

A Guide to Workers Rehabilitation and Compensation in Tasmania

*For injuries occurring on or after 1 July 2010
(incorporating amendments to the Workers
Rehabilitation and Compensation Act 1988
commencing 1 January 2018)*



Disclaimer

The information in this Guide is to assist readers to navigate and understand the *Workers Rehabilitation and Compensation Act 1988*. The Guide does not provide comment on or reference to every provision in the legislation and has no legal force. It should be read in conjunction with the *Workers Rehabilitation and Compensation Act*, the *Workers Rehabilitation and Compensation Regulations 2011* and any other relevant legislation. To find these, go to www.worksafe.tas.gov.au

This Guide was produced by staff from WorkSafe Tasmania and WorkCoverTasmania. We welcome your feedback on the Guide.

Please forward any comments to: wstinfo@justice.tas.gov.au.

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Introduction

What is workers compensation?

Workers compensation is compensation payable under legislation (the Workers Rehabilitation and Compensation Act 1988) to a worker who suffers an injury or disease arising out of or in the course of the worker's employment. For a disease, the worker's employment must have contributed to a substantial degree.

*Section 25(1)
(b)*

Under the legislation, a worker may be entitled to compensation for:

- lost earnings, while incapacitated for work
- medical expenses
- rehabilitation expenses
- permanent impairment.

In some circumstances, a worker may also be able to make a common law damages claim.

The legislation

The principal piece of legislation setting out the laws relating to workers rehabilitation and compensation in Tasmania is the Workers Rehabilitation and Compensation Act 1988 (the Act).

The objects of the Act are to establish a rehabilitation and compensation scheme for injured workers that:

Section 2A

- provides for the prompt and effective management of workplace injuries in a manner that promotes and assists the return to work of injured workers as soon as possible
- provides fair and appropriate compensation to workers and their dependants for workplace injuries
- assists in securing the health, safety and welfare of workers and in reducing the incidence of workplace injuries
- provides an effective and economical mechanism for resolving disputes relating to the treatment and management of, and compensation in relation to, workplace injuries
- is efficiently and effectively administered
- is fair, affordable, efficient and effective.

The Act is supported by the Workers Rehabilitation and Compensation Regulations 2011.

Workers compensation insurance

An employer must either:

- take out an insurance policy with a licensed insurer to cover it for workers compensation claims made by its workers; or
- apply to the WorkCover Tasmania Board (the Board) for a permit to self-insure against workers compensation claims made by its workers.

Section 97(1)

*Sections 104
and 105*

Licensed insurers

An insurer who wishes to provide workers compensation insurance in Tasmania must apply to the Board to obtain a licence. In considering a licence application, the Board is to be satisfied that the insurer:

Sections 98, 100 and 101

- will provide the necessary insurance service, including the ability to meet time limits imposed by the Act
- will set premiums reflecting:
 - the claims experience of an employer (whether the employer has previously had any workers compensation claims, and if so, the number and types of claims)
 - an employer's commitment to workplace health and safety
 - an employer's agreement to provide suitable alternative duties to injured workers
- is financially viable
- is capable of complying with injury management requirements
- will commit an appropriate level of resources to manage claims for compensation in a manner that furthers the objective of rehabilitating injured workers
- will involve an employer in the management of claims
- will provide statistical and other information required, or likely to be required, under the Act.

Licences are subject to any conditions imposed by the Board.

Sections 102, and 108

The Board can revoke or suspend a licence where it satisfied that certain circumstances exist: for example, where an insurer has substantially breached or been convicted of an offence under the Act, or where an insurer has failed to comply with a determination by the Workers Rehabilitation and Compensation Tribunal (Tribunal). The Board's decision to refuse to grant or revoke or suspend a licence can be appealed to the Supreme Court.

Sections 111 and 112

Self-insurers

A self-insurer is an employer who has been granted a permit to self-insure by the Board. This means the employer will manage and be liable for workers compensation claims made by its workers, as opposed to purchasing a policy of workers compensation insurance from a licensed insurer.

An employer who wishes to become a self-insurer must apply to the Board for a permit. In considering a permit application, the Board is to take into account the employer's:

Sections 104 and 105

- financial history
- ability to satisfy prudential standards determined by the Board
- capacity to comply with injury management requirements
- commitment to workplace health and safety
- ability to provide statistical and other information required, or likely to be required, under the Act.

Permits are granted subject to any conditions imposed by the Board.

Section 108

The Board can revoke or suspend a permit where it satisfied that certain circumstances exist: for example, where a self-insurer has substantially breached or been convicted of an offence under the Act, where a self-insurer has failed to comply with a determination by the Tribunal. The Board's decision to refuse to grant or revoke or suspend a permit can be appealed to the Supreme Court.

Sections 111 and 112

Who is entitled to claim workers compensation?

Definition of “worker”

To be entitled to compensation under the Act, a person must be a worker.

A worker is a person who has entered into, or works under a contract of service or training agreement. A contract does not necessarily have to be a formal, written document – it could be implied and/or an oral agreement. *Section 3(1)*

Where a worker has died, the term “worker” includes the legal personal representatives or dependants of the deceased worker. *Section 3(1)*

Deemed workers

Some persons are deemed or taken to be workers under the Act. They include:

- police volunteers, volunteer fire-fighters, and volunteer ambulance workers and other prescribed volunteers (if any) while they are engaged in their volunteer duties *Sections 5, 6 and 6A*
- taxi drivers while they are driving a taxi or performing any associated activity, such as loading; unloading or cleaning the taxi (except where the driver is the responsible operator of the taxi) *Section 4DB*
- luxury hire car drivers while they are driving a luxury hire car or performing any associated activity, such as loading, unloading or cleaning the car (except where the driver is the licensee of the luxury hire car) *Section 4DA*
- jockeys and apprentice jockeys while they are: *Section 4DC*
 - engaged to ride a horse for reward at a race meeting or official trial held in Tasmania under the Rules of Racing; or
 - engaged to ride a thoroughbred horse in a training session in Tasmania conducted by a licensed trainer or delegate
- salespeople, canvassers and collectors paid by commission *Section 4C*
- some contractors in very limited circumstances *Section 4B*
- participants in a prescribed training course. *Section 4D*

Although not specifically deemed to be workers under the Act, working directors have generally been determined by the Courts to be workers for the purposes of the Act. A working director means a director of the company who executes work for and on behalf of a company and whose earnings as a director, by whatever means, are in substance for personal manual labour or services.

People who are not workers

Some people are specifically excluded from coverage under the Act. This means that these people are not entitled to workers compensation under the Act if injured while working. These excluded people are: *Section 4(5)*

- workers employed on a casual basis for a purpose other than the employer’s trade or business
- outworkers
- workers employed as domestic servants with a private family who have completed less than 48 hours employment with their employer at the time they suffer an injury
- members of the crew of a fishing boat who are paid wholly or mainly on the basis of a share of the profits or gross earnings of the boat
- people participating in approved programs of work for unemployment payment (work-for-the-dole schemes)

- workers employed on ships covered by the Commonwealth Seafarers Rehabilitation and Compensation Act 1992. *Section 31A(7)*

In general, the Act does not apply to people engaged in sporting activities who receive payment simply for playing, training or travelling with a sporting body. *Section 7*

However, if a person is engaged under a contract of service with a sporting body (for example, as a paid coach, umpire or referee) they are considered to be a worker for the purposes of the Act.

The Act also covers sport-persons who are paid under a contract of service to perform tasks not related to competition.

Contractors

In most cases, independent contractors are not entitled to workers compensation under the Act. An independent contractor is engaged through a contract for services, rather than a contract of service.

However, there is an exception where a contractor is engaged to perform work exceeding \$100 in value that is not work related to a business or trade regularly carried on by the contractor; for example, a person who usually works as an accountant but is engaged to do some gardening. *Section 4B*

In such circumstances, provided the contractor does not sublet the contract or employ any workers, the contractor is taken to be a worker employed by the person who engaged them. However, this does not apply if the contractor has taken out their own personal accident insurance.

When is a worker entitled to compensation?

A worker is entitled to workers compensation if they suffer an injury or disease which is work-related according to the requirements of the Act.

“Injury” includes a disease and the recurrence, aggravation, acceleration, exacerbation or deterioration of any pre-existing injury or disease where the employment was the major or most significant contributing factor to that recurrence, aggravation, acceleration, exacerbation or deterioration. *Section 3(1)*

Injury arising out of or in the course of employment

A worker is entitled to compensation under the Act for an injury, not being a disease, arising out of or in the course of their employment. *Section 25(1)(a)*

Diseases are subject to different requirements set out below.

“Arising out of or in the course of employment” is not restricted to cases where a worker is injured at their workplace. A worker can make a claim where they suffer an injury:

- during a deviation from their normal route between home and work, if it can be shown that the deviation was at the request or direction of the employer or was work-related and with the authority of the employer; or *Section 25(6)*
- while temporarily absent from the workplace at the direction or request of the employer; or
- while engaged in a social or sporting activity away from the workplace, where it forms part of the worker’s employment, or is at the request or direction of the employer or is work-related with the authority of the employer.

However, some injuries suffered in the following situations or circumstances are specifically excluded from coverage under the Act:

- any injury that occurs while the worker is travelling between the worker’s home and work (unless, as stated above, the injury occurs during a deviation from the normal route made at the request or direction or with the authority of the employer) *Section 25(6)*
- any injury that occurs during an absence from the workplace which was not at the direction or request or with the authority of the employer
- any injury that is caused by a worker’s serious or wilful misconduct (unless the injury results in the worker’s death, or serious and permanent incapacity) *Section 25(2)(a)(i)*
- any injury that was intentionally self-inflicted. *Section 25(2)(a)(ii)*

Disease to which employment contributed to a substantial degree

“Disease” is any ailment, disorder, defect, or morbid condition, whether of sudden or gradual development. *Section 3(1)*

A worker is entitled to compensation under the Act for a disease that their employment contributed to by a substantial degree. To have contributed to a substantial degree, employment must be the major or most significant factor. *Section 25(1) (a)*

Section 3(2A)

A worker is not entitled to compensation for the following diseases or conditions:

- diseased heart valve, coronary heart disease, aortic aneurism or cerebral aneurism or other prescribed condition unless employment was the major contributing factor *Section 25(2)*
- a disease which is an illness or disorder of the mind that arises substantially from:
 - reasonable action taken by an employer to transfer, demote, discipline, counsel or cease employing a worker *Section 25(1A)*
 - a decision of an employer based on reasonable grounds, not to award promotion or benefit in connection with a worker’s employment
 - reasonable action taken by an employer under the Act in a reasonable manner affecting a worker
- a disease which, at the time of starting employment, the worker wilfully and falsely denied having previously suffered. *Section 25(2)*

Long latency/gradual process injuries and diseases

Some injuries and diseases are contracted by a gradual process or may not become apparent or symptomatic until some time after initial exposure or contraction.

To overcome issues associated with time limits for lodging a workers compensation claim: *Section 3(5)*

- the date of injury is deemed to have occurred on the day on which the worker became totally or partially incapacitated by reason of the disease
- if that date cannot be ascertained, then it is the day on which a medical practitioner has certified that the worker was first incapacitated by the disease*.

** The matter can be referred to the Tribunal for determination if the medical practitioner is unable to certify when a worker was first incapacitated or if there is a dispute.* *Section 3(6)*

Where an injury or disease has been contracted by a gradual process (that is, over a number of years), it is possible that the worker may have worked for a number of different employers within an industry/ies that could have contributed to them contracting the injury or disease. If it cannot be determined who the worker was employed by at the time of contracting the injury or disease, compensation is payable by the employer who last employed the worker if the nature of the employment was likely to have given rise to the injury or disease. However, the employer can seek contributions from other employers who employed the worker within the period of three years before the injury or disease occurred, provided the nature of the employment was such that it could give rise to the injury or disease. *Section 78*

For example, Worker X has been employed for five years from 2005 to 2010 by three different employers:

- Employer A – from 2005 to 2008
- Employer B – from 2008 to 2009
- Employer C – from 2009 to 2010.

In all positions, Worker X has been exposed to chemicals and has been diagnosed with an illness relating to his chemical exposure.

Employer C would be liable to pay workers compensation to Worker X. Employer C could then seek contributions from both Employer A and Employer B.

Industrial deafness

Industrial deafness is the permanent loss of hearing caused by exposure to industrial noise in a worker's employment.	<i>Section 3(1)</i>
A worker is entitled to workers compensation for industrial deafness which occurred after 16 August 1995 (this date was adopted as the starting point when the industrial deafness provisions were amended in 1995).	<i>Section 72A(2) and (3)</i>
To be eligible for compensation, a worker must have suffered more than 5% binaural hearing impairment due to industrial deafness since 16 August 1995.	
As with injuries and diseases caused by gradual process, industrial deafness may occur gradually over a number of years. For the purposes of making a claim, the date of injury for industrial deafness is the last day of the worker's employment out of which, or in the course of which, the deafness arose (that is, the last day of employment in which the worker was exposed to industrial noise). If the worker is still in that employment, the date of injury is the date the claim is made.	<i>Section 73A</i>
The Act also deems that a worker's hearing loss has been sustained at a constant rate over the course of a worker's exposure to workplace noise unless a hearing test, which has been conducted since 16 August 1995, establishes otherwise.	<i>Section 72A(4)</i>

Making a claim for compensation

Notice of injury

A worker must notify their employer as soon as practicable after suffering a workplace injury (including a disease) and before voluntarily leaving the employment where the injury occurred. Notice can be given in writing or verbally.

Sections 32 and 33

If the worker does not comply with these timeframes, it can jeopardise their right to claim compensation unless the failure was due to mistake, the worker's absence from Tasmania, or other reasonable cause. A reasonable cause may include someone making a payment to the worker that they believe is a payment of compensation; or someone making a representation to the worker that they believe has been made by or on behalf of the employer that compensation will or will not be payable under the Act.

Section 37

On receiving notice of an injury from a worker, an employer is required to inform the worker of their right to make a claim for compensation within 14 days. Notice must be given in writing and in the form prescribed in the regulations.* The prescribed written notice provides information about making a claim for compensation, including the time limits that a claim must be made in.

Section 33A

**Refer to page 11 for further information on this requirement.*

Claim for compensation

What constitutes a claim for compensation?

A workers compensation claim is made up of:

- a workers claim for compensation form (obtained from the employer, or in certain circumstances, from the insurer or WorkCover Tasmania); and either
- a workers compensation medical certificate obtained from and signed by a medical practitioner*

Section 34

Both the claim form and the medical certificate must be lodged with the employer. This may be done by delivering the claim personally to the employer or to a person the employer has designated to receive the claim, or by posting it to the employer's usual or last known place of business.

Section 35

The timeframes for making a claim

In most cases, a claim for compensation must be made within 6 months of the date of the worker's injury or death.

Section 32(1)

However, it is recognised that for claims relating to industrial deafness and diseases, particularly gradual onset diseases, there may be difficulties in determining a date of injury. In such cases, the timeframes for making a claim are:

- where the worker is claiming compensation for industrial deafness, the claim is to be made while still in the employment of the responsible employer or within 6 months after termination of that employment
- where the worker is claiming compensation for a disease, the claim is to be made within 6 months of the day that the worker first becomes incapacitated by the disease; or if that date can't be determined, the claim must be made within 6 months of the day a medical practitioner certifies that the worker was first incapacitated.

Section 32(2)

Section 32(1) and Section 3(5)

Failure by a worker to make a claim within the above timeframes will not make the worker's claim invalid if the failure was due to mistake, the worker's absence from Tasmania, a failure by the worker's employer to provide the prescribed section 33A notice to the worker* or another reasonable cause**.

Section 38

**Refer to page 11 for further information on the section 33A notice.*

*** Refer above under "Notice of injury" for further information on what is a "reasonable cause"*

Employer obligations on receiving notice of an injury or a claim

Notification of injury to insurer

Where a worker has notified their employer that they have suffered an injury, the employer must notify their insurer within 3 working days*. The notice must be in accordance with the requirements of the employer's injury management program.

Section 143A

**Refer to page 19 for further information as this is an injury management requirement.*

Notice of right to make claim

An employer who is notified of an injury must inform the worker of their right to make a claim for compensation within 14 days. Notice must be given in writing and in the form prescribed in the regulations *. The prescribed written notice provides information about making a claim for compensation, including the time limits that a claim must be made in.

Section 33A

The notice* must include the information set out in the regulations, including:

Regulation 23A and Schedule 2 of the regulations

- the date on which the worker notified the employer of the injury
- that the worker has the right to make a claim for compensation
- the timeframes within which a claim must be made;
- that a claim must be made on the approved form and accompanied by a medical certificate
- that the worker must tell the employer the name of their primary treating medical practitioner
- who the worker can speak to about their claim
- contact details for the WorkSafe Tasmania Helpline.

** Find this at www.worksafe.tas.gov.au by searching for GF172.*

There is a fine of up to 10 penalty units* for failure to meet this requirement. A worker may also have reasonable cause for failing to make a claim within the time limits if this notice has not been served.

Section 33A and 38(2)

** Refer to page 49 for further information on penalty units.*

Notice of claim to insurer or Board

If an employer receives a workers compensation claim from one of its workers, it must notify its insurer of the claim within 3 working days. If the employer does not satisfy this requirement, the insurer does not have to indemnify the employer for any weekly payments payable for the period between the third working day and the date that the insurer was notified.

Sections 36(1AA), (4), and (5)

The employer must also forward the workers compensation claim to its insurer within 5 working days after receiving the claim.

Sections 36(1)

Commencement of weekly payments and payment of medical expenses

On receiving a claim for compensation, the employer must:

- start making weekly payments of compensation if the worker has been certified as being totally or partially incapacitated for work* *Section 81*
- pay for medical and associated expenses up to the value of \$5000 unless the employer is of the opinion that the claimed expenses are unreasonable or unnecessary (in which case the employer must serve the worker and service provider with a notice to this effect and refer the matter to the Tribunal)**. *Section 77AB*

These payments are to start regardless of whether the employer disputes liability for the worker's claim. They are sometimes referred to as "without prejudice payments" as the fact that an employer makes such a payment cannot be used against the employer as an admission of liability. *Sections 77AB(3) and 81AA*

**Refer to page 27 for further information about without prejudice weekly payments.*

***Refer to pages 31-32 for further information about without prejudice payment of medical and other expenses.*

Notice of status of claim

On receiving a claim for compensation from a worker, the employer or its insurer must give the worker written notice of the status of the claim within 28 days. This ensures that the worker has some indication, at a reasonably early stage, of what is happening with their claim. *Section 39*

This means that the employer or insurer must notify the worker of whether they have decided to accept or dispute liability to pay compensation. If no decision has been made, the notice must state:

- the reasons why the decision has not been made
- the steps the employer or insurer intends to take before making a decision.

There is a fine of up to 10 penalty units* for breaching this requirement.

**Refer to page 49 for further information on penalty units.*

Accepting or disputing liability for claim

Once an employer has received a claim for compensation, they have 84 days to dispute liability to pay compensation. If the employer does not dispute liability to pay compensation within 84 days, the employer is taken to have accepted liability for the claim and the Tribunal can order the employer to pay compensation. *Sections 81A, 81AB and 81AC*

If the employer does dispute liability, then they must (within the 84 day period):

- serve a notice on the worker stating that the employer disputes liability to pay weekly payments or medical and other expenses or both
- inform the worker of the reasons for disputing liability
- refer the matter to the Tribunal*.

A section 81A dispute is scheduled for a hearing before either the Chief Commissioner or Commissioner of the Tribunal. The purpose of the hearing is not to decide whether there is a valid claim. Rather, it is a preliminary procedure to determine whether a reasonably arguable case exists concerning the employer's liability to pay compensation under the Act.

Once the Tribunal has made a finding on this preliminary issue, the claim can be referred back to the Tribunal for final resolution under section 42 of the Act*. For example, if the Tribunal finds there is a reasonably arguable case concerning the employer's liability to pay compensation, the worker can refer the claim back to the Tribunal to be resolved. If the Tribunal finds that there is not a reasonably arguable case, the employer or insurer can refer the matter back to the Tribunal. The dispute will then be dealt with through the Tribunal's usual dispute resolution processes including conciliation.

If the Tribunal finds that a reasonably arguable case exists, it can order that weekly payments and/or compensation for medical and other expenses are not payable by the employer. Payments will then cease from the date of the finding. If the worker refers the matter back to the Tribunal under section 42 and the Tribunal subsequently determines that the employer is liable for the claim, the worker may be entitled to be back paid for compensation payments to the date that payments ceased.

**Refer to page 43 for further information on referrals to the Tribunal under section 42 of the Act.*

Specific types of claims

Claims by dependants of deceased workers

Where a worker has died as a result of a work-related injury or disease, the deceased worker's dependants may be entitled to compensation*. A claim by a dependant must be:

Sections 34(1) and (2A)

- made within 6 months of the date of the deceased worker's death
- made using the "Claim form for Dependents of Deceased Workers" available at www.worksafe.tas.gov.au.
- personally delivered or sent by post to the employer or to a person designated by the employer.

**Refer to page 36 for information on the types of compensation that may be available to the dependants of a deceased worker.*

Cross border claims

Sometimes a worker is required to travel to different states or territories for work and/or to work temporarily in a different state or territory from where they are usually based.

In the past, this situation was complicated for employers, who were required to take out workers compensation insurance policies in each state or territory their workers carried out work in (even if a worker was only going to be in a state for a single day). It also presented difficulties for workers injured in a different state or territory from where they were usually based in determining which jurisdiction's workers compensation laws applied to their claim.

All Australian states and territories have now introduced similar legislative provisions to cover situations where workers work temporarily in different states. These provisions are known as "cross border" provisions. They are intended to:

- enable employers to readily determine which states or territories they need to obtain workers compensation insurance for (and to eliminate the need to obtain insurance in a state that a worker will be working in on a temporary basis)*
- ensure that workers only have access to the workers compensation entitlements, including common law access arrangements, in their "home" jurisdiction
- provide certainty for workers about their workers compensation entitlements
- ensure that each worker is connected to one state or territory.

**An employer will still need to take out insurance policies in different states and territories if it has workers with different States of connection.*

State of connection

The cross border provisions are based on a concept of "State of connection". Compensation is only payable under the Act if Tasmania was the "State of connection" for the injured worker. This means that:

Section 31A

- a worker who was injured outside of Tasmania may still be entitled to compensation under the Act if Tasmania was the worker's State of connection
- a worker who was injured in Tasmania will not be entitled to compensation under the Act if Tasmania was not the worker's State of connection.

Determining a worker's "State of connection" – the tests

To determine a worker's State of connection, there is a progressive series of tests: that is, if the worker's situation does not meet the first test, the second test is applied, and if that test is not met, the third test is applied and so on until one of the tests is satisfied, allowing the State of connection to be determined.

Section 31A(3)

The first test – State in which the worker usually works

Under the first test, the worker's State of connection is the State where the worker usually works in the employment. In deciding where a worker usually works, the factors to be considered are:

- the worker's work history with the employer over the preceding 12 months
- the worker's proposed future working arrangements
- the intentions of the worker and the employer
- any period during which the worker worked in a State or was in a State for the purposes of employment, whether or not the worker is regarded as working or employed in that State under its workers compensation law.

*Section
31A(6)*

Temporary working arrangements – where a worker works in another state for a period of 6 months or less – must not to be taken into account.

For example, if a worker has worked for an employer for 10 years in NSW and is temporarily transferred to Tasmanian for a fixed period of 5 months after which the worker is to return to NSW, the period of time in Tasmania does not count for the purposes of considering where a worker usually works.

The second test – State in which the worker is usually based

If no State of connection can be determined under the first test, then the second test is to be applied. Under the second test, the worker's State of connection is the state where the worker is usually based for the purposes of the employment. Deciding where the worker is usually based might involve looking at factors such as:

- the work location specified in the worker's contract of employment
- the location the worker attends on a routine basis to collect or use materials or equipment or to receive directions or instructions for the work
- the location that the worker reports to.

The third test – the employer's principal place of business

If the worker's State of connection cannot be determined using the first or second tests, the third test is to be applied. Under the third test, the worker's State of connection is the State where the employer's principal place of business in Australia is located. The employer's principal place of business may be identified by considering matters such as:

- the address registered on the Australian Business Register for the employer's Australian Business Number (ABN)
- if the employer doesn't have an ABN, the State registered on the Australian Securities and Investments Commission's National Names Index as being the state where the employer's trade or business is undertaken
- if the employer doesn't have an ABN as is not on the National Names Index, the employer's business mailing address.

The fourth test – the State in which the worker was injured

In the event that the worker's State of connection cannot be determined under the first, second or third tests, then a final test applies. Under this final test, the worker's State of connection is Tasmania if:

Section 31A(5)

- the worker was in Tasmania when injured
- the worker is not entitled to compensation for the injury under the workers compensation laws of an external Territory or a place outside of Australia.

Where a worker is working on a ship, and no State of connection can be identified using the first, second and third tests above, the worker's State of connection is, while working on the ship, the state where the ship is registered. If the ship is registered in more than one state, the State of connection is the state where the ship was most recently registered.

*Section
31A(4)*

Claims handled by the Nominal Insurer

The Nominal Insurer is an independent statutory body established to ensure that injured workers are not disadvantaged in circumstances where:

*Sections 121 –
131AA*

- the employer does not hold a policy of insurance
- the employer cannot be located
- the employer is insolvent (bankrupt), or
- the employer's insurer is insolvent or is unable to meet its liabilities under the policy.

The Nominal Insurer is administered by a committee comprising six members drawn from insurers, self-insurers and government. It is funded by contributions from licensed insurers and self-insurers.

Even if a worker believes that one of the above circumstances may apply, the worker must still lodge a claim for compensation on their employer. If the employer fails to meet its obligations (for example, to make weekly payments or pay compensation for medical and other expenses), the worker can refer the matter to the Tribunal under section 42 for an order requiring the employer to pay compensation. If the employer fails to comply with the Tribunal's order, the worker can seek a further order requiring the Nominal Insurer to meet the employer's liability for the claim. If the order is made, the Nominal Insurer will then handle the worker's claim. The Nominal Insurer can attempt to recover the amount it has paid from the employer or insurer involved.

Injury management

What is injury management?

Injury management is the management of an injured worker, intended to provide the worker with a timely, safe and durable return to work.

Section 3(1)

To promote and support the effective injury management of injured workers, the Board has developed an injury management model in consultation with key stakeholders, such as representatives of workers, employers, medical practitioners, insurers and the Tribunal.

The Board's Return to Work and Injury Management Model (the Model) provides a framework for improving and streamlining the management of workplace injury and illness with a view to delivering better health and return to work outcomes for injured workers with lower costs to employers and the workers compensation system.

Key elements of the Model have been incorporated into the Act; in particular, into Part XI, "Injury Management".

The following key principles underpin the Model and the injury management provisions in the Act:

Section 139(2)

- all parties, including the injured worker, should:
- view recovery and return to work as the prime goals following a work-related injury
- have a shared commitment to these goals; and
- work together through co-operation, collaboration and consultation to achieve these goals
- early intervention is critical – injury management should start as soon as possible following injury
- where possible, the injury management process will focus on maintaining the relationship between the employer and worker
- the injury management process should be transparent, cost efficient and effective
- all parties, particularly the injured worker, the employer and the medical practitioner, should have access to information and assistance in order to clearly understand their roles, rights and responsibilities
- injury management should be of a high standard to maintain the dignity and integrity of injured workers, and ensure that injured workers are active participants in the management of their injuries
- issues relating to injury management should be resolved as soon as practicable, and with any assistance that may be necessary, to ensure effective injury management.

Commitment to injury management – injury management programs

An injury management program is a set of documented policies and procedures for managing workplace injuries.

Both insurers and employers must have an approved injury management program in place (for insurers, they must ensure each of their clients has one). This is intended to foster employer and insurer commitment to injury management before any injuries occur.

Insurers and employers must comply with their program. There are penalties for failing to have a program and failing to comply with it.

Sections 142 and 143

Developing injury management programs

The requirements for developing an injury management program differ, depending on the type of employer.

Section 143

Where an employer has a policy of workers compensation with an insurer, it can:

- use an injury management program developed by their insurer; or
- develop their own injury management plan in consultation with and with the approval of their insurer.

Where an employer is a self-insurer, it must develop its own injury management program.

Where an employer is an agency of the Crown, it must develop its own injury management program (however, it is possible that a number of agencies could adopt the same injury management program).

A licensed insurer can develop a standard injury management program to apply to any of its employer clients.

The Board has issued guidelines on developing injury management programs*. Injury management programs must include any mandatory content specified in these guidelines.

Sections 142(1) and 143(8)

**Find these at www.workcover.tas.gov.au by searching for "GB195".*

Approving injury management programs

Programs developed by licensed insurers, self-insurers or agencies

Injury management programs that have been developed by licensed insurers, self-insurers or the agencies of the Crown must be submitted to the Board for approval.

Sections 143(1), (5), and (6)

The Board can approve or refuse to approve an injury management plan. It can only approve an injury management program if the program includes the mandatory content specified in the Board's guidelines.

Sections 143(7) and 143(8)

An injury management program takes effect from the date it is approved by the Board for a period determined by the Board not more than three years.

Section 143(9)

Programs developed by employers

Where an insured employer (one that is not a self-insurer or an agency of the Crown) develops its own injury management program, the program must be submitted to the employer's insurer for approval.

Section 143(4)

The insurer can approve or refuse to approve an injury management program. It can only approve a program that includes the mandatory content specified in the Board's guidelines.

Sections 143(7) and (8)

An injury management program takes effect from the date it is approved by the insurer for a period determined by the Board for up to three years.

Section 143(9)

Review and amendment

Injury management programs are to be reviewed as required by the Board. Where the Board requires an employer or insurer to review a program, the employer or insurer must provide the Board with a report on the program within the time specified by the Board.

Sections 142(5) and (6)

Any amendments made to a program that was developed by a licensed insurer, self-insurer or agency of the Crown must be submitted to the Board. The Board then has 60 days to disallow the amendment.

Sections 143(10) and (11)

Any amendments made to a program that that was developed by an insured employer must be submitted to the employer's licensed insurer. The licensed insurer then has 60 days to disallow the amendment.

Sections 143(10) and (11)

Early intervention – ensuring injury management starts as soon as possible

Early intervention by taking immediate action is a key principle of the injury management process. It is very important that injury management starts as soon as possible to improve the injured worker's chances of recovering from the injury and returning to work.

Notification of injury

To encourage early intervention, an employer who has a policy of insurance with a licensed insurer must notify its insurer within 3 working days of becoming aware that one of its workers has suffered a workplace injury that:

*Section
143A(1)*

- results in or is likely to result in the worker suffering an incapacity for work; or
- is required to be reported under the employer's injury management program.

There is a fine of up to 10 penalty units* for failing to comply with this notification requirement.

**Refer to page 49 for an explanation of penalty units.*

The way an employer notifies its insurer should be set out in the employer's injury management program. It may include telephone, email and fax.

*Section
143A(2)*

Application of injury management requirements

The injury management requirements apply even where there is a dispute about the employer's liability for the worker's injury.

Section 140

As with weekly payments of compensation (refer to page 27) and payment of expenses for medical and other services (refer to page 31), injury management must start as soon as the worker makes a claim for compensation.

The injury management obligations cease to apply where:

- there has been an agreement to settle (under the proposed new sections 132A or 138AB)*
- the Tribunal has found that there is a reasonably arguable case for disputing liability and made orders under section 81A(3)(c) or (d)*
- the Tribunal or a court has determined that the employer is not liable for the claim.

**If the Tribunal subsequently sets aside an agreement or the Tribunal or a court subsequently determines that an employer is liable for a claim, then the injury management requirements under Part XI recommence.*

Key roles in the injury management process

Aside from the three obvious parties in the injury management process – the injured worker, the employer and the insurer (if the employer is not a self-insurer) – there are some other important roles, including:

- the worker's primary treating medical practitioner
- the injury management coordinator
- the return to work coordinator
- the workplace rehabilitation provider.

Primary treating medical practitioner

A primary treating medical practitioner is a medical practitioner, usually a general practitioner, chosen by an injured worker to participate in the injury management process.

Choosing a primary treating medical practitioner

After suffering a workplace injury, an injured worker must notify their employer of the name of the medical practitioner they have chosen to be their primary treating medical practitioner. An injured worker must do this as soon as practicable after suffering the injury. *Section 143G(1)*

It is up to the injured worker to choose who they want to be their primary treating medical practitioner. A worker cannot be forced to choose a medical practitioner suggested by their employer or the insurer. *Section 143G(2)*

If a worker changes their primary treating medical practitioner, they must: *Section 143G(3)*

- notify their employer of the name of the new primary treating medical practitioner
- authorise their previous primary treating medical practitioner to release relevant medical records to the new primary treating medical practitioner.

If a worker does not notify their employer about their primary treating medical practitioner, the employer or insurer can notify the Tribunal**. *Section 143G(5)*

**For further information on accreditation go to www.workcover.tas.gov.*

***Refer to page 26 for further information on the Tribunal.*

Functions of a primary treating medical practitioner

An injured worker's primary treating medical practitioner plays a vital role in the injury management process. They: *Section 143G(4)*

- provide workers compensation medical certificates
- diagnose the worker's injury
- provide primary medical care
- co-ordinate medical treatment, including referring the worker to relevant specialists
- monitor, review and advise of the worker's condition and treatment
- advise on the suitability of and restrictions for work duties
- participate in developing return to work plans and injury management plans.

Injury management coordinator

An injury management coordinator is a person appointed to co-ordinate and oversee the entire injury management process for serious workplace injuries. The injury management coordinator provides one contact or liaison point for all parties.

Appointment of injury management coordinator

Licensed insurers, self-insurers, agencies of the Crown, and employers who have developed their own injury management programs must appoint an injury management coordinator. *Section 143B*

Injury management coordinators do not have to be employed in-house by the insurer or employer, although in some cases (particularly with insurers), they may be. Insurers or employers can outsource the role; that is, contract someone from outside their business to perform the injury management coordinator role.

To be appointed to the role of injury management coordinator, a person must have either: *Section 143B(5)*

- successfully completed any training approved by the Board; or
- completed training or obtained a qualification that the Board is satisfied is equivalent to the Board's approved training*.

**For more information on training, go to www.workcover.tas.gov and search under "health providers".*

When is a worker's case to be assigned to an injury management coordinator?

A worker who suffers a "significant injury" is to be assigned to an injury management coordinator as soon as practicable. *Section 143B(2), (5) and (4)*

A "significant injury" is a workplace injury that is likely to result in the worker being totally or partially incapacitated for work for more than 5 working days. *Section 141(1)*

Injury management coordinator's responsibilities *Section 143C*

The injury management coordinator is responsible for ensuring that:

- contact is made with the worker, the employer and the worker's primary treating medical practitioner as soon as practicable
- return to work plans and injury management plans are developed and implemented
- arrangements are made for the rehabilitation of the worker
- workplace rehabilitation providers are appointed where appropriate
- the work capacity of the injured worker is regularly reviewed
- options for retraining or redeployment are investigated and arranged as appropriate
- the management of the worker's injury involves relevant and appropriate people including the worker, employer, primary treating medical practitioner, return to work co-ordinator, supervisors, workplace rehabilitation providers and allied health professionals
- information on injury management is provided to the worker and the employer
- medical information is collated and relevant documentation maintained;
- attempts are made to resolve disputes about injury management
- any other prescribed requirements are carried out.

The injury management coordinator does not have to personally undertake these activities, but must ensure that they are undertaken when required.

Return to work coordinator

To help injured workers further with the return to work process, large employers (those that employ more than 100 workers) must appoint a return to work coordinator. The purpose of a return to work coordinator is to provide support and assistance to injured workers at the workplace. *Section 143D*

Appointment of return to work coordinators

To be appointed as a return to work coordinator, a person must have either: *Section 143D(2)*

- successfully completed any training for return to work coordinators that has been approved by the Board; or
- obtained a qualification or completed training that the Board is satisfied is at least equivalent to any Board approved training*.

**For further information on training, go to www.workcover.tas.gov.au and search for "GB229".*

When is a worker's case to be assigned to a return to work coordinator?

An employer must assign a worker's case to a return to work coordinator as soon as practicable after becoming aware that the worker has suffered a significant injury. A "significant injury" is one that is likely to result in the worker being totally or partially incapacitated for more than 5 working days.

*Sections
143D(3) and
(4)*

The return to work coordinator that the worker is assigned to must be familiar with the worker's workplace, including management and staff.

Return to work coordinator's responsibilities

The return to work coordinator is responsible for:

*Section
143D(5)*

- assisting with return to work planning and the implementation of return to work plans and injury management plans
- monitoring the worker's progress towards returning to work
- assisting the worker to perform their work duties in a safe and appropriate manner
- reassuring and encouraging the worker about their treatment and return to work
- encouraging and fostering a good relationship and effective communication between the worker, the employer and the insurer.

Interaction of injury management coordinator and return to work coordinator

In some cases, where an injured worker is employed by an employer with more than 100 workers, both an injury management coordinator and a return to work coordinator will be assigned to the injured worker's case.

The injury management coordinator will have overall responsibility for co-ordinating the injury management process for the worker: treatment, return to work and injury management planning.

The return to work coordinator is to help the injury management coordinator with return to work and injury management planning and to provide support and assistance to the worker "on the ground".

Workplace rehabilitation providers

In some cases, an injured worker may require workplace rehabilitation services to help them return to work.

Workplace rehabilitation services include:

- initial workplace rehabilitation assessment
- assessment of the functional capacity of a worker
- workplace assessment
- job analysis
- advice concerning job modification
- rehabilitation counselling
- vocational assessment
- any other prescribed service.

Section 3(1)

These services can only be provided by an accredited workplace rehabilitation provider*.

*Section
77A(4)*

**For further information on workplace rehabilitation providers, go to www.workcover.tas.gov.au and search under "health providers".*

Planning the worker's treatment and return to work

The medical certificate

The workers compensation medical certificate plays an important role in the injury management process. A certificate is required as part of a workers compensation claim and provides an initial indication of a worker's incapacity and any medical restrictions they may have when performing suitable alternative duties. As stated above, one of the functions of a primary treating medical practitioner is to provide workers compensation medical certificates. However, medical practitioners other than the primary treating medical practitioner can also provide certificates.

To be entitled to weekly payments of compensation, a worker must present a medical certificate stating that they are incapacitated (totally or partially) for work. *Section 69*

To ensure that incapacity is regularly reviewed and return to work measures can be effectively implemented, a medical practitioner is not to certify total incapacity for more than 28 days unless they provide reasons substantiating a longer period and nominate a review date. *Section 143H(1)*

In some circumstances, the medical practitioner may be of the opinion that the worker is unlikely to be able to return to their pre-injury hours or duties for a specified period, or indefinitely (for example, where the worker has suffered catastrophic injuries). In such a case, the medical practitioner must specify this opinion and the reasons for it on the certificate. *Section 143H(2)*

If the medical practitioner fails to meet these requirements, it will not make the worker's claim invalid. *Section 143H(3)*

Where a worker has been certified as totally or partially incapacitated for work, they must, as soon as reasonably practicable: *Section 143I*

- notify their employer of the period of incapacity
- provide a copy of the medical certificate to their employer.

Full disclosure of information to medical practitioner

An injured worker must tell their primary treating medical practitioner (and any other treating medical practitioner) any information that is relevant to the diagnosis or treatment of the worker's injury. This is to help the medical practitioner make accurate diagnoses and appropriate decisions about treatment and injury management. A worker who breaches this obligation may be prosecuted and fined up to 10 penalty units*. *Section 143J*

**Refer to page 49 for further information on penalty units.*

Return to work plans and injury management plans

Where a worker suffers a significant injury (defined on page 21), the injury management coordinator assigned to the worker must ensure that there is a plan for managing the worker's treatment, rehabilitation and return to work. *Section 143E(1)*

There are two types of plan for managing a significant workplace injury: return to work plans and injury management plans. The type of plan required depends on the requirements of the injury management program in place for the employer (usually the insurer's injury management program approved by the Board).

Return to work plans

A return to work plan is a simple plan for coordinating and managing the treatment, rehabilitation and return to work of an injured worker. It may simply be based upon the information provided in the initial medical certificate accompanying the worker's claim, such as time off work, medical restrictions and alternative duties.

A return to work plan is required to be developed and implemented within the time frames set out in the employer/insurer injury management program approved by the Board. *Section 143E(1)(a)*

Injury management plans

An injury management plan is a comprehensive plan for co-ordinating and managing the treatment, rehabilitation and return to work of an injured worker. It is more complex than a return to work plan.

An injury management plan is required to be developed and implemented in accordance with time frames set out in employer/insurer injury management programs approved by the Board. *Section 143E(1)(b)*

Preparation of plans

To ensure that the injury management process starts as soon as possible following an injury, return to work plans and injury management plans are to be prepared regardless of whether the employer has accepted or disputed liability for a worker's claim. The Act specifically states that preparing or giving consent to a return to work plan or injury management plan does not constitute an admission of liability; that is, the employer will not be considered to have accepted the worker's claim by participating in the preparation of a plan or by consenting to a plan. *Section 143E(8)*

If the employer disputes liability for the worker's claim under section 81A of the Act and the Tribunal finds that there is a reasonably arguable case (and makes an order that weekly payments and/or medical expenses are not payable), the obligation to prepare a plan ceases (unless and until the Tribunal or Court subsequently finds that the employer is liable). *Section 143E(6)*

The following parties must be consulted in preparing a return to work plan or injury management plan: *Section 143E(2)*

- the worker
- the employer
- the primary treating medical practitioner
- the insurer
- the injury management coordinator
- the workplace rehabilitation provider (if there is one).

Both the employer and the worker must give their consent to a return to work plan or injury management plan for it to become effective. A party to a dispute of which an injury management co-ordinator has been informed may notify the Tribunal of the dispute*. *Sections 143E(3) and (4)*

**Refer to page 26 for further information on notifications to the Tribunal.*

Review of plans

The injury management coordinator must ensure that return to work plans and injury management plans are regularly reviewed in consultation with the same parties that were consulted in preparing the plan (see above). *Section 143E(5)*

Complying with plans

Once a return to work plan or injury management plan is effective (that is, once it has been consented to by the worker and the employer), the worker and employer must take all reasonable steps to carry out what is in the plan. *Section 143E(7)*

Keeping the worker's job open

When a worker becomes totally or partially incapacitated for work as a result of a workplace injury, their employer cannot simply terminate their employment (fire them) due to their injury or incapacity. The employer must keep the worker's job available for the worker to return to for 12 months following the worker becoming incapacitated. An employer who breaches this requirement may be prosecuted and could receive a maximum fine of 100 penalty units*.

Section
143L(1)

**Refer to page 49 for an explanation of penalty units.*

There are some circumstances where the employer can terminate the worker's employment before 12 months:

Section
143L(2)

- where there is medical evidence indicating that it is highly improbable that the worker will be able to do their pre-injury job; or
- where the worker's pre-injury job is no longer required.

If the employer is going to terminate the worker's employment for one of the above reasons, they must notify both the worker and the insurer of the reasons why.

Section
143L(3)

Even where the employer has terminated the worker's employment, this does not necessarily mean that the employer's obligations to the worker for injury management, rehabilitation and compensation cease.

Suitable alternative duties

Where an injured worker cannot return to their pre-injury job following an injury, the employer must provide suitable alternative duties. This is considered to be a key component of the injury management process, so there is a maximum penalty of 100 penalty units* for failing to comply with this requirement.

Section
143M(1)

**Refer to page 49 for an explanation of penalty units.*

There is an exception to the requirement to provide suitable alternative duties where it is unreasonable or impracticable for the employer to do so. If an employer is relying on this exception, it must provide the worker with written reasons as to why it is unreasonable or impracticable to provide suitable alternative duties.

Sections
143M(3) and
(4)

Identifying "suitable alternative duties"

Suitable alternative duties are duties that the worker is suited to taking into account:

Section
143M(5)

- the nature of the worker's incapacity and pre-injury employment
- the worker's age, education, skills and work experience
- the worker's place of residence
- any suitable duties for which the worker has had rehabilitation training
- any other relevant circumstances.

Suitable alternative duties do not include duties which are:

- token in nature, or do not involve meaningful work related to the employer's trade or business; or
- demeaning given the worker's pre-injury employment, age, education, skills and work experience.

When considering whether alternative duties are suitable for an injured worker, it is a case of looking at the circumstances of both the worker and the employer. For example, at many workplaces, requiring a worker to count paperclips may be considered a token and meaningless task, but at a business supplying stationery, it may be a meaningful duty. Requiring an injured worker to carry out photocopying and filing may be demeaning for a worker whose pre-injury employment was as a surgeon, but may be appropriate for a worker whose pre-injury employment included office duties.

Consultation

An employer must consult with the injured worker in deciding what alternative duties to give the worker. The employer must also ensure that the duties:

*Section
143M(2)*

- are appropriate taking account of any medical advice or restrictions on what the worker can do
- comply with the worker's return to work plan or injury management plan.

Disputes about injury management

Where a dispute arises around injury management, the employer must inform the worker's injury management coordinator as soon as practicable. It is then up to the injury management coordinator to try to resolve the dispute through informal mediation between the parties or by discussing the matter individually with each of the parties.

*Sections
143P(2) and
(3)*

If the dispute is not resolved by the injury management coordinator, then any of the parties can notify the Tribunal. The notification, which is to be in a form approved by the Chief Commissioner, is to be filed with the Registrar of the Tribunal.

*Sections
143P(4),
143Q(1) and
(2)*

One of the Tribunal's conciliators will provide informal assistance to the parties to attempt to resolve the dispute. If this doesn't work, the Tribunal will deal with the matter in the same way as a referral made under section 42 of the Act*, and can make the following orders:

*Sections
143Q(3), (4),
and (6)*

- an order requiring the worker to attend work in accordance with a return to work plan or injury management plan
- an order requiring an employer to provide suitable alternative duties
- an order suspending weekly payments for a specified period
- an order increasing weekly payments for a specified period
- an order requiring a worker to undergo specified treatment or forego part or all of the weekly payments or compensation for services the worker would otherwise be entitled to
- an order requiring the worker to undergo an independent medical review or examination or forego part or all of the weekly payments or compensation for services that the worker would otherwise be entitled to
- an order requiring the worker to undertake specified rehabilitation or retraining or forego part or all of the weekly payments or compensation for services the worker would otherwise be entitled to
- an order varying a return to work plan or injury management plan
- any other order that the Tribunal thinks fit in the circumstances.

*Section
143Q(7)*

**Refer to page 43 for information on Tribunal proceedings.*

Find information on injury management at www.worksafe.tas.gov.au

Compensation under the Act (statutory benefits)

What are statutory benefits?

Statutory benefits are compensation payments or benefits payable to an injured worker under the Act.

Statutory benefits are paid on a “no fault basis”, which means that it is not necessary to prove that anyone was at fault for causing the worker’s injury or disease. As long as the requirements of the Act are met, the worker is entitled to benefits under the Act. This can be distinguished from common law damages, where a worker must prove that negligence on the part of another person (usually the employer) resulted in or contributed to the injury*.

**Refer to page 41 for further information on common law damages.*

Weekly payments of compensation

A worker who is incapacitated (either totally or partially) for work as a result of a work-related injury or disease is entitled to weekly payments*. *Section 69*

To receive weekly payments, a worker must provide a medical certificate stating that they are incapacitated. If the worker is still totally or partially incapacitated by the end of the period specified on the medical certificate, the worker will need to go back to their medical practitioner to get a new certificate. Where a worker ceases to reside in Tasmania, the worker must provide proof of their identity and address when required, as well as proof their incapacity is continuing. *Section 83*

**A person serving a term of imprisonment is not entitled to weekly payments during that term of imprisonment.* *Section 82*

Commencement of weekly payments

On receiving a claim for compensation (involving incapacity for work), an employer must start making weekly payments as follows: *Section 81*

- where the worker’s first pay day is within 14 days after the employer received the claim, on that first pay day, unless it is not reasonably practicable to do so, in which case payment must be made not later than 14 days after the employer received the claim; or
- where the worker’s first pay day is later than 14 days after the employer received the worker’s claim, on that pay day.

Weekly payments are payable from the date of incapacity or 14 days before the date the claim was given to the employer – whichever is later. *Section 81(3)*

Weekly payments are to be paid on the worker’s normal payday (pre-injury) unless the worker and employer have agreed, in writing, to alternative arrangements for payment. *Section 81B*

Without prejudice weekly payments

The employer must start making weekly payments regardless of whether they have accepted liability for the worker’s claim. These payments are sometimes described as being “without prejudice payments” as the fact that an employer pays weekly payments to a worker cannot be taken to be an admission that the employer is liable for the claim. *Section 81*
Section 81AA(1)

The employer may be entitled to recover some or all of these payments back from the worker if the Tribunal has found that: *Section 81AA(2)*

- the worker’s claim was fraudulent; or
- the worker obstructed or delayed determination of the claim and liability is subsequently determined not to exist; or
- the claim was for an injury that is not compensable under the Act (for example, an injury which is attributable to the serious and wilful misconduct of the worker or an intentional self-inflicted injury).

Without prejudice weekly payments cease upon the Tribunal finding that there is a reasonably arguable case for disputing liability and making an order under section 81A(3)(c). *Section 81A(3)*

If the Tribunal subsequently determines that the employer is not liable for the worker's claim, the employer can deduct an amount equal to the without prejudice payments they have paid from the worker's sick leave entitlements as at the date of the Tribunal's determination (not future sick leave entitlements). *Section 81AA(3)*

Calculation of weekly payments.

A worker is entitled to weekly payments at whichever is the highest amount out of these two options: *Section 69(1)*

- the normal weekly earnings of the worker averaged over the relevant period of employment; or
- the worker's ordinary time rate of pay for the employment (as set by an Award or other industrial instrument such as a workplace agreement) that the worker was engaged in immediately before the incapacity began.

The "relevant period" depends on how long the worker has been employed by the employer: *Section 69(14)*

- if continuously employed by the same employer for 12 months or more, the relevant period is the 12 month period immediately before the commencement of the worker's incapacity; or
- if continuously employed by the same employer for less than 12 months, the relevant period is the period the worker was employed by the employer immediately before becoming incapacitated.

If the injured worker was employed by the employer for 14 days or less before the injury, the injured worker's normal weekly earnings are taken to be: *Section 69(2)*

- the normal weekly earnings of another worker employed by the same employer performing comparable work; or
- if there is no other worker, the injured worker's expected weekly salary excluding any overtime or other allowances.

Normal weekly earnings include any regular allowances, but not travel or accommodation allowances. Overtime is excluded unless it is part of a regular pattern of employment.

In calculating normal weekly earnings, a general principle set out in the Act is that a worker should receive no more in weekly payments than the worker would have received if the worker had continued in the worker's usual employment. *Section 70(2)*

Calculating weekly payments where a worker has more than one job

Where a worker was employed in more than one part-time job before becoming incapacitated by their work-related injury, the worker's normal weekly earnings are calculated according to a formula in the Act. *Section 70(2) (b)*

Under this formula, the worker's normal weekly earnings are calculated by adding together the average weekly earnings from each of the jobs they were working in immediately before becoming incapacitated; that is, as if the earnings from each of those jobs were earnings from the employer who is liable to pay compensation to the worker.

This formula does not apply if one of the worker's jobs was a full-time job. In that instance, the normal weekly earnings of the worker are calculated by reference to the earnings in the full-time job only. *Section 70(2) (d)*

Step-downs in weekly payments

For the first 26 weeks of incapacity*, a worker receives weekly payments at 100% of their normal weekly earnings** (refer to page 28 above for what is included and excluded from “normal weekly earnings”). After the first 26 weeks, there are two reductions (known as “step-downs”) in weekly payments.

*Section
69B(1)(a)*

Where a worker is incapacitated for more than 26 weeks*, their weekly payments are paid at either 90% or 95% of their normal weekly earnings**. If the worker is able to return to some form of work but their employer fails to provide suitable alternative duties, then the worker will receive 95% of normal weekly earnings** rather than 90%.

*Sections
69B(1)(b) and
69B(2)*

Where a worker’s incapacity exceeds 78 weeks*, their weekly payments are reduced to either 80% or 85% of normal weekly earnings**. Again, a worker is entitled to 85% rather than 80% if the employer fails to provide suitable alternative duties.

*Sections
69B(1)(c) and
69B(2)*

*Incapacity can be total or partial. A period of incapacity does not necessarily have to be a continuous calendar week period – it can include the aggregate or sum of intermittent periods of incapacity.

**Ordinary time rate of pay is to be used to calculate weekly payments if greater than normal weekly earnings – refer to page 28.

The step-downs do not apply (that is, the worker is to continue to be paid at 100% of normal weekly earnings*) if the worker is back at work for 50% or more of the worker’s normal weekly hours**.

*Section
69B(2A)*

If the worker is back at work for less than 50% of the worker’s normal weekly hours, they are entitled to weekly payments to make up the difference between what they are earning for the duties they are performing and their normal weekly earnings/ordinary time rate of pay. Step-downs only apply to the amount of weekly payment that the worker receives.

*Ordinary time rate of pay is to be used to calculate weekly payments if greater than normal weekly earnings – refer to page 28.

**Normal weekly hours are the average number of hours per week for which the worker was employed by the employer unless the worker was employed for 14 days or less, in which case the normal weekly hours are the hours per week:

*Sections
69B(2B), (2C)
and (2D)*

- for which the worker agreed to work in the pay period in which the worker’s incapacity arose; or
- for which the worker was rostered to perform work in the pay period in which the worker’s incapacity arose

whichever is the highest. Overtime is excluded unless it is part of a regular pattern of work.

There is a safety net provision for low income-earning workers. Under this safety net, an injured worker is not to receive less than 70% of the basic salary* or 100% of their weekly payment, whichever is lower. For example, apprentices whose normal weekly earnings or ordinary time rate of pay are less than 70% of the basic salary will continue to receive weekly payments at 100% of normal weekly earnings/ordinary time rate of pay.

*Section
69B(3)*

*Refer to page 47 for an explanation of the basic salary.

Expiry of entitlement to weekly payments

Maximum period of entitlement

The maximum period that weekly payments can be paid depends upon the worker’s level of whole person impairment (WPI)*:

*Section
69B(1)*

- a worker with a WPI of less than 15% is entitled to weekly payments for up to nine years**
- a worker with a WPI of at least 15% but less than 20% is entitled to weekly payments for up to 12 years**

- a worker with a WPI of at least 20% but less than 30% is entitled to weekly payments for up to 20 years**
- a worker with a WPI of 30% or more is entitled to weekly payments until the worker reaches the pension age (it may be possible for a worker to receive weekly payments beyond the pension age in some circumstances)**.

**Refer to page 33 for further information on WPI.*

***These maximum periods of entitlement are subject to the age restrictions set out in section 87 of the Act. Refer to the next section on cessation of weekly payments at age 65*

Cessation of weekly payments at pension age

A worker ceases to be entitled to weekly payments once they reach the pension age. The pension age means the pension age defined by the Social Security Act 1991 of the Commonwealth. This age restriction overrides the maximum periods of entitlement referred to above. For example, a worker who is 60 years of age at the time of incapacity who has a WPI of 15% will receive weekly payments up to the pension age at the time rather than up to 12 years.

Section 87(1)

There are some exceptions:

- If a worker is injured in the 12 month period before they attain the pension age, weekly benefits will cease on the date one year after the injury occurs. For example, if the worker is injured just one day before they reach the pension age they will be entitled to weekly payments for a maximum period of one year.
- if a worker's terms and conditions of employment allow them to work beyond the pension age, the worker can apply to the Tribunal for a determination extending weekly payments beyond the pension age.

*Section 87(1)
(b)*

Section 87(2)

Reducing or terminating weekly payments under section 86

Section 86(1) of the Act enables an employer to reduce or terminate weekly payments where:

Section 86(1)

- the weekly payments the worker is receiving relate to total incapacity and the worker has returned to work
- the worker is partially incapacitated and is receiving more in wages and weekly payments than their normal weekly earnings or ordinary time rate of pay
- an accredited medical practitioner has examined the worker and certified in writing that in their opinion the worker has wholly or substantially recovered from the effects of the injury or that the incapacity is no longer wholly or substantially due to the work-related injury
- the worker's entitlement to weekly payments has expired*.

If the reason for reducing or terminating weekly payments is either (c) or (d), the employer must serve a written notice on the worker:

- stating that the employer intends reducing or terminating weekly payments
- advising that the worker has the right to refer the issue to the Tribunal.

Weekly payments will be terminated or reduced 10 days after the notice was served on the worker.

**Refer to pages 29-30 for further information on expiry of entitlement to weekly payments.*

The worker has the right to dispute a reduction or termination in weekly payments by referring the matter to the Tribunal*. The referral must be made within 60 days of the date on which weekly payments were terminated or reduced.

** The Tribunal has a specific form for referral of a section 86 dispute. Call the Tribunal on (03) 61 664 750.*

**Refer to page 43 for information on Tribunal proceedings.*

Compensation for medical and other expenses

An employer is liable for the cost of all reasonable expenses necessarily incurred by the worker as a result of the injury for the following services:

Sections 74 and 75

- medical services
- hospital services
- household services
- nursing services
- constant attendant services
- rehabilitation services
- workplace rehabilitation services
- road accident rescue services
- ambulance services.

An employer is also liable to pay reasonable expenses necessarily incurred by an injured worker for travelling and maintenance, such as food and accommodation, connected with any medical, hospital or rehabilitation services, or attending any medical examination organised by the employer.

Section 76

If a medical practitioner certifies that the injured worker needs to be accompanied for any treatment or examination, the employer is also liable for the reasonable travelling expenses of the person accompanying the worker.

The amount payable for the use of a private vehicle is calculated in accordance with the rates set out in the Tasmanian State Service Award.*

**The Tasmanian State Service Award can be found at www.tic.tas.gov.au under "Awards Public Sector".*

Reasonable and necessary

A worker is only entitled to payment of expenses for medical or other services if the expense was reasonable and necessarily incurred: that is, the treatment or service was necessary. This will largely depend on the individual circumstances of each case. For example, a course of massage therapy may not be seen as necessary for an injury such as a broken toe but may be considered necessary for a soft tissue back injury.

The amount of an expense may be considered unreasonable if it is much higher than the average charge for that type of service by other service providers. A service provider must not charge a fee that is more than they would normally charge if the service was not for a workers compensation matter.

Section 75(2A)

Any dispute about the reasonableness of or necessity for any medical or rehabilitation service which is or may become the subject of a claim may be referred by the worker, employer or insurer to the Tribunal for determination. The Tribunal can also determine the necessity for a medical or other service before it is obtained and a cost incurred.

Section 77

Forwarding accounts for medical and other expenses

When a worker receives an account for medical or other expenses, they are to take reasonable steps to forward the account to their employer within 7 days. Upon receiving the account, the employer (if not a self-insurer) must then take reasonable steps to forward it to their insurer within 7 days.

Section 76A

Without prejudice payment of medical and other expenses

An injured worker has immediate access to medical treatment and rehabilitation on lodging a claim for compensation.

As with weekly payments*, the Act provides for without prejudice payments of medical and other expenses. Where a worker has lodged a claim, the employer must pay for medical and other expenses up to a total maximum of \$5000 even where the claim has not yet been accepted or liability disputed. The fact that an employer pays these medical and other expenses does not constitute an admission of liability for the claim.

Section 77AB

**Refer to page 27 for information on without prejudice weekly payments.*

An employer can dispute payment of a without prejudice medical or other expense on the grounds that the expense is unreasonable or unnecessary. To do this, the employer must:

*Sections
77AB(2) and
77AC*

- serve written notice on the worker and the service provider stating:
- that the employer is disputing payment
- the reasons why the employer believes the expense is unreasonable or unnecessary.
- refer the dispute to the Tribunal along with any evidence that the employer intends to rely on at the Tribunal hearing*.

It is up to the employer to prove that expense is unreasonable or unnecessary.

*Section
77AC(4)*

If the Tribunal is satisfied that it is reasonably arguable that an expense is unreasonable or unnecessary, it can order that the employer is not liable to pay for the expense. It can also order that the employer is not liable to pay for a type of expense or treatment; for example, that the employer does not have to pay for physiotherapy or counselling, if the Tribunal is satisfied that it is reasonably arguable this type of treatment or expense is unreasonable or unnecessary. This saves the employer from having to dispute every single invoice and gives notice to the worker and service provider that the treatment or expense will not be covered.

*Section
77AC(3)*

**The Tribunal has a specific form for making a referral under section 77AB. Call the Tribunal on (03) 6166 4750.*

Payment of medical and other expenses once liability has been accepted or determined

Once an employer has accepted or been found liable for a worker's claim, the process changes for disputing payment of expenses.

On receiving an account, the employer has 28 days to dispute payment. As well as disputing liability for an individual account, the employer can dispute liability for payment of any medical or other expenses or for expenses for a particular type of treatment or service.

Section 77AA

If the employer disputes payment, they must, within 28 days of receiving the account:

- serve the worker with a written notice:
- indicating that the employer is disputing payment, and whether it is just for that particular account or for a particular type of expense or for all medical and other expenses
- stating the reasons why payment is disputed
- attaching or identifying any medical or other evidence that the employer is relying on
- informing the worker of their right to refer the matter to the Tribunal
- notify in writing the service provider who rendered the account that liability for the expense is disputed and outline the reasons why the employer disputes liability to pay the expense

On receiving a notice from their employer disputing payment of medical or other expenses, a worker has 60 days to refer the matter to the Tribunal* (this timeframe will be set out in the notice from the employer). If the worker does not do this, the employer will not have to pay the account.

*Section
77AA(5)*

It is particularly important to note that if the employer's notice disputes payment of all expenses or payments of expenses for a particular type of treatment or service, the employer will not have to pay for any further accounts for those types of expenses unless and until the Tribunal determines that they are liable to do so. The Tribunal cannot make this determination if the worker has not referred the matter to it.

*Sections
77AA(3) and
(4)*

Once the matter has been referred to the Tribunal, it is up to the employer to prove that the worker is not entitled to payment of the expense etc.

*Section
77AA(7)*

**This referral is to be made under section 42. Call the Tribunal on (03) 6166 4750 for the correct form.*

Stopping compensation for medical and other expenses

A worker's maximum period of entitlement to compensation for medical and other expenses depends on whether the worker is or has been entitled to weekly payments of compensation* or not.

**Refer to page 27 for information on weekly payments.*

Where a worker is or has been entitled to weekly payments as a result of their work-related injury, their entitlement to compensation for medical and other expenses stops 52 weeks after their weekly payments are terminated.

Section 75(2)

For example, if a worker receives weekly payments for 9 years after the date of injury, entitlement to compensation for medical and other expenses will stop after 10 years. If a worker's weekly payments are terminated 2 years after the date of injury due to the worker no longer suffering any incapacity for work, entitlement to compensation for medical and other expenses will stop 3 years after the date of injury.

For medical only claims (that is, claims where the worker is not and has never been incapacitated for work but has claimed compensation for medical or other expenses) entitlement stops 52 weeks after the date the claim for compensation was made.

*Section
75(2AA)*

The Tribunal can determine that a worker is entitled to compensation for an expense or type of expense after the worker's period of entitlement has stopped if:

*Sections
75(2AB) and
(2AC)*

- the worker has returned to work and requires surgery or other services to remain at work; or
- the service is related to the modification, replacement or maintenance of the worker's prosthesis; or
- the service is essential to ensure that the worker's health or ability to undertake the necessities of daily life do not significantly deteriorate.

Lump sum compensation for permanent impairment

In addition to any other compensation payable, a worker who suffers permanent impairment resulting from a work-related injury or disease for which a workers compensation claim has been lodged may be entitled to receive a lump sum payment.

Section 71

Whether a worker is entitled to lump sum permanent impairment compensation – and if so, the amount of that compensation – depends on the level of “whole person impairment” suffered by the worker.

Whole person impairment

Whole person impairment (WPI) is a medical issue, involving the alteration of a person's health status. Impairment is described as being a deviation from normal in a body part or organ system and its functioning. Impairment is assessed in terms of its effect on the person overall – the whole person.

Impairment is considered to be permanent if it is static, well-stabilised and unlikely to change substantially in future months regardless of treatment being undertaken.

Thresholds for lump sum compensation

To be entitled to lump sum permanent impairment compensation, a worker must meet the appropriate threshold. The thresholds are:

Section 71

- for the loss of part, or all, of a finger or toe – there is no threshold
- for any other permanent physical impairment – a threshold of 5% WPI applies
- for permanent psychological impairment – a threshold of 10% WPI applies
- for industrial deafness – a threshold of 5% binaural hearing loss, suffered since 16 August 1995 applies.

Section 72A

A worker who suffers a WPI of 20% for an injury which occurred on or after 1 July 2010 may be entitled to pursue common law damages (refer to page 41).

Assessment of impairment

A worker's degree of WPI is to be assessed by an accredited medical practitioner who has been accredited by the Board to undertake assessments of impairment. To grant accreditation, the Board must be satisfied that the medical practitioner has completed an appropriate training course.

Section 72

Assessments of impairment must be carried out using:

- the Tasmanian Workers Compensation Guidelines for the Assessment of Permanent Impairment under the Workers Rehabilitation and Compensation Act 1988* (the WorkCover Guidelines)
- the American Medical Association Guides to the Evaluation of Permanent Impairment, fourth edition (AMA Guides).

*Go to www.workcover.tas.gov.au and search for "Guidelines permanent impairment".

In cases where there may be a dispute over the degree of the worker's WPI (for example, where a medical assessor engaged by the employer disagrees with the assessment made by a medical assessor engaged by the worker), the matter can be referred to the Tribunal. The Tribunal may then refer the issue to a medical panel* for determination.

Sections 3, 50 and 51.

*Refer to page 45 for an explanation of and information on medical panels.

Amount of lump sum compensation

Once a worker's level of WPI has been determined, the amount of lump sum compensation they are entitled to is calculated in accordance with the formulas set out in the Act.

Section 71

A worker who suffers a WPI of more than 70% is entitled to the maximum amount of lump sum compensation which is 415 units*.

*One unit is equal to the basic salary. Refer to page 47 for more information.

Agreements to settle

In certain circumstances, a worker and an employer can enter into an agreement to settle the worker's claim. This means that the worker will receive one lump sum payment (a once and for all payment) to cover the worker's remaining entitlements to compensation (for example, weekly payments, medical and other expenses, permanent impairment) under the Act. Once this occurs, the worker will not be able to make any further claims for workers compensation in respect of that particular injury.

There are limitations on agreements to settle, as the key focus of the Act and the workers compensation scheme is on recovery and return to work.

Agreements to settle made within 2 years

Where the worker and employer wish to enter into an agreement to settle within 2 years from the date the claim for compensation was made, the agreement must be approved by the Tribunal. If the agreement has not been approved by the Tribunal, it will be of no effect. The Tribunal is to order the employer to pay the costs of referring a proposed agreement for approval.

Sections
132A(2), (3)
and (13)

In general, the Tribunal may only approve a proposed agreement to settle made within 2 years from the date of the claim if it is satisfied that:

Section
132A(6)(a)

- all reasonable steps have been taken to enable the worker to be rehabilitated, retrained or to return to work; or
- the worker has returned to work.

However, there are two exceptions.

Section
132A(6)(b)
and (c)

The first exception is where the Tribunal has determined under section 81A of the Act that there is a reasonably arguable case for disputing liability*. In these circumstances, the Tribunal can approve a proposed agreement to settle if it is satisfied that the agreement is in the best interests of the worker.

The second exception is where the Tribunal is satisfied that there are special circumstances which make the worker's rehabilitation, retraining or return to work impracticable, for example, where the worker suffers a severely disabling injury or terminal illness. Again, in such a case, the Tribunal can approve a proposed agreement to settle if it is satisfied that the agreement is in the best interests of the worker.

**Refer to page 13 for more information on section 81A disputes.*

For all proposed agreements made within 2 years of the date of claim, the Tribunal must also be satisfied that:

Section
132A(7)

- the worker has received appropriate professional advice about the proposed agreement to settle. This could be legal and/or financial advice (the employer or insurer is to pay for the advice)
- the worker's entitlement to lump sum compensation for permanent impairment* has been considered.

**Refer to page 33 for an explanation of lump sum permanent impairment compensation.*

Agreements to settle made after 2 years

Agreements to settle made more than 2 years after the date the claim was made do not have to be approved by the Tribunal.

However, the worker, employer or insurer can subsequently refer the agreement to the Tribunal to be reviewed and possibly set aside. A referral must be made within 3 months of the date of the agreement and must be in a form approved by the Tribunal.

Sections
132A(9) and
(10)

The Tribunal can set aside an agreement if it is of the opinion that:

Section
132A(11)

- a party entered the agreement under duress; or
- the worker has not received appropriate advice; or
- a party was induced to enter the agreement by a misrepresentation by another party (or their agent) as to a material fact.

If the Tribunal sets aside an agreement, it must make an order requiring either the repayment of any money paid under the agreement or the application of the money paid to any future workers compensation entitlements the worker may have. It must also order that the employer pay the costs of having the agreement reviewed even if it was the worker who referred it to the Tribunal. However, the employer will not have to pay the costs of a referral by a worker where the Tribunal is satisfied that the referral was frivolous or vexatious.

Section
132A(12)(b)

Section
132A(13)

Compensation to dependants of deceased workers (“death benefits”)

Where a worker dies as a result of their work-related injury or disease, their dependants may be entitled to compensation under the Act. This may include:

- weekly payments
- lump sum payments
- compensation for the worker’s medical expenses
- compensation for counselling costs
- compensation for burial or cremation costs.

Dependants

A deceased worker’s dependants means members of the deceased worker’s family who: Section 3(1)

- were wholly or partially dependent upon the earnings of the worker at the time of the worker’s death; or
- would have been wholly or partially dependent on the earnings of the worker had the worker not been incapacitated due to a work related injury or disease.

This includes the worker’s spouse or caring partner*.

**A caring partner is a person who was in a caring relationship with the worker which was the subject of a deed of relationship registered under the Relationships Act 2003.*

A dependent child means a person who is: Section 65

- under the age of 16 years; or
- 16 years of age or more, but less than 21 years of age and is a full time student and who was partially or totally dependent on the worker.

Weekly payments to dependants

Where a worker dies as a result of a work-related injury or disease, the deceased worker’s dependent spouse or caring partner and dependent children are entitled to weekly payments of compensation. Section 67A

A dependent spouse or caring partner is entitled to weekly payments paid as: Section 67A(2)

- 100% of the deceased worker’s normal weekly earnings/ordinary time rate of pay for the first 26 weeks following the date of death
- 90% of the deceased worker’s normal weekly earnings/ordinary time rate of pay for the period over 26 weeks and up to 78 weeks from the date of death
- 80% of the deceased worker’s normal weekly earnings/ordinary time rate of pay for the period over 78 weeks and up to 2 years from the date of death*.

A dependent spouse or caring partner has no further entitlement to weekly payments after 2 years from the date of death. Section 67A(4)

**If a worker dies more than 78 weeks after sustaining the work-related injuries which caused their death, their dependent spouse or caring partner will be entitled to 80% of the deceased worker’s normal weekly earnings or ordinary time rate of pay from the date of death up to 2 years from the date of death.* Section 67A(3)

As with weekly payments to an injured worker, the employer must start making weekly payments to a dependent spouse or caring partner upon receiving a claim regardless of whether the employer disputes the claim. These payments are not considered to be an admission of liability. Section 67B

Dependant children are entitled to weekly payments paid on a different basis. Instead of being paid a proportion of the deceased worker's normal weekly earnings or ordinary time rate of pay, dependant children are entitled to weekly payments of 15% of the basic salary*.

Section
67A(1)(b)

These weekly payments start 13 weeks from the date of the worker's death and continue until the child reaches 16 years of age (or 21 years of age if a full-time student) and they are to be paid to the child's parent or guardian where the child is under 18.

**Refer to page 47 for more information on the basic salary.*

An employer or insurer has 28 days from the date of receiving a claim for compensation to dispute liability to pay weekly compensation to dependants.

Section 67F

If the employer or insurer does decide to dispute liability, they must, within the 28 days:

- serve the dependants with a written notice indicating that liability is disputed and the reasons why
- refer the matter to the Tribunal.

The Tribunal will then determine whether there is a reasonably arguable case that the employer is not liable. If the Tribunal determines that there is a reasonably arguable case, the Tribunal must find that weekly payments are not payable to the dependant/s. It is then up to the dependant to refer the matter back to the Tribunal for determination.

If the employer does not dispute liability in accordance with the above processes, the employer is taken to have accepted liability.

Section 67G

Lump sum compensation to dependants

Dependent spouses, caring partners and children may also be entitled to lump sum compensation. When a worker dies as the result of a work-related injury, the total maximum amount of lump sum compensation available to the dependants is 415 units*.

Section 67(1)

**One unit is equal to the basic salary. Refer to page 47 for more information on the basic salary.*

The amount of the lump sum and the way it is distributed depends upon the dependants of the deceased worker and their degree of dependency on the deceased worker. The distribution of the lump sum is set out in accordance with section 67(2) of the Act:

Sections 67(2)
and (3)

In a situation where the deceased worker had no dependent spouse, caring partner or children, another family member or members may be entitled to lump sum compensation if the worker had been contributing towards the maintenance of that family member's home immediately before suffering the work-related injury. The amount of the lump sum the family member/s is/are entitled to is calculated on the basis that they were partially dependant on the deceased worker.

Section 67(4)

If there is a dispute about the level of dependency upon the deceased worker or the apportionment of the lump sum among the dependents, the matter can be referred to the Tribunal for determination.

Section 68

Compensation for medical expenses

The worker's dependents are entitled to compensation to cover expenses* incurred for any of the following services that the worker received as a result of the work-related injury:

Section 75(1)

- medical services
- hospital services
- nursing services
- constant attendant services
- rehabilitation services
- household services
- road accident rescue services
- ambulance services.

**These expenses must be both reasonable and necessary. Where the employer disputes liability for these expenses, the same process set out under "Payment of medical and other expenses once liability has been accepted or determined" must be followed. Refer to page 32.*

Compensation for counselling costs

Where members of a deceased worker's family require counselling services following the worker's death, the Act allows for the payment of reasonable costs up to \$4000 (this is total amount payable for counselling).

Sections 75(1) and (10)

Counselling services are services provided to a person to help them cope with the psychological impact of the death of a worker. To be covered by the Act, these services must be provided by a counselling professional: a medical practitioner, registered psychologist, social worker or a counsellor who is a member of or has qualifications recognised by the Australian Counselling Association.

Regulation 17A

Compensation for burial or cremation costs

Where a worker has died as a result of a work-related injury or disease, their dependants are entitled to compensation for reasonable expenses for the worker's burial or cremation.

Section 75(1) (b)

The maximum amount of compensation available is \$9500.

Regulation 17A

Independent medical reviews

What is an independent medical review?

An independent medical review is a review of the worker's injury carried out by a medical practitioner (not chosen by the worker) who has expertise in a field relating to the worker's injury. The review can include:

- one or more examinations of the worker *Section 90A(1)*
- a review of any diagnostic test results or other medical records in relation to the worker.

When does a worker have to undergo a medical review?

An employer or insurer can require a worker to submit to an independent medical review only if the employer or insurer: *Section 90A(3)*

- has discussed the matter with the worker's primary treating medical practitioner
- has informed the worker in writing of the reasons why the review is to be done.

The worker is either to:

- submit to the independent medical review provided *Section 90A(4)*
- the review is at a reasonable time and place (for example, it may not be reasonable to expect a worker who lives in Burnie to attend a review scheduled for 8.30am in Hobart in the middle of winter); and
- the worker has received reasonable notice in writing of the review; or
- refer the matter to the Tribunal within 30 days.

In terms of the frequency of independent medical reviews, a worker cannot be required to submit to more than one independent medical review every three months unless the worker has suffered multiple injuries or a complex injury which requires examination by different medical specialists. *Sections 90A(5) and (6)*

Where the matter is referred to the Tribunal, the Tribunal is to consider the following matters in determining whether an independent medical review should proceed: *Section 90C(5)*

- whether the reviewer has the appropriate expertise to properly assess the worker's injury
- whether, in the circumstances, an excessive number of reviews or examinations have been conducted of the worker
- whether the worker has previously made a complaint (on reasonable grounds) about the conduct of the proposed reviewer
- the location and timing of the review
- any other matter the Tribunal thinks fit.

Access to previous medical reports and records

A worker who must submit to an independent medical review is considered to have consented to the release of all relevant medical reports and records to the independent medical reviewer. *Section 90A(4)*

Independent medical review reports

On carrying out an independent medical review, the independent medical reviewer must prepare a report for the employer or insurer who requested the review. The independent medical reviewer must not provide a copy to the worker. *Section 90B(1)*

Within 7 days of receiving an independent medical review report, the employer or insurer must serve a copy on the worker's primary treating medical practitioner and the injury management coordinator. This is an important requirement as there may be information in the report which will help coordinate and plan the worker's treatment or return to work. There is a fine of up to 10 penalty units* for failing to meet this requirement. *Section 90B(3)*

**Refer to page 49 for information on penalty units.*

The worker's primary treating medical practitioner is to provide a copy of the report to the worker.

Section 90B(4)

Treatment recommended by an independent medical reviewer

If an independent medical reviewer reports that a particular type of medical or surgical treatment will shorten or terminate the injured worker's incapacity for work, the worker must either:

Section 90A(7)

- undergo that treatment; or
- notify their employer within 14 days of receiving a copy of the report that the worker is not satisfied with the report.

Where the worker has notified their employer that they are not satisfied with the report, the worker must undergo another medical examination for a second opinion. The worker is entitled to choose the medical practitioner who carries out this examination and the employer or insurer is to pay for the costs.

Section 90A(7)(d)

If the second opinion agrees with the treatment recommended by the independent medical reviewer, then the worker must undergo the treatment.

If the worker refuses to undergo the recommended treatment, the employer or insurer can refer the matter to the Tribunal. The worker's right to compensation and to take any proceedings under the Act is automatically suspended until the Tribunal has determined the issue. The suspension does not apply if the worker has refused surgical treatment given the seriousness and risks involved in surgical treatment as well as cultural or religious reasons for refusing surgery.

Section 90C(1), (2), and (3).

Disputes about independent medical reviews

If a worker:

- refuses, without reasonable excuse, to submit to an independent medical review or examination; or
- obstructs an independent medical review or examination; or
- refuses to submit to or undertake any required treatment (as referred to in the section above)

Section 90C(1), (2) and (3)

the matter can be referred to the Tribunal. There is an automatic suspension (except in the case of a refusal to undergo surgical treatment) of the worker's right to compensation and to take any proceedings under the Act until the Tribunal has determined the matter. The Tribunal can subsequently determine that the worker is to be back paid for the period of suspension.

Section 90C(6)

A referral to the Tribunal can also be made where a report has been served and the parties are unable to agree on:

- whether, and to what extent the worker's incapacity is due to the worker's work-related injury
- the worker's condition or fitness for work.

Section 90C(4)

Use of reports in Tribunal proceedings

Sometimes medical reports, including independent medical review reports, are used as evidence in Tribunal proceedings (for example, where a worker's claim or the level of the worker's incapacity is disputed).

Section 90D

A report cannot be used as evidence unless the report has been served on the other party. Other evidence (such as verbal testimony) from a medical practitioner cannot be admitted unless a report from that medical practitioner has been served on the other party.

Common law damages

What are common law damages?

Common law damages are a form of lump sum compensation agreed between parties or awarded by a court to compensate one party for loss or suffering caused by the negligence, breach of statutory duty or breach of contract of the other party.

Common law damages differ from statutory workers compensation benefits in that:

- common law damages are fault-based; that is, the worker must be able to prove that the injury resulted from negligence, breach of contract or breach of statutory duty on the part of the employer (or a person the employer is vicariously liable for); and
- common law damages can compensate for losses not covered by statutory benefits; for example, pain and suffering, loss of amenities, past and future loss of earning capacity.

Threshold for access to common law

A worker can only claim common law damages where the injury or disease suffered has resulted in a WPI* of 20% or more. It should be noted that where a female worker loses a foetus as a result of a workplace injury, the loss of the foetus is deemed to be a 20% WPI.

Section 138AB

The Act prevents a common law settlement or commencement of proceedings where this 20% threshold is not met.

**Refer to page 33 for further information on WPI.*

Claiming common law damages

Time limits under the Limitation Act 1974

A worker who is considering claiming common law damages should seek legal advice as early as possible. Common law claims are complex and, in addition to the threshold requirement mentioned above, there are other legal requirements that apply.

There are very strict time limits on starting common law proceedings. These are set out in the Limitations Act 1974. In some circumstances, the Court can grant an extension. If a worker does not commence proceedings (by issuing a writ) within the time period fixed by the Limitation Act or extended by the Court, then their right to claim common law damages will be extinguished and barred (this means that they will not be able to proceed with a common law claim). This will not, however, affect the worker's right to statutory benefits under the Act.

Meeting the 20% WPI threshold requirement

As mentioned above, the 20% WPI threshold must be met before common law proceedings can be commenced or settled by agreement. For all injuries other than the loss of a foetus, the threshold requirement is only met if:

Section 138AB

- the Tribunal has been provided with a written statement signed by a medical assessor certifying that the worker's WPI is not less than 20%*
- the Tribunal has made a determination that the worker has a WPI of not less than 20%.

Section 138AB(3)

Where the worker's workplace injury involves the loss of a foetus, the threshold requirement is met if the Tribunal is provided with a written statement signed by a medical practitioner certifying that the worker's workplace injury is the loss of a foetus.

Section 138AB(4)

If there is a dispute about the degree of a worker's WPI, e.g., if the accredited medical practitioner consulted by the worker assesses the worker's WPI as 21% and the medical assessor engaged by the employer assesses the worker's WPI as 19%, the Tribunal can refer the matter to a medical panel to determine.

Section
138AB(6)

**As with lump sum permanent impairment compensation, assessment of impairment must be carried out by an accredited medical assessor in accordance with the WorkCover Guidelines and AMA Guides (see page 34 for further information.)*

Relationship between common law damages and statutory benefits

A worker does not have to make a choice (sometimes called an "election") between claiming common law damages and claiming statutory benefits. Any statutory benefits (such as weekly payments and compensation for medical and other expenses) that the worker is entitled to under the Act will continue to be paid while the worker's common law damages claim is being determined.

However, the statutory benefits that the worker has received will be taken into account in determining the amount of common law damages agreed or awarded by the Court.

It is important to note that if a worker enters into an agreement to settle their entitlements to compensation under the Act*, they are not entitled to common law damages.

Section 138AD

**Refer to page 34 for information on settlements by agreement under the Act.*

Dispute resolution

Queries or complaints about workers compensation claims

WorkSafe Tasmania offers a number of services to assist workers and employers with queries or concerns about workers compensation matters. However, it does not provide legal advice.

General queries

The Helpline is a service providing free information and assistance by telephone to the general public. Any general query about workers rehabilitation and compensation can be directed to the Helpline by calling 1300 366 322 (inside Tasmania) or (03) 61 664 600 (outside Tasmania).

Complaints

WorkSafe Tasmania is responsible for enforcing the Act. Any possible breaches of the Act should be referred to WorkSafe Tasmania for investigation by either calling the Helpline (on the telephone numbers above) or by making a formal complaint to WorkSafe Tasmania in writing:

by mail:

WorkSafe Tasmania

GPO Box 56

ROSNY PARK TAS 7018

by email:

wstinfo@justice.tas.gov.au

The Workers Rehabilitation and Compensation Tribunal

The Workers Rehabilitation and Compensation Tribunal (the Tribunal) is an independent statutory body established under the Act. It has the primary responsibility for determining disputes about workers rehabilitation and compensation. The types of disputes that the Tribunal deals with include:

- liability for a claim; for example, whether an injury was work-related
- issues concerning weekly payments, such as the commencement, amount, reduction or termination of payments
- payment for medical and other services
- reimbursement of travelling expenses
- issues relating to injury management.

Referral to the Tribunal

Generally disputes about claims are referred to the Tribunal under section 42 of the Act*. This includes referrals to the Tribunal following a section 81A determination (refer to page 13 for further information).

However, referrals can be made under other sections of the Act including section 77AB, section 81A, section 67F and section 86(4).

A referral can be made by the worker, the employer or the insurer by completing the appropriate Referral to Tribunal form*. The form is to be lodged with the Tribunal.

**Call the Tribunal on (03) 6166 4750 for the correct form.*

Dispute resolution process

The dispute resolution process in the Tribunal begins when one of the parties refers a dispute to the Tribunal. There are time limits for some referrals, particularly in relation to disputes under sections 81A, 77AA, 77AB and 86. These are set out in more detail in other sections of this Guide.

Conciliation

The Tribunal's conciliation process is aimed at resolving disputed claims informally and reducing costs.

There are two stages to the conciliation process:

- the preliminary stage
- the conciliation conference.

The preliminary stage

Upon receiving a referral, a conciliator from the Tribunal will contact the parties to the dispute (usually the worker, the employer and/or insurer) by teleconference to:

- identify the issues that are in dispute
- discuss what is being done to investigate those issues, including any medical examinations that have been arranged
- to outline timeframes for completing investigations
- discuss the claim generally with the aim of identifying any possible options for resolving the dispute.

During this preliminary stage, the conciliator may give directions to any or all of the parties on what is to be done to facilitate a resolution.

The conciliation conference

If a dispute has not been resolved during the preliminary stage, the conciliator will hold a conciliation conference, usually after all investigations and medical examinations have taken place.

A conciliation conference is a meeting where the worker, the employer and/or the insurer discuss all issues and try to come to a resolution.

The parties required to attend a conference are notified in writing of the date, time and venue*. Attendance is compulsory. Employers and insurers must be represented by someone with full authority to act on their behalf, including binding them to any agreement reached.

Legal representation is not permitted (for any party) unless the conciliator determines that:

- a person's interests would be materially disadvantaged by not being represented; or
- the conference would be more likely to resolve the claim with the presence of a legal practitioner.

However, in practice, many parties do have legal representation during a conciliation conference.

A worker can also be accompanied by a family member, friend, or union official to provide assistance and support. Similarly, a representative of an employer organisation can attend a conference to provide advice and support to the employer.

Before the conference, the parties are to provide the Tribunal and the other parties with any evidence that they wish to rely on. Any expert medical evidence must be disclosed before the conference takes place unless the conciliator decides otherwise.

During a conference, parties are encouraged to:

- state their views
- listen to the views of the other parties
- try to develop ways to resolve the dispute themselves.

To encourage open and honest discussion, nothing said at the conference can be used later on in evidence at a Tribunal hearing.

If the parties reach agreement during a conference, the conciliator will refer the claim to the Tribunal to make an order giving effect to the agreement.

If the parties are unable to reach agreement, the conciliator can either:

- arrange another conference, particularly if further medical evidence or investigation is required; or
- refer the matter to the Tribunal to determine by way of an arbitrated hearing.

A conciliator can also make recommendations, including that a medical question be referred to a medical panel** for determination.

**Conciliation conferences and arbitrated hearings can be held in Hobart, Launceston or Devonport. The venue chosen is usually the one which is closest to the worker's place of residence.*

***Refer below for further information on medical questions and medical panels.*

Arbitrated hearings

An arbitrated hearing is a more formal process than a conciliation conference. A hearing is held before the Chief Commissioner or another Commissioner of the Tribunal*.

As with conciliation conferences, parties are required to disclose any expert evidence (such as medical reports) they are seeking to rely on to the other parties before the hearing. If they don't do this, they may not be able to use the evidence at the hearing. A party can also make a formal request for access to other documents in the possession of one of the other parties.

At the hearing, the Chief Commissioner or Commissioner will hear all of the evidence available, including testimonies from witnesses, and make a determination on the dispute. Legal representation is permitted with the approval of the Tribunal, and, generally, most parties chose to be represented by a lawyer at a hearing.

**Notice of the hearing date, time and venue is given to the parties.*

On making a determination, the Tribunal will make an order or orders to give effect to that determination.*

**Refer to page 46 for further information on Tribunal orders.*

Medical panels

The Act allows the Tribunal to refer any medical question to a medical panel, but only where:

- there is conflicting medical opinion on the issue
- one of the parties wishes to continue with the proceedings.

Medical questions include questions relating to:

- the existence, nature or extent of an injury
- whether an injury is, or is likely to be, permanent or temporary
- a worker's capacity for work or specific work duties
- the loss, or the degree of loss, of any of the parts or faculties of the body
- the permanent loss of the effective use of a part of the body
- the assessment of the degree of permanent impairment, including whether the impairment is permanent
- a medical service provided or to be provided to a worker for an injury, including the adequacy, appropriateness or frequency of that service.

A medical panel is chosen from a register of medical practitioners who have indicated their willingness to serve on medical panels. Each panel will consist of two or three medical practitioners. One of the members is to be a general practitioner and one is to be a specialist in the medical field to which the question relates. The panel members must not have treated, examined or provided any medical advice to the worker about their claim.

A medical panel has the power to:

- examine a worker
- require a worker to answer questions
- require a worker to produce or consent to the production of relevant documents (such as medical reports or records).

If the worker fails to appear before a medical panel or refuses to do any of the above things, the Tribunal can suspend the worker's right to compensation.

Within 7 days of making a determination, the medical panel is to provide the Tribunal with the determination, and the reasons for the determination, in writing.

A determination of a medical panel about a medical question is final and binding on all parties, including the Tribunal.

Orders

The Tribunal is to make an order or orders to give effect to any determination it makes (including for interim determinations). The type of order the Tribunal makes depends upon the type of dispute or matter that was before it. Some examples are:

- an order that the employer must make weekly payments from a specified date
- an order as to the amount of weekly payments
- an order that an employer must pay for medical and other services from a specified date
- an order that weekly compensation is not payable by the employer
- an order that the cost of medical and other services is not to be paid by the employer
- an order that an employer must pay for a particular expense for a medical or other service or for a type of medical or other service
- an order that an employer is not liable to pay for a particular expense or type of expense or treatment
- an order that an employer is entitled to recover payments of compensation made to the worker in certain circumstances, including where the worker's claim was fraudulent
- an order that a person is a dependent of a deceased worker and/or as to the degree of dependency.

There are a number of specific orders that the Tribunal can make in relation to injury management matters. These are set out at page 26.

The Tribunal can also make interim orders about urgent matters.

Where an order (including an interim order) relates to the payment of money, that order can be enforced by the Magistrates Court (Civil Division).

For further information on the Tribunal go to www.workerscomp.tas.gov.au

Definition of terms

accredited medical practitioner

A medical practitioner accredited under section 77C to assess the degree of a workers permanent impairment.

accredited person

A person accredited by the WorkCover Tasmania Board to provide prescribed services.

Act

The Tasmanian Workers Rehabilitation and Compensation Act 1988.

AMA Guides

The American Medical Association Guides to the Evaluation of Permanent Impairment, Fourth Edition, as modified by the Act, or such later edition of those Guides as may be prescribed.

basic salary

The basic salary for a period of a year commencing on 1 January in each year as determined by the Minister (in accordance with a formula set out in the Act) and published in the Tasmanian Government Gazette. The basic salary is also referred to as a “unit”. To find out the current basic salary rate, go to www.worksafe.tas.gov.au and search for ‘basic salary rate’.

Board

The WorkCover Tasmania Board.

caring partner

The person who is in a caring relationship with a worker which is the subject of a deed of relationship registered under Part 2 of the Tasmanian Relationships Act 2003; OR

The person who was, at the time of the death of a worker, in a caring relationship with that worker which was the subject of a deed of relationship registered under Part 2 of the Tasmania Relationships Act 2003.

Chief Commissioner

The Chief Commissioner of the Workers Rehabilitation and Compensation Tribunal, appointed and holding office under the Act.

claim for compensation

A claim for compensation under the Act, which includes any matter or question arising in connection with or incidental to such a claim.

Commissioner

A commissioner of the Workers Rehabilitation and Compensation Tribunal, appointed and holding office under the Act.

dependants

The members of the family of a deceased worker, who were partly or wholly dependent upon the worker’s earnings at the time of the worker’s death (or who would have been dependent on the worker’s earnings but for the worker’s incapacity due to his or her injury).

disease

Any ailment, disorder, defect or morbid condition, whether of sudden or gradual development.

employer

The person with whom a worker has entered into a contract of service or training agreement. This may include the Crown, the employer of any person or class of persons taken to be a worker for the purposes of the court, and the legal personal representative of a deceased employer.

Fund

The Workers Rehabilitation and Compensation Fund established under section 145 of the Act.

industrial deafness

Permanent loss of hearing caused by exposure to industrial noise in a worker's employment.

injury

Includes a disease and the recurrence, aggravation, acceleration, exacerbation or deterioration of any pre-existing injury or disease where the employment was the major or most significant contributing factor.

injury management

The management of an injured worker, intended to provide the worker with a timely, safe and durable return to work following an injury.

insurer

A body corporate authorised under the Commonwealth Insurance Act 1973 to carry out insurance business.

legal practitioner

A legal practitioner within the meaning of the Legal Profession Act 1993.

licensed insurer

An insurer who holds a licence issued by the Board authorising it to provide workers compensation insurance to employers.

medical panel

A medical panel formed under section 50 of the Act for the purpose of determining a medical question/s referred by the Tribunal.

medical practitioner

A person who is authorised under a law of another country to carry out all of the functions in respect of which the person would, if they were carried out in Australia, be required to be registered under the Health Practitioner Regulation National Law in the medical profession.

medical question

A question relating to:

- the existence, nature or extent of an injury; or
- whether an injury is, or is likely to be, permanent or temporary; or
- a worker's capacity for work or specific work duties; or
- the loss, or the degree of loss, of any of the parts or faculties of the body; or
- the permanent loss of the effective use of a part of the body; or
- the assessment of the degree of permanent impairment, including whether the impairment is permanent; or
- a medical service provided or to be provided to a worker for an injury, including the adequacy, appropriateness or frequency of that service.

member of the family

In relation to a worker means the spouse, caring partner, father, step-father, grandfather; mother, step-mother, grandmother, son, grandson, daughter, granddaughter, step-son, step-daughter, brother, sister, half-brother, and half-sister of the worker or a person to whom the worker acted in place of a parent.

Nominal Insurer

The body established as the Nominal Insurer under section 121 of the Act.

outworker

A person to whom articles or materials are given out to be made up, cleaned, washed, altered, ornamented, finished, repaired or adapted for sale, in premises not under the management or control of the person giving them out.

penalty unit

A penalty unit is a specified sum of money used to define the amount payable or maximum fine to be applied for many offences under different legislation. As at 1 July 2010, a penalty unit is \$130.00.

period of incapacity

A period of incapacity for work, whether partial, total or a combination of both, commencing on the date of initial incapacity, and in the case of separate periods of incapacity resulting from the same injury, the aggregate of those periods.

policy of insurance

A policy of insurance that an employer is required to maintain under the Act.

primary treating medical practitioner

In relation to a worker, means the medical practitioner referred to in a notice given by the worker in accordance with section 143G(1) of the Act.

psychiatric impairment

An illness or disorder of the mind.

Registrar

The Registrar of the Workers Rehabilitation and Compensation Tribunal appointed and holding office under the Act.

regulations

Any regulations made and in force under the Act.

Secretary

The Head of the Agency that administers the Act. At present, this Agency is the Department of Justice.

self-insurer

An employer who is the holder of a permit to self-insure issued by the WorkCover Tasmania Board.

specialized insurer

An insurer or proposed insurer, whose business is or is intended to be, specialized insurance for employers of a particular class or classes.

spouse

Includes the person with whom the worker is, or was at the time of the worker's death, in a significant relationship, within the meaning of the Relationships Act 2003.

State

Includes a Territory.

State of connection

The State with which the worker's employment is connected as determined by the Act.

training agreement

An agreement or contract between an employer and a trainee as described in the Vocational Education and Training Act 1994.

Tribunal

The Workers Rehabilitation and Compensation Tribunal.

unit

The amount represented by the basic salary. This is not the same as a penalty unit.

weekly payment

The weekly payment made to a worker who is partially or totally incapacitated for work. The amount of the weekly payment is determined in accordance with the Act. Weekly payments are to be paid on the same days and at the same intervals as the worker's normal payday.

worker

Any person who has entered into, or works under, a contract of service or training agreement with an employer, whether by way of manual labour, clerical work or otherwise, and whether the contract is express or implied, or is oral or in writing and any person or class of persons taken to be a worker for the purposes of the Act.

When used in relation to a person who has been injured and has died as a result of the injury, the term includes the legal personal representatives or dependants of that person, or other person, to whom or for whose benefit compensation is payable.

workers compensation insurance business

The business of insuring employers against their liability to their workers under the Act.

working day

In relation to a worker's place of employment, any day on which work is normally carried on at that place.

workplace injury

In relation to a worker, an injury for which the worker's employer is or may be liable to pay compensation under the Act.

workplace rehabilitation provider

A person who is accredited under section 77C of the Act to provide workplace rehabilitation services.

workplace rehabilitation services

The following services:

- initial workplace rehabilitation assessment
- assessment of the functional capacity of a worker
- workplace assessment
- job analysis
- advice concerning job modification
- rehabilitation counselling
- vocational assessment
- any other service that is prescribed by the regulations.

1300 366 322
www.workcover.tas.gov.au

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