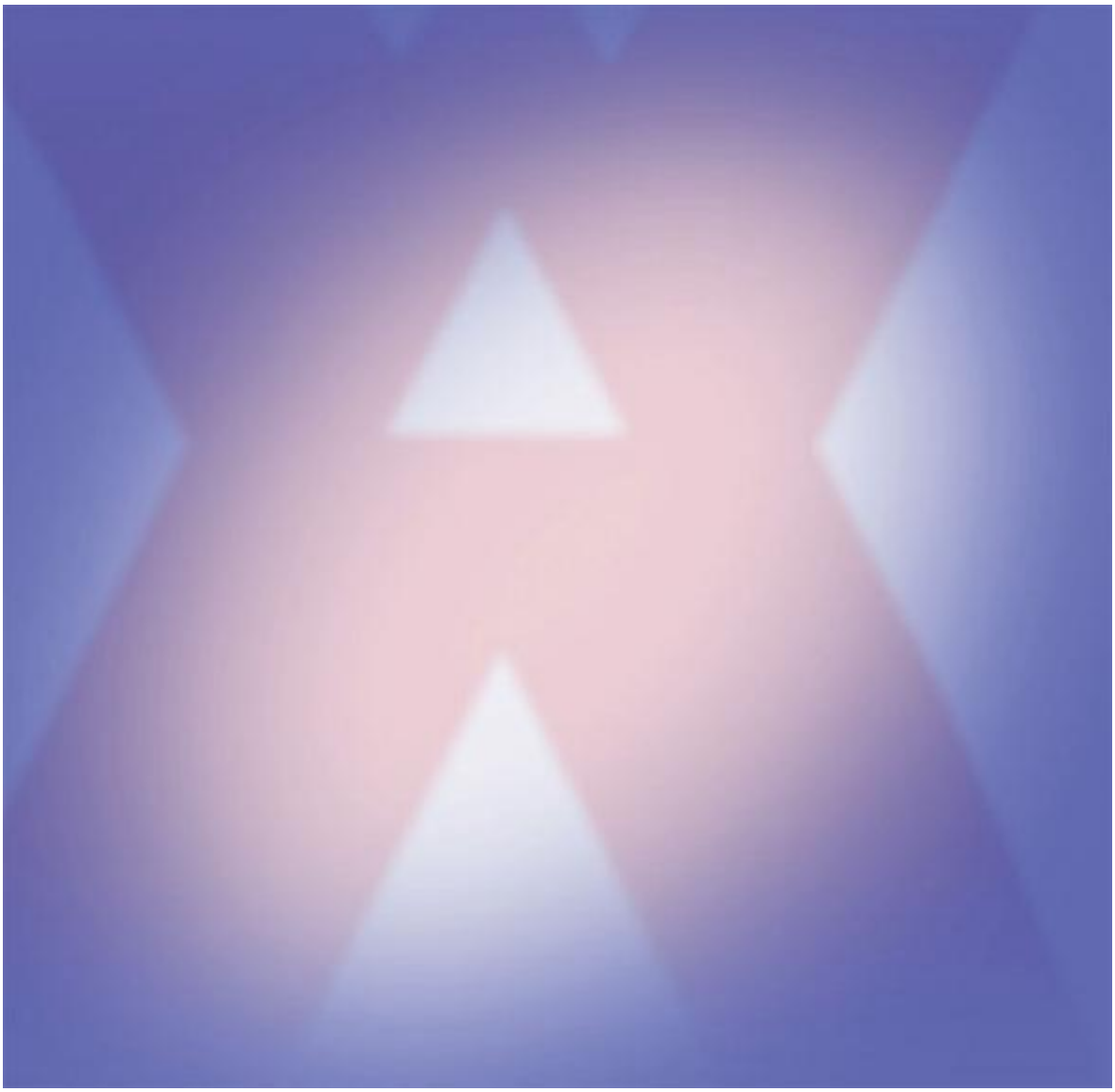
NSW WorkCover Scheme

SCHEME AGENT CASE MANAGEMENT

SELF AUDIT AND EVIDENCE GUIDE

MAY 2008



INTRODUCTION

1. HISTORY

WorkCover NSW has introduced a case management self audit guide that is designed to assist Scheme Agents to monitor their compliance with legislative and contractual requirements for injury and claims management.

The Scheme Governance Model under Schedule 14 of this Deed identifies case management as one of the key governance obligations and requirements of Scheme Agents. In accordance with this model, Scheme Agents are required to undertake periodic audits, inspections and reviews of their case management either through their quality assurance processes or their internal qualified auditors. This audit guide can be used as a tool to assist Scheme Agents in complying with these requirements.

In line with the importance that has been placed on case management, the Nominal Insurer has implemented a Key Performance Indicator (KPI) with respect to this key Scheme governance obligation and requirement. The Nominal Insurer will utilise and apply the results from this audit guide to measure the Scheme Agent's compliance with KPI 2 Case Management under Schedule 5, and the associated remuneration entitlements under Schedule 3 of this Deed.

2. CASE MANAGEMENT

The goal of case management is to ensure a timely, safe and durable return to work for injured workers. It focuses on cost effective service delivery and aims to achieve timely and sustainable return to work outcomes and maximum functional capacity.

When applied to workers compensation, case management means a coordinated and managed approach that integrates all aspects of injury and claims management including:

- payment of benefits
- liability determination
- treatment
- rehabilitation
- retraining
- factual investigation
- claims estimation
- investigation of potential recovery
- employment management practices e.g. actions to promote provision of suitable duties.

The Scheme Agent's case management framework must provide a set of clearly defined principles and practices underpinned by quality assurance and continuous improvement. It must ensure effective management of a claim from notification through to finalisation, supported by sound decision-making. Fundamental to the framework is the appointment of appropriately qualified and trained personnel responsible and accountable for actively managing claims.

3. CONDUCTING AN AUDIT

Scheme Agents are required to conduct case management audits, inspections and/or reviews in accordance with Subclauses 29.4, 29.7 and 29.11 of this Deed, Schedule 5 and Schedule 14.

Auditors

The audit team should comprise people who are experienced in auditing and have sound knowledge of injury and claims management. A comprehensive audit is likely to take an audit team several days to complete.

Sources Of Information

Information or evidence for auditors may include but is not limited to:

- documentation such as the Injury Management Program, claims and estimation manuals, other procedural manuals, training packages, information kits, training records
- files that record claims and injury management activities and access to associated electronic data
- interviews with relevant staff members, in particular the manager(s) responsible for workers compensation, case managers, claims staff, injury management advisers, technical advisers, team leaders, medical or claims consultants.

4. CASE MANAGEMENT AUDITING COMMITMENT

The audit guide will facilitate Scheme Agents with meeting their various case management auditing commitments.

Injury Management Program

The Scheme Agent's Injury Management Program is an integral part of the case management model described in the Business Model under Schedule 1 of this Deed. The Injury Management Program is a legislative requirement under section 43 of the *Workplace Injury Management and Workers Compensation Act 1998* and is reviewed by WorkCover separately to the case management audit process. The Injury Management Program is to be periodically revised and updated to reflect current procedures, legislation, regulations and guidelines or at the direction of WorkCover.

Quality Management Framework

The Scheme Agent's quality management framework is a component of the Business Model submitted to the Nominal Insurer under Schedule 1 of this Deed. This framework must incorporate quality assurance as part of the Scheme Agent's obligation in the provision of quality management. Scheme Agents are therefore expected to undertake quality assurance reviews of their case management model within their Business Model to ensure quality in the delivery of claims services, compliance with Scheme governance requirements, and the identification of deficiencies in the model.

KPI Performance Measurement

The Scheme Agent is required to measure its performance with respect to KPI 2 Case Management in accordance with the criteria, methodology and formula set out in Schedule 5 of this Deed. The self audit must be conducted by the Scheme Agent's suitably qualified independent auditor in accordance with Schedule 5, Subclause 29.4 of this Deed and Schedule 14.

Scheme Governance

The Scheme Governance Model in Schedule 14 of this Deed outlines the Scheme Agent's key contractual obligations and requirements in respect of case management, including the parties responsible for, and the frequency of, audits, inspections and reviews.

5. CASE MANAGEMENT FILE AUDIT

On or around 1 August each contract year, the Nominal Insurer will provide the Scheme Agent with a list of claim numbers to be audited. The Nominal Insurer expects Scheme Agents to self-audit all claims from the sample provided, by the due date each year.

a. Self Audit

i. Sample size

The Nominal Insurer will provide the Scheme Agent with a stratified and random sample of claim numbers from the CDR by 1 August each year n-1. The Nominal Insurer will use a simple random sampling method that ensures a minimum 95% confidence level. The number of claims to be audited will be derived from the number of significant injury claims open in the preceding 18 months to 2 years.

The sample population for the first year of contract will exclude claims that have recently transferred between Agents.

ii. Sample selection

The selected files will be a representative sample of the different categories of claims including:

- Major injuries
- 75% of the sample size will be claims with a date of injury less than 2 years old
- 25% of the sample size will be claims with a date of injury greater than 2 years old
- Long and short term claims
- Open and finalised claims
- Scheme Agent regional offices
- A minimum of 10 s66 claims
- A minimum of 5 Work Injury Damages claims (DOI post 2002)
- an extract of claims from the Workers Compensation Commission database in proportion to the Agent market share.

iii. Audit Standards

The Scheme Agent will undertake a performance audit in accordance with the details within this document by a suitably qualified independent auditor. Unless otherwise stated, an independent auditor can be a qualified person who is employed by the Scheme Agent and does not have a direct working involvement in the functional area subject to the audit.

b. Audit Verification

The Nominal Insurer, in conjunction with an external independent third party if it so requires, will conduct verification audits of Scheme Agent results. A Scheme Agent representative may also be a member of the verification audit team.

c. Assessment of conformance, reporting, remediation and impact on remuneration

iv. Audit reports and conformance levels

The case management audit report will detail performance on each of the 14 elements contained within the Case Management Audit section of the audit tool.

The following elements are **primary** to the success of a Scheme Agent's case management model and the capacity of the organisation to meet minimum legislative requirements:

2.2 Provisional liability
2.3 Claim liability
2.4 Payments to injured workers
2.7 Injury management
2.8 Return to work
2.10 Common law and work injury damages

The following elements are **secondary** to the success of a Scheme Agent's case management model:

2.1 Early contact
2.5 Reimbursements to employers
2.6 Claims estimates
2.9 Section 66 permanent impairment & section 67 pain and suffering
2.11 Commutations
2.12 Payments to service providers
2.13 Collecting and using data
2.14 Finalisation

Each element is made up of a number of sub elements. A conclusion that a Scheme Agent does not conform on a particular element will be based on the number of non-conformances found as a proportion of the total of the applicable sub elements.

The Scheme Agent must achieve a minimum of 70% - 80% conformance on all these elements to receive remuneration for the Case Management KPI. Refer to Schedule 5.

The Scheme Agent must send to the Nominal Insurer the case management audit report by 31 October each year. The report will detail performance of Measurable Elements on both Primary and Secondary Elements. A remediation plan to address all areas of non-conformance will be required within the timeframe specified in the report.

d. Exit interview and reporting

The Nominal Insurer audit team will discuss their audit findings with Scheme Agent representatives at the exit interview and identify all areas of conformance, non-conformance, other observations of concern and opportunities for improvement.

A draft audit report will be forwarded to the Scheme Agent for a response within 10 working days. A follow up meeting will be convened between WorkCover and senior management of the Scheme Agent to discuss the action necessary to ensure that the Scheme Agent is able to meet its contractual conditions.

WorkCover will review the final audit report and recommendations internally before forwarding to the Scheme Agent.

WorkCover will forward the final audit report within 14 days of the final meeting with the Scheme Agent. Where this includes remediation requirements, the report will detail what is required and by when.

Scheme Agents are required to submit their remediation plan and report on implementation of remedial actions to WorkCover by the specified date(s).

6. QUALITY ASSURANCE

In general, the application of the Scheme Agent's quality assurance system is assessed separately to the case management file audit in accordance with the Scheme Governance Model under Schedule 14 of this Deed. The auditors will ensure that the Injury Management Program has been reviewed appropriately and that scheduled and documented internal audits of the Scheme Agent's injury management systems have also occurred.

The case management file audit provides a further opportunity to assess application of the quality assurance system by ensuring that claims reviews are being conducted on individual files, consistent with the Scheme Agent's policies and with legislative requirements.

7. COMPLAINTS

Complaints received by the Nominal Insurer will instigate further inquiry from the Nominal Insurer with a copy or summary of the complaint forwarded to the Scheme Agent for a response. The investigation may involve a review of the file in question by the Nominal Insurer. If a number of complaints are received or there is a concern that there may be a systemic issue, this may lead to a broader case management audit.

SCOPE OF A SCHEME AGENT AUDIT

Indicator	Possible evidence/examples of verification
1. COMMITMENT	
Policy and Procedures Documents	
1.1 Injury Management Program	Complies with legislation and WorkCover guidelines
1.1.1 Procedures documented for: i) early notification process ii) informing Scheme Agent's managers and staff about their obligations iii) employment practices (e.g. resources available to insured employers, suitable employment, redeployment, OHS feedback) iv) case management process – integration of claims and injury management: - early contact - provisional liability - claim liability - injury management planning - provider management v) informing injured workers about their rights and obligations vi) internal grievance/complaints management vii) dispute prevention and resolution viii) quality assurance system incorporating review of injury management program and the system for internal audit of the Scheme Agent's injury management systems.	WorkCover approved Injury Management Program Scheduled internal audit process
1.1.2 Confidentiality – Procedures documented to ensure adherence to legislative requirements including section 243 of the 1998 Act.	WorkCover approved Injury Management Program
1.1.3 Scheme Agent management and staff responsibilities and obligations are defined.	Injury Management Program Position descriptions, contracts Organisational charts
1.1.4 Staff of Scheme Agent are made aware of their responsibilities under legislation and associated procedures and policies.	Injury Management Program Induction and training programs Duty statements Intranet
1.1.5 Information provided to policy holders/employers about their obligations and the requirements of the Scheme Agent's Injury Management Program.	Website Injury Management Program dissemination strategy

Indicator	Possible evidence/examples of verification
1.2 Integration with employers' Return to Work Programs	
1.2.1 Procedures documented for assisting policy holders/employers to adopt employment practices to support the achievement of positive injury management outcomes through for example: i) development of Return to Work Programs that are consistent with the Injury Management Program ii) provision of suitable employment iii) redeployment options iv) use of WorkCover vocational programs.	Resources available to employers Consistency of Return to Work Programs with Injury Management Program
1.3 Claims Estimation Manual	WorkCover *Claims Estimation Manual* or Scheme Agent's documented in-house estimation policy
1.4 Claims Manual	WorkCover *Claims Manual* and *Guidelines for Claiming Compensation Benefits*
2. CASE MANAGEMENT	
2.1 Early contact	
2.1.1 Early contact (within 3 working days of being notified of a significant injury) with injured worker, employer and nominated treating doctor.	Date of notification to Scheme Agent Date Scheme Agent first aware that injury is significant Dated record of contact File notes
2.2 Provisional liability (Primary element)	
2.2.1 Provisional liability decision made in accordance with *WorkCover Guidelines for Claiming Compensation Benefits*.	Date of notification to Scheme Agent Date Scheme Agent first aware that injury is significant File notes Letter to worker
2.2.2 Provisional liability payments are commenced within 7 days of notification, unless a reasonable excuse is provided.	Date of notification to Scheme Agent Date Scheme Agent first aware that injury is significant File notes Medical certificates Payment records

Indicator	Possible evidence/examples of verification
2.2.3 Written advice to worker of provisional liability decision is provided soon after decision is made and includes: i) advice that benefits have commenced on basis of provisional acceptance of liability ii) period of expected weekly payments iii) amount to be paid each week iv) what the worker should do if they do not receive payment v) that an injury management plan will be developed, if required vi) worker's entitlement to make a claim including details of how to do so vii) copy of WorkCover brochure for injured workers re rights and responsibilities.	Letter to worker
2.2.4 Written advice to worker re reasonable excuse is provided within 7 days of notification and includes: i) details of reasonable excuse ii) worker may contact the Claims Assistance Service 13 10 50 for assistance. iii) worker can make a claim and the claim will be determined within 21 days. iv) details of how to make a claim v) claim form.	Date of notification to Scheme Agent Date Scheme Agent first aware that injury is significant Letter to worker
2.3 Claim liability (Primary element)	
2.3.1 Decision on liability for weekly compensation and medical expenses made within 21 days of receiving the claim or prior to the date provisional liability weekly payments of compensation will end if a determination is still required.	File notes Letter of acceptance within 21 days of claim Section 74 notice advising of decision on liability Medical certificates Reports relevant to the decision e.g. medical, investigative
2.3.2 If accepting a claim for medical expenses: i) treatment is reasonably necessary ii) decision is communicated to worker and treatment provider (where written approval is required).	File notes Reports relevant to the decision e.g. medical, investigative Treatment plans Approval letters

Indicator	Possible evidence/examples of verification
2.3.3 If disputing all or part of a claim: i) decision is soundly based on all relevant information ii) internal review by someone other than the original decision maker iii) section 74 notice is sent to worker and includes a statement re: a. matter that is the subject of the decision b. matters limited to those in the notice, if disputed c. reasons for decision d. insurer and claimant issues e. all reports and documents relevant to the decision f. identify all relevant documents attached g. worker can request review of the claim h. worker can seek assistance from CAS, union or lawyer.	File notes Medical certificate Reports relevant to the decision e.g. medical, investigative Treatment plans Section 74 notice advising of decision on liability Letter to provider
2.3.4 If reducing or terminating weekly payments: i) decision is soundly based on all relevant information ii) internal review by someone other than the original decision maker iii) section 54 notice is sent to worker and includes a statement re : a. matter that is the subject of the decision b. matters limited to those in the notice, if disputed c. reasons for the decision d. insurer and claimant issues e. all reports and documents relevant to the decision f. identify all relevant documents attached g. worker can request review of the claim h. worker can seek assistance from CAS, union or lawyer.	File notes Medical certificate Reports relevant to the decision e.g. medical, investigative Treatment plans Section 54 notice advising of decision Letter to provider Section 40 reports Job seeking activity records
2.3.5 Utilisation of independent medical examiners is in accordance with *WorkCover Guidelines on Independent Medical Examinations and Reports*.	File notes Information nominated treating doctor Notice to worker Referral to independent medical examiner
2.4 Payments to injured workers (Primary element)	
2.4.1 Injured worker is paid correct amount of weekly benefits in accordance with legislative requirements and the medical certificate.	Payment records File notes Medical certificates Dates of total and partial periods of incapacity Letter to worker advising changes to applicable rate of weekly benefits
2.5 Reimbursements to employers	
2.5.1 Correct amount of weekly compensation benefits is reimbursed.	As per Subsection 2.4.1 Employer reimbursement schedule

Indicator	Possible evidence/examples of verification
2.5.2 Reimbursements are made to employer within time frame documented in Injury Management Program or procedures consistent with accepted business practices.	Employer reimbursement schedule Payment records
2.6 Claims estimates	
2.6.1 Claims estimates are applied in accordance with WorkCover's *Claims Estimation Manual* or documented self-insurer in-house policy.	Scheme Agent's claims estimation policy Claims estimation work sheets, electronic records
2.6.2 Claims estimates are updated at scheduled review points in accordance with WorkCover's *Claims Estimation Manual* or a documented in-house policy.	Claims estimation worksheets, electronic records. File notes
2.7 Injury management (Primary element)	
2.7.1 Injury management plan is issued within the timeframe specified in the Scheme Agent's approved Injury Management Program.	Injury management plan date File notes Correspondence
2.7.2 Injury management plan written for all workers with a significant injury.	Injury management plans for injured workers File notes
2.7.3 Injury management plan includes: injury management goal actions person(s) responsible review dates injured worker's rights and obligations.	Injury management plans for injured workers
2.7.4 Injury management plan established in consultation with injured worker, employer and nominated treating doctor.	Injury management plans for injured workers Correspondence attached to plan sent to worker, nominated treating doctor, employer File notes Medical certificate/report received before plan established
2.7.5 Regular and appropriate contact is maintained with injured worker.	Injury management plans for injured workers File notes Correspondence with worker
2.7.6 The injury management plan is reviewed regularly.	Injury management plans for injured workers File notes

Indicator	Possible evidence/examples of verification
2.7.7 Information to workers on obligations and penalties including procedure to change nominated treating doctor.	Letters to workers Information packs for injured workers Injury management plans for injured workers
2.7.8 Scheme Agent complies with obligations under injury management plan.	File notes Injury management plans for injured workers Correspondence
2.8 Return to work (Primary element)	
2.8.1 Suitable duties: i) Scheme Agent works with employer about provision of suitable duties and development of return to work plan ii) suitable duties comply with section 43A iii) use of WorkCover programs if appropriate e.g. JobCover, Work Trials.	Return to work plans consistent with the medical certificate Injury management plans File notes Reviews of progress in suitable employment Evidence re workers skills, experience, education, age, residence Reports e.g. medical, vocational assessment, functional capacity assessment, job analysis
2.8.2 Rehabilitation strategies for long term injured workers: i) employer made aware of their obligation to not terminate for 6 months post injury because of the injury ii) redeployment considered when appropriate iii) retraining offered, with realistic job prospects.	File notes Injury management plans Correspondence with worker Use of WorkCover programs such as JobCover, Work Trials, Equipment, Retraining Reports e.g. medical, vocational assessment, functional capacity assessment, job analysis
2.9 Section 66 permanent impairment & section 67 pain and suffering	
2.9.1 Section 66 entitlement: i) determine claim within timeframes (1 month after degree fully ascertainable/2 months after claim with all particulars) ii) assessed in accordance with WorkCover guidelines iii) if degree of impairment exists, offer made to injured worker iv) worker made aware to seek legal advice v) worker paid their correct entitlement.	Medical reports confirming maximum medical improvement Permanent impairment assessment report by WorkCover trained assessor if injury post 1/1/02 File notes Letter of offer to worker Agreement signed by worker or section 66A registration Payment records
2.9.2 Section 67 entitlement: i) if permanent impairment threshold met, offer made to injured worker ii) worker made aware to seek legal advice iii) worker paid their entitlement.	Impairment assessment report Letter of offer Letter accepting or declining the offer Payment records

Indicator	Possible evidence/examples of verification
2.10 Common law and work injury damages (Primary element)	
2.10.1: i) Claim for lump sum compensation made and whole person impairment threshold (15%) met ii) Respond to pre-filing statement within 28 days iii) Entitlement determined in accordance with WorkCover guidelines iv) Worker paid their entitlement within reasonable timeframe.	Permanent impairment assessment report by WorkCover trained assessor Letter of offer to worker Prefiling statement Response to pre-filing statement Settlement advice Payment records
2.11 Commutations	
2.11.1: i) Preconditions under section 87EA of the *Workers Compensation Act 1987* have been met ii) Certification has been obtained from WorkCover.	Injury management and return to work plans Permanent impairment assessment report by WorkCover trained assessor File notes Medical reports Correspondence from legal representative/worker Payment records WorkCover certification
2.12 Payments to service providers	
2.12.1 Payments to service providers in accordance with WorkCover's gazetted fees orders and approval letters/approved treatment plans.	Invoices Payment records Correspondence Approved treatment plans
2.12.2 Payments to service providers within time frame documented in Injury Management Program or Claims Manual consistent with accepted business practices to guarantee continuity of service provision.	Invoices Payment records Correspondence
2.13 Collecting and using data	
2.13.1 Work status code up to date on all claims with a significantly injury i.e. more than 5 days incapacity.	File notes Medical certificates Return to work plans Rehabilitation reports Electronic claims data Evidence that data has been submitted to WorkCover as required, and regularly updated

Indicator	Possible evidence/examples of verification
2.14 Finalisation	
2.14.1 Claim finalised when the worker has no further entitlement to workers compensation benefits, this decision is not being disputed and all payments have been made.	File notes Medical certificate Medical and other reports relevant to the decision
3. QUALITY ASSURANCE SYSTEM	
i) Scheduled and documented internal audits of the organisation's injury management systems ii) Injury Management Program reviewed, as nominated by the Scheme Agent, or when requested to do so by WorkCover (refer: WIMWC 1998, Ch 3, S43) iii) System for claims reviews	Audit reports Date of review on Injury Management Program Letter of Injury Management Program approval from WorkCover Claims review on file

AUDIT WORKPAPER

AUDIT:	**2. CASE MANAGEMENT**
Secondary Element:	**2.1 EARLY CONTACT**

							Sub Element		
Claim number	Date of injury	Date of injury notification	Date Scheme Agent aware injury is/likely to become significant *	Date employer contacted	Date NTD contacted	Date injured worker contacted	Contact with employer, worker and NTD (if appropriate and reasonably practicable) within 3 working days of significant injury notification (Yes/No)	Score	Max score
							Total Score		

* Significant injury : '...likely to result in worker being incapacitated for work for a continuous period of **more than 7 days**, whether or not any of those days are work days and whether or not the incapacity is total or partial or a combination of both' (ref: section 42(1) 1998 Act)

Yes = 1 No = 0 N/A = not applicable For **each non-conformance** rating, provide details below of the reason(s) for that non-conformance

AUDIT WORKPAPER

AUDIT:	**2. CASE MANAGEMENT**
Primary Element:	**2.2 PROVISIONAL LIABILITY**

				Sub Elements							
				Provisional liability accepted				Reasonable excuse			
Claim number	Date of injury	Date of injury notification	Date of PL decision	PL decision in accord with WorkCover guidelines (Yes/No) *	PL payments commence within 7 days of notification? (Yes/No) *	Did letter to worker include all matters required? (Yes/No) *	Evidence of written advice to worker in reasonable time (e.g. 5 days)? (Yes/No) *	Evidence of written advice to worker in 7 days? (Yes/No)	Did letter include all required information ? (Yes/No)	Score	Max score
									Total Score		

* If initial claim liability is accepted within 7 days of notification, then these sub -elements apply

Yes = 1 No = 0 N/A = not applicable For each **non-conformance rating**, provide details below of the reason(s) for that non-conformance

AUDIT WORKPAPER

AUDIT:	**2. CASE MANAGEMENT**
Primary Element:	**2.3 CLAIM LIABILITY**

		Sub Elements											
		If claim accepted (refers to all or part of claim/request for specific benefit)			If claim disputed (refers to all or part of claim)			If reducing/terminating weekly payments			IME		
Claim number	Date claim received	Evidence of decision made within 21 Days or before expiry of PL period? (Yes/No) *	Does medical treatment appear reasonably necessary? (Yes/No)	Evidence of written advice to worker at time of decision? (Yes/No) *	Evidence the decision is based on all relevant information? (Yes/No)	Evidence of internal review? (Yes/No)	Evidence of written advice to worker complying with s74 at time of decision? (Yes/No)	Evidence the decision is based on all relevant information? (Yes/No)	Evidence of internal review? (Yes/No)	Evidence of written advice to worker complying with s54 at time of decision? (Yes/No)	IME in accord W/C guide-lines? (Yes/No)	Score	Max score
											Total Score		

* If initial claim liability is accepted within 7 days of notification, then these sub-elements do **not** apply

Yes = 1 No = 0 N/A = not applicable For **each non-conformance** rating, provide details below of the reason(s) for that negative rating.

AUDIT WORKPAPER

AUDIT:	**2. CASE MANAGEMENT**
Primary Element:	**2.4 PAYMENTS TO INJURED WORKERS**

	Sub Element					
Claim number	Correct payment of weekly benefit payments?			Timely payment of last 3 reimbursements to worker (paid within 14 days)?	Score	Max score
	Incapacity first 26 weeks (Yes/No)	Incapacity after 26 weeks (Yes/No)	Section 40 (Yes/No)	(Yes/No)		
				Total Score		

Yes = 1 No = 0 N/A = not applicable For **each non-conformance** rating, provide details below of the reason(s) for that non-conformance

AUDIT WORKPAPER

AUDIT:	**2. CASE MANAGEMENT**
Secondary Element:	**2.5 REIMBURSEMENTS TO EMPLOYERS**

		Sub Element					
Claim number	Date of Injury	Correct amount of weekly compensation benefits reimbursed to employer?			Reimbursements are made to employer within time frame documented in IMP or Claims Manual	Score	Max score
		Incapacity first 26 weeks (Yes/No)	Incapacity after 26 weeks (Yes/No)	Section 40 (Yes/No)	(Yes/No)		
					Total Score		

Yes = 1 No = 0 N/A = not applicable For **each non-conformance** rating, provide details below of the reason(s) for that non-conformance

AUDIT WORKPAPER

AUDIT:	**2. CASE MANAGEMENT**
Secondary Element:	**2.6 CLAIMS ESTIMATES**

						Sub Element			
Claim number	Date of Injury	Date of notification	Estimation methodology (WorkCover/ in-house policy)	Last designated review point (e.g. 12/26/52/78/ 104/130/156 weeks)	Date of current estimate	Current estimate in accordance with estimation methodology or explanation why not documented? (Yes/No)	Estimate updated at designated review points in accordance with WorkCover manual or in-house policy? (Yes/No)	Score	Max score
							Total Score		

Yes = 1 No = 0 N/A = not applicable For **each non-conformance** rating, provide details below of the reason(s) for that non-conformance

AUDIT WORKPAPER

AUDIT:	**2. CASE MANAGEMENT**
Primary Element:	**2.7 INJURY MANAGEMENT**

			Sub Element									
Claim number	Date of injury notification	Date injury becomes significant	IMP written for workers with significant injury? (Yes/No)	Injury management plan issued within timeframe specified in Injury Management Program? (Yes/No)	Information provided to worker on obligations, penalties and procedure to change NTD? (Yes/No)	IMP includes required information and reflects worker's RTW and health status (Yes/No)	Evidence IMP established in consultation (with injured worker, employer and NTD) and distributed? (Yes/No)	IMP reviewed (IMP review dates, changed RTW or health status), updated if necessary, plan distributed/ outcome communicated? (Yes/No)	Scheme Agent complies with obligations under IMP? (Yes/No)	Evidence regular and appropriate contact maintained with worker? (Yes/No)	Score	Max score
										Total Score		

Yes = 1 No = 0 N/A = not applicable For **each non-conformance** rating, provide details below of the reason(s) for that non-conformance

AUDIT WORKPAPER

AUDIT:	**2. CASE MANAGEMENT**
Primary Element:	**2.8 RETURN TO WORK**

		Sub Elements							
Claim number	Date worker cleared for suitable duties by NTD	Scheme Agent works with employer about provision of suitable duties and development of RTW plan (Yes/No)	Suitable duties offered comply with Sec 43A? (Yes/No)	Considered or used WorkCover programs if appropriate e.g. work trials, retraining, JobCover, equipment and mods? (Yes/No)	Evidence of redeploy etc if not returned to PID? (Yes/No)	Evidence of retraining etc if not returned to PID? (Yes/No)	If terminated as result of injury, what was date of termination? Evidence that Scheme Agent made employer aware of obligations? (Yes/No)	Score	Max score
							Total Score		

Yes = 1 No = 0 N/A = not applicable For **each non-conformance** rating, provide details below of the reason(s) for that non-conformance

AUDIT WORKPAPER

AUDIT:	**2. CASE MANAGEMENT**
Secondary Element:	**2.9 SECTION 66 AND 67**

			Sub Elements										
	Claim made by injured worker						Scheme Agent initiated offer						
Claim number	Date S66/67 claim received	Date of relevant particulars *	Assessed in accordance with WorkCover guidelines (Yes/No)	S66/s67 claim determined within statutory timeframe? (Yes/No)	Correct payment? (Yes/No)	Timely payment s66/s67? (Yes/No))	Assessed in accordance with WorkCover guidelines (Yes/No)	Proper offer made within relevant timeframe (Yes/No)	Worker made aware to seek legal advice? (Yes/No)	Correct payment? (Yes/No)	Timely payment for s66/s67? (Yes/No)	Score	Max score
											Total Score		

*Date of relevant particulars:

- date of claim with all relevant particulars (defined in clause 2, Part 5 of *WorkCover Guidelines for Claiming Compensation Benefits*); or
- date of IME if organised within 2 weeks of receipt of s66 claim

Yes = 1 No = 0 N/A = not applicable For **each non-conformance** rating, provide details below of the reason(s) for that non-conformance

AUDIT WORKPAPER

AUDIT:	**2. CASE MANAGEMENT**
Primary Element:	**2.10 COMMON LAW AND WORK INJURY DAMAGES**

				Sub Element			**Sub Elements**				
Claim number	Date of injury	Date of WID Claim	15% WPI agreed/ disputed	Is there appropriate medical support for WPI claimed? (Yes/No)	Date of pre-filing statement	Date of response to pre-filing statement	Response to PFS within 28 days? (Yes/No)	Entitlement in accordance with WorkCover guidelines? (Yes/No)	Payment in reasonable time? (Yes/No)	Score	Max score
									Total Score		

Yes = 1 No = 0 N/A = not applicable For **each non-conformance** rating, provide details below of the reason(s) for that non-conformance

AUDIT WORKPAPER

AUDIT:	**2. CASE MANAGEMENT**
Secondary Element:	**2.11 COMMUTATION**

		Sub Element			
Claim number	Date of injury	Preconditions under section 87EA of WCA *1987* met? (Yes/No)	Certification of approval obtained from WorkCover? (Yes/No)	Score	Max Score
			Total Score	%	

Yes = 1 No = 0 N/A = not applicable For **each non-conformance** rating, provide details below of the reason(s) for that non-conformance.

AUDIT WORKPAPER

AUDIT:	**2. CASE MANAGEMENT**
Secondary Element:	**2.12 PAYMENTS TO SERVICE PROVIDERS**

	Sub Elements				
Claim number	Last 3 payments in accordance with WorkCover gazetted fees orders? (Yes/No)	Approval letter/approved treatment plans? (Yes/No)	Last 3 payments made within 30 days (Yes/No)	Score	Max Score
			Total Score		

Yes = 1 No = 0 N/A = not applicable For **each non-conformance** rating, provide details below of the reason(s) for that non-conformance

AUDIT WORKPAPER

AUDIT:	**2. CASE MANAGEMENT**
Secondary Element:	**2.13 COLLECTING AND USING DATA**

					Sub Element		
Claim number	Date of injury	Work status code up to date on all claims with a significant injury i.e. more than 5 days incapacity. What Work status code reflects worker's circumstances? What RTW status code reflects worker's circumstances	Work status code up to date? (Yes/No)	Score	Max Score		
					Total Score		

Yes = 1 No = 0 N/A = not applicable For **each non-conformance** rating, provide details below of the reason(s) for that non-conformance

AUDIT WORKPAPER

AUDIT:	**2. CASE MANAGEMENT**
Secondary Element:	**2.14 FINALISATION**

			Sub Element		
Claim number	Date of injury	Does evidence indicate that claim can be closed?	Has claim been closed? (Yes/No)	Score	Max Score
			Total Score		

Yes = 1 No = 0 N/A = not applicable For **each non-conformance** rating, provide details below of the reason(s) for that non-conformance

SCHEME AGENT CASE MANAGEMENT AUDIT

SUMMARY OF PERFORMANCE FOR EACH ELEMENT

(i.e. collated scores for each audit)

Element	Total Score	Maximum Score	Percentage	Comments	C / NC / NA
2.1 Early contact					
2.2. Provisional liability*					
2.3 Claim liability*					
2.4 Payments to injured workers*					
2.5 Reimbursements to employers					
2.6 Claims estimates					
2.7 Injury management*					
2.8 Return to work*					
2.9 Section 66/67					
2.10 Common law and WID*					
2.11 Commutations					
2.12 Payments to service providers					
2.13 Collecting and using data					
2.14 Finalisation					
Totals					

** Primary element*

<SCHEME AGENT> CASE MANAGEMENT AUDIT **AUDIT PERIOD __/__/__ to __/__/__**

SAMPLE SIZE (Claims) =

FINAL PERFORMANCE SCORE FOR EACH MEASURABLE ELEMENT

			Audit Sample Results		
Element	**Element Weight**	**Number of Potential Measurable Elements per claim**	**Maximum Score**	**Score**	**Measurable Element Weighted Score**
2.1 Early contact	10	1			
2.2. Provisional liability*	20	6			
2.3 Claim liability*	20	10			
2.4 Payments to injured workers*	20	4			
2.5 Reimbursements to employers	10	4			
2.6 Claims estimates	10	2			
2.7 Injury management*	20	8			
2.8 Return to work*	20	6			
2.9 Section 66/67	10	9			
2.10 Common law and WID*	20	4			
2.11 Commutations	10	2			
2.12 Payments to service providers	10	3			
2.13 Collecting and using data	10	1			
2.14 Finalisation	10	1			
Total	200	61			
*Note - * Primary Element*					
KPI 2 Score					

APPENDIX A
SCHEME AGENT
CASE MANAGEMENT AUDIT EVIDENCE GUIDE

INTRODUCTION

PURPOSE

The evidence guide has been developed to provide further guidance for auditors reviewing case management practices of Scheme Agents. It supplements the case management self audit guide developed by WorkCover to assist Scheme Agents in NSW to monitor their compliance with legislative and contract requirements for injury and claims management.

This evidence guide is not a separate level of verification. Rather, it provides an additional level of explanation about conformance and non-conformance on each case management element and the sub elements. This guide also describes circumstances where a sub element is not applicable and provides notes where necessary to define terms or further explain the requirements of a sub element.

ELEMENTS OF CASE MANAGEMENT PRACTICE

The following elements are **primary** to the success of a Scheme Agent's case management model and the capacity of the organisation to meet minimum legislative requirements:

2.2 Provisional liability
2.3 Claim liability
2.4 Payments to injured workers
2.10 Injury management
2.11 Return to work
2.10 Common law and work injury damages

The following elements are **secondary** to the success of a Scheme Agent's case management model:

2.1 Early contact
2.5 Reimbursements to employers
2.6 Claims estimates
2.12 Section 66 permanent impairment & section 67 pain and suffering
2.12 Commutations
2.12 Payments to service providers
2.13 Collecting and using data
2.14 Finalisation

REFERENCES

Workers Compensation Act, 1987
Workplace Injury Management and Workers Compensation Act 1998
Workers Compensation Legislation Amendment Act 2001
Workers Compensation Legislation Further Amendment Act 2001
Case Management Principles, November 2005
Workers Compensation Legislation Amendment (Miscellaneous Provisions) Act 2005 No 113
Workers Compensation Amendment (Miscellaneous Provisions) Regulation 2006
WorkCover Guidelines for Employers Return to Work Programs
WorkCover Guidelines for Claiming Compensation Benefits
WorkCover Guidelines on Independent Medical Examinations & Reports
WorkCover publications:

506	Guidelines for Employers' Return to Work Programs
517	Suitable Duties: Information for Employers and Injured Workers
541	Doctors and WorkCover: Injury Management Consultants
543	Doctors and WorkCover: Your Nominated Treating Doctor
544	Rehabilitation Providers and WorkCover
960	Information for Injured Workers
1291	Fact sheet 2 - Injury Management and Return to Work Programs
1292	Fact sheet 3 - What to do if there is an Injury
1293	Fact sheet 4 - Claims and Benefits
1294	Fact sheet 5 - Resolving Problems and Disputes about Workers Compensation
1295	Fact sheet 6 - Service Providers and Other Assistance
1296	Fact sheet 7 - Checklist for Employers
1297	Fact sheet 8 - Getting More Information
1384	Service Providers in the NSW Workers Compensation System
1406	Employers Guide: What to do if an Injury Occurs
1415	Your Recovery and Return to Work After a Workplace Injury
1417	Independent Medical Examinations: Information for Workers

SCHEME AGENT CASE MANAGEMENT AUDIT EVIDENCE GUIDE

CONFORMANCE EXAMPLES	NON-CONFORMANCE EXAMPLES	NOT APPLICABLE	NOTES
2.1 EARLY CONTACT			
2.1.1 Early contact (within 3 working days of being notified of a significant injury) with injured worker, employer and nominated treating doctor).			
• Contact (information exchange) is made and documented with worker and employer within 3 working days of notification of a significant injury. • Contact (information exchange) is made and documented with the nominated treating doctor when 'appropriate and reasonably practicable' e.g. Scheme Agent has: o insufficient information to make provisional liability decision o insufficient information to make decisions about reasonably necessary treatment o insufficient/conflicting information about the worker's restrictions o concerns about length of time worker certified unfit. • If unable to establish contact, all attempts to make contact are documented on file.	• No evidence of contact made with employer and/or worker. • No evidence of contact with or sufficient attempts to contact nominated treating doctor when contact was 'appropriate and reasonably practicable'. • Contact made with worker, employer but outside 3 working days.	• If the injury is clearly not significant at notification.	• Date of notification is the date when the injured worker/employer notifies the Scheme Agent that an injury has occurred in the workplace. • If the injury is significant at notification, 3 working days starts from the notification date. • If it is unclear at notification whether the injury is/likely to become a significant injury then use the 3 working days to make contact to determine this. • If the injury is not significant at notification, the 3 working days for contact starts from when the Scheme Agent becomes aware that the injury is significant.
2.2 PROVISIONAL LIABILITY – PRIMARY ELEMENT.			
2.2.1 Decisions made in accordance with the *WorkCover Guidelines for Claiming Compensation Benefits.*			
• Evidence (e.g. letter to worker, file note) that provisional liability decision made within 7 days or claim liability accepted within 7 days of notification. • Evidence that a decision to not commence provisional payments is based upon a reasonable excuse in accordance with the requirements of clause 7, Part 1 of the *WorkCover Guidelines for Claiming*	• No evidence that provisional liability decision made or claim liability accepted within 7 days. • No evidence that a reasonable excuse is in accordance with *the WorkCover Guidelines for Claiming Compensation Benefits.*		

CONFORMANCE EXAMPLES	NON-CONFORMANCE EXAMPLES	NOT APPLICABLE	NOTES
Compensation Benefits.			
2.2.2 Provisional liability payments are commenced within 7 days of notification, unless a reasonable excuse is provided.			
• Evidence that payments commence within 7 days. • Evidence that payments were not interrupted according to normal pay schedules.	• Normal pay is interrupted or delayed due to indecision / inaction.	• A reasonable excuse is applied in accordance with clause 7, Part 1 of the *WorkCover Guidelines for Claiming Compensation Benefits.*	
2.2.3 Written advice to worker of provisional liability decision is provided soon after decision is made and includes: i) advice that benefits have commenced on basis of provisional acceptance of liability ii) period of expected weekly payments iii) amount to be paid each week iv) what the worker should do if they do not receive payment v) that an injury management plan will be developed, if required vi) worker's entitlement to make a claim including details of how to do so vii) copy of WorkCover brochure "Information for Injured Workers" re rights and responsibilities			
• Evidence that written advice provided to worker within reasonable time e.g. 5 days of date of documented decision or commencement of payments. Written advice to worker contains all information as required in accordance with clause 6.7, Part 1 of the *WorkCover Guidelines for Claiming Compensation Benefits.* • If claim liability is accepted within 7 days of notification and hence no provisional liability decision is required, evidence that: o the claim liability acceptance letter includes all other information as required in the provisional liability notice to the worker (in accordance with clause 6.7, Part 1 of the *WorkCover Guidelines for Claiming Compensation Benefits*) and o is sent to worker within reasonable time e.g. 5 days of decision.	• Letter not sent within 5 days of decision or commencement of provisional payments.		• The WorkCover brochure (*Information for Injured Workers*) is still required even if the Scheme Agent sends their own tailored brochure to the worker. • A statement providing a name and contact number for queries is sufficient for who to contact if not paid. • Further written advice is provided to the worker if the initial provisional liability period is to be extended. This advice is prior to the expiry of that initial provisional period. • If provisional payments are made for at least 8 weeks, and weekly benefits are likely to exceed 12 weeks the Scheme Agent notifies the worker that they need to make a claim. • If the worker receives less than 12 weeks of weekly benefits (regardless of how long they may be receiving treatment but providing treatment costs do not exceed $7,500) and the worker is fully informed and participating in their

CONFORMANCE EXAMPLES	NON-CONFORMANCE EXAMPLES	NOT APPLICABLE	NOTES
			fully informed and participating in their return to work and injury management, the Scheme Agent can manage this under provisional liability.
2.2.4 Written advice to worker re reasonable excuse is provided within 7 days of notification and includes: i) details of reasonable excuse ii) worker may contact the Claims Assistance Service 13 10 50 for assistance iii) worker can make a claim and the claim will be determined within 21 days iv) details of how to make a claim v) claim form.			
• Evidence that letter sent within 7 days of date of notification of injury.	• No evidence that letter not sent within 7 days of date of notification of injury.	• Provisional liability accepted or claim liability accepted outright within 7 days.	
2.3 CLAIM LIABILITY – PRIMARY ELEMENT			
2.3.1 Decision on liability for weekly compensation and medical expenses made within 21 days of receiving the claim or prior to the date provisional liability weekly payments of compensation will end if a determination is still required.			
• Evidence that each claim decision is made within 21 days or prior to the end of the provisional liability period and in accordance with Part 2 of the *WorkCover Guidelines for Claiming Compensation Benefits.* • Section 74 notice sent at time of decision to advise worker that the Scheme Agent is disputing liability for all/part of the claim.	• No evidence that each claim decision is made within 21 days of receiving the claim or prior to the end of the provisional liability period.	• No claim made. • Claim finalised prior to end of provisional liability acceptance period. • If initial claim liability is accepted outright within 7 days of notification and there are no subsequent claims for a benefit such as treatment.	
2.3.2 If accepting a claim for medical expenses: i) treatment is reasonably necessary ii) decision is communicated to worker and treatment provider (where written approval is required).			
• Evidence that treatment is reasonably necessary (in accordance with definition provided in clause 10, Part 1 of the *WorkCover Guidelines for Claiming Compensation Benefits*) and decision to approve treatment is communicated to worker and treatment provider where required. • Written advice to worker about	• No evidence to support the treatment as reasonably necessary. • No evidence that decision to accept the claim for medical expenses has been communicated to worker. • No evidence that decision to accept the claim for medical expenses has been communicated to treatment provider and this is required.		

CONFORMANCE EXAMPLES	NON-CONFORMANCE EXAMPLES	NOT APPLICABLE	NOTES
acceptance of liability contains all required information.	• Scheme Agent has evidence indicating that treatment is not reasonably necessary but does not act upon this information.		
2.3.3 If disputing all or part of a claim: i) decision is soundly based on all relevant information ii) internal review by someone other than the original decision maker iii) section 74 notice is sent to worker and includes a statement re: a. matter that is the subject of the decision b. matters limited to those in the notice, if disputed c. reasons for decision d. Scheme Agent and claimant issues e. all reports and documents relevant to the decision f. identify all relevant documents attached g. worker can request review of the claim h. worker can seek assistance from CAS, union or lawyer.			
• Evidence on file supports the decision to dispute liability for all/part of a claim. • Evidence on file that internal review of all the evidence considered in arriving at the decision was conducted by someone other than the original decision maker and with requisite expertise prior to notifying the worker of the decision • Content of the section 74 notice reflects all information relevant to the decision. • Section 74 notice contains all relevant information in accordance with Part 3 of the *WorkCover Guidelines for Claiming Compensation Benefits*. • Evidence that section 74 notice sent to the worker at time of decision.	• Evidence on file does not support the decision to dispute liability for all/part of a claim. • No evidence that internal review of all the evidence considered in arriving at the decision was conducted by someone other than the original decision maker and with requisite expertise. • Contents of the section 74 notice does not reflect all information relevant to the decision. • Section 74 notice is not in accordance with Part 3 of the *WorkCover Guidelines for Claiming Compensation Benefits.* • No evidence that section 74 notice sent to the worker at time of decision	• No decision to dispute liability for all/part of the claim since 1 November 2006. • Claim has only been accepted provisionally.	

CONFORMANCE EXAMPLES	NON-CONFORMANCE EXAMPLES	NOT APPLICABLE	NOTES
2.3.4 If reducing or terminating weekly payments: i) decision is soundly based on all relevant information ii) internal review by someone other than the original decision maker iii) section 54 notice is sent to worker and includes a statement re : a. matter that is the subject of the decision b. matters limited to those in the notice, if disputed c. reasons for decision d. Scheme Agent and claimant issues e. all reports and documents relevant to the decision f. identify all relevant documents attached g. worker can request review of the claim h. worker can seek assistance from CAS, union or lawyer.			
• Evidence on file supports the decision to reduce/terminate weekly payments. • Evidence on file that internal review of all the evidence considered in arriving at the decision was conducted by someone other than the original decision maker and with requisite expertise. • Content of the section 54 notice reflects all information relevant to the decision. • Section 54 notice contains all relevant information in accordance with Part 4 of the *WorkCover Guidelines for Claiming Compensation Benefits*. • Evidence that section 54 notice sent to the worker at time of decision.	• Evidence on file does not support the decision to reduce/terminate weekly payments. • No evidence that internal review of all the evidence considered in arriving at the decision was conducted by someone other than the original decision maker and with requisite expertise. • Content of the section 54 notice does not reflect all information relevant to the decision. • Section 54 notice is not in accordance with Part 4 of the *WorkCover Guidelines for Claiming Compensation Benefits.* • No evidence that section 54 notice sent to the worker at time of decision.	No decision to reduce/terminate weekly payments since 1 November 2006.	•
2.3.5 Utilisation of independent medical examiners is in accordance with *WorkCover Guidelines on Independent Medical Examinations and Reports*			
• Evidence that information has been sought from nominated treating doctor(s) but information is inadequate, unavailable or inconsistent. • Reason for referral is appropriate and advised to injured worker.	• No evidence that information has been sought from nominated treating doctor • Reason for referral is not in accord with the guidelines. • Independent medical examiner is not appropriately qualified. • Worker is not given 10 working days	Independent medical examination arranged before 1 November 2006.	

CONFORMANCE EXAMPLES	NON-CONFORMANCE EXAMPLES	NOT APPLICABLE	NOTES
• Independent medical examiner is appropriately qualified i.e. specialist with qualifications relevant to treatment of worker's injury and to the question(s) being asked. • Worker is given at least 10 working days notice before the appointment. • Advice to the worker about the appointment contains all information as specified in the guidelines.	notice before the appointment. • Advice to the worker about the appointment does not contain all information as specified in the guidelines.		
2.4 PAYMENTS TO INJURED WORKERS – PRIMARY ELEMENT			
2.4.1 Injured worker is paid correct amount of weekly benefits in accordance with legislative requirements and the medical certificate.			
• Weekly benefit amount is determined and paid in accordance with legislation and medical certificates. • If injured worker or Scheme Agent identifies an inaccuracy it is promptly remediated by the Scheme Agent.	• Weekly benefit amount is incorrectly determined for any period where it is payable. • Injured worker or Scheme Agent identifies an inaccuracy but the Scheme Agent unnecessarily delays correction.	• No weekly benefits paid (for example, there is no lost time)	
2.4.2 Injured worker is reimbursed: i) expenses for reasonably necessary treatment and associated travel expenses. Requests are authorised within 7 days of receipt and paid within 14 days. ii) other expenses within timeframes stated in injury management program.			
• Evidence that the last 3 reimbursements were authorised in 7 days and paid within 14 days.	• Evidence that any of the last 3 reimbursements were not authorised in 7 days and paid within 14 days.	• No reimbursements claimed.	
2.5 REIMBURSEMENTS TO EMPLOYERS			
2.5.1 Correct amount of weekly compensation benefits is reimbursed to the employer.			
• Evidence that the correct amount is reimbursed to the employer.	• No evidence that the correct amount is reimbursed to the employer.	• Scheme Agent pays the worker's weekly benefits direct.	
2.5.2 Reimbursements are made to employer within time frame documented in injury management program or claims manual consistent with accepted business practices.			
• Reimbursements are made within timeframe specified in Injury Management Program/Claims manual.	• Reimbursements are not made within timeframe specified in Injury Management Program/claims manual.	• Scheme Agent pays the worker's weekly benefits direct.	
2.6 CLAIMS ESTIMATES			
2.6.1 Claims estimates are applied in accordance with WorkCover's *Claims Estimation Manual* or documented Scheme Agent's in-house policy.			

CONFORMANCE EXAMPLES	NON-CONFORMANCE EXAMPLES	NOT APPLICABLE	NOTES
• estimate in accord with WorkCover manual/in-house policy. • Reason for a deviation is documented.	• Estimates not in accord with WorkCover manual/in-house policy. • No evidence of an estimate completed.	• The Scheme Agent has a valid reasonable excuse to not commence provisional payments and this is documented.	• Date of initial estimate is the date the claim is received or date of notification – whichever comes first.
2.6.2 Claims estimates are updated at scheduled review points in accordance with WorkCover's *Claims Estimation Manual* or a documented Scheme Agent in-house policy.			
• Evidence that estimates are updated at scheduled review points or when new information necessitates an update.	• No evidence that estimates are reviewed in accordance with review points and/or when new information is received.	• The claim is finalised prior to the first review point and no new information necessitates an update. • If the claim is finalised within 2 weeks either side of a review point, it is not necessary to complete the estimate provided that there are no outstanding benefits or accounts to be paid.	
2.7 INJURY MANAGEMENT – PRIMARY ELEMENT			
2.7.1 Injury management plan is issued within the timeframe specified in the Scheme Agent's approved Injury Management Program.			
• Procedures in Scheme Agent's Injury Management Program are followed. • Plan is not issued within specified timeframe but appropriate reasons for the delay/non-issue have been documented and communicated.	• Inconsistency between practice on file and the procedure outlined in the Injury Management Program ie plan is not issued within specified timeframe and there is no evidence to justify delay.	• The worker does not have a significant injury.	
2.7.2 Injury management plan written for all workers with a significant injury.			
• Evidence of injury management planning on file with plan provided to worker, nominated treating doctor and employer in accordance with the Injury Management Program.	• Appropriate level of planning is not evident on file. • Periods of time are not covered by a relevant injury management plan.	• The worker does not have a significant injury.	• If an injured worker returns to pre injury duties before the timeframe specified to develop the plan in their Program, and there is no further need for treatment, there should be evidence of injury management planning in the notes.

CONFORMANCE EXAMPLES	NON-CONFORMANCE EXAMPLES	NOT APPLICABLE	NOTES
2.7.3 Injury management plan includes: i) injury management goal ii) actions iii) person responsible iv) review dates v) employee's rights and obligations.			
• Injury management plan is tailored to the individual injured worker's circumstances at the time the plan is developed. • Injury management plans contain all required information – appropriate goal, actions relevant to the injured worker's circumstances, person(s) responsible, plan review date(s), employee's rights and obligations.	• Injury management plan is not tailored to the individual injured worker's circumstances at the time the plan is developed. • Injury management plans do not contain all required information – appropriate goal, actions relevant to the injured worker's circumstances, person(s) responsible, review dates, employee's rights and obligations. • No injury management plan has been developed.	• The worker does not have a significant injury.	
2.7.4 Injury management plan established in consultation with injured worker, employer and nominated treating doctor.			
• Initial and revised injury management plans reflect consultation with injured worker, employer and nominated treating doctor. • Consultation with the nominated treating doctor conducted when there was inadequate medical information available to develop the injury management plan. • Injury management plan is consistent with medical information on file. • Injury management plan is consistent with file notes related to employer and worker contact. • Evidence that the initial and revised injury management plans are sent to injured worker and nominated treating doctor	• No evidence of consultation with the injured worker or employer. • No evidence of consultation with the nominated treating doctor when there was inadequate medical information available to develop the injury management plan. • Injury management plan does not reflect consultation with each party and is not tailored to the injured worker's specific circumstances. • Goal is inappropriate given other information on file. • Initial and subsequent copies not sent to injured worker and nominated treating doctor • There are no injury management plans on file.	• The worker does not have a significant injury.	
2.7.5 Regular and appropriate contact is maintained with injured worker.			

CONFORMANCE EXAMPLES	NON-CONFORMANCE EXAMPLES	NOT APPLICABLE	NOTES
• Evidence of appropriate and ongoing contact with worker (based on complexity of case, return to work and health status).	• Evidence that contact is insufficient given complexity of case, return to work and health status, (for example, it is clear that something important was not acted on because of lack of contact with the worker). • Use of rehabilitation provider in lieu of Scheme Agent contact.	• The worker does not have a significant injury.	
2.7.6 The injury management plan is reviewed regularly.			
• Evidence of appropriate review: o at review date on current injury management plan o on receipt of new information, for example change of work status or treatment o results communicated with the worker.	• Injury management plans are not reviewed on review dates. • Injury management plans not reviewed when new information received. • File note indicates plans reviewed and no change is required, but injured worker not informed the plan does not need updating. • No injury management plans developed.	• The worker does not have a significant injury. • The claim was finalised close to the scheduled review date. (e.g. the injured worker returned to pre injury duties and no further treatment was required before the scheduled review date).	
2.7.7 Information to workers on obligations and penalties including procedure to change nominated treating doctor.			
• Evidence that obligations and penalties including information on procedure to change nominated treating doctor is provided to worker with the injury management plan.	• No information about obligations, penalties and procedure is provided to the worker. • First injury management plan is very delayed and no prior information about obligations and penalties has been provided to the worker • No injury management plans developed.	• The worker does not have a significant injury.	
2.7.8 Scheme Agent complies with obligations under injury management plan.			
• Evidence that the injury management plan is clearly documented and actions and reviews are implemented.	• An obligation on the injury management plan is not complied with by the Scheme Agent (e.g. adequate time is not given to the worker to comply with obligations before benefits are suspended; Scheme Agent does not follow their stated procedure for change of nominated treating doctor.	• The worker does not have a significant injury.	

CONFORMANCE EXAMPLES	NON-CONFORMANCE EXAMPLES	NOT APPLICABLE	NOTES
	• No injury management plans are developed.		
2.8 RETURN TO WORK – PRIMARY ELEMENT			
2.8.1 Suitable duties: i) Scheme Agent works with employer about provision of suitable duties and development of return to work plan ii) suitable duties comply with section 43A iii) use of WorkCover programs if appropriate e.g. JobCover, Work Trials.			
• Evidence on file that Scheme Agent has worked with the employer about provision of suitable employment (e.g. with pre-injury employer or another local employer). • As evidenced on the return to work plan, duties comply with section 43A • If a rehabilitation provider is involved, the Scheme Agent has signed copies of return to work plans. • Evidence of consideration of return to work needs and appropriateness of utilising WorkCover vocational programs where necessary to facilitate a return to work.	• Evidence on file that Scheme Agent has not worked with the employer about provision of suitable employment or explored other local options. • Duties do not comply with section 43A. • Rehabilitation provider is developing the return to work plans but the Scheme Agent does not have signed copies of return to work plans on file. • No evidence of consideration of return to work needs and appropriateness of utilising WorkCover vocational programs where this was necessary to facilitate a return to work.	• Worker is never partially incapacitated. • Evidence that it was not practicable for employer to offer suitable duties.	
2.8.2 Rehabilitation strategies for long term injured workers: i) no termination for 6 months post injury because of the injury ii) redeployment considered when appropriate iii) retraining offered, with realistic job prospects			
• Evidence that the employer has been made aware of their obligation to not terminate within 6 months post injury because of the injury. • Evidence that consideration has been given to the return to work needs of long term injured workers and appropriate assistance (e.g. redeployment, use of WorkCover's vocational programs such as	• No evidence that the employer has been made aware of their obligation to not terminate within 6 months post injury because of the injury. • Evidence that the worker is unable to return to same or similar job and the options of redeployment or retraining have not been considered and provided where appropriate. • No evidence that retraining will result	• The worker is not a long-term injured worker. • The worker is able to return to the same or a similar job.	

CONFORMANCE EXAMPLES	NON-CONFORMANCE EXAMPLES	NOT APPLICABLE	NOTES
retraining, work trial scheme, JobCover, equipment) provided to facilitate return to work. • Evidence that retraining will lead to realistic and durable employment prospects that are reasonably comparable to the worker's pre-injury employment salary and status.	in realistic and durable employment prospects that are reasonably comparable to the worker's pre-injury employment salary and status.		
2.9 SECTION 66/67			
2.9.1 Section 66 entitlement: i) determine claim within timeframes (1 month after degree fully ascertainable/2 months after claim with all particulars) ii) assessed and quantified iii) if degree of impairment exists, offer made to injured worker iv) worker made aware to seek legal advice v) worker paid their correct entitlement.			
• When claim is received, the Scheme Agent determines liability within the later of: o 1 month after degree of permanent impairment becomes fully ascertainable; or o within 2 months after claimant has provided all relevant particulars about the section 66 claim. • Entitlement assessed in accordance with the *WorkCover Guides for the Evaluation of Whole Person Impairment* (for injuries from 1 January 2002), or the Table of Disabilities (for injuries pre 1 January 2002). • For injuries from 1 January 2002, assessment conducted by a medical specialist with qualifications and training relevant to the body system being assessed who has been trained in the WorkCover Guides. • There is evidence on file that the	• Independent medical examination not arranged and advised to worker within 2 weeks of date of relevant particulars. • No determination of the s66 claim within 2 months, • For injuries from 1 January 2002, assessment not conducted by an appropriately qualified medical specialist. • S66 entitlement estimated between the high and the low assessment rather than being quantified based on a reported assessment result. • There is evidence on file that the injured worker has a whole person impairment but an offer is not made to the worker. • An injured worker has no legal representation and the Scheme Agent has not informed them to seek legal advice. • The worker is not paid their correctly assessed section 66 entitlement.	• No evidence of impairment. • Section 66 / 67 claim not made.	• Date of relevant particulars is either the date of claim with all relevant particulars or the date of independent medical examination if organised within 2 weeks of receipt of section 66 claim. • If the employer requires the claimant to submit himself or herself for examination by a medical practitioner provided and paid for by the employer, the claimant is not considered to have provided all relevant particulars about the claim until the worker has complied with that requirement, and attended the examination. • The Scheme Agent is not entitled to delay the determination of a claim on the ground that any particulars about the claim are insufficient unless the Scheme Agent requested further relevant particulars within 2 weeks after the claimant provided particulars.

CONFORMANCE EXAMPLES	NON-CONFORMANCE EXAMPLES	NOT APPLICABLE	NOTES
injured worker has a whole person impairment and an offer is made to the worker. • Correspondence to the worker advises them of their entitlement to seek legal advice. • Worker is paid their correct section 66 entitlement in accordance with WorkCover's *Workers Compensation Benefits Guide.* • The worker is paid their entitlement promptly. • If level of whole person impairment is disputed, section 66 entitlement is paid within 21 days of WCC issue of Certificate of Determination.	• There is a delay in the payment of the workers entitlement. • Level of whole person impairment is disputed and section 66 entitlement is not paid within 21days of WCC issue of Certificate of Determination.		
2.9.2 Section 67 entitlement: i) if permanent impairment threshold met, offer made to injured worker ii) worker made aware to seek legal advice iii) worker paid their entitlement.			
• Section 67 threshold has been met and there is evidence that an offer has been made to the injured worker. • Correspondence to the worker advises them of their entitlement to seek legal advice. • The worker is paid their entitlement promptly.	• Section 67 offer made when a section 66 entitlement is below 10% threshold. • No section 67 offer made and section 66 entitlement is equal to or above 10% threshold. • An injured worker has no legal representation and the Scheme Agent has not informed them to seek legal advice. • There is a delay in the payment of the worker's entitlement. • The worker is not paid their correctly assessed entitlement.	• No evidence of impairment. • Section 66 / 67 claim not made. • Section 67 threshold has not been met.	
2.10 COMMON LAW AND WORK INJURY DAMAGES – PRIMARY ELEMENT			
2.10.1 i) Claim for lump sum compensation made and whole person impairment threshold (15%) met ii) Respond to pre-filing statement within 28 days iii) Entitlement determined in accordance with WorkCover guidelines iv) Worker paid their entitlement within reasonable timeframe.			

CONFORMANCE EXAMPLES	NON-CONFORMANCE EXAMPLES	NOT APPLICABLE	NOTES
• Evidence of a medical assessment supporting whole person impairment of 15% or more. • For injuries from 1 January 2002, assessment conducted by a medical specialist with qualifications and training relevant to the body system being assessed who has been trained in the WorkCover Guides. • 15% whole person impairment agreed by both parties before claim proceeds. • Claim determined within 28 days of pre-filing statement by accepting or denying liability (wholly or in part). • If liability is not accepted, there is evidence that there has been served on the worker a pre-filing defence setting out all particulars of the defence and the evidence that the Scheme Agent will rely on in order to defend the claim (as the Workers Compensation Commission rules may require). • Entitlement determined in accordance with WorkCover guidelines: o the work injury is a result of negligence by the employer o defective pre filing statement notified to worker within 7 days and advice sent to the worker includes how the worker can fix the defect. o settlements are correctly coded o claim is not settled until after the claim has been made by the injured worker. o Workers Compensation Commission is involved in	• No evidence of a medical assessment supporting a whole person impairment of 15% or more. • For injuries from 1 January 2002, assessment not conducted by an appropriately qualified medical specialist. • Claim not determined within 28 days of pre filing statement. • If liability is not accepted, a pre filing defence has not been served setting out all particulars of the defence including the evidence that the Scheme Agent will rely on in order to defend the claim. • Entitlement is not determined in accordance with WorkCover guidelines. • There is a dispute as to whether the degree of permanent impairment is sufficient for an award of damages. Level of permanent impairment has either not been accepted or it is not fully ascertainable. • Payment to the worker is unreasonably delayed. • Worker is paid within a reasonable timeframe, but the amount has not been correctly determined.	• No claim for lump sum compensation in respect to the injury has been made.	

CONFORMANCE EXAMPLES	NON-CONFORMANCE EXAMPLES	NOT APPLICABLE	NOTES
monitoring the terms of the settlement o there are no preconditions which are not in accordance with the *WorkCover Guidelines for Claiming Compensation Benefits* set down before settlement is reached. • The worker is paid their correct entitlement within a reasonable timeframe.			
2.11 COMMUTATIONS			
2.11.1 i) Preconditions under section 87EA of the *Workers Compensation Act 1987* have been met ii) Certification has been obtained from WorkCover.			
• Section 87EA conditions met i.e.: o the injury has resulted in a degree of permanent impairment of the injured worker that is at least 15% (assessed as provided by Part 7 of Chapter 7 of the 1998 Act), and o permanent impairment compensation and pain and suffering compensation to which the injured worker is entitled in respect of the injury has been paid, and o a period of at least 2 years has elapsed since the worker's first claim for weekly payments of compensation in respect of the injury was made, and o all opportunities for injury management and return to work for the injured worker have been fully exhausted, and o the worker has received weekly payments of compensation in respect of the injury regularly and periodically throughout the	• Section 87EA conditions not met • There is no evidence that certification from WorkCover has been obtained before commutation is settled.	• No commutation has been applied for. • Commutation of a liability in respect of compensation under the former Act.	

CONFORMANCE EXAMPLES	NON-CONFORMANCE EXAMPLES	NOT APPLICABLE	NOTES
preceding 6 months, and o the worker has an existing and continuing entitlement to weekly payments of compensation in respect of the injury (whether the incapacity concerned is partial or total), and o the injured worker has not had weekly payments of compensation discontinued under section 52A or reduced under section 38A. • There is evidence that certification from WorkCover has been obtained before commutation is settled.			
2.12 PAYMENTS TO SERVICE PROVIDERS			
2.12.1 Payments to service providers in accordance with WorkCover's gazetted fees orders and approval letters/approved treatment plans.			
• Evidence that providers paid in accord with gazetted fees and approved plans.	• Fees not paid in accord with gazetted schedules or approved plans for last 3 invoices paid.	• Provider fees not gazetted and requirement for approved treatment plans not applicable. • No invoices yet on file.	• If invoice is not date stamped, the date of the invoice is taken to be date invoice received.
2.12.2 Payments to service providers within time frame documented in Injury Management Program or claims manual consistent with accepted business practices to guarantee continuity of service provision.			
• Evidence that providers paid within appropriate timeframes (30 days).	• Any fees not paid in appropriate time frames for last 3 invoices paid.	• No invoices yet on file.	
2.13 COLLECTING AND USING DATA			
2.13.1 Work status code up to date on all claims with a significant injury i.e. more than 5 days incapacity.			
• Code on WorkCover database at a given date matches status of the worker at the same date.	• Code on WorkCover database at given date does not match status of the worker at the same date.		
2.14 FINALISATION			
2.14.1 Claim finalised when the worker has no further entitlement to workers compensation benefits, this decision is not being disputed and all payments have been made.			
• In accordance with *WorkCover Guidelines for Claiming Compensation Benefits*, claim is finalised when worker has no ongoing	• Claim has been closed and there is evidence on the file that it should remain open.		

CONFORMANCE EXAMPLES	NON-CONFORMANCE EXAMPLES	NOT APPLICABLE	NOTES
entitlement to benefits and this decision is not being disputed. Factors considered include: o worker has achieved optimal return to work and health outcomes o all payments have been made o no recovery action is current.			