



# **Performance Monitoring Methodology for Approved Insurers**

**2003**

# CONTENTS

	<b>Page</b>
<i>i) Introduction</i>	<b>3</b>
<b>1.0</b> <i>Financial Resources Program</i>	<b>4</b>
<b>2.0</b> <i>Compliance Monitoring Program</i>	<b>8</b>
<b>3.0</b> <i>Client Services Program</i>	<b>14</b>
<i>Insurer Audit Checklist</i>	<b>19</b>
<b>4.0</b> <i>Internal Dispute Resolution Program (incorporating Claims Management Review)</i>	<b>23</b>
<i>Insurer Audit Checklist</i>	<b>26</b>

*i) Introduction*

The following four Programs have been developed to assess approved insurer performance:

- 1. Financial Resources Program**
- 2. Compliance Monitoring Program**
- 3. Client Services Program**
- 4. Internal Dispute Resolution Program (incorporating Claims Management Review)**

An objective of the Guidelines is to increase the level of influence the WorkCover Western Australia Authority (the Authority) has over insurer performance.

Indicators for the Financial Resources Program require 100% insurer compliance. Non-compliance with these indicators will result in the insurer not meeting the minimum requirements for underwriting approval.

Please note the Sections of the Act referenced in the Guidelines have been updated to reflect the legislative changes to the Workers' Compensation and Injury Management Act 1981 in November 2005.

**WorkCover Western Australia**

**FINANCIAL RESOURCES PROGRAM**

## **1.0 Financial Resources Program**

### **Introduction**

The objective of the Financial Resources Program is to measure the degree to which an insurer complies with legislative and the Authority requirements.

### **GUIDELINES ON STANDARD OF PERFORMANCE REQUIRED**

Indicators for the Financial Resources Program require 100% insurer compliance. Non-compliance with these indicators will result in the insurer not meeting the minimum requirements for underwriting approval.

#### **1.0 Authority and Material and Financial Resources (Section 161(3)(a))**

##### **Authority and Material Resources**

Approved insurers are required to have adequate resources in the State to fulfill their obligations under the Act.

##### **Performance Indicator**

Approved insurers shall maintain an office in the State with authority and material and financial resources available to it that the Minister, on the advice of the Authority, considers sufficient to enable it to discharge its obligations for the purposes of this Act.

##### **Standard of Performance**

To enable the Authority to determine the adequacy of those resources, approved insurers are to provide the following information:

- (i) a copy of their organisational chart detailing the number of staff and the minimum levels of training and experience for each major classification of employee. Reference to industry wide standards may be considered with this indicator.
- (ii) demonstration by insurers that they have in place manuals on claims management / customer focus. This should include how responsibilities are delegated.
- (iii) demonstration that information management systems utilised by the insurer are able to meet the compliance standards.
- (iv) written confirmation from the Controlling Officer of the approved insurer that sufficient authority and material and financial resources exist in the State to make decisions for the expeditious handling of claims.

## **Financial Resources**

The Authority has determined that an approved insurer must comply with the following conditions and provide the information listed in order to maintain their status:

### **(i) Contributions** **Section 109**

Each insurer shall contribute annually to the General Fund a sum equal to –

- (a) The amount prescribed for the purposes of this subsection; or
- (b) A sum amounting to a percentage to be fixed by the Authority of the total amount of the premium income (whether received by or owing to the insurer) of the insurer in respect of the year ended 30 June then last past in respect of insurance of employers against their liability to pay compensation under this Act, and their liability under any other law in respect of persons employed by them, excluding any part of the premiums actually paid by way of reinsurance to any other insurer contributing under this Act, which percentage shall be uniform for all insurers.

### **(ii) Solvency**

Approved insurers are to comply with the minimum solvency margins stipulated for authorised general insurers as prescribed by the Australian Prudential Regulation Authority (APRA). The guidelines came into effect from July 2002. These standards will be used by WorkCover WA to assess insurer performance under this indicator.

The Authority is to receive from an approved insurer within 120 days after the close of such insurers financial year the following information.

- a) An actuarial assessment of non-current outstanding claims reserves to determine the adequacy of provisions included in the last published accounts.
- b) An independent actuarial assessment if requested by the Authority.
- c) An independent yearly auditor's certificate which attests that the approved insurer's assets have been properly assessed at "net market value" to the extent required by the Approved Accounting Standard ASRB 1023.

APRA D2A forms are to be provided where relevant on a quarterly and annual basis.

(Formerly the financial information required under the Commonwealth Insurance Act 1973 included: Form 3 Balance Sheet (annually), Form 4 Statement of Assets & Liabilities (annually), Form 16 Quarterly Statement of Assets, Liabilities, Premiums & Claims (quarterly) and the Approval of Section 30 assets. The APRA standards have superceded these financial requirements).

In addition, where requested by the Authority all correspondence (including, without limitation notices, demands and requests) sent from or on behalf of APRA or required under the Insurance Act 1973 to the insurer (or any agent or adviser of the insurer) or sent from or on behalf of the insurer to APRA or as required under the Insurance Act 1973 (or any agent, adviser or delegate of APRA).

(iii) **Credit Rating**

Credit ratings are to be considered as part of the annual review of approved insurer performance. The Standard and Poors rating is to be used.

Insurers are to maintain the minimum solvency levels as a general insurer as prescribed by APRA and maintain a satisfactory credit rating (where applicable) as determined by the Authority using the credit ratings agency Standard and Poors. Insurers that do not have a credit rating are also required to comply with APRA requirements.

**Performance Indicator**

Provision of information and returns as required for a general insurer under the Commonwealth Insurance Act 1973 and the returns indicating the solvency levels as prescribed by APRA. Maintenance, where necessary, of a satisfactory credit rating as determined by the Authority.

**Standard of Performance**

Insurers are to provide the required information and returns for a general insurer under the Commonwealth Insurance Act 1973 and maintain the minimum solvency levels as prescribed by APRA. Insurers are also required to maintain a satisfactory credit rating (where applicable) as determined by the Authority using the credit ratings agency Standard and Poors. Insurers that do not have a credit rating are also required to comply with APRA requirements.

**WorkCover Western Australia**

**COMPLIANCE MONITORING PROGRAM**

## 2.0 Compliance Monitoring Program

### GUIDELINES ON STANDARD OF PERFORMANCE REQUIRED

#### 1.0 DETERMINING LIABILITY/ADVICE TO PARTIES *Section 57A(3)*

Insurers shall ensure the Dispute Resolution Directorate, the employer and the worker are notified in the prescribed format, that a decision as to whether or not liability is to be accepted (including recurrences of an injury) in respect of the weekly payments claimed and the reasons for the decision is not able to be made. The time limit for the notification is within fourteen days after the claim was made upon the insurer by the employer.

##### *Performance Indicator*

Verification whether the insurer has notified the Dispute Resolution Directorate, employer and worker in the prescribed format, within fourteen days of the claim being made that a decision as to whether or not liability is to be accepted (including recurrences of an injury) in respect of weekly payments claimed and the reasons for the decision is not able to be made.

#### 2.0 ADVICE TO AUTHORITY IF THE INSURER REFUSES TO INDEMNIFY EMPLOYER *Section 57B(2b)*

Insurers shall ensure if they decline to indemnify an employer against the employer's liability to pay compensation claimed, procedures are in place to notify the Authority within fourteen days after the claim was made by the employer. It is proposed all notifications are to be made through "Insurer On-line".

##### *Performance Indicator*

The Authority is notified, within fourteen days of the claim being made, if the insurer declines to indemnify an employer against the employer's liability to pay compensation claimed.

#### 2.1 Loading not exceed 75% unless permitted by Authority

*Section 152*

Unless permitted by the Authority to do so, an insurer shall not charge a loading on a recommended premium rate of more than 75% of that rate.

##### *Performance Indicator*

Verification that loadings of more than 75% of the recommended premium rate have been approved by the Authority.

### **3.0 UNLAWFUL DISCONTINUANCE OR REDUCTION IN WEEKLY PAYMENTS** *Section 61*

Insurers are to ensure weekly payments of compensation for total or partial incapacity made to a worker under the Act (with the knowledge of the insurer) are not discontinued or reduced unless they have complied with the relevant provisions of the Act.

#### **Performance Indicator**

Verification of complaints and/or applications at the Dispute Resolution Directorate by or on behalf of the worker where it was proved the insurer failed to comply with the provisions of the Act to notify the worker on the discontinuance or reduction of compensation payments. Decisions impacting on workers entitlements are required to be reviewed by senior insurer staff and evidenced on file.

### **4.0 INSURER DISPUTES AS TO LIABILITY - LAST INSURER TO INDEMNIFY EMPLOYER UNTIL A DISPUTE RESOLUTION BODY ORDERS OTHERWISE OR THE MATTER IS RESOLVED** *Section 74*

Where a worker is entitled to compensation for a fresh disability or the recurrence of an old disability from an employer, but there is a dispute between insurers as to liability to indemnify the employer, the insurer of the employer at the time of the latest disability or recurrence is liable to indemnify the employer until a dispute resolution body determines otherwise.

#### **Performance Indicator**

Verification that where there is a dispute as to liability between insurers, the insurer of the employer of the worker at the time of the latest disability or occurrence has indemnified the employer and the dispute has been referred to a dispute resolution body.

## **5.0 REQUEST FOR INFORMATION FROM INSURER BY WORKCOVER WA** *Section 103A*

Insurers shall ensure any information or returns requested in writing by the Authority are accurate and within the time as specified in the request. Such returns and information are to include, but are not limited to, premium rating returns, premium income details and other returns as determined by the Authority.

### **Performance Indicator**

Verification that requests for information or returns by the Authority which are complied with by approved insurers are accurate and within the timeframe specified compared to the total number of requests.

## **5.1 Timeliness of Provision of Policy and Claims Data** *Section 171*

Insurers shall ensure policy (and claim) data returns are submitted to WorkCover within fourteen days of the following month. Issues outside of an insurer's control may be considered when assessing insurer performance.

### **Performance Indicator**

Insurer monthly policy and claim data received by the prescribed timeframe.

## **5.2 Edit Failures and the Requests for Revision of Data**

Insurers shall ensure requests for corrected claim and policy data are met within seven days of the insurer receiving the error commentary report.

### **Performance Indicator**

Verification that insurers have corrected their monthly claim and policy edit failures and that the data is returned to WorkCover WA within seven days after receiving the error commentary report. Issues outside of an insurer's control may be considered when assessing insurer performance.

## **6.0 INSURER TO MAKE CONTRIBUTIONS TO THE GENERAL FUND** *Section 109(3)*

Insurers are required to contribute annually to the Authority's General Fund. The amount of the contribution from an insurer is a sum amounting to a percentage fixed by the Authority of the total amount of the premium income of the insurer. The contribution payable is based on the premium income of an approved insurer for the previous year ended 30 June.

The contribution is payable by 1 October in each year unless it exceeds \$15,000 in which case it may be paid in quarterly instalments on 1 October, 1 January, 1 April and 1 June in each year or on other days as the Authority may determine.

### **Performance Indicator**

Verification contributions received are for the correct amount and are made on time.

#### **6.1 Failing to Send the Return** *Section 109(6)*

Any insurer failing to send the return in that month or by such other time as the Authority shall appoint, as the case may be, commits an offence.

### **Performance Indicator**

Verification of receipt of the return in that month or as appointed by the Authority.

#### **6.2 False Return from Insurer** *Section 109(7)*

An insurer who sends in a return which is false or incorrect in any material particular is guilty of an offence.

### **Performance Indicator**

Verification the return is correct.

**7.0 INSURANCE: AN APPROVED INSURER SHALL INSURE ANY EMPLOYER** *Section 160(3)*

An approved insurance office shall insure any employer requesting it for the full amount of liability of the employer to pay compensation under this Act to all workers employed by him.

**Performance Indicator**

Verification that insurers have insured any employer requesting it for the full amount of liability of the employer to pay compensation under the Act to all workers.

**7.1 Issue or Renewal of Policy Without Approval** *Section 161A*

An incorporated insurance office shall not issue or renew a policy insuring an employer against his liability to pay compensation under this Act unless the incorporated insurance office is approved by the Minister under section 161 and the approval is not suspended at the time of the issue or renewal of the policy or has not been revoked by the Minister.

**Performance Indicator**

Verification the issuing or renewal of a policy insuring an employer against his liability to pay compensation under the Act is in accordance with the Act.

**7.2 Insurer to Notify the Authority of New, Renewed and Lapsed Policies** *Section 171(3)*

Insurers shall ensure a statement of each employer who has effected or renewed a policy or contract of insurance with them against liability under the Act and who has lapsed a policy or contract of insurance are submitted to WorkCover within fourteen days of the following month.

**Performance Indicator**

Insurers new, renewed and lapsed policies received by the prescribed date.

**7.3 False Statement** *Section 171(4)*

If any statement required by this section is false or incorrect in any particular to the knowledge of any person who signs it, that person commits an offence.

**Performance Indicator**

Any statement by this section to the knowledge of the person signing it is correct.

**WorkCover Western Australia**

**CLIENT SERVICES PROGRAM**

### **3.0 Client Services Program**

#### ***Introduction***

The Client Services Program / Standard has been established to provide direction for approved insurers in managing workers' compensation claims and underwriting workers' compensation policies in the Western Australian workers' compensation system. The Program draws on stakeholder best practice principles and incorporates industry specific codes of conduct.

#### ***Purpose of the Standard***

The Standard is designed to facilitate a sensible, reasonable and consistent approach in managing workers' compensation claims and providing underwriting services in a fair, efficient and effective manner.

#### **Claims Management Service**

Customer service focuses on an insurer's processes to advise employers/ees (and service providers) on issues concerning a workers' compensation claim. Insurers should provide information to employers/ees as to their rights and responsibilities when a workers' compensation policy is agreed and when a claim has been determined. Documentary evidence of contact is to be maintained on the insurers file for review by WorkCover WA if necessary. Key elements of an insurer's provision of service include:

- ***Information on claims***
- ***Claims Management***
- ***Review of Files***
- ***Reimbursement of Weekly Payments***
- ***Payment of Accounts***

#### ***Information on Claims***

Insurers should encourage employers, injured workers and other relevant parties to contact them if they have any concerns about claims procedure. Only appropriately trained staff should undertake this task. WorkCover expects insurers would have staff development and training programs in place to ensure staff have knowledge of the Act and experience in claims processing to answer any queries concerning a workers' compensation claim.

#### ***Claims Management***

In the spirit of the Workers' Compensation and Injury Management Act 1981, an insurers' claims management practices should be carried out to provide a fair, equitable and effective service to compensation recipients.

### ***Review of Files***

Insurers are expected to continuously review active claim files to facilitate where possible claims progressing to an early finalisation. Where an external audit is considered necessary WorkCover will review insurer claim files to verify contact between the parties.

### ***Reimbursement of Weekly Payments***

Insurers shall ensure that upon receipt of a Compensation Reimbursement Invoice from the employer, payment to the employer is forwarded within ten working days unless other arrangements have been made with the employer.

### ***Payment of Accounts***

Insurers shall ensure that the payment of valid accounts, subject to the acceptance of the claim, is made within twenty working days of receiving the account.

### **Underwriting Service**

Under Section 160 of the Act insurers “...shall insure any employer requesting it for the full amount of the liability of the employer to pay compensation under this Act to all workers employed by him”. Insurers are reminded of the requirements of this provision in providing quotes/terms when requested by an employer. Applications to load greater than 75% are to be made one month from the acceptance of terms. Insurers are encouraged to outline the contractual obligations to an employer under an *Employers Indemnity Policy* when a policy is effected. The information should be transparent and detail each party’s rights and responsibilities.

### ***75% Loadings***

Under Section 152 of the Act an insurer unless permitted by the Authority cannot load a recommended premium rate by more than 75% of that rate. Insurers are requested to be aware of this provision when loading a premium rate and also the appeal processes under Section 154.

### ***Statutory Returns***

The Act requires a number of returns relating to an underwriting policy to be forwarded to WorkCover within prescribed timeframes. These returns include details of new, renewed, lapsed and cancelled policies. Insurers are advised to be aware of the prescribed timeframes in forwarding this information to WorkCover. Please note this requirement is covered in the Compliance Monitoring Program.

Evidence of contact with an employer advising the above is to be maintained on the insurer’s file for review by WorkCover WA if required.

## **Complaints**

Complaints refer to written complaints that have been received and investigated by WorkCover with respect to service delivery under the Act and the Guidelines by insurers to stakeholders in the system. Complaints forwarded to WorkCover can be received from injured workers and employers (or their representatives) and other parties who are able to access statutory entitlements.

Substantiated complaints refer to a breach of the Act or the insurer performance standards outlined in this report by an approved insurer that has been confirmed by WorkCover. By recording all complaints against insurer performance WorkCover is able to review and address areas in the Scheme that may require operational or legislative amendment.

(Insurer performance with respect to the timing of providing notices required under Regulation 19P will form part of the insurer's assessment).

All complaints received will be registered by WorkCover and form part of the annual report on insurer performance against the Guidelines. The report on insurer performance is forwarded for consideration to the WorkCover Western Australia Authority and the Hon Minister on an annual basis.

## **Insurer Self-Audit**

As part of the Authority's annual review for monitoring performance, insurers will be requested to develop their own Client Services Procedures Standard document (Procedures Standard). The Procedures Standard is to address the key principles as detailed below in the Insurer Audit Checklist. Insurers will be required to submit a copy of their Procedures Standard to WorkCover for evaluation each year.

If during the review period there are concerns with an insurer's procedures an on-site audit of its processes may be undertaken by WorkCover.

## **Insurer Audit Checklist**

The Audit Checklist comprises a list of the key principles and comments to ensure the completeness of an operation and to provide assurances that compliance with the performance indicator has been met. These key principles are listed on page 19.

### ***Objective of Checklist***

Assess the performance of an insurer against the key principles as documented in their Procedures Standard in delivering service as determined by the Authority.

### ***Scope of the Checklist***

Review the Procedures Standard of an insurer.

### ***Outcome of the Checklist***

Verification of the effectiveness of an insurer's Client Services Procedures Standard.

### ***Audit Approach***

The audit approach includes reviewing the insurers Self Audit Checklist with supporting documentation including manuals, charts and procedures to ensure compliance with the Standard.

If WorkCover were to undertake an on-site audit information will be obtained from the insurer's procedural manuals, file review, discussion with employees and other stakeholders.

**Program 3: Client Services Program – Insurer Audit Checklist**

**Key Principles**

**Comments**

**A) Underwriting Service**

- Employers are informed as to their contractual obligations under the Act.
- Premium rate loadings of greater than 75% are referred to and permitted by the Authority in accordance with established procedures. Applications to load greater than 75% are to be made one month from the acceptance of terms.
- Renewal notices are issued thirty days before expiry to insurance brokers and fourteen days prior to expiry for employers (with no broker involvement).
- Statutory returns are forwarded within the prescribed timeframe.

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**B) Claims Management Service**

**1. Consultation and Communication**

- Employers are consulted on proposed major developments in claims for feedback prior to taking action. A major development in a workers' compensation claim involves any action that may impact on an injured workers' statutory entitlements eg. a reduction, suspension and/or cessation in weekly payments, settlements, any decision/act that impacts on the worker's entitlement to medical, allied health or vocational rehabilitation services etc.

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**Program 3: Client Services Program – Insurer Audit Checklist**

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**2. Provision of Information**

- Employers and workers are advised of their rights and responsibilities when a claim has been determined.

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- Employers are provided with information on their claims on a proactive basis or within seven working days of a request.

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**3. Weekly Payments**

- Evidence is to be maintained on file for the calculation of weekly payments including step-downs.

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**4. Payment of Accounts**

- Valid accounts are correctly processed and paid within twenty days of receiving the account

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**Program 3: Client Services Program – Insurer Audit Checklist**

**5. Claims Reviews**

**Comments**

- All long duration claims (greater than 60 days) are to be reviewed at least on a quarterly basis in consultation with the employer, injured worker, doctor to assess the effectiveness of treatment, cost effectiveness and other relevant issues. Evidence is to be maintained on file indicating: the date and the name of the person undertaking review, names of other parties involved, status of the claim, case management plan for future management. This principle does not apply with respect to elections under Regulation 19P where there is no current action, continuation of an injured worker’s claims management plan may not be warranted.


- Regular reviews are to be conducted with employers on a mutually agreed schedule or from requests by the employer.


**6. Staff Competencies**

- Manuals on claims management/customer service are to be both accessible and communicated to staff and subject to regular review.


- Appropriate staff training programs addressing core staff competencies are documented, administered and subject to regular review.


**Program 3: Client Services Program – Insurer Audit Checklist**

**7. *Dispute Resolution (Dispute Resolution Directorate)***

- A fully documented process exists for resolving a dispute between relevant parties (ie. employer, injured worker, service provider, other insurer).
  
- Systems are in place to monitor disputes referred to the Dispute Resolution Directorate and these systems are sufficient so that insurers can provide consultation and communication to employers.
  
- Strategies are documented to minimise delays in hearing matters referred to the Dispute Resolution Directorate to any party to the claim.




**WorkCover Western Australia**

**INTERNAL DISPUTE RESOLUTION PROGRAM  
(incorporating Claims Management Review)**

## **4.0 Internal Dispute Resolution Program (incorporating Claims Management Review)**

### ***Introduction***

The objective of the Internal Dispute Resolution Program (IDRP) is for insurers to resolve disputes internally to reduce the number of disputes lodged at the Dispute Resolution Directorate.

To review the effectiveness of an insurers IDRP, consideration is to be given to altering the Dispute Resolution Directorate's Applications to include whether the injured worker/employer participated in the Internal Dispute Resolution Program and the level of satisfaction.

Approved insurers are to provide draft documentation of their internal dispute resolution procedures including manuals and other related documentation in August 2003. The self audit process for the 2003/2004 annual review will be based on performance for the ten months to June 2004.

### **Claims Management Review**

The objective of the Claims Management Review is for insurers to avoid unnecessary formal disputes being lodged at the Dispute Resolution Directorate. In the event of a proposed denial of liability, pending (timeframes), reduction or termination of a workers entitlement to compensation, senior insurer staff are to review the recommendation before any action is taken. This process ensures that considered decisions/actions that impact workers entitlements are taken in consultation with senior management thereby reducing the likelihood of internal and formal disputes.

### **Insurer Internal Dispute Resolution Processes**

As part of the Authority's annual review for monitoring performance, insurers will be requested to provide a self-audit documentation for consideration. The documentation is to include the insurer's procedures manual and any other relevant records in line with the audit checklist. If during the review period the Authority has concerns with an insurer's internal dispute resolution procedures WorkCover may undertake an on-site audit of its processes.

### **Insurer Audit Checklist**

The Audit Checklist comprises a list of the key principles and comments to ensure the completeness of an operation and to provide assurances that compliance with the performance indicator has been met. Insurers are to ensure that supporting documentation is provided confirming that the compliance standard has been met.

### ***Objective of Checklist***

*Assess the Procedures Standard provided by insurers to employers, workers and service providers that may be involved in the internal dispute resolution process.*

### ***Scope of the Checklist***

*Review the internal disputes resolution processes of an insurer.*

### ***Outcome of the Checklist***

*Verification of the effectiveness of an insurer's Procedures Standard.*

### ***Audit Approach***

The audit approach includes:

1. Reviewing the insurer's Self Audit Checklist with supporting documentation including manuals, charts and procedures to ensure compliance with the performance indicator;
2. Testing a sample of the insurer's internal disputes if WorkCover were concerned with insurer performance;
3. Assessing the results of the testing.

With respect to the above criteria, if WorkCover undertakes an on-site audit, information will be obtained from the insurer's procedural manuals, file review, discussion with employees and other stakeholders.

Testing will provide evidence of the level of compliance with the performance indicator and further support the assessment of the IDR. Where the results of testing indicate non-compliance WorkCover will advise the insurer the reason why so that recommendations for improvement can be made.

Note that decisions impacting on workers' entitlements to compensation must be reviewed by senior staff and evidenced on file.

**Program 4: Internal Dispute Resolution Program - Insurer Audit Checklist**

**Key Principles**

**Comments**

**1. Background**

Staff involved with the development of the IDRP (insurer to notify if any changes).

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Insurer staff are aware of IDRP and the document is accessible.

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**2. IDRP Manual**

IDRP manual cited.

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Date of implementation and updates cited.

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Definition of “Dispute” verified.

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IDRP processes documented.

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Processes in place for recording and monitoring disputes.

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**Program 4: Internal Dispute Resolution Program - Insurer Audit Checklist**

**3. File Audit**

Dispute received, recorded and responded to in timely manner.


Action progressed in line with insurer's IDRP.


Authority and actions evidenced on file adequate. Decisions impacting on workers' entitlements are to be reviewed by senior staff.


Outcome recorded.
