Queensland

Workers' Compensation and Rehabilitation Act 2003

Workers' Compensation and Rehabilitation Regulation 2003

Current as at 1 January 2006

Information about this reprint

This regulation is reprinted as at 1 January 2006. The reprint—

- shows the law as amended by all amendments that commenced on or before that day (Reprints Act 1992 s 5(c))
- incorporates all necessary consequential amendments, whether of punctuation, numbering or another kind (Reprints Act 1992 s 5(d)).

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.

Minor editorial changes allowed under the provisions of the Reprints Act 1992 mentioned in the following list have also been made to—

- use standard punctuation consistent with current drafting practice (s 27)
- use aspects of format and printing style consistent with current drafting practice (s 35)
- correct minor errors (s 44).

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 the reprint, including table of corrected minor errors**
- **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

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Workers' Compensation and Rehabilitation Regulation 2003

[as amended by all amendments that commenced on or before 1 January 2006]

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' (4th edition) 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.

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

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

binaural tables means the binaural tables recommended and published by National Acoustic Laboratories.

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.

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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

hearing loss tables means 'Report No. 118—Improved Procedure for Determining Percentage Loss of Hearing' (1988) published by National Acoustic Laboratories.

high risk industry means an industry stated in schedule 5A.

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.

last employment period see section 15(3)(b)(ii).

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 'Percentage Incapacity—A Guide for Members' published by the Royal 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.

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.

structural loss, for schedule 2, means anatomical loss.

Example—

an amputation of a finger

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.

5 WorkCover's capital adequacy—Act, s 453

In order to maintain capital adequacy for section 453(1)(b) of the Act, WorkCover must—

(a) meet the minimum capital requirements for insurers prescribed under Prudential Standard GPS 110[8] under the *Insurance Act 1973* (Cwlth); and

(b) calculate its capital adequacy in a way prescribed under Prudential Standard GPS 110 under the *Insurance Act 1973* (Cwlth).

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.

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

8 Prudential Standard GPS 110 (Capital adequacy for general insurers) can be obtained from the Australian Prudential Regulatory Authority (APRA) or <www.apra.gov.au>.

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.[9]

8 Assessment of premium

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

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

(3) 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.

(4) 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.

(5) 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.

9 Declaration of wages

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

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9 Section 11 (Payment of premium by instalments)

(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[10] 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.

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10 Section 48 (Employer's obligation to insure) 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.

(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)[11] 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[12] of the Act that applies to the period of insurance.

W means—

11 Section 569 (Starting appeals) of the Act

12 Section 54 (Setting of premium) of the Act

(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.

15 Former employer may apply to cancel policy

(1) This section applies if a person wishes to cancel a policy because the person has stopped employing workers (a ***former employer***).

(2) This section does not apply to a former employer of only household workers.

(3) The former employer must give WorkCover—

(a) written notice that the former employer—

(i) stopped employing workers on and from a date stated in the notice; and

(ii) wishes to cancel the policy; and

(b) written details of—

(i) the address to which any document addressed to the former employer may be sent; and

(ii) the former employer's wages in relation to the period starting on 1 July last preceding the day on which employment of workers stopped and ending on that day (***last employment period***).

15A Cancellation of policy if workers no longer employed

(1) This section applies if—

(a) a person (a ***former employer***) has notified WorkCover under section 15 that the former employer has stopped employing workers; or

(b) WorkCover is satisfied, after making reasonable enquiries, that a person has stopped employing workers (also a ***former employer)***.

(2) WorkCover may cancel the former employer's policy.[13]

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

(4) If the premium paid by the former employer for the last employment period is—

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

(b) less than the amount of premium assessed under subsection (3)—the former 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.

(5) This section does not limit anything in chapter 2, part 3, division 2[14] of the Act.

Division 2 Employer excess

16 Excess period—Act, s 65

(1) For section 65(2) of the Act, the amount prescribed is $500.

(2) However, if the amount of weekly compensation payable to a worker under chapter 3, part 9[15] of the Act is equal to or less than $500, the amount prescribed for section 65(2) of the Act is an amount equal to the weekly amount less $1.

Example of amount prescribed for subsection (2)—

An injured worker engaged in part-time employment has an entitlement to a weekly payment of compensation of $200. The amount prescribed is $199.

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13 For WorkCover's liability to pay compensation for an injury sustained by a worker, see section 109(2) (Who must pay compensation) of the Act.

14 Chapter 2 (Employer's obligations), part 3 (Insurance under WorkCover policies generally), division 2 (Assessments on contravention of general obligation to insure) of the Act

15 Chapter 3 (Compensation), part 9 (Weekly payment of compensation) of the Act

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) 5% of the employer's premium for the period of insurance; or

(b) $10.

(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 3 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—$15000; or

(b) for a group employer—$20000.

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—

$$L = (ECL \times R) + \$10000$$

(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[16] 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.

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16 Section 81 (Annual levy payable) of the Act

(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.

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.

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[17] 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—

17 Section 54 (Setting of premium) of the Act

(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.

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

(1) For section 569(2)(a)[18] of the Act, deemed levy, for a self-insurer for a financial year of the self-insurer's licence, is an amount calculated under the formula—

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

(2) In subsection (1)—

DL means deemed levy.

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 under section 81[19] of the Act for the particular financial year.

18 Section 569 (Starting appeals) of the Act

19 Section 81 (Annual levy payable) of the Act

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*.

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[20] 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).

(6) However, insurance cover provided under a contract of insurance under this section is limited to compensation under chapter 3, parts 10 and 11[21] 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.

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

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

26 Insurance of vocational placement students

(1) In this section—

registered training organisation see the *Training and Employment Act 2000*, section 14.[22]

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[23] of the Act apply as if—

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

(b) vocational placement were the employment; and

(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

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22 For references to the *Training and Employment Act 2000*, now see the *Vocational Education, Training and Employment Act 2000*, section 317.

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

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[24] 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.

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[25] of the Act with an eligible person.

(2) The eligible person must keep documents showing the remuneration or other benefit for performing work, or

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

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

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[26] 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[27] of the Act provides for a matter to be decided by a medical assessment tribunal in accordance with chapter 11[28] of the Act or for an appeal to a court in accordance with chapter 13[29] 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.

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26 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

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

28 Chapter 11 (Medical assessment tribunals) of the Act

29 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[30] 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—

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30 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

(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;

(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[31] of the Act.

31 Section 87 (Self-insurer replaces WorkCover in liability for injury) 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

(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,[32] 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—

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

(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

(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)[33] 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.

33 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[34] 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

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

(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***).

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 3B Self-insurers who become non-scheme employers

Subdivision 1 Preliminary

75M Purpose of div 3B

This division sets out the process for the calculation of an amount for a non-scheme employer's liability for section 105I[35] of the Act.

35 Section 105I (Assessing liability after cancellation) of the Act

75N Definition for div 3B

In this division—

continued licence, of a non-scheme employer, see section 105B(2)[36] of the Act.

Subdivision 2 Calculation

75O Appointment of actuary for calculation

WorkCover and the non-scheme employer must each appoint an actuary to calculate an amount for the non-scheme employer's liability.

75P 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 non-scheme employer'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 non-scheme employer's continued licence is cancelled under section 105E[37] (the ***cancellation day***) of the Act.

(3) The data may only relate to the period before the exit date.

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36 Section 105B (Non-scheme employer continues to be self-insurer for 12 months) of the Act

37 Section 105E (Cancellation of continued licence) of the Act

75Q Non-scheme employer to give actuaries information

The non-scheme employer 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 75R(3).

75R 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 non-scheme employer; and

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

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

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

(v) the frequency of claims for damages against the non-scheme 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 non-scheme employer 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.

75S 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 non-scheme employer within 2 months after the cancellation day.

75T Agreement

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

75U Reference to actuarial arbiter if no agreement

If WorkCover and the non-scheme 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 the summary report.

75V Arbiter's costs

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

75W Payment of amount for liability

(1) The amount the non-scheme employer must pay WorkCover for the liability is the amount agreed to by WorkCover and the non-scheme employer (the ***agreed amount***) or, if there is no agreement, the amount decided by the arbiter (the ***decided amount***).

(2) The agreed amount or decided amount paid to WorkCover must be adjusted by the non-scheme employer'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 non-scheme employer between the assessment day and the cancellation day.

Subdivision 3 Recalculation

75X Purpose of sdiv 3

This subdivision sets out the process for the finalisation under section 105I(5)[38] of the Act of an amount for a non-scheme employer's liability.

75Y Appointment of actuary for recalculation

At the end of 4 years after the non-scheme employer's continued licence is cancelled under section 105E of the Act, WorkCover and the non-scheme employer must each appoint an actuary to recalculate an amount for the non-scheme employer's liability under section 105I of the Act.

75Z Recalculation

(1) The recalculation must—

(a) be prepared under the actuarial standard; and

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

38 Section 105I (Assessing liability after cancellation) of the Act

(c) as far as practicable, be based on the self-insurer's claims experience; 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 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 WorkCover became liable for compensation and damages for the non-scheme employer's liability and the end of 4 years after that day.

(2) The recalculation must be based on data as at the last day of the last financial quarter for which data is available at the end of 4 years after the day WorkCover became liable for compensation and damages for the non-scheme employer's outstanding liability.

(3) The data may only relate to the period before the exit date.

75ZA WorkCover to give actuaries information

WorkCover must give the actuaries the information necessary to enable the actuaries to complete the recalculation within the time mentioned in section 75ZB(3).

75ZB 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 non-scheme employer; and

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

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

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

(v) the frequency of claims for damages against the non-scheme 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 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 4 years after the day WorkCover became liable for compensation and damages for the non-scheme employer's liability.

75ZC 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 non-scheme employer within 2 months after the end of 4 years after the day WorkCover became liable for compensation and damages for the non-scheme employer's liability.

75ZD Agreement on recalculation

WorkCover and the non-scheme employer may agree on the recalculation having regard to the summary report.

75ZE Reference to arbiter if no agreement

If WorkCover and the non-scheme employer 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.

75ZF Arbiter's costs

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

75ZG Payment of amount for recalculation

(1) If the amount agreed to by WorkCover and the non-scheme employer (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 amount calculated under subdivision 2—

(a) the amount the non-scheme employer must pay WorkCover for the non-scheme employer's liability is the agreed amount or decided amount; and

(b) the non-scheme employer must pay WorkCover—

(i) the difference between the amount of the payment made under section 75W (***interim payment***) and the agreed amount or decided amount for the non-scheme employer's 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 amount or decided amount is less than the interim payment—

(a) the amount the non-scheme employer must pay WorkCover for the non-scheme employer's liability is the agreed amount or decided amount; and

(b) WorkCover must pay the non-scheme employer—

(i) the difference between the interim payment and the agreed amount or decided amount for the 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 non-scheme employer must pay the amount of the difference within 28 days after—

(a) WorkCover and the non-scheme employer agree on the recalculation; or

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

(4) On payment of the amount—

(a) the non-scheme employer's liability is finalised for section 105I(5) of the Act; and

(b) no further amount is payable for the liability.

Division 3C Total liability—member of a group who becomes non-scheme employer

75ZH Purpose of div 3C

This division sets out the process for the calculation of an amount for total liability for section 105O[39] of the Act because a member of a group employer that is a self-insurer becomes a non-scheme employer (***non-scheme member***).

75ZI Appointment of actuary

(1) The self-insurer of which the non-scheme member was a member (the ***old insurer***) and WorkCover must each appoint an actuary to calculate an amount for the total liability.

(2) The actuary appointed by the old insurer must be approved by the non-scheme member.

75ZJ 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 non-scheme member; 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

39 Section 105O (Consequences of member becoming non-scheme member) of the Act

the day the non-scheme member stops being a member of the old insurer under section 105M[40] of the Act (***final day***).

(3) The data may only relate to the period before the exit date.

75ZK Parties to give actuaries information

The old insurer and WorkCover 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 75ZL(3).

75ZL 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 non-scheme member; and

(ii) the average amount of claims for damages against the non-scheme member; and

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

(iv) the frequency of claims for compensation against the non-scheme member; and

(v) the frequency of claims for damages against the non-scheme member; and

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

40 Section 105M (Non-scheme member continues as member of self-insurer for 12 months) of the Act

(vii) the net present value of the inflated value after allowing for income from assets set aside by the non-scheme 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 final day.

75ZM 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 old insurer, WorkCover and the Authority within 2 months after the final day.

75ZN Agreement on calculation

The old insurer and WorkCover may agree on the calculation having regard to the summary report.

75ZO Reference to arbiter if no agreement

If the old insurer and WorkCover 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.

75ZP Arbiter's costs

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

75ZQ Payment of amount for total liability

(1) The amount the old insurer must pay WorkCover for the non-scheme member's 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 amount or decided amount—

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

(b) on a later day agreed to by the old insurer and WorkCover.

(3) The agreed amount or decided amount paid to WorkCover 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 final day; and

(b) claims lodged against the non-scheme member between the assessment day and the final day.

(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 total liability;

(b) the day WorkCover assumes liability;

(c) details of the old insurer and the non-scheme member.

75ZR Transfer of claims information

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

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)[41] 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.

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.

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41 Section 132 (Applying for compensation) of the Act

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[42] 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

(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—

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

(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.

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[43] 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.

Division 3 Entitlement to compensation for permanent impairment

92 Table of injuries

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

(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

43 Section 216 (Extent of liability for hospitalisation at private hospital) of the Act

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[44] 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.[45]

(5) The worker's hearing levels must be determined separately for the left and right ears at audiometric test frequencies 500, 1000, 1500, 2000, 3000 and 4000Hz with an audiometer complying with AS IEC 60645.3–2002.[46]

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

95 Calculation of WRI—Act, s 183

(1) For section 183[47] of the Act, a worker's WRI is the percentage calculated using the following formula—

$$\frac{\mathbf{LSPI \times 100}}{\mathbf{MSC}}$$

(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.

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

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

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

47 Section 183 (Calculation of WRI) of the Act

MSC means maximum statutory compensation under chapter 3, part 6[48] of the Act.

Example—

A worker loses a thumb, the lump sum compensation payable under the table of injuries is $45495. The maximum statutory compensation is $157955. The worker's WRI is 28.8% [(45495 x 100) ÷ 157955].

95A Additional lump sum compensation—workers with latent onset injuries that are terminal conditions—Act, s 128B

The additional lump sum compensation payable for workers with latent onset injuries that are terminal conditions is set out in schedule 2A.

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)[49] 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

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

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

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

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

(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 1A Rehabilitation and return to work coordinators

99A Criteria for becoming rehabilitation and return to work coordinator—Act, s 41(a)

A person meets the criteria for becoming a rehabilitation and return to work coordinator by satisfactorily completing a workplace rehabilitation course approved or conducted by the Authority.

99B Functions of rehabilitation and return to work coordinator—Act, s 41(b)

The functions of a rehabilitation and return to work coordinator include the following—

(a) initiating early communication with an injured worker to clarify the nature and severity of the worker's injury and to compile initial notification information;

(b) providing overall coordination of the worker's return to work;

(c) developing the suitable duties program component of a rehabilitation and return to work plan, if a plan is required, in consultation with the worker and the worker's employer and ensuring the program is consistent with the current medical certificate or report for the worker's injury;

(d) liaising with—

(i) any person engaged by the employer to help in the worker's rehabilitation and return to work; and

(ii) the insurer about the worker's progress and indicating, as early as possible, if there is a need for the insurer to assist or intervene.

99C Employer's obligation to appoint rehabilitation and return to work coordinator—Act, s 226(1)

(1) An employer meets the criteria for being required to appoint a rehabilitation and return to work coordinator if—

(a) the employer employs 30 or more workers at a workplace in a high risk industry; or

(b) the wages of the employer in Queensland for the preceding financial year were more than $4.9 million.

(2) If QOTE varies, the amount mentioned in subsection (1)(b) must be varied proportionately.

(3) The amount as varied is to be rounded up to the nearest $1000.

(4) The Authority must notify the variation of the amount mentioned in subsection (1)(b) by industrial gazette notice.

(5) An employer may appoint 1 rehabilitation and return to work coordinator for more than 1 workplace if the person can reasonably perform the person's functions as a rehabilitation and return to work coordinator for each workplace.

Division 2 Workplace rehabilitation policy and procedures

99D Employer's obligation to have workplace rehabilitation policy and procedures—Act s 227(1)

(1) An employer meets the criteria for being required to have workplace rehabilitation policy and procedures if—

(a) the employer employs 30 or more workers at a workplace in a high risk industry; or

(b) the wages of the employer in Queensland for the preceding financial year were more than $4.9 million.

(2) If QOTE varies, the amount mentioned in subsection (1)(b) must be varied proportionately.

(3) The amount as varied is to be rounded up to the nearest $1000.

(4) The Authority must notify the variation of the amount mentioned in subsection (1)(b) by industrial gazette notice.

(5) An employer may have 1 workplace rehabilitation policy and procedures document for all workplaces of the employer.

100 Reporting requirement for review of workplace rehabilitation policy and procedures

For section 227(4)[50] 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[51] of the Act, to provide or manage the rehabilitation of workers.

103 Standard for rehabilitation

For section 228[52] 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 a rehabilitation and return to work plan if the doctor does not give sufficient information in the doctor's medical certificate or report on which to base the development of the plan.

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

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

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

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 and return to work plan

(1) A rehabilitation and return to work plan must be developed for each worker undertaking rehabilitation.

(2) The plan must be consistent with the worker's needs and with the current medical certificate or report for the worker's injury.

(3) The plan must be developed in consultation with the insurer, the worker, the worker's employer, the worker's treating registered persons and any person engaged by the worker's employer to help in the worker's rehabilitation and return to work.

(4) Any amendment of the plan must comply with subsections (2) and (3).

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

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

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

(c) the time frames for rehabilitation;

(d) review mechanisms and dates for review;

(e) progress to date;

(f) if it is practicable to provide the worker with suitable duties, a suitable duties program.

106A Suitable duties program

(1) An employer must develop a suitable duties program for a worker undertaking rehabilitation.

(2) The employer must develop the program in consultation with the worker.

(3) The program and any amendments to the program must be consistent with the current medical certificate or report for the worker's injury.

(4) The program must document what are suitable duties for the worker.

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

(6) The employer must give the insurer a copy of the suitable duties program.

(7) The employer must review a worker's suitable duties on a regular basis and progressively upgrade the program consistent with the worker's recovery.

107 Case notes

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

(2) Case notes must contain details of—

(a) all communications between the worker, the insurer, the worker's employer, the worker's treating registered persons, the rehabilitation and return to work coordinator and any person engaged by the employer to help in the worker's rehabilitation and return to work; 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 and return to work 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 and return to work plan; and

(c) the worker's rate of recovery.

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

(3) The worker's employer must ensure rehabilitation for a worker is coordinated with and understood by line managers, supervisors and coworkers.

(4) 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[53]—

(a) full particulars of the claimant, including—

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

(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

(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.

112A Insurer may add another person as contributor—Act, s 278A

For section 278A(1) of the Act, the time prescribed is the later of the following—

(a) 60 business days after the insurer receives the notice of claim;

(b) 5 business days after the insurer identifies someone else as a contributor.

112B Contributor's response—Act, s 278B

For section 278B(1)(a) of the Act, the contributor's response must state the following—

(a) the contributor's full name;

(b) the contributor's business address;

(c) the contributor's postal address;

(d) the name and contact details of the contributor's legal representatives, if appointed;

(e) the contributor's ABN, if any;

(f) if the contributor is a corporation—

(i) the corporation's ACN; and

(ii) the corporation's registered office.

Part 8 Costs

Division 1 Proceeding before industrial magistrate or industrial commission

113 Costs—proceeding before industrial magistrate or industrial commission

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

(2) However, if the magistrate or commission 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, scale E;[54] 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 or the industrial commission considers the amount of costs provided for under subparagraph (i) are inadequate remuneration, the magistrate or commission 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

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

(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;[55] 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.[56]

(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 or the industrial commission.

(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 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—

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

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

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 $150000 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 $50000 or more but less than $150000, the costs are 85% of the amount under subsection (2).

(4) If a claimant recovers less than $50000 net damages, the costs are 85% of the amount calculated under subsection (2) multiplied by the proportion that the net damages bear to $50000.

Example of subsection (4)—

If the net damages recovered are $30000, 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 $1000, 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 8A Medical assessment tribunals

118A Medical assessment tribunals

(1) Each of the following medical assessment tribunals is a tribunal continued in existence under section 635[57] of the Act—

(a) a General Medical Assessment Tribunal;

(b) the following specialty medical assessment tribunals—

(i) Cardiac Assessment Tribunal;

(ii) Orthopaedic Assessment Tribunal;

(iii) Dermatology Assessment Tribunal;

(iv) Ear, Nose and Throat Assessment Tribunal;

(v) Neurology/Neurosurgical Assessment Tribunal;

(vi) Ophthalmology Assessment Tribunal;

(vii) Disfigurement Assessment Tribunal.

(2) Also, a composite medical assessment tribunal (***composite tribunal***) is to be maintained for section 492[58] of the Act to assess workers with an injury or injuries who may require assessment by a number of different specialists.

57 Section 635 (Medical assessment tribunals) of the Act

58 Section 492 (Medical assessment tribunals to be maintained) of the Act

118B Constitution of General Medical Assessment Tribunal

(1) For deciding a matter referred to it, the General Medical Assessment Tribunal is constituted by—

(a) its chairperson; and

(b) 2 appointees to the panel of doctors for the Tribunal, designated by the chairperson.

(2) In designating a member of the panel to the Tribunal, the chairperson must have regard to the branch of medicine that is a speciality under the *Medical Practitioners Registration Act 2001* that is relevant to the matters referred to the tribunal for decision.

118C Chairperson and deputy chairperson of General Medical Assessment Tribunal

(1) The chairperson must preside over meetings of the General Medical Assessment Tribunal.

(2) If the chairperson is not available to attend to the business of the General Medical Assessment Tribunal, a deputy chairperson must act as its chairperson.

(3) A deputy chairperson may act as a member of the General Medical Assessment Tribunal only if the chairperson has designated the member for the purpose.

118D Constitution of specialty medical assessment tribunal

(1) For deciding a matter referred to it, a specialty medical assessment tribunal is constituted by—

(a) its chairperson; and

(b) 2 appointees to the panel of doctors for the tribunal, including persons appointed to the panel as deputy chairpersons, designated by the chairperson.

(2) In designating a member of the panel to a specialty medical assessment tribunal, the chairperson must have regard to the branch of medicine that is a speciality under the *Medical Practitioners Registration Act 2001* that is relevant to the matters referred to the tribunal for decision.

118E Chairperson and deputy chairperson of specialty medical assessment tribunal

(1) The chairperson must preside over meetings of a specialty medical assessment tribunal.

(2) If the chairperson is not available to attend to the business of a specialty medical assessment tribunal—

(a) if there is only 1 deputy chairperson of the tribunal—the deputy chairperson must act as its chairperson; or

(b) if there is more than 1 deputy chairperson of the tribunal—a deputy chairperson designated by the chairperson must act as its chairperson.

118F Constitution of composite tribunals

(1) The constitution of a composite tribunal is to be decided by—

(a) the chairperson of the composite tribunal; and

(b) the chairperson of each specialty medical assessment tribunal relevant to the matters to be decided; and

(c) if the chairperson of the composite tribunal is not the chairperson of the General Medical Assessment Tribunal—the chairperson of the General Medical Assessment Tribunal.

(2) The chairpersons must consult with the secretary of the composite tribunal about the constitution of the composite tribunal.

(3) In deciding the constitution of the composite tribunal, the chairpersons must have regard to the branch of medicine that is a speciality under the *Medical Practitioners Registration Act 2001* that is relevant to the matter referred to the composite tribunal for decision.

(4) For deciding a matter referred to it, a composite tribunal is constituted by—

(a) its chairperson; and

(b) at least 2 but not more than 4 appointees to the panel of doctors for the composite tribunal designated by the chairperson.

(5) The composite tribunal must consist of at least 1 specialist for each type of injury that is a subject of the reference to the tribunal.

(6) However, the number of specialists for each type of injury must be equal.

Example—

A worker has a post-traumatic stress disorder and a fractured arm, leg, and ribs. The tribunal would consist of—

(a) 1 psychiatrist and 1 orthopaedic surgeon; or

(b) 2 psychiatrists and 2 orthopaedic surgeons.

(7) If, because of subsection (5), there would be an even number of members on the composite tribunal, the chairperson must also designate a physician to be a member of the tribunal.

Example—

A worker has 3 different types of injuries. The tribunal would consist of the chairperson and 3 specialists. A physician is also to be a member of the tribunal.

118G Chairperson and deputy chairperson of composite tribunal

(1) The chairperson must preside over meetings of a composite tribunal.

(2) If the chairperson is not available to attend to the business of a composite tribunal—

(a) if there is only 1 deputy chairperson of the tribunal—the deputy chairperson must act as its chairperson; or

(b) if there is more than 1 deputy chairperson of the tribunal—a deputy chairperson designated by the chairperson must act as its chairperson.

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—

- income and profit lines
- 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, ss 540(4) and 546(3AA)

(1) For sections 540(4) and 546(3AA) 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 provisions

Division 1 Transitional provisions 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[59] of the Act for the particular financial year.

Division 2 Transitional provisions for Workers' Compensation and Rehabilitation and Other Legislation Amendment Regulation (No. 1) 2004

123 Costs in proceedings before industrial magistrate

Section 113,[60] as in force immediately before the commencement of this section, continues to apply in relation to a hearing that started before the commencement as if the *Workers' Compensation and Rehabilitation and Other Legislation Amendment Regulation (No. 1) 2004*, section 17(4) had not been made.

124 Excess period

Section 16,[61] as in force immediately before the commencement of this section, continues to apply in relation to an injury sustained by a worker before 1 July 2005 as if the *Workers' Compensation and Rehabilitation and Other Legislation Amendment Regulation (No. 1) 2004*, section 8 had not been made.

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59 Section 81 (Annual levy payable) of the Act

60 Section 113 (Costs—proceeding before industrial magistrate or industrial commission)

61 Section 16 (Excess period—Act, s 65)

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
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
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
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

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 $160000.

(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 particular upper extremity injuries.

(2) Injuries are stated in column 1, the maximum degree of permanent impairment resulting from the injury is 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) The maximum degree of permanent impairment resulting from an injury is stated as a degree of permanent impairment of the upper extremity.

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

Schedule 2 (continued)

(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) The processes that may be used under the AMA guide can not 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—

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

(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—

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

(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 subsections (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 3 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 2 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 Injury	Column 2 Maximum degree of permanent impairment	Column 3 Maximum lump sum compensation	Column 4 Maximum WRI
		$	%
Fingers and hand			
Sensory loss on either side of thumb	8	12 800	6.4
*Structural loss of index finger . . .	18	32 580	16.29
*Structural loss of 2 joints of index finger	13	24 400	12.22
*Structural loss of distal joint to index finger	8	16 280	8.14
Sensory loss to palmar surface of index finger	8	12 800	6.4
Structural loss of 2 joints of middle finger	13	20 800	10.4
Sensory loss to palmar surface of middle finger	8	12 800	6.4
*Structural loss of ring finger	8	16 280	8.14
*Structural loss of 2 joints of ring finger	6	16 280	8.14
*Structural loss of distal joint of ring finger	5	9 780	4.89
*Structural loss of little finger	8	16 280	8.14
*Structural loss of 2 joints of little finger	6	16 280	8.14
*Structural loss of distal joint of little finger	5	9 780	4.89
Structural loss of hand or arm below the elbow	90	144 000	72

Schedule 2 (continued)

Column 1 Injury	**Column 2 Maximum degree of permanent impairment**	**Column 3 Maximum lump sum compensation**	**Column 4 Maximum WRI**
		$	**%**
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	64 000	32
Wrist			
Carpal tunnel syndrome, whether operated or non-operated, with residual subjective symptoms or signs e.g. dysaesthesia or muscle wasting.	2	3 200	1.6
Fractured scaphoid, operated.	5	8 000	4
Fracture of radius or ulna or carpus bones with moderate limitation of wrist movements and mild limitation of elbow movements . . .	16	25 600	12.8
Elbow			
Medial or lateral epicondylitis of elbow, whether operated or non-operated, with residual subjective symptoms or signs e.g. pain and tenderness	2	3 200	1.6
Injury to elbow region resulting in moderate loss of all movements. . .	31	49 600	24.8

Schedule 2 (continued)

Column 1 Injury	Column 2 Maximum degree of permanent impairment	Column 3 Maximum lump sum compensation	Column 4 Maximum WRI
		$	%
Shoulder and arm			
Injury to shoulder region resulting in mild loss of all movements	6	9 600	4.8
Injury to shoulder region resulting in moderate loss of all movements	16	25 600	12.8

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 $150000.

(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.

Schedule 2 (continued)

2 How to use this part of the table

(1) Division 2 lists particular lower extremity injuries.

(2) Injuries are stated in column 1, the maximum degree of permanent impairment resulting from the injury is 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) 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.

Schedule 2 (continued)

(5) The processes that may be used under the AMA guide can not 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.

(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—

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

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

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

(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 subsections (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—

Schedule 2 (continued)

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 3 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 2 of the table of injuries.

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

Division 2 Lower extremity injuries

Column 1 Injury	Column 2 Maximum degree of permanent impairment	Column 3 Maximum lump sum compensation	Column 4 Maximum WRI
		$	%
Toes and foot			
*Structural loss of any toe (other than great toe)	2	16 280	8.14
*Structural loss of great toe	12	32 580	16.29
*Structural loss of joint of great toe	5	16 280	8.14
Fracture of any metatarsal, worst possible outcome e.g. pain or loss of weight transfer.	10	15 000	7.5
Structural loss of a foot	63	94 500	47.25
*Structural loss of two toes (other than great toe) of a foot	4	20 000	10
*Structural loss of three toes (other than great toe) of a foot	6	23 500	11.75
*Structural loss of four toes (other than great toe) of a foot	8	27 000	13.5

Schedule 2 (continued)

Column 1 Injury	Column 2 Maximum degree of permanent impairment	Column 3 Maximum lump sum compensation	Column 4 Maximum WRI
		$	%
*Structural loss of great toe and one other toe of a foot	14	40 000	20
*Structural loss of great toe and two other toes of a foot	16	50 000	25
*Structural loss of great toe and three other toes of a foot	18	60 000	30
*Structural loss of joint of great toe and one other toe of a foot	7	20 000	10
*Structural loss of joint of great toe and two other toes of a foot	9	23 500	11.75
*Structural loss of joint of great toe and three other toes of a foot	11	27 000	13.5
*Structural loss of joint of great toe and four other toes of a foot.	13	30 500	15.25
*Structural loss of all toes of a foot	20	67 500	33.75
Ankle			
Fracture of os calcis, worst possible outcome	25	37 500	18.75
Knee			
Chondromalacia patellae, non-operated	0	0	0
Chondromalacia patellae, operated	2	3 000	1.5
Patellar fracture, whether operated or non-operated	12	18 000	9

Schedule 2 (continued)

Column 1 Injury	Column 2 Maximum degree of permanent impairment	Column 3 Maximum lump sum compensation	Column 4 Maximum WRI
		$	%
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
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	10 500	5.25
Total knee replacement	50	75 000	37.5
Hip joint and leg			
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
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	10 500	5.25
Injury to hip region resulting in mild loss of all movements	12	18 000	9
Injury to hip region resulting in moderate loss of all movements. . .	25	37 500	18.75

Schedule 2 (continued)

Column 1 Injury	Column 2 Maximum degree of permanent impairment	Column 3 Maximum lump sum compensation	Column 4 Maximum WRI
		$	%
Fracture of femoral neck	50	75 000	37.5
Total hip replacement	45	67 500	33.75

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 $200000.

(3) The maximum lump sum compensation payable for a hearing injury under this part is $81460.

(4) The maximum lump sum compensation payable for loss of a breast under this part is $60000.

2 How to use this part of the table

(1) Division 2 lists particular 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 1, the maximum lump sum compensation for the injury is stated in column 2, and the maximum WRI is stated in column 3.

Schedule 2 (continued)

(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.

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.

Schedule 2 (continued)

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—

$$\frac{\mathbf{DPI \times LSC}}{\mathbf{100}}$$

(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—

(a) for hearing loss from industrial deafness—the assessed degree of permanent impairment resulting from the injury less 5%;[62] 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 Injury	Column 2 Maximum lump sum compensation $	Column 3 Maximum WRI %
Vision		
*Loss of vision in 1 eye (corrected vision) . . .	65 160	32.58

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

Schedule 2 (continued)

Column 1 Injury	Column 2 Maximum lump sum compensation	Column 3 Maximum WRI
	$	%
*Total loss of vision in 1 eye resulting from loss of an eyeball	73 300	36.65
Total loss of vision of 1 eye with serious diminution of vision in the other eye (less than 10% vision remaining)	170 000	85
Hearing		
Loss of hearing in 1 ear	40 000	20
*Binaural hearing loss	81 460	40.73
Injury to breast		
*Structural loss of breast	60 000	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;

Schedule 2 (continued)

(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 $200000.

(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 particular system injuries.

(2) Injuries are stated in column 1, the maximum degree of permanent impairment resulting from the injury is 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) 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.

Schedule 2 (continued)

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) The processes that may be used under the AMA guide can not result in a system 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 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

Schedule 2 (continued)

(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—

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

(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—

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

(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 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 3 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 2 of the table of injuries.

Schedule 2 (continued)

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

Division 2 System injuries

Column 1 Injury	Column 2 Maximum degree of permanent impairment	Column 3 Maximum lump sum compensation	Column 4 Maximum WRI
		$	%
Musculo-skeletal system			
Cervicothoracic spine			
Prolapsed intervertebral disc in cervical spine with referred pain, non-operated with resolution of subjective symptoms, and no loss of range of movements	10	20 000	10
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	30 000	15
Thoracolumbar spine			
Major compression fracture of vertebral body(s) in thoracic spine, healed with subjective symptoms, but no physical signs	10	20 000	10

Schedule 2 (continued)

Column 1 Injury	**Column 2 Maximum degree of permanent impairment**	**Column 3 Maximum lump sum compensation**	**Column 4 Maximum WRI**
		$	**%**
Lumbosacral spine			
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
Moderate to severe aggravation of pre-existing spondylolisthesis, treated surgically by discectomy or fusion with resolution of symptoms.	10	20 000	10
Major compression fracture of vertebral body(s) in lumbar region, healed with subjective symptoms, but no physical signs .	10	20 000	10
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	30 000	15
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	50 000	25

Schedule 2 (continued)

Column 1 Injury	Column 2 Maximum degree of permanent impairment	Column 3 Maximum lump sum compensation	Column 4 Maximum WRI
		$	%
Pelvis			
Healed fracture of pelvis with displacement in any region (other than acetabulum, coccyx and sacrum) with subjective symptoms, but no significant signs	5	10 000	5
Fracture or dislocation of symphysis or sacro-iliac joint . . .	10	20 000	10
Nervous system			
Brain and cranial nerves			
Severe vertigo with subjective symptoms and signs and totally dependent.	70	140 000	70
*Loss of smell	3	24 440	12.22
*Loss of smell and taste.	6	40 720	20.36
*Loss of speech	35	114 040	57.02
Fracture of the mid third of the face with permanent nerve involvement	24	48 000	24
Spinal cord injuries			
*Cervical cord injury with or without fracture	75	180 000	90
Thoracic cord injury with or without fracture	60	120 000	60
*Complete paraplegia	75	180 000	90

Schedule 2 (continued)

Column 1 Injury	Column 2 Maximum degree of permanent impairment	Column 3 Maximum lump sum compensation $	Column 4 Maximum WRI %
Cardiovascular system			
Coronary artery disease			
A history of myocardial infarction, with no post infarction angina, on optimal medical treatment	15	30 000	15
Alimentary system			
Splenectomy	5	10 000	5
Subjective symptoms (e.g. local pain or dysaesthesia) following hernia repair(s), but no significant signs	0	0	0
Subjective symptoms and signs (e.g. pain or dysaesthesia, tenderness) following hernia repair(s)	2	4 000	2
Primary or recurrent hernia when surgery is an absolute contraindication	10	20 000	10
Viral hepatitis—			
• mild	25	50 000	25
• moderate	50	100 000	50
• severe	100	200 000	100
Urinary and reproductive systems			
Loss of both kidneys or only functioning kidney	100	200 000	100
Loss of fertility	15	30 000	15
Impotence	15	30 000	15

Schedule 2 (continued)

Column 1 Injury	Column 2 Maximum degree of permanent impairment	Column 3 Maximum lump sum compensation	Column 4 Maximum WRI
		$	%
Loss of sexual function (both impotence and infertility)	30	60 000	30
Loss of genital organs	50	100 000	50
Skin			
Chronic contact dermatitis. Signs and subjective symptoms persist intermittently on removal from exposure to the primary irritant. Intermittent treatment required	10	20 000	10
Chronic contact dermatitis. Signs and subjective symptoms persist almost continuously on removal from exposure to the primary irritant. Intermittent to constant treatment required	20	40 000	20
Solar induced skin disease that is malignant	25	50 000	25
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	60 000	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 $100000.

(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 prescribed disfigurements.

(2) Prescribed disfigurements resulting from injury are stated in column 1, the maximum percentage of permanent impairment resulting from the disfigurement is stated in column 2,[63] the maximum lump sum compensation for the disfigurement is stated in column 3, and the maximum WRI is stated in column 4.

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63 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 **Injury**	**Column 2** **Maximum degree of permanent impairment**	**Column 3** **Maximum lump sum compensation**	**Column 4** **Maximum WRI**
		$	**%**
Prescribed disfigurement			
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
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	2 000	1
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	10 000	5
Area scarring to any part(s) of the body following surgery or trauma. Atrophic or hypertrophic, markedly discoloured.	20	20 000	10
Depressed cheek, nasal or frontal bones following trauma	35	35 000	17.5
Loss, or severe deformity, of outer ear	40	40 000	20

Schedule 2 (continued)

Column 1 Injury	**Column 2 Maximum degree of permanent impairment**	**Column 3 Maximum lump sum compensation**	**Column 4 Maximum WRI**
		$	**%**
Severe, bilateral gross facial deformity following burns or other trauma	50	50 000	25
Loss of entire nose	50	50 000	25
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	100 000	50

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 $200000.

(3) However, most injuries will entitle an injured worker to a lesser amount.

Schedule 2 (continued)

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—

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

(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 2A Graduated scale for additional compensation for workers with terminal latent onset injuries

section 95A

1 Graduated scale

(1) This schedule contains the graduated scale for additional compensation for a worker who has a terminal condition that is a latent onset injury.

(2) The maximum amount of lump sum compensation payable under this schedule is $200000.

2 How to use this graduated scale

(1) The age of the worker when the worker lodges the worker's application for compensation is shown in column 1.

(2) The worker's additional lump sum compensation entitlement is shown for the corresponding entry in column 2.

Graduated scale

Column 1 Worker's age	Column 2 Additional lump sum compensation $
70 years or under	200 000
71 years	180 000
72 years	160 000
73 years	140 000
74 years	120 000
75 years	100 000
76 years	80 000

Schedule 2A (continued)

Column 1 **Worker's age**	**Column 2** **Additional lump sum compensation**
	$
77 years	60 000
78 years	40 000
79 years	20 000
80 years or over	Nil

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 $182620.

2 How to use the graduated scale

(1) The WRI calculated under section 183[64] of the Act is shown in column 1.

(2) A worker who sustains a WRI shown in column 1 is entitled to additional lump sum compensation in the amount shown for the corresponding entry in column 2.

Graduated scale

Column 1 WRI	Column 2 Additional lump sum compensation
%	$
50	7 060
51	14 075
52	21 100
53	28 115
54	35 150
55	42 165

64 Section 183 (Calculation of WRI) of the Act

Schedule 3 (continued)

Column 1 **WRI**	**Column 2** **Additional lump sum compensation**
%	**$**
56	49 190
57	56 220
58	63 230
59	70 255
60	77 270
61	84 305
62	91 320
63	98 360
64	105 375
65	112 410
66	119 425
67	126 450
68	133 465
69	140 490
70	147 520
71	154 530
72	161 570
73	168 580
74	175 610
75–100	182 620

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 $226555.

2 How to use this graduated scale

(1) The WRI calculated under section 183[65] of the Act is shown in column 1.

(2) The range of dependency assessed under the modified barthel index is shown in column 2.

(3) In column 2—

- 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 3.

65 Section 183 (Calculation of WRI) of the Act

Schedule 4 (continued)

Graduated scale

Column 1 WRI %	Column 2 Range of dependency (modified barthel index)	Column 3 Additional lump sum compensation $
15–39	Moderate Severe Total	1 835 3 665 5 490
40–49	Moderate Severe Total	3 415 6 950 10 360
50–59	Moderate Severe Total	15 120 30 225 45 330
60–69	Moderate Severe Total	37 785 67 985 90 640
70–79	Moderate Severe Total	52 875 98 195 135 945
80–89	Moderate Severe Total	60 425 122 130 181 250
90–94	Moderate Severe Total	67 985 135 945 211 450
95–100	Moderate Severe Total	75 525 151 070 226 555

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 5A High risk industries

section 3, definition *high risk industry*

1 Categorisation of industries

(1) Industries are categorised in this schedule using a system known as the Australian and New Zealand Industrial Classification (ANZSIC).

(2) An industry stated in column 2 has the ANZSIC class stated in column 1.

Column 1 ANZSIC class	Column 2 Industry
	Agriculture, forestry and fishing
01	Agriculture
02	Services to agriculture; hunting and trapping
03	Forestry and logging
04	Commercial fishing
	Mining
11	Coal mining
12	Oil and gas extraction
13	Metal ore mining
14	Other mining
15	Services to mining
	Manufacturing
21	Food, beverage and tobacco manufacturing
22	Textile, clothing, footwear and leather manufacturing
23	Wood and paper product manufacturing
24	Printing, publishing and recorded media
25	Petroleum, coal, chemical and associated product manufacturing
26	Non-metallic mineral product manufacturing

Schedule 5A (continued)

Column 1 ANZSIC class	Column 2 Industry
27	Metal product manufacturing
28	Machinery and equipment manufacturing
29	Other manufacturing
	Construction
41	General construction
42	Construction trade services
	Transport and storage
61	Road transport
62	Rail transport
63	Water transport
64	Air and space transport
65	Other transport
66	Services to transport
67	Storage
	Health and community services
86	Health services
87	Community services
	Personal and other services—public order and safety services
9631	Police services
9632	Corrective centres
9633	Fire brigade services
9634	Waste disposal services

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

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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 January 2006. 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	2004 SL No. 74	1 July 2004	
1B	2004 SL No. 289	17 December 2004	
1C	2004 SL No. 289	1 April 2005	
1D	2004 SL No. 289	1 July 2005	
1E	2004 SL No. 289	22 August 2005	
1F	2005 SL No. 308	16 December 2005	
1G	2005 SL No. 308	1 January 2006	R1G withdrawn, see R2
2	—	1 January 2006	

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)

Workers' Compensation and Rehabilitation and Other Legislation Amendment Regulation (No. 1) 2004 SL No. 289 ss 1, 2(3)–(5), pt 2
notfd gaz 17 December 2004 pp 1277–85
ss 1–2 commenced on date of notification
ss 5–6, 8–9, 19 (to the extent it ins s 124) commenced 1 July 2005 (see s 2(3))
ss 13–14 commenced 1 April 2005 (see s 2(4) and 2005 SL No. 39)
ss 16, 17(1)–(3) commenced 22 August 2005 (see s 2(5), 2004 No. 45 s 68 and 2005 SL No. 203)
remaining provisions commenced on date of notification
Note—An explanatory note was prepared

Workers' Compensation and Rehabilitation and Other Legislation Amendment Regulation (No. 1) 2005 SL No. 308 ss 1–2(1), pt 2, s 3 sch
notfd gaz 16 December 2005 pp 1490–6
ss 1–2 commenced on date of notification
ss 4(2) (to the extent it ins def "high risk industry"), 7–8, 13–14, 16 commenced 1 January 2006 (see s 2(1))
remaining provisions commenced on date of notification
Note—Two regulatory impact statements and an explanatory note were prepared

6 List of annotations

Definitions
s 3 def **"AMA guide"** amd 2005 SL No. 308 s 4(3)
def **"binaural tables"** amd 2005 SL No. 308 s 4(4)
def **"estimated claims liability"** ins 2004 SL No. 74 s 4
def **"hearing loss tables"** sub 2005 SL No. 308 s 4(1)–(2)
def **"high risk industry"** ins 2005 SL No. 308 s 4(2)
def **"last employment period"** ins 2004 SL No. 289 s 4

def **"ophthalmologists guide"** sub 2005 SL No. 308 s 4(1)–(2)
def **"structural loss"** ins 2005 SL No. 308 s 4(2)

WorkCover's capital adequacy—Act, s 453
s 5 sub 2004 SL No. 289 s 5

PART 2—EMPLOYER INSURANCE
Assessment of premium
s 8 amd 2004 SL No. 289 s 6

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

Former employer may apply to cancel policy
s 15 sub 2004 SL No. 289 s 7

Cancellation of policy if workers no longer employed
s 15A ins 2004 SL No. 289 s 7

Excess period—Act, s 65
s 16 sub 2004 SL No. 289 s 8

Amount payable to insure against payment for excess period—Act, s 67
s 18 amd 2004 SL No. 289 s 9

Division 3—Self-insurance
div hdg (prev div 4 hdg) amd 2004 SL No. 289 s 10

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; 2004 SL No. 289 s 11

Deemed levy for appeals—Act, s 569(2)(a)
s 23A ins 2004 SL No. 74 s 10
sub 2004 SL No. 289 s 12

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

Division 3B—Self-insurers who become non-scheme employers
div hdg ins 2005 SL No. 308 s 5

Subdivision 1—Preliminary
sdiv 1 (ss 75M–75N) ins 2005 SL No. 308 s 5

Subdivision 2—Calculation
sdiv 2 (ss 75O–75W) ins 2005 SL No. 308 s 5

Subdivision 3—Recalculation
sdiv 3 (ss 75X–75ZG) ins 2005 SL No. 308 s 5

Division 3C—Total liability—member of a group who becomes non-scheme employer
div 3C (ss 75ZH–75ZR) ins 2005 SL No. 308 s 5

Maximum liability for cost of hospitalisation—Act, s 218
s 90 om 2004 SL No. 289 s 13

Special medical treatment, hospitalisation or medical aid
s 91 amd 2004 SL No. 289 s 14

Additional lump sum compensation—workers with latent onset injuries that are terminal conditions—Act, s 128B
s 95A ins 2005 SL No. 308 s 6

PART 6—REHABILITATION
Division 1A—Rehabilitation and return to work coordinators
div 1A (ss 99A–99C) ins 2005 SL No. 308 s 7

Employer's obligation to have workplace rehabilitation policy and procedures—Act s 227(1)
s 99D ins 2005 SL No. 308 s 8

Definition for div 3
s 102 om 2005 SL No. 308 s 3 sch

Doctor's approval
s 104 sub 2005 SL No. 308 s 9

Rehabilitation and return to work plan
s 106 sub 2005 SL No. 308 s 10

Suitable duties program
s 106A ins 2005 SL No. 308 s 10

Case notes
s 107 amd 2005 SL No. 308 s 11

Early worker contact
s 108 amd 2005 SL No. 308 s 3 sch

Rehabilitation
s 109 amd 2005 SL No. 308 s 12

Insurer may add another person as contributor—Act, s 278A
s 112A ins 2004 SL No. 289 s 15

Contributor's response—Act, s 278B
s 112B ins 2004 SL No. 289 s 15

PART 8—COSTS
Division 1—Proceeding before industrial magistrate or industrial commission
div hdg amd 2004 SL No. 289 s 16

Costs—proceeding before industrial magistrate or industrial commission
prov hdg amd 2004 SL No. 289 s 17(1)
s 113 amd 2004 SL No. 289 s 17(2)–(4)

PART 8A—MEDICAL ASSESSMENT TRIBUNALS
pt 8A (ss 118A–118G) ins 2005 SL No. 308 s 13

Documents to be kept—Act, s 520
s 119 amd 2005 SL No. 308 s 3 sch

Reasons for decisions must address certain matters—Act, ss 540(4) and 546(3AA)
prov hdg amd 2005 SL No. 308 s 14(1)
s 120 amd 2005 SL No. 308 s 14(2)

PART 10—TRANSITIONAL PROVISIONS
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
sub 2004 SL No. 289 s 18

Division 1—Transitional provisions for Workers' Compensation and Rehabilitation Amendment Regulation (No. 1) 2004
div hdg ins 2004 SL No. 289 s 18

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

Division 2—Transitional provisions for Workers' Compensation and Rehabilitation and Other Legislation Amendment Regulation (No. 1) 2004
div 2 (ss 123–124) ins 2004 SL No. 289 s 19

SCHEDULE 2—TABLE OF INJURIES
sub 2005 SL No. 308 s 15

SCHEDULE 2A—GRADUATED SCALE FOR ADDITIONAL COMPENSATION FOR WORKERS WITH TERMINAL LATENT ONSET INJURIES
ins 2005 SL No. 308 s 15

SCHEDULE 3—GRADUATED SCALE OF ADDITIONAL COMPENSATION FOR CERTAIN WORKERS
sub 2005 SL No. 308 s 15

SCHEDULE 4—GRADUATED SCALE FOR ADDITIONAL COMPENSATION FOR GRATUITOUS CARE
sub 2005 SL No. 308 s 15

SCHEDULE 5A—HIGH RISK INDUSTRIES
ins 2005 SL No. 308 s 16

SCHEDULE 7—SUBORDINATE LEGISLATION AMENDED
om R1 (see RA s 40)

7 Table of corrected minor errors

under the Reprints Act 1992 s 44

Provision	Description
sch 5A, item 25	om 'prodppuct' ins 'product'

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