Queensland

Workers' Compensation and Rehabilitation Act 2003

WORKERS' COMPENSATION AND REHABILITATION REGULATION 2003

Reprinted as in force on 1 July 2004
(includes commenced amendments up to 2004 SL No. 74)

Reprint No. 1A

This reprint is prepared by
the Office of the Queensland Parliamentary Counsel

Information about this reprint

This regulation is reprinted as at 1 July 2004. The reprint shows the law as amended by all amendments that commenced on or before that day (Reprints Act 1992 s 5(c)).

The reprint includes a reference to the law by which each amendment was made—see list of legislation and list of annotations in endnotes. Also see list of legislation for any uncommenced amendments.

This page is specific to this reprint. See previous reprints for information about earlier changes made under the Reprints Act 1992. A table of reprints is included in the endnotes.

Also see endnotes for information about—

- **when provisions commenced**
- **editorial changes made in earlier reprints.**

Dates shown on reprints

Reprints dated at last amendment All reprints produced on or after 1 July 2002, hard copy and electronic, are dated as at the last date of amendment. Previously reprints were dated as at the date of publication. If a hard copy reprint is dated earlier than an electronic version published before 1 July 2002, it means the legislation was not further amended and the reprint date is the commencement of the last amendment.

If the date of a hard copy reprint is the same as the date shown for an electronic version previously published, it merely means that the electronic version was published before the hard copy version. Also, any revised edition of the previously published electronic version will have the same date as that version.

Replacement reprint date If the date of a hard copy reprint is the same as the date shown on another hard copy reprint it means that one is the replacement of the other.

Queensland

WORKERS' COMPENSATION AND REHABILITATION REGULATION 2003

TABLE OF PROVISIONS

WORKERS' COMPENSATION AND REHABILITATION REGULATION 2003

[as amended by all amendments that commenced on or before 1 July 2004]

PART 1—PRELIMINARY

1 Short title

This regulation may be cited as the *Workers' Compensation and Rehabilitation Regulation 2003*.

2 Commencement

This regulation commences on 1 July 2003.

3 Definitions

In this regulation—

"actuarial standard" means 'Professional Standard 300—Actuarial reports and advice on outstanding claims in general insurance' issued by the Institute of Actuaries of Australia (ACN 000 423 656).[1]

"actuary" means an actuary approved by the Authority.

"AMA guide" means the 'Guides to the Evaluation of Permanent Impairment' published by the American Medical Association.

"arbiter" means the actuarial arbiter appointed under section 77.

"AS/NZS" means a standard published jointly by Standards Australia and Standards New Zealand.

"assessed premium", for an employer, means premium calculated using the employer's wages for a period of insurance.

---

1 A copy of the standard may be inspected at the Authority's office at 30 Makerston Street, Brisbane.

"binaural tables" means the binaural tables recommended and published by Hearing Australia.

"central estimate" has the meaning given by the actuarial standard, section 10.

"claim", for part 4, means—

(a) an application for compensation; or

(b) a claim for damages.

"estimated claims liability" has the same meaning as in section 84(6) of the Act.

"financial quarter" means a period of 3 months beginning on 1 January, 1 April, 1 July or 1 October.

"further premium", for an employer, means an amount, other than assessed premium or provisional premium, payable by an employer to WorkCover under the Act, and includes the following—

(a) arrears of premium;

(b) additional premium under section 9(4);

(c) interest on premium under section 11(2);

(d) an amount of unpaid premium or a payment or penalty payable under section 57(2)[2] of the Act;

(e) additional premium for late payment under section 61 or 62[3] of the Act;

(f) additional premium under section 63[4] of the Act;

(g) an amount payable under section 67[5] of the Act.

"hearing loss tables" means the hearing loss tables recommended and published by Hearing Australia.

---

2 Section 57 (Recovery of compensation and unpaid premium) of the Act

3 Section 61 (Additional premium payable if premium not paid) or 62 (Further additional premium payable after appeal to industrial magistrate) of the Act

4 Section 63 (Additional premium for out-of-State workers) of the Act

5 Section 67 (Employer may insure against payment for excess period) of the Act

"household worker" means a person employed solely in and about, or in connection with, a private dwelling house or the grounds of the dwelling house.

"lower extremity" see AMA guide.[6]

"modified barthel index" means the guidelines and modified scoring of the barthel index stated in the article 'Improving the Sensitivity of the Barthel Index for Stroke Rehabilitation' by S Shah, F Vanclay and B Cooper published in the Journal of Clinical Epidemiology, 1989, vol 42 no 8, pp 703-709.

"ophthalmologists guide" means the publication 'A Guide to Members of the Australian and New Zealand College of Ophthalmologists' published by the Australian College of Ophthalmologists.

"premium" includes assessed premium, provisional premium and further premium.

"presbycusis correction table" means the presbycusis correction table recommended and published by Hearing Australia.

"provisional premium", for an employer, means premium calculated using a reasonable estimate of wages for a period of insurance.

"prudential margin" has the meaning given by the actuarial standard, section 12.

"risk free rate of return" has the meaning given by the actuarial standard, section 13.

"upper extremity" see AMA guide.[7]

4 Authority's trading name—Act, s 328

For section 328 of the Act, Q-COMP is prescribed as the Authority's trading name.

6 Under the AMA guide, the lower extremity has 6 sections, namely, the foot, the hindfoot, the ankle, the leg, the knee and the hip.

7 Under the AMA guide, the upper extremity has 4 parts, namely, the hand, the wrist, the elbow and the shoulder.

5 WorkCover's solvency—Act, s 453

(1) The extra solvency requirement prescribed for section 453(1)(c) of the Act is 5%.

(2) To remove any doubt, the amount required under subsection (1) is in addition to the minimum solvency requirement under section 453(1)(b) of the Act.

PART 2—EMPLOYER INSURANCE

Division 1—Policies and premium assessments

6 Application for policy

An application for a policy must be made to WorkCover in the approved form.

7 Policies and renewals

(1) On payment of the premium shown as payable in a premium notice issued by WorkCover to an employer, WorkCover must issue to the employer a policy, in the approved form, for the period of insurance stated in the notice.

(2) A policy has no force or effect until—

(a) WorkCover receives the premium payable to WorkCover for the policy or its renewal; or

(b) WorkCover enters into an instalment plan for the policy under section 11.[8]

8 Assessment of premium

(1) This section does not apply to a policy for household workers.

8 Section 11 (Payment of premium by instalments)

(2) WorkCover must assess premium payable under a policy for each period of insurance shown in a premium notice.

(3) The following formula must be used to calculate premium—

$$P = AP - PPP + PP + FP$$

(4) However, if the policy relates to a government worker covered under an arrangement approved by WorkCover, WorkCover may assess premium at the rate decided by WorkCover after taking actuarial advice.

(5) For a period of insurance before 1 July 2003, an assessment of premium must be made in accordance with the provisions of a former Act in force at the time of the relevant period of insurance.

(6) If, after the premium is assessed, WorkCover is satisfied that premium for the period has been overpaid, WorkCover must refund or credit the amount of overpayment to the employer to whom the premium notice is given.

(7) If, after the premium is assessed, WorkCover is satisfied that premium for the period has been underpaid, the employer to whom the premium notice is given must pay the premium as assessed.

(8) The premium for a policy assessed under this section may be increased to take account of the following—

(a) GST payable for the supply of the policy;

(b) duty payable under the *Duties Act 2001* for the policy.

(9) In this section—

"AP" means assessed premium for the preceding period of insurance.

"FP" means further premium.

"government worker" means a worker employed by a government entity.

"P" means the premium payable.

"PP" means provisional premium for the period of insurance.

"PPP" means provisional premium for the preceding period of insurance.

9 Declaration of wages

(1) This section does not apply to an employer who employs only household workers.

(2) Each employer, other than a self-insurer, must, on or before 31 August in each year, lodge with WorkCover a declaration of wages so WorkCover can assess the employer's premium.

(3) The declaration must be in—

(a) the approved form; or

(b) with WorkCover's approval—another form acceptable to WorkCover.

(4) If an employer does not comply with subsection (2), the employer must pay an additional premium under schedule 1.

(5) The additional premium payable under schedule 1 is the amount specified opposite the time after 31 August in a year when the employer complies with subsection (2).

10 Value of board and lodging

(1) This section applies if an employer provides, or is to provide, board to a worker during a period of insurance.

(2) The value of board provided is taken to be wages paid, or to be paid, by the employer to the worker.

(3) For each week the employer provides, or is to provide board, the value of board is not less than—

(a) the weekly allowance for board provided for under the industrial instrument governing the calling in which the worker is engaged; or

(b) if paragraph (a) does not apply—6% of QOTE.

(4) In this section—

"board" means accommodation, meals, laundry services or any other entitlement having a monetary value provided when lodging.

11 Payment of premium by instalments

(1) WorkCover may accept payment of premium by instalments under an instalment plan approved by WorkCover if WorkCover is satisfied that payment of premium by the due date would impose financial hardship on the employer.

(2) The instalment plan is subject to the following conditions—

(a) interest at a rate specified by WorkCover's board by industrial gazette notice must be added to the amount of each instalment;

(b) interest must be calculated from the due date;

(c) the interest rate that applies at the start of the instalment plan remains constant until the plan ends;

(d) on acceptance of the instalment plan, the employer must, if required by WorkCover, enter into a payment arrangement acceptable to WorkCover;

(e) if an instalment of premium is not paid on or before the due date for payment of the instalment—

(i) the total amount of unpaid instalments and interest on outstanding instalments to that day immediately becomes payable to WorkCover; and

(ii) additional premium under section 12 applies to the unpaid instalments and interest; and

(iii) the policy for which the premium is payable ceases to have effect; and

(iv) the employer contravenes section 48[9] of the Act.

12 Additional premium for late payment of premium—Act, ss 61 and 62

(1) This section applies if, on or before the due date, an employer does not pay—

(a) the amount of premium payable under a premium notice; or

(b) the amount by which a final assessment of premium by an industrial magistrate or the Industrial Court is more than the amount of assessment of premium paid under section 551(4) of the Act.

(2) To remove any doubt, this section does not apply if WorkCover has accepted payment of the amount under an instalment plan and instalments are paid under the plan.

9 Section 48 (Employer's obligation to insure) of the Act

(3) This section does not apply to an employer who employs only household workers.

(4) The additional premium payable under section 61 or 62 of the Act is—

(a) if payment of the amount is made to WorkCover within 30 days after the due date—5% of the amount; or

(b) if payment of the amount is made to WorkCover after 30 days but within 60 days of the due date—10% of the amount; or

(c) if payment of the amount is made to WorkCover after 60 days of the due date or if no payment is made—10% of the amount plus interest at the annual rate mentioned in section 11(2)(a) for the period from the due date, or a later date decided by WorkCover, until the amount and all additional premium is paid to WorkCover.

14 Premium for appeals—Act, s 569(2)(a)

(1) For section 569(2)(a)[10] of the Act, premium, for an employer for a period of insurance, is an amount calculated under the formula—

$$P = \frac{W \times R}{100}$$

(2) In subsection (1)—

"P" means premium.

"R" means the rate for the employer's industry or business specified in the notice under section 54[11] of the Act that applies to the period of insurance.

"W" means—

(a) the wages of the employer for the preceding period of insurance; or

(b) if the employer has only been insured for part of a period of insurance—a reasonable estimate of the wages of the employer for the period of insurance.

10 Section 569 (Starting appeals) of the Act

11 Section 54 (Setting of premium) of the Act

15 Cancellation of policy on ceasing to employ workers

(1) This section applies if an employer wishes to cancel a policy because the employer has ceased to employ workers.

(2) This section does not apply to an employer who employs only household workers.

(3) The employer must give WorkCover—

(a) written notice that the employer—

(i) has ceased to employ workers on and from a date specified in the notice; and

(ii) wishes to cancel the policy; and

(b) written details of the employer's wages in relation to the period starting on 1 July last preceding the day on which employment of workers ceased and ending on that day.

(4) WorkCover must assess the premium payable by the employer for the period during which the employer was required by the Act to maintain a policy.

(5) If the premium paid by the employer for the period mentioned in subsection (3) is—

(a) greater than the amount of premium assessed under subsection (3)—WorkCover must refund to the employer the amount overpaid; or

(b) less than the amount of premium assessed under subsection (3)—the employer must pay WorkCover the amount of the deficit on or before the due date under a final premium notice issued for the amount of the deficit.

Division 2—Employer excess

16 Excess period—Act, s 65

(1) The excess period is calculated having regard to—

(a) the days worked under a worker's contract with an employer when the injury was sustained; and

(b) the period—

(i) if the worker's total incapacity is ongoing—of 1 week from when the worker's entitlement to weekly payment of compensation starts; or

(ii) if the worker's total incapacity is interrupted—of the worker's continuing incapacity because of the injury.

(2) If a worker is required to work for a stated number of days only, the excess period is up to the stated number of days, or 4 days, whichever is the lesser.

Example of excess period for subsection (1)(b)(i)—

1. A worker is employed 5 days a week (Monday to Friday). The worker sustains an injury on Tuesday and immediately stops work to attend for medical treatment. The treating doctor certifies total incapacity for work for 2 weeks. The excess period is 4 days (Wednesday to Monday).

Example of excess period for subsection (1)(b)(ii)—

1. A worker is employed 5 days a week (Monday to Friday). The worker sustains an injury on Wednesday, attends for medical treatment that day and the treating doctor certifies total incapacity for 2 days. The initial excess period is 2 days (Thursday and Friday).

   The worker returns to work on Monday and works Monday, Tuesday and Wednesday. However, the incapacity from the same injury continues and the worker obtains a subsequent medical certificate for 2 days. The balance of the excess period is 2 days (Thursday and Friday). The total excess period is 4 days.

Examples of excess period for subsection (2)—

1. A worker is employed 2 days a week (Thursday and Saturday). The worker sustains an injury on Saturday and continues to work until the end of the day. The worker attends for medical treatment the following Monday and the treating doctor certifies total incapacity for work for 10 days. The excess period is 2 days (Thursday and Saturday).

2. A worker is employed for 1 day only. The worker sustains an injury, attends for medical treatment and the treating doctor certifies total incapacity for 3 days. The excess period is 1 day.

17 Employer's election to insure against payment for excess period—Act, s 67

(1) An employer may only elect to insure against the employer's liability to pay for the excess period for a period of insurance—

(a) at the start of a new policy—by making written application to WorkCover on the application for a policy; or

(b) on renewal of a policy—by making written application to WorkCover on or before 31 August in the renewed period of insurance.

(2) The employer's election to insure for a period of insurance—

(a) applies from the day the employer's written application is received by WorkCover, or the start of the policy, whichever is the later; and

(b) applies until the end of the period of insurance; and

(c) cannot be withdrawn by the employer.

(3) However, if the employer elected to insure for the preceding period of insurance and elects to insure for the current period of insurance on or before 31 August in the current period of insurance, the election applies from the start of the current period of insurance.

(4) If the employer does not pay the premium for the period by the due date for payment of the premium or an instalment of premium under an instalment plan, the employer is taken never to have made the election to insure.

18 Amount payable to insure against payment for excess period—Act, s 67

(1) This section applies if an employer elects to insure under section 67 of the Act against the employer's liability to pay for the excess period.

(2) The amount payable by the employer is the greater of—

(a) 8.5% of the employer's premium for the period of insurance; or

(b) $10.00.

(3) For subsection (2)(a), the employer's premium is—

(a) if the employer elects to insure for the period of insurance and did not elect to insure for the preceding period of insurance—

P = PP; or

(b) if the employer elects to insure for the period of insurance and elected to insure for the preceding period of insurance—

P = AP - PPP + PP; or

(c) if the employer did not elect to insure for a period of insurance and elected to insure for the preceding period of insurance—

$$P = AP - PPP$$

(4) In subsection (3)—

"AP" means assessed premium for the preceding period of insurance.

"P" means premium.

"PP" means provisional premium for the period of insurance.

"PPP" means provisional premium for the preceding period of insurance.

Division 4—Self-insurance

19 Application fees—Act, s 70

For section 70 of the Act, the amount of the application fee is—

(a) for a single employer—$15 000; or

(b) for a group employer—$20 000.

20 Annual levy—Act, s 81

(1) For section 81 of the Act, the amount of the levy payable by a self-insurer for each financial year or part of a financial year of a licence is an amount calculated under the formula—

$$L = (ECL \times R) + \$10\,000$$

(2) In subsection (1)—

"ECL" means estimated claims liability calculated under part 4, division 3A stated in the most recent actuarial report agreed by the Authority, or decided by the arbiter, under that division, before a date fixed by the Authority by industrial gazette notice.

"L" means annual levy.

"R" means the rate published in the industrial gazette notice under section 81[12] of the Act for the particular financial year.

20A Provisional annual levy

(1) If—

(a) the Authority and the self-insurer have not agreed on the calculation of estimated claims liability under part 4, division 3A; and

(b) the arbiter has not decided the estimated claims liability;

the Authority may use the amount of the estimated claims liability assessed by the approved actuary to calculate a provisional annual levy for a financial year under section 20 to ensure the self-insurer's compliance with section 81 of the Act.

(2) If the Authority and the self-insurer agree to the amount of the estimated claims liability (**"agreed amount"**), the Authority must give the self-insurer an adjusted levy notice based on the agreed amount within 14 days after the Authority and the self-insurer agree to the amount of the estimated claims liability.

(3) If the Authority and the self-insurer do not agree to the amount of the estimated claims liability and the amount decided by the arbiter (the **"decided amount"**) is not the same as the amount of the estimated claims liability used to calculate the provisional annual levy, the Authority must give the self-insurer an adjusted levy notice based on the decided amount within 14 days after the Authority or the self-insurer receives the statement of the arbiter's decision about the estimated claims liability.

(4) If the amount of the adjusted levy is more than the provisional annual levy, the self-insurer must pay the Authority the difference between the amount of the provisional annual levy and the amount of the annual levy actually payable by the self-insurer.

(5) If the amount of the adjusted levy is less than the provisional annual levy paid by the self-insurer, the Authority must pay the self-insurer the difference between the actual annual levy payable and the amount paid as the provisional annual levy.

12 Section 81 (Annual levy payable) of the Act

21 Additional amount for late payment of levy—Act, s 82

(1) This section applies if, on or before the due date, a self-insurer does not pay the amount of levy payable under a notice given by the Authority under section 81 of the Act.

(2) The additional amount payable under section 82 of the Act is—

(a) if payment of the amount is made to the Authority within 30 days after the due date—5% of the amount; or

(b) if payment of the amount is made to the Authority after 30 days but within 60 days of the due date—10% of the amount; or

(c) if payment of the amount is made to the Authority after 60 days of the due date or if no payment is made—10% of the amount plus interest at a rate specified by the Authority's board by industrial gazette notice for the period from the due date, or a later date decided by the Authority, until the amount and all additional amounts are paid to the Authority.

22 Conditions of licence—Act, s 83

A self-insurer's licence is subject to the following conditions—

(a) the self-insurer must lodge with the Authority, for each year or part of a year of a licence, a declaration in the approved form of the self-insurer's wages;

(b) the unconditional bank guarantee lodged under section 84 of the Act—

(i) must be issued by a bank or Queensland Treasury Corporation; and

(ii) must not be issued by a bank that is a related body corporate to the self-insurer; and

(iii) must be satisfactory to the Authority;

(c) the annual assessment of estimated claims liability under section 84(3) of the Act must be calculated in the way set out in part 4, division 3A.

23 Premium payable after cancellation of self-insurer's licence—Act, s 98

(1) This section applies if a former self-insurer continues to be an employer after the self-insurer's licence is cancelled.

(2) The premium payable by the former self-insurer for the first 2 periods of insurance after cancellation is to be calculated according to the method and at the rate specified by WorkCover by industrial gazette notice under section 54[13] of the Act as if the employer were a new employer.

(3) However, the rate under subsection (2) cannot be less than the rate calculated under the following formula—

$$R = \frac{(P + L + A) \times 100}{W}$$

(4) In subsection (3)—

"A" means the administrative costs associated with claims incurred during the final period of licence, calculated by multiplying P + L by 0.095.

"final period of licence" means—

(a) for an employer licensed as a self-insurer for 3 or more years immediately before cancellation of the licence—3 years; or

(b) for an employer licensed as a self-insurer for less than 3 years immediately before cancellation of the licence—the period of the licence.

"L" means an actuarial estimate of the outstanding liability at the end of the self-insurer's licence for claims incurred during the final period of licence, excluding liability for the excess period.

"P" means the actual payments made by the former self-insurer, less recoveries received and payments made that are the equivalent of amounts payable for the excess period, for claims incurred during the final period of licence.

"R" means the premium rate.

"W" means the wages of the self-insurer during the final period of licence.

13 Section 54 (Setting of premium) of the Act

23A Deemed premium for appeals—Act, s 569(2)(a)

(1) For section 569(2)(a)[14] of the Act, deemed premium, for a self-insurer for a financial year of the self-insurer's licence, is an amount calculated under the formula—

$$\mathbf{DP = ECL \times R}$$

(2) In subsection (1)—

"DP" means deemed premium.

"ECL" means estimated claims liability calculated under part 4, division 3A that was used to calculate the annual levy under section 20.

"R" means the rate published in the industrial gazette notice under section 81[15] of the Act for the particular financial year.

24 Actuarial procedure—self-insurers

(1) Actuarial estimates required under this division must be carried out by an actuary.

(2) The actuary must calculate the estimate under guidelines issued by the Authority by industrial gazette notice.

PART 3—OTHER INSURANCES

Division 1—Students

25 Insurance of work experience students

(1) In this section—

"corporation" means the corporation sole of the Minister established under the *Education (General Provisions) Act 1989*.

14 Section 569 (Starting appeals) of the Act

15 Section 81 (Annual levy payable) of the Act

"educational establishment" see the *Education (Work Experience) Act 1996*, section 5.

"student" see the *Education (Work Experience) Act 1996*, schedule.

"work experience" has the meaning given by the *Education (Work Experience) Act 1996*, section 4.

"work experience place" means a place where work experience is, or is to be, provided for a student.

(2) WorkCover may enter into a contract of insurance with an educational establishment or the corporation to insure the educational establishment or the corporation against liability for compensation for injury to a student arising out of work experience.

(3) For this section, when deciding whether an injury arises out of, or in the course of, work experience, chapter 1, part 4, division 6, subdivisions 2 and 3[16] of the Act apply as if

(a) the student were a worker; and

(b) work experience were the employment; and

(c) the work experience place were the place of employment; and

(d) the corporation or the educational establishment were the employer.

(4) A student has the same entitlements to compensation as a worker.

(5) For the entitlements of a student to compensation, all the provisions of the Act under which entitlements are decided apply to the student in the same way as they would apply to a worker including, for example—

- the provisions of chapter 3 (Compensation)
- the provisions of chapter 11 (Medical Assessment Tribunals)
- the provisions of chapter 13 (Reviews and Appeals).

16 Chapter 1 (Preliminary), part 4 (Basic concepts), division 6 (Injuries and impairment), subdivisions 2 (Injury) and 3 (When injury arises out of, or in the course of, employment) of the Act

(6) However, insurance cover provided under a contract of insurance under this section is limited to compensation under chapter 3, parts 10 and 11[17] of the Act.

(7) Also, the contract does not cover payment of damages for injury sustained by the student.

(8) WorkCover has a liability under a contract of insurance entered into under this section only if the premium assessed for the contract has been paid in full.

26 Insurance of vocational placement students

(1) In this section—

"registered training organisation" see the *Training and Employment Act 2000*, section 14.

"vocational placement" has the meaning given by the *Training and Employment Act 2000*, section 17, but does not include a paid placement.

"vocational placement place" means a place where vocational placement is, or is to be, provided for a vocational placement student.

"vocational placement student" means a student undertaking a course at a registered training organisation.

(2) WorkCover may enter into a contract of insurance with a registered training organisation to insure the organisation against liability for compensation for injury to a vocational placement student arising out of a vocational placement.

(3) For this section, when deciding whether an injury arises out of, or in the course of, vocational placement, chapter 1, part 4, division 6, subdivisions 2 and 3[18] of the Act apply as if—

(a) the vocational placement student were a worker; and

(b) vocational placement were the employment; and

---

17 Chapter 3 (Compensation), parts 10 (Entitlement to compensation for permanent impairment) and 11 (Compensation on worker's death) of the Act

18 Chapter 1 (Preliminary), part 4 (Basic concepts), division 6 (Injuries and impairment), subdivisions 2 (Injury) and 3 (When injury arises out of, or in the course of, employment) of the Act

(c) the vocational placement place were the place of employment; and

(d) the registered training organisation were the employer.

(4) A vocational placement student has the same entitlements to compensation as a worker.

(5) For the entitlements of a vocational placement student to compensation, all the provisions of the Act under which entitlements are decided apply to the student in the same way as they would apply to a worker including, for example—

- the provisions of chapter 3 (Compensation)
- the provisions of chapter 11 (Medical Assessment Tribunals)
- the provisions of chapter 13 (Reviews and Appeals).

(6) However, insurance cover provided under a contract of insurance under this section is limited to compensation under chapter 3, parts 10 and 11[19] of the Act.

(7) Also, the contract does not cover payment of damages for injury sustained by the student.

(8) WorkCover has a liability under a contract of insurance entered into under this section only if the premium assessed for the contract has been paid in full.

Division 2—Eligible persons

27 Proposal for contract of insurance—Act, s 24

For section 24 of the Act, an eligible person is taken to express a wish to enter into a contract of insurance with WorkCover by lodging a fully completed and signed proposal in the approved form with WorkCover.

19 Chapter 3 (Compensation), parts 10 (Entitlement to compensation for permanent impairment) and 11 (Compensation on worker's death) of the Act

28 Documents to be kept by eligible person

(1) This section applies if WorkCover has entered into a contract of insurance for chapter 1, part 4, division 3, subdivision 4[20] of the Act with an eligible person.

(2) The eligible person must keep documents showing the remuneration or other benefit for performing work, or providing services, that the eligible person has received as an eligible person.

(3) If the eligible person applies for weekly payments of compensation under chapter 3, part 9, division 4, subdivision 4 or division 5, subdivision 2[21] of the Act but cannot substantiate remuneration or other benefit received, WorkCover may pay an amount WorkCover considers is reasonable.

Division 3—Other persons

29 Contracts of insurance for other persons

(1) This section applies if a contract of insurance for chapter 1, part 4, division 3, subdivision 5[22] of the Act provides for a matter to be decided by a medical assessment tribunal in accordance with chapter 11[23] of the Act or for an appeal to a court in accordance with chapter 13[24] of the Act.

(2) The provisions of the Act apply and jurisdiction is conferred on the tribunal or court to hear and decide the matter.

---

20 Chapter 1 (Preliminary), part 4 (Basic concepts), division 3 (Persons entitled to compensation other than workers), subdivision 4 (Eligible persons) of the Act

21 Chapter 3 (Compensation), part 9 (Weekly payment of compensation), division 4 (Entitlement for total incapacity), subdivision 4 (Eligible persons) or division 5 (Entitlement for partial incapacity), subdivision 2 (Eligible persons) of the Act

22 Chapter 1 (Preliminary), part 4 (Basic concepts), division 3 (Persons entitled to compensation other than workers), subdivision 5 (Other persons) of the Act

23 Chapter 11 (Medical assessment tribunals) of the Act

24 Chapter 13 (Reviews and appeals) of the Act

Division 4—Contracts of insurance generally

30 Entitlements of persons mentioned in ch 1, pt 4, div 3, subdivs 1, 2 and 4

For the entitlements of a person mentioned in chapter 1, part 4, division 3, subdivision 1, 2 or 4[25] of the Act to compensation, all the provisions of the Act apply to the person in the same way as they would apply to a worker including, for example—

- the provisions of chapter 11 (Medical Assessment Tribunals)
- the provisions of chapter 13 (Reviews and Appeals).

31 WorkCover not liable if premium not paid

WorkCover is not liable under a contract of insurance under chapter 1, part 4, division 3 of the Act if the premium for the contract has not been paid in full to WorkCover on or before the due date.

32 Duty to report injury

(1) This section applies if a person who is entitled to compensation under chapter 1, part 4, division 3 of the Act and is covered by a contract of insurance sustains an injury for which compensation may be payable.

(2) However, this section does not apply to an eligible person.

(3) The person with whom WorkCover has entered into the contract must complete a report in the approved form and send it to the nearest office of WorkCover.

(4) The report must be sent immediately after the first of the following happens—

(a) the person with whom WorkCover has entered into the contract knows the injury has been sustained;

(b) the person covered by the contract reports the injury to the person with whom WorkCover has entered into the contract;

---

25 Chapter 1 (Preliminary), part 4 (Basic concepts), division 3 (Persons entitled to compensation other than workers), subdivision 1 (Volunteers etc.), 2 (Persons performing community service etc.) or 4 (Eligible persons) of the Act

(c) the person with whom WorkCover has entered into the contract receives WorkCover's written request for a report.

(5) If the person with whom WorkCover has entered into the contract fails to comply with subsection (3) within 10 days after any of the circumstances mentioned in subsection (4), the person commits an offence, unless the person has a reasonable excuse.

Maximum penalty—20 penalty units.

PART 4—AMOUNT OF CALCULATION OF LIABILITY FOR SELF-INSURERS

Division 1—Outstanding liability

Subdivision 1—Purpose of div 1

33 Purpose of div 1

This division sets out the process for the calculation of an amount for a self-insurer's outstanding liability for section 87[26] of the Act.

Subdivision 2—Calculation

34 Appointment of actuary for calculation

WorkCover and the employer must each appoint an actuary to calculate an amount for the outstanding liability.

35 Calculation

(1) The calculation must—

(a) be prepared under the actuarial standard; and

26 Section 87 (Self-insurer replaces WorkCover in liability for injury) of the Act

(b) apply a central estimate of the outstanding liability; and

(c) as far as practicable, be based on the employer's claims experience from claims incurred before the employer becomes or became a self-insurer; and

(d) apply the risk free rate of return; and

(e) include claims administration expenses of 7% of the outstanding liability; and

(f) not include a prudential margin.

(2) The calculation must be based on data as at the last day (the **"assessment day"**) of the financial quarter immediately before the day the application for self-insurance is lodged.

36 Authority to give actuaries information

The Authority must give the actuaries the information necessary to enable the actuaries to complete the calculation within the time mentioned in section 37(3).

37 Actuarial report

(1) After completing the calculation, each actuary must prepare an actuarial report on the calculation the actuary made.

(2) The report must—

(a) be prepared under the actuarial standard; and

(b) clearly state the key assumptions made for the calculation and how the assumptions have been derived, including—

(i) the average amount of claims for compensation against the employer; and

(ii) the average amount of claims for damages against the employer; and

(iii) claims anticipated to have been incurred by the employer for which no formal claim has been lodged; and

(iv) the frequency of claims for compensation against the employer; and

(v) the frequency of claims for damages against the employer; and

(vi) the net amount of the claims after allowing for future inflation (**"inflated value"**); and

(vii) the net present value of the inflated value after allowing for income from assets set aside by the employer to pay the outstanding liability; and

(viii) the rate of inflation used; and

(c) state the following about the data used in the calculation—

(i) the nature of the data;

(ii) the actuary's assessment of its accuracy;

(iii) how the actuary interpreted the data; and

(d) state the actuarial model used in the calculation; and

(e) state the results of the calculation; and

(f) state the actuary's confidence in the results of the calculation.

(3) The actuaries must complete the calculations and the reports within 35 days after the day the application for self-insurance is lodged.

38 Summary report

(1) The actuaries must jointly prepare a summary report that—

(a) includes the individual actuarial reports; and

(b) states how the individual reports agree or differ.

(2) The actuaries must give a copy of the completed summary report to the Authority, WorkCover and the employer within 2 months after the day the application for self-insurance is lodged.

39 Agreement on calculation

WorkCover and the employer may agree on the calculation having regard to the summary report.

40 Reference to arbiter if no agreement

If WorkCover and the employer can not agree on the calculation, the Authority must refer the summary report to the arbiter for decision within 14 days after the Authority is given a copy of the summary report.

41 Arbiter's costs

The arbiter's costs in deciding on the calculation are to be paid by WorkCover and the employer in equal amounts.

42 Payment of amount for outstanding liability

(1) The amount WorkCover must pay for the employer's outstanding liability is the amount agreed to by WorkCover and the employer (the **"agreed amount"**) or, if there is no agreement, the amount decided by the arbiter (the **"decided amount"**).

(2) WorkCover must pay the employer—

(a) 75% of the agreed or decided amount on the day the licence commences; and

(b) the balance within 1 month after the day the licence commences.

(3) The agreed or decided amount paid to the employer must be adjusted by WorkCover's actuary to take into account—

(a) compensation and damages payments made between the assessment day and the day the employer becomes liable for the employer's outstanding liability; and

(b) claims lodged against the employer between the assessment day and the day the employer becomes liable for the employer's outstanding liability.

43 Transfer of claims information

WorkCover must give the employer claims information in relation to the employer's outstanding liability before the day the licence commences.

Subdivision 3—Recalculation

44 Purpose of sdiv 3

This subdivision sets out the process for the recalculation of an amount for a self-insurer's outstanding liability if the self-insurer has made an election under the repealed *WorkCover Queensland Regulation 1997,* part 9, division 1, subdivision 2,[27] as in force immediately before its repeal, to accept an interim payment on account of the outstanding liability.

45 Application of sdiv 3 for group employers

If the self-insurer is a group employer, this subdivision applies only in relation to—

(a) the members of the group as at the day the self-insurer became liable for compensation and damages for the self-insurer's outstanding liability; or

(b) if the self-insurer applied, on or before the day the self-insurer became liable for compensation and damages for the self-insurer's outstanding liability, for WorkCover's consent to change the group membership on the licence—the proposed members of the group as at that day.

46 Appointment of actuary for recalculation

At the end of 5 years after the self-insurer became liable for compensation and damages for the self-insurer's outstanding liability, WorkCover and the self-insurer must each appoint an actuary to recalculate an amount for the outstanding liability.

47 Recalculation

(1) The recalculation must—

(a) be prepared under the actuarial standard; and

(b) apply a central estimate of the outstanding liability; and

27 *Workcover Queensland Regulation 1997*, part 9 (Amount of calculation of liability for self-insurers), division 1 (Outstanding liability), subdivision 2 (Calculation)

(c) as far as practicable, be based on the self-insurer's claims experience from claims incurred before the self-insurer became a self-insurer; and

(d) apply the same risk free rate of return that was used in the calculation of an amount for the liability under subdivision 2; and

(e) include claims administration expenses of 7% of the outstanding liability; and

(f) not include a prudential margin; and

(g) have regard to compensation and damages payments made in relation to the liability between the day the self-insurer became liable for compensation and damages for the self-insurer's outstanding liability and the end of 5 years after that day; and

(h) exclude an amount for liability in relation to a change in the self-insurer's membership after the day the self-insurer became liable for compensation and damages for the self-insurer's outstanding liability.

(2) The recalculation must be based on data as at the last day (the **"assessment day"**) of the last financial quarter for which data is available at the end of 5 years after the self-insurer became liable for compensation and damages for the self-insurer's outstanding liability.

48 Authority to give actuaries information

The Authority must give the actuaries the information necessary to enable the actuaries to complete the recalculation within the time mentioned in section 49(3).

49 Actuarial report

(1) After completing the recalculation, each actuary must prepare an actuarial report on the calculation the actuary made.

(2) The report must—

(a) be prepared under the actuarial standard; and

(b) clearly state the key assumptions made for the recalculation and how the assumptions have been derived, including—

(i) the average amount of claims for compensation against the self-insurer; and

(ii) the average amount of claims for damages against the self-insurer; and

(iii) claims anticipated to have been incurred by the self-insurer for which no formal claim has been lodged; and

(iv) the frequency of claims for compensation against the self-insurer; and

(v) the frequency of claims for damages against the self-insurer; and

(vi) the net amount of the claims after allowing for future inflation (**"inflated value"**); and

(vii) the net present value of the inflated value as calculated at the same risk free rate of return that was used in the calculation of an amount for the liability under subdivision 2; and

(viii) the rate of inflation used; and

(c) state the following about the data used in the recalculation—

(i) the nature of the data;

(ii) the actuary's assessment of its accuracy;

(iii) how the actuary interpreted the data; and

(d) state the actuarial model used in the recalculation; and

(e) state the results of the recalculation; and

(f) state the actuary's confidence in the results of the recalculation.

(3) The actuaries must complete the recalculations and the reports within 35 days after the end of 5 years after the self-insurer became liable for compensation and damages for the self-insurer's outstanding liability.

50 Summary report

(1) The actuaries must jointly prepare a summary report that—

(a) includes the individual actuarial reports; and

(b) states how the individual reports agree or differ.

(2) The actuaries must give a copy of the completed summary report to the Authority, WorkCover and the self-insurer within 2 months after the end of 5 years after the self-insurer became liable for compensation and damages for the self-insurer's outstanding liability.

51 Agreement on recalculation

WorkCover and the self-insurer may agree on the recalculation having regard to the summary report.

52 Reference to arbiter if no agreement

If WorkCover and the self-insurer can not agree on the recalculation, the Authority must refer the summary report to the arbiter for decision within 14 days after the Authority is given a copy of the summary report.

53 Arbiter's costs

The arbiter's costs in deciding on the recalculation are to be paid by WorkCover and the self-insurer in equal amounts.

54 Payment of amount for recalculation

(1) If the amount agreed to by WorkCover and the self-insurer (the **"agreed amount"**) or, if there is no agreement, the amount decided by the arbiter (the **"decided amount"**), for the recalculation is more than the interim payment made under subdivision 2 on account of the outstanding liability—

(a) the amount WorkCover must pay for the self-insurer's outstanding liability is the agreed or decided amount; and

(b) WorkCover must pay the self-insurer—

(i) the difference between the interim payment and the amount for the outstanding liability; and

(ii) interest on the difference, from the day the whole of the interim payment was paid, at the same risk free rate of return that was used in the calculation of an amount for the liability under subdivision 2.

(2) If the agreed or decided amount is less than the interim payment—

(a) the amount WorkCover must pay for the self-insurer's outstanding liability is—

(i) the interim payment; less

(ii) 30% of the difference between the interim payment and the agreed or decided amount; and

(b) the self-insurer must pay WorkCover—

(i) the difference between the interim payment and the amount for the outstanding liability; and

(ii) interest on the difference, from the day the whole of the interim payment was paid, at the same risk free rate of return that was used in the calculation of an amount for the liability under subdivision 2.

(3) WorkCover or the self-insurer must pay the amount of the difference within 28 days after—

(a) WorkCover and the self-insurer agree on the recalculation; or

(b) if there is no agreement, WorkCover or the self-insurer receives the statement of the arbiter's decision about the recalculation.

(4) On payment of the amount, no further amount is payable for the outstanding liability.

Division 2—Total liability

55 Purpose of div 2

This division sets out the process for the calculation of an amount for total liability for section 90(1), (3), (5) or (7)[28] of the Act because of a change in a self-insurer's membership.

56 Appointment of actuary

The party with whom the liability currently resides (the **"old insurer"**) and the party assuming liability (the **"new insurer"**) must each appoint an actuary to calculate an amount for the total liability.

28 Section 90 (Consequences of change in self-insurer's membership) of the Act

57 Calculation

(1) The calculation must—

(a) be prepared under the actuarial standard; and

(b) apply a central estimate of the total liability; and

(c) as far as practicable, be based on the claims experience of the employer or member of a group employer that is the subject of the transfer of liability; and

(d) apply the risk free rate of return; and

(e) include claims administration expenses of 7% of the total or residual liability; and

(f) not include a prudential margin.

(2) The calculation must be based on data as at the last day (the **"assessment day"**) of the financial quarter immediately before the day the self-insurer applies to the Authority under section 89 of the Act for a change in the group membership on the licence.

58 Parties to give actuaries information

The parties must give the actuaries, in the form approved by the Authority, the information necessary to enable the actuaries to complete the calculation within the time mentioned in section 59(3).

59 Actuarial report

(1) After completing the calculation, each actuary must prepare an actuarial report on the calculation the actuary made.

(2) The report must—

(a) be prepared under the actuarial standard; and

(b) clearly state the key assumptions made for the calculation and how the assumptions have been derived, including—

(i) the average amount of claims for compensation against the employer or member; and

(ii) the average amount of claims for damages against the employer or member; and

(iii) claims anticipated to have been incurred by the employer or member for which no formal claim has been lodged; and

(iv) the frequency of claims for compensation against the employer or member; and

(v) the frequency of claims for damages against the employer or member; and

(vi) the net amount of the claims after allowing for future inflation (**"inflated value"**); and

(vii) the net present value of the inflated value after allowing for income from assets set aside by the employer or member to pay the total liability; and

(viii) the rate of inflation used; and

(c) state the following about the data used in the calculation—

(i) the nature of the data;

(ii) the actuary's assessment of its accuracy;

(iii) how the actuary interpreted the data; and

(d) state the actuarial model used in the calculation; and

(e) state the results of the calculation; and

(f) state the actuary's confidence in the results of the calculation.

(3) The actuaries must complete the calculations and the reports within 35 days after the Authority approves the application for the change in the self-insurer's membership (the **"consent day"**).

60 Summary report

(1) The actuaries must jointly prepare a summary report that—

(a) includes the individual actuarial reports; and

(b) states how the individual reports agree or differ.

(2) The actuaries must give a copy of the completed summary report to the parties and the Authority within 2 months after the consent day.

61 Agreement on calculation

The parties may agree on the calculation having regard to the summary report.

62 Reference to arbiter if no agreement

If the parties can not agree on the calculation, the Authority must refer the summary report to the arbiter for decision within 14 days after the Authority is given the summary report.

63 Arbiter's costs

The arbiter's costs in deciding on the calculation are to be paid by the parties in equal amounts.

64 Payment of amount for total liability

(1) The amount the old insurer must pay the new insurer for the total liability is the amount agreed to by them (the **"agreed amount"**) or, if there is no agreement, the amount decided by the arbiter (the **"decided amount"**).

(2) The old insurer must pay the agreed or decided amount—

(a) within 3 months after the consent day; or

(b) on a later day agreed to by the parties.

(3) The agreed or decided amount paid to the new insurer must be adjusted by the actuary of the old insurer to take into account—

(a) compensation and damages payments made between the assessment day and the day the new insurer assumes liability; and

(b) claims lodged against the employer or member between the assessment day and the day the new insurer assumes liability.

(4) The old insurer must advise the Authority of the following no later than the day total liability is paid—

(a) the amount of the liability;

(b) the day the new insurer assumes liability;

(c) details of the parties and the member leaving or becoming part of the self-insurer.

65 Transfer of claims information

The old insurer must give the new insurer claims information in relation to the liability no later than the day the agreed or decided amount is paid.

Division 3—Liability after cancellation of self-insurer's licence

66 Purpose of div 3

This division sets out the process for the calculation of an amount for a former self-insurer's liability for section 102[29] of the Act.

67 Appointment of actuary

WorkCover and the former self-insurer must each appoint an actuary to calculate an amount for the liability.

68 Calculation

(1) The calculation must—

(a) be prepared under the actuarial standard; and

(b) apply a central estimate of the liability; and

(c) as far as practicable, be based on the former self-insurer's claims experience; and

(d) apply the risk free rate of return; and

(e) include claims administration expenses of 7% of the liability; and

(f) not include a prudential margin.

(2) The calculation must be based on data as at the last day (the **"assessment day"**) of the financial quarter immediately before the day the former self-insurer's licence is cancelled (the **"cancellation day"**).

29 Section 102 (Assessing liability after cancellation) of the Act

69 Former self-insurer to give actuaries information

The former self-insurer must give the actuaries, in the form approved by the Authority, the information necessary to enable the actuaries to complete the calculation within the time mentioned in section 70(3).

70 Actuarial report

(1) After completing the calculation, each actuary must prepare an actuarial report on the calculation the actuary made.

(2) The report must—

(a) be prepared under the actuarial standard; and

(b) clearly state the key assumptions made for the calculation and how the assumptions have been derived, including—

(i) the average amount of claims for compensation against the former self-insurer; and

(ii) the average amount of claims for damages against the former self-insurer; and

(iii) claims anticipated to have been incurred by the former self-insurer for which no formal claim has been lodged; and

(iv) the frequency of claims for compensation against the former self-insurer; and

(v) the frequency of claims for damages against the former self-insurer; and

(vi) the net amount of the claims after allowing for future inflation (**"inflated value"**); and

(vii) the net present value of the inflated value after allowing for income from assets set aside by the former self-insurer to pay the liability; and

(viii) the rate of inflation used; and

(c) state the following about the data used in the calculation—

(i) the nature of the data;

(ii) the actuary's assessment of its accuracy;

(iii) how the actuary interpreted the data; and

(d) state the actuarial model used in the calculation; and

(e) state the results of the calculation; and

(f) state the actuary's confidence in the results of the calculation.

(3) The actuaries must complete the calculations and the reports within 35 days after the cancellation day.

71 Summary report

(1) The actuaries must jointly prepare a summary report that—

(a) includes the individual actuarial reports; and

(b) states how the individual reports agree or differ.

(2) The actuaries must give a copy of the completed summary report to the Authority, WorkCover and the former self-insurer within 2 months after the cancellation day.

72 Agreement

WorkCover and the former self-insurer may agree on the calculation having regard to the summary report.

73 Reference to actuarial arbiter if no agreement

If WorkCover and the former self-insurer can not agree on the calculation, the Authority must refer the summary report to the actuarial arbiter for decision within 14 days after the Authority is given the summary report.

74 Arbiter's costs

The arbiter's costs in deciding on the calculation are to be paid by WorkCover and the former self-insurer in equal amounts.

75 Payment of amount for liability

(1) The amount the former self-insurer must pay WorkCover for the liability is the amount agreed to by WorkCover and the former self-insurer

(the **"agreed amount"**) or, if there is no agreement, the amount decided by the arbiter (the **"decided amount"**).

(2) The agreed or decided amount paid to WorkCover must be adjusted by the former self-insurer's actuary to take into account—

(a) compensation and damages payments made between the assessment day and the cancellation day; and

(b) claims lodged against the former self-insurer between the assessment day and the cancellation day.

Division 3A—Estimated claims liability

75A Purpose of div 3A

This division sets out how to calculate estimated claims liability.

75B Definition for div 3A

In this division—

"approved actuary" means an actuary approved by the Authority under section 84(3) of the Act to assess the self-insurer's estimated claims liability.

75C Approved actuary

The approved actuary must calculate the estimated claims liability.

75D Calculation

(1) The calculation must—

(a) be prepared under the actuarial standard; and

(b) apply a central estimate of the liability; and

(c) as far as practicable, be based on the self-insurer's claims experience; and

(d) apply the risk free rate of return; and

(e) include claims administration expenses of 7% of the liability; and

(f) not include a prudential margin.

(2) The calculation must be based on data (**"self-insurer's data"**) necessary to enable the actuary to calculate the self-insurer's estimated claims liability and prepare and give to the Authority and the self-insurer an actuarial report on the calculation—

(a) as at the last day of the financial quarter immediately before the anniversary of the self-insurer's licence renewal day; or

(b) as at another day fixed by the Authority.

75E Self-insurer to give Authority and approved actuary information

The self-insurer must give the Authority and the approved actuary, in the form approved by the Authority, the self-insurer's data necessary to enable the actuary to calculate the self-insurer's estimated claims liability and prepare and give to the Authority an actuarial report on the calculation.

75F Actuarial report

(1) After completing the calculation, the approved actuary must prepare an actuarial report on the calculation the actuary made.

(2) The report must—

(a) be prepared under the actuarial standard; and

(b) clearly state the key assumptions made for the calculation and how the assumptions have been derived, including—

(i) the average amount of claims for compensation against the self-insurer; and

(ii) the average amount of claims for damages against the self-insurer; and

(iii) claims anticipated to have been incurred by the self-insurer for which no formal claim has been lodged; and

(iv) the frequency of claims for compensation against the self-insurer; and

(v) the frequency of claims for damages against the self-insurer; and

(vi) the net amount of the claims after allowing for future inflation (**"inflated value"**); and

(vii) the net present value of the inflated value after allowing for income from assets set aside by the self-insurer to pay the liability; and

(viii) the rate of inflation used; and

(c) state the following about the data used in the calculation—

(i) the nature of the data;

(ii) the approved actuary's assessment of its accuracy;

(iii) how the approved actuary interpreted the data; and

(d) state the actuarial model used in the calculation; and

(e) state the results of the calculation; and

(f) state the approved actuary's confidence in the results of the calculation; and

(g) state the estimated claims liability.

75G Copy of actuarial report to Authority and self-insurer

The approved actuary must give a copy of the actuarial report to the Authority and the self-insurer by the day fixed by the Authority for the purpose or a later day agreed between the Authority and the actuary.

75H Authority to advise self-insurer whether agreement

Within 35 days after the approved actuary gives the Authority a copy of the actuarial report, the Authority must advise the self-insurer whether the Authority agrees or does not agree with the approved actuary's assessment of the estimated claims liability.

75I Reference to Authority's actuary if no agreement

(1) After receiving a copy of the approved actuary's report, the Authority may ask an actuary (**"Authority's actuary"**) to calculate the amount of the self-insurer's estimated claims liability and give the Authority an actuarial report on the calculation the actuary made in accordance with section 75F.

(2) The Authority must give the Authority's actuary the approved actuary's report and the self-insurer's data.

75J Agreement on estimated claims liability

If, at any time, the Authority and the self-insurer agree on the calculation of estimated claims liability having regard to the approved actuary's actuarial report or any Authority's actuary's actuarial report the estimated claims liability is the amount agreed to by the Authority and the self-insurer.

75K Reference to arbiter

(1) If the Authority and the self-insurer can not agree on the calculation, the Authority must refer the approved actuary's report, the self-insurer's data and any Authority's actuary's actuarial report to the arbiter for decision.

(2) The Authority must make the referral within 14 days after the day the Authority advises the self-insurer that the Authority does not agree with the self-insurer's approved actuary's actuarial report under section 75H.

75L Arbiter's costs

The arbiter's costs in deciding on the calculation are to be paid by the Authority and the self-insurer in equal amounts.

Division 4—Actuarial arbiter

76 Function of actuarial arbiter

The function of the actuarial arbiter is to consider the actuarial reports and the calculations of an amount for liability made under this part and decide on an amount for the liability.

77 Appointment of actuarial arbiter

(1) The actuarial arbiter is to be selected by a selection panel consisting of—

(a) 2 individuals nominated by the Authority; and

(b) 2 individuals nominated by WorkCover; and

(c) 2 individuals nominated by the Queensland Workers' Compensation Self-Insurers' Association.

(2) The individual selected must be a Fellow of the Institute of Actuaries or be an Accredited Member of the Institute.

(3) The Authority must appoint the individual selected to be the arbiter for a term of not more than 3 years.

(4) The arbiter's conditions of appointment are to be set out in the contract made between the Authority and the arbiter.

78 Decision of arbiter

(1) After considering the actuarial reports and the calculations of an amount for the liability by the actuaries, the arbiter must decide on—

(a) the central estimate for the liability; and

(b) an amount for the liability.

(2) An amount for the liability decided by the arbiter can not be more than the higher of the amounts calculated by the actuaries and can not be less than the lower of the amounts.

(3) The arbiter must give a written statement of the arbiter's decision and the reasons for the decision within 21 days after the summary report is referred to the arbiter.

79 Arbiter's decision is final

The arbiter's decision is final.

PART 5—COMPENSATION

Division 1—Calculation of NWE

80 Calculation of NWE

Normal weekly earnings of a worker from employment are to be calculated under this division.

81 What amounts may or may not be taken into account

(1) Amounts paid to the worker by way of overtime, higher duties, penalties and allowances (other than amounts mentioned in subsection (2)) that are of a regular nature, required by an employer and that would have continued if not for the injury may be taken into account.

(2) Amounts mentioned in the Act, schedule 6, definition **"wages"**, paragraphs (a) to (d) are not to be taken into account.

82 NWE if impracticable to calculate rate of worker's remuneration

(1) This section applies if it is impracticable, at the date of injury to the worker, to calculate the rate of the worker's remuneration because of—

(a) the period of time for which a worker has been employed; or

(b) the terms of the worker's employment.

(2) Regard must be had to—

(a) the normal weekly earnings during the 12 months immediately before the date of injury of a person in the same grade, employed in the same work, by the same employer, as that of the worker; or

(b) if there is no such person—the normal weekly earnings of a person in the same grade, employed in the same class of employment, and in the same district as that of the worker.

83 NWE if worker worked for 2 or more employers

(1) This section applies if a worker has worked under concurrent contracts of service with 2 or more employers, under which the worker has

worked at 1 time for 1 employer and at another time for another of the employers.

(2) The worker's normal weekly earnings are to be calculated as if earnings under all the contracts were earnings in the employment of the employer for whom the worker was working when the injury was sustained.

84 NWE if insurer considers calculation unfair

(1) This section applies if an insurer considers that the calculation of normal weekly earnings under this division would be unfair.

(2) The normal weekly earnings may be calculated in the way the insurer considers to be fair, and the calculation under this subsection is taken to be the normal weekly earnings of the worker.

Division 2—Compensation application and other procedures

85 Application for compensation

For section 132(3)(b)[30] of the Act, a claimant must give the insurer, to the extent the insurer reasonably requires—

(a) proof of injury and its cause; and

(b) proof of the nature, extent and duration of incapacity resulting from the injury; and

(c) if the injury is, or results in, the death of a worker—proof of—

(i) the worker's death; and

(ii) the identity of the worker; and

(iii) the relationship to the worker and dependency of persons claiming to be the worker's dependants.

30 Section 132 (Applying for compensation) of the Act

86 Doctor's certificate

(1) The doctor's certificate required by section 132(3)(a) of the Act to accompany an application for compensation must be in the approved form.

(2) However, if a worker sustains an injury in another State or country, the insurer must accept from the doctor who attends the worker a written certificate that is substantially to the effect of the approved form.

(3) A doctor attending a worker who has sustained an injury must give the insurer a detailed report on the worker's condition within 10 days after receiving the insurer's request to do so.

(4) The fee payable to the doctor for the report is an amount accepted by the insurer to be reasonable, having regard to the relevant table of costs.

87 If doctor not available

(1) This section applies if a claimant does not lodge a medical certificate with an application for compensation because a doctor was not available to attend the claimant.

(2) The claimant must complete and lodge with the insurer a declaration in the approved form.

(3) For a non-fatal injury, the declaration—

(a) can be accepted by the insurer only once for injury to a claimant in any 1 event; and

(b) is acceptable proof of incapacity of a claimant for not more than 3 days.

88 Examination of claimant or worker—Act, ss 135 and 510

(1) For sections 135 and 510[31] of the Act, a personal examination must be requested in writing to the claimant or worker.

(2) The request must specify—

(a) the name of the doctor or other registered person, who is not employed by the Authority or the insurer under a contract of service, engaged to make the examination; and

31 Sections 135 (Examination by registered person) and 510 (Power of tribunal to examine worker) of the Act

(b) if the doctor is a specialist—the field of specialty; and

(c) the day, time and place when and where the examination is to be made.

(3) A doctor or other registered person who makes a personal examination of a claimant or worker must give the insurer, within 10 days after the examination—

(a) a written report on the examination; and

(b) an itemised account for the examination.

(4) Fees payable to a doctor or other registered person for a personal examination of a claimant or worker—

(a) are payable by the insurer; and

(b) are payable for—

(i) making the examination; and

(ii) giving a report to the insurer; and

(c) are the costs accepted by the insurer to be reasonable, having regard to the relevant table of costs.

89 Payment for treatment arranged by employer other than self-insurer

(1) An employer, other than a self-insurer, may, with WorkCover's consent, make an arrangement or agreement, on behalf of WorkCover, with a doctor, hospital or institution to provide—

(a) medical treatment; or

(b) hospitalisation; or

(c) medical aid;

to a worker who has sustained injury.

(2) WorkCover may ratify an arrangement or agreement made by an employer without WorkCover's consent if WorkCover is satisfied that—

(a) the case was one of emergency; and

(b) in the interests of the worker, it was necessary to take immediate action.

(3) WorkCover is liable to pay the reasonable expenses of medical treatment, hospitalisation or medical aid provided to the worker under the arrangement or agreement.

90 Maximum liability for cost of hospitalisation—Act, s 218

For section 218[32] of the Act, the maximum amount that an insurer is liable to pay for hospitalisation of a worker is $10 000.

91 Special medical treatment, hospitalisation or medical aid

(1) This section applies if an insurer considers that the injury sustained by a worker would require—

(a) special medical treatment; or

(b) special hospitalisation; or

(c) special medical aid.

(2) The insurer may make an arrangement or agreement with a doctor, hospital or institution to provide the worker with the special medical treatment, hospitalisation or medical aid.

(3) For special hospitalisation, the insurer may make the arrangement or agreement only to the extent specified in section 216[33] of the Act.

(4) The insurer is liable to pay the cost of the special medical treatment, hospitalisation or medical aid provided to the worker under the arrangement or agreement.

(5) However, the maximum amount that the insurer is liable to pay for special hospitalisation is $10 000.

Division 3—Entitlement to compensation for permanent impairment

92 Table of injuries

(1) The table of injuries is set out in schedule 2.

---

32 Section 218 (Maximum liability for cost of hospitalisation) of the Act

33 Section 216 (Extent of liability for period of hospitalisation) of the Act

(2) The table of injuries, parts 1, 2, 4 and 6 must be read in conjunction with the relevant provisions of the AMA guide.

(3) The methods that must be used in assessing the degree of permanent impairment resulting from an injury mentioned in part 1, 2, 4 or 6 are the methods stated in the AMA guide.

(4) However, not every injury a worker may sustain is mentioned in the table of injuries and, if a worker sustains permanent impairment from an injury that is not mentioned in the table of injuries (other than in part 3 or 5), the AMA guide must be used in assessing the degree of permanent impairment resulting from the injury.

(5) The table of injuries, part 3 must be read in conjunction with the ophthalmologists guide (for vision injuries) and the hearing loss tables (for hearing injuries).

(6) The methods that must be used in assessing the degree of permanent impairment resulting from an injury mentioned in the table of injuries, part 3 are the methods stated in the ophthalmologists guide or hearing loss tables.

(7) If there is an inconsistency between the table of injuries and the AMA guide, the ophthalmologists guide or the hearing loss tables, the table of injuries prevails to the extent of the inconsistency.

(8) For subsection (2), a provision of the AMA guide is a relevant provision of the guide for a part of the table of injuries if it is mentioned in the part as a relevant provision for the part.

93 Assessing degree of permanent impairment from multiple injuries using the table of injuries

(1) This section applies if a worker sustains permanent impairment from multiple injuries sustained in 1 event.

(2) The degree of permanent impairment for each injury is assessed separately and lump sum compensation is decided accordingly.

Example—

A worker sustains a fractured pelvis and a fractured wrist in the same event. The degree of permanent impairment resulting from each injury is assessed separately in the usual way under the table of injuries.

(3) However, for multiple injuries to a single limb, the degree of permanent impairment sustained by the worker in relation to the limb is

assessed by using the combined values chart in the AMA guide, unless the guide specifies otherwise.

Example—

A worker sustains injuries to the worker's right wrist and right elbow and a crush injury to the worker's left hand. The degree of permanent impairment resulting from the injuries to the right arm is assessed by using the combined values chart in the AMA guide. The degree of permanent impairment resulting from the injury to the left hand is assessed in the usual way under the table of injuries.

(4) Also, if a worker sustains multiple injuries of a kind mentioned in the table of injuries, part 4 in 1 event, the degree of permanent impairment sustained by the worker in relation to the injuries is assessed by using the combined values chart in the AMA guide.

94 Assessment for industrial deafness—Act, s 179

(1) This section sets out the way the degree of permanent impairment for industrial deafness must be assessed for section 179[34] of the Act.

(2) The worker must undergo an audiometric test for hearing conducted by an audiologist.

(3) The test must be preceded by a period of quiet of at least 8 hours.

(4) For air conduction testing, the test must comply with AS/NZS 1269.4:1998.[35]

(5) The worker's hearing levels must be determined separately for the left and right ears at audiometric test frequencies 500, 1 000, 1 500, 2 000, 3 000 and 4 000 Hz with an audiometer complying with AS IEC 60645.3–2002.[36]

(6) The percentage loss of hearing is to be calculated by using the binaural tables and adjusted, if required, under the presbycusis correction table.

34 Section 179 (Assessment of permanent impairment) of the Act

35 AS/NZS 1269.4:1998 (Occupational noise management—Auditory assessment)

36 AS IEC 60645.3–2002 (Electroacoustics—Audiological equipment—Auditory equipment signals of short duration for audiometric and neuro-otological purposes)

95 Calculation of WRI—Act, s 183

(1) For section 183[37] of the Act, a worker's WRI is the percentage calculated using the following formula—

$$\frac{\text{LSPI x 100}}{\text{MSC}}$$

(2) In subsection (1)—

"LSPI" means the lump sum compensation payable under the table of injuries for the degree of permanent impairment for the injury.

"MSC" means maximum statutory compensation under chapter 3, part 6[38] of the Act.

Example—

A worker loses a thumb, the lump sum compensation payable under the table of injuries is $45 495. The maximum statutory compensation is $157 955. The worker's WRI is 28.8% [(45 495 x 100) ÷ 157 955].

96 Additional lump sum compensation for certain workers—Act, s 192

The additional lump sum compensation payable for certain workers is set out in schedule 3.

97 Additional lump sum compensation for gratuitous care—Act, s 193

(1) The additional lump sum compensation payable for gratuitous care is set out in schedule 4.

(2) For section 193(5)[39] of the Act, the assessment report of an occupational therapist must state whether, in the relationship between the worker and the other person, the day-to-day care—

(a) was provided to the worker before the worker sustained the impairment; and

37 Section 183 (Calculation of WRI) of the Act

38 Chapter 3 (Compensation), part 6 (Maximum statutory compensation) of the Act

39 Section 193 (Additional lump sum compensation for gratuitous care) of the Act

(b) would ordinarily be provided in the worker's home; and

(c) is likely to continue to be provided in the worker's home.

(3) The method of assessing a worker's level of dependency is the method stated in the modified barthel index.

(4) In deciding the amount of the worker's entitlement to additional compensation, an insurer must have regard to the information in the report.

PART 6—REHABILITATION

Division 1—Caring allowance

98 Further information required in occupational therapist's report—Act, s 224

(1) An occupational therapist's assessment report must contain the information mentioned in section 97(2).

(2) In paying the caring allowance, an insurer must have regard to the information in the report.

99 Extent of liability for caring allowance—Act, s 225

(1) An insurer must decide the number of hours of care required for a worker having regard to the occupational therapist's report and the graduated scale in schedule 5.

(2) The method of assessing a worker's level of dependency is the method stated in the modified barthel index.

(3) The amount of the caring allowance—

(a) must be decided having regard to the number of hours of care required; and

(b) must be paid at an hourly rate equal to the carer pension rate divided by 35.

(4) In subsection (3)(b)—

"carer pension rate" means the weekly amount of the maximum single carer pension rate payable from time to time under a Commonwealth law but does not include an amount for allowances, for example, rent assistance or family payment.

Division 2—Workplace rehabilitation policy and procedures

100 Reporting requirement for review of workplace rehabilitation policy and procedures

For section 227(4)[40] of the Act, an employer must, within 30 days after completing a review of the employer's workplace rehabilitation policy and procedures, give the Authority written evidence, in the approved form, that the review has been completed.

Division 3—Standard for rehabilitation

101 Who this division applies to

This division applies to anyone who is required, under chapter 4, parts 3 and 4[41] of the Act, to provide or manage the rehabilitation of workers.

102 Definition for div 3

In this division—

"rehabilitation plan" means a written plan outlining the rehabilitation objectives and the steps required to achieve the objectives.

40 Section 227 (Employer's obligation to have workplace rehabilitation policy and procedures) of the Act

41 Chapter 4 (Injury management), parts 3 (Responsibility for rehabilitation) and 4 (Employer's obligation for rehabilitation) of the Act

103 Standard for rehabilitation

For section 228[42] of the Act, the standard of rehabilitation must be in accordance with this division.

104 Doctor's approval

Approval of a worker's treating doctor must be obtained and documented for all rehabilitation plans, including amendments to plans.

105 Worker's file

A file must be kept for each worker undertaking rehabilitation and must contain copies of all relevant documentation, correspondence and accounts.

106 Rehabilitation plan

(1) A rehabilitation plan must be developed for each worker undertaking rehabilitation.

(2) The plan must be consistent with the worker's needs.

(3) The plan must be developed in consultation with the worker.

(4) The plan must at least contain the following matters—

(a) clear and appropriate objectives with ways of achieving the objectives;

(b) details of rehabilitation required to meet the objectives;

(c) projected costs and time frames of rehabilitation;

(d) review mechanisms and dates for review;

(e) progress to date.

107 Case notes

(1) Accurate and objective case notes must be kept for each worker undertaking rehabilitation.

(2) Case notes must contain details of—

42 Section 228 (Employer's obligation to assist or provide rehabilitation) of the Act

(a) all communications between the worker, the rehabilitation coordinator and other relevant parties; and

(b) actions and decisions; and

(c) reasons for actions and decisions.

108 Early worker contact

A worker who sustains an injury and who requires rehabilitation must be contacted about rehabilitation as soon as practicable after the injury is sustained or is reported.

109 Rehabilitation

(1) Rehabilitation must be goal directed with timely and appropriate service provision having regard to—

(a) the worker's injury; and

(b) the objectives of the rehabilitation plan; and

(c) the worker's rate of recovery.

(2) Strategies used in rehabilitation must be evaluated by the rehabilitation coordinator as the case progresses to monitor their effectiveness.

(3) Rehabilitation must focus on return to work.

(4) However, if the worker's injury is so severe that a return to work is precluded, rehabilitation must focus on maximising the worker's independent functioning.

(5) Duties assigned to a worker for a suitable duties program must be meaningful and have regard to the objective of the worker's rehabilitation.

(6) The rehabilitation coordinator must ensure rehabilitation for a worker is coordinated with and understood by line managers, supervisors and coworkers.

(7) A worker must be treated with appropriate respect and equity.

110 Confidentiality

(1) Information obtained during rehabilitation must be treated with sensitivity and confidentiality by all parties.

(2) If it is necessary to obtain or release information associated with the worker's rehabilitation, the worker's authority to obtain or release the information must be obtained.

(3) The worker's authority is not required for the release of information to the Authority or the insurer.

PART 7—DAMAGES

111 Notice of claim for damages—Act, s 275

(1) A notice of claim must be made in the approved form and include the following particulars[43]—

(a) full particulars of the claimant, including—

(i) full name and any other known names; and

(ii) if the claimant is not the worker—the worker's full name; and

(iii) residential address; and

(iv) date of birth; and

(v) gender; and

(vi) usual occupation and, if that differs from the nature of employment at the time of the event, the nature of the employment at the time of the event; and

(vii) the name and address of every employer of the worker at the time of the event;

(b) full particulars of the event, including—

(i) the date, time and place of the event; and

43 See also section 276(2) (Noncompliance with s 275 and urgent proceedings) of the Act.

(ii) a description of the facts, as the claimant understands or recalls them to be, of the circumstances surrounding the event; and

(iii) names and addresses of all witnesses to the event, and their relationship, if any, to the worker; and

(iv) name and address of any person on behalf of the claimant's employer to whom the claimant reported the event and their employment details; and

(v) full particulars of the negligence alleged against the claimant's employer and any other party on which the claim is based; and

(vi) whether, and to what extent, liability expressed as a percentage is admitted for the injury and, if another party is involved, the liability expressed as a percentage that the claimant holds the other party responsible; and

(vii) if another party is involved—details of the notice given to the party;

(c) full particulars of the nature and extent of—

(i) all injuries alleged to have been sustained by the claimant because of the event; and

(ii) the degree of permanent impairment that the claimant alleges has resulted from the injuries; and

(iii) the amount of damages sought under each head of damage claimed by the claimant and the method of calculating each amount; and

(iv) how the claimant is presently affected by the injuries;

(d) the name and address of each hospital at which the claimant has been treated for the injury, and the name and address of each doctor by whom the claimant has been treated for the injury;

(e) the name and address of each provider of treatment or rehabilitation services who has made an assessment of, or provided treatment or rehabilitation services for, permanent impairment arising from the injury;

(f) all personal injuries, illnesses and impairments of a medical, psychiatric or psychological nature sustained by the claimant

either before or after the event that may affect the extent of the permanent impairment resulting from the injury to which the claim relates, or may affect the amount of damages in another way;

(g) all personal injuries, illnesses and impairments of a medical, psychiatric or psychological nature sustained by the claimant either before or after the event for which the claimant has claimed damages, compensation or benefits, the name and address of any person against whom a claim for damages or compensation was made and, if an insurer, whether or not within the meaning of the Act, was involved, the name and address of the insurer;

(h) the name and address of each hospital at which the claimant has been treated for an injury, illness or impairment mentioned in paragraph (f) or (g), and the name and address of each doctor by whom the claimant has been treated for the injury, illness or impairment;

(i) all steps taken by the worker to mitigate their loss;

(j) if the claimant claims damages for diminished income earning capacity—particulars of the claimant's employment during the 3 years immediately before and since the event including—

(i) the name and address of each of the claimant's employers; and

(ii) the period of employment by each employer; and

(iii) the capacity in which the claimant was employed by each employer; and

(iv) the claimant's gross and net (after tax) earnings for each period of employment; and

(v) the periods during which the claimant was in receipt of payments from Centrelink on behalf of the Department of Family and Community Services (Cwlth); and

(vi) the periods during which the claimant received no income, and the reasons why the claimant was not receiving any income.

(2) A notice of claim relating to an injury causing death must contain the following additional particulars (if relevant)—

(a) if the claimant is the spouse of the deceased worker—

(i) the date of marriage or the date on which the de facto relationship started; and

(ii) the place of marriage or the residential address where the de facto relationship started; and

(iii) the claimant's net (after tax) weekly income before and after the worker's death; and

(iv) the age to which the claimant intended to work and the basis of the claimant's future employment i.e. whether full-time or part-time; and

(v) details of any health problems that the claimant currently has; and

(vi) the amount of average weekly financial benefit derived by the claimant from the deceased worker before the worker's death and the method of calculating the amount; and

(vii) the expected date of birth of a posthumous child of the relationship; and

(viii) details of remarriage or start of a marriage-like relationship;

(b) if the claimant is not the spouse of the deceased worker—

(i) the claimant's relationship to the deceased worker; and

(ii) the claimant's net (after tax) weekly earnings; and

(iii) the age to which the claimant would have been dependent on the deceased worker and the basis of the dependency; and

(iv) details of any health problems that the claimant currently has; and

(v) the amount of average weekly financial benefit derived by the claimant from the deceased worker before the worker's death and the method of calculating the amount.

112 Notice of claim and urgent proceedings—Act, s 276

(1) This section applies if the claimant alleges an urgent need to start a proceeding for damages despite noncompliance with section 275 of the Act.

(2) For section 276(4) of the Act, the claimant's notice of claim must be faxed to the insurer at the insurer's registered office.

(3) The claimant's notice of claim must include a cover page stating—

(a) the sender's name and address; and

(b) the total number of pages sent, including the cover page; and

(c) the fax number from which the notice is sent; and

(d) the date of the transmission; and

(e) the name and fax number of the person to whom the fax is being sent; and

(f) the name and phone number of a person to contact if there is a problem with the transmission; and

(g) a statement that the transmission is for the giving of the notice of claim under section 276(4) of the Act.

(4) If there is a dispute about the giving of the notice of claim under section 276(4) of the Act, the transmission advice generated by the sender's fax machine confirming the transmission was successful must be included as an exhibit to any affidavit of service.

PART 8—COSTS

Division 1—Proceeding before industrial magistrate

113 Costs—proceeding before industrial magistrate

(1) The costs of a proceeding before an industrial magistrate are in the discretion of the magistrate.

(2) However, if the magistrate allows costs—

(a) for costs in relation to counsel's or solicitor's fees—

(i) the costs are to be under the *Uniform Civil Procedure Rules 1999*, schedule 3;[44] or

(ii) if, because of—

(A) the work involved; or

(B) the importance, difficulty or complexity of the matter to which the proceedings relate;

the industrial magistrate considers the amount of costs provided for under subparagraph (i) are inadequate remuneration, the magistrate may allow costs (in total or in relation to any item) in an amount up to 1.5 times the amount provided for under subparagraph (i) (in total or in relation to that item); and

(b) for costs in relation to witnesses' fees and expenses—the costs are to be under the *Uniform Civil Procedure (Fees) Regulation 1999*, part 4;[45] and

(c) for costs in relation to bailiff's fees—the costs are to be under the *Uniform Civil Procedure (Fees) Regulation 1999*, schedule 2, part 2.[46]

(3) Subsection (4) applies if—

(a) the Authority or an insurer is required to pay costs in a hearing in relation to a witness who is a doctor or otherwise is of a professional description; and

(b) the amount of fees and expenses payable in relation to the witness by the party that called the witness is more than the amount of costs allowed by the industrial magistrate.

(4) The Authority or the insurer may, on the application of the party that called the witness, pay an additional amount on account of the costs that

44 *Uniform Civil Procedure Rules 1999*, schedule 3 (Scale of costs—Magistrates Courts)

45 *Uniform Civil Procedure (Fees) Regulation 1999*, part 4 (Allowances for witnesses and interpreters)

46 *Uniform Civil Procedure (Fees) Regulation 1999,* schedule 2 (Magistrates Courts fees), part 2 (Bailiff's fees)

the Authority or the insurer accepts as reasonable, having regard to the subject matter of the hearing.

Division 2—Claim for damages

114 Who this division applies to

This division applies only to a claimant who is—

(a) a worker whose WRI is 20% or more; or

(b) a dependant.

115 Definition for div 2

In this division—

"net damages" means damages recovered less compensation paid by an insurer.

116 Costs before proceeding started

(1) This section prescribes the legal professional costs of a claim before a proceeding is started.

(2) If a claimant recovers at least $150 000 net damages, the costs are—

(a) if the claim is settled—

(i) without holding a compulsory conference—120% of the amount in schedule 6, column A; or

(ii) after a compulsory conference is held—the amounts in schedule 6, columns A and B; and

(b) for investigation of liability by an expert—the amount in schedule 6, column C; and

(c) for an application to the court—the amount in schedule 6, column D.

(3) If a claimant recovers net damages of $50 000 or more but less than $150 000, the costs are 85% of the amount under subsection (2).

(4) If a claimant recovers less than $50 000 net damages, the costs are 85% of the amount calculated under subsection (2) multiplied by the proportion that the net damages bear to $50 000.

Example of subsection (4)—

If the net damages recovered are $30 000, the costs are (85% of the amount calculated under subsection (2)) x $^{3}/_{5}$.

(5) However, if a court in the proceeding awards the payment of solicitor-client costs, the costs recoverable under subsections (2), (3) and (4) are multiplied by 120%.

117 Costs after proceeding started

(1) This section prescribes the legal professional costs of a claim after a proceeding is started.

(2) The costs are chargeable under the relevant court scale of costs.

(3) However, the costs under subsection (2) do not include—

(a) the cost of work performed before the proceeding is started; or

(b) the cost of work performed before the proceeding is started that is performed again after the proceeding is started.

118 Outlays

(1) In addition to legal professional costs, the following outlays incurred by the claimant are allowed—

(a) 1 hospital report fee for each hospital that provided treatment for the worker's injury;

(b) 1 report fee for each doctor in general practice who provided treatment for the worker's injury;

(c) 1 medical specialist's report fee for each medical discipline reasonably relevant and necessary for the understanding of the worker's injury;

(d) 1 report fee of an expert investigating liability, of not more than $1 000, less any proportion of the fee agreed to be paid by the insurer;

(e) Australian Taxation Office or tax agents' fees for supplying copies of income tax returns;

(f) fees charged by the claimant's previous employers for giving information necessary for the claimant to complete the notice of claim, but not more than $50 for each employer;

(g) fees charged by a mediator in an amount previously agreed to by the insurer;

(h) filing fees or other necessary charges incurred in relation to an application to the court before a proceeding is started;

(i) reasonable fees for sundry items properly incurred, other than photocopying costs.

(2) The fees—

(a) are allowable only for reports disclosed before the start of proceedings; and

(b) for subsection (1)(a) to (c)—are payable according to the recommended Australian Medical Association scale of fees.

PART 9—MISCELLANEOUS

119 Documents to be kept—Act, s 520

(1) An employer or contractor must keep the following documents for section 520 of the Act—

(a) the time and wages book, or wages book, and the register of employees, required to be kept under the *Industrial Relations Act 1999*;

(b) documents, or accurate and complete copies of documents, required to be kept under a law of the Commonwealth for payments made to the employer's workers or contractors for the performance of work, including, for example—

(i) group certificates; and

(ii) group employer's reconciliation statements; and

(iii) prescribed payment system payer's reconciliation statements;

(c) the person's profit and loss account, to the extent it relates to amounts paid for wages for workers, or to contractors.

(2) However, a document mentioned in subsection (1)(b) or (c) need not contain information an employer or contractor reasonably believes is confidential and not necessary to enable the Authority or WorkCover to calculate the person's actual expenditure on wages or for contracts for the period to which the document relates.

Examples—

1. Income and profit lines.
2. Tax file numbers.

(3) An employer or contractor need not comply with subsection (1) if—

(a) the Authority or WorkCover has given the employer or contractor notice that a document need not be kept, and the notice remains in force; or

(b) the employer or contractor was a corporation and has been wound-up.

(4) In this section—

"worker" does not include a household worker.

120 Reasons for decisions must address certain matters—Act, s 540(4)

(1) For section 540(4) of the Act, the reasons must—

(a) cite the provision of the Act under which the decision is made; and

(b) state the evidence considered for the decision; and

(c) state the evidence that was accepted or rejected for the decision and why it was accepted or rejected; and

(d) state the conclusions drawn from the evidence; and

(e) disclose the link between the evidence, the conclusions and the relevant provision of the Act.

(2) The reasons must also clearly state the decision made and be written in plain English.

PART 10—TRANSITIONAL PROVISION FOR WORKERS' COMPENSATION AND REHABILITATION AMENDMENT REGULATION (No. 1) 2004

121 Estimated claims liability for ss 20 and 23A

(1) This section applies for the calculation of the following for the financial year or part of the financial year starting on 1 July 2004—

(a) annual levy under section 20;

(b) deemed premium under section 23A.

(2) The estimated claims liability to be used in the calculations is the estimated claims liability assessed under section 84(3) of the Act before 1 February 2004.

122 Adjustment of annual levy

(1) This section applies for the calculation of an adjusted annual levy for a self-insurer who holds a self-insurer licence for the financial year or part of the financial year ending on 30 June 2004.

(2) If the amount of the deemed premium is more than the estimated deemed premium for the financial year or part of the financial year, the self-insurer must pay to the Authority the difference between the amounts calculated under the formula—

$$\mathbf{AAL = R \times (D - EDP)}$$

(3) If the amount of the deemed premium is less than the estimated deemed premium for the financial year or part of the financial year, the Authority must pay to the self-insurer the difference between the amounts calculated under the formula—

$$\mathbf{AAL = R \times (EDP - D)}$$

(4) In this section—

"AAL" means adjusted annual levy.

"D" means the deemed premium for the self-insurer for the financial year or the part of the financial year starting on 1 July 2003, calculated under section 13 as in force immediately before 1 July 2004.

"EDP" means the estimated deemed premium for the self-insurer for the end of the financial year starting on 1 July 2003, calculated under section 13 as in force immediately before 1 July 2004.

"R" means the rate published in the industrial gazette notice under section 81[47] of the Act for the particular financial year.

47 Section 81 (Annual levy payable) of the Act

SCHEDULE 1

ADDITIONAL PREMIUM

section 9

Time of lodgment of declaration of wages	**Additional premium**
On or after 1 September and not later than 31 October in 1 calendar year	The greater of— (a) 5% of assessed premium for the period of insurance to which the declaration relates; or (b) $5.00
On or after 1 November and not later than 30 November in 1 calendar year	The greater of— (a) 10% of assessed premium for the period of insurance to which the declaration relates; or (b) $10.00
On or after 1 December and not later than 31 December in 1 calendar year	The greater of— (a) 15% of assessed premium for the period of insurance to which the declaration relates; or (b) $15.00
On or after 1 January in the next calendar year	The greater of— (a) 20% of assessed premium for the period of insurance to which the declaration relates, or (b) $20.00.

SCHEDULE 2

TABLE OF INJURIES

section 92

PART 1—UPPER EXTREMITY INJURIES

Division 1—Preliminary

1 Application of pt 1

(1) This part deals with upper extremity injuries.

(2) The maximum lump sum compensation payable for an upper extremity injury is $126 365.

(3) To decide a worker's entitlement from injury, division 2 shows—

(a) the maximum degree of permanent impairment that may result from the injury; and

(b) the maximum lump sum compensation payable for the injury; and

(c) the maximum WRI.

2 How to use this part of the table

(1) Division 2 lists certain upper extremity injuries.

(2) Injuries are stated in column 2, the maximum degree of permanent impairment resulting from the injury is stated in column 3, the maximum lump sum compensation for the injury is stated in column 4, and the maximum WRI is stated in column 5.

(3) The maximum degree of permanent impairment resulting from an injury is stated as a degree of permanent impairment of the upper extremity.

SCHEDULE 2 (continued)

(4) Some injuries mentioned in division 2 are marked with an asterisk (*).

(5) These injuries may result in the same degree of maximum permanent impairment as other injuries mentioned in the division, but, for historical reasons, give rise to different amounts of maximum lump sum compensation.

(6) For more information on how to use the table of injuries, see sections 92 and 93 of the regulation.

3 Interaction between this part and the AMA guide

(1) The degree of permanent impairment resulting from an injury to an upper extremity is expressed in division 2 as a degree of permanent impairment of the upper extremity.

(2) Even though an injury is not precisely described under division 2, a similar injury often will be.

(3) If the injury is more severe than a particular similar injury, but less severe than another similar injury, the degree of permanent impairment must always be more than the less severe injury, but not as much as the more severe injury.

(4) If an injury to an upper extremity results in permanent impairment and the injury is not mentioned in division 2, the degree of permanent impairment must be assessed under the AMA guide.

(5) However, the processes that may be used under the AMA guide cannot result in an injury giving rise to a greater degree of permanent impairment from the injury than that specified under division 2.

(6) The degree of permanent impairment resulting from the injury assessed under the AMA guide must be expressed as a degree of permanent impairment of the upper extremity.

(7) The degree of permanent impairment so expressed is taken to be the degree of permanent impairment of the upper extremity for this part.

(8) For section 92 of the regulation, the relevant provision of the AMA guide is chapter 3.

SCHEDULE 2 (continued)

4 Formulas to be used for deciding lump sum compensation for permanent impairment

(1) The following formula must be used to work out the amount of lump sum compensation payable for single or multiple injuries to the upper extremity—

$$\frac{\textbf{DPI} \times \textbf{MLSC}}{\textbf{100}}$$

(2) However, for a single injury (other than an injury involving sensory loss) to the index, ring or little finger, the following formula must be used—

$$\frac{\textbf{DPI} \times \textbf{LSC}}{\textbf{MDPI}}$$

(3) Also, for multiple injuries where at least 1 injury (other than sensory loss) is to the index, ring or little finger, the amount of lump sum compensation payable for the injuries is the sum of the amounts worked out for each injury under subsection (1) and (2).

(4) In this section—

"DPI" means the degree of permanent impairment of the upper extremity assessed by a registered person as resulting from the injury or, for multiple injuries, the injuries.

"LSC" means the lump sum compensation payable for the maximum degree of permanent impairment for the injury set out in column 4 of the table of injuries.

"MDPI" means the maximum degree of permanent impairment resulting from the injury or another relevant injury set out in column 3 of the table of injuries.

"MLSC" means the maximum lump sum compensation specified in section 1(2).

SCHEDULE 2 (continued)

Division 2—Upper extremity injuries

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation $	Column 5 Maximum WRI %
1100	**Fingers and hand**			
1101	Loss of thumb	36	45 495	28.8
1102	Loss of joint of thumb. .	18	22 750	14.4
1103	Sensory loss to palmar surface of thumb	18	22 750	14.4
1104	Sensory loss on either side of thumb	8	10 110	6.4
1105	*Loss of index finger . .	18	25 735	16.29
1106	*Loss of 2 joints of index finger	13	19 305	12.22
1107	*Loss of distal joint to index finger	8	12 860	8.14
1108	Sensory loss to palmar surface of index finger .	8	10 110	6.4
1109	Sensory loss on either side of index finger	5	6 320	4
1110	Loss of middle finger . .	18	22 750	14.4
1111	Loss of 2 joints of middle finger.	13	16 430	10.4
1112	Loss of distal joint of middle finger.	8	10 110	6.4
1113	Sensory loss to palmar surface of middle finger	8	10 110	6.4
1114	Sensory loss on either side of middle finger . . .	5	6 320	4
1115	*Loss of ring finger. . . .	8	12 860	8.14
1116	*Loss of 2 joints of ring finger	6	12 860	8.14

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation $	Column 5 Maximum WRI %
1117	*Loss of distal joint of ring finger	5	7 725	4.89
1118	Sensory loss on either side of ring finger	3	3 795	2.4
1119	Sensory loss to palmar surface of ring finger. . .	5	6 320	4
1120	Sensory loss on either side of ring finger	3	3 795	2.4
1121	*Loss of little finger . . .	8	12 860	8.14
1122	*Loss of 2 joints of little finger.	6	12 860	8.14
1123	*Loss of distal joint of little finger.	5	7 725	4.89
1124	Sensory loss to palmar surface of little finger . .	5	6 320	4
1125	Sensory loss on either side of little finger.	3	3 795	2.4
1126	Loss of hand or arm below the elbow	90	113 730	72
1127	Aggravation of Dupuytren's contracture	0	0	0
1128	Crush injury to hand with multiple fractures (healed with no deformities) but resulting in mild loss of motion of all fingers with extensive scarring and soft tissue damage .	40	50 545	32

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation $	Column 5 Maximum WRI %
1200	**Wrist**			
1201	De Quervains disease, whether operated or non-operated	0	0	0
1202	Ganglion, whether operated or non-operated, with or without residual subjective symptoms or signs e.g. swelling or tenderness	0	0	0
1203	Carpal tunnel syndrome, non-operated, with no residual subjective symptoms or signs	0	0	0
1204	Carpal tunnel syndrome, whether operated or non-operated, with residual subjective symptoms or signs e.g. dysaesthesia or muscle wasting	2	2 530	1.6
1205	Fractured scaphoid, non-operated and healed with no residual subjective symptoms or signs	0	0	0
1206	Fractured scaphoid, operated.	5	6 320	4
1207	Fractured scaphoid, worst possible outcome i.e. fusion of the wrist joint	60	75 820	48

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation $	Column 5 Maximum WRI %
1208	Fracture of radius or ulna or carpus bones with moderate limitation of wrist movements and mild limitation of elbow movements	16	20 220	12.8
1300	**Elbow**			
1301	Medial or lateral epicondylitis of elbow, non-operated with no residual subjective symptoms or signs	0	0	0
1302	Medial or lateral epicondylitis of elbow, whether operated or non-operated, with residual subjective symptoms or signs e.g. pain and tenderness	2	2 530	1.6
1303	Injury to elbow region resulting in moderate loss of all movements . .	31	39 175	24.8
1400	**Shoulder and arm**			
1401	Injury to shoulder region resulting in mild loss of all movements	6	7 585	4.8
1402	Injury to shoulder region resulting in moderate loss of all movements . .	16	20 220	12.8

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation $	Column 5 Maximum WRI %
1403	Total loss of function of shoulder joint	60	75 820	48
1404	Loss of an arm.	100	126 365	80

PART 2—LOWER EXTREMITY INJURIES

Division 1—Preliminary

1 Application of pt 2

(1) This part deals with lower extremity injuries.

(2) The maximum lump sum compensation payable for a lower extremity injury is $118 465.

(3) To decide a worker's entitlement from injury, division 2 shows—

(a) the maximum degree of permanent impairment that may result from the injury; and

(b) the maximum lump sum compensation payable for the injury; and

(c) the maximum WRI.

2 How to use this part of the table

(1) Division 2 lists certain lower extremity injuries.

(2) Injuries are stated in column 2, the maximum degree of permanent impairment resulting from the injury is stated in column 3, the maximum lump sum compensation for the injury is stated in column 4, and the maximum WRI is stated in column 5.

SCHEDULE 2 (continued)

(3) The maximum degree of permanent impairment resulting from an injury is stated as a degree of permanent impairment of the lower extremity.

(4) Some injuries mentioned in division 2 are marked with an asterisk (*).

(5) These injuries may result in the same degree of maximum permanent impairment as other injuries mentioned in the division, but, for historical reasons, give rise to different amounts of maximum lump sum compensation.

(6) For more information on how to use the table of injuries, see sections 92 and 93 of the regulation.

3 Interaction between this part and the AMA guide

(1) The degree of permanent impairment resulting from an injury to a lower extremity is expressed in division 2 as a degree of permanent impairment of the lower extremity.

(2) Even though an injury is not precisely described under division 2, a similar injury often will be.

(3) If the injury is more severe than a particular similar injury, but less severe than another similar injury, the degree of permanent impairment must always be more than the less severe injury, but not as much as the more severe injury.

(4) If an injury to a lower extremity results in permanent impairment and the injury is not mentioned in division 2, the degree of permanent impairment must be assessed under the AMA guide.

(5) However, the processes that may be used under the AMA guide cannot result in an injury giving rise to a greater degree of permanent impairment from the injury than that specified under division 2.

(6) The degree of permanent impairment resulting from the injury assessed under the AMA guide must be expressed as a degree of permanent impairment of the lower extremity.

(7) The degree of permanent impairment so expressed is taken to be the degree of permanent impairment of the lower extremity for this part.

SCHEDULE 2 (continued)

(8) For section 92 of the regulation, the relevant provision of the AMA guide is chapter 3.

4 Formulas to be used for deciding lump sum compensation for permanent impairment

(1) The following formula must be used to work out the amount of lump sum compensation payable for single or multiple injuries to the lower extremity—

$$\frac{\textbf{DPI x MLSC}}{\textbf{100}}$$

(2) However, for a single injury to a toe, the following formula must be used—

$$\frac{\textbf{DPI x LSC}}{\textbf{MDPI}}$$

(3) Also, for multiple injuries where at least 1 injury (but not all injuries) is to the toes, the amount of lump sum compensation payable for the injuries is the sum of the amounts worked out for each injury under subsection (1) and (2).

(4) Also, for multiple toe injuries, the formula in subsection (2) must be used, but the value of LSC is as specified in division 2.

(5) In this section—

"DPI" means the degree of permanent impairment of the lower extremity assessed by a registered person as resulting from the injury or, for multiple injuries, the injuries.

"LSC" means the lump sum compensation payable for the maximum degree of permanent impairment for the injury set out in column 4 of the table of injuries.

"MDPI" means the maximum degree of permanent impairment resulting from the injury or another relevant injury set out in column 3 of the table of injuries.

"MLSC" means the maximum lump sum compensation specified in section 1(2).

SCHEDULE 2 (continued)

Division 2—Lower extremity injuries

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation $	Column 5 Maximum WRI %
2100	**Toes and foot**			
2101	*Loss of any toe (other than great toe)	2	12 860	8.14
2102	*Loss of great toe	12	25 735	16.29
2103	*Loss of joint of great toe	5	12 860	8.14
2104	Fracture of any metatarsal, worst possible outcome e.g. pain or loss of weight transfer	10	11 850	7.5
2105	Mid-foot amputation . . .	45	53 310	33.75
2106	Loss of a foot	63	74 635	47.25
2107	*Loss of two toes (other than great toe) of a foot.	4	15 800	10
2108	*Loss of three toes (other than great toe) of a foot	6	18 560	11.75
2109	*Loss of four toes (other than great toe) of a foot.	8	21 325	13.5
2110	*Loss of great toe and one other toe of a foot . .	14	31 595	20
2111	*Loss of great toe and two other toes of a foot .	16	39 490	25
2112	*Loss of great toe and three other toes of a foot	18	47 390	30
2113	*Loss of joint of great toe and one other toe of a foot	7	15 800	10

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation $	Column 5 Maximum WRI %
2114	*Loss of joint of great toe and two other toes of a foot	9	18 560	11.75
2115	*Loss of joint of great toe and three other toes of a foot	11	21 325	13.5
2116	*Loss of joint of great toe and four other toes of a foot	13	24 090	15.25
2117	*Loss of all toes of a foot	20	53 310	33.75
2200	**Ankle**			
2201	Ankylosis of ankle in neutral position	10	11 850	7.5
2202	Unstable ankle with ligamentous insufficiency, whether operated or non-operated	15	17 770	11.25
2203	Total loss of function of ankle joint with ankylosis in unfavourable position, worst possible outcome.	62	73 450	46.5
2204	Fracture of os calcis, worst possible outcome.	25	29 620	18.75

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation $	Column 5 Maximum WRI %
2205	Fracture of tibia and fibula resulting in shortening of the leg, gait difficulty, muscle wasting in the calf and moderate permanent stiffness of the knee and ankle joints	50	59 235	37.5
2300	**Knee**			
2301	Chondromalacia patellae, non-operated . .	0	0	0
2302	Chondromalacia patellae, operated	2	2 370	1.5
2303	Patellar subluxation or dislocation with residual instability	7	8 295	5.25
2304	Patellar fracture, whether operated or non-operated	12	14 220	9
2305	Patellectomy	22	26 065	16.5
2306	Single meniscectomy . .	7	8 295	5.25
2307	Mild aggravation of pre-existing degenerative disease in knee with subjective symptoms, but no significant clinical findings other than degenerative changes on X-ray	0	0	0

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation $	Column 5 Maximum WRI %
2308	Moderate to severe aggravation or acceleration of pre-existing disease in knee with subjective symptoms, but no significant clinical findings other than degenerative changes on X-ray	7	8 295	5.25
2309	Injury to knee region resulting in moderate loss of all movements . .	20	23 695	15
2310	Unstable knee (cruciate or collateral ligament insufficiency), whether operated or non-operated	25	29 620	18.75
2311	Unstable knee (cruciate and collateral ligament insufficiency), whether operated or non-operated	37	43 835	27.75
2312	Total knee replacement .	50	59 235	37.5
2313	Below knee amputation.	80	94 775	60
2314	Above knee amputation	100	118 465	75

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation $	Column 5 Maximum WRI %
2400	**Hip joint and leg**			
2401	Mild aggravation of pre-existing degenerative disease in hip joint with subjective symptoms, but no significant clinical findings other than degenerative changes on X-ray	0	0	0
2402	Moderate to severe aggravation or acceleration of pre-existing disease in hip joint with subjective symptoms, but no significant clinical findings other than degenerative changes on X-ray	7	8 295	5.25
2403	Injury to hip region resulting in mild loss of all movements	12	14 220	9
2404	Injury to hip region resulting in moderate loss of all movements . .	25	29 620	18.75
2405	Healed fracture of femur with moderate angulation or deformity	45	53 310	33.75
2406	Fracture of femoral neck	50	59 235	37.5
2407	Total hip replacement . .	45	53 310	33.75
2408	Loss of a leg	100	118 465	75

SCHEDULE 2 (continued)

PART 3—SPECIAL PROVISION INJURIES

Division 1—Preliminary

1 Application of pt 3

(1) This part deals with vision and hearing injuries and injury involving loss of a breast.

(2) The maximum lump sum compensation payable for a vision injury under this part is $157 955.

(3) The maximum lump sum compensation payable for a hearing injury under this part is $64 335.

(4) The maximum lump sum compensation payable for loss of a breast under this part is $47 390.

2 How to use this part of the table

(1) Division 2 lists certain vision and hearing injuries and injury involving loss of a breast.

(2) Vision and hearing injuries and injury involving loss of a breast are stated in column 2, the maximum lump sum compensation for the injury is stated in column 3, and the maximum WRI is stated in column 4.

(3) Some injuries mentioned in division 2 are marked with an asterisk (*).

(4) For historical reasons, the maximum lump sum compensation payable for these injuries may be higher relative to other injuries mentioned in this division.

(5) For more information on how to use the table of injuries, see section 92 of the regulation.

SCHEDULE 2 (continued)

3 Interaction between this part and the assessment guides

(1) The lump sum compensation payable for a vision or hearing injury mentioned in division 2 is the maximum lump sum compensation payable for the injury.

(2) If a vision or hearing injury results in permanent impairment of vision or hearing and the injury is not mentioned in division 2, the degree of permanent impairment resulting from the injury must be assessed under the relevant assessment guide.

(3) The degree of permanent impairment must be expressed as a degree of total vision or hearing loss—

(a) for each eye or ear; or

(b) if the injury is to both eyes or both ears—of both eyes or both ears.

(4) In this section—

"relevant assessment guide" means—

(a) for a vision injury—the ophthalmologists guide; or

(b) for a hearing injury—the hearing loss tables.

4 Formula to be used for deciding lump sum compensation for permanent impairment

(1) The following formula must be used to work out the amount of lump sum compensation payable for a vision or hearing injury—

$$\frac{\textbf{DPI x LSC}}{\textbf{100}}$$

(2) However, for multiple injuries involving at least 1 of an injury to vision, hearing or a breast, the amount of lump sum compensation payable for the injuries is the sum of the amounts worked out for each injury under subsection (1).

(3) In this section—

"DPI" means—

SCHEDULE 2 (continued)

(a) for hearing loss from industrial deafness—the assessed degree of permanent impairment resulting from the injury less 5%;[48] and

(b) for another injury under this part—the assessed degree of permanent impairment resulting from the injury.

"LSC" means the lump sum compensation payable under this part for the injury.

Division 2—Special provision injuries

Column 1 Code No.	Column 2 Injury	Column 3 Maximum lump sum compensation $	Column 4 Maximum WRI %
3100	**Vision**		
3101	*Loss of vision in 1 eye (corrected vision)	51 465	32.58
3102	*Total loss of vision in 1 eye resulting from loss of an eyeball	57 890	36.65
3103	Total loss of vision	157 955	100
3104	Total loss of vision of 1 eye with serious diminution of vision in the other eye (less than 10% vision remaining) . .	134 265	85
3200	**Hearing**		
3201	Loss of hearing in 1 ear.	31 595	20
3202	*Binaural hearing loss	64 335	40.73

48 For more information about the 5% reduction, see section 125 (Entitlements for industrial deafness) of the Act.

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum lump sum compensation $	Column 4 Maximum WRI %
3300	**Injury to breast**		
3301	*Loss of breast	47 390	30

PART 4—OTHER INJURIES

Division 1—Preliminary

1 Application of pt 4

(1) This part deals with the following injuries (**"system injuries"**)—

(a) injuries to the musculo-skeletal system;

(b) injuries to the nervous system;

(c) injuries to the respiratory system;

(d) injuries to the cardiovascular system;

(e) injuries to the alimentary system;

(f) injuries to the urinary or reproductive system;

(g) injuries to the skin.

(2) The maximum lump sum compensation payable for an injury under this part is $157 955.

(3) To decide a workers entitlement from injury, division 2 shows—

(a) the maximum degree of permanent impairment that may result from the injury; and

(b) the maximum lump sum compensation payable for the injury; and

(c) the maximum WRI.

SCHEDULE 2 (continued)

2 How to use this part of the table

(1) Division 2 lists certain system injuries.

(2) Injuries are stated in column 2, the maximum degree of permanent impairment resulting from the injury is stated in column 3, the maximum lump sum compensation for the injury is stated in column 4, and the maximum WRI is stated in column 5.

(3) The maximum degree of permanent impairment resulting from an injury is stated as a degree of permanent impairment of the whole person.

(4) Some injuries mentioned in division 2 are marked with an asterisk (*).

(5) These injuries may result in the same degree of permanent impairment as other injuries mentioned in the division, but, for historical reasons, give rise to different amounts of maximum lump sum compensation.

(6) For more information on how to use the table of injuries, see sections 92 and 93 of the regulation.

3 Interaction between this part and the AMA guide

(1) The degree of permanent impairment resulting from a system injury is expressed in division 2 as a degree of permanent impairment of the whole person.

(2) Even though an injury is not precisely described under division 2, a similar injury often will be.

(3) If the injury is more severe than a particular similar injury, but less severe than another similar injury, the degree of permanent impairment must always be more than the less severe injury, but not as much as the more severe injury.

(4) If a system injury results in permanent impairment and the injury is not mentioned in division 2, the degree of permanent impairment must be assessed under the AMA guide.

(5) However, the processes that may be used under the AMA guide cannot result in a system injury giving rise to a greater degree of permanent impairment from the injury than that specified under division 2.

SCHEDULE 2 (continued)

(6) The degree of permanent impairment resulting from the injury assessed under the AMA guide must be expressed as a degree of permanent impairment of the whole person.

(7) The degree of permanent impairment so expressed is taken to be the degree of permanent impairment of the whole person for this part.

(8) For section 92 of the regulation, the relevant provisions of the AMA guide are—

(a) for injuries to the cervicothoracic, thoracolumbar or lumbosacral spine—chapter 3; and

(b) for injuries to the pelvis—chapter 3; and

(c) for injuries to the brain and cranial nerves—chapters 4 and 9; and

(d) for spinal cord injuries—chapters 3 and 4; and

(e) for respiratory system injuries—chapter 5; and

(f) for cardiovascular system injuries—chapter 6; and

(g) for alimentary system injuries—chapter 10; and

(h) for urinary or reproductive system injuries—chapter 11; and

(i) for skin injuries—chapter 13.

4 Formulas to be used for deciding lump sum compensation for permanent impairment

(1) The following formula must be used to work out the amount of lump sum compensation payable for single or multiple system injuries—

$$\frac{\textbf{DPI x MLSC}}{\textbf{100}}$$

(2) However, for loss of smell, taste or speech, a cervical cord injury (with or without fracture) or complete paraplegia, the following formula must be used—

$$\frac{\textbf{DPI x LSC}}{\textbf{MDPI}}$$

(3) Also, for multiple injuries involving at least 1 injury that is loss of smell, taste or speech, a cervical cord injury or paraplegia, the amount of

SCHEDULE 2 (continued)

lump sum compensation payable for the injuries is the sum of the amounts worked out for each injury under subsections (1) and (2).

(4) In this section—

"DPI" means the degree of permanent impairment of the whole person assessed by a registered person as resulting from the injury or, for multiple injuries, the injuries.

"LSC" means the lump sum compensation payable for the maximum degree of permanent impairment for the injury set out in column 4 of the table of injuries.

"MDPI" means the maximum degree of permanent impairment resulting from the injury or another relevant injury set out in column 3 of the table of injuries.

"MLSC" means the maximum lump sum compensation specified in section 1(2).

Division 2—System injuries

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation $	Column 5 Maximum WRI %
4100	**Musculo-skeletal system**			
Cervicothoracic spine				
4101	Hyperextension musculo-ligamentous injury to cervical spine region with subjective symptoms, but no significant clinical findings	0	0	0

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation $	Column 5 Maximum WRI %
4102	Mild aggravation of pre-existing degenerative disease in cervical spine with subjective symptoms, but no significant clinical findings other than degenerative changes on X-ray	0	0	0
4103	Moderate to severe aggravation or acceleration of pre-existing degenerative disease in cervical spine with subjective symptoms, but no significant clinical findings other than degenerative changes on X-ray	5	7 900	5
4104	Compression fracture of a vertebral body(s) or posterior element fracture (spinous or transverse process) without dislocation, healed with no complications, but local subjective symptoms, referred pain and mild restriction of neck movements	5	7 900	5

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation $	Column 5 Maximum WRI %
4105	Prolapsed intervertebral disc in cervical spine with referred pain, non-operated with resolution of subjective symptoms, and no loss of range of movements .	10	15 800	10
4106	Prolapsed intervertebral disc in cervical spine with referred pain, treated surgically by discectomy and fusion with resolution of referred pain. Persisting neck pain with moderate loss of range of movements	15	23 695	15
4107	Vertebral fractures or dislocations of cervical spine, treated surgically by fusion with no residual neurological compromise, but severe loss of range of movements	25	39 490	25

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation $	Column 5 Maximum WRI %
Thoracolumbar spine				
4108	Mild aggravation of pre-existing degenerative disease in thoracic spine with subjective symptoms, but no significant clinical findings other than degenerative changes on X-ray	0	0	0
4109	Moderate to severe aggravation or acceleration of pre-existing degenerative disease in thoracic spine with subjective symptoms, but no significant clinical findings other than degenerative changes on X-ray	5	7 900	5
4110	Minor compression fracture of vertebral body(s) in thoracic spine, healed with subjective symptoms, but no physical signs. . .	5	7 900	5
4111	Major compression fracture of vertebral body(s) in thoracic spine, healed with subjective symptoms, but no physical signs. . .	10	15 800	10

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation $	Column 5 Maximum WRI %
Lumbosacral spine				
4112	Musculo-ligamentous injury to lumbosacral spine region with subjective symptoms, but no significant clinical findings.	0	0	0
4113	Mild aggravation of pre-existing degenerative disease in lumbosacral spine with subjective symptoms, but no significant clinical findings other than degenerative changes on X-ray	0	0	0
4114	Moderate to severe aggravation or acceleration of pre-existing disease in lumbosacral spine with subjective symptoms, but no significant clinical findings other than degenerative changes on X-ray	5	7 900	5
4115	Moderate to severe aggravation of pre-existing spondylolisthesis, treated surgically by discectomy or fusion with resolution of symptoms	10	15 800	10

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation $	Column 5 Maximum WRI %
4116	Minor compression fracture of vertebral body(s) in lumbar region, healed with subjective symptoms, but no physical signs. . .	5	7 900	5
4117	Major compression fracture of vertebral body(s) in lumbar region, healed with subjective symptoms, but no physical signs. . .	10	15 800	10
4118	Prolapsed intervertebral disc in lumbosacral spine with referred pain, non-operated with resolution of referred pain and back pain. No loss of range of movements	10	15 800	10
4119	Prolapsed intervertebral disc in lumbosacral spine with referred pain, treated surgically by discectomy or fusion with resolution of referred pain, but persisting low back pain. Mild loss of range of movements	15	23 695	15

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation $	Column 5 Maximum WRI %
4120	Prolapsed intervertebral disc in lumbosacral spine with referred pain, treated surgically by discectomy or fusion, but with persisting referred pain and low back pain. Moderate loss of range of movements .	25	39 490	25
Pelvis				
4121	Healed fracture of pelvis without displacement in any region (other than acetabulum, coccyx and sacrum) with subjective symptoms, but no significant signs	0	0	0
4122	Healed fracture of pelvis with displacement in any region (other than acetabulum, coccyx and sacrum) with subjective symptoms, but no significant signs	5	7 900	5
4123	Fracture of coccyx, whether operated or non-operated	5	7 900	5

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation $	Column 5 Maximum WRI %
4124	Healed fracture(s) of pelvis in any region (other than acetabulum, coccyx and sacrum) with displacement and deformity and subjective symptoms and signs . . .	10	15 800	10
4125	Fracture of sacrum with or without involvement of the sacro-iliac joint with subjective symptoms and signs . . .	10	15 800	10
4126	Fracture or dislocation of symphysis or sacro-iliac joint	10	15 800	10
4127	Fracture of acetabulum with displacement and deformity and residual subjective symptoms and signs in hip joint . . .	50	78 980	50
4200	**Nervous system**			
Brain and cranial nerves				
4201	Mild vertigo with subjective symptoms, but no significant signs .	0	0	0
4202	Severe vertigo with subjective symptoms and signs and totally dependent	70	110 570	70
4203	*Loss of smell	3	19 305	12.22
4204	*Loss of smell and taste	6	32 160	20.36

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation $	Column 5 Maximum WRI %
4205	*Loss of speech.	35	90 065	57.02
4206	Fracture of the mid third of the face with permanent nerve involvement.	24	37 910	24
4207	Chronic organic brain syndrome i.e. diffuse brain damage following head injuries, cerebral anoxia, inhalation of toxic substances etc., worst possible outcome.	100	157 955	100
Spinal cord injuries				
4208	*Cervical cord injury with or without fracture	75	142 160	90
4209	Thoracic cord injury with or without fracture	60	94 775	60
4210	Cauda equina syndrome with or without fracture	60	94 775	60
4211	*Complete paraplegia . .	75	142 160	90
4212	Totally dependent quadriplegia.	100	157 955	100
4300	**Respiratory system**			
4301	Healed fractured rib(s) with subjective symptoms, but no significant signs	0	0	0

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation $	Column 5 Maximum WRI %
4302	Healed pulmonary contusion with subjective symptoms, but no significant signs .	0	0	0
4303	Toxic inhalation injury, hypersensitivity pneumonitis, pneumoconioses, occupational asthma, C.O.A.D. (bronchitis or emphysema), R.A.D.S. (Reactive airways dysfunction syndrome), pulmonary embolus, all on optimal medical management—			
	• no respiratory subjective symptoms or significant signs . .	0	0	0
	• mild respiratory subjective symptoms or minor signs	25	39 490	25
	• moderate respiratory subjective symptoms or moderate signs . . .	50	78 980	50
	• severe respiratory subjective symptoms or significant signs . .	100	157 955	100

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation $	Column 5 Maximum WRI %
4304	Mesothelioma or lung cancer	100	157 955	100
4400	**Cardiovascular system**			
Coronary artery disease				
4401	A history of angina with demonstrated constitutional coronary artery disease, on optimal medical treatment	0	0	0
4402	A history of myocardial infarction, with no post infarction angina, on optimal medical treatment	15	23 695	15
4403	A history of myocardial infarction with persisting post infarction angina, on optimal medical treatment	50	78 980	50
4404	A history of myocardial infarction with persisting post infarction angina and subjective symptoms and signs of congestive heart failure, on optimal medical treatment	100	157 955	100

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation $	Column 5 Maximum WRI %
4500	**Alimentary system**			
4501	Musculo-ligamentous injury to abdominal wall	0	0	0
4502	Splenectomy	5	7 900	5
4503	Subjective symptoms (e.g. local pain or dysaesthesia) following hernia repair(s), but no significant signs	0	0	0
4504	Subjective symptoms and signs (e.g. pain or dysaesthesia, tenderness) following hernia repair(s)	2	3 160	2
4505	Primary or recurrent hernia when surgery is an absolute contraindication	10	15 800	10
4506	Viral hepatitis—			
	• mild	25	39 490	25
	• moderate	50	78 980	50
	• severe	100	157 955	100
4600	**Urinary and reproductive systems**			
4601	Loss of 1 kidney	10	15 800	10
4602	Urinary incontinence. . .	60	94 775	60
4603	Loss of both kidneys or only functioning kidney	100	157 955	100
4604	Loss of fertility	15	23 695	15
4605	Impotence	15	23 695	15

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation $	Column 5 Maximum WRI %
4606	Loss of sexual function (both impotence and infertility)	30	47 390	30
4607	Loss of genital organs . .	50	78 980	50
4700	**Skin**			
4701	Contact irritant dermatitis. Removal from exposure to irritant results in resolution of signs and subjective symptoms with no ongoing treatment required	0	0	0
4702	Aggravation of constitutional dermatitis, resolved by removal from exposure to irritant	0	0	0
4703	Moderate solar induced skin disease that is non-malignant	0	0	0
4704	Chronic contact dermatitis. Signs and subjective symptoms persist intermittently on removal from exposure to the primary irritant. Intermittent treatment required	10	15 800	10

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation $	Column 5 Maximum WRI %
4705	Chronic contact dermatitis. Signs and subjective symptoms persist almost continuously on removal from exposure to the primary irritant. Intermittent to constant treatment required	20	31 595	20
4706	Solar induced skin disease that is malignant	25	39 490	25
4707	Persistent neurodermatitis secondary to occupational contact irritant dermatitis. Signs and subjective symptoms persist continuously on removal from exposure to the primary irritant and are exacerbated by exposure to secondary irritants. Constant treatment required	30	47 390	30

SCHEDULE 2 (continued)

PART 5—PRESCRIBED DISFIGUREMENT

Division 1—Preliminary

1 Application of pt 5

(1) This part deals with prescribed disfigurement.

(2) The maximum lump sum compensation payable for prescribed disfigurement is $78 980.

(3) To decide a workers entitlement from injury, division 2 shows—

(a) the maximum degree of permanent impairment that may result from the injury; and

(b) the maximum lump sum compensation payable for the injury; and

(c) the maximum WRI.

2 How to use this part of the table

(1) Division 2 lists prescribed disfigurements.

(2) Prescribed disfigurements resulting from injury are stated in column 2, the maximum percentage of permanent impairment resulting from the disfigurement is stated in column 3,[49] the maximum lump sum compensation for the disfigurement is stated in column 4, and the maximum WRI is stated in column 5.

49 The actual percentage of permanent impairment resulting from the prescribed disfigurement must be assessed having regard to the severity of the prescribed disfigurement—see section 128(3) (Entitlements of worker who sustains prescribed disfigurement) of the Act.

SCHEDULE 2 (continued)

Division 2—Prescribed disfigurement

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation $	Column 5 Maximum WRI %
5100	**Prescribed disfigurement**			
5101	Mild almost invisible linear scarring following surgery or trauma in lines of election to any part(s) of the body with minimal discolouration, normal texture and elevation	0	0	0
5102	Moderate linear scarring following surgery or trauma crossing lines of election to any part(s) of the body with minimal discolouration, normal texture and elevation . . .	2	1 580	1
5103	Moderate to severe linear scarring following surgery or trauma in or crossing lines of election to any part(s) of the body. Discoloured, indurated, atrophic or hypertrophic	10	7 900	5
5104	Area scarring to any part(s) of the body following surgery or trauma. Atrophic or hypertrophic, markedly discoloured	20	15 800	10

SCHEDULE 2 (continued)

Column 1 Code No.	Column 2 Injury	Column 3 Maximum degree of permanent impairment	Column 4 Maximum lump sum compensation $	Column 5 Maximum WRI %
5105	Depressed cheek, nasal or frontal bones following trauma.	35	27 645	17.5
5106	Loss, or severe deformity, of outer ear. .	40	31 595	20
5107	Severe, bilateral gross facial deformity following burns or other trauma	50	39 490	25
5108	Loss of entire nose	50	39 490	25
5109	Gross scarring following burns to multiple body areas. Some areas healing spontaneously and some requiring grafting. Gross scarring at the burn and donor sites. Outcome resulting in fragile, dry, cracking skin at graft sites necessitating the need for wearing of special garments. Severe cases resulting in loss of sweat glands and lack of sweating leading to the necessity to be in a continuous air conditioned environment	100	78 980	50

SCHEDULE 2 (continued)

PART 6—PSYCHIATRIC OR PSYCHOLOGICAL INJURIES

1 Application of pt 6

(1) This part deals with psychiatric or psychological injuries.

(2) The maximum lump sum compensation payable for a psychiatric or psychological injury is $157 955.

(3) However, most injuries will entitle an injured worker to a lesser amount.

2 Interaction between this part and the AMA guide

(1) Permanent impairment resulting from a psychiatric or psychological injury must be assessed under the AMA guide.

(2) Permanent impairment resulting from an injury must be expressed as a degree of permanent impairment of the whole person.

(3) The degree of permanent impairment so expressed is taken to be the maximum degree of permanent impairment for this part.

(4) For section 92 of the regulation, the relevant provision of the AMA guide is chapter 14.

3 Formula to be used for deciding lump sum compensation for permanent impairment

(1) The following formula must be used to work out the amount of lump sum compensation payable for psychiatric or psychological injuries—

$$\frac{\text{DPI x MLSC}}{100}$$

(2) In this section—

"DPI" means the degree of permanent impairment assessed by a registered person as resulting from the injury.

"MLSC" means the maximum lump sum compensation specified in section 1(2).

SCHEDULE 3

GRADUATED SCALE OF ADDITIONAL COMPENSATION FOR CERTAIN WORKERS

section 96

1 Graduated scale

(1) This schedule contains the graduated scale for additional compensation for a worker who sustains an injury that results in a WRI of 50% or more.

(2) The maximum amount of lump sum compensation payable under this schedule is $157 955.

2 How to use the graduated scale

(1) The WRI calculated under section 183[50] of the Act is shown in column 2.

(2) A worker who sustains a WRI shown in column 2 is entitled to additional lump sum compensation in the amount shown for the corresponding entry in column 3.

GRADUATED SCALE

Column 1 Code No.	Column 2 WRI %	Column 3 Additional lump sum compensation $
8100	50	6 100
8101	51	12 165

50 Section 183 (Calculation of WRI) of the Act

SCHEDULE 3 (continued)

Column 1 Code No.	**Column 2 WRI %**	**Column 3 Additional lump sum compensation $**
8102	52	18 245
8103	53	24 310
8104	54	30 395
8105	55	36 460
8106	56	42 540
8107	57	48 620
8108	58	54 685
8109	59	60 765
8110	60	66 830
8111	61	72 915
8112	62	78 980
8113	63	85 075
8114	64	91 140
8115	65	97 225
8116	66	103 290
8117	67	109 370
8118	68	115 435
8119	69	121 515
8120	70	127 595
8121	71	133 660
8122	72	139 745
8123	73	145 810
8124	74	151 890
8125	75–100	157 955

SCHEDULE 4

GRADUATED SCALE FOR ADDITIONAL COMPENSATION FOR GRATUITOUS CARE

section 97

1 Graduated scale

(1) This schedule contains the graduated scale for additional compensation for gratuitous care.

(2) The maximum amount of lump sum compensation payable under this schedule is $157 955.

2 How to use this graduated scale

(1) The WRI calculated under section 183[51] of the Act is shown in column 2.

(2) The range of dependency assessed under the modified barthel index is shown in column 3.

(3) In column 3—

- moderate is a modified barthel index total score of 50–74
- severe is a modified barthel index total score of 25–49
- total is a modified barthel index total score of 0–24.

(4) The worker's additional lump sum compensation entitlement is shown for the corresponding entry in column 4.

51 Section 183 (Calculation of WRI) of the Act

SCHEDULE 4 (continued)

GRADUATED SCALE

Column 1 Code number	**Column 2 WRI %**	**Column 3 Range of dependency (modified barthel index)**	**Column 4 Additional lump sum compensation $**
9094	15–39	Moderate	1 580
9095		Severe	3 160
9096		Total	4 740
9097	40–49	Moderate	2 950
9098		Severe	6 005
9099		Total	8 955
9100	50–59	Moderate	13 075
9101		Severe	26 140
9102		Total	39 205
9103	60–69	Moderate	32 680
9104		Severe	58 800
9105		Total	78 395
9106	70–79	Moderate	45 730
9107		Severe	84 930
9108		Total	117 585
9109	80–89	Moderate	52 265
9110		Severe	105 630
9111		Total	156 775
9112	90–94	Moderate	58 800
9113		Severe	117 585
9114		Total	182 900
9115	95–100	Moderate	65 320
9116		Severe	130 665
9117		Total	195 960

SCHEDULE 5

GRADUATED SCALE OF CARE REQUIRED FOR PAYMENT OF CARING ALLOWANCE

section 99

1 Graduated scale

This schedule contains the graduated scale for the payment of caring allowance.

2 How to use this graduated scale

(1) The range of dependency assessed under the modified barthel index is shown in column 1.

(2) In column 1—

- minimal is a modified barthel index total score of 91–99
- mild is a modified barthel index total score of 75–90
- moderate is a modified barthel index total score of 50–74
- severe is a modified barthel index total score of 25–49
- total is a modified barthel index total score of 0–24.

(3) The maximum number of hours of care required in a week is shown for the corresponding entry in column 2.

SCHEDULE 5 (continued)

GRADUATED SCALE

Column 1 **Range of dependency** **(modified barthel index)**	**Column 2** **Maximum hours of care required in a week**
Minimal	<10
Mild	13.0
Moderate	20.0
Severe	23.5
Total	27.0

SCHEDULE 6

LEGAL PROFESSIONAL COSTS

section 116

Column A **Pre-proceeding notification and negotiation**	**Column B** **Compulsory conference**	**Column C** **Investigation by expert**	**Column D** **Pre-proceedings court applications**
$2 000	$135 for the first hour or part of an hour $105 for each additional hour or part of an hour	$270	$400

ENDNOTES

1 Index to endnotes

2 Date to which amendments incorporated

This is the reprint date mentioned in the Reprints Act 1992, section 5(c). Accordingly, this reprint includes all amendments that commenced operation on or before 1 July 2004. Future amendments of the Workers' Compensation and Rehabilitation Regulation 2003 may be made in accordance with this reprint under the Reprints Act 1992, section 49.

3 Key

Key to abbreviations in list of legislation and annotations

Key		Explanation	Key		Explanation
AIA	=	**Acts Interpretation Act 1954**	**(prev)**	=	**previously**
amd	=	**amended**	**proc**	=	**proclamation**
amdt	=	**amendment**	**prov**	=	**provision**
ch	=	**chapter**	**pt**	=	**part**
def	=	**definition**	**pubd**	=	**published**
div	=	**division**	**R[X]**	=	**Reprint No.[X]**
exp	=	**expires/expired**	**RA**	=	**Reprints Act 1992**
gaz	=	**gazette**	**reloc**	=	**relocated**
hdg	=	**heading**	**renum**	=	**renumbered**
ins	=	**inserted**	**rep**	=	**repealed**
lap	=	**lapsed**	**(retro)**	=	**retrospectively**
notfd	=	**notified**	**rv**	=	**revised edition**
o in c	=	**order in council**	**s**	=	**section**
om	=	**omitted**	**sch**	=	**schedule**
orig	=	**original**	**sdiv**	=	**subdivision**
p	=	**page**	**SIA**	=	**Statutory Instruments Act 1992**
para	=	**paragraph**	**SIR**	=	**Statutory Instruments Regulation 2002**
prec	=	**preceding**	**SL**	=	**subordinate legislation**
pres	=	**present**	**sub**	=	**substituted**
prev	=	**previous**	**unnum**	=	**unnumbered**

4 Table of reprints

Reprints are issued for both future and past effective dates. For the most up-to-date table of reprints, see the reprint with the latest effective date.

If a reprint number includes a letter of the alphabet, the reprint was released in unauthorised, electronic form only.

Reprint No.	Amendments included	Effective	Notes
1	none	1 July 2003	
1A	to 2004 SL No. 74	1 July 2004	

5 List of legislation

Workers' Compensation and Rehabilitation Regulation 2003 SL No. 119
made by the Governor in Council on 19 June 2003
notfd gaz 20 June 2003 pp 633–6
ss 1–2 commenced on date of notification
remaining provisions commenced 1 July 2003 (see s 2)
exp 1 September 2013 (see SIA s 54)
Note—The expiry date may have changed since this reprint was published. See the latest reprint of the SIR for any change.

amending legislation—

Workers' Compensation and Rehabilitation Amendment Regulation (No. 1) 2004 SL No. 74
notfd gaz 18 June 2004 pp 506–7
ss 1–2 commenced on date of notification
remaining provisions commenced 1 July 2004 (see s 2)

6 List of annotations

Definitions
s 3 def **"estimated claims liability"** ins 2004 SL No. 74 s 4

Deemed premium—s 20
s 13 om 2004 SL No. 74 s 5

Premium for appeals—Act, s 569(2)(a)
s 14 sub 2004 SL No. 74 s 6

Annual levy—Act, s 81
s 20 sub 2004 SL No. 74 s 7

Provisional annual levy
s 20A ins 2004 SL No. 74 s 8

Conditions of licence—Act, s 83
s 22 amd 2004 SL No. 74 s 9

Deemed premium for appeals—Act, s 569(2)(a)
s 23A ins 2004 SL No. 74 s 10

PART 4—AMOUNT OF CALCULATION OF LIABILITY FOR SELF-INSURERS
Division 3A—Estimated claims liability
div 3A (ss 75A–75L)ins 2004 SL No. 74 s 11

PART 10—TRANSITIONAL PROVISION FOR WORKERS' COMPENSATION AND REHABILITATION AMENDMENT REGULATION (No. 1) 2004
pt hdg prev pt 10 hdg om R1 (see RA s 7(1)(k))
pres pt 10 hdg ins 2004 SL No. 74 s 12

Estimated claims liability for ss 20 and 23A
s 121 prev s 121 om R1 (see RA s 40)
pres s 121 ins 2004 SL No. 74 s 12

Adjustment of annual levy
s 122 ins 2004 SL No. 74 s 12

SCHEDULE 7—SUBORDINATE LEGISLATION AMENDED
om R1 (see RA s 40)