Australian Capital Territory

Workers Compensation (Performance Standard) Approved Protocol 2012 (No 1)

Notifiable instrument NI2012–496

made under the

Workers' Compensation Regulation 2002, reg 101 (Approved protocols for Insurers)

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1 Name of instrument

This instrument is the *Workers Compensation (Performance Standard) Approved Protocol 2012 (No 1)**.

2 Commencement

This instrument commences on the day following notification.

3 Approval

I approve the attached Protocol for Performance Standards for Insurers.

Dr Chris Bourke
Minister for Industrial Relations
11 September 2012

*Name amended under Legislation Act, s 60

Protocol Number	2012-3
Protocol Name	Performance Standard Protocol for Insurers

Purpose

To establish a:

- minimum standard of performance for Approved Insurers and Self Insurers[1] in discharging their statutory responsibilities;
- framework for reporting and performance monitoring of services under the *Workers Compensation Act 1951*,[2] it's associated Regulation,[3] Approved Protocols and related instruments.[4]

Context – law and policy

The Act empowers the Attorney General to:

- grant commercial insurers a licence to underwrite workers' compensation insurance policies (known as compulsory insurance policies) to Territory employers in accordance with the Act (s145, the Act);
- exempt certain Territory employers from the requirement to have these insurance arrangements with an Approved Insurer, instead authorising these employers to operate as approved Self-Insurers (s151, the Act).

Insurers are subject to the conditions, obligations and requirements enshrined in the Regulatory Framework. In particular, the Regulations expressly require Insurers to participate in compliance audits as a mechanism to assess their compliance.

This Performance Standard Protocol for Insurers is approved by the Minister in accordance with s101 of the Act and forms part of the conditions of approval/exemption to which the Insurers are subject. The Protocol sets out the minimum performance standards that Insurers must comply with and that constitute part of the conditions of approval.

The performance standards articulated by the Protocol are enforceable under the Regulatory Framework as a condition of licence/exemption. They will also constitute part of the matters audited under the Regulations (Part 10A). The results of compliance audits will in turn be used to inform the exercise of Regulatory power for non-compliance and as evidence of an Insurer's compliance with the terms of its licence approval/exemption including as evidence of the same for the purposes of assessing future licence/exemption applications.

[1] Insurers
[2] The Act
[3] The Workers Compensation Regulations 2002 (the Regulations)
[4] The Regulatory Framework

Objectives

The Performance Standard Protocol for Insurers is intended to achieve the following objectives:

- enhance transparency around the conduct of Insurers and the areas of regulatory scrutiny;
- empower injured workers to understand the minimum standard of conduct that they are entitled to expect from their employer's Insurer in the event of an injury;
- empower employers to understand the minimum standard of conduct that they are entitled to expect from their Insurer;
- ensure the Regulatory Framework operates efficiently and effectively to achieve consistency in the discharge of Insurers' statutory responsibilities and duties;
- ensure Insurers comply with their conditions of approval/exemption and meet the undertakings made as part of the licence/exemption approval process.

Implementation and auditing

Bi- annually, Insurers are required to undertake a self-audit against the Performance Standards Protocol and submit the results to WorkSafe ACT for consideration. Results must include:

- the number of files audited;
- the standards against which 100% compliance was observed;
- the standards against which 100% compliance was not observed;
- reasons for any failure to satisfy the performance standards;
- proposed remedial action to address identified non-compliance.

Bi- annual audits must be undertaken on at least 5% of open non-nil claims managed by the Insurer at the time of the audit.

Claims selected for Audit must be a representative sample of the Insurer's claim profile in terms of both claim duration and common law/redemption/statutory benefit streams. Claims should not be audited more than once in each three year Insurer licence period.

Note: to ensure samples are representative, common law or redemption claims settled within three months of an audit may be selected for audit.

Audit results may be externally verified by WorkSafe ACT or a compliance auditor appointed under the Regulations.

In addition to bi-annual audits, WorkSafe ACT may require or direct an Insurer to undertake further audits against one or all elements of the performance standards established by this Protocol. WorkSafe ACT may engage an external auditor in accordance with the Regulations for the purposes of undertaking additional audits against this Protocol.

The results of the bi-annual audits must be submitted by **the last working Friday in January and July each year**. The information must be provided electronically via the following address worksafe@act.gov.au.

1. *Core Function-Communication*

1. Insurers assist injured workers to understand the compensation process and management of their individual claim, through early engagement with the worker.	
1.1 Description	Written correspondence to injured workers must include minimum content, be in 'plain English' and customised for the needs of the individual.
1.2 Quality	A. The minimum content required on written communication includes: i. the injured worker's claim number; ii. Case Manager name and contact details; iii. the injury or claim to which the correspondence relates. B. The minimum content in communications regarding decisions on initial liability includes: i. the injury for which liability is accepted/rejected; ii. the date on which liability is accepted/rejected; iii. reasons for the Insurer's decision; iv. reference to legislative provisions relevant to the Insurer's decision.
1.3 Measure	A. All written communication. B. All denials of liability must be approved by a Claims Manager or an equivalent Senior Claims Officer. C. All correspondence with the injured worker in line with the Insurer's commitment made in their licence application/business practices.
1.4 Audit Scope	A. Evidence[5] must be kept on file that: i. documents contact with injured workers; ii. documents that consideration has been given, where appropriate to ESL and/or communication barriers; iii. the worker is advised of changes to their Case Manager; iv. identifies and provides information on an internal or external resolution process if appropriate; v. initial contact at receipt of notification/claim has been made.
1.5 Timeliness	A. Within 10 business days Insurers should provide a written response to any enquiry from an injured worker. B. All injured workers enquiries are responded to via the telephone within three or five business days.

[5]Is information, documents and other material that can demonstrate the existence of a fact or truth of something, Administrative Review Council, Decision Making: EVIDENCE,FACTS AND FINDINGS, Best Practice Guide 3, August 2007

2. *Core Function-Claims Management*

2. Claims are managed in a manner that assists injured workers understand the claims process and their rights under the *Workers Compensation Act 1951.*	
2.1 Description	Information and advice is provided to injured workers to assist them understand the claims process and their entitlements under the *Workers Compensation Act 1951* (the Act).
2.2 Quality	A. On receipt of a notification of injury from a worker or their employer, the Insurer advises the worker or provides the worker with the: i. appropriate guidance notes as published on the WorkSafe ACT website relating to the claims process and benefits; ii. applicable legislative timeframes; iii. evidence required to support their claim (medical certificate). B. In accepting a claim for statutory lump sum compensation or common law damages related to a workers' compensation claim, the Insurer must provide the worker with confirmation of the: i. the total compensation benefits paid; ii. the injury for which the compensation or damages are paid. C. Insurers must make initial contact via telephone then by written correspondence or face to face meetings with an injured worker (or their representative) five business days prior to any reduction or cessation of an injured worker's incapacity benefits.
2.3 Measure	A. All claims for initial liability. B. All reductions in an injured workers incapacity benefits. C. All changes to Case Managers.
2.4 Audit Scope	A. All communication for claims for initial liability and/or and specific benefit entitlements and all reductions in benefits. B. If information is provided orally a file note or written record of interview must be maintained on file. C. Case Managers must have evidence on file of evidence of providing information to the worker regarding the step down of benefits before the reduction takes effect.
2.5 Timeliness	A. Insurers' licence commitments. B. Five business days prior to Legislative timeframes.

3. Core Function-Injury Management

3. Insurers implement active and robust injury management practices that facilitate the timely, safe and durable return to work of workers following workplace injuries.	
3.1 Description	Insurers have evidence of the implementation of active and robust injury management practices, executed in an appropriate manner having regard to the circumstances of the individual worker.
3.2 Quality	A. Insurers have evidence of: i. meeting statutory timeframes for considering each injury notification; ii. identifying significant injuries as defined by the Act; iii. contact and agreement with the injured worker, employer and the worker's treating practitioner (whether via telephone, written correspondence or face to face meetings) regarding management of the injury; iv. evidence or confirmation from the employee that they understand their injury management process; v. providing contact details to the injured worker for any rehabilitation/injury management specialist or provider that has been engaged to assist in the management of the worker's injury; vi. evidence of engagement with the injured worker on return to work commitments and agreed goals; vii. the evidence used to determine what rehabilitation services need to be delivered, over what timeframe/s and the expected results.
3.3 Measure	A. All significant injuries as defined under the legislation. B. All personal Injury Plans.
3.4 Audit Scope	A. All significant injuries must have evidence on file of contact with the worker, nominated treating doctor and the employer. B. All significant injuries as defined under the *Workers Compensation Act 1951*; and Person Injury Plans agreed goals/actual goals.
3.5 Timeliness	A. Legislative timeframes. B. Agreed return to work commitments.

4. *Core Function-Policy and Premium Management*

4. Insurers take action to assist employers understand their insurance obligations under the *Workers Compensation Act 1951* and ensure appropriate coverage is obtained for Territory employers and their workers.	
4.1 Description	A. Insurers are to provide information to assist employers: i. understand how premiums have been calculated; ii. understand the employer's insurance obligations as they relate to workers' compensation in the ACT; iii. ensure they have appropriate coverage for Territory workers.
4.2 Quality	A. Insurers have evidence of and disclose to employers if queried: i. premium estimates based on claims or potential claims; ii. specification of the Default Insurance Fund Levy in accordance with the Workers Compensation (Insurer Contribution Protocol).[6] B. Insurers have evidence on file of the information that has been provided/ requested from employers or brokers to ensure that appropriate compulsory insurance coverage is provided to an employer. C. Insurers have evidence on file of being provided with additional information or changes in employer circumstance that amends a compulsory insurance policy. D. Insurers conduct wage audits as directed by WorkSafe ACT as well as Insurers' own audit programs.
4.3 Measure	A. All premium notices. B. The number of wage audits as directed by WorkSafe.
4.4 Audit Scope	A. All premium notices. B. Evidence on file that questions have been asked in relation to: i. state of connection; ii. the wages declared/estimated; iii. the number of workers declared/estimated. C. Wage audits as directed by WorkSafe.
4.5 Timeliness	A. The time allowed for a response should be reasonable in the circumstances, having regard to the preparation time involved.

[6] As it applies and is updated from time to time

5. Core Function-Dispute Resolution

5. Insurers have robust, effective and transparent decision making processes that facilitate timely resolution of disputes and complaints.	
5.1 Description	Insurers have evidence of internal review procedures and policies that are available to workers.
5.2 Quality	A. In determining a worker's entitlement to compensation under the Act or to specific benefit entitlements, Insurers must: i. obtain a review by a senior claims officer where the Insurer intends to deny the worker's claim; ii. make contact with the injured worker before the formal letter denying liability; iii. provide the injured worker with the opportunity to provide reasons to support a review; iv. explain the sufficient reasons for the denial of liability in a language that is appropriate for the audience and in writing; v. describe the relevant sections of the *Workers Compensation Act 1951* and/or common law precedents.
5.3 Measure	A. All decisions that deny or cease liability on a claim.
5.4 Audit Scope	A. All denials for a claim for liability and/or weekly benefits.
5.5 Timeliness	A. Legislative timeframes. B. The time allowed for a response should be reasonable in the circumstances, having regard to the preparation time involved.[7]

[7] Administrative Review Council, Decision Making, NATURAL JUSTICE, Best practice guide 2, August 2007