

Claim reviews

What are claim reviews?

Claim Reviews occur in the claims management phase of the claim lifecycle. They are a systematic approach to ensuring regular monitoring and progression towards desired outcomes.

Claim Reviews are a multidisciplinary team discussion to review and revise the effectiveness of claim and injury management strategies. The purpose is to ensure the claim is progressing towards optimal recovery and return to work goals. By the end of the Claim Review everyone is aware of what needs to be done by whom and by when.

The Claim plan should be updated whenever there is a change to an action(s), timeframe(s).

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Claim review process

What is a claim review and why do we do it?

Claim review is a multi-disciplinary, collaborative review in the early stages of the claim lifecycle.

It involves the Claims Manager/Senior Claims Manager and Injury Manager proactively reviewing the claim and developing strategies to progress the claim towards optimal recovery and return to work (RTW) goals.

An effective claim review drives positive claim outcomes by proactively:

- reviewing and monitoring the treatment, recovery and return to work aspects of the claim
- engaging with stakeholders, including the employee and employer
- setting claim-specific goals and identifying the supports and actions needed to achieve them
- identifying barriers and risk factors and how to minimise and/or resolve them.

By the end of a claim review, all relevant parties are aware of what needs to be done by whom and by when. The actions, timeframes and responsibilities are updated in the Claim Plan. This process supports proactive claims management, allowing everyone involved to plan their work in a structured way.

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How often do claims need to be reviewed?

All claims must be reviewed regularly. Minimum review frequency is set out in the table below according to claim category and age. However, claims may be reviewed earlier when:

- The Claims Manager or Injury Manager identifies the need for a claim review. For example, recovery or return to work (RTW) is not progressing in line with expected timeframes (refer to MD Guidelines).
- The medical certificate identifies a change in capacity.
- There is conflicting medical evidence regarding diagnosis, prognosis, treatment and capacity to return to work.
- There are high Workplace Rehabilitation Provider (WRP) costs and duration of services, and no RTW or limited RTW progression.
- There is unexpected or high frequency of treatment and treatment costs, and the employee’s health status is not improving or changing.

No or Partial RTW	
Claim age	Minimum review interval – NDS Work Status Code
0-52 weeks	6 weeks
52-104 weeks	8 weeks

Employees with multiple open claims:

To ensure a holistic claims management approach, claims with multiple conditions (i.e. more than one accepted claim) should all be discussed in the one claim review meeting rather than separately.

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Which claims are due for review?

Reviews due each week in the coming 12 weeks can be seen in the 'Claim Reviews' Power BI Report. The report is refreshed weekly.

Each week the Team Assistant Director will download the Claim Review listing report and provide this to the Claims Managers and Injury Manager managing the claims to be reviewed.

The report has two tabs (accessible on the left side of the screen):



View of claim review tabs in Power BI

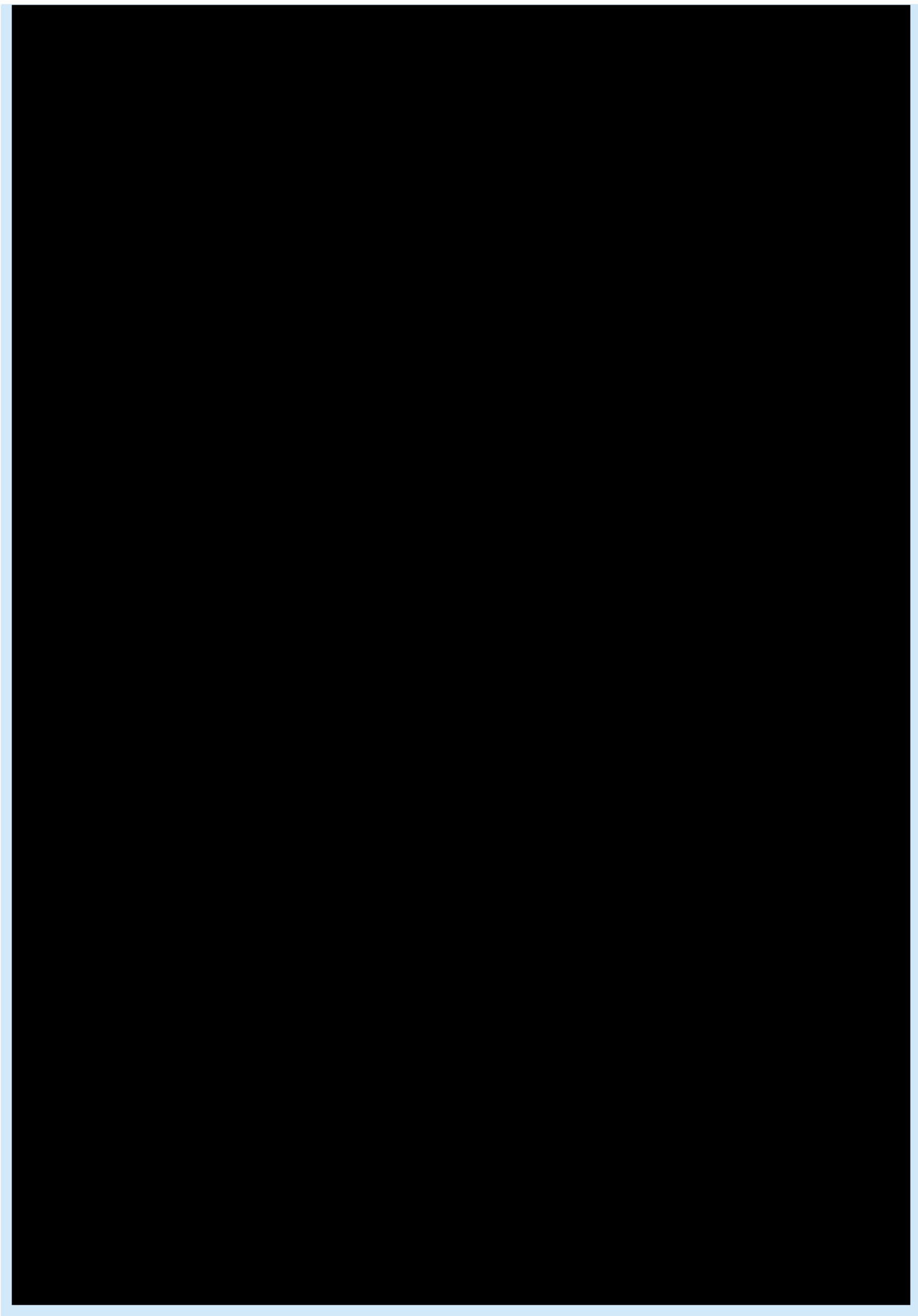
Claim Reviews tab provides an overview of reviews due this week by team, and reviews coming in the approaching 12 weeks and helps prioritise and manage workload. For example, claims can be filtered by RTW Status, injury type, claim Intensity, and whether there is a Claim Plan on file. Reviews can also be brought forward to even out the number of reviews to complete each week to help manage resources and leave, etc.

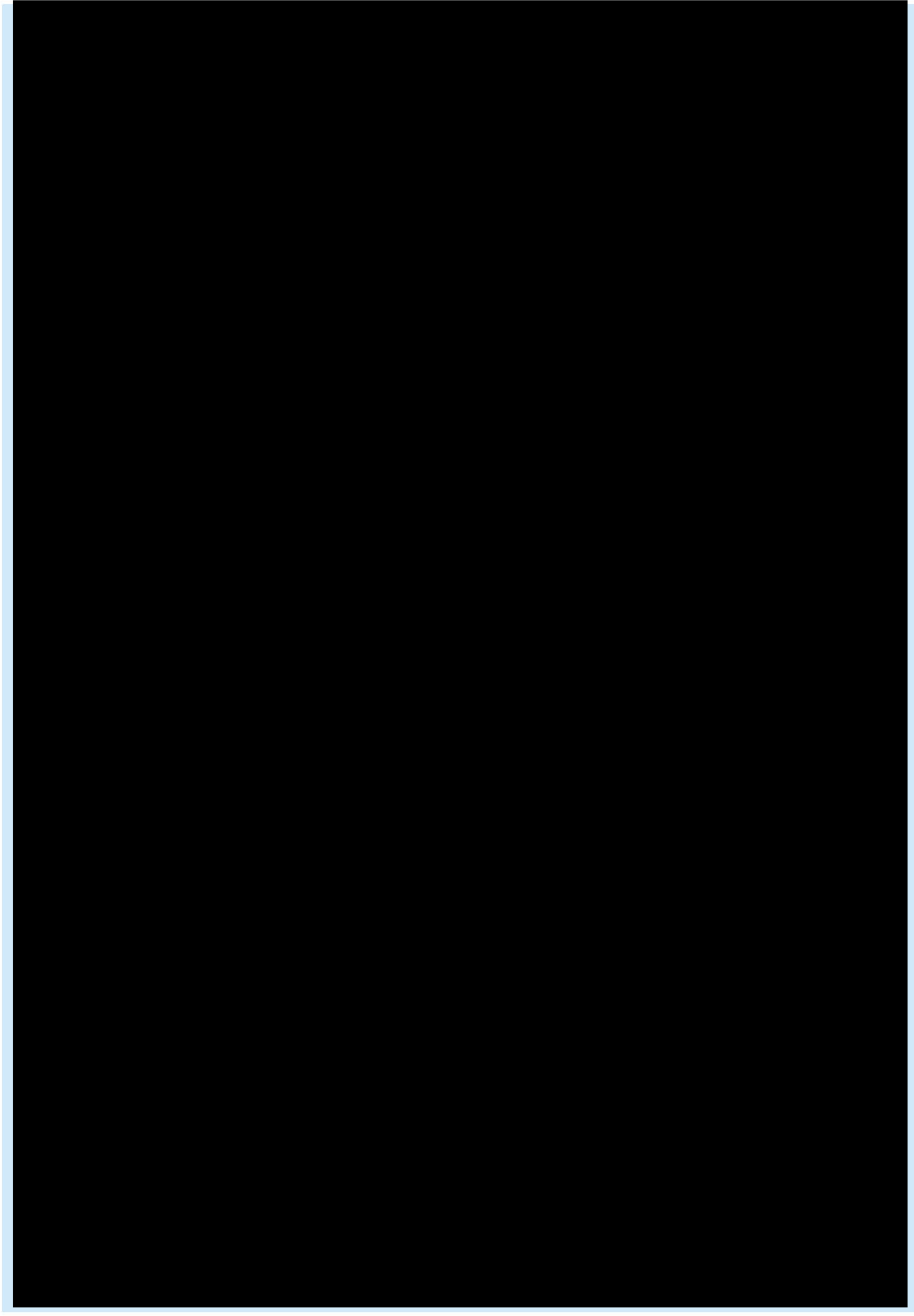
Claims Managers and Injury Managers will see the reviews they are responsible for completing. Assistant Directors and Directors will see the reviews due for their team/s.

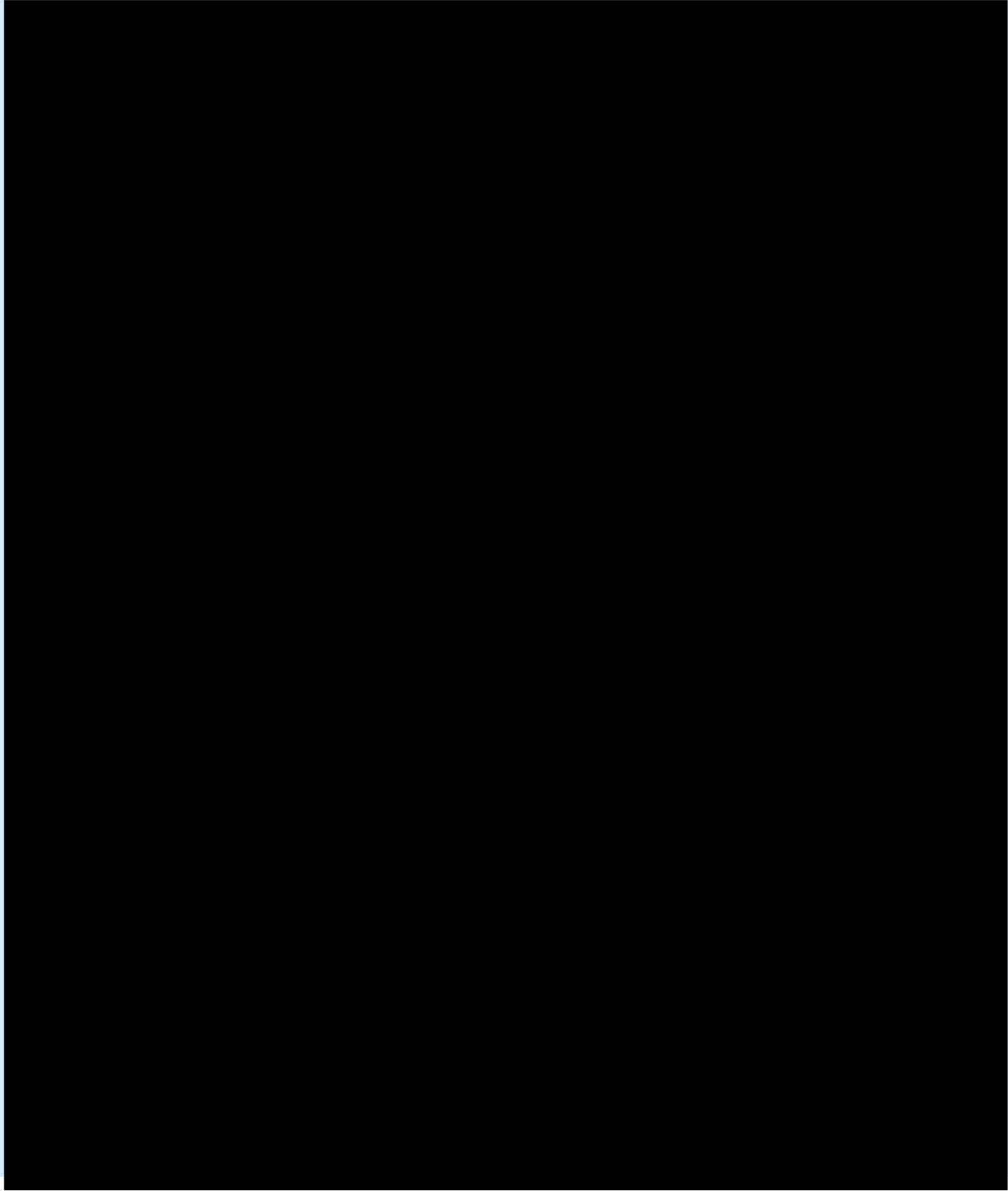
Export Reviews tab is where you can export your or your team's reviews into Excel for actioning. Follow the steps on the screen to export your list of reviews.

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Record Management

Good record-keeping is an essential part of the claim review process. It helps everyone working on the claim to better support our clients, as we can see an accurate record of what discussions and activities have taken place. It also helps everyone to understand the issues that have been raised and

provides a document trail of the rationale used in decision making should there be a query or complaint about the claim.

All conversations with stakeholders must be recorded using the Pracsys '*Manage Claim Comment*' (MCOM) function at the time of the conversation. Both incoming and outgoing calls should be captured. From the '*Category*' drop down menu, select either the '*Inbound*' or '*Outbound*' option depending on the source of the call, then select the relevant party from the '*Comment Code*' drop down menu, and document the discussion.

Outcomes of claim review meetings are also to be documented by the Claims Manager in the '*Manage Claim Comment*' (MCOM) function. From the '*Category*' drop down menu, select '*Action Plans*' and then from the '*Comment Code*' drop down menu, select '*Claim Review*'. The comment should summarise the confirmed actions/next steps arising from the claim review meeting.

Please ensure that the action plan tasks are allocated in the '*Manage Action Plan*' (MAP) function in Pracsys to the relevant staff as appropriate.

Finalised Claim Plans are uploaded via the '*Manage Claim Plan*' screen in Pracsys. This is the single point record of the discussion from the claim review meeting. There is no need for further comments in Pracsys.

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Claims that may not need a claim review

You may not need to conduct a claim review for the following claims:

- Claims where there is an intent to determine no present liability (NPL) or there is a NPL determination of the claim in process.
- Claims where there is a full return to work.
- Claims where there is a reconsideration or ART proceeding overturning the claim liability for a closed period.
- Accepted claims with a closed period.
- Claims in other circumstances that do not possess an ongoing section 19 entitlement.

If a claim falls into one of these categories, a file note must be placed in Pracsys explaining why the claim review is not progressing.

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Medical treatment and other support

Medical treatment and other support

Once a claim for compensation has been accepted, the SRC Act provides significant scope to pay for medical and other treatments to support an employee to return to health and, where possible, work. The relevant sections of the Act are sections 16 and 39.

Roles responsible

You, as the Claims Manager, have the authority to assess and determine liability for medical treatment and supports. For support in making determinations on liability for medical treatment and support, you can consult with the Injury Manager, a Senior Claims Manager, a Technical Capability Officer and the Assistant Director. Where you and the Injury Manager agree, a claim for medical treatment or other support can be referred to the Clinical Panel for advice on complex cases.

In this section

What is medical treatment?

This page provides information on what constitutes medical treatment, including:

- evidence required, and
- types of medical treatment outlined in the SRC Act.

What are appropriate costs?

This page provides information on:

- determining medical and allied health treatment rates
- how to identify appropriate costs for different types of treatment, and
- payment of fees for non-attendance at medical treatment appointments.

Medications

This page provides information on:

- medications Comcare will and will not pay for
- PBS and non-PBS medications
- compounded pharmaceutical products
- over the counter medications
- complementary medications
- Schedule 8 medications
- ketamine and esketamine

- medicinal cannabis, and
- procedure to assess and determine liability for Schedule 8 medications.

Psychology

This page provides information about:

- commencing psychology and counselling treatment
- extended consultations
- gaps in treatment
- ongoing treatment, and
- invoicing for psychology / counselling treatment.

Exercise, weight loss and gym

This page provides information about:

- Claiming for exercise as medical treatment
- Assessing whether exercise and related expenses are reasonable medical treatment
- Equipment for exercise
- Supervised exercise sessions
- Gymnasium and swimming pool memberships
- Exercise for treatment of psychological conditions
- Management of weight loss
- Exercise clothing
- Payment for reports

Dental Treatment

This page provides information about:

- when a Clinical Panel review is required
- assessing liability for dental treatment
- dental treatment costs
- Bruxism, and
- procedure to determine liability for dental treatment.

Hearing loss treatment

This page provides information about:

- Types of hearing loss and treatment options
- Assessing whether recommended hearing aids are reasonable

- Determining the appropriate cost of hearing aids
- Repair or replace hearing aids

Home help and attendant care

This page provides information about:

- what household and attendant care services are
- what is not included
- procedure to add 'catastrophic injury' tag in Pracsys
- applying for household and attendant care services
- home assessments and rehabilitation assessments
- assessing household services
- assessing childcare services
- assessing attendant care services
- Comcare's responsibilities
- how long services should be approved for
- payment of services
- considerations for hiring a provider
- GST considerations
- provision of services by a family or household member and requirements for family or household members providing services
- procedure to assess liability for services
- procedure to accept liability for services, and
- procedure to decline liability for services.

Rehabilitation aids, appliances, alterations and modifications under section 39

This page provides information about:

- what rehabilitation aids and appliances are
- what rehabilitation alterations and modifications are
- employer's responsibility for alteration or adjustment to a workplace
- alterations to a place of residence
- modifications to a vehicle or article
- Occupational Therapist assessments
- Independent Living Centres
- assessing liability for rehabilitation aids, appliances, alterations and modifications
- procedure to determine liability for rehabilitation aids, appliances, alterations and modifications

- previously paid alterations and modifications and financial gain
- procedure to arrange a valuation to assess potential significant net financial gain, and
- procedure to assess previously paid alterations and modifications.

Receiving and actioning travel requests

This page provides information about:

- assessing reasonableness of costs
- private vehicle use
- parking
- public transport and ambulance
- collecting medication
- flights
- cab vouchers
- support person travel costs
- meals and accommodation
- booking flights and accommodation
- paying for flights and accommodation
- procedure to approve and pay travel expenses
- rejecting or reducing travel expenses, and
- procedure to reject or reduce payment of travel expenses.

What is reasonable medical treatment?

This page provides information on assessing whether medical treatment is 'reasonable' including:

- information about the Clinical Framework
- the principles for assessing whether treatment is reasonable,
- obtaining additional medical evidence
- receiving similar therapies at the same time
- individual and group sessions by the same provider type
- family members or friends providing medical treatment, and
- medical treatment by phone or online.

Determining liability for medical treatment

This page provides information on determining liability for medical treatment, including:

- considerations for determining liability for medical treatment
- assessing whether medical treatment is reasonable
- payment for medical treatment

- treatment plans
- the procedure to determine liability for medical treatment, and
- the procedure to communicate the determination.

Allied health treatment

This page provides information about:

- what treatment falls under 'allied health'
- commencing allied health treatment
- gaps in treatment
- ongoing treatment
- invoicing for allied health treatment, and
- telehealth appointments for allied health treatment.

Transcranial Magnetic Stimulation (TMS) and Repetitive Transcranial Magnetic Stimulation (rTMS)

This page provides information about:

- what TMS and rTMS are
- treatment with rTMS
- what can be approved
- rTMS costs, and
- procedure to determine liability for rTMS.

Pain therapy

This page provides information about:

- pain management programs
- implantable pain therapy
- platelet-rich plasma injections
- spinal injection therapies, and
- cortisone injections.

Nursing homes

This page provides information about:

- interaction between SRC Act and Aged Care Act 1977
- benefits payable to employees in a nursing home
- benefits not payable to employees in a nursing home

- payment for nursing care services
- nursing home accommodation
- reduction of incapacity payments
- procedure to request information from a nursing care provider, and
- procedure to determine liability for nursing care.

Surgery

This page provides information about:

- what must be referred to the Clinical Panel
- surgery costs
- approval requests from hospitals
- urgent requests for surgery
- procedure to assess and determine liability for surgery, and
- after surgery.

Medical aids and appliances under section 16

This page provides information about:

- what medical aids and appliances are
- assessing liability for medical aids and appliances under section 16, and
- procedure to determine liability for medical aids and appliances.

Considerations for aids, appliances, alterations and modifications under sections 16 and 39

This page provides information about:

- claiming for aids, appliances, alterations or modifications
- meaning of 'reasonably required'
- reasonable costs
- procedure to get multiple quotes
- safety equipment and standards
- batteries, servicing, insurance and operating costs
- liability for repair and replacement of an aid or appliance
- procedure to determine liability for repair or replacement of an aid or appliance
- procedure to accept liability for aids, appliances, alterations or modifications, and
- procedure to decline liability for aids, appliances, alterations or modifications.

What is medical treatment?

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Introduction

'Medical treatment' is defined in the SRC Act under section 4. Under this section, medical treatment means:

- a. medical or surgical treatment by, or under the supervision of, a legally qualified medical practitioner (LQMP)
- b. therapeutic treatment obtained at the direction of a LQMP
- c. dental treatment by, or under the supervision of, a legally qualified dentist
- d. therapeutic treatment by, or under the supervision of, an allied health provider
- e. an examination, test or analysis and the provision of a report
- f. the supply, replacement or repair of an artificial limb or aid or appliance
- g. treatment and maintenance as a patient at a hospital
- h. nursing care, and the provision of medicines, medical and surgical supplies and curative apparatus
- i. any other form of treatment that is prescribed for the purposes of this definition.

Section 16 of the SRC Act provides for the payment of medical expenses.

When determining liability for medical treatment under section 16 of the SRC Act, you as the Claims Manager must be satisfied the treatment is:

- medical treatment as defined in the SRC Act
- obtained in relation to the compensable condition
- reasonable for the employee to obtain in the circumstances, and
- appropriate in cost.

Seek advice and support from your Injury Manager as needed.

Evidence for medical treatment

A recommendation for medical treatment is usually received from a legally qualified medical practitioner (LQMP), or registered treating practitioner, via a:

- medical certificate
- medical report
- letter, or
- provider treatment plan.

To assess liability to pay compensation for the medical treatment, you need to review the medical evidence and consider:

- whether the treatment is in relation to the compensable condition, and
- whether the medical treatment is reasonable.

Then you need to issue a determination to accept or reject liability for the medical treatment.

If you require further clarification before issuing a determination, you can phone or write to the employee's treating doctor and request a report.

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Types of medical treatment

The types of medical treatment defined in section 4 of the SRC Act are explained in detail below.

a) Medical or surgical treatment by, or under the supervision of, a LQMP

A legally qualified medical practitioner (LQMP) is a general practitioner or specialist registered to practice under the Australian Health Practitioner Regulation Agency.

A LQMP must have control of the relevant treatment. The LQMP provides or supervises a recommended treatment and decides on the frequency and duration of the treatment.

Examples of medical or surgical treatment include:

- consultations
- surgical procedures
- anaesthetist services
- treatment for broken or torn limbs, dressings for abrasions, stress and allergic reactions etc.

b) Therapeutic treatment at the direction of a LQMP

Section 4 of the SRC Act defines 'therapeutic' as including an examination, test or analysis for the purpose of diagnosing, or treatment given for the purpose of alleviating, an injury.

This would require all of the following:

- a diagnosis by the LQMP
- a referral
- a directive that a certain therapeutic treatment be undertaken. The directive should set out the form, frequency and duration of the treatment, and
- a follow up by the LQMP.

c) Dental treatment by, or under the supervision of, a legally qualified dentist

A legally qualified dentist (dentist) must have control of the relevant treatment. The dentist provides or supervises a recommended treatment and decides on the frequency and duration of the treatment.

d) Therapeutic treatment by an allied health provider

Under the definition for 'medical treatment' in subsection 4(d) of the SRC Act, medical treatment includes therapeutic treatment by, or under the supervision of, the following allied health practitioners:

- physiotherapist

- osteopath
- masseur
- chiropractor.

The provider must be a registered health practitioner in the State or Territory where the treatment is provided.

Treatments like those listed above but which are referred to with a different name must be provided by a registered provider of the 'recognised' treatment. For example, Feldenkrais (a form of physiotherapy) must be provided by a registered physiotherapist.

Other therapeutic treatment

Regulation 17(1) of the Safety, Rehabilitation and Compensation Regulations 2002 allows for therapeutic treatment by, or under the supervision of, any of the following persons:

- an occupational therapist
- an optometrist
- a podiatrist
- a psychologist, and
- a speech therapist.

This treatment does not require a referral from a LQMP.

Regulation 17(2) provides that the person must be:

- registered under the law of a State or Territory providing for the registration of persons of that kind, or
- if there is no such law, a member of a relevant professional association.

e) Examination, test or analysis

This item includes an examination, test or analysis carried out on, or in relation to, an employee. The examination or test must be at the request or direction of a LQMP or legally qualified dentist. It includes the provision of a report in respect of the examination, test or analysis. Tests or examinations may include:

- x-rays
- CT scans
- ultrasounds (US)
- MRIs
- lung function tests
- pathology tests.

Important: A discogram (or discography) is an uncommon X-ray procedure used to determine if a particular disc in the spine is the source of pain. Normally magnetic resonance imaging (MRI) or computer tomography (CT) scans are used for investigatory purposes.

If a claim for a discogram is received by Comcare, you should refer the claim to the Clinical Panel for their opinion on the reasonableness of this procedure in the relevant case.

f) Supply, replacement or repair of an artificial limb, or aid or appliance

Under section 4, medical treatment includes the supply, replacement or repair of an artificial limb or other artificial substitute, or of a medical, surgical or other similar aid or appliance. Examples of artificial aids and appliances include:

- hearing aids
- crutches, and
- consultations and fittings.

The cost of repair or replacement of the aids or appliances due to loss, damage or expiry is also compensable.

An aid or appliance under section 4 of the SRC Act must be similar in nature to a medical or surgical aid or appliance. A motor vehicle, even with modifications, is not similar in nature to a medical or surgical aid or appliance (*Heffernan v Comcare [2014] FCAFC 2*).

Section 16 and section 39: If an aid or appliance does not meet the criteria under section 16 for medical treatment it may also be considered under section 39 for rehabilitation aids and appliances.

g) Treatment and maintenance as a patient at a hospital

Section 4 includes treatment and maintenance as a patient at a hospital under compensable medical treatment. This includes:

- operative treatment
- room charges, and
- meals.

Room upgrades or extras such as television hire or telephone calls are not compensable.

h) Nursing care, and the provision of medicines, medical and surgical supplies and curative apparatus

Some examples of the types of items and treatment covered by part (h) include:

- medications, whether in a hospital or otherwise,
- nursing care outside of hospital (such as attendance of a nurse at home - see Nursing homes for more detailed information
- curative apparatus such as an orthopaedic brace that is medically recommended for a specific curative purpose.

Personal care (attendant care) is not nursing care and should be considered under section 29 of the SRC Act.

Medicines

Comcare can pay for the appropriate cost of medications prescribed by a legally qualified medical practitioner (LQMP) or dentist for the treatment of an injured employee's compensable condition.

For further guidance on Comcare's approach to medication and other pharmaceutical items, see the Medications page.

Curative apparatus

Medical treatment or the curative process is aimed at:

- curing or treating a medical condition, or
- slowing down or preventing the deterioration of a medical condition.

It is not aimed at:

- providing enjoyment, such as via recreational or leisure activity, or
- aiding general health and wellbeing (as opposed to curing a specific medical condition).

Examples of what would **not** be considered a curative apparatus:

- a modified motor vehicle (*Heffernan v Comcare [2014]*)
- home gymnasium equipment (*William Bernard Collins and Comcare [1995] AATA 282*)
- wheelchairs (these would more likely be considered an aid under section 39 of the SRC Act).

Example of what may be considered a curative apparatus:

- cushioning running shoes which are medically recommended to use for the purpose of maximising the efficacy of orthotic inserts (*Comcare v Dalglish [2018] FCA 2092*)
- orthotics
- orthopaedic footwear

Note: Claims for shoes must be assessed on the individual merits of the case and the medical evidence provided. There must be consideration regarding whether the claimed shoes fall within the definition of medical treatment (section 4(1)) in order for compensation to be payable under section 16 of the SRC Act.

See Shoes in the Exercise, weight loss and gym page for more information.

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What is reasonable medical treatment?

Introduction

To determine liability for medical treatment under section 16 of the SRC Act, you must be satisfied that the treatment is:

- medical treatment, as defined in section 4 of the SRC Act
- obtained in relation to the compensable condition
- appropriate in cost, and
- reasonable for the employee to obtain in the circumstances.

This page focuses on determining the reasonableness of medical treatment.

You will base your decision as to whether medical treatments claimed are reasonable on the medical evidence, the Clinical Framework and information about medical conditions and their treatment published in MDGuidelines. In most cases, particularly at the acute stage following an injury, it will be clear from this evidence that medical treatments claimed are reasonable.

In the post-acute (chronic) stage, particularly where the employee is beyond the expected recovery timeframe for their specific condition, you should carefully assess whether treatment is **reasonable** for the employee to obtain. The guidance on this page provides information to help you with this decision.

Roles and responsibilities

You, as the **Claims Manager**, have the authority to determine liability for medical treatments claimed by the employee.

If you are unsure about whether medical treatment is reasonable, your **Injury Manager** is the first contact to help you assess the reasonableness of medical treatment being claimed. They can also advise you whether you need to seek further medical evidence and what type of evidence to ask for.

Senior Claims Managers and your **Assistant Director** are also available to help.

Your Injury Manager may recommend a referral to the **Clinical Panel** in cases where the evidence is unclear. The guidance in the medical treatment pages in the claims manual also outlines the situations where you must refer a claim to the Clinical Panel.

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The meaning of 'reasonable' and the Clinical Framework

The term 'reasonable' is not defined in the SRC Act. However, in terms of medical treatment, it is commonly used to indicate something that is consistent with professional health care standards and community expectations.

The Clinical Framework provides a set of guiding principles for the provision of healthcare services for injured people, healthcare professionals and decision makers.

You should refer to the Clinical Framework when assessing the reasonableness of medical treatment. The principles outlined in the Clinical Framework should guide you when assessing whether medical treatment is effective in empowering an employee to manage their injury to return to work and health.

Note: **Clinically justified** is a term commonly used by health professionals to refer to medical treatment they consider reasonable.

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Assessing whether medical treatment is reasonable

The reasonableness of each claim for medical treatment should be assessed on its merits based on the employee's individual circumstances and available clinical evidence.

When assessing whether medical treatment is reasonable, you should consider the following principles, which are based on the Clinical Framework. The treatment should:

1. demonstrate effectiveness
2. follow a biopsychosocial approach
3. emphasise empowerment
4. be goal focused
5. be evidence based.

If the treating practitioner's response satisfies the expectations below related to each principle, the treatment is likely to be clinically justified and reasonable. If the expectations below are not satisfied, the treatment may not be clinically justified or reasonable.

The [Clinical Justification Assessment Guide](#) can assist you to work through the Clinical Framework principles when assessing the reasonableness of medical treatment.

Note: Experimental medical treatments are usually not reasonable. Claims for experimental treatments should be referred to the Clinical Panel for review.

If you are unsure whether the questions below are satisfied, you may need to obtain guidance on treatment options or additional medical evidence.

Clinical Framework principle one: Demonstrate effectiveness

The objective of this principle is to demonstrate the effectiveness of the proposed treatment. To determine if the proposed medical treatment is reasonable, you should consider whether:

- the treating practitioner has demonstrated the treatment will result in a measurable benefit to support the employee's return to work and health
- the treating practitioner has provided functional and health related goals relevant to the employee's injury
- there are reliable and valid outcome measures for the goals of the medical treatment.

Clinical Framework principle two: Biopsychosocial approach

The objective of this principle is to consider the proposed treatment in a holistic manner. The proposed treatment should consider not just the physical or biological factors but also social and environmental factors and individual thoughts and behaviours that may impact on recovery. To determine if the proposed medical treatment is reasonable, you should consider whether:

- the treating practitioner has addressed any biological factors likely to result in the treatment goals not being achieved (such as other serious medical conditions)

- the treating practitioner has addressed any psychosocial factors likely to result in the treatment goals not being achieved (including but not limited to the employee having unhelpful beliefs about their injury, job dissatisfaction, and/or low expectations about return to work).

Clinical Framework principle three: Empowerment

The objective of this principle is to ensure that the employee is empowered. To determine if the proposed medical treatment is reasonable, you should consider whether the employee is being empowered to manage their compensable condition independently. This may be through education, expectation setting and/or self-management strategies.

Clinical Framework principle four: Goal focused

The objective of this principle is to ensure that appropriate goals, developed in collaboration with the employee, have been set for the medical treatment. To determine if the proposed medical treatment is reasonable, you should consider whether:

- functional and health-related treatment goals been developed in collaboration with, and agreed to by, the employee
- considering other treatment options, the treatment is a good value investment towards meeting the treatment goals
- the treatment goals are SMART – i.e. specific, measurable, achievable, relevant and timed
- progress towards goal achievement is regularly assessed and reset or modified where necessary.

Clinical Framework principle five: Evidence based

The objective of this principle is to ensure that the proposed medical treatment is informed by the best available and highest-level research evidence. To determine if the proposed medical treatment is reasonable, you should consider whether:

- the treatment is based on the best available research evidence (e.g. a systematic literature review)
- the research evidence indicates that the treatment is effective and unlikely to cause harm.

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Obtaining additional medical evidence

If there is not enough evidence provided for to make a determination, you can request further evidence by:

- requesting a medical report from a legally qualified medical practitioner (LQMP) or other registered treatment provider
- referring the claim for a Clinical Panel Review – note that you must discuss the claim with your Injury Manager first
- arranging an Independent Medical Examination (section 57 of the SRC Act).

You should refer to MDGuidelines when drafting questions to LQMPs or in preparation for a section 57 assessment.

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Receiving similar physical therapies at the same time

Comcare considers physiotherapy, chiropractic and osteopathic treatments to be similar physical therapies. If an employee is receiving two or more of these therapies at the same time (concurrently), they may be treating the same issues. If two similar therapies are treating the same issues, it is difficult to measure the benefit and effectiveness of the individual therapies.

Treating practitioners (allied health professionals) are expected to closely communicate with the legally qualified medical practitioner (LQMP) (the treating doctor or specialist) in respect of an employee's compensable condition. This will ensure that the treatment is aligned with the employee's recovery, rehabilitation and return to work. It is particularly important in the case of concurrent similar medical treatment.

Unless multiple physical therapies form part of a coordinated Comcare-approved treatment plan, you should only approve one physical therapy by one provider type or practice at any one time. If a request is received for concurrent physiotherapy, chiropractic or osteopathic treatment, you should explain Comcare's policy to the LQMP.

You should consider the following points when asking an LQMP about their request for concurrent treatment:

- the clinical rationale as to why two or more physical therapies (physiotherapy / chiropractic / osteopathic) are required for the management of the employee's condition
- how the goals of two or more physical therapies differ and/or how they complement each other, and
- how the progress of two or more physical therapies will be measured.

If the LQMP still wishes to proceed with concurrent treatment, you should ask them to provide written clinical justification for the similar treatment.

Assessing a request for similar physical therapies at the same time

If an employee submits a claim for concurrent physical treatments, you should phone the employee and:

1. Advise them that Comcare would only pay for one physical treatment at a time, except where there is compelling clinical justification.
2. Ask them to choose which physical treatment type they would prefer Comcare to support.
3. Ask them to discuss which treatment is likely to be most beneficial with their doctor prior to liability being determined.
4. Reassure them that if the type of physical treatment they choose is not effective, Comcare could consider giving them approval to try another type of treatment.

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Individual and group sessions by the same provider type

Individual and group sessions provided concurrently by the same treating practitioner are reasonable because the same practitioner type is providing the services. Individual and group therapy sessions with different therapists can be funded as long as the same provider type (physiotherapist, chiropractor or osteopath) is providing the treatment.

For example, an employee may attend individual physiotherapy sessions and also attend group Pilates sessions run by the same physiotherapist or another physiotherapist. Both individual and group

sessions are provided by the same type of physical therapist – physiotherapist – and so can be considered reasonable medical treatment.

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Family members or friends providing medical treatment

Medical treatment from family members or friends, as well as self-treatment by the employee, are not considered reasonable medical treatment. Family or friend relationships can affect professional objectivity and judgement. It may also be difficult for a treating practitioner who is a family member or friend of the injured employee to obtain a complete medical history and to perform a thorough examination.

Medical or allied health providers should encourage their family members and friends to have an independent and trusted treating practitioner who can coordinate their care. They should avoid being a treating practitioner of a family member or friend. This is supported by professional codes of conduct. You should cite the code of conduct when informing employees that treatment provided by their family/friends is unreasonable. The Medical Board of Australia's Code of Conduct for Doctors states:

“Whenever possible, avoid providing medical care to anyone with whom you have a close personal relationship. In most cases, providing care to close friends, those you work with and family members is inappropriate because of the lack of objectivity, possible discontinuity of care, and risks to the doctor and patient. In some cases, providing care to those close to you is unavoidable. Whenever this is the case, good medical practice requires recognition and careful management of these issues.”

Although the Code of Conduct only applies to legally qualified medical practitioners (LQMPs), the same principal applies for allied health treatment providers. You should consider who is providing the treatment when assessing the reasonableness of the medical treatment.

You should ask for provider details if you think the treatment has been provided by a medical provider who might be related or known to the employee. If you discover something that does not look right, feel right or when you receive information either from the employee or another source (employer, rehabilitation provider etc) that is relevant and has the potential to impact the management of a claim, please refer to the "Just Ask" process.

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Medical treatment by online video call or telephone

In deciding whether approval should be given for treatment provided via online video conference or telephone (telehealth), you should consider the reasons why the treatment is being sought via that method.

The SRC Act does not define the manner by which treatment must take place. It is therefore open to you to determine that treatment via these methods is payable. The treatment must still constitute 'medical treatment' within the meaning of the SRC Act and be reasonable for the employee to obtain in the circumstances.

Where treatment can be obtained in person, without **significant difficulty**, then approval of treatment by online video conference / telephone would generally not be reasonable.

Significant difficulty may include situations where:

- the employee lives in a very remote location where treatment is not available, and
- their injury or personal circumstances would prevent them from being able to travel to obtain the necessary treatment.

It is likely that the type of treatment being sought via online video conference / telephone will be mental health counselling services. If you are concerned about an employee undertaking an 'unsupported' consultation (meaning the employee is alone during the consultation), you should discuss the concerns with the treating practitioner.

It is unlikely that treatment via telehealth services for physical conditions would be appropriate. If you get a request, you should discuss the case with your Injury Manager and Assistant Director to decide whether the specific treatment could be adequately provided via the requested method.

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What are appropriate costs?

Introduction

When determining liability for medical treatment you, as the Claims Manager, need to determine whether the cost of any quotes or invoices received are appropriate for that medical treatment or service.

Under the provisions of section 16(1) of the *Safety, Rehabilitation and Compensation Act 1988* (SRC Act) Comcare can determine an 'appropriate' amount for the cost of the medical treatment that was reasonable, in the circumstances, for the employee to have obtained in relation to their injury.

The SRC Act does not define or provide guidance on what is meant by 'appropriate' or how Comcare is to make this decision, it only provides that Comcare has the discretion to determine an 'appropriate' amount for that medical treatment.

Comcare has developed specific service rates for some medical or allied health treatments that are a guide as to the upper limit that Comcare will normally pay for medical and allied health treatment or services.

However, Comcare's service rates are not legally binding and as the Claims Manager, you have the discretion in certain circumstances (see below) to determine that it is reasonable to pay above the service rates for medical or allied health treatment costs.

See: Scheme guidance - Appropriate cost of medical treatment

Approving above-rate medical treatment costs

If you determine that a claimed medical treatment cost above the service rates is appropriate, you must add a comment in the treatment plan in Pracsys to this effect. If not, when CAIS receives the invoice or receipt for processing, they will either reduce the amount claimed to the relevant service rate limit, or they will flag the invoice for you to review.

To minimise delays in payment processing and to ensure that the correct amounts are paid for in the first instance (supporting good customer service), the comment in Pracsys needs to clearly outline your determination including your determined rate. For more information, see [Determining an appropriate amount for medical and allied health treatment](#).

Where it may be reasonable to pay above Comcare's rate

Circumstances where it may be reasonable to pay above the service rates include (but are not limited to):

- New claims where the employee has obtained medical treatment before submitting their workers' compensation claim to Comcare and was unaware that Comcare had service rates for some medical and allied health treatment and services. After the claim has been accepted, service rates should apply unless determined otherwise.
- The employee lives in an isolated or remote area and has limited access to medical or allied health service providers, who may normally charge more for all services than providers in towns or cities.

- Other service providers within the employee's immediate area all charge above the service rates and there are no other practical or reasonable options available to the employee to obtain treatment from a service provider who charges equal to or below Comcare's service rates.
- The service provider is **required** to travel to the employee's home due to the employee's compensable condition to provide treatment and includes their reasonable travel costs in their service fee which is above the service rates.

Please see: Service provider travel for more information.

Where Comcare has not developed specified service rates for medical or allied health treatment or services, you will need to investigate and use your discretion to determine what an 'appropriate' amount is for that treatment or service.

Where there are no specified rates

The following are some medical treatment and services that do not have Comcare specified service rates:

- medical aids and appliances
- gym or swimming pool memberships
- personal training sessions (not undertaken by an Exercise Physiologist)
- exercise equipment, and
- hospital accommodation or theatre fees.

The cost for these services will need to be assessed on a case by case basis.

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Medical and allied health treatment service rates

Medical treatment rates (not allied health)

Comcare's medical treatment rates are based on the recommended fees published by the Australian Medical Association (AMA) which is the peak professional body for doctors in Australia.

The AMA List of medical services and fees (AMA fees list) is published in November each year and provides for a comprehensive list of medical services. The AMA fees list includes the AMA item code, the description and the recommended fee for each service.

Where the same or a similar medical service is payable under the Medicare Benefit Scheme (MBS), the AMA fees list also quotes the corresponding MBS item code. When processing payments, both the AMA and corresponding MBS item codes are visible in Pracsys. The MBS item codes and services are paid in accordance with the AMA recommended fees.

Medical treatment with AMA rates includes consultations with General Practitioner, Psychiatrist, Specialist and Consultant Physician, and other services such as GP case conferences, anaesthetics, acupuncture provided by a GP or Magnetic Resonance Imaging (MRI).

Allied health rates

Comcare's allied health rates are based on the fee schedules from the workers compensation and transport accident schemes in most states and territories, or from professional allied health associations. These treatments include physiotherapy, chiropractic and exercise physiology treatment.

In some circumstances, where there are no fee schedules available from professional associations or other workers compensation schemes, Comcare may develop appropriate service rates for allied

health services in consultation with the Clinical Panel. Such treatments include acupuncture by a qualified acupuncturist (but not provided by a GP), massage and osteopathy treatment.

Updates to service rates

Claims Governance is responsible for updating the AMA service rates in Pracsys in accordance with the AMA’s list of medical services and fees. A bulk update of the AMA service rates occurs in early November each year.

Scheme Policy and Design (SP&D) in consultation with the Clinical Panel are responsible for reviewing allied health service rates. Claims Governance is then responsible for updating the allied health service rates in Pracsys in accordance with the information provided by SP&D.

While the majority of the allied health rates are updated in early July each year, some allied health rates are updated at other times of the year in line with the other workers compensation and transport schemes fee schedule updates.

SP&D are also responsible for updating the statutory rates.

Contact Claims Governance for queries about medical or allied health service rates and contact Scheme Policy and Design for queries on statutory rates.

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Rates for common claims

The following table provides information about the common medical or allied health treatment claims that you may receive and how their cost is generally determined.

Keep in mind that Comcare's medical and allied health service rates are a guide to the appropriate costs of medical treatment and are not binding. An assessment of appropriate costs for a claimed treatment should be made on its merits, on a case-by-case basis. See [Determining an appropriate amount for medical treatment](#) for more information on assessing above-rate costs.

If the claim is for:	Then determine costs based on:
Allied health: Acupuncture (provided by a qualified acupuncturist who is not a GP), Chiropractic, Exercise Physiology, Occupational Therapy, Osteopathy, Physiotherapy or Psychology	Comcare's allied health rates

Attendant care	Comcare's statutory rates for weekly rates. Note that the weekly rates are legislatively binding and you cannot approve a higher rate per week for these services unless the employee has a catastrophic injury. There are no hourly rates for attendant care, and it is up to you to determine an appropriate hourly amount, as long as you do not exceed the statutory rate per week.
Doctors: Consultant Physician, General Practitioner, Psychiatrist or Specialist consultations. Also includes acupuncture treatment provided by a GP, anaesthetics, GP case conferences and MRIs.	The Australian Medical Association (AMA) List of medical services and fees. Medicare (MBS) item codes and services that correspond with the services listed in the AMA fees list are reimbursed in line with the AMA fees.
(Doctors) Orthopaedic Surgeons (Consultations only)	NSW/SIRA rates apply to Orthopaedic Surgeon consultations across Australia.
(Doctors) Hand Surgery (NSW only) (Consultations - MBS codes 104 and 105 – AMA codes AC500 and AC510)	NSW/SIRA rates apply to NSW Hand Surgeons only. The AMA rates apply to Hand Surgeons in all other states/territories.
(Doctors) Neurosurgery (NSW only) (Consultations – MBS codes 104, 105, 6007 and 6009 – AMA codes AC500, AC510, AC600 and AC610)	NSW/SIRA rates apply to NSW Neurosurgeons only. The AMA rates apply to Neurosurgeons in all other states/territories.
Other doctors	For any other doctor costs, refer to the AMA list of medical services and fees.
Exercise equipment	Comcare can pay the cost of basic exercise equipment to enable exercise as part of medical treatment. Employees should be asked to provide three quotes for equipment that costs over \$2000. For less expensive equipment, you should assess whether the cost is appropriate and ask the employee for three quotes where relevant. See Exercise, weight loss and gym.
Gym or swimming pool memberships	Comcare can pay for joining fees where an employee needs to attend a gym or swimming

	pool to complete exercise as part of their medical treatment. If you are not satisfied that the cost of a gym/swimming membership is appropriate, you should ask the employee to provide three quotes or research the cost yourself.
Hospital	Shared room accommodation costs. A private room can be approved if it is medically required and medical evidence is provided supporting the request. Costs associated with TV hire, telephone calls and other personal expenses, e.g. additional food or snacks, or personal items such as newspapers, toiletries etc, are not payable by Comcare as they are not covered by the SRC Act.
Household and gardening help (weekly rate payable)	Comcare's statutory rates for weekly rates and Pracsys for hourly rates as well as rates for quoted/one off jobs, e.g. window cleaning, gutter cleaning and carpet cleaning. Note that the weekly rates are legislatively binding and you cannot approve a higher rate per week for these services unless the employee has a catastrophic injury. Hourly rates can be changed if appropriate, as long as you do not exceed the legislated rate per week. See Home help and attendant care for more details.
Medical aids (e.g. hearing aids, glasses, orthotics, crutches)	See: Medical aids and appliances under section 16 See: Hearing loss treatment
Pharmaceuticals	See: Medications and Comcare's Pharmacy Policy
Surgery	For more information about costs for surgery, see Surgery Costs.

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Determining an appropriate amount for above-rate medical or allied health treatment

You, as the Claims Manager, are ultimately responsible for determining liability for medical treatment or services including the appropriate amount payable for that medical treatment or service.

Relevant considerations when determining an appropriate amount for medical or allied health treatment include (but are not limited to):

- the actual cost incurred by the employee
- the average cost of a particular type of medical treatment
- medical treatment or services provided in isolated or remote locations

Payment processing for above-rate treatment

When an invoice is entered into Pracsys and the fee charged is **less than or equal to** Comcare's specified service rate for that treatment or service, Pracsys will automatically pay the amount charged to the service provider or employee providing that the treatment has been approved, and the treatment plan has been updated.

In instances where an invoice is entered into Pracsys for an amount **above** Comcare's specific service rates, Pracsys automatically **reduces** the amount to the maximum rate payable for that particular treatment or service.

The reduced amount is then paid to the service provider or employee **unless there are clear comments on the treatment plan** in the claim instructing CAIS to pay above the maximum service rate payable for that treatment or service. You should include the approved amount payable in the treatment plan comments.

In some cases, CAIS may place an invoice on hold and flag it with you for you to determine liability for the cost of the medical or allied health treatment.

Discretion to pay above the specified service rates

The specified service rates for medical and allied health treatment that are set by Comcare are not legally binding. You retain discretion to determine the appropriate amount of compensation payable on a case-by-case basis

Considerations when assessing whether or not to pay above Comcare's service rates for medical treatment could include:

- Billing policy

Where a medical treatment provider charges more than the recommended fee, you may ask the employee to provide the service provider's billing policy to determine if it is appropriate to pay the excess amount.

For example, the service provider may have a three-tiered fee system based on whether the patient is a public patient, has private health insurance, or is covered by workers' compensation. If this is the case, you may determine that the higher fee is not appropriate and that a lesser amount of compensation is payable. This is because the fee should be based on the treatment or service being provided, not on the patient's circumstances.

- Location factors

There may be a case where the majority of service providers for the same treatment in the same location charge slightly higher rates than the specified service rates for that treatment. If the cost

incurred by the employee is higher than the service rates but is within the amounts charged by the service providers within that location, then the cost may be appropriate in the circumstances. If so, the higher amount can be paid. See: Sinclair and Comcare [2002] AATA 23 (17 January 2002)

Where the majority of service providers in the same location charge within certain amounts for the same treatment and the cost incurred by the employee is much higher than that amount, you may determine that the cost is not appropriate, and a lesser amount of compensation can be paid.

However, a higher fee could be paid where, for example, because of the isolated location at which the medical treatment is provided, the medical or allied health provider may incur additional costs in order to run their practice.

Medical and allied health treatment – no specified service rates

Where there are no specified service rates for medical or allied health treatment, it will be up to you to determine what an appropriate amount is for the cost of the treatment or service.

To do this, you may consider the following:

- Review the fee schedules of other workers compensation insurers' websites to find out what they pay for that service.
- Review the fee schedules of other relevant service provider websites to find out what they charge for the same service.
- If the treatment is covered by the AMA, i.e. surgery costs, review the AMA list of medical services and fees.
- Request three quotes from the employee.
- The Clinical Panel may be able to provide clarification on what an appropriate cost is for the medical treatment.

Updating Pracsys and communicating with employees

Once you have made a determination to accept the medical or allied health treatment and/or costs, you will need to update the treatment plan in Pracsys with clear commentary.

Communicating with employees

To avoid inconsistencies and disputes about the cost of compensable medical treatment, you may want to:

- Refer employees to the Appropriate cost of medical treatment scheme guidance. Advise them of your intention, for example:
 - that you intend to pay the service rates for allied health treatment that Comcare has deemed appropriate to that treatment.
 - that you intend to pay the fees recommended by the AMA for that treatment.
 - that the reasons for paying a higher fee than the specified rate are established, based on the circumstances of that particular service, or claim.
- Encourage employees to seek advance approval for the payment of medical treatment.
- Provide the employee with the details of what costs you have determined are appropriate for the approved medical treatment (where applicable). If you have approved an amount above the specified service rates, remember to include a comment in Pracsys and update the treatment plan.

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Financial delegations for paying above scheduled rates

Where you have determined that it is appropriate to pay above the scheduled rates for medical treatment and/or other related services, you will need to adhere to the following financial delegations:

- You, as the Claims Manager, have the authority to approve the difference or gap between the relevant scheduled rate and the amount charged by the service provider where the difference is less than or equal to \$50.00 per consultation or item for that treatment or service without seeking approval from your Assistant Director.
- Differences or gaps between the scheduled rate and the amount charged by the service provider where the difference is greater than \$50.00 per consultation or item for that treatment or service will need to be approved by the Assistant Director.

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Invoiced costs must match approved quotes

Comcare **cannot process payments** for medical treatment from a quote.

While you may accept liability for medical treatment based on the information on the quote, Comcare requires a tax invoice from the service provider before we can pay for the medical treatment or services.

Comcare must not sign contracts or quotes for services

If you have requested quotes from the employee for medical treatment or in instances where the service provider has requested prior approval for the cost of the medical treatment and has provided you with a quote for your consideration, please note that Comcare staff should not sign forms or contracts with service providers authorising the provision of medical treatment on an employee's behalf.

This is because there is a risk that signing documents could make Comcare liable for costs if the employee fails to attend a scheduled admission or treatment.

In these circumstances, you can advise the service provider of your determination to accept liability for the medical treatment. No further information about the claim should be released to the service provider without the employee's permission.

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Requests to review paid medical or allied health costs

You may receive requests to review paid medical or allied health costs from service providers or employees, especially if Comcare has paid less than the amount charged for a particular treatment or service.

If the request comes from the employee or employer, you will need to review the payment and decide whether you need to undertake a reconsideration of own motion or if it is a request for a reconsideration.

Service providers do not have the right to request a reconsideration of the original determination. However, you may need to review the payment to ensure that it has been paid correctly.

If the payment has been processed incorrectly, please email CAIS – Complex Payments with the details and ask for the payment to be amended.

Comcare normally only makes payments from original invoices. If a service provider submits an amended invoice for treatment or services that have already been paid by Comcare, you will need to investigate whether the reason for the amended invoice is reasonable.

For example, where the service provider has made a genuine mistake and billed Comcare using an incorrect item code or used the wrong date of service then an amendment to the original payment may be considered reasonable in the circumstances.

Please email CAIS – Complex payments with the details that need amending and add a comment to Pracsys.

However, if the service provider has provided an amended invoice due to the provider recently finding out that the employee has a workers compensation claim with Comcare and now wants to increase their fees for the treatment or services that Comcare has already paid for, then it would not be considered reasonable to amend the original payment in the circumstances. The amended invoice should be returned to the service provider.

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GST and medical or allied health treatment

For the most part, medical and allied health treatment is considered GST-free under the *Goods and Services Tax Act 1999*.

However, some services such as massage therapy, exercise physiology, gym programs, and the provision of clinical notes or medical reports do attract the GST component.

In order for Comcare to pay the GST component, service providers **must** have an active ABN that **includes a current GST registration**.

If the service provider does not have an active ABN or has an active ABN but **does not have a current GST registration**, Comcare cannot pay the GST component even if the GST is normally payable for that treatment or service.

If the service provider does not have an ABN or is not required to have an ABN for taxation purposes, please see the relevant sections of the Glossary: ABN or Statement by a supplier form.

Service providers may also try to charge the GST component on GST-free medical treatment or services as they perceive Comcare to be a third-party insurer. This perception is incorrect. Employees have the right to engage the services of an appropriately qualified service provider of their choice to provide the approved medical treatment and Comcare then pays for the approved medical treatment **on behalf** of the employee.

If, however, Comcare requests a service from the employee's treating health practitioner, such as clinical notes or a medical report, then the GST is payable (but only if the service provider has an active ABN that includes a current GST registration).

For further information on GST requirements please see: [GST and health](#) | Australian Taxation Office

Non-attendance at medical treatment

If the employee makes an appointment for medical treatment and fails to attend, they may be charged non-attendance or cancellation fees. There is no provision under the SRC Act that makes Comcare responsible for the payment of such fees.

Non-attendance at a medical appointment does not meet the definition of medical treatment under the SRC Act because no treatment was received or provided. It is the responsibility of the employee to ensure they attend the appointment or cancel the appointment within a reasonable timeframe. Any non-attendance or cancellation fee charged is the responsibility of the employee.

Determining liability for medical treatment

Published 04/09/2025

Introduction

This page provides information on the processes of determining liability for medical treatment. You need to consider the medical evidence, the cost and the reasonableness of the treatment, and that it is aligned with the treatment plan. This page also includes information about payment of medical treatment. The procedure to determine liability for medical treatment claims and the procedure to communicate the medical treatment determination are also included.

Each request for medical treatment is considered on its merits based on the available information. For further guidance, refer to the Decision making under the SRC Act page.

Relevant legislation

The relevant legislation for determining liability for medical treatment is:

- Section 4 – Interpretation (SRC Act).
- Section 16 – Compensation in respect of medical expenses, etc. (SRC Act)

Roles and responsibilities

The Claims Manager is responsible for determining liability for medical treatment. The Injury Manager is available to consult on the proposed medical treatment. You can also consult your Assistant Director and, with the support of your Injury Manager, you can refer proposed treatment to the Undertaking Clinical Panel review for expert assessment.

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Considerations when determining liability for medical treatment

An employee needs to provide medical information from a legally qualified medical practitioner (LQMP) which may include a general practitioner, psychiatrist, dentist or specialist, to claim compensation for medical treatment for their compensable condition. Comcare may request further information.

When determining liability for medical treatment, you need to be satisfied:

- the employee has a compensable condition
- the treatment is:
 - [medical treatment](#) as defined in the SRC Act
 - obtained in relation to the compensable condition, and
 - reasonable for the employee to obtain in the circumstances.

For further guidance, refer to the [What is medical treatment?](#) and [What is reasonable medical treatment?](#) pages.

If any one of these criteria is not met, liability should be declined.

You also need to determine whether the cost is appropriate for the medical treatment. In some cases, Comcare may determine that the full amount claimed is not appropriate, but that Comcare will pay up to a lower amount. For further information, refer to the [What are appropriate costs?](#) page and the Scheme guidance [Appropriate cost of medical treatment](#).

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Assessing whether medical treatment is reasonable to obtain

You need to assess whether medical treatment is reasonable to obtain, and if so, for how long. If the treatment is reasonable, liability should only be approved for:

- a reasonable number of sessions (refer to the below table), or
- up to a date you are satisfied it will be reasonable for the employee to need the treatment.

To assess what is reasonable, consider the following.

- The treating practitioner recommendation - if this indicates a review date for the treatment, liability should not be accepted beyond that review date.
- [MD Guidelines](#) about the condition and recommended treatment approach.
- The Clinical Framework.
- The Injury Manager's opinion (and the Clinical Panel if necessary).
- The table below, which provides guidance on the maximum period of treatment that is reasonable in the circumstances.

If the treatment is...	then accept liability for a reasonable amount of treatment, but no more than...
a one-off treatment (e.g. surgery, a psychiatric hospital stay, medical imaging or pathology)	the specific instance of the treatment recommended.
physiotherapy, psychology or counselling	5 sessions before a treatment notification plan (TNP) is required, following which liability should only be accepted for sessions recommended on a TNP/review treatment plan (RTP) or agreed to through a Clinical Panel review.
massage, osteopathy, chiropractic treatment or acupuncture	up to the review date on the medical certificate or 3 months if no review date has been provided.
exercise	Generally, gym or pool memberships should only be approved for up to 3 months and no more than 6 supervised exercise sessions should be approved, by which time the employee is expected to be transitioned to independent exercise.
pharmacy	Schedule 8 (S8) medications should only be approved for a maximum of 2 months and as a PBS prescription. Clinical justification is required from the prescribing medical practitioner if the S8 medication is prescribed by a private/off label script and or for greater than 2 months. See Medications.

another treatment type (e.g. consultations with a medical practitioner or dentist, pharmaceuticals, or nursing care)	6 months for claims under two years old, or 12 months for claims over two years old.

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Payment for medical treatment

Claims for medical expenses may be submitted by the employee (either a receipt or invoice) or by their provider (an invoice) directly to Comcare. Invoices received for treatment go directly to Claims Administration and Income Support (CAIS) team for processing.

Where invoiced items are not specified in the treatment plan or fall outside the frequency or timeframe set in the treatment plan, Pracsys will generate an invoice diary to the relevant Claims Manager for consideration.

Comcare does not necessarily reimburse the full cost of treatment paid. Comcare specifies rates that are considered appropriate for various services. These are based on the Australian Medical Association (AMA), The Department of Health, Disability and Ageing: Pharmaceutical Benefits Scheme and allied health rates for each state/territory for the particular type of treatment. However, Claims Managers have the authority to accept claims for rates higher than the set rates, if they consider the costs to be reasonable. More information is available in Medical and allied health rates. Comcare generally issues payment within 30 days of receiving an invoice or receipt.

Medicare and private health funds

It is preferable an employee does not claim through Medicare or their private health fund for treatment relating to their compensable condition.

If Medicare or a private health fund makes payment and is then informed the service is related to a workers compensation claim, they can ask Comcare to repay the money they paid to the employee. This can cause delays in the processing of payments and the employee being reimbursed.

If the employee does make a claim through Medicare or their private health fund and wants to claim the gap payment from Comcare, then the employee will need to submit a copy of the original receipt from the service provider and the Medicare statement of benefits or an equivalent statement from the private health fund, e.g. a HICAPS receipt to Comcare for reimbursement.

Gap payments: When reimbursing the 'gap payment' (the difference between the amount charged by the service provider and the amount reimbursed by Medicare and/or the employee's private health fund), Comcare will normally reimburse the employee the full amount of the 'gap payment'. However, if the service provider is charging more than the standard amount payable in Pracsys, then the 'gap payment' payable to the employee will be the difference between the standard amount payable in Pracsys and the Medicare and/or private health fund reimbursement. The amount to be paid to the employee will need to be calculated by CAIS or the Claims Manager and entered into Pracsys.

Where the employee has received reimbursement through both Medicare **and** their private health fund, the 'gap payment' will be the difference between the amount charged by the service provider, the standard rate payable and the amounts reimbursed by Medicare **and** the private health fund. In

some instances, there may be no monies payable to the employee as they have already received the maximum amount payable from the combined reimbursements paid by Medicare and the private health fund.

EFTPOS receipts: Normally, Comcare cannot reimburse costs from EFTPOS receipts as they do not contain enough information for processing or auditing purposes.

The information that Comcare requires to process medical payments claimed through Medicare or a private health fund (including any gap payments to the employee) from invoices/receipts or statement of benefits include:

1. employee's name
2. claim number or date of birth
3. service provider's details
4. date of service
5. description of service including item code
6. the amount charged by the service provider for the service
7. the amount paid by the employee (if applicable)
8. the amount reimbursed by Medicare or the private health fund
9. if more than one service is being claimed for, then each service will need to be itemised individually on the receipt/invoice or statement of benefits.

Suspensions and payment of medical treatment

If a claim is suspended, medical treatment costs may not be payable, depending on the reason for the suspension. Refer to the [Suspending claims](#) page, in particular the section on the effects of suspending a claim.

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Treatment plan

The 'Amend Payment Authorisation (Treatment Plan)' (ACTP) function in Pracsys records all medical treatment that has been approved or rejected for that claim.

A treatment plan allows you to see:

- what medical treatment has previously been determined for the employee
- what treatment Comcare has made payments for
- how many times the treatment has been extended, and
- the nature, frequency and duration of medical treatment that has been accepted.

Updating the treatment plan is important because it allows for approved treatment to be automatically paid when invoices are entered into Pracsys. If an invoice is received for a treatment that is not accepted in the treatment plan, an invoice diary is generated, and the invoice will be sent to you for actioning.

When is a treatment plan created?

The initial treatment plan is created automatically during the initial liability assessment process. During this process, you are asked to enter the date to which liability is accepted for medical treatment and time off work.

After a claim has been accepted, Pracsys automatically allocates a generic treatment plan. This consists of general practitioner consultations and pharmaceuticals up to the date entered in iClaim for medical treatment. The generic treatment plan does not include other medical treatment received or time off work the employee may have had as a result of their injury.

If liability has been accepted for other medical treatment and/or time off work, you need to amend the treatment plan to include all appropriate medical treatments and incapacity payments. This will enable payments to be made.

When is a treatment plan updated?

You should review the treatment plan to ensure it is appropriate and up to date.

A treatment plan in Pracsys needs to be updated when a determination to accept or reject liability for claimed medical treatment is finalised.

Whenever you accept, reject or extend liability for medical treatment, you need to ensure that the '*Amend Payment Authorisation (Treatment Plan)*' (ACTP) in Pracsys is updated.

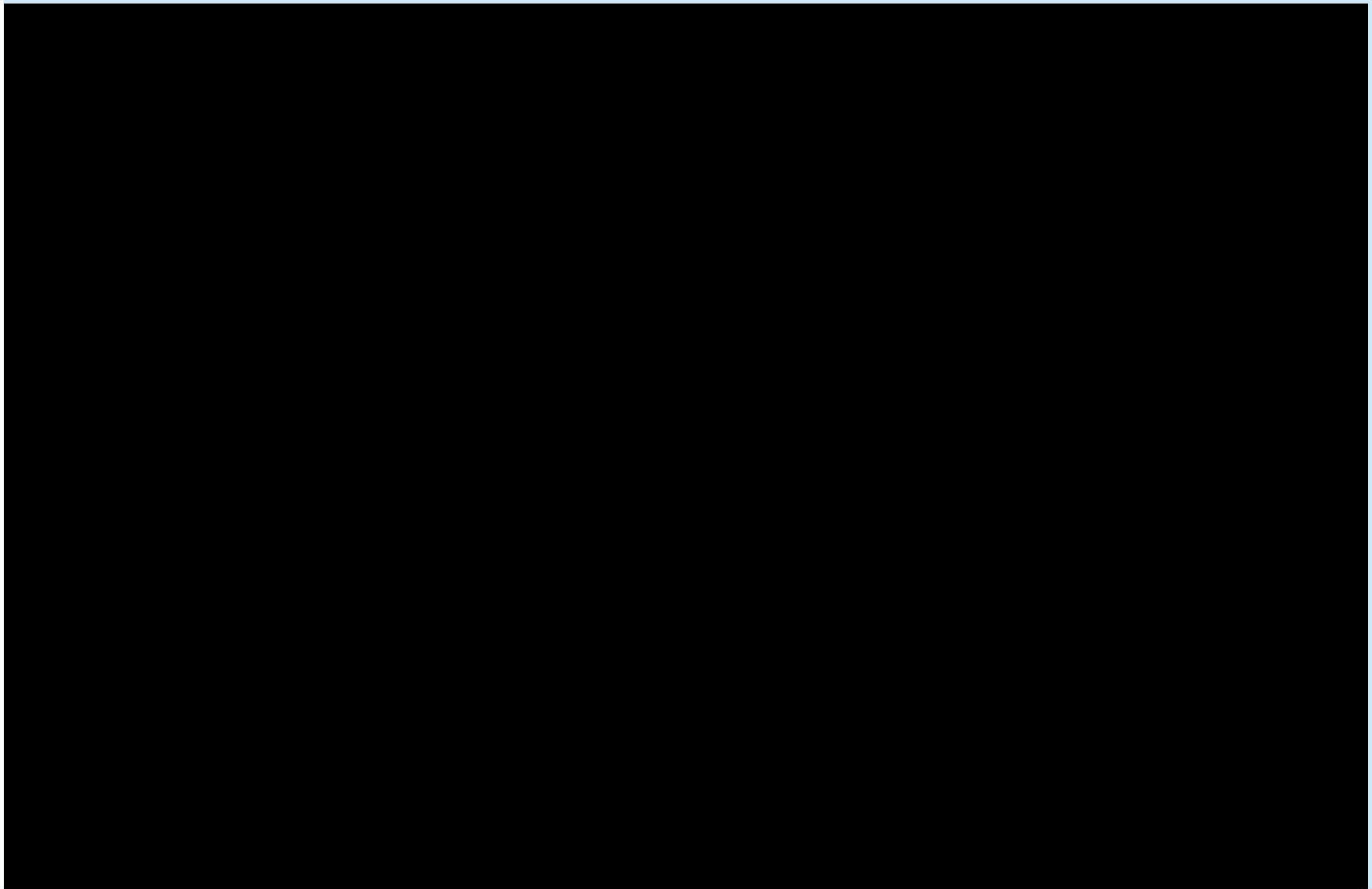
What information needs to be entered into the treatment plan?

This table details the information that needs to be entered in a treatment plan when a determination of liability is made:

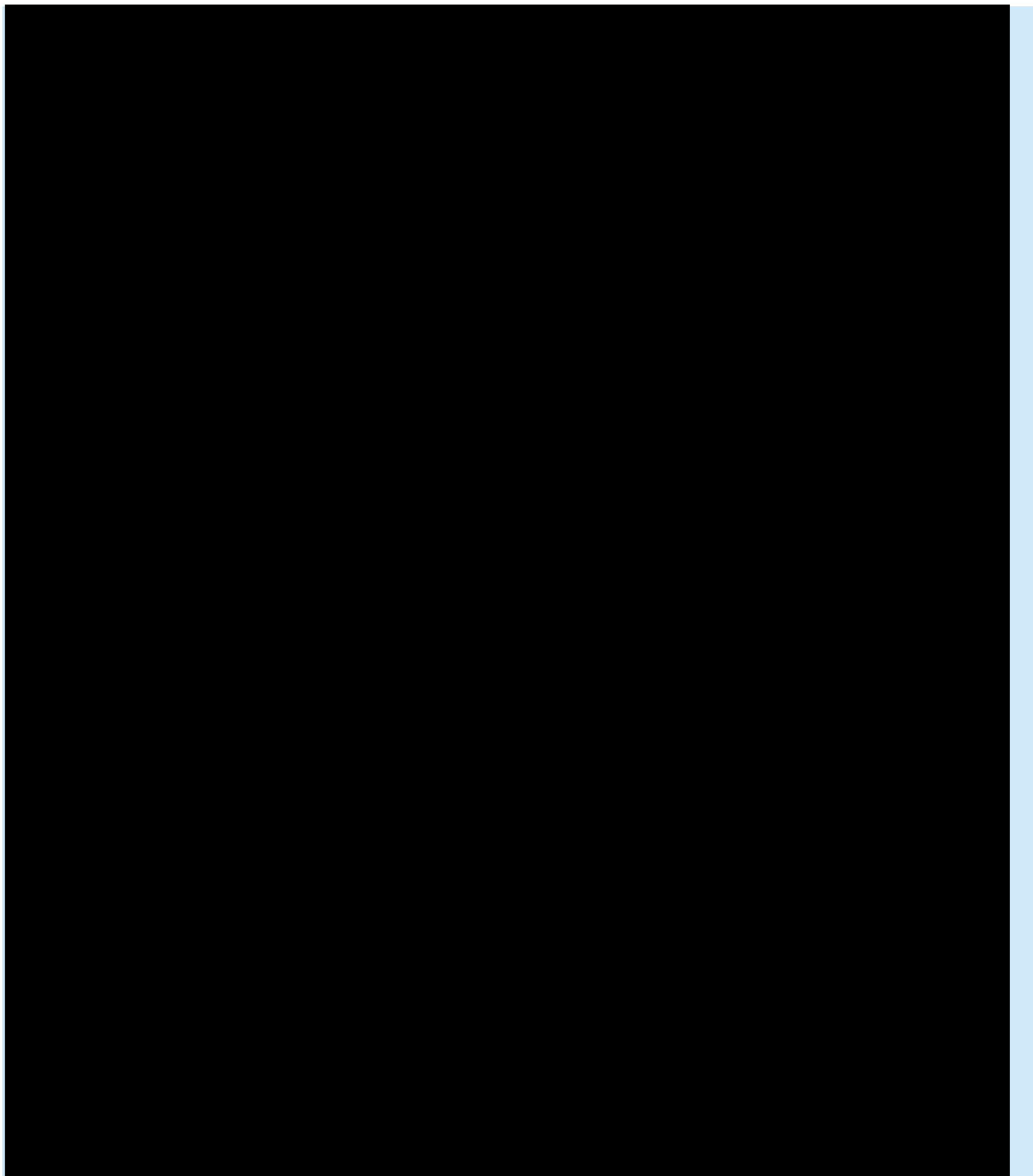
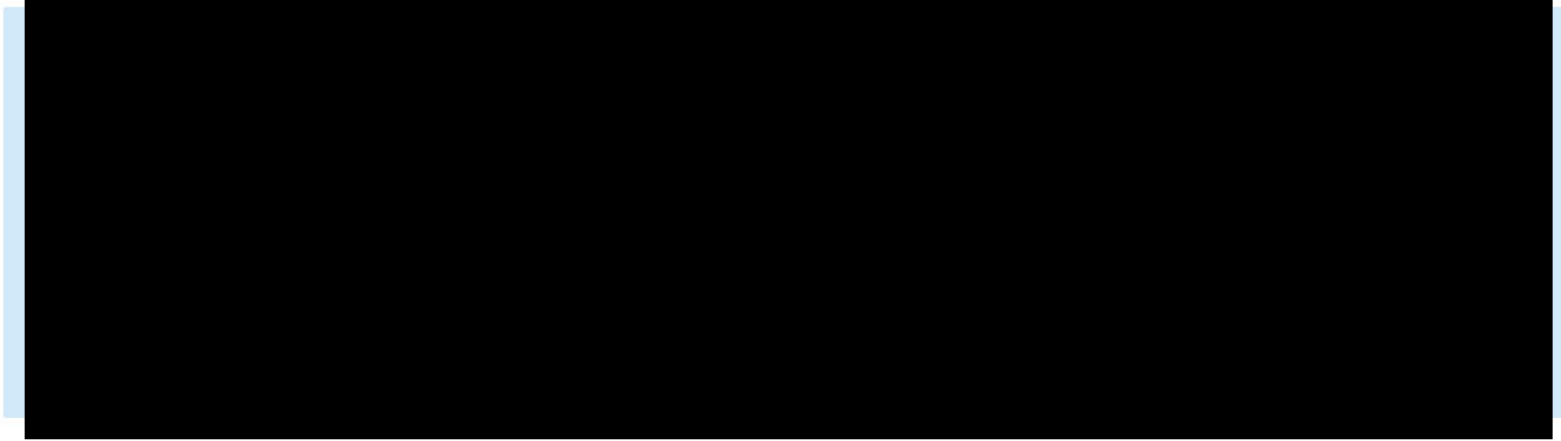
Field in Pracsys	Information to enter
Treatment Payment Type	Select the appropriate treatment type for the medical treatment that has been accepted or rejected. If the particular treatment is not listed in Pracsys then the payment type '<i>alternative</i>' should be used, and the name of the treatment and associated costs should be recorded in the '<i>Comment</i>' text box. Vitamins and medicinal supplements are paid under the treatment payment type '<i>Pharmaceuticals</i>'. The '<i>Spec Phys...</i>' treatment types are not limited by statutory rates. These codes are generally used for treatment like surgery where there is no specified rate. Do not use these for consultations with specialists.
Auto Payment	Determination status: • Allowed (A) - refers to medical treatment that is automatically assigned by Pracsys based on the injury profile of the claim and medical treatment the Claims Manager has approved. • Not allowed (N) - automatically applied by Pracsys for medical treatment types that are not usually reasonable based on the injury profile of the claim. The status can be changed from N to A if medical evidence indicates that the medical treatment is reasonable. • Rejected (R) - applies when a Claims Manager determines that particular medical treatment is not reasonable and must be manually entered on Pracsys. R status can be changed to A where future claims for that medical treatment are accepted, or an appeal is successful.
Received date	When the request for medical treatment was received by Comcare.

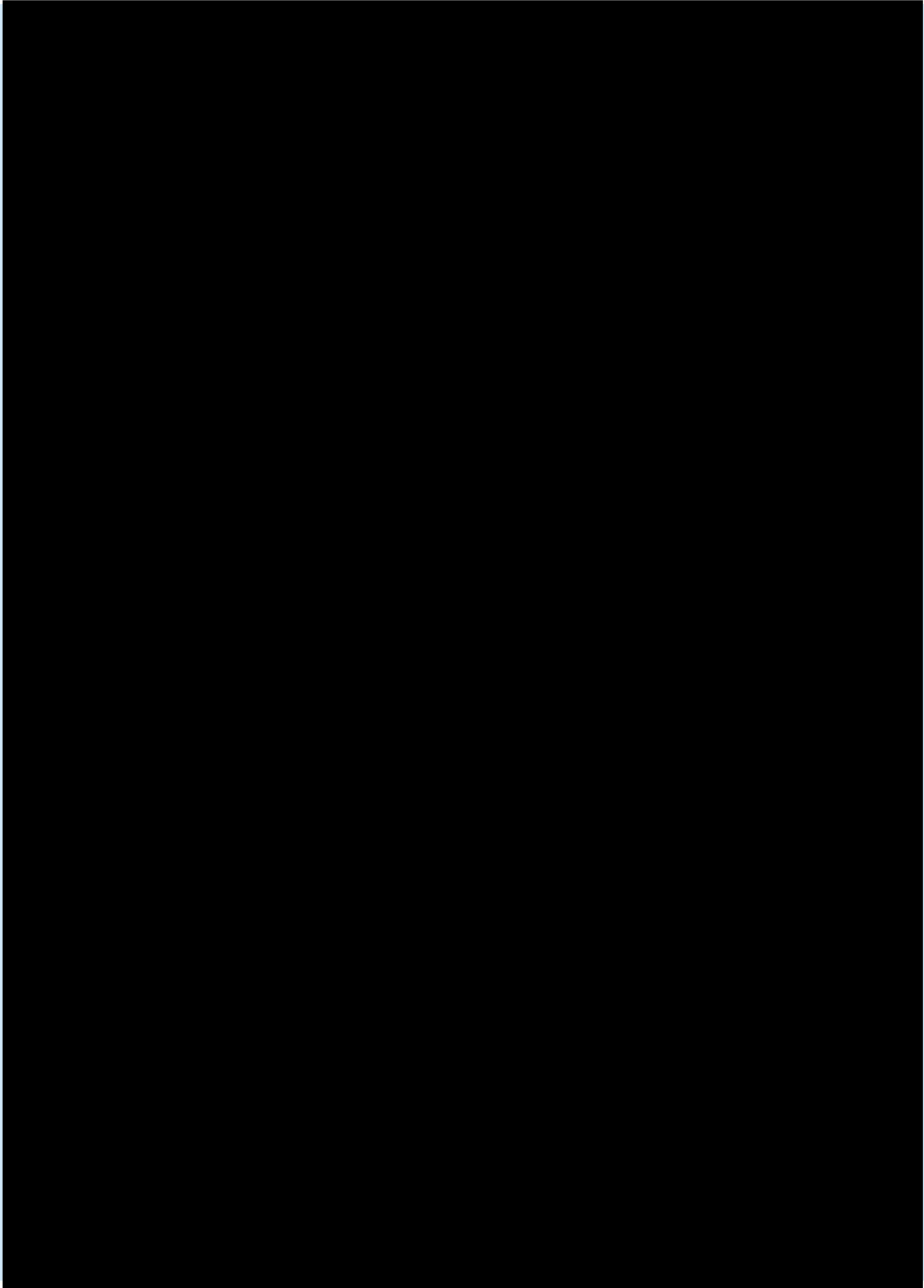
Determination date	The date the determination is made.
Review date	The date the medical treatment has been approved up to (and including).
Frequency	How often the employee can undertake the medical treatment.
Comments	Any other additional information that may be relevant. If the treatment payment type is '<i>Pharmaceutical</i>', the following information must be recorded if known: • date of comment • prescriber name • drug name (or drug type) • drug dosage • drug duration, and • frequency of treatment if it falls outside the automatic frequency fields. Example: '18/12/12 Dr Smith recommends the following medications as treatment for the compensable condition: Panadeine Forte 10mg 100, Oxycontin 5mg 28, for the next 3 months then review.'
Treatment notification plan	Enter in the relevant service provider number for the related treatment line period.
Allowed service items	Use </> to move the drugs in and out of the approved drugs list.

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Medications

Published 31/07/2025

Introduction

This page provides information about Comcare's policy on pharmaceutical medications including Schedule 8 medications such as ketamine / esketamine and medicinal cannabis.

Relevant legislation

Pharmaceutical medications are considered medical treatment and liability for these medications is determined under section 16 of the SRC Act.

Consult with your Injury Manager in the first instance and the Clinical Panel in the second instance on claims for medications, especially claims for Schedule 8 medicines such as ketamine/esketamine and medicinal cannabis.

For further information, see Comcare's Pharmacy Policy

Medications Comcare can pay for

Comcare can pay for the appropriate cost of pharmaceutical medications prescribed by a legally qualified medical practitioner (LQMP) or dentist for the treatment of an injured employee's compensable condition.

Comcare can pay for the appropriate cost of medications which are:

- requested or prescribed by a medical practitioner or registered dentist
- provided by a registered pharmacist
- reasonably required due to a compensable condition
- provided in accordance with the Pharmaceutical Benefits Scheme (PBS)
- provided as a 'private /off label prescription' if the medicine is clinically appropriate and not available on the PBS.

The Clinical Panel reviews pharmacy invoices. The [Clinical Panel Pharmacy Process FAQ](#) provides you with more information about the process.

Medications Comcare will not pay for

Comcare will not pay for medications:

- that a medical practitioner did not prescribe (in the case of prescription medicines)
- that a medical practitioner did not recommend (in the case of non-prescription/over the counter items)
- for a person other than the injured employee
- for which there is no clinical justification
- that are not related to the accepted workplace injury or illness
- that are prescribed as part of a clinical trial

- that were required prior to the accepted workplace injury or illness unless the dose levels increase as a direct result of the work-related injury or illness.

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PBS and non-PBS medications

PBS medications

Injured employees can receive medications under the Pharmaceutical Benefits Scheme (PBS). Where an injured employee is entitled to access the PBS, Comcare will fund all patient contributions set out in the PBS, including brand or therapeutic premiums.

Where a medical practitioner prescribes a quantity over the PBS limit for prescribed medications, an authority from Services Australia is required.

Non-PBS (private /off label prescription) medications

Medications should be prescribed under the PBS when clinically appropriate and available. Comcare can pay for non-PBS (private / off label prescription) medications if the medications are clinically appropriate for the work-related injury or illness and there are no readily available alternatives on the PBS.

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Compounded pharmaceutical products

The compounding of pharmaceutical products is highly regulated in Australia. Compounded pharmaceutical products may include medications, suppositories and topical creams.

Comcare may pay the reasonable costs of compounded pharmaceuticals which are:

- required as a result of a work-related injury or illness
- requested and supported by a written clinical rationale from a registered medical practitioner or dentist
- when it is clinically demonstrated that a commercially available/off the shelf product is not suitable.

Due to the nature of compounded pharmaceutical products, Comcare will require a copy of the prescription, proposed cost (if available) and clinical justification outlining the rationale for a compounded pharmaceutical product as opposed to a commercially available product.

Upon receipt of this information, the Claims Manager must refer the claim to the Clinical Panel for a liability determination in regard to the compounded pharmaceutical product/s.

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Over the counter medications

Over the counter (OTC) items include medications and non-drug pharmacy items. These items can be sold by a pharmacist without a prescription. This includes analgesics and laxatives, dressings, bandages, mobility aids and supports. Comcare can pay the appropriate cost of OTC items:

- required as a result of a work-related injury or illness
- requested and supported by a written clinical rationale from a legally qualified medical practitioner.

Comcare may pay for over the counter items if they are clinically justified by the prescribing medical practitioner, in accordance with current clinical practice guidelines.

Webster packs

A Webster pack, or Webster-Pak, is a container that people use to organise their medication by the seven days of the week, and by the time of day that each medication needs to be taken. An employee can fill their pack themselves or bring it to the pharmacy for the pharmacist to fill. Some health practitioners provide Webster-Paks to their patients free of charge. They can also be purchased at most pharmacies.

Like other over the counter medications and supplies, Comcare may pay for the appropriate cost of a Webster-Pak at a pharmacy provided that the above conditions are met.

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Complementary medications

Complementary medications include vitamins, minerals, herbal remedies, and nutritional supplements. Comcare can pay the reasonable costs of complementary medications which are:

- required as a result of a work-related injury or illness
- requested and supported by a written clinical rationale from a registered medical practitioner or dentist.

This will generally only be the case where the compensable condition has caused a deficiency in the employee that cannot otherwise be rectified by normal lifestyle and dietary improvements. For example, an employee who has suffered blood loss may be required to take iron supplements for a limited time to rectify an iron deficiency.

Dietary foods

Medicines also include packaged dietary foods that are recommended by a medical practitioner for weight loss and the relief of pain. You need to consult the Clinical Panel to assess and approve any recommendation for packaged dietary foods. However, Comcare will not accept liability for food including diet programs such as Light and Easy, dietary supplements or meal replacements. This is because food is an ordinary expense and is not medical treatment under the SRC Act.

See Exercise, weight loss and gym for more information about weight loss.

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Schedule 8 medications

Schedule 8 (S8) medications are subject to tighter restrictions than other medications because of their potential to cause addiction. Morphine, oxycodone, ketamine, fentanyl and medicinal cannabis are examples of S8 drugs.

Comcare will pay for Schedule 8 medications for a maximum of 2 months when they are prescribed through the PBS. Schedule 8 medications are subject to a high risk of abuse. As such, the prescribing

medical practitioner is expected to obtain a permit to prescribe the Schedule 8 medication via Services Australia. A copy of the permit obtained by the prescribing medical practitioner should be provided to Comcare.

Paying for these on private prescriptions reduces the effectiveness of the governmental systems in place to monitor their use.

If a medical practitioner believes a non-PBS S8 medication is more suitable or a S8 medication must be prescribed for more than 2 months, the medical practitioner must provide written clinical justification to Comcare for consideration prior to prescribing the medication. If Comcare does not accept liability based on the justification provided, the injured employee is responsible for the cost of the Schedule 8 medication.

For further information please see Comcare's Pharmacy Policy

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Ketamine and esketamine

Ketamine and esketamine are new or emerging treatments for mental health disorders with limited clinical evidence.

Clinical evidence suggests the use of ketamine/esketamine may be reasonable in limited circumstances. These circumstances include:

- where the patient has failed to respond to first-line treatments
- to reduce opioids prescribed following a surgical procedure
- to facilitate weaning of opioids prescribed to patients with limited options for managing chronic non-cancer pain.

Due to the complexities surrounding mental health conditions and insufficient evidence to support the use of ketamine as a first line treatment for chronic non-cancer pain, depression and PTSD, **all** requests for the use of ketamine / esketamine to treat psychiatric conditions **must** be referred to the Clinical Panel for review, to assist with appropriate and consistent decision making. For further guidance, see the page Undertaking a clinical panel review

When reviewing requests for ketamine/esketamine, the Clinical Panel applies the guidance recommended by the Department of Health and Therapeutic Goods Administration).

For further information on ketamine/esketamine, please see the Ketamine/esketamine for mental health conditions information sheet.

Information gathering

As ketamine/esketamine is a new or emerging treatment for mental health conditions with limited clinical evidence, it is important that Comcare has sufficient information to make an informed decision.

Before sending a request for ketamine/esketamine treatment to the Clinical Panel for review, you should review the information accompanying the original request.

The following information should be obtained from the referring psychiatrist, general practitioner and/or other relevant treating health practitioner (THP) if not addressed in the initial referral.

Questions to ask the prescribing Treating Health Practitioner (THP)

The questions detailed below must be chosen and modified for the circumstances of the individual employee and in accordance with the information already provided by the treating health practitioner.

If you need help with reviewing the information accompanying the request for ketamine/esketamine treatment, or with seeking additional information from the treating health practitioner, please contact your Injury Manager or a member of the Clinical Panel team.

Indication, details of proposed treatment, screening, consent and regulation

1. What is the clinical indication for the ketamine/esketamine prescription?
 - a. Please provide a clinical rationale for this treatment choice in this individual at this time.
2. What is the name of the product, the dose to be prescribed and length of treatment / course of treatment that you hope to consent your patient to?
3. What recent evidence-based level 1 or 2 studies or peer reviewed guidelines (i.e. RANZCP) can be provided to support the prescribing of ketamine/esketamine for this indication?
4. What psychotropic medications have been tried previously and what was the outcome?

The Therapeutic Goods Administration (TGA) guidelines state that 'SPRAVATO (esketamine) should be administered in conjunction with a newly initiated oral antidepressant (AD).'

5. What are the current psychotropic medications prescribed to your patient? Please include dose and frequency.
 - a. Noting the rules around the licensing of esketamine by the TGA, what is the proposed treatment plan for administering a newly initiated oral antidepressant with this trial of ketamine?
6. Has the individual had previous 'at risk' behaviours for drug dependence or substance abuse disorders or are they considered 'at risk' of such behaviours currently or in the future?
7. Please detail how your prescribing complies with S8 regulations in Australia and your state jurisdiction.
 - a. Please provide the necessary permits for your state jurisdiction for prescribing an S8 substance for your patient.
8. Have you sought institutional review, e.g. by a Medicines Advisory Committee or Clinical Governance Committee and/or discussed the treatment with peers, preferably seeking an opinion from a psychiatrist with expertise in the use of ketamine? If so, please provide details and documentation.
9. Does the individual have any contraindications for the prescription of ketamine/esketamine?
 - History (within 6 weeks) of cardiovascular event, including myocardial infarction (MI). Patients with a history of an MI should be clinically stable and cardiac symptom free prior to dosage administration.
 - History (within 6 months) of ischemic stroke or transient ischemic attack.
 - Haemodynamically significant valvular heart disease such as mitral regurgitation, aortic stenosis, or aortic regurgitation.
 - New York Heart Association (NYHA) Class III IV heart failure of any aetiology.

Management of risk around administration

10. In what manner and for how long will the individual be monitored post administration of ketamine/esketamine for side effects including sedation, dissociation and elevated blood pressure?

11. Can you please confirm that the individual has been instructed or advised to refrain from engaging in potentially hazardous activities requiring complete mental alertness and motor coordination, such as driving a motor vehicle or operating machinery on the day of administration of ketamine/esketamine?
 - a. Can you please confirm that the individual has been advised that engagement in activities requiring complete mental alertness and motor coordination cannot be re-commenced until the day following a restful sleep?

Assessment of outcome

12. Please outline what outcome measures will be conducted PRIOR to commencing the individual on ketamine/esketamine.
 - a. Please outline how often the outcome measures will be repeated whilst the individual undergoes treatment with ketamine/esketamine.
 - b. Please provide copies of those measures to Comcare for review.
13. If the ketamine/esketamine is found to be beneficial as assessed on outcome measures, what is the plan for treatment and or changing these medications in the future?

Prescribed timeframes

If the request is in relation to an initial liability determination, the prescribed timeframes and stop clock requests may apply if you are requesting the information from the employee's legally qualified medical practitioner.

To assess and determine liability for schedule 8 medications - please see the Procedure to assess and determine liability for schedule 8 medications below

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Medicinal cannabis

Medicinal cannabis is a new or emerging treatment for non-cancer chronic pain and psychological conditions such as anxiety with limited clinical evidence.

All requests for medicinal cannabis must be referred to the Clinical Panel for review, to assist with appropriate and consistent decision making. For further guidance, see the page [Undertaking a Clinical Panel review](#).

When reviewing requests for medicinal cannabis, the Clinical Panel applies the guidance recommended by the Department of Health and Therapeutic Goods Administration.

Side effects of medicinal cannabis

The extent of side effects can vary with the type of medicinal cannabis product and between individuals. If an employee reports that they are experiencing a side effect(s), you should advise the employee to seek advice from their medical practitioner.

Information gathering

As medicinal cannabis is a new or emerging treatment for treating non-cancer chronic pain and psychological conditions such as anxiety with limited clinical evidence, it is important that Comcare

has sufficient information to make an informed decision.

Before sending a request for medicinal cannabis to the Clinical Panel for review, you should review the information accompanying the original request.

The following information should be obtained from the referring psychiatrist, general practitioner and/or other relevant treating health practitioner (THP) if not addressed in the initial referral.

Questions to ask the prescribing Treating Health Practitioner (THP)

The questions detailed below must be chosen and modified for the circumstances of the individual employee and in accordance with the information already provided by the treating health practitioner.

If you need help with reviewing the information accompanying the request for medicinal cannabis treatment, or with seeking additional information from the treating health practitioner, please contact your Injury Manager or a member of the Clinical Panel team.

Questions

1. What type of medicinal cannabis is being prescribed (tetrahydrocannabinol (THC), cannabidiol (CBD), or both types) and in what proportions?
Note: any medicinal cannabis prescribed above 4% THC may also require a Schedule 8 (S8) permit depending on the state in Australia. See the Therapeutic Goods Administration (TGA) for more information.
2. What is the name of the product, and dose to be prescribed?
3. Ask them to provide a copy of their authorized prescriber letter from TGA or SAS Category B permit(s). See [Special Access Scheme \(SAS\) permit for more](#).
4. If the medicinal cannabis is being compounded, what is the clinical rationale for why it needs to be compounded?
Note: that there are over 37 off-the-shelf products of varying dosages currently available.
5. What is the clinical indication for the medicinal cannabis? For example, non-cancer chronic pain or other indication, such as for a psychological condition.
6. If the Treating Health Practitioner is prescribing a form of medicinal cannabis containing THC: Ask whether they have not only provided general written information but specifically advised the patient that they are NOT allowed to drive.
7. Ask them to clearly state:
 - a. what outcome measures will be conducted BEFORE starting the employee on medicinal cannabis and
 - b. how often the outcome measures will be repeated whilst prescribing medicinal cannabis to their patient.
 - c. They must also agree to provide copies of those measures to Comcare for review.
8. What are the current analgesic (pain relief) or psychiatric medications? If relevant to the request, include the dose and frequency. If the medicinal cannabis is found to be beneficial as assessed on outcome measures, what is the plan for changing these other medications in the future?
9. What are the other analgesic medications (or psychiatric medications) that have been tried previously and the outcome?
10. Does the employee have a past or family history of psychosis?
11. Has the employee had previous 'at risk' behaviours for drug dependence or substance abuse disorders or are they considered 'at risk' of such behaviours currently or in the future?

Note: In some states, a S8 permit is not required by the Treating Health Practitioner if the employee is considered not 'at risk' by the THP. If the employee has a past history of 'at risk' behaviours, however, most pain and addiction medicine specialists consider that a S8 permit should be obtained).

Optional questions if needed:

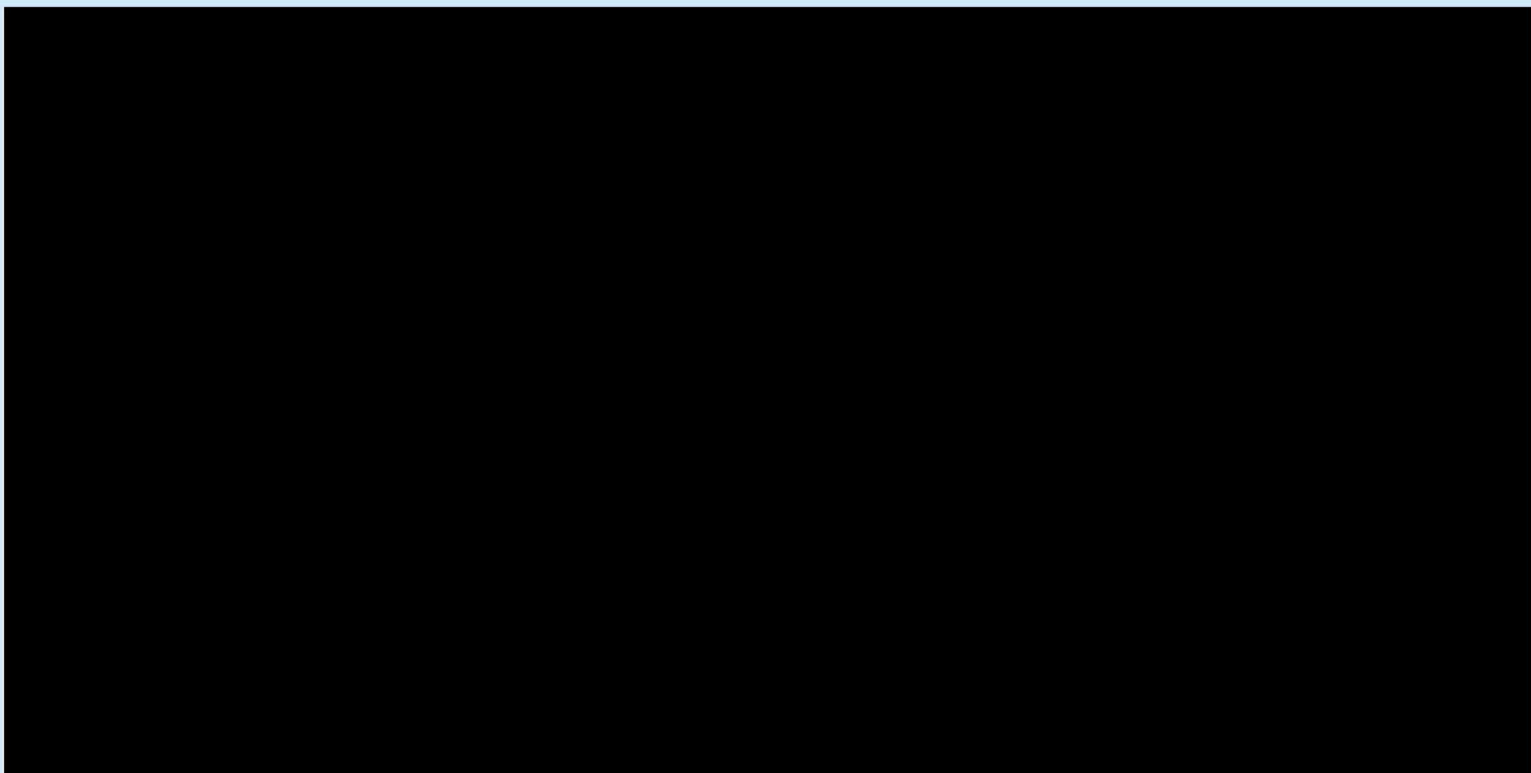
1. For a psychological condition:
 - a. The Treating Health Practitioner needs to provide a clinical rationale for their treatment choice.
 - b. A written copy of a second opinion should be provided. The Phoenix Australia 2020/21 annual report noted a lack of evidence currently to support the use of medicinal cannabis for psychological conditions. And the Royal Australian and New Zealand College of Psychiatrists (RANZCP) Guidelines indicate that a second opinion should be sought from another psychiatrist to support the prescribing of medicinal cannabis.
 - c. What recent evidence-based level 1 or 2 studies can be provided to support the prescribing of medicinal cannabis for a psychological condition?
2. If medicinal cannabis has already been prescribed:
 - a. When was the starting date, dosage and frequency?
 - b. If any changes in the type of medicinal cannabis were made, then what were the changes and when where those changes made?
 - c. Outcome measures should still be sought as per the questions above, including initial baseline measures and any subsequent review measures.

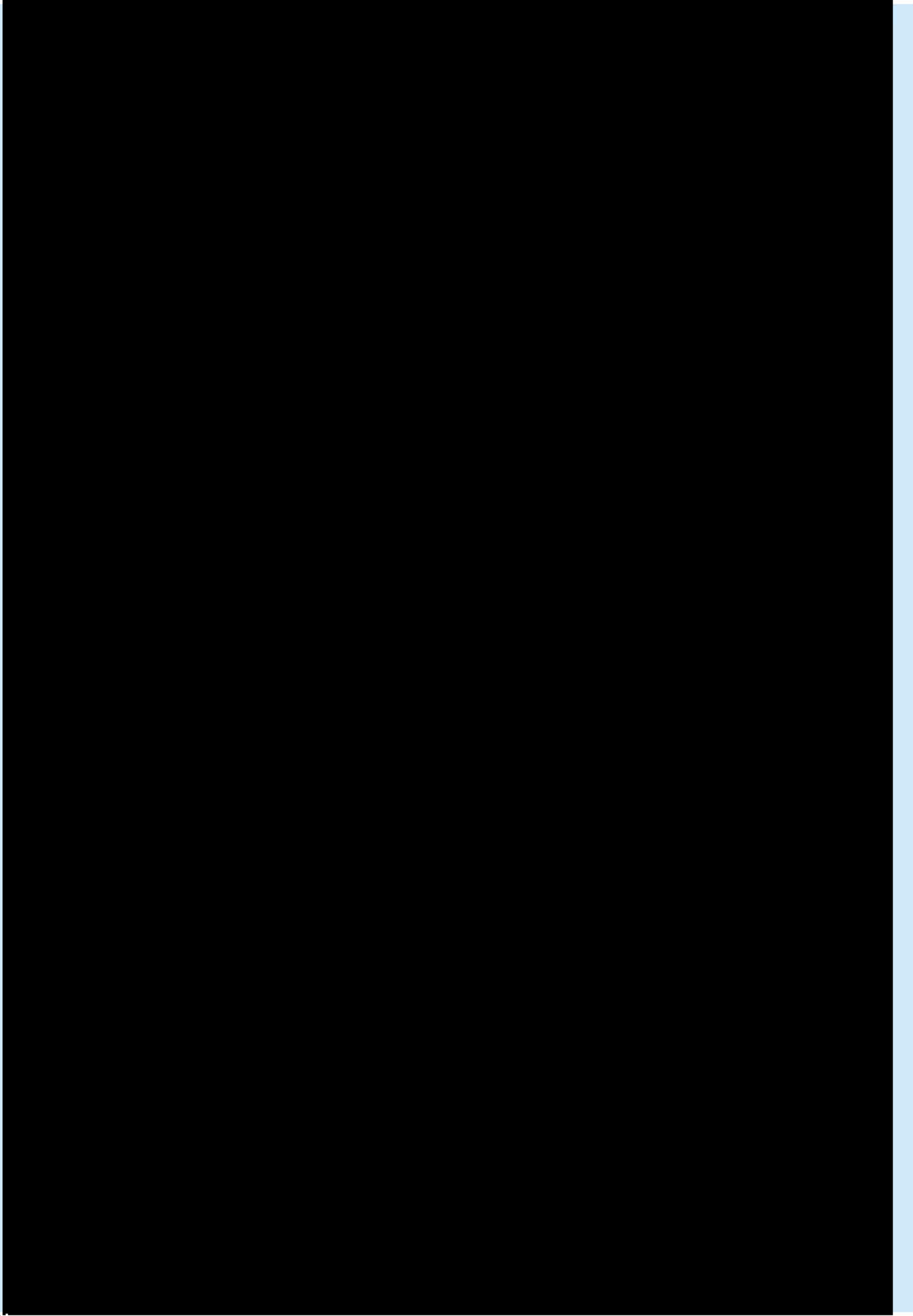
Prescribed timeframes

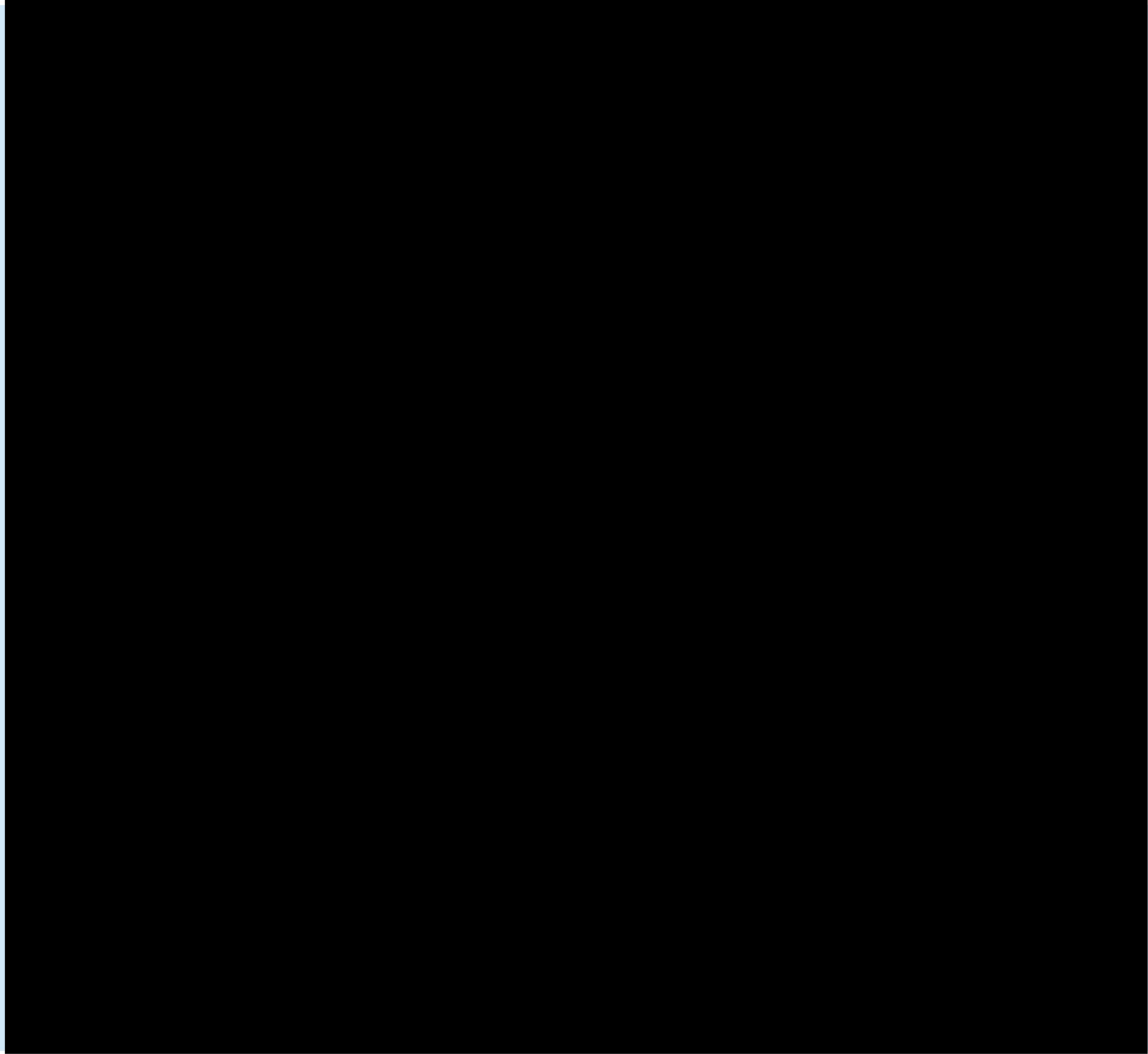
If the request is in relation to an initial liability determination, the prescribed timeframes and stop clock requests may apply if you are requesting the information from the employee's legally qualified medical practitioner.

To assess and determine liability for schedule 8 medications, please see the Procedure to assess and determine liability for schedule 8 medications below

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Allied health treatment

Introduction

Allied health treatment, like all medical treatment, falls under section 16 of the SRC Act. This page provides information on commencing allied health treatment, gaps in treatment and ongoing treatment, and invoicing.

The following treatment is covered under the banner of 'allied health':

- Chiropractic
- Osteopathy
- Speech Pathology
- Dietetics
- Physiotherapy
- Exercise Physiology
- Podiatry
- Occupational Therapy, and
- Social Work.

Please note that psychology is also an allied health treatment. However, the processes and forms are different. See Psychology for full details.

Comcare can pay for the appropriate cost of allied health services, as medical treatment, where:

- the service is for the purpose of diagnosing or alleviating an injury
- there is clinical justification for the treatment for the compensable condition
- the treatment is likely to be effective and achieve or maintain measurable functional improvement, and
- the treatment promotes progress towards functional independence, participation, and self-management.

To assess and determine liability for allied health treatment, please follow the Procedure to determine liability for medical treatment.

Roles and responsibilities

The Claims Manager determines liability for allied health treatment. The Injury Manager provides support to the Claims Manager to help with assessing and determining liability. In some cases, a referral to the Clinical Panel may be needed, following consultation with the Injury Manager.

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Commencing allied health treatment

For most allied health services, a referral from a medical practitioner is not required but is encouraged for the employee to begin allied health treatment sessions. For dietetics, exercise physiology and social work, a referral is required.

Comcare requires an Allied Health Treatment Plan to be completed and submitted by the allied health treatment practitioner when:

- allied health treatment is expected to exceed five treatment sessions
- there has been a gap in treatment of greater than 12 months, or
- the employee attends a new treatment clinic.

The Claims Manager should email the employee via Pracsys with a link to the form which the employee can provide to their treating practitioner. This is to ensure the employee is able to read and consent to the privacy information on the form. All fields on the form should be completed by the allied health provider before it is submitted to Comcare. Comcare will fund the completion of an Allied Health Treatment Plan as part of the consultation session. See Invoicing for allied health treatment for payment details.

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Gaps in treatment

A gap in treatment is when no allied health services have been sought for more than 12 months, and treatment resumes after this period. Comcare is able to fund allied health services after a gap in treatment via the following process:

- completion of an Allied Health Treatment Plan **and**
- confirmation that the treatment is related to the compensable condition.

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Ongoing treatment

An Allied Health Treatment Plan can be marked as '*Initial*' for the initial treatment plan and '*Review*' for subsequent plans. The allied health treatment provider must provide a subsequent treatment plan marked as '*Review*' for any additional allied health services required beyond the initial treatment plan.

Generally, Comcare should only continue to fund allied health treatment if it:

- is the most clinically justifiable treatment based on the best available research evidence
- is achieving measurable progress towards goals focused on optimising function, participation and return to work
- empowers the employee to manage their condition, and
- considers any biological, psychological and social factors that could influence the employee's recovery or return to work.

Any period of ongoing treatment should be covered by an Allied Health Treatment Plan, with approval being for the number of sessions indicated, or otherwise agreed to by the treating practitioner, i.e. via [Undertaking a clinical Panel Review](#). This provides transparency and opportunity for review regarding proposed treatment, goals and progress toward self-management.

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Invoicing for allied health treatment

Comcare requires that the actual provider of the service is identified on each invoice for payment. It is the responsibility of the registered provider to ensure invoices submitted to Comcare are correct,

regardless of who has prepared the account. Invoices sent to Comcare must display the following information:

- employee name
- employee claim number
- date of services
- description of services
- item code
- service location
- amount billed for each service, and
- name of the treating allied health practitioner.

Note: Comcare will pay service providers a fee for providing a completed Allied Health Treatment Plan required by Comcare. Comcare will not pay for an additional treatment session on the day that an Allied Health Treatment Plan is completed.

Please refer service providers or employees who have questions to the following Comcare web pages:

- For information on rates Comcare will pay to consult on a treatment plan: Rates for medical and allied health treatment
- For information for allied health professionals: Allied health professionals

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Telehealth appointments for allied health treatment

If an employee wishes to claim for a telehealth appointment with an allied health provider, you need to assess the claim with the support of your Injury Manager.

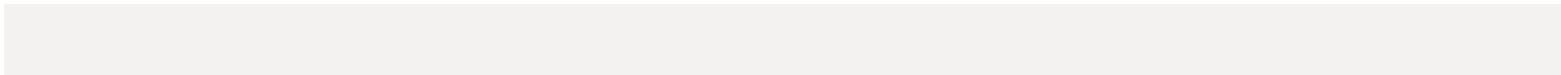
You can consider accepting claims for telehealth appointments if there are reasonable grounds for the employee to be unable to attend an appropriate appointment in person.

This may include physical inability to attend in person or the employee's remote location. However, you also need clear medical evidence, such as a clinical justification written by the treater or an appropriate medical practitioner, that the treatment can be effectively provided remotely.

Given the physical nature of most allied health treatment, it would not be appropriate to accept such a claim even if it is reasonable for the employee to attend an in-person appointment.

For more information, see [Medical treatment by online video call or telephone](#).

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Psychology

Introduction

Liability for psychology, as with other medical treatment, comes under section 16 of the SRC Act. Comcare can pay for the appropriate cost of psychology and/or counselling services as medical treatment, where:

1. the services are for the purpose of diagnosing or alleviating an injury
2. there is clinical justification for the treatment for the compensable condition
3. the treatment is likely to be effective and achieve or maintain measurable functional improvement, and
4. the treatment promotes progress towards functional independence, participation and self-management.

To assess and determine liability for psychology treatment, please follow the Procedure to determine liability for medical treatment.

Roles and responsibilities

The Claims Manager is responsible for determining liability for psychological treatment claims. The Injury Manager is available to provide support. Where advised by the Injury Manager, you can refer treatment claims to the Clinical Panel for expert review.

This page includes information about commencing psychology treatment, extended consultations, gaps in treatment, ongoing treatment, and invoicing for treatment.

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Commencing psychology treatment

A referral from a medical practitioner is not required for the employee to begin accessing psychological services. Comcare can fund an initial five sessions of psychology of up to 60 minutes each. After that, a Psychology Treatment Plan (PTP) must be submitted to Comcare.

Comcare requires a Psychology Treatment Plan to be completed and submitted when:

- psychology is expected to exceed 5 treatment sessions
- there has been a gap in treatment of greater than 12 months, or
- the employee attends a new psychology clinic.

The Claims Manager should email the employee via Pracsys with a link to the form which the employee can provide to their treating practitioner. This is to ensure the employee is able to read and consent to the privacy information on the form. All fields on the form should be completed before it is submitted to Comcare. Comcare will fund the completion of a PTP as part of the consultation session. See Invoicing for psychology/counselling treatment for information on payment.

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Extended consultations

Psychologists need to obtain prior approval where there is reasonable justification for consultations to exceed 60 minutes in duration. Without prior approval, Comcare will only fund a maximum of 60 minutes per consultation per day.

Requests for extended consultations can be made via a [Psychology Extended Consultation Request form](#). This form is required in addition to any Psychology Treatment Plan.

Note: All extended consultation requests are priority screened by the Clinical Panel.

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Gaps in treatment

A gap in treatment is when no psychology services have been received or requested for more than 12 months, and treatment resumes after this period. Comcare is able to fund psychology services after a gap in treatment via the following process:

- completion of a Psychology Treatment Plan form
- confirmation that the treatment is related to the work-related injury

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Ongoing treatment

A Psychological Treatment Plan can be marked as '*Initial*' for the initial treatment plan and '*Review*' for subsequent plans. The psychologist must provide a subsequent treatment plan marked as '*Review*' for any additional psychology services considered 'required' beyond the initial treatment plan.

Generally, Comcare should only continue to fund psychology treatment if it:

- is the most clinically justifiable treatment based on the best available research evidence
- is achieving measurable progress towards goals focused on optimising function, participation and return to work
- empowers the employee to manage their condition, and
- considers any biological, psychological and social factors that could influence the employee's recovery or return to work.

Any period of ongoing treatment should be covered by a Psychology Treatment Plan, with approval being for the number of sessions indicated, or as otherwise agreed to by the treating practitioner, for example following a [Clinical Panel Review](#). This provides transparency and opportunity for review regarding proposed treatment, goals and progress toward self-management.

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Invoicing for psychology/counselling treatment

Comcare requires that the actual provider of the service is identified on each invoice for payment. It is the responsibility of the registered provider to ensure invoices submitted to Comcare are correct, regardless of who has prepared the account. Invoices sent to Comcare must display the following information:

- employee name
- employee claim number
- date of services
- description of services
- item code
- service location
- amount billed for each service, and
- name of treating psychologist/counsellor.

Note: Comcare will pay service providers a fee for providing a completed Psychology Treatment Plan required by Comcare. Comcare will not pay for an additional treatment session on the day that a Psychology Treatment Plan is completed.

Please refer service providers or employees who have questions to the following Comcare web pages:

1. For information on rates Comcare will pay to consult on a treatment plan: Rates for medical and allied health treatment
2. For information for allied health professionals: Allied health professionals

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Transcranial Magnetic Stimulation (TMS) and Repetitive Transcranial Magnetic Stimulation (rTMS)

Introduction

This page provides information on Transcranial Magnetic Stimulation (TMS). Like all medical treatments, TMS falls under section 16 of the SRC Act.

You, as the Claims Manager, are responsible for determining liability for medical treatment. In the first instance, seek support from your Injury Manager when assessing and determining claims for TMS.

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What is Transcranial Magnetic Stimulation (TMS) and Repetitive Transcranial Magnetic Stimulation (rTMS)?

TMS is a mild form of brain stimulation. Magnetic fields, generated by a simple coil placed on the head, are used to stimulate a small area on the surface of the brain. In rTMS, pulses are given repeatedly for therapeutic effect.

Treatment is usually conducted in an outpatient setting over consecutive weekdays with an initial series of up to 35 rTMS sessions. The treatment does not require anaesthetic and is usually well tolerated with minimal side effects.

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Treatment with rTMS

Current evidence supports that rTMS may be used for Major Depressive Disorder that has been resistant to other forms of treatment. The evidence suggests that approximately 50% of these patients may experience a lower burden of disease. While research continues, there is a lack of current evidence for the use of rTMS for any psychiatric conditions other than treatment-resistant depression.

Provision of rTMS should always be under the supervision of a psychiatrist with appropriate expertise and accreditation by the Royal Australian and New Zealand College of Psychiatrists (RANZCP). This is to ensure the safe and effective application of treatment and accurate clinical decision making. For example, while rTMS may be effective for treating resistant depression, electroconvulsive therapy (ECT) may be a better choice for patients with extremely severe depression or depression with psychotic features. Monitoring outcomes of treatment should also occur regularly throughout treatment.

For further details on rTMS and its use in clinical practice, please refer to the RANZCP Repetitive Transcranial Magnetic Stimulation November 2018 Position statement: Repetitive Transcranial Magnetic Stimulation | RANZCP

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What can be approved?

The following actions can be approved:

- An initial comprehensive assessment with an rTMS-accredited psychiatrist. This assessment should:
 - determine the suitability of treatment
 - develop a treatment plan, and
 - provide baseline outcome measures such as the Hamilton Depression Scale to measure response to treatment.
- Acute outpatient rTMS treatment of up to 35 sessions after review by either an **Injury Manager** or, with agreement from the Injury Manager, the Clinical Panel.
- Repeat rTMS treatment of up to 15 sessions after review by the Clinical Panel in the case where:
 - an injured employee has relapsed (demonstrated through outcome measures) and
 - at least 4 months have passed since the acute series.

Any further request beyond one repeat series will be considered on its merits in consultation with the Clinical Panel psychiatrist.

Inpatient treatment

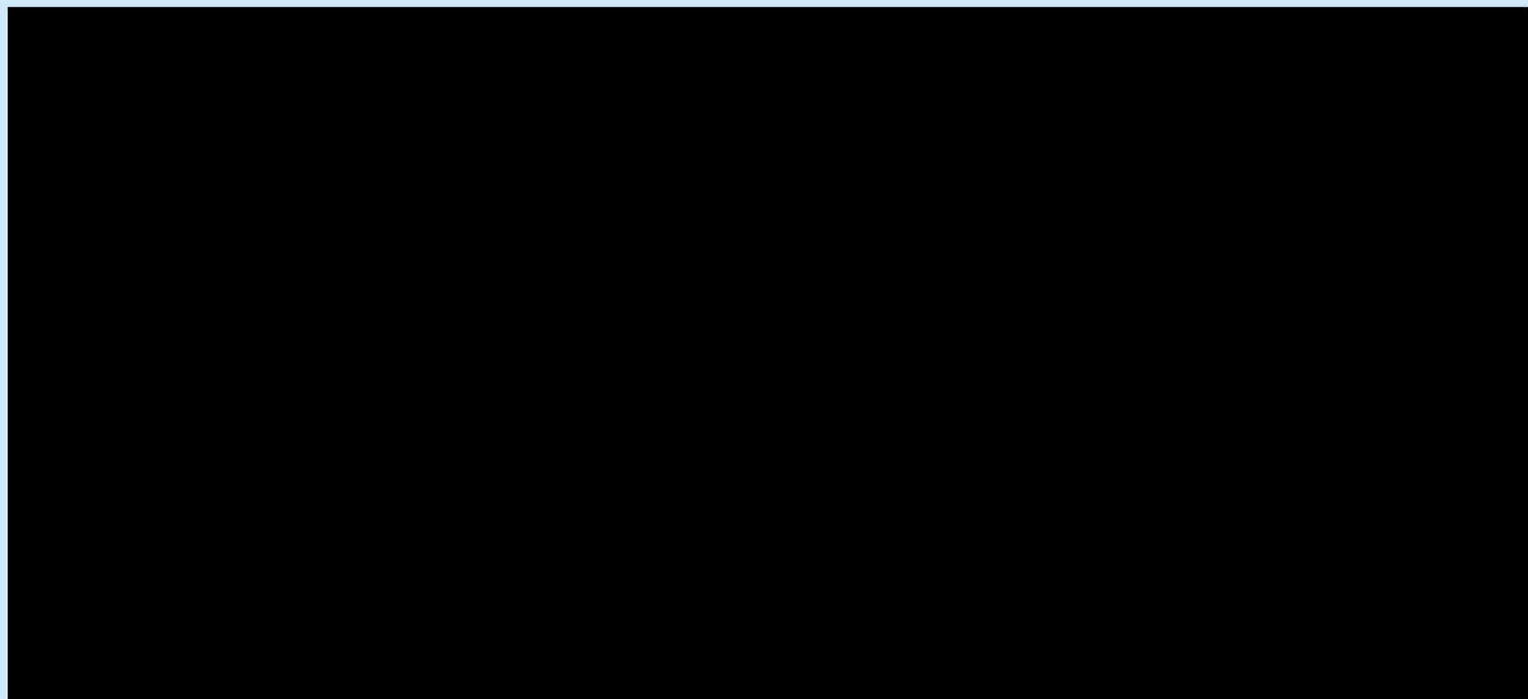
rTMS is not funded for inpatients. If an injured employee requires inpatient admission, this should be for reasons other than the need for rTMS treatment. If rTMS is separately approved for administration during an inpatient stay, then the cost is included in the bed fee for the inpatient admission. It cannot be billed as an additional fee.

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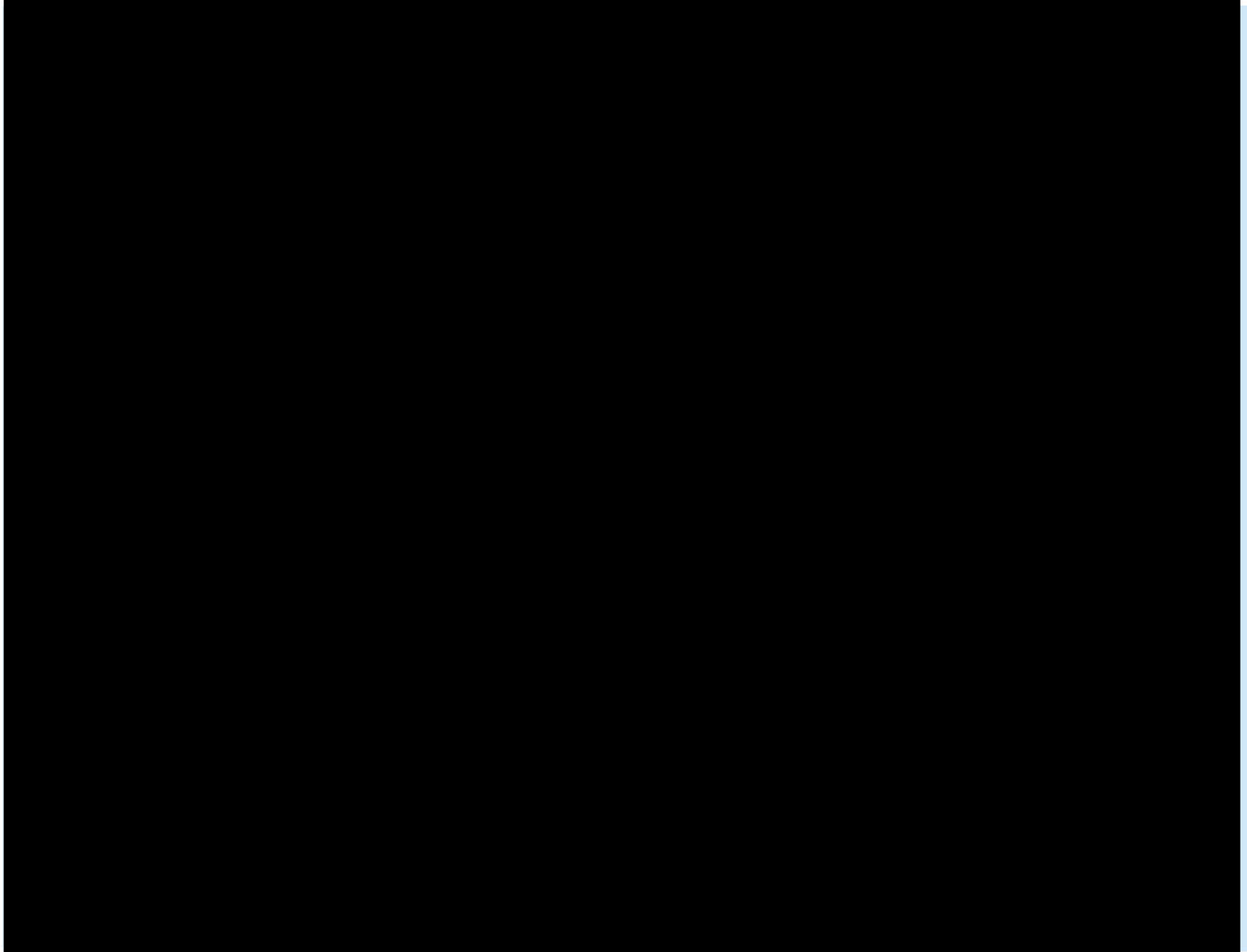
rTMS costs

Costs for requested rTMS should be in line with the Medical Benefits Scheme (MBS) schedule. You may determine to vary the amount paid in exceptional circumstances after discussion with an Injury Manager, your Assistant Director, and the Clinical Panel.

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Exercise, weight loss and gym

Introduction

Exercise as medical treatment includes activities such as gymnasium or swimming pool membership, personal training, exercise equipment and exercise classes such as hydrotherapy, yoga or Pilates. Requests may also include clothing and footwear used to perform exercise. This page also includes information about exercise to treat psychological conditions and to manage weight.

Relevant legislation

Liability for exercise as medical treatment and related expenses is provided under section 16 of the SRC Act. See also section 37 for exercise required for conditioning, strengthening or socialisation, described further in Exercise for treatment of psychological conditions. For further guidance on making a decision on medical treatment liability, refer to Determining liability for medical treatment.

Roles and responsibilities

The Claims Manager determines liability for exercise as medical treatment. The Injury Manager provides support to the Claims Manager to help with assessing and determining liability. In some cases, a referral to the Clinical Panel may be needed, following consultation with the Injury Manager.

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Claiming for exercise as medical treatment

A legally qualified medical practitioner (LQMP), physiotherapist, chiropractor, exercise physiologist or osteopath will usually prescribe exercises as medical treatment for the employee to perform independently at home or outdoors without supervision. This can occur during a standard consultation without Comcare being notified.

If an employee's clinical needs mean that they require additional assistance to complete their exercise, they can claim compensation for expenses related to the exercise. Additional support may include access to gymnasiums/pools, attendance at classes, assistance from personal trainers or equipment to allow them to complete the prescribed exercise.

Expenses for exercise as medical treatment are claimed by submitting a [Claim for Exercise as Medical Treatment](#) form. Part 1 of this form should be completed by the LQMP recommending exercise as medical treatment. Part 2 should be completed by the treating practitioner or exercise professional who will prescribe specific exercises to meet the employee's clinical needs.

Comcare can pay for a standard consultation with a LQMP during which an Exercise as Medical Treatment form is completed before determining liability for the exercises prescribed and related expenses.

If a claim for exercise and related expenses is received without a completed [Claim for Exercise as Medical Treatment](#) form, you should ask that the employee:

- submit a *Claim for Exercise as Medical Treatment* form completed by an LQMP and allied health practitioner to provide adequate information for Comcare to determine liability for the required exercise and related expenses
- have an LQMP, physiotherapist, exercise physiologist, osteopath or chiropractor prescribe appropriate exercises that can be performed independently. This should be referenced on the Allied Health Treatment plan submitted by the physiotherapist, exercise physiologist, osteopath or chiropractor. See the Allied Health page for more information.

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Assessing whether exercise and related expenses are reasonable medical treatment

Comcare can accept liability for exercise and related expenses that are:

- therapeutic medical treatment undertaken for the purpose of alleviating an injury
- obtained in relation to a compensable condition
- obtained at the direction of a legally qualified medical practitioner (LQMP)
- prescribed and/or supervised by a registered physiotherapist, exercise physiologist, osteopath or chiropractor
- reasonable for the employee to obtain in the circumstances (see Reasonableness criteria below), **and**
- appropriate in cost.

Support for exercise for the benefit of an employee's general health and fitness is not medical treatment under the SRC Act and is not compensable.

Maintenance treatment is not considered reasonable medical treatment under the SRC Act.

When considering requests for exercise as medical treatment, Comcare's preference is to facilitate the employee's return to work, their normal level of social function, and community integration. This goal should be considered when assessing requests for exercise as medical treatment.

Example: Supporting an employee to complete a prescribed exercise program at a gymnasium, or as a member of a class, may better support the employee's goal of improving social function, community integration and eventual return to work, compared with funding the provision of exercise equipment that allows the employee to complete the same exercises at home.

Reasonableness criteria

As with all claims for treatment, you will need to determine if the exercise and related expenses claimed are reasonable. Such expenses may be considered reasonable medical treatment if:

- the exercise is medical treatment based on the best available evidence in accordance with the definition of medical treatment in the SRC Act
- it is focused on meeting specific clinical needs and activity/functional related goals such as improved work capacity or ability to undertake activities of daily living
- support for the employee to exercise will end once the goals are achieved or the employee is empowered to manage their injury independently, and

the effectiveness of the exercise will be demonstrated using objective functional outcome measures and evidenced based practices in line with the Clinical Framework for the delivery of Health Services.

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Equipment for exercise

Comcare can pay for the cost of basic exercise equipment to empower employees to manage their injuries independently. Equipment for exercise needs to be recommended by a legally qualified medical practitioner (LQMP), the managing treatment practitioner or the exercise professional. Examples of such equipment are an exercise mat or foam roller. This is provided for under section 16 of the SRC Act.

If more expensive exercise equipment like an exercise bike is requested, consideration should be given as to whether the equipment is necessary and a reasonable way of meeting the employee's clinical needs in the circumstances. Hiring equipment can also be considered.

If an employee prefers exercise equipment with additional features to those required to perform the recommended exercise, the employee can pay the difference between the cost of adequate equipment and the equipment they would prefer at their own expense.

For exercise equipment that costs over \$2000, employees should be asked to provide three quotes. For less expensive exercise equipment, if you are not satisfied that the quoted price is appropriate, ask the employee to provide three quotes or research the appropriate cost independently.

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Supervised exercise sessions

Exercise sessions supervised by an exercise physiologist, personal trainer or other exercise professional, either at home or at a facility, may be reasonable if they are to teach an employee how to exercise safely, to review an employee's progress, or to transition an employee to independent exercise.

Supervised exercise sessions are generally not reasonable if the supervision is solely for the purpose of motivating an employee to exercise. You should discuss all requests for supervised exercise sessions with your Injury Manager.

For a non-complex injury, no more than **six supervised exercise sessions** would usually be needed to achieve treatment goals or transition an employee to independent exercise.

If more than six supervised sessions have been recommended, you should consider whether the number of sessions recommended is reasonable. You should base your decision about reasonableness on whether the sessions are necessary for the employee to perform the prescribed exercises and achieve the treatment goals.

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Gymnasium and swimming pool memberships

Comcare can pay joining fees for gymnasiums and swimming pools under section 16 of the SRC Act, where an employee needs to attend a gymnasium or swimming pool to complete exercise as medical treatment.

Requests for such memberships may be reasonable if an employee's treatment goals cannot be achieved safely through independent exercise or without expensive equipment. You should also consider the benefits of promoting social functioning and community integration.

Comcare should only pay for the level of gymnasium or swimming pool membership that is needed to perform the required exercises. If an employee would like to access additional services that a gymnasium or swimming pool facility offers, they can access the additional services at their own expense.

Generally, Comcare should only approve memberships of **up to three months**, as this is adequate to achieve most treatment goals. If a longer membership is recommended, you should consider whether it is a necessary and reasonable way for the employee to perform the prescribed exercises and achieve their treatment goals.

If you are not satisfied that a quote for a membership is an appropriate cost, you should ask the employee to provide three quotes or research the appropriate cost yourself.

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Exercise for treatment of psychological conditions

Requests for exercise as treatment for psychological conditions should be considered on a case-by-case basis and be discussed with your Injury Manager and Assistant Director. There is increasing evidence to support exercise as treatment for psychological conditions, however the evidence varies according to the specific psychological condition. For a request to be approved as treatment under section 16 of the SRC Act:

- evidence needs to be provided that the exercise is specifically for management of an employee's psychological condition, and
- there needs to be evidence that the requested exercise is an accepted treatment for that condition.

If the request is for general conditioning, strengthening or socialisation it would not be considered as treatment and not covered by section 16 of the SRC Act. However, such a request may be considered as preparation for return to work and may therefore be covered under section 37 of the SRC Act.

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Management of weight loss

Requests for exercise as treatment for weight loss should be considered on a case-by-case basis. For a request to be approved under section 16 of the SRC Act, the need for the employee's weight loss must relate to their compensable condition. The relationship between the compensable condition and the need to lose weight needs to be demonstrated. Typically, the weight gain (leading to the need for weight loss) will be a secondary consequence of the compensable condition. Reasons that treatment for weight gain / obesity may be compensable include:

- side effects of medication
- limitations on activity caused by a compensable condition
- psychological factors such as stress and depression
- weight loss being required to facilitate more effective treatment and return to work and health outcomes.

You may determine that Comcare is liable for an employee's weight loss treatment if the following criteria are met:

- the employee has gained weight as a direct result of a compensable condition or medical treatment for a compensable condition, **and**
- the weight gain is having an identifiable and harmful impact on the employee's health, **and**
- the employee is unable to manage their weight independently through a healthy diet and lifestyle due to their compensable condition.

Evidence should be provided to support claims for treatment related to weight gain. The evidence should support:

- the degree and cause of weight gain
- its impact on the employee's health and
- their inability to self-manage.

In the case where pharmacological treatment for a compensable condition has caused or is causing weight gain, evidence should show that marked weight increase is a recognised side effect of the medication being taken.

If Comcare has accepted that it is liable for an employee being overweight or obese, you may subsequently determine whether Comcare is liable for weight loss treatment. Comcare should generally only accept liability for weight loss treatment that will target a cause of weight gain or obesity related to a compensable condition or its treatment.

Weight loss treatment may not address the reason an employee is unable to manage their weight independently due to a compensable condition (or its treatment). In this case, the intervention may not be effective or reasonable for the employee to obtain. Requests for exercise as medical treatment for the **general health benefits** of weight loss would **not** be considered as treatment under Section 16 of the SRC Act.

Weight loss treatment for employees who were overweight prior to injury

You may receive requests for weight loss treatment for:

- the purpose of improving post-surgical outcomes
- reducing the risk of surgery being undertaken for a compensable condition, or
- to assist in the recovery of an injury, typically of a weight bearing joint or the spine.

These requests can be more complex when the employee was overweight prior to their injury, but when reduction in their post-injury weight will demonstrably improve treatment and return to work outcomes. In such cases, you will need to consider the specific circumstances of the claim. For example, has the employee gained weight since the injury for reasons related to that injury? Is the proposed weight loss treatment part of an overall treatment program? And what are the expected outcomes in relation to function and return to work?

Liability for food, diet programs and supplements

Comcare will not accept liability for food including diet programs such as Light and Easy, dietary supplements or meal replacements. This is because food is an ordinary expense and is not medical treatment under the SRC Act. Exceptions may apply where dietary supplements or meal replacements are medically necessary to treat or alleviate the compensable condition and there is clear clinical support from both an LQMP **and approval from** the Clinical Panel. See [Dietary foods](#) for more.

Example: An employee undergoes compensable stomach surgery. The surgeon advises that dietary supplements and meal replacements are required as part of post-surgery medical treatment. The Clinical Panel agrees with the surgeon and approves the supplements and meal replacements as medically necessary for a specified period of time.

The Claims Manager should assess the packaged foods as meeting the definition of 'medicine' under section 4(1)(h) of the SRC Act.

Bariatric surgery

In general, bariatric surgery (weight loss surgery) should only be considered when all other types of interventions to induce weight loss have failed. All requests for bariatric surgery should be forwarded to the Clinical Panel for review.

Injury Managers will be able to assist in making the appropriate determination for treatment to manage weight loss.

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Exercise clothing

Clothing

There is no provision under the SRC Act that provides compensation for clothing or the replacement of clothing. Clothing is considered an ordinary item required by all persons, whether they have suffered an 'injury' or 'impairment' and requires replacement due to wear and tear or bodily changes (however this occurred).

Shoes

Claims for shoes must be assessed on the individual merits of the case and the medical information provided. You must consider whether the claimed shoes fall within the definition of 'medical treatment' under section 4 of the SRC Act for compensation to be payable.

There may be cases where shoes, such as ordinary runners, meet the definition of medical treatment when recommended in combination with prescribed orthotic inserts.

You will need to consider (and possibly seek further information from the treating practitioner) about whether a specific type of ordinary shoe is required, or whether any shoe will suffice.

A recommendation of a specific type/brand of shoe does not mean it is compensable under the SRC Act. It is only when the type/brand of shoe (usually coupled with orthotics) is recommended to improve the efficacy of medical treatment (i.e. orthotics) that compensation for the shoes should be considered.

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Payment for reports

Comcare will not pay for reports related to exercise that it has not requested, because these unsolicited reports are not medical treatment under the SRC Act. For further guidance, refer

to [Obtaining medical report or clinical notes](#).

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Pain Therapy

Introduction

Pain therapy may consist of Pain Management Programs, Implantable Pain Therapy, Spinal Cord Stimulators, Platelet Rich Plasma Injections and Spinal Injection therapies. These are also referred to as invasive pain therapies. Pain therapy interventions usually occur in complex circumstances. These invasive therapies may also be requested in isolation or as part of a broader treatment program. Each type is discussed in a new section on this page.

This page also includes information on Pain Management Programs (PMPs). These may be provided by a multidisciplinary team that typically consists of a doctor, psychologist, nurse, occupational therapist and physiotherapist. A PMP may be requested with or without the invasive pain therapies mentioned above.

Legislation

Pain therapy, as with all medical treatment, falls under section 16 of the SRC Act.

Roles and responsibilities

The Claims Manager determines liability for pain therapy. The Injury Manager provides support to the Claims Manager to help with assessing and determining liability. In some cases, a referral to the Clinical Panel may be needed, following consultation with the Injury Manager.

Clinical Panel review required

There may be cases where significant complications or adverse conditions may arise as a result of such therapies/injections. Or there may be insufficient evidence to support the proposed intervention. Therefore, requests for these types of therapies **must** be referred to the Clinical Panel.

Before you contact the Clinical Panel, you must obtain relevant information on the specific therapy which you need to provide the Clinical Panel for review. The information required for each type of pain therapy is detailed in the following sections on this page.

Seek help from your Injury Manager in the first instance when assembling the information in preparation for the Clinical Panel review.

Requests for these treatments should be provided in writing by the legally qualified medical practitioner (LQMP) carrying out the procedure.

All pain therapy treatment requests must:

- meet the requirements of the Clinical Framework for the Delivery of Health Services
- be discussed with an Injury Manager
- be referred to the Clinical Panel – for further guidance refer to the [Clinical Panel review](#) page

- be determined under section 16 of the SRC Act.

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Pain Management Programs

Pain Management Programs (PMPs) may be appropriate for employees with an injury and resulting pain that:

- impacts their physical and mental health
- impacts their ability to undertake their normal activities
- requires them to take medication to control their pain that may further impact their long-term health or impede their function.

The aim of a PMP is to reduce the impact pain has on the injured person's life with a resultant improvement in independence and function.

PMPs have historically been used after all other treatments have been exhausted. However, they may be more effective if undertaken in the early stages of recovery. The goal of such programs is to support the injured person to develop skills to manage their health and wellbeing more independently, allowing more activity and less reliance on medication to manage pain.

The specifics of each PMP can vary. Typically, there will be one-on-one sessions with a doctor, psychologist and physiotherapist and group sessions for educational talks, learning new skills and exercise. The duration of PMPs can also vary but will typically be 8 to 12 weeks. PMPs may be delivered on an outpatient or inpatient basis. Because of the variation in PMPs, it is vital that the injured person is assessed as being suitable for the PMP being considered – the type and content of a particular PMP may not be suitable for a particular person, but another PMP may.

Possible **contraindications** (circumstances that suggest a particular treatment should **not** be used) to participating in a PMP are:

- severe and/or uncontrolled mental health conditions (such as depression, anxiety and post-traumatic stress disorder)
- taking high doses of some pain medications
- discomfort in group settings
- limited English language or reading skills.

The benefits of a PMP can take several months after the completion of the program to be realised. It may also be necessary to undertake a PMP more than once.

When assessing a request for a PMP, the general principles for providing medical treatment still apply. When receiving a request for a PMP (in addition to any other pain therapies), ensure the treating health practitioner recommending the therapy has advised:

- the diagnosis, location of pain and relationship to the work-related injury or illness
- objective outcome measures (e.g. pain scores) to be taken pre-PMP and post-PMP in line with the Clinical Framework for the Delivery of Health Services
- description (inpatient/outpatient, duration, components of the program) and expected costs of the program
- details regarding previous pain therapies/PMP for this injury and what were the objective outcome measures (i.e. pain chart scores) for the previous pain therapy/PMP

- they have considered how appropriate the PMP is for the injured person.

Due to the complexities associated with requests for PMPs, they need to be discussed with the aligned Injury Manager and sent to the Clinical Panel for advice. Following completion of an approved PMP, you should seek a post-program report. This should provide information on program outcomes and future treatment/rehabilitation needs of the injured person.

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Implantable Pain Therapy

Implantable Pain Therapy (IPT) involves the use of an implantable prosthetic device to address persistent pain. It may be considered when a range of alternatives for managing persistent pain have been fully explored.

IPT includes intrathecal analgesia (intraspinal pumps) and neurostimulation techniques (spinal cord stimulators).

There are three stages to IPT, and each stage must be completed in sequence:

1. Trial of neurostimulation or intrathecal analgesia
2. Implantation of a permanent IPT device
3. Replacement/repair of existing IPT (i.e. battery or device replacement).

Trial of neurostimulation or intrathecal analgesia

Where requests are received for trial of neurostimulation or intrathecal analgesia, you should ensure a written clinical rationale has been provided that includes the following information:

- the condition(s) being treated and the relationship to the work-related injury or illness
- a description of the IPT procedure with details of the prosthetic items being used
- the clinical indication for the IPT procedure, including reasons why more conservative treatments that the employee has tried for pain management have not been effective
- psychological suitability from treating psychologist/psychiatrist or independent psychiatrist
- anticipated effects the IPT will have on the employee's participation in activities of daily living and work, mobility, pain levels, mood, and medication use (i.e. expected reductions)
- objective pre-IPT and post-IPT outcome measures (e.g. pain charts) that will be used to measure the effectiveness of the procedure
- anticipated treatment plan following IPT procedure.

Where the above is not adequately addressed by the recommending doctor (you should attempt to follow up with the recommending doctor first, with help from your Injury Manager if necessary), you may consider seeking an opinion from an independent Pain Rehabilitation Specialist. This will help you to clarify the employee's suitability for the treatment, and the relationship to the compensable condition. See Independent Medical Examinations for more information.

Implantation of a permanent IPT device

Requests for implantation of a permanent IPT device, such as a spinal cord stimulator, should include the following information:

- a description of the IPT procedure with details of the prosthetic items to be used

- the objectively measured outcomes (e.g. pain charts) of the trial (stage 1 of the IPT procedure).

Replacement/repair of existing IPT

Requests for replacement or repair of an existing IPT device must include the following information:

- a description of the IPT procedure with details of the prosthetic being used
- evidence of the effectiveness of the IPT to date, including effect on employee's pain and function
- justification stating why the procedure or replacement is required and details regarding the urgency of the request
- an indication of whether replacement device parts are under warranty.

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Platelet Rich Plasma Injections

A Platelet Rich Plasma (PRP) injection involves injecting a small amount of a person's own blood into soft tissue injuries to facilitate the natural healing process. It is currently considered as a non-established and new or emerging therapy (NENET). Experimental medical treatments are usually not considered reasonable.

To assist the Clinical Panel review, you should ensure the treating health practitioner recommending the PRP injection has provided the following information:

- the diagnosis and the relationship to the work-related injury or illness
- evidence-based studies (Level 1 or 2) for the clinical indication being requested
- details of all previously trialled treatments and services for the compensable condition and their measurable outcomes
- description, expected costs of injections and whether they are intending to use MBS item codes
- objective outcome measures to be used (pre-procedure and post-procedure) and timing of assessment
- expected outcomes from the proposed treatment, including functional outcomes (e.g. return to work)
- the name, qualifications, skills and experience of the provider(s) requesting and performing the treatment.

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Spinal Injection Therapies

Spinal Injection Therapies include epidural injections, medial branch blocks, facet joint injections and sacroiliac joint injections.

You should ensure the treating health practitioner recommending the spinal injections has advised:

- the diagnosis, location of pain and relationship to the work-related injury or illness
- objective outcome measures (pain scores) to be taken pre and post injections in line with the Clinical Framework for the Delivery of Health Services
- description and expected costs of injections (MBS item numbers) in line with AMA rates
- the exact location (levels and sides) and number of proposed injections

- details regarding previous injections in these areas and what were the objective outcome measures (i.e. pain chart scores) for the previous injections.

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Cortisone injections

Unlike the other pain therapies on this page, cortisone injections do not require review by the Clinical Panel. However, as with all claimed medical treatment, you need to ensure that there is medical evidence to support its use to improve or alleviate the compensable condition. You need to discuss the claim for cortisone injections with your Injury Manager.

Cortisone injections involve injecting corticosteroids, usually into joints such as the hip, knee, shoulder, spine or wrist, to reduce pain and swelling or inflammation. Conditions that may require cortisone injections include:

- osteoarthritis (when people develop pain and inflammation in their joints)
- tendonitis (when tendons around bones and muscles become inflamed)
- lower back pain
- carpal tunnel syndrome, and
- bursitis (when the fluid sacs that normally act as a cushion between bones, muscles, and skin become inflamed and painful).

While the injection is useful in reducing pain, it typically doesn't cure the underlying problem that is causing the inflammation. In some cases, however, when the problem is caused by a temporary increase in inflammation, a steroid shot can reverse that process and cure the patient's pain. In some cases, one or several cortisone shots can cure a condition, particularly those that affect the hand and wrist. But for conditions that affect the knees, shoulders, and hips, a cortisone injection will make the pain better for a period of time but is seldom curative.

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Surgery

Introduction

Liability for surgery, as with other medical treatment, comes under section 16 of the SRC Act.

Surgery may range in complexity from the relatively simple (e.g. repairing a fractured finger) to the very complex (e.g. cardiac/cardiovascular surgery). The potential complications of surgery and post-surgical rehabilitation and recovery can also vary significantly. Degenerative or systemic effects of a disease (e.g. joint replacement surgery) can add additional complexity to determining liability.

This page contains information about surgery costs, requests from hospitals, urgent surgery requests, post-surgery reports and treatment, and the procedure to assess and determine claims for surgery.

Additional support and consultation

The Claims Manager is responsible for determining liability for surgery claims. You should consult your Injury Manager when considering requests for surgery.

Requests for complex and / or major surgery **must** be referred to the Clinical Panel for review. This includes (but is not limited to):

- back surgery
- cardiac pacemaker insertion
- joint replacement
- joint surgery and
- joint replacement revisions.

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Surgery costs

Costs for a requested surgery should be in line with the fees recommended by the Australian Medical Association (AMA).

While Comcare prefers to use the AMA list of medical services and fees as a guide for determining surgery costs, the AMA recommended fees are not legally binding.

You have the discretion to determine an amount above the AMA recommended fees in exceptional circumstances, depending on the facts and circumstances of the case, and after discussion with an Injury Manager and your Assistant Director.

When a surgery is charged above AMA rates, the details of the individual case must be reviewed to consider the appropriateness. For example, if the employee is in a remote location where alternative surgeons are limited, the surgery is particularly complex, or if the injured employee requires an unusual or emerging procedure, accepting an increase in rates may be appropriate.

You must consider each case on its merits. The enquiry template can be used to seek a rationale from the surgeon regarding their proposed fee if required.

Other factors that you may need to consider in determining surgery costs:

- the surgeon's specialties and/or experience required to perform the surgery
- the cost of any travel or accommodation the employee may need if they were to travel to another location to obtain the surgery
- the support or transport available to the employee if they were to travel to another location to obtain the surgery.

If all options have been exhausted, and the employee wishes to proceed with their selected surgeon, accepting an increase in rates should be considered in discussion with an Injury Manager and your Assistant Director. Unnecessary delays in making a determination should be avoided, as this leads to the employee's surgery being delayed which can have negative consequences and extend the employee's recovery time.

In cases where multiple surgeries are to be performed at the same time, the fees quoted need to comply with the Medicare Benefits Schedule (MBS) multiple operation rules. The Clinical Panel can help you review the appropriateness of proposed surgical item codes and surgical costs, provide insights on treatment, and apply the MBS rules.

A current copy of the AMA's list of medical services and fees can be found on Claims HQ rates page.

Previous copies of the AMA's list of medical services and fees can be requested from Claims Governance.

Internal use only: the AMA list of medical services and fees is for internal use only and should not be provided to external stakeholders including service providers.

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Hospital accommodation costs

Hospital accommodation costs are limited to a shared room (unless the hospital does not have shared rooms). In some cases, a private room can be approved if it is medically required, and medical evidence is provided supporting the request.

Comcare is unable to pay for television hire, telephone calls or other personal expenses such as additional food or snacks (not provided as part of the hospital accommodation costs), newspapers, toiletries etc as they are not covered by the SRC Act. These costs are the responsibility of the employee.

For more guidance on appropriate costs please refer to the [What are appropriate costs?](#) page

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Approval requests from hospitals

Hospitals may request a signature on a form or contract to authorise them to admit an employee to hospital and/or confirm that Comcare will pay for costs. Comcare staff **should not** sign forms or contracts from hospitals authorising admission or medical treatment on an employee's behalf. This is because there is a risk that signing documents could make Comcare liable for costs if the employee fails to attend a scheduled admission or treatment.

In these circumstances, you can advise the hospital of your determination to accept liability for the surgery and related costs. No further information about the claim should be released to the hospital

without the employee's permission.

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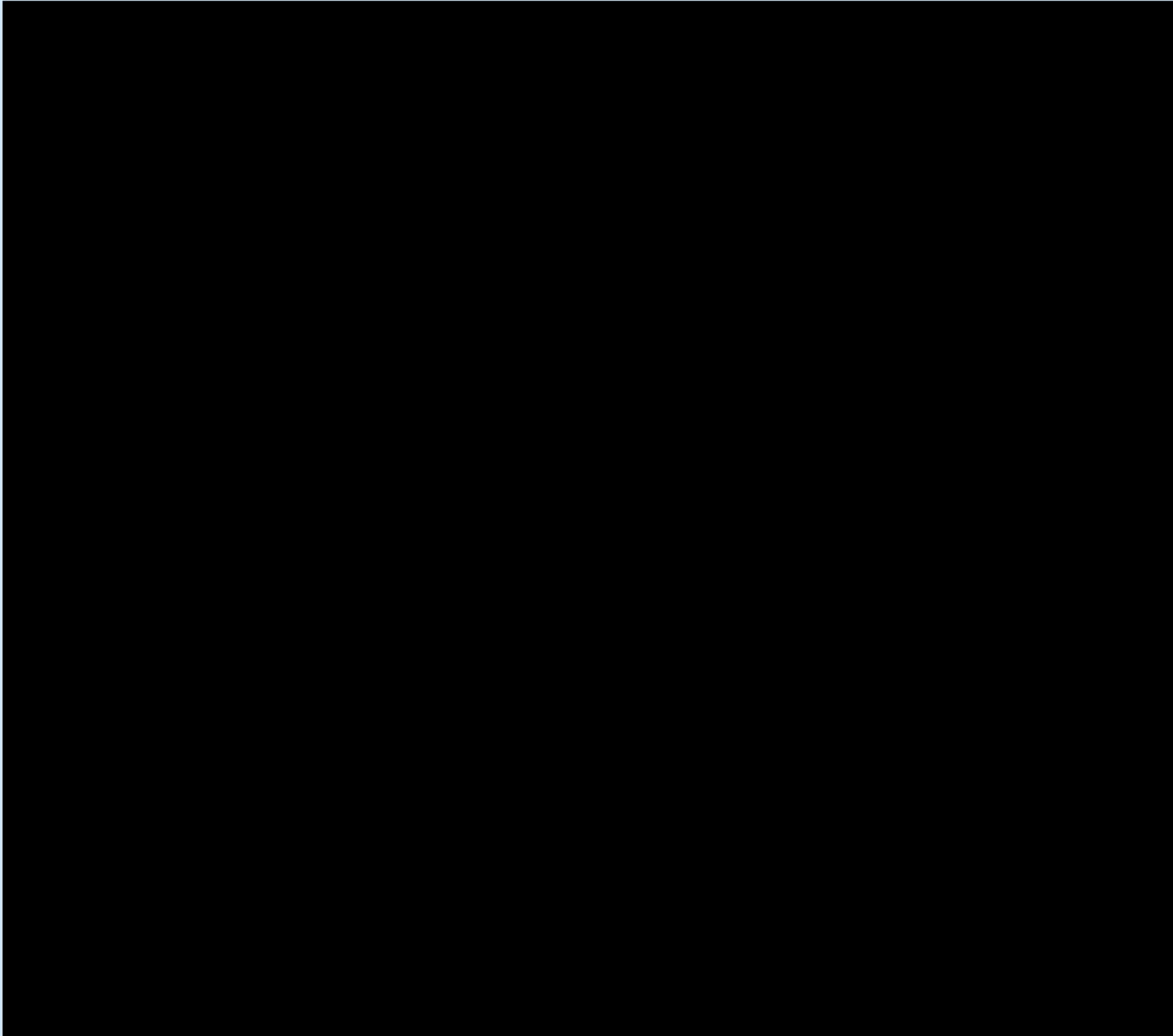
Urgent requests for surgery

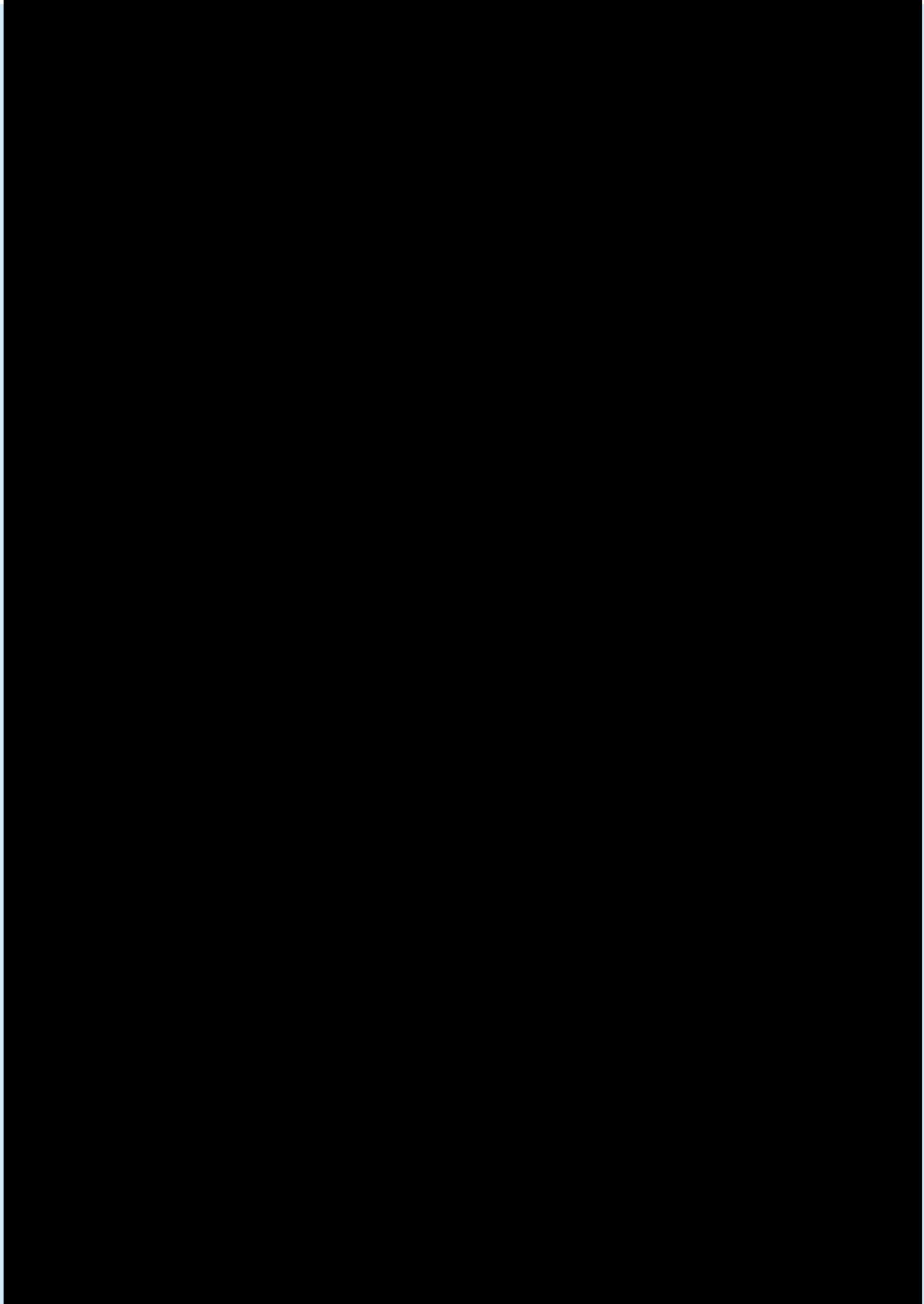
You may receive requests for approval of urgent surgery. Requests for surgery are considered urgent if the need for surgery is a medical emergency posing an immediate risk to the employee's life or long-term health.

Liability for surgery should not be accepted just because the need for the surgery is urgent. Where the need for surgery is urgent, it is expected that healthcare providers and employees will proceed with the necessary surgery, while a determination is made as to whether Comcare is liable for the costs.

This applies to requests for surgery that are advised as being urgent but where there is no immediate risk to the employee's life or long-term health. If you need assistance in relation to an urgent surgery request, speak with an Injury Manager first and contact the Clinical Panel if/as necessary.

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After surgery

Post-operative reports and processing invoice items related to surgery

Following surgery, you should obtain a copy of the surgeon's post-operative report. Please note that receipt of the post-operative report by Comcare is a requirement before payment of the surgical invoice is considered. This is to ensure that Comcare has a record of the surgical intervention undertaken (which may include different elements to what was originally proposed) and to provide a document which can be cross-referenced against the surgical invoice.

Once the post-operative report is on file, payment for surgery should be made on receipt of the invoice and in line with the amount Comcare accepted to pay pre-operatively. If there are additional charges or any charges that appear excessive, the invoice(s) should be placed on hold and referred to the Clinical Panel for review. For further guidance, consult with your Injury Manager and refer to the information in the Undertaking a clinical panel review page.

Further medical treatment and household assistance following surgery

Review of post-surgical requirements should be discussed with Injury Management either in a claim review meeting and/or in a separately scheduled meeting (when requirements are likely to be complex).

You should have a discussion with the Injury Manager about an employee's post-surgical requirements. If you agree that an employee will benefit from a Rehabilitation Program to assist them

to return to work following surgery, you should contact the employee's Rehabilitation Case Manager (RCM) to discuss the necessary requirements.

The employee may require further medical treatment and/or aids or appliances recommended by the surgeon to achieve an optimal level of function following surgery. For further guidance, refer to the following pages:

- Medical aids and appliances under section 16
- Rehabilitation aids, appliances, alterations and modifications under section 39
- Considerations for aids, appliances, alterations and modifications under sections 16 and 39

The employee may also require household assistance and/or attendant care for a period of time following surgery. You should discuss these with the employee before the surgery and again afterwards to ensure they receive the assistance they need. For further guidance, refer to the Home help and attendant care page.

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Nursing homes

Introduction

An employee may be required to live in a *nursing home* or other similar facility. As Claims Manager, it is your responsibility to determine claims for nursing home costs. Consult with your Injury Manager in the first instance for help with assessing liability for nursing home costs.

Relevant legislation

Section 16 of the SRC Act is the relevant section for liability for medical treatment.

Section 22 relates to an employee living in a hospital, nursing home or similar place for more than 12 months. If an employee lives (is maintained) in one of these places as a result of their compensable injury for more than 12 months, their entitlements to compensation for incapacity may be affected. In these circumstances you must ensure you are correctly determining liability for medical treatment, incapacity and any other benefits claimed by the employee or the employee's representative.

See also information below about the Aged Care Act 1997.

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Interaction between the Aged Care Act 1977 and the SRC Act

The Aged Care Act 1997 (AC Act) sets out matters relating to residential nursing home care. This Act itself does not have any impact upon the determining of benefits under the SRC Act.

Accommodation costs for nursing homes and aged care homes are provided via a subsidy under the Aged Care Act 1997. The subsidy is a payment by the 'The Department of Health, Disability and Ageing' to an approved provider for providing residential care to an approved care recipient as a certified service.

If an employee living in a nursing home receives compensation payments under the SRC Act, this should not result in a reduction of any residential care subsidy payment the provider is entitled to under the AC Act. The subsidy should not be affected at all by any compensation benefits determined under the SRC Act.

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What compensation benefits are payable when an employee is in a nursing home?

An employee living in a nursing home, hospital or other similar place may be entitled to compensation (in relation to their compensable condition) for:

- medical treatment (including nursing care)
- incapacity

- aids and appliances, and
- [permanent impairment](#) – for further guidance, refer to the [Permanent impairment](#) pages.

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What compensation benefits are not payable when an employee is in a nursing home?

An employee who is maintained in a nursing home is not eligible under the SRC Act for compensation in relation to:

- attendant care services
- household services (unless the employee is only in the nursing home for short-term respite care)
- nursing care provided as part of an overall package (i.e. it is included with the accommodation where the two services are not invoiced separately), or
- any costs associated with the nursing care accommodation (including respite care).

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Payment for nursing care services when employee is in a nursing home

When an employee is maintained in a nursing home, payment should only be made for nursing care where:

- the service(s) provided are in addition to those normally provided by the nursing home facility and
- no residential care subsidy has been paid. Specifically, in the case of a nursing home or aged care facility, no residential care subsidy can have been paid under the *Aged Care Act 1997* (AC Act) that includes payment for the services.

Payment for nursing care received at a hospital, nursing home or other similar place would generally only be made where the nursing care was provided by a qualified nurse who is not employed by the facility. That is, the service is not ordinarily provided by the facility and is required in relation to the compensable condition.

See the [Procedure to determine liability for nursing care](#) to assess liability for these claims.

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Compensation for nursing home accommodation

There is no provision under the SRC Act to pay nursing home accommodation and/or costs associated with nursing home accommodation, such as facilities and meals. The definition of 'medical treatment' in section 4(1)(g) of the SRC Act does not include maintenance as a resident in a nursing home, only maintenance as a patient in a hospital.

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Reduction of incapacity entitlements

When:

- an employee is maintained in a hospital, nursing home or similar place for more than 12 months as a result of their compensable condition, and
- there are no persons financially dependent on the employee,

Comcare is obliged to consider **reducing** the employee's incapacity entitlements, having regard to their present and probable future needs and expenses (section 22).

When considering whether to reduce an employee's incapacity payments you need to establish if the employee has any other needs or expenses beyond those being met as a patient in a hospital or nursing home environment.

Other needs and expenses may include, but are not limited to:

- costs of the hospital/nursing home/nursing care
- mortgages, loans, insurance, rent and other expenses relating to major items owned by the employee, such as a house and car
- medical insurance
- clothing and toiletries
- books, magazines and periodicals
- entertainment/gifts, and
- any other personal needs.

Other expenses and needs an employee may have that should also be taken into account can include:

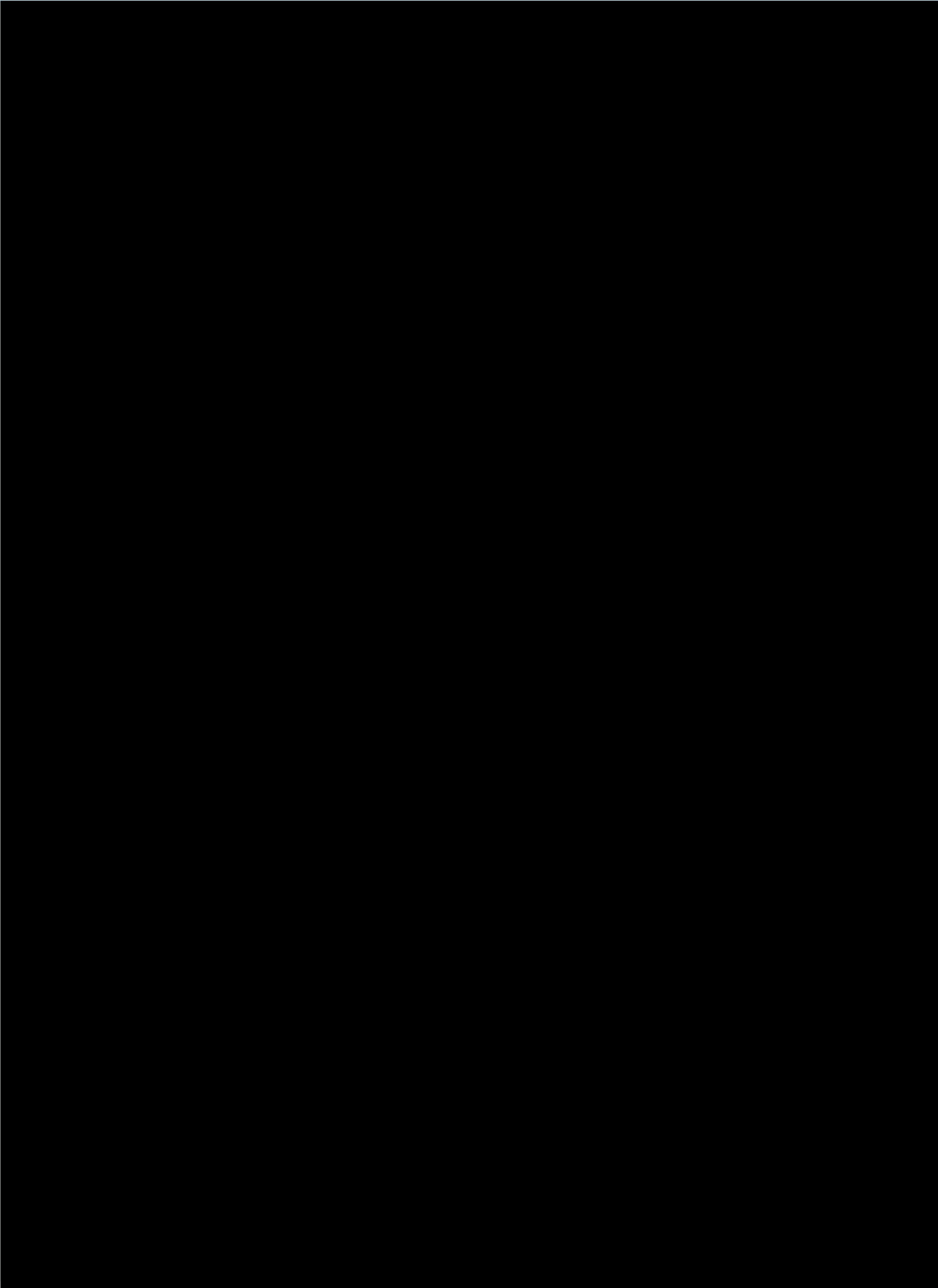
- those which may fall under 'enjoyment of life' expenses
- other expenses the employee is required to continue to pay such as child support maintenance, and
- the period the employee is expected to remain in hospital or the nursing home.

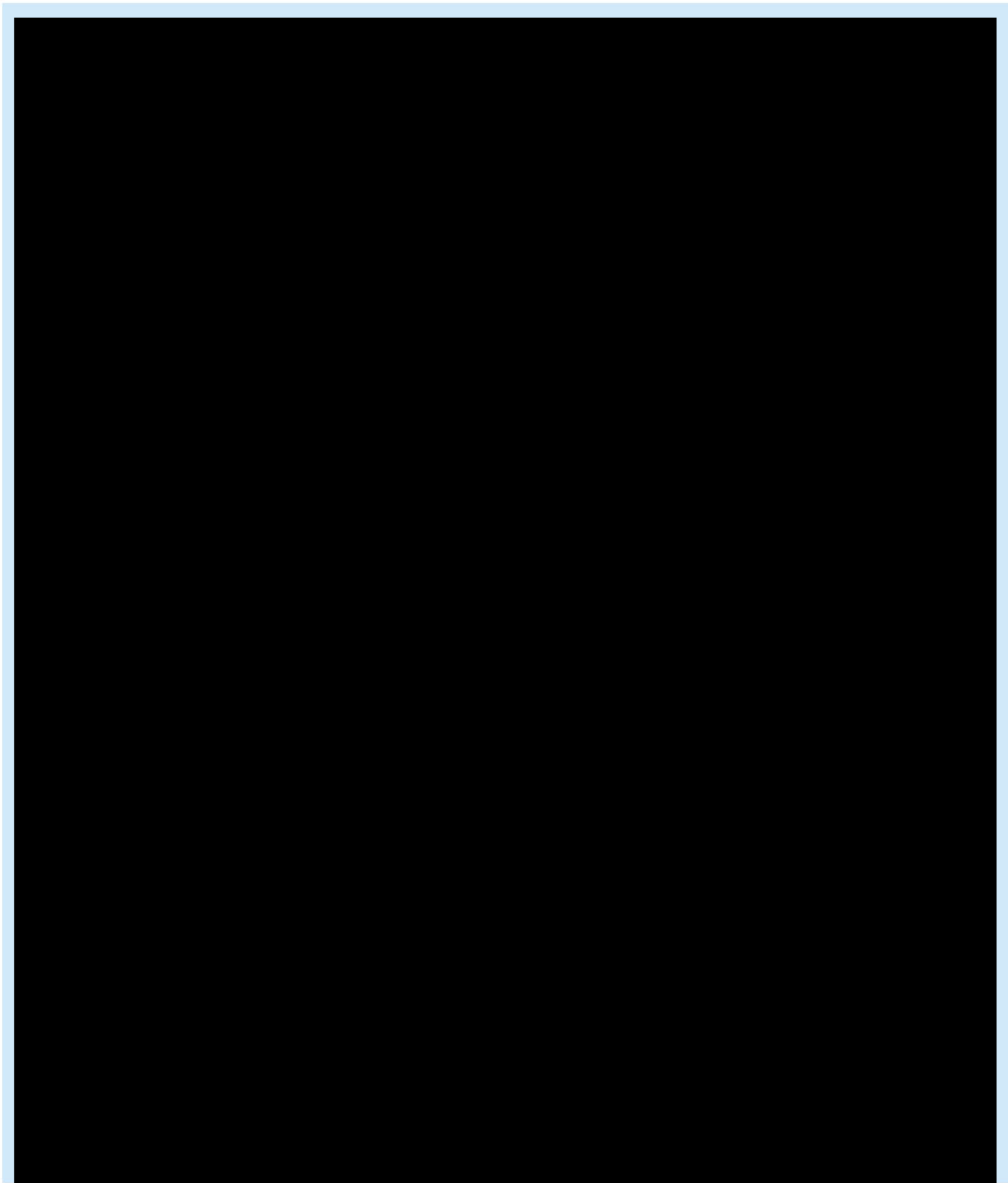
You should only consider reducing an employee's incapacity entitlements when the employee's total expenses are significantly smaller than their total income, inclusive of workers' compensation payments.

Note: Section 22 of the SRC Act specifies the amount determined **cannot be less than half** of the employee's current incapacity payments.

Example: An employee is, and continues to be, hospitalised for 53 weeks following a work-related accident. Their Normal Weekly Earnings (NWE) is \$500.00. As the employee has been incapacitated for more than 45 weeks their entitlement is currently 75% of their NWE (\$375.00).

Under section 22 of the SRC Act, the employee cannot receive less than half of their current entitlement ($\$375.00 \times 0.5 = \$187.50$) per week. A Claims Manager should have regard to all the considerations above before reducing the employee's incapacity payments.





Dental Treatment

Introduction

Liability for dental treatment comes under section 16 of the *Safety, Rehabilitation and Compensation Act 1988* (SRC Act). Dental treatment may vary in complexity from simple to very complex dental treatment or procedures, e.g. dental implants.

Dental treatment must be undertaken by, or under the supervision of, a legally qualified dentist (LQD). The legally qualified dentist must have control of the relevant treatment either by providing or supervising the recommended treatment.

Dental treatment may consist of:

- check ups
- x-rays
- fillings
- tooth removal/extraction
- restoration of teeth including crowns and veneers
- dental implants
- dentures or bridges
- orthodontic treatment
- oral-maxillofacial surgery

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Clinical Panel review required

Requests for complex or major dental treatment or procedures must be referred to the [Clinical Panel for review](#). This includes (but is not limited to):

- dental implants
- oral-maxillofacial surgery
- treatment for bruxism, and
- major ongoing dental treatment.

You should consult with your Injury Manager or Assistant Director before referring the request to the Clinical Panel.

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Considerations when determining liability for dental treatment

When determining liability for dental treatment, you need to be satisfied:

- the employee has a compensable condition
- the treatment is:

- medical treatment as defined in the SRC Act
- obtained in relation to the compensable condition, and
- reasonable for the employee to obtain in the circumstances.

If any one of these criteria is not met, then liability is likely to be declined with Assistant Director review as per guidance within 'Determining liability for medical treatment'

Compensable and non-compensable injury or conditions

Comcare is only liable for the cost of the dental treatment that is needed in relation to the employee's compensable injury or condition.

Where the employee needs dental treatment for both compensable and non-compensable injuries or conditions, you will need to discuss this with the employee and request a quote from the dentist in relation to the treatment for the compensable injury or condition only.

Secondary conditions

You may receive a claim for a secondary condition that is caused by or related to the employee's primary injury or condition.

Example

An employee suffers from a physical compensable condition, and you receive a claim for a secondary condition in relation to the erosion of the employee's tooth enamel.

The treating dentist has provided a report that indicates that the medication required to manage the physical condition was the main cause of the employee's tooth enamel erosion. In this case, liability for the secondary condition would be accepted.

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Dental treatment costs

There are no set fees for dental treatment costs and individual dentists can set their own fees.

Therefore, the cost of dental treatment will vary between dentists.

Dental treatment is considered medical treatment under the *Goods and Services Tax Act 1999* and is therefore GST-free.

If the dentist needs to use another business or third party to provide services, such as the provision or maintenance of dentures, the Goods and Services Tax (GST) may apply to the services provided by the other business or third party.

However, all other services undertaken by the dentist will still be GST-free.

Dental surgery fees

If the employee needs dental surgery at a hospital, the fees for the anaesthetist, surgical assistant, or surgeon (e.g. oral-maxillofacial surgery) may be covered by the Australian Medical Association's List of medical services and fees.

The Clinical Panel can provide information on the current AMA rates for surgical procedures (e.g. oral-maxillofacial surgery), anaesthetics, surgeon, and surgical assistant fees.

For further information on surgical requests please see [Surgery](#).

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What Comcare will pay for

- medical reports and clinical notes from the employee's legally qualified dentist (LQD) (these should include the current and preinjury/illness records).
- consultations with the LQD in relation to the compensable condition.
- the provision of a prescribed oral device (e.g. occlusal splint).
- pharmaceuticals prescribed to assist with the management of the compensable condition.

What Comcare will not pay for

- routine dental examination costs.
- routine dental imaging costs
- cosmetic procedures (i.e. teeth whitening etc.)
- costs required for the investigation, treatment, and monitoring of dental conditions unrelated to the compensable injury or illness.
- pharmaceuticals prescribed for conditions unrelated to the compensable injury or illness.
- treatment for an individual other than the employee.

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Bruxism

What is Bruxism?

Bruxism (BRUK-siz-um) is a condition involving unconscious/ involuntary excessive masticatory muscle activity.

That is, bruxism is a condition in which you grind, gnash, or clench your teeth, or thrust your jaw. If you have bruxism, you may unconsciously clench your teeth when you are awake (awake bruxism) or clench or grind them during sleep (sleep bruxism).

Bruxism is often asymptomatic (no symptoms). But it may become symptomatic and clinically significant if it impacts on sleep, or results in abnormal tooth wear or jaw discomfort.

Bruxism can be caused by many factors. No single definitive causative factor has been identified.

In otherwise healthy individuals, bruxism should not be considered a disorder, but rather a behaviour that can be a risk (and/or protective) factor for certain clinical consequences.

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How is Bruxism diagnosed?

Bruxism is generally asymptomatic until behaviours and/or related factors are brought to the attention of the individual. This often occurs well after the 'bruxing' began. For example, routine dental

examination may identify increased tooth wear.

Many causes of tooth wear and temporomandibular joint (TMJ) dysfunction exist, and it can be difficult to separate bruxism-related tooth wear from other causes.

Common ways bruxism may be diagnosed include:

- self-reporting (commonly noticed during sleep by a parent/caregiver/partner)
- clinical inspection by a dental physician
- Polysomnography/electromyography.

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Bruxism Treatment

For symptomatic bruxism, treatment may include:

- behavioural modifications such as sleep hygiene, cognitive behavioural therapy, avoidance of potential aggravating factors
- oral devices to protect teeth, such as occlusal splints, mandibular advancement devices
- pharmacotherapy (medication)
- restorative dental processes.

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Is there a link between bruxism and stress or psychological conditions?

Bruxism is common in children, becoming less common as individuals age.

There is evidence to suggest a correlation between an individual's bruxism and their experiencing stress or living with and/or being treated for psychological disorders. No significant relationship has been established, however, and the exact causative factors still are unknown.

Current literature on bruxism highlights that there are several factors that combine to cause bruxism. Bruxism likely occurs as the result of the interaction of several underlying psychosocial, physiological, and external factors.

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What to consider when reviewing claims for secondary bruxism

Reports vary widely about the number of cases of bruxism in the adult population. There is also a lack of a clear scientifically validated link between bruxism and psychological conditions. Therefore, when assessing a claim for secondary bruxism, it is important to establish whether a **very strong (significant) connection** exists between the compensable condition and the bruxism diagnosis.

Under the disease provisions of the SRC Act, bruxism as a secondary condition is required to meet the test of the primary condition being a **significant** contributing factor to its causation.

For this purpose, **all dental records (especially pre-injury/illness dental records) should be requested.**

Where the supporting evidence suggests that the bruxism began or worsened after the onset of an accepted psychological condition, a potential association could be considered.

There are many complexities surrounding a diagnosis of bruxism and there is poor evidence regarding the causes of bruxism. Therefore, it is recommended that before making a liability determination in relation to bruxism, you refer the claim to the [Clinical Panel](#) for review. In some instances, a dental independent medical examination (IME) may be necessary. The Clinical Panel can provide advice around this and help with drafting IME questions.

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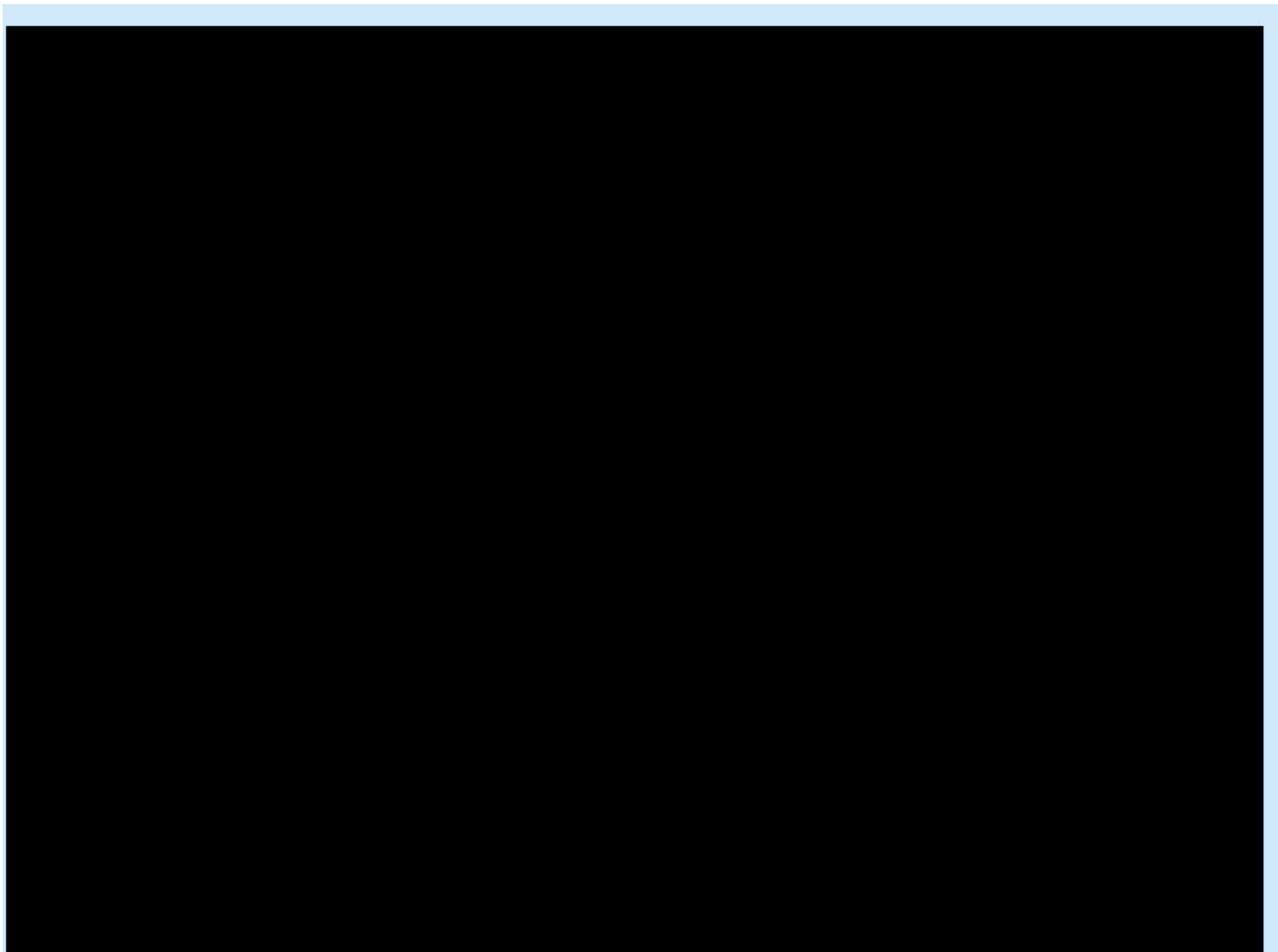
Bruxism costs

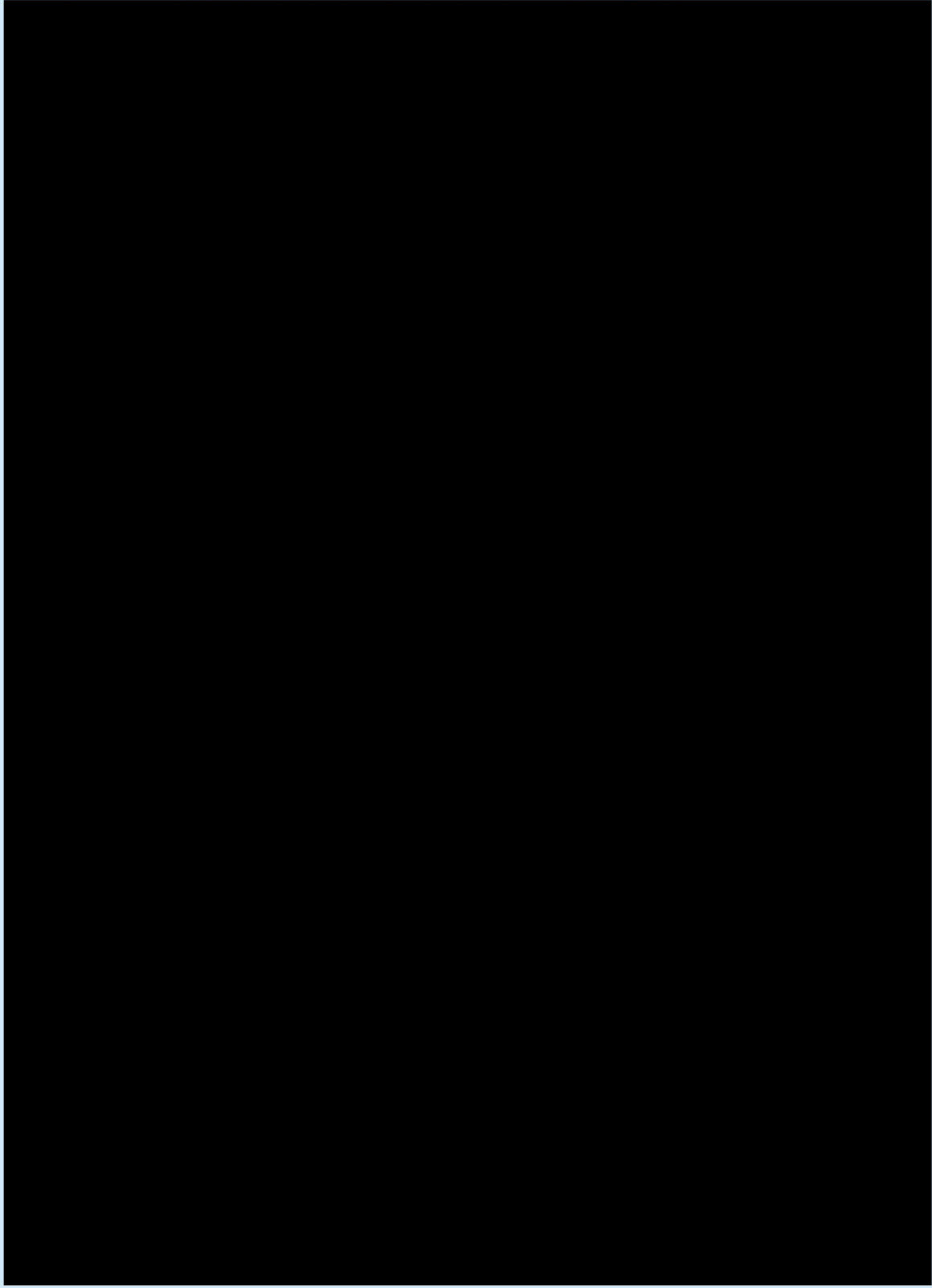
It is worth noting that restorative dental work can be high cost and ongoing in nature, so it is important to accurately establish liability at the outset.

Costs requested for the treatment of bruxism should be considered carefully and if you have any concerns about the cost of the treatment or the treatment itself, please discuss this with your Injury Manager

Note: All bruxism liability and treatment related requests should be reviewed by the [Clinical Panel](#). Information should be obtained from the referring legally qualified dentist or dental specialist before the request is sent to the Clinical Panel and a determination is made.

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Home help and attendant care

Published 06/10/2025

Introduction

An employee is entitled to claim compensation for **household services**, including childcare, and **attendant care services**, that are reasonably required as a result of their compensable injury. This may include appropriate short-term assistance provided in the acute post-injury (or post-surgery) stage, to enable an efficient return to health and, where appropriate, work. They can make a claim using the Household or Attendant Care Services application form. More information is available to employees on the Household services web page.

Relevant legislation

Section 29 of the SRC Act covers household and attendant care services.

Section 29A contains the provisions regarding household and attendant care services for employees with [catastrophic injuries](#). Catastrophic injuries must be tagged as such in Pracsys so that appropriate costs can be covered, and services can be approved. See the Procedure to add catastrophic injury tag if necessary.

Roles and responsibilities

The Claims Manager is responsible for determining liability for household and attendant care services.

The Injury Manager is available to consult with you on assessing liability for these services.

The Rehabilitation Case Manager may be consulted on matters of rehabilitation.

The Claims Administration and Support (CAIS) team processes and pays invoices for these services.

What are household services?

Household services are basic services of a domestic nature that are required for the proper running and maintenance of an employee's household (see section 4 of the SRC Act for the definition), and may include:

- food preparation / cooking
- assistance with grocery shopping (if home delivery is not available)
- house cleaning
- laundry duties
- gardening assistance, including pool or gutter cleaning
- firewood cutting and stacking at the employee's property (though not the actual cost of the firewood and its delivery if brought in from outside the property)
- one-off services, such as window cleaning, and
- childcare.

See also What is not included?

What are attendant care services?

Attendant care services are services required for the essential and regular personal care of an employee. Attendant care services assist and support an employee to undertake activities of daily living and may include:

- grooming
- bathing and toileting
- dressing
- feeding, and
- use and application of artificial aids and appliances.

For employees with a catastrophic injury, a broader definition of attendant care can apply to include support of tasks requiring cognitive processing such as prompting to task, decision making, assistance to control mood, etc.

See also What is not included?

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What is not included?

Household services

Household services do not include household maintenance and repairs such as:

- painting and decorating (exterior and interior)
- washing, servicing, repairing, or maintaining family vehicles
- repairing fences, doors, and windows
- cleaning products
- gardening supplies (soil, plants, fertiliser)
- the cost to purchase and deliver firewood to the employee's property (although cutting and stacking of firewood at the employee's property can be paid for)
- plumbing, and
- electrical repairs.

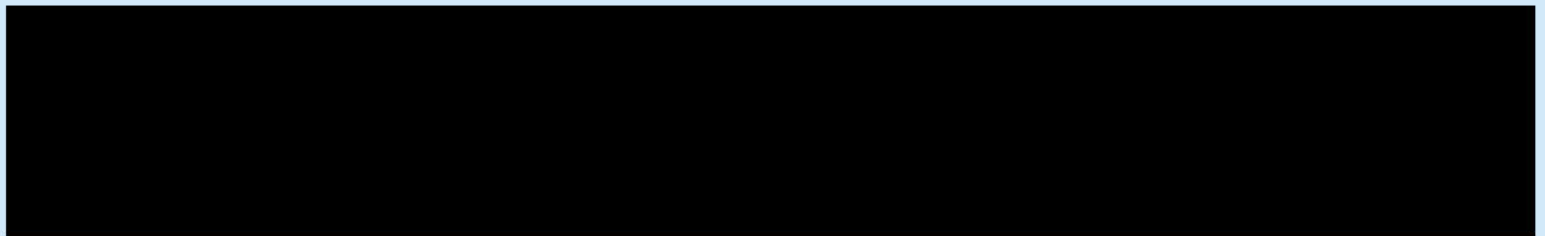
Attendant care services

Attendant care services do not include:

- medical services
- surgical services, or
- nursing care.

These services may be payable under other sections of the SRC Act.

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Applying for household or attendant care services

Claims for household and attendant care services must be supported by a legally qualified medical practitioner (LQMP). This provides evidence that the services are reasonably required as a result of a compensable condition.

If an employee requires household or attendant care services, the employee should complete the [Application for household and/or attendant care services form](#).

The application form requires both the employee and a LQMP to complete the relevant sections of the form. This application should be reviewed by you and the Injury Manager.

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Home assessments and rehabilitation assessments

When an application for household, attendant care and/or childcare services is received from an employee, the Claims Manager should follow the procedure to assess liability. This includes reviewing the employee's request and the claim file including any rehabilitation assessments or other medical evidence with an Injury Manager. Together, you should consider if the request for household, attendant care and/or childcare services is reasonable.

If you determine that the request is reasonable, follow the Procedure to accept liability for household and attendant care services.

Activities of Daily Living (ADL) assessment

For requests for household, attendant care or childcare services, it should be a standard occurrence for the Claims Manager and Injury Manager to arrange for a qualified Occupational Therapist (OT) to conduct an Activities of Daily Living (ADL) or home-based assessment.

See Undertaking a home assessment for full details of these assessments.

The evidence from a home-based or ADL assessment can be used to support your determination of the liability for household or attendant care services. The employee must consent to the assessment. You can explain the value of the assessment in providing you with the evidence you need to make a determination.

Rehabilitation assessments

A rehabilitation authority's power under section 36 of the SRC Act does not extend to an assessment of an employee's need for household and/or attendant care services. The rehabilitation authority should be encouraged to discuss with Comcare any observation or advice received that indicates household and/or attendant care services may be required.

Comcare is, however, required to take into consideration (but cannot rely solely on) any rehabilitation assessment when determining if household and/or attendant care services are reasonably required.

Comcare may obtain (with the employee's consent) an assessment of household services at the same time as a rehabilitation assessment.

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Considerations for determining household services

Section 29(2) of the SRC Act provides a list of non-exhaustive matters you may consider when determining whether an employee reasonably requires household services:

- The extent to which household services were provided by the employee before the date of the injury and whether they can provide those services after that date.
- The number of persons living with the employee as household members, their ages, and their need for household services.
- The extent to which household services were provided by the household or family members before the injury.
- The extent to which the household or family members might reasonably be expected to provide household service for themselves and for the employee after the injury.
- The need to avoid substantial disruption to the employment or other activities of household or family members.
- The functional capacity of the employee as assessed by their relevant treaters and advised via the Occupational Therapist (OT) activities of daily living assessment.

You may also consider, in discussion with the Injury Manager, other relevant matters based on the actual claim circumstances. These matters can also be reviewed by the assessing OT if relevant. For example:

- the time it is likely to take for the employee to recover and regain the ability to perform domestic tasks themselves, and
- the ability of the employee to learn adaptative techniques or use equipment to enable them to perform household tasks independently.

The provision of aids and appliances for the employee to use to assist with activities of daily living must be determined under section 39 of the SRC Act. See Aids and appliances for more information.

Where recovery is prolonged, employees should be empowered to perform tasks as independently as possible. Service provision should be reviewed at agreed intervals to ensure functional ability is aligned with the level of service.

You need to ensure that you have gathered all the necessary evidence to apply the above considerations, including obtaining a [home/ADL assessment](#) (if required) before determining liability for household services.

28-day exclusion period

Household and attendant care services are not payable within the first 28 days from the date of injury, unless the employee can demonstrate financial hardship or the need to provide supervision to children.

The 28-day exclusion period does not apply if the employee has a catastrophic injury.

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Considerations for determining childcare services

Childcare arrangements are something that all parents are required to organise, regardless of injury or ill-health.

Where a child is born before or after the injury, it must be the compensable injury that has caused the requirement for paid childcare, and not any other change in the employee's circumstances (such as separation or divorce).

Payment of childcare should only ever be considered on a short term basis to ensure the adequate supervision of children.

In dealing with the effects of an ongoing injury, employees should be expected to make reasonable adjustments to their childcare arrangements.

Example: If the injured employee can show that they would have been caring for a child/children were it not for the injury, then it is evident that childcare is payable.

Where a claim for childcare services is reasonably required, an employee should be encouraged to use a qualified childcare worker or service.

Children born before an injury

Compensation may be payable for childcare services if:

- an employee was looking after their own children before their injury **and**
- they now need to pay for childcare because their compensable condition prevents them from providing the care themselves.

If an employee was paying for childcare services before sustaining their injury, then compensation would generally not be payable for similar care obtained after the date of injury. In this case, the injury has not caused the need for childcare services.

The need for childcare services is likely reasonable where:

- an employee can show that the childcare services requested are in addition to what they required prior to their injury, **or**
- the childcare services requested have come about in connection with their compensable injury.

Children born after an injury

The considerations in section 29(2) of the SRC Act deals mainly with the employee's pre-injury circumstances.

Where an employee has a child after their date of injury (or where the employee did not use childcare prior to the date of injury), the following should be considered in relation to the payment of childcare:

- Is it the compensable injury that has now caused the requirement for paid childcare services (as opposed to childcare services being required because the employee now has a child or because of some other change in their circumstances)?
- Would the employee ordinarily have been required to arrange childcare if they had not been injured (i.e. if not injured, would the employee have been at work and required to arrange childcare at this time regardless)?

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Considerations for determining attendant care services

When considering claims for attendant care services, you should review all relevant information with an Injury Manager and consider (in line with section 29 of the SRC Act):

- the nature and degree of injury or illness sustained by the employee and the degree to which that injury or illness impacts their functional capacity
- the expected timeframe in which the employee will recover and regain the ability to perform tasks
- the extent to which any medical service or nursing care received by the employee provides for their essential and regular personal care
- whether the employee could be trained in adaptive techniques or the use of equipment to enable them to perform the tasks independently
- whether the provision of attendant care services would assist the employee to live relatively independently in their home as opposed to a nursing home or some other alternative environment
- the extent to which relatives of the employee, whether living in the employee's household or not, might reasonably be expected to provide attendant care services
- the extent to which attendant care services are necessary to enable the employee to undertake or continue employment.

What are Comcare's responsibilities?

Comcare's responsibility for household services (including childcare) and attendant care services is limited to determining liability for the services and where liability has been accepted, paying for the services in line with the statutory weekly limits.

Comcare has no responsibility for:

- the standard of service provided
- the conduct of the service provider in the employee's home, or
- liability issues, including workers' compensation for the service provider.

Important: Under no circumstances should you, as Claims Manager, enter into a contract or service agreement with a service provider.

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How long should services be approved for?

Initial claims for services are dependent upon the assessed functional limitations of the employee, based on the illness, injury, disease and/or relevant treatment, and their individual household circumstances.

An initial service should not be approved for longer than 3-6 months. The length of approval and review schedule should be determined through consultation and agreement between you and your Injury Manager and clearly communicated to the employee.

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Payment of household or attendant care services

Comcare can only pay up to a maximum weekly statutory rate when reimbursing household services.

Where an employee is receiving a combination of cleaning, gardening and/or childcare services during the same week, the maximum weekly statutory amount applies to the combined services and cannot be applied to each of the services separately.

Attendant care services are paid separately to household services and Comcare will pay up to the maximum weekly statutory rate for these services.

The exception to this is where an employee has a catastrophic injury, and in these cases, the maximum weekly statutory rates for household and attendant care services no longer applies.

The rate for maximum statutory weekly limit is updated on 1 July each year and displayed on Comcare's website.

Comcare's current recommended hourly rate for household services can be found in the 'Section 29 – household help – 756' letter or under the 'View Service Item' in Pracsys, which is updated each year.

However, the recommended hourly rate is **not a set limit or a statutory rate**. It is an **indicative rate** which represents the average hourly rate for services, factoring in the weekly statutory limits and market conditions. **You can approve invoices above the hourly rate**, provided they amount to less than the statutory weekly limit, and provided that you find the proposed rate to be '*reasonable*'. You need to discuss any changes to the recommended hourly rate with your Assistant Director before approving them.

Important: Comcare is only required to pay for basic services necessary to ensure the maintenance and running of a household at a reasonable standard based on practices in the general population, regardless of whether the employee has unusually high standards.

Reimbursement for service payments

Where an employee pays for the services, they should send a copy of the paid tax invoice or receipt for the services to Comcare for reimbursement. They may use a [Medical Services Claim Form](#) if they wish to.

Where the service provider and employee come to an arrangement where the provider invoices Comcare directly, Comcare will reimburse the provider on submission of a relevant tax invoice. You can direct employers to the Household services providers and Attendant care service providers web pages for more information.

All invoices received are scanned to the employee's claim file and actioned by the Claim Administration and Income Support (CAIS) team.

If services are not approved in the treatment plan or they fall outside the frequency set in the treatment plan, the invoice will be referred to you from CAIS for consideration.

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Considerations for engaging a service provider

Where an external service provider is needed, the **employee** is responsible for engaging their service. If an employee is unable to arrange for a service provider, their representative or health advocate may be able to do this for them.

You should make it clear to the employee that by engaging a service provider to provide household, childcare or attendant care services, the employee is responsible for any agreements they make with that service provider.

Household Services

It is recommended that the employee engages a reputable service provider with relevant business insurances, accredited through Australian Community Industry Alliance (ACIA), as they will be entering the employee's property to do the work. You can direct employees to the Household services web page for more information including a link to the statutory payment rates.

Travel to provide household services

There are no provisions under the SRC Act to pay for the travel of a household help provider to an employee's residence. The cost of the travel can be included in the provider's fees, rather than itemising the travel component separately. You will need to assess whether the fee charged by the provider is reasonable.

For example, it may be appropriate for a household help provider to include an additional amount over and above their normal rate if the employee lives in a rural or remote area where there are limited household help providers, and the provider needs to travel a considerable distance. If you have any questions about this, please discuss them with your Assistant Director.

Childcare services

It is recommended that the employee engages a qualified childcare worker.

Attendant care services

Comcare will only pay for attendant care services that are provided by a nationally accredited attendant care provider, where use of such a provider is possible. You can direct employees to the Attendant care services web page for more information.

The Attendant Care Industry Association (ACIA) is the national peak body that accredits attendant care provider organisations to the industry standard. See the list of ACIA accredited providers. You must advise employees to use a provider in this list to promote the provision of quality care services.

Whether using a provider from the ACIA listing or, where this is not possible, some other provider, the employee should confirm the provider has:

- appropriate insurance cover
- proper systems to ensure accountability for their services
- correct mechanisms for payment of taxation
- necessary backup in cases of sickness.

You should only approve payment of attendant care services that are provided by a nationally accredited attendant care provider, unless exceptional circumstances apply. For example, a non ACIA provider may be appropriate for a geographic area where there is no ACIA provider available. A non-ACIA provider may also be appropriate where there are specific language or cultural requirements or where an employee is not comfortable with someone other than a family member providing the service. You will need to assess each claim on its merits.

Where attendant care services are currently being provided by a family member, or other person who is not ACIA-accredited, you should assess whether those services continue to be reasonably required, and whether transition to the use of an ACIA provider is appropriate.

Travel to provide attendant care services

Attendant care services do not provide for expenses incurred by an employee for the incidental travel, accommodation, and meal costs of an attendant carer. These are expenses provided for another person (the carer) and are not required for the essential and regular personal care of the employee.

Household or attendant care services and the Goods and Services Tax

Household and attendant care services are all subject to the GST.

To be eligible to claim the GST component, a service provider must hold a current Australian Business Number (ABN) and a current GST registration with the Australian Taxation Office (ATO).

A service provider's ABN and GST registration details are available on the Australian Business Register (ABR) website.

It is the responsibility of the service provider to ensure that their ABN and GST registration details are kept up to date.

Providers who do not have an active GST registration should not be claiming the GST component for their services.

The hourly rates for household services determined by Comcare include a GST component.

Should a provider not be registered to claim the GST component for their services, the maximum hourly rate that Comcare can pay is reduced by 10%.

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Can family or household members be paid for the provision of services?

Household Services

The Claims Manager should encourage the use of professionally qualified service providers to ensure that the employee is receiving high quality household services

The use of family members or friends to provide paid household services is not encouraged as it may:

- cause issues in the relationship
- create conflicting responsibilities
- leave the employee without appropriate support if the family member or friend falls ill or requires leave.

Requests to have a family member provide household help should only be considered in exceptional circumstances such as:

- there is limited access to an accredited [Australian Community Industry Alliance \(ACIA\)](#) provider.
- the remoteness of the employee's place of residence
- there is a reasonable requirement of the employee for the household services provider to have particular skills, such as an ability to communicate in a particular language or comply with cultural expectations, or

- the nature of the services required as a result of the injury are far and above what is reasonably expected to be provided by a family member and the employee may not be comfortable with another person providing those services.

The Claims Manager should discuss any requests for family members or friends to provide paid household services to the employee with an Injury Manager or their Assistant Director before making a determination.

It is recommended that family members or friends providing household services are accredited by, and meet the same standards of, ACIA.

Section 29(2)(d) of the SRC Act provides that in determining liability for household services, consideration must be given to whether family or household members might reasonably be expected to provide such assistance to the employee following their injury.

Under section 29(2)(e), the Claims Manager must have regard for the need to avoid 'substantial disruption' to the employment, or other activities, of other members of the household.

The factors that will determine whether services provided by a family or household member are compensable include, but are not limited to:

- the type of service provided
- when the service/assistance is required, and
- whether family members are available to provide the services and whether it is reasonable for them to do so.

If services can be provided by family or household members without substantial disruption to their employment and other activities, then the Claims Manager may consider that it is not reasonable for Comcare to pay for household services.

Boarders or lodgers

Where an employee is receiving rent from a boarder who is not a family member, it is not reasonable to expect the boarder to undertake additional housework on behalf of the employee. It is however, expected that the boarder will continue to perform household maintenance tasks (i.e. cooking, cleaning) that the boarder was performing prior to the employee's injury whether for themselves or for the household.

All requests for household or attendant care services must be assessed on a case-by-case basis and the Claims Manager should always be guided by the evidence. This may include the rehabilitation assessment and/or [home/ADL assessment](#), and/or other medical evidence on the claim file.

Attendant care services

When determining whether a relative might reasonably be expected to provide attendant care services, consideration should be given to whether an employee would feel comfortable with a relative providing the type of services needed as a result of the compensable condition.

Also, especially with matters of personal hygiene, relatives may not be comfortable providing such services.

Alternatively, some employees may not feel comfortable with someone other than a relative providing the service.

Each claim will need to be assessed on a case-by-case basis.

The Claims Manager should discuss any requests for family members or friends to provide paid attendant care services to the employee with an Injury Manager or their Assistant Director before making a determination.

In the exceptional circumstance that a family member is engaged to provide attendant care services, they should be encouraged to seek the appropriate training and qualifications through [Australian Community Industry Alliance \(ACIA\)](#). This ensures the employee is provided quality care and minimises the risk of injury to the employee or the person providing care.

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Requirements for family members to provide household/attendant care

Where it has been determined that it is appropriate for a family or household member to provide household help and/or attendant care services to the employee, the family/household member will need to be registered as a service provider or payee in Pracsys before Comcare can reimburse the employee or the family/household member for the costs of the household help or attendant care services.

Regardless of whether Comcare reimburses the employee or pays the family/household help member directly for the household help/attendant care services, the family/household member will still need to meet the same invoicing and Australian Taxation Office (ATO) requirements as other household help/attendant care service providers.

The family/household member will need to submit invoices or receipts to Comcare that include the following information:

- employee's name
- claim number or date of birth
- the family/household member's details: name, contact number, address and ABN (if applicable)
- date of service
- description of the service/s provided
- number of hours worked
- cost of the service (including GST if applicable)
- if there is more than one date of service, then the details of each date of service should be listed individually.

ABN or Statement by a supplier form

Before Comcare can reimburse the costs of the household help or attendant care services, the family/household member or service provider will need to either provide Comcare with an active Australian Business Number (ABN) or a written statement explaining why they are not required to have an ABN as per the Australian Taxation Office's (ATO's) requirements.

If the family/household member or service provider is not required to have an active ABN, normally Comcare will request that the family/household member or service provider complete a Statement by a supplier form. See the ATO website for more information.

If the family/household member or service provider does not provide this information to Comcare or Comcare reasonable believes that the statement from the family/household member or service provider is false or misleading, then Comcare **MUST** withhold 47% of the payment being made to the family/household member or service provider. This is an ATO requirement. For further information, please refer to the [ATO website](#).

GST and household help/attendant care services

While household help and attendant care services attract the Goods and Services Tax (GST), the family/household member or service provider **MUST** have an active ABN and GST registration to claim the GST component on their invoices or receipts.

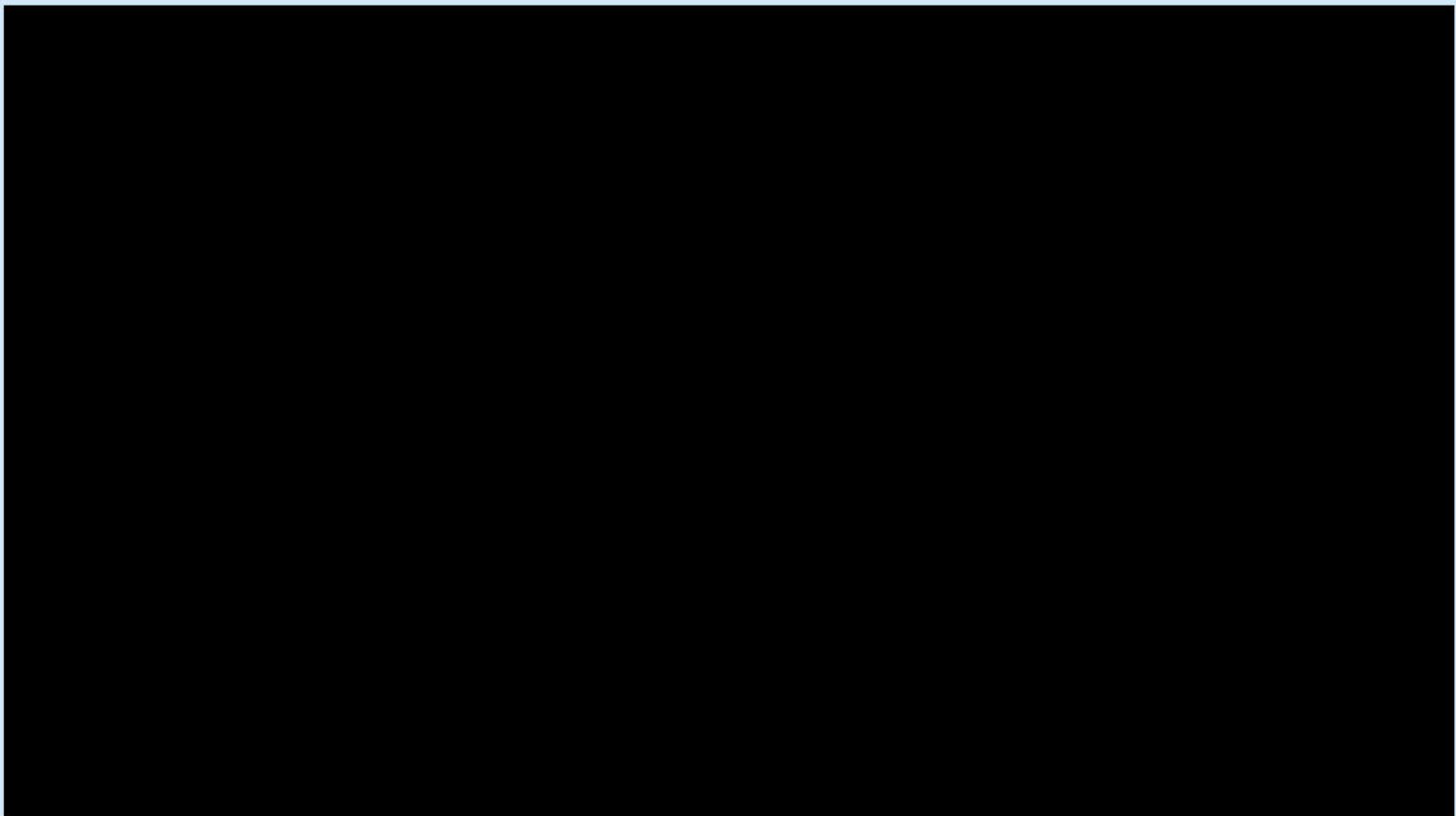
If the family/household member or service provider does not have an active ABN and/or is not registered to collect the GST component, then Comcare is not able to pay the GST component to them.

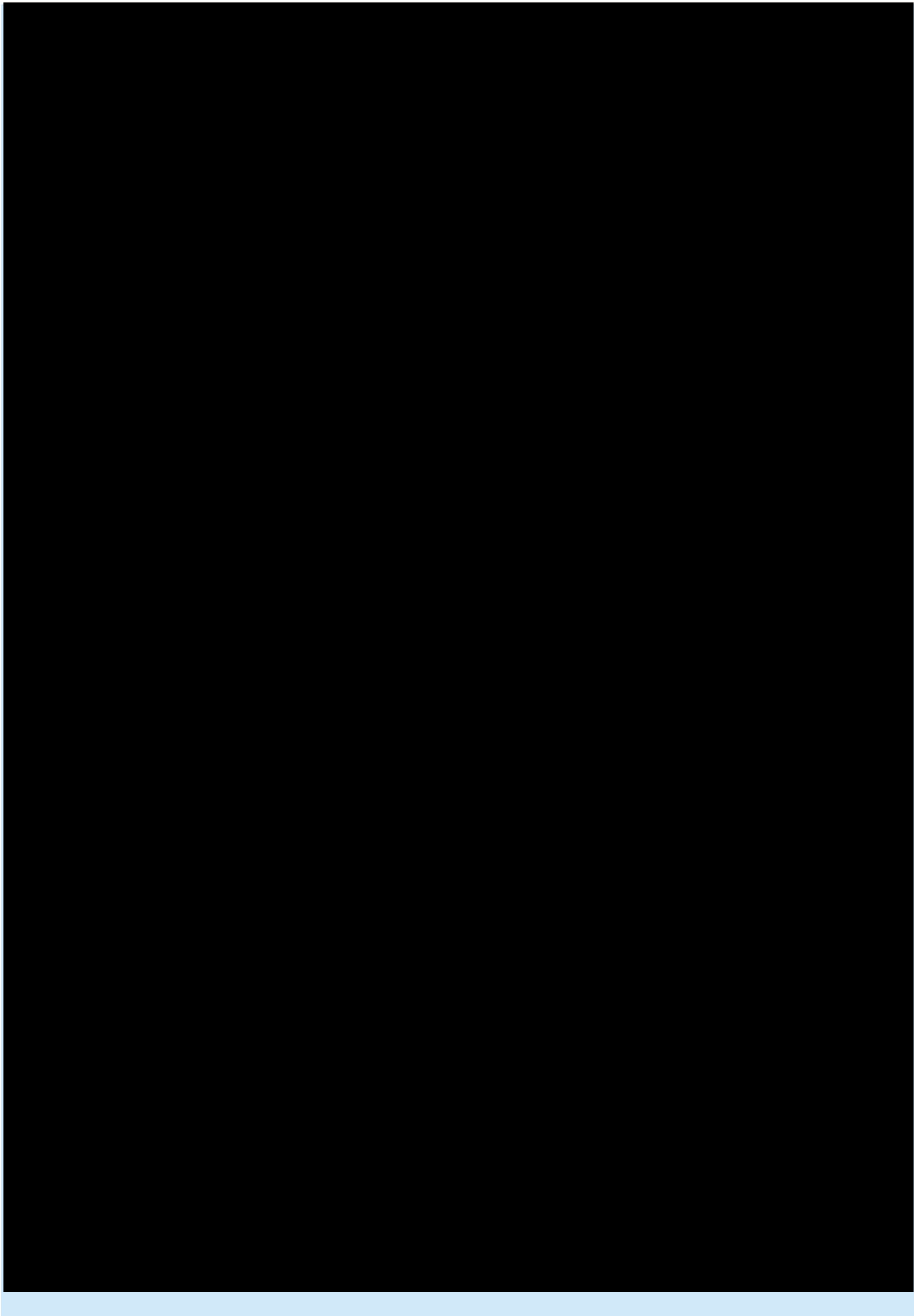
Please note that the household help service rates in Pracsys include the GST component. If the family/household help member is not entitled to claim the GST component, then the household help service rate will need to be reduced.

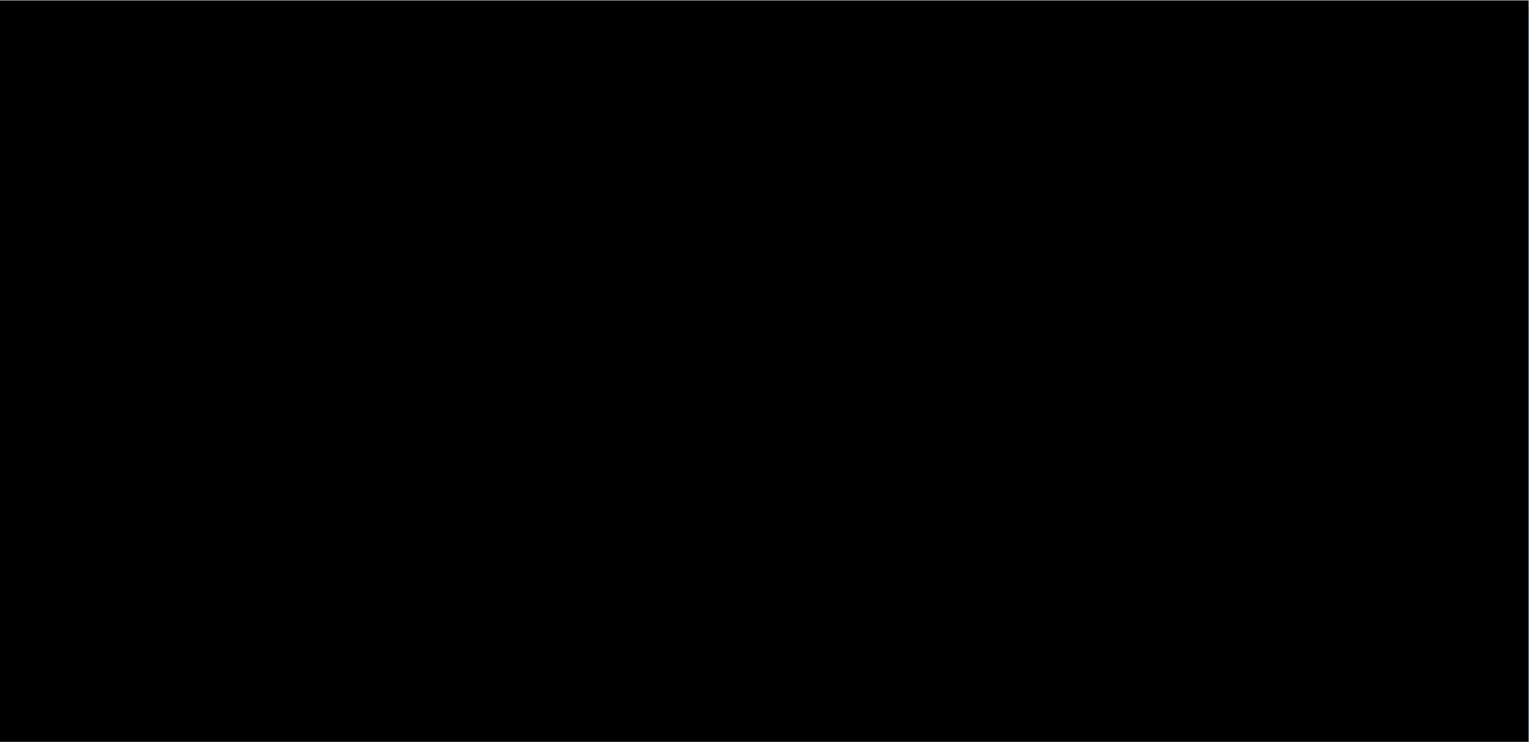
ATO advice: It is recommended that the family/household member seeks information from the Australian Taxation Office in relation to their own individual circumstances to ensure that they comply with any ATO requirements.

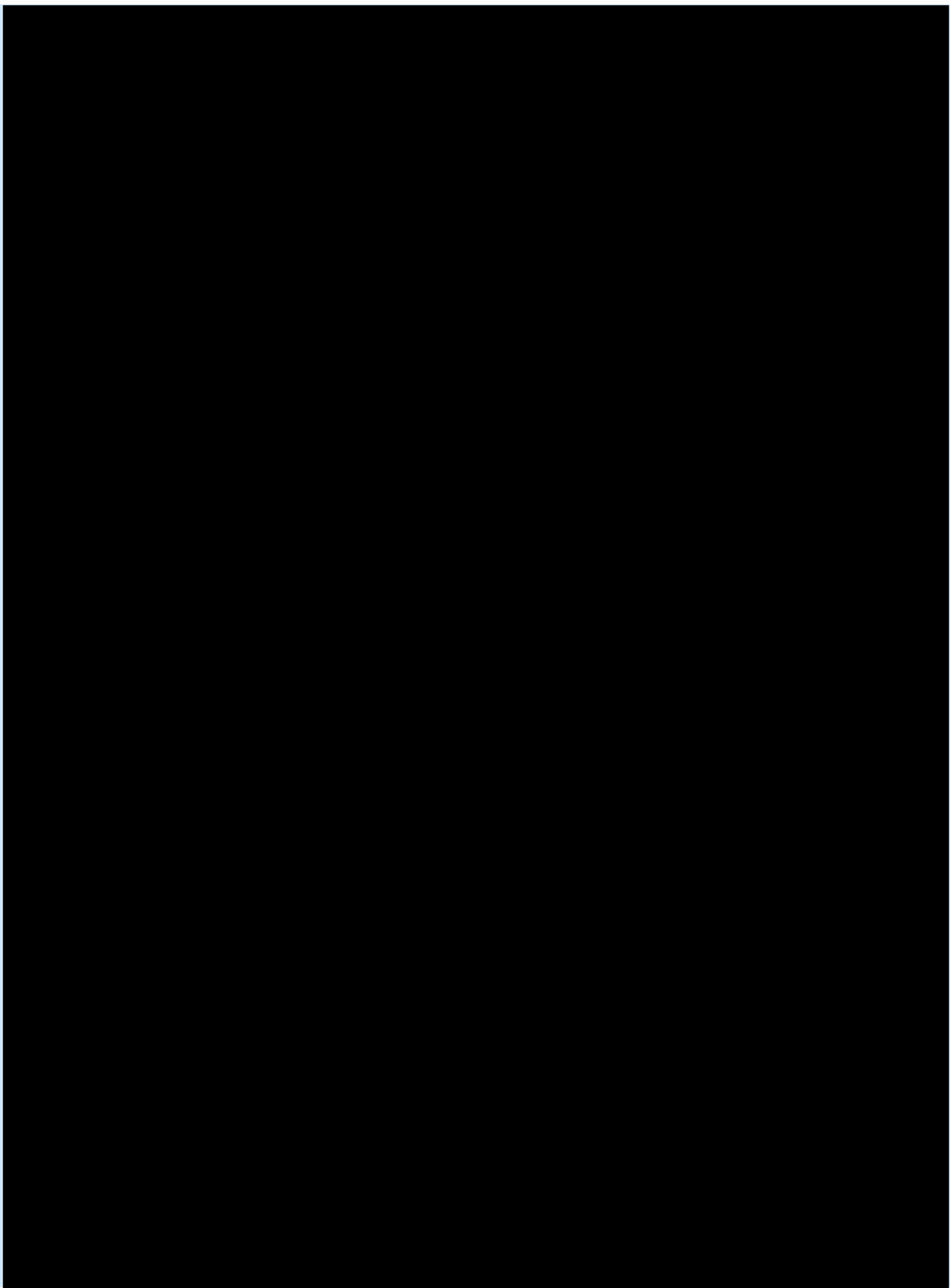
Centrelink advice: It is also recommended that the family/household member contact Centrelink if they are in receipt of any Centrelink benefits to find out if the payments that they receive from Comcare for providing household help/attendant care services has an effect on their Centrelink entitlements.

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Hearing loss treatment

Introduction

Hearing loss refers to a reduced level of hearing. Comcare is liable for medical treatment for hearing loss if the medical treatment is:

- reasonable for the employee to obtain in the circumstances
- obtained in relation to a compensable condition
- classified as medical treatment under the SRC Act, and
- appropriate in cost.

The guidance on this page outlines details about types of hearing loss and treatment options, and information about hearing aids.

Relevant legislation

See section 4 of the SRC Act for the meaning of 'medical treatment' and section 16 of the SRC Act for information about compensation for medical expenses.

See also section 24 of the SRC Act for information about compensation for injuries resulting in a permanent impairment and refer to the page [Assessing hearing loss claims for permanent impairment](#) if the hearing loss is permanent.

Roles and responsibilities

The Claims Manager determines liability for hearing loss treatment. The Injury Manager provides support to the Claims Manager to help with assessing and determining liability. In some cases, a referral to the Clinical Panel may be needed, following consultation with the Injury Manager.

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Types of hearing loss and treatment options

Hearing loss can occur in one ear or both ears, can vary in degree of severity, can occur in all age groups and be reversible, temporary or permanent. Hearing loss can occur suddenly or gradually, depending on the cause.

Generally, hearing loss is classified into five categories:

- **conductive** - can be acquired or congenital and is caused by blockage, illness, infection in the outer ear or abnormal bone growth in the middle ear. Conductive hearing loss results in sounds being heard but muffled. It may be temporary, depending on the cause, and can often be helped by medical treatment, surgery or hearing aids.
- **sensorineural** - can be acquired or congenital and is caused by damage to, or malfunction of, the cochlea (sensory part) or the vestibulocochlear (hearing) nerve (neural part). Sensorineural hearing loss leads to difficulty hearing higher-pitched tones due to reduced clarity. Sensorineural hearing loss is generally treated with hearing aids. Individuals with severe hearing loss who have not had

success with hearing aids may be appropriate candidates for cochlear implants. These are electronic devices that directly stimulate the hearing nerve.

- **mixed** – hearing loss with a combination of conductive and sensorineural causes. The conductive portion of the hearing loss may be improved by medical or surgical treatment. However, the sensorineural hearing loss portion is often permanent.
- **functional** – hearing loss occurring due to emotional or psychological factors. There is no organic cause or history of deafness in the family. Functional hearing loss results in all hearing ability being lost. Functional hearing loss may be improved by treating the emotional or psychological matter.
- **noise induced** – hearing loss occurs due to extended overexposure to hazardous noise (including but not limited to industrial noise, gunshots, loud music). Noise induced hearing loss results in permanent damage of the cochlear (*sensory part*) hair cells within the inner ear, often causing a ringing in the ears (**tinnitus**). Noise induced hearing loss cannot be corrected with medical or surgical treatment. Noise induced hearing loss is generally treated with hearing aids.
- Presbycusis (progressive age-related hearing loss) occurs as degenerative changes manifest within the cochlea (sensory part).

Also, some individuals experience **tinnitus** which is a sensation of noise when no external sound is actually present, such as ringing in the ears or another noise pattern. Tinnitus is not a disease, but a symptom of an underlying condition. The underlying cause of tinnitus can be treated medically or surgically when it is identifiable. When the underlying cause of tinnitus is not identifiable, treatment is focused on helping the patient learn to cope with tinnitus noise, such as by using other low-level noises to block out or 'mask' the tinnitus.

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Assessing whether recommended hearing aids are reasonable

Hearing aids are considered a medical aid or appliance under section 16 of the SRC Act. See Aids and appliances for more information on this section of the act.

Claims for hearing aids should be made using the [Hearing Aid Request Form](#) and completed by an audiologist, audiometrist or ear, nose and throat (ENT) surgeon. Employees can claim compensation for hearing aids under the SRC Act regardless of whether they are also eligible to receive hearing aids under the Australian Government's Hearing Service Program or another scheme.

However, Comcare considers that devices on the [Australian Government Hearing Services Program's](#) schedule of 'free-to-client' devices are generally reasonable and adequate for meeting an employee's basic hearing needs. Basic hearing needs include communicating with small groups in quiet environments or hearing the television. For this reason, Comcare requires clinical justification for any hearing aids and/or accessories (e.g table microphones) recommended that are more expensive than those on the schedule of free-to-client devices.

It may be reasonable for employees with more complex hearing needs, such as the need to work in an open plan office or participate in meetings, to benefit from hearing aids with more sophisticated noise-eliminating features.

A treating practitioner may indicate that there is not a device on the free-to-client schedule that could meet an employee's needs. They may recommend more sophisticated hearing aids. The Claims Manager should then assess whether the recommended aids are reasonable based on whether any extra features are necessary to meet the employee's reasonable hearing goals. You should refer any such requests to the Clinical Panel, following consultation with your Injury Manager.

Determining the appropriate cost of hearing aids

At least one quote for the cost of recommended hearing aids should be obtained before liability is accepted. Work with your Injury Manager to ensure that the requested hearing aids are within the average cost range for that particular product.

If you are not satisfied that a quote for hearing aids is an appropriate cost, you should obtain a competitive quote from another hearing aid provider that the employee could access.

You can directly request a competitive quote for hearing aids that would meet an employee's needs from another provider. However, you should first telephone the employee to get their permission to send the completed hearing aid request form, including any test results, to the other provider to obtain a competitive quote.

Costs requested for the treatment of hearing loss should be considered carefully and if you have any concerns about the hearing loss diagnosis, cost of the treatment or the treatment itself, please discuss this with your Injury Manager or Assistant Director, and with agreement, refer to the Clinical Panel.

Hearing loss liability, permanent impairment and treatment related requests, including reasonableness of prescribed hearing aids, should be reviewed by the Clinical Panel. All relevant information should be obtained from the referring audiologist, audiometrist or ear, nose and throat (ENT) surgeon before the request is sent to the Clinical Panel and a determination is made.

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Annual reviews of suitability of hearing aids

Comcare may receive invoices for annual reviews from the employee's audiologist once the hearing aids have been fitted.

Annual reviews are recommended to ensure that the employee's hearing aids are suitable for the employee's current level of hearing loss.

The annual review or checkup provides for:

- the monitoring of any changes to the employee's hearing
- adjustments to be made to the hearing aids to maintain optimal performance
- the opportunity for the employee to discuss any concerns they may have with the audiologist.

If you receive an invoice or claim for the cost of the annual review, you need to determine whether the treatment was reasonable for the employee to obtain in the circumstances and whether the fee charged by the service provider is an appropriate amount for the cost of the service.

There are no Comcare-specific service rates for the annual reviews.

The payment of these reviews should be in relation to the employee's compensable condition and not for other ear or hearing conditions that are not related to their compensable condition. If you have any concerns about the payment of an annual review fee, please discuss with your Assistant Director or Injury Manager.

Other costs associated with the annual review

Comcare may be billed for other services or costs as part of the annual review or check-up. These include:

- the provision of batteries or other consumables required to maintain the hearing aids e.g. wax filters, ear moulds, thin tube and dome replacements.
- cleaning and servicing of the hearing aids to help maintain their longevity

Replacement batteries and other consumables e.g. wax filters, ear moulds, thin tube and dome replacements which are integral to the working of the hearing aids can be paid for under the provisions of the SRC Act as a repair or replacement of an aid or appliance.

However, there are no provisions under the SRC Act for the maintenance or servicing of medical aids and appliances. These costs need to be included in the review fee and not added as a separate line item. If you receive a quote/invoice from a service provider which includes maintenance costs as a separate line item, you should ask the service provider to amend the quote/invoice.

Some service providers may offer employees a set annual fee or a reduced fee for the maintenance of their hearing aids including minor repairs as part of the provision of employee's hearing aids to help cover these costs.

For further information, please see: Considerations for aids, appliances, alterations and modifications under sections 16 and 39

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Repair or replace hearing aids

Comcare expects damaged or malfunctioning hearing aids to be repaired under warranty when this is possible.

Comcare may pay for the repair or replacement of damaged or malfunctioning hearing aids not under warranty. This will depend on which option is the best value investment towards meeting the employee's hearing needs.

Comcare will only fund the replacement of working hearing aids where there is clinical justification that the replacement aids will provide significant additional benefit towards meeting the employee's hearing goals.

Comcare may fund the replacement of lost or damaged hearing aids after it has received a signed statutory declaration explaining how the hearing aids were lost or damaged.

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Medical aids and appliances under section 16

Published 31/07/2025

Introduction

An employee can claim compensation for aids and appliances that will assist them with their basic personal functioning such as:

- their mobility
- undertaking activities of daily living
- undertaking rehabilitation and return to work activities
- Improving their level of functioning.

Under the SRC Act, in order for aids and appliances to be compensable they must:

- assist in alleviating the employee's injury
- assist the employee in performing basic personal or work functions, or
- support a return to work.

To be compensable, medical aids and appliances must also be reasonably required as a result of the claimed injury and be obtained for an appropriate cost according to section 16 of the SRC Act.

Relevant legislation

Aids and appliances, and their repair or replacement, can be assessed as:

- medical aids and appliances under section 16 of the SRC Act (this page provides information on aids and appliances under this section)
- rehabilitation aids and appliances under section 39 of the SRC Act.

Some aids and appliances may be covered under both sections, but as a general principle, payment for these items should first be assessed under section 16 of the SRC Act using the guidance on this page. Then, if you need to assess them under section 39 instead, see Rehabilitation aids, appliances, alterations and modifications for more information on section 39 provisions.

Roles and responsibilities

You as the Claims Manager are responsible for determining liability for medical aids and appliances. If you receive a request for an aid or appliance, speak with an Injury Manager for assistance.

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What are medical aids and appliances?

Under the SRC Act, medical treatment includes the supply, replacement or repair of medical aids and appliances (section 4).

Medical aids include medical/surgical supplies, curative apparatus, artificial limb or other similar aid or appliance that directly assists employees with their basic personal functioning.

For an aid or appliance to be considered a 'curative apparatus' within the meaning of 'medical treatment', the use of that device must cure, slow down or prevent the deterioration of the compensable condition.

Medical aids and appliances do not include aids or appliances that are recommended to prevent possible future injuries. The aid or appliance must be designed or adapted for use in medical treatment or the curative process.

Examples of medical aids include:

- hearing aids
- surgical footwear, such as a moonboot or crutches
- exercise equipment
- prosthetic devices, and
- consultations and fittings.

Example 1: Wrist splint

A physiotherapist seeks approval for reimbursement of the cost of a wrist splint under section 16 of the SRC Act. The wrist splint has been recommended for use by the employee to assist rehabilitation associated with the compensable wrist sprain.

The wrist splint may be considered a curative apparatus, under the definition of medical treatment. This is because the use of the splint by the employee provides a clear medical benefit in relation to their compensable condition.

The wrist splint meets the definition of medical treatment under section 4 of the SRC Act. However, it must still meet the other requirements for compensation under section 16. These are that it was **reasonable** for the employee to obtain the wrist splint, and it was obtained at an **appropriate cost**.

Example 2: Motorised wheelchair

An employee suffering from paraplegia due to a workplace accident requests reimbursement for the purchase of a motorised wheelchair under section 16 of the SRC Act.

A motorised wheelchair, while aiding an employee's mobility and independence, does not cure or treat a physical injury (i.e. paraplegia). A motorised wheelchair is not designed for that purpose, so it is unlikely to be defined as a curative apparatus.

However, it may be assessed as a rehabilitation aid under section 39 of the SRC Act.

Claims for clothing

See Exercise clothing in the Exercise, weight loss and gym page.

Claims for shoes

See Shoes in the Exercise, weight loss and gym page.

Training in the use of medical aids and appliances

If training in the use of a medical aid or appliance is carried out by an occupational therapist (OT) and otherwise meets the requirements of section 16, the training could be compensable under section 16 as a medical expense.

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Assessing liability for medical aids and appliances under section 16

You must first assess if the claimed aid or appliance meets the definition of medical treatment and can be considered a medical aid or appliance under section 16 of the SRC Act. For further guidance, see [What are medical aids and appliances?](#) and the [What is medical treatment?](#) page.

For Comcare to consider liability for medical aids and appliances, employees need to provide medical evidence from a legally qualified medical practitioner (LQMP).

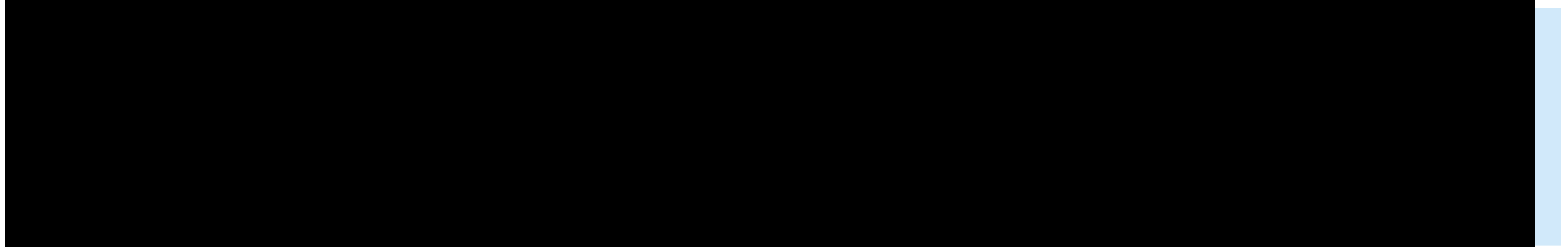
A treating practitioner may also submit a request for reimbursement directly to Comcare for consideration if they have purchased an aid or appliance.

If there is insufficient medical information, you can ask for specific information from an employee's treating practitioner to help you assess liability.

You need to make a determination of liability on each claim for a medical aid based on the available information. You need to be satisfied that the aid or appliance was reasonable to obtain for the employee's compensable condition and at an appropriate cost.

Where an employee has submitted a claim for an aid or appliance for their compensable condition that does not meet the above criteria, you should then assess the claim under section 39 as a rehabilitation aid or appliance. See [Rehabilitation aids, appliances, alterations and modifications under section 39](#).

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Rehabilitation aids, appliances, alterations and modifications under section 39

Introduction

An employee can claim compensation for aids, appliances, alterations and modifications that will assist them with basic personal functioning such as:

- their mobility
- undertaking activities of daily living
- undertaking rehabilitation and return to work activities
- improving their level of functioning

Under the SRC Act, in order for aids, appliances, alterations and modifications to be compensable they must:

- assist in alleviating the employee's injury,
- assist the employee in performing basic personal or work functions, or
- support a return to work.

To be compensable, rehabilitation aids, appliances, alterations and modifications must also be **reasonably required** and be obtained for an **appropriate cost**, according to section 16 of the SRC Act.

Relevant legislation

Aids, appliances, alterations and modifications, and their repair or replacement, can be assessed as:

- medical aids and appliances under section 16 of the SRC Act, or
- rehabilitation aids or appliances, alterations or modifications under section 39 of the SRC Act.

This page provides information on rehabilitation aids, appliances, alterations and modifications under section 39.

Some aids and appliances may be covered under both sections, but as a general principle, payment for these items should first be assessed under section 16 of the SRC Act. See Medical aids and appliances under section 16 for more information on section 16 provisions. If the item cannot be assessed as a medical aid or appliance, you may be able to assess it as a rehabilitation aid or appliance under section 39, using the guidance on this page.

Section 37 may also apply for items that are provided within a rehabilitation program.

Other legislation

The employer's responsibilities for providing aids and appliances in the workplace are described in section 19 of the *Work Health and Safety Act 2011* (the WHS Act), and the Disability Discrimination Act 1992.

Roles and responsibilities

You, as the Claims Manager, are responsible for determining liability for rehabilitation aids, appliances, alterations and modifications. If you receive a request for an aid or appliance, speak with an Injury Manager for assistance.

What are rehabilitation aids and appliances?

Rehabilitation aids and appliances are items that assist an employee, who has suffered an impairment associated with their compensable condition, to perform basic home or work functions, such as:

- grooming, dressing and personal hygiene
- eating and food preparation
- communication
- mobility
- maintaining correct posture.

Examples of what Comcare considers to be a rehabilitation aid or appliance:

- tap turners
- backrests
- over toilet aid
- shower chair
- non-slip mats
- door openers
- automatic recliner
- telephone aids
- kettle tippers
- special car cushions
- special pillows.

Examples of what Comcare does **not** consider to be a rehabilitation aid or appliance:

- general household items
- linen such as doonas / quilts and sheets
- toaster
- whitegoods (such as but not limited to fridges, washing machines, clothes dryers)
- breast pumps
- baby car seats
- vacuum cleaners
- irons
- bed ensembles.

What are rehabilitation alterations and modifications?

Under section 39(1) of the SRC Act, an employee can claim compensation for certain alterations or modifications where:

- an employee suffers an injury resulting in an impairment, and
- the employee is undertaking, or has completed, a [rehabilitation program](#), or has been assessed as not capable of undertaking such a program.

Comcare is liable to pay compensation for:

- any alteration of the employee's place of residence or place of work, or

- any modifications of a vehicle or article used by the employee.

The alterations or modifications need to be **reasonably required** by the employee, considering the nature of the employee's impairment and, where appropriate, the requirements of the rehabilitation program.

The amount of compensation payable for the alterations and modifications must also be reasonable.

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Employer's responsibilities for aids, appliances, alterations or adjustments to a workplace

Under section 19 of the *Work Health and Safety Act 2011*, a person conducting a business or undertaking (PCBU) has a primary duty of care to ensure the health and safety of workers. They must ensure the:

- provision and maintenance of a work environment without risks to health and safety
- provision and maintenance of safe plant and structures
- provision and maintenance of safe systems of work
- safe use, handling and storage of plant, structures, and substances
- provision of adequate facilities for the welfare at work of workers in carrying out work for the business or undertaking, including ensuring access to those facilities
- provision of any information, training, instruction, or supervision that is necessary to protect all persons from risks to their health and safety, and
- health of workers and the conditions at the workplace are monitored for the purpose of preventing illness or injury.

Further, the *Disability Discrimination Act 1992* (the DDA) requires employers to make **reasonable adjustments** to the workplace or working arrangements, if necessary, for a person with disability to do their job.

Therefore, employers will generally be responsible for the cost of any aids and appliances that are required in the workplace to enable an employee to safely undertake their duties.

However, if an employee requires specialised aids or appliances specifically related to their compensable condition, the aids or appliances may be payable under the SRC Act under sections 37 (if the employee is undertaking a rehabilitation program) or 39 (for general rehabilitation support).

Example: It would be a reasonable adjustment for an employer to provide an employee with a supportive ergonomic chair that meets the Australian Standard.

However, if the employee requires a specialised chair as a result of the compensable condition, it may be suitable for Comcare to supply the chair under section 37 of the SRC Act (if there is a current rehabilitation program in place) or under section 39 if there is no rehabilitation program.

Ownership

If an employer purchases an aid or appliance or makes an alteration to the workplace, the ownership of the equipment remains with the employer. If the employee changes their job, they may not be able to take the equipment with them. If the employee purchases the item through workplace

compensation with Comcare, the ownership of the item stays with the employee, and they can take the equipment if they leave that workplace. The implications of ownership should be explained to the employee before equipment is purchased.

Reasonable adjustments

What is considered 'reasonable' according to the *Disability Discrimination Act 1992* (the DDA) will depend on the facts and circumstances of the particular situation.

Under the DDA, an adjustment is considered reasonable unless it causes 'unjustifiable hardship' to the employer or organisation. Unjustifiable hardship could be in the form of significant financial loss, an amendment to the physical building that is not possible due to restrictions, or an adjustment that would unfairly disadvantage other employees.

An employer should therefore make reasonable adjustments for an employee with a compensable condition.

Example: An employee's compensable condition makes them sensitive to bright light. It would be reasonable for the employer to cover or turn off the lighting directly over the employee's workstation or supply blinds to any adjacent windows for the employee to do their job – providing that it is safe to do so and does not unfairly disadvantage other employees.

Examples of reasonable adjustment

The following are examples of when an employer might be responsible for aids and appliances:

- standard keyboards
- standard monitors
- new mouse
- hands free set for the phone
- adjustable workstations
- ergonomic chairs.

The following are some examples of when an employer is generally **not** responsible for aids or appliances. These may therefore be payable by Comcare:

- computer hire
- non-standard chair that is required due to the nature of the compensable condition. That is, the chair would not have been required if the employee had not sustained the injury
- custom trolley.

Note: You should consult with your Assistant Director and Injury Manager if you are unsure if aids or appliances should be the responsibility of the employer outside the SRC Act.

Example: Voice activated software

Voice activated software is an example of equipment that may be purchased under the SRC Act or by the employer, depending on the circumstances. There are **ownership implications** depending on who purchases the equipment.

Where voice activated software is commonly used in an organisation, and may be used as an injury prevention tool, then it should be purchased by the employer.

Where voice activated software is required as a result of a compensable condition and there is a rehabilitation program in place, Comcare's preferred approach is for the rehabilitation authority to purchase the software as part of the employee's rehabilitation program (including training) and seek reimbursement from Comcare under section 37 of the SRC Act.

The license for the software should be issued in the employee's name and will be transferrable to other organisations (should the employee leave) and/or to the employee's home, as it can also be considered as an aid to everyday living.

Where there is no rehabilitation program, the voice activated software can be paid for by Comcare as an aid or appliance under section 39 of the SRC Act.

When purchased under sections 37 or 39, the aid or appliance will remain the property of the employee, even if they leave their employer.

Comcare is not required to pay for the software twice under either section 37 or 39 of the SRC Act.

Note: The ownership implications of whether an employer or Comcare purchases voice recognition software should be brought to an employer's attention before the software is purchased.

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Alterations to a place of residence

'Alterations' refers to changes to the structure, layout or fittings of an employee's residence or work.

Employees are only entitled to claim compensation for alterations to their permanent or long-term residence.

If the employee is claiming alterations to a property they are renting, they must provide evidence of approval from the property owner and their intention to remain at the property (such as a rental agreement for at least one year for major alterations or six months for minor alterations).

If the property owner gives approval, then the alterations may be paid for if other requirements for liability are also met. If the owner of the property does not authorise the alterations, then temporary alternatives would need to be considered.

Important: When accepting liability for an alteration to a place of residence, valuations must be performed before and after the alterations are completed and kept on the claim file.

Examples of what alterations Comcare may pay for include (but are not limited) to:

- ramps to replace stairs
- widening of doorways
- installation of additional doorways
- installation of handrails
- bathroom and kitchen alterations
- necessary modification to household storage (i.e. height).

Examples of what alterations Comcare will **not** pay for include (but are not limited to):

- installation of additional cupboards

- alterations to a temporary place of residence (such as where an employee is house sitting)
- complete remodelling of kitchens, including painting and tiling
- new appliances
- purpose built homes.

Temporary accommodation during alterations

There are no provisions under the SRC Act to approve costs associated with temporary accommodation while alterations are undertaken and moving to a new house.

There is also no provision to pay for removalist expenses.

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Modifications to a vehicle or article

‘Modifications’ are enhancements to assist the employee with returning to work, mobility or activities of daily living. They are to a vehicle or ‘article’ that the employee already owns. Refer to section 39(1) (d) of the SRC Act.

Modifications to or for a vehicle may include, but are not limited to:

- wheelchair access for the employee to their vehicle
- hand controls to operate a vehicle
- specialised seating
- cruise control
- steering column adjustments
- electric windows
- automation of manual gears, and
- installation of power steering.

Modifications do not include items such as sunroofs, CD players, metallic paint, or new wheels.

New vehicles

Comcare will only pay for the cost of modifications to vehicles. There is no provision under the SRC Act to pay for new vehicles. If an employee chooses to purchase a new vehicle with the required modifications, then Comcare is not liable for the cost.

Modifications to ‘articles’

Whilst there is no definition of an ‘article’ under the SRC Act, it may be considered to be anything that is not a medical aid or appliance that requires modification and is reasonably required in relation to an employee's impairment at a reasonable cost.

Training in the use of altered vehicles or articles

Training costs are not considered aids, appliances, alterations or modifications under section 39 of the Act. Therefore, compensation is not payable for costs associated with training the employee in the use of a modified vehicle or article, or roadworthy certification following vehicle modifications.

However, if the training is included as part of the employee's rehabilitation program by their rehabilitation authority, the costs of this training could be payable under section 37 of the SRC Act.

Please discuss with your Assistant Director and/or Injury Manager for further clarification.

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Occupational Therapist Assessments

When assessing a claim for an aid, appliance, alteration or modification, it may be necessary to arrange for an Occupational Therapist (OT) to conduct an assessment of the suitability and benefits of the proposed aids, appliances, alterations or modifications.

The types of assessments that can be arranged include:

- worksite assessments
- functional capacity evaluations
- driving assessments, and
- activities of daily living (home assessments).

Example 1: Modifications to a car such as modification to driving controls.

You may require an assessment of the employee's driving capabilities to ensure that the modifications are appropriate and, the employee will be able to operate the vehicle safely once the modifications are complete.

Example 2: Alterations to a place of residence such as bathroom and kitchen alterations.

You may require an OT to assess the benefit of the requested alterations in relation to an employee's impairment associated with their compensable condition. Alternatively, they may recommend aids or appliances that may be of most benefit in the employee's circumstances at that time.

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Independent Living Centres

There are occasions where the treating doctor or rehabilitation provider recommends that the employee attend an Independent Living Centre (ILC). Here they will receive help to select aids and appliances that will assist the employee with their return to work.

The objective of ILCs is to provide an environment where varying aids and appliances are displayed and can be compared by the employee.

These visits are generally arranged by the rehabilitation provider as part of the rehabilitation program. However, there are occasions where the visit may be arranged by you.

If you need to arrange a visit, an Occupational Therapist (OT) assessment for rehabilitation aids should be arranged.

Any fees associated with the visit would be covered by the existing Return to Work Plan (RTWP).

Details of selected aids and appliances, where relevant, would then be listed and provided to Comcare for consideration under section 39 of the SRC Act for aids, appliances, alterations, and modifications.

Referral and approval to visit an ILC

A referral of support must be provided by the employee's treating practitioner prior to the visit. Any recommendations made by the ILC's qualified provider (usually an OT) must be provided in writing to Comcare for approval.

Aid or appliance recommendations must indicate how the item will assist with improving an employee's independent functioning and enhance their return-to-work options.

Reasonable cost of services

The cost for this service is payable based on the same hourly rate for services applicable to approved rehabilitation providers (ARPs), or OTs in each state.

This cost should be shown separately when the claim for aids and appliances is made.

However, where the ILC merely provides assistance by pointing out aids and appliances or has photocopied information sheets, an hourly rate will not apply, and you will be required to determine a reasonable cost commensurate with services provided.

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Assessing liability for rehabilitation aids, appliances, alterations and modifications under section 39

Legislation

Section 39 of the SRC Act provides:

- where an employee suffers an injury resulting in an impairment, and
- the employee is undertaking, or has completed, a rehabilitation program or has been assessed as not capable of undertaking such a program,

Comcare is liable to pay compensation of such amount as is reasonable in respect of the costs, payable by the employee, of:

- any alteration of the employee's place of residence or place of work
- any modifications of a vehicle or article used by the employee, or
- any rehabilitation aids or appliances for the use of the employee, or the repair or replacement of such aids or appliances.

The claimed aids, appliances, alterations or modifications must be reasonably required in relation to the employee's compensable condition.

Assessing liability

You need to investigate the facts of each particular case, having regard to factors such as:

- the likely period for which the aids, appliances, alterations or modifications will be required
- the nature of the impairment, and
- any requirements of the rehabilitation program.

You need to consider whether the amount invoiced or quoted is a reasonable amount to pay for the item and or service.

You must review the current medical and rehabilitation information to determine if the employee is eligible to receive compensation, and if the request for aids, appliances, alterations or modifications are 'reasonably required'. This is determined based on the individual circumstances of each claim.

Note: Where you are unsure if an aid or appliance is a medical or rehabilitation aid, you should speak to the aligned Injury Manager.

If, after this discussion additional clarification is required, advice may be sought from the Clinical Panel.

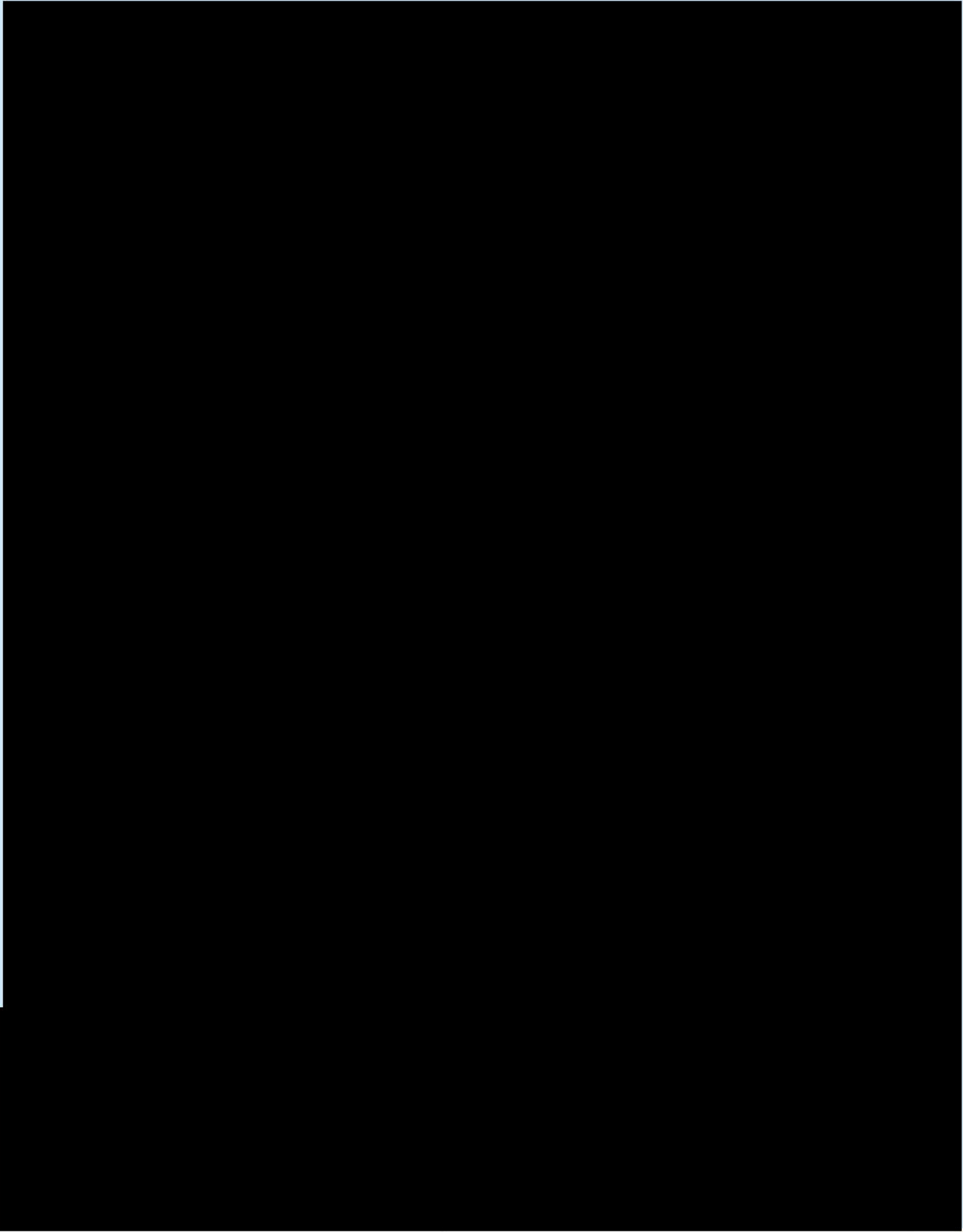
The rehabilitation authority

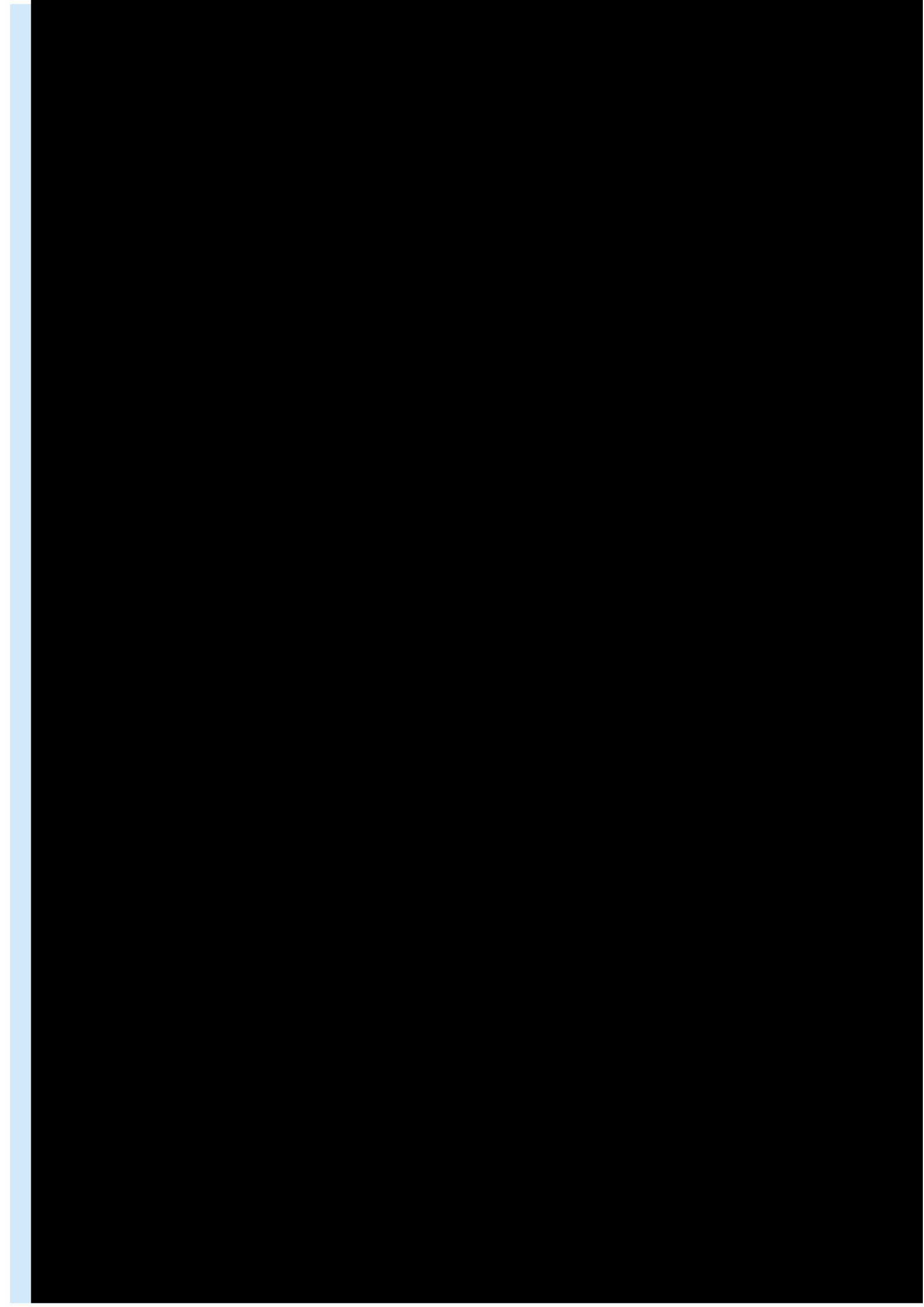
Before determining liability for rehabilitation aids, appliances, alterations or modifications under section 39, you need to advise the rehabilitation authority that an employee cannot receive payment under section 39 if they have not undertaken, completed, or been assessed as not capable of undertaking a rehabilitation program.

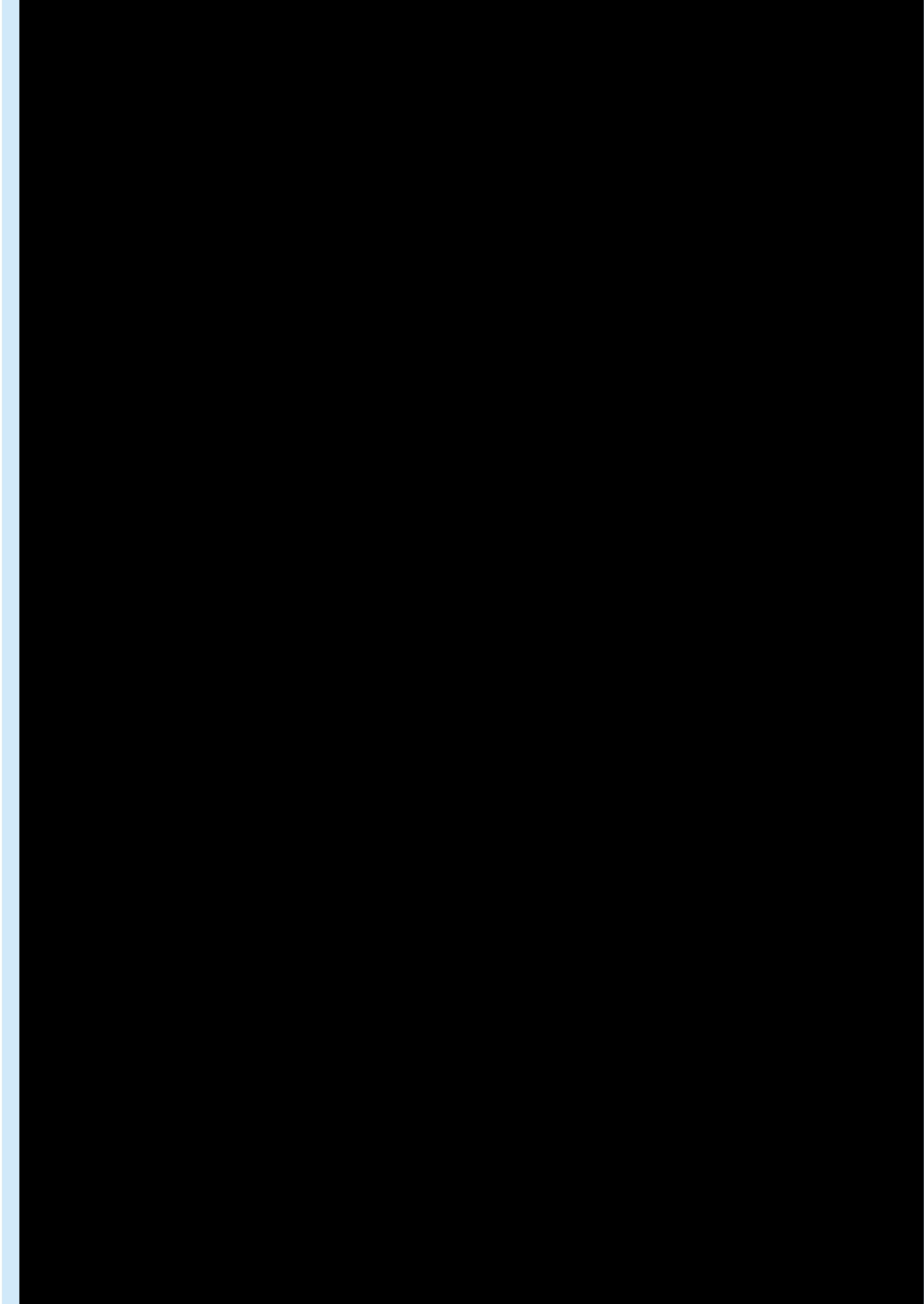
If the rehabilitation authority advises that:	Then...
• The employee has been assessed as not capable to undertake a rehabilitation program under section 36 of the SRC Act, or • The employee has commenced a rehabilitation program, or • The employee has undertaken a rehabilitation program.	• Ask the rehabilitation authority to provide information to confirm their advice. • Set a diary reminder for five days' time to check that information has been received. • Phone the employee to inform them that once the information is received from their rehabilitation authority a determination will be made. • Enter a comment in Pracsys and record all your conversations.
• They will not consider a rehabilitation program for the employee or arrange for the employee to be assessed for an ability to undertake a rehabilitation program.	Phone the employee to advise that: • If they have not been assessed under section 36 they have a right to make a written request to the rehabilitation authority that they arrange an assessment under section 36 of the SRC Act. • Upon receipt of the written request of the employee, the rehabilitation authority has an obligation to arrange for an assessment of the employee's capability of undertaking a rehabilitation program. • An employee cannot receive payment under section 39 if they have not undertaken, completed, or been assessed as not capable of undertaking a rehabilitation program. • You will proceed with a determination to reject the claim for rehabilitation aids and appliances at this time, and • If as a result of an assessment and further actions by the rehabilitation authority, the employee meets the threshold rehabilitation criteria under section 39 they can appeal the original determination.

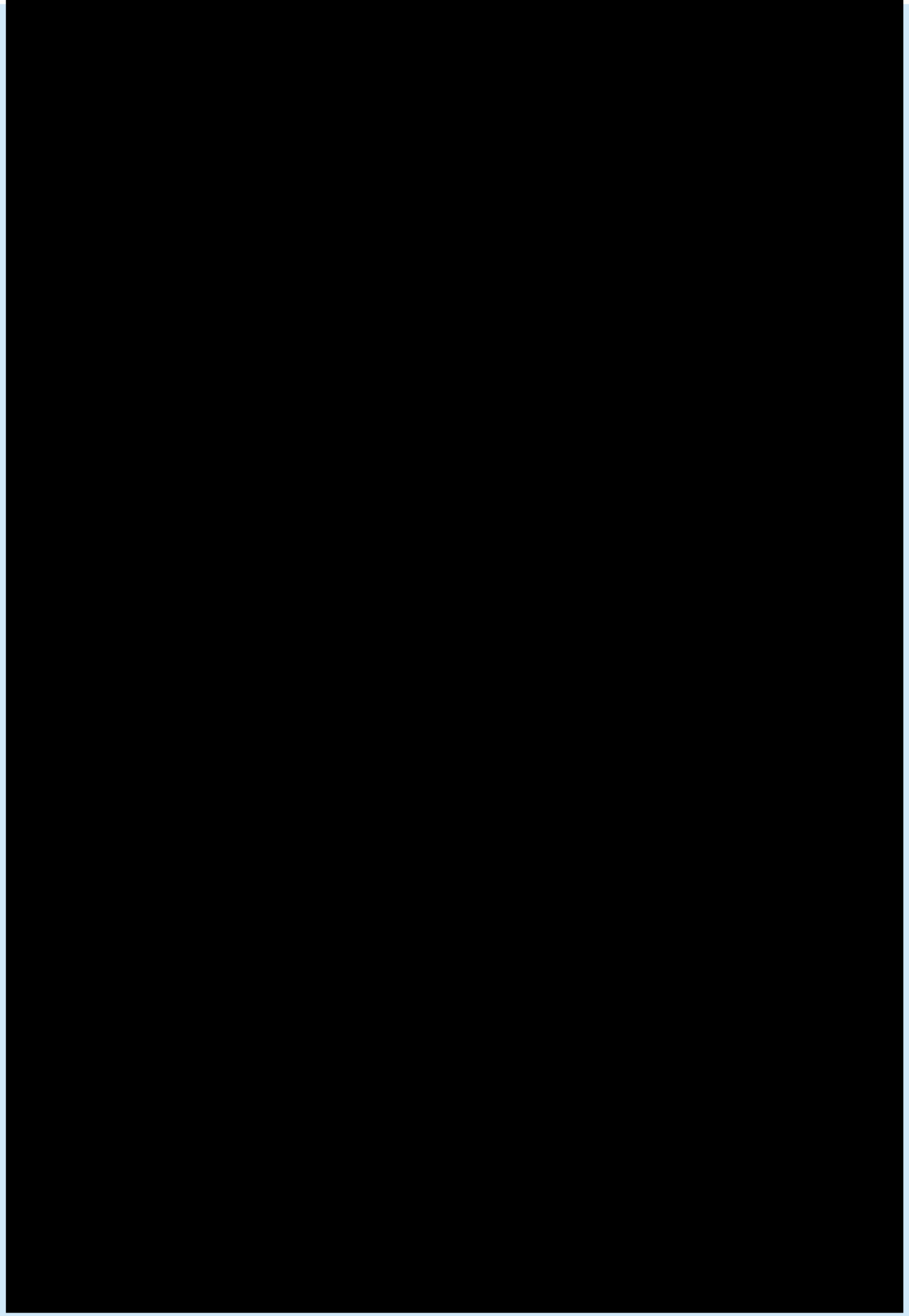
	• Enter a comment in Pracsys and ensure you record your conversation.

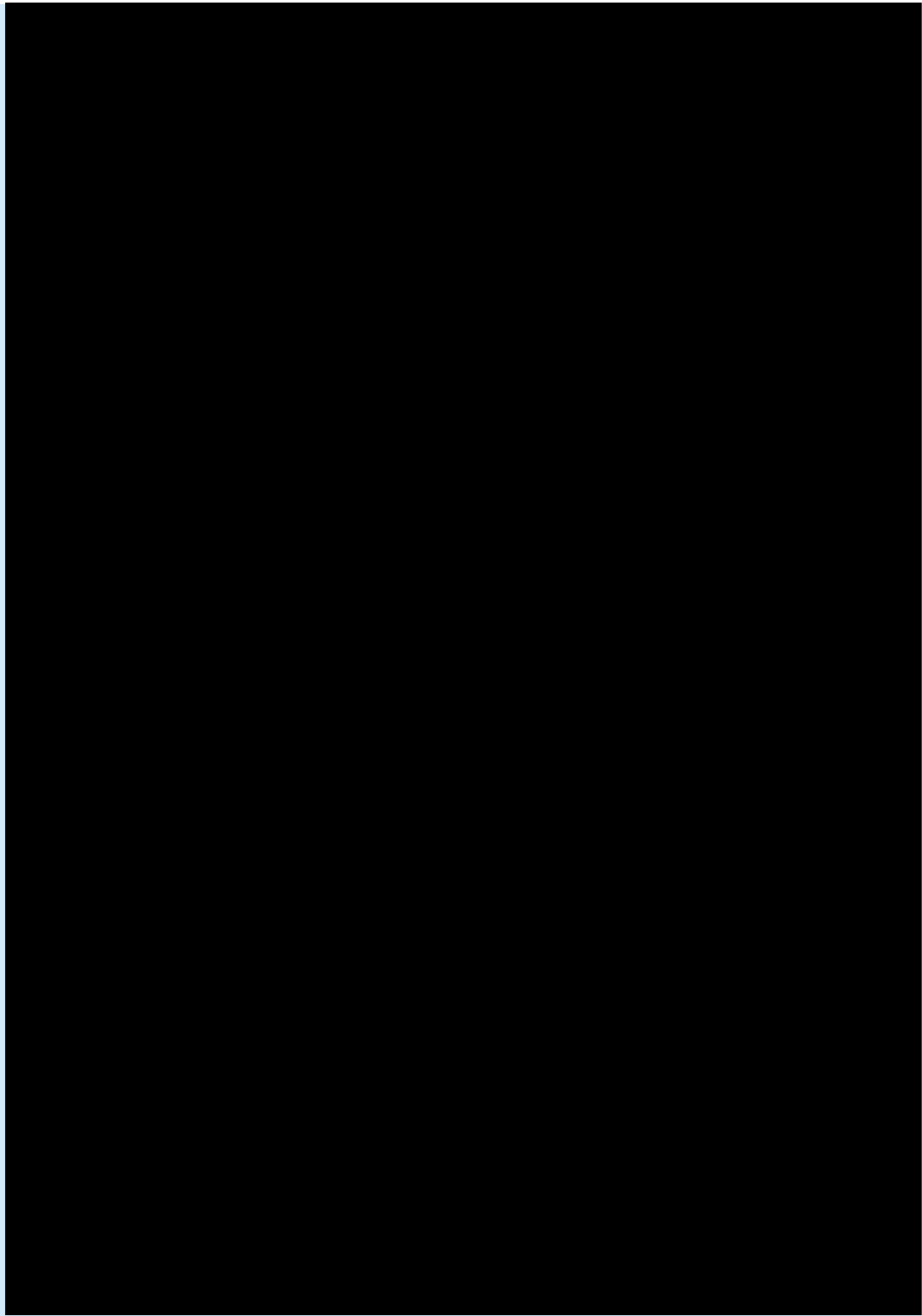
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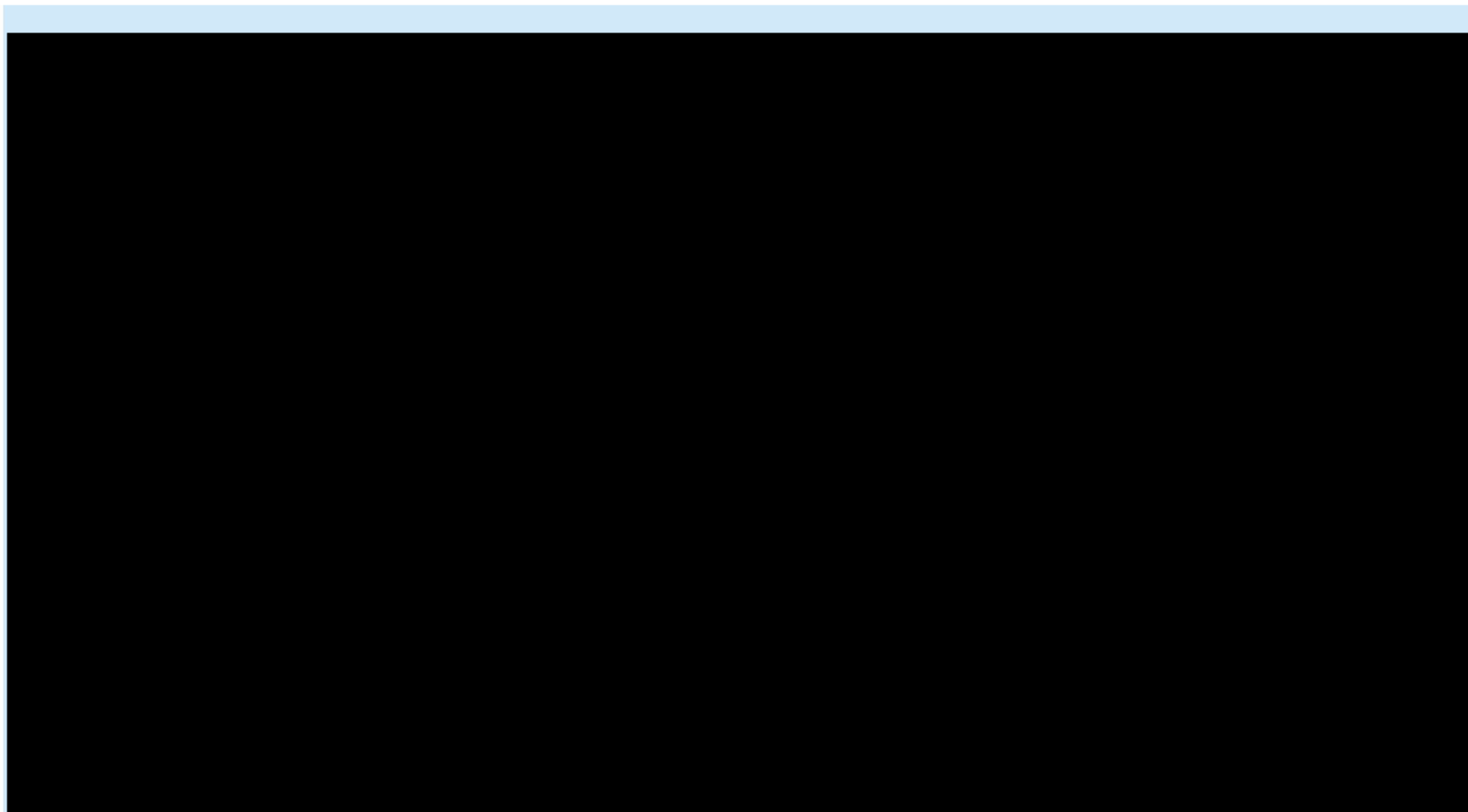












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Previously paid alterations and modifications and financial gain

Ownership of aids, appliances, alterations or modifications

Aids and appliances that have been approved under section 39 of the SRC Act become the property of the employee.

Structural alterations or modifications that have been approved under section 39 become the property of the property owner.

Where the employee's employer funds workplace alterations, modifications or aids and appliances, they remain the property of the employer.

Repair or replacement of previously paid alterations and modifications

While the SRC Act has specific provisions for the repair or replacement for aids and appliances, there are no provisions under the Act to consider liability for the repair or replacement of previously paid alterations or modifications to the same place of residence or work, vehicle, or article.

Once an alteration or modification has been made, the employee is responsible for the cost of any repairs or maintenance.

However, if the employee changes their place of residence or work, vehicle, or article, then compensation may be payable for any alterations or modifications to the new place of residence or work, or vehicle or article that may be required in relation to their impairment.

Significant net gain from previously paid alterations and modifications

There may instances where an employee who has previously received compensation for alterations or modifications to a place of residence or vehicle may make another claim for the same alteration or modification to a different house or vehicle.

The SRC Act requires that Comcare consider whether as a result of the previous alterations or modifications the employee made a financial gain on disposal of that asset. If so, this would need to be taken into account when considering the compensation payable for the subsequent request.

Under section 39(2)(f), you will need to consider compensation previously received for an alteration to an employee's place of residence, or modification of a vehicle that has been disposed of, to ensure:

- any significant net financial gain received by the employee arising out of its disposal is taken into account, and
- that Comcare is not effectively paying twice for alterations or modifications the employee previously received a financial benefit from.

It can be difficult and time consuming to assess if there was a net financial gain. Therefore, any decision to investigate should be discussed with your Assistant Director.

Decreases in value

Alterations and modifications may decrease the value of a residence or vehicle on disposal. There is no express provision in the SRC Act to compensate an employee for the decrease in value of a residence or vehicle.

Significant net financial gain to a house

A significant net financial gain to a house is considered to be in excess of \$5000.00.

When the cost of the original alterations to a house exceeds \$10,000.00, a valuation of the property must be arranged before the alterations are made, and a valuation arranged once the alterations have been completed. This information is kept on the claim file for reference and is arranged at the time of approval of the original alterations.

Example: An employee has alterations to their bathroom paid by Comcare which results in a brand-new bathroom being installed.

The employee disposes of the property 6 years later and based on the valuations, has obtained a significant net financial gain of \$8000.00.

The employee submits a claim for the same alterations to a new place of residence and liability is accepted. The quote for the alterations to the new residence is for \$18,000.00.

You must determine the compensable amount is \$10,000.00, which is \$18,000.00 minus the financial gain of \$8000.00.

Significant net financial gain to a vehicle

A significant net financial gain to a vehicle is considered to be in excess of \$2000.00.

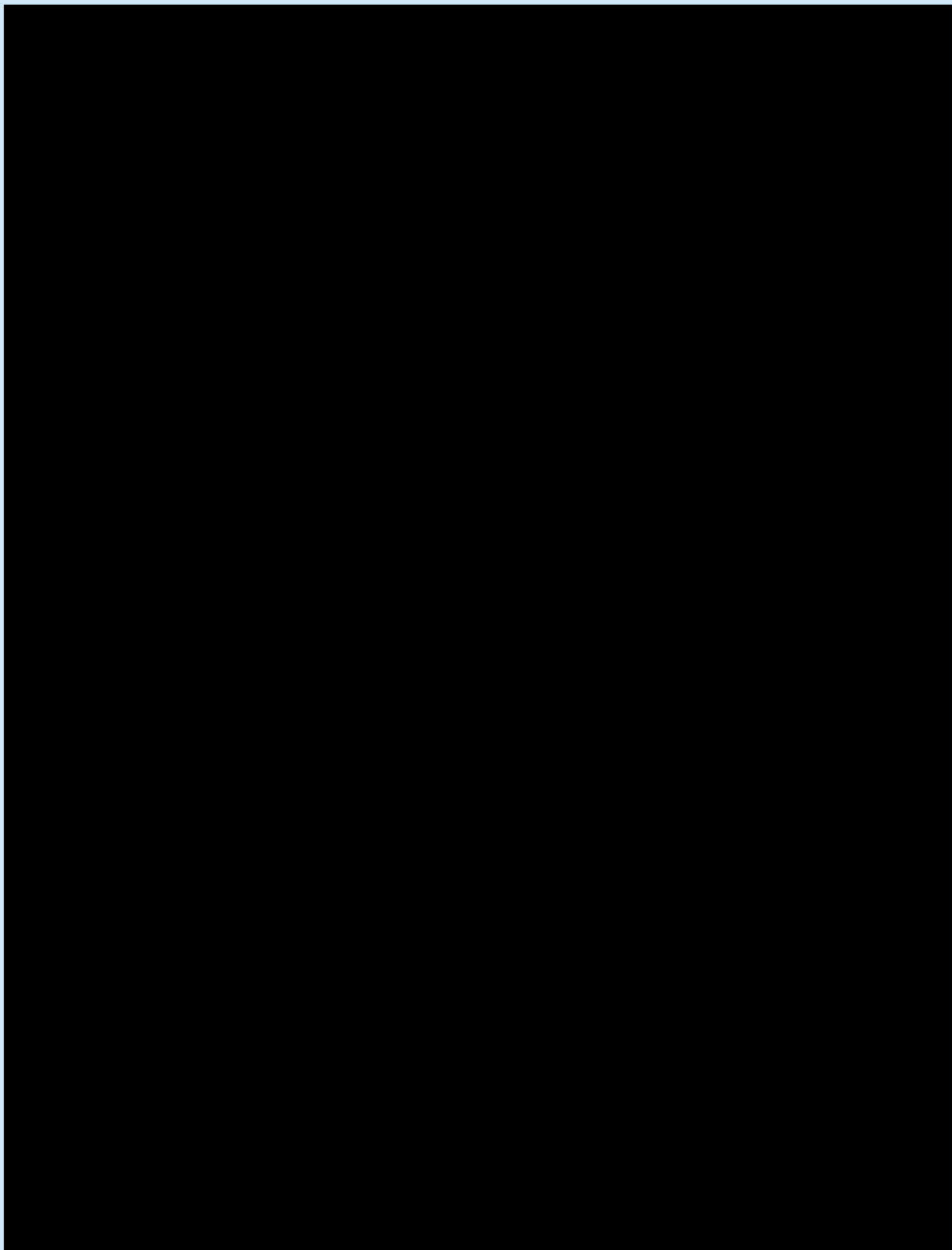
Modifications to vehicles are less likely to result in gains over \$2000.00 and therefore, valuations are not conducted when the modifications are first made.

Depending on the age of the vehicle, the following modifications may result in a financial gain:

- An employee sells their car which was modified from manual to automatic transmission.

- An employee has specialised seating, such as Recaro seats (sports seats) installed (for the employee as either a driver or passenger) which could increase a vehicle's value.
- The installation of power steering and power windows could increase a vehicle's value.

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the 'information' and 'communication' fields. The 'information' field is defined as:

...the study of the nature, uses and functions of information, and the ways in which it is created, communicated, evaluated and used. (p. 1)

The 'communication' field is defined as:

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The 'information science' field is defined as:

...the study of the nature, uses and functions of information science, and the ways in which it is created, communicated, evaluated and used. (p. 1)

The 'information studies' field is defined as:

...the study of the nature, uses and functions of information studies, and the ways in which it is created, communicated, evaluated and used. (p. 1)

The 'information research' field is defined as:

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The 'information practice' field is defined as:

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The 'information theory' field is defined as:

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The 'information technology' field is defined as:

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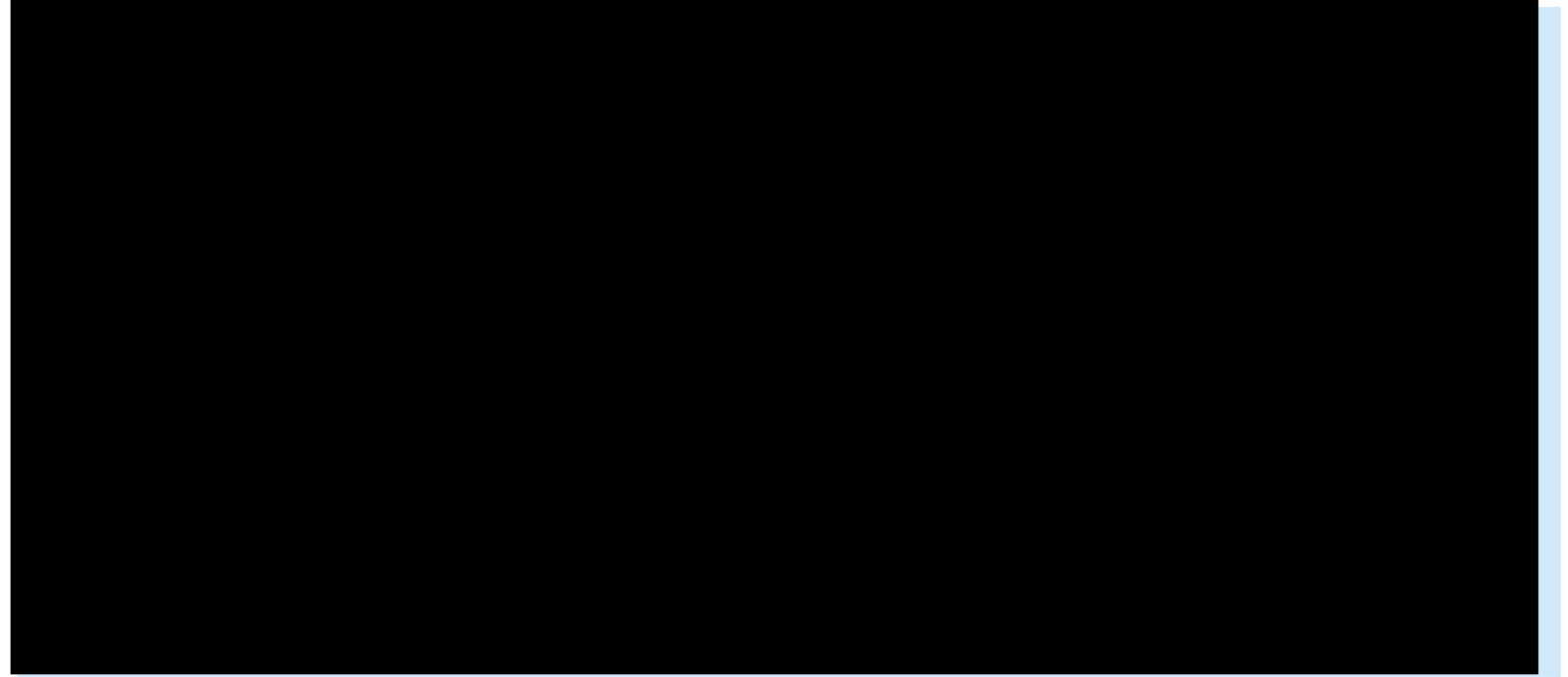
The 'information systems' field is defined as:

...the study of the nature, uses and functions of information systems, and the ways in which it is created, communicated, evaluated and used. (p. 1)

The 'information management' field is defined as:

...the study of the nature, uses and functions of information management, and the ways in which it is created, communicated, evaluated and used. (p. 1)

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Receiving and actioning travel requests

Published 06/10/2025

Introduction

An employee may be required to travel to obtain medical treatment (section 16 of the SRC Act) or attend an examination arranged by Comcare (section 57). Comcare may reimburse an employee's reasonably incurred costs associated with making the necessary journey or remaining at a place because of the journey. We may also make the necessary arrangements for the employee to undertake the travel.

Items of travel that may be reimbursed include:

- private vehicle use
- parking fees
- public transport (i.e. taxi, bus, train)
- ambulance
- flights
- meals and accommodation, and
- attendance by a support person.

Roles and responsibilities

It is the Claims Manager's role to assess and determine whether to pay costs for travel related to medical treatment or medical examinations. It may also be the Claims Manager's decision to organise and book travel on behalf of the employee. More information can be found under the Flights and Meals and accommodation and Booking flights and accommodation sections below.

Claims Administration and Support (CAIS) is responsible for paying reimbursement costs once a Claims Manager has approved them.

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Assessing the reasonableness of travel costs

To reimburse travel costs, you must consider:

- whether the medical treatment or examination was reasonably required for the compensable condition
- whether the journey was necessary, and
- whether the travel costs were **reasonably** incurred.

To assess whether travel was reasonable, you should consider the:

- means of transport available to the employee for the journey
- employee's ability to use certain modes of transport
- route or routes the employee could have travelled, and
- accommodation available to the employee.

When claiming travel for medical treatment, you must also consider the possible locations where the treatment is available. An appropriate treatment provider may be available near the employee's residence. In that case, Comcare would not usually approve travel to a distant location for the same treatment.

Note: If unsure of the distance claimed between employee residence and treatment provider, please refer to Google maps.

If you remain uncertain regarding the travel costs, please discuss with your Assistant Director before proceeding.

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Private vehicle use

An employee may request reimbursement for travel when they have used their private vehicle to travel to a medical examination or to obtain medical treatment for their compensable condition.

Medical treatment

Reimbursement for private vehicle use when travelling for medical treatment may be considered. The journey length must exceed 50km, including the outward and return parts of the journey (see section 16(7) of the SRC Act).

Independent medical examination

The employee can claim reimbursement for travel to a medical examination arranged by Comcare under section 57 of the SRC Act. There is no minimum distance requirement.

Rate payable

The rate payable per kilometre for private vehicle use is specified by the Minister. The rate for travel is updated periodically and is at the discretion of the Minister's office. This rate has been calculated to include provisions for on road costs.

Travel during work hours

If an employee attends a medical appointment during work hours, the cost of this travel is payable **IF**:

- the employee leaves from and returns to their place of employment, and
- the journey is over 50km (including outward and return components).

However, an employee's travel costs are **not payable** even if the journey is over 50km when:

- they are attending medical treatment on the way to or from work, or
- they only need to detour slightly to attend the appointment.

This is because the majority of their journey constitutes their usual travel to or from their place of employment.

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Parking

An employee may request reimbursement for parking costs where:

- they have used their private vehicle to travel for **medical treatment** for their compensable condition (section 16) - however, this is only the case if the entire journey, including outbound and return, **exceeds 50km**.
- they have used their private vehicle to travel to a **medical examination** (section 57). Parking costs reasonably incurred due to attendance at a medical examination (section 57) are payable **regardless of distance travelled**.

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Public transport and ambulance

Public transport includes buses, trains, trams, and taxis.

An employee can claim travel expenses where the mode of transport was public transport or ambulance services. There is no minimum distance requirement. However, these costs are only payable where the use of the transport is because of the employee's injury (section 16(7)). The employee will need to provide evidence from a legally qualified medical practitioner to show that their injury reasonably required the use of such transport.

Example: If an employee would normally catch a bus to a doctor's appointment, then this is their normal mode of transport. It is not medically required for them to catch the bus and therefore it is not compensable.

Example: An employee has broken their leg and as a result is unable to drive a car for six weeks. It is reasonable for the employee to claim for travel expenses when using public transport for the purpose of obtaining medical treatment.

Ambulance costs are subject to the same rules - it must have been medically required for the employee to use an ambulance.

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Collecting medication

If an employee travels to collect medication from a pharmacy, section 16(7) applies. That is, compensation is only payable if:

- when using a **private vehicle**, the entire journey, including outward and return, exceeds 50km, or
- when using **public transport**, there is no distance requirement, but the employee's injury had to reasonably require the use of such transport or services.

Where the employee's travel to collect medication falls within these conditions, the employee needs to provide medical justification to claim travel costs, as with any other claim for medical costs. Evidence could be in the form of a medical certificate from the Treating Health Practitioner explaining

why it is necessary for the employee to travel a long distance to collect the medication, or why it is necessary for the employee to use public transport.

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Flights

There are circumstances where an employee may need to travel interstate or from a remote location to obtain medical treatment or to attend a medical examination. Examples of when flights may be required include:

- when it is not reasonable for the employee to drive long distances to obtain treatment or attend an examination
- where the employee requires specialised treatment that is not available close to where they live.

Organising flights

You may consider it reasonable to organise flights for an employee to obtain medical treatment or attend a medical examination. However, you should offer the employee a choice. The employee may prefer Comcare to arrange and pay for their flights. Or they may wish to organise their own flights and seek reimbursement from Comcare.

Whether it is you (the Claims Manager) or the employee who is organising the flights, the following must be considered:

- where the employee lives
- scheduled time for the examination
- the availability/time of flights/connecting flights
- lowest flexi fare flight option in economy/ticketing conditions. **Note:** Flexible flights allow for cancellation/changes to be made to the travel dates without incurring additional charges.
- any medical restrictions/mobility issues that an employee may have.

Employee organising flights

If an employee is organising their own flights, they will need to seek approval for their flights from the Claims Manager. The employee will need to send a copy of their itinerary with their receipt confirming payment to the Claims Manager for reimbursement.

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Cab vouchers for claim-related travel

If employees are required to travel by air for a medical examination or medical treatment, they need to catch taxis to/from airports. Comcare can cover the costs of taxi fares in this case.

Comcare can also cover the costs of taxi fares where employees are unable to utilise other modes of transport. It is Comcare's preference that employees first pay the taxi costs and then seek reimbursement. However, you may authorise cab vouchers for the employee if the employee is not able to pay the taxi costs at the time of travel.

Claims Managers should send their requests for cab vouchers to Claims Management - CAIS - Complex Payments. Comcare has the option of issuing either paper vouchers (via post) or digital vouchers (via SMS or email). The Claims Administration and Income Support team (CAIS) will organise delivery of cab charges to the employee. The employee should not return any receipts after using the vouchers as the information is provided to Comcare digitally.

You should include the below information when requesting cab vouchers:

- **Employee Name:** [Surname, first name]
- **Claim number:** [xxxx/x]
- **Email address:** [employee's email]
- **Mobile:** [employee's mobile number]
- **Number of Vouchers:** [max is 32]
- **Expiry date:** [please specify expiry date or CAIS will put a 3 month expiry on vouchers]
- **Reason for Trip:** [e.g. medical appointment/IME]
- **Delivery preference:** [vouchers sent via email or SMS]
- **Have you confirmed Smart phone capability?** [yes/no]

Once CAIS have posted the paper cab charges (if paper vouchers were requested), a copy of the outgoing mail request form will be scanned to the Pracsys file.

If the employee is using digital vouchers for the first time, you will need to send them the Digital Cabcharge – User Guide.

If you need more information about cab vouchers, you can access more information from Cabcharges – Claims Manager's Guide.

Travel via a ride sharing company such as Uber is treated in the same way as a taxi. However, cab vouchers are not valid for use with ridesharing companies. Employees can submit their receipts from a ridesharing company to Comcare for reimbursement.

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Support person travel costs

Employees may require or request a friend or relative to attend a medical examination or treatment with them. Where an employee requires someone to accompany them for medical reasons, Comcare will meet the travel costs associated with that person attending. If a support person is not required for medical reasons, then costs associated with their travel will not be met by Comcare. Medical evidence from a legally qualified medical practitioner may be required to reimburse costs for a support person.

If a support person is required and you, as the Claims Manager, are booking the travel and accommodation for that person, you will need to collect details of the person (such as name and contact details) to be able to book the journey. You may need to ask the employee to supply these details to you.

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Meals and accommodation

Where an employee needs to travel long distances to obtain medical treatment or attend a medical examination, they may request reimbursement for meals and accommodation costs. If so, the employee will need to submit their receipts for reimbursement.

Where possible, the employee should submit a valid tax receipt or invoice with the EFTPOS receipts as EFTPOS receipts do not always contain sufficient information for processing purposes.

Costs associated with the following items are normally the responsibility of the employee:

- magazine/books
- Wi-fi or in-house movies
- mini bar purchases
- alcoholic beverages
- cigarettes/tobacco
- personal items e.g. soap, shampoo, toothpaste
- clothing e.g. pyjamas
- laundry services
- personal telephone calls

When discussing the employee's travel requirements with the employee, you may want to consider whether it is reasonable to organise the employee's accommodation.

If it is reasonable, you should always offer the employee the choice as to whether they would prefer:

- Comcare to arrange and pay for their accommodation; or
- to organise their own accommodation and seek reimbursement from Comcare.

For further details on how to book an employee's accommodation, please see [Booking flights and accommodation](#).

When assessing the reasonableness of costs for meals and accommodation, you should have regard to the:

- distance between the employee's home and the appointment location
- scheduled time of the appointment, and
- impact of travel on the employee's compensable condition.

To assess whether the costs claimed by the employee are reasonable, you should refer to Comcare's travel policies, especially the current accommodation expense caps.

While these are internal documents, they provide guidelines on appropriate travel costs that could be considered reasonable for the employee to claim for when travelling to obtain medical treatment and include indicative daily caps for accommodation and meals for all major cities and high-cost country areas.

Please note that the indicative daily caps are a guide only and, in some cases, it may be reasonable to determine amounts above the indicative daily cap.

Prior to the employee travelling to obtain the required medical treatment or attend the medical examination, you should advise the employee of the indicative daily cap for meals and accommodation in the city the employee is attending.

If costs claimed by the employee are above these caps, then further investigations will be required to determine whether the costs are reasonable.

When determining the reasonableness of these costs, you should always have regard to the individual circumstances of the claim.

Note: If you have any concerns regarding the costs for meals and accommodation, please discuss this further with your Assistant Director.

Example 1: You have arranged a section 57 assessment in Canberra for an employee with a psychiatric condition. The employee lives in Bateman's Bay (2.5 hours' distance by road). The assessment is scheduled for 12:00pm and will go for approximately one hour.

In this circumstance, it would not be reasonable to pay for overnight accommodation in Canberra, either before or after their assessment. This is because there is sufficient time for the employee to complete the travel in daylight hours on the day of the appointment.

However, it would be appropriate for the Claims Manager to reimburse the employee the reasonable cost of their lunch on the day of the appointment.

Example 2: An employee has a physical injury that prevents them from sitting for extended periods of time (for example, a back injury). The employee is required to travel from Canberra to Sydney for an appointment at 3.30pm.

The employee leaves home at 10.00am to make the appointment on time as their condition requires them to take regular breaks from driving. This means their journey will be significantly longer than would normally be expected.

As the employee's physical condition makes it difficult for the employee to sit for long periods of time you may consider paying for one night's accommodation to allow the employee to rest before heading back to Canberra.

If it is considered reasonable for the employee to stay overnight in Sydney, it would be appropriate for the Claims Manager to reimburse the employee for the reasonable cost of their lunch and dinner on the first day of their travel and breakfast on the following day.

As the employee would be expected to arrive home before 1.00pm on the day that they left Sydney, lunch for that day would not be included.

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Booking flights and accommodation

Comcare uses QBT ('CMT') online booking tool for work-related travel, accommodation, flights and car hire. The portal allows users to book air travel and accommodation. It is the preferred booking method as it is the most efficient way to book and manage travel.

To access the portal for the first time, you need to obtain approval from your Assistant Director by emailing 'Help Desk – Finance' requesting that a travel profile is created for you to access the portal. In your email, include the following information:

- Your Employee ID (AGS number)
- Title/First Name/Last Name
- Gender
- Date of Birth
- Email address
- Business Phone
- Cost Centre

The information above is required to set up your travel profile so that you can book travel for the future, and for the system to identify who has booked the travel. The cost centre advises Finance which group within Comcare your profile is to be set up under and is not used for any other purpose.

Finance will send an email confirming your profile has been set up and include details of how to log in to the portal, set up a password. They will attach information on how to make bookings in the portal.

Instructions on how to book air travel and accommodation can also be found in QBT/CTM under 'Knowledge Centre' and 'Training' (the guide is called 'Cytric - WoAG User Guide').

Refer also to the resources on ComNet under the Travel page on Comnet.

Your Assistant Director will also need a travel profile in order to approve travel bookings.

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Paying for flights and accommodation

If flights and/or accommodation have been arranged, these costs are paid against the employee's claim. Further details are provided below:

- You will not need to enter the card/payment details. When your travel profile is set up, a card is set up as a default account for users in the Claims Management Group booking travel for employees. Travel is charged to this card/default account.
- Each month QBT/CMT provide Finance with a list of all the charges (flights, accommodation etc) incurred on the account/card.
- Finance prepares a spreadsheet of the charges/invoices for employee travel and emails it to CAIS-Complex Payments for processing/payment.
- CAIS-Complex Payments process the travel in line with their normal processes. Payments are processed against the claim using the codes below:
 - **Financial Group:** Travel
 - **Payment Type:** Travel by Aeroplane (Flights)
 - **Financial Group:** Travel
 - **Payment Type:** Other Travel Expenses (Accommodation)

Once payments have been processed against a claim, CAIS-Complex Payment send an email to the CM to advise them of the travel processed.

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Service provider travel

Section 16 of the SRC Act provides for the payment of travel expenses incurred by an employee when they travel to obtain medical treatment.

However, there are no provisions under section 16 to reimburse medical, allied health and household help/attendant care service providers for their travel costs incurred when providing services to the employee.

Further, there is no provision under section 16(6) that allows Comcare to directly reimburse the specified rate per kilometre to service providers when travelling in a private vehicle.

Service providers including medical, allied health and household help/attendant care service providers should include their travel costs in their service fees.

Some fee schedules, for example the Australian Medical Association's List of medical services and fees include higher fees for consultations that are provided outside of the treating practitioner's usual consulting rooms such as home and hospital consultations to cover the cost of the service provider's travel.

Where there are standard rates for home or hospital consultations, the medical or allied health service provider should bill Comcare for these services using the appropriate item codes and fees.

In instances where the standard rates only cover consultations within the treating practitioner's consulting rooms and the service provider charges above the standard rate to cover their travel expenses, the Claims Manager has the delegation to decide whether the additional charge over and above the standard rate for the equivalent service is reasonable in the circumstances.

Where there are no set fee schedules or standard rates for medical or allied health treatment, the service provider should include their reasonable travel costs in their consultation or hourly fee.

In all cases, when invoicing Comcare for the cost of their travel, the cost of the travel needs to be included in the fee for the service and not itemised separately on the invoice.

If you need to talk to the service provider about their travel costs, you may need to explain that:

- Under the SRC Act, Comcare can only reimburse medical treatment costs, there are no provisions under the Act where Comcare can pay for the service provider's travel costs separately.
- Reasonable travel costs should be included in their medical treatment or service fees.
- Where the relevant medical or allied health service rates include item codes and rates for services that are performed in the home, hospital or not-in-rooms, (these usually have a higher fee than an in-room consultation or service to cover the travel costs), the service provider will need to bill Comcare using the correct item code and service rate.
- Where there are no relevant medical or allied health service rates for the treatment or service, the service provider should include their reasonable travel costs in the fee for the treatment or service and not bill them separately.
- Comcare will normally only pay for home visits in instances where the employee's compensable condition requires the service provider to travel to their home.
- If the employee is capable of travelling to the service provider's consultation rooms, then Comcare may not pay for the service provider's travel unless there are good reasons for doing so.
- All requests for reasonable travel costs will be assessed on their merits.

Remember: To update the treatment plan comments with the approval details including the date of service and amount that has been approved (if known).

Exceptions: There may be instances where Comcare may need to pay for the service provider's travel separately. For example, if the employee lives in a remote or rural area and is unable to travel due to their compensable injury.

If you have any concerns about the payment of a service provider's travel costs, please discuss these with the Technical Capability Officers or your Assistant Director

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Rejecting or reducing travel expenses

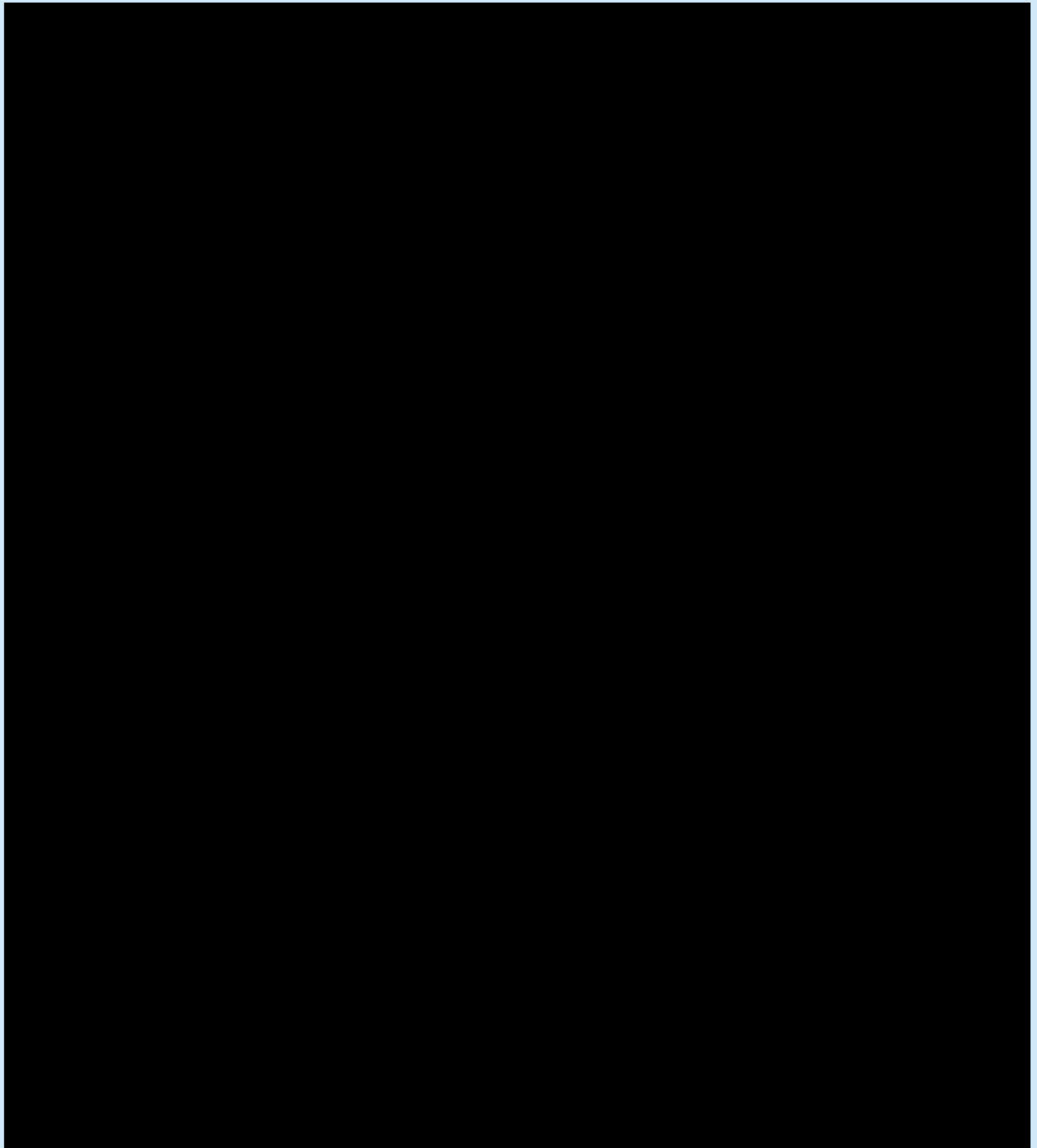
When considering a claim for travel costs, you may decide to reject or reduce travel costs claimed by the employee. You may determine that travel to attend a medical appointment was not necessary or

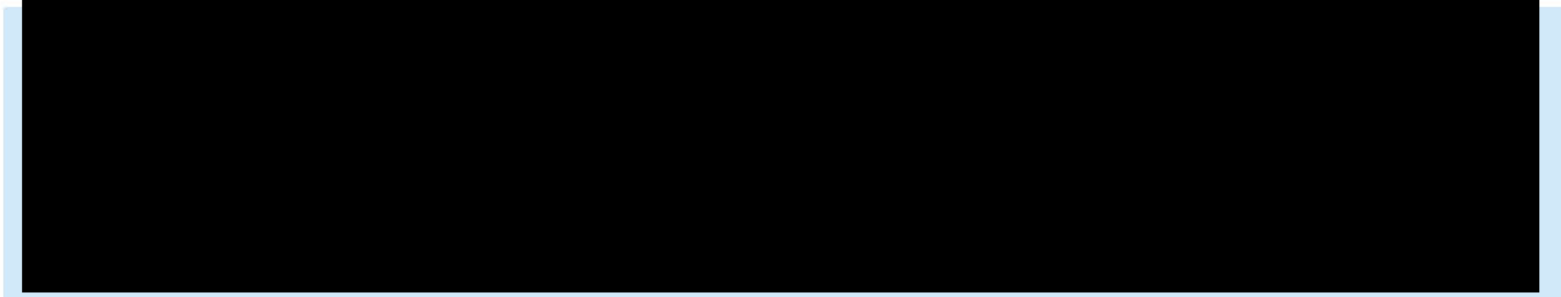
could have been minimised. In other circumstances, you may determine that the costs claimed are excessive.

It is important that you have fully investigated the individual circumstances of the claim. You also need to contact the employee to give them an opportunity to provide clarification and further evidence. Only then can you proceed to reject or reduce travel costs.

Note: Refer to the Assessing the reasonableness of travel costs detailed above for further information.

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Considerations for aids, appliances, alterations and modifications under sections 16 and 39

Introduction

Section 16 of the SRC Act provides for compensation for medical aids and appliances. Section 39 provides for compensation for rehabilitation aids, appliances, alterations and modifications.

See Medical aids and appliances under section 16 and Rehabilitation aids, appliances, alterations and modifications under section 39 for more information on items that are specific to each section.

This page provides information relevant to both sections of the Act. This includes:

- How an employee can claim for aids, appliances, alterations and modifications.
- The meaning of 'reasonably required'.
- Information on what are considered to be 'reasonable' costs.
- Assessment of the need for aids, appliances, alterations or modifications.
- Information on what a quote should include.
- The procedure to get multiple quotes.
- Safety equipment, safety standards and insurance for aids and appliances.
- Batteries, servicing, insurance and operating costs for aids and appliances.
- Repair and replacement of aids and appliances.
- Procedure to determine liability for repair or replacement of aids and appliances.
- Procedure to accept liability for aids, appliances, alterations and modifications.
- Procedure to decline liability for aids, appliances, alterations and modifications.

Roles and responsibilities

The Claims Manager determines liability for aids, appliances, alterations and modifications. The Injury Manager provides support to the Claims Manager to help with assessing and determining liability. In some cases, a referral to the Clinical Panel may be needed, following consultation with the Injury Manager.

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Claiming for aids, appliances, alterations and modifications

Comcare prefers that a claim is made in writing before the employee purchases an aid or appliance or contracts a service provider to undertake alterations or modifications.

The amount of compensation payable under section 16 or 39 of the SRC Act, for the purchase of an aid or appliance or for alterations or modifications is payable by Comcare to, or in accordance with the directions of, the employee.

This means that an employee can be either reimbursed if they have paid an amount themselves, or the employee can direct Comcare to pay the provider or supplier of an aid, appliance, alteration, or modification.

Such compensation must be reasonable in respect of costs incurred.

Requests can be received in writing from:

- the employee requesting payment for an account associated with the purchase of an aid or appliance using the:
 - [claim for aids and appliances excluding hearing aids](#) form, and
 - endorsed by a Legally Qualified Medical Practitioner (LQMP), treating practitioner or approved rehabilitation provider (ARP) or
- the employee requesting payment for an alteration or modification using the:
 - [claim for alterations to a place of residence/work or modifications to a vehicle/article](#) form, and
 - endorsed by a treating practitioner, ARP or a LQMP
 - this may or may not include a request for payment of an account.
- the employee requesting hearing aids using the [Hearing Aid Request](#) form
- an ARP who has completed a home assessment, initial needs assessment or workstation assessment
- a LQMP, who has made a recommendation on a medical certificate or in a medical report, or
- the employee otherwise requesting payment for an account.

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‘Reasonably required’ aids, appliances, alterations and modifications

An alteration, modification, aid, or appliance must be **reasonably required**, having regard to the nature of the employee’s impairment and the requirements of the rehabilitation program, where appropriate.

An alteration, modification, aid or appliance:

- may be considered reasonably required where it alleviates pain and increases safety while driving (*Pollanen and Comcare [2004] AATA 134*)
- would generally **not** be considered reasonably required where its purpose is to assist the employee in a leisure or recreational activity (*D’Costa and Comcare [2000] AATA 1109*)
- would generally not be considered reasonably required where it is unsuitable to use because of the nature of the impairment (*Birch and MRCC [2005] AATA 894*).

Other relevant matters for consideration may be whether:

- the employee has difficulties with independence (e.g. communication, mobility, personal hygiene) and how the aid, appliance, alteration, or modification assists them in these functions
- the employee could reasonably access the aid or appliance through other means, and
- the employee’s safety, or that of their family or carers, could be compromised without the aid, appliance, alteration, or modification.

Arranging an assessment of the need for aids, appliances, alterations or modifications

It may be necessary to arrange and pay for an assessment to determine what alterations or modifications, aids or appliances the employee reasonably requires.

Section 70 (for Comcare) or section 108F (for licensees) of the SRC Act provides the authority to arrange and pay for an assessment.

An employee is not obliged to attend or cooperate with the assessment, but it is in their interests to participate and progress their claim.

The assessment may be undertaken by an approved workplace rehabilitation provider or a suitably qualified person such as an occupational therapist, and cover issues such as:

- reasons for recommending any alterations, modification, aids or appliances
- alternatives considered
- how long it will be required
- whether it is likely to require repair or replacement
- recommended suppliers
- any other relevant matter.

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Reasonable costs under sections 16 and 39

Section 16 of the SRC Act provides that Comcare is liable to pay the appropriate cost of medical treatment the employee is reasonably required to obtain as a result of the injury (see: What is medical treatment?).

Section 39 of the SRC Act provides that:

- where an employee suffers an injury resulting in an impairment, and
- the employee is undertaking, or has completed, a rehabilitation program, or has been assessed as not capable of undertaking such a program,

the relevant authority is liable to pay compensation of **reasonable** costs, payable by the employee, of:

- any alteration of the employee's place of residence or place of work
- any modifications of a vehicle or article used by the employee, or
- any aids or appliances for the use of the employee, or the repair or replacement of such aids or appliances.

These are alterations, modifications, aids or appliances that are **reasonably required** by the employee, having regard to the nature of the employee's impairment and, where **appropriate**, the requirements of the rehabilitation program.

The SRC Act does not provide definitions on what is 'appropriate' or 'reasonable.'

There are many items for which Comcare may be liable, under section 16 or section 39 of the SRC Act, to assist an employee with their medical or rehabilitation needs.

Comcare supports a flexible approach to assessing reasonable cost. This allows you, with the knowledge of the individual circumstances of each claim, to decide on the best approach.

The Injury Management Team can help with reviewing the reasonableness of and associated costs for aids, appliances, alterations, and modifications.

Investigating reasonable cost

While the SRC Act gives the choice of provider/supplier to the employee, it permits payment of compensation of less than the cost where alternative supply was reasonably available at a lesser cost from another provider or supplier.

A majority of aids and appliance requests are for items under \$100. Requests for items under \$100 would generally not require an extensive investigation.

For more expensive items, Comcare usually requires a minimum of three quotes in order to determine whether the cost of the aids, appliances, alterations, or modifications is reasonable and to ascertain if there is an alternative supply that was reasonably available at a lesser cost from another provider or supplier.

If the employee has only provided one quote or invoice in relation to the requested aids, appliances, alterations, or modifications, the Claims Manager and/or the Rehabilitation Case Manager (RCM) will need to work with the employee to obtain the additional quotes where possible to do so.

See [What information should a quote contain?](#) for details on acceptable quotes.

There are a variety of ways to investigate the costs associated with an aid or appliance.

For example, check what Comcare has previously paid for such an item – discuss this with your Assistant Director and the Injury Manager. For more specialised or less commonly purchased items, seek other advice from your Injury Manager first and if necessary, from the Clinical Panel.

You can also work with the employee, prescribing health practitioner and/or the RCM to obtain three quotes. See [Procedure to get multiple quotes](#) for further cost investigation for more information on asking the employee to provide quotes.

The burden on the employee to seek additional quotes should be carefully considered taking into account the employee's age, incapacity, location, and any specific requirements the employee may have that might make it difficult for them to obtain the required quotes. In these instances, the Claims Manager and the RCM may need to work together to obtain the required quotes.

Usually, Comcare requires the original quote (or cost) and two additional quotes to assess whether the cost of the request is reasonable.

Unreasonable quoted costs

There may be scenarios where it is clear that the employee’s quoted price is unreasonable.

For example, you may believe that the product could be sourced for a lower price (less than 90 per cent of the employee's requested price) and that the lower price is the more reasonable. In that case, you should determine that the amount Comcare is prepared to pay is an amount equal to the lower price.

You should advise the employee that if they wish to purchase the more expensive product, they will need to personally pay the difference between the two quotes.

If compensation payable is less than the cost of the aids, appliances and alterations, the employee is personally liable to the supplier for the difference.

The table below shows factors for you to consider when investigating costs.

Considerations:	Guidance:
The cost	You need to consider if the cost payable is reasonable , not the cheapest available. If the employee's preferred quote cost is within 10%

	of the other quotes received, then the claimed amount would usually be considered reasonable. If the employee has sourced 3 quotes and they have expressed a preference for a product that is not the cheapest, consider whether their reasons are valid. Is it that the preferred product is likely to better meet their needs or just that they want additional functionality that, while nice to have, is not necessary to address their condition? Note: More than 60% of aids and appliance requests are for items under \$100. Requests for items under \$100 would generally not require an extensive investigation.
Your knowledge of the item purchased	Some items commonly purchased by employees may be items with which you are familiar in terms of what they cost, either from your personal experience or because you have processed several claims for such items in the past. Where you are familiar with the cost, there would be no need to undertake further investigation.
If the item is a specialised product	Some items requested are of a very specialised nature or need to be customised for the individual employee. These items would not be widely available for purchase so it may be difficult to obtain quotes. For these items further investigation would usually not be required. Example: Custom-made orthotics, prosthetic devices, expensive medical aids such as intrathecal pumps and heart valves and specialist software such as Dragon speaking software.
If the item provides a personal benefit to the employee	There is a greater risk associated with items that assist the employee with their compensable injury and also provide a personal benefit to the employee. These items are general household items that might be purchased regardless of an injury e.g. beds, chairs, pillows, desks etc.

	Example: If an employee is advised by a legally qualified medical practitioner or approved rehabilitation provider that they need a more supportive bed, they may be inclined to seek a \$8000 top of the line bed as opposed to a \$1500 bed that might meet their requirements. A further example would be paying for just the mattress rather than an ensemble or base. It is important to ensure that Comcare only compensates the employee for what is required to address the medical/rehabilitation need. The best way to do this is to be clear on the functionality required for the product, as specified in the evidence supporting the claim, so that you can check that the claimed product is appropriate to the compensable condition. On the other hand, there are many items requested that are of a medical nature and which are often supplied by a medical professional. There is a low level of risk that these types of items would not be obtained at a reasonable cost.
If it is more appropriate to buy or hire the item	A variety of aids and appliances that might be required by employees are available for hire as well as for purchase, e.g. crutches, wheelchairs, TENS machines, shower stools/chairs, back braces etc. It is important to consider how long the aid is likely to be required and the cost of hiring versus purchasing the aid or appliance. It may also be appropriate to hire the equipment if the employee is unsure which product may best suit their needs or if it a short-term need.
Who the payment is being made to	The employee must provide Comcare with an invoice as proof that the item has been paid for in full. It is important to ensure that the invoice provided is valid before making payment. Internet sourcing is becoming more common and will often yield a cheaper price than buying from a shop front. It is important to confirm the legitimacy of the quote/invoice particularly where an internet supplier has been used.

	Quotes from the internet may not have the level of detail that would be expected from a non-internet supplier and therefore may require further investigation.
The availability of alternate suppliers	The availability of alternate suppliers is also an important consideration. While cheaper quotes may be available from different shop fronts or online stores, these options may not be available to the employee. Or, in the case of internet suppliers, the employee may not feel comfortable with making online purchases. Consider whether it is reasonable to expect the employee to source the product from these alternate suppliers. Example: If the employee is living in a remote area or if the employee has limited mobility.
GST considerations	You also need to consider any GST implications for medical aids and appliances. Medical aids and appliances are GST-free if they are: • specifically designed for people with an illness or disability, • not widely used by people without an illness or disability and • listed in schedule 3 of the GST Act or in the GST regulations For example: Wheelchairs would be considered GST-free as they are specifically designed for people with an illness or disability. For further information see: Medical aids and appliances Australian Taxation Office Goods supplied as part of a GST-free health service Australian Taxation Office Please note: Service providers must have an active ABN with a current GST registration in order to claim the GST component.

What information should a quote contain?

A quote should contain, as a minimum, the following information:

- the specific type of aid/appliance (if applicable) - make, model and manufacturer
- details of the alteration/modification (if applicable)
- clearly note the itemised costs of alterations/modifications (if applicable), i.e. include details of cost of materials and labour
- include the cost, exclusive of GST, and state the total amount of GST payable
- contain the provider/organisation contact details, including its ABN
- be on a business letterhead
- be signed and dated.

Comcare cannot process payments from a quote. A tax invoice or receipt must be submitted for payment by the service provider or employee.

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Safety equipment and safety standards for aids and appliances

Safety equipment

Safety equipment that is **legally required** to operate an aid or appliance can be considered an integral part of an aid or appliance where, without it, the device could not provide the support or relief to the employee.

If the device cannot be operated without the safety equipment, the equipment is compensable. This is because the device is unable to legally provide the support or relief for which it is required for an impairment associated with an employee's compensable condition.

Equipment that is recommended to operate an aid or appliance but is not legally required is not compensable.

Example: Comcare accepts liability for a mobility device under section 39 for an employee with mobility issues arising from their compensable condition.

It is a legal requirement in the state in which they reside for a person using a mobility device to wear a safety helmet.

In this case, the mobility device could not legally provide the support or relief for which it was required without the safety helmet. So, the safety helmet is compensable.

Safety standards

There are several Commonwealth and State standards that govern alterations to a building and the modification of vehicles that are used on Australian roads.

Suppliers and manufacturers of aids and appliances must also meet product safety requirements under Australian Consumer Law. And they are legally obliged to comply with Australian safety standards and only sell safe products.

It is the responsibility of the employee to purchase aids and appliances that meet the product safety standards. It is the responsibility of the property owner to have any alterations or modifications carried out in accordance with the relevant standards and guidelines that apply.

Batteries, servicing, insurance and operating costs for aids and appliances

Batteries and operating costs

Where an aid or appliance is battery operated, the battery is considered an integral part of the aid or appliance itself. Replacement batteries can be paid for under the provisions of the SRC Act as a repair/replacement of an aid or appliance.

Operating costs, such as electricity, are considered to be money spent by the employee to operate the aid or appliance. But they are not an integral part of the aid/appliance. They cannot be physically repaired or replaced. Therefore, there are no provisions under the SRC Act to pay any associated costs incurred by the employee in operating the aid or appliance.

Example: A mobility device contains a chargeable battery to allow its operation. As the battery can be 'repaired' it can be considered part of the aid and therefore liability can be accepted for the repair or replacement of the battery.

However, the electricity used for charging the battery is non-compensable as it is not considered to be a part of the device but is instead an operating cost.

Servicing and maintenance

There is no provision to pay for servicing or maintenance of any aid/appliance, alteration, or modification. The SRC Act only allows for 'repair or replacement'.

An employee may have their aid or appliance serviced, and the provider may have to repair or replace a part to ensure it is operating within the normal functional use for which it was made. In this case, the employee may be eligible for compensation for the specific repair/replacement costs (excluding the other regular servicing costs).

Insurance

There is no provision under the SRC Act to pay for insurance.

Example: Comcare accepts liability for a mobility device and the employee requests reimbursement for costs associated with third party insurance they decided to purchase.

The insurance is 'optional' and not required to operate the device. Without insurance, the device can still be used for the purpose for which it was provided. It can be used by the employee to provide the support or relief for which it was purchased. Therefore, insurance is not compensable.

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Determining liability for the repair or replacement of an aid or appliance

An employee may claim compensation for the repair or replacement of aids and appliances provided by Comcare if such items are accidentally damaged, lost, or have deteriorated due to normal wear and tear.

Comcare does not cover the cost of replacement where the employee has chosen to dispose of the aid or appliance.

Repair of the aid or appliance should be considered before replacement.

Consideration needs to be given to the following:

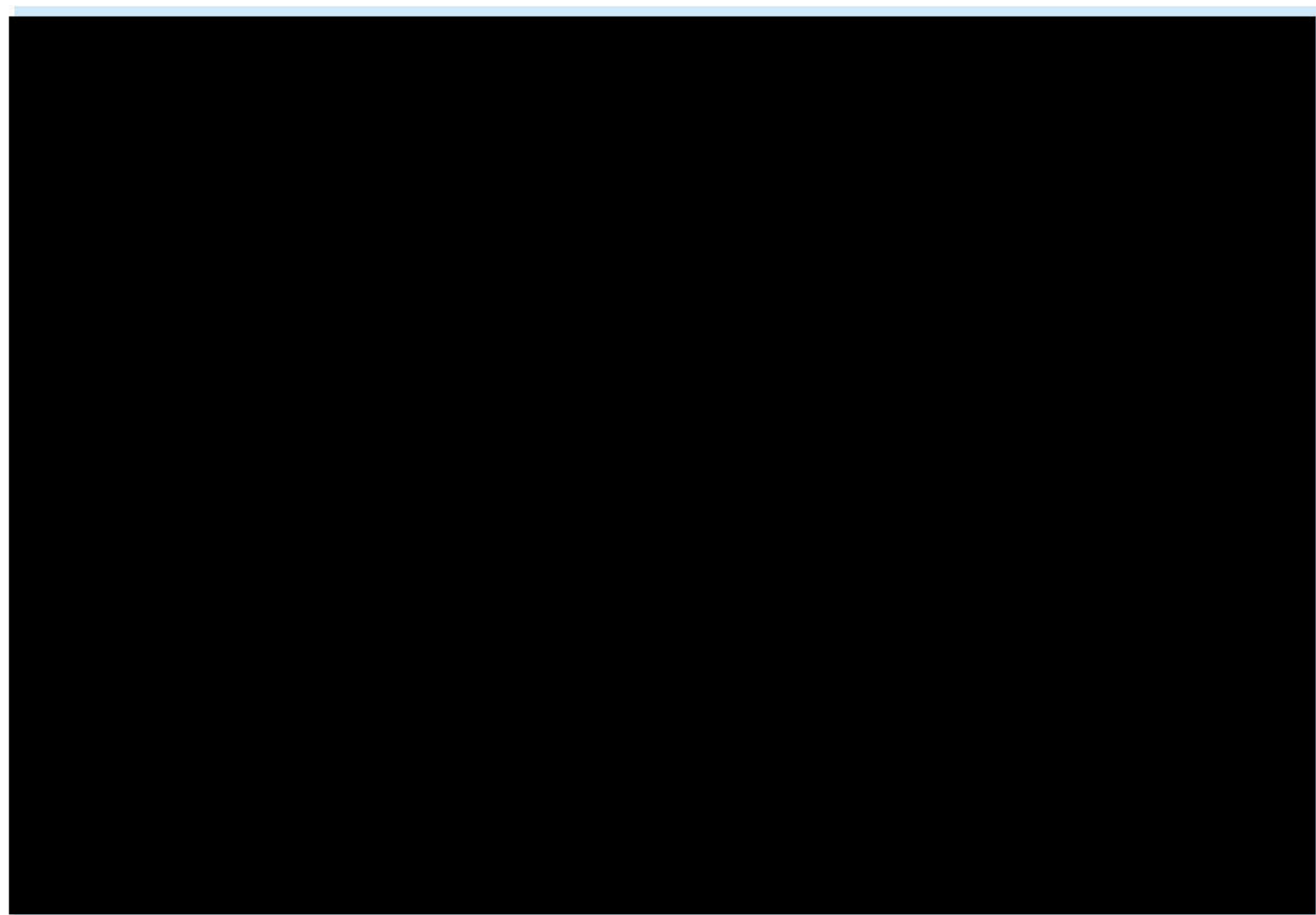
- if the employee requires the aid or appliance immediately
- the time it will take to make a repair
- the cost to repair the item as opposed to replacing it
- if the item is covered under warranty.

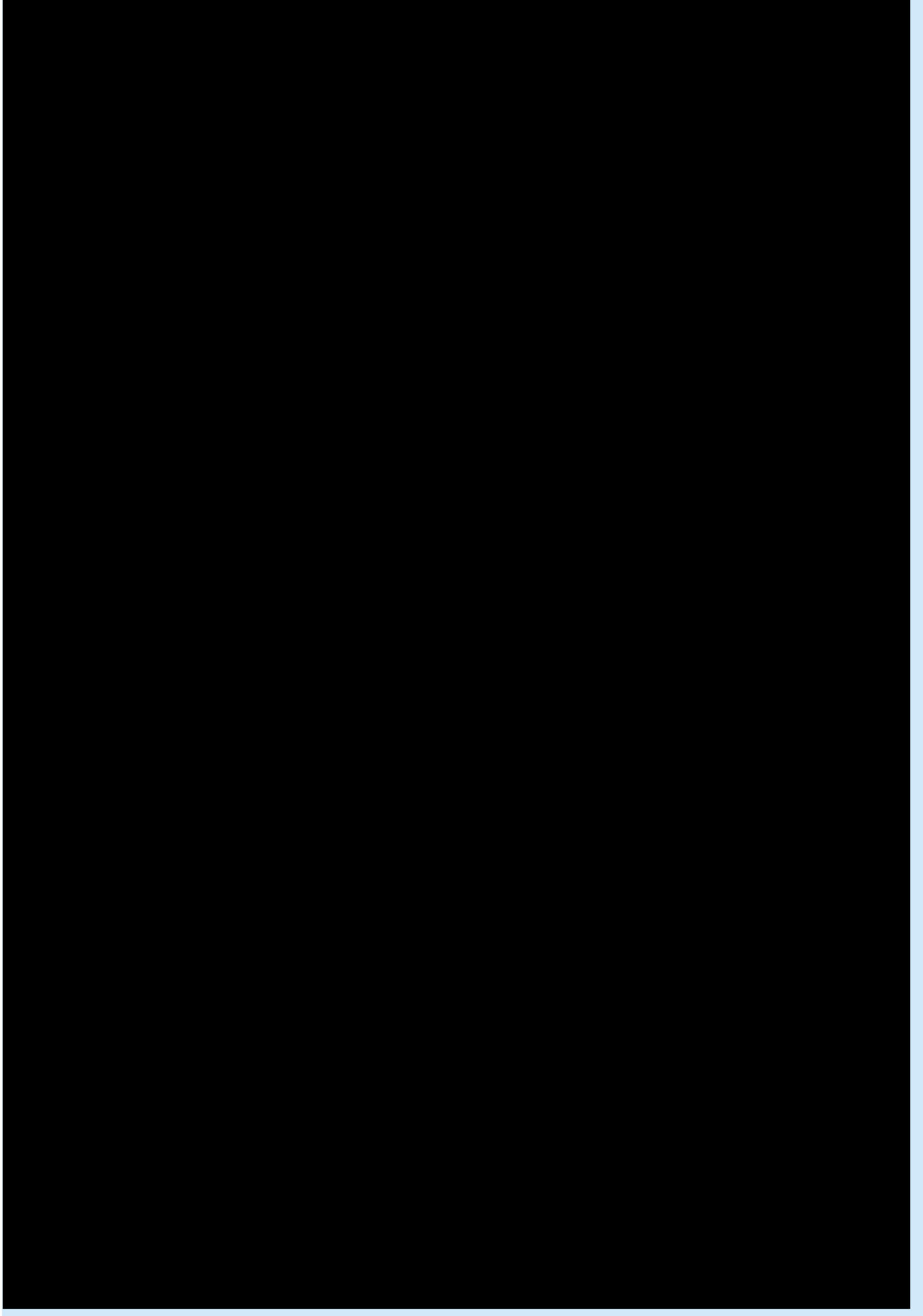
Note on warranties: If the claimed repair or replacement of the previously paid aid or appliance is covered under a valid warranty it is the employee's responsibility to arrange for such a repair or replacement.

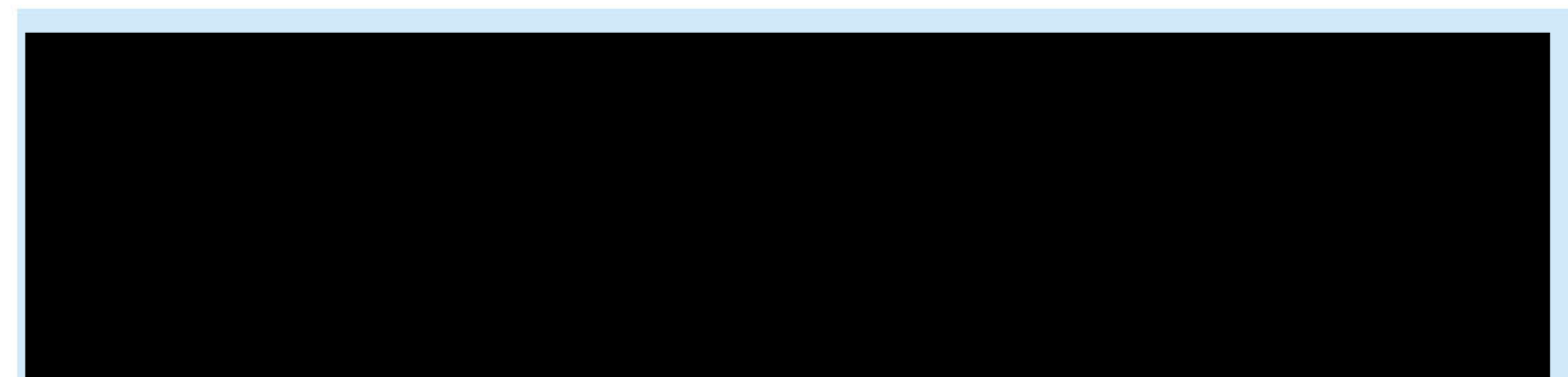
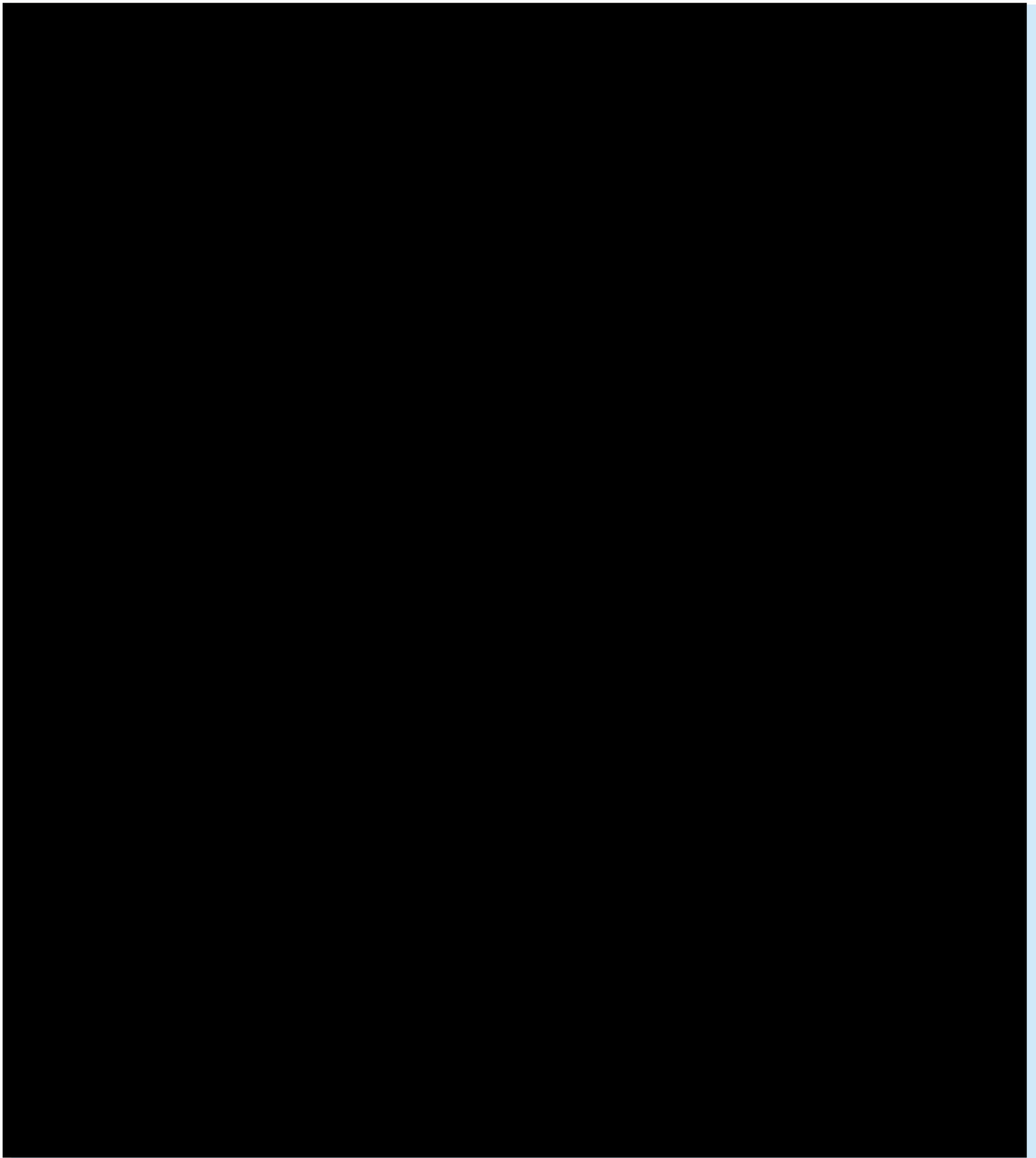
If the claimed repair or replacement that is covered under warranty will result in a significant period of time in which the aid or appliance is not available to the employee for their use, you may consider the option of temporary hire of the same aid or appliance.

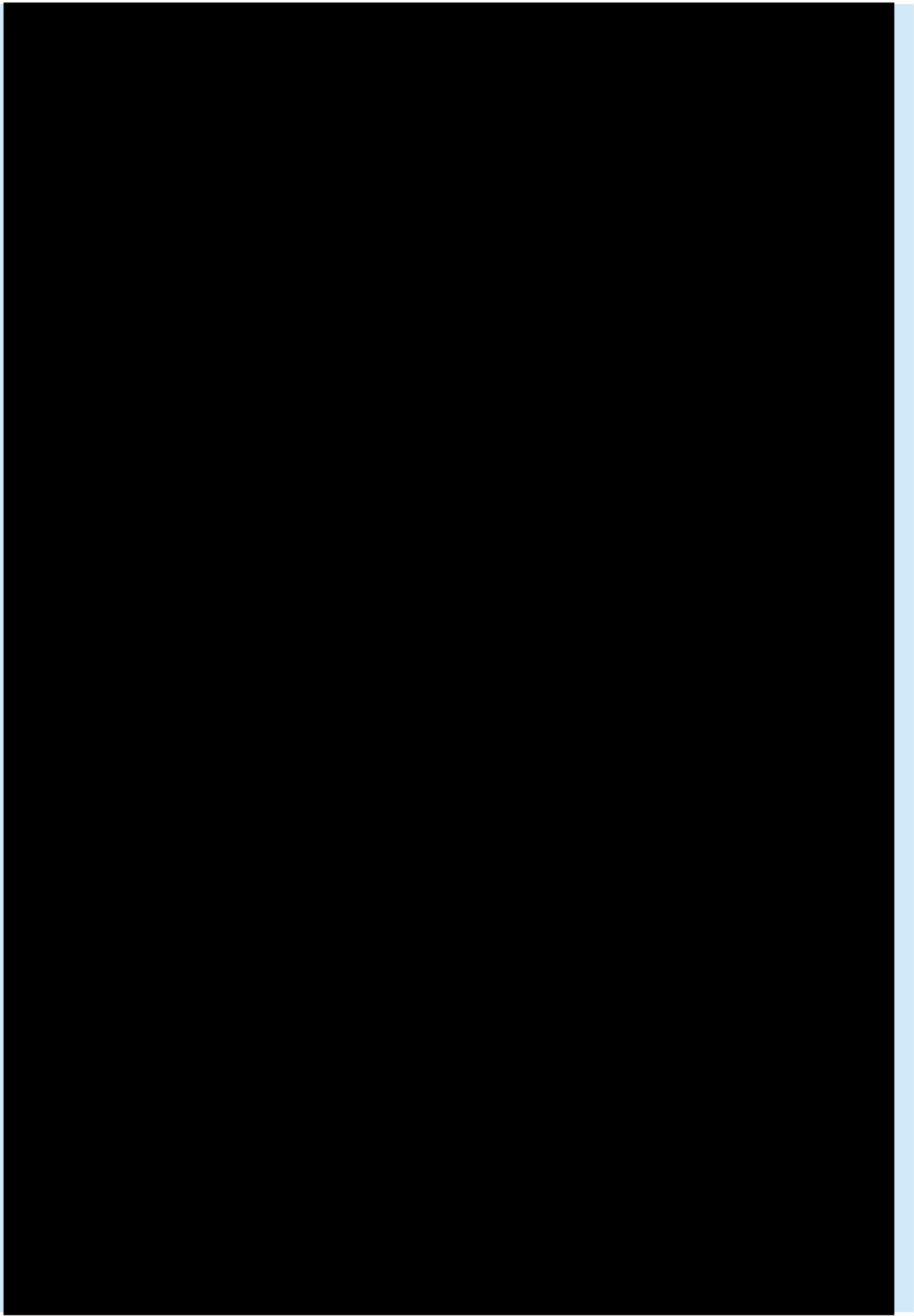
Follow the Procedure to determine liability for the repair or replacement of an aid or appliance below.

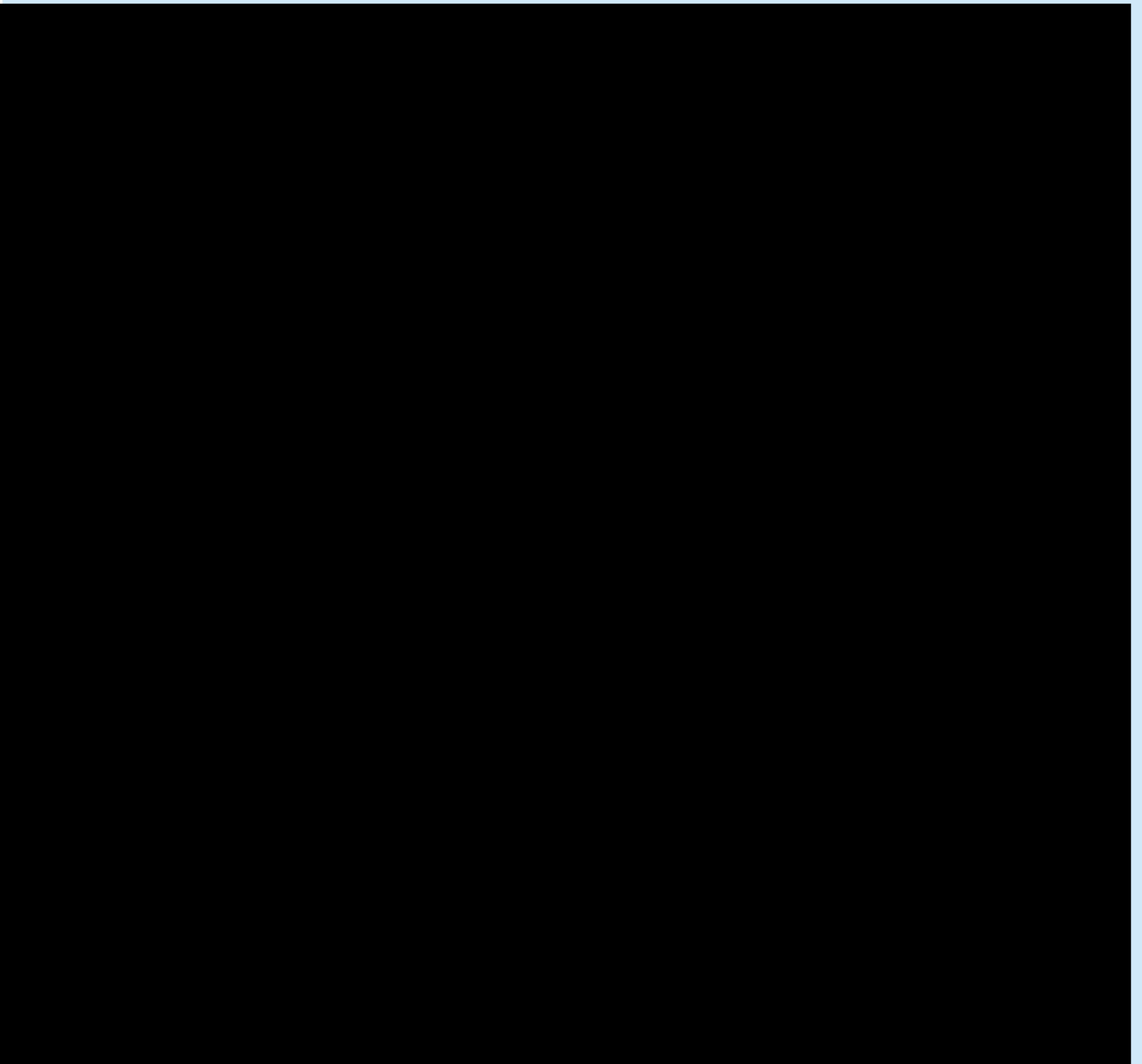
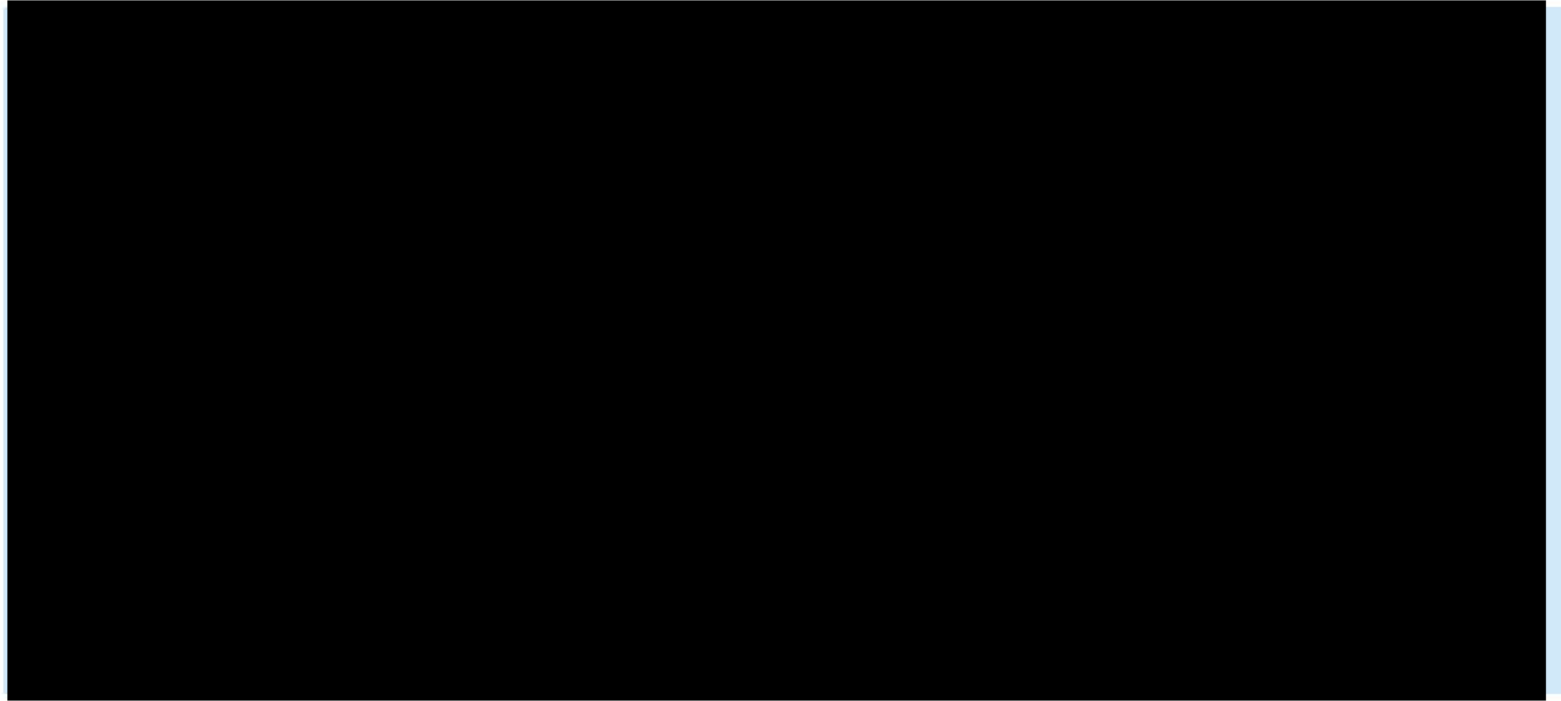
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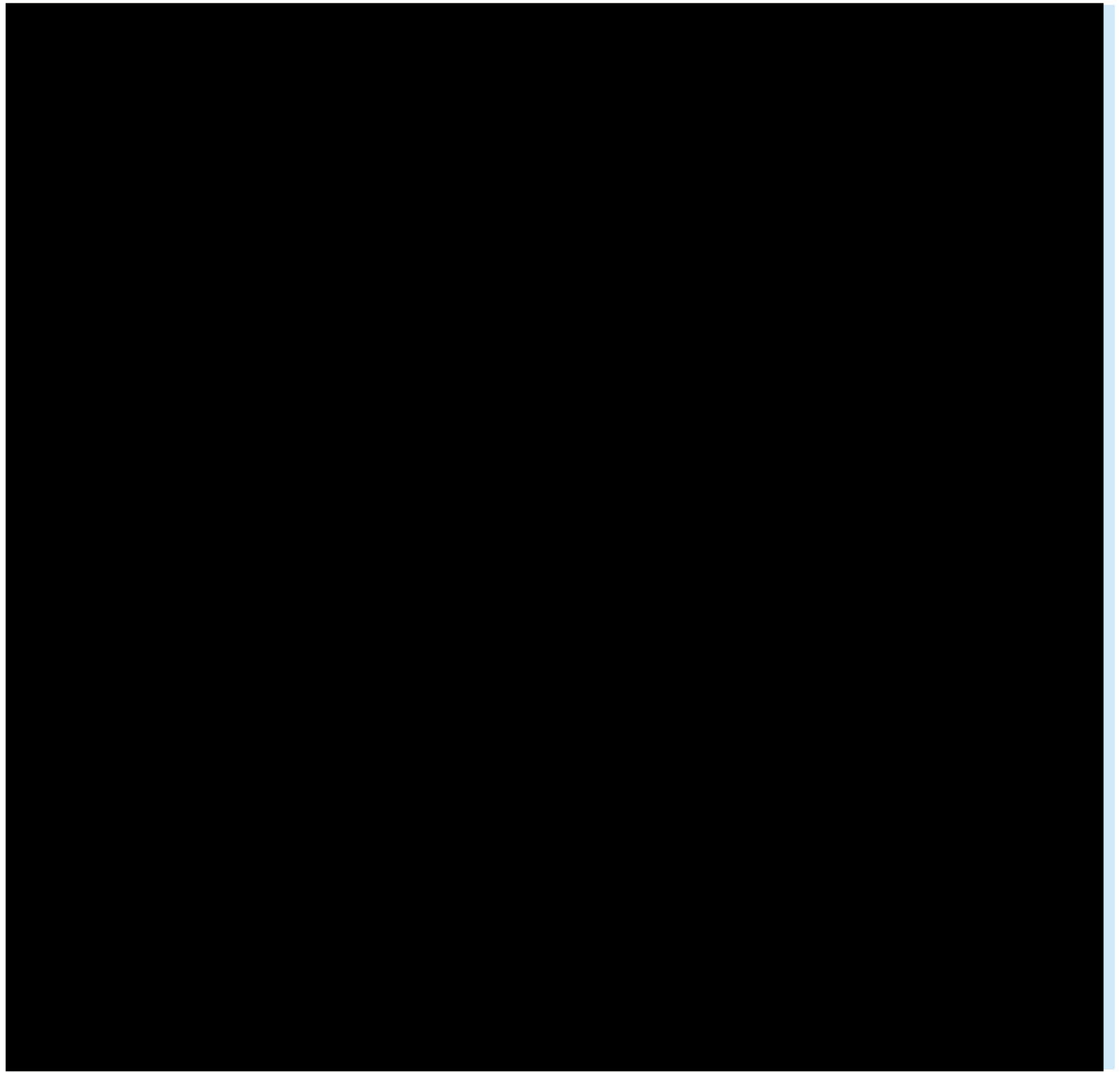












Rehabilitation and return to work

Rehabilitation and return to work

Rehabilitation is the process of returning an injured employee to their pre-injury duties and/or functions as quickly and safely as possible following a workplace injury. It is one of the primary objectives of the legislation and a key focus for Comcare.

In this section

Rehabilitation process

The SRC Act sets out the rehabilitation and return to work processes. This page provides an overview of the legislation and our processes to support an employee to return to health and, where possible, work. It includes information on:

- the [rehabilitation authority](#)
- types of [rehabilitation services](#)
- the [benefits of rehabilitation](#)
- [roles and responsibilities](#) in the rehabilitation process
- information relevant to [reconsiderations and appeals](#)
- [rehabilitation where no incapacity is payable](#)
- [rehabilitation costs, payments and cost codes](#)
- [rehabilitation forms](#), and
- [payment of rehabilitation costs on a claim where liability has been declined](#).

Rehabilitation programs

A rehabilitation program is a structured series of planned activities developed to support employees to return to their pre-injury employment, or any other suitable return to work or recovery goal identified through the rehabilitation assessment process. This page provides information on:

- the [characteristics of a rehabilitation program](#)
- [suitable employment and the return-to-work hierarchy](#)
- [requirements for determining that a rehabilitation program is necessary](#)
- [rehabilitation program options](#)
- [rehabilitation program exclusions](#), and
- [procedure to action a closed rehabilitation program](#).

Invalidity retirement

An invalidity retirement is when a person is retired from the workforce due to a medical condition which is likely to stop them from being able to work again. This page provides information on:

- [Comcare's role](#) in the invalidity retirement process
- [total and permanent incapacity](#)
- [partial and total invalidity retirement](#)

- [qualifying for invalidity retirement](#)
- [Comcare's recommendation](#) and considerations
- [retrospective invalidity retirement](#), and
- [procedure to action an invalidity retirement recommendation](#).

Rehabilitation assessments

A rehabilitation assessment is an assessment of an employee's capacity to undertake a rehabilitation program. It is arranged by the rehabilitation authority and Comcare can pay for costs of the assessment once a claim for compensation has been lodged. This page provides information on:

- [reasons to arrange a rehabilitation assessment](#)
- [who can conduct an assessment](#) or examination
- [things to consider in a rehabilitation assessment](#)
- Rehabilitation assessments performed by a Workplace Rehabilitation Provider
- [when an employee does not undergo or obstructs an assessment](#)
- [payment of a rehabilitation assessment](#)
- [fees for non-attendance at an assessment](#)
- [travel costs associated with assessments](#), and
- [support for rehabilitation assessments](#).

Case conferences

Case conferences involve relevant stakeholders who are brought together to develop a joint strategy to manage a claim or to discuss actions that will facilitate improved rehabilitation, return to work and recovery outcomes for an employee. This page provides information on:

- an overview of [the types of case conferences](#)
- [managing a case conference](#)
- [injury management and return to work case conference](#)
- [practitioner case conference](#)
- [employer case conference](#)

Arranging a vocational assessment

Comcare may arrange a vocational assessment to judge whether an employee has appropriate skills, qualifications or training to undertake suitable employment.

This page provides the following information:

- [When to arrange a vocational assessment](#).
- Refusal to attend.
- Privacy considerations.
- Procedure to arrange a vocational assessment.

Rehabilitation process

Published 31/07/2025

Introduction

In our context, rehabilitation is the process of providing guidance and support to an employee to enable recovery and return to work. Recovery and return to work are not mutually exclusive and rehabilitation should incorporate recovery at work wherever possible.

Under the SRC Act, the 'rehabilitation authority' is responsible for managing the rehabilitation and return to work of their employees.

Who is the rehabilitation authority?

The table below lists the rehabilitation authority for employees in different circumstances:

Status of employee	Rehabilitation authority
Currently employed by the Australian Government agency or statutory authority	The Australian Government agency or statutory authority who employs them.
Moves from one Australian Government employer to another	The new employer becomes the rehabilitation authority and is responsible for the management of the employee's rehabilitation. However, the liability is retained by the original Australian Government employer.
Temporarily transferred from one Australian Government employer to another where the employee continues to be paid by the liable employer	The liable employer remains the rehabilitation authority.
Temporarily transferred to another Australian Government employer (for example, on a work trial where the employee is paid by the new employer)	The role of the rehabilitation authority transfers to the new employer. This role reverts to the substantive employer at the end of the employee's temporary transfer.
Temporarily moves to an employer outside of the Comcare scheme, where the employee is paid by the new employer.	The last Australian Government employer remains the employee's rehabilitation authority.
Leaves an Australian Government employer by any means (such as redundancy, resignation or involuntary separation) and takes up employment with another Australian Government employer	The new employer becomes the employee's rehabilitation authority.
An ex-Australian Government employee who takes up employment with a private sector	The last Australian Government employer remains the employee's rehabilitation authority

company, becomes self-employed, or does not work	for the life of their claim.

Refer to Rehabilitation information for employers for further information.

A rehabilitation authority may engage the services of a Workplace Rehabilitation Provider (approved by Comcare's Scheme Management Group) to develop and implement a rehabilitation program. Or the rehabilitation authority may provide the rehabilitation program for the employee itself.

Comcare supports rehabilitation authorities during the rehabilitation process by:

- liaising with relevant stakeholders
- providing rehabilitation advice
- ensuring claims are managed effectively
- ensuring decisions are accurate and timely
- ensuring entitlements are processed quickly

Claim Operations teams work with the Injury Management Teams to provide this support.

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Rehabilitation services

Section 4 of the SRC Act defines a rehabilitation program as including 'medical, dental, psychiatric and hospital services (whether on an in patient or out patient basis), physical training and exercise, physiotherapy, occupational therapy and vocational training.'

This definition includes elements of both medical and occupational rehabilitation. Both elements come together to provide an effective rehabilitation program for an injured employee. Comcare advises rehabilitation authorities that it is preferable for medical treatment to be determined by Comcare under section 16 of the SRC Act, rather than provided as part of a rehabilitation program. This allows medical treatment to be determined consistently and with regard to Comcare policy and best practice principles as outlined in the [Clinical Framework](#).

Rehabilitation services included in a rehabilitation program approved by a rehabilitation authority may include:

- assessment of work requirements and potential suitable duties for return to work (return to work activities)
- workplace support
- work experience and training
- vocational assessments – for further guidance refer to the [Vocational assessments](#) page
- labour market assessments – for further guidance refer to the [Labour market assessments](#) page
- work trial identification, monitoring and support
- guidance or vocational counselling
- Career Transition Program
- functional capacity assessments
- mediation services
- adjustment to disability counselling, and
- assistance with resume development, job seeking and interview preparation.

If medical treatment is included as part of a rehabilitation program, you should discuss the program with the Rehabilitation Case Manager working with the rehabilitation authority, as well as your Senior Injury Manager, to agree on how best to meet the treatment needs of the employee. You should also flag this with the RTW Support team.

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Benefits of Rehabilitation

The benefits of providing rehabilitation and return to work support for an employee include (as per the Rehabilitation case manager handbook):

For employees:

- maintaining connections with the workplace and feeling supported
- returning to pre-injury activities and lifestyle and encouraging recovery through staying active
- increased confidence in managing their injury and a focus on ability rather than disability
- minimising the risk of long-term disability, absence from the workplace and development of other health issues
- supporting participation, independence and social inclusion.

For employers:

- retention of staff experience and skills
- reduction of costs associated with work-related injury
- improved organisational health
- increased productivity
- improved employee morale
- demonstrated employer commitment to looking after their employees
- demonstrated employer compliance with legislative requirements to provide suitable employment.

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Roles and responsibilities

There are a number of key stakeholders in the rehabilitation process:

Rehabilitation Authority

The rehabilitation authority has statutory powers and functions for the rehabilitation process specified in the SRC Act. The rehabilitation authority is responsible for managing the return to work and health of an injured employee in consultation with relevant stakeholders.

The rehabilitation authority must ensure that, in performing or exercising its functions or powers, it complies with Comcare guidelines issued under section 41 of the SRC Act. The objective of the rehabilitation guidelines is to assist employers to develop an effective approach to the rehabilitation of employees, consistent with their obligations under the SRC Act.

Requests for rehabilitation assessments: If an employee makes a request in writing for the rehabilitation authority to arrange an assessment of their ability to engage in a rehabilitation program, then the rehabilitation authority must arrange that assessment. A rehabilitation authority has

obligations under the Act in supporting any injured employee who meets relevant criteria in section 36 and section 37 of the SRC Act. These obligations continue after the employee ceases employment, irrespective of the cause of separation (including invalidity retirement). See Rehabilitation assessments for more information.

A rehabilitation authority's role is to assist employees by:

- arranging early assessment of the employee's capability to undertake rehabilitation, particularly when it is clear there will be a period of absence from the workplace.
- developing, monitoring and closure of a rehabilitation program
- accessing and monitoring the provision of rehabilitation services by a Workplace Rehabilitation Provider (WRP)
- ensuring the rehabilitation program is in line with the return to work hierarchy
- maintaining regular contact with the employee, supervisor, treating medical practitioners, and other health professionals as required
- ensuring ongoing consultation with the treating medical practitioner/s
- negotiating medically suitable return to work options such as graduated return to work, work hardening, work trials, job placements, or redeployment
- ensuring the confidentiality of information about the employee.

When arranging a rehabilitation assessment under section 36 of the SRC Act, the rehabilitation authority must adhere to the provisions under the Guide for Arranging Rehabilitation Assessments and Requiring Examinations.

Employee

Employees have rights and obligations in regard to their rehabilitation.

The employee's obligations are to:

- report to the employer details of any accident, injury or disease that might be related to work
- provide the doctor or provider of treatment with an accurate description of how the injury occurred, or of the circumstances in which the condition became apparent
- provide Comcare with information or copies of documents that Comcare considers relevant to the claim
- attend any rehabilitation assessment or examination arranged by the rehabilitation authority, unless they have a reasonable excuse as to why they are unable to attend
- undertake the rehabilitation program provided by the rehabilitation authority, unless they have a reasonable excuse not to participate
- participate in any meetings arranged by the rehabilitation authority that relate to the rehabilitation assessment or rehabilitation program, and
- cooperate with the rehabilitation authority and Workplace Rehabilitation Provider (WRP) (where appropriate).

The employee's rights are to:

- be consulted and provide their views in decisions about their rehabilitation assessment and program
- request a rehabilitation assessment under section 36 of the SRC Act once the claim is accepted
- access the employer's rehabilitation policy and participate in its design or change, via their employee representatives
- request, under section 59 of the SRC Act, copies of documents held by Comcare and which relate to their rehabilitation program or claim, and
- request reconsideration by Comcare of any determination made by the rehabilitation authority.

If the employee fails to participate in or obstructs this process in any way without a reasonable excuse, their entitlements to compensation may be suspended by the rehabilitation authority. For further guidance refer to the [Suspensions](#) page.

Workplace Rehabilitation Providers

Workplace Rehabilitation Provider (WRP) are an important resource for rehabilitation authorities as they help employees return to work by providing rehabilitation expertise. Any WRPs used in the rehabilitation process must be approved by Comcare's Scheme Management Group. A list of approved WRPs can be found at the Workplace Rehabilitation Providers directory.

Rehabilitation authorities expect WRPs to:

- deliver timely and cost-effective services
- conduct section 36 assessments in accordance with operational standards if requested
- assist in the development and implementation of rehabilitation programs under section 37 in accordance with the operational standards set by Comcare
- provide jargon-free advice and consultation
- provide a prompt response to referrals and other requests
- communicate regularly with all stakeholders
- provide an objective service, and
- ensure only members of staff who meet the Comcare training requirements provide services.

Medical Practitioners

The success of a rehabilitation program depends on the willing participation and cooperation of all stakeholders, including any treating medical practitioners.

The treating practitioners can participate in the rehabilitation program by:

- providing information about the employee's injury, current work capacity, any medical restrictions, their treatment program and likely recovery time frame
- evaluating the suitability of the employee to undertake specific duties at the workplace
- working in conjunction with key stakeholders to develop the rehabilitation program, and
- providing reports containing further information to the agency and/or Comcare.

Claim Managers

Your role as the Claim Manager is to assist rehabilitation authorities with rehabilitation program management by:

- reviewing rehabilitation programs
- identifying cases requiring rehabilitation program intervention
- providing advice about the development of rehabilitation programs
- conducting high-cost claims reviews
- conducting reconsiderations of rehabilitation authority determinations upon request (Review Officers)
- preparing for and participating in case conferences
- requesting information to assist in the management of the claim
- actioning determinations, and
- taking action, where appropriate, in the event of a failure to participate in a rehabilitation program or obstruction of a program, at the direction of a rehabilitation authority.

You should ask for information if you believe the employee has failed to disclose any relevant employment or self-employment information. If you discover something that does not look right, feel right or when you receive information either from the employee or another source (employer, rehabilitation provider, etc) that is relevant and has the potential to impact the management of a claim, please refer to the [“Just Ask”](#) process.

Injury Management Team

The Injury Management Team helps you and rehabilitation authorities when claims are identified as being at risk of poor rehabilitation outcomes. The team supports Comcare and assists rehabilitation authorities through:

- early intervention advice on potentially high-cost claims
- working with rehabilitation authorities to help them comply with any guidelines issued by Comcare
- collaboration in developing strategies for supporting an employee’s sustainable return to work
- identification and promotion of better practice for recovery at work and the health benefits of good work
- providing advice on prevention and injury management issues protracted recovery timeframes, suitable duties based on an employee’s work capacity
- attending case conferences when requested, and
- participating in the review of claims against planned actions or programs.

For further assistance, email the [Injury Management team](#)

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Reconsiderations and appeals

If an employee is dissatisfied with a determination made by the rehabilitation authority under section 36 or 37 in relation to a rehabilitation assessment or program, they can request a review, known as a reconsideration, by Comcare. For further guidance, refer to the [Reconsiderations](#) pages. The employee's rights in relation to reconsiderations are outlined in [section 38](#) and 62 of the SRC Act.

The employee and employer both have the right to seek a review by the Administrative Review Tribunal (ART) of a reviewable decision (the outcome of a reconsideration) made by Comcare. For further guidance, refer to the [Administrative Review Tribunal](#) pages.

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Rehabilitation where no incapacity is payable

If an employee is not entitled to incapacity payments, they may still be entitled to rehabilitation assessments and programs under section 36 and section 37 of the SRC Act.

Section 36 and section 37 provide for rehabilitation where an employee has suffered an injury resulting in an incapacity for work or an impairment. That incapacity or impairment must relate to an accepted compensable injury. Incapacity can still exist even where there is no liability to make incapacity payments (for example, the employee has turned age 65).

A determination by Comcare that incapacity is not presently payable would usually suggest that there is no current incapacity or impairment to be rehabilitated. However, this may not always be the case. Rehabilitation authorities still need to consider sections 37(3)(a) – (h) of the SRC Act when preparing any rehabilitation program. If you need further support for this type of scenario, discuss with an Injury Manager or your Assistant Director.

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Rehabilitation costs and cost codes

The rehabilitation authority has delegation to determine the section 36 and 37 rehabilitation costs, which Comcare then pays for. If you have any concerns about the reasonableness of rehabilitation costs you should discuss this with your Senior Injury Manager, and flag with the RTW Support team. Comcare will pay for these costs from the date of injury, even if liability is subsequently declined. Where liability for a claim is declined, costs for rehabilitation that have been authorised under sections 36 and 37, are payable up to the date the agency is advised that liability has been declined.

For rehabilitation service invoices to be paid, they must outline the relevant rehabilitation cost code on the invoice.

To approve invoices or receipts for rehabilitation costs, see [Invoice and receipt processing](#).

For claims where liability is declined, refer to the [Procedure to pay rehabilitation invoices on a claim where liability has been declined](#).

Payment of rehabilitation assessment costs (code 90 services)

Comcare is liable for all the costs associated with an assessment conducted under section 36 of the SRC Act. Payment includes fees associated with the provision of services by a Legally Qualified Medical Practitioner (LQMP) or a Workplace Rehabilitation Provider (WRP). A section 36 determination and Rehabilitation assessment referral form (section 36(1)) or a Rehabilitation assessment/examination form (section 36(3)) should be completed by the rehabilitation authority and provided to Comcare. These forms outline the details of the service provider for the rehabilitation assessment and approved costs.

These costs are entered into Pracsys under the service item 90 code.

Travel costs for a rehabilitation assessment (code 90 services)

Under the SRC Act, an employee can receive reimbursement of expenses reasonably incurred when travelling for a rehabilitation assessment.

These costs are determined by the rehabilitation authority and paid under section 36(5) of the SRC Act.

These costs are entered into Pracsys under the service item 90 code.

Rehabilitation program services (code 92 services)

These are the costs associated with rehabilitation programs that have been determined under section 37 of the SRC Act. These costs are usually payable to the approved Workplace Rehabilitation Provider WRP that the rehabilitation authority has engaged to provide a rehabilitation program. Rehabilitation program services may include the following:

- management of return to work – this covers the coordination of the rehabilitation program including organising, monitoring and report writing
- liaison with the workplace and other stakeholders as appropriate, including case conferences
- job search activities - this includes working with the Rehabilitation Case Manager (RCM) and supervisor to identify and assess the range of jobs suitable for the employee within the workplace. It involves resume preparation, interview skills and negotiating job placement outside of the employer if required
- vocational counselling - this covers all aspects of vocationally directed counselling and should be of short duration. Working with the employee to develop a return-to-work program, preparation of the employee for return to work / working at a different workplace / non return to work, etc. would be part of vocational counselling
- specialised assessments - includes functional capacity evaluations, vocational assessments and/or labour market assessments
- liaison with health providers - it is often necessary for a rehabilitation provider to attend appointments with medical practitioners to facilitate progression of the rehabilitation program.

These costs are entered into Pracsys under the service item 92 code.

Rehabilitation program support services (code 93 services)

The inclusion of return-to-work support services on a rehabilitation program supports the employee in reaching a sustainable return to work outcome.

For these services to be accurately captured in Pracsys as relating to a section 37 rehabilitation program, the costs for code 93 services need to be paid for by the approved Workplace Rehabilitation Provider (WRP), and then Comcare reimburses that provider. Where the cost is significant, the employer (rather than the WRP) may make the payment and then Comcare will reimburse the employer.

The following are examples of the types of services that could be included under code 93:

- travel costs for the employee - this includes funding for travel on public transport or by taxi to enable participation in a rehabilitation program. It would be anticipated that this funding would only be provided if the employee was unable to travel by their usual means of transport, or if they were required to travel a significantly further distance than they would on their normal route to work to participate in the rehabilitation program.
- interpreter services - this includes provision of services that enable active participation in the rehabilitation program
- external training - this includes course fees, tutoring costs and other associated expenses incurred when undertaking a course through an external institution. The appropriateness of a goal of redeployment should be evident in these cases (this does not include HECS fees as they are used for taxation purposes)
- carer's costs - costs incurred by severely incapacitated employees to undertake reasonable social, recreational, community or disability related activities (e.g. admission tickets, travel etc), that are not payable under attendant care or medical treatment, may be paid under section 37 of the SRC Act.
- Career coaching services, such as the EML Career Transition Program. The program allows employees to access one on one Career Coaching services for either a set 12-week or 26-week

program. See [Return to Work Pilot: EML Your Future program | Comcare](#)
These costs are entered into Pracsys under the service item 93 code.

Rehabilitation provider travel (code 94 services)

This code is to be used for Workplace Rehabilitation Provider (WRP) travel.

For travel costs to be paid by Comcare, travel should be permitted under the service level agreement or contract between the WRP and the rehabilitation authority .

When invoicing Comcare, rehabilitation provider travel costs (code 94) should be itemised separately from other rehabilitation services.

Case conferences

Costs associated with doctor participation in a Return to Work (RTW) case conference are payable under the rehabilitation provisions of the SRC Act. Before payment can be made, you must have authority from the rehabilitation authority (the employer) to make payments. Often this authority will be provided on the rehabilitation program under section 37 of the SRC Act, where RTW case conferences will be included as an activity on the plan.

However, where a rehabilitation program has not yet been developed, payments associated with RTW case conferencing can be made under section 36 (assessment of capability of undertaking a rehabilitation program). Authority to pay for case conferences under section 36 can be provided verbally or in writing by the Rehabilitation Case Manager (RCM). A copy of a recent section 36 referral to a Workplace Rehabilitation Provider (WRP) for a Rehabilitation Assessment is sufficient authority for payment under section 36.

When a doctor seeks payment from Comcare for a RTW case conference, the meeting must involve the medical practitioner, the employee and a minimum of Comcare and one other key stakeholder (usually this will be the RCM and/or WRP).

The doctor is not required to state on the invoice who participated in the RTW case conference. However, it is expected the doctor will make a clinical note in the employee's medical record to demonstrate their participation and who attended. This information can be requested in a clinical note if necessary.

Comcare has advised GPs that we will pay for their participation in RTW case conferences in line with the Australian Medical Association (AMA) rates. However, the authority for payment of rehabilitation costs lies with the rehabilitation authority, and the Rehabilitation Case Manager (RCM) may agree to pay a different rate for a doctors' participation in a case conference.

You may need to confirm with the Rehabilitation Case Manager if any other treating practitioner (i.e. physiotherapist, psychologist), attended the case conference and what cost the RCM has approved for their participation (normal discussions between an employee's GP and other treatment providers about the medical management of the employee are not a RTW case conference and are not payable by Comcare).

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Rehabilitation forms

There are several rehabilitation forms involved in a rehabilitation assessment and program:

- rehabilitation assessment referral form (section 36(1))
- rehabilitation assessment/examination form (section 36(3))
- rehabilitation program form
- rehabilitation program alteration form
- rehabilitation program closure record.

Each of these is detailed below.

With the implementation of the Workplace Rehabilitation Provider (WRP) portal, the rehabilitation program closure record can be completed through the portal.

Rehabilitation assessment/examination form

When a rehabilitation assessment is arranged by the rehabilitation authority, a Rehabilitation assessment referral form (section 36(1)) or a Rehabilitation assessment/examination form (section 36(3)) must be completed. These forms are used to provide relevant information to the person conducting the rehabilitation assessment. They include a maximum amount of pre-approved costs to complete the assessment. The rehabilitation authority sends Comcare a copy of the form for their records. The Claims Administration and Income Support (CAIS) team will input the details of the Rehabilitation referral into Pracsys and process relevant invoices.

Rehabilitation Program form

A rehabilitation program is a structured series of planned activities offered to an employee with the primary aim of returning them to their pre injury health and employment. A Rehabilitation Program form is sent to Comcare by the rehabilitation authority. The CAIS team updates the rehabilitation details in Pracsys and any expenses are paid against the approved program.

Due to the limited space within a rehabilitation program form, sometimes a Rehabilitation Case Manager (RCM) or Workplace Rehabilitation Provider (WRP) will attach appendices to the form to provide additional detail. Any attachments to the rehabilitation program still form part of the determination.

Rehabilitation program alteration form

When it is determined that the original goal cannot be achieved within the time frame and/or costings of the original program but the goal has not changed, a Rehabilitation Program Alteration may be developed. The Rehabilitation Alteration form may include changes to timeframes, costs or additional services. The CAIS team will input the details of the Rehabilitation Alteration into Pracsys and process relevant invoices.

Rehabilitation Program Closure Record

The Rehabilitation Program Closure Record notifies Comcare of the outcome of a rehabilitation program. Providing Comcare with closure information allows us to make accurate payments to providers and to monitor return to work outcomes across the scheme. A Rehabilitation Program Closure record is usually sent to Comcare by the RCM or WRP. It may also be a form from the WRP Portal.

At times the WRP may send through a Closure Report. This is not the Rehabilitation Closure record. The Closure report provides detailed information about what has happened during the program and the outcome. It is useful for both the Rehabilitation Case Manager (RCM) and the Claims Manager to see what has occurred during the program. This report does not provide the specific information CAIS needs to close off the program.

If you notice that the Rehabilitation Program Closure Form is on file and has not been processed, please forward details of the form (including claim number and folio) to the Rehabilitation enquiries team

The CAIS team updates the rehabilitation program closure details in Pracsys, updates the work status code, and processes any final expenses against the program.

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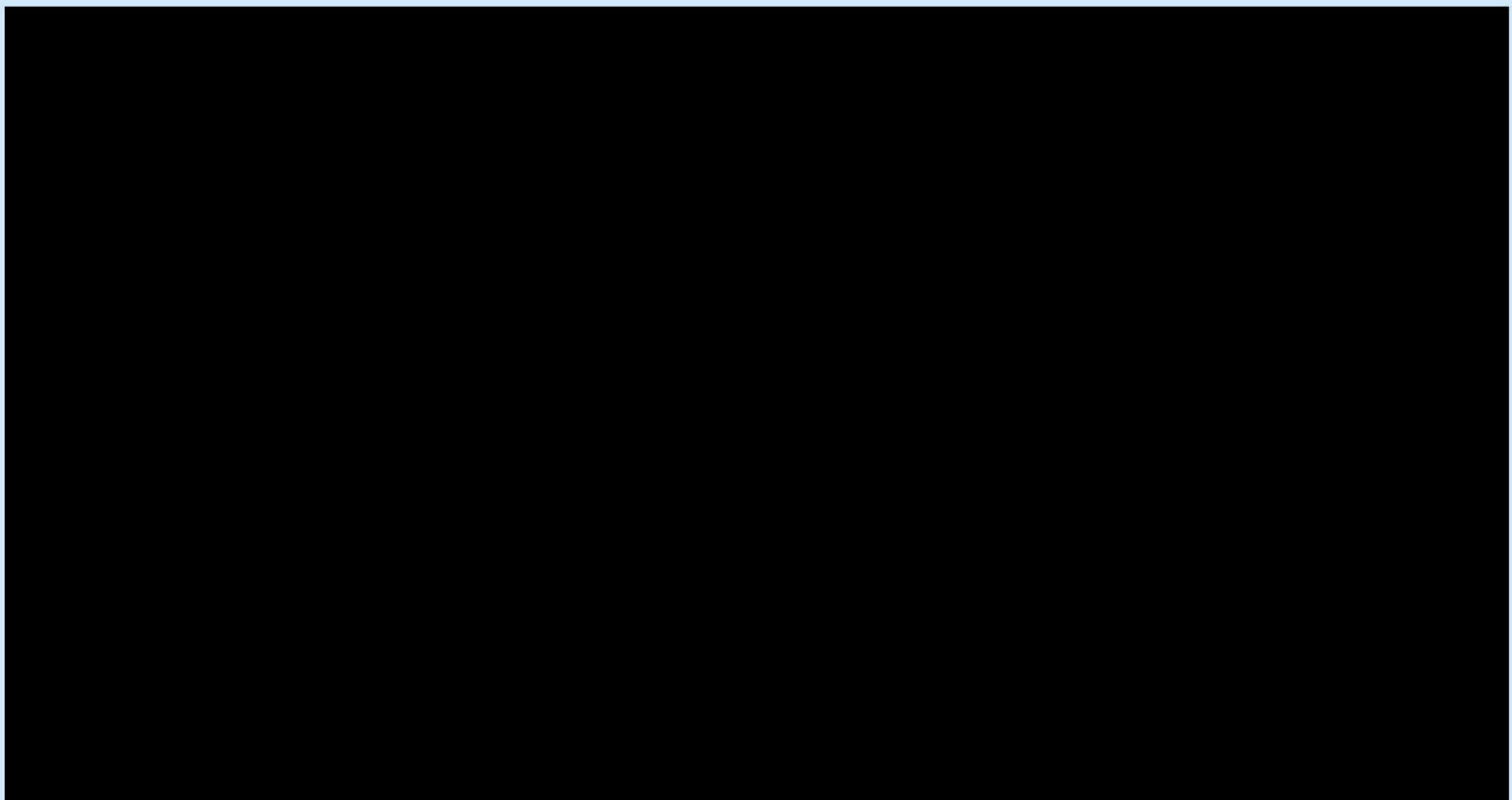
Payment of rehabilitation costs on a claim where liability has been declined

Comcare encourages rehabilitation authorities to commence rehabilitation under the SRC Act as soon as possible following an injury and claim lodgement.

Comcare will pay for section 36 and 37 rehabilitation costs incurred from the date of injury even if liability is subsequently rejected. Costs will be reimbursed up to the date the rehabilitation authority is notified that liability is rejected. There is no provision for Comcare to pay for these costs after the rehabilitation authority has been advised of the rejection of liability.

See Procedure to pay rehabilitation invoices on a claim where liability has been declined for the steps involved.

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Rehabilitation assessments

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Introduction

A rehabilitation assessment (under section 36 of the SRC Act) assesses an employee's capacity to undertake a rehabilitation program. It is arranged by the rehabilitation authority (in most cases the employer) directly with the assessor (not via Comcare). If, after an assessment takes place, the rehabilitation authority wants a supplementary report, it is their responsibility to arrange this with the assessor. A rehabilitation assessment may be initiated by the rehabilitation authority or requested in writing by the employee. A rehabilitation assessment may involve a medical examination.

Please note that if a rehabilitation assessment is conducted jointly with an independent medical assessment, this is arranged by Comcare. See Combined medical and rehabilitation examinations for full details.

A Guide for Arranging Rehabilitation Assessments and Requiring Examinations 2024 came into effect from 18 September 2024. Rehabilitation authorities need to conform to the Guide when arranging section 36 assessments. Please refer to the Guide for details. Comcare also has an external web page on rehabilitation assessments for more information.

Once a claim for compensation has been lodged, Comcare can pay for costs associated with a section 36 assessment from the date of injury. Even if liability is subsequently denied, these costs will be reimbursed up to the date that the rehabilitation authority is notified of the determination to disallow the claim. See Payment of a rehabilitation assessment for more information.

A rehabilitation assessment can be conducted in one of two ways. The assessment can be conducted as a desktop review (of the claim file) without an examination under section 36(1) **or** it can be conducted with an examination under section 36(3) of the SRC Act.

There are two forms for arranging a rehabilitation assessment, either with or without an examination:

- [Rehabilitation assessment](#) form
- [Rehabilitation assessment examination](#) form

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Reasons to arrange a rehabilitation assessment

The reasons for initiating a rehabilitation assessment will vary depending on the individual claim. The triggers could include:

- any extended absence from work
- the nature or circumstances of the injury or illness indicate a potentially complex condition, e.g. psychological, occupational overuse or musculoskeletal tissue injury
- progress of the claim is not as expected, whether undetermined or determined
- the medical evidence or prognosis suggests there is a risk of re-injury at work
- the employee has had a previous injury or illness, or

- some aspect of the work environment is potentially contributing to the injury or illness.

When a rehabilitation authority determines that a rehabilitation assessment is required, the rehabilitation authority must seek the employee's views. The rehabilitation authority also must seek the views of the employee's treating practitioners and consider the employee's circumstances in line with the requirements of the SRC Act.

For information on combining a section 36 rehabilitation assessment with a section 57 medical assessment, refer to the information on combined assessments in the [Independent medical examinations](#) page.

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Who can conduct a rehabilitation assessment or examination?

A rehabilitation assessment (with or without an examination) must be performed by one of the following:

- a legally qualified medical practitioner (LQMP) nominated by the rehabilitation authority, such as an Occupational Physician, Psychiatrist, or other medical specialist
- a suitably qualified person (other than a medical practitioner) nominated by the rehabilitation authority. Usually this is an allied health professional or a Workplace Rehabilitation Provider (WRP).
- a panel comprising legally qualified medical practitioners or other suitably qualified persons (or both), as nominated by the rehabilitation authority.

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Things to consider in a rehabilitation assessment

The rehabilitation assessment may include an examination of the employee, and the assessment and report should consider the:

- medical diagnosis and prognosis
- current capacity for work and daily activities
- pre-injury duties
- availability of suitable duties
- opportunity for reasonable adjustments in the workplace
- consideration of any workplace issues
- identified or potential barriers to the return-to-work process, including biopsychosocial barriers, and strategies to address these factors
- recommended services aimed to facilitate maintaining the injured employee at work or returning them to work.

Appropriate use of a section 36 assessment report: Comcare does not endorse the use of a section 36 report as the sole evidence in determining an entitlement and it can only be used as secondary or supporting evidence. This is because it was not obtained for the purposes of addressing the issues such as the requirement for treatment, or whether a condition is work-related. A section 36 report may be useful in situations where the report conflicts with a treating LQMP's opinion. In cases such as these, further medical evidence should be sought.

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Rehabilitation assessments performed by a Workplace Rehabilitation Provider

A workplace rehabilitation provider must be approved to operate within the Comcare scheme and must follow the performance and compliance expectations under the SRC Act. See [Find a workplace rehabilitation provider page | Comcare](#) for the list of approved providers.

A rehabilitation assessment (with or without an examination) and subsequent report may include:

Essential:

- an assessment of the employee's capability of undertaking a rehabilitation program – **this is a must**
- documentation of the rehabilitation assessment and examination findings with a written report containing recommendations about a rehabilitation program.

As needed:

- interview/examination with the employee
- a workplace visit, and meeting with the supervisor to plan for the employee's return to work
- an analysis of the employee's pre-injury duties
- confirmation of the medical diagnosis, prognosis and current work capacity as noted by the treating medical practitioner
- liaison with the treating medical practitioner and other treating practitioners to determine appropriate rehabilitation goals, expected timeframes for recovery, and to ensure that treatment options are evidence based and support return to work
- identification of suitable alternative duties, or other rehabilitation options, if the employee will not be able to return to pre-injury duties in the short or longer term
- other specific and appropriate assessments such as functional capacity, ergonomic assessment, work tolerance, transferable skills analysis, vocational assessment or home assessment
- identification of any potential barriers to return to work, and actions and strategies to manage these—the flags model framework can be used to identify biopsychosocial barriers (see the Rehabilitation case manager's handbook published by Comcare, page 10).

The rehabilitation assessment report should be provided to the rehabilitation authority as soon as practicable after the assessment has been completed. The rehabilitation authority should provide a copy of the report to Comcare and the employee.

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Employee not undergoing or obstructing an examination

Section 36(4) of the SRC Act states that if an employee refuses or fails, without a reasonable excuse, to undergo a rehabilitation examination, the employee's rights to compensation may be suspended. This is up to the rehabilitation authority to determine. Comcare does not make or QA the determination but completes the administration tasks in Pracsys following a determination by the rehabilitation authority.

Refer to the [Suspending claims](#) for further information.

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Payment of a rehabilitation assessment

Comcare is responsible for payment of costs associated with a rehabilitation assessment involving an examination under section 36(3). The costs are determined by the rehabilitation authority and paid by Comcare under section 36 of the SRC Act.

You should request a copy of the rehabilitation assessment determination and the report and add these to the claim file to assist in paying these costs.

If the assessment did not include an examination with the employee (i.e. a desktop review of the claim file under section 36(1)), Comcare is not responsible for costs.

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Fees for non-attendance at a rehabilitation assessment

Comcare is responsible for the costs of a rehabilitation assessment involving an examination. In the event that an employee fails to attend, Comcare is liable to cover reasonable costs associated with the non-attendance.

In circumstances where Comcare is issued a non-attendance fee, the rehabilitation authority may negotiate with the provider for the fee to be waived or reduced.

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Travel costs associated with rehabilitation assessments

Under section 36(5) of the SRC Act, an employee can receive reimbursement of expenses reasonably incurred when travelling for a rehabilitation assessment. When deciding if travel is payable you will need to have regard to:

- the means of transport available to the employee for the journey
- the route or routes by which the employee could have travelled, and
- the accommodation available to the employee.
- Other expenses may include:
 - accommodation
 - parking fees (but not fines), and
 - meals.

These costs are determined and paid by Comcare under section 36(5) of the SRC Act.

These costs are entered into Pracsys under the service item **90** code.

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Support for rehabilitation assessments

If you need any assistance with a rehabilitation assessment report, contact the Injury Management team or Return to Work Support team.

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Rehabilitation programs

Introduction

A rehabilitation program is a structured series of planned activities developed to support employees to return to their pre-injury employment, or any other suitable return to work or recovery goal identified through the rehabilitation assessment process. The overall goal of a rehabilitation program is either a Return to Work (RTW), non-RTW, or redeployment focus.

A rehabilitation program should:

- be developed in consultation with the employee, the employee's supervisor, and where applicable, the Workplace Rehabilitation Provider (WRP) and any relevant treating practitioners (i.e. GP, psychologist, psychiatrist, physiotherapist)
- be individualised, outcome based and set out the steps to be followed to achieve a return to work or return to health outcome
- be available to an employee irrespective of their certified work capacity. For employees who have no capacity for work, a rehabilitation program could have a non-RTW goal with a focus on return to health or other recovery goals to support building a work capacity.
- recognise transferrable skills, experience and capabilities of the employee to enable medically appropriate suitable duties to be found, and
- if necessary, utilise retraining and redeployment when it is not possible for the employee to return to pre-injury duties or pre-injury employer.

Your role as the Claims Manager is to provide any required guidance and/or advice to the rehabilitation authority, to assist them in developing rehabilitation programs.

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Suitable employment

Suitable employment is work for which the employee is suited, taking into consideration:

- the employee's age, experience, qualifications, training, language and other skills
- the location of the employment opportunity.

For ongoing employees of the Commonwealth, suitable employment is any employment within the Commonwealth.

The provision of suitable employment is the responsibility of the rehabilitation authority (in most cases the employer). Workplace rehabilitation aims to return employees to their pre-injury duties in their own workplace. This principle is supported by a hierarchy of preferences for return-to-work outcomes, referred to as the 'return to work hierarchy' (note that this hierarchy does not have to be followed chronologically, depending on individual circumstances):



The return to work hierarchy

The return to work hierarchy

- same job, same employer
- similar job, same employer
- new job, same employer
- same job, new employer
- similar job, new employer
- different job, new employer.

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Requirements for determining that a rehabilitation program is necessary

For a rehabilitation program to be lawful, it must be signed by the rehabilitation delegate from the rehabilitation authority.

Before a rehabilitation authority can make a determination under section 37 of the SRC Act that an employee should undertake a rehabilitation program, it must consider all the factors listed under section 37(3) of the SRC Act: (note, this is taken from the [Rehabilitation case manager handbook](#) (published by Comcare):

SRC Act reference	Criterion	Description
37(3)(a)	Any written assessment given under section 36(8).	Where a rehabilitation assessment under section 36(1) has been completed, you should consider the recommendations in the report and reference these when considering the appropriateness of the rehabilitation program.
37(3)(b)	Any reduction in the future liability to pay compensation if the program is undertaken.	Consideration can be given to how a successful completion of a rehabilitation program improves the employee's work capacity and results in a reduction in the claim costs.
37(3)(c)	The cost of the program.	Consideration can be given to the likelihood of the success of the rehabilitation program, based on the availability of suitable duties, and therefore the employee's likely return to work.

SRC Act reference	Criterion	Description
37(3)(d)	Any improvement in the employee's opportunity to be employed after completing the program.	Consideration can be given to the likelihood of the success of the rehabilitation program, based on the availability of suitable duties and suitable employment, and therefore the employee's likely return to work.
37(3)(e)	The likely psychological effect on the employee of not providing the program.	Consideration can be given to the: - the person's psychological health based on available medical information - the potential worsening of symptoms if a program is not provided - the employee's motivation to participate in the program - support mechanisms that may be required for the employee if a program is not required.
37(3)(f)	The employee's attitude to the program.	When considering the employee's attitude, the rehabilitation delegate should note their commitment to participating in a rehabilitation assessment, consult with them on the rehabilitation program and provide an opportunity to discuss the program with a medical practitioner, family and others.
37(3)(g)	The relative merits of any alternative and appropriate rehabilitation program.	Consider the return to work hierarchy when determining the program goals and whether an alternate program is more likely to be successful in achieving the same goal.
37(3)(h)	Any other relevant matter.	This subsection provides the opportunity for the rehabilitation delegate to consider any other individual circumstance that may impact on the success of the program. Note: The Injury Management Team and Return to Work Support team are available to provide guidance and support to the rehabilitation authority in relation to these matters.

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Rehabilitation program activities

The following are some of the options that the rehabilitation authority may consider when developing a rehabilitation program for an employee.

Graduated return to work

A graduated return to work (GRTW):

- allows an employee to return to work on reduced hours or duties when they are initially unable to return to their full pre-injury hours or duties
- allows an employee to return to work safely and earlier than would otherwise be possible
- builds up the employee's physical and/or psychological ability to manage tasks by using actual work tasks. This form of rehabilitation is referred to as work hardening or work conditioning.
- assists the employee to maintain their work habits and routines such as getting up to attend work, interacting with co-workers, and keeping pace with changes and developments in the workplace.

Components of a GRTW program include:

- clearly defined goals and objectives
- a well-structured and documented program outlining the specific duties and hours of work, and how and when it is proposed these should be upgraded (in line with medical evidence)
- other conditions of the program such as exercise and rest breaks
- clearly defined roles and responsibilities of all the parties involved in the program.

Pacing

Pacing is an alternative to an employee undertaking a GRTW. Instead of spending reduced hours in the workplace, the employee attends for the full workday, but their time is alternated between periods of productivity and rest. The productive time at work is the same as the employee would have been able to work on a part-time return to work, and consistent with the recommended hours as prescribed by the treating medical practitioner. During periods of rest, the employee may be required to undertake training (either virtually or face to face), attend meetings etc.

The major benefit of this approach is that the employee does not have extended hours out of the workplace and maintains the routine of attending the workplace for the usual workday. It also helps the employee maintain contact with fellow employees and reduces the risk of them losing their identity as a worker.

Work trials

For employees of the Commonwealth government, a work trial is a short-term agreement (usually for 12 weeks) where the employee is placed with a host employer for a period, while remaining employed and paid by the rehabilitation authority.

While on a work trial, the employee's rehabilitation authority does not change. The host employer is the new employer that is offering the work trial to the employee. The host employer can be another employer within the scheme or private sector.

The reasons for using a work trial may include:

- rebuilding work skills, self-confidence and establishing work routines following an extended absence from the workforce and/or loss of work skills due to sustaining a work-related injury
- work hardening, whereby an employee is offered a program aimed at improving physical or psychological work tolerances to allow a return to pre-injury work and pre-injury employer, or placement with a new employer (pending a suitable role being identified)

- learning alternative work skills - when an employee is unable to return to work with the pre-injury employer and requires the opportunity to build new work skills to improve their employment potential and increase the opportunity for placement with a new employer.

Refer to Work Trials: A guide for Rehabilitation Case Managers for information on work trials.

Trials longer than 3 months: If an employee has been participating in a work trial for longer than 3 months, you should refer the matter to the Injury Management team or Return to Work Support team, for further discussion.

Redeployment

Where an employee is permanently unable to return to work with the pre-injury employer, the rehabilitation authority should consider redeployment to a new employer.

Once redeployment has been identified as the only return to work option, a thorough rehabilitation assessment should be arranged, before implementation of a rehabilitation program. A vocational assessment may be required if one has not already been provided and should be included as an activity in the rehabilitation program.

A new rehabilitation program should be developed that outlines the new goal of a return to work with a new employer. Support for the program should be sought from the treating medical practitioner. The program may include job seeking activities and a job seeking agreement which outlines the agreed activities to be undertaken by the employee and Workplace Rehabilitation Provider (WRP) when pursuing a new position, as requested by the Rehabilitation Case Manager (RCM).

If the employee is unable to secure a new position using their existing skills, qualifications and experience, retraining may need to be considered.

Rehabilitation Case Managers are able to utilise the Career Transition Program facilitated by Employers Mutual Limited (EML) within a rehabilitation program, utilising code 93 (for payments). This program is available to all employees in Comcare's scheme with an open and active compensation claim. The program allows employees to access one on one Career Coaching services for either a set 12-week, or 26-week program. This program is designed to provide employees with greater skills and experience for independent job seeking and to be competitive candidates when applying to new roles.

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Impacts of Machinery of Government (MOG) changes

A Machinery of Government (MOG) change may affect the employee's work capacity, circumstances, or the availability of suitable employment. If so, the standard obligations under The Guidelines for Rehabilitation Authorities 2019 and Part III of the SRC Act apply. You can consider either developing a rehabilitation program (if one is not already in place) or altering an existing rehabilitation program.

A MOG change may only affect administrative details in a rehabilitation program rather than an employee's work capacity, circumstances or the availability of suitable employment. If so, (i.e. the change only affects things like the details of the supervisor, rehabilitation case manager or name of organisation), then you may decide to keep the current rehabilitation program open.

Maintain better practice by communicating any changes to the employee and the stakeholders supporting the employee's recovery and return to work. When considering what action to take you should consider each circumstance on a case by case basis.

Study and Retraining

Study and retraining should be considered when:

- the employee is unable to return to their pre-injury position or an alternate position
- the employee requires additional skills to move into a new job with the same or a new employer
- opportunities for suitable employment are limited and need to be increased
- assessment supports retraining to significantly improve employment and/or redeployment options.

A Vocational assessment should be conducted to assist in identifying suitable job options.

A Labour market assessment can also be requested to determine which of the job options are most viable considering the location, job demand, income and market trends.

The study or training course needs to be outlined in the rehabilitation program under code 93 (for third party payments).

Paying for training

The costs associated with the training course are outlined in the rehabilitation program, under code 93. When Comcare receives a signed copy of the rehabilitation program by the rehabilitation delegate (RCM), CAIS Rehabilitation team can approve these costs. See Rehabilitation costs and codes for more information.

Under the SRC Act, Comcare cannot usually pay a training institute directly. This is because a training institute is not considered a Workplace Rehabilitation Provider (WRP) and is therefore unable to provide rehabilitation services. By including retraining in a rehabilitation program, Comcare can reimburse the retraining costs to the WRP, who pays for them initially. Alternatively, if no WRP is involved, the employer pays and is reimbursed for the retraining costs.

If you are unsure of the activities included on a rehabilitation program, you should refer the matter to the Injury Management or Return to Work Support team for further discussion.

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Rehabilitation program exclusions

Services that relate to the treatment of an accepted compensable condition should not be included in a rehabilitation program. When discussing this with the RCM, use collaborative language – consider with them who is in the best position to supply the treatments quickly (usually direct medical service providers rather than via a Workplace Rehabilitation Provider).

Examples of services that should not be included are:

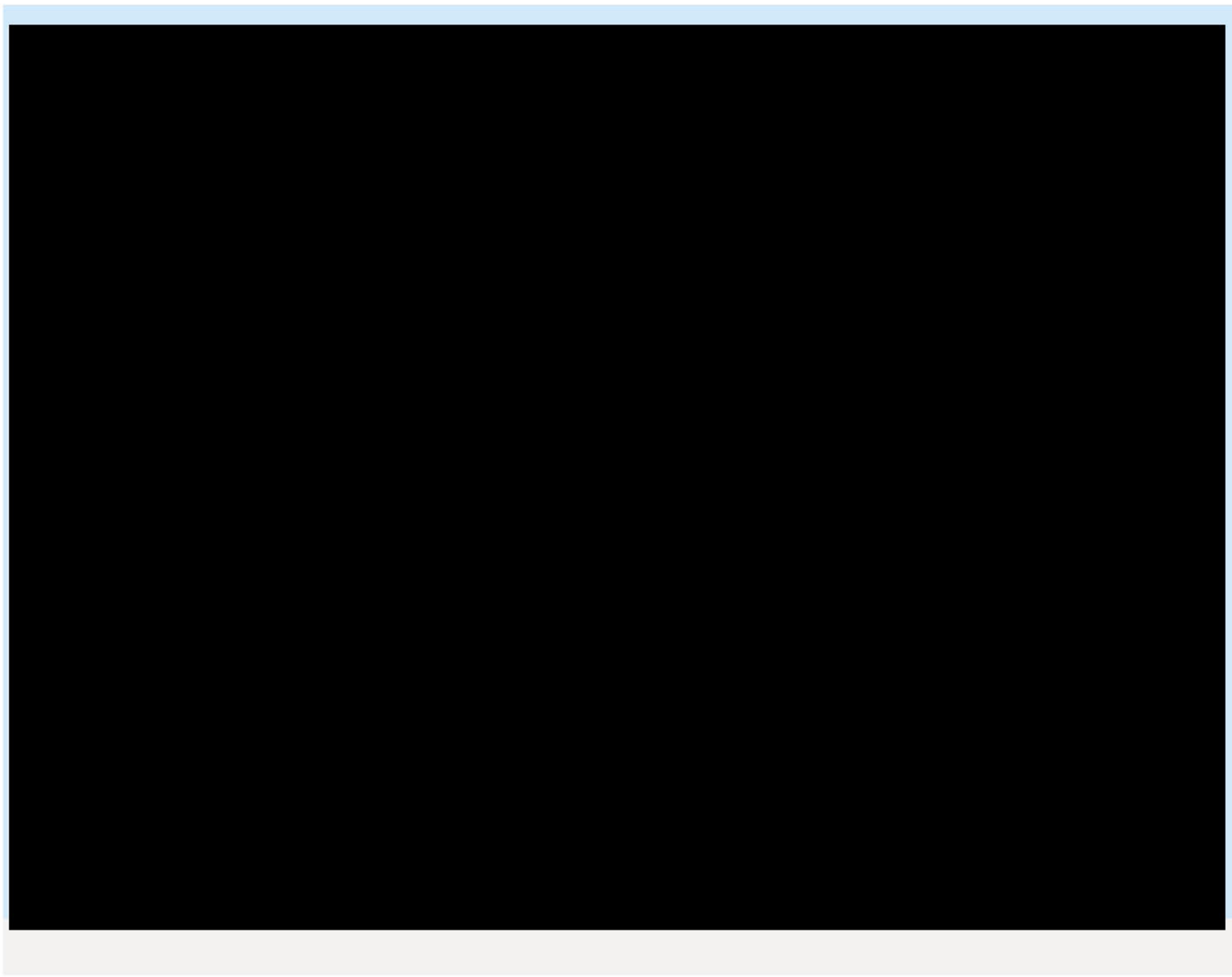
- treatment (including therapeutic counselling)
- pain management programs
- psychological therapy/counselling, other than brief vocational counselling or adjustment to injury counselling
- clinical occupational therapy as opposed to vocational therapy, e.g. splinting of an injury

- physiotherapy, exercise physiology
- chiropractic treatment
- hydrotherapy and/or treatment designed to build fitness
- travel to and from medical appointments
- overseeing/monitoring of injured worker's treatment
- work conditioning
- determining worker's ongoing entitlements
- claim management
- rehabilitation case manager activities.

Approval for these costs are Comcare's responsibility. See the Medical treatment pages for more information.

Aids and appliances are not generally part of a rehabilitation program, nor are Household, attendant care or childcare services.

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Case conferences

Introduction

Case conferences are meetings where participants strategically discuss an employee's claim, rehabilitation and return to work.

Claims management is collaborative and requires a multi-disciplinary approach with Claims Managers, Injury Managers and other team resources working together.

There are three types of case conferences that could occur:

- Return to work (RTW) case conference - a meeting between Comcare and other relevant stakeholders including the employee, employer and workplace rehabilitation provider (WRP) where appropriate to progress the employee's return to work and rehabilitation.
- Practitioner case conference – Comcare encourages practitioners (usually the treating GP) to participate in RTW case conferencing by providing them with the opportunity to request a case conference on the medical Certificate of Capacity - Certificate of Capacity for Work form; this type of case conference may also be arranged if deemed appropriate to progress a claim especially during an undetermined period.
- Employer/agency case conference – a meeting between Comcare and an employer to discuss liability and/or rehabilitation and RTW matters in relation to a single or several claims. The purpose of this type of case conference is to develop a joint strategy to review emerging claims that are impacting premiums, to support an agency to achieve their business plan objectives, to discuss RTW and rehabilitation strategies, and to progress claims.

More details can be found in each heading link.

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Managing a case conference

When opening a case conference:

- Introduce each participant and provide a brief description of their role.
- Agree on who will take minutes.
- Present the reason for the case conference (e.g. to discuss the claim(s) and any barriers in relation to strategy or RTW). This should be pre-determined with an agenda.

When closing a case conference:

- Always try to end the case conference within the allocated time and thank participants for their time.
- If the meeting is going to run over time and there are still issues to be discussed, suggest scheduling another time to continue the discussion.
- At the end of the case conference, review the outcomes and/or actions (e.g. who is going to undertake each action, and the agreed timeframes for completion).
- Minutes are to be documented and distributed to all parties.

When taking minutes, it is important to include:

- date and time of the case conference
- employee's name and claim number
- barriers discussed
- summary/action items and who is responsible for each including expected timeframes
- date for any review case conference or follow up discussion.

At the completion of a case conference, a summary of the minutes/actions are to be distributed to all participants. These actions will be followed up by the relevant parties to ensure implementation.

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Return to work case conference

Return to work case conferences bring relevant parties together to support recovery at work and return to work outcomes. They are a useful strategy to discuss complex cases and claims where return to work has stalled.

Case conferences require preparation by you (the Claims Manager), the Senior Injury Manager and the employer (where required). You and the Injury Manager should agree on the format and focus of the meeting and issues to be discussed (taking the employer's requirements into account), and consider the time required to undertake the case conference successfully.

The purpose of this type of case conference can include, but is not limited to:

- considering the employee's capacity for work
- identifying any barriers that may be impacting an employee's return to work
- discussing the health benefits of good work
- discussing the employer's exploration and identification of suitable duties and employment
- agreeing on the strategy required to support an employee's return to work (which can include flexible work arrangements, alternative duties, adjusting the workplace or providing workplace equipment).

The purpose and desired outcome of the case conference will determine who is involved. For example, in some instances it may be beneficial to include the workplace rehabilitation provider (WRP) to provide further detail regarding their involvement in the Rehabilitation Program underway. In other instances, it may be appropriate to include the treating practitioner e.g. GP, psychologist, physiotherapist etc.

Triggers for arranging a conference include, but are not limited to:

- decisions/actions arising out of a claim review
- Injury Management and/or RTW Support team receiving an enquiry
- lack of clarity regarding roles or responsibilities in the return to work and recovery process
- unexpected changes in the employee's condition.

Roles and responsibilities:

Role	When	Responsibility	Considerations
Claims Managers	Before the case conference	• Prepare the claim overview.	The Claims Manager should consider the following when

			preparing for a case conference: - the purpose and desired outcome of the case conference - the current claim status, outlined on a Claim Plan - the current medical treatment / services in place barriers to rehabilitation and / or return to work.
	During the case conference	- Provide overview of the claim including a brief history of the claim, the current strategy and goal, and any barriers identified to achieving that goal. - Participate in the claim discussion and contribute to the agreed actions. - Assist in the development of agreed actions.	
	After the case conference	Review the agreed actions to ensure accuracy.	
Claims Administration Officer	Before the case conference	- Schedule case conference time and date. - Send invitation to all attendees.	
	During the case conference	Take notes, document agreed actions.	
	After the case conference	Distribute to the internal attendees at first for confirmation,	

		specifying a due date for feedback. • Distribute agreed actions to all attendees as appropriate.	
Injury Manager	Before the case conference	• Prepare for the case conference	The Senior Injury Manager should consider the following when preparing for a case conference: • current functional status of the employee including medical certification • treatment regime including goals, timeframes and any relevant reference to MD guidelines • biopsychosocial issues/barriers that may be impacting on recovery and RTW status • review of the section 37 Rehabilitation Program and identification of any anomalies, i.e. are rehabilitation goals SMART and/or aligned to treatment goals? • strategies to overcome any identified barriers and/or issues.
	During the case conference	• Participate in the claim discussion, providing advice regarding rehabilitation and injury management strategies where required. • Assist in the development of	

		agreed actions.	
	After the case conference	• Review the agreed actions to ensure accuracy. • Add a case conference note in Pracsys.	

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Practitioner case conference

This type of case conference connects the treating practitioner (e.g. GP or a specialist), the employer, the employee and Comcare at the right time to support a return to work. This type of case conference can also be triggered by the Rehabilitation Case Manager (RCM) usually with the respective WRP, with a request for you and the Injury Manager to attend.

Case conferencing aims to enhance communication with all stakeholders to promote and support recovery at and return to work. The purpose and desired outcome of the case conference will determine who is involved.

Roles and responsibilities

Role	When	Responsibilities	Considerations
Claims Manager	Before the case conference	• Contact RCM to confirm who will be arranging the case conference. • (If the WRP attends, they usually schedule / book the meeting and they will often document the case conference and distribute notes to all parties involved.)	When a practitioner has ticked the box on the medical Certificate of Capacity requesting a RTW case conference, it is important that the case conference is organised in a timely way to respond to the practitioner's request. You can contact the RCM in the first instance (or ask for your Injury Manager's assistance to contact them) to ensure this is understood. If not, you can reinforce the need to respond to the request and to maintain good communication with the treating practitioner.

	During the case conference	- During the case conference provide an overview of the claim including a brief history of the claim, the current strategy and goal, and any barriers identified to achieving that goal. - Participate in the claim discussion and contribute to the agreed actions.	
	After the case conference	Review the agreed actions to ensure accuracy.	
Claims Administration Officer	Before the case conference	Schedule case conference time and date if required, sending an invite to all attendees.	
	During the case conference	Take notes, document agreed actions.	
	After the case conference	(if WRP does not do this) Distribute to the internal case conference attendees first, for confirmation, specifying a due date for feedback. - Distribute agreed actions to the Agency where required.	
Injury Manager	Before the case conference	Prepare for the case conference.	The Senior Injury Manager should consider the following when preparing for a case conference: current functional status of the employee including

			medical certification • treatment regime including goals, timeframes and any relevant reference to MD guidelines • biopsychosocial issues/barriers that may be impacting on recovery and RTW status • review of the section 37 Rehabilitation Program and identification of any anomalies, i.e. are rehabilitation goals SMART and/or aligned to treatment goals? • strategies to overcome any identified barriers and/or issues.
	During the case conference	• Contribute to the claim discussion, providing advice regarding rehabilitation and injury management strategies where required. • Assist in the development of agreed actions.	
	After the case conference	• Review the agreed actions to ensure accuracy. • Add a case conference note in Pracsys.	

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Employer case conference

Employer case conferences are held with nominated agencies on a regular basis (monthly, 6-weekly, quarterly) as part of Comcare’s delivery of claims management services.

The purpose of this type of case conference may be, but is not limited to:

- a review of emerging claims that are impacting premiums
- a review of claims that will support the agency achieve their business plan objectives e.g. improving rehabilitation and return to work outcomes
- a review of claims identified by the agency or Comcare
- the opportunity for all parties to learn more about the roles and responsibilities of each party in managing a claim, e.g. Claims Managers, Rehabilitation Case Managers, Injury Managers etc.

Claims reviewed should be identified by agreed criteria, such as (but not limited to):

- absence from work
- unmet work capacity, that is, where an employee is fit for work but either not at work or not working their certified hours
- protracted rehabilitation program and/or treatment with little or no progress
- claim complexity, e.g. secondary conditions, injury circumstance
- where risk factors are present, e.g. reputational to the agency or Comcare
- incurred costs increasing every month.

What type of queries should not be included in employer case conferences?

The following claims and queries should not be brought to a case conference:

- basic claim queries that could be resolved by a telephone call
- claims that are open due to ART proceedings that have not yet settled.

Roles and responsibilities

Roles	When	Responsibilities	Considerations
Comcare Account Manager	Monthly / quarterly or as agreed Before the case conference	• Confirm the frequency of case conferences for the calendar year with the Agency. • Schedule case conference time and date. • Send an invite to Agency contact, Claims AD, AD Injury Management and Claims Support Officer. • (Three weeks before the conference): Confirm the list of claims to be reviewed to the Claims AD (maximum of 8 claims to be discussed per case conference).	

	After the case conference	Enter the case conference interaction in CRM.	
Claims Operations AD	Before the case conference	(3 weeks before conference): Contribute to identifying suitable claims to be reviewed at each case conference (maximum of 8 claims to be discussed per case conference). - Forward invite to Claims Managers who will participate in the case conference. - If any Claims Managers are unable to attend, arrange for someone to cover the claim overview in their absence, e.g. Senior Claims Manager, aligned Injury Manager. - Ensure you are aware of the claims to be discussed during the case conference and are prepared accordingly. - Ensure claims have been reviewed (in consultation with an Injury Manager where required) and a Claim Plan completed prior to the case conference.	The claims team should nominate a couple of claims at each conference (not just the employer's nominated claims). This is an opportunity to share good news stories or flag rehabilitation case management opportunities. Claims within the premium window (up to a maximum of 8 per case conference to ensure meetings are used productively) will be reviewed as a priority. However, at times, a review of long-tail claims (claims 4-5+ years in age) may be appropriate. Use the Case conference template to identify the claims, including the reason for discussion at a case conference. This template will also be used for recording the agreed actions on completion of the case conference.
	During the case conference	- Lead the case conference. - Action items from previous conferences must be included as an agenda item at each case conference where the items are discussed and signed off as completed.	

		• Ensure attendees are clear about expectations of the provision of a succinct claim overview during the case conference and explanation of a clear claim strategy. • Provide input to claim discussions, advice and guidance as required during the case conference. • Ensure all stakeholders know who is responsible for managing actions, providing updates and ensuring they are completed in a timely manner.	
	After the case conference	• Quality check Claim Plans and claim conference records before they are distributed. • Update on action items should be provided to employers regularly including when items are completed. Follow ups should be conducted to ensure all action items are completed as agreed.	
Claims Manager	Before the case conference	• Ensure claims have been reviewed (in consultation with an Injury Manager where required) and a Claim Plan completed prior to the case conference. • Ensure your availability to attend the case conference at the designated time. • Ensure that any agency-specific requests highlighted in the Case Conference Record are addressed in the Claim	The claim summary / overview of each claim will include outlining a proactive claim strategy.

		Plans/claim discussions where required. • Ensure you make at least two attempts to call the employee (document in Pracsys) to gain a general update on their injury and claim before completing the claim summary. • Prepare a claim summary / overview of each claim in collaboration with the Senior Injury Manager.	
	During the case conference	• Provide an overview of the claim including a brief history of the claim, the current strategy and goal, and any barriers identified to achieving that goal. • Participate in the claim discussion and contribute to the agreed actions. • Provide input to claim discussions, advice and guidance as needed during the case conference.	
	After the case conference	• Review the agreed actions to ensure accuracy.	
Injury Manager	Before the case conference	• Ensure claims have been reviewed and a summary prepared with the Claims Manager prior to the case conference. • Contribute to the creation of Claim Plans ensuring that they include a proactive injury management strategy. • If unable to attend the case conference, arrange for someone to attend who can cover the Injury	

		Management perspective (e.g. the Injury Management AD).	
	During the case conference	Contribute to the information provided by the Claims Manager during the claim discussion, providing advice regarding treatment suitability, recovery timeframes and strategies to enable a return to work.	
	After the case conference	- Add a case conference note in Pracsys. - Review the agreed actions to ensure accuracy.	
Claims Support / Administration Officer	Before the case conference	- Forward the completed Case Conference Record outlining the claims to be reviewed, to the relevant Claims Managers, Injury Managers and copy in AD Claims and Account Manager. - Ensure the email includes the date the Claim Plans are to be reviewed by AD claims. - The Claim Plans will be forwarded to the agency contact and internal invitees as one document 5 business days prior to the Case Conferences.	
	During the case conference	Document agreed actions using the Case Conference Record template.	
	After the case conference	Distribute agreed actions to the case conference attendees internally first, for confirmation, specifying a due date for feedback.	Once all parties have agreed to the discussed actions items, the CSO/CAO should save the completed Case

		• Save the completed Case Conference Record within HP Content Manager within the Claims Management Folder (SC20/32) clearly labelling the document with the date the conference occurred. • Distribute agreed actions to the Agency (within 5 business days).	Conference template, clearly labelling the document with the date the conference occurred. Here is an example of how to label case conference minutes and action items: Claims Management > Case Conference – Minutes and Action Items > Airservices Australia > <i>"Conference Actions Items dated 20.03.2023"</i>. The CM folder has been set up for Claim Support Officers (CSO) and Claim Administration Officers (CAO) to record and store our external case conference minutes and action items in a centralised folder more easily. This will allow for any internal stakeholders of Comcare (Account Management, Compliance, Claims Managers etc) to search and find relevant information.

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Payment of case conferences

Case conferences should only be paid under sections 36 and 37 of the SRC Act.

Comcare will only pay for case conferences where a Comcare representative is present. If a practitioner seeks payment from Comcare for a RTW case conference, you must ensure that a Comcare representative was present, along with the medical practitioner, the employee and a minimum of one other key stakeholder (usually the RCM and/or WRP). The practitioner does not need to state on the invoice who participated in the case conference.

If the WRP is present at a case conference, they may pay the practitioner's costs under payment code 93. Comcare can then reimburse the cost as part of the section 37 rehabilitation program, where the case conference is included as an activity of the plan.

However, where a rehabilitation program has not yet been developed, payments associated with RTW case conferencing can be made under section 36 of the SRC Act. Authority to pay for case conferences under section 36 (code 90) can be provided verbally or in writing by the RCM. A copy of a recent section 36 referral to a WRP for an Initial Needs Assessment is sufficient authority for payment under section 36. Note that payment for a case conference can also be made under section 70 of the SRC Act if required (GP case conferences only), but only in the absence of a section 37 rehabilitation program not yet being in place.

Update Pracsys to authorise payment: To ensure payment for practitioner participation in a case conference, you should make a comment in Pracsys that rehabilitation is underway. Also, you should authorise payment of the case conference in the 'Payment Authorisation (Treatment Plan)' (ACTP) function in Pracsys.

Reasonable amounts to pay for participation in a case conference

Comcare has advised practitioners that we will pay for their participation in RTW case conferences (provided a member of Comcare is present, see the guidance in the previous section), in line with the Australian Medical Association (AMA) rates (in Pracsys).

However, note that the authority for payment of rehabilitation costs sits with the rehabilitation authority and the RCM may agree to pay a different rate for a practitioner's participation in a case conference.

Payment for other treatment provider participation

On occasion, another treatment provider such as a psychologist or physiotherapist may attend a RTW case conference. As they are not eligible to claim AMA rates, you will need to consider if the amount charged is reasonable for their participation.

Note: Normal discussions between an employee's GP and other treatment providers regarding the medical management of the employee are not a RTW case conference and these are not payable by Comcare, especially if no Comcare employee is present.

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Invalidity retirement

Introduction

An application for invalidity retirement can be made by the employee or their employer to the employee's superannuation fund. Once an employee makes a successful application for invalidity retirement, the rules governing how an employee can access their superannuation are managed by the relevant superannuation scheme.

If the employee requires more information as to which option their superannuation fund offers, they will need to contact their superannuation fund directly.

An invalidity retirement pension is payable to an employee if the administrators of the fund agree that an employee is suffering from a permanent medical condition that is likely to prevent the employee from working. The medical condition suffered by an employee may be compensable or a combination of compensable and non-compensable conditions.

Comcare has a role in this process when an employee applies for invalidity retirement as a result of a compensable condition. In this situation, Comcare's role is limited to providing a recommendation to the fund administrator, either supporting or not supporting the application for invalidity retirement. Ideally, the employee's rehabilitation authority will seek Comcare's recommendation for invalidity retirement, before the application is finalised.

If a Rehabilitation Case Manager does not ask Comcare to provide a recommendation and Comcare becomes aware that an employee is in the process of being invalidity retired, you (the Claims Manager) should contact the Rehabilitation Case Manager to discuss further (**Note:** invalidity retirement does not affect an employee's right to claim compensation in respect of their compensable condition).

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Total and permanent incapacity

An application for total and permanent incapacity, will ordinarily be approved by the fund administrator in situations where the employee is:

- unable to work again in a job which they are reasonably qualified for (or could be reasonably qualified for after retraining)
- unable to participate in any other employment with a government department
- unable to participate in any other employment.

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Partial and total invalidity retirement

An employee can apply to their superannuation fund for a partial or total invalidity retirement pension. A partial invalidity pension is a form of income maintenance. It is paid as a pension when an employee's salary is reduced permanently due to a medical condition.

An employee who is receiving incapacity payments from Comcare in respect of a compensable condition is not eligible for partial invalidity retirement as they are already receiving compensation payments for the hours they are unable to work.

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Qualifying for invalidity retirement

An application for invalidity retirement should not be undertaken unless a concerted effort has been made to maintain the employee at work in some capacity, with appropriate and recent rehabilitation support. Before an application is lodged, superannuation funds including Commonwealth Superannuation Corporation expect that a range of pre-application strategies have been attempted. These strategies could include, but are not limited to:

- appropriate leave to allow adequate recovery time
- health assessment/vocational assessment reports
- employing and undertaking any treatment or strategies recommended by an approved medical provider
- comprehensive rehabilitation assessment and program provision
- graduated return to work program
- reduction in hours
- redeployment, and
- any other treatment or strategy that has been recommended.

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Comcare's recommendation

When an employee applies for invalidity retirement in relation to their compensable condition, the Commonwealth Superannuation Corporation funds require that the employer seek Comcare's view on whether all return-to-work options have been attempted unsuccessfully or ruled out as a viable option. Comcare makes this assessment in line with the return-to-work hierarchy.

Comcare will support an application for invalidity retirement where there is substantial and consistent evidence indicating that the employee is totally and permanently incapacitated and no further treatment, rehabilitation or provision of suitable employment is likely to increase the employee's capacity for employment.

You should ask for more information when you notice any inconsistency about the employee's capacity regarding their eligibility for invalidity retirement. Also, if you discover something that does not look right, feel right or when you receive information either from the employee or another source (employer, rehabilitation provider etc) that is relevant and has the potential to impact the management of a claim, first discuss with your Injury Manager. If necessary, please refer to the "Just Ask" process.

Considerations when providing a recommendation for invalidity retirement

When providing a recommendation to a superannuation fund in respect of an employee's application for invalidity retirement there are certain considerations (e.g. age, support to get the employee back to work, length of time off work, etc) that are designed to provide an overall picture of the circumstances that have led to the application for invalidity retirement. Importantly, failure by an

employee to meet, or not meet, any of these individual considerations **does not** mean the application is automatically supported or not supported by Comcare.

When drafting a recommendation for invalidity retirement, you can seek help from your Injury Manager in complex cases. Use the following questions to guide your draft.

What is the age of the employee?

In general, where an employee is under 50 years old, Comcare is unlikely to support an application for invalidity retirement. An employee under 50 years old has at least 15 years before retirement age and has a greater capacity for retraining and/or redeployment.

Has there been any recent comprehensive rehabilitation assessment or rehabilitation program provided in line with medical recommendations?

To support an application for invalidity retirement, Comcare needs up to date, comprehensive rehabilitation information – i.e. reports that are no more than 6 months old. This information will help establish whether all rehabilitation options have been explored and will indicate whether rehabilitation programs were provided in line with medical recommendations, or not. Where a rehabilitation program was not provided in line with medical recommendations, there may be other rehabilitation avenues to explore.

Has a graduated return to work (GRTW) plan been put in place?

Any recommendations made are done so in line with the return to work hierarchy. To support an application for invalidity retirement, Comcare needs to be satisfied that the rehabilitation authority has done everything it can to return an employee to work, and exhausted all options. This includes putting a GRTW program into place and trialling different types of GRTW programs.

How many GRTW programs were attempted and when was the last attempt?

In a situation where there has been a significant gap between a GRTW program closing and the application for invalidity retirement being made, you need to consider whether the employee's circumstances have changed since the GRTW program finished. And, if so, you need to consider whether the employee may now have capacity to undertake a new GRTW program which may be successful.

Has the employer offered a range of suitable employment?

Section 40 of the SRC Act places a statutory duty on employers to take all reasonable steps to provide an employee with suitable employment where the employee is undertaking or has completed a rehabilitation program. Suitable employment involves duties which are appropriate to the employee's age, experience, training, language and other skills and are in line with any medical restrictions. Taking 'reasonable steps' to provide suitable employment may include, but is not limited to, modification to existing duties, alternative duties or modified hours, similar to the principle of reasonable adjustment in the *Disability Discrimination Act 1992*.

While an employee may be incapacitated for their pre-injury duties in their original form, they may be able to undertake these duties with modifications or adjustments. In some circumstances an employee may be totally incapacitated for their pre-injury duties but capable of undertaking alternative suitable employment, either within or external to their organisation. You need to be satisfied that the employer has taken reasonable steps to provide suitable employment to the employee.

Has redeployment to another employer (government or private) been considered?

An employee may be totally and permanently incapacitated for their pre-injury employment. However, they may be able to return to work with an alternative employer or with the same employer in a different area of the organisation. You need to be satisfied that all attempts have been made to return an employee to work, including redeploying the employee.

How long has the employee been off work?

Where an employee has been consistently totally incapacitated for a significant period (generally more than 6 to 12 months) this may be an indication that the employee does not have any capacity for employment. You need to determine the reasons behind this incapacity, i.e. is the employee incapacitated solely as a result of their injury or is it because a GRTW program has not been provided or suitable employment found.

What are the recommendations from treating practitioners regarding the employee's capacity for work?

Do the employee's treating practitioners consider the employee is totally and permanently incapacitated for any work? Have they recommended any rehabilitation programs or strategies which have not been adopted by the employer? Have they considered any jobs which the employee may be reasonably qualified for (or could be reasonably qualified for after retraining)?

Is there any potential for improvement in work capacity if the employee undertakes further medical treatment?

Invalidity retirement should only be supported where all reasonable medical treatment has been undertaken.

If an employee's capacity for work may improve with medical treatment, it is unlikely Comcare would support an application for invalidity retirement.

What are the recommendations from any independent medical examiners (IMEs) (section 57) regarding the employee's capacity for work?

Has the employee been assessed recently (e.g. in the past 6 to 12 months) by an IME and if so, do they believe the employee is totally and permanently incapacitated? Have they recommended any new rehabilitation strategies or programs which have not been implemented by the employer?

Where an independent medical examiner has provided advice on rehabilitation strategies (e.g. suggested a new program), you should be asking the employer why they have not implemented this advice.

Where an IME has recommended alternative medical treatment, you should discuss this with the employee's treating practitioner. If an employee's capacity for work may improve with medical treatment it is unlikely Comcare would support an application for invalidity retirement.

Does the rehabilitation provider believe all vocational options have been explored?

The rehabilitation provider works closely with the employee and should have a good understanding of the employee's capabilities, skills and qualifications.

Before making a recommendation on an application for invalidity retirement, you should review any documentation on file from the rehabilitation provider regarding their opinion on the employee's

capacity to return to work. If there is insufficient information, you should contact the rehabilitation provider to discuss and/or seek further information.

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Retrospective invalidity retirement

Ex-employees can apply for retrospective invalidity retirement under the Commonwealth Superannuation Scheme (CSS) and Public Sector Superannuation Scheme (PSS) through Commonwealth Superannuation Corporation, if they have a preserved superannuation component.

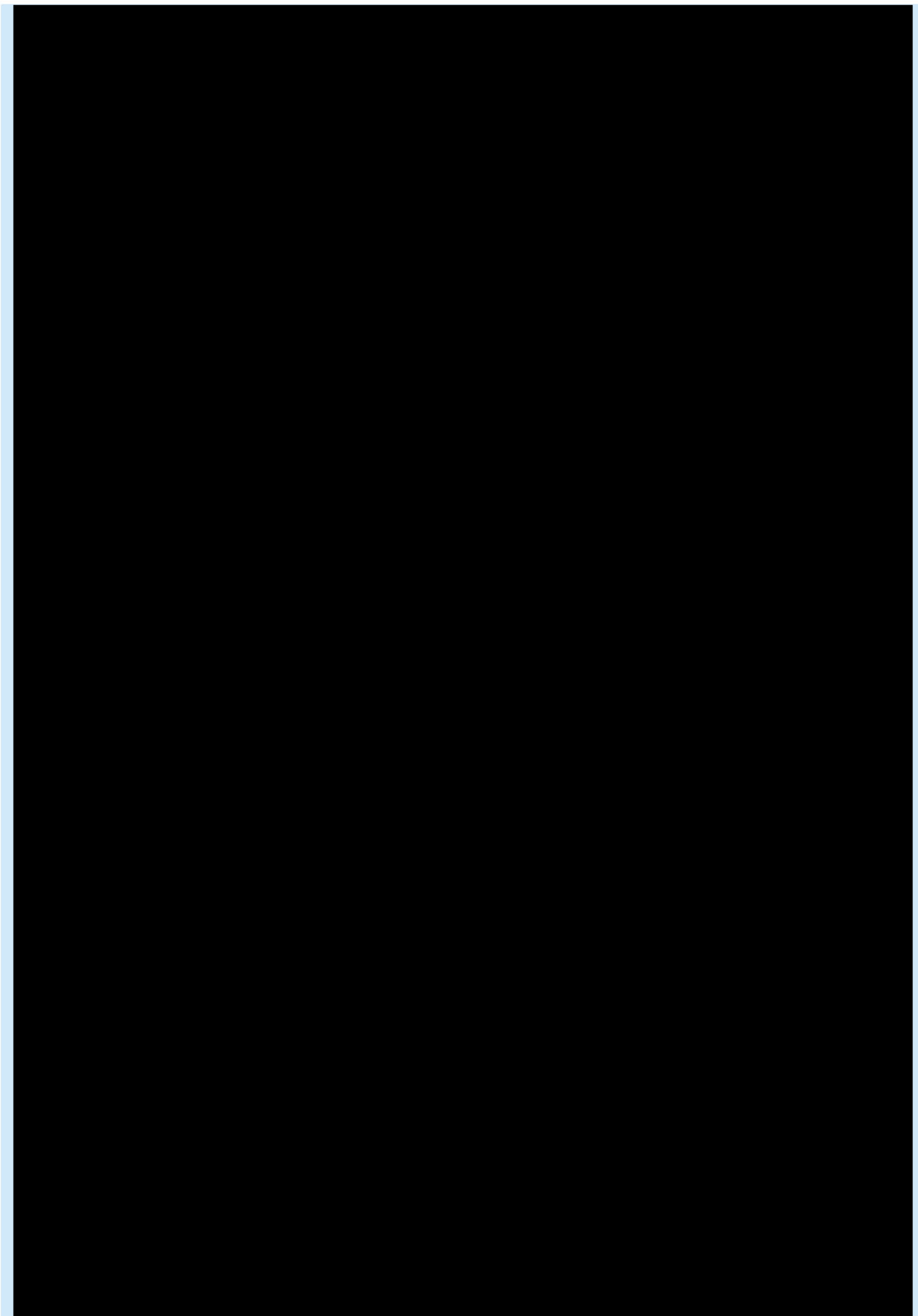
An ex-employee may do this in order to be granted payment of an invalidity pension from the date they originally exited their employment.

If you are asked to make a recommendation on a retrospective application for invalidity retirement, the process is the same as if the employee was currently employed. You need to be satisfied the ex-employee was totally and permanently incapacitated at the date of separation from their employment. Note that it is not Comcare's decision whether to accept an employee's application for invalidity retirement. Comcare can only provide a recommendation to the superannuation fund.

If you receive an application for a retrospective invalidity retirement, you will need to discuss the application with your Assistant Director.

Other superannuation funds: If an employee has a superannuation fund other than Commonwealth Superannuation Corporation, they will need to contact their fund to confirm if their fund allows for retrospective invalidity retirement.

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Arranging a vocational assessment

Introduction

A vocational assessment should be arranged when an employer and Comcare require evidence to judge whether an employee has appropriate skills, qualifications or training to undertake suitable employment. This type of assessment should be arranged when there are changes required to an employee's return to work goal.

A vocational assessor can be asked to provide an opinion on:

- whether the employee is competent to engage in suitable employment which the medical evidence has indicated the employee is fit to undertake, and
- where the vocational assessor has current and relevant labour market knowledge:
 - whether employment is actually available, and
 - what the earnings are from the available employment.

A vocational assessor is a Workplace Rehabilitation Provider (WRP) who has expertise in identifying vocational goals and/or suitable employment opportunities. This type of assessment is typically organised by the rehabilitation authority/employer (often by the assigned Rehabilitation Case Manager (RCM)). However, Comcare can request a vocational assessment (as well as a labour market assessment) when assessing and deeming an employee's ability to earn, when appropriate. See [Ability to earn](#) -guidance for more information.

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Refusal to attend

A vocational assessment is arranged under section 70 of the SRC Act, when Comcare is the requester. Under section 70, there is no power to compel an employee to attend an assessment. If an employee refuses to attend a vocational assessment, you will be unable to force the employee to attend, nor will you be able to suspend the employee's claim because of the non-attendance.

Typically, a vocational assessment is arranged under section 37 of the SRC Act by a delegate for a rehabilitation authority (usually the RCM). If an employee refuses to attend a vocational assessment that is included within a section 37 Rehabilitation Program, the delegate for the rehabilitation authority who has requested this assessment may be able to suspend the employee's right to claim compensation until the assessment takes place, unless a 'reasonable excuse' is provided by the employee.

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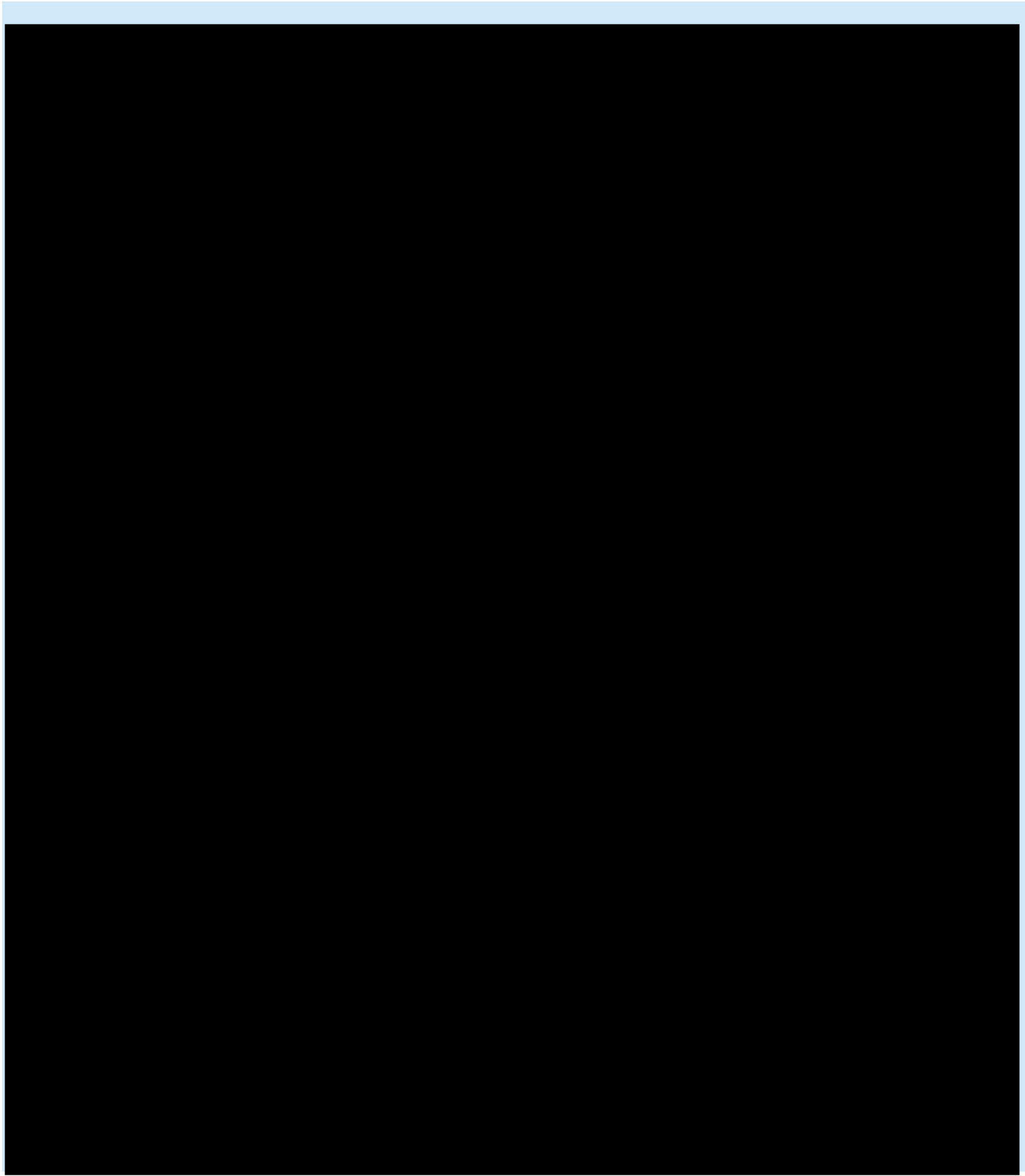
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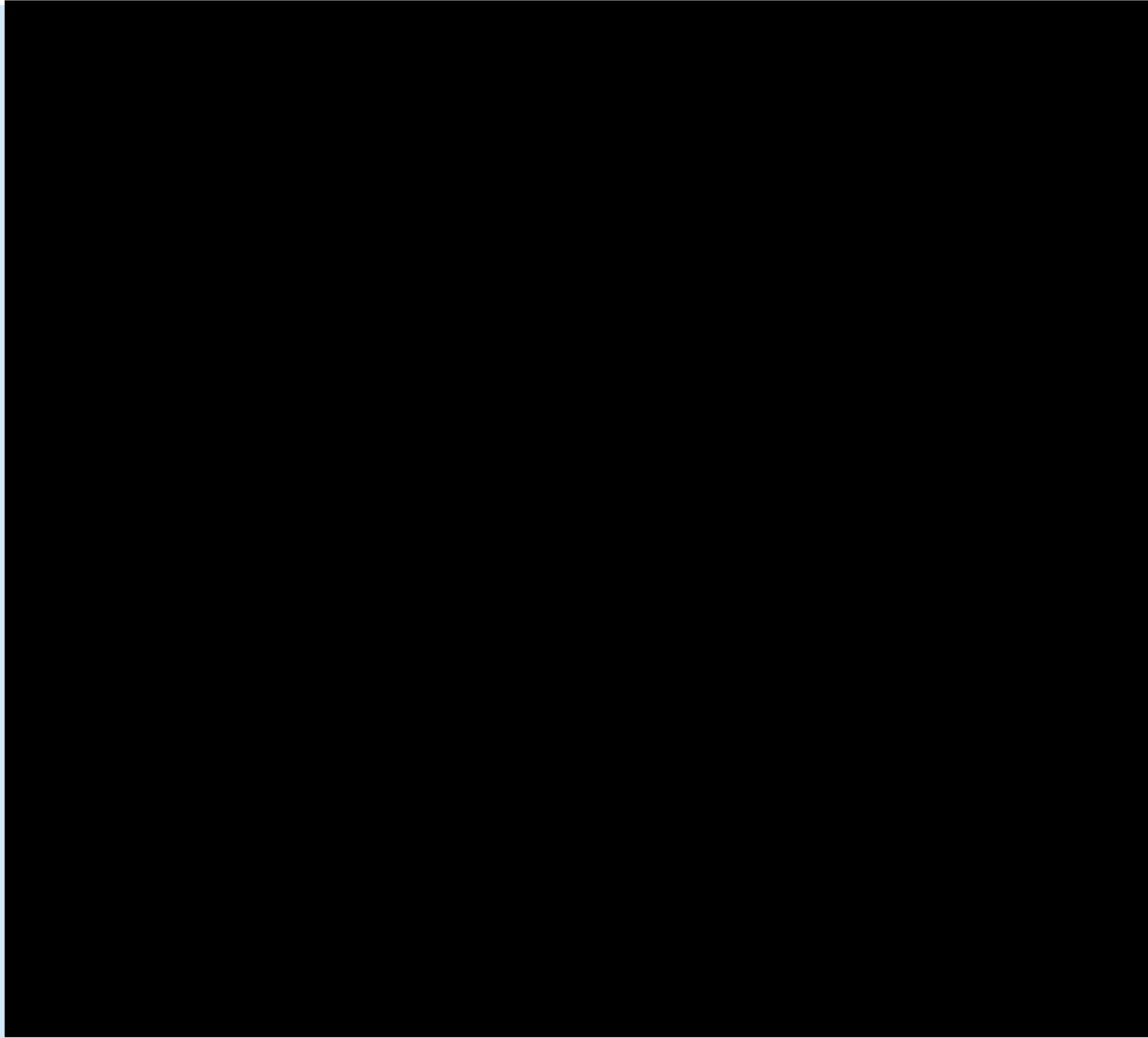
The Privacy Statement on the current Comcare claim form advises employees that Comcare may disclose personal information to, or collect personal information from, vocational and functional assessors. Previous versions of the claim form did not include this.

Before you arrange a vocational assessment for an employee, you will need to check whether vocational assessors were included in the privacy statement on the claim form that the employee signed. If not, you will need to ask the employee to sign an Authority and Consent for the Collection and Release of Medical Information Pertaining to My Claim form before any information can be shared with a vocational assessor.

If the employee does not consent to their personal information being released to a vocational assessor, you will not be able to arrange the assessment.

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Incapacity calculation and payment

Published 31/07/2025

Incapacity calculation and payment

Once a Claims Manager has accepted a claim for compensation under section 14 of the SRC Act, Comcare may be liable to pay for the time that an employee is not at work due to the compensable condition. These are known as **incapacity payments** for income support. For incapacity payments to be paid, the employee must submit a Claim for Time off Work (CTOW) either online ([online CTOW](#)) or via hard copy ([paper CTOW](#)).

Incapacity payments are assessed, determined and calculated by:

- assessing whether the employee is a current or ex-employee
- assessing the employee’s employment, specifically that it is suitable employment
- identifying the employee’s earnings from employment, superannuation payments received, and Centrelink payments where relevant
- considering leave and allowances
- identifying the employee’s Normal Weekly Hours (NWH)
- identifying the employee’s Normal Weekly Earnings
- considering whether the employee has an Ability to Earn (AE) that is greater than the actual earnings they are receiving from suitable employment, where relevant.

Roles and responsibilities

The process of incapacity payments requires Claims Managers and the Claims Administration and Income Support (CAIS) team to work closely together. A table showing the roles and responsibilities throughout the incapacity payments process is shown below.

Responsibilities	Claims Manager	CAIS
1. Acceptance of initial liability	x	
2. Discussion with the employee about the income support process	x	
3. Requesting/following up on medical evidence from the employee	x	
4. Requesting/following up on the initial Normal Weekly Earnings figure (NWE) from the employer		x

5. Confirmation from the employee of the initial NWE information	x	
6. Updating the treatment plan	x	
7. Determination of initial and subsequent NWEs		x
8. Processing claims for income support		x
9. Processing requests for out of cycle payments		x
10. Regularly reviewing the employee's entitlements	x	
11. Discussing calculation altering topics, such as employment superannuation and accessing Centrelink and supporting the employee to provide Comcare with accurate and up to date information whenever there is a change of circumstances	x	
12. Determination of an Ability to Earn (AE) or deeming an Ability to Earn where necessary	x	
13. Responding to agency payroll queries and requests for guidance		x
14. Pursuing debt recovery and overpayments		x
(For employees ceasing employment with agency)		
Responsibilities	Claims Manager	CAIS
15. Discussion with the employee about Xpay set up process	x	

16. Requesting/following up with CAIS on relevant information provided by employee	x	
17. Requesting/following up on cessation form from agency	x	
18. Requesting/following up on outstanding CTOWs or Records of Earnings (ROE) if required	x	
19. Requesting/following up on superannuation information		x
20. Sending Centrelink request for determined periods		x
21. Updating NWE if required		x
22. Determining incapacity periods post cessation		x
23. Providing communication to Claims Manager to send to employee		x

This table demonstrates that **Claims Managers are the contact point for employees** in all aspects of the management of their claims. While the Income Support team may make decisions, update information and complete processes around incapacity payments, the Claims Manager's name is on all correspondence with the employee. Therefore, it is important for you to have a strong understanding of the information you are sending or requesting, and the processes happening in the background. This will allow you to maintain clear and timely communication with employees and ensure they fully understand the progress and outcomes of their claims.

It is important to review an employee's entitlements to incapacity payments regularly. See the pages in this section of the manual for more information.

Relevant legislation

The sections of the SRC Act that relate to incapacity payments are:

- Section 4(9) - Interpretation
- Section 7(6) - Incapacity taken to have resulted from a disease
- Section 8 – Normal Weekly Earnings (NWE) and Normal Weekly Hours (NWH)

- Section 9 – Relevant period for calculating NWE and NWH
- Section 13 – Indexation of incapacity and other benefits
- Section 14 – Entitlement to compensation for incapacity
- Section 19 – Calculation of incapacity payments
- Section 20 – Incapacity payments where employee receives superannuation pension
- Section 21 – Incapacity payments where employee receives superannuation lump sum
- Section 21A – Incapacity payments where employee receives both lump sum and superannuation pension
- Section 22 – Compensation where employee is maintained in a hospital
- Section 23 – Compensation for incapacity not payable in certain cases
- Section 30 – Redemption of compensation
- Section 31 – Recurrent payments after payment of lump sum
- Section 33 – Reduction of compensation where certain other payments are received
- Section 134 – Reduction of compensation on reaching pension age
- Section 135 – Former employees 65 or older receiving superannuation benefits
- Section 136 – Former employees 65 or older not receiving superannuation benefits
- Section 137 – Redemption on request by former employee

See also the *Safety, Rehabilitation, Compensation and Other Legislation Amendment Act 2007* (SRCOLA 2007).

In this section

Process to claim incapacity

This page takes you through the entire process to claim incapacity after an employee has had their claim for initial liability accepted. The page includes information about:

- assessing NWE
- process for Commonwealth employees to claim incapacity
- process for employees leaving Commonwealth employment
- claiming incapacity for ex-employees
- employees no longer eligible for incapacity payments.

Incapacity for work

This page provides an overview of incapacity for work including:

- eligibility for incapacity payments
- medical certificates and evidence
- maintaining communication with employees
- tax and superannuation
- incapacity payments with two or more claims
- incapacity payments when attending medical treatment
- termination of employment and incapacity payments
- incapacity legislation.

Leave and incapacity

This page provides information about leave and how it interacts with incapacity payments, including:

- leave accrual during the first 45 weeks of a claim
- leave accrual after 45 weeks post-determination
- public holidays and shutdowns
- annual and personal leave
- maternity leave
- rostered days off (RDOs)
- absence from work due to rehabilitation activities
- overtime and allowances while on other leave
- scheme guidance.

Ability to earn assessment

Ability to earn is the greater of either an employee's ability to earn in suitable employment or their gross actual earnings in any employment. It is an element that is taken into considering when calculating incapacity payments. This page includes information about:

- Actual earnings
- suitable employment
- determining an ability to earn
- failed to accept, engage in or continue in suitable employment
- failed to complete rehabilitation or vocational training program
- failed to seek suitable employment
- any other matter considered relevant
- ability to earn and self-employment
- calculating an ability to earn figure.

Superannuation

An employee who is retired from Commonwealth employment and receives a pension and/or lump sum under a superannuation scheme as a result of their retirement, must have their incapacity payments determined under the superannuation provisions of the SRC Act (sections 20, 21 and 21A). This page includes information about:

- accessing superannuation
- superannuation provisions
- what superannuation is taken into account?
- calculating the appropriate superannuation amount
- calculating incapacity payments under sections 20, 21 and 21A

- superannuation contributions for employees on Xpay.

Calculating incapacity payments

The SRC Act provides different formulae for calculating incapacity depending on the circumstances of the employee. This page includes information about:

- factors affecting incapacity entitlements
- first 45 weeks of incapacity
- after 45 weeks of incapacity - adjustment percentage
- incapacity payments upon reaching pension age
- maximum compensation payable
- minimum earnings
- reviewing incapacity entitlements.

Normal weekly earnings (NWE)

NWE is a fair representation of what an employee would have earned in a week, had they not been injured, and may include overtime and certain allowances. NWE is an important part of calculating incapacity payments. This page includes information about:

- relevant period
- overtime
- allowances
- normal weekly hours (NWH)
- changes to normal weekly earnings
- increasing normal weekly earnings
- decreasing normal weekly earnings
- summary of NWE legislation.

Redemptions

When an employee's weekly rate of payment is at or below the redemption ceiling rate, they may be entitled to a lump sum payment instead of ongoing weekly payments. This page provides information about:

- eligibility for a redemption lump sum payment
- taxation on redemption payments
- incapacity payments after a redemption lump sum.

Separation from employment

When an employee separates from employment and has an incapacity for work, we have to consider this when assessing and calculating incapacity payments. This page includes information about:

- the separation process
- procedure to assess entitlements and capacity for work following separation
- information gathering
- after an employee is set up on Xpay.

Incapacity for work

Introduction to incapacity for work

An employee with an accepted and compensable condition may have an incapacity for work. Section 4(9) of the SRC Act provides that incapacity for work can include:

- an incapacity to engage in any work, or
- an incapacity to engage in work at the same level at which the employee was engaged prior to their injury.

Where an employee is incapacitated for work 'as a result' of their compensable condition, they may be entitled to **incapacity payments**. The phrase 'as a result of' involves causation. You need to be satisfied that it is the accepted compensable condition that has caused the incapacity, either directly or by some contribution, and that there is not some other cause.

Roles and responsibilities

The Claims Operations and Income Support teams work closely together in the incapacity payments process.

The Claims Manager:

- determines the employee's entitlement to incapacity payments for a particular period based on evidence (usually a medical certificate) and legislation (see this page for more details)
- discusses the process and requirements of claiming incapacity payments with the employee
- determines the employee's Ability to Earn (AE) where applicable (see [Assessment of ability to earn](#) for more information)
- regularly reviews the employee's eligibility for incapacity payments
- updates and reviews the incapacity treatment plan regularly, ensuring that time off work is appropriately extended in the treatment plan (via ACTP function in Pracsys) if liability has been accepted for incapacity payments. Payments will not be processed if the treatment plan is not extended.
- acts as the communication channel between the employee and the Income Support team under Claims Administration and Income Support (CAIS).

The Income Support team:

- processes the initial Normal Weekly Earnings (NWE) form
- processes the Claim for Time off Work (CTOW) form
- calculates the employee's incapacity payments for the claimed period
- communicates with and requests information from the employer/agency (including payroll teams), Centrelink, superannuation funds and other stakeholders
- does not communicate directly with the employee
- sends requests for further information via the Claims Manager, providing a template email to be sent to the employee.

Claims Managers should forward all incapacity-related diary and document notifications, and relevant correspondence to the Income Support team via the Incapacity Management team (IMT) in-tray

in [Pracsys](#). Any changes, questions or issues with an employee's incapacity payments should be raised with the [Income Support](#) team.

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Eligibility for incapacity payments

An employee can claim incapacity payments when, as a result of their compensable condition, they are:

- totally unable to work (total incapacity)
- partially unable to work (partial incapacity) - unable to work the same hours, duties, shifts, or overtime (see the **Note** below)
- redeployed to a lower paying position
- on an approved rehabilitation program
- on a graduated return to work ([GRTW](#))
- away from work because they are undertaking medical treatment, or
- injured two years or more before pension age (if they are still working after that time, they are eligible for up to a maximum of 104 weeks of incapacity payments).

Note: An employee may be eligible for incapacity payments even if they are working full-time hours, as long as they have medical evidence from a legally qualified medical practitioner (LQMP) showing that they are unable to earn the same amount as they did before they became incapacitated (section 4(9) of the SRC Act). For example, this may be because they have had to be redeployed to a lower paying position or because they are unable to work their usual overtime.

Incapacity payments are **not payable** if the employee:

- is in prison (after having been convicted of an offence)
- has reached pension age (unless they are still working or they are a 'former employee', i.e. due to the date of injury, the applicable compensation legislation pre-dates the 1988 SRC Act.
- suffered an injury within two years before pension age and has already received incapacity payments for 104 weeks
- received a redemption payment (unless their level of incapacity has increased) (see [Redemptions](#) for more on this topic)
- has an ability to earn which has exceeded their entitlement, or
- has had their compensation suspended under sections 36, 37, 50 or 57 of the SRC Act.

Pension age

Pension age will vary depending on when a person is born. See [Incapacity payments upon reaching pension age](#) for more information.

Incapacity payment for date of injury

An employee who injures themselves at work and is unfit for the remainder of the day is entitled to claim compensation for time off work that day. The claim for compensation must be supported by medical evidence from a LQMP.

Requests from employees or banks to provide information about Comcare payments

An employee or their bank may ask you to provide information about an employee's incapacity payments.

No information, written or verbal, is to be provided to anyone other than the employee without express written consent from the employee.

If the employee asks you to provide a letter, you may write a generic letter which the employee can share if they wish. Follow these principles:

- Provide only information relevant to the point in time the letter is provided. Do not discuss previous payments or anticipate amounts or longevity of future payments.
Example: "Mr/Ms XX is currently receiving incapacity payments of \$XX gross (before tax) per fortnight. These payments will continue in line with medical evidence and the relevant legislation."
- Be clear that these payments are subject to change.
Example: "Payments from Comcare are subject to ongoing reviews and subject to change based on medical and other evidence, the employee's capacity to work, legislative change and other circumstances."
- Explain that compensation payments from Comcare are not considered income.
Example: "Comcare is an insurer that determines liability for compensation payments for work-related injuries subject to legislation. Compensation payments are not wages or payments for work or services provided."

Incapacity payments for claims involving other insurance schemes

If there are other insurance schemes involved that may pay compensation to the employee for the same injury or a different injury, please see State and other workers compensation page for details.

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Medical certificates and evidence

A medical certificate must (subject to exceptions) meet the following criteria to be relied upon when assessing liability:

- be completed by a legally qualified medical practitioner (LQMP)
- provide a diagnosis of the claimed/ongoing injury, and
- provide an opinion regarding causation from employment.

Please refer to [Obtaining a medical certificate](#) page for details of what is acceptable as a medical certificate.

If the medical certificate being used to claim incapacity payments is not compliant, Income Support will ask the Claims Manager to request and document any missing information from the LQMP.

Period of coverage

Discretion and sound judgement should be exercised when actioning medical certificates that cover an extended period. Comcare requires periodic medical review and generally does not extend liability for periods greater than 12 months. At the end of an accepted period, a new medical certificate is required.

Regular contact with an employee will ensure they are aware of when a new medical certificate is required. Sometimes, it may be appropriate for a payment to be made for a short, specified time frame to minimise distress and disruption to our employees, for example whilst they obtain a new medical certificate. If a payment is approved without medical evidence on file, you must complete the comment section on the Incapacity Treatment Plan page in Pracsys to document why this has occurred and steps taken to gain appropriate medical evidence.

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Maintaining communication with employees

It is important to maintain strong communication channels with employees to ensure that they understand their entitlements and obligations, and to support them to provide Comcare with information relevant to their entitlements. You need to understand the processes and information needs of the Income Support team so that you can act as a clear and efficient communication gateway between the employee and Income Support.

You may be contacted by Income Support because they require further information from the employee to process a claim for incapacity payments. Claims Managers play an essential role in communicating with employees to ensure that all necessary information is received and confirmed. It is essential that you conduct regular **reviews** of an employee's eligibility for incapacity payments and support the employee to communicate to you any changes to their circumstances which might affect their entitlements. You must confirm this information and provide it as quickly as possible to Income Support. This is because delays in determining incapacity entitlements may place an employee in financial hardship. Incapacity payments will be backdated to the Date of Injury (DOI) once the determination process is complete.

If an employee accesses **Centrelink**, a **Department of Veterans' Affairs pension** and/or their **superannuation**, this can affect their entitlements under the SRC Act. It is important that you support the employee to keep you, as their Claims Manager, up to date on their circumstances to avoid any overpayment.

For the full process and timeline on claiming for and being paid incapacity payments, see [Process to claim incapacity](#).

If you notice inconsistencies with an employee's payslips, record of earning (ROE), superannuation etc, you should ask for more information. If you discover something that does not look right or feel right, or when you receive information either from the employee or another source (employer, rehabilitation provider etc) that is relevant and has the potential to impact the management of a claim, please refer to the ["Just Ask"](#) process.

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Tax and superannuation

Incapacity payments are taxable. Employees receive their incapacity payments via their employer [agency's](#) Payroll team and tax is withheld in the same way as with their regular salary. Ex-employees (who have separated from Commonwealth employment) who are paid directly by Comcare through the [Xpay](#) system also have tax withheld from their payments, which Comcare forwards to the Australian Taxation Office (ATO). Comcare reports fortnightly to the ATO about incapacity payments made directly to ex-employees.

Employees can access the income and tax information that Comcare reports to the ATO by logging into their myGov account under Employment > Income Statements.

Superannuation

The SRC Act does not provide for the payment of superannuation to an employee or employer. An employer must continue to pay their employee's superannuation based on their Employment Agreement. Incapacity payments made directly by Comcare to ex-employees are not eligible for superannuation. This is because Comcare is the insurer of the employee, not their employer. As a result, compensation payments are not considered Ordinary Time Earnings (OTE) by the ATO and superannuation is not payable.

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Incapacity payments with two or more claims

An employee may be partially or totally incapacitated for work as a result of conditions arising from two (or more) separate claims. As employees can only receive incapacity benefits once per claimed period, you will need to decide which claim the incapacity payments should be paid on.

What claim should incapacity be paid on?

When considering which claim to pay incapacity on, you should consider:

- what condition has caused the employee to be incapacitated, and if the employee is incapacitated as a result of more than one condition:
- which claim provides the highest Normal Weekly Earnings (NWE) after factoring in any adjustment percentage.

The following table provides a guide only on how to determine the claim on which to pay incapacity, depending on the circumstances. Incapacity payments should always be determined on a case-by-case basis.

Claim 1	Claim 2	Pre 45 weeks incapacity paid on:	Post 45 weeks incapacity paid on:
Fit for work	Partially / totally incapacitated	Claim 2	Claim 2
Fit for graduated return to work (GRTW) or reduced hours if not for claim 2	Totally incapacitated	Claim 2	Claim that provides the highest NWE after factoring in any adjustment percentage
Totally incapacitated	Totally incapacitated	Claim that provides the highest NWE after factoring in any adjustment percentage	

Examples

Example 1: An employee is partially incapacitated for work in relation to their first claim for a back injury for which they are working a graduated return to work (GRTW) of 20 hours per week. The same employee has a separate claim for a knee injury which, following surgery, develops into Deep Vein Thrombosis. The employee becomes totally incapacitated for work. It is not possible to separate the employee's incapacity as a result of the second claim from the incapacity resulting from the back injury.

In this case, the employee's incapacity payments should be made against the second claim as they are fully incapacitated as a result of the second condition.

Example 2: An employee with a claim for shoulder sprain has been incapacitated for more than 45 weeks. They have now been certified fit to work 5 half days per week and are therefore entitled to 85% of their NWE (see adjustment percentage for an explanation).

While still incapacitated and with the same NWE, the employee develops a new work-related condition, thoracic sprain, for which liability is accepted. As a result of the employee's thoracic sprain, they are certified fit to work five half days per week. The employee remains fit to work five half days per week in relation to their first claim.

As the employee is only entitled to receive 85% of their NWE on their first claim, based on the number of hours they have been medically certified fit to work, their incapacity payments are paid on the second claim as the employee is entitled to receive 100% of their NWE on this claim. This is because they have not surpassed 45 weeks for the second claim and are therefore not subject to an adjustment percentage.

Example 3: An employee has a claim for a psychological condition which has resulted in them being certified permanently unfit for work with their employer (agency 1). The employee has surpassed 45 weeks of incapacity.

A new position is found for the employee who commences work at a new Commonwealth agency (agency 2). In the new position the employee is working the normal weekly hours they were working prior to the date of injury at the first agency but earning less money.

As the employee is working the same normal weekly hours that they were working at on the date of injury, they are entitled to 100% of their NWE minus actual earnings (gross) from the second agency.

The employee later sustains an injury to their neck at the second agency which renders them totally unfit for work with that agency. The employee is therefore entitled to the higher of the following:

- 75% of agency 1's NWE – (minus) Ability to Earn (AE) (which may be \$nil), or
- 100% of agency 2's NWE - AE (until they pass 45 weeks of incapacity)

If the employee is incapacitated for more than 45 weeks as a result of their neck injury they will be entitled to the higher of the following:

- 75% of agency 1's NWE - AE (which may be \$nil), or

- 75% of agency 2's NWE – AE

Example 4: The same employee in example 3 is later certified fit for reduced hours with the second agency. During periods of partial incapacity, the employee is entitled to the higher of the following:

- (appropriate percentage of their original NWE) - (actual earnings (gross) from their new position), or
- (appropriate percentage of their new NWE) - (actual earnings (gross) from their new position).

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Incapacity payments when attending medical treatment

When an employee takes time off work to attend medical treatment for their compensable condition, they are entitled to claim incapacity payments for the period they are absent from work.

When can incapacity be paid?

When looking at what amount of time is reasonable to pay incapacity for, you should consider:

- the amount of time it would take to travel to the appointment
- the duration of the appointment (including delays at the surgery)
- the amount of time it would take to travel back to the employee's place of work/home (you can access websites like 'whereis' or 'travelmate' to calculate the journey), and
- whether it is reasonable for the employee to travel from home to the appointment before attending work for that day.

Attach evidence: All information accessed as part of making the determination (i.e. information from websites on calculating journeys) should be attached to the claim file as evidence.

Examples of what is reasonable

Example 1: The employee had a medical appointment at 9.30am but would normally begin work at 8.30am. It would be considered reasonable that the employee claimed for time off work from 8.30am to attend the treatment before attending work.

Example 2: The employee left work at 12.00pm to attend a physiotherapy appointment 5 mins away from her place of work and returned at 2.00pm. The employee informed their manager they would attend this appointment during their 1 hour appointed lunch break. Therefore, it would be considered reasonable for the employee to claim 1 hour for time off work.

Examples of what is not reasonable

Example 1: The employee has claimed incapacity payments for a full day due to attending a physiotherapy appointment. They would need to provide medical evidence from a legally qualified medical practitioner (LQMP), showing that they were unfit to work that day due to their compensable condition.

Example 2: The employee finishes work at 12.00pm to attend a massage appointment and claims incapacity payments for the remainder of the day. It is not considered reasonable that the employee requires five hours to attend a massage appointment. Medical evidence would need to be provided from a LQMP that showed why the employee was not fit to return to work.

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Termination of employment and incapacity payments

An employee’s termination of employment, regardless of the reason, does not necessarily mean that their entitlements under the SRC Act cease. While an employee continues to suffer the effects of a compensable condition, they will still be entitled to claim benefits under the *Safety, Rehabilitation and Compensation Act 1988* (the SRC Act), subject to the usual tests of eligibility (i.e. sections 4(9) and 19(1)).

An employee is entitled to claim incapacity payments following termination of employment if their compensable condition continues to cause some level of incapacity for employment.

An employee will need to continue to supply medical evidence from a legally qualified medical practitioner (LQMP) to Comcare in support of each claim for incapacity submitted to Comcare.

For more information on the information needed to determine if an ex-employee is eligible, please visit [Separation from Employment](#).

Employees suspended from work

If an employee is suspended from their work during a period of compensation leave, e.g. due to a code of conduct investigation, their incapacity payments will be affected according to how they are paid by their employer during the suspension. That is, their normal weekly earnings reported by their employer would continue to form the basis of any incapacity payments. See [Normal Weekly Earnings](#) for more information.

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Incapacity legislation

The following sections of the SRC Act are relevant to incapacity payments

SRC Act reference	Explanation
4(9)	Definition of 'incapacity for work.'

SRC Act reference	Explanation
7(6)	Incapacity taken to have resulted from a disease.
8	Normal weekly earnings (NWE) and Normal Weekly Hours (NWH).
9	Relevant period for calculating NWE and NWH.
13	Indexation of incapacity and other benefits.
14	Entitlement to compensation for incapacity.
19	Calculation of incapacity payments.
19(3)	Calculation of incapacity payments post 45 weeks.
19(4)	Deeming AE provisions.
19(5)	Maximum amount payable (AWOTEFA) provision.
19(6)-(14)	Minimum earnings provisions.
20	Calculation of incapacity where an employee is receiving a superannuation pension (retired on or after 1 December 1988).
21	Calculation of incapacity where an employee received a lump sum (retired on or after 1 December 1988).
21A	Calculation of incapacity where an employee received a superannuation lump sum and pension (retired on or after 24 December 1992).
22	Reduction in compensation for employee maintained in hospital.
23(1)	Cessation of incapacity payments at age pension age.
23(1A)	An employee with a date of injury that is within two years prior to the pension age may be entitled to 104 weeks of incapacity payments.
23(2)	Cessation of incapacity payments in respect of imprisonment.
30	Redemption of entitlement to incapacity compensation.
31	Resumption of incapacity compensation after redemption.
33	Reduction of compensation where certain other payments are received.
116	Employees on compensation leave.
120	Notice of departure from Australia.
123	Transitional – definitions.
124(6)-(7)	Transitional – application of Act to pre-existing injuries.
131-137	Calculation of incapacity compensation – 'former employees'.

Process to claim incapacity

Introduction

This page describes the processes required for an employee to claim incapacity payments. This can only be done after a workers compensation claim has been submitted, assessed and accepted.

The basic procedure is as follows.

What must happen first

An employee is injured at work, submits a workers compensation claim, and the claim is accepted.

When a workers compensation claim is submitted, initial liability is assessed and determined. For information on these processes, visit the Liability pages. The incapacity process begins once the claim is accepted, and the employee is determined as eligible for incapacity. The process is stepped out below.

First: Normal Weekly Earnings is calculated

This is done by the Income Support team in Claims Administration and Income Support (CAIS). See Normal Weekly Earnings on this page for detailed information.

Second: Information on earnings is gathered

If the employee is still employed by a Commonwealth agency and would like to claim incapacity:

1. The employee should complete a Claim for Time Off Work (CTOW) form each fortnight while they are incapacitated and have it verified by their employer. This is submitted to Comcare.
2. The completed CTOW form is processed by Income Support and the incapacity payment is paid to the employee's agency. The agency payroll team will then reconcile any leave taken during compensable periods and pay the employee compensation owed via their payroll system. This amount is taxed prior to payment.

See Process for Commonwealth employees on this page for detailed information. The point below does not apply to employees who remain employed by their Commonwealth agency.

If the employee is leaving or has left Commonwealth employment:

1. The employer completes the Cessation of Employment form and the employee submits other required documents.
2. The employee is set up on Comcare's Xpay Aurion system by CAIS.

See Employees leaving Commonwealth employment on this page for detailed information.

3. The ex-employee submits payslips or other records of earnings to Comcare every fortnight. CAIS reviews and calculates the incapacity payment amount and pays the employee via Xpay.

See Claiming incapacity for ex-employees on this page for detailed information.

Third: The employee is no longer eligible for incapacity payments

An employee stops being eligible for incapacity payments in the following situations:

- Medical evidence indicates that they are no longer incapacitated as a result of their compensable injury.
- The employee has an ability to earn (see Assessment of ability to earn for determining this).
- The employee reaches pension age.

See Employees no longer eligible for incapacity on this page for detailed information.

The roles, responsibilities, documents required, and step-by-step processes are provided in the following sections. For a detailed overview of the roles and responsibilities throughout the incapacity process, please see Incapacity payment and calculation.

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All employees: Normal Weekly Earnings (NWE)

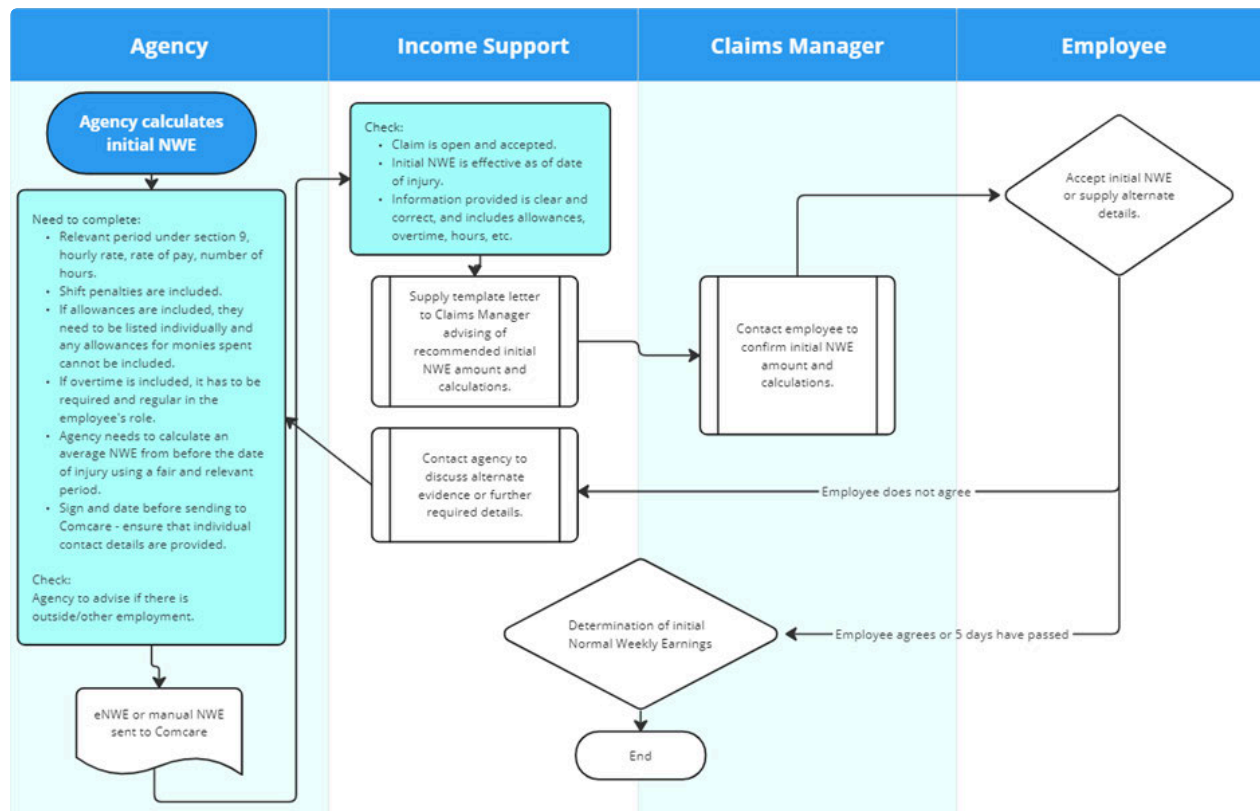
Finalisation of NWE is an Income Support responsibility.

To calculate an employee's income support entitlement, the employer's Payroll team will first calculate the employee's Normal Weekly Earnings (NWE). The Income Support team will review and determine whether the NWE is correct based on the employee's circumstances. The employee's NWE is the amount the employee would have earned if they had not been injured. See section 4(9) of the SRC Act.

Information about an employee's NWE is requested by Income Support from the employer's payroll team because they have the information on how much the employee was paid prior to their injury.

The Claims Manager should confirm pay information with the employee as soon as it is received from the employer. Income Support will accept the employer's submission of NWE within five business days. This is to avoid any delays in processing incapacity payments. If the employee disagrees with the NWE, they have the right to appeal via the Reconsideration process. See the Normal Weekly Earnings page for full details.

A summary of the initial NWE process can be found below or click on the Process for determining NWE for a pop-out view.



Process for determining NWE

Documentation required to determine NWE

The **employer** needs to provide Comcare with the paper form or online Normal Weekly Earnings form (recommended) via the Comcare Online Forms portal. Income Support will request this information from the employer.

If employees would like more information on calculating initial NWE, this can be found on the Comcare website under Scheme guidance - Calculating normal weekly earnings.

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Process for Commonwealth employees to claim incapacity

Once the employee's normal weekly earnings (NWE) have been determined, the employee can claim incapacity payments.

If an employee wishes to claim incapacity payments while they are with their Commonwealth employer, they need to submit a Claim for Time Off Work (CTOW) form. This should be claimed ideally via the [CTOW online form](#) or by submitting a [CTOW paper form](#) to their employer. They must submit a medical certificate provided by a legally qualified medical practitioner (LQMP) to support their claim (this is likely to have already been provided in the initial lodgement stage).

Strict compliance with a CTOW form approved by Comcare is not required and **substantial compliance** is sufficient. That is, a written claim which is lodged through another form of correspondence may be accepted. To meet the substantial compliance requirement, there must be **sufficient detail and information** to be able to determine the employee's entitlement to incapacity under the SRC Act. This must be verified by their employer payroll team.

The Income Support team will process the CTOW form. Income Support needs to be satisfied there is correspondence that can be identified as a 'claim' (for example an approved form, medical certificate

or other form of correspondence).

Steps in the Claim for Time Off Work process

Online submissions

If the employee submits an online CTOW, notification is automatically sent to their [agency](#) payroll team for them to update the payroll section. When this occurs, it will show up in Pracsys under Status as 'Agency'.

Once the agency has reviewed and completed the CTOW form, it will be sent to the Income Support team tray. The Status in Pracsys will then change to 'Not verified'. A member of the CAIS Assurance team will then review the information and verify it.

Paper submissions

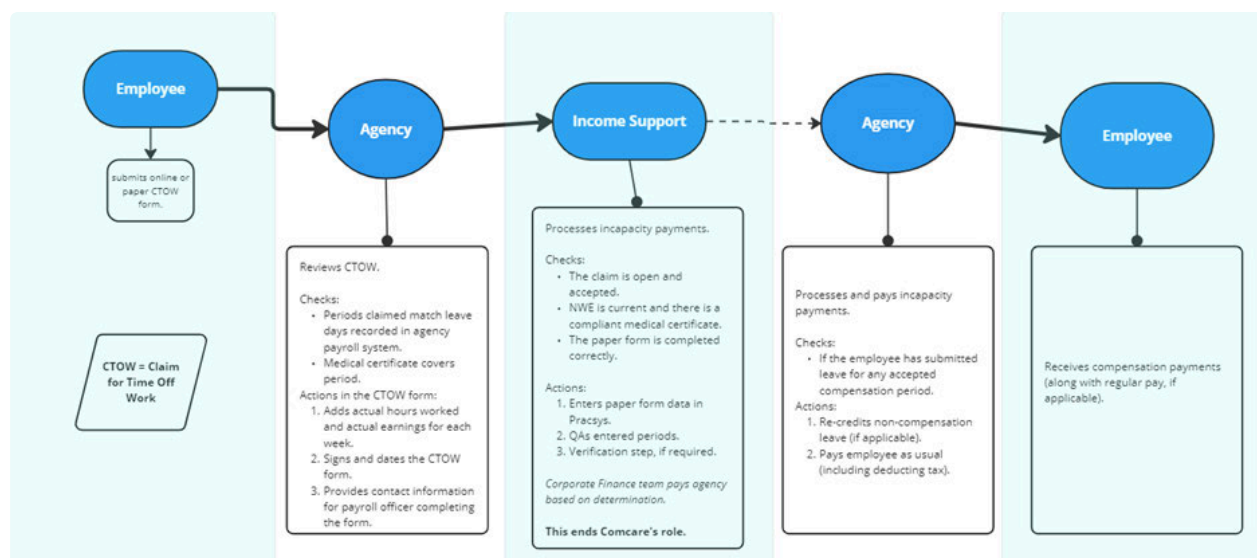
If an employee submits a paper CTOW form, the process is manual. They need to first fill in their section of the form then submit it to their payroll team. The payroll team will complete their part of the CTOW form and then email it to Comcare. Once received, this is scanned to the claim file and then the Income Support team tray is notified in Pracsys.

Processing the CTOW

The employee's submitted CTOW will be processed by Income Support. They will request follow-up information from the agency if required, such as clarification on earnings for non-compensable reasons (e.g. annual leave), and from other stakeholders if needed. Or they will contact you, as the Claims Manager, to get further information from the employee.

The status of incapacity payments may show as 'undetermined' in Pracsys whilst Income Support is querying further information from the agency or employee. They should enter a comment in the Pracsys screen MCOM to explain this.

This flowchart shows the steps involved in the CTOW process. Click [Process for CTOW](#) for a pop-out version.



Process for CTOW

Information required to process a Claim for Time Off Work

The following information is required from the employee and their employer to process a CTOW.

The employee must:

- complete the employee section of the Claim for Time Off Work online form or Claim for Time Off Work paper form
- provide a medical certificate from a legally qualified medical practitioner (LQMP)
- provide information about any earnings and hours worked from outside employment including self-employment and as a reservist (if applicable).

The employer must:

- complete the employer section of the Claim for Time Off Work online form or Claim for Time Off Work paper form.

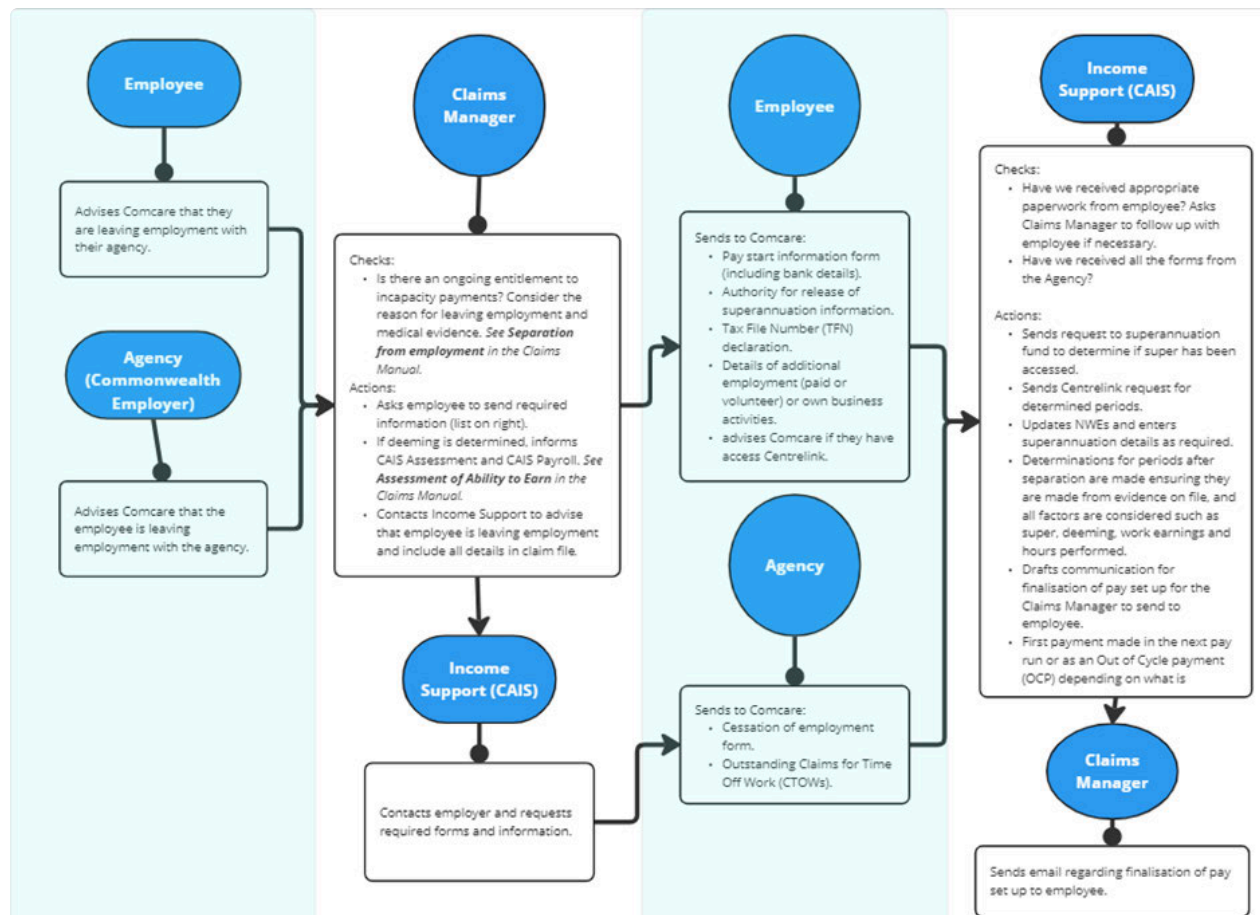
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Process for employees leaving Commonwealth employment

When an employee leaves Commonwealth employment and is still incapacitated for work, they could still be eligible for compensation. Please refer to Separation from Employment and Assessment of ability to earn to determine if employees are still eligible for incapacity payments.

If the employee is still eligible, Comcare will pay the employee directly through our Xpay Aurion system. To do this, the Income Support team requires documentation from the employee and the employer to ensure that we pay the employee their correct entitlement and withhold tax as per the ATO requirements.

See the following Process for when an employee is leaving Commonwealth employment (or click the link for a pop-out).



Process for when an employee is leaving Commonwealth employment

Information required to set up an ex-Commonwealth employee on Xpay

As outlined in the flow chart above, the following information is needed from the employee and their former Commonwealth agency (employer) to set up an employee on Comcare's Xpay Aurion system to receive incapacity payments directly from Comcare.

Only employees who are still eligible for incapacity payments will be set up on Xpay for payments.

Information needed from the employee – the Claims Manager is responsible for obtaining this information from the employee:

- Pay start form (Application for direct incapacity payments).
- Tax File Number Declaration.
- Superannuation authority (Authority and consent for the release of superannuation information).
- Information about any other earnings through paid employment or self-employment. See the section on Employment below.
- Advice about whether the employee has or will access:
 - Centrelink (see the section on Centrelink below)
 - Superannuation
 - DVA pension.

Information needed from the employer – Income Support (CAIS) is responsible for obtaining this information from the employer (Commonwealth agency):

- Cessation of employment form.
- Any outstanding Claims for Time Off Work (CTOW) that have not been claimed.

Centrelink

An employee is not entitled to both compensation payments and Centrelink benefits for the same period of time and for the same condition. Centrelink has legislation in place, the *Social Security Act 1991* (SS Act), Part 3.14, which provides them with a statutory right to recover monies paid by Comcare. Centrelink may recover money for a specified period because an employee has been paid a Centrelink benefit for a period Comcare has advised liability for.

If an employee has left their Commonwealth employer and has no other employment, they might claim Centrelink payments while they wait to see if their incapacity claim is successful. If it is likely that the employee has accessed Centrelink benefits for periods when they are claiming incapacity benefits, then confirmation and a clearance from Centrelink must be obtained by Income Support before incapacity payments are made.

You must advise Income Support immediately if you believe or receive information that an employee is accessing or has accessed Centrelink benefits during the time that they are claiming incapacity benefits. This is to ensure the employee receives their fair and accurate entitlements and does not end up with an overpayment that they may be required to repay.

Superannuation

Superannuation is considered as income in certain circumstances. Employees and ex-employees are treated differently in some circumstances. Superannuation has a reducing effect on an employee's incapacity payments and needs to be calculated from when they receive their payment or, for a retrospective pension, from the day after their retirement from the Commonwealth. Please see the Superannuation page for more information.

Employment (paid or self-employment)

Paid work

Actual earnings must be included in the assessment of incapacity compensation. The Assessment of ability to earn and Calculating incapacity payments pages provide further details about determining an employee's ability to earn and the process and formula that Income Support follows to calculate incapacity payments within the first 45 weeks and after 45 weeks of incapacity.

Unpaid work (Volunteer work, study leave, work trial)

Employees may be considered 'in employment' for the hours spent in formal study, an unpaid work trial, or volunteer work for the purpose of applying the incapacity calculation formula under subsection 19(3) of the SRC Act. However, the formal study, unpaid work trial or volunteer work must be part of an approved rehabilitation program under section 37 of the SRC Act. This is to ensure that

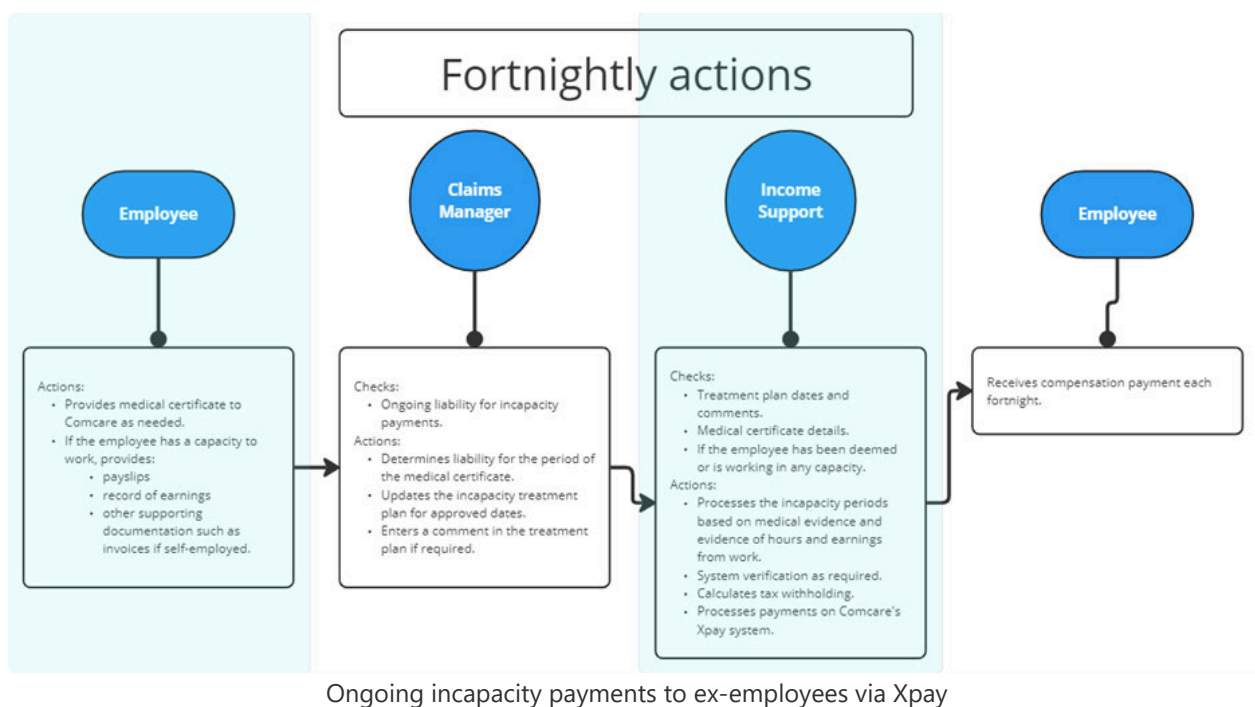
the employer and Comcare are taking steps to return the employee to full employment where possible.

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Claiming incapacity for ex-employees

After an ex-employee has been set up on Xpay Aurion, they must submit information every fortnight so that Income Support can calculate their incapacity entitlement. Their incapacity entitlement should be regularly reviewed by the Claims Manager to ensure that the employee receives their correct benefits.

The process for processing ongoing fortnightly incapacity payments for ex-employees is shown in the flow chart below. You can click [Ongoing incapacity payments to ex-employees via Xpay](#) to view a pop-out of the chart.



Information needed to pay incapacity payments to ex-employees each fortnight

The following information is needed from the ex-employee each fortnight in order to calculate and process their fortnightly incapacity payments. Please note that self-employed employees need to provide detailed information about their earnings. Full details and examples are provided in the [Assessment of ability to earn](#) page. Please review this information carefully to identify what evidence to ask the employee to provide.

The employee should provide:

- The Record of Earnings form for employees in either paid employment or self-employment. Gross earnings should be reported (including tax). This form can also be completed by ex-employees working in approved unpaid employment, for example voluntary work as part of a Work Trial Agreement under a section 37 rehabilitation program.

- Medical certificate from a legally qualified medical practitioner (LQMP) covering the period claimed.

Other evidence to demonstrate earnings and level of employment (the Claims Manager should check with Income Support and then discuss with the employee which evidence they should submit):

- Payslips
- Fortnightly timesheets
- Invoices from self-employment
- Profit and loss statement
- Business Activity Statement (BAS)
- ATO personal income tax return or statement
- Email or signed letter or spreadsheet from the supervisor/employer

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Employee no longer eligible for incapacity payments

An employee or ex-employee may become no longer eligible for incapacity payments because:

- medical evidence shows that they are no longer incapacitated as a result of their workplace injury
- the Claims Manager determines that the employee or ex-employee has an ability to earn, or
- the employee reaches pension age.

The Claims Manager is responsible for regularly reviewing the claim file and the employee's capacity for work. They can also consult with Income Support regarding the employee's submitted evidence for incapacity payments.

When you determine that the employee is no longer eligible for incapacity payments, you must advise the employee. You also need to update Pracsys to reflect the decision as either 'No Present Liability' or 'Cease' on the claim. This is to ensure that incapacity is not paid beyond the dates of acceptance. See No present liability for more information and procedures.

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Calculating incapacity payments

Published 04/08/2025

Introduction to calculating incapacity payments

When an employee seeks compensation for time off work or for reduced earnings due to their accepted condition, this is known as a claim for 'incapacity payments' (or 'incaps'). Incapacity payments are intended to substitute or supplement the income of an employee who is unable to earn their pre-injury income as a result of their compensable injury, in either their Commonwealth or other suitable employment.

Sections 19 to 23A of the SRC Act detail the circumstances in which incapacity payments are payable to an injured employee, and the basis upon which those entitlements are calculated.

The formula for calculating incapacity payments is based on the employee's Normal Weekly Earnings (NWE) (section 8 of the SRC Act), and these must have been entered into Pracsys and verified before any periods of incapacity can be processed. See [Normal Weekly Earnings](#) for more information on NWE.

Incapacity payments are not affected by passive forms of income an employee may receive, such as income from rental properties and inherited royalties. See [Assessment of ability to earn](#) for more information on different types of income.

If an employee receives superannuation payments from their superannuation fund, this needs to be considered in the calculation of incapacity payments. See [Superannuation](#) for more information.

Roles and responsibilities for reviewing incapacity

Calculating incapacity payments is undertaken by the Income Support team within Claims Administration and Income Support (CAIS). The **Income Support** team relies on accurate information provided by the employee and the employer/agency. The **Claims Manager** plays an important role in liaising with the employee, other stakeholders and Income Support to ensure accurate information is available for calculating incapacity payments.

Claims Manager's responsibilities:

- Regularly review the employee's entitlements to incapacity and update the incapacity treatment plan in Pracsys accordingly.
- Query any new information that may impact entitlements.
- Notify Income Support if circumstances have changed that may affect the employee's incapacity entitlements (e.g. access to superannuation, receipt of earnings, access of Centrelink payments).
- Engage with the Rehabilitation Case Manager (RCM) on rehabilitation options based on certified capacity/potential work and job-seeking opportunities.

Income Support responsibilities:

- Determine incapacity calculations as required based on information on file.

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Factors affecting incapacity entitlements

There are several factors that may affect a person's incapacity entitlements.

Incapacity entitlements are very complicated as many factors may not occur in a set order, and some can happen at different times of the claim. Each of these can change how the employee's entitlements are calculated or processed, although the Act should be applied in numerical order (for example, section 19(2) first, then 19(3), then 20, and so on, as appropriate).

Some of the many factors that Income Support may need to consider include (all, none, or some of these may apply to any given claim):

- changes in an employee's NWE
- whether the employee is working, or earning money in another way
- whether the employee is receiving income support through Centrelink, or the Department of Veterans' Affairs, or another source
- whether the employee is using leave entitlements (other than compensation leave)
- whether the employee has claimed a cumulative 45 weeks or more of incapacity
- whether the employee has an ability to earn income in suitable employment (see [Assessment of ability to earn](#) for more information)
- whether the employee's NWE is high enough to be affected by the Average Weekly Ordinary Time Earnings of Full-time Adults (AWOTEFA) - see section on Maximum compensation payable below for more information on this figure
- whether the employee's amount of compensation is low enough to be affected by the minimum earnings provisions, and whether the employee has 'prescribed persons' and/or children
- whether the employee has accessed a pension, or a lump sum payment, or both, through their superannuation, and whether the employee accessed their superannuation before or after 27 April 2007 (see [Superannuation](#) for more)
- whether the employee has reached their pension age, and how close to their pension age they were when they were injured
- whether the employee is in hospital, or has been imprisoned in connection with conviction of an offence
- whether the employee's weekly rate of compensation is low enough to consider a [redemption payment](#), and whether they have already accessed a redemption payment
- whether the employee's claim was accepted under legislation preceding the current SRC Act
- whether the employee is still employed by their agency, or has separated from Commonwealth employment
- whether the employer is an 'exit', 'licensee', or 'off-budget' agency.

See the Statutory rates for compensation page for all current rates such as maximum compensation payable, redemption rates, superannuation and minimum earnings.

For employees residing or planning to move overseas, see [Incapacity payments for overseas employees](#).

The most common factor which can affect the calculation of incapacity payments is **when an employee has been incapacitated for work for a cumulative total of 45 weeks**. [Pracsys](#) keeps a running total of the amount of time off work the employee has had. This is also available to employers via a CIS report.

Information on incapacity in the first 45 weeks and after 45 weeks is detailed in the following sections.

Note: Comcare does not include income protection in incapacity calculations as it's not considered as an ability to earn.

Hypothetical scenarios / predicting calculations

If you receive a request from an employee to undertake a hypothetical incapacity calculation or for a quote, please advise that we are unable to undertake this task. The reason for this is that we are not financial advisors, and we rely on other parties to provide accurate information to undertake our calculations. Instead, direct them to the information available on the Comcare website.

- Incapacity payments: Please visit Income support on the Comcare website
- Superannuation: Please visit Employees receiving superannuation benefits and incapacity payments on the Comcare website.

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First 45 weeks of incapacity

The basic calculation for incapacity payments during the first 45 weeks of incapacity is under section 19(2) of the SRC Act, and is as follows:

Amount of compensation	=	[	Normal Weekly Earnings	]	-	Ability to Earn or Actual Earnings

The first 45 weeks of incapacity compensation is based on an employee's Normal Weekly Earnings (NWE) minus the employee's actual earnings, or potential earnings, for that week (AE). The AE is the greater amount in that week that the employee:

- is able to earn in suitable employment, or
- actually earned.

In situations where an employee has capacity to work some hours of the week but not their total normal weekly hours (NWH), only the hours of incapacity paid will count towards their 45 weeks.

Example 1: An employee's NWH are 40 hours per week. The employee is on a graduated return to work (GRTW) working 30 hours per week. Therefore, 10 hours per week will count towards the 45-week incapacity compensation balance as this is the period in which compensation is payable under the SRC Act.

In situations where an employee has a capacity to work at a lower classification but is still working their full time normal weekly hours (NWH), they are considered to be partially incapacitated. Therefore, a full week will count towards the 45-week total. However, they will be entitled to the difference between their NWE and their AE.

Example 2: An employee's NWH are 40 hours per week at the APS 4 level. Due to their compensable condition the employee is able to work 40 hours per week and perform duties at the APS 2 level. Comcare pays top-up incapacity payments to the employer to cover the difference in the employee's NWE. The employee receives their NWE at the APS 4 level. Because Comcare is paying top up incapacity payments, 40 hours in each week will count towards the 45-week balance.

After 45 weeks of incapacity - adjustment percentage

After an employee has reached 45 weeks of incapacity, their incapacity payments are calculated based on the percentage of normal weekly hours (NWH) the employee works each week – this is known as the 'adjustment percentage'. This means that an employee’s normal weekly earnings figure (NWE) is multiplied by a percentage, starting at 75% if the employee has not worked any hours, and increasing depending on the percentage of their normal weekly hours which they have worked. See section 19(3) of the SRC Act.

The intention behind these provisions of the SRC Act is to encourage employees to return to work. So, if they work more hours, they will receive a higher adjustment percentage.

The following table outlines the percent of Normal Weekly Earnings (NWE) payable to an employee after they have reached 45 weeks.

NWH includes any hours of overtime that are included in the employee's NWE.

% Of NWH worked	Incapacity payable	SRC Act reference
0%	75% NWE	19(3)(a)
1% - 25%	80% NWE - AE	19(3)(b)
26% - 50%	85% NWE - AE	19(3)(c)
51% - 75%	90% NWE - AE	19(3)(d)
76% - 99%	95% NWE - AE	19(3)(e)
100%	100% NWE - AE	19(3)(f)

The reduction applies from the minute that the employee reaches 45 weeks of incapacity exactly. Therefore, it is very important for Income Support to calculate the time accurately, as it means that an employee may be paid at different rates for different times of a single day.

The letter informing the employee and employer’s payroll team of the upcoming change is sent by the Claims Manager at 40 weeks of incapacity compensation, and then again at 45 weeks. This allows the employee to prepare for the upcoming change in income.

Example: An employee’s NWH are 40 hours per week. The employee is on a graduated return to work (GRTW) working 30 hours per week. The adjustment percentage that applies as part of the incapacity payment calculation is based on the number of hours the employee actually works in a week (30 hours or 75% of NWH). The section 19(3)(d) adjustment percentage therefore applies, and the employee is entitled to 90% of their NWE minus their gross actual earnings.

Adjustment percentage and unpaid work

For the purposes of adjustment percentages, an employee is considered to be undertaking work if they are in paid employment. Employees may be considered ‘in employment’ for the hours spent in

formal study, an unpaid work trial or volunteer work for the purpose of applying the formula under subsection 19(3) of the SRC Act. However, the formal study, unpaid work trial or volunteer work **must** be part of an approved rehabilitation program under section 37 of the SRC Act. See section 37(5) for information on compensation for incapacity during a rehabilitation program.

In cases where the formal study, unpaid work trial or volunteer work **are not** part of an approved rehabilitation program, you should discuss the matter further with your Assistant Director, Injury Manager, and/or the RTW Support team. Further support may also be sought from the employer's relevant Account Manager (if required).

A discussion may need to take place with the employer concerning their obligations under the Act in supporting any injured employee who meets the relevant criteria in sections 36 and 37 of the SRC Act to engage in a rehabilitation program, even if they are unaware that the employee is undertaking one of the above activities. These obligations continue after the employee ceases employment, irrespective of the cause of separation (including invalidity retirement).

Refer to the Rehabilitation process for further information.

Two or more claims and adjustment percentage

If an employee has more than one compensable injury, incapacity can only be paid on one claim (i.e. incapacity can only be paid once per claimed period). An employee should receive incapacity payments on the claim that provides them the highest Normal Weekly Earnings after factoring in any adjustment percentage. This may mean that you need to change which claim you pay incapacity on during the course of the employee's incapacity, for example if they remain within the first 45 weeks on one claim but have reached 45 weeks of incapacity on another claim. The adjustment percentage is calculated per claim. See Incapacity payments on two or more claims for more details.

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Incapacity payments upon reaching pension age

Pension age is defined in section 4 of the SRC Act as follows:

“pension age” has the meaning given by subsection 23(5A), (5B), (5C) or (5D) of the Social Security Act 1991.’

The information for men and women born between 1 July 1952 onwards is provided in the below table. Full details for men and women born before this date can be viewed in the link to the Social Security Act above.

Period during which employee was born	Pension age
1 July 1952 to 31 December 1953	65 years and 6 months
1 January 1954 to 30 June 1955	66 years
1 July 1955 to 31 December 1956	66 years and 6 months
On or after 1 January 1957	67 years

Once an employee reaches pension age, incapacity benefits are no longer payable in accordance with section 23 of the SRC Act. However, if an employee is injured after the age that is two years before pension age, they are entitled to incapacity payments for a maximum of 104 weeks (section 23(1A) of the SRC Act).

Example: An employee is injured while working at the age of 70 and is incapacitated for work as a result. The pension age for this employee is 66 years and 6 months. However, the employee is entitled to a maximum of 104 weeks of incapacity payments as they have sustained an injury resulting in incapacity after the age that is two years before pension age.

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Maximum compensation payable

The Australian Bureau of Statistics (ABS) sets the Average Weekly Ordinary Time Earnings of Full-time Adults (AWOTEFA) rate twice a year, in February and August. The current 150% AWOTEFA rate is contained in Pracsys and updated biannually. It can also be found in the Statutory rates page under 'Maximum amount of compensation'.

In the first 45 weeks of incapacity, an employee is entitled to their total NWE. After 45 weeks, the maximum amount payable under section 19(3) is 150% of the AWOTEFA. The section 19(3) calculation is done first – i.e. the relevant adjustment percentage and any Ability to Earn (AE) are applied first – and the result is then compared to 150% of AWOTEFA.

Following this calculation, if the employee's incapacity payments exceed 150% of the AWOTEFA amount, the employee's payments will be reduced to 150% of the AWOTEFA amount (section 19(5)).

Pracsys automatically applies the AWOTEFA rate where an employee's NWE payments would be higher than the AWOTEFA amount. If a period of incapacity that has already been paid overlaps an updated AWOTEFA rate, the Income Support team will need to re-determine that period of incapacity.

Example 1: An employee with an NWE of \$4,800, whose NWH are 40 hours per week, reaches 45 weeks incapacity.

If the employee is totally incapacitated for work, they are entitled to 75% NWE, which is \$3,600. If this is greater than the current rate of 150% AWOTEFA, the 'maximum earnings' provision applies.

In this case, as the employee's incapacity payments calculated under section 19(3) would result in an entitlement greater than the 'maximum earnings' provision, the employee's weekly incapacity entitlement would be reduced to the current rate of 150% AWOTEFA per week.

Example 2: If the same employee (with an NWE of \$4,800) undertakes some paid employment during the week, this will change the calculation.

Using an example of this employee working five hours per week, and earning \$600, this would mean that the

incapacity calculation would normally be undertaken under section 19(3)(b) of the SRC Act, which provides that the employee would be entitled to 80% NWE minus the amount they are able to earn.

As such, the calculation for this claim would be 80% of NWE – AE under the provisions of section 19(3)(b), (or \$4,800 - \$600), which would otherwise result in an entitlement of \$4,200, which is greater than 150% of AWOTEFA, meaning the 'maximum earnings' provision applies.

Therefore, in this example the employee would be entitled to 150% of AWOTEFA (\$3600), which would be \$2,833.20. It should however be noted that the employee in this example would actually be in receipt of a combined income (salary plus compensation) of \$3,433.20 per week.

Example 3: Again, using the same employee but this time they are working 25 hours and earning \$3,000 per week.

The calculation would normally be undertaken under section 19(3)(d), being 90% of NWE – AE, or \$4,320 - \$3,000, which would result in an entitlement of \$1,320.

As this amount is less than 150% of AWOTEFA the 'maximum earnings' provision does not apply, and so the employee would be paid a weekly entitlement of \$1,320 under the provision of section 19(3)(d). It should be noted that even though the compensation entitlement in this scenario is \$1,320 per week, the employee would actually be in receipt of a combined income of \$4,320.

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Minimum earnings

Where an employee's incapacity entitlement is calculated under section 19(3)(a) and falls below the minimum earnings amount, their incapacity entitlements must be increased to the minimum earnings amount.

The application of minimum earnings is only relevant when an employee is receiving incapacity payments under section 19(3)(a) of the SRC Act (they did not work any hours in that week). This applies even in cases where an employee has a deemed Ability to Earn (AE) but has not worked any hours that week, i.e. 75% of Normal Weekly Earnings (NWE) minus the AE amount. See [Assessment of ability to earn for more on deeming](#).

The minimum earnings amount is a statutory amount which is updated annually on 1 July and found in [Statutory rates](#). When an employee's incapacity payments fall below the minimum earnings amount, they are entitled to the lesser of:

- 90% of their NWE, or
- the statutory minimum earnings rate, including any dependant persons/children amounts (section 19(7)).

Superannuation recipients: Minimum earnings do not apply if the employee is in receipt of superannuation payments because the employee would be paid under section 20, section 21 or section 21A of the SRC Act and not under section 19(3)(a).

Dependants

If minimum earnings apply to an employee, they may also be entitled to an additional amount for 'prescribed persons' wholly or mainly dependent on them. The definition of 'prescribed persons' is provided in section 19(12) of the SRC Act.

The additional amount includes a set rate for prescribed persons and the first prescribed child. For every child after the first, another rate (roughly half of the rate for a prescribed person) applies (section 19(9)).

For the purposes of section 19, the additional amount payable is a statutory amount updated annually on 1 July, as per the following guidelines:

Where an employee has:	Statutory rate to apply:
One dependent child under the age of 16, and at least one other prescribed person as dependant	Section 19(9) - prescribed child.
One dependent child under the age of 16, no other dependent prescribed persons.	Section 19(10). Here, section 19(9) does not apply, apply section 19(8) only.
Two or more dependent children under the age of 16.	Section 19(11). Here, section 19(8) applies to the first child and section 19(9) applies to all subsequent children.
One dependent child aged 16 or over.	Section 19(8) - prescribed person.
Two or more dependent children aged 16 or over.	Section 19(8) - applies to each child (prescribed person).
Two or more dependent children, some under the age of 16 and some over the age of 16.	Section 19(8) - applies to the children aged 16 or over (prescribed person) Section 19(9) - applies to the children aged under 16.

Reviewing incapacity entitlements

Incapacity entitlements may change over time due to one or more factors outlined in this page. The Claims Manager is responsible for regularly reviewing incapacity entitlements at least once every 12 months to ensure that the employee is receiving their fair entitlements.

However, it is likely that reviews will be needed more frequently than every 12 months. Whenever you receive information from an employee or other stakeholder which may affect an employee's entitlement to incapacity payments, you must:

- update the claim file accordingly
- discuss the information with the employee and
- contact Income Support to ensure that incapacity payments remain accurate.

Unmet capacity/changes in capacity

Unmet capacity arises when an employee has a capacity for work greater than what they are actually working. Unmet capacity can be identified through discussions with the employee, employer, or other stakeholders and through reviewing documentation on the claim, especially medical certificates.

Claims Managers must regularly check for any changes in the employee's capacity to support the employee's return to work (RTW) and ensure they are receiving the correct entitlements for their compensable condition. Determining an ability to earn (deeming) may need to be considered.

If you identify an unmet or decrease in capacity, take action by:

- contacting stakeholders, gathering information and identifying RTW barriers
- developing strategies to overcome those barriers in consultation with internal and external stakeholders.

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Leave and incapacity

Published 31/07/2025

Introduction to paid leave and incapacity

Section 116 of the *Safety Rehabilitation and Compensation Act 1988* (SRC Act) permits the accrual of sick leave and recreation leave entitlements during each of the first 45 weeks of post-determination compensation leave, and the accrual of long service leave entitlements during the whole of the post-determination compensation leave period.

Section 116 of the SRC Act bars an employee from taking any paid leave (other than maternity leave) for any period they are on compensation leave. In other words, any hours of paid leave cannot also be claimed as hours of compensation leave.

'Compensation leave' means any period during which an employee is absent from their employment due to an incapacity for work resulting from an injury for which compensation is payable under section 19 or section 22 of the SRC Act.

The guidance below is provided to help you understand the effects of section 116 on accrual of leave and the impact of other paid leave on an employee's compensation payments. It will also help you to understand relevant matters when an employee has taken other paid leave following a workplace injury.

This guidance applies to all incapacity compensation that was or is payable to an employee under section 19, 22 and 37(5) of the SRC Act on and from 1 July 2006.

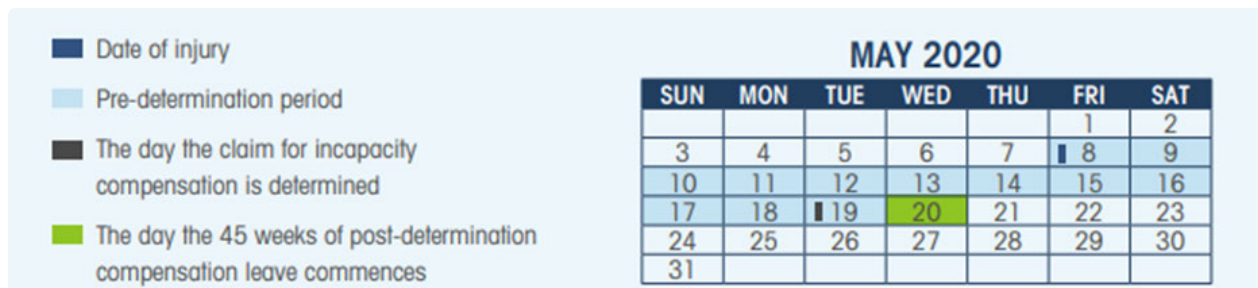
Difference between the two 45-week periods in the SRC Act

There are two different 45-week periods covered in the SRC Act which have different impacts.

- Section 116 of the SRC Act provides for 45 weeks of leave accrual during the post determination compensation period. **The guidance on this page focuses on this 45-week period.**
- Section 19(3) of the SRC Act provides for the calculation of the adjustment percentage after reaching 45 weeks of incapacity for work. See Calculating incapacity payments for guidance on adjustment percentages and incapacity calculations.

In most cases the 45-week counts do not align. The first 45 weeks of incapacity compensation for the purposes of section 19(3) of the SRC Act are based on the employee's absence from work (hours) and the clock starts on the first day of incapacity payable (i.e. retrospective incapacity payments are counted).

See the image below for an example of key dates in a compensation claim.



Example of 45-week period start dates

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Leave accrual during the first 45 weeks of a claim

During the first 45 weeks of post determination compensation leave, sick leave and recreation leave entitlements continue to accrue as though the employee was not absent from work. After 45 weeks, the employee's leave accrual is no longer protected by the SRC Act and is governed solely by employment law and agreements with their employer.

The pre-determination period

The pre-determination period is the period from the start of the day when the employee is injured until the end of the day on which Comcare determines the incapacity claim in favour of the employee.

Leave accrual during the pre-determination period

Leave accrues as per the employee's employment agreement until the day after the relevant authority (Comcare) determines the claim in favour of the employee.

The post-determination period

The 45-week **post-determination period** starts the day after the relevant authority determines the incapacity compensation claim in favour of the employee.

In practice, this means the post-determination period commences on the date the first incapacity determination is verified in Pracsys.

The post-determination start date for a claim is available in CIS Reports 30, 31, 32, 66 and 70 and can also be found in the 'View Claim' and 'View Claim for Finance' functions in Pracsys.

Important: The 45-week count relates to the date of the first incapacity determination. Note that this is different to the date of the decision to accept liability for the relevant injury.

Counting the first 45 weeks of the post-determination compensation period

The first 45 weeks of post-determination compensation leave are counted on a weekly basis from the date the first incapacity determination is verified in Pracsys.

If any compensation leave of any duration occurs in a weekly period (whether an hour or a week), then that week is counted towards the first 45 weeks of post-determination compensation leave accrual permitted by section 116 of the SRC Act.

The first 45 weeks of post-determination compensation leave do not need to be consecutive, and the way each week is counted does not need to align with the first 45 weeks of incapacity compensation under section 19 of the SRC Act (see Introduction on this page).

Post-determination date for a claim that is rejected or revoked and later accepted on appeal

An incapacity compensation claim may be rejected or revoked at first instance and later accepted following a reconsideration determination or appeal decision of the Administrative Review Tribunal (ART).

The post-determination compensation leave period still commences on the first day of compensation leave the day after the claim for incapacity compensation is determined in favour of the employee.

In the case of ART intervention, that may be as follows:

- If the claim for compensation is declined by Comcare but allowed by the ART: the day of the first verified incapacity determination made in Pracsys after the favourable decision is made by the ART.
- If the claim is accepted by Comcare initially, but declined or revoked on reconsideration by Comcare, and subsequently allowed by the ART: the day of the first verified incapacity determination made in Pracsys after the favourable decision by the ART.

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Leave accrual after 45 weeks post-determination

If an employee remains on compensation leave after the first 45 weeks of post-determination compensation leave, there is no provision under the SRC Act that addresses how subsequent leave should accrue, other than long service leave. Subsection 116(1)(b) of the SRC Act provides that long service leave continues to accrue as normal during any period of compensation leave (i.e. as if the employee were not absent from work).

Any accrual of sick or recreation leave after the first 45 weeks post-determination compensation leave is a matter for the employer to determine in line with the applicable Enterprise Agreement or industrial award.

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Summary of leave accrual

The below table sets out how leave is accrued during post-determination compensation leave throughout the claim lifecycle:

	Sick leave and annual leave	Long service leave
Totally absent/part hours: first 45 weeks	Normal Accrual	Normal Accrual

Totally absent/part hours: after 45 weeks	Employer to determine specific arrangements based on their enterprise agreement or industrial award	Normal Accrual

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Public holidays and shutdowns

Public holidays affect an employee's incapacity payments.

For any public holiday, it is the employer's responsibility to pay the employee for the day as per the applicable Enterprise Agreement.

- Where an employee would have ordinarily been paid for a public holiday and not worked: the amount paid for the public holiday is recorded as actual earnings, and the hours recorded as 0. This is because the employee would not have worked that day.
- Where an employee does not ordinarily work on the day of the week where there is a public holiday, e.g. part-time workers: no earnings and hours would be included for the day and the claim for time off work form would only seek compensation for the worker's ordinary days of work.
- Where an employee would have worked on the public holiday, e.g. shift workers: the amount recorded as actual earnings is the amount they would have ordinarily been paid for the day and the hours worked are any hours the employee would have worked that day.

Impact of public holidays on the adjustment percentage

If an employee is still receiving compensation payments after 45 weeks of incapacity, an adjustment percentage applies to their incapacity payment. Public holidays may affect this adjustment. See [After 45 weeks of incapacity: Adjustment percentage](#) for more information.

Example 1: A totally incapacitated employee is claiming incapacity in a week with a public holiday. As the employee is entitled to be paid for the public holiday (in line with their agency's Enterprise Agreement) the amount payable for the public holiday is included in their actual earnings. However, as the employee did not work that week, the hours the employee worked remains at nil. For employees post 45 weeks, the adjustment percentage would remain at 75%.

Example 2: An employee (post-45 weeks) on a graduated return to work (GRTW) is claiming incapacity in a week with a public holiday. As the employee is entitled to be paid for the public holiday (in line with their agency's Enterprise Agreement) the amount payable for the public holiday is included in their actual earnings. Comcare will consider the hours the employee 'worked' during the week to include the hours they would normally have worked as part of their GRTW on the day of the public holiday. The employee's adjustment percentage is therefore not going to be impacted in a week that includes a public holiday. This is to ensure that the employee is not disadvantaged by there being a public holiday.

Shutdown periods

A shutdown period, usually between Christmas Day and New Year's Day, is where most Commonwealth agencies close and employees receive paid leave (however, employees working in essential service roles may be required to work during this period).

If a shutdown period is specified in the employee's Enterprise Agreement, Comcare treats that period in the same way as public holidays. That is, if an employee is paid to not be at work during this period, incapacity calculations will include earnings and no hours. If an employee is directed to work or their role requires them to work during a shutdown period, incapacity calculations will include the earnings they would have received and the hours they would have ordinarily worked.

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Annual and personal leave (recreation and sick/carers leave)

Being incapacitated does not prevent an employee taking annual leave, personal leave, or sick leave (or other types of leave) whilst receiving incapacity payments. If an employee takes other paid leave, Comcare **must** be advised, and notes included on the Claim for Time Off Work (CTOW) form.

The CTOW must note the hours of other paid leave under 'hours worked' and the amount payable under the employee's Enterprise Agreement (EA) for that leave as 'actual earnings'. This ensures the additional paid leave is correctly offset against the employee's incapacity entitlements in compliance with section 116 of the SRC Act.

Example: An employee on a GRTW takes 20 hours of annual leave during a week they normally work 30 hours. The employer lodges a CTOW showing 20 hours of annual leave and 10 hours of ordinary work. The CTOW shows 20 hours of annual leave income per their EA (some allowances are not included in annual leave payments) and 10 hours of ordinary income on the days of ordinary work. The employee is not entitled to incapacity compensation for the hours of annual leave paid by their employer, so Comcare pays zero dollars for the 20 hours of annual leave. The employee's adjustment percentage is not unfairly impacted as the 20 hours of leave are treated as 20 hours worked given their ordinary work pattern.

Employees who **take sick or personal leave for reasons unrelated to their compensable conditions** (for example, an employee with a psychiatric condition breaks their arm while gardening on the weekend and is unable to attend work) would use non-compensable personal leave, and the hours and earnings claimed would offset their incapacity entitlements.

An employee who **takes leave for their compensable condition** should claim for incapacity payments in relation to this, and either have their leave re-credited, or be paid compensation leave by their employer.

Leave during periods of suspended incapacity payments

If an employee's compensation is suspended under section 36, 37 or 57 of the SRC Act then they will not be entitled to incapacity payments for the period of the suspension. See Suspending claims for more information.

The employee may choose to apply for other forms of paid leave during the period the claim is suspended. Approval of leave in these circumstances is up to the employer to decide in line with their Enterprise Agreement or industrial award.

Taking leave whilst working reduced hours

Where an employee is working reduced hours, for example on a Graduated Return to Work program (GRTW), the employer may grant paid leave for the hours the employee would be working. They are still entitled to receive incapacity payments for the hours they are incapacitated.

Example: An employee is on a GRTW working 30 hours per week. Their normal full-time hours are 40 per week. The employer can grant annual leave for 30 hours per week (the hours they would have been working on their GRTW) and Comcare continues to pay incapacity payments for the remaining 10 hours per week. When calculating the incapacity payments in Pracsys, the hours and payment for the annual leave are entered as 'hours worked' and 'actual earnings' (gross). This ensures the appropriate adjustment percentage under section 19(3) is applied and the employee does not receive incapacity payments while they are in receipt of annual leave payments.

Leave payouts on ceasing employment

When an employee separates from their employment, their leave entitlements will usually be paid out in their final payslip. A leave credit payout does not count as earnings, as it is a payout of accrued entitlements.

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Maternity leave

Maternity leave is the only type of leave which an employee can claim at the same time as compensation leave. This is due to the fact that an employee can be both incapacitated due to their injury, as well as having a child. Maternity leave payments are treated as actual earnings, in the same way as other leave entitlements, and they offset an employee's incapacity entitlement.

Verifying incapacity for work

Where an employee is in receipt of incapacity payments during a period they are on maternity leave, you should periodically obtain updated medical evidence to confirm the employee is still incapacitated for work as a result of their compensable condition, and the number of hours they are unfit to work (if they are not totally incapacitated for work).

An employee on maternity leave will still only be entitled to incapacity payments where they are incapacitated for work as a result of their compensable condition. When supporting an employee who is on maternity leave and who claims incapacity payments, you should display empathy, sensitivity and sound judgement.

Maternity leave at half-pay or unpaid

Where the employee takes maternity leave at half-pay or unpaid, their Normal Weekly Earnings (NWE) should be reduced accordingly under section 8(10)(a) of the SRC Act.

Section 8(10)(a) provides that where an employee's NWE is greater than the amount they would earn if not for their injury, then their NWE should be reduced to the amount they would be earning if not for the injury. Where an employee has taken maternity leave at half-pay or unpaid, then if the employee was not injured their earnings would have been reduced to half-pay or to nil during that period. The NWE should therefore be reduced accordingly.

Example – unpaid maternity leave: The employee takes unpaid maternity leave for a period of six months. During this six-month period the employee would earn nil if they were not injured. As such, their NWE should be reduced to nil during this period, as per section 8(10)(a) of the SRC Act.

Maternity leave and incapacity – in the first 45 weeks

If an employee claims incapacity during a period of maternity leave, paid maternity leave will be considered Actual Earnings (AE) for the purposes of calculating the employee's incapacity entitlements. In cases where the maternity leave is paid at a lower rate than the employee's NWE (see example below), the employee can continue to claim incapacity top-ups (on provision of medical evidence to support their incapacity) and the amount of weekly maternity leave paid will be considered as AE.

Example – paid maternity leave: Due to their compensable condition the employee is working in a lower paid role but at their full Normal Weekly Hours (NWH). The employee takes 12 weeks maternity leave at full pay and claims incapacity during the same period (as they are partially incapacitated). The maternity leave will be paid at the rate of the employee's current lower paid role. When calculating the employee's incapacity entitlement over the 12 weeks, the entitlement will be the employee's NWE minus the gross actual earnings (the paid maternity leave). As the employee's NWE is higher than their actual earnings, the employee will be entitled to incapacity 'top ups' for the 12 weeks they are on maternity leave. The 12 weeks of paid maternity leave will count towards the first 45 weeks of incapacity.

When calculating the incapacity payments in Pracsys for the above scenario, the hours on maternity leave are entered as 'hours worked' and the maternity leave payment is entered as 'actual earnings' to ensure the employee's incapacity top-ups are calculated correctly while the employee is in receipt of maternity leave.

Maternity leave and incapacity - post 45 weeks

Where an employee has been receiving incapacity payments for more than 45 weeks, the Actual Earnings (AE) figure is calculated the same way as it was in the first 45 weeks of incapacity (see the above section).

For an employee post 45 weeks of incapacity, maternity leave is considered hours 'in employment' when establishing the adjustment percentage used to calculate the employee's incapacity payments (section 19(3)).

Therefore, if an employee claims incapacity and takes maternity leave for the same week, the employee will be considered to be 'employed' for the number of hours per week that they are on maternity leave. For example, if, but for the maternity leave, the employee would be working 25 hours per week, then they will be considered to be 'employed' for 25 hours during that week, for the purpose of the adjustment percentage (this is regardless of whether they take their leave at full pay or half pay).

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Rostered days off (RDO)

Rostered days off (RDOs) are similar to flex arrangements in that employees generally work slightly longer hours each day in return for an RDO once a month. Regardless of whether an employee is entitled to RDOs or not, their entitlement to incapacity payments is calculated in the usual way by considering their Normal Weekly Hours (NWH), Normal Weekly Earnings (NWE), and any Actual Earnings (AE).

RDO arrangements are a matter for the employer to decide, according to their Enterprise Agreement. RDOs have no impact on the factors determining an employee's incapacity entitlements.

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Absence from work due to rehabilitation activities

If an employee:

- is incapacitated for work because of an injury where compensation is determined to be payable under section 19, and
- subsequently undertakes a rehabilitation program that involves time off work (e.g. a graduated return to work or time off work to attend medical appointments) in relation to that injury, and
- receives incapacity compensation under section 37(5),

the employee's absence from work undertaking the rehabilitation program is compensation leave and counts towards the 45 weeks of post-determination compensation leave.

Overtime and allowances while on other leave

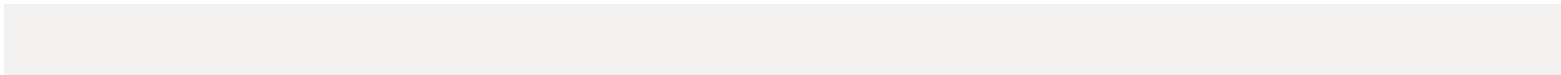
If the employee's Normal Weekly Earnings (NWE) includes amount(s) for overtime and/or allowances that are not payable when the employee is on annual, maternity or other personal leave, then those types of allowances should not be included in incapacity calculations while the employee is on any of those types of leave. Comcare must be notified by the employer of variations to pay when an employee is on leave so that entitlements can be correctly calculated.

If an allowance would normally be paid while the employee was on leave, then it should continue to be paid. The Income Support team will confirm this with the employer.

Scheme guidance

See the following scheme guidance documents for more information on accrual of leave during compensation leave:

- [Accrual of leave - section 116 - *Safety, Rehabilitation and Compensation Act 1988*](#)
- [Frequently asked questions - Accrual of leave during a period of compensation leave](#)



Normal weekly earnings

Published 27/11/2025

Introduction to Normal Weekly Earnings

Incapacity payments are determined using an employee's Normal Weekly Earnings (NWE).

NWE is intended to be a fair representation of what an employee would have earned in a week if they had not been injured. NWE is calculated based on the employee's salary at the Date of Injury (DOI) and may include overtime and allowances for the relevant period.

An initial NWE must have the same date of effect as the Date of Injury (DOI) for the primary condition on the claim. It must be based on written evidence from the employer agency regarding the employee's role, level, and allowances.

The Income Support team calculates and determines an employee's Normal Weekly Earnings based on the information provided by the employer. This requires identifying the **relevant period**, discussed in the next section, and the employee's **Normal Weekly Hours**.

Earnings from non-agency employment

Section 8(3) of the SRC Act specifies that if an employee is employed **part-time** by their Commonwealth employer/agency at the time of injury, and receives earnings from other employment as well, then their earnings from other employment are included in the determination of Normal Weekly Earnings (NWE). This may include earnings from self-employment. There is no provision under the SRC Act to allow for other income to be included in the NWE of a **full-time** employee.

NWE for a part-time or unpaid employee with no other earnings

Section 8(8) provides that where an unpaid employee (volunteer) or part-time employee has no earnings from any employment at the time of injury, the delegate must calculate the NWE to be an amount that the employee would have been able to earn in [suitable employment](#) at the date of injury.

Roles and responsibilities for confirming and processing NWE

Confirming and processing an employee's NWE requires input from both Claims Managers and the Income Support team. The process, roles and responsibilities are as follows (and see the flowchart below):

1. Once the claim has been accepted and the employee is eligible for incapacity payments, the **employer** will submit an NWE form to Comcare's Income Support team. The employee may lodge a Claim for Time Off Work (CTOW) form before this happens. In that case, **Income Support** will request the NWE information from the employee's Payroll team. The online NWE form, provides information about the employee's gross earnings during the relevant period, as well as information on any overtime and allowances.
2. **Income Support** reviews the information received and drafts an email to the employee to confirm their initial NWE. They will send this to the Claims Manager. The **Claims Manager** will contact the

employee to give them the opportunity to respond to the information provided by the employer. You should call or email the employee to advise what figures the employer has provided, and to ask if the employee agrees with this information. You should place a comment on file with the details of the phone call. If the employee has other employment to report, they can provide this information to the Claims Manager in writing following this phone call.

3. a. If the employee **agrees** with the information, then **Income Support** can process the NWE.

b. If the employee **disagrees**, they will need to provide evidence to support their idea of what the NWE should be. **Income Support** will then contact the employer to discuss the employee's reasons for disagreeing with the employer's figures. If the employee does not respond within 7 days or fails to provide evidence where they dispute the initial NWE figure, Income Support will process the NWE. The employee can then appeal the NWE through the Reconsiderations process on the Comcare website.

4. Once the NWE has been entered into Comcare's system, Claims for Time Off Work (CTOWs) can be processed as they are received.

The idea behind contacting the employee is to allow the employee an opportunity to respond to the information provided and prevent future reconsideration requests which might delay the employee's payments being made. By contacting the employee at the first stage, most disagreements can be resolved before any incapacity determination is made, leading to a faster and more accurate outcome.

Once the employee has verified that the initial NWE advice is correct, Comcare is not obliged to seek verification for subsequent NWE changes. The employee may still lodge a reconsideration request if they disagree with Comcare's NWE determination. Subsequent NWEs are processed following the same methods as initial NWEs, without the employee verification step. Please see Changes to Normal Weekly Earnings sections below for further detail.

Written NWE determinations (letters)

The initial NWE written determination that the Claims Manager sends to the employee is a letter in Pracsys. You need to amend the letter according to the details of the particular claim. The letter should include:

- that the NWE has been determined under section 8 of the SRC Act
- the period used to calculate the NWE
- an explanation as to why a particular period was chosen, for example that the usual relevant period or an alternative period was chosen and why (see next section for information about the relevant period)
- a summary of the data considered in arriving at the NWE figure, for example that pay records for a particular period were used.

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Relevant period

To calculate an employee's Normal Weekly Earnings (NWE), an average of their normal wages over a specified period of time is used. This period of time is called the 'relevant period', the two-week period immediately before the Date of Injury (section 9(1) SRC Act).

If this period is not a fair representation of what the employee would normally earn, the relevant period can be extended, shortened, or a different period used (section 8(5)). Alternatively, Comcare

may apply the NWE of another employee performing comparable work (section 8(4)). The reasons for changing the relevant period should always be provided in the NWE determination.

Extending the relevant period

Generally the two-week period prior to the date of injury will be the appropriate 'relevant period' where an employee works standard hours and their gross earnings do not fluctuate. However, if the employee works different shifts each week, or has varying overtime or allowances, then an extended period will generally be required to accurately determine the employee's NWE.

This extended period could be upwards of six weeks, 12 weeks or even possibly 12 months, depending on the complexity of the employee's gross earnings. The average of the employee's earnings over that time is calculated. This will ensure a fair representation of the employee's gross weekly earnings.

Example 1: When an employee works regular overtime each fortnight, it would be reasonable to extend the relevant period to gain an average of the amount of overtime worked over an extended period. Twelve weeks, or six pay cycles, may be a fair representation.

Example 2: An employee works casual hours on an as-needed basis. Their hours vary significantly from week to week. It may be necessary to extend the relevant period to six months to gain a fair and reasonable representation of their average weekly wage. Note that if an employee works casually, you will also need to consider any non-Commonwealth job earnings as part of their NWE.

Example 3: An employee receives an allowance, but not every week or fortnight. This can be included in their NWE because NWE should be a fair representation of the employee's earnings. The relevant period can be expanded as far as necessary to accurately reflect the employee's earnings and will often be averaged over a longer period of time if necessary.

Shortening the relevant period

Section 9(2) of the SRC Act provides that part of the relevant period can be disregarded where, during that period, the employee's gross earnings varied because of:

- an operation of a law
- the making, alteration or operation of an award or industrial agreement
- absence from employment (reduced or nil earnings).

Example: The relevant period is the two-week period immediately prior to the date of injury. However, the employee received a pay rise one week prior to the date of injury. Week one of the two-week period can be disregarded and therefore only week two would make up the relevant period.

Using a different relevant period

When the two weeks prior to the date of injury is not a fair representation of the employee's gross earnings, it will be reasonable in some cases to use another time period. This period can be any length

that would provide a fair representation of the employee's earnings prior to the employee's injury and before the usual two-week relevant period.

Example 1: The employee may be on a temporary graduated return to work on lesser hours, earnings and duties for a non-compensable injury in the months before a compensable injury occurs. In this case, it would be appropriate to use a window of time before the graduated return to work by using a time where the employee was last working their 'normal' hours and gross earnings.

Where no other alternative relevant period is found to provide a suitable NWE, the weekly earnings of an employee of the Commonwealth who performs comparable work can be used (section 8(4) SRC Act). This information can be obtained from the employer.

Example 2: If the employee commenced employment with the Commonwealth two days prior to being injured you might consider using a comparable employee's gross earnings to calculate the NWE.

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Overtime

When calculating NWE, the 'NH' figure in the section 8(1) calculation can only include the employee's ordinary non-overtime hours. Where an employee was required to work overtime on a regular basis before the date of injury, that overtime can be accounted for in the NWE calculation under subsection 8(2) (*Comcare Australia v Pires* [2005] FCA 747).

Regular and required overtime

Before overtime can be included in an employee's NWE it must be established that the overtime is 'regular' and 'required'. Neither of these terms are defined in the SRC Act.

When determining if an employee was **required** to work overtime, we need to establish if there was an agreement between the employee and employer that the overtime be performed. This agreement can be formal, i.e. a written contract or terms of employment, or it can be informal, i.e. a verbal request and agreement (*Peisley and Telstra Corporation Limited* [2005] AATA 929). Once the employee has the agreement of their employer to work a certain period of overtime, it is sufficient to determine it was 'required'.

When determining whether an employee worked overtime on a **regular** basis we must be satisfied the **requirement to work overtime was recurring**. The same hours of overtime do not need to recur each week to satisfy the notion of 'on a regular basis.' Rather, it is the requirement to work overtime that must be recurring (*Peisley*). In this case, it would generally be necessary to extend the relevant period beyond two weeks to a period that fairly represents what the employee would have been earning.

Example: During the 12-week period immediately prior to the date of injury, an employee worked 60 hours of overtime. The hours of overtime varied from week to week but there was always a requirement for overtime to be worked and there was a verbal agreement between the employee

and employer that the employee would undertake the overtime. In this instance we would calculate a weekly average (60 hours ÷ 12 weeks = 5 hours per week).

Seasonal overtime

A seasonal overtime component will be included as long as the seasonal period lasts.

Example: An employee working in a finance area is required to work overtime each year for three weeks leading up to the end of the financial year. This overtime is seasonal and would therefore be included in the NWE only for the applicable period.

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Allowances

An employee's Normal Weekly Earnings (NWE) can include a component for allowances that the employee was receiving on a weekly basis before their date of injury (section 8(1) of the SRC Act). Where the employee is receiving weekly allowances, the relevant period used to calculate their initial NWE may need to be extended.

Allowances to be included in NWE are for:

- conditions encountered during employment
- special skills/qualifications, and
- special duties.

Allowances for 'special expenses', or monies spent or likely to be spent, and then *reimbursed*, are not included in the 'A' figure when calculating NWE under section 8(1), as they are not classified as 'earnings'. This includes things like a meal allowance. A general rule of thumb is that taxable allowances, i.e. those allowances that represent monies 'obtained as a reward for work or merit' (Oxford English Dictionary definition of earnings) are considered as earnings.

Included and excluded allowances

The following table details the types of allowances that should be included in the employee's NWE, and the allowances that should be excluded. This list is not exhaustive.

Included	Excluded
Higher duties allowance (HDA)	Annual leave bonus
First aid allowance	Travelling allowance (TA)
Leading hand allowance	Meal allowance
Proficiency allowances	Tropical clothing allowance
Senior officer allowance (overtime component)	Senior officer allowance (work related expenses component)

Included	Excluded
Site allowance	Laundry allowance
Height allowance (danger money)	NewStart allowance under the <i>Social Security Act 1991</i>
X-ray allowance	Training allowance under the <i>Disability Services Act 1986</i>

Allowances paid for working outside Australia

Allowances paid for working outside Australia (other than allowances for expenses incurred or likely to be incurred) are included in NWE for the assigned deployment period. The following points detail how allowances would be treated in circumstances where the deployment is either shortened or extended due to the compensable injury:

- Where an employee returns to Australia in the middle of their deployment, due to their compensable condition, then their allowances paid for working outside Australia continue until such time as the intended deployment period expires.
- Where an employee's deployment overseas is extended due to their compensable condition (for example, because they are undergoing medical treatment), then their allowances paid for working outside Australia continue until such time as they return to Australia.

Where an employee returns to Australia at the completion of their deployment and is later incapacitated due to their compensable condition, then allowances paid for working outside Australia would not be included in the NWE calculation.

Reviewing allowances

The allowances included in an employee's NWE should be regularly reviewed to ensure the employee is still entitled to receive them. This can involve reviewing information on the employee's claim file or contacting the employer to see if there has been any change in an employee's work circumstances. If an employee is no longer entitled to an allowance, then their NWE should be reassessed to determine whether it needs to be decreased.

If you believe an allowance should be removed from an employee's NWE, please contact the employer and ask them to submit an updated NWE form via the Portal. The longer an allowance continues where the employee would not have received it, the greater the likelihood there will be an overpayment of incapacity.

Example: Higher Duties Allowance (HDA) is paid when an employee is performing work duties at a level above their substantive position. Once the period of higher duties would have ordinarily expired, e.g. the normal occupant of the position returns from leave, the allowance is likely to be no longer payable.

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Normal Weekly Hours

Normal Weekly Hours (NWH) refers to the average number of hours (including hours of overtime) that an employee worked in each week during the relevant period. This may include hours of work from

employment outside of the Commonwealth agency if the employee worked part time with the Commonwealth during their employment(section 8(3)).Once determined, the NWH figure does not change for the life of the claim. Refer to NWE for a part-time or unpaid employee with no other earnings for more information.

NWH must be based on an employee's pre-injury weekly hours (see section 4 definition). It is not possible in any circumstance to adjust an employee's pre-injury NWH to reflect post-injury circumstances. There is no provision under the SRC Act to vary NWH after the date of injury (*Comcare v Heffernan 2011, Federal Court of Australia Full Court (FCAFC) 131*).

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Changes to Normal Weekly Earnings

During the course of a claim, an employee's Normal Weekly Earnings (NWE) may change to accurately reflect the amount the employee would have earned had they not been injured. An employee or employer may request a review of the NWE if they disagree with the figure.

For current employees, NWE can change due to:

- a change in salary increment or annual indexation
- separation from employment, including when a contract expires
- promotion
- changes to an award or Enterprise Agreement - either increases, or decreases
- changes in allowances and/or overtime availability
- a change in the employee's working hours (e.g. they change to part-time hours)
- a change in the employee's employment status (e.g. they change from ongoing or non-ongoing to casual)
- a change in a part-time or unpaid employee's out-of-agency employment (i.e. a part-time or unpaid employee starts a new business or starts a new job in addition to their agency employment).

Notifying Income Support and the employer: A Claims Manager should contact the employer and the [Income Support](#) team when they identify a potential change to an employee's NWE.

Where an ex-Commonwealth employee is on [Xpay](#), and is still in receipt of incapacity payments, the Technology team will increase their NWE in line with indexation on 1 July as specified in Statutory rates for compensation.

See the following two sections for more on increasing and decreasing NWE.

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Increasing Normal Weekly Earnings

Normal Weekly Earnings (NWE) may increase due to increments, promotion, changes to enterprise or collective bargaining agreements, or indexation. Each of these is detailed further below.

A Claims Manager should contact the [Income Support](#) team when they identify a potential change to an employee's NWE.

Increment

An employee's NWE may increase after the date of their injury as a result of an increment (section 8(6) of the SRC Act). An increment may occur due to:

- an increase in age - increments may apply for certain classifications of employees on each birthday until age 21 (after that an employee is eligible for adult wages)
- the completion of a period of service, or
- an employee automatically moving to the next increment level, noting the following exceptions:
 - where the employer advises that the employee would not have received the increment because they did not satisfy good conduct/efficiency prerequisites
 - where the incremental advancement is dependent upon a performance assessment and the compensable injury precludes the employee from being assessed for the purposes of performance-based salary progression.

Increases to NWE as a result of an increment only apply to employees who remain employed by the Commonwealth – that is, current employees.

As a result of the *Safety, Rehabilitation and Compensation and Other Legislation Amendment Act 2001*, ex-employees cannot receive an increase in NWE as a result of an increment on or after 1 October 2001.

Promotion

Where an employee continues to be employed by the Commonwealth, their NWE may increase after the date of their injury as a result of a promotion. There must be an actual promotion to increase the NWE under section 8(7) of the SRC Act. Assertions that an employee would have been promoted 'but for their injury' are not sufficient grounds for an increase in NWE.

Where an employee continues to experience the effects of their workplace injury and obtains a position at another Commonwealth agency on the same classification but at a higher pay level, the NWE should be changed to the higher level in the same manner as if it was a 'promotion'. Note that if the pay is higher in the employee's pre-injury role than their promotion role, the pre-injury NWE should still be used. Please contact the Income Support team for further information.

If an employee is promoted to a position that has a specific range of allowances attached to it, these should be assessed for inclusion in the NWE.

A part-time employee obtaining a full-time position at the same classification and pay level is not considered to be a promotion.

Changes to enterprise/collective agreements

Enterprise/collective agreements set out the terms and conditions of employment between an employee, or a group of employees, and their employer. The terms and conditions of an enterprise/collective agreement will vary between agencies.

Section 8(9A) of the SRC Act provides that NWE should increase or reduce in respect of employees included in a class of employees, as a result of:

- the operation of a law of the Commonwealth, State or Territory, or
- the making, alteration or operation of an award, order, determination or industrial agreement (or other act or thing), under such a law.

Ex-employees or former employees do not receive NWE increases based on changes to enterprise agreements belonging to their former employment. Instead, once an employee leaves the Commonwealth Government, they will receive an annual increase to their NWE. This is determined based on the annual Wage Price Index (WPI) effective 1 July each year. See further details below under Indexation.

Example: A new Enterprise Agreement (EA) comes into effect at an injured employee's Commonwealth agency. Shift penalties for that employee are no longer payable. However, they receive an increase to their base rate of pay. The employee's NWE is redetermined effective from the date of the new EA. In the new determination, the base rate of NWE increases and shift penalties are removed.

Indexation

NWE can increase as a result of indexation (section 8(9E) and 8(9F) of the SRC Act). Indexation is the automatic adjustment of wages based on the Wage Price Index to compensate for inflation. The Wage Price Index is published by the Australian Bureau of Statistics and recommends a percentage increase based on an average of wages paid by Australian businesses. See Statutory rates for compensation.

Former and ex-employees

Changes to the SRC Act on 1 October 2001 provide for indexation of NWE in line with the Wage Price Index for ex-employees, and for former employees under 65 years of age, who have ceased employment in a 12-month period preceding the 1 July indexation date (section 8(9B), 8(9C) and 8(9D) of the SRC Act). The first indexation applied on 1 July 2002.

The Income Support team is responsible for increasing NWE in line with indexation on 1 July each year through a bulk update of NWEs for ex-employees.

The NWE for former employees aged 65 and over is not indexed (sections 134, 135 and 136 of the SRC Act).

Indexation for part-time employees with outside employment

In situations where a part time employee with outside employment has separated from their Commonwealth employment, annual indexation under the SRC Act applies to the employee's entire NWE figure. Once an employee's Commonwealth employment and other outside employment is combined to form an employee's NWE, only that combined figure will be subject to indexation. Any increases or decreases resulting from the employee's outside employment will not impact their NWE.

Example: An employee is working part-time in the Commonwealth and also part-time at a cafe on the weekends. The employee is injured in their Commonwealth employment and claims workers compensation. The employee's NWE figure is a combination of their Commonwealth and other employment. At a later date the employee separates from their Commonwealth employment but continues to work at the cafe on the weekend. As an ex-employee, the employee's NWE is increased through annual indexation under the SRC Act. However, any increases or decreases to the employee's café earnings cannot be used to adjust the employee's NWE.

Current employees

Technically we can also increase current employees' NWE by the Wage Price Index. However, where this amount is more than what the employee would have earned had they not been injured, we have to then reduce their NWE under section 8(10)(a) back to the amount that someone in their position in the organisation currently earns. This is to ensure the injured employee is not financially advantaged as a result of their injury.

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Decreasing Normal Weekly Earnings

An employee's Normal Weekly Earnings (NWE) may decrease after the date of their injury if the NWE no longer accurately reflects what they would have been earning if they had not been injured and incapacitated for work. The reason for a change in earnings (either due to their incapacity, or for some other reason) is the key factor as to whether incapacity should be reduced. The decision maker must carefully consider the relevant circumstances before applying section 8(10) to reduce an employee's NWE.

Contact Income Support: A Claims Manager should contact the [Income Support](#) team when they identify a potential change to an employee's NWE.

Current employees

A current employee's NWE may decrease as a result of:

- a demotion
- moving positions to a job with a lower salary for reasons unrelated to their compensable condition
- being suspended with no pay due to a code of conduct investigation
- decreasing their hours of work for reasons unrelated to their compensable condition (e.g. changing to part-time hours or a reduction of classification level due to a code of conduct breach), or
- their previously received allowance or overtime being reduced or no longer being available in their pre-injury role (e.g. an allowance not payable to employees while on annual, maternity or other personal leave).

Any changes to employment or earnings outside of the employee's job at the Commonwealth agency, such as earnings from self-employment or another part-time job, do not affect the employee's NWE.

Where the NWE of a current employee exceeds the amount of gross earnings they would have received if they had not been injured, section 8(10)(a) of the SRC Act applies to reduce the employee's NWE. See Examples 2, 3, 4 and 5 below.

Example 1: An employee is a substantive APS5 officer at the date of their injury. Two years after their date of injury they are demoted to the APS4 level for reasons not related to their compensable condition. Their NWE should be re-calculated to that of an APS4 officer from the date of demotion.

Example 2: An APS6 officer whose NWE includes a component for overtime moves to a new section within their department for personal reasons. The new position does not attract overtime.

Therefore, the overtime component of their NWE must be removed. It is assumed in this example that their base NWE remains the same.

Example 3: An employee had a Higher Duties Allowance (HDA) included in the calculation of their NWE. Six months after the date of injury, the employee is no longer undertaking higher duties because the HDA position's regular occupant has resumed in that position. The HDA component of the NWE must be removed.

Example 4: An APS4 officer who works in the field and is paid a site allowance is promoted to an APS5 position based in the office due to their injury. Site allowance does not apply to the office-based position and may need to be removed from the NWE. (In this case, the new NWE will be that of the APS5 position and so the overall total may actually increase rather than decrease). The site allowance would not be removed under section 8(10) if it is apparent the employee would not have changed roles but for the injury and the net result after considering the promotion and the allowance is a lower NWE. The employee should not have their NWE decreased because of their injury.

Example 5: A full-time employee decreases their work hours for personal reasons. Their NWE should be re-calculated to be reflective of their gross earnings in part-time employment from the date their hours are decreased.

Separating employees

When a current employee separates from Commonwealth employment, it is important to assess whether the employee still has an incapacity to work. See the page [Separation from employment](#) and [Assessing an ability to earn](#) for detailed information about separation. If incapacity payments are still payable, the employee needs to be set up on Xpay by Income Support. The Income Support team will review the employee's NWE.

Comcare must determine what the separating employee would be earning had they continued to be employed in the same employment they were engaged in at:

- the date of their injury, and
- the date their employment ceased.

The greater of these two figures will represent the 'cap' that the NWE must not exceed.

If the NWE recorded in Pracsys exceeds the 'cap' amount, the NWE must be reduced by the amount of the excess so that the employee is paid at no more than the capped rate. If the NWE does not exceed the cap amount, no action is required, and the employee will remain on their current NWE.

'Cap' amounts for former and ex-employees

Following the application of indexation to a former or ex-employee's NWE, a comparison calculation will be carried out by the Income Support team under subsections 8(10)(b)(i) and (ii) of the SRC Act.

If the newly indexed NWE recorded in Pracsys exceeds the ‘cap’ amount, the NWE must be reduced by the amount of that excess so that the employee is paid at no more than the capped rate. If the newly indexed NWE does not exceed the ‘cap’ amount, no action is required, and the employee will be entitled to the newly indexed amount.

Section 8(10)(b) means that at the time of indexation, an ex-employee’s new NWE figure should be compared to the amount they would have received if they had continued to be employed. The NWE should be reduced to match, if necessary.

This comparison calculation should be done:

- at the time of the indexation of NWE each July
- upon a change in gross earnings in the Enterprise/Collective Agreement of an employee’s agency.

If you believe there has been a change in an employee’s NWE, you should immediately notify the Income Support team who will then undertake the comparison calculation.

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Summary of NWE legislation

The calculation of NWE is governed by section 8 and section 9 of the SRC Act. The various elements of those sections are summarised in the table below.

SRC Act reference	Explanation
8(1)	Determines how the NWE for ordinary hours of employment is to be calculated. In brief, section 8(1) provides a formula which is, in effect: (hours worked per week x rate paid per hour) + allowances also paid with both rate and hours averaged from a 'relevant period' defined by section 9.
8(2)	Supplements the NWE calculated at subsection 8(1) by taking account of overtime the employee was 'required to work' on a 'regular basis' during the same 'relevant period' as referred to in subsection 8(1).
8(3)	Makes provision for the NWE of part-time Commonwealth employees. In summary, the NWE of a part-time employee is to incorporate all other income received, not just the gross earnings from the Commonwealth. Note: There is no provision under the SRC Act to allow for other income to be included in the NWE of a full-time employee.
8(4)	Provides that where it is impractical to calculate an NWE because of the short duration of the relevant period, the delegate may set the NWE by reference to the gross earnings of another employee doing similar work.
8(5)	Allows a decision maker to apply an alternative 'relevant period' of any duration that Comcare considers reasonable where the usual subsection 9(1) 'relevant period' does not provide a fair representation

SRC Act reference	Explanation
	of the employee's NWE (e.g. where the employee has variable hours of work or income).
8(6)	Allows for NWE to be updated to reflect increases to the employee's pay as a result of matters such as indexation, pay increments i.e. by indexation of pay rates or through regular pay increments that would have occurred automatically had the employee not been injured.
8(7)	Allows for NWE to be updated where an employee continues to be employed by the Commonwealth and obtains a promotion.
8(8)	Provides that where an unpaid employee (volunteer) or part-time employee has no other earnings at the date of injury, the delegate must calculate the NWE to incorporate an amount 'that the employee would have been able to earn at the date of injury... in suitable employment'.
8(9)-8(9A)	Provides that NWE for current employees must be revised to reflect increases or reductions in their pay due to the operation of a law, or the making, alteration or operation of an award or industrial agreement.
8(9B)-8(9G)	Specifies procedures for annually updating NWE for ex-employees. NWE is adjusted by a percentage in line with the Wage Price Index. These current procedures date from an amendment to the SRC Act effective from 1 October 2001.
8(10)	Caps the NWE figure to ensure the NWE does not exceed the employee's earnings if they had not been incapacitated or had continued in their Commonwealth employment.
9	Defines the term 'relevant period' used in section 8. In short, subsection 9(1) provides that the 'relevant period' is to be the latest 2-week period before the injury. Subsections 9(2), 9(3) and 9(4) make special provision where the employee's pay rate changed or was reduced during this period, or contained an interval without income etc.

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Assessment of ability to earn

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Introduction

Ability to earn (AE) forms part of the formula used to calculate an employee's incapacity payments under Section 19 of the SRC Act.

Important: The claims manager is responsible for determining AE based on medical and other information on the claim file, including information obtained by the rehabilitation authority (the employee's most recent Commonwealth employer). The CM assesses the information to determine the employee's capacity to work and any suitable employment identified as reasonably available to them.

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Actual earnings in any employment

Any income a current or ex-employee is actually receiving from any employment, whether suitable employment or not, must be considered when determining the employee's AE.

To determine the amount per week an employee is actually earning, you may need to request from the employee:

- pay slips
- business tax returns
- profit and loss statements, or
- any other relevant business record.

Please note that gross earnings are considered when calculating incapacity payments ie before tax

Bonuses and overtime

Bonuses, commissions or overtime received by an employee that are not part of their initial normal weekly earnings (NWE) figure, should be taken into account as actual earnings (gross) in the period the employee receives them.

In circumstances where a bonus/commission/overtime is likely to be received all at once, with the potential to significantly reduce the employee's incapacity payment in that period, Comcare has the discretion to average out the bonus/commission/overtime over a period of time.

Royalties

A royalty payment is commonly understood as monetary compensation for the use of property, usually copyrighted works, patented inventions, or natural resources. Payment of royalties can only be included in the calculation of AE if they are earnings relating to employment undertaken in a specific week when the employee was incapacitated due to a compensable injury.

The vast majority of royalty payments would be received some time after the completion of the work giving rise to the royalty payment. It is only where the work is undertaken during a week in which

incapacity is payable that the royalty payment can be included as AE for that week.

This will usually mean that an incapacity entitlement paid in the past will need to be varied by way of a reconsideration on own motion, likely resulting in an overpayment to be recovered.

Note: Royalty payments can only be taken into account as AE where the payment is in relation to an endeavour that could be classified as employment undertaken by the employee. An inherited right to royalty payments, for example, could not be taken into account.

The Income Support team is responsible for implementing all incapacity determinations relying on the AE figure provided by the claim manager.

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Suitable employment

You must take the employee's ability to earn in suitable employment into account. Where an ability to earn in suitable employment is determined, it will need to be deducted from the NWE or %NWE payable when calculating the weekly amount payable. For further guidance refer to [Calculating incapacity payments](#) page.

The definition of suitable employment (section 4 of the SRC Act) is divided into two distinct categories:

- for current Commonwealth employees - suitable employment can only be Commonwealth employment, and
- for employees separated from the Commonwealth (ex-employees) - suitable employment is any employment.

You should have regard to the following factors when establishing suitable employment:

- the employee's age, experience, training, language and other skills
- the employee's suitability for rehabilitation or vocational retraining
- where employment is available in a place that would require the employee to change his or her place of residence - whether it is reasonable to expect the employee to change his or her place of residence, and
- any other relevant matter.

'Any other relevant matter' is designed as a 'catch-all' and allows you to consider other factors that may impact on the employee's ability to undertake suitable employment, such as their compensable condition and/or any non-compensable conditions they may suffer. This factor also allows you to consider factors such as volunteer work, or any study the employee may be engaged in.

Rehabilitation authority and suitable employment

The employee's rehabilitation authority has a duty to provide suitable employment to an employee, or, to assist the employee to obtain suitable employment where it is not available (section 40 of the SRC Act). For current Commonwealth employees, the rehabilitation authority will be their current employer. For employees who have left Commonwealth employment, the rehabilitation authority will be their last Commonwealth employer.

Reports obtained by the rehabilitation authority may assist you to determine the employee's ability to earn, as they will include information on the employee's fitness and competency to work, their training needs, their availability and job prospects.

Where relevant, the rehabilitation authority should be encouraged to arrange a rehabilitation assessment, under section 36 of the SRC Act, when an employee separates from employment. This assessment may be used in conjunction with medical information to provide an indication of an employee's ability to earn prior to separation. You could also consider arranging a vocational assessment, with a relevant professional, to assess the employee's fitness and competency for work when they separate from employment.

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Determining an ability to earn (AE)

Section 19(4) of the SRC Act provides the legislative provisions for determining an employee's ability to earn ('determined AE'). A determined AE can only be established for an employee if they have:

- failed to accept an offer of suitable employment
- failed to engage or continue in suitable employment
- failed to complete a reasonable rehabilitation or vocational retraining program, or
- failed to seek suitable employment.

You will also need to consider whether the employee's failure was reasonable in the circumstances and take into account any other matter Comcare considers relevant.

When an AE figure has been determined, it should be reviewed regularly to ensure it continues to apply and where applicable, updated to take into account any changes to the AE figure.

Note: There is no provision in the SRC Act to index an employee's AE figure. An ex-employee's determined AE cannot be indexed under section 8(9B) of the SRC Act, as this section only applies to an employee's NWE figure.

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Failed to accept, engage or continue in suitable employment

If an employee has failed to:

- accept an offer of suitable employment,
- engage in suitable employment after accepting an offer of suitable employment, or
- continue to engage in suitable employment which was commenced after they became incapacitated,

The employee's determined AE should be determined based on the amount the employee would have earned had they accepted, engaged or continued to engage in the offer of employment.

When determining whether an employee has failed to accept or engage in suitable employment, you should review the information on the claim file. The type of information that can be used to support a determined AE, could include:

- proof of an offer of suitable employment (in writing)
- details of the duties offered
- information from the employer on the employee's employment history (in writing), i.e. information of redundancy or resignation
- medical information indicating the employee was fit for the duties
- the employee's reasons for not participating in suitable employment

- any other relevant information.

Voluntary separation

An employee may choose to voluntarily separate from Commonwealth employment, i.e. resign or take a voluntary redundancy. Where an employee separates by choice and not due to their compensable condition, the employee may be considered to have failed to accept, engage or continue in suitable employment. You should consider determining the employee's AE figure based on the hours they were working prior to their separation from the Commonwealth.

You should also inform the employee of the potential consequences of voluntary separation from Commonwealth employment once you become aware it is being considered.

If an employee has not been offered suitable employment prior to their separation from Commonwealth employment, you are unable to determine an AE based on their failure to continue in employment. Where an employee has a capacity to work, you should encourage the employer to initiate a rehabilitation program, preferably with obligations for the employee to seek employment. If an employee fails to complete a rehabilitation program or fails to seek employment, you should consider determining AE in line with the relevant provisions under section 19(4) of the SRC Act.

Example 1: Failure to accept an offer of suitable employment

A 48-year-old ex-employee with a psychological injury is receiving total incapacity payments. The employee receives an offer to work as a builder's labourer which is determined to represent suitable employment based on the employee's age, location, skill set, qualifications and experience. The employee fails to accept the offer.

You obtain information from the prospective employer advising the employee would earn \$500 per week in the offered position. The employee's AE is determined to be \$500 per week from the date they would have started working.

Over the next five years the claim manager reviews the employee's AE figure and determines the employee's earnings would have increased had they continued in that offered employment and increases AE accordingly.

After five years the claim manager determines the offered position is no longer suitable employment due to the employee's advancing age and the physical nature of the position. The claim manager then re-assesses the employee's AE to determine whether the employee now has any ability to earn in suitable employment, or whether the amount of AE should be reduced to zero.

Example 2: Failure to continue to engage in suitable employment

A Commonwealth employee is certified unfit to work in their current workplace, however, they are capable of undertaking similar employment with a different Commonwealth employer at reduced hours.

The employee accepts an offer of suitable employment with another Commonwealth employer earning \$500 per week.

Six months later the employee resigns without providing a reasonable excuse. After reviewing the information the claim manager determines the employee has an ability to earn in suitable employment at \$500 per week.

Example 3: Voluntary separation and determining AE

An employee with a compensable condition accepts a voluntary redundancy from her Commonwealth employer. At the time of termination the employee is working 14 hours per week as an APS6 which is supported by medical information. The employee does not obtain new employment following her separation.

As the employee has been separated from the Commonwealth for a short period of time, it is not necessary to obtain additional information around their fitness and competency to engage in other suitable employment. The claim manager therefore calculates the employee's ability to earn figure based on the hours the employee was working prior to separation.

Example 4: Voluntary separation for an employee unfit to work for the Commonwealth

An employee with a psychological condition has been certified as unfit to work for their employer by their treating practitioner. The treating practitioner indicates that the employee may be fit to work for another employer. The employer offers the employee a voluntary redundancy, which they accept. As suitable employment was unable to be provided to the employee, Comcare is unable to determine an AE for the employee.

Comcare advises the employer upon the employee's separation that a rehabilitation program should be set up for the employee with obligations/responsibilities to job seek. If the employee fails to complete their rehabilitation program or fails to seek employment, Comcare will consider determining AE based on the available information.

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Failed to complete rehabilitation or vocational training program

If an employee is offered suitable employment on the condition they complete a rehabilitation or vocational training program, but they fail to complete the program, you should determine the employee's AE based on the amount the employee would have earned from the suitable employment.

When determining whether an employee has failed to complete a rehabilitation or vocational training program, you should review the information on the claim file. The type of information that can be used to support a determined AE, could include:

- information from the employer on the employee's employment history (in writing)
- information on the rehabilitation/vocational program, i.e. required activities, what is expected of the employee
- medical information indicating the employee was fit for the program
- the employee's reasons for not undertaking/completing the program
- any other information you consider relevant.

Example: Failed to complete rehabilitation or vocational training program

A totally incapacitated Commonwealth employee is referred for a rehabilitation assessment following which a rehabilitation plan is developed between the employer, employee and any workplace

rehabilitation provider (WRP). The employer locates a suitable position for the employee earning \$900 a week in a different agency. Medical information confirms the employment is suitable.

One of the conditions of transfer is that the employee undertakes a vocational re-training program when he commences with the new agency. The employee refuses to undertake the program on the grounds that the WRP called him at home prior to his commencing work with the new agency and he considered that to be inappropriate. The new agency will not accept the employee without the program in place.

You determine the employee's excuse for failing to undertake the vocational re-training program is unreasonable and based on this determines the employee's ability to earn as \$900 per week.

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Failed to seek suitable employment

Ex-employees or non-ongoing employees who have a capacity for work have a responsibility to seek suitable employment when they have separated from employment with the Commonwealth. If the employee fails to seek suitable employment, you must take into account the amount per week the employee could reasonably earn in suitable employment, having regard to the state of the labour market at the time.

When determining whether an employee has failed to seek suitable employment, you should review the information on the claim file. The type of information that can be used to support a determined AE, could include:

- the employee's employment history from their employer (in writing), i.e., information the employee has been asked to job seek and support offered to job seek
- rehabilitation program, i.e., rehabilitation program outlining job seeking as a requirement and what is expected of the employee
- medical information indicating the employee was fit to job seek
- the employee's reasons for failing to seek employment
- any other information you consider relevant.

Note: If an employee has consistently tried but failed to obtain suitable employment, you should not determine their AE based on their failure to obtain suitable employment. AE can only be determined when an employee has failed to seek employment.

Example: Failed to seek suitable employment

An ex-employee is receiving total incapacity payments for a physical injury. The employee has completed a rehabilitation program and the medical information indicates they would be able to undertake employment as a clerical assistant for up to 20 hours per week. Positions have been identified; however, the employee has failed to attend any of the interviews made by the rehabilitation authority.

You arrange an assessment for the ex-employee with an Occupational Physician to confirm they remain fit to undertake work as a clerical assistant and, with assistance from a labour market expert, identifies a number of employment opportunities for part-time clerical assistants in the ex-employee's area.

The lowest salary is for a part time clerical assistant earning \$400 per week. The highest salary is for a part time executive assistant earning \$600 per week. Information from the labour market expert suggests there is a high unemployment rate for executive assistants. The claim manager determines the employee has an ability to earn of \$400 per week, based on the more readily available employment as a clerical assistant.

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Any other matter considered relevant

You can have regard to 'any other matter that Comcare considers relevant' when determining AE. This can include, but is not limited to volunteer work, and study.

Volunteering or studying may indicate the employee has an ability to engage in paid employment and you should investigate the employee's capacity to work further, having regard to the determining AE provisions.

Volunteer work and study

Where a partially or totally incapacitated employee is undertaking volunteer work and/or study, this may demonstrate that they have a greater ability for employment than they are currently undertaking. However, undertaking volunteer work or study does not necessarily mean that an employee has an ability to undertake suitable employment, and you will need to investigate the employee's capacity further before determining the employee's ability to earn.

You should contact the employee and request information regarding the type of volunteer work and the specific duties they are undertaking. If you want to obtain additional information from the volunteer agency, you should also request the employee provide them with written authorisation.

Undertaking study may increase an employee's ability to undertake suitable duties and/or expand their skill set which may open up new fields of suitable employment. You should contact the employee and request further information around:

- the type of study they are undertaking
- how long they will be studying for
- the qualifications they will attain as a result of completing the study, and
- the number of hours per week they are engaged in study.

Any other matter

Any other matter' may also include the following:

- state of the labour market
- relocation by an employee to a new area
- unemployment rates
- compensable and non-compensable conditions, and
- childcare arrangements.

You will need to decide what factors may be influencing the employee's ability to undertake suitable employment and if they are reasonable in the circumstances.

Example: Study and ability to earn

An employee with a psychological injury provides information indicating they are currently studying for a social science degree involving 20 hours of study per week. You request a medical report from the employee's treating psychiatrist, seeking details of the employee's ability to work in paid employment, which might involve similar research and analysis as the degree. The psychiatrist states that the employee has the ability to study at home, at their own pace, with no workplace pressures to perform particular tasks. However, due to the employee's condition there would be significant restrictions on the employee's ability to engage in the same activities within a workplace.

In this instance, there would be insufficient information to determine the employee's ability to earn in employment which involved tasks equivalent to their study.

Reasonable excuse

Before determining an employee's AE, you must first consider whether the employee has a reasonable excuse for failing to accept, engage, complete or seek suitable employment. What is reasonable will vary and depend on the individual circumstances of each claim.

If an employee has failed to undertake suitable employment without a reasonable excuse, you should investigate the potential to base the employee's determined AE on what the employee would have been earning if they had undertaken the relevant suitable employment.

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Ability to earn and self-employment

Where an employee is self-employed, their AE should be determined based on their:

- ability to earn in suitable employment (often referred to as 'determined AE'), or
- actual earnings in any employment.

Actual earnings vs determined AE

In some circumstances, an employee will have both actual earnings and a determined AE from self-employment. You must take into account the greater amount when calculating the employee's incapacity payments.

The actual earnings for a self-employed employee will be the gross wages or salary the employee is receiving in their own business. The determined AE for a self-employed employee will be the wages, or salary, the employee would have received in the same position if they were employed by another business, or, what someone undertaking the same duties would get paid.

For Commonwealth employees, suitable employment can only be Commonwealth employment. Therefore, self-employment cannot be suitable employment for Commonwealth employees and only their gross actual earnings from their self-employment (as opposed to their determined AE) can be taken into account.

Important: For a separated employee engaged in self-employment, it is important you consider the employee's gross actual earnings and their potential determined AE. Incapacity payments are not

designed to support the start-up of a new business. Where an employee's wages or salary are below their capacity to work, you should consider whether a determined AE can be applied based on the employee's capacity to work.

Self-employment - small business

Where an ex-employee is the owner/operator of a small business that required minimal or no investment capital, their gross actual earnings/revenue may be the same as their determined AE. This could include businesses along the lines of, but not limited to:

- gardening
- rubbish removal
- handy-person jobs, and
- plumbing.

Example: An employee with a psychological injury starts their own rubbish removal business. As the employee already owns a truck their start-up costs for the business are minimal, as are the overhead costs associated with running a business.

The medical information indicates the employee is fit to undertake work as a rubbish removalist, and strongly recommends they continue to operate the business as being active is assisting their recovery.

You request copies of the employee's profit and loss statements and business tax returns, which indicate the employee is turning a profit of \$250 a week.

Based on the information available you determine the employee has an ability to earn of \$250 a week. You should then create a diary on the employee's claim to remind you, or your successor to review the employee's ability to earn in 12 months' time, as the business will presumably be more stable and potentially more profitable.

Self-employment - medium to large business

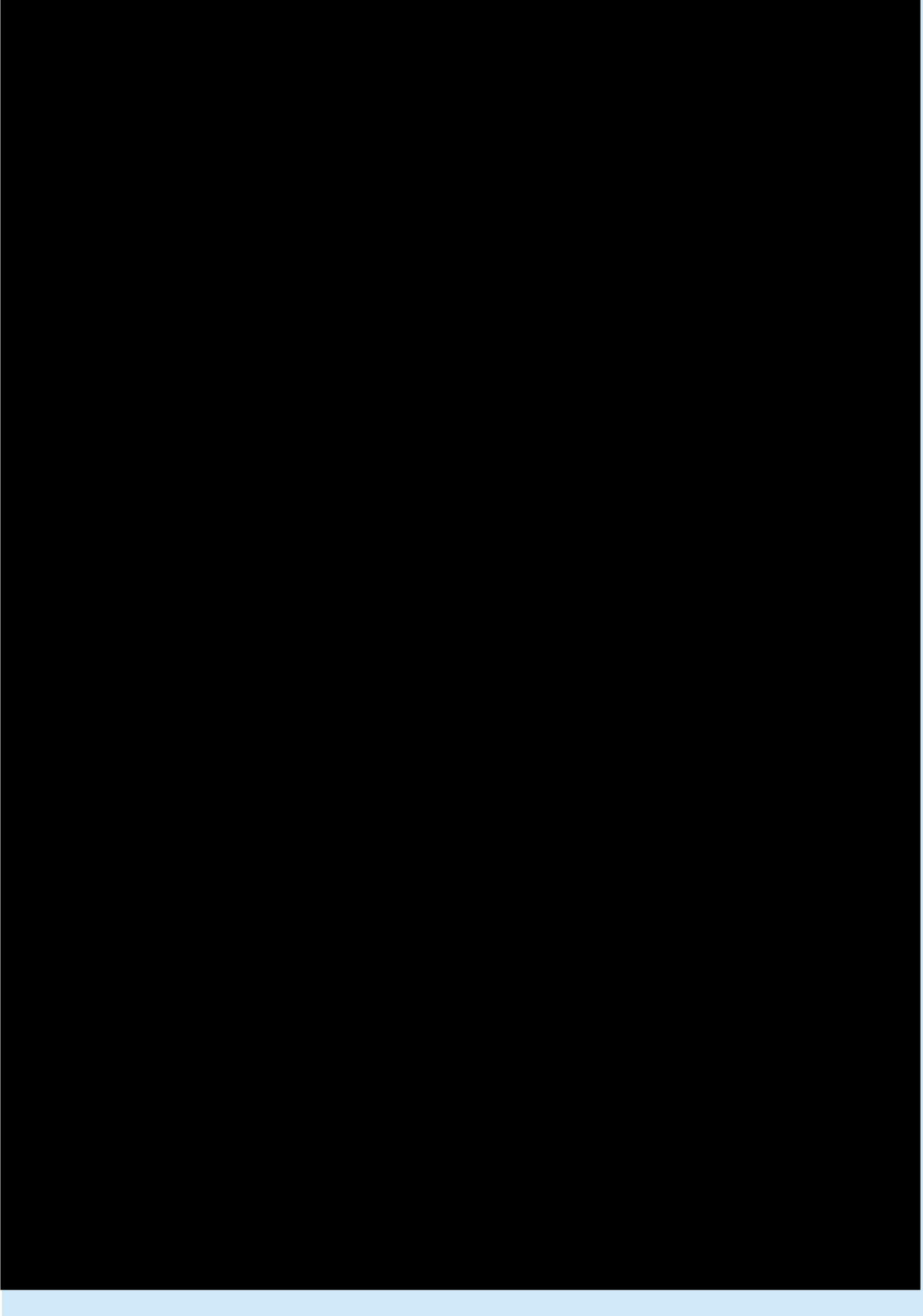
Where a business required significant investment capital, the appropriate measure of an employee's AE is the salary or wages they would have received as an employee performing the same work.

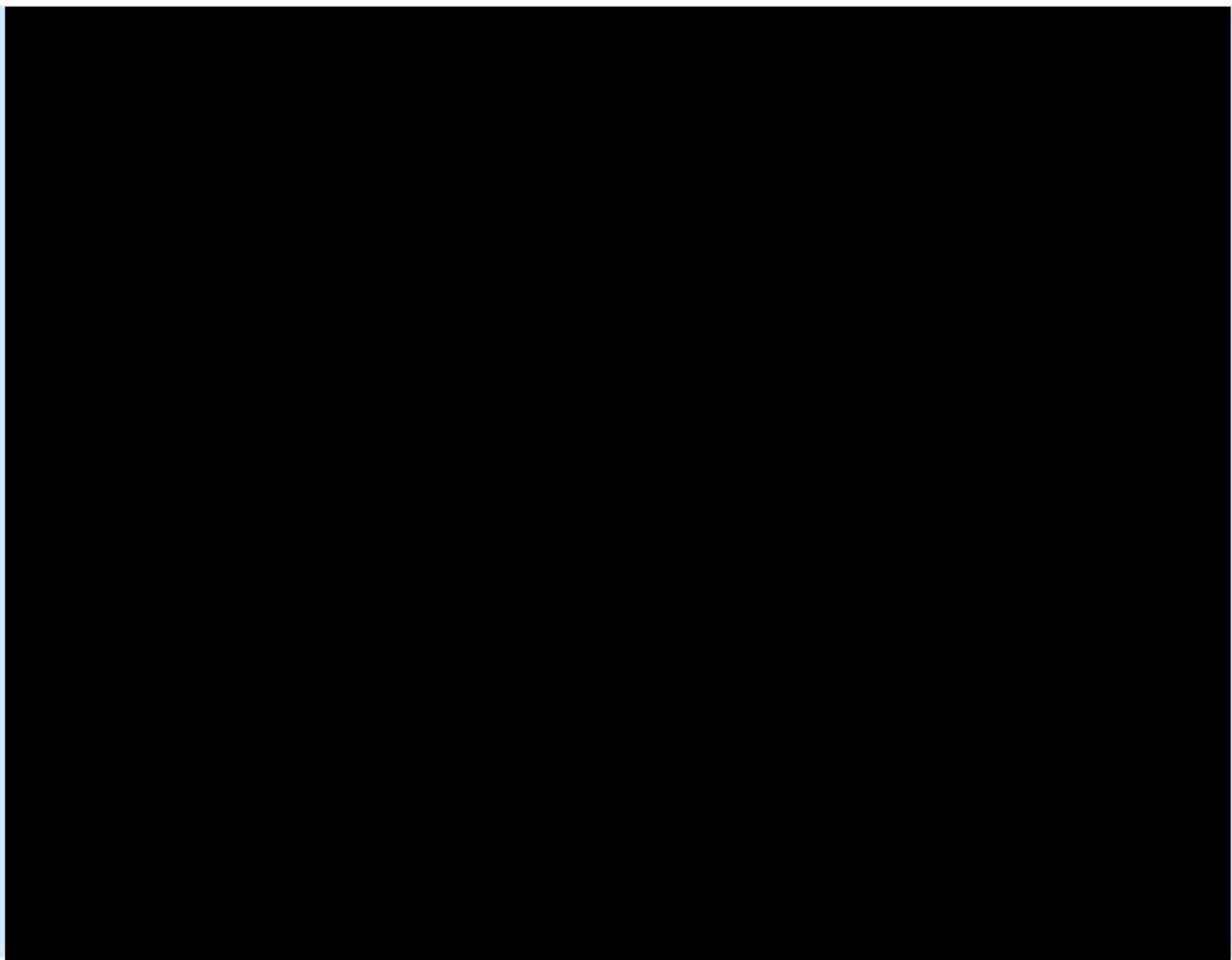
Example: An employee suffering from a psychological injury separates from Commonwealth employment. They lease a farm and purchase goods and equipment associated with growing produce on the farm. The employee demonstrates a capacity to work 20 hours a week on the farm and a further 20 hours a week administratively managing the farm and business. The business recorded a loss for the last two financial years.

As the employee is actually working in their chosen career the CM determines the employee's ability to earn based on the hours and duties they are currently working.

Information on the state of the labour market for the last two financial years is obtained and the salary for a full-time farm manager is found to range between \$500 and \$600 a week. Taking into account the size of the business, the actual or realistic levels of employment in the region, national statistics indicating trends in employment and the employee's demonstrated capabilities, you determine the employee is able to earn approximately \$600 a week.

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Redemptions (lump sum) payments

Introduction to redemption lump sum payments

A redemption payment is a lump sum payment of incapacity compensation, made instead of weekly payments. Redemption payments are only made where:

- an employee is in receipt of weekly incapacity payments
- the employee's gross weekly incapacity payments meet, or fall below, the redemption ceiling rate, and
- The employee's degree of incapacity is unlikely to change in the future based on medical evidence.

The redemption ceiling rate is a statutory rate which is updated on 1 July each year.

Incapacity payments may be payable after an employee has received a redemption payment. See [Incapacity payments after redemption](#) for more information.

Entitlements to other benefits

Receiving a redemption payment does not affect an employee's entitlement to claim for other SRC Act benefits such as medical treatment, household services, or permanent impairment.

Roles and responsibilities

The **Claims Manager** is responsible for liaising with the employee or ex-employee and determining that their incapacity payments should be redeemed by the payment of a lump sum.

The **Income Support** team is responsible for calculating and processing an employee's redemption payment. Any changes, questions or issues with an employee's redemption payment should be raised with the [Income Support](#) team.

Relevant legislation

The following sections of the SRC Act are relevant to redemption payments:

- Section 30 – Redemption of compensation
- Section 31 – Recurrent payments after redemption payment if eligible
- Section 137 – Redemption on request by former employee

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Eligibility for a redemption

To be eligible for a redemption payment, the employee must be receiving weekly incapacity payments.

Current employees and ex-employees

(employees whose liability was determined under the current SRC Act 1988)

Comcare must make a lump sum payment to the employee in lieu of ongoing weekly payments in the following circumstance, under section 30 of the SRC Act:

The amount of a current or ex-employee's weekly gross incapacity payment is:

- determined under section 19, 20, 21 or 21A
- equal to or below a set threshold (known as the redemption ceiling rate), **and**
- the degree of the employee's incapacity is unlikely to change based on medical evidence.

Former employees

(employees whose liability for compensation was determined under a pre-1988 version of the SRC Act)

A former employee of the Commonwealth may also be paid a lump sum instead of ongoing weekly incapacity payments if:

- incapacity is determined under section 131, 132, 133, or 134
- the weekly gross amount they are entitled to is equal to or less than the redemption ceiling rate, **and**
- the degree of incapacity is unlikely to change based on medical evidence.

You can suggest this option, or the former employee may request it, in writing. Redemption payments for former employees are paid under section 137 of the SRC Act. Unlike current or ex-employees, Comcare is not obligated to make a redemption payment for former employees unless they accept this option in writing.

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Taxation on redemption payments

Redemption payments are income and therefore tax is payable up to pension age.

According to the Australian Taxation Office (ATO), a lump sum redemption payment for future compensation income entitlements is assessable under section 6-5 of the *Income Tax Assessment Act 1997* in the income year it was received.

Employee questions: You should direct an employee to the Australian Taxation Office (ATO) if they have any questions about the tax component of a redemption. Comcare cannot advise employees on how a redemption payment will affect their overall taxation.

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Incapacity payments after a redemption lump sum

Current employees whose redemption payment were made under section 30 can claim further incapacity payments if their level of incapacity increases after the redemption payment is made. This resumption of incapacity payments is provided for under section 31 of the SRC Act.

Further incapacity payments can only be made to these employees where their incapacity increases to the extent that they cannot engage in suitable employment and their incapacity is likely to continue indefinitely.

To be eligible for a recurrent incapacity payment after receiving a redemption lump sum, the following conditions must be met:

- the employee must have previously received a redemption lump sum payment under section 30 of the SRC Act
- the employee's incapacity results in them being unable to engage in suitable employment, **and**
- the incapacity is likely to continue to pension age.

If it is found that a recurrent incapacity payment should be made, the amount of compensation is the amount that would otherwise have been payable to the employee under sections 19, 20, 21 or 21A, minus the amount per week that was redeemed at the date of the section 30 determination.

Former employees of the Commonwealth

Former employees of the Commonwealth who have received a redemption payment under section 137 cannot claim any further incapacity payments.

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Superannuation

Introduction to superannuation

This page provides information on superannuation and its effect on incapacity entitlements. You can use this information to inform employees and support them to provide the information we need to pay their rightful entitlements. You can also refer employees to the superannuation page on Comcare's website.

Superannuation as income

An employee can choose to access their superannuation in different circumstances. Some examples are invalidity retirement or when the employee reaches their preservation age. They may also be required to access their superannuation in some circumstances. This depends on the rules of each superannuation fund.

Superannuation is considered as income in certain circumstances. Employees and ex-employees are treated differently in some circumstances. Superannuation has a reducing effect on an employee's incapacity payments and needs to be calculated from when they receive their payment or, for a retrospective pension, from the day after their retirement from the Commonwealth.

Additional information can be found in the scheme guidance on superannuation.

Roles and responsibilities

The **Claims Manager** is the communication channel with the employee. During the life of the claim, the Claims Manager conducts reviews of the claim and requests information from the employee. Any information relating to superannuation (or information that may affect incapacity entitlements generally) should be passed onto Income Support.

The **Income Support** team will calculate entitlements and, if the changes result in an overpayment, refer the case to the **Debt Recovery** team.

Legislation summary

Several different sections of the SRC Act outline the details and conditions of superannuation as income, detailed below.

- **Employee still employed by the Commonwealth and does not access superannuation:** If an employee does not access their superannuation, their incapacity payments are generally made under section 19 of the SRC Act.
- **Employee still employed by the Commonwealth but has accessed a superannuation pension:** If the employee has not left Commonwealth employment, but has accessed a superannuation **pension**, their incapacity is calculated under section 19(3A) of the SRC Act. These cases are very rare.

There is no section of the Act that covers if a **lump sum** is taken while still employed with the Commonwealth. A lump sum in this case is **not included** as income for incapacity entitlements.

- **Transitional arrangements:** If an employee started receiving their incapacity payments after July 1989 and if the employee is compensated under the transitional arrangements from the previous 1971 Act, their payments are calculated under section 131 (totally unable to work) and section 132A (some capacity for work).
- **Employee has retired from Commonwealth employment and accessed their superannuation:** If the employee has retired and is accessing their superannuation, their payments are considered under sections 20, 21 and 21A. This scenario is also relevant to some AAT Implementation matters. These sections of the SRC Act constitute the 'superannuation provisions' of the SRC Act. Most employees accessing superannuation will have their payments calculated under one of these sections. They include:
 - a pension only for an ex-employee, under section 20
 - a lump sum only for an ex-employee, under section 21
 - a pension and a lump sum for an ex-employee, under section 21A

Gathering information about an employee's superannuation

In order for Comcare to collect information from superannuation funds about an employee's superannuation, the employee must complete and sign an Authority and Consent for the Release of Superannuation Information form. The Claims Manager will request information from the employee about which superannuation fund is relevant and ask them to complete the form and supply the identification documents for that superannuation fund.

The Claims Manager should inform Income Support when this is complete, and then the Income Support team will send the authority form plus the superannuation questionnaire / section 114b form to the superannuation fund to gather the required information.

Payment of incapacity during information gathering period

If an employee wants to be paid their current incapacity payments during the period where the superannuation details are being requested and a redetermination of their incapacity payments is being made, **they will be overpaid**. Claims Managers need to advise employees about this and confirm that the employee is comfortable to proceed knowing that they will be required to repay the overpayment amount to Comcare. A payment schedule will need to be discussed with the Debt Recovery team.

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Accessing superannuation

As superannuation is money invested for a person's retirement, strict government rules prevent early access to preserved benefits except in very limited and restricted circumstances, such as:

- permanent departure from Australia
- severe financial hardship
- serious illness or surgery, or
- compassionate grounds.

Generally, eligibility for access to superannuation benefits depends on an employee's 'preservation age'. Most of the grounds under which early access is permitted are administered by the superannuation funds and are subject to strict legal criteria.

Preservation age

Generally, employees cannot access their superannuation benefits until they reach preservation age. 'Preservation age' refers to the minimum age a person can access their superannuation based on their date of birth.

Employee date of birth	Minimum age for accessing superannuation
After June 1964	60
1 July 1963 - 30 June 1964	59
1 July 1962 - 30 June 1963	58
1 July 1961 - 30 June 1962	57
1 July 1960 - 30 June 1961	56
Before 1 July 1960	55

For more information on identifying the correct preservation age, please see [Preservation of super](#).

Accessing superannuation before preservation age

For incapacity purposes, if an employee accesses their superannuation benefit before reaching preservation age, Comcare would need to consider whether the employee was:

- retired
- receiving superannuation, **and**
- in receipt of superannuation as a result of that retirement.

See Superannuation provisions for explanations of 'retired' and 'received'. In most circumstances, early superannuation access is unlikely to meet all the criteria outlined above.

For example:

- an employee might be retired and receiving superannuation but the superannuation benefit was not received as a result of the retirement but due to financial hardship, or
- an employee may still be working but receiving superannuation on compassionate grounds.

Generally, superannuation benefits received before preservation age due to the circumstances listed above are unlikely to be taken into account under the superannuation provisions of the SRC Act.

Conditions of release

Conditions of release are the circumstances an employee needs to satisfy in order to access their superannuation benefits. Conditions of release may differ between superannuation funds, but the most common include:

- **retirement** – employees can access their superannuation benefits when they have reached preservation age and retired from employment. Generally, a retired employee cannot access their

superannuation if they have not reached preservation age unless they meet another condition of release. In order for Comcare to consider an employee as retired, they must have formally separated from their Commonwealth employer.

- **transition to retirement (attaining preservation age)** – employees who are under the pension age **and** have reached preservation age, but remain gainfully employed, may access their benefits as a non-commutable income stream. Superannuation accessed through a transition to retirement arrangement cannot be taken into account when calculating incapacity payments. Once the employee retires we would take into account any further superannuation that is accessed.
- **attaining age pension age** – employees who reach pension age can access their superannuation benefits at any time, regardless of whether they have retired from employment or not.

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Superannuation provisions - sections 20, 21 and 21A

Most employees who access super will do so once they retire. The superannuation provisions - sections 20, 21 and 21A of the SRC Act - apply when:

- an employee is both retired **and**
- receiving a superannuation benefit as a result of that retirement.

Meaning of 'retired'

The SRC Act does not define 'retired' or 'retirement'. In the context of the SRC Act, 'retirement' includes any separation from Commonwealth employment. See the Scheme guidance for more information: Employees receiving superannuation benefits and incapacity payments.

Superannuation schemes take a broad view of 'retired' and 'retirement'. For superannuation benefits to become payable, 'retirement' generally means that the retiree does not intend to become gainfully employed in the future. As a guide, gainful employment is considered to be more than 10 hours a week.

Retirement can therefore include, but is not limited to:

- voluntary or involuntary redundancy
- age retirement
- resignation
- dismissal
- retirement on the grounds of inefficiency, or
- retirement due to ill health/invalidity retirement.

An employee can retire at any age. However, most employees cannot access superannuation benefits until they have reached their preservation age unless they meet a different condition of release.

Please note: a superannuation fund may deem an employee as retired before their employment ceases with the Commonwealth. In this case, Comcare will deem retirement as having occurred on the date of cessation with their employer, not the date the superannuation fund has determined the employee has retired.

Meaning of 'received'

Comcare will consider an employee has 'received' their superannuation amount if they have retired from Commonwealth employment **and**:

- accessed their superannuation, or
- reached their minimum preservation age and elected to roll-over their superannuation benefits to another scheme (or their fund has automatically rolled over their benefits for them).

If an employee has not accessed their superannuation and has not made any decision or choice in respect of their superannuation and no action is taken in respect of their superannuation (including that the superannuation fund has not rolled-over any funds), then they have not 'received' their superannuation for the purposes of the SRC Act.

Meaning of 'rolling over'

'Rolling over' is a term that refers to the act of a superannuation fund transferring a benefit out of their fund to the employee directly, or to the employee's other superannuation fund. This can happen when an employee's situation changes and their benefit can no longer remain with a specific fund due to the strict rules governing superannuation funds.

For example, some funds cannot continue to manage an employee's benefits once an employee has retired or been terminated from the specific employment that fund was created to service. In this case, the fund will first seek to transfer the benefit to the employee, if they have reached preservation age or have retired. If this is not possible, the employee's super fund will transfer the employee's benefit to another super fund that is able to receive the employee's benefit according to the rules applicable to that fund. A 'roll-over' to an eligible fund can occur even if an employee does not agree to the transfer or fails to nominate an account.

Roll-overs that are 'received'

For an employee who has reached preservation age, 'rolling over' a superannuation amount demonstrates an 'unequivocal power of disposition' over that amount because the employee has notionally received the superannuation amount, even where the roll-over was undertaken automatically by the superannuation fund (see *Archer v Comcare* [2000] FCA 1296)

As a result, when calculating an employee's incapacity payments, the superannuation amount must be taken into account even though the employee has not accessed their funds. It is enough that the employee is eligible to access their funds and the rules of the fund require the employee to receive their benefit. In the event of refusal or inaction by the employee, an eligible fund will accept the benefit and act as custodian of the funds on behalf of the employee.

Roll-overs that are not 'received'

A 'roll-over' of a benefit does not always mean the funds have been received by the employee. In some cases, a 'roll-over' may occur if a fund is bought or sold, or for a reason unrelated to the employee's employment. A good guide is to consider if the employee can choose to spend the funds after the benefit has been rolled over to a new fund. If the answer is yes, the employee has likely 'received' the funds. If the benefit was preserved at the time of roll-over and remains preserved in the new fund, it is unlikely Comcare would treat the benefit as having been 'received' by the employee.

If an employee has not accessed their superannuation and has not made any decision or choice in respect of their superannuation and no action is taken in respect of their superannuation (including that the superannuation fund has not rolled over any funds), then they have not 'received' their superannuation for the purposes of the SRC Act.

Deferred/preserved superannuation benefits

Superannuation benefits that have been deferred or preserved in an existing superannuation fund have not been 'received' for the purposes of the SRC Act. Deferred/preserved benefits should not be taken into account when calculating an employee's incapacity entitlements (see *Dunstan and Comcare* [2013] AATA - 402 (17 June 2013)).

Date from when compensation is payable under the superannuation provisions

For an employee who is retired and has received their superannuation, the SRC Act provides that compensation is payable under the superannuation provisions for 'each week after the date of the retirement during which the employee is incapacitated.' This is taken to apply from the week the employee is **both retired and in receipt of** their superannuation benefit.

Example: An incapacitated employee separates (retires) from employment in March 2012. The employee reaches preservation age in November 2012 and decides to access their superannuation benefit. Until this point, the employee's incapacity payments are calculated under section 19 because they have not both retired and received their superannuation until now. The employee's incapacity payments will be calculated under the superannuation provisions (sections 20, 21 or 21A) from the date they actually received their superannuation in November 2012. The provision will not be backdated to when the employee was considered 'retired'.

This example can be distinguished from the case of *Webley and Telstra* [2003] AATA 539 in which the employee retired but it took over 12 months to organise the superannuation benefits which were eventually paid to the employee with effect from the original retirement date. In this case, the provisions of section 20, 21, 21A apply from the original retirement date.

Superannuation payments that cease

Some superannuation funds have a finite life of payments and at a point in time the money ceases. At this time the superannuation details need to be updated on Pracsys to 'Ceased' from the correct date by Income Support. The incapacity payments revert to section 19 of the SRC Act.

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What superannuation is taken into account?

Comcare can only take superannuation into account that is paid by the employer who is liable for the compensable injury. This means that Comcare excludes any superannuation, whether pension or lump sum, from non-Commonwealth employment AND from Commonwealth employment with an agency that is not the liable agency. Income Support is responsible for obtaining information from the super fund that allows Comcare to distinguish the various amounts of super from the different employers.

Divorce/separation

In situations where an employee's superannuation has been split following a divorce/separation arrangement, Comcare will only take into account the employer-financed superannuation amount the employee actually receives.

Employer-financed component

An employee's superannuation benefit is made up of a number of components. When calculating an employee's incapacity payments under the superannuation provisions of the SRC Act, Comcare only takes into account the Commonwealth employer-financed component of the superannuation benefit. Section 4(1) of the SRC Act defines 'superannuation amount'. Personal or employee-financed contributions, and contributions from non-Commonwealth employment, are not taken into account.

Commonwealth Superannuation Scheme (CSS) and Public Sector Superannuation (PSS) can advise on the Employer Financed Component (EFC) breakdown of the employee's superannuation payments. This is done through a section 114b form. The 114b form is generally sent to the super fund by CAIS.

Super funds can give a total amount of the employer's and employee's contribution so that Comcare can work out an apportionment percentage. If an employee has had a number of employers, establishing the liable Commonwealth employer's contribution may require further information from the fund and employee. If the superannuation fund is unable to break up the contribution amounts to allow Comcare to work out a percentage, Comcare uses the total payment. Income Support will send a questionnaire to the fund(s) to obtain this information.

Income Stream accounts

Any payments from a superannuation fund into an income stream account which the employee can access and use are classified as a lump sum under section 21 or 21A.

Productivity benefit

In some cases, a Productivity Benefit may form a separate part of the employer-financed contribution. Generally, the productivity benefit cannot be accessed by employees until they reach preservation age (except in certain defined circumstances). In cases where the productivity amount must be compulsorily preserved until preservation age, it cannot be taken into consideration when calculating an employee's incapacity benefits before they reach preservation age.

When an employee reaches preservation age, irrespective of whether an employee chooses to defer or roll over the productivity benefit, the benefit must be added to any existing superannuation amount and taken into account when calculating an employee's incapacity benefits under section 20, 21 or 21A of the SRC Act.

Superannuation from other employment

A superannuation pension from non-Commonwealth employment is not considered in relation to an employee's incapacity and does not reduce their payments.

Income Support must take care to ensure the super fund identifies contributions from private employers and non-liaable Commonwealth employers, so Comcare does not underpay the employee.

Superannuation 'insurance' amounts

Notification

Comcare needs to liaise with the superannuation fund paying superannuation insurance amounts when an employee is receiving income support payments, as the income support payments could affect their income protection entitlements. Therefore, when an employee is receiving a

superannuation insurance amount, the employee needs to sign a Superannuation Authority form to provide the superannuation fund permission to share information with Comcare.

Total and Permanent Disability payment

An employee may be able to access a Total and Permanent Disability (TPD) payment from their superannuation account. This is sometimes paid by a superannuation fund to, or on behalf of, an employee in the event of death or disability, and is commonly referred to as a 'TPD' payment. The TPD insurance benefit is considered an integral feature of many superannuation funds and provides benefits for those employees who have retired totally and permanently from their employment due to disability or ill health.

The insurance arrangement is usually funded by premiums paid by the superannuation fund to an insurer. Effectively, there is an amount taken each month from the employee's superannuation accounts to fund the insurance cover.

If the TPD benefit is a weekly or fortnightly payment, it is accessed as a pension. However, the TPD is sometimes paid as a quarterly or once-off lump sum. The 'insurance' lump sum which the superannuation fund trustee receives from their insurer is credited to the employee's superannuation account and paid to the employee. Comcare may assess the TPD payment as a superannuation amount irrespective of whether the employee receives the TPD as a lump sum or a pension. The gross amount of the TPD is considered in incapacity calculations and is treated in the same way as employer-funded superannuation components.

The TPD benefit should be apportioned according to the same contribution ratio as determined for the employer-funded component. For example, if the employer-funded component is assessed as 80 percent of the superannuation benefit, the TPD benefit should be assessed at the same ratio. The only exception to this is if the employee has privately paid for their superannuation insurance. In this case, the insurance amount is not considered employer-funded.

Where an employee is retired from their employment and receives or is given the choice to receive a TPD payment under a superannuation scheme, the employer-funded portion of that payment will be considered a superannuation amount for the purposes of the calculation of the compensation amount under section 20, 21 or 21A of the SRC Act.

In the unlikely event an employee is receiving a total permanent disability benefit and there was no Commonwealth employer contribution to the benefit, this should not be considered as earnings from employment under section 19(2) or a superannuation amount under section 4(1), 20, 21 and 21A of the SRC Act. As such, the benefit should not be taken into account when determining an employee's incapacity entitlements.

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Calculating the appropriate superannuation amount

The Claim Administration and Income Support (CAIS) – Assessment Team is responsible for calculating and determining an employee's incapacity payments, including superannuation calculations. The information in this section is provided for context.

Any changes, questions or issues with an employee's incapacity payments should be raised with the CAIS Assessment Team.

Calculating the employer-financed contribution

The superannuation amount is defined in section 4 of the SRC Act as an amount equal to the following:

1. The amount the employee's superannuation scheme identifies as contributions made by the employer identified by Comcare as the liable Commonwealth employer.
2. If the superannuation scheme cannot identify the liable employer's contributions, it is the amount Comcare assesses to be attributable to that employer's contributions, or
3. If Comcare cannot assess an amount to be attributable to that employer's contributions, the entire amount an employee receives is taken into account.

Where the employee is a member of an accumulation style superannuation scheme, such as PSSap, option 2 is commonly used. That is, Comcare would estimate the amount attributable to that part of the benefit funded by the liable Commonwealth employer's contributions.

Under option 2, CAIS would estimate a superannuation amount as follows. They would ask the superannuation fund for the raw contribution figures going into the employee's superannuation account from both the liable employer and the employee. They would then apportion the employer and employee contributions based on the raw figures (i.e. without interest, fees, charges etc. applied).

Example: The fund states that the liable employer's raw contributions into the member's account totals \$100,000 and, in addition to this, the employee's raw contributions are \$20,000. Comcare can estimate with reasonable accuracy that 83.3% of the benefit (including any insurance/TPD payout) is employer-financed and proceed from there.

Example: The fund states that the employee's account received contributions from a private sector employer, and these were rolled into the fund after commencing employment with Agency A. The employee ceased receiving contributions from Agency A after 10 years and then received contributions from Agency B. Agency B was the liable employer at the time of the employee's compensable injury. The private sector contributions totalled \$100,000. Agency A contributions totalled \$100,000. Agency B contributions totalled \$100,000. The employee made no raw contributions. After 30 years of investment of those contributions, the fund balance has grown to \$1,000,000. The superannuation contributions from the private employer and Agency A are excluded. Comcare can reasonably estimate that the liable employer financed component is 33.33 percent of the total raw contributions. Therefore, 33.33% of the total benefit is attributable to the liable employer's contribution and the amount of \$333,300 is treated as the 'superannuation amount'.

If for some reason there is no way of calculating the employer financed component, it is open to Comcare to consider all of the benefits as being employer-financed (i.e. option 3 above).

In some cases, particularly for defined benefit schemes, the superannuation fund is able to provide details of the employer-financed amount to Comcare upon request. It is only when the superannuation scheme cannot identify the employer-financed amount that Comcare will use options 2 or 3.

Calculating incapacity payments under section 20, 21 or 21A of the SRC Act

An employee who is retired from Commonwealth employment and receives a superannuation amount by way of a pension and/or lump sum under a superannuation scheme must have their incapacity payments determined in accordance with section 20, 21 or 21A of the SRC Act.

The formula used to determine the amount of compensation payable will depend on:

- when the employee had retired and was in receipt of their superannuation and
- if the period of incapacity is before or after 27 April 2007.

The *Safety, Rehabilitation, Compensation and Other Legislation Amendment Act 2007* (SRCOLA Amendments) changed the previous formula used to calculate incapacity under sections 20, 21 and 21A of the SRC Act to ensure that an employee's superannuation benefits would always be considered, regardless of whether an employee was incapacitated or not on the date they retired.

Employees retired before 27 April 2007 (Pre-SRCOLA) with a period of incapacity on or after 27 April 2007

If an employee is retired and in receipt of their superannuation before 27 April 2007, and the compensable incapacity arises on or after 27 April 2007, the following formulas apply:

If the employee is receiving a...	Then use formula...
Pension (section 20)	$AC - (SA + SC)$
Lump sum (section 21)	$AC - (WI + SC)$
Pension and lump sum (section 21A)	$AC - (SA + WI + SC)$

Note: Definitions for the formulas are outlined below.

Employees retired before 27 April 2007 (pre-SRCOLA) with a period of incapacity before 27 April 2007

If an employee is retired in receipt of their superannuation and claiming incapacity for a period before 27 April 2007, the following formulas apply:

If the employee is receiving a...	Then use formula...
Pension (section 20)	$AC - (SA + SC)$
Lump sum (section 21)	$AC - (Lump\ Sum/520 + SC)$
Pension and lump sum (section 21A)	$AC - (SA + Lump\ sum/520 + SC)$

Note: Definitions for the formulas are outlined below

Employees retired on or after 27 April 2007, with a period of incapacity on or after 27 April 2007

If an employee is retired and in receipt of their superannuation after 27 April 2007, and the compensable incapacity also arises on or after 27 April 2007, the following formulas apply:

If the employee is receiving a...	Then use formula...
Pension (section 20)	$AC - (SA + 5\% \text{ of NWE})$
Lump sum (section 21)	$AC - (WI + 5\% \text{ of NWE})$
Pension and lump sum (section 21A)	$AC - (SA + WI + 5\% \text{ of NWE})$

Note: Definitions for the formulas are outlined below.

Definitions:

Amount of compensation (AC)

Amount of compensation is based on the amount that an employee would otherwise be entitled to receive at the time of retirement under section 19(3) of the SRC Act, regardless of whether the employee has reached 45 weeks of incapacity or not.

Superannuation amount (SA)

The superannuation amount as defined in section 4 of the SRC Act (see the section Calculating the employer-financed contribution).

Weekly interest on the lump sum (WI)

The formulas for section 21 and section 21A provide for an amount to be deducted known as the 'weekly interest on the lump sum'. This part of the formula provides the mechanism to convert an employer-financed superannuation lump sum amount into a weekly amount.

Once the employer-financed amount of the superannuation lump sum is established, an interest rate as specified by the Minister is applied to the lump sum in order to convert the lump sum into a weekly amount. The interest rate specified by the Minister commences on 1 July each year and is available at Statutory [rates](#).

The rationale behind the interest rate being applied to the lump sum is that it represents the notional amount of interest that the employee would be considered able to earn if their lump sum was invested.

Note: Once the superannuation lump sum figure is initially established, the lump sum figure remains 'frozen' and the weekly lump sum amount to be deducted will only be varied by the interest rate on 1 July each year or if the employee accesses further superannuation.

Reduction of compensation amount by five per cent of the employee's

normal weekly earnings

Refers to the reduction of the employee's compensation amount by five per cent of the employee's normal weekly earnings (i.e. the total NWE, not just the base salary NWE). This part of the formula ensures that the combined workers' compensation and superannuation weekly amount cannot exceed 70 per cent of the retired employee's normal weekly earnings, as originally intended by the legislation.

Superannuation Contribution (SC)

The 'SC' or 'superannuation contribution' amount is an amount equivalent to the minimum contribution amount required by a superannuation fund. As there are numerous superannuation funds with different contribution rules, the percentage contribution rate of an employee would commonly range anywhere between 0% and 10%.

The SC amount is adjusted each year by reference to the base NWE amount that applied on the employee's birthday that year.

The SC amount is only applied to employees with a retirement date prior to 27 April 2007.

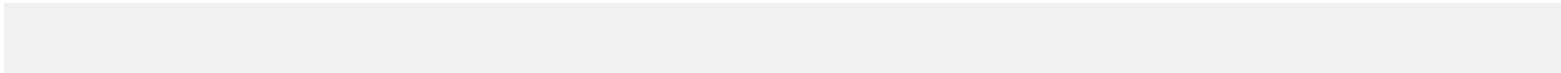
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Superannuation contributions for employees on Xpay

Generally, employees on Xpay have separated from Commonwealth employment. As Comcare is not their employer, Comcare is not required to make contributions to their superannuation fund.

An employee is able to make their own employee-financed (personal) contributions to their superannuation fund. If they work for a new, non-Commonwealth employer, their employer will be required to make superannuation payments under the National Employment Standards.

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Separation from employment

Introduction to separation from Commonwealth employment

An employee may separate from their Commonwealth agency employment through invalidity retirement, redundancy or other means, whilst receiving incapacity payments. These employees are referred to as ex-employees.

Current employees receive their incapacity payments via their agency employer's payroll system. However, when an employee separates from their agency, Comcare pays incapacity payments directly to the employee through the Xpay Aurion system.

Employees who change from one Commonwealth agency to another are still Commonwealth employees and would continue to receive incapacity payments through their new agency's payroll system.

Reviewing capacity for work

Claims Managers should regularly review an ex-employee's capacity for work. If Comcare identifies that the employee has a capacity to work in the future, we should ensure that appropriate rehabilitation and return to work actions are undertaken to return the employee to suitable employment. In some cases, it may be appropriate to determine (deem) that an employee has an 'ability to earn'. For further guidance on deeming and an ability to earn, refer to the Assessment of ability to earn page.

Roles and responsibilities

This table outlines the roles and responsibilities of Claims Managers and the Income Support team for employees separating from employment.

Responsibilities	Claims Manager	CAIS
Assessment of whether the employee is still entitled to incapacity payments at the time of separation	x	
Discussion with the employee about Xpay set up process	x	
Determine capacity for work and ability to earn if applicable	x	
Request/follow up with CAIS on relevant information provided by employee. See information gathering section below	x	
Request/follow up on cessation form from Agency	x	
Request/follow up on outstanding Claims for Time Off Work (CTOW) or Records of Earnings (ROE) if required	x	
Review employee's continued entitlement to incapacity payments (Ongoing)	x	
Set up ex-employee on Xpay		x
Request/follow up on superannuation information		x
Send Centrelink request for determined periods		x

Update Normal Weekly Earnings (NWE) if required		x
Determine incapacity periods post-cessation		x
Provide communication to Claims Manager to send to employee		x

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The separation process

The separation process is triggered when you become aware that an employee has separated or is soon to separate from Commonwealth employment. When this occurs, Pracsys must be updated to reflect the separation.

Usually, the employer (the Commonwealth agency) notifies Comcare or submits a Cessation of Employment form. Sometimes it is the employee who contacts Comcare to advise that they are separating from their employment. Separation can include, but is not limited to:

- voluntary or involuntary redundancy
- retirement age
- resignation
- dismissal, or
- retirement due to ill health (invalidity retirement).

Where an employee separates for a reason not due to their compensable condition, the employee may be considered to have failed to accept, engage in or continue in suitable employment. You should consider determining the employee's Ability to Earn (AE) figure based on the hours they were working before their separation from the Commonwealth.

You should also inform the employee of the potential consequences of voluntary separation from Commonwealth employment once you become aware it is being considered. Please refer to [Assessment of ability to earn](#) for further information.

Before setting an employee up on the Xpay Aurion system, the Claims Manager needs to make an assessment to determine if the employee is still eligible for incapacity based on medical evidence and their ability to earn.

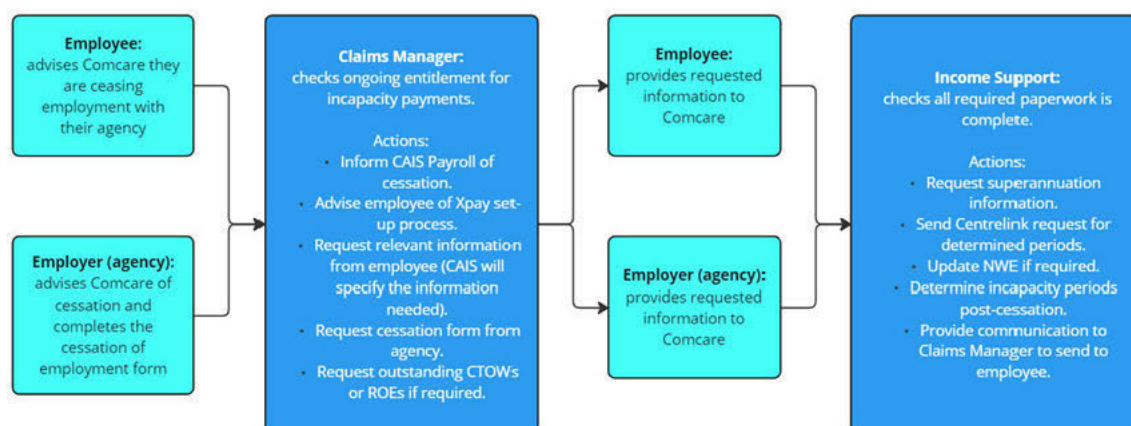
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Information gathering

The Income Support team requires certain information to complete the separation process and set up an exiting employee on Xpay. The Claims Manager will support the Income Support team to gather this information. It is important to be aware of the information required, the stakeholders involved, and the potential time periods that gathering information may take, to keep the employee informed.

This flowchart outlines the process including the requirements for each person in the process (click on the link [Separation from employment](#) for a pop-out view).



Separation from employment flowchart

The employee needs to provide:

- a valid Certificate of Capacity covering periods to be claimed
- completed Pay Start form
- completed Superannuation Authority form
- completed Tax File Number Declaration form

- any actual earnings from other employment. See Assessment of ability to earn

The employer needs to provide:

- a completed Cessation of employment form. Cessation of Employment form (Once this is received by Comcare, follow the Procedure to assess capacity for work following separation).

Please ensure that the following two sections are filled out:

1. *Reason for leaving:* When communicating with the employer about completing the cessation of employment form, ensure the employer is very clear about the reason for leaving, as this could affect entitlements. For example, using 'retirement' instead of 'medical retirement' could affect entitlements.
2. *Normal Weekly Earnings:* The Normal Weekly Earnings (NWE) amount at cessation is what the employee's NWE will be based on in future. It is important that the employer provides this in their Cessation of Employment paperwork.

- Any outstanding Claims for Time Off Work (CTOW) from the employee while with the agency.

Outstanding Claims for Time Off Work: It is important to support employees and employers to provide all up-to-date Claims for Time Off Work (CTOW) for periods before the cessation of employment before switching an employee over to Xpay. This will help to avoid delays in payments. Delays can occur when the employee switches between the agency and Xpay Aurion payment processes. Clear communication about the requirements in this process and getting all documents to Comcare as soon as possible will minimise delays.

Once an employee is set up on Xpay, Comcare can no longer pay incapacity to their employer.

Third parties may also need to provide information:

- If the employee has accessed superannuation, Comcare must request information about the superannuation and how it is accessed. The superannuation fund/s will supply the information to the Income Support team to use to make determinations. This information can take some time to receive (expect 4-6 weeks).
- If the employee has been in receipt of Centrelink benefits (excluding Family Tax Benefit), Comcare needs to advise Centrelink of the employee's entitlement in case Centrelink needs to recover the benefit from Comcare. If the benefits have already been paid to the employee, this will result in the benefit being deducted for those periods and an overpayment being raised for the employee to repay Comcare. This information can take some time to receive (expect 2-4 weeks).
- If the employee has a Department of Veteran Affairs (DVA) pension, this may need to be considered and information should be requested.

Income Support can only set the employee up on Xpay Aurion and begin to pay them for time off work after they have received all the above information and answers to the questions. By gathering the information required before setting the employee up on Xpay Aurion, it ensures we transition the employee onto our X-Pay Aurion system as soon as possible and can accurately calculate and pay their entitlements.

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After an employee is set up on Xpay

The Income Support team processes all payments through Xpay Aurion. The Claims Manager is responsible for regularly reviewing accepted claims and ensuring up-to-date information is provided to Income Support when needed.

Evidence whilst on Xpay

All ex-employees receiving incapacity payments must submit regular medical certificates and have their incapacity treatment plans updated.

Most ex-employees on Xpay belong to one of these four groups:

1. 'Totally incapacitated' (TI): ex-employees are certified totally unfit for work. They just need to supply medical evidence from their legally qualified medical practitioner (LQMP) and the Claims Manager needs to extend the treatment plan.
2. 'Payslip': ex-employees are working in non-Commonwealth employment or self-employed. These ex-employees must provide evidence, such as payslips, to receive incapacity payments.
3. 'Transitional': claims of ex-employees previously accepted under the *Compensation (Commonwealth Government Employees) Act 1971* (1971 Act) and now dealt with under sections 131-137 of the SRC Act. Due to the age of the employees, medical certificates may cover a longer period than usual, and the Income Support team looks for evidence of periodic contact with the employee to ensure continuance of payment.
4. Work trials, approved voluntary work and approved study: An ex-employee can be on a work trial or approved study program or voluntary work to assist them to return to work. If the work trial is in their rehabilitation plan, they can submit a fortnightly Incapacity for Work and Record of Earnings (Paid Employment) Claim form and enter their hours worked or studied. If their work trial/study/volunteer work isn't in their rehabilitation plan and has not been approved as part of their return to work, they cannot claim the hours worked when claiming for incapacity and are generally paid 75% of their NWE.

In some cases, the employee is certified by a doctor to be able to work but does not have current employment. The Claims Manager should periodically review these claims to assess the employee's capacity to work, and whether deeming an Ability to Earn is necessary.

Increases to Normal Weekly Earnings

An ex-employee no longer receives increases to their Normal Weekly Earnings (NWE) based on their previous employment agreement. Instead, they have an annual increase on 1 July based on the Wage Price Index. See Statutory rates for compensation.

Pay cycles

Incapacity payments are processed fortnightly (aligned to Commonwealth pay cycles) and deposited into the employee's nominated bank account on Public Service pay day Thursdays. To ensure payments are processed in a timely manner, Comcare sends ex-employees a pay cycle summary in June detailing the dates.

Supporting evidence must be received by 12pm on the Wednesday before Public Service pay day Thursday to enable Comcare to make payment by the Pay Cycle banking date.

Out of cycle payments

If an ex-employee's evidence was not received in time for the Xpay cut-off, they may not be paid along with the usual pay cycle. If the employee is experiencing financial hardship, a Claims Manager can request an Out of Cycle payment (OCP) from the Xpay team, and an OCP can be arranged. An employee will generally receive their payment within about three working days, or in line with the next pay cycle.

The OCP request should include the following:

- background/circumstances
- period
- reason
- document number/folio numbers (Payslip or ROE)
- priority - high/low.

Superannuation

Superannuation is not payable in relation to incapacity payments paid directly by Comcare. This is because Comcare is the workplace insurer and not the employer, and there is therefore no obligation on Comcare under the Superannuation Guarantee to pay superannuation to the employee. For more information, see Superannuation contributions for employees on Xpay.

Taxation

Comcare is required to pay tax on the ex-employee's incapacity payments as required under Australian taxation legislation. Employees can access their payment summary information through myGov/ATO. Information is provided to employees by Income Support before the end of the financial year about:

- reporting Comcare payments to the Australian Tax Office
- financial year Income Statement
- lump Sum E payment.

After-tax payments

Employees may query why the amount deposited into their bank account is different from the amount in their determination letter. The amounts on determination letters are gross amounts. When an employee is set up for Xpay Aurion, Comcare asks them to nominate whether they will be declaring the tax-free threshold for Comcare payments, and their fortnightly income tax is based on this declaration. If there is a reason they need to change their tax declaration or pay additional tax, they need to let the Income Support team know in writing. You can check the after-tax amount an employee has received by looking at the 'Direct Pay' tab for an incapacity line.

Rehabilitation for ex-employees

A separated employee may still be entitled to rehabilitation and return to work support. For separated employees, their rehabilitation authority is their former Commonwealth agency employer. For more information on rehabilitation for ex-employees, see Rehabilitation process.

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Reimbursement and other payments

Published 30/06/2025

Reimbursement and other payments

An employee can pay for a service they have received through the compensation process, such as travel costs for medical treatment or aids or appliances, and then seek reimbursement from Comcare. Service providers or employers can send an invoice directly to Comcare for payment.

Payment for medical treatment

Claims for medical expenses may be submitted by the employee (either a receipt or invoice) or by their provider (an invoice) directly to Comcare. Invoices received for treatment go directly to the Claims Administration and Income Support (CAIS) team for processing.

Where invoiced items are not specified in the treatment plan, or fall outside the parameters set in the treatment plan, Pracsys will generate an invoice diary to the relevant Claims Manager for consideration.

Comcare does not necessarily reimburse the full cost of treatment paid. Comcare nominates rates that are considered appropriate for various services. These are based on the Australian Medical Association (AMA) and allied health rates for each state/territory for the particular type of treatment.

Comcare generally issues payment within 30 days of receiving an invoice or receipt. See [What are appropriate costs?](#) for more information on costs for medical treatment.

Roles and responsibilities

The **Claims Manager** is responsible for approving or authorising payment of an invoice or receipt. They must ensure the Treatment Plan is up to date and that they update Pracsys to verify and authorise invoices when they receive a notification to do so; this also includes completing a determination.

The **Finance and Client Services team** in Claims Administration and Support (CAIS) is responsible for processing the invoices or receipts for payment, once authorisation is confirmed by the Claims Manager.

In this section

Invoice and receipt processing

Receipts and invoices from employees, employers and service providers are processed by the Claims Administration and Income Support (CAIS) Team.

In some cases, an invoice will be referred from CAIS to a Claims team for action, such as when the invoice has not been authorised in the Treatment Plan.

This page includes information about when an invoice or receipt may be referred back to the Claims team for review, email addresses for further support, and the Procedure to action invoices and receipts in Pracsys.

Tyro Health

Comcare has partnered with [Tyro Health](#) to provide a faster way for medical, pharmaceutical and allied healthcare providers to submit claim related invoices. Tyro Health (formerly Medipass) has now been available to our eligible providers since March 2022.

This page provides information about the Tyro Health system including dealing with errors, finding out whether a service provider is registered with Tyro Health, service item codes, authorisation of invoices and the importance of treatment plans, and further support.

Invoice and receipt processing

Introduction

Receipts and invoices from employees, employers and service providers are processed by the Financial and Client Services team.

Employees can pay for medical treatment or other services, and then submit their receipts to Comcare for reimbursement. Comcare considers the appropriateness of costs and has nominated fees to be used as a guide. See [What are appropriate costs?](#) for more information.

Service providers (such as medical practitioners) and employers can submit invoices directly to Comcare for payment of agreed services.

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Non-incapacity payment process

When invoices and receipts are received and processed by the Financial and Client Services (CAIS), Pracsys will generate an invoice diary notification to the relevant Claims Manager for consideration when:

- the claim is closed, rejected or undetermined
- there is a determination of no present liability against the claim and a 'cease' indicator has been added to the claim via the 'Manage Denial of Benefits' (MDOB) function
- the treatment has not been authorised by the Claims Manager in the 'Amend Payment Authorisation (Treatment Plan)' (ACTP) function in Pracsys as payable, or
- where invoiced items are not specified in the treatment plan or fall outside the parameters set in the treatment plan.

Claims Managers are required to review and process their Pracsys diaries and review approvals daily to determine if the payment is appropriate and to ensure timely payment processing. See [Determining liability for medical treatment](#) page for further information.

Once the Claims Managers have updated their diaries, Pracsys compiles all verified and approved payments in the evening on scheduled pay run days, allowing the Finance team to process the payments the following day.

There are two pay runs per week that occur for non-incapacity payments. They are:

1. Monday evening
2. Thursday evening

If a public holiday falls on one of these days, the pay run will be rescheduled to another day. Once the payment is processed in the evening before pay run day, Pracsys automatically sends out the remittance advice to the relevant stakeholders.

The Financial and Client Services team's normal timeframe for processing invoices and receipts for payment is 28 days.

Information Capture Document Scanning

The Financial and Client Services (CAIS) and the Information Capture Team (IC Team) processes emails received through General Enquiries, faxes and Email.RMC.

Physical mail items are managed by the Information Management team and are uploaded to the IC team to process on to claim files. If you have questions about physical mail, please contact the Information Management team for assistance. The standard processing time for document scanning is 2 business days.

The CAIS team will post updates three times per week in the MS Teams channel to advise of the current processing timeframes.

For further information on scanning and document management support, refer to the Information Capture page.

Reconsideration requests are prioritized using the Docsys flag system to be processed faster.

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Urgent non-incapacity payment requests

At times an urgent non-incapacity payment or uploading of a document is required. In these cases, please refer to the following process and criteria to determine if your request will be considered urgent.

Please note that if your request does not meet the below criteria, the CAIS Complex team and/or the IC team will close your ticket and advise you that it cannot be actioned urgently.

Urgent criteria for non-incapacity payment requests:

1. Payment for reports for undetermined claims, etc – this requires your Assistant Director approval.
2. Financial hardship/distressed employees – this requires your Assistant Director approval.
3. Reputational risk/media risk – this requires your Director's approval.

If you believe your request meets the above criteria, discuss with your Assistant Director or Director and obtain their approval by email.

For more details on urgent tasks and documents management handled by the IC team, refer to Information capture page.

Please then send the email using the template below to the following:

CAIS-Complex – all non-incapacity payments.

IC Help desk – all document related queries.

Template for urgent requests

Claim Number: [Insert Claim Number]

Requested Item: [Specify what is required. If referring to a payment, use the DOC ID in Pracsys, not the folio number, as folios may change when documents are added.]

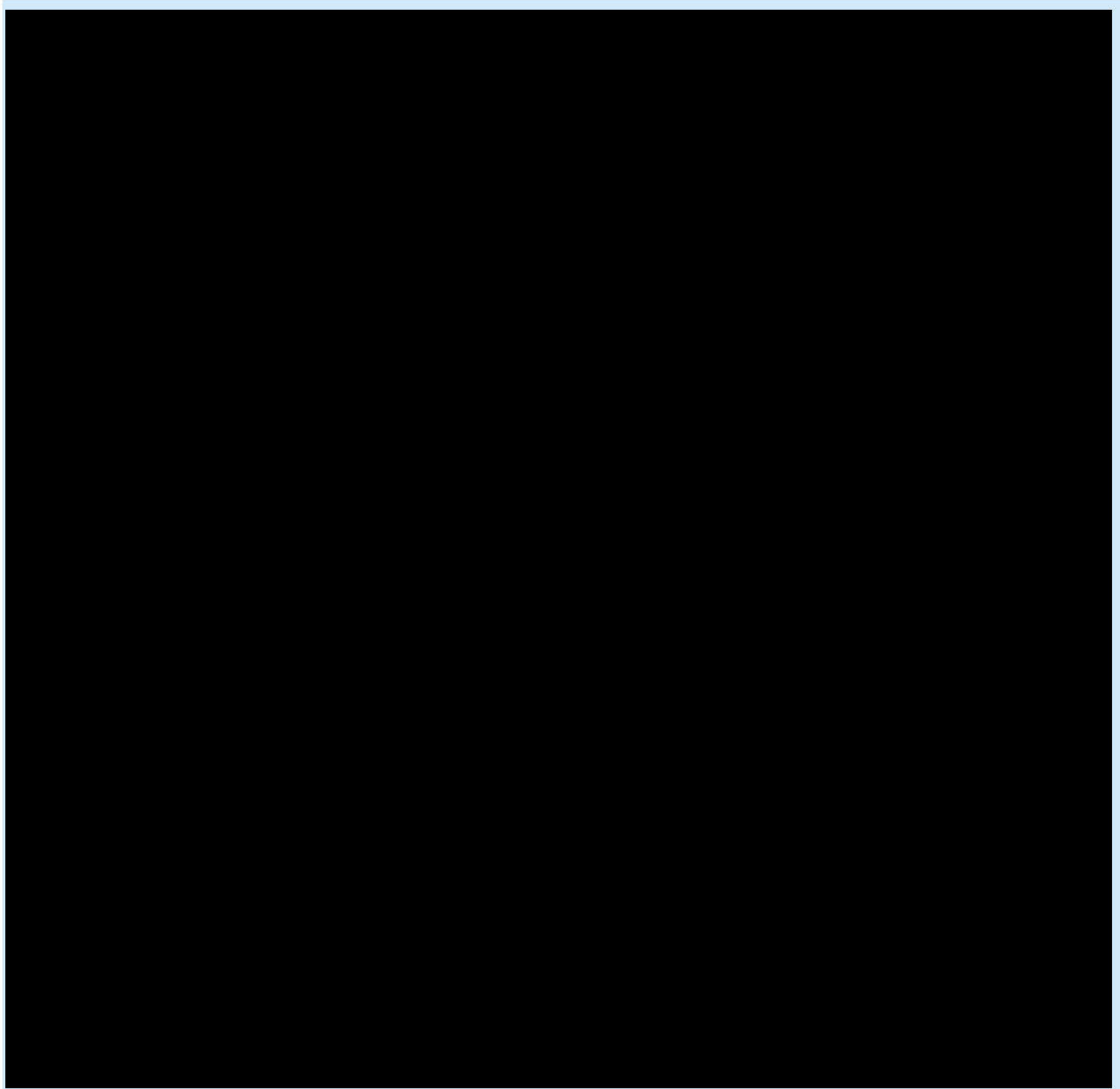
Reason for Urgency: [Detail why the matter meets the urgent criteria.]

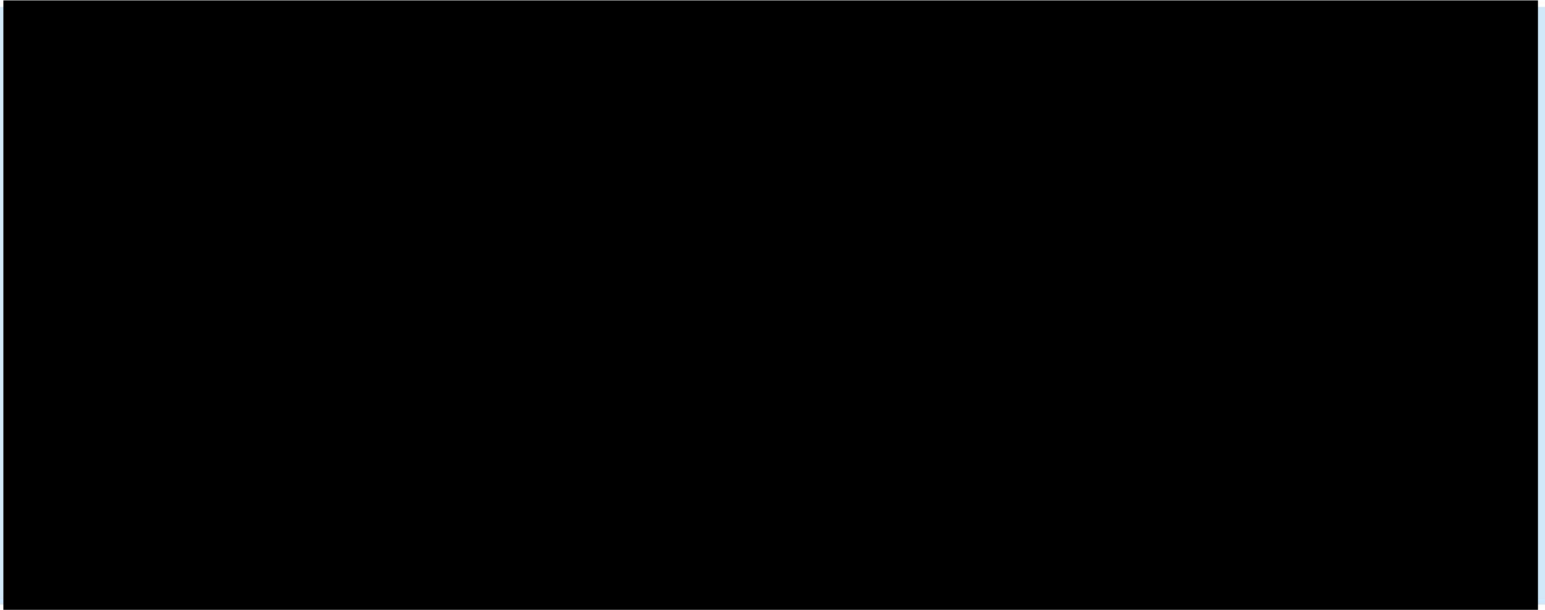
Assistant Director/Director Approval: [Attach approval email from Assistant Director or Director.]

Remember to 'just ask'

If you discover something that does not look right, feel right or when you discover concerning or previously undisclosed information either from the employee or another source (employer, rehabilitation provider etc) that is relevant and has the potential to impact the management of a claim, please refer to the "[Just Ask](#)" process.

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Introduction

Comcare has partnered with Tyro Health to provide a faster way for medical, pharmaceutical and allied healthcare providers to submit claim-related invoices. Tyro Health has now been available to our eligible providers since March 2022.

Tyro Health is a secure digital payment platform used by healthcare providers that allows them to submit and track the progress of their claim-related invoices and receive digital remittance advice through the secure digital platform.

By collaborating with Tyro Health, Comcare aims to reduce the financial burden on service providers by improving the processing timeframes for most invoices. Tyro Health allows the processing and payment of approved invoices by the next business day.

Further information about Tyro Health can be found through the Tyro Health Help Centre

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Can providers use Tyro Health to send through invoices for all claims?

Yes, providers can use Tyro Health to submit invoices for any claim.

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What if the provider is getting an error message for a specific claim?

Providers need to input a claim number and date of birth to create an invoice in Tyro Health. Tyro Health matches the claim number and date of birth to Pracsys. If it matches, then the Tyro Health invoice can be created.

If the details do not match what is recorded in Pracsys, the provider will not be able to submit an invoice. If the provider has incorrect details, ask them to confirm details with the employee before submitting the invoice. **DO NOT GIVE THE PROVIDER THE CORRECT DETAILS** due to privacy.

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Can a provider send through a paper invoice if they are registered for Tyro Health?

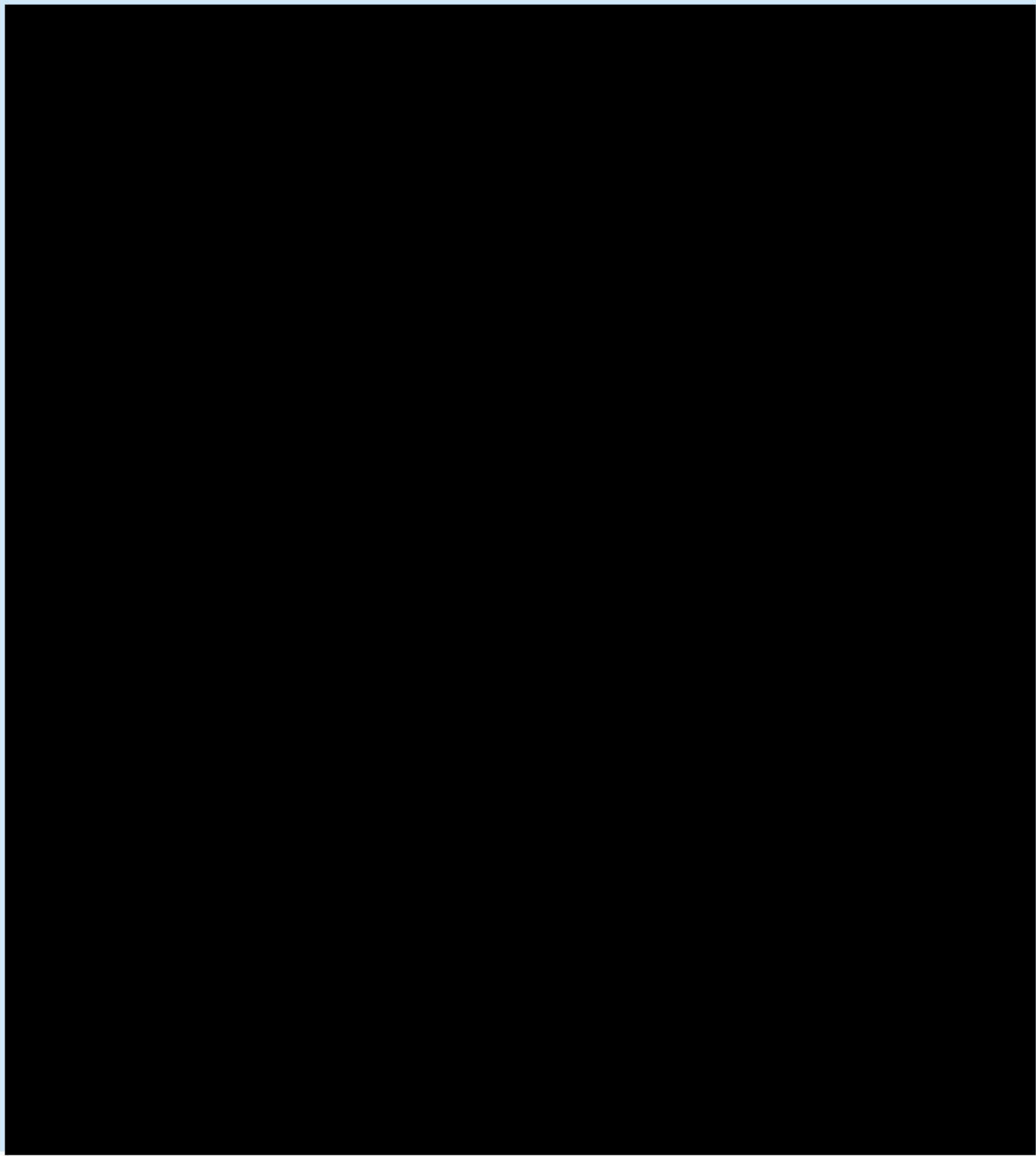
No. Once a provider has signed up to Tyro Health, they can no longer submit paper or electronic invoices to Comcare for manual processing as Pracsys will not allow the invoices to be created

manually.

If a service provider submits an invoice through Tyro Health and then submits a copy of the invoice to Comcare via post or electronically through the general enquiries email address, the Claims Administration and Income Support (CAIS) team will review the invoice and return it to the provider. They will ask the provider to submit their invoices through the Tyro Health Portal.

If the service provider is experiencing issues with the Tyro Health portal, please direct them to Tyro Health Support.

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Tyro Health FAQs - service items, rates and invoices

Providers that sign up to Tyro Health will have access to the service item codes assigned to their provider type. For example, physiotherapists will have access to all the physiotherapy codes that are stored in Pracsys.

There may be some medical providers that do not have codes. For example, Assistant Surgeons do not have codes in Pracsys. They may need to just enter a custom description of the service provided (they can include a service item number if they have one).

All Providers have access to the following 4 codes:

	Item Code in Tyro Health	Description
For Reports with examination	EXAMN	Report – Section 57(3) costs
Case Conference	OCACO	Case conference Non-GP
For any reports or clinical notes	REPOR	Claim Inv-Med rep/clinic notes
Any other medical item that does not have a code	GSTMD	Medical other – taxable supplies

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Authorisation to pay invoices and updated Treatment Plan

All rates in Tyro Health are the same as the rates in Pracsys.

Invoices submitted through Tyro Health must be verified and authorised, the same as for invoices in Pracsys. For example, line items over \$2000 need manual verification.

There is a 'view document' button in the View Invoice Screen. This shows a PDF of the invoice details that have been submitted through Tyro Health.

Please ensure that the correct provider is listed in the Treatment Plan for Physiotherapy and Psychology to allow payment of invoices.

Please ensure Treatment Plans are kept up to date so that invoices can be actioned and paid efficiently. See Procedure to action invoices and receipts for instructions on authorising invoices for payment.

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Support and resources

For any enquiries relating to the Tyro Health portal, please direct providers to Tyro Health Support. Tyro Health do not have a direct support number. The preference is the chat function on their website or email.

For help with Tyro Health issues that are not specific to the Tyro Health portal, please direct enquiries to Comcare Tyro Health Support.

If you have a provider that is interested in signing up to Tyro Health, please refer them to Invoicing and Payment on our website.

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Overpayments and recoveries

Overpayments and recoveries

Overpayments and recoveries are a sub-stage within the Claim Management stage of the claims lifecycle outlines the how overpayment can occur and how it can be recovered. The CAIS Debt Recovery Team oversees all the employee overpayment recoveries, and related queries should be directed to them. For employee related recoveries, documentation and notifications must be submitted to the Debt recovery team via Pracsys. Comcare is also responsible for recovering debts before considering any waivers or write offs. Additionally, the Specialist Claims Team (SCT) manages third-party and common law recoveries under sections 48 and 50 of the SRC Act, and all related correspondence should be sent to the SCT in tray in Pracsys.

In this section

Overpayments

An overpayment occurs when Comcare pays a person (employee, employer or service provider) more than they are legally entitled to receive. An overpayment is a debt due to the Commonwealth and is recoverable in a court of competent jurisdiction.

The CAIS Debt Recovery Team is responsible for all actions related to the recovery of overpayments. Any changes, question or issues with the recovery of an employee's overpayment should be raised with the Debt Recovery Team. This page also contains information on:

- What is an Overpayment?
- How do overpayments occur?
- Amount should not have been paid to a person that should not have been paid
- Non-incapacity related overpyaments
- Amount paid as a result of a false statement or misrepresentation
- Consideration for recovering an overpayment

Medicare notice and recoveries

In certain circumstances, Comcare will need to advise Medicare of the acceptance of a claim, seek information from Medicare and pay Medicare, before payment to the employee can be made. This page provides information on:

- What are the scenarios when the HOSC Act applies?
- Comcare cannot pay compensation until Medicare bill is paid
- Obtaining a Medicare History Statement and Notice of Past Benefits
- Deemed notice of past benefits or notice of charge
- Expired notice of past benefits
- Section 23A statement
- Refunding Medicare and releasing compensation payments
- Procedure for notifying Medicare of a judgement or settlement
- Actioning a Notice of Past Benefits or Notice of Charge for a Judgment or Settlement

- Procedure for actioning a notice of past benefits or notice of charge for a judgement of settlement
- Advance payments for judgements or settlements
- Procedure for arranging an advance payment for a judgement of settlement
- Procedure for notifying Medicare of a reimbursement arrangement
- Actioning a notice of past benefits or notice of charge for a reimbursement arrangement
- Procedure for actioning a NOPB or NOC for a reimbursement arrangement
- Actioning a valid deemed notice of past benefits or notice of charge
- Procedure for actioning a valid deemed NOPB or NOC
- Procedure for actioning a refund from Medicare
- Medicare contact details

Third party and common law recoveries

The Specialised Claims Team (SCT) manages all actions related to the recovery of compensation from liable third parties under section 48 of the SRC Act and provides instructions to the Legal team regarding recoveries under section 50. You should forward all third party recovery related diary and document notifications (e.g. letters from insurers/ solicitors) to the SCT team in-tray in Pracsys. This page provides information on:

- Comcare's role in recovering common law payments (Third party recoveries)
- Third party recoveries

Overpayments recoveries processes and defaulting relating to employees

This page contains information regarding key actions each team is responsible for when overpayments occur and recovered, including communicating with the relevant teams to ensure the appropriate steps are taken promptly.

- Roles and responsibilities
- Informing the employee of their overpayment
- Recovering overpayments
- Defaulting on payments
- Recovering overpayments from a deceased estate
- Non compensation Garnishee payments
- Recovering income tax from employees
- Recovery categories in Pracsys
- Notifying debt recovery about overpayments

Waivers and write-offs

Comcare has a responsibility to recover debts where an employee, employer or service provider receives money they are not entitled to receive. Recovery action must be initiated in most cases prior to any consideration for the write off or waiver of a debt. Only in certain circumstances will Comcare decide to write off or waive an overpayment.

The Debt Recovery team is responsible for preparing submissions for write off and waivers. This page provides information on:

- Who can request a write off or waiver of an overpayment?
- Write off of an overpayment

- Types of write offs
- Waiver of an overpayment
- Circumstances where an overpayment can be waived
- Appealing the decision to waive a debt
- Preparing a write-off or waiver submission

Overpayments

Published 31/07/2025

Introduction

The CAIS Debt Recovery Team are responsible for all actions related to the recovery of overpayments except for third party recoveries.

Effective from 1 July 2025 this will include Medicare recoveries and medical overpayments. This was previously managed by the CAIS Complex team. Any changes, questions or issues with the recovery of an employee's overpayment should be raised with the Debt Recovery Team.

Any changes, questions or issues with the recovery of an employee's overpayment should be raised with the Debt Recovery Team.

What is an Overpayment?

An overpayment occurs when Comcare pays a person (employee, employer or service provider) more than they are legally entitled to receive. An overpayment is a debt due to the Commonwealth and is recoverable in a court of competent jurisdiction.

When an overpayment occurs, Comcare has a responsibility to first recover the debt owed. Recovery action must be initiated in most cases prior to any consideration for the write-off or waiver of a debt.

There are two main types of payments that can lead to overpayments:

- incapacity payments – financial compensation for loss of earnings, and
- non-incapacity payments – payments not related to incapacity (i.e. medical expenses, rehabilitation and permanent impairment payments).

Sections 113 and 114 of the SRC Act provide the specific legislative provisions for overpayments.

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How do overpayments occur?

Overpayments can occur in a range of circumstances. However, the most common causes of overpayments include but are not limited to:

- an amount of compensation should not have been paid to a person
- an amount of compensation has been paid to a person as a result of a false or misleading statement/representation or due to a failure or omission to comply with the SRC Act, or
- the employee has received an award or damages settlement through a third party, State workers compensation or other State compensation.

Overpayments may occur as the result of a reconsideration or reconsideration of own motion. See the [Reconsideration](#) pages for more information.

Amount should not have been paid

This is the most common form of incapacity and non-incapacity overpayment and occurs when an amount of compensation has been paid to a person that should not have been paid.

An incapacity overpayment can occur in the following circumstances:

- Comcare makes an error (e.g. data is entered incorrectly into the system).
- An employer does not advise Comcare immediately of changes to an employee's Normal Weekly Earnings (NWE) (e.g. they do not include reductions to higher duties, overtime and/or other payable allowances).
- Superannuation has not been considered or there has been a change to the superannuation payment rate.
- Comcare receives advice of actual earnings from an Xpayee who has recommenced employment after payments have been made.
- A determination has been reviewed which changes the outcome, resulting in an overpayment (e.g. reconsideration or Administrative Review Tribunal decision).
- Compliance activities have identified instances of undeclared income.
- Comcare receives late advice about the death of an employee after payments have been made.
- An employee is imprisoned and the Claims Manager is not informed.

Non-incapacity related overpayments

Non-incapacity related overpayments can occur when:

- an incorrect employee or service provider is paid
- an employee or service provider is paid an incorrect amount
- duplicate payments are made to either the employee or service provider
- money prepaid for travel is not used
- a determination has been reviewed which changes the outcome, resulting in an overpayment (e.g. reconsideration or ART decision) of a determination
- a Common law or third-party settlement is reached
- there is a discovery of an overpayment through compliance activities, a claim review or following an audit of the claim
- an amount was paid as a result of a false statement or misrepresentation.

Example: An employee has submitted receipts related to their compensable condition for reimbursement. These receipts are mistakenly paid to the provider instead of the employee. This results in an overpayment in which the provider needs to be notified, and funds need to be recovered from the incorrect party and reimbursed to the correct party.

Amount paid as a result of a false statement or misrepresentation

An overpayment can occur when a person receives an amount of compensation as a result of a false or misleading statement or representation, or due to a failure or omission to comply with a provision of the SRC Act.

A person can be said to have made a deliberately or intentionally false or misleading statement in a situation where they have actual knowledge that their statement or representations are false or where they know they did not comply with the provisions of the SRC Act. Actual knowledge should be decided based on the facts of the claim and the circumstances in which the fraud occurred.

Example: An employee has an accepted claim for compensation for a back injury that occurred at work in the photocopying room when they lifted a heavy box. Ten years into the life of the claim, the employee is continuing to receive incapacity payments until new evidence indicates the employee's condition has resolved. Comcare reviews the claim and finds that the employee's injury resolved eight years ago. The employee later admits to falsely claiming compensation in respect of their back injury. Accordingly, Comcare revokes liability for all incapacity and medical treatment claims previously paid since the recovery.

Liable to pay an amount to Comcare

An overpayment can occur when a person is in receipt both of incapacity/non-incapacity benefits and of third-party or common law damages in relation to the same incident. Where compensation has been paid to a person and the person is subsequently awarded third-party or common law damages, the person is liable to pay an amount of compensation back to Comcare.

Example: An employee submits a claim for a neck injury after they were involved in a motor vehicle accident while travelling for work purposes. The claim is accepted by Comcare. However, the employee later decides to make a third-party claim. The matter is settled outside of court and third-party damages are awarded to the employee in respect of the motor vehicle accident. In this instance, the employee must repay any monies that Comcare has paid to them.

Overpayments raised by Compliance activities

Sometimes when the Claims Compliance and Assurance Team (CCAT) completes a compliance activity, they may find invalid invoices, receipts or instances of undeclared income.

In these instances, Comcare will consider raising an overpayment to recover the monies owed to Comcare.

If CCAT decides to raise an overpayment in relation to the invalid invoices or receipts or the undeclared income, they will work closely with the Claims Manager, Assistant Director and CAIS to recover the monies from the employee or service provider.

Please see the [Claims Compliance and Assurance Team procedure](#) for managing corrective action overpayments.

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Considerations for recovering an overpayment

When an overpayment occurs and before recovery action is initiated, and the Debt Recovery Team will consider the following:

- the statute of limitations
- the cost effectiveness of recovery, and
- the ability of the employee to repay the debt.

These factors will be examined together with the cause of the overpayment to determine appropriate action.

Statute of limitations

A statute of limitations is legislation that sets the maximum time after an event, that legal proceedings based on that event may be initiated. Each state and territory have their own legislation. When recovering an overpayment, the limitation period is the set time within which Comcare can recover overpayments in a court of competent jurisdiction as a debt owed to Comcare.

Where legal action is barred by the statute of limitations, a debt is not able to be recovered successfully by civil action through the courts. If the statute of limitations applies and an overpayment is unable to be recovered, the Debt Recovery Team will pursue a write off/waiver of the debt.

The limitation period in all states and territories is 6 years, except for the Northern Territory which has a limitation period of 3 years.

Cost Effectiveness

If all previous attempts at recovery have failed, the Debt Recovery Team will consider the cost effectiveness of the recovery process. If it is not economical to pursue recovery of a debt, Comcare does not have to institute recovery proceedings.

If the costs associated with the recovery of a debt from a debtor are greater than the debt, recovery is not cost effective. If recovery is not cost effective, the Debt Recovery team may need to pursue the wavier of the debt, noting that the Debt Recovery team will make this recommendation to the General Manager.

See the Recoveries processes and defaulting relating to employees and Waivers and write-offs pages for more information.

Ability of the employee to repay

If an employee is overpaid, depending on the size of the debt compared to the employee's weekly benefit or lump sum received, the Debt Recovery team may need to assess an employee's financial circumstances to decide:

- whether the debt should be recovered
- the rate of recovery, and
- whether a write-off or waiver should be pursued.

This is done by asking the employee to complete the [Statement of Financial Circumstances](#) form. When a Statement of Financial Circumstances form has been completed and returned, the Debt Recovery team must assess the information stated on the form to determine an appropriate repayment amount. The Debt Recovery team will undertake this process and communicate directly with the employee to make this assessment.

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Medicare notice and recoveries

Published 06/10/2025

Introduction

Services Australia administers and manages the notification requirements of the *Health and Other Services (Compensation) Act 1995* (HOSC Act), which operates to ensure that the Commonwealth recovers any Medicare benefits paid to an employee where an insurer is liable for the injury or illness.

The purpose of the HOSC Act is to prevent 'double-dipping' from occurring where an employee claims medical benefits via Medicare for an injury for which they are subsequently compensated.

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What are the scenarios when the HOSC Act applies?

The HOSC Act applies to the following Comcare scenarios:

- Where a claim for Permanent Impairment (PI) is accepted (excluding interim PI payments) of \$5,000 or more, whether that decision is an outcome of a primary determination, reviewable decision or ART/Court decision. These are judgments or in the case of an ART consent decision, settlements. For further guidance and information to support you through the PI and HOSC Act process, refer to the [Accepting a PI and the HOSC Act flowchart](#).
- Where a claim is accepted under section 14 of the SRC Act **6 months after the date the claim was lodged**, where there will be medical expenses (section 16), whether that decision is an outcome of a primary determination, reviewable decision or ART/Court decision. The amount of any potential medical payments does not matter. This is a reimbursement arrangement.
- Where medical expenses (section 16) have ceased and later **reinstated 6 months or more after the date of determination** to cease medical treatment was made, whether that decision is an outcome of a reviewable decision or ART/Court decision. This is also a reimbursement arrangement.

These matters above are notifiable within 28 days after the judgment/settlement or reimbursement arrangement has been made, noting that there are specific arrangements we have in place in relation to permanent impairment. For further guidance and the steps to follow see the **Procedure for notifying Medicare of a judgement of settlement** section below.

Comcare is required to notify Medicare by using the Notice of Judgment or Settlement (NOJS) form or the Notice of Reimbursement Arrangement (NORA) form (whichever is applicable) available on the Services Australia website.

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Comcare cannot pay compensation until Medicare bill is paid

Comcare is unable to pay an employee any part of the compensation payment (being the PI/NEL payment in the case of a judgment or settlement or any medical treatment compensation in the case

of a reimbursement arrangement) until Medicare is paid the amount owed (*note: this may be nil*).

Section 26(1) of the SRC Act provides that an amount of compensation payable to an employee under section 24 (for PI) shall be paid to the employee within 30 days after the date of the assessment amount. However, under section 30 of the HOSC Act, liability to pay compensation is suspended until such time as any amount owed to Medicare is paid.

Comcare's liability to pay an employee interest under section 26 for a late payment of PI is also suspended.

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Obtaining a Medicare History Statement and Notice of Past Benefits

Comcare lodges a request to Medicare to issue a Medicare History Statement to the employee by using the Medicare History Statement Request form.

Medicare will issue the History Statement directly to the employee to be completed and returned to Medicare. The employee is required to indicate which benefits in the statement relate to their compensable condition. Once the employee returns the completed History Statement, Medicare then issues a Notice of Past Benefits (NOPB) to Comcare.

The NOPB lists the services the employee has received (if any) in relation to the compensable injury. If no services related to the compensable injury, Medicare will issue Comcare with a NOPB with a nil amount.

If a judgment/settlement or reimbursement arrangement occurs within 6 months of the NOPB being issued it will become a 'Notice of Charge' (NOC).

If a NOPB becomes a NOC Comcare must pay Medicare the amount specified in the NOC within 28 days of the date of judgment/settlement or reimbursement arrangement. The amount specified in the NOC is paid to Medicare and the remainder of the compensation amount is paid to the employee.

A NOPB is only valid for 6 months. If the NOPB has expired and a judgment/settlement has occurred, then Comcare may make an advance payment (see **Advance payments for judgements or settlements** section below) rather than requesting a new History Statement/NOPB.

For PI matters, as soon as a PI claim is received the notification process commences by Comcare contacting the employee to discuss the process (refer to the Assessing and determining a PI claim page) and lodging a Medicare History Statement Request form to Medicare.

For section 14 primary determinations or disputed claim matters (where there will be section 16 medical expenses) the notification process commences once a claim is accepted more than 6 months after it was lodged (refer to the **Procedure for notifying Medicare of a reimbursement arrangement** section below). For section 14 ART matters (where there will be section 16 medical expenses), the notification process should commence once the ART matter is registered by Comcare.

For section 16 determinations (i.e. reviewable or ART/Court decisions) the notification process commences after a cease determination has been reinstated 6 months or more after the date of

determination to cease medical treatment was made (refer to the **Procedure for notifying Medicare of a reimbursement arrangement** section below).

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Deemed notice of past benefits or notice of charge

Where the employee fails to complete or return the History Statement to Medicare within the required time, Medicare will issue a 'deemed' NOPB or NOC to Comcare which deems all the services listed in the History Statement as relating to the compensable injury.

- Under the HOSC Act, Comcare is required to pay the full amount of the deemed NOPB or NOC to Medicare. The amount payable by Comcare to Medicare cannot be more than the amount of compensation awarded (being the PI/NEL entitlement in the case of a judgment/settlement).
- In the case of a reimbursement arrangement, the medical treatment payable from the date of injury/date of treatment reinstatement, to the date of the deemed notice).

The amount paid to Medicare is then deducted from the compensation payable to the employee. Subsection 31(1) of the HOSC Act provides that our payment of the NOC to Medicare operates as a discharge of our liability to pay the employee that amount of compensation. That is, once an amount of compensation is paid to Medicare it discharges our liability to pay that amount to the employee.

A deemed NOPB or NOC is treated the same as a NOPB. However, Medicare cannot be requested to amend a deemed NOPB or NOC. An employee has two years from the date of the judgment/settlement or reimbursement arrangement to complete a Medicare History Statement confirming which services relate to the compensable condition. If the employee has not claimed any services, they should still complete a History Statement with a Section 23A Statement (statutory declaration) and send the forms to Medicare. Medicare will assess the matter further, issue Comcare with an amended NOPB or NOC and reimburse Comcare any overpaid amount (if applicable).

Receiving a refund from Medicare

Refunds from Medicare are deposited into Comcare's bank account and the Finance team will identify the deposit as being claims related.

The Finance team advises the Reconciliations team in CAIS of any claim related deposits. The Reconciliations team then allocate this recovery of the funds against the appropriate claim in Pracsys.

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Expired notice of past benefits

If a judgment/settlement is made after the NOPB has expired or where a NOPB has not been issued, then Comcare will complete the NOJS form. If the employee claimed any benefits through Medicare, they may wish to make a Section 23A Statement. If the employee does not make a Section 23A statement, then Comcare will likely proceed to make an advance payment to Medicare.

Where a reimbursement arrangement is made after the NOPB has expired or where no NOPB has been issued, Comcare will complete the NORA form and send it to Medicare. Medicare will then ask the employee to complete a History Statement and will then issue a NOPB or NOC to Comcare.

Comcare cannot release the compensation payment to the employee until either an advance payment is made to Medicare or a NOC is paid to Medicare (refer to **Advance payments for judgements or settlements** section below).

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Section 23A statement

In the case of judgment/settlement, the HOSC Act provides that the employee may make a Section 23A Statement where a NOPB has not been issued by Medicare within the previous 6 months.

In making a Section 23A Statement the employee is declaring that:

- no Medicare benefits have been received for the compensable condition, or
- no further Medicare benefits have been received in relation to their compensable condition since the expired NOPB was issued.

A Section 23A Statement must be sent to Medicare with the NOJS form.

If a Section 23A Statement is lodged, Medicare will issue Comcare a NOPB or NOC within 28 days, however Comcare does not need to wait for the NOPB or NOC to be issued. Comcare can proceed with paying the employee the compensation payment as soon as the Section 23A Statement has been lodged with Medicare.

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Refunding Medicare and releasing compensation payments

For PI/NEL, Comcare is required to **deduct the amount payable to Medicare from the employee's compensation payment**. The compensation payment is limited to the amount awarded, being the combined PI/NEL entitlement.

For claims accepted under section 14 of the SRC Act 6 months after the date the claim was lodged where there are medical expenses, the compensation payment is the medical treatment expenses payable **between the date of injury and the date of the NOPB or NOC**.

For claims where payment of medical expenses has been ceased and then reinstated 6 months or more after they were ceased, the compensation payment is the medical treatment expenses **between the date of the cease and the date of the NOPB or NOC**.

Refunding Medicare

Email CAIS – FCS Complex and advise the amount as specified in the NOC to be paid to Medicare.

Releasing compensation payments

The compensation amounts payable to the employee are paid as per normal payments processes.

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The first part of the paper discusses the importance of understanding the cultural context of the research. It highlights how cultural differences can influence the interpretation of data and the design of the study. The author emphasizes the need for researchers to be sensitive to these differences and to adapt their methods accordingly.

The second part of the paper focuses on the challenges of conducting research in a multicultural environment. It discusses the difficulties of finding a common ground between different cultural perspectives and the potential for misunderstandings. The author suggests that researchers should strive for transparency and open communication throughout the research process.

The third part of the paper explores the role of ethics in multicultural research. It discusses the importance of obtaining informed consent from participants and the need to protect their privacy. The author also touches on the issue of data ownership and the potential for cultural appropriation.

The fourth part of the paper discusses the importance of collaboration in multicultural research. It highlights the benefits of working with local researchers and community members who have a deep understanding of the cultural context. The author suggests that researchers should build trust and rapport with their participants and work together to develop a shared understanding of the research goals.

The fifth part of the paper discusses the importance of reflexivity in multicultural research. It encourages researchers to reflect on their own cultural biases and how these might influence their research. The author suggests that researchers should keep a journal and engage in self-reflection throughout the research process.

The sixth part of the paper discusses the importance of communication in multicultural research. It highlights the need for clear and concise communication and the use of appropriate language and tone. The author suggests that researchers should be aware of the cultural norms of their participants and adapt their communication style accordingly.

The seventh part of the paper discusses the importance of documentation in multicultural research. It highlights the need for thorough and accurate record-keeping and the use of appropriate formats and tools. The author suggests that researchers should document their research process and findings in a way that is accessible and understandable to their participants and the wider community.

The eighth part of the paper discusses the importance of dissemination in multicultural research. It highlights the need for researchers to share their findings with their participants and the wider community. The author suggests that researchers should use a variety of communication channels and formats to reach their audience and ensure that their findings are accessible and understandable.

The ninth part of the paper discusses the importance of evaluation in multicultural research. It highlights the need for researchers to assess the impact of their research and the effectiveness of their methods. The author suggests that researchers should use a variety of evaluation tools and formats to assess their research and ensure that it is meeting its goals.

The tenth part of the paper discusses the importance of reflection in multicultural research. It encourages researchers to reflect on their own experiences and the experiences of their participants. The author suggests that researchers should keep a journal and engage in self-reflection throughout the research process.

Actioning a Notice of Past Benefits or Notice of Charge for a Judgment or Settlement

Where a judgment or settlement has been made, and there is a valid Notice of Past Benefits (NOPB) this becomes a Notice of Charge (NOC). Comcare must pay Medicare the full amount specified in the notice within 28 days of the date of the judgment or settlement. Once the notice has been paid, the compensation payments (accepted Permanent Impairment and Non-Economic Loss) can be released to the employee.

Important: Where there is a valid NOPB/NOC at the time of judgment or settlement, Comcare should aim to pay Medicare and the employee as soon as practicable within judgment or settlement being made. However, Comcare allows the employee 14 days to consider whether they wish to elect to sue the Commonwealth rather than receive the PI payment. Therefore, this procedure should not commence until that 14 day period has expired. If the employee or their solicitor has given an undertaking that they will not be electing to sue, commence this procedure.

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Advance payments for judgements or settlements

Advance payments are only relevant to PI determinations, and not section 14 matters.

When Comcare makes a decision to accept a PI, Comcare may arrange to pay Medicare an advance payment of 10% of the amount of compensation payable to the employee if:

- a NOPB has not been issued by Medicare in the 6 months prior to the date the judgment or settlement was made (see below further information regarding NOPB), and
- the compensation payable to the employee under the judgment/settlement is more than \$5000.

Comcare must have advised Medicare (in the NOJS form) that we intend to make an advance payment. Comcare must also have advised the employee, in writing, that we intend to make an advance payment (see below for further information on advising the employee).

Medicare must receive the advance payment within 28 days of the judgment or settlement. However, Comcare allows an employee 14 days to consider whether they wish to elect to sue the Commonwealth rather than receive the PI payment. Therefore, this procedure should not commence until that 14 day period has expired. If the employee or their solicitor has given an undertaking that they will not be electing to sue, commence this procedure.

Where an advance payment is made, Comcare's liability to Medicare is discharged and the balance of 90% can be paid to the employee.

When Medicare receives the advance payment, it will issue a Medicare history statement to the employee to complete and return within 28 days to enable Medicare to work out any amount owing. If the advance payment does not cover the amount owing to Medicare, the employee is required to pay Medicare the difference. If the advance payment is more than the amount owing to Medicare,

then Medicare will pay the difference directly to the employee. The employee will need to contact Medicare concerning any refunds owed to them.

Where there is a valid NOPB at the date of judgment/settlement OR where the employee has made a Section 23A Statement, an advance payment is not applicable.

Advance payments cannot be made for reimbursement arrangements.

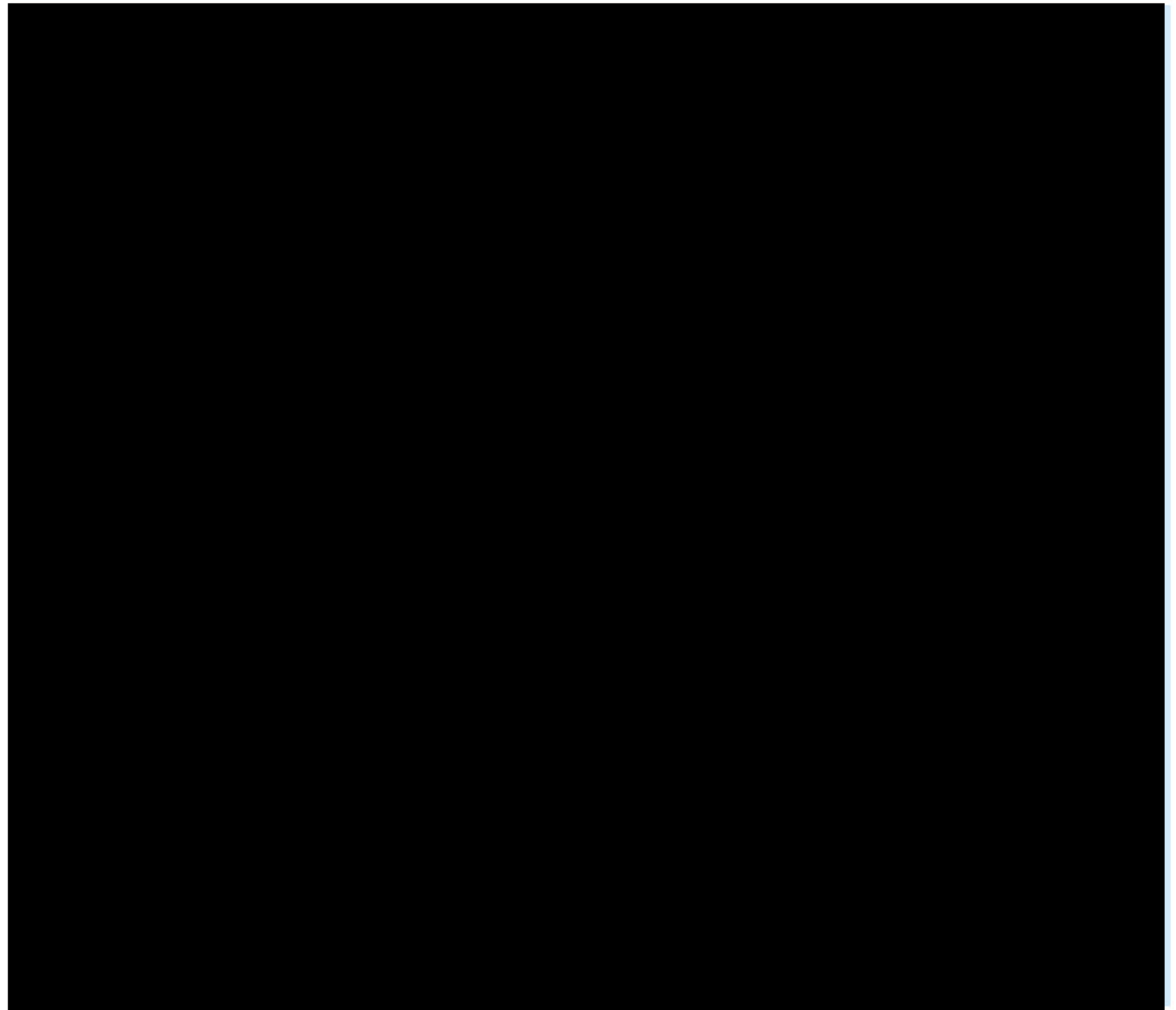
Notice to employee of intention to make advance payment

If Comcare intends to make an advance payment we must notify the employee of the following in writing:

- that Comcare may make an advance payment if a judgment/settlement is reached
- that prior to making an advance payment we will advise the employee of the amount of the advance payment
- the circumstances in which Medicare can retain some or all of the advance payment (i.e. once Medicare has issued a NOPB any amount owed to them will be retained by Medicare)
- the circumstances in which the employee will be required to make an additional payment to Medicare (i.e. if the advance payment does not cover the amount owing to Medicare, the employee is required to pay Medicare the additional amount).

Once a judgment or settlement is reached (e.g. a PI/NEL entitlement has been determined), if Comcare intends to make an advance payment then we must advise the employee of the above prior to making the payment.

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Actioning a notice of past benefits or notice of charge for a reimbursement arrangement

Where a reimbursement arrangement has been made, and there is a valid Notice of Past Benefits (NOPB) this becomes a Notice of Charge (NOC). Comcare must pay Medicare the full amount specified in the notice within 28 days of the date of the reimbursement arrangement being made. Once the notice has been paid, the compensation payments (accepted medical treatment expenses) can be released to the employee.

Where there is a valid NOPB/NOC at the time a reimbursement arrangement is made, Comcare should aim to pay Medicare and the employee as soon as practicable within the reimbursement arrangement being made.

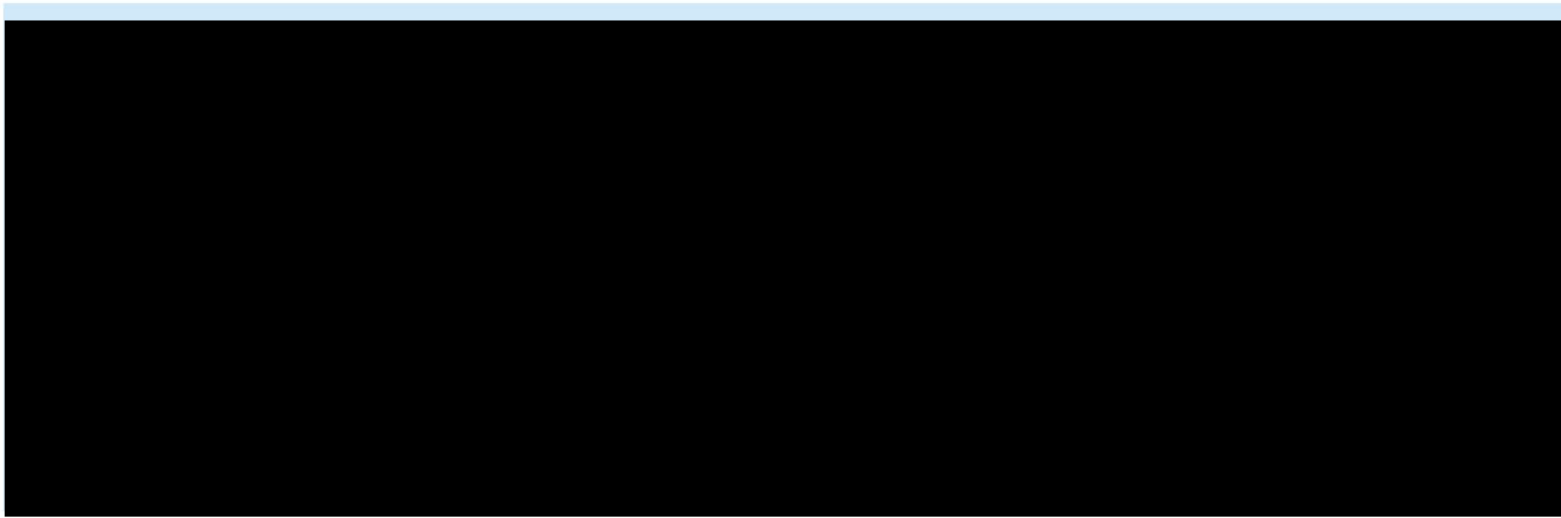
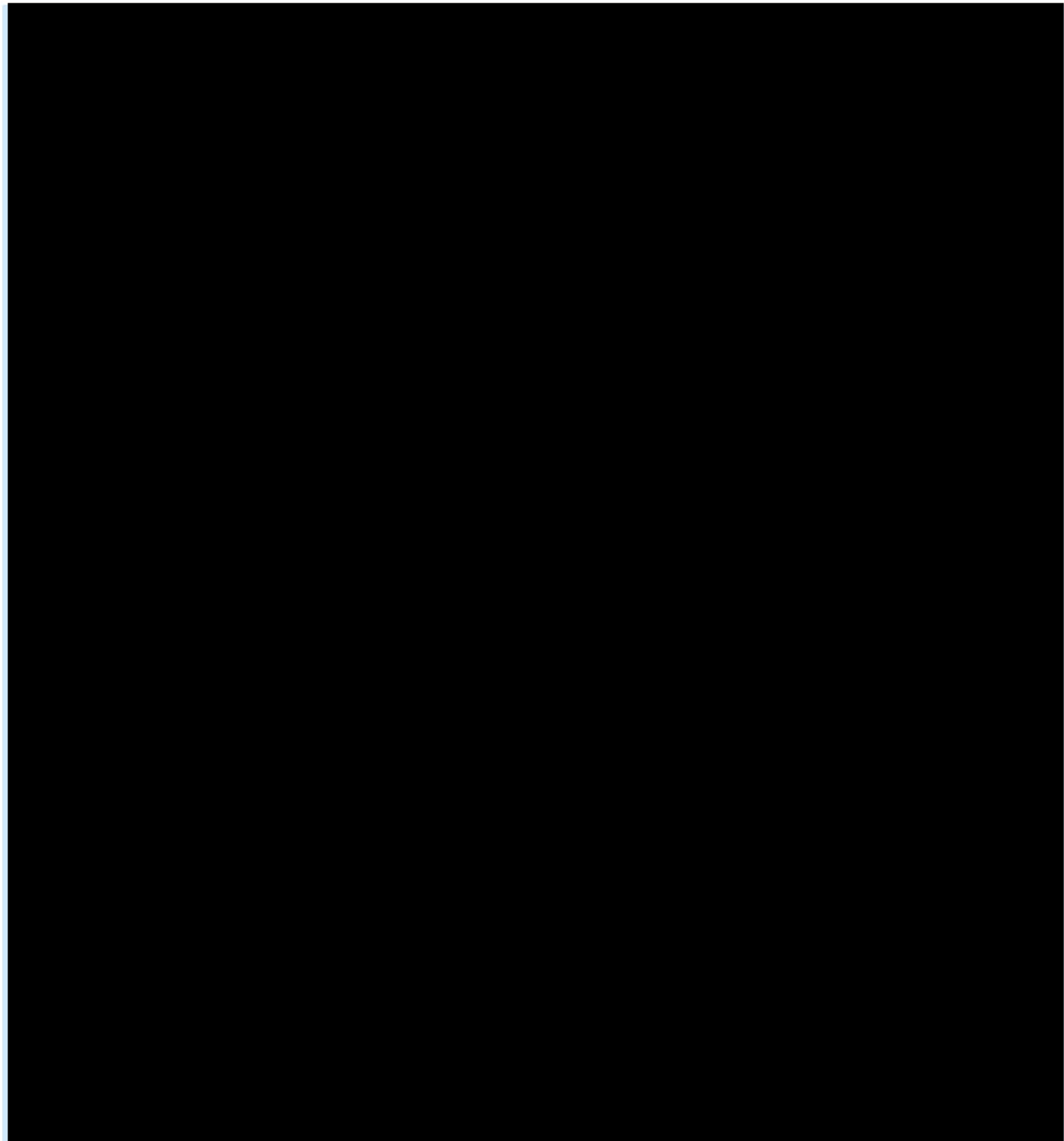
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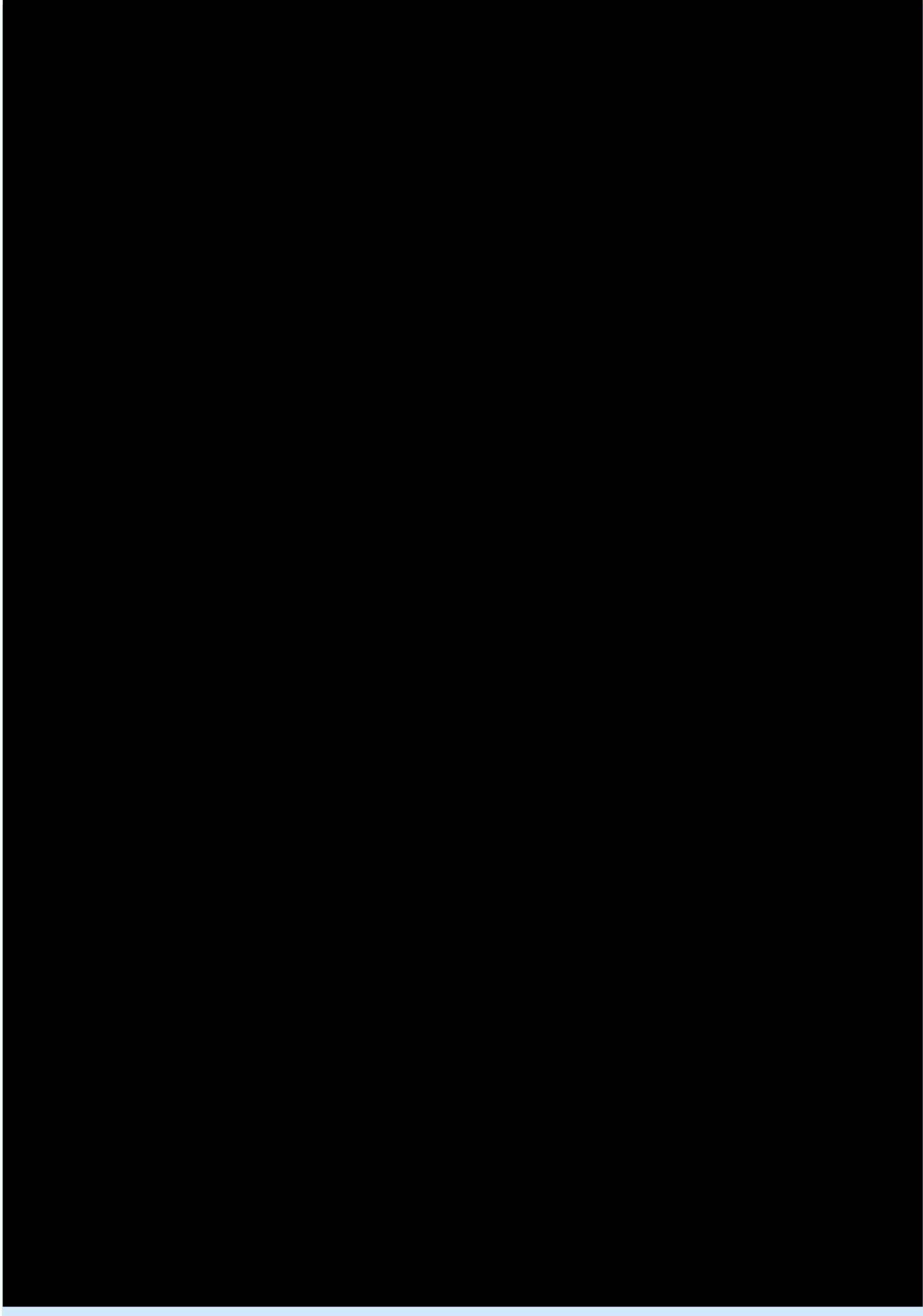
Actioning a valid deemed notice of past benefits or notice of charge

Where the employee fails to complete or return the History Statement to Medicare within the required time, Medicare will issue a 'deemed' Notice of Past Benefits (NOPB) or Notice of Charge to Comcare which deems all the services listed in the History Statement as relating to the compensable injury.

This deemed notice is valid for 6 months. If this notice is valid when the judgment, settlement or reimbursement arrangement is made, this is the amount Comcare must pay to Medicare within 28 days.

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Medicare contact details

All queries and forms are to be sent to Human Services Compensation recovery

If Medicare does not respond to queries in a timely manner or complete its actions within the stipulated timeframes, send an email to Human Services to follow up on your query/Medicare action.

Remember to send a copy of your email to Medicare to RMC Comcare and request that your email be scanned against the employee's claim file.

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Waivers and write-offs

Introduction

Comcare has a responsibility to recover debts where an employee, employer or service provider receives money they are not entitled to receive. Recovery action must be initiated in most cases prior to any consideration for the write off or waiver of a debt. Only in certain circumstances will Comcare decide to write off or waive an overpayment.

The Debt Recovery team is responsible for preparing submissions for write-offs and waivers.

Comcare's delegation instrument sets out the roles and amounts in relation to writing off and waiving debts. The Debt Recovery Team can only put forward a recommendation for a waiver/write-off to the delegate. It is up to the delegate to approve or decline the waiver/write-off requests.

Sections 114C and 114D of the SRC Act give the legislative provisions regarding write-offs and waivers.

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Who can request a write off or waiver of an overpayment?

An employee, employer or Claims Manager can request a write-off or waiver of an overpayment. No matter who requests the write-off or waiver, the Claims Manager managing the claim on which the overpayment has been raised is responsible for referring the overpayment to the Debt Recovery Team for review and action.

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Write off of an overpayment

Where a debt is written off by Comcare it means an administrative decision has been made not to recover the debt that is owed at that time. The debt remains legally payable until it is waived, repaid or the statute of limitations expires before legal proceedings have commenced.

A write-off of an overpayment should be considered when an employee does not have a current capacity to repay a debt but would, due to a change in circumstances, have a future capacity. A write off should also be considered when the decision that created the overpayment is subject to reconsideration by the Reconsideration and Appeals Team or appeal with the Administrative Appeals Tribunal (ART) or Federal Court.

The Debt Recovery Team will monitor all approved write-offs to ensure further action is taken at the end of the write-off period.

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Types of write offs

The ways a debt can be written off are outlined below.

Deferred recovery (write off)

Recovery of a debt may be written off for a specified period. This would normally be appropriate where recovery is not currently possible, but successful recovery of the whole or part of the debt may be possible within a reasonable period, usually two years.

The most common cases which may justify deferral are where the employee:

- is willing to repay but has no capacity to repay in the short term, i.e. limited income, but will resolve in one year
- cannot, or will not, repay at present, but may soon be entitled to third party compensation, lump sum payment (redemption or permanent impairment), employer-funded retirement benefit or a common law settlement
- has appealed against the decision which created the overpayment.

Generally, recovery should not be deferred for a period greater than one year. Reviews of the claim should be undertaken on a six-monthly basis to confirm whether recovery action is possible. The statute of limitations must be considered before recommending a write-off (i.e. will the overpayment become statute barred during the write-off period?).

Conditional write-off

A conditional write-off is a type of deferred recovery. An agreement is reached between Comcare and the employee that the debt be written off at present but will be recovered at a specified later date. A conditional deferment should be accompanied by a debtor agreement. A debtor agreement sets out the terms for the future recovery of the debt.

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Waiver of an overpayment

Where a debt is waived by Comcare, it means an administrative decision has been made to not recover the debt. When a debt is waived by Comcare it effectively ceases to exist and cannot be recovered later.

The legislative provisions for a waiver of an overpayment can be found in section 114D of the SRC Act.

The Debt Recovery Team must review all waiver requests to ensure recommendations are consistent.

The power to waive the recovery of an overpayment of compensation rests solely with the Chief Executive Officer (CEO).

On 3 September 2019, the CEO delegated the right to waive the recovery of an overpayment of compensation for amounts up to \$500,000.00 to the General Manager, Claims Management.

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Circumstances where an overpayment can be waived

There are a number of circumstances where a debt may be waived.

Administrative error

In general, wherever a mistake has been made in administering a payment, the debt will arise solely as a result of Comcare's administrative error providing the employee's conduct has not contributed to the debt in any way. Examples of administrative error may include, but are not limited to, mistakes made in:

1. calculating the amount of a payment
2. determining liability under the wrong section of the SRC Act, and/or
3. incorrectly actioning or not actioning information provided by the employee.

The requirement that the debt must have arisen 'solely' as a result of Comcare's error means that there must have been no other factors that caused the debt to arise or contributed to the debt arising.

Jurisdictional error

Jurisdictional errors of law are errors made when interpreting and applying legislation. Abuses of discretion and failure to exercise discretion may also constitute errors of law. If an administrator, such as Comcare, makes a jurisdictional error, whether of law or fact, the decision (or failure to make a decision) is invalid.

Where a finding of jurisdictional error is made, Comcare does not have to re-visit old claims or re-examine the circumstances surrounding the decision made. However, where Comcare becomes aware that an error has occurred, the initial determination must be reconsidered. The reconsideration of claims involving a 'jurisdictional error' has the capacity to create significant overpayments. It is Comcare's policy that where an overpayment has occurred due to a jurisdictional error, recovery of the overpayment should not be sought but a waiver request should be prepared. This should be coordinated through the Debt Recovery Team.

Waiver submissions should detail the financial impact of the intended decision and confirm that the payments involved were genuinely received in good faith. A completed Statement of Financial Circumstances form is not required in these cases.

Received in good faith

A payment is received in good faith if there is no fault on the part of the employee and they did not know or could not reasonably be expected to know that there was no entitlement to the payment that has been made in error. If the employee knows or had reason to know that they were not entitled to a payment they received, they cannot be said to have received the payment in good faith.

When deciding whether an employee received a payment in good faith the Debt Recovery Officer should have regard to the employee's state of mind and consider all circumstances of the claim, including, but not limited to the following:

- Information given to the employee via letters and other forms of correspondence such as Comcare publications, interviews, phone conversations etc – to establish the employee's reasonable expectations of their payments.
- Information provided to the employee about their circumstances – to establish their expectations about future payments and the impact of any new information they provide to Comcare.
- The employee's regular pattern of payment – what would they reasonably expect to receive on a regular basis and therefore what might represent an unexpected payment or amount?
- The amount of the excess payment – it might be expected that an employee would question a large amount of money received.

- The timeframe over which the incorrect payments were made – a short period may be considered by the employee to be administrative delay in actioning new information, while a longer period may not.

Consideration as to whether an employee has been 'wilfully blind' in relation to the overpayment they received.

Financial hardship

When an overpayment is raised, the Debt Recovery Officer must assess the employee's financial circumstances. If, following this assessment, the officer believes that recovery of the debt will cause financial hardship to the employee, they may make a recommendation to waive the debt.

The Debt Recovery Officer must consider whether there is likely to be an improvement in the employee's financial position in the near future, which would enable recovery of the debt. If improvement is likely, a write-off should be considered rather than a waiver.

Financial circumstances

When an overpayment occurs, the Debt Recovery Officer will need to assess an employee's financial circumstances to decide whether the debt should be recovered, waived or written off. This is normally done by requesting the employee to complete the [Statement of Financial Circumstances](#) form.

The Statement of Financial Circumstances form is used to assess an employee's financial circumstances and determine their ability to repay an overpayment. The form should be used when:

- a repayment plan is being negotiated due to a claim of financial hardship by the employee
- reviewing an existing repayment plan
- a write-off or waiver is being considered.

Where an employee claims that a repayment rate of 10% of their amount of compensation will cause them financial hardship or they have requested the write-off or waiver of an overpayment, the Debt Recovery Officer will need to assess the Statement of Financial Circumstances form and decide, based on the evidence provided, whether to negotiate the repayment rate or support a write-off or waiver of a debt. They should exercise discretion and common sense in their assessment of the Statement of Financial Circumstances form. Every employee's financial circumstance will be different and will depend on several factors. When reviewing the form, the Debt Recovery Officer will need to consider all the sections of the form before making a decision regarding if and/or how much an employee can repay of an overpayment.

Cost effectiveness

If it is not economical to pursue recovery of a debt, Comcare does not have to institute recovery proceedings. When considering whether to write off or waive a debt, the Debt Recovery Officer must consider the cost effectiveness of the recovery process and should only consider the administrative and legal costs associated with the recovery process, not costs already incurred.

When determining whether recovery is cost effective, consideration should be given, but is not limited to, the following factors:

- The amount of the debt – if the debt is small and it will cost more to try to recover the debt, it may be that it is not cost effective to recover the debt.

- The age of the debt and when the last (if any) recovery action occurred – if the debt is outside the limitation period or the limitation period is close to expiring and Comcare has been unable to recover the debt, it may not be cost effective to continue recovery action.
- The course of action required to pursue recovery (i.e. if the employee is no longer receiving benefits from Comcare and recovering directly from the employee is the only available option) – recovering from ongoing incapacity payments is more cost effective than attempting to negotiate a repayment plan with an employee who is not receiving any benefits.
- The likely outcome of pursuing recovery – not all recovery actions are successful. This may be because the debtor cannot afford to (or perceives that they cannot afford to) repay the debt or is refusing to cooperate with Comcare in our attempts to recover the money.
- Future administrative costs – in terms of staff resources, calculating and recording the debt and advising the recipient.

If the costs associated with the recovery of a debt from an employee are greater than the debt, recovery is not cost effective.

See the Recoveries process and defaulting relating to employees pages for more information.

Irrecoverable at law

A debt may be waived as irrecoverable at law where it is considered that recovery of a debt could not be pursued successfully by civil action through the courts. Debts may not be recovered at law in situations including, but not limited to:

- action is barred by the statute of limitations, or
- where there is insufficient evidence to prove the debt in court. A case of insufficient evidence would only arise where the claim information available does not adequately substantiate the debt, e.g. the file is lost.

Statute of limitations

- A statute of limitations is legislation within each state and territory that sets the maximum time after an event that legal proceedings based on that event may be initiated. This timeframe is known as the 'limitation period'. In terms of overpayments, the limitation period is the set time within which Comcare can recover overpayments in a court of competent jurisdiction as a debt owed to Comcare. If Comcare has not commenced recovery action, including legal proceedings, before the limitation period has expired Comcare cannot pursue the debt in court to recover the overpayment.
- The limitation period in all states and territories is 6 years, except for the Northern Territory which has a limitation period of 3 years.
- A debt may be written off as irrecoverable at law where it is considered that recovery of a debt could not be pursued successfully by civil action through the courts. Where legal action is barred by the statute of limitations, a debt cannot be recovered at law.

Exceptional circumstances

Exceptional circumstances are by their nature incapable of precise or exhaustive definition. They look to circumstances that are unusual, uncommon, or special. Whether the circumstances answer to any of these descriptions depends on the context in which they occur. At all times the circumstances must be considered in their entirety.

There may be certain circumstances where it would be unreasonable to take or to continue taking, recovery action. Some special or exceptional circumstances may include, but are not limited to, the

following:

- An employee is seriously or terminally ill and any funds available may be required for medical treatment or funeral costs.
- A term of imprisonment has been served in lieu of the repayment of the debt, as distinct from imprisonment for failure to pay a fine. Where it's not clear whether the term of imprisonment was imposed in lieu of repayment, the advice of Comcare's legal area will need to be sought.

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Appealing the decision to waive a debt

The decision to waive a debt under section 114D of the SRC Act is not reviewable by the Administrative Appeals Tribunal (AAT) because it is not a determination under section 60 of the SRC Act.

Waiver decisions are, however, subject to proceedings under the *Administrative Decisions (Judicial Review) Act 1977*.

See the Reconsideration pages for more information.

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Preparing a write-off or waiver submission

In most cases, the Debt Recovery Team is responsible for drafting a write-off or waiver submission. The Claims Manager will be made aware and can request the write-off or waiver submission. The submission provides information on:

- how the overpayment occurred
- steps taken to recover the monies owed
- a summary of information provided by the employee
- a recommendation on whether the debt should be written off or waived, and
- supporting evidence to justify the recommendation.

Once the write-off or waiver recommendation has been elevated to the delegate, a decision will be made one of three ways:

- agree with the recommendation
- reject the recommendation, or
- return the recommendation requesting clarification or supporting information.

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Third party and common law recoveries

This section provides information about common law recoveries (third party recoveries).

The Specialised Claims Team (SCT) manages all actions related to the recovery of compensation from liable third party under section 48 of the SRC Act and provides instructions to the Legal team regarding recoveries under section 50. You should forward all recoveries-related diary and document notifications (e.g. letters from insurers/solicitors) to the SCT team in-tray in Pracsys.

Any questions, or issues with third-party recoveries should be raised with the SCT.

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Third party recoveries

When an employee suffers a compensable injury as a result of an incident involving a third party, the employee may be entitled to seek damages from the third party or Comcare may seek damages on their behalf.

Below are some examples of circumstances giving rise to third-party claims:

- Motor vehicle accidents where the other party is at fault. Example: An employee is rear ended in a motor vehicle accident while driving between offices.
- An employee slipping on a supermarket floor whilst shopping for their work social club (at the direction of their employer, during work hours).
- An employee being mauled by a dog whilst performing their duties. Example: A parking inspector or census worker.
- Injury as a result of machine malfunction.
- Medical negligence. Example: An employee's compensable condition has significantly worsened as a result of medical treatment for that condition.

Where a settlement is reached, there are implications for the future payment of any claims for compensation by Comcare.

Where an employee recovers damages from a third party, the employee is not entitled to any further compensation from the date of the settlement.

Where Comcare recovers damages from a third party on an employee's behalf, the employee can receive further compensation from Comcare once they have exhausted the settlement amount. Sections 46 - 50 of the SRC Act are the provisions that deal with third-party recoveries.

Section 48 third party recoveries

If the employee elects to recover damages from a third party and successfully receives damages from the third party, they must reimburse Comcare for the expenses of the claim from date of injury to date of settlement from settlement funds. The employee has a responsibility to inform Comcare of any action they are taking against a third party and to inform Comcare within 28 days of any settlement reached.

The employee is not entitled to claim compensation from the date of they recover damages.

If you receive an account on a claim which has settled under section 48 of the SRC Act, you must return the account to the employee.

Section 50 third party recoveries

If the employee has elected not to pursue recovery of damages from a third party, Comcare can choose to undertake recovery of damages in the employee's name. If the claim is successful, Comcare will deduct a portion of the settlement to cover the expenses of the claim from date of injury to the date of settlement and the cost of any legal fees incurred by Comcare.

The remaining portion of the damages will be paid to the employee.

The employee is not eligible to claim compensation until such time as they can demonstrate that they have spent settlement monies on expenses related to their compensable condition that would have been payable had they been receiving compensation from Comcare.

These claims are managed by the Specialised Claims Team, until such time as Comcare is satisfied that the settlement funds have been spent on expenses reasonably required by their compensable condition. If there is any continuing liability past this point, the claim will be returned to the appropriate claims team for ongoing management.

If you receive an account on a claim which has settled under section 50 of the SRC Act, you should consult your Assistant Director and the Specialised Claims Team to decide whether the claim needs to be transferred to the Specialised Claims Team.

Example

Mr Smith is injured in a motor vehicle accident and advised Comcare he does not want to take action against the responsible third party. Comcare takes damages action against XYZ insurers, the insurer of the driver responsible for Mr Smith's injuries under s50 of the SRC Act.

The matter settles for \$1million which is disbursed as follows:

- \$500,000 is retained by Comcare for compensation cost previously paid to Mr Smith (s50(7)(a))
- \$100,000 is retained by Comcare for legal costs incurred from the damages claim (s50(7)(b))
- \$400,000 is paid to Mr Smith to offset any future costs in regard to the compensable injury (s50(7))

Mr Smith's claim is suspended under s50(8) until such time as he has exhausted the amount paid to him on costs associated with his compensable injury.

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Work related death

Work related death

When a claim for work-related death is received, it is registered by Claims Administration and Support (CAIS) and determined by the Specialised Claims Team (SCT).

Where an employee dies from a condition arising out of, or in the course of, employment:

- lump sum compensation is payable to their dependants under section 17 of the SRC Act
- weekly compensation payments are payable to prescribed children under section 17 of the SRC Act and
- compensation is payable for the reimbursement of funeral expenses under section 18, to the payer of the funeral.

Additionally:

- medical expenses incurred by the deceased employee before the date of death may be payable to the deceased employees' estate
- other entitlements that may have been payable prior to the death may be payable to the estate, and
- provider invoices dated prior to the date of death can still be determined.

In this section

Assessing a work-related death claim

When we receive a claim for work related death, we must assess the claim in line with the SRC Act. This page includes information on:

- submitting a work-related death claim
- the initial assessment procedure
- requesting information to support assessment and decision making
- conducting file reviews with the Clinical Panel or medical specialist.

Payments for dependants

A dependant of the deceased is entitled to claim compensation if liability for the death has been accepted under the SRC Act. This page includes information on:

- establishing dependency
- types of dependency (whole or partial)
- evidence required to establish dependency
- lump sum payments including assessing, apportioning and determining lump sum payments
- trust accounts
- weekly payments for prescribed children, and

- prescribed child reviews.

Paying for funeral and memorial services

When liability is accepted for a work-related death, Comcare becomes liable for reasonable costs associated with the deceased employee's funeral. This page includes information on:

- reimbursing funeral costs
- what can and cannot be reimbursed
- prepaid funerals
- funerals paid by an insurer
- memorial services, and
- transporting a deceased employee's body home.

Assessing a work related death claim

Published 31/07/2025

Introduction

Where an employee dies from a condition arising out of, or in the course of, employment:

- lump sum compensation is payable to their dependants under section 17 of the SRC Act and
- compensation is payable for the reimbursement of funeral expenses under section 18, to the payer of the funeral.

A claim can be submitted using the claim form Compensation for a Work-Related Death. When a claim for work-related death is received, it is registered by CAIS and determined by the Specialised Claims Team (SCT).

For the purposes of managing death claims, the term 'claimant' will be taken to mean the dependant(s) making the claim for work-related death.

Note: The claimant may indicate that they intend to take other action to recover personal injury damages, or expenses against another person or entity. In this case, further information may need to be obtained to establish any potential third-party recovery action.

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Requesting information to support assessment and decision making

You may need to collect further information from a claimant, employer, treating medical practitioner or coroner's office to support assessment and decision making on a work-related death claim. A claimant or employer may not wish to provide further supporting information or evidence. In that case, the claim will be assessed on the information available to you at the time of the determination. For further guidance, refer to the [Gathering claim information](#) page.

Evidence that can be collected to assist in the assessment of liability for a death claim can include but is not limited to:

- police reports
- clinical notes
- coroner's report
- medical reports
- hospital records

- medical certificates
- diagnostic imaging reports
- details of activities incidental to or not related to employment
- statements from the claimant, work colleagues and/or the employee's employer
- employment records (i.e. duration of employment, nature of the employee's duties).

Requesting evidence from a claimant

See [Requesting information from employees](#) for an overview of relevant procedures.

A claimant may be asked to provide a statement of facts in support of the death claim.

Requesting evidence from an employer

See [Requesting information from employers](#) for an overview of relevant procedures.

An employer can be asked to provide a statement of facts in response to a death claim. You can use letter template *822 – Section 71: Employer Statement Request* in Pracsys.

Examples of the types of documents that may be requested from an employer to support making a decision about a work-related death can include, but are not limited to:

- copies of emails
- duty statements
- incident notice
- investigation report
- witness statements
- sick leave records
- file notes/records of conversations
- pre-employment checks, such as health clearances
- employment records (i.e. evidence of employment, duration of employment, nature of the employee's duties).

Requesting evidence from a medical practitioner

To support your assessment, you may request:

- a medical report
- copies of the practitioner's clinical notes
- copies of hospital and ambulance records if relevant. **Note:** An Authority from the Executor of the Estate might be required before hospitals will send information to Comcare.

For further guidance, refer to the [Obtaining medical report or clinical notes](#) page.

Requesting evidence from a Coroner's office

If the cause of the deceased employee's death is unknown, you will need to contact the relevant coroner's office. You need to advise them that Comcare has received a claim, and request a copy of the coroner's report, when available.

Cause of death

A death claim cannot be determined without a cause of death. This means liability can take several months (or longer) to determine if the death is subject to a Coroner's enquiry. Claims received without a cause of death should remain 'non-compliant' in Pracsys.

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File Review by the Clinical Panel or a legally qualified medical practitioner

When determining liability for a work-related death, you may require a specialist opinion to support assessment and decision making.

For work-related death claims, this is usually in the form of a file review. A file review may be required in circumstances where:

- the cause of death is unknown
- medical information received is inconsistent
- the death is not directly connected to a compensable condition
- there are possible multiple causes of death.

File review by the Clinical Panel

You may request the Clinical Panel to complete a file review on a deceased employee's medical records and claim information. The Clinical Panel can provide you with guidance on what questions need to be asked of a legally qualified medical practitioner (LQMP) regarding the death of the employee. It can also assist with interpreting responses provided in medical evidence and reports from LQMPs or treating practitioners, as well as hospital records.

For further guidance on the process of arranging a Clinical Panel referral, refer to the [Undertaking a clinical panel review](#) page.

File review by legally qualified medical practitioner

You may require additional medical evidence or a specialist opinion. This may require you to arrange for a legally qualified medical practitioner (LQMP) to conduct a file review on the evidence held on the deceased employee's claim file.

You can request the LQMP to provide a report on how the deceased employee's employment is related to the illness or injury suffered that resulted in the death.

For further guidance on the process of arranging an independent medical examination, refer to the [Independent medical examinations](#) page.

To assist in the timely determination of the claim, the report should be requested with a due date of **seven calendar days**.

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Paying for funeral and memorial services

Introduction

When liability is accepted for a work-related death, Comcare becomes liable for reasonable costs associated with the deceased employee's funeral or memorial service. Funeral or memorial service expenses are paid under section 18 of the SRC Act. The amount payable is based on an annually indexed statutory rate based on the Consumer Price Index. Comcare can reimburse up to this amount. However, any costs over the statutory rate are the responsibility of the employee's estate.

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Reimbursement of funeral expenses

Costs are reimbursed to the person who paid for the cost of the funeral (usually the dependant) or to the person who carried out the funeral (the funeral director). Funeral expenses are paid when we receive a receipt from the claimant or an invoice from the funeral director/parlour.

You need to have regard for local costs for funerals, as well as the reasonable costs for a funeral. Comcare will not pay for 'extras' that family members may request, such as special handles on coffins, coffins made from particular timbers, headstones, food and drink etc.

Process for reimbursement of funeral expenses

If you receive an invoice or receipt for funeral or memorial services expenses, you need to forward the invoice/receipt to CAIS - Complex Payments for payment once liability for the death is accepted.

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Prepaid funerals

Funeral costs may be pre-paid for by the deceased employee prior to their death. In such a case, Comcare is not liable to pay compensation for funeral costs or to reimburse the executor/administrator of the deceased employee's estate or the deceased employee's dependant(s). This is because the executor/administrator or dependant(s) is not liable for the costs of the funeral.

Funerals paid for by an insurer

An employee may purchase a funeral insurance policy in which an insurer is liable to pay for funeral expenses on the employee's death. In such a case, Comcare would be liable to pay compensation in respect of funeral costs. The insurer can have their costs reimbursed up to the statutory cap. This falls under section 18(1) of the SRC Act. The section states that Comcare is liable to pay compensation in respect of the employee's funeral costs **to the person who paid the cost of the funeral**.

An insurer may refuse an insurance claim or only make a partial payment under a policy. In that case, the executor/administrator of the deceased employee's estate, or the deceased employee's dependant(s) would be liable for some of the funeral costs. Comcare would be liable to pay

compensation for funeral costs paid by the executor/administrator or the dependant(s). The amount of compensation would be capped at the indexed amount.

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Memorial services

In circumstances where there is no body for burial, payment for a memorial service is made in the absence of a funeral, as per the statutory rate at the date of death.

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Transporting the deceased's body home

Costs associated with transport of the deceased employee's body are considered and paid separately under section 16 of the SRC Act.

Costs of transporting a deceased employee's body where he or she has died interstate, may be covered by the deceased employee's employer. For an employee deployed overseas, special conditions may apply. If such a situation arises, you should discuss this with your Assistant Director.

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Payments for dependants

Introduction

A **dependant** is a person who is dependent for economic support on the employee at the time of the employee's death. A dependant is entitled to claim compensation if liability for the death has been accepted under the SRC Act.

In order for compensation to be payable, you must be satisfied that:

- the claimant's relationship with the employee was one of those referred to in the definition of dependant in [section 4\(1\) of the SRC Act](#).

Dependants may be entitled to claim compensation for weekly payments and lump sum payments. See [Weekly payments to prescribed children](#) for more information about weekly payments. See [Overview of lump sum payments](#) for more information on lump sum payments.

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Establishing dependency

You will need to have regard to the following considerations when establishing who is a dependant of the deceased employee:

- the dependant's social situation including:
 - separated families
 - extended families
 - foster families
 - polygamous families
 - culturally diverse families
 - any child support that may have been paid, and
 - expected future support (including school fees, uniforms, medical/dental expenses).
- evidence that is required to be provided to establish a relationship with an employee, such as:
 - birth certificate(s)
 - adoption certificates, and/or
 - marriage certificate(s) or other recognitions of legal partnership.

A statutory declaration can be provided where other evidence of dependency is not available.

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De facto relationships

You may need to assess a de facto relationship and determine whether two parties had a relationship as a couple living together on a genuine domestic basis. All of the circumstances of their relationship are to be considered, including any or all of the following circumstances:

- the duration of the relationship
- the nature and extent of their common residence

- whether a sexual relationship existed
- the degree of financial dependence or interdependence and any arrangements for financial support between them
- the ownership, use and acquisition of their property
- the degree of mutual commitment to a shared life
- the care and support of children
- the reputation and public aspects of the relationship.

A common household is important in determining whether a couple is living in a de facto relationship. However, parties may still be considered in a de facto relationship if they were living apart temporarily. Examples include:

- due to work commitments of one party or due to illness or infirmity of one or both parties
- one party is in a nursing home.

Other evidence that would assist in establishing a de facto relationship would include:

- mutual wills
- evidence of joint debts
- evidence of a common residence (such as a lease, mail from banks, utility providers showing the parties' address)
- evidence of jointly owned property (such as title deeds or mortgage documents)
- bank statements showing a joint account
- statutory declarations from persons who know the parties and are able to attest to the length of the relationship, nature of the relationship, use of property, degree of commitment to a shared life, and/or the public reputation of the relationship generally.

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Types of dependency

It is important to note that dependency under section 17 of the SRC Act varies between:

- wholly dependent
- mainly dependent, and
- partly dependent.

Wholly dependent

Whole dependence means that the dependant relied entirely on the deceased employee to provide economic support at the time of death. This is usually the partner and/or children living with the employee at the time of death.

The spouse and children living with the employee (prescribed children) at the date of death are wholly dependent, irrespective of financial dependency. This is according to section 4(5) of the SRC Act.

Example: A dependent child is under 16 and living with the employee at the date of the employee's death. The child is wholly dependent.

Mainly dependent

Mainly dependent means that the person was primarily reliant on the deceased employee for a large degree of economic support, although they also had some income of their own to rely on.

Example: A deceased employee was responsible for 70% of the dependent child's income prior to death (the other 30% was provided by the remaining parent). The child is mainly dependent.

Partly dependent

Partly dependent means the dependant relied on the employee financially to some degree at the date of death. A partial dependant may earn some income of their own. They had also relied on the deceased employee for economic support. People that fall into this category may include children not living at home, an ex-spouse, or a parent of the employee.

Example: The employee was giving their mother \$100 per fortnight to assist with day-to-day living. Their mother is working part-time but her wage is not enough to support herself. The mother is partly dependent.

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Evidence to demonstrate partial dependency

The employee needs to have been economically supporting the dependant who would be unable to live off their own income. Occasional gifts and money for entertainment is not sufficient to find a state of dependency.

Documents to support partial dependence can include:

- evidence of dependant's after-tax weekly income, which can be obtained from:
 - payslips or information from the dependant's employer and
 - income from investments (if applicable).

If a dependant is earning income, consideration needs to be given to the amount of income they are earning and the reason why they are working.

However, there are types of income that **should not** be considered. These include:

- income earned from increasing or commencing employment because of the employee's death
- family tax benefit
- carer allowance, and
- double orphan pension.

Evidence of total weekly household expenditure can include proof of payment of:

- mortgage
- rent
- food
- electricity
- gas
- rates

- schooling costs (if relevant), and
- any other related expenditure.

You will also need to estimate the expected period of dependency. This figure is the number of weeks over which the employee could have been expected to provide economic support to the dependant. This involves examining:

- the shorter of either the employee's life expectancy (if they had not died) or the dependant's life expectancy
- in the case of children under 16 years of age, when they will reach age 25 years
- in the case of children 16 years or older and under 25, when they will either reach the age of 25 or complete a course of studying or training.

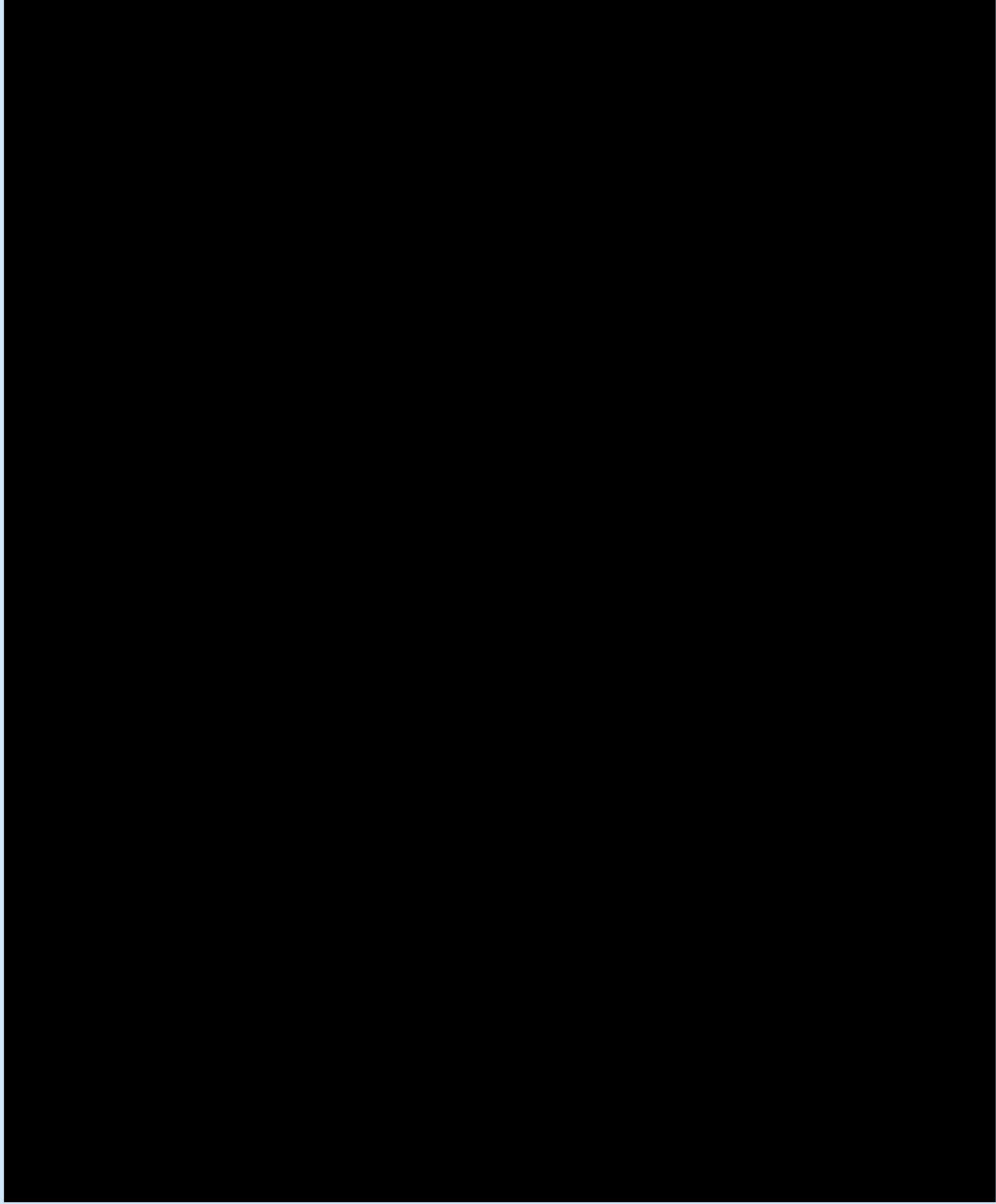
Example: The dependant is the deceased employee's child under the age of 25 years. The deceased employee made rental payments while the adult child was at university. The deceased employee was paying \$300 per week for the accommodation. The adult child had 2 years or 104 weeks left at university, $104 \times \$300 = \$31,200$. The lump sum amount payable to this partial dependant under section 17(4) is \$31,200.

There may be other circumstances that you may need to consider, such as where:

- a lesser degree of dependency is claimed, or
- someone else is contributing to the support of the dependant.

Example: The deceased employee and his spouse were divorced. The spouse (who does not qualify as a dependant) has custody of the child of that marriage and received child support in respect of that child. Following remarriage, the spouse's current husband contributes to the child's upkeep. The child was not wholly dependent on their father at the date of death but could be considered partly dependent because of the child support payments.

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Overview of Lump Sum Payments

Section 4(1) of the SRC Act defines dependent to mean 'dependent for economic support'. A person who is wholly or partly dependent on the employee at the time of death is entitled to claim a lump sum payment under the SRC Act in relation to the death of the employee.

Lump sum payments are based on an annually indexed statutory rate at the date of the death.

Compensation for injuries resulting in death

Where an injury to an employee results in death, section 17 of the SRC Act provides for:

- the payment of lump sum compensation to the dependants of the employee.

The dependants need to have been wholly or partly dependent on the employee at the date of the employee's death.

No lump sum compensation is payable if the employee had no dependants at the date of their death.

Section 4(1) of the SRC Act defines **dependant** as 'being a person who was wholly or partly dependent on the employee at the time of death.' Therefore, dependants, whether wholly and partially dependent, can receive a portion of the lump sum under section 17(3) of the SRC Act.

Amount to be paid

Sections 17(3) and 17(4) of the SRC Act prescribe the two lump sum options that are to be paid in the circumstances of either whole or partial dependence as follows:

- wholly dependent - at least one of the dependants was wholly dependent on the deceased employee at the date of death. The maximum sum must be paid.
- partly dependent - none of the dependants were wholly dependent on the deceased employee at the date of death. But one or more dependants were partly dependent on the employee as at the date of death. An amount up to, but not exceeding, the maximum lump sum may be paid.

Example: There are no dependants found to be wholly dependent upon the employee. However, an adult daughter claims partial dependency following the death of the employee. The daughter provides evidence by way of financial and personal records. These establish that the employee had provided financial support to her of \$150 per week. The support was to assist in paying off the daughter's loan, until repaid completely. The loan would have been repaid completely in five years' time - $\$150 \times 260 \text{ weeks} = \$39,000$ lump sum.

Amount to be shared

The total amount that is payable under either section 17(3) or 17(4) of the SRC Act is to be shared among all the dependants. This includes both wholly dependent and partly dependent dependants.

Under section 17(8), where compensation is payable to two or more dependants:

- you have the discretion to determine the percentages of compensation payable to those dependants in the amount that they 'think is fit'.

You need to have regard to any losses suffered by those dependants as a result of the cessation of the employee's earnings. Therefore, shares may or may not be equal.

As a guideline, the spouse of the deceased employee will receive 75% or more of the total amount and each of the dependent children will receive the following:

Number of Children	%
1	10% (90% remainder to spouse)
1-2	10% each (80% - 90% remainder to spouse)
3-5	5% each (75%-85% remainder to spouse)
More than 5	25% divided between all children (75% remainder to spouse)

Note: Each case must be assessed on its own merits and the circumstances of each dependant.

Apportioning the amount

You should apply the following principles when apportioning the amount of death lump sum compensation payable. Each case must also be considered on the evidence provided and the circumstances of the case:

- Every dependant is potentially entitled to receive some part of the lump sum.
- The lump sum payable must be distributed among wholly dependent (if any) and partly dependent dependants of the deceased employee.
- When considering distributing the lump sum payable among wholly and partly dependent dependants under section 17(8):
 - you are required to 'have regard to any losses suffered by those dependants as a result of the cessation of the employee's earnings.
- This creates an obligation on you to consider each dependant (whether wholly or partly dependent on the employee) in apportioning the lump sum.
- In assessing a dependant's share of the lump sum, you could conclude that a 'zero' share is appropriate, given the actual level of financial dependence of the dependant.

Note: A child that has not yet been born can be considered as part of the lump sum payable. A portion of the lump sum benefit can be attributed to the unborn child and be paid into a beneficiary trust account upon birth.

Losses suffered by each dependant as a result of the cessation of the employee's earnings

When apportioning the lump sum compensation, you must focus on 'losses suffered by those dependants as a result of the cessation of the employee's earnings.'

'Dependent' is defined as being 'dependent for economic support.' Apportionment of death lump sum compensation is based on the economic loss that results from the employee's death. The reference to 'cessation of earnings' above makes this clear.

Determining the nature and extent of the economic loss may not be straightforward. For example, a child who primarily lives with one parent may visit and stay with the other parent. Whilst residing at the other parent's home all expenses are met. In determining the loss of the child after the death of the non-custodial parent, it may be appropriate to consider:

- child support payments made by the non-custodial parent
- the value of economic support the child received whilst visiting the non-custodial parent.

Section 17 of the SRC Act provides for the maximum payment of a specified lump sum. That sum is not reflective of the monetary value of the income lost as a result of the employee’s death. Otherwise, the lump sum would vary depending on the dollar value of the income of the employee.

For similar reasons, this section of the SRC Act does not seek to replace the dollar value of the financial loss suffered by the dependant. Instead, the section seeks to allocate the lump sum in proportion to the level of dependence of each dependant, rather than the financial loss suffered by each dependant. For further clarification, see Apportioning the maximum amount of lump sum payable.

Ascertain the economic loss

The most appropriate way to ascertain the economic loss that a dependant has suffered (as a result of the cessation of the employee’s earnings) is to:

- consider all the sources of economic support that each dependant had at the date of the employee’s death, and
- determine what proportion of support was constituted by the employee’s earnings.

Superannuation

It is not appropriate to consider superannuation (or life insurance policies etc) as a form of economic support as there is separate legislation dealing with superannuation entitlements in the event of an employee’s death.

Compensation payments

Under section 17(7), in ascertaining the totality of economic support available, the following **should not be taken into account**:

- an amount of compensation paid or payable under the SRC Act before the death of an employee, or
- compensation available for a prescribed child.

For a dependent child, the following must not be taken into account:

Family tax benefit, carer allowance and double orphan pension

For a dependent child, the following **must not be taken into account**:

- family tax benefit calculated under Part 2 or 3 of Schedule 1 to the *A New Tax System (Family Assistance) Act 1999* (an individual’s Part A rate)
- carer allowance under that Act, and
- double orphan pension under that Act.

Reasonable duration of support

It is appropriate to consider the length of time that the deceased employee could reasonably have been expected to continue supporting that dependant. This will support you in ascertaining the loss that each dependant has suffered.

Dependant	Time period

Spouse/partner	It is reasonable to assume that the relevant period of loss is: from the date of the employee's death until the date when he or she would have reached statutory retirement age. This is because that period has a causal connection with the cessation of the employee's earnings. This may also be the relevant period of loss for other dependants. An example might be a disabled child whose economic dependence is likely to continue throughout their lifetime.
Child	It may be reasonable to assume in many cases that the relevant period of economic loss is from: the date of the employee's death until the child reaches 18 years of age unless they are in full time education. However, the use of this age is for illustrative purposes only and not prescriptive. In determining the likely period of a dependant's economic dependence, you must exercise discretion and have regard to the circumstances of the case.

Claims for compensation made by or on behalf of two or more dependants

Where claims for compensation are made by or on behalf of two or more dependants of the employee, you shall make **one determination** in respect of those claims.

It is important to ensure that all dependants of the deceased employee are included in the claim for a lump sum death payment.

Any dependants who make a claim after a determination has been made cannot be included in the lump sum payment.

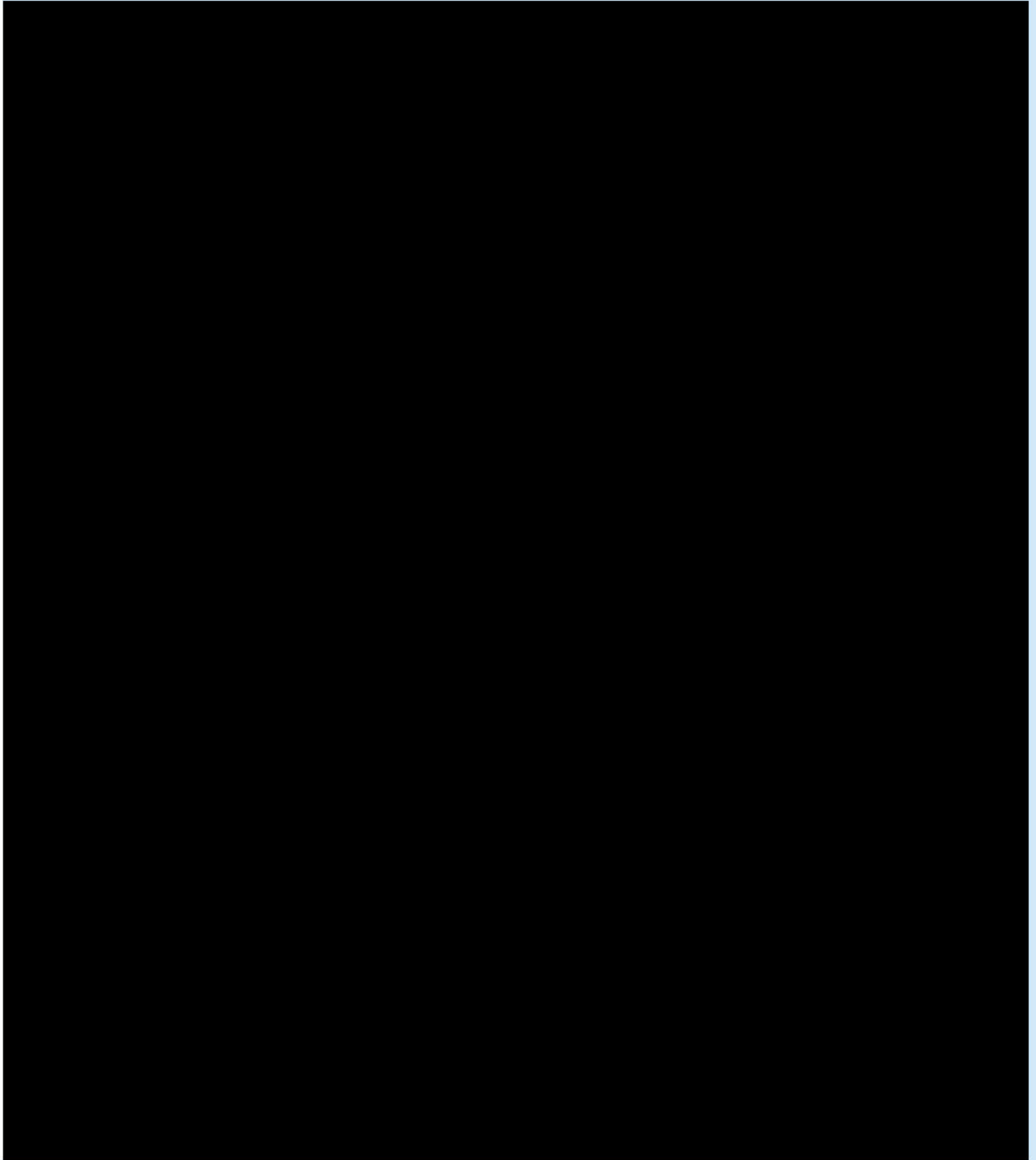
A detailed assessment of all dependants should be conducted prior to issuing a determination to ensure that all potential dependants have been identified. A death certificate will usually state the deceased's marital status and list any known children.

Any children under 18 should be assessed for dependency.

The determination

The determination should clearly document the relative apportionment of the lump sum to all dependants. This is especially important in situations where you have reasons to adopt a different approach to the apportionment of the lump sum between the various dependants. For example, you may determine that the application of the above principles is not appropriate. This may be because it would lead to a result which would not reasonably correspond with the respective economic losses suffered by each dependant.

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Apportioning the maximum amount of lump sum payable

You can apportion the maximum amount of lump sum payable between multiple wholly and partly dependants based on the evidence provided and the circumstances of the case. This falls under section 17(3) of the SRC Act.

Extended Example

The remaining content in this section provides an extended example to help you with apportioning a lump sum.

A deceased employee left 6 dependants (5 children and one current spouse) at the time of his death on 02/07/2012.

Children 1, 2 and 3 were living with the deceased employee's previous spouse, therefore were **partly dependent**.

Children 4 and 5 and the current spouse were living with the deceased employee before the date of death and were **wholly dependent** on the deceased employee.

The deceased employee was paying:

- child 1, 2 and 3 a \$100 allowance, and
- half of any medical expenses for all 5 children.

At the time of the deceased employee's death, the statutory benefit rate for death lump sum payments under section 17 of the SRC Act was \$475,962.79 (as from 1 July 2012).

Calculation and amount payable to child 1

Date of Birth: 02/07/1991

Child 1 was 21 years old at the time of the deceased employee's death.

It is reasonable to assume that the \$100 per week allowance may have continued until child 1 turned 25 on 02/7/2016 which equates to 208 weeks from the date of the deceased employee's death.

$$208 \text{ weeks} \times \$100 = \$20,800$$

It is reasonable to allow \$1000 a year for medical expenses up to the age of 25.

$$\$1000 \times 4 \text{ years} = \$4,000$$

$$\text{Total amount payable} = \$24,800$$

Calculation and amount payable to child 2

Date of Birth: 02/07/1993

Child 2 was 19 years old at the time of the deceased employee's death.

It is reasonable to assume that the \$100 per week allowance may have continued until child 2 turned 25 on 02/7/2018 which equates to 312 weeks from the date of the deceased employee's death.

$$312 \text{ weeks} \times \$100 = \$31,200$$

It is reasonable to allow \$1000 a year for medical expenses up to the age of 25.

$$\$1000 \times 6 = \$6,000$$

$$\text{Total amount payable} = \$37,200$$

Calculation and amount payable to child 3

Child 3 was 18 years old at the time of the deceased employee's death.

364 weeks x \$100 = \$36,400

\$1000 x 7 years = \$7,000

Total amount payable = \$43,400

Calculation and amount payable to current spouse, child 4 and child 5

Child 4 was 11 years old at the time of the deceased employee's death.

Child 5 was 7 years old at the time of the deceased employee's death.

After the payments to the deceased employee's 3 oldest children have been established, there remains a balance of \$370,562.79 payable.

In cases where a wholly dependent child is supported by a wholly dependent adult, the largest payment should be made to the dependent adult, therefore the:

- current spouse is entitled to 80% of \$370,562.79 which equals \$296,450.23, and
- child 4 is entitled to 10% of \$370,562.79 which equals \$37,056.28
- child 5 is entitled to 10% of \$370,562.79 which equals \$37,056.28

See a breakdown of this example in the table below.

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Trust accounts

Trust Accounts are set up by Comcare where a dependant is not yet eligible for a lump sum to be paid directly to them. This includes a child under the age of 18 and dependants with a legal disability who are unable to manage their own affairs.

The Beneficiary Trust Accounts Officer in Finance is responsible for the administration of trust accounts.

The lump sum is released to the dependant once they reach 18 years of age. Prior to the release, written notification is to be sent to the dependant advising of the lump sum payment. A request is also made for the dependant to nominate an account in their name for the payments to be made.

Early release of funds

At any time prior to the trust money being paid to the child, the parent or guardian may request funds to be released for the benefit of the child. However, to protect the interests of the child and to ensure that funds are being released for the purpose for which they are intended, this request must:

- specify the purpose for which the funds are required, e.g. educational expenses or emergency medical treatment, and
- provide proof of financial hardship which necessitates the early release of the funds.

It is important that approval is sought before any commitment or expenditure of funds occurs.

Note: Any enquiries about early release of funds should be referred to the Beneficiary Trust Accounts Officer in Finance (email [Help Desk – Finance](#)).

Weekly payments to prescribed children

Prescribed child

Section 4(1) of the SRC defines a prescribed child as a child under the age of 16, or a child between the ages of 16 and 25 that is studying full time and is not normally employed.

An unborn child may also be covered by the provisions of a prescribed child. If an employee's partner is pregnant at the date of the employee's death, compensation may be payable for the child from the child's date of birth.

Note: The meaning of **prescribed child** does not capture those in receipt of wages or salary, such as those undertaking an apprenticeship or internship. A dependent child (DC) undertaking an apprenticeship will no longer be considered as receiving full-time education. They will be considered as ordinarily engaged in employment, which would preclude the DC from claiming weekly payments.

A prescribed child may undertake employment during a school break or have casual/part time employment. They should continue to be regarded as a full-time student, not ordinarily in employment, so long as they remain in full-time study.

Under section 17(5) of the SRC Act, prescribed children of a deceased employee are entitled to a regular compensation payment, for as long as they meet the definition of a 'prescribed child'.

Rate of weekly payments

The weekly payment rate is the statutory rate payable at the time of the employee's death and is increased annually.

The date the weekly payment commences is based on:

- for a child already born – the date of the employee's death, or
- for a child yet to be born – the date of the child's birth.

However, compensation is not payable for:

- any period during which the child is not a prescribed child, and
- any period during which, if the employee had not died, the child would not have been wholly or mainly dependent on the employee.

Example: The child turns 16 and decides to work full time. However, after six months, they return to school and give up their employment. For the six-month period that the child worked, they were not a prescribed child.

Prescribed children's details are entered into Pracsys (see Procedure for establishing dependency and adding dependants to Pracsys). They are paid using a trust (if aged under 18) or the direct payment method. See Procedure for determining lump sum payments, **step 8**, for arranging this.

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Prescribed child reviews

Regular reviews need to be undertaken to ensure dependants are still meeting the criteria of a prescribed child, to avoid overpayment. Reviews should be undertaken yearly when the dependant is between the ages of 16 and 25 and pursuing studies.

Parents or guardians of prescribed children should be advised of the criteria for payment of the weekly benefit and asked to advise Comcare if their circumstances change. This includes:

- parent or guardian ceases to have care for the child (payments are to be redirected to the current guardian)
- the child ceases to be a student (if aged 16 or over)
- the child ceases to study full time
- the child commences employment.

Where a weekly payment is being made to a child and the child turns 16, you will need to send out a Student Review Form each November. This review form establishes whether the child:

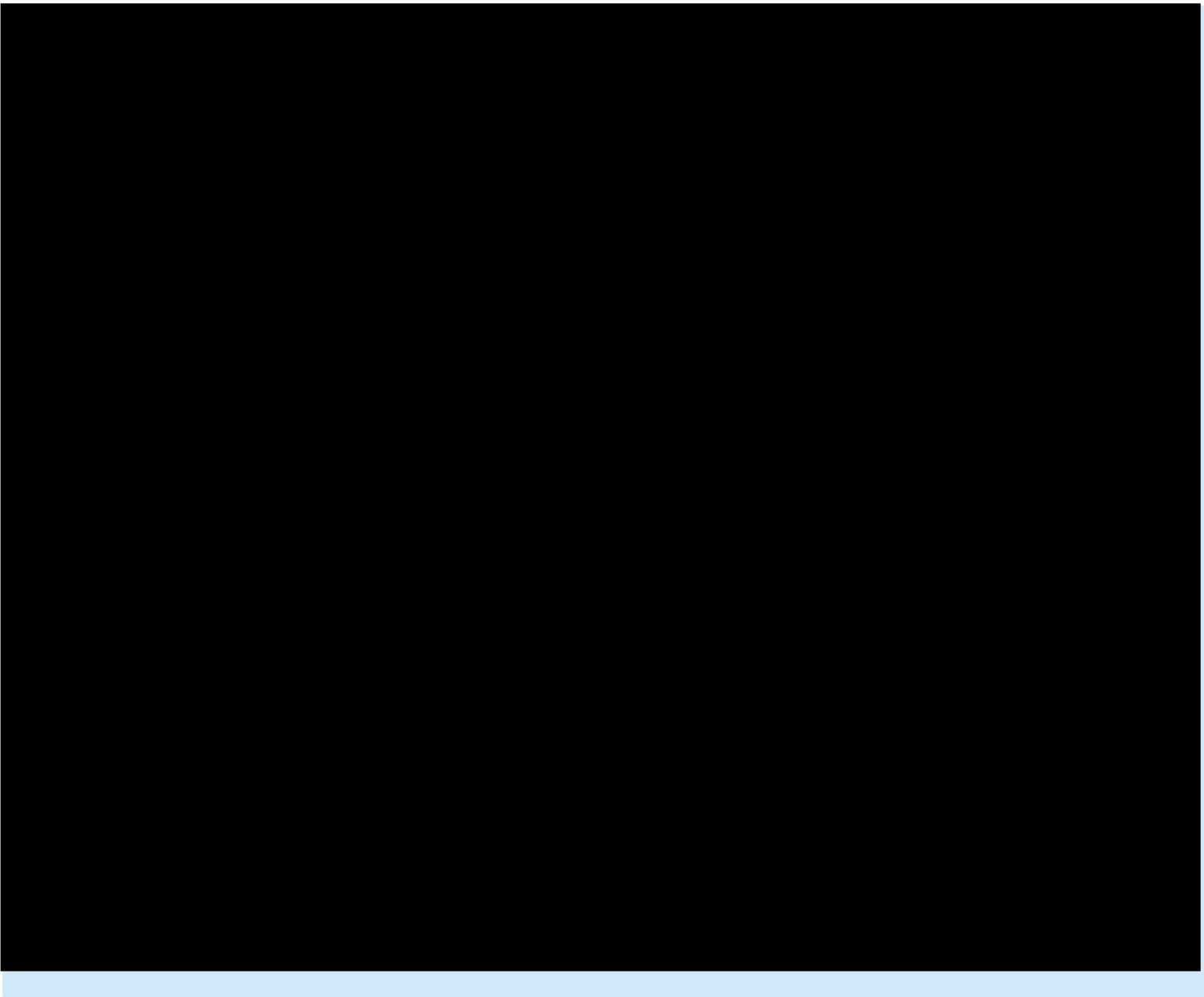
- continues to meet the definition of 'prescribed child' under the SRC Act, and therefore continues to qualify for payments under section 17(5), and
- is still wholly or mainly dependent.

To avoid overpayments, the Student Review Form is used to ask a prescribed child for evidence of enrolment in full time education. If this evidence is not received by Comcare, the prescribed child payments for dependants aged between 16 and 25 should not be extended.

Note: The payment is made directly to the prescribed child once they turn 18 years of age.

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New or changed conditions

New or changed conditions

You may receive notification of a newly reported condition for which liability has not been determined under the SRC Act. A newly reported condition is a condition that has not previously been claimed by an employee and may or may not be related to an existing compensation claim. Or you may receive notification that a condition's diagnosis has changed. This notification may come from the employee, medical evidence or from another source.

If you receive notification of a newly reported condition or a change in diagnosis, you are required to assess the condition and, if necessary, make a new determination.

Roles and responsibilities

Assessing newly changed conditions or potential new diagnoses is the responsibility of the **Claims Manager** assigned to the claim. Triage is a key step in assessing the change, as with any initial liability determination. You can seek support from Injury Managers and your Assistant Director through the triage process.

In this section

Changed diagnosis

You may receive a notification where the diagnosis provided has changed from the condition for which liability was originally determined by Comcare. When this occurs, you are responsible for assessing the new diagnosis and establishing whether it is the same, or different, from the compensable condition.

This page provides information about the three possible paths when a changed diagnosis is reported. The three paths are:

- Claimed condition has not fundamentally changed – no changes required
- The employee's condition has changed and it becomes a newly reported condition
- The injury descriptor (diagnosis) on the claim file is incorrect and a reconsideration on own motion is required.

The page includes detailed information on:

- Circumstances where a change to the accepted condition is not required
- The importance of actioning a changed diagnosis
- Factors to consider when deciding on the correct course of action, and
- Procedure to implement a changed diagnosis.

Newly reported conditions

You may receive notification of a newly reported condition for which liability has not been determined under the SRC Act. A newly reported condition is a condition that has not previously been claimed by an employee and may or may not be related to an existing compensation claim.

If you receive a notification of a newly reported condition, you are required to assess the condition, including the circumstances in which the condition occurred and decide whether the condition should be treated as:

- a new claim
- a secondary condition against an existing claim, or
- a continuation of an employee's compensable condition against an existing claim.

This page includes information on:

- Secondary conditions, including
 - More than one condition arising out of the same incident
 - Condition that has developed from an existing compensable condition
 - Condition as a result of compensable medical treatment
 - Condition as a result of compensable incidents
- Receiving a notification of a new condition and the need for a medical certificate
- Assessing the medical factors for a newly reported condition, including assessing the cause
- Exclusionary provisions
- Procedure to determine liability for a newly reported condition
- Procedure to accept liability for a newly reported condition, and
- Procedure to reject liability for a newly reported condition.

Changed diagnosis

Introduction

Once liability for a claimed condition has been accepted, the compensable condition can evolve, change, or vary over the life of the claim. A change in diagnosis may occur at different stages in the life of the claim.

You may receive a notification where the diagnosis provided has changed from the condition for which liability was originally determined by Comcare. When this occurs, you are responsible for assessing the new diagnosis and establishing whether it is the same, or different, from the compensable condition.

Importance of actioning a claim with a changed diagnosis

It is very important that you identify claims that have a change in diagnosis as early as possible, and action them accordingly, as this can assist with:

- supporting appropriate medical treatment
- ensuring that compensation is determined correctly
- understanding the effects of the compensable condition
- supporting return to work, rehabilitation, and recovery
- engaging appropriate technical support.

When a change occurs to an employee's diagnosed condition, there are three possible pathways which are outlined below. A triage meeting should be booked to discuss the change in diagnosis. As always, empathy and sound judgment should be demonstrated when taking a course of action that impacts a claim.

Option 1: Claimed condition has not fundamentally changed despite change in diagnostic terminology

This path can be followed when the available evidence demonstrates that a claimed condition has not essentially changed, despite the presence of material that provides a different diagnosis. This may include circumstances where alternative diagnostic labels describe the same condition or where medical terminology has evolved. In this case, the claim would continue to be managed as usual. See [Change to the accepted condition not required](#) section for more.

Option 2: The employee's condition has changed and new diagnosis reflects the change

This pathway is necessary when you receive a notification that the employee's condition has changed from the condition for which liability was originally determined by Comcare. This becomes a **newly reported condition**. You are responsible for assessing the newly reported condition. When the available evidence demonstrates that the employee's condition has evolved or changed so that it is no longer the same condition as when the injury occurred, the [Newly reported condition](#) process must be followed.

The outcome of this process may be that the changed condition is treated as a:

- new claim
- continuation of an employee's compensable condition against the existing claim (known as a 'secondary condition'), or
- neither. If you have considered the evidence and there is no new determination to be made, refer to the first path.

Option 3: The injury descriptor (diagnosis) on the claim file is incorrect

This is the path to take when Comcare receives evidence that the original diagnosis for the claimed condition was incorrect. The accepted condition is described according to the International Classification of Diseases and Injuries (ICD), and this condition is usually retained as the 'accepted condition' for the purposes of managing the claim.

However, if Comcare receives medical evidence that demonstrates that the decision was factually incorrect, the error can be rectified through a process known as a 'reconsideration on own motion'. This action would be appropriate if the error impacts the medical treatment and liability profile of an injury, or the compensation that is payable.

For further guidance, refer to the [Reconsideration of own motion](#) page.

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Change to the accepted condition not required

There are a range of scenarios where a change to the accepted condition may not be required. These are set out below:

International Classification of Diseases and Injuries descriptor vs diagnosed condition

Comcare links conditions with International Classification of Diseases (ICD) descriptors. ICD descriptors are standard diagnostic classifications and may not precisely match a condition diagnosed by a treating practitioner.

Issues related to the correct application of ICD codes are unlikely to require a change to the claim. If an employee has concerns related to ICD coding, this should be handled with sensitivity and in accordance with Comcare's communication protocols. For further guidance, refer to the [Communicating with an employee](#) and [International Classifications of Diseases](#) pages.

Other factors that may explain a changed condition

The same injury can be presented with an alternative diagnosis. A change in diagnosis does not necessarily mean that an employee's compensable condition has substantially altered. This may include changes in naming conventions or an alternative diagnostic label for the same condition. For example, *chronic fatigue syndrome* is also known as *myalgic encephalomyelitis*.

When a different diagnostic label is not impacting the employee or the appropriate management of the claim, then you should consider whether further action is warranted. If there is any doubt, it would be appropriate to book a triage meeting, seek further information from the treating practitioner, and consult with the Injury Management Team.

Alternative diagnosis for a condition previously declined

You should identify cases where an alternative or similar diagnosis is provided for a condition for which liability has already been assessed and declined, and the work circumstances are similar (essentially a duplicated claim with small changes to the details). You should advise the employee the condition has already been considered and determined by Comcare and advise them of their rights to appeal.

Factors to consider in deciding on the correct course of action

Below are some factors to consider when deciding on the correct course of action:

What caused the changed diagnosis and does the change impact the claim?

Some questions that you could explore include:

- What are the circumstances in which the change in diagnosis has occurred?
- What is the relationship between the new diagnosis and the compensable condition?
- Is the new diagnosis a natural progression of the compensable condition?
- Is there evidence to indicate that the compensable condition no longer exists and has been superseded by a new condition?
- Is the new diagnosis a progression of underlying or pre-existing conditions?

Why was the original diagnosis chosen?

You should seek to develop a good understanding of why a particular diagnosis was initially chosen by Comcare. To help, you should look for documents such as the initial claim plan, the decision file note, contemporaneous comments, original medical evidence, and the initial liability determination letter. For some older claims that were subject to litigation, the reconsideration decision or AAT (now called ART) decision can also be helpful.

What are the effects of changing the compensable condition?

It is important that consideration is given to how changing the compensable condition may affect the employee, such as:

- whether the new diagnosis will require different management of the claim
- if changing the accepted condition will result in a change in determination that may advantage or disadvantage the employee
- how the change may affect Comcare's relationship with both the employee and employer.

You should investigate further if you notice a new diagnosis on a medical certificate or on any other medical evidence. If you discover something that does not look right, feel right or you receive information from the employee or another source (employer, rehabilitation provider etc) that is relevant and has the potential to impact the management of a claim, please refer to the "Just Ask" process.



Newly reported conditions

Published 31/07/2025

Introduction

You may receive notification of a newly reported condition for which liability has not been determined under the SRC Act. A newly reported condition is a condition that has not previously been claimed and may or may not be related to an existing compensation claim.

When you are notified of a newly reported condition, you need to assess the condition, the circumstances in which the condition occurred, and decide whether the condition is:

- a new claim
- a secondary condition against an existing claim, or
- a continuation of an employee's compensable condition against an existing claim.

Important: All claims for newly reported conditions must be discussed at a triage meeting. For further guidance refer to the [Triage](#) page.

Prescribed timeframes for managing claims

From 1 April 2024, the prescribed timeframes will apply to all primary determinations.

When a claim for a newly reported condition is received on or from 1 April 2024, and registered as a new claim for compensation, having met the requirements set out under section 54 of the SRC Act, then the prescribed timeframes for the initial primary determinations under section 14 apply.

The prescribed timeframes do not apply to:

- a secondary condition against an existing claim, or
- a continuation of an employee's compensable condition against an existing claim.

Please refer to: Decision making under the SRC Act for more information on prescribed timeframes.

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Secondary conditions

A secondary condition may arise from any one of the following circumstances:

- more than one condition arising out of the same incident
- a condition with a causal link to an existing compensable condition
- a condition that has arisen from compensable medical treatment, or
- a condition that has arisen from certain compensable incidents specified under the SRC Act.

Each of these is outlined in more detail below.

More than one condition arising out of the same incident

An employee may sustain more than one condition from the same incident.

Example: An employee is involved in a motor vehicle accident. They suffer a blow to the head, whiplash and a broken leg.

Pracsys is unable to record more than one condition as the '*Primary*' condition. Where there is more than one condition sustained, the primary condition recorded is the one that is considered the most serious and incapacitating injury.

In the example above, the whiplash would be recorded as the primary condition as it is potentially the most serious and incapacitating injury. The broken leg and bruised head would be recorded as secondary conditions.

Condition that has developed from an existing compensable condition

A condition that has a 'causal relationship' to an existing compensable condition is also recorded in Pracsys as a secondary condition. These are new conditions that arise as a result of the first condition and are not simply the natural progression of the first condition.

Secondary injury

A secondary injury is where an injury has 'arisen out of' the compensable condition. It is not necessary to link the secondary injury back to the employment, as the compensable condition has already satisfied that link.

When assessing whether a secondary injury has 'arisen out of' the compensable condition, you need to be satisfied that there is a causal relationship between the secondary injury and the compensable condition.

Note: Claims for secondary injuries are uncommon. If you receive a claim you consider is for a secondary injury, please discuss the claim with your Assistant Director.

Secondary disease

A secondary disease is where the compensable condition 'significantly contributed' to the development of the secondary disease. It is not necessary to link the secondary disease back to the employment as the compensable condition has already satisfied that link.

When assessing if the compensable condition significantly contributed to the development of the secondary disease, you must be satisfied there is a very strong connection between the employee's compensable condition and the secondary disease.

In cases where there are other contributing factors (i.e. non-compensable factors), you must be satisfied that the compensable condition was a significant contributing factor in the development of the secondary disease.

Example: An employee has an accepted claim for a bulging lumbar disc. A year later, the employee lodges a claim for major depression which they attribute to the lumbar disc injury. The employee's treating general practitioner provides a medical certificate which states that major depression has developed as a result of the pain the employee experiences due to their bulging lumbar disc injury. There are no other known contributing factors. Therefore, the evidence has established that the major depression has been significantly contributed to by the compensable condition and is accepted as a secondary condition.

Conditions as a result of compensable medical treatment

A condition arising from approved medical treatment for a compensable condition is treated as a 'new injury' and is not recorded against the existing claim as a secondary condition. This is because there is a new causative factor, the medical treatment. The original employment-related incident or injury is not the cause of the new condition.

Conditions as a result of compensable incidents

A secondary condition that arises from an incident that occurred when the employee was travelling between his or her place of work and another place is covered under section 6(1)(g) of the SRC Act.

These injuries are treated as a 'new injury' and are not recorded against the existing claim as a secondary condition because there is a new causative factor. For further guidance, refer to the Injuries under section 6(1) page.

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Receiving a notification of a newly reported condition

The notification of a newly reported condition is usually received from a medical certificate or medical report provided to assist in the consideration of the claim.

When you identify a newly reported condition, you should contact the employee to discuss the condition and confirm whether they intend to claim compensation in respect of the condition. If so, under section 53 of the SRC Act, notification of a newly reported condition must be given to Comcare in writing.

If the employee wishes to claim for the new condition, and it appears to be a secondary condition, you should advise the employee that you will send them a Notification of a Reported Condition form to complete and return to Comcare. You should also advise that once the completed form is received, a copy will be sent to their employer for comment. You can assist the employee to complete the form but be clear they will need to review it, sign, and confirm in writing their agreement to progress a claim for the further condition.

Completion of a Notification of a Reported Condition form is not necessary for a newly reported condition. The employee can instead provide a written statement indicating they wish to claim for a new condition.

Discuss the following with the employee and explain that this will need to be provided in writing, either on the form or in a written statement:

- details of the condition including:
 - what caused the condition and how it occurred
 - where the condition occurred
 - the date the condition occurred
- the date the employee first sought medical treatment for the condition
- name and contact details of treating practitioner
- medical treatment obtained
- whether the employee has suffered any similar symptom, injury or illness, work-related or otherwise
- name of their employer (if any) at the time the newly reported condition occurred

- any other matters that may be relevant to the employee and their claim.

Obtaining the above information will assist you to establish whether the newly reported condition should be assessed as a secondary condition, a new claim, or neither (i.e. is non-compensable).

If the employee provides a statement, you will need to send the employee an Authority and Consent for the Collection and Release of Medical Information form to sign and return to Comcare, which will enable you to obtain medical information concerning the newly reported condition.

Medical certificate: Under section 54(3) of the SRC Act, a written notice of injury must be accompanied by a medical certificate from a legally qualified medical practitioner. In cases where a medical certificate is not provided with the written notice of injury, you should review the claim file to ensure no medical certificates (or other medical information) have previously been provided in relation to the newly reported condition.

Contact the employer: After speaking with the employee, you must contact the employer to advise them of the newly reported condition.

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Assessing the medical factors for a newly reported condition

You need to assess a notification of a newly reported condition and identify the condition the employee is suffering from, and the cause of the new condition. Further guidance to assist your assessment can be found in the Injury and disease under the SRC Act, Changed diagnosis and Aggravations, accelerations and recurrences pages.

Assessing the cause of a newly reported condition

You must assess whether a newly reported condition has been caused by any one of the following circumstances:

- the compensable condition
- a new set of circumstances
- medical treatment obtained for the compensable condition
- the same incident or set of circumstances as the compensable condition, or
- some other incident or factor(s).

The guidance and associated links outlined below will help when assessing the cause of a newly reported condition. In each case, you must ensure that the information supports the cause of the employee's newly reported condition and the circumstances in which the condition occurred. This is necessary for compensation to be payable for a newly reported condition.

Causes

Does the information support that the newly reported condition:

- arose from a separate incident or as a result of the compensable condition? For further guidance, refer to the section on Condition that has developed from an existing compensable condition above.
- arose out of the same incident or set of circumstances as the compensable condition? For further guidance, refer to the section on More than one condition arising out of the same incident above.
- arose as a result of approved medical treatment obtained for the compensable condition? For further guidance, refer to the section on Conditions as a result of compensable medical treatment

above.

Or:

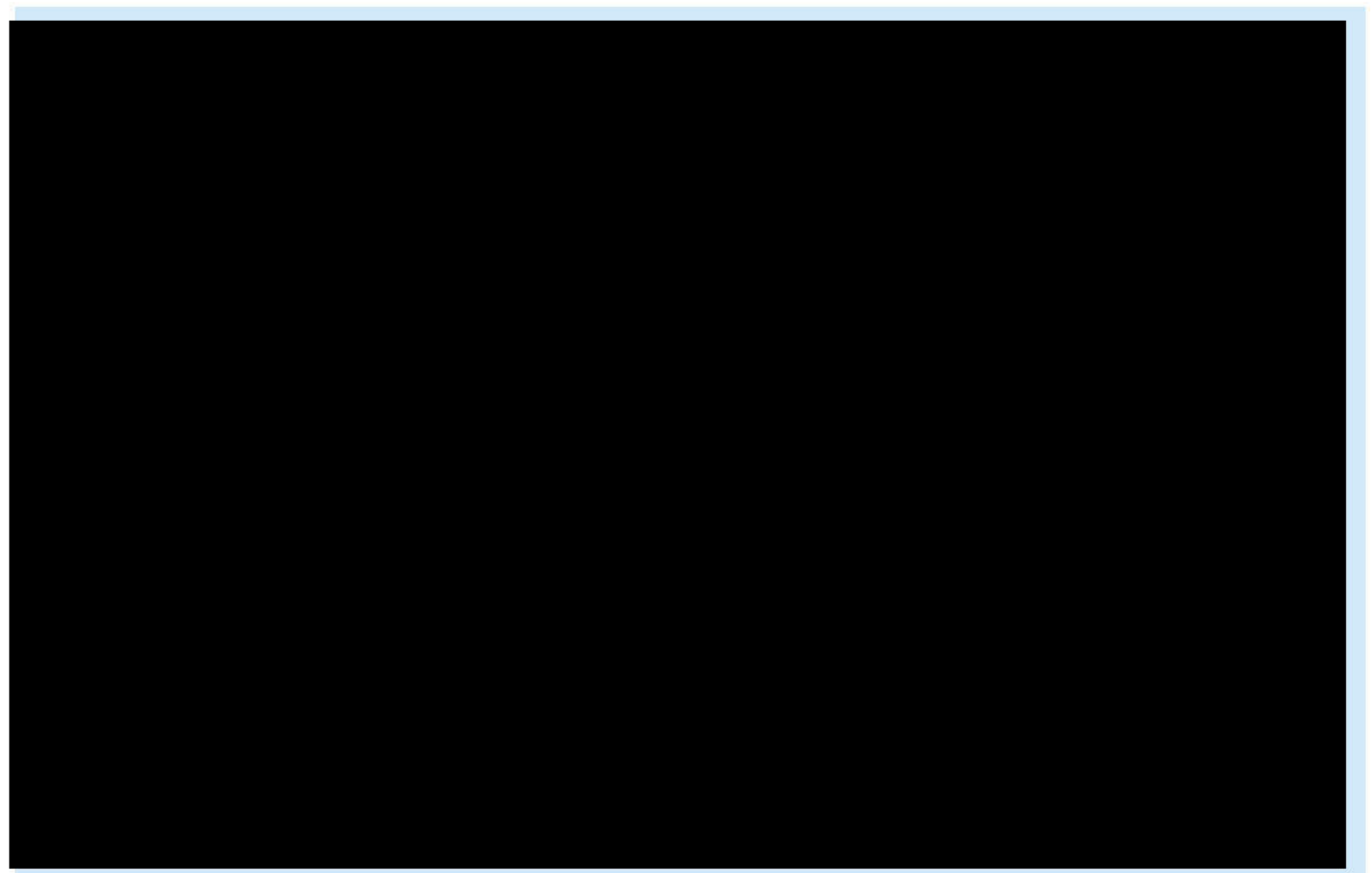
- Is the employee claiming that they have suffered from an aggravation of an underlying or pre-existing condition? For further guidance, refer to the Aggravations, accelerations and recurrences page.
- Does the information support that a work-related incident or other employment factor made an underlying or pre-existing condition evident sooner than would have otherwise been expected? For further guidance, refer to the Aggravations, accelerations and recurrences page.
- Is there information to support that an employee's symptoms of a previous condition or injury re-emerged either spontaneously or because of the ordinary stresses and strains of daily living and working? (This consideration is relevant in cases where an employee has suffered from a recurrence of symptoms of a previous injury. When this happens, a claim may be reopened if it is confirmed that the employee's current symptoms are associated with the original injury). For further guidance, refer to the Aggravations, accelerations and recurrences page.

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Exclusionary provisions

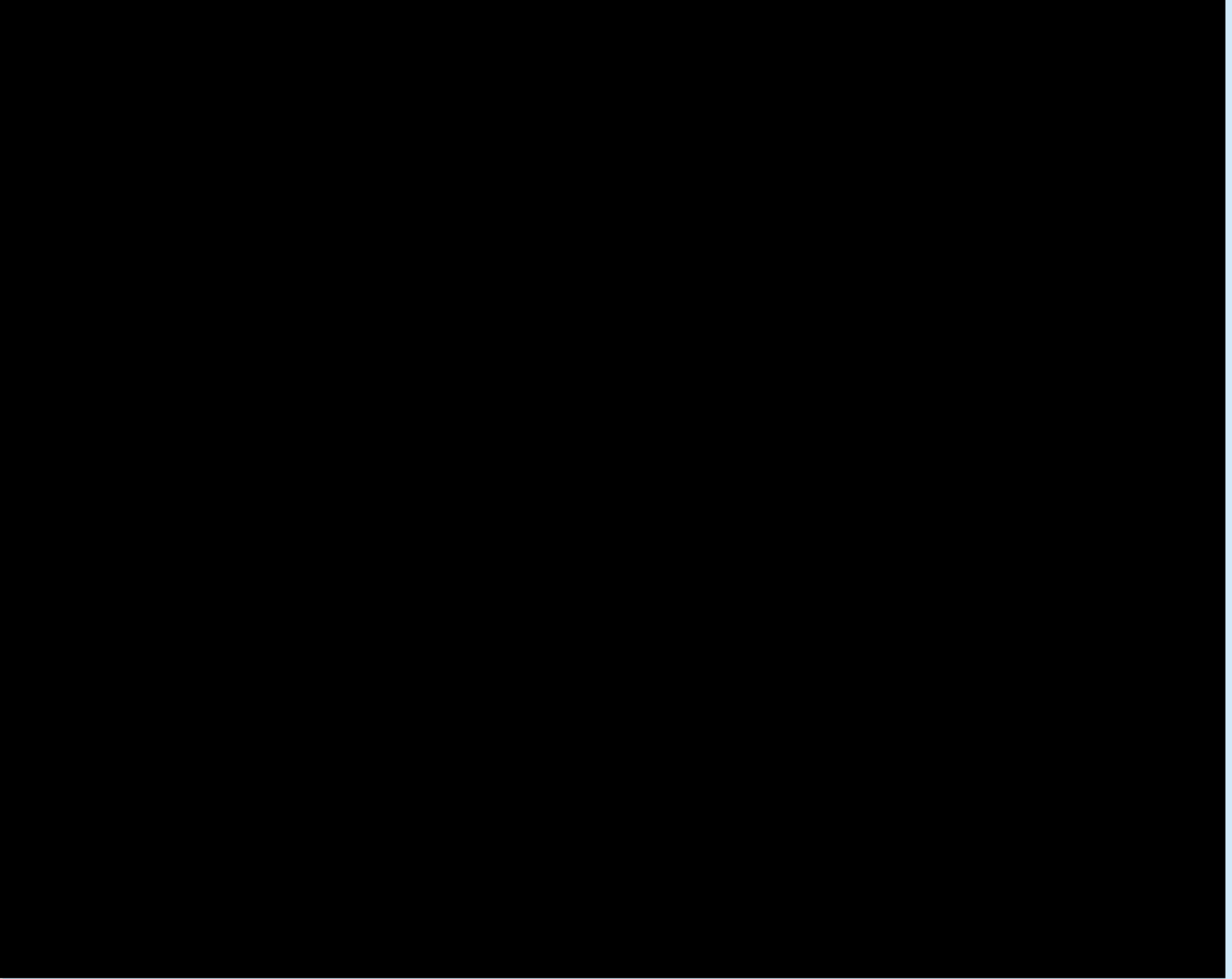
The same provisions that exclude an employee from receiving compensation for a primary condition applies to secondary conditions. They should form part of your considerations when assessing liability for a newly reported condition. For further guidance, refer to the Exclusionary provisions page. If you consider that a factor that has contributed to a newly reported condition falls within one of the exclusions, you should discuss the claim with your Assistant Director.

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Permanent impairment

Claims for permanent impairment

Comcare is liable to pay compensation to an employee where their accepted compensable condition has resulted in permanent impairment of any body part, system or function.

Permanent impairment payments are lump sum payments which are made separately and in addition to any incapacity payments which might be payable. A separate claim needs to be submitted to claim a permanent impairment payment.

There are two components to a permanent impairment payment: Permanent Impairment (PI) and Non-Economic Loss (NEL) payment. Each component is assessed separately, and an employee may be entitled to one, both, or neither component.

Relevant sections of SRC Act

The following sections of the SRC Act are relevant to claims for permanent impairment:

- section 24 – Compensation for injuries resulting in permanent impairment
- section 25 – Interim payment of compensation
- section 26 – Payment of compensation
- section 27 – Compensation for non-economic loss
- section 28 – Approved Guide.
- section 45 – Actions for damages – elections by employees

Roles and responsibilities

- Claims Managers are responsible for assessing, calculating and determining permanent impairment payments and communicating with the employee, medical practitioners and employer.
- Injury Managers can assist Claims Managers with assessing medical evidence and deciding when to request an independent medical examination (IME).
- The Claims Administration and Income Support (CAIS) team is responsible for registering new claims for permanent impairment and arranging payments.

In this section

Claiming permanent impairment

This page explains the permanent impairment payment for compensation where an accepted compensable condition is permanent. It includes information on:

- how an employee can claim for permanent impairment
- assessing if an injury is permanent
- the compensable degree of permanent impairment

- employees with multiple compensable impairments or injuries
- Medicare notification requirements, and
- permanent impairment guides.

Assessing and determining a permanent impairment claim

Once a claim for permanent impairment is received and registered, we need to take action promptly to assess and determine the claim.

This page includes a process flowchart to help you follow the permanent impairment determination process. It also includes information on:

- arranging an independent permanent impairment assessment
- non-economic loss payments
- Procedure to gather required information to determine a PI claim
- Procedure to determine liability for permanent impairment
- Procedure to accept liability for permanent impairment
- Procedure to offer an interim payment, and
- Procedure to action an interim payment request.

Assessing hearing loss claims for permanent impairment

This page provides further guidance in assessing claims for permanent hearing loss, including information on:

- employees with compensable and non-compensable hearing loss
- how to assess when hearing loss became permanent
- tinnitus, and
- identifying which Act is relevant.

Rejecting a claim for permanent impairment

Where the legislative tests are not met, Comcare may reject an employee's claim for permanent impairment.

This page includes information on transitional employees and the Procedure for rejecting liability for permanent impairment.

Registering a claim for permanent impairment

Pracsys has a separate function (MPIC) for registering and managing permanent impairment claims. This work is done by the CAIS team.

This page includes the procedure for registering a new claim for permanent impairment.

Calculating permanent impairment payment amounts

Where liability for a permanent impairment claim is likely to be accepted, we need to calculate the permanent impairment payment (or interim payment) before continuing with the acceptance process.

This page includes:

- Procedure to calculate a permanent impairment payment
- Procedure to calculate a non-economic loss payment
- information on late payment of permanent impairment, and
- Procedure to calculate interest payable on a PI payment.

Electing to sue the Commonwealth

Employees who are entitled to receive lump sum payments (under sections 24, 25 or 27 of the SRC Act) may make an election to sue the Commonwealth for damages (under section 45 of the SRC Act), instead of receiving compensation for permanent impairment.

This page includes information on when and how an employee can elect to sue the Commonwealth instead of receiving compensation payments. It also includes information about submitting a valid section 45 Election Form.

Claiming permanent impairment

Introduction

Permanent impairment (PI) payments are lump sum compensation payments which are claimed for and paid separately from incapacity payments. Compensation for PI can only be determined after liability has been accepted in accordance with section 14 of the SRC Act for:

- an injury
- a disease, or
- an aggravation of an injury or disease.

This means that the permanent impairment must have resulted from the compensable injury or disease.

Under the SRC Act, you are considered to have a permanent impairment when you experience a permanent loss, loss of use, damage or malfunction of a:

- part of your body
- bodily system or function, or
- part of a bodily system or function.

Permanent impairment payments consist of two separate payments: permanent impairment and non-economic loss (NEL). Employees may be eligible for both payments, or only the permanent impairment payment.

See: Non-economic loss for more information about this payment, including eligibility.

Relevant sections of SRC Act

The following sections of the SRC Act are relevant to claims for permanent impairment:

- section 24 – Compensation for injuries resulting in permanent impairment
- section 25 – Interim payment of compensation
- section 26 – Payment of compensation
- section 27 – Compensation for non-economic loss
- section 28 – Approved Guide

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How does an employee claim for PI?

When lodging a claim for permanent impairment (PI), Comcare recommends that employees complete a Compensation Claim for Permanent Impairment and Non-Economic Loss form. This form is required for employees to claim for both permanent impairment payment and non-economic loss (NEL) payment together.

A Permanent Impairment form should be completed by a Treating practitioner, such as a GP, Specialist or Psychologist. For further information, refer to [Assessing and determining a permanent impairment claim](#).

It is possible for Comcare to determine liability under section 24 without a Compensation Claim for Permanent Impairment and Non-Economic Loss form. This may occur, for example, in the case of injuries such as lung cancer and mesothelioma, in which a PI lump sum may be paid upon diagnosis of the condition. You can accept a letter from the employee or the employee's representative requesting a PI payment as a written notification to register a claim. However, a completed Compensation Claim for Permanent Impairment and Non-Economic Loss will still be required to determine liability for the NEL component.

Note: The PI and NEL form states that reasonable costs of completing this form will be met by Comcare. However, Comcare will only meet the cost of other submitted medical reports or assessments if the report or the assessment is used in determining the employee's permanent impairment.

For further information on claiming for permanent impairment, please refer to the following section on the Comcare website.

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When is a condition permanent?

Under the SRC Act, permanent means 'likely to continue indefinitely'. When determining permanent impairment (PI), you first need to determine whether the impairment from which the employee suffers is in fact permanent.

The SRC Act requires you to consider the following when determining whether the employee's impairment is permanent:

- the duration of the impairment
- the likelihood of improvement in the employee's condition
- whether the employee has undertaken active treatment and all reasonable rehabilitation treatment for the impairment, and
- any other relevant matters.

A condition should not be considered permanent if there is:

- a likelihood of the condition improving
- the employee will not suffer lasting effects as a result of the injury, or
- all active treatment (as opposed to treatment that maintains the condition) has not yet been completed.

Interim payments

If the employee's condition is not going to improve, and the medical evidence suggests that it may deteriorate further, an interim payment (section 25) option is available to the employee. Agreeing to accept an interim payment means the employee can seek a further assessment under section 24 upon exhausting all rehabilitative medical treatment. The final determined amount will be paid minus the amount of the interim payment already received.

Note: Non-economic loss (NEL) is not payable as an interim payment made under section 25. NEL can be determined at a later time when the impairment has stabilised, and PI is finalised under section 24.

Duration of impairment

Except in obvious cases, such as traumatic amputation, mesothelioma and hearing loss, the impairment should have been in existence for a considerable period of time before it is considered permanent, or the final degree of impairment can be measured with confidence. This is because there may be an increase in:

- medical treatment, and
- the requirement for aids or appliances.

The employee may lodge a claim for PI at a later date than their initial claim for compensation. This can be when their treating specialist is of the opinion that the condition has reached a stage where it is likely to continue indefinitely.

Likelihood of improvement

If the impairment is likely to improve or resolve through the natural healing process or medical or surgical treatment, the condition cannot be regarded as permanent.

In some cases, the condition is not likely to improve, although it may deteriorate. This means there is a quantifiable permanent level of impairment beyond which there is unlikely to be any improvement. In this case, although the condition is not 'stable', PI may still be able to be assessed.

The test to determine improvement is one of **likelihood** as opposed to **certainty** of improvement.

Reasonable rehabilitative treatment

An assessment of PI should not be undertaken until all reasonable rehabilitative treatment has been completed. You can discuss what treatment may be reasonable with your Injury Manager and the Clinical Panel as necessary. See the Clinical Panel page for more information.

Refusal to undertake reasonable rehabilitation treatment

Where an employee has refused to undertake rehabilitative treatment that may have some impact on the degree of PI, you must consider:

- whether the refusal by the employee was reasonable or not, and
- what the rehabilitative treatment consisted of.

When considering rehabilitative treatment, you must consider factors including:

- the risk of failure of the treatment, and
- the possible extent of benefit from the treatment.

When considering the reasonableness of refusal by the employee, you must compare the measures of success of the rehabilitative treatment with the following:

- the prospects of success of the treatment
- the risks of adverse consequences
- pain
- discomfort, and
- any inconvenience involved in the treatment.

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Compensable percentage of permanent impairment

If an employee's claim is assessed under the SRC Act, compensation is payable when the degree of Whole Person impairment (WPI) is 10% or more. The only exceptions are:

- hearing loss claims: in most cases, the degree of WPI will need to be equal to, or greater than 2.5% - (5% binaural hearing loss).
- loss of, or loss of the use of fingers and toes - there is no minimum requirement for the degree of WPI, and
- loss of the sense of taste and smell - there is no minimum requirement for the degree of WPI.

An employee who has had a subsequent increase in the degree of WPI by 10% or more is eligible to claim for a subsequent PI payment. The exception is PI for hearing loss where the increase level of WPI is 2.5% (5% binaural hearing loss).

For guidance on assessing and determining claims, refer to the [Assessing and determining a permanent impairment claim](#) page.

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Employees with multiple compensable impairments

If an employee has multiple impairments, you must determine if those impairments arose from a single injury or from multiple injuries. Such cases need to be discussed in triage before making a determination on combining values. For further guidance, refer to the [Triage](#) page.

Single injury leading to two or more impairments

A single injury to an employee may result in two or more impairments. In this case, you calculate the degree of whole person impairment (WPI) of the employee resulting from that injury, expressed as a percentage. This is to be determined in accordance with the combined values chart set out in the approved Guide. See Permanent impairment guides for the approved Guide to use.

Example: An employee suffers a **single** spinal cord injury. The injury results in a 5% WPI loss of function of their lower extremities, a 5% WPI to their urinary system and a 10% WPI to their reproductive functions. As all three impairments are the consequence of the one injury, the WPI values will be combined using the combined values chart within the approved Guide. Using the combined values chart, the employee's overall WPI rating is 19%.

Two or more injuries from the same incident

Two or more injuries to an employee may arise out of the same incident or the same state of affairs. Each of those injuries may result in one or more impairments. In this case, the injuries must be treated as separate injuries. Therefore, the WPI percentages arising from those injuries must be assessed separately (not combined). This provision is to be applied before making any reduction to the degree of the PI as a result of a pre-existing injury (if applicable).

Example 1: An employee suffers **multiple injuries** as a result of a motor vehicle accident. The injuries lead to individual PI assessments of 9% WPI for the right knee, 9% WPI for the left foot, and 9% WPI for the right shoulder. The employee is not entitled to compensation under the permanent impairment provisions as none of the injuries have reached the 10% permanent impairment threshold. Despite the impairments arising from the same incident, they cannot be combined as they are separate injuries.

Example 2: An employee suffered injuries to their right and left shoulders as a result of a fall at work. The injuries lead to individual PI assessments of 13% WPI for the right shoulder and 13% for the left shoulder. As the fall resulted in two separate injuries and there is an impairment because of each injury, the injuries must be treated as separate injuries (i.e. two separate PI and non-economic loss determinations).

Secondary conditions

Secondary conditions would generally be separate injuries. Therefore, any PI associated with the secondary condition would not be combined with the primary condition (or other secondary conditions).

Employees with compensable, non-compensable and pre-existing conditions

Some employees may submit a claim for multiple conditions (compensable, non-compensable and pre-existing). Some conditions may have liability accepted. The claim may also include conditions for which there is no current liability under section 14 of the SRC Act. For these conditions, you will first need to determine liability under section 14. You can only determine liability for PI for these conditions if liability is first accepted for the conditions under section 14.

Where the employee has multiple conditions contributing to their PI, including compensable, non-compensable and pre-existing conditions, you will need to review the current medical evidence to establish whether it is possible to isolate the degree of PI attributable only to the compensable injury. You may need to request additional medical evidence to confirm whether isolating the effects is possible.

- **Degree of PI attributable to the compensable injury can be isolated through medical evidence:** You must use only the percentage of whole person impairment (WPI) attributed to the compensable injury.
- **Degree of PI cannot be isolated from the compensable, non-compensable and pre-existing injuries:** The degree of PI should be considered as entirely attributable to the compensable injury.

For examples of compensable, non-compensable and pre-existing factors causing **hearing loss**, see [Employees with compensable and non-compensable hearing loss](#).

Where the employee's claim contains multiple conditions for which PI is requested, you need to ascertain which specialists are most appropriate. In some cases, multiple independent assessments may be required.

Medicare notification requirements

Services Australia administers and manages the notification requirements of the *Health and Other Services (Compensation) Act 1995* (the HOSC Act), which operates to ensure that the Commonwealth recovers any Medicare benefits paid to an employee where an insurer (such as Comcare) is liable for the injury or illness.

Section 23 of the HOSC Act requires Comcare to notify Medicare in writing of a 'judgment' or a 'settlement'. The notification must occur within 28 days after the judgment or settlement is made in respect of a claim.

Comcare is only obligated to inform **Medicare** of any PI and NEL payments under the HOSC Act. There is no legal obligation to notify Centrelink of a PI or NEL payment as these payments are not compensation (incapacity/income) payments for the purposes of the Social Security Act. Please make sure that notifications are sent to Medicare and **not Centrelink** to avoid any unnecessary delays in the finalisation of the PI and NEL payments.

Relevant to permanent impairment

The HOSC Act notification requirements apply **where a claim for PI is accepted (excluding interim PI payments) of \$5,000 or more**. The requirements apply whether that decision is an outcome of a primary determination, reviewable decision or ART/Court decision. This is the meaning of 'judgment' or 'settlement' for the purpose of the HOSC Act.

For further guidance refer to the [Medicare notice and recoveries](#) page and see the Assessing and determining a permanent impairment claim page.

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Permanent impairment guides

Section 28 of the SRC Act states that Comcare can prepare and issue a 'Guide to the Assessment of the Degree of Permanent Impairment'. This Guide sets out the criteria with which the degree of PI and NEL shall be determined.

Prior to the introduction of the SRC Act, employees could claim lump sum compensation under the *Compensation (Commonwealth Government Employees) Act 1971* (1971 Act). This act assessed compensation claims using the Table of Maims, listed in section 39(4) of the 1971 Act. The Table of Maims does not provide any compensation for non-economic loss (NEL).

Since the introduction of the SRC Act on the 1st December 1988, Comcare has issued four guides:

- Approved Guide (2023) - Guide to the Assessment of the Degree of PI - Edition 3.0 (Approved Guide)
- Approved Guide (2011) - Guide to the Assessment of the Degree of PI - Edition 2.1
- Approved Guide (2005) - Guide to the Assessment of the Degree of PI - 2nd Edition
- Approved Guide (1989) - Guide to the Assessment of the Degree of PI - 1st Edition.

Which approved Guide should be used to assess a permanent impairment claim?

Edition 3.0 should be used to assess PI claims received after 1 April 2023.

Edition 2.1 still applies for claims received before 1 April 2023.

Note: An employee may have previously been assessed under an earlier edition of the Approved Guide. If that employee applies for a subsequent increase, the claim for an increase will be determined under the relevant Approved Guide based on the date of the claim receipt. An exception is where the employee's PI is assessed as being **less** under the relevant current edition. In this case, the relevant percentage will be taken to be the same as the relevant percentage that was originally assessed under the earlier edition of the Approved Guide. This is to avoid the employee having to repay any monies.

Which employees does each part of the Guide apply to?

Part 1 of the Approved Guide applies to all Commonwealth employees who are not members or former members of the Australian Defence Force (ADF).

Part 2 applies only to ADF members who sustain an injury that occurred during their ADF service prior to the commencement of the *Military Rehabilitation Compensation Act 2004*.

American Medical Association's Guides to the Evaluation of Permanent Impairment

If permanent impairment cannot be assessed under the current approved Guide, you should use the relevant American Medical Association's Guide to the Evaluation of Permanent Impairment (AMA Guide).

The AMA Guide should not be used to evaluate the following conditions:

- mental and behavioural impairments (psychiatric conditions)
- impairments of the visual system
- hearing impairment, or
- chronic pain conditions, except for migraines or tension headaches.

Where unsure, you should seek assistance from your Injury Manager and Assistant Director.

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Registering a claim for permanent impairment

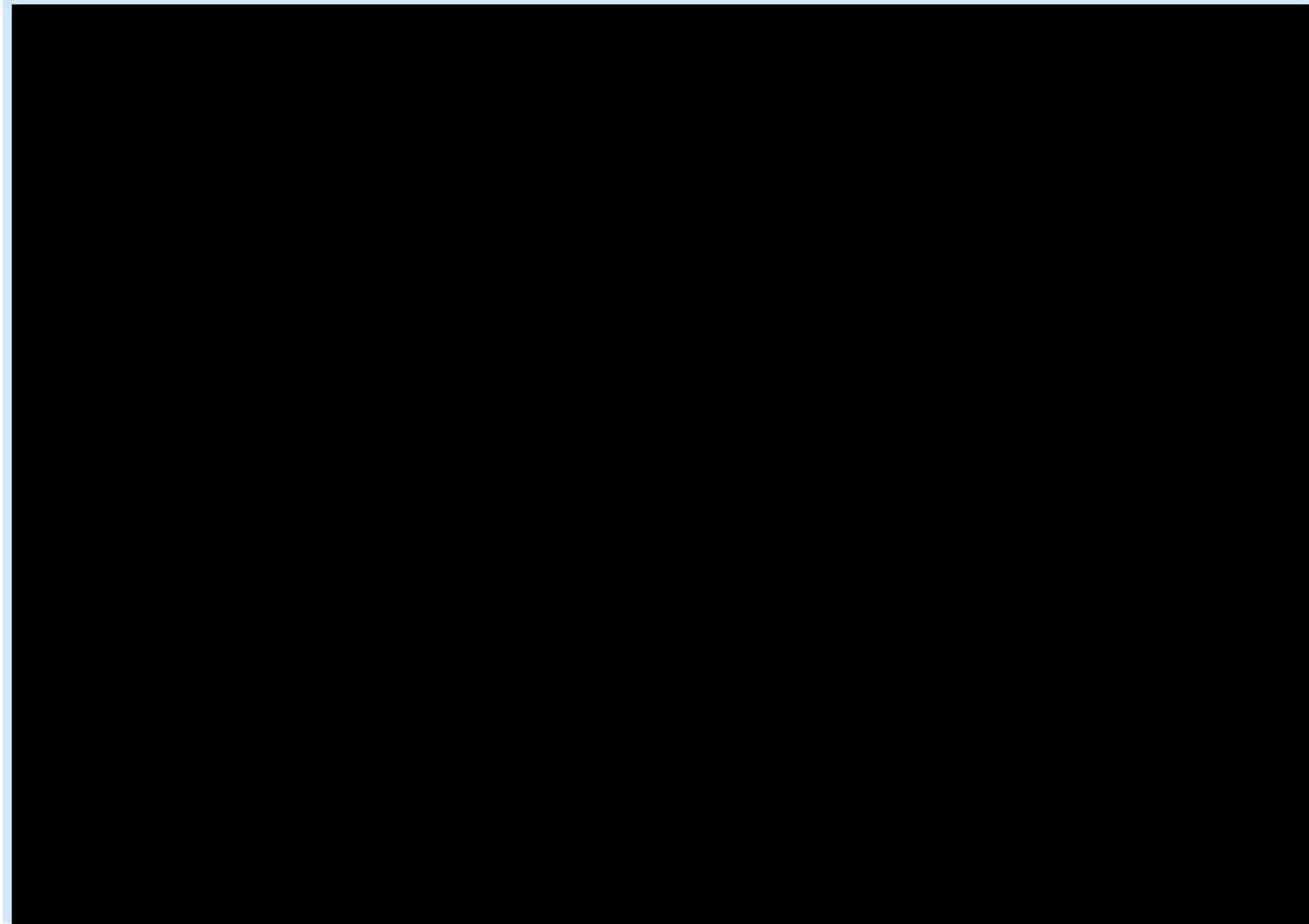
Introduction

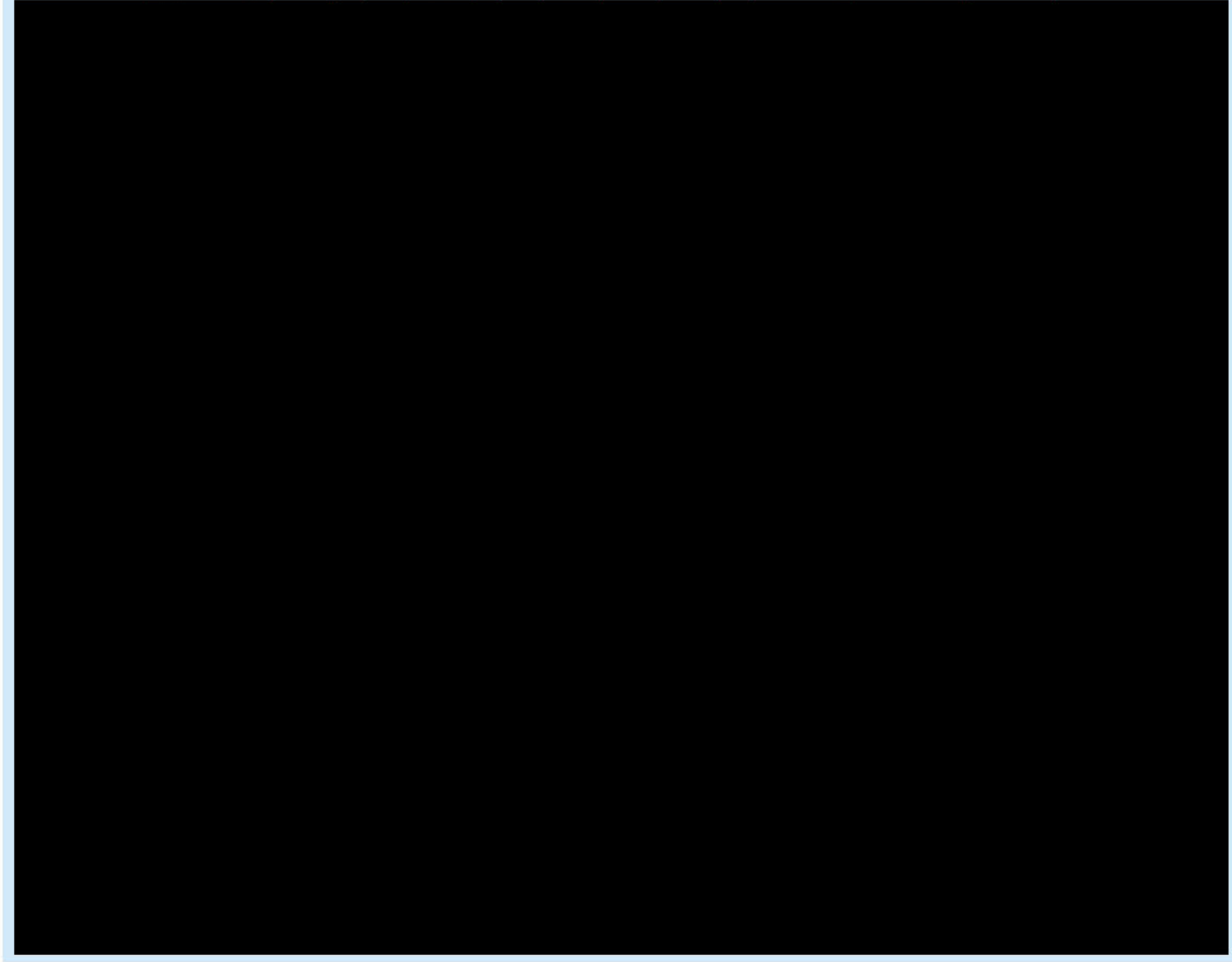
The Claims Administration and Income Support team (CAIS) will register new claims for permanent impairment (PI) within 24 hours of the claim being received by Comcare.

Comcare prefers that the employee provides the completed [Compensation Claim for Permanent Impairment and Non-Economic Loss](#) form for a PI claim. However, you can also accept a letter from the employee or the employee's representative requesting a PI payment as a notification to register a claim. In such cases, the employee will still be required to complete the formal [Compensation Claim for Permanent Impairment and Non-Economic Loss](#) form to assess both PI and non-economic loss (NEL) components.

For injuries such as lung cancer and mesothelioma (see Presumptive legislation), a permanent impairment lump sum may be paid upon diagnosis of the condition. In these cases, the employee may not be required to submit the form or letter to Comcare requesting a lump sum payment. However, the [Compensation Claim for Permanent Impairment and Non-Economic Loss](#) form will still be required to assess non-economic loss (NEL). See [Specified diseases and employment](#) for more information on diseases with presumptive liability.

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Assessing and determining a permanent impairment claim

Published 03/11/2025

Introduction

Claims for permanent impairment (PI) are registered by the Claims Administration and Income Support (CAIS) team (refer to the [Registering a claim for permanent impairment](#) page). Then the Claims Manager is responsible for assessing and determining the claim.

A new PI claim should be triaged within 7 days of PI claim receipt. At this time, a PI claim should be assessed, and the PI claim plan completed. The claim plan will help assess whether a determination can be made without an independent medical examination (IME), taking into account whether:

- there is enough medical evidence available to determine liability
- the employee has undertaken all reasonable rehabilitative treatment for the impairment
- the employee's condition has stabilised
- the employee has received a PI for the same injury previously
- the employee has elected to sue the Commonwealth previously for the same injury (refer to [Electing to sue the Government for more information](#))

and taking into consideration:

- the duration of the impairment
- the likelihood of improvement in the employee's condition
- any other relevant matters.

Timeframes

Comcare aims to determine 90% of permanent impairment claims within 90 days of receipt. Each claim is considered on its own merits and delays can occur due to:

- the complexity of the claim
- unavailability of specialists
- rescheduling of appointments.

Any predicted delays should be discussed with your Assistant Director.

Relevant sections of SRC Act

The following sections of the SRC Act are relevant to claims for permanent impairment:

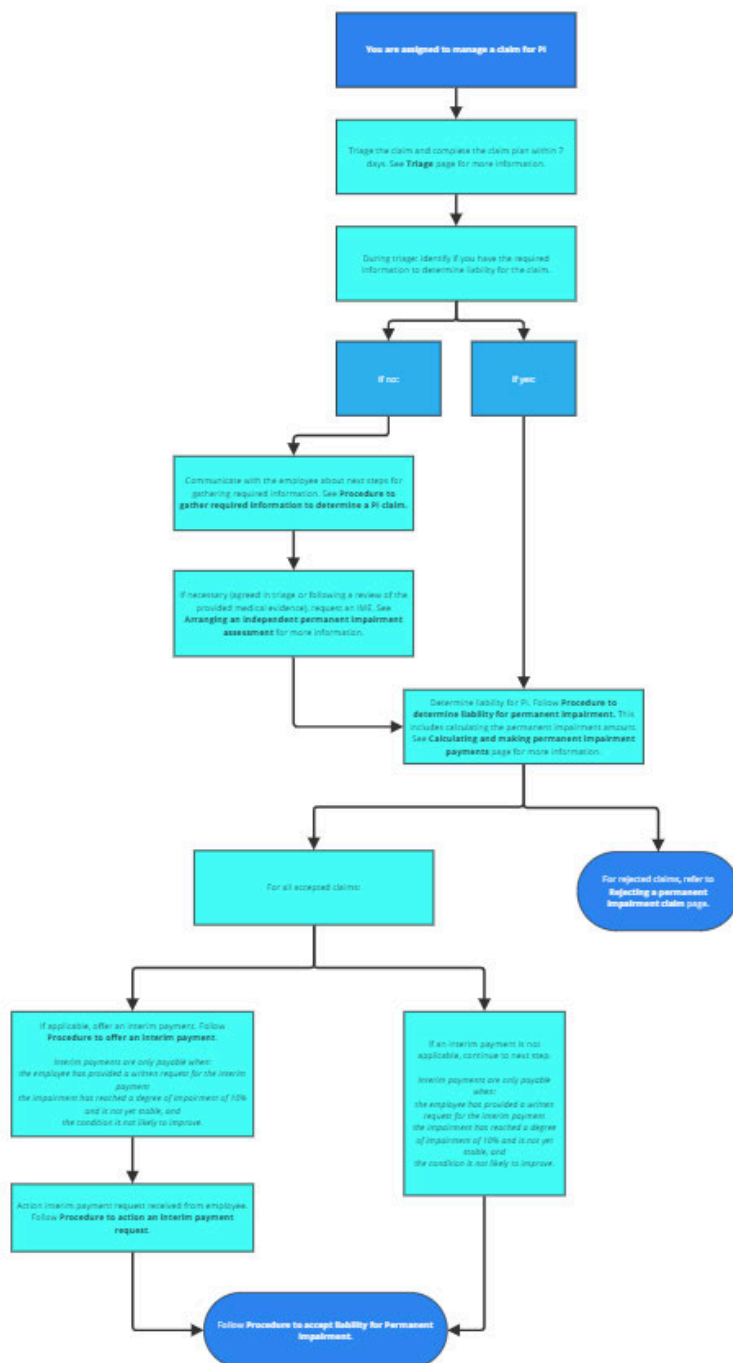
- section 23A – Repayment of salary, wages or pay, and re-crediting of paid leave, where compensation claim successful
- section 24 – Compensation for injuries resulting in permanent impairment
- section 25 – Interim payment of compensation
- section 26 – Payment of compensation
- section 27 – Compensation for non-economic loss
- section 28 – Approved Guide
- section 45 – Actions for damages – election by employees

Hearing loss permanent impairment claims

Please review the information in the Assessing hearing loss claims for permanent impairment page for more specific guidance on assessing hearing loss and factors to consider.

Managing a claim for permanent impairment - flowchart

Refer to this process flowchart to help you progress through the management of a PI claim. Click on the image or click on [Flowchart: assessing and determining a PI claim](#) for a pop-out version you can zoom on.



Flowchart: assessing and determining a PI claim

Arranging an independent permanent impairment assessment

Claims for permanent impairment may require an independent medical examination (IME) to gather necessary medical evidence. See [Independent medical examinations](#) for more information. A decision on whether an independent permanent impairment (PI) assessment is needed should be confirmed in [triage](#).

Before arranging an independent permanent impairment assessment

Before arranging a PI assessment, you should consider the following:

- does the employee have a treating *specialist*, i.e. not a general practitioner (GP), who can determine the degree of PI?
- is further information required from the treating specialist (a legally qualified medical practitioner (LQMP))?
- You may rely on a treating specialist's opinion regarding the degree of PI without arranging an independent assessment:
 - if the specialist is qualified in the field of medicine which most closely relates to the employee's condition.
- You may rely on a treating practitioner's specialist opinion regarding the degree of PI without arranging an independent assessment where:
 - the specialist has reasoned grounds for the degree of PI, with reference to the relevant tables and the application of the correct criteria in the Guide to the Assessment of the Degree of Permanent Impairment Edition 3.0 (Approved Guide).

It would be rare to rely solely on the opinion of the employee's treating general practitioner (GP) when determining a claim for PI.

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Non-economic loss

Compensation for permanent impairment falls under section 24 of the SRC Act. Where compensation under section 24 has been accepted, the employee may also be entitled to additional compensation for any non-economic loss (NEL) suffered. This falls under section 27 of the SRC Act.

The claim form for permanent impairment includes a section where the employee can claim for non-economic loss. The form explains the scoring system and criteria which the employee and medical practitioner must complete.

A NEL payment is designed to compensate the employee for the effect an impairment has had on the employee's life (pain and suffering). It also measures the employee's mobility, and enjoyment of and participation in:

- social relationships,
- recreation and
- leisure activities.

An employee must be **aware** of the losses suffered as a result of an impairment to claim compensation for NEL. Therefore, for example, an employee in a coma is not entitled to compensation for NEL.

The NEL is assessed in accordance with the Guide to the Assessment of the Degree of PI - Edition 3.0. The Claims Manager determines the final scores according to the presented evidence (see Non-economic loss questionnaire below).

Note: Transitional employees are not entitled to NEL under section 27(3) of the SRC Act regardless of the legislation under which the PI payment is calculated.

Interim payments and non-economic loss

An employee may be offered (or may request) an interim payment while their claim for permanent impairment compensation is being progressed.

Interim payments are only payable when:

- the employee has provided a written request for the interim payment
- the impairment has reached a degree of impairment of 10% and is not yet stable, and
- the condition is not likely to improve.

An employee may receive an interim payment for permanent impairment under section 25 of the SRC Act. However, they are not entitled to a non-economic loss (NEL) payment until a determination is made under section 24 of the SRC Act.

See Procedure to offer an interim payment for information on how to identify applicable claims and discuss interim payments with the employee.

See Procedure to action an interim payment request for how to update the claim following a written request for an interim payment by the employee.

Non-economic loss questionnaire

The non-economic loss (NEL) questionnaire is divided into the following sections:

- pain and suffering
- loss of amenities
- other loss
- treating practitioner's section and
- legally qualified medical practitioner's (LQMP's) section. This section is only for cases where there is both a treating practitioner and an independent medical examiner appointed by Comcare.

You, as the Claims Manager, need to use the non-economic loss (NEL) calculation tables to determine the percentage of NEL an employee is suffering. Scores from these tables are used to calculate a percentage of NEL.

When assessing and determining NEL, you must carefully consider and select the appropriate scores based on the overall evidence of the claim, in conjunction with any explanations or additional comments provided by:

- the employee
- the treating practitioner and
- the LQMP/examiner appointed by Comcare (if applicable).

The employee's scores may be different from those of the treating practitioner or LQMP/examiner. In such cases, Comcare is likely to accept the NEL score obtained from the treating practitioner or the

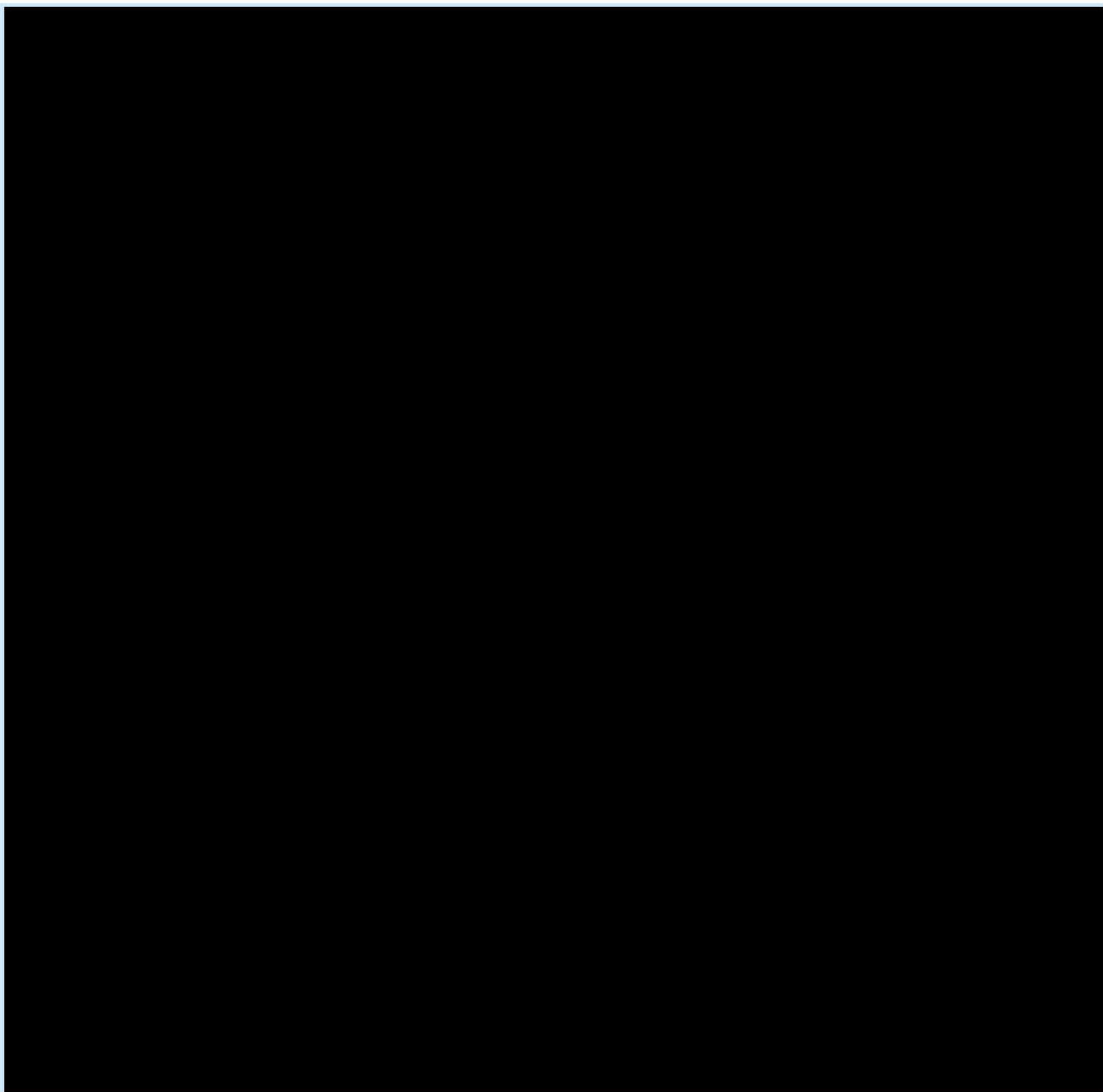
LQMP/examiner. However, any decision should be supported by medical evidence. Reference should be given to the employee's comments as well.

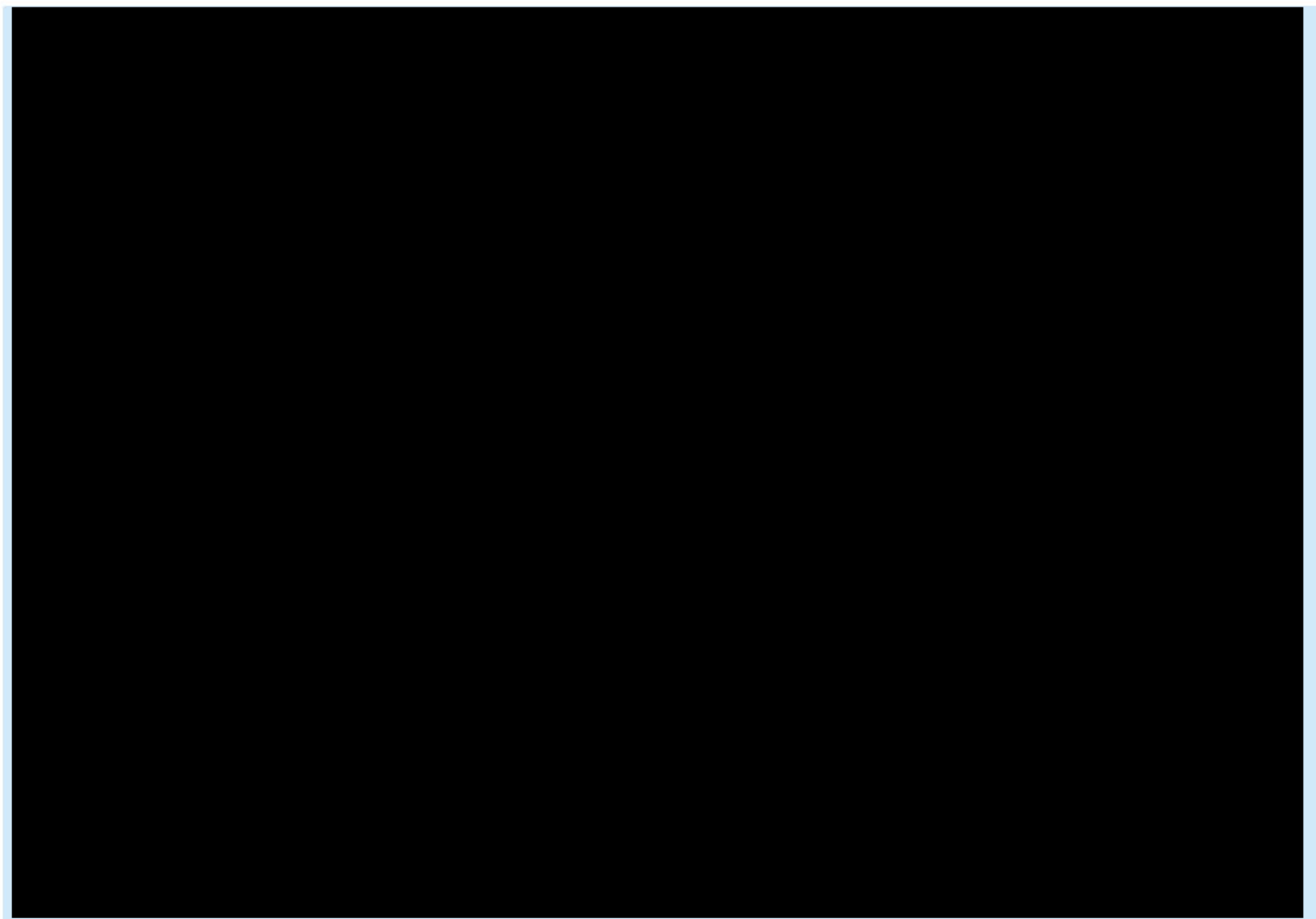
Non-economic loss previously paid

When determining NEL scores, the Claims Manager needs to consider whether the employee has ever received NEL payments previously. If so, you need to consider if the previous payments were for the same 'lifestyle' change that they are currently claiming for. If they are, Comcare can only pay an additional NEL payment if the suffering rating has increased since the first time Comcare paid the employee. That is, if the employee had a Suffering score of 3 last time and a score of 4 this time, Comcare would calculate the new payment so as to only pay them a score of 1 to account for the difference.

For further information, refer to the PI Guide.

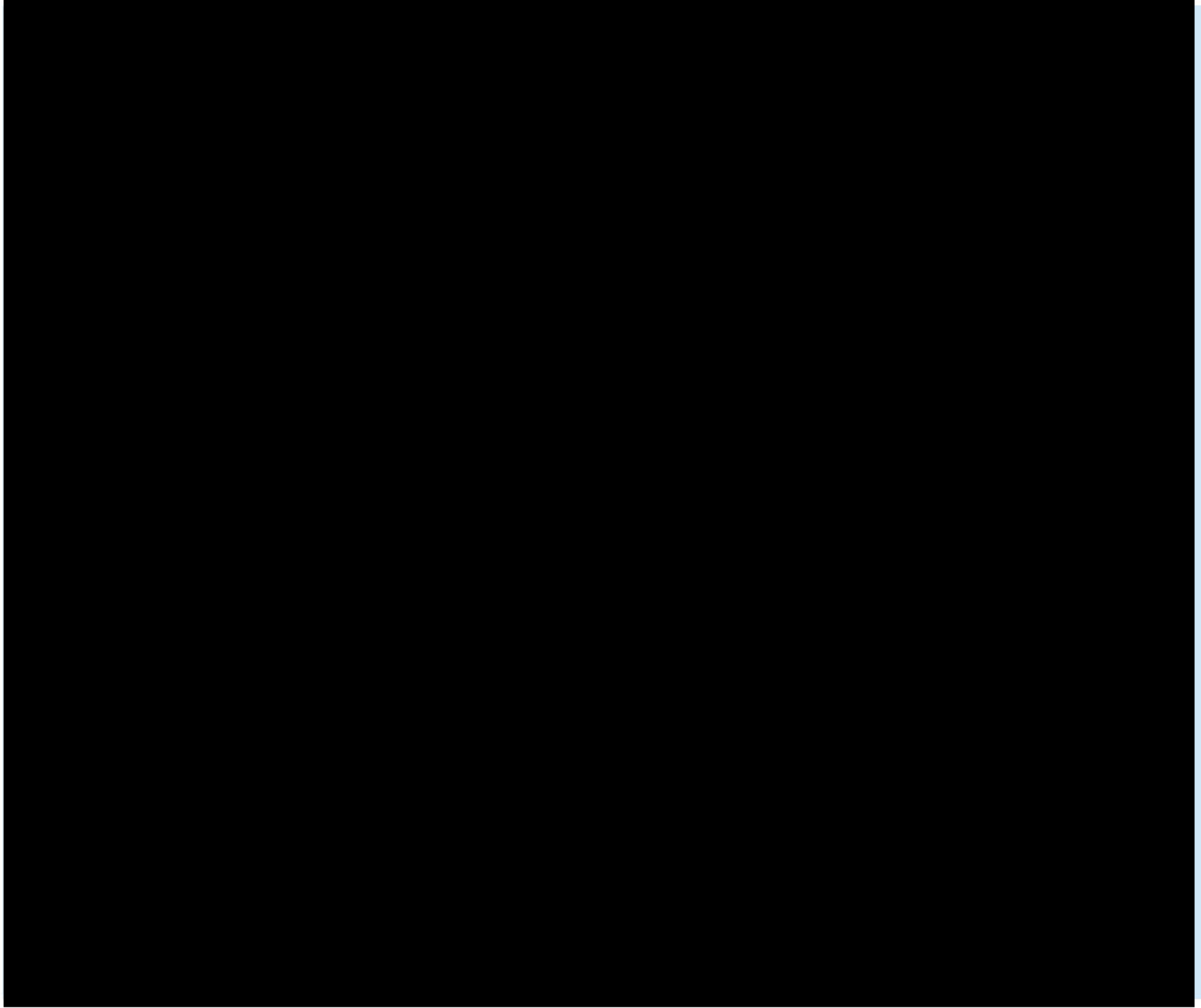
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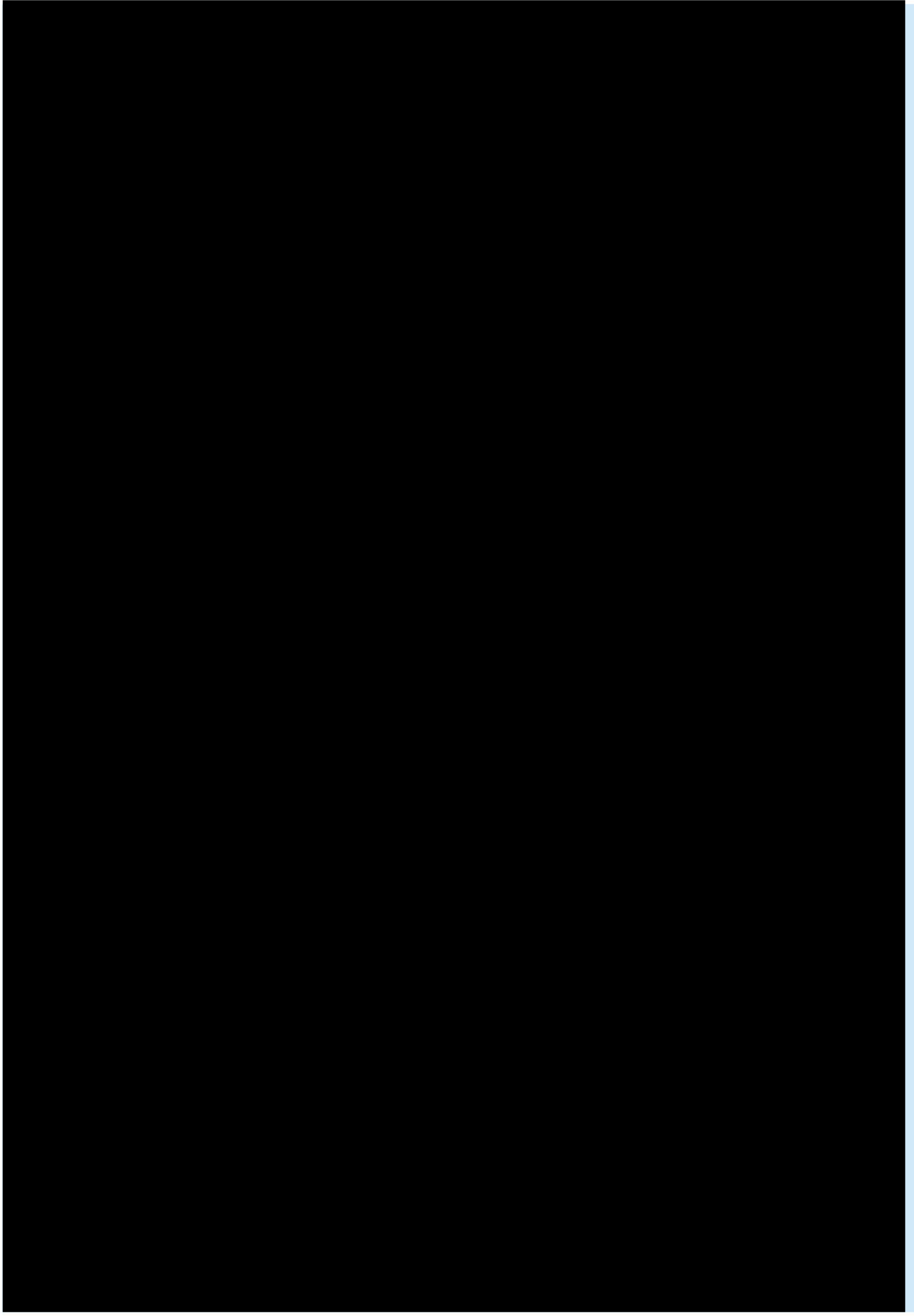
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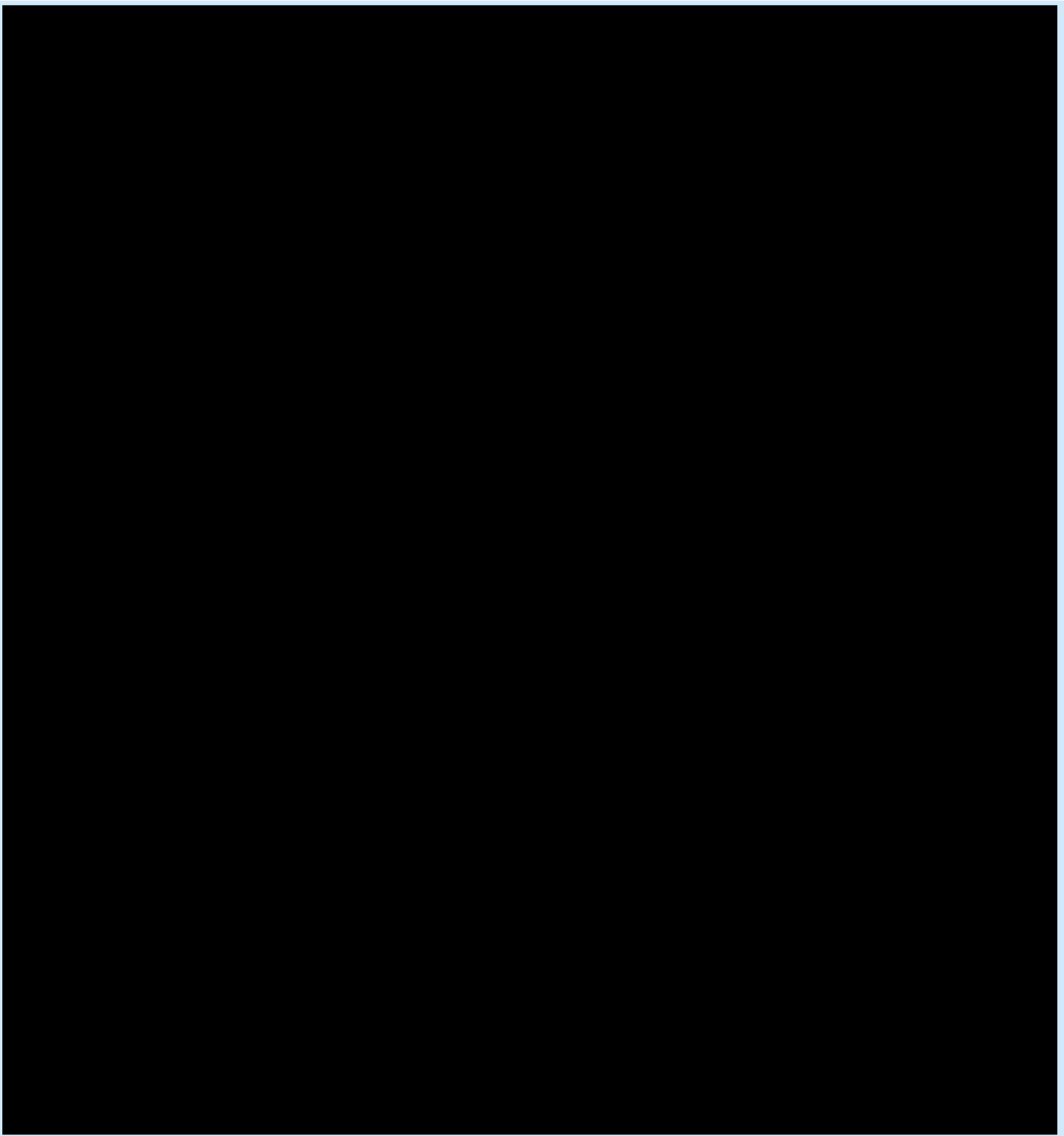
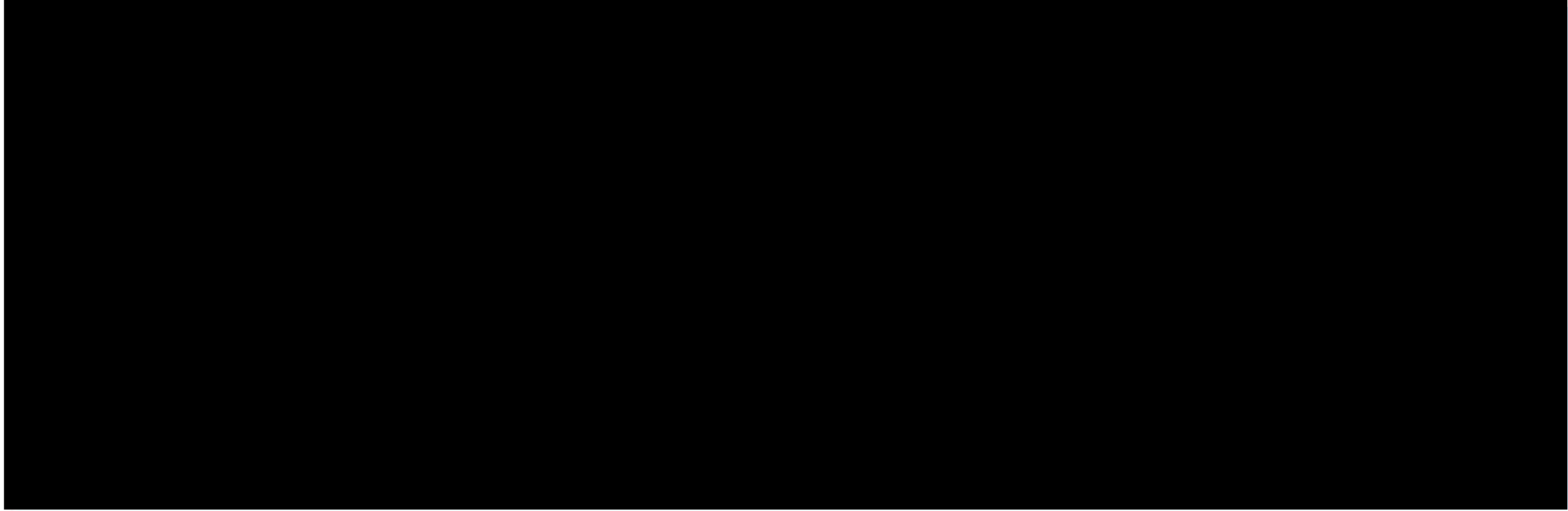
The first part of the paper discusses the importance of understanding the cultural context of the research. It highlights the need for researchers to be sensitive to the values and beliefs of the communities they are studying. This is particularly important in the field of education, where cultural differences can significantly impact learning outcomes. The paper then moves on to discuss the challenges of conducting research in culturally diverse settings. It notes that researchers often face difficulties in establishing rapport with participants and in interpreting their responses. To address these challenges, the paper suggests several strategies, including the use of local informants and the development of culturally appropriate research instruments. The final part of the paper discusses the importance of ethical considerations in cross-cultural research. It emphasizes the need for researchers to obtain informed consent from participants and to ensure that their research does not cause harm or exploitation. The paper concludes by noting that while cross-cultural research is a complex and challenging endeavor, it is also a highly rewarding one that can lead to a deeper understanding of human behavior and culture.

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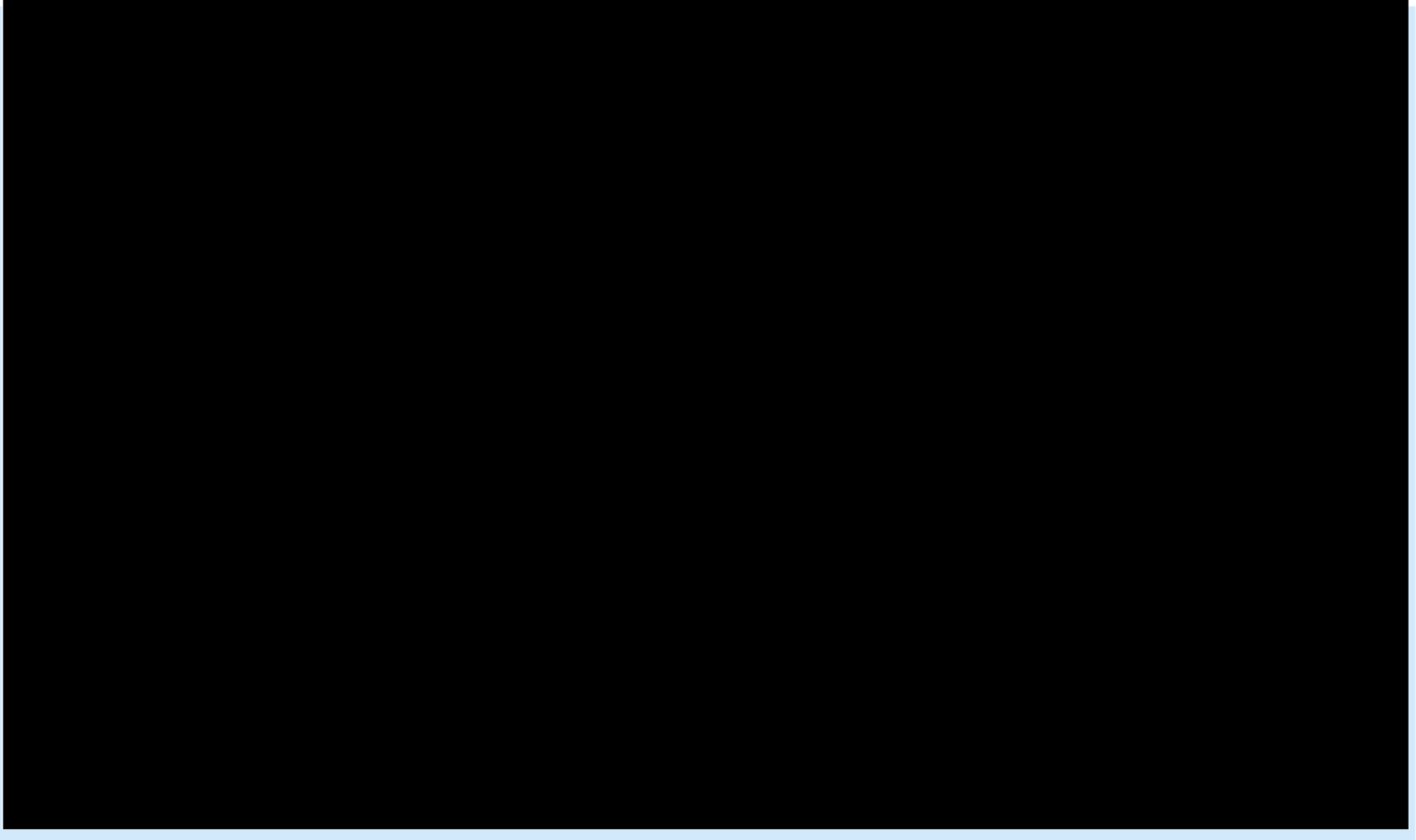
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Assessing hearing loss claims for permanent impairment

Introduction

Employees with an accepted claim for hearing loss may claim a lump sum payment under the *Safety, Rehabilitation and Compensation Act 1988* (SRC Act) if the hearing loss has resulted in permanent impairment (PI).

The calculation of the PI payment will be made with reference to the relevant Act that was in place **at the date of injury**. This includes cases where the employee is making a subsequent PI claim due to a worsening of the condition.

Relevant sections of SRC Act

The following sections of the SRC Act are relevant to claims for permanent impairment:

- section 7(4) - Provisions relating to diseases
- section 24 – Compensation for injuries resulting in permanent impairment
- section 25 – Interim payment of compensation
- section 26 – Payment of compensation
- section 27 – Compensation for non-economic loss
- section 28 – Approved Guide

Under the SRC Act, the *Guide to the Assessment of the Degree of Permanent Impairment Edition 3.0* (the Guide) is used to assess the degree of permanent impairment (PI) and Non-Economic Loss (NEL). Table 7.1 of the Guide allows for the assessment of permanent impairment for hearing loss.

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Hearing Loss

While you are not required to assess the type of hearing loss, nor the level of impairment, the guidance below will assist you to understand the causes of hearing loss, as well as how the medical assessor should assess the level impairment.

Types of hearing loss

There are three basic types of hearing loss:

- **Conductive:** This occurs when there are problems with the outer and/or middle ear and can be caused by:
 - fluid in the middle ear (ear infection)
 - foreign objects e.g. a grass seed or insect
 - a perforated eardrum
 - wax (cerumen) build up
 - allergies
 - damage to the tiny bones in the middle ear (ossicles)
- **Sensorineural:** This occurs when there is damage to the hair cells of the cochlea or damage to the fibres of the auditory nerve and can be caused by:

- aging
- acoustic shock
- noise damage
- drug side effect
- auditory tumours
- blast/explosion
- ototoxic substances e.g. industrial chemicals, chemotherapy drugs
- **Mixed:** This occurs when a person has both conductive and sensorineural hearing loss for example, the person has hearing loss to long term exposure to loud noises (sensorineural) and has hearing loss due to impacted earwax (conductive). May also include:
 - genetic disorders
 - infections
 - head trauma

Other types of hearing loss include congenital and functional or non-organic hearing loss.

Congenital sensorineural hearing loss is a hearing impairment present at birth due to damage to the inner ear or auditory nerve.

Functional or non-organic hearing loss is a condition where a person experiences hearing difficulties despite having no detectable physical or organic cause for the loss in their auditory system. Functional hearing loss can sometimes be related to psychological or emotional factors, such as stress, anxiety or underlying psychological condition.

Hearing loss can affect one (monaural) or both ears (binaural).

Common causes or symptoms of sensorineural hearing loss

Noise-induced hearing loss (NIHL) is caused by prolonged or repeated exposure to loud sounds or in some cases caused by a one-time exposure to an intense 'impulse' sound, such as an explosion.

Other potential causes of NIHL include exposure to ototoxic substances, such as, solvents, a family history of hearing loss, and ear infections that have not resolved.

Loud noises, whether sudden or sustained, can damage the tiny hairs in the cochlea or inner ear. These hairs move as sound waves go past them, passing signals to the brain which are then interpreted into messages that can be understood. When these tiny hairs are damaged, the ability to transfer sound waves is diminished. Once these hairs and inner ear structures are damaged, they cannot regenerate or be repaired.

Exposure to loud noise over a long period of time usually results in gradual hearing loss and may not be noticed until the hearing loss becomes pronounced.

Loud bursts of sound, such as gunshots or explosions, can also rupture the eardrum or damage the bones in the middle ear. This type of NIHL can be immediate and permanent.

Age-related hearing loss or presbycusis develops slowly over time due to the natural aging process caused by the degeneration of the inner ear structures, including the cochlea and auditory nerve and usually affects adults over the age of 65.

Tinnitus is a ringing, buzzing, clicking or roaring sound in the ears or head and is a symptom rather than a disease and may accompany hearing loss. Tinnitus may subside over time but can sometimes continue constantly or occasionally throughout a person's life and may occur in one or both ears.

How is hearing loss assessed?

Hearing loss is assessed by an audiogram test that is performed by an audiologist. The result of the audiogram test is then compared to the international hearing loss standards to determine the degree of hearing loss.

The audiogram is a simple graph. However, you may need to seek assistance from your Injury Manager or the Clinical Panel with interpreting the results.

The Volume axis (vertical) measures the intensity, or loudness, of the sound which are measured in decibels (dB). These range from –10 to 120 decibels on the audiogram. Low decibel sounds include whispers and high decibel sound include jackhammers.

The Frequency axis (horizontal) measures the frequency or pitch of the sound. The numbers on the audiogram range from 125 to 8,000 and are measured in hertz (Hz) or kilohertz (kHz). Low-frequency sounds include the sound of bullfrogs or thunder. High-frequency sounds include the sound a cricket makes or a whistling noise.

The audiogram displays how loud the sounds have to be for a person to hear them. The results are reported in frequency, if minimum thresholds are not met, hearing loss is detected.

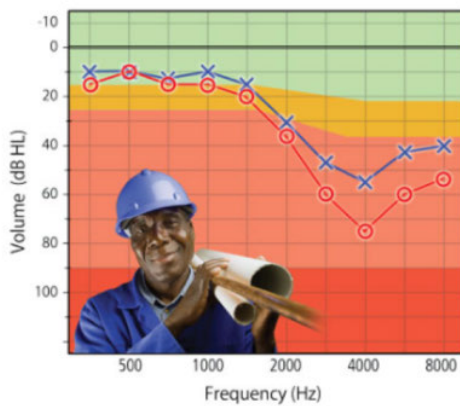
The severity of the hearing loss is measured by decibels (dB) and is categorised as follows:

- **Normal:** 0-25 dB HL
- **Slight/Mild:** 26 – 40 dB HL
- **Moderate:** 41-60 dB HL
- **Severe:** 61-80 dB HL
- **Profound:** 81+ dB HL

According to the SafeWork Australia [report](#) on work-related noise induced hearing loss, one of the first signs of hearing loss due to work related noise exposure is a 'notching' of the audiogram at 3, 4, or 6 kHz, with a recovery at 8 kHz.

A further [report](#) from SIRA NSW indicates that while noise induced hearing loss often results in high frequency notches, not all cases will present with these notches. Contemporary research has also indicated that the presence of high frequency notches is common among other types of hearing damage, and notches often occur in people who have not been exposed to excessive noise. While notches may be interpreted as an indication of noise-induced hearing loss, other indicators are required to substantiate a diagnosis of noise-induced hearing loss.

The report also indicates that damage resulting from noise exposure usually begins at 3-6 kHz. However, with continued noise exposure, damage can spread to both lower (2, 1 kHz) and higher frequencies (8 kHz). With prolonged (20+ years) or severe exposure damage can occur at frequencies as low as 0.5 kHz. However, noise-induced hearing loss typically affects audiometric thresholds at 4 and 6 kHz.



(from Australian Audiology Services)

Above is an example of how an audiogram may look for a builder who has NIHL. The 'x' represents the scores for the left ear, and the 'o' represents the scores for the right ear.

The hearing loss diagnosis should also be based on the combination of the:

- history of noise exposure
- the audiogram results; and
- findings from any other specialised tests or assessments.

If the audiogram or medical assessor's report is incomplete or does not clearly differentiate between compensable and non-compensable hearing loss, and/or you require assistance with reading the audiogram, please discuss this with your Assistant Director, or Injury Manager or Technical Capability Officer.

If necessary, please refer the matter to the Clinical Panel for review.

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How to assess when hearing loss became permanent

Under the SRC Act, noise induced hearing loss is treated as a disease as generally it develops over a period of time without the employee being aware of its development.

The Federal Court has confirmed that the date of last exposure to noise cannot be used as the date of injury for hearing loss claims. The provisions under section 7(4) must be applied to hearing loss claims in the same way as it is for other disease claims (*Comcare v Kemp* [2020] FCA 865).

Under section 7(4) of the SRC Act, when assessing the date of injury, you must take into consideration when:

- the employee first sought medical treatment for the disease or aggravation; or
- the disease or aggravation first resulted in the incapacity for work or impairment of the employee; or
- whichever happens first.

Liability to compensation commences from the date of injury, and if payable the amount of compensation cannot be apportioned across workers' compensation schemes (Commonwealth or State or Territory) that precede the date of injury.

As noise induced hearing loss causes permanent damage to the hair cells of the inner ear and the hearing nerve, **the date of injury may also be the date that the injury resulted in permanent impairment.**

Example: An individual was employed by the Commonwealth as a construction worker. They ceased their employment with the Commonwealth in the mid 1980s. Years later, the ex employee lodges a claim for Noise Induced Hearing Loss (NIHL) attributed to their employment as a construction worker where they were exposed to high levels of noise.

The employee's original claim form was accompanied by an audiogram test conducted on 21 December 2013. Employment records obtained from the employer confirmed that the employee was employed from August 1985 to January 1987.

Based on the evidence provided, the date that the hearing loss became permanent would be deemed to be the date the employee first sought medical treatment (i.e. the date the audiogram test was conducted) 21 December 2013.

Information that can assist with determining when the hearing loss became permanent can include, but is not limited to:

- IME reports
- previous or current audiograms
- letters from treating doctors
- medical certificates, medical reports, hearing assessments, clinical notes
- employment records confirming when the employee was employed, duration of employment, duties performed, pre-employment medicals and physical/psychiatric assessments undertaken in respect of their employment
- incident reports
- Informal and formal performance assessments and associated documents – is there a change in performance, particularly a downturn in performance, that may indicate impairment?
- leave records – is there a noticeable change in the amount or time of leave being taken?

If you have any concerns with assessing when the hearing loss became permanent, please discuss these with your Assistant Director.

Refer To: [*the Guide to the Assessment of the Degree of Permanent Impairment Edition 3.0*](#)

Monaural hearing loss

If an employee only suffers from monaural hearing loss (hearing loss in one ear), the hearing test needs to be performed on both ears. This is necessary to be able to determine the percentage of binaural hearing loss (hearing loss in both ears).

The threshold requirement for permanent impairment is expressed as **binaural** (relating to both ears) hearing loss percentage which is why the hearing tests need to be performed on both ears.

Once the binaural hearing loss has been calculated, the degree of PI can be established. This is done by dividing the percentage of binaural hearing loss by 2 (as per Table 7.1 of the *Guide to the Assessment of the Degree of PI - Edition 3.0*).

The degree of impairment must be at least 5% **binaural** hearing loss to achieve at least 2.5% WPI when the method set out in Table 7.1 is applied.

Employees with compensable and non-compensable hearing loss

Some employees may submit a PI claim for hearing loss which may include compensable, non-compensable and pre-existing factors contributing to the hearing loss. You can only determine liability for PI for the hearing loss where liability has first been accepted under section 14 (compensable factors).

Where the employee has compensable, non-compensable and pre-existing factors contributing to their PI, you will need to review the current medical evidence to establish whether it is possible to isolate the degree of PI attributable only to the compensable hearing loss.

You may need to request additional medical evidence to confirm whether isolating the effects is possible. This could include:

- pre-employment medical assessments
- audiology reports.

Where the degree of PI attributable to the compensable hearing loss can be isolated through medical evidence:

- you must only use the percentage of binaural hearing loss attributed to the compensable injury.

Example: An employee claims compensation for Noise Induced Hearing Loss which they contended is due to noise exposure in their workplace. Before the injury, the employee already had minor hearing impairment (due to factors not related to scheme covered employment or work).

There is medical evidence on the claim that indicates the level of hearing loss the employee suffered before the compensable injury,

Using the existing evidence, the medical assessor can isolate the effects of the compensable/scheme covered employment and therefore can undertake an assessment of the degree of the employee's hearing loss which is attributable to the compensable injury.

The report findings should provide the reasoning of how the degree of PI was isolated for you to determine the degree of PI resulting from the compensable hearing loss.

Where the degree of PI cannot be isolated from the compensable, non-compensable or pre-existing hearing loss:

- the degree of PI should be considered as entirely attributable to the compensable hearing loss injury.

Example: An employee claims compensation for Noise Induced Hearing Loss which they contend is due to their exposure to noise while at their scheme covered workplace. The employee has indicated that they may have had some hearing loss prior to their workplace injury due to recurring ear infections as a child.

However, there are limited medical records available, and no audiograms were undertaken to confirm the level of hearing loss that may have occurred due to the ear infections.

The employee's employment history indicates that the employee has been employed as mechanic since they left school and was often exposed to loud noises over an extended period.

The current audiogram shows significant hearing loss in both ears.

As the medical assessor is unable to isolate the possible non-compensable hearing loss from the compensable hearing loss, the hearing loss is solely attributed to the compensable injury.

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Tinnitus

A permanent impairment (PI) assessment can be undertaken to assess impairment arising **as a result of tinnitus in the presence of hearing loss** (refer Table 7.2 of the *Guide to the Assessment of the Degree of Permanent Impairment*).

An impairment arising as a result of tinnitus is not a separate injury. There must be the presence of employment-related hearing loss for a tinnitus assessment under Table 7.2 to be considered. Any impairment rating found for tinnitus should be combined with the percentage of hearing loss impairment under Table 7.1 using the combined values chart.

Table 7.2 used for the assessment of tinnitus cannot be used as a stand-alone table, and if it was it would not reach the threshold requirement of 10 WPI. It is not an exception like hearing loss is.

Further information can be found in the Claims Manual under [Employees with multiple compensable impairments](#).

Note: Tinnitus was not a condition for which PI was payable under the compensation legislation before 1 December 1988. Therefore, PI cannot be awarded for any claims of tinnitus where the injury, loss or damage was suffered before 1 December 1988.

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What Act is relevant?

The date of injury will determine whether the calculation of permanent impairment is made in reference to:

- *the Commonwealth Employees’ Compensation Act 1930-1970 (1930 Act) or*
- *the Compensation (Commonwealth Employees) Act 1971 (1971 Act) or*
- *the Safety, Rehabilitation and Compensation Act 1988.*

Noise induced hearing loss causes permanent damage to the inner ear and **the date of injury may therefore also be the date the injury became permanent.**

The table below provides the Commonwealth Acts that apply based on the date of injury.

Date of injury	Binaural hearing loss percentage	Relevant Act	Subsequent deterioration applications
From 11 January 1954	more than 0%	1930 Act	1930 Act (no NEL payment)
From 1 September 1971	more than 0%	1971 Act	1971 Act (no NEL payment)
From 1 December 1988	At least 20% binaural loss (to achieve 10% WPI)	SRC Act 1988	SRC Act 1988
From 1 October 2001	At least 5% binaural loss (to achieve 2.5% WPI)	SRC Act 1988	SRC Act 1988

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Calculating permanent impairment payment amounts

Published 31/07/2025 · 6 min read

Introduction

As the Claims Manager, you will receive information through the employee’s claim about their injury. You should be able to identify instances in which a permanent impairment claim is likely to be accepted.

Calculating the permanent impairment payment amount is an important step in the process for determining liability for permanent impairment (PI). It falls under Step 6 of the Procedure to determine liability for permanent impairment. The following page offers information and guidance on how to complete this process.

Where liability for a permanent impairment claim is likely to be accepted, refer to the Procedure to calculate a permanent impairment payment. You should calculate the permanent impairment payment (or interim payment) before continuing with the acceptance process.

Interim payments: The employee may have previously been paid an interim payment for permanent impairment in relation to the same injury (section 25 of the SRC Act). In that case, monies previously paid to the employee in relation to the same injury will be deducted from the calculations of the PI payment.

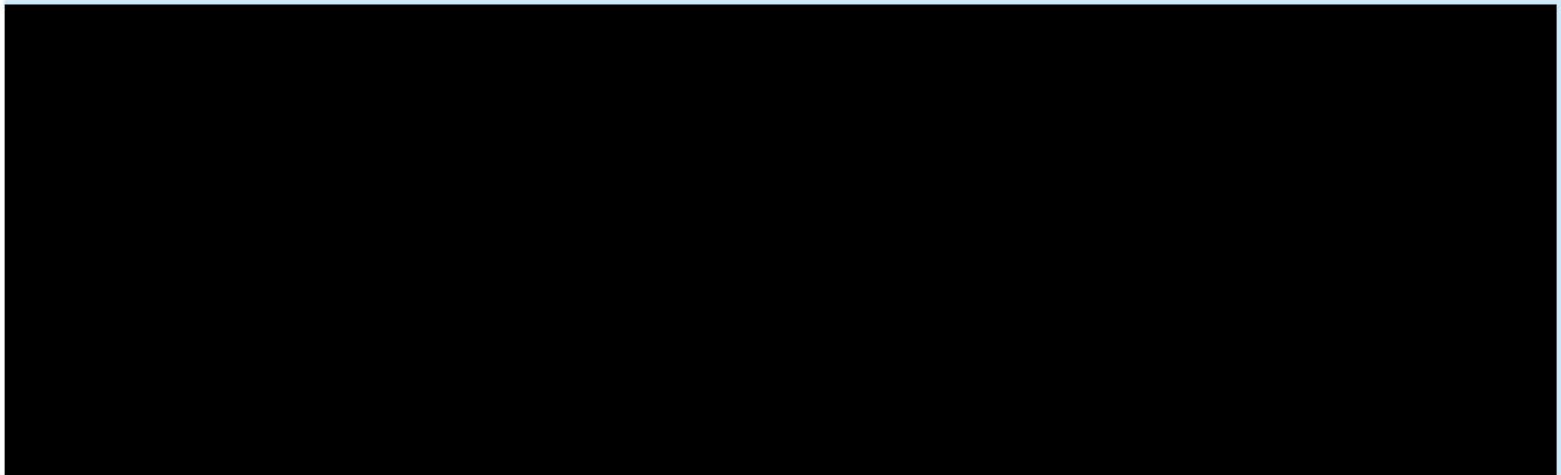
See Procedure to offer an interim payment and Procedure to action an interim payment request for more on interim payments.

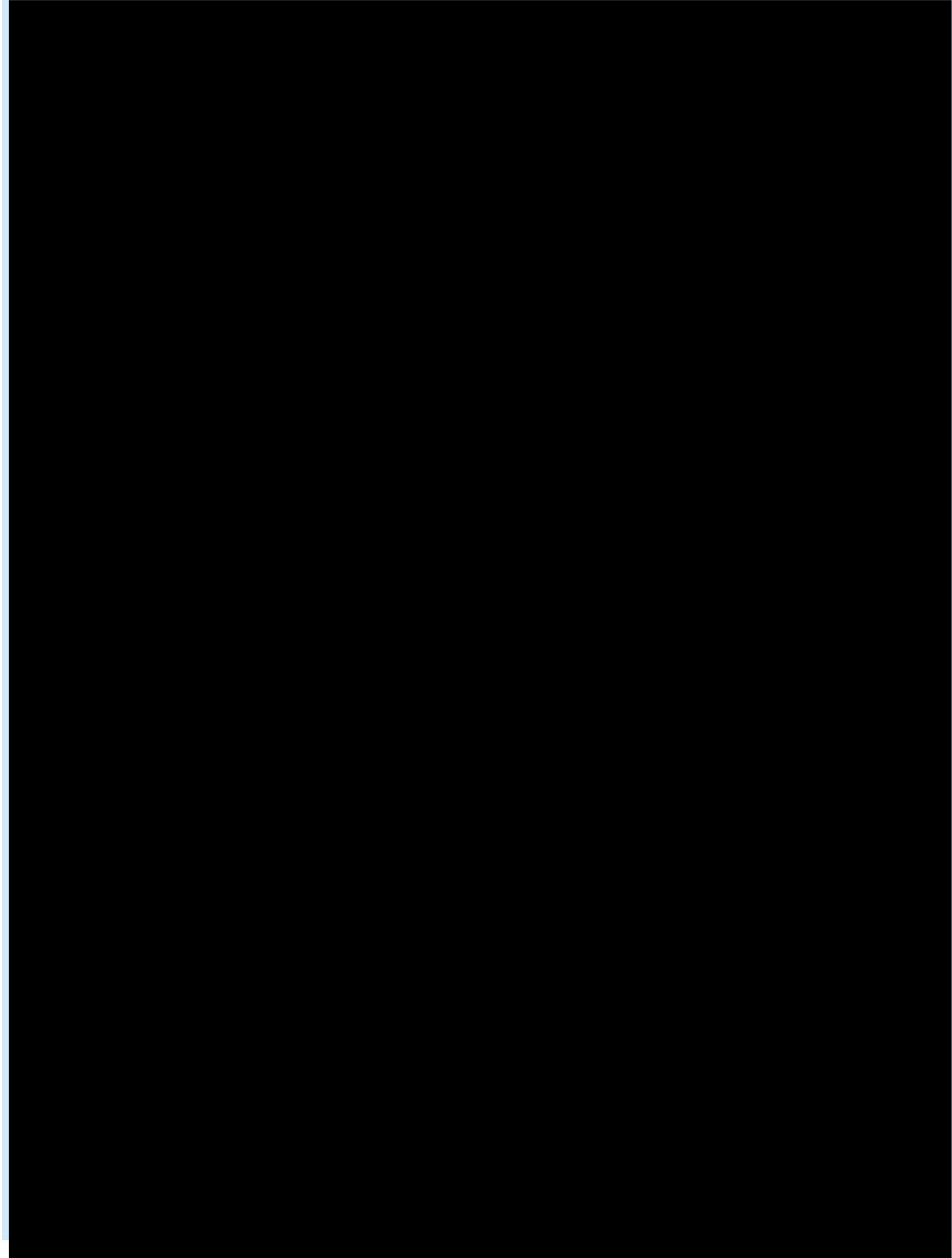
Relevant sections of SRC Act

The following sections of the SRC Act are relevant to claims for permanent impairment:

- section 24 – Compensation for injuries resulting in permanent impairment
- section 25 – Interim payment of compensation
- section 26 – Payment of compensation
- section 27 – Compensation for non-economic loss
- section 28 – Approved Guide

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Late payment of permanent impairment

If an employee has an accepted claim for permanent impairment (PI), Comcare must make the payment within 30 days of the determination being made. If payment is not made within 30 days, Comcare is liable to pay interest to the employee for each day the payment is late.

The 30-day timeframe does not apply:

- where the employee has requested a reconsideration in relation to the PI
- following a reviewable decision issued by the Review Officer
- where there is a proceeding before the Administrative Review Tribunal (ART) in relation to the PI
- following a decision issued by the ART.

Note: Payment is deemed to be made when the EFT is shown as '*PAID*' in Pracsys or the cheque is issued (posted).

Interest rate

The interest rate used when calculating a late payment for PI is decided by the Relevant Minister. The rate is based on the interest rates provided by the Reserve Bank of Australia (RBA).

If Comcare is required to calculate the interest on a late PI payment, you will need to use the following calculations:

- $\text{RBA interest rate} \div 100 = \text{interest rate percentage}$
- $\text{Interest rate percentage} \times \text{section 24 award amount} = \text{yearly amount}$
- $\text{Yearly amount} \div 365 = \text{daily amount}$
- $\text{Daily amount} \times \text{number of days late} = \text{amount payable.}$

Example

- Interest rate: 4.75%
- Section 24 award amount: \$12,706.00
- Days late: 168
- $4.75 \div 100 = 0.0475$ (interest rate percentage)
- $0.0475 \times 12706 = 603.535$ (yearly amount)
- $603.535 \div 365 = 1.6535$ (daily amount)
- $1.6535 \times 168 = \$277.79$ (amount payable)

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Electing to sue the Commonwealth

Introduction

Under section 45 of the SRC Act, eligible employees may elect to sue the Commonwealth for damages **instead of** receiving compensation for permanent impairment (PI). *Eligible employees* means employees who are entitled to receive lump sum payments under sections 24, 25 or 27 of the SRC Act.

An employee can elect to sue the Commonwealth (section 45 of the SRC Act) at any time **before compensation has been paid** under sections 24, 25 or 27 of the SRC Act. To pursue an election to sue the Commonwealth, the employee needs to show:

- that there is at least 10% whole person impairment (WPI) and
- that Comcare would be liable for the claim.

Note: Comcare does not have to make a permanent impairment determination for an employee to elect to sue the Commonwealth. In most circumstances, the employee will rely on Comcare's PI determination before considering whether to make an election to sue the Commonwealth.

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Section 45 election form

Once liability for permanent impairment (PI) compensation has been determined and accepted, the Claims Manager sends the employee a letter advising of the determination accepting liability under sections 24 and 27. See the Procedure to accept liability for permanent impairment for more information.

A [Section 45 Election Form](#) is sent to the employee with this letter.

If the employee elects to sue under section 45 of the SRC Act, Comcare asks for the form to be returned within 14 days of the PI determination being made. As the PI payment is processed at the end of 30 days, this allows time for the employee to return their form before the payment is made, if they elect to do so. If the Section 45 election form is not returned to Comcare before the payment is made, the employee's election to sue under section 45 of the SRC Act can no longer be exercised.

An election to sue the Commonwealth under section 45 of the SRC Act is irrevocable (section 45(3)) and can only be made before the employee receives a PI payment (section 45(1)). Therefore, all rights to compensation under sections 24, 25 and 27 are waived if the employee makes a valid election under section 45 of the SRC Act.

In order for an election to sue to be valid under section 45 of the SRC Act, the following actions need to be undertaken:

- an election needs to be made
 - in writing
 - before instituting proceedings in a Court
 - before any payment being made under sections 24, 25 or 27 of the SRC Act, and
- the Commonwealth (or Comcare) must be advised.

Invalid elections to sue

Elections can be invalid for a number of reasons. Some examples include:

- PI has been paid previously
- the employee's intentions are not clear (where an acceptance for PI and a signed election to sue are both received by Comcare)
- the form isn't signed or dated
- the form doesn't clearly identify the claim number.

If it's clear there is no liability on behalf of the Commonwealth, then any section 45 election is invalid.

Any completed section 45 election form should be referred to **Claims and Litigation Services** for review before any action is taken by a Claims Manager.

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Rejecting a claim for permanent impairment

Introduction

Under the SRC Act, Comcare may reject an employee's claim for permanent impairment (PI) where:

- the compensable injury has not resulted in an impairment
- the impairment is not permanent, or
- the degree of whole person impairment (WPI) is less than the minimum threshold under the Guide to the Assessment of the Degree of Permanent Impairment - Edition 3.0 (Approved Guide).

Relevant sections of SRC Act

The following sections of the SRC Act are relevant to claims for permanent impairment:

- section 24 – Compensation for injuries resulting in permanent impairment
- section 25 – Interim payment of compensation
- section 26 – Payment of compensation
- section 27 – Compensation for non-economic loss
- section 28 – Approved Guide

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Transitional employees

These claims are extremely rare. Get help from your Assistant Director and Decision Support team.

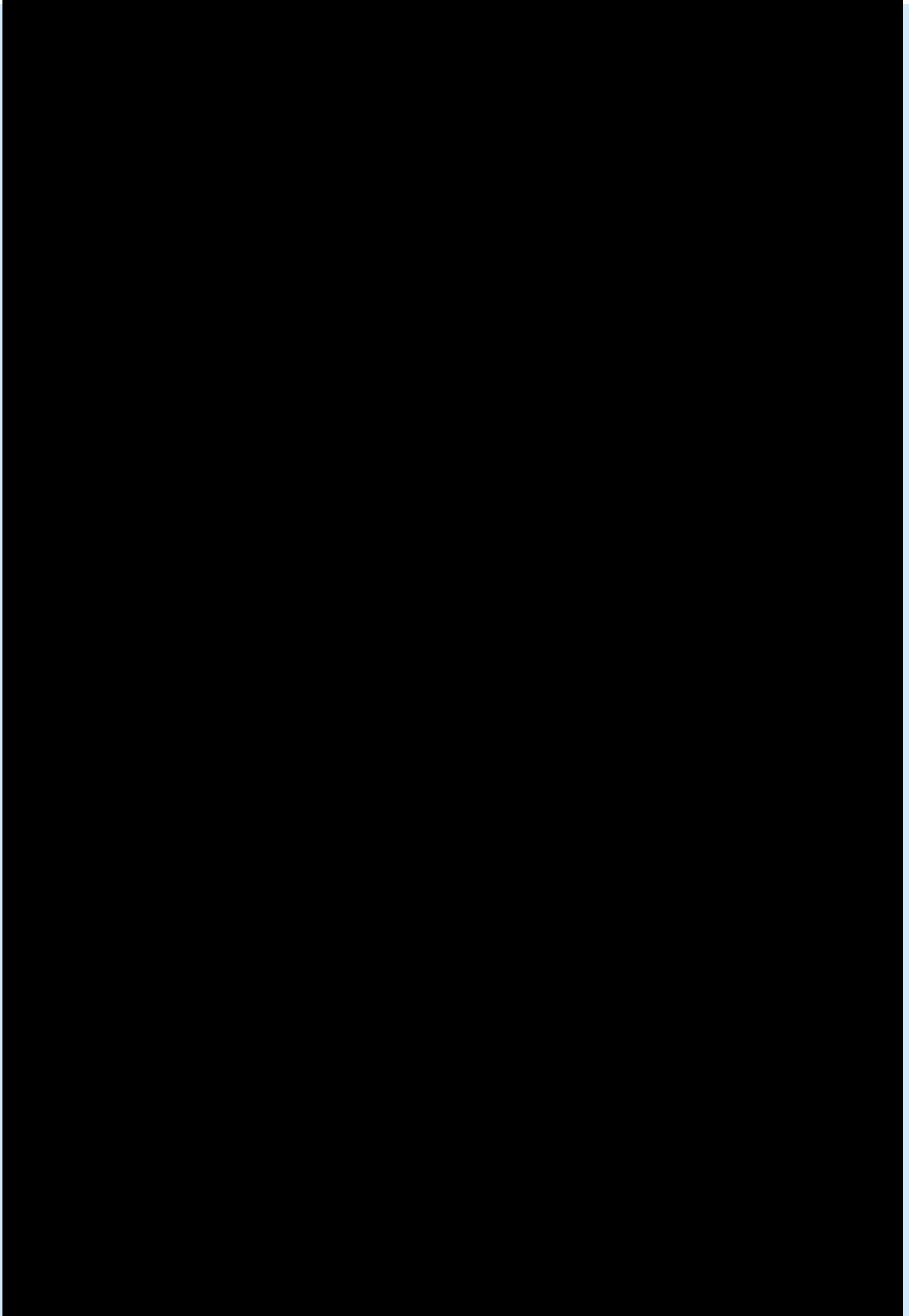
When claiming for PI under the *Compensation (Commonwealth Government Employees) Act 1971* (the 1971 Act), i.e. for compensable injuries or illnesses sustained prior to 30 November 1988, the claim may also be rejected because:

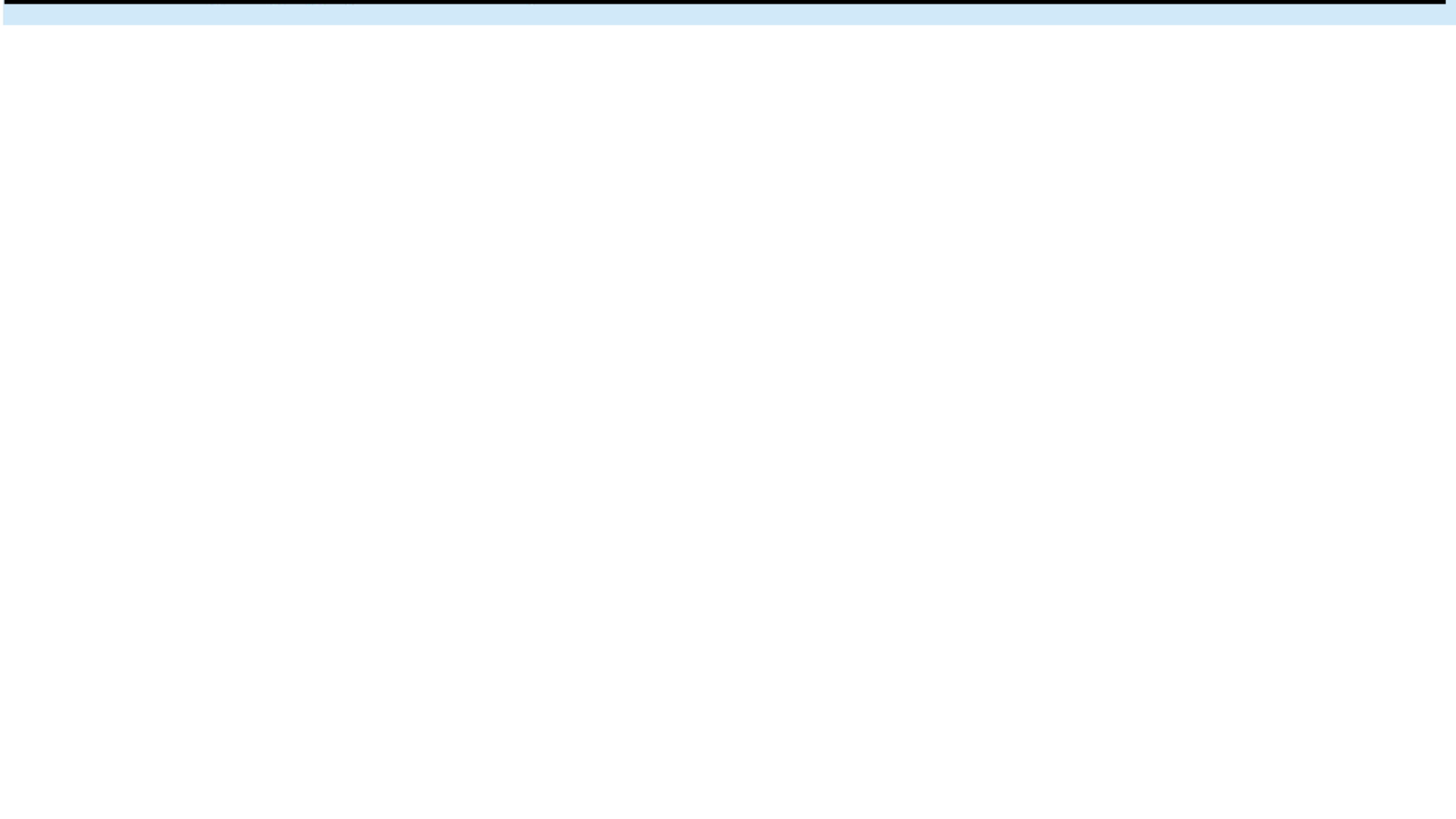
- the condition is not on the Table of Maims, or
- the employee was receiving (or likely to receive) incapacity payments at 30 November 1988 (or likely to receive or continue to receive incapacity payments on or post 30 November 1988).

Refer to section 39 of the 1971 Act for the provisions relating to PI for transitional employees.

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Miscellaneous

Published 03/11/2025

Miscellaneous

The following content relates to miscellaneous topics.

Compensation related to services in a peacekeeping force

Sections 43 and 115 of the SRC Act manage the overlap between the SRC Act and the VEA for persons who are eligible for compensation entitlements under both Acts.

Double Benefits - State workers compensation (section 118(1)) - the same and different injuries

The SRC Act (section 118) provides that compensation is not payable to:

- an employee in respect of an injury, where State workers' compensation has been received for that same injury by the employee, or:
- a dependant of a deceased employee in respect of an injury resulting in death, where State workers' compensation has been received by or paid for the benefit of the dependant in respect of the same injury resulting in death of the employee.

Workers compensation where State Compensation is payable (section 119)

Section 119 of the SRC Act applies to an employee or deceased employee entitled to receive State compensation. An employee or deceased employee is not entitled to receive both State compensation and compensation under the SRC Act for the same injury.

Employees living or travelling overseas

After suffering an injury, employees may leave Australia (whether on short-term or long-term basis) and intend to claim compensation entitlements under the SRC Act whilst they are residing overseas. Sections 3 and 120 are sections of the Act that are relevant to this topic.

Notification of employee death

You may receive notification of the death of an employee who has died as a result of a compensable or non-compensable condition. This page details the process and procedure for actioning a notification of employee death.

Compensation related to services in a peacekeeping force

Introduction

Section 43 of the SRC Act refers to individuals who are eligible to claim compensation entitlements under both the SRC Act and the Veteran's Entitlements Act 1986 (VEA), for claims with a date of injury before 1 July 2004. It allows eligible individuals to select which Act they believe will provide them with the greatest benefits.

Section 43 and section 115 of the SRC Act manage the overlap between the SRC Act and the VEA for persons who are eligible for compensation entitlements under both Acts.

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Eligibility for compensation under both Acts

Section 43 applies to the following eligible individuals:

- a member of a Peacekeeping Force, for the purposes of Part IV of the VEA
- a dependant of a member or veteran as identified above.

An eligible individual can request in writing, to terminate any compensation entitlements payable by Comcare under the SRC Act.

This request can be revoked by the eligible individual or in respect of a person who is under a legal disability, the request can be revoked by another person who Comcare is satisfied represents their interests. Payable compensation entitlements take effect once Comcare has been notified of the revocation, and individuals are not entitled to any retrospective payments.

Example: An Australian Federal Police (AFP) employee suffers an injury during secondment for the Australian Defence Force (ADF) during peacekeeping service in Timor-Leste, formerly known as East Timor, in 2001. The employee is considered an employee of both the AFP and ADF and is therefore eligible to claim compensation entitlements under both the VEA and SRC Acts.

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Background information - dual entitlements

The introduction of the Military Compensation Act 1994 (MCA) allowed the SRC Act to cover ADF employees in operational services. This resulted in injured ADF employees having dual compensation entitlements. This dual eligibility only applies for the veterans who were injured in service **before 1 July 2004**. Currently, section 43 only relates to Peacekeeping Forces. Any reference to other veterans was repealed on 12 October 2017.

Any injury suffered from **1 July 2004** is covered under the Military, Rehabilitation and Compensation Act 2004 (MRCA) and no dual entitlements apply.

Before the commencement of the MRCA in 2004, ADF employees were covered by either the SRC Act or the VEA, depending on the circumstances of their injury. Generally, if injury occurred in non-operational service, then coverage was provided under the SRC Act. If injury occurred during operational services, then employees would be covered under the VEA.

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Deduction of overpayments of repatriation pensions

The SRC Act (section 115) allows for the recovery of overpayments through 'compensation offsetting' where an individual is entitled to receive compensation benefits under both the VEA and SRC Act for the same injury. By law, an individual cannot be compensated twice for the same injury or death. Therefore, the VEA includes provisions to offset any compensation payable against the VEA pension.

The VEA covers service in wartime, certain operational deployments, and certain peacetime service between 7 December 1972 and 30 June 2004.

The SRC Act provides similar rehabilitation and compensation to the employee for incapacity or death as a result of peacetime and peacekeeping service up to and including 30 June 2004 and operational service between 7 April 1994 and 30 June 2004.

Example: An individual claims the VEA pension for incapacity and also lodges a claim under the SRC Act for the same incapacity. The claim is accepted by Comcare and under section 115 of the SRC Act, Comcare pays any incapacity entitlement directly to the Department of Veteran Affairs (DVA), to offset against the VEA entitlement.

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Double benefits – State workers compensation (section 118(1)) - the same and different injuries

Introduction

Employees employed in a peacekeeping force: The guidance on this page is **not** relevant to employees in a peacekeeping force. If the employee was in a peacekeeping force, see Compensation related to service in a peacekeeping force instead.

This page discusses what happens where an employee or their dependent claims entitlements under both the SRC Act, and a State workers' compensation scheme, in respect of the same injury. However, see the section Defence Force employees entitled to compensation for information about national compensation schemes.

Under section 118(6), '**State workers' compensation**' is defined as compensation recoverable under the law of a State, Territory, or a foreign country, relating to workers compensation.

Note that this is different to '**State compensation**', which is defined under section 119(7) as compensation recoverable under a specified law which is a law of a State or Territory that provides for the payment of compensation **other than workers compensation**. See State compensation payable for more information about this type of compensation.

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Employees claiming compensation for the same injury

Section 118(1) of the SRC Act provides that compensation is **not payable** to:

- an employee for an injury where State workers' compensation has been received for **that same injury** by the employee, or
- a dependant of a deceased employee for an injury resulting in death, where State workers compensation has been received by or paid for the benefit of the dependant in respect of **the same injury**.

This is known as the 'double benefits' section.

This section applies to the same injury – that is, compensation payments are not payable under both compensation schemes for the same injury.

For multiple or different injuries, see Employees claiming other compensation for a different or multiple injuries below.

Example of same injury

An employee working for the Commonwealth, and working part-time as a cleaner at a hostel, develops an overuse injury to their left hand. The employee seeks compensation by reference to their duties at the hostel job and is awarded payment by a State workers' compensation scheme. The employee then seeks compensation from Comcare for the same injury, claiming their Commonwealth employment contributed to their overuse injury. The claim against Comcare must be denied under section 118(1) because that employee has already received State workers compensation for the same injury.

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Employees entitled to compensation due to being part of the Defence Force

While the SRC Act has provisions to prevent double payments occurring as a result of state-based compensation claims or third-party damages, it remains mostly silent in regard to national compensation schemes. This causes issues when an employee has another claim under any of the following pieces of legislation:

- the Military Rehabilitation and Compensation Act 2004 (MRCA)
- the Safety, Rehabilitation and Compensation (Defence Related) Act 1988 (DRCA)
- the National Disability Insurance Scheme Act 2013.

For claims with a date of injury before 12 October 2017, the SRC Act had a provision under section 43 to deal with these situations, in which the DVA's compensation payments were offset and only Comcare compensation was paid. However, since the DRCA came into force on 12 October 2017, this offsetting ability is no longer available for DVA compensation payments.

What this means in practice is that for someone receiving incapacity payments under either the DRCA or MRCA for with a date of injury after 12 October 2017, Comcare has no power to stop paying the incapacity compensation they are entitled to under the SRC Act.

Please seek assistance from your Assistant Director in the first instance for these claims.

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Recovery of SRC Act compensation where State workers' compensation is paid for the same injury

Under section 118(2), Comcare may recover the amount paid to an employee or dependant if:

- an employee has already received compensation under the SRC Act in relation to an injury and then receives compensation under a State workers' compensation scheme for the same injury, or
- compensation has been received by or paid for the benefit of a dependant under the SRC Act in respect of an injury resulting in death of the employee and the dependant then receives compensation or has compensation paid for their benefit under a State workers' compensation scheme.

There is no discretion to recover a lesser amount than what Comcare paid.

All recovery processes are conducted by the Debt Recovery team. To find out more about how Comcare recovers money, please visit the [Overpayments](#) and [Recoveries](#) pages.

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Information gathering power for same injury compensation claims

Under section 118(3), when a claim for compensation is received, Comcare may request that the claimant provides a statutory declaration. This needs to state whether the claimant has received any State workers' compensation for the injury for which they are now claiming compensation from Comcare.

A claimant may refuse or fail to supply a statutory declaration without a reasonable excuse. If so, under section 118(4), their rights to compensation under the SRC Act or to bring proceedings under the SRC Act are suspended until a statutory declaration is provided. During the suspension period, no compensation is payable to the claimant. This suspension also extends to the employee's right to institute or continue any proceedings under the SRC Act, including appeals to the Administrative Review Tribunal (ART). For further information on suspension of claim, please refer to [Suspending claims](#).

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Employees claiming other compensation for different or multiple injuries

An employee may claim for other compensation for a different or multiple injuries, such as a total permanent disability (TPD) insurance claim or State or territory workers' compensation. If there is evidence that an employee may be incapacitated for work by an injury that is not covered by Comcare, then enquiries should be made to determine which injury is the cause of current incapacity for work. Comcare is unlikely to be liable to pay compensation for incapacity that is due to a different injury. Compensation for medical treatment may still be payable.

When you become aware of an employee claiming for other compensation, a liability review should occur promptly and with priority. Prior to requesting information, you should flag the situation with the Assistant Director (AD) of the claim and then review liability and assess current incapacity entitlements. Refer to [Claim review process](#) page for further information on how to review the claim.

Once the claim is discussed with your AD, follow the information gathering process to request information relevant to this decision. This may include confirmation from a state-based or private insurer that the employee has claimed for incapacity under their scheme.

If you are unable to get the required information from the employee's treating health practitioner, you may need to arrange an independent medical examination and liaise with the Injury Management team to formulate relevant questions.

It may be open for Comcare to recommence compensation if the employee recovers from the intervening injury and still has an incapacity for work due to their Commonwealth injury. Other

compensation schemes may stop paying for incapacity after a set period regardless of recovery. You should confirm if the other compensation has stopped due to injury recovery as part of your considerations in determining liability.

Seek support: Dealing with multiple injuries due to different incidents is often a complex undertaking and support should be sought from sources such as your Technical Capability Officer (TCO), Assistant Director, the Injury Management team, Clinical Panel, the treating health practitioner and independent medical examiners.

Example of different injury and incapacity payment assessment

Comcare has accepted liability for a neck and lumbar sprain injury causing incapacity. The injury occurred many years ago. The employee is working part time with a new employer and is receiving compensation for partial incapacity. Comcare receives notification from an insurer that the employee has claimed for incapacity with them for fractured wrist. The insurer is requesting information from Comcare.

Comcare gathers information that shows the employee's doctor has certified the employee is totally incapacitated for work as result of their fractured wrist and the employee's incapacity is not impacted by his injury to his neck and lumbar. A state-based insurer is paying compensation for incapacity for work related to the injury. This situation could result in the employee being significantly overpaid by Comcare, so the Claims Manager addresses it with priority. Accordingly, Comcare determines no present liability to pay incapacity compensation for the neck and lumbar sprain. Making a formal determination provides the employee with the ability to seek a review of the decision to stop payments. Reasonable medical treatment for neck and lumbar sprain injury continues to be compensable.

Dealing with multiple injuries due to different incidents is often a complex undertaking and support should be sought from sources such as your Assistant Director, Clinical Panel, the Injury Management team and independent medical examiners where required.

Dealing with multiple injuries due to different incidents is often a complex undertaking and support should be sought from sources such as your Assistant Director, Clinical Panel, the Injury Management team and independent medical examiners where required.

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Information gathering power for different injury compensation claims

As laid out in Comcare's privacy statement, Comcare is authorised to collect and disclose personal information from any relevant third party (including insurer) considered by Comcare to have contributed to, or to have information relevant to, the claimed injury. This includes information related to another injury that may establish Comcare's ongoing liability to pay compensation for the claimed injury.

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Workers' compensation where State compensation is payable (section 119)

Introduction

This page discusses State compensation, including its definition, and how it interacts with workers' compensation paid for under the SRC Act.

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Definition of State compensation and list of Acts

Section 119(7) of the SRC Act defines State compensation as compensation recoverable under a 'specified law'. Specified law is defined as a law of a State or Territory that provides for the payment of compensation, other than workers' compensation. A specified law is declared by the Minister, by legislative instrument, to be a specified law for the purposes of the SRC Act. The laws specified under s119 are those declared in Ministerial Notice number 1 of 2007.

This following lists details current specified Acts by State:

New South Wales

- *Compensation to Relatives Act of 1897*
- *Crimes Act 1990*
- *Damage by Aircraft Act 1952*
- *Civil Aviation (Carrier's Liability) Act 1967*
- *Sporting Injuries Insurance Act 1978*
- *Victims Support and Rehabilitation Act 1996*
- *Motor Accidents Act 1988*
- *Motor Accidents Compensation Act 1999*
- *Motor Accidents Compensation Act 2017*

Victoria

- *Civil Aviation (Carrier's Liability) Act 1961*
- *Victims of Crime Assistance Act 1996*
- *Transport Accident Act 1986*

Queensland

- *Criminal Code Act 1899*
- *Criminal Offence Victims Act 1995*

Western Australia

- *Criminal Code Act Compilation Act 1913*
- *Fatal Accidents Act 1959*
- *Civil Aviation (Carriers' Liability) Act 1961*
- *Damage by Aircraft Act 1964*
- *Criminal injuries Compensation Act 2003*

South Australia

- *Civil Aviation (Carriers' Liability) Act 1962*
- *Victims of Crime Act 2001*

Tasmania

- *Criminal Code Act 1924*
- *Fatal Accidents Act 1934*
- *Civil Aviation (Carriers' Liability) Act 1963*
- *Damage by Aircraft Act 1963*
- *Motor Accidents (Liabilities and Compensation) Act 1983*
- *Victims of Crime Assistance Act 1976*

Australian Capital Territory

- *Crimes Act 1900*
- *Victims of Crime (Financial Assistance) Act 1983*

Northern Territory

- *Compensation (Fatal Injuries) Act*
- *Motor Accidents (Compensation) Act*
- *Victims of Crime Assistance Act*

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Workers compensation under section 119

Section 119 of the SRC Act applies to an employee or a dependent of a deceased employee entitled to receive 'State compensation'. State compensation is not the same as 'State workers compensation' (see definition above for State compensation). See Double benefits – State workers compensation (section 118(1)) - the same and different injuries for more information on State workers compensation.

An employee or the dependant of a deceased employee is not entitled to receive both State compensation and compensation under the SRC Act for the same injury or the same injury resulting in death.

If the employee or dependant claims compensation from Comcare, and State compensation has been received for the same injury or the same injury resulting in death, Comcare is only liable for the amount in excess of the total received from State compensation (section 119(2)).

If an employee has already received compensation under the SRC Act and then receives State compensation for the same injury, Comcare can recover the amount paid to the employee (section 119(3)).

Example: A Commonwealth employee is assaulted in the course of their employment and suffers a fractured arm. Comcare accepted liability for the injury sustained and the employee received compensation payments. After receiving compensation from Comcare, the employee was compensated under the *Victims of Crime Assistance Act 1996* (VCA Act) in Victoria for the same injury. As the VCA Act is a specified law for the purposes of the SRC Act, Comcare is eligible to recover the lesser amount of compensation paid to the employee.

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Recovery by Comcare

Where an amount of compensation is recoverable by Comcare (section 119(3)), the lesser of the following can be recovered:

- either the amount paid under the SRC Act, or
- the amount paid by the State compensation scheme.

All recovery processes are conducted by the Debt Recovery team. To find out more about how Comcare recovers money, please visit the Recoveries page.

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Exceptions, where recovery is not possible

Under section 119(5) Comcare is unable to recover compensation paid under the SRC Act for the benefit of a prescribed child (any weekly payments made under section 17(5)).

Under section 119(6), where a claimant establishes that all, or part, of the State compensation does not relate to the same injury, Comcare cannot recover that compensation.

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Employees living or travelling overseas

Introduction

After suffering an injury, employees may leave Australia (whether on a short-term or long-term basis) and intend to claim compensation entitlements under the SRC Act while they are residing overseas. In these circumstances, there are two relevant provisions of the SRC Act:

- Section 3 provides that the application of the SRC Act extends to all places outside Australia, including the external territories.
- Section 120 provides that employees are required to give notice to Comcare if they depart Australia and have been in receipt of incapacity payments under section 19 for 3 months or longer. The employee can provide notice before they depart, but once they have departed Australia, they must provide notice within 7 days. This is irrespective of whether they intend to return to Australia.

The employee is also required to provide their overseas residential address every three months (section 120(4)).

Employees engaged outside Australia for employment outside Australia: The information in this page is not relevant to employees who were engaged outside Australia for employment outside Australia (locally engaged overseas employees). See [Locally engaged overseas employees](#) for more information.

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Management of claims for employees residing overseas

The usual compensation benefits apply to employees residing overseas, just the same as if they were still resident in Australia. However, there are some practical differences in managing overseas claims. For example, there is a different way of reimbursing medical expenses involving exchange rate conversions. Also, simply obtaining information such as compliant medical certificates may be more difficult in some cases.

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Interpreting foreign language documents

Medical certificates and any other documents provided by the employee in relation to their claim should be provided in English. Where applicable, the employee will need to arrange to have the documents translated into English by a registered translator before sending them to Comcare. Untranslated documents should be returned to the employee for them to arrange the necessary translation.

If for some exceptional reason the overseas employee has been unable to organise translation of the document, the Claims Manager will need to organise the translation. Where it is a routine type of document such as a medical certificate or an invoice, there are interpreting websites that may be sufficient to provide the necessary translation.

For more significant documents such as medical reports, recommendations for treatment, permanent impairment matters, legal matters etc, it would be prudent to engage a professional interpreting service. Claims Managers should discuss these matters with their Assistant Director when considering engaging an interpreting service.

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Compliant overseas medical certificate

As with medical certificates issued in Australia, to be compliant, an overseas medical certificate must:

- contain employee details
- provide the date of examination
- state the diagnosis
- contain a review date (not be open-ended)
- detail the treatment required in relation to the compensable condition
- be signed by the relevantly qualified doctor that examined the employee
- include contact details of the relevantly qualified doctor.

Comcare has designed a medical certificate (certificate of capacity) that, when fully completed, fulfills the requirements under the SRC Act. The use of this form, while preferred, is not mandatory. However, the medical certificate does have to be sufficiently compliant with this form. Overseas employees and their doctors can access this form on the Certificate of capacity page on Comcare's website.

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Overseas legally qualified medical practitioners (LQMP)

From an Australian perspective, a LQMP is a person with legally accepted qualifications to practice medicine. An indication of a medical practitioner's qualifications can be identified by the letters appearing after their name. For example:

- MB.BS = Bachelor of Medicine and Bachelor of Surgery
- FRACP = Fellow of the Royal Australasian College of Physicians
- FRACS = Fellow of the Royal Australasian College of Surgeons
- FRANZCP = Fellow of the Royal Australasian College of Psychiatrists

Medical practitioners in Australia must be registered with the Medical Board of Australia to practice medicine or provide medical services and treatment. The Australian Health Practitioner Regulation Agency (AHPRA) regulates Australia's health practitioners in partnership with various national boards including the Medical Board of Australia.

As to what constitutes a LQMP overseas, the following features should be in place:

- The medical practitioner is registered with that country's ruling medical body to practice medicine or provide medical services and treatment (e.g. the equivalent to the Medical Board of Australia).
- The practitioner must hold the relevant local, legally accepted qualifications and requirements for their field of medicine.

Claims Managers may in some cases be able to seek assistance from relevant authorities such as the Department of Foreign Affairs and Trade (DFAT) via the numerous Australian Embassies, Consulates

and Missions overseas, to assist in clarifying a practitioner's qualifications and registration in that country. No details about the employee or the claim can be provided to these authorities.

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Medical examinations for overseas employees (section 57)

Despite their location, employees residing overseas are subject to the same requirements as an employee residing in Australia. As such, a Claims Manager may arrange for the employee to undergo a medical examination under section 57 of the SRC Act.

The processes involved in arranging medical examinations for overseas employees are much the same as for Australia-based employees.

Legislative requirements for section 57 examinations

When arranging medical examinations for overseas based employees, you must follow the same requirements as for Australia-based employees. Comcare is required to do the following when considering requiring an employee to undergo a section 57 examination.

- You must first rely on existing information to manage the claim.
- If existing information on the claim is insufficient or inconsistent, you must seek further information from the employee's treating health practitioner.
- If a medical examination is required after receiving the information from the employee's treating health practitioner, you must seek and consider the employee's views on the person conducting the examination.
- You must issue a determination under section 57 together with a notice of rights to the employee.
- The frequency of the medical examinations must be no more often than every six months unless certain criteria are met.

Due regard must be had to the location of the employee and the availability of a properly accredited legally qualified medical practitioner (LQMP) in or near that location. The Claims Manager should provide an overseas employee with sufficient notice of an appointment.

For detailed information about independent medical examinations and Comcare's requirements under the legislation, please see [Independent medical examinations](#).

Selecting an examiner and scheduling the appointment

Selecting a legally qualified medical practitioner (LQMP)

In some cases, Claims Managers may be able to conduct their own search for legally qualified medical practitioners (LQMPs)/companies in the required region, for example via the internet. If a potential specialist in the required field of expertise is found, you should contact them to confirm whether they will be able to undertake the medical examination and provide a report. You should also advise overseas specialists conducting section 57 examinations on behalf of Comcare that they may be required to give evidence (by telephone) before an Administrative Review Tribunal if the employee appeals against any subsequent decisions by Comcare.

The Claims Manager may in some cases be able to seek assistance from relevant authorities such as the Department of Foreign Affairs and Trade (DFAT) via the numerous Australian Embassies, Consulates and Missions overseas, to identify an appropriate doctor to undertake the examination. No

details about the employee or the claim can be provided to these authorities. Many Australian Embassy websites have listings of local doctors and their specialties. Alternatively, the Embassy may be able to provide information regarding suitable doctors in their region. The Australian Embassy/Mission may also be able to provide advice regarding transport and accommodation logistics.

Scheduling an examination

Be aware of the geography and characteristics of the region you're dealing with. What may seem like a short or simple journey may prove, in some cases, to be logistically difficult. For example, the employee may live in a remote regional area a long distance from the closest appropriately qualified LQMP in a major city. In such cases where travel costs may be substantial and involve air travel, the Claims Manager can organise for flight bookings and accommodation in the same manner as booking for Australia-based employees.

Reasonable travel costs incurred by the employee attending an overseas medical examination arranged by Comcare can be considered for reimbursement in the same manner as those travelling within Australia.

Other alternatives to the above arrangements would be:

- Ask the employee if they will be in Australia any time in the near future. If so, it may be an opportune time to organise a medical examination to occur during their time in Australia.
- Some Australian medical specialist companies have teleconferencing facilities that could enable a section 57 examination to be conducted by a local, Australian specialist via teleconference in some cases.

Refer to the list of [Our embassies and consulates overseas](#) at the Department of Foreign Affairs and Trade.

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Medical treatment for overseas employees (section 16)

Employees residing overseas must continue to submit medical evidence for Comcare to approve payment of medical treatment. This is usually provided by way of a medical certificate. The provisions in section 16 of the SRC Act apply equally to employees residing overseas. The need for treatment and the frequency and/or duration of medical treatment should be managed in the same manner as for those employees residing in Australia. See the [Medical treatment](#) pages for detailed information.

For medical treatment costs in Australia, guidance on what is appropriate to pay is based on the Australian Medical Association (AMA) rates or allied health rates for each State and Territory. See [Medical and allied health treatment rates](#) for more information.

For treatment provided in other countries, the Claims Manager will need to determine what amount is appropriate to that treatment under section 16 of the SRC Act. The amount charged, once converted to Australian dollars, should be compared with the usual Comcare rate for that same service. If the amount charged appears excessive, the Claims Manager can investigate the matter further by contacting:

- the Australian embassy/consulate in that country to ascertain the level of fees that would generally be considered reasonable for the particular form of treatment

- the association that governs the particular speciality in that country, e.g. that country's Physiotherapy Association.

The treatment cost is paid at the exchange rate applicable at the time the employee paid for the treatment. The Reserve Bank of Australia (RBA) is the appropriate source for this information.

The employee is therefore reimbursed for the actual cost incurred, i.e. the Australian dollars (AUD) amount actually paid for that treatment. In the unlikely event that the service provider invoices Comcare directly, the same methodology would apply to payment to the overseas provider.

The Claims Administration and Income Support (CAIS) team would normally arrange for these transactions to occur.

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Incapacity payments for overseas employees

An employee residing overseas is entitled to receive incapacity payments in the same circumstances as if they were residing in Australia. The employee must submit medical evidence for Comcare to consider liability for incapacity payments. This is usually by way of a compliant medical certificate. For separated employees, Comcare will pay any entitlement into the employee's nominated Australian or overseas bank account. Payment is not available by any other means, e.g. cheque or money orders.

Employees residing overseas can incur various unavoidable bank fees and charges on payment transfers. The SRC Act contains no authority for the payment of any bank fees or charges.

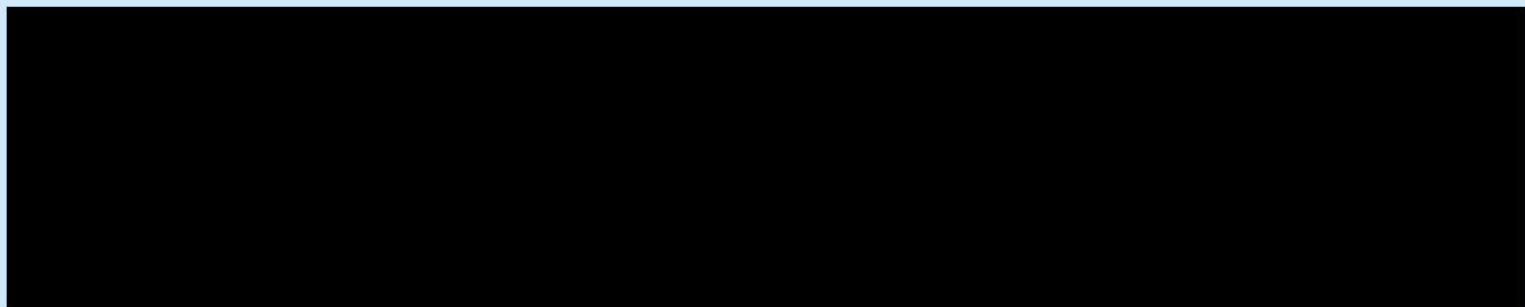
Transaction fees (including those for overseas money transfers) are not part of any compensation entitlement under the SRC Act. Comcare has no authority to pay them or deduct them from compensation payments, regardless of whether the fee is levied by an overseas bank or a local bank. Therefore, Comcare cannot top up compensation payments to allow for the cost of overseas funds transfers.

Reporting overseas travel or moving overseas

When an employee with a claim for compensation plans to travel overseas, they may have reporting requirements under section 120 of the SRC Act. This applies **only** to employees who have been receiving incapacity payments under section 19 of the SRC Act for three months or longer.

However, any employee who advises you they will be overseas can have a comment entered on their claim file to inform Comcare staff about their travel. Travel may impact communications, for example, and so it is good practice to record details when they are provided to you. Follow the procedure to update employee's overseas details.

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the 1990s, the number of people in the UK who are employed in the public sector has increased by 1.5 million (from 2.5 million in 1980 to 4 million in 1998). The public sector has become a major employer in the UK, and this has implications for the way in which the public sector is managed and the way in which it is funded.

The public sector is a complex organisation, and it is difficult to understand how it works. The public sector is made up of many different organisations, each of which has its own role to play. The public sector is responsible for providing a wide range of services, including health care, education, and social services. The public sector is also responsible for the management of the country's infrastructure, including roads, bridges, and public transport.

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Rehabilitation for overseas employees

The SRC Act provides the employer or Rehabilitation Authority (RA) with options to ensure rehabilitation occurs when an employee relocates overseas. The fact that an employee is residing overseas does not prevent the RA from deciding an employee should be assessed as capable of undertaking or should undertake a rehabilitation program.

Section 36 rehabilitation assessment while overseas

Under section 36(3) the RA can direct the employee to undertake an in-person rehabilitation examination. Deciding to do so will depend on the circumstances and the level of understanding of the employee's current fitness to engage in rehabilitation. The employee can be assessed overseas or remotely by an appropriate individual. If the employee unreasonably refuses to undertake an assessment, their compensation must be suspended under section 36(4). See [Suspending claims for more information on suspensions](#).

See [Rehabilitation assessments](#) for more information about section 36 assessments.

Section 37 rehabilitation program while overseas

Under section 37(1) the RA has the power to decide to provide a rehabilitation program with or without a section 36 assessment (natural justice still applies). If the RA deems that it is not reasonable to provide rehabilitation overseas or remotely, the RA is entitled to require the employee to undertake their rehabilitation program in any case. When an employee has an open rehabilitation program, and they unreasonably fail to participate, the employer must suspend their incapacity compensation under section 37(7).

See [Rehabilitation programs](#) for more information.

Section 19(4)(e)(f) Deeming ability to earn

In the context of compensation for incapacity, rehabilitation should be provided wherever possible, as return to work is known to have substantial benefits. If rehabilitation is required and a program is appropriate, services may still not be able to be provided due to the employee being overseas. If that is the case, the employee should, all other things being equal, return to Australia to undertake their rehabilitation if they wish to avoid non-compliance with their rehabilitation program.

Section 19(4) may apply where an employee had or has an offer of employment (section 19(4)(e)) or an active rehabilitation program (section 19(4)(f)) aiming to secure employment. If the employee removes themselves from the possibility of that employment by relocating overseas, consideration should be given to the amount the employee is able to earn as well as their actual earnings when calculating their compensation. The Claims Manager must consider if the employee has a reasonable excuse for any such failure. See Assessment of ability to earn for more information about assessing ability to earn.

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Notification of employee death

Introduction

You may receive notification of the death of an employee who has died as a result of a compensable or non-compensable condition.

You will usually receive such a notification from:

- the employer
- the rehabilitation provider
- the legal representative of the employee, or
- a family member of the employee.

Notification of the death of an employee may be received verbally or by written correspondence.

Important – minimisation of overpayments: When you receive notification of the death of an employee, it must be actioned within 24 hours of receipt to prevent any overpayments from occurring and to action any previous overpayments that may have occurred.

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Responsibility for managing death claims

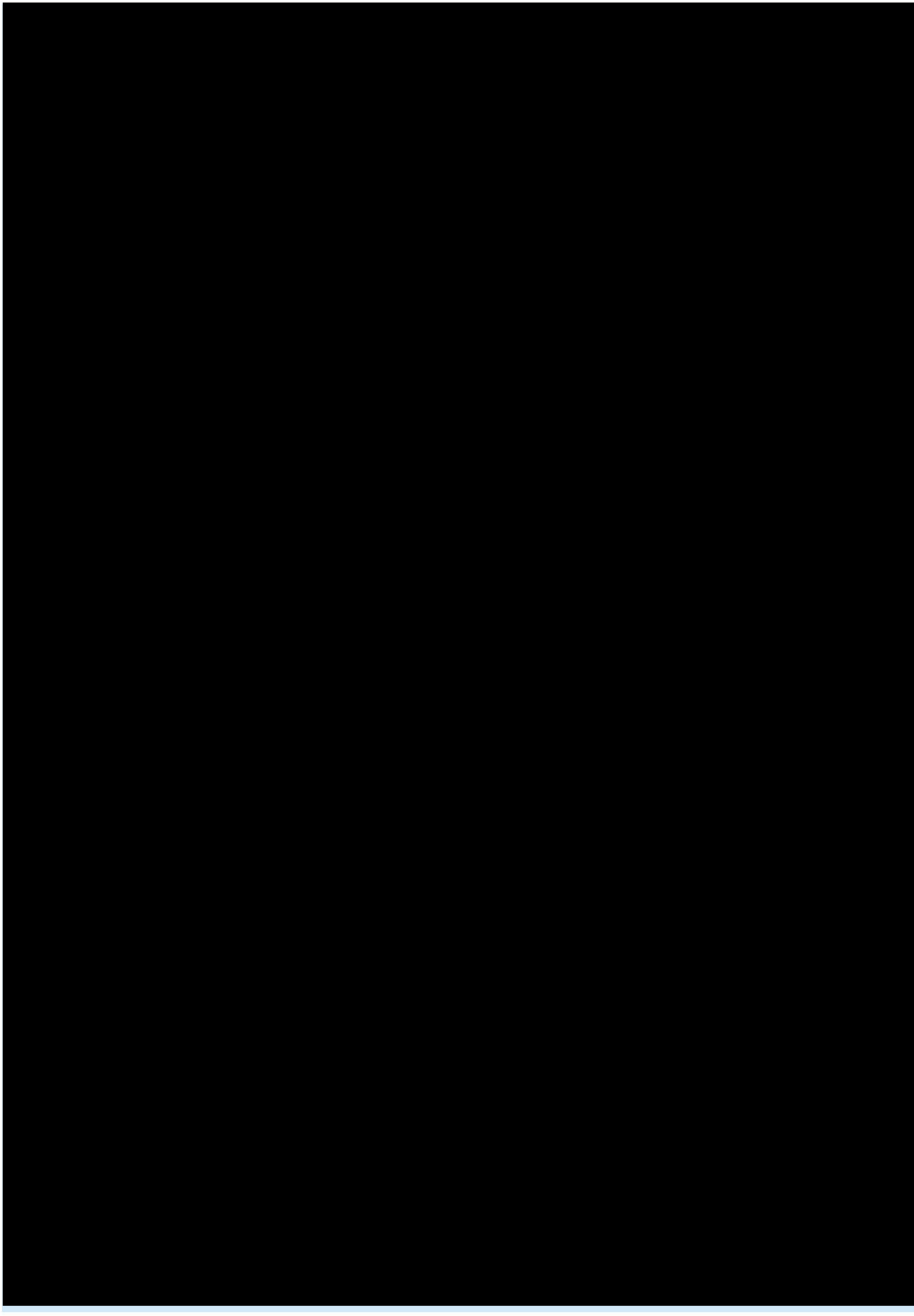
The Specialised Claims Team (SCT) is responsible for determination of liability under [section 17](#) of the SRC Act for all work-related death claims. However, where the death of the employee is not related to the compensable condition(s), you are responsible for any actions required.

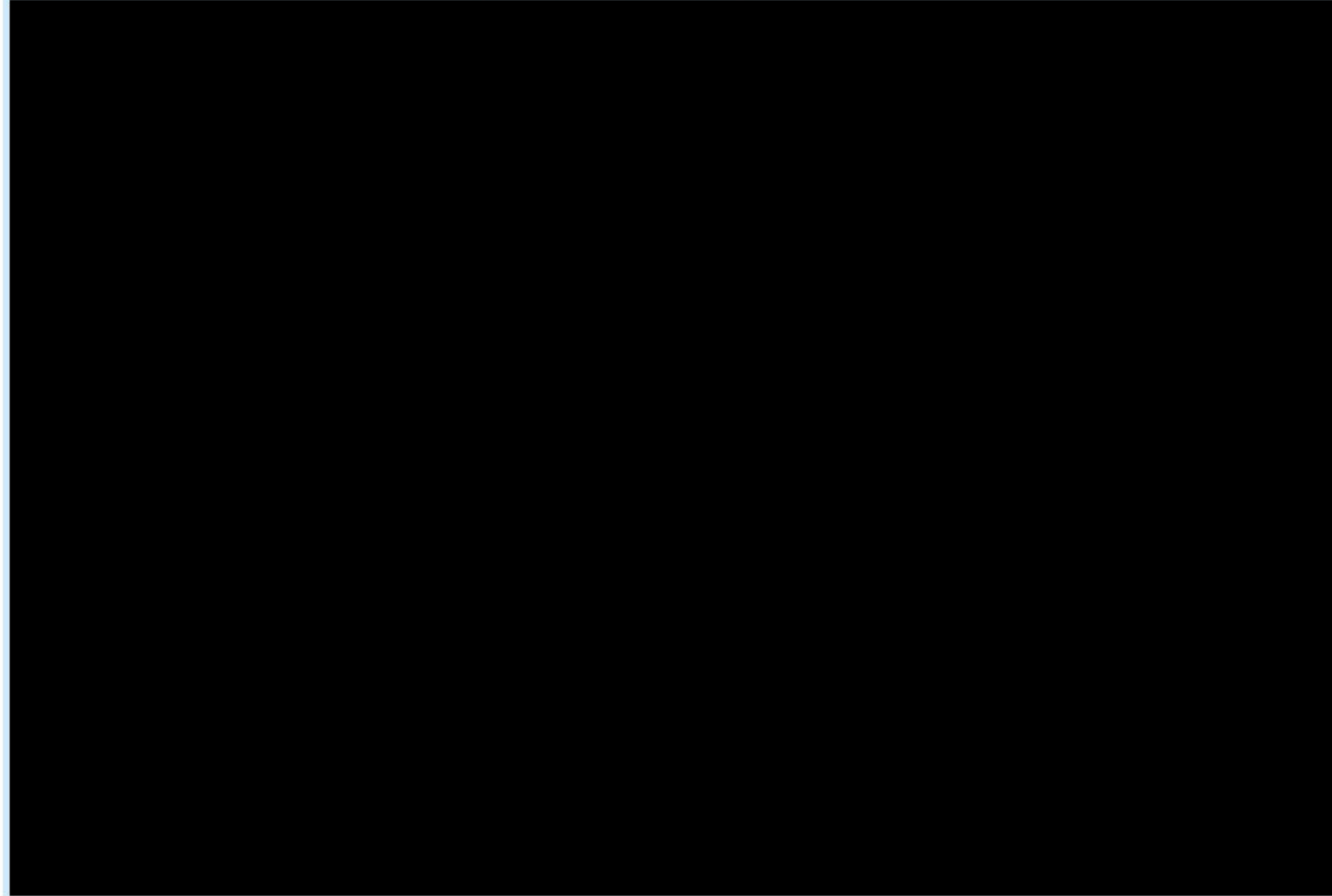
In cases where the cause of death is uncertain or there are possible multiple causes of death, you can discuss the claim with SCT.

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Closure

Closure

Closure is the final stage of the claim lifecycle when all actions on the claim have been actioned and/or the employee has returned to health and, where possible, work.

The closure process and objectives

When a claim is identified manually or through an automated report that it is suitable for closure, the claim will be administratively closed.

Our objective for this stage of the claim's lifecycle is that there is timely administrative closure of a claim when closure criteria are met.

Closing a claim

Where certain criteria are met, a claim is to be closed for administrative reasons. This page provides information on [identifying claims for closure](#) and [how to close a claim in Pracsys](#).

Reopening a claim and closed claim management

Information may be received about a claim that is administratively closed. In some cases, the claim can remain closed and in other cases, the claim needs to be reopened. This page provides information on [when a claim should be reopened](#), [how to action a task on a closed claim](#), and [how to reopen a claim](#).



Closing a claim



Reopening a claim and closed claim management

Closing a claim

Introduction

Where there has been no recent activity on a claim the claim should be closed for administrative reasons. As the SRC Act is a long tail scheme, a claim with accepted liability cannot be permanently closed unless there is a change in the liability status. Instead, a claim is administratively closed in our system so that it is moved off a Claims Manager's case load.

A claim closed for administrative reasons does not prevent an employee from providing further information and/or claiming benefits in relation to their compensable condition in the future. If this occurs, the claim can be re-opened. For further guidance, refer to the Reopening a claim page.

A claim can also be closed without being determined, if the employee has not provided sufficient information for a claim to be considered a claim under the SRC Act. For further guidance, refer to the Refusing to deal with a claim page.

A claim cannot be closed in Pracsys if there are outstanding:

- diaries
- treatment plans
- rehabilitation programs
- claims requiring determination
- invoices requiring payment
- ongoing reconsiderations or ART cases, or
- overpayments.

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Identifying open claims for closure

Assistant Directors and Claims Support Officers are provided a monthly report on open claims that can potentially be closed.

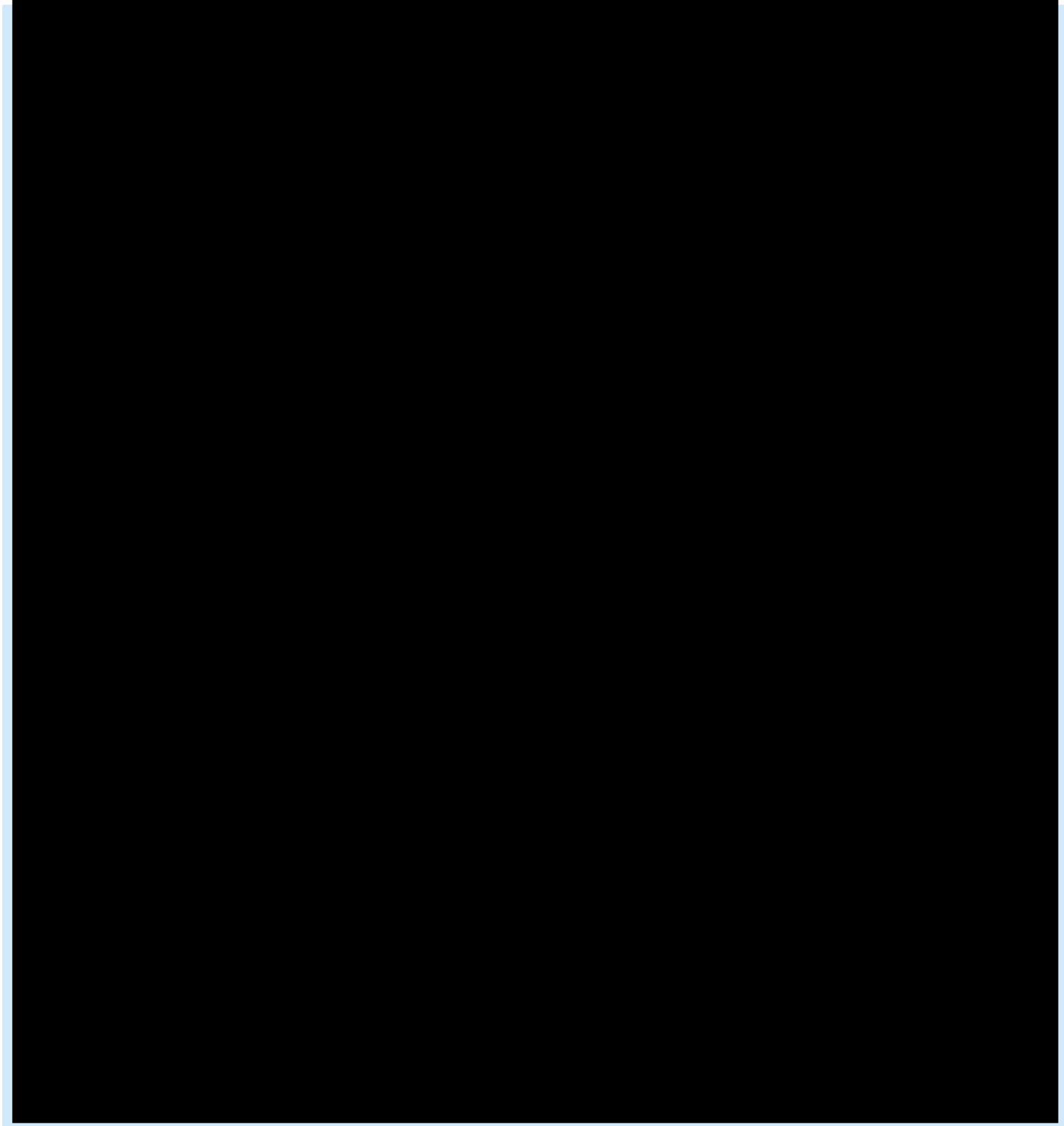
Working with your Assistant Director/s, the Claims Support Officers are expected to review the report monthly and:

- notify the Assistant Director of their intention to close the claim and, if there are no concerns raised, administratively close those claims with no outstanding items on them
- take action, as far as possible, to close outstanding items on claims.

Pracsys comments: Upon investigation of claims identified for closure, if actions are required, please ensure a relevant comment is added in Pracsys.

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Reopening a claim & closed claim management

Published 31/07/2025

Introduction

There may be circumstances when a closed claim needs to be reopened.

Most closed claims are allocated to Assistant Directors as per the agency alignment, although some are allocated to a Claims Manager. All claims allocated to the Specialised team are allocated to the team's Assistant Director. This ensures there is a consistent approach to the allocation and management of closed claims across the Claims Management Group.

Closure of claims is an administrative process in the claim lifecycle. For further guidance, refer to the Closing a claim page. The Assistant Director will receive a notification in Pracsys when a new document is scanned to a claim file that is closed, or a new invoice is processed on a closed claim. The Assistant Director will decide whether any action needs to be taken, including whether the claim needs to be reopened. They will then allocate the claim for action. Depending on the circumstances, the claim may need to go back to triage.

To reopen a claim, see the Procedure to reopen a claim.

To action a task on a closed claim (without reopening it), see the Procedure to action a task on a closed claim.

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When should a claim be reopened?

A claim should be re-opened when:

- an invoice is received that requires payment or investigation
- a claim for benefits (e.g. incapacity, medical treatment, permanent impairment) is made by an employee (or their representative) that may require further investigation
- correspondence is received from an employer relating to the claim for benefits
- a reconsideration or ART appeal is initiated
- rehabilitation action is being undertaken.

The decision to reopen or close a claim file is not a liability determination. It is purely an administrative process. Reopening a claim file for the purposes of investigating a claim for benefits does not automatically mean the employee is entitled to those benefits. Each claim for a benefit (e.g. medical treatment, permanent impairment) will still need to be assessed against the relevant legislative criteria for that benefit. The decision to reopen the claim file will have no bearing on the outcome.

A claim should **not** be re-opened when the information/document to be added to the claim file is:

- a duplicate of something already on the claim file
- unrelated to the claim (e.g. document added to the wrong claim file).

To reopen a claim, see the Procedure to reopen a claim.

