

WorkCover NSW Claims Estimation Manual

This Manual helps you correctly and proactively estimate claims on WorkCover files.

You must:

- use this manual at the time you make your estimate to determine the estimate that is reasonably likely to arise; and
- always keep your estimate up to date. As new information comes to hand, you must review your estimate—even if one of the set review points is still some time away.

Maintaining correct estimates is vital to ensure that each employer's premium is set at the right level.

The relevant law

This manual applies to claims and initial notifications of injury subject to:

- the *Workers Compensation Act 1987*; and
- the *Workplace Injury Management and Workers Compensation Act 1998*.

Definition of 'claim' in this Manual

In this Manual, a reference to “claim” includes an “initial notification of injury” as defined in section 266 of the *Workplace Injury Management and Workers Compensation Act 1998*.

Start date

This Manual applies to every estimate, and every review of an estimate, that takes place on or after 1 February 2002. That is regardless of the date of the injury and regardless of the date on which the relevant review point falls—what matters is when the review was actually done.

Using this Manual

The Manual sets out:

1. *An approach and process* that you must follow for every claim you estimate—see Part 1, pages 7-21.
2. More detailed separate *requirements for each type of claim*, see Part 2, pages 22-74.

For a detailed *Table of Contents*, see page 3.

Improving this Manual

WorkCover welcomes your comments on how to further improve this Manual. It will be updated and improved as needs be.

Monitoring estimates

WorkCover will continue to monitor estimates through self-audit results, statistical analysis and claim reviews.

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Part 1: Approach and process

Chapter A: Your approach to estimating

1. At all times, you need to take the following approach to estimating claims:
 - 1.1 Estimating claims is an ongoing process so you must keep your estimate up to date—even in between scheduled review points.
 - 1.2 Estimating is to be built in to your organisation's routine claims management and review processes.
 - 1.3 You must use this manual at the time you make your estimate to determine the estimate that is reasonably likely to arise. Your estimate must be based on sound evidence—rather than possibilities and vague understandings.
 - 1.4 Be alert to claims for which you are continually topping-up the estimate. This often indicates that the basis of the estimate is incorrect, that the injury is more severe than first thought, or sometimes, that fraud is involved. Redo the estimate for these claims, check everything carefully.
 - 1.5 You need to pay particular attention to claims involving workers who are off work for more than 12 weeks. Although these claims represent only 20% of all claims, they have the greatest influence on the scheme's costs. WorkCover needs particularly timely and accurate estimates from you to make sure that the employer's premium is correctly calculated.
 - 1.6 You are to ignore the possible effect of inflation when making an estimate. Always use current amounts—see Workers Compensation (Insurance Premiums) Amendment (Cost of Claims) Regulation 2001.
 - 1.7 All amounts in the Manual include GST.
 - 1.8 All amounts in your estimates are to include GST.

Chapter B: **Process for every estimate you make**

Place to start

2. Apart from the initial estimate, each review of an estimate starts with the production of a computer report, or diary note, listing outstanding claims that require review in accordance with the insurer's procedures.

Purpose

3. Although the main purpose of the review is to determine the adequacy of the claims estimate, you must also review at least:
 - That an effective injury management plan is in place and being implemented.
 - The adequacy of the medical information on the file and of the medical information being asked for.
 - Do you need to organise more information: an investigation, rehabilitation, s66 assessment etc?
 - The ongoing file management.
 - Any recovery action: do you need to implement any recovery, or follow it up?
 - Any offer of s66 entitlements to the worker.

Your records—the Work Sheet

4. You must keep clear records of each review showing at least:
 - that the review has been completed.
 - the factors making up the total estimate.
 - any reasons why the estimate is not in accordance with this Manual.
 - the date on which the estimate or review was completed; and
 - your signature or computer identification code.

You are to record the details of your estimate calculations in hard copy on the claim file or by computer record.

The Work Sheet shown on page 9 is a guide -;

CLAIMS OUTSTANDING ESTIMATE WORKSHEET as at
DO NOT INCLUDE ANY PAID AMOUNTS

WorkerDate of Birth
 Date of AccidentExpected Return to Work date.....

1. WEEKLY BENEFITS - Worker or Dependents - incl Death benefits paid under S25 (2)

- a) Compensation payments - Award Rates
 Fromto.....@ \$.....pw x weeks =\$.....
 - b) Compensation payments - Statutory Rates
 Fromto.....@ \$.....pw x weeks =\$.....
 Fromto.....@ \$.....pw x weeks =\$.....
 - c) Compensation payments - Partial
 Fromto.....@ \$.....pw x weeks =\$.....
 Fromto.....@ \$.....pw x weeks =\$.....
- TOTAL WEEKLY BENEFITS \$.....**

2. MEDICAL & ASSOCIATED EXPENSES

- a) Medical, Doctor etc. \$..... x years \$.....
- b) Hospital \$..... x years \$.....
- c) Rehabilitation \$..... x years \$.....
- d) Other \$..... x years \$.....

3. STATUTORY LUMP SUM AWARD

- a) Death Benefits S.25..... \$.....
 S.27 Funeral..... \$.....
 - b) S.66 Disabilities - include interest if applicable (Nil if Common Law Claim) \$.....
 - c) S.67 Pain & Suffering - include interest if applicable \$.....
- SUB TOTAL \$.....**

4. COSTS

- a) Investigation Costs \$.....
 - b) Claimants Legal Costs \$.....
 - c) Our Legal Costs (other than Common Law) \$.....
- SUB TOTAL \$.....**

5. CONTRIBUTION FROM OTHER INSURERS LESS \$.....

6. RECOVERABLE LESS \$.....

7. WORKERS COMPENSATION ESTIMATE SUB - TOTAL \$.....

8. COMMON LAW (refer to Insurer Guideline 98/26) \$.....

LATE NOTIFICATION RULE 28 \$.....
ESTIMATE \$.....

AUTHORISED BY..... DATE.....

Requirements for computer records

5. If the details are recorded only on computer, then the computer must keep an historical record of all the estimates and reviews on the file—including the date on which the estimate or review was prepared and the identification of the authorising officer. WorkCover needs these historical records to determine s170 applications.

Updating records after an estimate is amended

- 5.1 Each time you update an estimate, you need to complete a new claims estimation work sheet and keep a copy: either as a hard copy on file or on computer record.

Factors to consider when calculating an estimate

- 6 Your estimates:
 - Are to ignore the possible effects of inflation when making an estimate. Always use current amounts; and
 - Are to be at least for the amounts specified in this manual.
 - Are to exclude payments already made.

What can the worker claim?

7. The worker can claim the following benefits from WorkCover. Make sure you consider all the relevant benefits for every estimate, and for every review of an estimate. Remember, that as more information comes to light, a worker's entitlements may change.

Be alert; keep your estimate up to date in relation to every potential benefit the worker may receive.

	Description	WC Act 1987 Section
Death	With dependents	25
	With no dependents	27
	Expenses transporting body	28
Weekly Income Support	1st 26 weeks incapacity	36
	After 26 weeks incapacity	37
	Job seeking	38
	Make-up pay	40
Medical, Hospital & Rehab	Ambulance	60
	Dental	
	Hospital	
	Medical or related	
	Artificial aids	
	Pharmaceutical	
	Home care	
	Home modifications	
	Medical treatment	
	Occupational rehabilitation	
	Car travel for treatment	
Interpreter		
Non-economic loss	Permanent impairment	66 & 67
Property Damage	Artificial aids	74
	Damage to clothing	75
Common Law	Common Law	151

Chapter C: **Calculating expenses: medical, hospital, rehabilitation (s 60) and other expenses**

What do you consider when calculating expenses for medical, hospital, rehabilitation etc?

8. When calculating your estimate of future s 60 expenses (medical, hospital, rehabilitation etc.) you must take into account the nature and severity of the injury and the need for, and anticipated costs of, any medical treatment.

Think broadly about the types of medical treatment the worker may need. You should consider at least each of the types listed here:

- physiotherapy
- chiropractic
- other treatment regimes
- treatment provided by general practitioner
- treatment provided by treating specialist/s
- diagnostic and/or radiological services
- pharmaceutical
- travel expenses
- rehabilitation expenses
- hospital accommodation

When you find out about the cost

- 8.1 Often you won't know that your estimate needs to include a particular cost until you receive the invoice for that cost. At that point, review your estimate in light of the new information.

When the treatment is complete

- 8.2 Once the service or treatment is complete and paid for, you don't need to include it in your estimate—unless you receive new information indicating that further expenses or services will be most likely.

For example:

- Once a surgical operation has been performed and the accounts paid, you will generally not need to allow for future

hospital expenses—unless there will be costs for removing fixative devices.

- If a worker has returned to full duties for longer than 4 weeks in a way that is sustained and durable, then you generally will not need to include any allowances for rehabilitation expenses.

Limits for medical expenses and property damage compensation.

8.3 There are maximum payment limits for medical expenses compensation. See sections 61, 62, 63, 63A(3), 76 and 77 of the Workers Compensation Act, 1987. Estimate for the claim not the maximum payment limits.

Section	Rates and limits applicable for....	Limits
61	Medical or related treatment	Refer to WorkCover Benefits Guide issued April and October each year.
62	Hospital treatment	
63	Ambulance service	
63A	Occupational rehabilitation services	
76	Damage to artificial limbs, spectacles	
77	Damage to clothing	

Chapter D: Recoveries

When and where do you include recoveries in your estimate?

9. To include an amount for recovery in your estimate, a staff member with appropriate expertise and experience in relation to recovery must consider that the recovery:
- is clearly apparent;
 - is sustainable at law; and
 - is soundly anticipated.

On that basis, you can include the recovery in your estimate before the party who will pay it has admitted liability to pay it.

You include the amount of recovery on your WorkSheet and on your databases—allocate the amount to the relevant claim.

How much do you include for recovery?

10. Base the amount of recovery allowed for in the estimate on the information available to you. If you have no sound information, allow a 50% recovery estimate. However, if at the 26 week review you still have no clear information on the amount of recovery, then reduce the recovery estimate to zero.

If you receive more up to date information—even after the 26 week review—immediately update your estimate.

To which amounts do you apply the recovery percentage?

11. Apply the recovery percentage to *all parts* of your estimate *but not*:
- investigation costs; and
 - legal costs.

Example 1.

Worker allegedly slipped on foreign substance on shop floor during lunch hour. Exact circumstances unknown therefore the Recovery estimate is nil, pending investigation.

File Estimate - Sub Total	\$40,000
Nil Recovery Allowance	\$0
Gross Estimate	\$40,000

Example 2.

Worker alleges his stationery vehicle has been hit in the rear and is still awaiting the Police Report.

File Estimate - Sub Total	\$10,000
Less 50% Recovery Allowance	<u>\$5,000</u>
	\$5,000
Plus Investigation Estimate	<u>\$1,000</u>
Gross Estimate	\$6,000

Example 3.

During a property inspection the worker fell down an open ditch on third party property. Recovery potential exists.

File Estimate	\$40,000
(after allowing for contributory negligence)	
Investigation	\$2,000
Legal Costs	<u>\$2,000</u>
Gross Estimate	\$44,000
 Recovery Estimate	
File Estimate - Sub Total	\$40,000
Less 50% Recovery Allowance	<u>\$20,000</u>
	\$20,000
Plus Legal Costs Estimate	<u>2,000</u>
	\$22,000
Plus Investigation Costs	<u>\$2,000</u>
Gross Estimate	\$24,000

Chapter E: **Disputed and litigated claims**

Estimates cannot be discounted where a claim is disputed or litigated.

When may the insurer dispute a claim?

- 12 The insurer can dispute the claim:
- as soon as it receives the claim; or
 - at anytime during the management of the claim.

What estimate do you calculate for a disputed claim?

- 12.1 For a disputed claim calculate the estimate the same way you would for a claim that is not disputed, that is include all amounts claimed even if you think you may not have to pay them. Use Part 2 of this manual. Make sure you include an amount for legal and investigation costs, see rule 13.

What if the disputed claim is for common law or work injury damages?

- 12.2 For a common law or work injury damages claim refer to the procedures included in Insurer Guideline 98/26.

How much do you allow in your estimate for dispute related legal costs?

- 13 The Legal Profession Act 1987 requires barristers and solicitors, before providing any legal services to a client, to provide the client with a written disclosure of the basis of the costs (or an estimate of the likely costs) of the legal services concerned. This advice may be used when calculating estimates for legal costs.

Procedure for an “existing claim”

- 13.1 A claim is an “existing claim” if the claim was made before 1/1/2002 and legal proceedings commenced before 1/4/2002.

In your estimate allow at least \$17500 for legal expenses to cover both the employers and workers costs-unless you have sound information that another amount is more accurate.

Procedure for a “new claim”

13.2 A claim is a “new claim” if:

- it is not an existing claim; or
- the claim was made before 1/1/2002 and legal proceedings commenced on or after 1/4/2002.
- the claim is for work injury damages and the claim was made after 1/1/2002 regardless of the date of injury.

The Workers Compensation (General) Amendment (Costs) Regulation 2001 specifies amounts to be charged for legal services for “new claims”, see division 6, clause 148 for more information. To calculate the legal services estimate refer to Compensation Costs Table in this regulation.

A summary of the table follows:

Part 1	Making claim for permanent impairment compensation or pain and suffering compensation
Part 2A	Certain events or activities on <i>behalf of claimant</i> until dispute referred or order sought
Part 2B	Certain activities or events on <i>behalf of insurer</i> until dispute referred or order sought
Part 3	Certain applications for expedited assessment
Part 4	referral of dispute to determination of the dispute
Part 5	Appeal to a Medical Appeal Panel for dispute about degree of permanent impairment
Part 6	Referral of a question of law to President
Part 7	registration of agreement under sec 66A of 1987 Act or a commutation agreement
Part 8	Appeals to Presidential member
Part 9	Any other substantive proceedings before the Commission
	Work Injury Costs Table A
	Work Injury Costs Table B
	Other Work Injury Costs Table

In your estimate allow at least \$10000 for legal expenses to cover both the employers and workers costs -unless you have sound information that another amount is more accurate

Chapter F: Timing of estimates

When do you complete estimates?

14. You need to conduct:
- an immediate initial estimate, see rule 15; and
 - regular ongoing estimates, see rule 16.

This even applies to claims for which recovery is being pursued.

Initial estimates

- 15 You must complete an initial estimate of the claim as soon as you receive the claim or an Initial Notification. However, you don't have to complete the estimate immediately if you have a reasonable excuse as allowed under the WorkCover Guidelines. As soon as that reasonable excuse for not commencing provisional liability is no longer valid, you need to complete the estimate.

What if notification of the injury is delayed?

- 15.1 If the initial notification of the injury is made to the insurer more than 7 days after the worker notified the employer of the injury a minimum of \$3000 is to be estimated. This is the minimum estimate you must allow until the worker has returned to full duties.

Where information indicates \$3000 will not cover the expected cost of the claim then calculate the estimate based on that information.

Examples of the next review point.

- 15.2 If the first time you are notified of the claim is after one of the scheduled review points, then base the estimate on the next review point — see the examples below.

Example 1—next review point is 26 weeks

- If you receive the first notice of a claim 13 weeks after the date of the injury, you calculate the initial estimate as if you were completing a 26 week review. See rules 37 to 40.

You next review the claim at the 26 week review point—or when you receive new information.

Example 2—next review point is 52 weeks

- If you receive the first notice of a claim 10 months after the date of the injury, you calculate the initial estimate as if you were completing a 52 week review. See rules 41 to 45.

You next review the claim at the 52 week review point— or when you receive new information.

Example 3— next review point is 104 weeks.

- If you receive the first notice of a claim for weekly compensation benefits 19 months after the date of their injury, you calculate the initial estimate as if you were completing a 104 week review. See rules 41 to 45.

You next review the claim at the 104 week review point— or when you receive new information.

Ongoing review of estimates

16. You must review estimates:

- within 14 days either side of each of the review points shown below; and
- in between these review points as new information comes to hand.

In the first year

16.1 At the very least, you are to review each open claim you manage:

- 12 weeks after the date of injury;
- 26 weeks after the date of injury; and
- 52 weeks after the date of injury.

After the first year

16.2 At the very least, you are to review each open claim you manage:

- at 52, 78 and 104 weeks after the injury; and
- twice a year after 104 weeks after the injury.

Insurer's choice about timing of reviews in third and later years

16.3 Insurers can choose between 2 methods for deciding when to conduct the reviews in the third and later years. The 2 methods are known as Method A and Method B.

Method A is similar to the method that was compulsory in the past.

Insurers that choose Method A must conduct a review of claims that are still open more than 104 weeks after the date of the injury:

- sometime between 1 March and 31 May; and
- sometime between 1 September and 30 November.

The review must be completed within these periods and cannot be conducted within 14 days either side of the start or finish date of the review period.

Method B was created at the request of insurers that wished to be able to spread the workload more evenly throughout the year.

Insurers that choose Method B must conduct the reviews in the third and later years at ongoing 26 week anniversaries—eg, 156 weeks, 182 weeks and 208 weeks etc. from the date of the injury. As with

reviews in the first 2 years, the review may be conducted within 14 days either side of the relevant anniversary.

For example, if the worker is injured on 1 March, then the week 156 review must take place within 14 days either side of 1 March.

Method A and Method B

Also, there is an extra requirement for all claims for employers with a basic tariff premium of more than \$100,000 and whose period of insurance ends on a date other than 30 June or 31 December. For claims for those employers, insurers must also review the estimates again sometime within 2 months before the end of the employer's current period of insurance.

Annual independent peer reviews

- 17 Each year, an independent person is to comprehensively review every claim file. That person is to conduct the independent review during a scheduled review each year. The independent person is to be a suitably experienced, expert independent claims officer or a senior staff member who is not responsible for the daily management of the file.

The independent review is to examine:

- the estimate;
- the claims administration; and
- the injury management.

Chapter G: Reporting to WorkCover

- 18 Each year by 31 July and 31 January, insurers are required to confirm the following to WorkCover's Insurer Performance Evaluation and Appeals Branch:
- That the regular 26 week ongoing reviews have been completed (under Method B) or ongoing structured claim reviews are proceeding in a timely manner (under Method A). See rules 16.3 and rule 17 on pages 19 and 20 about Method A and Method B.
 - The total number of all outstanding claim files and their total outstanding value as at 30 June and 31 December each year. This includes all claims (not just claims that are still open 104 weeks after the date of injury). Do not include payments already made.
 - The total outstanding value of recoveries (do not include reinsurance recoveries).

Sample letter

- 18.1 The insurer's report to WorkCover can be in the form shown in this sample letter.

The Manager
**Insurer Performance Evaluation
 and Appeals Branch**
 WorkCover
 DX 13067, Market St, Sydney

Dear Sir

Review of Claims as at 30th June or 31st December (insert review period date)

1. We confirm that we have completed the review of claims that are still open more than 104 weeks after the date of the injury.

AND

2. The number of all outstanding claim files (including claims that are still open more than 104 weeks after the date of the injury) and their total outstanding value is as follows:

AND

* number of claims outstanding

* total outstanding value (net of payments already made & recoveries)

.....
 \$.....

Yours faithfully

Part 2: Requirements for each type of claim

Chapter H: How incapacitated is the worker?

Which part of the Manual applies?

19 With the approach and process set out in Part 1 in mind, you need to follow the separate instructions in this Manual that apply depending on whether the worker will be:

- temporarily totally incapacitated, see page 24.
- temporarily or permanently partially incapacitated, **s40**, see page 45.
- temporarily partially incapacitated, **s38**, see page 51.
- permanently totally incapacitated, see page 56.
- hearing impaired, see page 69 or page 71.
- permanently impaired, **s66**, see page 58 or page 65.
- affected by pain and suffering, **s67**, see page 58 or page 65.
- eligible for death benefits, see page 73.

The table on page 23 helps you decide in which of these categories the worker is in—and it refers you to the relevant section of the Manual.

If the worker is ...	then they are ...	and you go to ...
If the worker is unable to perform any work at all—but is expected to be able to return to work at some stage	Temporarily totally incapacitated	page 24
If the worker: <ul style="list-style-type: none"> • can only do some of the work requirements of their previous job; or • is able to continue with all of their duties—but only by working at a slower pace and they are earning less money as a result; or • is employed with different employer and is earning less as a result of the injury • is in receipt of a court award allowing for continuing weekly compensation benefits for partial incapacity. 	Temporarily partially incapacitated or permanently partially incapacitated – Section 40	page 45
If the worker is able to perform work but the employer is unable to offer suitable duties. To be eligible for these entitlements, the worker must have taken reasonable steps: <ul style="list-style-type: none"> • to obtain suitable employment; or • to improve their employment prospects. "Reasonable steps" include: seeking a job, or seeking or receiving rehabilitation training, job retraining or unpaid work trials.	Temporarily partially incapacitated – Section 38	page 51. However, this material applies to the worker only from the date on which their s 38 entitlement commenced
If the worker is (any one or more of the following): <ul style="list-style-type: none"> • unlikely to be re-employed or vocationally retrained • likely to require ongoing care • in receipt of a court award allowing for continuing weekly compensation benefits for total incapacity. 	Permanently totally incapacitated	Page 56
The worker's injury has resulted in a permanent impairment. It doesn't matter whether the injury has reduced their ability to earn.	Permanently impaired – s 66, 67	page 58 or page 65.

Chapter I: Temporary Total Incapacity

Which workers does this section apply to?

20 This section applies to workers:

- who present medical information showing they are totally unable to work; but
- who are expected to be able to return to work at some stage.

Workers covered by this chapter are not yet eligible for claims under section 38, and section 40. So ignore benefits under those sections until the worker becomes eligible for them.

Make sure you also follow the approach and instructions on pages 7-10

Be alert to claims for workers who may be off work for a long time. Identify them early—certainly within the first 26 weeks after the injury.

What weekly compensation payments do you include?

21 When you make an estimate you must always consider the workers capacity for work at the time of the review. You need to include the total amount of weekly compensation payments for the number of weeks the worker is expected to be off work in your estimate.

If the estimate is for.....	then go to rules.....	On page....
The initial estimate	27 to 36	28
12 week review	37 to 40	39
other reviews	41 to 45	42

What medical, hospital and rehabilitation expenses do you include?

22 You need to include medical, hospital and rehabilitation expenses. For all estimates and reviews, use the table shown in the information about that review. Also, take account of the maximum amounts and limits set in sections 61, 62, 63, 63A(3), 76 & 77. See Chapter C on page 12 if you want more information.

How do you increase an estimate that runs out before the next review is due?

- 23 If any estimate is likely to run out at any time because the worker's recovery and return to work has not gone as well as expected, you need to review the claim and estimate.

If the estimate runs out in the first 12 weeks

- 23.1 You need to base your new estimate on the information you have available to you. The information can be gathered from multiple sources; rule 29 suggests where the information could be obtained.

If the estimate runs out after 12 weeks

- 23.2 Check that you have calculated the estimate using this manual for the most recent review. If you have and there is still not enough estimate then base the estimate on the information you have for the scenario most likely to arise for that claim.

If the worker has a recurrence of their injury.

- 23.3 If the worker requires more time off after returning to work and the estimate was reduced as described in rule 24, then use the following table to work out how much to allow in your estimate.

Expected period of incapacity	Weekly Benefits	Medical	Other
Less than 2 weeks	Make the estimate on the scenario most likely to arise for that claim		
More than 2 weeks	Make the estimate using the next review point determined by the date of injury		

When may you reduce an estimate?

- 24 You can reduce an estimate for a claim for Temporary Total Incapacity when the worker returns to full pre-injury duties with no ongoing wage loss. The amount you can reduce the estimate is different depending on how long the worker has been off work from the date of the injury.

If the worker was off work:

- *for 12 weeks or less from the date of injury*, the worker must have returned to work on full hours on pre-injury duties for 2 continuous weeks before you reduce your estimate; or
- *for more than 12 weeks from the date of the injury*, the worker must have returned to work on full duties for 4 continuous weeks before you reduce your estimate.

If the worker has returned to work performing suitable duties (but not on full duties), you review your estimate in the way required for a s40 claim, see Chapter J; page 45.

If the worker has a medical certificate saying they can return to work for suitable duties but none are available, you review your estimate in the way required for a s 38 claim, see Chapter K; page 51.

Examples of insufficient evidence to adjust your estimate

- 24.1 You may not change your estimate on the basis of any of the following:
- unsupported information from any source (including the employer or a rehabilitation provider) that the worker has, or will, return to work on full duties
 - the worker returning to work without the support of the treating doctor —unless the worker has returned to work on full duties for a continuous period of more than 4 weeks
 - surveillance reports.

What if the employer has a Wage Reimbursement Agreement?

- 25 For an employer with a Wage Reimbursement Agreement, as defined in Insurer Guideline 97/46, you may not reduce the estimate without sound written evidence. You must not rely on anecdotal evidence of unsupported information (from any source, including the employer). Without sound evidence, you should tell the employer you will base your estimate on this manual as you cannot rely on their unsupported evidence. This may help encourage the employer to provide you with the sound evidence you need to adjust your estimate.

How do you adjust an estimate if the worker's employment is terminated?

- 26 If a worker who is receiving benefits under s 36 or s 37 has their employment terminated then you must immediately increase your estimate as shown in this table.

Increase the estimate so that the total amount of weekly compensation benefit, including amounts already paid and equals at least the number of weeks in this table.

You must also review the estimate at 78 and 104 weeks and at scheduled reviews; method A or method B. When reviewing the estimate at these reviews the estimate must not be any less than point 3 in this table.

If the worker's employment was terminated ...	increase the total estimate to...
1. up to 26 weeks after the date of their injury	104 weeks of weekly compensation benefits
2. after 26 weeks but before 52 weeks after the date of their injury	The lesser of- 6 years of weekly benefits compensation benefits; or 80% of the period of incapacity from the date of injury to retiring age plus an additional 1 year.
3. after 52 weeks from the date of the injury	The lesser of- 8 years of weekly benefits: or 80% of the period of incapacity from the date of injury to retiring age plus an additional 1 year.

Initial Estimates

- 27 You must complete an initial estimate of the claim as soon as you receive the claim or an Initial Notification. However, you don't have to complete the estimate immediately if you have a reasonable excuse as allowed under the WorkCover Guidelines. As soon as that reasonable excuse for not commencing provisional liability is no longer valid, you need to complete the estimate

What if notification of the injury is delayed?

- 28 If the initial notification of the injury to the insurer is more than 7 days after the worker notified the employer of the injury a minimum of \$3000 is to be estimated. If you have information that indicates \$3000 will not cover the expected cost of the claim then make the estimate using that information.

If the first time you are notified of the injury is after 10 weeks from the date of the injury, then base the estimate on the next review point - see rule 15.2 for examples of the next review point.

How do you estimate what weekly compensation benefits to include?

- 29 For the initial estimate, you need to include the total amount of weekly compensation payments for the number of weeks that the evidence you have suggests the worker will be off work. To do that, you need to gather information from multiple sources including as many of the following as possible:
- The current Injury Management Plan: duration and review dates
 - The current medical certificate: review dates and the expected period of incapacity
 - The anticipated duration of the injury and cost of any return to work plan
 - The anticipated duration and cost of any treatment plan (physiotherapy, chiropractic, osteopathy, psychology, etc.)
 - Any medical reports provided by the treating doctor and any treating specialist
 - Interviews with the employer, worker, doctor and rehabilitation provider
 - Evidence of the employer's previously demonstrated ability to return injured workers to work.
 - any background knowledge you have about the worker (see below)

Worker's background

29.1 When considering the Worker's background, consider:

- their age
- their geographic location
- their pre-injury duties
- their attitude
- their employment history
- prior known claims
- their level of education
- their lifestyle
- any previous similar injury the worker had and how they recovered after those injuries
- the availability of rehabilitation.

If you have no clear evidence about the length of that period, use the period shown in Schedule One for the type of injury the worker has.

If period of incapacity is expected to be less than 12 weeks

29.2 If the period shown in Schedule One for the injury is less than 12 weeks, you must monitor the file during the first 12 weeks and adjust the estimate as needed

If the worker has a recurrence of their injury.

29.3 If the worker requires more time off after returning to work and the estimate was reduced as described in rule 24, then use the following table to work out how much to estimate.

Expected period of incapacity	Weekly Benefits	Medical	Other
Less than 2 weeks	Make the estimate on the scenario most likely to arise for that injury		
More than 2 weeks	Make the estimate using the next review point determined by the date of injury		

Schedule One: **Estimated Injury Recovery Periods**

What is the aim of Schedule One?

- 30 Schedule One provides a guide as to the period of provisional weekly payments that is reasonably likely to arise for each type of injury. You use those periods, with the information specific to the worker's situation, to make your initial estimate.

What if the worker's injury is not listed?

- 31 If the worker's injury is not listed, then base your initial estimate on the scenario that is reasonably likely to arise. You may consider an injury type in schedule one that is similar to the worker's injury.

For example, a worker who has suffered third degree burns is reasonably likely to take more than 12 weeks to recover. So although you may approve provisional payments for the maximum 12 weeks, you need to base your estimate in accordance with the many factors that may influence the worker's recovery and eventual return to work.

What if the worker's experience differs from the expected period?

- 32 The periods for each injury shown in the table represent the optimal time it may take for an injury to heal. The table provides benchmarks that are based on the assumption that the injury is not complicated by multiple medical, physical, psychosocial, cognitive, or environmental factors.

Also, many workers will return to work within the expected recovery period. On the other hand, a few may not.

You need to base your estimate on the sound information you have available to you. Rule 29 suggests some sources of information you can use to make your decision.

How does the availability of suitable duties at the workplace affect the workers estimated return to work?

- 33 The type of injury the worker has and the type of duties available at the workplace will affect the time it takes for a worker to return to work. Some workers with certain injuries may be able to return to some kind of work before they have fully recovered. Some workers will not be able to return to any kind of work until they have fully recovered. You will need to consider this when making your estimate.

For example: A worker with epicondylitis who performs clerical duties may take longer to return to work than a labourer because of the type of duties they perform. The availability of suitable duties is a considerable factor when estimating when a worker is likely to return to work.

Schedule One

INJURY RECOVERY GUIDE

BODILY LOCATION and INJURY TYPE	EXPECTED PERIOD of RECOVERY
<p>GROUP 1: HEAD (includes cranium, eye, ear, mouth, nose and face)</p> <p style="padding-left: 40px;">Fracture of skull (without brain injury) 6 weeks Fracture of jaw (without dislocation) 6 weeks Fracture-dislocation of jaw 12 weeks Concussion 1 week</p> <p>Serious head injuries (including closed/open head and brain injuries, severe facial injuries involving face, nose and/or ear) Refer to Chapter L</p> <p style="text-align: right;">Eye:</p> <p style="padding-left: 40px;">i. Major burn/thermal injury 26 weeks ii. Moderate thermal or chemical burn 6 weeks iii. Foreign body (corneal) and abrasions 2 weeks iv. Foreign body (intraocular) 6 weeks v. Conjunctivitis/chemical irritation 1 week vi. Contusions/bruising 1 week vii. Retinal detachment 6 weeks</p> <p style="text-align: right;">Ear:</p> <p style="padding-left: 40px;">i. Perforated ear drum 2 weeks</p>	
<p>GROUP 2: NECK</p> <p style="padding-left: 40px;">Whiplash associated disorder (WAD)</p> <p style="padding-left: 80px;">i. WAD without radicular pain 4 weeks ii. WAD with radicular pain 12 weeks</p> <p style="padding-left: 40px;">Contusion/bruising/sprains 4 weeks</p> <p style="text-align: right;">Fracture:</p> <p style="padding-left: 40px;">i. to vertebral body 12 weeks ii. to spinous or transverse process 6 weeks</p> <ul style="list-style-type: none"> • Fracture – dislocation 26 weeks • Fracture with spinal cord injury Refer to Chapter L 	

GROUP 3: TRUNK	
(includes upper/lower back, chest, abdomen and pelvic region)	
Acute or recurrent back pain (non-radicular)	4 weeks
Radicular back pain	12 weeks
Fracture:	
of vertebral body	12 weeks
of transverse or spinous process	6 weeks
of sacrum	4 weeks
of coccyx	4 weeks
Contusion/bruising	4 weeks
(upper/lower back)	
Chest/thorax	
Closed rib fracture	4 weeks
Fracture with complications (eg: pneumothorax)	12 weeks
Contusion	1 week
Strain – intercostal muscles	1 week
Abdomen and pelvic region	
Hernia with repair by suture	8 weeks
Hernia with tension free or laparoscopic repair	4 weeks
Fracture of pelvis (without surgery)	12 weeks
Fracture of pelvis (with surgery)	26 weeks

GROUP 4: UPPER LIMB (including shoulder)	
Shoulder:	
Dislocation/subluxation (initial)	6 weeks
Dislocation/subluxation (recurrent)	10 weeks
Rotator cuff /scapular muscle (cumulative injury)	8 weeks
Rotator cuff/scapular muscles (traumatic injury)	12 weeks
Synovitis/tendonitis/ligament sprain	6 weeks
Other sprains/strains/contusions	4 weeks
Fracture – simple	8 weeks
Fracture – complex (no surgery)	12 weeks
Fracture – complex (with surgery)	16 weeks
Bursitis/impingement syndrome	8 weeks
Traumatic arthritis (acute)	6 weeks
Upper arm	
Fractured humerus	8 weeks
Tendon rupture	12 weeks
Tendonitis/sprain/contusion	6 weeks
Elbow	
Epicondylitis/bursitis/sprains	6 weeks
Fracture – simple	8 weeks
Complex fracture/fracture-dislocation	12 weeks
Ulnar nerve entrapment	12 weeks
Traumatic arthritis (acute)	6 weeks
Forearm	
Fracture – proximal radius/ulna	8 weeks
Sprain/contusion	4 weeks
Wrist flexor/extensor tendon rupture	12 weeks
Wrist	
Tenosynovitis/sprain/contusion	6 weeks
Fracture – scaphoid	12 weeks
Fracture – carpal (not scaphoid)	8 weeks
Carpal tunnel syndrome	8 weeks
Fracture-dislocation	12 weeks
Traumatic arthritis (acute)	6 weeks
Hands/fingers/thumb	
Fracture – simple (metacarpals/phalanges)	6 weeks
Fracture – complex with surgery	12 weeks
Sprain/contusion – finger/thumb	4 weeks
Tenosynovitis/De Quervain syndrome	6 weeks
Tendon rupture	12 weeks
Traumatic amputation - finger	12 weeks

GROUP 5: LOWER LIMB (including hip)	
Hip	
Fracture/dislocation (no surgery)	12 weeks
Fracture/dislocation (with surgery)	20 weeks
Tendonitis/bursitis	6 weeks
Traumatic arthritis (acute)	6 weeks
Sprain/contusion	4 weeks
Total hip replacement	26 weeks
Upper leg	
Thigh muscle strain	2 weeks
Fractured femur	12 weeks
Traumatic amputation	Refer to Chapter L
Knee	
Fracture – simple	8 weeks
Fracture – complex (with surgery)	26 weeks
Dislocation (patellar)	8 weeks
Knee replacement	26 weeks
Sprain/contusion (collateral ligaments)	4 weeks
Cruciate ligament sprain	6 weeks
Cruciate ligament rupture (with surgery)	12 weeks
Meniscus injury with surgery	6 weeks
Patellar tendonitis	4 weeks
Patellar bursitis	8 weeks
Patellar disorders	5 weeks
Traumatic arthritis (acute)	6 weeks
Lower leg	
Tendonitis –(incl Achilles tendonitis)	6 weeks
Fracture – tibia	12 weeks
Fracture – fibula	8 weeks
Achilles rupture	20 weeks
Ankle	
Fracture – simple	8 weeks
Fracture – complex (with/without dislocation)	12 weeks
Sprain/contusion	4 weeks
Traumatic arthritis (acute)	6 weeks
Foot/toes	
Fracture – tarsal/metatarsal	8 weeks
Fracture – phalanges	6 weeks
Sprain/contusion	4 weeks
Plantar fasciitis	6 weeks
Traumatic arthritis	6 weeks
Traumatic amputation – toe	12 weeks

<p>GROUP 6: NON-PHYSICAL LOCATIONS</p> <p>Psychological system including: Anxiety-related disorders Depressive disorders Adjustment disorders</p>	12 weeks
<p>GROUP 7: OTHER INJURIES/DISEASES</p> <p>Toxic reactions (eg: bee sting)</p> <p>Paraplegia</p> <p>Quadriplegia</p> <p>Skin diseases (eg: reactive dermatitis)</p> <p>Burns (localised on limb/hand/foot/trunk/face) First degree Second degree Third degree Severe burns (multiple locations)</p> <p>Peripheral nerve injuries</p> <p>Lacerations/puncture wounds Simple Complex (nerves or tendons involved)</p> <p>Infection Superficial Deep</p>	<p>1 week</p> <p>Refer to Chapter L</p> <p>Refer to Chapter L</p> <p>4 weeks</p> <p>4 weeks 6 weeks 26 weeks Refer to Chapter L</p> <p>12 weeks</p> <p>1 week 12 weeks</p> <p>2 weeks 8 weeks</p>

What medical, hospital and rehabilitation expenses do you include?

- 34 You need to include medical, hospital and rehabilitation expenses. For the initial estimate, use the amounts shown in the table here-unless you have information that some other amount is more appropriate. In which case, use that amount. Rule 29 suggests some sources of information you can use to make your decision.

Table of medical, hospital and rehabilitation expenses for initial estimate of Temporary Total Incapacity

	Non significant injuries < 7 days incapacity				Significant injuries > or = 7 days incapacity		
	Level 1 No time loss		Level 2 Minor claim Anticipated time loss Less than 7 calendar days		Level 3 Injuries involving soft tissue, musculo- ligamentous, simple fractures etc but excluding those requiring surgery.	Level 4 Operative treatment	Level 5 Permanently totally incapacitated
	No indication that ongoing treatment required	Indication that ongoing treatment required (Note 2)	No indication that ongoing treatment required	Indication that ongoing treatment required (Note 2)			
Medical & Treatment	\$550	\$1,000	\$700	\$1,000	\$2,500	\$5,000	Refer Chapter L
Hospital	Usually nil but if these services are required allow at least: <ul style="list-style-type: none"> • For medical & treatment, \$1500 • For rehabilitation, \$2000 • For hospital, \$5000 					\$5000	Refer Chapter L
Rehabilitation	Usually nil but if these services are required allow at least: <ul style="list-style-type: none"> • For medical & treatment, \$1500 • For rehabilitation, \$2000 • For hospital, \$5000 				\$2000	\$2000	Refer Chapter L

Note 2

Ongoing treatment means physiotherapy, chiropractic, osteopathic, remedial massage and the like.

What happens if any amount in the table in rule 34 is exceeded in first 12 weeks?

34.1 If any amount in the table in rule 34 is exceeded in the first 12 weeks, then review the initial assessment of the claim and re-estimate the claim and consider information to hand including:

- current work status
- need for future treatment and anticipated costs
- information available from injury management plans.

A simple way to review the estimate for these amounts is:

- for Level 1 and Level 2 claims, re-estimate them to allow at least the amounts shown for Level 3
- for Level 3 claims, re-estimate them to allow at least the amounts shown for Level 4
- for Level 4 claims, re-estimate them to allow at least the amounts shown for the 12-week review.

What medical or other investigation expenses (including factuials) should you allow?

35 If you expect that medical or other investigations may be required, allow at least \$2,000 for each claim—and review the allowance as you receive more information.

Injury Management Consultant fees are to be estimated as medical and treatment costs.

What else do you need to review?

36 You also need to consider these matters when making the initial estimate:

- check that an effective injury management plan is in place and being implemented.
- medical or other investigations—if any are likely, allow at least \$2,000, but review as new information comes to hand
- Recovery Action, see Chapter D on page 14.
- Permanent Impairment - see Chapter M on page 58 or Chapter N on page 65.
- Expected legal expenses – refer to Chapter E: Disputed and litigated claims on page 16.

Also, make sure you follow the approach and instructions on pages 7-11.

12-week review

What do you do at the 12-week review?

37 At the 12 week review:

- If the worker has returned to work on full duties with no expected wage loss, see 37.1
- If the worker remains totally incapacitated and has not returned to work, see 37.2 or 37.3
- If the worker has an injury for which the initial expected time off work is greater than 12 weeks, see 37.3
- If the worker's employment has been terminated, see 37.4.
- If the worker has returned to work but suffers ongoing wage loss, see the procedures for a Section 40 estimate; Chapter J: page 45.
- If the worker is able to perform duties but the employer is unable to offer suitable duties, see the procedures for a Section 38 estimate; Chapter K: page 51.

The worker has returned to work on full duties with no expected wage loss

37.1 If the worker has returned to work on full duties for at least 2 or 4 weeks (see Rule 24.1 about evidence that is not sufficient) with no expected wage loss, you must review the estimate and consider:

- any possible future incapacity—eg, future surgery, time loss for ongoing treatment, removal of internal fixatives, etc.
- medical or rehabilitation costs;
- possible permanent impairment entitlements, see Chapter M on page 58 or Chapter N on page 65.

Also, consider diarising the file for possible closure.

The worker has not returned to work even though the initial expected time off work was *less than 12 weeks*

37.2 If the worker remains totally incapacitated and has not returned to work even though the initial expected time off work was less than 12 weeks, then increase the estimate so that the total amount of weekly compensation benefit, including amounts already paid and expected to be paid, equals at least 52 weeks of incapacity. Also review the amount of compensation the worker should be receiving for each week they are off work—use the new amount to calculate the estimate.

Then diarise to review at 26 weeks—or earlier if appropriate.

The worker has not returned to work and the initial expected time off work is *greater than 12 weeks*

37.3 If the worker has an injury for which the initial expected time off work is greater than 12 weeks, you must diarise to review the estimate at the end of that period. (That review is regarded as part of the 12 week review.)

At that point, review the estimate as follows, if the worker is totally unfit for their pre-injury duties, increase the estimate so that the total amount of weekly compensation benefit, including amounts already paid and expected to be paid, equals at least 52 weeks of incapacity.

However, if you have sound evidence that some other outcome is more likely, then proceed on the basis of that more likely outcome—see rule 24.1 about evidence that is not sufficient.

Then diarise to review at 26 weeks—or earlier if appropriate.

If the worker's employment has been terminated.

37.4 If the worker's employment has been terminated:

- increase the estimate for weekly benefits to a total 104 weeks; and
- if the worker becomes able to work, and therefore entitled to s40 benefits, see Chapter J: page 45 or s38 benefits, see Chapter K: page 51.

Then diarise to review at 26 weeks—or earlier if appropriate.

What medical, hospital and rehabilitation expenses do you include?

- 38 When you calculate medical, hospital and rehabilitation expenses at the 12 week review, use the table here, and increase the estimate to at least that amount unless you have sound evidence (see rule 24.1 about evidence that is not sufficient) that another amount is more appropriate. In which case, use that amount.

Table of medical, hospital and rehabilitation expenses for 12 week review of estimate of Temporary Total Incapacity		
Description	Worker Back at Work	Worker Not Back at Work
Medical & treatment	\$1,500	\$3,000
Hospital	Usually NIL. If required allow at least \$5000	Usually NIL. If required allow at least \$5000
Rehabilitation	Usually NIL If required allow at least \$2000	\$2,000

What medical or other investigation expenses (including factuials) should you allow?

- 39 If you expect that medical or other investigations may be required, allow at least \$2,000 for each claim—and review the allowance as you receive more information.

Injury Management Consultant fees are to be estimated as medical and treatment costs.

What else do you need to review?

- 40 You also need to consider these matters when reviewing the estimate:
- check that an effective injury management plan is in place and being implemented.
 - check the Weekly Wage Rate – review from information included in the claim form and adjust if required.
 - any advances in the worker’s rehabilitation and potential for return to alternative forms of employment or Section 53 Vocational Re-education.
 - Permanent Impairment-see Chapter M on page 58 or Chapter N on page 65.
 - Recovery Action, see Chapter D on page 14.
 - Expected legal expenses – see Chapter E; Disputed and Litigated claims on page 16.

Also, make sure you follow the approach and instructions on pages 7-11.

26, 52, 78, 104 weeks and later reviews

Be alert ...

The costs of the WorkCover scheme are largely influenced by the 13% of workers who are unable to return to work within 26 weeks. It is vital that:

- you manage these claims carefully; and
- that you make sure your estimates are up to date and accurate.

What do you do at the review?

41 At this review:

- If the worker has returned to work on full duties with no expected wage loss, see rule 37.1
- If the worker remains totally incapacitated and has not returned to work, see rule 41.1.
- If the worker has been terminated refer to table in rule 26.
- If the worker has returned to work but suffers ongoing wage loss, see Section 40 estimates, Chapter J on page 45.
- If the worker is able to perform duties but the employer is unable to offer suitable duties, see Section 38 estimates, Chapter K on page 51.

The worker remains totally incapacitated and has not returned to work

41.1 If the worker remains totally incapacitated and has not returned to work, then increase the estimate so that the total amount of weekly compensation benefit, including amounts already paid and expected to be paid, covers the period:

26 week review.

- at least 130 weeks of incapacity.

52 & 78 week review. The lesser of

- at least 6 years of incapacity from the date of injury; or
- 80% of the period of incapacity from the date of injury to retiring age plus an additional one year.

104 week and later reviews. The lesser of

- at least 8 years of incapacity; or
- 80% of the period of incapacity from the date of injury to retiring age plus an additional one year.

What medical, hospital and rehabilitation expenses do you include?

- 42 When you calculate medical, hospital and rehabilitation expenses at the review, use the table here and increase the estimate to at least that amount—unless you have sound evidence (see rule 24.1 about evidence that is not sufficient) that another amount is more appropriate, in which case, use that amount. Also, take account of the maximum amounts in sections 61, 62, 63, 63A(3), 76 & 77.

Table of medical, hospital and rehabilitation expenses for 26 week and subsequent reviews of estimate of Temporary Total Incapacity		
Description	Worker Back at Work	Worker Not Back at Work
Medical & treatment	\$1,500	\$3,000 per year of estimated incapacity
Hospital	Usually NIL If required allow \$5000	Usually NIL. If required allow \$5000
Rehabilitation	Usually NIL If required allow \$2000	\$2,000

What medical or other investigation expenses (including factual) should you allow?

- 43 If you expect that medical or other investigations may be required, allow at least \$2,000 for each claim—and review the allowance as you receive more information.

Injury Management Consultant fees are to be estimated as medical treatment and costs.

What if a payment discontinuance notice has been issued to the worker?

- 44 If a payment discontinuance notice has been issued to the worker (see s52A), then maintain the estimate for weekly compensation benefits for at least 6 months after the date that notice was issued to the worker. If the worker has not responded within 6 months, then consider whether to reduce the estimate or finalise the claim.

What else do you need to review?

- 45 You also need to consider these matters when reviewing the estimate:
- check that an effective injury management plan is in place and being implemented.
 - check the Weekly Wage Rate and adjust if required – consider s37 – use the new amount to calculate the estimate.
 - any advances in the worker’s rehabilitation and potential for return to alternative forms of employment or Section 53 Vocational Re-education.
 - Permanent Impairment – see Chapter M on page 58 or Chapter N on page 65.
 - Recovery Action – see Chapter D on page 14.
 - expected legal expenses-see Chapter E: Disputed and litigated claims on page 16.

Also, make sure you follow the approach and instructions on pages 7-11

Chapter J: **Temporary and Permanent Partial Incapacity—S 40**

Which workers does this section apply to?

- 46 This section applies to workers who, because of the injury, are now earning less than they were earning before the injury. The payments are to make up the difference. The worker may be:
- working for the same employer, or a different employer;
 - performing different duties;
 - performing similar duties but at a lower rate of pay; or
 - performing pre-injury duties but working less hours; or
 - is in receipt of a court award allowing for continuing weekly compensation benefits for partial incapacity.

Make sure you also follow the approach and instructions on pages 7-11.

When do you need to include s 40 entitlements in your estimate?

- 47 You need to include s 40 entitlements in your estimate from as soon as the worker is entitled to them.

What do you base your estimate on?

- 48 If the actual economic loss is known or can be reasonably assessed, then base your estimate on that amount. Otherwise, use a weekly benefit of at least \$250—and review that estimate as you receive more information.

Employers and workers may provide information about the pre-injury award rate to an insurer to assess the actual economic loss. This information may be required for the initial assessment of loss or if ongoing benefits are being paid to a worker.

How long should you estimate S40 payments for?

- 48.1 In your initial s40 estimate, allow for payments to cover the period that you expect the worker to be entitled to s 40 benefits on the basis of the sound evidence you have. However, if you do not have any sound evidence, then use the period shown in this table:

If the worker resumed selected duties ...	Initial s40 estimate
less than 4 weeks after the injury	at least 4 weeks of entitlement
more than 4, but less than 8 weeks after the injury	at least 8 weeks of entitlement
more than 8, but less than 12 weeks after the injury	at least 12 weeks of entitlement
more than 12, but less than 26 weeks after the injury	at least 26 weeks of entitlement
more than 26, but less than 52 weeks after the injury	at least 52 weeks of entitlement
more than 52 after the injury	at least 104 weeks of entitlement

What if the worker or employer does not claim s 40 entitlements?

- 48.2 If the worker is entitled to s 40 benefits, then you include them in your estimate regardless of whether or not the employer is claiming those benefits.

Your obligations continue until the claim is finalised and the employer's liability is extinguished. That can't happen until the insurer has reimbursed the employer. So you need to get the payment information from the employer and allow for the relevant liability in your estimate. See Insurer Guideline 95/24.

What if a court has awarded a Continuing Award?

- 48.3 If a court has awarded a Continuing Award, calculate the estimate on the basis that it will be paid to the worker until one year after their retiring age. Also include any amounts that should have been paid to the worker in the past, but that have not yet been paid.

If the Award is altered or rescinded, update your estimate.

When do you review estimates for s 40 payments?

- 49 You must review estimates 12 weeks after the injury, and again at 26 weeks, 52 weeks, 78 weeks and 104 weeks after the injury. After 104 weeks you must review the estimate at least every 6 months in line with the indexation of statutory benefits every April and October.

At those reviews, base your estimate on the following table:

If the worker is still eligible for s 40 benefits ...	include in your estimate an amount equal to ...
At the review 12 weeks after the injury	At least 52 weeks at the benefit rate
at the review 26 weeks after the injury	At least 52 weeks at the benefit rate
at the review 52 weeks after the injury	At least 104 weeks at the benefit rate
At the review 78 weeks after the injury	At least 78 weeks at the benefit rate. <i>If s40 52 week review was completed no additional weekly benefit estimate increase is required.</i>
at the review 104 weeks after the injury and any subsequent review	The lesser of another 6 years at the benefit rate; or 80% of the period of incapacity from date of injury to retirement age + 1 additional year.

What do you consider in a review?

- 50 When you review a s 40 payments estimate:
- check the weekly rate being paid is correct. Consider the indexation of statutory benefits every April and October, and any increase in applicable pre-injury award rates.
 - consider information available from injury management plans, return to work plans, and rehabilitation plans
 - consider the possibility of an earlier return to normal duties without economic loss
 - consider a fundamental increase/decrease in the worker's actual economic loss
 - consider a change in the worker's medical condition
 - consider possible periods of future incapacity
 - need for further treatment.

What medical, hospital and rehabilitation expenses do you include?

- 51 When you calculate medical, hospital and rehabilitation expenses at the review, use the table here and increase the estimate to at least that amount—unless you have sound evidence (see rule 56.1 about evidence that is not sufficient) that another amount is more appropriate, in which case, use that amount.

Also, take account of the maximum amounts in sections 61,62, 63, 63A(3), 76 & 77.

Table of medical, hospital and rehabilitation expenses for section 40 reviews	
Description	Worker Back at Work
Medical & treatment	\$1,500 plus \$1500 for each year of estimated incapacity
Hospital	Usually NIL If required allow \$5000
Rehabilitation	Usually NIL If required allow \$2000

What medical or other investigation expenses (including factual) should you allow?

- 52 If you expect that any medical or other investigation will be required, allow at least \$2,000 for each claim—and review the allowance as you receive more information.

Injury Management Consultant Fees are to be estimated as medical treatment costs.

What if the worker becomes totally incapacitated?

- 53 If the worker becomes totally incapacitated, then you just immediately increase the estimate on the basis of Temporary Total Incapacity, see Chapter I, page 24.

What if the employer is unable to provide suitable duties?

- 54 If the employer is unable to provide suitable duties for the worker, then you just immediately increase the estimate on the basis of s 38 entitlements, see Chapter K: page 51.

What if a payment discontinuance notice has been issued to the worker?

- 55 If a payment discontinuance notice has been issued to the worker (see s 52A), then maintain the estimate for weekly compensation benefits for at least 6 months after the date that notice was issued to the worker. If the worker has not responded within 6 months, then consider whether to reduce the estimate or finalise the claim.

When may you reduce an estimate?

- 56 You can reduce an estimate for a claim for section 40 entitlements when the worker returns to full pre-injury duties with no ongoing wage loss. The amount you can reduce the estimate is different depending on how long the worker has been off work from the date of the injury.

If the worker was off work:

- *for 12 weeks or less from the date of injury*, the worker must have returned to work on full hours on pre-injury duties for 2 continuous weeks before you reduce your estimate; or
- *for more than 12 weeks from the date of the injury*, the worker must have returned to work on full duties for 4 continuous weeks before you reduce your estimate.

If the worker has a medical certificate saying they can return to work for suitable duties but none are available, you review your estimate in the way required for a s 38 claim, see Chapter K: page 51.

Examples of insufficient evidence to adjust your estimate

- 56.1 You may not change your estimate on the basis of any of the following:
- unsupported information from any source (including the employer or a rehabilitation provider) that the worker has, or will, return to work on full duties
 - the worker returning to work without the support of the treating doctor —unless the worker has returned to work on full duties for a continuous period of more than 4 weeks
 - surveillance reports.

What if the worker's employment is terminated?

57 If the worker's employment is terminated then increase the estimate as shown in this table.

Increase the estimate so that the total amount of weekly compensation benefit, including amounts already paid and equals at least the number of weeks in this table.

You must also review the estimate at 78 and 104 weeks and at scheduled reviews; method A or method B. When reviewing the estimate at these reviews the estimate must not be any less than point 3 in this table.

If the worker's employment was terminated ...	increase the total estimate to...
1. up to 26 weeks after the date of their injury	104 weeks of weekly compensation benefits
2. after 26 weeks but before 52 weeks after the date of their injury	The lesser of... 6 years of weekly benefits compensation benefits; or 80% of the period of incapacity from the date of injury to retiring age plus an additional 1 year.
3. after 52 weeks from the date of the injury	The lesser of... 8 years of weekly benefits: or 80% of the period of incapacity from the date of injury to retiring age plus an additional 1 year.

What else do you need to review?

58 You also need to consider these matters when reviewing the estimate:

- check that an effective injury management plan is in place and being implemented.
- review the weekly wage rate and consider s37; use the new amount to calculate the estimate.
- any advances in the worker's rehabilitation and potential for return to alternative forms of employment or Section 53 Vocational Re-education.
- Permanent Impairment, see Chapter M on page 58 or Chapter N on page 65.
- Recovery Action, see Chapter D on page 14.
- expected legal expenses – see chapter E: Disputed and litigated claims on page 16.

Also, make sure you follow the approach and instructions on pages 7-11.

Chapter K: Temporary Partial Incapacity—S 38

Which workers does this section apply to?

59 This section applies to workers:

- who are able to work; but
- whose employers are unable to provide them with suitable duties.

The worker is entitled to this compensation if they have taken reasonable steps to obtain suitable employment, including any of the following that are reasonably necessary to improve the worker's job prospects:

- seeking or receiving rehabilitation
- seeking a job
- job retraining
- unpaid work trials.

Make sure you also follow the approach and instructions on pages 7-11.

For how long are workers entitled to receive this compensation?

60 Workers can receive weekly compensation for Temporary Partial Incapacity:

- for up to 104 weeks if they first became entitled to benefits *before* 1 August 1998; or
- for up to 52 weeks if they first became entitled to benefits *on or after* 1 August 1998.

When do you review estimates for s 38 claims?

61 Section 38 claims are to be reviewed at 26, 52, 78 and 104 weeks from the date of injury and at 6 month intervals after that if s38 benefits are still being paid. Calculate the estimate using the table in rule 62 for initial and later estimates.

What do you base your estimate on?

62 Base your estimate of the workers s38 entitlements on this table:

If the worker is entitled to s 38 benefits ...	allow ...
less than 26 weeks after the date of the injury	at least 52 weeks of weekly compensation at the appropriate rates <i>This can include up to 52 weeks of s38 entitlements</i>
more than 26 weeks, but less than 52 weeks, after the date of the injury	at least 130 weeks of weekly compensation benefits at the appropriate rates. <i>This can include up to 52 weeks of s38 entitlements</i>
more than 52 weeks, but less than 104 weeks, after the date of the injury	The lesser of <ul style="list-style-type: none"> • 6 years of weekly compensation benefits at the appropriate rates; or • 80% of weekly compensation at the appropriate rates for the period from the injury to retiring age plus one year <i>This can include up to 52 or 104 weeks of s 38 entitlements – see rule 60</i>
More than 104 weeks after the date of the injury	The lesser of <ul style="list-style-type: none"> • 8 years of weekly compensation benefits at the appropriate rates; or • 80% of weekly compensation at the appropriate rates for the period from the injury to retiring age plus one year <i>This can include up to 52 or 104 weeks of s 38 entitlements –see rule 60</i>

What medical, hospital and rehabilitation expenses do you include?

- 63 When you calculate medical, hospital and rehabilitation expenses at the review, use the table here and increase the estimate to at least that amount—unless you have sound evidence (see rule 26.1) that another amount is more appropriate, in which case, use that amount. Also, take account of the maximum amounts in sections 61,62, 63, 63A(3), 76 & 77.

Description	Worker Not Back at Work
Medical & treatment	\$3,000 per year of estimated incapacity
Hospital	Usually NIL. If required allow \$5000
Rehabilitation	\$2,000

What medical or other investigation expenses (including factual) should you allow?

- 64 If you expect that medical or other investigations may be required, allow at least \$2,000 for each claim—and review the allowance as you receive more information.

Injury Management Consultant Fees are to be estimated as medical treatment costs.

What if a payment discontinuance notice has been issued to the worker?

- 65 If a payment discontinuance notice has been issued to the worker (see s 52A), then maintain the estimate for weekly compensation benefits for at least 6 months after the date that notice was issued to the worker. If the worker has not responded within 6 months, then consider whether to reduce the estimate or finalise the claim

When may you reduce an estimate?

66 You can reduce an estimate for a claim where the worker is claiming s38 entitlements when the worker returns to full pre-injury duties with no ongoing wage loss. The amount you can reduce the estimate is different depending on how long the worker has been off work from the date of the injury.

If the worker was off work:

- *for 12 weeks or less from the date of injury*, the worker must have returned to work on full duties for 2 continuous weeks before you reduce your estimate; or
- *for more than 12 weeks from the date of injury*, the worker must have returned to work on full duties for 4 continuous weeks before you reduce your estimate.

If the worker has a medical certificate saying they can return to work for suitable duties and the employer makes the duties available for the worker, you review your estimate in the way required for a s40 claim, see Chapter J: page 45.

Examples of insufficient evidence to adjust your estimate

66.1 You may not change your estimate on the basis of any of the following:

- unsupported information from any source (including the employer or a rehabilitation provider) that the worker has, or will, return to work on full duties
- the worker returning to work without the support of the treating doctor —unless the worker has returned to work on full duties for a continuous period of more than 4 weeks
- surveillance reports.

What if the worker's employment is terminated?

67 If the worker's employment is terminated then increase the estimate as shown in this table.

Increase the estimate so that the total amount of weekly compensation benefit, including amounts already paid and equals at least the number of weeks in this table.

You must also review the estimate at 78 and 104 weeks and at scheduled reviews; method A or method B. When reviewing the estimate at these reviews the estimate must not be any less than point 3 in this table.

If the worker's employment was terminated ...	increase the total estimate to...
1. up to 26 weeks after the date of their injury	104 weeks of weekly compensation benefits
2. after 26 weeks but before 52 weeks after the date of their injury	The lesser of: 6 years of weekly benefits compensation benefits; or 80% of the period of incapacity from the date of injury to retiring age plus an additional 1 year.
3. after 52 weeks from the date of the injury	The lesser of 8 years of weekly benefits: or 80% of the period of incapacity from the date of injury to retiring age plus an additional 1 year.

What else do you need to review?

68 You also need to consider these matters when reviewing the estimate:

- check that an effective injury management plan is in place and being implemented.
- check the Weekly Wage Rate and adjust if required – consider s37 – use the new amount to calculate the estimate.
- advances in the worker's rehabilitation and potential for return to alternative employment or Section 53 Vocational re-education.
- Permanent Impairment , see Chapter M on page 58 or Chapter N on page 65.
- Recovery Action, see Chapter D on page 14.
- expected legal expenses – see chapter E; Disputed and Litigated claims on page 16.

Also, make sure you follow the approach and instructions on pages 7-11.

Chapter L: Permanent Total Incapacity

Which workers does this section apply to?

69 This section applies to workers who are (any one or more of the following):

- unlikely to be re-employed or vocationally retrained
- likely to require ongoing hospitalisation, nursing home residence, or home care
- in receipt of a court award allowing for continuing weekly compensation benefits for total incapacity.

Make sure you also follow the approach and instructions on pages 7-11.

What weekly compensation payments do you include?

70 In your estimate, you need to include the total amount of weekly compensation payments that will be paid to the worker until one year after they reach retirement age.

What medical and hospital expenses do you include?

71 You need to include:

- *for workers who are permanently hospitalised*, at least \$150,000 a year for the worker's life expectancy
- *for workers in nursing homes*, at least \$75,000 a year for the worker's life expectancy
- *for workers needing home care*, at least \$35,000 a year for the worker's life expectancy.

If you have any information showing that any of the above amounts is too low, then increase the amount for your estimate. Also, take account of the maximum amounts in sections 61,62, 63, 63A(3), 76 & 77.

For more information see Chapter C: Calculating medical, hospital and rehabilitation expenses on page 12.

What else do you need to review?

- 72 You also need to consider these matters when calculating the estimate:
- Permanent Impairment, Sect. 66, Workers Compensation Act 1987, see Chapter M on page 58 or Chapter N on page 65.
 - Pain & Suffering, Sect. 67, Workers Compensation Act 1987, see Chapter M on page 58 or Chapter N on page 65.
 - Recovery Action, Section 151Z, Workers Compensation Act 1987, see Chapter D on page 14.
 - sundry expenditure, travel, house alterations etc. Allow at least \$150,000—more if you have information showing that more will be required.
 - medical or other investigations—if any are likely, allow at least \$10,000, but review as new information comes to hand
 - expected legal expenses—see Chapter E: Disputed and Litigated Claims: page 16.
 - any other entitlements the worker may be eligible for, see the table in rule 7.

Also, make sure you follow the approach and instructions on pages 7-11, relevant to this level of incapacity.

Chapter M: Permanent impairment—s 66
(for injuries before 1 January 2002,
 for injuries *on or after* that date, see Chapter N)

&

Pain and suffering entitlements—s 67
(for injuries before 1 January 2002,
 for injuries *on or after* that date, see Chapter N)

Which injuries does this chapter apply to?

- 73 This chapter applies to workers who suffered an injury before 1 January 2002:
- if the injury leaves them permanently impaired; and
 - if the workers entitlement to permanent impairment benefits under s66(1) is for more than 10% of the maximum allowed then they are entitled to compensation for their pain and suffering; or
 - if the claim is for permanent loss of hearing refer to Chapter O on page 68.

Do you have to tell workers they may be entitled to S 66 or 67 benefits?

- 74 Insurers must point out to a worker any entitlement the worker may have to s66 or s 67 benefits. This helps reduce legal costs.

When do you make an estimate for S66 and s67 entitlements?

- 75 Insurers must estimate for a permanent impairment loss when it is *reasonably likely to arise*. This must be done at the initial estimate for temporary or partial incapacity or when the worker makes a separate claim for a section 66 benefit. Insurers must notify the worker they may have an entitlement to s 66 or s 67 benefits as soon as the insurer is aware. This helps reduce legal costs.

Make sure you also follow the approach and instructions on pages 7-11.

What injury types should be considered for a possible S66 entitlement?

75.1 As a guide a section 66 estimate should be considered for the following injury types:

- Amputations
- Dislocations
- Crush injuries
- Surgery to the back, neck, shoulders, joints or limbs.
- Severe Burns
- Head Injuries

When do you estimate for pain and suffering-s67?

75.2 If the assessment of loss is more than 10% of the maximum amount payable of the Table of Disabilities (\$100,000 as at 12/1/97) then also estimate for section 67 benefits.

What evidence can you rely on to make your initial estimate?

76 If the worker is reasonably likely to be entitled to a benefit or if you receive a claim for s 66 benefits:

- you need to review the existing medical opinions and assessments to determine your estimate of the benefit payable to the worker in one of the ways shown in 76.1 to 76.4; and
- you need to include in the claims estimate an allowance for medical assessment costs, legal costs and any wage loss incurred.

You have an assessment from the treating specialist

76.1 If there is an assessment of permanent loss from a treating specialist (especially if that treating specialist has performed surgery), the estimate should be equal to the assessment.

You have an assessment from an Approved Medical Specialist

76.2 If you have an assessment from an Approved Medical Specialist use this to calculate the estimate.

You have a number of conflicting assessments

76.3 If there are a number of reports with conflicting medical assessments of the amount of permanent loss the worker has suffered, then average the amount and use that as the basis for your assessment. Ignore 0% assessments when calculating the average amount.

A permanent loss is likely, but the extent is unknown

76.3 If the worker is likely to suffer a permanent loss but the extent of the loss is unknown, or if a claim for permanent loss is made without

supporting medical evidence, then include in your estimate an amount equal to at least 10% of the maximum amount allowed for the body part affected. For example, allow at least 10% if:

- the medical evidence indicates a condition that may cause permanent loss; or
- you receive a written claim for permanent loss but there is no supporting medical evidence; or
- the worker is most likely to be entitled to a permanent loss benefit.

If you receive more medical information, update your estimate.

However, you must include at least the 10% in your estimate until credible medical evidence shows that there is no permanent loss at all—an opinion that "the injury may resolve in time" is not enough.

The worker has claimed too much

76.4 If you have medical evidence that the worker has claimed an inaccurate and excessive amount, then you are to engage an Approved Medical Specialist to assess the dispute and provide an opinion of the amount of the loss. (For more information, see *Procedures for Referral and Assessment of Medical Disputes by Approved Medical Specialists*.)

Ask the Approved Medical Specialist to specify:

- the permanent loss that is due to work injuries received *after* 30 June 1987 (even if the work injuries are part of the claim, and are therefore not pre-existing for the purposes of the claim); and
- the permanent loss that is due to work injuries received *before* 30 June 1987 (even if the work injuries are part of the claim, and are therefore not pre-existing for the purposes of the claim).
- the proportion of the permanent losses (including secondary losses) due to pre-existing injuries, abnormalities and conditions.

Allow 75% of the amount claimed by the worker until you receive the Approved Medical Specialist assessment. Increase or decrease the estimate to an amount equal to the Approved Medical Specialist assessment when it is completed.

How does the date the claim is made affect the estimate?

77 The date the claim is made is crucial. It effects the limit on the amount the worker may be paid, see this table:

If the claim was made ...	then the most the worker ...
on or after 12 January 1997 (it doesn't matter when the injury happened)	can receive under s 66 is: <ul style="list-style-type: none"> • for a single permanent loss, \$100,000 • for a multiple permanent loss, \$121,000 can receive under s 67 is \$50,000
before 12 January 1997	can receive is set in the WorkCover Benefits Guide on the basis of the date of the injury

What if multiple body parts are injured?

78 If there are multiple losses from the same injury, then the worker's entitlement under s66 for each loss is calculated as a percentage of the amount in s66(1). However, the total amount the worker can receive for all injuries is the amount in s66(2)

How do you allow for pre-existing injuries etc.?

79 If the worker has had any pre-existing injuries, abnormalities, or conditions, then you need to reduce your estimate to take account of them. The law about how to do this is set out in s68B, Workers Compensation Act 1987.

Does a common law claim affect the estimate?

80 Yes. If the worker makes a claim for Common Law damages under s 151 A or 151V, refer to insurer Guideline 98/26 – Common Law Claims.

Does an application for commutation affect the estimate?

81 No. Calculate the estimate using this manual.

What medical or other investigation expenses (including factual) should you allow?

82 If you expect that medical or other investigations may be required, allow at least \$2,000 for each claim—and review the allowance as you receive more information.

How do you calculate the estimate for s66 and s67?

83 To calculate the estimate use the amount of loss specified in rule 78 and the Table of Disabilities located in WorkCover Benefits Guide. Apply the percentage of loss to the maximum amount allowed for the effected body part.

How do you estimate for section 67 entitlements?

83.1 If the assessment of loss is more than 10% of the maximum amount payable of the Table of Disabilities (\$100,000 as at 12/1/97) then also estimate for section 67 benefits. The estimate for s67 is calculated using the same percentage of the maximum amount payable

Example of a s 66 & s 67 estimate calculation

83.2 Assume the worker suffers a permanent loss of 20% of their right hand

Section 66

Maximum payable under S66	=	\$100 000
Maximum payable for right hand	=	70% of max payable = \$70,000
S66 entitlement	=	20% of \$70 000 = \$14 000

Section 67

Maximum payable under S67	=	\$50 000.
Maximum payable for right hand	=	70% of max payable = \$35,000
S 67 entitlement	=	20% of \$35,000 = \$7,000

Alternatively the s67 estimate can also be calculated by multiplying the s66 entitlement by 50%:

S66 entitlement	=	\$14 000
S67 entitlement	=	50% of \$14 000 = \$7 000

What research do you need to do before you reduce an estimate or make any payments?

84 You need to be familiar with sections 66 and 67. Also, you need:

- to ask the worker for details of any previous settlements or judgements;
- to check with Workers Compensation Commission [and the Compensation Court] to see if the worker has had previous settlements or judgements in relation to that injury of that part of the body. The relevant settlements and Judgments include previous Section 66 and 67 claims, exit commutations and common law settlements and Judgements.

For which claims do you include interest in your estimate?

- 85 You need to include interest for claims for permanent loss if the injury happened *before* 1 January 1996. You calculate the interest according to a schedule notified by the Compensation Court;

(You ignore interest for claims with a date of injury *on or after* 1 January 1996.)

When is interest payable from?

- 86 The general rule for a loss suffered before 1 January 1996 is that you need to include an allowance for interest in your estimate. However, if the claim was made:
- *before* 1 January 1996, allow for interest from the date the worker gave notice of the claim;
 - *after* 1 January 1996, allow for interest from the date the worker made the claim for the relevant benefit.

What rate of interest applies?

- 87 Use the interest rate shown in this table:

Date of Injury	S.66 Rate	S.67 Rate
1987-1988	12%	6%
1989-1990	10%	5%
1991-1992	8%	4%
1993 →	6%	3%

Where are the rules about interest?

- 88 You can find out about the interest requirements in:
- the September and December 1995 Amendments to the Workers Compensation Act 1987; and
 - the Insurer Guidelines 96/5.

What happens if a dispute arises?

- 89 If there is a dispute about the amount of permanent impairment that has been assessed, the Workers Compensation Commission can appoint an Approved Medical Specialist if requested.

What else do you need to review?

90 When calculating or reviewing this estimate, also consider:

- Recovery Action, see Chapter D on page 14.
- expected legal expenses – see chapter E; Disputed and Litigated claims on page 16.
- Travel expenses for the worker to attend medical examinations
- Wage loss while attending medical examination

Also, make sure you follow the approach and instructions on pages 7-11.

Chapter N: Permanent impairment—s 66
(for injuries *on or after* 1 January 2002,
for injuries *before* that date, see Chapter M)

&

Pain and suffering entitlements—s 67
(for injuries *on or after* 1 January 2002,
for injuries *before* that date, see Chapter M)

Which injuries does this chapter apply to?

91 This section applies to workers who suffered an injury on or after 1 January 2002 that are permanently impaired, see WorkCover Guides for the evaluation of permanent impairment.

A worker is entitled to permanent impairment – s66 benefits

- If the permanent impairment is greater than 0% of the whole person; or
- If the injury is for a primary psychological injury, greater than 15% of the whole person impairment.

A worker is entitled to pain and suffering - s67 benefits

- If the injury (other than psychological injury) is for more than 10% of the whole person impairment or 15% whole person impairment for psychological injuries.

If the claim is for permanent loss of hearing see Chapter P on page 71.

Do you have to tell workers they may be entitled to S 66 or 67 benefits?

92 Insurers must point out to a worker any entitlement the worker may have to s66 or s 67 benefits. This helps reduce legal costs.

What evidence is required for a s 66 claim?

93 A claim for s66 benefits must be supported by a medical assessment from a person trained in the WorkCover Guides for the Evaluation of Permanent Impairment. Base your estimate on the amount of the assessment.

If the worker is most likely to be entitled to a permanent impairment benefit and you do not have a medical assessment the make the estimate based on no assessment, see rule 93.1.

What if you haven't received an assessment?

- 93.1 If you have not received an assessment from a properly trained person, you need to tell the worker, or their solicitor, to arrange one and send it to you. While you are waiting for the assessment allow 5% whole of person permanent impairment in your estimate and review when the assessment is received.

What if the assessment is done by a person not qualified to use the WorkCover Guides for the Evaluation of Permanent Impairment?

- 93.2 Base your estimate on 75% of the amount claimed or 5% whole of person permanent impairment whichever is greater. Arrange for a permanent impairment assessment to be done by a qualified assessor and review the estimate when the assessment is complete.

What if the amount of the assessment seems excessive or wrong?

- 93.4 To ensure accuracy, a review of the assessment may be conducted by another medical specialist trained in the use of the WorkCover Guides for the Evaluation of Permanent Impairment. Base your estimate on 75% of the amount claimed or 5% whole of person permanent impairment whichever is greater and review when the assessment has been reviewed.

If the reviewing specialist finds that the assessment is inaccurate, they are to give reasons to the permanent impairment assessor and ask them to review the assessment.

How do you calculate the estimate?

- 94 The amount you include in your estimate is the amount you expect to pay based on the percentage loss of permanent impairment of the whole person and the maximum amount allowed under s 66 & s 67. A formula is used to determine the amount of compensation payable, Reference s66: 1987 Workers Compensation Act.

An example of how to calculate the estimate:

- 94.1 Assume the worker suffers a whole of person impairment of 15%.

Section 66

Maximum payable for whole of person	=	\$200 000
S66 entitlement 15%	=	\$20 000

Section 67

Maximum payable under S67	=	\$50 000.
S 67 entitlement 15% of \$50 00 =	=	\$7,500

Permanent Impairment Estimate Calculation Table

WPI		WPI		WPI		WPI	
1%	\$1250	20%	\$27500	39%	\$75000	58%	\$140500
2%	\$2500	21%	\$30000	40%	\$77500	59%	\$144000
3%	\$3750	22%	\$32500	41%	\$81000	60%	\$147500
4%	\$5000	23%	\$35000	42%	\$84500	61%	\$151000
5%	\$6250	24%	\$37500	43%	\$88000	62%	\$154500
6%	\$7500	25%	\$40000	44%	\$91500	63%	\$158000
7%	\$8750	26%	\$42500	45%	\$95000	64%	\$161500
8%	\$10000	27%	\$45000	46%	\$98500	65%	\$165000
9%	\$11250	28%	\$47500	47%	\$102000	66%	\$168500
10%	\$12500	29%	\$50000	48%	\$105500	67%	\$172000
11%	\$14000	30%	\$52500	49%	\$109000	68%	\$175500
12%	\$15500	31%	\$55000	50%	\$112500	69%	\$179000
13%	\$17000	32%	\$57500	51%	\$116000	70%	\$182500
14%	\$18500	33%	\$60000	52%	\$119500	71%	\$186000
15%	\$20000	34%	\$62500	53%	\$123000	72%	\$189500
16%	\$21500	35%	\$65000	54%	\$126500	73%	\$193000
17%	\$23000	36%	\$67500	55%	\$130000	74%	\$196500
18%	\$24500	37%	\$70000	56%	\$133500	75%	\$200000
19%	\$26000	38%	\$72500	57%	\$137000	75%+	\$200000

WPI = Whole Person Impairment

What medical or other investigation expenses (including factual) should you allow?

- 95 If you expect that medical or other investigations may be required, allow at least \$2,000 for each claim—and review the allowance as you receive more information.

Does a s 67 claim have to be made with a s 66 claim?

- 96 A claim for s 67 entitlements may be made separately from a s66 claim. To make a claim for s67 the worker must have a permanent impairment of at least 10% whole of body.

Does a work injury damages claim affect the estimate?

- 97 You still need to estimate for a permanent impairment entitlement even if a work injury damages claim has been made. Refer to Insurer Guideline 98/26 for more information about how to estimate work injury damages. When reading this guideline substitute “work injury damages” for “common law”.

How do you allow for pre-existing injuries etc.?

- 98 The legislation about reducing a settlement for pre-existing injuries or diseases has changed from 1 January 2002. You can no longer automatically reduce an estimate for pre-existing injuries. More information is available in section 68(B) Workers Compensation Act, 1987.

What research do you need to do before you reduce your estimate?

- 99 You need to be familiar with sections 66 and 67. Also, you need:
- to ask the worker for details of any previous settlements or judgements;
 - to check with the Workers Compensation Commission [and the Compensation Court] to see if the worker has had previous settlements or judgements in relation to that injury of that part of the body. The relevant settlements and Judgments include previous Section 66 and 67 claims, exit commutations and common law settlements and Judgements.

Make sure you also follow the approach and instructions on pages 7-11.

What else do you need to review?

- 100 When calculating or reviewing this estimate, also consider:
- Recovery Action, see Chapter D on page 14.
 - expected legal expenses – see chapter E; Disputed and Litigated claims on page 16.
 - Travel expenses for the worker to attend medical examinations
 - Wage loss while attending medical examination

Also, make sure you follow the approach and instructions on pages 7-11.

Chapter O: **Permanent Loss of Hearing** (suffered before 1 January, 2002)

Which injuries does this chapter apply to?

- 101 This chapter applies to workers who gave notice of a permanent loss of hearing to their employer *before 1 January 2002*. When you receive a notice of hearing loss follow the process described here.

When must you make an estimate?

- 102 You must make an estimate when the worker notifies they have a permanent loss of hearing. You do this even if the worker has not properly made the claim. See Workers Compensation (General) Regulation 1995, Part 11, clause 38 for more information about how to give notice of injury involving loss of hearing.

How much do you allow in the estimate?

- 103 Insurer Guideline 96/5 includes additional information about the management and estimation of hearing loss claims.

If the claim for hearing loss is less than 6%:

- 103.1 include only the medical costs in your estimate (because the worker is not entitled to any other compensation).

If the claim for hearing loss is more than 6%:

- 103.2 then base your estimate on the percentage loss claimed. Also make an estimate for:

- investigation – at least \$500; and
- hearing aids – at least \$3000; and
- weekly payments if you think you need to.

If the notice of hearing loss has no assessment of the worker's hearing loss:

- 103.3 estimate at least \$6,000 and refer the worker for assessment of hearing impairment. Also make an estimate for:

- investigation – at least \$500; and
- hearing aids – at least \$3000; and
- weekly payments if you think you need to

Update the estimate when the assessment is received.

What if the medical assessment has not been done by a qualified assessor?

103.4 You will need to refer the worker to a qualified assessor who will make an assessment of the workers hearing loss. You must estimate the claim as if there is no assessment, see rule 103.3.

What should you try to do?

104 Once you have a valid assessment, you should try to negotiate settlement in accordance with that assessment. The estimate should be adjusted to an amount equal to the average of the hearing loss assessments, or 6% whichever is more. Ignore any 0% assessment when calculating the average loss.

Can you make a referral to the Medical Panel?

105 A claim can be referred to the medical panel for assessment. The medical panel assessment is conclusive evidence of the extent of the loss. The estimate and settlement offer is to be based on the Medical Panel assessment.

What else do you need to consider when making an estimate?

106 A claim for permanent loss of hearing is a claim for a permanent impairment under section 66. Other important factors that you need to consider when estimating a claim for permanent loss of hearing are detailed in Chapter M – Permanent Impairment. These include:

- An example of how to calculate an estimate, see example in rule 81.2
- If the date the claim was made is before 12/1/1997, see rule 76.
- Interest; see rules 83 to 86.
- Entitlement to s67 benefits if the permanent loss is more than 18.4%

What else do you need to review?

107 When calculating or reviewing this estimate, also consider:

- Recovery Action, see Chapter D on page 14, including any contribution from other employers. See section 17(1)(d) of the Workers Compensation Act, 1987 for more information.
- expected legal expenses – see chapter E; Disputed and Litigated claims on page 16.
- Travel expenses for the worker to attend medical examinations
- Wage loss while attending medical examination

Also, make sure you follow the approach and instructions on pages 7-11.

Chapter P: **Hearing impairment** (suffered on or after 1 January, 2002)

Which injuries does this chapter apply to?

- 108 This chapter applies to hearing loss claims with a date of injury on or after *1 January 2002*. If the workers' current employer is a noisy employer the *date of injury* is the date the worker gave notice of a loss of hearing to the employer. If the worker is no longer employed by a noisy employer the date of loss is the last day the worker was employed by the noisy employer.

When you receive a notice of hearing loss follow the process described here.

When must you make an estimate?

- 109 You must make an estimate when the worker notifies they have a permanent loss of hearing. You do this even if the worker has not properly made the claim. See Workers Compensation (General) Regulation 1995, Part 11, clause 38 for more information about how to give notice of injury involving loss of hearing.

Who may assess the hearing loss?

- 110 The hearing loss is to be assessed by a qualified assessor in accordance with the standards specified in the WorkCover Guides for the Evaluation of Permanent Impairment.

How much do you allow in the estimate?

- 111 Insurer Guideline 96/5 includes additional information about the management and estimation of hearing loss claims.

If the notice of hearing loss arrives with an assessment of the worker's hearing loss,

- 111.1 you need to check that the assessment has been done by a qualified assessor and that the whole person percentage loss is accurate according to the WorkCover Guidelines for the evaluation of permanent impairment. Then if the loss is:
- Less than 6% binaural hearing impairment or less, include only the medical costs in your estimate (because the worker is not entitled to any other compensation); or
 - 6% or more binaural hearing impairment, then base your estimate on the equivalent %whole person impairment, see Table 9.1 in the

WorkCover Guides for the evaluation of permanent impairment.
Also include:

- investigation – at least \$500; and
- hearing aids – at least \$3000; and
- weekly payments if you think you need to.

If the notice arrives without an assessment of the worker's hearing loss,
111.2 include at least \$6,000 in your estimate and refer the worker for assessment of hearing impairment in accordance with the WorkCover Guides. Also make an estimate for:

- investigation – at least \$500; and
- hearing aids – at least \$3000; and
- weekly payments if you think you need to.

What if the medical assessment has not been done by a qualified assessor?

111.3 refer the worker to a qualified assessor who will make an assessment of the workers hearing loss. You must estimate the claim as if there is no assessment, see rule 111.2.

What should you try to do ?

112 Once you have a valid assessment, you should try to negotiate settlement in accordance with that assessment. The estimate should be adjusted to an amount equal to the average of the hearing loss assessments, or 6% whichever is more. Ignore any 0% assessment when calculating the average loss

What else do you need to review?

113 When calculating or reviewing this estimate, also consider:

- Recovery Action, see Chapter D on page 14, including any contribution from other employers. See section 17(1)(d) of the Workers Compensation Act, 1987 for more information.
- Expected legal expenses – see chapter E; Disputed and Litigated claims on page 16.
- Travel expenses for the worker to attend medical examinations
- Wage loss while attending medical examination

Also, make sure you follow the approach and instructions on pages 7-11.

Chapter Q: Death benefits

When do you need to allow for death benefits?

114 If the worker dies as a result of a work-related injury or disease, you need to include in your estimate:

- if the worker died in Australia, the cost of transporting the body, see s28; and
- the death benefits shown in this table as affected by the circumstances of the claim.

If the worker dies leaving ...	then include in your estimate ...
no dependents	an amount to cover reasonable funeral costs, see s 27 (if a payment has been, or is intended to be made, under s 25 or 26, then this benefit is not payable)
any dependents who were partly dependent on the worker (and no dependents who were fully dependent on the worker)	<ul style="list-style-type: none"> • a lump sum in proportion to the degree of dependency (up to the maximum lump sum), see s 26 <i>plus</i> <ul style="list-style-type: none"> • weekly payments in relation to each dependent child until he or she reaches 21 or stops being dependent, see s 25 and the "Benefits Guide" issued by WorkCover
any dependents who were wholly dependent on the worker	<ul style="list-style-type: none"> • a lump sum, see s 25 <i>plus</i> <ul style="list-style-type: none"> • weekly payments in relation to each dependent child until he or she reaches 21 or stops being dependent, see s 25 and the "Benefits Guide" issued by WorkCover

Also, make sure you follow the approach and instructions on pages 7-11.

References – Schedule One; Estimated Injury Recovery Periods.

1. Accident Compensation Corporation, *Treatment Profiles 2001*, Accident Compensation Corporation, New Zealand, December 2000.
2. National Occupational health and Safety Commission, *Type of Occurrence Classification System*, Australian Government Publishing Service, Canberra, December, 1990.
3. Schibanoff, James M. (Ed), *Health Management Guidelines, Vol. 7, Workers Compensation*, Milliman and Robertson Inc, August 1998.