Injury Management Program

New South Wales

Guild INSURANCE

Don't go it alone

Contents

About Us

Guild has provided general insurance services to pharmacists since its inception in 1963. In that time, we have expanded our expertise to meet the insurance needs of a wide range of professional groups. Today, we enjoy a reputation for our customer service, honesty, integrity and professional competence. Our focus continues to be on developing lasting relationships with professional associations and their members.

Guild Insurance is a 100% Australian owned company and are an Australian Prudential Regulation Authority (APRA) regulated insurer. We work with over 130 associations and we insure over 80,000 customers across Australia. We provide a large variety of insurance services, including Business Insurance, Professional Indemnity, Home & Car Insurance and Workers Compensation.

In NSW, Guild Insurance has a specialised licence issued by the State Insurance Regulatory Authority (SIRA) to manage Workers Compensation claims in the pharmacy and child care service industries.

Overarching principles of Guild Claims Management:

Helping people when they need it most is central to what we do. Whether it be in our claims management process or working with you to safeguard your workplace. We focus on the right outcome for all parties, which is why we are trusted by our communities to deliver personalised workers compensation with professionalism, transparency, empathy and positivity.

We Know It – We are experts in workers compensation with specialists in claims management and injury prevention. We exceed regulatory requirements to adhere to our specialised and general licences.

We Create It – We enable innovative claims management and injury preventative tools at the forefront of WHS and personal injury industries.

We Own It – We deliver a coordinated national approach, tailored to understand the needs of your industry to drive continuous improvement and reduce cost.

Guild Insurance adhere to the system objectives outlined in Section 3 of the *Workplace Injury Management and Workers Compensation Act 1998* and the SIRA claims management principles of:

- Fairness and empathy
- Transparency and participation
- Timeliness and efficiency

Definitions

Please see below some detailed explanations of certain terms used in this document for your reference

Category 1 & Category 2 Employers

Employers are divided into two categories for the development of return to work programs, which have differences in their requirements for the program. The categories are based on the following criteria:

Category 1 Employers

- Basic tariff premium over $50,000 a year.
- Self-insured.
- Insured by a specialised insurer and has over 20 employees.

Category 1 employers must comply with the SIRA Guidelines for Workplace Return to Work Programs and regulations, which includes:

- Appoint a Return to Work Coordinator
- Develop a Return to Work Program in consultation with workers and unions
- Implement the Return to Work Program

Category 2 Employers

- Basic tariff premium of $50,000 a year or less
- Insured by a specialised insurer and has under 20 employees
- Any other employer that is not under Category 1

Category 2 employers must comply with the SIRA Guidelines for Workplace Return to Work Programs and regulations, which includes:

- Appoint a person responsible for recovery at work
- either adopt the SIRA Standard Return to Work Program for Category 2 Employers or develop own program based on this
- Implement the Return to Work Program

Independent Consultations

An independent consultant is an allied health practitioner who can provide an independent peer review of allied health practitioner treatment in the NSW workers compensation system. Referrals to a consultant will provide independent peer review of allied health practitioner (physical or psychological) treatment. An independent consultant for the review of treatment must be a registered:

- Physiotherapist
- Chiropractor
- Osteopath
- Psychologist

They must also be a SIRA approved independent consultant.

Independent Medical Examinations

Independent Medical Examiners are registered medical practitioners who provide impartial medical assessments. Insurers can arrange an Independent Medical Examination when medical information is inadequate, unavailable or inconsistent to allow effective management of claims and are unable to resolve the problems directly with the workers treating practitioners. The information obtained is used primarily to determine whether a worker is entitled to compensation or if the worker has a continuing entitlement to compensation, a work capacity, what that capacity is to resume work and if they have sustained a Whole Person Impairment

Injured Worker

An employee who has sustained a workplace injury

Injury

A personal injury arising out of or in the course of employment including:

i. A disease contracted by an employee in the course of employment, where the employment was a contributing factor to the disease, or

ii. The aggravation, acceleration, exacerbation or deterioration of any disease where the employment was a contributing factor to the aggravation, acceleration, exacerbation or deterioration, but

Section 4 of the *Workplace Injury Management and Workers Compensation Act 1998*

Injury Management

The process that comprises the activities and procedures that are undertaken or established for the purpose of achieving a timely, safe and durable return to work by the worker.

Injury Management Consultants

An Injury Management Consultant is a registered medical practitioner experienced in occupational injury and workplace-based rehabilitation. They are facilitators who will assist insurers, employers, workers and treating doctors find solutions to problems in complex return to work plans and injury management.

The consultant assesses the claim, examines the worker (if necessary), and discuss possible solutions with all parties (particularly the nominated treating doctor). They are not involved in the treatment of an injured worker, and do not provide opinion on the current treatment plan. The consultants also do not comment on liability for a workers compensation claim.

Definitions

Injury Management Plan

A documented plan for a co-ordinated and managed program that integrates all aspects of injury management that concern the treatment, rehabilitation and retraining of an injured worker with a significant injury, for the purpose of achieving a timely, safe and durable return to work by the worker. An Injury Management Plan may also provide for the payment of cost of any treatment for the workplace injury to a nominated treating doctor prepared to participate in the arrangements under the plan and, subject to circumstances, the cost of other specified treatment to the worker for the workplace injury. Each Injury Management Plan is developed for an individual worker. Each Injury Management Plan outlines the obligations of each stakeholder.

Injury Management Program

A co-ordinated and managed programme that integrates all aspects of injury management (including treatment, rehabilitation, retraining, claims management and employee management practices) for the purpose of achieving optimum results in terms of a timely, safe and durable return to work for injured workers.

Nominated Treating Doctor

The treating practitioner nominated by the worker for the purpose of an Injury Management Plan for the worker.

Insurer

A licensed insurer for NSW Workers Compensation

Provisional Payments

Reimbursement of weekly payments and treatment costs to an injured worker that are payable by the insurer without conceding a formal admission of liability for the injury

Return to Work Coordinator (or Appointed Person Responsible for Recovery at Work)

A Return to Work Coordinator, or the appointed person responsible for recovery at work is responsible for the implementation of an organisation's return to work program and supporting workers as they recover at work. They are a key link between the worker and their support team as they recover.

The person responsible for return to work at an insured's is a key person in the injury management process. They would be responsible within the workplace for ensuring that the activities associated with the return to work of the injured worker are implemented in accordance with any injury management plan and individual return to work plans and should ensure that the return to work plan is not in contradiction with the Injury Management Plan.

When a return to work plan is prepared, the person responsible should consult supervisors, the injured worker, treating health practitioners, the insurer, and, if appropriate, the nominated approved rehabilitation provider(s). Within the workplace, contact should be established with all key people to ensure that their role in enabling the injured worker to remain at work or return to suitable work is understood.

Recover at Work Plan

An individual plan that the employer develops in consultation with the worker to manage recovery at work.

SIRA Guidelines for Employers Return to Work Programs

Return to Work Program

A series of return to work commitments and procedures developed by the employer, aimed at ensuring timely, safe and durable return to work of injured employees that must be consistent with this Injury Management Program.

All NSW employers must have a return to work program in place within 12 months of starting a business, and it must be consistent with their insurer's injury management program. It is an employer's obligation to establish a Return to Work Program incorporating policies and procedures for the rehabilitation of injured workers. It nominates the employer's return to work coordinator (if required), lists the rehabilitation providers who will work with that employer and describes how suitable duties will be made available for workers who are certified fit for such duties. NSW employers are defined as either 'Category 1' or 'Category 2' employers

Section 52 of the *Workplace Injury Management and Workers Compensation Act 1998*

Part 6 of the Workers Compensation Regulation 2016

Significant Injury

A workplace injury that is likely to result in the worker being incapacitated for a continuous period of more than 7 days whether or not any of those days are work days and whether or not the incapacity is total or partial or a combination of both

Suitable Duties (Employment)

Suitable employment or duties, in relation to a worker, means employment in work for which the worker is suited, having regard to the following:

i. The nature of the worker's incapacity and details provided in medical information including, but not limited to, any certificate of capacity supplied by the worker, and

ii. The worker's age, education, skills and work experience,

iii. Any plan or document prepared as part of the return to work planning process, including an injury management plan,

Definitions

iv. Any occupational rehabilitation services that are being, or have been, provided to or for the worker, and

v. Such other matters as SIRA Guidelines may specify, and

Regardless of:

i. Whether the work or the employment is available, and

ii. Whether the work or the employment is of a type or nature that is generally available in the employment market, and

iii. The nature of the worker's pre-injury employment, and

iv. The worker's place of residence.

Section 32A, *Workers Compensation Act, 1987*

Suitable duties are intended to provide productive work for injured worker to assist them in returning to their pre-injury work capacity. Suitable duties are proposed after consideration of the multiple factors including, skills, experience, and access to the work area and medical restrictions.

Workplace Rehabilitation Providers

Accredited Workplace Rehabilitation Providers are organisations accredited by SIRA to offer specialised services to help injured workers to return to work. Accredited Workplace Rehabilitation Providers:

i. assess the needs of the injured worker and the workplace requirements to develop a rehabilitation plan of action, listing the services needed to return the injured worker to work

ii. employ different health professionals, such as occupational therapists, physiotherapists, psychologists and rehabilitation counsellors;

iii. are referred to by the employer, insurer or the treating doctor to help in complex cases;

iv. are nominated by the employer in the return-to-work program.

Injury Management Program

An Injury Management Program is a “co-ordinated and managed program that integrates all aspects of injury management (including treatment, rehabilitation, retraining, claims management and employment management practices) for the purpose of achieving optimum results in terms of a timely, safe and durable return to work for injured workers.”

Section 42 of the *Workplace Injury Management and Workers Compensation Act 1998*

As a NSW Workers Compensation specialised insurer Guild Insurance is required to “establish and maintain an injury management program and must revise its injury management program from time to time or when the Authority directs.”

Section 43 of the *Workplace Injury Management and Workers Compensation Act 1998*

This document is communicated to all NSW pharmacies holding a policy of Workers Compensation Insurance with Guild Insurance. This is distributed at the time of commencing a new policy with Guild Insurance and is available on our website: **www.guildinsurance.com.au**

The Injury Management Program is designed to assist in helping all injured workers:

- Return to work as soon as practicable and understanding that a recovery at work is a normal expectation
- When certified able to return to work in some capacity, they are provided with appropriate alternate duties (wherever possible) as part of the return to work process, and these duties are specified and agreed on in a Recover at Work/ Return to Work Plan
- Are assured that participation in the Injury Management Program will not, of itself, endanger job security
- Allowing a forum where consultation with relevant stakeholders can ensue (where necessary) for the effective operation of the program
- Is made aware of their, and other stakeholders, obligations during the worker’s compensation claims and return to work process

Workplace injury management is about returning injured workers to meaningful employment in a timely, safe and durable manner following a workplace injury with a focus on that monitored recovery in the workplace can be more effective than at home or in a medical institution

Roles and Responsibilities

There are responsibilities and obligations for facilitating workplace injury management. These are shared by the key stakeholders of workers compensation claims, which are:

- The Employer
- The Injured Worker
- The Insurer

Employer Roles and Responsibilities

- Demonstrate commitment to the injury management process
- Ensure that a suitable person is appointed to the role of the Return to Work Coordinator (or Appointed Person Responsible for Recovery at Work=-
- To notify Guild Insurance within 48 hours (or as soon as possible after) when becoming aware that an employee has sustained a workplace injury
- Participate and co-operate in the development of an Injury Management Plan established for any injured worker who sustains a significant injury
- Comply with responsibilities and obligations of the employer by under the Injury Management Plan
- Provide appropriate suitable duties for an injured worker and encourage an early return to work
- Section 49 of the *Workplace Injury Management and Workers Compensation Act 1998*
- Not terminate an injured worker as a result of a workplace injury for a minimum of 6 months post injury
- Provide a Return to Work Plan/Recover at Work Plan for any worker who sustains a significant injury (i.e. the worker is unfit or likely to be unfit to return to his/her normal duties within 7 days) unless a rehabilitation provider has been appointed to provide this service. Where a rehabilitation provider has been appointed the employer is still responsible for ensuring that the Return to Work Plan is formulated in consultation with the worker, nominated treating doctor and other relevant parties and is consistent with the Injury Management Plan provided by Guild Insurance for the worker. For those employers who are not required to have a Return to Work Co-ordinator, Guild Insurance may make a referral to an accredited Rehabilitation Provider to assist with the return to work process and to perform an initial return to work assessment. (A proforma Return to Work Plan document is provided at the end of this document for your use, if desired. A Return to Work Plan/Recover at Work is also available on the SIRA NSW website www.sira.nsw.gov.au

Injured Worker Roles and Responsibilities

- Notify their employer that they sustained a workplace injury as soon as possible after the injury happens
- Participate and co-operate in the development of the Injury Management Plan
- Comply with responsibilities and obligations of the injured worker under the Injury Management Plan
- Advise of their Nominated Treating Doctor, who is prepared to participate in the development and obligations of the Injury Management Plan. Agree that when the injured worker signs a SIRA NSW Certificate of Capacity, that action will be understood to be the worker's nomination of that doctor as the nominated treating doctor (a medical practice can be considered the Nominated Treating Doctor if required)
- Authorise their Nominated Treating Doctor to provide relevant information to the Insurer or the Employer for the purposes of an Injury Management Plan for the worker
- Provide written consent to Guild Insurance who may be required to collect, obtain and release certain information in the process of handling your claim.
- Make all reasonable efforts to return to work with their pre-injury employer as soon as possible, having regard to the nature of the injury
- Keep Guild Insurance and their employer information of the progress of their claim and changes of their capacity to work
- Comply with requests made by Guild Insurance during the management of their claim, including providing ongoing Certificates of Capacity, attending all relevant appointments with their treating practitioners, independent assessments and Rehabilitation Provider appointments.
- Understand that failure to reasonably comply with their Injury Management and return to work obligations may result in suspension of their weekly payment entitlements

Guild Insurance Roles and Responsibilities

- Establish an Injury Management Program and regularly update and maintain as required or when directed by SIRA.
- Take appropriate steps to ensure that each employer they insure is made aware of the employer's obligations imposed by workers compensation legislation and be made and be kept aware of the injury management program
- Within 3 working days after being notified of a significant injury to a worker, initiate action and must contact the worker, the employer and where appropriate and practicable, the worker's treating doctor

Roles and Responsibilities

- Establish an Injury Management Plan for the injured worker in consultation with the worker concerned, the worker's nominated treating doctor and the employer (to the maximum extent that their co-operation and participation allow) for any workplace injury which appears to be a significant injury
- Provide the employer, the employee and the nominated treating doctor information with respect to the Injury Management Plan. This information is to include that the worker, employer, nominated treating doctor and insurer must comply with the obligations imposed under such plan.

Case Management

Notification of a workplace injury

An initial notification is the first notification of a workplace injury that is given to Guild Insurance. A worker, employer, a treating doctor, or an appropriate representative (such as union official) can make an initial notification of workplace injury to Guild Insurance (from this point forward, this person is referred to as 'the notifier').

Injured workers are to notify their employer of their workplace injury as soon as possible after the injury happens, and employers are to notify their workers compensation insurer within 48 hours of being made aware of a workplace injury

The notifier may submit an initial notification to Guild Insurance electronically on our website, 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. Guild Insurance's preference of submission of the notification is through the online portal available on the Guild Insurance website, to allow quick and accurate lodgement.

We are required 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 submitted timely and efficiently. At the initial notification, the notifier is to give Guild Insurance the information set out below.

Worker's information:

- Name
- Telephone number
- Residential address

Employer's information:

- The employers' policy number and account number
- Name
- Telephone number
- Current business address

Treating doctor information:

- Name of the doctor or medical centre (We will need to exercise flexibility in relation to workers in remote rural areas where access to medical treatment is not readily available.);
- Or if the worker is hospitalised, the name of the hospital will suffice.

Injury or illness and accident details:

- Date and time of workplace injury
- Description of how the workplace injury happened
- Description of the workplace injury

Notifier information

- Name of person making the initial notification
- Relationship to worker or employer
- Telephone number
- Current postal address

Triage

At the time of the lodgement of the claim, the information is uploaded onto our claim management system ClaimCenter and the claim is registered and the assigned to the Team Leader. The Team Leader then reviews the risk rating and if there is a significant relationship aligning to the policy and claim to the appropriate Case Manager or Fast Track Case Manager.

Provision of interpreter services

If required, Guild Insurance will arrange for an interpreter for any stakeholder involved in a claim. Interpreter services can be for both written and oral translation.

Initial Contacts

Once the claim is allocated, the Case Manager is to (while complying with privacy obligations) make early, supportive contact with the worker, employer and, where appropriate and reasonably practicable, the worker's treating doctor within 3 days of the notification of injury and document the contact in detail on the claim file. If phone contact is unable to be achieved, at least 2 separate attempts by phone and a written attempt must be documented on the claim file.

The Case Managers are to as best as possible outline an understandable explanation of the system during the initial contact, as well as educating each party of their requirements and actions to take to ensure the best outcome. The contact should also outline each party's understanding of the injury, what actions have been taken and need to be taken to recover from the injury, what impact it has had on work, and what actions are to be taken as part of the workers compensation process.

Guild Insurance is to:

- establish contact in line with SIRA's Customer Service Conduct Principles
- seek to understand the worker's individual situation and circumstance
- set tailored expectations about frequency and method of agreed contact
- clarify rights and obligations of the worker, employer and providers.

Case Management

Early Intervention

Early and tailored contact with relevant stakeholders provides invaluable information to inform the early identification of potential risk factors for delayed recovery. A subsequent analysis and prioritisation of risk factors and matched actions will strengthen stakeholder commitment, prevent work loss and optimise recovery and work outcomes.

Guild Insurance aims to actively manage the first four weeks of a claim for a significant injury to establish effective relationships, assess for risk of delayed recovery and work loss, and identify and agree the tailored actions to optimise recovery and work outcomes.

Risk Analysis

Insurers are to gather information about risk factors for delayed recovery across the four domains (personal, workplace, insurance and healthcare)

Utilising the Early Intervention Risk Analysis tool. Guild Insurance are to analyse the information gathered to:

- appropriately allocate and/or prioritise the claim
- identify key risk factors most likely to affect recovery and work outcomes (for planning)

The determination of the above is to be documented on the claim file. Guild Insurance is to review and amend based on risks, needs and changes in circumstances and update the injury management plan when appropriate.

Risk Actions

Guild Insurance is to:

- match appropriate actions to address the identified risks for delayed recovery across the four domains (personal, workplace, insurance and healthcare)
- Collaborate and co-ordinate with the worker, employer (and treating medical practitioner and other providers, where appropriate) to determine, document and implement the matched actions (see Standard of practice S12. Injury Management Plans).

The determination of the above is to be documented on the claim file. Guild Insurance is to review and amend based on risks, needs and changes in circumstances and update the injury management plan when appropriate.

Early Intervention Support

Guild Insurance is to provide support to workers during the Early Intervention process by:

- Maximising the worker's input to their recovery
- build the worker's understanding of the health benefits of recovering at work
- consider the worker's capabilities, preferences and goals.

Guild Insurance is to provide support to employers during the Early Intervention process by:

- facilitating a supportive relationship between the employer and the worker
- assisting them in understanding and meeting their workers compensation obligations
- assisting in the employer identify and provide suitable work
- accessing services required to address work related barriers.

Coordinated Multi Domain Approach

Guild Insurance is to coordinate relevant stakeholders to achieve worker goals and work outcomes by:

- exchanging information about risks, goals and work
- monitoring response to treatment and liaising with the worker and providers if treatment is not contributing to the worker's goals and outcomes.

Initial determination of liability

Within 7 days of receiving a notification of injury, Guild Insurance must make an initial determination of liability of whether the injured worker is entitled to Workers Compensation benefits.

Guild Insurance will either determine the claim is provisionally accepted, accepted, there is insufficient information to make a determination by day 7, or decline liability.

If the claim is provisionally accepted, Guild Insurance can commence making Provisional Payments to the injured worker from day 7.

Provisional Liability

Provisional liability allows Guild Insurance to commence weekly payments to an injured worker without this effecting a formal decision of liability. This enables Guild Insurance to make payments to the worker and commence early intervention, while also continuing to investigate formal liability of the claim.

The limits of provisional liability are:

- 12 weeks of payments for total or partial time loss from work
- $10,000.00 for approved medical treatment

If deciding to commence weekly payments under provisional liability, then these payments are to start within 7 days after the initial notification. Guild Insurance must also give written notice about the decision to commence payments to both the worker and the employer within 7 days after the initial notification.

Case Management

Reasonable Excuse

When a notification of injury is submitted, Guild Insurance may delay payment of weekly compensation payments if it determines it has a reasonable excuse to do so within 7 calendar days from notification.

A Reasonable Excuse may be applied in the following circumstances:

- Insufficient medical information
- Unable to make initial contact the injured worker
- The injured worker does not provide notification to their employer within 2 months of the injury occurring
- The injured worker is unlikely to be a 'worker' as defined in the Workers Compensation legislation
- The injured worker refuses access to medical and/or personal information required to process the claim
- The injury is not work related
- There is no requirement for weekly payments

Please note that applying a Reasonable Excuse for weekly compensation payments does not affect an injured workers entitlement for compensation of medical treatment.

Guild Insurance must give written notice to the injured worker and employer within two working days after the decision that reasonable excuse to not commence provisional weekly payments has been applied.

The following information must be provided to the worker and employer:

- How the excuse can be resolved
- Details about how further information can be sought from the insurer
- That the worker can seek assistance from their union, a legal representative or the IRO, and;
- That the worker has a right to seek an expedited assessment by the Workers Compensation Commission

If the relevant information or evidence is supplied after a reasonable excuse has been applied, Guild Insurance can proceed to make a liability decision based on the evidence provided.

Ongoing Liability

After lodgement of a claim, evidence should be obtained to verify that the worker has suffered a work-related injury and to determine the likely period of incapacity (if this has not been fully completed at time of initial notification) or if further evidence is required beyond the initial advice. This evidence/ confirmation may be obtained from the treating doctor or hospital, (where it has been indicated that a worker was/or is hospitalised). Information may also be obtained from the employer, employer's representative, injured worker, or injured worker's representative.

The steps involved in making a soundly based liability decision include:

- Guild Insurance obtaining all the relevant facts (what is the nature of the injury, is the injury work related, are SIRA Certificates of Capacity available, etc)
- Gathering information to support the facts (medical reports, employer statements, worker statements, and doctor's advice)
- Identifying the relevant legislative provisions. Decisions must be based on the applicable provisions of the Act and Regulations, although other documents may be used as reference points, for example, guidelines provided from time to time, from regulators.

In following these steps, it is essential that there be appropriate evidence to support the findings. Suspicion is not enough, and if irrelevant matters or personal bias are relied on, or relevant facts are ignored when making the decision, it may not be in accordance with the legislation or able to be sustained on application for review by the worker.

Acceptance of Liability

If there are no grounds to dispute ongoing liability, Guild Insurance is to proceed with formal acceptance of the claim when:

- We determine we have sufficient information to make a soundly based decision to formally accept the claim
- Within 21 days from when an injured worker has submitted a formal claim form after being placed under a Reasonable Excuse
- Prior to the expiration of the Provisional Liability payment limits

Guild Insurance must also give written notice to the injured worker and employer once determines the claim is to be accepted.

Dispute of Liability

A dispute happens when Guild Insurance determines, based on the available information, that an injured worker is not entitled to workers compensation benefits. This includes the insurer disputing that:

- The injured worker has an entitlement to payment of weekly compensation
- The worker has an entitlement for a specific service or treatment
- That the worker is entitled to a lump sum payment or a Work Injury Damages payment

Case Management

If the case manager determines that they require to make a decision to dispute liability, it is to be internally peer reviewed to determine if it is a soundly based decision.

Guild Insurance must also give written notice to the injured worker and employer once determines that a dispute decision is to be made.

In accordance with section 79 of the 1998 Act, Guild Insurance's notice to the injured worker advising of a dispute of liability on a claim must contain:

- A concise and readily understandable statement of the reason for the insurer's decision
- A concise and readily understandable statement of the issues relevant to the decision.

Any provision of the workers compensation legislation on which the insurer relies to dispute

Liability Any dispute of liability must apply the relevant notice periods outlined in Section 80 of the 1998 Act.

Weekly Payments

If an injured worker sustains an injury that results partial or total incapacity from work, payments for weekly compensation for their time loss, Guild Insurance to gather information to determine the weekly compensation payment rate.

In NSW, when an injured worker requires time off work due to their injury, the workers compensation amount for their weekly payments may not necessarily be the workers usual weekly rate (for example, their usual hourly rate and hours worked). Their weekly payments are paid in accordance with the NSW Workers Compensation legislation, which advises that the amount paid is based on paying a percentage of their Pre-Injury Average Weekly Earnings (or PIAWE).

The injured worker's PIAWE is a calculated average of their past earnings during the 'Relevant Period', This calculation includes any paid leave and overtime amounts. The Relevant Period can vary for several reasons, but is generally:

- If the worker has been employed for at least a year at their pre-injury employer, 52 weeks of earnings during their employment
- If the worker has been employer for less than a year, the earnings during their entire period of employment

Case Managers are to seek this information from the employer as soon as possible in order to make a timely determination of the injured workers PIAWE.

Additionally, for injuries sustained on or after 21 October 2019, the worker's preinjury weekly earnings may be determined by agreement between the worker and employer within 5 days of initial notification.

Once the PIAWE is determined, the weekly amount to be paid to a worker will be a percentage of their PIAWE:

- For the first 13 weeks of total or partial incapacity from work, the worker is entitled to 95% of their PIAWE. Once Guild Insurance has determined the PIAWE, the Case Manager is to advise our employers the amount to be paid each week
- After 13 weeks of total or partial incapacity from work, if the worker is doing at least 15 hours per week of work, their rate remains at the rate of 95% of their PIAWE. If the worker remains totally unfit to work, or is doings less than 15 hours of work per week, the rate drops to the rate of 80% of their PIAWE.

Reduction in payments of compensation

While receiving weekly payments under Workers Compensation, injured workers are subject to several rate changes during their entitlement period, which are outlined in the Workers Compensation legislation. Guild Insurance are to ensure that workers payment rates are paid in accordance with the legislation at all times.

The following are a list of the rate changes that occur during the initial 260 weeks of weekly payment compensation:

14 – 130 weeks: Second entitlement period

Injured workers are to continue to receive 95% of their PIAWE after 13 weeks of payments, only if they have returned to employment and working at least 15 hours per week. Otherwise, the worker is to only receive 80% of their PIAWE each week.

After 52 weeks: Overtime and Shift Allowances deducted from PIAWE

When calculating the PIAWE, the rate determined includes an average amount for the any overtime or shift allowances during their relevant period (if applicable). Guild Insurance refer to the rate determined for normal hours as the Base PIAWE, and the rate with the Overtime and Shift Allowance as the Combined PIAWE.

After 52 weeks, this amount added is taken out of their weekly payment, and the worker is to receive payments at the appropriate rate based on the Base PIAWE.

There is no change to the rate for any workers who did not have any payments for overtime or shift allowances in their relevant period when initially determining their PIAWE.

Special requirements apply for weekly payments to continue after 130 weeks.

Case Management

131 – 260 weeks: Special requirements after second entitlement period

After 130 weeks of payments, the weekly payments to injured workers are to cease, unless:

- The worker is assessed as having no current work capacity which is likely to continue indefinitely.
- The worker has applied to the insurer after 78 weeks for continuation of weekly payments beyond 130 weeks, and
- is working 15 hours or more and has current weekly earnings of at least the amount specified in s38 (3) (b) (as indexed) per week, and the insurer has assessed the worker is, and is likely to continue indefinitely to be, incapable of undertaking additional employment that would increase the worker's current weekly earnings

OR

- The worker has applied to the insurer after 78 weeks for continuation of weekly payments beyond 130 weeks, and worker is deemed a 'High Needs'
- A worker that has been deemed as 'Highest Needs'
- There are certain circumstances that a worker continues to have an entitlement under s38 even if the worker, for up to four weeks in the first 12 consecutive week period (or any subsequent consecutive period of 12 weeks of s38 payments), has: worked more or less hours (even if less than 15hrs) than the hours worked at the time of making the s38 application, or received higher or lower current weekly earnings (even if less than the amount specified in s38 (3) (b) (as indexed) per week).

260 weeks or more

Weekly payments are to cease for all injured workers at 260 weeks (5 years), unless:

- The worker is deemed a 'High Needs'. These workers are to receive compensable weekly payments until retirement age, but are still subject to Work Capacity Decisions that may affect their weekly entitlement payments
- The worker is deemed as 'Highest Needs'. These workers are to receive compensable weekly payments until retirement age, and are not subject to Work Capacity Decisions

Sections 36, 37, 38, 39 and 40 of the *Workers Compensation Act 1987*

Wage Reimbursements

When determined that an injured worker is entitled to weekly compensation following an injury, weekly payments to workers will commence at the employers next usual time of payment of wages to the injured worker in accordance with section 84 of the 1987 Act.

Workers will not be disadvantaged if the insurer has not been able to obtain all information required to calculate PIAWE, or if an insurer has not yet approved a PIAWE agreement. This can be done by Guild Insurance calculating the PIAWE rate through past earnings information, an agreed PIAWE rate by the employer and worker, or an Interim PIAWE calculated on the best available information. Guild Insurance is to advise the worker and employer of the currently determined weekly rate as soon as possible after the notification of injury.

Reimbursement paid by the employer

When paying weekly compensation for time loss, Guild Insurance will always organise reimbursement of their wage payments through their employer via their usual wage payment method if:

- The worker is still employed by their pre-injury employer
- Direct payment of weekly payments has not been directly requested by the worker or employer
- Guild Insurance has not determined any issue with the employer completing the weekly compensation payments to the injured worker

Guild Insurance informs the employer of the PIAWE rate and applicable percentage of this rate to be paid to the employer each week. As soon as Guild Insurance determines that weekly compensation is payable, we instruct the employer to commence payment at the next applicable wage cycle. We instruct the employer to pay at the determined rate (minus any earnings the worker may earn through suitable employment) until:

- The injured worker earns above their applicable rate during a week for payment (in which case the worker is only paid their earnings)
- The worker has returned to pre-injury duties
- The workers entitled to weekly payments is otherwise suspended or declined.

During the life of the claim, Guild Insurance informs the employer of any applicable changes in their rate (e.g. drop from 95% to 80%) to ensure the correct rate is paid to the injured worker.

On payment of the weekly payments, Guild Insurance requests the employer to complete a Wage Reimbursement Form outlining the claimed workers compensation amount paid to the worker and proof of payment (e.g. the worker's payslip). On receipt of this information, Guild Insurance processes a reimbursement to the employer within 7 days.

Reimbursement to the injured worker

When Guild Insurance is required to pay weekly compensation directly to the injured worker, the following actions are taken:

Case Management

- Consult with the employer and advise that claims costs will continue to accrue
- Request the worker to complete an Australian Taxation Office tax file number declaration form, and arrange for tax to be paid on behalf of the worker Additionally, we request the injured workers nominated bank account details where to pay their weekly compensation, if they wish to receive directly into a bank account
- Send written advice to the worker and employer within 5 days after commencing payments

Section 59A

Section 59A limits the time in which Guild Insurance is required to pay medical expenses and related treatment expenses to:

- 12 months from when a claim for compensation in respect of the injury was first made, where weekly payments of compensation have not been paid – section 59A(1), or
- 12 months from when payments of weekly compensation were last made – section 59A(2). The 2013 regulation applies to:
- Treatment by a medical practitioner, a registered dentist or a dental prosthetist;
- Hospital treatment and any related workplace rehabilitation services;
- Any nursing, medicines, medical or surgical supplies or curative apparatus, supplied or provided for the worker otherwise than as hospital treatment; or
- The provision of artificial members, hearing aids, hearing aid batteries, crutches, spectacles, eyes or teeth and other artificial aids

Dependant on the workers assessed degree of permanent impairment (% of permanent impairment) will depend the ongoing entitlement period.

- Two years after weekly payments stop, where their degree of permanent impairment is 10 per cent or less
- Five years after weekly payments stop, where their degree of permanent impairment is 11 to 20 per cent.

Notification of cessation of benefits will be provided at least 13 weeks before cessation of benefits. The written notice will include:

- The date on which compensation for reasonably necessary medical treatment and services is due to cease, and
- In the case of the worker, who to contact for further information (including IRO).

Section 59A does not apply to seriously injured workers – section 59A(4). A seriously injured worker is defined as a worker who is suffering from more than 30% WPI or greater, or the insurer is satisfied the degree of permanent impairment is likely to be more than 30% WPI.

Section 39

Section 39 of the Workers Compensation Act provides that a worker has no entitlement to weekly payments in respect of an injury after receiving payments for 5 years or an aggregate of a period of 260 weeks, unless the worker's degree of permanent impairment resulting from the injury is more than 20% whole person impairment.

Weekly benefits will cease if:

- A claim was made before 1 October 2012 then the 26 week period will be calculated using weekly payments after 1 January 2013.
- A claim was made after 1 October 2012 then the calculation of the 260 week period commences from the first date of your incapacity.

Notification of cessation of benefits will be provided at least 13 weeks before cessation of benefits. The written notice will include:

- The date on which payments will cease and the date the last payment will be processed
- Supporting documentation for the assessment of permanent impairment
- The date on which entitlement to medical benefits will cease
- Information regarding the worker's entitlement to vocational and return to work assistance programs
- Information on how to contact Centrelink, and
- Who to contact for further information (including IRO)

Retiring age

Retiring age is defined as the age of a person who is eligible to receive the age pension.

When a worker is receiving weekly payments and they reach retirement age, the worker may be entitled to receive a further 12 months of weekly payments. If a worker is injured on or after retirement age the worker maybe entitled to weekly payments during the 12 month period of incapacity.

Notification of cessation of benefits will be provided at least 13 weeks before cessation of benefits. The written notice will include:

- The date on which compensation for reasonably necessary medical treatment and services is due to cease, and
- In the case of the worker, who to contact for further information (including WIRO).

Case Management

Finalisation of Claims

Once and injured worker has been issued with a pre-injury duties certificate of capacity with no restriction and no need for ongoing treatment, the case manager will review to ensure that they have made a safe and durable return to work. When the worker has been able to maintain their pre-injury duties and all invoices and or wage reimbursements have been paid, the claim will be finalised.

Guild Insurance may also finalise the claim if other circumstance occur, which include:

- A return to suitable employment with no ongoing loss of earnings
- Retirement or withdrawal of claim
- A Work Capacity Decision which results in ceasing ongoing weekly payments and there is no further medical treatment costs
- Commutation, Work Injury Damages or Common law settlement
- Settlement of a claim for the same injury by another party
- Declinature of ongoing liability
- Weekly compensation payments are terminated

Prior to finalising any claim, we will contact the worker advising of the pending finalisation of the claim and wait 14 days for any response before proceeding with the finalisation, unless it is otherwise agreed with by the injured worker that the claim can be finalised prior to this time.

The insurer is to confirm in writing within two days after the claim is closed, the closure of a claim to the worker and the employer, including:

- The date the claim was closed
- The date on which medical benefits will cease (not applicable to exempt workers), and
- What to do if the worker or employer believes the claim needs to be reopened

Re-opening of finalised claims

If the injured worker requires their previously finalised claim to be re-opened, they are to contact Guild Insurance as soon as possible to advise of reasons for reactivation of the claim.

Guild Insurance handle and recurrence or aggravation of a previous workplace injury in line the SIRA Standards of Practice.

Injury Management

Injury Management Plans

If any injured worker is determined to have, or likely to have, 7 or more days of continuous total or partial incapacity, Guild Insurance is to develop an initial Injury Management Plan within 20 working days after being notified of an injury, and a copy of this plan will be sent to the worker, employer and nominated treating doctor.

In line with the SIRA Standards of Practice, as well as the requirements of Injury Management Plans outlined in section 45 of the *Workplace Injury Management and Workers Compensation Act 1998*, the plan is expected to:

- be specific to the worker
- be developed in consultation with the worker, the nominated treating doctor and the employer
- be consistent with available medical and treatment information, an
- include:
  - The goal of the plan and actions tailored to delivery of the goal
  - A statement about how and when the plan will be reviewed the rights and obligations of all stakeholders.

Included in the plan will be advice from the nominated treating doctor of the anticipated length of time the worker will be totally incapacitated, whether a graduated return to work program will be necessary, the availability and nature of suitable duties with the employer, the necessity for any additional treatment (e.g. physiotherapy, specialist referral), the employer's internal rehabilitation process, the need to look to the appointment of an external rehabilitation provider and any other factors which may be relevant to a particular claim.

Case Managers are to continually review and issue updated plans while the worker remains totally or partially incapacitated throughout the life of the claim. This is to be done whenever there is a significant change in the claim, or every 3 months at minimum. The injured worker's recovery will be monitored to ensure that a return to work is affected at the earliest possible time, consistent with that worker's level of functioning.

Independent Medical Examinations

Independent Medical Examiners are registered medical practitioners who provide impartial medical assessments. Insurers can arrange an Independent Medical Examination when medical information is inadequate, unavailable or inconsistent to allow effective management of claims and are unable to resolve the problems directly with the workers treating practitioners. These examinations are organised and paid for by Guild Insurance.

Independent Medical Examiners do not contact the workers treating medical practitioner(s), and do not make treatment or return to work recommendations to the injured worker. Following the examination, the examiner will create a detailed report on the injury and the specific questions asked by Guild Insurance. Guild Insurance do not generally release these reports to any parties unless we deem it appropriate, or we use the report to make a liability decision or assessment of whole person impairment.

An independent medical examination is appropriate when information is required in relation to:

- diagnosis of an injury reported by the worker and determining the contribution of work incidents, duties and/or practices to that injury
- diagnosis of the worker's ongoing condition and whether it still results from the workplace injury
- recommendations and/or need for treatment
- fitness for pre-injury duties and hours, and the likelihood of, and timeframe for recovery
- fitness for other jobs and duties
- what past and/or ongoing incapacity results from the injury
- physical capabilities and any activities that must be avoided
- an assessment of whole person impairment.
- for the purpose of a Work Capacity Assessment

The independent medical examiner is to be a specialist medical practitioner with qualifications relevant to the treatment of the injury. The employer and Guild Insurance must meet any reasonable costs incurred by the worker, including wages, travel and accommodation to attend the examination

Independent medical examinations should be arranged at reasonable times and dates and with notice provided to the worker. The worker is to be advised in writing at least 10 working days before the appointment, unless a shorter time is required because of exceptional and unavoidable circumstances and agreed on.

Injured workers are required to submit themselves for Independent Medical Examinations as long as arranged in line with the WorkCover Guidelines of Independent Medical Examinations. Failure to do so may result in a suspension of their weekly benefits until the comply with the request to attend. Any decision to suspend payment of weekly compensation can only be made after the worker has had an opportunity to comply with a reasonable request and must be made on the basis of sound evidence and the worker advised in writing of the reasons for the suspension.

Injury Management Consultants

An Injury Management Consultant (IMC) is a registered medical practitioner experienced in occupational injury and workplace-based rehabilitation. They are facilitators who will assist

Injury Management

insurers, employers, workers and treating doctors find solutions to problems in complex return to work plans and injury management. The consultant assesses the claim, examines the worker (if necessary), and discuss possible solutions with all parties (particularly the nominated treating doctor). They are not involved in the treatment of an injured worker, and do not provide opinion on the current treatment plan. These reviews are organised and paid for by Guild Insurance.

In line with the SIRA Standards of Practice, Guild Insurance are only to refer to an IMC when:

- a worker has been identified at risk of delayed recovery
- a specific return to work or injury management issue has been identified, or
- referral has been requested by the worker (or their representative), employer, nominated treating doctor or other treating practitioner

and attempts have been made to resolve the issue.

Before making a referral to an IMC an insurer is to contact the worker to discuss the intended referral, explain the role of the IMC and the reasons for referral. If the insurer is considering a file review, the insurer is to ask the worker if they would like to be involved in discussions with the IMC, via a telephone call as part of a case conference with the NTD or relevant treatment provider. Alternatively, if the worker wishes to be more actively involved, the insurer is to offer a face-to-face appointment with the IMC instead of a file review. If an insurer refers to an IMC, the insurer is to advise the nominated treating doctor that the referral has been made, provide the reasons for referral, and advise that the nominated treating doctor can be paid for time taken to communicate with the consultant.

The IMC is required to assess the worker's fitness for work, to discuss return to work with the Nominated Treating Doctor, the Employer and other parties involved in the return to work process in order to facilitate agreement regarding the Return to Work Plan for the injured worker. The assessment can take place via a review of the claim file, followed by a discussion with the Nominated Treating Doctor, or, the assessment can be a physical examination of the worker, also followed by discussion with the treating doctor.

When a worker is required to attend an examination with an IMC, Guild Insurance is to:

- ensure the IMC is located within the worker's travel restrictions
- ensure any special requirements of the worker are accommodated, such as those arising from gender, culture, language and accessibility
- consult the worker and take into consideration the injury type when deciding which IMC to engage
- only engage an IMC who can provide an appointment within a reasonable timeframe
- enquire whether the IMC records consultations (audio or video) and if so, inform the worker and
- seek the worker's consent for the consultation to be recorded, and
- avoid conflicts of interest between the IMC and the NTD or employer.

Guild Insurance is to provide the worker with the following information before attending any appointment with an IMC:

- the name, speciality and qualification of the IMC and the date, time, location and likely duration of the appointment
- the reasons for the referral
- what information or documentation the worker must take to the consultation (for example, imaging or reports of investigations/tests)
- how costs (including for travel) will be paid
- that the worker may be accompanied by a support person
- that the worker and the nominated treating doctor will both receive a copy of the report
- what the worker is to do if they do not believe the assessment is reasonable or if they have a complaint about the conduct of the IMC
- the SIRA brochure about injury management consultations, and
- that the worker can contact the IRO or their union for assistance.

Independent Consultations

An independent consultant is an allied health practitioner who can provide an independent peer review of allied health practitioner treatment in the NSW workers compensation system.

Guild Insurance may refer the injured worker to an Independent Consultant to provide an independent opinion and/or expert advice regarding:

- the treatment duration, frequency and/or whether treatment is reasonably necessary
- treatment that has continued for an extended period without any improvement in functional outcomes, particularly in relation to the worker's capacity
- the treatment approach most likely to achieve positive work outcomes for the worker
- barriers to recovery at work and/or psychosocial risk factors for delayed recovery and work loss

Injury Management

In many cases it will not be necessary for an injured worker to attend personally as those reviews may be completed by a review of the papers forwarded to Independent Consultant, and the consultant in turn contacting the treatment provider and a discussion of the treatment. Alternatively, an examination could be conducted.

If an examination is required, it should be arranged at reasonable times and dates and with notice provided to the worker. The worker is to be advised in writing at least 10 working days before the appointment, unless a shorter time is required because of exceptional and unavoidable circumstances and agreed on.

External Rehabilitation Providers

Where required, Guild Insurance may refer the worker to an External Rehabilitation Provider to assist in return to work.

Rehabilitation providers help address risk factors which may impact the worker's ability to recover at/return to work. These factors may include difficulty identifying suitable work, assistance with equipment and workplace modification needs, complex injury or communication breakdown.

The provider will appoint a rehabilitation consultant who will work with the employer, worker, doctor and insurer to achieve a positive recovery at work outcome. The rehabilitation consultant will be a health professional such as an occupational therapist, physiotherapist, exercise physiologist, rehabilitation counsellor or psychologist.

Guild Insurance has a preferred panel of Rehabilitation Providers that we will refer our claims to, however the injured may request to nominate their own preferred provider prior to any referral. Guild Insurance is responsible for engaging the provider and paying for their services. Service costs are recorded as a claims cost.

Rehabilitation Provider Services

- **Recovering with the same employer**
  Depending on the needs of the worker and employer, a workplace rehabilitation provider can be engaged to provide a single service (such as a workplace assessment) or provide ongoing support until the worker has achieved a safe and durable recovery at work.

  Workplace rehabilitation services are usually delivered at the workplace in consultation with all parties. These may involve:

  - Assessing a worker's capacity to perform duties safely
  - Identifying duties that will support improvements in a worker's capacity
  - Identifying options to help reduce work demands (including providing advice on equipment, job or workplace modifications)
  - Identifying and addressing risks that may impact a worker's recovery at/return to work outcome
  - Implementing and monitoring a plan to achieve an agreed recovery at work goal.

- **Return to work with a new employer**
  Most workers can recover and remain with their preinjury employer. However, where this is not possible, workplace rehabilitation providers can help a worker obtain work with a new employer. This may involve:

  - Assessing the worker's skills, education and experience
  - Identifying suitable work options, providing job seeking assistance and organising training (where appropriate)
  - Accessing appropriate programs and services that support the worker to secure employment

Please see section 11 of this guide for further info on Injury Management and Return to Work

Ongoing Case Management

When Provisional Liability limits are close to expiring

When an initial notification is submitted, the injured worker does not have to make a formal claim for weekly benefits up to the provisional limit of 12 weeks. However, if an injured worker is coming close to the expiry of their 12 weeks of weekly compensation or $10,000 in medical expenses, Guild Insurance must seek all necessary information (or where applicable refer the injured worker to attend a medical examination or other assessments) to make a formal decision on liability.

When a formal liability decision needs to be made

A formal claim decision must be made:

- If Guild Insurance determines that an injured worker requires payments of compensation that exceed the provisional liability limits (12 weeks of weekly payments or compensation for medical expenses in excess of $10,000)
- Guild Insurance has stopped making provisional liability payments, and the worker believes they are entitled to additional compensation benefits
- Within 6 months of a worker's injury (this time limit may be extended in certain circumstances)

Section 261 of the *Workplace Injury Management and Workers Compensation Act 1998*

Guild Insurance must advise the worker and employer of the decision to accept or deny liability of the claim.

After lodgement of a claim, evidence should be obtained to verify that the worker has suffered a work-related injury and to determine the likely period of incapacity (if this has not been fully completed at time of initial notification) or if further evidence is required beyond the initial advice.

This evidence/confirmation may be obtained from the treating doctor or hospital, (where it has been indicated that a worker was/or is hospitalised). Information may also be obtained from the employer, employer's representative, injured worker, or injured worker's representative.

Seek from all sources, information regarding dates of consultation, injury diagnoses, expected period of incapacity and any other relevant information.

A SIRA Certificate of Capacity that confirms injury, its work-related nature, anticipated time off work and treatment required to return the worker to work is optimum and is also a normal expectation.

Steps involved in making a soundly based decision

1. Find all the relevant facts, for example, what is the nature of the injury, is the injury work related, are SIRA Certificates of Capacity available, etc.
2. Gather information to support the facts, for example, medical reports, employer statements, worker statements, and doctor's advice
3. Identify relevant legislative provisions. Decisions must be based on the applicable provisions of the Act and Regulations, although other documents may be used as reference points, for example, guidelines provided from time to time, from regulators

The objective remains to ensure that all available information, including any new or additional information, is considered and a proper and fair decision is made and is satisfactorily communicated.

Ongoing contacts

Case Managers are to maintain contact with the injured worker, employer and treating doctor (when required) throughout the life of the claim. At minimum, contact is made with all parties at least once a month.

The contacts should be substantial and for the purposes of getting updates on the progression of the claim and determining ongoing Injury Management and Return to Work actions to advance the outcome of the claim. Environments should be created, where possible, to:

- Nurture the employer-worker relationship, particularly where a breakdown in the relationship has triggered the claim
- Obtain all the relevant information to better inform the worker and employer of the basis on which decisions are made to ensure they have a full understanding
- Improve stakeholder communication so that all parties can focus on the safe, timely and durable return to work for the worker without extraneous influences becoming predominant
- That the worker and the employer feel confident that their views have been duly considered

Claim Reassignment

The current Case Manager will contact all stakeholders and review the current strategy and reserve on the claim. Within 7 days, letters confirming claim reassignment will be sent to all stakeholders advising of the claim reassignment.

Workers Compensation Certificates

All claims should be accompanied by a SIRA Certificate of Capacity related to the compensable injury being claimed. If the stated injury on a certificate does not correspond with the compensable injury described on the notification or claim forms, immediate clarification should be sought from the worker's treating practitioner. This contact should be attempted to be completed by telephone so as not to unnecessarily delay the claim.

Ongoing Case Management

Where the worker has a capacity for employment, claims staff should also liaise with the employer to arrange suitable employment. This should be part of the employer's return to work plan even at this early stage. The sooner return to work actions commence, the more effective it is likely to be, and it will establish an expectation for all parties to the claim.

Injured workers must provide obtain SIRA Certificates of Capacity for the duration of their claim for any total or partial incapacity from work. The worker must provide to Guild Insurance with:

a. Medical Certificates of Capacity (in an approved form) in respect of the period in respect of which the worker is entitled to weekly payments; and

b. A declaration as to whether or not the worker is engaged in any form of employment or in self employment or voluntary work for which he or she receives or is entitled to receive payment in money or otherwise or has been so engaged at any time since last providing a certificate.

Certificates which the worker provides to their legal representative will not satisfy the requirement until received. The insurer should where possible remind the worker and employer when a Certificate of Capacity is about to expire.

Weekly payments will generally not be paid for any period not covered by a valid Certificate of Capacity after they have been requested. To be valid, certificates must:

a. Be a certificate in the approved form, given by a medical practitioner (normally the treating doctor)

b. Certify the worker's capacity for work during the period, stated in the certificate, not exceeding 28 days (unless the treating doctor has provided a clinical reasoning behind writing a certificate of greater duration which is to be detailed in the comments section of the certificate)

c. Specify the expected duration of the worker's incapacity

d. If the treating doctor certifies the injured worker at a restricted capacity, the certificate must outline the details of this capacity including how many hours the injured worker can work for and if there are any specific restrictions on activities the worker can do.

A certificate that is not completed satisfactorily should be referred to the certifying practitioner with a request for the relevant information to be provided. The worker should be notified concerning this action. However, to foster the required involvement of treating practitioners in the injury management, return to work and rehabilitation process, we should, in the first instance, discuss any anomalies or omissions directly with the certifying practitioner. An adversarial approach with the treating practitioner may hinder return to work objectives.

Where there is a change in a signatory on certificates, especially after a long period of incapacity, the Case Manager should satisfy themselves as to the reasons. The Injury Management Plan, which would normally be developed for an injured worker, specifies the process for change of treating doctor.

Purpose of the content of Certificates of Capacity

a. Diagnosis

This information specifies the practitioner's opinion as to the diagnosis of the worker's injury/condition. It is also intended to clarify whether other medical conditions exist which may impact appropriate treatment, return to work and whether the worker's medical status has returned to that prior to injury. It is important to confirm that there is a clear clinical diagnosis using acceptable medical terminology and that if the treating doctor is unsure that they state that it is a provisional diagnosis pending further investigation.

All certificates must specify the nature of injury or disease and a bodily location. In some cases, the bodily location can reasonably be determined from the nature of the injury or disease (for example anxiety disorder, fractured tibia, etc.) in which case the bodily location does not need to be specified. Diagnosis such as sore arm, back pain, etc. are symptoms of injuries. They do not specify a nature of injury or disease and are not acceptable. Other non-specific diagnosis such as "medical condition" is not acceptable.

Where a certificate does not state the nature of injury or bodily location and this cannot otherwise be reasonably determined, the certificate should be returned to the worker if verification of the exact nature of the injury or disease and bodily location cannot be ascertained by a phone call to the treating doctor.

Particular attention should be paid to changes in diagnosis during the life of a claim. A change in diagnosis is more likely in the early stages of a claim as the nature of the injury becomes apparent. Where there is a change in the diagnosis, insurers should consider whether the new diagnosis is related to the compensable injury.

If a Certificate of Capacity only refers to an injury or disease which has not been previously identified, Guild Insurance are required to make a formal decision on liability of the previously unidentified injury within 21 days. If Guild Insurance dispute the additional injury, then we follow the dispute process and issue a section 78 notice if benefits are not applicable.

While the doctor's certification may be acceptable in the first instance, the introduction of such diagnosis would normally warrant a medical examination to verify the relationship to the original injury. Where the worker introduces an injury, which cannot be considered to be medically proximal to the injuries claimed the worker must submit fresh claim forms which should be accepted or rejected in the normal manner.

Ongoing Case Management

b. Management Plan (treatment/medication)

The information provided in this section should alert insurers as to whether any surgical procedure is contemplated. Also, emphasis is placed on early and appropriate referral to allied health and rehabilitation services. This information should allow Guild Insurance to reconcile ongoing treatment with the medical practitioner's referral, including type and frequency of service, and name of provider. The onus for monitoring ongoing treatment, directly and by referral therefore rests with the referring medical practitioner.

c. Capacity for Employment

Focuses on issues associated with the worker's capacities, and the ability to return to work. When the treating doctor certifies that the injured worker has capacity for some type of employment, they must complete the hours and days and the 'capacity' section. If certifying that the injured worker has no current capacity for employment, the treating doctor must estimate when they expect the injured worker will have work capacity.

d. Referral to Other Health Provider

A certifying practitioner may consider that a worker should receive treatment or diagnostic services from another practitioner. If this is so, the practitioner should indicate details of a referral to another health or rehabilitation provider on the Certificate of Capacity.

The insurer must ensure that there is evidence of a referral from the practitioner to the other provider for that service, prior to payment of a referred service (either a copy of the referral or referenced on the certificate). The insurer is within their rights to determine that there is no liability for payment of a service provided on the referral of a certifying practitioner unless:

- Details of the requested service are specified in the relevant certificate; and/or
- There is evidence of the referral from the referring practitioner to the required provider

The insurer should also ensure that referred services are provided:

- By the provider nominated by the referring practitioner; and
- In accordance with any specifications, e.g. frequency and duration, made by the referring practitioner. Documentation of any contact with service providers in relation to treatment provided is required

e. Who can issue Certificates

The Certificate of Capacity should only be completed by the worker's Nominated Treating Doctor. In some circumstances the insurer will accept Certificates of Capacity issued by a treating specialist to whom the worker has been referred by the Nominated Treating Doctor.

Work Status Code

Upon receipt of each new Certificate of Capacity, the case manager must review the 'Work Status' code on the Guild Insurance claim system to ensure that it reflects the current status. Where the worker's status has changed, the Case Manager must update the code accordingly. The 'Work Status Date' must also be updated when there is a change in status to reflect the date from when the worker's status changed.

Medical Payments

Injured workers are entitled to claim for medical treatment and related costs for the injury at the time of the notification. Guild Insurance are to pay these costs; unless we dispute that the cost in compensable.

In line with the SIRA Standards of Practice, before making a decision about approval for services, insurers are to determine:

- whether the service provider is appropriately qualified to provide the service
- whether the proposed fees are appropriate and/or consistent with workers compensation fees orders, and whether the services requested align to appropriate billing/ payment codes.

If the worker has paid for reasonably necessary medical treatment, Guild Insurance is to reimburse the worker within 7 days after the worker requests payment and has supplied a proof of purchase.

If the worker has paid for traveling expenses to receive medical treatment or to attend a medical appointment, Guild Insurance is to reimburse the worker within 7 days after the worker requests payment and provides a proof pf purchase of the travel costs, or a travel reimbursement log.

Reimbursement of medical treatment costs must be in accordance with section 60 of the *Workers Compensation Act 1987*, meaning they must be valid forms of treatment recommended by their nominated treating doctor and is considered reasonably necessary for treatment of the injury. In the case that Guild Insurance determine the medical costs is not compensable, we must formally dispute the requested treatment within 21 days of receiving it.

Pre-approved treatment

Injured workers are entitled to some treatments that are pre-approved by SIRA, meaning they do not require approval from Guild Insurance to receive reimbursement.

Pre-approved treatment includes:

- Any initial treatment within 48 hours of the injury happening
- Immediate hospital assistance
- All appointments with their nominated treating doctor

Ongoing Case Management

- Any x-ray scans within 2 weeks of the injury (if referred by their nominated treating doctor)
- Appointments with a specialist doctor within 3 months from the injury (if referred by their nominated treating doctor)
- Prescription and over-the-counter pharmacy items that are specifically prescribed to the worker for treatment of your workers compensation injury by their nominated treating doctor or specialist
- 8 sessions (including the initial consultation) of physiotherapy, osteopathy or chiropractic treatment with a SIRA-approved provider if the treatment starts within 3 months of the date of injury
- 8 sessions (including the initial consultation) with a SIRA-approved psychologist or counsellor (if referred by their nominated treating doctor) if the treatment starts within 3 months of the date of injury

Guild Insurance still requires the details of the treatment provider/s and appointments to be communicated by the worker.

All other treatment

Before commencing any other treatment, approval by Guild Insurance must be provided prior to commencement in order to reimburse under workers compensation. For treatment that requires our approval, the worker must advise the Case Manager by providing sufficient information (for example, a referral from a treating doctor). Once received, Guild Insurance must decide on approval of the treatment within 21 days.

Dispute of medical treatment

If Guild Insurance disputes any treatment claimed by the injured worker is not compensable, we must determine this within 21 days of receiving it and issue a dispute notice outlining why the treatment is not approved.

Case Conferencing

Case conferences engages the worker, the nominated treating doctor and other parties such as the insurer, the employer and workplace rehabilitation providers to injury management coordination to deliver the best possible return to work and treatment outcomes for the worker. The case conference should involve discussions around guiding and facilitating stakeholder accountability, establishing rapport between and stakeholders and influence claim outcomes via stakeholder collaboration. A case conference provides an open and transparent manor to discuss both treatment and return to work. An agenda will be provided to all stakeholders prior to the case conference and the agenda will outline the reasons for the case conference and who will be in attendance. A case conference can be facilitated both in person or over the phone. All case conferences are conducted confidentially.

Recurrence Aggravation

All available evidence will be considered to determine whether an injury is the recurrence of a previous injury or a new injury, and all reasonable support will be provided to the worker in either case.

A ‘Recurrence’ – is defined as ‘spontaneous’ in nature. For example: An injured worker wakes up in the morning in pain is there that was not the night before, or, a worker is standing still doing nothing when the pain reoccurs.

An ‘Aggravation’ – is defined as ‘Specific’ in nature. For example: An injured worker lifts something and the pain occurs while lifting or immediately after or the worker bends over, and the pain returns in the action of bending over or immediately thereafter.

Consequential or Additional medical conditions

Prompt action will be taken to assess and address any additional or consequential medical condition identified on a Certificate of Capacity.

When Guild Insurance receives a Certificate of Capacity with additional or consequential medical condition following the initial Certificate of Capacity, we will endeavour to contact the nominated treating doctor to establish causation. Once the additional or consequential medical Certificate of Capacity is received, Guild Insurance then have 21 days to make a determination on liability for the medical condition.

Factual and Surveillance Investigations

A factual investigation is where Guild Insurance will appoint an independent factual investigation company to investigate the events occurring on and around an injury. These investigations can include assessment of an injury location, obtaining statements from involved parties, and obtaining relevant documentation. Factual investigations are to only be used when necessary and when the required information cannot be obtained by other less intrusive means. They are to be undertaken in a fair and ethical manner and only and the purpose for undertaking factual investigations is clearly documented. Where an injured worker is requested to participate in a factual investigation, Guild Insurance will advise them in writing at least five working days prior to the proposed factual interview.

Surveillance investigations are where Guild Insurance will appoint an independent factual investigation company to obtain visual evidence of an injured workers actions. Decisions to engage surveillance services are based on firm evidence.

Ongoing Case Management

Surveillance of a worker is only conducted when:

- there is evidence that the worker is exaggerating an aspect of the claim or providing misleading information in relation to a claim; the insurer reasonably believes that the claim is inconsistent with information in the insurer's possession; or the insurer reasonably believes that fraud is being committed,
- the insurer is satisfied that it cannot gather the information required through less intrusive means and that the benefit of obtaining the information outweighs the intrusion into the worker's privacy and;
- the surveillance is likely to gather the information required

Any information obtained through surveillance is used and stored appropriately

Return/Recovery at Work

Return to Work Program

All NSW employers must have a return to work program in place within 12 months of starting a business, and it must be consistent with their insurer's injury management program. It is an employer's obligation to establish a Return to Work Program incorporating policies and procedures for the rehabilitation of injured workers. It nominates the employer's return to work coordinator (if required), lists the rehabilitation providers who will work with that employer and describes how suitable duties will be made available for workers who are certified fit for such duties.

SIRA has developed the Guidelines for Workplace Return to Work Programs in line with the Workers Compensation legislation to support employers in developing a return to work program for their workplace. As the specialised insurer, Guild Insurance is to also guide the policy holders in return to work planning and with injury management generally.

Employers are divided into two categories for the development of return to work programs, which have differences in their requirements for the program, identified as Category 1 and Category 2 employers. The obligations of these two categories is listed in the 'Definitions' section of this document.

The Return to Work Coordinator or Appointed Person Responsible for Recovery at Work is responsible for the management and facilitation of the Return to Work Program.

When a return to work plan is prepared, the person responsible should consult supervisors, the injured worker, treating health practitioners, the insurer, and, if appropriate, the nominated approved rehabilitation provider(s). Within the workplace, contact should be established with all key people to ensure that their role in enabling the injured worker to remain at work or return to suitable work is understood

Return/Recovery at Work Plans

When an injured worker can, or is likely soon able, to return to work, but not yet recovered to their pre-injury capacity, a Return to Work Plan is to be developed. The plan is an outline and agreement of appropriate duties that the injury worker can complete in their workplace, that is in agreement with their outlined medical restrictions.

A return to work plan should include:

- The name of the injured worker; and,
- The estimated date that the injured worker should be fit to return to work; and, review dates and milestones
- The steps to be taken to facilitate the worker's return to work. These steps can be interim measures which do not require the worker to be ready to return to work immediately;
- An offer of suitable employment once the worker is ready to return to work.

A return to work plan should specify any occupational rehabilitation services that are reasonably necessary for the return to work and the maintenance at work of the injured worker. Other medical and rehabilitation services that are appropriate may also be considered to assist the worker to return to work.

Employers should ideally have a return to work plan for all injured workers, not only those who have been totally incapacitated for 7 or more days.

The use of Rehabilitation Providers for Return to Work Assistance

In line with the SIRA Standards of Practice, when approving services from workplace rehabilitation providers, insurers are to ensure that services are consistent with the Guide: Nationally consistent approval framework for workplace rehabilitation providers and the NSW Supplement to the Guide.

When External Rehabilitation Providers are engaged and assisting with return to work they should:

- Initiate proposal for suitable duties for a worker;
- Initiate proposals for the worker to return to work and complete a return to work plan signed off by all participating stakeholders and provide a copy of such plan including the advice that these stakeholders have signed off (or been requested to sign off) on each plan;
- Identify any psychosocial factors affecting the worker;
- Identify other factors inhibiting the workers rehabilitation, vocational or otherwise;
- Ensure the plan meets the needs of the individual worker;
- Consider all the medical evidence at hand, and any timetable recommended by the workers nominated treating doctor.
- Ensure that the Injury Management Plan and the return to work plan are consistent.

Work Capacity Assessments

Where an injured worker is entitled to receive weekly payments, workers compensation insurers may review their capacity to work. This is called a work capacity assessment. Guild Insurance can perform a work capacity assessment to determine whether a worker has:

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

Return/Recovery at Work

A Work Capacity Assessment should consider whether the worker has a present ability to return to their pre-injury employment and if the worker has a present ability to return to suitable employment based on the available information on the claim.

Guild Insurance is to consider the principles of procedural fairness, including fair notice, when making any assessment that may affect a worker's rights or interests. Injured workers are also able to provide any information that they wish to be considered in the assessment (for example, a certificate of capacity, treating specialist reports, job description, etc). Before Guild Insurance commences the assessment, we must notify the worker in writing.

Work Capacity Decisions

When Guild Insurance has completed Work Capacity Assessment, we may make a Work Capacity Decision. The outcome of this decision may affect a worker's entitlement to weekly payments. We may make a Work Capacity Decision about:

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

When Guild Insurance makes a Non-Adverse Decision, we should contact the injured worker to inform them of the decision and the right to request an internal review if they do not agree with the decision.

When Guild Insurance makes an Adverse Decision, it is to be communicated to the injured worker in writing and should be accompanied by a phone call.

Management of Non-Participation in Injury Management & Return/Recovery At Work

Non-participation in the Return to Work process can result in penalties to parties involved, which are outlined below:

- Failure of the worker to comply with the requirements of Chapter 3 of the 1998 Act after being requested to do so by the insurer may result in the worker having no entitlement to weekly payments of compensation with the power to suspend, terminate and cease weekly benefits provided to the insurer pursuant to Section 48A of the 1998 Act. Any suspensions, terminations or cessation of benefits will be advised in writing by the insurer. Any subsequent resumption of weekly benefits does not entitle the worker to payment for the period the worker had no entitlement to weekly payments.
- Failure of a nominated treating doctor to participate in the development of and in the arrangements under an Injury Management Plan may result in the nomination of another medical practitioner who will participate in the development of the Plan.
- Failure by an injured worker to contact Guild Insurance and obtain a written authority for a change of nominated treating doctor may result in those medical costs not being paid by Guild Insurance and the new doctor not being recognised by Guild Insurance as the nominated treating doctor.
- Failure by an employer to comply with a requirement under Injury Management may result in a premium surcharge.

Permanent Impairment

An injured worker, who has suffered an assessed permanent injury or impairment as a result of a work related injury, may be entitled to receive lump sum compensation for the loss. This is outlined in section 66 of the *Workers Compensation Act 1987*.

The level of permanent impairment compensable is in accordance with the workers compensation legislation and depending on when the relevant work related injury occurred.

- For an injury that was received on or after 1 January 2002, the injured is to be assessed under Whole Person Impairment (WPI) and the injured is only entitled to receive a lump sum payment if:
- For a physical injury, the injured worker is assessed as having 11% or more WPI
- For a psychological injury, the injured worker is assessed as having 15% or more WPI
- For an injury that that was received prior to 1 January 2002, the injured worker is to be assessed under the Table of Disabilities

Where a claim for lump sum compensation has been made and that claim has been resolved, a worker has no further entitlement to lump sum compensation. The exception to this is if the injured worker made a claim for permanent impairment compensation prior to 19 June 2012, as they may be entitled to make one (1) further lump sum claim.

Section 65 of the *Workers Compensation Act 1987* states that if a worker sustains more than one injury from the same incident, they should be assessed as one injury for the purposes of permanent impairment. The exception to this, as defined under Section 65A, is where one injury is a psychological/psychiatric injury and the other is a physical injury as these cannot be aggregated to gain an assessment of WPI. They are to be assessed separately and the highest assessment of the individual injuries is to be compensated on the proviso that it is above the relevant threshold.

Claims for Permanent Impairment

An injured worker must submit a claim for permanent impairment in writing and have:

- If the claim is the first notification of the injury:
  - They were a worker as defined by section 4 of the 1998 Act at the date of the injury
  - The injury meets the definition in section 4 of the 1998 Act
- What the injury is and any impairments arising from it
- When it happened
- Any previous injury, condition or abnormality which caused or might have caused part of an impairment, including any related compensation
- Any previous employment which caused, or might have caused, the injury
- If the claim relates to hearing loss, a copy of the audiogram used for the medical report.

All claims for permanent impairment submitted at any time must include:

- For an injury that occurred prior to 1 January 2002:
  - The percentage amount of loss or impairment measured of an injury described in the Table of Disabilities
  - A medical report from a medical practitioner supporting claimed
- For any injury that occurred on 1 January 2002 or later:
  - A report from a permanent impairment assessor listed on the SIRA website, as trained in the assessment of the part or body system being assessed, which includes
  - A statement that the condition has reached maximum medical improvement
  - An assessment on the part or system of the body being assessed including the percentage of permanent impairment in line with the NSW workers compensation guidelines for the evaluation of permanent impairment in effect at the time of the examination

When determining and negotiating a claim for permanent impairment, Guild Insurance is to adhere to the SIRA Standards of Practice 20 and 21 as follows:

- Objectively consider any report on the assessment of permanent impairment to determine whether the assessment is consistent with the information in the claim file and consistent with the NSW workers compensation guidelines for the evaluation of permanent impairment (Permanent Impairment Guidelines) within 10 working days from receipt of the report
- If determined that further information is required in the report or that a report is not consistent with the Permanent impairment guidelines, we are to request clarification or amendment from the assessor within 10 working days after determining that further information is required or that the report is not consistent with the Guidelines.
- Provide worker with copies of all relevant reports and other evidence before negotiating the degree of permanent impairment, to allow for informed negotiation at least five working days before negotiations commence

Permanent Impairment

- Before entering into an agreement regarding the workers degree of permanent impairment, Guild Insurance is to be satisfied that the worker has obtained, or has waived the right to obtain, independent legal advice regarding the consequences of entering into the agreement and has documented this on the claim file.
- Where the insurer and the worker agree regarding the degree of permanent impairment, insurers are to ensure that any agreement entered into satisfies the requirements of section 66A of the 1987 Act and the workers compensation guidelines and documents it on the claim file.

Work Injury Damages Claims

A claim for Work Injury Damages is a request for settlement for an injured worker's past economic loss and future lost earnings because of a work injury resulting from the employer's negligence.

When can an injured worker claim for Work Injury Damages

For an injured worker to claim for Work Injury Damages, the following is required:

- An injury that resulted from the employers' negligence or other tort
- The injury has led to a permanent impairment of at least 15%
- The worker has received or submits a claim for a lump sum compensation for permanent impairment at the time of the claim for Work Injury Damages
- The worker is to submit the claim within three (3) years of the injury date (unless the worker has the courts leave to proceed if submitted after this timeframe).

Commutations

A commutation is where it is agreed between a worker and insurer to a single lump sum payment. This payment removes the insurer's liability to pay future weekly payments and/or medical, hospital and rehabilitation expenses for the injury. A commutation agreement is required to registered with the Workers Compensation Commission (WCC).

Upon registering the lump sum agreement with the WCC, workers will no longer be entitled to compensation for the benefit(s) referred to in the agreement.

Preconditions of commutation

A commutation is only available when SIRA has certified that the following preconditions have been met:

- There is an injury that has resulted in permanent impairment of at least 15 per cent
- Compensation for permanent impairment has been paid
- It has been more than two years since the injured worker first received weekly payments for the injury
- All opportunities for injury management and return to work have been fully exhausted
- The injured worker received weekly payments throughout the previous six months
- The injured worker has an existing and continuing entitlement to ongoing weekly payments
- Weekly payments have not been terminated as a result of the injured worker not complying with return to work obligations

Catastrophic injuries

Workers who have 'catastrophic injuries' as described in Part 9 of the workers compensation guidelines can commute their weekly payments only and may continue to be entitled to medical, hospital and rehabilitation expenses.

Injured workers, their legal representative or the insurer can make the application for the certification that all preconditions have been met. The completed application must include all relevant information about your claim.

Medicare and Centrelink Clearance

Guild Insurance will make every effort to ascertain the correct attribution of a lump sum payment once a claim has settled to calculate entitlements owing or payable to both Medicare and Centrelink. Information regarding a settlement of benefits will be provided to Centrelink as soon as possible.

Recoveries

When an injury occurs to a worker and requires payment of compensation, and the cause of the injury was under circumstances which creates liability for a party other than the employer, Guild Insurance may be able to recover costs paid for the claim for the liable party.

Section 151Z of the *Workers Compensation Act 1987*

Journey Claims

Changes to NSW Workers Compensation Legislation, as prescribed in the Workers Compensation Amendments Act 2012, means that an injury occurring on the normal journey to and from work are longer compensable injuries, unless there is a real and substantial connection to employment. For example, if a substitute teacher is called by a school to urgently fill in that day and causes the injured worker to rush to work when they sustain an injury. Injuries that occur on work related journeys (such as visits with clients, deliveries, etc) are still compensable journey claims.

Section 10 of the *Workers Compensation Act 1987*

For compensable journey claims, Guild Insurance is to pursue recovery on these matters, however the Case Manager must be mindful that the Limitations Act NSW 1969 provides a cut off point for recoveries of 6 years from the date of the incident, therefore only payments made after the conclusion of the 6 year period can be recovered.

Early identification

Guild Insurance is to make every endeavour to identify a party responsible for any potential recovery as unnecessary delays may result in the events becoming unclear or, in the case of a motor vehicle accident, it becomes difficult to identify a Compulsory Third-Party insurer.

Guild Insurance should identify the party who may be at fault for all claims involving motor vehicles, labour hire arrangements or injuries suffered at any premises other than that owned and operated by the insured. For motor vehicle accidents, we should request the registration number(s) of the vehicle(s) involved, if police were called and the event number if they were given one. If the police attended the accident, the Case Manager should ensure that a police report is obtained.

If any injury occurs on the property of a third party, then this may also be a potential recovery prospect against the liability insurance for the owner/occupier. For example, this may occur where the worker is injured within a shopping centre where the insured's premises is located, on this occasion Guild Insurance can potentially recover from the liability policy taken out by the shopping centre.

Audits and Quality Assurance

Audits

As a specialised insurer in the NSW Workers Compensation system, we are required to conduct audits if initiated by SIRA. Additionally, Guild Insurance are required to conduct annual self-audits (unless a SIRA initiated audit has already been conducted that financial year).

Audits are to be conducted in line with the NSW SIRA Specialised and Self Insurers Self Audit Tool.

For our self-audits, as well as the completed Insurer Audit Tool, Guild Insurance is to provide a report to SIRA outlining the details of the results of the audit and development and implementation an improvement plan based on the results of the audit. SIRA may request a copy of the improvement plan which Guild Insurance is to supply.

Dispute Resolution

Guild Insurance operate in line the NSW Workers Compensation legislation and the SIRA Guidelines. Any concern of dissatisfaction about a process or service should be reported to Guild Insurance to help us resolve the issue. All complaints are handled in line with the Guild Group Complaints Handling Policy

How to lodge a concern or complaint

The claim case manager of the injured worker's claim is the first point of contact for all enquires, concerns or complaints. Should, however a dispute not be resolved in this manner then contact may be made with the Injury Management Specialist, to facilitate resolution of issues arising in regard to an Injured Worker's fitness for work and suitability of duties offered.

Our Contact Information:

Phone: 1800 810 213
Email: wcclaims@guildinsurance.com.au
Fax: 02 7200 2891
Post: GPO Box 5357, Sydney NSW 2001

Should you feel the situation remains be unresolved, referral to NSW Dispute Resolution process can be initiated

Employer concerns or complaints:

State Insurance Regulatory Authority (SIRA): SIRA has a complaints solution service for employers who are unhappy with decision we make. An online enquire form is available at their website or alternate contact details are listed below:

Phone: 13 10 50
Email: contact@sira.nsw.gov.au
Web: www.sira.nsw.gov.au

Injured worker concerns or complaints:

Independent Review Office (IRO): IRO provides an independent complaints solution service for workers who are unhappy with a decision we make. The IRO has also established the Independent Legal Assistance and Review Service (ILARS). ILARS can facilitate access to free independent legal advice to in circumstances where there is a disagreement regarding entitlements. IRO contact details are:

Phone: 13 94 76
Web: www.iro.nsw.gov.au

Workers Compensation Commission (WCC):

The WCC is an escalation option for workers compensation disputes involving liability, medical and work injury management. The WCC contact details are:

Phone: 1300 368 040
Web: www.wcc.nsw.gov.au
Address: Level 20, 1 Oxford Street, Sydney

Privacy and Confidentiality

Guild Insurance comply with Section 243 of the 1998 Act, the Commonwealth privacy law, the National Privacy Principles and the NSW Health Records and Information Privacy Act 2002 apply to the information collected and used for the purposes of handling the worker's claim.

In line with the SIRA Standards of Practice, Guild Insurance are to advise workers of their right to access their personal and health information.

Informed consent is where a worker is properly and clearly informed about how their personal information will be handled before consenting to the release and exchange of information. It ensures the worker understands the benefits of providing consent and implications of not doing so.

On lodgement of a new claim, Guild Insurance sends an information letter and request for a signed consent form from an injured worker for consent to access and appropriately share personal and medical information where required.

- For claims where the SIRA Worker's injury claim form has not been completed, it is likely worker consent would only be provided through the SIRA certificate of capacity. Consent provided on the claim form explains to the worker that it is current for the duration of the claim and not just for the period of the certificate of capacity (or medical certificate).
- Insurers are to ensure third-party providers are aware that any report provided in relation to a worker may be released to the worker
- Insurers are to promptly respond to any request by the worker or their representative for information contained in our claim file

Any personal or medical information obtained for the purpose of a Workers Compensation claim is for the purpose of assessing and managing their claim. Disclosure of this information is used only for these purposes including determining liability, providing necessary services, or we are required to do so by law.

Information and Records Management

Guild Insurance sets for secure, accurate and timely information and records management on its workers compensation claim files.

Types of records and information used by Guild Insurance include:

- Claims information documents (notifications, Claim Forms, etc.)
- Medical information (medical certificates, reports, etc)
- Reports from third parties (rehabilitation providers, medical examiners, etc)
- Legal correspondence from injured worker's and our solicitors, as well as the Workers Compensation Commission
- Correspondence from injured workers, employers and third parties
- File notes

This information comes through to Guild via:

- Email
- Fax
- Post

This includes a large variety of information, some of it personal and medical information.

Guild Insurance utilises the Guidewire ClaimCenter case management system (currently version 10). Guild Insurance is a paperless environment, and all claim information is stored electronically onto this case management system. All documents received are entered directly onto ClaimCenter (emails, faxes and postal documents are directly scanned onto ClaimCenter by our administration team). Access to this system is restricted to the appropriate Guild Insurance staff members. Destruction of documents entered is possible if required but restricted to management staff.

Fraud

Fraud involves using deception to obtain, or attempting to obtain, financial advantage in connection with the workers compensation scheme. This is a serious offence and it can carry significant penalties.

Should there be an indication of fraud related to Employers, Workers, Health professionals or others Guild will investigate by:

- Gathering additional facts and background information
- Conducting an investigation where there is evidence that an offence may have been committed

Section 235A of the *Workplace Injury Management and Workers Compensation Act 1998* outlines the conditions and penalties of parties who perpetrate fraud on the workers compensation scheme.

Injury management program communication

Guild Insurance provide a link on the new business renewal notice to all documentation including the Injury Management Program.

Injury prevention strategies

Claims data analysis is completed at the Injury Management Advisory Board every quarter and strategies to reduce claims frequency and severity stem from it. Some of these include;

- Publications in association magazines
- Videos regarding how to do high risk activities safely

Appendices

1. NSW Workers Compensation Legislation – Pertinent Sections
2. Guild Insurance NSW Workers Compensation Injury Management Plan

Appendix 1:

NSW Workers Compensation Legislation – Pertinent sections

Workers Compensation Act 1987

Section 4 – Definition of Injury

In this Act injury:

a. means personal injury arising out of or in the course of employment,

b. (b) includes a disease injury, which means:

   i. a disease that is contracted by a worker in the course of employment but only if the employment was the main contributing factor to contracting the disease, and

   ii. the aggravation, acceleration, exacerbation or deterioration in the course of employment of any disease, but only if the employment was the main contributing factor to the aggravation, acceleration, exacerbation or deterioration of the disease, and

c. does not include (except in the case of a worker employed in or about a mine) a dust disease, as defined by the Workers' Compensation (Dust Diseases) Act 1942, or the aggravation, acceleration, exacerbation or deterioration of a dust disease, as so defined.

Section 59 – Definitions

In this Division:

> ambulance service includes any conveyance of an injured worker to or from a medical practitioner or hospital.

> hospital treatment means treatment (including treatment by way of rehabilitation) at any hospital or at any rehabilitation centre conducted by a hospital and includes:

   a. the maintenance of the worker as a patient at the hospital or rehabilitation centre,

   b. the provision or supply by the hospital, at the hospital or rehabilitation centre, of nursing attendance, medicines, medical or surgical supplies, or other curative apparatus, and

   c. any other ancillary service,
   but does not include ambulance service.

> medical or related treatment includes:

   a. treatment by a medical practitioner, a registered dentist, a dental prosthetist, a registered physiotherapist, a chiropractor, an osteopath, a masseur, a remedial medical gymnast or a speech therapist,

   b. therapeutic treatment given by direction of a medical practitioner,

   c. (Repealed)

   d. the provision of crutches, artificial members, eyes or teeth and other artificial aids or spectacles,

   e. (e) any nursing, medicines, medical or surgical supplies or curative apparatus, supplied or provided for the worker otherwise than as hospital treatment,

   f. care (other than nursing care) of a worker in the worker's home directed by a medical practitioner having regard to the nature of the worker's incapacity, (f1) domestic assistance services,

   g. the modification of a worker's home or vehicle directed by a medical practitioner having regard to the nature of the worker's incapacity, and

   h. treatment or other thing prescribed by the regulations as medical or related treatment, but does not include ambulance service, hospital treatment or workplace rehabilitation service.

> public hospital means:

a. a public hospital within the meaning of the Health Services Act 1997 controlled by a local health district or the Crown,

b. a statutory health corporation or affiliated health organisation within the meaning of the Health Services Act 1997,

c. (Repealed)

d. a hospital or other institution (whether in this State or in another State or a Territory of the Commonwealth) that:

   a. is prescribed by the regulations, or

   b. belongs to a class of hospitals or institutions prescribed by the regulations, for the purposes of this definition.

> workplace rehabilitation service means any service provided as a workplace rehabilitation service by or on behalf of a provider of rehabilitation services approved under section 52 of the 1998 Act.

Section 60 – Compensation for cost of medical or hospital treatment and rehabilitation etc

1. If, as a result of an injury received by a worker, it is reasonably necessary that:

   a. any medical or related treatment (other than domestic assistance) be given, or

Appendices

b. any hospital treatment be given, or

c. any ambulance service be provided, or

d. any workplace rehabilitation service be provided, the worker's employer is liable to pay, in addition to any other compensation under this Act, the cost of that treatment or service and the related travel expenses specified in subsection (2).

2. If it is necessary for a worker to travel in order to receive any such treatment or service (except any treatment or service excluded from this subsection by the regulations), the related travel expenses the employer is liable to pay are:

a. the cost to the worker of any fares, travelling expenses and maintenance necessarily and reasonably incurred by the worker in obtaining the treatment or being provided with the service, and

b. if the worker is not reasonably able to travel unescorted—the amount of the fares, travelling expenses and maintenance necessarily and reasonably incurred by an escort provided to enable the worker to be given the treatment or provided with the service.

2A. The worker's employer is not liable under this section to pay the cost of any treatment or service (or related travel expenses) if:

a. the treatment or service is given or provided without the prior approval of the insurer (not including treatment provided within 48 hours of the injury happening and not including treatment or service that is exempt under the Workers Compensation Guidelines from the requirement for prior insurer approval), or

b. the treatment or service is given or provided by a person who is not appropriately qualified to give or provide the treatment or service, or

c. the treatment or service is not given or provided in accordance with any conditions imposed by the Workers Compensation Guidelines on the giving or providing of the treatment or service, or

d. the treatment is given or provided by a health practitioner whose registration as a health practitioner under any relevant law is limited or subject to any condition imposed as a result of a disciplinary process, or who is suspended or disqualified from practice.

2B. The worker's employer is not liable under this section to pay travel expenses related to any treatment or service if the treatment or service is given or provided at a location that necessitates more travel than is reasonably necessary to obtain the treatment or service.

2C. The Workers Compensation Guidelines may make provision for or with respect to the following:

a. establishing rules to be applied in determining whether it is reasonably necessary for a treatment or service to be given or provided,

b. limiting the kinds of treatment and service (and related travel expenses) that an employer is liable to pay the cost of under this section,

c. limiting the amount for which an employer is liable to pay under this section for any particular treatment or service,

d. establishing standard treatment plans for the treatment of particular injuries or classes of injury,

e. specifying the qualifications or experience that a person requires to be appropriately qualified for the purposes of this section to give or provide a treatment or service to an injured worker (including by providing that a person is not appropriately qualified unless approved or accredited by the Authority).

3. Payments under this section are to be made as the costs are incurred, but only if properly verified.

4. The fact that a worker is a contributor to a medical, hospital or other benefit fund, and is therefore entitled to any treatment or service either at some special rate or free or entitled to a refund, does not affect the liability of an employer under this section.

5. The jurisdiction of the Commission with respect to a dispute about compensation payable under this section extends to a dispute concerning any proposed treatment or service and the compensation that will be payable under this section in respect of any such proposed treatment or service. Any such dispute may be referred by the Registrar for assessment under Part 7 (Medical assessment) of Chapter 7 of the 1998 Act

Workplace Injury Management and Workers Compensation Act 1998

Section 43 – Injury management programs

1. An insurer must establish and maintain an injury management program and must revise its injury management program from time to time or when the Authority directs. An insurer must lodge a copy of its injury management program, and any revised injury management program, with the Authority.

1A. Without limiting subsection (1), an insurer that is a scheme agent must revise its injury management program when directed to do so by the Nominal Insurer and lodge a copy of the revised program with the Nominal Insurer.

2. An insurer must give effect to its injury management program and for that purpose must comply with the obligations imposed on the insurer by or under the program.

Appendices

3. An insurer must take appropriate steps to ensure that each employer who is insured by the insurer is made aware of the employer's obligations under this Chapter and made and kept aware of the requirements of the insurer's injury management program. This subsection does not apply to a self-insurer.
4. Within 3 working days after being notified of a significant injury to a worker, the insurer must initiate action under the insurer's injury management program and must (in accordance with that program) make contact with the worker, the employer (except when the insurer is a self-insurer) and (if appropriate and reasonably practicable) the worker's treating doctor. A working day is any day except a Saturday, Sunday or public holiday.
5. An employer must comply with the obligations imposed on the employer by or under the insurer's injury management program. This subsection does not apply when the employer is a self-insurer.

Section 44 – Management Early notification of workplace injury

1. An injured worker must notify the employer that the worker has received a workplace injury as soon as possible after the injury happens.
2. The employer of an injured worker must notify the insurer or the Nominal Insurer within 48 hours after becoming aware that a worker has received a workplace injury in the manner prescribed by the regulations.
3. If an employer has given notice to the insurer in accordance with subsection (2) of a workplace injury to a worker, the insurer must forward that notice to the Nominal Insurer in accordance with the regulations.

3A. If an employer has given notice to the Nominal Insurer in accordance with subsection (2) of a workplace injury to a worker:

   a. the Nominal Insurer must as soon as practicable forward that notice to the insurer, and

   b. the notice given to the Nominal Insurer is taken to be notice given to the insurer for the purposes of the employer's policy of insurance.

3B. If an employer or an insurer has given notice to the Nominal Insurer in accordance with subsection (2) or (3) of a workplace injury to a worker, the Nominal Insurer must as soon as practicable forward that notice to the Authority in accordance with the regulations.

4. Subsection (2) do not apply when the insurer is a self-insurer.

Section 45 – Injury management plan for worker with significant injury

1. When it appears that a workplace injury is a significant injury, an insurer who is or may be liable to pay compensation to the injured worker must establish an injury management plan for the injured worker.
2. The injury management plan must be established in consultation with the employer (except when the insurer is a self-insurer), the treating doctor and the worker concerned, to the maximum extent that their co-operation and participation allow.
3. The insurer must provide both the employer and the injured worker with information with respect to the injury management plan.
4. The information that the insurer must provide to the injured worker includes a statement to the effect that the worker may have no entitlement to weekly payments of compensation if the worker fails unreasonably to comply with the requirements of this Chapter after being requested to do so by the insurer.
5. The insurer must keep the employer of a worker who has received a significant injury informed of significant steps taken or proposed to be taken under the injury management plan for the worker. This subsection does not apply when the insurer is a self-insurer.
6. An insurer must as far as possible ensure that vocational retraining provided or arranged for an injured worker under an injury management plan is such as may reasonably be thought likely to lead to a real prospect of employment or an appropriate increase in earnings for the injured worker.
7. An insurer must give effect to an injury management plan established for an injured worker and for that purpose must comply with the obligations imposed on the insurer by or under the plan.

Section 46 – Employer's injury management plan obligations

1. The employer must participate and co-operate in the establishment of an injury management plan required to be established for an injured worker.
2. The employer must comply with obligations imposed on the employer by or under an injury management plan for an injured worker.
3. This section does not apply when the employer is a self-insurer.

Appendices

Section 47 – Worker's injury management plan obligations

1. An injured worker must participate and co-operate in the establishment of an injury management plan required to be established for the worker.
2. The worker must comply with obligations imposed on the worker by or under an injury management plan for the worker.
3. The worker must, when requested to do so by the insurer, nominate as the worker's treating doctor for the purposes of an injury management plan for the worker a medical practitioner who is prepared to participate in the development of, and in the arrangements under, the plan.
4. A medical practice can be nominated as treating doctor for the purposes of subsection (3). Such a nomination operates as a nomination of the members of the practice who treat the worker from time to time and a reference in this Chapter to the nominated treating doctor is a reference to those members of the practice.
5. The worker must authorise the worker's nominated treating doctor to provide relevant information to the insurer or the employer for the purposes of an injury management plan for the worker.
6. An injury management plan must provide for the procedure for changing the worker's nominated treating doctor.

Section 48 – Return to work obligations of worker

1. A worker who has current work capacity must, in co-operation with the employer or insurer, make reasonable efforts to return to work in suitable employment or pre-injury employment at the worker's place of employment or at another place of employment.
2. For the purposes of this section, a worker is to be treated as making a reasonable effort to return to work in suitable employment or pre-injury employment during any reasonable period in which:
    a. the worker is waiting for the commencement of a workplace rehabilitation service that is required to be provided under an injury management plan for the worker, or
    b. the worker is waiting for a response to a request for suitable employment or pre-injury employment made by the worker and received by the employer, or
    c. if the employer's response is that suitable employment or pre-injury employment will be provided at some time, the worker is waiting for suitable employment or pre-injury employment to commence

Section 48A – Failure to comply with return to work obligations of worker

1. If a worker does not comply with an obligation of the worker imposed under section 48, the insurer may in accordance with this section:
    a. suspend the payment of compensation in the form of weekly payments to the worker, or
    b. terminate the payment of compensation in the form of weekly payments to the worker, or
    c. cease and determine the entitlement of the worker to compensation in the form of weekly payments in respect of the injury under this Act.
2. If the insurer seeks to suspend payments of compensation under subsection (1) (a), the insurer must give written notice to the worker stating:
    a. the reason for the giving of the notice, and
    b. that unless the worker complies with the obligation under section 48 specified in the notice, weekly payments to the worker will be suspended from the date specified in the notice which must be a date at least 14 days after notice is given but no more than 60 days after notice is given, and
    c. the consequences of failing to comply as specified in the notice.
4. If the worker fails to comply with a written notice under subsection (2), the insurer may suspend the payment of weekly payments to the worker for a period of 28 days after the date specified in the notice referred to in subsection (2) (b).
5. If the worker complies with the obligation specified in the notice under subsection (2) during the period that weekly payments are suspended under subsection (3), the insurer must, subject to and in accordance with this Act, resume the payment of weekly payments with effect from the date on which the worker complied with the obligation.
6. If subsection (4) applies, the worker forfeits any compensation in the form of weekly payments that would otherwise have been made during the period of suspension until the worker complied with the obligation and that period is included in determining the first or second entitlement period under Division 2 of Part 3 of the 1987 Act.
7. If the worker does not comply with the obligation specified in the notice under subsection (2) for the entire period that weekly payments are suspended under subsection (3), the insurer may terminate the payment of compensation in the form of weekly payments to the worker in respect of the injury by written notice stating the reasons for giving the notice.

Appendices

8. If the worker:
    a. does not comply with the obligation specified in the notice under subsection (2) for the entire period that weekly payments are suspended under subsection (3), and
    b. has within the last 12 months prior to the giving of the notice referred to in paragraph (a):
        i. been issued 2 notices under subsection (2) without a subsequent suspension of weekly payments, or
        ii. had compensation in the form of weekly payments suspended once under subsection (3),

the insurer may cease and determine the entitlement to compensation in the form of weekly payments in respect of the injury to the worker under this Act by written notice stating the reasons for giving the notice.

Section 49 – Employer must provide suitable work

1. If a worker who has been totally or partially incapacitated for work as a result of an injury is able to return to work (whether on a full-time or part-time basis and whether or not to his or her previous employment), the employer liable to pay compensation to the worker under this Act in respect of the injury must at the request of the worker provide suitable employment for the worker.
2. The employment that the employer must provide is employment that is both suitable employment (as defined in section 32A of the 1987 Act) and (subject to that qualification) so far as reasonably practicable the same as, or equivalent to, the employment in which the worker was at the time of the injury.
3. This section does not apply if:
    a. it is not reasonably practicable to provide employment in accordance with this section, or
    b. the worker voluntarily left the employment of that employer after the injury happened (whether before or after the commencement of the incapacity for work), or
    c. the employer terminated the worker's employment after the injury happened, other than for the reason that the worker was not fit for employment as a result of the injury.

Section 52 – Workplace rehabilitation

1. An employer must establish a return-to-work program with respect to policies and procedures for the rehabilitation (and, if necessary, vocational re-education) of any injured workers of the employer. An employer's return-to-work program must not be inconsistent with the injury management program of the employer's insurer and is of no effect to the extent of any such inconsistency.
2. A return-to-work program is to be established in accordance with the regulations and must, subject to the regulations:
    a. comply with any guidelines determined by the Authority, and
    b. be developed by the employer in consultation with the workers concerned and any industrial union of employees representing those workers, and
    c. be in writing and be displayed or notified at places of work.
3. The Authority may, in determining guidelines for the purposes of this section, consult with such persons and bodies as the Authority considers to be appropriate.
4. The regulations:
    a. may require a return-to-work program to be approved by the Authority or other person or body, and
    b. may exempt specified classes of employers from this section, and
    c. may provide for the approval of providers of rehabilitation services for the purposes of return-to-work programs and may require employers to use the services of approved providers in connection with the program, and
    d. may create offences with respect to any failure to comply with this section or with a return-to-work program, and
    e. may make other provisions that are necessary or convenient for the purposes of giving effect to this section.
5. A group of 2 or more employers may establish a single return-to-work program under this section for each member of the group if the employers are authorised to do so by the regulations.

Section 55 – Compliance by insurers

1. It is a condition of an insurer's licence that the insurer must comply with the requirements of this Chapter.
2. If the Authority is satisfied that an insurer has persistently or repeatedly failed to comply with the requirements of this Chapter without reasonable excuse, the Authority can do any of the following:
    a. cancel or suspend the insurer's licence,
    b. impose a pecuniary penalty of up to an amount that is equivalent to 100 penalty units,
    c. amend the terms or conditions of the insurer's licence (for example by the inclusion of a condition providing for increased supervision of the insurer by the Authority),

Appendices

d. issue a letter of censure to the insurer.

3. Before the Authority takes action under this section, the Authority must give the insurer concerned an opportunity to make submissions to the Authority regarding the proposed action. The Authority is to consider any submissions so made.
4. If the Authority then decides to take the proposed action or other action authorised by this section, the Authority is to give the insurer written notice of the action. Any action taken by the Authority under this section takes effect when notice of it is given to the insurer or on such later date as the notice may provide.
5. The Authority may, at any time, terminate or reduce a period of suspension of an insurer's licence.
6. A pecuniary penalty imposed on an insurer under this section may be recovered by the Authority in a court of competent jurisdiction as a debt due to the Crown.
7. The Authority is to monitor compliance by insurers with the requirements of this Chapter.

Section 56 – Compliance by employer

1. Any increased costs associated with a failure by an employer to comply with a requirement of this Chapter can be taken into account (in conformity with the requirements of this Act with respect to the determination of premiums) in the calculation of a claims experience factor for the employer for use in the determination of the premium payable for an insurance policy by the employer.
2. The regulations may make provision for or with respect to the payment by an employer who fails to comply with a requirement of this Chapter of an amount by way of a premium surcharge.
3. The amount of any such premium surcharge payable under the regulations need not be referable to any increase in costs attributable to or associated with the employer's failure to comply.
4. The amount of a premium surcharge payable under the regulations is to be added to, and becomes payable as part of, the premium payable by the employer for the issue or renewal of a policy of insurance as provided by the regulations.
5. It is a condition of any policy of insurance issued under the 1987 Act that the employer must comply with the requirements of this Chapter, but only if the insurer has taken appropriate steps to ensure that the employer is made aware of those obligations

Section 119 – Medical examination of workers at direction of employer

1. A worker who has given notice of an injury must, if so required by the employer, submit himself or herself for examination by a medical practitioner, provided and paid by the employer.
2. A worker receiving weekly payments of compensation under this Act must, if so required by the employer, from time to time submit himself or herself for examination by a medical practitioner, provided and paid by the employer.
3. If a worker refuses to submit himself or herself for any examination under this section or in any way obstructs the examination:
   a. the worker's right to recover compensation under this Act with respect to the injury, or
   b. the worker's right to the weekly payments, is suspended until the examination has taken place.
4. A worker must not be required to submit himself or herself for examination by a medical practitioner under this section otherwise than in accordance with the Workers Compensation Guidelines or at more frequent intervals than may be prescribed by the Workers Compensation Guidelines.
5. The regulations may make provision for or with respect to requiring an employer or insurer to provide a worker, a worker's legal representative or any other person, within the period required by the regulations, with a copy of any medical opinion or report furnished to the employer or insurer by a medical practitioner in connection with an examination of the worker pursuant to a requirement under this section.
6. If an employer or insurer fails to provide a copy of an opinion or report as required by the regulations under subsection (5):
   a. the employer or insurer cannot use the opinion or report to dispute liability to pay or continue to pay compensation or to reduce the amount of compensation to be paid and cannot use the opinion or report for any other purpose prescribed by the regulations for the purposes of this section, and
   b. the opinion or report is not admissible in proceedings on such a dispute before the Commission, and
   c. the opinion or report may not be disclosed to an approved medical specialist or an Appeal Panel in connection with the assessment of a medical dispute under Part 7 of Chapter 7.

Section 266 – Meaning of initial notification of injury

In this Part, initial notification to an insurer of an injury to a worker means the first notification of the injury that is given to the insurer, in the manner and form required by the Workers Compensation Guidelines, by the worker or the employer or by some other person (for example, a medical practitioner) acting for or on behalf of the worker or the employer.

Appendices

Appendix 2:

Guild Insurance NSW Workers Compensation Injury Management Plan

Injury Management Plan

Plan Details	
Plan Number	
Injured worker name	
Claim Number	
Date of Injury	
Employer	
Injury Diagnosis	

Injury Management and Return to Work Details	
Date of this plan	
Plan Review date	
Current capacity for work	
Restrictions	
Return to Work Goal	
Task recommendations/work restrictions	
Rehabilitation Provider required	
Workplace Assessment required	

Treatment Providers & Management Plan				
Type of Provider	Name of Provider	Goal/Outcome	Start date	End date

OPTION: ADD BELOW TABLE IF WORKER RECEIVING DOMESTIC ASSISTANCE

Domestic Assistance Care Plan							
Task	Provider	Hours	Frequency	Approved From	Approved to	Cost/rate	Total Cost

Appendices

Injured Worker Responsibilities
IMPORTANT: Please be advised that an injured worker may have lose their entitlement to weekly payment compensation if they fail, or unreasonably comply with, the requirements of this plan
> Participate and co-operate in the establishment of this plan and comply with its obligations, as per section 47 of the Workplace Injury and Workers Compensation Act 1998 (the 1998 Act)
> Nominate a treating doctor who will be treating them and providing Injury Management for their workers compensation injury. A nominated treating doctor must be a medical practitioner who is prepared to participate in the development of, and in the arrangements under, this plan. The injured worker may also nominate a medical practice or medical centre if required. > Authorise the nominated treating doctor to provide relevant information to Guild and/or their employer for the purposes of injury management as per section 47 of the 1998 Act.
> An injured worker may immediately change their nominated treating doctor when: > Their previous doctor retires, passes on, or moves to a different location > They refuse to participate in any meaningful injury management or the return to work program > Otherwise, if an injured worker wishes to change their nominated doctor, they are to contact Guild Insurance and advise of the new doctor's details and the reason for the change.
> Participate in their treatment plan, including any self-management exercises or activities and attending specialist appointments, as directed by the nominated treating doctor.
> Attend any appointments arranged by Guild Insurance for the purposes of injury management. Appointments may include attending Independent Medical Examinations and participating in Factual Investigations. If the worker is unable to attend any appointments arranged, sufficient notice is to be provided to Guild Insurance as soon as possible. Continual non-attendance, or non-attendance without timely notification to Guild Insurance, **may result in suspension of workers compensation benefits** as per section 119 of the 1998 Act and section 44A of the *Workers Compensation Act 1987* (the 1987 Act)
> Participate fully in the Return to Work obligations and assistance as per section 48 of the 1998 Act. This includes: > Co-operating with the employer and Guild Insurance > Participating in work duties with the employer. If an employer is able to provide suitable employment that is in accordance with any applicable restrictions advised by the treating doctor, the injured worker is to participate in this suitable employment. If appropriate suitable employment is available and offered to an injured worker, and the worker refuses to participate, **this may result in suspension of workers compensation benefits.** > To otherwise be making reasonable efforts to return to work in suitable employment with their pre-injury or an alternative employer > Meet with referred or nominated External Rehabilitation Provider for any appointments, assessments for return to work or functional capacity, return to work plans and Case Conferences as required to plan and achieve a sustainable return to work
> If an External Rehabilitation Provider is required or requested, the injured worker may use the provider as referred by Guild Insurance, or nominate your own accredited provider if preferred.
> Maintain regular contact with their employer and Guild Insurance for updates on return to work progress and injury recovery

Appendices

Injured Worker Responsibilities
> Obtain **State Insurance Regulatory Authority (SIRA) Medical Certificates of Capacity** issued by their nominated treating doctor, at appropriate review dates.
> Ensure that these certificates are provided to Guild Insurance as soon as possible. **Please be advised that this is a requirement in order for injured workers to receive weekly compensation benefits under section 44B of the 1998 Act**
> Prior to submitting the certificates to Guild Insurance, review and complete the '**Worker Consent**' and '**Worker Declaration**' sections of the certificate.
> If referred for medical treatment, and injured worker must provide Guild Insurance with the details of the treatment and the provider, as well as sufficient information to determine if it is reasonably necessary (such as a referral form from your treating doctor).
> Approval from Guild Insurance is required in order to claim for reimbursement of any medical treatment or procedures (apart from the authorised pre-approved treatments as per the SIRA 'Guidelines for Claiming Workers Compensation') as per section 60 of the 1987 Act
> **<Case Manager to add additional tailored actions>**

Employer Responsibilities
> Participate and co-operate in the establishment of this injury management plan and comply with the obligations as per section 46 of the 1998 Act
> As per section 49 of the 1998 Act, if the injured worker has a capacity to return to work, the employer must provide suitable employment to the injured worker (whether on a full-time or part time basis and whether or not it is the injured workers pre-injury role)
> Any suitable employment provided **must be in compliance with any restrictions** outlined in the injured workers SIRA Medical Certificate of Capacity issued by their nominated treating doctor
> Suitable employment should be the same as, or equivalent to, the employment in which the injured worker was performing prior to the injury, as far as is reasonably practicable to do so.
> The above does not apply if: > It is not reasonably practical for the employer to provide suitable employment as outlined > The injured worker is no longer an employee
> Ensure that any weekly compensation benefits that are paid to an injured worker is in compliance with the workers compensation legislation and as advised by Guild Insurance.
> If weekly compensation is being paid to an injured worker, ensure regular reimbursement schedules are sent to Guild Insurance to claim reimbursement at the correct rates under workers compensation and as advised by Guild Insurance
> Maintain regular contact with the injured worker and Guild Insurance for updates on the return to work progress and injury recovery
> Work in collaboration with the worker, external parties such as Rehabilitation Providers, and Guild Insurance in management of the workers compensation injury
> **<Case Manager to add additional tailored actions>**

Appendices

Insurer Responsibilities
> As per section 45 of the 1998 Act, Guild Insurance is to develop and establish this injury management plan in consultation with the employer, injured worker and nominated treating doctor
> Guild must provide this injury management plan to the employer and injured worker
> Keep the employer informed of significant steps taken or proposed to be taken under the injury management plan for the worker
> Advise the injured worker on this plan that they may have no entitlement to weekly payments of compensation if they fail unreasonably to comply with their requirements
> Review the Injury Management Plan regularly and at any significant changes of the injured workers capacity. If required, ensure updated Injury Management Plans are developed.
> Maintain regular contact with the injured worker, employer and nominated treating doctor for updates on the return to work progress and injury recovery
> Refer the claim to an External Rehabilitation Provider if deemed required, or if requested by the nominated treating doctor or injured worker.
> If the injured worker nominates a preferred External Rehabilitation Provider, ensure the claim is referred to nominated provider (unless this is not reasonably practicable)
> Review requests for reasonably necessary treatment when provided by the injured worker, and ensure to provide a response to the request in a timely manner (within 21 days of receiving)
> Review Allied Health Recovery Request (AHRR) forms submitted by SIRA accredited providers and provide a response within 5 days. It is accepted that unless otherwise advised, if the AHRR is not returned within 5 days, the treatment is considered pre-approved.
> If the injured worker incurs any expenses for reasonably necessary treatment that has been pre-approved, ensure that this cost is reimbursed as soon as possible (within 10 days)
> If it is necessary for the injured worker to travel in order to receive treatment, Guild Insurance will reimburse the costs of the travel. The injured is to submit a request for payment travel listing the 'to' and 'from' destinations and the reason for the travel. Travel reimbursement will be paid for: > The fare for any public transport on receipt of a proof of purchase > Travel by private transport (such as a car) at a rate of 55c per kilometre
> Any other travel cost that is not outlined above, requires approval from the insurer before reimbursement will be considered
> Ensure any Independent Medical Examinations are arranged in accordance with the 'Guidelines on Independent Medical Examinations and Reports'. This includes ensuring suitable notice is provided to the worker of: > When to attend the appointment (at least 10 days prior to the date, unless otherwise agreed) > The doctors' details and location > What to bring and expect from the examination
> If the worker is to participate in a Factual Investigation, ensure they are informed as soon as possible
> Provide suitable notice to the worker if there is any change to their entitlements to compensation, or changes to the decision of liability on their claim in compliance with the relevant legislation
> Reimburse weekly compensation on receipt of suitable information (such as a reimbursement schedule from the employer) in a timely manner
> **<Case Manager to add additional tailored actions>**

Appendices

Claim Contacts			
Contact	**Name**	**Phone Number**	**Email**
Injured Worker			
Nominated Treating Doctor			
Employer			
Rehabilitation Provider			
Case Manager			

Page intentionally left blank

Page intentionally left blank

1800 810 213
guildinsurance.com.au

Guild INSURANCE

Don’t go it alone