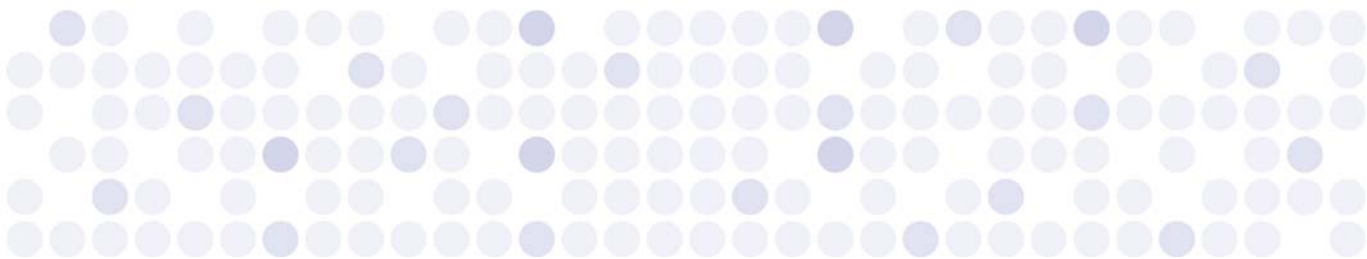


Claims management performance standards and guidelines

Queensland workers' compensation insurers

Effective: July 2011



Claims management standards and guidelines

Aim

High quality, consistent, compliant decision making across all workers' compensation insurers.

Philosophy of this document

Q-COMP's role as regulator of the Queensland workers' compensation scheme includes monitoring the performance and compliance of insurers. The performance of insurers includes the consistent application of the *Workers' Compensation and Rehabilitation Act 2003* (the Act), and the *Workers' Compensation and Rehabilitation Regulation 2003* (the Regulation). These guidelines are intended to support insurers in applying the legislation. The document does not diminish the insurers' obligation to comply with all legislative provisions.

To assist insurers in meeting their obligations under the Act and Regulation, Q-COMP has developed an *Insurer performance management program* (IPMP) which is aimed at both compliance and performance improvement.

This document provides guidance and sets standards, in addition to statutory obligations and licence conditions (where applicable) which will be taken into account in assessing insurer performance. Adherence to the standards in this document does not substitute for compliance with the requirements of the Act, Regulation and other licence conditions. Rather the aim in developing these standards is to assist insurers in achieving high quality, compliant, consistent decision making – across claims and insurers.

In some cases, specific guidelines have been developed which may assist insurers in meeting the standards. Where available these guidelines have been referenced in the document.

Insurers have identified the need for flexibility in the methods used to achieve consistent, quality claims outcomes. These performance standards focus on fair, compliant, consistent outcomes for workers and employers while allowing insurers to decide how best to meet the standards.

The onus is on insurers to demonstrate how they comply with the standards. Q-COMP will assess insurers' performance against the standards and guidelines through the elements of the IPMP including:

- Targeted Q-COMP audits as required and at licence renewal
- *Insurer self-assessment report* and *Action plans* as required by Q-COMP
- Stakeholder surveys
- Q-COMP monitoring of performance trends (e.g. claims decision timeframes) from insurer data and Q-COMP data
- Issues and complaints monitoring by Q-COMP.

The first section of the document discusses the principles that have informed the development of the specific performance standards.

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Principles

Give claimants and employers a reasonable opportunity to present their case

As a decision-maker, an insurer should give claimants and employers a reasonable opportunity to present their case prior to making a decision.

Act without bias

Decisions in relation to all aspects of claims should be made without bias. They should be made on the objective evidence available and exclude any assumptions or unsubstantiated information.

Apply procedural fairness

As decision-makers, insurers should ensure that procedural fairness principles are built in to their claims management process. Insurers should manage applications for compensation in the context of a 'no fault', non-adversarial statutory claims scheme and show reasonable flexibility in applying administrative requirements.

Respect privacy and confidentiality

Information collected during claims management activities should at all times be managed in accordance with the Act and Regulation, as well as any Commonwealth or State privacy requirements that apply. Any information collected by the insurer in its role as insurer may only be used for purposes related to the objects of the Act.

Be consistent

Insurers should develop processes which ensure consistent application of the legislation having regard to the requirement that each decision be based on its individual merits.

Clear and open written and verbal communication with stakeholders

Written and verbal communication with claimants, employers and medical and allied health providers should be clear, courteous and pitched at an appropriate level to convey information effectively. Information on workers' compensation insurer processes should be freely available to an insurer's stakeholders.

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Performance standards

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| 1. Compliance with all applicable legislation | |
| | The foundation for these performance standards and guidelines is compliance with the requirements of the Act, Regulation and, for self-insurers, any licence conditions. |
| 2. Privacy | |
| 2.1 | An insurer should have a privacy policy that complies with relevant legislation or government standards if applicable. |
| 2.2 | For self-insurers, all files, including archived files, both computerised and physical must be kept in secure facilities separate from other personnel files. |
| 2.3 | Access to files (including archived files, both computerised and physical) must be restricted to personnel using the files for workers' compensation and safe return to work purposes only. |
| 2.4 | Facilities for conducting interviews with claimants/workers in private should be provided. |
| 3. Communication | |
| 3.1 | Injured workers – access to information |
| 3.1.1 | An insurer should make information and documentation freely available and readily accessible to workers and other stakeholders regarding workers' compensation entitlements and claims lodgement processes. |
| 3.1.2 | When a dispute arises an insurer should make freely available and readily accessible suitable information which explains the dispute resolution processes available under the Act. |
| 3.1.3 | Requests for access to information by claimants are actioned in accordance with applicable legislation. Upon receipt of written notice of authority signed by the claimant or receipt of a request from the claimant's legal representative, appropriate documents are to be supplied within legislative timeframes. |
| 3.2 | Doctors and other registered persons |
| 3.2.1 | When communicating with a doctor an insurer should communicate in a clear, open and cooperative manner. An insurer should: <ul style="list-style-type: none">• be clear as to the purpose of contact e.g. claim determination, development of return to work plan, PI assessment etc• confine questions to matters that are medically and directly relevant to the current stage of the claim and for proactive case management• keep the claimant's treating doctor informed when an independent medical assessment has been requested and supply the treating doctor with a copy of the assessment. |

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| 3.2.2 | <p>When requesting a written report from a registered person an insurer should advise the registered person of:</p> <ul style="list-style-type: none"> • the type of report required • what the report is to be used for • relevant claims information including claim details and liability status • relevant previous reports • relevant workplace information. |
| 3.2.3 | <p>When requesting assessment of permanent impairment, an insurer should ensure the medical practitioner has access to a copy of the relevant <i>American Medical Association Guidelines to the Evaluation of Permanent Impairment</i>.</p> |
| 3.3 | Permanent impairment |
| 3.3.1 | <p>Adequate supporting documentation of assessment of permanent impairment should be documented on file.</p> <p>Correct notice of assessment/offer letter should be forwarded to claimant.</p> <p>All injuries are assessed and addressed in the offer.</p> |
| 3.3.2 | <p>When issuing a notice of assessment to a claimant an insurer must make it clear in the covering letter that:</p> <ul style="list-style-type: none"> • the claimant may agree or disagree with the notice of assessment; and • if an offer of lump sum compensation is made, the claimant may accept, reject or defer the offer • if the Notice of Assessment follows a medical assessment tribunal determination, there is no opportunity to agree or disagree |
| 3.3.3 | <p>When issuing a notice of assessment for 0% permanent impairment an insurer should not make an offer of lump sum compensation.</p> |
| 3.4 | Q-COMP directions |
| 3.4.1 | <p>Insurers are to comply with written Q-COMP Review Officer requests for information by providing complete files or copies of files including computerised, on-site records and hand written notes.</p> |
| 3.4.2 | <p>All potential fraud cases are reported to Q-COMP in a timely manner and in accordance with the Act (self-insurers only).</p> |
| 4. Data | |
| 4.1 | <p>Data supplied to Q-COMP is to be accurate and in accordance with the current Workers' Compensation Insurer's Data Specifications.</p> |
| 4.2 | <p>Insurers should action all data errors within one month and rectify within two to three months. No data errors are to be outstanding beyond six months.</p> |

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| 4.3 | Insurers should notify Q-COMP of any changes to their workers' compensation data systems at least 15 business days before implementation. |
| 5. Resourcing | |
| 5.1 | Claims management procedures |
| 5.1.1 | An insurer should have a comprehensive Claims Management Manual, or equivalent, that is consistent with all aspects of the <i>Workers' Compensation and Rehabilitation Act 2003</i> and <i>Workers' Compensation and Rehabilitation Regulation 2003</i> . |
| 5.1.2 | <p>The Claims Manual or equivalent should include policies and procedures relating to:</p> <ul style="list-style-type: none">• decision-making process• payment of claims• liability for treatment and other expenses• obtaining medical reports and opinions• ongoing management of claims• permanent impairment and lump sum compensation• claims for certain injuries such as industrial deafness, fatal claims and psychiatric and psychological disorders• journey and recess claims• referral to Return to work Assist• reviews and appeals• complaints handling• privacy, release of information, confidentiality• fraud identification• damages Claims• rehabilitation and Return to Work including Referral to internal / external rehabilitation providers• record keeping and documentation• quality management and improvement. |
| 5.2 | Professionalism, skills and competencies of workers' compensation personnel |
| 5.2.1 | The manager has at least a general knowledge of Queensland's system and legislation and ability to interpret the legislation. |
| 5.2.2 | Claims management personnel should be appropriately skilled. |

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| 5.2.3 | Claims management personnel that have decision-making responsibility for the management of applications for statutory compensation must be registered with Q-COMP. |
| 5.2.4 | All personnel participate in relevant ongoing training and professional development |
| 5.2.5 | All personnel have ready access to current information about the workers' compensation scheme such as Court decisions, guidance material from Q-COMP, the Act and Regulation as amended from time to time. |
| 5.3 | Managing the claim |
| 5.3.1 | <p>Processes and facilities must be in place to allow for files to be maintained for all individual cases. Evidence for each claim may include:</p> <ul style="list-style-type: none"> • application for compensation, and medical certification as required in the approved form • sufficient information to clearly identify the injury • sufficient information to enable a decision on liability at the time of determination • evidence of a decision on liability • calculation of weekly benefits (if applicable) • finalisation of claim (when appropriate) • adequate and accurate file notations and records for written and verbal communication, and are evidenced and dated by the responsible officer • sufficient information to pro-actively manage the rehabilitation and return to work aspects of claims • records of investigation expenses • medical and hospital expenses • rehabilitation expenses • lump sum compensation including assessment (where applicable) • recoveries (where applicable). |
| 6. Decisions on Claims | |
| 6.1 | An appropriate level of claims investigation should be carried out. |
| 6.2 | Decisions on liability on applications for compensation should be made in a timely manner and any delays or inactivity explained to the worker and employer. Whilst the legislation requires decisions within 20 business days (from January 2008). It is expected that for most claims decisions on liability will be made within 10 business days of intimation. |

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| 6.3 | <p>All material and information relied upon for decision-making should be:</p> <ul style="list-style-type: none">• clear, recorded and documented and capable of being proven if required upon a review or in any appeal court or tribunal• wherever possible provided to the other party for response if likely to affect them adversely prior to the making of the decision. |
| 6.4 | <p>Procedural fairness should be observed throughout the investigation, verification and decision-making process.</p> |
| 6.5 | <p>If an insurer requires a claimant to attend a medical examination for determination of liability or for assessment of ongoing capacity for work, the insurer should:</p> <ul style="list-style-type: none">• advise the claimant in writing of the purpose of the examination and make it clear that the examination is not related to treatment of the claimed injury• use a registered medical practitioner with appropriate expertise and having regard to the injury claimed in the application for compensation• provide the claimant's treating medical practitioner with a copy of the report. |
| 6.6 | <p>In making a decision on whether to allow, reject or cease an application for compensation an insurer should consider:</p> <ul style="list-style-type: none">• all reasonably obtainable evidence both adverse to and supportive of a worker's claim• relevant case law. |
| 6.7 | <p>Before an insurer decides to reject or cease an application for compensation on medical grounds:</p> <ul style="list-style-type: none">▪ there must be evidence in the form of a report from a registered medical practitioner qualified to give an opinion about the injury claimed and the medical practitioner shall have examined the claimant▪ there must be evidence in the form of a report from the claimant's treating medical practitioner. |
| 6.8 | <p>Where an insurer is unable to make a decision in the first instance due to conflicting medical evidence or the complex nature of injury, the insurer should make a referral to a medical assessment tribunal for determination of injury.</p> <p>The insurer should notify the claimant that they have been unable to make a decision and that the matter has been referred to a medical assessment tribunal.</p> <p>The referral to a medical assessment tribunal should be made within five business days of notifying the claimant.</p> |
| 7 Payments | |
| 7.1 | <p>Payment of weekly benefits, medical and other expenses should be made within five business days of the claim being accepted.</p> |
| 7.2 | <p>Payment of lump sums should be made in a timely manner upon receipt of claimant advice and payment details should be adequately recorded.</p> |

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| 8 Authority decisions | |
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| 8.1 | Subject to the operation of any law, act, regulation or rule of court to the contrary, an insurer must implement a review decision within five business days of receiving the decision. |
| 8.2 | If an insurer is unable to comply with a notice issued by Q-COMP under s544 of the Act, the insurer must notify Q-COMP within five business days of receiving advice of the notice providing reasons why the notice cannot be complied with. Q-COMP may extend the time for implementation of a review decision upon application by an insurer demonstrating good reason why more time should be allowed. |
| 9. Rehabilitation | |
| 9.1 | Policy |
| 9.1.1 | An insurer should have a policy setting out their commitment to rehabilitation for injured workers |
| 9.2 | Rehabilitation and return to work management |
| 9.2.1 | An insurer should have sufficient and appropriately trained resources to coordinate the development and maintenance of the rehabilitation and return to work plan for injured workers. |
| 9.2.2 | For each accepted claim of a serious or complex nature, or likely to result in total incapacity of more than four weeks, an insurer should develop a rehabilitation and return to work plan. The plan should be developed as early as is possible and in consultation with the worker, the employer and the worker's treating doctor and other registered persons. |
| 9.2.3 | An insurer should liaise with and support employers, employers' rehabilitation and return to work coordinators (RRTWC) and other relevant parties to monitor a worker's progress against the rehabilitation and return to work plan including the suitable duties plan if relevant. |
| 9.2.4 | Where appropriate, an insurer should assist the employer and the RRTWC to develop a suitable duties plan and, where required, refer the employer to appropriate medical and allied health professionals for assistance if required. |
| 9.2.5 | An insurer should provide an injured worker with the opportunity to raise concerns about their rehabilitation and return to work plan with the insurer. |
| 9.2.6 | An insurer must recognise an injured worker's right to choose his or her own treating doctor. |
| 9.2.7 | An insurer should keep accurate and objective case notes recording all communication between relevant parties for rehabilitation and return to work. |
| 10 Return to work Assist | |
| 10.1 | An insurer must refer an injured worker to Return to work Assist once the statutory claim is closed and the worker is unable to return to work. Referrals may also be made on receipt of a Notice of Claim if there hasn't been a referral previously. |