EML NSW Injury Management Program

May 2025

we help people get their lives back

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Injury Management Program

EML NSW

We Help People Get Their Lives Back

For over 110 years, the EML Group has helped Australians get their lives back after injury.

Our experienced team of +3,500 professionals are committed, and proud to have been able to provide support and care for over 155,000 workers and their employers since 2023.

EML is one of the largest providers of services in personal injury claims management, a large provider of outsourced claims management services to self-insurers, and one of the most experienced self-insurance claims managers in NSW.

EML has cared for workers and supported employers in NSW since 1910. Since then, EML have built a reputation in the industry as a trusted partner to regulators, government Agencies, employers, industry bodies and other stakeholders within the Scheme.

Focused exclusively on personal injury claims management, EML harness our extensive experience of the state's risk and claim profile to deliver customer-centred care for NSW workers and employers.

We are the largest and most experienced provider in NSW, with 1,400 personal injury specialists supported by an industry-leading capability development program.

Your dedicated claims team will actively collaborate, communicate and engage with you to deliver outcomes. We will seek to understand your needs and tailor our service to your business.

We have proactively invested over $142M since 2012 to push the boundaries of best practice; support long-term Scheme improvement and offer benefits to customers through our Mutual Benefits Program.

We are leading the NSW Scheme in key performance metrics released in December 2024, including return to work rates, customer satisfaction and compliance.

Years of experience with icare's claims management system have allowed us to develop bespoke tools, resources and reports that enhance compliance and operational effectiveness enabling our Case Managers to focus on proactive claim strategies that drive real results.

As we look towards the future, we continue to build on this value. We've helped generations of Australians cope with illness and injury in the workplace and we aim to be there for generations more.

Our customer promise

Our customer promise details our commitment to our customers and how our people will continue to provide all our customers with exceptional levels of service at all times.

Our promise to you is:

We will listen to understand your needs

We will work collaboratively with you to achieve the best outcomes

We will keep you updated and informed

We will treat you with dignity and respect

We will take responsibility and deliver promptly on our promise to you

We will always be open and honest in our dealings.

We set clear service standards and continuously improve them by valuing the feedback we receive and working constructively with our professional partners.

We provide training and ongoing support to our people, ensuring that they do the best job they can.

Our Injury Management Program

As a Claims Service Provider (CSP) for the Nominal Insurer (hereafter referred to as "*icare*"), and as legislated under Section 43 of the *Workplace Injury Management and Workers Compensation Act 1998* we are required to 'establish and maintain an Injury Management Program' and must revise the 'injury management program from time to time'.

An Injury Management Program is defined by Section 42 as 'a coordinated and managed program that integrates all aspects of injury management (including treatment, rehabilitation, retraining, claims management and employment practices) for the purpose of achieving optimal results in terms of timely, safe and durable return to work for Workers.

This program details our approach to claims and injury management and will serve as a guide to enable Employers to align their own Return to Work Program with the obligations and processes outlined in this document.

This Injury Management Program focuses on:

- Ensuring compliance with the legislative requirements
- Assisting our Employers to provide a safe workplace and promote the health, safety and welfare of their employees
- Ensuring Workers receive individual, prompt, proactive and effective treatment and management of their injuries to ensure a sustainable return to work (RTW) or recover at work
- Compliance with all legislative and regulatory requirements

1. References

- SIRA Guidelines for Claiming Workers Compensation 2016
- SIRA Claims Management Principles
- SIRA Guidelines on Independent Medical Examinations and Reports 2012
- SIRA Guidelines on Injury Management Consultants 2012
- SIRA Standards of Practice 2022
- SIRA Injury Management Program: A Guide and Checklist for Insurers
- The Workers Compensation Act 1987
- The Workplace Injury Management and Workers Compensation Act 1998
- The Workers Compensation Regulation 2016
- icare's Injury Management Program 2022
- Health and Other Services Compensation Act 1995

2. Working with you

2.1 Our obligations

We have responsibilities and obligations when managing claims under the Workers Compensation Legislation and to the State Insurance Regulatory Authority (SIRA) Standards of Practice. These include:

Helping everyone to understand their obligations and we do this by:

- Establishing this Injury Management Program and keeping it up to date in accordance with legislative requirements.
- Making sure the Injury Management Program is available to all Stakeholders.

We do this through consultation and communication with all Stakeholders throughout the life of the claim:

- Within three working days of being notified that a Worker has sustained a significant injury (where they are unable to perform their pre-injury duties for a continuous period of more than 7 days), contact the Employer, Worker and (where necessary) the Nominated Treating Doctor to discuss the claim. Subsequently, we must develop an Injury Management Plan tailored specifically for the Worker in line with timeframes outlined in this Injury Management Program.
- Consult with the Worker, Employer and Nominated Treating Doctor as well as any required Third Party Service Providers in the development of the Worker's Injury Management Plan.
- Provide the Worker, Employer and Nominated Treating Doctor as well as any required Third Party Service Providers with information on the Injury Management Plan initially and as the plan progresses.

Inform the Worker of their rights and benefits under the scheme:

- Have procedures in place for a Worker to change their Nominated Treating Doctor and inform the Worker of these requirements.
- Consult with the Worker, Employer and Nominated Treating Doctor when referring to a Workplace Rehabilitation Provider. Advise the Worker that they can choose a Workplace Rehabilitation Provider and inform the Worker of the process to be followed when changing a Provider.
- Ensure Vocational Programs are used appropriately and provide Workers with assistance to obtain employment with a new Employer if it is identified that a return to pre-injury duties or provision of suitable work with the pre-injury Employer is no longer possible.
- Ensure accuracy of payment of weekly compensation payments in accordance with the pre-injury wage pattern as advised by the Employer and legislative requirements.
- Provide Workers with information about their weekly compensation payments and entitlements and how they may change over time, providing suitable notice of changes.

2.2 Obligations as an Employer

Immediately after a workplace injury has occurred, we recommend that the Employer becomes actively engaged and is supportive of the return-to-work process. Various studies have shown that where an Employer is interested and involved in the return to work process the return-to-work outcome will be significantly better, lowering the cost of claims.

Employers who receive claims management services from us are to:

- Ensure the health, safety and welfare of all Employees at work.
- Participate and comply with the requirements of this Injury Management Program.
- Establish their own Recovery at Work and RTW Program in accordance with SIRA requirements and make details available to all Employees.
- Review and update their own RTW Program at least every two years to ensure it is amended in accordance with any potential legislation changes.
- Maintain a 'Register of Injuries' in which workers record details of work-related injuries.
- Workers Insurance NSW 'Category 1' Employers with a basic tariff premium exceeding $50,000 annually must appoint a trained RTW Coordinator with the necessary qualifications, authority and resources to negotiate, develop and implement RTW policies and procedures and advise us of the contact details of that person.
- A Category 2 employer is any employer who does not fall under Category 1. Establishing a RTW program for these employers includes appointing a recovery-at-work coordinator, developing a return-to-work program, and implementing the program.
- As an Employer a RTW Program must be in place within 12 months of establishing a business.

When an injury occurs:

- If a serious incident occurs notify SafeWork NSW immediately.
- Within 48 hours of an incident, notify EML of the work-related injury or illness to a Worker utilising online claim notification, phone, fax or hard copy claim form.
- Instigate and facilitate the rehabilitation process of a Worker.
- Work with us to develop and provide a RTW Plan within 5 days of injury notification.
- Participate and comply with obligations of the Worker's Injury Management Plan.
- Provide suitable work (as far as reasonably practicable) when a Worker is able to return to work, either on a full time or part time basis.
- Provide suitable work that is (as far as reasonably practicable) the same as or equivalent to the work being performed at the time of the injury.
- Collaborate with the Worker, Case Manager, and any other Third-Party Service Provider to provide suitable work options in accordance with certified work capacity.
- Understand the rights and responsibilities of all Stakeholders.
- If unable to provide suitable employment, to a Worker who has the capacity for work, notify your Case Manager immediately so that we can provide further assistance.
- Adhere to the relevant privacy laws when collecting and handling personal information of Workers.
- Retain accessible records of all relevant communication with key Stakeholders.

For further information please visit the relevant SIRA page:

https://www.sira.nsw. gov.au/theres-been-an-injury/im-an-employer-helping-my-worker-recover/return-to-work-programs

2.3 Obligations as a Worker

Workers have obligations under the legislation which includes, however is not limited to:

- Engaging in safe work practices to prevent workplace injuries to themselves and co-workers.
- Notifying the Employer of an injury or illness that occurs within the workplace as soon as practicable.

After a workplace injury:

Workers are encouraged to participate proactively to enable case management and injury management to commence as soon as possible. Such actions include:

- Actively engage with the Case Manager and the Employer to facilitate recovery at work
- Participate and cooperate in the establishment of an Injury Management Plan if the injury is significant.
- Designate a Nominated Treating Doctor to direct medical management and participate in Injury Management and Recovery at Work or Return to Work Planning.
- Participate with Recovery at Work obligations and make reasonable efforts to return to work in suitable employment or pre-injury employment at the worker's place of employment or at another place of employment.
- Authorise the Nominated Treating Doctor to provide all relevant information to the Case Manager or other key parties.

Throughout the life of the claim:

- Keep the Case Manager and Employer informed of progress and report changes in capacity for work immediately.
- Provide a certificate of capacity every 28 days or as agreed with us
- Adhere to the capabilities listed on the Certificate of Capacity as recommended by their Nominated Treating Doctor (or appropriately qualified persons) both at work and away from the workplace.
- Report any issues with the Injury Management Plan or Suitable Employment provided immediately to the Employer, Case Manager and if required the Workplace Rehabilitation Provider.
- Attend relevant appointments with Medical Practitioners, Treatment Providers and Workplace Rehabilitation Providers for any medical examinations or assessments arranged.
- Actively participate in assessments for the determination of capacity for work.
- Seek suitable employment with an alternative Employer if medical evidence and/or certified capacity does not support a return to pre-injury duties.
- Contact their Case Manager before starting any new treatment or requesting payment for medical services, to seek approval that it is reasonably necessary if required (noting some services are pre-approved).

2.4 Responsibilities of the Nominated Treating Doctor

If a worker is unable to perform their usual duties for seven days or more due to an injury, they are required to appoint a nominated treating doctor (NTD), in accordance with SIRA Guidance Note 6.3: Nominated Treating Doctor and Specialists.

The nominated treating doctor must work collaboratively with the worker's support team and is authorised—via the certificate of capacity—to share relevant information to support injury management and recovery. The NTD will:

- Actively participate in the responsibilities outlined in the Worker's Injury Management Plan.
- Support the Worker to return to, and where possible to recover at work, through appropriate clinical intervention and management.
- Contribute to collaboration with everyone involved in the Worker's Recovery. This includes the Case Manager, the Employer, other treatment providers and the Workplace Rehabilitation Provider.
- Provide updated Certificates of Capacity in line with legislative requirements and at intervals not greater than 28 days (unless approval is provided by the Case Manager to exceed this duration).
- Provide Certificates of Capacity that accurately reflect the Worker's capacity to work and what they can do.

2.5 How we keep Stakeholders informed

The Worker, Employer and Third-Party Service Providers are all able to access and view this Injury Management Program on our website: *www.eml.com.au*

All parties are informed of their obligations through the following strategies:

- During completion of 'initial contact' following a claim, all parties are informed of how the process works, approval requirements and their obligations.
- Workers receive a "Rights and Responsibilities" letter.
- As part of development of the Injury Management Plan (IMP) in the case of a significant injury. The IMP outlines all Stakeholders' legislative and specific requirements during the workers compensation and Recovery at Work processes.

2.6 How we assist Employers

Injury Prevention

Beyond delivering excellence in personal injury management services, we also offer a range of complimentary market leading benefits including online risk products, employer training, world-first research programs and injury prevention initiatives designed to improve health, safety and return to work outcomes through the Mutual Benefits Program.

EML invest heavily in research and services to help employers create safer workplaces and injured workers recover and get their lives back sooner. To assist employers to ensure the health and safety of their workers and comply with workplace health and safety laws we offer:

- Free access to workplace e-learning courses (EMlearning)
- Free online tools designed to simplify the way employers monitor and manage workplace health safety (EMsafe) and wellbeing (EMhealth).
- Employer training events facilitated by industry experts

- Access to over 100 free workplace health and safety resources including workplace health and safety videos, posters, articles and guides.
- access to innovative pilot programs, industry leading research and the benefits of our continuously improving operations.
- exceptional deals (EML Offers) from a selection of industry leaders in training, technology and consultancy services.
- invitations to thought leadership forums such as Here and Now.

For more information regarding the addition support provided to employers please visit our website.

Reduce Risk and Improve Return to Work Outcomes

We support employers to reduce risk and improve return to work outcomes for their injured workers by providing:

- **Client meetings** – to discuss areas of concern around employer obligations such as offering suitable employment, wage reimbursement schedules, PIAWE calculation; or to provide information on performance trends, matters or risks identified through claims management.
- **Claim reviews** – formal forum to discuss claims and agree upon strategy. Allows for education around offering suitable employment and how an employer can support recovery at work.
- **Claims data analysis** – to identify trends to support employer needs

3. How we help you manage your claim

3.1 Our Case Management Model

Our Case Management Model is the basic framework which forms the foundation of our approach to Case Management. The framework is standardised and consists of tailored activities and review points throughout the lifecycle of the claim which have been established to assist our Case Managers to strategically manage a claim. The process captures current and proven best practices. A similar model is used across all EML Group businesses nationally, irrespective of the state scheme. This methodology allows adjustments and modifications to be made to the structure to allow us to accommodate variations in legislation and contractual requirements between jurisdictions.

In each step of the process Case Managers are supported with principles, tools and templates to guide our involvement to ensure necessary information is obtained and key decisions are made. Underpinned by the concept of capacity management, the model has a strong focus on maximising capacity for employment, as well as maintaining independence and health outcomes for longer term Workers. Our Case Management Model assists us in achieving our purpose of *"helping people get their lives back".*

This model enables us to:

- Deliver a common customer experience for Workers, Employers and regulators
- Tailor strategies that drive early intervention and RTW outcomes
- Align our people and their experience to enhance the service to our clients
- Undertake a segmented approach to claims management, bound by timeframes with specific activities and review to drive claims strategically

Claims are separated into a series of 'segments' bound by time or capacity for review and assessment of Worker needs and support.

The Case Management Model underpins our claims and injury management processes and procedures and is developed in line with SIRA's Claims Management Principles:

- **Fairness and empathy**
  Claims will be managed with empathy and a focus on fairness by:
  - Clearly communicating workers' rights, entitlements, and responsibilities, as well as the roles of insurers and other parties.
  - Ensuring procedural fairness through evidence-based decisions that support the worker's recovery and return to work.

- **Transparency and participation**
  All parties will be supported to actively participate in claims management through:
  - Transparent, timely communication of decision-making processes, including reasons and evidence, with opportunities for response and review.

- Encouraging input from workers, employers, and other participants to inform and support claims decisions.

- **Timeliness and efficiency**
  Claims will be managed proactively to minimise delays and costs by:
  - Promptly processing claims, responding to inquiries, determining entitlements, and making payments.
  - Progressing claims efficiently and avoiding unnecessary delays.

3.2 Early intervention, initial notification and reporting of incidents

We acknowledge that early intervention is critical to achieving positive RTW outcomes. For this reason, it is critical, and we encourage, our Employers to report all incidents and injuries within 48 hours of first becoming aware of the incident or injury. Early reporting by the Employer ensures that critical information is provided which can facilitate prompt processing of the claim and enable early decision making. This means that injury management can commence quickly, and that the worker will have access to medical treatment promptly.

3.2.1 Lodging a claim

An incident can be notified by the Worker, the Employer or some other person acting on their behalf. There are several ways in which a notification of injury can be made:

- **Online Notification via the icare website:** www.icare.nsw.gov.au
- **Email:** emlnewclaims@workerscomp.nsw.gov.au
- **Phone:** 133 365 (Monday to Friday 8:30am – 5:00pm, closed public holidays).
- **Mail:** Locked Bag 2099,
  North Ryde BC, NSW 1670

To enable the incident notification to be processed quickly, a minimum amount of information about the Worker and the injury is required. To assist in the collection of this information, our standardised injury report form (which can be downloaded from our website www.eml.com.au, or completed online), contains all the information that we require. Where the notification is incomplete, we will follow up within 3 working days and explain what additional information is required for a liability decision to be made.

All Workers are advised in writing at the first available opportunity of their obligations. When informed that a potential claim exists, Employers are encouraged to use this opportunity to explain the Worker's obligations involved in lodging a claim.

3.2.2 Late reporting of injury - Employer excess

If the Employer does not report the injury within 5 calendar days of becoming aware of the workplace injury, the Employer may pay a claims excess payment. The excess is usually the equivalent of one week's worth of the Worker's weekly payments. Late reporting will be confirmed and discussed when the Case Manager makes initial contact with the Employer.

3.2.3 Triage and segmentation

Triage and segmentation assist us to identify specific factors which may impact the successful recovery and Return to Work of the Worker.

Critical to effective triage and segmentation is appropriate screening of claims. This refers to the process through which we can make an early identification of the needs, risks and possible barriers to achieving Recovery at Work outcomes. Effective and timely claims screening ensures key information is identified early so that the claim can be allocated to a suitably qualified Case Manager. Once claim allocation has occurred, targeted injury management planning and case management strategies can be implemented immediately.

Claims are then identified as significant, possibly significant or non-significant (as defined by section 42 of the Workplace Injury Management and Workers Compensation Act 1998) and are allocated to a claims team for further review and action.

> ***Note that:***
>
> *Claims classified as significant at notification regardless of the time lost as they have a high potential of becoming significant include: head injuries, psychological injuries, fractures, hernias, amputations, likely surgery, nature and conditions claims.*
>
> *The claim characteristics considered when allocating claims to Case Managers include: liability issues, recovery potential and injury severity (red flags), nature, duration and presence of psychosocial factors (yellow flags) as well as existing Employer or Broker relationships.*
>
> *This model ensures our claims are managed by a suitably qualified Case Manager, based on the complexity of the claim, from notification through to finalisation.*

3.3 Delegation framework

Our Delegations Framework details the authorisation limit and review process for key case management activities including liability, payments, referral to external providers, surgery, disputes, and Workplace Rehabilitation cost approvals.

This process ensures appropriate control of the decision-making process. Having experienced and capable staff review critical actions and decisions assists to ensure all decisions made are soundly based and in accordance with regulatory and internal requirements.

The authorisation process also provides the opportunity for the reviewer to provide feedback and coaching to the Case Manager regarding their decision making to assist in their ongoing development.

3.4 Managing death claims

If a work-related injury or disease results in a worker's death, compensation is payable. A workplace death may be investigated without a formal claim being lodged, depending on the circumstances of the incident, and a claim for death benefits may be lodged immediately following an incident or at a later date.

Fatality notifications and claims are managed by dedicated Fatalities Case Managers who are experienced in supporting families and workplaces following a workplace death. SIRA's Standards of Practice require that Case Managers make contact with the worker's family within five working days of being notified of the death.

If a workplace death occurs, you must notify SafeWork NSW immediately on 13 10 50, or as soon as possible. You must also notify EML and icare within 48 hours of the incident occurring.

The Fatalities Case Manager will help by:

- Providing an experienced, empathetic, single point of contact throughout the claim
- Explaining the claims investigation process and information required to make a liability decision
- Providing regular updates throughout the investigation
- Providing a liability decision verbally, and in writing

Case Managers will require information to confirm the worker's employment status, cause and circumstances of the incident leading to the fatality, and employers and employees may be required to participate in a factual investigation. The length of time to investigate a fatality depends on the type of incident and the availability of information from multiple sources which may include the family of the worker, medical practitioners and specialists, hospitals and ambulance, the NSW police, legal providers and in some instances, the coroner.

If liability for a fatality claim is accepted, the worker's dependents or estate are entitled to:

- A lump sum death benefit
- Weekly benefits for dependent children up to 16 years old, or if a student, 21 years old
- Reasonable funeral expenses up to the maximum statutory amount

The amounts payable are indexed periodically and can be found in SIRA's workers compensation benefits guide.

Fatality claims do not affect premiums. However, employers may be required to make a one-off Catastrophic Claim Contribution. If applicable, icare will contact you directly.

Workplace fatalities are deeply distressing. Your Case Manager is available to offer support and information to you and those affected.

4. Recovery and Return to Work

Work plays an important role in the rehabilitation, recovery, and wellbeing of our injured workers. Effective recovery at work or return to work can be facilitated using customised assessments, services and programs to help workers recover in their current or new workplace.

4.1 Certificate of capacity

The Certificate of Capacity is the formal communication tool completed by the Nominated Treating Doctor to describe the nature of a worker's injury/illness, their capacity for work, and the treatment required for a safe and durable recovery.

The information contained in this document will provide the Employer and/or Workplace Rehabilitation Provider with guidance when it comes to identifying suitable work options for the Worker.

The Certificate of Capacity will outline capacity defined as one of the following:

- Fit for pre-injury duties – the Worker is able to perform all aspects of their pre-injury role. There are no physical or psychological limitations relating to the work injury that are impacting the Worker's ability to perform their full role.
- Capacity for some type of employment - the Worker has a capacity to engage in some form of employment. Specific capabilities and any limitations will be outlined on the Certificate of Capacity. It may mean the Worker can perform all elements of their pre-injury role, but on reduced hours, or fit to perform some, but not all aspects of their pre-injury role.
- No current work capacity – the Worker is unable to participate in any work at that time.

4.2 Recover at Work or Return to Work plan

In relation to Recover at Work and RTW planning, it is pertinent to work towards an end goal. As such, injury management requires the establishment of an end goal that all parties can actively work towards. Primarily, the goal of returning the Worker to the same job as at the time of injury is preferable. However, given the diagnosis of the injury or the nature of the work, this may not always be possible and the RTW goal should be the most direct path back to employment.

The initial goal is established and agreed to by all Stakeholders once the Nominated Treating Doctor has provided a diagnosis of the injury and a prediction of the prognosis. This goal can be changed and updated dependent upon the ongoing needs and capacity of the Worker.

Wherever possible, the initial RTW focus will be with the goal of RTW to pre-injury duties and employment with the same Employer, or a different job with the same Employer. Although achieving this goal is not always possible and suitable employment may need to be explored with a different Employer – this is known as redeployment. We will work with Stakeholders to identify suitable employment goals and support Workers to achieve a return to suitable employment through appropriate, tailored support such as workplace rehabilitation.

4.2.1 Developing a Recover at Work or Return to Work plan

The Plan is a formal document individualised for the Worker which explains the Recover at Work or Return to Work Goal, capacity for work and lists the activities in the workplace that the Worker has the functional capacity to perform as well as how EML will support the process.

Key points found in this document include:

- The worker's pre-injury duties
- The worker's Recover at Work or Return to Work goal
- Details of the current Certificate of Capacity
- Details of suitable work that is available
- A review date for the plan
- Agreement to the plan by the worker and their supervisor.

The Worker, direct Supervisor and Treating Doctor will all be given a copy and must all agree with the Plan.

The Plan will need to be updated regularly so that it accommodates changes and upgrades in the capacity as outlined in the most recent certificate of capacity.

4.2.2 Monitoring progress

Once the Worker has returned to suitable employment and is participating in the recovery at work, regular reviews in the workplace will ensure adherence to the plan and ensure any challenges can be addressed immediately. It is important that any issues or problems with suitable employment or the RTW Plan are raised with the Case Manager as soon as possible.

4.3 Identification of Suitable Employment

Under Section 49 of the Workplace Injury Management and Workers Compensation Act 1998, Employers are required, so far as reasonably practicable, to provide suitable employment which is the same as or similar to the Worker's pre-injury role. Suitable Employment enables the Worker to remain active and recover at work. Recovery at work speeds healing, reduces symptoms, promotes an active lifestyle and fosters connectedness with the workplace.

As endorsed by the Australasian Faculty of Occupational and Environmental Medicine "*work is good for people*", "*work is generally good for health and wellbeing*" and the acknowledgement that "*long term work absence, work disability and unemployment have a negative impact on health and wellbeing*". Employers can have a positive impact on health and well-being by ensuring a positive workplace safety culture and accommodating ill or Workers to remain in the workplace where possible.

Suitable employment should be organised considering the nature of the injury and medical information available, and the age, education, skills and experience of the worker.

The following factors should be considered when the Employer is identifying suitable employment options within the workplace:

- Nature and severity of the Worker's injury
- Duties are deemed safe and in line with certified physical and psychological capacity

- Contain as many tasks as the Worker's normal role as possible
- May be provided in different ways (same or different workplace, same job with different hours, modified duties, different job altogether or a combination of these).
- Discuss possible work options with the Worker and Supervisor and if they have any ideas about suitable work options available.
- Thought about how the workplace could potentially be modified or if equipment can be prescribed to accommodate the Worker.

If the Employer is experiencing difficulties in identifying suitable work options within the workplace, the Employer should contact the Case Manager as soon as possible for assistance. If the Worker does have some work capacity, not offering suitable employment can delay the Worker's recovery, and in addition may contribute to escalating workers compensations costs for the Employer.

4.4 Injury Management Plans

If a Worker has sustained a significant injury, we develop an Injury Management Plan in collaboration with the Worker, Employer and Nominated Treating Doctor.

The Injury Management Plan is a tailored written plan developed in conjunction with the Recovery and Return to Work Plan is aimed at assisting to facilitate the timely, safe and durable RTW for a Worker. The plan identifies the goals and actions of all parties in helping the Worker recover from their injury and recover at/return to work.

The Case Manager develops an Injury Management Plan to communicate the case management goal and actions to be undertaken by each stakeholder to assist in achieving the goal. The Injury Management Plan reflects relevant information that is available at the date the plan is issued, it includes:

- Key participants in the management of treatment and Recovery at Work (Worker, Employer, Nominated Treating Doctor/ Specialist, Workplace Rehabilitation Provider and other Treatment Providers)
- RTW goal and actions to achieve the goal (The Recovery and Return to Work goal will be the most likely goal that can be established given the information available at that point in time).
- Other goals and actions identified by the Worker or other stakeholders, including social or wellness goals
- Legislative obligations and responsibilities of each stakeholder
- Procedure for changing the Nominated Treating Doctor (NTD)
- Actions for completion, responsibilities and timeframes
- Review date

The Injury Management Plan is informed by the risk assessment completed within the first 4 weeks from notification to identify risks delaying recovery. Following the identification of risk factors that may delay recovery, EML will collaborate with all stakeholders to identify, agree and implement appropriate actions to address the specific risks identified.

EML complete regular reviews to address a worker's risks, needs and return to work barriers as their circumstances change throughout the life of their claim. Reviews allow us to identify any new or emerging risks and review the controls for risks that were previously implemented. Reviews are also used to identify barriers to reaching milestones and the potential need for more intensive management or the need to explore different approaches. When new information about the Worker's injury or

treatment is received, or in circumstances where the Recovery and Return to Work goal has changed or is no longer appropriate, a revised Injury Management Plan is developed in consultation with all Stakeholders.

Depending on the activities identified in the plan, review dates may be specific, coincide with particular events (eg. Surgery, change in capacity), or they may be more general timeframes. A review will not automatically result in the creation of a revised plan; it will be documented if a new plan is not required.

Timeframes:

- **Initial Injury Management Plan** – within **20 business days** of notification of a significant injury for a Worker who has not returned to pre-injury duties or continues to require treatment or medical services, and who is not expected to do so.

4.5 Management and support for workers who are job seeking

By the time the Worker has reached 4 weeks post injury, a Recovery or Return to Work goal should have been clearly established in the majority of instances. The goal would either be a sustainable return to pre-injury duties or securing alternative suitable employment. If the goal remains unclear, there are tools and resources available for the Case Manager to apply specific strategies to determine the employment pathway and any support needed.

Where it has been determined that the Worker does not have the capacity to return to pre-injury duties and the Employer cannot offer suitable employment, the Worker will be required to seek alternative employment with a new Employer. In this instance we will arrange targeted and specific support with a suitable provider in job seeking and redeployment.

When it is identified that the Employer is unable to provide suitable employment the following is undertaken:

- Worker is reminded of their obligations under Section 48 of the Workplace Injury Management and Workers Compensation Act 1998
- Regular follow-up of job seeking evidence is obtained, to continue entitlement to, and payment of, weekly compensation payments
- Where there are changes to the actions or service provisions the IMP is updated and reissued to the key parties

The ability to effectively manage the participation of Workers in job-seeking programs is positively influenced by proactive Case Management and decision making to identify future potential sources of suitable employment. This also includes engaging an appropriate Workplace Rehabilitation Provider to undertake targeted RTW services and ensure that a Worker has the skills and knowledge to effectively job seek and gain durable employment in a timely manner.

Key activities that will be reviewed in order to support a Worker may include:

- Referral to an accredited Workplace Rehabilitation Provider
- Commencement of Career Coaching
- Review the need for a Vocational Assessment
- Agreement to new suitable employment goals
- Job seeking skills training
- Where required utilisation of Vocational Programs in accordance with Section 53 of the Workplace Injury Management and Workers Compensation Act 1998.

4.5.1 Recovery at work assistance with a Workplace Rehabilitation Provider (WRP)

There are times when expert assistance is required to assist with a Worker's Recovery at Work. WRP's are usually allied health professionals such as Occupational Therapists, Physiotherapists or Rehabilitation Counsellors with expertise in occupational rehabilitation. They are engaged to assist Employers, as required, to identify suitable employment and provide guidance on the development and management of Recovery at Work Plans if an Employer is unable to do so independently or support is needed to overcome Recovery at Work barriers. A Worker may choose to nominate their own preferred provider, or an Employer may have a preferred provider they wish to use.

The WRP and Case Manager will identify and implement targeted and tailored rehabilitation solutions to assess, gain agreement to, and obtain suitable employment goals. These solutions, where appropriate, will include utilisation of the Vocational Programs.

When tailored and targeted rehabilitation has not resulted in a return to work the Case Manager will have been able to gather the evidence to allow a soundly based work capacity decision to be made.

4.6 Case conferencing

A case conference is a meeting (face-to-face, teleconference or video conference) with the worker, their nominated treating doctor and with some or all of the support team such as EML, the employer, workplace rehabilitation providers, injury management consultants and other providers assisting the worker.

Case conferences are used to support a worker's recovery at or return to work by setting goals, ensuring roles and responsibilities are understood and agree to timeframes for recovery at or return to work.

When EML arranges a case conference we provide a letter to all parties involved that outlines the purpose and agenda for the conference.

The following items may be discussed:

- Capacity for work
- Progress and treatment plan
- Duties available to the worker (suitable duties)
- Workplace support and modifications the worker may require to return to work.
- Factors potentially delaying recovery or return to work and the potential support required to address these.

After the case conference all parties will be sent:

- Documented outcomes
- Timeframes & responsible parties for actionable items

4.7 Management of non-participation

Section 48A of the Workplace Injury Management and Workers Compensation Act 1998 supports that in order to receive weekly payments, a worker who has capacity to work must make reasonable efforts to return to work. Should a Worker have capacity and not make reasonable efforts to return to work then EML may suspend weekly payments, and this may lead to termination of weekly payments.

Prior to suspending or terminating an entitlement to weekly compensation payments, we will contact the Worker (or if contact is not able to be established, request that the Worker contact the Case Manager). In this contact the Case Manager will attempt to discover the reasons for the non-compliance or non-participation and if appropriate, a new plan and obligations may be developed.

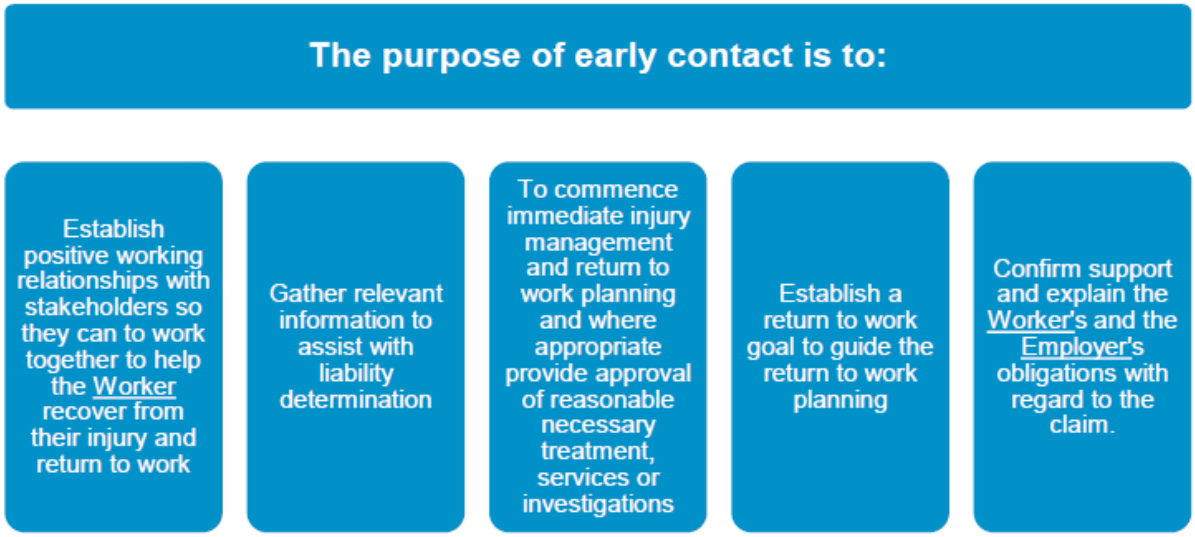
If unreasonable non-participation continues, a warning notice will be sent advising that the entitlement to weekly compensation payments are at risk of suspension and provide the Worker detailed requirements and a timeframe within which to comply. Should the Worker fail to comply within the required timeframe then the entitlement to weekly compensation payments will be suspended. Should the Worker continue to fail to actively participate then the entitlement to weekly compensation payments may cease and not be reinstated. Periods of suspended benefits may not be payable if, at a later date, the Worker becomes compliant.

5. Assessing liability

5.1 Initial contact

In all cases of significant injury, the Case Manager completes contact with the Worker, Employer and (where required) the Nominated Treating Doctor within three business days of the injury notification being received in accordance with the Workplace Injury Management and Workers Compensation Act 1998.

If contact is not able to be established via the telephone by the third business day, written correspondence (via email, fax or post) is sent requesting the Stakeholder to make contact with the Case Manager as soon as possible. We will then continue to follow up on a regular basis until meaningful contact is established.



5.2 Non significant injuries

When a Worker has been able to resume their pre-injury duties within 7 calendar days the claim is considered non-significant. In these circumstances the Case Manager will contact the Worker and Employer and confirm the information provided. A liability decision will then be made and communicated to the Stakeholders within 7 days of notification.

5.3 Use of interpreters

Case Managers have access to a range of providers for document, telephone and face to face interpreting services. When working with stakeholders from a non-English speaking background, Case Managers offer to arrange professional interpreters for all interactions to ensure clear independent communication and understanding is achieved.

When engaging the services of an interpreter, EML are to:

- Engage a NAATI-certified interpreter (for languages where this certification is available)

- Consider whether the communication should be face-to-face or whether using a telephone interpreter is sufficient
- Ensure there is no conflict of interest
- Ensure consideration of the workers cultural background, and
- Explain the purpose of the communication to the interpreter.

5.4 Determining Liability

We apply a structured approach to determining claim liability, in accordance with the appropriate Acts, Guidelines and Standards of Practice.

Our approach to liability determination is to ensure all required information is received promptly and reviewed critically to allow a soundly based decision to be made within the legislative timeframes. All liability decisions are communicated in writing to all Stakeholders.

5.4.1 Provisional liability

Provisional liability enables the commencement of weekly compensation payments for up to 12 weeks as well as implement injury management strategies without a decision on ongoing liability. Under provisional liability, interim payments can commence for reasonably necessary medical expenses up to a maximum which is indexed periodically.

Starting provisional payments does not mean EML or the Employer have admitted liability for the injury. It simply allows us to provide the Worker with financial assistance, by commencing payments of weekly payments, and early intervention whilst we collect additional factual and/or medical information to enable us to make a liability decision before the provisional liability expires.

5.4.2 Reasonable excuse

A Reasonable Excuse to not commence payments can be applied if there is insufficient information available regarding the circumstances surrounding the injury or insufficient details provided in the initial notification.

A Reasonable Excuse may be applied in the following circumstances:

- Insufficient medical information
- The Worker is unlikely to be a ‘worker’ under the Act
- Inability to contact the Worker
- The Worker refuses access to information
- The injury is not work related
- No requirement for weekly payments
- Failure by the Worker to report the injury to the Employer within 2 months

We will provide notice to the Employer and Worker that a claim has been reasonably excused within 7 calendar days of receipt of injury notification.

Whilst a reasonable excuse applies to provisional weekly payments, reasonable medical expenses will continue to be funded during this period.

If the relevant information or evidence is supplied after a reasonable excuse has been applied, EML will make a liability decision on the basis of the evidence provided. This will be determined within 7 calendar days of receiving all the required information, or 21 days of the claim being duly made, whichever is the earliest.

5.4.3 Accepting liability

After the initial notification of a claim, and where the evidence indicates that liability should be accepted, this will be done within 7 calendar days of notification.

If a provisional liability decision was made initially, then, if appropriate, liability will be determined prior to the expiry of the provisional liability period.

The Case Manager will:

- Communicate a decision to accept liability verbally and in writing to the Employer and Worker
- Calculate the Worker's PIAWE and communicate how that amount has been calculated
- Communicate who will pay the Worker and when and ensure that weekly payments are commenced within the legislative timeframe unless a reasonable excuse is applicable
- Provide an avenue for the Worker if they disagree with the PIAWE amount or does not receive payment
- Approve reasonably necessary costs and medical expenses in accordance with legislation
- Ensure medical expenses paid by the Employer and Worker are reviewed in accordance with SIRA requirements and gazetted fees
- Make certain other service provider fees and expenses are reviewed, and approval determined in accordance with SIRA requirements and gazetted fees.

5.4.4 Disputing all or part of a claim

When liability is to be disputed for all or part of the claim, this decision is reviewed internally to confirm a soundly based decision is applied. If the dispute decision is supported by an appropriately qualitied Reviewer, the Case Manager will contact the Worker to advise and discuss the decision. The Case Manger will then issue the Worker with a Section 78 Dispute Notice, which will include the name of the Reviewer. If there are concerns regarding the Worker's or their community's safety regarding the issuing of a Section 78 notice, then this notice may be released via a third party such as the Nominated Treating Doctor or Legal Representative.

The Section 78 notice will outline the reasons for which liability has been disputed and also attach the relevant reports that have been relied upon to make the decision.

Should a Worker require further information or wish to challenge a decision they can:

- Request an independent review of the liability decision via the icare Dispute Resolution and Litigation team, **email:** wiclaimsreviews@icare.nsw.gov.au. The reviewer will be required to respond to the internal review request within 14 days

- Contact the Independent Review Office (IRO) on 13 94 76
- Lodge a dispute to challenge a decision directly with the Personal Injury Commission (PIC) or with assistance from your lawyer
- Seek advice or assistance from your trade union organisation, an Australian legal practitioner or from any other relevant service established by the State Insurance Regulatory Authority (SIRA).

5.4.5 Additional or consequential injuries

As claims progress, it is not uncommon for additional medical conditions or consequential conditions to be added to a Certificate of Capacity. This may have an impact on the management of a claim including the need for treatment, entitlement to weekly payments, and the worker's degree of permanent impairment.

If a worker makes a claim for treatment or weekly payments for the additional or consequential medical condition, EML is required to make a liability decision within 21 days from the receipt of the Certificate of Capacity.

5.4.6 Recurrence or aggravation

New facts and medical evidence received by EML will be reviewed to determine whether an injury is a recurrence of a previous workplace injury or a new injury to a body part that was previously injured.

The distinction between a recurrence of an injury and a new injury can be significant for workers and employers. The decision will impact the calculation of a workers benefits and may impact an employer's premium.

A recurrence determination is made when, after a worker suffers a work-related injury, there is a later increase in symptoms or a re-emergence of symptoms needing treatment or causing incapacity.

If a worker suffers a new work-related injury to a body part that has previously been injured at work (i.e., an aggravation), EML will decide which of the two injuries caused or materially contributed to the incapacity or need for treatment.

5.5 Claims estimating

We are required to estimate all claims in accordance with the Claims Estimation Manual. This manual is developed by icare and applies to all open, reopened and new workers compensation claims.

The manual sets out a range of rules and approaches to estimating a claim. It states that we must:

- Keep claim estimates up to date, even in between scheduled and event driven review points
- Build claims estimation into the organisation's routine case management and review processes
- Use the amounts specified in this Manual unless there is evidence otherwise, then use a soundly-based decision-making process to estimate claims
- Maintain accurate estimates on claims to ensure the premium is correctly calculated
- Ignore the possible effect of inflation when estimating and always use current amounts
- Exclude payments already made

- Exclude recovery or adjustments arising from input tax credit or decreasing adjustment mechanism, and
- Maintain an appropriate estimate on the claim until it is finalised.

6. Entitlements

6.1 Entitlement to weekly payments

Once a decision has been made to commence weekly payments of compensation on the claim, timely and accurate payments will ensure Workers can focus on their recovery and return to work.

The Case Manager will communicate the PIAWE figure to the Worker and Employer in writing. This letter will outline the liability decision; the Worker's PIAWE, their current entitlement, how current payments are to be calculated, when payments are to be made and who will make the payment to the Worker.

Timeliness, quality and compliance with the payment of benefits to Workers is achieved through training and structured internal systems to manage the payment process.

Our payment process is as follows:

- Calculation of preinjury average weekly earnings (PIAWE) is verified for accuracy
- All payments are entered in the claims system. This activates a system automated workflow tool to ensure that payments are made regularly and timely
- All weekly compensation payments require coverage by a current Certificate of Capacity
- Where there is a "Wage Reimbursement Schedule (WRS) Agreement" in place, the payment is made in accordance with the accurate schedule received from the Employer within 10 business days of receipt
- Weekly compensation payments outside of the WRS arrangement will be paid within five business days of the receipt of a certificate of capacity and/or earning information such as payslips
- All weekly compensation payments are peer reviewed and authorised by Case Managers within set authorisation limits
- The tasks of generating a payment and authorising a payment are completed by two separate people to ensure accuracy.

6.1.1 Pre-Injury Average Weekly Earnings (PIAWE)

If a worker is unable to perform their pre-injury job because of a work-related injury, any weekly compensation that might be payable to them is calculated by reference to their pre-injury average weekly earnings (PIAWE).

The amount of PIAWE varies for each worker and is calculated based on their average weekly earnings in the 52 weeks prior to their date of injury.

An accurate PIAWE calculation is essential to determining the Injured Worker's entitlements, including weekly payments, for time off work. Unless there is a reasonable excuse to not pay a worker, payments are to commence within seven days of an injury notification.

The Case Manager will outline the specific information required for each claim during the early contact with the Employer. This information will enable the Case Manager to calculate the correct PIAWE in accordance with the legislation for each claim.

The PIAWE rate is communicated in writing to the Employer and Worker within 7 calendar days of claim notification when provisional liability commences or claim liability is accepted. This allows the Employer to commence correct payments to the Worker.

The written notice advises the Worker of the avenues to request a review of the PIAWE if they do not agree with the rate that has been calculated.

6.1.1(a) calculating PIAWE for workers injured prior to 21 October 2019

For these workers, PIAWE is the sum of a worker's gross weekly earnings over the 52 weeks before their date of injury.

This is calculated using:

- Ordinary earnings during the relevant period (either their base rate of pay or actual earnings, any amounts paid or payable as piece rates or commissions, and the monetary value of non-financial benefits), and
- Any permissible shift and overtime amounts.

In some instances, there may be exceptions considered where:

- the worker has not been continuously employed in the 52 weeks before the injury
- the worker had an ongoing financially material change in earnings in the 52 weeks before the injury
- it is simpler to align to the worker's usual pay cycle
- the worker has taken extended periods of unpaid leave (7 or more consecutive days) in the 52 weeks before injury

Special consideration is given to workers employed by more than one employer at the time of injury. Schedule 3 of the Workers Compensation Act 1987 sets out the method to determine PIAWE where a worker was employed by more than one employer at the time of injury.

6.1.1(b) calculating PIAWE for workers injured on or after 21 October 2019

For these workers, PIAWE is expressed as a weekly sum. It consists of:

- the average of a worker's ordinary earnings, and
- any permissible shift and overtime amounts.

Earnings can include:

- wages,
- shift and other allowances,
- overtime amounts,
- commissions,
- non-monetary benefits

6.1.2 Shift and overtime allowances

- Shift and overtime allowances are only included in the PIAWE calculation for the first 52 weeks of entitlement for Injuries prior to 26 October 2018. After that, they are removed from the calculation.
- Overtime and shift allowances will remain in PIAWE beyond 52 weeks for injuries on or after 26 October 2018.

6.1.3 PIAWE agreements

A worker and employer may enter into an agreement as to the PIAWE amount that EML will use when calculating weekly benefits.

An application to enter in to a PIAWE agreement must be provided to EML within 5 days of the initial notification of injury.

For more information on PIAWE by agreement, please see the SIRA website at www.sira.nsw.gov.au

6.1.4 Interim PIAWE

The expectation is that EML will communicate with the employer and worker before commencing weekly payments and inform that all relevant information should be provided to EML to complete a PIAWE calculation.

If an interim rate is used, the Case Manager will request from the Employer the additional information required to enable the final calculation of PIAWE. Upon receipt of PIAWE information, EML is to recalculate PIAWE within 5 working days and review for any adjustment payments due i.e.: over or under payments.

6.1.5 Minimum PIAWE

The minimum PIAWE is $155 and is set by clause 6 of the *Workers Compensation Regulation 2016* (2016 Regulation).

If a worker's PIAWE is calculated to be lower than the minimum PIAWE, then the worker's PIAWE is deemed to be the minimum amount of $155 (clause 2 of Schedule 3 of the *Workers Compensation Act 1987*).

6.1.6 Reimbursement of Weekly Payments to the Employer

Typically, we reimburse weekly payments to the employer, who should continue to pay the worker according to their regular pay schedule.

If it becomes necessary for us to make weekly payments directly to the worker, such as when they are no longer employed by you, we will discuss this with both you and the worker beforehand.

6.1.7 Indexation

Indexation ensures that weekly payments remain aligned with inflation. For further details, refer to Division 6A of the 1987 Act.

Pre-Injury Average Weekly Earnings (PIAWE) and the Statutory Maximum (Stat Max) are updated biannually on April 1st and October 1st, based on the indexation rate provided by SIRA in the Workers Compensation Benefits Guide. For the most current figures, visit the SIRA website at www.sira.nsw.gov.au.

We will inform you and your worker in writing of any changes.

6.2 Reduction in weekly payments

When a Worker is in receipt of weekly payments of compensation, they may progress through the different entitlements of the WCA 1987. As this occurs, depending on their capacity for work, their return to work status and their permanent impairment, their entitlements may be subject to step-downs pursuant to the legislation.

EML will notify the worker prior to any step downs and will notify the Employer if they are continuing to pay the worker directly. The application of legislative step-downs may depend on the circumstances of the worker when they were injured and their work status.

For more information, please see SIRA's website.

6.3 Work capacity assessments and decisions

A work capacity assessment is a comprehensive review of all information relevant to a Worker's functional, vocational, and medical status to determine their ability to Recovery at Work in their pre-injury employment or suitable employment with the same or a different Employer. Work Capacity Assessments and Decisions do not apply to Workers who are exempt from the 2012 legislation amendments

A work capacity assessment is coordinated by the Case Manager and may be completed at any point in time throughout the life of a claim. When conducting a work capacity assessment to determine current work capacity, the key first step to a successful decision will always be the determination of what constitutes suitable employment for that Worker. Case Managers review suitable employment in line with Section 32A of the Workers Compensation Act 1987.

Suitable Employment will have been identified and agreed to during the targeted Recovery at Work process.

A work capacity decision is a discrete decision that can be made at any point in time and can be about any one of the factors set out in Section 32A of the legislation.

At a minimum an assessment of work capacity must commence once the Worker has received a cumulative total of 78 weeks of weekly payments. Should the Worker have an ongoing entitlement to weekly compensation payments beyond 130 weeks, a Work Capacity Decision must be made at least once every two years after this point until such time that the Worker's entitlement to weekly compensation payments ceases or they have been assessed with a Whole Person Impairment (WPI) in excess of 30%.

A work capacity decision is different to a work capacity assessment. The assessment is a review process that may or may not lead to the making of a work capacity decision.

The first work capacity decision on a claim is determining the Pre-Injury Average Weekly Earnings (PIAWE) as per Section 43 (1)(d) of the Workers Compensation Act 1987.

If a Worker does not agree with the Work Capacity Decision that has been made, they are able to:

- Request we internally review the decision (this review will be undertaken by a different person, separate from the initial decision), email: NIInternalreviews@eml.com.au
- Seek assistance from the Union or Solicitor; or

- Lodge an Application to Resolve a Dispute online via the PIC **website:** Legal disputes | Personal Injury Commission (nsw.gov.au) or **phone**: 1800 PIC NSW (742 679).

6.4 Section 39

Section 39 of the Workers Compensation Act 1987 outlines that there is a 260-week limit to weekly payments of compensation, this section does not apply to Workers whose permanent impairment resulting from the injury is more than 20% Whole Person Impairment (WPI).

In order to ensure that each claim is assessed appropriately to determine whether there is an entitlement following the 260-week point, we are transparent with the limitations of the legislation in our communication.

- **From 6 to 12 months prior to the 260 week point** the Case Manager will contact the Worker and let them know of the legislation and what this might mean for their claim. We will discuss permanent impairment and section 66 (1A) of the WCA 1987 that indicates they are only able to have one claim for permanent impairment and encourage them to seek legal advice pursuant to section 66A of the Workers Compensation Act 1987.
- **Where the Worker is not considered to have reached the threshold** to continue to receive weekly payments of compensation, they will be notified by their Case Manager in writing 13 weeks prior to the cessation. This letter will also outline the Worker's ongoing entitlement to medical and related services pursuant to S59A of the Workers Compensation Act 1987.

The Case Manager will be in contact with the Worker and the NTD in order to ensure they understand entitlements and timeframes so that alternate plans can be put in place for the Worker (for example, seeking Centrelink benefits). We will also continue to assist the Worker with Workplace Rehabilitation (where appropriate) to support them obtain suitable employment. Should the Worker require further information or experience any dissatisfaction through the process they will be advised they can contact IRO on 13 94 76.

6.5 Retiring age notification

Workers whose weekly payments of compensation will cease 12 months after reaching the retiring age pursuant to section 52 of the Workers Compensation Act 1987 will be notified of this when they lodge their claim.

The Case Manager will discuss this with the Worker and their NTD in order to ensure that they are aware of the limitation and can plan for this. On the lead up to the cessation date the Case Manager will advise the Worker in writing at least 13 weeks before the weekly payments are to cease.

At this time the Case Manager will also communicate to the Worker and the NTD the date that their entitlement to medical and related services will cease pursuant to section 59A of the Workers Compensation Act 1987. Should the Worker require further information or experience any dissatisfaction through the process they will be advised they can contact IRO on 13 94 76.

6.6 Determination of permanent impairment

Whole Person Impairment (WPI) involves an assessment of the degree of permanent impairment that has arisen from the work-related injury. When a Worker has reached maximum medical improvement

(MMI) they may be assessed by a qualified medical specialist who utilises clinical assessment as well as SIRA and American Medical Association's (AMA) Guides to evaluate the WPI. This impairment is calculated as a percentage loss and equates to a monetary figure.

Our team of Impairment Specialists provide expertise to ensure assessments of permanent impairment are in line with SIRA requirements and the timeframes prescribed by the relevant legislation. Our Specialists are experts in the interpretation and application of the various methods to assess Permanent Impairment and have developed strong working relationships with both applicant and respondent legal firms. Our expertise allows us to ensure Workers receive fair compensation, and we achieve cost-effective and timely outcomes for all parties, and we endeavour to manage our claims within the Model Litigant Policy.

6.7 Common law claims and work injury damages

A claim for Work Injury Damages is a one-off lump sum to compensate a Worker for past and future economic losses resulting from an injury. Unlike workers' compensation rights that arise by virtue of statute, the right to sue for damages derives from a common law right to be compensated for the injury suffered, usually due to negligence for breach by an Employer of the duty of care owed to the Employee.

The Workers Compensation legislation limits common law rights to work injury damages. Only Workers who have 15% or more Whole Person Impairment are entitled to pursue a claim for work injury damages. On payment of Work Injury Damages, a Worker ceases to be entitled to workers compensation. Similarly, if a Worker receives damages from another party in relation to the same injury (i.e., an occupier, motor vehicle insurer), they will generally cease to be entitled to further workers compensation benefits. In many instances we recover payments of compensation made. A claim for Work Injury Damages cannot be made unless a claim for lump sum compensation is made before or at the same time.

Following notice of a claim, a Pre-filing Statement is issued with the draft statement of claim. All evidence that the parties seek to rely upon must be proffered at the pre-filing stage. Fully informed, the parties attempt mediation of the claim in the Personal Injury Commission prior to court proceedings being commenced in the District Court of NSW or the Supreme Court of NSW. Although Work Injury Damages claims are limited to economic loss, a Worker will often be prepared to forgo future medical expenses in favour of a lump sum payment. Work Injury Damages or Common law is the third largest expense to the scheme. These claims usually contain complex legal issues and multiple parties.

We utilise internal Legal Specialists and engage external Legal Providers to support manage Work Injury Damages litigation. In most situations, the Case Manager retains primary responsibility for management of the claim, and in particular the injury management obligations. The single most effective way to reduce the size of a damages claim is to upgrade a Worker's capacity and/or to secure a Recovery or Return to Work.

6.8 Commutation

A commutation is an agreement to pay out all of a Worker's future entitlements in a lump sum. The commutation results in no further payments for the Worker's injury.

If a Case Manager receives a request from a Worker for Commutation, they discuss this strategy with their Team Leader and work with the technical specialist to review whether the evidence on file would meet the criteria.

If we agree the criteria is met, an application is sent to icare with supporting documents to certify that Section 87EA of the Workers Compensation Act 1987 is met. Once reviewed by icare the application is submitted to SIRA who issues certification under Section 87EAA and 87EA of the Workers Compensation Act 1987. After SIRA issues the certificate, a referral is made to the legal panel to negotiate a settlement with the Worker's Solicitor.

7. Treatment and medical intervention

Workers can access reasonably necessary expenses relating to medical treatments and services, including hospital and rehabilitation. It is important to seek approval from EML before incurring any expenses.

Some treatment providers must be approved by the State Insurance Regulatory Authority (SIRA), including physiotherapy, exercise physiology, psychology, counselling, chiropractic and osteopathy. A list of providers approved by SIRA is available at www.sira.nsw.gov.au.

As outlined in Part 4 of the Workers Compensation Guidelines, there are some reasonably necessary treatments and services that are available without pre-approval from EML, including:

- Initial treatment within 48 hours of the injury occurring
- Consultation or case conferencing for the injury with the nominated treating doctor
- Services provided in a public hospital emergency department
- Standard x-rays referred by the treating doctor within two weeks of the date of the injury
- Prescription and over-the-counter pharmacy items prescribed by the nominated treating doctor within one month of the date of the injury
- Up to eight consultations with a SIRA approved treatment practitioner, with treatment starting within three months of the date of the injury. This includes treatment with a SIRA accredited Physiotherapist, Exercise Physiologist, Psychologist, Counsellor, Osteopath and Chiropractor.

The factors that may be considered when reviewing a request for reasonably necessary treatment or care include:

- Relationship to the injury – How is the treatment related to the workplace injury?
- Appropriateness – How does the treatment help improve the worker's functioning and participation in daily life?
- Cost – Is the treatment cost effective?
- Effectiveness – What is the actual or potential effectiveness of the treatment? How will it benefit the worker?
- Whether treatment is contributing to the worker's goals and outcomes.
- Alternatives – Are other treatments available?
- Acceptability – Do medical experts consider the treatment to be effective and reasonable?

In addition to the above, we understand that:

- What may be reasonably necessary treatment for one Worker may not be considered reasonably necessary for another Worker with the same / similar injury.
- Reasonably necessary does not mean "absolutely necessary"
- We are to give consideration to expert medical advice that supports that a similar outcome might be achieved using an alternate treatment method, and this does not mean that the treatment recommended is not reasonably necessary.

Case Managers will access our internal Specialist resources or relevant decision support tools to assist in making decisions to fund treatment as well as Evidence Based Practice Guidelines and Clinical Guidelines. If further information is not able to be obtained from the NTD, specialist(s) or Treating Provider(s), then an independent medical opinion may be sought.

A Worker (and support person if necessary) who needs to travel for an approved treatment or service is entitled to be reimbursed for fares, travel costs and maintenance, necessarily and reasonably

incurred. The Worker must gain prior approval from the Case Manager to cover the travel costs, except if they are using their private vehicle.

Once the Worker has received the treatment or service, the service provider will submit an invoice. The Case Manager will review the invoices prior to payment to ensure:

- Rates and items being billed are in line with pre-approvals
- Rates do not exceed the maximum amounts prescribed by any relevant Workers compensation fees orders,

  Invoices contain all relevant information, including application of GST or input tax credits where appropriate.

7.1 Medical payments

There are several reasons payments are made to workers or service providers and payment of invoices and reimbursement for medical, hospital and rehabilitation services ensures workers can focus on their recovery.

The SIRA Standards of Practice outline the principle that workers and providers will receive prompt payment of invoices and reimbursements for medical, hospital and rehabilitation services and our compliance is mandatory.

Expectations for medical payments includes:

- Payment no later than 10 working days from receipt of a valid invoice for approved treatment, or within a provider's terms, whichever is later.
- Invoices are reviewed to ensure the items billed align to approvals.
- Rates do not exceed the maximum amount dictated by relevant fee orders.
- Invoices contain the required relevant information, including the application of GST where appropriate.
- In instances where reimbursement will be delayed EML will advise the worker of the reasons and anticipated time to resolution.

7.2 Medical support panel (MSP)

MSP leverages specialist medical expertise to improve health outcomes and the experience for injured workers and employers. MSP medical specialists review case information to make timely treatment and medical causation recommendations to assist case managers. This equates to faster treatment approval for medical interventions and, it’s anticipated, faster return to work.

7.3 Section 59A

Workers who have not claimed weekly payments of compensation or are no longer in receipt of

weekly payments of compensation, have an ongoing entitlement to medical and related benefits which, is limited under Section 59A of the Workers Compensation Act 1987.

The limitation applies to the following:

- A Worker can receive up to 2 years of medical and related benefits if they have been assessed as having 10% or less permanent impairment.

- A Worker can receive up to 5 years of medical and related benefits if they have been assessed as having 10-20% permanent impairment.
- A worker has a lifetime entitlement to medical and related benefits if they have been assessed as having more than 20% permanent impairment.

When a Worker ceases to have an entitlement to weekly payments of compensation and they are in receipt of medical treatment only, the Case Manager will work with the Worker, Nominated Treating Doctor (NTD) and treatment providers in order to support them to receive the treatment they need and that they transition to new arrangements before their workers compensation medical entitlement cease. For example:

- The Case Manager will communicate and collaborate with these key stakeholders to support them to be independent of treatment by the time the limitation applies (where possible).
- If the Worker still requires ongoing treatment beyond the entitlement period, the Case Manager will work with the Worker and the NTD to transition them to alternative support.

In addition to the above, the Case Manager will advise the Worker in writing 13 weeks before the medical entitlements will cease. Should the Worker require further information or experience any dissatisfaction through the process they will be advised they can contact IRO on 13 94 76.

7.4 Use of independent opinions

In circumstances where liability and reasonably necessary treatment or medical management needs are not clear, the Case Manager will initially assess the available evidence and work in partnership with the Treating Parties to obtain the required information. If after seeking further information the evidence remains unclear, in accordance with SIRA Guidelines the Case Manager may refer for an independent opinion.

Independent Medical Examinations

If after requesting further information from the treating parties the information provided is inadequate, unavailable or inconsistent, the Case Manager may arrange a referral for an Independent Medical Examination (IME) with an appropriately qualified medical specialist with the expertise to provide a professional opinion on the issue.

When an IME is required, we will arrange such an assessment in accordance with the Guidelines on Independent Medical Examinations and Reports, specifically:

- Reason for referral will be very clear and the Nominated Treating Doctor, Worker and Employer will be advised of the referral in writing at least 10 working days before the appointment.
- The Case Manager will consider suitable providers.
- If the referral is a dispute of causation or treatment, the IME will be in current clinical practice.

Following receipt of the opinion, if it is determined that the requested treatment or procedure is reasonably necessary, the Case Manager will accept the request and notify all Stakeholders.

If the IME does not support the request as reasonably necessary, the Case Manager will address the report with the Treating Party and in some cases provide a summary or copy of the report to the Treating Party to justify the rationale. If an agreement cannot be achieved the Case Manager will provide written notice to the Worker and inform the Treating Party outlining the reasons for the decision. The notice will also provide information for the Worker regarding the process for requesting a review of the decision.

Independent Consultants

The Case Manager may utilise Independent Consultants when there are questions regarding the reasonable necessity of ongoing allied health treatment. Independent Consultants can provide advice and peer support to Treating Therapists as well opinion to Case Managers. SIRA approve consultants in the areas of Physiotherapy, Chiropractic, Osteopathy as well as Psychology and Counselling.

Injury Management Consultant (IMC)

Differences may arise between the Nominated Treating Doctor (NTD), Employer, Worker and EML about issues of RTW such as capacity for work, suitability of duties or the ongoing Recovery and Return to Work goals.

The Case Manager will first attempt to resolve any issues through consultation, collaboration and negotiation with the Stakeholders.

In cases where there are ongoing workplace, interpersonal or human resource issues, the Case Manager may refer to an external provider to overcome barriers and identify strategies and solutions to assist a worker to return to work.

If there are unresolved differences relating to capacity or RTW, the Case Manager will make a referral to an Injury Management Consultant (IMC) in accordance with the Guidelines on Injury Management Consultants.

IMC’s assist in providing clarification or attempt to mediate a solution about the RTW for the Worker. The IMC will either undertake an examination of the Worker or a file review of the claim documentation, contact appropriate Stakeholders to inform recovery and return to work planning, and other recommendations.

If agreement is achieved, a new Recovery or Return to Work plan will be developed which reflects agreed outcomes and is then implemented. If the issue or dispute remains unresolved further referral to another IMC or an IME may be indicated to seek further medical evidence. However, failure to reach agreement may lead to an injury management dispute being heard at the Personal Injury Commission (PIC). PIC proceedings may involve, conciliation, arbitration, medical assessment, mediation or expedited assessment. The PIC may also arrange for an Approved Medical Specialist (AMS) to make a final decision.

IMC’s are not able to provide an opinion on causation or liability or undertake a functional capacity evaluation, or work capacity assessment (as defined in section 44A of the 1987 Act).

8. Finalisation

8.1 Finalising a claim

Finalisation of a claim will occur when the injury is no longer impacting a Worker's ability to participate in suitable employment, no further treatment is being undertaken, and all claimed compensation has been paid. This may include:

- A Recovery at Work in pre-injury duties
- A sustainable return to appropriate suitable employment with no wage loss
- Retirement or withdrawal of claim
- A Work Capacity Decision which results in the completion of weekly payments
- Completion of medical treatment or medical entitlements under s59A
- Commutation, Work Injury Damages or Common law settlement
- Settlement of a claim for the same injury by another party (e.g., an occupier, motor vehicle insurer)
- Declinature of ongoing liability
- Weekly compensation payments are terminated under s48A (6).

8.2 Claim reopening

We have a dedicated team of eligibility specialists that focus on the appropriate management of re-opens, reactivations and recurrences. Where requests are received to re-open or reactivate claims that have been previously closed, this specialist team is responsible for gathering and assessing the required information to determine whether re-open is appropriate. This includes determining a Worker's entitlement to further benefits in accordance with the legislation prior to any re-open, as well as ensuring a clear liability decision is made and communicated appropriately to relevant Stakeholders on the claim.

When further benefits are deemed payable, the claim is either then paid and reclosed or sent to a Case Manager for ongoing management.

9. Claim handover

Claim handover is the transfer of a claim from one claim owner to another. A claim handover process facilitates efficient and effective transfers and ensures that all stakeholders are not disadvantaged when claim handover occurs.

Prior to transfer the claim owner will undertake key actions and notify stakeholders of the claim handover. They will provide key information to the new claim owner and ensure the strategy is shared.

Upon receipt of the file the new claim owner will review the information received and obtain any additional necessary information required to assist with management of the claim.

10. Recoveries

10.1 Third party recoveries

In certain circumstances, workers compensation insurers will be able to recover from other insurers or persons (third parties) who share a proportion of liability for an injury.

Enabling insurers to recover funds from third parties who share a proportion of the liability for an injury helps to ensure the sustainability of the workers compensation system.

Early identification and effective management of third party recoveries helps ensure the sustainability of the NSW workers compensation system. Insurers may also consider informing the worker or worker's representatives of the potential right to claim damages from a third party.

When recovery potential is identified the Case Manager works with the Recovery Specialist and Legal Specialist team to put in place strategies to advance the claim. The Case Manager will retain responsibility for the active management of the claim, which includes management of the recovery component. If the claim remains open only to pursue or finalise recovery, the claim transfers to the Recovery Specialist to follow up and finalise the claim.

10.2 Overpayments

On occasion overpayments occur due to:

- the payment amount being incorrect
- payment being issued to an incorrect payee, or
- payment being issued more than once for a service/date/amount (duplicate payment).

Overpayments are monitored using duplicate payment reports and reports identifying treatment that exceeds SIRA gazetted fee order amounts. In these instances EML will investigate where necessary.

Recovery of overpayment will be pursued when:

- the worker, employer or service provider provided inaccurate information that led to the error.
- the worker, employer or service provider was aware of the inaccuracy or should have been aware.
- The worker's personal circumstances have been considered and recovering the overpayment will not cause undue hardship.

Recovery of overpayment will NOT be pursued if:

- reimbursement of the expenses incurred by the worker exceed the maximums set by SIRA.
- the overpayment of their weekly benefit is a result of a change in PIAWE following an interim PIAWE being applied and the new PIAWE amount is now lower than the interim PIAWE previously applied.
- the individuals circumstances were evaluated and repayment would cause undue hardship.

SIRA Standards of Practice (standard 23) outline the recovery of overpayments to a Worker due to an error by EML and overpayments are managed in a fair and transparent manner. SIRA Standards of Practice include the expectations below. EML must:

- advise the worker of the details of the payment(s) and clearly describe the error and the impact to the worker in writing
- where a repayment arrangement is negotiated with the worker:
    - EML must demonstrate we have considered the individual circumstances of the worker, including potential financial hardship, and outline this in our letter to the worker;
    - EML must obtain the worker's informed consent for repayment in writing before commencement of any repayment arrangement.

10.3 Medicare and Centrelink clearance

Medicare

Proactive engagement with Medicare Australia and correctly attributing medical costs payments helps to ensure prompt payment of entitlements and reduces the risk a worker will inadvertently be subject to recovery action from Medicare.

When a worker has had a judgment or settlement in their favour and is currently (or was previously) receiving eligible benefits provided through a government program, such as Medicare, and those benefits relate to treatment and care costs related to the compensable injury / illness, EML must advise Services Australia within 28 days from the date of a judgment or settlement:

- About the judgement;
- The settlement; and
- Reimbursement arrangement.

A Notice of Past Benefits lists the medical services the worker had claimed under Medicare from the date of injury and the total amount of eligible benefits paid, relating to the compensable injury/ illness if any.

The amount to be paid is in addition to the compensable amount relating to the percentage of whole person impairment.

Centrelink Clearance

Prompt advice to Centrelink and appropriate attribution of lump sum payments helps ensure prompt payment of entitlements and reduces the risk a worker will inadvertently be subject to recovery action from Centrelink.

EML must provide appropriate documentation to Centrelink when:

- settlement occurs for commutation or damages matters or other matters settled in the Commission, and
- workers whose entitlements are affected by delays or reconsideration of entitlements are calculated.

11. Management of the supplier relationship

In our quest of helping people to get their lives back, we are often required to rely on our third party service provider to provide specialist services and advice outside the areas of our expertise. Some of these service providers include Workplace Rehabilitation Providers, Medical Providers, Legal Providers and Investigators.

icare has established direct contractual arrangements with a range of third-party service providers, which we are under obligation to utilise, in order to ensure effective and quality services for workers and employers. These contracts and associated SIRA regulations and fee orders govern service, organisational, insurance and reporting requirements, enabling icare to ensure quality around service delivery and outcomes. Each service provider is required to achieve and maintain any required registration status for the term of the contract, as well as maintain the required level of insurance for workers compensation, professional indemnity and public liability.

We have a dedicated team of experienced professionals who are trained to provide advice, monitor, and screen outcomes to monitor the performance of all suppliers through regular activities which include:

- **Data Analysis:** monthly performance data is obtained from the icare panel and Employer preferred providers and benchmarked against icare's KPI's to ascertain performance progress.
- **Auditing:** regular audits of all service types through use of standardised auditing tools in order to ensure quality of services purchased from the third party service providers.
- **Feedback loop:** internal claims teams are requested to provide live feedback regarding user experience of services purchased and customer service received whilst working with the provider.

Regular performance reviews (in line with the NSW guidelines) are undertaken with all icare suppliers to provide feedback gathered from the data analysis, auditing and feedback. During such meetings any performance / engagement issues are identified and action plans are put in place with clear timeframes and monitoring arrangements. For suppliers that are identified to be experiencing significant difficulties in delivering services as per icare's service standards, Performance Improvement Planning is feedback to icare to allow panel management. EML will still put in place subsequent actions in co ordination with icare to facilitate desired improvement. Ad-hoc performance reviews are also undertaken for urgent matters when identified through internal / external stakeholder feedback and or business as usual activities.

In addition to the above, we maintain records of (including, but not limited):

- Complaints (which are managed in line with the Complaints Management Protocols),
- Supplier service areas,
- Supplier staff and location registry
- Ad hoc stakeholder queries
- Practitioner listings

12. Management of Complaints and Compliments

Our Commitment

We have a team of dedicated and experienced professionals who are trained to provide advice and guidance for Employers, Workers and other customers.

Any concern or dissatisfaction about a process or service provided should be reported to us, because we are committed to getting things right.

How to lodge a concern or complaint

A dedicated Case Manager or Primary Contact is the first point of contact for all enquiries, concerns, or complaints. If the initial response is not satisfactory, we encourage further formal contact using one of the following options:

Email: info@eml.com.au

Telephone: NSW (02) 8251 9000 or 1800 469 931 (toll free)

Mail: Feedback Officer c/o- GPO Box 4143, SYDNEY NSW 2001

Internet: www.eml.com.au Click on 'Contact Us' and then 'Feedback'

What will we do when we receive a complaint?

We will acknowledge the complaint. This will be done by phone or email within 2 business days on receipt of the complaint. We will also provide the name and contact details of the person managing the complaint.

How we resolve customer feedback by:

- **Phone:** We are committed to contact via telephone. One of our managers will take responsibility to resolve the concern.
- **Email:** All complaints, where relevant, will be followed up with an email; this will confirm that the concern or complaint has been satisfactorily resolved. The email will be sent by the manager responsible for assisting in the resolution of the complaint.

How long might it take to resolve a complaint?

Wherever possible we will aim to satisfactorily resolve a complaint within 2 business days where practicable.

We are committed to making contact within 2 business days on receipt of the complaint to acknowledge and establish a timeframe for resolution.

If additional information or time is required due to the nature of the complaint, we will immediately advise the reason as to why it is taking longer and ensure an alternate date is provided by which a resolution can reasonably be expected, and we will provide updates as required.

How will we assess a complaint?

We will ensure that the complaint is managed:

- Professionally and with a sense of urgency;
- In a timely and efficient manner;
- Within legal and legislative parameters; and
- Based on sound and objective decision making.

Unresolved complaints or issues

If a complaint or issue cannot be resolved with us the matter can be referred to the following industry bodies that can help:

icare NSW
icare manages escalated complaints about service if the complaint cannot be resolved with us. The Customer Service Centre contact details are:

Telephone: 13 99 22
Website: www.icare.nsw.gov.au
Email: wiclaimsenquiries@icare.nsw.gov.au

State Insurance Regulatory Authority (SIRA)
Telephone: 13 74 72
Website: www.sira.nsw.gov.au
Email: contact@sira.nsw.gov.au

Independent Review Office (IRO)
IRO provides an independent complaints solution service for workers who are unhappy with a decision we make. IRO also provides funding for legal advice. IRO contact details are:

Telephone: 13 94 76
Website: www.iro.nsw.gov.au
Email: complaints@iro.nsw.gov.au

New South Wales Ombudsman
Telephone: 02 9286 1000
Toll Free (outside Sydney metro) 1800 451 524
Web: www.ombo.nsw.gov.au
Email: info@ombo.nsw.gov.au
Fax: 02 9283 2911

13. Dispute resolution

Our dispute process is in line with SIRA's Standards of Practice. If there is any kind of decision made on a claim, the Worker will be advised formally, in writing. The Worker is given the opportunity to provide additional information or evidence; or to request we review or reconsider the decision. An internal review application form is provided with the written notice, and we encourage the Worker to complete this form and submit with any additional information to be considered. The review will be completed within 14 days of receipt.

The Worker also has the right to seek review by any of the following independent options:

- Seek advice / assistance from your **trade union organisation or from a lawyer**, however we note that Workers are responsible for their own legal costs;

- icare's Dispute Resolution and Litigation team (excluding Work Capacity Decisions)

  Phone: 13 99 22

  Email: wiclaimsreviews@icare.nsw.gov.au or visit their website at www.icare.nsw.gov.au for more information.

  ***Note:** Internal Reviews relating to Work Capacity Decisions to be sent to NIInternalreviews@eml.com.au.

- **State Insurance Regulatory Authority (SIRA)**

  Phone: 13 74 72

  Email: contact@sira.nsw.gov.au

- Seek independent advice from the **Independent Review Office (IRO).** The IRO has also established the Independent Legal Assistance and Review Service (ILARS). ILARS can facilitate access to free independent legal advice to in circumstances where there is a disagreement regarding entitlements. For more information visit IRO's website at www.iro.nsw.gov.au or you can contact IRO on:

  Phone: 13 94 76 or

  Email: contact@iro.nsw.gov.au.

- Disputes can also be referred for determination by the **Personal Injury Commission (PIC)**. Matters that may be referred to the Commission are limited to matters specified in a dispute Notice. The Workers Compensation Commission may not allow introduction of any information not previously notified as in dispute. Such a dispute can be referred by lodging an Application to Resolve a Dispute form online via the PIC website at Legal disputes | Personal Injury Commission (nsw.gov.au) or you can contact them at:

  Phone: 1800 PIC NSW (1800 742 679)

  Email: help@pi.nsw.gov.au

It is important to remember that if you lodge a dispute with the PIC before the date the decision takes effect, there will be no change to your weekly payments until the PIC makes its decision.

Legal Proceedings

In the event of litigation, if the situation warrants, we will obtain legal advice from our panel solicitors or respond independently. We will discuss recommendations made with the Employer and consult on actions to be taken. As a Claim Service Provider, we cannot outsource any part of our function, including decision making in legal proceedings.

14. Fraud

We have a zero tolerance to fraud and are committed to minimising the likelihood of fraud occurring.

Our staff attend regular information and training sessions on fraud awareness. Each business unit has an allocated Fraud Liaison Officer who will assist staff in reporting any fraud activity to the required authorities. All allegations of fraud will be investigated and, where substantiated, the cases will be pursued thoroughly and reported to the appropriate authorities.

How to report fraud

If you have information about a suspected fraud committed by a claimant, an employer, or a service provider, please contact our fraud team on:

Phone: 02 8251 9229

Email: fraud@eml.com.au

You may choose to remain anonymous.

14.1 Factual and surveillance investigations

Factual investigations are used in instances where EML require information that cannot be acquired in a less intrusive manner. Whilst they can potentially play an important role, they can erode worker trust and must be used cautiously, in a fair and ethical manner that aligns to SIRA Standards of Practice.

When a factual investigation is required EML engages a third-party service provider from the icare panel to conduct an investigation to determine the available facts of a claim.

Factual investigations may be warranted but not limited to the following circumstances:

- determining if a worker meets the legislative definition of a worker
- where the issues surrounding the injury are unclear or disputed, or
- when there is potential for recovery from a third-party.

A factual investigation may involve interviews, a physical inspection or other external enquiries required to determine relevant details. Factual investigators are not to provide an opinion on medical aspects of the claim.

If a worker is requested to participate in a factual investigation EML will advise the worker of the purpose and the anticipated duration (which should not exceed two hours). The worker:

- can nominate the place of the interview
- can have a support person present at the interview, including a union representative
- can request an interpreter if required, who does not count as a support person
- can identify witnesses for consideration to assist the investigation and
- the worker is not obligated to participate in the factual investigation, however the factual investigation will be used to help determine liability for their claim.

- the worker will receive a copy of their statement or transcript within ten working days of the interview

14.2 Surveillance

Surveillance refers to the covert monitoring and recording of behaviour using photography, video recording, direct observations and social media monitoring. Surveillance is used to observe and record a worker's activities and capabilities.

While surveillance can play an important role in the workers compensation scheme, it can significantly erode worker trust, so EML only use it when all other avenues have been exhausted.

EML follows the SIRA Standards of Practice which outlines the expectations and benchmarks we must abide by when considering whether to conduct surveillance on a claim. Prior to undertaking covert surveillance, EML must make an application to icare for approval.

EML will only request approval from icare to conduct surveillance of a worker when:

- there is evidence the worker is exaggerating an aspect of the claim or providing misleading information in relation to a claim, we reasonably believe the claim is inconsistent with information in our possession, or we reasonably believe fraud is being committed, and
- we are satisfied we cannot gather the information required through less intrusive means and that the benefit of obtaining the information outweighs the intrusion into the worker's privacy, and
- the surveillance is likely to gather the information required.

EML relies on sound information when identifying the need for surveillance and does not rely on hearsay, innuendo or rumour.

15. Privacy and confidentiality

15.1 Information and records management

Access to personal and health information ensures workers are informed throughout the claims process and empowered to contribute to decisions about their recovery and return to work. Access to information promotes workers to fully participate in their return to health and work.

In accordance with Commonwealth and NSW privacy legislation and privacy principles, a worker's personal and health information should be made available to a worker on their request.

- There may be some limited circumstances where exceptions may apply to the provision of a worker's personal and health information.
- Access requests from a worker should be responded to within 10 working days in accordance with SIRA's Standards of Practice.
- Reports from third party providers may be released to the worker if the report is in regards to the worker.

Any grounds for caution regarding the release of information to a worker is based on concerns regarding the safety and well-being of the worker or others.

15.2 Privacy and confidentiality

EML takes the Privacy of customers very seriously and does its utmost to ensure it is always maintained. In the course of claims management, we handle confidential information about a Worker in accordance with section 243 of the Workplace Injury Management and Workers Compensation Act 1998. Personal and health information relevant to the management of the claim will only be shared with relevant parties after the Worker has provided written consent to authorise the release of such confidential and sensitive information.

Furthermore, storage and use of personal and private information is critical in the workers compensation Scheme and it is part of our underlying structure and culture to ensure that the interests of all customers are respected and protected.

The Privacy Act

We are bound by the Privacy Act 1988 and Australian Privacy Principles which govern the collection and handling of personal and sensitive information to ensure that organisations clearly outline what type of information they hold, the reasons this information is held, the way in which it is used and in what circumstances it is disclosed.

In addition to the provision of the Privacy Act, we are also bound by the relevant workers compensation legislation, regulation and guidelines in the collection, use and disclosure of information relating to workers compensation claims.

Worker's Consent

Personal information held by EML is confidential. Workers will be informed of how their personal information will be used prior to providing consent. We gain consent from the Worker to exchange and receive information about a Worker's health, injury and recovery. This promotes good communication and transparent decision-making between the Worker, Employer and the return to work team.

EML respect the Worker's right to privacy and values the trust placed in us to handle personal and sensitive information. Maintaining the privacy of all personal and sensitive information entrusted to us is paramount. EML only collect information required to provide a service to a Worker. For the purposes of Workers Compensation premium and claims management services, generally we keep a record of:

- Basic identity information such as name, address, Employer details and information concerning employment relationship arrangement.
- Sensitive information directly related to a Worker's claim.
- Information provided by other service providers collected for the purpose of assessing and managing a Workers Compensation claim.
- Banking and taxation details.
- Information in connection with policy or claims management

Usually, we will collect information directly from the Worker, if we need to collect personal or sensitive information from third parties we seek the Workers consent to do so, unless we are otherwise permitted by law to make the collection.

How we use or disclose personal information provided by the Worker:

- For the purpose of assessing and managing workers compensation claims, including determining liability, or
- In providing reasonably necessary clinical services (such as medical treatment, rehabilitation, medical investigations, tests or procedures); or
- If we are required or authorised by law to do so.

Stakeholder Rights

Workers may access their personal and health information in line with the relevant Privacy and Workers Compensation Laws. EML aims to ensure that the personal information we hold is accurate, complete, relevant, up-to-date and not misleading.

If the Worker would like to update any personal information that we currently hold in our systems, access their personal information or have concerns about the way that we have managed the information, we encourage the Worker to contact us. In the second instance, by contacting the EML Group Privacy officer, **email:** privacy@eml.com.au.

For further information, the EML Group Privacy Statement EML Privacy Statement and the EML Group Privacy Policy are available on our website. There is a dedicated Privacy Officer in each business unit to champion privacy and help ensure compliance with legislation.

A Worker's personal and health information will not be withheld due to the information being contradictory to the employer or EML's interests in the event of litigation (subject to legal privilege). Information will only be withheld when there are grounds for caution based on concerns for the safety and well-being of the worker or others.

16. Quality assurance

The Workers Compensation Claims Quality Management Framework is essential to ensuring claims management is consistent and transparent. The framework is used in conjunction with customer feedback and RTW results to identify and drive continuous improvement initiatives. It was created to:

- Support Workers Compensation Legislation and Regulation, SIRA Standards of Practice and Workers Compensation Guidelines
- Contribute to achieving SIRA's customer service conduct principles.
- Provide insight and understanding of the claims and customer experience.
- Escalate and effectively support areas identified as risk and/or areas for improvement.

Governance of Quality Assurance processes and targets are clearly documented to ensure the focus remains on continuous improvement.

Quality assurance is the responsibility of every staff member and is achieved through incorporating the following concepts into key policies and procedures:

Delegation	Provide people with the opportunity to take responsibility in line with their experience and skills.
Review	A formal review process links the manager to their ongoing responsibility for outcomes.
Feedback	A system of continuous improvement requires feeding back lessons learnt to improve practices.
Measures	What gets measured gets managed.

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