

Workers' Compensation

Licensed Insurers'

Best Practice Guidelines

2008

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Introduction

1. The Best Practice Guidelines has been developed by the W.A. Workers' Compensation Insurers Consultative Group.
2. These Guidelines are not presented as rules but rather as a framework within which approved insurers should work recognising the need for discretion for approved insurer management. They are intended as a minimum standard which approved insurers are encouraged to improve upon.
3. Recognising that workers compensation claims are the result of injury and incapacity suffered by members of the community, approved insurers will treat claimants with care and understanding. The image to fulfill is one of fairness and honesty in dealing with injured workers.
4. The Guidelines and appendices are designed to achieve a sensible and reasonable approach by approved Insurers as well as consistency as far as possible with the focus on a fair, speedy and effective handling of workers' compensation claims.
5. While the Guidelines should contribute to improving efficiency of claims management, they are not intended to replace existing sound practices.
6. Approved Insurers expect injured workers will reasonably and sensibly participate in the necessary medical treatment and rehabilitation programs to ensure an early return to the workplace. To achieve a cost effective, productive and meaningful workers' compensation system in W.A. there must not only be a commitment by insurers and employers, but also injured workers.
7. The Licenced Insurers Best Practice Guidelines 2008 will initially address the special requirements of the Act and replace the existing Guidelines. The Licenced Insurers Best Practice Guidelines is intended to be a living document and as such, may be progressively developed as operational requirements change or following consultation with all stakeholders and agreement between all Insurers..

Insurer Commitments

- Internal Claim Decision Review Process
Implementing a formal process for the internal review of all liability decisions that could give rise to a dispute.
- Redemptions
 - a) Observing the restrictions intended by the legislation;
 - b) Fair Dealing;
 - c) Avoidance of Perceptions of Conflict of Interest.

- Best Practice

Insurers commit to:

- a) A sensible and reasonable approach by Licenced Insurers;
- b) Consistency, with a focus on fair, speedy and effective handling of workers' compensation claims;
- c) An appropriate and committed emphasis on return to work;

- d) The avoidance of unnecessary referrals to the Dispute Resolution Directorate.
 - e) Making informed and reasoned decisions on claims issues based upon the amount and quality of information possessed. It is reasonable to expect that the optimal amount of evidence would have been collected;
 - f) Making recommendations for treatment and ancillary support services based on the principles of evidence based medicine.
- Licence Conditions
 - a) Compliance with the Licence Conditions for the Approval and Review of Insurers under the Workers' Compensation and Injury Management Act 1981;
 - b) Compliance with those sections within the Act which impose certain requirements upon Insurers with the supply of information and their conduct with regards to effecting or renewing a policy of insurance;
 - c) Continued assistance to WorkCover Western Australia with regard to audits and the provision of timely and accurate data;
 - d) DRD rules and regulations.
 - Privacy

Insurers commit to:

 - a) Compliance with federal privacy laws;
 - b) Privacy training for all new staff and refresher training for all staff involved in the management of claims;
 - c) The use of a clear privacy disclosure statement on the claim form that either speaks directly to collection, use and disclosure matters or provides detailed information on where it can be obtained.
 - Vocational Rehabilitation
 - a) Best practice injury management;
 - b) Timely provision of vocational rehabilitation assistance;
 - c) Treatment decisions supported, where possible, by evidence based medicine,
 - d) Routinely reviewing treatment programs to ensure their continued relevance and or efficacy for the worker;
 - e) Compliance with the Workers' Compensation Code of Practice (Injury Management) 2005.

The Objectives of the Guidelines

The Guidelines will:

- a) Outline standards for determination and review of liability decisions - initial and ongoing;
- b) Outline standards in respect of without prejudice medical treatment costs;
- c) Describe standards for fair dealing and avoidance of Conflict of Interest;
- d) Outline agreed minimum performance standards to be adopted by Licenced insurers;

- e) Describe Standards for handling claims efficiently, honestly and fairly;
- f) Outline an agreed commitment to the principles of self-regulation and accountability under the Guidelines;
- g) Reinforce insurer commitment to Privacy principles and legislation.

Definitions

"Act"

Means "The Workers' Compensation and Injury Management Act 1981"

"Alternative Duties"

Means duties that are meaningful and productive and within the medical restrictions of the worker.

"Claims Representative"

Means an employee of the Insurer primarily responsible for liability determination and case management of individual workers' compensation claims.

"Complaint"

Where a claimant and/or affected party expresses dissatisfaction with the service provided by an insurer and the matter remains unresolved to the complainant's satisfaction.

"Conflict of Interest"

Means a perception of bias for or against any party to any aspect of the claims process.

"Current Insurer"

Means the approved licenced Insurer of the employer at the time of the latest injury, aggravation or recurrence as set out in s74 of the Act.

"Fair Dealing"

Means full and frank disclosure to the worker and the employer by the insurer of all the worker's rights and entitlements pursuant to the Act.

"Dispute"

Where a claimant and/or affected party who is dissatisfied with a decision the insurer has made in relation to the application of the Workers' Compensation and Injury Management Act 1981.

"Formal Dispute"

Means the lodgment of an application or referral to the Dispute Resolution Directorate ("the DRD").

"ICA"

Means the Insurance Council of Australia.

"Incapacity"

Means either full or partial incapacity to perform pre-injury duties.

"Indemnity"

Means the cover provided by the insurer to the employer under the policy issued in accordance with the Act.

"Industry"

Means the ANZSIC classification of industry endorsed by the Australian Bureau of Statistics as adopted by WorkCover from time to time.

“Injury”

Means as defined by the Act.

"Injury Management"

Means facilitating a coordinated approach to achieving a maximum recovery and return to work for injured workers.

"Insurer"

Means an insurer approved by the Minister to conduct business in accordance with the provisions of the Act.

"Internal Dispute Resolution Process (IDRP)"

Means the formal process adopted by insurers to review decisions made in relation to any issue arising under the Act.

"Liability Determination Strategy"

Means the structured and consistent steps to be taken to gather information necessary to determine liability.

"Medical Interventions"

Means a without prejudice payment of a medical expenses by an insurer with or without an order of the DRD.

“Mediator”

Means an accredited mediator or other person with an extensive knowledge of the Workers’ Compensation and Injury Management Act 1981. Preferably, a solicitor who is not affiliated with any of the parties should conduct the Mediation.

"Performance Standards"

Means the minimum standards required by the Guidelines.

"Prima Facie"

Means the provision of sufficient evidence to support an arguable case.

“Prior Insurer”

Means any Insurer/s of the employer other than the “Current Insurer” as contemplated by s74 of the Act.

“Senior Claims representative”

Means an employee of an Insurer who has a higher level of authority than the claims representative.

"Senior Review Officer"

Means an employee of an Insurer, who has the highest level of claims authority charged with reviewing Claims Representative decisions.

"Senior State Representative"

Means the employee of the Insurer who retains the highest level of experience, authority or technical knowledge, within the organization in regard to Workers’ Compensation and Injury

Management.

"Serious Claim"

Means any claim where incapacity has or is likely to prevent a return to full pre-injury work duties within 60 working days of initial injury or illness.

"Settlement"

Means a settlement negotiated by agreement pursuant to section 24A & B, 26, 31, 67 or 76 of the Act.

"Vocational Rehabilitation Provider"

Means a person or organisation accredited by WorkCover WA, engaged by the Employer, Worker or Medical Practitioner, in consultation with the worker, to implement appropriate and effective rehabilitation measures.

"The Board"

Means the WorkCover Western Australia Board.

"Without Prejudice"

Means a payment, admission or agreement without admission of liability by any party.

Otherwise words and phrases have the same meaning and effect as within the Act.

Review of Liability Decisions

Internal review (IDRP) by the insurer is an important first step for better practice primary decision making. This involves reconsideration of a liability decision by a Senior Claims Representative or member of a different claims team to provide an objective view and to ensure consistency in decision making.

Initial Determination of Liability and Notification to Employer and Worker

On receipt of all required claim documentation from an employer, an Insurer shall make every reasonable effort to determine liability and, where liability is accepted, notify the parties within three working days of that decision

If additional information is required, the Insurer shall notify the employer/injured worker that liability cannot be determined within fourteen working days and the reasons why. For example, 'no clear diagnosis has been noted on the workers' compensation medical certificate.'

Notification to the employer/injured worker and attempts by the Insurer to obtain the missing information should be made without delay and (where possible) by telephone/facsimile/email to ensure that information is gathered as expeditiously as possible.

While Insurers will endeavor to determine liability in fourteen working days, the notice-requirements of the Act must be strictly adhered to.

Prior to a claim being declined, a Senior Claims Representative must independently review the file and the decision to decline the claim. Notification that a claim is being declined must only be communicated if the Senior Claims Representative agrees with the original decision.

Consultation with Employer where Further Information is Required

If a Claims Representative considers that further information is required before liability can be determined, or has determined that liability for a claim is in issue, the Claims Representative must contact the employer within 3 working days of reaching that decision to discuss the issues surrounding liability.

If during consultation the employer and Claims Representative agree that liability cannot be accepted without further information, the employer is to be apprised of the liability determination strategy and the timeframes for completion of the inquiries.

The Insurer acknowledges the need to seek out and consider the employer's position and preferences with regard to the liability decision. The weight attaching to these views will be determined in the context of all available information.

Consultation with Worker where Further Information is Required

If a Claims Representative and employer consider that further information is required before liability can be determined, or have determined that liability for a claim is in issue, the Claims Representative is to contact the worker within 24 hours of that decision to advise the worker of the issues surrounding liability. The worker is also to be told of the likely timeframes to complete the inquiries.

Internal Review of Initial Liability Determination

If liability for a claim is not accepted, the Claims Representative is to prepare a liability determination strategy detailing enquiries to be made and the timeframe for making necessary enquiries. The timeframe must be diarised to ensure that all required investigation occurs in a timely manner.

The liability determination strategy must be documented and the written strategy must be approved by a Senior Claims Representative. Compliance with the liability determination strategy is to be audited by the senior claims representative.

Insurers should ensure that Claims Representatives are fully aware of the provisions of the Act and performance standards relating to disputes or referrals to the WorkCover WA Dispute Resolution Directorate (DRD).

Notification to Employer and Worker in the Event of a Dispute

The employer is to be notified in writing at the time of a determination of liability of its rights and responsibilities. If a claim is being disputed under section 57 of the Act, the Insurer commits to providing the employer with clear advice on their decision and the reasons.

Subsequent Liability or Recurrence Determinations

On receipt of a medical certificate which certifies a change in the worker's capacity giving rise to a subsequent liability determination, an Insurer shall endeavour to determine liability within three working days.

If additional information is required, the Insurer shall notify the employer/injured worker that liability cannot be determined within three working days of the liability decision being made and the reasons.

Notification to the employer/injured worker and attempts by the Insurer to obtain any further required information should be undertaken without delay and (where possible), by telephone/facsimile/email to ensure that information is gathered expeditiously.

Consultation with Employer in regard to Subsequent Liability Determinations

If a Claims Representative considers that further information is required before subsequent liability can be determined (or that liability for a claim is in issue), the Claims Representative is to contact the employer within 24 hours of that decision to discuss the issues surrounding liability.

If during consultation the employer and claims representative agree that liability cannot be accepted without further information, the employer is to be informed of the liability determination strategy and the anticipated timeframes to complete the inquiries.

The Insurer acknowledges the need to seek out and consider the employer's position and preferences with regard to the liability decision. The weight attaching to these views will be determined in the context of all available information.

Consultation with Workers in regard to Subsequent Liability Determinations

If a claims representative and employer consider that further information is required before liability can be determined (or have determined consider that liability for a claim is in issue), the Claims Representative is to contact the worker within 24 hours of that decision to advise the worker of the issues surrounding liability and the liability determination strategy that has been put in place to determine the issues surrounding liability. The worker is also to be advised of the likely timeframes for completion of the enquiries.

Internal Review of Subsequent Liability Determination

If liability for a claim is not accepted, the worker is to be informed of the decision within fourteen days of that decision. The worker is also to be made aware of the operation of the Insurer's Internal Dispute Resolution Process (IDRP) and the Worker's right to have the decision reviewed.

Compliance with liability determination and notification of the IDRP is to be regularly audited by Insurers to ensure that workers are being informed of their rights.

Notification and Communication with WorkCover

Insurers commit to comply with the requirements of WorkCover to provide it with formal notice within fourteen days of its liability decision, entered electronically on the WorkCover website.-

Internal Dispute Resolution Access

Internal Dispute Resolution Policies

Disagreement with an Insurer's decision may be referred to the Insurer's (IDRP). It is intended that the IDRP will circumvent the need to refer matters to the DRD.

In certain instances some matters that are the subject of the IDRP will be referred to the DRD. This is necessary to ensure that the Insurer, employer or the worker preserve their legal rights in the event a mutually satisfactory result cannot be achieved through the IDRP. For example, where a worker disagrees with an Insurer's decision that further treatment is not reasonable, the worker may have already referred the matter to the DRD but the worker may elect to utilise the IDRP in regard to this matter. In these cases the IDRP must be given immediate attention to ensure that the matter is resolved as swiftly as possible. Hence it is possible that there may be IDRP and the DRD proceedings occurring in tandem.

Internal review by an Insurer is an important preliminary stage for reconsidering primary decisions. Once a dispute does arise, it is in the interests of all parties to seek resolution in a timely, considerate and non-litigious manner.

What a Worker can Expect Following Notification of a Dispute to an Insurer

The Insurer will within 3 days of receiving the notice, inform the worker (in writing) of the option to have an adverse decision reviewed by a Senior Review Officer of the insurer. The letter will include the name and telephone number of an appropriate contact person. This officer will not have made the original decision.

The Senior Review Officer will :-

- Review the decision;
- Review the material relied upon to make the decision;
- Consider any other material already on the claim file; and
- Contact the worker and the employer and request any further material that may be relevant.

Following this review, the Senior Review Officer will either :-

- Maintain the original decision;
- Have the decision withdrawn;
- Vary the decision.

The Senior Review Officer must then notify the outcome of the review to the worker in writing.

Dispute Resolution - Access to Internal Dispute Resolution Policies

Each Insurer will establish a fully documented internal procedure for resolving a dispute between the injured worker and the Insurer, or the injured worker and the Insurer's investigator or other service provider. This process will be readily accessible to injured workers without any charges imposed by the Insurer. The internal procedure will provide a fair and timely method for handling disputes. The Insurer will establish procedures for monitoring disputes proceeding through IDRP.

Each Insurer must have available a document providing general descriptive information on:

- a) the internal procedures for handling a dispute by the Insurer;
- b) the time within which a dispute will be normally handled by the Insurer;
- c) the fact that the dispute will be handled by a Senior Review Officer of the Insurer with appropriate powers to deal with the dispute and the internal review process.

Where an Insurer receives from a worker a written request for the resolution of a dispute or a request for a response from the Insurer in writing in relation to the dispute, the Insurer shall promptly reply to the worker and, if the dispute is not resolved in a manner acceptable to the worker, the Insurer shall provide:

- a) where appropriate, the general reasons for that outcome; and
- b) information on the further action that the worker can take.

Where reasons are supplied in relation to a dispute relating to a claim, an Insurer shall not be required to disclose information :-

- Provided by third parties that is confidential or that identifies those third parties;
- That may not be disclosed under privacy law;
- That is subject to legal professional privilege;
- That may prejudice the insurer in any further investigation or in any dispute over a claim.

The worker is to be informed further review of the decision is available through referral of the disputed claim to the DRD.

The Insurer will retain all IDRPs records in a central register and a copy of each decision on the relevant claims file.

Denial of Indemnity

Only Senior State Representatives of an Insurer will approve a decision to deny indemnity to an employer. The employer should be informed within 4 working days of the decision being made. This notice should incorporate the reasons for the denial and recommend that the employer obtain independent advice with regard to its employer's Indemnity policy and any potential liability for claims that have or may be incurred during the life of the policy.

Without Prejudice Medical Interventions

Insurers acknowledge that in certain circumstances injured workers may not be able to access recommended medical services because their claims have not been accepted.

Insurers acknowledge that the ability to voluntarily engage without prejudice medical intervention can assist in the management of claims.

Without prejudice payments must be confirmed in writing to a worker clearly stating the type, duration and frequency of the treatments. This is to avoid confusion and ensure that workers and treatment providers have a clear understanding of what payments will be met. The letter authorising payments will state that the payments are offered on the clear and express basis that they are being made on a without prejudice basis and do not correspond to, nor operate as, an admission of liability in respect of any claim that is or will be made.

Where a worker submits a claim for compensation or may reasonably be expected to submit a claim (but due to the nature of the injury cannot submit a claim on his/her own behalf) and the claim appears to be one that is usually accepted, it is expected that reasonable medical expenses will be paid on a without prejudice basis.

Such payments would only be granted after an informed decision making process has been undertaken. Information that would be required to facilitate an informed decision regarding the payment of medical and like expenses includes:

- Receiving a worker's claim for compensation;
- Medical evidence;
- Employer's and worker's views; and
- Other pertinent information.

The payments extend to reasonable expenses incurred by the worker as a result of his injury for medical services, hospital services, nursing services, constant attendance services, rehabilitation services, and ambulance services.

These payments are inclusive of mediation and counseling services in appropriate circumstances.

Insurers will not give consideration to treatments that are not covered by the Medicare Benefits Schedule, are experimental in nature, or are not medically evidence-based. The adoption of these protocols are Licenced Insurers' Best Practice Guidelines – 12 June 2008

necessary to ensure that appropriate assessments of a service have taken place to determine safety and efficacy of available treatment options.

Redemptions

Insurers commit to focus, in the first instance, on rehabilitation in accordance with the rehabilitation protocol for return to work. The Insurer will assist, encourage and support an employer in order to achieve a durable rehabilitation outcome and to maximise retained earning capacity. This is in the best interests of all stakeholders.

In some circumstances workers are better served by the provision of a redemption. In these instances, insurers commit to observing the restrictions of the legislation when engaging in negotiations for the settlement of Workers Compensation claims.

Insurers agree that a redemption will not be offered pursuant to section 67 of the Act, if a worker has not been receiving weekly payments for at least 26 weeks from the date of Injury.

Any decision by an Insurer to proceed with or respond to a settlement offer must be authorised by a Senior Claims Representative and noted on the file, with confirmation that settlement is both appropriate and permitted by the legislation.

As with all important decisions where reasonably practicable and/or the employer/employee relationship continues to exist, the employer will be made aware by the Insurer of the intention to commence settlement negotiations.

In any event, where reasonably practicable, all employers will be notified once settlement negotiations commence-(writing, email or telephone).

If a settlement offer is made, or parties commence engaging in settlement negotiations, the Insurer is to write to the worker and that letter should include:

- a) A recommendation that independent advice is obtained;
- b) Information as to worker's rights and entitlements to Act benefits and Common Law rights and the impact of a settlement on those benefits and rights;
- c) Information as to worker's rights and obligations to comply with legislation imposed by the Health Insurance Commission, Child Support Agency, Private Health Insurers and Centrelink;
- d) Providing WorkCover contact information.

Fair Dealing

Insurers commit to fair dealing at all times with regard to settlement of claims by agreement. All negotiations are to be conducted in an open, timely and fair fashion. Negotiations are to be in writing, or to be confirmed in writing, at all times to avoid confusion. Insurers expressly acknowledge that service providers are not to be engaged as agents for the purpose of settlement discussions.

Follow-up of Offer of Settlement of Act Benefits

Insurers should "diarise" an offer. If a response has not been received to the offer of settlement, then the insurer should, within a reasonable time frame, follow up the offer with the worker or his/her representative. Insurers respect the right of a worker not to engage in settlement negotiations. Insurers will not make further offers of settlement for a period of not less than 6 months, or unless approached by the worker or his/her representative.

Injury Management /Approved Vocational Rehabilitation Providers

Insurers commit to the principles of Injury Management outlined in the Guidance Notes for the Code of Practice Injury Management (2005) WA, including early intervention, timely and appropriate medical treatment and appropriate, early referral to vocational rehabilitation.

Insurers commit to ensuring employers are made aware of the value of and legislative requirements of the Code of Practice Injury Management. Insurers are committed to supporting employers in their efforts to comply with workplace based Injury Management and the early return to work of workers.

Approved Vocational Rehabilitation Providers (AVRP)

Insurers acknowledge the importance of AVRP's to facilitate early return to work and Injury Management in specific cases and will work collaboratively with them to achieve appropriate return to work outcomes. Insurers acknowledge that in line with the Act workers have the right to select the AVRP of their choice.

If an Insurer identifies a need for rehabilitation or the employer requests it be arranged, the Insurer will appoint the most appropriate AVRP in consultation with the key parties.

Confirmation of the appointment of a rehabilitation provider will be provided in writing (Form VR1)

Where a worker seeks to change rehabilitation provider, Insurers will assist employers to investigate the reasons provided by the worker for the review and facilitate a satisfactory resolution wherever possible.

Best Practice

Commitment To Employers

Reimbursement of Weekly Payments

On receipt of a properly documented claim for compensation reimbursement from an employer, the Insurer will reimburse the employer within 10 working days, unless other arrangements have been made with the employer.

An Insurer should provide guidance and training to employers to ensure workers receive their correct entitlement to weekly payments without delay and are paid on their ordinary pay day.

Claims Progress

When a decision has been made on a claim (whether by the Insurer or by the DRD) the Insurer shall notify the employer of the outcome within 7 working days of the decision being made.

Employers and workers should be kept informed of important matters relating to the progression of the claim, including the effectiveness of rehabilitation and medical procedures.

Employers' Responsibilities and Statutory Obligations

Insurers should ensure that employers are aware of their responsibilities in claim notification and the essential features of employers' obligations under the Act. In particular:

- Sections 57A, 57A(3c) - Claims Procedure - Insured Employer.

- Section 61 - Weekly payments.
- Rehabilitation obligations and the requirement to be committed to rehabilitation.
- Obligations to provide alternative duties for 12 months (s84AA)(1)(b).
- Obligations to keep the pre-accident position open for 12 months.
- Obligations to provide return to work plans (Code of Practice Injury Management).
- Termination compliance (s84AB)

In addition, Insurers should notify employers of significant legislative changes and other information that impacts on the employer's role in the workers' compensation scheme in Western Australia. Insurers commit to providing this ongoing education and legislative update information to employers in a timely manner.

Commitment to Workers

Reimbursement of Expenses

On receipt of a properly documented request for reimbursement of travel expenses from a worker, provided that the said expense is not the subject of a referral to the DRD, the Insurer will reimburse the worker within 5 working days of receipt of the expense claim.

An Insurer will provide guidance and advice to workers to ensure workers receive their correct reimbursements without delay.

Commitment To Service Providers Payment of Accounts

An Insurer shall pay accounts within 20 working days of the receipt of the account, subject to the acceptance of the claim and acceptance of liability for the expense. Payments will be in accordance with the schedule of fees agreed by WorkCover and the AMA.

Notification to Providers on disputed claims

Where liability for an expense or the claim has not been accepted, the Insurer should notify the relevant service providers in writing, within 10 days of the decision that it is unable to consider payment of its account.

Cross Border Legislation – workers temporarily Overseas

Pending clarification of the cross-border legislation, in relation to workers working overseas, either through the establishment of a legal precedent or an amendment to the Act, Licenced Insurers agree to interpret Section 20 (3) of the Act and the Act generally, to apply to Australian residents and workers working temporarily overseas. Working "temporarily" overseas is generally considered to be a period up to six months". By written agreement Insurers may extend this cover beyond six months.

Journey Claims

Intention

It is the intention of these guidelines that a worker will be deemed to have suffered a personal injury by accident arising out of or in the course of employment if the injury arises during a journey other than the normal commuting between his/her residence and regular place of employment.

However, journeys between the residence (or temporary residence) and the regular place of employment, which are essentially "under the employer's instructions" (refer definition of "injury" in the Act) should not be excluded. Nonetheless, the specific exclusion under sub-section 19(2)(a)(ii) must still apply.

Application of the Guidelines

The provisions in sub-section 19 (2)(b) and 19 (3) in relation to "substantial interruption of, or substantial deviation from the journey" similarly apply to these guidelines.

The definitions of "Place of Residence/Home" and "Place of Employment/Workplace" (although not included in the Act) should be applied as follows:

Place of Resident/Home

The boundary line is the line marked by the actual building or flat in which the worker eats, drinks or sleeps and not the boundary of the land on which the residence stands. Thus, the moment a worker steps out the front door, he/she would be regarded as having left the residence and the converse situation applies.

Temporary residences such as a holiday home or hotel/motel where the worker is staying are regarded as a "place of residence or home".

Place of Employment/Workplace.

Is the area of the employer's premises owned or controlled by the employer as opposed to the public domain. Thus, if an employer owns or controls a car park either within the building or adjacent to it, when the worker enters that building or car park and leaves the public domain, they should be regarded as having arrived at the place of employment and completed the journey.

Example

A worker will be at his/her place of employment:

- By entering through the main gates of the premises, as well as a car park outside these gates which is owned or controlled by the employer.
- Entering the main doors of an office building or car park connected to that building. If the workers employer is on one floor only, entering the building's main door is deemed to be at "the place of employment".

The following scenarios will assist claims staff to decide whether a "journey" is regarded (for the purposes of these guidelines) as being included or excluded.

NB: It has been assumed that the return journey is also included or excluded as the case may be.

Journeys regarded as compensable

- From home to the airport/train station for a trip (other than to the regular place of employment), and the ensuing travel including any travel during the visit, as long as all journeys/travel are in the course of employment.
- Examples of the journeys covered by this guideline are - visits to employer's office/client's office in other states or within WA.

- From home to business appointment other than between home and the office/workplace to which the worker reports and/or attends.
- The types of occupations this guideline might apply to are real estate agents, sales representatives, drivers (taxis, taxi trucks, etc) and the like.
- Journeys from home by workers "on call" who are required to attend emergency situations as directed by the employer, e.g. Western Power workers, Security Officers.
- Journeys from home to a destination where attendance is required by the employer other than to the office/workplace where the worker regularly works or reports. The exception in this guideline does not apply if the attendance is outside the worker's usual working hours or an emergency situation exists.
- Any travel during attendance at the destination must be in the course of employment.
- From home to the place of employment in company arranged/paid transport e.g. Company bus, taxis. This does not include company vehicles such as that forming part of the worker's salary package or provided to a sales representative to carry out his/her duties, and the like.
- Journeys between work sites and business appointments.

Journeys which are not compensable

- The usual or everyday travel by a worker between his/her home and their regular office/workplace. This includes workers who are under a contract or other business arrangement where the work being performed is for a continuous extended period even though the office/workplace is not where the worker usually works or reports e.g. Auditors, computer contractors.
- Also excluded is the journey from home by a building worker or tradesperson to a building site (whether domestic or commercial), at which he/she usually work or where the work is for a continuous extended period. If however, the tradesperson is required to visit several building sites, then the journey would be compensable -refer guideline 3 (a)(ii).
- A journey by a worker between his/her home and the places referred to in sub-section 19 (1) of the Act.
- Travel between workers' places of residence.

It is important to understand that these guidelines have been prepared in an attempt to avoid confusion for employers, employees and Insurers as to whether a "journey" is compensable or not under the Act.

Precursor to Section 73 – Section 74

Insurers as a matter of good practice will advise the employer/Insurer of any possible 73/74 matter within fourteen days of becoming aware even if the current employer/insurer has not determined whether section s73/74 is triggered. Should the current insurer elect not to pursue recovery or determine liability is not an issue then as a matter of courtesy will advise the employer/insurer accordingly.

Section 73

Claims issues involving section 73 of the Act will be managed in accordance with the protocol

governing section 74.

Please refer to Appendix "A".

Section 74 Disputes

Insurers seek to reduce the referrals and subsequent litigation in the DRD of disputes under section 74 of the Act and intend that these guidelines will provide a mechanism for alternative resolution of such disputes.

Insurers undertake to ensure that workers receive their rightful entitlements to compensation, irrespective of whether one or more Insurer is liable to pay such compensation.

During the process of resolving which Insurer is liable for compensation the latest Insurer on risk must consult closely with the employer and the worker involved and apply the Workers' Compensation Code of Practice Injury Management.

Insurers recognize the obligation of the Insurer on risk at the time of the latest Injury to pay compensation pursuant to section 57A and as required by section 74 of the Act until a decision is made, by agreement or mediation, that a prior Insurer/s is liable.

For the purposes of this agreement we quote section 74 of the Act.

- (1) "Where a worker is entitled to compensation for a fresh injury or the recurrence of an old injury, from an employer but there is a dispute between insurers as to liability to indemnify that employer, the insurer of the employer of the worker at the time of the latest injury or recurrence is liable to indemnify the employer until an arbitrator has otherwise determined.
- (1)(a) An employer or insurer may apply for determination by an arbitrator of a dispute between insurers notwithstanding any term or condition of any policy of insurance providing for some other means of settling disputes.
- (2) An arbitrator shall determine which insurer is liable or how liability is to be apportioned and may make such order as the arbitrator thinks proper for the reimbursement of one insurer by another and for the indemnity of the employer in respect of his liability under this Act.

Where there "is no dispute between insurers that a worker is entitled to compensation", the current employer's insurer at the time of the latest injury agrees to indemnify the employer and to then participate in section 74 negotiations in accordance with agreed guidelines.

All discussions, meetings and correspondence entered into by virtue of this agreement will be between relevant Insurers without legal representation and will be deemed to be on a strictly "without prejudice" basis unless otherwise stated.

The current Insurer shall not deny or defer payment/s of compensation to a worker where there is no dispute that the worker is entitled to compensation on the sole basis that it holds the belief that the prior Insurer is liable to pay the worker's claim pursuant to section 74 of the Act.

If a current Insurer receives a claim for compensation and believes that liability for the claim

rests with an prior Insurer, either in whole or part pursuant to section 74, but there is no dispute as to the worker's entitlement to compensation, the current Insurer shall within 7 days of its decision, write to the prior insurer providing the following information:

- Details of the worker's claim;
- Details of the claim being made against the previous Insurer and whether liability is accepted for the worker's claim to any extent.
- The extent to which liability is admitted;
- Copies of all relevant documents.

A prior Insurer which receives notification shall within 20 working days write to the current Insurer:

- Acknowledging receipt of the notification;
- Indicating to what extent liability is admitted, and
- Providing copies of all relevant documents.

If the prior insurer accepts liability it must notify the current insurer that it accepts liability and will assume conduct for the management of the worker's claim and Injury. Within 20 working days, all reasonably incurred statutory expenses and weekly compensation are to be reimbursed to the current insurer.

In the case of an apportionment being agreed

- Within 20 working days, all reasonably incurred statutory expenses and compensation, shall be reimbursed to the current Insurer in the proportion/s agreed with conduct of the claim passing to that insurer with the greatest proportion, unless otherwise agreed.
- Within 20 working days, where the proportion is equal, all reasonably incurred statutory expenses and compensation are to be paid to the equal proportion by the prior insurer, to the current insurer, who will retain the conduct of the claim.

Where agreement cannot be reached as to liability between Insurers, Insurers must agree to a time frame to attempt resolution of the matter.

Within 10 working days of completion of the further inquiries undertaken or the additional time frame expiring, the prior Insurer is to communicate to the current Insurer its decision on the extent to which liability is admitted.

If agreement is not reached, the Insurers are to refer the documents/claim to the respective "Senior Review Officers" who shall within 7 days, make contact and convene a meeting with each other. At this meeting, these "Senior Review Officers"-shall use their best endeavors to resolve the dispute and come to an agreement.

If agreement is not reached, the Insurers are to refer the documents/claim to the "Senior State Representatives" who shall within 7 days, make contact and convene a meeting with each party to the dispute. At this meeting the "Senior State Representatives" shall use their best endeavors to resolve the dispute and come to an agreement.

Should agreement not be reached between the "Senior State Representatives" then it is further agreed, within 5 days to:

- Agree a mediator to mediate upon the dispute

- Refer the dispute for mediation and the costs of the mediation will be borne in proportion to each party/Insurer's liability as agreed by the mediator.

It is further acknowledged, that the determination by the mediator is final and binding. The determination is not subject to judicial appeal to the Supreme Court or any other court or jurisdiction (DRD).

Please refer to Appendix "A"

Information on Claims

At all times Insurers should encourage employers, workers and relevant bodies such as trade unions to contact them with questions or concerns about claims or claims procedures. An Insurer should have staff appropriately trained to handle this task.

Representation at Conferences and Hearings before the Commissioner

Insurers should ensure that only registered capable and experienced Claims Representatives act as agents at arbitration hearings and appeals before the Commissioner and/or Arbitrator/s. In addition, Insurers should where possible seek to avoid the use of legal representation at such hearings, unless the circumstances warrant such representation.

It is expected that Claims Representatives will approach the hearings in the spirit of the legislation with the authority to make decisions and demonstrate a genuine willingness to achieve an outcome consistent with the objectives of the Act.

Payment of Monies

Upon receipt of a judgment, court verdict, decision by the Arbitrator/Commissioner or on reaching agreement on a settlement, the Insurers undertake to pay the compensation due to the worker and other parties without delay, and at the latest within 5 days unless there is a planned appeal.

Use of Medical Practitioners

Insurers must ensure there is not unreasonable use of independent medical practitioners for the purpose of obtaining independent medical reports and consistent with the requirements of s64/65 of the Act and regulations.

Where there is conflict in medical advice or opinion, every attempt should be made by the Insurer, employer and worker to resolve the issue. Where early resolution is unlikely, the matter should be referred promptly to the DRD.

Review of Files

Insurers should review all claim files on a continual basis, but in any event not less than quarterly, to ensure the claim is pro-actively progressed to an early finalisation and that best practice claims and injury management is in place.

Assessors/Investigators/Surveillance Operators

Insurers should ensure at all times that persons appointed by them to interview or investigate claims, conduct themselves in an acceptable, fair and reasonable manner and comply with Federal Privacy laws.

Insurers are committed to the use of service provider agreements and the ongoing monitoring and auditing of compliance with the service provider agreement of all assessors/investigators and surveillance operators. Insurers must ensure that all operators engaged are licensed under the relevant laws and regulations.

Medical Service Fees

Insurers are required to indemnify employers for Medical Expenses incurred pursuant to the clause 17, 18 & 19 of Schedule 1 of the Act.

Insurers undertake to monitor these fees to ensure that they do not exceed the prescribed fee, or are not in excess of the fee that would normally be charged by the service provider and as per the schedule of fees agreed upon by WorkCover WA and the AMA.

Staff Competency

Insurers should ensure that staff handling workers' compensation matters are kept abreast of changes to the relevant legislation and practices by conducting appropriate training.

Spirit of the Act

In all workers' compensation matters, especially claims handling, Insurers should ensure that the decisions and actions of claims staff reflect the spirit of the Act and avoid (where possible) a reliance upon pedantic legal interpretation.

Licence Conditions for the Approval and Review of Insurers

Insurers commit to compliance with the Licence Conditions for the Approval and Review of Insurers under the Act.

Insurers agree to liaise with WorkCover WA in a timely and regular fashion regarding Licence conditions and any proposed amendments or additional conditions that may be imposed upon Insurers.

Privacy

Insurers commit to compliance with the National Privacy Principles (NPP's). This commitment includes compliance with those laws that have been legislated to give people new rights, including the right to gain access to, or limit the use of, their personal information.

Insurers commit to ensuring that procedures in place for handling privacy complaints are current and that staff are trained in the handling of privacy complaints.

Monitoring

All Insurers shall ensure that they implement and maintain an appropriate system of internal quality control to perform their obligations, duties, powers and functions under the Act, the Insurance Contracts Act and any other applicable legislation.

Appendix A- Section 74 Disputes

