



*The Workers' Compensation  
Regulatory Authority*

## 2006–2007 STATISTICS REPORT

DELIVERING

 QUALITY

SERVICE

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# Introduction

**This is the eighth annual statistical report published by Q-COMP to circulate Queensland workers' compensation scheme-wide data.**

This report covers all aspects of the Queensland workers' compensation scheme, including:

- claims information reported by WorkCover Queensland and self-insured employers (numbers, average costs and payments) for statutory claims and common law claims
- scheme-wide information about the major regulatory services provided by Q-COMP for insurer and medical issues:
  - administrative review of insurers' decisions
  - appeals to the Industrial Magistrate and Queensland Industrial Relations Commission (QIRC)
  - medical assessment tribunals (MAT).

All figures reported are as at 30 June of the relevant financial year. The only exception to this is fatalities which are reported as at 30 June 2007.

## About Q-COMP

Q-COMP regulates Queensland's workers' compensation scheme, working with stakeholders to balance the needs of workers and employers and ensuring a fair and efficient scheme for all. Q-COMP provides a range of services, including:

- monitoring insurer performance and compliance with the *Workers' Compensation and Rehabilitation Act 2003* (the Act)
- deciding self-insurance applications
- reviewing insurer decisions
- managing appeals of review decisions
- monitoring employer rehabilitation compliance and providing advice
- supporting the MAT
- maintaining and analysing statistics and reporting on the scheme
- providing workers' compensation information and education
- administering grants.

The Act established Q-COMP as an independent regulatory authority from 1 July 2003. Q-COMP receives no funding from the Government's consolidated revenue and is primarily funded through contributions from insurers. As at 30 June 2007, there were 26 insurers in the scheme – WorkCover Queensland and 25 self-insured employers (visit [www.qcomp.com.au](http://www.qcomp.com.au) for a list of self-insurer licences and the individual companies listed under each licence).

# The overall scheme

- The majority of employers (9 in 10) covered by the scheme in 2006-2007 did not have a claim for workers' compensation in 2006-2007.
- Claim rates have increased due to the large increase in intimations.
- The manufacturing industry has the highest claim rate.

The Queensland workers' compensation scheme covers approximately 185,000 policies and an estimated 2.0 million workers.

As the following figure illustrates, small employers make up the largest proportion of employers in the scheme (95.9% of all employers).

**FIGURE I Number of claims per employer by declared wages 2006–2007**

Number of claims	Declared wages						Total employers
	< \$1M	\$1M to \$2.5M	\$2.5M to \$5M	\$5M to \$10M	\$10M to \$50M	Over \$50M	
<b>No claims</b>	<b>165,586</b>	<b>1,651</b>	<b>296</b>	<b>59</b>	<b>15</b>	<b>-</b>	<b>167,607</b>
1 claim	8,922	878	242	67	30	-	10,139
2 - 5 claims	3,203	1,312	522	187	67	-	5,291
6 - 10 claims	213	387	273	158	87	2	1,120
11 - 20 claims	108	141	161	171	134	4	719
Over 20 claims	111	52	116	154	299	109	841
<b>Total with claims</b>	<b>12,557</b>	<b>2,770</b>	<b>1,314</b>	<b>737</b>	<b>617</b>	<b>115</b>	<b>18,110</b>
<b>Total</b>	<b>178,143</b>	<b>4,421</b>	<b>1,610</b>	<b>796</b>	<b>632</b>	<b>115</b>	<b>185,717</b>
% without claims	93.0	37.3	18.4	7.4	2.4	0.0	90.2

The majority of employers (90.2%) did not have a claim for workers' compensation in 2006–2007. 93.0% of smaller employers (less than \$1 million in declared wages or approximately 20 staff) were most likely to have no claims.

In 2006–2007, 97,660 claims were intimated scheme-wide (excluding cancelled and withdrawn claims). The estimated rates per 100,000 employees are detailed below.

**FIGURE 2 Claim rates (per 100,000 employees covered by the scheme) 2002–2003 to 2006–2007**

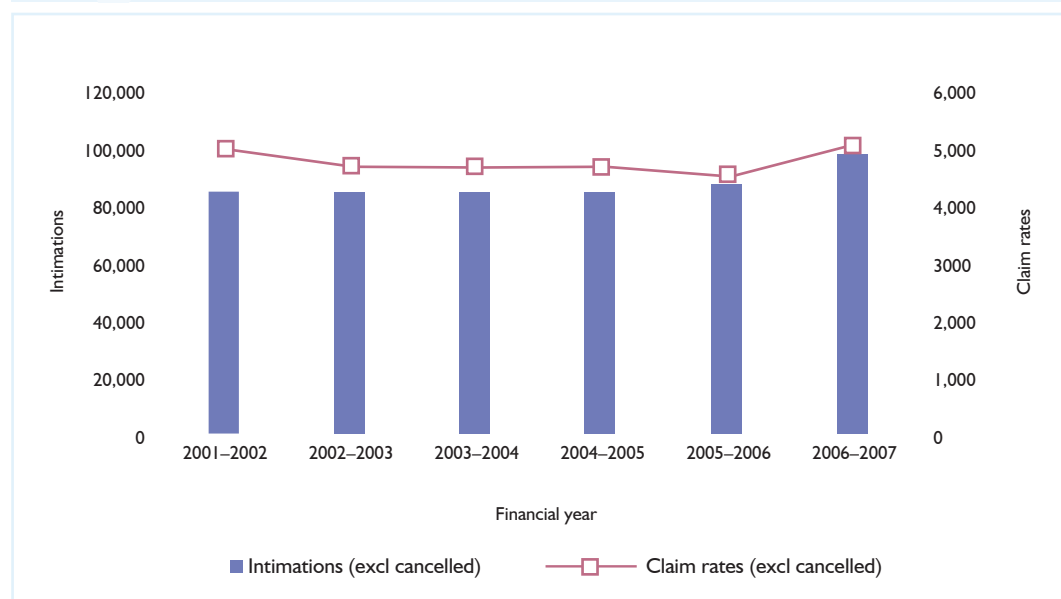
	Annual comparison				
	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
<b>Queensland Labour Force</b>					
Average number of employed people ('000) <sup>a</sup>	1,799.4	1,826.6	1,914.4	1,998.5	2,068.9
Change from previous year		1.5%	4.8%	4.4%	3.5%
Average number of employees covered ('000) <sup>b</sup>	1,713.0	1,747.0	1,836.6	1,927.1	1,996.1
Change from previous year		2.0%	5.1%	4.9%	3.6%
<b>Queensland Workers' Compensation Scheme</b>					
<b>Intimated claims</b>					
Number	82,447	83,848	83,485	85,751	97,660
Change from previous year		1.7%	-0.4%	2.7%	13.9%
<b>Claim rate</b>					
Number per 100,000 employees covered <sup>b</sup>	4,813.0	4,799.5	4,545.8	4,449.7	4,892.5
Change from previous year		-0.3%	-5.3%	-2.1%	10.0%

<sup>a</sup> Australian Bureau of Statistics, Labour Force, Queensland Average of May Quarter to February Quarter – for each of the above years, Cat No 6201.3

<sup>b</sup> "Employees covered" is a subset of all employed persons depending on the legislation in place (see definitions)

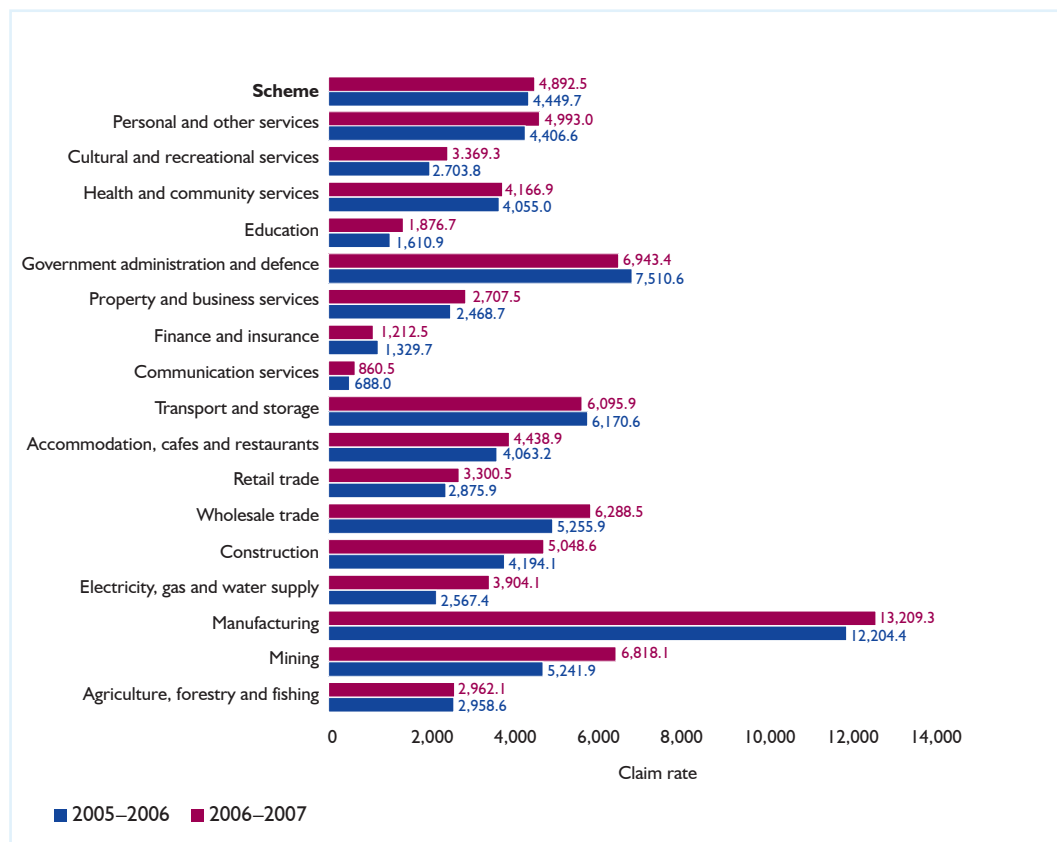
The following figure shows claim rates and claim intimations in the scheme for the past six years. Despite the high growth in intimations in Queensland (up 16.7%) since 2001–2002, subsequent claim rates have remained below the claim rate for the 2001–2002 year.

**FIGURE 3 Claim rates (per 100,000 employees covered by the scheme) and intimations by financial year 2001–2002 to 2006–2007**



Manufacturing has the highest claim rate in the scheme, with 13,209.3 claim intimations per 100,000 persons covered in the industry. Other industries where the claim rate is larger than the scheme rate of 4,892.5 include government administration and defence (6,943.4), mining (6,818.1), wholesale trade (6,288.5) and transport and storage (6,095.9).

**FIGURE 4 Claim rates (per 100,000 employees covered by the scheme) by industry 2005–2006 and 2006–2007**



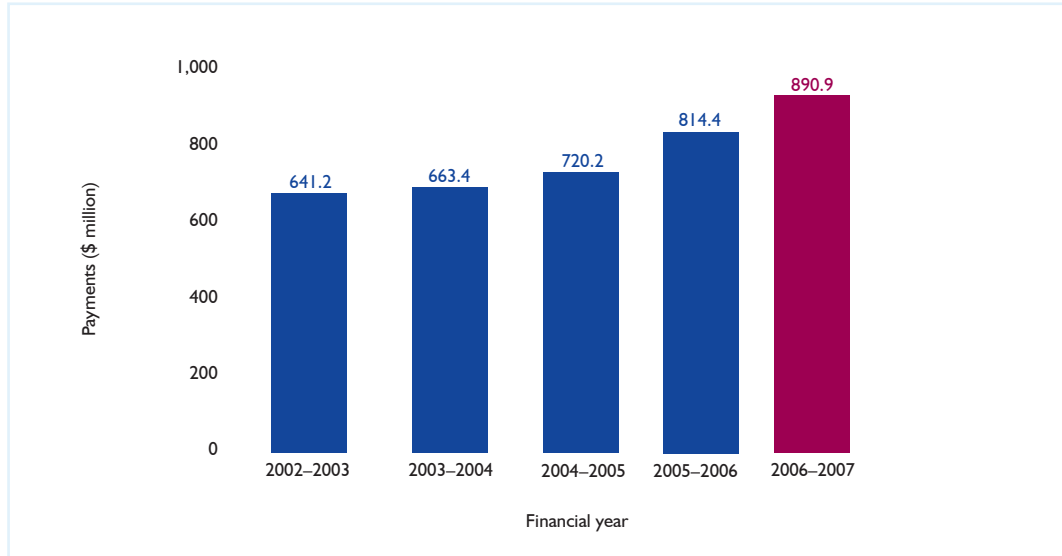
Australian Bureau of Statistics, Labour Force, Queensland Average of May Quarter to February Quarter – for each of the above years, Cat No. 6201.3.

## Workers' compensation payments

The total scheme payments increased by 9.4% and the statutory payments increased by 14.6%.

Total payments for workers' compensation claims in 2006–2007 were \$890.9 million. Common law payments made up 39.0% (\$347.8 million) and statutory claim payments made up 61.0% (\$543.1 million).

**FIGURE 5** Scheme payments by financial year 2002–2003 to 2006–2007



# Case study

## Payment increases in the Queensland workers' compensation scheme

Over the last five financial years, payments have increased consistently in the scheme. This increase has been split up into individual components for both weekly benefit payments and lump sum payments made in the Queensland scheme between 2002–2003 and 2006–2007 (see Figures 6 and 7 below).

### Weekly benefit payments

Over the past five years, the growth in weekly benefit payments equates to 45.2%.

The three key components that can influence increases in weekly compensation payments are:

- the numbers of claims receiving payments for weekly benefits in the year – either more claims in the scheme or a greater proportion of claims receiving weekly benefits for time off work
- the duration of these claims – an increase in the number of days paid on average for each claim
- an increase in the amount being paid per day either due to increased earnings or a change in the type of people being injured (higher trained labour).

In addition to the three factors cited above, changes in the legislated amount workers can be paid can affect the weekly benefit payments paid to injured workers. In November 2005, legislation was passed to change the step down provisions for weekly benefits and this has affected an increase in payments made after this point.

The impact of these factors on the weekly benefit payment increases observed between 2002–2003 and 2006–2007 are shown in the figure below.

**FIGURE 6 Summary of the key components to weekly benefit payments 2002–2003 and 2006–2007**

Component	2002–2003	2006–2007	Change	Impact on total costs
			%	\$M <sup>a</sup>
Average weekly benefits paid per day lost \$	113.95	138.65	21.7	35.8
Average days lost per claim	30.8	29.8	-3.0	-4.9
Number of claims receiving weekly benefits	47,131	57,980	23.0	38.0
Combined impact				5.7
<b>Total benefits paid \$ million</b>	<b>165.2</b>	<b>239.9</b>	<b>45.2</b>	<b>68.9</b>

<sup>a</sup> The impact on total costs assumes the impact of each component occurring sequentially i.e. impact of increase in average weekly benefits based all other factors remaining the same (average days and numbers) and the combined impact is the impact of the remaining additional costs. (Note: this does not take into account any interaction between the components.)

This shows that for the period in question, the average weekly benefit payment made per day has increased 21.7%. This increase can be directly attributed to the increase in QOTE which was 21.1% for the same period (ABS Cat No. 6302.0 February Quarter).

This figure also shows that the number of claims receiving weekly compensation benefits in each year increased 23.0%. This increase is directly in line with the increase in the labour force, which experienced 21.9% growth over the period (ABS Cat No. 6202.0).

Both of the above factors have contributed to the increase in payments, but this has been somewhat mitigated by a 3.0% decrease in the average number of days per claims being compensated.

## Lump sum payments

Over the past five years, the growth in lump sum payments equates to 42.0%. For the purposes of this case study, lump sum payments have been restricted to those made for permanent impairment (PI) assessments, additional PI and gratuitous care. Fatal lump sum payments have not been included due to their long tailed nature, which can skew results.

The three key components that can influence lump sum payments are:

- the number of claims receiving lump sums – how many claims have been paid for PI
- the severity of the injuries assessed – each degree of PI equates to a higher lump sum
- the maximum amount of benefit legislated for injuries – over recent years there have been several increases to the maximum lump sum benefit.

The impact of these factors on the lump sum payment increases observed between 2002–2003 and 2006–2007 are shown in the figure below.

**FIGURE 7 Summary of the key components to lump sum payments 2002-2003 and 2006-2007**

Component	2002–2003	2006–2007	Change	Impact on total costs <sup>a</sup>
			%	\$M
Average payment per WRI unit	\$1,479.64	\$2,336.86	57.9	37.3
Average WRI per claim	10.2	9.9	-2.5	-1.6
Number of claims receiving PI	4,289	3,955	-7.8	-5.0
Combined impact				-3.6
<b>Total benefits paid \$M</b>	<b>64.4</b>	<b>91.5</b>	<b>42.0</b>	<b>27.1</b>

<sup>a</sup> The impact on total costs assumes the impact of each component occurring sequentially i.e. impact of increase in average weekly benefits based all other factors remaining the same (average days and numbers) and the combined impact is the impact of the remaining additional costs. (Note: this does not take into account any interaction between the components.)

This shows that for the period in question, the average payment made per unit of impairment has increased 57.9%. While this increase is larger than that of QOTE which was 21.1% for the same period (ABS Cat No. 6302.0 February Quarter), legislated increases in the amount payable for each injury accounts for this difference. These legislated increases and the dates the amounts applied to occurred for:

- injuries 1/7/01 to 1/11/05 (increased to \$150,000)
- injuries post 2/11/05 (increased to \$200,000).

Note: These amounts are indexed by QOTE each year.

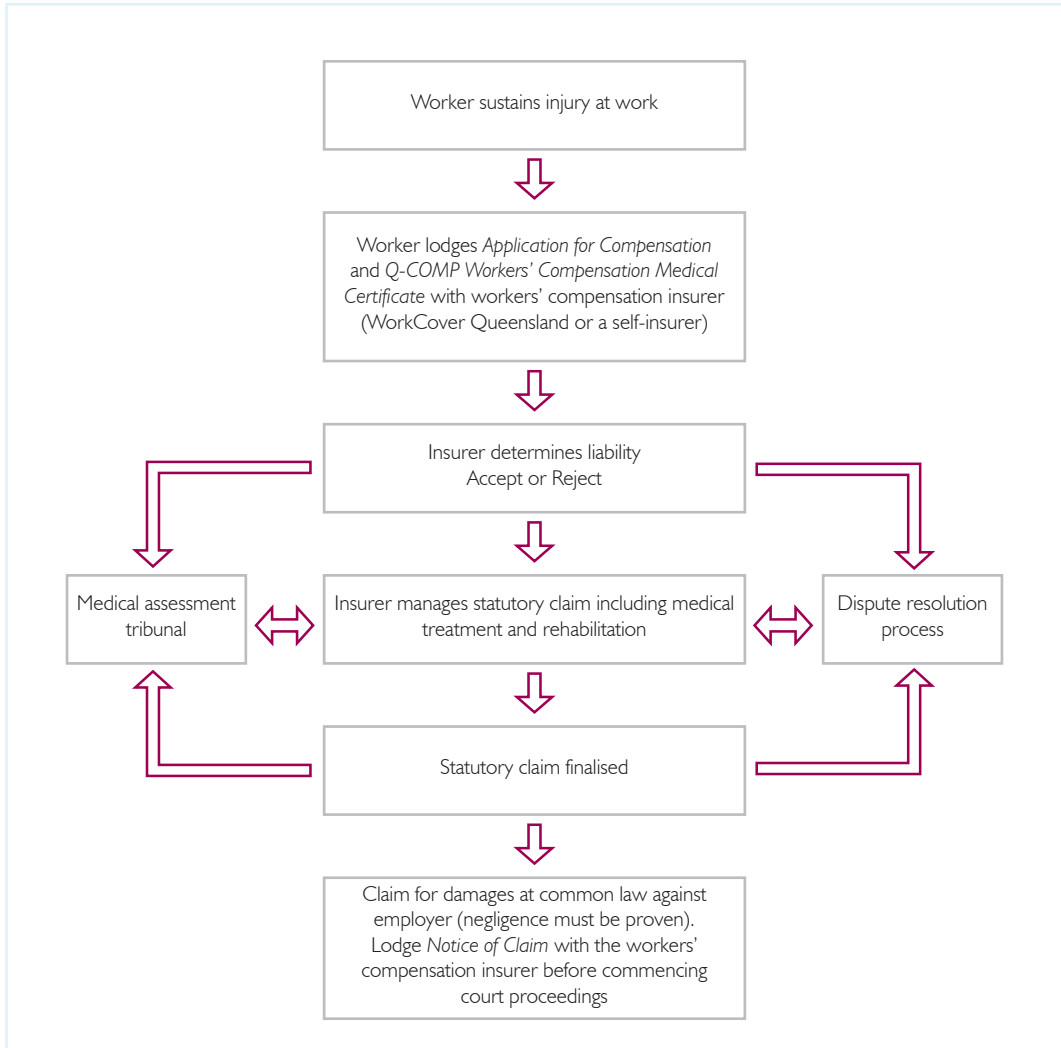
This figure also shows that the number of claims receiving lump sum benefits each year decreased 7.8% and the average PI percentage for claims receiving payments in each year has dropped 2.5%.

# Workers' compensation claims

In Queensland, workers have access to a no fault statutory workers' compensation scheme and, where negligence exists, injured workers may be able to access damages at common law.

The following figure illustrates the progression of a workers' compensation claim through the statutory claims process and on to common law. Each of the key phases of the claim are examined in more detail through this publication.

**FIGURE 8 Workers' compensation claims process**



# Claim intimations

Intimations increased by 13.9% in 2006–2007 mainly due to an administrative change in WorkCover Queensland's claim management process. WorkCover Queensland implemented a fax fee initiative<sup>a</sup> in July 2006 to encourage shorter timeframes between the time of injury, and access to both compensation and appropriate rehabilitation services. (The benefits of earlier lodgement are demonstrated in the case study on page 20.)

The potential impact of the fax fee initiative on intimations was to increase reporting of shorter duration or medical expense only claims which may have previously gone unreported. There is also the one off impact of earlier reporting of claims, which previously would have been lodged in the following reporting year. The potential impact of the fax fee is estimated at around 54% of the 13.9% increase in intimations in 2006–2007.

Note: cancelled and withdrawn claims have been excluded from the intimations reported.

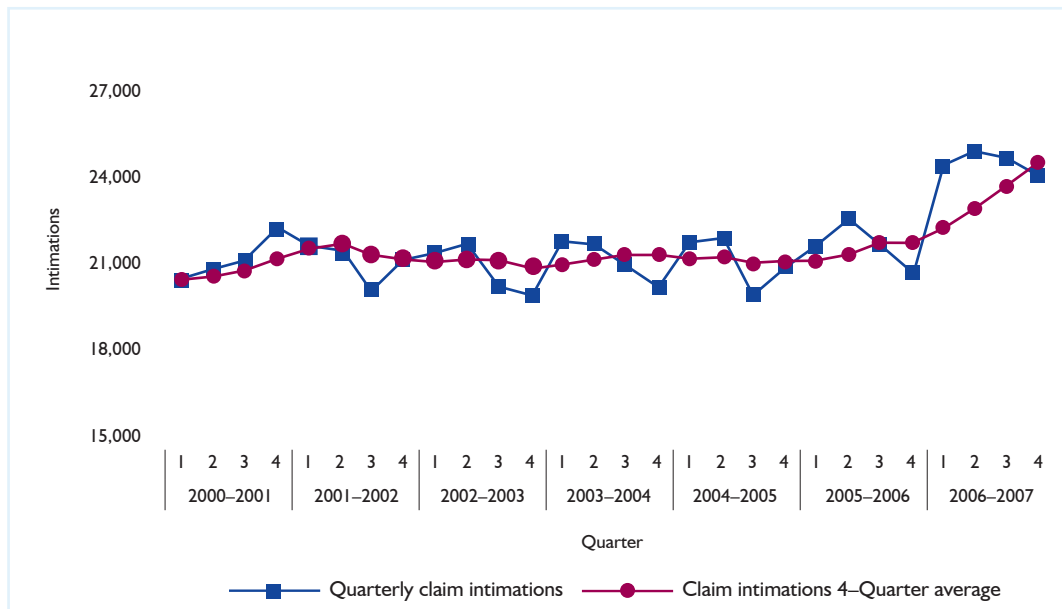
There were 130 fatal claims intimated in 2006–2007.

Many factors influence the number of claims intimated in the Queensland workers' compensation scheme. Some of the factors which may have contributed to changes in numbers of intimations over the years include:

- changing industry economics
- variations in the overall numbers in the workforce
- work process changes within industry – for example, automation, improved workplace health and safety practices
- changes in insurer practices – for example, the fax fee initiative by WorkCover Queensland.

In 2006–2007, there were 97,660 claims intimated (excluding cancelled and withdrawn claims), representing a 13.9% increase from 2005–2006. The figure below illustrates claim intimations per quarter from 2000–2001 to 2006–2007.

**FIGURE 9 Claim intimations, quarterly 2000–2001 to 2006–2007**



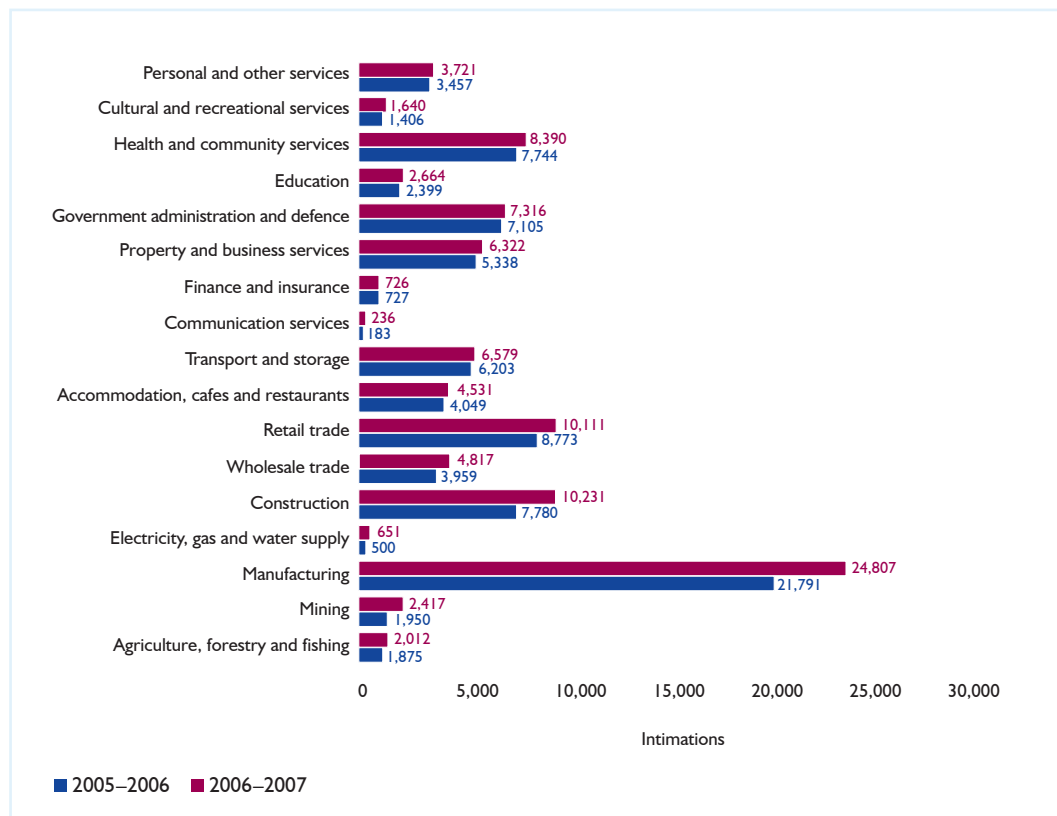
a Since July 2006, WorkCover Queensland has encouraged the early lodgement of claims through their fax fee initiative. WorkCover Queensland has implemented an administrative process through which they pay a \$10 fee to doctors when the medical practice faxes the injured worker's application form, medical certificate and invoice to WorkCover Queensland. Doctors are usually the first point of contact for an injured worker, so this initiative ensures the claim is lodged with WorkCover Queensland as early as possible, allowing for earlier rehabilitation intervention.

## Industry

The manufacturing industry accounts for the largest proportion of claim intimations with 25.4% of all scheme intimations.

The largest percentage increase in claim intimations was for construction (up 31.5%) and electricity, gas and water supply (up 30.2%).

**FIGURE 10 Statutory claim intimations by industry 2005–2006 and 2006–2007**



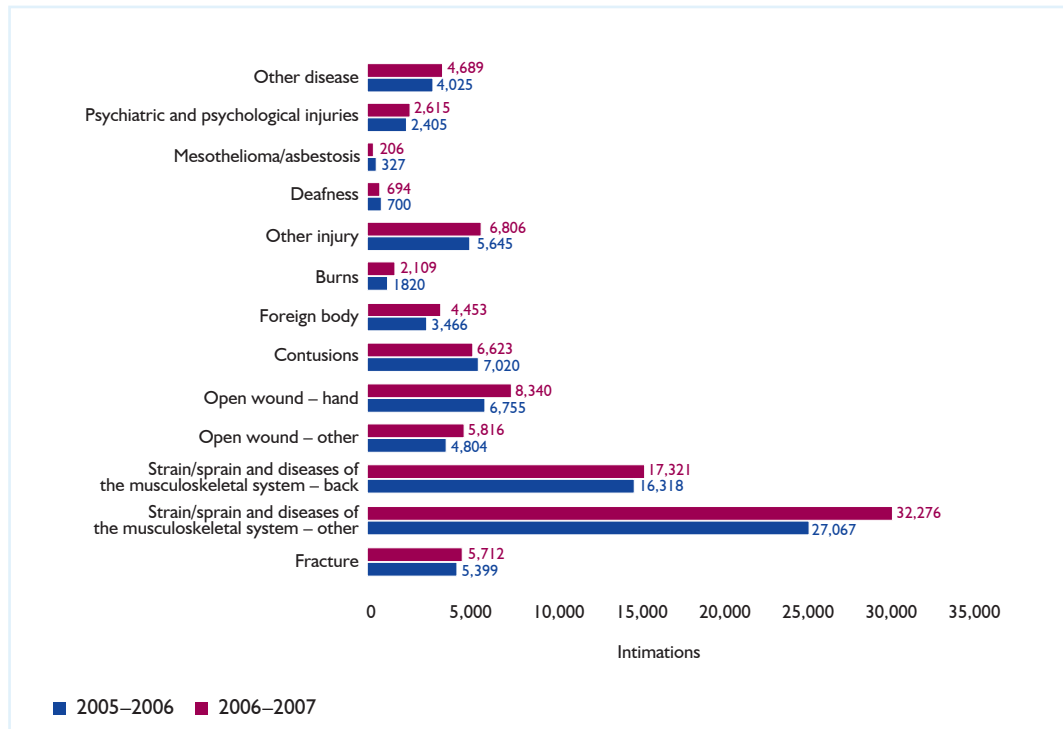
## Injury type

Strain/sprain injuries and diseases of the musculoskeletal system accounted for approximately half (50.8%) of all injuries intimated in 2006–2007. Of these, the back was the major body location (accounting for almost one fifth or 17.7% of all intimations).

Foreign body injury experienced a large increase (up 28.5%) from 3,466 in 2005–2006 to 4,453 in 2006–2007.

Mesothelioma/asbestosis experienced a decrease of 37.0% (down from 327 in 2005–2006 to 206 in 2006–2007). The only other injury type which experienced a decrease in intimations was contusion (down 5.7%).

**FIGURE 11 Statutory claim intimations by injury type 2005–2006 and 2006–2007**



Note: Due to a change in coding convention, strain/sprain injuries have been grouped with diseases of the musculoskeletal system for the current report.

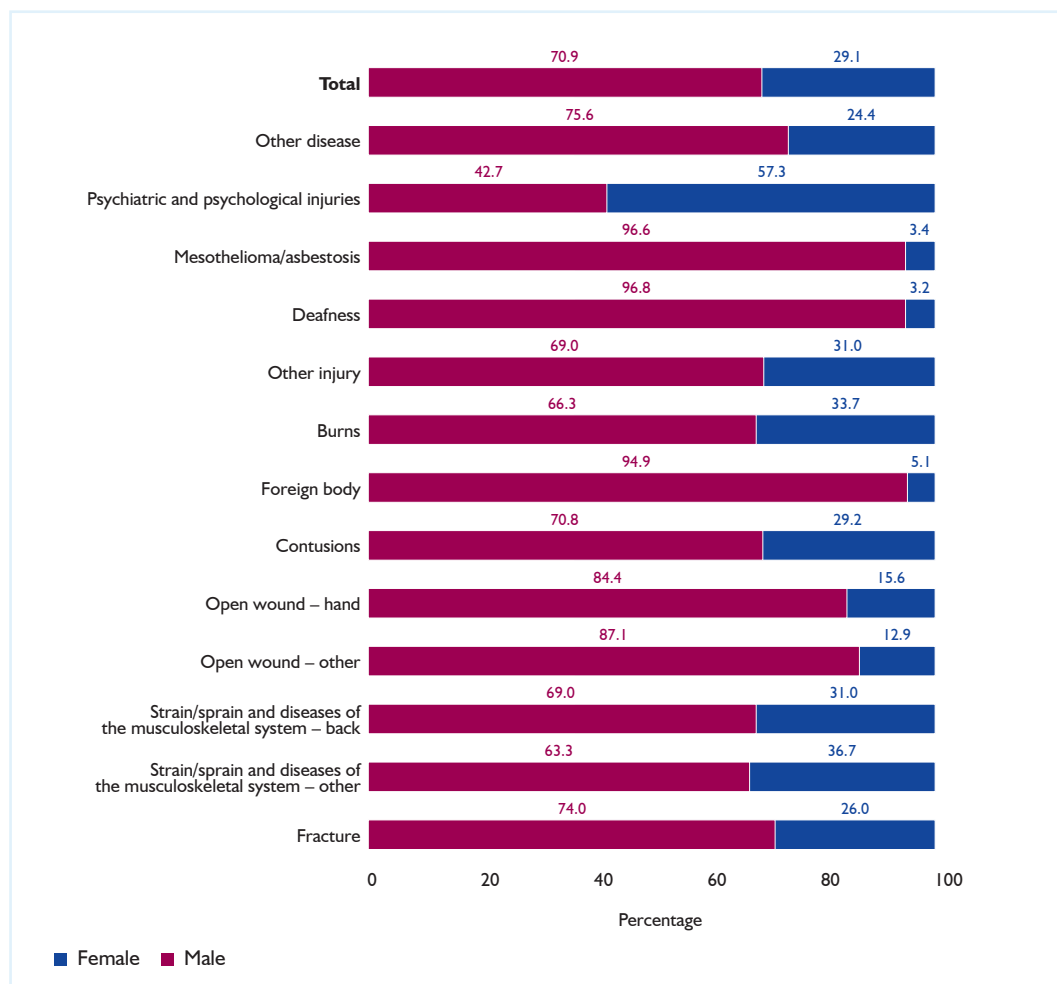
As previously noted, the fax fee initiative potentially increased the reporting of claims which may have otherwise been unreported. The main injury types which have increased are minor injuries such as foreign bodies (up 28.5%); open wounds (up 22.5%) and sprain/strains and diseases of the musculoskeletal system – other than the back (up 19.2%). All other injury categories combined increased by only 7.1%.

## Gender

In 2006–2007, males represented 70.9% (n = 69,226) of the 97,660 claims intimated in the Queensland workers' compensation scheme. Injuries where males represented a much higher proportion of claims than females were deafness (96.8%), mesothelioma/asbestosis (96.6%), foreign body injury (94.9%) and open wound to both the hand (84.4%) and other locations (87.1%).

The only injury type where females were represented more than males was psychiatric and psychological injury, where females accounted for 57.3% of claims.

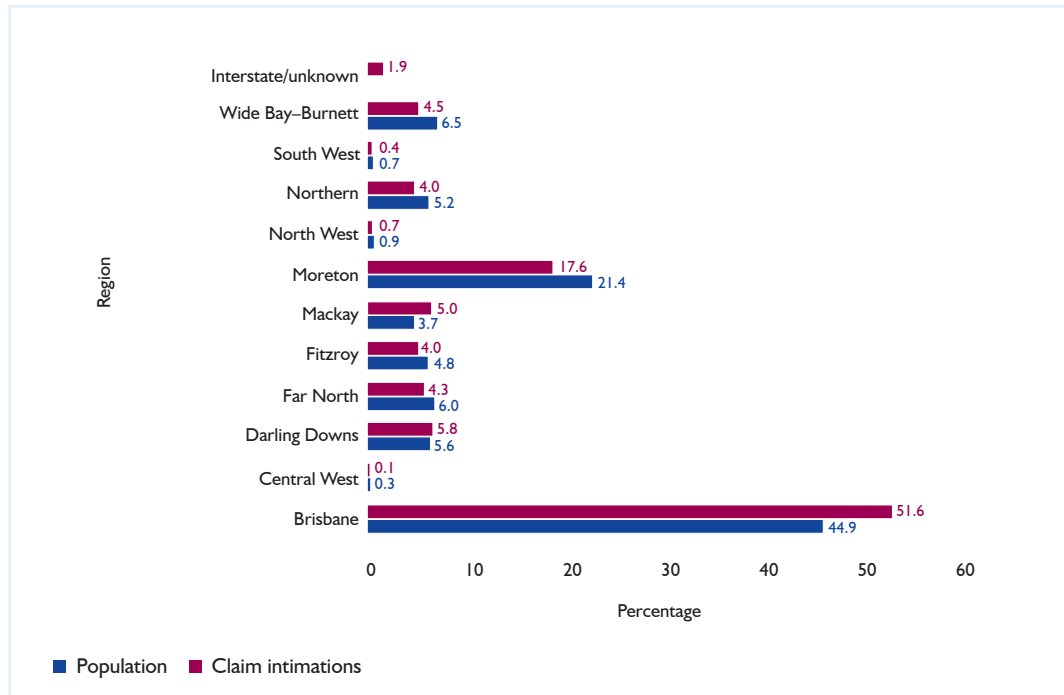
**FIGURE 12 Proportion of statutory claim intimations by injury type and gender 2006–2007**



## Geographical region

In 2006–2007, the Brisbane region represented more than half (51.6%) of the 97,660 claims intimated in the Queensland workers' compensation scheme, based on the address of the injured worker (compared to 44.9% of the Queensland population). The next largest region was Moreton, representing 17.6% of intimations (21.4% of the Queensland population).

**FIGURE 13 Proportion of statutory claim intimations and population by region 2006–2007**



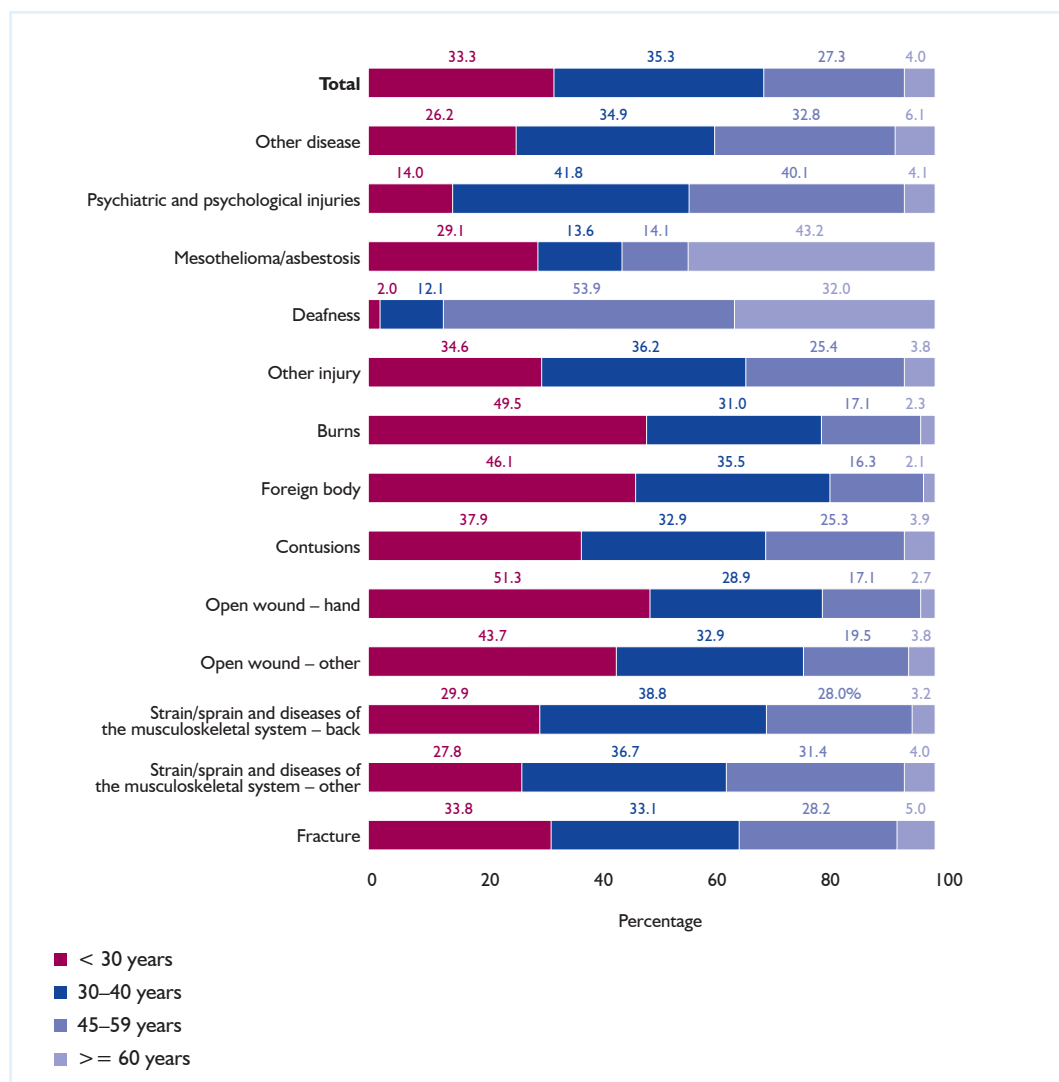
Note: Population figures are based on Australian Bureau of Statistics, Estimated Resident Population (ERP) for Qld, Regional Population Growth, 2006–2007, Cat No. 3218.0, February 2007.

## Age

While older workers (60 years +) represented only 4.0% of all claims intimations, they have a high representation for injuries such as deafness and mesothelioma/asbestosis.

Injury types where younger workers (< 30 years) represented a greater proportion include open wounds, burns and foreign body injuries.

**FIGURE 14 Proportion of statutory claim intimations by injury type and age group 2006–2007**



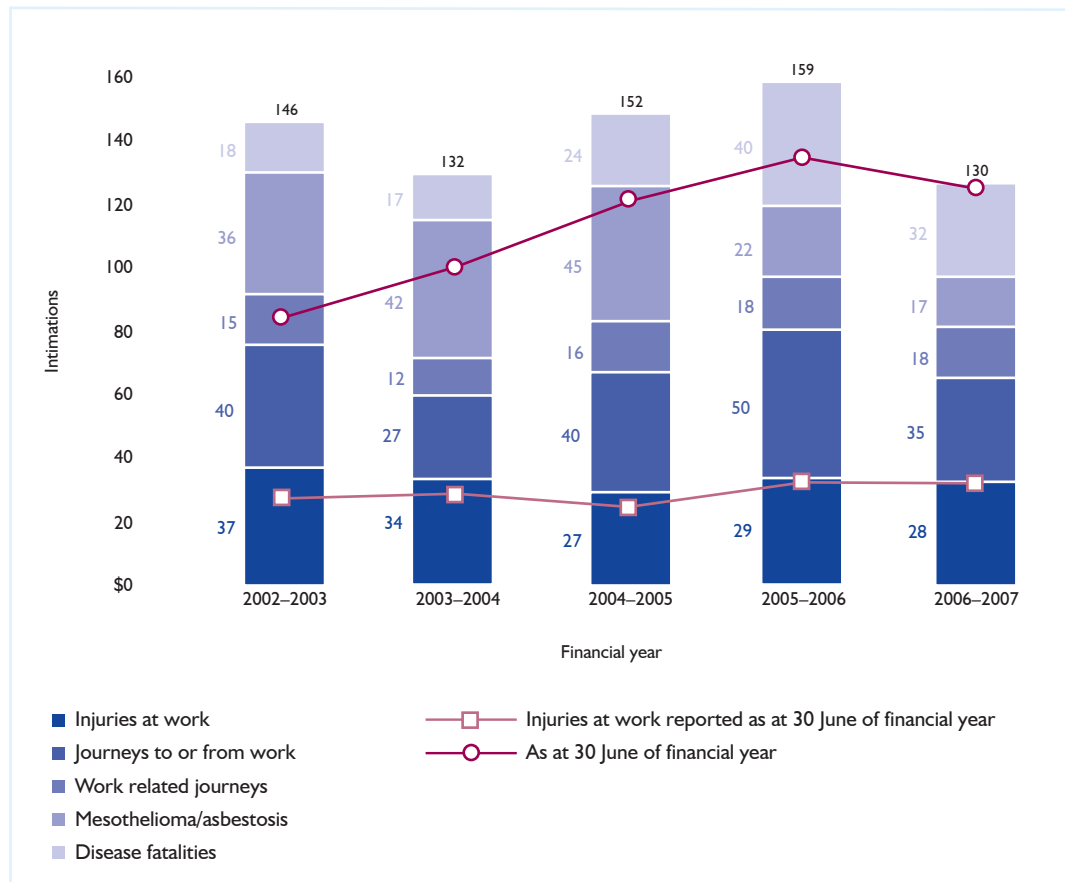
## Fatalities

Compensated fatalities are included in the year a workers' compensation claim is lodged, not the year the worker died. Considerable time can, therefore, elapse between claim lodgement and the death of the injured worker.

These figures are subject to development over time. For this reason comparisons between years have not been made.

There were 130 fatalities intimated in 2006–2007.

**FIGURE 15 Fatal claim intimations (excluding cancelled claims) by financial year 2002–2003 to 2006–2007**



The figure above shows how fatalities have developed each year from the figure reported as at 30 June of the financial year to 30 June 2007. The main reason for the increase is the development of journey and disease related fatalities, rather than injuries at work. In 2006–2007:

- over one-fifth (21.5%) of fatalities intimated were due to **injuries at work**
- over a quarter (26.9%) of fatalities resulted from **journeys to or from work**
- **work related journeys** – that is, journeys which occur as a part of the person's work – accounted for 13.8% of fatalities
- **disease** related fatalities (including mesothelioma/asbestosis) represented almost a quarter (37.7%) of fatalities intimated.

## Claim decision-making process

- Decision timeframes have remained steady for the 2006-2007 year.
- Rejections and claims for a psychiatric/psychological injury take longer to decide.
- Claims for psychiatric/psychological injuries and mesothelioma have a higher chance of rejection.
- 82% of rejections are due to the injury not meeting the definition under the Act.
- Claims which are lodged with the insurer early are determined quicker, on average.
- Rejections are more likely to progress to a review than claims which are accepted.

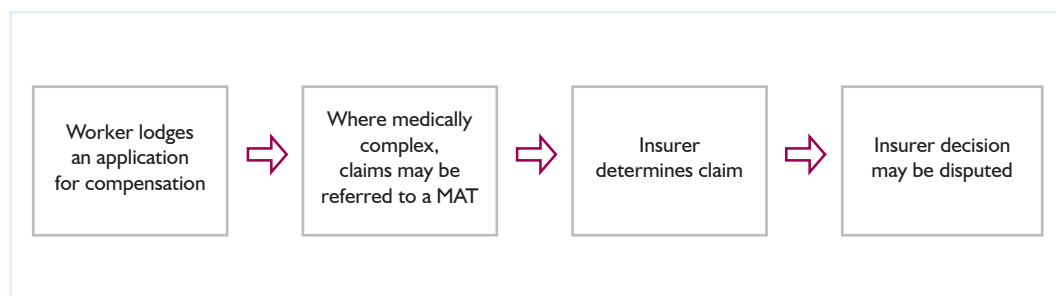
Once the insurer receives a complete application for compensation, they will determine whether or not the claim is compensable under the *Workers' Compensation and Rehabilitation Act 2003* (the Act). Insurers have 40 business days to determine liability for physical injuries and 60 business days for psychiatric and psychological injuries.

Where injuries are difficult to determine due to medical complexities, they may be referred to a medical assessment tribunal (MAT) to determine whether the medical matters alleged in the application for compensation constitute an injury.

If parties (either the worker or the employer) are dissatisfied with the insurer's decision, a dispute resolution process is available. The process involves an initial independent administrative review of the insurer's decision by Q-COMP, followed by an appeal to either the Industrial Magistrate or Queensland Industrial Relations Commission (QIRC) if the parties are dissatisfied with Q-COMP's review decision. The court or QIRC decision may be appealed in the Industrial Court.

The following figure demonstrates the decision-making process for new claims.

**FIGURE 16 Claims decision-making process**



The following figure illustrates the change in decision-making timeframes in the year to date.

**FIGURE 17 Average time to decide by injury type 2005–2006 and 2006–2007**

Injury type	Average decision timeframes	
	Calendar days	
	2005–2006	2006–2007
Fracture	7.4	7.4
Strain/sprain and diseases of musculoskeletal system – other	10.7	10.4
Strain/sprain and diseases of musculoskeletal system – back	10.6	10.5
Open wound – other	4.6	6.0
Open wound – hand	4.0	5.8
Contusion	5.6	6.9
Foreign body	3.3	5.7
Burn	4.2	5.9
Other Injury	10.2	9.7
Deafness	28.0	34.7
Mesothelioma/asbestosis <sup>a</sup>	113.5	119.4
Psychiatric/psychological injury	63.3	59.0
Other diseases	21.1	20.0
<b>Total average</b>	<b>10.8</b>	<b>10.9</b>

<sup>a</sup> Mesothelioma and asbestosis claims may have legal representation which can slow the decision-making process.

Overall, average decision-making timeframes have remained steady at 10.8 days in 2005–2006 and 10.9 days in 2006–2007. This follows a significant decrease in time to decide experienced between 2004–2005 and 2005–2006.

The injury types with increased decision times were deafness from 28.0 days to 34.7 days (23.9% increase) and mesothelioma/asbestosis, where average timeframes increased from 113.5 days to 119.4 days. However, these averages are based on small claim numbers and mesothelioma and asbestosis claims may have legal representation which can slow the decision-making process.

The following figure illustrates decision-making timeframes and outcomes for claims determined in 2006–2007.

**FIGURE 18 Decisions made and average time to decide by decision type and injury type 2006–2007**

Injury type	Decisions	Proportion of decisions		Average decision time		
	No.	Admitted	Rejected	Admitted	Rejected	Total
		%	%	Calendar days	Calendar days	Calendar days
Fracture	5,511	97.4	2.6	6.8	30.9	7.4
Sprain/strain and diseases of musculoskeletal system – other	30,973	97.6	2.4	9.6	42.8	10.4
Sprain/strain and diseases of musculoskeletal system – back	16,584	97.2	2.8	9.6	42.2	10.5
Open wound – other	5,492	99.1	0.9	5.8	27.6	6.0
Open wound – hand	7,951	99.7	0.3	5.8	24.7	5.8
Contusion	6,276	99.0	1.0	6.6	35.6	6.9
Foreign body	4,235	99.6	0.4	5.6	32.7	5.7
Burn	2,029	99.5	0.5	5.7	39.2	5.9
Other Injury	5,985	96.7	3.3	8.5	46.2	9.7
Deafness	622	90.0	10.0	31.2	66.1	34.7
Mesothelioma/asbestosis	113	74.3	25.7	93.9	193.2	119.4
Psychiatric/psychological injury	2,288	47.1	52.9	40.9	75.2	59.0
Other diseases	4,326	91.1	8.9	15.9	61.9	20.0
<b>Total</b>	<b>92,385</b>	<b>96.3</b>	<b>3.7</b>	<b>9.2</b>	<b>57.4</b>	<b>10.9</b>

Most claims (96.3%) are accepted by insurers with an average determination time of 9.2 days. On average, decision timeframes tend to be longer for:

- rejected claims – accepted claims are determined in 9.2 days on average compared to rejected claims determined in 57.4 days on average
- diseases, particularly psychiatric and psychological injuries (average 59.0 days to determine) and mesothelioma/asbestosis claims (average 119.4 days to determine).

Diseases tend to have higher rejection rates than injuries – 25.7% of mesothelioma and asbestosis injury claims are rejected and 52.9% of psychiatric and psychological claims are rejected.

## Reasons for claim rejection

Insurers reject claims where, for some reason, the event or the person is not covered under the Act. The following figure details the main reasons claims are rejected.

**FIGURE 19 Rejected claims by reason for rejection 2005–2006 and 2006–2007**

Reason for rejection	2005–2006		2006–2007	
	Rejections	Rejections	Rejections	Rejections
	No.	%	No.	%
Not an injury – s32	2,643	86.7	2,774	82.0
Not a worker – s11	102	3.4	137	4.0
Out of time – excluded under s131	50	1.6	121	3.6
Journey – substantial delay, interruption or deviation – s36(2)(b)	60	2.0	71	2.1
Invalid application – s132	53	1.7	104	3.1
Industrial deafness – excluded under s125 – initial application	34	1.1	40	1.2
Not a journey – s35	56	1.8	58	1.7
Other	52	1.7	78	2.3
<b>Total</b>	<b>3,050</b>	<b>100.0</b>	<b>3,383</b>	<b>100.0</b>

For 82.0% of rejected claims, the reason for rejection is that the injury does not meet the definition under the Act. Only a small percentage of claims are rejected for other reasons.

## Determination of medically complex claims

Where an insurer is unable to determine a claim due to complex medical issues, the matter may be referred to a medical assessment tribunal to determine whether the medical matters alleged in the application for compensation constitute an injury.

Of the 89,864 claims determined 2006–2007, only 116 claims were referred to a medical assessment tribunal for determination of the worker's injury for an application for compensation. In these cases, 75 were accepted (64.7%) and the remaining 41 (35.3%) cases were rejected.

## Disputation of insurer claim determination decisions

Both the injured worker and employer are able to dispute an insurer's claim determination decision. While only a small percentage of accepted claims are disputed by employers (0.3%), over one third (39.5%) of rejected claims are disputed by either the employer or the injured worker.

# Case study

## Impact of early claim lodgement

Delays in the lodgement of claims leads to delays in the decision making process and, ultimately, additional costs for the claim.

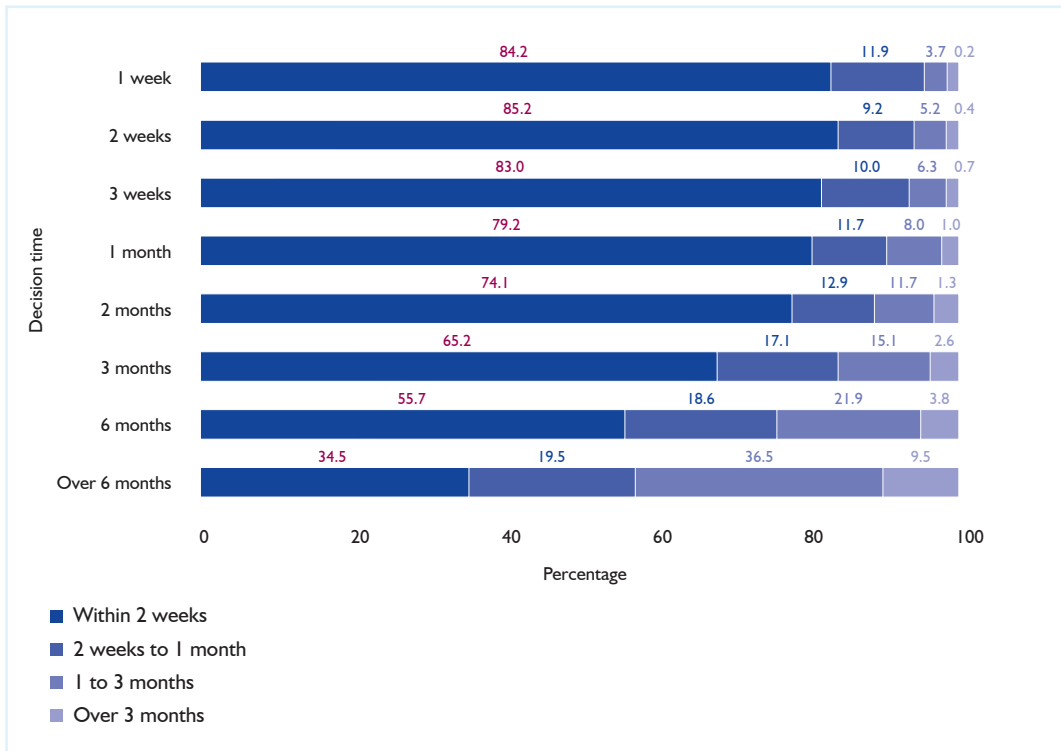
In this section we look at the impact of early lodgement of claims on decision times, average costs and durations.

## Impact of lodgement time on determination time

Over 80% of claims lodged within three weeks of the injury are determined by the insurer within two weeks. The number decided within the two weeks decreases as the time to lodge the claim increases. For claims lodged more than six months after an injury, the percentage determined in less than two weeks drops to 34.5%.

Delays in the time from injury to the lodgement of a claim also cause delays in the investigation and decision-making process. The following figure illustrates the link between lodgement and decision-making timeframes.

**FIGURE 20 Decision-making timeframes for claims decided 2006–2007 by the time taken to lodge the claim**



## Impact of lodgement time on claim costs and durations

Over 80% of claims finalised in 2006–2007 were lodged within four weeks of the injury.

Delays in the time from injury to the lodgement of a claim also cause delays in the investigation, decision-making process and costs of the claim.

**FIGURE 21** Proportion of claim types by time taken from injury date to intimation date for claims finalised in 2006–2007

	Claim type			Total
	MEO <sup>a</sup>	TLC <sup>b</sup>	Other	No.
Time from injury to intimation	%	%	%	
Within 1 week	45.0	52.6	2.4	30,632
1 – 2 weeks	32.6	63.9	3.5	23,319
2 – 3 weeks	32.2	64.2	3.6	12,387
3 – 4 weeks	34.2	61.8	4.0	6,642
4 – 8 weeks	39.4	55.9	4.7	8,948
8 – 12 weeks	45.5	48.7	5.8	2,989
12 – 26 weeks	45.3	48.7	6.0	2,965
Over 26 weeks	39.9	43.9	16.2	1,982
<b>Total</b>	<b>38.6</b>	<b>57.7</b>	<b>3.7</b>	<b>89,864</b>

a Medical expenses only claims

b Time lost claims

While only a small number of claims are lodged more than 26 weeks after the date of injury (2.2%), they consist of a large proportion of 'other' claims types, the majority of which are common law only claim types.

The following figure illustrates the average costs for claims finalised in 2006–2007 by the time taken from injury date to claim intimation for time lost claims and medical expense only claims. The figure shows how early lodgement of a claim lowers the average cost of the claim. The time lost claims that were lodged early also resulted in shorter average durations.

**FIGURE 22 Average cost of medical expenses only (MEO) and average cost and duration of time lost claims (TLC) for claims finalised 2006–2007 by time taken from injury date to intimation date**

	Average costs		Average duration of TLC claims
	MEO \$	TLC \$	(workdays)
<b>Time from injury to intimation</b>			
Within 1 week	501	5,928	23.4
1 – 2 weeks	692	8,290	33.8
2 – 3 weeks	785	8,394	34.5
3 – 4 weeks	879	9,293	38.6
4 – 8 weeks	972	10,337	40.4
8 – 12 weeks	1,524	12,300	48.9
12 – 26 weeks	1,377	16,000	65.8
Over 26 weeks	5,118	21,396	89.1
<b>Total</b>	<b>827</b>	<b>8,396</b>	<b>33.9</b>

# Claim management

## Open claims

The number of claims open at the end of the financial year increased 11.4%, while the duration of these claims increased by 4.0%.

The following figure illustrates the breakdown of current claims within the scheme.

**FIGURE 23** Number of claims and average duration for claims open as at 30 June 2007 by claim type and duration and injury nature

Claim type and duration	Claims				Average workdays lost		
	Psych	Other	Total	% of total	Psych	Other	Total
	No.	No.	No.	%			
Medical expense only claims	241	16,219	16,460	38.5	N/A	N/A	N/A
Time lost claims (TLC) (by work day lost timebands)							
1 – 5 days	57	7,868	7,925	18.5	2.6	2.7	2.7
6 – 10 days	36	3,209	3,245	7.6	7.9	7.8	7.8
11 – 20 days	43	3,027	3,070	7.2	15.3	14.9	14.9
21 – 40 days	71	3,306	3,377	7.9	29.7	29.6	29.6
41 – 65 days	61	2,287	2,348	5.5	52.6	51.8	51.8
66 – 130 days	158	2,863	3,021	7.1	99.7	92.9	93.3
131 – 260 days	203	1,973	2,176	5.1	187.2	180.6	181.2
Over 260 days	179	927	1,106	2.6	402.1	399.1	399.6
TLC sub-total	808	25,460	26,268	61.5	163.5	51.0	54.5
<b>Total</b>	<b>1,049</b>	<b>41,679</b>	<b>42,728</b>	<b>100</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>

In a fifth (22.2%) of psychiatric and psychological time lost claims currently open, the worker involved has had more than a year off work compared to only 3.6% of those where there is a physical claim.

**FIGURE 24** Number of claims and average duration for open time lost claims for 2006–2007

Open time lost claims as at:	Claims			Average workdays lost		
	Psych	Other	Total	Psych	Other	Total
	No.	No.	No.			
<b>2005–2006</b>	850	22,721	23,571	160.4	48.4	52.4
<b>2006–2007</b>	808	25,460	26,268	163.5	51.0	54.5
<b>% variance</b>	-4.9	12.1	11.4	1.9	5.4	4.0

The number of time lost claims increased from 23,571 in 2005–2006 to 26,268 in 2006–2007 and the average duration of open claims increased from 52.4 days to 54.5 days.

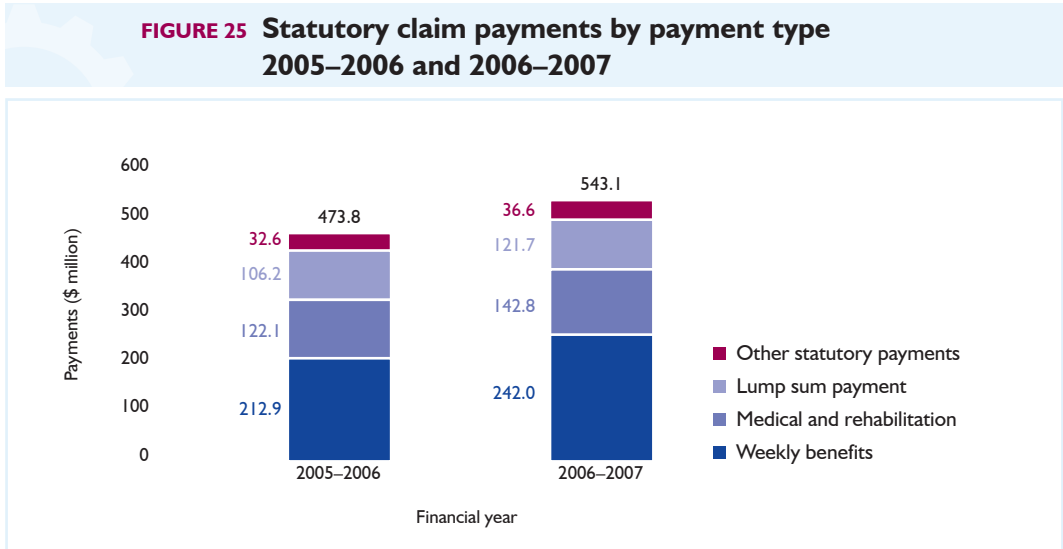
# Claim payments

- There was a 14.6% increase in statutory payments made in 2006-2007, consistent across all payment types.

Statutory payments made in 2006–2007 increased by 14.6%, consistent across all payment types.

During the management of a claim, payments are made to the worker for weekly compensation to replace wages, lump sums for PI and a broad range of services such as medical treatment and rehabilitation.

The following figure illustrates the amount paid on statutory claims in 2005–2006 and 2006–2007.

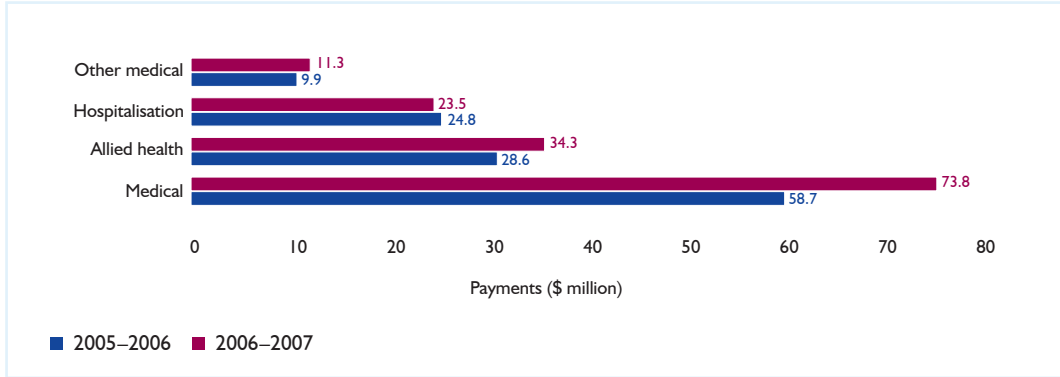


The total amount spent on claims for the year has increased by 14.6% from \$473.8 million in 2005–2006 to \$543.1 million in 2006–2007.

The category showing the largest increase was medical and rehabilitation payments (up 17.0%) followed by lump sum payments (up 14.6%).

There was also a 13.6% increase in weekly compensation payments and other statutory payments increased by 12.5%.

**FIGURE 26 Medical and rehabilitation payments by financial year 2005–2006 and 2006–2007**



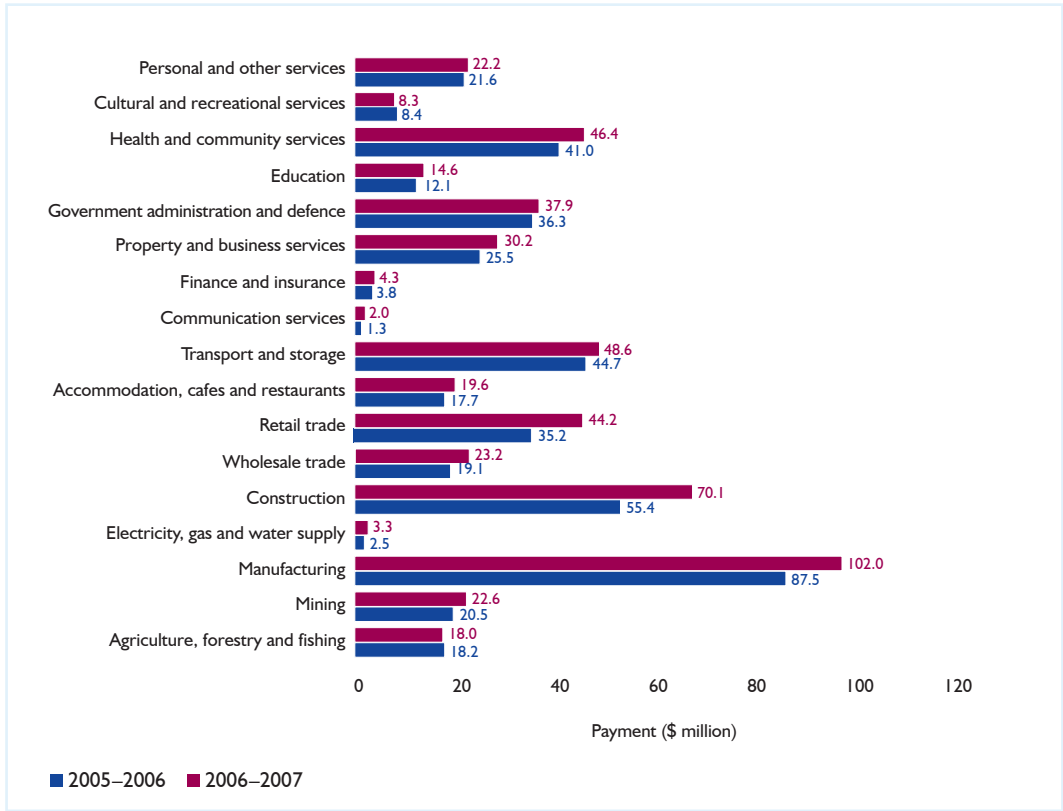
Payments for medical treatment accounted for more than half (51.6%) of all payments for medical and rehabilitation fees paid in the scheme in 2006–2007.

### Payments by industry

Claims from the manufacturing industry accounted for the largest proportion (18.8%) of statutory claim payments in 2006–2007.

While claim intimations for communication services increased by 29.0% (based on a small number of claims), it experienced the largest percentage increase in statutory claim payments (up 56.8%) from \$1.3 million in 2005–2006 to \$2.0 million in 2006–2007.

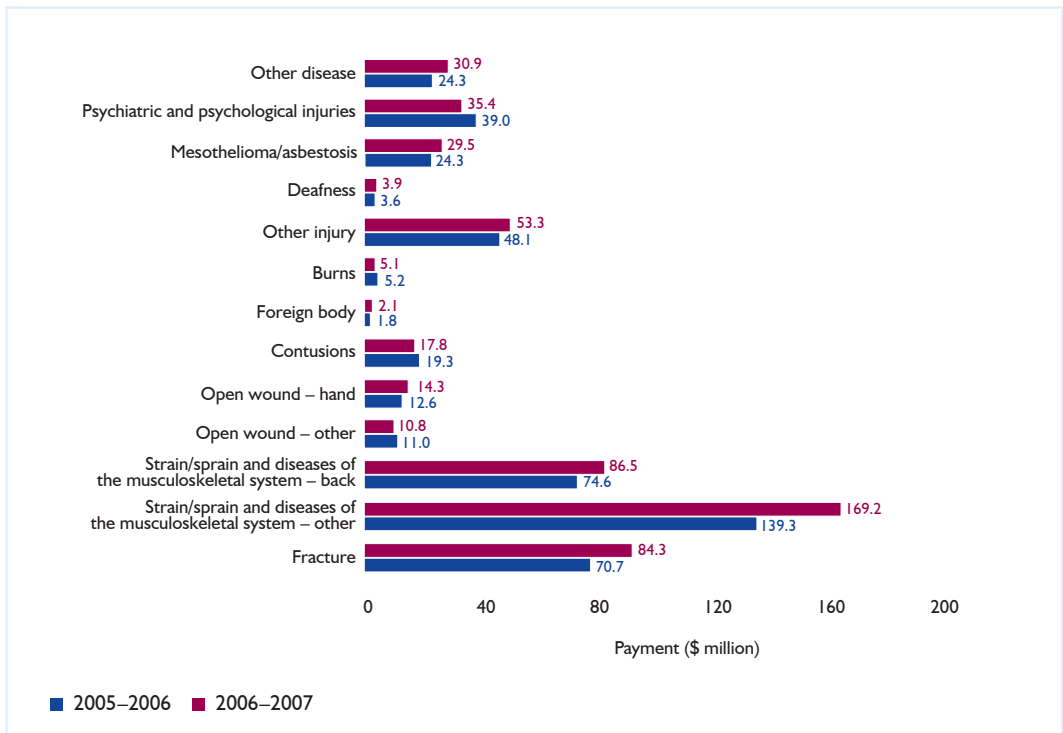
**FIGURE 27 Statutory claim payments by industry 2005–2006 and 2006–2007**



The majority of statutory claim payments (31.2%) in 2006–2007 were for claims with a primary injury type of sprains/strains/diseases of the musculoskeletal system to locations other than the back. Psychiatric and psychological injuries account for 6.5% of statutory claim payments made in 2006–2007.

Injury types that experienced the largest percentage increase in statutory claim payments were mesothelioma/asbestosis (up 21.6%), sprains/strains/diseases of the musculoskeletal system to locations other than the back (up 21.4%), and fractures (up 19.3%).

**FIGURE 28 Statutory claim payments by injury type  
2005–2006 and 2006–2007**



# Case study

## Evaluation of the medical services rollout

Since the Medical Services Rollout in February 2006:

- return to work outcomes have remained steady, with 90% of workers returning to the same job
- durations for time lost claims finalised have decreased 26.8%
- the number of payments for medical reports have decreased 17.6% on a quarterly basis
- the number of payments for both communication and the phone fax fee have increased 49.8% per financial quarter.

During 2004–2005 Q-COMP, in conjunction with other bodies including the Australian Faculty of Occupational Medicine, the Australian Medical Association of Queensland, the Queensland Workers' Compensation Self-Insurers' Association and WorkCover Queensland, conducted a major review into medical services. An initiative was developed with the following objectives:

- streamline and improve processes between doctors and insurers
- improve the communication between insurers and medical practitioners
- expand education initiatives for work-related injury and workers' compensation processes
- improve access to quality treatment and enhance return to work outcomes for injured workers while maintaining an affordable scheme for employers.

This initiative was rolled out by Q-COMP from February 2006. This case study summarises analyses conducted to evaluate the impact of this initiative against the above objectives.

## Method

This evaluation considers claims intimated in three time periods for comparability:

1. pre medical fee increase: 1 April 2004 to 30 June 2004
2. post medical fee increase: 1 July 2005 to 30 September 2005
3. post medical services rollout: 1 April 2006 to 30 June 2006.

The **pre medical fee increase** period represents a time period prior to the fee increases in July 2005, which impacts on the results of this evaluation. This period serves as a baseline as claims in this period have had sufficient time to develop. The timeframe has been deliberately chosen to remove any seasonal variations when compared with the post fees and medical services rollout period.

The **post medical fee increase** period represents the period immediately after the fee increases in July 2005 had occurred and before the medical services rollout came into effect. This serves as a second baseline for evaluation of the effect of the medical services rollout and indicates the effect of the fee increases themselves.

The **post medical services rollout** period is the current period of evaluation. It has been cut off at 30 June 2006 to remove the impact of claims which are still early enough in their development to affect the analytical outcomes.

Two key areas have been identified to assess the overall impact on claims of this initiative:

- the return to work outcomes achieved in these periods
- the distribution of workdays lost for claims intimated in these periods.

## Return to work outcomes

To enable a meaningful comparison of return to work outcomes for claims intimated in the various periods, the figure below shows the return to work outcomes for claim finalised within 12 months of each intimation period.

**FIGURE 29 Percentage of finalised time lost claims by return to work outcomes for claims finalised within 12 months of the end of each timeframe**

Return to work outcomes	Pre medical fee increases	Post medical fee increases	Post medical services rollout
	%	%	%
Fit for work: same job/same employer	90.3	91.2	90.9
Fit for work: same job/different employer	1.3	1.5	1.5
Fit for work: different job/same employer	1.3	1.1	0.9
Fit for work: different job/different employer	1.8	1.4	1.7
Fit for work: no job	1.2	0.9	0.9
Fit for work: worker does not return	2.2	2.6	2.7
Not fit for work	1.1	0.8	0.8
Alternative outcome – not claim related	0.8	0.5	0.6
<b>Total finalised number</b>	<b>8,581</b>	<b>10,666</b>	<b>10,310</b>
Total finalised as % of total claims intimated in the period	86.1	94.1	84.7

This figure shows that injured workers are just as likely to return to their previous job, irrespective of when the injury occurred.

## Workdays lost distribution

The average duration of finalised claims intimated in each time period is shown below.

**FIGURE 30 Average work days lost for time lost claims intimated in each period and finalised within 12 months of the end of each intimation**

Period	Average work days lost
Pre fees	32.9
Post fees	29.1
Post medical services rollout	21.3

This effect is more pronounced for claims with a psychiatric/psychological injury.

**FIGURE 31 Average work days lost for time lost claims intimated in each period and finalised within 12 months of the end of each intimation timeframe (psych claims only)**

Period	Average work days lost
Pre medical fee increases	98.5
Post medical fee increases	121.1
Post medical services rollout	83.7

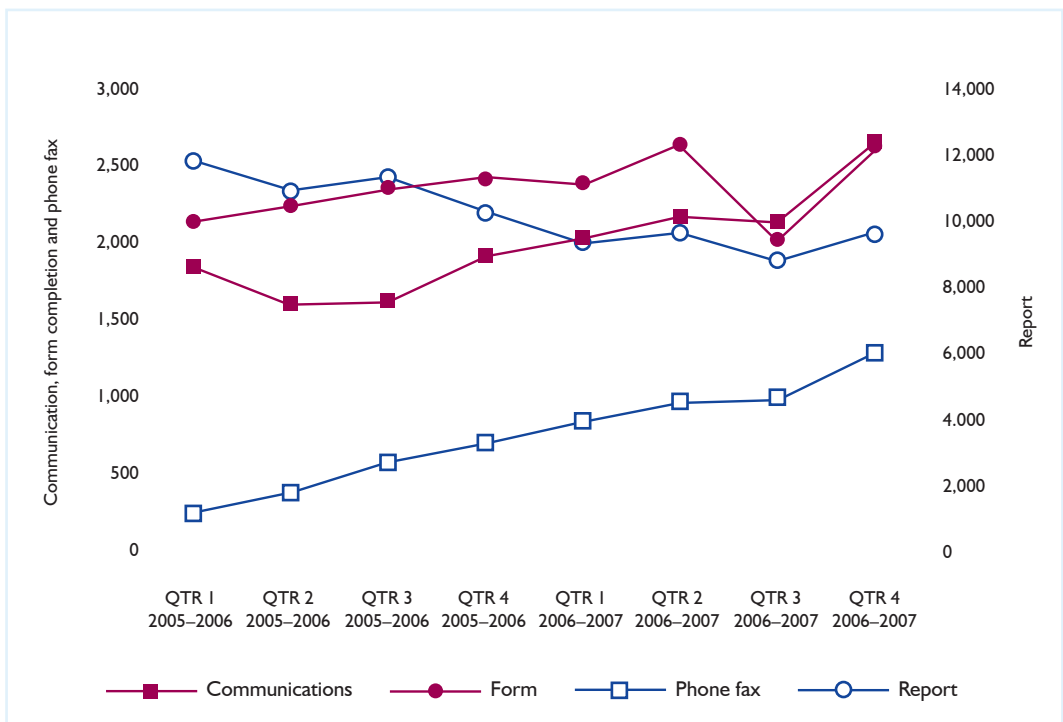
Note: 27.5% of claims for psychological injuries intimated in the post fee increases and medical services rollout period remain open as at 30 June 2007, and are still developing.

**Phone fax form and medical report usage**

One of the initiatives of the medical services rollout was the promotion of the use of the phone fax fee. An associated decline in the usage of item numbers which could be grouped as reports was also expected.

The usage of item numbers which fall into the categories of communication, form completion, phone fax and reports listed by the financial quarters for 2005–2006 and 2006–2007 appear in the figure below.

**FIGURE 32 Usage for item number categories by financial quarters 2005–2006 and 2006–2007**



Note: The right hand vertical axis is the usage for reports – the scale was altered as the differences in raw numbers were masking the movements in the communication, form completion and phone fax usage numbers.

The change in the usage from the previous quarter of these categories is shown in the figure below.

**FIGURE 33 Percentage change in usage of item number categories by financial quarters 2005–2006 and 2006–2007**

	Qtr 2 2005–2006	Qtr 3 2005–2006	Qtr 4 2005–2006	Qtr 1 2006–2007	Qtr 2 2006–2007	Qtr 3 2006–2007	Qtr 4 2006–2007
	%	%	%	%	%	%	%
Communication	-11.3	-0.6	18.0	5.3	10.8	-2.1	26.1
Form completion	3.3	7.6	1.7	-2.0	13.7	-24.0	29.8
Phone fax	45.4	87.0	18.8	26.4	19.3	2.9	32.5
Report	-9.5	5.7	-10.6	-9.8	7.0	-13.3	14.9

The above figure shows these expectations to be accurate, with the phone fax fee usage increasing six-fold on a quarterly basis throughout the period, while the quarterly figure for items associated with requests for reports decreased by over 2000 per quarter through the same period. Similarly, in this same period, payments in the communication category increased 49.8%.

These trends are clearly in line with the objectives of the medical services rollout in February 2006.

# Ongoing incapacity

- Psychiatric injuries are more likely than physical injury cases to proceed to a medical assessment tribunal (MAT) for determination of ongoing incapacity.
- Less than 15% of cases referred for an ongoing incapacity decision are denied.
- Just over a quarter (26.9%) of psychological injuries receive no permanent impairment (PI) at the tribunal.
- Just under half (47.8%) of cases referred for a disputed PI assessment are unchanged by the MAT.

Insurers are able to manage and cease claims administratively under the *Workers' Compensation and Rehabilitation Act 2003* and did so for 1,225 claims in 2006-2007. Where conflicting medical information means an insurer is unable to determine whether the worker is incapacitated for work because of the injury, the insurer may refer the worker to a medical assessment tribunal (MAT). In 2006-2007, 969 cases were referred to a MAT to determine ongoing incapacity for work.

The following figure illustrates the number of cases determined at a MAT for ongoing incapacity and the outcomes.

**FIGURE 34 Cases heard in 2006–2007 for ongoing incapacity and the outcomes by tribunal type**

	Psychiatric Tribunal (n=734)	Orthopaedic Tribunal (n=176)	Other (n=59)	TOTAL (n=969)
<b>Ongoing incapacity</b>	%	%	%	%
No ongoing incapacity for work from the injury	6.4	37.5	52.5	14.9
Ongoing incapacity (requires further treatment)	15.5	11.4	5.1	14.1
Ongoing incapacity (stable and stationary)	78.1	51.1	42.4	71.0
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>

Psychiatric cases are more likely to have an ongoing incapacity (93.6%) with 15.5% of all cases seen by this MAT requiring ongoing treatment.

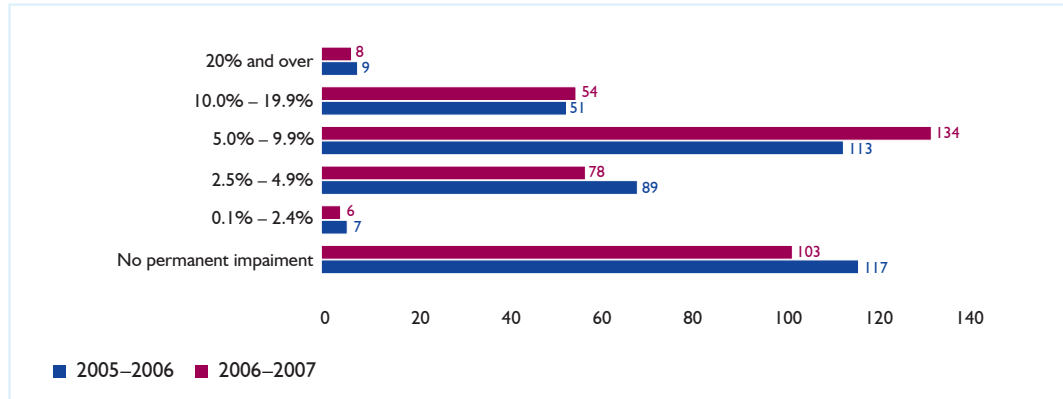
## Permanent impairment (PI)

This section looks at claims that have been assessed for PI. An assessment for PI is taken when the injury is stable and stationary and not likely to improve with further medical or surgical treatment.

### Psychiatric PI

Psychiatric and psychological injuries can only be assessed for PI by a medical assessment tribunal. The following figure shows the level of impairment determined for psychiatric PI cases heard in 2006-2007.

**FIGURE 35 Psychiatric permanent impairment cases heard by the MAT by level of impairment 2005–2006 and 2006–2007**

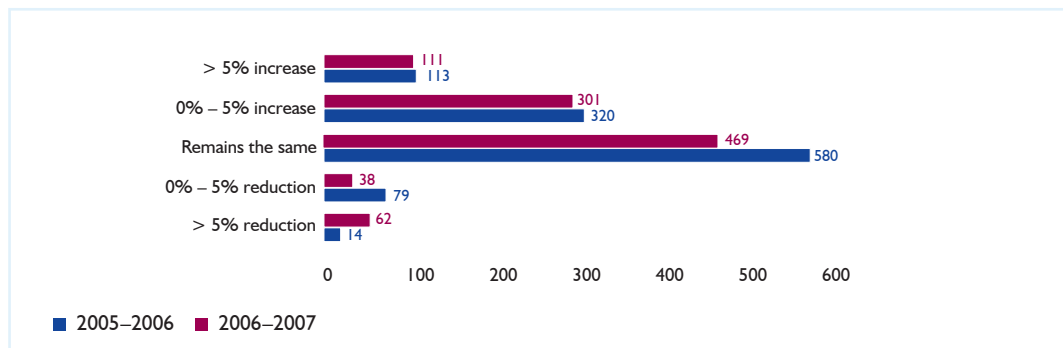


### Disputed PI

Where an injured worker does not agree with the assessed level of PI they may be referred to a MAT to determine the final level of PI.

In 2006-2007, 981 cases were heard by a MAT where the PI assessment had been disputed. The following figure illustrates the outcome of disputed PIs referred to a MAT.

**FIGURE 36 Outcomes of disputed permanent impairment cases heard by a MAT 2005–2006 and 2006–2007**



## Work Related Impairment (WRI)

Where a worker has a permanent impairment assessed, the degree of work related impairment (WRI) is calculated. While a person may have multiple permanent impairments, only one physical and one psychological WRI is calculated as a "whole of person" impairment for the purposes of calculating lump sum payments.

The table below shows the number of claims finalised and those that had a WRI in 2005–2006 and 2006–2007.

**FIGURE 37 Finalised claims with a work related impairment  
2005–2006 and 2006–2007**

	2005–2006	2006–2007	% Variance
<b>Finalised claims</b>	<b>77,788</b>	<b>89,864</b>	<b>15.5</b>
<b>Work related impairment</b>	9,168	7,675	-16.3
Proportion finalised with a work related impairment	11.8%	8.5%	
<b>Work related impairment range</b>			
0%	1,986	1,411	-29.0
0.1% – 19.9%	6,691	5,834	-12.8
20% – 49.9%	367	340	-7.4
50% – 99.9%	57	41	-28.1
100%	67	49	-26.9

For 2006–2007, 8.5% of claims were finalised with a WRI calculated. Of these, the majority of claims (94.4%) had a WRI of less than 20% and a fifth (18.4%) was calculated as having no WRI.

# Finalised claims and outcomes

- 87.7% of workers with claims finalised in 2006–2007 returned to their same job with the same employer
- Average costs of finalised medical expense only claims decreased 17.8%
- Average costs of finalised time lost claims decreased 2.5% while their durations decreased 8.4%
- While the number of finalised time lost claims increased 8.9%, the proportion of claims with less than 40 workdays lost increased.

## Return to work (RTW) outcomes

Returning an injured worker to the same job with the same employer is the best outcome which can be achieved on a claim. The following table analyses the RTW outcome of claims reported at the time the claim closed. As the following figure illustrates, this is the outcome achieved in most cases, with 87.7% of injured workers who had time off work returning to the same job and the same employer.

**FIGURE 38 Return to work status of finalised time lost claims  
2005–2006 and 2006–2007**

	2005–2006		2006–2007	
	Time lost claims		Time lost claims	
	No.	%	No.	%
Fit for work: same job/tasks with same employer	41,337	86.9	45,448	87.7
Fit for work: same job/tasks with different employer	831	1.7	879	1.7
Fit for work: different job/tasks with same employer	679	1.4	593	1.1
Fit for work: different job/tasks with different employer	1,059	2.2	1,316	2.5
Fit for work: no job	602	1.3	635	1.2
Fit for work: worker does not return	1,557	3.3	1,563	3.0
Not fit for work	815	1.7	788	1.5
Alternative outcome not related	706	1.5	621	1.2
<b>Total</b>	<b>47,586</b>	<b>100.0</b>	<b>51,843</b>	<b>100.0</b>

It has been found that nine out of 10 claimants return to some type of employment. In a small number of cases, the worker is deemed fit to return to work but there is no job for the worker to return to (1.2% of time lost claims) or the worker chooses not to return (3.0% of claims).

One of the factors which influence the RTW outcome on a claim is the severity of the injury. The following table compares claims which have had a permanent impairment assessed as an indicator of the impact of severity of injury on RTW outcomes.

**FIGURE 39 Return to work status of finalised time lost claims with/without a permanent impairment assessed 2006–2007**

	2006–2007		
	PI assessed		
	No %	Yes %	Number
Fit for work: same job/tasks with same employer	92.5	7.5	45,448
Fit for work: same job/tasks with different employer	73.4	26.6	879
Fit for work: different job/tasks with same employer	52.1	47.9	593
Fit for work: different job/tasks with different employer	56.5	43.5	1,316
Fit for work: no job	50.4	49.6	635
Fit for work: worker does not return	59.7	40.3	1,563
Not fit for work	27.5	72.5	788
Alternative outcome not related	59.3	40.7	621
<b>Total</b>	<b>87.9</b>	<b>12.1</b>	<b>51,843</b>

Workers with claims assessed for permanent impairment are less likely to return to the same job with the same employer. Only 7.5% of workers returning to the same job with the same employer had a permanent impairment assessed.

Another factor which influences the RTW outcome on claims is the existence of a psychological or psychiatric injury. The following table illustrates the impact of the injury type on RTW outcomes.

**FIGURE 40 Return to work status of finalised time lost claims by injury nature 2005–2006 and 2006–2007**

	2005–2006			2006–2007		
	Physical Only (%)	Psych Only (%)	Psych and Phys (%)	Physical Only (%)	Psych Only (%)	Psych and Phys (%)
Fit for work: same job/tasks with same employer	89.1	61.8	47.5	89.7	59.2	44.7
Fit for work: same job/tasks with different employer	1.7	4.1	2.4	1.6	4.1	3.0
Fit for work: different job/tasks with same employer	1.1	5.5	6.1	0.9	4.7	5.8
Fit for work: different job/tasks with different employer	1.8	7.5	8.6	2.1	9.9	11.1
Fit for work: no job	1.1	2.6	4.6	1.0	2.4	6.0
Fit for work: worker does not return	2.8	7.4	12.0	2.7	6.7	11.0
Not fit for work	1.1	8.6	12.3	1.0	9.4	13.4
Alternative outcome not related	1.3	2.5	6.5	1.0	3.7	5.2
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>
<i>n</i> =	44,577	1,296	1,713	49,128	1,085	1,630

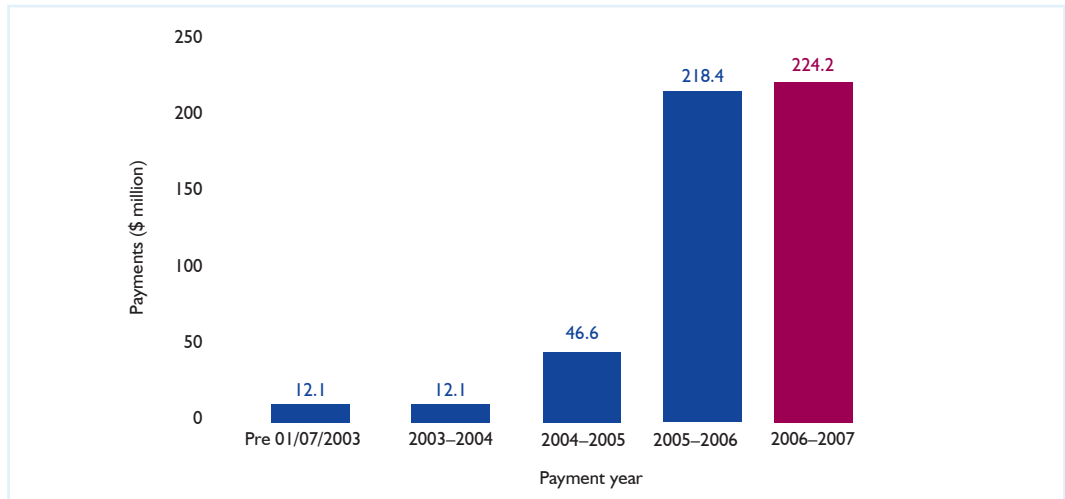
Workers having claims with both a physical and psychiatric component are the least likely to return to employment and more than one in 10 are not fit for work at the end of the claim.

## Average claim costs

The average finalised claim cost is calculated using statutory claim payments made on a claim that was ceased or finalised within the financial year – **the payments made on these claims may have occurred over several years.**

The figure below illustrates the payments made on claims finalised in 2006–2007. Over half of the payments for these claims occurred in previous years. Only 43.7% of the statutory payments made on claims finalised in 2006–2007 were also paid in that financial year. A further 42.5% of payments were made in the 2005–2006 financial year. The remaining 13.8% of the payments were made in 2004–2005 or earlier.

**FIGURE 41 Payments by payment year for claims finalised in 2006–2007**



The claims that cost more to the scheme tend to be those that have longer durations. These usually occur over several years and therefore would not impact on the average finalised claim cost until the year the claim is ceased or finalised.

The average cost has decreased for the financial year (down 8.4% from \$5,857 in 2005–2006 to \$5,362 in 2006–2007), however one of the reasons for this has been a change in the mix of claims finalised in the scheme.

The main increase in finalised claims has been in medical expense only claims (up 28.3%) and shorter duration (< 10 workdays) time lost claims (up 14.9%) rather than longer duration claims (increased 2.1%). This is believed to be primarily due to WorkCover Queensland's fax fee initiative which may have increased reporting of previously unreported minor injuries.

The table below shows the number of claims finalised in the past two years, and the average claim costs by claim type for time lost claims and medical expense only claims. These two claims types represent 96.3% of all finalised claims during 2006–2007.

**FIGURE 42 Finalised claims and average claim costs by claim type 2005–2006 and 2006–2007**

Claim type	Number of claims			Average claim cost (\$)		
	2005–2006	2006–2007	% Variance	2005–2006	2006–2007	% Variance
Time lost claim	47,586	51,843	8.9	8,612	8,396	-2.5
Medical expense only claim	27,032	34,684	28.3	1,007	827	-17.8
<b>Total</b>	<b>74,618</b>	<b>86,527</b>	<b>16.0</b>	<b>5,857</b>	<b>5,362</b>	<b>-8.4</b>

The average finalised claim cost decreased by 8.4% from \$5,857 in 2005–2006 to \$5,362 in 2006–2007.

This cost may vary depending on factors such as:

- the duration of claims, the longer an injured worker is away from work, the more weekly benefits and medical expenses the claim will incur, impacting on the time lost claims costs
- level of medical and other expenses required for the injury
- changes in industry claim rates and the average wages paid in industry
- the mix of injuries intimated scheme-wide (the severity of injury can impact on the average finalised time lost claim duration and cost)
- changes in practices by insurers can have an impact on claim finalisation and average costs
- changes to legislation to provide increased or additional benefits to claimants. The lump sum maximum payable increased from \$200,000 to \$209,000 (up 4.5%) for injuries on or after 1 January 2006.

The following table compares the variance in finalised claim costs to other indicators.

**FIGURE 43 Changes in average finalised claim costs and economic indices 2006–2007**

Indicator	% Change from previous year
Average Finalised Claim Cost	-8.4
Average Finalised Time Lost Claim Cost	-2.5
Average Finalised Medical Expense Only Claim Cost	-17.8
Consumer Price Index	
Average All Groups, Brisbane (excluding GST) <sup>a</sup>	2.9
Health, Brisbane (excluding GST) <sup>a</sup>	5.1
Full Time Adult Ordinary Time Earnings <sup>b</sup>	4.2

a Australian Bureau of Statistics, Consumer Price Index, Australia, Cat No. 6401.0 – All Groups CPI and Health CPI Brisbane, % change from March 2007 to the corresponding quarter of previous year.

b Australian Bureau of Statistics, Average Weekly Earnings, Australia, Cat No. 6302.0 – Change in Queensland full-time adult ordinary time earnings from February 2006 to February 2007.

## Average finalised medical expense only claim costs

This section looks at a further breakdown of the average costs of finalised medical expense only claims.

The average cost of finalised medical expense only claims has decreased 17.8% from \$1,007 in 2005–2006 to \$827 in 2006–2007.

The breakdown of the average cost for 2006–2007 shows more than a third (37.4%) of the cost is made up of medical costs followed by lump sum payments (30.3%). Allied health account for 13.9% and other statutory payments account for 13.0%. The remaining 5.3% of the average cost is made up of other medical payments (including hospitalisation).

The largest decreases in average costs were lump sum payments (down 37.8%), other statutory costs (down 20.7%). The only increases in cost were for medical costs (up 7.4%).

**FIGURE 44** Average finalised medical expense only claim costs by payment type by financial year 2005–2006 and 2006–2007



## Average finalised time lost claim durations

Average finalised time lost claim durations are calculated using finalised time lost claims over a financial year. The number of finalised time lost claims increased 8.9% from 47,586 in 2005–2006 to 51,843 in 2006–2007.

Over the past two years, durations for finalised time lost claims including the excess paid by the employer (where applicable) have decreased by 8.4%, from 37.1 days in 2005–2006 to 33.9 days in 2006–2007.

More than three-quarters of time lost claims have 40 or less workdays lost (79.6%), while the median workdays lost for all time lost claims is eight days. This illustrates how the small number of long term claims impact on the average duration. Only 6.7% of time lost claims have more than 130 workdays lost. It is at the 26 week point that the level of compensation benefits payable first begins to decrease (section 150, the Act).

**FIGURE 45** Number of time lost claims by workdays lost bands  
2005–2006 and 2006–2007

Workdays lost bands	2005–2006		2006–2007	
	No. claims	% of claims	No. claims	% of claims
1 – 5 days	18,435	38.7	21,505	41.5
6 – 10 days	6,917	14.5	7,628	14.7
11 – 20 days	6,010	12.6	6,395	12.3
21 – 40 days	5,398	11.3	5,719	11.0
41 – 65 days	3,394	7.1	3,367	6.5
66 – 130 days	3,832	8.1	3,779	7.3
131 – 260 days	2,511	5.3	2,364	4.6
> 260 days	1,089	2.3	1,086	2.1
<b>Total time lost claims</b>	<b>47,586</b>	<b>100.0</b>	<b>51,843</b>	<b>100.0</b>

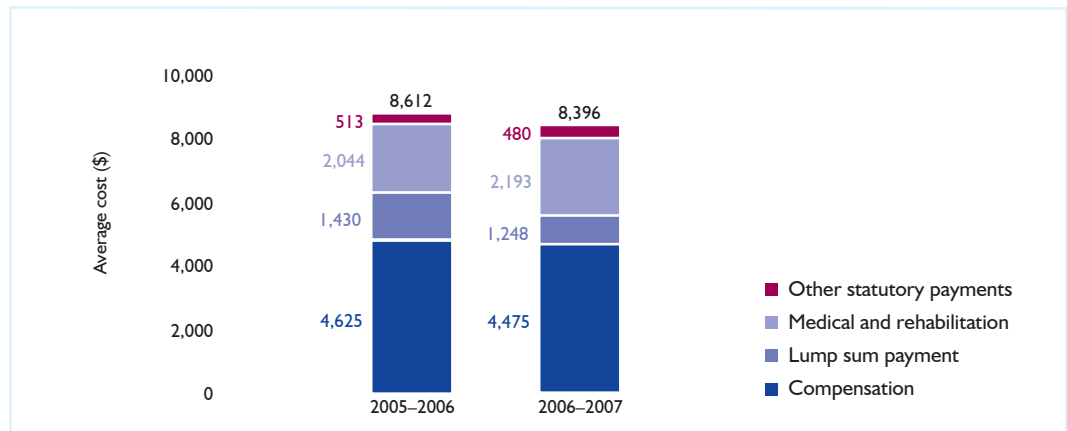
## Average finalised time lost claim costs

The average cost of finalised time lost claims has decreased 2.5% from \$8,612 in 2005–2006 to \$8,396 in 2006–2007.

The breakdown of the average cost in 2006–2007 shows over half (53.3%) of the cost is made up of weekly compensation payments. The average durations of claims have decreased by 8.4% between the two periods (37.1 days in 2005–2006 to 33.9 days in 2006–2007), the compensation component of the average costs also decreased by 3.2% (from \$4,625 in 2005–2006 to \$4,475 in 2006–2007).

In 2006–2007, medical and rehabilitation costs accounted for a quarter (26.1%) of the average cost, lump sum payments accounted for 14.9%, while the remaining 5.7% of the average cost was made up of other statutory payments.

**FIGURE 46 Average finalised time lost claim costs by payment type 2005–2006 and 2006–2007**



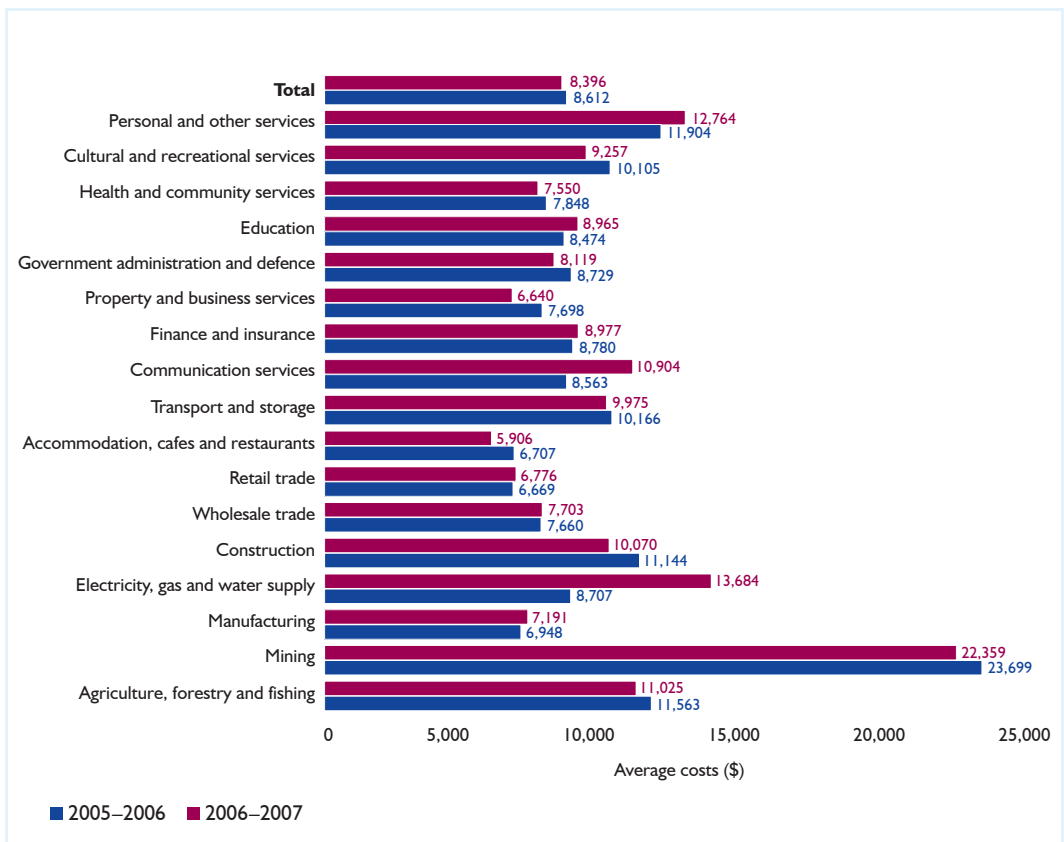
### Average cost by industry

Of all industry claims, mining industry claims had the highest average finalised time lost claim cost (\$22,359) partially due to the higher wages paid in the industry. The Australian average weekly earnings (full time adults) for employees in the mining industry of \$1,729.80 is the highest of all industries (Source: ABS, Average Weekly Earnings, Cat No. 6302.0, February 2007).

Similarly, industries that tended to have lower average finalised time lost claim cost, for example, retail trade and accommodation, cafes and restaurants – also had the lowest Australian average weekly earnings of all industries (between \$821 and \$840).

The largest percentage increase in average finalised time lost claim cost was in the electricity, gas and water supply industry, up 57.2% from \$8,707 in 2005–2006 to \$13,684 in 2006–2007. The communication services industry also experienced a percentage increase of 27.3% (from \$8,563 to \$10,904).

**FIGURE 47 Average finalised time lost claim costs by industry by financial year 2005–2006 and 2006–2007**



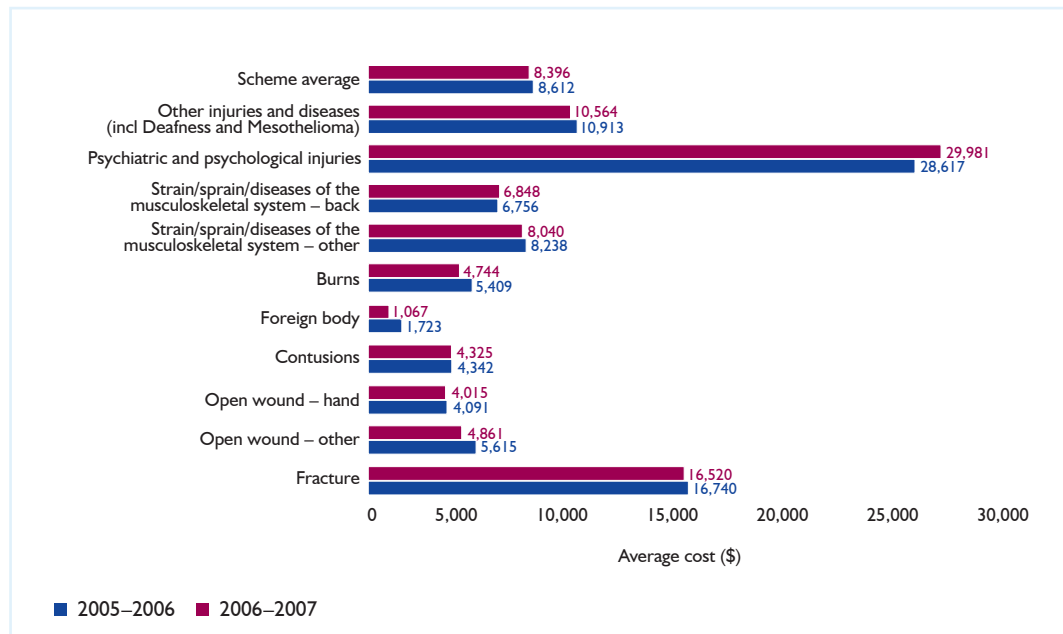
## Average cost by injury type

Although psychiatric and psychological injuries account for only 2.7% of all claims, they are the most expensive with an average finalised time lost claim cost of \$29,981 in 2006–2007 (up 4.8% from \$28,617 in 2005–2006).

In 2006–2007, the average duration of a psychiatric and psychological claim was 127.0 days (2005–2006: 125.8 days) compared with the overall scheme average of 33.9 days. Although there has been a 1.0% increase in 2006–2007, it is the long duration of psychiatric and psychological claims that impacts on the average finalised time lost claim cost for these claims.

The second most expensive injury type was fractures with an average cost of \$16,520, a decrease of 1.3% compared to the average cost in 2005–2006 of \$16,740.

**FIGURE 48 Average finalised time lost claim cost by injury type by financial year 2005–2006 and 2006–2007**



# Claims for damages at common law

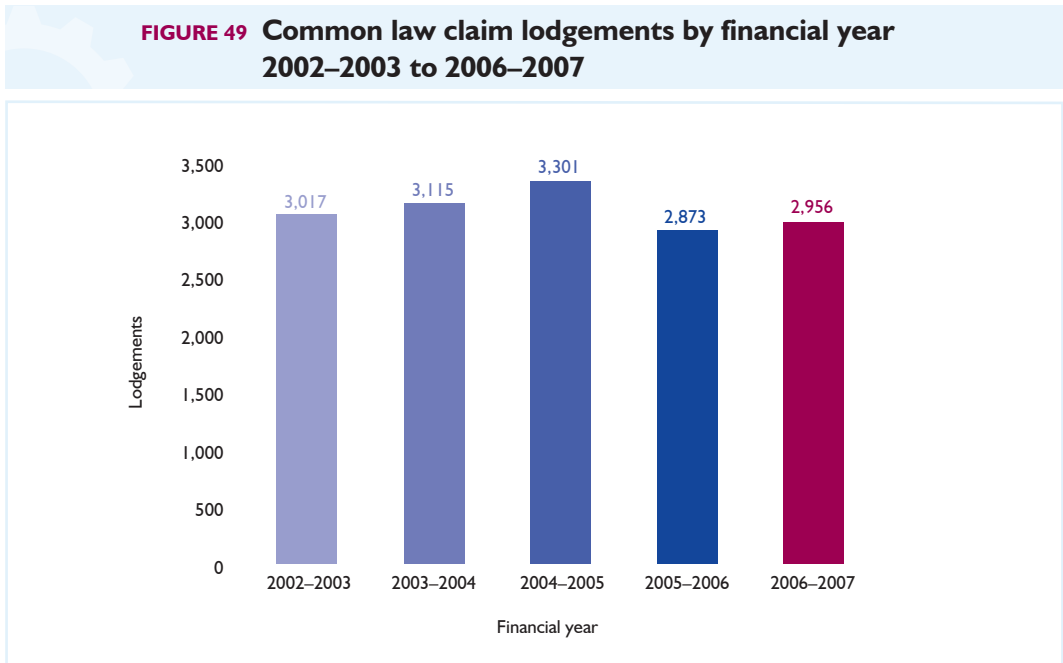
- Common law lodgements have remained relatively stable over the past five years.
- The majority of lodgements are for injuries that occurred two to three years prior.
- The largest proportion of common law lodgements are associated with claims that have a work related impairment of 0.1% – 19.9%.
- Psychiatric and psychological injuries represent 6.1% of common law lodgements; they represent only 2.7% of statutory claim intimations.

This section reports information about claims for damages at common law (common law claims).

## Lodgements

Common law claim lodgements have remained relatively stable over the past five years. Over the past year, common law claim lodgements have increased by 2.9% (from 2,873 in 2005–2006 to 2,956 in 2006–2007).

The figure below shows the common law claim lodgements over the past five years, by the date of injury.



**FIGURE 50 Common law claim lodgements by injury year  
2002–2003 to 2006–2007**

	2002–2003	2003–2004	2004–2005	2005–2006	2006–2007
Injury year	No.	No.	No.	No.	No.
Pre 01/07/1997	94	122	119	83	105
1997–1998	64	20	12	1	3
1998–1999	179	87	35	9	5
1999–2000	923	161	79	25	10
2000–2001	1,071	937	132	46	19
2001–2002	629	977	811	58	15
2002–2003	57	727	1,024	721	42
2003–2004		84	979	898	605
2004–2005			110	901	920
2005–2006				131	1,102
2006–2007					130
<b>Total</b>	<b>3,017</b>	<b>3,115</b>	<b>3,301</b>	<b>2,873</b>	<b>2,956</b>

The majority of common law claims lodged in any given year are for injuries that occurred two to three years prior. The figure below shows the breakdown of common law claim lodgements in 2006–2007 by the injured worker's work related impairment assessment.

**FIGURE 51 Common law claim lodgements by work related  
impairment assessment 2006–2007**

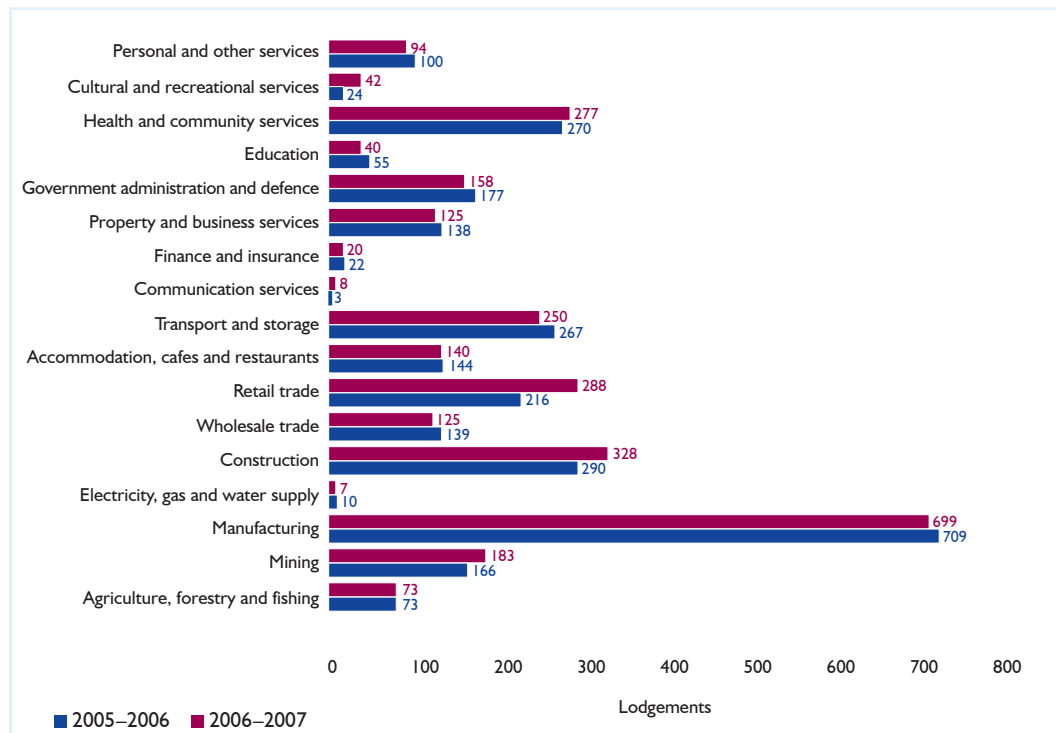
	Common law lodgements	Common law lodgements
Work related impairment assessment	No.	%
No work related impairment assessed	648	21.9
0%	502	17.0
0.1% – 19.9%	1,651	55.9
20% – 49.9%	136	4.6
50% – 99.9%	18	0.6
100%	1	<0.1
<b>Total</b>	<b>2,956</b>	<b>100</b>

If the injured worker's work related impairment is less than 20%, the worker has to make an irrevocable decision to either accept a payment of the statutory lump sum compensation for the injury or seek damages at common law. If the work related impairment is 20% or more, the injured worker can accept a payment of lump sum compensation and seek damages. Only a small proportion of common law claims (5.2%) are able to access lump sum payment and pursue common law.

## Industry

Manufacturing represents the highest proportion of common law claims lodged in the Queensland scheme, accounting for almost a quarter (23.6%) of all common law claim lodgements in 2006–2007.

**FIGURE 52 Common law claim lodgements by industry 2005–2006 and 2006–2007**

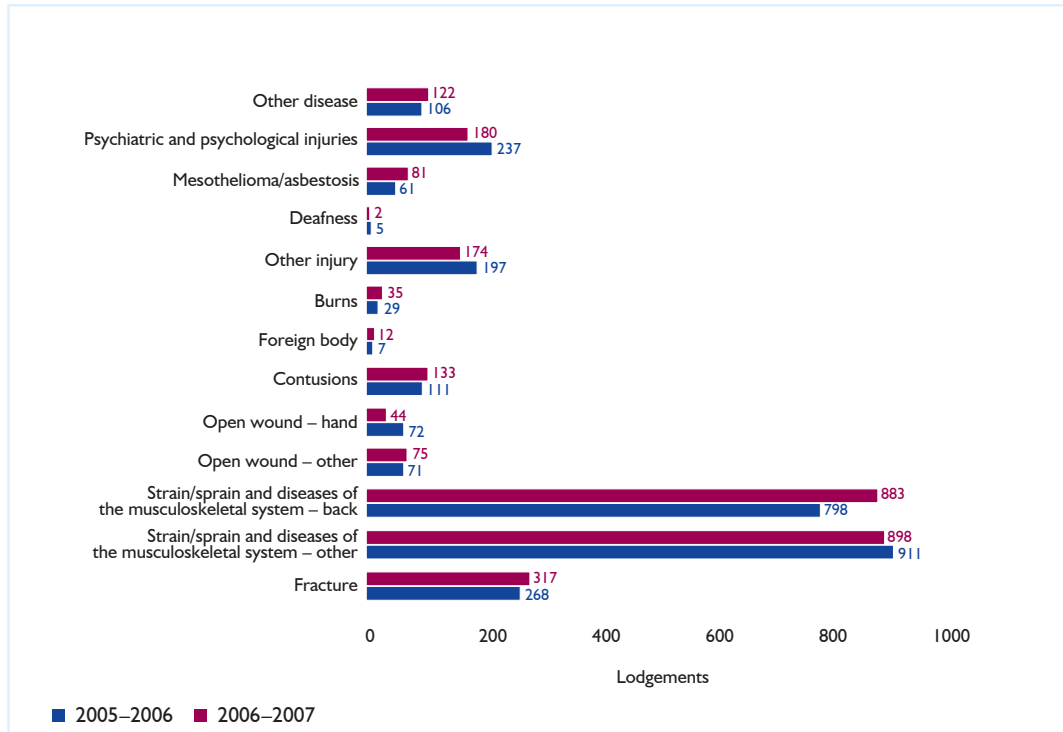


## Injury type

Sprain and strain injuries and diseases of the musculoskeletal system accounted for over half (60.3%) of all common law claim lodgements in 2006–2007.

Although psychiatric and psychological injuries represent only 2.7% of statutory claim intimations, they represent 6.1% of all common law claim lodgements in 2006–2007.

**FIGURE 53 Common law claim lodgements by injury type 2005–2006 and 2006–2007**



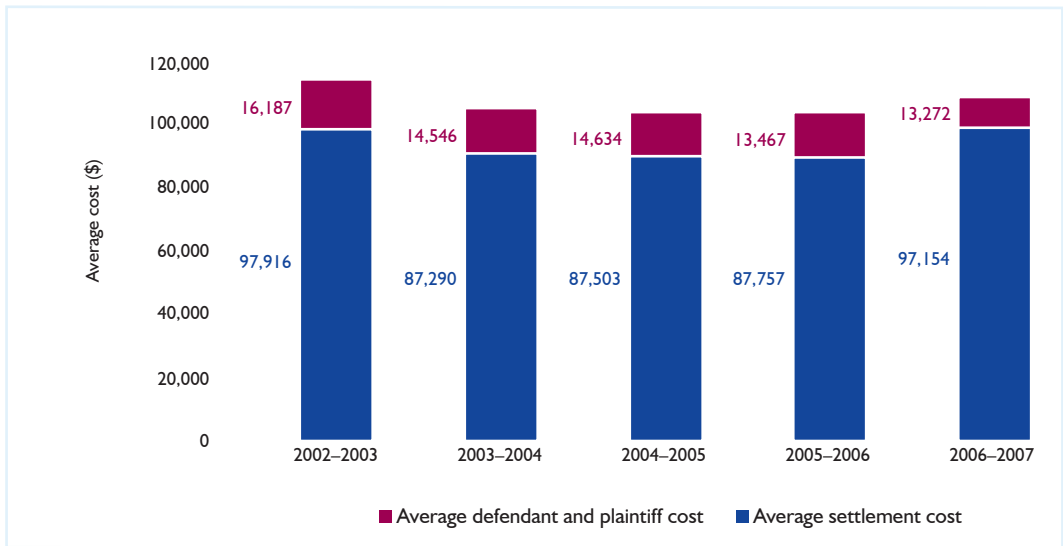
### Total common law payments

In 2006–2007 common law claims cost a total of \$347.8 million. This represented a 2.1% increase from the 2005–2006 cost of \$340.6 million.

### Average costs

Over the past two years, the average settlement cost of a finalised common law claim has increased 10.7% from \$87,757 in 2005–2006 to \$97,154 in 2006–2007. The average defendant and plaintiff costs remained relatively constant (\$13,467 in 2005–2006 and \$13,272 in 2006–2007). It should be noted that restrictions on awarding of plaintiff costs were introduced for injuries occurring on or after 1 January 1996.

**FIGURE 54 Average costs for finalised common law claims by payment type 2002–2003 to 2006–2007**



### Average timeframes

For claims lodged in the financial year, the average time from date of injury to lodgement of a common law claim has increased 10.4% from 2.92 years in 2005–2006 to 3.22 years in 2006–2007.

For claims finalised in the financial year, the average time from the lodgement of a common law claim to finalisation has decreased marginally (down 4.8%) from 1.15 years in 2005–2006 to 1.09 years in 2006–2007.

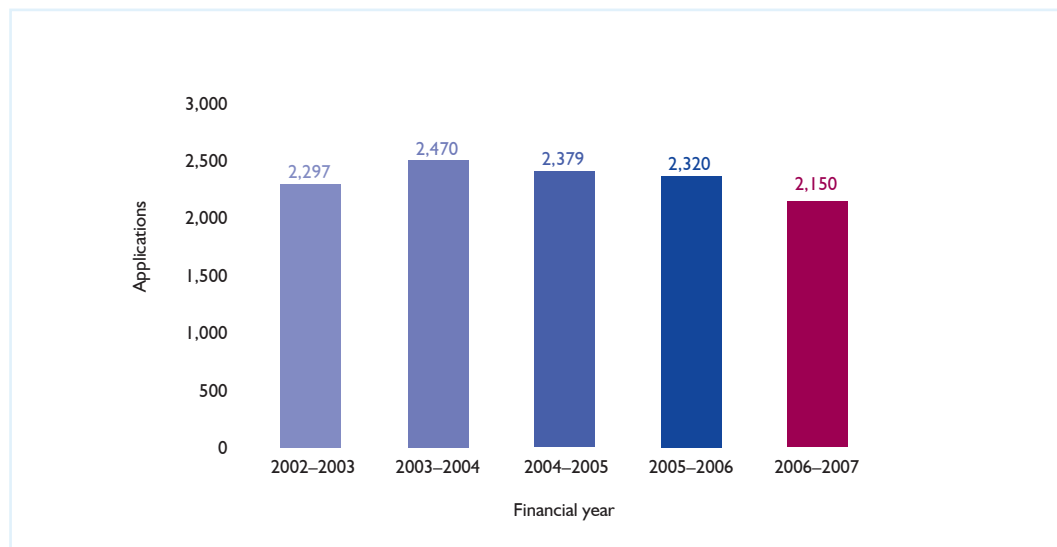
# Review of insurer decisions

## Applications received

In 2006–2007, 2,150 review applications were received (2,320 in 2005–2006). This 7.3% decrease continued the downward trend first experienced in 2004–2005.

The figure below shows the number of applications for review received over the last five years.

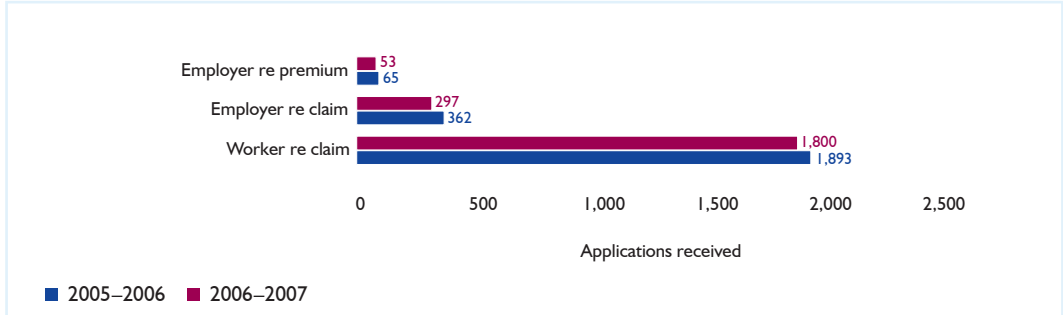
**FIGURE 55** Review applications received by financial year  
2002–2003 to 2006–2007



### Types of applications

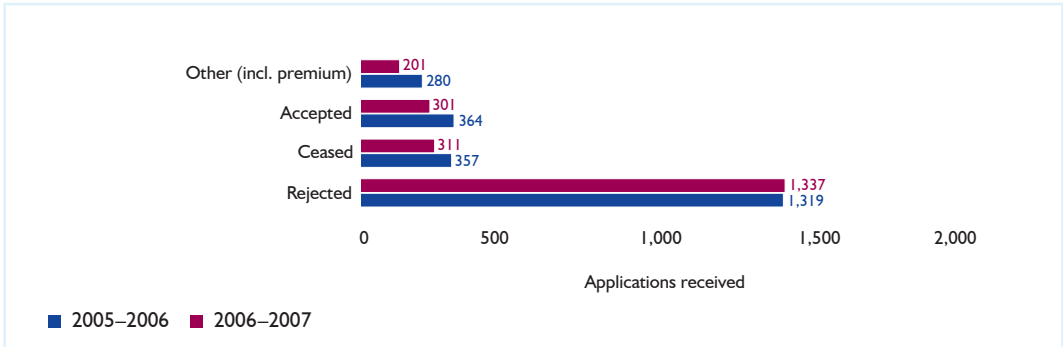
2006–2007 saw little change to the distribution of the type of review applications received compared to the previous financial year. Of the applications lodged, 83.7% were lodged by workers, 13.8% by employers, and the remaining 2.5% of applications were lodged by employers having a premium decision reviewed.

**FIGURE 56 Review applications received by type 2005–2006 and 2006–2007**



Over two thirds (62.2%) of all review applications received in 2006–2007 related to the insurer decision to reject the claim, 14.0% were lodged after the claim had been accepted, and a further 14.5% were following the cessation of the claim. In 2006–2007, the proportions for accepted, ceased and premium decisions claims have decreased, while rejected claims rose as a percentage of applications compared to 2005–2006.

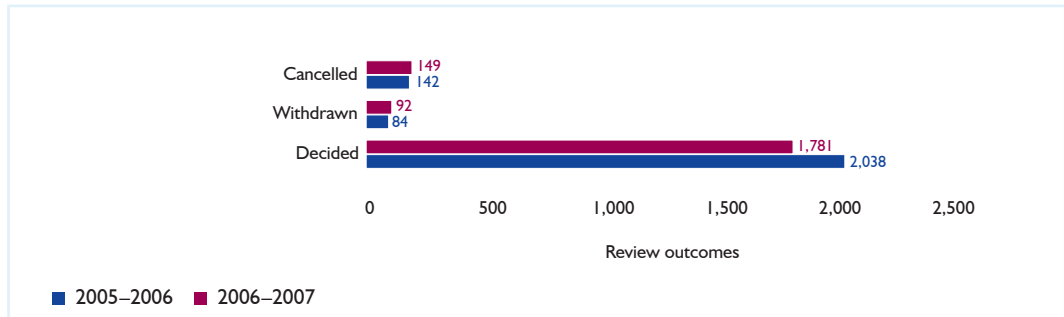
**FIGURE 57 Review applications received by insurer decision 2005–2006 and 2006–2007**



## Outcomes

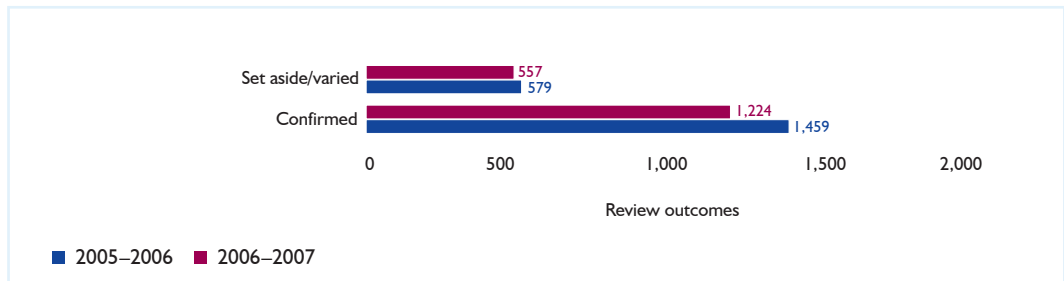
In 2006–2007, 88.1% of reviews finalised were decided (as compared to 90.0% in 2005–2006), 7.4% were cancelled (6.3% in 2005–2006), and the remaining 4.5% were withdrawn (3.7% in 2005–2006). made, compared to 71.6% in 2005–2006.

**FIGURE 58 Review outcomes 2005–2006 and 2006–2007**



In 2006–2007, the original decision of the insurer was confirmed by the Review Unit in 68.7% of review decisions made, compared to 71.6% in 2005–2006.

**FIGURE 59 Decided review outcomes 2005–2006 and 2006–2007**



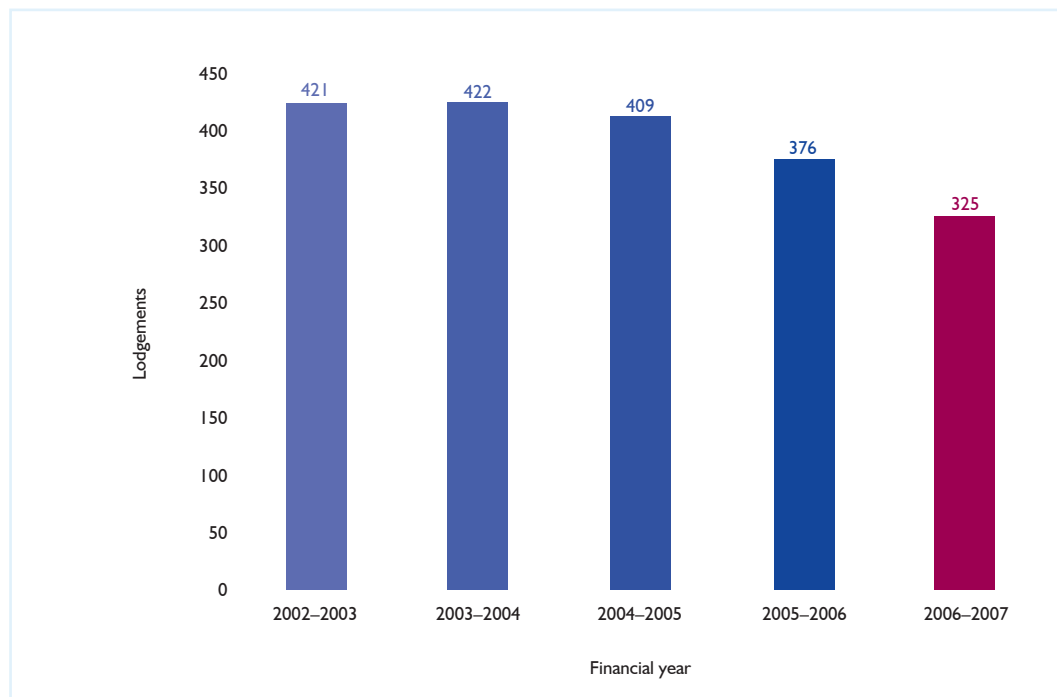
# Appeal of review decisions

## Appeal lodgements

In 2006–2007, 236 appeals were lodged with the Industrial Magistrate, 89 with the Queensland Industrial Relations Commission (QIRC) and 12 with the Industrial Court.

Appeal lodgements have experienced a decrease of 13.6% compared with 2005–2006.

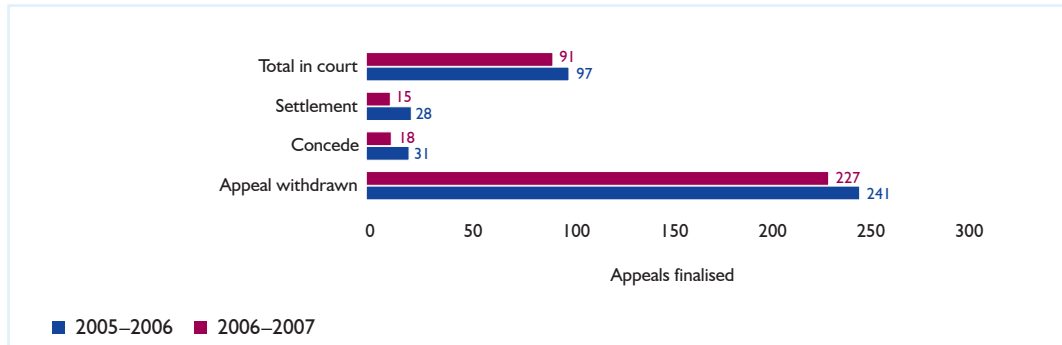
**FIGURE 60 Appeal lodgements by financial year 2002–2003 to 2006–2007**



## Appeal outcomes

In 2006–2007, almost three-quarters (74.1%) of appeals were finalised before reaching either the Industrial Magistrate or QIRC, with 87.3% of cases withdrawn by the appellant and a further 12.7% settled or conceded.

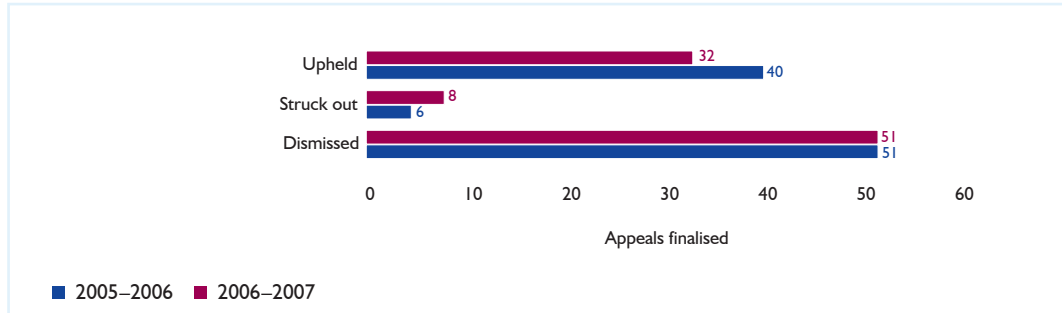
**FIGURE 61 Appeals finalised by outcome 2005–2006 and 2006–2007**



## Non-judicial resolution

In 2006–2007, 260 appeals were finalised before reaching the relative court/commission. This is a decrease of 13.3% when compared to 300 in 2005–2006.

**FIGURE 62 Appeals finalised judicially by outcome 2005–2006 and 2006–2007**



## Judicial resolution

A total of 91 cases were determined by a court/commission in the 2006–2007, representing a 6.2% decrease from the 97 cases determined in 2005–2006. Of these, 59 cases (64.8%) were dismissed or struck-out by the magistrate and 32 cases (35.2%) were upheld in favour of the appellant.

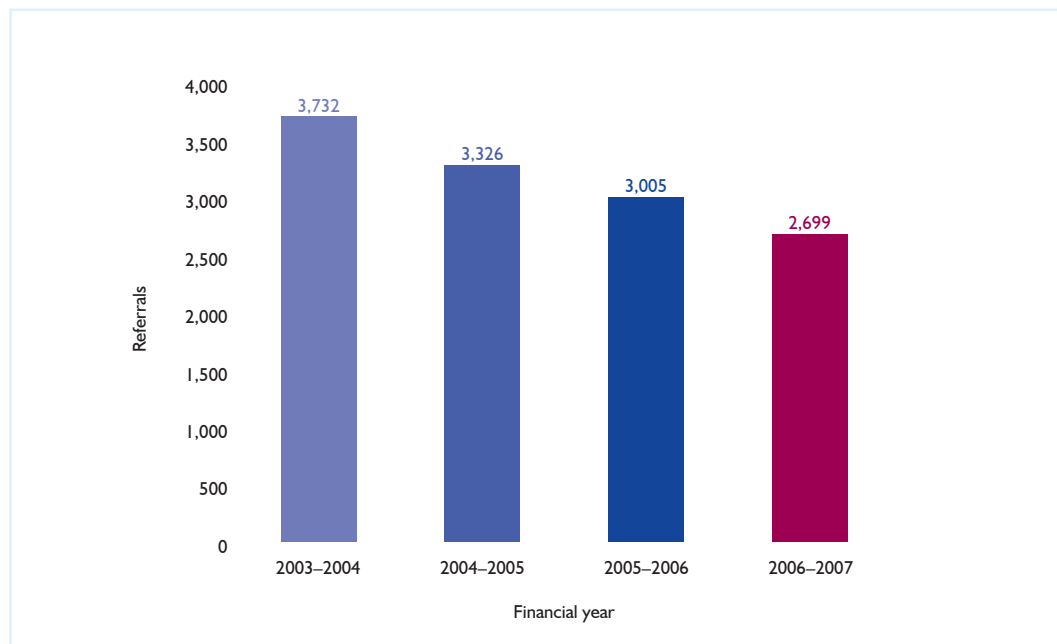
# Medical assessment tribunals (MAT)

## Referrals

In 2006–2007, 2,699 cases were referred to a MAT. This represented a 10.2% decrease on the 3,005 cases referred in 2005–2006. The main decrease was in the number of referrals to the Orthopaedic Tribunal, down 14.3% from 1,207 in 2005–2006 to 1,034 in 2006–2007.

The figure below illustrates the number of MAT referrals received over the past four years.

**FIGURE 63 MAT referrals received by financial year 2003–2004 to 2006–2007**



## Cases determined

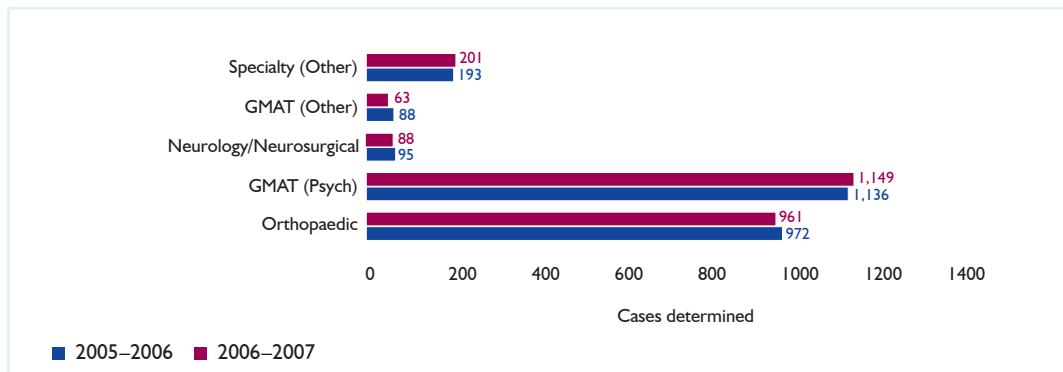
### Tribunal type

In 2006–2007, 2,462 cases were determined by a MAT. This represented a 0.9% decrease from 2005–2006 (2,484 determinations).

In 2006–2007, 1,149 cases were heard at a General Medical Assessment Tribunal – Psychiatric compared to 1,136 in 2005–2006 representing an increase of 1.1% for the period.

Almost half of all cases in 2006–2007 (46.7%) were determined at a General Medical Assessment Tribunal – Psychiatric compared to 45.7% in 2005–2006. A further 39.0% of cases were determined at an Orthopaedic Tribunal in 2006–2007 as compared to 39.1% in 2005–2006.

**FIGURE 64 Cases determined by tribunal type by financial year 2005–2006 and 2006–2007**



The figure below shows the average number of cases heard per tribunal in 2005–2006 and 2006–2007. While the number of cases determined has decreased, the average cases heard per tribunal has remained steady.

**FIGURE 65 Average number of cases heard per tribunal by tribunal type by financial year 2005–2006 and 2006–2007**

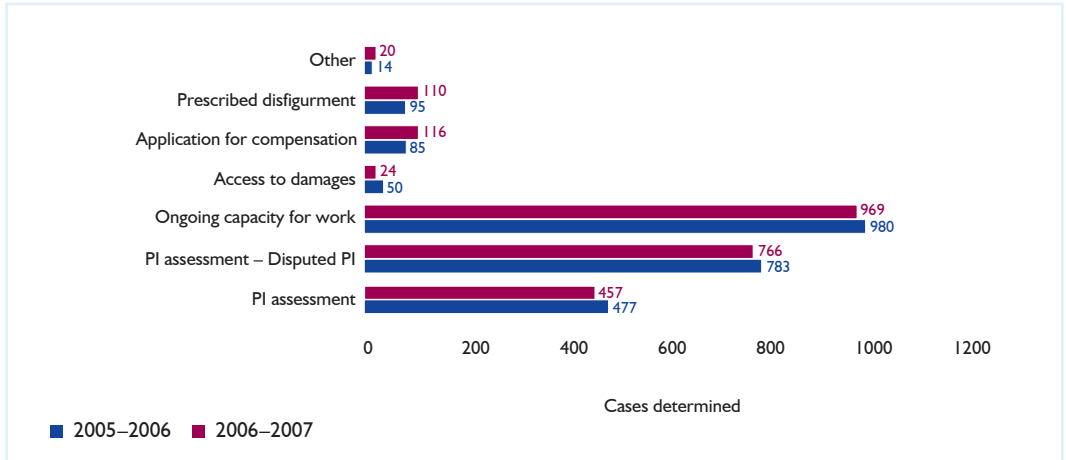
Tribunal	Average number of cases heard per tribunal	
	2005–2006	2006–2007
Orthopaedic	2.4	2.3
GMAT (Psych)	2.3	2.4
Neurology/Neurosurgical	1.9	2.0
GMAT (Other)	1.6	1.6
Specialty (Other)	5.2	4.7
<b>Average of all tribunals</b>	<b>2.4</b>	<b>2.4</b>

### Referral reason

In 2006–2007, approximately half (49.7%) of the cases determined by the MAT were for permanent impairment (PI) assessment, compared to 50.7% in 2005–2006.

There have been small decreases in the proportion of referrals for an initial PI assessment (down from 19.2% in 2005–2006 to 18.6% in 2006–2007) and for a disputed PI assessment (down from 31.5% in 2005–2006 to 31.1% in 2006–2007). The proportion of cases determined for assessment of ongoing capacity for work decreased slightly, down from 39.5% in 2005–2006 to 39.4% in 2006–2007.

**FIGURE 66 Cases determined by referral reason by financial year 2005–2006 and 2006–2007**



# Appendix: Definitions

## Statutory definitions

**Admitted claims** – The insurer allows the application for compensation and liability continues to be accepted by the insurer (this is considered to be an initial decision on the claim).

**Average finalised claim cost** – The average statutory cost of finalised claims.

**Average finalised time lost claim cost** – The average statutory cost of finalised time lost claims, including any excess amount paid for by the employer. Claims with compensation together with lump sum payments are included as time lost claims.

**Average finalised time lost claim durations** – Work days lost due to an injury on finalised time lost claims, including any work days lost paid for by the employer. Claims with compensation together with lump sum payments are included as time lost claims.

**Cancelled claims** – Intimated claims are cancelled when they are found not to need any further processing because the claim should never have been intimated (e.g. the application has already been intimated once on the system).

**Claim decisions** – The decision made on the claim after the claim has been entered or intimated onto the insurer's computer system. It refers to whether the insurer has accepted or rejected liability for the claim.

**Employees covered** – Under legislation, the type of workers covered by workers' compensation varies. Between 1 July 1997 and 30 June 2000 a "worker" was limited to PAYE taxpayers, before and after this period the definition of a worker included anybody working under a contract of service. Using ABS definitions, employees are always covered by workers' compensation. "Own account workers" are covered prior to 1 July 1997 and after 30 June 2000 and "employers" and "contributing family members" are not covered.

**Fatal claims** – All claims where an injury or disease caused the death of an injured worker, excluding cancelled and rejected claims.

**Finalised claims** – It is considered that the liability has ended through the normal course of the claim (even if it is possible that a continuation may occur in the future), or that an insurer has terminated entitlements to compensation.

**Industry** – All industry codes are based on the insurers' coding of industry to the divisions from the "Australian and New Zealand Standard Industry Classification" (ANZSIC), ABS.

**Injury nature** – All injury codes are based on the insurers' coding of injury to the nature and location codes of the "Type of Occurrence Classification System", Second Edition, National Occupational Health and Safety Commission (NOHSC) and the "Type of Occurrence Classification System", Third Edition, National Occupational Health and Safety Commission (NOHSC). Where large numbers of injury nature classifications occurred (such as strain/sprain and open wound) they have been further broken down using the location of the injury.

**Intimations** – All claims lodged with insurers, regardless of the outcome (i.e. includes cancelled and rejected claims).

**Medical expense only claim** – All claims which have had medical treatment and rehabilitation payments, excluding those that also had weekly compensation or fatality payments.

**Mesothelioma/asbestosis** – The injury nature codes '630', '810' and '860' from the "Type of Occurrence Classification System", Second Edition, National Occupational Health and Safety Commission (NOHSC) and injury nature codes '783', '861' and '866' from the "Type of Occurrence Classification System", Third Edition, National Occupational Health and Safety Commission (NOHSC) have been renamed mesothelioma/asbestosis injuries in this publication.

**Permanent impairment (PI)** – A permanent impairment from an injury is an impairment that is stable and stationary and not likely to improve with further medical or surgical treatment.

**Psychiatric and psychological injuries** – The injury nature code '910' from the "Type of Occurrence Classification System", Second Edition, National Occupational Health and Safety Commission (NOHSC), and injury nature codes '702', '703', '704', '705', '706', '707', '718' and '719' from the "Type of Occurrence Classification

System", Third Edition, National Occupational Health and Safety Commission (NOHSC) have been renamed psychiatric and psychological injuries in this publication and includes claims commonly referred to as "stress" claims.

**QOTE** – The *Workers' Compensation and Rehabilitation Act 2003* describes QOTE for a financial year as being "the seasonally adjusted amount of Queensland full time adult persons ordinary time earnings as declared by the Australian Statistician in the statistician's report about average weekly earnings published immediately before the start of the financial year". QOTE is used in certain circumstances by insurers when calculating a person's compensation payments.

**Rejected claims** – The application for compensation is rejected (this is considered to be an initial decision on the claim).

**Regions** – Regions are based on Australian Standard Geographical Classification (ASGC) 2005 Edition. More information concerning statistical areas is contained in "Australian Standard Geographical Classification, 2005", Cat No. 1216.0.

**Statutory claim payments** – All statutory payments made in the relevant year, including any payments for time lost made by the employer as part of the compensation period (excess) as reported by WorkCover Queensland.

**Time lost claims** – All claims which have resulted in time lost from work excluding fatalities, (i.e. compensation is paid for the time lost), including those with a lump sum payment. Claims with compensation together with lump sum payments are included as time lost claims.

**Withdrawn claims** – Intimated claims are withdrawn when no actual claim was lodged by the injured worker other than a medical certificate and account provided by the medical practitioner for the purpose of medical fax fee only. For the fee to be paid a claim number is required to be issued. This applies to WorkCover Queensland only.

## Common law definitions

**Average defendant's cost** – The average defendant's cost, regardless of when payments were made, of finalised common law claims (this does not include claims with a \$0 settlement amount).

**Average plaintiff's cost** – The average plaintiff's cost, regardless of when payments were made, of finalised common law claims (this does not include claims with a \$0 settlement amount).

**Average settlement cost** – The average settlement cost, regardless of when payments were made, of finalised common law claims (this does not include claims with a \$0 settlement amount).

**Average time from injury to lodgement** – The average time, in years, from injury date to common law lodgement. These are based on the lodgement year of the common law claim.

**Average time from lodgement to finalisation** – The average time, in years, from the common law claim lodgement to common law finalisation. These are based on the finalisation year of the common law claim.

**Common law claim lodgements** – All common law claims lodged with insurers, regardless of the outcome. If a common law claim is associated with more than one statutory claim, it will be counted for each statutory claim it is associated with (if one common law claim is associated with three statutory claims, the common law lodgement has been counted three times).

**Common law claim payments** – All common law payments made within the financial year.

**Defendant's costs** – Costs incurred by the defendant.

**Plaintiff's costs** – Costs incurred by the plaintiff.

**Settlement payments** – Settlement payments are calculated as the gross settlement amount less contributory negligence less contribution from third party less statutory claim payments.

## Medical assessment tribunal definitions

**Access to damages** – This is for instances where an application for statutory compensation has not been lodged and the insurer has not admitted that the worker sustained an injury. The worker is seeking common law damages.

**Application for compensation** – This reference is used when a worker has made an application for compensation. (Liability has not been accepted for the injury for which the worker is claiming). The insurer is unable to determine liability for the claim due to matters of a medical nature.

**Cases determined** – All cases heard and determined by the Medical Assessment Tribunals.

**GMAT (Other)** – General Medical Assessment Tribunals including the Medical, Vascular, Surgical, Urology, Gynaecology, Thoracic and Rheumatology specialties. (Excludes General Medical Assessment Tribunal – Psychiatric).

**GMAT (Psych)** – General Medical Assessment Tribunal – Psychiatric.

**Ongoing capacity for work** – The insurer is asking whether the worker's ongoing incapacity for work is related to the accepted work injury.

**Other reasons for referral** – Includes level of dependency, further material deterioration etc.

**PI assessment** – The insurer is asking the tribunal to determine whether the worker has sustained a permanent impairment. Under the legislation for psychiatric or psychological injuries the MAT must determine the degree of permanent impairment.

**PI assessment** – disputed PI – The insurer is asking the tribunal to determine whether the worker has sustained a permanent impairment. This reference would be used if the worker does not agree with the permanent impairment which has been independently assessed by the insurer.

**Prescribed disfigurement** – The insurer requests the tribunal to assess, by physical examination, whether the bodily scarring or facial disfigurement is severe enough to be considered prescribed disfigurement.

**Referral reasons** – The specific questions which can be asked of the Medical Assessment Tribunals are defined in the *Workers' Compensation and Rehabilitation Act 2003*.

**Specialty (Other)** – Medical Assessment Tribunals including the Cardiac, Dermatology, Ear, Nose and Throat, Ophthalmology and Disfigurement specialties.

## Review definitions

**Confirmed** – Insurers' decision is confirmed by the Review Unit.

**Set aside** – Insurers' decision is set aside by the Review Unit and a new decision substituted.

**Varied** – Insurers' decision is varied by the Review Unit.

## Appeal definitions

**Conceded** – Q-COMP indicates to the parties to the appeal and the court or commission that it will not be defending the review decision.

**Decided at court** – Appeals that have been dismissed, upheld or struck out at the Industrial Magistrates Court or Queensland Industrial Relations Commission.

**Dismissed** – After hearing evidence, the Magistrate or Commissioner has dismissed the appeal and confirmed the review decision.

**Settled** – The parties to the appeal have negotiated a settlement out of court.

**Struck out** – Appeals struck out by the Magistrate or Commissioner because of failure of the appellant to comply with legislative, court or Commission requirements.

**Upheld** – After hearing evidence, the Magistrate or Commissioner has upheld the appeal and set aside or varied the review decision.

**Withdrawn** – Appeals withdrawn by the appellant prior to hearing.

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