# Impairment Benefit Claims Management Policy

## Summary

The *Workplace Injury Rehabilitation and Compensation Act 2013* (the Act) prescribes the method of managing an Impairment Benefit (IB) claim. This policy is designed to provide proactive guidance to the Impairment Benefits Specialist (IBS) for managing IB claims covering topics from suspensions, inactive workers, multiple examination non-attendances and requests to withdraw, cancel or hold a claim in abeyance.

This policy replaces all previous policies issued by WorkSafe Victoria under Circular No: 2013/22 - Policies Relating to the Management of Impairment Benefit Claims:

- Suspension Policy
- Inactive Claim Policy
- Worker Non-Attendance at IIA Policy
- Request to Withdraw, Cancel or Hold in Abeyance Policy
- Lost Worker Policy

## Suspensions

Section 200(1) of the Act provides that an IB claim may be suspended within 90 days of Agent Received Date (ARD) for any of the following reasons:

a) insufficient medical information
b) condition or the injury of the worker is not stable.

The process flow identification for the claim must be A3: Suspended (excl Election to Common Law) using ACCtion suspension code 15 (90 days).

### Insufficient medical information

This relates to insufficient medical information to determine matters specified in section 201(1) of the Act including liability, obtaining an impairment assessment, determining the degree of permanent impairment resulting from the injury and calculating any entitlement to compensation.

Insufficient medical information usually relates to insufficient treating information, medical records, post-operative reports and psychiatric/psychological treating medical information; however this is not an exhaustive list.

Independent Impairment Assessment (IIA) reports and Worker Questionnaires are not considered to be medical information, therefore not a valid reason to suspend the claim.

Insufficient medical information does not include matters within the control of the agent such as inability to locate the primary file or inability to book an IIA.

### Injury/condition not stable

For the purposes of an IB application, stability refers to a permanent impairment that;

> *"is considered to be unlikely to change substantially and by more than 3% in the next year with or without treatment…"* as stated on page 315 of the AMA Guides, 4th Edition.

The definition of stability should be used as a guide to assist in determining whether the condition / injury has stabilised, with consideration to section 55 of the Act which states that an assessment must be made:

> *"based on the worker's current impairment as at the date of the assessment, including any changes in the signs and symptoms following any medical or surgical treatment undergone by the worker in respect of the injury."*

It is appropriate to regard an injury as not stable if the worker has recently undergone a surgical procedure and no post-operative report or medical documentation has been received to confirm current stability of injury. The post-operative information must be requested by the agent.

If it is determined that the injury is not stable, the claim should be suspended in accordance with section 200.

**Suspending a claim**

The claim is required to meet one or more of the following criteria:

- Agents must ensure that documents on file substantiates that the worker's condition has not stabilised.
- Evidence that the worker recently underwent a surgical procedure and no post-operative report or medical documentation has been received to confirm stability of injury.
- If it has been determined that further information is required this must be detailed in either the Initial Eligibility Review (IER) or in a Novus case note with the reasons for the suspension and what information has been requested and from whom.

In addition to the above, the following criteria must be met:

- Notify the worker within 90 days of ARD by the way of a standard letter advising the reasons their claim for IB has been suspended and the Agents action plan to progress the claim.
- Update ACCtion using suspension code 15 (90 days).
- Evidence that an action plan to progress the claim has been implemented (if appropriate).

**Multiple Unjustified Examination Non-Attendance**

Where a worker has had multiple non-attendances at either the IIA or Hearing Loss Assessment (HLA), in certain circumstances a claim can be suspended in accordance with section 200 of the Act.

Multiple non-attendance is defined as two IIAs or HLAs, on alternative days, which the worker has failed to attend.

If the worker has advised prior to the assessment that they are unable to attend, the Agent should accommodate the workers needs and be flexible in rescheduling. Have consideration to the workers needs such as work schedule, transport assistance and personal circumstances such as the need to pick up and drop off children at school.

Where the worker has multiple unjustifiable non-attendances at scheduled examinations, despite being made aware of their obligations under the Act, the Agent is able to suspend the claim in accordance with section 200 on the basis that there is insufficient medical information to make a determination in accordance with section 201(1).

Further examinations should be arranged upon confirmation from the worker or their legal representatives that they will attend. The suspension may remain in place until it is confirmed that the worker did attend the examination. Where multiple specialities are required, the suspension is to be lifted upon confirmation of attendance at the first examination.

### Managing a suspended claim

It is expected that the agent will manage each claim on its merits and acknowledge that there may be circumstances in which a claim may be both limited by insufficient medical information and an injury that is not stable. Agents are expected to be aware of actions taken by the claims teams (i.e. determining whether a post-operative report has been requested or obtaining latest treating medical information).

The minimum requirements for managing a suspended claim are identified as follows:

1. Not stable injury/condition:
    - File note at time of suspension detailing reasons for suspension, including reference to the evidence supporting decision
    - Documentation on file substantiating worker's condition as not stable
    - In cases where worker is to undergo surgery/further treatment, determine date/s this is to occur
    - Obtain prognosis and anticipated timeframes for stabilisation (i.e. Treating Health Practitioner (THP) report, post-op report)
    - Regular file reviews noted on Novus to monitor the progression of claim.

Agents are to use their discretion in determining a suitable timeframe for review of the claim. However, WorkSafe recommends the following periodic reviews of the information on file and case management action plan as a minimum:

- Every three months following surgical intervention.
- Every two months for further medical treatment (non-surgical).
- Every month for industrial deafness/asthma/mental injury.

In circumstances where less time is anticipated for stabilisation, agents should review the claim more regularly, as deemed appropriate on a case to case basis.

2. Insufficient medical information:
    - File note at time of suspension detailing information required in order to determine matters specified in section 201(1) including liability, obtaining an impairment assessment, determining level of permanent impairment or calculating any entitlement (i.e. hospital records, THP report).
    - Evidence on file of requests made to obtain this information.

In cases where the requested information has not been received in a timely manner, evidence of reasonable attempts to follow up (i.e. file notes, correspondence) and use of available alternative avenues of seeking the required information.

### Reinstating a suspended claim

In complying with section 200, the suspension must be lifted within 14 days of confirming the stability of an injury or receiving the information required to progress a claim, by notice in writing to the worker. Where the suspension is being removed to schedule an IIA, the notice of suspension removal may be including in the appointment letter to the worker providing it is clear from the letter that the suspension has been removed.

Suspended claims must be reinstated prior to referring a worker to an IIA.

### Business Rules

Upon reinstatement of a claim on ACCtion, and removal of that claim from the A3 process flow, the period in which the claim was suspended will be deducted from the calculation of the 'Unresolved Claim Age in Years' when the:

- claim was suspended within 90 days of ARD in accordance with section 200(1) and the Suspension Policy
- suspended claim was identified in the process flow as 'A3: Suspended (excl Election to Common Law)' AND suspension code '15 (90 days)' used
- claim is reinstated and removed from the 'A3: Suspended' process flow.

Suspended claims may be subject to review by WorkSafe to ensure the claim was managed in accordance with the Suspension Policy and reinstated in accordance with section 200(2).

The reinstatement of a suspended claim will not alter the 'Unresolved Day Count' of a claim.

## Inactive Workers

If a worker is beyond reach, communication or influence (such as overseas for an extended period of time) or refuses to cooperate at any stage during the impairment benefits process, the agent may not be able to process the claim within the legislated time frames.

In such circumstances, there is provision for the agent to seek approval from WorkSafe to determine that the worker's claim has now become 'inactive' and the claim can now be considered resolved/inactive in accordance with the IB Datamart rules.

It is the agent's responsibility to ensure that all reasonable attempts to contact the worker and progress the claim have been made and appropriately documented before a request can be made.

In circumstances where the worker is overseas for an extended period of time or refuses to cooperate, it is the agent's responsibility to ensure that the worker (or their legal representative) is assisted with the impairment process and made aware of the implications of not pursing their claim (i.e. section 197(5) of the Act permits only one claim for compensation under section Division 5 for injuries arising out of the same event or circumstance).

**What is an inactive claim?**

There are various reasons why a worker cannot be located and each claim must be assessed on its own merits. The following is a non-exhaustive list of reasons why a claim may be considered inactive:

- Agent correspondence to the worker is 'returned to sender'
- Telephone calls to the worker and/or nominated person are unanswered or the contact telephone number is disconnected
- The worker's legal representative has advised of their inability to contact the worker
- The worker or their legal representative has advised that they are going overseas for an indefinite period of time
- A worker who has zero-dollar entitlement has requested that their claim be withdrawn or cancelled after they have made a request for Conciliation or a Medical Panel referral
- A worker refuses to attend multiple impairment examinations
- A worker refuses to respond to a *Worker's Response Form* after a $ offer has been made by the agent
- A worker has not, and will not, be stable for an extended period of time (only if the 90$^{th}$ day has passed and a suspension cannot be coded).

### What constitutes a 'reasonable' attempt?

All attempts to progress a worker's impairment benefit claim must be documented on Novus, all correspondence must be held on the claim file.

The following work practices are considered reasonable 'attempts' to progress a worker's impairment benefit claim;

- A reasonable amount of correspondence sent to the worker's last known address
- Use internet searches, including yellow and white pages to locate the worker
- Attempts to obtain the worker's current contact details from a third party such as the worker's employer or legal representative.

The Agent must determine whether to pursue all or some of the above recommendations based on the particular circumstances and justify within their case note on Novus. It is expected, at a minimum, multiple attempts are made to contact the worker directly using different methods.

### When is it appropriate to refer the matter to WorkSafe?

If the agent has made reasonable but unsuccessful attempts to contact the worker, as per the above list, the agent can request WorkSafe to consider the claim in accordance with the *Inactive Claim Policy* by completing the Helpdesk Referral template and forwarding it to the IB Helpdesk inbox.

### When is it not appropriate to refer the matter to WorkSafe?

The Agent should not refer inactive claims to WorkSafe if the worker has been assessed with a $0 entitlement, either by IIA or the Medical Panel, and a Notice of Liability and Entitlement (NOLE) has been issued and the worker has not returned the Worker's Response Form.

Such claims will be resolved in accordance with the Datamart Business rules.

> For claims assessed by the agent where the Worker's Response Form has not been received, the claim will resolve in accordance with the Datamart Business rules after a period of 90 days after the NOLE is issued.
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> For claims assessed by the Medical Panel where the Worker's Response Form has not been received, the claim will resolve in accordance with the Datamart Business rules when the worker is issued with a NOLE and the Agent enters an '09' code on ACCtion confirming the $0 entitlement.

The Agent should not refer claims that can be suspended in accordance with section 200 of the Act.

### WorkSafe's role

Once a claim is 'inactive' and has been accepted in accordance with the Inactive Claim Policy, WorkSafe will remove the claim from the current process flow (in accordance with the Datamart business rules) and place it in the process flow A2 (withdrawn/cancelled). The claim will thereafter be considered resolved.

### Agent's role in managing an inactive claim

WorkSafe recommends that Agents conduct periodic reviews of the information on Novus to establish if at any point the impairment benefit claim needs to be reactivated or to identify that circumstances may have changed and a further contact with the worker should be made.

### What happens when the claim can be reactivated?

If a worker's impairment benefit claim has been determined inactive in accordance with the Inactive Claim Policy and the agent has evidence and/or the worker has advised that they wish to pursue their impairment benefits claim, the agent must contact WorkSafe and confirm that the claim no longer meets the Inactive Claim Policy requirements.

WorkSafe will ensure that the impairment benefits claim is reactivated (and will be considered unresolved in accordance with the IB Datamart Rules) on ACCtion so that the agent can proceed to progress the claim in accordance with the legislative requirements.

**Business rules**

Upon reactivation of a claim on ACCtion and removal of that claim from the A2 process flow, the period in which the claim was inactive will be deducted from the calculation of the 'Unresolved Claim Age in Days' when the agent has notified WorkSafe within 28 days with evidence and/or information the impairment benefits claim can proceed

Should the agent not notify WorkSafe within the required time frame, the period in which the claim was inactive will not be deducted from the calculation of the 'Unresolved Claim Age in Days'.

Inactive claims will be reviewed by WorkSafe periodically to ascertain Agents compliance with the policy.

The reinstatement of an inactive claim will not alter the 'Unresolved Day Count' of a claim.

## Request to Cancel or Withdraw

Where an Agent has received a request from a worker or their legal representative to cancel or withdraw their impairment benefit claim the following applies;

The Act provides that a worker can only make one claim for impairment benefits in respect of injuries arising out of the same event or circumstance and provides specific times frames for an impairment claim to be processed.

Prior to consideration of any request to cancel or withdraw a claim, the Agent must ensure the worker is aware of their legal rights in accordance with the Act. The worker must be aware that they cannot make more than one claim for compensation under section 197(5) for injuries arising out of the same event or circumstance.

WorkSafe's position is that a claim is 'made' when a claim that complies with the statutory requirements as to form and content is given or served in accordance with the Act. WorkSafe maintains that it is not possible for a worker to withdraw an impairment benefit claim.

Agents are not to permit a worker to withdraw or cancel their claim. If the worker is not able to proceed with their claim, the consideration should be given to suspending the claim within 90 days of ARD. In other limited circumstances consideration should be given to make the claim inactive. These should be discussed with WorkSafe prior to advising the worker or the legal representatives to determine if the Inactive policy applies.

**Agent expectations**

If a worker or their legal representative requests to withdraw or cancel an impairment benefit claim, the Agent must at all times protect the worker's rights to their one claim for an impairment benefit and should consider the following actions:

- Ascertain the reason/s why the worker no longer wishes to pursue their claim and determine the best course of action for the worker. For example, provide assisted transport to IIA or consider a 'desktop' assessment.
- If the worker has a concurrent common law claim, the agent should follow up the progress of the common law claim with the worker's legal representative or WorkSafe's Legal Panel solicitor to ascertain whether the common law claim has resolved. If the common law claim is rejected, not pursued or unsuccessful, the worker may still have an entitlement to impairment benefits. The

Agent should determine the status of common law claim prior to seeking resolution of the impairment benefit claim from WorkSafe in accordance with this policy.

Where WorkSafe approves a request to make a claim inactive following the request to cancel or withdraw an impairment benefit claim, the Agent should advise the worker in writing that their claim will be held in abeyance indefinitely. The Agent must also advise the worker that if they wish to resume their claim for impairment benefits, they must advise the Agent in writing of their intention either by mail or email.

**WorkSafe's role**

WorkSafe will remove the claim from the current process flow in accordance with Datamart business rules and place it in the process flow A2 (withdrawn/cancelled). The claim will thereafter be considered resolved in accordance with the Inactive Workers section of this policy.

WorkSafe will keep a register of all claims resolved in accordance with this policy.

WorkSafe recommends that Agents conduct periodic reviews of the information on file to establish if at any point the impairment benefit claim needs to be reactivated or to identify that circumstances may have changed and further contact with the worker should be made.

**Reinstating a claim**

If a claim has been held in abeyance in accordance with this policy and at a later date the worker requests to resume their claim, the Agent must contact WorkSafe and advise that the worker has requested to pursue their impairment benefit claim. The worker does not have to submit a new IB claim form for injuries arising from the same circumstances. The claim should be processed using the original claim form and a new claim should not be raised.

WorkSafe will ensure that the impairment benefits claim returns to the 'active' process flow so that the Agent may progress the claim in accordance with the IB Datamart business rules.