



WORKCOVER NSW 2009 CLAIMS ESTIMATION MANUAL

DECEMBER 2009

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Purpose

The *Claims Estimation Manual* outlines WorkCover's requirements regarding the estimation of claims. This Manual applies to all open, reopened and new workers compensation claims that are subject to the *Workers Compensation Act 1987* ("1987 Act") and *Workplace Injury Management and Workers Compensation Act 1998* ("1998 Act").

Scheme Agents/Insurers must:

- estimate the claim in accordance with this Manual
- review estimates at each review of the claim (either scheduled or event driven) to ensure the estimate is up to date

This Manual is not a claims administration or injury management manual – for requirements regarding claims management and administration refer to:

- *WorkCover Guidelines for Claiming Workers Compensation Benefits;*
- *WorkCover Benefits Guide;*
- Nominal Insurer *Operational Instructions* and *Self and Specialised Insurer Guidelines;*
- *WorkCover Claims Technical Manual;*
- various gazetted Fees Orders; and
- *Workers Compensation Regulation 2003.*

Commencement

This Manual applies to every new estimate and every review of an estimate that takes place on or after 4pm 31 December 2009, regardless of the date of the injury.

Using this Manual

The Manual sets out:

1. The approach and process that must be followed for every claim estimated - refer to Part 1;
2. Detailed requirements for each type of claim - refer to Part 2; and
3. This Manual is also used to calculate estimates for claims administered under the retro paid loss scheme.
4. Amounts used in this Manual will be reviewed as required in accordance with changes in legislation, gazettes, Operational Instructions and Self and Specialised Insurer guidelines. The Manual will be updated in accordance with the changes.

Monitoring estimates

WorkCover will monitor estimates through self-audit results, statistical analysis and claim reviews. Correct estimates are critical to the accurate calculation of premium.

PART 1: APPROACH AND PROCESS

Chapter A: Estimating Approach

1. The Scheme Agent/Insurer must:
 - 1.1 keep claim estimates up to date even in between scheduled and event driven review points;
 - 1.2 build claims estimation into the organisation's routine case management and review processes;
 - 1.3 use the amounts specified in this Manual unless there is evidence otherwise, then use a soundly-based decision making process to estimate claims
 - 1.4 maintain accurate estimates on claims to ensure the premium is correctly calculated;
 - 1.5 ignore the possible effect of inflation when estimating and always use current amounts;
 - 1.6 where the estimate is constantly being changed review the claim in its entirety for accuracy;
 - 1.7 exclude payments already made, unless otherwise directed in the relevant section in this Manual;
 - 1.8 all amounts in this Manual and all estimate amounts are to include GST;
 - 1.9 exclude recovery or adjustments arising from Input Tax Credit or Decreasing Adjustment Mechanism;
and
 - 1.10 maintain an appropriate estimate on the claim until it is finalised.

Chapter B: Estimating Process

Evidence Required To Support Review Estimate (the Worksheet)

2. The Scheme Agent/Insurer must keep detailed records of each review showing at least:

- the review has been completed;
- the factors making up the total estimate;
- any reasons why the estimate is not in accordance with this Manual;
- the date on which the estimate or review was completed; and
- signature of estimate reviewer or computer identification code.

Details of the estimate calculations must be documented in hard copy on the claim file or by an IT system record. This document is required for any future section 170 applications.

Requirements for computer records

3. If the details are recorded only on the Scheme Agent/Insurer IT system, the system must keep a historical record of all the estimates and reviews on the file including the date on which the estimate or review was prepared and the identification of the authorising officer. These documents are required for any future applications for review of the premium by an employer under section 170 of the 1987 Act.

The following worksheet shown is a guide:

CLAIMS OUTSTANDING ESTIMATE WORKSHEET as at
DO NOT INCLUDE ANY PAID AMOUNTS

WorkerDate of Birth
Date of accident or injuryExpected Return to Work date.....

1. WEEKLY BENEFITS - Worker or Dependents - include Death benefits paid under S25 (2)

- a) Compensation payments - Award Rates
Fromto.....@ \$.....pw x weeks =\$.....
Fromto.....@ \$.....pw x weeks =\$.....
- b) Compensation payments - Statutory Rates
Fromto.....@ \$.....pw x weeks =\$.....
Fromto.....@ \$.....pw x weeks =\$.....
- c) Compensation payments - Partial
Fromto.....@ \$.....pw x weeks =\$.....
Fromto.....@ \$.....pw x weeks =\$.....
- TOTAL WEEKLY BENEFITS** \$.....

2. MEDICAL & ASSOCIATED EXPENSES

- a) Medical, Doctor etc. \$..... x years \$.....
- b) Hospital \$..... x years \$.....
- c) Rehabilitation \$..... x years \$.....
- d) Other (e.g. aids, equipment, travel, accommodation, home care, etc). \$.....
- SUB TOTAL** \$.....

3. STATUTORY LUMP SUM AWARD

- a) Death Benefits S.25 Lump sum & dependants \$.....
S.27/28 Funeral expenses \$.....
- b) S.66 Permanent Impairment \$.....
- c) S.67 Pain & Suffering \$.....
- SUB TOTAL** \$.....

4. COSTS

- a) Investigation Costs \$.....
- b) Worker's Legal Costs \$.....
- c) Agent/Insurer Legal Costs (other than Common Law) \$.....
- SUB TOTAL** \$.....

5. CONTRIBUTION FROM OTHER INSURERS LESS \$.....

6. RECOVERABLE LESS \$.....

7. WORKERS COMPENSATION ESTIMATE SUB - TOTAL \$.....

8. WORK INJURY DAMAGES (refer to Operational Instruction 1.17) \$.....

ESTIMATE \$.....

AUTHORISED BY..... DATE.....

Worker Entitlements

4. The worker and/or their dependants are entitled to the benefits set out under New South Wales legislation. The relevant sections are outlined in the table below. The Scheme Agent/Insurer must ensure a soundly based decision making process has been undertaken using all the available information in consideration of all the relevant benefits for every estimate, and for every review of an estimate. As more information becomes available, a worker's entitlements may change. The estimate must be kept up to date in relation to every potential benefit the worker may be entitled to receive.

	Description	The 1987 Act Section
Death	With and without dependents	25
	Funeral expenses	26
	Expenses transporting body	28
Weekly Income Support	First 26 weeks total incapacity	36
	After 26 weeks total incapacity	37
	Job seeking	38
	Make-up pay	40
Medical, Hospital & Rehab	Ambulance	60
	Dental	
	Hospital	
	Medical or related	
	Artificial aids	
	Pharmaceutical	
	Home care	
	Home modifications	
	Medical treatment	
Occupational rehabilitation		
Other	Car and other travel for treatment	63
	Interpreter	64A
Non-economic loss	Permanent impairment	66
	Pain and Suffering	67
Property Damage	Artificial aids	74
	Damage to clothing	75
Work Injury Damages	Work Injury Damages	151

Chapter C: Calculating medical, hospital, rehabilitation (section 60) and other expenses

Considerations when calculating expenses for medical, hospital, rehabilitation etc

5. When calculating the estimate of future section 60 expenses (medical, hospital, rehabilitation, etc.) the Scheme Agent/Insurer must take into account the nature and severity of the injury, as well as the need for and the anticipated costs of any medical treatment. The Scheme Agent/Insurer must ensure the treatment is reasonably necessary and evidence based.

Evidence of Costs

- 5.1 The Scheme Agent/Insurer must pro-actively gather relevant information to make an informed decision about the costs to estimate. Always review estimates when new information comes to hand. Information can include but not be limited to:

- specialist reports;
- Injury Management Consultant and/or other investigation reports;
- requests for approval for surgery and/or provision of services;
- rehabilitation reports; and
- WorkCover Medical Certificates, etc.

Treatment is complete

- 5.2 The Scheme Agent/Insurer must remove the estimate when the service or treatment is complete and paid and it is anticipated that no further service or treatment is required.

For example:

- Once surgery has been performed and the post operative specialist report has been reviewed to exclude further surgery or extended hospital admission, and confirmation has been received from the provider that all payments have been made, future expenses are not required unless there will be costs for removing fixative devices.
- If a worker has returned to duties for longer than 4 weeks without wage loss in a manner that is sustained and durable, generally any allowances for rehabilitation expenses need not be included.

Limits for medical expenses and property damage compensation

- 5.3 Sections 61, 62, 63, 63A(3), 76 and 77 of the 1987 Act outline the maximum limits prior to further approval by WorkCover for which an employer is liable to pay compensation. These limits are gazetted through the *WorkCover Benefits Guide*, which is issued each April and October. Scheme Agents/Insurers must estimate in accordance with this Manual. Estimated amounts are not to be restricted to the applicable limits.

Section	Description
61	Medical or related treatment
62	Hospital treatment
63	Ambulance service
63A	Occupational rehabilitation services
76	Damage to artificial limbs, spectacles
77	Damage to clothing

Chapter D: Recoveries

6. Scheme Agents/Insurers are able to recover costs incurred on a claim through the application of Section 151z. Some common forms of recovery include:

- Compulsory Third Party;
- Industrial deafness;
- Public liability; and
- Shared claims.

Recovery can be included in an estimate when the other party has admitted liability, or where the potential for recovery is:

- clearly apparent;
- sustainable at law;
- soundly anticipated; and
- verified by a suitably qualified person.

Recovery Amounts

7. The recovery estimate must be based on the information available on file. If Rule 6 pre-conditions have been met and there is insufficient evidence for quantum then estimate 50%.

At subsequent review points, if there is no clear information regarding the likelihood of recovery, then reduce the recovery estimate to zero. If there is evidence that liability exists but the quantum is unknown, continue to use 50%. In consideration of reducing the estimate, review any police reports, factual investigation reports, etc or obtain legal advice before reducing the estimate to zero. Where these reports confirm clear liability exists, then continue to estimate for recovery.

If up to date information is received, at any point, immediately update the estimate. This may result in a recovery greater than 50%.

Amounts to apply the recovery percentage to

8. Apply the recovery percentage to all parts of the estimate but not the:
- first five days of a worker's weekly benefit where the injury was sustained in a motor vehicle accident for injuries prior to 1/10/2008;
 - investigation costs; and
 - legal costs.

Agents/Insurers should familiarise themselves with the provisions and limitations pursuant to CTP legislation e.g. assessment of lump sum entitlements, and calculate the estimate accordingly.

Example 1.

The worker allegedly slipped on a foreign substance on the floor of the local take-away shop during their lunch hour. The exact circumstances are unknown. Therefore, the recovery estimate is nil, pending investigation.

File Estimate	\$40,000
Nil Recovery Allowance	\$0
Gross Estimate	\$40,000

Example 2.

The worker alleges his stationary vehicle has been hit in the rear and is still awaiting the Police Report. The worker's initial medical certificate states the worker will be unfit for 4 weeks. The worker is paid \$1,000 per week under an award. The first five days of weekly compensation benefits is only recoverable from the Compulsory Third Party insurer for accidents on or after 1/10/2008.

	Injury prior to 1/10/2008	Injury on or after 1/10/2008
File Estimate	\$10,000	\$10,000
Less 1 st week of weekly compensation benefits	\$1,000	N/A
Sub-total	\$9,000	\$10,000
Less 50% Recovery Allowance	\$4,500	\$5,000
Sub-total	\$4,500	\$5,000
Plus Investigation Estimate	\$1,000	\$1,000
Gross Estimate	\$5,500	\$6,000

Example 3.

During a property inspection the worker fell down an open ditch on third party property. Recovery potential exists.

File Estimate	\$40,000
Less 50% Recovery Allowance	\$20,000
Sub-total	\$20,000
Plus Legal Costs Estimate	\$2,000
Plus Investigation Estimate	\$2,000
Gross Estimate	\$24,000

Example 4

The worker has lodged an industrial deafness claim on their current employer. The worker has worked for the current employer for 2 years. Prior to that they worked for another employer for three years. Investigations confirm both employers are classified as noisy. The worker has received no previous settlement for industrial deafness.

File estimate for hearing loss, hearing aids and medical expenses.	\$20,000
Less recovery estimate from previous employer (3 years / 5 years)	\$12,000
Gross estimate	\$8,000

Chapter E: Disputed and litigated claims

9. Claims must be estimated in accordance with this Manual even when the claim is disputed, litigated or 'reasonably excused' (refer to the *WorkCover Guidelines to Claiming Compensation Benefits* for information on potential grounds for dispute). Schedules 6 and 7 of the *Workers Compensation Regulation 2003* must be used when estimating for legal costs.

Calculating an estimate for a disputed claim

- 9.1 For a disputed claim, the estimate is calculated the same way as for a claim that is not in dispute. Include all amounts claimed even if they may not be paid and include an estimate for legal costs. Use Part 2 of this Manual to calculate the estimate.

This includes those notifications where a reasonable excuse has been applied (for not commencing provisional payments of weekly compensation).

Claim for Work Injury Damages

- 9.2. Refer to Operational Instruction 1.17.

Removing or reducing estimates on litigated/disputed claims

- 9.3 If a reasonable excuse exists or if a dispute or payment discontinuance notice has been issued to the worker, maintain the estimate for at least 3 months after the date that notice was issued to the worker. If the worker and/or their solicitor have not responded within 3 months, then consider whether to reduce the estimate or finalise the claim.

If a claim has been disputed and a Scheme Agent/Insurer receives a request for a review under s287A of the 1998 Act and/or a request for information from a solicitor in order for them to advise the worker on their entitlements, the claim must remain open for a further 3 months after either the date of the review or the supply of the requested information.

The claim must remain open with an estimate for any outstanding reimbursement schedules or accounts for investigation expenses requested by the Scheme Agent/Insurer. The claim may be finalised once these payments have been made and a sound decision process regarding finalisation has taken place.

Estimated legal amounts for litigated/disputed claims

- 9.4 Scheme Agents / Insurers are to estimate for legal costs in a staged and sequential manner.

General resolution types

- 9.5 Initial estimates for legal costs for a disputed matter that falls within "General resolution types", must as a minimum reflect the item cost associated with resolution of the issue/s in dispute using the criteria for a "Application to Resolve a Dispute accepted by the Registrar of the Workers Compensation Commission".

If the matter does not resolve in accordance with the anticipated outcome, the estimate must be increased to reflect the next stage of dispute resolution.

Estimates must also include allowances for regulated disbursements as appropriate.

Estimates for all other matters

- 9.6 Estimates for legal costs in all other matters must have regard to the issue/s in dispute and use the corresponding Item/s from the relevant Table/s.

Chapter F: Timing of Estimates

10. The Scheme Agent/Insurer must complete:

- an estimate on receipt of an initial notification or a claim - refer to Rule 11;
- regular ongoing estimates - refer to Rule 12;
- an updated estimate upon receipt of any new information or documentation (e.g. request for medical procedure or change in circumstances such as a change in medical certification) - refer to Rule 12; and

This also applies to claims for which recovery is being pursued.

Initial Estimates

11. The Scheme Agent/Insurer must complete an initial estimate of the claim within one week of receiving the claim or an initial notification. This includes those claims where a reasonable excuse has been applied for not commencing provisional payments of weekly compensation benefits.

Delay in notification of the injury

11.1 If the initial notification of the injury to the Scheme Agent/Insurer is more than 5 days but less than 6 weeks after the worker notified the employer of the injury, estimate in accordance with Schedule One and/or the appropriate Table. If notification of the injury is delayed by 6 weeks or greater, use the relevant review point outlined in the following table to determine the estimate, unless medical evidence supports an alternative estimate:

If the claim is reported ...	Use the following review points ...
6 weeks and greater after the date of the injury	12 week review
12 weeks and greater after the date of the injury	26 week review
26 weeks and greater after the date of the injury	52 week review
52 weeks and greater after the date of the injury	104 week review

Examples of the next review point – when the notification of injury has been delayed

Example 1 – next review point is 26 weeks

- If the first notice of a claim is received 16 weeks after the date of injury, calculate the initial estimate as a 26-week review. Refer to Chapter I, Table 1.

Review the claim next at the 26-week review point or when new information is received.

Example 2 – next review point is 52 weeks

- If the first notice of a claim is received 40 weeks after the date of injury, calculate the initial estimate as a 52-week review. Refer to Chapter I, Table 1.

Review the claim next at the 52-week review point or when new information is received.

Ongoing review of estimates

12. The Scheme Agent/Insurer must review estimates:

- within 14 calendar days (but no later than the policy renewal date) either side of each of the review points shown below; and
- in between these review points as new information comes to hand.

12.1 As a minimum, review each open claim:

- 12 weeks after the date of injury;
- 26 weeks after the date of injury;
- 52 weeks after the date of injury;
- 78 weeks after the date of injury;
- 104 weeks after the date of injury; and
- bi-annually after 104 weeks after the date of injury.

Timing of reviews in third and later years

12.2 Scheme Agents/Insurers can select between 2 methods for deciding when to conduct reviews in the third and later years. The 2 methods are known as Method A and Method B.

Method A

Scheme Agents/Insurers must review all claims that are still open more than 104 weeks after the date of the injury:

- between 1 March and 31 May; and
- between 1 September and 30 November.

Method B

Scheme Agents/Insurers must review open claims in the third and later years at ongoing 26-week anniversaries (e.g. 156 weeks, 182 weeks and 208 weeks, etc.) from the date of the injury. As with reviews in the first 2 years, the review must be conducted within 14 calendar days either side of the relevant anniversary.

For example, if the worker is injured on 1 March, then the 156-week review must take place within 14 calendar days either side of 1 March.

Other factors to consider when completing ongoing estimates

12.3 The Scheme Agent/Insurer must consider these factors when completing the estimate:

- factual, surveillance or medical investigations. If any are likely, allow as a minimum \$1,000 but review as new evidence becomes available;
- recovery action - refer to Chapter D;
- Permanent Impairment/Pain and Suffering (Section 66/67) - refer to Chapter M;
- wage re-imbusement schedules - refer to Rule 16;
- expected legal expenses - refer to Chapter E; and
- check the weekly benefit rate. For example, the section 37 statutory rate, the current weekly wage rate, or the average weekly earning increases as well as the number of dependants. Adjust as required and use the new amount to calculate the estimate.

Annual independent peer reviews

13. Each year, an independent person is to comprehensively review the estimate for every open claim. The independent person is to be a suitably experienced, expert independent case manager or a senior staff member who is not responsible for the daily management of the file. The independent review is to be conducted during a scheduled review each year.

Chapter G: General Estimate Practices

Workers on a Continuing Award

14. If the worker has a Continuing Award, calculate the estimate on the basis that it will be paid to the worker until one year after their retiring age. If the Award is altered or rescinded, update the estimate. Refer to Operational Instruction 1.25 regarding the management of Continuing Award claims.

Insufficient evidence to adjust the estimate

15. The Scheme Agent/Insurer must not change the estimate based on the following:
 - unsupported information from any source (including the employer or a rehabilitation provider) that the worker has, or will, return to work on full duties;
 - the worker returning to work with or without the support of the treating doctor:
 - unless the worker was off work for 12 weeks or less from the injury date and has returned to work with no ongoing wage loss for a continuous period of more than 2 weeks;
 - in all other instances, the worker has returned to work on full duties for a continuous period of more than 4 weeks.
 - surveillance reports;
 - An allegation of fraud.

Wage Reimbursement Agreements

16. Claims must be estimated in accordance with this Manual. Scheme Agents/Insurers must not reduce or change an estimate without supporting evidence that substantiates a worker's capacity for work i.e. whether there is an entitlement to weekly compensation benefits or not. Scheme Agents/Insurers should refer to Operational Instruction 1.2 for further information on the approach to managing wage reimbursement schedules and agreements.

Estimating Requirements - Weekly Benefits – Retiring

17. In calculating estimates for weekly compensation benefits, if a worker remains totally unfit for work or is working but continuing to receive 'make-up' pay or is able to work but the employer is unable to provide suitable duties, then:
 - if the injury occurred before the retiring age, weekly benefits are paid for a maximum of 12 months after the worker has reached retiring age; or
 - if the injury occurred after the retiring age, weekly benefits are paid for a maximum of 12 months after the first date of weekly benefits for the incapacity for work.

Any estimate should take this into account. If there is no clear evidence about expected period of incapacity, use the period shown in Schedule One for the worker's type of injury.

Worker's employment is terminated/made redundant

18. If a worker who has an entitlement to weekly compensation benefits under section 36, 37, 38 or 40 has their employment terminated or is made redundant (including a worker who was working suitable duties with no "make up" pay), the Scheme Agent/Insurer must immediately increase the estimate as shown in the following table, plus include an allowance for any unpaid or outstanding weekly benefit amounts:

If the worker's employment was terminated and/or made redundant ...	increase the total estimate to ...
up to 26 weeks after the date of the injury	104 weeks of weekly compensation benefits.
more than 26 weeks but before 52 weeks after the date of the injury	The lesser of 6 years of weekly compensation benefits; or 80% of the period of incapacity from the date of review to retiring age plus one year.
more than 52 weeks from the date of the injury	The lesser of 8 years of weekly compensation benefits; or 80% of the period of incapacity from the date of review to retiring age plus one year.
subsequent review points. That is, after 78 and 104 weeks from the date of the injury, and ongoing bi-annual reviews for the life of the claim.	the lesser of 8 years of weekly compensation benefits; or the period of incapacity from date of review to retiring age plus one year.

Worker Recommences Employment

18.1 If the worker recommences employment after termination adjust the estimate having regard to the circumstances of the claim and Rule 15.

PART 2: REQUIREMENTS FOR EACH TYPE OF CLAIM

Chapter H: Worker Incapacity

19. The following table assists in determining which of these categories the worker is in and refers to the relevant section of this Manual:

Worker's Incapacity	Incapacity status	Refer to
If the worker is unable to perform any work at all but is expected to be able to return to work at some stage.	Temporarily totally incapacitated Section 36/37	Chapter I
If the worker is (any one or more of the following): <ul style="list-style-type: none"> unlikely to be re-employed or vocationally retrained; likely to require ongoing care; and/or is in receipt of an award allowing for continuing weekly compensation benefits for total incapacity. 	Permanently totally incapacitated Section 36/37	Chapter J
If the worker: <ul style="list-style-type: none"> can only do some of the work requirements of their previous job; is able to continue with all of their duties but only by working at a slower pace and they are earning less money as a result; is employed with the same or a different employer and is earning less as a result of the injury; and/or is in receipt of an award allowing for continuing weekly compensation benefits for partial total incapacity. 	Temporarily partially incapacitated or permanently partially incapacitated Section 40	Chapter K
If the worker is able to perform work but the employer is unable to offer suitable duties. To be eligible for these entitlements, the worker must be taking reasonable steps: <ul style="list-style-type: none"> to obtain suitable employment; and/or to improve their employment prospects. "Reasonable steps" include: seeking a job, or seeking or receiving rehabilitation training, job retraining or WorkCover approved work trials. If the worker is able to perform work but the employer is unable to offer suitable duties and 52 weeks of section 38 weekly compensation benefits have elapsed, then the worker is compensated under section 40. Refer to Chapter K.	Temporarily partially incapacitated Section 38	Chapter L
If the worker's injury has resulted in a permanent impairment.	Permanently impaired Section 66 Section 67	Chapter M
If the worker sustained a hearing loss	Section 66 Section 69A Section 69B	Chapter N
If the worker is deceased	Section 25 Section 26 Section 28	Chapter O

Chapter I: Temporary Total Incapacity

20. This section applies to Workers:
- where there is evidence demonstrating total incapacity to work; but
 - they are expected to be able to return to work at some stage.

You may also use this section to estimate costs where there is evidence on file to indicate that the worker will only be off work for short periods, such as an aggravation or removal of internal fixatives following surgery. Estimate should be based on the facts of each case.

In situations where a worker sustains an injury (e.g. Hernia) but does not initially require time off work but at a later date undergoes surgery and is then unfit, estimate the claim in accordance with Schedule One or such other available information.

Estimating for weekly compensation payments

21. When estimating, the Scheme Agent/Insurer must always consider the worker's capacity for work at the time of the review. Include in the estimate the total amount of weekly compensation payments for the number of weeks the worker is expected to be off work. Refer to Table 1: Temporary Total Incapacity.

Worker or employer does not claim section 36/37 entitlements:

- 21.1 If the worker is entitled to section 36/37 benefits, the Scheme Agent/Insurer must include the amount in the estimate regardless of whether or not the employer is claiming those benefits. The Scheme Agent/Insurer must maintain an estimate until the claim is finalised. Refer to Operational Instruction 1.4.

Current estimate likely to be inadequate prior to the next scheduled review

22. If an estimate is likely to be inadequate at any time, the Scheme Agent/Insurer must review the claim and re-estimate as appropriate.

If the estimate is likely to be inadequate in the first 12 weeks

- 22.1 Base the new estimate on the information available.

If the estimate is likely to be inadequate after 12 weeks

- 22.2 Ensure the estimate is calculated using this Manual for the most recent review. If there is still not enough estimate then base the estimate on any information available. If no information is available or if it is insufficient the Scheme Agent/Insurer should then proceed to the next review point in advance.

Reducing an estimate

23. The Scheme Agent/Insurer can reduce an estimate for a claim for Temporary Total Incapacity when the worker returns to work with no ongoing wage loss. The timeframe for reducing an estimate is different depending on how long the worker has been off work from the date of the injury.

If the Worker was off work for:

- 12 weeks or less from the injury date and has returned to work with no ongoing wage loss for a continuous period of more than 2 weeks; and
- in all other instances, the worker has returned to work on full duties for a continuous period of more than 4 weeks.

If the worker has returned to work performing suitable duties (and has an ongoing wage loss), review the estimate in accordance with Section 40. Refer to Chapter K.

If the worker has a medical certificate certifying them as fit for suitable duties but none are available, review the estimate in accordance with Section 38. Refer to Chapter L.

Worker requires time off work after returning to work

23.1 If the worker requires time off work after returning to work and the estimate has been previously reduced as described in Rule 23, the Scheme Agent/Insurer must estimate in accordance with the following table:

Expected period of incapacity on available evidence ...	Weekly Benefits, Medical, Hospital, Other ...
Less than 4 weeks	Estimate on the scenario most likely to arise for that claim. This may be a Schedule One estimate.
4 weeks and more	Estimate using the next review point determined by the date of injury unless medical evidence indicates a Schedule One estimate is more appropriate.

Worker has returned to work with no wage loss but requires ongoing medical treatment

23.2 Where a worker has returned to work and there is an indication that ongoing medical treatment is required, allow a minimum of \$1,250 for medical treatment. If a referral has been made for rehabilitation, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional \$2,000. Update the estimate upon receipt of additional information and review the estimate at the next review point.

**WORKCOVER NSW
2009 CLAIMS ESTIMATION MANUAL
Table 1: Temporary Total Incapacity**

Benefits – Section 36 and 37								
1.1: Initial Estimate								
Weekly	Medical, Hospital, Rehabilitation expenses						Investigation and Other expenses	
<p>Include the total amount of weekly compensation payments for the number of weeks that the evidence suggests the worker will be off work or refer to Schedule 1.</p> <p>Evidence to consider:</p> <ul style="list-style-type: none"> discussions with the employer, worker, doctor and rehabilitation provider; the current medical certificate. Review dates and the expected period of incapacity; the anticipated duration of the injury and associated weekly benefit costs; the anticipated duration and cost of any treatment plan (physiotherapy, chiropractic, osteopathy, psychology, etc.); any medical reports provided by the treating doctor and any treating specialist; evidence of the employer's previously demonstrated ability to return injured workers to work; and background knowledge of the worker (refer to Operational Instruction 1.23, Self Insurer Guideline 08.05 or Specialised Insurer Guideline 08.04). 	<p>The estimate for medical, hospital and rehabilitation expenses must reflect those expenses for reasonably necessary treatment.</p> <p>Use the amounts shown in the following table unless there is evidence that another amount is more appropriate.</p>							
	Non significant injuries < 7 days incapacity				Significant injuries ≥ 7 days incapacity			
	Level 1		Level 2		Level 3		Level 4	
	No time loss		Minor claim Anticipated time loss Less than 7 calendar days		Injuries involving soft tissue, musculo-ligamentous, simple fractures etc (excludes those requiring surgery).		Operative treatment	
	No indication that ongoing treatment required		Indication that ongoing treatment required		No indication that ongoing treatment required		Indication that ongoing treatment required	
	Medical & Treatment	\$550	\$1,250	\$700	\$1,250	\$3,000	\$5,000	Refer to Chapter J
	Hospital	Usually nil but if the worker is or will be hospitalised allow at least \$5,000 for hospital costs and review the estimate for medical and rehabilitation to reflect increased costs.					\$5,000	Refer to Chapter J
	Rehabilitation	Usually nil but if these services are required allow at least \$3,000.				\$3,000	\$3,000	Refer to Chapter J
<p>§ Ongoing treatment refers to physiotherapy, chiropractic, osteopathic, remedial massage, pharmacy, domestic assistance etc.</p> <ul style="list-style-type: none"> If any amount detailed in the above table is exceeded in the first 12 weeks, the Scheme Agent/Insurer must review the initial assessment of the claim and re-estimate the claim based on the available evidence. <p>Review the estimate for these amounts as follows:</p> <ul style="list-style-type: none"> Level 1 and Level 2 claim - re-estimate them to allow at least the amounts shown for Level 3; Level 3 claims - re-estimate them to allow at least the amounts shown for Level 4; and Level 4 claims - re-estimate them to allow at least the amounts shown for the 12-week review. 								
							<p>Investigation costs</p> <p>If an independent medical or other investigation may be required, allow as a minimum \$1,000 and review the estimate as more information is received.</p> <p>Other expenses</p> <p>Consider also estimating, as appropriate, future costs of other compensation payments such as: aids and equipment; property damage; travel and accommodation; home care services; interpreter costs; etc.</p>	

**WORKCOVER NSW
2009 CLAIMS ESTIMATION MANUAL**

Benefits – Section 36 and 37 - continued

1.2: 12 Week Review

Weekly	Medical, Hospital, Rehabilitation expenses		Investigation and Other expenses						
<p>The worker has returned to work with no further expected wage loss:</p> <p>If the worker has returned to work for at least 2 weeks with no further expected wage loss, the Scheme Agent/Insurer must review the estimate and consider:</p> <ul style="list-style-type: none"> any future incapacity (e.g. future surgery, time loss for ongoing treatment, removal of internal fixatives, etc.); medical or rehabilitation costs; possible Permanent Impairment entitlements and Pain and Suffering entitlements; and ensure the estimate is sufficient to pay any outstanding Wages Reimbursement Schedules. 	<p>The estimate for medical, hospital and rehabilitation expenses should reflect those expenses for reasonably necessary treatment.</p> <p>Use the amounts shown in the following table unless there is evidence that another amount is more appropriate.</p> <p>Where the worker is not back at work ...</p> <table border="1" data-bbox="632 451 1488 654"> <tr> <td data-bbox="632 451 779 505">Medical & treatment</td> <td data-bbox="779 451 1488 505">\$3,000</td> </tr> <tr> <td data-bbox="632 505 779 570">Hospital</td> <td data-bbox="779 505 1488 570">Usually NIL. If required, allow at least \$5,000.</td> </tr> <tr> <td data-bbox="632 570 779 654">Rehabilitation</td> <td data-bbox="779 570 1488 654">If required but no referral has been made, allow \$3,000. If a referral has been made, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional \$2,000.</td> </tr> </table>		Medical & treatment	\$3,000	Hospital	Usually NIL. If required, allow at least \$5,000.	Rehabilitation	If required but no referral has been made, allow \$3,000. If a referral has been made, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional \$2,000.	<p>Investigation costs</p> <p>If an independent medical or other investigation may be required, allow as a minimum \$1,000 and review the estimate as more information is received.</p> <p>Injury Management Consultant fees are to be estimated as investigation costs.</p> <p>Other expenses</p> <p>Consider also estimating, as appropriate, future costs of other compensation payments such as: aids and equipment; property damage; travel and accommodation; home care services; interpreter costs; etc.</p>
Medical & treatment	\$3,000								
Hospital	Usually NIL. If required, allow at least \$5,000.								
Rehabilitation	If required but no referral has been made, allow \$3,000. If a referral has been made, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional \$2,000.								
<p>The worker has not returned to work even though the initial expected time off work was less than 12 weeks:</p> <p>Increase the estimate to allow for a further 40 weeks of weekly compensation benefits, plus an allowance for any unpaid or outstanding weekly benefit amounts. Also, review the weekly benefit rate of compensation the worker should be receiving for each week they are off work and use the new amount to calculate the estimate.</p>	<p>The estimate for medical, hospital and rehabilitation expenses should reflect those expenses for reasonably necessary treatment.</p> <p>Use the amounts shown in the following table unless there is evidence that another amount is more appropriate.</p> <p>Where the worker is not back at work ...</p> <table border="1" data-bbox="632 805 1488 1008"> <tr> <td data-bbox="632 805 779 859">Medical & treatment</td> <td data-bbox="779 805 1488 859">\$3,000</td> </tr> <tr> <td data-bbox="632 859 779 924">Hospital</td> <td data-bbox="779 859 1488 924">Usually NIL. If required, allow at least \$5,000.</td> </tr> <tr> <td data-bbox="632 924 779 1008">Rehabilitation</td> <td data-bbox="779 924 1488 1008">If required but no referral has been made, allow \$3,000. If a referral has been made, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional \$2,000.</td> </tr> </table>		Medical & treatment	\$3,000	Hospital	Usually NIL. If required, allow at least \$5,000.	Rehabilitation	If required but no referral has been made, allow \$3,000. If a referral has been made, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional \$2,000.	<p>Investigation costs</p> <p>If an independent medical or other investigation may be required, allow as a minimum \$1,000 and review the estimate as more information is received.</p> <p>Injury Management Consultant fees are to be estimated as investigation costs.</p> <p>Other expenses</p> <p>Consider also estimating, as appropriate, future costs of other compensation payments such as: aids and equipment; property damage; travel and accommodation; home care services; interpreter costs; etc.</p>
Medical & treatment	\$3,000								
Hospital	Usually NIL. If required, allow at least \$5,000.								
Rehabilitation	If required but no referral has been made, allow \$3,000. If a referral has been made, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional \$2,000.								
<p>The worker has not returned to work and the initial expected time off work is greater than 12 weeks:</p> <p>If the worker has an injury for which the initial expected time off work is greater than 12 weeks, the Scheme Agent/Insurer must review the estimate at the end of that period with that review regarded as part of the 12 week review. At this point, review the estimate as follows:</p> <ul style="list-style-type: none"> If the worker is totally unfit for their pre-injury duties, increase the estimate to allow for a further 40 weeks of weekly compensation benefit, plus an allowance for any unpaid or outstanding weekly benefit amounts. <p>If there is sound evidence that some other outcome is more likely, proceed on the basis of the more likely outcome. Also, review the weekly benefit rate of compensation the worker should be receiving for each week they are off work and use the new amount to calculate the estimate.</p>	<p>The estimate for medical, hospital and rehabilitation expenses should reflect those expenses for reasonably necessary treatment.</p> <p>Use the amounts shown in the following table unless there is evidence that another amount is more appropriate.</p> <p>Where the worker is not back at work ...</p> <table border="1" data-bbox="632 1159 1488 1438"> <tr> <td data-bbox="632 1159 779 1213">Medical & treatment</td> <td data-bbox="779 1159 1488 1213">\$3,000</td> </tr> <tr> <td data-bbox="632 1213 779 1278">Hospital</td> <td data-bbox="779 1213 1488 1278">Usually NIL. If required, allow at least \$5,000.</td> </tr> <tr> <td data-bbox="632 1278 779 1438">Rehabilitation</td> <td data-bbox="779 1278 1488 1438">If required but no referral has been made, allow \$3,000. If a referral has been made, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional \$2,000.</td> </tr> </table>		Medical & treatment	\$3,000	Hospital	Usually NIL. If required, allow at least \$5,000.	Rehabilitation	If required but no referral has been made, allow \$3,000. If a referral has been made, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional \$2,000.	<p>Investigation costs</p> <p>If an independent medical or other investigation may be required, allow as a minimum \$1,000 and review the estimate as more information is received</p> <p>Injury Management Consultant fees are to be estimated as investigation costs.</p> <p>Other expenses</p> <p>Consider also estimating, as appropriate, future costs of other compensation payments such as: aids and equipment; property damage; travel and accommodation; home care services; interpreter costs; etc.</p>
Medical & treatment	\$3,000								
Hospital	Usually NIL. If required, allow at least \$5,000.								
Rehabilitation	If required but no referral has been made, allow \$3,000. If a referral has been made, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional \$2,000.								

**WORKCOVER NSW
2009 CLAIMS ESTIMATION MANUAL**

Benefits – Section 36 and 37 - continued

1.3: 26, 52, 78, 104 Week and Later Reviews

Weekly		Medical, Hospital, Rehabilitation expenses		Investigation and Other expenses								
<p>The worker has returned to work with no further expected wage loss:</p> <p>If the worker has returned to work for at least 4 weeks with no further expected wage loss, the Scheme Agent/Insurer must review the estimate considering:</p> <ul style="list-style-type: none"> any future incapacity (e.g. future surgery, time loss for ongoing treatment, removal of internal fixatives, etc.); medical or rehabilitation costs; possible Permanent Impairment entitlements and Pain and Suffering entitlements; and ensure the estimate is sufficient to pay any outstanding Wages Reimbursement Schedules. <p>The worker remains totally incapacitated and has not returned to work:</p> <p>Increase the estimate to reflect the allowances in the following table plus an allowance for any unpaid or outstanding weekly benefit amounts:</p>		<p>The estimate for medical, hospital and rehabilitation expenses should reflect those expenses for reasonably necessary treatment.</p> <p>Use the amounts shown in the following table unless there is evidence that another amount is more appropriate.</p> <p>Where the worker is not back at work ...</p> <table border="1"> <tr> <td>Medical & treatment</td> <td>\$4,000 per year of estimated incapacity</td> </tr> <tr> <td>Hospital</td> <td>Usually NIL. If required, allow \$5,000</td> </tr> <tr> <td>Rehabilitation</td> <td>If required but no referral has been made, allow \$3,000. If a referral has been made, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional \$2,000.</td> </tr> </table>		Medical & treatment	\$4,000 per year of estimated incapacity	Hospital	Usually NIL. If required, allow \$5,000	Rehabilitation	If required but no referral has been made, allow \$3,000. If a referral has been made, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional \$2,000.	<p>Investigation costs</p> <p>If an independent medical or other investigation may be required, allow as a minimum \$1,000 and review the estimate as more information is received.</p> <p>Injury Management Consultant fees are to be estimated as investigation costs.</p> <p>Other expenses</p> <p>Consider also estimating, as appropriate, future costs of other compensation payments such as: aids and equipment; property damage; travel and accommodation; home care services; interpreter costs; etc.</p>		
Medical & treatment	\$4,000 per year of estimated incapacity											
Hospital	Usually NIL. If required, allow \$5,000											
Rehabilitation	If required but no referral has been made, allow \$3,000. If a referral has been made, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional \$2,000.											
<p>The worker is not back at work at the ...</p> <table border="1"> <tr> <td>26-week review after the date of the injury</td> <td>At least 104 weeks of incapacity.</td> </tr> <tr> <td>52-week review after the date of the injury</td> <td>The lesser of At least 5 years of incapacity; or 80% of the period of incapacity from date of review to retiring age plus one year.</td> </tr> <tr> <td>78-week review after the date of the injury</td> <td>The lesser of At least 4.5 years of incapacity; or 80% of the period of incapacity from date of review to retiring age plus one year.</td> </tr> <tr> <td>104-week review after the date of the injury</td> <td>The lesser of At least 6 years of incapacity; or 80% of the period of incapacity from date of review to retiring age plus one year.</td> </tr> <tr> <td>Subsequent bi-annual reviews. That is, after 104 weeks from the date of the injury, and ongoing bi-annual reviews for the life of the claim.</td> <td>The lesser of At least 8 years of incapacity; or The period of incapacity from date of review to retiring age plus one year.</td> </tr> </table>	26-week review after the date of the injury	At least 104 weeks of incapacity.	52-week review after the date of the injury	The lesser of At least 5 years of incapacity; or 80% of the period of incapacity from date of review to retiring age plus one year.	78-week review after the date of the injury	The lesser of At least 4.5 years of incapacity; or 80% of the period of incapacity from date of review to retiring age plus one year.	104-week review after the date of the injury	The lesser of At least 6 years of incapacity; or 80% of the period of incapacity from date of review to retiring age plus one year.	Subsequent bi-annual reviews. That is, after 104 weeks from the date of the injury, and ongoing bi-annual reviews for the life of the claim.	The lesser of At least 8 years of incapacity; or The period of incapacity from date of review to retiring age plus one year.	<p>The above amounts also apply at the relevant review points for a worker who has reached retiring age but is no longer in receipt of weekly compensation benefits and is receiving ongoing treatment for their work related injury.</p>	
26-week review after the date of the injury	At least 104 weeks of incapacity.											
52-week review after the date of the injury	The lesser of At least 5 years of incapacity; or 80% of the period of incapacity from date of review to retiring age plus one year.											
78-week review after the date of the injury	The lesser of At least 4.5 years of incapacity; or 80% of the period of incapacity from date of review to retiring age plus one year.											
104-week review after the date of the injury	The lesser of At least 6 years of incapacity; or 80% of the period of incapacity from date of review to retiring age plus one year.											
Subsequent bi-annual reviews. That is, after 104 weeks from the date of the injury, and ongoing bi-annual reviews for the life of the claim.	The lesser of At least 8 years of incapacity; or The period of incapacity from date of review to retiring age plus one year.											

Chapter J: Permanent Total incapacity

24. This section applies to Workers:

- unlikely to be re-employed or vocationally retrained;
- likely to require ongoing hospitalisation, nursing home residence, or home care;
- in receipt of a Compensation Court and/or WCC Award confirming the worker is totally incapacitated for employment; or
- in receipt of a consent award.

The suggested estimates for medical, hospital, homecare, home modifications, etc are provided as a guide until further information is obtained. Estimates need to be calculated having regard to the individuals circumstances of each case.

**WORKCOVER NSW
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Table 2: Permanent Total Incapacity

Benefits – Section 36 and 37								
2.1. All Review Points								
Weekly	Medical, Hospital, Rehabilitation expenses	Investigation and Other expenses						
<p>The estimate needs to include the total amount of weekly compensation payments that will be paid to the worker until one year after they reach retiring age.</p>	<ul style="list-style-type: none"> • Workers who are permanently hospitalised - at least \$300,000 a year for the worker's life expectancy; • workers in nursing homes - at least \$200,000 a year for the worker's life expectancy; and • workers needing full time attendant home care - at least \$200,000 a year for the worker's life expectancy. <p>If evidence indicates the above amounts are too low, the Scheme Agent/Insurer must increase the estimate.</p> <p>The above amounts also apply at the relevant review points for a worker who has reached retiring age but is no longer in receipt of weekly compensation benefits and is receiving ongoing treatment for their work related injury.</p>	<p>Permanent Impairment and Pain and Suffering (Section 66 & 67), refer to Chapter M;</p> <ul style="list-style-type: none"> • expenses such as travel, house alterations, etc., allow at least \$20,000 more if there is information showing that more will be required; • if any medical or other investigations are likely, allow at least \$20,000, but review as new information is available; • expected legal expenses, refer to Chapter E; and • any other entitlements the worker may be eligible to receive. 						
<p>Compensation Court and/or WCC Awards (including Consent Awards)</p>	<p>The estimate for medical, hospital and rehabilitation expenses should reflect those expenses for reasonably necessary treatment.</p> <p>Use the amounts shown in the following table unless there is evidence that another amount is more appropriate.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; padding: 5px;">Medical & treatment</td> <td style="padding: 5px;">\$4,000 per year of estimated incapacity</td> </tr> <tr> <td style="padding: 5px;">Hospital</td> <td style="padding: 5px;">Usually NIL. If required allow at least \$5,000.</td> </tr> <tr> <td style="padding: 5px;">Rehabilitation</td> <td style="padding: 5px;">Generally not required but if referral is made allow for \$3,000. If a referral identifies rehabilitation assistance is appropriate, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional \$2,000.</td> </tr> </table>	Medical & treatment	\$4,000 per year of estimated incapacity	Hospital	Usually NIL. If required allow at least \$5,000.	Rehabilitation	Generally not required but if referral is made allow for \$3,000. If a referral identifies rehabilitation assistance is appropriate, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional \$2,000.	<p>Investigation costs</p> <p>If an independent medical or other investigation may be required, allow as a minimum \$1,000 and review the estimate as more information is received</p> <p>Injury Management Consultant fees are to be estimated as investigation costs.</p> <p>Other expenses</p> <p>Consider also estimating, as appropriate, future costs of other compensation payments such as: aids and equipment; property damage; travel and accommodation; home care services; interpreter costs; etc.</p>
Medical & treatment	\$4,000 per year of estimated incapacity							
Hospital	Usually NIL. If required allow at least \$5,000.							
Rehabilitation	Generally not required but if referral is made allow for \$3,000. If a referral identifies rehabilitation assistance is appropriate, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional \$2,000.							

Chapter K: Temporary or Permanent Partial Incapacity (Section 40)

25. This section applies to workers:
- working for the same employer, or a different employer;
 - performing different duties and having an ongoing wage loss;
 - performing similar duties and having an ongoing wage loss;
 - performing suitable duties and having an ongoing wage loss;
 - who are fit for suitable duties but the injured worker's section 38 entitlements have been exhausted;
 - who are fit for suitable duties as a result of an injury, and have an ongoing wage loss in secondary employment;
 - who are in receipt of an Compensation Court and/or WCC Award (including Consent Awards) allowing for continuing weekly compensation benefits for partial incapacity; or
 - who are not complying with their injury management and/or statutory obligations and are paid under section 40. Refer to Rule 54.

Scheme Agents/Insurers must base the estimate on:

26. If the actual economic loss is known or can be reasonably assessed, base the estimate on that amount. Otherwise, use the applicable statutory rate for a single worker. Review the estimate as new information is received. Employers and workers may provide information about the pre-injury average weekly earning rate to a Scheme Agent/Insurer to assess the actual economic loss. This information may be required for the initial assessment of loss or if ongoing benefits are being paid to a worker.

Worker or employer does not claim section 40 entitlements:

- 26.1 If the worker is entitled to section 40 benefits, the Scheme Agent/Insurer must include the amount in the estimate regardless of whether or not the employer is claiming those benefits. The Scheme Agent/Insurer must maintain an estimate until the claim is finalised. Refer to Operational Instruction 1.4.

Section 40 benefits payable after the expiration of section 38 entitlements

- 27 Calculate the initial section 40 estimate on the lesser of 6 years at the benefit rate or 80% of the period of incapacity from the date of review to retiring age plus one year.

Subsequent bi-annual reviews must be for the lesser of 8 years at the benefit rate or 80% of the period of incapacity from date of review to retiring age plus one year.

Considerations when reviewing a Section 40 estimate

28. When reviewing a section 40 estimate:
- check the accuracy of the weekly rate being paid, review wage reimbursement schedules and consider the indexation of statutory benefits every April and October and any increase in the applicable average weekly earnings; and
 - monitor any fundamental variations in the worker's actual economic loss as a result of changes in circumstances including the workers medical condition.

Worker requires time off work after returning to work

29. If the worker has demonstrated a durable return to work of at least 4 weeks and requires time off work, then immediately review the estimate as per Rule 23.1. If the worker's return to work was for a period

of less than 4 weeks, the Scheme Agent/Insurer must immediately increase the estimate on the basis of the next review point with regard to the type of incapacity, refer to Chapter I.

Employer unable to provide suitable duties

30. If the employer is unable to provide suitable duties for the worker, review the estimate on the basis of section 38 entitlements, refer to Chapter L.

Worker refuses appropriate suitable duties and/or refuses to participate in the injury management process and/or abandons their employment

31. The Scheme Agent/Insurer must:
- amend the estimate to reflect the reduced level of section 40 weekly compensation benefits for the balance of the estimated period of incapacity, plus an allowance for any unpaid or outstanding weekly benefit amounts at the review point, based on sound evidence, following appropriate issue of advice to the worker and expiration of the statutory periods (s54 of the 1987 Act and s74 of the 1998 Act);
 - at subsequent review points apply the timeframes applicable at that review point but use the reduced rate in calculating the estimate; and
 - estimate for the amounts and period claimed if the worker issues legal proceedings, refer to Chapter E.

Note: The estimate for weekly compensation benefits cannot be amended unless and until the worker has been advised of the reduction and payments at the amended rate have commenced. Refer to Operational Instruction 1.23, Self Insurer Guideline 08.05 or Specialised Insurer Guideline 08.04 on the case management aspect.

Amending the estimate

32. The Scheme Agent/Insurer can reduce an estimate for a claim for section 40 entitlements when the worker either returns to duties with no ongoing wage loss, or there is a significant decrease of 20% or greater in section 40 weekly compensation benefits. The timeframe in amending the estimate will depend upon how long the worker has been off work from the date of the injury.
- If the worker was off work 12 weeks or less from the injury date and has returned to work with no ongoing wage loss for a continuous period of more than 2 weeks.
 - In all other instances, the worker has returned to work on full duties for a continuous period of more than 4 weeks.
 - Where the worker has returned to work and there is a significant decrease of 20% or greater in section 40 weekly compensation benefits for a period of 4 continuous weeks the estimate is to be amended to reflect the revised section 40 weekly compensation benefits for the balance of the estimate period.
 - If the return to work is not sustained review the claim in accordance with the relevant review point.

**WORKCOVER NSW
2009 CLAIMS ESTIMATION MANUAL**

Table 3: Temporary or Permanent Partial Incapacity (Section 40)

Benefits – Section 40				
3.1: Initial Estimate				
Weekly		Medical, Hospital, Rehabilitation expenses		Investigation and Other expenses
Allow for payments to cover the period the worker to be entitled to section 40 benefits on the basis of sound evidence. If there is no sound evidence, use the period shown in this table plus an allowance for any unpaid or outstanding weekly benefit amounts:		The estimate for medical, hospital and rehabilitation expenses should reflect those expenses for reasonably necessary treatment. Use the amounts shown in the following table unless there is evidence that another amount is more appropriate.		Investigation costs If an independent medical or other investigation may be required, allow at least \$1,000 and review the allowance as you receive more information.
If the worker resumed selected duties ...	Initial section 40 estimate of at least...	Where the worker is back at work and is entitled to section 40 benefits ...		Injury Management Consultant Fees are to be estimated as investigation costs.
less than or equal to 4 weeks after the date of the injury	4 weeks of entitlement.	Medical & treatment	\$1,500 plus \$1500 for each year of estimated incapacity	Other Costs Consider estimating, as appropriate, future costs of other compensation payments such as aids and equipment; property damage; travel and accommodation; home care services; interpretation costs; etc.
more than 4, but less than or equal to 8 weeks after the date of the injury	8 weeks of entitlement.	Hospital	Usually NIL If required, allow \$5,000	
more than 8, but less than or equal to 12 weeks after the date of the injury	12 weeks of entitlement.	Rehabilitation	If required but no referral has been made, allow \$3,000. If a referral has been made, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional \$2,000.	
more than 12, but less than or equal to 26 weeks after the date of the injury	26 weeks of entitlement.			
more than 26, but less than or equal to 52 weeks after the date of the injury	52 weeks of entitlement.			
more than 52 weeks after the date of the injury	104 weeks of entitlement.			

*Where the worker has returned to work with no wage loss but requires ongoing medical treatment refer to Rule 23.2

**WORKCOVER NSW
2009 CLAIMS ESTIMATION MANUAL**

Benefits – Section 40 - continued

3.2: 12, 26, 52, 104 Week and Later Reviews

Weekly		Medical, Hospital, Rehabilitation expenses		Investigation and Other expenses
<p>If the worker is entitled to section 40 benefits at the relevant review point, the Scheme Agent/Insurer must review the estimate to ensure any calculation reflects the indexation of statutory benefits every April and October plus an allowance for any unpaid or outstanding weekly benefit amounts.</p> <p>Base the estimate on the following table:</p>		<p>The estimate for medical, hospital and rehabilitation expenses should reflect those expenses for reasonably necessary treatment.</p> <p>Use the amounts shown in the following table unless there is evidence that another amount is more appropriate.</p> <p>Where the worker is back at work and is entitled to section 40 benefits ...</p>		<p>Investigation costs</p> <p>If an independent medical or other investigation may be required, allow at least \$1,000 and review the allowance as you receive more information.</p>
If the worker is eligible for section 40 benefits at the review ...	include in your estimate an amount equal to ...			<p>Injury Management Consultant Fees are to be estimated as investigation costs.</p> <p>Other Costs</p> <p>Consider estimating, as appropriate, future costs of other compensation payments such as aids and equipment; property damage; travel and accommodation; home care services; interpretation costs; etc.</p>
12 weeks after the date of the injury	At least 26 weeks at the benefit rate.	Medical & treatment	\$1,500 plus \$1500 for each year of estimated incapacity.	
26 weeks after the date of the injury	At least 52 weeks at the benefit rate.	Hospital	Usually NIL If required allow \$5,000.	
52 weeks after the date of the injury	At least 104 weeks at the benefit rate.	Rehabilitation	If required but no referral has been made, allow \$3,000. If a referral has been made, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional \$2,000.	
104 weeks after the date of the injury	The lesser of another 6 years at the benefit rate or 80% of the period of incapacity from date of review to retiring age plus one year.	<p>The above amounts also apply at the relevant review points for a worker:</p> <ul style="list-style-type: none"> who was on suitable duties and has reached retiring age but is no longer in receipt of weekly compensation benefits and is receiving ongoing treatment for their work related injury, or who is working on suitable duties with no wage loss and is receiving ongoing treatment for their work related injury. 		
subsequent bi-annual reviews, i.e. after 104 weeks from the date of the injury, and ongoing bi-annual reviews for the life of the claim.	The lesser of At least 8 years of incapacity or 80% of the period of incapacity from date of review to retiring age plus one year.			
Compensation Court and/or WCC Awards (including Consent Awards)	The estimate for medical, hospital and rehabilitation expenses should reflect those expenses for reasonably necessary treatment. Use the amounts shown in the following table unless there is evidence that another amount is more appropriate. Where the worker is not back at work ...			
	Medical & treatment	\$4,000 per year of estimated incapacity.		
	Hospital	Usually NIL. If required allow at least \$5,000.		
	Rehabilitation	Generally not required but if referral is made allow for \$3,000. If a referral identifies rehabilitation assistance is appropriate, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional \$2,000.		

*Where the worker has returned to work with no wage loss but requires ongoing medical treatment refer to Rule 23.2

Chapter L: Temporary Partial Incapacity (Section 38)

33. This section applies to Workers:
- who are fit for suitable duties; but
 - whose employers are unable to provide them with suitable duties.

Note: If the worker is fit for suitable duties and section 38 entitlements have been exhausted, the Scheme Agent/Insurer must estimate for section 40 weekly compensation benefits, in accordance with the timeframes outlined in this chapter. Workers can receive weekly compensation under section 38 for up to 52 weeks if they first became entitled to benefits *on or after* 1 August 1998.

Worker supplies a medical certificate for total incapacity

34. If the worker is certified as totally unfit, immediately review the estimate as per Rule 23.1, Chapter I.

Worker refuses appropriate suitable duties and/or refuses to participate in the injury management process and/or abandons their employment

35. The Scheme Agent/Insurer must review the estimate as per Rule 31, Chapter K.

Amending the estimate

36. The Scheme Agent/Insurer can reduce an estimate for a claim for section 38 entitlements when the worker either returns to suitable duties (refer to Table 3, Chapter K) or work with no further expected wage loss. The timeframe in amending the estimate will depend upon how long the worker has been off work from the date of the injury.

If the worker was off work:

- 12 weeks or less from the injury date and has returned to work with no ongoing wage loss for a continuous period of more than 2 weeks.
- in all other instances, the worker has returned to work on full duties for a continuous period of more than 4 weeks.

If the return to work is not sustained review the claim in accordance with the relevant review point.

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Table 4: Temporary Partial Incapacity (Section 38)

Benefits – Section 38				
4.1: Initial Estimate				
Weekly		Medical, Hospital, Rehabilitation expenses		Investigation and Other expenses
Estimate for payments to cover the period that the worker will be entitled to section 38 benefits on the basis of sound evidence. If there is no sound evidence, use the period shown in this table plus an allowance for any unpaid or outstanding weekly benefit amounts:		The estimate for medical, hospital and rehabilitation expenses should reflect those expenses for reasonably necessary treatment. Use the amounts shown in the following table unless there is evidence that another amount is more appropriate. Where the worker is not back at work and is entitled to section 38 benefits ...		Investigation costs If an independent medical or other investigation may be required, allow at least \$1,000 and review the allowance as you receive more information Injury Management Consultant Fees are to be estimated as investigation costs.
If the worker is entitled to section 38 benefits ...	Initial section 38 estimate ...	Medical & treatment	\$4,000 per year of estimated incapacity	Other costs
less than 26 weeks after the date of the injury	at least 52 weeks of weekly compensation at the appropriate rates. <i>This can include up to 52 weeks of section 38 entitlements.</i>	Hospital	Usually NIL. If required allow \$5,000.	Consider estimating, as appropriate, future costs of other compensation payments such as aids and equipment; property damage; travel and accommodation; home care services; interpretation costs; etc.
more than 26 weeks, but less than 52 weeks, after the date of the injury	at least 130 weeks of weekly compensation benefits at the appropriate rates. <i>This can include up to 52 weeks of section 38 entitlements.</i>	Rehabilitation	If required but no referral has been made, allow \$3,000. If a referral has been made, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional \$2,000.	
more than 52 weeks, but less than 104 weeks, after the date of the injury	the lesser of 6 years of weekly compensation benefits at the appropriate rates; or 80% of weekly compensation at the appropriate rates for the period from the date of the review to retiring age plus one year. <i>This can include up to 52 weeks of section 38 entitlements.</i>			
more than 104 weeks after the date of the injury	the lesser of 8 years of weekly compensation benefits at the appropriate rates; or The period of incapacity from date of review to retiring age plus one year. <i>This can include up to 52 weeks of section 38 entitlements.</i>			

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Benefits – Section 38 - continued

4.2: 12, 26, 52, 78, 104 Week and Later Reviews

Weekly		Medical, Hospital, Rehabilitation expenses		Investigation and Other expenses
Estimate for payments to cover the period the worker to be entitled to section 38 benefits on the basis of sound evidence. If there is no sound evidence, use the period shown in this table plus an allowance for any unpaid or outstanding weekly benefit amounts:		Use the amounts shown in the following table unless there is evidence that another amount is more appropriate.		<p>Investigation costs</p> <p>If an independent medical or other investigation may be required, allow at least \$1,000 and review the allowance as you receive more information</p> <p>Injury Management Consultant Fees are to be estimated as investigation costs.</p> <p>Other costs</p> <p>Consider estimating, as appropriate, future costs of other compensation payments such as aids and equipment; property damage; travel and accommodation; home care services; interpretation costs; etc.</p>
If the worker is still entitled to section 38 benefits at the ...	allow ...	Where the worker is not back at work and is entitled to section 38 benefits ...		
12 week review after the date of the injury	at least 52 weeks of weekly compensation at the appropriate rates <i>This can include up to 52 weeks of section 38 entitlements.</i>	Medical & treatment	\$4,000 per year of estimated incapacity	
26 week review after the date of the injury	at least 130 weeks of weekly compensation benefits at the appropriate rates. <i>This can include up to 52 weeks of section 38 entitlements.</i>	Hospital	Usually NIL. If required allow \$5,000.	
52 week review after the date of the injury	the lesser of 6 years of weekly compensation benefits at the appropriate rates; or 80% of weekly compensation at the appropriate rates for the period from the date of the review to retiring age plus one year. <i>This can include up to 52 weeks of section 38 entitlements</i>	Rehabilitation	If required but no referral has been made, allow \$3,000. If a referral has been made, the estimate should allow for the cost of the approved plan (less any amounts previously paid) plus an additional \$2,000.	
78 week review after the date of the injury	the lesser of 5.5 years of weekly compensation benefits at the appropriate rates; or 80% of weekly compensation at the appropriate rates for the period from the date of the review to retiring age plus one year. <i>This can include up to 52 weeks of section 38 entitlements.</i>	The above amounts also apply at the relevant review points for a worker who is able to perform work (but the employer is unable to offer suitable duties) and has reached retiring age but is no longer in receipt of weekly compensation benefits and is receiving ongoing treatment for their work related injury.		
104 week after the date of the injury	the lesser of 8 years of weekly compensation benefits at the appropriate rates; or 80% of weekly compensation at the appropriate rates for the period from the date of the review to retiring age plus one year. <i>This can include up to 52 weeks of section 38 entitlements.</i>			
Subsequent review points, i.e. after 104 weeks from the date of the injury and ongoing bi-annual reviews for the life of the claim.	the lesser of 8 years of weekly compensation benefits at the appropriate rates; or The period of incapacity from date of review to retiring age plus one year. <i>This can include up to 52 weeks of section 38 entitlements.</i>			

Chapter M: Permanent Impairment (Section 66) and Pain and Suffering (Section 67) Entitlements

37. Any claim by the worker for benefits under sections 66 and 67 of the 1987 Act, must include relevant particulars of the claim as outlined in Part 5 of the *WorkCover Guidelines For Claiming Compensation Benefits*. Further the Scheme Agent/Insurer must administer the claim in accordance with these Guidelines.

Note: if the permanent impairment relates to hearing loss refer to Chapter N.

Timing of estimate for sections 66 and 67 entitlements

38. Scheme Agents/Insurers must estimate for a permanent impairment loss when it is *reasonably likely to arise* as a result of the nature and severity of the injury. This must be done at the initial estimate and subsequent review points and/or when the worker makes a separate claim for s66/67 benefits and/or the Scheme Agent/Insurer receives information in a medical report which indicates s66/67 benefit entitlements may arise.

Evidence to calculate the initial section 66 estimate

39. If the worker is reasonably likely to be entitled to a benefit or if you receive a claim for section 66 benefits:
- review the provided information and any existing medical opinions and assessments to determine the estimate of the benefit payable to the worker; and
 - include in the estimate an allowance for medical assessment costs (as per the gazetted WorkCover guidelines on *Independent Medical Examinations and Reports*), legal costs (as per Schedule 6 and 7 of the *Workers Compensation Regulation 2003*).

Medical Assessment Certificate (MAC) from the Workers Compensation Commission (WCC)

40. If there is an assessment provided in a MAC from the WCC, the estimate should be based on the assessment.

Matter referred for independent medical examination or to the WCC

41. If it becomes necessary to refer the matter to an Independent Medical Examiner and/or the WCC, maintain the current estimate but once the report is received the estimate should be calculated based on the assessment contained in the report.

Research required prior to reducing an estimate or making a payment

42. The Scheme Agent/Insurer must request the worker provide details of any previous settlements or Judgements. The relevant settlements and Judgements include previous section 66 and section 67 claims, exit commutations and common law settlements and Judgements.

Any estimate or payment must be reduced by the previous settlement and/or Judgements.

Other factors to consider when calculating or reviewing the estimate

43. The Scheme Agent/Insurer must check for the following factors:
- recovery action, refer to Chapter D;
 - expected legal expenses, refer to Chapter E;
 - travel expenses for the worker to attend medical examinations; and
 - wage loss while attending medical examination.

Injuries sustained before 1 January 2002

44. A worker is entitled to section 66 and 67 benefits:
- If the injury leaves the worker with an impairment or loss as described in the Table of Disabilities; and
 - If the worker's entitlement to permanent impairment benefits under section 66(1) is for more than 10% of the maximum allowed, then they are entitled to compensation for pain and suffering.

Injuries sustained on or after 1 January 2002

45. A worker is entitled to permanent impairment section 66 benefits:
- If the permanent impairment is greater than 0% of the whole person; or
 - If the injury is a primary psychological injury and their level of impairment is 15% or greater of the whole person.
46. A worker is entitled to pain and suffering section 67 benefits:
- If the injury (other than psychological injury) is 10% or greater of the whole person impairment or 15% or greater whole person impairment for psychological injuries.

Estimating for pain and suffering (section 67)

47. If the assessment of loss is 10% or greater of the maximum amount payable under the Table of Disabilities (for the corresponding period applicable to the date of injury), then also estimate for section 67 benefits.

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Table 5: Permanent Impairment (Section 66) and Pain and Suffering (Section 67) Entitlements

Benefits – Section 66 and 67		
Estimating Factor	Injuries sustained on or after 1 January 2002	Injuries sustained prior to 1 January 2002
A permanent loss is likely, but the extent is unknown.	If the worker is likely to suffer a permanent loss but the extent of the loss is unknown, or if a claim for permanent impairment is made without supporting medical evidence, include in the estimate an amount equal to at least 5% of the Whole Person Impairment ("WPI") table. The Scheme Agent/Insurer must include at least the 5% in the estimate until further medical evidence shows that there is no permanent loss at all. An opinion that "the injury may resolve in time" is not enough. Update the estimate on receipt of further medical evidence.	If the worker is likely to suffer a permanent loss but the extent of the loss is unknown, include in the estimate an amount equal to at least 10% of the maximum amount allowed for the body part affected. The Scheme Agent/Insurer must include at least the 10% in the estimate until further medical evidence shows that there is no permanent loss at all. An opinion that "the injury may resolve in time" is not enough. Update the estimate on receipt of further medical evidence.
Assessment from treating specialist.	If there is an assessment of permanent impairment from the treating specialist, the estimate should equal the assessment.	If there is an assessment of permanent loss from a treating specialist, the estimate should equal the assessment.
Conflicting assessments.	If there are a number of reports with conflicting medical assessments of the amount of permanent loss the worker has suffered, base the estimate only on information supplied by providers who are trained in the assessment of permanent impairment. If there is a substantial variation or difference of opinion, seek clarification from the provider/s concerned and recalculate the estimate based on any new/revised information. Maintain the current estimate or allow a minimum of 5%.	If there are a number of reports with conflicting medical assessments of the amount of permanent loss the worker has suffered, base the estimate only on information supplied by providers who are trained in the assessment of permanent impairment. If there is a substantial variation or difference of opinion, seek clarification from the provider/s concerned and recalculate the estimate based on any new/revised information. In the interim, maintain 10% of the maximum amount allowed for the body part affected.
Worker makes a claim for lump sum compensation.	<p>Trained Assessor and Scheme Agent/Insurer accepts findings of report.</p> <p>If the assessment of permanent impairment provided is in accord with other information and assessments on file and the Scheme Agent/Insurer accepts the findings of the report, estimate based on the assessment in the report.</p> <p>Trained Assessor but assessment is at odds with other information and assessments and/or Scheme Agent/Insurer determines report is deficient.</p> <p>If the assessment of permanent impairment is at odds with other information and assessments on file, estimate based on 75% of the assessment in the report. Undertake action to clarify the assessment with the author of the report. Once clarification is received, recalculate the estimate based on any new/revised information.</p>	<p>Trained Assessor and Scheme Agent/Insurer accepts findings of report.</p> <p>If the assessment of permanent loss provided is in accord with other information and assessments on file and the Scheme Agent/Insurer accepts the findings of the report, estimate based on the assessment in the report.</p> <p>Trained Assessor but assessment is at odds with other information and assessments and/or Scheme Agent/Insurer determines report is deficient.</p> <p>If the assessment of permanent loss is at odds with other information and assessments on file, estimate based on 75% of the assessment in the report. Undertake action to clarify the assessment with the author of the report. Once clarification is received, recalculate the estimate based on any new/revised information.</p>
	<p>Assessor not trained but assessment is at odds with other information and assessments and/or Scheme Agent/Insurer determines report is deficient.</p> <p>Maintain the current estimate or allow a minimum of 5%.</p> <p>Assessor not trained but assessment reflects other information and assessments on file.</p> <p>Maintain the current estimate or allow a minimum of 5%.</p>	<p>Assessor not trained but assessment is at odds with other information and assessments and/or Scheme Agent/Insurer determines report is deficient.</p> <p>If a provider is not trained in the assessment of permanent impairment guides and the assessment of permanent loss is at odds with other information and assessments on file, estimate based on 50% of the assessment in the report. Undertake action to clarify the assessment with the author of the report. Once clarification is received, recalculate the estimate based on any new/revised information.</p> <p>Assessor not trained but assessment reflects other information and assessments on file.</p> <p>If a provider is not trained in the assessment of permanent impairment guides but the assessment of permanent loss reflects other information and assessments on file either maintain the current estimate for section 66 or if this is the first indication of section 66 entitlement, base the estimate on that information.</p>

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Benefits – Section 66 and 67 - continued

Estimating Factor	Injuries sustained on or after 1 January 2002	Injuries sustained prior to 1 January 2002
Estimate based on the date the claim is made.	Please refer to the <i>WorkCover Benefits Guide</i> on the limits on the amount the worker may be paid and apply to the estimate.	Please refer to the <i>WorkCover Benefits Guide</i> on the limits on the amount the worker may be paid and apply to the estimate.
Multiple body parts injured.	If there are multiple body systems involved, a provisional estimate of 5% Whole Person Impairment is required until the medical report is received that confirms the level of Whole Person Impairment. If there are conflicting reports (i.e. worker compared to the Agent/Insurer), then the higher whole person permanent impairment rate is to be estimated until the lower offer is accepted or a Medical Assessment Certificate and a Certificate of Determination has been issued.	If there are multiple losses from the same injury, the worker's entitlement to section 66 for each loss is calculated as a percentage of the amount applicable to the location of injury as shown in the applicable Table of Disabilities. Where there are multiple losses, the amount of compensation payable under section 66 cannot exceed the maximum amount payable for multiple losses in the applicable Table of Disabilities. The applicable Table of Disabilities is dependent on the date of injury. The Tables of Disabilities are included in the <i>WorkCover Benefits Guide</i> .
Estimating for pre-existing injuries/prior section 66/67 settlements.	The Scheme Agent/Insurer can no longer automatically reduce an estimate for pre-existing injuries. Further information is available in section 68(B) of the 1987 Act. Refer to Rule 42 for deductions for prior settlements.	If the worker has had any pre-existing injuries, abnormalities, or conditions, reduce the estimate to take account of them. The Scheme Agent/Insurer must refer to section 68B, of the 1987 Act for further information. Refer to Rule 42 for deductions for prior settlements.
Common law/Work Injury Damages claims and the estimate.	The Scheme Agent/Insurer must estimate for a permanent impairment entitlement even if a Work Injury Damages claim has been made. Refer to Operational Instruction 1.17 for more information about how to estimate Work Injury Damages. The estimate for Whole Person Permanent impairment should be maintained at 15% unless previously paid. If there are conflicting reports as to the amount of whole person permanent impairment (i.e. worker compared to Agent/Insurer), then the higher whole person permanent impairment rate is to be estimated until the lower offer is accepted or a Medical Assessment Certificate and a Certificate of Determination has been issued.	The Scheme Agent/Insurer must estimate for a permanent impairment entitlement even if a Work Injury Damages claim has been made. Refer to Operational Instruction 1.17 for more information regarding when to estimate for Work Injury Damages. The estimate for permanent impairment should be maintained at 15% unless previously paid. If there are conflicting reports as to the amount of permanent impairment (i.e. worker compared to Agent/Insurer), then the higher permanent impairment rate is to be estimated until the lower offer is accepted or a Medical Assessment Certificate and a Certificate of Determination has been issued.
Calculating the estimate for section 66 and section 67.	<p>The amount to include in the estimate is the amount expected to be paid based on the percentage loss of Whole Person Impairment and the maximum amount allowed under section 66 & section 67. A formula is used to determine the amount of compensation payable. Refer to section 66 of the 1987 Act.</p> <p>For example: Assume the worker suffers a whole person permanent impairment of 15%.</p> <p>Section 66</p> <p>The <i>WorkCover Benefits Guide</i> states the Section 66 entitlement applicable for injuries received on or after</p> <p>1 January 2002 with a WPI of 15% = \$20,000</p> <p>Section 67</p> <p>Maximum payable under section 67 = \$50,000 (as indexed)</p> <p>Section 67 entitlement 15% of \$50,000 = \$7,500</p>	<p>Section 66 entitlements</p> <p>Use the amount of loss based on this Chapter and the Table of Disabilities located in the <i>WorkCover Benefits Guide</i>. Apply the percentage of loss to the maximum amount allowed for the affected body part.</p> <p>Section 67 entitlements</p> <p>If the assessment of loss is 10% or greater of the maximum amount payable under the Table of Disabilities (for the corresponding period applicable to the date of injury), estimate for section 67 benefits. The estimate for section 67 is calculated using the same percentage of the maximum amount payable.</p> <p>For example: Assume the worker suffers a permanent loss of 20% of their right hand</p> <p>Section 66</p> <p>Maximum payable under section 66 = \$100,000</p> <p>Maximum payable for right hand = 70% of max payable = \$70,000</p> <p>Section 66 entitlement = 20% of \$70,000 = \$14,000</p> <p>Section 67</p> <p>Maximum payable under section 67 = \$50,000</p> <p>Maximum payable for right hand = 70% of max payable = \$35,000</p> <p>Section 67 entitlement = 20% of \$35,000 = \$7,000</p> <p>Alternatively, the section 67 estimate can also be calculated by multiplying the section 66 entitlement by 50%:</p> <p>Section 66 entitlement = \$14,000</p> <p>Section 67 entitlement = 50% of \$14,000 = \$7,000</p>

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Investigation and legal costs.	Read as per Rule 39 dot point 2.	Read as per Rule 39 dot point 2.
Benefits – Section 66 and 67 - continued		
Estimating Factor	Injuries sustained on or after 1 January 2002	Injuries sustained prior to 1 January 2002
Other Costs.	Consider estimating, as appropriate, for future costs of other compensation payments that may be identified as being reasonably necessary in the section 66 assessment reports. These may include any aids and/or home care requirements identified. In addition, as appropriate, consider travel and accommodation costs associated with the worker's travel to any assessment and any loss of wages to attend an assessment.	Consider estimating, as appropriate, for future costs of other compensation payments that may be identified as being reasonably necessary in the section 66 assessment reports. These may include any aids and/or home care requirements identified. In addition, as appropriate, consider travel and accommodation costs associated with the worker's travel to any assessment and any loss of wages to attend an assessment.

Chapter N: Hearing Impairment (Permanent Loss of Hearing)

48. This section applies to:

- workers who gave notice of a permanent loss of hearing to their employer before 1 January 2002; or
- hearing loss claims with a date of injury on or after 1 January 2002. If the worker's current employer is a noisy employer, the date of injury is the date the worker gave notice of a loss of hearing to the employer. If the worker is no longer employed by a noisy employer, the date of loss is the last day the worker was employed by the most recent noisy employer.

Hearing Loss Threshold

49. Section 69A of the 1987 Act provides that before being entitled to lump sum compensation for hearing loss, the worker's hearing loss must be assessed as being at least 6% binaural loss of hearing after relevant deductions. If a worker's hearing loss is assessed as being less than the 6% threshold, the worker remains entitled to be compensated for the cost of the assessment.

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Table 6: Hearing Impairment (Permanent Loss of Hearing)

Benefits – Hearing Impairment		
Estimating Factor	Injuries sustained on or after 1 January 2002	Injuries sustained prior to 1 January 2002
Initial Estimate	The Scheme Agent/Insurer must calculate an estimate when the worker notifies they have permanent loss of hearing. This is done even if the worker has not properly made the claim.	The Scheme Agent/Insurer must calculate an estimate when the worker notifies they have permanent loss of hearing. This is done even if the worker has not properly made the claim.
Qualifications for Hearing Loss Assessment	The hearing loss is to be assessed by a qualified assessor in accordance with the standards specified in the <i>WorkCover Guides for the Evaluation of Permanent Impairment</i> .	Not applicable.
Calculating the estimate.	<p>Section 69A of the 1987 Act provides that before being entitled to lump sum compensation for hearing loss, the worker's hearing loss must be assessed as being at least 6% binaural loss of hearing after relevant deductions.</p> <p>Notice of hearing loss is received with an assessment of the worker's hearing loss.</p> <p>The Scheme Agent/Insurer must ensure a qualified assessor has done the assessment and that the whole person percentage loss is accurate according to the <i>WorkCover Guidelines for the Evaluation of Permanent Impairment</i>. If the loss is:</p> <ul style="list-style-type: none"> • Less than 6% binaural hearing impairment, include only the medical costs in your estimate (as the worker is not entitled to any other compensation); or • 6% or more binaural hearing impairment, base the estimate on the equivalent percentage Whole Person Impairment. Refer to Table 9.1 in the <i>WorkCover Guides for the Evaluation of Permanent Impairment</i>. The estimate must also include: <ul style="list-style-type: none"> • investigation of at least \$1,000; • hearing aids of at least \$6,000 or as quoted; and • weekly payments, if applicable. <p>Notice of hearing loss is received without an assessment of the worker's hearing loss.</p> <p>The Scheme Agent/Insurer must include at least 6% in the estimate and refer the worker for assessment of hearing impairment in accordance with the <i>WorkCover Guides for the Evaluation of Permanent Impairment</i>. The estimate must also include:</p> <ul style="list-style-type: none"> • investigation of at least \$1,000; • hearing aids of at least \$6,000 or as quoted; and • weekly payment, if applicable. <p>Medical assessment is not completed by a qualified assessor</p> <p>If a claim does not have a hearing loss assessment report from a qualified Ear, Nose and Throat (ENT) Specialist or other appropriately qualified medical specialist, the worker and/or their solicitor should be advised that the claim is deficient and be requested to supply the appropriate report.</p> <p>The Scheme Agent/Insurer must estimate the claim as if there is no assessment. Refer to the section above, "Notice of hearing loss is received without an assessment of the worker's hearing loss."</p>	<p>Section 69A of the 1987 Act provides that before being entitled to lump sum compensation for hearing loss, the worker's hearing loss must be assessed as being at least 6% binaural loss of hearing after relevant deductions.</p> <p>Hearing loss is less than 6%:</p> <ul style="list-style-type: none"> • Include only the medical costs in your estimate. <p>Hearing loss is 6% or greater:</p> <p>Base the estimate on the percentage loss claimed. Also estimate for:</p> <ul style="list-style-type: none"> • investigation of at least \$1,000; • hearing aids of at least \$6,000 or as quoted; and • weekly payments, if applicable. <p>Notice of hearing loss is received without an assessment of the worker's hearing loss:</p> <p>Estimate at least 6% and refer the worker for assessment of hearing impairment.</p> <p>Also estimate for:</p> <ul style="list-style-type: none"> • investigation of at least \$1,000; • hearing aids of at least \$6,000 or as quoted; and • weekly payments, if applicable. <p>The Scheme Agent/Insurer must update the estimate when the assessment is received.</p>

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Benefits – Hearing Impairment (Permanent Loss of Hearing) - continued

Estimating Factor	Injuries sustained on or after 1 January 2002	Injuries sustained prior to 1 January 2002
Claims handling & estimate practice.	Operational Instruction 1.22 includes additional information about the management and estimation of hearing loss claims. This also should be read in conjunction with Part 5 of the <i>WorkCover Guidelines For Claiming Compensation Benefits</i> . Once there is a valid assessment, the Scheme Agent/Insurer must manage the claim in accordance with the above requirements.	Operational Instruction 1.22 includes additional information about the management and estimation of hearing loss claims. This also should be read in conjunction with Part 5 of the <i>WorkCover Guidelines For Claiming Compensation Benefits</i> . Once there is a valid assessment, the Scheme Agent/Insurer must manage the claim in accordance with the above requirements.
Other considerations when making an estimate	A claim for permanent loss of hearing is a claim for a permanent impairment under section 66. Other important factors that the Scheme Agent/Insurer needs to consider when estimating a claim for permanent loss of hearing are detailed in Part 5, Clause 2 - Permanent Impairment (section 66) and Pain and Suffering Entitlements (section 67) of the <i>WorkCover Guidelines For Claiming Compensation Benefits</i> .	A claim for permanent loss of hearing is a claim for a permanent impairment under section 66. Other important factors that the Scheme Agent/Insurer needs to consider when estimating a claim for permanent loss of hearing are detailed in Part 5, Clause 2 - Permanent Impairment (section 66) and Pain and Suffering Entitlements (section 67) of the <i>WorkCover Guidelines For Claiming Compensation Benefits</i> . These include: <ul style="list-style-type: none"> • Example of calculating the estimate, refer to Chapter M, Table 5 "Calculating the estimate for section 66 and section 67" Before 1 January 2002 • If the date the claim was made is before 12 January 1997, refer to Chapter M, Table 5 "Estimate based on the date the claim is made" Before 1 January 2002; and • Entitlement to section 67 benefits if the permanent loss is more than 18.4% binaural hearing loss.
Additional estimate considerations	When calculating or reviewing this estimate, the Scheme Agent/Insurer must consider: <ul style="list-style-type: none"> • recovery action, refer to Chapter D; • expected legal expenses, refer to Chapter E; • travel and accommodation costs associated with the worker's travel to any assessment; and • wage loss while attending medical examination. 	When calculating or reviewing this estimate, the Scheme Agent/Insurer must consider: <ul style="list-style-type: none"> • recovery action, refer to Chapter D; • expected legal expenses, refer to Chapter E; • travel and accommodation costs associated with the worker's travel to any assessment; and • wage loss while attending medical examination.
Re-activation of a claim	When receiving a subsequent claim for additional hearing loss, hearing aid repairs, replacement of hearing aids and/or ongoing hearing aid batteries, the Scheme Agent/Insurer must estimate for these expenses based on the information received, while considering payment of these amounts.	When receiving a subsequent claim for additional hearing loss, hearing aid repairs, replacement of hearing aids and/or ongoing hearing aid batteries, the Scheme Agent/Insurer must estimate for these expenses based on the information received, while considering payment of these amounts.

Chapter O: Death Benefits

Benefits payable

50. The benefits that are payable when a worker dies as a result of a workplace injury include:

- a lump sum;
- weekly payments for dependant children (if applicable); and
- funeral expenses (including transportation of the deceased).

The lump sum benefit payable is the amount that is applicable at the date of the worker's death. With the exception of funeral expenses, all death benefits including weekly payments for dependants are indexed in April and October each year. The benefit payable for funeral expenses is specified by section 26 of the 1987 Act.

Scheme Agents/Insurers must ensure that the estimate for death benefits is calculated having regard to the individual circumstances of each claim including the number and age of dependants. Please refer to the *WorkCover Benefits Guide* for further information.

Chapter P: Schedule One: Minimum Weekly Compensation Estimate for Certain Injuries

Aim of Schedule One

51. Schedule One provides a general guide only as to the minimum period to include as the estimate for weekly compensation payments for certain injuries. A soundly based decision making process must be undertaken and Schedule One only used if no other information is available. In the absence of other evidence the Scheme Agent/Insurer should use the periods contained in Schedule One, with the information specific to the worker's situation, to make the initial estimate.

Worker's injury is not listed

52. If the worker's injury is not listed, base the initial estimate on the scenario that is reasonably likely to arise. The Scheme Agent/Insurer must align an injury type in Schedule One that is similar to the worker's injury.

Initial Estimate for Weekly Compensation Benefits

53. The period for each injury shown in the table attached to Schedule One represents the initial financial estimate to be applied for weekly compensation benefits for those injury types. For those workers who do not return to work within the initial estimate period, the Scheme Agent/Insurer must base the ongoing weekly compensation estimate on the evidence available and in accordance with Chapters I, J, K and L of this Manual.

Effect of suitable duties availability on the worker's estimated return to work

54. The Scheme Agent/Insurer must include the availability of suitable duties in the decision making process when estimating when a worker is likely to return to work.

Schedule One: Minimum Weekly Compensation Estimate for Certain Injuries

Bodily Location And Injury Type	Minimum Estimate
GROUP 1: HEAD (includes cranium, eye, ear, mouth, nose and face)	
Fracture of skull (without brain injury)	6 weeks
Fracture of jaw (without dislocation)	6 weeks
Fracture-dislocation of jaw	12 weeks
Concussion	1 week
Serious head injuries (including closed/open head and brain injuries, severe facial injuries involving face, nose and/or ear)	Refer to Chapter J
Eye	
Major burn/thermal injury	26 weeks
Moderate thermal or chemical burn	6 weeks
Foreign body (corneal) and abrasions	2 weeks
Foreign body (intraocular)	6 weeks
Conjunctivitis/chemical irritation	1 week
Contusions/bruising	1 week
Retinal detachment	6 weeks
Ear	
Perforated ear drum	2 weeks
GROUP 2: NECK	
Whiplash associated disorder (WAD) without radicular pain	4 weeks
Whiplash associated disorder (WAD) with radicular pain	12 weeks
Contusion/bruising/sprains	4 weeks
Fracture:	
to vertebral body	12 weeks
to spinous or transverse process	6 weeks
Fracture – dislocation	26 weeks
Fracture with spinal cord injury	Refer to Chapter J
GROUP 3: TRUNK (includes upper/lower back, chest, abdomen and pelvic region)	
Acute or recurrent back pain (non-radicular)	4 weeks
Radicular back pain	12 weeks
Fracture:	
of vertebral body	12 weeks
of transverse or spinous process	6 weeks
of sacrum	4 weeks
of coccyx	4 weeks
Contusion/bruising (upper/lower back)	4 weeks
Chest/thorax:	
Closed rib fracture	4 weeks
Fracture with complications (eg: pneumothorax)	12 weeks
Contusion	1 week
Strain – intercostal muscles	1 week
Abdomen and pelvic region	
Hernia with repair by suture	8 weeks
Hernia with tension free or laparoscopic repair	4 weeks
Fracture of pelvis (without surgery)	12 weeks
Fracture of pelvis (with surgery)	26 weeks

GROUP 4: UPPER LIMB (including shoulder)	
Shoulder:	
Dislocation/subluxation (initial)	6 weeks
Dislocation/subluxation (recurrent)	10 weeks
Rotator cuff /scapular muscle (cumulative injury)	8 weeks
Rotator cuff/scapular muscles (traumatic injury)	12 weeks
Synovitis/tendonitis/ligament sprain	6 weeks
Other sprains/strains/contusions	4 weeks
Fracture – simple	8 weeks
Fracture – complex (no surgery)	12 weeks
Fracture – complex (with surgery)	16 weeks
Bursitis/impingement syndrome	8 weeks
Traumatic arthritis (acute)	6 weeks
Upper arm	
Fractured humerus	8 weeks
Tendon rupture	12 weeks
Tendonitis/sprain/contusion	6 weeks
Elbow	
Epicondylitis/bursitis/sprains	6 weeks
Fracture – simple	8 weeks
Complex fracture/fracture-dislocation	12 weeks
Ulnar nerve entrapment	12 weeks
Traumatic arthritis (acute)	6 weeks
Forearm	
Fracture – proximal radius/ulna	8 weeks
Sprain/contusion	4 weeks
Wrist flexor/extensor tendon rupture	12 weeks
Wrist	
Tenosynovitis/sprain/contusion	6 weeks
Fracture – scaphoid	12 weeks
Fracture – carpal (not scaphoid)	8 weeks
Carpal tunnel syndrome	8 weeks
Fracture-dislocation	12 weeks
Traumatic arthritis (acute)	6 weeks
Hands/fingers/thumb	
Fracture – simple (metacarpals/phalanges)	6 weeks
Fracture – complex with surgery	12 weeks
Sprain/contusion – finger/thumb	4 weeks
Tenosynovitis/De Quervain syndrome	6 weeks
Tendon rupture	12 weeks
Traumatic amputation - finger	12 weeks
GROUP 5: LOWER LIMB (including hip)	
Hip	
Fracture/dislocation (no surgery)	12 weeks
Fracture/dislocation (with surgery)	20 weeks
Tendonitis/bursitis	6 weeks
Traumatic arthritis (acute)	6 weeks
Sprain/contusion	4 weeks
Total hip replacement	26 weeks
Upper leg	
Thigh muscle strain	2 weeks
Fractured femur	12 weeks
Traumatic amputation	Refer to Chapter J
Knee	
Fracture – simple	8 weeks

Fracture – complex (with surgery)	26 weeks
Dislocation (patella)	8 weeks
Knee replacement	26 weeks
Sprain/contusion (collateral ligaments)	4 weeks
Cruciate ligament sprain	6 weeks
Cruciate ligament rupture (with surgery)	12 weeks
Meniscus injury with surgery	6 weeks
Patella tendonitis	4 weeks
Patella bursitis	8 weeks
Patella disorders	5 weeks
Traumatic arthritis (acute)	6 weeks
Lower leg	
Tendonitis –(including Achilles tendonitis)	6 weeks
Fracture – tibia	12 weeks
Fracture – fibula	8 weeks
Achilles rupture	20 weeks
Ankle	
Fracture – simple	8 weeks
Fracture – complex (with/without dislocation)	12 weeks
Sprain/contusion	4 weeks
Traumatic arthritis (acute)	6 weeks
Foot/toes	
Fracture – tarsal/metatarsal	8 weeks
Fracture – phalanges	6 weeks
Sprain/contusion	4 weeks
Plantar fasciitis	6 weeks
Traumatic arthritis	6 weeks
Traumatic amputation – toe	12 weeks
GROUP 6: NON-PHYSICAL LOCATIONS	
Psychological system (including: Anxiety-related disorders; Depressive disorders; Adjustment disorders)	12 weeks
GROUP 7: OTHER INJURIES/DISEASES	
Toxic reactions (e.g.: bee sting)	1 week
Paraplegia	Refer to Chapter J
Quadriplegia	Refer to Chapter J
Skin diseases (e.g.: reactive dermatitis)	4 weeks
Burns (localised on limb/hand/foot/trunk/face)	
First degree	4 weeks
Second degree	6 weeks
Third degree	26 weeks
Severe burns (multiple locations)	Refer to Chapter J
Peripheral nerve injuries	12 weeks
Lacerations/puncture wounds	
Simple	1 week
Complex (nerves or tendons involved)	12 weeks
Infection	
Superficial	2 weeks
Deep	8 weeks