Medical Assessment Tribunal – referral guidelines

Effective from 1 July 2023

The Medical Assessment Tribunal (tribunal) requires comprehensive medical and claims information to make efficient and quality decisions.

An insurer's failure to meet their legislative obligations under section 500A of the *Workers' Compensation and Rehabilitation Act 2003* to accurately provide all relevant information at the time of referral can impact on a fair hearing for the claimant, the outcome of the tribunal decision and affect the claimant's entitlement to compensation.

These guidelines outline the mandatory and relevant information that must be provided at the time of referring a claim to the tribunal.

Mandatory referral documents:

These documents **must** be submitted at the time of a referral:

☐ **Application for Compensation/Notice of claim for damages/Section 132A Application for Permanent Impairment Assessment**

- Each claim to be assessed must be referred separately and must have its own separate documentation.

For WorkCover only, if there is no handwritten application for compensation, the Claim Summary.

☐ **Full Claim History**

- This must list all claims for the worker and be generated using the *Workers' Compensation Regulator Online Services* portal.

☐ **All Medical Reports including a Comprehensive Specialist Report**

- All relevant medical reports including any reports for physical injuries when the referral is for a psychiatric condition.

- A comprehensive medical report from a relevant specialist, either treating or independent, is also required for all tribunal types

This report should include:

- a full, comprehensive and detailed history which includes full details of the current injury (please note that time sequences are important)
- a detailed medical history including a summary of previous similar or related injuries which includes a full social history, past medical and surgical history
- clinical findings

- diagnosis
- results of investigations – radiology or pathology
- prognosis
- full details of treatment including medication, workers' engagement and willingness to participate in treatment and compliance
- opinion of capacity for work – either original job or alternative work
- future management of the case
- if the comprehensive report is more than 6 months old; a progress report or copy of the report assessment the degree of permanent impairment is also required (DPI referrals)

In addition to the above, **for psychiatric reports** the following must also be included:

- a full employment, social and developmental history which includes family, educational, recreational, and personal history
- full details of any past drug and/or alcohol and/or tobacco history

☐ **Section 186 Referrals: *Worker's disagreement with the assessment of permanent impairment***

- Notice of Assessment
- Response to Notice of Assessment

☐ **Section 160 Referrals: *Total incapacity – reference about impairment to medical assessment tribunal***

- Advice of 2 year drop down to Worker
- Response to advice

Other required documents and information to be submitted:

☐ **Work Capacity Certificates**

- This must include the first and last *work capacity certificate* and any other certification relevant (for example where there is a change in diagnosis or additional injury introduced). There is no need to send all *work capacity certificates*.

☐ **Return to work details**

- Please include all dates and full details of suitable duties and host employment programs. This can be in the form of a suitable duties plan or relevant case notes.

☐ **Allied health reports**

☐ **Post-operative reports for any physical injuries involving surgery**

☐ **Hospital records / GP records that relate to the injury being referred or a previous similar injury**

☐ **Reasons for decision from both insurer and Workers' Compensation Regulatory Services**

☐ **Factual information; including investigation reports and witness statements relating to the specific injury referred** (for undetermined claims only)

☐ **Documents relating to previous or subsequent claims for a similar injury**

- For each previous or subsequent claim all mandatory referral documents and other documents listed in these Guidelines are to be provided

Process for invalid or incomplete referrals (Immediate cancellation)

A referral will be considered invalid or incomplete and **<u>will be immediately cancelled</u>** where:

- Information on the approved *Medical Assessment Tribunal Referral form* is incomplete or cannot be substantiated by the evidence provided. For example, over period of time dates or the diagnosis at time of referral.
- Mandatory referral documents were not provided at the time of submitting the referral.
- Documents provided at time of referral were not in PDF format with identifiable naming conventions.
- The Notice of Assessment (NOA) is incomplete or not valid and requires re-issuing (for example - all injuries not assessed, scarring not assessed, incorrect injury description that does not match the assessment of permanent impairment).
- The date of injury, including when an injury has occurred over a period of time is listed in the referral however cannot be substantiated in other referral documents received.
- There is an unaccepted primary injury that requires determination and/or assessment by the insurer.
- A comprehensive specialist report from either an Independent Medical Examiner or treating practitioner has not been provided and/or, if the comprehensive report is more than 6 months old, a progress report or updated information has not been provided.
- The worker is not yet three months post-surgery; and
- An assessment of the two-year drop-down rate has not yet been undertaken, provided to the worker and the worker has not yet responded.

Process for referrals requiring further information and/or clarification – for other required documents and information only

The insurer will be notified if any other document or information provided:

- requires a minor correction; and/or
- was not provided at the time of referral but other documents indicate is available or
- clarification is required regarding a liability issue.

If this information is not received within (5) business days, the referral will be cancelled without notice, the claimant will be informed of the cancellation in writing and a new referral will need to be submitted.

Priority or traumatic referral tips

Referrals are actioned by Tribunal Services in the order that they are received unless there are exceptional or extenuating circumstances, including where there is potential distress or harm for the worker.

If an Insurer has a referral requiring immediate attention, contact must be made with Tribunal Services and the referral will be considered on a priority basis if evidence of significant financial hardship or risk of significant psychological distress or harm to the worker are provided.

An Insurer should also contact Tribunal Services directly to discuss any worker specific requirements (for example – interpreter) or to flag information on a file of a graphic or sensitive nature.

Helpful referral tips

- If the claim has been recently cancelled or has been to a previous tribunal, the Insurer is only required to attach mandatory documents and any new documents received since that tribunal when re-referring the matter. These must be listed on the new referral form.
- The treating specialist or the specialist who performed surgery is the appropriate specialty for the referral.
- If you don't have all mandatory documents and other documents and information, wait for these before submitting the referral to avoid cancellation.
- The list of injuries and illnesses by tribunal is a helpful document for insurers to use to confirm the type of tribunal to refer to.
- If an Insurer has any queries relating to referring, please contact us on 1300 738 197 before referring.

Further information for insurers referring a worker to the Medical Assessment Tribunal is available on our website.