Queensland Self-Insurer Audit Process

Version 1.0

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Queensland Government

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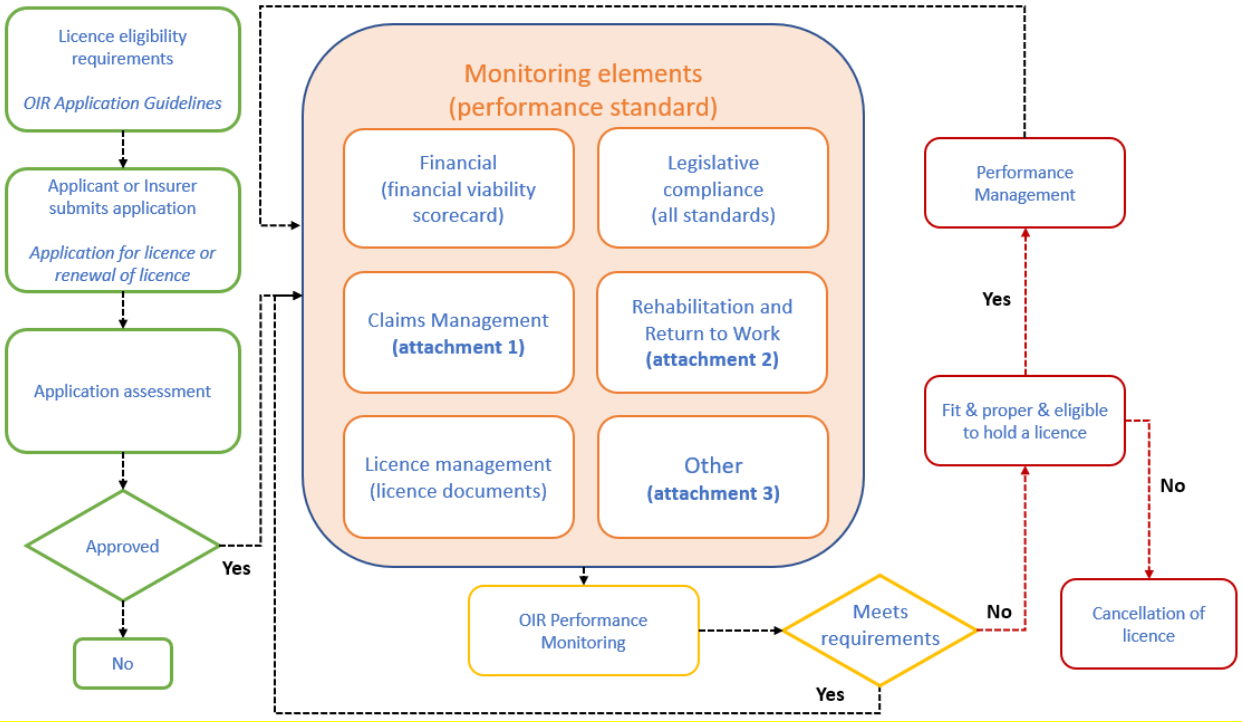
Introduction

Workers' Compensation Regulatory Services (WCRS) is responsible for regulating the scheme and monitoring self-insurer performance to assess whether they are fit and proper and complying with their licence conditions and other obligations. WCRS uses a risk-based *Self-Insurer Performance and Compliance Framework* (the Framework) to undertake this role.

The *Queensland Self-Insurer Audit Process* (the Audit Process) outlines how WCRS undertakes auditing as part of monitoring a self-insurer's performance under the Framework.



The Audit Process provides:

1. an overview of the monitoring activities used to assess the compliance and performance of self-insurers and each party's roles and responsibilities
2. how WCRS conducts audits
3. the audit criteria and *Queensland Self-Insurer Audit Tool* (the Audit Tool) used for undertaking standard compliance and performance audit assessments.

It is noted that in applying the Audit Process:

1. WCRS considers the acts of any third party engaged by a self-insurer to undertake its powers, functions and obligations as a self-insurer, as acts of the self-insurer. Third parties can include: a claims agent, legal firm, medical provider or rehabilitation provider engaged by or on behalf of the self-insurer.
2. WCRS is guided by the *Workers' Compensation and Rehabilitation Act 2003 – Compliance and Enforcement Policy*, which sets out the principles that underpin the approach WCRS will take with all duty holders to monitor and enforce compliance with legislative requirements.

1. Audit roles and responsibilities

Under the Audit Process both WCRS and self-insurers have roles and responsibilities. These are:

WCRS responsibility	Self-insurer responsibility
• Make self-insurers aware of expectations, process and criteria • Consulting with self-insurers in setting audit scope and criteria • Timely notification of audit and expectations of any change • Afford procedural fairness and provide self-insurer with preliminary audit report for review and comment	• Cooperate with WCRS and provide access to all information • Be responsive to any requests • Develop and implement performance management plans • Commitment to continuous improvement

2. Audit criteria and tool

The Audit Process establishes audit criteria and the Audit Tool to provide a standardised and transparent way of assessing a self-insurer's claims management and return to work performance in standard compliance and performance management audits.

The audit criteria and Audit Tool align with and build upon a self-insurer's obligations under the Act and the standard conditions of the self-insurance licence.

Audit criteria includes:

- Claims Management (Attachment 1);
- Rehabilitation and Return to Work (Attachment 2); and
- Other - Information and Communication (Attachment 3).

The audit criteria and the Audit Tool is not intended to provide an exhaustive overview of all aspects of a self-insurer's performance, or a self-insurer's compliance with all of a self-insurer's obligations (for example, it does not assess a self-insurer's financial viability).

The Audit Process and Audit Tool will be updated regularly to reflect changes in the regulatory environment, such as changes in the Act, or to make the audit approach more effective for assessing performance.

WCRS is committed to consulting with self-insurers and other stakeholders prior to making changes to the Audit Process and Audit Tool in a manner that is proportionate to the scale and impact of the changes.

3. Types of audit

WCRS will undertake the following types of audits, including:

Type	Description	Timing
Compliance audits	WCRS will audit the performance of self-insurers against all criteria in the Audit Process and Audit Tool at least once during a self-insurer's licence term. WCRS may recommend and validate the implementation of specific actions to address moderate or low risk findings in a compliance audit.	WCRS will conduct this audit at least six months prior to the licence end date.
Performance management audits	Where WCRS identifies significant and / or systematic deficiencies in the self-insurer's performance, it may require the self-insurer to implement an improvement action plan. In some cases, WCRS will undertake a performance management audit to verify that the self-insurer has implemented the agreed improvement actions.	This type of audit will follow a compliance audit, allowing enough time for the self-insurer to design and implement the improvement actions. For example, WCRS may conduct the audit six months after the original compliance audit.
Targeted audits	WCRS may perform targeted audits including one or more self-insurers to confirm that they are appropriately managing specific areas of, or changes in, the scheme. For example, to confirm that self-insurers updated their practices to comply with legislative changes.	WCRS will announce the subject matter and criteria for a targeted audit at least six months prior to undertaking the audit. WCRS will notify the self-insurers included in the audit more than eight weeks prior to commencing the audit.
Special audits	WCRS will perform special audits where circumstances or events give rise to risks that the Workers' Compensation Regulator needs to understand and address.	Will depend on the timing of the event or circumstances that give rise to the need for a special audit.
Self-audits	WCRS will require self-insurers with a licence duration of three years or more to perform a self-audit at the mid-point of their licence. Refer to section 5 - self-audits.	Refer to section 5 - self-audits

WCRS will provide the self-insurer with an audit scope letter for each audit. The audit scope letter will contain details of the audit process, the tool, and logistical matters such the self-insurer's responsibility to arrange for the auditor's access to the claims management system.

4. Audit planning and timeline

WCRS will provide self-insurers with adequate and reasonable planning time and information prior to undertaking compliance, performance management and targeted audits. WCRS may not provide the same level of notice or information prior to commencing special audits.

The following table outlines the timeline and steps WCRS will follow in the lead up to compliance, targeted and performance audits. Section five outlines the timeline for self-audits.

Timing	Steps
More than eight weeks prior to audit	WCRS will contact the self-insurer to confirm the upcoming audit and approximate dates for the conduct of the audit.
More than four weeks prior to the audit	WCRS and the self-insurer to agree and confirm the dates that the WCRS auditors will be on site to conduct the audit.
At least two weeks prior to the audit	WCRS will: • provide the audit scope letter; • provide the sample of claim files it will assess; • request other relevant documentation; and • request the name and contact details of a designated audit contact.

5. Audit evidence

WCRS will collect a range of types of audit evidence to assess the performance of self-insurers. The following table summarises the types of evidence WCRS will collect during an audit to use as part of the assessment:

Evidence type	Description
Documentation	WCRS may request the following relevant documentation: • the full claim file for all claims in the sample; • the claims manual, policies and procedures; • organisational information (for example charts, position descriptions and delegations); • internal audits or other internal performance reviews relating to workers' compensation and rehabilitation and return to work; • service level agreements between the self-insurer and their third-party service providers; and • other documents it considers relevant.
File review	WCRS will review the compliance and performance of self-insurers claims management and rehabilitation and return to work by selecting and assessing a sample of claims files. Refer to section 4 - Sampling.
Interviews	WCRS may collect evidence through interviews or correspondence with any of the following: • the self-insurers licence manager; • claims managers; • the employer; • claimants; • workers; and • any other relevant stakeholder (for example - unions).

6. Sampling

WCRS will aim to select a sample of claims for audit that enables an efficient and effective audit. This means selecting and assessing the fewest possible claim files (audit efficiency) to gain reasonable assurance about the self-insurer's compliance and performance (audit effectiveness).

Population of claims

For a compliance audit, WCRS will select the sample from a population of claims where the self-insurer submitted data showing activity on a claim in the 18 months preceding the audit. If the population of claims from the preceding 18 months does not provide sufficient coverage to assess the self-insurer's performance, WCRS may select earlier files.

Activity on a claim includes where:

- self-insurer intimated a statutory claim;
- self-insurer referred a claim to the Medical Assessment Tribunal;
- claimant / self-insurer lodged an application for review with WCRS;
- self-insurer made a decision to reject, cease or suspend a claim;
- self-insurer made the claim status: "No action required";
- self-insurer changed the worker's return to work status;
- self-insurer made payments on claims with more than 20 working days lost;
- self-insurer made an offer for the Degree of Permanent Impairment;
- self-insurer intimated a notice of claim for damages (common law claim);
- WCRS received a complaint about the self-insurer's claim management.

Sample size

The table below provides guidance on the minimum number of claims WCRS will test based on the size of the population of claims in the first population described above. The table is for guidance only, where WCRS identifies risks that may affect a self-insurer's performance or it requires additional coverage in specific areas of the claims management process, it will increase the number of claims in the sample.

Population of unique claims	Minimum sample size
Less than 50	10 - 15
50 to 100	15 - 20
100 to 500	30 - 50
More than 500	50

Sample selection

To conduct an effective audit, WCRS will select a sample of claims that covers all elements of the self-insurer's claims management performance.

WCRS will select a targeted sample with the aim of covering all criteria and requirements it includes in the audit tool attached to this audit process.

Where possible, the sample will cover the different types of claims the self-insurer manages. This may include files that reflect:

- the self-insurer's geographical spread; and
- the self-insurer's entities, businesses and operations.

7. Self-audits

To bridge the gap between WCRS' compliance audits, WCRS will require self-insurers with a licence duration of three years or more to perform a self-audit at the mid-point of their licence.

Resourcing a self-audit

The self-insurer will allocate appropriate resources to complete the self-audit. The self-insurer's auditors can be either independent of the claims management team or from within the claims management team but must have appropriate knowledge and experience with Queensland workers' compensation legislative requirements and claims management and rehabilitation processes. There are benefits to engaging an independent third party to undertake a self-audit such as obtaining recommendations for organisational improvements. The view from an independent external source may benefit continual improvement.

Documenting a self-audit

WCRS will provide the self-insurer with an audit work paper in Microsoft Excel to document the audit work.

Sample

The sample of files to best tested in the self-audit can either be provided by WCRS or selected by the self-insurer. WCRS' sampling approach for self-audits will be consistent with the sampling approach in section 4.

Re-performance and validation of results

To validate the results of the self-audit process, WCRS may re-perform the self-insurer's audit work for a subsample of claims. If WCRS identifies significant divergence in the results of the re-performance and the results provided by the self-insurer, it will extend the re-performance to a larger subsample.

If the results of the re-performance are systematically and significantly different to the self-insurers results, WCRS may take enforcement actions (refer to section 8).

Self-audit planning and timing

The following table outlines the timeline and steps WCRS will follow in the lead up to a self-audit.

Timing	Steps
At least 12 weeks prior to self-audit	WCRS will contact the self-insurer to confirm the upcoming audit and agree dates for the conduct of the audit.
More than four weeks prior to self-audit	WCRS and the self-insurer to agree and confirm the dates that the external claims auditor will • perform the self-audit conduct; and • provide their audit work papers back to WCRS.
At least two weeks prior to the audit	WCRS will provide the self-insurer with the sample of claims. WCRS will provide timeline for the results of any re-performance.
After WCRS receives self-audit work paper	WCRS may request a subsample of claims for re-performance and validation of self-audit results.

8. Documentation and systems access

It is the responsibility of the self-insurers to ensure documents and systems are accessible for the duration of the audit.

Under section 93 of the Act, the self-insurer must keep documents relating to all claims made and other documents that may assist in assessing the quality and timeliness of the claims and rehabilitation management.

To understand more about the document retention requirements, refer to the *Retention and Disposal Schedule*.

9. Procedural fairness

The Audit Process and Audit Tool provides clear and objective ways of assessing a self-insurer's performance where this is possible. In instances where this is not possible and a subjective assessment is required, WCRS will document the evidence and professional judgment required to form conclusions about the self-insurer's performance. WCRS will document all findings and conclusions with sufficient and appropriate audit evidence to demonstrate to the self-insurer how it reached its conclusions.

To provide procedural fairness, WCRS will communicate preliminary findings and provide supporting evidence to the self-insurer for their comment prior to finalising reports (refer **Appendix 2**). Procedural fairness can be defined as a minimum of ten business days.

10. Enforcement actions

The Workers' Compensation Regulator will determine appropriate enforcement actions for non-compliance or performance issues. To understand more about the potential enforcement actions available to the Workers' Compensation Regulator to manage a compliance or performance issue, refer to the *WCRS Compliance and Enforcement Policy* and the *Self-Insurer Performance and Compliance Framework*.

Attachment 1 – Claims management criteria (CM)

Claims management systems (CM-S)

These standards apply to aspects of a self-insurer's performance that can have a pervasive effect on the effectiveness and compliance of a self-insurer's claims management practices.

Requirement	Description	Legislative references
CM – S: 1 Self-insurer has a comprehensive claims management manual.	1-1 The claims manual or equivalent includes policies and procedures outlined in Appendix 1. 1-2 The claims manual is consistent with all aspects of the *Workers' Compensation and Rehabilitation Act 2003* and *Workers' Compensation and Rehabilitation Regulation 2014,* these standards and other guidance material issued by WCRS. 1-3 The self-insurer's claims manual addresses the impact of Queensland's historical legislation on current claims management. 1-4 The claims manual is reviewed at least every two years and after legislative changes.	
CM – S: 2 The self-insurer is appropriately resourced for claims management in Queensland	2-1 The self-insurer has an appropriate number of claim managers to effectively manage its peak volume of claims and to backfill in the event of short-term absences or departures with minimal disruption.	

CM – S: 3 Claims management personnel are appropriately skilled and trained for workers' compensation	3-1 A more senior claims officer supervises the actions of a new claims manager on all claims until the earlier of managing 20 claims or three months experience with the self-insurer. 3-2 New claims team personnel undertake mandatory induction training including training in the self-insurer's claims manual. 3-3 Claims management personnel have the required skills and experience to successfully meet the self-insurer's obligations under the Act and relevant performance standards. 3-4 The self-insurer maintains a training log to demonstrate claims management personnel participate in relevant ongoing training and professional development. 3-5 The self-insurer maintains a register of claims management personnel registered with WCRS that have decision-making responsibility in administering claims. To ensure self-insurer staffing arrangements reported to WCRS can be corroborated if required.	
CM – S: 4 Claims management service providers are appropriately engaged and monitored to ensure appropriate claims management practices.	4-1 The self-insurer has a tailored service level agreement in place with claims management service provider. 4-2 The self-insurer's service level agreement and contract with the service provider establishes appropriate performance and accountability measures over claim management, which are consistent with a beneficial approach to the objects of the Act. 4-3 The self-insurer retains evidence showing all claims management personnel at the service provider are appropriately skilled and trained per CM – S: 2. 4-4 The self-insurer has documented procedures on how it will monitor the service provider's compliance with legislation and WCRS guidelines.	

	4-5 The self-insurer retains evidence of its regular monitoring over the service provider's performance. 4-6 The self-insurer has documented evidence of regular meetings with the service-provider to discuss current claims.	
CM – S: 5 The self-insurer effectively informs the claimant and manages early intervention.	5-1 The self-insurer has documented policies to guide the appropriate use of its early-intervention program(s). 5-2 The employer notifies the self-insurer and provides access to complete records of all workers treated in an early intervention program(s) and treatment provided. 5-3 The self-insurer retains all correspondence, treatment and payments related to an injury that is treated in an early intervention program. 5-4 The self-insurer retained evidence of advice to injured workers treated through an early intervention program, informing them of their rights and the process to lodge a claim for compensation.	
CM – S: 6 The self-insurer effectively informs the claimant about how it will access and use the claimant's medical information.	6-1 The self-insurer's forms and / or factsheets inform the claimant of the type of medical information requests the self-insurer may make and that the authority to request medical information will last for the duration of the claim or until the claimant revokes the authority. 6-2 The self-insurer's forms and / or factsheets inform the claimant about their right to revoke the self-insurer's authorisation to access medical information at any time. 6-3 The self-insurer forms and / or factsheets inform the claimant that the self-insurer cannot provide information it obtains as the self-insurer to the worker's employer for purposes related to the worker's employment.	Section 572A - *Workers' Compensation and Rehabilitation Act 2003*
CM – S: 7	7-1 The self-insurer has established appropriate principles for managing psychological claims **Appendix 3**.	

The self-insurer has established appropriate principles for the management of psychological claims.		
CM – S: 8 The self-insurer has established appropriate principles to guide its litigation practices in common law claims.	8-1 The self-insurer has established appropriate principles to guide its litigation practices in common law claims which, at a minimum, reflect the standards in **Appendix 4**.	

Management of statutory claims (CM – C)

These criteria apply to the self-insurer's management of individual claims to determine liability and make compensation payments.

Requirement	Description	Legislative reference
CM – C: 1 The self-insurer lodged and intimated applications for compensation in a timely manner.	1-1 The self-insurer intimated a claimant's application for worker's compensation made in the approved form within two business days of receiving and lodging the application. Approved form means the application: • used an approved application for compensation form. • was accompanied by a certificate in the approved form.	Section 132 - *Workers' Compensation and Rehabilitation Act 2003* Regulation 102 - *Workers' Compensation and Rehabilitation Regulation 2014*
CM – C: 2 The self-insurer has provided appropriate and accurate advice to its workers.	2-1 The self-insurer made information and documentation freely available and readily accessible to workers and other stakeholders regarding workers' compensation entitlements and claims lodgement processes. 2-2 The self-insurer provided timely and accurate advice to a potential claimant about how to lodge an application for worker's compensation in the approved form.	
CM – C: 3 The self-insurer has made timely decisions on applications for compensation.	3-1 The self-insurer decided to allow or reject the application within 20 business days of: • lodging the application for compensation; or • the claimant applying to reopen a claim. (In instances where standard CM-C: 3-1 does not apply standard CM-C 7-1 will be used) 3-2 The self-insurer was proactive in obtaining the evidence required to decide on a claim as soon as possible.	Section 134 - *Workers' Compensation and Rehabilitation Act 2003*

Requirement	Description	Legislative reference
	3-3 The self-insurer decided on a claim when, on the balance of probabilities, they had reasonable evidence to determine liability.	
CM – C: 4 The self-insurer considered all relevant and obtainable evidence.	4-1 The self-insurer considered all relevant and obtainable evidence both adverse to and supportive of a claim before deciding on a claim. 4-2 Prior to deciding to reject or cease an application for compensation on medical grounds, the self-insurer has made documented attempts to obtain a report or comment from the claimant's treating medical practitioner. 4-3 The self-insurer has considered and acted on new information regarding the injury type or any additional diagnoses linked to the work event.	
CM – C: 5 An appropriate person made the self-insurer's decision.	5-1 The self-insurer's claim decision was made by a person registered with WCRS. 5-2 In the case of an adverse decision, the proposed decision was reviewed by a more senior officer prior to issuing the decision. The more senior officer: • did not at any stage of the claim, undertake the role or functions of the claim manager. • is someone that is appropriately qualified to review the claim.	Section 538(2) - *Workers' Compensation and Rehabilitation Act 2003*
CM – C: 6 The self-insurer appropriately communicated the decision to reject the application for compensation or cease benefits.	6-1 The self-insurer offered the claimant natural justice prior to deciding to reject their application for compensation or cease the entitlement to benefits (refer **Appendix 2**). 6-2 In a decided claim, the self-insurer has provided the claimant with written reasons for the decision and informed the claimant that they have the right to review the decision under the legislation. The written reasons must include: • the evidence considered for the decision	Section 540(1)(b)&(c)(4) - *Workers' Compensation and Rehabilitation Act 2003* Regulation 148 - *Workers' Compensation and Rehabilitation Regulation 2014*

Requirement	Description	Legislative reference
	• the evidence that was accepted or rejected for the decision and why the evidence was accepted or rejected • the conclusions drawn from the evidence • the link between the evidence, the conclusions and the relevant provision of the Act; and • the decision made. 6-3 The self-insurer gave the claimant reasonable notice prior to ceasing their entitlement to benefits.	
CM – C: 7 The self-insurer has notified the claimant where they failed to decide within 20 business days.	7-1 Where the self-insurer has failed to decide on a claim within 20 business days, the self-insurer notified the claimant of the reasons for not deciding within five business days of the decision deadline. 7-2 The self-insurer provided the claimant with written reasons for the failure to decide and informed the claimant in writing that • they have the right to review the failure to decide (section 540 of the Act); and • they have the right to request, in writing, a copy of the claim file. 7-3 In instances where liability was not determined within 20 business days, there is documented evidence that the insurer took reasonable steps to determine liability. *"Reasonable" meaning an insurer promptly requested all information required to determine liability, regularly followed-up, and reviewed expeditiously upon receipt.*	Section 134(6) - *Workers' Compensation and Rehabilitation Act 2003* Section 540(2) - *Workers' Compensation and Rehabilitation Act 2003* Section 148 - *Workers Compensation and Rehabilitation Regulation 2014*
CM – C: 8 The self-insurer's communication with the claimant's treating medical	8-1 The self-insurer informed the claimant about the nature and purpose of medical assessments and any related medical reports requested by the self-insurer.	

Requirement	Description	Legislative reference
practitioners was authorised and appropriate	8-2 The self-insurer confined questions to the claimant's treating medical practitioner(s) to matters that were medically and directly relevant to the current stage of the claim and for proactive case management. 8-3 The self-insurer provided the worker's treating medical practitioner(s) with a copy of any medical reports it obtained while managing the claim.	
CM – C: 9 The self-insurer's use of medical experts to conduct a file review or examination of the claimant was appropriate having regard to the worker's injury.	When obtaining a report on the claim from a medical expert: 9-1 The self-insurer engaged a registered medical expert with appropriate expertise and having regard the injury claimed in the application. 9-2 The self-insurer confined questions to matters that were medically and directly relevant to the current stage of the claim and for proactive case management. 9-3 The self-insurer provided the medical expert with an objective overview of the available and relevant evidence pertaining to the cause of the worker's injury and the extent of incapacity. 9-4 The self-insurers questions to the medical expert were concerned with establishing whether there was a link between the work-related event and the injury. 9-5 The self-insurer questions to the medical expert did not require the medical expert to make unreasonable assumptions or fill in gaps in the available evidence. 9-6 The self-insurer provided the medical expert with a copy of any relevant previous reports.	
CM – C: 10 The self-insurer's requirement for a claimant to	10-1 When requiring the claimant to submit to a medical examination, the self-insurer used a registered medical practitioner with appropriate expertise having regard to the injury.	Section 135(1) - *Workers'*

Requirement	Description	Legislative reference
submit to a personal examination by a registered person was reasonable.	10-2 The self-insurer arranged for the examination in a place that was reasonable and convenient for the injured worker. 10-3 The self-insurer advised the claimant of the following in writing: • the name of the examiner who is not employed by the insurer. • the day, time and place for the examination. • the doctor's field of speciality (if the doctor is a specialist). • the purpose of the examination. • that the examination was not related to treating of the claimed injury. 10-4 The self-insurer reimbursed reasonable travel and other expenses incurred by the claimant to attend the examination.	*Compensation and Rehabilitation Act 2003* Section 106 - *Workers' Compensation and Rehabilitation Regulation 2014*
CM – C: 11 The self-insurer appropriately communicated all medical evidence to the claimant.	11-1 The self-insurer provided a copy of any medical reports it obtained to the claimant and the claimant's treating medical practitioner. As a minimum, insurers should be adhering to the standards set out in **Appendix 2.** 11-2 The self-insurer requested comments from the claimant's treating medical practitioner on any medical reports it obtained.	
CM – C: 12 The self-insurer appropriately implemented and communicated WCRS review decisions.	12-1 The self-insurer actioned all instructions in a WCRS review decision within five business days. 12-2 If it was unable to comply with a review decision, the self-insurer notified WCRS of the reasons why within five business days of receiving the decision. 12-3 The self-insurer communicated the outcome of a review decision to the claimant within two business days of receiving the decision from WCRS. This communication articulated the impact the review decision would have on the worker's claim and the steps the self-insurer would undertake as a result of the review decision.	

Requirement	Description	Legislative reference
CM – C: 13 The self-insurer made an appropriate referral to the medical assessment tribunal	13-1 The self-insurer notified the claimant that they were unable to decide and that they were referring the matter to the medical assessment tribunal. 13-2 The self-insurer referred the decision to the medical assessment tribunal within five days of notifying the claimant. 13-3 The self-insurer attached the current (< six months old) and relevant specialist reports with conflicting medical evidence to the file prior to referral to the medical assessment tribunal.	
CM – C: 14 The self-insurer appropriately and proactively managed claims involving National Injury Insurance Scheme Queensland (NIISQ)	14-1 The self-insurer initiated early contact with NIISQ to determine whether the worker's injury was eligible for NIISQ by either: • making its own decision on eligibility; or • referring the decision on eligibility to NIISQ. 14-2 The self-insurer documented a reasonable decision on the workers' eligibility. 14-3 If the self-insurer determined that the worker was an eligible worker, the self-insurer referred the worker's claim to NIISQ.	

Management of common law claims (CM – CL)

These criteria apply to the self-insurer's management of individual claims where the claimant has lodged a notice of claim for damages on a claim that ceased up to and including 30 October 2019.

Requirement	Description	Legislative reference
CM – CL: 1 The self-insurer has appropriately referred a worker to their accredited rehabilitation and return to work program	1-1 Where the injured worker lodged a notice of claim for damages, the self-insurer referred the worker to its accredited return to work program (effective up until and including 30 October 2019). 1-2 Where the self-insurer did not refer the claimant to its accredited return to work program, it has clearly documented why the injury would prevent the worker from participating.	Section 220(2) - *Workers' Compensation and Rehabilitation Act 2003*

Management of claims that include an assessment of permanent impairment (CM – PI)

These criteria apply to the self-insurer's management of individual claims where the worker may have suffered a permanent impairment.

Requirement	Description	Legislative reference
CM – PI: 1 The self-insurer appropriately arranged for an assessment of degree of permanent impairment.	1-1 Except when requested by the claimant, the self-insurer only arranged an assessment of degree of permanent impairment when it reasonably believed the worker's injury was stable and stationary. 1-2 The self-insurer referred the claimant to an assessor that was appropriately trained in, and with access to, the applicable guidelines for evaluation of permanent impairment for the date of the injury. 1-3 The self-insurer used a registered medical practitioner with relevant and appropriate expertise having regard to the injury being assessed for permanent impairment. 1-4 For a psychiatric or psychological injury, the self-insurer arranged for an assessment of permanent impairment by the Medical Assessment Tribunal. 1-5 Where the claimant requested a second permanent impairment assessment, within 10 business days the self-insurer: • arranged for a second assessment of permanent impairment; or • referred the question of degree of permanent impairment to the medical assessment tribunal for decision. 1-6 If the self-insurer decided not to agree to a second assessment of permanent impairment requested by the worker (refer 1-5), it provided the worker with written notification of the decision and articulated that the matter was being referred to the Medical Assessment Tribunal.	Section 38 - *Workers' Compensation and Rehabilitation Act 2003* Section 179 - *Workers' Compensation and Rehabilitation Act 2003* Section 179(2)(b) - *Workers' Compensation and Rehabilitation Act 2003* Section 186(3) - *Workers' Compensation and Rehabilitation Act 2003*

Requirement	Description	Legislative reference
CM – PI: 2 The self-insurer gave the claimant an appropriate notice of assessment of the injured worker's degree of permanent impairment (DPI).	2-1 The self-insurer, within 10 days of receiving the assessment of the worker's permanent impairment, gave the worker a notice of assessment. 2-2 The self-insurer's notice of assessment of DPI included the following information: • where the assessment of DPI was not performed by the Medical Assessment Tribunal, that the claimant may agree or disagree with the assessment. • the ability to have a second impairment assessment of DPI under s186(2)(b)(i) of the Act. • if the notice of assessment follows a medical assessment tribunal determination, there is no opportunity to agree or disagree. 2-3 The self-insurer's notice of assessment of DPI included the assessment of all the workers' injuries. 2-4 The diagnosed injuries listed in the notice of assessment matched the doctor's diagnosis in their assessment of permanent impairment report.	Section 185 - *Workers' Compensation and Rehabilitation Act 2003*
CM – PI: 3 The self-insurer gave the claimant an appropriate offer of lump sum compensation in the notice of assessment.	3-1 When issuing a notice of assessment where there is no degree of permanent impairment (zero), the self-insurer did not make an offer of lump sum compensation. 3-2 If the worker has an entitlement to lump sum compensation greater than zero, the insurer included in the notice of assessment an offer of lump sum compensation accurately calculated in accordance with the regulation. 3-3 When issuing a notice of assessment for **less than** 20 per cent degree of permanent impairment, the self-insurer included the following information: • a copy of sections 10, 237(3), 239, 240 and 316 of the Act.	Section 187 - *Workers' Compensation and Rehabilitation Act 2003* Regulation 108 - Workers' Compensation and Rehabilitation Regulation 2014

Requirement	Description	Legislative reference
	• if an offer of lump sum compensation is made, that the claimant may accept, reject or defer the offer. • that the worker must make an irrevocable election as to whether the worker accepts the offer of payment or seeks damages for the injury. 3-4 When issuing a notice of assessment, the self-insurer informed the worker of all additional lump sum amounts the worker is or may be entitled to resulting from their assessed DPI and diagnosis. 3-5 The self-insurer provided the claimant with a separate offer for each entitlement to additional lump sum compensation.	Section 189 - *Workers' Compensation and Rehabilitation Act 2003*
CM – PI: 4 The self-insurer appropriately assessed and offered the worker any entitlement to lump sum compensation for gratuitous care.	4-1 Where an injury results in a DPI of 15 per cent or more, the self-insurer arranged for a registered occupational therapist to assess the worker's level of dependency resulting from the impairment. 4-2 The self-insurer informed the worker of their right to disagree with the level of dependency assessed and to refer the matter to the General Medical Assessment Tribunal for decision.	Section 193(4)(7) - *Workers' Compensation and Rehabilitation Act 2003*
CM – PI: 5 For a claim relating to a worker with a diagnosis of pneumoconiosis, the self-insurer has appropriately arranged for the worker's assessment.	5-1 For a worker that may have pneumoconiosis, the self-insurer arranged for an assessment of the worker's pneumoconiosis score in accordance with schedule 4B of the regulation. 5-2 For a worker that has pneumoconiosis, where requested by the worker, the self-insurer arranged to have the injury further assessed to determine whether the level of permanent impairment from the injury has increased.	Division 5 - *Workers' Compensation and Rehabilitation Act 2003* Schedule 4C - *Workers' Compensation and Rehabilitation Regulation 2014*

Management of payments on individual claims (CM – Pay)

These criteria apply to the self-insurer's management of individual claims where they are required to make compensation payments.

Requirement	Description	Legislative reference
CM – Pay: 1 For a time-loss claim, the self-insurer has accurately calculated the employee's entitlement to weekly compensation.	1-1 The self-insurer accurately calculated the worker's average normal weekly earnings. 1-2 The self-insurer accurately calculated the applicable compensation payable for each period of incapacity. 1-3 The self-insurer paid weekly compensation from the date the worker's entitlement to payments arose, being the latter of: • the day the worker saw a doctor, nurse practitioner or dentist; or • 20 days prior to the claimant lodging their application for compensation 1-4 The self-insurer informed the claimant in writing how it calculated the normal weekly earnings and applicable weekly compensation rate; and their right to review the self-insurer's decision on the value of weekly compensation payments.	Section 150 - 153 - *Workers' Compensation and Rehabilitation Act 2003* Section 141 - *Workers' Compensation and Rehabilitation Act 2003* Section 131(2) – *Workers' Compensation and Rehabilitation Act 2003* Section 540(1)(b)(iiia) – *Workers' Compensation and Rehabilitation Act 2003*
CM – Pay: 2 The self-insurer paid workers' compensation in a timely manner.	2-1 The self-insurer made payments of initial weekly benefits within five business days of accepting the claim, or on the next pay run date for a worker in ongoing employment. 2-2 The self-insurer reimbursed medical and other reasonable expenses within five business days of accepting the claim, or on the next pay run date for a worker in ongoing employment.	

<table>
<tr>
<td></td>
<td>2-3 The self-insurer paid accurate lump sum compensation in a timely manner after receipt of claimant advice of acceptance on a PI offer or confirmation of a person's entitlement to compensation.</td>
<td></td>
</tr>
<tr>
<td>CM – Pay: 3

For an entitlement to additional lump-sum compensation, the self-insurer has accurately calculated and paid the right amount of compensation.</td>
<td>3-1 The self-insurer paid the correct additional lump sum compensation per the Act and the "Table of benefits" for workers with:
• a DPI of 30 per cent or more from a physical injury; or
• a DPI of 15 per cent or more from a physical injury and an entitlement to lump sum compensation for gratuitous care; or
• an injury that is pneumoconiosis.</td>
<td>Section 192 - 193 – Workers' Compensation and Rehabilitation Act 2003</td>
</tr>
<tr>
<td>CM – Pay: 4

If a worker dies because of a work-related injury, the self-insurer has accurately calculated and paid all entitlements per Part 11 of the Act.</td>
<td>4-1 The self-insurer paid the applicable compensation to the appropriate recipient
<table>
<tr><th>Payment type</th><th>Payment to</th></tr>
<tr><td colspan="2">If the worker had a personal legal representative…</td></tr>
<tr><td>All compensation payments</td><td>The worker's personal legal representative</td></tr>
<tr><td colspan="2">If the worker did not have a personal legal representative…</td></tr>
<tr><td>Expenses</td><td>To the person(s) that incurred the expenses.</td></tr>
<tr><td>Compensation</td><td>To the persons with an entitlement to compensation.</td></tr>
</table>
4-2 The self-insurer paid reasonable expenses for
• the medical treatment of, or attendance on, the worker.
• The worker's funeral.</td>
<td>Section 196 – Workers' Compensation and Rehabilitation Act 2003

Section 199 – Workers' Compensation and Rehabilitation Act 2003

Section 200-202 – Workers' Compensation and Rehabilitation Act 2003</td>
</tr>
</table>

	4-3 The self-insurer accurately calculated and paid compensation per the "Table of benefits" to: • Persons that were totally or partially dependent on the worker's income; or • A spouse, issue or next of kin entitled to compensation where there were no total or partially dependent persons; or • The worker's parents where the worker was under 21.	
CM – Pay: 5 The self-insurer paid all reasonable costs of rehabilitation.	5-1 In an accepted claim, the self-insurer responded to the claimant's requests to approve funding of additional rehabilitation treatment in a timely manner. 5-2 The self-insurer paid all reasonable fees or costs for rehabilitation of the injured worker in a timely manner until the worker's entitlement to compensation stopped. **From 30 October 2019:** 5-3 During claim determination for a psychiatric or psychological injury, the self-insurer paid for reasonable services on a without prejudice basis during claim determination. 5-4 If the self-insurer did not provide support services, the self-insurer conducted an internal review over its decision **not** to pay for psychiatric or psychological injury services during claim determination under 5-3. 5-5 After ceasing a claim, the self-insurer paid for the worker to complete any existing pre-approved injury management plan(s).	Section 222 – *Workers' Compensation and Rehabilitation Act 2003* Section 232 AB(2) – *Workers' Compensation and Rehabilitation Act 2003*
CM – Pay: 6 The employer did not pay compensation to the worker without an application for compensation.	**From 1 July 2020:** 6-1 The employer did not pay compensation to the worker for a work-related injury unless the worker first made an application for compensation and the employer reported the payment to the insurer.	Section 109 – *Workers' Compensation and Rehabilitation Act 2003*

Attachment 2 – Rehabilitation and return to work audit criteria (RRTW)

Self-Insurer's responsibilities for rehabilitation and return to work (RRTW – I)

Requirement	Description	Legislative reference
RRTW – I: 1 The self-insurer has an accredited rehabilitation and return to work program.	1-1 The self-insurer has an accredited rehabilitation and return to work program.	Section 220 – *Workers' Compensation and Rehabilitation Act 2003*
RRTW – I: 2 The self-insurer has appropriate resources for rehabilitation and return to work.	2-1 The self-insurer has adequate appropriately trained resources, based in Queensland, to coordinate the development and maintenance of the rehabilitation and return to work plan for injured workers. **From 1 July 2020:** 2-2 The self-insurer provided WCRS with a complete and accurate annual submission of the employers' rehabilitation and return to work coordinators.	Section 220 – *Workers' Compensation and Rehabilitation Act 2003*

Employer's responsibilities for rehabilitation and return to work (RRTW – E)

Requirement	Description	Legislative reference
RRTW – E: 1 The employer has appropriate rehabilitation and return to work policies and procedures.	1-1 Employer has published workplace rehabilitation policies and procedures. 1-2 The employer has reviewed their workplace rehabilitation policy and procedures within the last 3 years.	Section 227(2) - *Workers' Compensation and Rehabilitation Act 2003*
RRTW – E: 2 The employer has appropriate resources for rehabilitation and return.	2-1 The employer has appointed appropriately qualified rehabilitation and return to work coordinator(s) in Queensland.	Section 226 - *Workers' Compensation and Rehabilitation Act 2003* Section 115 - *Workers' Compensation and Rehabilitation Regulation 2014*
RRTW – E: 3 The employer has a standard worker authority form which appropriately restricts the access and use of the worker's medical information.	3-1 The employer's worker authority form outlines reasonable restrictions on the rehabilitation and return to work coordinator's access to, and use of, medical information, including: • the person(s) and positions within the self-insurer that will be able to access the medical information • how the information will be used • the scope of medical information the medical provider	

Management of rehabilitation and return to work on individual claims (RRTW - C)

Requirement	Description	Legislative reference
RRTW – C: 1 The self-insurer referred injured workers to its accredited rehabilitation and return to work program.	**From 30 October 2019:** 1-1 The self-insurer referred a worker to its accredited rehabilitation and return to work program, where the worker: • was receiving compensation and requested a referral; or • had stopped receiving compensation under sections 144A, 168 or 190(2) for an injury and had not returned to work because of the injury. 1-2 If the self-insurer did not refer a worker under 1-1 to its rehabilitation and return to work program, it provided written reasons for why it did not refer the worker. The self-insurer informed the worker that they have the right to review the decision. 1-3 The self-insurer only ceased a worker's entitlement to remain in the accredited rehabilitation and return to work program when the worker was unwilling or unable to participate; or the program was not able to further assist the worker. The self-insurer informed the worker that they have the right to review the decision.	Section 220(2)(b)(c) – *Workers' Compensation and Rehabilitation Act 2003* Section 540(1)(b) (viaa&viab) – *Workers' Compensation and Rehabilitation Act 2003*
RRTW – C: 2 The self-insurer has coordinated the development of a rehabilitation and return to work plan.	**From 30 October 2019:** 2-1 The self-insurer has taken the steps it considers practicable to coordinate the development and maintenance of a rehabilitation and return to work plan in consultation with the injured worker, the worker's employer and treating registered persons. A rehabilitation and return to work plan usually includes: • clear and appropriate objectives with considerations of how these objective will be achieved;	Section 220(5) - *Workers' Compensation and Rehabilitation Act 2003* Section 220(7) - *Workers' Compensation and Rehabilitation Act 2003*

	• details of rehabilitation activities required to meet the objectives; • time frames for expected stages of recovery and return to work opportunities; • when and by who reviews will be undertaken to assess the injured worker's progress; • how and when relevant parties will be informed of progress; and • if a suitable duties program or a return to the previous role is planned, how this will be achieved at the workplace and how the worker and employer will be advised 2-2 The self-insurer consulted with the worker, worker's employer and registered persons treating the worker to develop a written rehabilitation and return to work plan. 2-3 The self-insurer provided a copy of the worker's written rehabilitation and return to work plan to all parties listed in 2-2.	
RRTW – C: 3 During claim determination, the self-insurer provided reasonable support to workers with psychiatric or psychological injuries.	**From 30 October 2019:** 3-1 During claim determination, the self-insurer took all reasonable steps to provide reasonable services to support workers with a psychiatric or psychological injury on a without prejudice basis.	Section 232AB(1) – *Workers' Compensation and Rehabilitation Act 2003*
RRTW – C: 4 The rehabilitation and return to work coordinator proactively engaged with the	4-1 The rehabilitation and return to work coordinator: • initiated early communication with the injured worker to clarify nature and severity of injury; and • provided overall coordination of the workers' return to work.	Section 226 - *Workers' Compensation and Rehabilitation Act 2003*

worker on their rehabilitation and return to work.	4-2 The self-insurer and rehabilitation and return to work coordinator tailored their return to work services to the injured worker. This may include considering, offering or arranging activities such as: • vocational assessments • functional capacity evaluations • vocational counselling • transferable skills assessments • job placement services • suitable duties plans • host placement • assistance with sourcing alternative employment; and • reskilling or retraining **From 30 October 2019:** 4-3 The employer met their obligation to assist and provide rehabilitation from the day of the worker's injury until the insurer's responsibility for rehabilitation ceased. **From 1 July 2020:** 4-4 The employer had correctly provided the rehabilitation and return to work coordinator's details to the self-insurer.	Section 114 - *Workers Compensation and Rehabilitation Regulation* 2014
RRTW – C: 5 The rehabilitation and return to work coordinator developed and implemented suitable duties plans where recommended by the	5-1 Where recommended by the worker's treating medical practitioner, the employer's rehabilitation and return to work coordinator developed a suitable duties program in consultation with the: • injured worker; • employer; and • treating registered persons.	Section 114 - *Workers' Compensation and Rehabilitation Regulation 2014*

worker's treating medical practitioner.	5-2 The suitable duties program covered all periods of the worker's partial incapacity. 5-3 The suitable duties program was consistent with the treating medical practitioner's recommended restrictions in the worker's corresponding medical certificate or report. **From 30 October 2019:** 5-4 The employer provided the self-insurer with written evidence if they did not consider it was practicable to provide the worker with suitable duties.	Section 228 – *Workers' Compensation and Rehabilitation Act 2003*
RRTW – C: 6 The rehabilitation and return to work coordinator has appropriately controlled the use of the worker's medical information.	6-1 The rehabilitation and return to work coordinator obtained the worker's signed authority on the standard form prior to contacting the workers' treating doctor. 6-2 The rehabilitation and return to work coordinator and the employer only used the workers' medical information for the purpose of aiding the workers' rehabilitation and return to work.	
RRTW – C: 7 The rehabilitation and return to work coordinator kept detailed notes on the worker's rehabilitation.	7-1 The rehabilitation and return to work coordinator maintained accurate, concise and objective case notes on the worker's rehabilitation.	
RRTW – C: 8 The self-insurer and the employer provided	8-1 The self-insurer and the employer provided the worker with the return to work options that would lead to the most favourable long-term outcome possible for the worker, i.e. the worker attaining the capacity for a durable return to work.	

meaningful work opportunities.	8-2 The self-insurer offered the worker the opportunity to raise concerns about their rehabilitation and return to work and acted on the worker's feedback. 8-3 When ceasing or finalising the worker's claim, the self-insurer documented the outcomes of the workers' rehabilitation and any additional planned rehabilitation activities. The insurer also summarised the worker's prospects for returning to work.	

Attachment 3 – Other - information and communication criteria (IC)

Other information systems (IC – S)

Requirement	Description	Legislative reference
IC – S: 1 The self-insurer has appropriate privacy policies and procedures in place.	1-1 Self-Insurer has a comprehensive and current privacy policy in place that complies with the requirements of the Act and the *Information Privacy Act 2009*. 1-2 The self-insurer stores workers' compensation files, including archived files, both computerised and physical, in secure facilities separate from other personnel files.	
IC – S: 2 The self-insurer has implemented an appropriate complaint handling process	2-1 The self-insurer published policies and procedures for receiving and handling complaints from claimants and workers' regarding workers compensation practices. 2-2 The self-insurer maintains a register of complaints received from workers and claimants and records all subsequent actions and communication with the complainant.	

Other information and communication on individual claims (IC – C)

Requirement	Description	Legislative reference
IC – C: 1 The self-insurer maintained regular communication with the claimant throughout the claim.	1-1 The self-insurer claims manager maintained regular communication with the claimant until finalisation of the claim.	

IC – C: 2 The self-insurer provided complete, accurate and timely information to WCRS.	2-1 The information on the self-insurer's claim file is consistent with data submitted to WCRS. 2-2 The self-insurer provided information requested by the Workers' Compensation Regulator in a written notice within five business days after receiving the notice or within the period stated in the notice.	Section 75(2)(d) - *Workers' Compensation and Rehabilitation Act 2003* Section 544 – *Workers' Compensation and Rehabilitation Act 2003*
IC – C: 3 The self-insurer responded promptly and accurately to the claimant's request for documentation.	3-1 The self-insurer provided the claimant with a copy of requested documents within 20 business days after the request.	Section 572(2) - *Workers' Compensation and Rehabilitation Act 2003*
IC – C: 4 The self-insurer maintained appropriate separation from the employer on workers' compensation matters.	4-1 The self-insurer did not provide any workers' compensation documents to the claimant's employer for a purpose relating to the worker's employment. 4-2 The self-insurer documented its justification for providing information to the employer where it reasonably believed it was: • in the claimant's best interest; and / or • necessary to ensure workplace health and safety. 4-3 The self-insurer acted in accordance with its privacy policy and all relevant legislation in the way it provided the workers' compensation information. 4-4 The self-insurer provided the employer with information about its privacy obligations under the Act and relevant privacy legislation when it provided the information. 4-5 The employer did not dismiss the worker solely or mainly because of their injury within 12 months of the injury.	Section 572A(1) - *Workers' Compensation and Rehabilitation Act 2003* Section 232B(1) - *Workers' Compensation and Rehabilitation Act 2003*

Other information – employer/insurer reporting of potentially compensable injury data and associated payments (EI – R)

EI – R: 1 Employer's reporting of potentially compensable injury data and associated payments is timely and comprehensive	1-1 The employer notifies the self-insurer within 8 business days when: a worker sustains an injury (personal injury, disease, aggravation of a personal injury, disease or medical condition, loss of hearing or death); and, they are aware of the injury; and, the injury may be compensable (compensable meaning the injury has arisen out of, or in the course of employment, the injury will require medical certification and time off work or time away from their normal duties). 1-2 The employer reported the injury using the approved form or an appropriate reporting system that details: employer member number, worker DOB, name, gender, occupation, injury narrative, injury date, date reported to employer, address where injury occurred, details of medical treatment known to employer, has employer made wage/time lost payments to worker, has employer paid treatment expenses, date and details of any payments made. 1-3 The employer has documents to show that the worker has been advised of their right to lodge an application for compensation in a way that the worker can understand. 1-4 The employer has documents to show that the worker was advised of any limit on services provided through early intervention or employee assistance programs, and ability to continue to access those services if an application for compensation is lodged (up to the point it is decided) in a way that the worker can understand. 1-5 In instances where an injury has been sustained but an application for compensation has not been lodged, the employer reported the injury to the insurer and only provided treatment or support through a positive early intervention program or positive employee assistance program. (Refer Appendix 5 for further guidance material regarding reportable injuries under sections 133 and 133A)	Section 133/133A – *Workers' Compensation and Rehabilitation Act 2003* Section 109 – *Workers' Compensation and Rehabilitation Act 2003*

EI – R: 2 The self-insurer has implemented appropriate systems and policies to capture, secure and report all potentially compensable injuries and related payments.	2-1 The self-insurer has documented policies and procedures for capturing and retaining all information reported by the employer for all potentially compensable injuries. 2-2 The self-insurer has the appropriate systems in place to record all relevant data given to it by the employer regarding potentially compensable injuries. In turn, these systems allow the same data to be reported to WCRS if required. 2-3 The self-insurer retains all correspondence with the employer, worker or third party related to a potentially compensable injury 2-4 The self-insurer retains evidence of advice to injured workers who have sustained a potentially compensable injury, informing them of their rights and the process to lodge a claim for compensation. 2-5 The self-insurer has documented policies and procedures in place for capturing and reporting all payments that are compensation payable under the Act. 2-6 The self-insurer has the appropriate systems in place to record all relevant data given to it by the employer regarding all payments that are compensation payable under the Act. In turn, these systems allow the same data to be reported to WCRS, if required.	

Appendix 1: Claims management manual

Claims management manual should include:

- organisational structure or overview outlining the distinct and physical separation of insurer and employer responsibilities
- roles and responsibilities including amongst claims staff, the self-insurer and the employer
- decision-making process and providing procedural fairness
- minimum standards for communication with claimants (e.g. regularity of updates on long-term undecided claims)
- payment of claims
- liability for treatment and other expenses
- advising claimants of their rights and responsibilities including their right to review
- obtaining medical reports and opinions
- ongoing management of claims
- permanent impairment and lump sum compensation
- claims for injuries such as industrial deafness, fatal claims and psychiatric and psychological disorders
- journey and recess claims
- accredited return to work program
- rehabilitation and return to work including referral to internal or external rehabilitation providers
- rehabilitation and return to work including when to access vocational assessments, reskilling or retraining, job placement and host employment services
- damages claim
- reviews and appeals
- complaints handling
- privacy, release of information, confidentiality
- fraud identification
- record keeping and documentation (including evidence for all individual cases)
- quality management and improvement
- references to historical legislation where applicable for any of the above list.

Appendix 2: Procedural Fairness

The Queensland Ombudsman provides the following points about providing procedural fairness.

- Procedural fairness is about providing a person who might be adversely affected by a decision a 'fair hearing' before the decision is made.
- Generally, a fair hearing involves disclosure, a reasonable opportunity to respond and impartiality.
- The affected person should be notified of the key issues and given enough information to participate meaningfully in the decision-making process. Reasonable steps should be taken to notify the affected person.
- The affected person should be given a reasonable opportunity and time to respond. The decision-maker should genuinely consider the affected person's submission in making their decision.
- The decision-maker should be seen to be impartial and open to persuasion on the information and arguments presented.
- Check that you have provided a fair hearing to anyone who may be affected by the decision.
- To address any concerns regarding the effect on decision time frames in adopting procedural fairness practices, it is recommended that when inviting the person to make a submission including any further evidence which supports their position in relation to the proposed decision that an appropriate time frame be given in which to reply.

Appendix 3: Principles for self-insurer's behaviour in psychological claims

Best practice principles in management of psychological claims

During claim determination, the self-insurer:

- Engages with the worker in a proactive, positive and supportive manner.
- Provides the claimant and employer with clear information about the claim determination process.
- Describes the roles of the self-insurer, employer and other parties involved in the claim and clearly explains internal and external dispute resolution processes.

Where liability is disputed, the self-insurer:

- Expedites dispute resolution processes for psychological injury claims.
- Continues to engage with the claimant and employer during the dispute resolution process.
- Encourages the employer to continue to pursue opportunities for return to work.

During claim management, the self-insurer:

- Uses systems and processes that support provision of early access to treatment for psychological injuries.
- Ensures the claimant and employer understand the process and likely time frames for managing the claim.
- Supports the employer to actively engage in the claimant's return to work.
- Assesses the recovery time in consultation with the worker and employer in a non-threatening and non-directive manner.
- Engages with employers to review work systems and psychosocial hazards which may cause aggravation of injury, based on insights gained through claim management.
- Acknowledges that clinical improvement does not always translate to work capacity and sensitively identifies and addresses the major barriers to return to work.

Source: *Principles adapted from SafeWork Australia's: A best practice framework for the management of psychological claims in the Australian workers' compensation sector*

Appendix 4: Principles for self-insurer's behaviour in common law claims

The self-insurer's standards on their behaviour in common law claims must include, at a minimum, the following principles:

Fairness:

- Acting consistently in the handling common law claims
- Dealing with common law claims promptly and not causing unnecessary delay in the handling of common law claims
- Endeavouring to avoid, prevent and limit the scope of legal proceedings wherever possible. This includes giving consideration in all common law claims to alternative dispute resolution before initiating legal proceedings and participating in alternative dispute resolution processes where appropriate.
- Where it is not possible to avoid litigation, keeping the costs of litigation to a minimum.
- Paying legitimate claims without litigation, including making partial settlements of claims, or interim payments, where the self-insurer's established liability is at least as much as the amount it would pay.
- Not seeking to take advantage of the impecunious opponent.
- Not contesting matters which it accepts as correct, by:
    - not requiring a claimant to prove a matter it knows to be true; and
    - not contesting liability if it knows the dispute is really about quantum.
- Not instituting and pursuing appeals unless it believes that it has reasonable prospects for success.

Firmness:

- Not seeking to take advantage of an impecunious opponent

Alternative dispute resolution

- The self-insurer only to start court proceedings if it has considered other methods of dispute resolution (for example, alternative dispute resolution or settlement negotiations)
- When participating in alternative dispute resolution, the self-insurer must ensure that its representatives
    - Participate fully and effectively; and
    - Have authority to settle the matter to facilitate appropriate and timely resolution of a dispute.

Source: *Principles adapted from the Queensland Government's Model Litigant Principles.*

Appendix 5 – Reporting of injuries under the *Workers' Compensation and Rehabilitation Act 2003*

All employers are required to report injuries sustained by workers for which workers' compensation may be payable once they are aware of an injury occurring. The employer is required to report the injury to their workers' compensation insurer. Injuries must be reported regardless of whether the worker makes a claim for workers' compensation. The employer must also report the injury even if the employer does not believe the injury is a valid injury under the provisions of the *Workers' Compensation and Rehabilitation Act 2003*.

What injuries must be reported?

You must report injuries to your insurer where:

1. A worker sustains an injury (personal injury, disease, aggravation of a personal injury, disease or medical condition, loss of hearing or death); and
2. You are aware of the injury: and
3. The injury may be compensable. An injury may be compensable when you and/or a worker reasonably believes:
   a. The injury has arisen our of, or in the course of employment; and
   b. The injury will require medical treatment resulting in the issue of a medical certificate or will require the worker to have time off work (beyond the day of sustaining the injury) or time away from their normal duties to recover from the injury.

If the employer is not sure, the employer should report the injury. If the Employer has concerns in relation to an injury, they should convey these concerns to the insurer when reporting the injury.

The employer must also report the making of any payments made to or on behalf of the worker, for compensation or instead of compensation for the injury. This includes payments:

- In place of wages due to time off as a result of the injury; and
- In connection with treatment provided to the worker either by a medical or allied health provider, an in-house provider, or funded through an early intervention program.

It is important that an employer considers how an early intervention program or employee assistance program interacts with an employer's workers' compensation obligations.

If a worker **has lodged** an application for compensation:

- A worker can access treatment via an employer-funded early intervention or employee assistance program while a claim is being decided. During this period an employer must report the types of payments made to the insurer.

If a worker who sustains an injury in the course of employment and **has not lodged** an application for compensation:

- The employer is required to report the injury to the employer's insurer; and
- Any treatment of support for the injury provided by an employer should be provided under a positive early intervention program or positive employee assistance program.

If an employer does not meet these two requirements, then the employer may be at risk of non-compliance with their workers' compensation obligations. Any regulatory response by Workers' Compensation Regulatory Services will be in accordance with the published compliance and enforcement policy.