Claim administration

Claim administration

Claim administration is a broad term to describe the range of tools, tasks and practices for the effective and efficient management of a claim. The information on these pages in the manual apply across the lifecycle of a claim and are not specific to any stage.

Information capture

Communication with stakeholders

Effective communication with stakeholders is a key element to achieving claim objectives. This guidance supports your to become an excellent communicator for all employees and other stakeholders.

Communicating with an employee

Communicating with an employer

Communication protocol

Complaints and feedback

Communicating a decision

Commitment claims

Authority and consent on claims

This section explains authority and consent considerations. Given the sensitive information in claim management, we are required to use legal authorities (legally valid written authority from a stakeholder regarding their information) to request and provide information. Legal authorities may also be withdrawn.

Authority, or withdrawal of authority, to act on employee's...

Authority to release medical information

Quality assurance

This section explains Comcare's quality assurance processes. Quality assurance drives high quality service delivery and helps strengthen capability. Different determinations require different quality assurance processes.

Quality assurance

File and diary maintenance

Proper claim file management and maintenance is key to meeting various legislative responsibilities and to ensure effective and efficient management of a claim.

Privacy

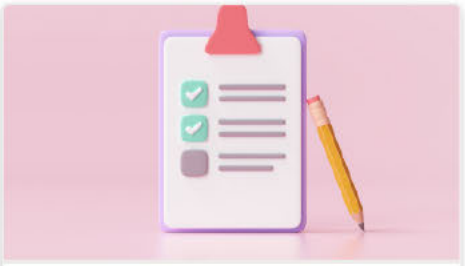
Record keeping

Change of personal information

Removing and redacting information from a file

Managing diaries

Reallocation/transfer of claims



Information capture

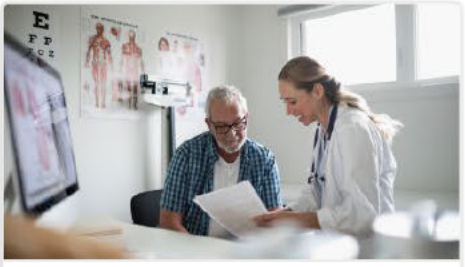
Entering TOOCS codes

Work status codes

Claim chronology

Receiving and actioning requests for a claim file

Claims Managers may be asked to provide part, or all, of a claim file either under the SRC Act or the Freedom of Information (FOI) Act.



Freedom of information requests

Requests for a claim file

Suspensions, ceases and refusal to deal

Claims managers, or an employer, may need to take action on a claim such as refusing to deal with a claim, determining no present liability, denying benefits or suspending a claim due to nonattendance or obstruction of a medical examination or rehabilitation assessment or program.

Refusing to deal with a claim

Suspending claims

Determining no present liability

Compliance and fraud referrals

Claims managers may identify a compliance issue on a claim, or a fraud matter.

Compliance and fraud concerns

'Just ask' process

Agency Information

Find information related to Practice Support and Account Management and Delegated Claims, including information on Commonwealth agencies and their relationship to Comcare.

Practice support and account management

Delegated claims

Authority and consent on claims

Authority and consent on claims

Given the personal and sensitive information Comcare collects, uses and discloses as part of the claims management process, there is an authorisation and declaration on Comcare's workers' compensation claim form. This also acts as a medical release authority

The signed authorisation and declaration in the workers' compensation claim form is generally valid for the life of the claim.

You may need to request an updated authority from an employee if:

- the employee changes their name, or
- if a claim has been inactive for a period of time, or
- if a claim has been ongoing for an extended period of time, or
- the employee makes a claim for a new condition.

This is to ensure the authority from the employee stays current.

In this section

Authority, or withdrawal of authority, to act on employee's behalf

An employee may want someone else to represent them or discuss matters in relation to their claim. The employee may also want to remove the authority for someone else to represent them or discuss matters relating to their claim.

Authority to release medical information

A medical release authority permits Comcare to collect personal information relevant to a claim.

Authority, or withdrawal of authority, to act on employee's behalf

Introduction

An employee may advise Comcare that someone else can deal with Comcare or discuss matters relating to their claim on their behalf. This could include legal representation or another form of representation such as family members, a union delegate or another person.

There are two levels of authority someone might have:

- Act on Behalf - this includes receiving all correspondence and making decisions in relation to the claim including but not limited to claiming benefits, requesting reviews and requesting personal information.
- Authority to discuss - this allows someone to discuss all matters in relation to the claim, but without authority to make a decision.

There may also be cases where an employee wishes to withdraw their consent for a third party to act on their behalf with Comcare or to discuss matters relating to their claim.

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How does the employee nominate someone to have authority?

When an employee requests they would like to give or withdraw authority for a third party to act on behalf or to discuss their claim, you need to ask them to provide this information in writing either by email with the employee's signature included or by completing an Authority/Removal of Authority to Act on Employee's Behalf form ('Authority to Act' form). On this form, they need to identify what level of authority they give.

You do not need to request the completion of the 'Authority to Act' form if the employee:

- has indicated in their Workers' Compensation Claim Form that they have a third party acting on their behalf
- has provided an email with a signed statement that they give/withdraw authority to a third party acting on their behalf and it contains the information required.

Employee's signature: There must be clear and informed consent when someone provides or withdraws authority for another person to act on their behalf. While there is no specific legal requirement for an individual to provide a *signed* authority or withdrawal of authority, it is best practice to request a signature as this gives you assurance that the individual and their intent are verified.

Where the employee has provided authority for a representative to act on their behalf, you must communicate with the employee only through that representative. However, should the employee contact Comcare directly you must still action any requests they make.

Where a solicitor advises Comcare they are acting for an employee, Comcare will take this declaration at face value and accept this as an authority to act on the employee's behalf. In this case, a letter must

be sent to the employee advising that Comcare will direct all relevant correspondence through the solicitor, unless advised otherwise by the solicitor or the employee.

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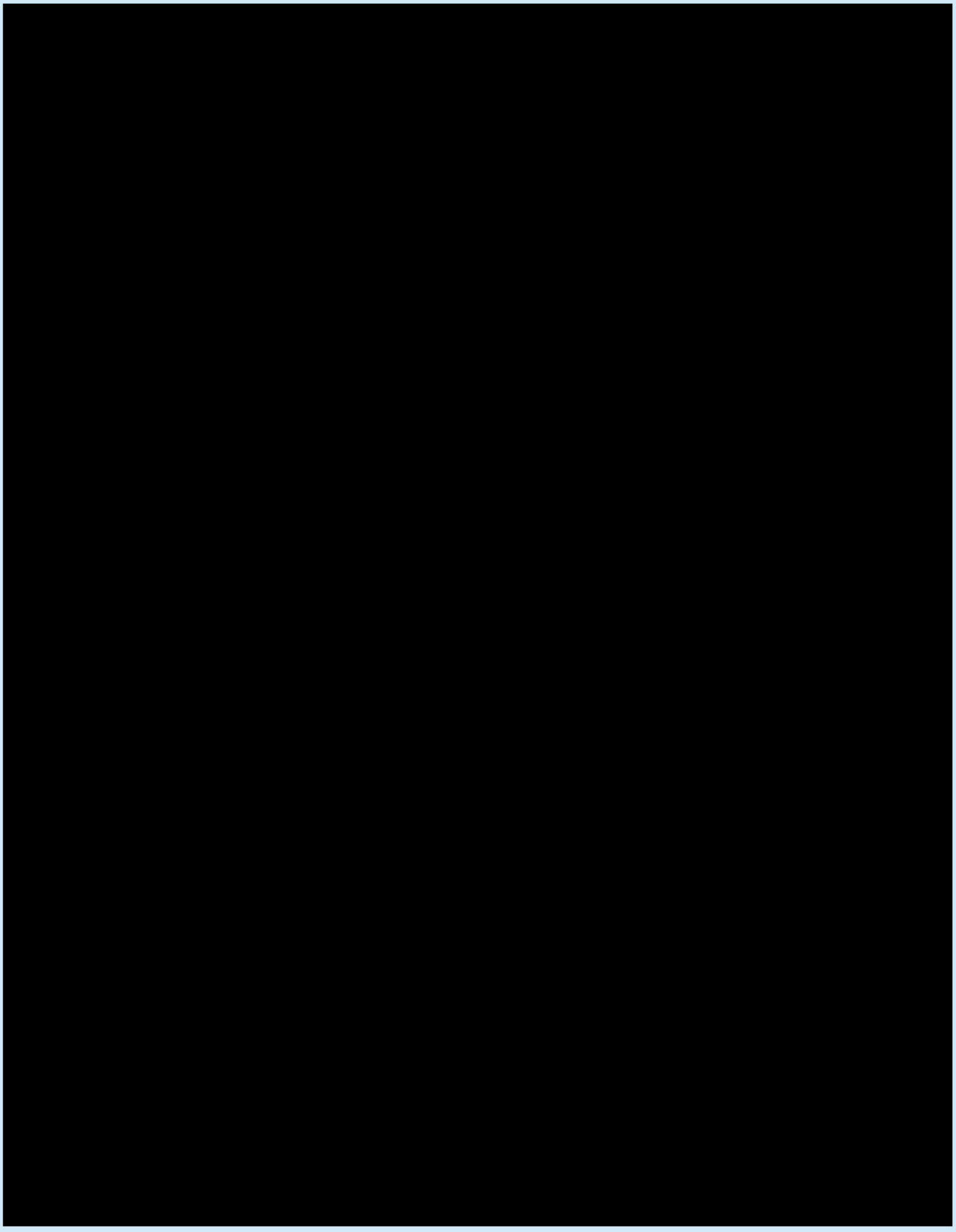

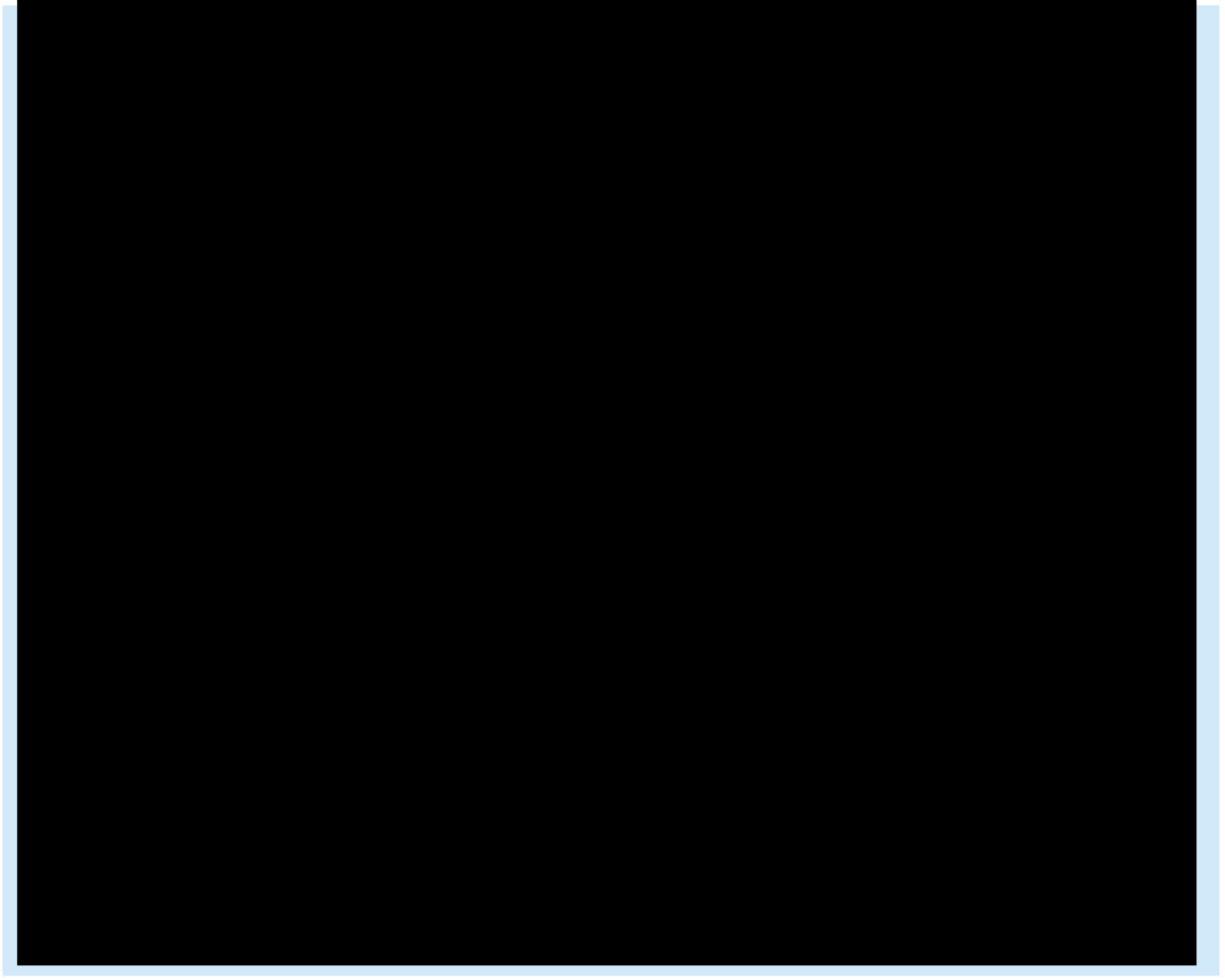

Authority to release medical information

Introduction

A medical release authority (MRA) allows Comcare to collect personal information relevant to a claim for compensation. This is generally signed when the employee first submits a claim for compensation.

There are circumstances when you may need to request an updated Authority and Consent for the Collection and Release of Medical Information Pertaining to my Claim form from the employee. For example, an employee changes their name or makes a claim for a new condition.

Treating practitioners and treating legally qualified medical practitioners (LQMPs, being general practitioners or specialists registered to practice under the Australian Health Practitioner Regulation Agency) may also request a recently signed authorisation or an original copy of the authorisation before releasing an employee's medical information.

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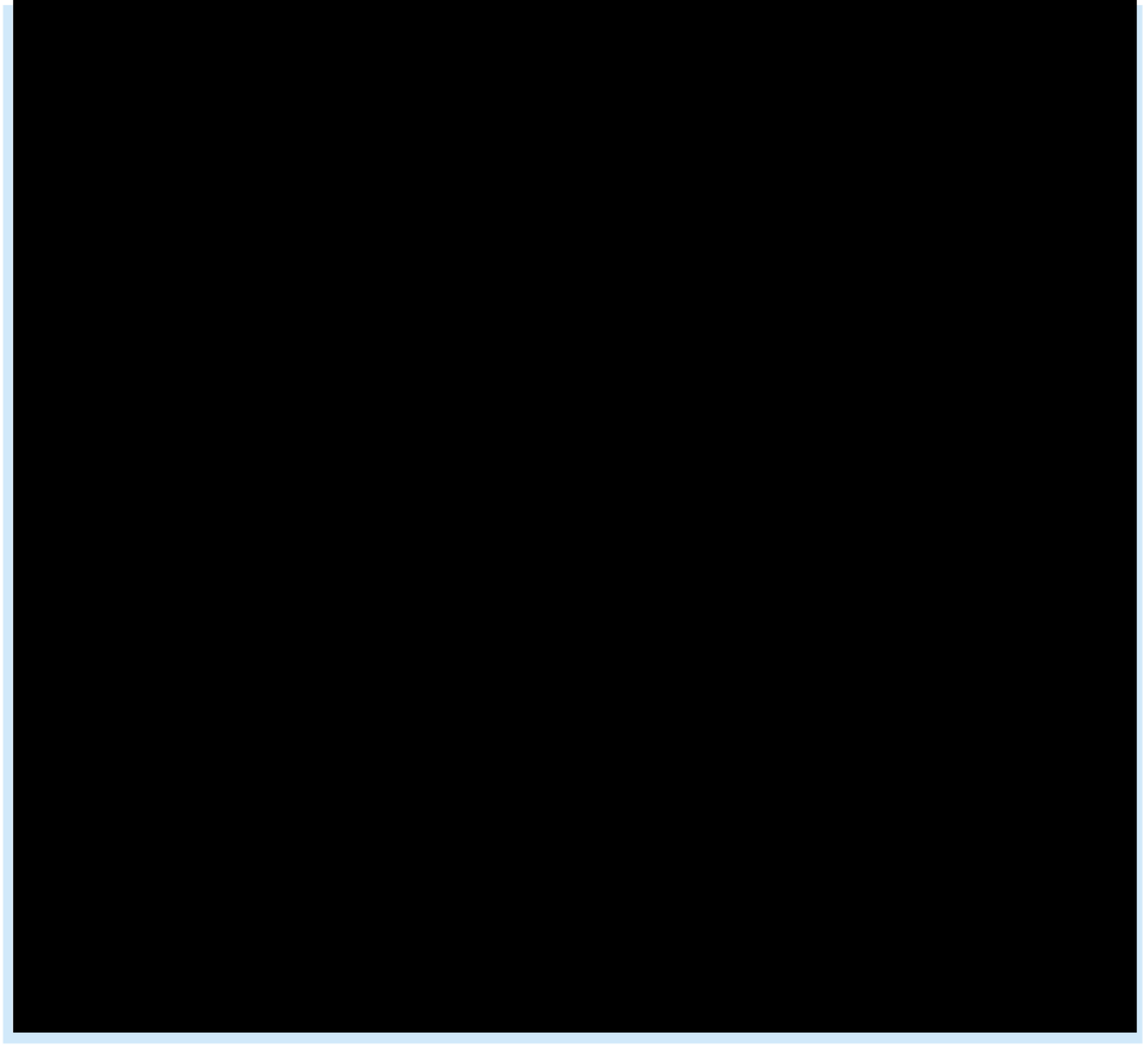

Communication with stakeholders

Communication with stakeholders

At all times, remember that you are the first line of support for employees who are vulnerable and may be apprehensive or in pain. It is important to be understanding and focus on positive outcomes in every interaction, including with our other stakeholders.

When communicating with our stakeholders, including employees and employers, we must consider and apply the Claims Communication Principles.

These are the key points for each communication principle:

- **Be transparent and set expectations** – we should always be transparent, set expectations and have a goal of what we aim to achieve.
- **Communicate simply** – keep our conversation clear and concise. Avoid industry acronyms, legalistic jargon or quoting legislation verbatim.
- **Consider the context** – communications need to be tailored to reflect the context of the client, thinking about their past experience, current situation and next steps.
- **Be curious and listen** – ask open questions, give time to respond and actively listen.
- **Adjust to your medium and audience** – select the most appropriate medium to engage with our clients, adjusting your content, language and tone to that audience and medium.

Read the Claims Communication Principles in full.

Comcare's values

Please keep in mind Comcare's values and think about how you can embody these during communication with clients. For example:

Act with integrity and respect – you commit to being honest and keeping your promises, and you give your clients respect by listening to them and treating them as you would wish to be treated.

Strive to have a positive impact – you commit to leaving your client with a positive feeling about the communication (phone call or email), even if it isn't good news, by your use of language and tone and the service you provide.

Collaborate and innovate – you commit to building strong and productive relationships with your client in which they feel empowered in decisions about their health and return to work.

In this section

Communicating with an employee

Regular communication with employees is a critical part of effective claims management and supporting an employee to return to health and, where possible, work.

This page provides guidance on communicating by email, phone, mail and in person, and also offers support for difficult communications including aggressive, threatening or suicidal callers.

Communicating a determination or decision

Communicating our decisions well is as equally important as making good decisions. This page offers guidance on how to structure a call accepting a new claim and also how to communicate an adverse decision, such as declining liability.

Communicating with an employer

Regular communication with the employer's Rehabilitation Case Manager is a critical part of effective claims management and supporting an employee to return to health and, where possible, work.

This page provides guidance on how to structure an initial call to a Rehabilitation Case Manager about a new claim. It also provides information about employers who have shared services arrangements for payroll and claims management.

There is also information for when an employee changes employment and moves to a new employer, the Procedure to update an employee's rehabilitation authority in Pracsys, and where to look for help if an employer becomes an off-budget or exit agency.

Communication protocol

This page provides information about communication protocols. These are put in place only after all attempts at respectful and productive communication between Comcare and another stakeholder have failed.

A communication protocol provides instructions on how two or more parties must communicate with one another. This page outlines information on:

- how to identify a communication protocol is in place
- when a communication protocol is needed
- the steps you must follow before considering a communication protocol
- the process of developing a communication protocol including roles and responsibilities
- the procedure to flag a claim as having a communication protocol
- dealing with stakeholder communications when a protocol is in place including complaints
- reviewing protocols
- the procedure to review a communication protocol, and
- the roles of the CCF team, Claims Ops team, and Contact Centre team.

Commitment claims

Comcare makes specific service commitments to individual employees in relation to their claim(s) where necessary. Staff involved in managing the claim need to be aware of these commitments.

This page provides information on commitment claims, including when to flag and review commitments on claims, the Procedure to flag a commitment on a claim and the Procedure to review a commitment claim.

Complaints and feedback

Complaints and feedback are a valuable learning opportunity that help us continuously improve as we strive to improve our service delivery.

This page provides information on identifying the type of complaint or feedback, roles and responsibilities, how stakeholders can make complaints, what to do if you receive a complaint,record-keeping, unreasonable complainant conduct, and the Procedure to manage complaints in Claims Operations.

Communicating with an employee

Introduction

- Aggressive Caller Guide
- Suicidal Caller Guide
- Threatening Caller Guide

Regular and respectful communication with employees is a critical part of effective claims management. Our aim is to support employees through their return to health and, where possible, return to work

Our claims communication principles are key to supporting effective communication with our employees.

In essence, we aim to always treat all stakeholders with dignity and empathy through supportive communication. Remember that claims processes can be new, scary, and confusing for already sick or injured employees, adding to their mental burden. We aim to work in partnership to support employees through this challenging time.

Claim Allocation: Claims Managers are required to attempt contact with an employee within 2 business days of a claim being allocated to them.

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Communicating with an employee

A Claims Manager can communicate with an employee in the following ways:

- telephone calls
- emails
- letters sent by mail
- face to face.

Note: It is important to check Pracsys priority comments (VCOMP screen in Pracsys) for the preferred contact method or whether there is an Act on Behalf of, before making contact with an employee.

Communicating with employees by telephone

Communicate by telephone in the first instance

Telephone discussions are Comcare's preferred method of communication. Telephone provides opportunities to take a person-centred approach to building relationships. It allows us to support return to work and health, for example by providing regular updates to employee regarding progress of their claim. For assistance with planning and undertaking an initial conversation with an employee, please refer to the Initial contact with employee call guide.

Provide your direct phone number to employees

A direct phone number will be included on formal written correspondence unless an arrangement is in place as agreed with your Assistant Director. Your direct phone number can also be provided to employees by the Contact Centre.

Verify the identity of the employee

When you receive a phone call to your direct telephone number, you must verify the caller's identity to avoid a potential privacy breach. Refer to the Verifying Caller Identity document for more information.

When a call is received by the Contact Centre, they will verify the identity of the employee. Then they will transfer the phone call to the Claims Manager and advise the name of the caller.

When you make a phone call, you must first confirm that you are speaking to the intended person. Only then can you disclose any personal or sensitive information. If the person answering the phone is not the employee, you can advise that you are calling from Comcare and provide your name. Then you can ask to speak to the intended person. No other information should be disclosed.

Record details of all telephone conversations with employees

For all initial calls with employees, please use the Pracsys initial call record template to document your conversation.

You should record a comment in Pracsys (MCOM, '*Manage Claim Comment*') including:

- the date and time the phone call took place
- details of the query
- response or advice provided
- any actions that you have committed to doing with agreed timeframes
- any other relevant information.

Please be mindful that comments should always be factual, leaving out emotion and/or personal opinions. This is because they could be subject to release outside of internal Comcare processes.

Action call-back requests within 1 business day

Call back requests should be actioned within **one business day**. In some situations, you may need to arrange a suitable time to return a phone call to answer a query. This could include:

- when additional investigation is required to obtain the requested information or
- consultation with other Comcare business areas or external stakeholders is needed to provide a response.

Consider an employee's privacy when leaving a voicemail message

You may leave a message using an employee's voicemail advising of your call and any other relevant information **where the voice message confirms the identity of the employee**. If the voicemail message does not identify the employee, you should advise that you are calling from Comcare and provide your name and contact number. No other information should be disclosed.

Do not consent to an employee recording a phone conversation

An employee may indicate they would like to record a phone conversation. You should not give your consent for the phone conversation to be recorded. You may also advise the employee that you will terminate the call if you believe you are, or may be, being recorded.

If you become aware that an employee has recorded or intends to record a conversation, you should discuss the claim with your Assistant Director.

Communicating with employees by email

Emails are the preferred form of written communication

Formal correspondence, such as determinations or report requests, should be sent to an employee by email.

Emails to employees must be sent from Pracsys

You must send your emails to employees from Pracsys. Sending emails from Pracsys minimises the risk of a privacy breach.

To send an email from Pracsys:

- click on the '*Contacts'* button from within the '*Manage Claim*' screen
- click the email icon next to the relevant email address to compose the email.

To email a letter template:

- use the '*Manage Letter*' function to locate the relevant letter
- select the Print/Email button
- select the Email button to compose the email.

Multiple letters can be sent by selecting the '*Email Folio*' button.

Attempt to obtain an email address from the employee if one is not recorded in Pracsys

If there is no email recorded in Pracsys, you should phone the employee to ask for their preferred email address. Enter the email address into the '*Amend Claim Registration*' function in Pracsys.

Communicating with employees by mail

Although email is the preferred formal communication option, in some circumstances an employee may arrange to receive communication by mail. When sending communication by mail, refer to the below guide to determine which type of mail to use:

Registered post

- medical reports or sensitive material
- documents requested under section 59 of the *Safety, Rehabilitation and Compensation Act 1988* (SRC Act)
- when notifying employees of a cessation of entitlements
- where materials being sent include sensitive information such as a lengthy determination with extensive or multiple medical reports and cab vouchers.

Express post

- when faster than standard mail delivery is required, such as
- a request for information under section 58 of the SRC Act where a response is required within a specified timeframe.

Standard post

- all standard correspondence.
- **Posting CDs, DVDs or USBs**

- Before being mailed, all information on the device must be quality checked by an Assistant Director to ensure only relevant information is included. This is to prevent privacy breaches.

Communicating with employees in person

Employees may arrange to meet with their Claims Manager in person at a Comcare office or visit without prior notice. All face-to-face meetings must take place in a safe and confidential environment.

Before agreeing to meet with an employee in person, you must consult with your Director. If the Director agrees to a face to face meeting, you must have a colleague present at the meeting. This is regardless of whether it is a quick meeting at reception, or whether you will be using an interview room.

If you choose to use an interview room, you should advise the Security team prior to the meeting (see Security contacts, or call #50000). Ensure you are familiar with how to use the interview rooms including the security arrangements. The Security team will be able to advise you on this.

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Handling difficult conversations, aggressive, threatening and suicidal persons

At all times, have regard to your wellbeing. We always endeavour to treat everyone with dignity and respect. However, there may be times when an employee or other stakeholder responds to you negatively.

Comcare provides various guides to assist you in handling these situations. See the sections below. There is also a set of more general guides that may help you, designed for all Comcare staff (not just claims management staff):

- Defusing and de-escalating strategies
- Handling and de-escalating difficult conversations
- How to deliver an adverse decision
- Self care after a difficult or distressing interaction
- Supporting an employee after a difficult or distressing interaction
- Responding to a suicidal person

Rather than trying to read a lengthy guidance document during a difficult conversation, take some time to familiarise yourself with the guidance before you need it. There are quick-read caller guides available to help you in the moment:

- Aggressive Caller Guide
- Suicidal Caller Guide
- Threatening Caller Guide

Please review Comcare's Escalated Behaviours Framework page and resources for details and a full list of relevant resources.

Responding to aggression

You can access guidance on responding to aggression in the Responding to aggression guide. This guide contains prompts and examples relating to claims management.

Suicidal caller

For quick-referral guidance on responding to suicidal callers, refer to the Suicidal Caller guide. Please print and display this guide at your workstation.

Threatening caller guide

For information on responding to callers who threaten you, another Comcare employee or Comcare property, refer to the Threatening Caller Guide.

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Communication protocol

Introduction

A communication protocol establishes the framework for communication between Comcare and a stakeholder. It is implemented when communication has become unproductive or is causing undue distress for either party or raises a work health and safety concern.

A communication protocol:

- obligates both parties to engage in communication that is respectful, appropriate and productive
- establishes the communication parameters including volume and frequency for a specified duration with the intention for the protocol to continue subject to review
- is intended to be reviewed annually or sooner if considered appropriate in the particular circumstances.

A communication protocol does not cease all communication with a stakeholder and, unless specified in the protocol, does not prevent Comcare staff from communicating with the stakeholder. However, the communication must be consistent with the terms of the protocol. The communication protocol sets communication requirements on each of the parties.

A claim with a communication protocol, like a commitment claim, is highlighted in pink in Pracsys in the claim header next to the display for the primary condition. If you see this, check the claim file comments to see if a communication protocol is in place or whether the claim is a commitment claim.

BEFORE ACTIONING THE CLAIM: You must check for and view comments on communication protocols

Anyone who accesses a claim that has been marked as a commitment claim is required to review the 'View Priority Comments' function for comments describing the communication protocol or commitment made by Comcare to the employee. Look in MCOM or VCOM in Pracsys and filter by comment category to 'commitment claim'.

Difference between a service agreement (commitment claim) and a communication protocol

A service agreement (commitment claim) is where Comcare makes specific service commitments (not just communication commitments) to individual employees in relation to their claim(s). They are noted as commitment comments on a claim file. For further guidance, refer to the Commitment claims page. An example of a commitment comment could be:

'EE (employee) does not have email access. All determination letters need to be sent by post.'

On the other hand, a communication protocol establishes the framework for communication between Comcare and a stakeholder. For example:

'If EE (employee) phones, call should be forwarded to the listed claims manager only. In their absence, please refer to their AD (Assistant Director) or the Feedback team.'

Another example is:

'*The EE is only to communicate by email with Comcare and all calls will be terminated.'*

Impact on Claims Managers and Contact Centre Staff

Being involved in difficult and aggressive conversations and interactions can be extremely stressful. At all times, take care of your wellbeing and communicate with your Assistant Director.

All incidents should be reported – this includes **hazards**, which are *dangerous incidents that have not resulted in injury or illness but had the potential to do so*. Reporting hazards and incidents is very important for Comcare. As the Work Health and Safety site explains:

> 'The purpose of incident reporting is not to assign blame, rather to identify patterns of incidents to determine common risks or minimise risk so far as reasonably practicable and identify opportunities to implement preventative actions.'

Refer to Comcare's Work Health and Safety hub on ComNet for information on reporting a work health and safety incident. Additional resources can be found in the WHS Management System page.

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When is a communication protocol needed?

A communication protocol may be appropriate if a stakeholder is:

- causing undue distress to Comcare staff, or
- demonstrating behaviour or a communication style that is unproductive, or
- feeling undue stress as a result of our communication approach, particularly if that stress may increase the risk of self-harm to the stakeholder, or
- showing behaviour that appears to contravene Comcare's Zero tolerance of aggression towards Comcare employees.

Whether a communication protocol is appropriate in the circumstances is an issue to be considered by the claims team in consultation with the relevant Assistant Director (AD) and Director. Consideration should be given to what other measures can be taken before progressing to a communications protocol in order to mitigate any risks.

For example, an AD or Director of Operations may contact the stakeholder to discuss the concern and that Comcare has a zero tolerance policy. The AD or Director of Operations may then escalate to Claims Complaints and Feedback, and an assessment may be made on whether a communications protocol is appropriate or whether the conversation itself is sufficient to mitigate the presenting risk.

Written records

All phone conversations and verbal discussions must be recorded in writing. An accurate and comprehensive record of each interaction, detailing the behaviour observed, must be recorded on the claim file to support the need for a warning letter and/or a communications protocol. All comments should be factual and, if subjective comments are made, then they should describe the behaviour or conduct or circumstance that led to that assessment or observation. Bear in mind that documents and comments on a claim file may be subject to release under Freedom of Information requests.

The record of all conversations should include the date, communication topic and behaviour that was unproductive, unacceptable or offensive. It should include efforts made to encourage the employee to improve their communication or behaviour. For example,' *the employee was reminded of the requirement to engage respectfully and appropriately and not use offensive language*.'

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Steps before considering a communication protocol

A communication protocol is not the first solution for addressing challenging communication. There are clear steps to follow which aim to reduce the difficulties and minimise the need for communication protocols.

In all cases, you should take timely action in following these steps so that measures can be put in place as soon as possible. This will help to reduce the potential risk of harm to Comcare staff and the other stakeholders.

The recommended steps to follow (to be considered as a guide) are, in order:

1. Claims Manager gives a verbal warning if they consider themselves in a position to do so. Alternatively, it may be appropriate for the Claims Manager to terminate the call.
2. If considered appropriate, the Assistant Director may contact the stakeholder to 'circuit break' the relationship and reinforce Comcare's position on zero tolerance of aggressive behaviour towards employees.
3. A letter from the Claims Ops Assistant Director or Director outlining Comcare's zero tolerance policy is sent to the stakeholder. If, following the release of the letter, there is no change in stakeholder behaviour, consideration should be given to putting a communications protocol in place.
4. A communication protocol is put into place by CCF in consultation with the claims team and other relevant areas across CMG and Comcare.

See detailed information on each step in the links above or subheadings below.

There may be exceptional circumstances where the steps are not followed in this strict order, i.e. a circumstance which warrants going straight to steps 3 and 4. This will be considered on a case-by-case basis.

Examples of when a communication protocol may be implemented include when an employee is:

- making threats against Comcare or staff or to themselves
- refusing to accept an outcome and has exhausted all available review and complaint options
- demonstrating an unwillingness or inability to accept reasonable explanations
- sending regular and numerous emails or phone calls that have been deemed as notably persistent
- demonstrating abusive, aggressive or threatening behaviour or offensive language

- continually refusing to speak to you and seeking to escalate their call directly through to management without allowing you a chance to resolve the issue.

Step 1: Claims Manager warning

Claims Managers are empowered to give a stakeholder a verbal warning about their behaviour. Refer to the Responding to aggression guidance document.

Take steps to end the conversation if you need to. From the Responding to aggression guidance:

- When the behaviour occurs, warn the person you will end the conversation. *"I will be unable to assist if you continue to use offensive language. I will end the conversation if the offensive language persists."*
- End the conversation if the aggressive behaviour continues. *"As I mentioned earlier, I am unable to assist you while you continue to use offensive language. I will now end this conversation and allow you some time to reflect on our conversation before we speak again."*

Make a detailed record of the conversation in the claim file.

When you have finished the call, discuss the situation with your Assistant Director or Director to agree on next steps.

Step 2: Assistant Director 'circuit breaker' warning

After a difficult communication event, the Claims Manager needs to discuss the stakeholder's behaviour with their Assistant Director. During the discussion, you should consider whether it is appropriate for the Assistant Director or Director to contact the stakeholder to discuss their behaviour and its impact on the claims team. This contact should be preferably by phone, or otherwise by email.

The Assistant Director or Director will try to get agreement from the stakeholder about the way forward and expectations about future interactions. You should also consider confirming the details of the agreement in writing by email if appropriate.

Details of this discussion with the stakeholder need to be recorded in the claim file to ensure that, if the behaviour happens again, there is a clear record of the steps that Comcare is taking to address the problem.

Step 3: Zero tolerance warning letter

If the stakeholder fails to acknowledge or alter their behaviour after the previous warnings, you should send a formal letter to the stakeholder referring to Comcare's Zero tolerance of aggression policy. Use Letter template '1071 Zero tolerance of behaviour warning letter' available in Pracsys.

The Director of Claims Ops will usually be the signatory on the letter. However, in certain circumstances it may be appropriate for the signatory to be the Claims Complaints and Feedback team, the Senior Director of Claims Management Group or even the General Manager of Claims Management Group.

You should document this step in the claim file with details about the circumstances leading to the letter being sent and the level of signatory that was considered appropriate.

Step 4: Develop and implement a communication protocol

When all attempts to resolve the difficult communication have failed, developing a communication protocol is appropriate.

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Developing a communication protocol

A communication protocol means that Comcare's services will be restricted. Therefore, it should only be considered when other measures to resolve the problem have been exhausted (by following the steps above before considering a communication protocol).

Roles and responsibilities

The Claims Complaints and Feedback (CCF) team will assist with the development of a communication protocol. They will determine if a communication protocol is necessary, record the details and timeframes for the protocol to be in place and work with the Claims Manager, the Contact Centre and other relevant staff to implement the communication protocol.

Reach out to CCF as early as possible to discuss who will take the lead on the work required.

This includes:

- considering the risks if a protocol was to be implemented
- coordinating consultation
- drafting the communication protocol if appropriate
- implementing the protocol, and
- reviewing the protocol.

The Claims Manager (with support from their Assistant Director) needs to provide the CCF team with:

- collated evidence of incidents, or a summary of incidents
- any actions taken so far, and
- how Steps 1, 2 and 3 have been completed before considering Step 4.

The Claims Manager also needs to flag the communication protocol in Pracsys. See Procedure to flag a claim as a commitment claim (including for communication protocols).

Approval for a communication protocol

Approval to implement a communication protocol is required by the General Manager of Claims Management Group. This is because it can represent a restriction to Comcare's service delivery to that stakeholder.

Consultation

It is recommended that the following staff should be consulted in the development of a communication protocol:

- Claims Operations
- Claims Complaints and Feedback
- Contact Centre
- Work Health and Safety
- Statutory Oversight in certain circumstances

- Security team in certain circumstances
- Injury Management/Clinical Panel psychologist to conduct a risk assessment about the impact a protocol may have on the stakeholder.

What is covered in a communication protocol?

This will depend on the circumstances of the stakeholder. Appropriate limitations may include email-only correspondence (no phone conversations or in-person visits) and limitations on how often the stakeholder can contact Comcare. Other limitations may include call or email diversions to a dedicated Comcare recipient or, in extreme cases, blacklisting.

Measures may be interim or temporary or they may be permanent and ongoing. Measure are subject to review (see Reviews of communication protocols).

Notifying the stakeholder

The Claims Complaints and Feedback team will release the communication protocol in writing once it has been agreed. In consultation with the Claims Team, they will determine the most appropriate channel and considerations for release to the employee. For example, they may release the protocol via a treating practitioner. They will consider the most appropriate timing for the release, whether there is (or needs to be) an Act on Behalf on the claim file and any other factors.

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When a communication protocol is in place

Once a communication protocol has been put in place, the Claims Complaints and Feedback team maintains it in a register.

What to do when you have a stakeholder with a communication protocol

When you become aware that a communication protocol is in place in one of your claims, follow this guidance:

- Read the communication protocol and make sure the claims team and Contact Centre are also aware.
- Make sure this information is clearly communicated whenever a claim is transferred to a new Claims Manager.
- Reach out to Claims Complaints and Feedback team with any questions or concerns, including reporting any further examples of inappropriate behaviour.
- Keep to the terms of the communication protocol.
- Any revisions to the communication protocol need to go through the process for review.
- If the stakeholder doesn't comply with the communication protocol and you have taken a call:
    - Advise the stakeholder there is a communication protocol in place which is (state the details) and that as per the plan, communication is only via (state the details) and you are going to terminate the call as this communication is outside of the communication protocol.
    - End the conversation.

- Make a detailed note in the claim file documenting the conversation.
- Notify your Assistant Director and the Claims Complaints and Feedback team.

Non-compliance with communication protocol

A stakeholder may not comply with a communication protocol. Where appropriate, further arrangements may be made to control incoming email through a specific mailbox or route incoming phone calls to a voicemail.

Where behaviour becomes persistently escalated, it may be appropriate to consult with or refer the situation to the Security and/or the Statutory Oversight teams. An internal working group may be established that is led by the General Manager for Claims Management Group or the Senior Director for Claims Management Group.

Examples of escalated behaviour include:

- threats to Comcare staff or property
- complaints about members of the Claims Complaints and Feedback team
- creating a new email address or calling anonymously or from a different phone number to circumvent restrictions.

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Reviews of communication protocols

A communication protocol needs to be reviewed regularly and amended as appropriate. Each communication protocol will include a review date. A protocol will usually be reviewed before the review date and onwards on a periodic basis. The Claims Complaints and Feedback team will lead the review. They will collaborate with the claims team, other teams, the Executive as appropriate, and the stakeholder to review the protocol. The stakeholder will be provided with the opportunity to re-engage in an appropriate manner.

Possible outcomes of review

There are three possible outcomes of a communication protocol review:

- **Maintain** – the stakeholder is continuing to demonstrate inappropriate behaviour.
- **Vary** – some aspects of the limitations are lifted (for example, no limitations on the number of emails; however, still restricted from calling Comcare).
- **End** – the stakeholder has engaged with Comcare in an appropriate manner and restrictions are removed.

Actions following review

Once a review is complete, the Claims Complaints and Feedback (CCF) team will issue notifications internally and to the stakeholder in writing. They will set a further review date.

They will then update the communications protocol register.

See the Procedure to review a communication protocol for more.

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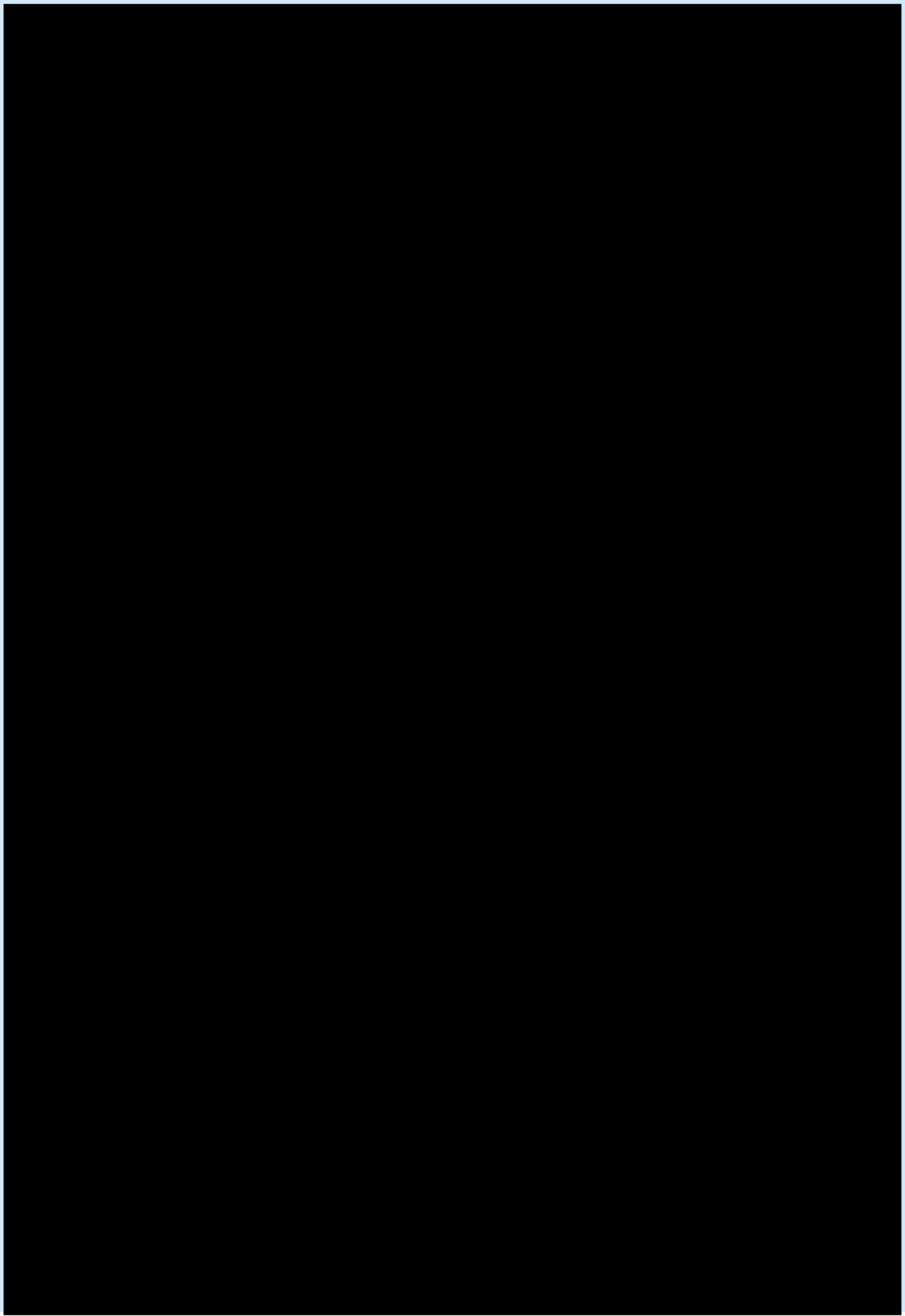

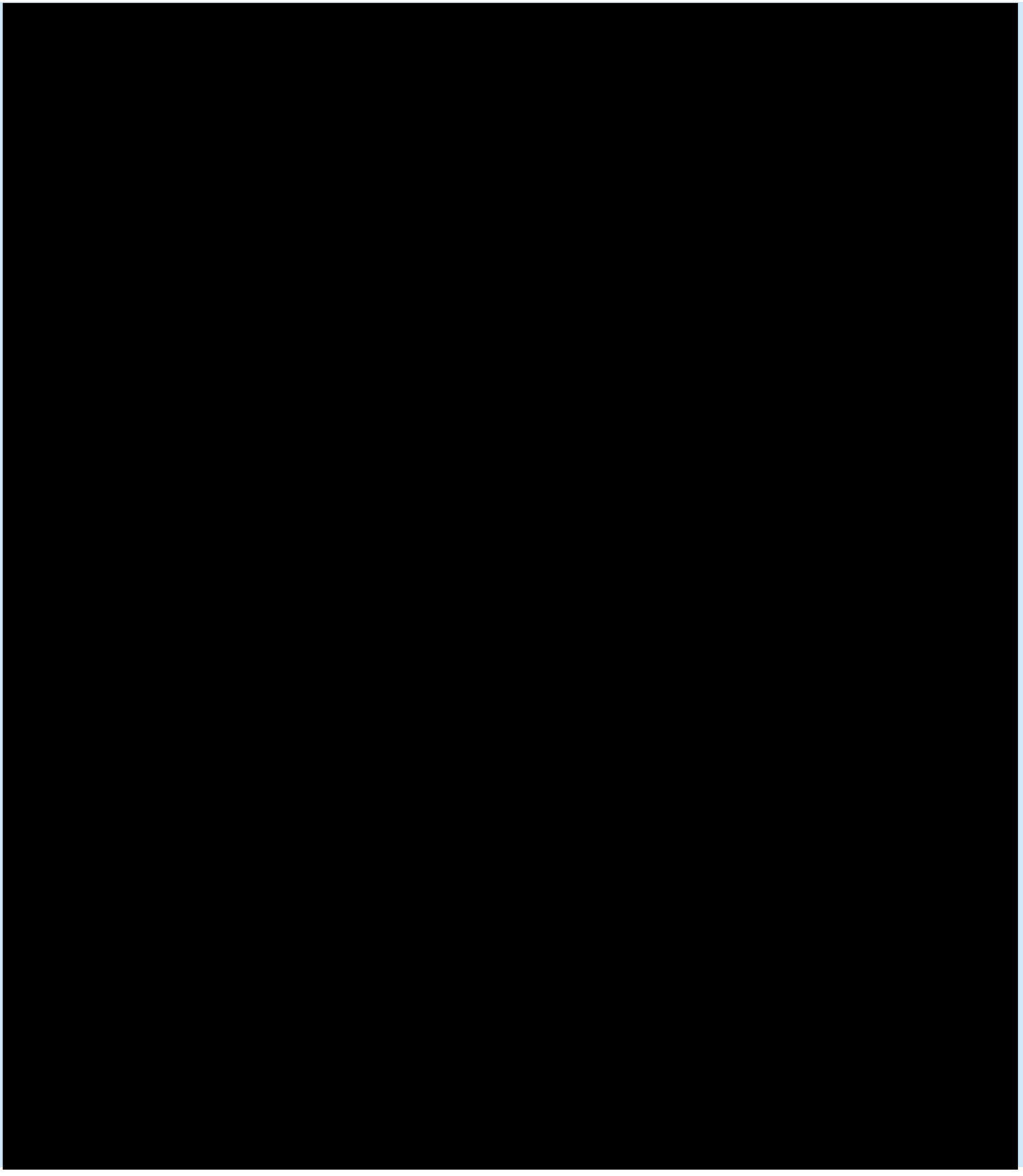

The role of the Claims Complaint & Feedback team

The Claims Complaints & Feedback team will do the following:

- Determine whether a communication protocol is necessary or whether the stakeholder's behaviour could be managed in another way and discuss further with the relevant team(s). **Note:** A communication protocol will only be implemented in cases where all other options have been exhausted.
- Register the details of all communication protocols.

- Determine the restrictions and timeframe a communication protocol will remain in place.
- Implement and advise the stakeholder, relevant team and the Contact Centre of the details of the communication protocol. **Note:** The Claims Manager will enter a Pracsys commitment comment with the details of the communication protocol.
- Review existing communication protocols in place and liaise with the relevant team on whether the protocol should be maintained, varied or ended.
- Advise the stakeholder, the relevant team(s) and the Contact Centre of the outcome of the review of the communication protocol and update the 'Communication Protocol List' that is shared with Claims Contact Centre team.

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The role of the Claims Operations team

The Claims Operations team, generally the Claims Manager with support from the Assistant Director, will:

- follow the steps before considering a communications protocol
- prepare the required information before referring a claim to Claims Complaints and Feedback (CCF)
- inform the Contact Centre
- update comments in the commitment claim function in Pracsys
- set review dates for communication protocols and contact CCF when a review date is coming up.

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The role of the Claims Contact Centre team

Call Centre Agents are to be regularly informed and have access to the 'Communication Protocol list' maintained by the Claims Complaints and Feedback (CCF) team.

The risk that Call Centre Agents communicate with an employee on a communication protocol is high and must be identified through risk assessments of introducing the protocol.

Call Centre Agents who receive a call where the caller is identified as being on a communication protocol will remind the caller of the protocol and promptly end the call. The Call Centre Agents will notify their supervisor of the breach and update the claim comments as well as completing an incident report. The Supervisor will inform CCF of the breach in protocol.

If the caller continues to call the Call Centre, the Assistant Director or Director may activate the 'No Caller ID' diversion for a specified period or liaise with CCF to have the caller's identified phone number redirected to the CCF blocked call mailbox.

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Complaints from stakeholders with a communication protocol in place

If an employee with a communication protocol wishes to make a complaint about Comcare, they can do so via phone, email or the online feedback form within the parameters of their individual communication protocol. This will be viewed and actioned by the Customer Complaints and Feedback team (CCF).

Please refer to the Complaints and feedback page for more information on how Comcare manages complaints and feedback.

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Communicating a determination or decision

Introduction

As with all communications with our stakeholders, you must consider the Claims Communication Principles, when contacting an employee (and employer) to advise them we are accepting or declining their claim.

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Communicating a newly accepted claim

This information is designed to help you plan and conduct your telephone conversation with the employee or their representative.

Begin the call

Introduce yourself and that you are calling from Comcare.

Privacy

Undertake a privacy check to ensure you are speaking to the correct person. For guidance, refer to the Verifying Caller Identity document.

Ask if now is a good time to talk? If not, when?

Set the scene. "*Today, I'd like to talk to you about acceptance of your claim…*"

Explain the claim determination – accept

Explain to the employee that their claim has been accepted and the specifics of what has been accepted.

Comcare's role

Explain your role in a claim for compensation:

- Assess and manage the claim. You could say "*As you know, I have been assessing yoru claim to make the determination. I will continue to manage your claim while you are receiving compensation from Comcare (and until you are back at work).*"
- Work with you, your employer and treating health practitioners to support you to:
  - return to health and where possible, safely remain at or return to work
  - support you throughout the claim process.

Entitlements

As the claim is accepted, discuss the various entitlements the employee may have access to. These can include the following:

- Normal Weekly Earnings calculation information, including obligations for informing Comcare of any changes, 45 weeks till reduction etc. See the Incapacity payment and calculation pages for all the guidance on this topic.
- Incapacity payments – explain the process for claiming for incapacity.
- Medical treatment/household services - advise of the process for claiming for medical treatment or other supports. This includes seeking prior approval and where to find the relevant forms. See the Medical treatment and other support pages for all the guidance on this topic.
- Process for claiming reimbursements.

Return to work (RTW)

Discuss the following with the employee:

- Has a return to work been achieved?
- If not, confirm current work capacity and identify any potential return to work barriers. Barriers include medical, workplace and external factors.

Capacity and motivation

Discuss with the employee any workplace support including:

- rehabilitation
- whether their employer has contacted them to discuss RTW options (if not, the Claims Manager will discuss with the Rehabilitation Case Manager (RCM)).

Treatment

During the conversation with the employee, it is a great opportunity to gain an understanding of their treatment (current and potential). You can confirm with them the following:

- What treatment is currently recommended and being undertaken.
- When did they commence treatment?
- Frequency of treatment.
- Treating practitioners or specialists the employee has been referred to.
- Any potential or recommended treatment they have been looking to undertake.

Employee responsibilities/obligations

It is always important to set expectations and explain to the employee their obligations in relation to their claim. These can include the following:

- Attend medical examinations arranged by Comcare (as appropriate).
- Participate in the return-to-work process by co-operating with your employer, rehabilitation case manager and rehabilitation provider.
- Ensure you supply up to date medical certificates to support your claims.
- Notify us if your personal circumstances change such as name, address, earnings, capacity for work, and bank details.

Employer responsibilities/obligations

It is also a good opportunity to explain the employer's role. They must take reasonably practicable steps to ensure the health and safety of you and others. This may include:

- making changes to the workplace to minimise the chance of further injuries or accidents
- providing you with claims information, including relevant forms and advice about processes and procedures
- working with the Claims Manager to support an accurate and timely determination of your claim
- supporting you to return to health and safely remain at or return to work, where possible.

If the employee raises concerns about their employer with you, this may prompt you to have a discussion with the Rehabilitation Case Manager (RCM).

Call wrap up

Ask the employee if there is anything they want to discuss.

Summarise the conversation and discuss next steps. For example:

- Today we discussed that Comcare has accepted yoru claim for (insert claimed compensation). We also discussed the claims process, your diagnosis, treatment, return to work, entitlements and responsibilities.
- Comcare may request a report from your treating health practitioners seeking their input on your injury, capacity for employment and recovery.
- We may liaise with various stakeholders to support the management of your claim such as Rehabilitation Case Managers at your employer.
- Our Clinical Panel may liaise with your treating health practitioner to support treatment and return to health outcomes.

Thank the employee for their time.

Record your conversation and set diaries

At the end of the call, make sure you update the claim plan and add claim comments that detail the conversation. Set diaries to ensure any specific commitments are actioned.

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Communicating an adverse decision

This information is designed to help you plan and conduct your telephone conversation with the employee or their representative.

Before you make the call, please read and consider the information in Communicating with an employee. This page provides useful guidance on managing difficult conversations, and dealing with aggression, threats or suicidal callers. Familiarise yourself with this information **before** you start a phone call, particularly when you are declining a claim.

Timing of conversation

When delivering an adverse decision, it is critical to consider the best time to have this conversation. You should select a time that allows you the opportunity to fully explain the decision and allows the employee to ask questions about the decision. For further information on delivering adverse decisions, refer to the 'How to deliver an adverse decision' guidance document.

Managing risk to the employee

Before communicating an adverse decision to an employee, you should consider the impact and risk to the employee of receiving such information. If you do have concerns, discuss with your Assistant Director the most appropriate way of communicating the information to the employee. This may include a discussion with an Injury Manager as well.

Following consultation with your Assistant Director you may need to contact the treating practitioner to better understand the risk of adverse effect on the employee receiving the information. If the risk is deemed high, the treating practitioner should be asked to assist with communicating the information to the employee.

If the employee is experiencing financial distress, they may be able to seek financial assistance from other sources. For more information, please refer to the Comcare website.

Begin the call

Introduce yourself and that you are calling from Comcare.

Privacy

Undertake a privacy check to ensure you are speaking to the correct person. For guidance refer to the Verifying Caller Identity document.

Ask if now is a good time to talk? If not, when?

Set the scene. "*Today, I'd like to talk to you about your claim…*"

Explain the claim determination – decline

Explain to the employee that their claim has been declined and the specifics of what has been declined.

When advising the employee of the decision you should:

- clearly explain the decision
- provide the employee with the information and evidence you have relied upon to make the decision, for example, Independent Medical Examination opinion, treating health practitioner information, employer statements
- allow the employee to ask questions about the decision
- explain to the employee their appeal rights
- provide the decision in writing following the conversation
- encourage the employee to seek support from their treating health practitioner.

Throughout the conversation, do not state to the employee that you understand what they are going through, as this may make a difficult situation worse.

Call wrap up

At the end of the call, thank them for their time.

Record your conversation and set diaries

At the end of the call, make sure you update the claim plan and add claim comments that detail the conversation. Set diaries to ensure any specific commitments are actioned.

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Commitment claims

Introduction

Comcare sometimes makes specific service commitments to individual employees in relation to their claim(s). You and any other staff involved in managing the claim need to be aware of these commitments.

A commitment claim is highlighted in pink in Pracsys in the claims header next to the display for the primary condition.

You must view comments on commitment claims
Anyone who accesses a claim that has been marked as a commitment claim needs to review the 'View Priority Comments' function for comments describing the commitment made by Comcare to the employee. You need to do this before any action is undertaken on the claim. Look in MCOM or VCOM in Pracsys and filter by comment category to 'commitment claim'.

If the notes indicate that there is a communication protocol in place, refer to Communication protocol for guidance on how to communicate with stakeholders involved in the claim.

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When should a claim be flagged as a commitment claim?

You should consider flagging a commitment on a claim in situations where we commit to performing a specific service.

For example:

- We commit to communicate with the employee in a specific way, such as all correspondence is in writing, no phone calls. Please refer to Communication protocol for more information.
- During the course of communication with an employee, you identify that the employee has vulnerabilities which may warrant a commitment about how we provide service to that employee.
- A common law settlement exists on the claim.
- There is a specific agreement or undertaking about the management of the employee's claim, for example, for example for the wellbeing of the employee or because of a CEO complaint or Ministerial representation.
- Claims that belong to a cluster of claims which Comcare has agreed to service in a particular manner.

Before requesting a commitment claim flag be placed on the claim, you should consider other ways that will allow you to address any issues the employee has raised, such as setting a diary reminder.

If you believe a claim should be flagged as a commitment claim, you should discuss this with your Assistant Director. Only an Assistant Director or above can approve the adding or removing of a commitment claim flag.

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Can a commitment flag be reviewed or removed?

Not all commitment claims represent long-term agreements made between Comcare and the employee. You should regularly review the reasons for a flag being created and any agreements that have been made. To do this, ensure that you **set action diary reminders** for review, when flagging the claim. Consult with your Assistant Director about the appropriate date to review the commitment.

Some claims are flagged as commitment claims for short-term reasons and some may be flagged because of historical issues. The flag should be removed if the commitment is no longer relevant or once Comcare has completed all actions that were agreed upon with the employee.

Consult with your Assistant Director before removing a commitment flag.

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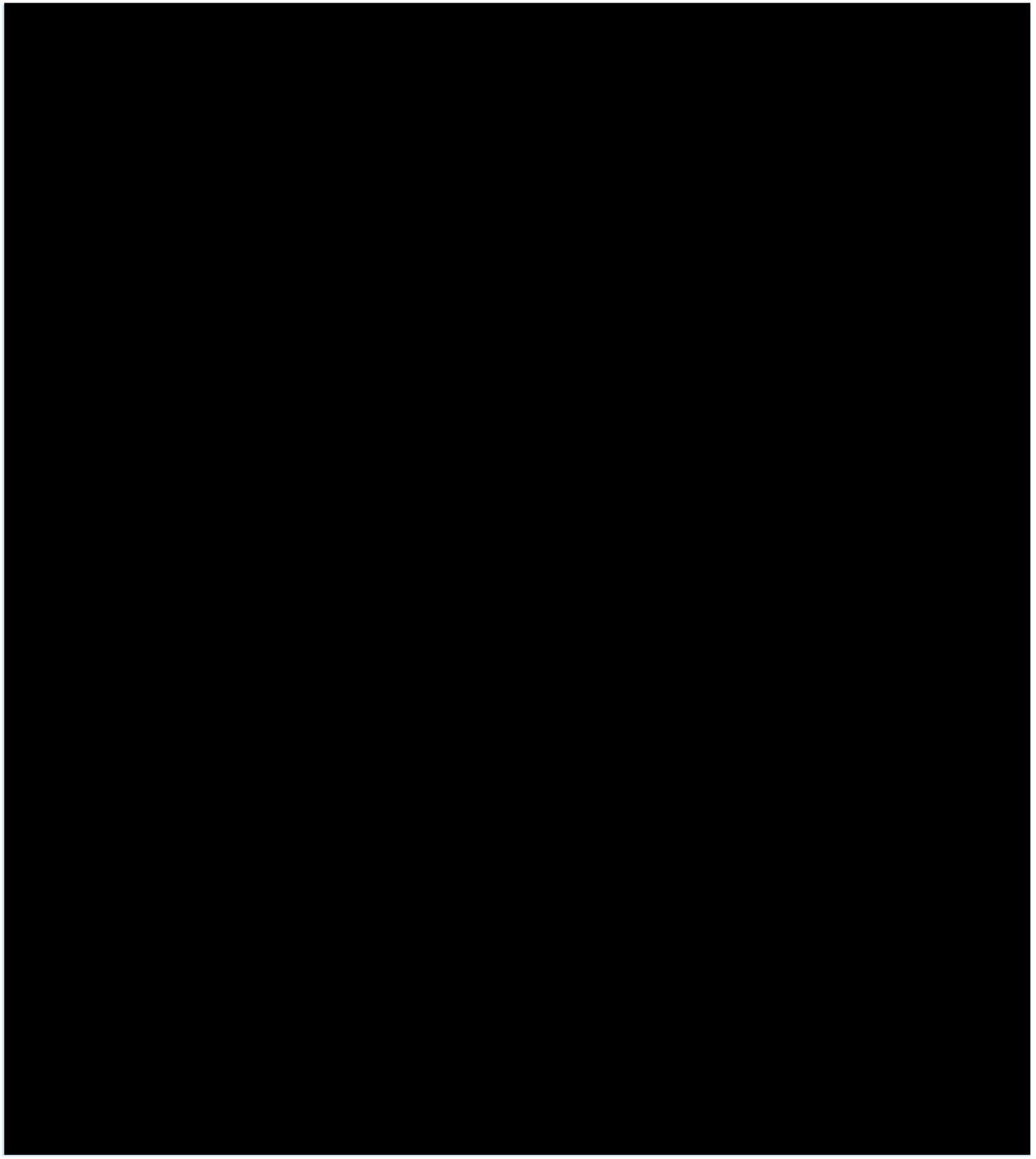

Communicating with an employer

Introduction

Regular communication is critical to building positive stakeholder relationships with our employers and enabling effective and proactive claims management.

Our Claims Communication Principles are key to supporting effective communication with our employers.

A Claims Manager can communicate with an employer in a range of circumstances, including but not limited to:

- initial discussion with a rehabilitation case manager on receipt of a new claim
- shared service arrangements when services such as payroll are outsourced to another agency
- when an employee changes employment and moves to a new employer
- when an agency becomes an off-budget or exit agency.

Claim Allocation: Claims Managers are required to attempt contact with the employer within 2 business days of a claim being allocated to them.

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New claim discussion with a rehabilitation case manager

When a new claim for workers compensation is received, you are required to contact the employer's rehabilitation case manager (RCM) to discuss the employee's claim and their return to work.

As new claims are triaged within 2 business days of the claim being allocated, the conversation with the employer must take place prior to any triage meeting.

The initial conversation with the RCM can help you with gathering information to assist in the consideration of the claim, and:

- identify any return-to-work barriers
- assess the employee's current work capacity
- ascertain the current status of the employee's condition, and
- set expectations about the claims process, including the claim determination process.

The following subheadings are discussion points and questions you can ask a RCM to enable you to:

- find out what has happened to date with the employee up till now
- identify the employee's support needs for returning to work
- set agreed actions with the employer about rehabilitation, and
- explain the claim determination process.

For help with planning and having an initial conversation with an employer, please refer to the Initial contact with employer guidance document.

The information captured during this discussion can also be valuable when creating the Claim Plan.

Status of the condition

Discuss:

- the employee's diagnosis
- treatment currently recommended and undertaken
- what other barriers exist, besides medical capacity, to the employee achieving a successful return to work (RTW) or commencing a graduated RTW
- what the latest medical certificate indicated
- check that a copy of this certificate is on the file and if not, request a copy, and note:
  - what, if any, is the current capacity?
  - when is next review date with doctor?
  - what treatments/referrals have been recommended?
- where appropriate, the need for the employee to attend an independent medical examination under section 57.

Current capacity to work

Advise the Rehabilitation Case Manager of your review of documents and your conversation with the employee about their current work capacity and find out the current work status of the employee and their current duties.

Return to work (RTW)

Discuss rehabilitation actions the employer has undertaken, specifically:

- if a rehabilitation provider has been engaged
- if a Return to Work (RTW) Program is in place
- details of any section 36 rehabilitation assessments
- any other rehabilitation needs.

Important: If no actions have been taken to date, note the reasons why. Following your conversation, discuss the matter with the Assistant Director and Injury Manager for support.

Identify RTW expectations by discussing:

- what RTW expectations the employee expressed to you as the Claims Manager
- what is the employer's opinion of how the employee's RTW will progress:
  - have interactions with the employee been positive?
  - has the employee expressed motivation to RTW?
- prospects for RTW to pre-injury duties and/or modified duties with same employer, including:
  - medical indications (compensable and non-compensable)
  - organisational availability of role/s
  - any interpersonal factors
  - any performance issues, and if so, has the employee been approached regarding these issues?
- discuss Comcare's role in promoting early and sustainable return to work.

Part 2 of the claim form and employer statement (where required)

Explain to the RCM that you need them to complete Part 2 of the claim form and that you require a statement and documentation.

Discuss timeframes and that a response will be needed within 14 days.

Due date: It is important that clear expectations are set with the employer regarding the due date of their response. For further guidance, refer to the Requesting information from employers page.

Closing the call

Summarise the conversation and any agreed actions, in particular:

- reports you will be requesting
- arrangement of a medical examination under section 57 (if appropriate), and
- requests for statements and/or documents under section 71 of the SRC Act.

Discuss what the next steps are in the claims process.

Reiterate what the employee's/employer's responsibilities are in respect of following up or providing information and the impact it will have if the information is not received by the due dates.

Discuss the time it takes to determine liability on a claim, i.e., 20 or 60 days for injury and disease claims respectively, but that we try and determine claims as quickly as possible.

Prescribed timeframes and stop clock provisions
Explain about the prescribed timeframes for determining a claim under section 61(1A) and the 'stop clock' provisions in which timeframes are paused while Comcare awaits requested information. See the information in Decision making under the SRC Act for more details.

Claims Managers must record details of all telephone conversations with employers.

A comment must be recorded including the date and time the phone call took place, details of the query and response or advice provided, any actions that the Claims Manager has committed to doing with agreed timeframes and any other relevant information. For all initial calls with employers, please use the Pracsys initial call record template to document your conversation.

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Shared service arrangements

Some employers have negotiated shared services arrangements that outsource certain functions, such as payroll and claims management. In these scenarios, the contact person for queries about these functions may be different to the key employer contact recorded in Pracsys, so it is important to consider this when contacting the employer.

Payroll functions usually include but are not limited to:

- completion of Claim for Time Off Work (CTOW) forms
- completion of Normal Weekly Earnings (NWE) forms
- leave processing
- compensation payments related to work and leave.

Please refer to the list below outlining those employers who have shared service arrangements:

Agency	Supporting Agency	Service
Asbestos Safety and Eradication Agency (ASEA)	Service Delivery Office (SDO) - an organisational unit within the Department of Finance	Payroll

Australian Commission on Safety and Quality in Health Care	Department of Health	Payroll
Australian Digital Health Agency	Department of Health	Payroll
Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS)	Service Delivery Office (SDO) - an organisational unit within the Department of Finance	Payroll
Australian Institute of Family Studies	Department of Industry, Science, Energy & Resources	Payroll
Australian Public Service Commission (APSC)	Service Delivery Office (SDO) - an organisational unit within the Department of Finance	Payroll
Australian Signals Directorate	Department of Defence	Payroll & Case Management
Australian Skills Quality Authority (ASQA)	Service Delivery Office (SDO) - an organisational unit within the Department of Finance	Payroll
Australian Submarine Agency (ASA)	Department of Defence	Payroll & Case Management
Australian Naval Nuclear Powered Safety Regulator	Department of Industry, Science and Resources, Service	Payroll
Clean Energy Regulator	Department of Industry, Science, Energy & Resources	Payroll
Climate Change Authority	Department of Industry, Science, Energy & Resources	Payroll
Commonwealth Department of Public Prosecutions	Department of Industry, Science, Energy & Resources	Payroll
Commonwealth Ombudsman	Department of Industry, Science, Energy & Resources	Payroll
Department of Education (EDU)	Service Delivery Office (SDO) - an organisational unit within the Department of Finance	Payroll
Department of Employment and Workplace Relations (DEWR)	Service Delivery Office (SDO) - an organisational unit within the Department of Finance	Payroll
Department of Finance (DoF)	Service Delivery Office (SDO) - an organisational unit within the Department of Finance	Payroll
Department of Veterans Affairs	Services Australia	Payroll
Digital Transformation Agency (DTA)	Service Delivery Office (SDO) - an organisational unit within the Department of Finance	Payroll
Geoscience Australia	Department of Industry, Science, Energy & Resources	Payroll

Independent Parliamentary Expenses Authority (IPEA)	Service Delivery Office (SDO) - an organisational unit within the Department of Finance	Payroll
Murray Darling Basin Authority	Department of Industry, Science, Energy & Resources	Payroll
National Disability Insurance Agency	Services Australia	Payroll
National Health Funding Body	Department of Health	Payroll
National Indigenous Australians Agency	Department of Prime Minister & Cabinet	Payroll
National Emergency Management Agency	Department of Home Affairs	Payroll
Office of the Australian Information Commissioner (OAIC)	Service Delivery Office (SDO) - an organisational unit within the Department of Finance	Payroll
Office of National Assessments	Department of Industry, Science, Energy & Resources	Payroll
Office of the Official Secretary to the Governor-General	Department of Industry, Science, Energy & Resources	Payroll
Office of Parliamentary Counsel	Department of Industry, Science, Energy & Resources	Payroll
Safe Work Australia (SWA)	Service Delivery Office (SDO) - an organisational unit within the Department of Finance	Payroll
Sport Integrity Australia	Department of Health	Payroll (Note: if employee is casual, payroll is managed by Sport Integrity Australia)
Workplace Gender Equality Agency (WGEA)	Service Delivery Office (SDO) - an organisational unit within the Department of Finance	Payroll

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When an employee changes employment and moves to a new employer

How Comcare communicates with a new employer will depend on several factors.

Disclosing information to new employer

Comcare is authorised to disclose to the employer that they are the employee's rehabilitation authority. Please check the employee's claim file to ensure that they have provided their signed consent before disclosing any information.

If a claim is active, and if an employer makes a request to confirm whether they are the rehabilitation authority for a particular employee, Comcare must confirm the employment status of the employee before disclosing information to the employer. After confirming the employment status of the employee, Comcare is authorised to disclose to the employer information relevant to the rehabilitation of the employee.

The employer may request a copy of information on an employee's claim file under section 59 of the SRC Act. Normally, when an employee changes employment from one Australian Government agency and moves to another Australian Government agency, the liable employer will request authority from the employee to contact the new employer, as they have become the new rehabilitation authority. This is so that there can be an appropriate handover of rehabilitation activities and case management support to the employee.

Open Rehabilitation Programs

If there is an open Rehabilitation Program, it is the responsibility of the new rehabilitation authority to take over the rehabilitation management, and it is important that both employers work in collaboration to minimise any adverse impact on the employee's recovery.

Where Comcare has the employee's authority to contact the new employer, Comcare will support the appropriate handover of such information to assist with rehabilitation.

Leaving Commonwealth employment

When an employee changes employment and moves to a non-Australian Government or private employer, or is separated from employment and is not working, the liable agency remains the rehabilitation authority.

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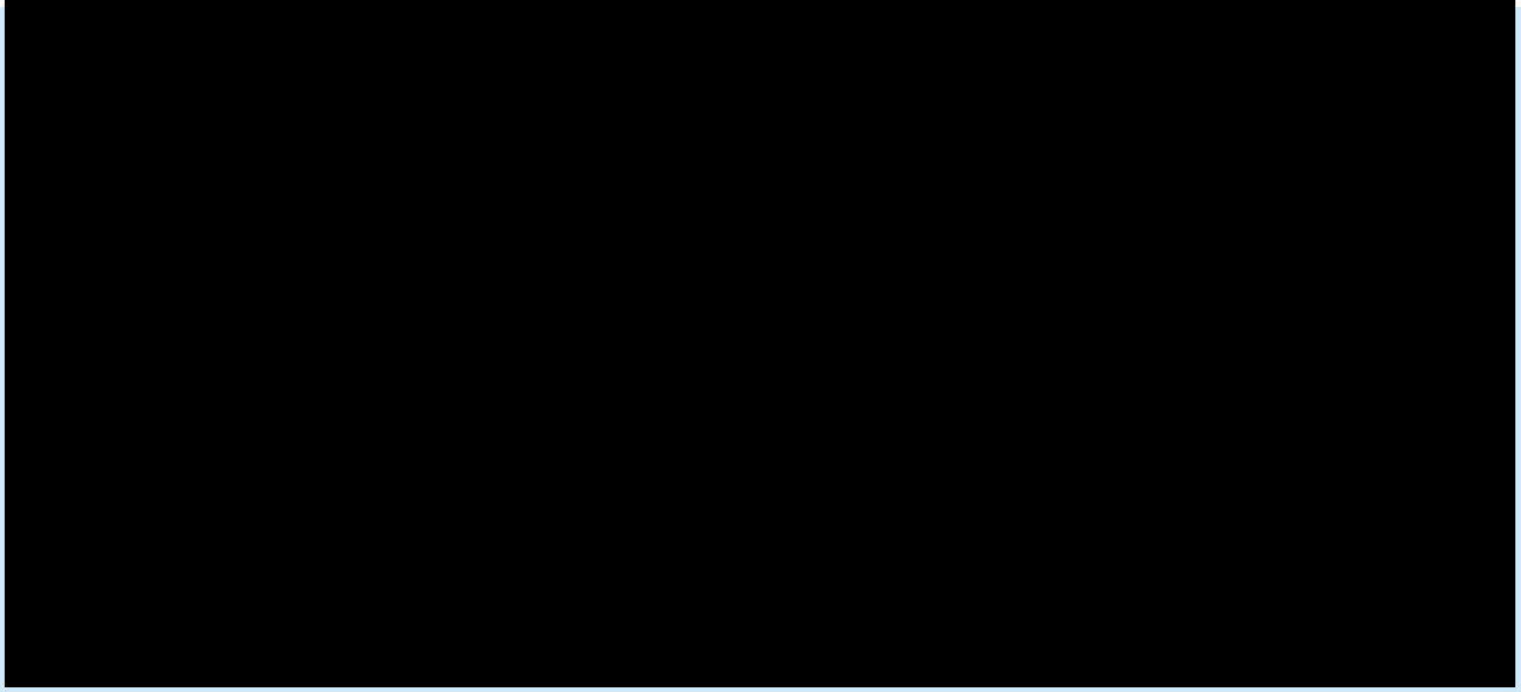

When an agency becomes an off-budget or exit agency

Please see Practice support and account management for details on off-budget and exit agencies.

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Complaints and feedback

Introduction

Stakeholders, such as employees, employee representatives or employers, may provide positive or negative feedback about different aspects of claims. For example, they may provide feedback about an outcome or something that Comcare or a service provider did. They may also provide feedback about our timeliness or responsiveness in managing their claim, or they may provide feedback about something else.

Feedback is a valuable learning opportunity that helps us continuously improve as we strive to have a positive impact and achieve excellent service delivery.

Comcare values feedback and recognises that effective complaint handling reassures our stakeholders that we are committed to resolving issues, acting with integrity and respect, improving our service delivery, and being accountable and transparent in our decision making.

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What is a complaint?

The Comcare Complaints Handling Framework defines the following types of feedback:

- Negative feedback - detailing dissatisfaction about some aspect of the service, functions or conduct of Comcare, or its representatives, that can be managed routinely by the team involved and does not require a formal written response.
- Operational issue - some aspect of Comcare's service delivery or functions that requires action, but the communication about the issue is not expressed as negative feedback or as a complaint and can be managed routinely by the team involved.
- Complaint - an expression of dissatisfaction about some aspect of the services, functions or conduct of Comcare, or its representatives, where a formal written response or resolution is explicitly or implicitly expected or legally required and cannot be managed routinely.

You can talk to your Assistant Director or contact the Claims Complaints and Feedback mailbox if you need help differentiating between or resolving negative feedback, operational issues or complaints.

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Roles and responsibilities

Complaints and Feedback team

Claims feedback and complaints in Comcare are handled by the **Claims Complaints and Feedback** team, a team within the Client Experience team of Claims Management Group.

The team is responsible for registering and coordinating responses to complaints made by employees, service providers and other stakeholders relating to the claim's aspect of Comcare's work.

The progress of complaints handled by Claims Complaints and Feedback team is tracked using a SharePoint database and Pracsys.

Other responsibilities by other roles are outlined below.

All staff

All Claims Management staff must be aware of the Complaints Handling Framework and its importance to our work. All staff must be able to:

- recognise and differentiate between negative feedback, operational issues and complaints, and take appropriate action in relation to them including acknowledging and resolving issues where possible
- advise people how to make a complaint
- understand and engage with the complaint assessment process, including providing information to respond to the complaint
- inform Assistant Directors, Directors and the Claims Complaints and Feedback team about complaints.
- recognise the Claims Complaints and Feedback team as the point of contact if they receive a complaint.

You can seek guidance from the Assistant Director or the Claims Complaints and Feedback team if you need help to differentiate between negative feedback, operational issues or complaints, or to resolve negative feedback.

Assistant Directors and Directors

Where the complaint relates to a specific claim, the Claims Operations Director or Contracted Claims Services Director for delegated claims is the key contact in Claims Management Group for responding to the Claims Complaints and Feedback team about the complaint. The Director may nominate an Assistant Director to perform this role.

The Assistant Director and/or Director is responsible for:

- ensuring a complaint summary and chronology is prepared with input from all teams involved in the issue
- coordinating responses requested by the Claims Complaints and Feedback team on behalf of CMG in the required timeframe
- reviewing draft complaint outcomes and providing comments to the Claims Complaints and Feedback team within the agreed timeframe
- Ensuring that any actions required as a result of the complaint are completed and that any broader issues are identified and actioned.

Delegated claims

For complaints relating to delegated claims, the third-party service provider will respond to the complaint in the first instance. If it cannot be resolved, the Claims Complaints and Feedback Team responds to the complaint.

Commonwealth Ombudsman

An employee may also ask the Commonwealth Ombudsman to investigate concerns about the management of their claim.

The Commonwealth Ombudsman will ask Comcare for a response and does not investigate unless the employee has first attempted to resolve their complaint with Comcare directly.

Members of Parliament (MP)

Ministerial and parliamentary requests are triaged by the Director Statutory Oversight and the Senior Director, Claims, copying in the relevant team Director. Negative feedback and operational issues will be handled by the relevant team, while complaints will be handled by the Claims Complaints and Feedback team.

For more information on the process of managing Ministerial and Parliamentary Requests, refer to the Complaints Handling Framework.

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How do stakeholders make complaints?

Our stakeholders (employees, dependants, employers and providers) can make complaints directly to Comcare or through a representative such as their lawyer, a treating health provider, union or a Member of Parliament. They may also ask the Commonwealth Ombudsman to look into an issue for them.

Comcare has a web page you can direct stakeholders to if they wish to leave feedback called Provide feedback.

The Claims Management Group receives complaints in a range of ways. Complaints can come through directly to the Claims Manager or others in the team, for example through the general enquiries mailbox. Or they may come through the Claims Complaints and Feedback Team, our Practice Support and Account Management teams, or our legal providers. And sometimes people write to the Chief Executive Officer (CEO) or their office. Complaints made through a Member of Parliament also go to the CEO's office.

Complaints may be received by:

- telephone
- email
- fax
- ordinary mail
- in person.

Complaints received via the Contact Centre are referred directly to the Claims Complaints and Feedback team.

When you receive a complaint, keep accurate written records of any conversations with the person making the complaint and of internal discussions about it.

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What to do if you receive a complaint

When someone expresses dissatisfaction about any aspect of our claim management service or our providers:

- actively listen and recognise the person's right to complain about Comcare's service
- treat the person with respect and courtesy in line with Comcare's values (which are located with the claims management strategy) and the APS Values and Code of Conduct
- try to resolve the issue
- if you are unable to resolve the issue, speak with your Assistant Director to seek guidance
- if the person is still dissatisfied or indicate they want to complain (or have already complained) through another avenue (e.g. CEO, MP, Ombudsman):
    - provide information about our complaints process
    - offer to refer them to our Claims Complaints and Feedback team
    - provide details so they can contact the Claims Complaints and Feedback team directly
    - inform your Assistant Director and Director.
- keep an accurate record of all conversations in Pracsys
- treat all information confidentially.

Always inform the following about any complaint immediately:

- your Assistant Director and Director
- the Claims Complaints & Feedback team

In addition, please refer the following types of complaints and enquiries for assessment and action as follows:

Type of complaint	**Refer to:**
If you receive a call or correspondence directly: • from a Member of Parliament (or their office) • from the Commonwealth Ombudsman • addressed to the Chief Executive Officer, or that looks like the CEO should be informed (e.g. mentions the CEO or an MP).	Your Assistant Director and Director immediately, who will then brief the Claim Complaints and Feedback team, the Senior Director, General Manager and the Office of the CEO as necessary to respond to the communication.
Complaints regarding Medical Practitioners or Independent Medical Examiners (IME)	The Claims Complaints and Feedback team, who will work with the Injury Management and Return to Work (IM & RTW) team for assessment and resolution. If the specialist's conduct triggers a mandatory notification the IM & RTW team will consider whether to report the conduct to the Australian Health Practitioner Regulation Agency (AHPRA) in accordance with their guidelines.
Rehabilitation providers	Provider Frameworks and RTW team for assessment and action. Injury Management and Return to Work (IM & RTW) team for assessment, resolution or escalation to Provider Frameworks and RTW team.

Legal Service Providers or Legal Service Directions	Legal Practice Management (LPM) who will manage these under the Model Litigant complaints process.
Privacy complaint	Privacy – Statutory Oversight team – for assessment and action. The Privacy Team will consider if the Office of the Australian Information Commissioner needs to be notified and manage this – contact Comcare Privacy team

Please include the Complaints and Feedback team when referring the above matters.

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Complaint record-keeping

When dealing with a complaint, ensure you keep records of all conversations.

The Director (or Assistant Director) ensures that both the following are completed:

- complaint summary
- complaint chronology.

Key events for the complaint chronology relate to the subject of the complaint. For example, if someone complains about a delay, it should record:

- when the person first made the request
- what steps were taken to action the request, when and by whom, including any follow-up
- any communication with the person who made the request including progress updates.

Several teams may need to contribute to the chronology. Teams should not create separate chronologies but contribute to the same document so that there is one record of all actions taken that are relevant to the complaint.

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Unreasonable complainant conduct

There may be instances where claims teams receive calls or correspondence from complainants with unreasonable demands or behaviours.

Examples of unreasonable conduct include:

- raising the same issues that have been assessed previously without presenting new evidence
- being abusive towards staff (e.g. swearing and threatening behaviour)
- unreasonable persistence regarding outcomes
- unreasonable demands relating to timeframes for resolutions
- complaints that are frivolous, vexatious or not made in good faith.

If an employee making a complaint becomes unreasonable, Claims Managers should escalate the complaint to their Assistant Director or Director, or refer the complainant to the Claims Complaints and Feedback team for support (see Procedure to manage complaints in Claims Operations).

Resources are also available in Communicating with employees to support Claims Managers with handling and de-escalating difficult conversations.

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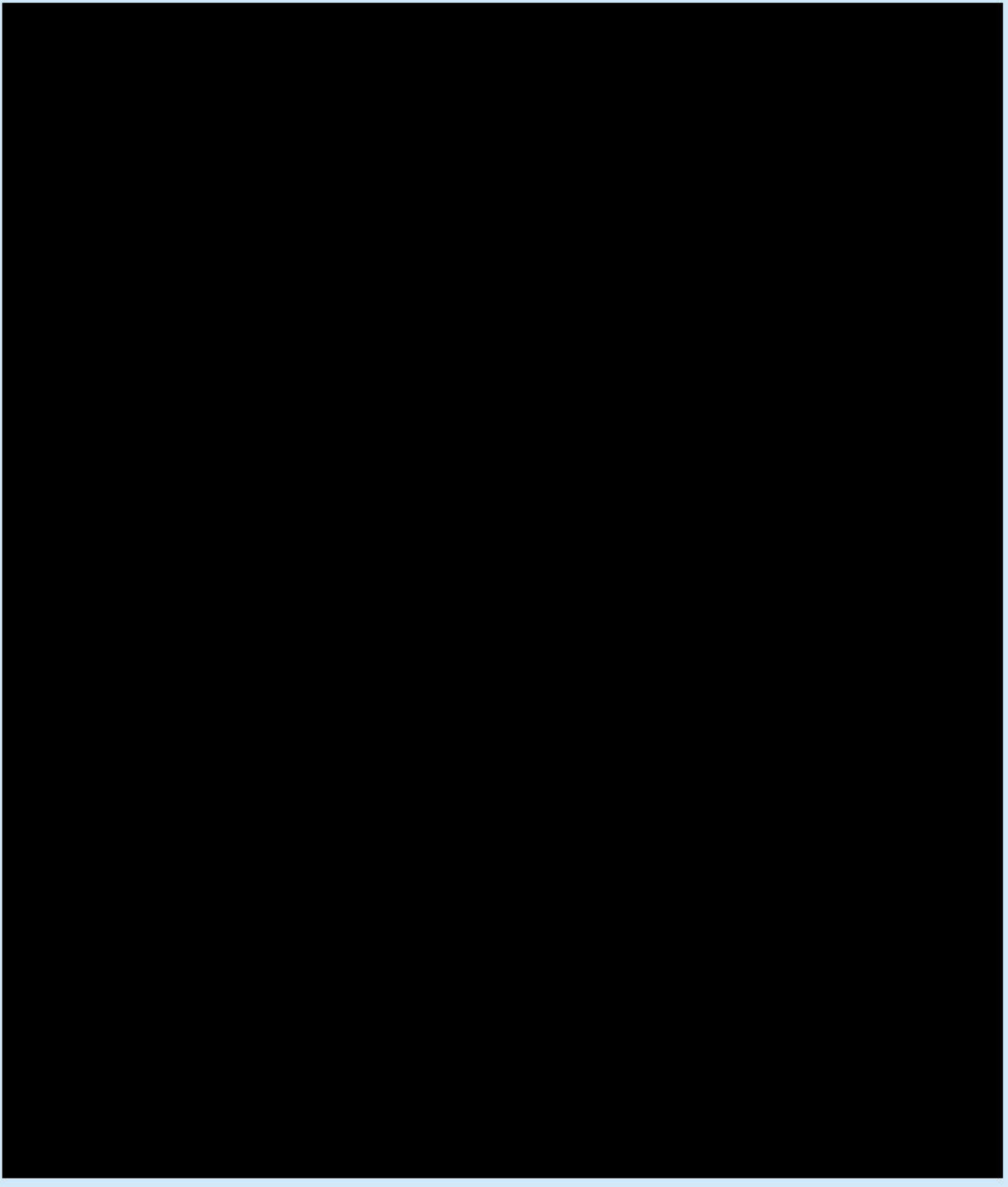

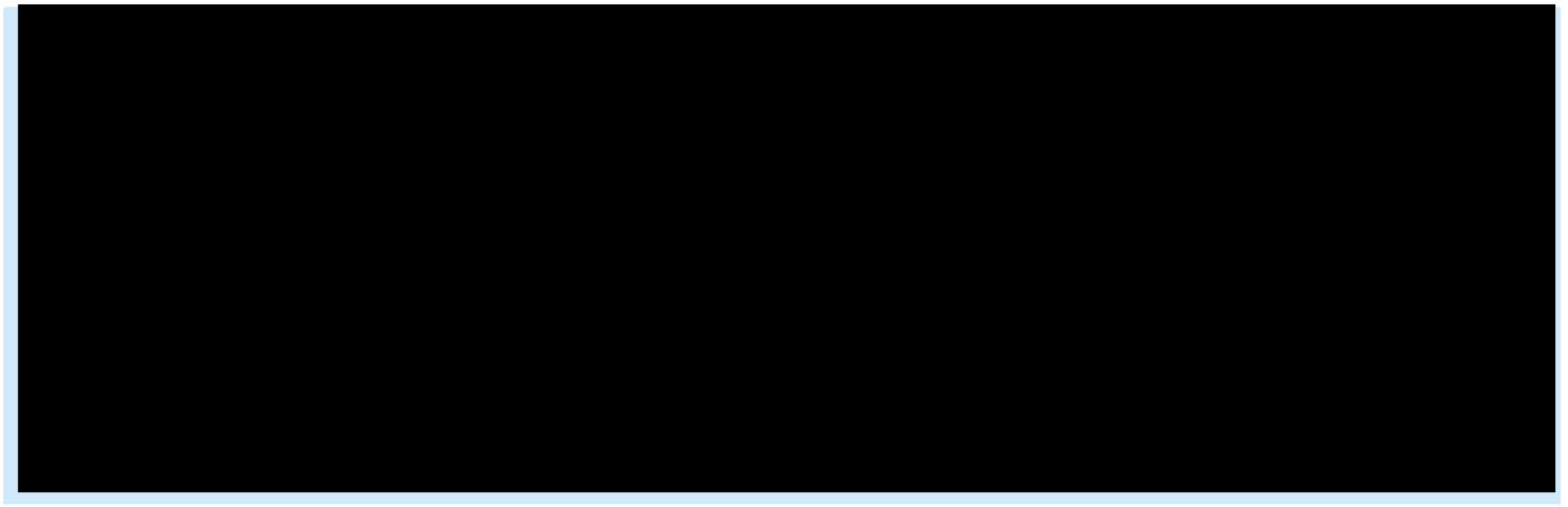

Quality assurance

Introduction

This page provides guidance on the internal quality assurance (QA), or review and clearance process for:

- claim determinations
- reviewable decisions
- key communications on claims, and
- other operational claims documents.

This guidance is not intended to govern supporting documents or processes or the review and clearance of financial calculations.

Quality assurance drives high quality service delivery and helps strengthen capability by ensuring:

- Our decisions are:
  - made accurately and quickly (section 69 of the SRC Act)
  - guided by equity, good conscience, and the substantial merits of the case (section 72 of the SRC Act)
  - based on clear and valid information
  - able to demonstrate sound judgement (the balance of probabilities).
- Our communications and decisions are consistent with our templates and communication principles and reflect Comcare's values in action.
- Feedback and coaching are provided to build staff skills and capability, encourage consistent practice across all teams, and develop understanding of the Claims Management Strategy and Comcare's Purpose, Priorities and Values.

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What needs a quality assurance review?

A quality assurance review is required for final draft documents conveying complex or contentious messages about the claim.

A quality assurance review is always required for decisions and letters involving the below:

Determinations	Description	QA completed by	Determination/letter signed by
14	Initial liability determinations (acceptance of new claims /newly reported and secondary conditions)	Assistant Director Claim plans are QA'd by the Assistant Director.	Assistant Director
14	Initial liability determinations (denial of claims and death claims)	Assistant Director then Director	Director

		Claim plans are only QA'd by the Assistant Director. Initial liability determinations for death claims are completed by the Specialist Claims Team only	
16	Accept medical treatment (e.g. medications, invoices, reasonableness/costs) *	Claims Managers are to use internal information or support frameworks to support determinations.	Claims Manager
16	Approve gap in treatment payments totalling **less** than $50 per consultation/item for medical & like service	Claims Managers	Claims Managers
16	Approve gap in treatment payments totalling **more** than $50 per consultation/item for medical & like service	Claims Managers	Assistant Directors
16	Decline medical treatment (e.g. medications, invoices, reasonableness/costs) *	Assistant Director	Assistant Director
16	Complex / unusual / high-cost requests for medical treatment (e.g. high-cost surgery, inpatient psychiatric treatment)*	Reviewed through Triage	Claims Manager
17	Compensation of injuries resulting in death (e.g. payments to deceased employee's dependants)	Assistant Director then Director (Specialised Claims team only)	Director
24, 27	Permanent Impairment/Non-Economic Loss determinations (including hearing loss) All adverse Permanent Impairment/Non-Economic Loss determinations (including hearing loss)	Assistant Director Assistant Director then Director	Assistant Director Director
25	Interim Payments	Assistant Director	Assistant Director
29	Household and attendant care services	Claims Managers are to use internal information or support frameworks to support determinations.	Claims Manager

29	Denial of services, or complex / unusual / high-cost household and attendant care services *	Assistant Director	Assistant Director
57	Suspension of entitlements (by Comcare). See note below table for suspension of entitlements by employer.	Assistant Director then Director	Director
39	Aids, appliances, and modifications up to $50,000.	Assistant Director	Assistant Director
39	Aids, appliances, and modifications above $50,000 *	Assistant Director	Director
62	Reconsiderations and Reconsideration of Own Motion (ROM) concerning the determinations listed above (excluding the ROMs specified below)	Assistant Director then Director	Director
8, 19, 20, 21, 21A	CAIS Income Support registers, calculates and drafts ROMs concerning normal weekly earnings and incapacity payments for ex-employees on X-pay	Senior CAIS Income Support Officer **Note:** Senior Claims Manager or Claims Manager to distribute ROM.	Claims Managers Assistant Director to be consulted on escalated matters.
19	Final determination of ability to earn	Assistant Director then Director	Director
Intent letters	Intent to determine ability to earn	Assistant Director	Assistant Director
	Intent to determine no present liability (NPL)	Assistant Director	Assistant Director
	Intent to issue a ROM	Assistant Director	Assistant Director
Other letters	Final NPL (after intent to NPL issued)	Assistant Director then Director	Director
	Refusal to deal with a claim (section 58)	Assistant Director then Director	Director
	Write-off	Assistant Director then Director	Director
	Waiver of debt	Assistant Director - Director - General Manager	General Manager
	Third party recoveries	Non-complex matters (i.e. updates to other insurers) - Assistant Director Matters involving recovery amounts -	Assistant Director Director

		Director Applicable to Specialised Claims Team only.	
	Matters that are escalated (e.g. sensitive / high profile / aggressive / threatening behaviour involved) *	Assistant Director - Director (Senior Director and/or General Manager if required)	Delegation will be determined on what has been agreed on upon consultation with the CMG leadership group.

* Note: If you are unsure about whether a quality assurance review is required on a claim, a decision or any other claim related correspondence, you should consult your Assistant Director and discuss further.

Suspension of entitlements by employer
A rehabilitation authority may suspend an employee's compensation entitlements under sections 36 and 37. This decision is not made by Comcare and quality assurance by Comcare is not required. Once a determination to suspend is made by a rehabilitation authority, they will advise Comcare so that the suspension can be processed in Pracsys.

A quality assurance review is not usually required for routine correspondence or previously agreed decisions, such as:

- medical treatment within an approved claim plan
- household and attendant care, aids and appliances within the approved claim plan.

Correspondence drafted by new starters and the duration that the quality assurance is required for, including who it is completed by (e.g Senior Claims Manager, buddy, Injury Manager, Technical Capability Officer) is at the Assistant Director's discretion.

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What does a quality assurance review check?

Documents provided for quality assurance should demonstrate:

- clear, professional and empathetic communication
- alignment with the communication principles
- collaboration across the Group, Comcare, and external stakeholders
- accurate interpretation of, and compliance with, legislation and guidance
- sound judgement, based on clear and valid information consistent with the information available
- decisions guided by equity, good conscience, and the substantial merits of the case
- correct templates, spelling and grammar.

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Roles and responsibilities in quality assurance reviews

The quality assurance review is the last 'check' of final draft documents before a decision is made or communication sent. Key roles and responsibilities include:

- **Senior Claims Manager/Claims Manager or Senior Reconsideration Officer/ Reconsideration Officer** – prepare or oversee preparation (when the drafting is being undertaken by a Claims Support Officer) of documents to the required standard, submit documents for a quality assurance review in a timely manner, and implement feedback.

- **Assistant Director** – undertakes an initial quality assurance review and provide feedback (They will also consider quality assurance feedback as part of the performance development process in coaching conversations with staff). For initial liability decisions, they complete the review by using the Create Claim Determination Review (CDETR) function in Pracsys.

  A key part of quality assuring the determination is to ensure that the correct TOOCS code has been applied to the claim. See Entering TOOCS codes for more information.

- **Director** – undertake quality assurance reviews in line with the table above. Directors to brief the Senior Director and/or the General Manager in matters when required. Any documents submitted to the Director must be cleared by the Assistant Director (If the quality of a staff member's written work is consistently good, the Assistant Director may ask them to refer work straight to the Director without their review; such an approach is agreed on an ad hoc basis and managed through coaching, supervision and performance review).

- **Senior Director or General Manager (GM) Claims Management Group** – undertake a quality assurance review where a claim is escalated or at their request (e.g. for individual claims or correspondence or particular types of claims). Before a document is submitted to either the Senior Director or GM Claims Management Group, it must have been reviewed by the relevant Director.

See the Quality Assurance and Determinations Review and QA and Determination Review - Talking Points documents for further information.

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Record keeping and document handling

The person who created the document is responsible for ensuring it is stored consistent with Comcare's information management guidance.

Claim records are stored on Pracsys, including the email confirming that a quality assurance review has been completed and final approved copies of correspondence.

Quality assurance review records are stored in Content Manager, including draft documents with tracked changes or comments, e-mails or completed feedback templates (If comments are provided by e-mail, the claimant details should be redacted).

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File and diary maintenance

File and diary maintenance

Claim files that are kept up to date, well organised and adhere to our obligations under the *Privacy Act 1988* are critical for effective claims management. Well managed diaries also support effective claim management by allowing claim managers to record, monitor and remind them of specific actions that need to be undertaken on claims.

In this section

Privacy

Comcare takes its privacy obligations very seriously and is committed to meeting the highest standards when collecting, storing, using and disclosing personal information.

Change of personal information

An employee's personal information may change at any time. Upon receipt of notification of a change in personal information and any relevant supporting information, the claim file needs to be updated in a timely manner.

Managing diaries

Electronic diaries are created in Pracsys and used by Claims Managers to record, monitor, and remind them of specific actions that need to be completed when managing a claim.

Entering TOOCS codes

The 'type of occurrence classification system' (TOOCS) codes are entered on to Pracsys when a claim is registered.

Claim chronology

The claim chronology template records key claim events in a consistent chronological manner and assists in the management of complex claims and/or long tail claims. Complaints chronologies assist in managing complaints.

Record keeping

Claim files should only contain information relevant to the specific claim and be stored in accordance with the requirements of the Privacy Act 1988.

Removing and redacting information

Where information is received that is not directly related to an employee's claim, it may be appropriate to remove or redact it from the claim file.

Reallocation/transfer of claims

This page outlines the steps that must be undertaken and by who when it is identified that claims are to be reallocated.

Information capture

Information capture provides the scanning and document management support provided to the Claims Management Group.

Work status codes

Claims Management Group uses the National Data Set work status codes as our primary tool for capturing and reporting on the return to work outcomes of employees.

Privacy

Introduction

Comcare takes its privacy obligations very seriously and is committed to meeting the highest standards when collecting, storing, using and disclosing personal information. In claims management this includes:

- telling employees why their personal information is being collected and whether it can be given to anyone else
- enabling employees to see what personal information is held by Comcare and to have it corrected
- storing personal information securely
- enabling employees to make a complaint if they believe their privacy has been infringed.

For further guidance, see Comcare's Privacy Policy and Privacy at Comcare which includes guidance on how the Australian Privacy Principles are applied in Comcare and how to undertake relevant Corporate Fundamentals training on privacy.

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What privacy legislation and rules apply to Comcare?

Comcare is required to comply with the *Privacy Act 1988* (Privacy Act) when handling personal information and must have a clearly expressed and up-to-date Privacy Policy.

Comcare's activities are governed by:

- the Privacy Act, including the Australian Privacy Principles (APPs)
- the Privacy (Australian Government Agencies – Governance) APP Code 2017 (code), and
- Privacy Regulations 2013 (Cth)

Comcare implements practices, procedures and systems relating to its functions and activities to ensure that it complies with the Australian privacy legislation, code and regulations. This includes:

- ensuring all Comcare staff understand and comply with Comcare's privacy obligations and the privacy policy
- responding promptly and transparently to privacy complaints
- conducting audits and quality inspections of data systems and information processes
- maintaining an effective working relationship with the Office of the Australian Information Commissioner (OAIC).

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What is personal information and sensitive information?

Personal information

The Privacy Act defines personal information as information or an opinion about an identified individual, or an individual who is reasonably identifiable:

- whether the information or opinion is true or not, and
- whether the information or opinion is recorded in a material form or not.

Some common examples of personal information are:

- an individual's name, signature, address, email addresses, phone number or date of birth
- credit information, pay slips or bank statements (may also contain sensitive information).

Sensitive information

Certain information Comcare collects is 'sensitive information' as defined in the Privacy Act. Sensitive information may include:

- an individual's health information, including medical information contained in workers compensation or asbestos-related claim records
- membership of a trade union
- sexual orientation or practices
- racial or ethnic origin records
- criminal records.

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What is personal information used for?

Comcare may collect, hold, use and disclose personal information for the purposes of performing claims functions and exercising powers under the *Safety, Rehabilitation and Compensation Act* 1988 (SRC Act) or the *Asbestos-related Claims (Management of Commonwealth Liabilities) Act 2005* (ARC Act). This includes disclosing personal information to third parties who assist Comcare in performing these functions and exercising these powers.

Comcare may only collect personal information if it is reasonably necessary for, or directly related to, Comcare's functions or activities.

Where you may have collected information not directly connected with Comcare's functions contact the Privacy Team for advice.

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How can an employee access or correct their personal information?

Employees can ask to access, amend or annotate the personal information Comcare holds on their file. There are three options to do this.

Option 1:

Employees can provide a request to change their personal information in writing by contacting their Claims Manager. See Change of personal information for more.

Option 2:

Employees can contact the Privacy team to action such requests, either by email or by writing to the Privacy Officer:

Privacy Officer
Comcare GPO Box 9905
CANBERRA ACT 2601

Option 3:

The *Freedom of Information Act 1982* (FOI Act) allows personal information held by Comcare to be amended where it is incorrect, incomplete, out of date or misleading. Employees can email the FOI team for assistance.

If an employee or employer is seeking information on how they can access documents held on their claim file, you can refer them to the following page on Comcare's website How Do I Request a Copy of My Claim File?

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What is a privacy breach?

A privacy interference can occur when personal information has been improperly disclosed or accessed. Common privacy interferences include, but are not limited to:

- when information is sent to a similar, but incorrect, email address
- when correspondence is incorrectly addressed or placed in an incorrect envelope
- when information about one person is placed on the claim file of another person
- when staff inappropriately access information without a business need to do so.

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How do I report a privacy breach?

You must advise your Assistant Director and Director immediately if you identify a privacy interference, including a suspected or potential interference. The relevant person should then immediately complete a Privacy Incident report form and email it to the Privacy team, copying in your Assistant Director and Director.

If a document is identified as being on the wrong claim file and is removed and placed on the correct file (see Information Capture under Urgent requests), a Privacy Incident Report is not required. However, a Privacy Incident Report must be completed if the document has incorrectly been provided to an external party.

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What happens if an employee refuses to let Comcare collect personal information?

Employees can submit a compensation claim with Comcare by completing the *Workers' Compensation Claim Form*. Since the claims management process involves the collection, use and disclosure of personal and sensitive information, the form requires that employees provide signed authorisation and consent, which also serves as a medical release authority.

The signed authorisation and declaration in the *Workers' Compensation Claim Form* is generally valid for the life of the claim unless it is withdrawn, or an updated authority is required – see Authority and consent on claims.

If an employee claims compensation and chooses not to provide Comcare with personal information required for their claim, or they withdraw consent for Comcare to use their personal information, Comcare may not be able to process an employee's claim until they provide the requested information or consent.

If an employee makes a claim for compensation and does not provide consent for Comcare to collect personal information from their treatment providers, you should contact the Privacy Team for advice.

As always, empathy and sound judgment must be displayed when dealing with an employee who has privacy concerns about their claim.

Withdrawal of consent

Under the Privacy Act, employees have the right to withdraw their consent for the collection, use or disclosure of their personal information at any time. Once consent is withdrawn, Comcare cannot rely on the employee's past consent for any future use or disclosure of their personal information.

However, if an employee does not want their personal information to be collected, used or disclosed for the management of their claim, they may need to withdraw their claim.

Withdrawal of consent requires careful claims management. Where a claim has not been withdrawn but consent has, Comcare may continue to exercise certain functions under the SRC Act. You should contact the Privacy Team for advice.

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How does Comcare manage the disclosure of claim information when an employee changes employers?

When an employee moves from one agency to another, a couple of scenarios might arise:

- Inactive claim – an employee may have had a claim in the past. Comcare cannot disclose to the new employing agency information about that claim without the consent of the employee.
- Reopened claim – an employee may have had an inactive claim in the past that becomes active. Comcare may disclose to the new employing agency information about that claim where the disclosure is consistent with the rehabilitation authority functions. You should seek advice from the Privacy Team if you do not have the consent of the employee.
- Active claim with, or without, a current rehabilitation program – if an employer makes a request to confirm whether they are the rehabilitation authority for a particular employee, Comcare must confirm the employment status of the employee before disclosing information to the employer.

After confirming the employment status of the employee, Comcare is authorised to disclose to the employer information relevant to the rehabilitation of the employee. The employer may request a copy of information on an employee's claim file under section 59 of the SRC Act.

The liable employer will often request the employee's authority to contact the new rehabilitation authority, so that there can be an appropriate handover of rehabilitation activities and case management support to the employee. Comcare supports the appropriate handover of such information to assist with rehabilitation.

Comcare is authorised to disclose to the employer that they are the employee's rehabilitation authority where the employee has given us current written consent to do so. Where consent has been refused, you should seek advice from the Privacy Team. Please check the employee's claim file to ensure that they have provided their signed consent prior to disclosing any information. For further guidance on disclosing information to employers when an employee changes employers, please refer to the Communicating with an employer page.

If an employee or employer is seeking information on how they can access documents held on their claim file, you can refer them to the following page on Comcare's website How Do I Request a Copy of My Claim File?

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Record Keeping

Published 31/07/2025

Introduction

All claims received by Comcare have a claim number assigned to them. Each electronic document associated with a claim file receives a separate record and folio number.

Claim files should only contain information relevant to that specific claim and all information on files must be managed and stored in accordance with the Australian Privacy Principles (APPs).

Under APP 10 - *Quality of personal information,* you are responsible for ensuring information on claim files is accurate, up to date and complete. If information is found on a file that does not relate to that file, then you are responsible for ensuring it is removed and placed on the correct file. **See**: Removing and redacting information from a file

The following documents must be included in a claim file:

- a copy of all letters sent (including attachments)
- copies of emails and other electronic materials related to the claim
- copies of any manual calculations made when determining benefits
- file notes (written records of conversation and actions), and
- all correspondence Comcare receives related to the claim, such as:
    - letter and emails received from stakeholders
    - medical certificates
    - medical reports
    - claim for time off work forms
    - rehabilitation and return to work forms
    - rehabilitation reports
    - medical accounts and invoices
    - rehabilitation accounts and invoices
    - a copy of any original document where the copy has been annotated with further information.

Letters generated in Pracsys are automatically attached to the claim file.

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File notes

All phone conversations and verbal discussions, such as meetings or case conferences, that occur during the course of managing a claim must be recorded in writing using the file note functionality in Pracsys.

File notes must also be made to document reasons for decisions being made, such as determinations of entitlements, to flag a claim as a commitment claim or a decision not to action a Clinical Panel recommendation.

File notes are important because they:

- document information provided orally by the employee, their employer or another representative
- detail and explain why a decision was made

- are useful in the event of a handover to another Claims Manager
- provide an accurate record that can be relied on as evidence
- provide guidance on planned next steps or future actions to be undertaken.

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Making File notes

File notes can be transcribed directly into Pracsys using the '*Manage Claim Comment*' (MCOM) function.

File notes should ideally be objective rather than subjective. Objective information is factual, measurable and observable. Subjective statements are based on personal opinion, interpretation, emotion and judgement. If a subjective statement is used, it must be clear it is an opinion. For example, 'the employee seemed frustrated when I told him the adverse decision'.

File notes must:

- be written as soon as possible after the relevant event
- be noted under the correct category and code
- include the date of the occurrence, if a claim comment is not being added on the day of the activity.
- state the name of the person, or people, you spoke to, who they are, and the purpose of the conversation
- accurately record any explanations or undertakings given
- document any agreed actions or follow up dates
- be confined to the facts
- record the reasons why a decision was made
- be concise, use short sentences, paragraphs and plain language
- take into consideration that the information recorded can be obtained under section 59 of the *Safety, Rehabilitation and Compensation Act 1988*, or the *Freedom of Information Act 1982*.

File notes must not:

- state any irrelevant or unsubstantiated personal observations or views
- include any personal information relating to another person unless that information is relevant to the management of the claim
- use or contain more words than are necessary for recording an accurate record.

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Maintaining a claim file

Claim files that are kept up to date and well organised assist not only the Claims Manager but also work colleagues and other areas of Comcare who may need to access the file.

Comcare also has obligations under the *Privacy Act 1988* to ensure that the personal information collected, used and disclosed is accurate, up to date, complete and relevant.

You are responsible for maintaining the electronic files and must ensure that the metadata information is correct.

Metadata

Metadata is the information entered to describe a document on an electronic file. This data is used to manage, find and categorise documents.

There are two sections in the metadata which you are responsible for updating:

1. **Document type**

This field provides broad classifications of data for most correspondence you will receive. You must classify documents to the lowest appropriate 'Document Type' level on files you manage. The lowest appropriate Document Type is the document types that show when the document type tree is fully expanded.

2. **Title**

This column is a free text field where you can enter a brief, meaningful title. It is not to be used as a substitute for correctly classifying documents via the 'Document Type' field. If there is a document type which adequately titles the document, select that document type and then enter the date into the title field.

When entering the title field, it is important that:

- the date be entered first, and
- meaningful information be provided about the content of the document.

You must ensure that graphic or distressing material is not kept on the claim file. If you receive graphic or distressing material, you should:

- store the information in an appropriate place in accordance with your team's protocols
- depending on your team's protocols, the file may need to be locked to protect others from accidentally opening it
- do not pass the content on unless appropriate or necessary. Ensure if you are sending on to someone it is labelled appropriately, and you provide warning to the recipient.

If you are unsure, please discuss with your AD.

For further information on managing/viewing graphic or distressing content, please see the guidance documents below.

How to prepare to view graphic content
How to protect others from graphic content

Labelling metadata

Metadata labelling of electronic documents can be actioned in Pracsys from several locations.

You can right or double click on the 'document type' field from metadata in your team or personal in-tray to bring up the 'Changing Document Type' screen.

When labelling documents, it is important to:

- classify the document as accurately as possible (expand and navigate the document type tree to select the correct document type)
- give the document a correct title (click on the title field, this will allow the title to be edited).

You can also edit the metadata through 'Manage Claim Documents' (MDOC). In the MDOC screen, the current document type will be listed in the 'document type' field. To change the document type, select document and the 'Edit' option, which will open a new window 'Editing Document Metadata'.

To make any changes to the document type, select the button next to the 'document type' field. To change the document type:

- expand and navigate the document type tree

- select the appropriate document type
- click 'OK'.

See: Metadata Quickstart Guide

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Maintaining a hybrid or paper claim file

A hybrid file consists of paper documents (usually dated on or before 31 December 2006) and electronic documents after that date.

In Pracsys the button next to the claim number in the top left corner will be labelled 'Hybrid' instead of 'Electronic' and there will also be a notation in the top right corner of the 'Manage Claim Documents' screen labelling the file as 'Hybrid'.

All paper-based components of hybrid files have an advisory sheet attached to the top of the last file advising that the file is a hybrid file, and no further documents can be attached. Hybrid notations are also attached to the file cover to give a visual alert on the current file status.

Paper files are no longer created; however it may be necessary to access an old paper file in the instance of a claim re-opening.

Appropriate maintenance of a paper file includes ensuring:

- all papers are securely attached to the claim file to prevent loss
- all documents have a folio number in ink in the top right-hand corner
- the file location is recorded in Pracsys, and
- no records from the file are removed or destroyed.

Requesting a paper-based claim file

To request a paper-based claim file, you will need to submit a request through CONNECT.

To do this, you will need to:

- open ComNet
- click on the Corporate Service Desk (CONNECT) icon
- click on the 'Submit a form' icon
- click on the 'Information – forms relating to information requests' icon
- click on the 'Claim File Digitisation – Submit a Claim File Digitisation' icon
- from the '**Scan Type**' drop down menu on the Claim File Digitisation Request form, choose '**Scan to Claim**'
- add the following details to the form:
  - Claim number
  - Injured employee name
  - Additional information e.g. 'paper claim file will need to be requested from archives'
- Choose the '**Scan with Notification**' tick box from the three tick boxes at the bottom of the form
- Choose any other tick boxes that are relevant to your request
- Click on the '**Submit**' button on the bottom of the form
- Once the form has been submitted, you will receive a ticket number, and your request will be sent to the appropriate team to be actioned

- All scanning requests will be scanned without notifications unless otherwise stated.
- If you already have the paper claim file or any other documents that you require to be digitised, please send them to the Information Management team via internal mail or if you are in the Canberra office, you can deliver them by hand to the Information Management team on Level 4.
- For urgent requests please contact the IM Helpdesk on (02) 6275 0000 and select Option 1.

Lifting paper claim files

- Know your personal capacity.
- Bend legs at the knees and keep your back straight.
- Use aids to lift heavy files.

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Change of personal information

Introduction

An employee may change their details at any time. It is preferable that all requests for amendments be submitted in writing by the employee.

Reasons for a change can include:

1. death
2. marriage/divorce
3. moving houses
4. changing email address
5. change of phone number or loss of mobile phone
6. solicitor, family member or a friend nominated to act on the employee's behalf.

An employee may be represented by someone else. For information about representation/authorisation to act on someone's behalf, refer to the Authority, or withdrawal of authority, to act on employee's behalf page.

For more information about managing a notification of the death of an employee, refer to the Notification of employee death page.

An employee can add and change their email and bank account details using the online form on the Comcare website: Comcare Online Forms. If an employee uses this online form, the information automatically flows through to Pracsys and no further action is required.

If the changes apply to incapacity payments a notification is sent to the CAIS Payroll team to update the EFT details in Aurion. Where the employee provides new or updated EFT (bank account) details:

- If they are due to receive medical payments, please email CAIS Complex
- If they are due to receive incapacity payments, please email CAIS Incapacity assessment

If they are due to receive both, please email both teams.

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Name and/or gender change

When an employee changes their name, they should provide Comcare with a copy of their marriage, divorce or name change certificate. Only a legal document can be used to change a name. In the absence of these documents, a Statutory Declaration can be provided to support a name change and the supporting documentation must be retained on the employee's claim file.

For information on storing the document on file, refer to the Record keeping page.

An employee is not required to supply evidence where they advise of a change in their gender or preferred title.

Removing and redacting information from a file

Introduction

Where information is received that is not directly related to an employee's claim, it may be appropriate to remove or redact it from the claim file.

The two main reasons why it is appropriate to remove or redact information from a claim file is because the information is:

- not relevant to the claim
- material that should not be stored on Pracsys, even though it may be relevant to the claim.

When you identify information that is irrelevant to a claim or should not be held on Pracsys, you should consider whether to **remove** the entire document or **redact** specific information within a larger document.

The Claims Manager takes action to ensure the claim record is accurate so that irrelevant information is not used or disclosed inappropriately. This could be harmful to the person the information is about.

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Understanding irrelevant information?

Information may be irrelevant because it:

- is about the employee but is not required to manage their claim
- relates to another employee's claim
- relates to a person who does not have a claim with Comcare.

The most common situations in which Comcare may receive irrelevant information are:

- after seeking records from an employee's treating practitioner
- after seeking records from an employer (section 71)
- when receiving unsolicited information from a third party, such as an employee's solicitor or another insurer.

Deciding whether information is relevant to an employee's claim will be clear-cut in some situations. In others, it will involve making a judgement call. This is particularly the case when considering whether medical information is relevant to an employee's claim.

Irrelevant medical information is frequently provided by a treating practitioner. It may also be provided by an employee's lawyer, or another party. In these instances, it is appropriate to remove information about the employee which is:

- sensitive
- personal, and
- unrelated to the claim.

Where an employee has disclosed irrelevant information to Comcare, there is no need to remove it from the file.

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Deciding what is relevant and irrelevant information

This general advice should assist you when deciding whether information is relevant or could be irrelevant. These may not apply in every case, since every claim is different, but they may be a helpful starting point.

Is it an IME or GP report?

We generally consider that information contained in independent medical examination (IME) reports is relevant. For IMEs, employees sign specific consent forms with the understanding that any information they provide to the specialist may be included in the final report. IME and GP reports are commissioned by Comcare (or the agency), so anything included can be reasonably assumed to have relevance to the claim.

Clinical notes attached to GP reports should be reviewed as they may not have been reviewed for relevance by the GP.

Does the information relate to medications?

Comcare does not redact information relating to medications, regardless of apparent relevance. Medications can have side-effects or reactions with other treatments, which can have significant impacts on claims.

Could the information relate to the claim?

If the information may be related to the claim, or if a relevant party (employee, treating practitioners, etc.) says it's related, it should remain on file.

Serious/debilitating/long term physical conditions, such as severe back pain, neck pain, or diabetes can impact both physical and psychological claims. It's recommended that references to other serious conditions are left on file. On the other hand, documents related to less serious/debilitating/long term physical conditions (e.g. a wrist MRI on a psychological claim) not related to the claim should be removed.

Is the information sensitive?

If the information is sensitive, consider removing it.

Comcare does not typically remove information relating to common short-term illnesses, injuries, or routine investigations (colds, ear infections, blood tests, vaccinations, etc.).

Be cautious with more sensitive conditions and investigations such as sexual health, mammograms, prostate conditions, hemorrhoids, etc. (these are often listed in Clinical Notes). If sensitive conditions and investigations are unrelated to the claim, Comcare typically removes them as we do not need to know about these things to manage the claim.

Third party information

Comcare does not typically remove the names of an employee's colleagues or supervisors, especially where it has relevance to the claim. There may be occasional exceptions to this rule, especially where there are significant sensitivities. Typically, if an employee's name has been provided to Comcare, either by the employee or the employer, it is likely to have relevance to the claim.

Spouses/partners and family members

Comcare does not generally remove names of partners, spouses or children, especially as this information is sometimes requested by Comcare (for example, Periodic Review Forms, applications for household help, etc.).

If personal information other than the spouse's name appears in medical notes, such as 'spouse has been having recurrent ear infections', Comcare would generally look to remove this, as it does not relate to the employee's claim.

Some family history may be relevant to the claim, either for an injured worker's predisposition to similar condition/s, or if a family member's health (or death) may have an impact on an injured worker's mental state or compensable psychological claim.

If you receive graphic or distressing material, refer to the Record Keeping page.

Handling of Unsolicited Personal Information

Comcare, as an APP entity under the *Privacy Act 1988*, must comply with the Australian Privacy Principles (APPs). APP 4 specifically deals with unsolicited personal information and requires the following:

- Assessment of Unsolicited Information:
  - If Comcare receives personal information that was not requested, it must decide within a reasonable time whether it could have collected the information lawfully under APP 3 (which governs the collection of solicited information).
  - This decision involves assessing if the unsolicited information is relevant to Comcare's functions or activities.
  - The assessment should focus on the connection between the personal information and Comcare's functions and activities. It should not be confused with evaluating the relevance or value of evidence (e.g., clinical notes) for a specific compensation claim, which is a separate process.
- Retention and Destruction:
  - If the unsolicited information could not have been legally collected under APP 3, and is not contained in a Commonwealth record, Comcare must handle it responsibly, including deleting or de-identifying it as soon as practicable, unless legal obligations require otherwise.
  - The reference to a 'Commonwealth record' ensures that the requirements for agencies to retain such information under the *Archives Act 1983* (the Archives Act) will override the destruction or de-identification requirements.
  - According to the Office of the Australian Information Commissioner (OAIC) Guidelines, if the unsolicited personal information is contained in a Commonwealth record, the agency is not required to destroy or de-identify the personal information under APP 4, even if it determines that it could not have collected the information under APP 3. The agency will instead be required to comply with the provisions of the Archives Act in relation to the Commonwealth record (*see further below*).

What information should not be held in Pracsys?

Certain types of information should not be stored on Pracsys, even though it may be relevant to the claim. This includes:

- fraud investigation material, which is filed separately by the Fraud Investigations team

- most information related to an employee's Administrative Review Tribunal (ART) or legal proceedings. This does not include decisions made by the ART which are stored in Pracsys to assist with implementation, along with other evidence and materials added to the claim file by the ART Instructing Officer.
- documents containing employee's tax file number

Where you identify information that is irrelevant or that should not be held on Pracsys, **you should** contact the relevant team to confirm whether the information should be removed from Pracsys. These teams could be CAIS, Fraud, Reconsideration and Appeals or Claims Litigation Services.

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Obligations under the Archives Act

Comcare, as a Commonwealth institution, is subject to the Archives Act, which governs how Commonwealth records are managed. According to section 3 of the Act, a Commonwealth record is defined as:

> *'A record that is the property of the Commonwealth or of a Commonwealth institution.'*

In general terms, if a record is the property of the Commonwealth, it will be a Commonwealth record. This distinction is important, as the Archives Act is concerned with records which are the 'property' of the Commonwealth, not necessarily in the 'possession' of Commonwealth agencies. For example, any unsolicited information received by Comcare cannot automatically be described as a Commonwealth record unless it meets the criteria for retention.

The Archives Act outlines strict rules for how Comcare must handle its records, including those that contain personal information. The primary obligations include:

- Commonwealth records can only be altered or destroyed in accordance with section 24 of the Archives Act. Records may be disposed of only if authorised by a records authority, a general records authority, or under normal administrative practices.
- Under subsection 24(1), it is an offence to engage in activities that result in the unauthorised destruction, alteration, or transfer of Commonwealth records. This includes actions that affect their custody, ownership, or condition.

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When to remove an entire document

If you identify information on a claim file that should not be on that file, the information must be removed and filed appropriately. A file note should be documented into '*Manage Claim Comment*' (MCOM) function in Pracsys stating which folios were removed, when, and why this was done.

There are three main scenarios in which documents should be removed from a file. This includes when a document:

- relates to another claim
- has been sent to Comcare in error
- should not be held in Pracsys.

Whole documents can be removed from Pracsys files by contacting the Information Capture help desk. If you identify an instance where you want to remove a document from a file, you should refer to the **Procedure to move, remove or redact information a file.**

Please note that the Information Capture team is unable to delete letters from Pracsys. However, if a letter has been created incorrectly, you may inactivate it instead.

Document relates to another claim

You can move a document that relates to another claim via the Manage Claim Documents (MDOC) function in Pracsys. If you identify an instance where you want to move a document to the correct file when it is scanned to the wrong file, you should refer to the **Procedure to move, remove or redact information a file.**

Information sent to Comcare in error

Here are two examples of where information may have been sent to Comcare in error.

Example 1: A Claims Manager receives copies of clinical notes and there are pages that are not relevant to the employee's claim. These pages should be removed from the claim file. It is also appropriate to notify the sender that they included information in error (i.e. email the treatment provider/hospital and indicate that they included information about another person).

Example 2: An employer provides copies of documents in response to a section 71 notice. Some of the documents provided are not relevant to the claim. These documents should be removed from the claim file. It is also appropriate to notify the sender that they included information in error.

If you receive hard copies of information that should not have been sent to Comcare, please contact the Privacy team for advice on how to deal with the information.

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Redacting information from a document

If you receive a document and there is information contained within the document that is not relevant to the employee's claim, you will need to redact the irrelevant information.

Where information is redacted, the reason should be noted in its place. For example, stating 'redacted under APP4' or 'tax file number redacted'. This will ensure that any future review of the document or file will clearly indicate why the redaction was applied.

There are three main scenarios in which it will be necessary to redact information:

- where documents contain details of third parties that are not required to manage the claim (other injured employees, or individuals unrelated to the claim)
- where documents contain an employee's tax file number
- where documents contain sensitive, personal information that is related to the employee but not relevant to the management of their claim.

Refer to the Guide to Redaction for information on how to redact information from a document. If you have questions concerning redacting information, further advice can be obtained from the Privacy team.

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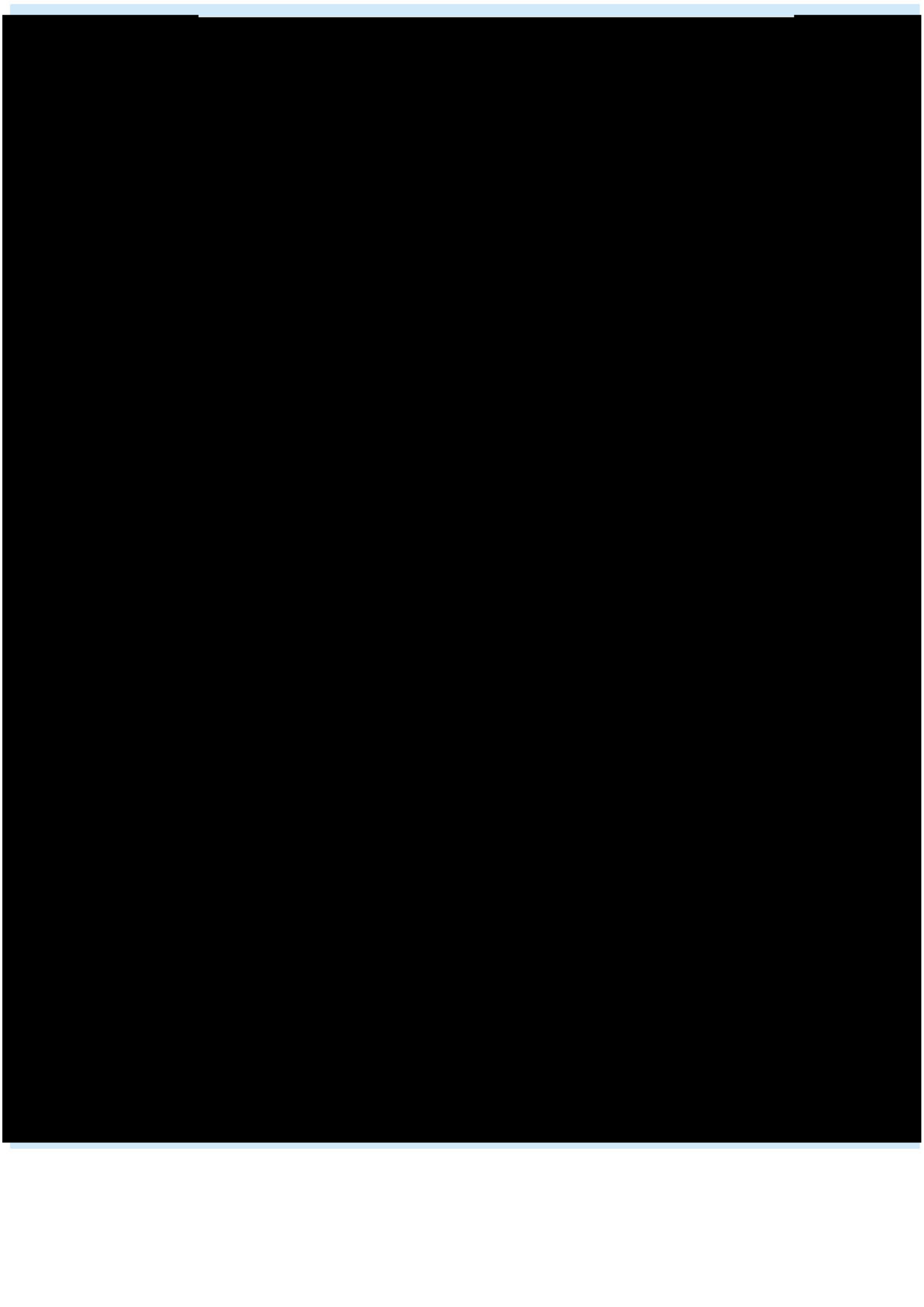

Managing diaries

Introduction

Electronic diaries are created in Pracsys and used by Claims Managers to record, monitor, and remind them of specific actions that need to be completed when managing a claim.

Pracsys diaries are created either:

- automatically by the system (auto generated), or
- manually by the Claims Manager or another user.

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What are auto generated (system) diaries?

Auto generated diaries are system-generated based on activity such as a document being added to a claim file or an existing arrangement (such as a treatment plan) reaching its expiry.

There are two types of auto-generated diaries:

- Action diaries - which provide advice that information or action is required. For example, invoice validation, incapacity determination reminders or 'cannot auto update' advice.
- Information diaries - which provide advice within various categories but can be amended or actioned without the need to perform any specific task. For example, Electronic Funds Transfer details updated for Xpayee.

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What are manual (user) diaries?

These diaries are created by the Claims Manager or other user using the Manage Action Plan (MAP) function in Pracsys where they require the system to remind them at a later date of an action they need to take. For example, an action plan diary for requesting a report from a treating practitioner.

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Diary types

Diaries are not restricted to claims management activity. Other users/work groups can generate diaries for the purpose of identifying and managing activities specific to their function. These may include Reconsiderations and Appeals and Return to Work plan diaries.

Claims Managers mostly manage and action diaries that relate to claims management functions such as:

- action plans
- invoices
- claims management
- direct payments
- e-doc notifications.

Action plan diaries are the usual method of diary management for Claims Managers and form part of a permanent record of actions performed on a claim. Certain claim categories are required to have open action plans on them at all times, such as action plan diaries.

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Invoice diaries

Invoice diaries are system diaries which alert you that an invoice has been entered on a claim and has not been paid. Invoice diaries may be generated for a variety of reasons, including:

- The date of service on the invoice is outside the treatment plan.
- The Financial and Client Services team have placed the invoice on hold as the item/s purchased do not appear to relate to the accepted claim.
- The claim is '*Closed*' (inactive).

You can review invoice diaries by printing the Business Objects report **'Unactioned diaries by claims services officer' (Report E0760A).**

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Incapacity diaries

Incapacity diaries are actioned by the Income Support team. It remains your role as Claims Manager to determine liability.

Incapacity diaries relating to the payment of weekly compensation are time sensitive and reminders requiring action by a due date are issued to ensure an employee is paid without any delays. The most common types of incapacity diaries include:

- determination reminders
- undetermined incapacity payments
- unverified incapacity payments
- cannot auto update.

You should liaise with the Income Support team to ensure incapacity diaries are promptly actioned.

You need to ensure that you have determined liability for incapacity payments, so the Income Support team can enter incapacity payments into Pracsys to action incapacity diaries.

Refer to the Incapacity for work page for further information on incapacity payments.

Determination reminders

The purpose of this diary is to ensure the continuity of payment to Xpayees. An Xpayee is an employee receiving compensation paid directly by Comcare, rather than via the employer. Xpayees are usually ex-employees of the Commonwealth, or dependents of deceased employees.

If the Income Support team receives this diary, they must enter the incapacity entitlements into Pracsys in line with the determination on liability.

Undetermined incapacity

Creating or making changes to incapacity payments, Normal Weekly Earnings (NWE) or superannuation in Pracsys requires an overnight batch process to automatically update the new information.

A 'cannot auto update' diary is generated where Pracsys cannot be automatically updated. The most common 'cannot auto update' generated diaries are:

Diary comment	Reason for diary
The automatic update program has failed to update this record.	The automatic update program has failed to update a period of incapacity.
Payments of $..... have already been made.	The duration of the original incapacity period is incorrect, and the batch program couldn't establish the correct durations around the split. A 'split' is when the period of incapacity that has been entered into Pracsys has required a change which has resulted in the period having to be split. This will need to be manually corrected.
Incapacity start and end times should be entered.	The split will create a single day of incapacity, and the batch program does not know what the start and end times should be.
This incapacity was manually calculated.	The batch program couldn't automatically calculate the new weekly rate because the original incapacity period was manually calculated.
This incapacity has ability to earn present.	The batch program will not automatically update incapacity with an ability to earn amount in case that amount needs to be changed as well.
Duration lost should be entered.	The split will create an incapacity period that starts and ends on the same weekend and the batch program couldn't calculate the duration (would be zero).
The incapacity is prior to reached 45 weeks date.	The incapacity period is before the 45-week date so it will need to be manually calculated under subsection 19(2) of the SRC Act.
Payment type is not valid for this claim type.	The NWE or superannuation change covers periods that are pre-XPay. If changes to NWE or superannuation are made to an XPay claimant retrospectively those incapacity payments will not be updated automatically and will need to be calculated manually.
Duration should be less than standard weekly duration.	The incapacity period doesn't have an exact duration so the system cannot calculate the correct split (most often related to a claim that has unusual standard hours).
This incapacity is part of the old voiding structure.	The incapacity period was created as part of the former incapacity system that existed prior to 8 March 2004 and had a different voiding structure. It will need to be deleted or voided and then redetermined manually.
The duration does not match the start and end dates.	The batch program couldn't automatically calculate the new duration because the original incapacity period appears to have

	the incorrect duration. It could also be because the claim has unusual standard hours, and the system was uncertain about the correct split to apply.
Weekly rate has changed. Please make amendments as required.	The weekly rate of the entire original incapacity period has changed.
No active current NWE exists at the start date.	The batch program couldn't automatically calculate the incapacity determination because it found no active NWE for all or part of the period.

Incapacity diaries can be reviewed by printing **Business Objects report 'DIRPAY Incapacity Determinations Expiring Report - Daily' (Report ci0126A).'**

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How do I view unactioned diaries?

Effective diary management is a fundamental task you perform in the course of your day to day work. You can view a list of unactioned diaries in Pracsys or can request a specified diary category report through Business Objects:

Pracsys	Business objects reports
In Pracsys: • Open the '*Diary Management*' folder. • Double click on *'Manage Diary'* (MD). Click on the *'+'* next to each category to identify the diary and then double click on the chosen diary to expand further.	Go to the ComNet homepage: • Go to systems & technology > systems and applications > select *'Business Objects'*. • In the search box at the top right hand side, type '*E0760A*'. The search result should be a report titled '*Unactioned diaries by claims services officer report - Daily*'. This report can be used to identify unactioned diaries.

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Reallocation/transfer of claims

Published 04/08/2025

Introduction

This page discusses the reallocation of claims from one Claims Manager to another, including when it should occur, who should do it and how reallocation should be done.

Guiding principles

The guiding principles of reallocating a claim are:

1. An employee should always know, or be able to quickly determine, who is managing their claim.
2. An employee should not have to tell their story again as a result of a change in Claims Manager.
3. An employee should always be attached to a current and active Claims Manager in the Claims Management Group.

Background

Claims will need to be re-allocated in situations where a claim moves for operational reasons, or a Claims Manager moves teams within the Group, changes roles within the Group, or departs the Group either permanently or for an extended period. This does not apply to short periods (less than two weeks) of annual or other leave. Please refer to the availability protocols for further information.

If a Claims Manager leaves and their claims are not reallocated to an active Claims Manager, the claims move into the *inactive* user's workgroup which will result in a lack of consistent and effective claims management. All open and closed claims allocated to a Claims Manager in the circumstances above must be reallocated to ensure adequate oversight and ongoing effective and accountable management of these claims.

Roles

Allocation of claims is the responsibility of the Assistant Director (AD). Any reallocation of a claim must be completed at the direction of an AD or above.

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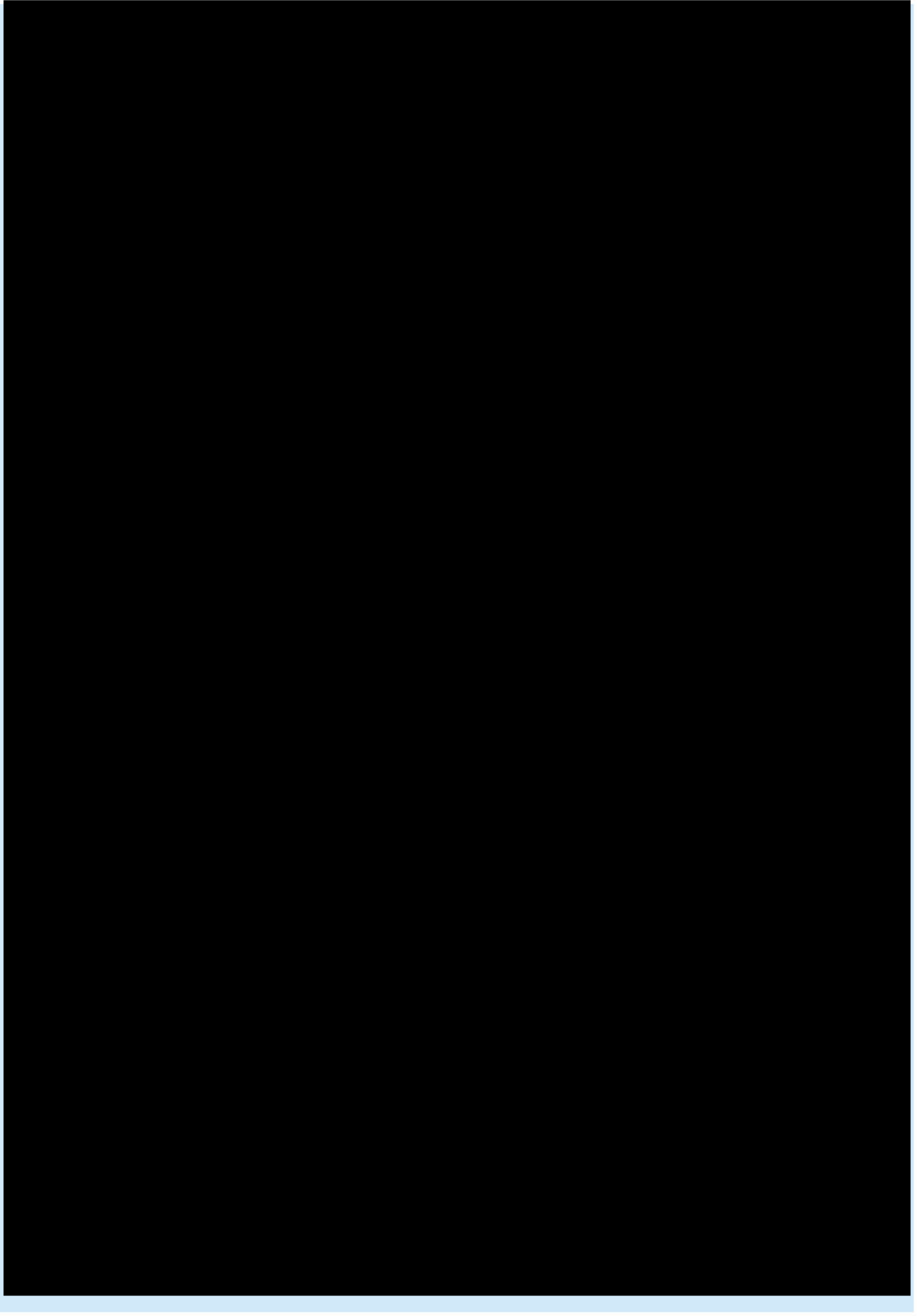

Key Reminders

Pre-transfer communication

Please telephone the employee first and follow up in writing, particularly where a claim has been identified as complex/high intensity or sensitive (unless the employee has requested only written contact or there is a communication protocol in place).

Post transfer communication

Please email the employee first and diarise to call them (at their nominated day/time if they have a preference).

For pre and post transfer email correspondence

When sending written correspondence to the employee regarding the change in Claims Manager, please cc the Rehabilitation Case Manager (RCM), unless there are sensitivities, and the RCM needs to be contacted separately.

Act on Behalf

If there is an 'act on behalf' of the injured employee, please adjust both verbal and written (email) communications accordingly. Representative's name, phone number and email address can be found in the 'Comcare Details' tab in the '*View Claim Registration (VCLM)*' function in Pracsys.

For information about representation/authorisation to act on someone's behalf, refer to the Authority, or withdrawal of authority, to act on employee's behalf page.

Closed claims

All closed claims must be moved from the Claims Manager no longer within the Group. Weekly PowerBI reporting is to be reviewed by Assistant Directors to ensure no claims are allocated to inactive users.

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Entering TOOCS codes

Introduction

The National Data Set (NDS) has been implemented across Australia for workers' compensation schemes to enable the production of nationally comparable workers' compensation data. This data assists in identifying current and emerging work health and safety (WHS) issues or trends and provides an indication of the nature and extent of WHS problems across Australian workplaces.

The type of occurrence classification system (TOOCS) forms part of the NDS. TOOCS consists of a series of rules and guidelines for coding details of workers' compensation claims.

Relevant training for this section includes *((Type of Occurrence Classification System (TOOCS))*

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Who enters and updates TOOCS codes?

The Claims Administration and Income Support team (CAIS) enters TOOCS codes at the time of registering a claim. For further guidance, refer to the Registering a new claim page.

The Claims Manager then needs to check the TOOCS codes during the initial determination process. This then needs to be quality assured the AD. For further guidance, refer to the Quality assurance page.

The underlying principle is that the TOOCS code reflects the primary condition for which liability has been accepted (**note**: TOOCS codes may be changed where the primary condition has been changed).

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Selecting the appropriate TOOCS codes

The information provided may be limited or unclear and you may need to use your best judgement to select TOOCS codes. To achieve as accurate coding as possible, you will need to be mindful of the following:

- Generally, rely on the information provided on the claim form and medical certificates when coding injuries.
- If it is unclear from the claim form and certificates, use other information attached to the claim to assist in understanding the type and cause of injuries, such as an incident report or an employer's statement.
- Read all injury descriptions objectively and code according to the wording used on the claim form.

Example: If an employee is claiming that they were ‘verbally abused/harassed’ by a co-worker, code to ‘workplace harassment or bullying’, not to ‘work pressure’ (interpersonal conflict).

If you are unsure of which code to select, refer to the information below, the TOOCS manual and discuss with your Assistant Director.

COVID-19

There are TOOCS codes for claims related to COVID-19. For further guidance see the Safe Work Australia advice.

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TOOCS – Nature of Injury/Disease

The Nature of Injury/Disease classification identifies the most significant injury or disease the employee has sustained, i.e. the diagnosis.

You will generally find the nature of injury on the employee's medical certificate or medical evidence submitted in support of the claim for compensation.

The Nature of Injury/Disease code represents the most basic level of classification of the injury or disease and does not necessarily need to indicate a bodily location as this will be further specified by the 'Body Location' field.

Each section of the Nature of Injury/Disease classification includes a code for unspecified locations. You should only use this option when none of the other options apply.

Description of type of injuries

Pracsys contains descriptions of the type of injury covered by each code. If you are unsure if you have selected the correct code, you can select the code and click the 'Next' button to navigate to another screen that lists the injuries covered by the code.

Example 1:

A claim for Coccydynia has been submitted. The Claims Manager types 'coccy' into the Nature of Injury text field in Pracsys and locates the code, 'Back Pain, Lumbago, and Sciatica'

However, the code appears to be quite generic. If the Claims Manager selects the code and clicks on the 'Next' button, this brings up the following list of conditions covered by this code:

1. Coccydynia
2. Back Pain
3. Back strain - non-traumatic
4. Low back pain
5. Lumbago
6. Schmohl's Nodes
7. Sciatica - without objective neurological loss or unspecified
8. Spondylitis
9. Spondylolisthesis - acquired or unspecified, and
10. Back pain, lumbago and sciatica

As Coccydynia is covered by this code, the code is the correct one.

Example 2:

A claim for anxiety and depression has been submitted. When registering the claim, the CAIS officer types 'anxiety' into the Nature of Injury text field in Pracsys and is presented with two options:

1. Anxiety/Stress Disorder
2. Anxiety/Depression combined.

As both anxiety and depression are listed on the medical certificate, the code 'Anxiety/Depression combined' is selected as the correct code.

After assessing initial liability, the Claims Manager confirms the correct diagnosis is 'Generalised anxiety disorder'.

The Claims Manage updates the Nature of Injury code from 'Anxiety/Depression combined' to 'Anxiety/Stress Disorder' as the employee has not been diagnosed with depression.

Nature of Injury Quick Reference Guide for Psychological Conditions

See 'Multiple Conditions' for selecting a code where there is more than one condition **EXCEPT** where a person has been diagnosed with anxiety and depression (see the following table).

Medical Diagnosis	Nature of Injury Code
Anxiety, Generalised Anxiety Disorder	703 - Anxiety/Stress Disorder
Depression, Major Depressive Disorder	704 - Depression
BOTH Anxiety and Depression	705 - Anxiety/depression combined

Medical Diagnosis	Nature of Injury Code
Adjustment Disorder	707 - Reaction to stressors - other, multiple or not specified
Post-Traumatic Stress Disorder	702 - Post-Traumatic Stress Disorder
Anorexia, Bulimia, Obsessive-Compulsive Disorder, Psychotic conditions, Schizophrenia, Bipolar Disorder, or other mental diseases not elsewhere classified.	718 - Other mental diseases, not elsewhere classified

Multiple conditions

If an employee has suffered multiple conditions, the most serious condition is coded in Pracsys. You should take the following into account when determining the most serious condition:

- only use multiple conditions as a last resort
- treat secondary conditions (those that would disappear if the other conditions were treated) as less serious, and
- the injury/disease likely to have the most serious effect on the employee's life, in terms of reduced life expectancy and impact on activities of daily living.

Ranking of injuries table

The following is a guide to assist you with deciding the most serious condition by order of seriousness where '1' is the most serious and '6' the least serious:

Rank	Injury
1	• brain injury • fracture of skull • broken neck • spinal cord injury or lesion
2	• internal injury of the abdomen, chest, or pelvis
3	• other head injury • open wound of the neck or chest • traumatic amputation of limb
4	• fracture of a limb(s)
5	• burn
6	• other injuries

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TOOCS – Bodily Location of Injury/Disease

The Bodily Location classification identifies the body location most afflicted by an employee's injury or disease.

Unspecified locations

Each section of the bodily location classification includes codes for 'unspecified locations'. 'Unspecified locations' should only be used when insufficient information exists to adequately code the condition, or the correct bodily location code does not exist.

When coding, you must make sure you avoid generalised assumptions about the 'normal' location for specific types of injury.

Example: An injury described as 'broken arm' should be allocated code 490 for 'upper limb unspecified locations' which references the entire limb rather than making a possibly invalid assumption that it was the lower arm that was broken.

Multiple parts of the body

If the most serious injury or disease has affected more than one bodily location, the most appropriate multiple bodily location code should be used.

Note: This rule is different to the nature of injury/disease classification, where the multiple injuries code is only to be used as a last resort.

Amputations

Amputations are generally coded to the site of amputation, not to the parts amputated. The exceptions to this are:

- ears
- eyes
- nose
- finger(s), and
- toes.

If any of the above body parts are amputated, they should be coded to the part lost.

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TOOCS – Mechanism of Incident

The Mechanism of Incident identifies the overall action, exposure or event that best describes the circumstances that resulted in the most serious injury or disease.

Important: The mechanism of incident classification does not have an alphabetical index due to the many ways in which a specific action, exposure or event could be described and interpreted. Keywords alone could, in some cases, be misleading and result in incorrect coding.

Coding the mechanism of incident

When coding the mechanism of incident, you are required to identify the action, exposure or event that best describes the circumstances that resulted in the most serious injury/disease. These could be:

Mechanism...	Includes...
Action	• being struck • striking against • lifting • handling objects • carrying objects
Exposure to	• virus • environmental factors • mental stress
Events	• motor vehicle incidents • cave-ins

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TOOCS – Agency of Injury/Disease

The agency classification identifies the chemical, products, processes or pieces of equipment that were involved in the sustaining of an injury or disease. You should code the whole of an agency, not just part of the agency.

Agency Codes

The table below provides details of the agency codes that represent two TOOCS codes in Pracsys:

Codes	Description	Examples
Breakdown Agency	Describes the object, substance or circumstance that was principally involved in, or most closely associated with the injury/disease. This is the point at which things started to go wrong and which ultimately led to the most serious injury or disease.	An employee falls off a ladder and is then hit by a forklift. In this instance the ladder is the breakdown agency.

Agency of Injury	Identifies the object, substance or circumstance directly involved in inflicting the most serious injury or disease.	An employee falls off a ladder and is then hit by a forklift. In this instance the forklift is the agency of the injury.

Repetitive Strain Injury or Occupational Overuse Syndrome

When the nature of injury has been identified as 'repetitive strain injury' (RSI) or 'occupational overuse syndrome' (OOS) and code 542 was identified, the machinery that was being used which caused the injury or disease should be identified as the breakdown agency.

Example: An employee has been diagnosed with RSI as a result of excessive keyboard use. 'Computers and keyboards' should be identified as the breakdown agency, and agency of injury.

Psychological Conditions

Code 9199, 'non-physical agencies' should be used as the breakdown agency in all mental stress cases where the condition has arisen as a result of a situation, as opposed to an object or substance.

Packaging Equipment

Breakdown Agency: In cases involving fastening, packing and packaging equipment, the breakdown agency should be coded to the type of fastening equipment or container.

Agency of Injury: In cases involving fastening, packing and packaging equipment, the agency of injury should be coded to the product fastened or contained in the package.

Surfaces with Hazardous Substances

In occurrences involving objects, indoor or outdoor traffic and floor or ground surfaces where the mechanism of the incident involved the employee falling, tripping, slipping, or stepping, the object(s) should be considered part of the surface.

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Information capture

Introduction

Information Capture (IC) refers to the scanning and document management support provided to the Claims Management Group.

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Urgent requests

An urgent request includes:

- Reconsiderations - correspondence forwarded from Reconsiderations team members to be scanned to claim.
- Claim registration - all requests addressed to the claim registration team, e.g. new claim registration requests, editing of new claim documents, feedback regarding claim registration. etc. Please also copy in the Assistant Director of FCS team to ensure oversight.
- Requests to remove a document from the Pracsys file because of information that is irrelevant to a claim or should not be held on Pracsys (except deidentification).
- Sensitive/secure correspondence – any correspondence in relation to sensitive/secure claims.
- Any other requests that have a deadline or strict timeframe which impacts an employee or expected outcome, e.g. add an invoice to claim so it can be paid today before the cut off, PI payments, clinical notes and report invoices for undetermined claims, requests for surgery, section 71 responses etc.

To request an urgent task within required timeframes, send an email to the Information Capture helpdesk. Copy in the Assistant Director of FCS team to ensure oversight. Include the following information in the email:

1. Type of request.
2. Detail what is required.
3. Claim number.
4. Date of email/document required and sender to assist with finding the document.
5. Timeframe in the Subject heading. For example, *SUBJECT: "Claim NUMBER, Urgent Surgery request. Required by xxx'.*

Then in the body of the request, provide specific details to assist IC in finding the email in the General Enquires inbox.

For further information on urgent non-incapacity payment processing, refer to the Invoice and receipt page.

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Options for Claims Managers to separate attachments

If you receive correspondence that relates to more than one claim, you may be able to separate the attachments and attach them to the appropriate claims. Alternatively, you may need help from the

Information Capture team.

Below are the options available for Claims Managers to separate attachments:

Option 1

1. Claims Managers can separate attachments using Adobe Pro and then reattach to claim (if you do not have access to the Adobe Pro, please follow steps outlined in option 2).
2. Send the modified pages as an attachment to Claim correspondence.
3. The word “claim” must be entered into the subject line first, and then the claim name and number.
4. This action will result in the new attachments being scanned directly onto claim.

Option 2

1. Send a request to the Information Capture helpdesk.
2. Give specific instructions as to which pages you require to be separated and the DOC number from Pracsys.
3. Include in the subject heading “Request to separate documents.” In the body of the email include: Claim number, record number (which starts with ‘DOC’), what you would like to be done. Please be as specific as possible. If specific details are not provided, the request may be returned to the Claims Manager.

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Claim Chronology

What is a claim chronology template and why was it developed?

The claim chronology template records key claim events in a consistent chronological manner.

The template was developed to assist in the management of complex claims and/or long tail claims. A complex claim history may contain multiple accounts of significant events. Visualising the relationship between key events can help with choosing an appropriate approach to managing the claim.

A claim chronology can also help in understanding a complaint.

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When to use a claim chronology?

You should complete a Claim Chronology for:

- undetermined claims or reconsiderations with complicated facts e.g., where the date of injury is unclear or where there are different accounts about what caused the condition
- any claim with a complaint
- other claims where it may be helpful.

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What to include in a claim chronology?

You should record key claim events in the chronology.

Key claim events will vary from claim to claim but will usually include items such as:

- events leading to the development of an injury (where there are different accounts about this a chronology can help identify the differences and work out what is most likely)
- dates when the employee sought medical treatment for the condition or first noticed the condition or a deterioration
- date of injury, impairment, etc.

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Work status codes

Introduction to work status codes

The Claims Management Group's priority is to support an employee to return to health and, where possible, work. We use the National Data Set (NDS) work status codes as our primary tool for capturing and reporting on the return to work (RTW) outcomes of employees.

Comcare started capturing the work status codes for all new claims from 1 July 2017. The NDS work status codes are used across the Comcare scheme and other workers compensation schemes. This supports a comparison of RTW outcomes across and between schemes. It also supports Comcare to meet the Safe Work Australia data submission requirements.

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What are the work status codes?

The table below sets out the work status codes as they are presented in Pracsys and the description from Safe Work Australia.

Note that 'income maintenance' in the below table refers to incapacity payments.

Information in Pracsys				**Safe Work Australia NDS Description**
Code	**Status level**	**Description**	**Description in RP drop down list in Pracsys**	**Definition**
01	**Working**	Working with no income maintenance - unknown employer	W - no income maint - Unknown ER	Employee is currently working, and it is unknown whether work is with pre-injury employer or different employer. Employee is not receiving any income maintenance.
02	**Working**	Working with no income maintenance – pre-injury employer	W - no income maint - Pre-inj ER	Employee is currently working with the pre-injury employer and is not receiving any income maintenance.
03	**Working**	Working with no income maintenance – different employer	W - no income maint - Diff ER	Employee is currently working with a different employer and is not receiving any income maintenance.
04	**Working**	Working with income maintenance - unknown employer	GRTW - income maint - unknown ER	Employee is currently working and it is unknown whether work is with pre-injury employer or different employer. Employee is receiving income maintenance. Income maintenance payments

				may be due to the employee working fewer hours than prior to the injury/disease or due to the employee working the same hours but in a job with lower remuneration and is receiving top-up payments.
05	**Working**	Working with income maintenance – pre-injury employer	GRTW - income maintenance - pre-inj ER	Employee is currently working with the pre-injury employer but is receiving some income maintenance. Income maintenance payments may be due to the employee working fewer hours than prior to the injury/disease or due to the employee working the same hours but in a job with lower remuneration and is receiving top-up payments.
06	**Working**	Working with income maintenance – different employer	GRTW - income maintenance - Diff ER	Employee is currently working with a different employer but is receiving some income maintenance. Income maintenance payments may be due to the employee working fewer hours than prior to the injury/disease or due to the employee working the same hours but in a job with lower remuneration and is receiving top-up payments.
07	**Working**	Working – capacity unknown	W - capacity unknown	Employee is at work however it is unclear whether the worker is back at full or partial capacity, or is or is not receiving income maintenance.
08	**Not working**	Not working with no income maintenance	NW - no income maintenance	Employee is not working and is no longer receiving income maintenance. For example, redundancy, retrenchment, resigned, studying, seasonal worker.
09		Not working with income maintenance	TI - income maintenance	Employee is not working at all and is receiving income maintenance. **Note:** for Comcare pre-premium claims, this includes retirement and receiving incapacity payments.

10		Deceased	NW - Deceased	Employee is deceased. Includes deaths related to the compensated injury and death unrelated to the compensated injury.
11	**Unknown**		Unknown	Employee is no longer eligible for compensation and his or her work status is unknown. For example, employee has reached retirement age, payment thresholds have been reached, or a redemption lump sum has been paid and the work status is unknown. *This code may be used as a default code where there is no work status for an individual.*

Work status codes in Pracsys

The work status codes are found in the 'Manage Claim NDS Work Status' (MCWS) function in Pracsys.

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Reviewing and updating work status codes

As a general rule, the work status code in Pracsys should reflect the work status of the employee:

- **On receipt of a claim** - on receipt of the claim (either new or a reallocation) the Claims Manager should ensure an accurate work status code is entered.
- **Ongoing** - the work status code of a claim is to be updated when there is a change in the return-to-work status of the employee. The work status of a claim is also to be reviewed as part of the claim review process.
- **On claim closure** - the Claims Manager should confirm the work status code is correct prior to closing a claim.
- **On claim reopening** - the Claims Manager should confirm the work status code when a claim is reopened.

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Identifying the return-to-work status of an employee

The most accurate and timely way to identify the return-to-work status of an employee is by discussing work status directly with the employee, as part of ongoing engagement about their claim. Other options include:

- contacting the Rehabilitation Case Manager
- reviewing medical certificates and rehabilitation reports
- contacting the Workplace Rehabilitation Provider (if one is involved).

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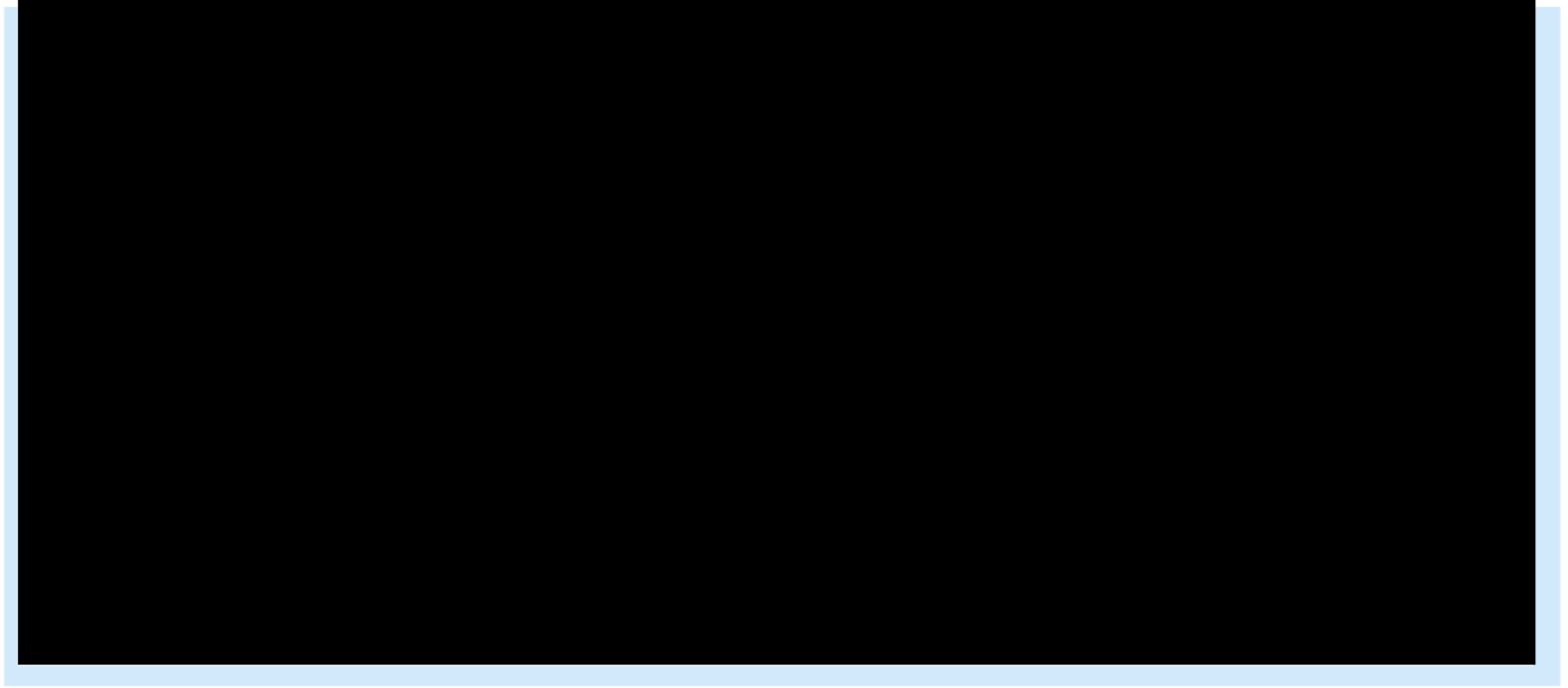

Receiving and actioning requests for claim file

Receiving and actioning requests for claim file

You may receive a request to provide an employee, their authorised representative or an employer with documents related to an employee's compensation claim.

In this section

Freedom of information requests (FOI)

An employee can request access to their claim file under the *Freedom of Information Act 1982*.

Request for claim file

An employee can request a copy of their claim file under section 59 of the *Safety, Rehabilitation and Compensation Act 1988*.

Freedom of information requests

Introduction

Comcare makes a range of information available for public access. An employee can formally request access under the *Freedom of Information Act 1982* (the FOI Act) to documents Comcare holds.

Before making a formal request for information under the FOI Act to Comcare, the employee should browse Comcare's Information Publication Scheme to see if the information is already available there.

If you receive an enquiry concerning accessing other documents held by Comcare, you can refer the applicant to the following page Requests for information under the Freedom of Information Act 1982.

If you receive an FOI request, you should advise your Assistant Director of the request as soon as possible.

The FOI and Privacy team is responsible for actioning request documents. All FOI requests for documents should be forwarded to the FOI team for action.

Requests for information under Section 59 of the SRC Act

Claim file information is not provided under FOI. Section 59 of the SRC Act provides the legislative basis to supply certain documents on request. Comcare is obliged to release the information it holds in relation to an employee's claim under section 59 of the SRC Act.

Note: If an employee or employer is seeking information on how they can access documents held on their claim file, you can refer them to the following page How Do I Request a Copy of My Claim File?

Differences between Section 59 of the SRC Act and the FOI Act

The key differences between Section 59 of the SRC Act and the FOI Act are as follows:

- there is no requirement under the FOI Act for the person requesting the information to have a personal interest in that information
- requesting documents and providing them under the FOI Act is a more formalised process, and
- there are costs associated with the processing of an FOI request, however the applicant can request these be waived with their request application.

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What makes a compliant FOI request?

For access to any other document held by Comcare, which is not on the claim file, the employee will need to make a valid FOI request. For a request to be valid under the FOI Act, it must:

- be in writing
- state that the request is an application for the purposes of the FOI Act
- provide information concerning the document as is reasonably necessary to enable Comcare to identify it

- give details of how notices under the FOI Act may be sent to the requesting party (for example by providing an electronic address to which notices may be sent by electronic communication).

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What timeframes apply for actioning FOI requests?

It is a requirement of the FOI Act that any request for information be met within timeframes specified by that Act.

On receiving a request, Comcare must take all reasonable steps to:

- notify the applicant that the request has been received as soon as practicable, but not later than 14 days after the day on which the request is received by or on behalf of the agency or Minister, and
- notify the applicant of a decision on the request (including a decision under Section 21 to defer the provision of access to a document), as soon as practicable, but not later than the end of the period of 30 days after the day on which the request is received by or on behalf of the agency or Minister.

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FOI requests that can be processed under section 59

In circumstances where you or the FOI Officer receives an FOI request for documents relating to a claim file, Comcare considers the request as creating concurrent obligations under both the FOI Act and the SRC Act.

It is Comcare's preference and practice, wherever possible, to process the request under Section 59 of the SRC Act. For further guidance refer to the Request for claim file page or the *How do I request a copy of my claim file?* page on Comcare's website.

It is also preferred because Comcare's disclosure obligations are generally broader under Section 59, processing timeframes are shorter, and there is no requirement for fees to be borne by the applicant.

In many instances, the request can be processed under Section 59 of the SRC Act. However, there will be certain situations where the request will need to be actioned specifically under the FOI Act. The FOI Officer will determine whether the request is to be completed as a Section 59 request or an FOI request.

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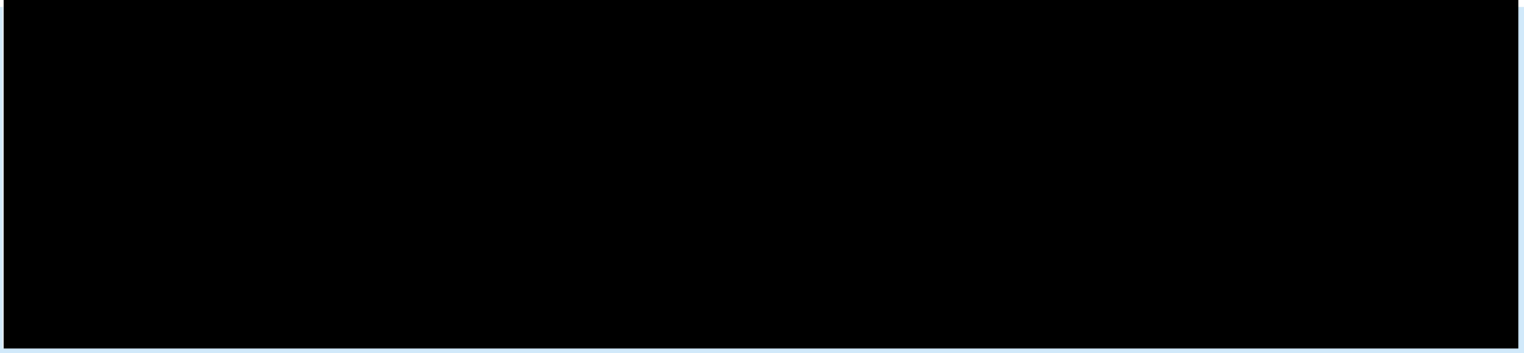

Request for claim file

Introduction

Comcare may receive a request to provide an employee, their authorised representative or an employer with documents related to an employee's compensation claim.

Section 59 of the SRC Act provides the legislative basis to supply certain documents on request. Comcare is obliged to release the information it holds in relation to an employee's claim under section 59 of the SRC Act.

An employee can also request access to their claim file under the *Freedom of Information Act 1982* (FOI Act), refer to the Freedom of Information requests page for more information.

There are other parties, such as the Ombudsman's Office, that can also request access to claim files.

Section 59 and FOI Act requests, and requests by other stakeholders such as the Ombudsman, are managed by Comcare's Statutory Oversight team. All requests under section 59 should be forwarded to the S59 team.

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What makes a compliant section 59 request?

Section 59 of the SRC Act does not expressly require a request to be made in writing. However, it is preferred that requests for documents under section 59 should be made in writing. This ensures that there is no dispute:

- over the terms of the request, and
- that the person requesting the documents is:
- the employee to whom the documents relate, or
- the employee's authorised representative.

Also, to prevent any breaches of the *Privacy Act 1988,* Comcare requires identification in the form of:

- the employee's claim number and/or signature, and
- some other form of identification which positively identifies the person as being who they claim to be.

Note: If an employee or employer is seeking information on how they can access documents held on their claim file, you can refer them to the following page on Comcare's website How Do I Request a Copy of My Claim File?

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What Comcare does not have to provide under section 59?

Comcare's view is that requests from employees for documents which are:

- not on the employee's file
- not related to the employee's claim, or
- publicly available through other sources and can be easily purchased or otherwise obtained do not have to be provided under a section 59 request.

Documents protected from release

There are certain documents that could be protected from release under section 59. These include:

- documents not related to the claim (especially any documents with personal information attached to the wrong claim file)
- information protected by Legal Professional Privilege
- information on Comcare's fraud investigations files, and/or
- medical reports containing information which, in Comcare's opinion, if released, could cause the employee or a third-party harm.

In circumstances where requests are received for documents which may fall into any of the above categories, you should discuss this with your Assistant Director.

Legal Professional Privilege

Legal Professional Privilege (LPP) may be broadly described as confidential communications passing between a client and legal adviser, that may not be given in evidence or otherwise disclosed without the client's consent.

Comcare can claim LPP in situations involving confidential communications between Comcare officers and its solicitors in relation to any court (i.e., the Federal Court, Magistrates Court, District or Supreme Court) or tribunal (i.e., the Administrative Review Tribunal (ART) matters, as long as those communications were:

- made for the dominant purpose of giving or receiving legal advice or of conducting actual or anticipated litigation
- there is a professional relationship of lawyer and client, so as to render the advice independent, notwithstanding any employment relationship, and
- the person who provided the advice is qualified to practice law and is subject to the duty to observe professional standards and the liability to professional discipline.

Legal Professional Privilege (LPP) may be waived either expressly or impliedly, where there has been an inconsistency between the conduct of the party seeking to rely on the privilege, and the confidential nature of the communication. This may include disclosing the content or substance of legal advice to a third party, for example quoting or closely paraphrasing legal advice received from a panel firm in correspondence to another agency. Loss of LPP may result in Comcare having to produce documents in proceedings, or release documents pursuant to an FOI request or other compulsory disclosure mechanism.

Medical reports

The underlying principle governing the release, or protection from release, of medical reports or other such material (particularly psychiatric or psychological reports) is that they should not be released where there is a real risk that the report could lead to the employee harming (physically or mentally) themselves or another person.

The person best placed to determine the risk involved would be the employee's treating practitioner or specialist. It would, therefore, be considered appropriate to consult with the doctor/specialist

before releasing any potentially sensitive information to the employee.

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Release of information to employers

Employers have the right to request and be provided with information relating to an employee's claim. This only extends to documents relating to a claim affecting that agency. In general, this will not extend to documents relating to claims lodged by the same person in relation to employment with another employer, although there may be occasions where the new employer is affected by the other claim(s) and as such has a legitimate reason to request that information (for example where the new employer is required to take action as the rehabilitation authority).

Where an employee has advised Comcare that they do not want documents to be provided to a particular person in their agency, you will need to advise the employee that the employer nominates on the claim form a contact person in the agency (usually a Rehabilitation Case Manager) that Comcare is required to communicate with and send information relating to an employee's claim to. Comcare has no control over who the nominated person on the claim form shares the information relating to an employee's claim with within the agency. The sharing of claim related information within the agency is subject to their own privacy obligations.

If an employee has concerns or questions in relation to how their employer handles information relating to their claim, they should contact the Privacy team within their employing agency about their collection, use or disclosure of their personal information.

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Release of single documents to employee outside of section 59

An employee may request, outside of a formal request under section 59, for up to 5 non-complex documents.

Non-complex documents can include:

- claims forms
- medical certificates
- copies of letters or emails that Comcare has issued
- medical reports – under section 57 or provided by the treating practitioner
- medical imaging reports
- employee / employer statements.

You can provide these to the employee outside of section 59, in discussion with your Assistant Director, as long as they are reviewed to ensure there are no privacy breaches, and risk of potential harm to the employee is assessed.

If an employee requests many documents or their whole claim file, without reference to section 59, you should consider this a request under section 59, advise the employee of this, and refer the request to the Statutory Oversight team.

'Complex' documents such as full clinical notes, full section 71 responses from employers or whole claim file requests should still be referred to the Statutory Oversight team.

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Suspensions, ceases and refusal to deal

Suspensions, ceases and refusal to deal

Through the life of a claim, there may be occasions when you need to consider suspending an employee's rights to compensation on a claim or refusing to deal with the claim. You may also need to determine no present liability on a claim.

The following section provides information and guidance on suspending claims, steps to determine 'No present liability' and refusing to deal with a claim.

In this section

Suspending claims

Where an employee has refused, without reasonable excuse, to participate in an independent medical examination or a rehabilitation assessment or rehabilitation program, Comcare may suspend an employee's rights to compensation on that claim. This page provides more information about:

- rehabilitation suspensions
- suspensions related to medical examinations
- the effects of suspending a claim
- requesting a reconsideration of a suspension
- suspension duration
- the procedure to suspend a claim
- lifting a suspension on a claim, and
- the procedure to lift a suspension on a claim.

Refusing to deal with a claim

Where an employee does not, without a reasonable excuse, provide information requested under section 58 of the SRC Act, Comcare may refuse to deal with the claim. This page provides more information about refusing to deal with a claim, including:

- information about natural justice and the limits of a refusal to deal including that it is not a determination and cannot be reconsidered.
- the procedure to refuse to deal with a claim, and
- the procedure to lift a refusal to deal.

Determining no present liability

Comcare cannot 'cease' liability, however it may determine that there is no present liability for compensation under the SRC Act on a claim. This page provides more information about:

- when you can determine no present liability
- examples of determining no present liability

- information specific to aggravations
- information on the concept of ‘ceased’ liability and that it is not possible to ‘cease’ liability
- inactive claims, which are not the same as ‘no present liability’ claims
- wording for determinations of no present liability, and
- the procedure to determine no present liability.

Suspending claims

Introduction

There are three provisions under the SRC Act where a claim may be suspended:

- Section 36 – rehabilitation assessment
- Section 37 – rehabilitation program
- Section 57 – medical examination

Rehabilitation suspension

A rehabilitation authority has the authority determine that an employee's claim is suspended where the employee:

- refuses or fails to attend or obstructs a rehabilitation assessment under section 36 of the SRC Act without a reasonable excuse, or
- refuses or fails to undergo a rehabilitation program under section 37 of the SRC Act, without a reasonable excuse.

Once a determination to suspend is made by a rehabilitation authority, the rehabilitation authority will advise Comcare so that the suspension can be processed.

Suspension under section 57 (medical examinations)

Section 57(2) provides Comcare with the power to suspend a claim if an employee refuses or fails, without reasonable excuse, to undergo a medical examination, or in any way obstructs a medical examination.

Please review the information about Independent medical examinations to ensure you are clear on the processes required for you to determine the necessity for a medical examination and to organise the examination in consultation with the employee.

Reasonable excuse

When considering suspending a claim, the Claims Manager must establish whether the employee has a reasonable excuse for not participating in or attending the assessment, examination or program. If the employee has a reasonable excuse, you cannot suspend their claim.

It may be necessary to contact the employee, either by phone or in writing, to gather information about their excuse or reason for not attending or participating. This will allow you to determine whether their excuse was reasonable.

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What is the effect of suspending a claim?

When a suspension on a claim occurs, entitlements on that claim cease until the suspension is lifted. This includes the employee’s right to institute or continue any proceedings under the SRC Act, such as an appeal to the Administrative Review Tribunal (ART).

Suspension under the rehabilitation provisions

Where a suspension occurs under the rehabilitation provisions (sections 36 or 37), an employee's right to compensation for medical treatment under section 16 of the SRC Act is **excluded from suspension**. The suspension of compensation rights only relates to the specific injury claim on which the rehabilitation requirement was made.

Suspension under section 57 (medical examinations)

Where a suspension occurs under section 57, all entitlements including medical treatment are ceased for the duration of the suspension. The suspension applies to the injury (or injuries) that were to be assessed at the medical examination which the employee has failed to attend or obstructed.

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Can an employee request a reconsideration of a suspension?

Suspension under the rehabilitation provisions are determinations

Decisions made by the rehabilitation authority under sections 36 or 37 of the SRC Act to suspend a claim are determinations under section 60 of the SRC Act. They are therefore subject to reconsideration by Comcare and subsequent review by the Administrative Review Tribunal (ART). For further guidance, refer to the Reconsiderations and Administrative Review Tribunal pages.

Suspension under section 57 are determinations

From 14 June 2024, decisions to suspend under section 57(2) are also determinations under section 60 of the SRC Act. They are therefore subject to reconsideration by Comcare and subsequent review by the Administrative Review Tribunal (ART). For further guidance, refer **to t**he Reconsiderations and Administrative Review Tribunal pages.

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How long does the suspension apply for?

Suspension under the rehabilitation provisions (sections 36 and 37)

The suspension applies from the date the rehabilitation authority makes a determination to suspend. It remains in place until the rehabilitation authority notifies Comcare that the employee has complied with the rehabilitation assessment and/or program.

Suspension under section 57 (medical examinations)

The suspension applies from the date the employee is advised of the suspension by correspondence until the employee attends the medical examination (section 57).

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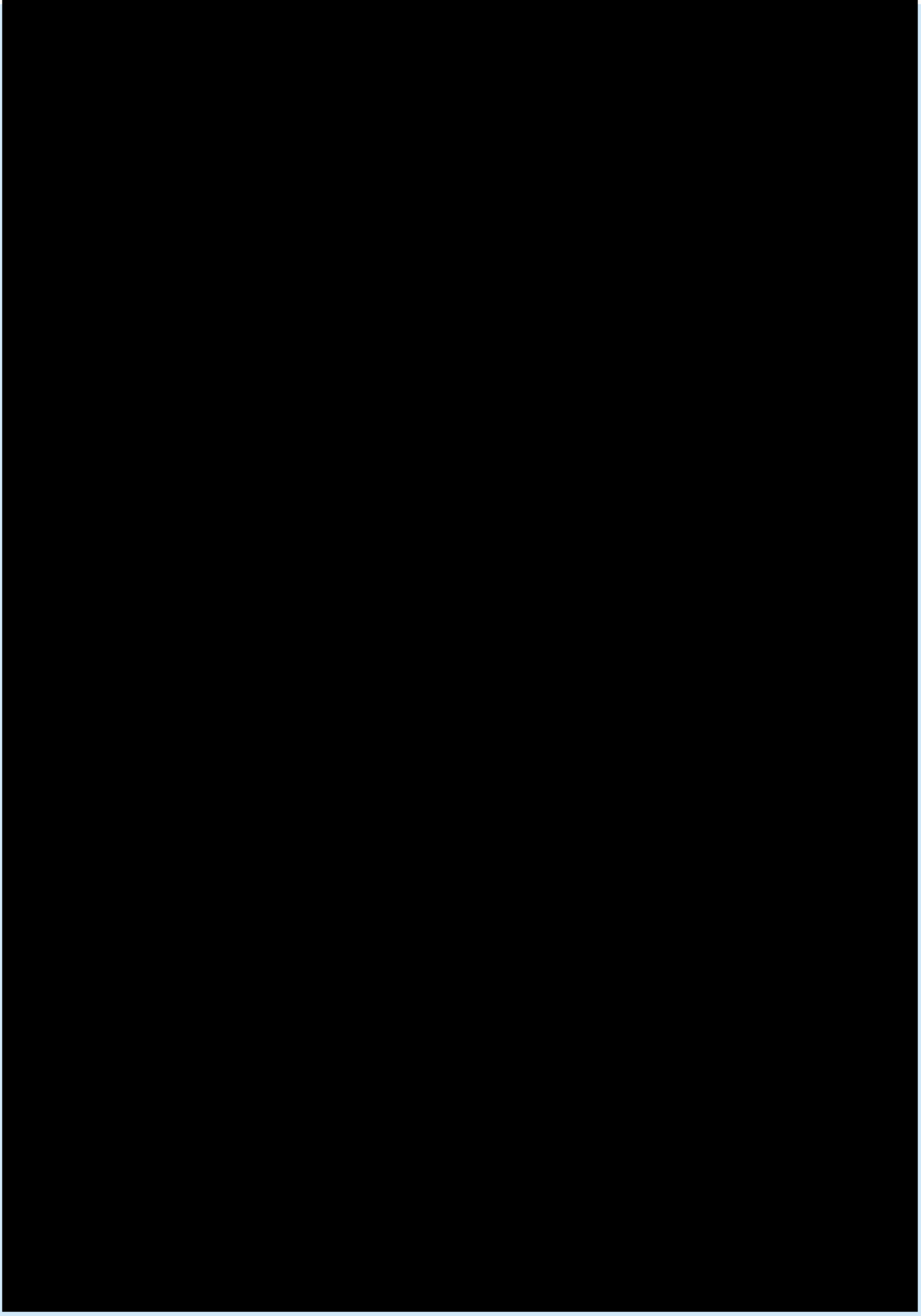

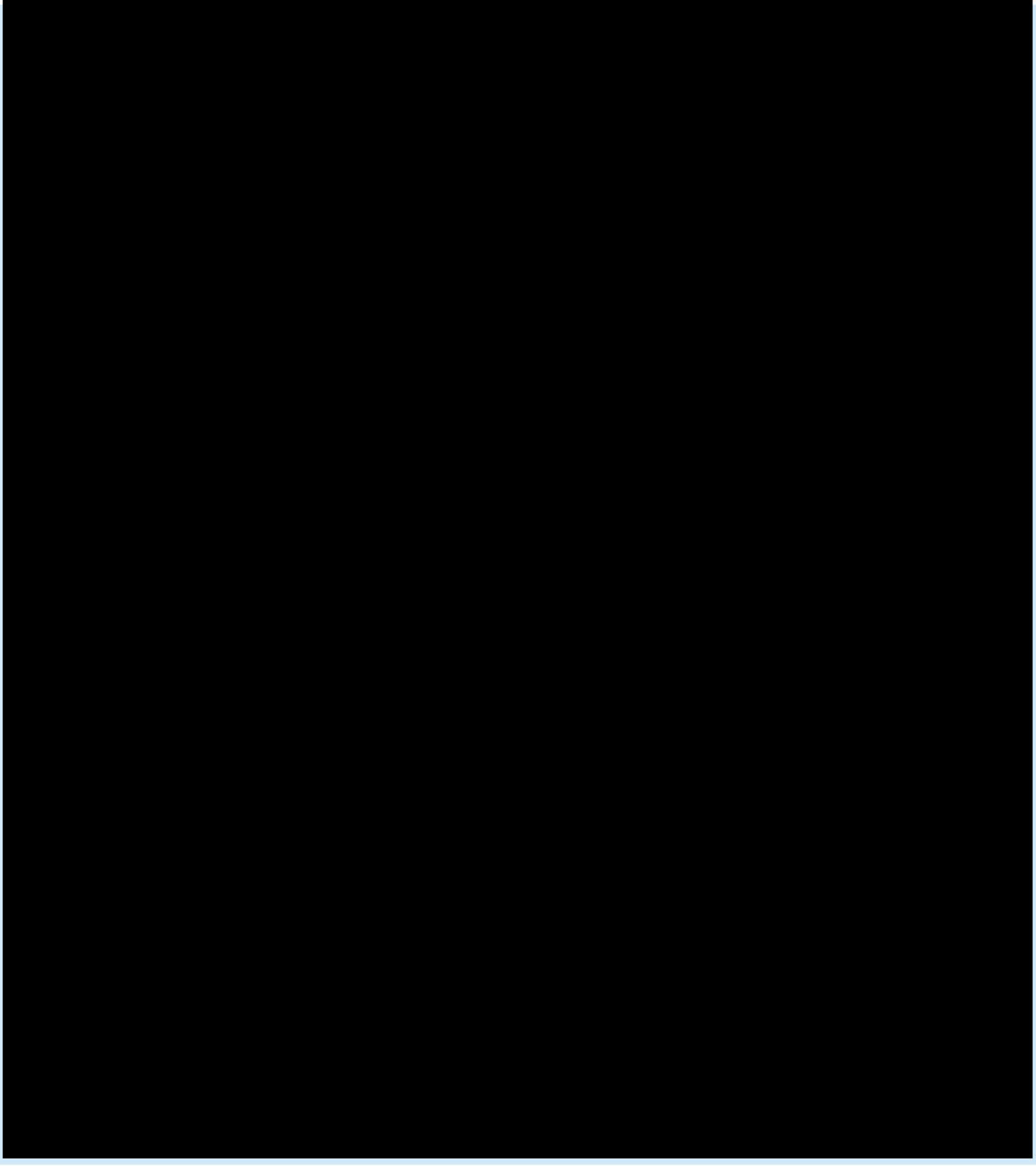

Lifting a suspension on a claim

Once a suspension is no longer in place as a result, for example, of an employee attending a medical examination or a rehabilitation authority advising that a rehabilitation suspension has been lifted, Comcare must lift the suspension on the claim. Processing of any requests for compensation can then resume.

You should always consider taking the suspended claim to triage to discuss lifting the suspension. If you are unsure, discuss this with your Assistant Director.

Effect of lifting a suspension

Once the suspension is lifted, an employee cannot recover any monies for incapacity that relate to the period of suspension **unless** the suspension was revoked following a reconsideration or Administrative Review Tribunal (ART) decision.

If the suspension is revoked during the reconsiderations process, the employee's entitlements will be reinstated.

If the suspension is revoked or set aside by the Administration Review Tribunal, the employee's will also be reinstated.

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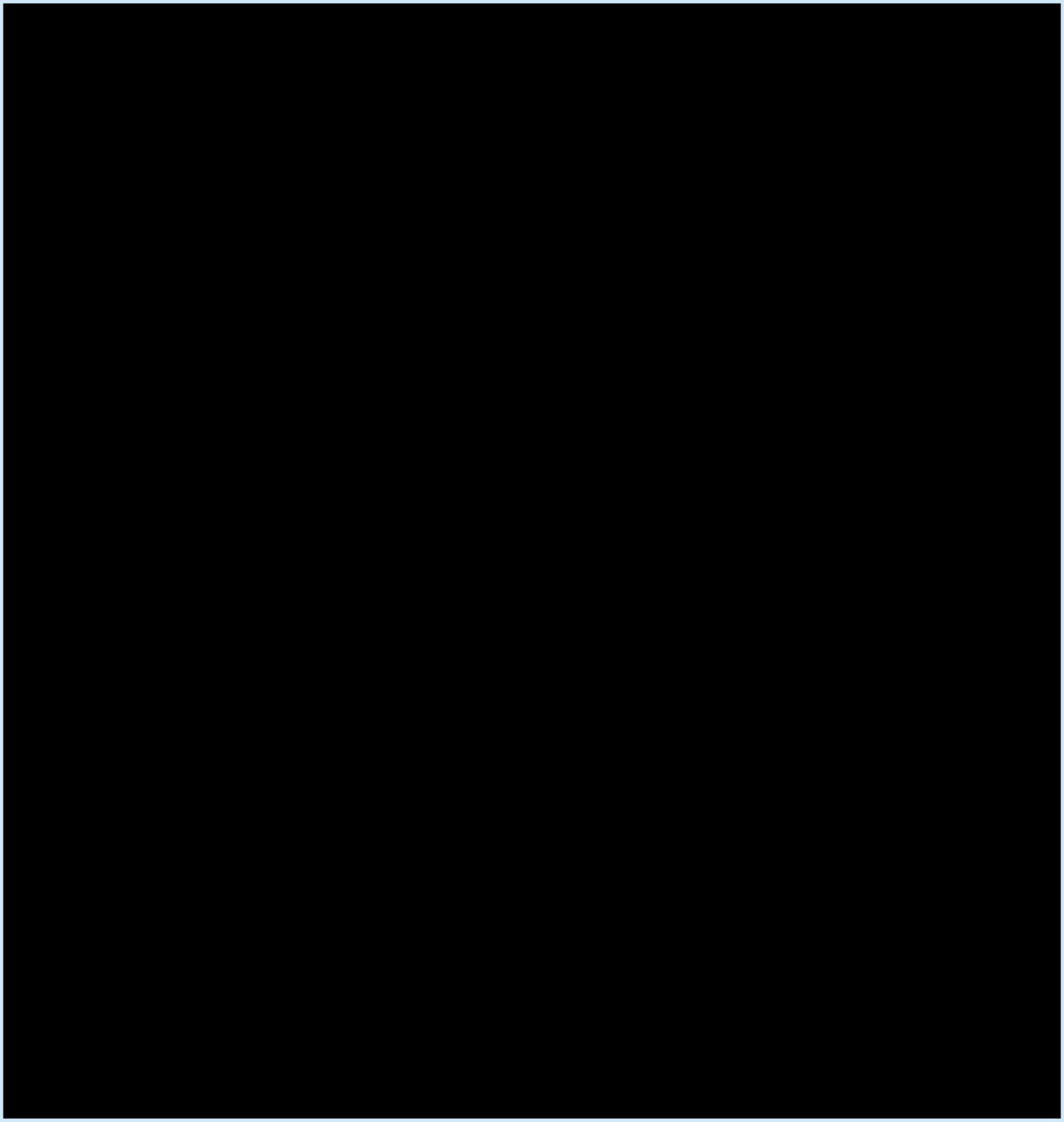

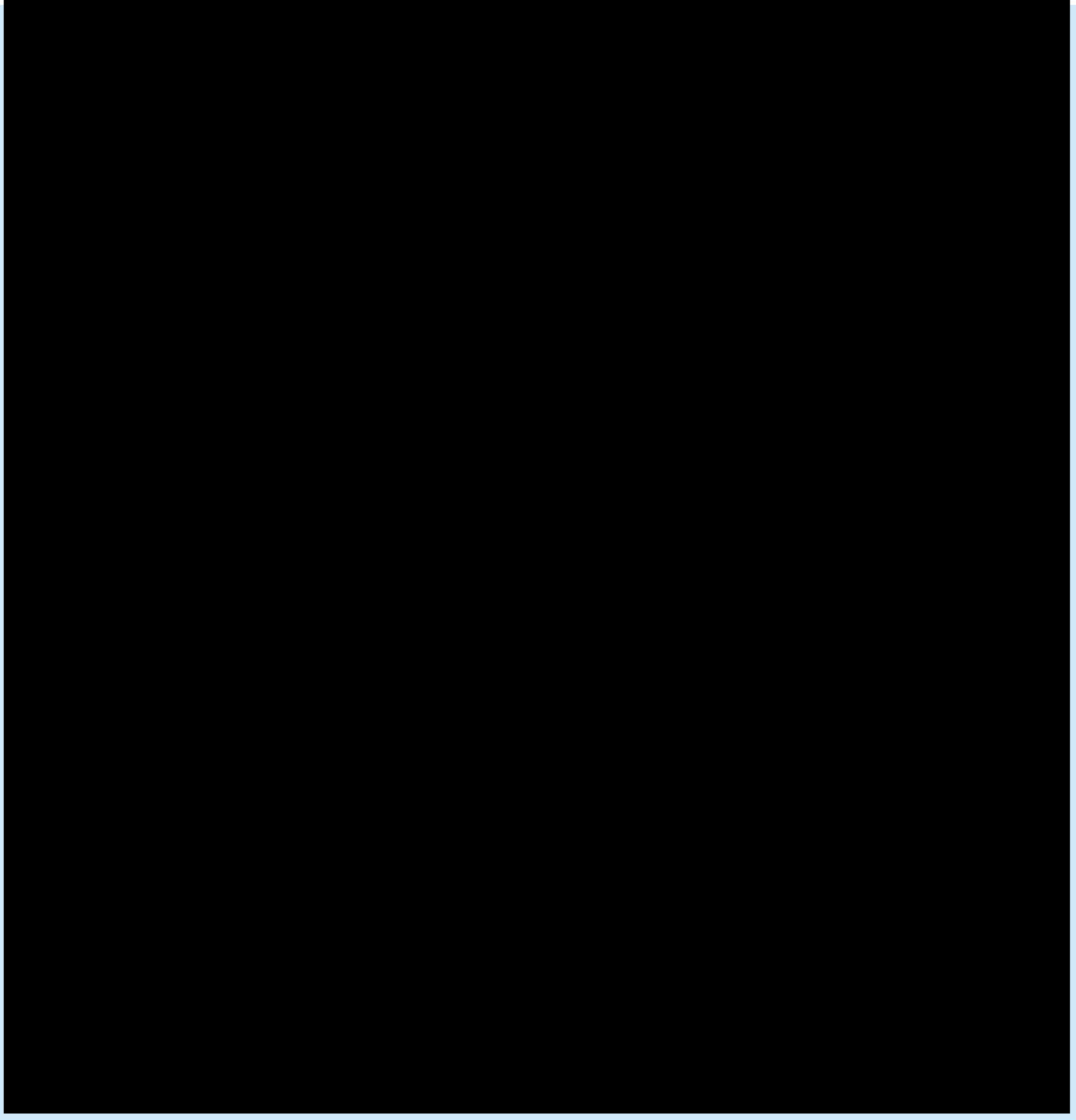

Refusing to deal with a claim

Introduction

Under section 58(3) of the SRC Act, if an employee fails to comply with a section 58 request information without reasonable excuse, Comcare may choose to refuse to deal with the employee's claim until the information or documentation has been provided.

A refusal to deal is a discretionary power. This means Comcare can decide whether to issue a refusal to deal notice or not. A refusal to deal should only be used where Comcare has been unable to identify any other reasonable means of obtaining the information.

Natural justice requires that we clearly advise an employee of the consequences of not complying with a request for information under section 58 of the SRC Act. We cannot lawfully refuse to deal with a claim if we do not provide this advice.

From a procedural fairness perspective, employees should be given a fair opportunity to respond to the section 58 request. This may mean that we give more than one opportunity to respond. If you are unsure, talk with your Assistant Director.

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Refusing to deal with an employee's claim under section 58

When refusing to deal with a claim, you need to consider the nature of the information or documentation that has been requested, and whether the refusal should apply to all matters associated with the claim or just an individual benefit. A refusal to deal does not automatically apply to all claims that an employee may have, only to the claim for which information under section 58 of the SRC Act was sought.

A refusal to deal notice under section 58 of the SRC Act applies until the employee has provided the requested information or documentation. When an employee complies with the section 58 notice, any amounts of compensation that have been withheld become payable in full.

Refusal to deal cannot be reconsidered: A decision to refuse to deal with a claim is not a determination made under section 60 of the SRC Act and therefore is not subject to reconsideration. If an employee wants to dispute the refusal to deal, they have to take the matter directly to the Administrative Decisions Judicial Review by making an application to the Federal Court of Australia.

For further guidance, refer to the Requesting information from employees page.

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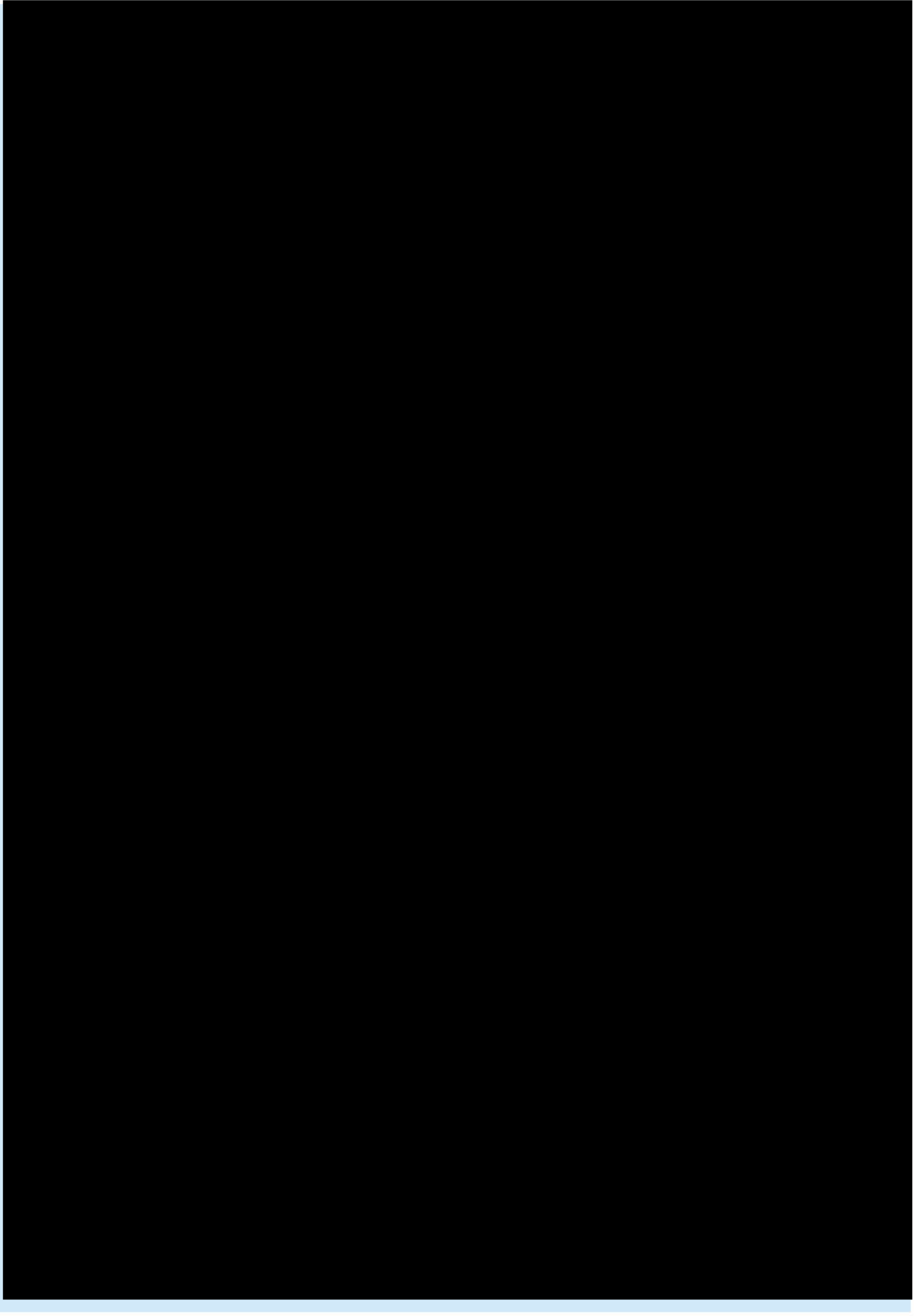

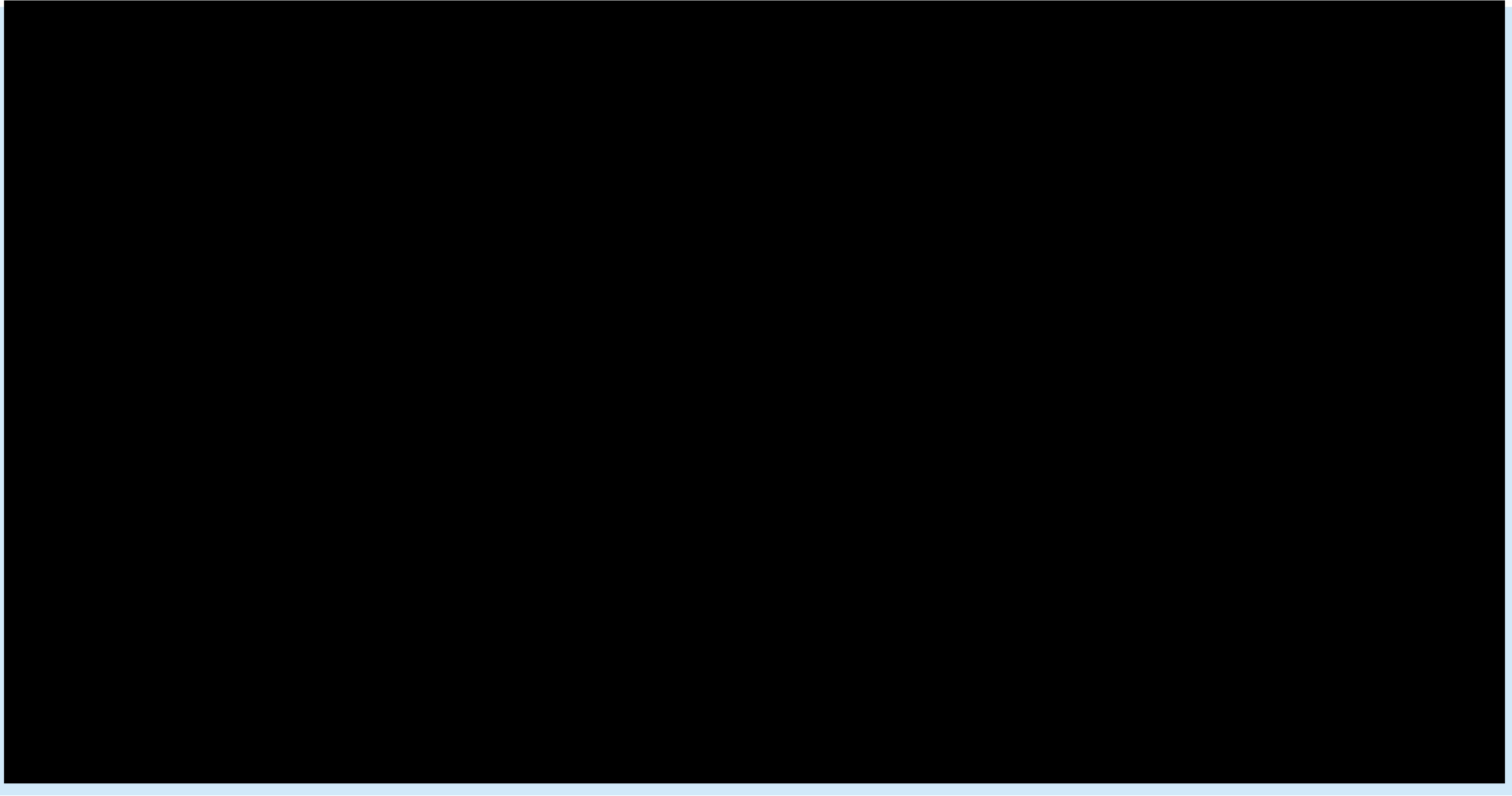

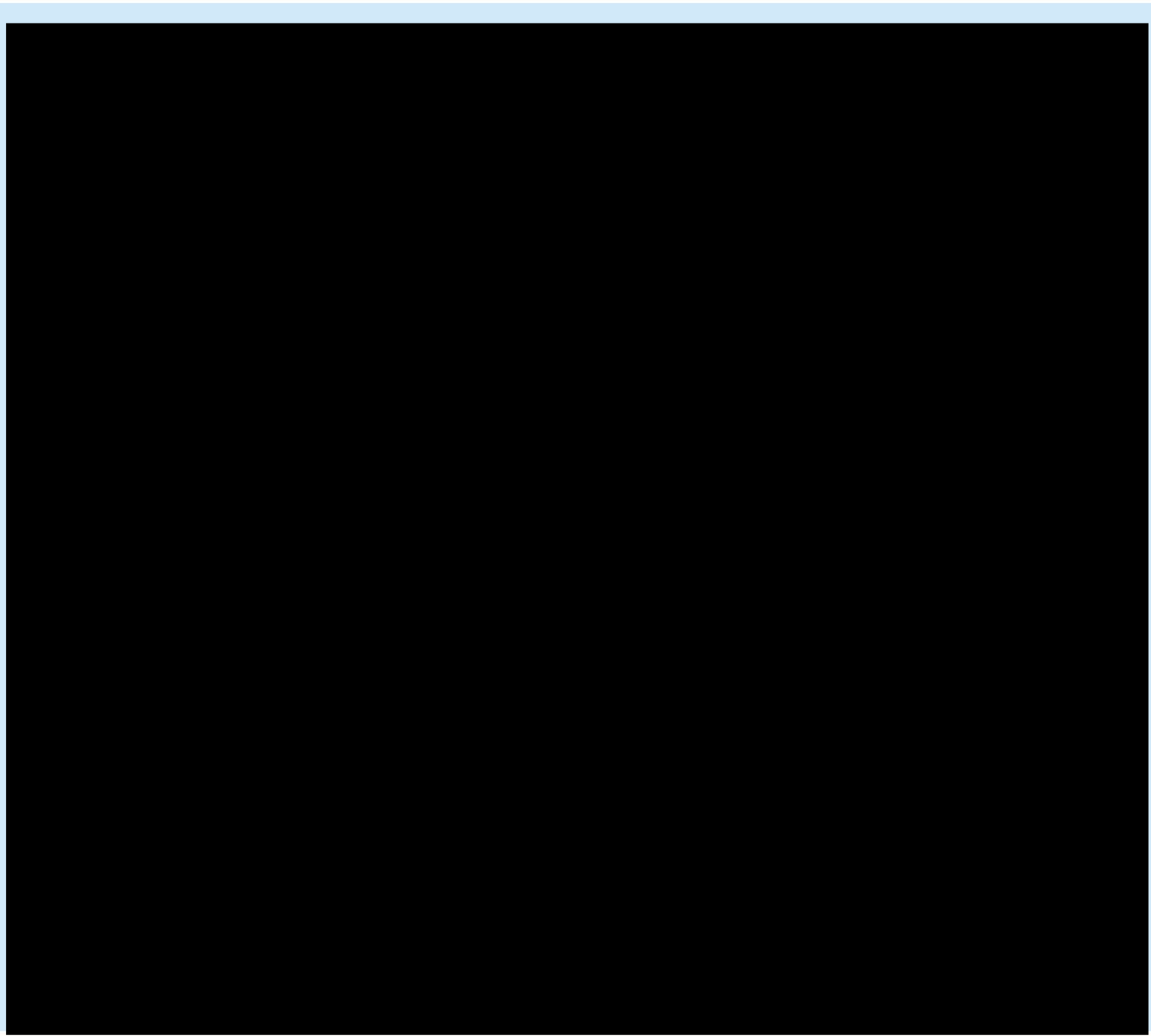

No present liability

Published 27/11/2025

What is no present liability?

A determination of ‘no present liability’ (often shortened to NPL) can only be made on an existing claim for compensation.

You should not determine that there is no present liability for a compensation claim under the SRC Act if an employee is not currently claiming compensation for a cost or benefit. That is, ‘no present liability’ is different from there being ‘no current claim’. There must be a claim submitted for a ‘no present liability’ determination to be possible. You can identify a submitted claim based on the submission of a claim form, medical certificate, invoice, receipt etc.

If such a claim has been made, then you should only consider the current claim(s) for compensation benefits. You cannot extend the determination of no present liability to capture forms of compensation that have not been claimed for by the employee.

A determination of no present liability does not prevent the employee from making future claims under the SRC Act. Where the employee makes a new claim for a benefit, or for a new injury, you must assess any new claim(s) in accordance with normal processes and issue a new determination.

See also Scheme guidance No present liability determinations.

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When can you determine no present liability?

A Claims Manager may determine that there is no present liability for compensation under the SRC Act where:

- there is sufficient medical information to indicate that the employee no longer suffers from their compensable injury or condition, or
- when the relevant legislative tests indicate that the employee no longer has an ongoing entitlement to compensation.

For example, this may be if:

- the employee no longer suffers from the effects of their compensable injury, for which liability was accepted under section 14
- a specific claim for compensation (incapacity, medical treatment, or another form of compensation) is no longer payable because the employee is no longer suffering from the effects of their compensable injury
- in the case of disease claims, the employment has ceased to be a ‘significant’ contributor to the employee’s current condition (see section 5B).

Degree of contribution may change with date of injury

- If the date of injury is on or after 1 December 1988 but before 13 April 2007, you should consider whether the employment has ceased to contribute to a ‘material’ degree to the employee’s

current condition.
- If the date of injury is before 1 December 1988, under the *Compensation (Commonwealth Government Employees) Act 1971*, employment merely has to be 'a contributing factor' without any need to meet a material or significant degree test.

Employee may still be suffering from a condition

If the employee is no longer suffering from their compensable injury, this does not necessarily mean that the employee no longer suffers from any condition. It may be that the current condition is not the same injury or condition, or is not due to the same cause, as the injury or condition for which liability was originally accepted.

In the case of disease claims, a no present liability determination may also be made when the employment factors have ceased to significantly contribute to the employee's current condition. When considering if an employee's employment still significantly contributes to the current condition, you should consider whether:

- the original employment factors are still contributing to the injury to a significant degree (section 5B)
- any non-employment factors or new issues are contributing to the condition more than the original employment factors
- different employment issues are now contributing to the employee's condition.

You will need to establish the facts, consider the information, and decide whether it is the original employment factor or some other factor(s) that are now significantly contributing to the condition.

In cases where the condition itself remains compensable, you can determine that an employee is not presently entitled to compensation under specific sections of the SRC Act if there is sufficient medical evidence to support such a determination, having regard to the specific provisions of those relevant sections. See the examples below.

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Examples of determining no present liability

No longer suffering from the compensable condition

Current medical information indicates that the employee is no longer suffering from the effects of their compensable back condition. The pain the employee suffers from is attributed to a degenerative condition. The Claims Manager determines that the employee's claim for incapacity under section 19 of the SRC Act is not as a result of the compensable condition but related to the degenerative condition.

No longer has an ongoing entitlement due to the relevant legislative test

An employee has been receiving massage treatment for their compensable injury for many years. Current medical information and consideration of the Clinical Framework indicates this treatment is no longer reasonable for the employee to obtain. While the condition itself has not resolved, the Claims Manager determines under section 16 of the SRC Act that there is no present liability for massage treatment.

Employment has ceased to be a significant contributor to the condition (disease claims only)

An employee has a claim for a psychological condition as a result of bullying and harassment in their workplace. A substantial period of time has passed since the date of injury. Current medical information indicates that factors arising post-injury, such as the employee's marriage breakdown, a car accident that they were involved in and financial troubles, are now significantly contributing to their condition.

The Claims Manager determines that the employee's employment no longer significantly contributes to their condition according to section 5B or the SRC Act. It is not necessary to demonstrate a break in causation. It is necessary to demonstrate that the employment factors are no longer contributing to the condition to a significant degree.

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Aggravations

Where an employee has an accepted claim for an aggravation, they do not need to be symptom free in order for no present liability to be determined.

You should compare the employee's current level of impairment/symptomology with the levels that existed before their work-related aggravation.

Once the employee returns to their former level of impairment or symptomology, the employee may no longer be entitled to any further compensation, and you should undertake a review of the medical information to determine whether or not there is any present liability for the claim submitted by the employee.

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Liability cannot be 'ceased'

Once an initial claim for compensation has been accepted, subsequent determinations cannot cease all liability under section 14 of the SRC Act. If liability under section 14 should not have been accepted in the first place, the determination to accept the claim should be reviewed in accordance with the reconsideration provisions of the SRC Act. For further guidance, refer to the Reconsiderations of own motion page.

The Claims Manager must discuss any proposed decision to revoke section 14 liability with their Director before they proceed with any such decision.

Where a no present liability determination has been made because the employee is no longer suffering from their compensable condition, or where an employee's employment no longer significantly contributes to their condition, the initial section 14 determination is not revoked. The determination of no present liability essentially means there is no current liability for the condition and/or the specific benefit being claimed.

A determination of no present liability does not prevent the employee from making future claims under the SRC Act. Where the employee makes a further claim for compensation that has already been subject to a no present liability determination, you may have regard to the evidence relied on

earlier, as well as considering any new evidence in making a determination to accept or reject that claim.

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Inactive claim

When a claim is inactive or has been 'closed' in Pracsys as an administrative action, it does not necessarily mean there is no present liability. You should not determine that there is no present liability on an inactive or closed claim when the employee has not claimed compensation for a cost or benefit under the SRC Act.

An inactive or closed claim does not prevent an employee from claiming compensation in relation to their compensable condition in the future.

If an employee lodges a claim for a compensation cost or payment against an inactive or closed claim, you can re-open the claim, undertake the usual assessments and issue a determination based on the available evidence.

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What should the determination state?

A determination of no present liability must speak only in the present tense and specify the section(s) of the SRC Act for which no present liability is being found. The determination cannot use wording to suggest that an employee cannot make further claims or attempt to prevent them from doing so.

Appropriate wording for determinations includes:

- **(where the employee no longer suffers from the condition)** – *'Based on the available information, I find that as at (date) you are not presently suffering from your compensable condition (state the condition). Therefore, I determine that you are not presently entitled to (specify the benefit) under (specify the section) of the SRC Act and the claim for (specify the benefit) made to Comcare on (date) is denied'.*

- **(where a specific benefit is no longer payable)** – *'Based on the available information, I have determined that as at (date) you are not presently entitled to (specify the benefit) under (specify the section) of the SRC Act and the claim for (specify the benefit) made to Comcare on (date) is denied'.*

- **(for disease claims where the employment is no longer a significant contributor)** – *Based on the available information, I have determined that as at (date) you are not eligible for (specify the benefit) under (specify the section) of the SRC Act for the condition (state the condition) as your employment no longer significantly contributes to that condition. Therefore, the claim for (specify the benefit) made to Comcare on (date) is denied'.*

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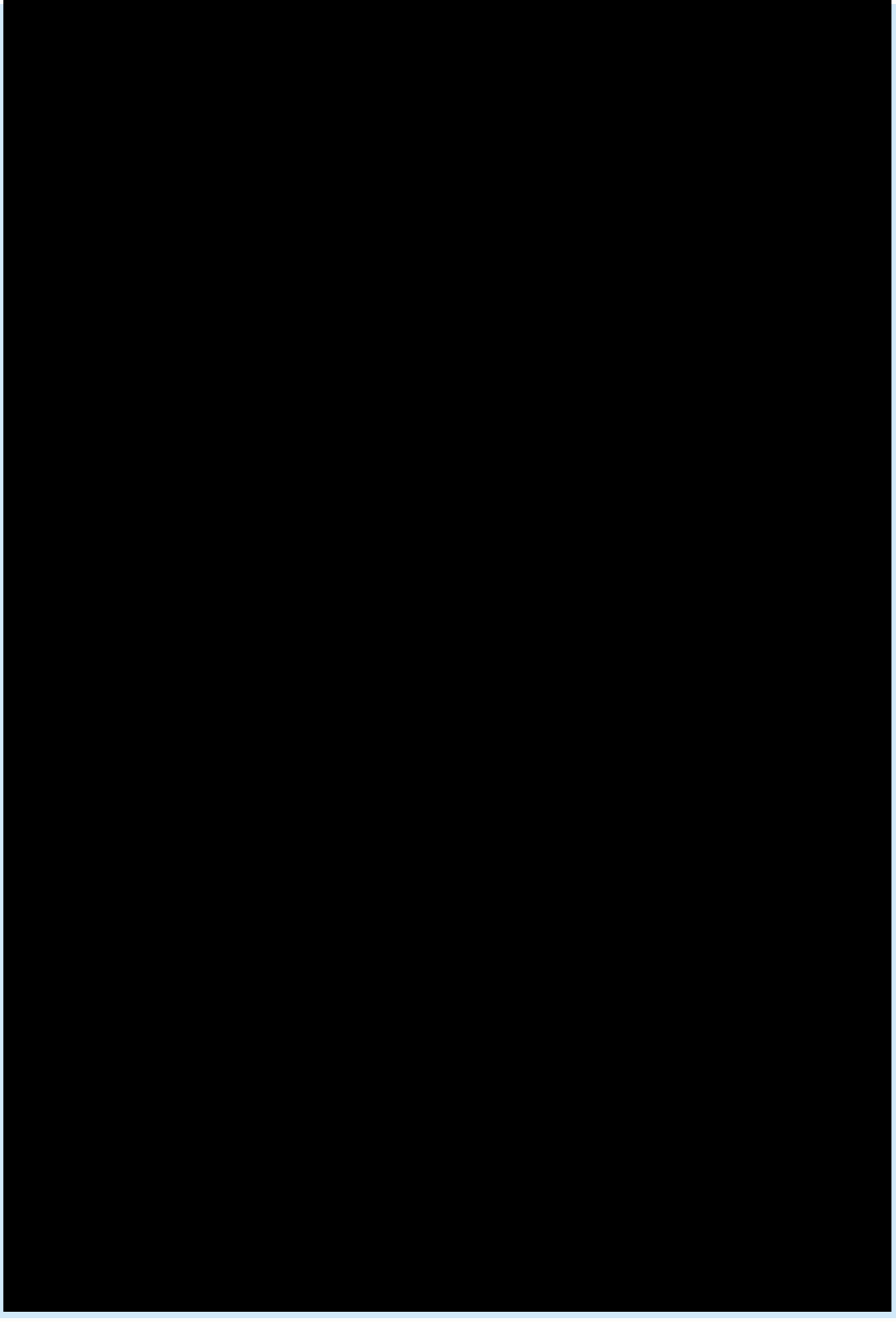

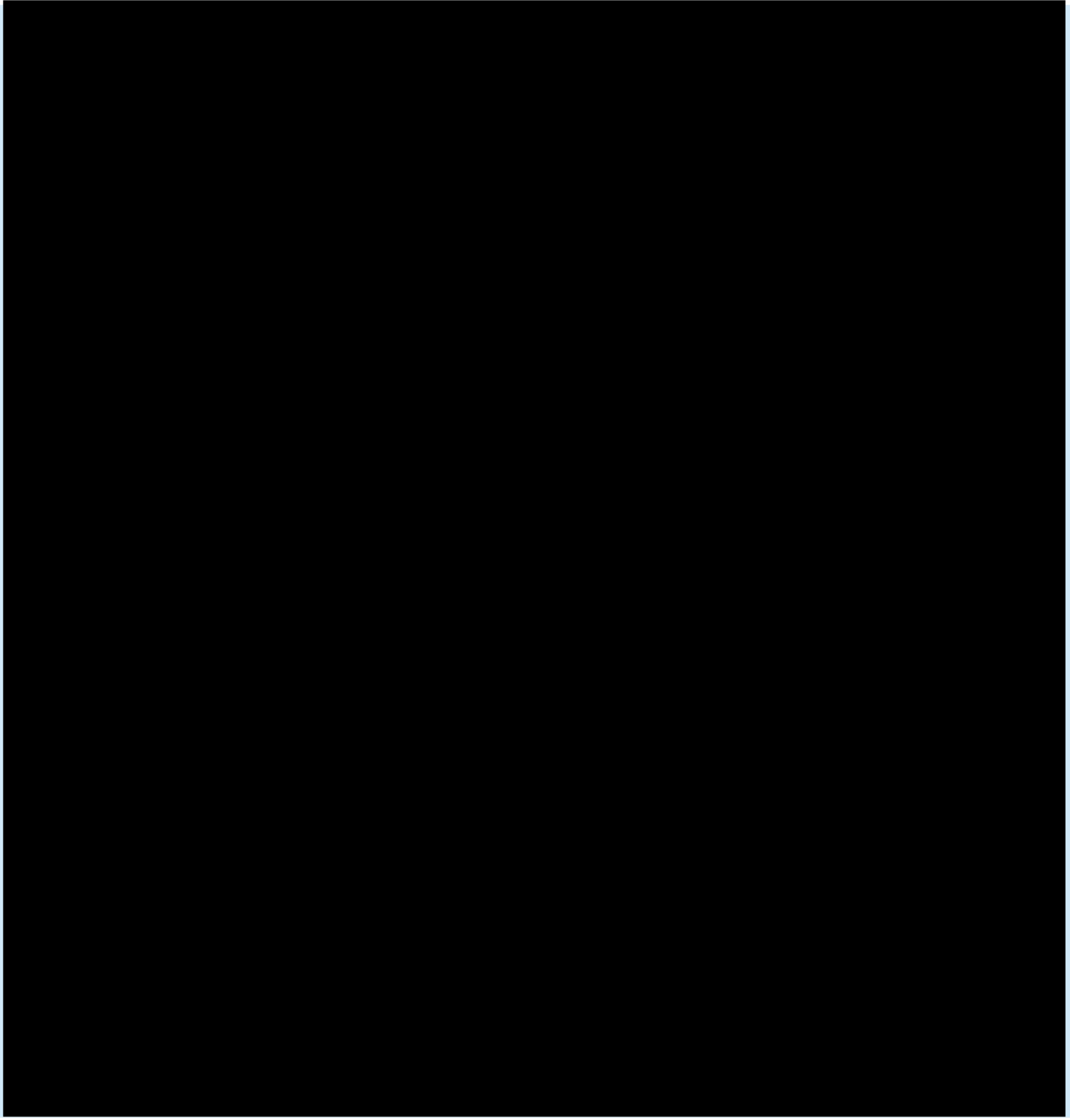

Compliance and fraud

Compliance and fraud

This section includes information on compliance & fraud referrals and the 'Just ask' process.

In this section

Compliance and fraud concerns

Compliance means adhering to the requirements set by the legislation and any procedures, rules or requirements set by Comcare and our Group in relation to the claims management process.

You do not need to determine which category your concern falls into. The Fraud Investigations Unit and Claims Compliance and Assurance team work closely together to assess all referrals we receive to determine the most appropriate pathway for assessment.

'Just Ask' process

This process is to assist and provide direction on what to do if you discover something that does not look or feel right or when you receive information either from the employee or another source (employer, rehabilitation provider etc) that has the potential to impact the management of a claim.

Compliance and fraud concerns

Published 31/07/2025

Introduction

Compliance means following the requirements set by the legislation and any procedures, rules or requirements set by Comcare and our Group in relation to the claims management process. Non-compliance is not always intentional and does not always meet the definition of criminal fraud.

Most of the time, non-compliance is a mistake or misunderstanding and can be resolved through:

- open, honest, and transparent communication with the relevant individual
- educating our clients about their obligations and rights and/or
- corrective claims management action.

These actions are designed to support the achievement of voluntary compliance. Voluntary compliance is the act of obeying a particular rule or law, or of acting according to an agreement without being forced. We can encourage this by making our requirements clear and achievable.

The 'Just Ask Process' has been developed to guide you on what action can be taken when you identify a concern that indicates potential non-compliance or fraud. A **concern** is information of any form that is **inconsistent** with what we currently know, or information that **was not previously disclosed.**

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Examples of non-compliance or fraud concerns that may arise in the claims process

Examples of concerns you might have could include, but are not limited to:

- Indication or information received of a business or paid or unpaid activity that an employee is engaged in, that has not been previously declared to Comcare.
- Documentation, such as receipts or a medical certificate, which appears to have been altered or manipulated or that appears different from invoices that have been previously submitted by the provider.
- Information from an employee that they have not received a service Comcare has been invoiced for.
- An undeclared non-compensable condition that may impact the liability of the claim.

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What should I do if I have concerns?

If you have concerns that something is potentially non-compliant or fraudulent, in the first instance you should apply the “Just Ask” process.

You should make a referral to Claims Compliance and Assurance team (CCAT) when:

- the Just Ask process is not considered appropriate in the circumstances (see Just Ask process – considerations), or
- voluntary compliance could not be achieved through the Just Ask process, or
- you have ongoing concerns that cannot be resolved through reasonable claims management action.

You should not take any action that is not related to the management of the claim or conduct an investigation related to the concern, to support a referral.

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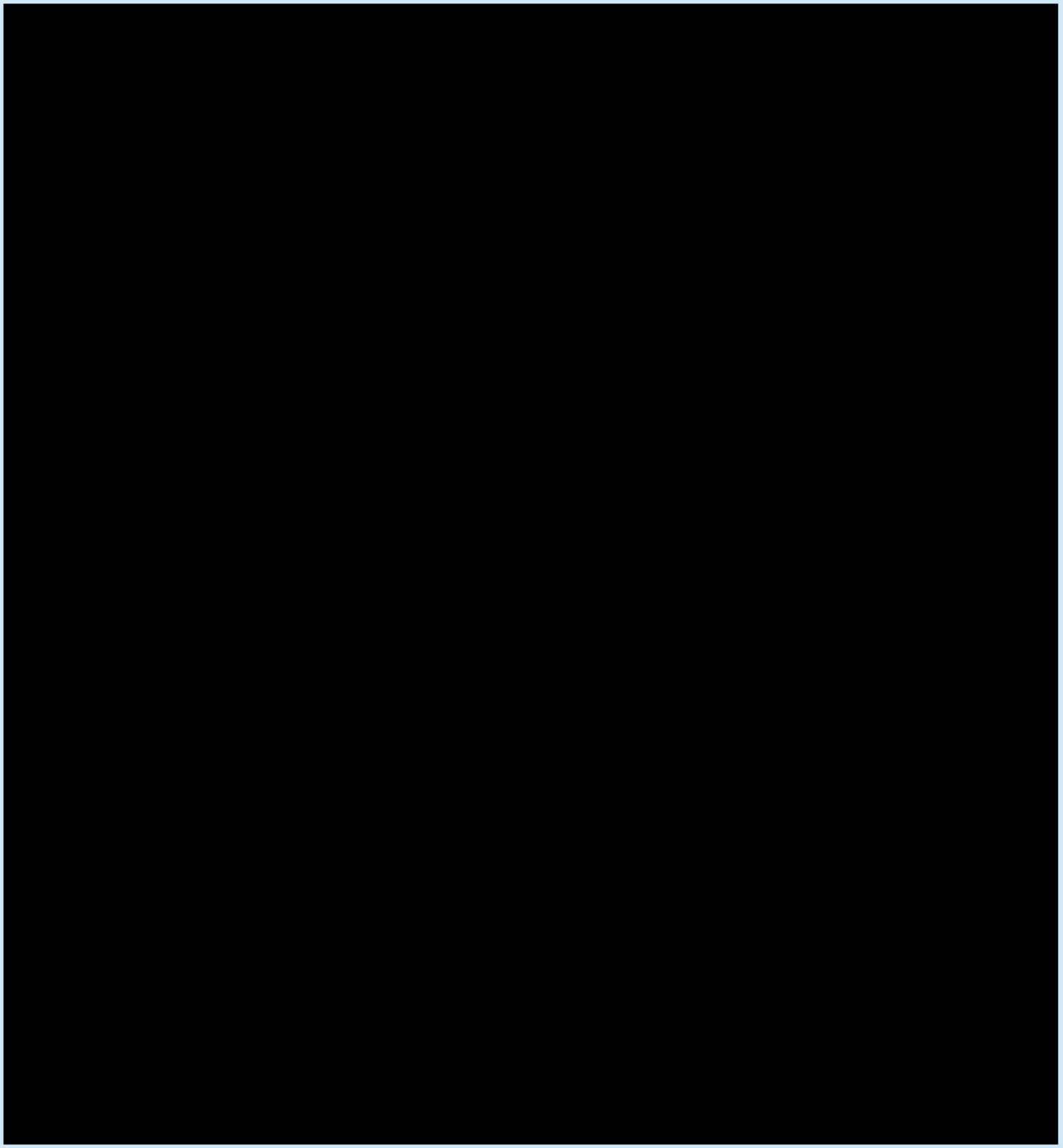

What happens after a referral to the Claims Compliance and Assurance Team (CCAT)?

Once a referral is received, CCAT will complete an assessment which generally involves a deep dive review of the Pracsys file and research on available information sources. As a result of this assessment there are three likely outcomes:

1. The information available does not indicate that further action is required.
2. A recommendation is made for further claims management action.
3. A referral to the Fraud Investigations Unit is made.

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What if I suspect Fraud?

Fraud is dishonestly obtaining a benefit, or causing a loss, by deception or other means.

It can also be a breach of the APS Code of Conduct, a breach of contract, or a civil wrong. Fraud can be committed by individuals from outside the entity or by officials. It can involve financial fraud on program or operational funds, or non-financial activities that can impact upon the operations and reputation of the entity.

If you suspect Comcare employee misconduct or corruption, this MUST be referred directly to the Fraud investigations unit via their mailbox or you can report anonymously: Comcare: Fraud report

All other suspected fraud should follow the process outlined in the What should I do if I have concerns? section. It is no longer the responsibility of claim management group staff to determine if a concern meets the definition of fraud. The Claims Compliance and Assurance team will determine through their assessment process whether they reasonably suspect that the concern meets the definition of fraud and should be referred to the Fraud Investigations Unit.

You should not under any circumstances conduct your own investigations, including online searches, to obtain information to further define a concern as fraud.

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Other resources

- 'Just Ask' process
- Fraud Control
- Allegation management guidelines

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'Just ask' process

Published 04/08/2025

Introduction

What should I do if I notice inconsistencies, non-compliance or potential fraud on a claim?

This process is to help and advise you on what to do if:

- you discover something that does not look or feel right or
- when you discover concerning or previously undisclosed information that is relevant and has the potential to impact the management of a claim.

The information could come from the employee or another source (employer, rehabilitation provider etc).

Non-compliance and potential fraud are not always obvious or overt. Most times, it is an inconsistency that just does not quite add up. This process aims to help you understand or resolve the inconsistency and to support your decisions about any actions that need to be done to achieve compliant claim management.

At any time before, during or after this process is implemented, you can contact Claims Compliance and Assurance for advice or guidance.

For further information on fraud control refer to: Comnet: Fraud and Corruption control

Why do we need to apply the “Just Ask” process?

This process is an opportunity to be open and transparent with the employee, to inform them of the information that Comcare is aware of, and to explain the information they need to provide which ensures that:

- Comcare has the correct information to achieve compliant claims management
- the employee’s claim is being managed accurately, and
- the correct entitlements are paid to the employee based on their current and historical circumstances.

When potential non-compliance, fraud or inconsistencies are observed on a claim file, it is important to give the employee Natural Justice. This means the injured employee, person, or organisation has an opportunity to explain, provide information and be involved in the process to achieve voluntary compliance. Natural justice demonstrates that Comcare is acting in good faith and supports Comcare to be a model litigant.

Natural justice applies throughout a claim's life cycle, supporting open transparency with employees. This includes when we have a concern that a claim or an element of a claim is non-compliant or invalid.

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Legal obligations

Comcare's obligation to manage claims under the SRC Act, and its obligation to properly use resources under the *Public Governance, Performance and Accountability Act 2013* (PGPA Act), continue irrespective of the existence of a related criminal fraud investigation. As such, Comcare Claims Managers can continue to exercise claims management powers under the SRC Act (including requesting information under section 58 of the SRC Act) as and when required for claims management purposes.

The Just Ask process helps the employee gain voluntary compliance and continue compliance in the ongoing management of the claim.

Examples of the type of information or documents that might be asked of an employee to achieve compliance include, but are not limited to:

- Current medical certificates
- Clinical notes and medical reports
- Records of earnings and hours, including payslips, business documents
- Financial statements including BAS statements, profit, and loss statements and ATO (Australian Taxation Office) group certificates
- Partnership agreements
- Incident reports.

Only ask for necessary information: Comcare employees should only request information from the employee that is required to conduct claims management functions. You should avoid any suggestion of bias by never requesting irrelevant information which may be related to a criminal fraud investigation.

The "Just Ask" approach is a conversation about concerns that may impact on the management of a claim. This is not an investigation or the assessment of fraud or non-compliance. Please do not take it upon yourself to seek to investigate or research any concerns you have using the internet or social media. If you feel internet or social media searches are necessary based on your concerns, refer to the Claims Compliance and Assurance team for review and guidance.

Refer to: Requesting information from employees

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Considerations before you "Just Ask"

Before proceeding with the Just Ask process, you should consider the following:

- Does the employee have capacity to receive information or answer questions about the concern? Should the request be delivered in the presence of or by the employee's treating health professional?
- Is the claim a commitment claim with specific communication requirements?
- Does the employee have an Authority to Act on the claim file? Should the request be delivered in the presence of or by the employee's nominated Authority to Act?
- Are you the right person to be making this request or to deliver this request?
- If there is concern the conversation may cause damage to the relationship or about the employee's responses in general, you can refer to Claims Compliance and Assurance team for assistance.

Note: If the above considerations, or any other concerns, indicate that this process may not be appropriate, please discuss with your Assistant Director or the Claims Compliance and Assurance team for guidance first.

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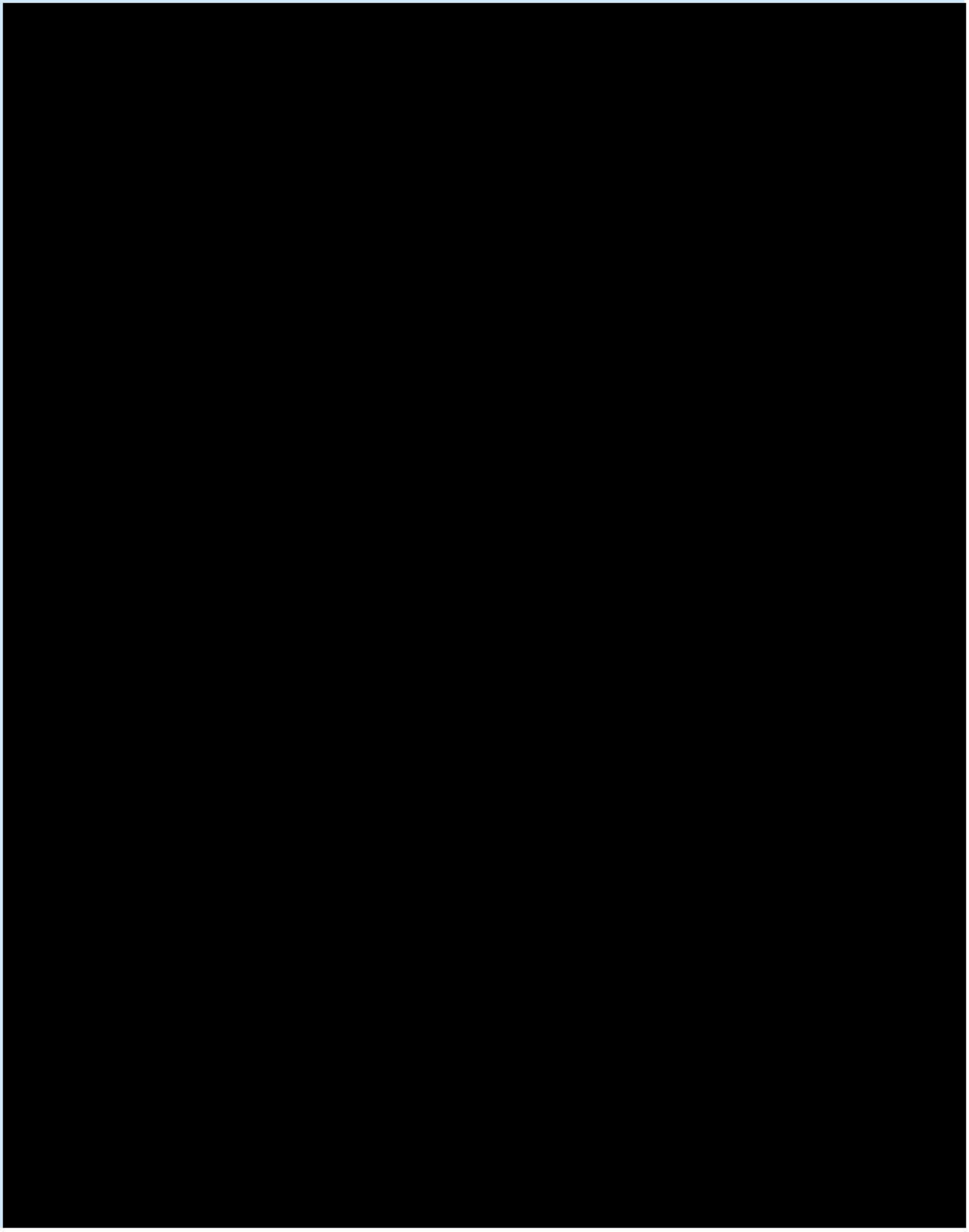

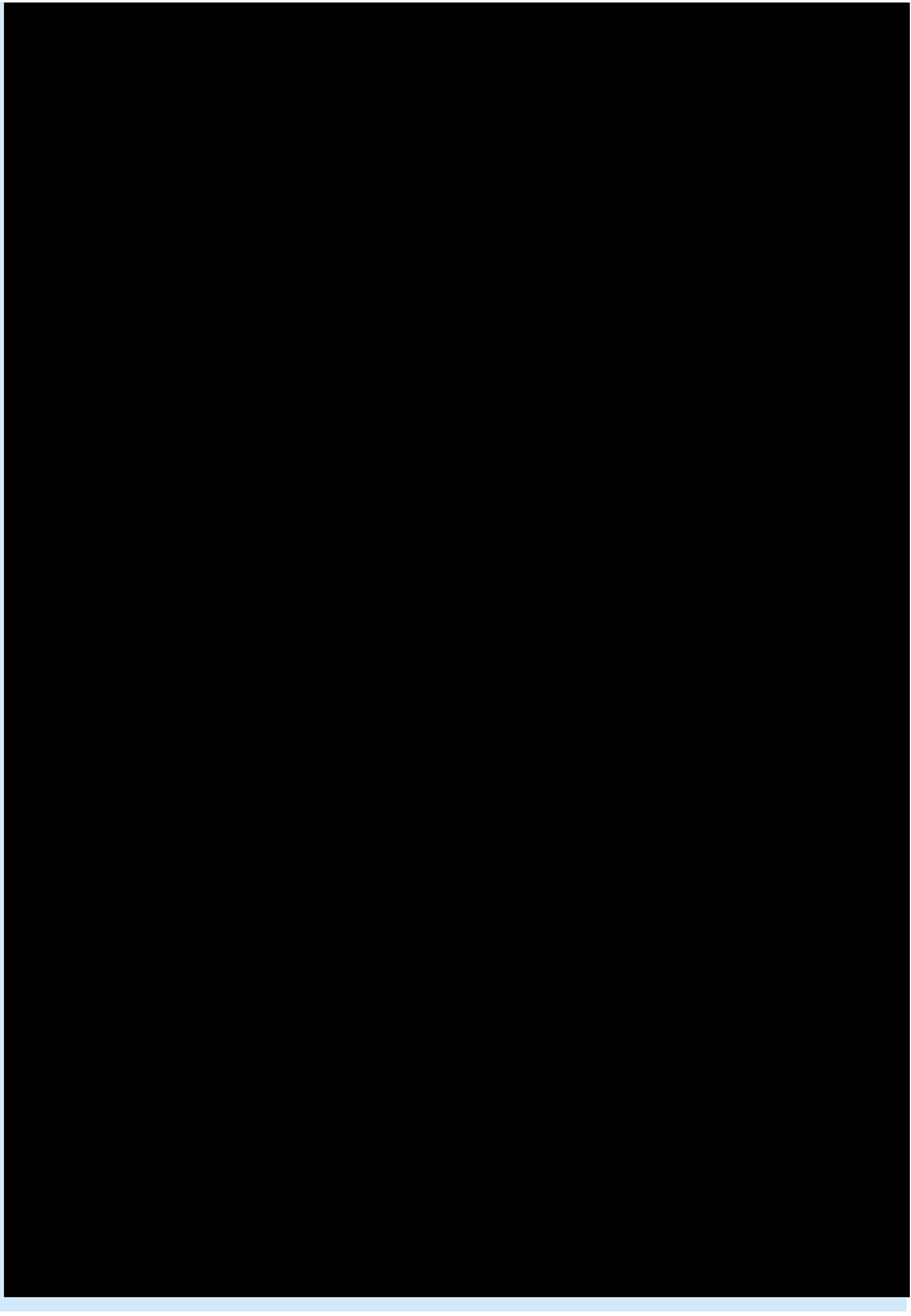

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What if the employee does not provide the information needed?

Follow the information in Requesting information from employees.

Information you may consider requesting under section 58 includes but is not limited to:

- Tax records, Bas Statements, Profit loss statements
- Payslips or invoices to support reported income
- Business records – hours, activities, income etc
- Valid medical documents
- Valid invoices, receipts, or other proof of payment
- Medicare summary or Medicare PBS (Pharmaceutical Benefits Scheme) summary
- Partnership agreements/ contracts
- Bank statements

Refer to: S58 information request wording examples

All information requested under section 58 must be for the purpose of supporting and achieving compliant claims management.

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Scenarios / case studies

Scenario 1:

An employee has a compensable mental health condition and was recently certified fit for 20 hours of modified duties per week. Their medical certificate states “Sammy is unable to return to their preinjury employment.”

The employee is referred to a Workplace Rehabilitation provider for help in preparing and obtaining suitable employment. The employee attends their first appointment and advises they are going to start their own lawn mowing business, recently obtaining an ABN (Australian Business Number). The Rehabilitation provider contacts the Rehabilitation Case Manager (RCM) and Claims Manager to notify of the business status, acknowledging the employee does not have a client base and has not made any income.

The Claims Manager contacts the employee to “Just ask,” provide support, acknowledge the business and to inform the employee of their obligations to report all gross income, providing a definition of “gross income” and what employment is. The Claims Manager explains the Record of Earning (ROE) form and the Work Activity declaration form, which need to be completed. Copies of these forms are sent to the employee and returned with all relevant information.

In these types of circumstances where the employee is voluntarily compliant, there does not appear to be reasonable grounds to utilise a specific section 58 notice. An informal approach such as a conversation could be used to obtain information about the employee's business and income. It is also an opportunity to educate the employee on their reporting obligations including ROEs.

Scenario 1a:

The employee has been operating their lawn mowing business for 2 years now. They have been lodging fortnightly ROEs and declaring 20 hours per week, earning $400 ($20 per hour).

A recent report from an independent medical examination (IME) notes the employee is self-employed and has a weekly client base of 15-20 per week.

On receipt of this information, you conduct a review of the file and identify that the employee's hours and income have not varied at all in the past 18 months.

Medical certificates continue to certify him fit for 20 hours of modified duties per week.

You recognise that the employee's reported income and hours, unchanged for 18 months, do not seem to reflect the varying number of 15-20 clients per week they reported at the IME.

You then discuss this new information and concerns with your Assistant Director and decide to commence the "just ask" process.

You follow the "just ask" process specifically addressing concerns about the employee's hours, income, and activities.

Response 1 example:

The employee provides a valid explanation for their reported hours and income and supports their explanation by providing payslips, invoices, and bank statements.

Initial concerns are resolved, and no further action is required.

Response 2 example:

The employee responds and answers all the specific questions asked. The employee explains that their hours and income fluctuate so they just provide an average. They provide previous financial year tax statement and payslips. The tax statement clearly identifies that the employee has earnt a far greater amount than reported.

You then discuss the response with your Assistant Director and consider claims management actions to continue supporting the employee toward voluntary compliance through education. There does not appear to be any evidence on file of the employee being clearly instructed on reporting requirements. You then inform CAIS for potential recalculation of future incapacity payments and a discussion with the relevant Assistant Director for consideration of overpayment.

Response 3 example:

The employee responds and answers **most** of the specific questions asked by the Claims Manager. The employee confirms the hours and income reported on ROEs to be true and accurate. The employee advises they have not completed their tax return for the previous financial year and therefore cannot

provide it. Despite follow up and direct questions about the employee's unchanging income and hours, the employee does not provide a satisfactory or justifiable reason. You still have a concern that the employee may not be disclosing all gross income and hours.

You discuss the response with your Assistant Director and consider referral to Claims Compliance and Assurance outlining your concerns of the employee's evasiveness.

You also make a diary entry reminder on claim file to request tax return on a later date.

Response 4 example:

The employee refuses to answer questions about their employment hours and income or uses avoidance tactics, becoming aggressive or changing the subject. Despite multiple attempts to gain the information needed from the employee verbally, you are unsuccessful. You discuss your concerns and conversation with your Assistant Director and make the decision to issue a section 58 notice to obtain the information from the employee.

The due date for the information request under section 58 notice has passed and employee has made no attempt to provide information requested. Despite an offer to extend the due date by 14 days, the employee insist they do not have to provide Comcare anything.

You have been unsuccessful in obtaining information utilising a section 58 notice.

You discuss the response with your Assistant Director and consider claims management actions and refusal to deal. Due to the employee's evasiveness and non-compliance with the section 58 notice, you also consider a referral to Claims Compliance and Assurance as this type of behaviour is considered a fraud indicator.

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Scenario 2:

An employee has been certified fit to work 10 hours per week following an extended period of complete incapacity due to their compensable condition. The employee's certificate is about to expire, and you contact them to remind and request a new certificate. The employee acknowledges and provides a new certificate 2 days later.

The new medical certificate certifies the employee as totally incapacitated for work for 3 months due to their compensable condition. You notice that the certificate appears to be an older medical certificate that seems to have been altered, with dates and fitness for work whited out and new dates applied. The alterations are not verified by the doctor's initials or a signature.

You are concerned, as this is the first time the employee has lodged a medical certificate from their normal doctor with alterations. You are also concerned that the medical certificate is non-compliant and decide to commence the "just ask" process.

Response 1 example:

The employee explains they called their doctor to request a new certificate, but the doctor was busy and agreed to send a new certificate in an email. The employee says they did not pay any attention to the certificate alterations or that it certified them as unfit for work. The employee confirmed that they

remained fit for 10 hours per week and would request a new medical certificate from the doctor, providing a new medical certificate 2 days later.

You are satisfied with the validity of the new medical certificate and you document the conversation in Pracsys claim comments and in an overview email to the employee.

Response 2 example:

The employee tells you that the medical certificate is valid and came from their doctor. The employee states they do not have time to go back to the doctor to request a new one and requests that you contact the doctor to confirm it. You then contact the relevant doctor and confirm that the medical certificate is valid. The doctor explains the employee has had a deterioration in their compensable condition since the previous certificate and will require surgery soon. The doctor further confirms the employee is unfit for work for 3 months; however, will continue to review every month.

You are satisfied that the medical certificate is valid, and you document the conversation with the employee and doctor in Pracsys claim comments and in an overview email to the employee.

Response 3 example:

The employee states the medical certificate is valid and becomes upset that you are questioning it. The employee does not provide an explanation for the altered medical certificate and declines to provide a new one. You advise the employee that they will need to contact their doctor to verify the certificate.

You are not satisfied that the medical certificate is valid and then contact the employee's doctor for verification. The doctor advises they have not seen or spoken to the employee, nor have they provided a recent medical certificate, confirming the medical certificate is invalid.

You then contact the employee again to advise them of the information received from the doctor and the impacts this may have on the employee's claim. The employee acknowledges they altered the medical certificate and explains they do not feel ready to engage in work due to non-compensable reasons.

You provide the employee with information on how their claim will be impacted, continue management of the claim and refer this matter to Claims Compliance and Assurance team.

(In a scenario where the employee insists the medical certificate is valid, a referral to Claims compliance and assurance team can be actioned.)

Response 4 example:

The employee is upfront and acknowledges they altered an old certificate because they did not have time to see their doctor and did not believe that they were fit for 10 hours per week. The employee apologises and says they have never done this before. The employee confirms they will go to their GP to get a valid medical certificate.

You then provide the employee with education and information on how their claim will be impacted. You continue management of the claim and refer this matter to Claims Compliance and Assurance team.

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Agency Information

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Premium paying agencies may be responsible for a range of different types of claims depending on when an employee was employed with them and depending on the history of the agency.

An agency could be liable for long latency claims, premium claims and pre-premium claims.

This page provides information on premium paying entities, premium and pre-premium claims, long latency claims, and liable and payroll agencies as the Rehabilitation Authority. It also discusses Machinery of Government changes, Exit Agencies, Self administration and self-insurance, the QWL Corporation, Off-budget agencies, and the Northern Territory Government.

Delegated claims

This page provides information on agencies with delegation to manage their own claims. It includes detailed information on Australian Defence Force claims and general information on other agencies with delegation to manage their claims.

Practice support and account management

Introduction

This page provides information about Commonwealth agencies and their relationship to Comcare. The Practice Support and Account Management staff are available to assist with queries regarding Commonwealth agencies and employers.

Premium paying agencies may be responsible for a range of different types of claims depending on when an employee was employed with them and depending on the history of the agency.

An agency could be liable for long latency claims, premium claims and pre-premium claims. There are also complexities surrounding which agency may be the Rehabilitation Authority for a claim.

It is important to consider the date of injury (DOI) of a claim, and where the employee was working at the time the injury was sustained. A premium paying agency at an employee's date of injury may no longer be a premium paying agency, but instead may be an exit agency or a licensee.

This page provides information on premium paying entities, premium and pre-premium claims, long latency claims, and liable and payroll agencies as the Rehabilitation Authority. It also discusses Machinery of Government changes, Exit Agencies, the QWL Corporation, Off-Budget Agencies, and the Northern Territory Government.

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Premium paying entities

Premium-paying entities are liable for workers compensation injuries and diseases through the payment of annual premiums to Comcare. Under the SRC Act, Comcare determines the amount of annual premium each Commonwealth entity/agency pays each financial year and the premium paid funds the liabilities for all accepted claims expected to occur during that financial year.

When an employer/entity pays their annual premium to Comcare, it is expected to fund their future liabilities associated with claims incurred in the upcoming financial year for the life of those claims, as well as Comcare's claims management costs.

There are around 160 to 175 separate premium paying entities each year depending on machinery of government changes that occur during the year.

Some entities have premium claims, but do not actually pay their own premium. Instead, for the purposes of premium calculations, they are considered part of their parent entity. These entities may have their own injury management staff and Rehabilitation Case Managers, but they do not receive an annual premium notice from Comcare.

This is the case for the following employers:

Entity	Parent entity responsible for premium

IP Australia	Dept of Industry, Science and Resources
Geoscience Australia	Dept of Industry, Science and Resources
The Royal Australian Mint	Dept of the Treasury

These parent entities may apportion some of the premium costs to their child entities and request reimbursement directly from them. In that regard, Comcare Account Managers usually provide those parent entities with a breakdown of incurred claim costs from each child entity that contributed to the premium.

Premium claims

Premium claims are those claims where the date of injury was on or after 1 July 1989. Claims that are accepted and have a date of injury from that date form part of the 'premium pool' calculations. This is regardless of whether the claim is open, closed or whether a *No present liability* decision is in place. The *'premium pool'* is the total premium to be charged across all entities in the Comcare insured scheme for predicted claims for injuries and diseases sustained in the financial year.

The premiums for an entity or Commonwealth Authority respond to general trends in both the aggregate '*premium pool*' and the respective entity's claim performance. Accepted claims with a date of injury within the four most recently completed financial years fall within an entity's 'premium window'. Each year, the *'premium window'* shifts forward by one year. This means that the period used to assess an entity's claim experience is updated to include the most recent claims data. These claims directly impact the entity's share of the premium pool and it's the costs of those claims that are a key input into the calculation.

For more information about the premium system refer to the information about premium calculations on Comcare's website.

Pre-premium claims

Pre-premium claims are those with a date of injury prior to 1 July 1989 and all long latency claims where the event or exposure occurred before 1 December 1988. Regardless of when these claims are submitted or liability is accepted by Comcare, the claim costs do not impact an entity's premium.

Note that off-budget agencies have unique arrangements for funding of their pre-premium claims. This is discussed in detail in the Off budget agencies section.

Long Latency claims

For long latency disease claims and information about premiums, exposure and date of injury, please see Long latency disease claims.

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Liable and payroll agencies (rehabilitation authority)

It is not uncommon for employees with active compensation claims to move between Commonwealth and APS entities. This could be due to a Machinery of Government (MoG) change (discussed in the next section) or because the employee has transferred to a new entity due to their injury, or because they have successfully obtained a position with a new employer.

Comcare maintains a record, and history of a claim's 'liable agency' and its 'payroll agency'. These can be seen in the 'View Claim Cost Centre' (VCCC) function in Pracsys.

The difference between the two terms are:

- ***'Liable agency'*** – the entity responsible for the premium costs of the claim. This is usually the entity where the injury was sustained.
- ***'Payroll agency'*** – the entity where the employee now works. This agency will be the recipient of any incapacity payments from Comcare for that claim while the employee is employed there. The payroll agency will also be the 'rehabilitation authority' with delegation to make return to work determinations.

Rehabilitation Authority

The rehabilitation authority (who is usually the current employer) has the delegation to make decisions under the SRC Act in relation to the return to work of an injured employee. That delegation must lie with an officer of the rehabilitation authority and not to any contracted case manager or rehabilitation provider. In most instances the rehabilitation authority will be the liable agency, however if an injured employee leaves the liable agency and takes up employment with another Commonwealth agency/entity, the rehabilitation authority will change to that new employer.

There are a range of scenarios outlined on Comcare's website that explain who the rehabilitation authority is in circumstances where an employee changes employer or ceases to be employed at all. Refer to: Rehabilitation information for employers.

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Machinery of Government (MoG) changes

A Machinery of Government (MoG) change follows a government decision to abolish or create an entity, move functions or responsibilities between entities, or move functions into, or out of, the Australian Public Service. These changes may be documented in correspondence from the Prime Minister, or in orders issued by the Governor-General.

Once a MoG change has occurred, Comcare is required to assess whether responsibility for claims has changed between employers and whether premiums need to be adjusted.

New agencies

Some MoG changes will result in the creation of a new entity. This could be because a function within a larger department is being moved out on its own, or it could be that a new entity has been established. In these circumstances, the Account Managers and the Claims Data and Reporting team will liaise with the appropriate stakeholders within the new entity to obtain details of payroll, full-time equivalent (FTE) and a claims history (if there is one).

MoG changes to existing entities

For entities that have functions transferring between them, Comcare will work with those employers to identify whether there were any claims for compensation incurred in that function and whether any people with compensation claims are moving between agencies with that function.

The movement of claims could look like the following:

Where was the claim incurred	Where is the claimant moving	MOG outcome
Claim was incurred in the function that is moving as part of the MoG	Claimant is transferring to the new agency as part of the MoG change	New agency will become both the liable and payroll agency for that worker's claim
	Claimant is not moving to the new agency as part of the MoG change	New agency becomes the liable agency, and the old agency remains the payroll agency
Claim was not incurred in the function that is moving as part of the MoG change	Claimant is transferring to the new agency as part of the MoG change	Original agency remains the liable employer for the existing claim and the new agency becomes the payroll agency

The Account Managers work with the Claims Data and Reporting team to perform the following steps with agencies subject to a MoG:

- Have the agency losing a function identify any claims incurred in that function using Customer Information System (CIS) reporting.
- Provide a list of those claims identified to the gaining agency for their scrutiny and agreement.
    - If agreement is reached, arrange for the transfer of those claims in Pracsys.
- Have both agencies provide Comcare with details of the changes in their payroll and FTE as a result of the MoG change.

The changes in liable agency for a group of claims may also result in changes to the Claims Manager alignment especially if the MoG involves a change in the government portfolio.

You can see the MoG history of a claim via the 'View Claim Cost Centre' (VCCC) in Pracsys. A history of MoG changes will be visible including the date they took effect in this screen.

The changes made to an agency's payroll and liable claims may result in an adjustment being calculated to their premium.

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Exit Agencies

An exit agency is a former premium paying entity that has either exited the Comcare compensation scheme or they have been granted a self-insurance license and now administer their own claims.

Depending on the circumstances of the entity's exit, Comcare may not be liable for claims for compensation where the injury date is after the entity's exit date. In some instances, an entity may cease to be a stand-alone employer and instead it may be absorbed or merged into another parent department through a Machinery of Government (MoG) change. In those instances, coverage would continue for those employees under the responsibility of the new entity.

In cases where an entity ceases to exist in any form, the legislation governing the abolishment may indicate which entity is to manage ongoing liabilities and obligations under the SRC Act.

Premium payers who become self-insured licensees will have the details of their future claims management arrangements outlined in their licence conditions. In most instances, Comcare continues to manage those claims which occurred before the exit date but in some cases (such as ACT Government and Australian National University) the licensee takes on responsibility for claims before the exit date as well.

In the case of ACT Government, there are some intricacies with the licence conditions and the dates surrounding the ACT Government's status as an employer under the SRC Act. ACT Government employees were technically employees of the Commonwealth before 11 May 1989.

As a result, the ACT Government is only liable for disease claims made by an ACT employee if both of the following are satisfied:

- The disease was contributed to by their employment with ACT after 11 May 1989 (noting that ACT was not an employer for the purposes of the SRC Act until 11 May 1989).
- The date of injury for the disease is on or after 1 July 1989. See clause 6 of ACT's licence and section 7(4) of the SRC Act.

Claims which do not fit those conditions will be managed by Comcare and not the ACT Government.

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Types of Exit agencies

Exit Agency	Outcome
Agency merges into another agency via a MoG change	The new agency takes on responsibility for all claims and is the new liable and payroll agency (and rehabilitation authority)
Agency is privatised and is no longer a Commonwealth employer	Ongoing responsibility for claims will depend on the circumstances around the privatisation. Advice should be sought from Practice Support & Account Management
Agency is abolished entirely and ceases to exist	Responsibility for existing claims will likely lie with whichever parent agency has been identified in the relevant legislation. Advice should be sought from Practice Support & Account Management
Agency becomes a self-insured licensee	Responsibility for management of claims incurred prior to the licence taking effect will depend on the conditions of the specific licence. Advice should be sought from Practice Support & Account Management

The status of an exit agency and its exit date can be viewed in the 'View Customer' (VCUS) function of Pracsys. The 'License Class' and date of exit is visible on the History tab. Exit details for some exit agencies with active claims are also available in Comcare's Customer Relationship Management (CRM) platform.

If you are unsure who the correct employer is for an exit agency contact the Practice Support and Account Management team for assistance at Practice Support and Account Management team

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Self-Administration/Self Insurance

Some employers within the SRC Scheme have not had their claims managed by Comcare but instead have self-administered and/or self-insured under the SRC Act themselves – these are called licensed authorities. Refer to List of current and former self-insured licensees | Safety, Rehabilitation and Compensation Commission (SRCC).

When the SRC Act commenced in 1988, provision was made for both Australia Post and Telstra (Telecom) to become self-administrators of the Commonwealth workers compensation scheme. This was for a two-year trial period. Under these arrangements the two organisations were responsible for all aspects of the administration of the SRC Act for their employees. However, following an independent review of the scheme a recommendation was made that these self-administration arrangements should end and be replaced with a system of licences for self-insurance and in-house claims management.

Becoming a self-insured licensee under the SRC Act is a two-step process.

1. The Minister responsible for Industrial Relations (currently the Attorney General) must first declare a corporation eligible to be granted a licence to self-insure under the SRC Act.
2. Once declared eligible by the Minister, a corporation may apply to the Safety Rehabilitation and Compensation Commission (SRCC) for a self-insurance licence.

Current and former Commonwealth authorities may apply to the SRCC for a self-insurance licence after consulting with their portfolio minister.

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QWL Corporation

In the 1990s, Comcare created a subsidiary organisation called QWL Corporation Pty Ltd (now de-registered). The purpose of this subsidiary was to perform the functions that may be performed by Comcare under the SRC Act. In particular, it managed the claims of specific self-insured licensees including CSL Limited, Pacific National (formerly Asciano and National Rail Corp) as well as a subsidiary of Telstra called Network Design and Construction (NDC).

Comcare claims staff performed the work for QWL and used Comcare systems (such as Pracsys) to manage these claims. In 2003/04, QWL ceased to provide workers compensation services to corporations following a decision by Comcare's then-Minister (and subsequent changes to licence conditions). Those claims were transferred to the licensees for them to manage via other insurers or licensees. The closed claims are still visible in Pracsys however but should remain closed and any queries from employees about their claim should be referred to the licensee directly. Contact Practice Support and Account Management if you receive a query for one of these claims.

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Off Budget Agencies

Off-budget agencies (prescribed Commonwealth authorities) do not receive funding from the Department of Finance to pay for compensation claims where the date of injury occurs before 1 July 1989. Section 128A of the SRC Act contains the provisions regarding the funding of these compensation claims. For claims from employees of these agencies with a date of injury on or after 1 July 1989, the usual premium arrangements apply.

Comcare is the determining authority for these agencies (other than Telstra Corporation Limited) and will issue determinations as required for claims where the date of injury occurred before 1 July 1989. Payments made as a result of these determinations are sought from the agency in two different ways:

1. The off-budget agency makes incapacity payments directly to the injured worker. Comcare will determine these payments and claims staff should advise the agency of the details including the periods and quantum of the incapacity.
    a. Agencies can also utilise the Customer Information System (CIS) to monitor incapacity determinations made by Comcare on off-budget claims.
2. Comcare makes non-incapacity payments directly to the employee or the service provider as per normal processes. Each month, Comcare's Finance team invoices the off-budget agency for those costs determined and paid in the previous month.

It is important the Claims Manager keeps the off-budget agency consulted on determinations being made so that the agency is aware of the funds it may need to spend.

A list of relevant off budget agencies (prescribed Commonwealth authorities) is provided in section 128A(4) of the SRC Act. However, over the years, some of those agencies have changed names, merged with other agencies or been abolished completely. The list below shows prescribed Commonwealth authorities listed currently under s 128A(4) and the changes to the off-budget status of that agency:

Original listing in section 128A(4)	Current name of the agency	Comments
(a) Aboriginal Hostels Limited	Aboriginal Hostels Limited	Current premium payer, only claims prior to 1/7/89 are off-budget.
(b) A.C.T. Electricity and Water	ACTEW AGL	Exit agency. No longer pays a premium. Claims prior to 1/7/89 are off-budget.
(c) Army and Airforce Canteen Service	Army and Airforce Canteen Service	Current premium payer, only claims prior to 1/7/89 are off-budget.
(d) Australian Airlines Limited	QANTAS	Exit agency. No longer pays a premium. Claims prior to 1/7/89 are off-budget.
(f) Australian Dried Fruits Corporation	Abolished	Exit agency. Abolished. Responsibility for claims likely lies with Dept of Agriculture. Any claims prior to 1/7/89 are off-budget.
(g) Australian Honey Board	Abolished	Exit agency. Abolished. Responsibility for claims likely lies with Dept of Agriculture. Any claims prior to 1/7/89 are off-budget.
(i) Australian Meat and Livestock Corporation	Abolished	Exit agency. Abolished. Responsibility for claims likely lies

		with Dept of Agriculture. Any claims prior to 1/7/89 are off-budget.
(k) Australian National University	Australian National University	Exit agency and now self-insured licensee. No longer pays a premium. All claims are part of license agreement.
(n) Australian Shipping Commission	Abolished	Exit agency. Abolished. Responsibility for claims likely lies with Dept of Finance. Any claims prior to 1/7/89 are off-budget.
(p) Australian Tobacco Board	Abolished	Exit agency. Abolished. Responsibility for claims likely lies with Dept of Agriculture. Any claims prior to 1/7/89 are off-budget.
(q) Australian Wheat Board	Abolished	Exit agency. Abolished. Responsibility for claims likely lies with Dept of Agriculture. Any claims prior to 1/7/89 are off-budget.
(r) Wine Australia Corporation	Wine Australia	Current premium payer, only claims prior to 1/7/89 are off-budget.
(s) Australian Wool Corporation	Abolished	Exit agency. Abolished. Responsibility for claims likely lies with Dept of Agriculture. Any claims prior to 1/7/89 are off-budget.
(t) Central Land Council	Central Land Council	Current premium payer, only claims prior to 1/7/89 are off-budget.
(u) Civil Aviation Authority	Civil Aviation Safety Authority	Current premium payer, only claims prior to 1/7/89 are off-budget.
	Airservices Australia	Current premium payer, only claims prior to 1/7/89 are off-budget.
(v) Commonwealth Banking Corporation	Commonwealth Bank of Australia	Exit agency and now self-insured licensee. No longer pays a premium. Claims prior to 1/7/89 are off-budget.
(w) Commonwealth Serum Laboratories Commission	CSL Ltd	Exit agency and now self-insured licensee. No longer pays a premium. Claims prior to 1/7/89 are off budget.
(x) Coselco Insurance Pty Ltd	Subsidiary of CSL	Exit agency. Claims prior to 1/7/89 are off budget.
(y) Coselco Mimotopes Pty Ltd	Subsidiary of CSL	Exit agency. Claims prior to 1/7/89 are off budget.
(z) Federal Airports Corporation	Abolished	Exit agency. Abolished. Responsibility for claims likely lies with Dept of Infrastructure. Any claims prior to 1/7/89 are off budget.

(zb) Housing Loans Insurance Corporation	Abolished	Exit agency. Claims prior to 1/7/89 are off budget.
(zc) National Exhibition Centre Trust	EPIC	Exit agency. Claims prior to 1/7/89 are off budget.
(zd) Northern Land Council	Northern Land Council	Current premium payer, only claims prior to 1/7/89 are off budget
(ze) Snowy Mountains Engineering Corporation	SMEC Holdings	Exit agency. Claims prior to 1/7/89 are off budget.
(zg) Superannuation Fund Investment Trust	Commonwealth Funds Management	Exit agency. Claims prior to 1/7/89 are off budget.
(zh) Telstra Corporation Limited	Telstra Corporation Limited	Self-Insured licensee. Any claims prior to 1/7/89 are off budget.
(zi) The Pipeline Authority	Abolished	Exit agency. Abolished. Responsibility for claims likely lies with Dept of Industry. Any claims prior to 1/7/89 are off budget.
(zj) Reserve Bank of Australia	Reserve Bank of Australia	Exit agency and now self-insured licensee. No longer pays a premium. Claims prior to 1/7/89 are off budget.

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Northern Territory Government (NT Government)

The NT Government has a similar arrangement to off-budget agencies. Section 124A of the SRC Act provides that the NT Government must reimburse Comcare for the amount of any payments of compensation made by Comcare under the SRC Act, in relation to claims for NT Government employees which occurred between 1 July 1978 and 1 January 1987.

Comcare makes non-incapacity payments and incapacity payments to those employees no longer employed by NT Government. The NT Government are then invoiced the costs of compensation payments made by Comcare each month from Comcare's Finance team.

As with off-budget agencies, communication with NT Government representatives is necessary to keep them informed of compensation determined.

Further to those claim costs, section 124A(2) allows for Comcare to charge the NT Government for the cost of administering their claims.

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Delegated claims

Agencies with delegation to manage claims

Australian Defence Force (ADF)

Comcare manages the claims for Department of Defence **civilian** employees. However, the Claims Management Group does not, and has not in the past, managed claims for compensation for military employees. Those claims have been managed by delegates of both the Department of Veteran's Affairs (DVA) and Department of Defence under the SRC Act and later under the *Military Rehabilitation and Compensation Act 2004* (MRCA).

Three key pieces of legislation provide for this coverage and the extent of the coverage depends on the circumstances of the specific dates of service for the member and whether the medical conditions were sustained in operational circumstances or deployments. Those three pieces of legislation are:

- The *Veterans' Entitlements Act 1986* (VEA)
- The *Safety, Rehabilitation (Defence-related Claims) Act 1988 (DRCA)*
- The *Military Compensation Act 1994* (MRCA)
    - This act amended the VEA and SRC Act for specific ADF claims.

From the commencement of the SRC Act in 1988, compensation claims for ADF members were originally managed by the Department of Defence under delegation from Comcare's CEO. Delegation later moved from the Department of Defence to the DVA in 1999 following a Federal Government review of all veterans' entitlements and a subsequent new delegation instrument being signed by Comcare's then CEO.

The federal review of the veterans' entitlements also resulted in the MRCA being introduced. It provided coverage for medical conditions suffered by current and former ADF members from their Defence service, sustained on or after 1 July 2004. This coverage is currently managed by DVA directly with no delegation required from Comcare.

The *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA) then amended the SRC Act again to remove cover for ADF claims from 12 October 2017. The DRCA created a second modified version of the SRC Act applicable to ADF members for injuries/diseases sustained prior to 1 July 2004, removing the requirement for delegation from Comcare for those matters.

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Other Delegated Claims Arrangements

Comcare has offered alternative claims management arrangements to enable some agencies to play a greater role in managing their organisation's claims. Under these arrangements, Comcare's CEO can

delegate claims management powers and responsibilities, including decision making, to appropriate delegates of certain Commonwealth employers.

To be eligible for an alternative claims management arrangement, an agency must be a non-corporate Commonwealth entity. Current agencies undertaking this system include Services Australia and the Australian Taxation Office. More details on delegated claims arrangements can be found on the Comcare website under Delegated claims management arrangements. For any queries, you should contact the Contracted Claims Services team.

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