



Future Empowered Workshop – Employers & Employer Representatives

7 June 2024



CURRENT STATUS

- Act has been proclaimed to commence 1 July 2024
- New Regulations supporting the new Act enacted
- Administrative instruments published on the WorkCover WA website
 - Approved forms and notices
 - Guidelines, orders, determinations
 - Blueprints
- Stakeholder workshops



ADMINISTRATIVE INSTRUMENTS

Instrument	Description	Current Status
Principal Regulations	The principal regulations supporting the new Act.	Completed and enacted by the Governor.
WorkCover WA issued instruments	WorkCover WA issued Guidelines, Orders, and determinations – various.	Permanent Impairment Guidelines, Insurance related instruments published end of March.
Act approved forms	WorkCover WA CEO approved forms under the Act.	All key approved forms published.
Conciliation Rules and Arbitration Rules	Rules made by the Director, Conciliation Services, and Registrar, Arbitration Services.	Publication of Rules completed.
Costs Determination	New 2024 Costs Determination required to replace 2018 Costs Determination for legal and agent services in CAS.	Costs Committee convened in May. Draft determination out for consultation.
Medical and health fees orders (x4)	Fees orders for: medical and allied health services, workplace rehabilitation, impairment assessment.	Fee orders made and gazetted.
Transitional directions.	Transitional directions issued by CEO, Registrar, or Director relating to pending dispute proceedings.	In development.

SESSION OUTLINE

Topic	Content	Resources
Issuing or renewing policies - before 1 July 2024	• Status of pre-1 July 2024 WC & CIDF policies • Status of >75% loading applications • Status of pending appeals	• Act and regulations • Blueprint for Underwriters
Issuing or renewing policies - on or after 1 July 2024	• Status of policies issued or renewed from 1 July 2024 • Employer & insurer obligations • Remuneration declarations – approved form • Obligation to quote premium & insure • Prescribed policy & indemnity • WorkCover WA insurance instruments	• Act and regulations • Remuneration declaration approved forms • WorkCover WA issued instruments • Blueprint for Underwriters • Approved forms
Premium & industry classification reviews	• Requirements for premium review & industry classification review • Outcome of a review • WorkCover WA expectations	• Act and regulations • WorkCover WA issued instruments • Blueprint for Underwriters
Compensation claims & injury management	• Claims & liability decision notices • Provisional payments • Stopping income compensation – RTW • Settlements • Worker's treating medical practitioner & medical examinations • Return to work programs & return to work case conferences • Employer obligations - pre-injury position and dismissal	• Act and regulations • Blueprint for Liability decisions & provisional payments • Approved forms

ISSUING OR RENEWING POLICIES BEFORE 1 JULY 2024

Former (1981) Act policy:

- Issued or renewed with policy period commencing before 1 July 2024
- Includes 30 June 2024 renewals
- Savings & transitional provisions address inconsistencies between 1981 Act policy wording and coverage and indemnity required under new Act

Status of CIDF policies:

- Insurance Commission CIDF policy covers liabilities arising in respect of injury from employment up to 1 July 2024
- Workers compensation policy covers liabilities arising in respect of injury from employment from 1 July 2024
- Seamless transition: no gap

PENDING PREMIUM LOADING APPLICATIONS AND APPEALS

Status of pending >75% loading applications:

- Applications not determined by WorkCover WA Board lapse 1 July 2024

Status of pending premium and industry classification appeals:

- Pending appeals continue as reviews under new Act
- A pending appeal includes:
 1. If employer indicated intention to appeal before 1 July 2024
 2. If right to appeal arises because policy period commenced before 1 July 2024

ISSUING OR RENEWING POLICIES ON OR AFTER 1 JULY

What applies on or after 1 July 2024?

- Insurance obligations in Act and regulations
- Obligation to quote and insure
- Prescribed policy wording
- Remuneration declaration in approved form
- WorkCover WA recommended premium rates 2024/25
- WorkCover WA Remuneration Guidelines
- WorkCover WA Industry Classification Order
- Premium and industry classification review process



KEY EMPLOYER INSURANCE OBLIGATIONS

Must have a workers compensation policy & provide remuneration declarations at policy inception and renewal:

- increased penalties for non-compliance

Maintain records:

- keep insurance policy related records for 7 years

Principals and contractors:

- Principal not required to make remuneration declaration if covered by contractor's policy
- No change to status of contractual indemnities



REMUNERATION DECLARATION

Workers Compensation and Injury Management Act 2023
DECLARATION OF ESTIMATED REMUNERATION

The *Workers Compensation and Injury Management Act 2023* requires an employer applying for the issue or renewal of a workers compensation policy to declare the estimated total remuneration to be paid or payable to the employer's workers for the proposed policy period of their workers compensation policy. This estimate is used to calculate the employer's premium for the proposed policy period.

To help you complete this form we have enclosed or attached a supporting document for your reference titled **Important Information**, which explains terms used in this form, and includes other information relevant to making a declaration of estimated total remuneration.

1. Policy details
Policy number: _____
Policy period: _____
From: _____
To: _____
WorkCover WA Number: _____

2. Employer details
Insured employer name: _____
Postal address: _____
ABN: _____
Business description: _____
Primary business location: _____
Contact phone number: _____
Contact email: _____

Workers Compensation and Injury Management Act 2023
DECLARATION OF ACTUAL REMUNERATION

The *Workers Compensation and Injury Management Act 2023* requires an employer as soon as practicable after the end of the policy period in their workers compensation policy to declare the total remuneration actually paid or payable to the employer's workers over the previous policy period.

To help you complete this form we have enclosed or attached a supporting document for your reference titled **Important Information**, which explains terms used in this form, and includes other information relevant to making a declaration of actual total remuneration.

1. Policy details
Policy number: _____
Policy period: _____
From: _____
To: _____
WorkCover WA Number: _____

2. Employer details
Insured employer name: _____
Postal address: _____
ABN: _____
Business description: _____
Primary business location: _____
Contact phone number: _____
Contact email: _____

0002496276
WorkCover WA Approved Form 902 – v1.0 (01/01/2023) (08)
Effective from 1 July 2024

Approved forms:

- Declaration of Estimated Remuneration
- Declaration of Actual Remuneration
- Employer must provide at policy inception/ renewal

Important information document:

- Provided by insurer to employer
- Flexibility in content and delivery

Employer non-compliance:

- Offence – WorkCover WA regulatory action
- Policy can still be issued or renewed

INSURER OBLIGATION TO QUOTE AND ISSUE POLICY

Insurer must not refuse to:

- Issue a workers compensation policy to any employer
- Renew a workers compensation policy to an employer
- Provide a quote of the premium demanded

Exception:

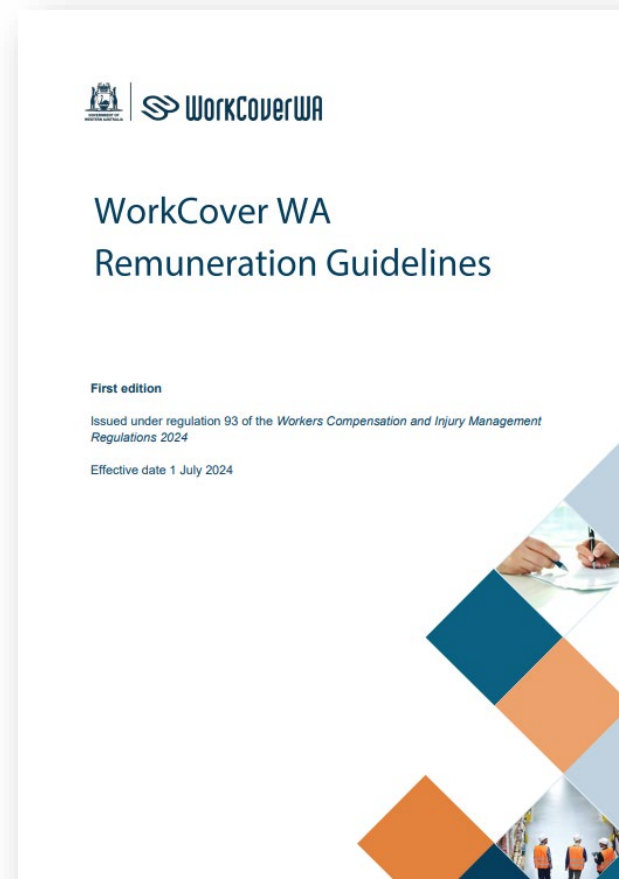
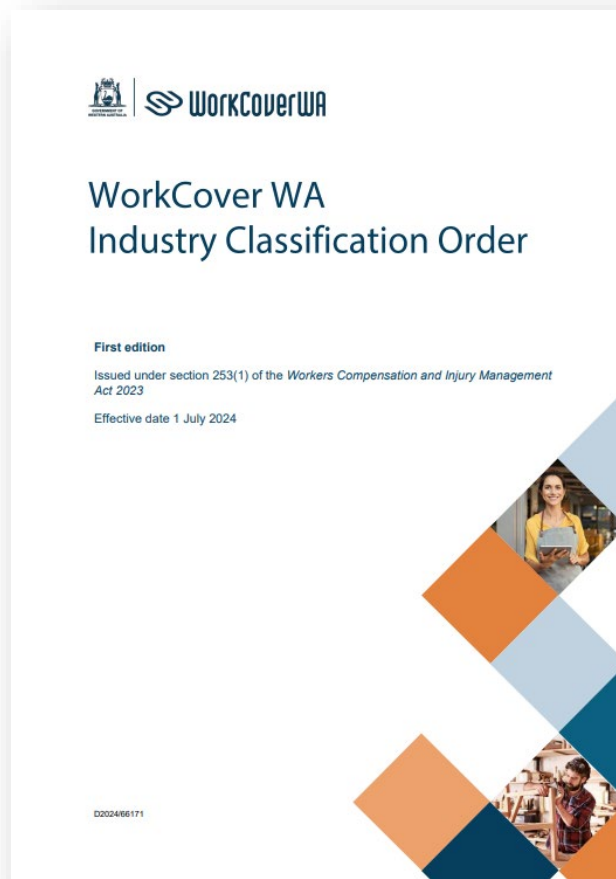
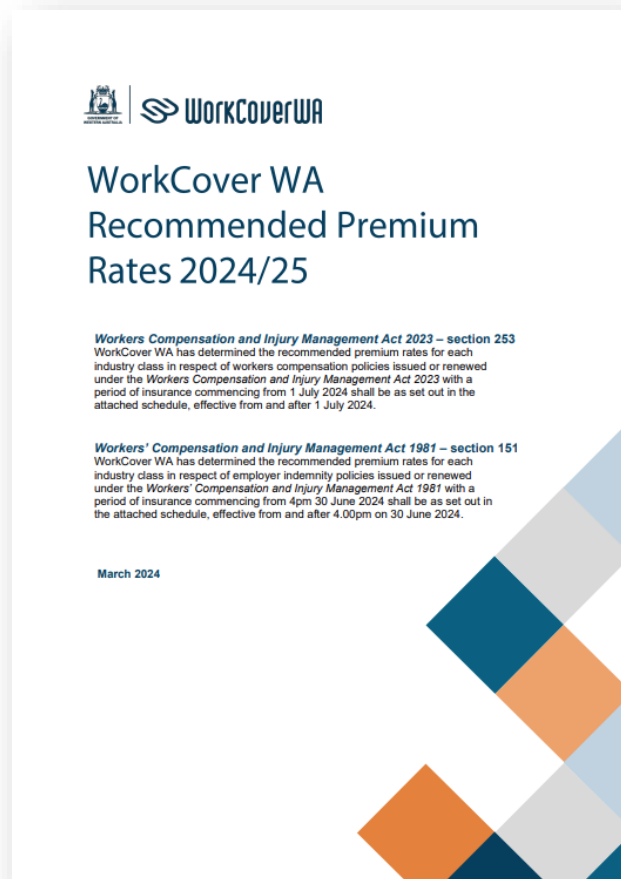
- Employer failed to comply with request for information 'reasonably required' by insurer
- Regulations sets out information that can be reasonably required



WHAT'S IN THE POLICY?

- Prescribed terms, conditions, exclusions
- Generally consistent with longstanding industry policy wording
- Removal of “reasonable precautions” clause
- Flexibility to make additions via schedule
- Flexibility for principal/ contractual indemnities/ waivers
- Indemnity refusal constrained

WORKCOVER WA INSURANCE INSTRUMENTS



PREMIUM AND INDUSTRY CLASSIFICATION REVIEWS

Requirements apply to review application:

- Application made within 1 month
- Reasonable efforts to resolve
- State grounds of objection & industry classification or premium sought

Premium review:

- Available only if premium determined is at least 75% greater than recommended premium rate

Outcome of review & WorkCover WA expectations



MAKING A CLAIM

Workers Compensation and Injury Management Act 2023

Workers Compensation Claim Form

Insurer please complete

Insurer name: _____ Estimated time off work: ☐ less than one day ☐ 1-4 work days (inclusive) ☐ 5-9 work days (inclusive) ☐ 10-20 work days (inclusive) ☐ more than 20 work days

Claim number: _____

ANZSIC Code: _____

Policy number: _____

WorkCover number: _____

Has employer contacted medical practitioner: ☐ Y ☐ N ☐ fatality

Date form received from employer: _____

DATE STAMP

ANZSCO (office use only)

Employer please complete

Name of policy holder/employer: _____ ABN: _____

Trading as (if different to above): _____

Contact person name: _____ Phone: _____ Email: _____ Postcode: _____

Address of injured worker's usual workplace or base: _____

Major activity of workplace (eg sheep farming, stumping): _____

Date employer received the completed claim form from the injured worker: _____

Date employer sent the claim form and Certificate(s) of Capacity to insurer: _____

Worker please complete

Surname: _____ Date of Birth: ☐ Male ☐ Female ☐ Unspecified

Other names: _____

Address: _____ Preferred language: (if not English)

Suburb/City/Town: _____ Postcode: _____

Email: _____

Daytime contact phone number: _____

Occupation: _____

Main tasks/duties performed (eg welding of high pressure steam pipes): _____

☐ full time (F) ☐ part time (P) ☐ casual (C)

☐ permanent (P) ☐ temporary (T) ☐ casual (C)

At the time of the injury I was working as a: ☐ direct employee ☐ sub contractor ☐ working director ☐ visa worker ☐ contractor ☐ other ☐ employee of contractor ☐ if other, please specify: _____

Other Employment *If more than one employer, please attach details on separate sheet*

Do you have any other job? ☐ Y ☐ N If yes, please give details: _____

Employer name: _____ Phone no: _____ Hours per week: _____

Occurrence details *Attach separate sheet if more space is required*

Day of occurrence: _____ Date of occurrence: _____ Time of occurrence: ☐ AM ☐ PM

At what address did the occurrence happen? _____

Did you have to stop working? ☐ Y ☐ N If so when? Date: _____ Time: ☐ AM ☐ PM

Where you: ☐ working - at your normal workplace ☐ working from home ☐ on work break - at normal workplace ☐ working - away from normal workplace ☐ on work break - away from normal workplace ☐ working - road traffic accident ☐ commuting/journey ☐ other duty status

Describe the occurrence. Include: _____

(i) What action was involved (i.e. lift, work by object) _____

(ii) What object/machine/substance was involved (i.e. forklift, door frame) _____

(iii) The injury or disease caused (i.e. fracture, torn discus) _____

(iv) The bodily location of the injury or disease (i.e. upper arm, eye) _____

WorkCover WA Staff Only

Mechanism

Agency

Nature

Bodily location

WorkCover WA Approved Form CPT - v1 (3-2022) Effective from 1 July 2024

Workers Compensation Claim Form

Workers - Keep this section for your information

Who can make a claim?

You are entitled to make a claim if you suffer an injury from employment and are defined as a worker.

How to claim:

Seek first aid and report the injury to your employer

See a doctor of your choice as soon as possible and get a Certificate of Capacity. This is known as a First Certificate of Capacity in the workers compensation system.

Fill out the inside pages of this form and give it and your First Certificate of Capacity to your employer.

Your employer must complete their part of the claim form and give it together with the First Certificate of Capacity to their insurer within 7 days of receiving the claim form.

The insurer has 14 days to assess the claim and make a decision to do one of the following

Accept the claim

Not accept the claim

Defer making a decision

Workers compensation entitlements are payable

No entitlements are payable - you can dispute this decision

No entitlements are payable unless liability decision notice not given in time

What happens if you don't agree with the insurer's decision?

Your employer's insurer has an internal dispute resolution process. You can approach the insurer to re-examine their decision.

In addition, WorkCover WA provides assistance regarding resolving disputes.

To find out more about having a dispute resolved or for general information about workers compensation and injury management contact WorkCover WA's Advice and Assistance line on 1300 794 744.

What happens when my claim is deferred?

An insurer or self-insurer can defer making a decision on your claim if they need more time to make a decision.

Insurers and self-insurers must give you either a liability decision notice or a deferred decision notice within 14 days of receipt of the claim. If neither of these notices are given within 14 days, liability is taken to be accepted.

If a liability decision notice cannot be given within 28 days of receipt of the claim, provisional payments will become payable.

While your claim is being assessed, consider using any accrued leave (sick leave or annual leave) to provide you with interim financial support. If your claim is accepted, any leave you have used will be reinstated by your employer.

WorkCover WA is the government agency responsible for overseeing the Workers Compensation and Injury Management Act 2023.

Workers Compensation and Injury Management Act 2023

FIRST certificate of capacity

1. WORKER'S DETAILS

First name: _____ Last name: _____

Date of birth: _____ Email: _____

Phone: _____ Address: _____

2. EMPLOYMENT DETAILS

Worker's job title: _____ Employer's name: _____

Employer's address: _____

3. CONSENT AUTHORITY

I consent to any medical practitioner who treats me (whether named on this certificate or not) to discuss my medical condition with my employer, insurer and other medical or allied health professionals for the purpose of my claim for workers compensation and return to work options.

Worker's signature: _____ Print name: _____

Date: _____

4. WORKER'S DESCRIPTION OF INJURY

Date of injury: _____

What happened?: _____

Worker's symptoms: _____

5. MEDICAL ASSESSMENT

Date of this assessment: _____

Clinical findings: _____

Diagnosis: _____

The injury is consistent with worker's description of how injury occurred ☐ yes ☐ no ☐ uncertain

The injury is: ☐ a new condition ☐ a recurrence of a pre-existing condition

03/24/2023 WorkCover WA Approved Form CPT - v1 (3-2022) Effective from 1 July 2024

Workers Compensation and Injury Management Act 2023

PROGRESS certificate of capacity

1. WORKER'S DETAILS

First name: _____ Last name: _____

Date of birth: _____ Claim no. _____

Phone: _____ Email: _____

Address: _____

2. EMPLOYER'S DETAILS

Employer's name: _____ Employer's phone: _____

Employer's address: _____

3. MEDICAL ASSESSMENT

Date of this assessment: _____ Date of injury: _____

Diagnosis: _____

4. WORK CAPACITY

Having considered the health benefits of work, I find this worker to have:

☐ full capacity for work from _____ to _____ but requires further treatment

☐ some capacity for work from _____ to _____ performing: _____

☐ pre-injury duties ☐ modified or alternative duties ☐ workplace modifications

☐ pre-injury hours ☐ modified hours of ☐ hrs/day ☐ days/week

☐ no capacity for any work from _____ to _____ (outline clinical reason on next page)

5. WORK CAPACITY

Worker's usual duties: _____

Having considered the health benefits of work, I find this worker to have:

☐ full capacity for work from _____ to _____ but requires further treatment

☐ some capacity for work from _____ to _____ performing: _____

☐ pre-injury duties ☐ modified or alternative duties ☐ workplace modifications

☐ pre-injury hours ☐ modified hours of ☐ hrs/day ☐ days/week

☐ no capacity for any work from _____ to _____ (outline clinical reason on next page)

6. MEDICAL PRACTITIONER'S DETAILS

Name: _____ AHNRA no. MED _____

Address: _____ Email: _____

Phone: _____ Signature: _____

Fax: _____ Date: _____

03/24/2023 WorkCover WA Approved Form CPT - v1 (3-2022) Effective from 1 July 2024

Workers Compensation and Injury Management Act 2023

FINAL certificate of capacity

1. WORKER'S DETAILS

First name: _____ Last name: _____

Date of birth: _____ Claim no. _____

Phone: _____ Email: _____

Address: _____

2. EMPLOYER'S DETAILS

Employer's name: _____ Employer's phone: _____

Employer's address: _____

3. MEDICAL ASSESSMENT

Date of this assessment: _____ Date of injury: _____

☐ The worker's condition is unlikely to change substantially in the next 12 months

4. WORK CAPACITY

Having considered the health benefits of work, I find this worker to have:

☐ full capacity for work from _____ to _____ but requires further treatment (outline specific needs)

☐ capacity for work from _____ hours per day and _____ days per week from _____

as outlined below. (Please outline the worker's physical and/or psychosocial capacity for work, functional limits, ongoing need for workplace modifications, and/or further treatment needs)

☐ lift up to _____ kg

☐ sit up to _____ mins

☐ stand up to _____ mins

☐ walk up to _____ m

☐ work below shoulder height

☐ The worker's incapacity is no longer a result of the injury

5. REASON FOR CAPACITY/INCAPACITY

Please outline your clinical reason for the worker's capacity/incapacity: _____

6. MEDICAL PRACTITIONER'S DETAILS

Name: _____ AHNRA no. MED _____

Address: _____ Email: _____

Phone: _____ Signature: _____

Fax: _____ Date: _____

03/24/2023 WorkCover WA Approved Form CPT - v1 (3-2022) Effective from 1 July 2024

6. WORK CAPACITY

Worker's usual duties: _____

Having considered the health benefits of work, I find this worker to have:

☐ full capacity for work from _____ to _____ but requires further treatment

☐ some capacity for work from _____ to _____ performing: _____

☐ pre-injury duties ☐ modified or alternative duties ☐ workplace modifications

☐ pre-injury hours ☐ modified hours of ☐ hrs/day ☐ days/week

☐ no capacity for any work from _____ to _____ (outline clinical reason below)

Worker has capacity to: _____

(Please outline the worker's physical and/or psychosocial capacity - refer to explanatory notes for examples. Where there is no capacity for work, please provide clinical reasoning.)

☐ lift up to _____ kg

☐ sit up to _____ mins

☐ stand up to _____ mins

☐ walk up to _____ m

☐ work below shoulder height

7. INJURY MANAGEMENT PLAN

Activities/interventions: _____ Purpose/goal (likely change in symptoms, function, activity and work participation): _____

I would like: ☐ more information about available duties ☐ a RTW program to be established ☐ to be involved in developing the RTW program

Examples of injury management activities/interventions include:

- Further assessment - diagnostic imaging, medical specialist consults, workplace assessment
- Intervention - physiotherapy, clinical psychology, exercise physiology, provided medications, workplace modification
- Return to work planning - identify suitable duties, establish return to work program

8. NEXT REVIEW DATE

☐ Worker does not need to be reviewed again (FIRST and FINAL certificate of capacity)

☐ I will review worker again on _____ (if greater than 14 days, please provide clinical reasoning)

Comments: _____

9. MEDICAL PRACTITIONER'S DETAILS

Name: _____ AHNRA no. MED _____

Address: _____ Email: _____

Phone: _____ Signature: _____

Fax: _____ Date: _____

(Practice stamp - optional)

03/24/2023 WorkCover WA Approved Form CPT - v1 (3-2022) Effective from 1 July 2024

5. WORK CAPACITY (CONTINUED)

Worker has capacity to: _____

(Please outline the worker's physical and/or psychosocial capacity - refer to explanatory notes for examples. Where there is no capacity for work, please provide clinical reasoning.)

☐ lift up to _____ kg

☐ sit up to _____ mins

☐ stand up to _____ mins

☐ walk up to _____ m

☐ work below shoulder height

6. INJURY MANAGEMENT PLAN

Activities/interventions: _____ Purpose/goal (likely change in symptoms, function, activity and work participation): _____

I support the RTW program established by the employer/insurer/WSP dated _____

I would like more information about available duties

I would like to be involved in developing the RTW program

Please engage a workplace rehabilitation provider (if you have made a referral, provide name and contact details below)

Examples of injury management activities/interventions include:

- Further assessment - diagnostic imaging, medical specialist consults, workplace assessment
- Intervention - physiotherapy, clinical psychology, exercise physiology, provided medications, workplace modification
- Return to work planning - identify suitable duties, establish return to work program

7. NEXT REVIEW DATE

☐ I will review worker again on _____ (if greater than 28 days, please provide clinical reasoning)

Comments: _____

8. MEDICAL PRACTITIONER'S DETAILS

Name: _____ AHNRA no. MED _____

Address: _____ Email: _____

Phone: _____ Signature: _____

Fax: _____ Date: _____

(Practice stamp - optional)

03/24/2023 WorkCover WA Approved Form CPT - v1 (3-2022) Effective from 1 July 2024

RESPONDING TO CLAIMS

- Completing liability decision notices
- Must be in approved form

Workers Compensation and Injury Management Act 2023
LIABILITY DECISION NOTICE – ACCEPTED

Worker
Name: _____
Address: _____
Date of birth: _____
Phone number: _____
Email address: _____

Employer
Name: _____
Address: _____
ABN: _____

Claim
Insurer: _____
Insurer claim number: _____
Date of injury: _____
Date claim given to insurer: _____

Date of notice: _____

LIABILITY DECISION
In relation to the above claim we accept the employer is liable to compensate you for the injury.

We accept / do not accept *[delete as applicable]* the employer is liable for payment of income compensation for incapacity for work resulting from the injury.

Compensation
Compensation includes:

- Reasonable medical and health expenses. Please provide the claim number above to the health provider or practitioner for these expenses to be paid. Other forms of compensation are subject to eligibility.

D2024/08863 WorkCover WA Approved Form DN1 – v1 [s.28(2)(a)]
Effective from 1 July 2024

Workers Compensation and Injury Management Act 2023
DEFERRED DECISION NOTICE

Worker
Name: _____
Address: _____
Date of birth: _____
Phone number: _____
Email address: _____

Employer
Name: _____
Address: _____
ABN: _____

Claim
Insurer: _____
Insurer claim number: _____
Date of injury: _____
Date claim given to insurer: _____

Date of notice: _____

DEFERRED DECISION
In relation to the above claim we are informing you that a decision on whether liability is to be accepted for this claim is not able to be made within the time allowed and the decision has been deferred.

Reason(s) and details:

- ☐ Further medical information required: _____
- ☐ Wage information required: _____
- ☐ Further investigations required: _____
- ☐ Other information required: _____

D2024/08865 WorkCover WA Approved Form DN4 – v1 [s. 28(4)]
Effective 1 July 2024

LIABILITY DECISIONS – CRITICAL TIMEFRAMES

- **Liability decision notice or deferred decision notice:** within 14 days after insurer or self-insurer receives the claim.
- **Provisional payments day:** day after the period of 28 days beginning on the day on which the insurer or self-insurer receives the claim.
- **Deemed liability acceptance day:** day after the period of 120 days beginning on the day on which the insurer or self-insurer receives the claim.



LIABILITY DECISIONS – MAKING PROVISIONAL PAYMENTS

- **Provisional payments of income compensation:**
from date of incapacity until insurer or self-insurer gives liability decision, or Certificate of Capacity indicates no longer any incapacity for work.
- **Provisional payments for medical and health expenses:**
from date of injury until insurer or self-insurer gives liability decision. Capped at 5% of medical and health expenses general limit.



WORKCOVER WA EXPECTATIONS

Liability decisions:

- Made in time, no exceptions
- No declining claims simply to avoid making provisional payments
- No inappropriate use of CAS to dispute claims due to administrative error

Deferred decisions:

- Complete medical and factual investigations in timely manner
- Consider other options if preferred specialist not available

Provisional payments:

- Paid in all cases where decision not given in time

Evaluation and monitoring



STOPPING OR REDUCING INCOME COMPENSATION

Income compensation payments cannot be reduced, suspended or discontinued, except in accordance with the Act.

Return to work

- Requirement if worker has returned to work: notice to worker in approved form

Medical evidence

- Requirement if medical evidence given by insurer or self insurer indicates capacity for work: notice to worker in approved form & 21 days for response

Consent by worker

Other circumstances & notices



SETTLEMENTS

- Single statutory settlement pathway. Separate pathway to common law damages and settlement.
- Streamlined process for lodging settlement documents.
- Compliance and expectations.
- PI % and PI compensation amount must be recorded correctly
- New settlement agreement form to be used after 1 July 2024
- Transitional issues

INJURY MANAGEMENT & RETURN TO WORK

Rights and obligations:

- Worker's treating medical practitioner
- Medical examinations
- Return-to-work programs
- Return-to-work case conferences
- Maintain pre-incapacity position for 12 months
- Worker cannot be dismissed solely or mainly due to incapacity for work
- Workplace rehabilitation services



RETURN TO WORK CASE CONFERENCES

Attendance:

- Worker (mandatory) and support person (optional)
- Treating medical practitioner, employer, employer's insurer, WRP

To be discussed:

- Matters to support worker's recovery and return to work

Not to be discussed:

- Challenging clinical findings, or factual information in claim form or Certificate of Capacity

Frequency:

- Worker not required to attend more frequently than once every four weeks

workcover.wa.gov.au



Advice and Assistance
1300 794 744



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