical judgement of the assessor.

Table 3.2: Lower extremity worksheet

Item	Impairment	AMA5 Table	AMA5 page	Potential impairment	Selected impairment
1	Limb length discrepancy	17–4	528		
2	Gait derangement	17–5	529		
3	Unilateral muscle atrophy	17–6	530		
4	Muscle weakness	17–8	532		
5	Range of motion	17–9 to 17–14	537		
6	Joint ankylosis	17–15 to 17–30	538–543		
7	Arthritis	17–31	544		
8	Amputation	17–32	545		
9	Diagnosis-based estimates	17–33 to 17–35	546–549		
10	Skin loss	17–36	550		
11	Peripheral nerve deficit	17–37	552		
12	Complex regional pain syndrome	Section 16.5e	495–497		
13	Vascular disorders	17–38	554		
	Combined impairment rating (refer to Table 17–2, p 526 AMA5 for permissible combinations)				

Potential impairment is the impairment percentage for that method of assessment. Selected impairment is the impairment, or impairments, selected that can be legitimately combined with other lower extremity impairments to give a final lower extremity impairment rating.

Table 3.3: Lower extremity impairment flow chart

(1) Question	(2) Answer	(3) Go to			(4) Enter impairment			(5) Can be combined with another parameter: See Table 17–2, AMA5 p526
		Section	Table	Page	Joint	Lower extremity	Whole person	
Is there gait derangement?	→ YES	17.2c	17–5	529				No
↓ No								
Is there unilateral muscle atrophy?	→ YES	17.2d	17–6	530				Line 1, 9, 12
↓ No								
Is there true muscle weakness?	→ YES	17.2e	17–8	532				Lines 1, 9, 12
↓ No								
Is joint movement restricted but not absent?	→ YES	17.2f	17–9 to 17–14	537				Lines 1, 7, 9, 10, 12
↓ No								
Is joint ankylosed?	→ YES	17.2g	17–15 to 17–30	538–543				Lines 1, 7, 9, 10, 12
↓ No								
Is there arthritis?	→ YES	17.2h	17–31*	544				Lines 1, 7, 8, 9, 10, 11, 12
↓ No								
Is a part amputated?	→ YES	17.2i	17–32	545				Lines 4, 5, 6, 8, 9, 10, 11, 12
↓ No								
Can a diagnosis-based estimate be applied?	→ YES	17.2j	17–33 to 17–35	546–549				Lines 1, 6, 7, 9, 10, 11, 12
↓ No								
Is there limb length discrepancy?	→ YES	17.2b	17–4	528				Lines 3, 4, 5, 6, 8, 9, 10, 11, 12
↓ No								
Is there skin loss?	→ YES	17.2k	17–36	550				Lines 1, 3, 4, 5, 6, 7, 8, 10, 11, 12
↓ No								

*Provided radiography performed in defined positions. see paragraph 3.21 (page 17).

continued...

Table 3.3: Lower extremity impairment flow chart continued

(1) Question	(2) Answer	(3) Go to			(4) Enter impairment			(5) Can be combined with another parameter: See Table 17–2, AMA5 p526
		Section	Table	Page	Joint	Lower extremity	Whole person	
Is there peripheral nerve injury?	→ YES	17.2l	17–37	552				Lines 1, 5, 6, 7, 8, 9, 12
↓ No								
Is there complex regional pain syndrome?	→ YES	16.5e	16–16	496				Lines 1, 6, 7, 8, 9
↓ No								
Is there peripheral vascular disease?	→ YES	17.2n	17–38	554				Lines 1, 3, 4, 5, 6, 7, 8, 9, 10
↓ No								
Can any of the above be combined?	→ YES	Check AMA5 Table 17–2, p526. Ensure all are lower limb impairments or whole person impairments. Combine using Combined Values Chart (AMA5 pp604-606). Convert to WPI.						
Combined total Lower extremity whole person impairment								
If other body regions are impaired, combine them using Combined Values Chart (AMA5 pp604–606) to arrive at final WPI.					Specify which other impairment			

4 The spine (excluding spinal cord injury)

AMA5 Chapter 15 applies to the assessment of permanent impairment of the spine, subject to the modifications set out below.

Introduction

4.1 The spine is discussed in AMA5 Chapter 15 (pp373–431). That Chapter presents two methods of assessment, the diagnosis-related estimates method and the range of motion method. Evaluation of impairment of the spine under WorkCover is to be done using diagnosis-related estimates (DREs).

4.2 The method relies especially on evidence of neurological deficits and less common, adverse structural changes, such as fractures and dislocations. Using this method, DREs are differentiated according to clinical findings that can be verified by standard medical procedures.

4.3 The assessment of spinal impairment is made when the person's condition has stabilised and has reached maximal medical improvement (MMI), as defined in AMA5. If surgery has been performed, the outcome of the surgery as well as structural inclusions must be taken into consideration when making the assessment.

Assessment of the spine

4.4 The DRE model for assessment of spinal impairment should be used. The Range of Motion model (Section 15.1b, AMA5 pp378–379) should *not* be used.

4.5 If a person has spinal cord damage, he or she is assessed according to the method described in Chapter 5 of the *WorkCover Guides*. AMA5 Sections 15.2 (pp379–381), and 15.7–15.12 (pp395–426) are not used for assessing impairments of the spinal cord.

4.6 Table 4.1 (see over) is a summary table that refers to all areas of the spine. It is to be used in conjunction with the specific criteria for rating impairment categories of DREs in Tables 15–3, 15–4 and 15–5 (AMA5 pp384, 389 and 392).

4.7 If an assessor is unable to distinguish between two DRE categories, then the higher of those two categories should apply. The inability to differentiate should be noted in the assessor's report.

4.8 Possible influence of future treatment should not form part of the impairment assessment. The assessment should be made on the basis of the person's status at the time of interview and examination, if the assessor is convinced that the condition is stable and permanent. Likewise, the possibility of subsequent deterioration, as a consequence of the underlying condition, should not be factored in to the impairment evaluation. Commentary can be made regarding the possible influence, potential or requirements for further treatment, but this does not affect the assessment of the individual at the time of impairment evaluation.

4.9 All spinal impairments are to be expressed as a percentage whole person impairment (%WPI).

Table 4.1: Assessing spinal impairment

	Diagnosis-related estimate category				
Patient's Condition	**I**	**II**	**III**	**IV**	**V**
Low back pain, neck pain [back pain (lumbago), WAD* I] Complaints or symptoms	I				
Vertebral body compression, < 25%	II				
Low back pain, neck pain, guarding, non-verifiable radicular complaints [Somatic leg pain, WAD II]		II			
Posterior element fracture, healed, stable, no dislocation or radiculopathy		II			
Transverse or spinous process fracture with displacement of fragment, healed, stable		II			
Low back or neck pain with radiculopathy [Sciatica, WAD III]			III		
Vertebral body compression fracture 25–50%			III		
Posterior element fracture with spinal canal deformity or radiculopathy, stable, healed			III		
Radiculopathy			III		
Vertebral body compression > 50%				IV	V
Multilevel structural compromise				IV	V
Spondylolysis with radiculopathy			III	IV	V
Spondylolisthesis without radiculopathy	I	II			
Spondylolisthesis with radiculopathy			III	IV	V
Vertebral body fracture without radiculopathy		II	III	IV	
Vertebral body fracture with radiculopathy			III	IV	V
Vertebral body dislocation without radiculopathy		II	III	IV	
Vertebral body dislocation with radiculopathy			III	IV	V
Previous spine operation without radiculopathy		II	III	IV	
Previous spine operation with radiculopathy			III	IV	V
Stenosis, facet arthrosis or disease, or disc arthrosis	I	II	III		

*Whiplash associated disorder. WAD 1: Neck complaint of pain, stiffness or tenderness only. No physical sign(s). WAD II: Neck complaint AND musculoskeletal sign(s). Musculoskeletal signs include decreased range of motion and point tenderness. WAD III: Neck complaint AND neurological sign(s). Neurological signs include decreased or absent deep tendon reflexes, weakness and sensory deficits. WAD IV: Neck complaint AND fracture or dislocation. (Motor Accidents Authority. *Update of Quebec Task Force Guidelines for the Management of Whiplash-associated Disorders.* January 2001: p5.)

4.10 The assessment should include a comprehensive, accurate history; a review of all pertinent records available at the assessment; a comprehensive description of the individual's current symptoms and their relationship to daily activities; a careful and thorough physical examination; and all findings of relevant laboratory, imaging, diagnostic and ancillary tests available at the assessment. Imaging findings that are used to support the impairment rating should be concordant with symptoms and findings on examination. The assessor should record whether diagnostic test and radiographs were seen or whether they relied on reports.

4.11 Section 15.1a (AMA5 pp374–377) is a valuable summary of history and physical examination, and should be thoroughly familiar to all assessors.

4.12 Table 4.2 below (adapted from Figure 61, AMA4 pp96–97) *may* be used for a summary of the spinal history.

4.13 The assessor should include in the report a description of how the impairment rating was calculated, with reference to the relevant tables and/or figures used.

Table 4.2: History of spinal complaint

1. History of impairment or injury

Describe all symptoms, location, frequency of occurrence, duration, quality with particular attention to time and circumstances of onset, course of condition, treatment, treatment response; note presence of pain, numbness, weakness, stiffness.

2. Condition limits the patient or interferes with which daily activities?

List the activities. What activities has the patient reduced or given up? Describe them

3. Patient's perceptions

a How long at one time and over an 8-hour period can the patient do the following without serious discomfort? (Express in terms of half-hours or hours and note the unit used)

Sit..... Walk..... Stand.....

b How many kgs can the patient lift at frequent intervals?.....

Occasionally? .....

4. Present symptoms

a. Starting date of present symptoms:.....

b. How long have symptoms been the same? If changing, Describe how.

.....

.....

c. Previous back or neck problems or surgeries (Dates)

1 .....

2 .....

3 .....

4 .....

d. Special tests or procedures

Type	Date	Results

e. What exercises does the patient do to stay physically fit or "in shape?"

Type	Duration	Frequency per week?

f. Usual daily activities and postures (tick those that apply):

Sit..... Walk..... Stand.....

Lift..... Maximum number of kilograms.....

Other (describe):

.....

.....

5. Patient's understanding of reason for this impairment evaluation:

.....

.....

History taken by: .....

Specific interpretation of AMA5

4.14 The range-of-motion (ROM) method is *not* used, hence any reference to this is omitted. Specifically, omit AMA5 Section 15.2.

4.15 Motion segment integrity alteration can be either *increased* translational or angular motion, or *decreased* motion resulting from developmental changes, fusion, fracture healing, healed infection or surgical arthrodesis. Motion of the individual spine segments cannot be determined by a physical examination, but is evaluated with flexion and extension radiography.

4.16 The assessment of altered motion segment integrity is to be based upon a report of the result of an injury, and not on developmental or degenerative changes.

4.17 When routine imaging is normal and severe trauma is absent, motion segment disturbance is rare. Thus, flexion and extension imaging is indicated *only* when a history of trauma or other imaging leads the physician to suspect alteration of motion segment integrity. Generally, further studies are not to be ordered by the assessor.

DRE definitions of clinical findings

4.18 The clinical findings used to place an individual in a DRE category are described in Box 15–1 (AMA5, pp382–383).

4.19 In "Clinical Findings" in Box 15–1 (AMA5, pp382–383), references to electrodiagnostic verification of the cauda equina syndrome should be disregarded.

(The use of electrodiagnostic procedures such as electromyography is proscribed as an assessment aid for decisions about the category of impairment into which a person should be placed. It is considered that competent assessors can make decisions about which DRE category a person should be placed in from the clinical features alone. The use of electrodiagnostic differentiators is both unnecessary and subject to artefact. If there is doubt about which of two DRE categories should be used, the higher should be chosen.)

4.20 Cauda equina syndrome and neurogenic bladder disorder are to be assessed by the method prescribed in the nervous system Chapter of AMA5 (pp305–356).

Applying the DRE method

4.21 The specific procedures and directions section of AMA5 (Section 15.2a, pp380–381) indicates the steps that should be followed to evaluate impairment of the spine. Table 4.3 is a simplified version of that section, incorporating the amendments listed above.

Table 4.3: Procedures in evaluating impairment of the spine

History

Physical examination

⇓

Diagnosis

⇓

Find the condition in Table 4.1

⇓

Use clinical findings to place an individual's condition in a DRE category according to Box 15.1, AMA5 pp382–383

⇓

Choose the category that determines the percentage impairment:

Lumbar region	**AMA5 Table 15–3, p384**
Thoracic region	**AMA5 Table 15–4, p389**
Cervical region	**AMA5 Table 15–5, p392**

4.22 Common developmental findings, spondylolysis, spondylolisthesis and disc protrusions without radiculopathy occur in 7%, 3 %, and up to 30% respectively in individuals up to the age of 40 (AMA5, p383). Their presence does not of itself mean that the individual has an impairment due to injury.

4.23 **Impotence** should only be assessed as an impairment related to spinal injury where there is other objective evidence of spinal cord, cauda equina or bilateral nerve root dysfunction. The ratings described in Table 13–21 on p342 of AMA5 are used in this instance. There is no additional impairment rating system for impotence in the absence of objective clinical findings.

4.24 **Radiculopathy** is the impairment caused by malfunction of a spinal nerve root or nerve roots. Assigning of a DRE for spinal injury includes the presence or absence of radiculopathy (Category III in the lumbo-sacral region). In general, in order to conclude that a radiculopathy is present two or more of the following signs should be found:

- Dermatomal distribution of pain or numbness or paraesthesia;
- Positive root tension sign;
- Concordant finding on an imaging study (Box 15–1, AMA5 p382);
- Loss or asymmetry of reflexes;
- Muscle weakness that is anatomically localised to an appropriate spinal nerve root distribution;
- Reproducible sensory loss that is anatomically localised to an appropriate spinal nerve root distribution.

4.25 Note that radicular complaints of pain or sensory features that follow anatomical pathways but cannot be verified by neurological findings (somatic pain, non-verifiable radicular pain) do *not* alone constitute radiculopathy.

4.26 Global weakness of a limb related to pain or inhibition or other factors does not constitute weakness due to spinal nerve malfunction.

4.27 If imaging is to be used to support a diagnosis, the anatomical features that are reported to be abnormal on the imaging studies must be concordant with the distribution of the radicular malfunction.

4.28 **Multilevel structural compromise** implies spinal fractures and/or dislocations at more than one spinal level, without spinal cord compromise. If there is no radiculopathy, the individual is assigned to DRE category IV; if radiculopathy is present, then the person is assigned to category DRE category V.

(Multilevel structural compromise is to be interpreted as fractures of more than one vertebra. Such fractures are defined as *any* fracture of the vertebral body, or of the posterior elements forming the ring of the spinal canal. It *does not* include fractures of transverse processes or spinous processes, even at multiple levels.)

4.29 Fractures of transverse or spinous processes are assessed as DRE Category II because the fracture does not disrupt the spinal canal (AMA5, p385) and they do not cause multilevel structural compromise.

4.30 Effect of surgery: Tables 15–3, 15–4 and 15–5 (AMA5, pp384, 389 and 392), do not adequately account for the effect of surgery upon the impairment rating for certain disorders of the spine.

- Operations where the radiculopathy has resolved are considered under the DRE category III (AMA5, Tables 15–3, 15–4, 15–5);
- Operations with surgical ankylosis (fusion) are considered under DRE category IV (AMA5, Tables 15–3, 15–4, 15–5).

Table 4.4 indicates the additional ratings which should be *combined* with the rating determined using the DRE method where an operation for an intervertebral disc prolapse or spinal stenosis has been performed and where there is a residual radiculopathy following surgery.

Table 4.4: Modifiers for DRE categories where radiculopathy persists after surgery

Procedures	Cervical	Thoracic	Lumbar
Discectomy, or single-level decompression with residual signs and symptoms	3%	2%	3%
Multiple levels, operated on, with medically documented pain and rigidity	1% each level	1% each level	1% each level
Second operation	2%	2%	2%
Third and subsequent operations	1%	1%	1%

4.31 Impairment due to **pelvic fractures** should be evaluated with reference to AMA5 Section 15.14 (pp427–428). Specific ratings for pelvic fractures are provided in Table 15–19 (AMA5, p428). Impairment due to disorders of the pelvis, other than those due to specific pelvic fractures, should be estimated using the criteria and categories indicated in Table 17–33 (AMA5, p546).

4.32 **Arthritis:** See sections 3.20–3.23 of Chapter 3 of these *WorkCover Guides* (p17–19).

5 Nervous system

AMA5 Chapter 13 applies to the assessment of permanent impairment of the nervous system, subject to the modifications set out below.

Introduction

5.1 AMA5 Chapter 13, The Central and Peripheral Nervous System (pp305–356), provides guidelines on methods of assessing permanent impairment involving the central nervous system. It is logically structured and consistent with the usual sequence of examination of the nervous system. Cerebral functions are discussed first, followed by the cranial nerves, station, gait and movement disorders, the upper extremities related to central impairment, the brain stem, the spinal cord and the peripheral nervous system, including neuromuscular junction and muscular system. A summary concludes the Chapter.

5.2 Spinal cord injuries are to be assessed using AMA5 Chapter 13.

5.3 The relevant parts of the upper extremity, lower extremity and spine sections of AMA5 Chapter 13 should be used to evaluate impairments of the peripheral nervous system.

The approach to assessment of permanent neurological impairment

5.4 AMA5 Chapter 13 disallows combination of cerebral impairments. However, for the purpose of the *WorkCover Guides,* cerebral impairments should be evaluated and *combined* as follows:

- Consciousness and awareness
- Mental status, cognition and highest integrative function
- Aphasia and communication disorders
- Emotional and behavioural impairments.

The Assessor should take care to be as specific as possible and not to double-rate the same impairment, particularly in the mental status and behavioural categories.

These impairments are to be combined using the Combined Values Chart (AMA5, pp 604–606). These impairments should then be combined with other neurological impairments indicated in AMA5 Table 13–1 (p308).

5.5 Impairments due to spinal cord pathology (AMA5, pp340–342) are to be combined using the Combined Values Chart (AMA5, pp604–606). It should be noted that AMA5 Sections 13.5 and 13.6 (pp336–340) should be used for *all* motor or sensory impairments caused by a central nervous system lesion**.** Thus this section covers hemiplegia due to cortical injury as well as spinal cord injury.

5.6 Complex regional pain syndrome is to be assessed using the method indicated in AMA5 Chapter 16, The Upper Extremities (pp495–497).

5.7 The nervous system Chapter of AMA5 (Chapter 13) lists many impairments where the range for the associated whole person impairment is 0–9% or 0–14%. Where there is a range of impairment percentages listed, the assessor should nominate an impairment

percentage based on the complete clinical circumstances revealed during the consultation and in relation to all other available information.

Specific interpretation of AMA5

5.8 In assessing **disturbances of mental status and integrative functioning, and emotional or behavioural disturbances** (Sections 13.3d and 13.3f, AMA5 pp319–322, 325– 327), the assessor should make ratings of mental status impairments and emotional and behavioural impairments based on clinical assessment and the results of neuropsychometric testing. Clinical assessment should indicate at least one of the following:

- significant medically verified abnormalities in initial post injury Glasgow Coma Scale score, or
- significant duration of post traumatic amnesia, or
- significant intracranial pathology on CT scan or MRI.

Neuropsychological testing should be conducted by a registered clinical neuropsychologist who is a member, or is eligible for membership, of the Australian Psychological Society's College of Neuropsychology.

5.9 Assessment of **arousal and sleep disorders** (AMA5 Section 13.3c, pp 317–319): refers to assessment of primary sleep disorders following neurological injury. The assessor should make ratings of arousal and sleep disorders based on the clinical assessment that would normally have been done for clinically significant disorders of this type (ie, sleep studies or similar tests).

5.10 **Olfaction and taste:** the assessor should use AMA5 Chapter 11, Section 11.4c (p262) and Table 11–10 (pp272–275) to assess olfaction and taste, for which a maximum of 5% whole person impairment is allowable for total loss of either sense.

5.11 **Visual impairment** assessment (AMA4 Chapter 8, pp209–222): An ophthalmologist should assess all impairments of visual acuity, visual fields, extra-ocular movements or diplopia.

5.12 **Trigeminal nerve** assessment (AMA5, p331): Sensory impairments of the trigeminal nerve should be assessed with reference to AMA5 Table 13–11 (p331). The words "sensory loss or dysaesthesia" should be added to the table after the words "neuralgic pain" in each instance. Impairment percentages for the three divisions of the trigeminal nerve should be apportioned with extra weighting for the first division. If present, motor loss for the trigeminal nerve should be assessed in terms of its impact on mastication and deglutition (AMA5, p262).

5.13 **Spinal accessory nerve:** AMA5 provide insufficient reference to the spinal accessory nerve (cranial nerve XI). This nerve supplies the trapezius and sternomastoid muscles. For loss of use of the nerve to trapezius, the assessor should refer to AMA5 Chapter 16 on upper limb assessment, and a maximum of 10% impairment of the upper limb may be assigned. For additional loss of use of sternomastoid, a maximum of 3% upper limb impairment may be added.

5.14 Assessment of **sexual functioning** (AMA5, Chapter 7, pp 143–171): Impotence is assessed as an impairment only if there is an associated neurological impairment.

6 Ear, nose, throat and related structures

AMA5 Chapter 11 applies to the assessment of permanent impairment of the ear (with the exception of hearing impairment), nose, throat and related structures, subject to the modifications set out below.

Introduction

6.1 AMA5 Chapter 11 (pp 245–275) details the assessment of the ear, nose, throat and related structures. **With the exception of hearing impairment, which is dealt with in Chapter 9 of the *WorkCover Guides*,** AMA5 Chapter 11 should be followed in assessing permanent impairment, with the variations included below.

6.2 The level of impairment arising from conditions that are not work related needs to be assessed by the medical assessor and taken into consideration in determining the level of permanent impairment. The level at which pre-existing conditions and lifestyle activities such as smoking contribute to the level of permanent impairment requires judgement on the part of the clinician undertaking the impairment assessment. The manner in which any deduction for these is applied needs to be recorded in the assessing practitioner's report.

The ear

6.3 **Equilibrium** is assessed according to AMA 5 Section 11.2b (pp252–255), but add these words to AMA5 Table 11–4 (p253), Class 2:

"..without limiting the generality of the above, a positive Hallpikes test is a sign and an objective finding."

The face (AMA5, pp255–259)

6.4 AMA5 Table 11–5 (p256) should be replaced with Table 6.1, below, when assessing permanent impairment due to facial disorders and/or disfigurement.

Table 6.1: Criteria for rating permanent impairment due to facial disorders and/or disfigurement

Class 1 0%–5% impairment of the whole person	Class 2 6%–10% impairment of the whole person	Class 3 11%–15% impairment of the whole person	Class 4 16%–50% impairment of the whole person
Facial abnormality limited to disorder of cutaneous structures, such as visible simple scars (not hypertrophic or atrophic) or abnormal pigmentation (refer to AMA5 Chapter 8 for skin disorders) or mild, unilateral, facial paralysis affecting most branches or nasal distortion that affects physical appearance or partial loss or deformity of the outer ear	Facial abnormality involves loss of supporting structure of part of face, with our without cutaneous disorder (eg, depressed cheek, nasal, or frontal bones) or near complete loss of definition of the outer ear	Facial abnormality involves absence of normal anatomic part or area of face, such as loss of eye or loss of part of nose, with resulting cosmetic deformity, combine with any functional loss, eg, vision (AMA5 Chapter 12) or severe unilateral facial paralysis affecting most branches or mild, bilateral, facial paralysis affecting most branches	Massive or total distortion of normal facial anatomy with disfigurement so severe that it precludes social acceptance, combine with any mental and behavioural impairment (AMA5 Chapter 14) or severe, bilateral, facial paralysis affecting most branches or loss of a major portion of or entire nose

Note: Tables used to classify the examples in AMA5 Section 11.3 (pp256–259) should also be ignored and assessors should refer to the modified table above for classification.

6.5 AMA5 Example 11–11 (p257): Add "Visual impairment related to **enophthalmos** must be assessed by an Ophthalmologist".

The nose, throat and related structures

Respiration (AMA5 Section 11.4a, pp259–261)

6.6 In regard to **sleep apnea** (3rd paragraph, AMA5 Section 11.4a, p259): a sleep study and an examination by an ear, nose and throat specialist is mandatory before assessment by an approved assessor.

6.7 The assessment of sleep apnea is addressed in AMA5 Section 5.6 (p105) and assessors should refer to this Chapter, as well as sections 8.8–8.10 in these *WorkCover Guides*.

6.8 **AMA5 Table 11–6 criteria for rating impairment due to air passage defects** (AMA5, p260): this table should be replaced with Table 6.2, below, when assessing permanent impairment due to air passage defects.

Table 6.2: criteria for rating permanent impairment due to air passage defects

Percentage impairment of the whole person					
Class 1a 0%–5%	**Class 1 0%–10%**	**Class 2 11%–29%**	**Class 3 30%–49%**	**Class 4 50%–89%**	**Class 5 90%+**
There are symptoms of significant difficulty in breathing through the nose. Examination reveals significant partial obstruction of the right and/or left nasal cavity or nasopharynx or significant septal perforation.	Dyspnea does not occur at rest and dyspnea is not produced by walking freely on a level surface, climbing stairs freely, or performance of other usual activities of daily living and dyspnea is not produced by stress, prolonged exertion, hurrying, hill-climbing, or recreational or similar activities requiring intensive effort* and examination reveals partial obstruction of the oropharynx, laryngopharynx, larynx, upper trachea (to the fourth cartilaginous ring), lower trachea, bronchi, or complete (bilateral) obstruction of the nose or nasopharynx	Dyspnea does not occur at rest and dyspnea is not produced by walking freely on a level surface, climbing one flight of stairs, or performance of other usual activities of daily living but dyspnea is produced by stress, prolonged exertion, hurrying, hill-climbing, or recreational or similar activities (except sedentary forms) and examination reveals partial obstruction of the oropharynx, laryngopharynx, larynx, upper trachea (to the fourth cartilaginous ring), lower trachea, bronchi, or complete (bilateral) obstruction of the nose or nasopharynx	Dyspnea does not occur at rest and dyspnea is produced by walking freely more than one or two level blocks, climbing one flight of stairs even with periods of rest, or performance of other usual activities of daily living and dyspnea is produced by stress, prolonged exertion, hurrying, hill-climbing, or recreational or similar activities and examination reveals partial obstruction of the oropharynx, laryngopharynx, larynx, upper trachea (to the fourth cartilaginous ring), lower trachea or bronchi	Dyspnea occurs at rest, although individual is not necessarily bedridden and dyspnea is aggravated by the performance of any of the usual activities of daily living (beyond personal cleansing, dressing or grooming) and examination reveals partial obstruction of the oropharynx, laryngopharynx, larynx, upper trachea (to the fourth cartilaginous ring), lower trachea, and/or bronchi	Severe dyspnea occurs at rest and spontaneous respiration is inadequate and respiratory ventilation is required and examination reveals partial obstruction of the oropharynx, laryngopharynx, larynx, upper trachea (to the fourth cartilaginous ring), lower trachea or bronchi

*Prophylactic restriction of activity, such as strenuous competitive sport, does not exclude subject from class 1.

Note: Individuals with successful permanent tracheostomy or stoma should be rated at 25% impairment of the whole person. AMA5 Example 11–16 (p261): Partial obstruction of the larynx affecting only one vocal cord is better linked to voice (AMA5 Section 11.4e).

6.9 When using AMA5 Table 11–7, Relationship of Dietary Restrictions to Permanent Impairment (p262), consider % impairment of the whole person — first category to be 0–19%, not 5%–19%.

Speech (AMA5, pp262–264)

6.10 Regarding the first sentence of the "Examining procedure" subsection (pp263–264): the examiner should have sufficient hearing for the purpose — disregard "normal hearing as defined in the earlier section of this Chapter on hearing".

6.11 Examining procedure (pp263–264), second paragraph: "The examiner should base judgements of impairment on two kinds of evidence: (1) attention to and observation of the individual's speech in the office — for example, during conversation, during the interview, and while reading and counting aloud — and (2) reports pertaining to the individual's performance in everyday living situations." Disregard the next sentence: "The reports or the evidence should be supplied by reliable observers who know the person well."

6.12 Examining procedure (pp263–264): where the word "American" appears as a reference, substitute "Australian", and change measurements to the metric system (eg, 8.5 inch = 22 cm).

The voice (AMA5 Section 11.4e, pp264–267)

6.13 Substitute the word "laryngopharyngeal" for "gastroesophageal" in all examples where it appears.

6.14 Example 11.25 (Impairment Rating, p269), second sentence: add the underlined phrase "Combine with appropriate ratings due to other impairments <u>including respiratory impairment</u> to determine whole person impairment."

Ear, nose, throat and related structures impairment evaluation summary

6.15 AMA5 Table 11–10 (pp272–275): Disregard this table, except for impairment of olfaction and/or taste, and hearing impairment as determined in the *WorkCover Guides*.

7 Urinary and reproductive systems

AMA5 Chapter 7 applies to the assessment of permanent impairment of the urinary and reproductive systems, subject to the modifications set out below.

Introduction

7.1 AMA5 Chapter 7 (pp143–171) provides clear details for assessment of the urinary and reproductive systems. Overall the Chapter should be followed in assessing permanent impairment, with the variations included below.

7.2 For both male and female sexual dysfunction, identifiable pathology should be present for an impairment percentage to be given.

Urinary diversion

7.3 AMA5 Table 7–2 (p150) should be replaced with Table 7.1, below, when assessing permanent impairment due to urinary diversion disorders. This table includes ratings for neobladder and continent urinary diversion.

7.4 **Continent urinary diversion** is defined as a continent urinary reservoir constructed of small or large bowel with a narrow catheterisable cutaneous stoma through which it must be emptied several times a day.

Table 7.1: Criteria for rating permanent impairment due to urinary diversion disorders

Diversion type	% Impairment of the whole person
Ureterointestinal	10%
Cutaneous ureterostomy	10%
Nephrostomy	15%
Neobladder/replacement cystoplasty	15%
Continent urinary diversion	20%

Bladder

7.5 AMA5 Table 7–3 (p151) should be replaced with Table 7.2, below, when assessing permanent impairment due to bladder disease. This table includes ratings involving urge and total incontinence (defined in paragraph 7.80).

Table 7.2: Criteria for rating permanent impairment due to bladder disease

Class 1 0%–15% impairment of the whole person	Class 2 16%–40% impairment of the whole person	Class 3 41%–70% impairment of the whole person
Symptoms and signs of bladder disorder and requires intermittent treatment and normal functioning between malfunctioning episodes	Symptoms and signs of bladder disorder (eg, urinary frequency (urinating more than every two hours; severe nocturia (urinating more than three times a night); urge incontinence more than once a week and requires continuous treatment	Abnormal (ie under- or over-) reflex activity (eg, intermittent urine dribbling, loss of control, urinary urgency and urge incontinence once or more each day) and/or no voluntary control of micturition; reflex or areflexic bladder on urodynamics and/or total incontinence eg, fistula

7.6 AMA 5 Example 7–16 (p151) should be reclassified as an example of Class 2, as the urinary frequency is more than every two hours and continuous treatment would be expected.

Urethra

7.7 AMA5 Table 7–4 (p153) should be replaced with Table 7.3, below, when assessing permanent impairment due to urethral disease. This table includes ratings involving stress incontinence

Table 7.3: Criteria for rating permanent impairment due to urethral disease

Class 1 0%–10% impairment of the whole person	Class 2 11%–20% impairment of the whole person	Class 3 21%–40% impairment of the whole person
Symptoms and signs of urethral disorder And requires intermittent therapy for control	Symptoms and signs of urethral disorder; stress urinary incontinence more than three times a week and cannot effectively be controlled by treatment	Urethral dysfunction resulting in intermittent urine dribbling, or stress urinary incontinence at least daily

Urinary incontinence

7.8 **Urge urinary incontinence** is the involuntary loss of urine associated with a strong desire to void. **Stress urinary incontinence** is the involuntary loss of urine occurring with clinically demonstrable raised intra-abdominal pressure. It is expected that urinary incontinence of a regular or severe nature (necessitating the use of protective pads or appliances) will be assessed as follows:

Stress urinary incontinence (demonstrable clinically):	11–25% according to severity
Urge urinary incontinence:	16–40% according to severity
Mixed (urge and stress) incontinence:	16–40% according to severity
Nocturnal enuresis or wet in bed:	16–40% according to severity
Total incontinence (continuously wet, eg, from fistula):	50–70%

The highest scoring condition is to be used to assess impairment — combinations are not allowed.

Male reproductive organs

Penis

7.9 AMA5, p157: the box labelled "Class 3, 21–35% " should read "Class 3, 20% Impairment of the Whole Person" as the descriptor "No sexual function possible" does not allow a range. (The correct value is shown in Table 7–5). Note, however, that there is a loading for age, so a rate higher than 20% is possible.

Testicles, epididymides and spermatic cords

7.10 AMA5 Table 7–7 (p159) should be replaced with Table 7.4, below, when assessing permanent impairment due to testicular, epididymal and spermatic cord disease. This table includes rating for infertility and equates impairment with female infertility (see Table 7.5, in this Chapter of the *WorkCover Guides*). Infertility in either sex must be considered to be of equal impact, age for age.

7.11 **Male infertility** is defined as azoospermia or other cause of inability to cause impregnation even with assisted contraception techniques.

Table 7.4: Criteria for rating permanent impairment due to testicular, epididymal and spermatic cord disease

Class 1 0%–10% impairment of the whole person	Class 2 11%–15% impairment of the whole person	Class 3 16%–35% impairment of the whole person
Testicular, epididymal or spermatic cord disease symptoms and signs and anatomic alteration and no continuous treatment required and no seminal or hormonal function or abnormalities or solitary testicle	Testicular, epididymal or spermatic cord disease symptoms and signs and anatomic alteration and cannot effectively be controlled by treatment and detectable seminal or hormonal abnormalities	Trauma or disease produces bilateral anatomic loss of the primary sex organs or no detectable seminal or hormonal function or infertility

Female reproductive organs

Fallopian tubes and ovaries

7.12 AMA5 Table 7–11 (p167) should be replaced with Table 7.5, below, when assessing permanent impairment due to fallopian tube and ovarian disease. This table includes rating for infertility and equates impairment with male infertility (see Table 7.4, above). Infertility in either sex must be considered to be of equal impact, age for age.

7.13 **Female infertility:** a woman in the childbearing age is infertile when she is unable to conceive naturally. This may be due to anovulation, tubal blockage, cervical or vaginal blocking or an impairment of the uterus.

Table 7.5: Criteria for rating permanent impairment due to fallopian tube and ovarian disease

Class 1 0%–15% impairment of the whole person	Class 2 16%–25% impairment of the whole person	Class 3 26%–35% impairment of the whole person
Fallopian tube or ovarian disease or deformity symptoms and signs do not require continuous treatment or only one functioning fallopian tube or ovary in the premenopausal period or bilateral fallopian tube or ovarian functional loss in the postmenopausal period	Fallopian tube or ovarian disease or deformity symptoms and signs require continuous treatment, but tubal patency persists and ovulation is possible	Fallopian tube or ovarian disease or deformity symptoms and signs and total tubal patency loss or failure to produce ova in the premenopausal period or bilateral fallopian tube or bilateral ovarian loss in the premenopausal period; infertility

8 Respiratory system

AMA5 Chapter 5 applies to the assessment of permanent impairment of the respiratory system, subject to the modifications set out below.

Introduction

8.1 AMA5 Chapter 5 provides a useful summary of the methods for assessing permanent impairment arising from respiratory disorders.

8.2 The level of impairment arising from conditions that are not work related needs to be assessed by the medical assessor and taken into consideration in determining the level of permanent impairment. The level at which pre-existing conditions and lifestyle activities such as smoking contribute to the level of permanent impairment requires judgement on the part of the clinician undertaking the impairment assessment. The manner in which any deduction for these is applied needs to be recorded in the assessing practitioner's report.

Examinations, clinical studies and other tests for evaluating respiratory disease (AMA5 Section 5.4)

8.3 AMA5 Tables 5–2b, 5–3b, 5–4b, 5–5b, 5–6b and 5–7b give the lower limits of normal values for pulmonary function tests. These are used in Table 5–12 to determine the impairment classification for respiratory disorders.

8.4 Classes 2, 3 and 4 in Table 5–12 list ranges of whole person impairment. The assessor should nominate the nearest whole percentage based on the complete clinical circumstances when selecting within the range.

Asthma (AMA5 Section 5.5)

8.5 In assessing permanent impairment arising from occupational asthma, the assessor will require evidence from the treating physician that:

- At least three lung function tests have been performed over a six month period and that the results were consistent and repeatable over that period;
- the worker has received maximal treatment and is compliant with his/her medication regimen.

8.6 Bronchial challenge testing should not be performed as part of the impairment assessment, therefore in AMA5 Table 5–9 (p104) ignore column four (PC_{20} mg/mL or equivalent, etc).

8.7 Permanent impairment due to asthma is rated by the score for the best post-bronchodilator forced expiratory volume in one second (FEV_1) (score in column 2, AMA5 Table 5–9) plus per cent of FEV_1 (score in column 3) plus minimum medication required (score in column 5). The total score derived is then used to assess the percent impairment in AMA5 Table 5–10 (p104).

Obstructive sleep apnea (AMA5 Section 5.6)

8.8 This section needs to be read in conjunction with AMA5 Section 11.4 (p259) and Section 13.3c (p317).

8.9 Before permanent impairment can be assessed, the person must have appropriate assessment and treatment by an ear, nose and throat surgeon and a respiratory physician who specialises in sleep disorders.

8.10 Degree of permanent impairment due to sleep apnea should be calculated with reference to AMA5 Table 13–4 (p317).

Hypersensitivity pneumonitis (AMA5 Section 5.7)

8.11 Permanent impairment arising from disorders included in this section are assessed according to the impairment classification in AMA5 Table 5–12.

Pneumoconiosis (AMA5 Section 5.8)

8.12 This section is excluded from the *WorkCover Guides* as these impairments are the subject of the Dust Diseases Legislation.

Lung cancer (AMA5 Section 5.9)

8.13 Permanent impairment due to lung cancer should be assessed at least six months after surgery. Table 5–12 (not Table 5–11) should be used for assessment of permanent impairment.

8.14 Persons with residual lung cancer after treatment are classified in Respiratory Impairment Class 4 (Table 5–12).

Permanent impairment due to respiratory disorders (AMA5 Section 5.10)

8.15 Table 5–12 (AMA5, p107) should be used to assess permanent impairment for respiratory disorders. The pulmonary function tests listed in Table 5–12 must be performed under standard conditions. Exercise testing is not required on a routine basis.

8.16 An isolated abnormal diffusing capacity for carbon monoxide (DCO) in the presence of otherwise normal results of lung function testing should be interpreted with caution and its aetiology should be clarified.

9 Hearing

AMA5 Chapter 11 applies to the assessment of permanent impairment of hearing, subject to the modifications set out below.

Assessment of hearing impairment (hearing loss)

9.1 A worker may present for assessment of hearing loss for compensation purposes before having undergone all or any of the health investigations that generally occur before assessment of permanent impairment. For this reason and to ensure that conditions other than "occupational hearing impairment" are precluded, the medical assessment should be undertaken by an ear, nose and throat specialist or other appropriately qualified medical specialist. The medical assessment needs to be undertaken in accordance with the hearing impairment section of AMA5 Table 11–10 (pp272–275). The medical practitioner performing the assessment must examine the worker. The medical practitioner's assessment must be based on medical history and ear, nose and throat examination, evaluation of relevant audiological tests and evaluation of other relevant investigations available to the medical assessor. Only medical practitioners can sign medical reports.

9.2 Disregard AMA5 Sections 11.1b and 11.2 (pp246-255), but retain Section 11.1a (Interpretation of Symptoms and Signs, p246).

9.3 Some of the relevant tests are discussed in the AMA 5 Hearing Impairment Evaluation Summary Table 11–10 (pp272–275). The relevant row for these guides is the one headed "Hearing impairment" with the exception of the last column headed "Degree of impairment". The degree of impairment is determined according to this WorkCover guide.

9.4 The level of hearing impairment caused by non-work-related conditions is assessed by the medical practitioner and considered when determining the level of work-related hearing impairment. While this requires medical judgement on the part of the examining medical practitioner, any non-work-related deductions should be recorded in the report.

9.5 Disregard AMA 5 Tables 11–1, 11–2, 11–3 (pp247–250). For the purposes of the *WorkCover Guides*, National Acoustic Laboratory (NAL) Tables from the NAL Report No. 118, "Improved Procedure for Determining Percentage Loss of Hearing" (January 1988) are adopted as follows:

- Tables RB 500–4000 (pp11–16)
- Tables RM 500–4000 (pp18–23)
- Appendix 1 and 2 (pp8–9)
- Appendix 5 and 6 (pp24–26)
- Tables EB 4000–8000 (pp28–30)
- Table EM 4000–8000 (pp32–34)

In the presence of significant conduction hearing loss, the extension tables do not apply.

AMA5 Table 11–3 is replaced by Table 9.1 at the end of this chapter.

Hearing impairment

9.6 Impairment of a worker's hearing is determined according to evaluation of the individual's binaural hearing impairment.

9.7 *Permanent hearing impairment* should be evaluated when the condition is stable. Prosthetic devices (that is, hearing aids) must not be worn during the evaluation of hearing sensitivity.

9.8 *Hearing threshold level for pure tones* is defined as the number of decibels above standard audiometric zero for a given frequency at which the listener's threshold of hearing lies when tested in a suitable sound attenuated environment. It is the reading on the hearing level dial of an audiometer that is calibrated according to Australian Standard AS 2586–1983.

9.9 *Evaluation of binaural hearing impairment*: Binaural hearing impairment is determined by using the tables in the 1988 NAL publication with allowance for presbycusis according to the presbycusis correction table, if applicable, in the same publication.

The Binaural Tables RB 500–4000 (NAL publication, pp11–16) are to be used, except when it is not possible or would be unreasonable to do so. For the purposes of calculating binaural hearing impairment, the better and worse ear may vary as between frequencies.

Where it is necessary to use the monaural tables, the binaural hearing impairment (BHI) is determined by the formula:

$$BHI = \frac{[4 \times (\text{better ear hearing loss})] + \text{worse ear hearing loss}}{5}$$

9.10 *Presbycusis correction* (NAL publication, p24) only applies to occupational hearing loss contracted by gradual process — for example, occupational noise induced hearing loss and/or occupational solvent induced hearing loss.

9.11 *Binaural hearing impairment and severe tinnitus:* Up to 5% may be added to the work-related binaural hearing impairment for severe tinnitus caused by a work-related injury:

- after presbycusis correction, if applicable, and
- before determining whole person impairment.

Assessment of severe tinnitus is based on a medical practitioner's assessment.

9.12 *Only hearing ear*: A worker has an "only hearing ear" if he or she has suffered a non-work-related severe or profound sensorineural hearing loss in the other ear. If a worker suffers a work-related injury causing a hearing loss in the only hearing ear of *x* dBHL at a relevant frequency, the worker's work-related binaural hearing impairment at that frequency is calculated from the binaural tables using *x* dB as the hearing threshold level in both ears. Deduction for presbycusis if applicable and addition for severe tinnitus is undertaken according to this guide.

9.13 When necessary, binaural hearing impairment figures should be rounded to the nearest 0.1%. Rounding up should occur if equal to or greater than .05%, and rounding down should occur if equal to or less than .04%.

9.14 Table 9.1 is used to convert binaural hearing impairment, after deduction for presbycusis if applicable and after addition for severe tinnitus, to whole person impairment.

Table 9.1: Relationship of binaural hearing impairment to whole person impairment

% Binaural hearing impairment	% Whole person impairment	% Binaural hearing impairment	% Whole person impairment
0.0–6.0	0	51.1–53.0	26
		53.1–55.0	27
6.1–6.7	3	55.1–57.0	28
6.8–8.7	4	57.1–59.0	29
8.8–10.6	5	59.1–61.0	30
10.7–12.5	6	61.1–63.0	31
12.6–14.4	7	63.1–65.0	32
14.5–16.3	8	65.1–67.0	33
16.4–18.3	9	67.1–69.0	34
18.4–20.4	10	69.1–71.0	35
20.5–22.7	11	71.1–73.0	36
22.8–25.0	12	73.1–75.0	37
25.1–27.0	13	75.1–77.0	38
27.1–29.0	14	77.1–79.0	39
29.1–31.0	15	79.1–81.0	40
31.1–33.0	16	81.1–83.0	41
33.1–35.0	17	83.1–85.0	42
35.1–37.0	18	85.1–87.0	43
37.1–39.0	19	87.1–89.0	44
39.1–41.0	20	89.1–91.0	45
41.1–43.0	21	91.1–93.0	46
43.1–45.0	22	93.1–95.0	47
45.1–47.0	23	95.1–97.0	48
47.1–49.0	24	97.1–99.0	49
49.1–51.0	25	99.1–100	50

9.15 AMA5 Examples 11.1,11.2, 11.3 (pp250–251) are replaced by *WorkCover* Examples 9.1–9.7, below, which were developed by the Working Party.

Table 9.2: Medical assessment elements in examples

Element	Example No.
General use of binaural table — NAL 1988	1,2
"Better ear"–"worse ear" crossover	1,2
Assessable audiometric frequencies	7 — also 1,2,4,5,6
Tinnitus	1,2,3,4
Presbycusis	All examples
Binaural hearing impairment	All examples
Conversion to whole person impairment	All examples
Gradual process injury	3
Noise-induced hearing loss	1,2,3,5,6,7
Solvent-induced hearing loss	3
Acute occupational hearing loss	4,5
Acute acoustic trauma	5
Pre-existing non-occupational hearing loss	6
Only hearing ear	6
NAL 1988 Extension Table Use	7
Multiple Causes of Hearing Loss	3,5,6
Head injury	4

Example 9.1: Occupational noise-induced hearing loss and severe tinnitus

A 60-year-old man, a boilermaker for 30 years, gave a history of progressive hearing loss and tinnitus. The assessing medical practitioner has assessed the tinnitus as severe. The external auditory canals and tympanic membranes were normal. Rinne test was positive bilaterally and the Weber test result was central. Clinical assessment of hearing was consistent with results of pure tone audiometry, which showed a bilateral sensorineural hearing loss. The medical practitioner diagnosed noise induced hearing loss.

Pure tone audiometry

Frequency (Hz)	Left (dB HL)	Right (dB HL)	Binaural hearing impairment (%BHI)
500	15	10	0
1000	15	15	0
1500	15	20	0.4
2000	25	30	1.5
3000	50	45	4.2
4000	65	70	6.8
6000	30	30	–
8000	20	20	–
Total %BHI			12.9
Less Presbycusis correction of 0.8			12.1
Add 3.0% for severe tinnitus			15.1
Adjusted total %BHI			15.1
Resultant total BHI of 15.1% = 8% whole person impairment (Table 9.1)			

Example 9.2: Occupational noise-induced hearing loss and mild tinnitus

A 55-year-old man, a steelworker for 30 years, gave a history of increasing difficulties with hearing and tinnitus. The assessing medical practitioner diagnosed occupational noise-induced hearing loss with mild tinnitus.

Pure tone audiometry

Frequency (Hz)	Left (dB HL)	Right (dB HL)	Binaural hearing impairment (%BHI)
500	15	15	0.0
1000	15	15	0.0
1500	20	25	1.0
2000	30	35	2.5
3000	50	45	4.2
4000	55	55	5.2
6000	30	30	–
8000	20	20	–
Total %BHI			12.9
No presbycusis correction			12.9
Adjusted total %BHI			12.9
Resultant total BHI of 12.9% = 7% whole person impairment (Table 9.1)			

Comment

The assessing medical practitioner's opinion is that the tinnitus suffered by the worker is not severe and thus no addition to the binaural hearing impairment was made for tinnitus.

Example 9.3: Multiple gradual process occupational hearing loss

A 63-year-old male boat builder and printer gave a history of hearing difficulty and tinnitus. There had been marked chronic exposure to noise and solvents in both occupations for 35 years altogether. The assessing medical practitioner diagnosed bilateral noise-induced hearing loss and bilateral solvent-induced hearing loss with severe tinnitus.

The assessing medical practitioner's opinion is that the solvent exposure contributed to the hearing impairment as a gradual process injury. The total noise-induced and solvent-induced BHI was 17.5%.

The appropriate presbycusis deduction was applied. Then, the assessing medical practitioner added 2% to the after-presbycusis binaural hearing impairment for severe tinnitus.

Pure tone audiometry

Frequency (Hz)	Left (dB HL)	Right (dB HL)	Binaural hearing impairment (%BHI)
500	15	15	0.0
1000	15	15	0.0
1500	25	25	1.4
2000	35	40	3.8
3000	60	60	6.3
4000	60	60	6.0
6000	45	50	–
8000	40	40	–
Total noise-induced and solvent-induced BHI (%)			17.5
Presbycusis correction of 1.7%			15.8
2% addition for medically assessed severe tinnitus			17.8
Adjusted Total BHI			17.8
Resultant total BHI of 17.8% = 9% whole person impairment (Table 9.1)			

Example 9.4: Occupational hearing loss from head injury

A 62-year-old male worker sustained a head injury after falling from a ladder. He suffered left hearing loss and tinnitus unaccompanied by vertigo. The assessing medical practitioner assesses his tinnitus as severe. External auditory canals and tympanic membranes are normal. Rinne test is positive bilaterally and Weber test lateralises to the right. CT scan of the temporal bones shows a fracture on the left. Clinical assessment of hearing is consistent with pure tone audiometry, which shows a flat left sensorineural hearing loss and mild right sensorineural hearing loss.

Pure tone audiometry

Frequency (Hz)	Left (dB HL)	Right (dB HL)	Binaural hearing impairment (%BHI)
500	45	15	2.0
1000	50	15	2.8
1500	55	10	2.5
2000	50	15	1.7
3000	60	20	1.7
4000	60	25	1.5
6000	60	15	–
8000	60	20	–
Total %BHI			12.2
No correction for presbycusis applies			–
Add 4.0% for severe tinnitus			16.2
Adjusted total BHI			16.2
Resultant total BHI of 16.2% = 8% whole person impairment (Table 9.1)			

Example 9.5: Occupational noise-induced hearing loss with acute occupational hearing loss

A 65-year-old production worker for 10 years was injured in an explosion at work. He reported immediate post-injury otalgia and acute hearing loss in the left ear. The assessing medical practitioner diagnosed occupational noise-induced hearing loss and left acute acoustic trauma. The assessing medical practitioner had no medical evidence that, immediately before the explosion, the hearing in the left ear was significantly different from that in the right ear.

Pure tone audiometry

Frequency (Hz)	Left (dB HL)	Right (dB HL)	Binaural hearing impairment (%BHI)	BHI due to noise-induced hearing loss
500	30	15	1.0	0.0
1000	45	15	2.5	0.0
1500	55	15	2.5	0.0
2000	70	15	2.2	0.0
3000	80	25	2.4	0.7
4000	80	30	2.3	0.8
6000	>80	30	–	–
8000	>80	25	–	–
Total BHI (%)			12.9	
Occupational noise-induced BHI(%) before presbycusis correction				1.5
Occupational noise-induced BHI(%) after presbycusis correction of 2.4%				0
Acute acoustic trauma BHI (%)			11.4	
Presbycusis does not apply to acute acoustic trauma			–	
Resultant total BHI due to acute acoustic trauma of 11.4% = 6% whole person impairment (Table 9.1)				

Example 9.6: Occupational noise-induced hearing loss in an only hearing ear

A 66-year-old woman has been a textile worker for 30 years. Childhood mumps had left her with profound hearing loss in the left ear. She gave a history of progressive hearing loss in her only hearing ear unaccompanied by tinnitus or vertigo. External auditory canals and tympanic membranes appeared normal. Rinne test was positive on the right and was false negative on the left. Weber test lateralised to the right. Clinical assessment of hearing is consistent with pure tone audiogram showing a profound left sensorineural hearing loss and a partial right sensorineural hearing loss. The medical assessor diagnosed noise induced hearing loss in the right ear.

Pure tone audiometry

Frequency (Hz)	Left (dB HL)	Right (dB HL)	Binaural hearing impairment (%BHI)	Occupational %BHI
500	>95	10	3.4	0
1000	>95	15	4.3	0
1500	>95	20	4.2	0.6
2000	>95	25	3.8	1.1
3000	>95	50	5.4	4.8
4000	>95	70	8.0	7.5
6000	>95	50	–	–
8000	>95	40	–	–
Total %BHI			29.1	
Total occupational %BHI				14.0
Presbycusis correction does not apply to a 66 year old woman				–
No addition for tinnitus				–
Adjusted total occupational %BHI				14.0
Total occupational BHI of 14% = 7% whole person impairment (Table 9.1)				

Example 9.7: Occupational noise-induced hearing loss where there is a special requirement for ability to hear at frequencies above 4000 Hz

A 56-year-old female electronics technician who worked in a noisy factory for 20 years had increasing hearing difficulty. The diagnosis made was bilateral occupational noise-induced hearing loss extending to 6000 Hz or 8000 Hz. The assessing medical practitioner was of the opinion that there was a special requirement for hearing above 4000 Hz. There was no conductive hearing loss.

Pure tone audiometry

			Binaural hearing impairment (%BHI)	
Frequency (Hz)	Left (dB HL)	Right (dB HL)	Using extension table – 4000, 6000 and 8000 Hz	Not using extension table
500	10	10	0.0	0.0
1000	15	15	0.0	0.0
1500	20	25	1.0	1.0
2000	30	35	2.5	2.5
3000	45	45	4.1	4.1
4000	45	50	2.2	3.6
6000	60	55	1.6	–
8000	50	20	0.2	–
Total BHI (%) using extension table			11.6	
Total BHI (%) not using extension table				11.2
Presbycusis correction			0	
The assessing medical practitioner is of the opinion that the binaural hearing impairment in this matter is 11.6% rather than 11.2%				
Adjusted total %BHI			11.6	
Resultant Total BHI of 11.6% = 6% whole person impairment (Table 9.1)				

10 The visual system

AMA4 Chapter 8 applies to the assessment of permanent impairment of the visual system, subject to the modifications set out below.

Introduction and approach to assessment

10.1 The visual system must be assessed by an ophthalmologist.

10.2 Chapter 8 (pp209–222) of the American Medical Association Guides to the Assessment of Permanent Impairment ***Fourth Edition*** (AMA4) are adopted for the *WorkCover Guides* without significant change.

10.3 AMA4 is used rather than AMA5 for the assessment of permanent impairment of the visual system because:

- the equipment recommended for use in AMA5 is expensive and not owned by most privately practising ophthalmologists (eg, the Goldman apparatus for measuring visual fields);
- the assessments recommended in AMA5 are considered too complex, raising a risk that resulting assessments may be of a lower standard than if the AMA4 method was used.
- There is little emphasis on diplopia in AMA5, yet this is a relatively frequent problem.
- Many ophthalmologists are familiar with the Royal Australian College of Ophthalmologists' impairment guide, which is similar to AMA4.

10.4 Impairment of vision should be measured with the injured worker wearing their prescribed corrective spectacles and/or contact lenses, if that was normal for the injured worker before the workplace injury. If, as a result of the workplace injury, the injured worker has been prescribed corrective spectacles and/or contact lenses for the first time, or different spectacles and/or contact lenses than those prescribed before injury, the difference should be accounted for in the assessment of permanent impairment.

10.5 The ophthalmologist should perform, or review, all tests necessary for the assessment of permanent impairment rather than relying on tests, or interpretations of tests, done by the orthoptist or optometrist.

10.6 An ophthalmologist should assess visual field impairment in all cases.

10.7 In AMA4 Section 8.5, "Other Conditions" (p222), the "additional 10% impairment" referred to means 10% *whole person* impairment, not 10% impairment of the visual system.

11 Psychiatric and psychological disorders

AMA5 Chapter 14 is excluded and replaced by this chapter.

Introduction

11.1 This chapter lays out the method for assessing psychiatric impairment. The evaluation of impairment requires a medical examination.

11.2 Evaluation of psychiatric impairment is conducted by a psychiatrist who has undergone appropriate training in this assessment method.

11.3 Permanent impairment assessments for psychiatric and psychological disorders are only required where the primary injury is a psychological one. The psychiatrist needs to confirm that the psychiatric diagnosis is the injured worker's primary diagnosis. This assessment is not done for the purposes of determining "pain and suffering" as defined for the purposes of section 67 of the *Workers Compensation Act 1987*. "Pain and suffering" means actual pain, distress or anxiety, suffered or likely to be suffered by the injured worker, whether resulting from the permanent impairment concerned or from any necessary treatment of that impairment.

Background to the development of the scale

11.4 The psychiatric impairment rating scale (PIRS) used here was originally developed, using AMA4, for the New South Wales Motor Accidents Authority. It was then further modified for Comcare. At this time the conversion table was added. Finally, to ensure relevance in the NSW Workers' Compensation context, the PIRS was extensively reviewed with reference to AMA5. Changes have been made to the method for assessing pre-injury impairment, and to some of the descriptors within each of the functional areas.

Diagnosis

11.5 The impairment rating must be based upon a psychiatric diagnosis (according to a recognised diagnostic system) and the report must specify the diagnostic criteria upon which the diagnosis is based. Impairment arising from any of the somatoform disorders (DSM IV, pp445–469) are excluded from this chapter.

11.6 If pain is present as the result of an organic impairment, it should be assessed as part of the organic condition under the relevant table. This does not constitute part of the assessment of impairment relating to the psychiatric condition. The impairment ratings in the body organ system chapters in AMA5 make allowance for any accompanying pain.

11.7 It is expected that the psychiatrist will provide a rationale for the rating based on the injured worker's psychiatric symptoms. The diagnosis is among the factors to be considered in assessing the severity and possible duration of the impairment, but is not the sole criterion to be used. Clinical assessment of the person may include information from the injured worker's own description of his or her functioning and

limitations; from family members and others who may have knowledge of the person. Medical reports, feedback from treating professionals, results of standardised tests, including appropriate psychometric testing performed by a qualified clinical psychologist, and work evaluations may provide useful information to assist with the assessment. Evaluation of impairment will need to take into account variations in the level of functioning over time. Percentage impairment refers to "whole person impairment".

Permanent impairment

11.8 A psychiatric disorder is permanent if in your clinical opinion, it is likely to continue indefinitely. Regard should be given to:

- the duration of impairment;
- the likelihood of improvement in the injured workers' condition;
- whether the injured worker has undertaken reasonable rehabilitative treatment;
- any other relevant matters.

Effects of treatment

11.9 Consider the effects of medication, treatment and rehabilitation to date. Is the condition stable? Is treatment likely to change? Are symptoms likely to improve? If the injured worker declines treatment, this should not affect the estimate of permanent impairment. The psychiatrist may make a comment in the report about the likely effect of treatment or the reasons for refusal of treatment.

Co-morbidity

11.10 Consider co-morbid features (eg, Alzheimer's disease, personality disorder, substance abuse) and determine whether they are directly linked to the work-related injury or whether they were pre-existing or unrelated conditions.

Pre-existing impairment

11.11 To measure the impairment caused by a work-related injury or incident, the psychiatrist must measure the proportion of WPI due to a pre-existing condition. Pre-existing impairment is calculated using the same method for calculating current impairment level. The assessing psychiatrist uses all available information to rate the injured workers pre-injury level of functioning in each of the areas of function. The percentage impairment is calculated using the aggregate score and median class score using the conversion table below. The injured worker's current level of impairment is then assessed, and the pre-existing impairment level (%) is then subtracted from their current level to obtain the percentage of permanent impairment directly attributable to the work-related injury. If the percentage pre-existing impairment cannot be assessed, 10% of the estimated level of the condition now being assessed is to be deducted.

Psychiatric impairment rating scale (PIRS)

11.12 Behavioural consequences of psychiatric disorder are assessed on six scales, each of which evaluates an area of functional impairment:

1. Self care and personal hygiene (Table 11.1)
2. Social and recreational activities (Table 11.2) } Activities of daily living
3. Travel (Table 11.3)
4. Social functioning (relationships) (Table 11.4)
5. Concentration (Table 11.5)
6. Employability (Table 11.6)

11.13 Impairment in each area is rated using class descriptors. Classes range from 1 to 5, in accordance with severity. The standard form must be used when scoring the PIRS. The examples of activities are examples only. The assessing psychiatrist should take account of the person's cultural background. Consider activities that are usual for the person's age, sex and cultural norms.

Table 11.1: Psychiatric impairment rating scale — Self care and personal hygiene

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population
Class 2	Mild impairment: able to live independently; looks after self adequately, although may look unkempt occasionally; sometimes misses a meal or relies on take-away food.
Class 3	Moderate impairment: Can't live independently without regular support. Needs prompting to shower daily and wear clean clothes. Does not prepare own meals, frequently misses meals. Family member or community nurse visits (or should visit) 2–3 times per week to ensure minimum level of hygiene and nutrition.
Class 4	Severe impairment: Needs supervised residential care. If unsupervised, may accidentally or purposefully hurt self.
Class 5	Totally impaired: Needs assistance with basic functions, such as feeding and toileting.

Table 11.2: Psychiatric impairment rating scale — Social and recreational activities

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population: regularly participates in social activities that are age, sex and culturally appropriate. May belong to clubs or associations and is actively involved with these.
Class 2	Mild impairment: occasionally goes out to such events without needing a support person, but does not become actively involved (eg, dancing, cheering favourite team).
Class 3	Moderate impairment: rarely goes out to such events, and mostly when prompted by family or close friend. Will not go out without a support person. Not actively involved, remains quiet and withdrawn.
Class 4	Severe impairment: never leaves place of residence. Tolerates the company of family member or close friend, but will go to a different room or garden when others come to visit family or flat mate.
Class 5	Totally impaired. Cannot tolerate living with anybody, extremely uncomfortable when visited by close family member.

Table 11.3: Psychiatric impairment rating scale — Travel

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population: Can travel to new environments without supervision.
Class 2	Mild impairment: can travel without support person, but only in a familiar area such as local shops, visiting a neighbour.
Class 3	Moderate impairment: cannot travel away from own residence without support person. Problems may be due to excessive anxiety or cognitive impairment.
Class 4	Severe impairment: finds it extremely uncomfortable to leave own residence even with trusted person.
Class 5	Totally impaired: may require two or more persons to supervise when travelling.

Table 11.4: Psychiatric impairment rating scale — Social functioning

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population: No difficulty in forming and sustaining relationships (eg, partner, close friendships lasting years).
Class 2	Mild impairment: existing relationships strained. Tension and arguments with partner or close family member, loss of some friendships.
Class 3	Moderate impairment: previously established relationships severely strained, evidenced by periods of separation or domestic violence. Spouse, relatives or community services looking after children.
Class 4	Severe impairment: unable to form or sustain long term relationships. Pre-existing relationships ended (eg, lost partner, close friends). Unable to care for dependants (eg, own children, elderly parent).
Class 5	Totally impaired: unable to function within society. Living away from populated areas, actively avoiding social contact.

Table 11.5: Psychiatric impairment rating scale — Concentration, persistence and pace

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population. Able to pass a TAFE or university course within normal time frame.
Class 2	Mild impairment: can undertake a basic retraining course, or a standard course at a slower pace. Can focus on intellectually demanding tasks for periods of up to 30 minutes, then feels fatigued or develops headache.
Class 3	Moderate impairment: unable to read more than newspaper articles. Finds it difficult to follow complex instructions (eg, operating manuals, building plans), make significant repairs to motor vehicle, type long documents, follow a pattern for making clothes, tapestry or knitting.
Class 4	Severe impairment: can only read a few lines before losing concentration. Difficulties following simple instructions. Concentration deficits obvious even during brief conversation. Unable to live alone, or needs regular assistance from relatives or community services.
Class 5	Totally impaired: needs constant supervision and assistance within institutional setting.

Table 11.6: Psychiatric impairment rating scale — Employability

Class 1	No deficit, or minor deficit attributable to the normal variation in the general population. Able to work full time. Duties and performance are consistent with the injured worker's education and training. The person is able to cope with the normal demands of the job.
Class 2	Mild impairment. Able to work full time but in a different environment from that of the pre-injury job. The duties require comparable skill and intellect as those of the pre-injury job. Can work in the same position, but no more than 20 hours per week (eg, no longer happy to work with specific persons, or work in a specific location due to travel required).
Class 3	Moderate impairment: cannot work at all in same position. Can perform less than 20 hours per week in a different position, which requires less skill or is qualitatively different (eg, less stressful).
Class 4	Severe impairment: cannot work more than one or two days at a time, less than 20 hours per fortnight. Pace is reduced, attendance is erratic.
Class 5	Totally impaired. Cannot work at all.

Using the PIRS to measure impairment

11.14 Rating psychiatric impairment using the PIRS is a two-step procedure:

1. Determine the median class score.
2. Calculate the aggregate score.

Determining the median class score

11.15 Each area of function described in the PIRS is given an impairment rating which ranges from Class 1 to 5. The six scores are arranged in ascending order, using the standard form. The median is then calculated by averaging the two middle scores. Eg:

Example A: 1, 2, **3, 3,** 4, 5 Median Class = 3

Example B: 1, 2, **2, 3,** 3, 4 Median Class = 2.5 = 3*

Example C: 1, 2, **3, 5,** 5, 5 Median Class = 4

*If a score falls between two classes, it is rounded up to the next class. A median class score of 2.5 thus becomes 3.

11.16 The median class score method was chosen as it is not influenced by extremes. Each area of function is assessed separately. While impairment in one area is neither equivalent nor interchangeable with impairment in other areas, the median seems the fairest way to translate different impairments onto a linear scale.

Median class score and percentage impairment

11.17 Each median class score represents a range of impairment, as shown below.

Class 1 = 0–3%

Class 2 = 4–10%

Class 3 = 11–30%

Class 4 = 31–60%

Class 5 = 61–100%

Calculation of the aggregate score

11.18 The aggregate score is used to determine an exact percentage of impairment within a particular Median Class range. The six class scores are added to give the aggregate score.

Use of the conversion table to arrive at percentage impairment

11.19 The aggregate score is converted to a percentage score using the conversion table.

11.20 The conversion table was developed to calculate the percentage impairment based on the aggregate and median scores.

11.21 The scores within the conversion table are spread in such a way to ensure that the final percentage rating is consistent with the measurement of permanent impairment percentages for other body systems.

Table 11.7: Conversion table

% Impairment	Aggregate score																								
	6	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**
Class 1	0	0	1	1	2	2	2	3	3																
Class 2				4	5	5	6	7	7	8	9	9	10												
Class 3								11	13	15	17	19	22	24	26	28	30								
Class 4												31	34	37	41	44	47	50	54	57	60				
Class 5																61	65	70	74	78	83	87	91	96	100

Conversion table — explanatory notes

A. Distribution of aggregate scores

- The lowest aggregate score that can be obtained is: 1+1+1+1+1+1=6
- The highest aggregate score is 5+5+5+5+5+5= 30
- The table therefore has aggregate scores ranging from 6 to 30.
- Each Median Class score has an impairment range, and a range of possible aggregate scores (eg, Class 3 = 11–30%)
- The lowest aggregate score for Class 3 is 13 (1+1+2+3+3+3= 13)
- The highest aggregate score for Class 3 is 22. (3+3+3+3+5+5=22)
- The conversion table distributes the impairment percentages across aggregate scores

B. Same aggregate score in different classes

- The conversion table shows that the same aggregate score leads to different percentages of impairment in different median classes.
- For example, an aggregate score of 18 is equivalent to an impairment rating of
  - 10% in Class 2,
  - 22% in Class 3,
  - 34% in Class 4.
- This is due to the fact that an injured worker whose impairment is in Median Class 2 is likely to have a lower score across most areas of function. They may be significantly impaired in one aspect of their life, such as travel, yet have low impairment in Social Function, Self-care or Concentration.
- Someone whose impairment reaches Median Class 4 will experience significant impairment across most aspects of his or her life.

Examples: (Using the previous cases)

Example A

PIRS scores						Median class
1	2	**3**	**3**	4	5	= 3

Aggregate score						Total	% Impairment
1 +	2 +	3 +	3 +	4 +	5 =	18	22%

Example B

PIRS scores						Median class
1	2	**2**	**3**	3	4	= 3

Aggregate score						Total	% Impairment
1 +	2 +	2 +	3 +	3 +	4 =	15	15%

Example C

PIRS scores						Median class
1	2	**3**	**5**	5	5	= 4

Aggregate score						Total	% Impairment
1 +	2 +	3 +	5 +	5 +	5 =	21	44%

Table 11.8: PIRs rating form

Name		Claim reference number	
D.O.B.		Age at time of injury	
Date of injury		Occupation before injury	
Date of assessment		Marital status before injury	

Psychiatric diagnoses	1.	2.
	3.	4.
Psychiatric treatment		
Is impairment permanent?	Yes No (Circle one)	

PIRS category	Class	Reason for decision
Self care and personal hygiene		
Social and recreational activities		
Travel		
Social functioning		
Concentration, persistence and pace		
Employability		

Score						Median Class
						=

Aggregate Score Impairment						Total	%
+	+	+	+	+	=		

12 Haematopoietic system

AMA5 Chapter 9 applies to the assessment of permanent impairment of the haematopoietic system, subject to the modifications set out below.

Introduction

12.1 AMA5 Chapter 9 (pp191–210) provides guidelines on the method of assessing permanent impairment of the haematopoietic system. Overall, that chapter should be followed in conducting the assessment, with variations indicated below.

12.2 Impairment of end organ function due to haematopoietic disorder should be assessed separately, using the relevant chapter of the *WorkCover Guides*. The percentage whole person impairment due to end organ impairment should be combined with any percentage whole person impairment due to haematopoietic disorder, using the Combined Values Table (AMA5, pp604–606).

Anaemia

12.3 Table 12.1 (below) replaces AMA5 Table 9–2 (, p193).

Table 12.1: Classes of anaemia and percentage whole person impairment

Class 1: 0–10% WPI	Class 2: 11–30% WPI	Class 3: 31–70% WPI	Class 4: 71–100% WPI
No symptoms and haemoglobin 100–120g/L and no transfusion required	Minimal symptoms and haemoglobin 80–100g/L and no transfusion required	Moderate to marked symptoms and haemoglobin 50–80g/L before transfusion and transfusion of 2 to 3 units required, every 4 to 6 weeks	Moderate to marked symptoms and haemoglobin 50–80g/L before transfusion and transfusion of 2 to 3 units required, every 2 weeks

12.4 The assessor should exercise clinical judgement in determining whole person impairment, using the criteria in Table 12.1. For example, if comorbidities exist which preclude transfusion, the assessor may assign Class 3 or Class 4, on the understanding that transfusion would under other circumstances be indicated. Similarly, there may be some claimants with Class 2 impairment who, because of comorbidity, may undergo transfusion.

12.5 Pre-transfusion haemoglobin levels in Table 12.1 are to be used as indications only. It is acknowledged that for some claimants, it would not be medically advisable to permit the claimant's haemoglobin levels to be as low as indicated in the criteria of Table 12.1.

12.6 The assessor should indicate a percentage whole person impairment, as well as the Class.

Polycythaemia and myelofibrosis

12.7 The level of symptoms (as in Table 12.1) should be used a guide for the assessor in cases where non-anaemic tissue iron deficiency results from venesection.

White blood cell diseases

12.8 In cases of functional asplenia, the assessor should assign 3% whole person impairment. This should be combined with any other impairment rating, using the Combined Values Table (AMA5, pp604–606).

12.9 AMA5 Table 9–3 (p200) should not be used for rating impairment due to HIV infection or auto immune deficiency disease. Section 67A (1) of the *Workers Compensation Act 1987* indicates that HIV infection and AIDS are each considered to result in a degree of permanent impairment of 100%.

Haemorrhagic and platelet disorders

12.10 AMA5 Table 9–4 (p203) is to be used as the basis for assessing haemorrhagic and platelet disorders.

12.11 For the purposes of these *WorkCover Guides*, the criteria for inclusion in Class 3 of AMA5 Table 9–4 (p203) is:

- Symptoms and signs of haemorrhagic and platelet abnormality

  and/or

- Requires continuous treatment

  and

- Interference with daily activities; requires occasional assistance.

12.12 For the purposes of these *WorkCover Guides*, the criteria for inclusion in Class 4 of Table 9–4 (p203, AMA5) is:

- Symptoms and signs of haemorrhagic and platelet abnormality

  and/or

- Requires continuous treatment

  and

- Difficulty performing daily activities; requires continuous care.

Thrombotic disorders

12.13 AMA5 Table 9–4 (p203) is used as the basis for determining impairment due to thrombotic disorder.

13 The endocrine system

AMA5 Chapter 10 applies to the assessment of permanent impairment of the endocrine system, subject to the modifications set out below.

Introduction

13.1 AMA5 Chapter 10 provides a useful summary of the methods for assessing permanent impairment arising from disorders of the endocrine system.

13.2 Refer to other chapters in AMA5 for related structural changes — the visual system (Chapter 12), the skin (eg, pigmentation — Chapter 8), the central and peripheral nervous system (memory, Chapter 13), the urinary and reproductive system (infertility, renal impairment, Chapter 7), the digestive system (dyspepsia, Chapter 6), the cardiovascular system (Chapters 3 and 4).

13.3 The clinical findings to support the impairment assessment are to be reported in the units recommended by the Royal College of Pathologists of Australia. (See Appendix 1 of this Chapter, page 64).

13.4 Westergren erythrocyte sedimentation rate (WSR) is equivalent to ESR.

Adrenal cortex

13.5 AMA5, p222, first paragraph: disregard the last sentence, "They also affect inflammatory response, cell membrane permeability, and immunologic responses, and they play a role in the development and maintenance of secondary sexual characteristics." Replace with: "Immunological and inflammatory responses are reduced by these hormones and they play a role in the development and maintenance of secondary sexual characteristics."

13.6 AMA5 Example 10–18 (p224–225): see reference to ESR (13.4, above).

13.7 AMA5 Example 10–20 (p225): History: For "hypnotic bladder" read "hypotonic bladder".

Diabetes mellitus

13.8 AMA5, p231: refer to the Australian Diabetes Association Guidelines with regard to levels of fasting glucose. (Position statement from the Australian Diabetes Society, reprinted in Appendix 2 to this chapter).

13.9 AMA5, p231: insert at the end of the second paragraph: 'The goal of treatment is to maintain haemoglobin A Ic within 1% of the normal range (4%–6.3%)'.

Mammary glands

13.10 AMA5 Example 10–45 (p239), Current Symptoms: Disregard the last sentence, "Both bromocriptine and cabergoline cause nausea, precluding use of either drug" and replace with: "Routine use of bromocriptine and cabergoline is normal in Australia. It is rare that nausea precludes their use."

Criteria for rating permanent impairment due to metabolic bone disease

13.11 AMA5, p240: Impairment due to a metabolic bone disease itself is unlikely to be associated with a work injury and would usually represent a pre-existing condition.

13.12 Impairment from fracture, spinal collapse or other complications may arise as a result of a work injury associated with these underlying conditions (as noted in AMA5, Section 10.10c) and would be assessed using the other Chapters indicated, with the exception of Chapter 18 (Pain) which is excluded from the *WorkCover Guides*.

Appendix 13 .1: Interpretation of pathology tests

From *Manual of Use and Interpretation of Pathology Tests*, 3rd edition. Reprinted with kind permission of the Royal College of Pathologists of Australasia.

Reference ranges, plasma or serum, unless otherwise indicated

Alanine aminotransferase (ALT)	(adult)	< 35 U/L
Albumin	(adult)	32–45 g/L
Alkaline phosphatase (ALP)	(adult, non-pregnant)	25–100 U/L
Alpha fetoprotein	(adult, non-pregnant)	< 10 μg/L
Alpha-1-antitrypsin		1.7–3.4 g/L
Anion gap		8–16 mmol/L
Aspartate aminotransferase (AST)		< 40 U/L
Bicarbonate (total CO_2)		22–32 mmol/L
Bilirubin (total)	(adult)	< 20 μmol/L
Calcium	(total)	2.10–2.60 mmol/L
	(ionised)	1.17–1.30 mmol/L
Chloride		95–110 mmol/L
Cholesterol (HDL)	(male)	0.9–2.0 mmol/L
	(female)	1.0–2.2 mmol/L
Cholesterol (total) *(National Heart Foundation [Australia] recommendation)*		< 5.5 mmol/L
Copper		13–22 μmol/L
Creatine kinase (CK)	(male)	60–220 U/L
	(female)	30–180 U/L
Creatinine	(adult male)	0.06–0.12 mmol/L
	(adult female)	0.05–0.11 mmol/L
Gamma glutamyl transferase (GGT)	(male)	< 50 U/L
	(female)	< 30 U/L
Globulin	adult	25–35g/L
Glucose	(venous plasma) - (fasting)	3.0–5.4 mmol/L
	(venous plasma) - (random)	3.0–7.7 mmol/L
Lactate dehydrogenase (LD)	(adult)	110–230 U/L
Magnesium	(adult)	0.8–1.0 mmol/L
Osmolality	(adult)	280–300 m.osmoll/kg water

Reference ranges, plasma or serum, unless otherwise indicated (continued)

pCO_2	(arterial blood)	4.6–6.0 kPa (35–45 mmHg)
PH	(arterial blood)	7.36–7.44 (36–44 nmol/L)
Phosphate		0.8–1.5 mmol/L
pO_2	(arterial blood)	11.0–13.5 kPa (80–100 mmHg)
Potassium	(plasma)	3.4–4.5 mmol/L
	(serum)	3.8–4.9 mmol/L
Prolactin	(male)	150–500 mU/L
	(female)	0–750 mU/L
Protein, total	(adult)	62–80 g/L
Sodium		135–145 mmol/L
Testosterone and related androgens	*See* Table A (below)	

Therapeutic intervals

Amitriptyline	150–900 nmol/L	60–250 µg/L
Carbamazepine	20–40 µmol/L	6–12 mg/L
Digoxin	0.6–2.3 nmol/L	0.5–1.8 µg/L
Lithium	0.6–1.2 mmol/L	
Nortriptyline	200–650 nmol/L	50–170 µg/L
Phenobarbitone	65–170 µmol/L	15–40 mg/L
Phenytoin	40–80 µmol/L	10–20 mg/L
Primidone	22–50 µmol/L	4.8–11.0 mg/L
Procainamide	17–42 µmol/L	4–10 mg/L
Quinidine	7–15 µmol/L	2.3–4.8 mg/L
Salicylate	1.0–2.5 mmol/L	140–350 mg/L
Theophylline	55–110 µmol/L	10–20 mg/L
Valproate	350–700 µmol/L	50–100 mg/L
Thyroid stimulating hormone (TSH)		0.4–5.0 mIU/L
Thyroxine (free)		10–25 pmol/L
Triglycerides (fasting)		< 2.0 mmol/L
Triiodothyronine (free)		4.0–8.0 pmol/L
Urate	(male)	0.20–0.45 mmol/L
	(female)	0.15–0.40 mmol/L
Urea	(adult)	3.0–8.0 mmol/L
Zinc		12–20 µmol/L

Table A: Reference intervals for testosterone and related androgens (serum)

	Male		Female	
	Pre-pubertal	Adult (age related)	Pre-pubertal	Adult (age related)
Free testosterone (pmol/L)		170–510		< 4.0
Total testosterone (nmol/L)	< 0.5	8–35	< 0.5	< 4.0
SHBG (nmol/L)	55–100	10–50	55–100	30–90 (250–500 in the 3rd trimester)
Dihydrotestosterone (nmol/L)		1–2.5		

Reference ranges, urine

Calcium		2.5–7.5 mmol/24 hours
Chloride (depends on intake, plasma levels)		100–250 mmol/24 hours
Cortisol (free)		100–300 nmol/24 hours
Creatinine	(child)	0.07–0.19 mmol/24 hours/kg
	(male)	9–18 mmol/24 hours
	(female)	5–16 mmol/24 hours
HMMA	(infant)	< 10 mmol/mol creatinine
	(adult)	< 35 µmol/24 hours
Magnesium		2.5–8.0 mmol/24 hours
Osmolality (depends on hydration)		50–1200 m.osmol/kg water
Phosphate (depends on intake, plasma levels)		10–40 mmol/24 hours
Potassium (depends on intake, plasma levels)		40–100 mmol/24 hours
Protein, total		< 150 mg/24 hours
	(pregnancy)	< 250 mg/24 hours
Sodium (depends on intake, plasma levels)		75–300 mmol/24 hours
Urate	(male)	2.2–6.6 mmol/24 hours
	(female)	1.6–5.6 mmol/24 hours
Urea (depends on protein intake)		420–720 mmol/24 hours

Reference ranges, whole blood

Haemoglobin (Hb)	(adult male)	130–180 g/L
	(adult female)	115–165 g/L
Red cell count (RCC)	(adult male)	4.5–6.5 x 10^{12}/L
	(adult female)	3.8–5.8 x 10^{12}/L
Packed cell volume (PCV)	(adult male)	0.40–0.54
	(adult female)	0.37–0.47
Mean cell volume (MCV)		80–100 fL
Mean cell haemoglobin (MCH)		27–32 pg
Mean cell haemoglobin concentration (MCHC)		300–350 g/L
Leucocyte (White Cell) Count (WCC)		4.0–11.0 x 10^{9}/L
Leucocyte differential count		
– Neutrophils		2.0–7.5 x 10^{9}/L
– Eosinophils		0.04–0.4 x 10^{9}/L
– Basophils		< 0.1 x 10^{9}/L
– Monocytes		0.2–0.8 x 10^{9}/L
– Lymphocytes		1.5–4.0 x 10^{9}/L
Platelet count		150–400 x 10^{9}/L
Erythrocyte sedimentation rate (ESR)	male 17–50 years	1–10 mm/hour
	male >50 years	2–14 mm/hour
	female 17–50 years	3–12 mm/hour
	female >50 years	5–20 mm/hour
Reticulocyte count		10–100 x 10^{9}/L
		(0.2–2.0%)

Reference ranges, plasma or serum, unless otherwise indicated

Iron	(adult)	10–30 μmol/L
Iron (total) binding capacity (TIBC)		45–80 μmol/L
Transferrin		1.7–3.0 g/L
Transferrin saturation		0.15–0.45 (15–45%)
Ferritin	(male)	30–300 μg/L
	(female)	15–200 μg/L
Vitamin B12		120–680 pmol/L
Folate	(red cell)	360–1400 nmol/L
	(serum)	7–45 nmol/L

Reference ranges, citrated plasma

Activated partial thromboplastin time (APTT)	25–35 seconds
– Therapeutic range for continuous infusion heparin	1.5–2.5 x baseline
Prothrombin time (PT)	11–15 seconds
International normalised ratio (INR)	
– Therapeutic range for oral anticoagulant therapy	2.0–4.5
Fibrinogen	1.5–4.0 g/L

Reference ranges, serum

Rheumatoid factor (nephelometry)	< 30 IU/L
C3	0.9–1.8 g/L
C4	0.16–0.50 g/L
C-reactive protein	< 5.0 mg/L
Immunoglobulins:	
IgG	6.5–16.0g/L
IgA	0.6–4.0g/L
IgM	0.5–3.0g/L

Reference intervals for lymphocyte subsets

	Adult
Total lymphocytes	1.5–4.0
CD3	0.6–2.4
CD4 (T4)	0.5–1.4
CD8 (T8)	0.2–0.7
CD19	0.04–0.5
CD16	0.2–0.4
CD4/CD8 ratio	1.0–3.2

Appendix 13.2: New classification and criteria for diagnosis of diabetes mellitus

Position Statement from the Australian Diabetes Society,* New Zealand Society for the Study of Diabetes,† Royal College of Pathologists of Australasia‡ and Australasian Association of Clinical Biochemists§

Peter G Colman,* David W Thomas,‡ Paul Z Zimmet,* Timothy A Welborn,* Peter Garcia-Webb§ and M Peter Moore†

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Key messages

Diagnosis of diabetes is not in doubt when there are classical symptoms of thirst and polyuria and a random venous plasma glucose level ≥ 11.1 mmol/L.

The Australasian Working Party on Diagnostic Criteria for Diabetes Mellitus recommends:

- Immediate adoption of the new criterion for diagnosis of diabetes as proposed by the American Diabetes Association (ADA) and the World Health Organization (WHO) — fasting venous plasma glucose level ≥ 7.0 mmol/L;
- Immediate adoption of the new classification for diabetes mellitus proposed by the ADA and WHO, which comprises four aetiological types — type 1, type 2, other specific types, and gestational diabetes — with impaired glucose tolerance and impaired fasting glycaemia as stages in the natural history of disordered carbohydrate metabolism.
- Awareness that some cases of diabetes will be missed unless an oral glucose tolerance test (OGTT) is performed. If there is any suspicion or other risk factor suggesting glucose intolerance, the OGTT should continue to be used pending the final WHO recommendation.

Introduction

Recently, there has been major growth in knowledge about the aetiology and pathogenesis of different types of diabetes and about the predictive value of different blood glucose levels for development of complications. In response, both the American Diabetes Association (ADA) and the World Health Organization (WHO) have re-examined, redefined and updated the classification of and criteria for diabetes, which have been unchanged since 1985. While the two working parties had cross-representation, they met separately, and differences have emerged between their recommendations.

The ADA published its final recommendations in 1997,[1] while the WHO group published its provisional conclusions for consultation and comment in June 1998.[2] The WHO process called for comments on the proposal by the end of September 1998, with the intention of finalising definitive classification and criteria by the end of December 1998 and of publishing these soon thereafter. However, WHO publications need to go through an internal approval process and it may be up to 12 months before the final WHO document appears.

A combined working party of the Australian Diabetes Society, New Zealand Society for the Study of Diabetes, Royal College of Pathologists of Australasia and Australasian Association of Clinical Biochemists was formed to formulate an Australasian position on the two sets of recommendations and, in particular, on the differences between them. This is an interim statement pending the final WHO report, which will include recommendations on diabetes classification as well as criteria for diagnosis. We see it as very important to inform Australasian health professionals treating patients with diabetes about these changes.

What are the new diagnostic criteria?

The new WHO criteria for diagnosis of diabetes mellitus and hyperglycaemia are shown in Box 1. The major change from the previous WHO recommendation[3] is the lowering of the diagnostic level of fasting plasma glucose to ≥ 7.0 mmol/L, from the former level of ≥ 7.8 mmol/L. For whole blood, the proposed new level is ≥ 6.1 mmol/L, from the former ≥ 6.7 mmol/L.

This change is based primarily on cross-sectional studies demonstrating the presence of microvascular[4] and macrovascular complications[5] at these lower glucose concentrations. In addition, the 1985 WHO diagnostic criterion for diabetes based on fasting plasma glucose level (≥ 7.8 mmol/L) represents a greater degree of hyperglycaemia than the criterion based on plasma glucose level two hours after a 75 g glucose load (≥ 11.1 mmol/L).[6] A fasting plasma glucose level of ≥ 7 mmol/L accords more closely with this 2 h post-glucose level.

Recommendation: *The ADA and the WHO committee are unanimous in adopting the changed diagnostic level, and the Australasian Working Party on Diagnostic Criteria recommends that healthcare providers in Australia and New Zealand should adopt it immediately.*

Clinicians should note that the diagnostic criteria differ between clinical and epidemiological settings. In clinical practice, when symptoms are typical of diabetes, a single fasting plasma glucose level of ≥ 7.0 mmol/L or 2 h post-glucose or casual postprandial plasma glucose level of ≥ 11.1 mmol/L suffices for diagnosis. If there are no symptoms, or symptoms are equivocal, at least one additional glucose measurement (preferably fasting) on a different day with a value in the diabetic range is necessary to confirm the diagnosis. Furthermore, severe hyperglycaemia detected under conditions of acute infective, traumatic, circulatory or other

1: Values for diagnosis of diabetes mellitus and other categories of hyperglycaemia[2]

	Glucose concentration (mmol/L [mg/dL])			
	Whole blood		Plasma	
	Venous	Capillary	Venous	Capillary
Diabetes mellitus				
Fasting	≥ 6.1 (≥ 110)	≥ 6.1 (≥ 110)	≥ 7.0 (≥126)	≥ 7.0 (≥ 126)
or 2 h post-glucose load	≥ 10.0 (≥ 180)	≥ 11.1 (≥ 200)	≥ 11.1 (≥ 200)	≥ 12.2 (≥ 220)
or both				
Impaired glucose tolerance (IGT)				
Fasting (if measured)	< 6.1 (< 110)	< 6.1 (< 110)	< 7.0 (< 126)	< 7.0 (< 126)
and 2 h post-glucose load	≥ 6.7 (≥ 120) and < 10.0 (< 180)	≥ 7.8 (≥ 140) and < 11.1 (< 200)	≥ 7.8 (≥ 140) and < 11.1 (< 200)	≥ 8.9 (≥ 160) and < 12.2 (< 220)
Impaired fasting glycaemia (IFG)				
Fasting	≥ 5.6 (≥ 100) and < 6.1 (< 110)	≥ 5.6 (≥ 100) and < 6.1 (< 110)	≥ 6.1 (≥ 110) and < 7.0 (< 126)	≥ 6.1 (≥ 110) and < 7.0 (< 126)
2 h post-glucose load (if measured)	< 6.7 (< 120)	< 7.8 (< 140)	< 7.8 (< 140)	< 8.9 (< 160)

For epidemiological or population screening purposes, the fasting or 2 h value after 75 g oral glucose may be used alone. For clinical purposes, the diagnosis of diabetes should always be confirmed by repeating the test on another day, unless there is unequivocal hyperglycaemia with acute metabolic decompensation or obvious symptoms. Glucose concentrations should not be determined on serum unless red cells are immediately removed, otherwise glycolysis will result in an unpredictable underestimation of the true concentrations. It should be stressed that glucose preservatives do not totally prevent glycolysis. If whole blood is used, the sample should be kept at 0–4°C or centrifuged immediately, or assayed immediately. Table reproduced with permission from Alberti KGMM, Zimmet PZ. Definition, diagnosis and classification of diabetes mellitus and its complications. Part 1: diagnosis and classification of diabetes mellitus. Provisional Report of a WHO Consultation. *Diabet Med* 1998; 15: 539–553.

stress may be transitory and should not be regarded as diagnostic of diabetes. The situation should be reviewed when the primary condition has stabilised.

In epidemiological settings, for study of high-prevalence populations or selective screening of high-risk individuals, a single measure — the glucose-level 2 h post-glucose load — will suffice to describe prevalence of impaired glucose tolerance (IGT).

2: Aetiological classification of disorders of glycaemia*

Type 1 (β-cell destruction, usually leading to absolute insulin deficiency)

- Autoimmune
- Idiopathic

Type 2 (may range from predominantly insulin resistance with relative insulin deficiency to a predominantly secretory defect with or without insulin resistance)

Other specific types

- Genetic defects of β-cell function
- Genetic defects in insulin action
- Diseases of the exocrine pancreas
- Endocrinopathies
- Drug or chemical induced
- Infections
- Uncommon forms of immune-mediated diabetes
- Other genetic syndromes sometimes associated with diabetes

Gestational diabetes

* As additional subtypes are discovered, it is anticipated they will be reclassified within their own specific category. Includes the former categories of gestational impaired glucose tolerance and gestational diabetes. Table reproduced with permission from Alberti KGMM, Zimmet PZ. Definition, diagnosis and classification of diabetes mellitus and its complications. Part 1: diagnosis and classification of diabetes mellitus. Provisional Report of a WHO Consultation. Diabet Med 1998; 15: 539-553. Copyright John Wiley & Sons Limited.

What about the oral glucose tolerance test?

Previously, the oral glucose tolerance test (OGTT) was recommended in people with a fasting plasma glucose level of 5.5–7.7 mmol/L or random plasma glucose level of 7.8–11.0 mmol/L. After a 75 g glucose load, those with a 2 h plasma glucose level of < 7.8 mmol/L were classified as normoglycaemic, of 7.8–11.0 mmol/L as having IGT and of ≥ 11.1 mmol/L as having diabetes.

The new diagnostic criteria proposed by the ADA and WHO differ in their recommendations on use of the OGTT. The ADA makes a strong recommendation that fasting plasma glucose level can be used on its own and that, in general, the OGTT need not be used.[1] The WHO group[2] argues strongly for the retention of the OGTT and suggests using fasting plasma glucose level alone only when circumstances prevent the performance of the OGTT.

There are concerns that many people with a fasting plasma glucose level < 7.0 mmol/L will have manifestly abnormal results on the OGTT and are at risk of microvascular and macrovascular complications. This has major ramifications for the approach to diabetes screening, particularly when the Australian National Diabetes Strategy proposal,[7] launched in June 1998 by Dr Michael Wooldridge, Federal Minister for Health and Aged Care, has early detection of type 2 diabetes as a key priority.

Recommendation: The Australasian Working Party on Diagnostic Criteria has major concerns about discontinuing use of the OGTT and recommends that a formal recommendation on its use in diabetes screening be withheld until the final WHO recommendation is made. However, in the interim, the OGTT should continue to be used.

Diabetes in pregnancy

The ADA has retained its old criteria for diagnosis of gestational diabetes.[1] These differ from those recommended by both WHO[2] and the Australian Working Party on Diabetes in Pregnancy[8] and are generally not recognised outside the United States. The new WHO statement retains the 1985 WHO recommendation that both IGT and diabetes should be classified as gestational diabetes. This is consistent with the recommendations of the Australasian Diabetes in Pregnancy Society, which recommended a diagnostic 2 h venous

plasma glucose level on the OGTT of ≥ 8.0 mmol/L. In New Zealand, a cut-off level of ≥ 9.0 mmol/L has been applied.[8]

How has the classification of diabetes changed?

The proposed new classification encompasses both clinical stages and aetiological types of hyperglycaemia and is supported by numerous epidemiological studies. The classification by aetiological type (Box 2) results from new knowledge of the causes of hyperglycaemia, including diabetes. The terms insulin-dependent and non-insulin-dependent diabetes (IDDM and NIDDM) are eliminated and the terms type 1 and type 2 diabetes retained. Other aetiological types, such as diabetes arising from genetic defects of β-cell function or insulin action, are grouped as "other specific types", with gestational diabetes as a fourth category.

The proposed staging (Box 3) reflects the fact that any aetiological type of diabetes can pass or progress through several clinical phases (both asymptomatic and symptomatic) during its natural history. Moreover, individuals may move in either direction between stages.

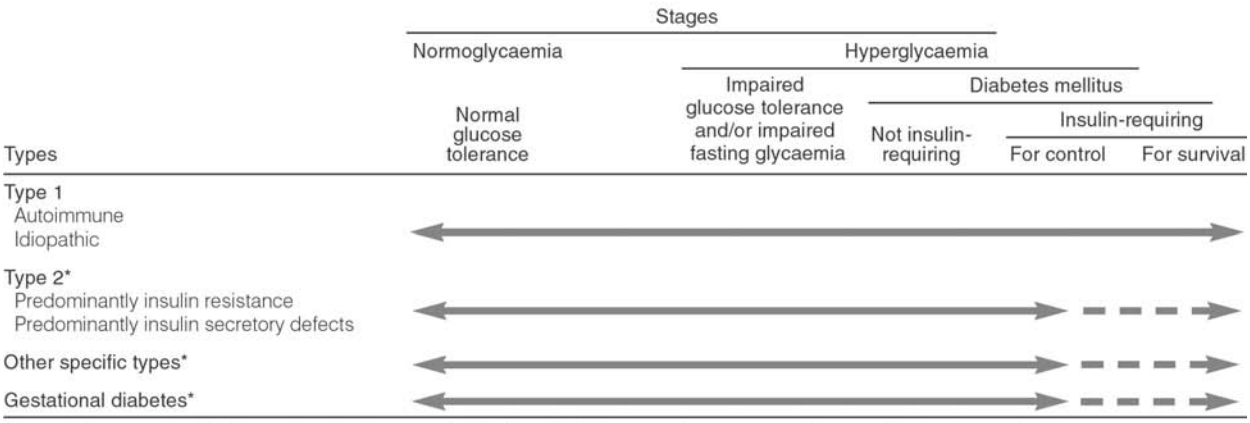
Impaired glucose tolerance and impaired fasting glycaemia

Impaired glucose tolerance (IGT), a discrete class in the previous classification, is now categorised as a stage in the natural history of disordered carbohydrate metabolism. Individuals with IGT are at increased risk of cardiovascular disease, and not all will be identified by fasting glucose level.

In reducing the use of the OGTT, the ADA recommended a new category — impaired fasting glycaemia (IFG) — when fasting plasma glucose level is lower than that required to diagnose diabetes but higher than the reference range (< 7.0 mmol/L but ≥ 6.1 mmol/L). Limited data on this category show that it increases both risk of progressing to diabetes[9] and cardiovascular risk.[5] However, data are as yet insufficient to determine whether IFG has the same status as IGT as a risk factor for developing diabetes and cardiovascular disease and as strong an association with the metabolic syndrome (insulin resistance syndrome).

IFG can be diagnosed by fasting glucose level alone, but if 2 h glucose level is also measured some individuals with IFG will have IGT and some may have diabetes. In addition, the number of people with OGTT results indicating diabetes but fasting plasma glucose level < 7.0 mmol/L is unknown, but early data suggest there may be major variation across different

3: Disorders of glycaemia: aetiological types and clinical stages



* In rare instances, patients in these categories (eg, vacor toxicity, type 1 diabetes presenting in pregnancy) may require insulin for survival.
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populations.[10] A number of studies, including the DECODE initiative of the European Diabetes Epidemiology Group, have reported that individuals classified with IFG are not the same as the IGT group.[11-15] The European Group believes that, on available European evidence, the ADA decision to rely solely on fasting glucose level would be unwise.

Recommendation: *The Australasian Working Party on Diagnostic Criteria recommends immediate adoption of the new classification. However, clinicians should be aware that some cases of diabetes will be missed unless an OGTT is performed. Thus, if there is any suspicion or other risk factor suggesting glucose intolerance, the working party continues to recommend use of an OGTT pending the final WHO recommendation.*

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14 The skin

AMA5 Chapter 8 applies to the assessment of permanent impairment of the skin, subject to the modifications set out below.

14.1 AMA5 Chapter 8 (pp173–190) refers to skin diseases generally rather than work-related skin diseases alone. This Chapter has been adopted for measuring impairment of the skin system, with the following variations.

14.2 Disfigurement, scars and skin grafts may be assessed as causing significant permanent impairment when the skin condition causes limitation in the performance of activities of daily living (ADL).

14.3 For cases of facial disfigurement, refer to Table 6.1 in the *WorkCover Guides* (page 33).

14.4 AMA5 Table 8–2 (p178) provides the method of classification of impairment due to skin disorders. Three components — signs and symptoms of skin disorder, limitations in activities of daily living and requirements for treatment — define five classes of permanent impairment. The assessing physician should derive a specific percentage impairment within the range for the class that best describes the clinical status of the claimant.

14.5 The case examples provided in AMA5 Chapter 8 do not, in most cases, relate to permanent impairment that results from a work-related injury. The following New South Wales examples are provided for information.

14.6 Work-related case study examples 14.1, 14.2, 14.3, 14.4, 14.5, 14.6 are included below, in addition to AMA5 Examples 8.1–8.22 (pp178–187) .

Example 14.1:	**Cumulative irritant dermatitis**
Subject:	42-year-old man.
History:	Spray painter working on ships in dry dock. Not required to prepare surface but required to mix paints (including epoxy and polyurethane) with “thinners” (solvents) and spray metal ships’ surface. At end of each session, required to clean equipment with solvent. Not supplied with gloves or other personal protective equipment until after onset of symptoms. Gradual increase in severity in spite of commencing to wear gloves. Off work two months leading to clearance, but frequent recurrence, especially if the subject attempted prolonged work wearing latex or PVC gloves or wet work without gloves.
Current:	Returned to dry duties only at work. Mostly clear of dermatitis, but flares.
Physical examination:	Varies between no abnormality detected to mild dermatitis of the dorsum of hands.
Investigations:	Patch test standard + epoxy + isocyanates (polyurethanes). No reactions.
Impairment:	0%.
Comment:	No interference with activities of daily living (ADL).

Example 14.2: Allergic contact dermatitis to hair dye

Subject: 30-year-old woman.

History: Hairdresser 15 years, with six month history of hand dermatitis, increasing despite beginning to wear latex gloves after onset. Dermatitis settled to very mild after four weeks off work, but not clear. As the condition flared whenever the subject returned to hairdressing, she ceased and is now a computer operator.

Current: Mild continuing dermatitis of the hands which flares when doing wet work (without gloves) or when wears latex or PVC gloves. Has three young children and impossible to avoid wet work.

Investigation: Patch test standard + hairdressing series. Possible reaction to paraphenylene diamine.

Impairment: 5%.

Comment: Able to carry out ADL with difficulty, therefore limited performance of *some* ADL.

Example 14.3: "Cement dermatitis" due to chromate in cement

Subject: 43-year-old man.

History: Concreter since age 16. Eighteen month history of increasing hand dermatitis eventually on dorsal and palmar surface of hands and fingers. Off work and treatment led to limited improvement only.

Physical examination: Fissured skin, hyperkeratotic chronic dermatitis.

Investigation: Patch test. Positive reaction to dichromate.

Current: Intractable, chronic, fissured dermatitis.

Impairment: 12%.

Comment: Unable to obtain any employment because has chronic dermatitis and on invalid pension. Difficulty gripping items including steering wheel, hammer and other tools. Unable to do any wet work, (eg, painting). Former home handyman, now calls in tradesman to do any repairs and maintenance. Limited performance in *some* ADL.

Example 14.4: Latex contact urticaria/angioedema with cross reactions

Subject: Female nurse, age 40.

History: Six month history of itchy hands minutes after applying latex gloves at work. Later swelling and redness associated with itchy hands and wrists and subsequently widespread urticaria. One week off led to immediate clearance. On return to work wearing PVC gloves, developed anaphylaxis on first day back.

Physical examination: No abnormality detected or generalised urticaria/angioedema.

Investigation: Latex radioallergosorbent test, strong positive response.

Current: The subject experiences urticaria and mild anaphylaxis if she enters a hospital, some supermarkets or other stores (especially if latex items are stocked), at children's parties or in other situations where balloons are present, or on inadvertent contact with latex items including sport goods handles, some clothing, and many shoes (latex based glues). Also has restricted diet (must avoid bananas, avocados and kiwi fruit).

Impairment: 17%

Comment: Severe limitation in *some* ADL in spite of intermittent activity.

Example 14.5: Non-melanoma skin cancer

Subject: 53-year-old married man.

History: "Road worker" since 17 years of age. Has had a basal cell carcinoma on the left forehead, squamous cell carcinoma on the right forehead (graft), basal cell carcinoma on the left ear (wedge resection) and squamous cell carcinoma on the lower lip (wedge resection) excised since 45 years of age. No history of loco-regional recurrences. Multiple actinic keratoses treated with cryotherapy or Efudix over 20 years (forearms, dorsum of hands, head and neck).

Current: New lesion right preauricular area. Concerned over appearance — "I look a mess."

Physical examination: Multiple actinic keratoses forearms, dorsum of hands, head and neck. Five millimetre diameter nodular basal cell carcinoma right preauricular area, hypertrophic red scar 3 cm length left forehead, 2 cm diameter graft site (hypopigmented with 2 mm contour deformity) right temple, non-hypertrophic scar left lower lip (vermilion) with slight step deformity and non-hypertrophic pale wedge resection scar left pinna leading to 30% reduction in size of the pinna. Graft sites taken from right post auricular area. No regional lymphadenopathy.

Impairment rating: 6%

Comment: Refer to Table 6.1 (facial disfigurement), page 33.

Example 14.6:	**Non-melanoma skin cancer**
Subject:	35-year-old single female professional surf life-saver.
History:	Occupational outdoor exposure since 19 years of age. Basal cell carcinoma on tip of nose excised three years ago with full thickness graft following failed intralesional interferon treatment.
Current:	Poor self esteem because of cosmetic result of surgery.
Physical examination:	One centimetre diameter graft site on the tip of nose (hypopigmented with 2 mm depth contour deformity, cartilage not involved). Graft site taken from right post-auricular area.
Impairment rating:	10%
Comment:	Refer to Table 6.1 (facial disfigurement), page 33.

15 Cardiovascular system

AMA5 Chapters 3 and 4 apply to the assessment of permanent impairment of the cardiovascular system, subject to the modifications set out below.

Introduction

15.1 The cardiovascular system is discussed in AMA5 Chapters 3 (Heart and Aorta) and 4 (Systemic and Pulmonary Arteries) (pp25–85). These Chapters can be used to assess permanent impairment of the cardiovascular system with the following minor modifications.

15.2 It is noted that in this chapter there are wide ranges for the impairment values in each category. When conducting a WorkCover assessment, assessors should use their clinical judgement to express a specific percentage within the range suggested.

Exercise stress testing

15.3 As with other investigations, it is not the role of a WorkCover medical assessor to order exercise stress tests purely for the purpose of evaluating the extent of permanent impairment.

15.4 If exercise stress testing is available, then it is a useful piece of information in arriving at the overall percentage impairment.

15.5 If previous investigations are inadequate for a proper assessment to be made, the Medical Assessor should consider the value of proceeding with the evaluation of permanent impairment without adequate investigations and data (see Chapter 1, page 11 — Ordering of additional investigations).

Permanent impairment — maximum medical improvement

15.6 As for all assessments, maximal medical improvement it considered to have occurred when the worker's condition has been medically stable for the previous three months, and is unlikely to change substantially in the next 12 months without further medical treatment (see Chapter 1, page 8).

Vascular diseases affecting the extremities

15.7 Note that in this section, AMA5 Table 4–4 and Table 4–5 (p76) refer to percentage impairment of the upper or lower extremity. Therefore, an assessment of impairment concerning vascular impairment of the arm or leg requires that the percentages identified in Tables 4–4 and 4–5 be converted to whole person impairment. The table for conversion of the upper extremity is AMA5 Table 16–3 (p439) and the table for conversion of the lower extremity is AMA5 Table 17–3 (p527).

Thoracic outlet syndrome

15.8 Impairment due to thoracic outlet syndrome is assessed according to AMA5 Chapter 16, The Upper Extremities and *WorkCover Guides*, Chapter 2 (page 13).

Effect of medical treatment

15.9 If the claimant has been offered, but refused, additional or alternative medical treatment which the Medical Assessor considers is likely to improve the claimant's condition, the Assessor should evaluate the current condition, without consideration for potential changes associated with the proposed treatment. The Assessor may note the potential for improvement in the claimant's condition in the evaluation report, and the reason for refusal by the claimant, but should not adjust the level of impairment on the basis of the worker's decision (Chapter 1, Permanent impairment — maximum medical improvement, page 8).

Future deterioration

15.10 If a Medical Assessor forms the opinion that the claimant's condition is stable in the foreseeable future, but expected to deteriorate in the longer term, the Assessor should make no allowance for deterioration, but note its likelihood in the evaluation report. Where the claimant's condition suffers long term deterioration, the claimant may reapply for further evaluation of the condition at a later time.

16 Digestive system

AMA5 Chapter 6 applies to the management of permanent impairment of the digestive system.

16.1 The digestive system is discussed in AMA5 Chapter 6 (pp117–142). That Chapter can be used to assess permanent impairment of the digestive system. There are no modifications for the purposes of the *WorkCover Guides*.

Note: Evaluation of permanent impairment arising from chronic pain (exclusion of AMA5, Chapter 18)

Following consultation with Professor Michael Cousins and Doctor Mike Nicholas of the University of Sydney Pain Management and Research Centre, the AMA5 Chapter devoted to assessment of chronic pain is to be disregarded for the purposes of the *WorkCover Guides*.

The reasons for this are:

- The Chapter does not contain validated instruments that convert the rating given by an examiner into a whole body impairment rating.
- No work has been done at this time to enable such conversion to occur.
- Measuring impairment for this condition is complex and requires a high degree of specialised knowledge and experience. This level of knowledge and experience is not widespread and it would be difficult to ensure consistency and equity in the assessment process.

Impairment ratings in the *WorkCover Guides* attempt to account for the pain commonly associated with many disorders and others, such as complex regional pain syndrome, are specifically included in the Guides. It is recognised in AMA5 that chronic pain is not adequately accounted for in the other Chapters. However, work on a better method is still in progress and it would be premature to specify an alternative at present.

Work is being undertaken by the University of Sydney Pain Management and Research Centre that will enable such a chapter to be written in the future.

As with all largely subjective complaints in compensation systems, there is a concern that monetary compensation for non-specific conditions such as chronic pain can in some cases complicate the restorative and rehabilitative efforts of the worker and his or her health advisers. Hence the need for further investigation to determine a better and fairer system that recognises the difficulties associated with these conditions while, at the same time, promoting effective rehabilitation.

When the work is completed, it will be possible to review this policy decision and introduce assessment of permanent impairment arising from chronic pain, at which time it may be possible to use this assessment as the means of quantifying “pain and suffering” compensation under section 67 of the *Workers Compensation Act 1987*.

Appendix 1: Working groups on permanent impairment

Permanent Impairment Co-ordinating Group

Name	Position
Dr Jim STEWART	Chair
Ms Kate McKENZIE	WorkCover
Mr John ROBERTSON	Labor Council of NSW
Ms Mary YAAGER	Labor Council of NSW
Dr Ian GARDNER	Medical Representative to Workers Compensation and Workplace Occupational Health and Safety Council of NSW
Dr Stephen BUCKLEY	Rehabilitation Physician
Prof Michael FEARNSIDE	Professor of Neurosurgery
Dr John HARRISON	Orthopaedic Surgeon
Dr Jonathan PHILLIPS	Psychiatrist
Prof Bill MARSDEN	Professor of Orthopaedic Surgery
Dr Dwight DOWDA	Occupational Physician
Assoc Prof Ian CAMERON	Professor of Rehabilitation Medicine
Dr Robin CHASE	Australian Medical Association

Working Groups

Psychiatric and Psychological

Dr Julian PARMEGIANI
Dr Derek LOVELL
Dr Rod MILTON
Dr Yvonne SKINNER
Dr Jonathan PHILLIPS
Dr Chris BLACKWELL
Dr Bruce WESTMORE
Dr Susan BALLINGER
Ms Lyn SHUMACK
Dr Jack WHITE
Ms Sandra DUNN
Dr Tim HANNON

Hearing

Dr Brian WILLIAMS
Dr Joseph SCOPPA
Dr Stanley STYLIS
Dr Paul NIALL
Assoc Prof Ian CAMERON

Spine

Prof Michael FEARNSIDE
Dr John CUMMINE
Prof Michael RYAN
Dr Dwight DOWDA
Assoc Prof Ian CAMERON
Dr Hugh DICKSON
Dr Conrad WINER
Dr Mario BENANZIO
Dr Jim ELLIS
Dr Jim BODEL
Dr William WOLFENDEN
Dr Kevin BLEASEL
Dr John HARRISON
Prof Sydney NADE

Urinary and Reproductive

Prof Richard MILLARD
Dr Kim Boo KUAH
Assoc Prof Ian CAMERON

Upper Limb

Dr Dwight DOWDA
Assoc Prof Ian CAMERON
Prof Bill MARSDEN
Dr Bruce CONOLLY
Dr David CROCKER
Dr Richard HONNER
Dr Jim ELLIS
Dr Conrad WINER
Dr David DUCKWORTH

Respiratory and Nose and Throat

Dr Julian LEE
Prof David BRYANT
Dr Joseph SCOPPA
Dr Michael BURNS
Dr Frank MACCIONI
Dr Peter CORTE
Dr Brian WILLIAMS
Assoc Prof Ian CAMERON

Skin

Dr Victor ZIELINSKI
Dr Scott MENZIES
Dr Edmund LOBEL
Assoc Prof Ian CAMERON

Cardiovascular

Dr Thomas NASH
Dr John GUNNING
Dr George MICHELL
Dr Stephen BUCKLEY
Dr Melissa DOOHAN
Dr Charles FISHER

Endocrine

Dr Alfred STEINBECK
Prof Peter HALL
Dr Stephen BUCKLEY

Vision

Dr Michael DELANEY
Dr Peter DUKE
Dr Peter ANDERSON
Dr John KENNEDY
Dr Neville BANKS
Assoc Prof Ian CAMERON

Digestive

Prof Philip BARNES
Dr David De CARLE
Dr Dwight DOWDA

Nervous System

Dr Stephen BUCKLEY
Assoc Prof Ian CAMERON
Dr Dwight DOWDA
Dr Ivan LORENTZ
Dr Keith LETHLEAN
Dr Peter BLUM
Prof Michael FEARNSIDE
Dr Tim HANNON

Lower Limb

Dr Dwight DOWDA
Assoc Prof Ian CAMERON
Prof Bill MARSDEN
Dr Peter HOLMAN
Dr Jay GOVIND
Dr Jim BODEL
Dr Mario BENANZIO
Dr Jim ELLIS
Dr Conrad WINER
Dr Cecil CASS
Dr John HARRISON
Dr John KORBER

Haematopoietic

Prof John GIBSON
Dr Stephen FLECKNOE-BROWN
Dr Peter SLEZAK
Assoc Prof Ian CAMERON
Prof John DWYER

Appendix 2: Guidelines for medico-legal consultations and examinations

(issued by the New South Wales Medical Board, September 2001)

The Medical Board is aware of a number of complaints by examinees about the manner in which they have been dealt with by doctors conducting examinations for medico-legal reasons or for other third parties. In these cases, the doctor is not in a therapeutic relationship with the examinee, and the history-taking and examination may need to be more extensive than the examinee might have been expecting. In addition, the examinee may be generally nervous and, in particular, anxious about the possibility of receiving an adverse medical report from the doctor.

Doctors are reminded that they have a duty to act in an ethical, professional and considerate manner when examining people, whether or not they are responsible for the examinee's care. It is the Board's view that the same level of professional skill and care is required of a medical practitioner acting in a medico-legal capacity as in a therapeutic setting. Whilst some procedures may be simple or routine for the doctor, they may not be seen as such by the examinee. Effective communication is integral to this aspect of the doctor-examinee relationship, especially when the doctor is examining the examinee on behalf of a third party.

Medical practitioners should generally only work in their areas of expertise, whether in medico-legal or clinical practice.

In order to avoid appearing insensitive, rude, or abrupt in their manner or rough in their examination, doctors are advised to give particular attention to identifying the examinee's concerns, and to explain adequately the reasons for the examination. Adequate time should be allowed for appointments to enable a proper history to be taken and examination to be made.

In order to prevent misunderstandings between doctors and examinees, the Board has proposed the following guidelines:

The introduction

1. The doctor should properly introduce himself or herself and explain his or her specialty field of medicine in language which the examinee can understand.
2. The doctor should explain the purpose and nature of the consultation and examination.
3. The doctor should explain that his or her role is that of an independent reviewer who is providing an impartial opinion for use in a court or before another decision-making body.
4. The examinee has the option of having an accompanying person to be present during the history and/or the examination. This should be explained to the examinee when the interview is being scheduled. The role of the accompanying person should normally be to support the examinee — and not to answer questions. However, should the examinee have an intellectual, speech or language difficulty , it is appropriate for the accompanying person to assist in the communication between doctor and examinee. An interpreter should be used where the examinee has a difficulty with spoken English.
5. The doctor should consider the needs of examinees with an intellectual disability. Further, the doctor should be aware of differing cultural sensitivities such as being touched on parts of the body.
6. Some doctors choose to video or audio record the examination. The reason for this should be clearly explained to the examinee and consent must be obtained in advance.

Explanation to the examinee

1. It is essential that before commencing an examination, the doctor explains which part of the body is to be examined, why it is to be examined, and what the examination entails.
2. Similarly, the position of the doctor during the examination should be explained (this is particularly important when the doctor is standing behind the examinee).
3. Before commencing the examination, the doctor should explain the extent to which undressing is required.

Conversation during the consultation

1. The doctor should not offer any opinion on the examinee's claim on the third party concerned.
2. The doctor should not offer any opinion on the examinee's medical or surgical management.
3. The doctor should not make any unnecessary personal remarks, especially when the consultation involves an intimate examination.

Physical examination

1. The doctor should examine the examinee in privacy, unless the examinee has brought a friend to be with them at that time.
2. Before the examination the doctor should provide a sheet, or a gown or some other garment, with which to preserve the examinee's modesty.
3. The examinee's modesty should be preserved in undressing before, and dressing after, the physical examination.
4. Modesty may be preserved by:
   i. the provision of a screen behind which the examinee can undress; or
   ii the doctor excusing himself or herself from the consulting room whilst the examinee in undressing;
5. The doctor ought to consider the desirability of having a chaperone present during the examination.
6. Examination should be limited to the area relevant to the examinee's problem. It is inappropriate for a medical practitioner to examine any part of the body without the examinee's consent. This may limit the scope of a practitioner's examination and subsequent report.
7. If an intimate examination is warranted, ie breasts or anogenital region, the reasons and nature of the examination must be carefully explained to the examinee, and the examinee's permission obtained. This should be noted in the medical records. The examinee's wishes concerning the presence of a chaperone or friend should be respected.
8. In the majority of cases it is appropriate to notify the examinee of an incidental problem which has been identified by the examining doctor. There may be some situations where it is preferable to notify the examinee's treating doctor.

Appendix 3: Understanding medico-legal examinations

[Text of a pamphlet prepared by the New South Wales Branch of the Australian Medical Association and the Law Society of New South Wales for the information of members of the public.]

You have been asked to go to a medical examination as part of the legal action you are taking. This brochure will help you understand the examination and your part in it.

This examination aims:

- To find out what injury or medical condition you have;
- To find out its cause;
- To find out if your condition is caused by an accident or by your work conditions;
- To find out if an accident or your work has aggravated some underlying condition.

The examination is intended to be an independent and honest effort to assess your problem so that an impartial report can be prepared.

Who arranges the examination?

The examination has been arranged by your solicitor or by one of the other parties to the legal action, such as the employer, the insurance company or a solicitor acting for one of the other parties.

You have the right to know who has arranged the examination, and you may ask your solicitor or the doctor who carries out the examination.

A report will be sent from the doctor to the person who has arranged the examination. That person pays the doctor for the report. The report will be confidential and the doctor will not be able to give you an opinion about your condition or about any treatment you have had.

About the doctor

The doctor is a specialist who is generally an expert in diagnosing and advising about conditions such as yours. The doctor is usually not an employee of an insurance company or legal firm but a privately or self-employed doctor who often runs a busy medical or surgical practice. The doctor will write a report based on what he learns from you, and your cooperation will be most important. The report will be independent; that is, it will be saying exactly what the doctor thinks about your condition and not aiming to be for or against any side in the legal case.

As you are not seeing the examining doctor as his/her patient, the doctor is not able to give you advice about your problem. The doctor cannot give you treatment. Please do not embarrass the doctor by asking. You will need to ask your own doctor about such matters.

Before the appointment

Please check that you have the correct appointment time and address. You should tell your solicitor or the person arranging the appointment if you are likely to need an interpreter. You should bring all x-rays and tests relevant to your condition so that the doctor can make a thorough assessment.

The report

This will be sent to the person who has arranged the examination and who has paid for it. The report could be used in determining the outcome of your claim. It becomes a legal document and could be used as evidence in court.

The examination

The examination has several parts.

The doctor's secretary will ask you to give some routine particulars. The doctor will introduce himself/herself and try to put you at ease.

The examining doctor will not know whether you need the help of an interpreter. If such help is needed, your solicitor should arrange the interpreter. By mutual agreement with the doctor, you may wish to have a friend or relative with you, but that person should not interrupt or interfere with the examination.

The doctor will ask you about your work history and will ask you about the accident or circumstances that caused your injury or condition. He/she will ask you about the treatment you have had and about how the injury

or condition affects you now. He/she will ask you about your medical history. The questions may be wide-ranging and not just about the body part that has been injured.

Your x-rays and any other investigations will be examined.

The doctor will carry out a physical examination and will explain or demonstrate what he/she wants you to do. The doctor will examine the injured parts of your body and possibly other parts of your body as well. The examination may involve measuring height and weight and the movement of various joints and reflexes.

Every consideration will be given

The doctor will carry out an examination of you in a respectful manner. In the physical examination he/she will not hurt you. The doctor will not expect you to do anything that would cause pain.

A complex medical history may take an hour or more, but many examinations are completed in less than that time. The doctor will be aiming to let you go as soon as possible.

How can you help?

Be punctual. The doctor will try and be punctual too, but remember that doctors sometimes have to deal will urgent matters.

It is best to turn off your mobile phone.

Be pleasant to the doctor, particularly if the examination has been arranged by the other side. Remember that the doctor will be giving an independent report. No one benefits from an unpleasant atmosphere. A hostile attitude might mean deferral or termination of the examination.

Be prepared if possible with important dates and names. Don't be worried if you cannot remember — the doctor simply wants your best recollection.

Be honest and straightforward with your answers, even if you think that the questions are not closely related to the main problem.

Wear clothes that are suitable. For example, if your back is to be examined, it is usual for outer clothing to be removed. Women should wear a bra and pants so that the back can be examined thoroughly while preserving the modesty of the patient and out of respect for the practitioner. It is never necessary to fully disrobe a patient.

Modesty will be considered at all times, but an adequate examination requires adequate exposure. The doctor's report may mention the fact if a patient is unwilling to undress sufficiently for adequate examination.

What if there are problems during an examination?

Reading this brochure should help you know what to expect.

If the doctor asks you a question that you do not wish to answer, then you may say so. However, this may be mentioned in the medical report.

If the doctor asks you to do something that would cause pain, then mention this to the doctor. But don't forget that the doctor is expecting your best cooperation during the examination.

If you believe that there is a complete breakdown in your relationship with the doctor, then you may choose to say so and to leave the examination. However, if you do, you may be liable for the cost of the examination and report.

If you are in doubt about something during the examination, a quick phone call to your solicitor may help.

Repeat examinations

Sometimes legal cases go on for a long time. Repeat examinations are arranged so that the doctor can report on your progress. The doctor has no say about whether the case is resolved or whether you get compensation and simply reports on your condition.

Feedback

Please let the AMA or the Law Society know if you think this brochure can be improved; everyone is keen to make this necessary examination as easy as possible for you.

Comments in writing on suggested brochure improvements will be received by:

The Australian Medical Association (NSW)
33 Atchison Street
St Leonards, NSW 2065

and

The Law Society of New South Wales
170 Phillip Street
Sydney NSW 2000

WORKCOVER PROVISIONAL LIABILITY AND CLAIMS GUIDELINES

WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998

EXPLANATORY NOTE

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

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

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

Kate McKenzie
General Manager
WorkCover NSW

December 2001

WorkCover NSW Guidelines

These Guidelines are in 2 Parts:

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

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

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

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

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

Governing principles

1. **The WorkCover Guidelines are founded on the following principles:**

1.1 ***Timely*** To satisfy legislative requirements, insurer's, employers, worker's, and advisers will obtain and provide information about the injury in a timely manner.

1.2 ***Active insurer's*** Insurer's are required to obtain certain information to make certain assessments.

1.3 ***Sound up to date decisions*** Insurer's will make sound decisions on the information available within the timeframes the law allows and they will keep those decisions up to date as they receive new information.

1.4 ***Documented reasons*** Insurer's will record the reasons for their decisions and show that they have considered all relevant decisions.

1.5 ***Peer review*** Insurer's will arrange for all decisions not to pay provisional liability weekly payments to be reviewed by a suitably experienced person.

1.6 ***Consent*** Worker's consent to the collection, use and disclosure of personal and health information when they sign the medical certificate.

1.7 ***Privacy*** The Commonwealth privacy law and the National Privacy Principles apply to the information collected and used for the purposes of handling the worker's claim.

Aims

2. **The aims of these guidelines are:**

2.1 to ensure the prompt management of a worker's injuries

2.2 to ensure a worker's return to work as early as possible

2.3 to give a worker's certainty and proper income support while they are incapacitated by work injuries

2.4 to facilitate timely and sound decision-making

2.5 to reduce disputes

2.6 to maintain the employment relationship between the worker and the employer

2.7 to promptly resolve disputes if they happen

2.8 to set the requirements for making a claim under the *Workplace Injury Management Act* and the *Worker's Compensation Act* 1998

Table of Contents Part 1- Initial notifications and provisional liability

Part 1 Initial notifications and provisional liability

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

What is provisional liability?

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

What is an initial notification of injury?

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

Who can make an initial notification?

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

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

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

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

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

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

Criteria 1 - Minimum identifying information

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

5.1.1 **Worker's information**:

- name
- residential address
- date of birth

5.1.2 **Employer's information:**

- name and
- current business address

5.1.3 **Treating doctor information:**

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

5.1.4 **Injury or illness and accident details:**

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

5.1.5 **Notifier information**

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

Supporting information

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

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

When is initial notification complete?

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

What happens if Criteria 1 information is not provided?

7. If the Criteria 1 information is not provided at the initial notification, then the initial notification is not complete. However, if the missing information:

   7.1 *is not materially necessary* for the insurer to decide about a worker's entitlement to provisional liability, then the insurer may start payments.

   7.2 *is materially necessary*, then the initial notification is incomplete and the insurer must, within the next 3 working days, inform the person (verbally, or in writing) who made the notification that the notification has not been made. The person may then make another initial notification.

What if the insurer can't find the policy?

8. If the insurer can not find a current policy that covers an initial notification within 7 days after the notification, then the insurer is to either:

   8.1 contact the employer, and the person who made the notification, and request more information in order to identify the policy. If the policy still cannot be identified, then the insurer is to inform the employer and the person who made the notification that the insurer is not the current insurer. The insurer must then refer the initial notification to the Claims Assistance Service (CAS); or

   8.2 pass the initial notification to the current insurer if known. The insurer who received the initial notification may be able to find out who is the current insurer (by looking for a request for past claims experience from the new insurer or from the cancellation request made by the employer).

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

9. Within 7 days after the initial notification is made, the insurer is to gather enough information to satisfy:

   9.1 Criteria 2, see Part 1, rule 10;

   9.2 Criteria 3, see Part 1, rule 11; and

   9.3 Criteria 4, see Part 1, rule 12.

What medical information is the insurer to gather? Criteria 2

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

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

Information from the Doctor or hospital

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

Information about the worker's hospitalisation

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

Information from the employer

10.3 Information from the employer (including the employer's nominated return to work coordinator, the employer's designated worker's compensation officer, or another person the employer has nominated to the insurer):

10.3.1 as to the date of consultation

10.3.2 about the diagnosis of a workplace injury and expected period of incapacity taken from a WorkCover medical certificate for that injury

10.3.3 obtained by any means confirming that the worker received a workplace injury.

Information from the worker

10.4 Information from the worker (or if the worker is unable to participate in the verification, someone acting for the worker):

10.4.1 as to the date of consultation

10.4.2 about the diagnosis of a workplace injury and expected period of incapacity taken from a WorkCover medical certificate for that injury

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

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

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

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

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

11.1.1 a signed statement from a third party that includes information specific to the circumstances of the worker's injury that conflicts with the workplace injury as notified

11.1.2 available public information specific to the circumstances of the worker's injury that conflicts with the workplace injury as notified

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

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

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

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

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

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

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

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

guidelines when making a decision.

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

13 When an insurer receives an initial notification, it is to:

13.1 *issue a notification number* to the notifier at the time of initial notification (if made by telephone) and to the worker and employer within 7 days after the notification is made;

13.2 *gather information for Criteria 2, Criteria 3 and Criteria 4*, see Part 1, rules 10, 11 and 12;

13.3 *start injury management* if the worker is likely to be off work for more than 7 continuous days even if any of the days are for partial incapacity. *Reference section 45*

13.4 ***Within 7 days*** *decide whether to start provisional weekly payments of compensation* (and if so for how long) on the basis of the nature of the injury, the period of the worker's incapacity and the expected future period of their incapacity. If payments are to be paid, see Part 1, rule 14. If the insurer decides that it has a reasonable excuse (as set out in Part 1, rule 16) for not making payments, see Part 1, rule 15. *Reference section 267*

13.5 ***Within 7 days*** *decide whether to approve provisional medical expenses up to $5000 or approve medical expenses as part of an injury management plan.* *Reference section 50 and section 280.*

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

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

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

14.1 The insurer's notice to the worker must include the following: *Reference 269.*

14.1.1 that payments have commenced on the basis of provisional acceptance of liability

14.1.2 the period of expected provisional weekly payments

14.1.3 the amount to be paid each week

14.1.4 whether the insurer or the employer will pay the worker

14.1.5 what the worker should do if they do not receive payment.

14.1.6 that an injury management plan will be developed if required

14.1.7 details of how to make a claim

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

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

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

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

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

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

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

15.2 to inform the employer as soon as practicable

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

15.3 The Insurer's notice to the worker is to include the following:
Reference section 268

15.3.1 details of the reasonable excuse

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

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

15.3.4 details of how to make a claim

15.3.5 a claim form.

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

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

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

What is a reasonable excuse for not commencing provisional payments?

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

Insufficient medical information

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

Worker unlikely to be a "worker"

16.2 The insurer has a reasonable excuse if:

16.2.1 the worker has been unable to verify their status as a worker as described in; Criteria 4, Part 1, rule 12; or

16.2.2 the employer is able to verify that the worker is not a worker

Insurer unable to contact "worker"

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

Worker refuses access to information (privacy)

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

Injury is not work related

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

Acceptable forms of evidence could include:

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

16.5.2 available public information specific to the circumstances of the worker's injury that conflicts with the workplace injury as notified

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

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

Injury is not significant

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

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

Injury notified after 2 months

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

How a notice of injury can be given to an employer
Reference Part 2 Division 1 – Giving notice of injury and making a claim.

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

A notice of injury must state:

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

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

When are payments to start?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18.2.1 the period paid and amount

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

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

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

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

For how long are provisional weekly payments to be paid?

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

When does the 12 week period start?

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

Does the insurer have to receive a WorkCover medical certificate?

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

What period can the first provisional weekly payment cover?

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

- The expected period of incapacity
- Information available to the insurer
- Whether the worker is already back at work
- The date of the workplace injury and the date of initial notification
- If the insurer has requested a WorkCover medical certificate, see rule 19.4 or an authority to obtain information regarding treatment or the worker's medical condition, see Part 1, rule 21.3
  Reference section 270.

When can an insurer request a WorkCover Medical Certificate?

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

19.4.1 Of the period of incapacity the WorkCover medical certificate is to cover
19.4.2 That the worker must give the WorkCover medical certificate to the insurer within 7 days after the request
19.4.3 That weekly payments may stop of the WorkCover medical certificate is not received by the insurer

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

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

What if payments are stopped during the 12 weeks?

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

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

What happens if payments are made for 8 weeks?

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

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

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

What provisional medical expenses can be paid?

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

What if the worker has already paid for medical treatment?

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

What if the worker has paid for traveling expenses?

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

May the insurer stop provisional weekly payments?

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

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

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

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

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

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

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

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

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

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

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

21.3.2.2 information regarding the worker's medical condition; or

21.3.2.3 information regarding treatment relevant to the injury:or

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

21.4 **What must a section 74 dispute notice include?**

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

21.4.1 of the reason the insurer disputes liability

21.4.2 of what part of the legislation the insurer relies on to dispute liability

21.4.3 of the particulars that support the reason for the decision, including the required details for each report (if any) on which the insurer relies to support that reason, and

21.4.4 advising that the claimant may request a copy of a report specified in the statement of particulars from the insurer, and

21.4.5 advising that the claimant may request the insurer to review the decision, and advising of the procedure for making such a request, and

21.4.6 to the effect that:

i. in the case of a dispute about a claim that is an existing claim within the meaning of Chapter 7 of the 1998 Act, the claimant may apply to the Compensation Court for determination of the dispute, or

ii. in the case of a dispute about a claim within the meaning of Chapter 7 of the 1998 Act, the claimant may refer the dispute to the Registrar for determination by the Commission, and

21.4.7 of the address and fax number for the Registrar of the Court or the Registrar of the Commission, as appropriate.

21.4.8 that the worker can seek assistance from a trade union or from a lawyer

21.4.9 that the worker or the employer may contact the Claims Assistance Service on 131050 for assistance

When may a provisional claim be reopened?

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

22.1 for administration purposes to make further payments; or

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

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

Table of Contents Part 2 – Making and handling claims

Part 2 Making and handling claims

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

Does the worker have to make a claim?

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

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

1.1 A worker does not have to make a claim for weekly benefits or medical expenses if an initial notification of their workplace injury was made and the worker was paid provisional liability payments. However, the worker must make a claim if:

1.1.1 the worker requires benefits that exceed their entitlements under provisional liability; that is weekly payments more than 12 weeks, see Part 1, rule 19 or compensation for medical expenses more than $5000, see Part 1, rule 20.

1.1.2 the insurer has stopped making provisional liability payments and the worker thinks they are still entitled to more benefits

1.1.3 the insurer requests a claim to be made

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

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

What are the time limits on making a claim?

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

However*:*

2.1 the Authority may approve to extend this period; and

2.2 if the worker first became aware of the injury after they received the injury, then the 3 year period doesn't start until the date on which the worker became aware of the injury; and

2.3 if the claim is for compensation for death, or serious and permanent impairment, the claim may be made at any time.

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

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

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

What must a notice of injury state?

3.1 A notice of injury must state:

3.1.1 The name and address of the person injured, and

3.1.2 The cause of the injury (in ordinary language), and

3.1.3 The date on which the injury happened.

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

What if the injury involves loss of hearing?

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

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

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

3.3.1 if the worker is employed by an employer in an employment to the nature of which that injury is due to that employer; or

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

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

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

Industrial deafness Notice of injury

1 Name and address of worker:

2 Age and occupation of worker:

3 Name and address of employer to whom notice of injury is given:

4 If not employed by the above employer at the date that this notice of injury is given, date of last day of employment with the employer:

5 Has the worker been paid any compensation for loss of hearing in Australia or elsewhere? YES/NO If YES give details:

6 Using the following list, give the worker's complete work history in any noisy work in Australia or elsewhere, including work as an employee, in any business carried on by the worker (either alone or with anyone else), in military service or otherwise. Include work in the list even if unsure about

how noisy the work was.

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

Signature of Worker
Date signed by worker.

How does a worker make a claim?

4 To make a claim, a worker must serve the information listed in Part 2, rule 6 on the relevant person which is either:

4.1 the employer from whom the worker claims compensation; or
4.2 the insurer responsible for covering the worker for compensation.

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

How may a worker serve a claim?

5. A worker may serve a claim in any of the following ways:

5.1 by giving it in writing personally to the relevant person, see Part 2 rule 4.

5.2 by having it delivered or sent by post to the current residence of the relevant person or to any current place of business of that person

5.3 by sending it by email or facsimile to the relevant person

5.4 by leaving it at, or posting it to, the relevant company's registered office

5.5 by having it delivered to a director of the company who resides in Australia

5.6 if a liquidator or administrator of the company has been appointed, by leaving it at, or posting it to, the address of the liquidator's or administrator's office

5.7 if the claim is for only medical expenses up to $5,000, the worker may make the claim verbally to the employer or the insurer, or the employer may make the claim verbally to the insurer. Supporting documentation of the amount claimed must be provided for payment to be made.

What is the minimum information required to make a claim?

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

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

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

6.1 Information about the worker:

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

6.2 Information about the employer

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

6.3 Information about the treating doctor

- Name

6.4 Information about the worker's employment

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

6.5 Information about the workplace injury

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

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

6.6 Additional information

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

What must the "worker's declaration" include?

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

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

What information is required from the employer?

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

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

What if the claim is for weekly benefits?

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

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

What if the claim is for medical expenses?

6.10 To make a claim for medical expenses compensation the worker must:

- provide the minimum information listed in rule 6.1 to rule 6.7

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

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

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

6.11.2 all impairments arising from the injury; and

6.11.3 any previous injury, or any pre-existing condition or abnormality, to which any proportion of an impairment is or may be due (whether or not it is an injury for which compensation has been paid or is payable under Division 4 of Part 3 of the 1987 Act);and

6.11.4 in the case of a claim for work injury damages, any economic losses and other losses that are being claimed as damages; and

6.11.5 information relevant to a determination as to whether or not the degree of permanent impairment resulting from the injury will change; and

6.11.6 in the case of a claim for lump sum compensation, details of all previous employment to the nature of which the injury is or may be due.
Reference section 282.

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

What if the claim is for permanent impairment hearing loss?

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

6.12.1 Information in Form 1– Notice of hearing loss, see Part 2 rule 3.4

6.12.2 Workers declaration, see Part 2, rule 6.7.

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

6.12.4 A medical report completed as described in WorkCover Guidelines on Assessment of Permanent Impairment.

Reference section 282, regulation clause 39

What if the claim is for property damage?

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

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

6.13.2 provide documentation to support the amount claimed.

What if the claim is for pain and suffering?

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

The relevant particulars to be provided to the insurer are:

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

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

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

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

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

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

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

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

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

8. When an insurer is served with a claim it must:

8.1 **If the claim is for weekly or medical expenses compensation?**

8.1.1 Determine the claim within 21 days, see Part 2, rule 10.1 and

8.1.2 notify the employer within 7 days that a claim has been made by their worker.

8.2 **If the claim is for permanent impairment or lump sum damages?**

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

8.2.1 *Within 1 month after* the degree of permanent impairment first becomes fully ascertainable, as agreed by the parties or as determined by an approved medical specialist, or

8.2.2 *Within 2 months after* the claimant has provided to the insurer all relevant particulars about the claim

Reference section 281.

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

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

What if the insurer can't find the policy?

9. If the insurer can not find a current policy that covers a claim within 7 days after the claim is made, then the insurer is to either:

9.1 contact the employer, and person who made the claim, and request more information in order to identify the policy. If the policy still cannot be identified, then the insurer is to inform the employer and the person who made the claim that the insurer is not the current insurer. The insurer must then refer the claim to the Claims Assistance Service (CAS); or

9.2 pass the claim to the current insurer if known. (maybe known by a request for past claims experience from the new insurer or from the cancellation request made by the employer).

When must the insurer determine the claim?

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

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

10.1 An insurer must determine a claim for weekly benefits or medical expenses compensation within 21 days after the claim was made see Part 2, rule 4 unless one of the reasonable excuses in Part 2, rule 10.1.1 to 10.1.5 for not determining the claim applies *Reference section 274 and 283.*

10.1.1 *Expiry date greater than due date* The expiry date of the expected provisional liability period is greater than the claim determination due date. In that case, the insurer must determine the claim when the provisional liability weekly payments end if a determination is still required.

10.1.2 *Returned to work* The worker has returned to work on pre-injury duties, and received provisional liability payments for the amounts claimed, and is not expected to suffer any future loss from the injury.

10.1.3 *Medical expenses only* The claim is for only medical expenses compensation and has been provisionally accepted. *Reference section 280.*

10.1.4 *Medical expenses for permanent impairment*. The claim is for artificial aids, spectacles, home care or vehicle or home modifications and is made at the same time as a lump sum or work injury damages claim. *Reference section 59 (d), (f), (g)* . The insurer must determine this claim at the same time as the claim for permanent impairment.

10.1.5 *Deficient claim* Within 7 days after the insurer received the claim, the insurer has notified the worker in writing that the claim contains an error that is not obvious or typographical; and how to correct that deficiency. This could include

- Worker refuses to sign the declaration
- No medical certificate received

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

What if the claim is for permanent impairment?

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

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

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

What must the insurer do if it accepts liability for a permanent impairment or work injury damages claim?
Reference section 281

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

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

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

What if the claim is for property damages?

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

What must an insurer do if it disputes any claim?

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

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

10.6 A claim can be re-opened after it has been closed for the following reasons:

- Recurrence of original injury
- Further payments or recoveries
- Claim is litigated
- Claims administration

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

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

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