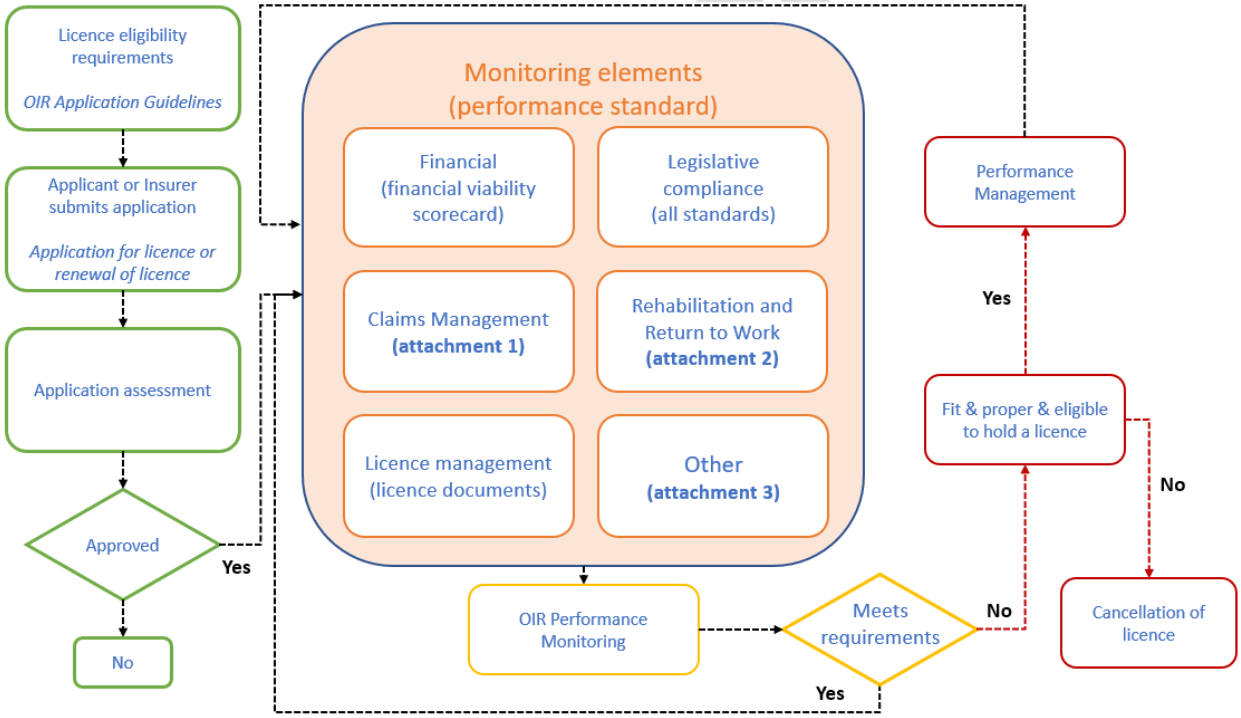
Contents

Office of Industrial Relations – Self-Insurer Performance and Audit Framework

Introduction

The Workers' Compensation Regulator (the Regulator) is responsible for regulating the Queensland workers' compensation scheme. This includes monitoring the compliance of insurers with the *Workers' Compensation and Rehabilitation Act 2003* (the Act), monitoring the performance of insurers under the Act and deciding applications relating to self-insurance. The Regulator delegates these functions to the Office of Industrial Relations (OIR), except for the issuing or renewing of self-insurance licences.

The following diagram summarises the OIR's overarching process for managing self-insurer licence applications, renewals and performance.



The OIR monitors several elements self-insurers' performance to assess whether they are fit and proper and complying with their licence conditions and other obligations. This Self-Insurer Performance and Audit Framework (the Audit Framework) establishes the self-insurer Performance Standards and provides an overview of the OIR's approach to conducting audits.

The framework establishes the minimum Performance Standards that a self-insurer must meet. These standards align with and build upon a self-insurers' obligations under the Act and self-insurance licence. Performance standards are established for:

- Claims Management (Attachment 1)
- Rehabilitation and Return to Work (Attachment 2)
- Other - Information and Communication (Attachment 3).

The Performance Standards provided in the Audit Framework are not an exhaustive list of all the self-insurer's obligations, however, they provide transparency and clarity about how the OIR will assess a self-insurers performance through its monitoring activities. It is noted that the OIR separately assesses a self-insurer's ongoing financial viability.

The Performance Standards will also be updated regularly to reflect changes in the regulatory environment, such as changes in the Act, or to make the Performance Standards a more effective for assessing performance. The OIR will consult with self-insurers and other stakeholders prior to making changes to the Performance Standards in a manner that is proportionate to the scale and impact of the changes.

The Audit Framework also provides guidance on how OIR undertakes a range of monitoring activities to assess the compliance and performance of self-insurers against the Act and the Performance Standards. These include:

- reviewing claims data;
- undertaking audits; and
- requiring self-insurers to undertake self-audits.

When the OIR reviews the self-insurer's performance, it will consider the acts of a third party engaged by the self-insurer, for the purposes of undertaking the powers, functions and obligations of self-insurers, are the acts of the self-insurer itself. This includes a claims agent, legal firm, medical provider or rehabilitation provider engaged by or on behalf of the self-insurer.

In addition, when monitoring the performance of the self-insurer, the OIR will consider any contravention of the legislation or a condition of licence by an employer that is part of the self-insurance licence.

1. Types of audit

The OIR will perform four types of audits. The following table provides an overview of each:

Type	Description	Timing
Compliance audits	The OIR will audit the performance of self-insurers against all standards in this framework at least once during a self-insurer's licence term. The OIR may recommend and validate the implementation of specific actions to address moderate or low risk findings in a compliance audit.	The OIR will conduct this audit at least six months prior to the licence end date.
Performance management audits	Where the OIR identifies significant and / or systematic deficiencies in the self-insurer's performance, it may require the self-insurer to implement an improvement action plan. In some cases, the OIR will undertake a performance management audit to verify that the self-insurer has implemented the agreed improvement actions.	Will follow a compliance audit, allowing enough time for the self-insurer to design and implement the improvement actions. For example, the OIR may conduct the audit six months after the original compliance audit.

Targeted audits	The OIR may perform targeted audits including one or more self-insurers to confirm that they are appropriately managing specific areas of or changes in the scheme. For example, to confirm that self-insurers updated their practices to comply with legislative changes.	The OIR will announce the subject matter for a targeted audit at least six months prior to undertaking the audit. The OIR will notify the self-insurers included in the audit more than eight weeks prior to commencing the audit.
Special audits	The OIR will perform special audits where circumstances or events give rise to risks that the regulator needs to understand and address.	Will depend on the timing of the event or circumstances that give rise to the need for a special audit.
Self-audits	Refer to section 5 - self-audits.	Refer to section 5 - self-audits

The OIR will provide the self-insurer with an audit scope letter for each audit. The audit scope letter will contain details of the audit process and logistical matters such the self-insurer's responsibility to arrange for the auditor's access to the claims management system.

2. Audit planning and timeline

The OIR will provide self-insurer's with adequate and reasonable planning time and information prior to undertaking compliance, performance management and targeted audits. The OIR may not provide the same level of notice or information prior to commencing special audits.

The following table outlines the timeline and steps the OIR will follow in the lead up to compliance, targeted and performance audits. Section five outlines the timeline for self-audits.

Timing	Steps
More than eight weeks prior to audit	OIR will contact the self-insurer to confirm the upcoming audit and approximate dates for the audit conduct.
More than four weeks prior to the audit	OIR and the self-insurer to agree and confirm the dates that the OIR auditors will be on site to conduct the audit.
At least two weeks prior to the audit	OIR will: • provide the audit scope letter; • provide the sample of claim files it will assess; • request other relevant documentation; and • request the name and contact details of a designated audit contact.

3. Audit evidence

OIR will collect a range of types of audit evidence to assess the performance of self-insurers. The following table summarises the types of evidence the OIR will collect during an audit to use as part of the assessment.

Evidence type	Description
Documentation	The OIR may request the following relevant documentation: • the full claim file for all claims in the sample

	• the claims manual, policies and procedures; • organisational information (for example charts, position descriptions and delegations); • internal audits or other internal performance reviews relating to workers' compensation and rehabilitation and return to work.; • service level agreements between the self-insurer and their third-party service providers; and • other documents it considers relevant.
File review	The OIR will review the compliance and performance of self-insurers claims management and rehabilitation and return to work by selecting and assessing a sample of claims files. Refer claim file audit sampling below.
Interviews	The OIR may collect evidence through interviews or correspondence with any of the following: • the self-insurers licence manager; • claims managers; • the employer; • claimants; • workers; and • any other relevant stakeholder (for example - unions).

4. Sampling

The OIR will aim to select a sample of claims for audit that enables an efficient and effective audit. This means selecting and assessing the fewest possible claim files (audit efficiency) to gain reasonable assurance about the self-insurer's compliance and performance (audit effectiveness).

Population of claims

For a compliance audit, the OIR will select the sample from a population of claims where the self-insurer submitted data showing activity on a claim in the 18 months preceding the audit. If the population of claims from the preceding 18 months does not provide sufficient coverage to assess the self-insurer's performance, the OIR may select earlier files.

Activity on a claim includes where:

- self-insurer intimated a statutory claim;
- claimant / self-insurer referred a claim to the Medical Assessment Tribunal;
- claimant / self-insurer lodged an application for review with the OIR;
- self-insurer made an adverse decision (rejected, ceased or suspended);
- self-insurer made the claim status: "No action required";
- self-insurer changed the worker's return to work status;
- self-insurer made payments on claims with more than 20 working days lost;
- self-insurer made an offer for the Degree of Permanent Impairment;
- self-insurer intimated a notice of claim for damages (common law claim);
- OIR received a complaint about the self-insurer's claim management.

Sample size

The table below provides guidance on the minimum number of claims the OIR will test based on the size of the population of claims in the first population described above. The table is for guidance only, where the OIR identifies risks that may affect a self-insurer's performance or it

requires additional coverage in specific areas of the claims management process, it will increase the number of claims in the sample.

Population of claims	Minimum sample size
Less than 50	10 - 15
50 to 100	15 - 20
100 to 500	30 - 50
More than 500	50

Sample selection
To conduct an effective audit, the OIR will select a sample of claims that covers all elements of the self-insurer's claims management performance.

The OIR will select a targeted sample with the aim of covering all standards and requirements it includes in the audit standards attached to this framework.

Where possible, the sample will cover the different types of claims the self-insurer manages. This may include files that reflect:

- the self-insurer's geographical spread; and
- the self-insurer's entities, businesses and operations.

5. Self-audits

To bridge the gap between the OIR's compliance audits, the OIR will require self-insurers with a licence duration of three years or more to perform a self-audit at the mid-point of their licence.

Resourcing a self-audit
The self-insurer will allocate appropriate resources to complete the audit. The self-insurer's auditors must be independent of the claims management team and have appropriate knowledge and experience with the Act and claims management processes.

Documenting a self-audit
The OIR will provide the self-insurer with an audit workpaper in Microsoft Excel to document the audit work.

Sample
The OIR will provide the self-insurer with the sample of files they will test in the self-audit. The OIR's sampling approach for self-audits will be the same as the sampling approach in section 4.

Reperformance and validation of results
To validate the results of the self-audit process, the OIR may reperform the self-insurer's audit work for a subsample of claims. If the OIR identifies significant divergence in the results of the reperformance and the results provided by the self-insurer, it will extend the reperformance to a larger subsample.

If the results of the reperformance are systematically and significantly different to the self-insurers results, the OIR may take enforcement actions (refer section 8).

Self-audit planning and timing
The following table outlines the timeline and steps the OIR will follow in the lead up to a self-audit.

Timing	Steps
More than eight weeks prior to self-audit	OIR will contact the self-insurer to confirm the upcoming audit and agree dates for the audit conduct.
More than four weeks prior to self-audit	OIR and the self-insurer to agree and confirm the dates that the self-insurer will • perform the self-audit conduct; and • provide their audit workpapers back to the OIR. OIR and the self-insurer to agree on the self-insurer's proposed resourcing for the audit.
At least two weeks prior to the audit	OIR will provide the self-insurer with the sample of claims. OIR will provide timeline for the results of the reperformance.
After OIR receives self-audit workpaper	OIR may request a subsample of claims for reperformance and validation of self-audit results.

6. Documentation standards

Under section 93 of the Act, the self-insurer must keep documents relating to all claims made and other documents that may assist in assessing the quality and timeliness of the claims and rehabilitation management.

The OIR will deem the self-insurer is not compliant with a standard where the self-insurer has not retained and provided sufficient and appropriate evidence of their performance.

7. Procedural fairness

The Performance Standards are designed to, where possible, provide a clear and objective way of assess a self-insurer's performance.

However, where a subjective assessment is required the OIR will document the evidence and professional judgment required to form conclusions about the self-insurer's performance. The OIR will document all findings and conclusions with sufficient and appropriate audit evidence to demonstrate to the self-insurer how it reached its conclusions.

To provide procedural fairness, the OIR will communicate findings and provide supporting evidence to the self-insurer for their feedback prior to finalising reports (refer **Appendix 2**).

8. Enforcement actions

The Regulator will determine appropriate enforcement actions for non-compliance or performance issues in accordance with the OIR's Compliance and Enforcement Policy and the Self-Insurer Performance and Compliance Framework.

Under that policy and framework, the severity of enforcement actions will depend on the nature of the audit findings. In deciding on the most appropriate action to take, the OIR will consider:

- the adverse effect, that is the extent of the risk, the seriousness of the breach and the actual or potential consequences;
- the culpability of the duty holder, that is, how far below acceptable standards the conduct falls and the extent to which the duty holder contributed to the risk;
- the compliance history and attitude of the duty holder;
- if it is a repeat offence or there is a likelihood of the offence being repeated;
- impact of enforcement on encouragement or deterrence; and

- any mitigating or aggravating circumstances, including efforts undertaken by the duty holder to control risks.

In cases of more serious breaches or performance issues, the Regulator will make the final decision about the nature of the enforcement action. The OIR's or the Regulator's actions may include:

- requiring a self-insurer to provide specific evidence of how they have addressed minor or isolated audit finding;
- requiring a self-insurer to develop and implement a performance management plan to rectify its performance issues;
- attaching new conditions to the self-insurer's licence; and
- requiring a self-insurer to show cause to keep their self-insurer licence.

Attachment 1 – Claims management standard (CM)

Claims management systems (CM-S)

These standards apply to aspects of a self-insurer's performance that can have a pervasive effect on the effectiveness and compliance of a self-insurer's claims management practices.

Requirement	Description	Legislative references
CM – S: 1 Self-insurer has a comprehensive claims management manual.	1-1 The claims manual or equivalent includes policies and procedures outlined in Appendix 1. 1-2 The claims manual is consistent with all aspects of the *Workers' Compensation and Rehabilitation Act 2003* and *Workers' Compensation and Rehabilitation Regulation 2014*, these standards and other guidance material issued by the OIR. 1-3 The self-insurer's claims manual addresses the impact of Queensland's historical legislation on current claims management. 1-4 The claims manual is reviewed at least every two years and after legislative changes.	
CM – S: 2 The self-insurer is appropriately resourced for claims management in Queensland	2-1 The self-insurer has an appropriate number of claim managers to effectively manage its peak volume of claims and to backfill in the event of short terms absences or departures with minimal disruption.	
CM – S: 3 Claims management personnel are appropriately	3-1 A more senior claims officer supervises the actions of a new claims manager on all claims until the earlier of managing 20 claims or three months experience with the self-insurer.	

Requirement	Description	Legislative references
skilled and trained for workers' compensation	3-2 New claims team personnel undertake mandatory induction training including training in the self-insurer's claims manual. 3-3 Claims management personnel hold relevant claims management qualifications or demonstrable experience prior to independently managing claims. 3-4 The self-insurer maintains a training log to demonstrate claims management personnel participate in relevant ongoing training and professional development. 3-5 The self-insurer maintains a register of claims management personnel registered with OIR that have decision-making responsibility in administering claims.	
CM – S: 4 Claims management service providers are appropriately engaged and monitored to ensure appropriate claims management practices.	4-1 The self-insurer has a tailored service level agreement in place with claims management service provider. 4-2 The self-insurer's service level agreement and contract with the service provider establishes appropriate performance and accountability measures over claim management, which are consistent with a beneficial approach to the objects of the Act. 4-3 The self-insurer retains evidence showing all claims management personnel at the service provider are appropriately skilled and trained per CM – S: 2. 4-4 The self-insurer has documented procedures on how it will monitor the service provider's compliance with legislation and OIR guidelines. 4-5 The self-insurer retains evidence of its regular monitoring over the service provider's performance.	

Requirement	Description	Legislative references
	4-6 The self-insurer has documented evidence of regular meetings with the service-provider to discuss current claims.	
CM – S: 5 The self-insurer's use of an early intervention program(s) is appropriately managed	5-1 The self-insurer has documented policies to guide the appropriate use of its early-intervention program(s). 5-2 The employer notifies the self-insurer and provides access to complete records of all workers treated in an early intervention program(s) and treatment provided. 5-3 The self-insurer retains all correspondence, treatment and payments related to an injury that is treated in an early intervention program. 5-4 The self-insurer retains evidence of advice to injured workers treated through an early intervention program, informing them of their rights and the process to lodge a claim for compensation.	
CM – S: 6 The self-insurer effectively informs the claimant about how it will access and use the claimant's medical information.	6-1 The self-insurer's forms and / or factsheets inform the claimant of the type of medical information requests the self-insurer may make and that the authority to request medical information will last for the duration of the claim or until the claimant revokes the authority. 6-2 The self-insurer's forms and / or factsheets inform the claimant about their right to revoke the self-insurer's authorisation to access medical information at any time. 6-3 The self-insurer forms and / or factsheets inform the claimant that the self-insurer cannot provide information it obtains as the self-insurer to the worker's employer for purposes related to the worker's employment.	Section 572A - *Workers' Compensation and Rehabilitation Act 2003*
CM – S: 7 The self-insurer has established appropriate	7-1 The self-insurer has established appropriate principles for managing psychological claims **Appendix 3**.	

Requirement	Description	Legislative references
principles for the management of psychological claims.		
CM – S: 8 The self-insurer has established appropriate principles to guide its litigation practices in common law claims.	8-1 The self-insurer has established appropriate principles to guide its litigation practices in common law claims which, at a minimum, reflect the standards in **Appendix 4**.	

Management of statutory claims (CM – C)

These standards apply to the self-insurer's management of individual claims to determine liability and make compensation payments.

Requirement	Description	Legislative reference
CM – C: 1 The self-insurer lodged and intimated applications for compensation in a timely manner.	1-1 The self-insurer intimated a claimant's application for worker's compensation made in the approved form within two business days of receiving and lodging the application. Approved form means the application: • used an approved application for compensation form. • was accompanied by a certificate in the approved form.	Section 132 - *Workers' Compensation and Rehabilitation Act 2003* Regulation 102 - *Workers' Compensation and Rehabilitation Regulation 2014*
CM – C: 2 The self-insurer has provided appropriate and accurate advice to its workers.	2-1 The self-insurer made information and documentation freely available and readily accessible to workers and other stakeholders regarding workers' compensation entitlements and claims lodgement processes. 2-2 The self-insurer provided timely and accurate advice to a potential claimant about how to lodge an application for worker's compensation in the approved form.	

Requirement	Description	Legislative reference
CM – C: 3 The self-insurer has made timely decisions on applications for compensation.	3-1 The self-insurer decided to allow or reject the application within 20 business days of • lodging the application for compensation; or • the claimant applying to reopen a claim. 3-2 The self-insurer was proactive in obtaining the evidence required to decide on a claim as soon as possible. 3-3 The self-insurer decided on a claim when, on the balance of probabilities, they had reasonable evidence to determine liability.	Section 134 - *Workers' Compensation and Rehabilitation Act 2003*
CM – C: 4 The self-insurer considered all relevant and obtainable evidence.	4-1 The self-insurer considered all relevant and obtainable evidence both adverse to and supportive of a claim before deciding on a claim. 4-2 Prior to deciding to reject or cease an application for compensation on medical grounds, the self-insurer requested and considered a report from the claimant's treating medical practitioner. 4-3 The self-insurer has considered and acted on new information regarding the injury type or any additional diagnoses linked to the work event.	
CM – C: 5 An appropriate person made the self-insurer's decision.	5-1 The self-insurer's claim decision was made by a person registered with the OIR. 5-2 In the case of an adverse decision, the proposed decision was reviewed by a more senior officer prior to issuing the decision. The more senior officer: • did not at any stage of the claim, undertake the role or functions of the claim manager. • is someone that is appropriately qualified to review the claim.	Section 538(2) - *Workers' Compensation and Rehabilitation Act 2003*

Requirement	Description	Legislative reference
CM – C: 6 The self-insurer appropriately communicated the decision to reject the application for compensation or cease benefits.	6-1 The self-insurer offered the claimant natural justice prior to deciding to reject their application for compensation or cease the entitlement to benefits (refer **Appendix 2**). 6-2 In a decided claim, the self-insurer has provided the claimant with written reasons for the decision and informed the claimant that they have the right to review the decision under the legislation. The written reasons must include: • the evidence considered for the decision • the evidence that was accepted or rejected for the decision and why the evidence was accepted or rejected • the conclusions drawn from the evidence • the link between the evidence, the conclusions and the relevant provision of the Act; and • the decision made. 6-3 The self-insurer gave the claimant reasonable notice prior to ceasing their entitlement to benefits.	Section 540(1)(b)&(c)(4) - *Workers' Compensation and Rehabilitation Act 2003* Regulation 148 - *Workers' Compensation and Rehabilitation Regulation 2014*
CM – C: 7 The self-insurer has notified the claimant where they failed to decide within 20 business days.	7-1 Where the self-insurer has failed to decide on a claim within 20 business days, the insurer notified the claimant of the reasons for not deciding within five business days of the decision deadline. 7-2 The self-insurer provided the claimant with written reasons for the failure to decide and informed the claimant in writing that • they have the right to review the failure to decide (section 540 of the Act); and • they have the right to request, in writing, a copy of the claim file. 7-3 The self-insurer's reasons for not deciding on the claim within 20 days are reasonable.	Section 134(6) - *Workers' Compensation and Rehabilitation Act 2003* Section 540(2) - *Workers' Compensation and Rehabilitation Act 2003* Section 148 - *Workers Compensation and*

Requirement	Description	Legislative reference
	"Reasonable" means a high-performing insurer could not reasonably have made decision before 20 days.	*Rehabilitation Regulation 2014*
CM – C: 8 The self-insurer's communication with the claimant's treating medical practitioners was authorised and appropriate	8-1 The self-insurer informed the claimant about the nature and purpose of medical information requests it would make. 8-2 The self-insurer confined questions to the claimant's treating medical practitioner(s) to matters that were medically and directly relevant to the current stage of the claim and for proactive case management. 8-3 The self-insurer provided the worker's treating medical practitioner(s) with a copy of any medical reports it obtained while managing the claim.	
CM – C: 9 The self-insurer's use of medical experts to conduct a file review or examination of the claimant was appropriate having regard to the worker's injury.	When obtaining a report on the claim from a medical expert: 9-1 The self-insurer engaged a registered medical expert with appropriate expertise and having regard the injury claimed in the application. 9-2 The self-insurer confined questions to matters that were medically and directly relevant to the current stage of the claim and for proactive case management. 9-3 The self-insurer provided the medical expert with an objective overview of the available and relevant evidence pertaining to the cause of the worker's injury and the extent of incapacity. 9-4 The self-insurers questions to the medical expert were concerned with establishing whether there was a link between the work-related event and the injury. 9-5 The self-insurer questions to the medical expert did not require the medical expert to make unreasonable assumptions or fill in gaps in the available evidence. 9-6 The self-insurer provided the medical expert with a copy of any relevant previous reports.	

Requirement	Description	Legislative reference
CM – C: 10 The self-insurer's requirement for a claimant to submit to a personal examination by a registered person was reasonable.	10-1 When requiring the claimant to submit to a medical examination, the self-insurer used a registered medical practitioner with appropriate expertise having regard to the injury. 10-2 The self-insurer arranged for the examination in a place that was reasonable and convenient for the injured worker. 10-3 The self-insurer advised the claimant of the following in writing: • the name of the examiner who is not employed by the insurer. • the day, time and place for the examination. • the doctor's field of speciality (if the doctor is a specialist). • the purpose of the examination. • that the examination was not related to treating of the claimed injury. 10-4 The self-insurer reimbursed reasonable travel and other expenses incurred by the claimant to attend the examination	Section 135(1) - *Workers' Compensation and Rehabilitation Act 2003* Section 106 - *Workers' Compensation and Rehabilitation Regulation 2014*
CM – C: 11 The self-insurer appropriately communicated all medical evidence to the claimant.	11-1 The self-insurer provided a copy of any medical reports it obtained to the claimant and the claimant's treating medical practitioner. 11-2 The self-insurer requested comments from the claimant's treating medical practitioner on any medical reports it obtained.	
CM – C: 12 The self-insurer appropriately implemented and communicated OIR review decisions.	12-1 The self-insurer actioned all instructions in an OIR review decision within five business days. 12-2 If it was unable to comply with a review decision, the self-insurer notified the OIR of the reasons why within five business days of receiving the decision.	

Requirement	Description	Legislative reference
	12-3 The self-insurer communicated the outcome of a review decision to the claimant within two business days of receiving the decision from the OIR.	
CM – C: 13 The self-insurer made an appropriate referral to the medical assessment tribunal	13-1 The self-insurer notified the claimant that they were unable to decide and that they were referring the matter to the medical assessment tribunal. 13-2 The self-insurer referred the decision to the medical assessment tribunal within five days of notifying the claimant. 13-3 The self-insurer attached the current (< six months old) and relevant specialist reports with conflicting medical evidence to the file prior to referral to the medical assessment tribunal.	
CM – C: 14 The self-insurer appropriately and proactively managed claims involving National Injury Insurance Scheme Queensland (NIISQ)	14-1 The self-insurer initiated early contact with NIISQ to determine whether the worker's injury was eligible for NIISQ by either: • making its own decision on eligibility; or • referring the decision on eligibility to NIISQ. 14-2 The self-insurer documented a reasonable decision on the workers' eligibility. 14-3 If the self-insurer determined that the worker was an eligible worker, the self-insurer referred the worker's claim to NIISQ.	

Management of common law claims (CM – CL)

These standards apply to the self-insurer's management of individual claims where the claimant has lodged a notice of claim for damages on a claim that ceased up to and including 30 October 2019.

Requirement	Description	Legislative reference
CM – CL: 1 The self-insurer has appropriately referred a	1-1 Where the injured worker lodged a notice of claim for damages, the self-insurer referred the worker to its accredited return to work program.	Section 220(2) - *Workers' Compensation*

Requirement	Description	Legislative reference
worker to their accredited rehabilitation and return to work program	1-2 Where the self-insurer did not refer the claimant to its accredited return to work program, it has clearly documented why the injury would prevent the worker from participating.	*and Rehabilitation Act 2003*

Management of claims that include an assessment of permanent impairment (CM – PI)

These standards apply to the self-insurer's management of individual claims where the worker may have suffered a permanent impairment.

Requirement	Description	Legislative reference
CM – PI: 1 The self-insurer appropriately arranged for an assessment of permanent impairment.	1-1 Except when requested by the claimant, the self-insurer only arranged an assessment of permanent impairment when it reasonably believed the worker's injury was stable and stationary. 1-2 The self-insurer referred the claimant to an assessor that was appropriately trained in, and with access to, the applicable guidelines for evaluation of permanent impairment for the date of the injury. 1-3 The self-insurer used a registered medical practitioner with relevant and appropriate expertise having regard to the injury being assessed for permanent impairment. 1-4 For a psychiatric or psychological injury, the self-insurer arranged for an assessment of permanent impairment by the Medical Assessment Tribunal. 1-5 Where the claimant requested a second permanent impairment assessment, within 10 business days the self-insurer decided to: • arrange for a second assessment of permanent impairment; or • refer the question of degree of permanent impairment to the medical assessment tribunal for decision.	Section 38 - *Workers' Compensation and Rehabilitation Act 2003* Section 179 - *Workers' Compensation and Rehabilitation Act 2003* Section 179(2)(b) - *Workers' Compensation and Rehabilitation Act 2003* Section 186(3) - *Workers' Compensation and Rehabilitation Act 2003*

Requirement	Description	Legislative reference
	1-6 If the self-insurer decided not to agree to a second assessment of permanent impairment requested by the worker (refer 1-5), it provided the worker with written reasons for the decision.	
CM – PI: 2 The self-insurer gave the claimant an appropriate notice of assessment of the injured worker's degree of permanent impairment.	2-1 The self-insurer, within 10 days of receiving the assessment of the worker's permanent impairment, gave the worker a notice of assessment. 2-2 The self-insurer's notice of assessment of DPI included the following information: • where the assessment of DPI was not performed by the Medical Assessment Tribunal, that the claimant may agree or disagree with the assessment. • the ability to have a second impairment assessment of DPI under s186(2)(b)(i) of the Act. • if the notice of assessment follows a medical assessment tribunal determination, there is no opportunity to agree or disagree. 2-3 The self-insurer's notice of assessment of DPI included the assessment of all the workers' injuries. 2-4 The diagnosed injuries listed in the notice of assessment matched the doctor's diagnosis in their assessment of permanent impairment report.	Section 185 - *Workers' Compensation and Rehabilitation Act 2003*
CM – PI: 3 The self-insurer gave the claimant an appropriate offer of lump sum compensation in the notice of assessment.	3-1 When issuing a notice of assessment where there is no degree of permanent impairment, the self-insurer did not make an offer of lump sum compensation. 3-2 If the worker has an entitlement to lump sum compensation, the insurer included in the notice of assessment an offer of lump sum compensation accurately calculated in accordance with the regulation. 3-3 When issuing a notice of assessment for **less than** 20 per cent degree of permanent impairment, the self-insurer included the following information: • a copy of sections 10, 237(3), 239, 240 and 316 of the Act.	Section 187 - *Workers' Compensation and Rehabilitation Act 2003* Regulation 108 - Workers' Compensation and Rehabilitation Regulation 2014

Requirement	Description	Legislative reference
	• if an offer of lump sum compensation is made, that the claimant may accept, reject or defer the offer. • that the worker must make an irrevocable election as to whether the worker accepts the offer of payment or seeks damages for the injury. 3-4 When issuing a notice of assessment, the self-insurer informed the worker of all additional lump sum amounts the worker is or may be entitled to resulting from their assessed DPI and diagnosis. 3-5 The self-insurer provided the claimant with a separate offer for each entitlement to additional lump sum compensation.	Section 189 - *Workers' Compensation and Rehabilitation Act 2003*
CM – PI: 4 The self-insurer appropriately assessed and offered the worker any entitlement to lump sum compensation for gratuitous care.	4-1 Where an injury results in a DPI of 15 per cent or more, the self-insurer arranged for a registered occupational therapist to assess the worker's level of dependency resulting from the impairment. 4-2 The self-insurer informed the worker of their right to disagree with the level of dependency assessed and to refer the matter to the General Medical Assessment Tribunal for decision.	Section 193(4)(7) - *Workers' Compensation and Rehabilitation Act 2003*
CM – PI: 5 For a claim relating to a worker with a diagnosis of pneumoconiosis, the self-insurer has appropriately arranged for the worker's assessment.	5-1 For a worker that may have pneumoconiosis, the self-insurer arranged for an assessment of the worker's pneumoconiosis score in accordance with schedule 4B of the regulation. 5-2 For a worker that has pneumoconiosis, where requested by the worker, the self-insurer arranged to have the injury further assessed to determine whether the level of permanent impairment from the injury has increased.	Division 5 - *Workers' Compensation and Rehabilitation Act 2003* Schedule 4C - *Workers' Compensation and Rehabilitation Regulation 2014*

Management of payments on individual claims (CM – Pay)

These standards apply to the self-insurer's management of individual claims where they are required to make compensation payments.

Requirement	Description	Legislative reference
CM – Pay: 1 For a time-loss claim, the self-insurer has accurately calculated the employee's entitlement to weekly compensation.	1-1 The self-insurer accurately calculated the worker's average normal weekly earnings. 1-2 The self-insurer accurately calculated the applicable compensation payable for each period of incapacity. 1-3 The self-insurer paid weekly compensation from the date the worker's entitlement to payments arose, being the latter of: • the day the worker saw a doctor, nurse practitioner or dentist; or • 20 days prior to the claimant lodging their application for compensation 1-4 The self-insurer informed the claimant of their right to review the self-insurer's decision on the value of weekly compensation payments.	Section 150 - 153 - *Workers' Compensation and Rehabilitation Act 2003* Section 141 - *Workers' Compensation and Rehabilitation Act 2003* Section 131(2) – *Workers' Compensation and Rehabilitation Act 2003* Section 540(1)(b)(iiia) – *Workers' Compensation and Rehabilitation Act 2003*
CM – Pay: 2 The self-insurer paid workers' compensation in a timely manner.	2-1 The self-insurer made payments of initial weekly benefits within five business days of accepting the claim, or on the next pay run date for a worker in ongoing employment. 2-2 The self-insurer reimbursed medical and other reasonable expenses within five business days of accepting the claim, or on the next pay run date for a worker in ongoing employment. 2-3 The self-insurer paid accurate lump sum compensation in a timely manner after receipt of claimant advice of acceptance on a PI offer or confirmation of a person's entitlement to compensation.	

<table>
<tr>
<td>CM – Pay: 3

For an entitlement to additional lump-sum compensation, the self-insurer has accurately calculated and paid the right amount of compensation.</td>
<td>3-1 The self-insurer paid the correct additional lump sum compensation per the Act and the “Table of benefits” for workers with:
a DPI of 30 per cent or more from a physical injury; or
a DPI of 15 per cent or more from a physical injury and an entitlement to lump sum compensation for gratuitous care; or
an injury that is pneumoconiosis.</td>
<td>Section 192 - 193 – Workers’ Compensation and Rehabilitation Act 2003</td>
</tr>
<tr>
<td>CM – Pay: 4

If a worker dies because of a work-related injury, the self-insurer has accurately calculated and paid all entitlements per Part 11 of the Act.</td>
<td>4-1 The self-insurer paid the applicable compensation to the appropriate recipient

<table>
<tr><th>Payment type</th><th>Payment to</th></tr>
<tr><td colspan="2">If the worker had a personal legal representative…</td></tr>
<tr><td>All compensation payments</td><td>The worker’s personal legal representative</td></tr>
<tr><td colspan="2">If the worker did not have a personal legal representative…</td></tr>
<tr><td>Expenses</td><td>To the person(s) that incurred the expenses.</td></tr>
<tr><td>Compensation</td><td>To the persons with an entitlement to compensation.</td></tr>
</table>

4-2 The self-insurer paid reasonable expenses for
the medical treatment of, or attendance on, the worker.
The worker’s funeral.
4-3 The self-insurer accurately calculated and paid compensation per the “Table of benefits” to:
Persons that were totally or partially dependent on the worker’s income; or
A spouse, issue or next of kin entitled to compensation where there were no total or partially dependent persons; or
The worker’s parents where the worker was under 21.</td>
<td>Section 196 – Workers’ Compensation and Rehabilitation Act 2003

Section 199 – Workers’ Compensation and Rehabilitation Act 2003

Section 200-202 – Workers’ Compensation and Rehabilitation Act 2003</td>
</tr>
</table>

CM – Pay: 5 The self-insurer paid all reasonable costs of rehabilitation.	5-1 In an accepted claim, the self-insurer responded to the claimant's requests to approve funding of additional rehabilitation treatment in a timely manner. 5-2 The self-insurer paid all reasonable fees or costs for rehabilitation of the injured worker in a timely manner until the worker's entitlement to compensation stopped. 5-3 After ceasing a claim, the self-insurer paid for the worker to complete any existing pre-approved injury management plan(s).	Section 222 – *Workers' Compensation and Rehabilitation Act 2003*

Attachment 2 – Rehabilitation and return to work standard (RRTW)

Self-Insurer's responsibilities for rehabilitation and return to work (RRTW – I)

Requirement	Description	Legislative reference
RRTWC – I: 1 The self-insurer has an accredited return to work program.	1-1 The self-insurer has an accredited Return to Work Program.	Section 220 – *Workers' Compensation and Rehabilitation Act 2003*
RRTWC – I: 2 The self-insurer has appropriate resources for rehabilitation and return to work.	2-1 The self-insurer has adequate appropriately trained resources, based in Queensland, to coordinate the development and maintenance of the rehabilitation and return to work plan for injured workers.	Section 220 – *Workers' Compensation and Rehabilitation Act 2003*

Employer's responsibilities for rehabilitation and return to work (RRTW – E)

Requirement	Description	Legislative reference
RRTW – E: 1 The employer has appropriate rehabilitation and return to work policies and procedures.	1-1 Employer has published workplace rehabilitation policies and procedures. 1-2 The employer has reviewed their workplace rehabilitation policy and procedures within the last 3 years.	Section 227(2) - *Workers' Compensation and Rehabilitation Act 2003*
RRTW – E: 2 The employer has appropriate resources for rehabilitation and return.	2-1 The employer has appointed appropriately qualified rehabilitation and return to work coordinator(s) in Queensland.	Section 226 - *Workers' Compensation and Rehabilitation Act 2003* Section 115 - *Workers' Compensation and*

		Rehabilitation Regulation 2014
RRTW – E: 3 The employer has a standard worker authority form which appropriately restricts the access and use of the worker's medical information.	3-1 The employer's worker authority form outlines reasonable restrictions on the rehabilitation and return to work coordinator's access to, and use of, medical information, including: • the person(s) and positions within the self-insurer that will be able to access the medical information • how the information will be used • the scope of medical information the medical provider	

Management of rehabilitation and return to work on individual claims (RRTW - C)

Requirement	Description	Legislative reference
RRTW – C: 1 The self-insurer has coordinated the development of a rehabilitation and return to work plan.	1-1 The self-insurer has taken the steps it considers practicable to coordinate the development and maintenance of a rehabilitation and return to work plan in consultation with the injured worker, the worker's employer and treating registered persons. A rehabilitation and return to work plan usually includes • clear and appropriate objectives with considerations of how these objectives will be achieved; • details of rehabilitation activities required to meet the objectives; • time frames for expected stages of recovery and return to work opportunities; • when and by who reviews will be undertaken to assess the injured worker's progress; • how and when relevant parties will be informed of progress; and • if a suitable duties program or a return to the previous role is planned, how this will be achieved at the workplace and how the worker and employer will be advised	Section 220(3) - *Workers' Compensation and Rehabilitation Act 2003*
RRTW – C: 2	2-1 The rehabilitation and return to work coordinator: • initiated early communication with the injured worker to clarify nature and severity of injury; and	Section 226 - *Workers' Compensation and Rehabilitation Act 2003*

The rehabilitation and return to work coordinator proactively engaged with the worker on their rehabilitation and return to work.	• provided overall coordination of the workers' return to work. 2-2 The self-insurer and rehabilitation and return to work coordinator tailored their return to work services to the injured worker. This may include considering, offering or arranging activities such as: • vocational assessments • functional capacity evaluations • vocational counselling • transferable skills assessments • job placement services • suitable duties plans • host placement • assistance with sourcing alternative employment; and • reskilling or retraining	Section 114 - *Workers Compensation and Rehabilitation Regulation* 2014
RRTW – C: 3 The rehabilitation and return to work coordinator developed and implemented suitable duties plans where recommended by the worker's treating medical practitioner.	3-1 Where recommended by the worker's treating medical practitioner, the employer's rehabilitation and return to work coordinator developed a suitable duties program in consultation with the: • injured worker; • employer; and • treating registered persons. 3-2 The suitable duties program covered all periods of the worker's partial incapacity. 3-3 The suitable duties program was consistent with the recommended restrictions in the worker's corresponding medical certificate or report.	Section 114 - *Workers' Compensation and Rehabilitation Regulation 2014*
RRTW – C: 4 The rehabilitation and return to work coordinator has appropriately controlled the use of the worker's medical information.	4-1 The rehabilitation and return to work coordinator obtained the worker's signed authority on the standard form prior to contacting the workers' treating doctor 4-2 The rehabilitation and return to work coordinator and the employer only used the workers' medical information for the purpose of aiding the workers' rehabilitation and return to work.	

RRTW – C: 5 The rehabilitation and return to work coordinator kept detailed notes on the worker's rehabilitation.	5-1 The rehabilitation and return to work coordinator maintained accurate, concise and objective case notes on the worker's rehabilitation.	
RRTW – C: 6 The self-insurer and the employer provided meaningful work opportunities.	6-1 The self-insurer and the employer provided the worker with the return to work options that would lead to the most favourable long-term outcome possible for the worker, i.e. the worker attaining the capacity for a durable return to work. 6-2 The self-insurer offered the worker the opportunity to raise concerns about their rehabilitation and return to work and acted on the worker's feedback. 6-3 When ceasing or finalising the worker's claim, the self-insurer documented the outcomes of the workers' rehabilitation and any additional planned rehabilitation activities. The insurer also summarised the worker's prospects for returning to work.	

Attachment 3 – Other - information and communication standard (IC)

Other information systems (IC – S)

Requirement	Description	Legislative reference
IC – S: 1 The self-insurer has appropriate privacy policies and procedures in place.	1-1 Self-Insurer has a comprehensive and current privacy policy in place that complies with the requirements of the Act and the *Information Privacy Act 2009*. 1-2 The self-insurer stores workers' compensation files, including archived files, both computerised and physical, in secure facilities separate from other personnel files.	
IC – S: 2 The self-insurer has implemented an appropriate complaint handling process	2-1 The self-insurer published policies and procedures for receiving and handling complaints from claimants and workers' regarding workers compensation practices. 2-2 The self-insurer maintains a register of complaints received from workers and claimants and records all subsequent actions and communication with the complainant.	

Other information and communication on individual claims (IC – C)

Requirement	Description	Legislative reference
IC – C: 1 The self-insurer maintained regular communication with the claimant throughout the claim.	1-1 The self-insurer claims manager maintained regular communication with the claimant until finalisation of the claim.	
IC – C: 2	2-1 The information on the self-insurer's claim file is consistent with data submitted to the OIR.	Section 75(2)(d) - *Workers' Compensation*

The self-insurer provided accurate information to the OIR.		*and Rehabilitation Act 2003*
IC – C: 3 The self-insurer responded promptly and accurately to the claimant's request for documentation.	3-1 The self-insurer provided the claimant with a copy of requested documents within 20 business days after the request.	Section 572(2) - *Workers' Compensation and Rehabilitation Act 2003*
IC – C: 4 The self-insurer maintained appropriate separation from the employer on workers' compensation matters.	4-1 The self-insurer did not provide any workers' compensation documents to the claimant's employer for a purpose relating to the worker's employment. 4-2 The self-insurer documented its justification for providing information to the employer where it reasonably believed it was: • in the claimant's best interest; and / or • necessary to ensure workplace health and safety. 4-3 The self-insurer acted in accordance with its privacy policy and all relevant legislation in the way it provided the workers' compensation information. 4-4 The self-insurer provided the employer with information about its privacy obligations under the Act and relevant privacy legislation when it provided the information. 4-5 The employer did not dismiss the worker solely or mainly because of their injury within 12 months of the injury.	Section 572A(1) - *Workers' Compensation and Rehabilitation Act 2003* Section 232B(1) - *Workers' Compensation and Rehabilitation Act 2003*

Appendix 1: Claims management manual

Claims management manual should include:

- roles and responsibilities including amongst claims staff, the self-insurer and the employer
- decision-making process and providing procedural fairness
- minimum standards for communication with claimants (e.g. regularity of updates on long-term undecided claims)
- payment of claims
- liability for treatment and other expenses
- advising claimants of their rights and responsibilities including their right to review
- obtaining medical reports and opinions
- ongoing management of claims
- permanent impairment and lump sum compensation
- claims for injuries such as industrial deafness, fatal claims and psychiatric and psychological disorders
- journey and recess claims
- accredited return to work program
- rehabilitation and return to work including referral to internal or external rehabilitation providers
- rehabilitation and return to work including when to access vocational assessments, reskilling or retraining, job placement and host employment services
- damages claim
- reviews and appeals
- complaints handling
- privacy, release of information, confidentiality
- fraud identification
- record keeping and documentation (including evidence for all individual cases)
- quality management and improvement
- references to historical legislation where applicable for any of the above list.

Appendix 2: Procedural Fairness

The Queensland Ombudsman provides the following points about providing procedural fairness.

- Procedural fairness is about providing a person who might be adversely affected by a decision a 'fair hearing' before the decision is made.
- Generally, a fair hearing involves disclosure, a reasonable opportunity to respond and impartiality.
- The affected person should be notified of the key issues and given enough information to participate meaningfully in the decision-making process. Reasonable steps should be taken to notify the affected person.
- The affected person should be given a reasonable opportunity and time to respond. The decision-maker should genuinely consider the affected person's submission in making their decision.
- The decision-maker should be seen to be impartial and open to persuasion on the information and arguments presented.
- Check that you have provided a fair hearing to anyone who may be affected by the decision.
- To address any concerns regarding the effect on decision time frames in adopting procedural fairness practices, it is recommended that when inviting the person to make a submission including any further evidence which supports their position in relation to the proposed decision that an appropriate time frame be given in which to reply.

Appendix 3: Principles for self-insurer's behaviour in psychological claims

Best practice principles in management of psychological claims

During claim determination, the self-insurer:

- Engages with the worker in a proactive, positive and supportive manner.
- Provides the claimant and employer with clear information about the claim determination process.
- Describes the roles of the self-insurer, employer and other parties involved in the claim and clearly explains internal and external dispute resolution processes.

Where the self-insurer disputes liability, the self-insurer:

- Expedites dispute resolution processes for psychological injury claims.
- Continues to engage with the claimant and employer during the dispute resolution process.
- Encourages the employer to continue to pursue opportunities for return to work.

During claim management, the self-insurer:

- Uses systems and processes that support provision of early access to treatment for psychological injuries.
- Ensures the claimant and employer understand the process and likely time frames for managing the claim.
- Supports the employer to actively engage in the claimant's return to work.
- Assesses the recovery time in consultation with the worker and employer in a non-threatening and non-directive manner.
- Engages with employers to review work systems and psychosocial hazards which may cause aggravation of injury, based on insights gained through claim management.
- Acknowledges that clinical improvement does not always translate to work capacity and sensitively identifies and addresses the major barriers to return to work.

Source: *Principles adapted from SafeWork Australia's: A best practice framework for the management of psychological claims in the Australian workers' compensation sector*

Appendix 4: Principles for self-insurer's behaviour in common law claims

The self-insurer's standards on their behaviour in common law claims must include, at a minimum, the following principles:

Fairness:

- Acting consistently in the handling common law claims
- Dealing with common law claims promptly and not causing unnecessary delay in the handling of common law claims
- Endeavouring to avoid, prevent and limit the scope of legal proceedings wherever possible. This includes giving consideration in all common law claims to alternative dispute resolution before initiating legal proceedings and participating in alternative dispute resolution processes where appropriate.
- Where it is not possible to avoid litigation, keeping the costs of litigation to a minimum.
- Paying legitimate claims without litigation, including making partial settlements of claims, or interim payments, where the self-insurer's established liability is at least as much as the amount it would pay.
- Not seeking to take advantage of the impecunious opponent.
- Not contesting matters which it accepts as correct, by:
    - not requiring a claimant to prove a matter it knows to be true; and
    - not contesting liability if it knows the dispute is really about quantum.
- Not instituting and pursuing appeals unless it believes that it has reasonable prospects for success.

Firmness:

- Not seeking to take advantage of an impecunious opponent

Alternative dispute resolution

- The self-insurer only to start court proceedings if it has considered other methods of dispute resolution (for example, alternative dispute resolution or settlement negotiations)
- When participating in alternative dispute resolution, the self-insurer must ensure that its representatives
    - Participate fully and effectively; and
    - Have authority to settle the matter to facilitate appropriate and timely resolution of a dispute.

Source: *Principles adapted from the Queensland Government's Model Litigant Principles.*