THE LAW SOCIETY
OF NEW SOUTH WALES

COPY

25 May 2012

The Hon. Robert Borsak MLC
Chair
Joint Select Committee on the NSW Workers Compensation Scheme
Parliament House
Macquarie Street
SYDNEY NSW 2000

By email : workerscompinquiry@parliament.nsw.gov.au

Dear Mr Borsak,

Inquiry on the Workers Compensation System

The Law Society of New South Wales (the Law Society) thanks you for the opportunity to appear before the Joint Select Committee on the NSW Workers Compensation Scheme on Monday 21 May 2012.

The Law Society's Injury Compensation Committee (the Committee) acknowledges receipt of Ms Vanessa Viaggio's correspondence dated 22 May 2012 and a copy of the uncorrected Transcript of Evidence (the transcript).

Thank you further for the opportunity to:

1. Correct transcription errors;
2. Clarify certain issues and correct errors of fact;
3. Respond to questions taken on notice, and
4. Provide additional information.

1. CORRECTION OF TRANSCRIPT ERRORS

Enclosed is a copy of the corrected transcript marked up as requested.

2. CLARIFICATION OF ISSUES AND CORRECTIONS OF ERROR OF FACT

The Committee refers to page 44 and following of the transcript and seeks to correct the factual errors contained within a discussion concerning lump sums. The question put by the Honourable Adam Searle was *"You mentioned the lump sums. What are the lump sums for Section 66 and 67?"*

The Committee wishes to correct its response to reflect, *"the maximum lump sum for section 66 is $220,000 and $50,000 for section 67".*

In response to the question from the Honourable Adam Searle, *"How long have those been*

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the lump sums?", the Committee respectfully seeks to correct its response to read, "*In respect of section 66 the maximum was $200,000 until 1 January 2007 when it was increased to $220,000. From 1 January 2007 there was also an increase in the value per one percent in a claim under section 66. The maximum under section 67 has remained the same since 1987"*.

The Committee seeks to correct the response from Ms May, "*The maximum value has not changed*" in lines 3 to 5 on page 45 to read, "*The maximum value of $50,000 for this section has not changed since 1987.*"

The Committee seeks to correct its response in answer to the question from the Honourable Adam Searle, "*The maximum of say $87,000 would have been eroded by inflation over the past couple of decades?"* by restricting the answer to "*Yes*".

The Committee seeks to strike Mr Concannon's answer *"2005"* and correspondingly strike Ms May's *"No, 1995. I am sorry, but I disagree with my colleague"* from the record as non-responsive.

3. RESPONSES TO QUESTIONS ON NOTICE

The Committee seeks to respond to the questions on notice:

(a) Page 47, line 1: Referring to page 6 of the Committee's submission relating to premiums in NSW, *"Would you identify what you say are the top three operational risks that are different as between New South Wales on the one hand and Victoria and/or Queensland on the other hand, that would result in higher risk and premiums in New South Wales?"*.

(b) Page 47, line 9: Referring to page 6 of the Committee's submission, *"What are the three top differences in wage structures that would cause premiums in New South Wales to be higher?"*.

(c) Page 47, line 10: Referring to page 6 of the Committee's submission, *"And I ask the same question about commercial practices of companies."*

(d) Page 47, line 37: Referring to paragraph 3 on page 3 of the Committee's correspondence to the Minister for Finance and Services dated 22 March 2012, *"What is the rationale arriving at that figure of 50 percent?"*.

The Committee's response to questions (a), (b) and (c) is as follows:

The Committee concedes that the use of the expressions "operational risks and the like", "wages structures" and "commercial practices of companies" are cumbersome expressions which do not appropriately or clearly articulate our position regarding premiums.

Premiums are usually expressed as a percentage of employers' total wages bills. The rates depend on an employer's size, industry, individual claims experience, and the way that "wages" are defined for workers' compensation purposes, which can vary across the jurisdictions (*Comparison of Workers' Compensation Arrangements in Australia and New Zealand,* Safe Work Australia, March 2011, page 72).

"Wages" or "remuneration" is the basis for insurers to quantify workers' compensation premiums which are paid by employers annually. NSW, Victoria and Queensland each have

different definitions of "remuneration" which impacts upon the calculation of premium absent any other factors (Ibid, pages 80–82).

Average weekly full time earnings in NSW are higher than in Victoria (*Australian Bureau of Statistics,* 6302.0 - Average Weekly Earnings, Australia Tables 11A and 11B, February 2012). As a consequence the cost of workers compensation claims will be higher in NSW because weekly compensation is affected by earnings levels. As a direct consequence the cost to business of insuring risk of injuries in NSW will be, and should be, higher in NSW than in Victoria.

In addition, premiums vary from industry to industry and as between the States as a consequence of the risks involved in industry (*Comparison of Workers' Compensation Arrangements in Australia and New Zealand,* Safe Work Australia, March 2011, Table 4.4 Selected industry premium rates as at September 2010, pages 75-77.*)* The Committee notes the following extract from the *Comparison of Workers Compensation Arrangements,* Safe Work Australia, March 2011, page 78:

> ***"4.2.2 Premium setting: Notes relating to the industry rates comparison table***
> *As it is difficult to make exact comparisons between states, the following qualifications should be noted:*
>
> - *Industry classifications vary from jurisdiction to jurisdiction. For example, Victorian industry classifications are based on the Australian Bureau of Statistics (ABS) ASIC code, and WA and NSW on ANZSIC. SA industry classifications are based on the ABS code and are progressively being aligned to ANZSIC, with some alterations designed specifically for SA localised conditions.*
> - *On 1 July 1997, Queensland introduced an industry classification system based on the ANZSIC system, with some alterations specifically designed for Queensland. The classifications have been named the WorkCover Industry Classifications. On 1 July 2010, WorkCover Queensland moved from ANZSIC 1993 to ANZSIC 2006 to better reflect the evolution of technology and changes in industry during that period. The ABS uses ANZSIC 2006 in most of its economic collections and for the compilation of the national accounts. Current rates are published by Gazette notice.*
> - *On 30 June 2001, NSW introduced an industry classification system based on the ANZSIC system (WorkCover Industry Classification – WIC), with some alterations specifically designed for NSW. All WIC rates were reduced by up to 30% between June 2005 and June 2008. Current industry classes and rates were published in a NSW Gazette notice on 18 June 2010. Refer to the Insurance Premiums Order on the WorkCover NSW website, WorkCover Authority of New South Wales, (http://www.workcover.nsw.gov.au/Pages/default.aspx).*
> - *Levy/Premium category comparisons are done on a 'best match' basis and should not be regarded as exact equivalents."*

For example, in NSW there are approximately 536 industry classes and "rates are calculated by external actuaries using objective, data-based rating methodology, based on recent wages declared and claims costs. An actuarial model is applied to small industry classes. The rates are calibrated to achieve the target collection rate" (Ibid, page 79). In Victoria, "each industry's rate is calculated based on claim cost rates and claim frequency rates over a five year period with 12 months of development. The rates are calibrated to achieve the average premium rate" (Ibid, page 79). In Queensland by way of further comparison, "there are currently 561 WorkCover Industry Classifications (WIC). Rates are annually calculated based on an actuarially verified methodology considering seven years of wages and claims data" (Ibid, page 79).

The Committee contends that these elements alone are sufficient to warn against comparing employers in different States, and the premiums imposed upon employers in different States, as a basis for reform.

The Committee's response to question (d) is as follows:

Experience tells us that the cost of commutations relative to the estimate of outstanding liability on a claim generally runs at 50% or less. When considering the impact of commutations on costs savings, regard has to be had to the future cost of medical treatment and rehabilitation expenses which are subsumed in the commutation value and thereby reduced to zero.

4. ADDITIONAL INFORMATION.

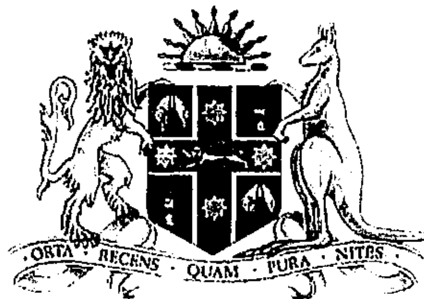
The Committee encloses a copy of the *Guidelines for Independent Medical Examinations and Reports*, March 2012 referred to on page 50 of the transcript.

With reference to the exchange on transcript, page 48, lines 6 to 9, the reporting requirements of this Committee will not afford sufficient time in which to commission, consider and provide a proper actuarial analysis of the PwC report and its appendices, noting that the Law Society was provided with the appendices to the PwC Actuarial Valuation on 21 May 2012.

Should you wish to contact the Law Society regarding this submission, the policy lawyer with responsibility for this matter is Patrick McCarthy who may be contacted on (02) 9926 0323.

Yours sincerely,

President



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SPECIAL SUPPLEMENT

WORKCOVER GUIDELINES ON INDEPENDENT MEDICAL EXAMINATIONS AND REPORTS

I, Julie Newman, Acting Chief Executive Officer of the WorkCover Authority of New South Wales, under section 119 (4) and section 376 of the Workplace Injury Management and Workers Compensation Act 1998, issue the following guidelines.

Dated this 13th day of March 2012.

JULIE NEWMAN,
A/ Chief Executive Officer,
WorkCover Authority of NSW

WORKCOVER GUIDELINES ON INDEPENDENT MEDICAL EXAMINATIONS AND REPORTS

Workplace Injury Management and Workers Compensation Act 1998

These guidelines are issued under section 119 (4) and section 376 of the Workplace Injury Management and Workers Compensation Act 1998. The guidelines set out WorkCover's policy in respect of independent medical examinations as well as the mandatory obligations for employers/insurers when referring a worker for a medical. They also provide guidance for all parties, including referrers, examining medical practitioners, and injured workers.

These guidelines replace guidelines dated 14 April 2009 and published in the NSW Government Gazette No. 63.

These guidelines commence on 23 March 2012.

In this guideline, the Workers Compensation Act 1987 is referred to as the 1987 Act and the Workplace Injury Management and Workers Compensation Act 1998, is referred to as the 1998 Act.

Definition of Insurer

Insurer is an insurer within the meaning of the Workers Compensation Act 1987 and the Workplace Injury Management and Workers Compensation Act 1998 and includes Scheme Agents and self and specialised insurers.

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INTRODUCTION

Purpose and Scope of the Guidelines

The purpose of these guidelines is to provide the basis for a shared understanding of the role of independent medical examinations in the management of compensable injuries in the NSW workers compensation system.

The guidelines outline mandatory [as per section 119 (4) of the 1998 Act] and other obligations for the referral, conduct and reporting of independent medical examinations, and complaints management.

Mandatory obligations are set out in Part 1 of these guidelines. These are made in accordance with section 119 (4) of the 1998 Act which states that an examination of a worker who has given notice of an injury must be in accordance with the WorkCover guidelines.

The other obligations set out in the Introduction and Part 2 of the guidelines apply to all independent medical examinations.

This document is intended for use by those who:

- refer injured workers for independent medical examinations
- undertake independent medical examinations and provide reports
- use independent medical examination reports in managing injuries, claims and disputes.

This document is also intended for use by injured workers and their representatives. A brochure is available from WorkCover for injured workers who are referred for independent medical examinations. The NSW Medical Board policy Medico-Legal Guidelines provides useful information for workers and referrers (available from their website www.nswmb.org.au).

This document covers referrals by employers/insurers and lawyers involved in the workers compensation system, but not referrals to approved medical specialists by the Workers Compensation Commission of New South Wales.

Definition of Independent Medical Examination

Independent medical examination means an impartial assessment based on the best available evidence that is requested by a worker, a worker's solicitor or employer/insurer and undertaken by an appropriately qualified and experienced medical practitioner (who is not in a treating relationship with the worker) for the purposes of providing information to assist with workers compensation injury and claims management.

PART 1 MANDATORY OBLIGATIONS FOR EMPLOYERS/INSURERS

Part 1 sets out the mandatory obligations (pursuant to section 119 (4) of the 1998 Act for employers/insurers when they require a worker to attend an independent medical examination.

Referral for an independent medical examination is appropriate when information from the treating medical practitioner(s) is inadequate, unavailable or inconsistent and where the referrer has been unable to resolve the issues related to the problem directly with the practitioners.

All referrals for independent medical examinations are to be arranged at reasonable times and dates and with adequate notice provided to the worker, as outlined on page 7, 'Notification and explanation to the worker'.

Referrals for an independent medical examination are made when answers to one or more of the questions outlined on page 5, 'Reasons for referral' are sought.

All referrals for independent medical examinations are to be to appropriately qualified medical practitioners who have the expertise to adequately respond to the question(s) outlined in the referral. The independent medical examiner is to be a specialist medical practitioner with qualifications relevant to the treatment of the injured worker's injury. Care is to be taken when referring a worker with complex injuries. Referrers are to ensure that medical specialists with specific expertise are selected, e.g. a hand or plastic surgeon for hand injuries, a spinal surgeon for complex back injuries, a neurosurgeon or rehabilitation specialist for head injuries.

The employer/insurer must meet any reasonable costs incurred by the worker, including wages, travel and accommodation. This may include pre-payment of travel and accommodation expenses. If the worker is not reasonably able to travel unescorted, this may include expenses for the worker's escort. *Reference section 125 of the 1998 Act.*

A worker receiving weekly compensation payments can be required to submit themselves for subsequent independent medical examinations when information from the treating medical practitioners remains inadequate, unavailable or inconsistent and where the referrer cannot resolve the issues related to the problem directly with the treating practitioner(s) and:

- the subsequent independent medical examination is with a specialist medical practitioner with qualifications relevant to the treatment of the injured worker's injury; and
- the employer/insurer has evidence that the worker's medical condition as a result of the injury has changed; or
- the employer/insurer has evidence of a change in the worker's health not resulting from the injury which will affect the worker's participation in the labour market; or
- the employer/insurer has evidence of a material change or need for material change, in the manner or type of treatment; or
- the worker makes a claim for section 66 lump sum compensation or work injury damages; or
- the worker requests a review pursuant to a notice issued under section 54 of the 1987 Act or section 74 of the 1998 Act and includes additional medical information that the employer/insurer is asked to consider; or
- there has been at least 6 months since the last independent medical examination required by the employer/insurer; or
- the last independent medical examination was unable to be completed.

Subsequent independent medical examinations must be with the same medical practitioner unless they have ceased to practise (permanently or temporarily) in the specialty concerned, they no longer practise in a location convenient to the worker or both parties agree that a different medical practitioner is required.

If the worker considers the requirement to attend an independent medical examination is unreasonable, the worker is to advise the referrer of the reasons for their objection. The referrer must take account of this objection and advise the worker of their decision following this consideration. Benefits are not to be affected prior to adequate written notice being received by the worker following this consideration (see WorkCover Guidelines for Claiming Compensation Benefits, clause 9.3, Part 2). Any decision to suspend payment of weekly compensation can only be made after the worker has had an opportunity to comply with a reasonable request and must be made on the basis of sound evidence and the worker advised in writing of the reasons for the suspension. The worker may contact WorkCover's Claims Assistance Service on 13 10 50 or their union for assistance in relation to such requests and decisions. The insurer is to respond to these requests.

PART 2 OBLIGATIONS FOR ALL INDEPENDENT MEDICAL EXAMINATIONS

Part 2 sets out the obligations for all independent medical examinations (in addition to the mandatory obligations set out in Part 1).

1. Referral for Independent Medical Examination

Reasons for referral

An independent medical examination is appropriate where the information required relates to:

- diagnosis of an injury reported by the worker and determining the contribution of work incidents, duties and/or practices to that injury
- diagnosis of the worker's ongoing condition and whether it still results from the injury
- recommendations and/or need for treatment
- fitness for pre-injury duties and hours, and the likelihood of, and timeframe for recovery
- fitness for other jobs/duties, including those in the worker's recent employment history (descriptions of such duties are to be provided to the independent medical examiner)
- what past and/or ongoing incapacity results from the injury
- physical capabilities and any activities that must be avoided
- an assessment of permanent loss (injuries pre 1 January 2002) or whole person impairment (injuries on and after 1 January 2002) resulting from the injury, including any proportion to be deducted that is due to a pre-existing injury, abnormality or condition
- When an injured worker submits a report from an assessor of permanent impairment who is the worker's treating medical practitioner and the assessment of permanent impairment is less than 10% whole person impairment, if questions regarding that assessment arise they are to be posed to the author in the first instance. If the response from the assessor is inadequate, unavailable, inconsistent or not received in 10 working days, a referral for an independent medical examination may be made.
- The worker can be referred for an independent medical assessment if the worker submits an assessment of permanent impairment that is equal to or more than 10% whole person impairment.
- The worker can be required to submit themselves for an independent medical assessment if the claim is for additional permanent impairment or permanent loss, when one or more previous claims for permanent impairment or permanent loss have already been determined and paid.
- In any case, if the worker submits an assessment of permanent impairment by an assessor who is not the worker's treating medical practitioner, and the employer/insurer determines to refer the worker for an independent medical examination, the worker should be referred to the treating medical practitioner for assessment of permanent impairment if that practitioner is trained in whole person impairment.

Barriers in relation to return to work and difficulties in communicating with a treating doctor might best be resolved through use of an Injury Management Consultant (refer to WorkCover's Guidelines on Injury Management Consultants).

Responsibility of referrer

The referrer has a responsibility to ensure that:

- the referral is made to an appropriate medical practitioner
- an appointment can be made within a reasonable period of time (usually 4 weeks)
- all parties are informed of the appointment details of the examination
- the worker is provided with an explanation of the nature of the examination and the details of the appointment
- the worker's special needs are catered for, eg interpreter, disabled access
- the independent medical examiner is provided with details of the worker and the specific reason for the referral
- all the information relevant to the referral question(s) is provided to the independent medical examiner
- the independent medical examiner is paid promptly for providing the service at the rate set out in the Workplace Injury Management and Workers Compensation (Medical Examinations and Reports) Order in force at the time of the examination (www.workcover.nsw.gov.au).
- there is no conflict of interest in relation to the worker and referrer.

It is not acceptable to list standard questions that are not relevant to the specific aspect of the claim leading to this referral.

Selection of an appropriate medical practitioner for the examination

It is important that the independent medical examiner who is selected to provide the examination is appropriately qualified and has the expertise to competently provide an opinion on the question(s) in the referral. The independent medical examiner is to be a medical specialist with qualifications relevant to the treatment of the injured worker's injury. If the referral includes a question of causation or treatment, the independent medical examiner is to be in current clinical practice.

If the medical report relates to a claim for permanent impairment, it must be completed in accordance with the WorkCover Guides for the Evaluation of Permanent Impairment by a medical specialist with qualifications and training relevant to the body system being assessed who has been trained in the WorkCover Guides.

If there is more than one impairment that requires assessment by different medical specialists, one specialist must be nominated as the lead assessor and determine the final amount of whole person impairment.

A subsequent examination is to be with the same independent medical examiner who conducted the original examination, whenever practical.

The location of the independent medical examiner's rooms should be as geographically close to the worker's home address as possible or accessible by direct transport routes. The rooms should contain appropriate facilities, including access for people with ambulatory difficulties, and accommodate the worker's specific physical needs.

Special requirements of the worker relating to gender, culture or language are to be accommodated.

If the worker wishes to have an accompanying person with them at the examination, the independent medical examiner's agreement to the presence of a companion is to be obtained.

The independent medical examiner should be able to provide an appointment within a reasonable time, usually 4 weeks, and a report of the examination within 10 working days, unless different arrangements are agreed by the parties.

Where it is the independent medical examiner's routine practice to record the examination on audio or video, the worker must be informed of this and be in agreement prior to the examination being scheduled. The recording of the examination is only to proceed if the worker consents.

Communication with the selected medical practitioner

The letter of referral to the independent medical examiner must provide clear direction about the question(s) to be addressed and the medical opinions sought.

Documents to be included

The independent medical examiner must be provided with all the information that is relevant to the questions to be addressed. Documents could include a claim form, medical certificates, witness reports, employer reports of injury, clinical notes/reports of treating doctors, medical reports, medical investigation reports, rehabilitation and functional assessment reports, job descriptions and duty statements, details of work with other employers and details of other settlements or awards.

Independent medical examiners are not able to order additional radiological or similar investigations so the results of all existing investigations are to be made available to the independent medical examiner.

Reports and/or electronic records of lay investigators are not to be provided with referrals for assessment of permanent impairment.

Documents are to be provided to the independent medical examiner at least 10 days prior to the arranged appointment. They should be supplied in a manner that facilitates review/perusal by the independent medical examiner. This includes the provision of an index of all documents provided with the documentation organised accordingly. The index is to be attached to the referral.

Notification and explanation to the worker

The worker is to be first advised in writing at least 10 working days before the appointment, unless a shorter time is required because of exceptional and unavoidable circumstances and agreed to by the parties, eg a need to consider an urgent request for treatment.

Advice about the appointment for the independent medical examination must include:

- the specific reason for the examination
- if applicable, an explanation of why the response from the treating medical practitioner or author of the assessment report to the insurer's enquiry was inadequate, inconsistent or unavailable
- the likely duration of the examination
- name, specialty and qualifications of the examiner
- date, time and location of the appointment and contact details of the examiner's offices and appropriate travel directions
- the need to be punctual
- what to take, eg x-rays, reports of investigations/tests, comfortable clothing to enable an appropriate examination to be conducted
- how costs are to be paid
- that a failure to attend the examination or an obstruction of the examination may lead to –
  - a suspension of weekly compensation and/or
  - the right to recover compensation under the1987 Act

- that the worker may be accompanied by a person other than their legal representative with the agreement of the independent medical examiner, however, the accompanying person must not participate in the examination and may be required to withdraw from the examination if requested
- that no one may be present during the actual physical/psychological examination of the injured worker, unless agreed by the worker and by the medical examiner
- whether the travel costs for an accompanying person will be met (this usually only applies if the worker requires an attendant as a result of the injury)
- how complaints are to be managed
- that the workers compensation legislation gives the worker or a nominee a right to a copy of any report relevant to a decision made by a referrer to dispute liability for or reduce, compensation benefits.

A WorkCover brochure about independent medical examinations is to be provided to the worker with the written notice of the appointment.

2. Conduct of an Independent Medical Examination

The NSW Medical Board's policy Medico-Legal Guidelines provides principles for the independent medical examiner's conduct during the examination.

If the worker provides the independent medical examiner with any additional information at the time of the examination, this information is to be noted in the examiner's report.

If the injured worker fails to attend the examination, the independent medical examiner must notify the referrer as soon as possible.

3. Reporting an Independent Medical Examination

The suggested format for the report is attached as Attachment A.

The report is to be written in plain English and use accepted medical terminology as the intended audience is insurer staff, workers and workers' representatives, eg unions, legal representatives.

The report is to answer the referrer's question(s) and include other information elicited during the examination that is relevant to those questions. The examination report is to list the material reviewed, provided by the referrer and/or any material provided by the worker at the time of consultation, any facts relied upon, the relevant medical history, examination findings, and the medical reasons for their conclusions.

The report should be provided to the referrer within 10 working days of the examination or within a different timeframe if agreed between the parties.

4. Corrections and Updating of Reports

Where a report contains an obvious error, the referrer may request the independent medical examiner to clarify and correct the report at no extra cost. Such requests are to be made in writing.

Where the referrer requests that the examiner review additional information and seeks a supplementary report, that report will attract an additional cost.

5. Complaints about Independent Medical Examinations

If the worker has concerns about the conduct of the independent medical examiner during the examination, they should raise those issues with the examiner at the time of the examination. The examiner should record the complaint and forward this to the referrer with their report and advise the worker to do likewise.

If the worker does not feel confident enough to do this, the worker should raise their concerns with the referring party as soon as possible after the examination. All insurers have in place a complaints management process. Making such a complaint can be facilitated by a union.

If the complaint is unable to be satisfactorily resolved, the worker may forward their complaint to WorkCover. WorkCover will advise the independent medical examiner of the complaint and provide an opportunity for the examiner to respond to the complaint.

WorkCover may refer the matter to the Health Care Complaints Commission, if it meets the criteria for such referral, eg more than 5 complaints about one independent medical examiner are received within a 12 month period and found to be justified or if professional misconduct or fraudulent action are alleged.

The worker may at any time make a complaint to WorkCover, the insurer, the Health Care Complaints Commission or the NSW Medical Board.

6. Complaints about Workers

Independent medical examiners should report any unreasonably late or non- attendance by the worker to the referring party. Similarly, any inappropriate behaviour or behaviour which impeded the examination should likewise be brought to the notice of the referrer within 2 days.

7. Fees and Payments for Properly Completed Reports

The maximum fees to be charged and paid are those set out in the Workplace Injury Management and Workers Compensation (Medical Examinations and Reports) Order in force at the time of the examination.

The referrer is to either:

a. agree the category of report being requested with the independent medical examiner and confirm the request in writing indicating that payment will be made within 10 days of receipt of a properly completed report and invoice; or

b. pay in accordance with a contractual arrangement between the medical practice and the referring body on receipt of a properly completed tax invoice.

Either arrangement cannot agree to a fee above the maximum fee prescribed in the Workers Compensation (Medical Examinations and Reports) Order.

The referrer's liability to pay for a report will be contingent on the report containing the information listed in the standard format or as agreed between the parties.

If it involves an assessment of permanent impairment for an injury on or after 1 January 2002, the assessment must be in conducted by a WorkCover approved assessor of permanent impairment in accordance with the *WorkCover Guides for the Evaluation of Permanent Impairment.*

In some instances, the referrer will require an assessment in accordance with the WorkCover Guides for the Evaluation of Permanent Impairment, even though the injury is before 1 January 2002. The independent medical examiner must be advised if this is the case.

Use of an interpreter, multiple system injuries and more complex matters will attract a surcharge in addition to the basic fees. These are listed in the Workplace Injury Management and Workers Compensation (Medical Examinations and Reports) Order current at the time of the examination.

In some instances, the referrer will require an assessment in accordance with the *WorkCover Guides for the Evaluation of Permanent Impairment*, even though the injury is before 1 January 2002. The independent medical examiner must be advised if this is the case.

Use of an interpreter, multiple system injuries and more complex matters will attract a surcharge in addition to the basic fees. These are listed in the Workplace Injury Management and Workers Compensation (Medical Examinations and Reports) Order current at the time of the examination.

The Workplace Injury Management and Workers Compensation (Medical Examinations and Reports) Order classifies the problems to be addressed into standard, moderately complex and complex. Definitions of these are:

A. **Standard Reports** are reports relating solely to a single event or injury in relation to:
   - causation; or
   - fitness for work; or
   - treatment; or
   - simple permanent impairment assessment of one body system.

B. **Moderately Complex Reports** are:
   - reports relating to issues involving a combination of two of the following:
     - causation
     - fitness for work
     - treatment
     - simple permanent impairment assessment of one body system

     or
   - reports of simple permanent impairment assessment of two body systems or more than one injury to a single body system.

C. **Complex Reports** are:
   - reports relating to issues involving a combination of 3 or more of the following:
     - causation
     - fitness for work
     - treatment
     - simple permanent impairment assessment of one body system.

     or
   - A complex method of permanent impairment assessment on single body system or multiple injuries involving more than one body system.

The referrer is to indicate the expected level of complexity on referral and the independent medical examiner should advise the reason for any difference from this level at the time of receiving the referral.

Fees for cancellations, non-attendance or late cancellation by the worker or another party, such as an interpreter, are included in the Workplace Injury Management and Workers Compensation (Medical Examinations and Reports) Order current at the time of the examination.

Complaints about patterns of late or non-payment by insurers should be referred for investigation to the WorkCover doctors' hotline on 1800 661 111 or by email to provider.services@workcover.nsw.gov.au

ATTACHMENT A

Report format

- Worker's details including:
  - ‰ date of examination
  - ‰ worker's name
  - ‰ date of birth/age
  - ‰ details of who attended the examination (ie interpreter, family member or friend).
- General history including:
  - ‰ date of injuries
  - ‰ brief history of the circumstances of the injuries
  - ‰ job description/work tasks (when relevant).
- Clinical history including:
  - ‰ summary of injuries received and diagnoses made of the worker's condition.
  - ‰ summary of all treatment provided
  - ‰ details and dates of clinical investigations carried out
  - ‰ details of any previous or subsequent injuries, condition or abnormality.
- Examination findings including:
  - ‰ list of injuries assessed
  - ‰ your findings on comprehensive clinical examination, including negative findings
  - ‰ your comments on consistency of presentation and, where appropriate, how this compares to the medical reports and other material sighted.
- Conclusions
  - ‰ Your opinion in relation to the specific questions asked in the letter of referral (refer to page 5).
- If the referral is about permanent loss of use as a result of injuries received before 1 January 2002 or for whole person impairment for injuries received on or after 1 January 2002, questions regarding maximum medical improvement, whether the condition has resulted in a permanent impairment, and whether there is any deduction for a pre-existing condition must be addressed. A summary table (see Table 1) and a copy of all calculations must be included.

Table 1 – Whole Person Impairment (WPI)

Body part or system	*Date of injury*	*Chapter, page and paragraph number in WorkCover Guides*	*Chapter, page, paragraph, figure and table numbers in AMA5 Guides*	*% WPI*	*% WPI deductions pursuant to section 323 for pre-existing injury, condition and abnormality*	*Sub-total/s % WPI in whole numbers (after any deduction/s in column 5)*
1.						
2.						
3.						
Total % WPI (the Combined Table values of all sub-totals in whole numbers)						