

WORKERS COMPENSATION
BEST PRACTICE GUIDELINES
for APPROVED INSURERS
and SELF INSURERS
in the Northern Territory

Workers Compensation

NT WorkSafe

is the administrative arm of the *Work Health Authority* and administers the *Workplace Health and Safety Act*, the *Workers Rehabilitation and Compensation Act* (the Act), the *Transport of Dangerous Goods by Road and Rail (National Uniform Legislation) Act*, the *Dangerous Goods Act* and the *Radioactive Ores and Concentrates (Packaging and Transport) Act* and related Regulations on behalf of the Northern Territory Government.

One of the functions of NT WorkSafe is to approve insurers and self insurers for providing workers' compensation insurance. It is important that insurers and self insurers work co-operatively with NT WorkSafe to help achieve the best performance for our scheme.

With this in mind, NT WorkSafe has developed best practice guidelines with a view to achieving the following outcomes:

- Consistent claims management with a focus on fairness, timeliness and effectiveness.
- An understanding by employers that there is a relationship between effective risk management and a reduction in workplace accidents.
- Premiums set by insurers for individual employers:
 - Encourage employers to develop and maintain safe work practices, and
 - Penalize employers that do not ensure the maintenance of safe work practices
- Information is made available to employers and workers so that there is increased awareness of the key issues, rights and responsibilities in the workers' compensation process.
- Data is transferred from insurers to NT WorkSafe in a timely and accurate manner.

Throughout this document the use of the words "approved insurers" or "insurers", includes self insurers except for the Employer check list in Guideline 2, Guidelines 19, 20 and 24 and where we specifically note the guideline does not apply.

Recognising that workers' compensation claims are the result of injury and incapacity suffered by members of the community, approved insurers will treat claimants with care and understanding. The image to fulfil is one of fairness and honesty in dealing with injured workers.

The **Guidelines** are designed to achieve a sensible and reasonable approach by approved insurers as well as consistency as far as possible with the focus on a fair, speedy and effective handling of workers' compensation claims.

While the **Guidelines** should contribute to improving efficiency of claims management, they are not intended to replace existing sound practices.

Approved insurers expect injured workers will reasonably and sensibly participate in the necessary medical treatment and rehabilitation programs to ensure an early return to the workplace. To achieve a cost effective, productive and meaningful workers' compensation system in the NT, it is recognised that there must not only be a commitment by insurers and employers, but also injured workers.

The **Best Practice Guidelines** is intended to be a living document and as such, may be progressively developed following consultation with stakeholders and approved insurers.

The Best Practice Guidelines has been developed in consultation with approved insurers.

These Guidelines are not presented as rules but rather a framework within which approved insurers should work recognising the need for discretion for approved insurer management. They are intended as minimum standards which approved insurers are encouraged to improve upon.

BEST PRACTICE GUIDELINES for APPROVED INSURERS in the Northern Territory

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SECTION 1 – general obligations

1. Compliance

In the interests of raising service standards and achieving consistency insurers have committed to voluntarily comply with these general obligations and have agreed to undertake self audits against the guidelines and service standards shown in the [Schedule of Performance Indicators](#).

TABLE 1 ■ Schedule of Performance Indicators

Performance indicator	No	Standard	Measure	Frequency
Employer information *	2	In accordance with guideline	Document developed and supplied	Annual
Worker information	2	In accordance with guideline	Document developed and supplied	Annual
Free or local call number	3	In accordance with guideline	Number available	Annual
Staff competency	5	In accordance with guideline	Staff trained	Annual
Early intervention guideline / personal injury management plans	7	Insurer's own guideline	Developed and staff trained	Annual
Contact with workers	8	Minimum 6 months	Self Audit	Quarterly
Notice of Decision	9	Legislation	Compliance	Annual
Permanent impairment	10	Notifying workers of rights and ongoing entitlements	Self Audit	Quarterly
Internal dispute resolution	11	Insurer to develop	In place and promoted	Annual
Use of medical practitioners	15	Legislation	Compliance	Annual
Review of files / case management plans	16	Insurer's own guideline	Developed and staff trained	Annual
Premium setting *	24	In accordance with guideline	Undertaking to NT WorkSafe	Annual
Taxi arrangements	27	In accordance with guideline	Self Audit	Quarterly
Data returns	29	In accordance with guideline 90% compliance	Error rates assessed by NT WorkSafe	Monthly

* Not Applicable to Self Insurers

SECTION 1

general obligations

Employers

At the time a policy is issued, insurers will provide employers with information on the claims process (which may be electronic, or in writing at the employer's request) which will include but is not limited to:

- statutory requirements – Section 84
- calculation of compensation rates
- the process for payment of compensation and reimbursement
- the importance of promptly passing on receipts or other documentation to the insurer
- the consequences of each of the three possible liability decisions
- the possibility of claims being deemed unlawful discontinuance of weekly payments – Section 69
- requirement to take all reasonable steps to provide suitable employment – Section 75A
- the benefits of an employer having an injury management program and making this known to its workers
- late payments of compensation (penalty interest) – Section 89

This information is to be reinforced at the time of any claim.

2. Provision of information to Employers and Workers

For many employers and workers the workers' compensation claim is an infrequent event and there is a lack of knowledge about the actual process and the entitlements under legislation.

To change this situation insurers are required to develop **information kits** as follows:

TABLE 2 ■ Employer and Worker Information Kit checklists

Workers

Injured workers are to be treated with care and understanding and insurers should supply all workers who claim with general information about the claim.

FOR ACCEPTED CLAIMS

Including but not limited to:

- an explanation of the entitlement based on normal weekly earnings, including an invitation to receive further detail on how compensation was calculated. Workers should be informed that they may have an entitlement to be paid for the value of benefits received in lieu of cash (non cash benefits).
- an outline of entitlements (e.g. reasonable medical expenses)
- travelling costs for treatment
- obligations in relation to the rehabilitation process
- information that if workers are unable to pay in advance for the cost of medications that they should discuss their circumstances with the insurer.
- reduction in weekly benefits at 26 weeks
- for long term incapacity the implications of re-assessing loss of earning capacity after 104 weeks having regard to most profitable employment, whether or not such employment is available. Information should be included that any action to reduce payments will be subject to the right of appeal.

It is acceptable for relevant information to be provided at appropriate trigger points rather than providing unnecessary information up front.

FOR DEFERRED CLAIMS

The letter from the insurer must provide full information about the deferral and the entitlements to compensation during the deferral period.

FOR DISPUTED CLAIMS

Formal notice must be provided, including information on mediation.

Injured workers will be given the name of their case manager and a direct telephone number for personal contact. If a Deferred Claim or Disputed Claim is subsequently Accepted, then the information outlined for Accepted Claims must then be supplied.

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3. Free Call, or Cost of a Local Call Telephone Access

Insurers are to make available a free call 1800 number, or cost of a local call 13 or 1300 number, which must be supplied in addition to the direct telephone number.

Where practicable, the number for workers' compensation claimants should be shown on the insurer's website for the Darwin Office contact details.

4. Without Prejudice Medical Interventions

The best outcome may not be achieved when workers are unable to obtain medical services because the claims decision has been to defer accepting liability.

The inability to access treatment and rehabilitation services could have an adverse outcome in terms of the period of recovery and time that a worker is unable to resume work.

It is the observation of NT WorkSafe that many deferred claims are subsequently accepted. Therefore insurers should make a value judgement case by case as to the likelihood of their decision being maintained.

Insurers will consider, case by case, voluntarily funding reasonable medical treatment clearly indicating which treatments will be paid and clearly indicating the decision to pay is on a without prejudice basis.

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general obligations

5. Staff Competency

Approved insurers should ensure staff handling workers' compensation matters are kept abreast of changes to relevant legislation and practices by conducting appropriate training sessions, workshops and the like. Insurers should give consideration to development of a code of conduct in relation to dealing with workers.

6. Payment for First Medical Certificate

The First Medical Certificate is an important administrative tool to help insurers determine liability and as such insurers should pay for the cost of the certificate regardless of the decision on liability.

7. Early Intervention/Personal Injury Management Plans

Insurers should have their own best practice guidelines for early intervention including where appropriate, personal injury management plans (personalised plan) for incapacitated workers. Insurance claims staff are to apply these guidelines to help achieve best outcomes.

8. Contact with Workers

Best outcomes are achieved if workers are contacted on a regular basis for discussion on the progress and future plan for managing their claim.

Unless exceptional circumstances apply, insurers should not allow more than six months between contacts.

9. Notice of Decision and Rights of Appeal

The intention of the approved form “Notice of Decision and Rights of Appeal” is to advise the worker of a rejection, cancellation or reduction of workers’ compensation benefits and advise the worker of their right to appeal. The reasons for this decision must be detailed on the form, and shall provide **sufficient information for the claimant to understand fully** why liability is disputed or benefits reduced or cancelled. For example, a general statement “you are not incapacitated for work” does not provide enough information – the insurer should include an explanation as to why the insurer is of that opinion.

Plain language should be used, avoiding wording that is overly legalistic.

The approved form must accompany any decision to dispute liability, reduce or cancel benefits except as provided otherwise in the Act e.g. fraudulent claims where issuance of the form is not required.

10. Permanent Impairment Claims (Sections 70, 71 & 72)

When the approved insurer has information to support an entitlement to a permanent impairment claim, it should inform the worker of their rights and the means to achieve any entitlement. Workers must be informed that a permanent impairment payment does not result in other entitlements ceasing.

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general obligations

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11. Internal Dispute Resolution

Each approved insurer should have an internal process for resolving a dispute between the injured worker and the approved insurer, or its representatives. This process should be readily accessible by injured workers without any charges imposed by the approved insurer. The internal process should provide a fair and timely method of handling disputes. NT WorkSafe considers a 5 working days response time to be reasonable. The insurer should establish procedures for the monitoring of such disputes and report annually to NT WorkSafe.

12. Representation at Mediation Hearings

Approved insurers should ensure that only claims officers with appropriate authority and experience attend mediation conferences and that the authority the officer carries is such as to be able to make decisions concerning the claim in dispute, whether in person or by way of a process that allows for decisions to be made during the mediation process (for example telephone instructions).

It is expected all parties to the mediation will approach mediation in the spirit of the legislation and demonstrate a genuine willingness to help resolve the dispute. Even if an insurer's position is correct and not changing, mediation is a valuable opportunity to fully explain to a worker the reasons for a decision – possibly avoiding unnecessary legal action.

The insurer's representative should always be mindful that the legislation is social in nature and intended for the benefit and protection of injured workers.

13. Denial of Claims and Variations in Compensation

The decision to deny (dispute) a worker's compensation claim is a serious and onerous decision and must only be made after careful consideration by a staff member with appropriate authority and delegations. It is important that insurers make fair and consistent decisions.

Variations in compensation should only be made by staff with appropriate authority, delegations and experience.

14. Settling of Journey Claims

It is expected that approved insurers will observe the NT WorkSafe bulletin "Guidelines for the Settling of Journey Claims".

15. Use of Medical Practitioners

The primary care provider is the worker's treating medical practitioner and in accordance with Section 90B, any requests for medical opinions must in the first instance be obtained from this source.

If the insurer wishes to seek another opinion the treating practitioner must be given the name and contact details of the medical practitioner who will be giving another opinion. A copy of any other opinion must be given to the treating medical practitioner (section 91).

Where there is conflict in medical advice or opinion, every attempt should be made by the approved insurer to resolve the issue. It is the view of NT WorkSafe that the best outcomes will be achieved when insurers discuss any possible alternatives or actions (such as cancellation of an entitlement) with the treating medical practitioner before action is taken.

The possibility of a case conference involving the medical practitioners (using teleconferencing if necessary), the worker, the rehabilitation provider and the insurer should be explored as another way of dealing with this issue.

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general obligations

16. Review of Files

Approved insurers should review their active claim files on a continual basis to ensure the claim, where possible, is proactively progressed to an early finalisation.

Claims exceeding 13 weeks lost time should have a case management plan prepared to ensure there is a planned, considered approach to ongoing management.

17. Case Conferences

Case conferences between the employer, worker, medical practitioner and rehabilitation provider is an effective tool for achieving best outcomes and all claims involving more than 13 weeks lost time should, where reasonably appropriate, have a case conference arranged.

Consultation with injured workers should occur so that at the worker's request, case conferences may be arranged separately to treatment appointments.

18. Rehabilitation

Rehabilitation services are to be a priority consideration of the approved insurer in the early stages of managing a claim. Only rehabilitation providers approved by NT WorkSafe may be used.

While approved insurers have their own internal strategies for effective rehabilitation, the guidelines as promulgated by NT WorkSafe should be considered.

Where a worker has an adequate reason for seeking to change rehabilitation provider, insurers will facilitate a satisfactory resolution wherever possible.

19. Denial of indemnity to employer

Denial of indemnity to an employer should only be made by a staff member with appropriate authorities and delegations. The employer should be informed within 7 working days, incorporating the reason for the denial. Such action should be notified to NT WorkSafe.

20. Employers to be kept Informed

Employers should be kept informed of important matters relating to the progress of the claim including the effectiveness of rehabilitation and medical procedures.

21. Notification to Providers

Where liability is rejected or remains uncertain after the statutory period, the approved insurer should notify the relative service providers of this fact.

22. Assessors/Investigators/Surveillance Operators

Approved insurers should have prescribed standards for Assessors/Investigators/Surveillance Operators (such as a requirement to be licenced) and codes of conduct for persons appointed by them to interview or investigate injured workers. Insurers should ensure that these agents conduct themselves in an acceptable, fair and reasonable manner.

SECTION 1

general obligations

23. Risk management

It is important employers understand there is a relationship between effective risk management and the risk of injury at work.

The primary goal of risk management is to eliminate or minimise workplace risk as far as is reasonably practicable. An employer shall ensure that a worker's exposure to a hazard at a workplace is controlled to minimise the risk to the health and safety of the worker.

Where there is a need to control a worker's exposure to a hazard, the control shall be achieved, as far as practicable, through the progressive application of one or more of the following measures:

- eliminate the relevant source of risk entirely
- isolate the source of the risk from workers
- control the source of the risk by engineering means
- control the risk by administrative means (such as the adoption of a different system of work, different working practices, or the introduction of warning systems)
- avoid or reduce the risk by the use of personal protective clothing or equipment.

NT WorkSafe would like insurers to take advantage of whatever opportunities exist to provide education and reinforcement to encourage employers to eliminate accidents by adopting a risk management approach.

24. Premium Setting

Insurers are to set underwriting and pricing guidelines that ensure premiums for individual employers should:

- Encourage employers to develop and maintain safe work practices, and
- Penalize employers which do not ensure the maintenance of safe work practices.

25. Disputes Between Approved Insurers

If there is a dispute over indemnity between insurers, and the claim from the injured worker is genuine, approved insurers must follow the procedures set down for this purpose outlined in Section 126A of the *Workers Rehabilitation and Compensation Act*.

26. Difficulty calculating Normal Weekly Earnings (NWE)

Section 85 (2) requires weekly payments to commence within 3 working days of liability being accepted but on occasions there is non compliance because of difficulty calculating the NWE for casual or temporary employees.

It is the responsibility of the employer and insurer to comply with the legislation.

Reasonable alternatives must be explored in these circumstances (such as a percentage of an award rate) rather than non compliance. If necessary such payments can be made on a without prejudice basis.

27. Taxi Arrangements for Interstate Medical Appointments

Where workers are travelling interstate for medical treatment and the use of a taxi is necessary for medical reasons, insurers should make arrangements for an account to be arranged with a local provider or pre-payment of taxi expenses rather than expect workers to fund expensive travel costs.

28. Interpreter Services

Where an insurer provides indemnity to an employer who is employing overseas workers (for example Section 457 visa holders) and a language difficulty exists, then in the absence of an alternative arrangement (friend, community group) insurers must arrange and pay for interpreter services to ensure injured workers are given full information in relation to a claim.

29. Return of Data to NT WorkSafe

As part of their approved insurer status insurers must comply with NT WorkSafe conditions and information requirements. Each year NT WorkSafe will request information concerning financial performance and other statistical data.

NT WorkSafe also requires data and information as outlined in the document “Insurer Guide to NT WorkSafe Data Requirements”. Additional copies are available on request.

In order to fulfil its functions under the *Workers Rehabilitation and Compensation Act*, NT WorkSafe requires compliance with quality and timeliness standards for the data supplied to NT WorkSafe. As part of this process NT WorkSafe will be monitoring compliance rates against the requirements listed below. The target for insurers is 90% compliance.

WORKERS COMPENSATION CLAIMS:

- The worker's compensation claim form and medical certificates to be forwarded to NT WorkSafe within 10 working days of the initial decision on the claim
- For claim forms downloaded from the internet, the NT WorkSafe claim number is recorded in the field in the top right hand corner of the claim
- The insurer's mandatory fields at the top of Page 1 of the claim form are to be completed as follows:
 - Date claim form received
 - Date claimant notified
 - Status (Accept/Reject/Defer) and reason if refused
- Page 3 of the claim (employers report page) is to be provided
- Ensure insurance policy information provided in Section 10 on Page 3 (employers report page) is correct
- Initial medical certificate is to be provided
- If claimant or employer has written "see attached or refer attached" in the description of the incident field on Page 1 of the claim, ensure the attachment is forwarded with the claim.

PROGRESS REPORTS:

Insurers are to provide:

- All current and re-opened claims must be reported whether or not there are any payments in a particular month
- The correct NT WorkSafe claim number
- The status of the claim (Accepted/Rejected/Deferred)
- Finalised claims must not be reported with a Deferred status
- Date claimant stopped work
- Date claimant resumed work – this is mandatory when the claim is finalised but can be supplied at any time during the life of the claim
- Correct NT WorkSafe benefit code. In particular the correct new benefit codes for rehabilitation costs (75.1 to 75.9) and when paying against an Accredited Vocational Rehabilitation Provider (Benefit 75), the Vocational Rehabilitation Provider number must be reported
- Correct spelling of claimant's names
- If reversing a cheque payment for wages (Benefit 64, 65.0 or 65.7) the negative number of days must be provided.

INSURANCE POLICY REPORTS:

The ABN number is to be provided (not Applicable to Self Insurers).

SECTION 2 – service standards

The following timelines are **minimum** response times:

TABLE 3 ■ Service Standards

Activity	Timeline	Quality assurance	Frequency
<input type="checkbox"/> Decisions on claims	10 working days from date claim received by employer	Self audit	Quarterly
<input type="checkbox"/> Written correspondence (including email)	5 working days	Self audit	Quarterly
<input type="checkbox"/> Telephone responses	24 hours	Self audit	Quarterly
<input type="checkbox"/> Reimbursement of compensation to employer *	10 working days	Self audit	Quarterly
<input type="checkbox"/> Notification to employer of claim decision *	2 working days	Self audit	Quarterly
<input type="checkbox"/> Denial of indemnity to employer *	7 working days	Self audit	Quarterly
<input type="checkbox"/> Payment of accounts	Credit terms or 30 working days	Self audit	Quarterly
<input type="checkbox"/> Refunds to workers (travel costs etc)	10 working days	Self audit	Quarterly
<input type="checkbox"/> Internal dispute resolution	5 working days	Self audit	Quarterly
<input type="checkbox"/> Settlement payment following court decision, mediation, agreement	21 days	Self audit	Annual
<input type="checkbox"/> Actions agreed at mediation	Time frame set by Mediator	Self audit	Annual
<input type="checkbox"/> Permanent impairment payments	As per statutory timeframes	Self audit	Annual

* *Not Applicable to Self Insurers*

Subject to having other internal processes or procedures in place to monitor compliance with these Performance Indicators and Service Standards, insurers may apply to NT WorkSafe for variations in the frequencies shown in this Schedule.