

Workers Compensation FAQ's For Employers

One of my employees has reported being hurt at work, what should I do?

If one of your workers has a workplace injury (including injuries that happen on the way to or from work, or during lunch and rest breaks) you should ensure they seek and receive appropriate first aid or medical treatment if required and record the details in the register of injuries. For injuries requiring medical treatment or involving lost time, notify your Insurer as soon as possible and in any case within 48 hours. Investigate the accident thoroughly, capture as much detail as possible in writing, photograph the scene of the accident and take statements from any witnesses.

But she only needed a band-aid, do I still need to go through the whole process?

If the injury is minor and only requires superficial first aid, or no treatment at all, this may well be the end of the matter. But you should still at the very least record it in the register of injuries in case it later develops into something more serious. Encourage your employees to report all accidents no matter how minor. Use the opportunity to learn the lessons of the experience and ensure the incident doesn't happen again, next time the consequences could be more serious. Consider in consultation with your employees or OHS Committee if the work procedures need to be reviewed, or more training for the workers is required.

My employee says he doesn't need to go the Doctor, I'm not so sure, but isn't it his choice?

Yes it is. But if you are unsure whether medical treatment is required, encourage your employee to see a Doctor to be on the safe side and sooner rather than later. Early intervention is important. Diagnosis and treatment of injuries is easier before the onset of secondary conditions such as swelling and infection. A stitch in time, saves nine.

My employee needed medical treatment or time off for a work injury, what should I do?

For injuries that require medical treatment and / or involve lost time you must notify your Insurer within 48 hours. These will involve a claim against your workers compensation policy for the cost of the medical treatment and any lost wages in excess of \$500. Your employee must see a qualified Medical Practitioner and provide a WorkCover Medical Certificate. Send the original certificate to your Insurer and always keep a copy for your records.

Do they have to see a particular Doctor?

No. An injured worker has the right to choose their own Doctor, in most cases injured workers choose their family GP who may already know them as a patient and hold the records of their medical history. The Workplace Injury Management & Workers Compensation Act 1998 requires that an injured worker must nominate a treating Doctor who is willing to become involved in their rehabilitation. The Doctor and the injured worker must sign the bottom of the WorkCover Medical Certificate to indicate they have established this relationship and that they both agree to the sharing of necessary medical information regarding the workers injury and return to work with the Insurer and the employer. The Insurer may ask the worker to attend a Doctor of their nomination for a second opinion.

When my employee has signed the release of information consent on the WorkCover medical certificate, does this allow access to all their personal medical history?

No. This is privileged information, only information directly relevant to the management of the work injury can be divulged, unless a court orders otherwise. Medical records can be subpoenaed if there is evidence that the claimed injury is a result of a pre-existing condition.

Can my employee change their treating Doctor?

Once an injured worker has nominated a treating Doctor, they must have a valid reason and also seek permission from the Insurer to change Doctors. This is to discourage, a claimant from, "Doctor shopping" until they find one who will give the opinion they want. However there are many genuine reasons why an injured worker may want to change. These include instances where the initial treatment was provided at the nearest hospital casualty department or medical centre and the worker wants to use their own local GP, the worker may want to choose a Doctor closer to their home or work, or choose the specialist they have been referred to be their nominated treating Doctor so they don't have to see one Doctor for treatment and another one to issue medical certificates.

Some medical centres operate with several Doctors on duty at a time and patients have to see the first available Doctor. It's quite acceptable for an injured worker to choose one medical practice that operates on this basis to be their nominated treating Doctor. A locum Doctor who is relieving for the nominated treating Doctor during their absence is also regarded to be the nominated treating Doctor for the purposes of workers compensation injury management.

How do I make a workers compensation claim?

Your workers compensation insurance company must be notified within 48 hours of the injury when a workers compensation claim is to be made. The notification can be made by telephone, fax, e-mail, electronic means via the internet (where this facility exists), or postal mail and can be done by the employer, the injured worker or someone acting on their behalf (Eg. a relative, friend or Union Officer.)

It is not necessary to fill out a claim form when initially making a claim, although the Insurer may later request that your employee do this in which case they must fill out, sign, date and return the completed claim form. Ask for a copy of the claim form for your records.

What happens next?

The claim will be given a unique number that identifies it. Write this number down and keep it in a safe place. Quote this number if you need to contact the Insurer and write it clearly on all documents that you send to them.

By law, the Insurer must accept, "Provisional Liability" and commence payments of reasonably necessary medical expenses and lost wages within seven days of notification unless they have a "reasonable excuse" not to. An Insurer has reasonable excuse not to accept provisional liability where:

- There is insufficient medical information about the injury to determine liability
- The claimant is not a, "worker" within the meaning of that term for workers compensation purposes (Eg. A contractor who holds their own workers compensation policy and not a direct employee)
- The Insurer has been unable to contact the worker
- The worker has not consented to the release of medical and other relevant personal information to the Insurer, (Eg. By signing the consent to release information on the bottom of the WorkCover medical certificate.)
- There is evidence that the injury is not work related (Ie. The employment is not a substantial contributing factor to the injury)
- More than 2 months have elapsed since the date of injury
Remember you are responsible for the first \$500 of lost wages, but you should only make this payment if you have been advised by the Insurer that provisional or ongoing liability has been accepted.

Following the Insurer being notified of the injury, they must make contact with you, your employee and their nominated treating Doctor. If you don't hear from them within a few days, take the initiative to phone the Insurer yourself. Ask to be put through to the Claims Officer who is dealing with the claim and discuss the current situation with them. Obtain the claim number (if you don't already have it,) the Claims Officer's name and direct line phone number. Write down these details down and keep them in a safe place.

What is Provisional Liability and how long does it last?

Provisional liability is not an admission of ongoing liability and it does not automatically mean that the claim will be ultimately accepted. Provisional liability is intended to ensure that payments to an injured worker are not unnecessarily delayed while the Insurer goes through the administrative and legislative steps to process the claim.

Provisional liability can be accepted for a maximum of up to twelve weeks or a maximum of \$5,000 expenditure in medical expenses, whichever happens sooner. At that stage the Insurer must accept ongoing liability or decline the claim and they can choose to accept on an ongoing basis, or decline a claim at any time within the twelve weeks. When this decision occurs, you and your employee must be notified in writing by the Insurer.

Provisional liability may not be accepted where the Insurer is not notified of the claim within eight weeks of the date of injury. In these circumstances the Insurer must decide to accept ongoing liability and commence payments or decline the claim within twenty-one days.

My employee's medical certificate says he's fit for suitable duties. What are "suitable duties"?

If the treating Doctor believes that the injured worker is not fit enough to return to their pre-injury job, but is able to do some lighter work, or shorter hours, they will tick the suitable duties box on the WorkCover medical certificate and indicate what work restrictions currently apply to the worker. This may include a weight lifting restriction, shorter working hours, or restrict a particular activity (Eg "No ladder climbing" or "No repetitive bending" etc.)

Suitable duties should always be provided wherever possible and take into account all the relevant factors of the individual case (Eg. *the nature of the injury, the workers pre-injury job, their age, experience, education, means of travel to work* etc.) Suitable duties most similar to the employee's pre-injury job are best. Generally the preferred option is the pre-injury job itself with any particular tasks (Eg. *Lifting weights*) conflicting with the medical certificate removed. This way your employee is least likely to object to the suitable duties offered. If the nature of the pre-injury job and / or the workers medical restrictions means that the worker cannot return immediately to at least some aspects of their job, then other suitable duties should be offered in consultation with your injured worker and the treating Doctor. Suitable duties should involve useful work that is not token in nature or demeaning to the worker.

It's a good idea to ring the treating Doctor to advise that you have suitable duties available for your worker and the type of work you can make available. (Eg. *Answering the phone, opening the mail* etc.) The Doctor will be more willing to certify your employee fit for return to work if they can be confident about them being able to cope with the job. If you are having difficulty finding suitable duties for your injured worker, then call Mend and we can undertake an assessment of your workplace and your employee to identify what work they are currently able to do.

Why is it so important to provide suitable duties for my injured employee?

If the worker is certified as fit for some sort of work from the date of injury then it is in the best interests of an employer to endeavour to provide suitable duties as soon as possible. The provision of suitable duties is a legal requirement under Section 49 of the Workplace Injury Management and Workers Compensation Act 1998. Furthermore, experience has demonstrated that the longer an employee remains off work whilst being certified fit for suitable duties, then the greater the likelihood that the worker will be slow to respond to rehabilitation initiatives and return to the workforce. Such circumstances impact markedly on individual employer workers compensation premiums and on the WorkCover scheme in general.

What compensation benefits is my employee entitled to?

- Medical and related treatment expenses. Section 60 of the Workers Compensation Act 1987 provides for the payment of all, "reasonably necessary" medical, hospital, ambulance and rehabilitation expenses and for travelling expenses incurred receiving these treatments. For expensive medical procedures like surgery, or investigative tests like MRI and CT scans, the Insurer should be contacted first to obtain their approval and agreement that the procedure is considered reasonably necessary.
- Lost wages. Division 2, Sections 35 - 42 of the Workers Compensation Act 1987 (The Act) deals with compensation for lost wages. If your employee is totally unfit for work, Section 36 of The Act provides for payment at the current weekly wage rate for the first twenty-six weeks. For most people this will mean their award rate excluding things like overtime, bonuses and the majority of over award payments. The entitlement under Section 36 need not be twenty-six consecutive weeks of being totally unfit for work. If a worker returns to work within the period, but then later goes off work again due to the injury, it's the cumulative total that counts.
- If the worker is unfit for work after a total of twenty-six weeks following the injury, their entitlement under Section 37 of the Act is to be paid at a statutory rate set by WorkCover which is determined by the number of dependants they have and is indexed twice yearly in April and October.
- If they are able to do some work and are working on suitable duties, (either with you, or a different employer) but because of their work injury, are not earning their pre-injury income,

Section 40 of the Act provides that the Insurer must pay, "Make up pay," - the difference between what they could reasonably expect to be earning now if they had continued in their pre-injury occupation, (including all extra payments like overtime and bonuses etc.) and their current actual income.

- If the employee is fit for suitable duties, but you cannot provide them, then under Section 38 of the Workers Compensation Act 1987, the employee will be entitled to up to 26 weeks of weekly compensation at their award rate and up to a further 26 weeks at 80% of that rate.
- Lump sum compensation for permanent impairment. Employees who have suffered a permanent impairment as a result of a work injury may have an entitlement under Section 66 of The Act to lump sum compensation in addition to weekly benefits and medical expenses. Depending on the degree of impairment, they may also have an entitlement to compensation for any associated pain and suffering under Section 67 of The Act. They must seek legal advice from a Solicitor to be eligible to claim lump sum compensation under these sections of The Act. A claim for permanent impairment cannot be made until maximum medical improvement has been reached and / or the injury has stabilised.

What is a Rehabilitation Service Provider and how can they help?

WorkCover has accredited a number of Rehabilitation Service Providers. These are organisations that assist with a workers rehabilitation after a workplace injury and liase between the parties involved to ensure the best possible outcome. The Insurer will pay for the cost of any reasonably necessary rehabilitation services as part of the claim. A rehabilitation provider can help by: -

- Making an accurate, independent and objective assessment of the situation
- Liasing between the parties involved to establish an effective and appropriate return to work plan
- Monitoring progress against the plan and keeping all parties informed by issuing regular progress reports with follow up recommendations as required
- Identifying suitable duties for an injured worker to facilitate their return to the workforce
- Reducing your claims experience factor through effective injury management
- Ensuring all parties are kept aware of their rights and obligations

Can I nominate a particular Rehabilitation Service Provider to be my preferred provider?

Yes. But you should do this in consultation with your employees as part of your Return to Work Program. An injured worker has the right to nominate their Rehabilitation Service Provider, so it's wise to reach mutual agreement prior to anyone being injured and have an effective, pro-active Injury Management system with an action plan ready in case of emergency. Make sure your Insurer is advised of your choice of preferred provider.

How should I choose a Rehabilitation Service Provider, is there a difference between Providers?

There are many rehabilitation providers accredited by WorkCover available. In making your choice you would be wise to consider the difference between the types providers, their qualifications, experience and success rate. There is a public sector provider and a number of private sector providers that operate as for-profit businesses.

Why should I choose Mend?

Mend Services Pty Ltd is a not-for-dividend organisation set up as joint function between the Construction, Forestry, Mining and Energy Union and the Master Builders Association of NSW to service the needs of the Building, Construction and associated industries. This unique balance of stakeholder involvement at an ownership level gives Mend an objective, balanced focus towards rehabilitation and injury management that gives both employers and workers confidence that their interests are being fairly considered.

All proceeds go back into the organisation to improve our services to our members and clients. Mend can help you reduce the cost of your workers compensation claims experience factor through effective injury management strategies.

Mend was set up in 1989 to service the needs of the construction industry and is the only rehabilitation provider in NSW that specialises in the rehabilitation of injured building workers. 97% of our clients return to work with their pre-injury employer.

We have offices in Sydney at Glebe and Lidcombe and regional offices in Newcastle and Wollongong. Mend employs an extremely dedicated, multi-disciplinary team of highly qualified and experienced allied health professionals who thoroughly understand your industry. Mend's Mission statement says it all: -

"To be leaders in the provision of rehabilitation services to those involved in the construction and other industries by dedicating ourselves to treating injured workers and their employers with respect, maintaining best practice standards, encouraging constant innovation, and supporting each other in the pursuit of these aims."

What if my employee can't return to their old job?

Mend will explore all the available vocational options with them, advise on the re-training, wage subsidy and re-deployment programs available, actively assist them with job search if required and generally help recovery as fully and quickly as possible to achieve the best quality of life possible for the worker and the best, most cost effective outcome for the employer.

What obligations does an injured worker have whilst receiving workers compensation?

An injured worker must:-

- Make all reasonable efforts to return to work with their pre-injury employer as soon as possible
- Complete and return a claim form to the Insurer when requested to do so
- Nominate a treating Doctor who is willing to be involved in their rehabilitation and return to work
- Supply a current medical certificate to the employer or the Insurer and continue to supply a current progress certificate when requested
- Participate and co-operate in the establishment of an injury management plan and comply with any obligations of the injury management plan
- Be willing to become involved in a rehabilitation program provided for the worker
- Be willing to accept an offer of suitable employment and / or vocational retraining
- Attend all medical and assessment appointments arranged by the Insurer

How are my workers compensation premiums calculated?

The calculation of workers compensation Insurance is a complex formula involving a number of factors. Put in its most simple form, the calculation is made by the dollar value of your payroll multiplied by a percentage determined by the risk factor of the industry you work in (Industry classification factor.) The cost of any claims made (claims experience factor) is added to this, plus or minus any adjustment to these figures from previous and future anticipated payroll changes and claims experience.

If a claim is made, how long does it affect my premium for?

Workers compensation claims are premium impacting for three years from the date of injury.

Do claims for journey injuries to my employees on the way to or from work affect my premium?

No. Journey claims on the way to or from work and recess claims for offsite injuries during lunch, tea and rest breaks etc are not premium impacting, (ie. They are not charged to your claims experience factor. The cost of these claims is borne by the Workers Compensation Scheme.

What is a claims review, how can these help me?

A claims review is a meeting between you and your Insurance company to review the status of each outstanding claim and ensure effective injury and claims management is occurring. It's an opportunity to check that your claims are progressing appropriately towards the most positive outcome possible. It's a good idea to do this three or four times a year if you have a number of active claims and if you have any claims at all, schedule at least one a year preferably three months prior to your premium renewal to ensure that everything is being done to bring outstanding claims to a resolution or an improvement that allows the forward estimate to be reduced so that your claims experience factor is as low as possible when the premium falls due for renewal.

Mend services Pty Ltd will attend up to three claims reviews a year with and on behalf of our members to ensure their interests are protected.

How can I reduce the cost of my workers compensation?

There are two ways: -

1. Reduce the cost of your direct employee payroll (Not always possible, practical or desirable)
2. Reduce the cost of your claims experience by reducing the number of workplace injuries. By effective injury management and by regularly reviewing claims.

What can I do if I doubt my employee's claim is genuine?

The vast majority of workers compensation claims are genuine, however some aren't.

A very small percentage of claims are pre-conceived, contrived acts of deliberate fraud. Either orchestrated to conceal a claim for a non work injury, pre-existing condition, or fabricated to obtain a monetary benefit or time off work and sometimes just as an act of malice by a hostile employee against their employer. Claims can also arise initially from a genuine workplace injury, but end up being exaggerated by a malingering employee for their own benefit.

If you have hard evidence that challenges the genuineness of a workers compensation claim you should write to your Insurer and the WorkCover Authority setting out the information that you have. Fraudulent workers compensation claims can involve criminal prosecution with a maximum penalty of a \$55,000 fine and / or two years jail. You will need more than just a vague suspicion though for the Insurer or WorkCover to expend resources on an exhaustive investigation.

Where there is sufficient reason to warrant it, you can ask the Insurer to conduct a factual investigation of the circumstances of the accident that caused the alleged injury, or ask for surveillance of the claimant's daily activities to be undertaken. There have been instances of factual investigations revealing that the claimed injury is not work related at all and surveillance investigations revealing that the claimant who is certified as being totally unfit for work is actually working and claiming workers compensation at the same time.

You can also ask the Insurer to obtain an independent medical opinion on claimed injuries where there is suspicion that the injury is caused by a pre-existing, degenerative or genetic condition.

Whilst many genuine claims may fall into the following categories, WorkCover advise that indicators that a claim should be viewed with suspicion include:

- Alleged injuries that occur immediately before or after a holiday
- Alleged injuries that occur first thing on Monday morning, or late Friday afternoon, but not reported until Monday - these could be sporting injuries sustained over the weekend
- Injuries reported after job termination, an industrial dispute, end of a project or at the end of seasonal work
- A witness of questionable character, or an unreliable description of the accident that does not support the cause of the injury
- Injuries to a worker with a history of suspicious claims
- Late reporting of claims without reasonable explanation
- Conflicting descriptions of the accident, inconsistencies with the medical records
- Difficulty contacting a claimant at home when they are allegedly disabled
- Refusal by the worker to take medical tests to confirm the nature and extent of an injury.

Claims that involve a number of the above elements should come under particular scrutiny.

What if I don't believe I am getting fair treatment from the system?

You can always talk to the friendly staff at Mend for advice and support on our toll free hotline, 1800 300 011.

If you believe the Insurer is not properly considering your interests in relation to management of a claim, be patient. Contact the Insurer's Claims Officer dealing with the file and explain your point of view. It could possibly be the result of a misunderstanding or simply that the Insurer is not in possession of the full information, In which case, ask them to review the claim.

If you are not able to resolve the dispute with the Insurer, you can contact the Claims Assistance Service of the WorkCover Authority on 131050 or speak to your employer organisation or Solicitor.

I want Mend to be my preferred Rehabilitation Service Provider, how do I go about it?

You can call Mend on 1800 300 011 and give us your details over the phone, we'll do the rest.